DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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

[CMS–1390–P]

RIN 0938–AP15

Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2009 Rates; Proposed Changes to Disclosure of Physician Ownership in Hospitals and Physician Self-Referral Rules; Proposed Collection of Information Regarding Financial Relationships Between Hospitals and Physicians

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

ACTION: Proposed rule.

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

Among the other policy decisions and changes that we are proposing to make are changes related to: Limited proposed revisions of the classification of cases to Medicare severity diagnosis-related groups (MS–DRGs), proposals to address charge compression issues in the calculation of MS–DRG relative weights, the proposed revisions to the classifications and relative weights for the Medicare severity long-term care diagnosis-related groups (MS–LTC–DRGs); applications for new medical services and technologies add-on payments; wage index reform changes and the wage data, including the occupational mix data, used to compute the proposed FY 2009 wage indices; submission of hospital quality data; proposed changes to the postacute care transfer policy relating to transfers to home for the furnishing of home health services; and proposed policy changes relating to the requirements for furnishing hospital emergency services under the Emergency Medical Treatment and Labor Act of 1986 (EMTALA).

In addition, we are proposing policy changes relating to disclosure to patients of physician ownership or investment interests in hospitals and soliciting public comments on a proposed collection of information regarding financial relationships between hospitals and physicians. We are also proposing changes or soliciting comments on issues relating to policies on physician self-referrals.

DATES: To be assured consideration, comments must be received at one of the addresses provide below, no later than 5 p.m. E.S.T. on June 13, 2008.

ADDRESSES: When commenting on issues presented in this proposed rule, please refer to filecode CMS–1390–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically*. You may submit electronic comments on this regulation to *http://www.regulations.gov*. Follow the instructions for ''Comment or Submission'' and enter the file code CMS–1390–P to submit comments on this proposed rule.

2. *By regular mail*. You may mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, *Attention:* CMS–1390–P, P.O. Box 8011, Baltimore, MD 21244–1850.

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

3. *By express or overnight mail*. You may send written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, *Attention:* CMS–1390–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier*. If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to either of the following addresses:

a. Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201.

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

b. 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786-7195 in advance to schedule your arrival with one of our staff members.

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

Submission of comments on paperwork requirements. You may submit comments on this document's paperwork requirements by following the instructions at the end of the ''Collection of Information Requirements'' section in this document.

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

FOR FURTHER INFORMATION, CONTACT:

Michele Hudson, (410) 786–4487, Operating Prospective Payment, MS–DRGs, Wage Index, New Medical Service and Technology Add-On Payments, Hospital Geographic Reclassifications, and Postacute Care Transfer Issues.

Tzvi Hefter, (410) 786–4487, Capital Prospective Payment, Excluded Hospitals, Direct and Indirect Graduate Medical Education, MS–LTC–DRGs, EMTALA, Hospital Emergency Services, and Hospital-within-Hospital Issues.

Siddhartha Mazumdar, (410) 786–6673, Rural Community Hospital Demonstration Program Issues.

Sheila Blackstock, (410) 786–3502, Quality Data for Annual Payment Update Issues.

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

Anne Hornsby, (410) 786–1181, Collection of Managed Care Encounter Data Issues.

Jacqueline Proctor, (410) 786–8852, Disclosure of Physician Ownership in

Hospitals and Financial Relationships between Hospitals and Physicians Issues.

Lisa Ohrin, (410) 786–4565, and Don Romano, (410) 786–1404, Physician Self-Referral Issues.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: *http://www.regulations.gov*. Follow the search instructions on that Web site to view public comments.

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Acronyms

AARP American Association of Retired Persons
AAHKS American Association of Hip and Knee Surgeons
AAMC Association of American Medical Colleges
ACGME Accreditation Council for Graduate Medical Education
AF Artrial fibrillation
AHA American Hospital Association
AICD Automatic implantable cardioverter defibrillator
AHIMA American Health Information Management Association
AHIC American Health Information Community
AHRQ Agency for Healthcare Research and Quality
AMA American Medical Association
AMGA American Medical Group Association
AMI Acute myocardial infarction
AOA American Osteopathic Association
APR DRG All Patient Refined Diagnosis Related Group System
ASC Ambulatory surgical center
ASITN American Society of Interventional and Therapeutic Neuroradiology
BBA Balanced Budget Act of 1997, 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
CARE [Medicare] Continuity Assessment Record & Evaluation [Instrument]
CART CMS Abstraction & Reporting Tool
CBSAs Core-based statistical areas
CC Complication or comorbidity
CCR Cost-to-charge ratio
CDAC [Medicare] Clinical Data Abstraction Center
CDAD *Clostridium difficile*-associated disease
CIPI Capital input price index
CMI Case-mix index
CMS Centers for Medicare & Medicaid Services
CMSA Consolidated Metropolitan Statistical Area
COBRA Consolidated Omnibus Reconciliation Act of 1985, Pub. L. 99–272
CoP [Hospital] condition of participation
CPI Consumer price index
CY Calendar year
DFRR Disclosure of financial relationship report
DRA Deficit Reduction Act of 2005, Pub. L. 109–171
DRG Diagnosis-related group
DSH Disproportionate share hospital
DVT Deep vein thrombosis
ECI Employment cost index
EMR Electronic medical record
EMTALA Emergency Medical Treatment and Labor Act of 1986, Pub. L. 99–272
FAH Federation of Hospitals
FDA Food and Drug Administration
FHA Federal Health Architecture
FIPS Federal information processing standards
FQHC Federally qualified health center
FTE Full-time equivalent
FY Fiscal year
GAAP Generally Accepted Accounting Principles
GAF Geographic Adjustment Factor
GME Graduate medical education
HACs Hospital-acquired conditions
HCAHPS Hospital Consumer Assessment of Healthcare Providers and Systems
HCFA Health Care Financing Administration
HCRIS Hospital Cost Report Information System
HHA Home health agency
HHS Department of Health and Human Services
HIC Health insurance card
HIPAA Health Insurance Portability and Accountability Act of 1996, Pub. L. 104–191
HIPC Health Information Policy Council
HIS Health information system
HIT Health information technology
HMO Health maintenance organization
HPMP Hospital Payment Monitoring Program
HSA Health savings account
HSCRC [Maryland] Health Services Cost Review Commission
HSRV Hospital-specific relative value
HSRVcc Hospital-specific relative value cost center
HQA Hospital Quality Alliance
HQI Hospital Quality Initiative
HWH Hospital-within-a hospital
ICD–9–CM International Classification of Diseases, Ninth Revision, Clinical Modification
ICD–10–PCS International Classification of Diseases, Tenth Edition, Procedure Coding System
ICR Information collection requirement
IHS Indian Health Service
IME Indirect medical education
IOM Institute of Medicine
IPF Inpatient psychiatric facility
IPPS [Acute care hospital] inpatient prospective payment system
IRF Inpatient rehabilitation facility
LAMCs Large area metropolitan counties
LTC–DRG Long-term care diagnosis-related group
LTCH Long-term care hospital
MA Medicare Advantage
MAC Medicare Administrative Contractor
MCC Major complication or comorbidity
MCE Medicare Code Editor
MCO Managed care organization
MCV Major cardiovascular condition
MDC Major diagnostic category
MDH Medicare-dependent, small rural hospital
MedPAC Medicare Payment Advisory Commission
MedPAR Medicare Provider Analysis and Review File
MEI Medicare Economic Index
MGCRB Medicare Geographic Classification Review Board
MIEA–TRHCA Medicare Improvements and Extension Act, Division B of the Tax Relief and Health Care Act of 2006, 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
MRSA Methicillin-resistant *Staphylococcus* aureus
MSA Metropolitan Statistical Area
MS–DRG Medicare severity diagnosis-related group
MS–LTC–DRG Medicare severity long-term care diagnosis-related group
NAICS North American Industrial Classification System
NCD National coverage determination

NCHS National Center for Health Statistics
NCQA National Committee for Quality Assurance
NCVHS National Committee on Vital and Health Statistics
NECMA New England County Metropolitan Areas
NQF National Quality Forum
NTIS National Technical Information Service
NVHRI National Voluntary Hospital Reporting Initiative
OES Occupational employment statistics
OIG Office of the Inspector General
OMB Executive Office of Management and Budget
O.R. Operating room
OSCAR Online Survey Certification and Reporting [System]
PE Pulmonary embolism
PMSAs Primary metropolitan statistical areas
POA Present on admission
PPI Producer price index
PPS Prospective payment system
PRM Provider Reimbursement Manual
ProPAC Prospective Payment Assessment Commission
PRRB Provider Reimbursement Review Board
PSF Provider-Specific File
PS&R Provider Statistical and Reimbursement (System)
QIG Quality Improvement Group, CMS
QIO Quality Improvement Organization
RCE Reasonable compensation equivalent
RHC Rural health clinic
RHQDAPU Reporting hospital quality data for annual payment update
RNHCI Religious nonmedical health care institution
RRC Rural referral center
RUCAs Rural-urban commuting area codes
RY Rate year
SAF Standard Analytic File
SCH Sole community hospital
SFY State fiscal year
SIC Standard Industrial Classification
SNF Skilled nursing facility
SOCs Standard occupational classifications
SOM State Operations Manual
TEFRA Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248
TMA TMA [Transitional Medical Assistance], Abstinence Education, and QI [Qualifying Individuals] Programs Extension Act of 2007, Pub. L. 110–09
TJA Total joint arthroplasty
UHDDS Uniform hospital discharge data set
VAP Ventilator-associated pneumonia
VBP Value-based purchasing

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Addendum—Proposed Schedule of Standardized Amounts, Update Factors, and Rate-of-Increase Percentages Effective With Cost Reporting Periods Beginning On or After October 1, 2008

I. Background

A. Summary

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

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

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

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

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

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

payment, it would be inadequately paid under the regular DRG payment.

The costs incurred by the hospital for a case are evaluated to determine whether the hospital is eligible for an additional payment as an outlier case. This additional payment is designed to protect the hospital from large financial losses due to unusually expensive cases. Any outlier payment due is added to the DRG-adjusted base payment rate, plus any DSH, IME, and new technology or medical service add-on adjustments.

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

Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of inpatient hospital services ''in accordance with a prospective payment system established by the Secretary.'' The basic methodology for determining capital prospective payments is set forth in our regulations at 42 CFR 412.308 and 412.312. Under the capital IPPS, payments are adjusted by the same DRG for the case as they are under the operating IPPS. Capital IPPS payments are also adjusted for IME and DSH, similar to the adjustments made under the operating IPPS. However, as discussed in section V.B.2. of this preamble, we are phasing out the IME adjustment beginning with FY 2008. 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. For cost reporting periods beginning on or after January 1, 2008, all IPFs are paid 100 percent of the Federal per diem payment amount established under the IPF PPS. (For cost reporting periods beginning on or after January 1, 2005, and ending on or before December 31, 2007, some IPFs received transitioned payments for inpatient hospital services based on a blend of reasonable cost-based payment and a Federal per diem payment rate.) The existing regulations governing payment under the IPF PPS are located in 42 CFR part 412, Subpart N.

3. Critical Access Hospitals (CAHs)

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

4. Payments for Graduate Medical Education (GME)

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

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

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

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

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

Section 106(b)(2) of the MIEA–TRHCA instructs the Secretary of Health and Human Services to include in the FY 2009 IPPS proposed rule one or more proposals to revise the wage index adjustment applied under section 1886(d)(3)(E) of the Act for purposes of the IPPS. The Secretary was also instructed to consider MedPAC's recommendations on the Medicare wage index classification system in developing these proposals. In section III. of the preamble of this proposed rule, we discuss MedPAC's recommendations in a report to Congress and present our proposed changes to the FY 2009 wage index in response to those recommendations.

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

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

E. Major Contents of This Proposed Rule

In this proposed rule, we are setting forth proposed changes to the Medicare IPPS for operating costs and for capital-related costs in FY 2009. We also are setting forth proposed changes relating to payments for IME costs and payments to certain hospitals and units that continue to be excluded from the IPPS and paid on a reasonable cost basis. In addition, we are presenting proposed changes relating to disclosure to patients of physician ownership and investment interests in hospitals, proposed changes to our physician self-referral regulations, and a solicitation of public comments on a proposed collection of information regarding financial relationships between hospitals and physicians.

The following is a summary of the major changes that we are proposing to make:

1. Proposed Changes to MS–DRG Classifications and Recalibrations of Relative Weights

In section II. of the preamble to this proposed rule, we are including—

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

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

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

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

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

2. Proposed Changes to the Hospital Wage Index

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

- Proposed wage index reform changes in response to recommendations made to Congress as a result of the wage index study required under Pub. L. 109–432. We discuss changes related to reclassifications criteria, application of budget neutrality in reclassifications, and the rural floor and imputed floor budget neutrality at the State level.
- Changes to the CBSA designations.
- The methodology for computing the proposed FY 2009 wage index.
- The proposed FY 2009 wage index update, using wage data from cost reporting periods that began during FY 2006.
- Analysis and implementation of the proposed FY 2009 occupational mix adjustment to the wage index.
- Proposed revisions to the wage index based on hospital redesignations and reclassifications.
- The proposed adjustment to the wage index for FY 2009 based on commuting patterns of hospital employees who reside in a county and work in a different area with a higher wage index.
- The timetable for reviewing and verifying the wage data used to compute the proposed FY 2009 wage index.
- The proposed labor-related share for the FY 2009 wage index, including the labor-related share for Puerto Rico.

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

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

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

plan and current testing and further development of the plan.

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

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

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

5. Proposed Changes to the Payment Rates for Excluded Hospitals and Hospital Units: Rate-of-Increase Percentages

In section VI. of the preamble to this proposed rule, we discuss proposed changes to payments to excluded hospitals and hospital units, proposed changes for determining LTCH CCRs under the LTCH PPS, including a discussion regarding changing the annual payment rate update schedule for the LTCH PPS, and proposed changes to the regulations on hospitals-within-hospitals.

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

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

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

In section VIII. of the preamble of this proposed rule, we present proposed changes to the policies on physician self-referrals relating to the ''Stand in Shoes'' provision, In addition, we solicit public comments regarding physician-owned implant companies and gainsharing arrangements.

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

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

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

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

10. Impact Analysis

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

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

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

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

12. Disclosure of Financial Relationships Report (DFRR) Form

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

13. Discussion of Medicare Payment Advisory Commission Recommendations

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

F. Public Comments Received on Issues in Related Rules

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

In the FY 2008 IPPS final rule with comment period, we solicited public comments on our policy changes related to phase-out of the capital teaching adjustment to the capital payment update under the IPPS (72 FR 47401). We received approximately 90 timely pieces of correspondence in response to our solicitation. (These public comments may be viewed on the following Web site: *http://www.cms.hhs.gov/eRulemaking/ECCMSR/list.asp* under file code CMS–1533–FC.) In section V. of the preamble of this proposed rule, we acknowledge receipt of these public comments and again solicit public comments on the phase-out in this proposed rule. We will respond to the public comments received in response to both the FY 2008 IPPS final rule with comment period and this proposed rule in the FY 2009 IPPS final rule, which is scheduled to be published in August 2008.

2. Policy Revisions Related to Medicare GME Group Affiliations for Hospitals in Certain Declared Emergency Areas

We have issued two interim final rules with comment periods in the **Federal Register** that modified the GME

regulations as they apply to Medicare GME affiliated groups to provide for greater flexibility in training residents in approved residency programs during times of disasters: on April 12, 2006 (71 FR 18654) and on November 27, 2007 (72 FR 66892). We received a number of timely pieces of correspondence in response to these interim final rules with comment period. (The public comments that we received may be viewed on the Web site at: *http://www.cms.hhs.gov/eRulemaking/ECCMSR/list.asp* under the file codes CMS–1531–IFC1 and CMS–1531–IFC2, respectively.) We will summarize and address these public comments in the FY 2009 IPPS final rule, which is scheduled to be published in August 2008.

II. Proposed Changes to Medicare Severity DRG (MS–DRG) Classifications and Relative Weights

A. Background

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

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

B. MS–DRG Reclassifications

1. General

As discussed in the preamble to the FY 2008 IPPS final rule with comment period (72 FR 47138), we focused our efforts in FY 2008 on making significant reforms to the IPPS consistent with the recommendations made by MedPAC in its ''Report to the Congress, Physician-Owned Specialty Hospitals'' in March 2005. MedPAC recommended that the Secretary refine the entire DRG system by taking 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. For FY 2008, we adopted 745 new Medicare Severity DRGs (MS–DRGs) to replace the CMS DRGs. We refer readers to section II.D. of the FY 2008 IPPS final rule with comment period for a full detailed discussion of how the MS–DRG system was established based on severity levels of illness (72 FR 47141).

Currently, cases are classified into MS–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 MS–DRGs, classification is also based on the age, sex, and discharge status of the patient. The diagnosis and procedure information is reported by the hospital using codes from the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD–9–CM).

The process of forming the MS–DRGs was begun by dividing all possible principal diagnoses into mutually exclusive principal diagnosis areas, referred to as Major Diagnostic Categories (MDCs). The MDCs were 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 MS–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 2008, cases are assigned to one of 745 MS–DRGs in 25 MDCs. The table below lists the 25 MDCs.

MAJOR DIAGNOSTIC CATEGORIES (MDCS)

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

In general, cases are assigned to an MDC based on the patient's principal diagnosis before assignment to an MS–DRG. However, under the most recent version of the Medicare GROUPER (Version 26.0), there are 9 MS–DRGs to

[1] Medicare Payment Advisory Commission: *Report to the Congress, Physician-Owned Specialty Hospitals,* March 25, page viii.

which cases are directly assigned on the basis of ICD–9–CM procedure codes. These MS–DRGs are for heart transplant or implant of heart assist systems, liver and/or intestinal transplants, bone marrow transplants, lung transplants, simultaneous pancreas/kidney transplants, pancreas transplants, and for tracheostomies. Cases are assigned to these MS–DRGs before they are classified to an MDC. The table below lists the nine current pre-MDCs.

PRE-MAJOR DIAGNOSTIC CATEGORIES (PRE-MDCS)

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

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) or a major complication or comorbidity (MCC).

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

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

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

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

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

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

As we indicated above, for FY 2008, we made significant improvement in the DRG system to recognize severity of illness and resource usage by adopting MS–DRGs. The changes we adopted were reflected in the FY 2008 GROUPER, Version 25.0, and were effective for discharges occurring on or after October 1, 2007. Our DRG analysis for the FY 2008 final rule with comment period was based on data from the March 2007 update of the FY 2006 MedPAR file, which contained hospital bills received through March 31, 2007, for discharges occurring through September 30, 2006. For this proposed rule, for FY 2009, our DRG analysis is based on data from the September 2007 update of the FY 2007 MedPAR file, which contains hospital bills received through September 30, 2007, for discharges through September 30, 2007.

2. Yearly Review for Making MS–DRG Changes

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

C. Adoption of the MS–DRGs in FY 2008

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

For FY 2007, we began this process. In the FY 2007 IPPS proposed rule, we proposed to adopt Consolidated Severity DRGs (CS DRGs) for FY 2008 (if not earlier). However, based on public comments received on the FY 2007 IPPS proposed rule, we decided not to adopt the CS DRGs. 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 CMS DRGs in the public comments. Second, we indicated our intent to review over 13,000 ICD–9–CM diagnosis codes as part of making further refinements to the current CMS DRGs to better recognize severity of illness based on the work that CMS (then HCFA) did in the mid-1990's in connection with adopting severity DRGs. We describe below the progress we have made on these two initiatives, our actions for FY 2008, and our proposals for FY 2009 based on our continued analysis of reform of the DRG system. We note that the adoption of the MS–DRGs to better recognize severity of illness has implications for the outlier threshold, the application of the postacute care transfer policy, the measurement of real case-mix versus apparent case-mix, and the IME and DSH payment adjustments. We discuss these implications for FY 2009 in other sections of this preamble and in the Addendum to this proposed rule.

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

We believe that revisions to the DRG system to better recognize severity of

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

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

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

1. MS–DRG Documentation and Coding Adjustment

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

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

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

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

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

We continue to have concerns about this issue. Because hospitals paid based on the hospital-specific rate use the same MS–DRG system as other hospitals, we believe they have the potential to realize increased payments from coding improvements that do not reflect real increases in patients' severity of illness. In section 1886(d)(3)(A)(vi) of the Act, Congress stipulated that hospitals paid based on the standardized amount should not receive additional payments based on the effect of documentation and coding changes that do not reflect real changes in case-mix. Similarly, we believe that hospitals paid based on the hospital-specific rate should not have the potential to realize increased payments due to documentation and coding improvements that do not reflect real increases in patients' severity of illness. While we continue to believe that section 1886(d)(3)(A)(vi) of the Act does not provide explicit authority for application of the documentation and coding adjustment to the hospital-specific rates, we believe that we have the authority to apply the documentation and coding adjustment to the hospital-specific rates using our special exceptions and adjustment authority under section 1886(d)(5)(I)(i) of the Act. The special exceptions and adjustment authority authorizes us to provide ''for such other exceptions and adjustments to [IPPS] payment amounts * * * as the Secretary deems appropriate.'' In light of this authority, for the FY 2010 rulemaking, we plan to

examine our FY 2008 claims data for hospitals paid based on the hospital-specific rate. If we find evidence of significant increases in case-mix for patients treated in these hospitals, we would consider proposing application of the documentation and coding adjustments to the FY 2010 hospital-specific rates under our authority in section 1886(d)(5)(I)(i) of the Act. As noted previously, the documentation and coding adjustments established in the FY 2008 IPPS final rule with comment period are cumulative. For example, the −0.9 percent documentation and coding adjustment to the national standardized amount in FY 2009 is in addition to the −0.6 percent adjustment made in FY 2008, yielding a combined effect of −1.5 percent in FY 2009. Given the cumulative nature of the documentation and coding adjustments, if we were to propose to apply the documentation and coding adjustment to the FY 2010 hospital-specific rates, it may involve applying the FY 2008 and FY 2009 documentation and coding adjustments (−1.5 percent combined) plus the FY 2010 documentation and coding adjustment, discussed in the FY 2008 IPPS final rule with comment period, to the FY 2010 hospital-specific rates.

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

Puerto Rico hospitals are paid based on 75 percent of the national standardized amount and 25 percent of the Puerto Rico-specific standardized amount. As noted previously, the documentation and coding adjustment we adopted in the FY 2008 IPPS final rule with comment period relied upon our authority under section 1886(d)(3)(A)(vi) of the Act, which provides the authority to adjust ''the standardized amounts computed under this paragraph'' to eliminate the effect of changes in coding or classification that do not reflect real change in case-mix. Section 1886(d)(3)(A)(vi) of the Act applies to the national standardized amounts computed under section 1886(d)(3) of the Act, but does not apply to the Puerto Rico-specific standardized amount computed under section 1886(d)(9)(C) of the Act. In calculating the FY 2008 payment rates, we made an inadvertent error and applied the FY 2008 −0.6 percent documentation and coding adjustment to the Puerto Rico-specific standardized amount, relying on our authority under section 1886(d)(3)(A)(vi) of the Act. We are currently in the process of developing a **Federal Register** notice to correct that error in the Puerto Rico-specific standardized amount for FY 2008 retroactive to October 1, 2007.

While section 1886(d)(3)(A)(vi) of the Act is not applicable to the Puerto Rico-specific standardized amount, we believe that we have the authority to apply the documentation and coding adjustment to the Puerto Rico-specific standardized amount using our special exceptions and adjustment authority under section 1886(d)(5)(I)(i) of the Act. Similar to SCHs and MDHs that are paid based on the hospital-specific rate, discussed in section II.D.2. of this preamble, we believe that Puerto Rico hospitals that are paid based on the Puerto Rico-specific standardized amount should not have the potential to realize increased payments due to documentation and coding improvements that do not reflect real increases in patients' severity of illness. Consistent with the approach described for SCHs and MDHs in section II.D.2. of the preamble of this proposed rule, for the FY 2010 rulemaking, we plan to examine our FY 2008 claims data for hospitals in Puerto Rico. If we find evidence of significant increases in case-mix for patients treated in these hospitals, we would consider proposing application of the documentation and coding adjustments to the FY 2010 Puerto Rico-specific standardized amount under our authority in section 1886(d)(5)(I)(i) of the Act. As noted previously, the documentation and coding adjustments established in the FY 2008 IPPS final rule with comment period are cumulative. Given the cumulative nature of the documentation and coding adjustments, if we were to propose to apply the documentation and coding adjustment to the FY 2010 Puerto Rico-specific standardized amount, it may involve applying the FY 2008 and FY 2009 documentation and coding adjustments (−1.5 percent combined) plus the FY 2010 documentation and coding adjustment, discussed in the FY 2008 IPPS final rule with comment period, to the FY 2010 Puerto Rico-specific standardized amount.

4. Potential Additional Payment Adjustments in FYs 2010 Through 2012

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

In order to implement these requirements of section 7 of Pub. L. 110–90, we are planning a thorough retrospective evaluation of our claims data. Results of this evaluation would be used by our actuaries to determine any necessary payment adjustments in FYs 2010 through 2012 to ensure the budget neutrality of the MS–DRG implementation for FY 2008 and FY 2009, as required by law. We are currently developing our analysis plans for this effort.

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

While we believe that the data analysis plan described previously will produce an appropriate estimate of the extent of case-mix changes resulting from documentation and coding improvements, we may also decide, if feasible, to use historical data from our Hospital Payment Monitoring Program

(HPMP) to corroborate the within base DRG shift analysis. The HPMP is supported by the Medicare Clinical Data Abstraction Center (CDAC). From 1999 to 2007, the CDAC obtained medical records for a sample of discharges as part of our hospital monitoring activities. These data were collected on a random sample of between 30,000 to 50,000 hospital discharges per year. The historical CDAC data could be used to develop an upper bound estimate of the trend in real case-mix growth (that is, real change in underlying patient severity) prior to implementation of the MS–DRGs.

We welcome public comments on our analysis plans, as well as suggestions on other possible approaches for conducting a retrospective analysis to identify the amount of case-mix changes that occurred in FY 2008 and FY 2009 that did not reflect real increases in patients' severity of illness. Our analysis, findings, and any resulting proposals to adjust payments for discharges occurring in FYs 2010 through 2012 to offset the estimated amount of increase or decrease in aggregate payments that occurred in FY 2008 and FY 2009 will be discussed in future years' rulemakings.

E. Refinement of the MS–DRG Relative Weight Calculation

1. Background

In the FY 2008 IPPS final rule with comment period (72 FR 47188), we continued to implement significant revisions to Medicare's inpatient hospital rates by basing relative weights on hospitals' estimated costs rather than on charges. We continued our 3-year transition from charge-based relative weights to cost-based relative weights. Beginning in FY 2007, we implemented relative weights based on cost report data instead of based on charge information. We had initially proposed to develop cost-based relative weights using the hospital-specific relative value cost center (HSRVcc) methodology as recommended by MedPAC. However, after considering concerns raised in the public comments, we modified MedPAC's methodology to exclude the hospital-specific relative weight feature. Instead, we developed national CCRs based on distinct hospital departments and engaged a contractor to evaluate the HSRVcc methodology for future consideration. To mitigate payment instability due to the adoption of cost-based relative weights, we decided to transition cost-based weights over 3 years by blending them with charge-based weights beginning in FY 2007. In FY 2008, we continued our transition by blending the relative weights with one-third charge-based weights and two-thirds cost-based weights.

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

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

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

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

We did not adopt RTI's short-term recommendation to create four

additional regression-based CCRs for several reasons, even though we had received comments in support of the regression-based CCRs as a means to immediately resolve the problem of charge compression, particularly within the Medical Supplies and Equipment CCR. We were concerned that RTI's analysis was limited to charges on hospital inpatient claims while typically hospital cost report CCRs combine both inpatient and outpatient services. Further, because both the IPPS and OPPS rely on cost-based weights, we preferred to introduce any methodological adjustments to both payment systems at the same time. We have since expanded RTI's analysis of charge compression to incorporate outpatient services. RTI has been evaluating the cost estimation process for the OPPS cost-based weights, including a reassessment of the regression-based CCR models using both outpatient and inpatient charge data. The RTI report was finalized at the conclusion of our proposed rule development process and is expected to be posted on the CMS Web site in the near future. We welcome comments on this report.

A second reason that we did not implement regression-based CCRs at the time of the FY 2008 IPPS final rule with comment period was our inability to investigate how regression-based CCRs would interact with the implementation of MS–DRGs. We stated that we would consider the results of the second phase of the RAND study as we prepared for the FY 2009 IPPS rulemaking process. The purpose of the RAND study was to 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. We had intended to include a detailed discussion of RAND's study in this FY 2009 IPPS proposed rule. However, due to some delays in releasing identifiable data to the contractor under revised data security rules, the report on this second stage of RAND's analysis was not completed in time for the development of this proposed rule. Therefore, we continue to have the same concerns with respect to uncertainty about how regression-based CCRs would interact with the MS–DRGs or an HSRV methodology. Therefore, we are not proposing to adopt the regression-based CCRs or an HSRV methodology in this FY 2009 IPPS proposed rule. Nevertheless, we welcome public comments on our proposals not to adopt regression-based CCRs or an HSRV methodology at this time or in the future. The RAND report on regression-based CCRs and the HSRV methodology was finalized at the conclusion of our proposed rule development process and is expected to be posted on the CMS Web site in the near future. Although we are unable to include a discussion of the results of the RAND study in this proposed rule, we welcome public comment on the report.

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

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

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

The CY 2008 OPPS/ASC final rule with comment period (72 FR 66601) also discussed the issue of charge compression and regression-based CCRs, and noted that RTI is currently evaluating the cost estimation process underpinning the OPPS cost-based weights, including a reassessment of the regression models using both outpatient and inpatient charges, rather than inpatient charges only. In responding to comments in the CY 2008 OPPS/ASC final rule with comment period, we emphasized that we ''fully support'' the educational initiatives of the industry and that we would ''examine whether the educational activities being undertaken by the hospital community to improve cost reporting accuracy under the IPPS would help to mitigate charge compression under the OPPS, either as an adjunct to the application of regression-based CCRs or in lieu of such an adjustment'' (72 FR 66601). However, as we stated in the FY 2008 IPPS final rule with comment period that we would consider the results of the RAND study before considering whether to adopt regression-based CCRs, in the CY 2008 OPPS/ASC final rule with comment period, we stated that we would determine whether refinements should be proposed, after reviewing the results of the RTI study.

On February 29, 2008, we issued Transmittal 321, Change Request 5928, to inform the fiscal intermediaries/

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

2. Refining the Medicare Cost Report

In developing this FY 2009 proposed rule, we considered whether there were concrete steps we could take to mitigate the bias introduced by charge compression in both the IPPS and OPPS relative weights in a way that balance hospitals' desire to focus on improving the cost reporting process through educational initiatives with device industry interest in adopting regression-adjusted CCRs. Although RTI recommended adopting regression-based CCRs, particularly for medical supplies and devices, as a short-term solution to address charge compression, RTI also recommended refinements to the cost report as a long-term solution. RTI's draft interim March 2007 report discussed a number of options that could improve the accuracy and precision of the CCRs currently being derived from the Medicare cost report and also reduce the need for statistically-based adjustments. As mentioned in the FY 2008 IPPS final rule with comment period (72 FR 47193), we believe that RTI and many of the public commenters on the FY 2008 IPPS proposed rule concluded that, ultimately, improved and more precise cost reporting is the best way to minimize charge compression and improve the accuracy of cost weights. Therefore, in this proposed rule, we are proposing to begin making cost report changes geared to improving the accuracy of the IPPS and OPPS relative weights. However, we also received comments last year asking that we proceed cautiously with changing the Medicare cost report to avoid unintended consequences for hospitals that are paid on a cost basis (such as CAHs and, to some extent, SCHs and MDHs), and to consider the administrative burden associated with adapting to new cost reporting forms and instructions. Accordingly, we are proposing to focus at this time on the CCR for Medical Supplies and Equipment because RTI found that the largest impact on the relative weights could result from correcting charge compression for devices and implants. When examining markup differences within the Medical Supplies Charged to Patients cost center, RTI found that its ''regression results provide solid evidence that if there were distinct cost centers for items, cost ratios for devices and implants would average about 17 points higher than the ratios for other medical supplies'' (January 2007 RTI report, page 59). This suggests that much of the charge compression within the Medical Supplies CCR results from inclusion of medical devices that have significantly different markups than the other supplies in that CCR. Furthermore, in the FY 2007 final rule and FY 2008 IPPS final rule with comment period, the Medical Supplies and Equipment CCR received significant attention by the public commenters.

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

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

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

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

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

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

d. The device is not any of the following:

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

These requirements are the OPPS criteria used to define a device for pass-through payment purposes and do not include additional criteria that are used

under the OPPS to determine if a candidate device is new and represents a substantial clinical improvement, two other requirements for qualifying for pass-through payment.

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

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

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

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

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

d. The device is not any of the following:

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

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

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

The criteria we are proposing above for instructing hospitals as to what to report in the device cost center specify that a device is not a material or supply furnished incident to a service (for example, a surgical staple, a suture, *customized surgical kit*, or clip, other than a radiological site marker) (emphasis added). We understand that hospitals may sometimes receive surgical kits from device manufacturers that consist of a high-cost primary implantable device, external supplies required for operation of the device, and other disposable surgical supplies required for successful device implantation. Often the device and the attending supplies are included on a single invoice from the manufacturer, making it difficult for the hospital to determine the cost of each item in the kit. In addition, manufacturers sometimes include with the primary device other free or ''bonus'' items or supplies that are not an integral and necessary part of the device (that is, not actually required for the safe surgical implantation and subsequent operation of that device). (We note that arrangements involving free or bonus items or supplies may implicate the Federal anti-kickback statue, depending on the circumstances.) One option is for the hospital to split the total combined charge on the invoice in a manner that the hospital believes best identifies the cost of the device alone. However, because it may be difficult for hospitals to determine the respective costs of the actual device and the attending supplies (whether they are required for the safe surgical implantation and subsequent operation of that device or not), we are soliciting comments with respect to how supplies, disposable or otherwise, that are part of surgical kits should be reported. We are distinguishing between such supplies that are an integral and necessary part of the primary device (that is, required for the safe surgical implantation and subsequent operation of that device) from other supplies that are not directly related to the implantation of that device, but may be included by the device manufacturer with or without charge as ''perks'' along with the kit. If it is difficult to break out the costs and charges of these lower cost items that are an integral and necessary

part of the primary device, we would consider allowing hospitals to report the costs and charges of these lower cost supplies along with the costs and charges of the more expensive primary device in the cost report cost center for implantable devices. However, to the extent that device manufacturers could be encouraged to refine their invoicing practices to break out the charges and costs for the lower cost supplies and the higher cost primary device separately, so that hospitals need not ''guesstimate'' the cost of the device, this would facilitate more accurate cost reporting and, therefore, the calculation of more accurate cost-based weights. Under either scenario, even for an aggregated invoice that contains an expensive device, we believe that RTI's findings of significant differences in supply CCRs for hospitals with a greater percentage of charges in device revenue codes demonstrate that breaking the Medical Supplies Charged to Patients cost center into two cost centers and using appropriate revenue codes for devices, and walking those costs to the new Implantable Devices Charged to Patients cost center, will result in an increase in estimated device costs.

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

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

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

Furthermore, although a cost threshold directly addresses charge compression, it may not eliminate all charge compression from the device cost center because a fixed cost threshold may not accurately capture differential markup policies for an individual hospital. At the same time, we are also concerned that establishing a cost threshold may interfere with the pricing practices of device manufacturers in that the prices for certain devices or surgical kits could be inflated to ensure that the devices met the cost threshold. We believe our proposed approach of identifying a group of items that are relatively expensive based on the existing criteria for OPPS device pass-through payment status, rather than adopting a cost threshold, would not influence pricing by the device industry. In addition, if a cost threshold were adopted for distinguishing between high-cost devices and low-cost supplies on the cost report, we would need to periodically reassess the threshold for changes in markup policies and price inflation over time.

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

3. Timeline for Revising the Medicare Cost Report

As mentioned in the FY 2008 IPPS final rule with comment period (72 FR 47198), we have begun a comprehensive review of the Medicare hospital cost report, and the proposed splitting of the current cost center for Medical Supplies Charged to Patients into one line for Medical Supplies Charged to Patients and another line for Implantable Devices Charged to Patients, is part of

our initiative to update and revise the hospital cost report. Under an effort initiated by CMS to update the Medicare hospital cost report to eliminate outdated requirements in conjunction with the Paperwork Reduction Act, we plan to propose the actual changes to the cost reporting form, the attending cost reporting software, and the cost report instructions in Chapter 36 of the Medicare Provider Reimbursement Manual (PRM), Part II. We expect the proposed revision to the Medicare hospital cost report to be issued after publication of this IPPS proposed rule. If we were to adopt as final our proposal to create one cost center for Medical Supplies Charged to Patients and one cost center for Implantable Devices Charged to Patients in the FY 2009 IPPS final rule, the cost report forms and instructions would reflect those changes. We expect the revised cost report would be available for hospitals to use when submitting cost reports during FY 2009 (that is, for cost reporting periods beginning on or after October 1, 2008). Because there is approximately a 3-year lag between the availability of cost report data for IPPS and OPPS ratesetting purposes and a given fiscal year, we may be able to derive two distinct CCRs, one for medical supplies and one for devices, for use in calculating the FY 2012 IPPS relative weights and the CY 2012 OPPS relative weights.

4. Revenue Codes Used in the MedPAR File

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

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

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

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

1. General

In its landmark 1999 report ''To Err is Human: Building a Safer Health System,'' the Institute of Medicine found that medical errors, particularly hospital-acquired conditions (HACs) caused by medical errors, are a leading cause of morbidity and mortality in the United States. The report noted that the number of Americans who die each year as a result of medical errors that occur in hospitals may be as high as 98,000. The cost burden of HACs is also high. Total national costs of these errors due to lost productivity, disability, and health care costs were estimated at $17

billion to $29 billion.[2] In 2000, the CDC estimated that hospital-acquired infections added nearly $5 billion to U.S. health care costs every year.[3] A 2007 study found that, in 2002, 1.7 million hospital-acquired infections were associated with 99,000 deaths[4] Research has also shown that hospitals are not following recommended guidelines to avoid preventable hospital-acquired infections. A 2007 Leapfrog Group survey of 1,256 hospitals found that 87 percent of those hospitals do not follow recommendations to prevent many of the most common hospital-acquired infections.[5]

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

The President's FY 2009 Budget outlines another approach for addressing serious preventable adverse events (''never events''), including HACs. The President's Budget proposal would: (1) Prohibit hospitals from billing the Medicare program for ''never events'' and prohibit Medicare payment for these events; and (2) require hospitals to report occurrence of these events or receive a reduced annual payment update.

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

Service: MS–DRG Assignment* (Examples below with CC/MCC indicate a single secondary diagnosis only)	Present on admission (status of secondary diagnosis)	Average payment (based on 50th percentile)
Principal Diagnosis		$5,347.98
• Intracranial hemorrhage or cerebral infarction (stroke) without CC/MCC—MS–DRG 066.		
Principal Diagnosis	Y	6,177.43
• Intracranial hemorrhage or cerebral infarction (stroke) with CC—MS–DRG 065.		
Example Secondary Diagnosis		
• Dislocation of patella-open due to a fall (code 836.4 (CC)).		
Principal Diagnosis	N	5,347.98
• Intracranial hemorrhage or cerebral infarction (stroke) with CC—MS–DRG 065.		
Example Secondary Diagnosis		
• Dislocation of patella-open due to a fall (code 836.4 (CC)).		
Principal Diagnosis	Y	8,030.28
• Intracranial hemorrhage or cerebral infarction (stroke) with MCC—MS–DRG 064.		
Example Secondary Diagnosis		
• Stage III pressure ulcer (code 707.23 (MCC)).		
Principal Diagnosis	N	5,347.98
• Intracranial hemorrhage or cerebral infarction (stroke) with MCC—MS–DRG 064.		
Example Secondary Diagnosis		
• Stage III pressure ulcer (code 707.23 (MCC)).		

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

2. Statutory Authority

Section 1886(d)(4)(D) of the Act required the Secretary to select at least two conditions by October 1, 2007, that are: (a) High cost, high volume, or both; (b) assigned to a higher paying DRG when present as a secondary diagnosis; and (c) could reasonably have been prevented through the application of evidence-based guidelines. Beginning October 1, 2008, Medicare can no longer assign an inpatient hospital discharge to

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

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

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

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

a higher paying MS–DRG if a selected HAC was not present on admission. That is, the case will be paid as though the secondary diagnosis was not present. (Medicare will continue to assign a discharge to a higher paying MS–DRG if the selected condition was present on admission.) Section 1886(d)(4)(D) of the Act provides that the list of conditions can be revised from time to time, as long as the list contains at least two conditions. Beginning October 1, 2007, we required hospitals to begin submitting information on Medicare claims specifying whether diagnoses were present on admission (POA).

The POA indicator reporting requirement and the HACs payment provision apply to IPPS hospitals only. At this time, non-IPPS hospitals such as CAHs, LTCHs, IRFs, and hospitals in Maryland operating under waivers, among others, are exempt from POA reporting and the HAC payment provision. Throughout this section, ''hospital'' refers to IPPS hospitals.

3. Public Input

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

4. Collaborative Process

CMS experts worked with public health and infectious disease professionals from the CDC to identify the candidate preventable HACs. CMS and CDC staff also collaborated on the process for hospitals to submit a POA indicator for each diagnosis listed on IPPS hospital Medicare claims.

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

5. Selection Criteria for HACs

CMS and CDC staff evaluated each candidate condition against the criteria established by section 1886(d)(4)(D)(iv) of the Act.

- Cost or Volume—Medicare data [6] must support that the selected conditions are high cost, high volume, or both. At this point, there are no Medicare claims data indicating which secondary diagnoses were POA because POA indicator reporting began only recently; therefore, the currently available data for candidate conditions includes all secondary diagnoses.
- Complicating Condition (CC) or Major Complicating Condition (MCC)—Selected conditions must be represented by ICD–9-CM diagnosis codes that clearly identify the condition, are designated as a CC or an MCC, and result in the assignment of the case to an MS-DRG that has a higher payment when the code is reported as a secondary diagnosis. That is, selected conditions must be a CC or an MCC that would, in the absence of this provision, result in assignment to a higher paying MS-DRG.
- Evidence-Based Guidelines—Selected conditions must be reasonably preventable through the application of evidence-based guidelines. By reviewing guidelines from professional organizations, academic institutions, and entities such as the Healthcare Infection Control Practices Advisory Committee (HICPAC), we evaluated whether guidelines are available that hospitals should follow to prevent the condition from occurring in the hospital.
- Reasonably Preventable—Selected conditions must be reasonably preventable through the application of evidence-based guidelines.

6. HACs Selected in FY 2008 and Proposed Changes to Certain Codes

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

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[6] For this FY 2009 IPPS proposed rule, the DRG analysis is based on data from the September 2007 update of the FY 2007 MedPAR file, which contains hospital bills received through September 30, 2007, for discharges through September 30, 2007.

Selected HAC	Medicare Data (FY 2007)	CC/MCC (ICD-9-CM Codes)	Selected Evidence-Based Guidelines
Foreign Object Retained After Surgery	• 750 cases* • $63,631/hospital stay**	998.4 (CC) 998.7 (CC)	NQF Serious Reportable Adverse Event NQF's Safe Practices for Better Healthcare available at the Web site: http://www.ahrq.gov/qual/nqfpract.htm
Air Embolism	• 57 cases • $71,636/hospital stay	999.1 (MCC)	NQF Serious Reportable Adverse Event NQF's Safe Practices for Better Healthcare available at the Web site: http://www.ahrq.gov/qual/nqfpract.htm
Blood Incompatibility	• 24 cases • $50,455/hospital stay	999.6 (CC)	NQF Serious Reportable Adverse Event NQF's Safe Practices for Better Healthcare available at the Web site: http://www.ahrq.gov/qual/nqfpract.htm
Stage III & IV Pressure Ulcers	• 257,412 cases*** • $43,180/hospital stay	New codes (to replace 707.00–707.09) 707.23 (MCC) 707.24 (MCC) All other pressure ulcer codes will not be a CC.	NQF Serious Reportable Adverse Event Available at the Web site: http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat2.chapter.4409
Falls and Trauma: - Fractures - Dislocations - Intracranial Injuries - Crushing Injuries - Burns	• 193,566 cases**** • $33,894/hospital stay	Codes within the these ranges on the CC/MCC list: 800-829 830-839 850-854 925-929 940-949 991-994	NQF Serious Reportable Adverse Events address falls, electric shock, and burns. NQF's Safe Practices for Better Healthcare available at the Web site: http://www.ahrq.gov/qual/nqfpract.htm

Selected HAC	Medicare Data (FY 2007)	CC/MCC (ICD-9-CM Codes)	Selected Evidence-Based Guidelines
Catheter-Associated Urinary Tract Infection (UTI)	• 12,185 cases • $44,043/hospital stay	996.64 (CC) Also excludes the following from acting as a CC/MCC: 112.2 (CC) 590.10 (CC) 590.11 (MCC) 590.2 (MCC) 590.3 (CC) 590.80 (CC) 590.81 (CC) 595.0 (CC) 597.0 (CC) 599.0 (CC)	Available at the Web site: http://www.cdc.gov/ncidod/dhqp/gl_catheter_assoc.html
Vascular Catheter-Associated Infection	• 29,536 cases • $103,027/hospital stay	999.31 (CC)	Available at the Web site: http://www.cdc.gov/ncidod/dhqp/gl_intravascular.html
Surgical Site Infection-Mediastinitis after Coronary Artery Bypass Graft (CABG)	• 69 cases • $299,237/hospital stay	519.2 (MCC) And one of the following procedure codes: 36.10–36.19	Available at the Web site: http://www.cdc.gov/ncidod/dhqp/gl_surgicalsite.html

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

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

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

****Note: The number of cases for the falls and trauma HAC is significantly higher for this FY 2009 IPPS proposed rule than for the FY 2008 IPPS final rule with comment period. The FY 2008 IPPS final rule with comment period only included cases in which patients fell out of bed. This FY 2009 IPPS proposed rule includes all cases within the CC/MCC code range listed.

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We are seeking public comments on the following refinements to two of the previously selected HACs:

a. Foreign Object Retained After Surgery: Proposed Inclusion of ICD–9–CM Code 998.7 (CC)

In the FY 2008 IPPS final rule with comment period (72 FR 47206), we indicated that a foreign body accidentally left in the patient during a procedure (ICD–9–CM code 998.4) was one of the conditions selected. It has come to our attention that ICD–9–CM diagnosis code 998.7 (Acute reaction to foreign substance accidentally left during a procedure) should also be included. ICD–9–CM code 998.7 describes instances in which a patient developed an acute reaction due to a retained foreign substance. Therefore, we are proposing to make this code subject to the HAC payment provision.

b. Pressure Ulcers: Proposed Changes in Code Assignments

As discussed in the FY 2008 IPPS final rule with comment period (72 FR 47205–47206), we referred the need for more detailed ICD–9–CM pressure ulcer codes to the CDC. The topic of expanding pressure ulcer codes to capture the stage of the ulcer was addressed at the September 27–28, 2007, meeting of the ICD–9–CM Coordination and Maintenance Committee. A summary report of this meeting is available on the Web site at: *http://www.cdc.gov/nchs/about/otheract/icd9/maint/maint.htm.*

Numerous wound care professionals supported modifying the pressure ulcer codes to capture staging information. The stage of the pressure ulcer is a powerful predictor of severity and resource utilization. At its September 27–28, 2007 meeting, the ICD–9–CM Coordination and Maintenance Committee discussed the creation of pressure ulcer codes to capture this information. The new codes, along with their proposed CC/MCC classifications, are shown in Table 6A of the Addendum to this proposed rule. The new codes are as follows:

- 707.20 (Pressure ulcer, unspecified stage).
- 707.21 (Pressure ulcer stage I).
- 707.22 (Pressure ulcer stage II).
- 707.23 (Pressure ulcer stage III).
- 707.24 (Pressure ulcer stage IV).

While the code titles are final, we are soliciting comment on the proposed MS–DRG classifications of these codes, as indicated in Table 6A of the Addendum to this proposed rule. We are proposing to remove the CC/MCC classifications from the current pressure ulcer codes that show the site of the ulcer (ICD–9–CM codes 707.00 through 707.09). Therefore, the following codes would no longer be a CC:

- 707.00 (Decubitus ulcer, unspecified site).
- 707.01 (Decubitus ulcer, elbow).
- 707.09 (Decubitus ulcer, other site).

The following codes would no longer be an MCC:

- 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).

We are proposing to instead assign the CC/MCC classifications to the stage of the pressure ulcer as shown in Table 6A of the Addendum to this proposed rule. We are proposing to classify ICD–9–CM codes 707.23 and 707.24 as MCCs. We are proposing to classify codes 707.20, 707.21, and 707.22 as non-CCs.

Therefore, we are proposing that, beginning October 1, 2008, the codes used to make MS–DRG adjustments for pressure ulcers under the HAC provision would include the proposed MCC codes 707.23 and 707.24.

7. HACs Under Consideration as Additional Candidates

CMS and CDC have diligently worked together and with other stakeholders to identify additional HACs that might appropriately be subject to the HAC payment provision. If the additional candidate HACs are selected in the FY 2009 IPPS final rule, the payment provision will take effect for these candidate HACS on October 1, 2008. The statutory criteria for each HAC candidate are presented in tabular format. Each table contains the following:

- HAC Candidate—We are seeking public comment on all HAC candidates.
- Medicare Data—We are seeking public comment on the statutory criterion of high cost, high volume, or both as it applies to the HAC candidate.
- CC/MCC—We are seeking public comment on the statutory criterion that an ICD–9–CM diagnosis code(s) clearly identifies the HAC candidate.
- Selected Evidence-Based Guidelines—We are seeking public comment on the degree to which the HAC candidate is reasonably preventable through the application of the identified evidence-based guidelines.

a. Surgical Site Infections Following Elective Surgeries

HAC Candidate	Medicare Data (FY 2007)	CC/MCC (ICD-9-CM Codes)	Selected Evidence-Based Guidelines
Surgical Site Infections Following Elective Procedures: - Total Knee Replacement - Laparoscopic Gastric Bypass and Gastroenterostomy - Ligation and Stripping of Varicose Veins	Total Knee Replacement • 539 cases • $63,135/hospital stay Laparoscopic Gastric Bypass and Gastroenterostomy • 208 cases • $180,142/hospital stay Ligation and Stripping of Varicose Veins • 3 cases • $66,355/hospital stay	Total Knee Replacement (81.54): 996.66 (CC) and 998.59 (CC) Laparoscopic Gastric Bypass (44.38) and Gastroenterostomy (44.39): 998.59 (CC) Varicose Veins (38.59): 998.59 (CC)	Available at theWeb site: http://www.cdc.gov/ncidod/dhqp/gl_surgicalsite.html Available at the Web site: http://www.cdc.gov/ncidod/dhqp/gl_isolation.html

In the FY 2008 IPPS final rule with comment period (72 FR 47213), surgical site infections were identified as a broad category for consideration, and we selected mediastinitis after coronary artery bypass graft (CABG) as one of the initial eight HACs for implementation. We are now considering the addition of other surgical site infections, particularly those following elective procedures. In most cases, patients selected as candidates for elective surgeries should have a relatively low-risk profile for surgical site infections.

The following elective surgical procedures are under consideration:

- Total Knee Replacement (81.54): ICD–9–CM codes 996.66 (CC) and 998.59 (CC)
- Laparoscopic Gastric Bypass (44.38) and Laparoscopic Gastroenterostomy (44.39): ICD–9–CM code 998.59 (CC)
- Ligation and Stripping of Varicose Veins (38.50 through 38.53, 38.55, 38.57, and 38.59): ICD–9–CM code 998.59 (CC)

Evidence-based guidelines for preventing surgical site infections emphasize the importance of appropriately using prophylactic antibiotics, using clippers rather than razors for hair removal and tightly controlling postoperative glucose.

While we are seeking public comments on the applicability of each of the statutory criteria to surgical site infections following elective procedures, we are particularly interested in receiving comments on the degree of preventability of surgical site infections following elective procedures generally, as well as specifically for those listed above. We also are seeking public comments on additional elective surgical procedures that would qualify for the HAC provision by meeting all of the statutory criteria. Based on the public comments we receive, we may select some combination of the four procedures presented here along with additional conditions that qualify and are supported by the comments.

b. Legionnaires' Disease

HAC Candidate	Medicare Data (FY 2007)	CC/MCC (ICD-9-CM Code)	Selected Evidence-Based Guidelines
Legionnaires' Disease	• 351 cases • $86,014/hospital stay	482.84	Available at the Web site: http://www.cdc.gov/ncidod/dbmd/diseaseinfo/legionellosis_g.htm Available at the Web site: http://www.legionella.org/

We discussed Legionnaires' Disease in the FY 2008 IPPS final rule with comment period (72 FR 47216). Legionnaires' Disease is a type of pneumonia caused by the bacterium *Legionella pneumophila*. It is contracted

by inhaling contaminated water vapor or droplets. It is not spread person to person. Individuals at risk include those who are elderly, immunocompromised, smokers, or persons with underlying lung disease. The bacterium thrives in warm aquatic environments and infections have been linked to large industrial water systems, including hospital water systems such as air conditioning cooling towers and potable water plumbing systems. Prevention depends primarily on regular monitoring and decontamination of these water systems. While we are seeking public comments regarding the applicability of each of the statutory criteria to Legionnaires' Disease, we are particularly interested in receiving comments on the degree of preventability of Legionnaires' Disease through the application of hospital water system maintenance guidelines.

Legionnaires' Disease is typically acquired outside of the hospital setting and may be difficult to diagnose as present on admission. We are seeking comments on the degree to which hospital-acquired Legionnaires' Disease can be distinguished from community-acquired cases.

We also are seeking public comments on additional water-borne pathogens that would qualify for the HAC provision by meeting the statutory criteria. Based on the public comments we receive, we may finalize some combination of Legionnaires' Disease and additional conditions that qualify and are supported by the public comments.

c. Glycemic Control

HAC Candidate	Medicare Data (FY 2007)	CC/MCC (ICD-9-CM Code)	Selected Evidence-Based Guidelines
Glycemic Control: - Diabetic Ketoacidosis - Nonketotic Hyperosmolar Coma - Diabetic coma - Hypoglycemic Coma	Diabetic Ketoacidosis • 11,469 cases • $42,974/hospital stay Nonketotic Hyperosmolar Coma • 3,248 cases • $35,215/hospital stay Diabetic Coma • 1,131 cases • $45,989/hospital stay Hypoglycemic Coma • 212 cases • $36,581/hospital stay	Diabetic Ketoacidosis: 250.10 – 250.13 (CC) Nonketotic Hyperosmolar Coma: 250.20 – 250.23 (CC) Diabetic coma: 250.30 - 250.33 (CC) Hypoglycemic Coma: 251.0 (CC)	NQF Serious Reportable Adverse Events addresses hypoglycemia. Available at the Web site: http://www.diabetes.org/uedocuments/InpatientDMGlycemicControlPositionStmt02.01.06.REV.pdf

During the December 17, 2007 HAC and POA Listening Session, one of the commenters suggested that we explore hyperglycemia and hypoglycemia as HACs for selection. NQF's list of Serious Reportable Adverse Events includes death or serious disability associated with hypoglycemia that occurs during hospitalization.

Hyperglycemia and hypoglycemia are extremely common laboratory findings in hospitalized patients and can be complicating features of underlying diseases and some therapies. However, we believe that extreme forms of poor glycemic control should not occur while under medical care in the hospital setting. Thus, we are considering whether the following forms of extreme glucose derangement should be subject to the HAC payment provision:

- Diabetic Ketoacidosis: ICD–9–CM codes 250.10–250.13 (CC)
- Nonketotic Hyperosmolar Coma: ICD–9–CM code 251.0 (CC)
- Diabetic Coma: ICD–9–CM codes 250.30–250.33 (CC)
- Hypoglycemic Coma: ICD–9–CM codes 250.30–251.0 (CC)

While we are seeking public comments regarding the applicability of each of the statutory criteria to these extreme aberrations in glycemic control, we are particularly interested in receiving comments on the degree to which these extreme aberrations in glycemic control are reasonably preventable, in the hospital setting, through the application of evidence-based guidelines. Based on the public comments we receive, we may select some combination of these glycemic control-related conditions as HACs.

d. Iatrogenic Pneumothorax

HAC Candidate	Medicare Data (FY 2007)	CC/MCC (ICD-9-CM Code)	Selected Evidence-Based Guidelines
Iatrogenic Pneumothorax	• 22,665 cases • $75,089/hospital stay	512.1 (CC)	Available at the Web site: http://www.ncbi.nlm.nih.gov/pubmed/1485006

Iatrogenic pneumothorax refers to the accidental introduction of air into the pleural space, which is the space between the lung and the chest wall. When air is introduced into this space it partially or completely collapses the lung. Iatrogenic pneumothorax can occur during any procedure where there is the possibility of air entering pleural space, including needle biopsy of the lung, thoracentesis, central venous catheter placement, pleural biopsy, tracheostomy, and liver biopsy. Iatrogenic pneumothorax can occur secondary to positive pressure mechanical ventilation when an air sac in the lung ruptures allowing air into the pleural space.

While we are seeking public comments on the applicability of each of the statutory criteria to iatrogenic pneumothorax, we are particularly interested in receiving comments on the degree to which iatrogenic pneumothorax is reasonably preventable through the application of evidence-based guidelines. Based on the public comments we receive, we may select iatrogenic pneumothorax as an HAC.

e. Delirium

HAC Candidate	Medicare Data (FY 2007)	CC/MCC (ICD-9-CM Code)	Selected Evidence-Based Guidelines
Delirium	• 480 cases • $23,290/hospital stay	293.1 (CC)	Available on the Web site: http://www.ahrq.gov/clinic/ptsafety/chap28.htm

Delirium is a relatively abrupt deterioration in a patient's ability to sustain attention, learn, or reason. Delirium is strongly associated with aging and treatment of illnesses that are associated with hospitalizations. Delirium affects nearly half of hospital patient days for individuals age 65 and older, and approximately three-quarters of elderly individuals in intensive care units have delirium. About 14 to 24 percent of hospitalized elderly individuals have delirium at the time of admission. Having delirium is a very serious risk factor, with 1-year mortality of 35 to 40 percent, a rate as high as those associated with heart attacks and sepsis. The adverse effects of delirium routinely last for months. Delirium is a clinical diagnosis, commonly assisted by screening tests such as the Confusion Assessment Method.

Well-established practices, such as reducing certain medications, reorienting the patient, assuring sensory input and sleep, and avoiding malnutrition and dehydration, prevent 30 to 40 percent of the possible cases. While we are seeking public comments on the applicability of each of the statutory criteria to delirium, we are particularly interested in receiving comments on the degree to which delirium is reasonably preventable through the application of evidence-based guidelines. Based upon the public comments we receive, we may select delirium as an HAC.

f. Ventilator-Associated Pneumonia (VAP)

HAC Candidate	Medicare Data (FY 2007)	CC/MCC (ICD-9-CM Code)	Selected Evidence-Based Guidelines
Ventilator-Associated Pneumonia (VAP)	• 30,867 cases* • $135,795/hospital stay	The new code for VAP is 997.31. To identify cases in current Medicare data, use a ventilator code (96.70 – 96.72), plus one of the following: 073.0 (MCC) 112.4 (MCC) 136.3 (MCC) 480.0-480.4 (MCCs) 480.8-480.9 (MCCs) 481 (MCC) 482.0-482.2 (MCC) 482.39-482.41 (MCCs) 482.49 (MCC) 482.81-482.84 (MCCs) 482.89 (MCC) 482.9 (MCC) 483.0 (MCC)	Available on the Web site: http://www.rcjournal.com/cpgs/09.03.0869.html

*Note: The number of cases for VAP is significantly lower for this FY 2009 IPPS proposed rule than that shown in the FY 2008 IPPS final rule with comment period. The FY 2008 IPPS final rule with comment period included all pneumonia cases. This FY 2009 IPPS proposed rule includes only cases with a diagnosis of VAP and where a ventilator code was also included.

We discussed ventilator-associated pneumonia (VAP) in the FY 2008 IPPS final rule with comment period (72 FR 47209–47210). VAP is a serious hospital-acquired infection associated with high mortality, significantly increased hospital length of stay, and high cost. It is typically caused by the aspiration of contaminated gastric and/or oropharyngeal secretions. The presence of an endotracheal tube facilitates both the contamination of secretions as well as aspiration.

During the past year, the ICD–9–CM Coordination and Maintenance Committee discussed the creation of a new ICD–9–CM code 997.31 to identify VAP. This new code is shown in Table 6A of the Addendum to this proposed rule. The lack of a specific code was one of the barriers to including VAP as an HAC that we discussed in the FY 2008 IPPS final rule with comment period. We also discussed the degree to which VAP may be reasonably preventable through the application of evidence-based guidelines. Specifically, the FY 2008 IPPS final rule with comment period referenced the American Association for Respiratory Care's Clinical Practice Guidelines at the Web site: *http://www.rcjournal.com/cpgs/09.03.0869.html.*

To further investigate the extent to which VAP is reasonably preventable, we reviewed published clinical research. The literature, including recommendations by CDC and the HICPAC, from 2003 shows numerous prevention guidelines that can significantly reduce the incidence of VAP in the hospital setting. These guidelines include interventions such as educating staff, hand washing, using gowns and gloves, properly positioning the patient, elevating the head of the bed, changing ventilator tubing, sterilizing reusable equipment, applying chlorhexadine solution for oral decontamination, monitoring sedation daily, administering stress ulcer prophylaxis, and administering pneumococcal vaccinations. Further review of the literature, specifically regarding the proportion of VAP cases that might be preventable, revealed two large-scale analyses that were completed recently. One study concluded that an estimated 40 percent of VAP cases are preventable. A second study concluded that at least 20 percent of nosocomial infections in general (not just VAP) are preventable.[7]

During the December 17, 2007 HAC and POA Listing Session, we also received comments on evidence-based guidelines for preventing VAP. Commenters referenced two articles[8] [9] that both state there is a high degree of risk associated with endotracheal tube insertions, suggesting that VAP may not always be preventable.

While we are seeking public comments on the applicability of each of the statutory criteria to VAP, we are particularly interested in receiving comment on the degree to which VAP

[7] *American Association for Respiratory Care Clinical Practice:* Guideline: Care of the Ventilator Circuit and Its Relation to Ventilator Associated Pneumonia. *Available at the Web site: http://www.rcjournal.com/cpgs/09.03.0869.html.*

[8] Ramirez et al.: Prevention Measures for Ventilator-Associated Pneumonia: A New Focus on the Endotracheal Tube. *Current Opinion in Infectious Disease,* April 2007, Vol.20 (2), pp. 190–197.

[9] Safdar et al.: The Pathogenesis of Ventilator-Associated Pneumonia: Its Relevance to Developing Effective Strategies for Prevention. *Respiratory Care,* June 2005, Vol. 50, No. 6, pp.725–741.

is reasonably preventable through the application of evidence-based guidelines. Based on the public comments we receive, we may select VAP as an HAC.

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

HAC Candidate	Medicare Data (FY 2007)	CC/MCC (ICD-9-CM Codes)	Selected Evidence-Based Guidelines
Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE)	• 149,010 cases • $50,937/hospital stay	453.40 – 453.42 415.11 415.19	Available on the Web site: http://www.chestjournal.org/cgi/reprint/126/3_suppl/172S Available on the Web site: http://orthoinfo.aaos.org/topic.cfm?topic=A00219

We discussed deep vein thrombosis (DVT) and pulmonary embolism (PE) in the FY 2008 IPPS final rule with comment period (72 FR 47215). DVT and PE are common events. DVT occurs when a blood clot forms in the deep veins of the leg and causes local swelling and inflammation. PE occurs when a clot or a piece of a clot migrates from its original site into the lungs, causing the death of lung tissue, which can be fatal. Risk factors for DVTs and PEs include inactivity, smoking, use of oral contraceptives, prolonged bed rest, prolonged sitting with bent knees, certain types of cancer and other disease states, certain blood clotting disorders, and certain types of orthopedic and other surgical procedures. DVT is not always clinically apparent because the manifestations of pain, redness, and swelling may develop some time after the venous clot forms.

As we discussed in the FY 2008 IPPS final rule with comment period, DVTs and PEs may be preventable in certain circumstances, but it is possible that a patient may have a DVT that is difficult to detect on admission. We also received comments during the December 17, 2007 HAC and POA Listening Session reiterating that not all cases of DVTs and PEs are preventable. For example, common patient characteristics such as immobility, obesity, severe vessel trauma, and venous stasis put certain trauma and joint replacement surgery patients at high risk for these conditions.

In our review of the literature, we found that there are definite pharmacologic and nonpharmacologic interventions that may reduce the likelihood of developing DVTs and PEs, including exercise, compression stockings, intermittent pneumatic boots, aspirin, enoxaparin, dalteparin, heparin, coumadin, clopidogrel, and fondaparinux. However, the evidence-based guidelines indicate that some patients may still develop clots despite these therapies.

While we are seeking public comments on the applicability of each of the statutory criteria to DVTs and PEs, we are particularly interested in receiving comments on the degree of preventability of DVTs and PEs. We are also interested in comments on determining the presence of DVT and PE at admission. Based on the public comments we receive, we may select DVTs and PEs as HACs.

h. *Staphylococcus aureus* Septicemia

HAC Candidate	Medicare Data (FY 2007)	CC/MCC (ICD-9-CM Codes)	Selected Evidence-Based Guidelines
Staphylococcus aureus Septicemia	• 27,737 cases • $84,976/hospital stay	038.11(MCC) 995.91 (MCC) 995.92 (MCC) 998.59 (CC) 999.3 (CC)	Available on the Web site: http://www.cdc.gov/ncidod/dhqp/gl_isolation.html Available on the Web site: http://www.cdc.gov/ncidod/dhqp/gl_intravascular.html (Intravascular catheter-associated *Staphylococcus aureus* Septicemia only)

We discuss *Staphylococcus aureus* Septicemia in the FY 2008 IPPS final rule with comment period (72 FR 47208). *Staphylococcus aureus* is a bacterium that lives in the nose and on the skin of a large percentage of the population. It usually does not cause physical illness, but it can cause infections ranging from superficial boils to cellulitis to pneumonia to life threatening bloodstream infections (septicemia). It usually enters the body through traumatized tissue, such as cuts or abrasions, or at the time of invasive procedures. *Staphylococcus aureus* Septicemia can also be a late effect of an injury or a surgical procedure. Risk factors for developing *Staphylococcus aureus* Septicemia include advanced age, debilitated state, immunocompromised status, and a history of an invasive medical procedure.

CDC has developed evidence-based guidelines for the prevention of the *Staphylococcus aureus* Septicemia. Most preventable cases of septicemia are primarily related to the presence of a central venous or vascular catheter. During the December 17, 2007 HAC and POA Listening Session, commenters noted that intravascular catheter-associated infections are only one cause of septicemia. Therefore, catheter-oriented evidence-based guidelines would not cover all cases of *Staphylococcus aureus* Septicemia.[10]

We identified evidence-based guidelines that suggest *Staphylococcus aureus* Septicemia is reasonably preventable. These guidelines emphasize the importance of effective and fastidious hand washing by both staff and visitors, using gloves and gowns where appropriate, applying proper decontamination techniques, and exercising contact isolation where clinically indicated.

While we are seeking public comments on the applicability of each of the statutory criteria to *Staphylococcus aureus* infections generally, we are particularly interested in receiving comments on the degree of preventability of *Staphylococcus aureus* infections generally, and specifically *Staphylococcus aureus* Septicemia. Based on the public comments we receive, we may select *Staphylococcus aureus* Septicemia as an HAC.

i. *Clostridium Difficile*-Associated Disease (CDAD)

HAC Candidate	Medicare Data (FY 2007)	CC/MCC (ICD-9-CM Code)	Selected Evidence-Based Guidelines
Clostridium Difficile Associated Disease (CDAD)	• 96,336 cases • $59,153/hospital stay	008.45 (CC)	Available on the Web site: http://www.cdc.gov/ncidod/dhqp/gl_isolation.html Available on the Web site: http://www.cdc.gov/ncidod/dhqp/id_CdiffFAQ_HCP.html#9

We discussed *Clostridium difficile*-associated disease (CDAD) in the FY 2008 IPPS final rule with comment period. *Clostridium difficile* is a bacterium that colonizes the gastrointestinal (GI) tract of a certain number of healthy people. Under conditions where the normal flora of the gastrointestinal tract is altered, *Clostridium difficile* can flourish and release large enough amounts of a toxin to cause severe diarrhea or even life threatening colitis. Risk factors for CDAD include prolonged use of broad spectrum antibiotics, gastrointestinal surgery, prolonged nasogastric tube insertion, and repeated enemas. CDAD can be acquired in the hospital or in the community. Its spores can live outside of the body for months and thus can be spread to other patients in the absence of meticulous hand washing by care providers and others who contact the infected patient.

We continue to receive strong support in favor of selecting CDAD as an HAC. During the December 17, 2007 HAC and POA Listening Session, representatives of consumers and purchasers advocated to include CDAD as an HAC.

The evidence-based guidelines for CDAD prevention emphasize that hand washing by staff and visitors and effective decontamination of environmental surfaces prevent the spread of *Clostridium difficile.* While we are seeking public comments on the applicability of each of the statutory criteria to CDADs, we are particularly interested in receiving comments on the degree of preventability of CDAD. Based on the public comments we receive, we may select CDAD as an HAC.

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

[10] Jensen, A.G. Importance of Focus Identification in the Treatment of *Staphylococcus aureus* Bacteremia. 2002. Vol. 52, pp. 29–36.

HAC Candidate	Medicare Data (FY 2007)	CC/MCC (ICD-9-CM Code)	Selected Evidence-Based Guidelines
Methicillin-Resistant *Staphylococcus aureus* (MRSA) (Code V09.0 includes infections with microorganisms resistant to penicillins	• 88,374 (V09.0) cases • $32,049/hospital stay	No CC/MCC	Available at the Web site: http://www.cdc.gov/ncidod/dhqp/gl_isolation.html

We discussed the special case of methicillin-resistant *Staphylococcus aureus* (MRSA) in the FY 2008 IPPS final rule with comment period (72 FR 47212). In October 2007, the CDC published in the *Journal of the American Medical Association* an article citing high mortality rates from MRSA, an antibiotic-resistant ''superbug.'' The article estimates 19,000 people died from MRSA infections in the United States in 2005. The majority of invasive MRSA cases are health care-related—contracted in hospitals or nursing homes—though community-acquired MRSA also poses a significant public health concern. Hospitals have been focused for years on controlling MRSA through the application of CDC's evidence-based guidelines outlining best practices for combating the bacterium in that setting.

MRSA is currently addressed by the HAC payment provision. For every infectious condition selected, MRSA could be the etiology of that infection. For example, if MRSA were the cause of a vascular catheter-associated infection (one of the eight conditions selected in the FY 2008 IPPS final rule with comment period), the HAC payment provision would apply to that MRSA infection.

As we noted in the FY 2008 IPPS final rule with comment period, colonization by MRSA is not a reasonably preventable HAC according to the current evidence-based guidelines; therefore, MRSA does not meet the reasonably preventable statutory criterion for an HAC. An estimated 32.4 percent of Americans are colonized with MRSA, which may reside in the nose or on the skin of asymptomatic carriers.[11] In addition, in last year's final rule with comment period, we noted that there is no CC/MCC code available for MRSA, and therefore it also does not meet the codeable CC/MCC statutory criterion for an HAC. Only when MRSA causes an infection does a codeable condition occur. However, we referenced the possibility that new codes for MRSA were being considered by the ICD–9–CM Coordination and Maintenance Committee. The creation of unique codes to capture MRSA was discussed during the March 19–20, 2008 Committee meeting. While these codes will enhance the data available and our understanding of MRSA, the availability and use of these codes will not change the fact that the mere presence of MRSA as a colonizing bacterium does not constitute an HAC.

Because MRSA as a bacterium does not meet two of our statutory criteria, codeable CC/MCC and reasonably preventable through evidence-based guidelines, we are not proposing MRSA as an HAC. However, we recognize the significant public health concerns that were raised by representatives of consumers and purchasers at the HAC and POA Listening Session, and we are committed to reducing the spread of multi-drug resistant organisms, such as MRSA.

In addition, we are pursuing collaborative efforts with other HHS agencies to combat MRSA. The Agency for Healthcare Research and Quality (AHRQ) has launched a new initiative in collaboration with CDC and CMS to identify and suppress the spread of MRSA and related infections. In support of this work, Congress has appropriated $5 million to fund research, implementation, management, and evaluation practices that mitigate such infections.

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

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

8. Present on Admission (POA) Indicator Reporting

POA indicator information is necessary to identify which conditions were acquired during hospitalization for the HAC payment provision and for broader public health uses of Medicare data. Through Change Request No. 5679 (released June 20, 2007), CMS issued instructions requiring IPPS hospitals to submit the POA indicator data for all diagnosis codes on Medicare claims. Specific instructions on how to select the correct POA indicator for each diagnosis code are included in the ICD–9–CM Official Guidelines for Coding and Reporting, available at the Web site: *http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/icdguide07.pdf* (POA

[11] Kuehnert, M.J., et al.: Prevalence of *Staphylococcusa aureus* Nasal Colonization in the United States, 2001-2002. The Journal of Infectious Disease, January 15, 2006; Vol. 193.

reporting guidelines begin on page 92). Additional instructions, including information regarding CMS's phased implementation of POA indicator reporting and application of the POA reporting options, are available at the Web site: *http://www.cms.hhs.gov/HospitalAcqCond.*

There are five POA indicator reporting options: ''Y,'' ''N,'' ''W,'' ''U,'' and ''1.'' Under the HAC payment provision, we are proposing to pay the CC/MCC MS–DRGs only for those HACs coded as ''Y'' and ''W'' indicators. The ''Y'' option indicates that the condition was present on admission. The ''W'' indicator affirms that the provider has determined, based on data and clinical judgment, that it is not possible to document when the onset of the condition occurred. We expect that this approach will encourage better documentation and promote the public health goals of POA reporting by providing more accurate data about the occurrence of HACs in the Medicare population. We anticipate that true clinical uncertainty will occur in only a very small number of cases. We plan to analyze how frequently the ''W'' indicator is used, and we leave open the possibility of proposing in future IPPS rulemaking not paying the CC/MCC MS–DRGs for HACs coded with the ''W'' indicator. In addition, we plan to analyze whether both the ''Y'' and ''W'' indicators are being used appropriately. Medicare program integrity initiatives closely monitor for inaccurate coding and coding that is inconsistent with medical record documentation. We are seeking public comments regarding the proposed treatment of the ''Y'' and ''W'' POA reporting options under the HAC payment provision.

We are proposing to not pay the CC/MMC MS–DRGs for HACs coded with the ''N'' indicator. The ''N'' option indicates that the condition was not present on admission. We are also proposing to not pay the CC/MCC MS–DRGs for HACs coded with the ''U'' indicator. The ''U'' option indicates that the medical record documentation is insufficient to determine whether the condition was present at the time of admission. Not paying for the CC/MCC MS–DRGs for HACs that are coded with the ''U'' indicator is expected to foster better medical record documentation.

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

PATIENT DISCHARGE STATUS CODES

Form locator code	Code descriptor
Exception for Patient Death	
20	Expired.
Exception for Patient Elopement (Leaving Against Medical Device)	
7	Left against medical advice or discontinued care.
Exception for Transfer	
02	Discharged/transferred to a short-term general hospital for inpatient care.
03	Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care.
04	Discharged/transferred to an intermediate care facility (ICF).
05	Discharged/transferred to a designated cancer center or children's hospital.
06	Discharged/transferred to home under care of organized home health service organization.
43	Discharged/transferred to a Federal health care facility.
50	Hospice-home.
51	Hospice-medical facility (certified) providing hospice level of care.
61	Discharged/transferred to a hospital-based Medicare approved swing bed.
62	Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital.
63	Discharged/transferred to a Medicare certified long term care hospital (LTCH).
64	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare.
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital.
66	Discharged/transferred to a critical access hospital (CAH).
70	Discharged/transferred to another type of health care institution not otherwise defined in this code list.

We plan to analyze whether both the ''N'' and ''U'' POA reporting options are being used appropriately. The American Health Information Management Association (AHIMA) has promulgated Standards of Ethical Coding that require accurate coding regardless of the payment implications of the diagnoses. That is, diagnoses must be reported accurately regardless of their effect on payment. Medicare program integrity initiatives closely monitor for inaccurate coding and coding inconsistent with medical record documentation. We are seeking public comments regarding the proposal to not pay the CC/MCC MS–DRGs for HACs coded with ''N'' and ''U'' indicators.

9. Enhancement and Future Issues

The preventable HAC payment provision is one of CMS' VBP initiatives, as noted earlier in this section. VBP ties payment to performance through the use of incentives based on quality measures and cost of care. The implementation of VBP is rapidly transforming CMS from being a passive payer of claims to an active purchaser of higher quality, more efficient health care for Medicare beneficiaries. Other VBP initiatives include hospital pay for reporting (the RHQDAPU program discussed in section IV.B. of the preamble of this proposed rule), physician pay for reporting (the Physician Quality Reporting Initiative), home health pay for reporting, the Hospital VBP Plan Report to Congress (discussed in section IV.C. of the preamble of this proposed rule), and various VBP demonstration

programs across payment settings, including the Premier Hospital Quality Incentive Demonstration and the Physician Group Practice Demonstration.

The success of CMS' VBP initiatives depends in large part on the validity of the performance measures and on the effectiveness of incentives in driving desired changes in behavior that will result in greater quality and efficiency. We are committed to enhancing the Medicare VBP programs, in close collaboration with stakeholders, to fulfill VBP's potential to promise of promoting higher value health care for Medicare beneficiaries. It is in this spirit that we seek public comment on enhancements to the preventable HACs payment policy and to concomitant POA indicator reporting.

We welcome all public comments presenting ideas and models for combating preventable HACs through the application of VBP principles. To stimulate reflection and creativity, we present several options:

- Risk adjustment could be applied to make the HAC payment provision more precise.
- Rates of HACs could be collected to obtain a more robust longitudinal measure of a hospital's incidence of these conditions.
- POA information could be used in various ways to decrease the incidence of preventable HACs.
- The adoption of ICD–10–PCS could facilitate more precise identification of HACs.
- The principle behind the HAC payment provision (Medicare not paying more for preventable HACs) could be applied to Medicare payments in settings of care other than the IPPS.
- CMS is using authority other than the HAC payment provision to address other events on the NQF's list of Serious Reportable Adverse Events.

We note that we are not proposing new Medicare policy in this Enhancements and Future Issues discussion, as some of these approaches may require new statutory authority.

a. Risk Adjustment

To make the HAC payment provision more precise, the adjustments to payment made when one of the selected HACs occurs during the hospitalization could be further adjusted to account for patient-specific risk factors. The expected occurrence of an HAC may be greater or lesser depending on the health status of the patient, as reflected by severity of illness, presence of comorbidities, or other factors. Rather than not paying any additional amount for the complication, the additional payment for the complication could range from zero for the lowest risk patient to the full amount for the highest risk patient. An option may be individualized adjustment for every hospitalization based on the patient's unique characteristics, but state-of-the-art risk adjustment currently precludes such individualized adjustment.

b. Rates of HACs

Given our limited capability at present for precise patient-level risk adjustment, adding a consideration of risk to the criteria for selecting HACs could be an alternative. If primarily high-risk patients are acquiring a certain condition during hospitalization, that condition could be considered a less-fit candidate for selection. Other alternatives to precise individualized risk adjustment could be adjustment for overall facility case mix or facility case-mix by condition. At the highest level, national Medicare program data could be used to make adjustments to the payment implications for the selected HACs based on expected rates of complications. Another option could be to designate certain patient risk factors as exemptions that would prohibit or mitigate the application of the HAC payment policy to the claims of patients with those risk factors.

The Medicare Hospital VBP Plan was submitted in a Report to Congress on November 21, 2007. The plan includes a performance assessment model that scores a hospital's attainment or improvement on various measures. The scores for each measure would be summed within each domain, such as the clinical process of care domain or the patient experience domain, and then the domains would be weighted and summed to yield a total performance score. The total performance score would then be translated into an incentive payment, proposed to be a certain percentage of each MS–DRG payment, using an exchange function. The plan also calls for public reporting of hospitals' performance scores by domain and in total. (Section IV.C. of this preamble included a related discussion of the Hospital VBP Plan Report to Congress.)

In accordance with this hospital VBP model, a hospital's rates of HACs could be included as a domain within each hospital's total performance score. The measurement of rates over time could be a more meaningful, actionable, and fair way to adjust a hospital's MS–DRG payments for the incidence of HACs. The consequence of a higher incidence of measured conditions would be a lower VBP incentive payment. Public reporting of the measured rates of HACs would give hospitals an additional, nonfinancial incentive to prevent occurrence of the conditions to avoid lower public ratings.

c. Use of POA Information

Information obtained from hospitals' reporting of POA data could be used in various ways to better understand and prevent the occurrence of HACs. The POA information could be provided to health services researchers to analyze factors that lead to HACs and disseminate the best practices for prevention of HACs. At least two states, New York and California, already collect POA data from their hospitals. Comparison of the State POA data with the Medicare data could fill in gaps in the databases and yield valuable insights about POA data validity.

POA data could also be used to calculate the incidence of HACs by hospital. This application of the POA data would be particularly powerful if the Medicare POA data were combined with state or private sector payer POA data. The Medicare-only or combined quality of care information could be initially shared with hospitals and thereafter publicly reported to support better healthcare decision making by Medicare beneficiaries, other health care consumers, professionals, and caregivers.

d. Transition to ICD–10–PCS

Accurate identification of HACs requires unambiguous and precise diagnosis codes. The current ICD–9–CM diagnosis coding system is three decades old. It is outdated and contains numerous instances of broad and vague codes. Attempts to add necessary detail to the ICD–9–CM system are inhibited by lack of expansion capacity. These factors negatively affect CMS' attempts to identify HAC cases.

ICD–10–PCS codes are more precise and capture information using more current medical terminology. For example, ICD–9–CM codes for pressure ulcers do not provide information about the size, depth, or exact location of the ulcer, while ICD–10–PCS has 60 codes to capture this information. ICD–10–PCS would also provide codes, beyond the current ICD–9–CM codes, that would enable the selection of additional surgical complications and adverse drug events.

e. Application of Nonpayment for HACs to Other Settings

The broad principle of Medicare not paying for preventable health care-associated conditions could potentially be applied to Medicare payment settings other than IPPS hospitals. Other

possible settings of care might include hospital outpatient departments, SNFs, HHAs, end-stage renal disease facilities, and physician practices. The implications would be different for each setting, as each payment system is different and the reasonable preventability through the application of evidence-based guidelines would vary for candidate conditions over the different settings. However, alignment of incentives across settings of care is an important goal for all of CMS' VBP initiatives, including the HAC provision.

A related application of the broad principle behind the HAC payment could be accomplished through modification to the Medicare secondary payer policy which would allow us to directly recoup from the provider that failed to prevent the occurrence of a preventable condition in one setting to pay for all or part of the necessary followup care in a second setting. This would help shield the Medicare program from inappropriately paying for the downstream effects of a preventable condition acquired in the first setting but treated in the second setting.

f. Relationship to NQF's Serious Reportable Adverse Events

CMS is applying its authority to address the events on the NQF's list of Serious Reportable Adverse Events (also known as ''never events''). In May 2006 testimony before the Senate Finance Committee, the CMS Administrator noted that paying hospitals for serious preventable events is contrary to the promise that hospital payments should support higher quality and efficiency. There is growing consensus that health care purchasers should not be paying for these events when they occur during a hospitalization. In January 2005, HealthPartners, a Minnesota-based not-for-profit HMO, announced that it would no longer reimburse hospitals for services associated with events enumerated in the Minnesota Adverse Health Care Events Reporting Act (essentially the NQF's list of Serious Reportable Adverse Events). Further, HealthPartners' contracts preclude hospitals from seeking reimbursement from the patient for these costs. During 2007, several State hospital associations adopted policies stating that their members will not bill payers or patients when these events occur in their hospitals.

In the FY 2008 IPPS final rule with comment period, we adopted several items from the NQF's list of events as HACs, including retained foreign object after surgery, air embolism, blood incompatibility, stage III and IV pressure ulcers, falls, electric shock, and burns. In this proposed rule, we are seeking public comments regarding adding hypoglycemic coma, which is closely related to NQF's listing of death or serious disability associated with hypoglycemia. However, as we discussed in the FY 2008 IPPS final rule with comment period, the HAC payment provision is not ideally suited to address every condition on the NQF's list of Serious Reportable Adverse Events. To address the events on the NQF's list beyond the effect of the HAC policy, CMS is exploring the application of Medicare authority, including other payment provisions, coverage policy, conditions of participation, and Quality Improvement Organization (QIO) retrospective review.

We note that we are not proposing new Medicare policy in this discussion of the HAC payment provision for IPPS hospitals, as some of these approaches may require new statutory authority. We are seeking public comments on these and other options for enhancing the preventable HACs payment provision and maximizing the use of POA indicator reporting data. We look forward to working with stakeholders in the fight against HACs.

G. Proposed Changes to Specific MS–DRG Classifications

1. Pre-MDCs: Artificial Heart Devices

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

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

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

On August 1, 2007, CMS began a national coverage determination process for artificial hearts. SynCardia Systems, Inc. submitted a request for reconsideration of the longstanding noncoverage policy when its device, the CardioWest Temporary Total Artificial Heart (TAH–t) System, is used for ''bridge to transplantation'' in accordance with the FDA-labeled indication for the device. ''Bridge to transplantation'' is a phrase meaning that a patient in end-stage heart failure may qualify as a heart transplant candidate, but will require mechanical circulatory support until a donor heart becomes available. The CardioWest TAH–t System is indicated for use as a bridge to transplantation in cardiac transplant-eligible candidates at risk of imminent death from biventricular

failure. The system is intended for use inside the hospital as the patient awaits a donor heart. The ultimate desired outcome for insertion of the TAH–t is a successful heart transplant, along with the potential that offers for cure from heart failure.

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

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

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

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

During FY 2008, we are making mid-year changes to portions of the GROUPER program that do not affect MS–DRG assignment or ICD–9–CM coding. However, as the proposed coverage decision memorandum for artificial hearts was published after the CMS contractor's testing and release of the mid-year product, the above proposed changes to the MCE will not be included in that revision of the GROUPER Version 25.0. GROUPER Version 26.0, which will be in use for FY 2009, will contain the proposed changes if they are approved. If the proposed revisions to the MCE are accepted, the edits in the MCE Version 25.0 will be effective retroactive to May 1, 2008. (To reduce confusion, we note that the version number of the MCE is one digit lower than the current GROUPER version number; that is, Version 26.0 of the GROUPER uses Version 25.0 of the MCE.)

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

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

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

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

For FY 2008, with the adoption of MS–DRGs, CMS DRG 559 became MS–DRGs 061 (Acute Ischemic Stroke with Use of Thrombolytic Agent with MCC), 062 (Acute Ischemic Stroke with Use of Thrombolytic Agent with CC), and 063 (Acute Ischemic Stroke with Use of Thrombolytic Agent without CC/MCC). Stroke cases in which no thrombolytic

agent was administered were grouped to MS–DRGs 064 (Intracranial Hemorrhage or Cerebral Infarction with MCC), 065 (Intracranial Hemorrhage or Cerebral Infarction with CC), or 066 (Intracranial Hemorrhage or Cerebral Infarction without CC/MCC). The MS–DRGs that reflect use of a thrombolytic agent, that is, MS–DRGs 061, 062, and 063, have higher relative weights than the hemorrhagic or cerebral infarction MS–DRGs 064, 065, and 066.

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

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

b. Intractable Epilepsy With Video Electroencephalogram (EEG)

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

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

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

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

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

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

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

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

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

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

In applying the criteria to establish subgroups, the data do not support the creation of a new subdivision for MS–DRG 101 for cases with intractable epilepsy and vEEG nor does the data support moving the 879 cases from MS–DRG 101 to MS–DRG 100. Moving the 879 cases to MS–DRG 100 would mean moving cases with average charges of approximately $19,000 into an MS–DRG with average charges of $28,000. Therefore, we are not proposing to refine MS–DRG 101 by subdividing cases with a primary diagnosis of intractable epilepsy (codes 345.01 through 345.91) when vEEG (code 89.19) is also performed into a separate MS–DRG.

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

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

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

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

Commenters on the FY 2008 IPPS proposed rule supported this new MS–DRG, which recognizes the distinct differences in resource utilization between pacemaker and defibrillator generators and leads, but suggested 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.

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

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

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

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

In our analysis of the FY 2007 MedPAR data, we found a total of 5,546 cases in MS–DRG 245 with average charges of $62,631 and an average length of stay of 3.3 days. We found 1,894 cases with implantation or replacement of the defibrillator leads (codes 37.95, 37.97, and 00.52) with average charges of $42, 896 and an average length of stay of 3.4 days. We also found a total of 3,652 cases with implantation or replacement of the pulse generator (codes 37.96, 37.98, 00.54) with average charges of $72, 866 and an average length of stay of 3.2 days.

We agree with the requestor that the IPPS should accurately recognize differences in resource utilization for clinically distinct procedures. As the data demonstrate, average charges for the implantation or replacement of the AICD pulse generators are significantly higher than for the implantation or replacement of the AICD leads. Therefore, we are proposing to create a new MS–DRG 265 to separately identify these distinct procedures. The proposed new MS–DRG 265 would be titled ''AICD Lead Procedures'' and would include procedure codes that identify the AICD leads (codes 37.95, 37.97 and 00.52). The title for MS–DRG 245 would be revised to ''AICD Generator Procedures'' and include procedure codes 37.96, 37.98, 00.54. We believe these changes would better reflect the clinical differences and resources utilized for these distinct procedures.

b. Left Atrial Appendage Device

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

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

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

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

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

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

With regard to the request to create a specific DRG for the insertion of this device entitled ''Percutaneous Cardiovascular Procedures with Implantation of a Left Atrial Appendage Device without CC/MCC'', we would point out that the payments under a prospective payment system are predicated on averages. The device is already assigned to MS–DRGs containing other percutaneous cardiovascular devices; to create a new MS–DRG specific to this device would be to remove all other percutaneously inserted devices and base the MS–DRG assignment solely on the presence of code 37.90. This approach negates our longstanding method of grouping like procedures, and removes the concept of averaging. Further, to ignore the structure of the MS–DRG system solely for the purpose of increasing payment for one device would set an unwelcome precedent for defining all of the other MS–DRGs in the system. We would also point out that the final rule establishing the MS–DRGs set forth five criteria, all five of which are required to be met, in order to warrant creation of a CC or an MCC subgroup within a base MS–DRG. The criteria can be found in the FY 2008 IPPS final rule with comment period (72 FR 47169). One of the criteria specifies that there will be at least 500 cases in the CC or MCC subgroup. To date, there are not enough cases of code 37.90 reported within the MedPAR data.

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

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

MS–DRG	Number of cases	Average length of stay	Average charges
251—Cases with code 37.90	101	1.30	20,846.09
251—Cases without code 37.90	39,335	2.85	35,757.98

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

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

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

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

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

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

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

CMS DRG 545 included the following procedure code assignments:

- 00.70, Revision of hip replacement, both acetabular and femoral components.
- 00.71, Revision of hip replacement, acetabular component.
- 00.72, Revision of hip replacement, femoral component.
- 00.73, Revision of hip replacement, acetabular liner and/or femoral head only.
- 00.80, Revision of knee replacement, total (all components).
- 00.81, Revision of knee replacement, tibial component.
- 00.82, Revision of knee replacement, femoral component.
- 00.83, Revision of knee replacement, patellar component.
- 00.84, Revision of knee replacement, tibial insert (liner).
- 81.53, Revision of hip replacement, not otherwise specified
- 81.55, Revision of knee replacement, not otherwise specified

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

b. Prior Recommendations of the AAHKS

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

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

characteristics, procedure characteristics, resource utilization, and procedure code payment rates between total hip and total knee replacements, separate DRGs were warranted. Furthermore, the AAHKS recommended that CMS create separate base DRGs for routine versus complex joint revision or replacement procedures as shown below.

Routine Hip Replacements

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

Complex Hip Replacements

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

Routine Knee Replacements and Ankle Procedures

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

Complex Knee Replacements and Other Reattachments

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

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

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

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

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

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

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

In the FY 2008 IPPS final rule with comment period, we acknowledged the valuable assistance the AAHKS had provided to CMS in creating the new joint replacement procedure codes and modifying the joint replacement DRGs beginning in FY 2006. These efforts greatly improved our ability to categorize significantly different groups of patients according to severity of illness. Commenters on the FY 2008 proposed rule had encouraged CMS to continue working with the orthopedic community, including the AAHKS, to monitor the need for additional new DRGs. The commenters stated that MS–DRGs 466 through 470 are a good first step. However, they stated that CMS should continue to evaluate the data for these procedures and consider additional refinements to the MS–DRGs, including the need for additional severity levels. AAHKS stated that its data suggest that all three base DRGs (primary replacement, revision of major joint replacement, and bilateral joint replacement) should be separated into three severity levels (that is, MCC, CC, and non-CC). (We had proposed three severity levels for revision of hip and knee replacement (MS–DRGs 466, 467, and 468), and AAHKS agreed with this 3-level subdivision.)

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

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

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

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

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

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

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

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

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

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

d. AAHKS' Recommendations for FY 2009

The AAHKS' current request involves the following recommendations:

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

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

(1) AAHKS Recommendation 1: Consolidate and reassign patients with hip and knee prosthesis related infections or malignancies.

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

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

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

After the completion of antibiotic therapy, the hip or knee may be reaspirated to look for evidence of persistent infection or eradication of infection. A second stage procedure is then undertaken, where the patient is readmitted, the hip or knee is reexplored, and the cement spacer removed. If there are no signs of persistent infection, a hip or knee prosthesis is reimplanted, often using bone graft and costly revision implants in order to address extensive bone loss

and distorted anatomy. Thus, the entire course of treatment for patients with infected joint replacements is 4 to 6 months, with an additional 6 to 12 months of rehabilitation. Furthermore, clinical outcomes following revision for infection are poor relative to outcomes following revision for other, aseptic causes. The AAHKS noted that patients with bone malignancy have a similar treatment focus—surgery to remove diseased tissue, chemotherapy to treat the malignancy, and implantation of the new prosthesis. They also have similar resource use. For simplicity, the AAHKS' discussion focused on infected joint prostheses, but it suggested that the issues it raises would apply to patients with a malignancy as well.

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

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

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

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

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

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

Stage 1 Infection/Neoplasm/Defect Principal Diagnosis Codes

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

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

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

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

Stage 2 Infection/Neoplasm/Defect Secondary Diagnosis Codes

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

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

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

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

e. CMS' Response to AAHKS' Recommendations

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

(1) Changing the MS–DRG Assignment for Codes 00.73, 00.83, and 00.84

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

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

MS–DRG	Number of cases	Average length of stay	Average charges
485—All Cases	1,122	12.20	$64,672.47
485—Cases with Code 00.83 or 00.84	179	11.83	64,446.68
485—Cases without Code 00.83 or 00.84	943	12.27	64,715.33
486—All Cases	2,061	8.03	40,758.55
486—Cases with Code 00.83 or 00.84	464	7.34	39,864.39
486—Cases without Code 00.83 or 00.84	1,597	8.23	41,018.34
487—All Cases	1,236	5.67	29,180.88
487—Cases with Code 00.83 or 00.84	284	5.61	31,231.79
487—Cases without Code 00.83 or 00.84	952	5.68	28,569.06
488—All Cases	2,374	5.17	30,180.80
488—Cases with code 00.83 or 00.84	754	4.09	28,432.06
488—Cases without code 00.83 or 00.84	1,620	5.67	30,994.73
489—All Cases	5,493	3.04	21,385.67
489—Cases with code 00.83 or 00,.84	2,154	3.07	23,122.18
489—Cases without code 00.83 or 00.84	3,339	3.03	20,265.44
469—All cases	29,030	8.17	56,681.64
470—All Cases	385,123	3.93	36,126.23
466—All Cases	3,888	9.18	76,015.66
466—Cases with Code 00.73	273	10.02	71,293.33

MS–DRG	Number of cases	Average length of stay	Average charges
466—Cases without Code 00.73	3,616	9.12	76,372.06
467—All Cases	13,551	5.50	53,431.63
467—Cases with Code 00.73	1,078	5.94	43,635.63
467—Cases without Code 00.73	12,484	5.47	54,284.13
468—All Cases	19,917	3.94	44,055.62
468—Cases with Code 00.73	1,688	3.93	33,449.22
468—Cases without Code 00.73	18,232	3.94	45,037.09
469—All Cases	29,030	8.17	56,681.64
470—All Cases	385,123	3.93	36,126.23

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

(2) Excluding Sepsis and Septicemia From Being a MCC With Code 996.66

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

(3) Differences Between Stage 1 and 2 Cases With Severe Diagnoses

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

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

STAGE 1.—CASES WITH INFECTION, NEOPLASM, OR STRUCTURAL DEFECT

Stage 1	Total cases	Average length of stay	Average charges
With MCC	1,306	14.1	$79,232
Without MCC	4,115	7.6	44,716

STAGE 2.—CASES WITH INFECTION, NEOPLASM, OR STRUCTURAL DEFECT

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

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

(4) Moving Joint Procedure Cases to New MS–DRGs Based on Secondary Diagnoses of Infection

We examined AAHKS' recommendation that Stage 2 joint cases with specific secondary diagnoses of infection or neoplasm be moved out of their current MS–DRG assignments and into a newly constructed MS–DRG.

We are reluctant to make this type of significant DRG change to the joint MS–DRGs based on the presence of a secondary diagnosis. This results in the movement of cases out of MS–DRGs which were configured based on the reason for the admission (for example, principal diagnosis) and surgery. The cases would instead be assigned based on conditions that are reported as secondary diagnoses. In some cases, the infection may have developed or be diagnosed during the admission. This would be a significant logic change to the MS–DRGs for joint procedures. We have not had an opportunity to examine

claims data based on hospital discharges under the MS–DRGs which began October 1, 2008. Our clinical advisors believe it would be more appropriate to wait for data under the new MS–DRG system to determine how well the new severity levels are addressing accurate payment for these cases before considering this approach to assigning cases to a MS–DRG.

(5) Moving Cases With Infection, Neoplasms, or Structural Defects Out of 19 MS–DRGs and Into Two Newly Developed MS–DRGs

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

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

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

MS–DRGs	Number of cases	Average length of stay	Average charges
463—All Cases	4,747	16.25	$73,405.46
463—Cases with PDX of Infection/Malignancy/React	1,009	17.79	81,089.07
464—All Cases	5,499	10.21	44,387.73
464—Cases with PDX of Infection/Malignancy/React	1,420	10.59	46,800.60
465—All Cases	2,271	5.95	26,631.57
465—Cases with PDX of Infection/Malignancy/React	557	10.59	29,816.40
466—All Cases	3,888	9.18	76,015.66
466—Cases with PDX of Infection/Malignancy/React	890	10.67	79,334.69
467—All Cases	13,551	5.50	53,431.63
467—Cases with PDX of Infection/Malignancy/React	2,401	6.71	58,506.86
468—All Cases	19,917	3.94	44,055.62
468—Cases with PDX of Infection/Malignancy/React	1,994	4.76	54,322.03
469—All Cases	29,030	8.17	56,681.64
469—Cases with PDX of Infection/Malignancy/React	136	11.74	85,256.07
470—All Cases	385,123	3.93	36,126.23
470—Cases with PDX of Infection/Malignancy/React	673	6.44	59,676.31
480—All Cases	25,391	9.32	52,281.65
480—Cases with PDX of Infection/Malignancy/React	880	14.53	76,355.15
481—All Cases	68,655	5.94	32,963.64
481—Cases with PDX of Infection/Malignancy/React	878	8.78	48,655.30
482—All Cases	45,832	4.86	27,266.20
482—Cases with PDX of Infection/Malignancy/React	577	6.19	37,572.38
485—All Cases	1,122	12.20	64,672.47
485—Cases with PDX of Infection/Malignancy/React	1,122	12.20	64,672.47
486—All Cases	2,061	8.03	40,758.55
486—Cases with PDX of Infection/Malignancy/React	2,061	8.03	40,758.55
487—All Cases	1,236	5.67	29,180.88
487—Cases with PDX of Infection/Malignancy/React	1,236	5.67	29,180.88
488—All Cases	2,374	5.17	30,180.80
488—Cases with PDX of Infection/Malignancy/React	31	7.13	50,155.42
489—All Cases	5,493	3.04	21,385.67
489—Cases with PDX of Infection/Malignancy/React	36	3.72	35,313.84
495—All Cases	1,860	10.94	55,103.91
495—Cases with PDX of Infection/Malignancy/React	1,025	11.74	59,453.69
496—All Cases	5,203	5.95	32,177.29
496—Cases with PDX of Infection/Malignancy/React	2,759	6.98	36,940.99
497—All Cases	6,259	3.01	21,445.60
497—Cases with PDX of Infection/Malignancy/React	1,500	5.18	29,966.98

Given the wide variety of charges and the small number of cases where there are differences in charges, we do not believe the data support the AAHKS' recommendations. The data do not support removing these cases from the 19 MS–DRGs above and consolidating them into a new set of MS–DRGs, either newly created, or by adding them to

MS–DRG 461 or 462, which have average charges of $80,718 and $57,355, respectively.

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

f. Conclusion

The AAHKS recommended a number of complicated, interrelated MS–DRG changes to the joint procedure MS–DRGs. We have not yet had the opportunity to review data for these cases under the new MS–DRGs. We did analyze the impact of these recommendations using cases prior to the implementation of MS–DRGs. The recommendations were difficult to analyze because there were so many separate logic changes that impacted a number of MS–DRGs. We did examine each major suggestion separately, and found that our data and clinical analysis did not support making these changes. Therefore, we are not proposing any revisions to the joint procedure MS–DRGs for FY 2009. We look forward to examining these issues once we receive data under the MS–DRG system. We also welcome additional recommendations from the AAHKS and others on a more incremental approach to resolving its concerns about the ability of the current MS–DRGs to adequately capture differences in severity levels for joint procedure patients.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Therefore, we are proposing to add traumatic compartment syndrome codes 958.90 through 958.99 to MS–DRGs 963 and MS–DRG 965 in MDC 24. Under

this proposal, codes 958.90 through 958.99 would be added to the list of principal diagnosis of significant trauma. In addition, code 958.91 would be added to the list of significant trauma of upper limb, code 958.92 would be added to the list of significant trauma of lower limb, and code 958.93 would be added to the list of significant abdominal trauma.

7. Medicare Code Editor (MCE) Changes

As explained under section II.B.1. of the preamble of this proposed rule, the Medicare Code Editor (MCE) is a software program that detects and reports errors in the coding of Medicare claims data. Patient diagnoses, procedure(s), and demographic information are entered into the Medicare claims processing systems and are subjected to a series of automated screens. The MCE screens are designed to identify cases that require further review before classification into a DRG. For FY 2009, we are proposing to make the following changes to the MCE edits:

a. List of Unacceptable Principal Diagnoses in MCE

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

b. Diagnoses Allowed for Males Only Edit

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

c. Limited Coverage Edit

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

8. Surgical Hierarchies

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

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

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

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

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

A second example occurs when the difference between the average charges for two surgical classes is very small. We have found that small differences generally do not warrant reordering of the hierarchy because, as a result of reassigning cases on the basis of the hierarchy change, the average charges are likely to shift such that the higher-ordered surgical class has a lower

average charge than the class ordered below it.

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

9. CC Exclusions List

a. Background

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

b. CC Exclusions List for FY 2009

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

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

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

The creation of the CC Exclusions List was a major project involving hundreds of codes. We have continued to review the remaining CCs to identify additional exclusions and to remove diagnoses from the master list that have been shown not to meet the definition of a CC.[12]

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

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

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

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

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

Code	Description
249.10	Secondary diabetes mellitus with ketoacidosis, not stated as uncontrolled, or unspecified.
249.11	Secondary diabetes mellitus with ketoacidosis, uncontrolled.
249.20	Secondary diabetes mellitus with hyperosmolarity, not stated as uncontrolled, or unspecified.

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

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

Code	Description
249.21	Secondary diabetes mellitus with hyperosmolarity, uncontrolled.
249.30	Secondary diabetes mellitus with other coma, not stated as uncontrolled, or unspecified.
249.31	Secondary diabetes mellitus with other coma, uncontrolled.
707.23	Pressure ulcer, stage III.
707.24	Pressure ulcer, stage IV.
777.50	Necrotizing enterocolitis in newborn, unspecified.
777.51	Stage I necrotizing enterocolitis in newborn.
777.52	Stage II necrotizing enterocolitis in newborn.
777.53	Stage III necrotizing enterocolitis in newborn.
780.72	Functional quadriplegia.

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

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

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

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

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

Code	Description
209.10	Malignant carcinoid tumor of the large intestine, unspecified portion.
209.11	Malignant carcinoid tumor of the appendix.
209.12	Malignant carcinoid tumor of the cecum.
209.13	Malignant carcinoid tumor of the ascending colon.
209.14	Malignant carcinoid tumor of the transverse colon.
209.15	Malignant carcinoid tumor of the descending colon.
209.16	Malignant carcinoid tumor of the sigmoid colon.
209.17	Malignant carcinoid tumor of the rectum.
209.20	Malignant carcinoid tumor of unknown primary site.
209.21	Malignant carcinoid tumor of the bronchus and lung.
209.22	Malignant carcinoid tumor of the thymus.
209.23	Malignant carcinoid tumor of the stomach.
209.24	Malignant carcinoid tumor of the kidney.
209.25	Malignant carcinoid tumor of foregut, not otherwise specified.
209.26	Malignant carcinoid tumor of midgut, not otherwise specified.
209.27	Malignant carcinoid tumor of hindgut, not otherwise specified.
209.29	Malignant carcinoid tumor of other sites.
209.30	Malignant poorly differentiated neuroendocrine carcinoma, any site.
238.77	Post-transplant lymphoproliferative disorder (PTLD).
279.50	Graft-versus-host disease, unspecified.
279.51	Acute graft-versus-host disease.
279.52	Chronic graft-versus-host disease.
279.53	Acute on chronic graft-versus-host disease.
346.60	Persistent migraine aura with cerebral infarction, without mention of intractable migraine without mention of status migrainosus.
346.61	Persistent migraine aura with cerebral infarction, with intractable migraine, so stated, without mention of status migrainosus.
346.62	Persistent migraine aura with cerebral infarction, without mention of intractable migraine with status migrainosus.
346.63	Persistent migraine aura with cerebral infarction, with intractable migraine, so stated, with status migrainosus.
511.81	Malignant pleural effusion.
511.89	Other specified forms of effusion, except tuberculous.
649.70	Cervical shortening, unspecified as to episode of care or not applicable.
649.71	Cervical shortening, delivered, with or without mention of antepartum condition.
649.73	Cervical shortening, antepartum condition or complication.
695.12	Erythema multiforme major.
695.13	Stevens-Johnson syndrome.
695.14	Stevens-Johnson syndrome-toxic epidermal necrolysis overlap syndrome.
695.15	Toxic epidermal necrolysis.
695.53	Exfoliation due to erythematous condition involving 30–39 percent of body surface.
695.54	Exfoliation due to erythematous condition involving 40–49 percent of body surface.
695.55	Exfoliation due to erythematous condition involving 50–59 percent of body surface.
695.56	Exfoliation due to erythematous condition involving 60–69 percent of body surface.
695.57	Exfoliation due to erythematous condition involving 70–79 percent of body surface.
695.58	Exfoliation due to erythematous condition involving 80–89 percent of body surface.
695.59	Exfoliation due to erythematous condition involving 90 percent or more of body surface.
997.31	Ventilator associated pneumonia.
997.39	Other respiratory complications.
998.30	Disruption of wound, unspecified.
998.33	Disruption of traumatic wound repair.
999.81	Extravasation of vesicant chemotherapy.
999.82	Extravasation of other vesicant agent.

SUMMARY OF DELETIONS TO THE MS–DRG CC LIST.—TABLE 6J.2

Code	Description
046.1	Jakob-Creutzfeldt disease.
337.0	Idiopathic peripheral autonomic neuropathy.
695.1	Erythema multiforme.
707.00	Pressure ulcer, unspecified site.
707.01	Pressure ulcer, elbow.
707.09	Pressure ulcer, other site.
997.3	Respiratory complications.
999.8	Other transfusion reaction.

Alternatively, the complete documentation of the GROUPER logic, including the current CC Exclusions List, is available from 3M/Health Information Systems (HIS), which, under contract with CMS, is responsible for updating and maintaining the GROUPER program. The current DRG Definitions Manual, Version 25.0, is available for $225.00, which includes $15.00 for shipping and handling. Version 26.0 of this manual, which will include the final FY 2009 DRG changes, will be available in hard copy for $250.00. Version 26.0 of the manual is also available on a CD for $200.00; a combination hard copy and CD is available for $400.00. These manuals may be obtained by writing 3M/HIS at the following address: 100 Barnes Road, Wallingford, CT 06492; or by calling (203) 949–0303. Please specify the revision or revisions requested.

10. Review of Procedure Codes in MS DRGs 981, 982, and 983; 984, 985, and 986; and 987, 988, and 989

Each year, we review cases assigned to former CMS DRG 468 (Extensive O.R. Procedure Unrelated to Principal Diagnosis), CMS DRG 476 (Prostatic O.R. Procedure Unrelated to Principal Diagnosis), and CMS DRG 477 (Nonextensive O.R. Procedure Unrelated to Principal Diagnosis) to determine whether it would be appropriate to change the procedures assigned among

these CMS DRGs. Under the MS–DRGs that we adopted for FY 2008, CMS DRG 468 was split three ways and became MS–DRGs 981, 982, and 983 (Extensive O.R. Procedure Unrelated to Principal Diagnosis with MCC, with CC, and without CC/MCC). CMS DRG 476 became MS–DRGs 984, 985, and 986 (Prostatic O.R. Procedure Unrelated to Principal Diagnosis with MCC, with CC, and without CC/MCC). CMS DRG 477 became MS–DRGs 987, 988, and 989 (Nonextensive O.R. Procedure Unrelated to Principal Diagnosis with MCC, with CC, and without CC/MCC).

MS–DRGs 981 through 983, 984 through 986, and 987 through 989 (formerly CMS DRGs 468, 476, and 477, respectively) are reserved for those cases in which none of the O.R. procedures performed are related to the principal diagnosis. These DRGs are intended to capture atypical cases, that is, those cases not occurring with sufficient frequency to represent a distinct, recognizable clinical group. MS–DRGs 984 through 986 (previously CMS DRG 476) are assigned to those discharges in which one or more of the following prostatic procedures are performed and are unrelated to the principal diagnosis:

- 60.0, Incision of prostate.
- 60.12, Open biopsy of prostate.
- 60.15, Biopsy of periprostatic tissue.
- 60.18, Other diagnostic procedures on prostate and periprostatic tissue.
- 60.21, Transurethral prostatectomy.
- 60.29, Other transurethral prostatectomy.
- 60.61, Local excision of lesion of prostate.
- 60.69, Prostatectomy, not elsewhere classified.
- 60.81, Incision of periprostatic tissue.
- 60.82, Excision of periprostatic tissue.
- 60.93, Repair of prostate.
- 60.94, Control of (postoperative) hemorrhage of prostate.
- 60.95, Transurethral balloon dilation of the prostatic urethra.
- 60.96, Transurethral destruction of prostate tissue by microwave thermotherapy.
- 60.97, Other transurethral destruction of prostate tissue by other thermotherapy.
- 60.99, Other operations on prostate.

All remaining O.R. procedures are assigned to MS–DRGs 981 through 983 and 987 through 989, with MS–DRGs 987 through 989 assigned to those discharges in which the only procedures performed are nonextensive procedures that are unrelated to the principal diagnosis.[13]

For FY 2009, we are not proposing to change the procedures assigned among these DRGs.

a. Moving Procedure Codes From MS–DRGs 981 Through 983 or MS–DRGs 987 Through 989 to MDCs

We annually conduct a review of procedures producing assignment to MS–DRGs 981 through 983 (formerly CMS DRG 468) or MS–DRGs 987 through 989 (formerly CMS DRG 477) on the basis of volume, by procedure, to see if it would be appropriate to move procedure codes out of these DRGs into one of the surgical DRGs for the MDC into which the principal diagnosis falls. The data are arrayed in two ways for comparison purposes. We look at a frequency count of each major operative procedure code. We also compare procedures across MDCs by volume of procedure codes within each MDC.

We identify those procedures occurring in conjunction with certain principal diagnoses with sufficient frequency to justify adding them to one of the surgical DRGs for the MDC in which the diagnosis falls. For FY 2009, we are not proposing to remove any procedures from MS–DRGs 981 through 983 or MS–DRGs 987 through 989.

b. Reassignment of Procedures Among MS–DRGs 981 Through 983, 984 Through 986, and 987 Through 989)

We also annually review the list of ICD–9–CM procedures that, when in combination with their principal diagnosis code, result in assignment to MS–DRGs 981 through 983, 984 through 986, and 987 through 989 (formerly, CMS DRGs 468, 476, and 477, respectively), to ascertain whether any of those procedures should be reassigned from one of these three DRGs to another of the three DRGs based on average charges and the length of stay. We look at the data for trends such as shifts in treatment practice or reporting practice that would make the resulting DRG assignment illogical. If we find these shifts, we would propose to move cases to keep the DRGs clinically similar or to provide payment for the cases in a similar manner. Generally, we move only those procedures for which we have an adequate number of discharges to analyze the data.

For FY 2009, we are not proposing to move any procedure codes among these DRGs.

c. Adding Diagnosis or Procedure Codes to MDCs

Based on our review this year, we are not proposing to add any diagnosis codes to MDCs for FY 2009.

11. Changes to the ICD–9–CM Coding System

As described in section II.B.1. of the preamble of this proposed rule, the ICD–9–CM is a coding system used for the reporting of diagnoses and procedures performed on a patient. In September 1985, the ICD–9–CM Coordination and Maintenance Committee was formed. This is a Federal interdepartmental committee, co-chaired by the National Center for Health Statistics (NCHS), the Centers for Disease Control and Prevention, and CMS, charged with maintaining and updating the ICD–9–CM system. The Committee is jointly responsible for approving coding changes, and developing errata, addenda, and other modifications to the ICD–9–CM to reflect newly developed procedures and technologies and newly identified diseases. The Committee is also responsible for promoting the use of Federal and non-Federal educational programs and other communication techniques with a view toward standardizing coding applications and upgrading the quality of the classification system.

The Official Version of the ICD–9–CM contains the list of valid diagnosis and procedure codes. (The Official Version of the ICD–9–CM is available from the Government Printing Office on CD–ROM for $27.00 by calling (202) 512–1800.) Complete information on ordering the CD–ROM is also available at: *http://www.cdc.gov/nchs/products/prods/subject/icd96ed.htm.* The Official

[13] The original list of the ICD–9–CM procedure codes for the procedures we consider nonextensive procedures, if performed with an unrelated principal diagnosis, was published in Table 6C in section IV. of the Addendum to the FY 1989 final rule (53 FR 38591). As part of the FY 1991 final rule (55 FR 36135), the FY 1992 final rule (56 FR 43212), the FY 1993 final rule (57 FR 23625), the FY 1994 final rule (58 FR 46279), the FY 1995 final rule (59 FR 45336), the FY 1996 final rule (60 FR 45783), the FY 1997 final rule (61 FR 46173), and the FY 1998 final rule (62 FR 45981), we moved several other procedures from DRG 468 to DRG 477, and some procedures from DRG 477 to DRG 468. No procedures were moved in FY 1999, as noted in the final rule (63 FR 40962); in FY 2000 (64 FR 41496); in FY 2001 (65 FR 47064); or in FY 2002 (66 FR 39852). In the FY 2003 final rule (67 FR 49999) we did not move any procedures from DRG 477. However, we did move procedure codes from DRG 468 and placed them in more clinically coherent DRGs. In the FY 2004 final rule (68 FR 45365), we moved several procedures from DRG 468 to DRGs 476 and 477 because the procedures are nonextensive. In the FY 2005 final rule (69 FR 48950), we moved one procedure from DRG 468 to 477. In addition, we added several existing procedures to DRGs 476 and 477. In the FY 2006 (70 FR 47317), we moved one procedure from DRG 468 and assigned it to DRG 477. In FY 2007, we moved one procedure from DRG 468 and assigned it to DRGs 479, 553, and 554. In FY 2008, no procedures were moved, as noted in the final rule with comment period (72 FR 46241).

Version of the ICD–9–CM is no longer available in printed manual form from the Federal Government; it is only available on CD–ROM. Users who need a paper version are referred to one of the many products available from publishing houses.

The NCHS has lead responsibility for the ICD–9–CM diagnosis codes included in the *Tabular List* and *Alphabetic Index for Diseases*, while CMS has lead responsibility for the ICD–9–CM procedure codes included in the *Tabular List* and *Alphabetic Index for Procedures.*

The Committee encourages participation in the above process by health-related organizations. In this regard, the Committee holds public meetings for discussion of educational issues and proposed coding changes. These meetings provide an opportunity for representatives of recognized organizations in the coding field, such as the American Health Information Management Association (AHIMA), the American Hospital Association (AHA), and various physician specialty groups, as well as individual physicians, health information management professionals, and other members of the public, to contribute ideas on coding matters. After considering the opinions expressed at the public meetings and in writing, the Committee formulates recommendations, which then must be approved by the agencies.

The Committee presented proposals for coding changes for implementation in FY 2009 at a public meeting held on September 27–28, 2007 and finalized the coding changes after consideration of comments received at the meetings and in writing by December 3, 2007. Those coding changes are announced in Tables 6A through 6F in the Addendum to this proposed rule. The Committee held its 2008 meeting on March 19–20, 2008. 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 2008 will be included in the October 1, 2008 update to ICD–9–CM. Code revisions that were discussed at the March 19–20, 2008 Committee meeting but that could not be finalized in time to include them in the Addendum to this proposed rule are not included in Tables 6A through 6F. These additional codes will be included in Tables 6A through 6F of the 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 27–28, 2007 meeting can be obtained from the CMS Web site at: *http://cms.hhs.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp*. The minutes of the diagnosis codes discussions at the September 27–28, 2007 meeting are found at: *http://www.cdc.gov/nchs/icd9.htm*. Paper copies of these minutes are no longer available and the mailing list has been discontinued. These Web sites also provide detailed information about the Committee, including information on requesting a new code, attending a Committee meeting, and timeline requirements and meeting dates.

We encourage commenters to address suggestions on coding issues involving diagnosis codes to: Donna Pickett, Co-Chairperson, ICD–9–CM Coordination and Maintenance Committee, NCHS, Room 2402, 3311 Toledo Road, Hyattsville, MD 20782. Comments may be sent by E-mail to: *dfp4@cdc.gov*.

Questions and comments concerning the procedure codes should be addressed to: Patricia E. Brooks, Co-Chairperson, ICD–9–CM Coordination and Maintenance Committee, CMS, Center for Medicare Management, Hospital and Ambulatory Policy Group, Division of Acute Care, C4–08–06, 7500 Security Boulevard, Baltimore, MD 21244–1850. Comments may be sent by E-mail to: *patricia.brooks2@cms.hhs.gov*.

The ICD–9–CM code changes that have been approved will become effective October 1, 2008. The new ICD–9–CM codes are listed, along with their DRG classifications, in Tables 6A and 6B (New Diagnosis Codes and New Procedure Codes, respectively) in the Addendum to this proposed rule. As we stated above, the code numbers and their titles were presented for public comment at the ICD–9–CM Coordination and Maintenance Committee meetings. Both oral and written comments were considered before the codes were approved. In this proposed rule, we are only soliciting comments on the proposed classification of these new codes.

For codes that have been replaced by new or expanded codes, and the corresponding new or expanded diagnosis codes are included in Table 6A. New procedure codes are shown in Table 6B. Diagnosis codes that have been replaced by expanded codes or other codes or have been deleted are in Table 6C (Invalid Diagnosis Codes). These invalid diagnosis codes will not be recognized by the GROUPER beginning with discharges occurring on or after October 1, 2008. Table 6D contains invalid procedure codes. These invalid procedure codes will not be recognized by the GROUPER beginning with discharges occurring on or after October 1, 2008. Revisions to diagnosis code titles are in Table 6E (Revised Diagnosis Code Titles), which also includes the MS–DRG assignments for these revised codes. Table 6F includes revised procedure code titles for FY 2009.

In the September 7, 2001 final rule implementing the IPPS new technology add-on payments (66 FR 46906), we indicated we would attempt to include proposals for procedure codes that would describe new technology discussed and approved at the Spring meeting as part of the code revisions effective the following October. As stated previously, ICD–9–CM codes discussed at the March 19–20, 2008 Committee meeting that received consensus and that are finalized by May 2008, will be included in Tables 6A through 6F of the Addendum to the final rule.

Section 503(a) of Pub. L. 108–173 included a requirement for updating ICD–9–CM codes twice a year instead of a single update on October 1 of each year. This requirement was included as part of the amendments to the Act relating to recognition of new technology under the IPPS. Section 503(a) amended section 1886(d)(5)(K) of the Act by adding a clause (vii) which states that the ''Secretary shall provide for the addition of new diagnosis and procedure codes 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 approved for an expedited April l, 2008 implementation of an ICD–9–CM code at the September 27–28, 2007 Committee meeting. Therefore, there were no new ICD–9–CM codes implemented on April 1, 2008.

We believe that this process captures the intent of section 1886(d)(5)(K)(vii) of the Act. This requirement was included in the provision revising the standards and process for recognizing new technology under the IPPS. In addition, the need for approval of new codes outside the existing cycle (October 1) arises most frequently and most acutely where the new codes will identify new technologies that are (or will be) under consideration for new technology add-on payments. Thus, we believe this provision was intended to expedite data collection through the assignment of new ICD–9–CM codes for new technologies seeking higher payments.

Current addendum and code title information is published on the CMS Web site at: *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.

H. Recalibration of MS–DRG Weights

In section II.E. of the preamble of this proposed rule, we state that we are proposing to fully implement the cost-based DRG relative weights for FY 2009, which is the third year in the 3-year transition period to calculate the relative weights at 100 percent based on costs. In the FY 2008 IPPS final rule with comment period (72 FR 47267), as recommended by RTI, for FY 2008, we added two new CCRs for a total of 15 CCRs: one for ''Emergency Room'' and one for ''Blood and Blood Products,'' both of which can be derived directly from the Medicare cost report.

In developing the FY 2009 proposed system of weights, we used two data sources: claims data and cost report data. As in previous years, the claims data source is the MedPAR file. This file is based on fully coded diagnostic and procedure data for all Medicare inpatient hospital bills. The FY 2007 MedPAR data used in this proposed rule include discharges occurring on October 1, 2006, through September 30, 2007, based on bills received by CMS through December 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 2007 MedPAR file used in calculating the relative weights includes data for approximately 11,433,806 Medicare discharges from IPPS providers. Discharges for Medicare beneficiaries enrolled in a Medicare Advantage managed care plan are excluded from this analysis. The data exclude CAHs, including hospitals that subsequently became CAHs after the period from which the data were taken. The second data source used in the cost-based relative weighting methodology is the FY 2006 Medicare cost report data files from HCRIS (that is, cost reports beginning on or after October 1, 2005, and before October 1, 2006), which represents the most recent full set of cost report data available. We used the

December 31, 2007 update of the HCRIS cost report files for FY 2006 in setting the relative cost-based weights.

The methodology we used to calculate the DRG cost-based relative weights from the FY 2007 MedPAR claims data and FY 2006 Medicare cost report data is as follows:

- To the extent possible, all the claims were regrouped using the proposed FY 2009 MS–DRG classifications discussed in sections II.B. and G. of the preamble of this proposed rule.
- The transplant cases that were used to establish the relative weights for heart and heart-lung, liver and/or intestinal, and lung transplants (MS–DRGs 001, 002, 005, 006, and 007, respectively) were limited to those Medicare-approved transplant centers that have cases in the FY 2007 MedPAR file. (Medicare coverage for heart, heart-lung, liver and/or intestinal, and lung transplants is limited to those facilities that have received approval from CMS as transplant centers.)
- Organ acquisition costs for kidney, heart, heart-lung, liver, lung, pancreas, and intestinal (or multivisceral organs) transplants continue to be paid on a reasonable cost basis. Because these acquisition costs are paid separately from the prospective payment rate, it is necessary to subtract the acquisition charges from the total charges on each transplant bill that showed acquisition charges before computing the average cost for each DRG and before eliminating statistical outliers.
- Claims with total charges or total length of stay less than or equal to zero were deleted. Claims that had an amount in the total charge field that differed by more than $10.00 from the sum of the routine day charges, intensive care charges, pharmacy charges, special equipment charges, therapy services charges, operating room charges, cardiology charges, laboratory charges, radiology charges, other service charges, labor and delivery charges, inhalation therapy charges, emergency room charges, blood charges, and anesthesia charges were also deleted.
- At least 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. Because hospital charges include charges for both operating and capital costs, we standardized total charges to remove the effects of differences in geographic adjustment factors, cost-of-living adjustments, DSH payments, and IME adjustments under the capital IPPS as well. Charges were then summed by DRG for each of the 15 cost groups so that each DRG had 15 standardized charge totals. These charges were then adjusted to cost by applying the national average CCRs developed from the FY 2006 cost report data.

The 15 cost centers that we used in the relative weight calculation are shown in the following table. The table shows the lines on the cost report and the corresponding revenue codes that we used to create the 15 national cost center CCRs.

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Cost Center Group Name (15 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field	Cost Report Line Description (Wksheet C Part 1 & Wksheet D-4)	Cost from HCRIS (Wksheet C, Part 1, Column 5 and line number)	Charges from HCRIS (Wksheet C, Part 1, Column 6 & 7 and line number)	Medicare Charges from HCRIS (Wksheet D-4, Column & line number)
Routine Days	Private Room Charges	011X and 014X	Adults & Pediatrics (General Routine Care)	C_1_C5_25	C_1_C6_25	D4_HOS_C2_25
	Semi-Private Room Charges	010X, 012X, 013X and 016X-019X			C_1_C7_25	D4_HOS_C2_26
	Ward Charges	015X				
Intensive Days	Intensive Care Charges	020X	Intensive Care Unit	C_1_C5_26	C_1_C6_26	D4_HOS_C2_26
					C_1_C7_26	
	Coronary Care Charges	021X	Coronary Care Unit	C_1_C5_27	C_1_C6_27	D4_HOS_C2_27
					C_1_C7_27	
			Burn Intensive Care Unit	C_1_C5_28	C_1_C6_28	D4_HOS_C2_28
					C_1_C7_28	
			Surgical Intensive Care Unit	C_1_C5_29	C_1_C6_29	D4_HOS_C2_29
					C_1_C7_29	
			Other Special Care Unit	C_1_C5_30	C_1_C6_30	D4_HOS_C2_30
					C_1_C7_30	
Drugs	Pharmacy Charges	025X, 026X and 063X	Intravenous Therapy	C_1_C5_48	C_1_C6_48	D4_HOS_C2_48
					C_1_C7_48	
			Drugs Charged To Patient	C_1_C5_56	C_1_C6_56	D4_HOS_C2_56
					C_1_C7_56	

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)
Supplies and Equipment	Medical/Surgical Supply Charges	027X and 062X	Medical Supplies Charged to Patients	C_1_C5_55	C_1_C6_55 C_1_C7_55	D4_HOS_C2_55
	Durable Medical Equipment Charges	0290, 0291, 0292 and 0294-0299	DME-Rented	C_1_C5_66	C_1_C6_66 C_1_C7_66	D4_HOS_C2_66
	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	D4_HOS_C2_49

Cost Center Group Name (15 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field	Cost Report Line Description (Wksheet C Part 1 & Wksheet D-4)	Cost from HCRIS (Wksheet C, Part 1, Column 5 and line number)	Charges from HCRIS (Wksheet C, Part 1, Column 6 & 7 and line number)	Medicare Charges from HCRIS (Wksheet D-4, Column & line number)
					C_1_C7_49	
Operating Room For all DRGs but Labor & Delivery	Operating Room Charges	036X, 071X and 072X	Operating Room	C_1_C5_37	C_1_C6_37	D4_HOS_C2_37
					C_1_C7_37	
			Recovery Room	C_1_C5_38	C_1_C6_38	D4_HOS_C2_38
					C_1_C7_38	
Labor & Delivery **ONLY FOR THE 6 Labor & Delivery DRGs**	Operating Room Charges	036X, 071X and 072X	Delivery Room and Labor Room	C_1_C5_39	C_1_C6_39	D4_HOS_C2_39
					C_1_C7_39	
370, 371, 372, 373, 374, 375	Clinic Charges	051X	Obstetrics Clinic	C_1_C5_63	C_1_C6_63	D4_HOS_C2_63
					C_1_C7_63	
Anesthesia	Anesthesia Charges	037X	Anesthesi-ology	C_1_C5_40	C_1_C6_40	D4_HOS_C2_40
					C_1_C7_40	
Cardiology	Cardiology Charges	048X and 073X	Electro-cardiology	C_1_C5_53	C_1_C6_53	D4_HOS_C2_53

Cost Center Group Name (15 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field	Cost Report Line Description (Wksheet C Part 1 & Wksheet D-4)	Cost from HCRIS (Wksheet C, Part 1, Column 5 and line number)	Charges from HCRIS (Wksheet C, Part 1, Column 6 & 7 and line number)	Medicare Charges from HCRIS (Wksheet D-4, Column & line number)
					C_1_C7_53	
Laboratory	Laboratory Charges	030X, 031X, 074X and 075X	Laboratory	C_1_C5_44	C_1_C6_44	D4_HOS_C2_44
					C_1_C7_44	
			PBP Clinic Laboratory Services	C_1_C5_45	C_1_C6_45	D4_HOS_C2_45
					C_1_C7_45	
			Electro-encep halography	C_1_C5_54	C_1_C6_54	D4_HOS_C2_54
					C_1_C7_54	
Radiology	Radiology Charges	028X, 032X, 033X, 034X, 035X and 040X	Radiology - Diagnostic	C_1_C5_41	C_1_C6_41	D4_HOS_C2_41
					C_1_C7_41	
	MRI Charges	061X	Radiology - Therapeutic	C_1_C5_42	C_1_C6_42	D4_HOS_C2_42
			Radioisotope	C_1_C5_43	C_1_C6_43	D4_HOS_C2_43
					C_1_C7_43	
Emergency Room	Emergency Room Charges	045x	Emergency	C_1_C5_61	C_1_C6_61	D4_HOS_C2_61

Cost Center Group Name (15 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field	Cost Report Line Description (Wksheet C Part 1 & Wksheet D-4)	Cost from HCRIS (Wksheet C, Part 1, Column 5 and line number)	Charges from HCRIS (Wksheet C, Part 1, Column 6 & 7 and line number)	Medicare Charges from HCRIS (Wksheet D-4, Column & line number)
					C_1_C7_61	
Blood and Blood Products	Blood Charges	038x	Whole Blood & Packed Red Blood Cells	C_1_C5_46	C_1_C6_46	D4_HOS_C2_46
					C_1_C7_46	
	Blood Storage / Processing	039x	Blood Storing, Processing, & Transfusing	C_1_C5_47	C_1_C6_47	D4_HOS_C2_47
					C_1_C7_47	
Other Services	Lithotripsy Charge	079X				
	Other Service Charge	0002-0099, 022X, 023X, 024X,052X,053X 055X-060X, 064X-070X, 076X-078X, 090X-095X and 099X				
			ASC (Non Distinct Part)	C_1_C5_58	C_1_C6_58	D4_HOS_C2_58
					C_1_C7_58	
	Outpatient Service Charges	049X and 050X	Other Ancillary	C_1_C5_59	C_1_C6_59	D4_HOS_C2_59
					C_1_C7_59	
			Clinic	C_1_C5_60	C_1_C6_60	D4_HOS_C2_60
					C_1_C7_60	
	Ambulance Charges	054X				

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)
	ESRD Revenue Setting Charges	080X and 082X-088X	Observation beds	C_1_C5_62	C_1_C6_62	D4_HOS_C2_62
					C_1_C7_62	
	Clinic Visit Charges (excluding Labor & Delivery DRGs)	051X	Observation beds	C_1_C5_6201	C_1_C6_6201	D4_HOS_C2_6201
					C_1_C7_6201	
			Rural Health Clinic	C_1_C5_6350	C_1_C6_6350	D4_HOS_C2_6350
	Professional Fees Charges	096X, 097X, and 098X			C_1_C7_6350	
			FQHC	C_1_C5_6360	C_1_C6_6360	D4_HOS_C2_6360
					C_1_C7_6360	
			Home Program Dialysis	C_1_C5_64	C_1_C6_64	D4_HOS_C2_64
					C_1_C7_64	
			Ambulance	C_1_C5_65	C_1_C6_65	D4_HOS_C2_65
					C_1_C7_65	
			Other Reimbursable	C_1_C5_68	C_1_C6_68	D4_HOS_C2_68
					C_1_C7_68	

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We developed the national average CCRs as follows:

Taking the FY 2006 cost report data, we removed CAHs, Indian Health Service hospitals, all-inclusive rate hospitals, and cost reports that represented time periods of less than 1 year (365 days). We included hospitals located in Maryland as we are including their charges in our claims database. We then created CCRs for each provider for each cost center (see prior table for line items used in the calculations) and removed any CCRs that were greater than 10 or less than 0.01. We normalized the departmental CCRs by dividing the CCR for each department by the total CCR for the hospital for the purpose of trimming the data. We then took the logs of the normalized cost center CCRs and removed any cost

center CCRs where the log of the cost center CCR was greater or less than the mean log plus/minus 3 times the standard deviation for the log of that cost center CCR. Once the cost report data were trimmed, we calculated a Medicare-specific CCR. The Medicare-specific CCR was determined by taking the Medicare charges for each line item from Worksheet D–4 and deriving the Medicare-specific costs by applying the hospital-specific departmental CCRs to the Medicare-specific charges for each line item from Worksheet D–4. Once each hospital's Medicare-specific costs were established, we summed the total Medicare-specific costs and divided by the sum of the total Medicare-specific charges to produce national average, charge-weighted CCRs.

After we multiplied the total charges for each DRG in each of the 15 cost centers by the corresponding national average CCR, we summed the 15 ''costs'' across each DRG to produce a total standardized cost for the DRG. The average standardized cost for each DRG was then computed as the total standardized cost for the DRG divided by the transfer-adjusted case count for the DRG. The average cost for each DRG was then divided by the national average standardized cost per case to determine the relative weight.

The new cost-based relative weights were then normalized by an adjustment factor of 1.50612 so that the average case weight after recalibration was equal to the average case weight before recalibration. The normalization adjustment is intended to ensure that recalibration by itself neither increases nor decreases total payments under the IPPS, as required by section 1886(d)(4)(C)(iii) of the Act.

The 15 proposed national average CCRs for FY 2009 are as follows:

Group	CCR
Routine Days	0.527
Intensive Days	0.476
Drugs	0.205
Supplies & Equipment	0.341
Therapy Services	0.419
Laboratory	0.166
Operating Room	0.293
Cardiology	0.186
Radiology	0.171
Emergency Room	0.291
Blood and Blood Products	0.449
Other Services	0.419
Labor & Delivery	0.482
Inhalation Therapy	0.198
Anesthesia	0.150

As we explained in section II.E. of the preamble of this proposed rule, we are proposing to complete our 2-year transition to the MS–DRGs. For FY 2008, the first year of the transition, 50 percent of the relative weight for an MS–DRG was based on the two-thirds cost-based weight/one-third charge-based weight calculated using FY 2006 MedPAR data grouped to the Version 24.0 (FY 2007) DRGs. The remaining 50 percent of the FY 2008 relative weight for an MS–DRG was based on the two-thirds cost-based weight/one-third charge-based weight calculated using FY 2006 MedPAR grouped to the Version 25.0 (FY 2008) MS–DRGs. In FY 2009, we are proposing that the relative weights will be based on 100 percent cost weights computed using the Version 26.0 (FY 2009) MS–DRGs.

When we recalibrated the DRG weights for previous years, we set a threshold of 10 cases as the minimum number of cases required to compute a reasonable weight. We are proposing to use that same case threshold in recalibrating the MS–DRG weights for FY 2009. Using the FY 2007 MedPAR data set, there are 8 MS–DRGs that contain fewer than 10 cases. Under the MS–DRGs, we have fewer low-volume DRGs than under the CMS DRGs because we no longer have separate DRGs for patients age 0 to 17 years. With the exception of newborns, we previously separated some DRGs based on whether the patient was age 0 to 17 years or age 17 years and older. Other than the age split, cases grouping to these DRGs are identical. The DRGs for patients age 0 to 17 years generally have very low volumes because children are typically ineligible for Medicare. In the past, we have found that the low volume of cases for the pediatric DRGs could lead to significant year-to-year instability in their relative weights. Although we have always encouraged non-Medicare payers to develop weights applicable to their own patient populations, we have heard frequent complaints from providers about the use of the Medicare relative weights in the pediatric population. We believe that eliminating this age split in the MS–DRGs will provide more stable payment for pediatric cases by determining their payment using adult cases that are much higher in total volume. All of the low-volume MS–DRGs listed below are for newborns. Newborns are unique and require separate DRGs that are not mirrored in the adult population. Therefore, it remains necessary to retain separate DRGs for newborns. In FY 2009, because we do not have sufficient MedPAR data to set accurate and stable cost weights for these low-volume MS–DRGs, we are proposing to compute weights for the low-volume MS–DRGs by adjusting their FY 2008 weights by the percentage change in the average weight of the cases in other MS–DRGs. The crosswalk table is shown below:

Low-volume MS–DRG	MS-DRG title	Crosswalk to MS–DRG
768	Vaginal Delivery with O.R. Procedure Except Sterilization and/or D&C.	FY 2008 FR weight (adjusted by percent change in average weight of the cases in other MS–DRGs).
789	Neonates, Died or Transferred to Another Acute Care Facility	FY 2008 FR weight (adjusted by percent change in average weight of the cases in other MS–DRGs).
790	Extreme Immaturity or Respiratory Distress Syndrome, Neonate.	FY 2008 FR weight (adjusted by percent change in average weight of the cases in other MS–DRGs).
791	Prematurity with Major Problems	FY 2008 FR weight (adjusted by percent change in average weight of the cases in other MS–DRGs).
792	Prematurity without Major Problems	FY 2008 FR weight (adjusted by percent change in average weight of the cases in other MS–DRGs).
793	Full-Term Neonate with Major Problems	FY 2008 FR weight (adjusted by percent change in average weight of the cases in other MS–DRGs).
794	Neonate with Other Significant Problems	FY 2008 FR weight (adjusted by percent change in average weight of the cases in other MS–DRGs).
795	Normal Newborn	FY 2008 FR weight (adjusted by percent change in average weight of the cases in other MS–DRGs).

I. Proposed Medicare Severity Long-Term Care (MS–LTC–DRG) Reclassifications and Relative Weights for LTCHs for FY 2009

1. Background

Section 123 of the BBRA requires that the Secretary implement a PPS for LTCHs (that is, a per discharge system with a diagnosis-related group (DRG)-based patient classification system reflecting the differences in patient resources and costs). Section 307(b)(1) of the BIPA modified the requirements of section 123 of the BBRA by requiring that the Secretary examine ''the feasibility and the impact of basing payment under such a system [the long-term care hospital (LTCH) PPS] on the use of existing (or refined) hospital DRGs that have been modified to account for different resource use of LTCH patients, as well as the use of the most recently available hospital discharge data.''

When the LTCH PPS was implemented for cost reporting periods beginning on or after October 1, 2002, we adopted the same DRG patient classification system (that is, the CMS DRGs) that was utilized at that time under the IPPS. As a component of the LTCH PPS, we refer to the patient classification system as the ''long-term care diagnosis-related groups (LTC–DRGs).'' As discussed in greater detail below, although the patient classification system used under both the LTCH PPS and the IPPS are the same, the relative weights are different. The established relative weight methodology and data used under the LTCH PPS result in LTC–DRG relative weights that reflect ''the differences in patient resource use * * *'' of LTCH patients (section 123(a)(1) of the BBRA (Pub. L. 106–113). As part of our efforts to better recognize severity of illness among patients, in the FY 2008 IPPS final rule with comment period (72 FR 47130), the MS–DRGs and the Medicare severity long-term care diagnosis related groups (MS–LTC–DRGs) were adopted for the IPPS and the LTCH PPS, respectively, effective October 1, 2007 (FY 2008). For a full description of the development and implementation of the MS–DRGs and MS–LTC–DRGs, we refer readers to the FY 2008 IPPS final rule with comment period (72 FR 47141 through 47175 and 47277 through 47299). (We note that, in that same final rule, we revised the regulations at § 412.503 to specify that for LTCH discharges occurring on or after October 1, 2007, when applying the provisions of 42 CFR Part 412, Subpart O applicable to LTCHs for policy descriptions and payment calculations, all references to LTC–DRGs would be considered a reference to MS–LTC–DRGs. For the remainder of this section, we present the discussion in terms of the current MS–LTC–DRG patient classification unless specifically referring to the previous LTC–DRG patient classification system (that was in effect before October 1, 2007).) We believe the MS–DRGs (and by extension, the MS–LTC–DRGs) represent a substantial improvement over the previous CMS DRGs in their ability to differentiate cases based on severity of illness and resource consumption.

The MS–DRGs represent an increase in the number of DRGs by 207 (that is, from 538 to 745) (72 FR 47171). In addition to improving the DRG system's recognition of severity of illness, we believe the MS–DRGs are responsive to the public comments that were made on the FY 2007 IPPS proposed rule with respect to how we should undertake further DRG reform. The MS–DRGs use the CMS DRGs as the starting point for revising the DRG system to better recognize resource complexity and severity of illness. We have generally retained all of the refinements and improvements that have been made to the base DRGs over the years that recognize the significant advancements in medical technology and changes to medical practice.

Consistent with section 123 of the BBRA as amended by section 307(b)(1) of the BIPA and § 412.515, we use information derived from LTCH PPS patient records to classify LTCH discharges into distinct MS–LTC–DRGs based on clinical characteristics and estimated resource needs. We then assign an appropriate weight to the MS–LTC–DRGs to account for the difference in resource use by patients exhibiting the case complexity and multiple medical problems characteristic of LTCHs.

Generally, under the LTCH PPS, a Medicare payment is made at a predetermined specific rate for each discharge; and that payment varies by the MS–LTC–DRG to which a beneficiary's stay is assigned. Cases are classified into MS–LTC–DRGs for payment based on the following six data elements:

- Principal diagnosis.
- Up to eight additional diagnoses.
- Up to six procedures performed.
- Age.
- Sex.
- Discharge status of the patient.

Upon the discharge of the patient from a LTCH, the LTCH must assign appropriate diagnosis and procedure codes from the most current version of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD–9–CM). HIPAA Transactions and Code Sets Standards regulations at 45 CFR Parts 160 and 162 require that no later than October 16, 2003, all covered entities must comply with the applicable requirements of Subparts A and I through R of Part 162. Among other requirements, those provisions direct covered entities to use the ASC X12N 837 Health Care Claim: Institutional, Volumes 1 and 2, Version 4010, and the applicable standard medical data code sets for the institutional health care claim or equivalent encounter information transaction (see 45 CFR 162.1002 and 45 CFR 162.1102). For additional information on the ICD–9–CM Coding System, we refer readers to the FY 2008 IPPS final rule with comment period (72 FR 47241 through 47243 and 47277 through 47281). We also refer readers to the detailed discussion on correct coding practices in the August 30, 2002 LTCH PPS final rule (67 FR 55981 through 55983). Additional coding instructions and examples are published in the *Coding Clinic for ICD–9–CM*, a product of the American Hospital Association.

Medicare contractors (that is, fiscal intermediaries or MACs) enter the clinical and demographic information into their claims processing systems and subject this information to a series of automated screening processes called the Medicare Code Editor (MCE). These screens are designed to identify cases that require further review before assignment into a MS–LTC–DRG can be made. During this process, the following types of cases are selected for further development:

- Cases that are improperly coded. (For example, diagnoses are shown that are inappropriate, given the sex of the patient. Code 68.69 (Other and unspecified radical abdominal hysterectomy) would be an inappropriate code for a male.)
- Cases including surgical procedures not covered under Medicare. (For example, organ transplant in a nonapproved transplant center.)
- Cases requiring more information. (For example, ICD–9–CM codes are required to be entered at their highest level of specificity. There are valid 3-digit, 4-digit, and 5-digit codes. That is, code 262 (Other severe protein-calorie malnutrition) contains all appropriate digits, but if it is reported with either fewer or more than 3 digits, the claim will be rejected by the MCE as invalid.)

After screening through the MCE, each claim is classified into the appropriate MS–LTC–DRG by the Medicare LTCH GROUPER software.

The Medicare GROUPER software, which is used under the LTCH PPS, is specialized computer software, and is the same GROUPER software program used under the IPPS. The GROUPER software was developed as a means of classifying each case into a MS–LTC–DRG on the basis of diagnosis and procedure codes and other demographic information (age, sex, and discharge status). Following the MS–LTC–DRG assignment, the Medicare contractor determines the prospective payment amount by using the Medicare PRICER program, which accounts for hospital-specific adjustments. Under the LTCH PPS, we provide an opportunity for the LTCH to review the MS–LTC–DRG assignments made by the Medicare contractor and to submit additional information within a specified timeframe as specified in § 412.513(c).

The GROUPER software is used both to classify past cases to measure relative hospital resource consumption to establish the DRG weights and to classify current cases for purposes of determining payment. The records for all Medicare hospital inpatient discharges are maintained in the MedPAR file. The data in this file are used to evaluate possible MS–DRG classification changes and to recalibrate the MS–DRG and MS–LTC–DRG relative weights during our annual update under both the IPPS (§ 412.60(e)) and the LTCH PPS (§ 412.517), respectively.

In the June 6, 2003 LTCH PPS final rule (68 FR 34122), we changed the LTCH PPS annual payment rate update cycle to be effective July 1 through June 30 instead of October 1 through September 30. In addition, because the patient classification system utilized under the LTCH PPS uses the same DRGs as those used under the IPPS for acute care hospitals, in that same final rule, we explained that the annual update of the LTC–DRG classifications and relative weights will continue to remain linked to the annual reclassification and recalibration of the DRGs used under the IPPS. Therefore, we specified that we will continue to update the LTC–DRG classifications and relative weights to be effective for discharges occurring on or after October 1 through September 30 each year. We further stated that we will publish the annual proposed and final update of the LTC–DRGs in same notice as the proposed and final update for the IPPS (69 FR 34125).

In the RY 2009 LTCH PPS proposed rule (73 FR 5351–5352), due to administrative considerations as well as in response to numerous comments urging CMS to establish one rulemaking cycle that would encompass the update of the LTCH PPS payment rates (currently updated on a rate year basis, effective July 1) as well as the development of the LTC–DRG weights (currently updated on a fiscal year basis, effective October 1), we proposed to amend the regulations at § 412.535 in order to consolidate the rate year and fiscal year rulemaking cycles. Specifically, we proposed that the annual update of the LTCH PPS payment rates (and description of the methodology and data used to calculate these payment rates) and the annual update of the MS–LTC–DRG classifications and associated weighting factors for LTCHs would be effective on October 1 each Federal fiscal year. In order to revise the payment rate update (currently on a rate year cycle of July 1 through June 30) to an October 1 through September 30 cycle, we proposed to extend the 2009 rate period to September 30, 2009, so that RY 2009 would be 15 months. This proposed 15-month rate period would extend from July 1, 2008, through September 30, 2009. We believe that extending RY 2009 by 3 months (July, August, and September) would provide for a smooth transition to a consolidated annual update for both the LTCH PPS payment rates and the LTCH PPS MS–LTC–DRG classifications and weighting factors. (We believe that proposing to shorten the 2009 rate year period to an October 1 through September 30 period so that RY 2009 would only be 3 months (that is, July 1, 2008 through September 30, 2008) would exacerbate the current time-consuming, biannual update process by resulting in two payment rate changes within a very short period of time.) Consequently, under the proposal to extend RY 2009 to a 15-month rate period, after September 30, 2009, when the RY 2009 cycle ends, the LTCH PPS payment rates and other policy changes would subsequently be updated on an October 1 through September 30 cycle in conjunction with the annual update to the MS–LTC–DRG classifications and relative weights. Accordingly, the next update to the LTCH PPS payment rates, after the proposed 15-month RY 2009, would begin October 1, 2009, coinciding with the 2010 Federal fiscal year.

In the past, the annual update to the DRGs used under the IPPS has been based on the annual revisions to the ICD–9–CM codes and was effective each October 1. As discussed in the RY 2009 LTCH PPS proposed rule (73 FR 5348–5349), 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). The use of the ICD–9–CM code set is also compliant with the current requirements of the Transactions and Code Sets Standards regulations at 45 CFR Parts 160 and 162, promulgated in accordance with HIPAA.

As noted above, the patient classification system used under the LTCH PPS is the same patient classification system that is used under the IPPS. Therefore, the ICD–9–CM codes currently used under both the IPPS and the LTCH PPS have the potential of being updated twice a year. This requirement is included as part of the amendments to the Act relating to recognition of new medical technology under the IPPS.

Because we do not publish a midyear IPPS rule, any April 1 ICD–9–CM coding update will not be published in the **Federal Register**. Rather, we will assign any new diagnosis or procedure codes to the same DRG in which its predecessor code was assigned, so that there will be no impact on the DRG assignments (as also discussed in section II.G.11. of the preamble of this proposed rule). Any coding updates will be available through the Web sites provided in section II.G.11. of the preamble of this proposed rule and through the *Coding Clinic for ICD–9–CM*. Publishers and software vendors currently obtain code changes through these sources in order to update their code books and software system. If new codes are implemented on April 1, revised code books and software systems, including the GROUPER

software program, will be necessary because the most current ICD–9–CM codes must be reported. Therefore, for purposes of the LTCH PPS, because each ICD–9–CM code must be included in the GROUPER algorithm to classify each case under the correct LTCH PPS, the GROUPER software program used under the LTCH PPS would need to be revised to accommodate any new codes.

In implementing section 503(a) of Pub. L. 108–173, there will only be an April 1 update if new technology diagnosis and procedure code revisions are requested and approved. We note that any new codes created for April 1 implementation will be limited to those primarily needed to describe new technologies and medical services. However, we reiterate that the process of discussing updates to the ICD–9–CM is an open process through the ICD–9–CM Coordination and Maintenance Committee. Requestors will be given the opportunity to present the merits for a new code and to make a clear and convincing case for the need to update ICD–9–CM codes for purposes of the IPPS new technology add-on payment process through an April 1 update (as also discussed in section II.G.11. of the preamble of this proposed rule).

At the September 27, 2007 ICD–9–CM Coordination and Maintenance Committee meeting, there were no requests for an April 1, 2008 implementation of ICD–9–CM codes. Therefore, the next update to the ICD–9–CM coding system will occur on October 1, 2008 (FY 2009). Because there were no coding changes suggested for an April 1, 2008 update, the ICD–9–CM coding set implemented on October 1, 2008, will continue through September 30, 2009 (FY 2009). The update to the ICD–9–CM coding system for FY 2009 is discussed in section II.G.11. of the preamble of this proposed rule. Accordingly, in this proposed rule, as discussed in greater detail below, we are proposing to modify and revise the MS–LTC–DRG classifications and relative weights to be effective October 1, 2008 through September 30, 2009 (FY 2009). As discussed in greater detail below, the MS–LTC–DRGs for FY 2009 in this proposed rule are the same as the MS–DRGs proposed for the IPPS for FY 2009 (GROUPER Version 26.0) discussed in section II.B. of the preamble to this proposed rule.

2. Proposed Changes in the MS–LTC–DRG Classifications

a. Background

As discussed earlier, 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.''

Consistent 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 proposed rule, for FY 2008, we adopted MS–DRGs under the IPPS because we believe that this system results in a significant improvement in the DRG system's recognition of severity of illness and resource usage. We stated that we believe these improvements in the DRG system are equally applicable to the LTCH PPS. The changes we are proposing to make for the FY 2009 IPPS are reflected in the proposed FY 2009 GROUPER, Version 26.0, that would be effective for discharges occurring on or after October 1, 2008 through September 30, 2009.

Consistent with our historical practice of having LTC–DRGs correspond to the DRGs applicable under the IPPS, under the broad authority of section 123(a) of Pub. L. 106–113, as modified by section 307(b) of Pub. L. 106–554, under the LTCH PPS for FY 2008, we adopted the use of MS–LTC–DRGs, which correspond to the MS–DRGs we adopted under the IPPS. In addition, as stated above, we are proposing to use the FY 2009 GROUPER Version 26.0 to classify cases effective for LTCH discharges occurring on or after October 1, 2008, through September 30, 2009. The changes to the MS–DRG classification system that we are proposing to use under the IPPS for FY 2009 (GROUPER Version 26.0) are discussed in section II.B. of the preamble to this proposed rule.

Under the LTCH PPS, as described in greater detail below, we determine relative weights for each of the MS–LTC–DRGs to account for the difference in resource use by patients exhibiting the case complexity and multiple medical problems characteristic of LTCH patients. (Unless otherwise noted in this proposed rule, our MS–LTC–DRG analysis is based on LTCH data from the December 2007 update of the FY 2007 MedPAR file, which contains hospital bills received through December 31, 2007, for discharges occurring in FY 2007.)

LTCHs do not typically treat the full range of diagnoses as do acute care hospitals. Therefore, as we discussed in the August 30, 2002 LTCH PPS final rule (67 FR 55985), which implemented the LTCH PPS, and the FY 2008 IPPS final rule with comment period (72 FR 47283), we use low-volume quintiles in determining the DRG relative weights for DRGs with less than 25 LTCH cases (low-volume MS–LTC–DRGs). Specifically, we group those low-volume DRGs into 5 quintiles based on average charges per discharge. (A listing of the composition of low-volume quintiles for the FY 2008 MS–LTC–DRGs (based on FY 2006 MedPAR data) appears in section II.I.3. of the FY 2008 IPPS final rule with comment period (72 FR 47281 through 47288).) We also adjust for cases in which the stay at the LTCH is less than or equal to five-sixths of the geometric average length of stay; that is, short-stay outlier cases, as discussed below in section II.I.4. of the preamble of this proposed rule.

b. Patient Classifications Into MS–LTC–DRGs

Generally, under the LTCH PPS, Medicare payment is made at a predetermined specific rate for each discharge; that is, payment varies by the DRG to which a beneficiary's stay is assigned. Just as cases have been classified into the MS–DRGs for acute care hospitals under the IPPS (section II.B. of the preamble of this proposed rule), cases have been classified into MS–LTC–DRGs for payment under the LTCH PPS based on the principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay, as well as demographic information about the patient. The diagnosis and procedure information is reported by the hospital using the ICD–9–CM coding system. Under the MS–DRGs for the IPPS and the MS–LTC–DRGs for the LTCH PPS, these factors will not change.

Section II.B. of the preamble of this proposed rule discusses the organization of the existing MS–DRGs, which we are maintaining under the MS–LTC–DRG system. As noted above, the patient classification system for the LTCH PPS is derived from the IPPS DRGs and is similarly organized into 25 major diagnostic categories (MDCs).

Most of these MDCs are based on a particular organ system of the body and the remainder involves multiple organ systems (such as MDC 22, Burns). Accordingly, the principal diagnosis determines MDC assignment. Within most MDCs, cases are then divided into surgical DRGs and medical DRGs. Under the MS–DRGs, some surgical and medical DRGs are further defined for severity purposes based on the presence or absence of MCCs or CCs. The existing MS–LTC–DRGs are similarly categorized. (We refer readers to section II.B. of the preamble of this proposed rule for further discussion of surgical DRGs and medical DRGs.)

Therefore, consistent with the MS–DRGs, a base MS–LTC–DRG may be subdivided according to three alternatives. The first alternative includes division of the DRG into one, two, or three severity levels. The most severe level has cases with at least one code that is a major CC, referred to as ''with MCC''. The next lower severity level contains cases with at least one CC, referred to as ''with CC''. Those DRGs without an MCC or a CC are referred to as ''without CC/MCC''. When data do not support the creation of three severity levels, the base DRG is divided into either two levels or the base is not subdivided.

The two-level subdivisions consist of one of the following subdivisions: ''with CC/MCC'' or ''without CC/MCC.'' In this type of subdivision, cases with at least one code that is on the CC or MCC list are assigned to the '' CC/MCC'' DRG. Cases without a CC or an MCC are assigned to the ''without CC/MCC'' DRG.

The other type of two-level subdivision is as follows: ''with MCC'' and ''without MCC.'' In this type of subdivision, cases with at least one code that is on the MCC list are assigned to the ''with MCC'' DRG. Cases that do not have an MCC are assigned to the ''without MCC'' DRG. This type of subdivision could include cases with a CC code, but no MCC.

3. Development of the Proposed FY 2009 MS–LTC–DRG Relative Weights

a. General Overview of Development of the MS–LTC–DRG Relative Weights

As we stated in the August 30, 2002 LTCH PPS final rule (67 FR 55981), one of the primary goals for the implementation of the LTCH PPS is to pay each LTCH an appropriate amount for the efficient delivery of medical care to Medicare patients. The system must be able to account adequately for each LTCH's case-mix in order to ensure both fair distribution of Medicare payments and access to adequate care for those Medicare patients whose care is more costly. To accomplish these goals, we have annually adjusted the LTCH PPS standard Federal prospective payment system rate by the applicable relative weight in determining payment to LTCHs for each case. (As we have noted above, in last year's final rule, we adopted the MS–LTC–DRGs for the LTCH PPS beginning in FY 2008. However, this change in the patient classification system does not affect the basic principles of the development of relative weights under a DRG-based prospective payment system.

Although the adoption of the MS–LTC–DRGs resulted in some modifications of existing procedures for assigning weights in cases of zero volume and/or nonmonotonicity, as discussed in the FY 2008 IPPS final rule with comment period (72 FR 47289 through 47295) and discussed in detail in the following sections, the basic methodology for developing the proposed FY 2009 MS–LTC–DRG relative weights in this proposed rule continue to be determined in accordance with the general methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 55989 through 55991). Under the LTCH PPS, relative weights for each MS–LTC–DRG are a primary element used to account for the variations in cost per discharge and resource utilization among the payment groups (§ 412.515). To ensure that Medicare patients classified to each MS–LTC–DRG have access to an appropriate level of services and to encourage efficiency, we calculate a relative weight for each MS–LTC–DRG that represents the resources needed by an average inpatient LTCH case in that MS–LTC–DRG. For example, cases in an MS–LTC–DRG with a relative weight of 2 will, on average, cost twice as much to treat as cases in an MS–LTC–DRG with a weight of 1.

b. Data

To calculate the proposed MS–LTC–DRG relative weights for FY 2009, we obtained total Medicare allowable charges from FY 2007 Medicare LTCH bill data from the December 2007 update of the MedPAR file, which are the best available data at this time, and we used the proposed Version 26.0 of the CMS GROUPER that is also proposed for use under the IPPS to classify cases for FY 2009. We also are proposing that if more recent data are available, we will use those data and the finalized Version 26.0 of the CMS GROUPER in establishing the FY 2009 MS–LTC–DRG relative weights in the final rule.

Consistent with our historical methodology, 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 or section 222(a) of Pub. L. 92–603 (We refer readers to the FY 2008 IPPS final rule with comment period (72 FR 47282)). Therefore, in the development of the proposed FY 2009 MS–LTC–DRG relative weights in this proposed rule, we have excluded the data of the 17 all-inclusive rate providers and the 2 LTCHs that are paid in accordance with demonstration projects that had claims in the FY 2007 MedPAR file.

c. Hospital-Specific Relative Value (HSRV) Methodology

By nature, LTCHs often specialize in certain areas, such as ventilator-dependent patients and rehabilitation and wound care. Some case types (DRGs) may be treated, to a large extent, in hospitals that have, from a perspective of charges, relatively high (or low) charges. This nonarbitrary distribution of cases with relatively high (or low) charges in specific MS–LTC–DRGs has the potential to inappropriately distort the measure of average charges. To account for the fact that cases may not be randomly distributed across LTCHs, we are proposing to use a hospital-specific relative value (HSRV) methodology to calculate the MS–LTC–DRG relative weights instead of the methodology used to determine the MS–DRG relative weights under the IPPS described in section II.H. of the preamble of this proposed rule. We believe this method will remove this hospital-specific source of bias in measuring LTCH average charges. Specifically, we are proposing to 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 methodology, we standardize charges for each LTCH by converting its charges for each case to hospital-specific relative charge values and then adjusting those values for the LTCH's case-mix. The adjustment for case-mix is needed to rescale the hospital-specific relative charge values (which, by definition, average 1.0 for each LTCH). The average relative weight for a LTCH is its case-mix, so it is reasonable to scale each LTCH's average relative charge value by its case-mix. In this way, each LTCH's relative charge

value is adjusted by its case-mix to an average that reflects the complexity of the cases it treats relative to the complexity of the cases treated by all other LTCHs (the average case-mix of all LTCHs).

In accordance with the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 55989 through 55991), we continue to standardize charges for each case by first dividing the adjusted charge for the case (adjusted for short-stay outliers under § 412.529 as described in section II.I.4. (step 3) of the preamble of this proposed rule) 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 (§ 412.529 and § 412.503). The average adjusted charge reflects the average intensity of the health care services delivered by a particular LTCH and the average cost level of that LTCH. The resulting ratio is multiplied by that LTCH's case-mix index to determine the standardized charge for the case.

Multiplying by the LTCH's case-mix index accounts for the fact that the same relative charges are given greater weight at a LTCH with higher average costs than they would at a LTCH with low average costs, which is needed to adjust each LTCH's relative charge value to reflect its case-mix relative to the average case-mix for all LTCHs. Because we standardize charges in this manner, we count charges for a Medicare patient at a LTCH with high average charges as less resource intensive than they would be at a LTCH with low average charges. For example, a $10,000 charge for a case at a LTCH with an average adjusted charge of $17,500 reflects a higher level of relative resource use than a $10,000 charge for a case at a LTCH with the same case-mix, but an average adjusted charge of $35,000. We believe that the adjusted charge of an individual case more accurately reflects actual resource use for an individual LTCH because the variation in charges due to systematic differences in the markup of charges among LTCHs is taken into account.

d. Treatment of Severity Levels in Developing Proposed Relative Weights

Under the proposed MS–LTC–DRGs, for purposes of the proposed setting of the relative weights, there would be three different categories of DRGs based on volume of cases within specific MS–LTC–DRGs. MS–LTC–DRGs with at least 25 cases are each assigned a unique relative weight; low-volume MS–LTC–DRGs (that is, MS–LTC–DRGs that contain between one and 24 cases annually) are grouped into quintiles (described below) and assigned the weight of the quintile. No-volume MS–LTC–DRGs (that is, no cases in the database were assigned to those MS–LTC–DRGs) are crosswalked to other MS–LTC–DRGs based on the clinical similarities and assigned the relative weight of the crosswalked MS–LTC–DRG. (We provide in-depth discussions of our proposed policy regarding weight setting for low-volume MS–LTC–DRGs in section II.I.3.e. of the preamble of this proposed rule and for no-volume MS–LTC–DRGs, under Step 5 in section II.I.4. of the preamble of this proposed rule.)

As described above, in response to the need to account for severity and pay appropriately for cases, we developed a severity-adjusted patient classification system which we adopted for both the IPPS and the LTCH PPS in FY 2008. As described in greater detail above, the MS–LTC–DRG system can accommodate three severity levels: ''with MCC'' (most severe); ''with CC,'' and ''without CC/MCC'' (the least severe) with each level assigned an individual MS–LTC–DRG number. In cases with two subdivisions, the levels are either ''with CC/MCC'' and ''without CC/MCC'' or ''with MCC'' and ''without MCC''. For example, under the MS–LTC–DRG system, multiple sclerosis and cerebellar ataxia with MCC is MS–LTC–DRG 58; multiple sclerosis and cerebellar ataxia with CC is MS–LTC–DRG 59; and multiple sclerosis and cerebellar ataxia without CC/MCC is MS–LTC–DRG 60. For purposes of discussion in this section, the term ''base DRG'' is used to refer to the DRG category that encompasses all levels of severity for that DRG. For example, when referring to the entire DRG category for multiple sclerosis and cerebellar ataxia, which includes the above three severity levels, we would use the term ''base-DRG.''

As noted above, while the LTCH PPS and the IPPS use the same patient classification system, the methodology that is used to set the DRG weights for use in each payment system differs because the overall volume of cases in the LTCH PPS is much less than in the IPPS. As a general rule, consistent with the methodology we used when we adopted the MS–LTC–DRGs in the FY 2008 IPPS final rule with comment period (72 FR 47278 through 47281), we are proposing to determine the FY 2009 relative weights for the MS–LTC–DRGs using the following steps: (1) if an MS–LTC–DRG has at least 25 cases, it is assigned its own relative weight; (2) if an MS–LTC–DRG has between 1 and 24 cases, it is assigned to a quintile for which we will compute 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 below in detail in Step 5 of the Steps for Determining the proposed FY 2009 MS–LTC–DRG Relative Weights). Furthermore, in determining the proposed FY 2009 MS–LTC–DRG relative weights, when necessary, we are proposing to make adjustments to account for nonmonotonicity, as explained below.

Theoretically, cases under the MS–LTC–DRG system that are more severe require greater expenditure of medical care resources and will result in higher average charges. Therefore, in the three severity levels, weights should increase with severity, from lowest to highest. If the weights do not increase (that is, if based on the relative weight methodology outlined above, the MS–LTC–DRG with MCC would have a lower relative weight than one with CC, or the MS–LTC–DRG without CC/MCC would have a higher relative weight than either of the others), there is a problem with monotonicity. Since the start of the LTCH PPS for FY 2003 (67 FR 55990), 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 for both LTC–DRGs. We continue to believe that utilizing nonmonotonic relative weights to adjust Medicare payments would result in inappropriate payments because, in a nonmonotonic system, cases that are more severe and require greater expenditure of medical care resources would be paid based on a lower relative weight than cases that are less severe and require lower resource use. The procedure for dealing with nonmonotonicity under the MS–LTC–DRG classification system is discussed in greater detail below in section II.I.4. (Step 6) of the preamble of this proposed rule.

e. Proposed Low-Volume MS–LTC–DRGs

In order to account for MS–LTC–DRGs with low volume (that is, with fewer than 25 LTCH cases), consistent with the methodology we established when we implemented the LTCH PPS (August 30, 2002; 67 FR 55984 through 55995), we group those ''low-volume MS–LTC–DRGs'' (that is, MS–LTC–DRGs that contained between 1 and 24 cases annually) into one of five categories (quintiles) based on average charges, for the purposes of determining relative weights (72 FR 47283 through 47288). In determining the proposed FY

2009 MS–LTC–DRG relative weights in this proposed rule, we are proposing to continue to employ this quintile methodology for proposed low-volume MS–LTC–DRGs. In addition, in cases where the initial assignment of a low-volume MS–LTC–DRG to quintiles results in nonmonotonicity within a base DRG, in order to ensure appropriate Medicare payments, consistent with our historical methodology, we are proposing to make adjustments to the treatment of low-volume MS–LTC–DRGs to preserve monotonicity, as discussed in detail below in section II.I.4 (Step 6 of the methodology for determining the proposed FY 2009 MS–LTC–DRG relative weights). In this proposed rule, using LTCH cases from the December 2007 update of the FY 2007 MedPAR file, we identified 290 MS–LTC–DRGs that contained between 1 and 24 cases. This list of proposed MS–LTC–DRGs was then divided into one of the proposed 5 low-volume quintiles, each containing 58 MS–LTC–DRGs (290/5 = 58). We are proposing to make the assignment of a low-volume MS–LTC–DRG to a specific low-volume quintile by sorting the proposed low-volume MS–LTC–DRGs in ascending order by average charge in accordance with our established methodology. Specifically, for this proposed rule, the 290 proposed low-volume MS–LTC–DRGs are sorted by ascending order by average charge and assigned to a specific proposed low-volume quintile (as described below). After sorting the 290 proposed low-volume MS–LTC–DRGs by average charge in ascending order, we are proposing to group the first fifth (1st through 58th) of proposed low-volume MS–LTC–DRGs (with the lowest average charge) into Quintile 1. This process is repeated through the remaining proposed low-volume MS–LTC–DRGs so that each of the 5 proposed low-volume quintiles contains 58 proposed MS–LTC–DRGs. The highest average charge cases would be grouped into Quintile 5. (We note that, consistent with our historical methodology, if the number of proposed low-volume MS–LTC–DRGs had not been evenly divisible by 5, we would have used the average charge of the proposed low-volume MS–LTC–DRG to determine which proposed low-volume quintile would have received the additional proposed low-volume MS–LTC–DRG.)

Accordingly, in order to determine the proposed relative weights for the proposed MS–LTC–DRGs with low-volume for FY 2009, we are proposing to use the five low-volume quintiles described above. The composition of each of the proposed five low-volume quintiles shown in the chart below was used in determining the proposed MS–LTC–DRG relative weights for FY 2009 (Table 11 of the Addendum of this proposed rule). We would determine a proposed relative weight and (geometric) average length of stay for each of the proposed five low-volume quintiles using the methodology that we are proposing to apply to the regular MS–LTC–DRGs (25 or more cases), as described in section II.I.4. of the preamble of this proposed rule. We are proposing to assign the same relative weight and average length of stay to each of the proposed low-volume MS–LTC–DRGs that make up an individual low-volume quintile. We note that, as this system is dynamic, it is possible that the number and specific type of MS–LTC–DRGs with a low volume of LTCH cases will vary in the future. We use the best available claims data in the MedPAR file to identify low-volume MS–LTC–DRGs and to calculate the relative weights based on our methodology.

PROPOSED COMPOSITION OF LOW-VOLUME QUINTILES FOR FY 2009

Proposed MS–LTC–DRG (version 26.0)	Proposed MS–LTC–DRG description (version 26.0)
PROPOSED QUINTILE 1	
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.
79	Hypertensive encephalopathy w/o CC/MCC.
87	Traumatic stupor & coma, coma <1 hr w/o CC/MCC.
89	Concussion w CC.
125	Other disorders of the eye w/o MCC.
135	Sinus & mastoid procedures w CC/MCC.
136	Sinus & mastoid procedures w/o CC/MCC.**
148	Ear, nose, mouth & throat malignancy w/o CC/MCC.
149	Dysequilibrium.
159	Dental & Oral Diseases w/o CC/MCC.
183	Major chest trauma w MCC.
184	Major chest trauma w CC.
185	Major chest trauma w/o CC/MCC.
201	Pneumothorax w/o CC/MCC.
257	Upper limb & toe amputation for circ system disorders w/o CC/MCC.
261	Cardiac pacemaker revision except device replacement w CC.***
263	Vein ligation & stripping.
304	Hypertension w MCC.
305	Hypertension w/o MCC.
311	Angina pectoris.
313	Chest pain.
382	Complicated peptic ulcer w/o CC/MCC.
387	Inflammatory bowel disease w/o CC/MCC.
437	Malignancy of hepatobiliary system or pancreas w/o CC/MCC.
443	Disorders of liver except malig, cirr, alc hepa w/o CC/MCC.
468	Revision of hip or knee replacement w/o CC/MCC.
510	Shoulder, elbow or forearm proc, exc major joint proc w MCC.***
537	Sprains, strains, & dislocations of hip, pelvis & thigh w CC/MCC.

PROPOSED COMPOSITION OF LOW-VOLUME QUINTILES FOR FY 2009—Continued

Proposed MS–LTC–DRG (version 26.0)	Proposed MS–LTC–DRG description (version 26.0)
544	Pathological fractures & musculoskelet & conn tiss malig w/o CC/MCC.
547	Connective tissue disorders w/o CC/MCC.
556	Signs & symptoms of musculoskeletal system & conn tissue w/o MCC.
563	Fx, sprn, strn & disl except femur, hip, pelvis & thigh w/o MCC.
601	Non-malignant breast disorders w/o CC/MCC.
618	Amputat of lower limb for endocrine, nutrit, & metabol dis w/o CC/MCC.
642	Inborn errors of metabolism
645	Endocrine disorders w/o CC/MCC.
694	Urinary stones w/o esw lithotripsy w/o MCC.
723	Malignancy, male reproductive system w CC.
726	Benign prostatic hypertrophy w/o MCC.
730	Other male reproductive system diagnoses w/o CC/MCC.
756	Malignancy, female reproductive system w/o CC/MCC.
781	Other antepartum diagnoses w medical complications.
810	Major hematol/immun diag exc sickle cell crisis & coagul w/o CC/MCC.
816	Reticuloendothelial & immunity disorders w/o CC/MCC.
864	Fever of unknown origin.
869	Other infectious & parasitic diseases diagnoses w/o CC/MCC.
880	Acute adjustment reaction & psychosocial dysfunction.
882	Neuroses except depressive.
886	Behavioral & developmental disorders.
895	Alcohol/drug abuse or dependence w rehabilitation therapy.
897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC.
917	Poisoning & toxic effects of drugs w MCC.
918	Poisoning & toxic effects of drugs w/o MCC.
958	Other O.R. procedures for multiple significant trauma w CC.
965	Other multiple significant trauma w/o CC/MCC.
PROPOSED QUINTILE 2	
59	Multiple sclerosis & cerebellar ataxia w CC.
60	Multiple sclerosis & cerebellar ataxia w/o CC/MCC.
75	Viral meningitis w CC/MCC.
78	Hypertensive encephalopathy w CC.
83	Traumatic stupor & coma, coma >1 hr w CC.
84	Traumatic stupor & coma, coma >1 hr w/o CC/MCC.
99	Non-bacterial infect of nervous sys exc viral meningitis w/o CC/MCC.
102	Headaches w MCC.
103	Headaches w/o MCC.
121	Acute major eye infections w CC/MCC.
122	Acute major eye infections w/o CC/MCC.
124	Other disorders of the eye w MCC.
153	Otitis media & URI w/o MCC.
156	Nasal trauma & deformity w/o CC/MCC.
157	Dental & Oral Diseases w MCC.
158	Dental & Oral Diseases w CC.
182	Respiratory neoplasms w/o CC/MCC.*
188	Pleural effusion w/o CC/MCC.*
203	Bronchitis & asthma w/o CC/MCC.
254	Other vascular procedures w/o CC/MCC.
294	Deep vein thrombophlebitis w CC/MCC.
354	Hernia procedures except inguinal & femoral w CC.
376	Digestive malignancy w/o CC/MCC.
379	G.I. hemorrhage w/o CC/MCC.
381	Complicated peptic ulcer w CC.
390	G.I. obstruction w/o CC/MCC.
409	Biliary tract proc except only cholecyst w or w/o c.d.e. w CC.
433	Cirrhosis & alcoholic hepatitis w CC.
440	Disorders of pancreas except malignancy w/o CC/MCC.
446	Disorders of the biliary tract w/o CC/MCC.*
489	Knee procedures w/o pdx of infection w/o CC/MCC.
533	Fractures of femur w MCC.
534	Fractures of femur w/o MCC.
553	Bone diseases & arthropathies w MCC.
578	Skin graft &/or debrid exc for skin ulcer or cellulitis w/o CC/MCC.
584	Breast biopsy, local excision & other breast procedures w CC/MCC.
624	Skin grafts & wound debrid for endoc, nutrit & metab dis w/o CC/MCC.
661	Kidney & ureter procedures for non-neoplasm w/o CC/MCC.
663	Minor bladder procedures w CC.
665	Prostatectomy w MCC.***

PROPOSED COMPOSITION OF LOW-VOLUME QUINTILES FOR FY 2009—Continued

Proposed MS–LTC–DRG (version 26.0)	Proposed MS–LTC–DRG description (version 26.0)
669	Transurethral procedures w CC.
671	Urethral procedures w CC/MCC.
688	Kidney & urinary tract neoplasms w/o CC/MCC.
696	Kidney & urinary tract signs & symptoms w/o MCC.
722	Malignancy, male reproductive system w MCC.
759	Infections, female reproductive system w/o CC/MCC.*
815	Reticuloendothelial & immunity disorders w CC.
835	Acute leukemia w/o major O.R. procedure w CC.***
842	Lymphoma & non-acute leukemia w/o CC/MCC.
844	Other myeloprolif dis or poorly diff neopl diag w CC.
845	Other myeloprolif dis or poorly diff neopl diag w/o CC/MCC.
866	Viral illness w/o MCC.
876	O.R. procedure w principal diagnoses of mental illness.
881	Depressive neuroses
923	Other injury, poisoning & toxic effect diag w/o MCC.
929	Full thickness burn w skin graft or inhal inj w/o CC/MCC.
964	Other multiple significant trauma w CC.
976	HIV w major related condition w/o CC/MCC.
PROPOSED QUINTILE 3	
23	Craniotomy w major device implant or acute complex CNS PDX w MCC.***
27	Craniotomy & endovascular intracranial procedures w/o CC/MCC.
53	Spinal disorders & injuries w/o CC/MCC.
58	Multiple sclerosis & cerebellar ataxia w MCC.
82	Traumatic stupor & coma, coma >1 hr w MCC.
98	Non-bacterial infect of nervous sys exc viral meningitis w CC.
113	Orbital procedures w CC/MCC.
116	Intraocular procedures w CC/MCC.
136	Sinus & mastoid procedures w/o CC/MCC.***
152	Otitis media & URI w MCC.
165	Major chest procedures w/o CC/MCC.
168	Other resp system O.R. procedures w/o CC/MCC.
238	Major cardiovascular procedures w/o MCC.
241	Amputation for circ sys disorders exc upper limb & toe w/o CC/MCC.
261	Cardiac pacemaker revision except device replacement w CC.**
262	Cardiac pacemaker revision except device replacement w/o CC/MCC.**
284	Circulatory disorders w AMI, expired w CC.*
287	Circulatory disorders except AMI, w card cath w/o MCC.
369	Major esophageal disorders w CC.
370	Major esophageal disorders w/o CC/MCC.
380	Complicated peptic ulcer w MCC.
384	Uncomplicated peptic ulcer w/o MCC.
424	Other hepatobiliary or pancreas O.R. procedures w CC.
471	Cervical spinal fusion w MCC.
472	Cervical spinal fusion w CC.
476	Amputation for musculoskeletal sys & conn tissue dis w/o CC/MCC.
482	Hip & femur procedures except major joint w/o CC/MCC.
494	Lower extrem & humer proc except hip, foot, femur w/o CC/MCC.
497	Local excision & removal int fix devices exc hip & femur w/o CC/MCC.*
502	Soft tissue procedures w/o CC/MCC.
504	Foot procedures w CC.
505	Foot procedures w/o CC/MCC.
510	Shoulder, elbow or forearm proc, exc major joint proc w MCC.**
511	Shoulder, elbow or forearm proc, exc major joint proc w CC.**
535	Fractures of hip & pelvis w MCC.
542	Pathological fractures & musculoskelet & conn tiss malig w MCC.
555	Signs & symptoms of musculoskeletal system & conn tissue w MCC.
562	Fx, sprn, strn & disl except femur, hip, pelvis & thigh w MCC.
598	Malignant breast disorders w CC.
599	Malignant breast disorders w/o CC/MCC.**
600	Non-malignant breast disorders w CC/MCC.
626	Thyroid, parathyroid & thyroglossal procedures w CC.
630	Other endocrine, nutrit & metab O.R. proc w/o CC/MCC.
665	Prostatectomy w MCC.**
666	Prostatectomy w CC.**
668	Transurethral procedures w MCC.
686	Kidney & urinary tract neoplasms w MCC.
687	Kidney & urinary tract neoplasms w CC.
693	Urinary stones w/o esw lithotripsy w MCC.

PROPOSED COMPOSITION OF LOW-VOLUME QUINTILES FOR FY 2009—Continued

Proposed MS–LTC–DRG (version 26.0)	Proposed MS–LTC–DRG description (version 26.0)
725	Benign prostatic hypertrophy w MCC.
744	D&C, conization, laparoscopy & tubal interruption w CC/MCC.
755	Malignancy, female reproductive system w CC.
800	Splenectomy w CC.
809	Major hematol/immun diag exc sickle cell crisis & coagul w CC.
814	Reticuloendothelial & immunity disorders w MCC.
824	Lymphoma & non-acute leukemia w other O.R. proc w CC.
834	Acute leukemia w/o major O.R. procedure w MCC.
835	Acute leukemia w/o major O.R. procedure w CC.**
836	Acute leukemia w/o major O.R. procedure w/o CC/MCC.**
843	Other myeloprolif dis or poorly diff neopl diag w MCC.
883	Disorders of personality & impulse control.
903	Wound debridements for injuries w/o CC/MCC.
905	Skin grafts for injuries w/o CC/MCC.
922	Other injury, poisoning & toxic effect diag w MCC.
941	O.R. proc w diagnoses of other contact w health services w/o CC/MCC.
963	Other multiple significant trauma w MCC.
989	Non-extensive O.R. proc unrelated to principal diagnosis w/o CC/MCC.
PROPOSED QUINTILE 4	
23	Craniotomy w major device implant or acute complex CNS PDX w MCC.**
24	Craniotomy w major device implant or acute complex CNS PDX w/o MCC.**
28	Spinal procedures w MCC.
29	Spinal procedures w CC.
30	Spinal procedures w/o CC/MCC.
37	Extracranial procedures w MCC.
38	Extracranial procedures w CC.**
42	Periph & cranial nerve & other nerv syst proc w/o CC/MCC.*
77	Hypertensive encephalopathy w MCC.
133	Other ear, nose, mouth & throat O.R. procedures w CC/MCC.
164	Major chest procedures w CC.
237	Major cardiovascular procedures w MCC.
242	Permanent cardiac pacemaker implant w MCC.***
246	Percutaneous cardiovascular proc w drug-eluting stent w MCC.
247	Percutaneous cardiovascular proc w drug-eluting stent w/o MCC.
248	Percutaneous cardiovasc proc w non-drug-eluting stent w MCC.
249	Percutaneous cardiovasc proc w non-drug-eluting stent w/o MCC.**
259	Cardiac pacemaker device replacement w/o MCC.
260	Cardiac pacemaker revision except device replacement w MCC.
262	Cardiac pacemaker revision except device replacement w/o CC/MCC.***
286	Circulatory disorders except AMI, w card cath w MCC.
327	Stomach, esophageal & duodenal proc w CC.
328	Stomach, esophageal & duodenal proc w/o CC/MCC.**
348	Anal & stomal procedures w CC.
358	Other digestive system O.R. procedures w/o CC/MCC.*
405	Pancreas, liver & shunt procedures w MCC.
406	Pancreas, liver & shunt procedures w CC.**
417	Laparoscopic cholecystectomy w/o c.d.e. w MCC.***
466	Revision of hip or knee replacement w MCC.
467	Revision of hip or knee replacement w CC.
469	Major joint replacement or reattachment of lower extremity w MCC.***
478	Biopsies of musculoskeletal system & connective tissue w CC.
481	Hip & femur procedures except major joint w CC.
485	Knee procedures w pdx of infection w 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.
492	Lower extrem & humer proc except hip, foot, femur w MCC.
493	Lower extrem & humer proc except hip, foot, femur w CC.
503	Foot procedures w MCC.
511	Shoulder, elbow or forearm proc, exc major joint proc w CC.***
513	Hand or wrist proc, except major thumb or joint proc w CC/MCC.
514	Hand or wrist proc, except major thumb or joint proc w/o CC/MCC.**
597	Malignant breast disorders w MCC.
599	Malignant breast disorders w/o CC/MCC.***
625	Thyroid, parathyroid & thyroglossal procedures w MCC.
659	Kidney & ureter procedures for non-neoplasm w MCC.
660	Kidney & ureter procedures for non-neoplasm w CC.
666	Prostatectomy w CC.***

PROPOSED COMPOSITION OF LOW-VOLUME QUINTILES FOR FY 2009—Continued

Proposed MS–LTC–DRG (version 26.0)	Proposed MS–LTC–DRG description (version 26.0)
695	Kidney & urinary tract signs & symptoms w MCC.
711	Testes procedures w CC/MCC.
717	Other male reproductive system O.R. proc exc malignancy w CC/MCC.
739	Uterine, adnexa proc for non-ovarian/adnexal malig w MCC.
749	Other female reproductive system O.R. procedures w CC/MCC.
754	Malignancy, female reproductive system w MCC.
802	Other O.R. proc of the blood & blood forming organs w MCC.
808	Major hematol/immun diag exc sickle cell crisis & coagul w MCC.
823	Lymphoma & non-acute leukemia w other O.R. proc w MCC.
896	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC.
909	Other O.R. procedures for injuries w/o CC/MCC.*
928	Full thickness burn w skin graft or inhal inj w CC/MCC.
933	Extensive burns or full thickness burns w MV 96+ hrs w/o skin graft.
957	Other O.R. procedures for multiple significant trauma w MCC.
969	HIV w extensive O.R. procedure w MCC.
970	HIV w extensive O.R. procedure w/o MCC.**
984	Prostatic O.R. procedure unrelated to principal diagnosis w MCC.
985	Prostatic O.R. procedure unrelated to principal diagnosis w CC.
PROPOSED QUINTILE 5	
11	Tracheostomy for face, mouth & neck diagnoses w MCC.
12	Tracheostomy for face, mouth & neck diagnoses w CC.
24	Craniotomy w major device implant or acute complex CNS PDX w/o MCC.***
25	Craniotomy & endovascular intracranial procedures w MCC.
26	Craniotomy & endovascular intracranial procedures w CC.
31	Ventricular shunt procedures w MCC.
32	Ventricular shunt procedures w CC.
38	Extracranial procedures w CC.***
132	Cranial/facial procedures w/o CC/MCC.
137	Mouth procedures w CC/MCC.
226	Cardiac defibrillator implant w/o cardiac cath w MCC.
227	Cardiac defibrillator implant w/o cardiac cath w/o MCC.
242	Permanent cardiac pacemaker implant w MCC.**
243	Permanent cardiac pacemaker implant w CC.
244	Permanent cardiac pacemaker implant w/o CC/MCC.
249	Percutaneous cardiovasc proc w non-drug-eluting stent w/o MCC.***
250	Perc cardiovasc proc w/o coronary artery stent or AMI w MCC.
326	Stomach, esophageal & duodenal proc w MCC.
328	Stomach, esophageal & duodenal proc w/o CC/MCC.***
330	Major small & large bowel procedures w CC.
331	Major small & large bowel procedures w/o CC/MCC.
335	Peritoneal adhesiolysis w MCC.
344	Minor small & large bowel procedures w MCC.
347	Anal & stomal procedures w MCC.
353	Hernia procedures except inguinal & femoral w MCC.
406	Pancreas, liver & shunt procedures w CC.***
411	Cholecystectomy w c.d.e. w MCC.
414	Cholecystectomy except by laparoscope w/o c.d.e. w MCC.
415	Cholecystectomy except by laparoscope w/o c.d.e. w CC.
417	Laparoscopic cholecystectomy w/o c.d.e. w MCC.**
418	Laparoscopic cholecystectomy w/o c.d.e. w CC.
423	Other hepatobiliary or pancreas O.R. procedures w MCC.
456	Spinal fusion exc cerv w spinal curv, malig or 9+ fusions w MCC.
457	Spinal fusion exc cerv w spinal curv, malig or 9+ fusions w CC.
459	Spinal fusion except cervical w MCC.
469	Major joint replacement or reattachment of lower extremity w MCC.**
470	Major joint replacement or reattachment of lower extremity w/o MCC.
477	Biopsies of musculoskeletal system & connective tissue w MCC.
480	Hip & femur procedures except major joint w MCC.
487	Knee procedures w pdx of infection w/o CC/MCC.***
488	Knee procedures w/o pdx of infection w CC/MCC.
496	Local excision & removal int fix devices exc hip & femur w CC.*
498	Local excision & removal int fix devices of hip & femur w CC/MCC.
507	Major shoulder or elbow joint procedures w CC/MCC.
514	Hand or wrist proc, except major thumb or joint proc w/o CC/MCC.***
582	Mastectomy for malignancy w CC/MCC.
619	O.R. procedures for obesity w MCC.
653	Major bladder procedures w MCC.
656	Kidney & ureter procedures for neoplasm w MCC.

PROPOSED COMPOSITION OF LOW-VOLUME QUINTILES FOR FY 2009—Continued

Proposed MS–LTC–DRG (version 26.0)	Proposed MS–LTC–DRG description (version 26.0)
662	Minor bladder procedures w MCC.
709	Penis procedures w CC/MCC.
713	Transurethral prostatectomy w CC/MCC.
746	Vagina, cervix & vulva procedures w CC/MCC.
826	Myeloprolif disord or poorly diff neopl w maj O.R. proc w MCC.
827	Myeloprolif disord or poorly diff neopl w maj O.R. proc w CC.
829	Myeloprolif disord or poorly diff neopl w other O.R. proc w CC/MCC.
836	Acute leukemia w/o major O.R. procedure w/o CC/MCC.***
855	Infectious & parasitic diseases w O.R. procedure w/o CC/MCC.*
906	Hand procedures for injuries.
927	Extensive burns or full thickness burns w MV 96+ hrs w skin graft.
970	HIV w extensive O.R. procedure w/o MCC.***

*One of the original 290 proposed low-volume MS–LTC–DRGs initially assigned to this proposed low-volume quintile; removed from this proposed low-volume quintile in addressing nonmonotonicity (refer to step 6 in section II.I.4..of the preamble of this proposed rule).

**One of the original 290 proposed low-volume MS–LTC–DRGs initially assigned to a different proposed low-volume quintile but moved to this proposed low-volume quintile in addressing nonmonotonicity (refer to step 6 in section II.I.4. of the preamble of this proposed rule).

***One of the original 290 proposed low-volume MS–LTC–DRGs initially assigned to this proposed low-volume quintile but moved to a different proposed low-volume quintile in addressing nonmonotonicity (refer to step 6 in section II.I.4. of the preamble of this proposed rule).

We note that we will continue to monitor the volume (that is, the number of LTCH cases) in the low-volume quintiles to ensure that our proposed 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 Proposed FY 2009 MS–LTC–DRG Relative Weights

In general, the proposed FY 2009 MS–LTC–DRG relative weights in this proposed rule were determined based on the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 55989 through 55991). In summary, for FY 2009, we are proposing to group LTCH cases to the appropriate proposed MS–LTC–DRG, while taking into account the proposed low-volume MS–LTC–DRGs (as described above), before the proposed FY 2009 MS–LTC–DRG relative weights are determined. After grouping the cases to the appropriate proposed MS–LTC–DRG (or proposed low-volume quintile), we would calculate the proposed relative weights for FY 2009 by first removing statistical outliers and cases with a length of stay of 7 days or less (as discussed in greater detail below). Next, we would adjust the number of cases in each proposed MS–LTC–DRG (or proposed low-volume quintile) 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 proposed MS–LTC–DRG (or proposed low-volume quintile) using the HSRV method (described above). In general, to determine the proposed FY 2009 MS–LTC–DRG relative weights in this proposed rule, we are proposing to use the same methodology we used in determining the FY 2008 MS–LTC–DRG relative weights in the FY 2008 IPPS final rule with comment period (72 FR 47281 through 47299). However, we are proposing to make a modification to our methodology for determining proposed relative weights for MS–LTC–DRGs with no LTCH cases (as discussed in greater detail in Step 5 below). Also, we note that, although we are generally proposing to use the same methodology in this proposed rule (with the exception noted above) as the methodology used in the FY 2008 IPPS final rule with comment, the discussion presented below of the steps for determining the proposed FY 2009 MS–LTC–DRG relative weights varies slightly from the discussion of the steps for determining the FY 2008 MS–LTC–DRG relative weights (presented in the FY 2008 IPPS final rule with comment) because we are taking this opportunity to refine our description to more precisely explain our methodology for determining the MS–LTC–DRG relative weights.

As discussed in the FY 2008 IPPS final rule with comment when we adopted the MS–LTC–DRGs, the adoption of the MS–LTC–DRGs with either two or three severity levels resulted in some slight modifications of procedures for assigning relative weights in cases of zero volume and/or nonmonotonicity (described in detail below) from the methodology we established when we implemented the LTCH PPS in the August 30, 2002 LTCH PPS final rule. As also discussed in the FY 2008 IPPS final rule with comment when we adopted the MS–LTC–DRGs, we implemented the MS–LTC–DRGs with a 2-year transition beginning in FY 2008. For FY 2008, the first year of the transition, 50 percent of the relative weight for a MS–LTC–DRG was based on the average LTC–DRG relative weight under Version 24.0 of the LTC–DRG GROUPER. The remaining 50 percent of the relative weight was based on the MS–LTC–DRG relative weight under Version 25.0 of the MS–LTC–DRG GROUPER. In FY 2009, the MS–LTC–DRG relative weights are based on 100 percent of the MS–LTC–DRG relative weights. Accordingly, in determining the proposed FY 2009 MS–LTC–DRG relative weights in this proposed rule, there is no longer a need to include a step to calculate MS–LTC–DRG transition blended relative weights (see Step 7 in the FY 2008 IPPS final rule with comment period (72 FR 47295)). Therefore, in this proposed rule, we determined the proposed FY 2009 MS–LTC–DRG relative weights based solely on the proposed MS–LTC–DRG relative weight under proposed Version 26.0 of the MS–LTC–DRG GROUPER, which is discussed in section II.B. of the preamble of this proposed rule. Furthermore, we are proposing that we would determine the final FY 2009 MS–LTC–DRG relative weights in the final rule based on the final Version 26.0 of the MS–LTC–DRG GROUPER that will be presented in that same final rule.

Below we discuss in detail the steps for calculating the proposed FY 2009 MS–LTC–DRG relative weights. We note that, as we stated above in section II.I.3.b. of the preamble of this proposed rule, we have excluded the data of all-inclusive rate LTCHs and LTCHs that

are paid in accordance with demonstration projects that had claims in the FY 2007 MedPAR file.

Step 1—Remove statistical outliers.

The first step in the calculation of the proposed FY 2009 MS–LTC–DRG relative weights is to remove statistical outlier cases. Consistent with our historical relative weight methodology, we are proposing to continue to define statistical outliers as cases that are outside of 3.0 standard deviations from the mean of the log distribution of both charges per case and the charges per day for each proposed MS–LTC–DRG. These statistical outliers are removed prior to calculating the proposed relative weights because we believe that they may represent aberrations in the data that distort the measure of average resource use. Including those LTCH cases in the calculation of the proposed relative weights could result in an inaccurate proposed relative weight that does not truly reflect relative resource use among the proposed MS–LTC–DRGs.

Step 2—Remove cases with a length of stay of 7 days or less.

The MS–LTC–DRG relative weights reflect the average of resources used on representative cases of a specific type. Generally, cases with a length of stay of 7 days or less do not belong in a LTCH because these stays do not fully receive or benefit from treatment that is typical in a LTCH stay, and full resources are often not used in the earlier stages of admission to a LTCH. If we were to include stays of 7 days or less in the computation of the proposed FY 2009 MS–LTC–DRG relative weights, the value of many relative weights would decrease and, therefore, payments would decrease to a level that may no longer be appropriate. We do not believe that it would be appropriate to compromise the integrity of the payment determination for those LTCH cases that actually benefit from and receive a full course of treatment at a LTCH, by including data from these very short-stays. Therefore, consistent with our historical relative weight methodology, in determining the proposed FY 2009 MS–LTC–DRG relative weights, we are proposing to 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. As the next step in the calculation of the proposed FY 2009 MS–LTC–DRG relative weights, consistent with our historical relative weight methodology, we are proposing 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, 2008). (We note that even if a case was removed in Step 2 (that is, cases with a length of stay of 7 days or less), it was paid as 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.)

We would 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 proposed MS–LTC–DRG for nonshort-stay outlier cases. This has the effect of proportionately reducing the impact of the lower charges for the short-stay outlier cases in calculating the average charge for the proposed 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 proposed MS–LTC–DRG.

Counting short-stay outlier cases as full discharges with no adjustment in determining the proposed FY 2009 MS–LTC–DRG relative weights would lower the proposed FY 2009 MS–LTC–DRG relative weight for affected proposed MS–LTC–DRGs because the relatively lower charges of the short-stay outlier cases would bring down the average charge for all cases within a proposed MS–LTC–DRG. This would result in an ''underpayment'' for nonshort-stay outlier cases and an ''overpayment'' for short-stay outlier cases. Therefore, we are proposing to 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 proposed FY 2009 MS–LTC–DRG relative weights on an iterative basis.

Consistent with our historical relative weight methodology, we are proposing to calculate the proposed MS–LTC–DRG relative weights using the HSRV methodology, which is an iterative process. First, for each LTCH case, we calculate a hospital-specific relative charge value by dividing the 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 proposed MS–LTC–DRG, the proposed FY 2009 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 (that is, its 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 LTCH's 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 a proposed FY 2009 relative weight for proposed MS–LTC–DRGs with no LTCH cases.

As we stated above, we determine the proposed FY 2009 relative weight for each proposed MS–LTC–DRG using total Medicare allowable charges reported in the best available LTCH claims data (that is, the December 2007 update of the FY 2007 MedPAR file for this proposed rule). Of the proposed FY 2009 MS–LTC–DRGs, we identified a number of proposed MS–LTC–DRGs for which there were no LTCH cases in the database. That is, based on data from the FY 2007 MedPAR file used for this proposed rule, no patients who would have been classified to those proposed MS–LTC–DRGs were treated in LTCHs during FY 2007 and, therefore, no charge data are available for those proposed MS–LTC–DRGs. Thus, in the process of determining the proposed MS–LTC–DRG relative weights, we are unable to calculate proposed relative weights for these proposed 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 proposed MS–LTC–DRGs may be treated at LTCHs, consistent with our historical methodology, we are proposing to assign relative weights to each of the proposed no-volume MS–LTC–DRGs based on clinical similarity and relative costliness (with the

exception of proposed ''transplant'' MS–LTC–DRGs and proposed ''error'' MS–LTC–DRGs as discussed below). In general, we are proposing to determine proposed FY 2009 relative weights for the proposed MS–LTC–DRGs with no LTCH cases in the FY 2007 MedPAR file used in this proposed rule (that is, proposed ''no-volume MS–LTC–DRGs) by cross-walking each proposed no-volume MS–LTC–DRG to another proposed MS–LTC–DRG with a proposed relative weight (determined in accordance with the proposed methodology described above). Then, under our proposed methodology presented in this proposed rule, the proposed ''no-volume'' MS–LTC–DRG would be assigned the same proposed relative weight of the proposed MS–LTC–DRG to which it would be cross-walked (as described in greater detail below). As noted above, we are proposing to make a modification to our methodology for determining proposed relative weights for MS–LTC–DRGs with no LTCH cases in this proposed rule, which is discussed in greater detail below. As also noted above, even where we are not proposing changes to our existing methodology, we are taking this opportunity to refine our description to more precisely explain our proposed methodology for determining the MS–LTC–DRG relative weights in this proposed rule.

Specifically, in this proposed rule, we are proposing to determine the relative weight for each proposed MS–LTC–DRG using total Medicare allowable charges reported in the December 2007 update of the FY 2007 MedPAR file. Of the 746 proposed MS–LTC–DRGs for FY 2009, we identified 203 proposed MS–LTC–DRGs for which there were no LTCH cases in the database (including the 8 proposed ''transplant'' MS–LTC–DRGs and 2 proposed ''error'' MS–LTC–DRGs). For this proposed rule, as noted above, we are proposing to assign proposed relative weights for each of the 203 proposed no-volume MS–LTC–DRGs (with the exception of the 8 proposed ''transplant'' proposed MS–LTC–DRGs and the 2 proposed ''error'' MS–LTC–DRGs, which are discussed below) based on clinical similarity and relative costliness to one of the remaining 543 (746 − 203 = 543) proposed MS–LTC–DRGs for which we are able to determine relative weights, based on FY 2007 LTCH claims data. (For the remainder of this discussion, we refer to one of the 543 proposed MS–LTC–DRGs for which we are able to determine relative weight as the proposed ''cross-walked'' MS–LTC–DRG.) Then we are proposing to assign the proposed no-volume MS–LTC–DRG the proposed relative weight of the proposed cross-walked MS–LTC–DRG. This proposed approach differs from the one we used to determine the FY 2008 MS–LTC–DRG relative weights when there were no LTCH cases (see 72 FR 47290). Specifically, in determining the FY 2008 MS–LTC–DRG relative weights in the FY 2008 IPPS final rule with comment period, if the no volume MS–LTC–DRG was cross-walked to a MS–LTC–DRG that had 25 or more cases and, therefore, was not in a low-volume quintile, we assigned the relative weight of a quintile to a no-volume MS–LTC–DRG (rather than assigning the relative weight of the cross-walked MS–LTC–DRG). While we believe this approach would result in appropriate LTCH PPS payments (because it is consistent with our methodology for determining relative weights for MS–LTC–DRGs that have a low volume of LTCH cases (which is discussed above in section II.I.3.e. of this preamble)), upon further review during the development of the proposed FY 2009 MS–LTC–DRG relative weights in this proposed rule, we now believe that proposing to assign the proposed relative weight of the proposed cross-walked MS–LTC–DRG to the proposed no-volume MS–LTC–DRG would result in more appropriate LTCH PPS payments because those cases generally require equivalent relative resource (and therefore should generally have the same LTCH PPS payment). The relative weight of each MS–LTC–DRG should reflect relative resource of the LTCH cases grouped to that MS–LTC–DRG. Because the proposed no-volume MS–LTC–DRGs would be cross-walked to other proposed MS–LTC–DRGs based on clinical similarity and relative costliness, which usually require equivalent relative resource use, we believe that assigning the proposed no-volume MS–LTC–DRG the proposed relative weight of the proposed cross-walked MS–LTC–DRG would result in appropriate LTCH PPS payments. (As explained below in Step 6, when necessary, we are proposing to make adjustments to account for nonmonotonicity.)

Our proposed methodology for determining the proposed relative weights for the proposed no-volume MS–LTC–DRGs is as follows: We cross-walk the proposed no-volume MS–LTC–DRG to a proposed MS–LTC–DRG for which there are LTCH cases in the FY 2007 MedPAR file and to which it is similar clinically in intensity of use of resources and relative costliness as determined by criteria such as care provided during the period of time surrounding surgery, surgical approach (if applicable), length of time of surgical procedure, postoperative care, and length of stay. We then assign the proposed relative weight of the proposed cross-walked MS–LTC–DRG as the proposed relative weight for the proposed no-volume MS–LTC–DRG such that both of these proposed MS–LTC–DRGs (that is, the proposed no-volume MS–LTC–DRG and the proposed cross-walked MS–LTC–DRG) would have the same proposed relative weight. We note that if the proposed cross-walked MS–LTC–DRG had 25 cases or more, its proposed relative weight, which was calculated using the proposed methodology described in steps 1 through 4 above, would be assigned to the proposed no-volume MS–LTC–DRG as well. Similarly, if the proposed MS–LTC–DRG to which the proposed no-volume MS–LTC–DRG is cross-walked has 24 or less cases, and therefore was designated to one of the proposed low-volume quintiles for purposes of determining the proposed relative weights, we would assign the proposed relative weight of the applicable proposed low-volume quintile to the proposed no-volume MS–LTC–DRG such that both of these proposed MS–LTC–DRGs (that is, the proposed no-volume MS–LTC–DRG and the proposed cross-walked MS–LTC–DRG) would have the same proposed relative weight. (As we noted above, in the infrequent case where nonmonotonicity involving a proposed no-volume MS–LTC–DRG results, additional measures as described in Step 6 would be required in order to maintain monotonically increasing relative weights.)

For this proposed rule, a list of the proposed no-volume FY 2009 MS–LTC–DRGs and the proposed FY 2009 MS–LTC–DRG to which it is cross-walked (that is, the proposed cross-walked MS–LTC–DRG) is shown in the chart below.

PROPOSED NO-VOLUME MS–LTC–DRG CROSSWALK FOR FY 2009

Proposed MS–LTC–DRG (Version 26.0)	Proposed MS–LTC–DRG description (version 26.0)	Proposed cross-walked MS–LTC–DRG
9	Bone marrow transplant	823
13	Tracheostomy for face, mouth & neck diagnoses w/o CC/MCC	12
20	Intracranial vascular procedures w PDX hemorrhage w MCC	31
21	Intracranial vascular procedures w PDX hemorrhage w CC	32
22	Intracranial vascular procedures w PDX hemorrhage w/o CC/MCC	32
33	Ventricular shunt procedures w/o CC/MCC	32
34	Carotid artery stent procedure w MCC	37
35	Carotid artery stent procedure w CC	38
36	Carotid artery stent procedure w/o CC/MCC	38
39	Extracranial procedures w/o CC/MCC	38
61	Acute ischemic stroke w use of thrombolytic agent w MCC	70
62	Acute ischemic stroke w use of thrombolytic agent w CC	71
63	Acute ischemic stroke w use of thrombolytic agent w/o CC/MCC	72
76	Viral meningitis w/o CC/MCC	75
88	Concussion w MCC	89
90	Concussion w/o CC/MCC	89
114	Orbital procedures w/o CC/MCC	113
115	Extraocular procedures except orbit	125
117	Intraocular procedures w/o CC/MCC	125
123	Neurological eye disorders	125
129	Major head & neck procedures w CC/MCC or major device	146
130	Major head & neck procedures w/o CC/MCC	148
131	Cranial/facial procedures w CC/MCC	132
134	Other ear, nose, mouth & throat O.R. procedures w/o CC/MCC	133
138	Mouth procedures w/o CC/MCC	137
139	Salivary gland procedures	137
150	Epistaxis w MCC	152
151	Epistaxis w/o MCC	153
215	Other heart assist system implant	238
216	Cardiac valve & oth maj cardiothoracic proc w card cath w MCC	237
217	Cardiac valve & oth maj cardiothoracic proc w card cath w CC	238
218	Cardiac valve & oth maj cardiothoracic proc w card cath w/o CC/MCC	238
219	Cardiac valve & oth maj cardiothoracic proc w/o card cath w MCC	237
220	Cardiac valve & oth maj cardiothoracic proc w/o card cath w CC	238
221	Cardiac valve & oth maj cardiothoracic proc w/o card cath w/o CC/MCC	238
222	Cardiac defib implant w cardiac cath w AMI/HF/shock w MCC	242
223	Cardiac defib implant w cardiac cath w AMI/HF/shock w/o MCC	243
224	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w MCC	242
225	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w/o MCC	243
228	Other cardiothoracic procedures w MCC	252
229	Other cardiothoracic procedures w CC	253
230	Other cardiothoracic procedures w/o CC/MCC	254
231	Coronary bypass w PTCA w MCC	237
232	Coronary bypass w PTCA w/o MCC	238
233	Coronary bypass w cardiac cath w MCC	237
234	Coronary bypass w cardiac cath w/o MCC	238
235	Coronary bypass w/o cardiac cath w MCC	237
236	Coronary bypass w/o cardiac cath w/o MCC	238
245	AICD generator procedures	244
251	Perc cardiovasc proc w/o coronary artery stent or AMI w/o MCC	250
258	Cardiac pacemaker device replacement w MCC	259
265	AICD lead procedures	259
285	Circulatory disorders w AMI, expired w/o CC/MCC	284
295	Deep vein thrombophlebitis w/o CC/MCC	294
296	Cardiac arrest, unexplained w MCC	283
297	Cardiac arrest, unexplained w CC	284
298	Cardiac arrest, unexplained w/o CC/MCC	284
332	Rectal resection w MCC	356
333	Rectal resection w CC	357
334	Rectal resection w/o CC/MCC	358
336	Peritoneal adhesiolysis w CC	335
337	Peritoneal adhesiolysis w/o CC/MCC	335
338	Appendectomy w complicated principal diag w MCC	371
339	Appendectomy w complicated principal diag w CC	372
340	Appendectomy w complicated principal diag w/o CC/MCC	373
341	Appendectomy w/o complicated principal diag w MCC	371
342	Appendectomy w/o complicated principal diag w CC	372
343	Appendectomy w/o complicated principal diag w/o CC/MCC	373
345	Minor small & large bowel procedures w CC	344
346	Minor small & large bowel procedures w/o CC/MCC	344

PROPOSED NO-VOLUME MS–LTC–DRG CROSSWALK FOR FY 2009—Continued

Proposed MS–LTC–DRG (Version 26.0)	Proposed MS–LTC–DRG description (version 26.0)	Proposed cross-walked MS–LTC–DRG
349	Anal & stomal procedures w/o CC/MCC	348
350	Inguinal & femoral hernia procedures w MCC	348
351	Inguinal & femoral hernia procedures w CC	348
352	Inguinal & femoral hernia procedures w/o CC/MCC	348
355	Hernia procedures except inguinal & femoral w/o CC/MCC	354
383	Uncomplicated peptic ulcer w MCC	384
407	Pancreas, liver & shunt procedures w/o CC/MCC	406
408	Biliary tract proc except only cholecyst w or w/o c.d.e. w MCC	409
410	Biliary tract proc except only cholecyst w or w/o c.d.e. w/o CC/MCC	409
412	Cholecystectomy w c.d.e. w CC	411
413	Cholecystectomy w c.d.e. w/o CC/MCC	411
416	Cholecystectomy except by laparoscope w/o c.d.e. w/o CC/MCC	415
419	Laparoscopic cholecystectomy w/o c.d.e. w/o CC/MCC	418
420	Hepatobiliary diagnostic procedures w MCC	424
421	Hepatobiliary diagnostic procedures w CC	424
422	Hepatobiliary diagnostic procedures w/o CC/MCC	424
425	Other hepatobiliary or pancreas O.R. procedures w/o CC/MCC	424
434	Cirrhosis & alcoholic hepatitis w/o CC/MCC	433
453	Combined anterior/posterior spinal fusion w MCC	457
454	Combined anterior/posterior spinal fusion w CC	457
455	Combined anterior/posterior spinal fusion w/o CC/MCC	457
458	Spinal fusion exc cerv w spinal curv, malig or 9+ fusions w/o CC/MCC	457
460	Spinal fusion except cervical w/o MCC	459
461	Bilateral or multiple major joint procs of lower extremity w MCC	480
462	Bilateral or multiple major joint procs of lower extremity w/o MCC	482
473	Cervical spinal fusion w/o CC/MCC	472
479	Biopsies of musculoskeletal system & connective tissue w/o CC/MCC	478
483	Major joint & limb reattachment proc of upper extremity w CC/MCC	480
484	Major joint & limb reattachment proc of upper extremity w/o CC/MCC	482
491	Back & neck procedures except spinal fusion w/o CC/MCC	490
499	Local excision & removal int fix devices of hip & femur w/o CC/MCC	498
506	Major thumb or joint procedures	514
508	Major shoulder or elbow joint procedures w/o CC/MCC	507
509	Arthroscopy	505
512	Shoulder, elbow or forearm proc, exc major joint proc w/o CC/MCC	511
517	Other musculoskelet sys & conn tiss O.R. proc w/o CC/MCC	516
538	Sprains, strains, & dislocations of hip, pelvis & thigh w/o CC/MCC	537
583	Mastectomy for malignancy w/o CC/MCC	582
585	Breast biopsy, local excision & other breast procedures w/o CC/MCC	584
614	Adrenal & pituitary procedures w CC/MCC	629
615	Adrenal & pituitary procedures w/o CC/MCC	630
620	O.R. procedures for obesity w CC	619
621	O.R. procedures for obesity w/o CC/MCC	619
627	Thyroid, parathyroid & thyroglossal procedures w/o CC/MCC	626
654	Major bladder procedures w CC	653
655	Major bladder procedures w/o CC/MCC	653
657	Kidney & ureter procedures forneoplasm w CC	656
658	Kidney & ureter procedures for neoplasm w/o CC/MCC	656
664	Minor bladder procedures w/o CC/MCC	663
667	Prostatectomy w/o CC/MCC	666
670	Transurethral procedures w/o CC/MCC	669
672	Urethral procedures w/o CC/MCC	671
675	Other kidney & urinary tract procedures w/o CC/MCC	674
691	Urinary stones w esw lithotripsy w CC/MCC	694
692	Urinary stones w esw lithotripsy w/o CC/MCC	694
697	Urethral stricture	688
707	Major male pelvic procedures w CC/MCC	660
708	Major male pelvic procedures w/o CC/MCC	661
710	Penis procedures w/o CC/MCC	709
712	Testes procedures w/o CC/MCC	711
714	Transurethral prostatectomy w/o CC/MCC	713
715	Other male reproductive system O.R. proc for malignancy w CC/MCC	717
716	Other male reproductive system O.R. proc for malignancy w/o CC/MCC	717
718	Other male reproductive system O.R. proc exc malignancy w/o CC/MCC	717
724	Malignancy, male reproductive system w/o CC/MCC	723
734	Pelvic evisceration, rad hysterectomy & rad vulvectomy w CC/MCC	717
735	Pelvic evisceration, rad hysterectomy & rad vulvectomy w/o CC/MCC	717
736	Uterine & adnexa proc for ovarian or adnexal malignancy w MCC	754
737	Uterine & adnexa proc for ovarian or adnexal malignancy w CC	755
738	Uterine & adnexa proc for ovarian or adnexal malignancy w/o CC/MCC	756

PROPOSED NO-VOLUME MS–LTC–DRG CROSSWALK FOR FY 2009—Continued

Proposed MS–LTC–DRG (Version 26.0)	Proposed MS–LTC–DRG description (version 26.0)	Proposed cross-walked MS–LTC–DRG
740	Uterine, adnexa proc for non-ovarian/adnexal malig w CC	739
741	Uterine, adnexa proc for non-ovarian/adnexal malig w/o CC/MCC	739
742	Uterine & adnexa proc for non-malignancy w CC/MCC	755
743	Uterine & adnexa proc for non-malignancy w/o CC/MCC	756
745	D&C, conization, laparascopy & tubal interruption w/o CC/MCC	744
747	Vagina, cervix & vulva procedures w/o CC/MCC	746
748	Female reproductive system reconstructive procedures	749
750	Other female reproductive system O.R. procedures w/o CC/MCC	749
760	Menstrual & other female reproductive system disorders w CC/MCC	744
761	Menstrual & other female reproductive system disorders w/o CC/MCC	744
765	Cesarean section w CC/MCC	744
766	Cesarean section w/o CC/MCC	744
767	Vaginal delivery w sterilization &/or D&C	744
768	Vaginal delivery w O.R. proc except steril &/or D&C	744
769	Postpartum & post abortion diagnoses w O.R. procedure	744
770	Abortion w D&C, aspiration curettage or hysterotomy	744
774	Vaginal delivery w complicating diagnoses	744
775	Vaginal delivery w/o complicating diagnoses	744
776	Postpartum & post abortion diagnoses w/o O.R. procedure	744
777	Ectopic pregnancy	744
778	Threatened abortion	759
779	Abortion w/o D&C	759
780	False labor	759
782	Other antepartum diagnoses w/o medical complications	781
789	Neonates, died or transferred to another acute care facility	781
790	Extreme immaturity or respiratory distress syndrome, neonate	781
791	Prematurity w major problems	781
792	Prematurity w/o major problems	781
793	Full term neonate w major problems	781
794	Neonate w other significant problems	781
795	Normal newborn	781
799	Splenectomy w MCC	800
801	Splenectomy w/o CC/MCC	800
803	Other O.R. proc of the blood & blood forming organs w CC	802
804	Other O.R. proc of the blood & blood forming organs w/o CC/MCC	802
820	Lymphoma & leukemia w major O.R. procedure w MCC	823
821	Lymphoma & leukemia w major O.R. procedure w CC	824
822	Lymphoma & leukemia w major O.R. procedure w/o CC/MCC	824
825	Lymphoma & non-acute leukemia w other O.R. proc w/o CC/MCC	824
828	Myeloprolif disord or poorly diff neopl w maj O.R. proc w/o CC/MCC	827
830	Myeloprolif disord or poorly diff neopl w other O.R. proc w/o CC/MCC	829
837	Chemo w acute leukemia as sdx or w high dose chemo agent w MCC	829
838	Chemo w acute leukemia as sdx or w high dose chemo agent w CC	829
839	Chemo w acute leukemia as sdx or w high dose chemo agent w/o CC/MCC	829
848	Chemotherapy w/o acute leukemia as secondary diagnosis w/o CC/MCC	847
887	Other mental disorder diagnoses	881
894	Alcohol/drug abuse or dependence, left ama	881
915	Allergic reactions w MCC	918
916	Allergic reactions w/o MCC	918
955	Craniotomy for multiple significant trauma	26
956	Limb reattachment, hip & femur proc for multiple significant trauma	482
959	Other O.R. procedures for multiple significant trauma w/o CC/MCC	958
986	Prostatic O.R. procedure unrelated to principal diagnosis w/o CC/MCC	985

To illustrate this methodology for determining the proposed relative weights for the proposed MS–LTC–DRGs with no LTCH cases, we are providing the following example, which refers to the proposed no-volume MS–LTC–DRGs crosswalk information for FY 2009 provided in the chart above.

Example: There were no cases in the FY 2007 MedPAR file used for this proposed rule for proposed MS–LTC–DRG 61 (Acute ischemic stroke w use of thrombolytic agent w MCC). We determined that MS–LTC–DRG 70 (Nonspecific cebrovascular disorders w MCC) is similar clinically and based on resource use to proposed MS–LTC–DRG 61. Therefore, we are proposing to assign the same proposed relative weight of proposed MS–LTC–DRG 70 of 0.8718 for FY 2009 to proposed MS–LTC–DRG 61 (Table 11 of the Addendum of this proposed rule).

Furthermore, for FY 2009, consistent with our historical relative weight methodology, we are proposing to establish MS–LTC–DRG relative weights of 0.0000 for the following proposed transplant MS–LTC–DRGs: Heart Transplant or Implant of Heart Assist System with MCC (MS–LTC–DRG 1); Heart Transplant or Implant of Heart Assist System without MCC (MS–LTC–DRG 2); Liver Transplant with MCC or Intestinal Transplant (MS–LTC–DRG 5);

Liver Transplant without MCC (MS–LTC–DRG 6); Lung Transplant (MS–LTC–DRG 7); Simultaneous Pancreas/Kidney Transplant (MS–LTC–DRG 8); Pancreas Transplant (MS–LTC–DRG 10); and Kidney Transplant (MS–LTC–DRG 652). This is because Medicare will only cover these procedures if they are performed at a hospital that has been certified for the specific procedures by Medicare and presently no LTCH has been so certified. Based on our research, we found that most LTCHs only perform minor surgeries, such as minor small and large bowel procedures, to the extent any surgeries are performed at all. Given the extensive criteria that must be met to become certified as a transplant center for Medicare, we believe it is unlikely that any LTCHs will become certified as a transplant center. In fact, in the more than 20 years since the implementation of the IPPS, there has never been a LTCH that even expressed an interest in becoming a transplant center.

If in the future a LTCH applies for certification as a Medicare-approved transplant center, we believe that the application and approval procedure would allow sufficient time for us to determine appropriate weights for the MS–LTC–DRGs affected. At the present time, we would only include these eight proposed 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 proposed MS–LTC–DRGs would be administratively burdensome.

Again, we note that, as this system is dynamic, it is entirely possible that the number of proposed 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 proposed MS–LTC–DRGs and to determine the proposed relative weights in this proposed rule.

Step 6—Adjust the proposed FY 2009 MS–LTC–DRG relative weights to account for nonmonotonically increasing relative weights.

As discussed in section II.B. of the preamble of this proposed rule, the MS–DRGs (used under the IPPS) on which the MS–LTC–DRGs are based provide a significant improvement in the DRG system's recognition of severity of illness and resource usage. The proposed 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 those base MS–LTC–DRGs that are split into either two or three severity levels, cases classified into the ''without CC/MCC'' MS–LTC–DRG are expected to have a lower resource use (and lower costs) than the ''with CC/MCC'' MS–LTC–DRG (in the case of a two-level split) or the ''with CC'' and ''with MCC'' MS–LTC–DRGs (in the case of a three-level split). That is, theoretically, cases that are more severe typically require greater expenditure of medical care resources and will result in higher average charges. Therefore, in the three severity levels, relative weights should increase by severity, from lowest to highest. If the relative weights do not increase (that is, if within a base MS–LTC–DRG, a MS–LTC–DRG with MCC has a lower relative weight than one with CC, or the MS–LTC–DRG without CC/MCC has a higher relative weight than either of the others, they are nonmonotonic). We continue to believe that utilizing nonmonotonic relative weights to adjust Medicare payments would result in inappropriate payments. Consequently, in general, we are proposing to combine proposed MS–LTC–DRG severity levels within a base MS–LTC–DRG for the purpose of computing a relative weight when necessary to ensure that monotonicity is maintained. In determining the proposed FY 2009 MS–LTC–DRG relative weights in this proposed rule, in general, we are proposing to use the same methodology to adjust for nonmonotonicity that we used to determine the FY 2008 MS–LTC–DRG relative weights in the FY 2008 IPPS final rule with comment (72 FR 47293 through 47295). However, as noted above, we are taking this opportunity to refine our description to more precisely explain our methodology for determining the MS–LTC–DRG relative weights in this proposed rule. Specifically, in determining the proposed FY 2009 MS–LTC–DRG relative weights in this proposed rule, 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 a MS–LTC–DRG pertains to a base MS–LTC–DRG with a three-level split and each of the three levels has 25 or more LTCH cases and, therefore, none of those MS–LTC–DRGs is assigned to one of the five low-volume quintiles. In this proposed rule, if nonmonotonicity is detected in the proposed relative weights of the proposed MS–LTC–DRGs in adjacent severity levels (for example, the proposed 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 would combine the nonmonotonic adjacent proposed MS–LTC–DRGs and re-determine a proposed relative weight based on the case-weighted average of the combined LTCH cases of the nonmonotonic proposed MS–LTC–DRGs. The case-weighted average charge is calculated by dividing the total charges for all LTCH cases in both severity levels by the total number of LTCH cases for both proposed MS–LTC–DRGs. The same proposed relative weight would be assigned to both affected levels of the base MS–LTC–DRG. If nonmonotonicity remains an issue because the above process results in a proposed relative weight that is still nonmonotonic to the remaining proposed MS–LTC–DRG relative weight within the base MS–LTC–DRG, we would combine all three of the severity levels to redetermine the proposed relative weights based on the case-weighted average charge of the combined severity levels. This same proposed relative weight is then assigned to each of the proposed MS–LTC–DRGs in that base MS–LTC–DRG.

A second example of nonmonotonically increasing relative weights for a base MS–LTC–DRG pertains to the situation where there are three severity levels and one or more of the severity levels within a base MS–LTC–DRG has less than 25 LTCH cases (that is, low-volume). In this proposed rule, if nonmonotonicity occurs in the case where either the highest or lowest severity level (''with MCC'' or ''without CC/MCC'') has 25 LTCH cases or more and the other two severity levels are low-volume (and therefore the other two severity levels would otherwise be assigned the proposed relative weight of the applicable proposed low-volume quintile(s)), we would combine the data for the cases in the two adjacent proposed low-volume MS–LTC–DRGs for the purpose of determining a proposed relative weight. If the combination results in at least 25 cases,

we re-determine one proposed relative weight based on the case-weighted average charge of the combined severity levels and assign this same proposed relative weight to each of the severity levels. If the combination results in less than 25 cases, based on the case-weighted average charge of the combined proposed low-volume MS–LTC–DRGs, both proposed MS–LTC–DRGs would be assigned to the appropriate proposed low-volume quintile (discussed above in section II.I.3.e. of this preamble) based on the case-weighted average charge of the combined proposed low-volume MS–LTC–DRGs. Then the proposed relative weight of the affected proposed low-volume quintile would be redetermined and that proposed relative weight would be assigned to each of the affected severity levels (and all of the proposed MS–LTC–DRGs in the affected proposed low-volume quintile). If nonmonotonicity persists, we would combine all three severity levels and redetermine one proposed relative weight based on the case-weighted average charge of the combined severity levels and this same proposed relative weight would be assigned to each of the three levels.

Similarly, in nonmonotonic cases where the middle level has 25 cases or more but either or both of the lowest or highest severity level has less than 25 cases (that is, low volume), we would combine the nonmonotonic proposed low-volume MS–LTC–DRG with the middle level proposed MS–LTC–DRG of the base MS–LTC–DRG. We would redetermine one proposed relative weight based on the case-weighted average charge of the combined severity levels and assign this same proposed relative weight to each of the affected proposed MS–LTC–DRGs. If nonmonotonicity persists, we would combine all three levels for the purpose of redetermining a proposed relative weight based on the case-weighted average charge of the combined severity levels, and assign that proposed relative weight to each of the three severity levels.

In the case where all three severity levels in the base MS–LTC–DRGs are proposed low-volume MS–LTC–DRGs and two of the severity levels are nonmonotonic in relation to each other, we would combine the two adjacent nonmonotonic severity levels. If that combination results in less than 25 cases, both proposed low-volume MS–LTC–DRGs would be assigned to the appropriate proposed low-volume quintile (discussed above in section II.I.3.e. of this preamble) based on the case-weighted average charge of the combined proposed low-volume MS–LTC–DRGs. Then the proposed relative weight of the affected proposed low-volume quintile would be redetermined and that proposed relative weight would be assigned to each of the affected severity levels (and all of the proposed MS–LTC–DRGs in the affected proposed low-volume quintile). If the nonmonotonicity persists, we would combine all three levels of that base MS–LTC–DRG for the purpose of redetermining a proposed relative weight based on the case-weighted average charge of the combined severity levels, and assign that proposed relative weight to each of the three severity levels. If that combination of all three severity levels results in less than 25 cases, we would assign that ''combined'' base MS–LTC–DRG to the appropriate proposed low-volume quintile based on the case-weighted average charge of the combined proposed low-volume MS–LTC–DRGs. Then the proposed relative weight of the affected proposed low-volume quintile would be redetermined and that proposed relative weight would be assigned to each of the affected severity levels (and all of the proposed MS–LTC–DRGs in the affected proposed low-volume quintile).

Another example of nonmonotonicity involves a base MS–LTC–DRG with three severity levels where at least one of the severity levels has no cases. As discussed above in greater detail in Step 5, based on resource use intensity and clinical similarity, we propose to cross-walk a proposed no-volume MS–LTC–DRG to a proposed MS–LTC–DRG that has at least one case. Under our proposed methodology for the treatment of proposed no-volume MS–LTC–DRGs, the proposed no-volume MS–LTC–DRG would be assigned the same proposed relative weight as the proposed MS–LTC–DRG to which the proposed no-volume MS–LTC–DRG is cross-walked. For many proposed no-volume MS–LTC–DRGs, as shown in the chart above in Step 5, the application of our proposed methodology results in a proposed cross-walk MS–LTC–DRG that is the adjacent severity level in the same base MS–LTC–DRG. Consequently, in most instances, the proposed no-volume MS–LTC–DRG and the adjacent proposed MS–LTC–DRG to which it is cross-walked would not result in nonmonotonicity because both of these severity levels would have the same proposed relative weight. (In this proposed rule, under our proposed methodology for the treatment of proposed no-volume MS–LTC–DRGs, in the case where the proposed no-volume MS–LTC–DRG is either the highest or lowest severity level, the proposed cross-walk MS–LTC–DRG would be the middle level (''with CC'') within the same base MS–LTC–DRG, and therefore the proposed no-volume MS–LTC–DRG (either the ''with MCC'' or the ''without CC/MCC'') and the proposed cross-walk MS–LTC–DRG (the ''with CC'') would have the same proposed relative weight. Consequently, no adjustment for monotonicity would be necessary.) However, if our proposed methodology for determining proposed relative weights for proposed no-volume MS–LTC–DRGs results in nonmonotonicity with the third severity level in the base-MS–LTC–DRG, all three severity levels would be combined for the purpose of redetermining one proposed relative weight based on the case-weighted average charge of the combined severity levels. This same proposed relative weight would be assigned to each of the three severity levels in the base MS–LTC–DRG.

Thus far in the discussion, we have presented examples of nonmonotonicity in a base MS–LTC–DRG that has three severity levels. We would apply the same process where the base MS–LTC–DRG contains only two severity levels. For example, if nonmonotonicity occurs in a base MS–LTC–DRG with two severity levels (that is, the proposed relative weight of the higher severity level is less than the lower severity level), where both of the proposed MS–LTC–DRGs have at least 25 cases or where one or both of the proposed MS–LTC–DRGs is low volume (that is, less than 25 cases), we would combine the two proposed MS–LTC–DRGs of that base MS–LTC–DRG for the purpose of redetermining a proposed relative weight based on the combined case-weighted average charge for both severity levels. This same proposed relative weight would be assigned to each of the two severity levels in the base MS–LTC–DRG. Specifically, if the combination of the two severity levels would result in at least 25 cases, we would redetermine one proposed relative weight based on the case-weighted average charge and assign that proposed relative weight to each of the two proposed MS–LTC–DRGs. If the combination results in less than 25 cases, we would assign both proposed MS–LTC–DRGs to the appropriate proposed low-volume quintile (discussed above in section II.I.3.e. of this preamble) based on their combined case-weighted average charge. Then the proposed relative weight of the affected proposed low-volume quintile would be redetermined and that proposed relative

weight would be assigned to each of the affected severity levels.

Step 7—Calculate the proposed FY 2009 budget neutrality factor.

As we established in the RY 2008 LTCH PPS final rule (72 FR 26882), under the broad authority conferred upon the Secretary under section 123 of 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. Specifically, in that same final rule, we established under § 412.517(b) that the annual update to the MS–LTC–DRG classifications and relative weights be done in a budget neutral manner. For a detailed discussion on the establishment of the requirement to update the MS–LTC–DRG classifications and relative weights in a budget neutral manner, we refer readers to the RY 2008 LTCH PPS final rule (72 FR 26880 through 26884). Updating the MS–LTC–DRGs in a budget neutral manner results in an annual update to the individual MS–LTC–DRG classifications and relative weights based on the most recent available data to reflect changes in relative LTCH resource use. To accomplish this, the MS–LTC–DRG relative weights are uniformly adjusted to ensure that estimated aggregate payments under the LTCH PPS would not be affected (that is, decreased or increased). Consistent with that provision, we are proposing to update the MS–LTC–DRG classifications and relative weights for FY 2009 based on the most recent available data and include a proposed budget neutrality adjustment that would be applied in determining the proposed MS–LTC–DRG relative weights.

To ensure budget neutrality in updating the proposed MS–LTC–DRG classifications and proposed relative weights under § 412.517(b), consistent with the budget neutrality methodology we established in the FY 2008 IPPS final rule with comment period (72 FR 47295 through 47296), in determining the proposed budget neutrality adjustment for FY 2009 in this proposed rule, we are proposing to use a method that is similar to the methodology used under the IPPS. Specifically, for FY 2009, after recalibrating the proposed MS–LTC–DRG relative weights as we do under the methodology as described in detail in Steps 1 through 6 above, we would calculate and apply a normalization factor to those relative weights to ensure that estimated payments are not influenced by changes in the composition of case types or the changes being proposed to the classification system. That is, the proposed normalization adjustment is intended to ensure that the recalibration of the proposed MS–LTC–DRG relative weights (that is, the process itself) neither increases nor decreases total estimated payments.

To calculate the proposed normalization factor for FY 2009, we would use the following steps: (1) We use the most recent available claims data (FY 2007) and the proposed MS–LTC–DRG relative weights (determined above in Steps 1 through 6 above) to calculate the average CMI; (2) we group the same claims data (FY 2007) using the FY 2008 GROUPER (Version 25.0) and FY 2008 relative weights (established in the FY 2008 IPPS final rule with comment period (72 FR 47295 through 47296)) and calculate the average CMI; and (3), we compute the ratio of these average CMIs by dividing the average CMI determined in step (2) by the average CMI determined in step (1). In determining the proposed MS–LTC–DRG relative weights for FY 2009, based on the latest available LTCH claims data, the normalization factor is estimated as 1.038266, which would be applied in determining each proposed MS–LTC–DRG relative weight. That is, each proposed MS–LTC–DRG relative weight would be multiplied by 1.038266 in the first step of the budget neutrality process. Accordingly, the proposed relative weights in Table 11 in the Addendum of this proposed rule reflect this proposed 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 proposed FY 2009 MS–LTC–DRG classifications and relative weights) are equal to estimated aggregate LTCH PPS payments (for the same most recent available LTCH claims data) before reclassification and recalibration (the existing FY 2008 MS–DRG classifications and relative weights). Therefore, we would calculate the proposed 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 2007 MedPAR file).

Accordingly, we are proposing to use RY 2008 LTCH PPS rates and policies in determining the proposed FY 2009 budget neutrality adjustment in this proposed rule, using the following steps: (1) We simulate estimated total payments using the normalized proposed relative weights under GROUPER Version 26.0 (as described above); (2) we simulate estimated total payments using the FY 2008 GROUPER (Version 25.0) and FY 2008 MS–LTC–DRG relative weights (as established in the FY 2008 IPPS final rule (72 FR 47295 through 47296)); (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, each of the normalized proposed relative weights is multiplied by the proposed budget neutrality factor to determine the budget neutral proposed relative weight for each proposed MS–LTC–DRG.

Accordingly, in determining the proposed MS–LTC–DRG relative weights for FY 2009 in this proposed rule, based on the most recent available LTCH claims data, we are proposing a budget neutrality factor of 0.99965, which would be applied to the normalized proposed relative weights (described above). The proposed FY 2009 MS–LTC–DRG relative weights in Table 11 in the Addendum of this proposed rule reflect this proposed budget neutrality factor. Furthermore, we expect that we will have established payments rates and policies for RY 2009 prior to the development of the FY 2009 IPPS final rule. Therefore, for purposes of determining the FY 2009 budget neutrality factor in the final rule, we are proposing that we would simulate estimated total payments using the most recent LTCH PPS payment policies and LTCH claims data that are available at that time.

Table 11 in the Addendum to this proposed rule lists the proposed MS–LTC–DRGs and their respective proposed 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 2009.

J. Proposed 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, 42CFR412.87(b)(2) states that a specific medical service or technology will be considered new for purposes of new medical service or technology add-on payments until such time as Medicare data are available to fully reflect the cost of the technology in the DRG weights through recalibration. Typically, there is a lag of 2 to 3 years from the point a new medical service or technology is first introduced on the market (generally on the date that the technology receives FDA approval/clearance) and when data reflecting the use of the medical service or technology are used to calculate the DRG weights. For example, data from discharges occurring during FY 2007 are used to calculate the FY 2009 DRG weights in this proposed rule. Section 412.87(b)(2) of our existing regulations provides that ''a medical service or technology may be considered new within 2 or 3 years after the point at which data begin to become available reflecting the ICD–9–CM code assigned to the new medical service or technology (depending on when a new code is assigned and data on the new medical service or technology become available for DRG recalibration). After CMS has recalibrated the DRGs based on available data to reflect the costs of an otherwise new medical service or technology, the medical service or technology will no longer be considered ''new'' under the criterion for this section.''

The 2-year to 3-year period during which a medical service or technology can be considered new would ordinarily begin on the date on which the medical service or technology received FDA approval or clearance. (We note that, for purposes of this section of the proposed rule, we refer to both FDA approval and FDA clearance as FDA ''approval.'') However, in some cases, initially there may be no Medicare data available for the new service or technology following FDA approval. For example, the newness period could extend beyond the 2-year to 3-year period after FDA approval is received in cases where the product initially was generally unavailable to Medicare patients following FDA approval, such as in the case of a national noncoverage determination, or if 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 following FDA approval due to shelf life concerns or manufacturing issues). After the DRGs have been recalibrated to reflect the costs of an otherwise new medical service or technology, the medical service or technology is no longer eligible for special add-on payment for new medical services or technologies (§ 412.87(b)(2)). For example, an approved new technology that received FDA approval in October 2007 and entered the market at that time may be eligible to receive add-on payments as a new technology for discharges occurring before October 1, 2010 (the start of FY 2011). Because the FY 2011 DRG weights would be calculated using FY 2009 MedPAR data, the costs of such a new technology would be fully reflected in the FY 2011 DRG weights. Therefore, the new technology would no longer be eligible to receive add-on payments as a new technology for discharges occurring in FY 2011 and thereafter.

Section 412.87(b)(3) further provides that, to be eligible for the add-on payment for new medical services or technologies, the DRG prospective payment rate otherwise applicable to the discharge involving the new medical services or technologies must be assessed for adequacy. Under the cost criterion, to assess whether a new technology would be inadequately paid under the applicable DRG-prospective payment rate, we evaluate whether the charges for cases involving the new technology exceed certain threshold amounts. In the FY 2004 IPPS final rule (68 FR 45385), we established the threshold at the geometric mean standardized charge for all cases in the DRG plus 75 percent of 1 standard deviation above the geometric mean standardized charge (based on the logarithmic values of the charges and converted back to charges) for all cases in the DRG to which the new medical service or technology is assigned (or the case-weighted average of all relevant DRGs, if the new medical service or technology occurs in more than one DRG).

However, section 503(b)(1) of Pub. L. 108–173 amended section 1886(d)(5)(K)(ii)(I) of the Act to provide that, beginning in FY 2005, CMS will apply ''a threshold * * * that is the lesser of 75 percent of the standardized amount (increased to reflect the difference between cost and charges) or 75 percent of one standard deviation for the diagnosis-related group involved.'' (We refer readers to section IV.D. of the preamble to the FY 2005 IPPS final rule (69 FR 49084) for a discussion of the revision of the regulations to incorporate the change made by section 503(b)(1) of Pub. L. 108–173.) Table 10 in section XIX. of the interim final rule with comment period published in the **Federal Register** on November 27, 2007, contained the final thresholds that are being used to evaluate applications for new technology add-on payments for FY 2009 (72 FR 66888 through 66892). An applicant must demonstrate that the cost threshold is met using information from inpatient hospital claims.

With regard to 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 addressed this issue in the September 7, 2001 final rule that established the new technology add-on payment regulations (66 FR 46917). 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 164.506(c)(1) and (c)(3), and the Standards for Privacy of Individually Identifiable Health Information published in the **Federal**

Register on August 14, 2002, for a full discussion of changes in consent requirements.)

Section 412.87(b)(1) of our existing regulations provides that a new technology is an appropriate candidate for an additional payment when it represents ''an advance that substantially improves, relative to technologies previously available, the diagnosis or treatment of Medicare beneficiaries.'' For example, a new technology represents a substantial clinical improvement when it reduces mortality, decreases the number of hospitalizations or physician visits, or reduces recovery time compared to the technologies previously available. (We refer readers to the September 7, 2001 final rule for a complete discussion of this criterion (66 FR 46902).)

The new medical service or technology add-on payment policy under the IPPS provides additional payments for cases with relatively high costs involving eligible new medical services or technologies while preserving some of the incentives inherent under an average-based prospective payment system. The payment mechanism is based on the cost to hospitals for the new medical service or technology. Under § 412.88, if the costs of the discharge (determined by applying CCRs as described in § 412.84(h)) exceed the full DRG payment, Medicare will make an add-on payment equal to the lesser of: (1) 50 percent of the estimated costs of the new technology (if the estimated costs for the case including the new technology exceed Medicare's payment) or (2) 50 percent of the difference between the full DRG payment and the hospital's estimated cost for the case. If the amount by which the actual costs of a new medical service or technology case exceeds the full DRG payment (including payments for IME and DSH, but excluding outlier payments) by more than the 50-percent marginal cost factor, Medicare payment is limited to the full DRG payment plus 50 percent of the estimated costs of the new technology.

Section 1886(d)(4)(C)(iii) of the Act requires that the adjustments to annual DRG classifications and relative weights must be made in a manner that ensures that aggregate payments to hospitals are not affected. Therefore, in the past, we accounted for projected payments under the new medical service and technology provision during the upcoming fiscal year 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. However, 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 2010 must submit a formal request, including a full description of the clinical applications of the medical service or technology and the results of any clinical evaluations demonstrating that the new medical service or technology represents a substantial clinical improvement, along with a significant sample of data to demonstrate the medical service or technology meets the high-cost threshold. Complete application information, along with final deadlines for submitting a full application, will be available on our Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/08_newtech.asp#TopOfPage.* To allow interested parties to identify the new medical services or technologies under review before the publication of the proposed rule for FY 2010, the Web site will also list the tracking forms completed by each applicant.

The Council on Technology and Innovation (CTI) at CMS oversees the agency's cross-cutting priority on coordinating coverage, coding and payment processes for Medicare with respect to new technologies and procedures, including new drug therapies, as well as promoting the exchange of information on new technologies between CMS and other entities. The CTI, composed of senior CMS staff and clinicians, was established under section 942(a) of Pub. L. 108–173. It is co-chaired by the Director of the Center for Medicare Management (CMM), who is also designated as the CTI's Executive Coordinator, and the Director of the Office of Clinical Standards and Quality (OCSQ).

The specific processes for coverage, coding, and payment are implemented by CMM, OCSQ, and the local claims-payment contractors (in the case of local coverage and payment decisions). The CTI supplements rather than replaces these processes by working to assure that all of these activities reflect the agency-wide priority to promote high-quality, innovative care, and at the same time to streamline, accelerate, and improve coordination of these processes to ensure that they remain up to date as new issues arise. To achieve its goals, the CTI works to streamline and create a more transparent coding and payment process, improve the quality of medical decisions, and speed patient access to effective new treatments. It is also dedicated to supporting better decisions by patients and doctors in using Medicare-covered services through the promotion of better evidence development, which is critical for improving the quality of care for Medicare beneficiaries.

The agency plans to continue its Open Door forums with stakeholders who are interested in CTI's initiatives. In addition, to improve understanding of CMS processes for coverage, coding, and payment and how to access them, the CTI is developing an ''innovator's guide'' to these processes. This guide will, for example, outline regulation cycles and application deadlines. The intent is to consolidate this information, much of which is already available in a variety of CMS documents and in various places on CMS's Web site, in a user-friendly format. In the meantime, we invite any product developers with specific issues involving the agency to contact us early in the process of product development if they have questions or concerns about the evidence that would be needed later in the development process for the agency's coverage decisions for Medicare.

The CTI aims to provide information on CTI activities to stakeholders, including Medicare beneficiaries, advocates, medical product manufacturers, providers, and health policy experts, and other stakeholders with useful information on CTI initiatives. Stakeholders with further questions about Medicare's coverage, coding, and payment processes, or who want further guidance about how they can navigate these processes, can contact the CTI at *CTI@cms.hhs.gov* or from the ''Contact Us'' section of the CTI home page (*http://www.cms.hhs.gov/CouncilonTechInnov/*).

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; and
- Provide, before publication of a proposed rule, for a meeting at which organizations representing hospitals, physicians, manufacturers, and any other interested party may present comments, recommendations, and data regarding whether a new medical service or technology represents a substantial clinical improvement to the clinical staff of CMS.

In order to provide an opportunity for public input regarding add-on payments for new medical services and technologies for FY 2009 before publication of the FY 2009 IPPS proposed rule, we published a notice in the **Federal Register** on December 28, 2007 (72 FR 73845 through 73847), and held a town hall meeting at the CMS Headquarters Office in Baltimore, MD, on February 21, 2008. In the announcement notice for the meeting, we stated that the opinions and alternatives provided during the meeting would assist us in our evaluations of applications by allowing public discussion of the substantial clinical improvement criterion for each of the FY 2009 new medical service and technology add-on payment applications before the publication of the FY 2009 IPPS proposed rule.

Approximately 70 individuals attended the town hall meeting in person, while approximately 20 additional participants listened over an open telephone line. Each of the four FY 2009 applicants presented information on its technology, including a focused discussion of data reflecting the substantial clinical improvement aspect of the technology. We received two comments during the town hall meeting, which are summarized below. We considered each applicant's presentation made at the town hall meeting, as well as written comments submitted on each applicant's application, in our evaluation of the new technology add-on applications for FY 2009 in this proposed rule. We have summarized these comments below or, if applicable, indicated that no comments were received at the end of the discussion of each application.

Comment: One commenter addressed the substantial clinical improvement criterion. A medical device association stated that CMS' interpretation of the statutory criteria for new technology add-on payments is narrow and makes it difficult for potential applicants, especially small manufacturing companies, to qualify for new technology add-on payments. The commenter urged CMS to ''deem a device to satisfy the substantial clinical improvement criteria if it was granted a humanitarian device exemption or priority review based on the fact that it represents breakthrough technologies, which 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.'' In addition, the commenter remarked that this process would simplify CMS' evaluation of applications for new technology add-on payments and would promote access to innovative treatments, as intended by Congress. Although the commenter also made remarks that were unrelated to substantial clinical improvement, because the purpose of the town hall meeting was specifically to discuss substantial clinical improvement of pending new technology applications, those comments are not summarized in this proposed rule.

Response: With respect to the comment that CMS has a narrow interpretation of the statute that makes it difficult for applicants to meet the statutory criteria for a new technology add-on payment, we note that we have already specifically addressed the issue in the past (71 FR 47997 and 72 FR 47301). In addition, we addressed the comment concerning automatically deeming technologies granted a humanitarian device exemption (HDE) at 72 FR 47302. Further, because the purpose of the new technology town hall meeting was to discuss substantial clinical improvement of pending applications, we are not providing a response to the unrelated comments in this proposed rule.

Comment: One commenter, a medical technology association, submitted comments in reference to the MS–DRGs and the need to account for complexity as well as severity in making refinements to the DRG classification system. The commenter also made the following comments: CMS should raise the new technology marginal cost factor, adjust the newness policy to begin with the issuance of an ICD–9–CM code instead of the FDA approval date, provide access to the quarterly MedPAR updates, and allow for the use of external data for determining new technology payments (when CMS determines that the external data are unbiased and valid).

Response: Section 1886(d)(5)(K)(viii) of the Act requires that CMS accept comments, recommendations, and data from the public regarding whether a service or technology represents a substantial clinical improvement. Because the comments above are not related to the substantial clinical improvement criterion of pending applications, we are not providing a response to them in this proposed rule.

3. FY 2009 Status of Technologies Approved for FY 2008 Add-On Payments

We did not approve any applications for new technology add-on payments for FY 2008. For additional information, refer to the FY 2008 IPPS final rule with comment period (72 FR 47305 through 47307).

4. FY 2009 Applications for New Technology Add-On Payments

We received four applications to be considered for new technology add-on payment for FY 2009. A discussion of each of these applications is presented below. We note that, in the past, we have considered applications that had not yet received FDA approval, but were anticipating FDA approval prior to publication of the IPPS final rule. In such cases, we generally provide a more limited discussion of those technologies in the proposed rule because it is not known if these technologies will meet the newness criterion in time for us to conduct a complete analysis in the final rule. This year, three out of four applicants do not yet have FDA approval. Consequently, we have presented a limited analysis of them in this proposed rule.

a. CardioWest™ Temporary Total Artificial Heart System (CardioWest™ TAH–t)

SynCardia Systems, Inc. submitted an application for approval of the CardioWest™ temporary Total Artificial Heart system (TAH–t) for new technology add-on payments for FY 2009. The TAH–t is a technology that is used as a bridge to heart transplant device for heart transplant-eligible patients with end-stage biventricular failure. The TAH–t pumps up to 9.5 liters of blood per minute. This high level of perfusion helps improve hemodynamic function in patients, thus making them better heart transplant candidates.

The TAH–t was approved by the FDA on October 15, 2004, for use as a bridge to transplant device in cardiac transplant-eligible candidates at risk of imminent death from biventricular failure. The TAH–t is intended to be used in hospital inpatients. Some of the FDA's post-approval requirements include that the manufacturer agree to provide a post-approval study demonstrating that the success of the device at one center can be reproduced at other centers. The study was to include at least 50 patients who will be followed up to 1 year, including (but not limited to) the following endpoints; survival to transplant, adverse events, and device malfunction.

Presently, Medicare does not cover artificial heart devices, including the TAH–t. However, on February 01, 2008, CMS proposed to reverse a national noncoverage determination that would extend coverage to this technology within the confines of an FDA-approved clinical study. (To view the proposed National Coverage Determination (NCD), we refer readers to the CMS Web site at *http://www.cms.hhs.gov/mcd/viewdraftdecisionmemo.asp?from2=viewdraftdecisionmemo.asp&id=211&.*) Should this proposal be finalized, it would become effective on May 01, 2008. Because Medicare's existing coverage policy with respect to this device has precluded it from being paid for by Medicare, we would not expect the costs associated with this technology to be currently reflected in the data used to determine MS–DRGs relative weights. As we have indicated in the past, although we generally believe that the newness period would begin on the date that FDA approval was granted, in cases where the applicant can demonstrate a documented delay in market availability subsequent to FDA approval, we would consider delaying the start of the newness period. This technology's situation represents one such case. We also note that section 1886(d)(5)(K)(ii)(II) of the Act requires that we provide for the collection of cost data for a new medical service or technology for a period of at least 2 years and no more than 3 years ''beginning on the date on which an inpatient hospital code is issued with respect to the service or technology.'' Furthermore, the statute specifies that the term ''inpatient hospital code'' means any code that is used with respect to inpatient hospital services for which payment may be made under the IPPS and includes ICD–9–CM codes and any subsequent revisions. Although the TAH–t has been described by the ICD–9–CM code(s) (described below in the cost threshold discussion) since the time of its FDA approval, because the TAH–t has not been covered under the Medicare program (and, therefore, no Medicare payment has been made for this technology), this code is not ''used with respect to inpatient hospital services for which payment'' is made under the IPPS, and thus we assume that none of the costs associated with this technology would be reflected in the Medicare claims data used to recalibrate the MS–DRG weights. For this reason, despite its FDA approval date, it appears that this technology would still be eligible to be considered ''new'' for purposes of the new technology add-on payment if and when the proposal to reverse the national noncoverage determination concerning this technology is finalized. Therefore, based on this information, it appears that the TAH–t would meet the newness criterion on the date that Medicare coverage begins, should the proposed NCD be finalized.

In an effort to demonstrate that TAH–t would meet the cost criterion, the applicant submitted data based on 28 actual cases of the TAH–t. The data included 6 cases (or 21.4 percent of cases) from 2005, 13 cases (or 46.5 percent of cases) from 2006, 7 cases (or 25 percent of cases) from 2007, and 2 cases (or 7.1 percent of cases) from 2008. Currently, cases involving the TAH–t are assigned to MS–DRG 215 (Other Heart Assist System Implant). As discussed below in this section, we are proposing to remove the TAH–t from MS–DRG 215 and reassign the TAH–t to MS–DRGs 001 (Heart Transplant or Implant of Heart Assist System with MCC) and 002 (Heart Transplant or Implant of Heart Assist System without MCC). Therefore, to determine if the technology meets the cost criterion, it is appropriate to compare the average standardized charge per case to the thresholds for MS–DRGs 001, 002, and 215 included in Table 10 of the November 27, 2007 interim final rule (72 FR 66888 through 66889). The thresholds for MS–DRGs 001, 002, and 215 from Table 10 are $345,031, $178,142, and $151,824, respectively. Based on the 28 cases the applicant submitted, the average standardized charge per case was $731,632. Because the average standardized charge per case is much greater than the thresholds cited above for MS–DRG 215 (and MS–DRGs 001 and 002, should the proposal to reassign the TAH–t be finalized), the applicant asserted that the TAH–t meets the cost criterion whether or not the costs were analyzed by using either a case-weighted threshold or case-weighted standardized charge per case.

In addition to analyzing the costs of actual cases involving the TAH–t, the applicant searched the FY 2006 MedPAR file to identify cases involving patients who would have potentially been eligible to receive the TAH–t. The applicant submitted three different MedPAR analyses. The first MedPAR analysis involved a search for cases using ICD–9–CM diagnosis code 428.0 (Congestive heart failure) in combination with ICD–9–CM procedure code 37.66 (Insertion of implantable heart assist system), and an inpatient hospital length of stay greater than or equal to 60 days. The applicant found two cases that met this criterion, which had an average standardized charge per case of $821,522. The second MedPAR analysis searched for cases with ICD–9–CM diagnosis code 428.0 (Congestive heart failure) and one or more of the following ICD–9–CM procedure codes: 37.51 (Heart transplant), 37.52 (Implantation of total heart replacement system), 37.64 (Removal of heart assist system), 37.66 (Insertion of implantable heart assist system), or 37.68 (Insertion of percutaneous external heart assist device), and a length of stay greater than or equal to 60 days. The applicant found 144 cases that met this criterion, which had an average standardized charge per case of $841,827. The final MedPAR analysis searched for cases with ICD–9–CM procedure code 37.51 (Heart transplant) in combination with one of the following ICD–9–CM procedure codes: 37.52 (Implantation of total heart replacement system), 37.65 (Implantation of external heart system), or 37.66 (Insertion of implantable heart assist system). The applicant found 37 cases that met this criterion, which had an average standardized charge per case of $896,601. Because only two cases met the criterion for the first analysis, consistent with historical practice, we would not consider it to be of statistical significance and, therefore, would not rely upon it to demonstrate whether the TAH–t would meet the cost threshold. However, both of the additional analyses seem to provide an adequate number of cases to demonstrate whether the TAH–t would meet the cost threshold. We assume that none of the costs associated with this technology would be reflected in the MedPAR analyses that the applicant used to demonstrate that the technology would meet the cost criterion. We note that, under all three of the analyses the applicant performed, it identified cases that would have been eligible for the TAH–t, but did not remove charges that

were unrelated to the TAH–t, nor did the applicant insert a proxy of charges related to the TAH–t. However, as stated above, the average standardized charge per case is much greater than any of the thresholds for MS–DRGs 001, 002, and 215. Therefore, even if the applicant were to approximate what the costs of cases eligible to receive the TAH–t would have been by removing non-TAH–t associated charges and inserting charges related to the TAH–t, it appears that the average standardized charges per case for cases eligible for the TAH–t would exceed the relevant thresholds from Table 10 (as discussed above) and would therefore appear to meet the cost criterion. We invite public comment on whether TAH–t meets the cost criterion.

As noted in section II.G. of this preamble, we are proposing to remove the TAH–t from MS–DRG 215 and reassign the TAH–t to MS–DRGs 001 and 002. As stated earlier, CMS is proposing to reverse a national noncoverage determination that would extend coverage to artificial heart devices within the confines of an FDA-approved clinical study, effective May 1, 2008. If this proposal is finalized, the MCE will require both the procedure code 37.52 (Implantation of total replacement heart system) and the diagnosis code reflecting clinical trial—V70.7 (Examination of participant in clinical trial). As we have previously mentioned, the TAH–t appears to meet the cost thresholds for MS–DRGs 001, 002, and 215. Therefore, its proposed reassignment from MS–DRG 215 to MS–DRGs 001 and 002 should have no material effect on meeting the cost thresholds in MS–DRGs 001 and 002 should the reassignment proposal be finalized.

The manufacturer states that the TAH–t is the only mechanical circulatory support device intended as a bridge-to-transplant for patients with irreversible biventricular failure. It also asserts that the TAH–t improves clinical outcomes because it has been shown to reduce mortality in patients who are otherwise in end-stage heart failure. In addition, the manufacturer claims that the TAH–t provides greater hemodynamic stability and end-organ perfusion, thus making patients who receive it better candidates for eventual heart transplant. We welcome comments from the public regarding whether the TAH–t represents a substantial clinical improvement.

We did not receive any written comments or public comments at the town hall meeting regarding the substantial clinical improvement aspects of this technology.

b. Emphasys Medical Zephyr® Endobronchial Valve (Zephyr® EBV)

Emphasys Medical submitted an application for new technology add-on payments for FY 2009 for the Emphasys Medical Zephyr® Endobronchial Valve (Zephyr® EBV). The Zephyr® EBV is intended to treat patients with emphysema by reducing volume in the diseased, hyperinflated portion of the emphysematous lung with fewer risks and complications than with more invasive surgical alternatives. Zephyr® EBV therapy involves placing small, one-way valves in the patients' airways to allow air to flow out of, but not into, the diseased portions of the lung thus reducing the hyperinflation. A typical procedure involves placing three to four valves in the target lobe using a bronchoscope, and the procedure takes approximately 20 to 40 minutes to complete. The Zephyr® EBVs are designed to be relatively easy to place, and are intended to be removable so that, unlike more risky surgical alternatives such as Lung Volume Reduction Surgery (LVRS) or Lung Transplant, the procedure has the potential to be fully reversible.

Currently, the Zephyr® EBV has yet to receive approval from the FDA, but the manufacturer indicated to CMS that it expects to receive its FDA approval in the second or third quarter of 2008. Because the technology is not yet approved by the FDA, we will limit our discussion of this technology to data that the applicant submitted, rather than make specific proposals with respect to whether the device would meet the new technology add-on criteria.

In an effort to demonstrate that the Zephyr® EBV would meet the cost criterion, the applicant searched the FY 2006 MedPAR file for cases with one of the following ICD–9–CM diagnosis codes: 492.0 (Emphysematous bleb), 492.8 (Other emphysema, NEC), or 496 (Chronic airway obstruction, NEC). Based on the diagnosis codes searched by the applicant, cases of the Zephyr® EBV would be most prevalent in MS–DRGs 190 (Chronic Obstructive Pulmonary Disease with MCC), 191 (Chronic Obstructive Pulmonary Disease with CC), and 192 (Chronic Obstructive Pulmonary Disease without CC/MCC). The applicant found 1,869 cases (or 12.8 percent of cases) in MS–DRG 190, 5,789 cases (or 39.5 percent of cases) in MS–DRG 191, and 6,995 cases (or 47.7 percent of cases) in MS–DRG 192 (which equals a total of 14,653 cases). The average standardized charge per case was $21,567 for MS–DRG 190, $15,494 for MS–DRG 191, and $11,826 for MS–DRG 192. The average standardized charge per case does not include charges related to the Zephyr® EBV; therefore, it is necessary to add the charges related to the device to the average standardized charge per case in evaluating the cost threshold criteria. Although the applicant submitted data related to the estimated cost of the Zephyr® EBV per case, the applicant noted that the cost of the device was proprietary information because the device is not yet available on the open market. The applicant estimates $23,920 in charges related to the Zephyr® EBV (based on a 100 percent charge markup of the cost of the device). In addition to case-weighting the data based on the amount of cases that the applicant found in the FY 2006 MedPAR file, the applicant case-weighted the data based on its own projections of how many Medicare cases it would expect to map to MS–DRGs 190, 191, and 192 in FY 2009. The applicant projects that, 5 percent of the cases would map to MS–DRG 190, 15 percent of the cases would map to MS–DRG 191, and 80 percent of the cases would map to MS–DRG 192. Adding the charges related to the device to the average standardized charge per case (based on the applicant's projected case distribution) resulted in a case-weighted average standardized charge per case of $36,782 ($12,862 plus $23,920). Using the thresholds published in Table 10 (72 FR 66889), the case-weighted threshold for MS–DRGs 190, 191, and 192 was $18,394. Because the case-weighted average standardized charge per case for the applicable MS–DRGs exceed the case-weighted threshold amount, the applicant maintains that the Zephyr® EBV would meet the cost criterion. As noted above, the applicant also performed a case-weighted analysis of the data based on the 14,653 cases the applicant found in the FY 2006 MedPAR file. Based on this analysis, the applicant found that the case-weighted average standardized charge per case ($38,441 based on the 14,653 cases) exceeded the case-weighted threshold ($20,606 based on the 14,653 cases). Based on both analyses described above, it appears that the applicant would meet the cost criterion. We invite public comment on whether Zephyr® EBV meets the cost criterion.

The applicant asserts that the Zephyr® EBV is a substantial clinical improvement because it provides a new therapy along the continuum of care for patients with emphysema that offers improvement in lung function over standard medical therapy while incurring significantly less risk than more invasive treatments such as LVRS

and lung transplant. Specifically, the applicant submitted data from the ongoing pivotal Endobronchial Valve for Emphysema Palliation (VENT) trial,[14] which compared 220 patients who received EBV treatment to 101 patients who received standard medical therapy, including bronchodilators, steroids, mucolytics, and supplemental oxygen. At 6 months, patients who received the Zephyr® EBV had an average of 7.2 percent and 5.8 percent improvement (compared to standard medical therapy) in the primary effectiveness endpoints of the Forced Expiratory Volume in 1 second test (FEV1), and the 6 Minute Walk Test (6MWT), respectively. Both results were determined by the applicant to be statistically significant. The FEV1 results were determined using the t-test parametric confidence intervals (the p value determined using the one-side t-test adjusted for unequal variance) and the 6MWT results were determined using the Mann-Whitney nonparametric confidence intervals (the p value was calculated using the one-sided Wilcoxon rank sum test). However, the data also showed that patients who received the Zephyr® EBV experienced a number of adverse events, including hemoptyis, pneumonia, respiratory failure, pneumothorax, and COPD exacerbations, as well as valve migrations and expectorations that, in some cases, required repeat bronchoscopy. The manufacturer also submitted the VENT pivotal trial 1-year follow-up data, but has requested that the data not be disclosed because it has not yet been presented publicly nor published in a peer-reviewed journal.

While CMS recognizes that the Zephyr® EBV therapy is significantly less risky than LVRS and lung transplant, we are concerned that the benefits as shown in the VENT pivotal trial may not outweigh the risks when compared with medical therapy alone. Further, we note that, according to the applicant, the Zephyr® EBV is intended for use in many patients who are ineligible for LVRS and/or lung transplant (including those too sick to undergo more invasive surgery and those with lower lobe predominant disease distribution), but that certain patients (that is, those with upper lobe predominant disease distribution) could be eligible for either surgery or the Zephyr® EBV. We welcome comments from the public on both the patient population who would be eligible for the technology, and whether the Zephyr® EBV represents a substantial clinical improvement in the treatment of patients with emphysema.

We received written comments from the manufacturer and its presenters at the town hall meeting clarifying some questions that were raised at the town hall meeting. Specifically, these commenters explained that, in general, the target population for the Zephyr® EBV device was the same population that could benefit from LVRS, and also includes some patients who were too sick to undergo surgery. The commenters also explained that patients with emphysema with more heterogeneous lung damage were more likely to benefit from the device.

We welcome public comments regarding where exactly this technology falls in the continuum of care of patients with emphysema, and for whom the risk/benefit ratio is most favorable.

c. Oxiplex®

FzioMed, Inc. submitted an application for new technology add-on payments for FY 2009 for Oxiplex®. Oxiplex® is an absorbable, viscoelastic gel made of carboxymethylcellulose (CMC) and polyethylene oxide (PEO) that is intended to be surgically implanted during a posterior discectomy, laminotomy, or laminectomy. The manufacturer asserts that the gel reduces the potential for inflammatory mediators that injure, tether, or antagonize the nerve root in the epidural space by creating an acquiescent, semi-permeable environment to protect against localized debris. These proinflammatory mediators (phospholipase A and nitric oxide), induced or extruded by intervertebral discs, may be responsible for increased pain during these procedures. The manufacturer also asserts that Oxiplex® is a unique material in that it coats tissue, such as the nerve root in the epidural space, to protect the nerve root from the effects of inflammatory mediators originating from either the nucleus pulposus, from blood derived inflammatory cells, or cytokines during the healing process.

Oxiplex® is expecting to receive premarket approval from the FDA by June 2008. Because the technology is not yet approved by the FDA, we will limit our discussion of this technology to data that the applicant submitted, rather than make specific proposals with respect to whether the device would meet the new technology add-on payment criteria.

With regard to the newness criterion, we are concerned that Oxiplex® may be substantially similar to adhesion barriers that have been on the market for several years. We also note that Oxiplex® has been marketed as an adhesion barrier in other countries outside of the United States. The manufacturer maintains that Oxiplex® is different from adhesion barriers in several ways, including chemical composition, method of action, surgical application (that is, it is applied liberally to the nerve root and surrounding neural tissues as opposed to minimally only to nerve elements), and tissue response (noninflammatory as opposed to inflammatory). We welcome comments from the public on this issue.

In an effort to demonstrate that the technology meets the cost criterion, the applicant searched the FY 2006 MedPAR file for cases with ICD–9–CM procedure codes 03.09 (Other exploration and decompression of spinal canal) or 80.51 (Excision of interveterbral disc) that mapped to CMS DRGs 499 and 500 (CMS DRGs 499 and 500 are crosswalked to MS–DRGs 490 and 491 (Back and Neck Procedures except Spinal Fusion with or without CC)). Because these cases do not include charges associated with the technology, the applicant determined it was necessary to add an additional $7,143 in charges to the average standardized charge per case of cases that map to MS–DRGs 490 and 491. (To do this, the applicant used a methodology of inflating the costs of the technology by the average CCR computed by using the average costs and charges for supplies for cases with ICD–9–CM procedure codes 03.09 and 80.51 that map to MS–DRGs 490 and 491). Of the 221,505 cases the applicant found, 95,340 cases (or 43 percent of cases) would map to MS–DRG 490, which has an average standardized charge of $60,301, and 126,165 cases (or 57 percent of cases) would map to MS–DRG 491, which has an average standardized charge per case of $43,888. This resulted in a case-weighted average standardized charge per case of $50,952. The case-weighted threshold for MS–DRGs 490 and 491 was $27,481. Because the case-weighted average standardized charge per case exceeds the case-weighted threshold in MS–DRGs 490 and 491, the applicant maintains that Oxiplex® would meet the cost criterion. We invite public comment on whether Oxiplex® meets the cost criterion.

The manufacturer maintains that Oxiplex® is a substantial clinical improvement because it ''creates a protective environment around the neural tissue that limits nerve root exposure to post-surgical irritants and damage and thus reduces adverse outcomes associated with Failed Back

[14] Strange, Charlie., et al., design of the Endobronchial Valve for Emphysema Palliation trial (VENT): A Nonsurgical Method of Lung Volume Reduction, *BMC Pulmonary Medicine.* 2007; 7:10.

Surgery Syndrome (FBSS) following surgery.'' The manufacturer also claims that the Oxiplex® gel reduces leg and back pain after discectomy, laminectomy, and laminotomy. The manufacturer also asserts that the use of Oxiplex® is consistent with fewer revision surgeries. (During the FDA Investigational Device Exemption (IDE) trial, one Oxiplex® patient required revision surgery compared to six control patients.) However, as we noted previously in this section, we are concerned that Oxiplex® may be substantially similar to adhesion barriers that have been on the market for several years. We are also concerned that even if we were to determine that Oxiplex is not substantially similar to existing adhesion barriers, there may still be insufficient evidence to support the manufacturer's claims that Oxiplex® reduces pain associated with spinal surgery. In addition, we have found no evidence to support the manufacturer's claims regarding mode of action, degree of dural healing, degree of wound healing, and local tissue response such as might be shown in animal studies. We welcome comments from the public regarding whether Oxiplex® represents a substantial clinical improvement.

We did not receive any written comments or public comments at the town hall meeting regarding the substantial clinical improvement aspects of this technology.

d. TherOx Downstream® System

TherOx, Inc. submitted an application for new technology add-on payments for FY 2009 for the TherOx Downstream® System (Downstream® System). The Downstream® System uses SuperSaturatedOxygen Therapy (SSO2) that is designed to limit myocardial necrosis by minimizing microvascular damage in acute myocardial infarction (AMI) patients following intervention with Percutaneous Transluminal Coronary Angioplasty (PTCA), and coronary stent placement by perfusing the affected myocardium with blood that has been supersaturated with oxygen. SSO2 therapy refers to the delivery of superoxygenated arterial blood directly to areas of myocardial tissue that have been reperfused using PTCA and stent placement, but which may still be at risk. The desired effect of SSO2 therapy is to reduce infarct size and thus preserve heart muscle and function. The DownStream® System is the console portion of a disposable cartridge-based system that withdraws a small amount of the patient's arterial blood, mixes it with a small amount of saline, and supersaturates it with oxygen to create highly oxygen-enriched blood. The superoxygenated blood is delivered directly to the infarct-related artery via the TherOx infusion catheter. SSO2 therapy is a catheter laboratory-based procedure. Additional time in the catheter lab area is an average of 100 minutes. The manufacturer claims that the SSO2 therapy duration lasts 90 minutes and requires an additional 10 minutes post-procedure preparation for transfer time. The TherOx Downstream® System is currently not FDA approved; however, the manufacturer states that it expects to receive FDA approval in the second quarter of 2008. Because the technology is not yet approved by the FDA, we will limit our discussion of this technology to data that the applicant submitted, rather than make specific proposals with respect to whether the device would meet the new technology add-on criteria.

In an effort to demonstrate that it would meet the cost criterion, the applicant submitted two analyses. The applicant believes that cases that would be eligible for the Downstream® System would most frequently group to MS–DRGs 246 (Percutaneous Cardiovascular Procedure with Drug-Eluting Stent with MCC or 4+Vessels/Stents), 247 (Percutaneous Cardiovascular Procedure with Drug-Eluting Stent without MCC), 248 (Percutaneous Cardiovascular Procedure with Non-Drug-Eluting Stent with MCC or 4+Vessels/Stents), and 249 (Percutaneous Cardiovascular Procedure with Non-Drug-Eluting Stent without MCC). The first analysis used data based on 83 clinical trial patients from 10 clinical sites. Of the 83 cases, 78 were assigned to MS–DRGs 246, 247, 248, or 249. The data showed that 32 of these patients were 65 years old or older. There were 12 cases (or 15.4 percent of cases) in MS–DRG 246, 56 cases (or 71.8 percent of cases) in MS–DRG 247, 2 cases (or 2.6 percent of cases) in MS–DRG 248, and 8 cases (or 10.3 percent of cases) in MS–DRG 249. (The remaining five cases grouped to MS–DRGs that the technology would not frequently group to and therefore are not included in this analysis.) The average standardized charge per case for MS–DRGs 246, 247, 248, and 249 was $66,730, $53,963, $54,977, and $41,594, respectively. The case-weighted average standardized charge per case for the four MS–DRGs listed above is $54,665. Based on the threshold from Table 10 (72 FR 66890), the case-weighted threshold for the four MS–DRGs listed above was $49,303. The applicant also searched the FY 2006 MedPAR file to identify cases that would be eligible for the Downstream® System. The applicant specifically searched for cases with primary ICD–9–CM diagnosis code 410.00 (Acute myocardial infarction of anterolateral wall with episode of care unspecified), 410.01 (Acute myocardial infarction of anterolateral wall with initial episode of care), 410.10 (Acute myocardial infarction of other anterior wall with episode of care unspecified), or 410.11 (Acute myocardial infarction of other anterior wall with initial episode of care) in combination with ICD–9–CM procedure code of 36.06 (Insertion of non-drug-eluting coronary artery stent(s)) or 36.07 (Insertion of drug-eluting coronary artery stent(s)). The applicant's search found 13,527 cases within MS–DRGs 246, 247, 248, and 249 distributed as follows: 2,287 cases (or 16.9 percent of cases) in MS–DRG 246; 9,691 cases (or 71.6 percent of cases) in MS–DRG 247; 402 cases (or 3 percent of cases) in MS–DRG 248; and 1,147 cases (or 8.5 percent of cases) in MS–DRG 249. Not including the charges associated with the technology, the geometric mean standardized charge per case for MS–DRGs 246, 247, 248, and 249 was $59,631, $42,357, $49,718 and $37,446, respectively. Therefore, based on this analysis, the total case-weighted geometric mean standardized charge per case across these MS–DRGs was $45,080. The applicant estimated that it was necessary to add an additional $21,620 in charges to the total case-weighted geometric mean standardized charge per case. The applicant included charges for supplies and tests related to the technology, charges for 100 minutes of additional procedure time in the catheter laboratory and charges for the technology itself in the additional charge amount referenced above. The inclusion of these charges would result in a total case-weighted geometric mean standardized charge per case of $66,700. The case-weighted threshold for MS–DRGs 246, 247, 248, and 249 (from Table 10 (72 FR 66889)) was $49,714. Because the total case-weighted average standardized charge per case from the first analysis and the case-weighted geometric mean standardized charge per case from the second analysis exceeds the applicable case-weighted threshold, the applicant maintains the Downstream® System would meet the cost criterion. We invite public comment on whether Downstream® System meets the cost criterion.

The applicant asserts that the Downstream® System is a substantial clinical improvement because it reduces infarct size in acute AMI where PTCA and stent placement have also been performed. Data was submitted from the Acute Myocardial Infarction Hyperbaric

Oxygen Treatment (AMIHOT) II trial, which was presented at the October 2007 Transcatheter Cardiovascular Therapeutics conference, but has not been published in peer reviewed literature, that showed an average of 6.5 percent reduction in infarct size as measured with Tc–99m Sestamibi imaging in patients who received supersaturated oxygen therapy. We note that those patients also showed a significantly higher incidence of bleeding complications. While we recognize that a reduction of infarct size may correlate with improved clinical outcomes, we question whether the degree of infarct size reduction found in the trial represents a substantial clinical improvement, particularly in light of the apparent increase in bleeding complications. We welcome comments from the public on this matter.

We received one written comment from the manufacturer clarifying questions that were raised at the town hall meeting. Specifically, the commenter explained the methodology of Tc–99m Sestamibi scanning and interpretation in the AMIHOT II trial. In addition, the commenter explained that the AMIHOT [15] and AMIHOT II trials did not attempt to measure differences in heart failure outcomes nor mortality outcomes.

5. Proposed Regulatory Change

Section 1886(d)(5)(K)(i) of the Act directs us to establish a mechanism to recognize the cost of new medical services and technologies under the IPPS, with such mechanism established after notice and opportunity for public comment. In accordance with this authority, we established at § 412.87(b) of our regulations criteria that a medical service or technology must meet in order to qualify for the additional payment for new medical services and technologies. Specifically, we evaluate applications for new medical service or technology add-on payment by determining whether they meet the criteria of newness, adequacy of payment, and substantial clinical improvement.

As stated in section III.J.1. of the preamble of this proposed rule, § 412.87(b)(2) of our existing regulations provides that a specific medical service or technology will be considered new for purposes of new medical service or technology add-on payments after the point at which data begin to become available reflecting the ICD–9–CM code assigned to the new service or technology. The point at which these data become available typically begins when the new medical service or technology is first introduced on the market, generally on the date that the medical service or technology receives FDA approval. Accordingly, for purposes of the new medical service or technology add-on payment, a medical service or technology cannot be considered new prior to the date on which FDA approval is granted.

In addition, as stated in section III.J.1. of the preamble of this proposed rule, § 412.87(b)(3) of our existing regulations provides that, to be eligible for the add-on payment for new medical services or technologies, the DRG prospective payment rate otherwise applicable to the discharge involving the new medical service or technology must be assessed for adequacy. Under the cost criterion, to assess the adequacy of payment for a new medical service or technology paid under the applicable DRG prospective payment rate, we evaluate whether the charges for cases involving the new medical service or technology exceed certain threshold amounts.

Section 412.87(b)(1) of our existing regulations provides that, to be eligible for the add-on payment for new medical services or technologies, the new medical service or technology must represent an advance that substantially improves, relative to technologies previously available, the diagnosis or treatment of Medicare beneficiaries. In addition, § 412.87(b)(1) states that CMS will announce its determination as to whether a new medical service or technology meets the substantial clinical improvement criteria in the **Federal Register** as part of the annual updates and changes to the IPPS.

Since the implementation of the policy on add-on payments for new medical services and technologies, we accept applications for add-on payments for new medical services and technologies on an annual basis by a specified deadline. For example, applications for FY 2009 were submitted in November 2007. After accepting applications, CMS then evaluates them in the annual IPPS proposed and final rules to determine whether the medical service or technology is eligible for the new medical service or technology add-on payment. If an application meets each of the eligibility criteria, the medical service or technology is eligible for new medical service or technology add-on payments beginning on the first day of the new fiscal year (that is, October 1).

We have advised prior and potential applicants that we evaluate whether a medical service or technology is eligible for the new medical service or technology add-on payments prior to publication of the final rule setting forth the annual updates and changes to the IPPS, with the results of our determination announced in the final rule. We announce our results in the final rule for each fiscal year because we believe predictability is an important aspect of the IPPS and that it is important to apply a consistent payment methodology for new medical services or technologies throughout the entire fiscal year. For example, hospitals must train their billing and other staff after publication of the final rule to properly implement the coding and payment changes for the upcoming fiscal year set forth in the final rule. In addition, hospitals' budgetary process and clinical decisions regarding whether to utilize new technologies are based in part on the applicable payment rates under the IPPS for the upcoming fiscal year, including whether the new medical services or technologies qualify for the new medical service or technology add-on payment. If CMS were to make multiple payment changes under the IPPS during a fiscal year, these changes could adversely affect the decisions hospitals implement at the beginning of the fiscal year. For these reasons, we believe applications for new medical service or technology add-on payments should be evaluated prior to publication of the final IPPS rule for each fiscal year. Therefore, if an application does not meet the new medical service or technology add-on payment criteria prior to publication of the final rule, it will not be eligible for the new medical service or technology add-on payments for the fiscal year for which it applied for the add-on payments.

Because we make our determination regarding whether a medical service or technology meets the eligibility criteria for the new medical service or technology add-on payments prior to publication of the final rule, we have advised both past and potential applicants that their medical service or technology must receive FDA approval early enough in the IPPS rulemaking cycle to allow CMS enough time to fully evaluate the application prior to the publication of the IPPS final rule. Moreover, because new medical services or technologies that have not received FDA approval do not meet the newness criterion, it would not be necessary or prudent for us to make a final determination regarding whether a new

[15] Oneill, WW., et al., Acute Myocardial Infarction with Hyperoxemic Therapy (AMIHOT): A Prospective Randomized Trial of Intracoronary Hyperoxemic Reperfusion after Percutaneous Coronary Intervention. *Journal of the American College of Cardiology*, Vol. 50, No. 5, 2007, pp. 397–405.

medical service or technology meets the cost threshold and substantial clinical improvement criteria prior to the medical service or technology receiving FDA approval. In addition, we do not believe it is appropriate for CMS to determine whether a medical service or technology represents a substantial clinical improvement over existing technologies before the FDA makes a determination as to whether the medical service or technology is safe and effective. For these reasons, we first determine whether a medical service or technology meets the newness criteria, and only if so, do we then make a determination as to whether the technology meets the cost threshold and represents a substantial clinical improvement over existing medical services or technologies. For example, even if an application has FDA approval, if the medical service or technology is beyond the timeline of 2–3 years to be considered new, in the past we have not made a determination on the cost threshold and substantial clinical improvement. Further, as we have discussed in prior final rules (69 FR 49018–49019 and 70 FR 47344), it is our past and present practice to analyze the new medical service or technology add-on payment criteria in the following sequence: Newness, cost threshold, and finally substantial clinical improvement. Under our proposal in this proposed rule, we would continue this practice of analyzing the eligibility criteria in this sequence and announce in the annual **Federal Register** as part of the annual updates and changes to the IPPS our determination on whether a medical service or technology meets the eligibility criteria in § 412.87(b).

In the interest of more clearly defining the parameters under which CMS can fully and completely evaluate new medical service or technology add-on payment applications, we are proposing to amend the regulations at § 412.87 by adding a new paragraph (c) to codify our current policy and specify that CMS will consider whether a new medical service or technology meets the eligibility criteria in § 412.87(b) and announce the results in the **Federal Register** as part of the annual updates and changes to the IPPS. As a result, we are proposing to remove the duplicative text in § 412.87(b)(1) that specifies that CMS will determine whether a new medical service or technology meets the substantial clinical improvement criteria and announce the results of its determination in the **Federal Register** as part of the annual updates and changes to the IPPS. We note that this proposal is not a change to our current policy, as we have always given consideration to whether an application meets the new medical service or technology eligibility criteria in the annual IPPS proposed and final rules. Rather, this proposal simply codifies our current practice of fully evaluating new medical service or technology add-on payment applications prior to publication of the final rule in order to maintain predictability within the IPPS for the upcoming fiscal year.

In addition, we are proposing in new paragraph (c) of § 412.87 to set July 1 of each year as the deadline by which IPPS new medical service or technology add-on payment applications must receive FDA approval. This proposed deadline should provide us with enough time to fully consider all of the new medical service or technology add-on payment criteria for each application and maintain predictability in the IPPS for the coming fiscal year.

Finally, under this proposal, applications that have not received FDA approval by July 1 would not be considered in the final rule, even if they were summarized in the corresponding IPPS proposed rule. However, applications that receive FDA approval of the medical service or technology after July 1 would be able to reapply for the new medical service or technology add-on payment the following year (at which time they would be given full consideration in both the IPPS proposed and final rules).

In summary, for the reasons cited above, we are proposing to revise § 412.87 to remove the second sentence of (b)(1) and add a new paragraph (c) to codify our current practice of how CMS evaluates new medical service or technology add-on payment applications and establish in paragraph (c) a deadline of July 1 of each year as the deadline by which IPPS new medical service or technology add-on payment applications must receive FDA approval in order to be fully evaluated in the applicable IPPS final rule each year.

III. Proposed Changes to the Hospital Wage Index

A. Background

Section 1886(d)(3)(E) of the Act requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts ''for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.'' In accordance with the broad discretion conferred under the Act, we currently define hospital labor market areas based on the definitions of statistical areas established by the Office of Management and Budget (OMB). A discussion of the proposed FY 2009 hospital wage index based on the statistical areas, including OMB's revised definitions of Metropolitan Areas, appears under section III.C. of this preamble.

Beginning October 1, 1993, section 1886(d)(3)(E) of the Act requires that we update the wage index annually. Furthermore, this section provides that the Secretary base the update on a survey of wages and wage-related costs of short-term, acute care hospitals. The survey must exclude the wages and wage-related costs incurred in furnishing skilled nursing services. This provision also requires us to make any updates or adjustments to the wage index in a manner that ensures that aggregate payments to hospitals are not affected by the change in the wage index. The proposed adjustment for FY 2009 is discussed in section II.B. of the Addendum to this proposed rule.

As discussed below in section III.I. of this preamble, we also take into account the geographic reclassification of hospitals in accordance with sections 1886(d)(8)(B) and 1886(d)(10) of the Act when calculating IPPS payment amounts. Under section 1886(d)(8)(D) of the Act, the Secretary is required to adjust the standardized amounts so as to ensure that aggregate payments under the IPPS after implementation of the provisions of sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act are equal to the aggregate prospective payments that would have been made absent these provisions. The proposed budget neutrality adjustment for FY 2009 is discussed in section II.A.4.b. of the Addendum to this proposed rule.

Section 1886(d)(3)(E) of the Act also provides for the collection of data every 3 years on the occupational mix of employees for short-term, acute care hospitals participating in the Medicare program, in order to construct an occupational mix adjustment to the wage index. A discussion of the occupational mix adjustment that we are proposing to apply beginning October 1, 2008 (the FY 2009 wage index) appears under section III.D. of this preamble.

B. Requirements of Section 106 of the MIEA–TRHCA

1. Wage Index Study Required Under the MIEA–TRHCA

Section 106(b)(1) of the MIEA–TRHCA (Pub. L. 109–432) required

MedPAC to submit to Congress, not later than June 30, 2007, a report on the Medicare wage index classification system applied under the Medicare IPPS. Section 106(b) of MIEA–TRHCA required the report to include any alternatives that MedPAC recommends to the method to compute the wage index under section 1886(d)(3)(E) of the Act.

In addition, section 106(b)(2) of the MIEA–TRHCA instructed the Secretary of Health and Human Services, taking into account MedPAC's recommendations on the Medicare wage index classification system, to include in this 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.
- 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 its June 2007 Report to Congress, ''Report to the Congress: Promoting Greater Efficiency in Medicare'' (Chapter 6 with Appendix), MedPAC made three broad recommendations regarding the wage index:

(1) Congress should repeal the existing hospital wage index statute, including reclassifications and exceptions, and give the Secretary authority to establish a new wage index system;

(2) The Secretary should establish a hospital compensation index that—

- Uses wage data from all employers and industry-specific occupational weights;
- Is adjusted for geographic differences in the ratio of benefits to wages;
- Is adjusted at the county level and smoothes large differences between counties; and
- Is implemented so that large changes in wage index values are phased in over a transition period; and

(3) The Secretary should use the hospital compensation index for the home health and skilled nursing facility prospective payment systems and evaluate its use in the other Medicare fee-for-service prospective payment systems.

The full June 2007 Report to Congress is available at the Web site: *http://www.medpac.gov/documents/Jun07_EntireReport.pdf)*.

In the presentation and analysis of its alternative wage index system, MedPAC addressed almost all of the nine points for consideration under section 106(b)(2) of Pub. L. 109–432. Following are the highlights of the alternative wage index system recommended by MedPAC:

- Although the MedPAC recommended wage index generally retains the current labor market definitions, it supplements the metropolitan areas with county-level adjustments and eliminates single wage index values for rural areas.
- In the MedPAC recommended wage index, the county-level adjustments, together with a smoothing process that constrains the magnitude of differences between and within contiguous wage areas, serve as a replacement for geographical reclassifications.
- The MedPAC recommended wage index uses BLS data instead of the CMS hospital wage data collected on the Medicare cost report. MedPAC adjusts the BLS data for geographic differences in the ratio of benefits to wages using Medicare cost report data.
- The BLS data are collected from a sample of all types of employers, not just hospitals. The MedPAC recommended wage index could be adapted to other providers such as HHAs and SNFs by replacing hospital occupational weights with occupational weights appropriate for other types of providers.
- In the MedPAC recommended wage index, volatility over time is addressed by the use of BLS data, which is based on a 3-year rolling sample design.
- MedPAC recommends a phased implementation for its recommended wage index in order to cushion the effect of large wage index changes on individual hospitals.
- MedPAC suggests that using BLS data automatically addresses occupational mix differences, because the BLS data are specific to health care occupations, and national industry-wide occupational weights are applied to all geographic areas.
- The MedPAC report does not provide any evidence of the impact of its wage index on staffing practices or the quality of care and patient safety.

To assist CMS in meeting the requirements of section 106(b)(2) of Pub. L. 109–432, in February 2008, CMS awarded a Task Order under its Expedited Research and Demonstration Contract, to Acumen, LLC. The two general responsibilities of the Task Order are to (1) conduct a detailed impact analysis that compares the effects of MedPAC's wage and hospital compensation indexes with the CMS wage index and (2) assist CMS in developing a proposal (or proposals) that addresses the nine points for consideration under section 106(b)(2) of Pub. L. 109–432. Specifically, the tasks under the Task Order include, but are not limited to, an evaluation of whether differences between the two types of wage data (that is, CMS cost report and occupational mix data and BLS data) produce significant differences in wage index values among labor market areas, a consideration of alternative methods of incorporating benefit costs into the construction of the wage index, a review of past and current research on alternative labor market area definitions, and a consideration of how aspects of the MedPAC recommended wage index can be applied to the CMS wage data in constructing a new methodology for the wage index. We will present any analyses and proposals resulting from this Task Order in the FY 2009 IPPS final rule or in a special **Federal Register** notice issued after the final rule is published.

2. CMS Proposals in Response to Requirements Under Section 106(b) of the MIEA–TRHCA

As discussed in section III.A. of this preamble, the purpose of the hospital wage index is to adjust the IPPS standardized payment to reflect labor market area differences in wage levels. The geographic reclassification system exists in order to assist ''hospitals which are disadvantaged by their current geographic classification because they compete with hospitals that are located in the geographic area to which they seek to be reclassified'' (56 FR 25469). Geographic reclassification is

established under section 1886(d)(10) of the Act and is implemented through 42 CFR Part 412, Subpart L. (We refer readers to section III.I. of this preamble for a detailed discussion of the geographic reclassification system and other area wage index exceptions.)

In its June 2007 Report to Congress, MedPAC discussed its findings that geographic reclassification, and numerous other area wage index exceptions added to the system over the years, have created major complexities and ''troubling anomalies'' in the hospital wage index. A review of the IPPS final rules reveals a long history of legislative changes that have permitted certain hospitals, that otherwise would not be able to reclassify under section 1886(d)(10) of the Act, to receive a higher wage index than calculated for their geographic area. MedPAC reports that more than one-third of hospitals now receive a higher wage index due to geographic reclassification or other wage index exceptions. We are concerned about the integrity of the current system, and agree with MedPAC that the process has become burdensome.

As noted above, MedPAC recommended the elimination of geographic reclassification and other wage index exceptions. In addition, the President's FY 2009 Budget included a proposal to apply the geographic reclassification budget neutrality requirement at the State level rather than by adjusting the standardized rate for hospitals nationwide. Given the language in section 1886(d)(10) of the Act establishing the MGCRB, we believe a statutory change would be required to make these changes. However, we do have the authority to make some regulatory changes to the reclassification system as discussed below. We note that these proposals do not preclude future consideration of MedPAC's recommendations that could be implemented through additional changes to our regulations, once our analysis of those recommendations is complete (after the publication of the FY 2009 IPPS proposed rule).

a. Proposed Revision of the Reclassification Average Hourly Wage Comparison Criteria

Regulations at 42 CFR 413.230(d)(1) set forth the average hourly wage comparison criteria that an individual hospital must meet in order for the MGCRB to approve a geographic reclassification application. Our current criteria (requiring an urban hospital to demonstrate that its average hourly wage is at least 108 percent of the average hourly wage of hospitals in the area in which the hospital is located and at least 84 percent of the average hourly wage of hospitals in the area to which it seeks redesignation) were adopted in the FY 1993 IPPS final rule (57 FR 39825). In that final rule, we explained that the 108 percent threshold ''is based on the national average hospital wage as a percentage of its area wage (96 percent) plus one standard deviation (12 percent).'' We also explained that we would use the 84-percent threshold to reflect the average hospital wage of the hospital as a percentage of its area wage less one standard deviation. We stated that ''to qualify for a wage index reclassification, a hospital must have an average hourly wage that is more than one national standard deviation above its original labor market area and not less than one national standard deviation below its new labor market area'' (57 FR 39770). In response to numerous public comments we received, we expressed our policy and legal justifications for adopting the specific thresholds. Among other things, we stated that geographic reclassifications must be viewed not just in terms of those hospitals that are reclassifying, but also in terms of the nonreclassifying hospitals that, through a budget neutrality adjustment, are required to bear a financial burden associated with the higher wage indices received by those hospitals that reclassify. We also indicated that the Secretary has ample legal authority under section 1886(d)(10) of the Act to set the wage comparison thresholds and to revise such thresholds upon further review. We refer readers to that final rule for a full discussion of our justifications for the standards.

In the FY 2000 IPPS final rule (65 FR 47089 through 47090), the wage comparison criteria for rural hospitals seeking individual hospital reclassifications were reduced to 82 percent and 106 percent to compensate for the historic economic underperformance of rural hospitals. The 2-percent drop in both thresholds was determined to allow a significant benefit to some hospitals that were close to meeting the existing criteria but would not make the reclassification standards overly liberal for rural hospitals.

CMS has not evaluated or recalibrated the average hourly wage criteria for geographic reclassification since they were established in FY 1993. In consideration of the MIEA–TRHCA requirements and MedPAC's finding that over one-third of hospitals are receiving a reclassified wage index or other wage index adjustment, we decided to reevaluate the average hourly wage criteria for geographic reclassification. We ran simulations with more recent wage data to determine what would be the appropriate average hourly wage criteria. We found that the average hospital average hourly wage as a percentage of its area's wage has increased from approximately 96 percent in FY 1993 to closer to 98 percent over FYs 2006, 2007, and 2008 (97.8, 98.2, and 98 percent, respectively). We also determined that the standard deviation has been reduced from approximately 12 percent in FY 1993 to closer to 10 percent over the same 3-year period (10.7, 10.4, and 10.4 percent, respectively); that is, assuming normal distributions, approximately 68 percent of all hospitals would have an average hourly wage that deviates less than 10 percentage points above or below the mean. This assessment indicates that the new baseline criteria for reclassification should be set to 88/108 percent. While the 108 criterion appears not to require adjustment, the current 84 percent standard appears to be too low a threshold to serve the purpose of establishing wage comparability with a proximate labor market area.

To assess the impact that these changes would have had on hospitals that reclassified in FY 2008, we ran models that set urban individual reclassification standards to 88/108 percent and the county group reclassification standard to 88 percent. We retained the 2-percent benefit for rural hospitals by setting an 86/106 percent standard. We used 3-year average hourly wage figures from the 2005, 2006, and 2007 wage surveys and compared them to 3-year average hourly wage figures for CBSAs over the same 3-year period.

Of the 295 hospitals that applied for and received individual reclassifications in FY 2008, 45 of them (15.3 percent) would not meet the proposed 88/86 percent threshold. Of the 66 hospitals that applied for and received county group reclassification in FY 2008, 6 hospitals (9.1 percent) in 3 groups would not have qualified with the new standards. We also ran comparisons for hospitals that reclassified in FY 2006 and FY 2007 to determine if they would have been able to reclassify in FY 2008, using 3-year averages available in FY 2008. We found that, of all hospitals that were reclassified in FY 2008 (that is, applications approved for FYs 2006 through 2008), 14.7 percent of individual reclassifications and 8.5 percent of county group reclassification would not have qualified to reclassify in FY 2008.

Section 106 of MIEA–TRHCA requires us to propose revisions to the hospital wage index system after considering the recommendations of MedPAC. To address this requirement, we are proposing that the 84/108 criteria for urban hospital reclassifications and the 82/106 criteria for rural hospital reclassifications be recalibrated using the methodology published in the FY 1993 final rule and more recent wage data (that is, data used in computing the FYs 2006, 2007, 2008 wage indices). We believe that hospitals that are seeking to reclassify to another area should be required to demonstrate more similarity to the area than the current criteria permit, and our recent analysis demonstrates that those criteria are no longer appropriate. Therefore, we are proposing to change the criterion for the comparison of a hospital's average hourly wage to that of the area to which the hospital seeks reclassification to 88 percent for urban hospitals and 86 percent for rural hospitals for new reclassifications beginning with the FY 2010 wage index and, accordingly, revise our regulations at 42 CFR 412.230 to reflect these changes. The criterion for the comparison of a hospital's average hourly wage to that of its geographic area would be unchanged (108 percent for urban hospitals and 106 percent for rural hospitals). We also are proposing that, when there are significant changes in labor market area definitions, such as CMS' adoption of new OMB CBSA definitions based upon the decennial census (69 FR 49027), we would again reevaluate and, if warranted, recalibrate these criteria. This would allow CMS to consider the effects of periodic changes in labor market boundaries and provide a regular timeline for updating and validating the reclassification criteria. Finally, we are proposing to adjust the 85 percent criterion for both urban and rural county group reclassifications to be equal to the proposed 88 percent standard for urban reclassifications, and to revise the regulations at 42 CFR 412.232 and 412.234 to reflect the change. The urban and rural county group average hourly wage standard has always been equivalent for both urban and rural county groups and has always been 1 percent higher than the 84 percent urban area individual reclassification standard. We would continue the policy of having an equivalent wage comparison criterion for both urban and rural county groups, as these groups have always used the same wage comparison criteria. We also would use the individual urban hospital reclassification standard of 88 percent because this threshold would ensure that the hospitals in the county group are at least as comparable to the proximate area as are individual hospitals within their own areas. Also, we do not believe it would be appropriate to have a group reclassification standard lower than the individual reclassification standards, thus potentially creating a situation where all of the hospitals in a county could reclassify, even though no single hospital within such county would be able to meet any average hourly wage-related comparisons for an individual reclassification.

We considered raising the group reclassification criterion to 89 percent in order to preserve the historical policy of the standard being set at 1 percent higher than the individual reclassification standard. However, we determined that making the group standard equal to the individual standard would adequately address our stated concerns.

We note that the proposed changes in the reclassification criteria apply only to new reclassifications beginning with the FY 2010 wage index. Any hospital or county group that is in the midst of a 3-year reclassification in FY 2010 will not be affected by the proposed criteria change until they reapply for a geographic reclassification. Therefore, we are proposing the effective date for these changes would be September 1, 2008, the deadline for hospitals to submit applications for reclassification for the FY 2010 wage index.

b. Within-State Budget Neutrality Adjustment for the Rural and Imputed Floors

Section 4410 of the Balanced Budget Act of 1997 (BBA) established the rural floor by requiring that the wage index for a hospital in an urban area of a State cannot be less than the area wage index determined for that State's rural area. Section 4410(b) of the BBA imposed the budget neutrality requirement and stated that the Secretary shall ''adjust the area wage index referred to in subsection (a) for hospitals not described in such subsection.'' Therefore, in order to compensate for the increased wage indices of urban hospitals receiving the rural floor, a nationwide budget neutrality adjustment is applied to the wage index to account for the additional payment to these hospitals. As a result, urban hospitals that qualify for their State's rural floor wage index receive enhanced payments at the expense of all rural hospitals nationwide and all other urban hospitals that do not receive their State's rural floor. In the FY 2009 proposed wage index, 266 hospitals in 27 States benefit from the rural floor. The first chart below lists the percentage of total payments each State either received or contributed to fund the current rural floor and imputed floor provisions with national budget neutrality adjustments (as indicated in the discussion of the imputed floor below in this section III.B.2.b.). The second chart below provides a graphical depiction of the proposed FY 2009 impacts.

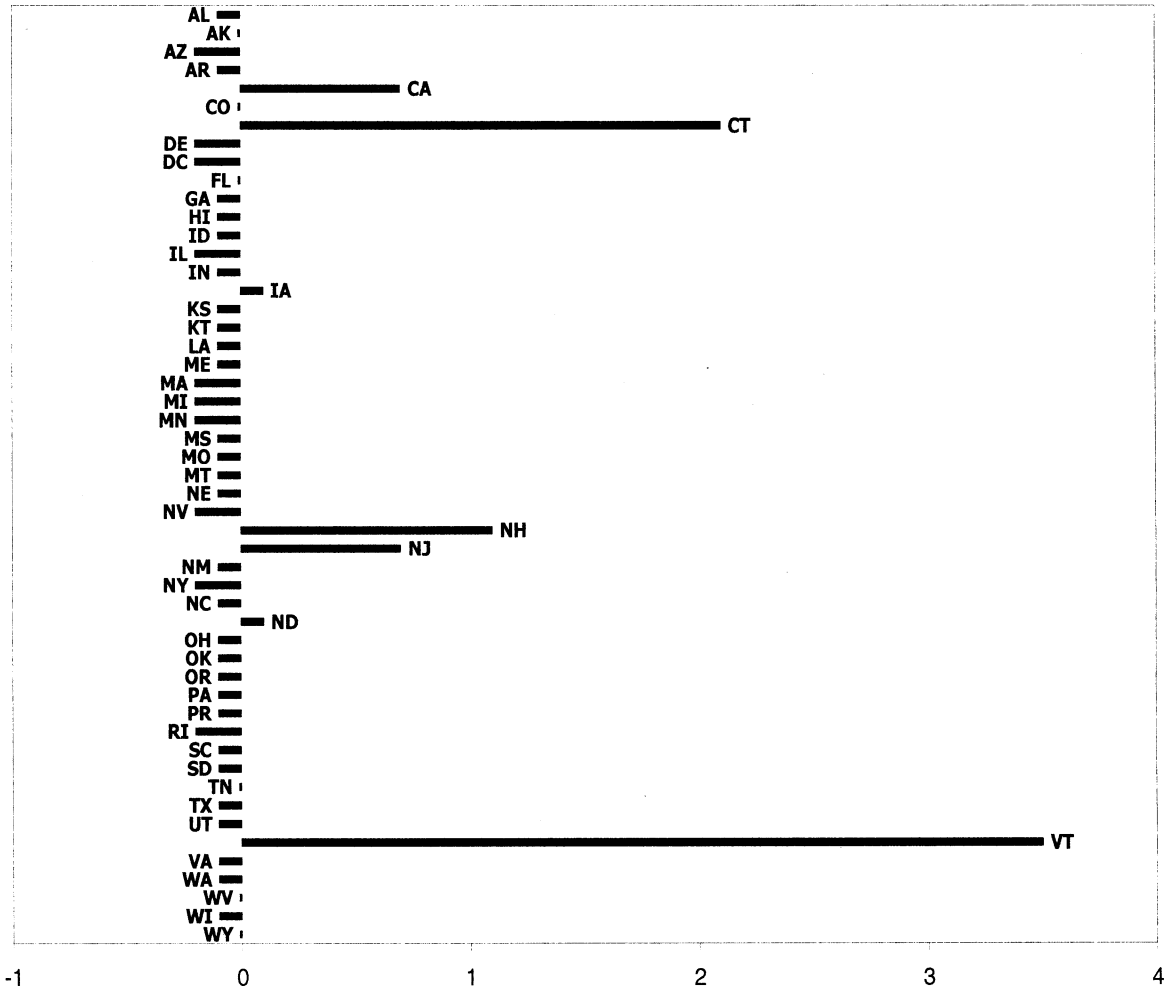
FY 2009 IPPS ESTIMATED PAYMENTS WITH PROPOSED WITHIN-STATE RURAL FLOOR AND IMPUTED FLOOR BUDGET NEUTRALITY

State	Current policy application of national rural floor and imputed floor budget neutrality	Proposed policy application of rural floor and imputed floor budget neutrality within each state
Alabama	−0.1	0.3
Alaska	0.0	−0.2
Arizona	−0.2	0.3
Arkansas	−0.1	0.3
California	0.7	−0.8
Colorado	0.0	−0.1
Connecticut	2.1	−2.2
Delaware	−0.2	0.3
Washington, DC	−0.2	0.3

FY 2009 IPPS ESTIMATED PAYMENTS WITH PROPOSED WITHIN-STATE RURAL FLOOR AND IMPUTED FLOOR BUDGET NEUTRALITY—Continued

State	Current policy application of national rural floor and imputed floor budget neutrality	Proposed policy application of rural floor and imputed floor budget neutrality within each state
Florida	0.0	0.0
Georgia	−0.1	0.3
Hawaii	−0.1	0.3
Idaho	−0.1	0.3
Illinois	−0.2	0.1
Indiana	−0.1	0.0
Iowa	0.1	−0.1
Kansas	−0.1	0.3
Kentucky	−0.1	0.3
Louisiana	−0.1	0.0
Maine	−0.1	0.3
Massachusetts	−0.2	0.3
Michigan	−0.2	0.3
Minnesota	−0.2	0.3
Mississippi	−0.1	0.3
Missouri	−0.1	0.0
Montana	−0.1	0.2
Nebraska	−0.1	0.3
Nevada	−0.2	0.3
New Hampshire	1.1	−1.2
New Jersey	0.7	−0.8
New Mexico	−0.1	0.0
New York	−0.2	0.3
North Carolina	−0.1	0.1
North Dakota	0.1	−0.1
Ohio	−0.1	0.1
Oklahoma	−0.1	0.1
Oregon	−0.1	0.0
Pennsylvania	−0.1	0.1
Rhode Island	−0.2	0.3
South Carolina	−0.1	0.0
South Dakota	−0.1	0.3
Tennessee	0.0	0.0
Texas	−0.1	0.1
Utah	−0.1	0.3
Vermont	3.5	−3.4
Virginia	−0.1	0.0
Washington	−0.1	−0.1
West Virginia	0.0	−0.1
Wisconsin	−0.1	−0.1
Wyoming	0.0	0.1

Estimated Payment Percentage Differential Due to Change from National Budget Neutrality to Proposed FY 2009 Within-State Budget Neutrality for Rural Floor and Imputed Floor



The above charts demonstrate how, at a State-by-State level, the rural floor is creating a benefit for a minority of States that is then funded by a majority of States, including States that are overwhelmingly rural in character. The intent behind the rural floor seems to have been to address anomalous occurrences where certain urban areas in a State have unusually depressed wages when compared to the State's rural areas. However, because these comparisons occur at the State level, we believe it also would be sound policy to make the budget neutrality adjustment specific to the State, redistributing payments among hospitals within the State, rather than adjusting payments to hospitals in other States.

In addition, a statewide budget neutrality adjustment would address the situation we discussed in the FY 2008 IPPS final rule with comment period (72 FR 47324) in which rural CAHs were converting to IPPS status, apparently to raise the State's rural wage index to a level whereby all urban hospitals in the State would receive the rural floor. Medicare payments to CAHs are based on 101 percent of reasonable costs while the IPPS pays hospitals a fixed rate per discharge. In addition, as a CAH, a hospital is guaranteed to recover its costs, while an IPPS hospital is provided with incentives to increase efficiency to cover its costs. Thus, we stated that the identified CAHs were converting back to IPPS, even though the conversion would not directly benefit them. Because these hospitals' wage levels are higher than most, if not all, of the urban hospitals in the State, the wage indices for most, if not all, of the State's urban hospitals would increase as a result of the rural floor provision if the CAHs convert to IPPS status. In simulating the effect of the hospitals setting the State's rural floor, we estimated that payment to hospitals in the State would increase in excess of $220 million in a single year. The MedPAC, in its June 2007 Report to the Congress stated, ''The fact that the movement of one or two CAHs in or out of the [I]PPS system can increase (or decrease) Medicare payments by $220 million suggests there is a flaw in the design of the wage index system.'' (We refer readers to page 131 of the report.)

For the above reasons, we are proposing to apply a State level rural floor budget neutrality adjustment to the wage index beginning in FY 2009. States that have no hospitals receiving a rural floor wage index would no longer have a negative budget neutrality adjustment applied to their wage indices. Conversely, hospitals in States with hospitals receiving a rural floor would

have their wage indices downwardly adjusted to achieve budget neutrality within the State. All hospitals within each State would, in effect, be responsible for funding the rural floor adjustment applicable within that specific State.

In the FY 2005 IPPS final rule and the FY 2008 IPPS final rule with comment period (69 FR 49109 and 72 FR 47321, respectively), we temporarily adopted an ''imputed'' floor measure to address a concern by some individuals that hospitals in all-urban States were disadvantaged by the absence of rural hospitals. Because no rural wage index could be calculated, no rural floor could be applied within such States. We originally limited application of the policy to FYs 2005 through 2007 and then extended it one additional year, through FY 2008. We are proposing to extend the imputed floor for 3 additional years, through FY 2011, and to revise the introductory text of § 412.64(h)(4) of our regulations to reflect this extension. For FY 2009, 26 hospitals in New Jersey (33.8 percent) would receive the imputed floor. Rhode Island, the only other all-urban State, has no hospitals that would receive the imputed floor. In past years, we applied a national budget neutrality adjustment to the standardized amount to ensure that payments remained constant to payments that would have occurred in the absence of the imputed floor policy. As a result, payments to all other hospitals in the Nation were adjusted downward to subsidize the higher payments to New Jersey hospitals receiving the imputed floor. As the intent of the imputed floor is to create a protection to all-urban States similar to the protection offered to urban-rural mixed States by the rural floor, and the effect of the measure is also State-specific like the rural floor, we believe that the budget neutrality adjustments for the imputed floor and the rural floor should be applied in the same manner. Therefore, beginning with FY 2009, we are also proposing to apply the imputed floor budget neutrality adjustment to the wage index and at the State level.

Based on our impact analysis of these proposals for FY 2009, of the 49 States (Maryland is excluded because it is under a State waiver), the District of Columbia, and Puerto Rico, 39 would see either no change or an increase in total Medicare payments as a result of applying a budget neutrality adjustment to the wage index for the rural and imputed floors at the State level rather than the national level. The total payments of the remaining 12 States would decrease 0.1 percent to 3.4 percent compared to continuing our prior national adjustment policy. The full impact analysis is reflected in the two charts presented earlier in this section III.B.2.b. of the preamble of this proposed rule. Tables 4D–1 and 4D–2 in the Addendum to this proposed rule reflect the proposed FY 2009 State level budget neutrality adjustments for the rural and imputed floors. We are specifically requesting public comments from national and State hospital associations regarding these proposals, particularly the national associations, as they represent member hospitals that are both positively and negatively affected by our proposed policies, and are, therefore, in the best position to comment on the policy merits of these proposals. We will view the absence of any comments from the national hospital associations as a sign that they do not object to our proposed policies.

c. Within-State Budget Neutrality Adjustment for Geographic Reclassification

Currently, section 1886(d)(8)(D) of the Act requires us to adjust the standardized amount to ensure that the effects of geographic reclassification do not increase aggregate IPPS payments. This means that, in the case of a reclassification, budget neutrality is achieved by reducing the standardized amount for all hospitals nationwide. The FY 2009 President's Budget includes a legislative proposal to apply geographic reclassification budget neutrality at the State level (available at the Web site: *www.hhs.gov/budget/09budget/2009BudgetInBrief.pdf* under FY 2009 Medicare Proposals, page 54). If this proposal is enacted by the Congress, budget neutrality would be achieved by adjusting the wage index for all hospitals within the State rather than reducing the standardized amount for all hospitals nationwide.

As noted also in MedPAC's June 2007 Report to Congress, over the years, there have been many changes to the Medicare law that are intended to broaden the ability for a hospital to receive a wage index that is higher than the value that is calculated for its geographic area and not be subject to the proximity or wage level criteria for geographic reclassification established under section 1886(d)(10) of the Act. These more targeted geographic reclassification provisions are creating inequities in the wage index by sometimes allowing hospitals to be reclassified to areas where other hospitals that are closer in proximity are ineligible to reclassify. Applying budget neutrality at the State level would focus the costs of geographic reclassification closer to the areas where hospitals that benefit from the reclassification are located. We expect that a legislative provision on applying geographic reclassification budget neutrality at the State level would be applied to all reclassifications and wage index exceptions that are implemented through 42 CFR Part 412, Subpart L, and certain provisions of the Social Security Act that permit hospitals to receive a higher wage index than is calculated for their geographic area. (As discussed above, as a proposed regulatory matter, there also would be a separate within-State budget neutrality adjustment for the imputed and rural floors.) We expect that reclassification budget neutrality at the State level would operate through adjustments to the IPPS payments to hospitals in the State in which the reclassifying hospital is geographically located.

We are seeking public comments regarding MedPAC's recommendations for reforming the wage index, our plan for our contractor's review of the wage index, and the regulatory proposals for modifying the current hospital wage index system. We also welcome additional suggestions for reforming the hospital wage index.

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

The wage index is calculated and assigned to hospitals on the basis of the labor market area in which the hospital is located. In accordance with the broad discretion under section 1886(d)(3)(E) of the Act, beginning with FY 2005, we define hospital labor market areas based on the Core-Based Statistical Areas (CBSAs) established by OMB and announced in December 2003 (69 FR 49027). For a discussion of OMB's revised definitions of CBSAs and our implementation of the CBSA definitions, we refer readers to the preamble of the FY 2005 IPPS final rule (69 FR 49026 through 49032).

As with the FY 2008 final rule, for FY 2009 we are proposing to provide 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 2009 employing wage index data from FY 2005 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, it has been our longstanding policy that where an MSA has been divided into Metropolitan Divisions, we consider the Metropolitan Division to comprise the labor market areas for purposes of calculating the

wage index (69 FR 49029). We are proposing to codify this longstanding policy into our regulations at § 412.64(b)(1)(ii)(A).

On November 20, 2007, OMB announced the revision of titles for eight urban areas (OMB Bulletin No. 08–01). The revised titles are as follows:

- Hammonton, New Jersey qualifies as a new principal city of the Atlantic City, New Jersey CBSA. The new title is Atlantic City-Hammonton, New Jersey CBSA;
- New Brunswick, New Jersey, located in the Edison, New Jersey Metropolitan Division, qualifies as a new principal city of the New York-Northern New Jersey-Long Island, New York, New Jersey, Pennsylvania CBSA. The new title for the Metropolitan Division is Edison-New Brunswick, New Jersey CBSA;
- Summerville, South Carolina qualifies as a new principal city of the Charleston-North Charleston, South Carolina CBSA. The new title is Charleston-North Charleston-Summerville, South Carolina;
- Winter Haven, Florida qualifies as a new principal city of the Lakeland, Florida CBSA. The new title is Lakeland-Winter Haven, Florida;
- Bradenton, Florida replaces Sarasota, Florida as the most populous principal city of the Sarasota-Bradenton-Venice, Florida CBSA. The new title is Bradenton-Sarasota-Venice, Florida. The new CBSA code is 14600;
- Frederick, Maryland replaces Gaithersburg, Maryland as the second most populous principal city in the Bethesda-Gaithersburg-Frederick, Maryland CBSA. The new title is Bethesda-Frederick-Gaithersburg, Maryland;
- North Myrtle Beach, South Carolina replaces Conway, South Carolina as the second most populous principal city of the Myrtle Beach-Conway-North Myrtle Beach, South Carolina CBSA. The new title is Myrtle Beach-North Myrtle Beach-Conway, South Carolina;
- Pasco, Washington replaces Richland, Washington as the second most populous principal city of the Kennewick-Richland-Pasco, Washington CBSA. The new title is Kennewick-Pasco-Richland, Washington.

The OMB bulletin is available on the OMB Web site at *https://www.whitehouse.gov/OMB*— go to ''Bulletins'' or ''Statistical Programs and Standards.'' CMS will apply these changes to the IPPS beginning October 1, 2008.

D. Proposed Occupational Mix Adjustment to the Proposed FY 2009 Wage Index

As stated earlier, section 1886(d)(3)(E) of the Act provides for the collection of data every 3 years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program, in order to construct an occupational mix adjustment to the wage index, for application beginning October 1, 2004 (the FY 2005 wage index). The purpose of the occupational mix adjustment is to control for the effect of hospitals' employment choices on the wage index. For example, hospitals may choose to employ different combinations of registered nurses, licensed practical nurses, nursing aides, and medical assistants for the purpose of providing nursing care to their patients. The varying labor costs associated with these choices reflect hospital management decisions rather than geographic differences in the costs of labor.

1. Development of Data for the Proposed FY 2009 Occupational Mix Adjustment

On October 14, 2005, we published a notice in the **Federal Register** (70 FR 60092) proposing to use a new survey, the 2006 Medicare Wage Index Occupational Mix Survey (the 2006 survey) to apply an occupational mix adjustment to the FY 2008 wage index. In the proposed 2006 survey, we included several modifications based on the comments and recommendations we received on the 2003 survey, including (1) allowing hospitals to report their own average hourly wage rather than using BLS data; (2) extending the prospective survey period; and (3) reducing the number of occupational categories but refining the subcategories for registered nurses.

We made the changes to the occupational categories in response to MedPAC comments to the FY 2005 IPPS final rule (69 FR 49036). Specifically, MedPAC recommended that CMS assess whether including subcategories of registered nurses would result in a more accurate occupational mix adjustment. MedPAC believed that including all registered nurses in a single category may obscure significant wage differences among the subcategories of registered nurses, for example, the wages of surgical registered nurses and floor registered nurses may differ. Also, to offset additional reporting burden for hospitals, MedPAC recommended that CMS should combine the general service categories that account for only a small percentage of a hospital's total hours with the ''all other occupations'' category because most of the occupational mix adjustment is correlated with the nursing general service category.

In addition, in response to the public comments on the October 14, 2005 notice, we modified the 2006 survey. On February 10, 2006, we published a **Federal Register** notice (71 FR 7047) that solicited comments and announced our intent to seek OMB approval on the revised occupational mix survey (Form CMS–10079 (2006)). OMB approved the survey on April 25, 2006.

The 2006 survey 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 beginning and ending dates to accommodate some hospitals' biweekly payroll and reporting systems. That is, the 6-month reporting period had to begin on or after December 25, 2005, and end before July 9, 2006.

We are proposing to use the entire 6-month 2006 survey data to calculate the occupational mix adjustment for the FY 2009 wage index. The original timelines for the collection, review, and correction of the 2006 occupational mix data were discussed in detail in the FY 2007 IPPS final rule (71 FR 48008). The revision and correction process for all of the data, including the 2006 occupational mix survey data to be used for computing the FY 2009 wage index, is discussed in detail in section III.K. of the preamble of this proposed rule.

2. Calculation of the Proposed Occupational Mix Adjustment for FY 2009

For FY 2009 (as we did for FY 2008), we are proposing to calculate the occupational mix adjustment factor using the following steps:

Step 1—For each hospital, determine the percentage of the total nursing category attributable to a nursing subcategory by dividing the nursing subcategory hours by the total nursing category's hours (registered nurse management personnel and registered nurse staff nurses or clinicians are treated as separate nursing subcategories). Repeat this computation for each of the five nursing subcategories: registered nurse management personnel; registered nurse staff nurses or clinicians; licensed practical nurses; nursing aides, orderlies, and attendants; and medical assistants.

Step 2—Determine a national average hourly rate for each nursing subcategory by dividing a subcategory's total salaries for all hospitals in the occupational mix survey database by the subcategory's total hours for all hospitals in the occupational mix survey database.

Step 3—For each hospital, determine an adjusted average hourly rate for each nursing subcategory by multiplying the percentage of the total nursing category (from Step 1) by the national average hourly rate for that nursing subcategory (from Step 2). Repeat this calculation for each of the five nursing subcategories.

Step 4—For each hospital, determine the adjusted average hourly rate for the total nursing category by summing the adjusted average hourly rate (from Step 3) for each of the nursing subcategories.

Step 5—Determine the national average hourly rate for the total nursing category by dividing total nursing category salaries for all hospitals in the occupational mix survey database by total nursing category hours for all hospitals in the occupational mix survey database.

Step 6—For each hospital, compute the occupational mix adjustment factor for the total nursing category by dividing the national average hourly rate for the total nursing category (from Step 5) by the hospital's adjusted average hourly rate for the total nursing category (from Step 4).

If the hospital's adjusted average hourly rate is less than the national average hourly rate (indicating the hospital employs a less costly mix of nursing employees), the occupational mix adjustment factor would be greater than 1.0000. If the hospital's adjusted average hourly rate is greater than the national average hourly rate, the occupational mix adjustment factor would be less than 1.0000.

Step 7—For each hospital, calculate the occupational mix adjusted salaries and wage-related costs for the total nursing category by multiplying the hospital's total salaries and wage-related costs (from Step 5 of the unadjusted wage index calculation in section III.G. of this preamble) by the percentage of the hospital's total workers attributable to the total nursing category (using the occupational mix survey data, this percentage is determined by dividing the hospital's total nursing category salaries by the hospital's total salaries for ''nursing and all other'') and by the total nursing category's occupational mix adjustment factor (from Step 6 above).

The remaining portion of the hospital's total salaries and wage-related costs that is attributable to all other employees of the hospital is not adjusted by the occupational mix. A hospital's all other portion is determined by subtracting the hospital's nursing category percentage from 100 percent.

Step 8—For each hospital, calculate the total occupational mix adjusted salaries and wage-related costs for a hospital by summing the occupational mix adjusted salaries and wage-related costs for the total nursing category (from Step 7) and the portion of the hospital's salaries and wage-related costs for all other employees (from Step 7).

To compute a hospital's occupational mix adjusted average hourly wage, divide the hospital's total occupational mix adjusted salaries and wage-related costs by the hospital's total hours (from Step 4 of the unadjusted wage index calculation in section III.G. of this preamble).

Step 9—To compute the occupational mix adjusted average hourly wage for an urban or rural area, sum the total occupational mix adjusted salaries and wage-related costs for all hospitals in the area, then sum the total hours for all hospitals in the area. Next, divide the area's occupational mix adjusted salaries and wage-related costs by the area's hours.

Step 10—To compute the national occupational mix adjusted average hourly wage, sum the total occupational mix adjusted salaries and wage-related costs for all hospitals in the Nation, then sum the total hours for all hospitals in the Nation. Next, divide the national occupational mix adjusted salaries and wage-related costs by the national hours. The proposed FY 2009 occupational mix adjusted national average hourly wage is $32.2252.

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 proposed FY 2009 occupational mix adjusted Puerto Rico specific average hourly wage is $13.7851.

The table below is an illustrative example of the proposed occupational mix adjustment.

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Example of Proposed Occupational Mix Adjustment

Hospital A								
			Step 1	Step 2	Step 3	Step 5	Step 6	in Step 7
	Provider Occupational Mix Hours	Provider Occupational Mix Salaries	Provider % by Subcategory	National AHWs by Subcategory	Provider Adjusted AHW	National Adjusted Nurse AHW	Nurse Occupa-tional Mix Adjust-ment Factor	Provider % by Total
RN Management	202,387.00	$780,640.00	**9.84%**	$50.00	**$4.92**			
RN Staff	1,439,742.00	$17,345,123.00	**70.00%**	$30.00	**$21.00**			
LPNs	67,860.00	$404,822.00	**3.30%**	$20.00	**$0.66**			
Nurse Aides	259,177.00	$1,762,579.00	**12.60%**	$13.00	**$1.64**			
Medical Assistants	87,622.00	$577,045.00	**4.26%**	$12.00	**$0.51**			
Total Nurse Hours and Salaries	2,056,788.00	$20,870,209.00			**$28.73**	**$27.00**	**0.9398**	**52.40%**
ALL OTHER	5,000,000.00	$18,957,010.00			Step 4			**47.60%**
TOTAL	**7,056,788.00**	**$39,827,219.00**						
Wage Data from Cost Report								
Wages (From S-3, Parts II and III)	$83,312,942.55							
Hours (From S-3, Parts II and III)	3,836,299.60							
Hospital A Unadjusted AHW	**$21.72**							
Nurse Occupational Mix Wages	**$41,030,019**	Step 7						
All Other Unadjusted Occupational Mix Wages	**$39,655,400**	Step 7						

Total Occupational Mix Wages	**$80,685,419**	Step 8						
Hospital A Final Occupational Mix Adjusted AHW	**$21.03**	Step 8						
Hospital B								
			Step 1	Step 2	Step 3	Step 5	Step 6	in Step 7
	Provider Occupational Mix Hours	**Provider Occupational Mix Salaries**	**Provider % by Subcategory**	**National AHWs by Subcategory**	**Provider Adjusted AHW**	**National Adjusted Nurse AHW**	**Nurse Occupa-tional Mix Adjustment Factor**	**Provider % by Total**
RN Management	70,333.00	$680,650.00	**3.01%**	$50.00	**$1.51**			
RN Staff	1,430,114.00	$17,245,113.00	**61.27%**	$30.00	**$18.38**			
LPNs	159,795.00	$304,832.00	**6.85%**	$20.00	**$1.37**			
Nurse Aides	391,201.00	$2,762,589.00	**16.76%**	$13.00	**$2.18**			
Medical Assistants	282,728.00	$677,035.00	**12.11%**	$12.00	**$1.45**			
Total Nurse Hours and Salaries	2,334,171.00	$21,670,219.00			**$24.89**	**$27.00**	**1.0848**	**53.34%**
ALL OTHER	5,000,000.00	$18,957,010.00			Step 4			**46.66%**
TOTAL	**7,334,171.00**	**$40,627,229.00**						
Wage Data from Cost Report								
Wages (From S-3, Parts II and III)	$25,979,714							
Hours (From S-3, Parts II and III)	1,097,585							
Hospital B Unadjusted AHW	**$23.67**							
Nurse Occupational Mix Wages	**$15,032,916**	Step 7						
All Other Unadjusted Occupational Mix Wages	**$12,122,355**	Step 7						
Total Occupational Mix Wages	**$27,155,271**	Step 8						
Hospital B Final Occupational Mix Adjusted AHW	**$24.74**	Step 8						
Note: The numbers in this example are hypothetical, including all National AHW amounts.								

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Because the occupational mix adjustment is required by statute, all hospitals that are subject to payments under the IPPS, or any hospital that would be subject to the IPPS if not granted a waiver, must complete the occupational mix survey, unless the hospital has no associated cost report wage data that are included in the proposed FY 2009 wage index.

For the FY 2008 wage index, if a hospital did not respond to the occupational mix survey, or if we determined that a hospital's submitted data were too erroneous to include in the wage index, we assigned the hospital the average occupational mix adjustment for the labor market area (72 FR 47314). We believed this method had the least impact on the wage index for other hospitals in the area. For areas where no hospital submitted data for purposes of calculating the occupational mix adjustment, we applied the national occupational mix factor of 1.0000 in calculating the area's FY 2008 occupational mix adjusted wage index. We indicated in the FY 2008 IPPS final rule that we reserve the right to apply a different approach in future years, including potentially penalizing nonresponsive hospitals (72 FR 47314).

For the FY 2009 wage index, we are proposing to handle the data for hospitals that did not respond to the occupational mix survey (neither the 1st quarter nor 2nd quarter data) in the same manner as discussed above for the FY 2008 wage index. In addition, if a hospital submits survey data for either the 1st quarter or 2nd quarter, but not for both quarters, we are proposing to use the data the hospital submitted for one quarter to calculate the hospital's proposed FY 2009 occupational mix adjustment factor. Lastly, if a hospital submits a survey(s), but that survey data can not be used because we determine it to be aberrant, we will also assign the hospital the average occupational mix adjustment for its labor market area. For example, if a hospital's individual nurse category average hourly wages are out of range (that is, unusually high or low), and the hospital does not provide sufficient documentation to explain the aberrancy, or the hospital does not submit any registered nurse staff salaries or hours data, we will assign 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 0.8968 (CBSA 39820, Redding, CA), to a high of 1.0775 (CBSA 43300, Sherman-Denison, TX). Also, in computing a hospital's occupational mix adjusted salaries and wage-related costs for nursing employees (Step 7 of the calculation), in the absence of occupational mix survey data, we multiplied the hospital's total salaries and wage-related costs by the percentage of the *area's* total workers attributable to the *area's* total nursing category. For FY 2009, there was one CBSA for which we did not have occupational mix data for any of its providers (CBSA 12020, Athens-Clark County, GA). 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 data. In response to the FY 2008 IPPS proposed rule, some commenters suggested a 1-percent to 2-percent reduction in the hospital's wage index value or a set percentage of the standardized amount. We noted that any penalty that we would determine for nonresponsive hospitals would apply to a future wage index, not the FY 2008 wage index.

In the FY 2008 final rule with comment period, we assigned nonresponsive hospitals the average occupational mix adjustment for the labor market area. For areas where no hospital submitted survey data, we applied the national occupational mix adjustment factor of 1.0000 in calculating the area's FY 2008 occupational mix adjusted wage index. We appreciate the suggestions we received regarding future penalties for hospitals that do not submit occupational mix survey data. We stated in the FY 2008 final rule with comment period that we may consider proposing a policy to penalize hospitals that do not submit occupational mix survey data for FY 2010, the first year of the application of the new 2007–2008 occupational mix survey, and that we expected that any such penalty would be proposed in the FY 2009 IPPS proposed rule so hospitals would be aware of the policy before the deadline for submitting the data to the fiscal intermediaries/MAC. At this time, however, we are not proposing a penalty for FY 2010. Rather, we are reserving the right to propose a penalty in the FY 2010 IPPS proposed rule, once we collect and analyze the FY 2007–2008 occupational mix survey data. Hospitals are still on notice that any failure to submit occupational mix data for the FY 2007–2008 survey year may result in a penalty in FY 2010, thus achieving our policy goal of ensuring that hospitals are aware of the consequences of failure to submit data in response to the most recent survey.

3. 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 data collected on the 2006 survey to compute the proposed occupational mix adjustment for FY 2009. In the FY 2008 IPPS final rule with comment period (72 FR 47315), we discussed how we modified the occupational mix survey. The revised 2007–2008 occupational mix survey provides for the collection of hospital-specific wages and hours data for the 1-year period of July 1, 2007, through June 30, 2008, additional clarifications to the survey instructions, the elimination of the registered nurse subcategories, some refinements to the definitions of the occupational categories, and the inclusion of additional cost centers that typically provide nursing services. The revised 2007–2008 occupational mix survey will be applied beginning with the FY 2010 wage index.

On February 2, 2007, we published in the **Federal Register** a notice soliciting comments on the proposed revisions to the occupational mix survey (72 FR 5055). The comment period for the notice ended on April 3, 2007. After considering the comments we received, we made a few minor editorial changes

and published the final 2007–2008 occupational mix survey on September 14, 2007 (72 FR 52568). OMB approved the survey without change on February 1, 2008 (OMB Control Number 0938 0907). The 2007–2008 Medicare occupational mix survey (Form CMS–10079 (2008)) is available on the CMS Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp#TopOfPage*, and through the fiscal intermediaries/MAC. Hospitals must submit their completed surveys to their fiscal intermediaries/MAC by September 1, 2008. The preliminary, unaudited 2007–2008 occupational mix survey data will be released in early October 2008, along with the FY 2006 Worksheet S–3 wage data, for the FY 2010 wage index review and correction process.

E. Worksheet S–3 Wage Data for the Proposed FY 2009 Wage Index

The proposed FY 2009 wage index values (to be effective for hospital discharges occurring on or after October 1, 2008, and before October 1, 2009) in section II.B. of the Addendum to this proposed rule are based on the data collected from the Medicare cost reports submitted by hospitals for cost reporting periods beginning in FY 2005 (the FY 2008 wage index was based on FY 2004 wage data).

1. Included Categories of Costs

The proposed FY 2009 wage index includes the following categories of data associated with costs paid under the IPPS (as well as outpatient costs):

- Salaries and hours from short-term, acute care hospitals (including paid lunch hours and hours associated with military leave and jury duty).
- Home office costs and hours.
- Certain contract labor costs and hours (which includes direct patient care, certain top management, pharmacy, laboratory, and nonteaching physician Part A services, and certain contract indirect patient care services (as discussed in the FY 2008 final rule with comment period (72 FR 47315).
- Wage-related costs, including pensions and other deferred compensation costs. We note that, on March 28, 2008, CMS published a technical clarification to the cost reporting instructions for pension and deferred compensation costs (sections 2140 through 2142.7 of the Provider Reimbursement Manual, Part I). These instructions are used for developing pension and deferred compensation costs for purposes of the wage index, as discussed in the instructions for Worksheet S–3, Part II, Lines 13 through 20 and in the FY 2006 final rule (70 FR 47369).

2. Excluded Categories of Costs

Consistent with the wage index methodology for FY 2008, the proposed wage index for FY 2009 also excludes the direct and overhead salaries and hours for services not subject to IPPS payment, such as SNF services, home health services, costs related to GME (teaching physicians and residents) and certified registered nurse anesthetists (CRNAs), and other subprovider components that are not paid under the IPPS. The proposed FY 2009 wage index also excludes the salaries, hours, and wage-related costs of hospital-based rural health clinics (RHCs), and Federally qualified health centers (FQHCs) because Medicare pays for these costs outside of the IPPS (68 FR 45395). In addition, salaries, hours, and wage-related costs of CAHs are excluded from the wage index, for the reasons explained in the FY 2004 IPPS final rule (68 FR 45397).

3. Use of Wage Index Data by Providers Other Than Acute Care Hospitals Under the IPPS

Data collected for the IPPS wage index are also currently used to calculate wage indices applicable to other providers, such as SNFs, home health agencies, and hospices. In addition, they are used for prospective payments to IRFs, IPFs, and LTCHs, and for hospital outpatient services. We note that, in the IPPS rules, we do not address comments pertaining to the wage indices for non-IPPS providers. Such comments should be made in response to separate proposed rules for those providers.

F. Verification of Worksheet S–3 Wage Data

The wage data for the proposed FY 2009 wage index were obtained from Worksheet S–3, Parts II and III of the FY 2005 Medicare cost reports. Instructions for completing Worksheet S–3, Parts II and III are in the Provider Reimbursement Manual (PRM), Part II, sections 3605.2 and 3605.3. The data file used to construct the proposed wage index includes FY 2005 data submitted to us as of February 29, 2008. As in past years, we performed an intensive review of the wage data, mostly through the use of edits designed to identify aberrant data.

We asked our fiscal intermediaries/MAC to revise or verify data elements that resulted in specific edit failures. For the proposed FY 2009 wage index, we identified and excluded 37 providers with data that was too aberrant to include in the proposed wage index, although if data elements for some of these providers are corrected, we intend to include some of these providers in the FY 2009 final wage index. We instructed fiscal intermediaries/MACs to complete their data verification of questionable data elements and to transmit any changes to the wage data no later than April 14, 2008. We believe all unresolved data elements will be resolved by the date the final rule is issued. The revised data will be reflected in the FY 2009 IPPS final rule.

In constructing the proposed FY 2009 wage index, we included the wage data for facilities that were IPPS hospitals in FY 2005; inclusive of those facilities that have since terminated their participation in the program as hospitals, as long as those data did not fail any of our edits for reasonableness. We believe that including the wage data for these hospitals is, in general, appropriate to reflect the economic conditions in the various labor market areas during the relevant past period and to ensure that the current wage index represents the labor market area's current wages as compared to the national average of wages. However, we excluded the wage data for CAHs as discussed in the FY 2004 IPPS final rule (68 FR 45397). For this proposed rule, we removed 20 hospitals that converted to CAH status between February 16, 2007, the cut-off date for CAH exclusion from the FY 2008 wage index, and February 18, 2008, the cut-off date for CAH exclusion from the FY 2009 wage index. After removing hospitals with aberrant data and hospitals that converted to CAH status, the proposed FY 2009 wage index is calculated based on 3,533 hospitals.

1. Wage Data for Multicampus Hospitals

In the FY 2008 final rule with comment period (72 FR 47317), we discussed our policy for allocating a multicampus hospital's wages and hours data, by full-time equivalent (FTE) staff, among the different labor market areas where its campuses are located. During the FY 2009 wage index desk review process, we requested fiscal intermediaries/MACs to contact multicampus hospitals that had campuses in different labor market areas to collect the data for the allocation. The proposed FY 2009 wage index in this proposed rule includes separate wage data for campuses of three multicampus hospitals.

As with the FY 2008 wage index, we allowed hospitals the option of allocating their wages and hours for the FY 2009 wage index based on either FTE staff or discharge data. Again, we

are providing this option until a revised cost report is available that will allow a multicampus hospital to report the number of FTEs by location of its different campuses. Two of the three multicampus hospitals chose to have their wage data allocated by their Medicare discharge data. One of the hospitals provided FTE staff data for the allocation. The average hourly wage associated with each geographical location of a multicampus hospital is reflected in Table 2 of the Addendum to this proposed rule.

2. New Orleans' Post-Katrina Wage Index

Since 2005 when Hurricane Katrina devastated the Gulf States, we have received numerous comments suggesting that current Medicare payments to hospitals in New Orleans, Louisiana are inadequate, and the wage index does not accurately reflect the increase in labor costs experienced by the city after the storm. The post-Katrina effects on the New Orleans wage index will not be realized in the wage index until FY 2010, when the wage index will be based on cost reporting periods beginning during FY 2006 (that is, beginning on or after October 1, 2005 and before October 1, 2006).

In responding to the health-related needs of people affected by the hurricane, the Federal Government, through the Deficit Reduction Act of 2005 (DRA), appropriated $2 billion in FY 2006. These funds allowed the Secretary to make available $160 million in February 2007 to Louisiana, Mississippi, and Alabama for payments to hospitals and skilled nursing facilities facing financial stress because of changing wage rates not yet reflected in Medicare payment methodologies. In March and May 2007, the Department provided two additional DRA grants of $15 million and $35 million, respectively, to Louisiana for professional health care workforce recruitment and sustainability in the greater New Orleans area, namely the Orleans, Jefferson, St. Bernard, and Plaquemines Parishes. In addition, the Department issued a supplemental award of $60 million in provider stabilization grant funding to Louisiana, Mississippi, and Alabama to continue to help health care providers meet changing wage rates not yet reflected by Medicare's payment policies. On July 23, 2007, HHS awarded to Louisiana a new $100 million Primary Care Grant to help increase access to primary care in the Greater New Orleans area. The resulting stabilization and expansion of the community based primary care infrastructure, post Katrina, helps provide a viable alternative to local hospital emergency rooms for all citizens of New Orleans, especially those who are poor and uninsured. In other Department efforts, the OIG has performed an in-depth review of the post-Katrina infrastructure of five New Orleans hospitals, including the hospitals' staffing levels and wage costs. The OIG's final reports and recommendations are scheduled to be published in Spring 2008.

G. Method for Computing the Proposed FY 2009 Unadjusted Wage Index

The method used to compute the proposed FY 2009 wage index without an occupational mix adjustment follows:

Step 1—As noted above, we based the proposed FY 2009 wage index on wage data reported on the FY 2005 Medicare cost reports. We gathered data from each of the non-Federal, short-term, acute care hospitals for which data were reported on the Worksheet S–3, Parts II and III of the Medicare cost report for the hospital's cost reporting period beginning on or after October 1, 2004, and before October 1, 2005. In addition, we included data from some hospitals that had cost reporting periods beginning before October 2004 and reported a cost reporting period covering all of FY 2004. These data are included because no other data from these hospitals would be available for the cost reporting period described above, and because particular labor market areas might be affected due to the omission of these hospitals. However, we generally describe these wage data as FY 2005 data. We note that, if a hospital had more than one cost reporting period beginning during FY 2005 (for example, a hospital had two short cost reporting periods beginning on or after October 1, 2004, and before October 1, 2005), we included wage data from only one of the cost reporting periods, the longer, in the wage index calculation. If there was more than one cost reporting period and the periods were equal in length, we included the wage data from the later period in the wage index calculation.

Step 2—Salaries—The method used to compute a hospital's average hourly wage excludes certain costs that are not paid under the IPPS. (We note that, beginning with FY 2008 (72 FR 47315), we include lines 22.01, 26.01, and 27.01 of Worksheet S–3, Part II for overhead services in the wage index. However, we note that the wages and hours on these lines are not incorporated into line 101, column 1 of Worksheet A, which, through the electronic cost reporting software, flows directly to line 1 of Worksheet S–3, Part II. Therefore, the first step in the wage index calculation for FY 2009 is to compute a ''revised'' Line 1, by adding to the Line 1 on Worksheet S–3, Part II (for wages and hours respectively) the amounts on Lines 22.01, 26.01, and 27.01.) In calculating a hospital's average salaries plus wage-related costs, we subtract from Line 1 (total salaries) the GME and CRNA costs reported on Lines 2, 4.01, 6, and 6.01, the Part B salaries reported on Lines 3, 5 and 5.01, home office salaries reported on Line 7, and exclude salaries reported on Lines 8 and 8.01 (that is, direct salaries attributable to SNF services, home health services, and other subprovider components not subject to the IPPS). We also subtract from Line 1 the salaries for which no hours were reported. To determine total salaries plus wage-related costs, we add to the net hospital salaries the costs of contract labor for direct patient care, certain top management, pharmacy, laboratory, and nonteaching physician Part A services (Lines 9 and 10), home office salaries and wage-related costs reported by the hospital on Lines 11 and 12, and nonexcluded area wage-related costs (Lines 13, 14, and 18).

We note that contract labor and home office salaries for which no corresponding hours are reported are not included. In addition, wage-related costs for nonteaching physician Part A employees (Line 18) are excluded if no corresponding salaries are reported for those employees on Line 4.

Step 3—Hours—With the exception of wage-related costs, for which there are no associated hours, we compute total hours using the same methods as described for salaries in Step 2.

Step 4—For each hospital reporting both total overhead salaries and total overhead hours greater than zero, we then allocate overhead costs to areas of the hospital excluded from the wage index calculation. First, we determine the ratio of excluded area hours (sum of Lines 8 and 8.01 of Worksheet S–3, Part II) to revised total hours (Line 1 minus the sum of Part II, Lines 2, 3, 4.01, 5, 5.01, 6, 6.01, 7, and Part III, Line 13 of Worksheet S–3). We then compute the amounts of overhead salaries and hours to be allocated to excluded areas by multiplying the above ratio by the total overhead salaries and hours reported on Line 13 of Worksheet S–3, Part III. Next, we compute the amounts of overhead wage-related costs to be allocated to excluded areas using three steps: (1) We determine the ratio of overhead hours (Part III, Line 13 minus the sum of lines 22.01, 26.01, and 27.01) to revised hours excluding the sum of lines 22.01, 26.01, and 27.01 (Line 1 minus the sum of

Lines 2, 3, 4.01, 5, 5.01, 6, 6.01, 7, 8, 8.01, 22.01, 26.01, and 27.01). (We note that for the FY 2008 and subsequent wage index calculations, we are excluding the sum of lines 22.01, 26.01, and 27.01 from the determination of the ratio of overhead hours to revised hours, 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 proposing to make any changes to the usage at this time. The factors used to adjust the hospital's data were based on the midpoint of the cost reporting period, as indicated below.

MIDPOINT OF COST REPORTING PERIOD

After	Before	Adjustment factor
10/14/2004	11/15/2004	1.05390
11/14/2004	12/15/2004	1.05035
12/14/2004	01/15/2005	1.04690
01/14/2005	02/15/2005	1.04342
02/14/2005	03/15/2005	1.03992
03/14/2005	04/15/2005	1.03641
04/14/2005	05/15/2005	1.03291
05/14/2005	06/15/2005	1.02940
06/14/2005	07/15/2005	1.02596
07/14/2005	08/15/2005	1.02264
08/14/2005	09/15/2005	1.01943
09/14/2005	10/15/2005	1.01627
10/14/2005	11/15/2005	1.01308
11/14/2005	12/15/2005	1.00987
12/14/2005	01/15/2006	1.00661
01/14/2006	02/15/2006	1.00333
02/14/2006	03/15/2006	1.00000
03/14/2006	04/15/2006	0.99670

For example, the midpoint of a cost reporting period beginning January 1, 2005, and ending December 31, 2005, is June 30, 2005. An adjustment factor of 1.02596 would be applied to the wages of a hospital with such a cost reporting period. In addition, for the data for any cost reporting period that began in FY 2005 and covered a period of less than 360 days or more than 370 days, we annualize the data to reflect a 1-year cost report. Dividing the data by the number of days in the cost report and then multiplying the results by 365 accomplishes annualization.

Step 6—Each hospital is assigned to its appropriate urban or rural labor market area before any reclassifications under section 1886(d)(8)(B), section 1886(d)(8)(E), or section 1886(d)(10) of the Act. Within each urban or rural labor market area, we add the total adjusted salaries plus wage-related costs obtained in Step 5 for all hospitals in that area to determine the total adjusted salaries plus wage-related costs for the labor market area.

Step 7—We divide the total adjusted salaries plus wage-related costs obtained under both methods in Step 6 by the sum of the corresponding total hours (from Step 4) for all hospitals in each labor market area to determine an average hourly wage for the area.

Step 8—We add the total adjusted salaries plus wage-related costs obtained in Step5 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 proposed national average hourly wage (unadjusted for occupational mix) is $32.2489.

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 proposed average hourly wage (unadjusted for occupational mix) of $13.7956 for Puerto Rico. For each labor market area in Puerto Rico, we calculate the Puerto Rico-specific wage index value by dividing the area average hourly wage (as calculated in Step 7) by the overall Puerto Rico average hourly wage.

Step 11—Section 4410 of 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 2009, this proposed change would affect 266 hospitals in 69 urban areas. The areas affected by this provision are identified by a footnote in Table 4A in the Addendum of this proposed rule.

In the FY 2005 IPPS final rule (69 FR 49109), we adopted the ''imputed'' floor as a temporary 3-year measure to address a concern by some individuals that hospitals in all-urban States were disadvantaged by the absence of rural hospitals to set a wage index floor in those States. The imputed floor was originally set to expire in FY 2007, but we extended it an additional year in the FY 2008 IPPS final rule with comment period (72FR47321). As explained in section III.B.2.b. of the preamble of this proposed rule, we are proposing to extend the imputed floor for an additional 3 years, through FY 2011.

H. Analysis and Implementation of the Proposed Occupational Mix Adjustment and the Proposed FY 2009 Occupational Mix Adjusted Wage Index

As discussed in section III.D. of this preamble, for FY 2009, we are proposing to apply the occupational mix adjustment to 100 percent of the FY

2009 wage index. We calculated the occupational mix adjustment using data from the 2006 occupational mix survey data, using the methodology described in section III.D.3. of this preamble.

Using the 1st and 2nd quarter occupational mix survey data and applying the occupational mix adjustment to 100 percent of the proposed FY2009 wage index results in a proposed national average hourly wage of $32.2252 and a proposed Puerto-Rico specific average hourly wage of $13.7851. After excluding data of hospitals that either submitted aberrant data that failed critical edits, or that do not have FY 2005 Worksheet S–3 cost report data for use in calculating the proposed FY2009 wage index, we calculated the proposed FY 2009 wage index using the occupational mix survey data from 3,364 hospitals. Using the Worksheet S–3 cost report data of 3,533 hospitals and occupational mix 1st and/or 2nd quarter survey data from 3,364 hospitals represents a 95.2 percent survey response rate. The proposed FY2009 national average hourly wages for each occupational mix nursing subcategory as calculated in Step 2 of the occupational mix calculation are as follows:

Occupational mix nursing subcategory	Average hourly wage
National RN Management	$38.6341
National RN Staff	$33.4795
National LPN	$19.2316
National Nurse Aides, Orderlies, and Attendants	$13.6954
National Medical Assistants	$15.7714
National Nurse Category	$28.7291

The proposed national average hourly wage for the entire nurse category as computed in Step 5 of the occupational mix calculation is $28.7291. 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 proposed national percentage of hospital employees in the Nurse category is 42.99 percent, and the proposed national percentage of hospital employees in the All Other Occupations category is 57.01 percent. At the CBSA level, the percentage of hospital employees in the Nurse category ranged from a low of 27.26 percent in one CBSA, to a high of 85.30 percent in another CBSA.

The proposed wage index values for FY 2009 (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 proposed rule.

Tables 3A and 3B in the Addendum to this proposed rule list the 3-year average hourly wage for each labor market area before the redesignation of hospitals based on FYs 2007, 2008, and 2009 cost reporting periods. Table 3A lists these data for urban areas and Table 3B lists these data for rural areas. In addition, Table 2 in the Addendum to this proposed rule includes the adjusted average hourly wage for each hospital from the FY 2003 and FY 2004 cost reporting periods, as well as the FY 2005 period used to calculate the proposed FY 2009 wage index. The 3-year averages are calculated by dividing the sum of the dollars (adjusted to a common reporting period using the method described previously) across all 3 years, by the sum of the hours. If a hospital is missing data for any of the previous years, its average hourly wage for the 3-year period is calculated based on the data available during that period.

The proposed 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 proposed rule include the proposed occupational mix adjustment. The proposed wage index values in Tables 2, 4A, 4B, and 4C also include the proposed State-specific rural floor and imputed floor budget neutrality adjustments that are discussed in section III.B.2. of this preamble. The proposed State budget neutrality adjustments for the rural and imputed floors are included in Tables 4D–1 and 4D–2 in the Addendum to this proposed rule.

I. Proposed Revisions to the Wage Index Based on Hospital Redesignations

1. General

Under section 1886(d)(10) of the Act, the MGCRB considers applications by hospitals for geographic reclassification for purposes of payment under the IPPS. Hospitals must apply to the MGCRB to reclassify 13 months prior to the start of the fiscal year for which reclassification is sought (generally by September 1). Generally, hospitals must be proximate to the labor market area to which they are seeking reclassification and must demonstrate characteristics similar to hospitals located in that area. The MGCRB issues its decisions by the end of February for reclassifications that become effective for the following fiscal year (beginning October 1). The regulations applicable to reclassifications by the MGCRB are located in 42 CFR 412.230 through 412.280.

Section 1886(d)(10)(D)(v) of the Act provides that, beginning with FY 2001, a MGCRB decision on a hospital reclassification for purposes of the wage index is effective for 3 fiscal years, unless the hospital elects to terminate the reclassification. Section 1886(d)(10)(D)(vi) of the Act provides that the MGCRB must use average hourly wage data from the 3 most recently published hospital wage surveys in evaluating a hospital's reclassification application for FY 2003 and any succeeding fiscal year.

Section 304(b) of 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 42 CFR 412.235.

Section 1886(d)(8)(B) of the Act requires the Secretary to treat a hospital located in a rural county adjacent to one or more urban areas as being located in the MSA to which the greatest number of workers in the county commute, if the rural county would otherwise be considered part of an urban area under the standards for designating MSAs and if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or counties of *all* contiguous MSAs. In light of the CBSA definitions and the Census 2000 data that we implemented for FY 2005 (69 FR 49027), we undertook to identify those counties meeting these criteria. Eligible counties are discussed and identified under section III.I.5. of this preamble.

2. Effects of Reclassification/Redesignation

Section 1886(d)(8)(C) of the Act provides that the application of the wage index to redesignated hospitals is dependent on the hypothetical impact that the wage data from these hospitals would have on the wage index value for the area to which they have been redesignated. These requirements for determining the wage index values for

redesignated hospitals are applicable both to the hospitals deemed urban under section 1886(d)(8)(B) of the Act and hospitals that were reclassified as a result of the MGCRB decisions under section 1886(d)(10) of the Act. Therefore, as provided in section 1886(d)(8)(C) of the Act, the wage index values were determined by considering the following:

- If including the wage data for the redesignated hospitals would reduce the wage index value for the area to which the hospitals are redesignated by 1 percentage point or less, the area wage index value determined exclusive of the wage data for the redesignated hospitals applies to the redesignated hospitals.
- If including the wage data for the redesignated hospitals reduces the wage index value for the area to which the hospitals are redesignated by more than 1 percentage point, the area wage index determined inclusive of the wage data for the redesignated hospitals (the combined wage index value) applies to the redesignated hospitals.
- If including the wage data for the redesignated hospitals increases the wage index value for the urban area to which the hospitals are redesignated, both the area and the redesignated hospitals receive the combined wage index value. Otherwise, the hospitals located in the urban area receive a wage index excluding the wage data of hospitals redesignated into the area.

Rural areas whose wage index values would be reduced by excluding the wage data for hospitals that have been redesignated to another area continue to have their wage index values calculated as if no redesignation had occurred (otherwise, redesignated rural hospitals are excluded from the calculation of the rural wage index). The wage index value for a redesignated rural hospital cannot be reduced below the wage index value for the rural areas of the State in which the hospital is located.

CMS has also adopted the following policies:

- The wage data for a reclassified urban hospital is included in both the wage index calculation of the area to which the hospital is reclassified (subject to the rules described above) and the wage index calculation of the urban area where the hospital is physically located.
- In cases where urban hospitals have reclassified to rural areas under 42 CFR 412.103, the urban hospital wage data are: (a) Included in the rural wage index calculation, unless doing so would reduce the rural wage index; and (b) included in the urban area where the hospital is physically located.

3. FY 2009 MGCRB Reclassifications

Under section 1886(d)(10) of the Act, the MGCRB considers applications by hospitals for geographic reclassification for purposes of payment under the IPPS. The specific procedures and rules that apply to the geographic reclassification process are outlined in 42 CFR 412.230 through 412.280.

At the time this proposed rule was constructed, the MGCRB had completed its review of FY 2009 reclassification requests. There were 314 hospitals approved for wage index reclassifications by the MGCRB for FY 2009. Because MGCRB wage index reclassifications are effective for 3 years, hospitals reclassified during FY 2007 or FY 2008 are eligible to continue to be reclassified based on prior reclassifications to current MSAs during FY 2009. There were 175 hospitals approved for wage index reclassifications in FY 2007 and 324 hospitals approved for wage index reclassifications in FY 2008. Of all of the hospitals approved for reclassification for FY 2007, FY 2008, and FY 2009, 813 hospitals are in a reclassification status for FY 2009.

Under 42 CFR 412.273, hospitals that have been reclassified by the MGCRB are permitted to withdraw their applications within 45 days of the publication of a 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 2009 must be received by the MGCRB within 45 days of the publication of this proposed rule. If a hospital elects to withdraw its wage index application after the MGCRB has issued its decision, but within 45 days of publication of this proposed rule date, it may 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 (42 CFR 412.273(b)(2)(i)). The request to cancel a prior withdrawal or termination must be in writing to the MGCRB no later than the deadline for submitting reclassification applications for the following fiscal year (42 CFR 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 42 CFR 412.273, as well as the August 1, 2002 IPPS final rule (67 FR 50065), and the August 1, 2001 IPPS final rule (66 FR 39887).

Changes to the wage index that result from withdrawals of requests for reclassification, wage index corrections, appeals, and the Administrator's review process will be incorporated into the wage index values published in the FY 2009 final rule. These changes may 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 be affected.

Applications for FY 2010 reclassifications are due to the MGCRB by September 2, 2008 (the first working day of September 2008). We note that this is also the deadline for canceling a previous wage index reclassification withdrawal or termination under 42 CFR 412.273(d). Applications and other information about MGCRB reclassifications may be obtained, beginning in mid-July 2008, via the CMS Internet Web site at: *http://cms.hhs.gov/providers/prrb/mgcinfo.asp,* or by calling the MGCRB at (410) 786-1174. The mailing address of the MGCRB is: 2520 Lord Baltimore Drive, Suite L, Baltimore, MD 21244–2670.

4. FY 2008 Policy Clarifications and Revisions

We note below several policies related to geographic reclassification that were clarified or revised in the FY 2008 IPPS final rule with comment period (72 FR 47333):

- *Reinstating Reclassifications*—As provided for in 42 CFR 412.273(b)(2), once a hospital (or hospital group) accepts a newly approved reclassification, any previous reclassification is permanently terminated.
- *Geographic Reclassification for Multicampus Hospitals*—Because campuses of a multicampus hospital can now have their wages and hours data allocated by FTEs or discharge data, a hospital campus located in a geographic area distinct from the geographic area associated with the provider number of the multicampus hospital will have official wage data to supplement an individual or group reclassification application (§ 412.230(d)(2)(v)).
- *New England Deemed Counties*—Hospitals in New England deemed counties are treated the same as Lugar hospitals in calculating the wage index. That is, the area is considered rural, but the hospitals within the area are deemed to be urban (§ 412.64(b)(3)(ii)).
- *''Fallback'' Reclassifications*—A hospital will automatically be given its most recently approved reclassification

(thereby permanently terminating any previously approved reclassifications) unless it provides written notice to the MGCRB within 45 days of publication of the notice of proposed rulemaking that it wishes to withdraw its most recently approved reclassification and ''fall back'' to either its prior reclassification or its home area wage index for the following fiscal year.

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

Section 1886(d)(8)(B) of the Act requires us to treat a hospital located in a rural county adjacent to one or more urban areas as being located in the MSA if certain criteria are met. Effective beginning FY 2005, we use OMB's 2000 CBSA standards and the Census 2000 data to identify counties in which hospitals qualify under section 1886(d)(8)(B) of the Act to receive the wage index of the urban area. Hospitals located in these counties have been known as ''Lugar'' hospitals and the counties themselves are often referred to as ''Lugar'' counties. We provide the proposed FY 2009 chart below with the listing of the rural counties containing the hospitals designated as urban under section 1886(d)(8)(B) of the Act. For discharges occurring on or after October 1, 2008, hospitals located in the rural county in the first column of this chart will be redesignated for purposes of using the wage index of the urban area listed in the second column.

RURAL COUNTIES CONTAINING HOSPITALS REDESIGNATED AS URBAN UNDER SECTION 1886(D)(8)(B) OF THE ACT

[Based on CBSAs and Census 2000 Data]

Rural county	CBSA
Cherokee, AL	Rome, GA
Macon, AL	Auburn-Opelika, AL
Talladega, AL	Anniston-Oxford, AL
Hot Springs, AR	Hot Springs, AR
Windham, CT	Hartford-West Hartford-East Hartford, CT
Bradford, FL	Gainesville, FL
Hendry, FL	West Palm Beach-Boca Raton-Boynton, FL
Levy, FL	Gainesville, FL
Walton, FL	Fort Walton Beach-Crestview-Destin, FL
Banks, GA	Gainesville, GA
Chattooga, GA	Chattanooga, TN-GA
Jackson, GA	Atlanta-Sandy Springs-Marietta, GA
Lumpkin, GA	Atlanta-Sandy Springs-Marietta, GA
Morgan, GA	Atlanta-Sandy Springs-Marietta, GA
Peach, GA	Macon, GA
Polk, GA	Atlanta-Sandy Springs-Marietta, GA
Talbot, GA	Columbus, GA-AL
Bingham, ID	Idaho Falls, ID
Christian, IL	Springfield, IL
DeWitt, IL	Bloomington-Normal, IL
Iroquois, IL	Kankakee-Bradley, IL
Logan, IL	Springfield, IL
Mason, IL	Peoria, IL
Ogle, IL	Rockford, IL
Clinton, IN	Lafayette, IN
Henry, IN	Indianapolis-Carmel, IN
Spencer, IN	Evansville, IN-KY
Starke, IN	Gary, IN
Warren, IN	Lafayette, IN
Boone, IA	Ames, IA
Buchanan, IA	Waterloo-Cedar Falls, IA
Cedar, IA	Iowa City, IA
Allen, KY	Bowling Green, KY
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 COUNTIES CONTAINING HOSPITALS REDESIGNATED AS URBAN UNDER SECTION 1886(D)(8)(B) OF THE ACT—Continued

[Based on CBSAs and Census 2000 Data]

Rural county	CBSA
Greene, NY	Albany-Schenectady-Troy, NY
Schuyler, NY	Ithaca, NY
Sullivan, NY	Poughkeepsie-Newburgh-Middletown, NY
Wyoming, NY	Buffalo-Niagara Falls, NY
Ashtabula, OH	Cleveland-Elyria-Mentor, OH
Champaign, OH	Springfield, OH
Columbiana, OH	Youngstown-Warren-Boardman, OH-PA
Cotton, OK	Lawton, OK
Linn, OR	Corvallis, OR
Adams, PA	York-Hanover, PA
Clinton, PA	Williamsport, PA
Greene, PA	Pittsburgh, PA
Monroe, PA	Allentown-Bethlehem-Easton, PA-NJ
Schuylkill, PA	Reading, PA
Susquehanna, PA	Binghamton, NY
Clarendon, SC	Sumter, SC
Lee, SC	Sumter, SC
Oconee, SC	Greenville, SC
Union, SC	Spartanburg, SC
Meigs, TN	Cleveland, TN
Bosque, TX	Waco, TX
Falls, TX	Waco, TX
Fannin, TX	Dallas-Plano-Irving, TX
Grimes, TX	College Station-Bryan, TX
Harrison, TX	Longview, TX
Henderson, TX	Dallas-Plano-Irving, TX
Milam, TX	Austin-Round Rock, TX
Van Zandt, TX	Dallas-Plano-Irving, TX
Willacy, TX	Brownsville-Harlingen, TX
Buckingham, VA	Charlottesville, VA
Floyd, VA	Blacksburg-Christiansburg-Radford, VA
Middlesex, VA	Virginia Beach-Norfolk-Newport News, VA
Page, VA	Harrisonburg, VA
Shenandoah, VA	Winchester, VA-WV
Island, WA	Seattle-Bellevue-Everett, WA
Mason, WA	Olympia, WA
Wahkiakum, WA	Longview, WA
Jackson, WV	Charleston, WV
Roane, WV	Charleston, WV
Green, WI	Madison, WI
Green Lake, WI	Fond du Lac, WI
Jefferson, WI	Milwaukee-Waukesha-West Allis, WI
Walworth, WI	Milwaukee-Waukesha-West Allis, WI

As in the past, hospitals redesignated under section 1886(d)(8)(B) of the Act are also eligible to be reclassified to a different area by the MGCRB. Affected hospitals are permitted to compare the reclassified wage index for the labor market area in Table 4C in the Addendum to this proposed rule into which they have been reclassified by the MGCRB to the wage index for the area to which they are redesignated under section 1886(d)(8)(B) of the Act. Hospitals may withdraw from an MCGRB reclassification within 45 days of the publication of this proposed rule.

6. Reclassifications Under Section 1886(d)(8)(B) of the Act

As discussed in last year's FY 2008 IPPS final rule with comment period (72 FR 47336–47337), Lugar hospitals are treated like reclassified hospitals for purposes of determining their applicable wage index and receive the reclassified wage index (Table 4C in the Addendum to this proposed rule) for the urban area to which they have been redesignated. Because Lugar hospitals are treated like reclassified hospitals, when they are seeking reclassification by the MCGRB, they are subject to the rural reclassification rules set forth at 42 CFR 412.230. The procedural rules set forth at § 412.230 list the criteria that a hospital must meet in order to reclassify as a rural hospital. Lugar hospitals are subject to the proximity criteria and payment thresholds that apply to rural hospitals. Specifically, the hospital must be no more than 35 miles from the area to which it seeks reclassification (§ 412.230(b)(1)); and the hospital must show that its average hourly wage is at least 106 percent of the average hourly wage of all other hospitals in the area in which the hospital is located (§ 412.230(d)(1)(iii)(C)). Under current rules, the hospital must also 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)). However, we are proposing to increase this threshold to 86 percent (as discussed in section III.B.2.a. of this preamble).

Hospitals not located in a Lugar County seeking reclassification to the urban area where the Lugar hospitals have been redesignated are not permitted to measure to the Lugar County to demonstrate proximity (no more than 15 miles for an urban

hospital, and no more than 35 miles for a rural hospital or the closest urban or rural area for RRCs or SCHs) in order to be reclassified to such urban area. These hospitals must measure to the urban area exclusive of the Lugar County to meet the proximity or nearest urban or rural area requirement. As discussed in the FY 2008 final rule with comment period, we treat New England deemed counties in a manner consistent with how we treat Lugar counties. (We refer readers to 72 FR 47337 for a discussion of this policy.)

J. Proposed FY 2009 Wage Index Adjustment Based on Commuting Patterns of Hospital Employees

In accordance with the broad discretion under section 1886(d)(13) of the Act, as added by section 505 of 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 ''out-migration'' adjustment). The process, outlined in the FY 2005 IPPS final rule (69 FR 49061), provides for an increase in the wage index for hospitals located in certain counties that have a relatively high percentage of hospital employees who reside in the county but work in a different county (or counties) with a higher wage index. Such adjustments to the wage index are effective for 3 years, unless a hospital requests to waive the application of the adjustment. A county will not lose its status as a qualifying county due to wage index changes during the 3-year period, and counties will receive the same wage index increase for those three years. However, a county that qualifies in any given year may no longer qualify after the 3-year period, or it may qualify but receive a different adjustment to the wage index level. Hospitals that receive this adjustment to their wage index are not eligible for reclassification under section 1886(d)(8) or section 1886(d)(10) of the Act. Adjustments under this provision are not subject to the budget neutrality requirements under section 1886(d)(3)(E) of the Act.

Hospitals located in counties that qualify for the wage index adjustment are to receive an increase in the wage index that is equal to the average of the differences between the wage indices of the labor market area(s) with higher wage indices and the wage index of the resident county, weighted by the overall percentage of hospital workers residing in the qualifying county who are employed in any labor market area with a higher wage index. Beginning with the FY 2008 wage index, we use post-reclassified wage indices when determining the out-migration adjustment (72 FR 47339).

For the proposed FY 2009 wage index, we calculated the out-migration adjustment using the same formula described in the FY 2005 IPPS final rule (69 FR 49064), with the addition of using the post-reclassified wage indices, to calculate the out-migration adjustment. This adjustment is calculated as follows:

Step 1. Subtract the wage index for the qualifying county from the wage index of each of the higher wage area(s) to which hospital workers commute.

Step 2. Divide the number of hospital employees residing in the qualifying county who are employed in such higher wage index area by the total number of hospital employees residing in the qualifying county who are employed in any higher wage index area. For each of the higher wage index areas, multiply this result by the result obtained in Step 1.

Step 3. Sum the products resulting from Step 2 (if the qualifying county has workers commuting to more than one higher wage index area).

Step 4. Multiply the result from Step 3 by the percentage of hospital employees who are residing in the qualifying county and who are employed in any higher wage index area.

These adjustments will be effective for each county for a period of 3 fiscal years. For example, hospitals that received the adjustment for the first time in FY 2008 will be eligible to retain the adjustment for FY 2009. For hospitals in newly qualified counties, adjustments to the wage index are effective for 3 years, beginning with discharges occurring on or after October 1, 2008.

Hospitals receiving the wage index adjustment under section 1886(d)(13)(F) of the Act are not eligible for reclassification under sections 1886(d)(8) or (d)(10) of the Act unless they waive the out-migration adjustment. Consistent with our FY 2005, 2006, 2007, and 2008 IPPS final rules, we are proposing 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, should follow the termination/withdrawal procedures specified in 42 CFR 412.273 and section III.I.3. of the preamble of this proposed rule. Otherwise, they will be deemed to have waived the out-migration adjustment. Hospitals redesignated under section 1886(d)(8) of the Act will be deemed to have waived the out-migration adjustment, unless they explicitly notify CMS within 45 days from the publication of this proposed rule that they elect to receive the out-migration adjustment instead. These notifications should be sent to the following address: Centers for Medicare and Medicaid Services, Center for Medicare Management, Attention: Wage Index Adjustment Waivers, Division of Acute Care, Room C4–08–06, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Table 4J in the Addendum to this proposed rule lists the proposed out-migration wage index adjustments for FY 2009. 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 would be deemed to have waived the out-migration adjustment unless CMS is otherwise notified. Hospitals that are eligible to receive the out-migration wage index adjustment and that withdraw their application for reclassification would automatically receive the wage index adjustment listed in Table 4J in the Addendum to this proposed rule.

K. Process for Requests for Wage Index Data Corrections

The preliminary, unaudited Worksheet S–3 wage data and occupational mix survey data files for the FY 2009 wage index were made available on October 5, 2007, through the Internet on the CMS Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp#TopOfPage.*

In the interest of meeting the data needs of the public, beginning with the proposed FY 2009 wage index, we posted an additional public use file on our Web site that reflects the actual data that are used in computing the proposed wage index. The release of this new file does not alter the current wage index process or schedule. We notified the hospital community of the availability of these data as we do with the current public use wage data files through our Hospital Open Door forum. We 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/.*

In a memorandum dated October 5, 2007, we instructed all fiscal

intermediaries/MACs to inform the IPPS hospitals they service of the availability of the wage index data files and the process and timeframe for requesting revisions (including the specific deadlines listed below). We also instructed the fiscal intermediaries/MACs to advise hospitals that these data were also made available directly through their representative hospital organizations.

If a hospital wished to request a change to its data as shown in the October 5, 2007 wage and occupational mix data files, the hospital was to submit corrections along with complete, detailed supporting documentation to its fiscal intermediary/MAC by December 7, 2007. Hospitals were notified of this deadline and of all other possible deadlines and requirements, including the requirement to review and verify their data as posted on the preliminary wage index data files on the Internet, through the October 5, 2007 memorandum referenced above.

In the October 5, 2007 memorandum, we also specified that a hospital requesting revisions to its 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/MAC no later than December 7, 2007.

The fiscal intermediaries (or, if applicable, the MACs) notified the hospitals by mid-February 2008 of any changes to the wage index data as a result of the desk reviews and the resolution of the hospitals' early-December revision requests. The fiscal intermediaries/MACs also submitted the revised data to CMS by mid-February 2008. CMS published the proposed wage index public use files that included hospitals' revised wage index data on February 25, 2008. In a memorandum also dated February 25, 2008, we instructed fiscal intermediaries/MACs to notify all hospitals regarding the availability of the proposed wage index public use files and the criteria and process for requesting corrections and revisions to the wage index data. Hospitals had until March 11, 2008 to submit requests to the fiscal intermediaries/MACs for reconsideration of adjustments made by the fiscal intermediaries/MACs as a result of the desk review, and to correct errors due to CMS's or the fiscal intermediary's (or, if applicable, the MAC's) mishandling of the wage index data. Hospitals were also required to submit sufficient documentation to support their requests.

After reviewing requested changes submitted by hospitals, fiscal intermediaries/MACs are to transmit any additional revisions resulting from the hospitals' reconsideration requests by April 14, 2008. The deadline for a hospital to request CMS intervention in cases where the hospital disagreed with the fiscal intermediary's (or, if applicable, the MAC's) policy interpretations is April 21, 2008.

Hospitals should also examine Table 2 in the Addendum to this proposed rule. Table 2 in the Addendum to this proposed rule contains each hospital's adjusted average hourly wage used to construct the wage index values for the past 3 years, including the FY 2005 data used to construct the proposed FY 2009 wage index. We note that the hospital average hourly wages shown in Table 2 only reflect changes made to a hospital's data and transmitted to CMS by February 29, 2008.

We will release the final wage index data public use files in early May 2008 on the Internet at *http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp#TopOfPage.* The May 2008 public use files will be 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/MACs by April 14, 2008). If, after reviewing the May 2008 final files, a hospital believes that its wage or occupational mix data are incorrect due to a fiscal intermediary or MAC or CMS error in the entry or tabulation of the final data, the hospital should send a letter to both its fiscal intermediary or MAC and CMS that outlines why the hospital believes an error exists and to provide all supporting information, including relevant dates (for example, when it first became aware of the error). CMS and the fiscal intermediaries (or, if applicable, the MACs) must receive these requests no later than June 9, 2008. Requests mailed to CMS should be sent to: Centers for Medicare & Medicaid Services, Center for Medicare Management, Attention: Wage Index Team, Division of Acute Care, C4–08–06, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Each request also must be sent to the fiscal intermediary or the MAC. The fiscal intermediary or the MAC will review requests upon receipt and contact CMS immediately to discuss its findings.

At this point in the process, that is, after the release of the May 2008 wage index data files, changes to the wage and occupational mix data will only be 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 will approve the following types of requests:

- Requests for wage index data corrections that were submitted too late to be included in the data transmitted to CMS by fiscal intermediaries or the MACs on or before April 21, 2008.
- Requests for correction of errors that were not, but could have been, identified during the hospital's review of the February 25, 2008 wage index public use files.
- Requests to revisit factual determinations or policy interpretations made by the fiscal intermediary or the MAC or CMS during the wage index data correction process.

Verified corrections to the wage index data received timely by CMS and the fiscal intermediaries or the MACs (that is, by June 9, 2008) will be incorporated into the final wage index in the FY 2009 IPPS final rule, which will be effective October 1, 2008.

We created the processes described above to resolve all substantive wage index data correction disputes before we finalize the wage and occupational mix data for the FY 2009 payment rates. Accordingly, hospitals that do 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 will have access to the final wage index data by early May 2008, they have the opportunity to detect any data entry or tabulation errors made by the fiscal intermediary or the MAC or CMS before the development and publication of the final FY 2009 wage index by August 1, 2008, and the implementation of the FY 2009 wage index on October 1, 2008. If hospitals availed themselves of the opportunities afforded to provide and make corrections to the wage and occupational mix data, the wage index implemented on October 1 should be accurate. Nevertheless, in the event that errors are identified by hospitals and brought to our attention after June 9, 2008, we retain the right to make midyear changes to the wage index under very limited circumstances.

Specifically, in accordance with 42 CFR 412.64(k)(1) of our existing regulations, we make midyear corrections to the wage index for an area only if a hospital can show that: (1) The fiscal intermediary or the MAC or CMS made an error in tabulating its data; and (2) the requesting hospital could not have known about the error or did not have an opportunity to correct the error, before the beginning of the fiscal year. For purposes of this provision, ''before the beginning of the fiscal year'' means by the June 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 42 CFR 412.64(k)(2) to specify that, effective on October 1, 2005, that is beginning with the FY 2006 wage index, a change to the wage index can be made retroactive to the beginning of the Federal fiscal year only when: (1) The fiscal intermediary (or, if applicable, the MAC) or CMS made an error in tabulating data used for the wage index calculation; (2) the hospital knew about the error and requested that the fiscal intermediary (or if applicable the MAC) and CMS correct the error using the established process and within the established schedule for requesting corrections to the wage index data, before the beginning of the fiscal year for the applicable IPPS update (that is, by the June 9, 2008 deadline for the FY 2009 wage index); and (3) CMS agreed that the fiscal intermediary (or if applicable, the MAC) or CMS made an error in tabulating the hospital's wage index data and the wage index should be corrected.

In those circumstances where a hospital requested a correction to its wage index data before CMS calculates the final wage index (that is, by the June 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.

L. Labor-Related Share for the Proposed Wage Index for FY 2009

Section 1886(d)(3)(E) of the Act directs the Secretary to adjust the proportion of the national prospective payment system base payment rates that are attributable to wages and wage-related costs by a factor that reflects the relative differences in labor costs among geographic areas. It also directs the Secretary to estimate from time to time the proportion of hospital costs that are labor-related: ''The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs of the DRG prospective payment rates * * *'' We refer to the portion of hospital costs attributable to wages and wage-related costs as the labor-related share. The labor-related share of the prospective payment rate is adjusted by an index of relative labor costs, which is referred to as the wage index.

Section 403 of 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 interpret this to mean that hospitals receive payment based on either a 62-percent labor-related share, or the labor-related share estimated from time to time by the Secretary, depending on which labor-related share resulted in a higher payment.

We have continued our research into the assumptions employed in calculating the labor-related share. Our research involves analyzing the compensation share separately for urban and rural hospitals, using regression analysis to determine the proportion of costs influenced by the area wage index, and exploring alternative methodologies to determine whether all or only a portion of professional fees and nonlabor intensive services should be considered labor-related.

In the FY 2006 IPPS final rule (70 FR 47392), we presented our analysis and conclusions regarding the methodology for updating the labor-related share for FY 2006. We also recalculated a labor-related share of 69.731 percent, using the FY 2002-based PPS market basket for discharges occurring on or after October 1, 2005. In addition, we implemented this revised and rebased labor-related share in a budget neutral manner, but consistent with section 1886(d)(3)(E) of the Act, we did not take into account the additional payments that would be made as a result of hospitals with a wage index less than or equal to 1.0 being paid using a labor-related share lower than the labor-related share of hospitals with a wage index greater than 1.0.

The labor-related share is used to determine the proportion of the national PPS base payment rate to which the area wage index is applied. In this proposed rule, we are not proposing to make 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 proposing to continue to use a labor-related share of 69.731

percent for discharges occurring on or after October 1, 2008. Tables 1A and 1B in the Addendum to this proposed rule reflect this proposed 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 proposing to continue to use a labor-related share for the Puerto Rico-specific standardized amounts of 58.7 percent for discharges occurring on or after October 1, 2008. Consistent with our methodology for determining the national labor-related share, we added the Puerto Rico-specific relative weights for wages and salaries, fringe benefits, contract labor, nonmedical professional fees, and other labor-intensive services to determine the labor-related share. Puerto Rico hospitals are paid based on 75 percent of the national standardized amounts and 25 percent of the Puerto Rico-specific standardized amounts. For Puerto Rico hospitals, the national labor-related share will always be 62 percent because the wage index for all Puerto Rico hospitals is less than 1.0. A Puerto Rico-specific wage index is applied to the Puerto Rico-specific portion of payments to the hospitals. The labor-related share of a hospital's Puerto Rico-specific rate will be either 62 percent or the Puerto Rico-specific labor-related share depending on which results in higher payments to the hospital. If the hospital has a Puerto Rico-specific wage index of greater than 1.0, we will set the hospital's rates using a labor-related share of 62 percent for the 25 percent portion of the hospital's payment determined by the Puerto Rico standardized amounts because this amount will result in higher payments. Conversely, a hospital with a Puerto Rico-specific wage index of less than 1.0 will be paid using the Puerto Rico-specific labor-related share of 58.7 percent of the Puerto Rico-specific rates because the lower labor-related share will result in higher payments. The proposed Puerto Rico labor-related share of 58.7 percent for FY 2008 is reflected in the Table 1C of the Addendum to this proposed rule.

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

A. Proposed Changes to the Postacute Care Transfer Policy (§ 412.4)

1. Background

Existing regulations at § 412.4(a) define discharges under the IPPS as situations in which a patient is formally released from an acute care hospital or dies in the hospital. Section 412.4(b) defines transfers from one acute care hospital to another. Section 412.4(c) establishes the conditions under which we consider a discharge to be a transfer for purposes of our postacute care transfer policy. In transfer situations, the transferring hospital is paid based on a per diem rate for each day of the stay, not to exceed the full MS–DRG payment that would have been made if the patient had been discharged without being transferred.

The per diem rate paid to a transferring hospital is calculated by dividing the full MS–DRG payment by the geometric mean length of stay for the MS–DRG. Based on an analysis that showed that the first day of hospitalization is the most expensive (60 FR 5804), our policy generally provides for payment that is double the per diem amount for the first day, with each subsequent day paid at the per diem amount up to the full DRG payment (§ 412.4(f)(1)). Transfer cases are also eligible for outlier payments. The outlier threshold for transfer cases is equal to the fixed-loss outlier threshold for nontransfer cases (adjusted for geographic variations in costs), divided by the geometric mean length of stay for the MS–DRG, multiplied by the length of stay for the case plus one day. The purpose of the IPPS postacute care transfer payment policy is to avoid providing an incentive for a hospital to transfer patients to another hospital, a SNF, or home under a written plan of care for home health services early in the patients'' stay in order to minimize costs while still receiving the full MS–DRG payment. The transfer policy adjusts the payments to approximate the reduced costs of transfer cases.

Beginning with the FY 2006 IPPS, the regulations at § 412.4 specified that, effective October 1, 2005, a DRG would be subject to the postacute care transfer policy if, based on Version 23.0 of the DRG Definitions Manual (FY 2006), using data from the March 2005 update of FY 2004 MedPAR file, the DRG meets the following criteria:

- The DRG had a geometric mean length of stay of at least 3 days;
- The DRG had at least 2,050 postacute care transfer cases; and
- At least 5.5 percent of the cases in the DRG were discharged to postacute care prior to the geometric mean length of stay for the DRG.

In addition, if the DRG was one of a paired set of DRGs based on the presence or absence of a CC or major cardiovascular condition (MCV), both paired DRGs would be included if either one met the three criteria above.

If a DRG met the above criteria based on the Version 23.0 DRG Definitions Manual and FY 2004 MedPAR data, we made the DRG subject to the postacute care transfer policy. We noted in the FY 2006 final rule that we would not revise the list of DRGs subject to the postacute care transfer policy annually unless we made a change to a specific CMS DRG. We established this policy to promote certainty and stability in the postacute care transfer payment policy. Annual reviews of the list of CMS DRGs subject to the policy would likely lead to great volatility in the payment methodology with certain DRGs qualifying for the policy in one year, deleted the next year, only to be reinstated the following year. However, we noted that, over time, as treatment practices change, it was possible that some CMS DRGs that qualified for the policy will no longer be discharged with great frequency to postacute care. Similarly, we explained that there may be other CMS DRGs that at that time had a low rate of discharges to postacute care, but which might have very high rates in the future.

The regulations at § 412.4 further specify that if a DRG did not exist in Version 23.0 of the DRG Definitions Manual or a DRG included in Version 23.0 of the DRG Definitions Manual is revised, the DRG will be a qualifying DRG if it meets the following criteria based on the version of the DRG Definitions Manual in use when the new or revised DRG first became effective, using the most recent complete year of MedPAR data:

- The total number of discharges to postacute care in the DRG must equal or exceed the 55th percentile for all DRGs; and
- The proportion of short-stay discharges to postacute care to total discharges in the DRG exceeds the 55th percentile for all DRGs. A short-stay discharge is a discharge before the geometric mean length of stay for the DRG.

A DRG also is a qualifying DRG if it is paired with another DRG based on the presence or absence of a CC or MCV that meets either of the above two criteria.

The MS–DRGs that we adopted for FY 2008 were a significant revision to the CMS DRG system (72 FR 47141). Because the MS–DRGs were not reflected in Version 23.0 of the DRG Definitions Manual, consistent with § 412.4, we established policy to recalculate the 55th percentile thresholds in order to determine which MS–DRGs would be subject to the postacute care transfer policy (72 FR 47186 through 47188). Further, under

the MS–DRGs, the subdivisions within the base DRGs are different than those under the previous CMS DRGs. Unlike the CMS DRGs, the MS–DRGs are not divided based on the presence or absence of a CC or MCV. Rather, the MS–DRGs have up to three subdivisions based on: (1) The presence of a MCC; (2) the presence of a CC; or (3) the absence of either an MCC or CC. Consistent with our previous policy under which both CMS DRGs in a CC/non-CC pair were qualifying DRGs if one of the pair qualified, we established that each MS–DRG that shared a base MS–DRG will be a qualifying DRG if one of the MS–DRGs that shared the base DRG qualifies. We revised § 412.4(d)(3)(ii) to codify this policy.

Similarly, the adoption of the MS–DRGs also necessitated a revision to one of the criteria used in § 412.4(f)(5) of the regulations to determine whether a DRG meets the criteria for payment under the ''special payment methodology.'' Under the special payment methodology, a case subject to the special payment methodology that is transferred early to a postacute care setting will be paid 50 percent of the total IPPS payment plus the average per diem for the first day of the stay. In addition, the hospital will receive 50 percent of the per diem amount for each subsequent day of the stay, up to the full MS–DRG payment amount. A CMS DRG was subject to the special payment methodology if it met the criteria of § 412.4(f)(5). Section 412.4(f)(5)(iv) specifies that, for discharges occurring on or after October 1, 2005, and prior to October 1, 2007, if a DRG meets the criteria specified under § 412.4(f)(5)(i) through (f)(5)(iii), any DRG that is paired with it based on the presence or absence of a CC or MCV is also subject to the special payment methodology. Given that this criterion was no longer applicable under the MS–DRG system, in the FY 2008 final rule with comment period, we added a new § 412.4(f)(6) (42 FR 47188 and 47410). Section 412.4(f)(6) provides that, for discharges on or after October 1, 2007, if an MS–DRG meets the criteria specified under §§ 412.4(f)(6)(i) through (f)(6)(iii), any other MS–DRG that is part of the same MS–DRG group is also subject to the special payment methodology. We updated this criterion so that it conformed to the changes associated with adopting MS–DRGs for FY 2008. The revision makes an MS–DRG subject to the special payment methodology if it shares a base MS–DRG with an MS–DRG that meets the criteria for receiving the special payment methodology.

Section 1886(d)(5)(J) of the Act provides that, effective for discharges on or after October 1, 1998, a ''qualified discharge'' from one of DRGs selected by the Secretary to a postacute care provider would be treated as a transfer case. This section required the Secretary to define and pay as transfers all cases assigned to one of the DRGs selected by the Secretary, if the individuals are discharged to one of the following postacute care settings:

- A hospital or hospital unit that is not a subsection 1886(d) hospital. (Section 1886(d)(1)(B) of the Act identifies the hospitals and hospital units that are excluded from the term ''subsection (d) hospital'' as psychiatric hospitals and units, rehabilitation hospitals and units, children's hospitals, long-term care hospitals, and cancer hospitals.)
- A SNF (as defined at section1819(a) of the Act).
- Home health services provided by a home health agency, if the services relate to the condition or diagnosis for which the individual received inpatient hospital services, and if the home health services are provided within an appropriate period (as determined by the Secretary). In the FY 1999 IPPS final rule (63 FR 40975 through 40976 and 40979 through 40981), we specified that a patient discharged to home would be considered transferred to postacute care if the patient received home health services within 3 days after the date of discharge. In addition, in the FY 1999 IPPS final rule, we did not include patients transferred to a swing-bed for skilled nursing care in the definition of postacute care transfer cases (63 FR 40977).

2. Proposed Policy Change Relating to Transfers to Home with a Written Plan for the Provision of Home Health Services

As noted above, in the FY 1999 IPPS final rule (63 FR 40975 through 40976 and 40979 through 40981), we determined that 3 days is an appropriate period within which home health services should begin following a beneficiary's discharge to the home in order for the discharge to be considered a ''qualified discharge'' subject to the payment adjustment for postacute care transfer cases. In that same final rule, we noted that we would monitor whether 3 days would remain an appropriate timeframe.

Section 1886(d)(5)(J)(ii)(III) of the Act provides that the discharge of an individual who receives home health services upon discharge will be treated as a transfer if ''such services are provided within an appropriate period as determined by the Secretary * * *''. The statute thus confers upon the Secretary the authority to determine an appropriate timeframe for the application of the postacute care transfer policy in cases where home health services commence subsequent to discharge from an acute care hospital. In the FY 1999 final IPPS rule, we established the policy that the postacute care transfer policy would apply to cases in which the home health care begins within 3 days of the discharge from an acute care policy. We noted in that rule that we did not believe that it was appropriate to limit the transfer definition to cases in which home health care begins on the same day as the patient is discharged from the hospital. We observed that data indicated that less than 8 percent of discharged patients who receive home health care begin receiving those services on the date of discharge. It is unreasonable to expect that patients who are discharged later in the day would receive a home health visit that same day. Furthermore, we believed that the financial incentive to delay needed home health care for only a matter of hours would be overwhelming if we limited the timeframe to one day. At the time of that final rule, we explained that we believed that 3 days would be a more appropriate timeframe because it would mitigate the incentive to delay home health services to avoid the application of the postacute care transfer policy, and because a 3-day timeframe was consistent with existing patterns of care.

In that final rule, we also noted that a number of commenters had raised issues and questions concerning the proposal to adopt 3 days as the appropriate timeframe for the application of the postacute care transfer policy in these cases. While most of the commenters advocated shorter timeframes, on the grounds that postacute care beginning 3 days after a discharge should not be considered a substitute for inpatient hospital care, others suggested that a 3-day window might still allow for needlessly prolonged hospital care or delayed home health in order to avoid the application of the postacute care transfer policy. Although MedPAC agreed with the commenters who asserted that home health care services furnished after a delay of more than one day may not necessarily be regarded as substituting for inpatient acute care, they also noted that a 3-day window allows for the fact that most home health patients do not receive care every day, as well as for those occasions in which there may be a delay in arranging for the provision of planned care (for

example, an intervening weekend). The commission also stated that a shorter period may create a stronger incentive to delay the provision of necessary care beyond the window so that the hospital will receive the full DRG payment. In the light of these comments and, in particular, of the concern that a 3-day timeframe still allowed for some incentive to delay necessary home health services in order to avoid the application of the postacute care transfer policy, we indicated that we would continue to monitor this policy in order to track any changes in practices that may indicate the need for revising the window.

Since the adoption of this policy in FY 1999, we have continued to receive reports that some providers discharge patients prior to the geometric mean length of stay but intentionally delay home health services beyond 3 days after the acute hospital discharge in order to avoid the postacute care transfer payment adjustment policy. These reports, and the concerns expressed by some commenters in FY 1999 about the adequacy of a 3-day window to reduce such incentives, have prompted us to examine the available data concerning the initiation and program payments for home health care subsequent to discharge from postacute care.

We merged the FY 2004 MedPAR file with postacute care bill files matching beneficiary identification numbers and discharge and admission dates and looked at the 10 DRGs that were subject to the postacute care transfer policy from FYs 1999 through 2003 (DRG 14 (Intracranial Hemorrhage and Stroke with Infarction (formerly ''Specific Cerebrovascular Disorders Except Transient Ischemic Attack'')); DRG 113 (Amputation for Circulatory System Disorders Except Upper Limb and Toe); DRG 209 (Major Joint Limb Reattachment Procedures of Lower Extremity); DRG 210 (Hip and Femur Procedures Except Major Joint Procedures ≤17 with CC); DRG 211 (Hip and Femur Procedures Except Major Joint Procedures Age ≤17 without CC); DRG 236 (Fractures of Hip and Pelvis); DRG 263 (Skin Graft and/or Debridement for Skin Ulcer or Cellulitis with CC); DRG 264 (Skin Graft and/or Debridement for Skin Ulcer or Cellulitis without CC); DRG 429 (Organic Disturbances and Mental Retardation); and DRG 483 (Tracheostomy with Mechanical Ventiliation 96+ Hours or Principal Diagnosis Except Face, Mouth, and Neck Diagnoses (formerly ''Tracheostomy Except for Face, Mouth, and Neck Diagnoses'')). We selected the original 10 ''qualified DRGs'' because they were the DRGs to which the postacute care transfer policy applied for FYs 1999 through 2003 and because we expect that trends that we found in the data with those DRGs would be likely to accurately reflect provider practices after the inception of the postacute care transfer policy. We expect that provider practices for the original 10 DRGs would be consistent even with the expansion of the DRGs that are subject to the postacute care transfer policy. We note that providers may have even a greater incentive to delay the initiation of home health care in an effort to avoid the postacute care transfer policy now that there are more DRGs to which the policy applies. We compared data on home health services provided to patients who were discharged prior to the geometric mean length of stay to patients who were discharged at or beyond the geometric mean length of stay. For purposes of this analysis, we assumed that home health was the first discharge designation from the acute care hospital setting.

The data showed that, on average, the Medicare payment per home health visit was higher for patients who were discharged prior to the geometric mean length of stay (as compared to patients who were discharged at or beyond the geometric mean length of stay). Additionally, we found some evidence in the data suggesting that, for patients discharged prior to the geometric mean length of stay for many DRGs, hospitals may indeed be discharging patients earlier than advisable, providing less than the optimal amount of acute inpatient care, and are instead substituting home health care for inpatient services, resulting in higher home health care payments under the Medicare program. One generally would expect that patients discharged prior to the geometric mean length of stay are genuinely less severely ill than patients discharged at or after the geometric mean length of stay because patients in the former group are judged to be appropriate for discharge after less acute inpatient care. However, our data paint a different picture. For example, the data on the average per day Medicare payments for home health care for those patients who are discharged from the hospital prior to the geometric mean length of stay in the DRGs to which the postacute care transfer policy applies, as compared to Medicare payments for patients discharged from the hospital at or after the geometric mean length of stay, show patterns other than what might be expected if hospitals are generally discharging patients for home health care only after the full amount of acute inpatient care. Specifically, average Medicare payments per home health care visit are consistently higher for patients discharged prior to the geometric mean length of stay than for patients discharged at or after the geometric mean length of stay. The average home health care per visit payments for patients treated for the relevant DRGs and discharged before the geometric mean length of stay are $204 when the initiation of home health care began on the second day after discharge, $199 on the third day, and $182 on the sixth day, compared to $177, $163, and $171, respectively for patients discharged on or after the geometric mean length of stay. Furthermore, the ratio of the payments for these two groups actually increases from 1.16 on the third day after discharge to 1.22 on the fourth day, before falling again to 1.04, 1.07, and 1.08 on the fifth, sixth, and seventh days. This suggests the possibility that home health care for some relatively sicker patients is being delayed until just beyond the 3-day window during which the postacute care transfer policy applies. In the light of these data, we believe that it is appropriate to propose extending the applicable timeframe in order to reduce the incentive for providers to delay home health care when discharging patients from the acute care setting. Further examination of the data indicates that the average per day Medicare payments for home health care for those patients, in the DRGs to which the postacute care transfer policy applies, who are discharged from the hospital prior to the geometric mean length of stay, stabilizes at a somewhat lower amount when the initiation of home health visits begins on the seventh and subsequent days after discharge. Specifically, average payments per visit for this group fall from $182 when home health services began on the sixth day after the acute care hospital discharge to $174 on the seventh day, and then remain relatively steady at $171, $177, and $172 on the eighth, ninth, and tenth days. This suggests that a 7-day period would be an appropriate point at which to establish a new timeframe. The stabilization of average home health care visit payments at and after the seventh day suggests that this may be the point at which the incentives to delay the start of home health care in order to avoid the application of the postacute care transfer policy are reduced. As a consequence of this analysis, in this proposed rule, we are proposing to revise § 412.4(c)(3) to extend the timeframe to within 7 days of discharge to home under a written

plan for the provision of home health services, effective October 1, 2008. We believe that extending the applicable timeframe will lessen the incentive for providers to delay the start of home health care after discharging patients from the acute care hospital setting. During the comment period on this proposed rule, we plan to continue to search our data on postacute care discharges to home health services. We welcome comments and suggestions on other data analyses that can be performed to determine an appropriate timeframe for which the postacute care transfer policy would apply.

In addition to the reasons noted above, we believe that 7 days is currently an appropriate timeframe because we believe that accommodates current practices and it is sufficiently long enough to lessen the likelihood that providers would delay the initiation of necessary home health services. At the same time, we believe that 7 days is narrow enough that we would still expect the majority of the home health services to be related to the condition to which the acute inpatient hospital stay was necessary. Further, we note that there may be some cases for which it is not clinically appropriate to begin home health services immediately following an acute care discharge, and that even when home health services are clinically appropriate sooner than within 7 days of acute care discharge, home health services may not be immediately available.

We note that, as we stated in the FY 2000 IPPS final rule (65 FR 47081), if the hospital's continuing care plan for the patient is not related to the purpose of the inpatient hospital admission, a condition code 42 must be entered on the claim. If the continuing care plan is related to the purpose of the inpatient hospital admission but begins after 7 days (formerly after 3 days) of discharge, a condition code 43 must be entered on the claim. The presence of either of these condition codes in conjunction with patient status discharge code 06 (Discharged/Transferred to Home under Care of Organized Home Health Service Organization in Anticipation of Covered Skilled Care) will result in full payment rather than the transfer payment amount.

3. Evaluation of MS–DRGs Under Postacute Care Transfer Policy for FY 2009

For FY 2009, we are not proposing to make any changes to the criteria by which an MS–DRG would qualify for inclusion in the postacute care transfer policy. However, because we are proposing to revise some existing MS–DRGs and to add one new MS–DRG (discussed under section II.G. of this preamble), we are proposing to evaluate those MS–DRGs under our existing postacute care transfer criteria in order to determine whether any of the revised or new MS–DRGs will meet the postacute care transfer criteria for FY 2009. Therefore, for 2009, we are evaluating MS–DRGs 001, 002, 215, 245, 901 through 909, 913 through 923, 955 through 959, and 963 through 965. Any revisions made would not constitute a change to the application of the postacute care transfer policy. A list indicating which MS–DRGs would be subject to the postacute care transfer policy for FY 2009 can be found in Table 5 in the Addendum to this proposed rule.

B. Reporting of Hospital Quality Data for Annual Hospital Payment Update (§ 412.64(d)(2))

1. Background

a. Overview

CMS is transforming the Medicare program from a passive payer to an active purchaser of higher quality, more efficient health care. Such care will contribute to the sustainability of the Medicare program, encourage the delivery of high quality care while avoiding unnecessary costs, and help ensure high value for beneficiaries. To support this transformation, CMS has worked with stakeholders to develop and implement quality measures, make provider and plan performance public, link payment incentives to reporting on measures, and ultimately is working to link payment to actual performance on these measures. Commonly referred to as value-based purchasing, this policy aligns payment incentives with the quality of care as well as the resources used to deliver care to encourage the delivery of high-value health care.

The success of this transformation is supported by and dependent upon an increasing number of widely-agreed upon quality measures. The Medicare program has defined measures of quality in almost every setting and measures some aspect of care for almost all Medicare beneficiaries. These measures include clinical processes, patient perception of their care experience, and, increasingly, outcomes.

The Medicare program has established mechanisms for collecting information on these measures, such as QualityNet, an Internet-based process that hospitals use to report all-payer information. Initial voluntary efforts were supplemented beginning in FY 2005 by a provision in the Medicare Prescription Drug Improvement and Modernization Act (MMA), which provided the full annual payment update only to ''subsection (d) hospitals'' (that is, hospitals paid under the IPPS) that successfully reported on a set of widely-agreed upon quality measures. Since FY 2007, as required by subsequent legislation (the Deficit Reduction Act (DRA)) the number of quality measures and the amount of the financial incentive have increased.

As a result, the great majority of hospitals now report on quality measures for heart failure, heart disease, pneumonia, and surgical infection and received the full annual update for FY 2008. The number of measures has continued to grow and the types of measures have grown as well, with the addition of outcomes measures, such as heart attack and heart failure mortality measures, and the HCAHPS measure of patient satisfaction. In section IV.B.2. of this preamble, we are seeking public comments on proposed additional quality measures.

Reporting on these measures provides hospitals a greater awareness of the quality of care they provide and provides actionable information for consumers to make more informed decisions about their health care providers and treatments.

Moving beyond reporting to performance, CMS has designed a Hospital Value-Based Purchasing Plan that would link hospital payments to their actual performance on quality measures. In accordance with the DRA, the Plan was submitted to Congress in November 2007. We discuss the Plan more fully in section IV.C. of this preamble.

The ongoing CMS Premier Hospital Quality Incentive Demonstration project is another effort linking payments to quality performance. Launched in 2003, the Premier Hospital Quality Incentive Demonstration project promotes measurable improvements in the quality of care, examining whether economic incentives to hospitals are effective at improving the quality of care. Early evidence from the project indicates that linking payments to quality performance can be effective.

As required by section 5001(c) the DRA, CMS also has implemented a program intended to encourage the prevention of certain avoidable or preventable hospital-acquired conditions (HACs), including infections, that may occur during a hospital stay. Beginning October 1, 2007, CMS required hospitals to begin reporting information on Medicare claims specifying whether certain diagnoses were present on admission (POA). Beginning October 1, 2008, CMS will no

longer pay hospitals for a DRG using the higher-paying CC or MCC associated with one or more of these conditions (if no other condition meeting the higher paying CC or MCC criteria is present) unless the condition was POA (that is, not acquired during the hospital stay). Linking a payment incentive to hospitals' prevention of avoidable or preventable HACs is a strong approach for encouraging high quality care. Combating these HACs can reduce morbidity and mortality as well as reducing unnecessary costs. In the FY 2008 IPPS final rule with comment period (72 FR 47217), CMS identified eight HACs. In section II.F. of this preamble, CMS is seeking comment on additional proposed conditions.

CMS is committed to enhancing these value-based purchasing programs, in close collaboration with stakeholders, through the development and use of new measures for quality reporting, expanded public reporting, greater and more widespread incentives in the payment system for reporting on such measures, and ultimately performance on those measures. These initiatives hold the potential to transform the delivery of health care by rewarding quality of care and delivering higher value to Medicare beneficiaries.

A critical element of value-based purchasing is well-accepted measures. Hospitals can then measure their performance relative to other hospitals. Further, this information can be posted for consumers to use to make more informed choices about their care. In this section IV.B. of this preamble, we describe past and current efforts to make this information available and proposals to expand these efforts and make even more useful hospital quality information available to the public.

b. Voluntary Hospital Quality Data Reporting

In December 2002, the Secretary announced a partnership with several collaborators intended to promote hospital quality improvement and public reporting of hospital quality information. These collaborators included the American Hospital Association (AHA), the Federation of American Hospitals (FAH), the Association of American Medical Colleges (AAMC), the Joint Commission on Accreditation of Healthcare Organizations (the Joint Commission), the National Quality Forum (NQF), the American Medical Association (AMA), the Consumer-Purchaser Disclosure Project, the American Association of Retired Persons (AARP), the American Federation of Labor-Congress of Industrial Organizations (AFL–CIO), the Agency for Healthcare Research and Quality (AHRQ), as well as CMS and others. In July 2003, CMS began the National Voluntary Hospital Reporting Initiative. This initiative is now known as the Hospital Quality Alliance: Improving Care through Information (HQA).

We established the following ''starter set'' of 10 quality measures for voluntary reporting as of November 1, 2003:

Heart Attack (Acute Myocardial Infarction or AMI)

- Was aspirin given to the patient upon arrival to the hospital?
- Was aspirin prescribed when the patient was discharged?
- Was a beta blocker given to the patient upon arrival to the hospital?
- Was a beta blocker prescribed when the patient was discharged?
- Was an Angiotensin Converting Enzyme (ACE) Inhibitor given for the patient with heart failure?

Heart Failure (HF)

- Did the patient get an assessment of his or her heart function?
- Was an Angiotensin Converting Enzyme (ACE) Inhibitor given to the patient?

Pneumonia (PN)

- Was an antibiotic given to the patient in a timely way?
- Had the patient received a pneumococcal vaccination?
- Was the patient's oxygen level assessed?

This starter set of 10 quality measures was endorsed by the NQF. The NQF is a voluntary consensus standard-setting organization established to standardize health care quality measurement and reporting through its consensus development process. In addition, this starter set is a subset of measures currently collected for the Joint Commission as part of its hospital inpatient certification program.

We chose these 10 quality measures in order to collect data that would: (1) Provide useful and valid information about hospital quality to the public; (2) provide hospitals with a sense of predictability about public reporting expectations; (3) begin to standardize data and data collection mechanisms; and (4) foster hospital quality improvement.

Hospitals submit quality data through the QualityNet secure Web site (formerly known as QualityNet Exchange) *(www.qualitynet.org).* This Web site meets or exceeds all current Health Insurance Portability and Accountability Act requirements for security of personal health information. Data from this initiative are used to populate the *Hospital Compare* Web site, *www.hospitalcompare.hhs.gov.* This Web site assists beneficiaries and the general public by providing information on hospital quality of care for consumers who need to select a hospital. It further serves to encourage consumers to work with their doctors and hospitals to discuss the quality of care hospitals provide to patients, thereby providing an additional incentive to improve the quality of care that they furnish.

c. Hospital Quality Data Reporting Under Section 501(b) of Pub. L. 108–173

Section 1886(b)(3)(B)(vii) of the Act, as added by section 501(b) of Pub. L. 108–173, revised the mechanism used to update the standardized amount of payment for inpatient hospital operating costs. Specifically, the statute provided for a reduction of 0.4 percentage points to the update percentage increase (also known as the market basket update) for each of FYs 2005 through 2007 for any subsection (d) hospital that does not submit data on a set of 10 quality indicators established by the Secretary as of November 1, 2003. The statute also provided that any reduction would apply only to the fiscal year involved, and would not be taken into account in computing the applicable percentage increase for a subsequent fiscal year. This measure established an incentive for IPPS hospitals to submit data on the quality measures established by the Secretary.

We initially implemented section 1886(b)(3)(B)(vii) of the Act in the FY 2005 IPPS final rule (69 FR 49078). In addition, we established the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program and added 42 CFR 412.64(d)(2) to our regulations. We adopted additional requirements under the RHQDAPU program in the FY 2006 IPPS final rule (70 FR 47420).

d. Hospital Quality Data Reporting Under Section 5001(a) of Pub. L. 109–171

Section 5001(a) of the Deficit Reduction Act of 2005, Pub. L. 109–171 (DRA), further amended section 1886(b)(3)(B) of the Act to revise the mechanism used to update the standardized amount for payment for hospital inpatient operating costs. Specifically, sections 1886(b)(3)(B)(viii)(I) and (II) of the Act provide that the payment update for FY 2007 and each subsequent fiscal year be reduced by 2.0 percentage points for any subsection (d) hospital that does not

submit certain quality data in a form and manner, and at a time, specified by the Secretary. Section 1886(b)(3)(B)(viii)(III) of the Act requires that the Secretary expand the ''starter set'' of 10 quality measures that were established by the Secretary as of November 1, 2003, as the Secretary determines to be appropriate for the measurement of the quality of care furnished by a hospital in inpatient settings. In expanding this set of measures, section 1886(b)(3)(B)(viii)(IV) of the Act requires that, effective for payments beginning with FY 2007, the Secretary begin to adopt the baseline set of performance measures as set forth in a December 2005 report issued by the Institute of Medicine (IOM) of the National Academy of Sciences under section 238(b) of the MMA.[16]

The IOM measures include: 21 HQA quality measures (including the ''starter set'' of 10 quality measures); the HCAHPS patient experience of care survey; and 3 structural measures. The structural measures are: (1) Implementation of computerized provider order entry for prescriptions; (2) staffing of intensive care units with intensivists; and (3) evidence-based hospital referrals. These structural measures constitute the Leapfrog Group's original ''three leaps,'' and are part of the NQF's 30 Safe Practices for Better Healthcare.

Sections 1886(b)(3)(B)(viii)(V) and (VI) of the Act require that, effective for payments beginning with FY 2008, the Secretary add other quality measures that reflect consensus among affected parties, and to the extent feasible and practicable, have been set forth by one or more national consensus building entities, and provide the Secretary with the discretion to replace any quality measures or indicators in appropriate cases, such as where all hospitals are effectively in compliance with a measure, or the measures or indicators have been subsequently shown to not represent the best clinical practice. Thus, the Secretary is granted broad discretion to replace measures that are no longer appropriate for the RHQDAPU program.

Section 1886(b)(3)(B)(viii)(VII) of the Act requires that the Secretary establish procedures for making quality data available to the public after ensuring that a hospital would have the opportunity to review its data before these data are made public. In addition, this section requires that the Secretary report quality measures of process, structure, outcome, patients' perspective of care, efficiency, and costs of care that relate to services furnished in inpatient settings on the CMS Web site.

Section 1886(b)(3)(B)(viii)(I) of the Act also provides that any reduction in a hospital's payment update will apply only with respect to the fiscal year involved, and will not be taken into account for computing the applicable percentage increase for a subsequent fiscal year.

In the FY 2007 IPPS final rule (71 FR 48045), we amended our regulations at 42 CFR 412.64(d)(2) to reflect the 2.0 percentage point reduction in the payment update for FY 2007 and subsequent fiscal years for subsection (d) hospitals that do not comply with requirements for reporting quality data, as provided for under section 1886(b)(3)(B)(viii) of the Act. In the FY 2007 IPPS final rule, we also added 11 additional quality measures to the 10-measure starter set to establish an expanded set of 21 quality measures (71 FR 48033 through 48037).

Commenters on the FY 2007 IPPS proposed rule requested that we notify the public as far in advance as possible of any proposed expansions of the measure set and program procedures in order to encourage broad collaboration and to give hospitals time to prepare for any anticipated change. Taking these concerns into account, in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68201), we adopted six additional quality measures for the FY 2008 IPPS update, for a total of 27 measures. The measure set that we adopted for the FY 2008 payment determination was as follows:

Topic	Quality measure
Heart Attack (Acute Myocardial Infarction).	• Aspirin at arrival.* • Aspirin prescribed at discharge.* • Angiotensin Converting Enzyme Inhibitor (ACE–I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction.* • Beta blocker at arrival.* • Beta blocker prescribed at discharge.* • Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival.** • Percutaneous Coronary Intervention (PCI) received within 120 minutes of hospital arrival.** • Adult smoking cessation advice/counseling.**
Heart Failure (HF)	• Left ventricular function assessment.* • Angiotensin Converting Enzyme Inhibitor (ACE–I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction. • Discharge instructions.** • Adult smoking cessation advice/counseling.**
Pneumonia (PN)	• Initial antibiotic received within 4 hours of hospital arrival * • 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.**

[16] Institute of Medicine, ''Performance Measurement: Accelerating Improvement,'' December 1, 2005, available at: *www.iom.edu/CMS/3809/19805/31310.aspx.*

Topic	Quality measure
	• SCIP–VTE–1: Venous thromboembolism (VTE) prophylaxis ordered for surgery patients.*** • SCIP–VTE–2: VTE prophylaxis within 24 hours pre/post surgery.*** • SCIP Infection 2: Prophylactic antibiotic selection for surgical patients.***
Mortality Measures (Medicare patients)	• Acute Myocardial Infarction 30-day mortality Medicare patients*** • Heart Failure 30-day mortality Medicare patients.***
Patients' Experience of Care.	HCAHPS patient survey.***

*Measure included in 10 measure starter set.
**Measure included in 21 measure expanded set.
***Measure added in CY 2007 OPPS/ASC final rule with comment period (data submission required as of January 2007 for three additional SCIP measures).

For FY 2008, hospitals were required to submit data on 25 of the 27 measures. No data submission was required for the two mortality outcome measures (30-Day Risk Standardized Mortality Rates for Heart Failure and AMI), because they were calculated using existing administrative Medicare claims data. The measures used for the payment determination included, for the first time, the HCAHPS patient experience of care survey as well as two outcome measures. These measures expanded the types of measures available for public reporting as required under section 1886(b)(3)(B)(viii) of the Act. In addition, the outcome measures, which are claims-based measures, did not increase the data submission requirements for hospitals, thereby reducing the burden associated with collection of data for quality reporting.

In the FY 2008 IPPS proposed rule (72 FR 24805), we proposed to add 1 outcome measure and 4 process measures to the existing 27-measure set to establish a new set of 32 quality measures to be used under the RHQDAPU program for the FY 2009 IPPS annual payment determination. We proposed to add the following five measures for the FY 2009 IPPS annual payment determination:

• PN 30-day mortality measure (Medicare patients)

• SCIP Infection 4: Cardiac Surgery Patients with Controlled 6AM Postoperative

Serum Glucose

• SCIP Infection 6: Surgery Patients with Appropriate Hair Removal

• SCIP Infection 7: Colorectal Patients with Immediate Postoperative

Normothermia

• SCIP Cardiovascular 2: Surgery Patients on a Beta Blocker Prior to Arrival Who Received a Beta Blocker During the Perioperative Period

We stated that we planned to formally adopt these measures a year in advance in order to provide time for hospitals to prepare for changes related to the RHQDAPU program. We also stated that we anticipated that the proposed measures would be endorsed by the NQF, as a national consensus building entity. Finally, we stated that any proposed measure that was not endorsed by the NQF by the time that we published the FY 2008 IPPS final rule with comment period would not be finalized in that final rule.

At the time we published the FY 2008 IPPS final rule with comment period, only the PN 30-day mortality measure had been endorsed by the NQF. Therefore, we finalized only that measure as part of the FY 2009 IPPS measure set and stated that we would further address adding additional measures in the CY 2008 OPPS/ASC final rule and, if necessary, in the FY 2009 IPPS proposed and final rules. We also responded to comments we had received on the five proposed measures (72 FR 47348 through 47351).

In the CY 2008 OPPS/ASC final rule with comment period (72 FR 66875), we noted that the NQF had endorsed the following additional process measures that we had proposed to include in the FY 2009 RHQDAPU program measure set:

• SCIP Infection 4: Cardiac Surgery Patients with Controlled 6AM Postoperative

Serum Glucose

• SCIP Infection 6: Surgery Patients with Appropriate Hair Removal

As we stated in the FY 2008 IPPS proposed rule (72 FR 24805), these measures reflect our continuing commitment to quality improvement in both clinical care and quality. These quality measures reflect consensus among affected parties as demonstrated by endorsement by a national consensus building entity. The addition of these two measures for the FY 2009 measure set bring the total number of measures in that measure set to 30 (72 FR 66876).

The measure set to be used for FY 2009 annual payment determination is as follows:

Topic	Quality measure
Heart Attack (Acute Myocardial Infarction)	• Aspirin at arrival*. • Aspirin prescribed at discharge*. • Angiotensin Converting Enzyme Inhibitor (ACE–I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction*. • Beta blocker at arrival*. • Beta blocker prescribed at discharge*. • Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival**. • Primary Percutaneous Coronary Intervention (PCI) received within 120 minutes of hospital arrival**. • Adult smoking cessation advice/counseling**.
Heart Failure (HF)	• Left ventricular function assessment*.

Topic	Quality measure
	• Angiotensin Converting Enzyme Inhibitor (ACE–I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction*. • Discharge instructions**. • Adult smoking cessation advice/counseling**.
Pneumonia (PN)	• Initial antibiotic received within 4 hours of hospital arrival*. • 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***. • SCIP–Infection 4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose*****. • SCIP Infection 6: Surgery Patients with Appropriate Hair Removal*****.
Mortality Measures (Medicare patients)	• Acute Myocardial Infarction 30-day mortality Medicare patients***. • Heart Failure 30-day mortality Medicare patients***. • Pneumonia 30-day mortality Medicare patients****.
Patients' Experience of Care	• HCAHPS patient survey***.

* Measure included in 10 measure starter set.
** Measure included in 21 measure expanded set.
*** Measure added in CY 2007 OPPS/ASC final rule with comment period.
**** Measure added in FY 2008 IPPS final rule with comment period.
***** Measure added in CY 2008 OPPS/ASC final rule with comment period (data submission required effective with discharges starting January 1, 2008).

We also stated in the FY 2008 IPPS final rule with comment period and the CY 2008 OPPS/ASC final rule with comment period that the RHQDAPU program participation requirements for the FY 2009 program would apply to additional measures we adopt for the FY 2009 program (72 FR 47361; 72 FR 66877).

Therefore, hospitals are required to start submitting data for SCIP Infection 4 and SCIP Infection 6 starting with first quarter calendar year 2008 discharges and subsequent quarters until further notice. Hospitals must submit their aggregate population and sample size counts for Medicare and non-Medicare patients. These requirements are consistent with the requirements for the other AMI, HF, PN, and SCIP process measures included in the FY 2009 measure set. The complete list of procedures for participating in the RHQDAPU program for FY 2009 are provided in the FY 2008 IPPS final rule with comment period (72 FR 47359 through 47361).

Because SCIP Cardiovascular 2 and SCIP Infection 7 had not been endorsed by a national consensus building entity by the publishing deadline for the CY 2008 OPPS/ASC final rule with comment period, we did not adopt these measures as part of the FY 2009 IPPS measure set.

In the FY 2008 IPPS proposed rule, we also solicited public comments on 18 measures and 8 measure sets that could be selected for future inclusion in the RHQDAPU program (72 FR 24805). These measures and measure sets highlight our interest in improving patient safety and outcomes of care, with a particular focus on the quality of surgical care and patient outcomes. In order to engender a broad review of potential performance measures, the list included measures that have not yet received endorsement by a national consensus review process for public reporting. The list also included measures developed by organizations other than CMS as well as measures that can be calculated using administrative data (such as claims).

We solicited public comment not only on the measures and measure sets that were listed, but also on whether there were any critical gaps or ''missing'' measures or measure sets. We specifically requested input concerning the following issues:

• Which of the measures or measure sets should be included in the FY 2009 RHQDAPU program or in subsequent years?

• What challenges for data collection and reporting are posed by the identified measures and measure sets?

• What improvements could be made to data collection or reporting that might offset or otherwise address those challenges?

In the FY 2008 IPPS final rule with comment period (72 FR 47351), after consideration of the public comments received, we decided not to adopt any of these measures or measure sets for FY 2009. We indicated that we will continue to consider some of these measures and measure sets for subsequent years.

2. Proposed Quality Measures for FY 2010 and Subsequent Years

a. Proposed Quality Measures for FY 2010

For FY 2010, we are proposing to require continued submission of data on 26 of the 30 existing AMI, Heart Failure,

Pneumonia, HCAHPS, and SCIP measures adopted for FY 2009. As noted above, the three outcome measures do not require hospitals to submit data. In addition, we are proposing to remove the Pneumonia Oxygenation Assessment measure from the RHQDAPU program measure set. We are proposing to discontinue requiring hospitals to submit data on the Pneumonia Oxygenation Assessment measure, effective with discharges beginning January 1, 2009. Section 1886(b)(3)(B)(viii)(VI) of the Act provides the Secretary with the discretion to replace any quality measures or indicators in appropriate cases, such as where all hospitals are effectively in compliance with a measure. We interpret this to authorize the Secretary to remove or retire measures from the RHQDAPU program.

In the case of the Pneumonia Oxygenation Assessment measure, the vast majority of hospitals are performing near 100 percent. In addition, oxygenation assessment is routinely performed by hospitals for admitted patients without regard to the specific diagnosis. Thus, the measure is topped out so completely across virtually all hospitals as to provide no significant opportunity for improvement. We believe that the burden to hospitals to abstract and report these data outweighs the benefit in publicly reporting hospital level data with very little variation among hospitals. We do not expect that the retirement of the Pneumonia Oxygenation Assessment measure will result in the deterioration of care. However, if we determine otherwise, we may seek to reintroduce the measure.

The proposed removal of the Pneumonia Oxygenation Assessment measure for FY 2010 represents the first instance of retiring a measure. We intend to review other existing chart-abstracted measures recognizing the significant burden to hospitals that chart abstraction requires. In this way, we seek to maximize the value of the RHQDAPU program to promote quality improvement by hospitals and to report information that the public will find beneficial in choosing inpatient hospital services. We invite comment on the retirement of the Pneumonia Oxygenation Assessment measure. In addition, we invite comment on other measures that may be suitable for retirement from the RHQDAPU program measure set. Finally, we invite comment on the following general considerations relevant to retiring measures:

- Should CMS retire a RHQDAPU program measure when hospital performance on the measure has reached a high threshold (that is, performance on the measure has topped out) even if the measure still reflects best practice?
- Are there reasons to consider retiring a measure other than high overall performance?
- When a measure is retired on the basis of substantially complete compliance by hospitals, should data collection on the measure again be required after 1 or 2 years to assure that a high compliance level remains, or should some other way of monitoring continued hospital compliance be used?

The specifications for two of the existing measures have been updated by the NQF, effective May 2007, with respect to the applicable timing interval. For the measures previously identified as:

- AMI—Primary Percutaneous Coronary Intervention (PCI) received within 120 minutes of hospital arrival, the NQF has revised its endorsement of the specifications to reflect that the timing interval has been changed to PCI within 90 minutes of arrival.
- Pneumonia—Initial antibiotic received within 4 hours of hospital arrival, the NQF has revised its endorsement of the specifications to reflect that the initial antibiotic must be received within 6 hours of arrival.

In the FY 2008 IPPS final rule with comment period, one commenter ''urged CMS to develop a policy to harmonize measures that related to payment, such as the NQF's move from a 4-hour timeframe for initial antibiotic administration for pneumonia patients to a 6-hour timeframe (72 FR 47357).'' Another commenter raised the issue of the timing for PCI in the AMI topic (72 FR 47347–8). In response to these comments, we responded that if we believe that a change is an appropriate change for the RHQDAPU program, we would expect to adopt it.

Because the NQF is now endorsing different timing intervals with respect to these measures, we are proposing to also update these measures for the purposes of the FY 2010 RHQDAPU program. The updated measures are as follows:

- AMI—Timing of Receipt of Primary Percutaneous Coronary Intervention (PCI); and
- Pneumonia—Timing of receipt of initial antibiotic following hospital arrival.

We note that the technical specifications for these measures will not change, and hospitals will continue to submit the same data that they currently submit. However, beginning with discharges on or after January 1, 2009, CMS will calculate the measures using the updated timing intervals.

The NQF updated these two measures to reflect the most current consensus standards effective May 2007. Because this was after we issued the FY 2008 IPPS proposed rule, we could not adopt the updated measures in the FY 2008 IPPS final rule with comment period or CY 2008 OPPS/ASC final rule with comment period. We also recognized that we did not have in place a subregulatory process that would have permitted us to update the measures. Therefore, we announced that hospitals could suppress the public reporting of the quality data for the two measures for hospital discharges starting with April 1, 2007 discharges. We did this because we believe that hospitals should not be held to out-of-date consensus standards for public reporting pending the next regulatory cycle.

We propose, in the future, to act on updates to existing RHQDAPU program measures made by a consensus building entity such as the NQF through a subregulatory process. This is necessary to be able to utilize the most up-to-date consensus standards in the RHQDAPU program, and recognizes that neither scientific advances nor consensus building entity standard updates are linked to the timing of regulatory actions. We propose to implement updates to existing RHQDAPU program measures and provide notification through the Qualitynet Web site, and additionally in the CMS/Joint Commission Specifications Manual for National Hospital Inpatient Quality Measures where data collection and measure specifications changes are necessary. We invite comment on this proposal.

Under section 1886(b)(3)(B)(viii)(III) of the Act, the Secretary shall expand the RHQDAPU program measures beyond the measures specified as of November 1, 2003. Under section 1886(b)(3)(B)(viii)(V) of the Act, these measures, to the extent feasible and practicable, shall include measures set forth by one or more national consensus building entities.

We are proposing to add the following 43 measures for the FY 2010 payment determination: a SCIP measure that we proposed last year; 4 nursing sensitive measures; 3 readmission measures; 6 Venous Thromboembolism measures; 5 stroke measures; 9 AHRQ measures; and 15 cardiac surgery measures.

We are proposing to add SCIP Cardiovascular 2, Surgery Patients on a Beta Blocker Prior to Arrival Who Received a Beta Blocker During the Perioperative Period. This measure was initially proposed last year in the FY 2008 IPPS proposed rule, but because the NQF had not endorsed this measure

at the time we issued the FY 2008 IPPS final rule with comment period or the CY 2008 OPPS/ASC final rule with comment period, we did not adopt it. For the purposes of proposing the FY 2010 RHQDAPU program measure set, CMS believes that NQF endorsement of a measure represents a standard for consensus among affected parties as specified in section 1886(b)(3)(B)(viii)(V) of the Act. The NQF is an independent health care quality endorsement organization with a diverse representation of consumer, purchaser, provider, academic, clinical, and other health care stakeholder organizations.

In November 2007, the NQF endorsed SCIP Cardiovascular 2. CMS believes that this measure targets an important process of care, beta blocker administration for noncardiac surgery patients. Therefore, we are now proposing to add SCIP Cardiovascular 2 to the RHQDAPU program measures for FY 2010. The specifications and data collection tools are currently available through the Qualitynet Web site and in the CMS/Joint Commission Specifications Manual for National Hospital Inpatient Quality Measures for hospitals to utilize and submit data for this measure. We are proposing that hospitals be required to submit data on this measure beginning with January 1, 2009 discharges.

We also are proposing to add four nursing sensitive measures to the RHQDAPU program measure set for FY 2010. The four measures are:

- Failure to Rescue
- Pressure Ulcer Prevalence and Incidence by Severity (Joint Commission developed measure; all patient data from chart abstraction)
- Patient Falls Prevalence
- Patient Falls with Injury

These measures broaden the ability of the RHQDAPU program measure set to assess care generally associated with nursing staff. In addition, these measures are directed toward outcomes that are underrepresented among the RHQDAPU program measures. These measures apply to the vast majority of inpatient stays and provide a great deal of critical information about hospital quality to consumers and stakeholders. The specifications and data collection tools are scheduled to be available in the specifications manual by December 2008 for hospitals to utilize and submit data for these measures. We are proposing that hospitals be required to submit data on these four measures effective with discharges beginning April 1, 2009. While these measures are endorsed by NQF, the Joint Commission has initiated rigorous field testing of the measures, which may not be completed until late 2008. Therefore, it is possible that the endorsement status of these measures may change in the next several months. If this rigorous field testing results in uncertainty as to the NQF endorsement status at the time we issue the FY 2009 IPPS final rule, we will defer our final decision on whether to require these measures for the RHQDAPU program for FY 2010 until the time that we issue the CY 2009 OPPS/ASC final rule with comment period. This deferral is consistent with our measure expansion during the past 2 years, when we finalized some RHQDAPU program measures in the annual OPPS/ASC final rules.

We are proposing to adopt three readmission measures for FY 2010 that will be calculated using Medicare administrative claims data. The proposed measures are:

- Pneumonia (PN) 30-Day Risk Standardized Readmission Measure (Medicare patients)
- Heart Attack (AMI) 30-Day Risk Standardized Readmission Measure (Medicare patients)
- Heart Failure (HF) 30-Day Risk Standardized Readmission Measure (Medicare patients)

These readmission measures assess both quality of care and efficiency of care. They also promote coordination of care among hospitals and other providers. They compliment the existing 30-Day Risk Standardized Mortality Measures for Pneumonia, Heart Attack, and Heart Failure. These measures require no additional data collection from hospitals. The measures are risk adjusted to account for differences between hospitals in the characteristics of their patient populations.

These three claims-based readmission measures are pending NQF endorsement. The NQF endorsement decision on these three measures is expected before we issue the FY 2009 IPPS final rule. We are proposing to add these three measures contingent upon NQF endorsement. We are also proposing to defer our decision on whether to include these measures until we issue the CY 2009 OPPS/ASC final rule, in the event that NQF endorsement status is still pending when we issue the FY 2009 IPPS final rule. This deferral is consistent with our measure expansion during the past 2 years, when we finalized some RHQDAPU program measures in the annual OPPS/ASC final rules.

We are also proposing to add six Venous Thromboembolism (VTE) measures. These measures comprehensively address a major cause of morbidity and mortality among hospitalized patients.

- VTE–1: VTE Prophylaxis
- VTE–2: VTE Prophylaxis in the ICU
- VTE–4: Patients with overlap in anticoagulation therapy
- VTE–5/6: (as combined measure) Patients with UFH dosages who have platelet count monitoring and adjustment of medication per protocol or nomogram
- VTE–7: Discharge instructions to address: follow-up monitoring, compliance, dietary restrictions and adverse drug reactions/interactions
- VTE–8: Incidence of preventable VTE

These VTE measures are pending NQF endorsement. The NQF endorsement decision on these measures is expected before we issue the FY 2009 IPPS final rule. We are proposing to add these measures contingent upon NQF endorsement. We also are proposing to defer our decision on whether to include these measures until we issue the CY 2009 OPPS/ASC final rule with comment period, in the event that NQF endorsement status is still pending when we issue the FY 2009 IPPS final rule. This deferral is consistent with our measure expansion during the past 2 years, when we finalized some RHQDAPU program measures in the annual OPPS/ASC final rules. We are proposing that hospitals be required to submit data on these six measures effective with discharges beginning January 1, 2009.

We also are proposing to add five Stroke measures that will apply only to certain identified groups under specific ICD–9–CM codes as specified in the specifications manual. These measures comprehensively address an important condition not currently covered by the RHQDAPU program that is associated with significant morbidity and mortality.

- STK–1 DVT Prophylaxis
- STK–2 Discharged on Antithrombotic Therapy
- STK–3 Patients with Atrial Fibrillation Receiving Anticoagulation Therapy
- STK–5 Antithrombotic Medication By End of Hospital Day Two
- STK–7 Dysphasia Screening

These Stroke measures are pending NQF endorsement. The NQF endorsement decision on these measures is expected before we issue the FY 2009 IPPS final rule. We are proposing to add these measures contingent upon NQF endorsement. We also are proposing to defer our adoption of these measures until we issue the CY 2009 OPPS/ASC final rule with comment period in the event that NQF

endorsement status is still pending as of the time we issue the FY 2009 IPPS final rule. This approach is consistent with our measure expansion during the past 2 years, when CMS finalized some RHQDAPU program measures in the annual OPPS/ASC final rules. We are proposing that hospitals be required to submit data on these five measures effective with discharges beginning July 1, 2009.

We also are proposing to add the following nine AHRQ Patient Safety Indicators (PSI) and Inpatient Quality Indicators (IQI) that have been endorsed by the NQF:

- Patient Safety Indicator (PSI) 4—Death among surgical patients with treatable serious complications
- PSI 6—Iatrogenic pneumothorax, adult
- PSI 14—Postoperative wound dehiscence
- PSI 15—Accidental puncture or laceration
- Inpatient Quality Indicator (IQI) 4 and 11—Abdominal aortic aneurysm (AAA) mortality rate (with or without volume)
- IQI 19—Hip fracture morality rate
- IQI Mortality for selected medical conditions (composite)
- IQI Mortality for selected surgical procedures (composite)
- IQI Complication/patient safety for selected indicators (composite)

These are claims-based outcome measures. They are important additional measures that can be calculated for hospital inpatients without the burden of additional chart abstraction. Hospitals currently collect and submit these data to CMS and other insurers for reimbursement. These measures will be calculated using all-payer claims data that hospitals currently collect with respect to each patient discharge. We are proposing to require hospitals to submit to CMS the all-payer claims data that we specify in the technical specifications manual as necessary to calculate the AHRQ PSI/IQI measures. We are proposing that hospitals begin submitting data on a quarterly basis on these measures to CMS by April 1, 2010 beginning with October 1, 2009 discharges.

However, we are aware that a large number of hospitals already submit these data on a voluntary basis to third party data aggregators such as State health agencies or State hospital associations. We seek comments on whether a hospital that already submits the data necessary to calculate these measures to such entities should be permitted to authorize such an entity to transmit these data to CMS, in accordance with applicable confidentiality laws, on their behalf. This would relieve the hospital of the burden of having to submit the same data directly to CMS via the QIO Clinical Warehouse.

As an alternative to requiring that hospitals submit all-payer claims data for purposes of calculating the AHRQ PSI/IQI measures, CMS is considering whether it should initially calculate the AHRQ PSI/IQI measures using Medicare claims data only, and at a subsequent date require submission of all-payer claims data. We also seek comment on this alternative.

We also are proposing to add 15 cardiac surgery measures. Cardiac surgical procedures carry a significant risk of morbidity and mortality. We believe that the nationwide public reporting of these cardiac surgery measures would provide highly meaningful information for the public.

Currently, over 85 percent of hospitals with a cardiac surgery program submit data on the proposed cardiac surgery measures listed below to the Society of Thoracic Surgeons (STS) Cardiac Surgery Clinical Data Registry. We are proposing to accept these data from the STS registry beginning on July 1, 2009, on a quarterly basis for discharges on or after January 1, 2009. Hospitals that participate in the RHQDAPU program, but that do not submit data on the proposed cardiac surgery measures to the STS registry for discharges on or after January 1, 2009, would need to submit such data to CMS. Although we would accept cardiac surgery data from other clinical data registries, we are unaware of any other registries that collect all of the data necessary to support calculation of the proposed cardiac surgery measures. Hospitals and CMS would need to establish appropriate legal arrangements, to the extent such arrangements are necessary, to ensure that the transfer of these data from the STS registry to CMS complies with all applicable laws. By accepting these registry-based data, only those hospitals with cardiac surgery programs that do not already collect such data to submit to the STS registry will have any additional data submission burden. All of the proposed measures are currently NQF-endorsed. We are proposing that hospitals begin submitting data by July 1, 2009, on a quarterly basis on the following 15 cardiac surgery measures to the STS data registry or CMS for 1st quarter calendar year 2009 discharges:

- Participation in a Systematic Database for Cardiac Surgery
- Pre-Operative Beta Blockade
- Prolonged Intubation
- Deep Sternal Wound Infection Rate
- Stroke/CVA
- Post-Operative Renal Insufficiency
- Surgical Reexploration
- Anti-Platelet Medication at Discharge
- Beta Blockade Therapy at Discharge
- Anti-Lipid Treatment at Discharge
- Risk-Adjusted Operative Mortality for CABG
- Risk-Adjusted Operative Mortality for Aortic Valve Replacement
- Risk-Adjusted Operative Mortality for Mitral Valve Replacement/Repair
- Risk-Adjusted Mortality for Mitral Valve Replacement and CABG Surgery
- Risk-Adjusted Mortality for Aortic Valve Replacement and CABG Surgery

The following table lists the 72 proposed measures for FY 2010:

Topic	Quality measure
Heart Attack (Acute Myocardial Infarction)	• AMI–1 Aspirin at arrival *. • AMI–2 Aspirin prescribed at discharge *. • AMI–3 Angiotensin Converting Enzyme Inhibitor (ACE–I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction *. • AMI 6 Beta blocker at arrival *. • AMI–5 Beta blocker prescribed at discharge *. • AMI–7a Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival**. • AMI–4 Adult smoking cessation advice/counseling**. • AMI–8a Timing of Receipt of Primary Percutaneous Coronary Intervention (PCI).
Heart Failure (HF)	• HF–2 Left ventricular function assessment *.

Topic	Quality measure
	• HF–3 Angiotensin Converting Enzyme Inhibitor (ACE–I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction *. • HF–1 Discharge instructions**. • HF–4 Adult smoking cessation advice/counseling**.
Pneumonia (PN)	• PN–2 Pneumococcal vaccination status *. • PN–3b Blood culture performed before first antibiotic received in hospital**. • PN–4 Adult smoking cessation advice/counseling**. • PN–6 Appropriate initial antibiotic selection**. • PN–7 Influenza vaccination status**. • PN–5c Timing of receipt of initial antibiotic following hospital arrival******.
Surgical Care Improvement Project (SCIP)—named SIP for discharges prior to July 2006 (3Q06).	• SCIP–1 Prophylactic antibiotic received within 1 hour prior to surgical incision**. • SCIP–3 Prophylactic antibiotics discontinued within 24 hours after surgery end time**. • SCIP–VTE–1: Venous thromboembolism (VTE) prophylaxis ordered for surgery patients***. • SCIP–VTE–2: VTE prophylaxis within 24 hours pre/post surgery***. • SCIP Infection 2: Prophylactic antibiotic selection for surgical patients***. • SCIP–Infection 4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose*****. • SCIP Infection 6: Surgery Patients with Appropriate Hair Removal*****. • SCIP Cardiovascular 2: Surgery Patients on a Beta Blocker Prior to Arrival Who Received a Beta Blocker During the Perioperative Period******.
Mortality Measures (Medicare patients)	• MORT–30–AMI Acute Myocardial Infarction 30-day mortality Medicare patients***. • MORT–30–HF Heart Failure 30-day mortality Medicare patients***. • MORT–30–PN Pneumonia 30-day mortality Medicare patients****.
Patients' Experience of Care	• HCAHPS patient survey***.
Readmission Measures (Medicare patients)	• Heart Attack (AMI) 30-Day Risk Standardized Readmission Measure (Medicare patients)******. • Heart Failure (HF) 30-Day Risk Standardized Readmission Measure (Medicare patients)******. • Pneumonia (PN) 30-Day Risk Standardized Readmission Measure (Medicare patients) ******.
Inpatient Stroke Care	• STK–1 DVT Prophylaxis******. • STK–2 Discharged on Antithrombotic Therapy******. • STK–3 Patients with Atrial Fibrillation Receiving Anticoagulation Therapy******. • STK–5 Antithrombotic Medication By End of Hospital Day Two******. • STK–7 Dysphasia Screening******.
Venous Thromboembolic Care	• VTE–1: VTE Prophylaxis******. • VTE–2: VTE Prophylaxis in the ICU******. • VTE–4: Patients with overlap in anticoagulation therapy******. • VTE–5/6: (as combined measure) patients with UFH dosages who have platelet count monitoring and adjustment of medication per protocol or nomagram******. • VTE–7: Discharge instructions to address: followup monitoring, compliance, dietary restrictions, and adverse drug reactions/interactions******. • VTE–8: Incidence of preventable VTE******.
AHRQ Patient Safety Indicators	• Death among surgical patients with treatable serious complications******. • Iatrogenic pneumothorax, adult******. • Postoperative wound dehiscence******. • Accidental puncture or laceration******.
AHRQ Inpatient Quality Indicators (IQI)	• Abdominal aortic aneurysm (AAA) mortality rate (with or without volume) ******. • Hip fracture morality rate******.
AHRQ IQI Composite Measures	• Mortality for selected surgical procedures (composite) ******.

Topic	Quality measure
	• Complication/patient safety for selected indicators (composite) ******. • Mortality for selected medical conditions (composite) ******.
Nursing Sensitive Measures	• Failure to Rescue******. • Pressure Ulcer Prevalence and Incidence by Severity ******. • Patient Falls Prevalence******. • Patient Falls with Injury******.
Cardiac Surgery Measures	• Participation in a Systematic Database for Cardiac Surgery ******. • Pre-operative Beta Blockade******. • Prolonged Intubation******. • Deep Sternal Wound Infection Rate******. • Stroke/CVA******. • Postoperative Renal Insufficiency******. • Surgical Reexploration******. • Anti-platelet Medication at Discharge******. • Beta Blockade Therapy at Discharge******. • Anti-lipid Treatment at Discharge******. • Risk-Adjusted Operative Mortality for CABG******. • Risk-Adjusted Operative Mortality for Aortic Valve Replacement******. • Risk-Adjusted Operative Mortality for Mitral Valve Replacement/Repair******. • Risk-Adjusted Mortality for Mitral Valve Replacement and CABG Surgery******. • Risk-Adjusted Mortality for Aortic Valve Replacement and CABG Surgery ******.

*Measure included in 10 measure starter set.
**Measure included in 21 measure expanded set.
***Measure added in CY 2007 OPPS/ASC final rule with comment period.
****Measure added in FY 2008 IPPS final rule with comment period.
*****Measure added in CY 2008 OPPS/ASC final rule with comment period.
******Measure proposed in FY 2009 IPPS proposed rule.

In summary, we are proposing to increase the RHQDAPU program measures from 30 measures for FY 2009 to a total of 72 measures for FY 2010. The following table lists the increase in the RHQDAPU program measure set since the program's inception:

IPPS payment year	Number of RHQDAPU program quality measures	Topics covered
2005–2006	10	AMI, HF, PN.
2007	21	AMI, HF, PN, SCIP.
2008	27	AMI, HF, PN, SCIP, Mortality, HCAHPS.
2009	30	AMI, HF, PN, SCIP, Mortality, HCAHPS.
2010	72	AMI, HF, PN, SCIP, Mortality, HCAHPS, Nursing Sensitive, Readmission, VTE, Stroke, AHRQ IQI/PSI measures and composites, Cardiac Surgery.

The above measures reflect our continuing commitment to quality improvement in both clinical care and patient safety. These additional measures also demonstrate our commitment to include in the RHQDAPU program only those quality measures that reflect consensus among the affected parties and that have been reviewed by a consensus building process.

To the extent that the proposed measures have not already been endorsed by a consensus building entity such as the NQF, we anticipate that they will be endorsed prior to the time that we issue the FY 2009 IPPS final rule. We intend to finalize the FY 2010 RHQDAPU program measure set in the FY 2009 IPPS final rule, contingent on the endorsement status of the proposed measures. However, to the extent that a measure has not received NQF endorsement by the time we issue the FY 2009 IPPS final rule, we intend to finalize that measure for the FY 2010 RHQDAPU program measure set in the CY 2009 OPPS/ASC final rule with comment period if the measure is endorsed prior to the time we issue the CY–2009–OPPS/ASC final rule with comment period. We are requesting public comment on these measures.

b. Possible New Quality Measures, Measure Sets, and Program Requirements for FY 2011 and Subsequent Years

The following table contains a list of 59 measures and 4 measure sets from which 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 endorsed by a consensus review process such as the NQF. 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 are seeking public comment on the measures and measure sets that are listed as well as any critical gaps or missing measures or measure sets. We specifically request input concerning the following:

- Which of the measures or measure sets should be included in the RHQDAPU program for FY 2011 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?

We are soliciting public comment on the following measure sets for consideration in FY 2011 and subsequent years:

POSSIBLE MEASURES AND MEASURE SETS FOR THE RHQDAPU PROGRAM FOR FY 2011 AND SUBSEQUENT YEARS

Topic	Quality measure
Chronic Pulmonary Obstructive Disease Measures:	
Complications of Vascular Surgery	AAA stratified by open and endovascular methods. Carotid Endarterectomy. Lower extremity bypass.
Inpatient Diabetes Care Measures:	
Healthcare Associated Infection	Central Line-Associated Blood Stream Infections.
Timeliness of Emergency Care Measures, including Timeliness	Surgical Site Infections. Median Time from ED Arrival to ED Departure for Admitted ED Patients. Median Time from ED Arrival to ED Departure for Discharged ED Patients. Admit Decision Time to ED Departure Time for Admitted Patients.
Surgical Care Improvement Project (SCIP)—named SIP for discharges prior to July 2006 (3Q06).	SCIP Infection 8—Short Half-life Prophylactic Administered Preoperatively Redosed Within 4 Hours After Preoperative Dose. SCIP Cardiovascular 3—Surgery Patients on a Beta Blocker Prior to Arrival Receiving a Beta Blocker on Postoperative Days 1 and 2.
Complication Measures (Medicare patients):	
Healthcare Acquired Conditions	Serious reportable events in healthcare (never events). Pressure ulcer prevalence and incidence by severity. Catheter-associated UTI.
Hospital Inpatient Cancer Care Measures	Patients with early stage breast cancer who have evaluation of the axilla. College of American Pathologists breast cancer protocol. Surgical resection includes at least 12 nodes. College of American Pathologists Colon and rectum protocol. Completeness of pathologic reporting.
Serious Reportable Events in Healthcare (“Never Events”)	Surgery performed on the wrong body part. Surgery performed on the wrong patient. Wrong surgical procedure on a patient. Retention of a foreign object in a patient after surgery or other procedure. Intraoperative or immediately post-operative death in a normal health patient (defined as a Class 1 patient for purposes of the American Society of Anesthesiologists patient safety initiative). Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility. Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility. Patient death or serious disability associated with patient elopement (disappearance) for more than four hours. Patient suicide, or attempted suicide resulting in serious disability, while being cared for in a healthcare facility. Patient death or serious disability associated with a medication error (e.g., error involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration). Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products.

POSSIBLE MEASURES AND MEASURE SETS FOR THE RHQDAPU PROGRAM FOR FY 2011 AND SUBSEQUENT YEARS—Continued

Topic	Quality measure
	Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a health care facility. Stage 3 or 4 pressure ulcers acquired after admission to a health care facility. Patient death or serious disability due to spinal manipulative therapy. Patient death or serious disability associated with an electric shock while being cared for in a healthcare facility. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances. Patient death or serious disability associated with a burn incurred from any source while being cared for in a health care facility. Patient death associated with a fall while being cared for in a health care facility. Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a health care facility. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider. Abduction of a patient of any age. Sexual assault on a patient within or on the grounds of a health care facility. Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a health care facility.
Average Length of Stay Coupled with Global Readmission Measure: Preventable Hospital-Acquired Conditions (HACs)	Catheter-Associated Urinary Tract Infection (UTI). Vascular Catheter-Associated Infection. Surgical Site Infections—Mediastinitis after Coronary Artery Bypass Graft (CABG). Surgical Site Infections following Elective Procedures—Total Knee Replacement, Laparoscopic Gastric Bypass, Litigation and Stripping of Varicose Veins. Legionnaires' Disease. Glycemic Control—Diabetic Ketoacidosis, Nonketotic Hypersmolar Coma, Hypoglycemic Coma. Iatrogenic pneumothorax. Delirium. Ventilator-Associated Pneumonia (VAP). Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE). Staphylococcus aureus Septicemia. Clostridium-Difficile Associated Disease (CDAD). Methicillin-Resistant Staphylococcus aureus (MRSA).

c. Considerations in Expanding and Updating Quality Measures Under the RHQDAPU Program

The RHQDAPU program has significantly expanded from an initial set of 10 measures to 30 measures for the FY 2009 payment determination. Initially, the conditions covered by the RHQDAPU program measures were limited to Acute Myocardial Infarction, Heart Failure, and Pneumonia, three high-cost and high-volume conditions. In expanding the process measures, Surgical Infection Prevention was the first additional focus, now supplemented by the two Venous Thromboembolism SCIP measures SCIP VTE–1 and SCIP VTE–2 for surgical patients. Of the 30 current measures, 27 require data collection from chart abstraction and surveying patients and submission of detailed data elements.

In looking forward to further expansion of the RHQDAPU program, we believe it is important to take several goals into consideration. These include: (a) Expanding the types of measures beyond process of care measures to include an increased number of outcome measures, efficiency measures, and experience-of-care measures; (b) expanding the scope of hospital services to which the measures apply; (c) considering the burden on hospitals in collecting chart-abstracted data; (d) harmonizing the measures used in the RHQDAPU program with other CMS quality programs to align incentives and promote coordinated efforts to improve quality; (e) seeking to use measures based on alternative sources of data that do not require chart abstraction or that utilize data already being broadly reported by hospitals, such as clinical data registries or all-payer claims data bases; and (f) weighing the meaningfulness and utility of the measures compared to the burden on hospitals in submitting data under the RHQDAPU program.

We request comments on how to reduce burden on the hospitals participating in the RHQDAPU program. We realize that our proposal to expand the RHQDAPU program measure set from submission of 30 measures in FY 2009 to 72 measures in FY 2010 is potentially burdensome. However, to minimize hospitals' burden, the proposed expansion uses many existing

data sources, including Medicare claims and registry data. We also request comment about which measures would be most useful while minimizing burden.

(1) Expanding the Types of Measures

Section 1886(b)(3)(B)(viii)(III) of the Act requires the Secretary to add other quality measures that the Secretary determines to be appropriate for the measurement of the quality of care furnished by hospitals in inpatient settings. We intend to expand outcome measures such as mortality measures and measures of complications. For FY 2010, the proposed measure set includes:

- Patient Experience of Care. HCAHPS collects data regarding a patient's experience of care in the hospital and provides a very meaningful perspective from the patient standpoint.
- Efficiency. Efficiency is a Quality Domain, as defined by the IOM, that relates Quality and Cost. The three proposed readmission measures address hospital efficiency. These are considered efficiency measures because higher hospital readmission rates are linked to higher costs and also to lower quality of care received during hospitalization and after the initial hospital stay. We are also seeking additional ways in which to address efficiency.
- Outcomes. The three 30-day mortality measures, the STS cardiac surgery measures, the AHRQ PSI/IQI measures, and the four outcome-related nursing sensitive measures represent significant expansion of the RHQDAPU program outcome measures. Additional outcome measures are provided in the list under consideration for inclusion in the RHQDAPU program for FY 2010 and beyond.

(2) Expanding the Scope of Hospital Services To Which Measures Apply

Many of the most common and high-cost Medicare DRGs were posted on the Hospital Compare Web site in March 2008 as part of the President's transparency initiative. We have assessed these DRGs and have found that the FY 2009 RHQDAPU program measure set does not capture data regarding care in important areas such as Inpatient Diabetes Care, Chronic Obstructive Pulmonary Disease (COPD), and Chest Pain. These are areas for which we currently do not have quality measures but which constitute a significant portion of the top paying DRGs for Medicare beneficiaries. We intend to develop measures in these areas in order to provide additional quality information on the most common and high-cost conditions that affect Medicare beneficiaries. In the proposed FY 2010 measure set, measures have been expanded to comprehensively address services related to preventing Venous Thromboembolism, treatment of stroke, and nursing services.

(3) Considering the Burden on Hospitals in Collecting Chart-Abstracted Data for Measures

Although we are proposing to add additional chart-abstracted measures for FY 2010, we also are proposing to stagger the dates for which data collection for these measures must begin, which we believe will lessen the burden on hospitals as they incorporate these new measures into their systems. We also intend to work to simplify the data abstraction specifications that add to the burden of data collection.

(4) Harmonizing With Other CMS Programs

We intend to harmonize measures across settings and other CMS programs as evidenced by the implementation of the readmission measures not only for the RHQDAPU program but also for the QIOs' 9th Scope of Work (SOW) Patient Pathways/Care Transitions Theme, which also uses the 30-Day Readmission Measures and will provide assistance to engage hospitals in improving care. The 9th SOW also focuses on disparities in health care, which is another important area of interest for CMS. We plan to analyze current RHQDAPU measures to identify particular RHQDAPU program measures needed to evaluate the existence of health care disparities, to require data elements that would support better identification of health care disparities, and to find more efficient ways to ascertain this information from claims data. In addition, at least some of the CY 2008 Physician Quality Reporting Initiative (PQRI) measures align with the current RHQDAPU program AMI and SCIP measures reported starting with the FY 2007 RHQDAPU measure set. In other words, there are financial incentives that cover the same clinical processes of care across different providers and settings. For example, Aspirin for Heart Attack corresponds to PQRI measure number 28, and Surgical Infection Antibiotic Timing corresponds to PQRI measure number 20. Outpatient quality measures under the Hospital Outpatient Data Quality Data Reporting Program (HOP QDRP) are also aligned with the RHQDAPU program measures. For example, the HOP QDRP addresses Acute Myocardial Infarction treatment for transferred patients and surgical infection prevention for outpatient surgery.

(5) Using Alternative Data Sources Not Requiring Chart Abstraction

We are actively pursuing alternative data sources, including data sources that are electronically maintained. Alternative data submission methodologies that we are proposing in this rule include:

- Use of registry-collected clinical data for which there is broad existing hospital participation as previously described with the STS registry.
- Use of data collected by State data organizations, State hospital associations, Federal entities such as AHRQ, and/or other data warehouses.

In addition, we are considering adopting the following methods of data collection in the future and request comments on these methods:

- Use of the CMS Continuity Assessment Record & Evaluation (CARE) tool, a standardized data collection instrument, which would allow data to be transmitted in ''real time.'' This recently developed, Internet-based, quality data collection tool was developed as a part of the Post Acute Care Reform Demonstration Program mandated by section 5008 of the DRA. The CARE tool consists of a core set of assessment items, common to all patients and all care settings (meeting criteria of being predictive of cost, utilization, outcomes, among others), organized under five major domains: Medical, Functional, Social, Environmental, and Cognitive—Continuity of Care. The Internet-based CARE tool will communicate critical information across settings accurately, quickly, and efficiently with reduced time burden to providers and is intended to enhance beneficiaries' safe transitions between settings to prevent avoidable, costly events such as unnecessary rehospitalizations or medication errors. We believe that the CARE tool may provide a vehicle for collection of data elements to be used for calculating RHQDAPU program quality measures. CMS is considering utilizing the CARE tool in this manner. The Care tool is available at: *www.cms.hhs.gov/PaperworkReductionActof1995/PRAL/list.asp#TopOfPage.* (Viewers should select ''Show only items with the word ''10243'', click on show items, select CMS–10243, click on downloads, and open Appendices A & B, pdf files.)

We are particularly interested in receiving public comment on this tool. Our goal is to have a standardized, efficient, effective, interoperable, common assessment tool to capture key

patient characteristics that will help CMS capture information related to resource utilization; expected costs as well as clinical outcomes; and post-discharge disposition. The CARE tool will also be useful for guiding payment and quality policies.

Specifically, we are interested in receiving public comments on how CARE might advance the use of health information technology in automating the process for collecting and submitting quality data.

• Submission of data derived from electronic versions of laboratory test reports that are issued by the laboratory in accordance with CLIA to the ordering provider and maintained by the hospital as part of the patient's medical record during and after the patient's course of treatment at the hospital. We are considering using these data to support risk adjustment for claims-based outcome measures (for example, mortality measures) and to develop other outcomes measures. This would support use of electronically maintained data and our goal of reducing manual data collection burden on hospitals.

• Submission of data currently being collected by clinical data registries in addition to the STS registry. This would support and leverage existing clinical data registries and existing voluntary clinical data collection efforts, such as:

• American College of Cardiology (ACC) data registry for Cardiac Measures.

• ACC data registry for ICD.

• ACC data registry for Carotid Stents.

• Vascular Surgery Registry for Vascular Surgical Procedures.

• ACC-sponsored ''Get with the Guidelines'' registry for Stroke Care.

(6) Weighing the Meaningfulness and Utility of the Measures Compared to the Burden on Hospitals in Submitting Data Under the RHQDAPU Program

We are proposing to retire one measure from the RHQDAPU program for FY 2010 because we have determined that the burden on hospitals in abstracting the data outweighs the meaningful benefit that we can ascertain from the measure. As we explained more fully above, we are seeking comments on the applicability to the RHQDAPU program of criteria currently described in the Hospital VBP Issues Paper for inclusion and retirement of measures. The Hospital VBP Issues Paper is located on the CMS Web site at the following location: *http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/hospital_VBP_plan_issues_paper.pdf.*

3. Form and Manner and Timing of Quality Data Submission

In the FY 2007 IPPS final rule (71 FR 48031 through 48045), we set out RHQDAPU program procedures for data submission, program withdrawal, data validation, attestation, public display of hospitals'' quality data, and reconsiderations. Section 1886(b)(3)(B)(viii)(I) of the Act requires that subsection (d) hospitals submit data on measures selected under that clause with respect to the applicable fiscal year. In addition, section 1886(b)(3)(B)(viii)(II) of the Act requires that each subsection (d) hospital submit data on measures selected under that clause to the Secretary in a form and manner, and at a time, specified by the Secretary. The technical specifications for each RHQDAPU program measure are listed in the CMS/Joint Commission Specifications Manual for National Inpatient Hospital Quality Measures (Specifications Manual). We update this manual semiannually or more frequently in unusual cases, and include detailed instructions and calculation algorithms for hospitals to collect and submit the data for the required measures.

The maintenance of the specifications for the measures selected by the Secretary occurs through publication of the Specifications Manual. Thus, measure selection by the Secretary occurs through the rulemaking process; whereas the maintenance of the technical specifications for the selected measures occurs through a subregulatory process so as to best maintain the specifications consistent with current science and consensus. The data submission, Specifications Manual, and submission deadlines are posted on the QualityNet Web site at *www.qualitynet.org*. We require that hospitals submit data in accordance with the specifications for the appropriate discharge periods. When measure specifications are updated, we are proposing to require that hospitals submit all of the data required to calculate the required measures as outlined in the Specifications Manual current as of the patient discharge date.

4. Current and Proposed RHQDAPU Program Procedures

a. RHQDAPU Program Procedures for FY 2009

In the FY 2008 IPPS final rule with comment period, we stated that the requirements for FY 2008 would continue to apply for FY 2009 (72 FR 47361). The ''Reporting Hospital Quality Data for Annual Payment Update Reference Checklist'' section of the QualityNet Web site contains all of the forms to be completed by hospitals participating in the RHQDAPU program.

Under these requirements hospitals must—

• Register with QualityNet, before participating hospitals initially begin reporting data, regardless of the method used for submitting data.

■ Identify a QualityNet Administrator who follows the registration process located on the QualityNet Web site (*www.qualitynet.org*).

■ Complete the revised RHQDAPU program Notice of Participation form (only for hospitals that did not submit a form prior to August 15, 2007). For hospitals that share the same Medicare Provider Number (now CMS Certification Number (CCN)), report the name and address of each hospital on this form.

■ Collect and report data for each of the required measures except the Medicare mortality measures (AMI, HF, and PN 30-day Mortality for Medicare Patients). Hospitals must continuously report these data. Hospitals must submit the data to the QIO Clinical Warehouse using the CMS Abstraction & Reporting Tool (CART), The Joint Commission ORYX® Core Measures Performance Measurement System, or another third-party vendor tool that has met the measurement specification requirements for data transmission to QualityNet. All submissions will be executed through QualityNet. Because the information in the QIO Clinical Warehouse is considered QIO information, it is subject to the stringent QIO confidentiality regulations in 42 CFR Part 480. The QIO Clinical Warehouse will submit the data to CMS on behalf of the hospitals.

• Submit complete data regarding the quality measures in accordance with the joint CMS/Joint Commission sampling requirements located on the QualityNet Web site for each quality measure that requires hospitals to collect and report data. These requirements specify that hospitals must submit a random sample or complete population of cases for each of the topics covered by the quality measures. Hospitals must meet the sampling requirements for these quality measures for discharges in each quarter.

• Submit to CMS on a quarterly basis aggregate population and sample size counts for Medicare and non-Medicare discharges for the four topic areas (AMI, HF, PN, and SCIP).

• Continuously collect and submit HCAHPS data in accordance with the HCAHPS Quality Assurance Guidelines, Version 3.0, located at the Web site: *www.hcahpsonline.org.* The QIO

Clinical Warehouse has been modified to accept zero HCAHPS-eligible discharges. We remind the public to refer to the QualityNet Web site for any questions about how to submit ''zero cases'' information.

For the AMI 30-day, HF 30-day, and PN 30-day mortality measures, CMS uses Part A and Part B claims for Medicare fee-for-service patients to calculate the mortality measures. For FY 2009, hospital inpatient claims (Part A) from July 1, 2006 to June 30, 2007, will be used to identify the relevant patients and the index hospitalizations. Inpatient claims for the index hospitalizations and Part A and Part B claims for all inpatient, outpatient, and physician services received one year prior to the index hospitalizations are used to determine patient comorbidity, which is used in the risk adjustment calculation (see the Web site: *www.qualitynet.org/dcs/ContentServer?cid=1163010398556&pagename=QnetPublic%2FPage%2FQnetTier2&c=Page*). No other hospital data submission is required to calculate the mortality rates.

b. Proposed RHQDAPU Program Procedures for FY 2010

We are proposing to continue requiring the FY 2009 RHQDAPU program procedures for FY 2010 for hospitals participating in the RHQDAPU program, with the following modifications:

• Notice of Participation. New subsection (d) hospitals and existing hospitals that wish to participate in RHQDAPU for the first time must complete a revised ''Reporting Hospital Quality Data for Annual Payment Update Notice of Participation'' that includes the name and address of each hospital that shares the same CCN.

• Data Submission. In order to reduce the burden on hospitals that treat a low number of patients who are covered by the submission requirements, we are proposing the following:

■ AMI. We are proposing that a hospital that has five or fewer AMI discharges (both Medicare and non-Medicare combined) in a quarter will not be required to *submit* AMI patient level data for that quarter. We are proposing to begin implementing this requirement with discharges on or after January 1, 2009. However, the hospital must still submit its aggregate AMI population and sample size counts to CMS for that quarter as part of its quarterly RHQDAPU data submission.

■ HCAHPS. We are proposing that a hospital that has five or fewer HCAHPS-eligible discharges in any month will not be required to submit HCAHPS surveys for that month. However, the hospital must still submit its total number of HCAHPS-eligible cases for that month as part of its quarterly HCAHPS data submission. We are proposing to begin implementing this requirement with discharges on or after January 1, 2009.

■ HF. We are proposing that a hospital that has five or fewer HF discharges (both Medicare and non-Medicare combined) in a quarter will not be required to *submit* HF patient level data for that quarter. However, the hospital must still submit its aggregate HF population and sample size counts to CMS for that quarter as part of its quarterly RHQDAPU data submission. We are proposing to begin implementing this requirement with discharges on or after January 1, 2009.

■ PN. We are proposing that a hospital that has five or fewer PN discharges (both Medicare and non-Medicare combined) in a quarter will not be required to *submit* PN patient level data for that quarter. However, the hospital must still submit its aggregate PN population and sample size counts to CMS for that quarter as part of its quarterly RHQDAPU data submission. We are proposing to begin implementing this requirement with discharges on or after January 1, 2009.

■ SCIP. We are proposing that a hospital that has five or fewer SCIP discharges (both Medicare and non-Medicare combined) in a quarter will not be required to *submit* SCIP patient level data for that quarter. However, the hospital must still submit its aggregate SCIP population and sample size counts to CMS for that quarter as part of its quarterly RHQDAPU data submission. We are proposing to begin implementing this requirement with discharges on or after January 1, 2009.

In addition, we are proposing the following quarterly deadlines for hospitals to submit the FY 2010 AMI, HF, SCIP, PN, Stroke, VTE, and nursing sensitive measure data:

• The data submission deadline for hospitals to submit the patient level measure data for 1st calendar quarter of 2009 discharges would be August 15, 2009. Data must be submitted for each of these measures 4.5 months after the end of the preceding quarter. The specific deadlines will be listed on the QualityNet Web site.

• Even though data on applicable measures will not be due until 4.5 months after the end of the preceding quarter, hospitals must submit their aggregate population and sample size counts no later than 4 months after the end of the preceding quarter (the exact dates will be posted on the QualityNet Web site). This deadline falls approximately 15 days before the data submission deadline for the clinical process measures, and we are proposing it so that we can inform hospitals about their data submission status for the quarter before the 4.5 month clinical process measure deadline. We have found from past experience that hospitals need sufficient time to submit additional data when their counts differ from Medicare claims counts generated by CMS. We will provide hospitals with these Medicare claims counts and submitted patient level data counts on the QualityNet Web site approximately 2 weeks before the quarterly submission deadline. We plan to use the aggregate population and sample size data to assess submission completeness and adherence to sampling requirements for Medicare and non-Medicare patients.

We propose the following quarterly deadlines for hospitals to submit cardiac surgery and the AHRQ PSI/IQI measure data to CMS or other entities:

• The data submission deadline for hospitals to submit cardiac surgery patient level measure data to CMS or STS data registry for 1st calendar quarter of 2009 discharges would be June 1, 2009. Data must be submitted for each of these measures 2 months after the end of the preceding quarter. The specific deadlines will be listed on the QualityNet Web site.

• The data submission deadline for hospitals to submit the AHRQ PSI/IQI measure data to CMS for 4th calendar quarter of 2009 discharges would be April 1, 2010. Data must be submitted for each of these measures 3 months after the end of the preceding quarter. The specific deadlines will be listed on the QualityNet Web site.

We are proposing these quarterly submission deadlines for cardiac surgery and AHRQ PSI/IQI measure data to coordinate submission deadlines with external data registries and provide more timely information to the consumers. We are proposing this quarterly submission deadline for cardiac surgery measure data to coincide with the STS quarterly submission deadline that is approximately 2 months following the discharge quarter. We also propose to shorten the time lag between the date of discharge and the public reporting of these quality measures to provide more timely consumer information.

5. Current and Proposed HCAHPS Requirements

a. FY 2009 HCAHPS Requirements

For FY 2009, hospitals must continuously collect and submit HCAHPS data to the QIO Clinical

Warehouse by the data submission deadlines posted on the Web site at: *www.hcahpsonline.org.* The data submission deadline for first quarter CY 2008 (January through March) discharges is July 9, 2008. To collect HCAHPS data, a hospital can either contract with an approved HCAHPS survey vendor that will conduct the survey and submit data on the hospital's behalf to the QIO Clinical Warehouse, or a hospital can self-administer the survey without using a survey vendor, provided that the hospital meets Minimum Survey Requirements as specified on the Web site at: *www.hcahpsonline.org.* A current list of approved HCAHPS survey vendors can be found on the Web site at: *www.hcahpsonline.org.*

Every hospital choosing to contract with a survey vendor should provide the sample frame of hospital-eligible discharges to its survey vendor with sufficient time to allow the survey vendor to begin contacting each sampled patient within 6 weeks of discharge from the hospital (see the *Quality Assurance Guidelines* for details about HCAHPS eligibility and sample frame creation) and must authorize the survey vendor to submit data via QualityNet on the hospital's behalf. CMS strongly recommends that the hospitals employing a survey vendor promptly review the two HCAHPS Feedback Reports (the Provider Survey Status Summary Report and the Data Submission Detail Report) that are available after the survey vendor submits the data to the QIO Clinical Warehouse. These reports enable a hospital to ensure that its survey vendor has submitted the data on time and it has been accepted into the Warehouse.

In the FY 2008 IPPS final rule with comment period (72 FR 47362), we stated that hospitals and survey vendors must participate in a quality oversight process conducted by the HCAHPS project team. Starting in July 2007, we began asking hospitals/survey vendors to correct any problems that were found and provide followup documentation of corrections for review within a defined time period. If the HCAHPS project team finds that the hospital has not made these corrections, CMS may determine that the hospital is not submitting HCAHPS data that meet the requirements for the RHQDAPU program. As part of these activities, HCAHPS project staff reviews and discusses with survey vendors and hospitals self-administering the survey their specific Quality Assurance Plans, survey management procedures, sampling and data collection protocols, and data preparation and submission procedures.

b. Proposed FY 2010 HCAHPS Requirements

For FY 2010, we are proposing continuous collection of HCAHPS in accordance with the *Quality Assurance Guidelines* located at the Web site: *www.hcahpsonline.org*, by the quarterly data submission deadlines posted on the Web site: *www.hcahpsonline.org*. As stated above, starting with January 1, 2009 discharges, we are proposing that hospitals that have five or fewer HCAHPS-eligible discharges in a month would not be required to submit HCAHPS patient-level data for that month as part of the quarterly data submission that includes that month, but they would still be required to submit the number of HCAHPS-eligible cases for that month as part of their HCAHPS quarterly data submission.

With respect to HCAHPS oversight, we are proposing that the HCAHPS Project Team will continue to conduct site visits and/or conference calls with hospitals/survey vendors to ensure the hospital's compliance with the HCAHPS requirements. During the onsite visit or conference call, the HCAHPS Project Team will review the hospital's/survey vendor's survey systems and will assess protocols based upon the most recent Quality Assurance Guidelines. All materials relevant to survey administration will be subject to review. The systems and program review includes, but it is not necessarily limited to: (a) survey management and data systems; (b) printing and mailing materials and facilities; (c) telephone/IVR materials and facilities; (d) data receipt, entry and storage facilities; and (e) written documentation of survey processes. Organizations will be given a defined time period in which to correct any problems and provide followup documentation of corrections for review. Hospitals/survey vendors will be subject to followup site visits and/or conference calls, as needed. If CMS determines that a hospital is noncompliant with HCAHPS program requirements, CMS may determine that the hospital is not submitting HCAHPS data that meet the requirements of the RHQDAPU program.

6. Current and Proposed Chart Validation Requirements

a. Chart Validation Requirements for FY 2009

In the FY 2008 IPPS final rule with comment period (72 FR 47361), we stated that, until further notice, we would continue to require that hospitals meet the chart validation requirements that we implemented in the FY 2006 IPPS final rule (70 FR 47421 and 47422). These requirements, as well as additional information on validation requirements, continue and are being placed on the QualityNet Web site.

We also stated in the FY 2008 IPPS final rule with comment period that, until further notice, hospitals must pass our validation requirement that requires a minimum of 80-percent reliability, based upon our chart-audit validation process (72 FR 47361).

In the FY 2008 IPPS final rule with comment period (72 FR 47362), we indicated that, for the FY 2009 update, all FY 2008 validation requirements would apply, except for the following modifications. We would modify the validation requirement to pool the quarterly validation estimates for 4th quarter CY 2006 through 3rd quarter 2007 discharges. We would also expand the list of validated measures in the FY 2009 update to add SCIP Infection-2, SCIP VTE–1, and SCIP VTE–2 (starting with 4th quarter CY 2006 discharges). We would also drop the current two-step process to determine if the hospital is submitting validated data. For the FY 2009 update, we stated that we will pool validation estimates covering the four quarters (4th quarter CY 2006 discharges through 3rd quarter 2007 discharges) in a similar manner to the current 3rd quarter pooled confidence interval.

In summary, the following chart validation requirements apply for the FY 2009 RHQDAPU program:

- The 21-measure expanded set will be validated using 4th quarter CY 2006 (4Q06) through 3rd quarter CY 2007 (3Q07) discharges.
- SCIP VTE-1, VTE-2, and SCIP Infection 2 will be validated using 2nd quarter CY 2007 and 3rd quarter CY 2007 discharges.
- SCIP Infection 4 and SCIP Infection 6 must be submitted starting with 1st quarter CY 2008 discharges but will not be validated.
- HCAHPS data must continuously be submitted and will be reviewed as discussed above.
- AMI, HF, and PN 30-day mortality measures will be calculated as discussed below.

In the FY 2008 IPPS final rule with comment period (72 FR 47364), we stated that, for the FY 2008 update and in subsequent years, we would revise and post up-to-date confidence interval information on the QualityNet Web site explaining the application of the confidence interval to the overall validation results. The data are being validated at several levels. There are consistency and internal edit checks to

ensure the integrity of the submitted data; there are external edit checks to verify expectations about the volume of the data received.

b. Proposed Chart Validation Requirements for FY 2010

For FY 2010, we are proposing the following chart validation requirements to reflect the proposed 72-measure set:

• The following 21 measures from the FY 2009 RHQDAPU program measure set will be validated using data from 4th quarter 2007 through 3rd quarter 2008 discharges.

Topic	Quality measure validated from 4th quarter 2007 through 3rd quarter 2008 discharges
Heart Attack (Acute Myocardial Infarction)	Aspirin at arrival Aspirin prescribed at discharge Angiotensin Converting Enzyme Inhibitor (ACE–I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction Beta blocker at arrival Beta blocker prescribed at discharge Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival Adult smoking cessation advice/counseling
Heart Failure (HF)	Left ventricular function assessment Angiotensin Converting Enzyme Inhibitor (ACE–I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction Discharge instructions Adult smoking cessation advice/counseling
Pneumonia (PN)	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 SCIP–VTE–1: Venous thromboembolism (VTE) prophylaxis ordered for surgery patients*** SCIP–VTE–2: VTE prophylaxis within 24 hours pre/post surgery*** SCIP Infection 2: Prophylactic antibiotic selection for surgical patients*** SCIP-Infection 3: Prophylactic antibiotics discontinued within 24 hours after surgery end time

• SCIP Infection 4 and Infection 6 will be validated using data from 2nd and 3rd quarter CY 2008 discharges.

In addition, we are proposing to include the following three measures in the FY 2010 RHQDAPU program validation process that are included the FY 2009 RHQDAPU program measure set but have been updated or deleted for the FY 2010 measure set:

• Pneumonia antibiotic prophylaxis timing within 4 hours will be validated using data from 4th quarter 2007 through 3rd quarter 2008 discharges.

• Percutaneous Coronary Intervention (PCI) Timing within 120 minutes will be validated using data from 4th quarter 2007 through 3rd quarter 2008 discharges.

• Pneumonia Oxygenation Assessment will be validated using data from 4th quarter through 3rd quarter 2008 discharges.

These measures will be submitted by hospitals during 2008 and early 2009, and are available to be validated by CMS in time for the FY 2010 RHQDAPU program payment eligibility determination.

As explained above, will also revise and post up-to-date confidence interval information on the QualityNet Web site explaining the application of the confidence interval to the overall validation results.

c. Chart Validation Methods and Requirements Under Consideration for FY 2011 and Subsequent Years

Under the current and proposed RHQDAPU program chart validation process, we validate measures by reabstracting on a quarterly basis a random sample of five patient records for each hospital. This quarterly sample results in an annual combined sample of 20 patient records across 4 calendar quarters, but because the samples are random, they do not necessarily include patient records covering each of the clinical topics.

We anticipate that the proposed expansion of the RHQDAPU program measure set to include additional clinical topics will decrease the percentage of RHQDAPU clinical topics, as well as the total number of measures, covered in many hospitals' annual chart validation. In addition to the measures for which hospitals must submit data for FY 2009 (with the exception of the Pneumonia Oxygenation Assessment measure), we have proposed that hospitals will submit data on the proposed five stroke measures, six VTE measures, and four nursing sensitive measures for FY 2010 using chart abstraction. CMS is considering the addition of these measures to the current RHQDAPU program validation process for FY 2011 and future years.

However, we are considering whether registries and other external parties that may be collecting data on proposed RHQDAPU program measures could validate the accuracy of those measures beginning in FY 2011. In addition, we note that the proposed readmission measures are calculated using Medicare claims information and do not require chart validation.

We are interested in receiving public comments from a broad set of stakeholders on the impact of adding measures to the validation process, as well as modifications to the current validation process that could improve

the reliability and validity of the methodology. We specifically request input concerning the following:

- Which of the measures or measure sets should be included in the FY 2010 RHQDAPU program chart validation process or in the chart validation process for subsequent years?
- What validation challenges are posed by the RHQDAPU program measures and measure sets? What improvements could be made to validation or reporting that might offset or otherwise address those challenges?
- Should CMS switch from its current quarterly validation sample of five charts per hospital to randomly selecting a sample of hospitals, and selecting more charts on an annual basis to improve reliability of hospital level validation estimates?
- Should CMS select the validation sample by clinical topic to ensure that all publicly reported measures are covered by the validation sample?

7. Data Attestation Requirements

a. Proposed Change to Requirements for FY 2009

In the FY 2008 IPPS final rule with comment period (72 FR 47364), we stated that we would require for FY 2008 and subsequent years that hospitals attest each quarter to the completeness and accuracy of their data, including the volume of data, submitted to the QIO Clinical Warehouse in order to improve aspects of the validation checks. We stated that we would provide additional information to explain this attestation requirement, as well as provide the relevant form to be completed on the QualityNet Web site, at the same time as the publication of the FY 2008 IPPS final rule with comment period.

We are now proposing to defer the requirement in FY 2009 for hospitals to separately attest to the accuracy and completeness of their submitted data due to the burden placed on hospitals to report paper attestation forms on a quarterly basis. We continue to expect that hospitals will submit quality data that are accurate to the best of their knowledge and ability.

b. Proposed Requirements for FY 2010

For FY 2010 and subsequent years, we are soliciting public comment on the electronic implementation of the attestation requirement at the point of data submission to the QIO Clinical Warehouse. Hospitals would electronically pledge to CMS that their submitted data are accurate and complete to the best of their knowledge. Hospitals would be required to designate an authorized contact to CMS for attestation in their patient-level data submission.

Resubmissions would continue to be allowed before the quarterly submission deadline, and hospitals would be required to electronically update their pledges about data accuracy at the time of resubmission. We welcome comments on this approach.

8. Public Display Requirements

Section 1886(b)(3)(B)(viii)(VII) of the Act provides that the Secretary shall establish procedures for making data submitted under the RHQDAPU program available to the public. The RHQDAPU program quality measures are posted on the Hospital Compare Web site (*http://www.hospitalcompare.hhs.gov*). CMS requires that hospitals sign a ''Reporting Hospital Quality Data for Annual Payment Update Notice of Participation'' form when they first register to participate in the RHQDAPU program. Once a hospital has submitted a form, the hospital is considered to be an active RHQDAPU program participant until such time as the hospital submits a withdrawal form to CMS (72 FR 47360). Hospitals signing this form agree that they will allow CMS to publicly report the quality measures as required in the applicable year's RHQDAPU program requirements.

We are proposing to 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 CCN (formerly known as 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 CCNs. Beginning with the FY 2008 RHQDAPU program, hospitals must report the name and address of each hospital that shares the same CCN. This information will be gathered through the RHQDAPU program Notice of Participation form for new hospitals participating in the RHQDAPU program. To increase transparency in public reporting and improve the usefulness of the *Hospital Compare* Web site, we will note on the Web site where publicly reported measures combine results from two or more hospitals.

9. Proposed Reconsideration and Appeal Procedures

For FY 2009, we are proposing to continue the current RHQDAPU program reconsideration and appeal procedures finalized in the FY 2008 IPPS final rule with comment period. The deadline for submitting a request for reconsideration in connection with the FY 2009 payment determination is November 1, 2008. We also are proposing to use the same procedural rules finalized in the FY 2008 IPPS final rule with comment period (72 FR 47365). We posted these rules on the *QualityNet* Web site for the FY 2008 RHQDAPU program reconsideration process.

Under the procedural rules, in order to receive reconsideration for FY 2009, the hospital must—

- Submit to CMS, via QualityNet, a Reconsideration Request form (available on the *QualityNet* Web site) containing the following information:
  - Hospital Medicare ID number.
  - Hospital Name.
  - CMS-identified reason for failure (as provided in the CMS notification of failure letter to the hospital).
  - Hospital basis for requesting reconsideration. (This must identify the hospital's specific reason(s) for believing it met the RHQDAPU program requirements and should receive the full FY 2009 IPPS annual payment update.)
  - CEO contact information, including name, e-mail address, telephone number, and mailing address (must include physical address, not just the post office box).
  - QualityNet System Administrator contact information, including name, e-mail address, telephone number, and mailing address (must include physical address, not just the post office box).
- The request must be signed by the hospital's CEO.
- Following receipt of a request for reconsideration, CMS will—
- Provide an e-mail acknowledgement, using the contact information provided in the reconsideration request, to the CEO and the QualityNet Administrator that the letter has been received.
- Provide a formal response to the hospital CEO, using the contact information provided in the reconsideration request, notifying the facility of the outcome of the reconsideration process. CMS expects the process to take 60 to 90 days from the due date of November 1, 2008.

If a hospital is dissatisfied with the result of a RHQDAPU program

reconsideration decision, the hospital may file a claim under 42 CFR part 405, subpart R (a Provider Reimbursement Review Board (PRRB) appeal).

10. Proposed RHQDAPU Program Withdrawal Deadline for FYs 2009 and 2010

We propose to accept RHQDAPU program withdrawal forms for FY 2009 from hospitals through August 15, 2008. We are proposing this deadline to provide CMS with sufficient time to update the RHQDAPU FY 2009 payment to hospitals starting on October 1, 2008. If a hospital withdraws from the program for FY 2009, it will receive a 2.0 percentage point reduction in its FY 2009 annual payment update.

We also propose to accept RHQDAPU program withdrawal forms for FY 2010 from hospitals through August 15, 2009. If a hospital withdraws from the program for FY 2010, it will receive a 2.0 percentage point reduction in its FY 2010 annual payment update.

11. Requirements for New Hospitals

In the FY 2008 IPPS final rule with comment period (72 FR 47366), we stated that a new hospital that receives a provider number on or after October 1 of each year (beginning with October 1, 2007) will be required to report RHQDAPU program data beginning with the first day of the quarter following the date the hospital registers to participate in the RHQDAPU program. For example, a hospital that receives its CCN on October 2, 2008, and signs up to participate in the RHQDAPU program on November 1, 2007, will be expected to meet all of the data submission requirements for discharges on or after January 1, 2009.

In addition, we strongly recommend that each new hospital participate in an HCAHPS dry run, if feasible, prior to beginning to collect HCAHPS data on an ongoing basis to meet RHQDAPU program requirements. We refer readers to the Web site at *www.hcahpsonline.org* for a schedule of upcoming dry runs. The dry run will give newly participating hospitals the opportunity to gain first-hand experience collecting and transmitting HCAHPS data without the public reporting of results. Using the official survey instrument and the approved modes of administration and data collection protocols, hospitals/survey vendors will collect HCAHPS data and submit the data to QualityNet.

12. Electronic 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 establishment of Federal Health Architecture (FHA) data standards. We encouraged hospitals that are developing systems to conform them to industry standards, and in particular to FHA data standards, once identified, taking measures to ensure that the data necessary for quality measures are captured. Ideally, such systems will also provide point-of-care decision support that enables detection of high levels of performance on the measures. Hospitals using 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 FY 2007 IPPS proposed (71 FR 24095), we again invited public comment on these requirements and related options. In the FY 2007 IPPS final rule (71 FR 48045), we summarized and addressed the additional comments we received. In the FY 2008 IPPS proposed rule (72 FR 24809), we noted that we would welcome additional comments on this issue.

In the FY 2008 IPPS final rule with comment period (72 FR 47366), we responded to the additional comments we received and noted that CMS plans to continue working with the American Health Information Community (AHIC) and other entities to explore processes through which an EMR could speed the collection and minimize the resources necessary for quality reporting. (The AHIC is a Federal advisory body, chartered in 2005 to make recommendations to the Secretary on how to accelerate the development and adoption of health information technology.) In addition, we noted that we will continue to participate in appropriate HHS studies and workgroups, as mentioned by a GAO report (GAO–07–320) about hospital quality data and 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 HQA, the AHA, the FAH, the AAMC, and the Joint Commission. We further anticipate that as HIT is implemented, a formal plan, including training, will be developed to assist providers in understanding and utilizing HIT in reporting quality data. In addition, we will assess the effectiveness of our communications with providers and stakeholders as it relates to all information dissemination pertinent to collecting hospital quality data as part of an independent and comprehensive external evaluation of the RHQDAPU program.

We are again soliciting comments on the issues and challenges associated with EMRs. Specifically, we invite comment on our proposed changes to our data submission requirements to be more aligned with currently implemented HIT systems, including data collection from registries and laboratory data.

We recognize the potential burden on hospitals of increased data reporting requirements for process measures that require chart abstraction. In FY 2007 IPPS rulemaking, we listed a variety of additional possible measures for future years. The measures included and emphasized additional outcomes measures. Additional measures were included for which the data sources are claims. For these, no additional data abstraction or submission would be required for reporting hospitals beyond the claims data. In proposing measures for FY 2010, we seek to emphasize outcome measures and to minimize any additional data collection burden. In addition, as provided in section 1886(b)(3)(B)(viii)(VI) and discussed in section IV.B.2.a. of this proposed rule, we are proposing to retire one measure where there is no meaningful difference among hospitals as a means of reducing data collection burden.

C. Medicare Hospital Value-Based Purchasing (VBP)

1. Medicare Hospital VBP Plan Report to Congress

Through section 5001(b) of the Deficit Reduction Act of 2005, Congress authorized the development of a plan to implement value-based purchasing (VBP) beginning FY 2009 for IPPS hospital services. By statute, the plan must address: (a) The ongoing development, selection, and modification process for measures of quality and efficiency in hospital inpatient settings; (b) reporting, collection, and validation of quality

data; (c) the structure, size, and source of value-based payment adjustments; and (d) public disclosure of hospital performance data.

To develop the plan, CMS created a Hospital VBP Workgroup with members from various CMS components and the Office of the Assistant Secretary for Planning and Evaluation. The Workgroup completed an environmental scan of existing hospital VBP programs, an issue paper outlining the topics to be addressed in the plan, and an options paper presenting design alternatives for the plan.

CMS hosted two public Listening Sessions in early 2007 to solicit comments from interested parties on outstanding design questions associated with development of the plan. The perspectives expressed by stakeholders (including hospitals, consumers, and purchasers) during these sessions and in writing assisted the Workgroup in creating the Medicare Hospital VBP Plan Report to Congress. The Report was submitted to Congress on November 21, 2007.

The Medicare Hospital VBP Plan builds on the foundation of Medicare's current RHQDAPU program (discussed in section IV.B. of the preamble of this proposed rule), which, since FY 2005, has provided differential payments to hospitals that report their performance on a defined set of inpatient measures for public posting on the *Hospital Compare* Web site. If authorized by Congress, the VBP Plan would replace the current quality reporting program with a new program that would include both public reporting and financial incentives to drive improvements in clinical quality, patient-centeredness, and efficiency.

The proposed plan contains the following key components: (a) A performance assessment model that incorporates measures from different quality domains (that is, clinical process of care, patient experience of care, outcomes, among others) to calculate a hospital's total performance score; (b) options for translating this score into an incentive payment that would make a portion of the hospital's base DRG payment contingent on its total performance score; (c) criteria for selecting performance measures for the financial incentive and candidate measures for FY 2009 and beyond; (d) a phased approach for transitioning from the RHQDAPU program to the VBP plan; (e) proposed enhancements to the current data transmission and validation infrastructure to support VBP program requirements; (f) refinements to the *Hospital Compare* Web site to support expanded public reporting; and (g) an approach to monitoring VBP impacts.

The Medicare Hospital VBP Plan Report to Congress is available on the CMS Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/HospitalVBPPlanRTCFINALSUBMITTED2007.pdf.*

2. Testing and Further Development of the Medicare Hospital VBP Plan

The Hospital VBP Workgroup has undertaken testing of the VBP Plan. This ''dry run'' or ''simulation'' of the Plan will use the most recent clinical process-of-care and HCAHPS measurement data available from the RHQDAPU program. New information generated by the VBP Plan testing will include: (a) Performance scores by domain; (b) total performance scores; and (c) financial impacts. Following a process similar to that used in developing the Plan, CMS will analyze this information by individual IPPS hospital, by segment of the hospital industry (that is, geographic location, size, teaching status, among others), and in aggregate for all IPPS hospitals.

The results of VBP Plan testing will be used to further develop the Plan. Priorities for Plan completion include addressing the small numbers issue (described on pages 74 and 75 of the Hospital VBP Plan Report to Congress) and developing a scoring methodology for the outcomes domain (pages 57–58 of the Hospital VBP Plan Report to Congress), which will become an additional aspect of the performance model. After completion, the Plan will be retested.

We are seeking public comments on how to take full advantage of the new information generated through this testing and further Plan development. For example: Should the testing and retesting results be publicly posted? If the testing results were to be posted, would the best location be the *Hospital Compare* Web site or the CMS Web site at: *http://www.cms.hhs.gov*? In what format would public posting be most useful to potential audiences? At what level would the data be posted—individual hospital or some higher level? Which data elements from the testing results would be most useful to share?

D. Sole Community Hospitals (SCHs) and Medicare-Dependent, Small Rural Hospitals (MDHs): Volume Decrease Adjustment (§§ 412.92 and 412.108)

1. Background

Under the IPPS, special payment protections are provided to a sole community hospital (SCH). Section 1886(d)(5)(D)(iii) of the Act defines an SCH as a hospital that, by reason of factors such as isolated location, weather conditions, travel conditions, absence of other like hospitals (as determined by the Secretary), or historical designation by the Secretary as an essential access community hospital, is the sole source of inpatient hospital services reasonably available to Medicare beneficiaries. The regulations that set forth the criteria that a hospital must meet to be classified as an SCH are located in 42 CFR 412.92 of the regulations.

Under the IPPS, separate special payment protections also are provided to a Medicare-dependent, small rural hospital (MDH). Section 1886(d)(5)(G)(iv) of the Act defines an MDH as a hospital that is located in a rural area, has not more than 100 beds, is not an SCH, and has a high percentage of Medicare discharges (not less than 60 percent in its 1987 cost reporting year or in 2 of its most recent 3 audited and settled Medicare cost reporting years). The regulations that set forth the criteria that a hospital must meet to be classified as an MDH are located in 42 CFR 412.108.

Although SCHs and MDHs are paid under special payment methodologies, they are hospitals that are paid under section 1886(d) of the Act. Like all IPPS hospitals paid under section 1886(d) of the Act, SCHs and MDHs are paid for their discharges based on the DRG weights calculated under section 1886(d)(4) of the Act.

Effective with hospital cost reporting periods beginning on or after October 1, 2000, section 1886(d)(5)(D)(i) of the Act (as amended by section 6003(e) of Pub. L. 101–239) and section 1886(b)(3)(I) of the Act (as added by section 405 of Pub. L. 106–113 and further amended by section 213 of Pub. L. 106–554), provide that SCHs are paid based on whichever of the following rates yields the greatest aggregate payment to the hospital for the cost reporting period:

- The Federal rate applicable to the hospital;
- The updated hospital-specific rate based on FY 1982 costs per discharge;
- The updated hospital-specific rate based on FY 1987 costs per discharge; or
- The updated hospital-specific rate based on FY 1996 costs per discharge.

For purposes of payment to SCHs for which the FY 1996 hospital-specific rate yields the greatest aggregate payment, payments for discharges during FYs 2001, 2002, and 2003 were based on a blend of the FY 1996 hospital-specific rate and the greater of the Federal rate or the updated FY 1982 or FY 1987

hospital-specific rate. For discharges during FY 2004 and subsequent fiscal years, payments based on the FY 1996 hospital-specific rate are 100 percent of the updated FY 1996 hospital-specific rate.

Through and including FY 2006, under section 1886(d)(5)(G) of the Act, MDHs are paid based on the Federal rate or, if higher, the Federal rate plus 50 percent of the difference between the Federal rate and the updated hospital-specific rate based on FY 1982 or FY 1987 costs per discharge, whichever is higher. However, section 5003 of Pub. L. 109–171 (DRA) modified these rules for discharges occurring on or after October 1, 2006. Section 5003(c) changed the 50 percent adjustment to 75 percent. Section 5003(b) requires that an MDH use the 2002 cost reporting year as its base year (that is, the FY 2002 updated hospital-specific rate), if that use results in a higher payment. MDHs do not have the option to use their FY 1996 hospital-specific rate.

For each cost reporting period, the fiscal intermediary/MAC determines which of the payment options will yield the highest aggregate payment. Interim payments are automatically made at the highest rate using the best data available at the time the fiscal intermediary/MAC makes the determination. However, it may not be possible for the fiscal intermediary/MAC to determine in advance precisely which of the rates will yield the highest aggregate payment by year's end. In many instances, it is not possible to forecast the outlier payments, the amount of the DSH adjustment, or the IME adjustment, all of which are applicable only to payments based on the Federal rate and not to payments based on the hospital-specific rate. The fiscal intermediary/MAC makes a final adjustment at the close of the cost reporting period after it determines precisely which of the payment rates would yield the highest aggregate payment to the hospital.

If a hospital disagrees with the fiscal intermediary's or MAC's determination regarding the final amount of program payment to which it is entitled, it has the right to appeal the fiscal intermediary's or MAC's decision in accordance with the procedures set forth in 42 CFR Part 405, Subpart R, which concern provider payment determinations and appeals.

2. Volume Decrease Adjustment for SCHs and MDHs: Data Sources for Determining Core Staff Values

Section 1886(d)(5)(D)(ii) of the Act requires that the Secretary make a payment adjustment to an SCH that experiences a decrease of more than 5 percent in its total number of inpatient discharges from one cost reporting period to the next, if the circumstances leading to the decline in discharges were beyond the SCH's control. Section 1886(d)(5)(G)(iii) of the Act requires that the Secretary make a payment adjustment to an MDH that experiences a decrease of more than 5 percent in its total number of inpatient discharges from one cost reporting period to the next, if the circumstances leading to the decline in discharges were beyond the MDH's control. These adjustments were designed to compensate an SCH or MDH for the fixed costs it incurs in the year in which the reduction in discharges occurred, which it may be unable to reduce. Such costs include the maintenance of necessary core staff and services. Our records indicate that less than 10 SCHs/MDHs request and receive this payment adjustment each year.

We believe that not all staff costs can be considered fixed costs. Using a standardized formula specified by us, the SCH or MDH must demonstrate that it appropriately adjusted the number of staff in inpatient areas of the hospital based on the decrease in the number of inpatient days. This formula examines nursing staff in particular. If an SCH or MDH has an excess number of nursing staff, the cost of maintaining those staff members is deducted from the total adjustment. One exception to this policy is that no SCH or MDH may reduce its number of staff to a level below what is required by State or local law. In other words, an SCH or MDH will not be penalized for maintaining a level of staff that is consistent with State or local requirements.

The process for determining the amount of the volume decrease adjustment can be found in Section 2810.1 of the Provider Reimbursement Manual, Part 1 (PRM–1). Fiscal intermediaries/MACs are responsible for establishing whether an SCH or MDH is eligible for a volume decrease adjustment and, if so, the amount of the adjustment. To qualify for this adjustment, the SCH or MDH must demonstrate that: (a) a decrease of more than 5 percent in total number of inpatient discharges has occurred; and (b) the circumstance that caused the decrease in discharges was beyond the control of the hospital. Once the fiscal intermediary/MAC has established that the SCH or MDH satisfies these two requirements, it will calculate the adjustment. The adjustment amount is determined by subtracting the second year's DRG payment from the lesser of: (a) the second year's costs minus any adjustment for excess staff; or (b) the previous year's costs multiplied by the appropriate IPPS update factor minus any adjustment for excess staff. The SCH or MDH receives the difference in a lump-sum payment.

In order to determine whether or not the hospital's nurse staffing level is appropriate, the fiscal intermediary/MAC compares the hospital's actual number of nursing staff in each area with the staffing of like-size hospitals in the same census region. If a hospital employs more than the reported average number of nurses for hospitals of its size and census region, the fiscal intermediary/MAC reduces the amount of the adjustment by the cost of maintaining the additional staff. The amount of the reduction is calculated by multiplying the actual number of nursing staff above the reported average by the average nurse salary for that hospital as reported on the Medicare cost report. The complete process for determining the amount of the adjustment can be found at Section 2810.1 of the PRM–1.

Prior to FY 2007, our policy was for fiscal intermediaries/MACs to obtain average nurse staffing data from the AHA HAS/Monitrend Data Book. However, in light of concerns that the Data Book had been published in 1989 and is no longer updated, in the FY 2007 IPPS rule, we proposed and finalized our policy to update the data sources and methodology used to determine the core staffing factors (that is, the average nursing staff for similar bed size and census region) for purposes of calculating the volume decrease adjustment (71 FR 48056 through 48060). We specified that for adjustment requests for decreases in discharges beginning with FY 2007 (that is, a decrease in discharges in 2007 as compared to 2006), an SCH or MDH could opt to use one of two data sources: the AHA Annual Survey or the Occupational Mix Survey, but could not use the HAS/Monitrend Data Book. (For any open adjustment requests prior to FY 2007, we allowed SCHs and MDHs the option of using the results of any of three sources: (1) The 2006 Occupational Mix Survey for cost reporting periods beginning in FY 2006; (2) the AHA Annual Survey (where available); or (3) the AHA HAS/Monitrend Data Book. We also specified a methodology for calculating those core staffing factors. For purposes of explaining the methodology, we applied it to the 2003 Occupational Mix Survey data. In our explanation, we recognized that some of the 2003 data seemed anomalous, and we solicited comments on a possible alternative methodology. However, there were no suggested alternative methodologies from the

commenters. We also explained that, while we used the 2003 Occupational Mix Survey data ''for purposes of describing how we would implement this methodology,'' the final policy was to use FY 2006 Occupational Mix Survey data going forward. At the time we published the proposed and final rules, however, we had not yet processed the FY 2006 data, and could not present the core staffing figures that resulted from such data.

We have now processed the 2006 Occupational Mix Survey data using the methodology specified in the FY 2007 IPPS final rule and continue to see some results that cause us to believe that the methodology for calculating the core staffing factors should be slightly revised from the methodology discussed in the FY 2007 IPPS final rule (71 FR 48056 through 48060). The new methodology uses a revised formula to remove outliers from the core staffing values.

a. Occupational Mix Survey

In the FY 2007 IPPS final rule (71 FR 48055), we explained the methodology we would use for calculating core staffing values from the Occupational Mix Survey. We stated that we would calculate the nursing hours per patient day for each SCH or MDH by dividing the number of paid nursing hours (for registered nurses, licensed practical nurses and nursing aides) reported on the Occupational Mix Survey by the number of patients days reported on the Medicare cost report. The results would be grouped in the same bed-size groups and census regions as were used in the HAS/Monitrend Data Book.

We indicated that we would publish the mean number of nursing hours per patient day, for each census region and bed-size group, in the **Federal Register** and on the CMS Web site. For purposes of the volume decrease adjustment, the published data would be utilized in the same way as the HAS/Monitrend data: The fiscal intermediary/MAC would multiply the SCH's and MDH's number of patient days by the applicable published hours per patient day. This figure would be divided by the average number of worked hours per year per nurse (for example, 2,080 for a standard 40-hour week). The result would be the target number of core nursing staff for the particular SCH or MDH. If necessary, the cost of any excess staff (number of FTEs that exceed the published number) would be removed from the second year's costs or, if applicable, the previous year's costs multiplied by the IPPS update factor when determining the volume decrease adjustment.

In the FY 2007 IPPS final rule (71 FY 48057), we stated that we would use the results of the FY 2006 Occupational Mix Survey and begin applying the methodology for adjustments resulting from a decrease in discharges in FY 2007. Because the occupational mix survey is conducted once every 3 years, we would update the data set every 3 years. However, at the time of the FY 2007 IPPS final rule, the FY 2006 Occupational Mix Survey data were not available. In that final rule, we described our methodology using the FY 2003 occupational mix data and the FY 2003 Medicare cost report file. However, these data were used only in order to present an example of how our methodology would work. Our final policy was to use FY 2006 occupational mix and cost report data when actually processing adjustment requests.

In the FY 2007 IPPS final rule, to illustrate how we would calculate the average number of nursing hours per patient day by bed size and region, we first merged the FY 2003 Occupational Mix Survey data with the FY 2003 Medicare cost report file. We eliminated all observations for non-IPPS providers, providers who failed to complete the occupational mix survey and the providers for which provider numbers, bed counts, and/or days counts were missing.

For each provider in the pool, we calculated the number of nursing hours by adding the number of registered nurses, licensed practical nurses, and nursing aide hours reported on the Occupational Mix Survey. We divided the result of this calculation by the total number of inpatient days reported on the cost report to determine the number of nursing hours per patient day. For purposes of calculating the census regional averages for the various bed-size groups, we finalized our rule to only include observations that fell within three standard deviations of the mean of all observations, thus removing potential outliers in the data.

When the FY 2006 Occupational Mix Survey data became available, our analysis of the results indicated that the methodology for computing core staffing factors should be further revised in order to further eliminate outlier data.

After consulting with the Office of the Actuary on appropriate statistical methods to remove outlier data, we are proposing to modify our methodology for calculating the average nursing hours per patient day using the FY 2006 Occupational Mix Survey data and FY 2006 Medicare cost report data. Similar to what was finalized in the FY 2007 IPPS rule, we are proposing to merge the FY 2006 Occupational Mix Survey data with the FY 2006 Medicare cost report file. We would then eliminate all observations for non-IPPS providers, providers who failed to complete the occupational mix survey and the providers for which provider numbers, bed counts and/or days counts were missing. We would annualize the results so that the nursing hours from the Occupational Mix Survey and the patient days reported on the Medicare cost report is representative of one year.

For each provider in the pool, we would calculate the number of nursing hours by adding the number of registered nurses, licensed practical nurses, and nursing aide hours reported on the Occupational Mix Survey. We would divide the result of this calculation by the total number of patient days reported on line 12 on Worksheet S–3, Part I, Column 6 of the Medicare cost report. This includes patient days in the general acute care area and the intensive care unit area. The result is the number of nursing hours per patient day.

For purposes of calculating the census regional averages for the various bed-size groups, we are proposing a different method to remove outliers in the data. First, we would calculate the difference between the observations in the 75th percentile and the 25th percentile, which is the inter-quartile range. We would remove observations that are greater than the 75th percentile plus 1.5 times the inter-quartile range and less than the 25th percentile minus 1.5 times the inter-quartile range. This methodology, known as the Tukey method, is a common statistical method used by the Office of the Actuary. Under the standard deviation method described in the FY 2007 IPPS final rule, the mean and standard deviation can be influenced by extreme values (because the standard deviation is increased by the very observations that would otherwise be discarded from the analysis). Our proposed methodology is a more robust technique because it uses the quartile values instead of variance to describe the spread of the data, and quartiles are less influenced by extreme outlier values that may be present in the data.

Our proposed method would prevent the mean from being influenced by extreme observations and assumes that the middle 50 percent of the data has no outlier observations. The application of this methodology would result in a pool of approximately 2,578 providers. Each census region and bed group category required at least three providers in order for their average to be published. The results of the average nursing hours per patient day by bed size and region using

the FY 2006 Occupational Mix Survey Data and the FY 2006 hospital cost report data are shown in the table below. As stated in the FY 2007 IPPS final rule (71 FR 48059), the results of the FY 2006 Occupational Mix Survey may be used for the volume decrease adjustment calculations for decreases in discharges beginning with cost reporting periods beginning in FYs 2006, 2007, and 2008.

PAID NURSING HOURS PER PATIENT DAY

Number of beds	Census Region								
	New England	Middle Atlantic	South Atlantic	East North Central	East South Central	West North Central	West South Central	Mountain	Pacific
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
0–49	25.47	20.60	21.08	24.52	20.27	25.92	22.16	24.52	20.99
50–99	20.99	18.51	20.36	23.44	19.00	22.44	20.44	22.54	18.89
100–199	18.12	16.31	17.31	18.87	17.43	19.50	17.01	18.70	16.25
200–399	16.92	13.80	16.23	17.79	16.06	18.66	14.56	16.82	16.63
400+	17.52	14.43	16.68	18.41	14.14	16.90	16.25	15.50	18.15

b. AHA Annual Survey

In the FY 2007 IPPS final rule (71 FR 48058), we also allowed SCHs or MDHs that experienced a greater than 5 percent reduction in the number of discharges in a cost reporting period the option of using the AHA Annual Survey results, where available, to compare the number of hospital's core staff with other like-sized hospitals in its geographic area. Our methodology for calculating the nursing hours per patient day using the AHA Annual Survey data and the Medicare hospital cost report was similar to the methodology using the Occupational Mix Survey data (eliminating outliers outside of three standard deviations from the mean). For this reason, as with the occupational mix data, both standard deviations and the mean could be influenced by extreme values. Therefore, we are proposing to refine our methodology to calculate the core staffing factors using the AHA Annual Survey data as well. The AHA Annual Survey contains FTE counts for registered nurses, practical and vocational nurses, nursing assistive personnel, and other personnel in both inpatient and outpatient areas of the hospital. This is consistent with the Occupational Mix Survey which collects data on both the inpatient and outpatient areas of the hospital.

In the FY 2007 IPPS final rule, we stated we would calculate the nursing hours per patient day using the AHA Annual Survey data in a similar method to the Occupational Mix Survey. Consistent with the HAS/Monitrend Data book, we would only calculate the average number of nursing staff for a bed-size/census group if there are data available for three or more hospitals. First, we would merge the AHA Annual Survey Data with the corresponding Medicare cost report. We would eliminate all observations for non-IPPS providers, providers with hospital-based SNFs, and the providers for which provider numbers, bed counts, and/or days counts were missing. We would multiply the number of nurse, licensed practical nurse, and nursing aide FTEs reported on the AHA Annual Survey by 2,080 hours to derive the number of nursing hours per year (based on a 40-hour work week). We would then divide this number by the total number of patient days reported on line 12 on Worksheet S–3, Part I, Column 6 of the Medicare cost report. In the FY 2007 IPPS final rule (71 FR 48060), we had stated that we would eliminate all providers with results beyond three standard deviations from the mean. However, to be consistent with our methodology with the Occupational Mix Survey data, we are also proposing that we would remove outliers from the AHA Annual Survey data by calculating the difference between the observations in the 75th percentile and the 25th percentile, which is the inter-quartile range. Then, we are proposing to remove observations that are greater than the 75th percentile plus 1.5 times the inter-quartile range and less than the 25th percentile minus 1.5 times the inter-quartile range. After removing the outliers, we would group the hospitals by bed size and census area to calculate the average number of nursing hours per patient day for each category. Using the 2006 AHA Annual Survey data as an example, this would result in a pool of approximately 1,205 providers. The results of the nursing hours per patient day using the 2006 AHA Annual Survey data and the Medicare cost report data are shown below. The 2006 Survey would be used for the volume decrease adjustment calculations for decreases in discharges occurring during cost reporting periods beginning in FY 2006. As we stated in the FY 2007 IPPS final rule, for other years, the corresponding AHA Annual Survey would be used for the year in which the decreased occurred. For example, if a hospital experienced a decrease between its 2004 and 2005 cost reporting periods, the fiscal intermediary/MAC would compare the hospital's 2005 staffing with the results of the 2005 AHA Annual Survey, using the methodology discussed above.

PAID NURSING HOURS PER PATIENT DAY

Number of beds	Census Region								
	New England	Middle Atlantic	South Atlantic	East North Central	East South Central	West North Central	West South Central	Mountain	Pacific
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
0–49	25.82	23.48	21.77	26.12	17.25	24.75	23.66	25.44	24.50
50–99	23.42	19.40	20.69	23.47	22.06	23.28	20.55	19.28	19.91

PAID NURSING HOURS PER PATIENT DAY—Continued

Number of beds	Census Region								
	New England	Middle Atlantic	South Atlantic	East North Central	East South Central	West North Central	West South Central	Mountain	Pacific
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
100–199	18.89	17.46	18.43	20.08	19.64	20.23	19.02	18.80	18.71
200–399	18.89	14.96	15.75	17.02	15.07	19.81	15.85	18.17	18.01
400+	18.98	16.66	17.39	21.59	16.47	17.71	15.06	17.76	21.11

E. Rural Referral Centers (RRCs) (§ 412.96)

Under the authority of section 1886(d)(5)(C)(i) of the Act, the regulations at § 412.96 set forth the criteria that a hospital must meet in order to qualify under the IPPS as an RRC. For discharges occurring before October 1, 1994, RRCs received the benefit of payment based on the other urban standardized amount rather than the rural standardized amount. Although the other urban and rural standardized amounts are the same for discharges occurring on or after October 1, 1994, RRCs continue to receive special treatment under both the DSH payment adjustment and the criteria for geographic reclassification.

Section 402 of 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 the average hourly wage of the labor market area where the hospital is located by a certain percentage (106/108 percent in FY 2008).

Section 4202(b) of 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.

One of the criteria under which a hospital may qualify as a RRC is to have 275 or more beds available for use (§ 412.96(b)(1)(ii)). A rural hospital that does not meet the bed size requirement can qualify as an RRC if the hospital meets two mandatory prerequisites (a minimum CMI and a minimum number of discharges), and at least one of three optional criteria (relating to specialty composition of medical staff, source of inpatients, or referral volume) (§ 412.96(c)(1) through (c)(5) and the September 30, 1988 **Federal Register** (53 FR 38513)). With respect to the two mandatory prerequisites, a hospital may be classified as an RRC if—

- The hospital's CMI is at least equal to the lower of the median CMI for urban hospitals in its census region, excluding hospitals with approved teaching programs, or the median CMI for all urban hospitals nationally; and
- The hospital's number of discharges is at least 5,000 per year, or, if fewer, the median number of discharges for urban hospitals in the census region in which the hospital is located. (The number of discharges criterion for an osteopathic hospital is at least 3,000 discharges per year, as specified in section 1886(d)(5)(C)(i) of the Act.)

1. Case-Mix Index

Section 412.96(c)(1) provides that CMS establish updated national and regional CMI values in each year's annual notice of prospective payment rates for purposes of determining RRC status. The methodology we used to determine the national and regional CMI values is set forth in the regulations at § 412.96(c)(1)(ii). The proposed national median CMI value for FY 2009 includes all urban hospitals nationwide, and the proposed regional values for FY 2009 are the median CMI values of urban hospitals within each census region, excluding those hospitals with approved teaching programs (that is, those hospitals that train residents in an approved GME program as provided in § 413.75). These values are based on discharges occurring during FY 2007 (October 1, 2006 through September 30, 2007), and include bills posted to CMS' records through December 2007.

We are proposing that, in addition to meeting other criteria, if rural hospitals with fewer than 275 beds are to qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2008, they must have a CMI value for FY 2007 that is at least—

- 1.4285; or
- The median CMI value (not transfer-adjusted) for urban hospitals (excluding hospitals with approved teaching programs as identified in § 413.75) calculated by CMS for the census region in which the hospital is located.

The proposed 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)	1.2515
2. Middle Atlantic (PA, NJ, NY)	1.2691
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.3589

Region	Case-mix index value
4. East North Central (IL, IN, MI, OH, WI)	1.3572
5. East South Central (AL, KY, MS, TN)	1.3040
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.3557
7. West South Central (AR, LA, OK, TX)	1.4405
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.4692
9. Pacific (AK, CA, HI, OR, WA)	1.3872

The preceding numbers will be revised in the FY 2009 IPPS final rule to the extent required to reflect the updated FY 2007 MEDPAR file, which will contain data from additional bills received through March 2008.

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.

2. Discharges

Section 412.96(c)(2)(i) provides that CMS set forth the national and regional numbers of discharges in each year's annual notice of prospective payment rates for purposes of determining RRC status. As specified in section 1886(d)(5)(C)(ii) of the Act, the national standard is set at 5,000 discharges. We are proposing to update the regional standards based on discharges for urban hospitals' cost reporting periods that began during FY 2006 (that is, October 1, 2005 through September 30, 2006), which is the latest cost report data available at the time this proposed rule was developed.

Therefore, we are proposing that, in addition to meeting other criteria, a hospital, if it is to qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2008, must have as the number of discharges for its cost reporting period that began during FY 2006 a figure that is at least—

- 5,000 (3,000 for an osteopathic hospital); or
- The median number of discharges for urban hospitals in the census region in which the hospital is located, as indicated in the following table.

Region	Number of discharges
1. New England (CT, ME, MA, NH, RI, VT)	8,158
2. Middle Atlantic (PA, NJ, NY)	10,443
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	10,344
4. East North Central (IL, IN, MI, OH, WI)	8,900
5. East South Central (AL, KY, MS, TN)	7,401
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	7,988
7. West South Central (AR, LA, OK, TX)	5,816
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	9,919
9. Pacific (AK, CA, HI, OR, WA)	8,600

These numbers will be revised in the FY 2009 IPPS final rule based on the latest available cost reports.

We note that the median number of discharges for hospitals in each census region is greater than the national standard of 5,000 discharges. Therefore, 5,000 discharges is the minimum criterion for all hospitals.

We reiterate that, if an osteopathic hospital is to qualify for RRC status for cost reporting periods beginning on or after October 1, 2008, the hospital would be required to have at least 3,000 discharges for its cost reporting period that began during FY 2005.

F. Indirect Medical Education (IME) Adjustment (§ 412.105)

1. Background

Section 1886(d)(5)(B) of the Act provides for an additional payment amount under the IPPS for hospitals that have residents in an approved graduate medical education (GME) program in order to reflect the higher indirect patient care costs of teaching hospitals relative to nonteaching hospitals. The regulations regarding the calculation of this additional payment, known as the indirect medical education (IME) adjustment, are located at § 412.105.

The Balanced Budget Act of 1997 (Pub. L. 105–33) established a limit on the number of allopathic and osteopathic residents that a hospital may include in its full-time equivalent (FTE) resident count for direct GME and IME payment purposes. Under section 1886(h)(4)(F) of the Act, for cost reporting periods beginning on or after October 1, 1997, a hospital's unweighted FTE count of residents for purposes of direct GME may not exceed the hospital's unweighted FTE count for its most recent cost reporting period ending on or before December 31, 1996. Under section 1886(d)(5)(B)(v) of the Act, a similar limit on the FTE resident count for IME purposes is effective for discharges occurring on or after October 1, 1997.

2. IME Adjustment Factor for FY 2009

The IME adjustment to the MS–DRG payment is based in part on the applicable IME adjustment factor. The IME adjustment factor is calculated by using a hospital's ratio of residents to beds, which is represented as r, and a formula multiplier, which is represented as c, in the following equation: $c \times [\{1 + r\}^{.405} - 1]$. The formula is traditionally described in terms of a certain percentage increase in payment for every 10-percent increase in the resident-to-bed ratio.

Section 502(a) of 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. In the FY 2005 IPPS final rule, we announced the schedule of formula multipliers to be used in the calculation of the IME adjustment and incorporated the schedule in our

regulations at § 412.105(d)(3)(viii) through (d)(3)(xii). Section 502(a) modifies the formula multiplier beginning midway through FY 2004 and provides for a new schedule of formula multipliers for FYs 2005 and thereafter as follows:

- For discharges occurring on or after April 1, 2004, and before October 1, 2004, the formula multiplier is 1.47.
- For discharges occurring during FY 2005, the formula multiplier is 1.42.
- For discharges occurring during FY 2006, the formula multiplier is 1.37.
- For discharges occurring during FY 2007, the formula multiplier is 1.32.
- For discharges occurring during FY 2008 and fiscal years thereafter, the formula multiplier is 1.35.

Accordingly, for discharges occurring during FY 2009, the formula multiplier would be 1.35. We estimate that application of this formula multiplier for FY 2009 IME adjustment will result in an increase in IME payment of 5.5 percent for every approximately 10-percent increase in the hospital's resident-to-bed ratio.

G. Medicare GME Affiliation Provisions for Teaching Hospitals in Certain Emergency Situations; Technical Correction (§ 413.79(f)(6)(iv))

1. Background

Under section 1886(h) of the Act, as amended by section 9202 of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (Pub. L. 99–272), the Secretary is authorized to make payments to hospitals for the direct costs of approved GME programs. Section 1886(d)(5)(B) of the Act provides that prospective payment acute care hospitals that have residents in an approved GME program receive an additional payment for a Medicare discharge to reflect the higher patient care costs of teaching hospitals, that is, IME costs. Sections 1886(h)(4)(F) and 1886(d)(5)(B)(v) of the Act establish limits on the number of allopathic and osteopathic residents that hospitals may count for purposes of calculating direct GME payments and the IME adjustment, respectively, establishing hospital-specific direct GME and IME FTE resident caps. Under the authority granted by section 1886(h)(4)(H)(ii) of the Act, the Secretary issued rules to allow institutions that are members of the same affiliated group to apply their direct GME and IME FTE resident caps on an aggregate basis through a Medicare GME affiliation agreement. The Medicare regulations at §§ 413.75 and 413.76 permit hospitals, through a Medicare GME affiliation agreement, to adjust IME and direct GME FTE resident caps to reflect the rotation of residents among affiliated hospitals.

In response to circumstances in the aftermath of Hurricanes Katrina and Rita, we supplemented regulations in the April 12, 2006 interim final rule with comment period published in the **Federal Register** (71 FR 18654). The regulatory changes allowed certain hospitals to engage in emergency Medicare GME affiliations so that Medicare funding for GME is maintained while there are displaced residents training at various host hospitals even as the hurricane-affected hospitals are rebuilding their training programs. The modifications to the regulations at § 413.75(b) and § 413.76(f) provided flexibility for home hospitals whose residency programs have been disrupted due to an emergency to enter into *emergency* Medicare GME affiliation agreements with host hospitals where the hospitals may not otherwise meet the regulatory requirements to form Medicare GME affiliations. (We note that on November 27, 2007, we issued a second interim final rule with comment period providing further flexibility relating to emergency Medicare GME affiliation agreements (72 FR 66893 through 66898). We expect to address the public comments received on both interim final rules with comment period and finalize our policies in the FY 2009 IPPS final rule scheduled to be published in August 2008.)

2. Technical Correction

In the April 12, 2006 interim final rule, we revised § 413.79(f) by adding a new paragraph (6) to provide for more flexibility in Medicare GME affiliations for home hospitals located in section 1135 emergency areas to allow the home hospitals to efficiently find training sites for displaced residents. We have discovered that, under § 413.79(f)(6)(iv), in our provisions on the host hospital exception from the rolling average for the period from August 29, 2005 to June 30, 2006, we included an incorrect cross-reference to the rolling average requirements for direct GME as ''§ 413.75(d).'' The correct citation to the rolling average requirements for direct GME is § 413.79(d). We are proposing to correct the cross-reference under § 413.79(f)(6)(iv) to read ''paragraph (d) of this section''.

H. Payments to Medicare Advantage Organizations: Collection of Risk Adjustment Data (§ 422.310)

Section 1853 of the Act requires CMS to make advance monthly payments to a Medicare Advantage (MA) organization for each beneficiary enrolled in an MA plan offered by the organization for coverage of Medicare Part A and Part B benefits. Section 1853(a)(1)(C) of the Act requires CMS to adjust the monthly payment amount for each enrollee to take into account the health status of the MA plan's enrollees. Under the CMS-Hierarchical Condition Category (HCC) risk adjustment payment methodology, CMS determines risk scores for MA enrollees for a year and adjusts the monthly payment amount using the appropriate enrollee risk score.

Under section 1853(a)(3)(B) of the Act, MA organizations are required to ''submit data regarding inpatient hospital services . . . and data regarding other services and other information as the Secretary deems necessary'' in order to implement a methodology for ''risk adjusting'' payments made to MA organizations. Risk adjustments to payments are made in order to take into account ''variations in per capita costs based on [the] health status'' of the Medicare beneficiaries enrolled in an MA plan offered by the organization. Submission of data on inpatient hospital services has been required with respect to services beginning on or after July 1, 1997. Submission of data on other services has been required since July 1, 1998.

While we initially required the submission of comprehensive data regarding services provided by MA organizations, including comprehensive inpatient hospital encounter data, we subsequently permitted MA organizations to submit an ''abbreviated'' set of data. Our regulations at 42 CFR 422.310(d)(1) currently explicitly provide MA organizations with the option of submitting an abbreviated data set. Under this provision, we currently collect limited risk adjustment data from MA organizations, primarily diagnosis data.

From calendar years 2000 through 2006, application of risk adjustment to MA payments was ''phased in'' with an increasing percentage of the monthly capitation payment subjected to risk adjustment. Beginning with calendar year 2007, 100 percent of payments to MA organizations are risk-adjusted. Given the increased importance of the accuracy of our risk adjustment methodology, we are proposing to amend § 422.310 to provide that CMS will collect data from MA organizations regarding each item and service provided to an MA plan enrollee. This will allow us to include utilization data and other factors that CMS can use in developing the CMS–HCC risk

adjustment models in order to reflect patterns of diagnoses and expenditures in the MA program.

Specifically, we are proposing to revise § 422.310(a) to clarify that risk adjustment data are data used not only in the application of risk adjustment to MA payments, but also in the development of risk adjustment models. For example, once encounter data for MA enrollees are available, CMS would have beneficiary-specific information on the utilization of services by MA plan enrollees. These data could be used to calibrate the CMS–HCC risk adjustment models using MA patterns of diagnoses and expenditures.

We are proposing to revise §§ 422.310(b), (c), (d)(3), and (g) to clarify that the term ''services'' includes items and services.

We are proposing to revise § 422.310(d) to clarify that CMS has the authority to require MA organizations to submit encounter data for each item and service provided to an MA plan enrollee. The proposed revision also would clarify that CMS will determine the formats for submitting encounter data, which may be more abbreviated than those used for the fee-for-service claims data submission process.

We are proposing to revise § 422.310(f) to clarify that one of the ''other'' purposes for which CMS may use risk adjustment data collected under this section would be to update risk adjustment models with data from MA enrollees. In addition, when providing that CMS may use risk adjustment data for purposes other than adjusting payments as described at §§ 422.304(a) and (c), we are proposing to delete the phrase ''except for medical records data'' from paragraph (f). Any use of medical records data collected under paragraph (e) of § 422.310 is governed by the Privacy Act and the privacy provisions in the HIPAA. Furthermore, there may be occasions when we learn from analysis of medical record review data that some organizations have misunderstood our guidance on how to implement an operational instruction. We want to be able to provide improved guidance to MA organizations based on any insights that may emerge during analysis of the medical record review data.

In addition, we are proposing a technical correction to § 422.310(f) to clarify that risk adjustment data are used not only to adjust payments to plans described at §§ 422.301(a)(1), (a)(2), and (a)(3) (which refer to coordinated care plans and private fee-for-service plans), but also to adjust payments for ESRD enrollees and payments to MSA plans and Religious Fraternal Benefit society plans, as described at § 422.301(c).

Under § 422.310(g), we would continue to provide that data that CMS receives after the final deadline for a payment year will not be accepted for purposes of the reconciliation. However, we are proposing to revise paragraph (g)(2) of § 422.310 to change the deadline from ''December 31'' of the payment year to ''January 31'' of the year following the payment year. We are also proposing to add language to provide that CMS may adjust deadlines as appropriate.

I. Hospital Emergency Services under EMTALA (§ 489.24)

1. Background

Sections 1866(a)(1)(I), 1866(a)(1)(N), and 1867 of the Act impose specific obligations on certain Medicare-participating hospitals and CAHs. (Throughout this section of this proposed rule, when we reference the obligation of a ''hospital'' under these sections of the Act and in our regulations, we mean to include CAHs as well.) These obligations concern individuals who come to a hospital emergency department and request examination or treatment for a medical condition, and apply to all of these individuals, regardless of whether they are beneficiaries of any program under the Act.

The statutory provisions cited above are frequently referred to as the Emergency Medical Treatment and Labor Act (EMTALA), also known as the patient antidumping statute. EMTALA was passed in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), 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. Under section 1866(a)(1)(I)(i) of the Act, a hospital that fails to fulfill its EMTALA obligations under these provisions may be subject to termination of its Medicare provider agreement, which would result in loss of all Medicare and Medicaid payments.

Section 1867 of the Act sets forth requirements for medical screening examinations for individuals who come to the hospital and request examination or treatment for a medical condition. The section further provides that if a hospital finds that such an individual has an emergency medical condition, it is obligated to provide that individual with either necessary stabilizing treatment or an appropriate transfer to another medical facility where stabilization can occur.

The EMTALA statute also outlines the obligation of hospitals to receive appropriate transfers from other hospitals. Section 1867(g) of the Act states that a participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or, with respect to rural areas, regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires these specialized capabilities or facilities if the hospital has the capacity to treat the individual. The regulations implementing section 1867 of the Act are found at 42 CFR 489.24. The regulations at 42 CFR 489.20(l), (m), (q), and (r) also refer to certain EMTALA requirements. The Interpretive Guidelines concerning EMTALA are found at Appendix V of the CMS State Operations Manual.

2. EMTALA Technical Advisory Group (TAG) Recommendations

Section 945 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Pub. L. 108–173, required the Secretary to establish a Technical Advisory Group (TAG) to advise the Secretary on issues related to the regulations and implementation of EMTALA. The MMA specified that the EMTALA TAG be composed of 19 members, including the Administrator of CMS, the Inspector General of HHS, hospital representatives and physicians representing specific specialties, patient representatives, and representatives of organizations involved in EMTALA enforcement.

The EMTALA TAG's functions, as identified in the charter for the EMTALA TAG, were as follows: (1) Review EMTALA regulations; (2) provide advice and recommendations to the Secretary concerning these regulations and their application to hospitals and physicians; (3) solicit comments and recommendations from hospitals, physicians, and the public regarding the implementation of such regulations; and (4) disseminate information concerning the application of these regulations to hospitals, physicians, and the public. The TAG met 7 times during its 30-month term, which ended on September 30, 2007. At its meetings, the TAG heard testimony from representatives of physician groups, hospital associations, and others regarding EMTALA issues and concerns. During each meeting, the three subcommittees established by the TAG (the On-Call Subcommittee, the Action Subcommittee, and the Framework Subcommittee) developed

recommendations, which were then discussed and voted on by members of the TAG. In total, the TAG submitted 55 recommendations to the Secretary. If implemented, some of the recommendations would require regulatory changes. Of the 55 recommendations developed by the TAG, 5 have already been implemented by CMS. A complete list of TAG recommendations will be available shortly in the Emergency Medical Treatment and Labor Act Technical Advisory Group final report available at the Web site: *http://www.cms.hhs.gov/FACA/07_emtalatag.asp.* The following recommendations have already been implemented by CMS:

• That CMS revise, in the EMTALA regulations [42 CFR 489.24(b)], the following sentence contained in the definition of ''labor'': ''A woman experiencing contractions is in true labor unless a physician certifies that, after a reasonable time of observation, the woman is in false labor.''

This recommendation was adopted with modification in the FY 2007 IPPS final rule (71 FR 48143). We revised the definition of ''labor'' in the regulations at § 489.24(b) to permit a physician, certified nurse-midwife, or other qualified medical person, acting within his or her scope of practice in accordance with State law and hospital bylaws, to certify that a woman is experiencing false labor. We issued Survey and Certification Letter S&C–06–32 on September 29, 2006, to clarify the regulation change. (The Survey and Certification Letter can be found at the following Web site: *http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp*).

• That hospitals with specialized capabilities (as defined in the EMTALA regulations) that do not have a dedicated emergency department be bound by the same responsibilities under EMTALA as hospitals with specialized capabilities that do have a dedicated emergency department.

This recommendation was adopted in the FY 2007 IPPS final rule (71 FR 48143). We added language at § 489.24(f) that makes explicit the current policy that all Medicare-participating providers with specialized capabilities are required to accept an appropriate transfer if they have the capacity to treat the individual. We issued Survey and Certification Letter S&C–06–32 on September 29, 2006, to clarify the regulation change. (The Survey and Certification Letter can be found at the following Web site: *http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp*).

• That CMS clarify the intent of regulations regarding obligations under EMTALA to receive individuals who arrive by ambulance. Specifically, the TAG recommended that CMS revise a letter of guidance that had been issued by the agency to clarify its position on the practice of delaying the transfer of an individual from an emergency medical service provider's stretcher to a bed in a hospital's emergency department.

This recommendation was adopted with modification by CMS in Survey and Certification Letter S&C–07–20, which was released on April 27, 2007. (The Survey and Certification Letter can be found at the following Web site: *http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp).*

• That CMS clarify that a hospital may not refuse to accept an individual appropriately transferred under EMTALA on the grounds that it (the receiving hospital) does not approve the method of transfer arranged by the attending physician at the sending hospital (for example, a receiving hospital may not require the sending hospital to use an ambulance transport designated by the receiving hospital). In addition, CMS should improve its communication of such clarifications with its regional offices.

This recommendation was adopted and implemented by CMS in Survey and Certification Letter S&C–07–20, which was released on April 27, 2007. (The Survey and Certification Letter can be found at the following Web site: *http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp*).

• That CMS strike the language in the Interpretive Guidelines (CMS State Operations Manual, Appendix V) that addresses telehealth/telemedicine (relating to the regulations at § 489.24(j)(1)) and replace it with language that clarifies that the treating physician ultimately determines whether an on-call physician should come to the emergency department and that the treating physician may use a variety of methods to communicate with the on-call physician. A potential violation occurs only if the treating physician requests that the on-call physician come to the emergency department and the on-call physician refuses.

This recommendation was adopted and implemented by CMS in Survey and Certification Letter S&C–07–23, which was released on June 22, 2007. (The Survey and Certification Letter can be found at the following Web site: *http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp).*

We are considering the remaining recommendations of the EMTALA TAG and may address them through future changes to or clarifications of the existing regulations or the Interpretive Guidelines, or both.

At the end of its term, the EMTALA TAG compiled a final report to the Secretary. This report includes, among other materials, minutes from each TAG meeting as well as a comprehensive list of all of the TAG's recommendations. The final report will be available shortly at the following Web site: *http://www.cms.hhs.gov/FACA/07_emtalatag.asp.*

3. Proposed Changes Relating to Applicability of EMTALA Requirements to Hospital Inpatients

While many issues pertaining to EMTALA involve individuals presenting to a hospital's dedicated emergency department, questions have been raised regarding the applicability of the EMTALA requirements to inpatients. We have previously discussed the applicability of the EMTALA requirements to hospital inpatients in both the May 9, 2002 IPPS proposed rule (67 FR 31475) and the September 9, 2003 stand alone final rule on EMTALA (68 FR 53243). As we stated in both of the aforementioned rules, in 1999, the United States Supreme Court considered a case (*Roberts* v. *Galen of Virginia*, 525 U.S. 249 (1999)) that involved, in part, the question of whether EMTALA applies to inpatients in a hospital. In the context of that case, the United States Solicitor General advised the Court that HHS would develop a regulation clarifying its position on that issue. In the 2003 final rule, CMS took the position that a hospital's obligation under EMTALA ends when that hospital, in good faith, admits an individual with an unstable emergency medical condition as an inpatient to that hospital. In that rule, CMS noted that other patient safeguards protected inpatients, including the CoPs as well as State malpractice law. However, in the 2003 final rule, CMS did not directly address the question of whether EMTALA's ''specialized care'' requirements (section 1867(g) of the Act) applied to inpatients.

As noted in section IV.I.2. of this preamble, the EMTALA TAG has developed a set of recommendations to the Secretary. One of those recommendations calls for CMS to revise its regulations to address the situation of an individual who: (1)

Presents to a hospital that has a dedicated emergency department and is determined to have an unstabilized emergency medical condition; (2) is admitted to the hospital as an inpatient; and (3) the hospital subsequently determines that stabilizing the individual's emergency medical condition requires specialized care only available at another hospital.

We believe that the obligation of EMTALA does not end for all hospitals once an individual has been admitted as an inpatient to the hospital where the individual first presented with a medical condition that was determined to be an emergency medical condition. Rather, once the individual is admitted, admission only impacts on the EMTALA obligation of the hospital where the individual first presented. (Throughout this section of the preamble of this proposed rule, we will refer to the hospital where the individual first presented as the ''admitting hospital.'') Section 1867(g) of the Act states: ''Nondiscrimination—A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.'' Section 1867(g) of the Act therefore requires a receiving hospital with specialized capabilities to accept a request to transfer an individual with an unstable emergency medical condition as long as the hospital has the capacity to treat that individual, regardless of whether the individual had been an inpatient at the admitting hospital. Furthermore, in the September 9, 2003 final rule (68 FR 53263), we amended the regulations at § 489.24(d)(2)(i) to state: ''If a hospital has screened an individual under paragraph (a) of this section and found the individual to have an emergency medical condition, and admits that individual in good faith in order to stabilize the emergency medical condition, the hospital has satisfied its special responsibilities under this section with respect to that individual'' (emphasis added). We did not intend for the regulation to end the EMTALA obligation for any other hospital to which the individual may appropriately be transferred to stabilize his or her emergency medical condition. Permitting inpatient admission at the admitting hospital to end EMTALA obligations for another hospital to which an unstabilized individual is being appropriately transferred to receive specialized care would seemingly contradict the intent of section 1867(g) of the Act to ensure that hospitals with specialized capabilities provide medical treatment to individuals with emergency medical conditions to stabilize their conditions.

We also note that, as we discussed in the preamble of the September 9, 2003 stand alone final rule, once a hospital has admitted an individual as an inpatient, the individual is protected under the Medicare CoPs and may also have additional protections under State law. Accordingly, we believe it is consistent with the intent of EMTALA to limit its protections to individuals who need them most; for example, individuals who present to a hospital but may not have been formally admitted as patients and thus are not covered by other protections applicable to inpatients of the hospital. As noted above, once the individual is admitted, the CoPs apply to the admitting hospital's care of that individual. A hospital that fails to provide treatment to such individuals could face termination of its Medicare provider agreement for a violation of the CoPs. However, these CoPs do not, of course, apply to a hospital with specialized capabilities to which the individual might be transferred unless and until the individual is formally admitted as a patient at that hospital. Therefore, in order to ensure an individual the protections intended by the EMTALA statute, especially section 1867(g) of the Act (obligating a hospital with specialized capabilities to accept an appropriately transferred individual if it has the capacity to treat that individual), we believe it is appropriate to propose to clarify that section 1867(g) of the Act continues to apply so as to protect even an individual who has been admitted as an inpatient to the admitting hospital who has not been stable since becoming an inpatient. We believe that this proposed clarification is necessary to ensure that EMTALA protections are continued for individuals who are not otherwise protected by the hospital CoPs. (We note that this proposed clarification is consistent with the EMATLA TAG's recommendation that EMTALA does not apply when an individual is admitted to the hospital for an elective procedure and subsequently develops an emergency medical condition.)

We recognize that this proposed clarification that EMTALA applies to a hospital with specialized capabilities when an inpatient (who presented to the admitting hospital under EMTALA) is in need of specialized care to stabilize his or her emergency medical condition may raise concerns among the provider community that such a clarification in policy could hypothetically result in an increase in the number of transfers. However, the intention of this proposed clarification is *not* to encourage patient dumping to hospitals with specialized capabilities. Rather, even if the hospital with specialized capabilities has an EMTALA obligation to accept an individual who was an inpatient at the admitting hospital, the admitting hospital transferring the individual should take all steps necessary to ensure that it is providing needed treatment within its capabilities prior to transferring the individual. This means that an individual with an unstabilized emergency medical condition should be transferred only when the capabilities of the admitting hospital have been exceeded.

Accordingly, we are proposing to revise § 489.24(f) by adding to the existing text a provision that specifies that paragraph (f) also applies to an individual who has been admitted under paragraph (d)(2)(i) of the section and who has not been stabilized.

While we are not including the following in our proposed clarification, we are seeking public comments on whether the EMTALA obligation imposed on hospitals with specialized capabilities to accept appropriate transfers should apply to a hospital with specialized capabilities in the case of an individual who had a period of stability during his or her stay at the admitting hospital and is in need of specialized care available at the hospital with specialized capabilities. CMS takes seriously its duty to protect patients with emergency medical conditions as required by EMTALA. Thus, we are seeking public comments as to whether, with respect to the EMTALA obligation on the hospital with specialized capabilities, it should or should not matter if an individual who currently has an unstabilized emergency medical condition (which is beyond the capability of the admitting hospital) (1) remained unstable after coming to the hospital emergency department or (2) subsequently had a period of stability after coming to the hospital emergency department.

In summary, to implement the recommendation by the EMTALA TAG and clarify our policy regarding the applicability of EMTALA to hospital inpatients, we are proposing to amend § 489.24(f) to add a provision to state that when an individual covered by EMTALA was admitted as an inpatient and remains unstabilized with an

emergency medical condition, a receiving hospital with specialized capabilities has an EMTALA obligation to accept that individual, assuming that the transfer of the individual is an appropriate transfer and the participating hospital with specialized capabilities has the capacity to treat the individual.

4. Proposed Changes to the EMTALA Physician On-Call Requirements

a. Relocation of Regulatory Provisions

During its term, the EMTALA TAG dedicated a significant portion of its discussion to a hospital's physician on-call obligations under EMTALA and made several recommendations to the Secretary regarding physician on-call requirements that are included in its final report (will be available shortly at the Web site: *http://www.cms.hhs/gov/FACA/07_emtalatag.asp).* The TAG recommended that CMS move the regulation discussing the obligation to maintain an on-call list from the EMTALA regulations at § 489.24(j)(1) to the regulations implementing provider agreements at § 489.20(r)(2). We agree with the TAG's recommendation. The requirement to maintain an on-call list is found at section 1866(a)(1)(I)(iii) of the Act, the section of the Act that refers to provider agreements. Section 1867 of the Act, which outlines the EMTALA requirements, makes no mention of the requirement to maintain an on-call list.

To implement the EMTALA TAG's recommendation, we are proposing to delete the provision relating to maintaining a list of on-call physicians from § 489.24(j)(1). We note that a provision for an on-call physician list is already included in the regulations as a hospital provider agreement requirement at § 489.20(r)(2). We are proposing to incorporate the language of § 489.24(j)(1) as replacement language for the existing § 489.20(r)(2) and amend the regulatory language to make it more consistent with the statutory language found at section 1866(a)(1)(I)(iii) of the Act. Proposed revised § 489.20(r)(2) would read: ''An on-call list of physicians on its medical staff available to provide treatment necessary after the initial examination to stabilize individuals with emergency medical conditions who are receiving services required under § 489.24 in accordance with the resources available to the hospital; and''. These proposed changes would make the regulations consistent with the statutory basis for maintaining an on-call list.

The EMTALA TAG made additional recommendations regarding how a hospital would satisfy its on-call list obligations, including calling for an annual plan by the hospital and medical staff for on-call coverage that would include an assessment of factors such as the hospital's capabilities and services, community need for emergency department services as indicated by emergency department visits, emergent transfers, physician resources, and past performance of previous on-call plans. The TAG also recommended that a hospital have a backup plan for viable patient care options when an on-call physician is not available, including such factors as telemedicine, other staff physicians, transfer agreements, and regional or community call arrangements. While community call arrangements are discussed below, we intend to address the remainder of the TAG recommendations at a later date.

b. Shared/Community Call

As noted in the previous section, section 1866(a)(1)(I)(iii) of the Act states, as a requirement for participation in the Medicare program, that a hospital must keep a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition. If a physician on the list is called by a hospital to provide stabilizing treatment and either fails or refuses to appear within a reasonable period of time, the hospital and that physician may be in violation of EMTALA as provided for under section 1867(d)(1)(C) of the Act. Thus, hospitals are required to maintain a list of on-call physicians, and physicians or hospitals, or both, may be held responsible under the EMTALA statute if a physician who is on call fails or refuses to appear within a reasonable period of time.

In the May 9, 2002 proposed rule (67 FR 31471), we stated that we were aware of hospitals' increasing concerns regarding their physician on-call requirements. Specifically, we noted that we were aware of reports of physicians, particularly specialty physicians, severing their relationships with hospitals because of on-call obligations, especially when those physicians belong to more than one hospital medical staff. We further noted that physician attrition from these medical staffs could result in hospitals having no specialty physician service coverage for their patients. In the September 9, 2003 final rule (68 FR 53264), we clarified the regulations at § 489.24(j) to permit on-call physicians to schedule elective surgery during the time that they are on call and to permit on-call physicians to have simultaneous on-call duties. We also specified that physicians, including specialists and subspecialists, are not required to be on call at all times, and that the hospital must have policies and procedures to be followed when a particular specialty is not available or the on-call physician cannot respond because of situations beyond his or her control. We expected these clarifications would help to improve access to physician services for all hospital patients by permitting hospitals flexibility to determine how best to maximize their available physician resources. Furthermore, we expected that these clarifications would permit hospitals to continue to attract physicians to serve on their medical staffs, thereby continuing to provide services to all patients, including those individuals who are covered by EMTALA.

As part of its recommendations concerning physician on-call requirements, the EMTALA TAG recommended that hospitals be permitted to participate in ''community call.'' Specifically, the language of the recommendation states: ''The TAG recommends that CMS clarify its position regarding shared or community call: that such community call arrangements are acceptable if the hospitals involved have formal agreements recognized in their policies and procedures, as well as backup plans. It should also be clarified that a community call arrangement does not remove a hospital's obligation to perform an MSE [medical screening examination].'' The TAG also recommended in a subsequent recommendation that ''A hospital may satisfy its on-call coverage obligation by participation in an approved community/regional call coverage program. (CMS to determine appropriate approval process).''

We believe that community call (as described below) would afford additional flexibility to hospitals providing on-call services and improve access to specialty physician services for individuals in an emergency department. Therefore, we are proposing to amend our regulations at § 489.24(j) to provide that hospitals may comply with the on-call list requirement specified at § 489.20(r)(2) (under our proposed revision), by participating in a formal community call plan so long as the plan meets the elements outlined below. We are further proposing to revise the regulations to state that, notwithstanding participation in a community call plan, hospitals are still required to perform medical screening examinations on individuals who present seeking treatment and to

provide for an appropriate transfer when appropriate.

We propose ''community call,'' to be a formal on-call plan that permits a specific hospital in a region to be designated as the on-call facility for a specific time period, or for a specific service, or both. For example, if there are two hospitals that choose to participate in community call, Hospital A could be designated as the on-call facility for the first 15 days of each month and Hospital B could be designated as the on-call facility for the rest of each month. Alternatively, Hospital A could be designated as on-call for cases requiring specialized interventional cardiac care, while Hospital B could be designated as on-call for neurosurgical cases. We anticipate that hospitals and their communities would have the flexibility to develop a plan that reflects their local resources and needs. Such a community on-call plan will allow various physicians in a certain specialty in the aggregate to be on continuous call (24 hours a day, 7 days a week), without putting a continuous call obligation on any one physician. We note that generally if an individual arrives at a hospital other than the designated on-call facility, is determined to have an unstabilized emergency medical condition, and requires the services of an on-call specialist, the individual would be transferred to the designated on-call facility in accordance with the community call plan.

As noted above, we are proposing that a community call plan must be a formal plan among the participating hospitals. While we do not believe it is necessary for the formal community call plan to be subject to preapproval by CMS, if an EMTALA complaint investigation is initiated, the plan will be subject to review and enforcement by CMS. We are proposing that, at a minimum, hospitals must include the following elements when devising a formal community call plan:

- The community call plan would include a clear delineation of on-call coverage responsibilities, that is, when each hospital participating in the plan is responsible for on-call coverage.
- The community call plan would define the specific geographic area to which the plan applies.
- The community call plan would be signed by an appropriate representative of each hospital participating in the plan.
- The community call plan would ensure that any local and regional EMS system protocol formally includes information on community on-call arrangements.
- Hospitals participating in the community call plan would engage in an analysis of the specialty on-call needs of the community for which the plan is effective.
- The community call plan would include a statement specifying that even if an individual arrives at the hospital that is not designated as the on-call hospital, that hospital still has an EMTALA obligation to provide a medical screening examination and stabilizing treatment within its capability, and hospitals participating in community call must abide by the EMTALA regulations governing appropriate transfers.
- There would be an annual reassessment of the community call plan by the participating hospitals.

Proposed revised § 489.24(j) would read *''Availability of on-call physicians.* In accordance with the on-call list requirements specified in § 489.20(r)(2), a hospital must have written policies and procedures in place—(1) To respond to situations in which a particular specialty is not available or the on-call physician cannot respond because of circumstances beyond the physician's control; and (2) To provide that emergency services are available to meet the needs of individuals with emergency medical conditions if a hospital elects to—(i) Permit on-call physicians to schedule elective surgery during the time that they are on call; (ii) Permit on-call physicians to have simultaneous on-call duties; and (iii) Participate in a formal community call plan. Notwithstanding participation in a community call plan, hospitals are still required to perform medical screening examinations on individuals who present seeking treatment and to conduct appropriate transfers. The formal community call plan must include the following elements: [proposed elements noted above in the bullets are included in regulations text].''

We welcome public comments on the proposed elements of the formal community call plan noted above. We are also soliciting public comments on whether individuals believe it is important that, in situations where there is a governing State or local agency that would have authority over the development of a formal community call plan, the plan be approved by that agency. In summary, we are proposing that, as part of the obligation to have an on-call list, hospitals may choose to participate in community call, provided that the formal community call plan includes, at a minimum, the elements noted in bullets above. Additionally, each hospital participating in the community call plan must have written policies and procedures in place to respond to situations in which the on-call physician is unable to respond due to situations beyond his or her control. We are further proposing that a hospital would still be responsible for performing medical screening examinations on individuals who present to the hospital seeking treatment and conducting appropriate transfers, regardless of which hospital has on-call responsibilities on a particular day.

5. Proposed Technical Change to Regulations

In the FY 2008 IPPS final rule with comment period (72 FR 47413), we revised § 489.24(a)(2) (which refers to the nonapplicability of the EMTALA provisions in an emergency area during an emergency period) to conform it to the changes made to section 1135 of the Act by the Pandemic and All-Hazards Preparedness Act. When we made the change to the regulations, we inadvertently left out language consistent with the following statutory language found in section 1135: ''pursuant to an appropriate State emergency preparedness plan; or in the case of a public health emergency described in subsection (g)(1)(B) that involves a pandemic infectious disease, pursuant to a State pandemic preparedness plan or a plan referred to in clause (i), whichever is applicable in the State.'' We also inadvertently left out the phrase in section 1135 ''during an emergency period'' when we state the nonapplicability of the sanctions in an emergency area. We are proposing to revise the language at § 489.24(a)(2) to include the aforementioned language to conform the regulation text to the statutory language. Proposed revised § 489.24(a)(2) would read as follows: *''Nonapplicability of provisions of this section.* Sanctions under this section for an inappropriate transfer during a national emergency or for the direction or relocation of an individual to receive medical screening at an alternate location pursuant to an appropriate State emergency preparedness plan or, in the case of a public health emergency that involves a pandemic infectious disease, pursuant to a State pandemic preparedness plan do not apply to a hospital with a dedicated emergency department located in an emergency area during an emergency period, as specified in section 1135(g)(1) of the Act. A waiver of these sanctions is limited to a 72-hour period beginning upon the implementation of a hospital disaster protocol, except that, if a public health emergency involves a pandemic infectious disease (such as pandemic

influenza), the waiver will continue in effect until the termination of the applicable declaration of a public health emergency, as provided for by section 1135(e)(1)(B) of the Act.''

J. Application of Incentives To Reduce Avoidable Readmissions to Hospitals

1. Introduction

A significant portion of Medicare spending—$15 billion each year—is related to hospital readmissions. According to a 2005 MedPAC analysis ,[17] nearly 18 percent of beneficiaries who are discharged from the hospital are readmitted within 30 days, resulting in approximately 2 million readmissions. By MedPAC's method, over 13 percent of 30-day hospital readmissions and an associated $12 billion in spending (4/5 of all Medicare spending for readmissions) were found to be potentially avoidable. Beyond cost considerations, readmissions may reflect poor quality of care and affect beneficiaries'' quality of life. Though not all readmissions are avoidable, hospitals should share accountability for readmission rates that could be much lower through the application of evidence-based best practices. Interventions that have been shown to reduce readmissions include better quality of care during the hospitalization, more complete care plans, emphasis on coordination of care at the point of transitions to home or postacute care, better use of after-hospital care, and more active involvement of patients and caregivers in decision making.

The application of incentives to reduce hospital readmissions, including payment and public reporting approaches, could promote the adoption and development of best practice interventions for averting avoidable readmissions, resulting in higher quality of care for Medicare beneficiaries and reduction in unnecessary costs for the program. Under the current payment system, readmissions are financially rewarding for hospitals. Application of payment incentives to encourage reduction of avoidable readmissions could help address unintended incentives in the current payment system.

In this section, following discussion of readmission issues related to measurement, accountability, and interventions, we are presenting three approaches to applying incentives to reduce avoidable readmissions for public comment: (1) Direct adjustment to hospital DRG payments for avoidable readmissions, (2) adjustments to hospital DRG payments through a performance-based payment methodology, and (3) public reporting of readmission rates. We note that either type of adjustment to hospital payments for readmissions would likely require new statutory authority for the Medicare program. We are seeking public comments on all of the ideas presented in this section.

2. Measurement

Routine, valid, and reliable measurement of hospital-specific rates of readmissions would be a prerequisite to any method of applying incentives for reducing hospital readmissions. Measurement data should be meaningful and actionable for hospitals and should be fair to encourage trust and engagement in the effort. Risk adjustment of measurement data is necessary to account for patientπspecific factors that influence the likelihood of readmission, such as age, disease severity, and comorbidities.

Another important consideration in measurement of readmission rates is the time period from discharge to readmission (for example, 7, 15, 30, or 90 days). In section IV.B. of the preamble of this proposed rule, measures of risk-adjusted 30-day readmission rates are proposed for the RHQDAPU program. The 9th Scope of Work for Medicare Quality Improvement Organizations (QIO 9th SOW) also includes 30-day readmission measures for communities.

Measures should be aligned across settings of care. Hospitals are not the only providers that affect the occurrence of readmissions. For example, the care delivered by SNFs and HHAs also has an important impact on whether a beneficiary is readmitted. Data from aligned readmissions measures, applicable to various settings of care, would provide better information about care coordination problems within and between settings. Alignment of readmissions measures would also facilitate more powerful application of incentives across Medicare's payment systems.

Another consideration is whether to focus on all readmissions or to focus on those that are known to be higher cost, more easily preventable, or most frequently occurring. For example, numerous hospitals have successfully implemented programs to reduce readmissions of heart failure patients, so more is known about the prevention of heart failure readmissions. Further, heart failure readmissions may be more costly than readmissions for other conditions. Another focus of efforts to prevent readmissions could be patients with multiple chronic conditions, who may be at the highest risk to experience readmissions.

3. Accountability

In the assignment of accountability for readmissions, risk adjustment of measurement data is one consideration of fairness; however, other factors must also be considered, including avoidability and shared accountability. Most clinicians would agree that a goal of zero readmissions may not be appropriate, as an extremely low rate of readmissions could indicate restricted access to needed medical services, overuse of hospital resources during the initial hospitalization (for example, prolonged length of stay), or excessive intensity of post-acute care services. Adequate risk adjustment could help to elucidate the avoidability of readmissions by identifying an expected readmission rate for a given patient or patient population.

Shared accountability is another important consideration. Hospitals are clearly accountable for the care provided during hospitalization and can also affect the quality of care provided after the hospitalization, but hospitals are not the only accountable entity. Both during and after hospitalization, physicians and other health professionals share accountability for the quality of care. Other provider entities, including skilled nursing facilities, rehabilitation facilities, home health agencies, and end-stage renal disease facilities, also share accountability for avoidable readmissions. Medicare beneficiaries themselves and their caregivers and social support systems play important roles in avoiding readmissions, particularly when beneficiaries have been discharged to home.

Assignment of accountability also requires consideration of situations where the patient presents for readmission with a different diagnosis or presents to a different hospital. If the

[17] Medicare Payment Advisory Commission: Report to Congress: Promoting Greater Efficiency in Medicare. June 2007, Chapter 5, page 103.

[18] Coleman, E.A., C. Parry, S. Chalmers, et al. 2006. The care transitions intervention: Results of a randomized controlled trial. *Archives of Internal Medicine,* 166 (September 25): 1822–1828.

[19] Coleman, E.A., J.D. Smith, R. Devbani, et al. 2005. Posthospital medication discrepancies: Prevalence and contributing factors. *Archives of Internal Medicine* 165, (September 12): 1842–1847.

[20] Coleman, E., and R. Berenson. 2004. Lost in transition: Challenges and opportunities for improving the quality of transitional care. *Annals of Internal Medicine,* 141, no. 7 (October 5): 533–536.

[21] Institute for Healthcare Improvement. 2004a. *Reducing readmissions for heart failure patients:*

Continued

locus of accountability were at the hospital level, a second hospital should not be held accountable for a readmission resulting from a first hospital's lack of adherence to evidence-based best practices for averting readmissions. If the locus of accountability were at the community level, then shared accountability could encourage hospitals to work together to reduce readmissions.

4. Interventions

A number of interventions have been identified as best practices for averting avoidable readmissions.[18,19,20,21,22,23,24,25,26] Some of these evidence-based interventions are listed below:

- Better, safer care during the hospitalization.
- Improved communication among providers and with the patient and caregivers.
- Care planning that begins with assessment at admission.
- Clear discharge instructions, with specific attention to medication management.
- Shared accountability for care coordination, with attention to transitions and hand-offs.
- Discharge to a proper setting of care.
- Better, safer care in the post-acute setting of care.
- Appropriate use of palliative care and honest planning for the likely course.
- Timely physician follow up visits.
- Active involvement of patients and their caregivers.

Interventions such as these have been employed by several participants in CMS Physician Group Practice Demonstration and have contributed to improvements in the quality and cost-efficiency of care provided to Medicare beneficiaries. For example, the University of Michigan Faculty Group Practice's transitional care call-back program contacts Medicare patients discharged from the emergency department and acute care hospital to address gaps in care during the transition between care settings. The program provides short-term care coordination with linkages to visiting nurse and community services, as well as coordination with primary care and specialty clinics. The Everett Clinic utilizes hospital coaches to guide patients and caregivers through complicated care processes during hospital stays and on discharge. The clinic proactively reaches out to recently hospitalized patients to assure that they have a physician followup visit within 10 days after discharge to address any unresolved or new health problems.

CMS is considering strategies for distributing a discharge checklist that the agency developed to help beneficiaries and their caregivers prepare for discharge from a hospital or nursing home. The checklist includes a range of issues to consider and address with physicians and other health care providers to facilitate a smooth transition to home or postacute care setting. In addition, the checklist provides information about supportive home and community-based services.

The QIO 9th SOW includes a theme entitled Patient Pathways (Care Transitions). The goal of this theme is to measurably improve the quality of care for Medicare beneficiaries who transition among care settings, resulting in reduced readmissions and replicable strategies to sustain reduced readmission rates. The QIO 8th SOW included initiatives to reduce avoidable readmissions of home health patients.

5. Financial Incentive: Direct Payment Adjustment

The first of three approaches presented for comment is direct adjustment to hospital DRG payments for readmissions. This approach would likely require new statutory authority for the Medicare program. In section II.F. of the preamble of this proposed rule, we discuss direct adjustments to MS–DRG payment for selected preventable HACs. Similarly, a payment adjustment could be applied for readmissions determined to be avoidable because the hospital did not follow evidence-based best practices for averting readmissions. The magnitude of the payment adjustment could be based on patient-specific risk factors and on the apportionment of shared accountability among the involved entities.

A variation of this approach could be adjustment of all hospital payments for readmissions, nationwide or by some regional designation, based on aggregate information about avoidable readmissions for the entire relevant Medicare population (national or regional) under typical circumstances. Under this approach, hospitals would receive less Medicare payment for readmissions for conditions with lower expected rates of readmission and less shared accountability.

Potential unintended consequences resulting from a financial incentive to avert readmissions also need to be considered. For example, hospitals could begin discharging patients to settings that provide more intensive postacute care to avoid readmissions, thereby potentially driving up total costs for episodes of care and total Medicare spending. As another example of potential unintended consequences, hospitals could begin to resist medically necessary readmissions from postacute care providers, creating an access problem.

6. Financial Incentive: Performance-Based Payment Adjustment

The second approach presented for comment is adjustment to hospital MS–DRG payments using a performance-based payment methodology, such as the Medicare Hospital VBP Plan referenced in section IV.C. of the preamble of this proposed rule and available at: *http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/HospitalVBPPlan RTCFINALSUBMITTED2007.pdf.* The intent of the VBP Plan methodology is to promote adherence to evidence-based best practices in the delivery of care and to provide rewards for those who are successful in improving their measured performance. Implementation of the VBP methodology would require new statutory authority for the Medicare program.

Under the VBP Plan, measures of clinical processes of care, patient experience (HCAHPS), and outcomes (30-day mortality) would be scored and translated into an incentive payment. These measures of process, outcome, and patient-centeredness address areas of quality that are important to reducing readmissions; however, other measures could be added to more fully adjust payments for readmissions. Direct measures of hospital-specific, risk adjusted readmission rates could be included in the VBP Plan performance

Hackensack University Medical Center. Available at *http://www.ihi.org.*

[22] Institute for Healthcare Improvement. 2004b. *The MedProvider inpatient care unit-congestive heart failure project.* Available at: *http://www.ihi.org.*

[23] Lappe, J.M., J.B. Muhlestein, D.L. Lappe, et al. 2004. Improvements in 1-year cardiovascular clinical outcomes associated with a hospital-based discharge medication program. *Annals of Internal Medicine,* 141, no.6 (September 21): 446–453.

[24] Naylor, M.D., D. Brooton, R. Campbell, et al. 1999. Comprehensive discharge planning and home follow-up of hospitalized elders. *Journal of the American Medical Association,* 281, no.7 (February 17): 613–620.

[25] VanSuch, M., J.M. Naessens, R.J. Stroebel, et al. 2006. Effect of discharge instructions on readmission of hospitalized patients with heart failure: Do all of the Joint Commission on Accreditation of Healthcare Organizations heart failure core measures reflect better care? *Quality and Safety in Healthcare,* 15: 414–417.

[26] Weinberg D.B., J.H. Gittell, R.W. Lusenhop, et al. 2007. Beyond our walls: Impact of patient and provider coordination across the continuum on outcomes for surgical patients. *Health Services Research,* 42, no. 1, pt. 1 (February): 7–24.

assessment model. In addition, other measures of care coordination that indirectly address readmissions could also be included.

The direct adjustment approach and the VBP Plan approaches for applying financial incentives to the reduction of avoidable readmissions could be implemented separately or in combination.

7. Nonfinancial Incentive: Public Reporting

A third approach presented for comment is public reporting of hospital-specific, risk adjusted readmission rates. The Administration's Value-Driven Health Care initiative, which stems from the President's Executive Order Promoting Quality and Efficient Health Care in Federal Government Health Care Programs, calls for Federal agencies to make health care quality and cost information more transparent. Health care consumers, including Medicare beneficiaries, and their providers and caregivers need better information to support more informed decision making about their care. The public reporting of readmission rates would likely not require new statutory authority for the Medicare program.

The *Hospital Compare* Web site could be used to report readmission rates along with the other quality and cost of care parameters displayed on that site. Public reporting has been demonstrated to be a strong non-financial incentive with a competitive effect, as hospitals appropriately focus on maintaining and enhancing their reputations as providers of high quality of care. The VBP Plan envisions public reporting in concert with the VBP financial incentive, but the public reporting incentive could be applied regardless of statutory authority to implement the VBP Plan.

8. Conclusion

The purpose of this section is to solicit and encourage public comments on considerations and options for applying incentives to reduce avoidable hospital readmissions. We welcome public comments on readmission issues related to measurement, accountability, and interventions, as well as on potential approaches to applying financial and nonfinancial incentives to reduce avoidable readmissions.

K. 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.

Section 410A(a)(4) of Pub. L. 108–173 states that no more than 15 such hospitals may participate in the demonstration program.

As we indicated in the FY 2005 IPPS final rule (69 FR 49078), in accordance with sections 410A(a)(2) and (a)(4) of 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. (Of the 13 hospitals that participated in the first 2 years of the demonstration program, 4 hospitals located in Nebraska have become CAHs and have withdrawn from the program.)

In a notice published in the **Federal Register** on February 6, 2008 (73 FR 6971 through 6973), we announced a solicitation for up to six additional hospitals to participate in the demonstration program. Hospitals that enter the demonstration under this solicitation will be able to participate for no more than 2 years. The February 6, 2008 notice specifies the eligibility requirements for the demonstration program.

Under the demonstration program, participating hospitals are paid the reasonable costs of providing covered inpatient hospital services (other than services furnished by a psychiatric or rehabilitation unit of a hospital that is a distinct part), applicable for discharges occurring in the first cost reporting period beginning on or after the October 1, 2004 implementation date of the demonstration program. 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 participating small rural hospitals are likely to increase Medicare outlays without producing any offsetting reduction in Medicare expenditures elsewhere. Therefore, a rural community hospital's

participation in this demonstration program is unlikely to yield benefits to the participant if budget neutrality were to be implemented by reducing other payments for these providers.

In order to achieve budget neutrality for this demonstration program for FY 2009, we are proposing to adjust the national inpatient PPS rates by an amount sufficient to account for the added costs of this demonstration program. We are proposing to apply budget neutrality across the payment system as a whole rather than merely across the participants in this demonstration program. As we discussed in the FY 2005, FY 2006, FY 2007 and FY 2008 IPPS final rules (69 FR 49183; 70 FR 47462; 71 FR 48100; and 72 FR 47392), we believe that the language of the statutory budget neutrality requirements permits the agency to implement the budget neutrality provision in this manner. For FY 2009, using data from the cost reports from each of the nine hospitals' first year of participation in the demonstration program, that is, cost reports for years beginning in CY 2005, and estimating the cost of six additional hospitals based on these data, we estimate that the additional cost would be $32,011,849. (In the final rule, we should know the exact number of hospitals participating in the demonstration program and would revise our estimates accordingly.) This estimated adjusted amount reflects the estimated difference between the participating hospitals costs and the IPPS payment based on data from the hospitals' cost reports. We discuss the payment rate adjustment that is required to ensure the budget neutrality of the demonstration program for FY 2009 in section II.A.4. of the Addendum to this proposed rule.

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

A. Background

Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of inpatient acute hospital services ''in accordance with a prospective payment system established by the Secretary.'' Under the statute, the Secretary has broad authority in establishing and implementing the IPPS for acute care hospital inpatient capital-related costs. We initially implemented the IPPS for capital-related costs in the Federal fiscal year (FY) 1992 IPPS final rule (56 FR 43358), in which we established a 10-year transition period to change the payment methodology for Medicare hospital inpatient capital-related costs from a reasonable cost-based methodology to a prospective methodology (based fully on the Federal rate).

FY 2001 was the last year of the 10-year transition period established to phase in the IPPS for hospital inpatient capital-related costs. For cost reporting periods beginning in FY 2002, capital IPPS payments are based solely on the Federal rate for most acute care hospitals (other than hospitals receiving certain exception payments and certain new hospitals). The basic methodology for determining capital prospective payments using the Federal rate is set forth in § 412.312. For the purpose of calculating payments for each discharge, the standard Federal rate is adjusted as follows:

(Standard Federal Rate) × (DRG Weight) × (Geographic Adjustment Factor (GAF)) × (Large Urban Add-on, if applicable) × (COLA for hospitals located in Alaska and Hawaii) × (1 + Capital DSH Adjustment Factor + Capital IME Adjustment Factor, if applicable).

Hospitals also may receive outlier payments for those cases that qualify under the threshold established for each fiscal year as specified in § 412.312(c) of the regulations.

1. Exception Payments

The regulations at § 412.348(f) provide that a hospital may request an additional payment if the hospital incurs unanticipated capital expenditures in excess of $5 million due to extraordinary circumstances beyond the hospital's control. This policy was originally established for hospitals during the 10-year transition period, but as we discussed in the FY 2003 IPPS final rule (67 FR 50102), we revised the regulations at § 412.312 to specify that payments for extraordinary circumstances are also made for cost reporting periods after the transition period (that is, cost reporting periods beginning on or after October 1, 2001). Additional information on the exception payment for extraordinary circumstances in § 412.348(f) can be found in the FY 2005 IPPS final rule (69 FR 49185 and 49186).

During the transition period, under §§ 412.348(b) through (e), eligible hospitals could receive regular exception payments. These exception payments guaranteed a hospital a minimum payment percentage of its Medicare allowable capital-related costs depending on the class of the hospital (§ 412.348(c)), but were available only during the 10-year transition period. After the end of the transition period, eligible hospitals can no longer receive this exception payment. However, even after the transition period, eligible hospitals receive additional payments under the special exceptions provisions at § 412.348(g), which guarantees all eligible hospitals a minimum payment of 70 percent of its Medicare allowable capital-related costs provided that special exceptions payments do not exceed 10 percent of total capital IPPS payments. Special exceptions payments may be made only for the 10 years from the cost reporting year in which the hospital completes its qualifying project, and the hospital must have completed the project no later than the hospital's cost reporting period beginning before October 1, 2001. Thus, an eligible hospital may receive special exceptions payments for up to 10 years beyond the end of the capital IPPS transition period. Hospitals eligible for special exceptions payments are required to submit documentation to the intermediary indicating the completion date of their project. (For more detailed information regarding the special exceptions policy under § 412.348(g), we refer readers to the FY 2002 IPPS final rule (66 FR 39911 through 39914) and the FY 2003 IPPS final rule (67 FR 50102).)

2. New Hospitals

Under the IPPS for capital-related costs, § 412.300(b) of the regulations defines a new hospital as a hospital that has operated (under current or previous ownership) for less than 2 years. (For more detailed information, we refer readers to the FY 1992 IPPS final rule (56 FR 43418).) During the 10-year transition period, a new hospital was exempt from the capital IPPS for its first 2 years of operation and was paid 85 percent of its reasonable costs during that period. Originally, this provision was effective only through the transition period and, therefore, ended with cost reporting periods beginning in FY 2002. Because, as discussed in the FY 2003 IPPS final rule (67 FR 50101), we believe that special protection to new hospitals is also appropriate even after the transition period, we revised the regulations at § 412.304(c)(2) to provide that, for cost reporting periods beginning on or after October 1, 2002, a new hospital (defined under § 412.300(b)) is paid 85 percent of its Medicare allowable capital-related costs through its first 2 years of operation, unless the new hospital elects to receive fully prospective payment based on 100 percent of the Federal rate. (We refer readers to the FY 2002 IPPS final rule (66 FR 39910) for a detailed discussion of the statutory basis for the system, the development and evolution of the system, the methodology used to

determine capital-related payments to hospitals both during and after the transition period, and the policy for providing exception payments.)

3. Hospitals Located in Puerto Rico

Section 412.374 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. Revisions to the Capital IPPS Based on Data on Hospital Medicare Capital Margins

As noted above, under the Secretary's broad authority under the statute in establishing and implementing the IPPS for hospital inpatient capital-related costs, we have established a standard Federal payment rate for capital-related costs, as well as the mechanism for updating that rate each year. For FY 1992, we computed the standard Federal payment rate for capital-related costs under the IPPS by updating the FY 1989 Medicare inpatient capital cost per case by an actuarial estimate of the increase in Medicare inpatient capital costs per case. Each year after FY 1992, we update the capital standard Federal rate, as provided at § 412.308(c)(1), to account for capital input price increases and other factors. 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 final rule with comment period (72 FR 47398 through 47401), based on our analysis of data on inpatient hospital Medicare capital margins that we obtained through our monitoring and comprehensive review of the adequacy of the standard Federal payment rate for capital-related costs and the updates provided under the existing regulations, we made changes in the payment structure under the capital IPPS beginning with FY 2008. We summarize these changes below. We refer readers to section V.B. of the preamble of the FY 2008 final rule with comment period (72 FR 47393 through 47401) for a detailed discussion of the data used as a basis for these changes. These data showed that hospital inpatient Medicare capital margins were very high across all hospitals during the period from FY 1996 through FY 2004.

In the FY 2008 IPPS final rule with comment period, as background, we noted that, in general, under a PPS, standard payment rates should reflect the costs that an average, efficient provider would bear to provide the services required for quality patient care. Payment rate updates should also account for the changes necessary to continue providing such services. Updates should reflect, for example, the increased costs that are necessary to provide for the introduction of new technology that improves patient care. Updates should also take into account the productivity gains that, over time, allow providers to realize the same, or even improved, quality outcomes with reduced inputs and lower costs. Hospital margins, the difference between the costs of actually providing services and the payments received under a particular system, thus provide some evidence concerning whether payment rates have been established and updated at an appropriate level over time for efficient providers to provide necessary services. All other factors being equal, sustained substantial positive margins demonstrate that payment rates and updates have exceeded what is required to provide those services. 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, 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 FYs1992 through 1995, established under the budget neutrality provision to pay 90 percent of hospitals' inpatient Medicare capital costs in the aggregate, appropriate for the capital IPPS. The statutory history of the capital IPPS thus suggests that the system in the aggregate should not provide for continuous, large positive margins.

As we also discussed in the FY 2008 IPPS final rule with comment period, we believed that there could be a number of reasons for the relatively high margins that most IPPS hospitals have realized under the capital IPPS. One possibility is that the updates to the capital IPPS rates have been higher than the actual increases in Medicare inpatient capital costs that hospitals

have experienced in recent years. Another possible reason for the relatively high margins of most capital IPPS hospitals may be that the payment adjustments provided under the system are too high, or perhaps even unnecessary. Specifically, the adjustments for teaching hospitals, disproportionate share hospitals, and large urban hospitals appear to be contributing to excessive payment levels for these classes of hospitals. Since the inception of the capital IPPS in FY 1992, the system has provided adjustments for teaching hospitals (the IME adjustment factor, under § 412.322 of the regulations), disproportionate share hospitals (the DSH adjustment factor, under § 412.320), and large urban hospitals (the large urban location adjustment factor, under § 412.316(b)). The classes of hospitals eligible for these adjustments have been realizing much higher margins than other hospitals under the system. Specifically, teaching hospitals (11.6 percent for FYs 1998 through 2004), disproportionate share hospitals (8.4 percent), and urban hospitals (8.3 percent) have had 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 believed that the evidence indicates that these adjustments have been contributing to the significantly large positive margins experienced by the classes of hospitals eligible for these adjustments.

Therefore, in the FY 2008 IPPS final rule with comment period, we made two changes to the structure of payments under the capital IPPS, as discussed under items 1. and 2. below.

1. Elimination of the Large Add-On Payment Adjustment

In the FY 2008 IPPS final rule with comment period, we determined that the data we had gathered on inpatient hospital Medicare capital margins provided sufficient evidence to warrant elimination of the large urban add-on payment adjustment starting in FY 2008 under the capital IPPS. Therefore, for FYs 2008 and beyond, we discontinued the 3.0 percent additional payment that had been provided to hospitals located in large urban areas (72 FR 24822). This decision was supported by comments from MedPAC.

2. Changes to the Capital IME Adjustment

a. Background and Changes Made for FY 2008

In the FY 2008 IPPS proposed rule, we noted that margin analysis indicated that several classes of hospitals had experienced continuous, significant positive margins. The analysis indicated that the existing payment adjustments for teaching hospitals and disproportionate share hospitals were contributing to excessive payment levels for these classes of hospitals. Therefore, we stated that it may be appropriate to reduce these adjustments significantly, or even to eliminate them altogether, within the capital IPPS. These payment adjustments, unlike parallel adjustments under the operating IPPS, were not mandated by the Act. Rather, they were included within the original design of the capital IPPS under the Secretary's broad authority in section 1886(g)(1) of the Act to include appropriate adjustments and exceptions within a capital IPPS. In the FY 2008 final rule with comment period, we also noted a MedPAC recommendation that we seriously reexamine the appropriateness of the existing capital IME adjustment, that the margin analysis indicated such adjustment may be too high, and that MedPAC's previous analysis also suggested the adjustment may be too high. In light of MedPAC's recommendation, we extended the margin analysis discussed in the FY 2008 IPPS proposed rule in order to distinguish the experience of teaching hospitals from the experience of urban and rural hospitals generally. Specifically, we isolated the margins of urban, large urban, and rural teaching hospitals, as opposed to urban, large urban, and rural nonteaching hospitals. In conducting this analysis, we employed updated cost report information, which allowed us to incorporate the margins for an additional year, FY 2005, into the analysis. The data on the experience of urban, large urban, and rural teaching hospitals as opposed to nonteaching hospitals provided significant new information. As the analysis demonstrated, teaching hospitals in each class (urban, large urban, and rural) performed significantly better than comparable nonteaching hospitals. For the period covering FYs 1998 through 2005, urban teaching hospitals realized aggregate positive margins of 11.9 percent, compared to a positive margin of 0.9 percent for urban nonteaching hospitals. Similarly, large urban teaching hospitals realized an aggregate positive margin of 12.8 percent during that period, while large urban nonteaching hospitals had an aggregate positive margin of only 2.9 percent. Finally, rural teaching hospitals experienced an aggregate positive margin of 4.5 percent, as compared to a negative 1.3 percent margin for nonteaching rural hospitals. We noted that the positive margins for teaching hospitals did not exhibit a decline to the same degree as the margins for all hospitals. For example, the positive margins for all IPPS hospitals declined from 8.7 percent in FY 2002 to 5.3 percent in FY 2004 and 3.7 percent in FY 2005. For urban hospitals, aggregate margins decreased from 10.3 percent in FY 2002 to 6.4 percent in FY 2004 and 4.8 percent in FY 2005. Rural hospitals experienced a decrease from 1.5 percent in FY 2001 to a negative margin of -4.2 percent in FY 2005. In comparison, the aggregate margin for teaching hospitals was 12.1 percent in FY 2001 and 10.6 percent in FY 2005. For urban teaching hospitals, margins were 12.5 percent in FY 2001, 14.0 percent in FY 2002, 13.6 percent in FY 2003, 11.9 percent in FY 2004, and 10.9 percent in FY 2005. Rural teaching hospital margins were more variable, but did not exhibit a pattern of significant decline. In FY 2001, rural teaching hospitals had a positive margin of 3.2 percent; in FY 2002, 8.2 percent; in FY 2003, 4.7 percent; in FY 2004, 5.7 percent; and in FY 2005, 4.0 percent. We are reprinting below the table found in the FY 2008 IPPS final rule with comment period showing our analysis (72 FR 47400).

HOSPITAL INPATIENT MEDICARE CAPITAL MARGINS

	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	Aggregate 1996–2005	Aggregate 1998–2005
U.S.	17.6	13.4	7.0	6.8	7.3	8.1	8.7	7.6	5.3	3.7	8.5	6.8
URBAN	17.7	13.8	7.8	7.5	8.4	9.2	10.3	9.0	6.4	4.8	9.4	7.9
RURAL	16.8	11.0	2.1	2.4	1.0	1.5	−1.7	−1.4	−2.3	−4.2	2.6	−0.4
No DSH Payments	16.2	11.7	4.2	4.3	5.6	5.5	4.7	4.4	−1.3	−4.7	5.9	3.2
Has DSH Payments	18.5	14.4	8.6	8.1	8.2	9.0	10.0	8.5	7.0	5.9	9.5	8.1

HOSPITAL INPATIENT MEDICARE CAPITAL MARGINS—Continued

	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	Aggregate 1996–2005	Aggregate 1998–2005
$1–$249,999	14.5	12.9	−0.4	3.1	1.6	4.1	3.2	1.4	−1.7	−4.8	3.2	1.9
$250,000–$999,999	15.5	9.0	2.3	1.6	2.8	2.7	−2.4	−1.5	−4.3	−7.3	1.5	−0.9
$1,000,000–$2,999,999	16.8	13.0	8.7	9.0	8.7	7.0	10.1	5.2	3.2	2.0	8.2	6.6
$3,000,000 or more	20.3	16.6	10.4	9.3	9.7	12.1	13.2	12.5	10.6	9.5	12.2	11.0
TEACHING	19.5	15.7	9.8	9.7	11.2	12.1	13.8	13.2	11.7	10.6	12.7	11.6
Urban	19.7	15.9	10.2	10.0	11.4	12.5	14.0	13.6	11.9	10.9	13.0	11.9
Large Urban	20.5	16.8	11.0	10.1	12.5	13.9	15.2	14.7	12.0	11.9	13.9	12.8
Rural	13.9	8.5	1.0	2.9	5.8	3.2	8.2	4.7	5.7	4.0	5.7	4.5
NONTEACHING	15.3	10.5	3.4	2.8	2.2	2.6	1.7	0.0	−3.2	−5.1	2.8	0.3
Urban	14.4	10.1	3.8	3.0	3.0	3.1	3.6	0.9	−2.9	−4.9	3.1	0.9
Large Urban	15.5	11.3	6.2	6.1	5.7	5.2	5.3	1.7	−0.9	−3.2	5.1	2.9
Rural	17.3	11.4	2.3	2.4	0.2	1.2	−3.7	−2.6	−3.9	−6.0	2.0	−1.3
Census Division:												
New England (1)	27.9	25.9	17.1	15.1	18.2	20.7	21.3	21.1	20.5	20.3	21.0	19.5
Middle Atlantic (2)	19.1	15.5	11.1	11.6	14.1	16.5	18.7	18.0	14.7	16.0	15.6	15.2
South Atlantic (3)	18.1	13.9	5.9	4.0	6.0	5.0	6.6	6.9	5.8	2.8	7.4	5.4
East North Central (4)	18.2	12.7	6.4	7.1	8.8	8.5	6.1	7.1	6.6	3.2	8.4	6.7
East South Central (5)	14.9	11.1	3.3	4.1	3.8	3.8	3.8	−0.9	−3.4	−5.8	3.2	0.9
West North Central (6)	14.3	7.0	0.1	−-0.3	−1.5	2.0	1.9	3.4	1.6	−0.4	2.8	0.9
West South Central (7)	13.2	8.3	3.3	2.6	−0.7	0.0	1.2	−2.0	−4.0	−6.5	1.2	−1.0
Mountain (8)	17.2	14.7	8.5	7.7	7.2	6.4	2.9	3.3	0.8	−4.7	5.8	3.6
Pacific (9)	20.4	16.1	12.3	11.3	11.9	13.3	14.7	12.1	9.8	8.8	13.0	11.7
Code 99	23.7	24.1	14.5	16.8	19.8	20.7	20.5	25.1	21.6	24.8	21.4	20.8
Bed Size:												
< 100 beds	17.7	13.0	4.6	3.5	2.7	2.5	−1.8	−1.2	−6.1	−9.6	2.0	−0.9
100–249 beds	15.1	10.5	3.7	4.5	4.3	6.1	6.0	4.2	1.5	0.8	5.6	3.8
250–499 beds	18.9	14.1	8.9	8.3	10.6	10.7	12.1	11.6	10.3	7.7	11.4	10.1
500–999 beds	19.9	17.1	10.7	10.4	11.3	10.8	12.6	10.1	7.3	7.8	11.6	10.1
>= 1000 beds	8.2	14.0	2.2	−1.3	−6.6	−3.6	6.5	8.1	6.5	2.1	3.5	2.3

Notes:
Based on Medicare Cost Report hospital data updated as of the 1st quarter of 2007.
Medicare payments are from Worksheet E, Part A, Lines 9 and 10.
Expenses are from Worksheet D, Part I, columns 10 and 12 and Part II, columns 6 and 8.
We apply the outlier trimming methodology developed with MedPAC.
Code 99 applies when census division information was not specified in the Medicare Cost Report hospital data.

As we indicated in the FY 2008 IPPS final rule with comment period (72 FR 47401), the statutory history of the capital IPPS suggests that the system in the aggregate should not provide for continuous, large positive margins. As we also indicated, a possible reason for the relatively high margins of many capital IPPS hospitals may be that the payment adjustments provided under the system are too high, or perhaps even unnecessary. We agreed with MedPAC's recommendation and reexamined the appropriateness of the teaching adjustment. We concluded that the record of relatively high and persistent positive margins for teaching hospitals under the capital IPPS indicated that the teaching adjustment is unnecessary, and that it was therefore appropriate to exercise our discretion under the capital IPPS to eliminate this adjustment. At the same time, we believed that we should mitigate abrupt changes in payment policy and that we should provide time for hospitals to adjust to changes in the payments that they can expect under the program.

Therefore, in the FY 2008 IPPS final rule with comment period, we adopted a policy to phase out the capital teaching adjustment over a 3-year period beginning in FY 2008. Specifically, we maintained the adjustment for FY 2008, in order to give teaching hospitals an opportunity to plan and make adjustments to the change. During the second year of the transition, FY 2009, the formula for determining the amount of the teaching adjustment was revised so that adjustment amounts will be half of the amounts provided under the current formula. For FY 2010 and after, hospitals will no longer receive an adjustment for teaching activity under the capital IPPS.

b. Public Comments Received on Phase Out of Capital IPPS Teaching Adjustment Provisions Included in the FY 2008 Final Rule With Comment Period and Further Solicitation of Public Comments

As indicated above, in the FY 2008 IPPS final rule with comment period, we formally adopted as final policy a phase out of the capital IPPS teaching adjustment over a 3-year period, maintaining the current adjustment for FY 2008, making a 50-percent reduction in FY 2009, and eliminating the adjustment for FY 2010 and subsequent years. However, because we concluded that this change to the structure of payments under the capital IPPS was significant, we provided the public with an opportunity for further comment on these provisions through a 90-day comment period after publication of the FY 2008 IPPS final rule with comment period (72 FR 47401). In addition, as we indicated in that final rule with comment period, to provide a more than adequate opportunity for hospitals, associations, and other interested parties to raise issues and concerns related to our policy, we are providing additional opportunity for public comment during this FY 2009 proposed rulemaking cycle for the IPPS.

We received numerous timely pieces of correspondence that commented on the policy of phasing out the capital IPPS teaching adjustment as described in the FY 2008 IPPS final rule with comment period. These comments are available on our e-rulemaking Web site, at *http://www.cms.hhs.gov/eRulemaking/ECCMSR/list.asp*. We will also accept public comments on this policy during the comment period for this proposed rule. We will respond to

both sets of public comments when we issue the FY 2009 IPPS final rule, which is scheduled for publication in August 2008.

VI. Proposed Changes for Hospitals and Hospital Units Excluded From the IPPS

A. Proposed Payments to Excluded Hospitals and Hospital Units

Historically, hospitals and hospital units excluded from the prospective payment system received payment for inpatient hospital services they furnished on the basis of reasonable costs, subject to a rate-of-increase ceiling. An annual per discharge limit (the target amount as defined in § 413.40(a)) was set for each hospital or hospital unit based on the hospital's own cost experience in its base year. The target amount was multiplied by the Medicare discharges and applied as an aggregate upper limit (the ceiling as defined in § 413.40(a)) on total inpatient operating costs for a hospital's cost reporting period. Prior to October 1, 1997, these payment provisions applied consistently to all categories of excluded providers, which include 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 this FY 2009 IPPS proposed rule, we are proposing that the percentage increase in the rate-of-increase limits for cancer and children's hospitals and RNHCIs would be the proposed percentage increase in the FY 2009 IPPS operating market basket, which is estimated to be 3.0 percent. Consistent with our historical approach, we calculated the proposed IPPS operating market basket for FY 2009 using the most recent data available. However, if more recent data are available for the final rule, we will use them to calculate the IPPS operating market basket. For cancer and children's hospitals and RNHCIs, the proposed FY 2009 rate-of-increase percentage that is applied to FY 2008 target amounts in order to calculate FY 2009 target amounts is 3.0 percent, based on Global Insight, Inc.'s 2008 first quarter forecast of the IPPS operating market basket increase, in accordance with the applicable regulations in 42 CFR 413.40.

IRFs, IPFs, and LTCHs were paid previously under the reasonable cost methodology. However, the statute was amended to provide for the implementation of prospective payment systems for IRFs, IPFs, and LTCHs. In general, the prospective payment systems for IRFs, IPFs, and LTCHs provided transition periods of varying lengths during which time a portion of the prospective payment was based on cost-based reimbursement rules under Part 413 (certain providers do not receive a transition period or may elect to bypass the transition period as applicable under 42 CFR Part 412, Subparts N, O, and P). We note that the various transition periods provided for under the IRF PPS, the IPF PPS, and the LTCH PPS have ended.

For cost reporting periods beginning on or after October 1, 2002, all IRFs are paid 100 percent of the adjusted Federal rate under the IRF PPS. Therefore, for cost reporting periods beginning on or after October 1, 2002, no portion of an IRF PPS payment is subject to 42 CFR Part 413. Similarly, for cost reporting periods beginning on or after October 1, 2006, all LTCHs are paid 100 percent of the adjusted Federal prospective payment rate under the LTCH PPS. Therefore, for cost reporting periods beginning on or after October 1, 2006, no portion of the LTCH PPS payment is subject to 42 CFR Part 413. (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.) Likewise, for cost reporting periods beginning on or after January 1, 2008, all IPFs are paid 100 percent of the Federal per diem amount under the IPF PPS. Therefore, for cost reporting periods beginning on or after January 1, 2008, no portion of an IPF PPS payment is subject to 42 CFR Part 413.

B. IRF PPS

Section 1886(j) of the Act, as added by section 4421(a) of 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 for services furnished under the PPS for inpatient rehabilitation hospitals and inpatient rehabilitation units of hospitals (referred to as IRFs), and to establish classes of patient discharges by functional-related groups. Section 305 of 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. LTCH PPS

On August 30, 2002, we issued a final rule in the **Federal Register** (67 FR 55954) establishing the PPS for LTCHs, effective for cost reporting periods beginning on or after October 1, 2002. Except for a LTCH that made an election under § 412.533(c) or a LTCH that is defined as new under § 412.23(e)(4), there was a transition period under § 412.533(a) for LTCHs. For cost reporting periods beginning on or after October 1, 2006, all LTCHs are paid 100 percent of the adjusted Federal prospective payment rate.

D. IPF PPS

In accordance with section 124 of 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 that final rule, we computed a Federal per diem base rate to be paid to all IPFs for inpatient psychiatric services based on the sum of the average routine operating, ancillary, and capital costs for each patient day of psychiatric care in an IPF, adjusted for budget neutrality. The Federal per diem base rate is adjusted to reflect certain patient characteristics, including age, specified DRGs, selected high-cost comorbidities, days of the stay, and certain facility characteristics, including a wage index

adjustment, rural location, indirect teaching costs, the presence of a full-service emergency department, and COLAs for IPFs located in Alaska and Hawaii.

We established a 3-year transition period during which IPFs whose cost reporting periods began on or after January 1, 2005, and before January 1, 2008, would be paid a PPS payment, a portion of which was based on reasonable cost principles and a portion of which was the Federal per diem payment amount. For cost reporting periods beginning on or after January 1, 2008, all IPFs are paid 100 percent of the Federal per diem payment amount.

E. Determining Proposed LTCH Cost-to-Charge Ratios (CCRs) Under the LTCH PPS

In general, we use a LTCH's overall CCR, which is computed based on either the most recently settled cost report or the most recent tentatively settled cost report, whichever is from the latest cost reporting period, in accordance with § 412.525(a)(4)(iv)(B) and § 412.529(c)(4)(iv)(B) for high cost outliers and short-stay outliers, respectively. (We note that, in some instances, we use an alternative CCR, such as the statewide average CCR in accordance with the regulations at § 412.525(a)(4)(iv)(C) and § 412.529(c)(4)(iv)(C), or a CCR that is specified by CMS or that is requested by the hospital under the provisions of the regulations at § 412.525(a)(4)(iv)(A) and § 412.529(c)(4)(iv)(A).) Under the LTCH PPS, a single prospective payment per discharge is made for both inpatient operating and capital-related costs. Therefore, we compute a single ''overall'' or ''total'' LTCH-specific CCR based on the sum of LTCH operating and capital costs (as described in Chapter 3, section 150.24, of the Medicare Claims Processing Manual (CMS Pub. 100–4)) as compared to total charges. Specifically, a LTCH's CCR is calculated by dividing a LTCH's total Medicare costs (that is, the sum of its operating and capital inpatient routine and ancillary costs) by its total Medicare charges (that is, the sum of its operating and capital inpatient routine and ancillary charges).

Generally, a LTCH is assigned the applicable statewide average CCR if, among other things, a LTCH's CCR is found to be in excess of the applicable maximum CCR threshold (that is, the LTCH CCR ceiling). This is because CCRs above this threshold are most likely due to faulty data reporting or entry, and, therefore, these CCRs should not be used to identify and make payments for outlier cases. Such data are clearly errors and should not be relied upon. Thus, under our established policy, generally, if a LTCH's calculated CCR is above the applicable ceiling, the applicable LTCH PPS statewide average CCR is assigned to the LTCH instead of the CCR computed from its most recent (settled or tentatively settled) cost report data.

In the FY 2008 IPPS final rule with comment period, in accordance with § 412.525(a)(4)(iv)(C)(*2*) for high-cost outliers and § 412.529(c)(4)(iv)(C)(*2*) for short-stay outliers, using our established methodology for determining the LTCH total CCR ceiling, based on IPPS total CCR data from the March 2007 update to the Provider-Specific File (PSF), we established a total CCR ceiling of 1.284 under the LTCH PPS effective October 1, 2007, through September 30, 2008. (For further detail on our methodology for annually determining the LTCH total CCR ceiling, we refer readers to the FY 2007 IPPS final rule (71 FR 48117 through 48121) and the FY 2008 IPPS final rule with comment period (72 FR 47403 through 47404).)

Our general methodology established for determining the statewide average CCRs used under the LTCH PPS is similar to our established methodology for determining the LTCH total CCR ceiling (described above) because it is based on ''total'' IPPS CCR data. Under the LTCH PPS high-cost outlier policy at § 412.525(a)(4)(iv)(C) and the short-stay outlier policy at § 412.529(c)(4)(iv)(C), the fiscal intermediary (or MAC) may use a statewide average CCR, which is established annually by CMS, if it is unable to determine an accurate CCR for a LTCH in one of the following circumstances: (1) A new LTCH that has not yet submitted its first Medicare cost report (for this purpose, a new LTCH is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with § 489.18); (2) a LTCH whose CCR is in excess of the LTCH CCR ceiling (as discussed above); and (3) any other LTCH for whom data with which to calculate a CCR are not available (for example, missing or faulty data). (Other sources of data that the fiscal intermediary (or MAC) may consider in determining a LTCH's CCR include data from a different cost reporting period for the LTCH, data from the cost reporting period preceding the period in which the hospital began to be paid as a LTCH (that is, the period of at least 6 months that it was paid as a short-term acute care hospital), or data from other comparable LTCHs, such as LTCHs in the same chain or in the same region.)

In this proposed rule, in accordance with § 412.525(a)(4)(iv)(C)(*2*) for high-cost outliers and § 412.529(c)(4)(iv)(C)(*2*) for short-stay outliers, using our established methodology for determining the LTCH total CCR ceiling (described above), based on IPPS total CCR data from the December 2007 update to the PSF), we are proposing a total CCR ceiling of 1.262 under the LTCH PPS, effective for discharges occurring on or after October 1, 2008, and before October 1, 2009. If more recent data become available before publication of the final rule, we will use such data to determine the final total CCR ceiling under the LTCH PPS for FY 2009.

In this FY 2009 IPPS proposed rule, in accordance with § 412.525(a)(4)(iv)(C) for high-cost outliers and § 412.529(c)(4)(iv)(C) for short-stay outliers, using our established methodology for determining the LTCH statewide average CCRs (described above), based on the most recent complete IPPS total CCR data from the December 2007 update of the PSF, we are proposing LTCH PPS statewide average total CCRs for urban and rural hospitals that would be effective for discharges occurring on or after October 1, 2008, and before October 1, 2009, presented in Table 8C of the Addendum to this proposed rule. If more recent data become available before publication of the final rule, we will use such data to determine the final statewide average total CCRs for urban and rural hospitals under the LTCH PPS for FY 2009 using our established methodology described above.

We note that, for this 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 proposed rural statewide average total CCRs listed for those jurisdictions in Table 8C of the Addendum to this proposed rule. 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 2007. Therefore, for this proposed rule, there is no proposed rural statewide average total CCR listed for rural Massachusetts in Table 8C of the

Addendum of this proposed rule. 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 PSF for Maryland hospitals may not be accurate (as discussed in greater detail in that same final rule (71 FR 48120)).

F. Proposed Change to the Regulations Governing Hospitals-Within-Hospitals

On September 1, 1994, we published hospital-within-hospital (HwH) regulations for LTCHs to address inappropriate Medicare payments to entities that were effectively units of other hospitals (59 FR 45330). There was concern that the HwH model was being used by some acute care hospitals paid under the IPPS as a way of inappropriately receiving higher payments for a subset of their cases. Moreover, IPPS-exclusion of long-term care ''units'' was and remains inconsistent with the statutory scheme.

Therefore, we established the HwH regulations at 42 CFR 412.23 (currently at § 412.22) for a LTCH HwH that is co-located with another hospital. A co-located hospital is a hospital that occupies space in the same building or on the same campus as another hospital. The regulations at § 412.23(e) required that, to be excluded from the IPPS, long-term care HwHs must have a separate governing body, chief medical officer, medical staff, and chief executive officer from that of the co-located hospital. In addition, the HwH must meet either of the following two criteria: The HwH must perform certain specified basic hospital functions on its own and not receive them from the host hospital or a third entity that controls both hospitals; or the HwH must receive at least 75 percent of its inpatients from sources other than the co-located hospital. A third option was added to the regulations on September 1, 1995 (60 FR 45778) that allowed HwHs to demonstrate their separateness by showing that the cost of the services that the hospital obtains under contracts or other agreements with the co-located hospital or a third entity that controls both hospitals is no more than 15 percent. In 1997, we extended application of the HwH rules at § 412.22 to all classes of IPPS excluded hospitals. Therefore, effective for cost reporting periods beginning on or after October 1, 1997, psychiatric, rehabilitation, cancer, and children's hospitals that are co-located with another hospital are also required to meet the ''separateness'' criteria at § 412.22(e).

In addition, a ''grandfathering'' provision was added to the regulations at § 412.22(f), as provided for under section 4417 of the Balanced Budget Act (BBA) of 1997 (Pub. L. 105–33). This provision of the regulations allowed a LTCH that was excluded from the IPPS on or before September 30, 1995, and at that time occupied space in a building also used by another hospital, or in one or more buildings located on the same campus as buildings used by another hospital, to retain its IPPS-excluded status even if the HwH criteria at § 412.22(e) could not be met, as long as the hospital continued to operate under the same terms and conditions as were in effect on September 30, 1995. Consistent with the grandfathering provision under the BBA, which only applied to LTCHs, we extended the application of the grandfathering rule to the other classes of IPPS-excluded hospitals that are HwHs but did not meet the criteria at § 412.22(e). (We subsequently expanded this provision to allow for a grandfathered hospital to make specified changes during particular timeframes.)

Despite our efforts to allow those HwHs for whom the IPPS-exclusion status is appropriate to meet the HwH criteria, it appears that there may be a gap in our regulations. There remain certain HwHs under current rules that may be unnecessarily restricted from expanding their bed size. These HwHs are State hospitals that are co-located with another State hospital and that are grandfathered under § 412.22(f). Where a State law defines the structure and authority of the State's agencies and institutions, and the State hospital is co-located with another hospital that is under State governance, each hospital may have control over the day-to-day operations of its respective facility and have separate management, patient intake, and billing systems and medical staff, as well as a governing board. However, State law may require that the legal accountability for the budgets and activities of entities operating within a State-run institution rests with the State. Therefore, the co-located State hospitals may also be governed by a common governing body. Because of State law requirements, these HwHs are, therefore, precluded from meeting the HwH criteria at § 412.22(e)(1)(i) that requires the governing body of a co-located hospital to be separate from the governing body of the hospital with which it shares space. The excluded hospital's governing body cannot be under the control of the hospital occupying space in the same building or on the same campus, or of any third entity that controls both hospitals. Currently, there are State HwHs in these types of arrangements that have been able to retain their IPPS-excluded status solely because of the grandfathering provision in § 412.22(f). These HwHs were IPPS-excluded even before the HwH criteria were implemented and only remain excluded HwHs under § 412.22(f) as long as they continue to meet the requirements specified under § 412.22(f)(1), (f)(2), and (f)(3). Because they are grandfathered, these HwHs cannot increase their bed size without losing their IPPS-excluded status under the grandfathering provisions (§ 412.22(f)). Furthermore, if a grandfathered State-run HwH increased its bed size, it would be unable to qualify as an IPPS-excluded HwH under § 412.22(e) because it cannot meet the HwH criteria at § 412.22(e)(1)(i) as a result of State law requirements regarding its organizational structure and governance. These HwHs are precluded from the flexibility to expand their bed size, which is available to other HwHs whose organizational structure is not bound by State law.

As discussed in the previous paragraph, the organizational arrangements were in place for these State-operated HwHs before the HwH regulations were adopted. To the extent the arrangements are required by State law, we believe they do not reflect attempts by entities to establish a nominal hospital and, in turn, seek inappropriate exclusions. We also believe it may be unnecessary to prevent hospitals that were created before the HwH requirements, and that because of State statutory requirements cannot meet the subsequently issued separate governing body requirements, from being excluded from the IPPS. Accordingly, we are proposing to add a provision to the regulations that would apply only to State hospitals that were in existence when the HwH regulations were established. This proposed provision would not apply to other State hospitals that chose to open as a HwH subsequent to the establishment of the HwH regulations in FY 1994, under an organizational structure the same as or similar to the one described in this section. These hospitals knew, in advance of becoming a HwH, the requirements that had to be met in order to be an IPPS-excluded HwH, unlike

those hospitals that existed before the HwH regulations were established.

Accordingly, we are proposing to add a new paragraph (e)(1)(vi) to § 412.22 to provide that if a hospital cannot meet the criteria in § 412.22(e)(1)(i) solely because it is a State hospital occupying space with another State hospital, the HwH can nevertheless qualify for an exclusion from the IPPS if that hospital meets the other applicable criteria in § 412.22(e) and—

- Both State hospitals share the same building or same campus and have been continuously owned and operated by the State since October 1, 1995;
- Is required by State law to be subject to the governing authority of the State hospital with which it shares space or the governing authority of a third entity that controls both hospitals; and
- Was excluded from the inpatient prospective payment system before October 1, 1995, and continues to be excluded from the IPPS through September 30, 2008.

We believe the proposed criteria capture the segment of grandfathered, State-operated HwHs that are unable to increase their bed size because of State law regarding governance. We emphasize that we intend to allow an exception to the criteria in § 412.22 (e)(1)(i) only if the hospital that meets the proposed criteria above cannot meet the separate governing body requirement because of State law. We do not intend to provide similar treatment for hospitals that are not subject to State statutory requirements regarding governance but have chosen not to organize in a manner that would allow them to be an IPPS-excluded hospital that meets the HwH criteria at § 412.22(e)(1)(i).

VII. Disclosure Required of Certain Hospitals and Critical Access Hospitals Regarding Physician Ownership (§ 489.2(u) and (v))

Section 1866 of the Act states that any provider of services (except a fund designated for purposes of sections 1814(g) and 1835(e) of the Act) shall be qualified to participate in the Medicare program and shall be eligible for Medicare payments if it files with the Secretary a Medicare provider agreement and abides by the requirements applicable to Medicare provider agreements. These requirements are incorporated into our regulations in 42 CFR Part 489, Subparts A and B. Section 1861(e) of the Act defines the term ''hospital.'' Section 1861(e)(9) of the Act authorizes the Secretary to establish requirements for hospitals 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 ''critical access hospital.''

In the FY 2008 IPPS final rule with comment period, we revised our regulations governing Medicare provider agreements, specifically § 489.20(u), to require a hospital to disclose to all patients whether it is physician-owned and, if so, the names of its physician owners (72 FR 47385 through 47387). In addition, we added a definition of physician-owned hospital at § 489.3. The disclosure requirement in current § 489.20(u) is applicable only to those hospitals with physician ownership. (For purposes of this proposal, the term ''hospital'' also includes ''critical access hospital'' (CAH).) We neglected to include those hospitals in which no physician held an ownership or investment interest, but in which an immediate family member of a physician held an ownership or investment interest. However, it was always our intent to have consistency between the disclosure requirements and the physician self-referral statute and regulations. The physician self-referral statute and regulations, which recognize the potential for program and patient abuse where a financial relationship exists, are applicable to both a physician and the immediate family member of the physician. We believe that it is necessary to revise our definition of physician-owned hospital because a physician's potential conflict of interest occurs not only in those instances where he or she has a financial relationship in the form of an ownership or investment interest, but also where his or her immediate family member has a similar interest, and patients should be informed of this as part of making an informed decision concerning treatment. Therefore, we are proposing to revise the language in § 489.3 to define a ''physician-owned hospital'' as a participating hospital in which a physician, or an immediate family member of a physician (as defined at § 411.351), has an ownership or investment interest in the hospital.

To effectuate the changes made in the FY 2008 IPPS final rule with comment period, we relied on our authority in sections 1861(e)(9), 1820(e)(3) and 1866 of the Act, and on our general rulemaking authority in sections 1871 and 1102 of the Act. Following publication of the FY 2008 IPPS final rule with comment period, we became aware that some physician-owned hospitals have no physician owners who refer patients to the hospital (for example, in the case of a hospital whose physician-owners have retired from the practice of medicine). We believe that requiring a hospital with no *referring* physician owners to disclose to all patients that it is physician-owned and to provide the patients with a list of the (nonreferring) physician owners would be an unnecessary burden on the hospital and of no value in assisting a patient in making an informed decision as to where to seek treatment. Similarly, we do not believe that it is useful to require a hospital to make such disclosures when no referring physician has an immediate family member who has an ownership or investment interest in the hospital. Accordingly, we are proposing to include in § 489.20(v) new language to provide for an exception to the disclosure requirements for a physician-owned hospital (as defined at § 489.3) that does not have any physician owners who refer patients to the hospital (and that has no referring physicians (as defined at § 411.351) who have an immediate family member with an ownership or investment interest in the hospital), provided that the hospital attests, in writing, to that effect and maintains such attestation in its files for review by State and Federal surveyors or other government officials. (We note that, as explained below, we are proposing to redesignate the existing paragraphs (v) and (w) of § 489.20 as paragraphs (w) and (x), respectively.)

We are proposing to revise § 489.20(u) to specify that a hospital must furnish to patients the list of owners and investors who are physicians (or immediate family members of physicians) at the time the list is requested by or on behalf of the patient. In response to the FY 2008 IPPS proposed rule, we received public comments that noted that our proposal did not establish a timeframe within which the hospital must furnish to patients the required list of the hospital's physician owners or investors. These commenters suggested that we require that the list be provided to the patient at the time the request for the list is made by or on behalf of the patient. We stated in the preamble of the FY 2008 IPPS final rule with comment period that we would not revise the provision to include any specific timeframe for making the list available because we believed that it was important to allow hospitals some degree of flexibility regarding the manner and form in which it notified patients of the identity of its physician owners and investors (72 FR 47386). However, we also stated later in the preamble that we were revising proposed § 489.20(u) to specify that the

hospital should furnish a list of physician owners to a patient at the beginning of his or her hospital stay or outpatient visit, but the regulation text did not reflect this change (72 FR 47387).

We have reconsidered the issue and are proposing in § 489.20(u)(1) that the list of the hospital's owners or investors who are physicians or immediate family members of physicians (as defined at § 411.351) must be furnished at the time the patient or someone on the patient's behalf requests it. We are proposing this change for two reasons. First, in the FY 2008 IPPS final rule with comment period, in response to public comments received on the FY 2008 IPPS proposed rule, we stated that we believed that the physician ownership disclosure proposal would permit an individual to make more informed decisions regarding his or her treatment and to evaluate whether the existence of a financial relationship, in the form of an ownership interest, suggests a conflict of interest that is not in his or her best interest. However, we maintain that the provision of a generic notice that the hospital is owned by physicians or immediate family members of physicians is insufficient to permit an individual to make a truly informed decision. We believe that it is critical that the patient receives the list of names of the relevant owners or investors at the time the request is made by or on behalf of the patient so that the patient may make a determination as to whether his or her admitting or referring physician has a potential conflict of interest. Second, furnishing the list at the time the request is made by the patient or on behalf of the patient is crucial to affording the patient an opportunity to make an informed decision *before* treatment is furnished at the hospital. We are not specifying a form to be used for the list; rather, we are addressing the timeframe for the hospital to furnish the list to the patient.

In addition, we are proposing to add new § 489.20(u)(2) to require a hospital to require all physicians who are members of the hospital's medical staff to agree, as a condition of continued medical staff membership or admitting privileges, to disclose in writing to all patients who they refer to the hospital any ownership or investment interest in the hospital held by themselves or by an immediate family member. We would require that physicians agree to make such disclosures at the time they refer patients to the hospital. We proposed a similar requirement in the FY 2008 IPPS proposed rule, but decided not to adopt it as final. In response to a public comment, we stated that we would not finalize the proposal because we believed that it would not provide any additional protections for patients that would not already be offered by the requirement for hospitals to disclose their physician ownership to patients. We have revisited this issue.

In the FY 2008 IPPS final rule with comment period, we stated that the scheduling of most hospital inpatient or outpatient services is performed by a staff member in the physician's office, often weeks, or even months, in advance of the furnishing of the service. As discussed previously, we believe that early notification of physician ownership or investment in the hospital is beneficial to the patient's decisionmaking concerning his or her treatment. Currently, under § 489.20(u), scheduling of inpatient stays and outpatient visits at physician-owned hospitals would be permitted without notification to the patient of the referring physician's ownership or investment interest in the hospital. If a patient were notified of the physician ownership or investment at the time of the referral, he or she would have an opportunity to discuss the physician's ownership or investment in the hospital and make a more informed decision. We believe that it would be in the best interests of the patient and the physician owner or investor to disclose the physician's (or his or her immediate family member's) ownership in the hospital at the time the physician is referring the patient to the hospital. We are revising § 489.20(u) accordingly.

We note that notification of physician ownership or investment in a hospital may not be viewed negatively by all interested parties. For instance, some physician owners or investors in hospitals believe that disclosing their ownership or investment interests in the hospital to their patients at the time of the referral is extremely beneficial for both the physician and the patient. They communicate to patients their belief that their ownership in the hospital permits them to have total control over scheduling, staffing, and quality mechanisms. Section 5006 of the Medicare, Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) required, among other things, that HHS study the quality of care and patient satisfaction with specialty hospitals. HHS concluded that specialty hospital patients have very favorable perceptions of the clinical quality of care they receive, and that overall patient satisfaction is very high.

We are also proposing to revise § 489.53 to permit CMS to terminate the Medicare provider agreement if the hospital fails to comply with the provisions of proposed § 489.20(u)(1) or (u)(2). We believe that these revisions would be necessary to enforce the proposed disclosure requirements set forth in § 489.20.

We are not inclined to make a corresponding change to the medical staff bylaws condition of participation (CoP) in § 482.22(c). We believe that the proposed disclosure requirement is appropriate for inclusion in the regulations governing Medicare provider agreements for the following reasons. As stated in the FY 2008 IPPS final rule with comment period, each participating provider must comply with all applicable provisions of the provider agreement regulations found in 42 CFR Part 489, and CMS may terminate a provider agreement if the provider is not in substantial compliance with these requirements (72 FR 47391). A provider's compliance with applicable provider agreement regulations is reviewed through a variety of means, including onsite investigation of complaints. Thus, compliance with this proposed requirement could be easily monitored. We also note that any revisions to the medical staff bylaws concerning the requirement that the disclosure be given at the time of the referral would be difficult to enforce as a CoP because the required notification generally would be given outside of the hospital's or CAH's premises. However, we are considering whether these proposed changes would be better effectuated through changes to our regulations governing the CoPs applicable to hospitals and CAHs, which appear at 42 CFR Part 482 and 42 CFR Part 485, Subpart F, respectively, and, therefore, we are soliciting public comments on this issue.

In the FY 2008 IPPS final rule with comment period, we added a new provision at § 489.20(v) to require that hospitals and CAHs: (1) Furnish all patients written notice at the beginning of their inpatient hospital stay or outpatient service if a doctor of medicine or a doctor of osteopathy is not present in the hospital 24 hours per day, 7 days per week; and (2) describe how the hospital or CAH will meet the medical needs of any patient who develops an emergency medical condition at a time when no physician is present in the hospital (72 FR 47387). (We are proposing to redesignate existing § 489.20(v) and (w) as § 489.20(w) and (x), respectively, to accommodate the addition of the proposed exception to the requirements in § 489.20(v) discussed above.) We stated that 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. In order to be fully informed, consumers should be made aware of whether a hospital or CAH has a physician on-site 24 hours per day, 7 days per week, and should be made aware of the hospital's or CAH's processes for addressing medical emergencies that may occur when a physician is not on site. Given the patient safety measures addressed by these provisions, we are proposing to set forth penalties for failure to comply with these requirements. Specifically, we are proposing to revise § 489.53 to permit CMS to terminate the provider agreement of any hospital or CAH that fails to comply with the requirements set forth in proposed redesignated § 489.20(w).

We are also soliciting public comments on whether hospitals and CAHs should educate patients about the availability of information regarding physician ownership under the proposed disclosure requirements and, if so, by what means (for example, by a posting in the admissions office or in a patient brochure).

VIII. Physician Self-Referral Provisions (§§ 411.351, 411.352 and 411.354)

A. Stand in the Shoes Provisions

1. Physician ''Stand in the Shoes'' Provisions

a. Background

Section 1877 of the Act, also known as the physician self-referral law: (1) Prohibits a physician from making referrals for certain designated health services (''DHS'') payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship (ownership, investment or compensation), unless an exception applies; and (2) prohibits the entity from filing claims with Medicare (or billing another individual, entity, or third party payor) for those referred services. The statute establishes a number of specific exceptions and grants the Secretary the authority to create regulatory exceptions for financial relationships that pose no risk of program or patient abuse. Determining whether DHS entities and referring physicians (or their immediate family members) have direct or indirect financial relationships is a key step in applying the statute.

In the final rule entitled ''Medicare Program; Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships (Phase III),'' published in the **Federal Register** on September 5, 2007 (72 FR 51012) (''Phase III''), we interpreted certain provisions of section 1877 of the Act, including provisions relating to direct and indirect compensation arrangements. Specifically, the Phase III final rule included provisions under which referring physicians are treated as standing in the shoes of their physician organizations for purposes of applying the rules that describe direct and indirect compensation arrangements in § 411.354 (72 FR 51026 through 51030). A ''physician organization'' is defined at § 411.351 as ''a physician (including a professional corporation of which the physician is the sole owner), a physician practice, or a group practice that complies with the requirements of § 411.352.'' Therefore, when determining whether a direct or indirect compensation arrangement exists between a physician and an entity to which the physician refers Medicare patients for DHS, the referring physician stands in the shoes of: (1) Another physician who employs the referring physician; (2) his or her wholly-owned professional corporation (''PC''); (3) a physician practice (that is, a medical practice) that employs or contracts with the referring physician or in which the physician has an ownership interest; or (4) a group practice of which the referring physician is a member or independent contractor. The referring physician is considered to have the same compensation arrangements (with the same parties and on the same terms) as the physician organization in whose shoes the referring physician stands.

Subsequent to the publication of Phase III, industry stakeholders, including academic medical centers (''AMCs''), integrated tax-exempt health care delivery systems, and their representatives, expressed concern about the application of the Phase III ''stand in the shoes'' provisions to compensation arrangements involving ''mission support payments'' and ''similar payments'' (referred to in this proposed rule generally as ''support payments''). The stakeholders believed that certain payments did not previously trigger application of the physician self-referral law but, after Phase III, need to satisfy the requirements of an exception. One example offered was a DHS entity component (such as a hospital) of an AMC that transfers funds to the faculty practice plan component of the AMC. If a referring physician stands in the shoes of his or her faculty practice plan, the compensation arrangement between the hospital providing the support payment and the faculty practice plan will be considered to be a direct compensation arrangement between the hospital and the physician and would need to satisfy the requirements of a direct compensation arrangement exception, if the physician is to continue referring Medicare patients to the component for DHS. According to the industry stakeholders, before Phase III, such arrangements would have been analyzed under the rules regarding indirect compensation arrangements and would, in their view, have been permitted. After Phase III, in their view, it is unlikely that the requirements of an available exception could be satisfied given the nature of support payments; that is, support payments usually are not tied to specific items or services provided by the faculty practice plan (or group practice within an integrated health care delivery system), but rather are intended to support the overall mission of the AMC or maintain operations in an integrated health care delivery system. For this reason, support payments likely do not satisfy the requirement, present in many exceptions, that the compensation be fair market value for items or services provided. Similarly, some stakeholders raised concerns about support payments made from faculty practice plans to AMC components. Although AMCs are free to use the exception for services provided by an AMC in § 411.355(e) (which would protect support payments made among AMC components if all of the conditions of the exception are met), industry stakeholders explained that many AMCs do not do so, preferring instead to rely on other available exceptions and the rules regarding indirect compensation arrangements (especially prior to Phase III).

To provide CMS sufficient time to study the ''stand in the shoes'' provisions as they relate to compensation arrangements involving support payments, seek additional public comment, and develop an approach for addressing this issue, on November 15, 2007, we issued a final rule entitled ''Medicare Program; Delay of the Date of Applicability for Certain Provisions of Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships (Phase III)'' (72 FR 64164) that delayed the effective date of the provisions in § 411.354(c)(1)(ii), § 411.354(c)(2)(iv), and § 411.354(c)(3) for 12 months after the effective date of Phase III (that is, until December 4, 2008). That final rule was applicable to the following compensation arrangements between the following physician organizations and entities ONLY:

- With respect to an AMC as described in § 411.355(e)(2),

compensation arrangements between a faculty practice plan and another component of the same AMC; and

• With respect to an integrated section 501(c)(3) health care system, compensation arrangements between an affiliated DHS entity and an affiliated physician practice in the same integrated section 501(c)(3) health care system.

Following the publication of the November 15, 2007 final rule, other industry stakeholders asserted that, in addition to section 501(c)(3) health care systems, most integrated health care delivery systems, including ones involving for-profit entities, make support payments. The stakeholders further asserted that, although under the ''stand in the shoes'' provisions such payments must now satisfy a direct compensation arrangement exception, there is, in fact, no applicable exception. These stakeholders urged that any approach to addressing the impact of the Phase III ''stand in the shoes'' provisions on support payments and other monetary transfers within integrated health care delivery systems should have universal applicability that is not dependent on whether the system meets the definition of an AMC or has a particular status under the rules of the Internal Revenue Service.

b. Proposals

Given the potential widespread impact of the ''stand in the shoes'' provisions, as well as the considerable industry interest in their application, we are revisiting the ''stand in the shoes'' policy and regulations issued in Phase III. We believe that a more refined approach to the ''stand in the shoes'' provisions would accomplish our goals of simplifying the analysis of many financial arrangements and reducing program abuse by bringing more financial relationships within the scope of the physician self-referral law (such as certain potentially abusive arrangements between DHS entities and physician organizations that may not have met the definition of an ''indirect compensation arrangement''). We note that we are not suggesting that support payments and other similar compensation arrangements are without risk of program or patient abuse, nor are we endorsing such payments and arrangements.

We are proposing here two alternative ways to address the ''stand in the shoes'' issues described above, and are seeking industry input on each proposal, as well as on other possible approaches. The first is a multi-faceted approach to revising the Phase III ''stand in the shoes'' provisions. The second proposal would leave the Phase III ''stand in the shoes'' provisions as promulgated and would, instead, create a new exception using our authority under section 1877(b)(4) of the Act for nonabusive arrangements that warrant protection not available under existing exceptions. We are also interested in public comments on other approaches and on whether changes to the existing ''stand in the shoes'' provisions are needed at all.

For the first proposal, we propose revising § 411.354(c)(2)(iv) to provide that a physician would be deemed not to stand in the shoes of his or physician organization if the compensation arrangement between the physician organization and the physician satisfies the requirements of the exception in § 411.357(c) (for *bona fide* employment relationships), the exception in § 411.357(d) (for personal service arrangements), or the exception in § 411.357(l) (for fair market value compensation). Currently, all physicians stand in the shoes of their physician organizations, regardless of the nature of the compensation they receive from the physician organization. Under our proposal, the first step in the analysis would be to look at the compensation a referring physician receives from his or her physician organization. A compensation arrangement between a physician organization and a physician that satisfies the requirements of § 411.357(c), (d), or (l) would be consistent with fair market value by design and not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the physician to the *physician organization*. Although such compensation could, in some circumstances, be determined in a manner that takes into account (directly or indirectly) the volume or value of the physician's referrals *to the DHS entity* (see 66 FR 869), we believe that the risk of program or patient abuse will be addressed sufficiently by analyzing such arrangements between DHS entities and referring physicians who do not stand in the shoes of their physician organizations using the rules regarding indirect compensation arrangements. Therefore, under this proposal, if the compensation arrangement between a physician organization and one of its referring physicians satisfies the requirements of one of the exceptions noted above, the referring physician would be deemed not to stand in the shoes of the physician organization for purposes of applying the definitions of, and provisions related to, direct and indirect compensation arrangements in § 411.354(c). Arrangements between DHS entities and physician organizations whose physicians do not stand in their shoes may still create indirect compensation arrangements that would need to satisfy the requirements of the exception for indirect compensation arrangements in § 411.357(p).

Under this first proposed approach, physician owners and investors would continue to stand in the shoes of their physician organizations. However, we are concerned that considering all physician owners of, or physician investors in, a physician organization to stand in the shoes of the physician organization, as they currently do under the Phase III ''stand in the shoes'' provisions, might be over-inclusive. For example, in a State that prohibits the corporate practice of medicine, a physician owner of a captive or ''friendly'' PC who has no right to the distribution of profits would stand in the shoes of his or her physician organization, even though his or her employment arrangement with the group satisfies the requirements of the exception for *bona fide* employment relationships in § 411.357(c). We are considering whether these and similarly situated physician owners should have to stand in the shoes of their physician organizations when their ownership interest is nominal in nature and their compensation arrangement with the physician organization satisfies the requirements of one of the exceptions in § 411.357(c), (d), or (l). We are soliciting public comments on this issue.

As described above, a physician-employee or contractor whose compensation arrangement with a physician organization does not satisfy the requirements of § 411.357(c), (d), or (l) would stand in the shoes of the physician organization. This is necessary to address our concern that an arrangement between a DHS entity and a physician organization that compensates its physicians in a manner that does not satisfy the requirements of an exception may be particularly prone to abuse. For example, where a physician-employee's compensation arrangement with his or her group practice exceeds fair market value for services provided to the group practice employer (and, thus, does not satisfy the requirements of the exception in § 411.357(c)), and the physician-employee's DHS referrals to the group practice instead are protected under the exception for in-office ancillary services in § 411.355(b), there is risk that the physician-employee's above-fair-market-value compensation may reflect the volume or value of referrals to the DHS

entity. This could be the result of a support or other payment between the DHS entity and the group practice that is designed to channel compensation to the physician-employee for referrals to the DHS entity.

We are also considering, and solicit comments on, an approach under which *only* owners of a physician organization would stand in the shoes of that physician organization (in which case, a physician would not stand in the shoes of a physician organization unless he or she holds an ownership or investment interest, even if the physician's compensation arrangement with that physician organization does not satisfy the requirements of § 411.357(c), (d), or (l)). In conjunction with this approach, we are interested in receiving comments on whether and under what circumstances the ''stand in the shoes'' provisions should apply to a physician organization that has no physician owners.

In this first approach, we also propose to revise § 411.354(c)(3)(ii) to provide that the provisions of §§ 411.354(c)(1)(ii) and (c)(2)(iv) do not apply when the requirements of § 411.355(e) are satisfied. In other words, a physician would not stand in the shoes of his or her physician organization (for example, a faculty practice plan) when his or her referral for DHS is protected under the exception in § 411.355(e) for services provided by an AMC. We note that, if all of the requirements of the exception in § 411.355(e) are *not* satisfied, a physician would stand in the shoes of his or her physician organization unless, as discussed above with respect to proposed revised § 411.354(c)(2)(iv), the compensation from the physician organization to the physician satisfies the requirements of the exception for *bona fide* employment relationships, the exception for personal service arrangements, or the exception for fair market value compensation in § 411.357(c), (d), and (l), respectively. We are proposing to include a specific revision to the regulation in § 411.354(c)(2)(iv); however, we are seeking public comment as to whether this policy is better achieved by revising § 411.354(c)(3) to delete the reference to applying the exceptions in § 411.355, and thereby providing that the ''stand in the shoes'' provisions do not apply where the prohibition on referrals is not applicable because all of the requirements of any of the exceptions in § 411.355 are satisfied.

In this first approach, we also propose to revise § 411.354(c)(3)(ii) to provide that the provisions of § 411.354(c)(1)(ii) and (c)(2)(iv) do not apply when compensation is provided by a component of an AMC to a physician organization affiliated with that AMC through a written contract to provide services required to satisfy the AMC's obligations under the Medicare graduate medical education (GME) rules where the contract is limited to only services necessary to fulfill the GME obligations as set forth in 42 CFR, Part 413, Subpart F. We have in mind certain arrangements between a hospital component of an AMC and a community physician group to serve as a teaching site for the AMC's residents, as required by the GME rules. If adopted, this proposal would not mean that such arrangements necessarily are lawful, but rather that they would be analyzed by applying the rules regarding indirect compensation arrangements.

Under this first proposal, if adopted, some referring physicians would no longer stand in the shoes of their physician organizations as they currently do under the Phase III ''stand in the shoes'' provisions. In such circumstances, the rules regarding direct and indirect compensation arrangements would still apply, and financial relationships would still need to be analyzed for compliance with the statute and regulations. We are concerned that, where physicians do not stand in the shoes of their physician organizations, some potentially abusive arrangements between DHS entities and physician organizations might be viewed incorrectly as falling outside the definition of an ''indirect compensation arrangement'' at § 411.354(c)(2) and, therefore, as not within the scope of the physician self-referral law. The definition of ''indirect compensation arrangement'' generally requires that three elements be present: (1) An unbroken chain of financial relationships between the DHS entity and the referring physician; (2) aggregate compensation to the referring physician (from the entity in the chain closest to the physician) that varies with or takes into account in any manner the volume or value of referrals to, or other business generated for, the DHS entity; and (3) knowledge by the DHS entity that the referring physician receives such compensation. (We refer readers to 66 FR 864 through 870, 69 FR 16057 through 16063, and 72 FR 51026 through 51031 for further explanation.) We believe that some parties may be construing these elements (particularly the second and the third) too narrowly. For example, we believe that aggregate compensation can vary with or take into account the volume or value of referrals to, or business generated for, DHS entities in a wide range of circumstances, including, without limitation, arrangements involving: variable, per-click, or percentage-based compensation; exclusive contracts; inflated fixed payments; or explicit or implicit tying of compensation to other referrals. To address this issue, we may provide additional guidance on the application of the three elements of the definition of ''indirect compensation arrangement'' in the FY 2009 IPPS final rule. We are interested in public comments regarding ways in which we can ensure that the full range of potentially abusive arrangements between DHS entities and physician organizations are appropriately addressed in situations where physicians do not stand in the shoes of their physician organizations.

As discussed above, we are proposing an alternative approach to addressing the Phase III ''stand in the shoes'' provisions. (However, we are proposing regulation text for the first proposal only.) Our alternative proposal is to make no revisions to the Phase III ''stand in the shoes'' provisions in §§ 411.354(c)(1)(ii), (c)(2)(iv), and, (c)(3) and, to the extent necessary to protect nonabusive arrangements, promulgate a separate exception using our authority under section 1877(b)(4) of the Act to create exceptions for arrangements that do not pose a risk of program or patient abuse. The new exception would apply to specific types of nonabusive payments or arrangements that are not otherwise covered by existing exceptions (for example, certain support payments, as described above), subject to conditions necessary to protect against program and patient abuse, similar to those conditions incorporated into the existing exception for services provided by an AMC in § 411.355(e). Specifically, we are considering establishing a new exception, using our authority under section 1877(b)(4) of the Act, for compensation arrangements between DHS entities and physician organizations and physicians for ''mission support'' payments (or similar compensation arrangements) and, if so, how we should define those payments (or similar compensation arrangements), and what criteria such an exception should include to protect against program or patient abuse. We are soliciting comments about this proposal, including whether an exception should be limited to ''mission support'' payments, whether other specific types of payments or compensation arrangements should be eligible for such an exception, the types of parties that should be permitted to use the

exception (for example, AMC components, physician practices), and the conditions that should apply to such an exception to ensure that a protected compensation arrangement poses no risk of program or patient abuse. We are concerned that some ''mission support'' payments or similar payments are subject to fraud and abuse. We are interested in public comments that identify with specificity the types of compensation agreements that should be permitted under an applicable exception.

Under this approach, the proposed exception might address compensation arrangements between components of certain well-defined integrated delivery systems, perhaps with tightly-crafted conditions similar to those in the existing exception for services provided by an AMC in § 411.355(e). For example, some industry stakeholders have recommended that we establish an exception for compensation arrangements between a DHS entity component of an integrated health care delivery system and a physician organization component of the same integrated health care delivery system. We are concerned that the term ''integrated health care delivery system'' is loosely used in the industry to describe a wide variety of systems, with varying degrees of actual integration, and that it may prove infeasible to craft a sufficiently circumscribed definition. In many circumstances, payment arrangements between components of ''integrated health care delivery systems,'' as well as payments from ''integrated health care delivery systems'' to physicians affiliated with those systems are susceptible to fraud and abuse. However, we are soliciting public comments defining a fully integrated health care delivery system, what types of compensation arrangements should be protected (for example, support payments), and what conditions should be included in an exception that would ensure no risk of program or patient abuse. We note that any exception established using our authority under section 1877(b)(4) of the Act would include documentation requirements and a requirement that the arrangement not violate the anti-kickback statute or any Federal or State law or regulation governing billing or claims submission, consistent with the existing exceptions created under this authority.

According to some industry stakeholders, an ''integrated health care delivery system'' could be defined, for example, as a health care delivery system comprised of two or more entities that are related and substantially integrated by common ownership or control, and which includes at least one hospital and one physician organization that has no physician owners or investors who make referrals for DHS to any component of the health care delivery system. Entities that file consolidated financial statements could be deemed to be substantially integrated for purposes of this definition. For purposes of this approach, ownership could exist if an individual or individuals possess 50 percent ownership or equity in the component of the integrated health care delivery system, and control would exist if an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of the component of the integrated health care delivery system. As noted above, it would be necessary to define ''integrated health care delivery system,'' as well as ''ownership'' and ''control,'' and to determine whether to permit integrated health care delivery systems to include entities related through written contractual affiliation agreements and, if so, what limitations (if any) should be placed on the types of contractually affiliated entities we would permit to be included as components of an integrated health care delivery system. We would need also to determine what characteristics indicate substantial integration and identify the types of compensation arrangements that exist between components of integrated health care delivery systems. We are seeking public comments regarding this possible approach (including the specific issues noted), as well as public comments on other alternative approaches to addressing the concerns regarding support payments and similar monetary transfers noted by industry stakeholders and described above.

2. DHS Entity ''Stand in the Shoes'' Provisions

On July 12, 2007, we published in the **Federal Register** a proposed rule entitled ''Medicare Program; Proposed Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Revisions to the Payment Policies of Ambulance Services Under the Ambulance Fee Schedule for CY 2008; and the Proposed Elimination of the E-Prescribing Exemption for Computer-Generated Facsimile Transmissions; Proposed Rule'' (the ''CY 2008 PFS proposed rule'') (72 FR 38122). In that rule, we proposed a corollary provision to the Phase III ''stand in the shoes'' provisions that addressed the DHS entity side of physician—DHS entity financial relationships. Specifically, we proposed to amend § 411.354(c) to provide that, where a DHS entity owns or controls an entity to which a physician refers Medicare patients for DHS, the DHS entity would stand in the shoes of the entity that it owns or controls and would be deemed to have the same compensation arrangements with the same parties and on the same terms as does the entity that it owns or controls. For example, a hospital would stand in the shoes of a medical foundation that it owns or controls (such as where the hospital is the sole member of a nonprofit corporation). Thus, under the CY 2008 PFS proposed rule proposal, if a hospital owns or controls a medical foundation that contracts with a physician to provide physician services at a clinic owned by the medical foundation, the hospital would stand in the shoes of the medical foundation and would be deemed to have a direct compensation relationship with the contractor physician. We solicited public comments as to whether and how we would employ a ''stand in the shoes'' approach for these types of relationships, as well as for other types of financial relationships.

In response to the CY 2008 PFS proposed rule, we received comments from a variety of industry stakeholders, including physicians, medical associations, and their representatives. Although several commenters supported the proposed entity ''stand in the shoes'' provisions because they share our concerns regarding parties ability to avoid application of the physician self-referral law by simply inserting an entity in the chain of financial relationships linking a DHS entity and a referring physician, many commenters expressed concern that the proposal was unclear and potentially overly broad. Commenters requested guidance regarding the level of ownership or control that would trigger the application of the entity ''stand in the shoes'' provisions. One commenter recommended that, instead of finalizing the entity ''stand in the shoes'' provisions, we issue, through a notice of proposed rulemaking, a more detailed proposal that would give industry stakeholders the opportunity to provide more meaningful comments.

We did not finalize the DHS entity ''stand in the shoes'' provisions in the CY 2008 PFS final rule published in the **Federal Register** on November 27, 2007 (72 FR 66222, 66306). Because the DHS entity ''stand in the shoes'' provisions are integrally related to the physician ''stand in the shoes'' provisions that we finalized in Phase III and for which we

are proposing the regulatory revisions described above, we are re-proposing here the DHS entity ''stand in the shoes'' provisions, with some modification. We believe that a comprehensive approach to the ''stand in the shoes'' provisions that addresses both physicians and physician organizations, as well as DHS entities and other entities that they own or control, is the best vehicle to address the goals outlined in the Phase III final rule, namely: (1) Simplifying the analysis of many financial arrangements; and (2) reducing program abuse by bringing more financial relationships within the ambit of the physician self-referral law.

We are proposing to revise § 411.354(a) to provide that an entity that furnishes DHS would be deemed to stand in the shoes of an organization in which it has a 100 percent ownership interest and would be deemed to have the same compensation arrangements with the same parties and on the same terms as does the organization that it owns. We believe this approach is straightforward and can be readily applied. We note that, under this approach (as compared to our CY 2008 PFS proposal), a DHS entity would stand in the shoes of *any* wholly-owned organization, not merely a wholly-owned DHS entity. An organization may be in any legal form (for example, a limited liability company, partnership, or corporation, regardless of status as nonprofit or exempt from taxation). We are seeking public comments specifically as to whether we should consider a DHS entity to stand in the shoes of another organization in which the DHS entity holds less than a 100 percent ownership interest and, if so, what amount of ownership should trigger application of the entity ''stand in the shoes'' provisions. In addition, we are seeking public comments as to whether we should deem a DHS entity to stand in the shoes of an organization that it controls (for example, an entity would stand in the shoes of a nonprofit organization of which it is the sole member); we would consider a DHS entity to control an organization if the DHS entity has the power, directly or indirectly, significantly to influence or direct the actions or policies of the organization. We are seeking public comments as to what level of control should trigger the application of the entity ''stand in the shoes'' provisions.

3. Application of the Physician ''Stand in the Shoes'' and the Entity ''Stand in the Shoes'' Provisions

In order to protect against program and patient abuse when multiple links involving various corporate and other entities exist in a chain of financial relationships between a DHS entity and a referring physician, we are proposing that, when applying the physician ''stand in the shoes'' provisions and the entity ''stand in the shoes'' provisions to a chain of financial relationships between a physician and a DHS entity, the following conventions would apply:

- First, parties would apply the physician ''stand in the shoes'' provisions and deem the physician to stand in the shoes of his or her physician organization (in those instances where the physician ''stand in the shoes'' provisions apply to the particular physician and physician organization).
- However, if applying the physician ''stand in the shoes'' provisions would result in only one financial relationship remaining between the DHS entity and the ''collapsed'' physician/physician organization *and* that relationship is an ownership interest, the physician ''stand in the shoes'' provisions would not be applied, and the entity ''stand in the shoes'' provisions instead would be applied first.
- If more than two organizations remain after first ''collapsing'' the physician and the physician organization (that is, if at least two links remain in the chain of financial relationships between the physician who is standing in the shoes of his or her physician organization and the DHS entity), the next step would be to apply the entity ''stand in the shoes'' provisions.

These conventions ensure that at least one compensation arrangement remains between the DHS entity and the referring physician for purposes of analyzing the chain of relationships under the physician-self referral rules. For example, if a chain of financial relationships runs: hospital—wholly-owned home health agency—group practice—physician owner of the group practice, the first step would be to apply the physician ''stand in the shoes provisions'' such that the physician owner would stand in the shoes of the group practice. The next step would be to apply the entity ''stand in the shoes'' provisions and deem the hospital to stand in the shoes of its wholly-owned home health agency. Assuming that the financial relationship between the home health agency and the group practice is a compensation arrangement, the remaining financial relationship would be deemed to be a direct compensation arrangement between the hospital (standing in the shoes of the home health agency) and the physician (standing in the shoes of the group practice). By contrast, the example of a chain of financial relationships that runs: hospital—group practice wholly-owned by the hospital—employed physician of the group practice (whose compensation does not satisfy the requirements of the exception in § 411.357(c)), is illustrative. If the relationship between the hospital and the group practice is solely an ownership interest (that is, there is no separate compensation arrangement between them), applying the physician ''stand in the shoes'' provisions first, so that the physician-employee stands in the shoes of the group practice, would result in one remaining financial link between the group practice and the hospital, and that relationship would be an ownership interest. In those circumstances, the entity ''stand in the shoes'' provisions would be applied first and the hospital would stand in the shoes of its wholly-owned group practice. The physician would not stand in the shoes of the group practice. The remaining financial relationship would be deemed to be a direct compensation arrangement between the hospital (standing in the shoes of the group practice) and the physician. (We note that, in this example, the physician's compensation from the group practice does not satisfy the requirements of the exception for *bona fide* employment relationships in § 411.357(c) and, thus, no direct exception would apply to that compensation arrangement.) Using the same chain of financial relationships, but assuming instead that the hospital has a compensation arrangement with (in addition to being the sole owner of) the group practice (for example, an office space rental agreement), under the proposals described above, the physician would stand in the shoes of the group practice, but the hospital would not stand in the shoes of the group practice because, after first applying the physician ''stand in the shoes'' provisions, only two organizations would remain (that is, only one link in the chain of financial relationships remains). The remaining financial relationship created by the rental agreement would be deemed to be a direct compensation arrangement between the hospital and the physician, which would need to satisfy the requirements of an exception.

We are not proposing regulation text at this time with respect to the application of the physician and entity ''stand in the shoes'' provisions. At such time as these provisions are finalized, we would amend the regulation text, as appropriate, to codify requirements

related to the application of the provisions.

4. Definitions: ''Physician'' and ''Physician Organization''

In an interim final rule with comment period entitled ''Medicare Program; Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships (Phase II); Interim Final Rule,'' published in the **Federal Register** on March 26, 2004 (72 FR 16054) (''Phase II''), we revised the definition of ''referring physician'' at § 411.351 to provide that a referring physician is deemed to stand in the shoes of his or her wholly-owned PC (69 FR 16060). In that rule, we stated that it is not necessary to treat a referring physician as separate from his or her wholly-owned PC. In the Phase III final rule, for purposes of implementing the physician ''stand in the shoes'' provisions, the term ''physician organization'' was newly defined at § 411.351 as ''a physician (including a professional corporation of which the physician is the sole owner), a physician practice, or a group practice that complies with the requirements of § 411.352.'' Our intent was that, when applying the physician ''stand in the shoes'' provisions in § 411.354, a physician would stand in the shoes of: (1) Another physician who employs the physician; (2) his or her wholly-owned PC; (3) a physician practice that employs or contracts with the physician or in which the physician has an ownership interest; or (4) a group practice of which the physician is a member or independent contractor.

Essentially, we intended this definition to incorporate the Phase II policy that a physician stands in the shoes of, or is considered the same as, the PC of which he or she is the sole owner. In determining whether a direct or indirect compensation arrangement exists between a DHS entity and a referring physician, we intended that parties should first ''collapse'' the physician into his or her wholly-owned PC, and then deem that ''collapsed'' physician/PC unit to stand in the shoes of the physician organization (if one exists). However, we are concerned that parties may interpret the rules, using the definition of ''physician organization'' exclusive of the definition of ''referring physician,'' as requiring only that they deem a physician to stand in the shoes of his or her wholly-owned PC without further deeming the ''collapsed'' physician/PC unit to stand in the shoes of the physician organization. That is, with respect to a chain of financial relationships that runs: hospital—group practice—PC—physician, parties might interpret our rules as requiring only that the physician stand in the shoes of the PC and not in the shoes of the group practice, so that the resulting chain of financial relationships (after the application of the ''stand in the shoes'' provisions) would run: hospital—group practice—PC/physician. However, our intention was that, after application of the ''stand in the shoes'' provisions, the chain of financial relationships would run: hospital—group practice/PC/physician.

Therefore, we are proposing revisions to the definitions of ''physician'' and ''physician organization'' to clarify that: (1) A physician and the PC of which he or she is the sole owner are always treated the same for purposes of applying the physician self-referral rules; and (2) a physician who stands in the shoes of his or her wholly-owned PC also stands in the shoes of his or her physician organization in accordance with § 411.354(c)(1)(ii) and (c)(2)(iv).

B. Period of Disallowance

In response to the Phase II interim final rule with comment period, several commenters questioned what the time period would be for which the physician could not refer patients for DHS to an entity and for which the entity could not bill Medicare (the ''period of disallowance'') where a financial relationship between a referring physician and an entity failed to satisfy the requirements of an exception to the general prohibition on self-referral. (*See* 72 FR 51024 through 51025; and 72 FR 38183.) In the Phase III final rule, in response to these inquiries, we stated that the statute provides no explicit limitation on the billing and claims submission prohibition (72 FR 51025). In the CY 2008 PFS proposed rule, we stated that the statute contemplates that the period of disallowance begins with the date that a financial relationship failed to comply with the statute and the regulations, and ends with the date that the arrangement came into compliance or ended (72 FR 38183). We noted that, in some cases, it may not be clear when a financial relationship has ended. We provided the example of an entity leasing space to a physician at a rental price that is substantially below fair market value. We stated that such an arrangement may raise the inference that the below-market rent was in exchange for future referrals, including referrals made beyond the expiration of the lease. We solicited comments with respect to: (1) The types of noncompliance for which it is not clear when a financial relationship ended; and (2) whether we should always employ a case-by-case approach or deem certain types of financial relationships to continue for a prescribed period of time. We also solicited public comments as to whether we should allow a prescribed period of disallowance to terminate where the parties have returned (or paid back the value of) any excess compensation. For example, if we were to impose a period of disallowance for a prescribed period of time because it would not be clear when a noncompliant compensation arrangement ended, we stated that we might allow the parties to terminate the period of disallowance sooner than the prescribed period if the prohibited compensation were returned. In the CY 2008 PFS proposed rule, we cautioned that we did not envision allowing such an option where the parties knew or, in our judgment, reasonably should have known, that the arrangement did not satisfy the requirements of an exception. Finally, we sought public comments as to whether we should impose a period of disqualification, prohibiting the parties from using an exception where an arrangement has failed to satisfy the requirements of that exception. We gave the example of nonmonetary compensation provided by an entity to a physician that greatly exceeded the permissible limit prescribed in § 411.357(k), and questioned whether, in addition to whatever period of disallowance would apply, the parties should be disqualified, for some period of time, from using this exception.

We received few public comments in response to the CY 2008 PFS proposed rule solicitation of comments; however, with respect to the length of the period of disallowance, one commenter asserted that the appropriate period of disallowance should match the period that the financial relationship did not satisfy the requirements of an exception, but that the period should be limited to a maximum term. In addition, commenters asserted that, if the parties unwind the relationship and return the prohibited compensation, the period of disallowance should end. Another commenter suggested that the period of disallowance should end once the hospital corrects or terminates the arrangement and the physician repays to the hospital any compensation in excess of what is permitted. Alternatively, according to the commenter, if the physician does not repay the excess compensation, the period of disallowance should end once the hospital repays to Medicare the excess compensation, and the hospital should be prohibited from paying any further compensation to the physician until the

physician reimburses the hospital for the excess compensation. One commenter asserted that certain circumstances warrant no period of disallowance. For instance, according to the commenter, if parties to an arrangement were unaware that the arrangement violates the physician self-referral law but later were notified by CMS or its contractor of the possible violation, they should be able to amend the arrangement so that it satisfies the requirements of an exception without any period of disallowance. The commenter also asserted that there should be no period of disqualification preventing the parties from using an exception in light of the onerous penalties under the physician self-referral law.

At this time, we are proposing to amend § 411.353(c) to provide that, where the reason(s) a financial relationship does not meet any applicable exception is not related to compensation (for example, a signature is missing or an agreement is not in writing as required by the applicable exception), the period of disallowance would begin on the date the arrangement first was out of compliance and end no later than the date the arrangement was brought into compliance (for example, by obtaining a missing signature on an agreement or executing a written agreement as required by the applicable exception). For example, where a hospital and a physician enter into a personal service arrangement for medical director services and begin performing under the arrangement on January 1, but do not execute a written agreement until January 31, provided that all of the requirements of § 411.357(d) (the exception for personal service arrangements) are satisfied as of January 31, the period of disallowance would begin on January 1 and end no later than January 31. As discussed below, we believe that it is possible that a financial arrangement may end prior to the arrangement being brought into compliance. In such circumstances, a determination as to the duration of the period of disallowance necessarily would be made on a case-by-case basis considering the facts and circumstances, and we are not proposing a prescribed period of disallowance for such a situation.

We are also proposing that, where the reason a financial relationship does not meet any applicable exception is related to the payment or receipt of excess compensation (for example, the compensation paid to a physician is greater than fair market value or exceeds the limits in § 411.357(k) or (m)), the period of disallowance would begin on the date the arrangement first was out of compliance *and* end no later than the date the excess compensation (including interest, as appropriate) was returned by the party receiving it to the party that provided it and *all* other requirements of the applicable exception are met. For example, if a hospital provided nonmonetary compensation totaling $100 in excess of the limits in § 411.357(k) on February 1 and the parties did not discover the noncompliance until October 1 (and, therefore, could not avail themselves of the provisions in § 411.357(k)(3) permitting parties to remain in compliance with the exception if excess nonmonetary compensation (within certain limits) provided inadvertently is discovered and returned with 180 days of its receipt), the period of disallowance would begin on February 1 and end no later than the date that the physician returned the excess nonmonetary compensation or its value ($100 plus interest, as appropriate) to the hospital. Assuming that the physician paid the hospital $100 (plus interest, as appropriate) on October 15, the period of disallowance would run from February 1 through no later than October 15.

Our proposal would also prescribe a period of disallowance where the reason a financial relationship does not meet any applicable exception is related to the payment or receipt of compensation that is insufficient to satisfy the requirements of an exception (for example, office space or equipment rental payments that are below fair market value). We are proposing that the period of disallowance would begin on the date the arrangement first was out of compliance and end no later than the date the shortfall was paid to the party to which it is owed *and* all other requirements of the applicable exception are met. The ''shortfall'' would be that amount (including interest, as appropriate) necessary to bring the arrangement into compliance from the date of its inception. For example, assume a hospital and physician entered into a 2-year office space rental agreement on January 1 (of Year 1) which specified rental charges (consistent with fair market value) of $20 per square foot during Year 1 and automatically adjusted upward each January 1 by any increase in the CPI–U. If, on January 1 of Year 2 of the agreement, the rental charges increased to $21 per square foot based on the amount of increase in the CPI–U, but the physician continued to pay $20 per square foot until the compliance failure was identified on June 30 of Year 2, the period of disallowance would run from January 1 of Year 2 until no later than June 30 of Year 2, *provided that* the physician paid the hospital on June 30 of Year 2 the shortfall of $1 per square foot for the 6-month shortfall period (plus interest, as appropriate) *and,* as of July 1 through the term of the agreement, the physician paid $21 per square foot for the office space, and the arrangement otherwise satisfied the requirements of the exception in § 411.357(d). As discussed below, we believe that it is possible that an arrangement may end prior to excess compensation being returned or a shortfall being paid; however, such a determination as to the duration of the period of disallowance necessarily would be made on a case-by-case basis considering the facts and circumstances, and we are not proposing a prescribed period of disallowance for such a situation.

We also note that an arrangement may be noncompliant for reasons that are related to compensation, but which do not involve the payment or receipt of excess compensation or a shortfall in compensation paid or received. For example, many of our exceptions require that the compensation not take into account the volume or value of referrals or other business generated between the parties and that the compensation be commercially reasonable, even if no referrals were made between the parties. It is possible that the amount of compensation provided under an arrangement is fair market value or is consistent with a prescribed limit in one of the exceptions (such as in § 411.357(k)), but, for example, takes into account the volume or value of referrals and this results in a noncompliant arrangement. We are not proposing a prescribed period of disallowance for arrangements that are noncompliant for reasons that are related to compensation but which do not involve only the payment or receipt of excess compensation or a shortfall in compensation paid or received. Rather, the appropriate period of disallowance for such arrangements would need to be determined on a case-by-case basis.

Essentially, our proposals place an outside limit on the period of disallowance in certain circumstances. That is, where the reason(s) for noncompliance does not relate to compensation, the latest the period of disallowance would end would be the date the arrangement was brought into compliance. Where the reason for noncompliance is the fact that excess compensation was provided or too little compensation was paid, the latest the

period of disallowance would end would be the date that the party receiving the excess compensation returned it to the party that provided it or the party owing the shortfall in compensation paid it to the party to which it was owed (assuming the arrangement otherwise satisfies the requirements of an applicable exception).

We recognize, of course, that parties to a financial relationship that is noncompliant may never bring the relationship into compliance with an applicable exception. The financial relationship may expire according to the terms of the underlying agreement (such as the date of expiration of a personal service contract), or it may end earlier or later than the expiration date provided in the underlying agreement. However, we do not propose to prescribe with specificity when such a noncompliant financial relationship (and, thus, the period of disallowance) might end. Likewise, if a party that receives excess compensation never repays the excess compensation, or a party who owes additional compensation (the shortfall) never pays it, the question arises as to when the financial relationship ends. To return to the example that we gave in the CY 2008 PFS proposed rule and that we reference above, if an entity leases space to a physician at a rental price that is substantially below fair market value, the inference may be raised that the below-market rent was in exchange for future referrals, including referrals made beyond the expiration of the lease agreement. Therefore, in such a situation, if the physician does not pay the rental charges shortfall, the financial relationship may not end at the expiration of the written lease agreement, but rather could extend for some period beyond the expiration of the written lease agreement. We are not proposing to establish any specific time period or even guidelines for when the financial relationship in the above example would be deemed to end (so that future referrals would not be tainted); rather the determination of when the financial relationship ends must depend on the facts and circumstances. We note that our proposals pertain only to placing an outside limit on the period of disallowance for making referrals and billing the Medicare program in the case of certain noncompliant financial relationships; they do not address whether the anti-kickback statute is implicated and/or whether civil monetary penalties under the physician self-referral statute are potentially applicable due to noncompliant financial relationships.

We are not proposing, as one commenter suggested, that, in a situation involving noncompliance due to excess compensation paid by an entity to a physician (or the physician's immediate relative), the period of disallowance would end no later than the date the entity repays the excess compensation to the Medicare program, should the physician not repay the excess compensation to the entity. This approach is not consistent with the statute. We are also not proposing, as another commenter suggested, to impose no period of disallowance for the situation in which parties allegedly were unaware of the noncompliant nature of a financial relationship. We do not have the authority under section 1877 of the Act to waive violations of the physician self-referral law. We note also that there would be practical problems in determining whether parties were unaware of the noncompliant nature of the arrangement and that we would be discouraging parties from carefully structuring arrangements and monitoring them. In the CY 2008 PFS proposed rule, we proposed an alternative method of compliance that may address some of the commenter's concerns, and that proposal is still under consideration for final rulemaking. Finally, we are not proposing to impose a period of disqualification during which the parties to a noncompliant financial relationship would be prohibited from using a particular exception due to that relationship. We may propose rulemaking on this subject in the future.

C. Gainsharing Arrangements

1. Background

The term ''gainsharing'' typically refers to an arrangement under which a hospital gives physicians a share of the reduction in the hospital's costs (that is, the hospital's cost savings) attributable in part to the physicians' efforts. Gainsharing may take several forms. Some arrangements are narrowly targeted, giving the physician a financial incentive to select specific medical devices and products that are less expensive or to adopt specific clinical practices or protocols that reduce costs. Other, more problematic arrangements are not targeted at utilization of specific supplies or specific clinical practices, but instead offer the physician payments to reduce total average costs per case below target amounts.

Gainsharing arrangements seek to align physician incentives with those of hospitals by offering physicians a share of the hospital's variable cost savings attributable to the physicians' efforts in controlling the cost of providing patient care. Following the institution of the Medicare Part A DRG system of hospital reimbursement and with the growth of managed care, hospitals have experienced significant financial pressure to reduce costs. However, because physicians are paid separately under Medicare Part B and Medicaid, physicians do not share necessarily a hospital's incentive to control the hospital's patient care costs. Gainsharing arrangements are designed to align hospital and physician incentives by offering physicians a portion of the hospital's cost savings in exchange for identifying and implementing cost-saving strategies.

2. Statutory Impediments to Gainsharing Arrangements

Whereas gainsharing promotes hospital cost reductions by aligning physician incentives with those of the hospital, these arrangements also implicate the physician self-referral statute (section 1877 of the Act). Section 1877(a)(1) of the Act states that, except as provided in section 1877(b) of the Act, if a physician (or an immediate family member of such physician) has a financial relationship with an entity, the physician may not make a referral to the entity for the furnishing of DHS for which payment otherwise may be made under title XVIII of the Act. The provision of monetary or nonmonetary remuneration by a hospital to a physician through a gainsharing arrangement would constitute a financial relationship with an entity for purposes of the physician self-referral statute.

Gainsharing arrangements also implicate two specific fraud and abuse statutes. First, sections 1128A(b)(1) and (b)(2) of the Act, commonly referred to as the Civil Monetary Penalty, or CMP, statute, prohibit a hospital from knowingly making a payment directly or indirectly to a physician as an inducement to reduce or limit items or services furnished to Medicare or Medicaid beneficiaries, and a physician from knowingly accepting such payment. Second, gainsharing arrangements implicate section 1128B(b) of the Act (the ''anti-kickback statute'') if one purpose of the cost savings payment is to influence referrals of Federal health care program business.

3. Office of Inspector General (OIG) Approach Towards Gainsharing Arrangements

The HHS Office of Inspector General (''OIG'') historically has been wary of

gainsharing arrangements. In July 1999, OIG issued a Special Advisory Bulletin that addressed the application of sections 1128A(b)(1) and (2) of the Act to gainsharing arrangements. Although OIG recognized that appropriately structured gainsharing arrangements may offer significant benefits where there is no adverse impact on the quality of care received by patients, section 1128A(b) of the Act clearly prohibits arrangements that are intended as an inducement to limit or reduce services to Medicare or Medicaid patients. In addition, OIG stated that regulatory relief from the CMP prohibition would require statutory authorization.

OIG has issued several favorable advisory opinions regarding individual gainsharing arrangements, although the opinions (like all OIG advisory opinions) do not have general applicability. When evaluating the risks posed by a gainsharing arrangement, OIG has generally looked for three types of safeguards, namely: (1) Measures that promote accountability and transparency; (2) adequate quality controls; and (3) controls on payments related to referrals. Properly structured, gainsharing arrangements may offer opportunities for hospitals to reduce costs without causing inappropriate reductions in medical services or rewarding referrals of Federal health care program patients. In a number of specific cases involving limited proposed arrangements, OIG has issued advisory opinions in which it concluded that the proposed arrangement presents a low risk of abuse and, therefore, it would exercise its prosecutorial discretion not to impose sanctions. In these cases, OIG has concluded, based on the totality of facts and circumstances and the presence of adequate safeguards, that: (1) The proposed arrangement would constitute an improper payment to induce the reduction or limitation of services as prohibited by sections 1128A(b)(1) and (2) of the Act, but that OIG would not impose sanctions on the requestors of the advisory opinion; and (2) the proposed arrangement would potentially generate prohibited remuneration under the anti-kickback statute if the requisite intent to induce or reward referrals of Federal health care program business were present, but that OIG would not impose administrative sanctions on the requestors under section 1128A(a), or under section 1128(b)(7) or section 1128A(a)(7), as those sections relate to the commission of acts described in the anti-kickback statute.

4. MedPAC Recommendation

MedPAC, in its March 2005 Report to Congress, ''Physician-owned Specialty Hospitals,'' recommended that gainsharing arrangements between physicians and hospitals be permitted. Specifically, MedPAC stated that, ''[t]he Congress should grant the Secretary the authority to allow gainsharing arrangements between physicians and hospitals and to regulate those arrangements to protect the quality of care and minimize financial incentives that could affect physician referrals.'' (See *http://www.medpac.gov/publications/congressional repots/Mar05EntireReport.pdf,* at page 47). In addition, MedPAC stated that, drawing on OIG's work, the Secretary could require that gainsharing arrangements:

- Identify specific actions that would produce savings, such as limiting the inappropriate use of supplies;
- Are transparent and disclosed to patients;
- Include periodic reviews of quality of care by an independent organization;
- Limit the amount of time during which physicians can share cost savings in order to prevent hospitals from using these agreements as a mechanism to induce physician referrals;
- Avoid rewarding physicians for increasing referrals to the hospitals, such as capping potential savings based on the number of prior year admissions; and
- Monitor changes in the severity, age, and insurance coverage of patients affected by the gainsharing arrangement.

5. Demonstration Programs

CMS has long been interested in evaluating the association between payments and the quality of care. In 1991, CMS initiated a demonstration program entitled the ''Medicare Participating Heart Bypass Center Demonstration.'' This demonstration was conducted to assess the feasibility and cost effectiveness of a negotiated all-inclusive bundled payment arrangement for coronary artery bypass graft (CABG) surgery while maintaining high quality care. CMS originally negotiated contracts with four applicants. In 1993, the demonstration was expanded to include three more participants. The results of the demonstration showed that an all-inclusive bundled payment arrangement can provide an incentive to physicians and hospitals to work together to provide services more efficiently, improve quality, and reduce costs. The bundling of the physician and hospital payments did not have a negative impact on the post-discharge health improvements of the demonstration patients. Three of the four original hospitals were able to make major changes in physician practice patterns and operations that generated significant cost savings. A hospital's participation in the demonstration appeared to have little or no effect on physician referral patterns.

A second demonstration project that involves gainsharing arrangements is authorized by section 646 of the MMA, which added a new section 1866C of the Act and established the Medicare Health Care Quality MHCQ Demonstration Program. MHCQ demonstration projects are intended to ''* * * examine health delivery factors that encourage the delivery of improved quality in patient care.'' Using the authority provided by section 1866C of the Act, CMS decided to implement a 3-year demonstration that would test gainsharing models involving physicians and collaborations between hospitals working with physicians in a single geographic area to improve the quality of inpatient hospital care. In contrast to traditional models of gainsharing, the proposed demonstration approaches must be across single or multiple organizations and involve long-term followup to ensure both documented improvements in quality and reductions in the overall costs of care. CMS is particularly interested in demonstration designs that: (1) Track patients well beyond a hospital episode to determine the impact of hospital-physician collaborations on preventing short and longer-term complications, duplication of services, and coordination of care across settings; and (2) offer other quality improvements for eliminating preventable complications and unnecessary costs.

A third series of demonstration projects was authorized by section 5007 of the Deficit Reduction Act of 2005 (the ''DRA'') (Pub. L. 109–171). This provision requires the Secretary to establish a qualified gainsharing demonstration under which the Secretary shall approve up to six demonstration projects. Section 5007 demonstration projects would involve arrangements between a hospital and physicians and practitioners under which the hospital provides for remuneration (that is, gainsharing payments) to certain physicians and to certain practitioners (as defined in 1842(b)(18)(C) of the Act) that represents solely a share of the savings incurred directly as a result of collaborative efforts between the hospital and a particular physician (or practitioner) to improve overall quality and efficiency. Each demonstration

project must also provide measures to monitor quality and efficiency in the participating project hospital(s).

6. Solicitation of Comments

In the CY 2008 PFS proposed rule, we noted that we are concerned about compensation arrangements between entities and physicians under which compensation is determined on a percentage basis (for example, rental charges for office space that are determined based on a percentage of a group practice's revenues) (72 FR 38184). We proposed to clarify that percentage-based compensation arrangements may be used only for paying for personally performed physician services and that such arrangements must be based on the revenues directly resulting from the physician services rather than based on some other factor such as a percentage of the savings by the hospital department. The proposed changes, if finalized, might prevent typical gainsharing arrangements between physicians and hospitals to which they refer for DHS. We have not yet finalized our proposal in the CY 2008 PFS final rule; however, it remains under active consideration.

Notwithstanding our general concern with arrangements that involve the use of a percentage-based compensation formula (other than payment to a physician for work personally performed by the physician), we recognize the value to the Medicare program and its beneficiaries where the alignment of hospital and physician incentives results in improvements in quality of care. Therefore, we are considering whether to issue an exception specific to gainsharing arrangements. Under section 1877(b)(4) of the Act, we may issue additional exceptions (that is, exceptions not specified in the statute) only where doing so would create no risk of program or patient abuse. At this time, we decline to issue a specific proposal concerning an exception for gainsharing arrangements, but rather are soliciting comments as to whether we should establish an exception for gainsharing arrangements, and, if so, what safeguards should be included in the exception. Specifically, we are interested in receiving comments on: (1) What types of requirements and safeguards should be included in any exception for gainsharing arrangements; and (2) whether certain services, clinical protocols, or other arrangements should not qualify for the exception.

D. Physician-Owned Implant and Other Medical Device Companies

1. Background

We have recently become aware of an increase in physician investment in implant and other medical device manufacturing, distribution, and purchasing companies. We recognize that physician involvement often adds value to device manufacturing companies and that many physicians may have legitimate investment interests in these companies. Physicians participate in the research, development, and testing involved in creating and producing many lifesaving and quality-of-life enhancing medical devices. The added value of physician involvement in distribution and purchasing companies, essentially middlemen companies, is less clear. When physicians profit from the referrals they make to hospitals through physician-owned implant and medical device companies (''POCs''), we are concerned about possible program or patient abuse. POCs exist in three primary forms: manufacturers, distributors, and group purchasing organizations (''GPOs''). Our understanding, however, is that many POCs are not manufacturers, but rather are companies that profit from the purchase and resale of products made by another organization (that is, they act as distributors) or from GPO fees paid by device vendors. In many cases, the physician investors bear little, if any, economic risk with respect to the medical devices. It is also our understanding that some physicians are offered investment interests in ''private label'' or similar manufacturing entities when the physicians have provided little, if any, necessary research, design, or testing services. We are concerned that some physician-owned organizations may serve little purpose other than providing physicians the opportunity to earn economic benefits in exchange for nothing more than ordering medical devices or other products that the physician-investors use on their own patients. The financial incentives paid to the physicians may foster an anti-competitive climate, raise quality of care concerns, and lead to overutilization of the device or other product to which the physician is linked. Physicians are responsible for selecting or recommending the devices ordered for the hospital's patients. It is reasonable to believe that medical device or implant companies without physician investment will have difficulty finding referral sources in areas where many physicians are invested in a POC that offers competing products.

In response to our proposed change to the definition of ''entity'' at § 411.351 in the CY 2008 PFS proposed rule, we received public comments regarding whether a physician-owned implant or other medical device company should or should not be considered to be an ''entity.'' One commenter noted that orthopedic surgeons may have an ownership interest in a manufacturer of spinal implants that sells its implants to the hospital where the surgeon performs his or her surgeries. According to the commenter, because the proposed definition of ''entity'' would extend to an entity that ''performs the DHS,'' the manufacturer arguably could be considered to be an ''entity'' under § 411.351. This commenter urged us to exclude such manufacturers from the definition of ''entity.'' The commenter stated that indirect arrangements involving spinal implants would trigger the self-referral prohibition if they are not at fair market value. Comments submitted on behalf of a manufacturer of spinal implants asserted that, despite superficial similarities, joint ventures involving medical devices differ in many material ways from the types of arrangements about which we expressed concern. This commenter also asserted that the meaning of ''has performed the DHS'' is unclear and that we should clarify that the proposal applied only to ''true'' ''under arrangement'' relationships with hospitals, but that, in any event, implantable devices are not DHS. According to the commenter, even if implantable devices were deemed to be DHS, the rigorous physician self-referral exceptions (for example, the exception for indirect compensation arrangements in § 411.357(p)) are still available to protect the arrangement and against program or patient abuse.

In an October 6, 2006 letter response to a request for guidance regarding certain physician investments in the medical device industry, OIG stated that it was aware of an apparent proliferation of physician investments in medical device and distribution companies, including GPOs, and that, given the strong potential for improper inducements between and among the physician investors, the companies, device vendors, and medical device purchasers, it believed that all of these ventures should be closely scrutinized under the fraud and abuse laws. OIG also clarified that its 1989 Special Fraud Alert on Joint Ventures applies to all physician joint ventures and would, therefore, apply to physician investments in medical device manufacturing and distribution

companies, as well as GPOs. OIG confirmed that the fact that a substantial portion of a venture's gross revenues is derived from participant-driven referrals is a potential indicator of a problematic joint venture. The October 6, 2006 letter response is available at *http://oig.hhs.gov/fraud/docs/alertsandbulletins/GuidanceMedicalDevice%20(2).pdf.* See also *http://oig.hhs.gov/testimony/docs/2008/demske_testimony022708.pdf.*

A medical device company requested that we take a closer look at the current prevalence of POCs and the impact that these companies may have on program or patient abuse, as well as the negative impact on competition among POCs and nonphysician owned medical device companies. This company noted that, in the CY2008 PFS proposed rule, we proposed revising the definition of ''entity'' to include, among other things, an entity that causes a claim to be submitted to Medicare. It suggested that we finalize our proposal and that we deem POCs to be DHS entities under certain circumstances. It also suggested that, in certain circumstances, physician investors in POCs should be deemed to have a direct compensation relationship with the hospitals that order and use implantable devices furnished by the POCs. The company suggested that a POC should not be considered to have caused a claim to be presented where the referring physician is named as an inventor on an issued patent for the implantable item, provided that the physician does not receive any remuneration from the POC based on the volume or value of his or her referrals, or where the physician's investment interest satisfies the requirements of the exception in § 411.356(a) for large, publicly traded entities. We note that it is not clear to us under what circumstances a patent holder physician, who presumably receives royalty payments from the POC, would receive remuneration that does not relate to the volume or value of referrals or other business generated by the physician. In the Phase II final rule with comment period, we noted that we received a comment that questioned whether the payment of a royalty by an equipment manufacturer to a physician inventor for a device implanted during surgeries performed by the physician inventor is permitted or whether that arrangement would create an indirect compensation relationship with the hospital that purchased the device. We stated, in response, that the physician inventor would have an indirect compensation arrangement with the hospital in which the surgeries are performed but, provided the royalty payment was fair market value, the relationship should satisfy the exception for indirect compensation arrangements in § 411.357(p) (69FR 16060).

2. Solicitation of Comments

At this time, we are not issuing a specific proposal regarding POCs. The statute and our existing regulations, specifically those related to indirect compensation arrangements, address many POCs. In some problematic circumstances, an unbroken chain of financial relationships will connect the physician owner of a POC to a DHS entity to which the physician makes referrals, and the other elements of an indirect compensation arrangement contained in § 411.354(c)(2) will also be present, including the requisite knowledge by the DHS entity of the physician's interest in the POC. In many instances, the arrangement would not satisfy the requirements of the exception for indirect compensation arrangements in § 411.357(p), and would, therefore, run afoul of the physician self-referral statute. However, we are soliciting public comments as to whether our physician self-referral rules should address POCs and similar physician owned companies more specifically, or whether the concerns surrounding POCs and similar organizations, to the extent that they are not addressed by the statute and our current rules, are better addressed through enforcement of the False Claims Act, the anti-kickback statute and similar fraud and abuse laws, other public laws, and through other applicable Federal, State, and local regulations. In this regard, we are seeking comments as to whether, and to what degree, physician investment in POCs and similar organizations presents risks of overutilization, substandard care, and increased costs to the Medicare program and its beneficiaries, or whether the risk is confined to possible anti-competitive behavior. To the extent that commenters believe that certain physician investment in POCs and similar organizations should be addressed more specifically under our physician self-referral rules, commenters are encouraged to provide us with suggestions as to specific actions we should take (for example, considering POCs to be DHS entities under certain circumstances, considering physician investors in POCs who influence hospitals as to the ordering of medical devices to have direct compensation relationships with the hospitals, excepting certain investment interests from coverage under our rules, etc.).

IX. Financial Relationships Between Hospitals and Physicians

A. Background

As stated earlier, under section 1877 of the Act, a physician is prohibited from referring a Medicare patient for DHS to an entity (including an individual) with which the physician (or an immediate family member of the physician) has a financial relationship, unless an exception applies. In addition, section 1877 of the Act provides that an entity may not present or cause to be presented a claim or bill to Medicare or any individual, third party payor, or other entity for DHS furnished as a result of a prohibited referral. Also, section 1877 of the Act prohibits us from making payment for DHS furnished pursuant to a prohibited referral. The statute contains several exceptions for certain types of compensation arrangements and ownership or investment interests, including the exception in section 1877(d)(3) of the Act for ownership or investment by a physician in the hospital itself and not merely in a subdivision of the hospital (that is, the ''whole'' hospital). Section 1877(b)(4) of the Act authorizes us to create additional exceptions, provided that they do not create a risk of program or patient abuse. As a result of the statutory exceptions in section 1877 of the Act, and the exceptions we have created using our authority under section 1877(b)(4) of the Act, our regulations contain approximately 40 exceptions to the prohibition on physician self-referrals. (We refer readers to 42 CFR 411.351 through 411.357 of our regulations and the September 5, 2007 ''Phase III'' final rule (72 FR 51012).)

Section 1877(f) of the Act provides that: ''Each entity providing covered items or services for which payment may be made under this title [42 USCS 1395 et seq.] shall provide the Secretary with the information concerning the entity's ownership, investment, and compensation arrangements, *including:* (1) The covered items and services provided by the entity, and (2) the names and unique physician identification numbers of all physicians with an ownership or investment interest (as described in subsection (a)(2)(A)), or with a compensation arrangement (as described in subsection (a)(2)(B)), in the entity, or whose immediate relatives have such an ownership or investment interest or who have a compensation relationship with the entity. Such information shall be provided in such form, manner, and

at such times as the Secretary shall specify.'' (Emphasis added)

Some industry representatives have argued that the reference to financial relationships as described in section 1877(a)(2)(A) and (a)(2)(B) of the Act limits our ability to obtain information on financial relationships that do not satisfy one of the statutory or regulatory exceptions. We disagree. The statute clearly contains a broad authorization for the Secretary to obtain information concerning an entity's financial relationships, ''including,'' but not limited to, financial relationships that satisfy an exception. We believe that there would have been little point to the Congress providing us with the authority to compel information on excepted arrangements only, because, as we have noted previously, ''an entity could decide that one or more of its financial relationships falls within an exception, fail to retain data concerning those financial relationships, and thereby prevent the government from reviewing the arrangements to determine if they qualify for an exception.'' (72 FR 51069.) Accordingly, our regulation in § 411.361 requires entities to report ''*any* ownership or investment interest, as defined at § 411.354(b), or any compensation arrangement, as defined at § 411.354(c), except for ownership or investment interests that satisfy the exceptions set forth in § 411.356(a) and § 411.356(b) regarding publicly-traded securities and mutual funds'' (emphasis added). The statute provides that an ownership or investment interest in the entity may be through equity, debt, or other means, and includes an interest in an entity that holds an ownership or investment interest in any entity that furnishes DHS.

Our regulations have been drafted to reflect clearly our commonsense interpretation of the statutory reporting requirements. In the proposed rule entitled ''Medicare and Medicaid Programs; Physicians'' Referrals to Health Care Entities With Which They Have Financial Relationships,'' published in the **Federal Register** on January 9, 1998 (63 FR 1703), we proposed to modify § 411.361 to require that entities report information concerning their reportable financial relationships to us on a prescribed form and thereafter report annually all changes to the submitted information that occurred in the previous 12 months. In addition, we revisited the statute and interpreted the opening paragraph of section 1877(f) of the Act to permit us to gather any data on financial relationships, including, but not necessarily limited to, financial relationships for which there are no exceptions under section 1877(a)(2)(A) or (a)(2)(B) of the Act. Therefore, we proposed to amend § 411.361 to reflect explicitly our authority to ask for a broader scope of information than the regulation permitted at that time.

In the Phase II final rule with comment period (69 FR 16121), we modified the reporting requirement in § 411.361 to remove all references to the use of a prescribed form, to require entities to make information available only upon request, and to maintain the information only for the length of time specified by the applicable regulatory requirements for the information (that is, the rules of the Internal Revenue Service, Securities and Exchange Commission, Medicare, Medicaid, or other programs). In addition, we modified § 411.361 to provide that entities need not report ownership or investment interests that satisfy the exceptions in § 411.356(a) and (b) for publicly-traded securities and mutual funds.

Most, if not all, hospitals have financial relationships with referring physicians. These financial relationships may involve ownership or investment interests, compensation arrangements, or both. The financial relationships can be direct or they may be indirect (such as through a physician group practice or limited liability company). The physician self-referral statute was first enacted in 1989, and the reporting requirements in the regulations in § 411.361 were first implemented in our December 3, 1991 interim final rule with comment period, published in the **Federal Register** at 56 FR 61374. Since that time, CMS has not engaged in a comprehensive reporting initiative to examine financial relationships between hospitals and physicians. Consistent with congressional intent in enacting the physician self-referral statute, we believe it is important to query hospitals concerning their financial relationships with physicians.

B. Section 5006 of the Deficit Reduction Act (DRA) of 2005

Section 5006 of the DRA required the Secretary to develop a strategic and implementing plan to address certain issues relating to physician-owned specialty hospitals. The specific issues the Secretary was required to address were: (1) Proportionality of investment return; (2) *bona fide* investment; (3) annual disclosure of investment information; (4) the provision by specialty hospitals of (i) care to patients who are eligible for Medicaid (or who are not eligible for Medicaid but who are regarded as such because they receive benefits under a section 1115 waiver) and (ii) charity care; and (5) appropriate enforcement. In order to assist us in preparing the report and implementing plan required by section 5006 of the DRA, we sent a voluntary survey to 130 specialty hospitals and 220 competitor hospitals, which sought information regarding, among other things, the hospitals' ownership and investment relationships, and their compensation arrangements with physicians. In the enforcement section of the strategic and implementing plan that was included in our ''Final Report to the Congress and Strategic and Implementing Plan Required under Section 5006 of the Deficit Reduction Act of 2005'' issued on August 8, 2006, 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 we would require *all* hospitals (that is, not just specialty hospitals) to provide us information on a periodic basis concerning the investment interests in the hospital of physicians and the hospital's compensation arrangements with physicians (DRA Report to Congress 69). We stated that we would not limit our requirement to information concerning physician investments in *specialty* hospitals for two reasons. First, physician investments in any type of hospital raise potential issues concerning compensation arrangements that can be associated with the investment. For example, a disproportionate return on investment or non-*bona fide* investment (through, for example, a sham loan), creates a prohibited compensation arrangement under the physician self-referral law and raises the possibility of an illegal kickback scheme. Second, other types of compensation arrangements (that is, those that are not associated with an investment interest), implicate the physician self-referral law, such as leasing, employment, and personal service arangements. It is also important to note that, although a physician may be highly motivated to refer patients to a hospital in which he or she has an ownership interest, the physician may be just as likely to refer patients to a hospital with which he or she has a compensation relationship, given that the physician may see a more direct and immediate financial benefit from the compensation arrangement. In the DRA Report to Congress, we stated that we would implement a regular disclosure process, but that we had not designed

the process at that point, and that we would consider such issues as whether we should: (1) Survey all hospitals annually; (2) stagger our survey so that all hospitals are queried but not all in the same year; and/or (3) focus our inquiry on certain types of relationships or certain hospitals. We stated that we would also consider whether, having once provided information, hospitals need only submit updated information on a yearly or other periodic basis.

C. Disclosure of Financial Relationships Report (DFRR)

Following up on our commitment to capture information concerning financial relationships between all types of hospitals and physicians, and to assist in enforcement of the physician self-referral statute and implementing regulations, we created an information collection instrument, referred to as the Disclosure of Financial Relationships Report (''DFRR''). The DFRR is designed to collect information concerning the ownership and investment interests and compensation arrangements between hospitals and physicians. (Appendix C of this proposed rule contains the DFRR instrument and instructions for public comment.) We believe information submitted by hospitals would permit us to analyze the types of financial relationships involving hospitals and physicians, the structure of various compensation arrangements and trends therein, and potentially whether the hospitals are in compliance with the physician self-referral law and implementing regulations. Using our authority under section 1877(f) of the Act and 42 CFR 411.361, we are proposing to send the DFRR to 500 hospitals, a number that we believe is necessary to provide us with sufficient information: (1) To determine compliance; and (2) to assist us in any future rulemaking concerning the reporting requirements and other physician self-referral provisions.

We intend for our sample size to be a significant percentage of the total number of Medicare-participating hospitals. The 2007 CMS Statistics Handbook determined that, as of December 2006, there were approximately 6,200 Medicare-participating hospitals. Our goal is to begin by sending the DFRR to 8 to 10 percent of the Medicare-participating hospitals (496 to 620 hospitals). We reviewed our available funding and determined that our resources would permit us to review data from 500 hospitals (both general acute care hospitals and specialty hospitals).

As discussed further below, the DFRR also may assist us in making an informed decision as to whether to propose rulemaking for an annual (or other periodic) disclosure requirement for all hospitals. By posing a comprehensive set of questions to a significant number of hospitals, we believe that we will be informed not only as to whether we should engage in such rulemaking, but also as to what the design of the proposed information collection should look like.

Originally, we had planned to pilot this information collection request in advance of rulemaking. Thus, we prepared a proposed information collection request in accordance with the Paperwork Reduction Act. We announced and sought public comment on the information collection request in a 60-day **Federal Register** notice (CMS–10236) that was published on May 18, 2007 (72 FR 28056). On September 14, 2007, we published in the **Federal Register** a revised information collection request in which we increased the time estimate for completing the DFRR and increased the time for submission of the DFRR from 45 days to 60 days (72 FR 52568). (For additional information, we refer the reader to 72 FR 28056 and 72 FR 52568.)

In this proposed rule, we are providing a discussion of the potential burden associated with completing the DFRR, including an analysis that provides estimates of the burden for small, medium, and large hospitals. To better understand the potential burden for completing the DFRR collection, we reviewed the bed size of Medicare-participating hospitals and developed three categories of hospitals (small, medium, and large hospitals). We randomly selected 20 hospitals from each category and requested that these 60 hospitals estimate the aggregate number of hours it would take them to complete and submit the entire DFRR collection. The 33 hospitals that responded included 11 small, 11 medium, and 11 large hospitals. We reviewed the responses from the 33 hospitals and determined that the average number of hours to complete the DFRR was 31 hours. This figure represents a significant increase from our most recent time and burden estimate. Therefore, we believe it would be beneficial to seek further comments on the accuracy of the time and burden estimates associated with this information collection instrument. Because the information that we seek is that which hospitals should already be keeping in the normal course of their business activities (even apart from the need to document compliance with the physician self-referral law), we anticipate that the majority of the time spent completing the DFRR will be spent by administrative staff. We believe that the tasks involved would include retrieving the information and printing it from electronic files or copy it from hard files, which largely should involve administrative personnel. In addition, the review and organization of the materials would also impose burden on the respondent. Nevertheless, in order to err on the side of more potential burden rather than less, we have calculated costs using an hourly rate for accountants.

D. Civil Monetary Penalties

We are proposing that the DFRR be completed, certified by the appropriate officer of the hospital, and received by CMS within 60 days of the date that appears on the cover letter or e-mail transmission of the DFRR. We are soliciting comment on the proposed 60-day timeframe for completing the DFRR.

Section 411.361(f) provides that failure to timely submit the requested information concerning an entity's ownership, investment, and compensation arrangements may result in civil monetary penalties of up to $10,000 for each day beyond the deadline established for disclosure. Although we have the authority to impose civil monetary penalties, we seek not to invoke this authority and will work with entities to comply with the reporting requirements. Prior to imposing a civil monetary penalty in any amount, we would issue a letter to any hospital that does not return the completed DFRR, inquiring as to why the hospital did not return timely the completed DFRR. In addition, a hospital may, upon a demonstration of good cause, receive an extension of time to submit the requested information.

E. Uses of Information Captured by the DFRR

As noted above, we anticipate that the DFRR will be useful in determining whether the financial relationships between 500 hospitals and the physicians associated with those hospitals are in compliance with the physician self-referral statute and regulations. In addition, the results of the DFRR may assist us in other rulemaking efforts.

In the CY 2008 PFS proposed rule, we proposed certain changes to our physician self-referral rules (72 FR 38179 through 38187). With the exception of the anti-markup provisions, however, we have not yet finalized any of the proposals. We are actively working on the proposals, and although we expect to finalize the proposals before receiving and

analyzing the completed DFRRs, information gleaned from the completed DFRRs may shape our final rulemaking if that rulemaking is delayed. Our analysis of the DFRRs may affect subsequent proposals on these and other related issues.

F. Solicitation of Comments

We are soliciting comments on the DFRR information collection instrument through this proposed rule as follows:

- Whether the collection effort should be recurring, and, if so, whether it should be implemented on an annual or some other periodic basis.
- Whether we are collecting too much or not enough information, and whether we are collecting the correct (or incorrect) type of information.
- The amount of time it will take hospitals to complete the DFRR and the costs associated with completing the DFRR; the amount of time we should give hospitals to complete and return their responses to us.
- Whether we should direct the collection instrument to all hospitals, and, if so, whether we should stagger the collection so that only a certain number of hospitals are subject to it in any given year.
- Whether hospitals, once having completed the DFRR, should have to send in yearly updates and report only changed information.

X. MedPAC Recommendations

We are required by section 1886(e)(4)(B) of the Act to respond to MedPAC's recommendations regarding hospital inpatient payments in our annual proposed and final IPPS rules. We have reviewed MedPAC's March 2008 ''Report to the Congress: Medicare Payment Policy'' and have given it careful consideration in conjunction with the proposed policies set forth in this document. MedPAC's Recommendation 2A–1 states that ''The Congress should increase payment rates for the acute inpatient and outpatient prospective payment systems in 2009 by the projected rate of increase in the hospital market basket index, concurrent with implementation of a quality incentive payment program.'' This recommendation is discussed in Appendix B to this proposed rule.

Recommendation 2A–2: MedPAC recommended that ''The Congress should reduce the indirect medical education adjustment in 2009 by 1 percentage point to 4.5 percent per 10 percent increment in the resident-to-bed ratio. The funds obtained by reducing the indirect medical education adjustment should be used to fund a quality incentive payment program.''

Response: Redirecting funds obtained by reducing the IME adjustment to fund a quality incentive payment program is consistent with the VBP initiatives to improve the quality of care and, therefore, merits consideration. However, section 502(a) of Pub. L. 108–173 modified the formula multiplier (c) to be used in the calculation of the IME adjustment beginning midway through FY 2004 and provided for a new schedule of formula multipliers for FYs 2005 and thereafter. Consequently, CMS could not implement MedPAC's recommendation to reduce the IME adjustment in 2009 without a statutory change. We note that included in the President's FY 2009 budget proposal was a proposal to reduce the IME adjustment from 5.5 percent to 2.2 percent over 3 years, starting in FY 2009, in order to better align IME payments with the estimated costs per case that teaching hospitals may face.

In its June 2007 ''Report to Congress: Promoting Greater Efficiency in Medicare,'' MedPAC made recommendations concerning the Medicare hospital wage index. Section 106(b)(1) of the MIEA–TRHCA (Pub. L. 109–432) required MedPAC to submit to Congress, not later than June 30, 2007, a report on the Medicare hospital wage index classification system applied under the Medicare IPPS, including any alternatives that MedPAC recommended to the method to compute the wage index under section 1886(d)(3)(E) of the Act. In addition, section 106(b)(2) of the MIEA–TRHCA instructed the Secretary taking into account MedPAC's recommendations on the Medicare hospital wage index classification system, to include in this FY 2009 IPPS proposed rule one or more proposals to revise the wage index adjustment applied under section 1886(d)(3)(E) of the Act for purposes of the IPPS. The MedPAC recommendations and our proposals concerning the Medicare hospital wage index are discussed in section III.B. of the preamble of this proposed rule.

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.*

XI. Other Required Information

A. Requests for Data From the Public

In order to respond promptly to public requests for data related to the prospective payment system, we have established a process under which commenters can gain access to raw data on an expedited basis. Generally, the data are available in computer tape or cartridge format. However, some files are available on diskette as well as on the Internet at: *http://www.cms.hhs.gov/providers/hipps.* Data files and the cost for each file, if applicable, are listed below. Anyone wishing to purchase data tapes, cartridges, or diskettes should submit a written request along with a company check or money order (payable to CMS-PUF) to cover the cost to the following address: Centers for Medicare & Medicaid Services, Public Use Files, Accounting Division, P.O. Box 7520, Baltimore, MD 21207–0520, (410)–786–3691. Files on the Internet may be downloaded without charge.

1. CMS Wage Data

This file contains the hospital hours and salaries for FY 2005 used to create the proposed FY 2009 prospective payment system wage index. The file is currently available for the NPRM and will be available by the beginning of May for the final rule.

Processing year	Wage data year	PPS fiscal year
2008	2005	2009
2007	2004	2008
2006	2003	2007
2005	2002	2006
2004	2001	2005
2003	2000	2004
2002	1999	2003
2001	1998	2002
2000	1997	2001
1999	1996	2000
1998	1995	1999
1997	1994	1998
1996	1993	1997
1995	1992	1996
1994	1991	1995
1993	1990	1994
1992	1989	1993
1991	1988	1992

These files support the following:

- Notice of proposed rulemaking published in the **Federal Register**.
- Final rule published in the **Federal Register**.

Media: Diskette/most recent year on the Internet.

File Cost: $165.00 per year.

Periods Available: FY 2009 PPS Update.

2. CMS Hospital Wages Indices (Formerly: Urban and Rural Wage Index Values Only)

This file contains a history of all wage indices since October 1, 1983.

Media: Diskette/most recent year on the Internet.

File Cost: $165.00 per year.

Periods Available: FY 2009 PPS Update.

3. FY 2009 Proposed Rule Occupational Mix Adjusted and Unadjusted AHW by Provider

This file includes each hospital's adjusted and unadjusted average hourly wage.

Media: Internet.

Periods Available: FY 2009 PPS Update.

4. FY 2009 Proposed Rule Occupational Mix Adjusted and Unadjusted AHW and Pre-Reclassified Wage Index by CBSA

This file includes each CBSA's adjusted and unadjusted average hourly wage.

Media: Internet.

Periods Available: FY 2009 PPS Update.

5. Provider Occupational Mix Adjustment Factors for Each Occupational Category

This file contains each hospital's occupational mix adjustment factors by occupational category.

Media: Internet.

Periods Available: FY 2009 PPS Update.

6. PPS SSA/FIPS MSA State and County Crosswalk

This file contains a crosswalk of State and county codes used by the Social Security Administration (SSA) and the Federal Information Processing Standards (FIPS), county name, and a historical list of Metropolitan Statistical Areas (MSAs).

Media: Diskette/Internet.

File Cost: $165.00 per year.

Periods Available: FY 2009 PPS Update.

7. Reclassified Hospitals New Wage Index (Formerly: Reclassified Hospitals by Provider Only)

This file contains a list of hospitals that were reclassified for the purpose of assigning a new wage index. Two versions of these files are created each year. They support the following:

- Notice of proposed rulemaking published in the **Federal Register**.
- Final rule published in the **Federal Register**.

Media: Diskette/Internet.

File Cost: $165.00 per year.

Periods Available: FY 2009 PPS Update.

8. PPS–IV to PPS–XII Minimum Data Set

The Minimum Data Set contains cost, statistical, financial, and other information from Medicare hospital cost reports. The data set includes only the most current cost report (as submitted, final settled, or reopened) submitted for a Medicare participating hospital by the Medicare fiscal intermediary to CMS. This data set is updated at the end of each calendar quarter and is available on the last day of the following month.

Media: Tape/Cartridge.

File Cost: $770.00 per year.

	Periods beginning on or after	and before
PPS–IV	10/01/86	10/01/87
PPS–V	10/01/87	10/01/88
PPS–VI	10/01/88	10/01/89
PPS–VII	10/01/89	10/01/90
PPS–VIII	10/01/90	10/01/91
PPS–IX	10/01/91	10/01/92
PPS–X	10/01/92	10/01/93
PPS–XI	10/01/93	10/01/94
PPS–XII	10/01/94	10/01/95

(NOTE: The PPS–XIII, PPS–XIV, PPS–XV, PPS–XVI, PPS–XVII, PPS–XVIII, PPS–XIX PPS–XX, PPS–XXI, PPS–XXII, and PPS–XXIII Minimum Data Sets are part of the PPS–XIII, PPS–XIV, PPS–XV, PPS–XVI, PPS–XVII, PPS–XVIII, PPS–XIX, PPS–XX, PPS–XXI, PPS–XXII, and PPS–XXIII Hospital Data Set Files (refer to item 10 below).)

9. PPS–IX to PPS–XII Capital Data Set

The Capital Data Set contains selected data for capital-related costs, interest expense and related information and complete balance sheet data from the Medicare hospital cost report. The data set includes only the most current cost report (as submitted, final settled or reopened) submitted for a Medicare certified hospital by the Medicare fiscal intermediary to CMS. This data set is updated at the end of each calendar quarter and is available on the last day of the following month.

Media: Tape/Cartridge.

File Cost: $770.00 per year.

	Periods beginning on or after	and before
PPS–IX	10/01/91	10/01/92
PPS–X	10/01/92	10/01/93
PPS–XI	10/01/93	10/01/94
PPS–XII	10/01/94	10/01/95

(Note: The PPS–XIII, PPS–XIV, PPS–XV, PPS–XVI, PPS–XVII, PPS–XVIII, PPS–XIX PPS–XX, PPS–XXI, PPS–XXII, and PPS–XXIII Capital Data Sets are part of the PPS–XIII, PPS–XIV, PPS–XV, PPS–XVI, PPS–XVII, PPS–XVIII, PPS–XIX, PPS–XX, PPS–XXI, PPS–XXII, and PPS–XXIII Hospital Data Set Files (refer to item 10 below).)

10. PPS–XIII to PPS–XXIII Hospital Data Set

The file contains cost, statistical, financial, and other data from the Medicare Hospital Cost Report. The data set includes only the most current cost report (as submitted, final settled, or reopened) submitted for a Medicare-certified hospital by the Medicare fiscal intermediary to CMS. The data set is updated at the end of each calendar quarter and is available on the last day of the following month.

Media: Diskette/Internet.

File Cost: $2,500.00.

	Periods beginning on or after	and before
PPS–XIII	10/01/95	10/01/96
PPS–XIV	10/01/96	10/01/97
PPS–XV	10/01/97	10/01/98
PPS–XVI	10/01/98	10/01/99
PPS–XVII	10/01/99	10/01/00
PPS–XVIII	10/01/00	10/01/01
PPS–XIX	10/01/01	10/01/02
PPS–XX	10/01/02	10/01/03
PPS–XXI	10/01/03	10/01/04
PPS–XXII	10/01/04	10/01/05
PPS–XXIII	10/01/05	10/01/06

11. Provider-Specific File

This file is a component of the PRICER program used in the fiscal intermediary's or the MAC's system to compute DRG payments for individual bills. The file contains records for all prospective payment system eligible hospitals, including hospitals in waiver States, and data elements used in the prospective payment system recalibration processes and related activities. Beginning with December 1988, the individual records were enlarged to include pass-through per diems and other elements.

Media: Diskette/Internet.

File Cost: $265.00.

Periods Available: FY 2009 PPS Update.

12. CMS Medicare Case-Mix Index File

This file contains the Medicare case-mix index by provider number as published in each year's update of the Medicare hospital inpatient prospective payment system. The case-mix index is a measure of the costliness of cases treated by a hospital relative to the cost of the national average of all Medicare hospital cases, using DRG weights as a measure of relative costliness of cases. Two versions of this file are created each year. They support the following:

- Notice of proposed rulemaking published in the **Federal Register**.
- Final rule published in the **Federal Register**.

Media: Diskette/most recent year on Internet.

Price: $165.00 per year/per file.

Periods Available: FY 1985 through FY 2009.

13. MS–DRG Relative Weights (Formerly Table 5 DRG)

This file contains a listing of MS–DRGs, MS–DRG narrative descriptions, relative weights, and geometric and arithmetic mean lengths of stay as published in the **Federal Register**. The hard copy image has been copied to diskette. There are two versions of this file as published in the **Federal Register:**

- Notice of proposed rulemaking.
- Final rule.

Media: Diskette/Internet.
File Cost: $165.00.
Periods Available: FY 2009 PPS Update.

14. PPS Payment Impact File

This file contains data used to estimate payments under Medicare's hospital inpatient prospective payment systems for operating and capital-related costs. The data are taken from various sources, including the Provider-Specific File, Minimum Data Sets, and prior impact files. The data set is abstracted from an internal file used for the impact analysis of the changes to the prospective payment systems published in the **Federal Register**. This file is available for release 1 month after the proposed and final rules are published in the **Federal Register**.

Media: Diskette/Internet.
File Cost: $165.00.
Periods Available: FY 2009 PPS Update.

15. AOR/BOR Tables

This file contains data used to develop the MS–DRG relative weights. It contains mean, maximum, minimum, standard deviation, and coefficient of variation statistics by MS–DRG for length of stay and standardized charges. The BOR tables are ''Before Outliers Removed'' and the AOR is ''After Outliers Removed.'' (Outliers refer to statistical outliers, not payment outliers.)

Two versions of this file are created each year. They support the following:

- Notice of proposed rulemaking published in the **Federal Register**.
- Final rule published in the **Federal Register**.

Media: Diskette/Internet.
File Cost: $165.00.
Periods Available: FY 2009 PPS Update.

16. Prospective Payment System (PPS) Standardizing File

This file contains information that standardizes the charges used to calculate relative weights to determine payments under the prospective payment system. Variables include wage index, cost-of-living adjustment (COLA), case-mix index, disproportionate share, and the Metropolitan Statistical Area (MSA). The file supports the following:

- Notice of proposed rulemaking published in the **Federal Register**.
- Final rule published in the **Federal Register**.

Media: Internet.
File Cost: No charge.
Periods Available: FY 2009 PPS Update.

For further information concerning these data tapes, contact the CMS Public Use Files Hotline at (410) 786–3691.

Commenters interested in discussing any data used in constructing this proposed rule should contact Nisha Bhat at (410) 786–5320.

B. Collection of Information Requirements

1. Legislative Requirement for Solicitation of Comments

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

2. Solicitation of Comments on Proposed Requirements in Regulatory Text

We are soliciting public comment on each of the issues listed under section XI.B.1. of this preamble for the following sections of this document that contain information collection requirements (ICRs):

a. ICRs Regarding Physician Reporting Requirements (§ 411.361)

Section 411.361(a) of the regulations states that except for entities that furnish 20 or fewer Part A and Part B services during a calendar year or for Medicare covered services furnished outside the United States, all entities furnishing services for which payment may be made under Medicare must submit information to CMS or to the Office of the Inspector General (OIG) concerning their reportable financial relationships (any ownership or investment interest, or compensation arrangement) in the form, manner, and at times that CMS or OIG specifies. As described in section IX. of the preamble of this proposed rule, and in accordance with its authority under 42 CFR 411.361(e), CMS is requiring that hospitals provide information concerning their ownership, investment and compensation arrangements with physicians by completing the DFRR instrument.

An information collection request concerning the DFRR was previously submitted to OMB for approval. We announced and sought public comment on the information collection request in both 60-day and 30-day **Federal Register** notices that published on May 18, 2007 (72 FR 28056), and September 14, 2007 (72 FR 52568), respectively. As further discussed in section IX. of this preamble, we have decided to obtain additional input from the public concerning the time and cost burden associated with completing and submitting the DFRR instrument. (The instrument is included as Appendix C to this proposed rule.) We believe that hospital accounting personnel would be responsible for: (1) Ensuring that the appropriate data or supporting documentation is retrieved; (2) completing the DFRR; and (3) submitting the DFRR to the Chief Executive Officer, Chief Financial Officer, or comparable officer of the hospital for his or her signature on the certification statement.

Initially, CMS would require 500 hospitals to complete and submit the DFRR instrument. We estimate that these tasks would require 31 hours for each of the 500 hospitals to complete the DFRR. Thus, the total number of burden hours required for 500 hospitals to complete the DFRR instrument is 15,500 hours.

b. ICRs Regarding Risk Adjustment Data (§ 422.310)

As discussed in section IV.H. of the preamble of this proposed rule, § 422.310(b) states that each MA organization must submit to CMS (in accordance with CMS instructions) the data necessary to characterize the context and purposes of each item and service provided to a Medicare enrollee by a provider, supplier, physician, or other practitioner. In addition, § 422.310(b) states that CMS may collect data necessary to characterize the functional limitations of enrollees of

each MA organization. Section 422.310(c) lists the nature of the data elements to be submitted to CMS.

The burden associated with these requirements is the time and effort necessary for the MA organization to submit the necessary data to CMS. These requirements are subject to the PRA and the associated burden is currently approved under OMB control number 0938–0878. However, under notice and comment periods separate from this proposed rule, we intend to revise the currently approved information collection to include burden estimates as they pertain to § 422.310. The preliminary burden estimate for this proposed rule is as follows: Currently, there are 676 MA organizations. Assuming that 99 percent of encounter data claims are submitted electronically and 1 percent are submitted manually, we estimate that it will take 1,089 hours annually for submission of electronic claims and 73,335 hours annually for submission of manual claims. The estimated annual burden associated with these requirements is an annual average of 110 hours per MA organization.

c. ICRs Regarding Basic Commitments of Providers (§ 489.20)

As discussed in section IV.I. of the preamble of this proposed rule, proposed § 489.20(r)(2) states that a hospital, as defined in § 489.24(b), must maintain an on-call list of physicians on its medical staff to provide treatment necessary to stabilize patients who are receiving services required under § 489.24 in accordance with the resources available to the hospital. The burden associated with this requirement is the time and effort necessary to draft, maintain, and periodically update the list of on-call physicians. We estimate that it will take 3 hours for each of the 100 Medicare-participating hospitals to comply with this recordkeeping requirement. The estimated annual burden associated with this requirement is 300 hours.

As discussed in section VII. of the preamble of this proposed rule, proposed § 489.20(u)(1) states that, in the case of a physician-owned hospital as defined in § 489.3, the hospital must furnish written notice to all patients at the beginning of their hospital stay or outpatient visit that the hospital is a physician-owned facility. In addition, patients must be advised that a list of the hospital's owners or investors who are physicians (or immediate family members of physicians) is available upon request. Upon receiving the request of the patient or an individual on behalf of the patient, a hospital must immediately disseminate the list to the requesting patient.

The burden associated with the requirements in this section is the time and effort necessary for a hospital to furnish written notice to all patients that the hospital is a physician-owned hospital. Whereas this requirement is subject to the PRA, the associated burden is currently approved under OMB control number 0938–1034, with an expiration date of February 28, 2011.

In addition, there is burden associated with furnishing a patient with the list of the hospital's owners or investors who are physicians (or immediate family members of physicians) at the time of the patient request. However, CMS has no way to accurately quantify the burden because we cannot estimate the number of this type of request that a hospital may receive. We are soliciting public comments on the annual number of requests a hospital may receive for lists of physician-owners and investors, and will reevaluate this issue in the final rule stage of rulemaking.

Proposed § 489.20(u)(2) would require disclosure of physician ownership as a condition of continued medical staff membership or admitting privileges. The burden associated with this requirement is the time and effort required for a hospital to develop, draft, and implement changes to its medical staff bylaws and other policies governing admitting privileges. Approximately 175 physician-owned hospitals would be required to comply with this requirement. We estimate that it will require a hospital's general counsel 4 hours to revise a hospital's medical staff bylaws and policies governing admitting privileges. Therefore, the total annual hospital burden would be 700 hours.

In addition, the proposed § 489.20(u)(2) imposes a burden on physicians. As stated earlier, all physicians who are also members of the hospital's medical staff must agree, as a condition of continued medical staff membership or admitting privileges, to disclose, in writing, to all patients they refer to the hospital any ownership or investment interest in the hospital held by themselves or by an immediate family member. The disclosure must be made at the time the referral is made. The burden associated with this requirement is the time and effort necessary for a physician to draft a disclosure and to provide it to the patient at the time the referral is made to the physician-owned hospital. We estimate that it will take each physician, or designated office staff member, 1 hour to develop a disclosure notice and make copies that will be distributed to patients. In addition, we estimate 30 seconds to provide the disclosure to each patient and an additional 30 seconds to record the proof of disclosure into each patient's medical record.

Although we can estimate the number of physician-owned hospitals, we are unable to quantify the number of physicians that possess an ownership or investment interest in hospitals. There is limited data available concerning physician ownership in hospitals. The studies to date, including those by CMS and the Government Accountability Office, pertain to physician ownership in specialty hospitals (cardiac, orthopedic, and surgical hospitals). These specialty hospital studies published data concerning the average percentage of shares of direct ownership by physicians (less than 2 percent), indirect ownership through group practices, and the aggregate percentage of physician ownership, but did not publish the number of physician owners in these types of hospitals. More importantly, proposed § 489.20(u)(2) would apply to physician ownership in any type of hospital. Our other research involved a review of enrollment data. However, the CMS enrollment application (CMS–855) requires the reporting of ownership interests that exceed 5 percent or greater, and, thus, most physician ownership is not captured. In summary, because we are unable to estimate the total physician burden associated with this reporting requirement, we are seeking public comment pertaining to this burden and will reevaluate this issue in the final rule stage of rulemaking.

Proposed § 489.20(v) states that the aforementioned requirements in § 489.20(u)(1) and (u)(2) do not apply to a physician-owned hospital that does not have at least one referring physician who has an ownership or investment interest in the hospital or who has an immediate family member who has an ownership or investment interest in the hospital. To comply with this exception, an eligible hospital must sign an attestation to that effect and maintain the document in its records. Therefore, the number of hospitals that are now subject to the disclosure requirement would be slightly reduced. However, there may be a minimal burden attributable to the proposed requirement that the hospital maintain an attestation statement in its records.

The burden associated with this requirement will be limited to those physician-owned hospitals that do not have at least one referring physician who has an ownership or investment interest in the hospital or who has an immediate family member who has an

ownership or investment interest in the hospital. The burden would include the time and effort for these hospitals to develop, sign, and maintain the attestations in their records. We estimate that 10 percent, or approximately 18, of the estimated 175 physician-owned hospitals would be subject to this requirement. We estimate that it would take each of these physician-owned hospitals an average of 1 hour to develop, sign, and maintain the attestation in its records. The estimated annual burden associated with this requirement is 18 hours. However, because we have no way of knowing for certain the number of physician-owned hospitals that do not have at least one referring physician who has an ownership or investment interest in the hospital or who has an immediate family member who has an ownership or investment interest in the hospital, we are requesting public comment regarding the accuracy of our estimate and the associated burden with the attestation requirement.

Section 489.20(w) requires all hospitals, as defined in § 489.24(b), to furnish all patients notice, in accordance with § 482.13(b)(2), at the beginning of their hospital stay or outpatient visit if a doctor of medicine or a doctor of osteopathy is not present in the hospital 24 hours per day, 7 days per week. The notice must indicate how the hospital will meet the medical needs of any inpatient who develops an emergency medical condition, as defined in § 489.24(b), at a time when there 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. Whereas this requirement is subject to the PRA, the associated burden is approved under OMB control number 0938–1034 with a current expiration date of February 28, 2011.

ESTIMATED ANNUAL REPORTING AND RECORDKEEPING BURDEN

Regulation section(s)	OMB control No.	Respondents	Responses	Burden per response (hours)	Total annual burden (hours)
§ 411.361	0938–New	500	500	31	15,500
§ 422.310(b)	0938–0878	676	676	110	* 74,424
§ 489.20(r)	0938–New	100	100	3	300
§ 489.20(u)(1) and (w)	0938–1034	2,679	49,735,635	**	839,599
§ 489.20(u)(2)	0938–New	175	175	4	700
§ 489.20(v)	0938–New	18	18	1	18
Total					930,541

* Burden estimate is based on proposed revisions to the currently approved OMB control number.
** There are multiple requirements associated with the regulation section approved under this OMB control number. There is no uniform estimate of the burden per response.

3. Associated Information Collections Not Specified in Regulatory Text

This proposed rule imposes collection of information requirements as outlined in the regulation text and specified above. However, this proposed 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 OMB approval.

a. Present on Admission (POA) Indicator Reporting

Section II.F.8 of the preamble of this proposed rule discusses the present on admission indicator (POA) reporting requirements. As stated earlier, POA indicator information is necessary to identify which conditions were acquired during hospitalization for the hospital-acquired condition (HAC) payment provision and for broader public health uses of Medicare data. Through Change Request No. 5499 (released May 11, 2007), CMS issued instructions requiring IPPS hospitals to submit the POA indicator data for all diagnosis codes on Medicare claims.

The burden associated with this requirement is the time and effort necessary to place the appropriate POA codes on Medicare claims. While the requirement is subject to the PRA; the associated burden is approved under 0938–0997 with an expiration date of August 31, 2009.

b. Proposed Add-On Payments for New Services and Technologies

Section II.J. of the preamble of this proposed rule discusses proposed add-on payments for new services and technologies. Specifically, this section states that applicants for add-on payments for new medical services or technologies for FY 2010 must submit a formal request. A formal request includes a full description of the clinical applications of the medical service or technology and the results of any clinical evaluations demonstrating that the new medical service or technology represents a substantial clinical improvement. In addition, the request must contain a significant sample of the data to demonstrate that the medical service or technology meets the high-cost threshold.

We detailed the burden associated with this requirement in 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.

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

As noted in section IV.B. of the preamble of this proposed rule, the RHQDAPU program was originally established to implement section 501(b) of Pub. L. 108–173, thereby expanding our voluntary Hospital Quality Initiative. The RHQDAPU program originally consisted of a ''starter set'' of 10 quality measures. OMB approved the collection of data associated with the original starter set of quality measures under OMB control number 0938–0918, with a current expiration date of January 31, 2010.

We added additional quality measures to the RHQDAPU program and submitted the information collection request to OMB for approval. This expansion of the RHQDAPU measures was part of our implementation of section 5001(a) of the DRA. Section 1886(b)(3)(B)(viii)(III) of the Act, added

by section 5001(a) of the DRA, requires that the Secretary expand the ''starter set'' of 10 quality measures that were established by the Secretary as of November 1, 2003, to include measures ''that the Secretary determines to be appropriate for the measurement of the quality of care furnished by hospitals in inpatient settings.'' The burden associated with these reporting requirements is currently approved under OMB control number 0938–1022 with a current expiration date of December 31, 2008.

However, for FY 2009, we submitted to OMB for approval a revised information collection request using the same OMB control number (0938–1022). In the revised request, we proposed to add three new RHQDAPU quality measures that we adopted for the FY 2009 RHADAPU program to the PRA process. These three measures are as follows:

- Pneumonia 30-day Mortality (Medicare patients);
- SCIP Infection 4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose; and
- SCIP Infection 6: Surgery Patients with Appropriate Hair Removal.

The revised information collection request was announced in the **Federal Register** via an emergency notice on January 28, 2008 (73 FR 4868). The information collection request is currently under review by OMB. Once approved, we will submit another revision of the information collection request to obtain approval for the new measures contained in this proposed rule.

Section IV.B.5. of the preamble of this proposed rule also discusses the requirements for the continuous collection of HCAHPS quality data. The HCAHPS 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. We also added the HCAHPS survey to the PRA process in the information collection request currently approved under OMB control number 0938–1022 with a current expiration date of December 31, 2008.

Section IV.B.9. of the preamble of this proposed rule addresses the reconsideration and appeal procedures for a hospital that we believe did not meet the RHQDAPU program requirements. If a hospital disagrees with our determination, it may submit a written request to 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.

d. Occupational Mix Adjustment to the FY 2009 Index (Hospital Wage Index Occupational Mix Survey)

Section III. of the preamble of this proposed rule details the proposed changes to the hospital wage index. Specifically, section III.D. addresses the proposed occupational mix adjustment to the proposed FY 2009 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.

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 February 28, 2011.

4. Addresses for Submittal of Comments on Information Collection Requirements

If you comment on these information collection and recordkeeping requirements, please do either of the following:

1. Submit your comments electronically as specified in the **ADDRESSES** section of this proposed rule; or

2. Mail copies to the address specified in the **ADDRESSES** section of this proposed rule and to— Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Carolyn L. Raffaelli, CMS Desk Officer, CMS–1390–P; E-mail: *Carolyn_L._Raffaelli@omb.eop.gov.* Fax (202) 395–6974.

C. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

List of Subjects

42 CFR Part 411

Kidney diseases, Medicare, Physician referral, Reporting and recordkeeping requirements.

42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 422

Administrative practice and procedure, Grant programs—health, Health care, Health insurance, Health maintenance organizations (HMO), Loan programs—health, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 489

Health facilities, Medicare, Reporting and recordkeeping requirements.

For the reasons stated in the preamble of this proposed rule, the Centers for Medicare & Medicaid Services is proposing to amend 42 CFR Chapter IV as follows:

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

1. The authority citation for part 411 continues to read as follows:

Authority: Secs. 1102, 1860D–1 through 1860D–42, 1871, and 1877 of the Social Security Act (42 U.S.C. 1302, 1395w–101 through 1395w–152, 1395hh, and 1395nn).

2. Section 411.351 is amended by—

a. Revising the definition of ''physician''.

b. Revising the definition of ''physician organization''.

The revisions read as follows:

§ 411.351 Definitions.

* * * * *

Physician means a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor, as defined in section 1861(r) of the Act. A physician and the

professional corporation of which he or she is a sole owner are the same for purposes of this subpart.

* * * * *

Physician organization means a physician, a physician practice, or a group practice that complies with the requirements of § 411.352.

* * * * *

3. Section 411.353 is amended by revising paragraph (c) to read as follows:

§ 411.353 Prohibition on certain referrals by physicians and limitations on billing.

* * * * *

(c) *Denial of payment.* Except as provided in paragraph (e) of this section, no Medicare payment may be made for a designated health service that is furnished pursuant to a prohibited referral. The period during which referrals are prohibited is the period of disallowance. For purposes of this section, with respect to the following types of noncompliance, the period of disallowance begins at the time the financial relationship fails to satisfy the requirements of an applicable exception and ends no later than—

(1) Where the noncompliance is unrelated to compensation, the date that the financial relationship satisfies all of the requirements of an applicable exception;

(2) Where the noncompliance is due to the payment of excess compensation, the date on which the excess compensation is returned to the party that paid it and the financial relationship satisfies all of the requirements of an applicable exception; or

(3) Where the noncompliance is due to the payment of compensation that is of an amount insufficient to satisfy the requirements of an applicable exception, the date on which the additional required compensation is paid to the party to which it is owed such that the financial relationship would satisfy all of the requirements of the exception as of its date of inception.

* * * * *

4. Section 411.354 is amended by—

a. Adding a new paragraph (a)(1)(iii).

b. Revising paragraph (c)(2)(iv).

c. Revising paragraph (c)(3)(ii).

The addition and revisions read as follows:

§ 411.354 Financial relationship, compensation, and ownership or investment interest.

(a) * * *

(1) * * *

(iii) For purposes of paragraph (c) of this section, an entity that furnishes DHS is deemed to stand in the shoes of an organization in which it has a 100 percent ownership interest.

* * * * *

(c) * * *

(2) * * *

(iv) For purposes of paragraph (c)(2)(i) of this section, a physician is deemed to ''stand in the shoes'' of his or her physician organization unless the total compensation from the physician organization to the physician satisfies the requirements of § 411.357(c), (d), or (l).

(3) * * *

(ii) The provisions of paragraphs (c)(1)(ii) and (c)(2)(iv) of this section—

(A) Need not apply during the original term or current renewal term of an arrangement that satisfied the requirements of § 411.357(p) as of September 5, 2007 (42 CFR parts 400–413, revised as of October 1, 2007);

(B) Do not apply to an arrangement that satisfies the requirements of § 411.355(e); and

(C) Do not apply with respect to an arrangement between a physician organization and a component of an academic medical center listed in § 411.355(e)(2) for the provision to that academic medical center of only services required to satisfy the academic medical center's obligations under the Medicare graduate medical education (GME) rules in part 413, subpart F of this chapter.

* * * * *

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

5. The authority citation for part 412 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh), and sec. 124 of Pub. L. 106–113 (113 Stat. 1501A–332).

6. Section 412.4 is amended by revising paragraph (c)(3) to read as follows:

§ 412.4 Discharges and transfers.

* * * * *

(c) * * *

(3) To home under a written plan of care for the provision of home health services from a home health agency and those services begin—

(i) Effective for fiscal years prior to FY 2009, within 3 days after the date of discharge; and

(ii) Effective FY 2009, within 7 days after the date of discharge.

* * * * *

7. Section 412.22 is amended by—

a. In the introductory text of paragraph (e), removing the phrase ''paragraph (f) of this section'' and adding in its place ''paragraphs (e)(1)(vi) and (f) of this section''.

b. Adding a new paragraph (e)(1)(vi).

The addition reads as follows:

§ 412.22 Excluded hospitals and hospital units: General rules.

* * * * *

(e) * * *

(1) * * *

(vi) Effective October 1, 2008, if a State hospital that is occupying space in the same building or on the same campus as another State hospital cannot meet the criterion under paragraph (e)(1)(i) of this section solely because its governing body is under the control of the State hospital with which it shares a building or a campus, or is under the control of a third entity that also controls the State hospital with which it shares a building or a campus, the State hospital can nevertheless qualify for an exclusion if it meets the other applicable criteria in this section and—

(A) Both State hospitals occupy space in the same building or on the same campus and have been continuously owned and operated by the State since October 1, 1995;

(B) Is required by State law to be subject to the governing authority of the State hospital with which it shares space or the governing authority of a third entity that controls both hospitals; and

(C) Was excluded from the inpatient prospective payment system before October 1, 1995, and continues to be excluded from the inpatient prospective payment system through September 30, 2008.

* * * * *

8. Section 412.64 is amended by—

a. Republishing the introductory text of paragraph (b)(1)(ii) and revising paragraph (b)(1)(ii)(A).

b. In the introductory text of paragraph (h)(4), removing the date ''September 30, 2008'' and adding in its place ''September 30, 2011''.

The revision reads as follows:

§ 412.64 Federal rates for inpatient operating costs for Federal fiscal year 2005 and subsequent fiscal years.

* * * * *

(b) * * *

(1) * * *

(ii) The term *urban area* means—

(A) A Metropolitan Statistical Area or a Metropolitan division (in the case where a Metropolitan Statistical Area is divided into Metropolitan Divisions), as defined by the Executive Office of Management and Budget; or

* * * * *

9. Section 412.87 is amended by—

a. Revising paragraph (b)(1).

b. Adding a new paragraph (c).

The revision and addition read as follows:

§ 412.87 Additional payment for new medical services and technologies: General provisions.

* * * * *

(b) * * *

(1) A new medical service or technology represents an advance that substantially improves, relating to technologies previously available, the diagnosis or treatment of Medicare beneficiaries.

* * * * *

(c) *Announcement of determinations and deadline for consideration of new medical service or technology applications.* CMS will consider whether a new medical service or technology meets the eligibility criteria specified in paragraph (b) of this section and announce the results in the **Federal Register** as part of its annual updates and changes to the IPPS. CMS will only consider, for add-on payments for a particular fiscal year, an application for which the new medical service or technology has received FDA approval or clearance by July 1 prior to the particular fiscal year.

10. Section 412.230 is amended by—

a. Revising paragraph (d)(1)(iv)(C).

b. Adding a new paragraph (d)(1)(iv)(D).

The addition and revision read as follows:

§ 412.230 Criteria for an individual hospital seeking redesignation to another rural area or an urban area.

* * * * *

(d) * * *

(1) * * *

(iv) * * *

(C) With respect to redesignations for fiscal years 2002 through 2009, the hospital's average hourly wage is equal to, in the case of a hospital located in a rural area, at least 82 percent, and in the case of a hospital located in an urban area, at least 84 percent of the average hourly wage of hospitals in the area to which it seeks redesignation.

(D) With respect to redesignations for fiscal year 2010 and later fiscal years, the hospital's average hourly wage is equal to, in the case of a hospital located in a rural area, at least 86 percent, and in the case of a hospital located in an urban area, at least 88 percent of the average hourly wage of hospitals in the area to which it seeks redesignation.

* * * * *

11. Section 412.232 is amended by revising paragraphs (c)(1) and (c)(2) to read as follows:

§ 412.232 Criteria for all hospitals in a rural county seeking urban redesignation.

* * * * *

(c) * * *

(1) *Aggregate hourly wage for fiscal years before fiscal year 2010*—(i) *Aggregate hourly wage.* With respect to redesignations effective beginning fiscal year 1999 and before fiscal year 2010, the aggregate average hourly wage for all hospitals in the rural county must be equal to at least 85 percent of the average hourly wage in the adjacent urban area.

(ii) *Aggregate hourly wage weighted for occupational mix.* For redesignations effective before fiscal year 1999, the aggregate hourly wage for all hospitals in the rural county, weighed for occupational categories, is at least 90 percent of the average hourly wage in the adjacent urban area.

(2) *Aggregate hourly wage for fiscal year 2010 and later fiscal years.* With respect to redesignations effective for fiscal year 2010 and later fiscal years, the aggregate average hourly wage for all hospitals in the rural county must be equal to at least 88 percent of the average hourly wage in the adjacent urban area.

* * * * *

12. Section 412.234 is amended by revising paragraphs (b)(1) and (b)(2) to read as follows:

§ 412.234 Criteria for all hospitals in an urban county seeking redesignation to another urban area.

* * * * *

(b) * * *

(1) *Aggregate hourly wage for fiscal years before fiscal year 2010*—(i) *Aggregate hourly wage.* With respect to redesignations effective beginning fiscal year 1999 and before fiscal year 2010, the aggregate average hourly wage for all hospitals in the urban county must be at least 85 percent of the average hourly wage in the urban area to which the hospitals in the county seek reclassification.

(ii) *Aggregate hourly wage weighted for occupational mix.* For redesignations effective before fiscal year 1999, the aggregate hourly wage for all hospitals in the county, weighed for occupational categories, is at least 90 percent of the average hourly wage in the adjacent urban area.

(2) *Aggregate hourly wage for fiscal year 2010 and later fiscal years.* With respect to redesignations effective for fiscal year 2010 and later fiscal years, the aggregate average hourly wage for all hospitals in the urban county must be at least 88 percent of the average hourly wage in the urban area to which the hospitals in the county seek reclassification.

* * * * *

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

13. The authority citation for Part 413 continues to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1861(v), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395d(d), 1395f(b), 1395g, 1395l(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww); and sec. 124 of Pub. L. 106–133 (113 Stat. 1501A–332).

§ 413.79 [Amended]

14. In § 413.79(f)(6)(iv), remove the cross-reference ''§ 413.75(d)'' and add the cross-reference ''paragraph (d) of this section'' in its place.

PART 422—MEDICARE ADVANTAGE PROGRAM

15. The authority citation for Part 422 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

16. Section 422.310 is revised to read as follows:

§ 422.310 Risk adjustment data.

(a) *Definition of risk adjustment data.* Risk adjustment data are all data that are used in the development and application of a risk adjustment payment model.

(b) *Data collection: Basic rule.* Each MA organization must submit to CMS (in accordance with CMS instructions) the data necessary to characterize the context and purposes of each item and service provided to a Medicare enrollee by a provider, supplier, physician, or other practitioner. CMS may also collect data necessary to characterize the functional limitations of enrollees of each MA organization.

(c) *Sources and extent of data.* (1) To the extent required by CMS, risk adjustment data must account for the following:

(i) Items and services covered under the original Medicare program.

(ii) Medicare-covered items and services for which Medicare is not the primary payer.

(iii) Other additional or supplemental benefits that the MA organization may provide.

(2) The data must account separately for each provider, supplier, physician,

or other practitioner that would be permitted to bill separately under the original Medicare program, even if they participate jointly in the same service.

(d) *Other data requirements.* (1) MA organizations must submit data that conform to CMS' requirements for data equivalent to Medicare fee-for-service data, when appropriate, and to all relevant national standards. CMS may specify abbreviated formats for data submission required of MA organizations.

(2) The data must be submitted electronically to the appropriate CMS contractor.

(3) MA organizations must obtain the risk adjustment data required by CMS from the provider, supplier, physician, or other practitioner that furnished the item or service.

(4) MA organizations may include in their contracts with providers, suppliers, physicians, and other practitioners, provisions that require submission of complete and accurate risk adjustment data as required by CMS. These provisions may include financial penalties for failure to submit complete data.

(e) *Validation of risk adjustment data.* MA organizations and their providers and practitioners will be required to submit a sample of medical records for the validation of risk adjustment data, as required by CMS. There may be penalties for submission of false data.

(f) *Use of data.* CMS uses the data obtained under this section to determine the risk adjustment factors used to adjust payments, as required under §§ 422.304(a) and (c). CMS may also use the data for other purposes, including updating of risk adjustment models.

(g) *Deadlines for submission of risk adjustment data.* Risk adjustment factors for each payment year are based on risk adjustment data submitted for items and services furnished during the 12-month period before the payment year that is specified by CMS. As determined by CMS, this 12-month period may include a 6-month data lag that may be changed or eliminated as appropriate. CMS may adjust these deadlines, as appropriate.

(1) The annual deadline for risk adjustment data submission is the first Friday in September for risk adjustment data reflecting items and services furnished during the 12-month period ending the prior June 30, and the first Friday in March for data reflecting services furnished during the 12-month period ending the prior December 31.

(2) CMS allows a reconciliation process to account for late data submissions. CMS continues to accept risk adjustment data submitted after the March deadline until January 31 of the year following the payment year. After the payment year is completed, CMS recalculates the risk factors for affected individuals to determine if adjustments to payments are necessary. Risk adjustment data that are received after the annual January 31 late data submission deadline will not be accepted for the purposes of reconciliation.

PART 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

17. The authority citation for part 489 continues to read as follows:

Authority: Secs. 1102, 1819, 1820(e), 1861, 1864(m), 1866, 1869, and 1871 of the Social Security Act (42 U.S.C. 1302, 1395i–3, 1395x, 1395aa(m), 1395cc, 1395ff, and 1395hh).

18. Section 489.3 is amended by revising the definition of ''physician-owned hospital'' to read as follows:

§ 489.3 Definitions.

* * * * *

Physician-owned hospital means any participating hospital (as defined in § 489.24) in which a physician, or an immediate family member of a physician (as defined in § 411.351 of this chapter), has an ownership or investment interest. The ownership or investment interest may be through equity, debt, or other means, and includes an interest in an entity that holds an ownership or investment interest in the hospital. This definition does not include a hospital with physician ownership or investment interests that satisfy the requirements at § 411.356(a) or (b) of this chapter.

* * * * *

19. Section 489.20 is amended by—

a. Revising paragraph (r)(2).

b. Revising paragraph (u).

c. Redesignating paragraphs (v) and (w) as paragraphs (w) and (x), respectively.

d. Adding a new paragraph (v).

The revisions and addition read as follows:

§ 489.20 Basic commitments.

* * * * *

(r) * * *

(2) An on-call list of physicians on its medical staff available to provide treatment necessary after the initial examination to stabilize individuals with emergency medical conditions who are receiving services required under § 489.24 in accordance with the resources available to the hospital; and

* * * * *

(u) Except as provided in paragraph (v) of this section, in the case of a physician-owned hospital as defined in § 489.3—

(1) 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 an informed decision 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 owners or investors who are physicians or immediate family members of physicians (as defined at § 411.351 of this chapter) must be provided to the patients at the time the request for the list is made by or on behalf of the patient. For purposes of this paragraph (u)(1), the hospital stay or outpatient visit begins with the provision of a package of information regarding scheduled preadmission testing and registration for a planned hospital admission for inpatient care or outpatient service.

(2) To require all physicians who are members of the hospital's medical staff to agree, as a condition of continued medical staff membership or admitting privileges, to disclose, in writing, to all patients they refer to the hospital any ownership or investment interest in the hospital that is held by themselves or by an immediate family member (as defined in § 411.351 of this chapter). Disclosure must be required at the time the referral is made.

(v) The requirements of paragraph (u) of this section do not apply to any physician-owned hospital that does not have at least one referring physician (as defined at § 411.351 of this chapter) who has an ownership or investment interest in the hospital or who has an immediate family member who has an ownership or investment interest in the hospital, provided that such hospital signs an attestation statement to that effect and maintain such a notice in its records.

* * * * *

20. Section 489.24 is amended by—

a. Revising paragraph (a)(2).

b. Revising paragraph (f).

c. Revising paragraph (j).

The revisions read as follows:

§ 489.24 Special responsibilities of Medicare hospitals in emergency cases.

(a) * * *

(2) *Nonapplicability of provisions of this section.* Sanctions under this section for an inappropriate transfer during a national emergency or for the direction or relocation of an individual to receive medical screening at an

alternate location pursuant to an appropriate State emergency preparedness plan or, in the case of a public health emergency that involves a pandemic infectious disease, pursuant to a State pandemic preparedness plan do not apply to a hospital with a dedicated emergency department located in an emergency area during an emergency period, as specified in section 1135(g)(1) of the Act. A waiver of these sanctions is limited to a 72-hour period beginning upon the implementation of a hospital disaster protocol, except that, if a public health emergency involves a pandemic infectious disease (such as pandemic influenza), the waiver will continue in effect until the termination of the applicable declaration of a public health emergency, as provided for by section 135(e)(1)(B) of the Act.

* * * * *

(f) *Recipient hospital responsibilities.* A participating hospital that has specialized capabilities or facilities (including, but not limited to, facilities such as burn units, shock-trauma units, neonatal intensive case units, or, with respect to rural areas, regional referral centers (which, for purposes of this subpart, mean hospitals meeting the requirements of referral centers found at § 412.96 of this chapter)) may not refuse to accept from a referring hospital within the boundaries of the United States an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual. This provision applies to—

(1) Any participating hospital with specialized capabilities, regardless of whether the hospital has a dedicated emergency department; and

(2) An individual who has been admitted under paragraph (d)(2)(i) of this section and who has not been stabilized.

* * * * *

(j) *Availability of on-call physicians.* In accordance with the on-call list requirements specified in § 489.20(r)(2), a hospital must have written policies and procedures in place—

(1) To respond to situations in which a particular specialty is not available or the on-call physician cannot respond because of circumstances beyond the physician's control; and

(2) To provide that emergency services are available to meet the needs of individuals with emergency medical conditions if a hospital elects to—

(i) Permit on-call physicians to schedule elective surgery during the time that they are on call;

(ii) Permit on-call physicians to have simultaneous on-call duties; and

(iii) Participate in a formal community call plan. Notwithstanding participation in a community call plan, hospitals are still required to perform medical screening examinations on individuals who present seeking treatment and to conduct appropriate transfers. The formal community plan must include the following elements:

(A) A clear delineation of on-call coverage responsibilities; that is, when each hospital participating in the plan is responsible for on-call coverage.

(B) A description of the specific geographic area to which the plan applies.

(C) A signature by an appropriate representative of each hospital participating in the plan.

(D) Assurances that any local and regional EMS system protocol formally includes information on community on-call arrangements.

(E) Evidence of engagement of the hospitals participating in the community call plan in an analysis of the specialty on-call needs of the community for which the plan is effective.

(F) A statement specifying that even if an individual arrives at a hospital that is not designated as the on-call hospital, that hospital still has an obligation under § 489.24 to provide a medical screening examination and stabilizing treatment within its capability, and that hospitals participating in the community call plan must abide by the regulations under § 489.24 governing appropriate transfers.

(G) An annual assessment of the community call plan by the participating hospitals.

21. Section 489.53 is amended by revising paragraph (c) to read as follows:

§ 489.53 Termination by CMS.

* * * * *

(c) *Termination of agreements with physician-owned hospitals.* In the case of a physician-owned hospital, as defined at § 489.3, CMS may terminate the provider agreement if the hospital failed to comply with the requirements of § 489.20(u) or (w).

* * * * *

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

Dated: April 1, 2008.

Kerry Weems,

Acting Administrator, Centers for Medicare & Medicaid Services.

Dated: April 10, 2008.

Michael O. Leavitt,

Secretary.

[Editorial Note: The following Addendum and appendixes will not appear in the Code of Federal Regulations.]

Addendum—Proposed Schedule of Standardized Amounts, Update Factors, and Rate-of-Increase Percentages Effective With Cost Reporting Periods Beginning On or After October 1, 2008

I. Summary and Background

In this Addendum, we are setting forth the methods and data we used to determine the proposed prospective payment rates for Medicare hospital inpatient operating costs and Medicare hospital inpatient capital-related costs. We are also setting forth the proposed 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 that was previously set to expire on October 1, 2006, to include discharges occurring on or after October 1, 2006, but before October 1, 2011. Under section 5003(b) of 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 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 an updated Puerto Rico-specific rate based on average costs per case of Puerto Rico hospitals for the base year and 75 percent of the Federal national rate. (We refer readers to section II.D.3. of this Addendum for a complete description.)

As discussed below in section II. of this Addendum, we are proposing to make changes in the determination of the prospective payment rates for Medicare inpatient operating costs for FY 2009. In section III. of this Addendum, we discuss our proposed policy changes for determining the prospective payment rates for Medicare inpatient capital-related costs for FY 2009. Section IV. of this Addendum sets forth our proposed changes for determining the rate-of-increase limits for certain hospitals excluded from the IPPS for FY 2009. The tables to which we refer in the preamble of this proposed rule are presented in section V. of this Addendum of this proposed rule.

II. Proposed Changes to Prospective Payment Rates for Hospital Inpatient Operating Costs for FY 2009

The basic methodology for determining prospective payment rates for hospital inpatient operating costs for FY 2005 and subsequent fiscal years is set forth at § 412.64. The basic methodology for determining the prospective payment rates for hospital inpatient operating costs for hospitals located in Puerto Rico for FY 2005 and subsequent fiscal years is set forth at §§ 412.211 and 412.212. Below we discuss the factors used for determining the prospective payment rates.

In summary, the proposed standardized amounts set forth in Tables 1A, 1B, and 1C, of section VI. of this Addendum reflect—

- Equalization of the standardized amounts for urban and other areas at the level computed for large urban hospitals during FY 2004 and onward, as provided for under section 1886(d)(3)(A)(iv) of the Act, updated by the applicable percentage increase required under sections 1886(b)(3)(B)(i)(XX) and 1886(b)(3)(B)(viii) of the Act.
- The labor-related share that is applied to the 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.
- Proposed updates of 3.0 percent for all areas (that is, the estimated full market basket percentage increase of 3.0 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.
- A proposed update of 3.0 percent to the Puerto Rico-specific standardized amount (that is, the full estimated rate-of-increase in the hospital market basket for IPPS hospitals), as provided for under § 412.211(c), which states that we update the Puerto Rico-specific standardized amount using the percentage increase specified in § 412.64(d)(1), or the percentage increase in the market basket index for prospective payment hospitals for all areas.
- An adjustment to the standardized amount to ensure budget neutrality for DRG recalibration and reclassification, as provided for under section 1886(d)(4)(C)(iii) of the Act.
- An adjustment to ensure the wage index update and changes are budget neutral, as provided for under section 1886(d)(3)(E) of the Act.
- An adjustment to ensure the effects of geographic reclassification are budget neutral, as provided for in section 1886(d)(8)(D) of the Act, by removing the FY 2008 budget neutrality factor and applying a revised factor.
- An adjustment to remove the FY 2008 outlier offset and apply an offset for FY 2009.
- 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, as discussed below and in section II.D. of the preamble to this proposed rule.

We note that, beginning in FY 2008, we applied the budget neutrality adjustment for the rural floor to the hospital wage indices rather than the standardized amount. For FY 2009, we are proposing to continue to apply the rural floor budget neutrality adjustment to hospital wage indices rather than the standardized amount. In addition, instead of applying the budget neutrality adjustment for the imputed rural floor adopted under section 1886(d)(3)(E) of the Act to the standardized amounts, beginning with FY 2009, we are proposing to apply the imputed rural floor budget neutrality adjustment to the wage indices. Beginning in FY 2009, we are also proposing to apply the budget neutrality adjustments for the rural floor and imputed rural floor at the State level rather than the national level. For a complete discussion of the budget neutrality proposals concerning the rural floor and the imputed rural floor, including the proposal for a within-State budget neutrality adjustment, we refer readers to section III.B.2.b. of the preamble to this proposed rule.

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 for urban and rural hospitals in the initial development of standardized amounts for the IPPS. The September 1, 1987 final rule (52 FR 33043 and 33066) contains a detailed explanation of how the target amounts were determined and how they are used in computing the Puerto Rico rates.

Sections 1886(d)(2)(B) and (d)(2)(C) of the Act require us to update base-year per discharge costs for FY 1984 and then standardize the cost data in order to remove the effects of certain sources of cost variations among hospitals. These effects include case-mix, differences in area wage levels, cost-of-living adjustments for Alaska and Hawaii, indirect medical education costs, and costs to hospitals serving a disproportionate share of low-income patients.

In accordance with section 1886(d)(3)(E) of the Act, the Secretary estimates, from time-to-time, the proportion of hospitals' costs that are attributable to wages and wage-related costs. In general, the standardized amount is divided into labor-related and nonlabor-related amounts; only the proportion considered to be the labor-related amount is adjusted by the wage index. Section 1886(d)(3)(E) of the Act requires that 62 percent of the standardized amount be adjusted by the wage index, unless doing so would result in lower payments to a hospital than would otherwise be made. (Section 1886(d)(9)(C)(iv)(II) of the Act extends this provision to the labor-related share for hospitals located in Puerto Rico.)

For FY 2009, we are not proposing to change the national and Puerto Rico-specific labor-related and nonlabor-related shares from the percentages established for FY 2008. Therefore, the labor-related share continues to be 69.7 percent for the national standardized amounts and 58.7 percent for the Puerto Rico-specific standardized amount. Consistent with section 1886(d)(3)(E) of the Act, we are applying the wage index to a labor-related share of 62 percent for all non-Puerto Rico hospitals whose wage indexes are less than or equal to 1.0000. For all non-Puerto Rico hospitals whose wage indices are greater than 1.0000, we are applying the wage index to a labor-related share of 69.7 percent of the national standardized amount. For hospitals located in Puerto Rico, we are applying a labor-related share of 58.7 percent if its Puerto Rico-specific wage index is less than or equal to 1.0000. For hospitals located in Puerto Rico whose Puerto Rico-specific wage index values are greater than 1.0000, we are applying a labor share of 62 percent.

The standardized amounts for operating costs appear in Table 1A, 1B, and 1C of the Addendum to this proposed rule.

2. Computing the Average Standardized Amount

Section 1886(d)(3)(A)(iv)(II) of the Act requires that, beginning with FY–2004 and thereafter, an equal standardized amount be computed for all hospitals at the level computed for large urban hospitals during FY 2003, updated by the applicable percentage update. Section 1886(d)(9)(A)(ii)(II) of the Act equalizes the Puerto Rico-specific urban and rural area rates. Accordingly, we are calculating FY 2009 national and Puerto Rico

standardized amounts irrespective of whether a hospital is located in an urban or rural location.

3. Updating the 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 2009 is 3.0 percent. Thus, for FY 2009, the proposed update to the average standardized amount is 3.0 percent for hospitals in all areas. The estimated market basket increase of 3.0 percent is based on the 2008 first quarter forecast of the hospital market basket increase (as discussed in Appendix B of this proposed rule).

Section 1886(b)(3)(B) of the Act specifies the mechanism to be used to update the standardized amount for payment for inpatient hospital operating costs. Section 1886(b)(3)(B)(viii) of the Act, as added by section 5001(a)(3) of 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 proposed rule. The standardized amounts in Tables 1A through 1C of section V. of the Addendum to this proposed rule reflect these differential amounts.

Section 412.211(c) states that we update the Puerto Rico-specific standardized amount using the percentage increase specified in § 412.64(d)(1) or the percentage increase in the market basket index for prospective payment hospitals for all areas. We are proposing to apply the full rate-of-increase in the hospital market basket for IPPS hospitals to the Puerto Rico-specific standardized amount. Therefore, the proposed update to the Puerto Rico-specific standardized amount is estimated to be 3.0 percent.

Although the update factors for FY 2009 are set by law, we are required by section 1886(e)(4) of the Act to recommend, taking into account MedPAC's recommendations, appropriate update factors for FY 2009 for both IPPS hospitals and hospitals and hospital units excluded from the IPPS. Our recommendation on the update factors (which is required by sections 1886(e)(4)(A) and (e)(5)(A) of the Act) is set forth in Appendix B of this proposed rule.

4. Other Adjustments to the Average Standardized Amount

As in the past, we are adjusting the FY 2009 standardized amount to remove the effects of the FY 2008 geographic reclassifications and outlier payments before applying the FY 2009 updates. We then applied budget neutrality offsets for outliers and geographic reclassifications to the standardized amount based on proposed FY 2009 payment policies.

We do not remove the prior year's budget neutrality adjustments for reclassification and recalibration of the DRG weights and for updated wage data because, in accordance with sections 1886(d)(4)(C)(iii) and 1886(d)(3)(E) of the Act, estimated aggregate payments after updates in the DRG relative weights and wage index should equal estimated aggregate payments prior to the changes. If we removed the prior year's adjustment, we would not have satisfied these conditions.

Budget neutrality is determined by comparing aggregate IPPS payments before and after making changes that are required to be budget neutral (for example, changes to DRG classifications, recalibration of the DRG relative weights, updates to the wage index, and different geographic reclassifications). We included outlier payments in the simulations because they may be affected by changes in these parameters.

We are also proposing to adjust 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 2009, we are proposing to no longer apply budget neutrality for the imputed rural floor to the standardized amount, and to apply it instead to the wage index, as discussed in section of II.B.2. of the preamble to this proposed rule. For FY 2009, we are also proposing 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, by the percentage specified in section 7 of Pub. L. 110–90.

a. Proposed 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 proposed rule, we normalized the recalibrated DRG weights by an adjustment factor so that the average case weight after recalibration is equal to the average case weight prior to recalibration. However, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals because payments to hospitals are affected by factors other than average case weight. Therefore, as we have done in past years, we made a budget neutrality adjustment to ensure that the requirement of section 1886(d)(4)(C)(iii) of the Act is met.

Section 1886(d)(3)(E) of the Act requires us to update the hospital wage index on an annual basis beginning October 1, 1993. This provision also requires us to make any updates or adjustments to the wage index in a manner that ensures that aggregate payments to hospitals are not affected by the change in the wage index. Consistent with current policy, for FY 2009, we are adjusting 100 percent of the wage index factor for occupational mix. We describe the occupational mix adjustment in section III.D. of the preamble to this proposed rule.

To comply with the requirement that DRG reclassification and recalibration of the relative weights and the updated wage index be budget neutral, we used FY 2007 discharge data to simulate payments and compared aggregate payments using the FY 2008 relative weights and wage indices to aggregate payments using the proposed FY 2009 relative weights and wage indices. The same methodology was used for the FY 2008 budget neutrality adjustment. Based on this comparison, we computed a proposed budget neutrality adjustment factor equal to 0.999525 to be applied to the national standardized amount. We are also adjusting the Puerto Rico-specific standardized amount for the effect of DRG reclassification and recalibration. We computed a proposed budget neutrality adjustment factor of 0.998700 to be applied to the Puerto Rico-specific standardized amount. These proposed budget neutrality adjustment factors are applied to the standardized amounts for FY 2008 without removing the prior year's budget neutrality adjustments. In addition, as discussed in section IV. of this Addendum, we are applying the same proposed DRG reclassification and recalibration budget neutrality factor of 0.998700 to the hospital-specific rates that would be effective for cost reporting periods beginning on or after October 1, 2008.

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 proposed budget neutrality factor for FY 2009, we used FY 2007 discharge data to simulate payments, and compared total IPPS payments prior to any reclassifications under sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act to total IPPS payments after such reclassifications.

Based on these simulations, we calculated a proposed adjustment factor of 0.992333 to ensure that the effects of these provisions are budget neutral, consistent with the statute.

The proposed adjustment factor is applied to the standardized amount after removing the effects of the FY 2008 budget neutrality adjustment factor. We note that the FY 2009 adjustment reflects FY 2009 wage index reclassifications approved by the MGCRB or the Administrator. (Section 1886(d)(10)(D)(v) of the Act makes wage index reclassifications effective for 3 years. Therefore, the FY 2009 geographic reclassification could either be the continuation of a 3-year reclassification that began in FY 2007 or FY 2008, or a new one beginning in FY 2009.)

c. Case-Mix Budget Neutrality Adjustment

As stated earlier, beginning in FY 2008, we adopted the new MS–DRG patient classification system for the IPPS to better recognize severity of illness in Medicare payment rates. In the FY 2008 IPPS final rule with comment period, we indicated that we believe the adoption of the MS–DRGs had the potential to lead to increases in aggregate payments without a corresponding increase in actual patient severity of illness due to the incentives for improved documentation and coding. In that final rule, using the Secretary's authority under section 1886(d)(3)(A)(vi) of the Act to maintain budget neutrality by adjusting the national standardized amounts to eliminate the effect of changes in coding or classification that do not reflect real change in case-mix, we established prospective documentation and coding adjustments of −1.2 percent for FY 2008, −1.8 percent for FY 2009, and −1.8 percent for FY 2010. On September 29, 2007, Pub. L. 110–90 was enacted. Section 7 of Pub. L. 110–90 included a provision that reduces the documentation and coding adjustment for the MS–DRG system that we adopted in the FY 2008 IPPS final rule with comment period to −0.6 percent for FY 2008 and −0.9 percent for FY 2009. To comply with the provision of section 7 of Pub. L. 110–90, in a final rule that appeared in the **Federal Register** on November 27, 2007 (72 FR 66886), we changed the IPPS documentation and coding adjustment for FY 2008 to −0.6 percent, and revised the FY 2008 national standardized amounts (as well as other payment factors and thresholds) accordingly, with these revisions effective October 1, 2007. For FY 2009, section 7 of Pub. L. 110–90 requires a documentation and coding adjustment of −0.9 percent instead of the −1.8 percent adjustment specified in the FY 2008 IPPS final rule with comment period. As required by statute, we are applying a documentation and coding adjustment of −0.9 percent to the FY 2009 IPPS national standardized amounts. The documentation and coding adjustments established in the FY 2008 IPPS final rule with comment period are cumulative. As a result, the −0.9 percent documentation and coding adjustment in FY 2009 is in addition to the −0.6 percent adjustment in FY 2008, yielding a combined effect of −1.5 percent.

As discussed in more detail in section II.D. of the preamble of this proposed rule, in calculating the FY 2008 Puerto Rico standardized amount, we made an inadvertent error and applied the documentation and coding adjustment established using our authority in section 1886(d)(3)(A)(vi) of the Act (which only applies to the national standardized amounts) to the Puerto Rico-specific standardized amount. We are currently in the process of developing a **Federal Register** notice to remove the −0.6 percent documentation and coding adjustment from the FY 2008 Puerto Rico-specific standardized amount retroactive to October 1, 2007. As discussed in section II.D. of the preamble of this proposed rule, we are not applying the documentation and coding adjustment to the Puerto Rico-specific standardized amount for FY 2009, but we may consider doing so for the FY 2010 Puerto Rico-specific standardized amount in the FY 2010 rulemaking. In calculating the FY 2009 Puerto Rico-specific standardized amount for this proposed rule, we have removed the −0.6 percent documentation and coding adjustment that was inadvertently applied to the FY 2008 Puerto Rico-specific standardized amount.

d. Outliers

Section 1886(d)(5)(A) of the Act provides for payments in addition to the basic prospective payments for ''outlier'' cases involving extraordinarily high costs. To qualify for outlier payments, a case must have costs greater than the sum of the prospective payment rate for the DRG, any IME and DSH payments, any new technology add-on payments, and the ''outlier threshold'' or ''fixed loss'' amount (a dollar amount by which the costs of a case must exceed payments in order to qualify for an outlier payment). We refer to the sum of the prospective payment rate for the DRG, any IME and DSH payments, any new technology add-on payments, and the outlier threshold as the outlier ''fixed-loss cost threshold.'' To determine whether the costs of a case exceed the fixed-loss cost threshold, a hospital's CCR is applied to the total covered charges for the case to convert the charges to estimated costs. Payments for eligible cases are then made based on a marginal cost factor, which is a percentage of the estimated costs above the fixed-loss cost threshold. The marginal cost factor for FY 2009 is 80 percent, the same marginal cost factor we have used since FY 1995 (59 FR 45367).

In accordance with section 1886(d)(5)(A)(iv) of the Act, outlier payments for any year are projected to be not less than 5 percent nor more than 6 percent of total operating DRG payments plus outlier payments. Section 1886(d)(3)(B) of the Act requires the Secretary to reduce the average standardized amount by a factor to account for the estimated proportion of total DRG payments made to outlier cases. Similarly, section 1886(d)(9)(B)(iv) of the Act requires the Secretary to reduce the average standardized amount applicable to hospitals located in Puerto Rico to account for the estimated proportion of total DRG payments made to outlier cases. More information on outlier payments may be found on the CMS Web site at *http://www.cms.hhs.gov/AcuteInpatientPPS/04_outlier.asp#TopOfPage.*

(1) Proposed FY 2009 Outlier Fixed-Loss Cost Threshold

For FY 2009, we are proposing to use the same methodology used for FY 2008 (72 FR 47417) to calculate the outlier threshold. Similar to the methodology used in the FY 2008 final rule with comment period, for FY 2009, we are applying an adjustment factor to the CCRs to account for cost and charge inflation (as explained below). As we have done in the past, to calculate the proposed FY 2009 outlier threshold, we simulated payments by applying FY 2009 rates and policies using cases from the FY 2007 MedPAR files. Therefore, in order to determine the proposed FY 2009 outlier threshold, we inflate the charges on the MedPAR claims by 2 years, from FY 2007 to FY 2009.

We are proposing to continue using a refined methodology that takes into account the lower inflation in hospital charges that are occurring as a result of the outlier final rule (68 FR 34494), which changed our methodology for determining outlier payments by implementing the use of more current CCRs. Our refined methodology uses more recent data that reflect the rate-of-change in hospital charges under the new outlier policy.

Using the most recent data available, we calculated the 1-year average annualized rate-of-change in charges-per-case from the last quarter of FY 2006 in combination with the first quarter of FY 2007 (July 1, 2006 through December 31, 2006) to the last quarter of FY 2007 in combination with the first quarter of FY 2008 (July 1, 2007 through December 31, 2007). This rate of change was 5.84 percent (1.0585) or 12.03 percent (1.1204) over 2 years.

As we have done in the past, we are proposing to establish the proposed FY 2009 outlier threshold using hospital CCRs from the December 2007 update to the Provider-Specific File (PSF)—the most recent available data at the time of this proposed rule. This file includes CCRs that reflected implementation of the changes to the policy for determining the applicable CCRs that became effective August 8, 2003 (68 FR 34494).

As discussed in the FY 2007 final rule (71 FR 48150), we worked with the Office of Actuary to derive the methodology described below to develop the CCR adjustment factor. For FY 2009, we are proposing to use the same methodology to calculate the CCR adjustment by using the FY 2007 operating cost per discharge increase in combination with the actual FY 2007 operating market basket increase determined by Global Insight, Inc., as well as the charge inflation factor described above to estimate the adjustment to the CCRs. (We note that the FY 2007 actual (otherwise referred to as ''final'') operating market basket increase reflects historical data whereas the published FY 2007 operating market basket update factor was based on Global Insight, Inc.'s 2006 second quarter forecast with historical data through the first quarter of 2007.) By using the operating market basket rate-of-increase and the increase in the average cost per discharge from hospital cost reports, we are using two different measures of cost inflation. For FY

2009, we determined the adjustment by taking the percentage increase in the operating costs per discharge from FY 2005 to FY 2006 (1.0538) from the cost report and dividing it by the final operating market basket increase from FY 2006 (1.0420). We repeated this calculation for 2 prior years to determine the 3-year average of the rate of adjusted change in costs between the operating market basket rate-of-increase and the increase in cost per case from the cost report (FY 2003 to FY 2004 percentage increase of operating costs per discharge of 1.0629 divided by FY 2004 final operating market basket increase of 1.0400, FY 2004 to FY 2005 percentage increase of operating costs per discharge of 1.0565 divided by FY 2005 final operating market basket increase of 1.0430). For FY 2009, we averaged the differentials calculated for FY 2004, FY 2005, and FY 2006, which resulted in a mean ratio of 1.0154. We multiplied the 3-year average of 1.0154 by the 2007 operating market basket percentage increase of 1.0340, which resulted in an operating cost inflation factor of 5.0 percent or 1.05. We then divided the operating cost inflation factor by the 1-year average change in charges (1.058474) and applied an adjustment factor of 0.9920 to the operating CCRs from the PSF.

As stated in the FY 2008 final rule with comment period, we continue to believe it is appropriate to apply only a 1-year adjustment factor to the CCRs. On average, it takes approximately 9 months for fiscal intermediaries (or, if applicable, the MAC) to tentatively settle a cost report from the fiscal year end of a hospital's cost reporting period. The average ''age'' of hospitals' CCRs from the time the fiscal intermediary or the MAC inserts the CCR in the PSF until the beginning of FY 2008 is approximately 1 year. Therefore, as stated above, we believe a 1-year adjustment factor to the CCRs is appropriate.

We used the same methodology for the capital CCRs and determined the adjustment by taking the percentage increase in the capital costs per discharge from FY 2005 to FY 2006 (1.0462) from the cost report and dividing it by the final capital market basket increase from FY 2006 (1.0090). We repeated this calculation for 2 prior years to determine the 3-year average of the rate of adjusted change in costs between the capital market basket rate-of-increase and the increase in cost per case from the cost report (FY 2003 to FY 2004 percentage increase of capital costs per discharge of 1.0315 divided by FY 2004 final capital market basket increase of 1.0050, FY 2004 to FY 2005 percentage increase of capital costs per discharge of 1.0311 divided by FY 2005 final capital market basket increase of 1.0060). For FY 2009, we averaged the differentials calculated for FY 2004, FY 2005, and FY 2006, which resulted in a mean ratio of 1.0294. We multiplied the 3-year average of 1.0294 by the 2007 capital market basket percentage increase of 1.0120, which resulted in a capital cost inflation factor of 4.17 percent or 1.0417. We then divided the capital cost inflation factor by the 1-year average change in charges (1.058474) and applied an adjustment factor of 0.9842 to the capital CCRs from the PSF. We are using the same charge inflation factor for the capital CCRs that was used for the operating CCRs. The charge inflation factor is based on the overall billed charges. Therefore, we believe it is appropriate to apply the charge factor to both the operating and capital CCRs.

For purposes of estimating the proposed outlier threshold for FY 2009, we assume 3.0 percent case-mix growth in FY 2009 compared with our FY 2007 claims data (that is, a 1.2 percent increase in FY 2008 and an additional 1.8 percent increase in FY 2009). The 3 percent case-mix growth was projected by the Office of the Actuary as the amount case-mix is expected to increase in response to adoption of the MS–DRGs as a result of improvements in documentation and coding that do not reflect real changes in patient severity of illness. It is necessary to take the 3 percent expected case-mix growth into account when calculating the outlier threshold that results in outlier payments being 5.1 percent of total payments for FY 2009. If we did not take this 3 percent projected case-mix growth into account, our estimate of total payments would be too low, and as a result, our estimate of the outlier threshold would be too high. While we assume 3 percent case-mix growth for all hospitals in our outlier threshold calculations, the FY 2009 national standardized amounts used to calculate the outlier threshold reflect the statutorily mandated documentation and coding adjustment of −0.9 percent for FY 2009, on top of the −0.6 percent adjustment for FY 2008.

Using this methodology, we are proposing an outlier fixed-loss cost threshold for FY 2009 equal to the prospective payment rate for the DRG, plus any IME and DSH payments, and any add-on payments for new technology, plus $21,025.

As we did in establishing the FY 2008 outlier threshold (72 FR 47417), in our projection of FY 2009 outlier payments, we are not making any adjustments for the possibility that hospitals' CCRs and outlier payments may be reconciled upon cost report settlement. We continue to believe that, due to the policy implemented in the outlier final rule (68 FR 34494, June 9, 2003), CCRs will no longer fluctuate significantly and, therefore, few hospitals will actually have these ratios reconciled upon cost report settlement. In addition, it is difficult to predict the specific hospitals that will have CCRs and outlier payments reconciled in any given year. We also noted that reconciliation occurs because hospitals' actual CCRs for the cost reporting period are different than the interim CCRs used to calculate outlier payments when a bill is processed. Our simulations assume that CCRs accurately measure hospital costs based on information available to us at the time we set the outlier threshold. For these reasons, we are not making any assumptions about the effects of reconciliation on the outlier threshold calculation.

We also note that there are some factors that contributed to a proposed lower fixed loss outlier threshold for FY 2009 compared to FY 2008. First, the case-weighted national average operating CCR declined by approximately an additional 1 percentage point from the March 2007 update (used to calculate the FY 2008 outlier threshold) to the December 2007 update of the PSF (used to calculate the proposed FY 2009 outlier threshold). In addition, as discussed in sections II.C. and II.H. of the preamble of this proposed rule, we began a 2-year phase-in of the MS–DRGs in FY 2008, with the DRG relative weights based on a 50 percent blend of the CMS DRGs and MS–DRGs in FY 2008 and based on 100 percent of the MS–DRGs beginning in FY 2009. Better recognition of severity of illnesses with the MS–DRGs means that 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. In addition, as noted previously, in our modeling of the outlier threshold, we included a 3-percent adjustment for expected case-mix growth between FY 2007 and FY 2009. Together, we believe that the above factors cumulatively contributed to a lower proposed fixed-loss outlier threshold in FY 2009 compared to FY 2008.

(2) Other Proposed Changes Concerning Outliers

As stated in the FY 1994 IPPS final rule (58 FR 46348), we establish an outlier threshold that is applicable to both hospital inpatient operating costs and hospital inpatient capital-related costs. When we modeled the combined operating and capital outlier payments, we found that using a common threshold resulted in a lower percentage of outlier payments for capital-related costs than for operating costs. We are projecting that the proposed thresholds for FY 2009 will result in outlier payments that will equal 5.1 percent of operating DRG payments and 5.73 percent of capital payments based on the Federal rate.

In accordance with section 1886(d)(3)(B) of the Act, we are reducing the FY 2009 standardized amount by the same percentage to account for the projected proportion of payments paid as outliers.

The outlier adjustment factors that are applied to the standardized amount for the proposed FY 2009 outlier threshold are as follows:

	Operating standardized amounts	Capital federal rate
National	0.948928	0.942711
Puerto Rico ...	0.955988	0.925627

Consistent with current policy, we are applying the outlier adjustment factors to FY 2009 rates after removing the effects of the FY 2008 outlier adjustment factors on the standardized amount.

To determine whether a case qualifies for outlier payments, we apply hospital-specific CCRs to the total covered charges for the case. Estimated operating and capital costs for the case are calculated separately by applying separate operating and capital CCRs. These costs are then combined and

compared with the outlier fixed-loss cost threshold.

The outlier final rule (68 FR 34494) eliminated the application of the statewide average CCRs for hospitals with CCRs that fell below 3 standard deviations from the national mean CCR. However, for those hospitals for which the fiscal intermediary or MAC computes operating CCRs greater than 1.213 or capital CCRs greater than 0.148, 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.[27] Table 8A in this Addendum contains the statewide average operating CCRs for urban hospitals and for rural hospitals for which the fiscal intermediary or MAC is unable to compute a hospital-specific CCR within the above range. Effective for discharges occurring on or after October 1, 2008, these statewide average ratios would replace the ratios published in the IPPS final rule for FY 2008 (72 FR 48126–48127). Table 8B in this Addendum contains the comparable statewide average capital CCRs. Again, the CCRs in Tables 8A and 8B would be used during FY 2009 when hospital-specific CCRs based on the latest settled cost report are either not available or are outside the range noted above. For an explanation of Table 8C, we refer readers to section V. of this Addendum.

We finally note that we published a manual update (Change Request 3966) to our outlier policy on October 12, 2005, which updated Chapter 3, Section 20.1.2 of the Medicare Claims Processing Manual. The manual update covered an array of topics, including CCRs, reconciliation, and the time value of money. We encourage hospitals that are assigned the statewide average operating and/or capital CCRs to work with their fiscal intermediaries (or MAC if applicable) on a possible alternative operating and/or capital CCR as explained in Change Request 3966. Use of an alternative CCR developed by the hospital in conjunction with the fiscal intermediary or MAC can avoid possible overpayments or underpayments at cost report settlement, thus ensuring better accuracy when making outlier payments and negating the need for outlier reconciliation. We also note that a hospital may request an alternative operating or capital CCR ratio at any time as long as the guidelines of Change Request 3966 are followed. To download and view the manual instructions on outlier and cost-to-charge ratios, visit the Web site: *http://www.cms.hhs.gov/manuals/downloads/clm104c03.pdf*.

(3) FY 2007 and FY 2008 Outlier Payments

In the FY 2008 IPPS final rule (72 FR 47420), we stated that, based on available data, we estimated that actual FY 2007 outlier payments would be approximately 4.6 percent of actual total DRG payments. This estimate was computed based on simulations using the FY 2006 MedPAR file (discharge data for FY 2006 bills). That is, the estimate of actual outlier payments did not reflect actual FY 2007 bills, but instead reflected the application of FY 2007 rates and policies to available FY 2006 bills.

Our current estimate, using available FY 2007 bills, is that actual outlier payments for FY 2007 were approximately 4.64 percent of actual total DRG payments. Thus, the data indicate that, for FY 2007, the percentage of actual outlier payments relative to actual total payments is lower than we projected before FY 2007. Consistent with the policy and statutory interpretation we have maintained since the inception of the IPPS, we do not plan to make retroactive adjustments to outlier payments to ensure that total outlier payments for FY 2007 are equal to 5.1 percent of total DRG payments.

We currently estimate that actual outlier payments for FY 2008 will be approximately 4.8 percent of actual total DRG payments, 0.3 percentage points lower than the 5.1 percent we projected in setting the outlier policies for FY 2008. This estimate is based on simulations using the FY 2007 MedPAR file (discharge data for FY 2007 bills). We used these data to calculate an estimate of the actual outlier percentage for FY 2008 by applying FY 2008 rates and policies, including an outlier threshold of $22,185 to available FY 2007 bills.

e. Proposed 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.K. of the preamble to this proposed rule, 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. There are currently nine hospitals participating in the demonstration program. CMS is currently conducting a solicitation for up to six additional hospitals to participate in the demonstration program. For this proposed rule, we used data from the cost reports of the 9 currently participating hospitals to estimate a total cost number for 15 hospitals that could potentially participate in the demonstration program in FY 2009. (In the final rule, we will know the exact number of hospitals participating in the demonstration program, and we will revise our estimates accordingly.) We estimate that the average additional annual payment that will be made to each participating hospital under the demonstration will be approximately $2,134,123. 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. As an estimate of the cost for a total of 15 hospitals that may participate, the total annual impact of the demonstration program for FY 2009 is projected to be $32,011,849. The required adjustment to the Federal rate used in calculating Medicare inpatient prospective payments as a result of the demonstration is 0.999666.

In order to achieve budget neutrality, we are adjusting the national IPPS rates by an amount sufficient to account for the added costs of this demonstration. In other words, we are applying budget neutrality across the payment system as a whole rather than merely across the participants of this demonstration, 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. Proposed FY 2009 Standardized Amount

The adjusted proposed standardized amount is divided into labor-related and nonlabor-related portions. Tables 1A and 1B of this Addendum contain the national standardized amounts that we are proposing to apply to all hospitals, except hospitals located in Puerto Rico, for FY 2009. The proposed Puerto Rico-specific amounts are shown in Table 1C of this Addendum. The proposed 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 are applying 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 proposed standardized amounts reflecting the full 3.0 percent update for FY 2009, and proposed standardized amounts reflecting the 2.0 percentage point reduction to the update (a 1.0 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 proposed amount is set forth in Table 1A). The proposed labor-related and nonlabor-related portions of the national average standardized amounts for Puerto Rico hospitals for FY 2009 are set forth in Table 1C of this Addendum. This table also includes the proposed 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

[27] These figures represent 3.0 standard deviations from the mean of the log distribution of CCRs for all hospitals.

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 proposed changes from the FY 2008 national average standardized amount. The second and third columns show the proposed changes from the FY 2008 standardized amounts for hospitals that satisfy the quality data submission requirement for receiving the full update (3.0 percent) with the different labor-related shares that apply to hospitals. The fourth and fifth columns show the proposed changes for hospitals receiving the reduced update (1.0 percent) with the different labor-related shares that apply to hospitals. The first row of the table shows the updated (through FY 2008) average standardized amount after restoring the FY 2008 offsets for outlier payments, demonstration budget neutrality, the New Jersey imputed floor budget neutrality, and the geographic reclassification budget neutrality. The DRG reclassification and recalibration and wage index budget neutrality factor is cumulative. Therefore, the FY 2008 factor is not removed from this table. Also, in order to properly apply the documentation and coding adjustment, it was necessary to first remove the FY 2008 adjustment from the FY 2008 rate in the first row of the table and then later in the table to cumulatively apply the sum of the FY 2008 and FY 2009 adjustments (that is, 1 − (.006 + .009)) to the FY 2009 rate. (For a complete discussion on the documentation and coding adjustment, we refer readers to section II.D of the preamble to this proposed rule.)

COMPARISON OF FY 2008 STANDARDIZED AMOUNTS TO THE PROPOSED FY 2009 SINGLE STANDARDIZED AMOUNT WITH FULL UPDATE AND REDUCED UPDATE

	Full update (3.0 percent); wage index is greater than 1.0000	Full update (3.0 percent); wage index is less than 1.0000	Reduced update (1.0 percent); wage index is greater than 1.0000	Reduced update (1.0 percent); wage index is less than 1.0000
FY 2008 Base Rate, after removing geographic reclassification budget neutrality, demonstration budget neutrality, documentation and coding adjustment, NJ imputed floor budget neutrality and outlier offset (based on the labor and market share percentage for FY 2009).	Labor: $3,723.07 ..... Nonlabor: $1,618.50 ..	Labor: $3,311.77 ..... Nonlabor: $2,029.80 ..	Labor: $3,723.07 ..... Nonlabor: $1,618.50 ..	Labor: $3,311.77 Nonlabor: $2,029.80
FY 2009 Update Factor	1.030	1.030	1.010	1.010
FY 2009 DRG Recalibrations and Wage Index Budget Neutrality Factor.	0.999525	0.999525	0.999525	0.999525
FY 2009 Reclassification Budget Neutrality Factor.	0.992333	0.992333	0.992333	0.992333
FY 2009 Outlier Factor	0.948928	0.948928	0.948928	0.948928
Rural Demonstration Budget Neutrality Factor.	0.999666	0.999666	0.999666	0.999666
FY 2009 Documentation and Coding Adjustment and Actual FY 2008 Adjustment.	0.985	0.985	0.985	0.985
Proposed Rate for FY 2009	Labor: $3,553.98 ..... Nonlabor: $1,544.98 ..	Labor: $3,161.36 ..... Nonlabor: $1,937.60 ..	Labor: $3,484.97 ..... Nonlabor: $1,514.98 ..	Labor: $3,099.97 Nonlabor: $1,899.98

Under section 1886(d)(9)(A)(ii) of the Act, the Federal portion of the Puerto Rico payment rate is based on the national average standardized amounts. 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 this Addendum. 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. Proposed Adjustments for Area Wage Levels and Cost-of-Living

Tables 1A through 1C, as set forth in this Addendum, contain the proposed labor-related and nonlabor-related shares that we are using to calculate the proposed prospective payment rates for hospitals located in the 50 States, the District of Columbia, and Puerto Rico for FY 2009. This section addresses two types of adjustments to the standardized amounts that were made in determining the prospective payment rates as described in this Addendum.

1. Proposed 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 proposed rule, we discuss the data and methodology for the FY 2009 wage index.

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

Section 1886(d)(5)(H) of the Act authorizes the Secretary to make an adjustment to take into account the unique circumstances of hospitals in Alaska and Hawaii. Higher labor-related costs for these two States are taken into account in the adjustment for area wages described above. For FY 2009, we are proposing to adjust 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

TABLE OF COST-OF-LIVING ADJUSTMENT FACTORS: ALASKA AND HAWAII HOSPITALS—Continued

Area	Cost of living adjustment factor
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. Proposed MS–DRG Relative Weights

As discussed in section II.H. of the preamble of this proposed rule, we have developed proposed relative weights for each MS–DRG that reflect the resource utilization of cases in each MS–DRG relative to Medicare cases in other MS–DRGs. Table 5 of this Addendum contains the proposed relative weights that we will apply to discharges occurring in FY 2009. These factors have been recalibrated as explained in section II. of the preamble of this proposed rule.

D. Calculation of the Proposed Prospective Payment Rates

General Formula for Calculation of the Proposed Prospective Payment Rates for FY 2009

In general, the operating prospective payment rate for all hospitals paid under the IPPS located outside of Puerto Rico, except SCHs and MDHs, for FY 2009 equals the Federal rate.

The prospective payment rate for SCHs for FY 2009 equals the higher of the applicable Federal rate, or the hospital-specific rate as described below. The prospective payment rate for MDHs for FY 2009 equals the higher of the Federal rate, or the Federal rate plus 75 percent of the difference between the Federal rate and the hospital-specific rate as described below. The prospective payment rate for hospitals located in Puerto Rico for FY 2009 equals 25 percent of the Puerto Rico rate plus 75 percent of the applicable national rate.

1. Federal Rate

The Federal rate is determined as follows:

Step 1—Select the applicable average standardized amount depending on whether the hospital submitted qualifying quality data (full update for qualifying hospitals, update minus 2.0 percentage points for nonqualifying hospitals).

Step 2—Multiply the labor-related portion of the standardized amount by the applicable wage index for the geographic area in which the hospital is located or the area to which the hospital is reclassified.

Step 3—For hospitals in Alaska and Hawaii, multiply the nonlabor-related portion of the standardized amount by the applicable cost-of-living adjustment factor.

Step 4—Add the amount from Step 2 and the nonlabor-related portion of the standardized amount (adjusted, if applicable, under Step 3).

Step 5—Multiply the final amount from Step 4 by the relative weight corresponding to the applicable MS–DRG (see Table 5 of this Addendum).

The Federal rate as determined in Step 5 is then further adjusted if the hospital qualifies for either the IME or DSH adjustment. In addition, for hospitals that qualify for a low-volume payment adjustment under section 1886(d)(12) of the Act and 42 CFR 412.101(b), the payment in Step 5 is increased by 25 percent.

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

a. Calculation of Hospital-Specific Rate

Section 1886(b)(3)(C) of the Act provides that 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 III. of this Addendum. The resulting rate will be used in determining the payment rate an SCH or MDH will receive for its discharges beginning on or after October 1, 2007.

b. Updating the FY 1982, FY 1987, FY 1996, and FY 2002 Hospital-Specific Rates for FY 2009

We are proposing to increase the hospital-specific rates by 3.0 percent (the proposed estimated hospital market basket percentage increase) for FY 2009 for those SCHs and MDHs that submit qualifying quality data and by 1.0 percent for SCHs and MDHs that fail to submit qualifying quality data. Section 1886(b)(3)(C)(iv) of the Act provides that the update factor applicable to the hospital-specific rates for SCHs is equal to the update factor provided under section 1886(b)(3)(B)(iv) of the Act, which, for SCHs in FY 2008, is the market basket rate-of-increase for hospitals that submit qualifying quality data and the market basket rate-of-increase minus 2 percent for hospitals that fail to submit qualifying quality data. Section 1886(b)(3)(D) of the Act provides that the update factor applicable to the hospital-specific rates for MDHs also equals the update factor provided for under section 1886(b)(3)(B)(iv) of the Act, which, for FY 2009, is the market basket rate-of-increase for hospitals that submit qualifying quality data and the market basket rate-of-increase minus 2 percent for hospitals that fail to submit qualifying quality data.

3. General Formula for Calculation of Proposed Prospective Payment Rates for Hospitals Located in Puerto Rico Beginning On or After October 1, 2008, and Before October 1, 2009

Section 1886(d)(9)(E)(iv) of the Act provides that, effective for discharges occurring on or after October 1, 2004, hospitals located in Puerto Rico are paid based on a blend of 75 percent of the national prospective payment rate and 25 percent of the Puerto Rico-specific rate.

a. Puerto Rico Rate

The Puerto Rico prospective payment rate is determined as follows:

Step 1—Select the applicable average standardized amount considering the applicable wage index (Table 1C of this Addendum).

Step 2—Multiply the labor-related portion of the standardized amount by the applicable Puerto Rico-specific wage index.

Step 3—Add the amount from Step 2 and the nonlabor-related portion of the standardized amount.

Step 4—Multiply the amount from Step 3 by the applicable MS–DRG relative weight (Table 5 of this Addendum).

Step 5—Multiply the result in Step 4 by 25 percent.

b. National Rate

The national prospective payment rate is determined as follows:

Step 1—Select the applicable average standardized amount.

Step 2—Multiply the labor-related portion of the standardized amount by the applicable wage index for the geographic area in which the hospital is located or the area to which the hospital is reclassified.

Step 3—Add the amount from Step 2 and the nonlabor-related portion of the national average standardized amount.

Step 4—Multiply the amount from Step 3 by the applicable MS–DRG relative weight (Table 5 of this Addendum).

Step 5—Multiply the result in Step 4 by 75 percent.

The sum of the Puerto Rico rate and the national rate computed above equals the prospective payment for a given discharge for a hospital located in Puerto Rico. This rate is then further adjusted if the hospital qualifies for either the IME or DSH adjustment.

III. Proposed Changes to Payment Rates for Acute Care Hospital Inpatient Capital-Related Costs for FY 2009

The PPS for acute care hospital inpatient capital-related costs was implemented for cost reporting periods beginning on or after October 1, 1991. Effective with that cost reporting period, hospitals were paid during a 10-year transition period (which extended through FY 2001) to change the payment methodology for Medicare acute care hospital inpatient capital-related costs from a reasonable cost-based methodology to a prospective methodology (based fully on the Federal rate).

The basic methodology for determining Federal capital prospective rates is set forth in the regulations at 42 CFR 412.308 through 412.352. Below we discuss the factors that we are proposing to use to determine the capital Federal rate for FY 2009, which would be effective for discharges occurring on or after October 1, 2008.

The 10-year transition period ended with hospital cost reporting periods beginning on or after October 1, 2001 (FY 2002). Therefore, for cost reporting periods beginning in FY 2002, all hospitals (except ''new'' hospitals under § 412.304(c)(2)) are paid based on the capital Federal rate. For FY 1992, we computed the standard Federal payment rate for capital-related costs under the IPPS by updating the FY 1989 Medicare inpatient capital cost per case by an actuarial estimate of the increase in Medicare inpatient capital costs per case. Each year after FY 1992, we update the capital standard Federal rate, as provided at § 412.308(c)(1), to account for capital input price increases and other factors. The regulations at § 412.308(c)(2) provide that the capital Federal rate be adjusted annually by a factor equal to the estimated proportion of outlier payments under the capital Federal rate to total capital payments under the capital Federal rate. In addition, § 412.308(c)(3) requires that the capital Federal rate be reduced by an adjustment factor equal to the estimated proportion of payments for (regular and special) exceptions under § 412.348. Section 412.308(c)(4)(ii) requires that the capital standard Federal rate be adjusted so that the effects of the annual DRG reclassification and the recalibration of DRG weights and changes in the geographic adjustment factor (GAF) are budget neutral.

For FYs 1992 through 1995, § 412.352 required that the capital Federal rate also be adjusted by a budget neutrality factor so that aggregate payments for inpatient hospital capital costs were projected to equal 90 percent of the payments that would have been made for capital-related costs on a reasonable cost basis during the respective fiscal year. That provision expired in FY 1996. Section 412.308(b)(2) describes the 7.4 percent reduction to the capital Federal rate that was made in FY 1994, and § 412.308(b)(3) describes the 0.28 percent reduction to the capital Federal rate made in FY 1996 as a result of the revised policy for paying for transfers. In FY 1998, we implemented section 4402 of 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), the 2.1 percent reduction was restored to the unadjusted capital payment rates effective October 1, 2002.

To determine the appropriate budget neutrality adjustment factor and the regular exceptions payment adjustment during the 10-year transition period, we developed a dynamic model of Medicare inpatient capital-related costs; that is, a model that projected changes in Medicare inpatient capital-related costs over time. With the expiration of the budget neutrality provision, the capital cost model was only used to estimate the regular exceptions payment adjustment and other factors during the transition period. As we explained in the FY 2002 IPPS final rule (66 FR 39911), beginning in FY 2002, an adjustment for regular exception payments is no longer necessary because regular exception payments were only made for cost reporting periods beginning on or after October 1, 1991, and before October 1, 2001 (see § 412.348(b)). Because payments are no longer made under the regular exception policy effective with cost reporting periods beginning in FY 2002, we discontinued use of the capital cost model. The capital cost model and its application during the transition period are described in Appendix B of the FY 2002 IPPS final rule (66 FR 40099).

Section 412.374 provides for 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 is equal to 75 percent and the Puerto Rico portion of operating IPPS payments is equal to 25 percent for discharges occurring on or after October 1, 2004. Consistent with that change in operating IPPS payments to hospitals 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 Proposed Federal Hospital Inpatient Capital-Related Prospective Payment Rate Update

In the FY 2008 IPPS final rule with comment period (72 FR 66886 through 66888), we established a capital Federal rate

of $426.14 for FY 2008. In the discussion that follows, we explain the factors that we are proposing to use to determine the proposed FY 2009 capital Federal rate. In particular, we explain why the proposed FY 2009 capital Federal rate would decrease approximately 1.14 percent, compared to the FY 2008 capital Federal rate. However, taking into account an estimated increase in Medicare fee-for-service discharges in FY 2009 as compared to FY 2008, as well as the estimated increase in payments due to documentation and coding (discussed in section VIII. of Appendix A to this proposed rule), we estimate that the increase in aggregate capital payments would be negligible during this same period (approximately $6 million). Total payments to hospitals under the IPPS are relatively unaffected by changes in the capital prospective payments. Because capital payments constitute about 10 percent of hospital payments, a 1-percent change in the capital Federal rate yields only about a 0.1 percent change in actual payments to hospitals. As noted above, aggregate payments under the capital IPPS are projected to increase in FY 2009 compared to FY 2008.

1. Projected Capital Standard Federal Rate Update

a. Description of the Update Framework

Under § 412.308(c)(1), the capital standard Federal rate is updated on the basis of an analytical framework that takes into account changes in a capital input price index (CIPI) and several other policy adjustment factors. Specifically, we have adjusted the projected CIPI rate-of-increase as appropriate each year for case-mix index-related changes, for intensity, and for errors in previous CIPI forecasts. The proposed update factor for FY 2009 under that framework is 0.7 percent based on the best data available at this time. The proposed update factor under that framework is based on a projected 1.2 percent increase in the CIPI, a 0.0 percent adjustment for intensity, a 0.0 percent adjustment for case-mix, a −0.5 percent adjustment for the FY 2007 DRG reclassification and recalibration, and a forecast error correction of 0.0 percent. As discussed below in section III.C. of the Addendum to this proposed rule, we continue to believe that the CIPI is the most appropriate input price index for capital costs to measure capital price changes in a given year. We also explain the basis for the FY 2009 CIPI projection in that same section of this Addendum. In addition, as also noted below, the proposed capital rates would be further adjusted to account for documentation and coding improvements under the MS–DRGs discussed in section II.D. of the preamble of this proposed rule. Below we describe the policy adjustments that we are proposing to apply in the update framework for FY 2009.

The case-mix index is the measure of the average MS–DRG weight for cases paid under the IPPS. Because the MS–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 MS–DRG assignments (''coding effects''); and
- The annual MS–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 MS-DRGs but do not reflect higher resource requirements. The capital update framework includes the same case-mix index adjustment used in the former operating IPPS update framework (as discussed in the May 18, 2004 IPPS proposed rule for FY 2005 (69 FR 28816)). (We no longer use an update framework to make a recommendation for updating the operating IPPS standardized amounts as discussed in section II. of Appendix B in the FY 2006 IPPS final rule (70 FR 47707).)

Absent the projected increase in case-mix resulting from documentation and coding improvements under the recently adopted MS-DRGs, for FY 2009, we are projecting a 1.0 percent total increase in the case-mix index. We estimate that the real case-mix increase will also equal 1.0 percent for FY 2009. The net adjustment for change in case-mix is the difference between the projected real increase in case-mix and the projected total increase in case-mix. Therefore, the net adjustment for case-mix change in FY 2009 is 0.0 percentage points.

The capital update framework also contains an adjustment for the effects of DRG reclassification and recalibration. This adjustment is intended to remove the effect on total payments of prior year's changes to the DRG classifications and relative weights, in order to retain budget neutrality for all case-mix index-related changes other than those due to patient severity. Due to the lag time in the availability of data, there is a 2-year lag in data used to determine the adjustment for the effects of DRG reclassification and recalibration. For example, we are adjusting for the effects of the FY 2007 DRG reclassification and recalibration as part of our proposed update for FY 2009. We estimate that FY 2007 DRG reclassification and recalibration resulted in a 0.5 percent change in the case-mix when compared with the case-mix index that would have resulted if we had not made the reclassification and recalibration changes to the DRGs. Therefore, we are proposing to make a −0.5 percent adjustment for DRG reclassification in the proposed update for FY 2009 to maintain budget neutrality.

The capital update framework also contains an adjustment for forecast error. The input price index forecast is based on historical trends and relationships ascertainable at the time the update factor is established for the upcoming year. In any given year, there may be unanticipated price fluctuations that may result in differences between the actual increase in prices and the forecast used in calculating the update factors. In setting a prospective payment rate under the framework, we make an adjustment for forecast error only if our estimate of the change in the capital input price index for any year is off by 0.25 percentage points or more. There is a 2-year lag between the forecast and the availability of data to develop a measurement of the forecast error. A forecast error of 0.10 percentage point was calculated for the FY 2007 update. That is, current historical data indicate that the forecasted FY 2007 CIPI (1.1 percent) used in calculating the FY 2007 update factor slightly understated the actual realized price increases (1.2 percent) by 0.10 percentage point. This slight underprediction was mostly due to the incorporation of newly available source data for fixed asset prices and moveable asset prices into the market basket. However, because this estimation of the change in the CIPI is less than 0.25 percentage points, it is not reflected in the update recommended under this framework. Therefore, we are proposing to make a 0.0 percent adjustment for forecast error in the update for FY 2009.

Under the capital IPPS update framework, we also make an adjustment for changes in intensity. We calculate this adjustment using the same methodology and data that were used in the past under the framework for operating IPPS. The intensity factor for the operating update framework reflects how hospital services are utilized to produce the final product, that is, the discharge. This component accounts for changes in the use of quality-enhancing services, for changes within DRG severity, and for expected modification of practice patterns to remove noncost-effective services.

We calculate case-mix constant intensity as the change in total charges per admission, adjusted for price level changes (the CPI for hospital and related services) and changes in real case-mix. The use of total charges in the calculation of the intensity factor makes it a total intensity factor; that is, charges for capital services are already built into the calculation of the factor. Therefore, we have incorporated the intensity adjustment from the operating update framework into the capital update framework. Without reliable estimates of the proportions of the overall annual intensity increases that are due, respectively, to ineffective practice patterns and the combination of quality-enhancing new technologies and complexity within the DRG system, we assume that one-half of the annual increase is due to each of these factors. The capital update framework thus provides an add-on to the input price index rate of increase of one-half of the estimated annual increase in intensity, to allow for increases within DRG severity and the adoption of quality-enhancing technology.

We have developed a Medicare-specific intensity measure based on a 5-year average. Past studies of case-mix change by the RAND Corporation (*Has DRG Creep Crept Up? Decomposing the Case Mix Index Change Between 1987 and 1988* by G. M. Carter, J. P. Newhouse, and D. A. Relles, R–4098–HCFA/ProPAC (1991)) suggest that real case-mix change was not dependent on total change, but was usually a fairly steady increase of 1.0 to 1.5 percent per year.

However, we used 1.4 percent as the upper bound because the RAND study did not take into account that hospitals may have induced doctors to document medical records more completely in order to improve payment.

We calculate case-mix constant intensity as the change in total charges per admission, adjusted for price level changes (the CPI for hospital and related services), and changes in real case-mix. As we noted above, in accordance with § 412.308(c)(1)(ii), we began updating the capital standard Federal rate in FY 1996 using an update framework that takes into account, among other things, allowable changes in the intensity of hospital services. For FYs 1996 through 2001, we found that case-mix constant intensity was declining, and we established a 0.0 percent adjustment for intensity in each of those years. For FYs 2002 and 2003, we found that case-mix constant intensity was increasing, and we established a 0.3 percent adjustment and 1.0 percent adjustment for intensity, respectively. For FYs 2004 and 2005, we found that the charge data appeared to be skewed (as discussed in greater detail below), and we established a 0.0 percent adjustment in each of those years. Furthermore, we stated that we would continue to apply a 0.0 percent adjustment for intensity until any increase in charges can be tied to intensity rather than attempts to maximize outlier payments.

As noted above, our intensity measure is based on a 5-year average, and therefore, the intensity adjustment for FY 2009 is based on data from the 5-year period beginning with FY 2003 and extending through FY 2007. There continues to be a substantial increase in hospital charges for three of those 5 years without a corresponding increase in the hospital case-mix index. Most dramatically, for FY 2003, the change in hospitals' charges is over 16 percent, which is reflective of the large increases in charges that we found in the 4 years prior to FY 2003 and before our revisions to the outlier policy in 2003 (discussed below). For FY 2004 and FY 2005, the change in hospitals' charges is somewhat lower in comparison to FY 2003, but is still significantly large. For FY 2006 and FY 2007, the change in hospitals' charges appears to be slightly moderating. However, the change in hospitals' charges for FYs 2003 and 2004 and to a somewhat lesser extent FY 2005 remains similar to the considerable increase in hospitals' charges that we found when examining hospitals' charge data in determining the intensity factor in the update recommendations for the past few years, as discussed in the FY 2004 IPPS final rule (68 FR 45482), the FY 2005 IPPS final rule (69 FR 49285), the FY 2006 IPPS final rule (70 FR 47500), the FY 2007 IPPS final rule (72 FR 47500), and the FY 2008 IPPS final rule with comment period (72 FR 47426). If hospitals were treating new or different types of cases, which would result in an appropriate increase in charges per discharge, then we would expect hospitals' case-mix to increase proportionally. As we discussed most recently in the FY 2008 IPPS final rule with comment period (72 FR 47426), because our intensity calculation relies heavily upon charge data and we believe that these charge data may be inappropriately skewed, we established a 0.0 percent adjustment for intensity for FY 2008 just as we did for FYs 2004 through 2007.

On June 9, 2003, we published in the **Federal Register** revisions to our outlier policy for determining the additional payment for extraordinarily high-cost cases (68 FR 34494 through 34515). These revised policies were effective on August 8, 2003, and October 1, 2003. While it does appear that a response to these policy changes is beginning to occur, that is, the increase in charges for FYs 2004 and 2005 are somewhat less than the previous 4 years, they still show a significant annual increase in charges without a corresponding increase in hospital case-mix. Specifically, the increases in charges in FY 2004 and FY 2005 (approximately 12 percent and 8 percent, respectively), for example, which, while less than the increase in the previous 3 years, are still much higher than increases in years prior to FY 2001. In addition, these increases in charges for FYs 2003, FY 2004, and FY 2005 significantly exceed the respective case-mix increases for the same period. Based on the significant increases in charges for FYs 2003 through 2005 that remain in the 5-year average used for the intensity adjustment, we believe residual effects of hospitals' charge practices prior to the implementation of the outlier policy revisions established in the June 9, 2003 final rule continue to appear in the data, because it may have taken hospitals some time to adopt changes in their behavior in response to the new outlier policy. Thus, we believe that the FY 2003, FY 2004, FY 2005 charge data may still be skewed. Although it appears that the change in hospitals' charges is more reasonable because the intensity adjustment is based on a 5-year average, and although the new outlier policy was generally effective in FY 2004, we believe the effects of hospitals attempting to maximize outlier payments, while lessening costs, continue to skew the charge data.

Therefore, we are proposing to make a 0.0 percent adjustment for intensity for FY 2009. In the past (FYs 1996 through 2001) when we found intensity to be declining, we believed a zero (rather than negative) intensity adjustment was appropriate. Similarly, we believe that it is appropriate to apply a zero intensity adjustment for FY 2009 until any increase in charges during the 5-year period upon which the intensity adjustment is based can be tied to intensity rather than to attempts to maximize outlier payments.

Above, we described the basis of the components used to develop the proposed 0.7 percent capital update factor for all hospitals under the capital update framework for FY 2009 as shown in the table below.

CMS PROPOSED FY 2009 UPDATE FACTOR TO THE CAPITAL FEDERAL RATE

Capital Input Price Index	1.2
Intensity	0.0
Case-Mix Adjustment Factors:	
Real Across DRG Change	−1.0
Projected Case-Mix Change	1.0
Subtotal	1.2
Effect of FY 2007 Reclassification and Recalibration	−0.5
Forecast Error Correction	0.0
Total Update for Hospitals	0.7

b. Comparison of CMS and MedPAC Update Recommendation

In its March 2008 Report to Congress, MedPAC did not make a specific update recommendation for capital IPPS payments for FY 2009. However, in that same report, in assessing the adequacy of current payments and costs, MedPAC recommended an update to the hospital inpatient and outpatient PPS rates equal to the increase in the hospital market basket in FY 2009, concurrent with a quality incentive program. (MedPAC's Report to the Congress: Medicare Payment Policy, March 2008, Section 2A.)

2. Proposed 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.

In the FY 2008 IPPS final rule with comment (72 FR 66887), we estimated that outlier payments for capital would equal 4.77 percent of inpatient capital-related payments based on the capital Federal rate in FY 2008. Based on the proposed thresholds as set forth

in section II.A. of this Addendum, we estimate that proposed outlier payments for capital-related costs would equal 5.73 percent for inpatient capital-related payments based on the proposed capital Federal rate in FY 2009. Therefore, we are proposing to apply an outlier adjustment factor of 0.9427 to the capital Federal rate. Thus, we estimate that the percentage of capital outlier payments to total capital standard payments for FY 2009 will be higher than the percentages for FY 2008. This increase is primarily due to the proposed decrease to the fixed-loss amount, which is discussed section II.A. of this Addendum.

The outlier reduction factors are not built permanently into the capital rates; that is, they are not applied cumulatively in determining the capital Federal rate. The proposed FY 2009 outlier adjustment of 0.9427 is a −1.01percent change from the FY 2008 outlier adjustment of 0.9523. Therefore, the net change in the proposed outlier adjustment to the capital Federal rate for FY 2009 is 0.9899 (0.9427/0.9523). Thus, the proposed outlier adjustment decreases the FY 2009 capital Federal rate by 1.01 percent compared with the FY 2008 outlier adjustment.

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

Section 412.308(c)(4)(ii) requires that the capital Federal rate be adjusted so that aggregate payments for the fiscal year based on the capital Federal rate after any changes resulting from the annual DRG reclassification and recalibration and changes in the GAF are projected to equal aggregate payments that would have been made on the basis of the capital Federal rate without such changes. Because we implemented a separate GAF for Puerto Rico, we apply separate budget neutrality adjustments for the national GAF and the Puerto Rico GAF. We apply the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. Separate adjustments were unnecessary for FY 1998 and earlier because the GAF for Puerto Rico was implemented in FY 1998.

In the past, we used the actuarial capital cost model (described in Appendix B of the FY 2002 IPPS final rule (66 FR 40099)) to estimate the aggregate payments that would have been made on the basis of the capital Federal rate with and without changes in the DRG classifications and weights and in the GAF to compute the adjustment required to maintain budget neutrality for changes in DRG weights and in the GAF. During the transition period, the capital cost model was also used to estimate the regular exception payment adjustment factor. As we explain in section III.A. of this Addendum, beginning in FY 2002, an adjustment for regular exception payments is no longer necessary. Therefore, we will no longer use the capital cost model. Instead, we are using historical data based on hospitals' actual cost experiences to determine the exceptions payment adjustment factor for special exceptions payments.

To determine the proposed factors for FY 2009, we compared (separately for the national capital rate and the Puerto Rico capital rate) estimated aggregate capital Federal rate payments based on the FY 2008 DRG relative weights and the FY 2008 GAF to estimated aggregate capital Federal rate payments based on the proposed FY 2009 relative weights and the proposed FY 2009 GAFs. We established the final FY 2008 budget neutrality factors of 0.9902 for the national capital rate and 0.9955 for the Puerto Rico capital rate. In making the comparison, we set the exceptions reduction factor to 1.00. To achieve budget neutrality for the changes in the national GAFs, based on calculations using updated data, we are proposing to apply an incremental budget neutrality adjustment of 1.0013 for FY 2009 to the previous cumulative FY 2008 adjustments of 0.9902, yielding a proposed adjustment of 0.9915, through FY 2009. For the Puerto Rico GAFs, we are proposing to apply a proposed incremental budget neutrality adjustment of 1.0009 for FY 2009 to the previous cumulative FY 2008 adjustment of 0.9955, yielding a proposed cumulative adjustment of 0.9965 (calculated with unrounded numbers) through FY 2009.

We then compared estimated aggregate capital Federal rate payments based on the FY 2008 DRG relative weights and the proposed FY 2009 GAFs to estimated aggregate capital Federal rate payments based on the cumulative effects of the proposed FY 2009 DRG relative weights and the proposed FY 2009 GAFs. The proposed incremental adjustment for proposed DRG classifications and proposed changes in relative weights is 0.9994 both nationally and for Puerto Rico. The proposed cumulative adjustments for DRG classifications and changes in relative weights and for proposed changes in the GAFs through FY 2009 are 0.9909 nationally and 0.9959 for Puerto Rico. The following table summarizes the adjustment factors for each fiscal year:

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BUDGET NEUTRALITY ADJUSTMENT FOR DRG RECLASSIFICATIONS AND RECALIBRATION AND THE GEOGRAPHIC ADJUSTMENT FACTORS

Fiscal Year	National				Puerto Rico			
	Incremental Adjustment			Cumulative	Incremental Adjustment			Cumulative
	Geographic Adjustment Factor	DRG Reclassifications and Recalibration	Combined		Geographic Adjustment Factor	DRG Reclassifications and Recalibration	Combined	
1992	---	---	---	1.00000	---	---	---	---
1993	---	---	0.99800	0.99800	---	---	---	---
1994	---	---	1.00531	1.00330	---	---	---	---
1995	---	---	0.99980	1.00310	---	---	---	---
1996	---	---	0.99940	1.00250	---	---	---	—
1997	---	---	0.99873	1.00123	---	---	---	---
1998	---	---	0.99892	1.00015	---	---	---	1.00000
1999	0.99944	1.00335	1.00279	1.00294	0.99898	1.00335	1.00233	1.00233
2000	0.99857	0.99991	0.99848	1.00142	0.99910	0.99991	0.99901	1.00134
2001[1]	0.99782	1.00009	0.99791	0.99933	1.00365	1.00009	1.00374	1.00508
2001[2]	0.99771[3]	1.00009[3]	0.99780[3]	0.99922	1.00365[3]	1.00009[3]	1.00374[3]	1.00508
2002	0.99666[4]	0.99668[4]	0.99335[4]	0.99268	0.98991[4]	0.99668[4]	0.99662[4]	0.99164
2003[5]	0.99915	0.99662	0.99577	0.98848	1.00809	0.99662	1.00468	0.99628
2003[6]	0.99896[7]	0.99662[7]	0.99558[7]	0.98830	1.00809	0.99662	1.00468	0.99628
2004[8]	1.00175[9]	1.00081[9]	1.00256[9]	0.99083	1.00028	1.00081	1.00109	0.99736
2004[10]	1.00164[9]	1.00081[9]	1.00245[9]	0.99072	1.00028	1.00081	1.00109	0.99736
2005[11]	0.99967[12]	1.00094	1.00061[12]	0.99137	0.99115	1.00094	0.99208	0.98946
2005[13]	0.99946[12]	1.00094	1.00040[12]	0.99117	0.99115	1.00094	0.99208	0.98946
2006	1.00185[14]	0.99892	1.00076[14]	0.99198	1.00762	0.99892	1.00653	0.99592
2007	1.00000	0.99858	0.99858	0.99057	1.00234	0.99858	1.00092	0.99683
2008	1.00172	0.99792	0.99963	0.99021	1.00079	0.99792	0.99870	0.99554
2009	1.00131	0.99942	1.00073	0.99093	1.00094	0.99942	1.00036	0.99590

[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.

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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 or indirect medical education payments.

In the FY 2008 IPPS correction notice (72 FR 57636), we calculated a GAF/DRG budget neutrality factor of 0.9996 for FY 2008. For FY 2009, we are proposing to establish a GAF/DRG budget neutrality factor of 1.0007. The GAF/DRG budget neutrality factors are

built permanently into the capital rates; that is, they are applied cumulatively in determining the capital Federal rate. This follows the requirement that estimated aggregate payments each year be no more or less than they would have been in the absence of the annual DRG reclassification and recalibration and changes in the GAFs. The incremental change in the proposed adjustment from FY 2008 to FY 2009 is 1.0007. The cumulative change in the proposed capital Federal rate due to this proposed adjustment is 0.9909 (the product of the incremental factors for FYs 1994 though 2008 and the proposed incremental factor of 1.0007 for FY 2009). (We note that averages of the incremental factors that were in effect during FYs 2004 and 2005, respectively, were used in the calculation of the proposed cumulative adjustment of 0.9909 for FY 2009.)

The proposed factor accounts for DRG reclassifications and recalibration and for changes in the GAFs. It also incorporates the effects on the proposed GAFs of FY 2009 geographic reclassification decisions made by the MGCRB compared to FY 2008 decisions. However, it does not account for changes in payments due to changes in the DSH and IME adjustment factors.

4. Exceptions Payment Adjustment Factor

Section 412.308(c)(3) of our regulations requires that the capital standard Federal rate be reduced by an adjustment factor equal to the estimated proportion of additional payments for both regular exceptions and special exceptions under § 412.348 relative to total capital PPS payments. In estimating the proportion of regular exception payments to total capital PPS payments during the transition period, we used the actuarial capital cost model originally developed for determining budget neutrality (described in Appendix B of the FY 2002 IPPS final rule (66 FR 40099)) to determine the exceptions payment adjustment factor, which was applied to both the Federal and hospital-specific capital rates.

An adjustment for regular exception payments is no longer necessary in determining the FY 2009 capital Federal rate because, in accordance with § 412.348(b), regular exception payments were only made for cost reporting periods beginning on or after October 1, 1991 and before October 1, 2001. Accordingly, as we explained in the FY 2002 IPPS final rule (66 FR 39949), in FY 2002 and subsequent fiscal years, no payments are made under the regular exceptions provision. However, in accordance with § 412.308(c), we still need to compute a budget neutrality adjustment for special exception payments under § 412.348(g). We describe our methodology for determining the exceptions adjustment used in calculating the FY 2008 capital Federal rate below.

Under the special exceptions provision specified at § 412.348(g)(1), eligible hospitals include SCHs, urban hospitals with at least 100 beds that have a disproportionate share percentage of at least 20.2 percent or qualify for DSH payments under § 412.106(c)(2), and hospitals with a combined Medicare and Medicaid inpatient utilization of at least 70 percent. An eligible hospital may receive special exceptions payments if it meets the following criteria: (1) A project need requirement as described at § 412.348(g)(2), which, in the case of certain urban hospitals, includes an excess capacity test as described at § 412.348(g)(4); (2) an age of assets test as described at § 412.348(g)(3); and (3) a project size requirement as described at § 412.348(g)(5).

Based on information compiled from our fiscal intermediaries, six hospitals have qualified for special exceptions payments under § 412.348(g). Because we have cost reports ending in FY 2005 for all of these hospitals, we calculated the adjustment based on actual cost experience. Using data from cost reports ending in FY 2005 from the December 2007 update of the HCRIS data, we divided the capital special exceptions payment amounts for the six hospitals that qualified for special exceptions by the total capital PPS payment amounts (including special exception payments) for all hospitals. Based on the data from cost reports ending in FY 2005, this ratio is rounded to 0.0002. We also computed the ratios for FY 2004 and FY 2003, which both round to 0.0003. Since the ratios are trending downward, we are proposing an adjustment of 0.0002. Because special exceptions are budget neutral, we are proposing to offset the proposed capital Federal rate by 0.02 percent for special exceptions payments for FY 2009. Therefore, the proposed exceptions adjustment factor is equal to 0.9998 (1 − 0.0002) to account for special exceptions payments in FY 2009.

In the FY 2008 IPPS final rule with comment period (72 FR 47430), we estimated that total (special) exceptions payments for FY 2008 would equal 0.03 percent of aggregate payments based on the capital Federal rate. Therefore, we applied an exceptions adjustment factor of 0.9997 (1 − 0.0003) to determine the FY 2008 capital Federal rate. As we stated above, we estimate that exceptions payments in FY 2009 would equal 0.02 percent of aggregate payments based on the proposed FY 2009 capital Federal rate. Therefore, we are proposing to apply an exceptions payment adjustment factor of 0.9998 to the proposed capital Federal rate for FY 2009. The proposed exceptions adjustment factor for FY 2009 is slightly lower than the factor used in determining the FY 2008 capital Federal rate in the FY 2008 IPPS final rule. The exceptions reduction factors are not built permanently into the capital rates; that is, the factors are not applied cumulatively in determining the capital Federal rate. Therefore, the net change in the proposed exceptions adjustment factor used in determining the proposed FY 2009 capital Federal rate is 1.0001 (0.9998/0.9997).

5. Proposed Capital Standard Federal Rate for FY 2009

In the FY 2008 IPPS final rule with comment period (72 FR 66888), we established a capital Federal rate of $426.14 for all hospitals for FY 2008. We are proposing to establish an update of 0.7 percent in determining the proposed FY 2009 capital Federal rate for all hospitals. However, under the statutory authority at section 1886(d)(3)(A)(vi) of the Act, and as specified in section 7 of Pub. L. 110–90, we are proposing an additional 0.9 percent reduction to the proposed standardized amounts for both capital and operating Federal payment rates in FY 2009. The proposed 0.9 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 proposed 0.9 percent reduction is outside the established process for developing the proposed 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 proposed national capital Federal payment rate proposed in this proposed rule was determined by applying the proposed 0.9 percent reduction. (As discussed below in section II.A.6. of this Addendum, we are not proposing to apply the proposed 0.9 percent reduction in developing the proposed FY 2009 Puerto Rico-specific capital rate.) As a result of the proposed 0.70 percent update and other proposed budget neutrality factors discussed above, we are proposing to establish a capital Federal rate of $421.29 for FY 2009. The proposed capital Federal rate for FY 2009 was calculated as follows:

- The proposed FY 2009 update factor is 1.0070, that is, the update is 0.70 percent.
- The proposed FY 2009 budget neutrality adjustment factor that is applied to the capital standard Federal payment rate for changes in the DRG relative weights and in the GAFs is 1.0007.
- The proposed FY 2009 outlier adjustment factor is 0.9427.
- The proposed FY 2009 (special) exceptions payment adjustment factor is 0.9998.
- The proposed FY 2009 reduction for improvements in documentation and coding under the MS–DRGs is 0.9 percent.

Because the proposed 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 proposing to make additional adjustments in the proposed capital standard Federal rate for these factors, other than the budget neutrality factor for changes in the DRG relative weights and the GAFs.

We are providing the following chart that shows how each of the proposed factors and adjustments for FY 2009 affected the computation of the proposed FY 2009 capital Federal rate in comparison to the FY 2008 capital Federal rate. The proposed FY 2009 update factor has the effect of increasing the proposed capital Federal rate by 0.70 percent compared to the FY 2008 capital Federal rate. The proposed GAF/DRG budget neutrality factor has the effect of increasing the proposed capital Federal rate by 0.07 percent. The proposed FY 2009 outlier adjustment factor has the effect of decreasing the proposed capital Federal rate by 1.01 percent compared to the FY 2008 capital Federal rate. The proposed FY 2009 exceptions payment adjustment factor has the effect of increasing the proposed capital Federal rate by 0.01 percent. The proposed adjustment for improvements in documentation and coding

under the MS–DRGs has the effect of decreasing the proposed FY 2009 capital Federal rate by 0.9 percent as compared to the FY 2008 capital Federal rate. The combined effect of all the proposed changes decreases the proposed capital Federal rate by 1.14 percent compared to the FY 2008 capital Federal rate.

COMPARISON OF FACTORS AND ADJUSTMENTS: FY 2008 CAPITAL FEDERAL RATE AND PROPOSED FY 2009 CAPITAL FEDERAL RATE

	FY 2008	Proposed FY 2009 [4]	Change	Percent change [5]
Update Factor [1]	1.0090	1.0070	1.0070	0.70
GAF/DRG Adjustment Factor [1]	0.9996	1.0007	1.0007	0.07
Outlier Adjustment Factor [2]	0.9523	0.9427	0.9899	−1.01
Exceptions Adjustment Factor [2]	0.9997	0.9998	1.0001	0.01
MS–DRG Coding and Documentation Improvements Adjustment Factor [3]	0.9940	0.9910	0.9910	−0.90
Capital Federal Rate	$426.14	$421.29	0.9886	−1.14

[1] The update factor and the GAF/DRG budget neutrality factors are built permanently into the capital rates. Thus, for example, the incremental change from FY 2008 to FY 2009 resulting from the application of the proposed 1.0007 GAF/DRG budget neutrality factor for FY 2009 is 1.0007.

[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 proposed FY 2009 outlier adjustment factor is 0.9427/0.9523, or 0.9899.

[3] Proposed adjustment to FY 2009 IPPS rates to account for documentation and coding improvements expected to result from the adoption of the MS–DRGs, as discussed above in section III.D. of the Addendum to this proposed rule.

[4] Proposed factors for FY 2009, as discussed above in section III. of this Addendum.

[5] Percent change of individual factors may not sum due to rounding.

6. Proposed 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 compute a separate payment rate specific to hospitals located in Puerto Rico using the same methodology used to compute the national Federal rate for capital-related costs. Under the broad authority of section 1886(g) of the Act, as discussed in section V. of the preamble of this proposed rule, beginning with discharges occurring on or after October 1, 2004, capital payments to hospitals located in Puerto Rico are based on a blend of 25 percent of the Puerto Rico capital rate and 75 percent of the capital Federal rate. The Puerto Rico capital rate is derived from the costs of Puerto Rico hospitals only, while the capital Federal rate is derived from the costs of all acute care hospitals participating in the IPPS (including Puerto Rico).

To adjust hospitals' capital payments for geographic variations in capital costs, we apply a GAF to both portions of the blended capital rate. The GAF is calculated using the operating IPPS wage index, and varies depending on the labor market area or rural area in which the hospital is located. We use the Puerto Rico wage index to determine the GAF for the Puerto Rico part of the capital-blended rate and the national wage index to determine the GAF for the national part of the blended capital rate.

Because we implemented a separate GAF for Puerto Rico in FY 1998, we also apply separate budget neutrality adjustments for the national GAF and for the Puerto Rico GAF. However, we apply the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. As we stated above in section III.A.4. of this Addendum, for Puerto Rico, the proposed GAF budget neutrality factor is 1.0009, while the DRG adjustment is 0.9994, for a combined proposed cumulative adjustment of 1.0004.

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 2008, before application of the GAF, the special capital rate for hospitals located in Puerto Rico was $201.67 for discharges occurring on or after October 1, 2007, through September 30, 2008 (72 FR 66888). However, as discussed in greater detail in section II.D. of the preamble of this proposed rule, we are revising this rate in a forthcoming correction notice that will be retroactive to October 1, 2007, to remove the application of the 0.6 percent documentation and coding adjustment for FY 2008, consistent with the correction to the Puerto Rico specific standardized amount for FY 2008. The statute gives broad authority to the Secretary under section 1886(g) of the Act, with respect to the development of and adjustments to a capital PPS. Although we would not be outside the authority of section 1886(g) of the Act in applying the documentation and coding adjustment to the Puerto Rico-specific portion of the capital payment rate, we have historically made changes to the capital PPS consistent with those changes made to the IPPS. Thus, we are removing the documentation and coding adjustment from the FY 2008 Puerto Rico-specific portion of the blended capital payment rate, consistent with its removal from the Puerto Rico-specific standardized amount under the IPPS for operating costs. Furthermore, we are not proposing to apply the 0.9 percent documentation and coding adjustment to the proposed FY 2009 Puerto Rico-specific portion of the blended capital payment. However, as also discussed in section II.D. of the preamble of this proposed rule, we may propose to apply such an adjustment to the Puerto Rico operating and capital rates in the future. With the changes we are proposing to make to the other factors used to determine the capital rate, the proposed FY 2009 special capital rate for hospitals in Puerto Rico is $197.19.

B. Calculation of the Proposed Inpatient Capital-Related Prospective Payments for FY 2009

Because the 10-year capital PPS transition period ended in FY 2001, all hospitals (except ''new'' hospitals under § 412.324(b) and under § 412.304(c)(2)) are paid based on 100 percent of the capital Federal rate in FY 2007. The applicable capital Federal rate was determined by making the following adjustments:

- For outliers, by dividing the capital standard Federal rate by the outlier reduction factor for that fiscal year; and
- For the payment adjustments applicable to the hospital, by multiplying the hospital's GAF, disproportionate share adjustment factor, and IME adjustment factor, when appropriate.

For purposes of calculating payments for each discharge during FY 2009, the capital standard Federal rate would be adjusted as follows: (Standard Federal Rate) × (DRG weight) × (GAF) × (COLA for hospitals located in Alaska and Hawaii) × (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 proposed rule, we eliminated 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 proposed outlier thresholds for FY 2009 are in section II.A. of this Addendum. For FY 2009, a case qualifies as a cost outlier if the cost for the case plus the IME and DSH payments is greater than the prospective payment rate for the DRG plus the proposed fixed-loss amount of $21,025.

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 2009

Based on the latest forecast by Global Insight, Inc. (first quarter of 2008), we are forecasting the CIPI to increase 1.2 percent in FY 2009. This reflects a projected 1.9 percent increase in vintage-weighted depreciation prices (building and fixed equipment, and movable equipment), and a 2.9 percent increase in other capital expense prices in FY 2009, partially offset by 2.8 percent decline in vintage-weighted interest expenses in FY 2009. The weighted average of these three factors produces the 1.2 percent increase for the CIPI as a whole in FY 2009.

IV. Proposed 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 are proposing that the FY 2009 rate-of-increase percentage for cancer and children's hospitals and RNHCIs is the percentage increase in the FY 2009 IPPS operating market basket, estimated to be 3.0 percent. Consistent with our historical approach, if more recent data are available for the final rule, we will use those data to calculate the IPPS operating market basket. For this proposed rule, we are proposing to calculate the IPPS operating market basket for FY 2009 using the most recent data available. For cancer and children's hospitals and RNHCIs, the proposed FY 2009 rate-of-increase percentage that is applied to FY 2008 target amounts in order to calculate the proposed FY 2009 target amounts is based on Global Insight, Inc.'s 2008 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 42 CFR Part 413 (certain providers do not receive a transitioning period or may elect to bypass the transition as applicable under 42 CFR part 412, subparts N, O, and P.) We note that the various transitioning periods provided for under the IRF PPS, the IPF PPS, and the LTCH PPS have ended. For cost reporting periods beginning on or after October 1, 2002, all IRFs are paid 100 percent of the adjusted Federal rate under the IRF PPS. Therefore, for cost reporting periods beginning on or after October 1, 2002, no portion of an IRF PPS payment is subject to 42 CFR part 413. Similarly, for cost reporting periods beginning on or after October 1, 2006, all LTCHs are paid 100 percent of the adjusted Federal prospective payment rate under the LTCH PPS. Therefore, for cost reporting periods beginning on or after October 1, 2006, no portion of the LTCH PPS payment is subject to 42 CFR part 413. Likewise, for cost reporting periods beginning on or after January 1, 2008, all IPFs are paid 100 percent of the Federal per diem amount under the IPF PPS. Therefore, for cost reporting periods beginning on or after January 1, 2008, no portion of an IPF PPS payment is subject to 42 CFR part 413.

V. Tables

This section contains the tables referred to throughout the preamble to this proposed rule and in this Addendum. Tables 1A, 1B, 1C, 1D, 2, 3A, 3B, 4A, 4B, 4C, 4D, 4D–1, 4D–2, 4E, 4F, 4G, 4H, 4J, 5, 6A, 6B, 6C, 6D, 6E, 6F, 7A, 7B, 8A, 8B, 8C, 9A, 9C, 10, and 11 are presented below. The following tables discussed in section II. of the preamble of this proposed rule are available only through the Internet on the CMS Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/:* Table 6G.—Additions to the CC Exclusions List; Table 6H.—Deletions from the CC Exclusions List; Table 6I.—Complete List of Complication and Comorbidity (CC) Exclusions; Table 6J.—Major Complication and Comorbidity (MCC) List; and Table 6K.—Complication and Comorbidity (CC).

The tables presented in this section of the Addendum 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
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TABLE 1A.—NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR

[69.7 Percent Labor Share/30.3 Percent Nonlabor Share if Wage Index Greater Than 1]

Full update (3.0 percent)		Reduced update (1.0 percent)	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$3,553.98	$1,544.98	$3,484.97	$1,514.98

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 (3.0 percent)		Reduced update (1.0 percent)	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$3,161.36	$1,937.60	$3,099.97	$1,899.98

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	$3,553.98	$1,544.98	$3,161.36	$1,937.60
Puerto Rico	1,501.82	920.46	1,421.88	1,000.40

TABLE 1D.—CAPITAL STANDARD FEDERAL PAYMENT RATE

	Rate
National	$421.29

TABLE 1D.—CAPITAL STANDARD FEDERAL PAYMENT RATE—Continued

	Rate
Puerto Rico	197.19

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
010001	1.5513	0.8397	22.1989	23.2195	24.7672	23.3821
010005	1.1192	0.8636	23.6022	23.0203	25.7755	24.1406
010006	1.4819	0.7883	23.4975	23.7502	25.0258	24.0951
010007	1.0611	0.7647	19.9329	21.3492	22.0185	21.1334
010008	1.0242	0.7821	17.9533	22.0793	23.2562	20.8430
010009	0.9973	0.8636	23.5626	25.9011	25.8405	25.1048
010010	1.0945	0.8786	27.0385	22.8602	24.8375	24.7458
010011	1.6762	0.8786	27.6658	27.4668	27.1978	27.4380
010012	1.1633	0.9524	24.4059	25.5767	26.4968	25.4682
010015	1.0453	0.7693	22.3383	27.0806	23.6811	24.1695
010016	1.5794	0.8786	24.6488	26.8611	28.9705	26.8024
010018	1.4886	0.8786	23.7048	24.8974	26.9498	25.1709
010019	1.2556	0.7883	22.8766	23.3460	25.0154	23.7418
010021	1.2285	0.7677	19.7367	21.0624	21.7592	20.8458
010022	0.9940	0.9760	25.8404	27.4318	28.7520	27.3475
010023	1.7665	0.8192	25.4272	26.1739	27.0693	26.2901
010024	1.5997	0.8192	22.0819	25.0715	26.6617	24.5911
010025	1.2929	0.8495	22.7635	23.6186	23.8602	23.4229
010027	0.7391	0.7662	16.4682	17.0513	18.2507	17.2827
010029	1.5947	0.8495	23.9007	25.0468	24.3605	24.4407
010032	0.8805	0.7972	19.3311	18.5545	20.8446	19.6445
010033	2.1342	0.8786	27.4181	29.1471	29.2005	28.6046
010034	1.0166	0.8192	17.7457	19.1549	21.2713	19.3572
010035	1.2478	0.8786	24.2425	24.2746	26.5285	25.0065
010036	1.1526	0.7647	21.5796	24.2887	23.7923	23.2285
010038	1.3336	0.8054	23.7039	27.0752	28.9624	26.4786
010039	1.6454	0.8987	26.9919	28.6462	29.8012	28.4927
010040	1.6515	0.8052	24.3207	24.7657	25.9851	25.0414
010043	1.0854	0.8786	21.9774	23.9121	25.3624	23.7097
010044	1.0626	0.7647	22.5009	24.4276	23.4009	23.4233
010045	1.1529	0.7869	20.4927	23.1695	23.5160	22.3334
010046	1.5241	0.8052	23.4219	25.9105	25.4444	24.8777
010047	0.8836	0.7774	26.4851	19.7542	21.7347	22.0981
010049	1.1411	0.7662	21.7888	22.4248	23.1186	22.4564
010050	1.0831	0.8786	22.9620	24.4060	25.3663	24.2272
010051	0.8989	0.8695	18.7701	18.0305	20.0755	18.9088
010052	0.8813	0.8192	25.9233	36.3638	23.4990	28.7904
010054	1.1310	0.8636	23.3624	24.4810	25.4189	24.4485
010055	1.5957	0.8322	22.5396	22.4145	25.3295	23.4244
010056	1.5856	0.8786	23.7398	24.5754	25.7272	24.7305
010058	1.0206	0.8786	19.5092	17.0150	31.1856	21.2663
010059	1.0080	0.8636	23.0012	24.8199	27.8607	25.3457
010061	0.9842	0.8740	24.1185	25.2454	25.5878	24.9798
010062	1.0319	0.7718	21.4805	21.7112	22.9481	22.0341
010064	1.7124	0.8786	24.8155	27.6149	26.6313	26.3101
010065	1.5119	0.8786	23.0477	24.3346	24.5833	24.0058
010066	0.8885	0.7647	19.8692	25.4612	25.6055	23.6384
010068	***	*	22.7156	24.4145	*	23.5620
010069	0.9721	0.7647	23.1243	23.6272	27.3424	24.6217
010072	***	*	24.4989	*	*	24.4989
010073	0.9451	0.7647	18.3963	19.0046	20.7832	19.3949
010078	1.6130	0.8054	23.5279	24.3828	25.2879	24.4148
010079	1.2409	0.8987	22.7337	22.3034	23.1015	22.7293
010083	1.1817	0.8115	22.4279	24.0036	25.0403	23.8754
010084	***	*	26.3238	26.5079	27.5054	26.7172
010085	1.3040	0.8636	24.2609	23.6280	24.0460	23.9691
010086	1.0270	0.7647	22.2096	21.5584	26.8993	23.3292
010087	2.2105	0.7809	22.4318	24.8320	26.2401	24.3812
010089	1.2944	0.8786	25.0811	26.2628	25.9704	25.7574
010090	1.7257	0.8030	26.0494	26.3957	25.6095	26.0158
010091	0.9075	0.7693	23.1310	22.5272	23.6554	23.1156
010092	1.4953	0.8695	26.6796	26.9959	28.5598	27.4270
010095	0.8389	0.8695	16.5250	17.0024	17.8242	17.1161
010097	0.7528	0.8192	19.4511	19.2481	18.4215	18.9973
010099	0.9928	0.7647	20.8383	20.6736	22.3677	21.2837
010100	1.7251	0.8115	23.8919	25.1460	25.4338	24.8850
010101	1.1737	0.8786	24.2575	25.0974	26.2731	25.2372

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
010102	0.9506	0.8192	25.6158	26.9859	26.6935	26.4289
010103	1.8628	0.8786	27.8272	28.9636	30.4015	29.0796
010104	1.8548	0.8786	27.6471	28.3126	30.4938	28.7438
010108	1.0595	0.8192	24.6740	25.4325	26.8882	25.7625
010109	0.9572	0.8098	17.6733	21.0449	21.9296	20.0804
010110	0.7382	0.7862	26.0038	19.8738	22.1164	22.5113
010112	0.9794	0.7647	17.1833	20.4027	21.3150	19.6839
010113	1.6320	0.7809	22.3282	24.7170	25.0689	24.0138
010114	1.4032	0.8786	25.6152	25.7090	25.3646	25.5596
010118	1.2125	0.8192	21.4630	22.7191	25.3678	23.1085
010120	1.0320	0.7647	20.9019	22.1868	22.8170	21.9915
010125	1.0385	0.8123	21.5123	22.8911	23.6542	22.7013
010126	1.1498	0.8192	23.9327	24.4957	25.7234	24.7205
010128	0.9062	0.7693	23.6647	24.9881	25.9417	24.9328
010129	1.0676	0.7781	22.1574	21.8502	24.4806	22.8945
010130	1.0051	0.8786	23.7528	24.5644	25.2775	24.5383
010131	1.3760	0.8987	26.4297	27.2707	28.0468	27.2971
010137	1.2318	0.8786	27.5782	28.5843	30.4347	28.8905
010138	0.6210	0.7713	16.7602	14.5551	15.0814	15.4264
010139	1.5846	0.8786	26.8726	28.1473	29.3543	28.1531
010143	1.2041	0.8636	26.2762	24.0674	25.0859	25.0921
010144	1.7285	0.7809	22.5133	22.3916	23.8581	22.9469
010145	1.4494	0.8695	24.5092	25.8293	27.3277	25.8981
010146	1.1251	0.8054	22.6586	22.6879	23.7803	23.0525
010148	0.8893	0.7647	23.9246	23.5714	25.0949	24.1955
010149	1.2271	0.8192	24.4805	25.4354	26.8895	25.7355
010150	0.9968	0.8192	23.6080	24.4098	25.0060	24.3378
010152	1.2632	0.7809	22.4075	23.7803	26.0777	24.1152
010157	1.1630	0.7883	23.3828	24.2206	27.1156	24.7415
010158	1.2536	0.7883	23.5533	25.5905	26.2350	25.0899
010162	***	*	33.8777	*	*	33.8777
010163	***	*	*	34.0325	*	34.0325
010164	1.2261	0.8786	*	23.2447	25.6659	24.4751
010165	***	*	*	28.8040	*	28.8040
010166	***	*	*	29.7256	*	29.7256
010167	1.6912	0.8786	*	*	*	*
010168	1.3124	0.9061	*	*	*	*
020001	1.7281	1.1884	35.4232	36.5298	38.1754	36.7192
020004	***	*	31.8004	*	*	31.8004
020006	1.2847	1.1884	34.3752	37.0211	37.2838	36.2129
020008	1.2046	1.1884	36.1250	39.3432	40.6758	38.7262
020012	1.3619	1.1884	32.5975	33.9375	36.1891	34.2975
020014	1.0617	1.1884	29.4472	30.9722	30.6325	30.3727
020017	2.0201	1.1884	35.4119	35.8804	38.2137	36.5154
020018	0.9475	1.9292	*	*	*	*
020019	0.9038	*	*	*	*	*
020024	1.1768	1.1884	29.5195	38.6934	39.9916	35.5845
020026	1.5400	1.9292	*	*	*	*
020027	0.9585	1.9292	*	*	*	*
030001	1.5351	1.0271	32.4791	33.4178	35.9045	33.8225
030002	2.1087	1.0271	30.2200	31.0818	32.9061	31.4265
030006	1.7187	0.9442	27.0599	27.7421	29.1218	28.0025
030007	1.4597	1.1305	31.1928	33.7213	35.5193	33.5056
030009	***	*	26.5408	*	*	26.5408
030010	1.4417	0.9442	28.5684	30.6261	31.8606	30.4135
030011	1.5335	0.9442	28.1423	28.8203	30.2062	29.0981
030012	1.4301	1.0198	27.3895	29.1042	31.3041	29.3702
030013	1.5318	0.9903	27.0111	31.2815	31.9135	30.1305
030014	1.5815	1.0271	29.6582	29.8296	30.6276	30.0779
030016	1.2770	1.0271	29.1980	30.7896	31.1854	30.4653
030017	2.0581	1.0271	30.6007	34.4852	34.8458	33.3763
030018	1.3639	1.0271	29.4566	31.8056	31.7220	31.0137
030019	1.3016	1.0271	29.5921	30.1934	33.6528	31.0565
030022	1.8063	1.0271	30.5710	30.3746	35.0728	31.9469
030023	1.8138	1.1652	34.2142	35.8287	37.5481	35.8798
030024	2.1440	1.0271	31.9247	33.1797	35.6078	33.6344
030030	1.6952	1.0271	32.0994	34.4166	36.4747	34.2670

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
030033	1.3116	1.1305	28.7508	29.9383	32.0342	30.2702
030036	1.5415	1.0271	30.9834	33.0523	36.2020	33.6063
030037	1.9894	1.0271	31.2877	34.1079	35.1314	33.3937
030038	1.6433	1.0271	29.9314	31.7238	31.2906	31.0104
030040	***	*	27.5322	*	*	27.5322
030043	1.2301	0.8857	26.5834	27.3856	28.3147	27.4531
030055	1.4731	1.0011	27.1473	27.1621	30.9311	28.4812
030060	1.1614	*	24.8373	*	*	24.8373
030061	1.6370	1.0271	28.0696	28.1337	33.0826	29.7496
030062	1.2360	0.8857	26.6880	28.9587	29.9331	28.5898
030064	2.0334	0.9442	28.3853	29.8226	31.6603	30.0071
030065	1.6347	1.0271	29.5883	31.0817	31.4568	30.7651
030067	1.0057	0.9155	20.7591	27.4497	27.0766	25.0396
030068	1.1245	0.8857	23.1394	23.8792	26.0276	24.3896
030069	1.4761	1.1254	30.2224	29.7802	30.7696	30.2553
030071	1.0045	1.4448	*	*	*	*
030073	1.1300	1.4448	*	*	*	*
030074	0.9181	1.4448	*	*	*	*
030077	0.8053	1.4448	*	*	*	*
030078	1.1355	1.4448	*	*	*	*
030080	***	*	27.1360	28.6568	30.7660	28.9576
030083	1.3493	1.0271	27.4983	33.5302	35.8488	32.0946
030084	1.0175	1.4448	*	*	*	*
030085	1.6306	0.9442	26.8364	28.1388	29.0750	28.0469
030087	1.7040	1.0271	29.5962	31.2331	31.1070	30.6895
030088	1.3727	1.0271	27.8604	29.9758	30.5716	29.5054
030089	1.5952	1.0271	28.9068	30.1591	31.3148	30.1497
030092	1.5055	1.0271	31.7512	30.6343	30.4361	30.8516
030093	1.3209	1.0271	26.4430	27.8821	33.0699	29.2816
030094	1.5460	1.0271	31.5422	33.4050	34.2007	33.1194
030099	0.9137	0.8857	27.1402	26.9227	24.9115	26.3285
030100	2.0982	0.9442	31.5628	34.7532	35.0944	33.8057
030101	1.4909	1.1388	27.8302	30.6764	33.2110	30.6802
030102	2.4535	1.0271	31.6285	33.6247	36.9492	34.0941
030103	1.7698	1.0271	31.7322	32.2833	33.9387	32.6963
030105	2.3493	1.0271	31.2970	32.7449	33.9846	32.7833
030106	1.5634	1.0271	32.9840	36.4667	40.1625	36.8304
030107	1.9107	1.0271	35.6197	35.5386	35.4524	35.5298
030108	2.0613	1.0271	*	29.9395	34.8483	32.9293
030109	***	*	16.5906	*	*	16.5906
030110	1.6838	1.0271	31.4852	29.7949	36.2124	32.4772
030111	1.0463	0.9442	*	33.3711	28.5133	30.2230
030112	2.0028	1.0271	*	36.6601	33.4776	34.6249
030113	0.9099	1.4448	*	*	*	*
030114	1.4838	0.9442	*	*	28.8439	28.8439
030115	1.4714	1.0271	*	*	32.5857	32.5857
030117	1.2494	0.9817	*	*	*	*
030118	1.1423	1.0198	*	*	*	*
030119	1.2774	1.0271	*	*	*	*
030120	0.8689	1.0271	*	*	*	*
030121	1.0784	1.0271	*	*	*	*
040001	1.0747	0.9131	22.9327	22.9948	24.4950	23.4592
040002	1.1735	0.7641	21.2020	25.0000	24.0479	23.3250
040004	1.6814	0.9131	27.1741	28.1117	29.2695	28.2056
040007	1.7434	0.8754	40.1291	29.1941	27.4839	32.0643
040010	1.4746	0.9131	24.2315	26.5287	28.2363	26.3909
040011	1.0296	0.7641	21.0967	22.2431	22.6320	22.0004
040014	1.3517	0.8650	26.4777	28.9855	34.8259	29.4945
040015	1.1207	0.7641	20.4279	20.1061	22.3145	20.9794
040016	1.7125	0.8754	25.8056	26.5911	26.4787	26.3029
040017	1.1221	0.8952	21.9147	23.8768	24.3768	23.3605
040018	1.1123	0.7843	24.0026	25.6751	26.2511	25.2931
040019	1.0410	0.8909	23.8706	24.9113	26.4915	25.0680
040020	1.6290	0.8909	22.6497	23.9470	26.1519	24.2422
040021	1.5502	0.8754	25.4046	26.1853	27.6779	26.3611
040022	1.4648	0.9131	29.5000	27.9902	30.0234	29.1589
040026	1.5430	0.9146	27.7931	29.5299	31.8579	29.7126

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
040027	1.5239	0.8477	21.4252	23.8220	25.7922	23.6373
040029	1.4258	0.8754	24.8409	25.1479	27.8865	25.9688
040036	1.6268	0.8754	27.6234	29.7150	30.4885	29.2730
040039	1.2296	0.8291	21.2712	21.4819	22.9798	21.9027
040041	1.1562	0.8650	23.7787	26.4964	26.4417	25.5529
040042	1.2893	0.9329	21.1716	19.8709	23.1648	21.3821
040047	1.0408	0.7758	22.4249	23.0358	23.3547	22.9631
040050	1.1948	0.7641	17.6906	18.5119	19.6944	18.6284
040051	0.9470	0.7641	21.3342	22.0394	22.1983	21.8575
040054	***	*	18.0509	19.5353	*	18.7591
040055	1.5598	0.7843	23.0448	24.9164	26.0132	24.6243
040062	1.6247	0.7843	23.8994	25.2303	25.6541	24.9287
040067	1.1145	0.7648	19.0471	18.9872	20.9688	19.6151
040069	1.0608	0.8909	24.8060	24.9996	23.3108	24.3661
040071	1.5798	0.8650	25.4680	25.2840	26.6629	25.8031
040072	1.1274	0.7641	22.4741	22.1058	22.9668	22.5262
040074	1.2633	0.8754	25.2699	26.2661	27.3878	26.2955
040076	0.9952	0.8650	23.5742	23.0954	24.7891	23.8273
040078	1.6712	0.8650	23.5915	26.1937	25.6870	25.0529
040080	1.0467	0.8291	24.1921	24.8760	26.5895	25.2945
040081	0.8888	0.7998	16.8437	17.2536	18.4756	17.5296
040084	1.2389	0.8754	27.7626	26.6449	28.1552	27.5095
040085	1.0085	0.8909	22.9916	25.7215	26.6972	25.1591
040088	1.6650	0.7789	22.4860	23.6276	24.7107	23.6212
040091	1.1951	0.8093	24.2398	23.1913	22.3295	23.2265
040100	***	*	21.3051	22.6131	24.5448	22.8466
040114	1.8332	0.8754	26.7581	27.7928	28.5682	27.7154
040118	1.5334	0.8291	26.0388	26.8908	26.5770	26.5251
040119	1.3884	0.8650	24.3680	24.2419	25.6769	24.7942
040126	***	*	15.6985	17.3715	*	16.4167
040132	***	*	*	22.0054	21.8131	21.8928
040134	2.3449	0.8754	31.9325	32.2832	34.9636	33.0707
040137	1.3582	0.8754	25.9979	27.7360	27.7619	27.1679
040138	1.5085	0.9131	27.8584	28.3342	33.0048	29.8698
040141	0.7864	0.9131	26.1041	30.3475	33.8758	29.9321
040142	1.5543	0.9146	21.4222	23.8620	23.1293	22.9022
040143	***	*	37.1976	*	*	37.1976
040144	***	*	21.4008	*	*	21.4008
040145	1.7933	0.8291	*	24.4367	20.3865	22.2702
040146	***	*	*	33.7876	*	33.7876
040147	1.7491	0.8754	*	*	35.7643	35.7643
040148	1.3585	0.8754	*	*	*	*
050002	1.4597	1.5288	35.5184	41.7336	43.1732	40.2432
050006	1.5912	1.2730	33.5751	37.1639	41.7694	37.1459
050007	1.4363	1.5025	43.4440	45.8773	46.3257	45.2428
050008	1.4460	1.4905	49.3167	46.8706	50.9532	49.0479
050009	1.6477	1.3974	43.0584	46.2186	49.7145	46.4654
050013	1.8267	1.3974	35.7591	43.5623	43.4884	40.8362
050014	1.2659	1.2710	36.0305	37.4135	39.4733	37.6850
050015	1.6268	*	32.2188	*	*	32.2188
050016	1.3208	1.1925	24.5768	31.0653	34.4877	30.1759
050017	2.0225	1.2827	39.6653	42.2200	44.3892	42.1245
050018	1.2702	1.1916	23.3204	31.8310	43.5594	30.7984
050022	1.5850	1.1822	31.6467	33.0592	36.6332	33.8292
050024	1.1169	1.1822	29.4062	33.4334	33.5179	32.1616
050025	1.7936	1.1822	33.5466	32.7476	36.4068	34.2656
050026	1.5921	1.1822	31.5250	33.1277	35.0276	33.2678
050028	1.2946	1.1822	27.3826	28.5736	28.1194	28.0466
050030	1.2276	1.1822	27.2945	30.9014	33.5634	30.5981
050036	1.6000	1.1822	33.8000	36.0905	37.8493	35.9795
050038	1.6319	1.5766	44.2265	48.7483	55.2150	49.5117
050039	1.6727	1.1822	35.2630	36.6943	34.9232	35.5973
050040	1.3922	1.1916	35.8322	35.7054	38.1639	36.6252
050042	1.4804	1.2730	37.3760	40.3326	40.4361	39.4000
050043	1.6147	1.5288	45.4887	48.2283	50.5011	48.0790
050045	1.3307	1.1822	25.0150	27.0676	28.5930	26.9305
050046	1.1963	1.1822	26.1926	29.1125	31.8120	29.0132

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
050047	1.7553	1.4905	55.9367	45.1675	48.5921	49.7760
050054	1.1791	1.1822	21.3650	24.0338	27.1306	24.3249
050055	1.3418	1.4905	42.9516	44.2926	48.2759	45.1972
050056	1.4226	1.1916	30.6126	32.7693	34.7937	32.7247
050057	1.6897	1.1822	30.0236	31.7467	33.7545	31.8592
050058	1.6320	1.1916	33.1409	37.2538	39.1657	36.5431
050060	1.5084	1.1822	29.9762	32.0196	34.1151	31.9978
050063	1.4482	1.1916	34.0906	36.3085	36.6271	35.6915
050065	***	*	34.9110	38.2421	42.0052	38.4607
050067	1.2075	1.1963	38.8070	40.1393	41.8949	40.2601
050069	1.7361	1.1822	34.6353	35.3850	38.1313	36.1111
050070	1.3124	1.5025	47.4099	46.4009	49.3910	47.8284
050071	1.4512	1.5766	50.7602	49.6495	52.5202	51.0422
050072	1.4096	1.5278	49.4344	50.0343	51.9174	50.5640
050073	1.2488	1.5278	49.9730	49.0069	50.6478	49.8748
050075	1.3747	1.5288	54.4089	49.8290	51.5366	51.6907
050076	1.8168	1.5278	52.3788	50.2039	51.0338	51.1894
050077	1.5379	1.1822	34.8660	36.5384	37.4961	36.4378
050078	1.2512	1.1916	32.0133	30.4274	37.1909	33.1204
050079	1.5736	1.5278	47.3449	48.8994	48.2983	48.1333
050082	1.6600	1.1822	38.2878	37.8905	42.1694	39.4148
050084	1.5667	1.1954	35.5196	39.5748	41.0288	38.7442
050089	1.3670	1.1822	33.9593	36.4018	39.2412	36.5180
050090	1.2562	1.4879	33.8953	37.7421	41.5994	37.7203
050091	1.0354	1.1916	32.1301	37.1223	40.1032	36.4125
050093	1.5575	1.1822	36.9481	36.8486	37.7213	37.1762
050095	***	*	*	*	44.2364	44.2364
050096	1.2641	1.1916	34.9237	33.1322	33.3800	33.8096
050099	1.5398	1.1822	33.4174	32.0650	34.3480	33.2470
050100	1.8205	1.1822	31.4404	33.3959	34.2814	33.0478
050101	1.3210	1.5278	42.4589	47.9327	48.7447	46.4291
050102	1.3903	1.1822	32.0617	32.8434	33.2811	32.8150
050103	1.5437	1.1916	34.0935	35.6773	37.5528	35.8192
050104	1.4136	1.1916	32.3043	33.6204	37.1418	34.4090
050107	1.5287	1.1822	32.5846	33.5687	36.6966	34.2821
050108	1.8628	1.2827	38.8672	42.0131	43.0409	41.3295
050110	1.2335	1.1822	26.8408	28.0670	30.9036	28.6069
050111	1.1657	1.1916	28.7875	31.8766	31.9371	30.8306
050112	1.5363	1.1916	37.7281	38.9483	39.9904	38.9358
050113	1.1706	1.5025	39.4882	42.8884	46.3447	42.8008
050114	***	*	34.0309	35.7274	37.5895	35.8060
050115	1.4716	1.1822	28.8051	32.5257	33.8575	31.7873
050116	1.6387	1.1916	36.8825	37.6018	39.1213	37.9136
050117	***	*	34.2020	35.0531	*	34.3889
050118	1.2470	1.1963	39.9683	41.6701	41.8166	41.1955
050121	1.2657	1.1822	30.6105	34.6244	35.1123	33.4898
050122	1.6278	1.1954	33.9812	34.0259	36.8803	34.9559
050124	1.2976	1.1916	30.2522	29.9944	31.7666	30.6975
050125	1.4819	1.5766	44.9523	47.7578	53.6251	49.3187
050126	1.5255	1.1916	31.7619	32.6686	30.6587	31.6279
050127	1.2888	1.2827	32.0355	40.7610	42.5307	37.9357
050128	1.4865	1.1822	31.1308	33.4233	34.2327	32.9837
050129	1.8869	1.1822	34.7359	36.9887	40.7010	37.4287
050131	1.4641	1.5278	45.3152	47.5257	50.5592	48.0185
050132	1.4120	1.1916	35.9199	39.6807	39.5311	38.3266
050133	1.5874	1.2710	31.9527	33.1814	34.7446	33.5182
050135	1.0174	1.1916	25.1813	25.3209	25.4416	25.3286
050136	1.3870	1.4879	43.3747	46.6619	52.9752	47.9218
050137	1.5096	1.1916	39.1496	40.2457	45.3315	41.8810
050138	1.4788	1.1916	45.3727	40.6343	46.7946	44.1215
050139	1.3979	1.1916	37.8986	38.7385	44.3290	40.6568
050140	1.3188	1.1822	40.9725	39.4954	44.5658	41.7792
050144	***	*	33.6662	38.2424	40.4728	37.3677
050145	1.5409	1.4671	42.2921	48.0796	49.2634	46.7040
050146	1.8140	*	*	*	*	*
050148	1.0935	*	28.2305	*	*	28.2305
050149	1.5423	1.1916	35.8821	37.3616	43.3419	39.0535

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
050150	1.2344	1.2710	33.6583	37.9946	43.5908	38.2550
050152	1.4480	1.4905	46.1553	51.6567	54.7138	50.9486
050153	1.4515	1.5766	42.8955	47.6374	50.4838	47.2422
050155	***	*	16.9516	16.7756	*	16.8520
050158	1.3682	1.1916	35.7805	39.9160	42.7838	39.6127
050159	1.2951	1.1822	32.5704	34.6915	35.0123	34.1437
050167	1.4830	1.1954	31.4798	34.0418	38.0704	34.4888
050168	1.5682	1.1822	37.9784	40.5973	40.8318	39.8615
050169	1.5146	1.1916	29.4693	31.4115	33.1105	31.4624
050173	1.3454	1.1822	29.0576	31.6717	32.3240	30.9921
050174	1.5492	1.4879	44.4199	48.1740	53.7062	48.9658
050175	***	*	33.3061	35.0152	*	34.1608
050177	***	*	24.0717	*	*	24.0717
050179	1.1909	1.1963	30.4973	31.6651	34.6529	32.3080
050180	1.5822	1.5278	42.0358	45.7099	48.7392	45.6253
050188	1.5411	1.5766	41.0943	43.7381	45.8470	43.4416
050189	1.0400	1.4671	30.1155	28.7580	31.5787	30.2839
050191	1.5029	1.1916	37.7805	37.8756	42.0018	39.2858
050192	0.9799	1.1822	27.1400	27.8386	27.4599	27.4784
050193	1.2329	1.1822	33.9520	29.0623	36.7215	32.9051
050194	1.3496	1.5758	44.7107	49.0030	49.8490	47.9003
050195	1.5733	1.5288	48.8595	53.5583	57.6511	53.3853
050196	1.0787	1.1822	34.0956	32.8293	41.1280	35.9355
050197	1.9800	1.5758	50.0728	52.9998	55.2982	52.8587
050204	1.4038	1.1916	32.0121	35.3954	38.8654	35.4348
050205	1.3872	1.1916	29.3334	30.6322	30.6087	30.1774
050207	***	*	30.0062	31.3431	*	30.6661
050211	1.3077	1.5288	35.0515	35.0289	42.9220	37.8234
050214	***	*	25.4647	*	*	25.4647
050215	***	*	48.8112	50.7578	*	49.8014
050219	1.3346	1.1916	26.4143	25.8378	26.7043	26.3093
050222	1.6635	1.1822	32.3882	33.7510	35.4673	33.9374
050224	1.6644	1.1822	32.5010	35.7280	37.2306	35.2444
050225	1.3992	1.1822	34.0836	35.1227	37.5227	35.6603
050226	1.5964	1.1822	32.4411	35.4597	36.5328	34.8249
050228	1.3082	1.4905	43.7939	47.1430	49.9023	46.9935
050230	1.5485	1.1822	34.0600	35.8490	38.8880	36.2981
050231	1.7120	1.1916	32.1813	33.7139	37.0216	34.3576
050232	1.7085	1.1925	26.3004	34.3242	35.5078	32.2261
050234	1.2780	1.1822	32.3726	34.8308	37.7096	34.9915
050235	1.4885	1.1916	30.5405	37.0858	39.1708	35.6922
050236	1.4514	1.1822	33.0686	32.6462	34.4239	33.3573
050238	1.5286	1.1916	33.3346	34.0823	35.1235	34.2447
050239	1.6781	1.1916	33.1148	35.9041	36.3232	35.1511
050240	***	*	36.1154	40.7427	*	38.4427
050242	1.3854	1.5758	46.4844	50.9882	53.7118	50.5362
050243	1.5755	1.1822	32.9385	36.1209	37.8510	35.6823
050245	1.3731	1.1822	27.3866	33.2556	34.5668	31.8473
050248	1.1239	1.4671	*	40.4941	46.0285	43.3497
050251	***	*	27.8452	*	*	27.8452
050253	***	*	23.5381	*	*	23.5381
050254	1.2803	1.2827	31.2386	33.0865	33.5043	32.6688
050256	***	*	29.6793	32.7159	32.6816	31.5748
050257	0.9389	1.1822	20.1829	24.0737	29.2635	24.4838
050261	1.2967	1.1822	29.2150	30.8704	33.7180	31.3396
050262	2.2067	1.1916	39.9946	41.4835	43.7672	41.7544
050264	1.3674	1.5288	47.7024	43.4181	48.0876	46.3588
050270	***	*	33.6855	36.0111	*	34.8609
050272	1.4019	1.1822	29.4671	30.9290	31.5894	30.7391
050276	1.1193	1.5278	41.1406	43.7943	47.2414	44.0832
050277	1.1820	1.1916	35.4443	35.0079	*	35.2189
050278	1.5456	1.1916	31.8712	34.3798	38.5649	35.0167
050279	1.1978	1.1822	29.7118	31.6738	32.1678	31.1945
050280	1.7360	1.2730	38.8341	41.3912	43.5214	41.2937
050281	1.4053	1.1916	29.4882	31.6639	31.0678	30.7699
050283	1.6153	1.5288	44.3122	43.6855	44.8602	44.2950
050289	1.6158	1.5025	44.2814	50.1762	52.0875	49.0216

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
050290	1.7575	1.1916	37.3563	40.6192	42.0066	39.9556
050291	1.9821	1.4879	38.4365	41.2100	43.2395	41.1200
050292	1.0615	1.1822	26.9786	27.3365	30.9112	28.4996
050295	1.4386	1.1822	34.7382	38.4256	39.5132	37.7732
050296	1.1373	1.5758	39.9842	42.5405	44.8105	42.4568
050298	1.2078	1.1839	30.2022	33.7864	33.6925	32.5818
050299	***	*	35.1249	32.3707	*	33.6024
050300	1.4161	1.1822	30.2874	33.6821	37.1244	33.7458
050301	1.2490	1.4497	35.9491	37.1103	36.3661	36.4668
050305	1.4137	1.5288	44.9681	48.5339	52.8531	48.7916
050308	1.5368	1.5766	43.7413	46.4180	49.0086	46.4303
050309	1.4523	1.2827	38.2659	40.1499	41.1612	39.8863
050312	***	*	36.8498	*	*	36.8498
050313	1.2021	1.1954	35.0478	37.5024	37.8834	36.8450
050315	1.3141	1.1822	33.2038	32.5538	37.3526	34.4352
050320	1.2624	1.5288	45.7686	46.2071	50.6670	47.5834
050324	1.7781	1.1822	34.5503	36.3474	37.1854	36.0605
050325	1.1860	1.1855	31.3730	37.0441	34.0333	34.2474
050327	1.6676	1.1822	33.9507	35.9349	36.9523	35.6196
050329	1.2676	1.1822	23.2927	33.0390	36.7650	31.1927
050333	1.0488	1.1822	19.6352	18.6534	32.2010	21.9629
050334	1.5881	1.4671	43.9656	47.2968	50.9796	47.4795
050335	1.3834	1.1963	30.9928	34.7192	37.2324	34.3853
050336	1.2384	1.1954	30.4664	31.5480	33.0304	31.7345
050342	1.2489	1.1822	29.2244	30.4226	29.8368	29.8437
050348	1.7714	1.1822	31.5156	32.7107	33.5253	32.6280
050349	0.9688	1.1822	24.4863	25.4266	23.1089	24.2535
050350	1.4256	1.1916	31.0136	31.7908	34.0896	32.2951
050351	1.5307	1.1916	30.6599	33.3064	35.0010	33.0083
050352	1.3551	1.2827	36.7673	37.0807	38.6234	37.4921
050353	1.5204	1.1916	29.4215	30.4206	37.1683	32.2253
050357	1.5056	1.1822	32.6763	36.2089	38.9202	35.9956
050359	1.1869	1.1822	29.8345	31.3391	30.3963	30.5262
050360	1.5234	1.5278	47.4497	52.3811	53.4113	51.1213
050366	1.1511	1.1837	33.6714	37.1527	41.8302	37.3699
050367	1.4838	1.5278	38.6330	40.1904	40.0423	39.6594
050369	1.4765	1.1916	30.6439	32.2467	33.3330	32.1001
050373	1.4477	1.1916	35.1380	34.3737	37.6802	35.7093
050376	1.7774	1.1916	34.3539	35.2837	36.6487	35.4753
050378	1.0502	1.1916	37.9904	40.1923	42.0465	40.0787
050380	1.6776	1.5766	46.0276	49.4258	52.5752	49.4098
050382	1.4478	1.1916	30.4014	32.6683	32.9220	31.9903
050385	1.2993	1.4879	36.8107	36.4188	36.5610	36.5948
050390	1.1220	1.1822	27.3183	27.9359	33.0438	29.3100
050391	***	*	17.2141	*	*	17.2141
050393	1.3848	1.1916	34.1743	35.6356	35.1855	35.0078
050394	1.6185	1.1822	27.4861	32.1894	32.1720	30.6682
050396	1.5625	1.1822	32.4918	37.3972	38.9901	36.2041
050397	0.8787	1.1822	28.3671	29.6825	31.1603	29.8101
050407	1.1900	1.4905	42.2748	44.6839	47.5560	44.8602
050411	1.3207	1.1916	38.8294	38.6328	44.7079	40.9918
050414	1.3194	1.2827	38.7585	41.8688	45.0472	42.0484
050417	1.3093	1.1822	32.9341	36.1222	37.0117	35.4225
050420	***	*	35.2869	39.9237	*	37.6935
050423	1.0114	1.1822	28.3768	31.9751	32.4104	31.1452
050424	1.9524	1.1822	34.5680	36.6091	37.5218	36.2762
050425	1.3696	1.2827	49.2245	46.6628	45.7794	47.0234
050426	1.4616	1.1822	33.2031	34.9855	37.6483	35.2291
050430	0.9394	1.1822	23.9045	24.5327	25.9363	24.7203
050432	***	*	33.1876	35.2416	*	34.2247
050433	***	*	21.3573	21.1287	23.0629	21.6609
050434	0.9988	1.1822	32.6255	33.7794	35.4799	33.9524
050435	1.1984	1.1822	30.6530	33.0372	35.7401	33.2043
050438	1.5503	1.1916	36.3026	36.2044	38.2823	36.9424
050441	1.9553	1.5766	44.5694	46.6160	49.2095	46.8421
050444	1.4083	1.2202	34.6313	37.6821	39.3915	37.5291
050447	2.2656	1.1822	26.7960	29.0780	27.1252	27.7351

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
050448	1.2948	1.1822	30.6201	32.7748	32.6666	31.9996
050454	1.9380	1.4905	38.5833	40.2811	43.3674	40.8320
050455	1.5610	1.1822	30.4606	34.5445	35.0200	33.3430
050456	***	*	21.6261	27.7659	27.9693	25.0702
050457	1.5970	1.4905	47.8947	50.0282	53.3144	50.4334
050464	1.7391	1.1963	38.3058	41.6235	42.6660	40.8465
050468	1.7714	1.1916	31.1111	35.7409	37.3361	34.8277
050469	***	*	30.6502	*	*	30.6502
050470	***	*	27.8678	31.0466	32.5012	30.5202
050471	1.7119	1.1916	35.4768	36.8680	36.4887	36.2903
050476	1.4110	1.4497	38.7856	41.1042	40.5395	40.1623
050477	***	*	37.7668	40.1566	*	39.0877
050478	1.0325	1.1822	40.2558	41.1668	41.5592	41.0379
050481	1.5130	1.1916	36.1394	38.8650	42.8499	39.2898
050485	1.6505	1.1916	36.1488	34.6219	34.7050	35.1967
050488	1.4378	1.5288	42.6854	45.0630	47.1937	45.0874
050491	***	*	34.3598	*	*	34.3598
050492	1.3241	1.1822	28.0826	30.7718	32.6577	30.4668
050494	1.4344	1.2710	38.1177	40.6384	42.3086	40.3782
050496	1.6970	1.5278	48.2468	51.6363	51.1433	50.4172
050498	1.3475	1.2827	37.1667	41.0350	42.2469	40.1486
050502	1.6482	1.1916	28.7046	31.8872	32.9773	31.1609
050503	1.5152	1.1822	34.0994	37.3605	37.7183	36.4438
050506	1.5249	1.1925	37.7420	39.8586	40.6497	39.4417
050510	1.3370	1.5278	52.5376	49.4533	51.3691	51.0324
050512	1.4990	1.5288	50.9264	48.8057	50.1599	49.9366
050515	1.3185	1.1822	38.9542	40.2957	41.0328	40.1925
050516	1.5093	1.2827	39.8161	43.0249	45.5247	42.8485
050517	1.2967	1.1822	20.0213	22.4096	29.3674	23.6394
050523	1.2869	1.5278	40.6535	43.4579	46.9830	43.8643
050526	1.1843	1.1822	28.1997	33.3964	35.5437	32.2787
050528	1.1507	1.1822	31.4941	36.2908	38.3022	35.4339
050531	1.0520	1.1916	27.1974	28.3348	28.4865	28.0127
050534	1.4315	1.1822	33.1666	36.6447	38.1859	36.0367
050535	***	*	34.6143	37.8174	*	36.2328
050537	1.4828	1.2827	34.9931	38.2145	40.1908	37.8814
050541	1.4378	1.5758	52.5908	48.0867	51.5270	50.6366
050543	0.7526	1.1822	29.4443	24.4913	32.8347	28.6007
050545	0.7226	1.1916	31.3080	35.3209	*	33.2475
050546	0.6945	1.1822	33.2245	36.5099	*	34.9356
050547	1.0205	1.4879	34.8401	33.8036	*	34.2850
050548	0.6180	1.1822	39.2234	41.1075	*	40.1570
050549	1.6510	1.1822	35.2792	38.3927	40.6759	38.1001
050550	***	*	30.9612	34.9476	39.2133	34.7849
050551	1.3452	1.1822	34.0467	37.2506	37.6198	36.3778
050552	0.9428	1.1916	33.0711	33.9810	35.3466	34.1389
050557	1.5993	1.1963	33.3654	35.7023	38.6871	35.9147
050561	1.4093	1.1916	38.0196	38.2543	39.1298	38.5223
050567	1.5110	1.1822	35.7063	37.6384	39.0084	37.5231
050568	1.2464	1.1822	25.2337	26.0908	26.7719	26.0576
050569	1.3207	*	31.6785	*	*	31.6785
050570	1.5519	1.1822	34.5161	38.4373	40.6719	37.8603
050571	***	*	34.7627	39.0649	*	36.9575
050573	1.5662	1.1822	34.7279	35.2842	36.8535	35.6371
050575	1.3192	1.1916	25.1457	23.7990	22.1000	23.5654
050577	***	*	32.3744	*	*	32.3744
050578	1.4310	1.1916	35.2390	31.3639	43.4883	36.9415
050579	***	*	42.5081	*	*	42.5081
050580	1.1517	1.1822	31.5806	34.1531	35.0950	33.6230
050581	1.4139	1.1916	34.0136	37.7567	40.0883	37.3040
050583	1.6442	1.1822	34.5747	37.4450	40.5818	37.4769
050584	1.4508	1.1839	30.3434	30.7839	31.9887	31.0588
050585	***	*	22.2521	*	*	22.2521
050586	1.3101	1.1822	26.4782	31.3513	31.1898	29.6927
050588	1.3759	1.1916	32.7556	37.7387	39.4229	36.6367
050589	1.2424	1.1822	34.5100	37.6886	37.2032	36.5093
050590	1.2814	1.2827	38.4971	41.7519	44.2900	41.5361

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
050591	***	*	30.6106	34.7133	*	32.5892
050592	***	*	27.3606	31.8053	32.2351	30.0884
050594	***	*	36.5256	42.0788	*	39.2148
050597	1.2983	1.1916	28.8294	31.5625	32.8964	31.1668
050599	1.8547	1.2827	32.7835	34.7187	36.6122	34.7394
050601	1.5329	1.1916	36.0572	39.7717	43.2367	39.7359
050603	1.4506	1.1822	34.0275	35.0279	35.4778	34.9101
050604	1.3664	1.5766	55.0821	49.4446	49.6225	50.8907
050608	1.2665	1.1822	30.4169	31.2909	30.7266	30.8122
050609	1.2511	1.1822	41.7208	39.7397	42.4128	41.2383
050613	***	*	42.8108	42.9930	*	42.8892
050615	***	*	35.9547	39.1299	*	37.5269
050616	1.4930	1.1822	37.7284	37.1200	40.8621	38.5549
050618	1.0232	1.1822	31.3182	33.1472	34.9156	33.1400
050624	1.3457	1.1916	33.9594	35.9346	39.2531	36.4371
050625	1.7610	1.1916	38.6591	41.0439	44.8446	41.6090
050633	1.2411	1.1925	36.8302	38.4916	40.7347	38.7394
050636	1.2748	1.1822	32.5576	33.0718	35.4525	33.7338
050641	1.3434	1.1916	39.6921	32.3586	32.0483	34.3171
050644	1.0499	1.1916	28.8237	30.7981	33.2746	30.9581
050660	1.7555	*	*	*	*	*
050662	0.7264	1.5766	33.2446	38.3017	*	35.5809
050663	1.4166	1.1916	27.7334	17.7035	17.8180	19.8971
050667	0.9359	1.3974	24.2771	25.9161	25.8444	25.2820
050668	1.2668	1.4905	56.6555	51.6049	52.6968	53.2587
050674	1.2833	1.2827	48.0893	47.0720	48.6658	47.9616
050677	1.3833	1.1916	38.5770	39.2161	40.7889	39.6370
050678	1.3254	1.1822	32.4473	33.7633	35.8378	34.1139
050680	1.2900	1.5278	38.2871	37.9856	39.0346	38.4541
050682	0.8353	1.1822	17.9077	22.2193	22.3883	20.9013
050684	1.1150	1.1822	27.5256	28.8378	33.5883	30.1544
050686	1.5945	1.1822	41.0188	39.7757	41.3815	40.7110
050688	1.2103	1.5766	44.1510	49.4062	53.2703	49.0705
050689	1.5822	1.5278	45.0951	48.8533	48.9898	47.6626
050690	1.3422	1.4879	50.9094	49.0226	51.7590	50.5850
050693	1.3899	1.1822	34.5797	39.6838	42.8232	38.9551
050694	1.0517	1.1822	30.7858	32.1065	34.8458	32.6630
050695	***	*	39.6004	49.0340	*	44.6756
050696	2.2640	1.1916	37.3837	39.8963	39.4330	38.9118
050697	1.1055	1.2730	16.6605	22.1441	26.7588	21.2675
050699	***	*	28.9083	21.5725	28.8973	26.4337
050701	1.3490	1.1822	31.9529	34.9876	37.2811	34.8704
050704	1.0435	1.1916	29.7740	31.6097	32.1995	31.2008
050707	***	*	35.7311	43.5555	44.0218	40.8918
050708	1.4932	1.1822	30.5860	31.8442	28.3051	30.2199
050709	1.4478	1.1822	26.8549	24.5621	29.5339	27.1486
050710	1.2058	1.1822	45.8022	44.2482	46.2957	45.4488
050713	***	*	21.1273	21.4825	*	21.2886
050714	1.4054	1.5818	31.9527	34.1542	42.9756	36.5738
050717	1.5439	1.1916	39.3227	38.8773	37.0867	38.4090
050718	***	*	25.5140	31.9622	*	28.5587
050720	0.9656	1.1822	29.4726	30.3595	32.1156	30.5944
050722	0.9138	1.1822	31.4867	33.7991	35.6698	33.7766
050723	1.3255	1.1916	38.5446	38.7140	41.1633	39.6081
050724	2.0000	1.1822	31.6910	35.2344	35.0980	34.1972
050725	0.8736	1.1916	24.3100	30.0580	28.8366	27.6830
050726	1.5371	1.1963	30.6479	28.6361	30.6054	29.9355
050727	1.3473	1.1916	33.9118	32.7783	33.0915	33.2499
050728	***	*	39.3581	41.8263	*	40.4993
050729	***	*	36.5432	38.1882	*	37.4033
050730	***	*	37.0629	39.2046	*	38.1210
050732	2.3278	1.1822	*	33.6831	34.3456	34.0196
050733	1.5906	1.2730	*	40.1517	40.6287	40.3877
050734	***	*	*	31.2883	*	31.2883
050735	1.3963	1.1916	*	*	36.6052	36.6052
050736	1.2104	1.1916	*	*	41.8905	41.8905
050737	1.4996	1.1916	*	*	38.0395	38.0395

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
050738	1.5052	1.1916	*	*	43.9225	43.9225
050739	1.6284	1.1916	*	*	57.2436	57.2436
050740	1.4538	1.1916	*	*	54.0328	54.0328
050741	1.4520	1.1916	*	*	51.1485	51.1485
050742	1.4454	1.1916	*	*	39.0793	39.0793
050744	1.7412	1.1822	*	*	48.4913	48.4913
050745	1.3450	1.1822	*	*	42.5490	42.5490
050746	1.8196	1.1822	*	*	43.1981	43.1981
050747	1.5410	1.1822	*	*	44.5852	44.5852
050748	1.1344	1.1954	*	*	42.9957	42.9957
050749	1.3856	1.1822	*	*	28.1978	28.1978
050750	***	*	*	*	33.9880	33.9880
050751	2.9380	1.1916	*	*	29.5465	29.5465
050752	1.4092	1.1916	*	*	39.8004	39.8004
050753	1.6850	1.1916	*	*	*	*
050754	1.1933	1.5025	*	*	*	*
050755	1.3602	1.1916	*	*	*	*
050757	1.5947	1.1822	*	*	*	*
050758	1.3399	1.1822	*	*	*	*
050759	2.1683	1.1822	*	*	*	*
060001	1.5186	1.0070	29.6191	31.0018	32.4200	30.9988
060003	1.4098	1.0409	29.4809	31.3616	31.8621	30.9372
060004	1.1053	1.0561	32.4609	32.0095	34.8408	33.1185
060006	1.3131	0.9303	25.2139	27.2057	26.8067	26.4045
060008	1.2609	0.9303	23.0947	26.5175	27.2059	25.5276
060009	1.4736	1.0561	31.5210	32.4208	34.0129	32.6683
060010	1.5411	0.9734	27.1916	29.5304	30.6402	29.1093
060011	1.5219	1.0561	35.1573	32.1001	34.4158	33.8458
060012	1.5548	0.9738	27.3885	28.7724	29.4348	28.5090
060013	1.5942	0.9303	26.8675	27.9145	28.0786	27.6090
060014	1.8805	1.0561	31.0542	31.9389	33.0340	32.0056
060015	1.8679	1.0561	32.5285	32.2927	36.3270	33.6071
060016	1.1848	0.9303	26.5427	27.1430	28.3040	27.3080
060018	1.2897	0.9303	24.1086	25.3897	26.5770	25.3463
060020	1.5516	0.9303	24.5992	25.9147	26.7340	25.7382
060022	1.6011	0.9738	28.2944	29.3379	31.9353	29.8727
060023	1.6260	1.0409	29.5760	31.1556	32.7901	31.1705
060024	1.8688	1.0561	30.0279	31.5411	32.8183	31.5099
060027	1.5941	1.0409	29.6121	30.9212	31.6117	30.7134
060028	1.4266	1.0561	31.6900	32.1656	33.4942	32.4479
060030	1.4302	0.9734	27.8642	29.9513	31.2907	29.7046
060031	1.5357	1.0409	27.8345	29.3907	30.8385	29.3398
060032	1.4900	1.0561	31.0686	32.7383	34.6417	32.7827
060034	1.7145	1.0561	30.9359	32.1252	33.3625	32.1070
060036	1.0946	0.9303	20.3226	22.8256	20.9359	21.3443
060041	0.9254	0.9303	24.6142	25.9710	31.4722	27.2226
060043	0.9724	0.9303	18.2143	21.9955	23.3899	21.1620
060044	1.1929	0.9303	26.5611	24.8352	29.4060	26.8390
060049	1.4157	0.9581	29.3724	30.2192	32.1570	30.6358
060054	1.4812	0.9925	24.3389	25.0980	24.6714	24.6993
060064	1.7013	1.0561	32.3681	33.2428	37.2384	33.8162
060065	1.4081	1.0561	32.4735	33.8538	34.9177	33.7649
060071	1.1347	0.9303	27.6657	28.1762	31.5370	29.2648
060075	1.3842	0.9925	32.2545	37.6023	35.8069	35.2179
060076	1.2641	0.9303	26.5631	30.7808	31.6033	29.6210
060096	1.6188	1.0409	32.1310	37.8243	38.2230	36.0395
060100	1.7198	1.0561	32.6104	33.2145	33.5326	33.1192
060103	1.3654	1.0409	31.6314	32.9690	33.7519	32.8044
060104	1.4279	1.0561	32.4232	35.4409	37.1405	34.8954
060107	1.5071	1.0561	26.8388	28.0660	30.3986	28.4350
060112	1.6339	1.0561	34.9272	34.7116	35.1275	34.9373
060113	1.4241	1.0561	*	32.6073	35.2074	33.9039
060114	1.3878	1.0561	*	34.8536	35.3035	35.0938
060115	0.8560	0.9303	*	*	*	*
060116	1.2796	1.0409	*	*	33.1528	33.1528
060117	1.4396	0.9303	*	*	28.3098	28.3098
060118	1.4247	0.9303	*	*	*	*

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
060119	2.0319	0.9734	*	*	*	*
070001	1.5932	1.2038	35.8958	37.0403	37.9403	36.9862
070002	1.8116	1.1897	33.4398	34.7636	36.4240	34.8862
070003	1.1297	1.1897	34.1352	35.6320	36.0505	35.2926
070004	1.1791	1.1897	29.4448	29.9557	31.2093	30.2307
070005	1.4770	1.2038	33.7813	34.9404	36.5469	35.0801
070006	1.3529	1.2391	37.9148	39.3935	41.2133	39.5140
070007	1.2875	1.1897	35.9617	36.2914	36.8054	36.3570
070008	1.2515	1.1897	28.5506	30.7305	35.4942	31.5216
070009	1.3430	1.1897	32.9299	35.5670	36.6355	34.9997
070010	1.6851	1.2391	35.3730	36.7227	38.6086	36.9439
070011	1.4127	1.1897	31.8987	31.6843	34.1325	32.5714
070012	1.4106	1.1897	29.4216	31.9345	33.2459	31.5134
070015	1.4333	1.2391	35.3385	37.3454	39.9225	37.5863
070016	1.4989	1.2038	31.4930	33.2391	34.1238	32.9404
070017	1.3644	1.2038	34.0490	35.6456	37.5821	35.7978
070018	1.3783	1.2391	39.7515	41.8460	42.4745	41.4021
070019	1.3857	1.2038	34.5125	33.7246	35.8591	34.6869
070020	1.2985	1.1897	33.6453	32.9714	35.6515	34.1183
070021	1.1854	1.1897	36.9241	38.5623	39.7761	38.4026
070022	1.6626	1.2038	39.0462	40.2283	41.4692	40.2883
070024	1.3628	1.1897	35.2323	34.7419	36.8976	35.6415
070025	1.7385	1.1897	32.4085	34.5887	36.1293	34.3741
070027	1.4463	1.1897	29.8513	30.4433	33.5960	31.3085
070028	1.5690	1.2391	35.1966	38.0855	43.1846	38.7150
070029	1.2883	1.1897	30.9299	31.0662	32.8478	31.6076
070031	1.2891	1.2038	30.1915	30.4054	30.5906	30.4009
070033	1.4498	1.2391	40.1594	41.7955	44.6692	42.2677
070034	1.4240	1.2391	38.3965	40.1685	42.4078	40.3330
070035	1.2479	1.1897	30.7440	32.2766	33.4024	32.1114
070036	1.6115	1.1897	38.3413	42.3391	43.6345	41.4903
070038	0.8866	1.2038	25.7914	35.8053	29.9492	29.4507
070039	0.9487	1.2038	36.1369	34.7219	32.7121	34.7190
070040	1.0777	1.1897	*	*	*	*
080001	1.6391	1.0799	32.0105	33.5310	34.9490	33.5152
080002	***	*	29.6800	31.3391	33.0378	31.3601
080003	1.6226	1.0799	30.7697	34.3048	30.5113	31.8516
080004	1.5578	1.0645	30.1094	32.2443	34.3823	32.3013
080006	1.3096	1.0304	27.4749	28.8862	31.0299	29.2083
080007	1.4835	1.0909	30.1100	31.1645	33.4764	31.6259
090001	1.7487	1.1018	36.6577	38.3043	40.1629	38.3535
090003	1.2254	1.0670	31.0419	32.1960	32.8939	31.9877
090004	1.9209	1.1018	35.6964	37.3798	38.5646	37.2403
090005	1.4073	1.0670	33.0178	33.7448	35.2850	34.0306
090006	1.3917	1.0670	29.4912	31.3562	32.3448	31.0266
090008	1.2958	1.0670	32.0745	33.7471	36.6606	34.0292
090011	2.0065	1.1018	36.7579	38.0654	39.0086	37.9688
100001	1.4956	0.9092	26.4631	27.2809	27.8509	27.2111
100002	1.4292	1.0025	27.2350	28.7068	30.6650	28.8632
100006	1.6260	0.9189	29.1505	28.3673	28.9654	28.8205
100007	1.5846	0.9189	28.5702	29.0472	30.3800	29.3589
100008	1.6979	0.9865	29.1705	30.3392	32.1650	30.5829
100009	1.3613	0.9865	27.4424	27.8618	30.0468	28.3830
100012	1.6154	0.9502	28.4600	29.8353	30.8602	29.7781
100014	1.4551	0.9073	25.1524	27.4019	27.4048	26.6903
100015	1.2730	0.8993	26.0916	27.2483	28.6813	27.3086
100017	1.6234	0.9073	27.9654	28.2402	29.8685	28.7071
100018	1.6116	0.9820	30.2423	30.6545	32.8609	31.2755
100019	1.6071	0.9401	28.6630	30.3008	31.4521	30.1350
100020	***	*	27.1257	*	*	27.1257
100022	1.6470	1.0025	32.8088	36.7912	36.3330	35.3146
100023	1.5384	0.9073	25.2652	25.4270	27.1008	26.0111
100024	1.2924	0.9865	29.1894	29.5423	29.8902	29.5369
100025	1.7145	0.8633	23.3843	26.7013	27.1652	25.7513
100026	1.5761	0.8633	23.4730	26.0147	27.3027	25.6436
100027	***	*	18.9432	*	*	18.9432
100028	1.3554	0.9401	27.7497	27.5664	28.7776	28.0281

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
100029	1.2121	0.9865	28.8842	30.5382	31.5979	30.3873
100030	1.3539	0.9189	24.6314	25.3513	26.3096	25.4476
100032	1.6723	0.8993	26.8162	26.9275	27.8918	27.2236
100034	1.7942	0.9865	28.1280	27.2915	28.9362	28.1268
100035	1.6017	0.9757	29.4803	30.2382	32.5568	30.7182
100038	1.7177	1.0025	31.3403	31.6657	32.8363	31.9625
100039	1.5743	1.0025	28.2531	29.3699	29.0221	28.8790
100040	1.7008	0.9092	26.2429	27.2835	28.3342	27.2945
100043	1.4134	0.8993	26.4221	27.0054	26.8400	26.7591
100044	1.5389	0.9905	30.3659	33.1141	34.3895	32.6318
100045	1.3128	0.9073	29.7375	26.5413	25.5601	27.1971
100046	1.4584	0.8993	26.9469	26.7702	27.7856	27.1801
100047	1.6986	0.9648	26.7674	29.9729	31.4038	29.3525
100048	0.9293	0.8633	19.3226	20.2657	21.7684	20.4248
100049	1.2227	0.8715	24.0385	24.5571	27.6295	25.3718
100050	1.1486	0.9865	21.5101	25.3354	23.5194	23.4888
100051	1.3882	0.9189	28.0946	28.6225	30.1464	29.0839
100052	1.4592	0.8715	23.6796	23.4036	25.1096	24.0877
100053	1.3335	0.9865	28.5118	31.7415	31.9242	30.6741
100054	1.4058	0.8703	28.7646	30.5515	30.9825	30.1173
100055	1.4682	0.8993	25.6243	27.3826	29.6999	27.4746
100057	1.4366	0.9189	24.8010	26.3134	27.7025	26.3249
100061	1.5221	0.9865	31.4413	30.4528	31.9154	31.2647
100062	1.6289	0.8633	25.1280	25.9597	26.3043	25.8131
100063	1.2914	0.8993	25.5097	26.4139	27.0754	26.3647
100067	1.4240	0.8993	26.8628	27.4762	27.5486	27.3159
100068	1.6629	0.9073	26.1341	27.6576	27.6975	27.1712
100069	1.5199	0.8993	25.7450	27.2108	29.0462	27.3031
100070	1.6948	0.9757	26.8461	29.2005	29.1098	28.3496
100071	1.3016	0.8993	26.3768	25.3667	25.1867	25.6298
100072	1.3899	0.9073	25.7962	27.1889	27.6927	26.8986
100073	1.7604	1.0025	30.5845	29.4165	31.0379	30.3564
100075	1.5137	0.8993	25.7612	27.6534	26.7551	26.7473
100076	1.2093	0.9865	23.4551	24.0412	24.0262	23.8474
100077	1.3908	0.9648	30.6925	30.7564	27.9764	29.8150
100079	1.4454	*	*	*	*	*
100080	1.6170	1.0025	28.2188	29.5346	31.0487	29.6112
100081	0.9435	0.8633	16.9756	19.5711	19.7407	18.7147
100084	1.7063	0.9189	27.4947	32.7503	30.6285	30.2189
100086	1.3909	1.0025	28.5971	29.9072	31.3169	29.9261
100087	1.8447	0.9757	29.5823	30.5938	32.1290	30.7622
100088	1.5784	0.9092	26.7574	28.2825	29.5464	28.3236
100090	1.4708	0.9092	26.5703	27.6175	28.9548	27.7918
100092	1.5273	0.9401	27.8341	26.6315	28.6765	27.7162
100093	1.7183	0.8633	21.6438	22.5555	23.4836	22.5921
100099	1.0283	0.8715	25.8454	26.2395	28.0669	26.7407
100102	1.1035	0.8758	26.1015	27.8551	29.0373	27.7069
100105	1.5837	0.9741	29.9745	30.9915	30.8907	30.6081
100106	1.0497	0.8633	24.7650	24.8098	25.6284	25.0615
100107	1.1889	0.9502	27.4760	30.5764	31.2927	29.8950
100108	0.8653	0.8633	21.3540	22.6270	22.8139	22.2176
100109	1.2509	0.9073	25.5669	26.2446	26.7361	26.2234
100110	1.5739	0.9189	29.4788	29.5985	30.3729	29.8429
100113	1.9724	0.9427	28.0440	29.2429	30.5837	29.3004
100114	1.7025	0.9865	29.2862	30.2544	32.3934	30.6145
100117	1.2439	0.9092	27.7198	28.4928	30.0549	28.8365
100118	1.3879	0.8633	27.6438	27.0981	28.3179	27.7197
100121	1.1178	0.8715	26.2990	27.9353	24.9371	26.3668
100122	1.2316	0.8703	24.6285	26.7175	27.6162	26.3632
100124	1.1998	0.8633	24.0333	24.8880	26.2310	25.0380
100125	1.2235	0.9865	29.7750	31.7749	33.3469	31.6838
100126	1.3212	0.8993	29.6247	28.3213	28.9151	28.9566
100127	1.5761	0.8993	26.0923	27.4632	27.0669	26.8835
100128	2.1341	0.8993	29.2566	30.0324	30.3690	29.9099
100130	1.1458	1.0025	26.0268	28.3651	30.9735	28.5262
100131	1.4707	0.9865	27.8164	29.7647	30.9586	29.6460
100132	1.2889	0.8993	26.0526	27.8180	27.6613	27.2139

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
100134	0.8985	0.8633	20.7367	21.6544	22.9624	21.8248
100135	1.6390	0.8981	26.7030	29.1856	29.8423	28.5445
100137	1.3328	0.8715	24.8519	26.8391	28.2969	26.7255
100139	0.8641	0.9427	18.2197	21.1310	21.4420	20.1386
100140	1.1161	0.9092	26.1352	27.8352	28.5466	27.5007
100142	1.1395	0.8633	24.8853	25.6999	26.8978	25.8482
100150	1.2603	0.9865	26.8492	27.7740	29.3690	27.9646
100151	1.7355	0.9092	30.6447	29.7267	31.3820	30.5873
100154	1.6098	0.9865	28.2506	29.7332	31.3618	29.8234
100156	1.1428	0.9427	27.5706	28.3927	28.3041	28.1071
100157	1.5705	0.8993	29.7455	30.3086	30.3339	30.1497
100160	1.2508	0.9865	30.7454	30.6902	32.3113	31.2761
100161	1.5295	0.9189	28.0545	29.5673	30.8955	29.5189
100166	1.5059	0.9757	28.8685	30.1811	31.9053	30.2720
100167	1.2272	1.0025	30.2166	31.7813	32.4711	31.5289
100168	1.5608	1.0025	27.6739	27.0938	28.0517	27.6177
100172	***	*	20.7857	22.2183	20.5502	21.2381
100173	1.6082	0.8993	26.5436	28.6402	30.2470	28.5123
100175	0.9474	0.8633	23.9665	25.0913	26.1711	25.0707
100176	1.8223	1.0025	30.7087	33.3181	35.5821	33.1514
100177	1.3295	0.9401	28.0089	29.6284	31.0063	29.5570
100179	1.7392	0.9092	29.1111	29.2795	30.5213	29.6480
100180	1.5114	0.8993	29.9238	31.0099	31.5463	30.8513
100181	1.1566	0.9865	24.3708	23.9656	26.0656	24.7884
100183	1.2816	0.9865	29.0270	30.5042	32.9863	30.7987
100187	1.3637	0.9865	27.8144	30.7705	31.6639	30.0560
100189	1.3348	1.0025	28.8320	29.9376	30.5491	29.8033
100191	1.3365	0.8993	28.3710	29.4533	30.9183	29.5986
100200	1.3715	1.0025	28.7694	29.6400	29.0719	29.1618
100204	1.5799	0.9427	27.4763	27.2819	29.9311	28.2769
100206	1.2774	0.8993	27.0295	27.7551	28.8609	27.8936
100209	1.5193	0.9865	26.8473	28.5336	29.0435	28.1481
100210	1.5671	1.0025	29.8515	32.0830	32.4538	31.4634
100211	1.2490	0.8993	24.7533	26.2859	28.8303	26.5619
100212	1.4634	0.8633	26.1846	27.7960	29.2475	27.7618
100213	1.5367	0.9757	27.9283	29.5218	30.2251	29.2000
100217	1.3065	0.9741	27.3989	27.7683	30.3301	28.4907
100220	1.6181	0.9502	28.3868	29.3601	30.8265	29.5174
100223	1.5286	0.8703	25.0332	26.1115	27.6756	26.3160
100224	1.2624	1.0025	26.6446	28.0455	29.1992	27.9615
100225	1.3079	1.0025	28.5259	30.8782	32.6890	30.6971
100226	1.3028	0.9092	28.8165	28.8791	30.2828	29.3578
100228	1.3954	1.0025	28.1396	30.1635	31.0195	29.7490
100230	1.3499	1.0025	29.8493	31.9448	34.6099	32.1778
100231	1.7092	0.8633	25.7037	26.6773	28.3633	26.9108
100232	1.2640	0.9092	28.5537	28.3892	29.3783	28.7734
100234	1.3320	1.0025	27.4456	28.8835	29.7800	28.7289
100236	1.4357	0.9648	28.9955	28.3017	30.5701	29.2818
100237	1.8545	1.0025	31.7848	33.1536	33.9606	32.9295
100238	1.5484	0.8993	30.1094	31.4198	31.6331	31.0862
100239	1.3821	0.8993	28.6893	29.0650	30.3212	29.3632
100240	0.9591	0.9865	27.3523	29.7000	31.0943	29.4319
100242	1.5092	0.8633	25.6083	26.1988	27.8149	26.5486
100243	1.4703	0.8993	27.4534	28.3894	29.8294	28.5415
100244	1.4338	0.9502	26.6876	28.2881	29.8266	28.3031
100246	1.5457	0.9905	29.3310	30.1061	30.0261	29.8298
100248	1.5452	0.8993	28.8082	30.2133	32.4702	30.5161
100249	1.2896	0.8993	24.9876	26.4676	28.5107	26.7077
100252	1.1632	0.9741	27.8256	27.1639	29.1429	28.0419
100253	1.3893	1.0025	27.4927	28.7770	28.5597	28.3018
100254	1.4934	0.8981	26.1406	27.4900	28.5240	27.3995
100255	1.3025	0.8993	26.5571	27.3866	29.5157	27.8451
100256	1.7382	0.8993	30.3081	30.2093	33.3907	31.2430
100258	1.5591	1.0025	31.2203	33.8630	35.2197	33.4797
100259	1.2682	0.8993	27.4809	29.0612	29.9274	28.8444
100260	1.3830	0.9905	26.7129	28.2301	29.4885	28.1387
100264	1.4156	0.8993	26.8216	28.0370	30.1956	28.3177

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
100265	1.3296	0.8993	25.7432	26.3326	26.6920	26.2976
100266	1.3896	0.8633	23.0208	24.2517	25.6366	24.3555
100267	1.2811	0.9757	28.7259	28.9674	30.6033	29.4523
100268	1.1771	1.0025	29.0668	30.5750	33.6114	31.0650
100269	1.3742	1.0025	26.6047	27.8407	28.3722	27.6319
100271	2.0607	*	*	*	*	*
100275	1.3310	1.0025	26.8943	28.7797	31.0459	28.9926
100276	1.2874	1.0025	29.7606	30.5720	31.7050	30.6750
100277	1.5574	0.9865	20.4791	24.1122	25.5878	23.9890
100279	1.4040	0.9502	28.6383	29.2257	31.1921	29.7250
100281	1.3929	1.0025	29.6698	30.9131	32.8807	31.2127
100284	1.0632	0.9865	22.3134	25.2637	21.4401	22.7441
100285	1.2639	1.0025	*	41.9481	34.7963	39.4585
100286	1.5465	0.9820	28.3645	25.8085	26.5795	26.8126
100287	1.3877	1.0025	28.1051	29.7536	30.3059	29.3361
100288	1.7404	1.0025	28.7902	31.0506	32.9558	30.8729
100289	1.6231	1.0025	29.6376	31.9011	31.4701	31.0127
100290	1.2302	0.9215	27.1011	28.7111	29.7566	28.5282
100291	1.3483	0.9401	28.4722	28.1515	28.3762	28.3296
100292	1.3753	0.8633	26.7063	27.7644	28.5799	27.7205
100293	***	*	32.7963	*	*	32.7963
100294	***	*	30.7557	*	*	30.7557
100295	***	*	26.1983	*	*	26.1983
100296	1.3271	0.9865	*	29.3870	31.1449	30.2840
100297	***	*	*	32.1536	*	32.1536
100298	0.8450	0.8981	*	19.0297	21.9226	20.3569
100299	1.2918	0.9757	*	34.3697	31.6820	33.1821
100300	***	*	*	*	33.1669	33.1669
100302	1.1546	0.9189	*	*	*	*
110001	1.3724	0.8740	26.4338	26.5640	27.4189	26.8009
110002	1.3136	0.9760	26.4715	26.2228	28.9001	27.2273
110003	1.3119	0.7840	22.7066	24.2097	25.0083	23.9366
110004	1.3686	0.8880	24.9978	25.1846	27.2513	25.7796
110005	1.2944	0.9760	28.1209	27.2826	29.5994	28.4189
110006	1.5596	0.9589	28.3839	*	32.3714	30.3778
110007	1.5907	0.8770	26.6396	26.3133	28.0665	27.0191
110008	1.3589	0.9760	29.2947	30.9757	31.8366	30.6980
110010	2.1741	0.9760	31.7185	33.2396	33.9818	32.9905
110011	1.2809	0.9760	28.0598	28.5892	30.3526	29.0303
110015	1.0815	0.9760	28.1274	28.8796	30.5004	29.2479
110016	1.2537	0.8495	22.7263	24.3563	25.9193	24.3226
110018	1.1989	0.9760	26.8016	30.1849	30.9429	29.3022
110020	1.2987	0.9760	28.3822	27.5559	29.4629	28.5809
110023	1.3269	0.9760	29.8061	29.3282	29.2001	29.4297
110024	1.4712	0.8943	27.0225	27.3357	28.5637	27.6412
110025	1.4799	1.0139	31.0703	30.2845	32.6731	31.3350
110026	1.0963	0.7840	21.8018	22.8820	24.3858	23.0082
110027	1.0459	0.7840	22.6058	25.5291	25.6536	24.4936
110028	1.7426	0.9604	30.4641	31.4568	32.8679	31.5933
110029	1.7563	0.9760	27.3618	29.2134	30.0367	28.8932
110030	1.3857	0.9760	29.6841	29.9531	32.0250	30.6320
110031	1.2793	0.9760	27.1989	29.5533	30.7447	29.1990
110032	1.2564	0.7840	23.2586	25.1896	24.4949	24.3026
110033	1.7263	0.9760	30.3415	32.4178	32.7019	31.8557
110034	1.7739	0.9604	27.2338	28.7915	29.6801	28.5541
110035	1.7859	0.9760	28.9408	30.1852	31.5705	30.2749
110036	1.8235	0.8943	26.6664	27.2280	28.4022	27.4638
110038	1.5488	0.8397	22.2720	22.9685	23.3659	22.8669
110039	1.3716	0.9604	26.3503	26.2485	28.4347	26.8945
110040	1.1123	0.9760	20.9487	23.9526	21.5761	22.1590
110041	1.2061	0.9760	24.8864	26.1948	27.6593	26.2845
110042	1.0795	0.9760	34.9954	33.4391	34.5117	34.3025
110043	1.7560	0.8943	27.8477	28.8551	30.3702	28.9989
110044	1.2146	0.7840	23.3039	24.3772	27.0418	24.8928
110045	1.0279	0.9760	24.4275	27.7619	28.2217	26.7950
110046	1.1453	0.9760	26.7464	*	28.6264	27.6790
110050	1.0857	0.8499	27.5985	27.0651	27.1525	27.2626

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
110051	1.1244	0.7840	20.1756	21.4898	22.1488	21.3080
110054	1.4223	0.9760	28.9254	29.4691	31.5780	30.0224
110059	1.1567	0.7840	23.2137	24.7838	24.9265	24.3029
110064	1.5836	0.9061	24.1219	26.9363	28.7283	26.5861
110069	1.3437	0.9618	26.2085	29.9098	30.6443	28.9853
110071	1.1205	0.7840	21.3963	21.2041	23.6494	22.1661
110073	1.0228	0.7840	18.5753	23.3571	23.0067	21.5478
110074	1.4894	0.9589	27.9190	31.0062	30.3996	29.7348
110075	1.3134	0.8841	23.7585	24.8244	26.1068	24.8944
110076	1.4843	0.9760	28.7871	29.4344	31.0636	29.7176
110078	1.9462	0.9760	29.9625	30.5196	31.1064	30.5424
110079	1.5678	0.9760	26.8412	27.3274	29.0882	27.7224
110080	***	*	18.4714	*	*	18.4714
110082	1.9672	0.9760	30.8320	30.1072	31.1407	30.6976
110083	1.9525	0.9760	30.4287	34.0610	34.5768	33.0335
110086	1.2641	0.7840	21.6898	22.9959	23.4762	22.7087
110087	1.4285	0.9760	28.1633	31.0403	32.8007	30.7266
110089	1.1392	0.7840	23.9026	24.3327	26.0096	24.7677
110091	1.2915	0.9760	29.5337	27.0994	28.0609	28.1665
110092	1.1137	0.7840	20.8911	21.4168	22.8591	21.7047
110095	1.4622	0.8397	26.3075	28.0526	27.9005	27.4450
110100	0.9787	0.8630	16.2575	20.8201	20.0633	18.9182
110101	0.9836	0.7907	19.4257	21.0983	23.8601	21.3923
110104	1.2036	0.7840	20.3777	21.8966	22.2585	21.5748
110105	1.3643	0.7840	23.1405	23.4010	23.7738	23.4420
110107	1.9504	0.9815	28.9352	30.1027	31.5754	30.2370
110109	1.0213	0.7840	23.0376	21.6023	21.6011	22.0502
110111	1.1524	0.9604	25.1270	25.7084	27.2234	26.0060
110112	1.0413	0.8397	22.7672	26.4089	24.2924	24.5380
110113	0.9563	0.9604	21.3417	22.0793	22.0479	21.8312
110115	1.7706	0.9760	31.5074	32.7927	33.3880	32.5794
110121	1.0024	0.8397	26.2336	23.4571	24.5645	24.7827
110122	1.5445	0.8397	25.1934	25.4439	26.3052	25.6427
110124	1.0887	0.7840	22.9212	22.9571	24.8540	23.5883
110125	1.2577	0.9618	23.7834	24.7347	26.4991	24.9905
110128	1.2891	0.8841	25.7839	25.4190	24.5272	25.2129
110129	1.5763	0.9061	25.9625	30.0444	29.7304	28.5402
110130	0.9171	0.7840	19.1284	20.4349	21.7084	20.4154
110132	1.0348	0.7840	20.2502	21.2642	21.6033	21.0527
110135	1.2731	0.7840	22.5346	24.0945	25.1022	23.9470
110136	***	*	18.8212	*	*	18.8212
110142	0.9807	0.8025	21.3935	21.6286	22.2156	21.7484
110143	1.4253	0.9760	28.6583	29.9139	30.9590	29.8777
110146	1.0832	0.9112	27.0987	29.0193	30.1159	28.7418
110149	***	*	28.4040	*	*	28.4040
110150	1.2994	0.9760	25.3742	26.9884	27.7908	26.7261
110153	1.1210	0.9618	25.7467	29.3305	30.2424	28.4006
110161	1.5555	0.9760	30.4885	31.5001	31.9981	31.3389
110163	1.4520	0.8770	28.2169	27.7679	29.5674	28.5127
110164	1.7038	0.9815	28.8946	30.0145	31.2804	30.1111
110165	1.4333	0.9760	27.0977	28.7902	28.7898	28.2209
110168	1.7664	0.9760	28.5700	29.7774	30.8727	29.7602
110172	1.4736	0.9760	31.1234	31.3999	33.0426	31.8709
110177	1.9238	0.9604	28.8356	29.7079	30.5507	29.7260
110183	1.2868	0.9760	28.6208	28.3505	29.6606	28.9003
110184	1.2634	0.9760	28.3545	29.4071	30.2897	29.4131
110186	1.3171	0.9061	27.4925	28.2880	29.6479	28.4857
110187	1.2029	0.9760	25.2139	26.9638	31.0150	27.7895
110189	1.1025	0.9760	26.1418	26.2799	27.4200	26.6304
110190	1.0867	0.8081	23.3204	24.5224	29.4199	25.5710
110191	1.3278	0.9760	27.7760	30.9481	28.7481	29.1019
110192	1.4139	0.9760	28.8267	30.0843	31.6605	30.2562
110193	***	*	27.9161	*	*	27.9161
110194	0.8957	0.7840	19.1920	21.0826	20.5257	20.2837
110198	1.3546	0.9760	31.0557	32.8171	34.0021	32.6125
110200	2.0256	0.9061	24.9236	27.2974	29.4610	27.3150
110201	1.4532	0.9815	31.0841	32.0967	33.4267	32.2165

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Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
110203	0.9588	0.9760	29.7888	32.3441	32.0585	31.3300
110205	1.1768	0.8347	22.0207	23.9738	26.1963	24.0311
110209	0.6196	0.7840	21.1534	21.2428	22.4539	21.6327
110212	1.2087	0.8163	*	*	*	*
110214	***	*	37.1450	*	*	37.1450
110215	1.3584	0.9760	27.5566	29.5238	30.1770	29.1787
110219	1.4002	0.9760	28.8814	32.2603	33.4462	31.6155
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	1.2065	0.9760	*	29.5373	28.9757	29.2212
110226	1.1952	0.9760	*	*	32.1814	32.1814
110228	0.8800	0.9760	*	*	*	*
110229	1.2950	0.9760	*	*	*	*
110230	1.3685	0.7840	*	*	*	*
120001	1.7874	1.1608	34.1385	39.6348	39.0344	37.5738
120002	1.2448	1.1219	32.3784	34.1709	37.7249	34.7927
120004	1.2549	1.1608	30.0668	31.3555	32.5141	31.3602
120005	1.2949	1.1219	31.1985	33.6942	35.1716	33.3840
120006	1.2614	1.1608	31.6785	34.2231	35.7058	33.9086
120007	1.6360	1.1608	30.2473	30.8773	35.0167	31.9560
120010	1.9848	1.1608	29.5714	30.8526	34.3338	31.4351
120011	1.4966	1.1608	37.1792	39.1941	44.0519	40.3992
120014	1.3531	1.1219	30.3463	30.9839	34.2101	31.8841
120019	1.1710	1.1219	30.4257	33.0114	36.1586	33.2188
120022	1.8673	1.1608	29.9527	32.5326	34.9024	32.4610
120026	1.4190	1.1608	32.4566	34.2244	35.8383	34.2218
120027	1.3261	1.1608	28.7905	29.5825	31.8146	30.1238
120028	1.2595	1.1608	32.4847	34.0451	34.6327	33.7338
120029	***	*	*	44.6382	*	44.6382
130002	1.4057	0.9100	24.7871	24.7266	24.3491	24.6130
130003	1.4692	0.9560	28.6158	28.6136	29.8774	29.0074
130006	1.7566	0.9290	27.2158	28.0048	28.8325	28.0328
130007	1.7298	0.9290	28.7246	30.4958	31.2250	30.1204
130013	1.3634	0.9290	30.9609	36.1570	33.8909	33.6903
130014	1.2442	0.9290	27.2543	27.5936	28.2815	27.7157
130018	1.7489	0.9327	27.3439	28.4041	30.2030	28.6009
130024	1.1981	0.8272	23.6212	24.8035	25.3184	24.5765
130025	1.2309	0.7597	21.1998	22.7962	23.8581	22.6625
130028	1.4347	0.9103	27.2195	28.4934	29.3360	28.3737
130049	1.5627	1.0315	27.3597	29.0185	29.7190	28.7360
130062	***	*	25.6467	29.1925	28.3416	27.9024
130063	1.4068	0.9290	26.0955	27.7607	27.7664	27.1825
130065	1.9441	0.9327	21.9792	30.4547	25.8977	26.3095
130066	2.0484	0.9504	*	28.9883	28.1483	28.5227
130067	2.5439	*	*	21.3867	26.8243	23.8814
140001	1.1235	0.8797	22.3001	22.2003	23.2221	22.5895
140002	1.3464	0.8993	27.0165	27.4779	29.1084	27.9303
140007	1.4044	1.0334	30.7378	31.4024	32.4342	31.5521
140008	1.4402	1.0334	29.1767	31.8008	32.7592	31.2208
140010[3]	1.4980	1.0334	31.8806	40.1360	39.3702	36.3250
140B10[3]	***	*	*	40.1360	39.3702	39.7545
140011	1.2146	0.8428	23.8575	25.8864	26.2125	25.4083
140012	1.3120	1.0334	29.0336	31.8213	31.9498	30.8913
140013	1.4671	0.9043	23.9269	25.0951	26.4178	25.1250
140015	1.3506	0.8993	24.4687	24.6409	25.2491	24.8022
140018	1.3731	1.0334	26.3533	30.7398	31.5604	29.4466
140019	0.9139	0.8428	21.3438	22.3179	22.2899	21.9787
140026	1.1531	0.8743	25.9669	26.0493	28.1690	26.7518
140029	1.5837	1.0334	30.2688	36.7722	36.3824	34.4448
140030	1.5087	1.0334	30.2776	31.6822	32.1110	31.3500
140032	1.2668	0.8993	26.7310	27.5367	28.5229	27.5996
140033	***	*	27.9993	29.5256	31.4328	29.1997
140034	1.1683	0.8993	24.0470	24.4653	26.7233	25.0924
140040	1.2236	0.9043	23.2293	24.5589	28.4995	25.3375

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
140043	1.2647	0.8606	27.3469	29.8633	31.3736	29.5994
140046	1.4727	0.8993	24.7334	25.6230	25.7906	25.3934
140048	1.2788	1.0334	29.3877	30.6686	31.6262	30.5704
140049	1.5369	1.0334	29.0976	30.8617	32.0217	30.6556
140051	1.5614	1.0334	30.9696	32.1730	32.7506	31.9766
140052	1.3408	0.8993	25.9617	26.9907	26.7896	26.5759
140053	1.7853	0.9133	27.4518	28.4513	29.9472	28.5957
140054	1.4862	1.0334	33.1406	34.2378	34.5342	33.9734
140058	1.2320	0.8993	24.6058	25.2568	26.5660	25.4975
140059	1.0669	0.8993	22.6743	21.6230	22.8588	22.3764
140062	1.3719	1.0334	34.1230	36.8271	36.6461	35.8580
140063	1.4103	1.0334	28.6559	30.5465	31.1242	30.0979
140064	1.2191	0.9043	23.8639	25.7551	26.6231	25.4620
140065	1.4143	1.0334	30.1856	31.5510	32.4631	31.3610
140066	1.1167	0.8993	22.1524	22.0225	23.6295	22.6003
140067	1.8104	0.9043	28.3506	29.8982	30.6882	29.6686
140068	1.2321	1.0334	28.3938	26.7166	31.3440	28.7631
140075	1.2712	1.0334	26.2626	35.9507	33.6844	31.5469
140077	0.9374	0.8993	20.3999	21.6468	22.5061	21.5537
140080	1.4286	1.0334	28.8791	29.9067	30.3760	29.7135
140082	1.6302	1.0334	28.3429	31.0516	32.0539	30.4270
140083	0.9706	1.0334	26.8919	27.2189	26.1622	26.6852
140084	1.2689	1.0334	30.5036	30.7251	31.3281	30.8596
140088	1.8601	1.0334	30.5450	32.6866	34.0556	32.5121
140089	1.2292	0.8428	24.1066	24.9120	26.6942	25.2540
140091	1.7570	0.9353	27.8536	28.2095	29.4099	28.5130
140093	1.2251	0.9711	28.3298	28.6709	31.2955	29.5310
140094	1.0614	1.0334	27.3841	28.7647	28.8596	28.3324
140095	1.2067	1.0334	28.7617	29.7385	29.9452	29.4617
140100	1.4165	1.0334	41.3374	37.2961	37.3023	38.5940
140101	1.2742	1.0334	29.4081	28.9723	31.0048	29.8038
140103	1.1919	1.0334	23.6406	24.0926	25.3608	24.3942
140105	***	*	29.5274	29.6590	30.7135	29.8404
140110	1.1348	1.0334	28.6364	30.3432	31.3460	30.1323
140113	1.5825	0.9353	29.5452	30.2542	31.6124	30.5020
140114	1.5001	1.0334	28.2151	29.8316	31.1390	29.7616
140115	1.2630	1.0334	26.0383	25.4576	26.2578	25.9061
140116	1.3668	1.0341	34.5537	34.3876	34.1356	34.3550
140117	1.5097	1.0334	27.7201	30.9679	28.5785	29.0528
140118	1.4623	1.0334	32.5518	33.1987	33.6634	33.1346
140119	1.8095	1.0334	34.2118	32.2185	34.3896	33.5609
140120	1.3098	0.9043	23.9724	25.9275	26.2398	25.4006
140122	1.5055	1.0334	30.5653	30.2888	32.4728	31.1094
140124	1.2504	1.0334	35.7563	38.2191	38.8956	37.6290
140125	1.1586	0.8993	22.7571	26.5801	27.6333	25.6694
140127	1.6283	0.9520	25.6668	27.8363	29.3326	27.6412
140130	1.2280	1.0334	32.6209	32.5425	34.5053	33.2090
140133	1.4054	1.0334	31.0269	30.3259	32.8907	31.4186
140135	1.4168	0.8840	23.3196	24.6645	25.9046	24.6639
140137	1.0555	0.8993	23.4174	31.4349	*	26.5232
140143	1.1818	1.0334	27.4499	26.1126	27.0294	26.8354
140145	1.0941	0.8993	26.0875	25.2040	26.9326	26.0849
140147	1.0800	0.8428	21.0686	21.1817	22.1026	21.4534
140148	1.6364	0.9133	25.5677	27.0038	28.9453	27.2136
140150	1.6423	1.0334	52.0970	35.5951	45.8193	44.1226
140151	0.7986	1.0334	27.0312	26.0825	27.3539	26.8313
140152	***	*	30.2209	29.8647	32.2789	30.7789
140155	1.3176	1.0334	29.5734	32.7960	35.0804	32.3959
140158	1.3565	1.0334	27.3721	30.4445	32.1130	30.0627
140160	1.1748	0.9756	25.8684	27.6905	28.9023	27.4932
140161	1.1449	0.8596	25.2898	28.8266	28.8132	27.6822
140162	1.5506	0.9520	29.4121	32.1810	33.0967	31.5165
140164	1.7462	0.8993	24.6009	25.9726	27.3117	26.0022
140166	1.1830	0.8428	26.4800	26.2875	27.2398	26.6846
140167	1.1518	0.8428	22.8703	24.9904	24.2733	24.0635
140172	1.3856	1.0334	32.1220	33.0926	33.4586	32.9106
140174	1.5880	1.0334	30.5905	31.2231	34.2433	32.0655

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
140176	1.2311	1.0341	32.9794	32.6145	33.2116	32.9375
140177	0.9832	1.0334	26.4340	25.5725	26.0709	26.0349
140179	1.3098	1.0334	29.3657	30.2944	31.3599	30.3150
140180	1.1869	1.0334	27.8887	29.1352	29.7982	28.9361
140181	1.1559	1.0334	25.0226	27.6835	27.3815	26.6876
140182	1.4662	1.0334	30.1755	32.8972	26.4085	29.5346
140184	1.3087	0.8428	25.2327	26.6104	27.5837	26.4843
140185	1.4359	0.8993	25.2423	26.5398	27.9409	26.5570
140186	1.4967	1.0334	29.8022	30.7212	41.2521	33.4222
140187	1.5073	0.8993	24.8332	25.5873	26.9246	25.7702
140189	1.1619	0.8428	22.5965	24.7013	29.1349	25.4810
140191	1.3271	1.0334	28.5836	31.9943	29.7497	30.0468
140197	1.0759	1.0334	24.0463	24.9103	24.8700	24.5943
140200	1.5134	1.0334	28.8435	30.6641	31.3692	30.2724
140202	1.4541	1.0334	32.7915	32.9433	34.3762	33.4137
140206	1.2021	1.0334	29.7953	29.6275	31.1376	30.1671
140207	1.1245	1.0334	26.0535	28.2262	31.6793	28.4326
140208	1.6424	1.0334	29.5380	31.4035	26.1728	28.8260
140209	1.5750	0.9043	26.3230	29.7965	27.4032	27.7656
140210	1.0667	0.8428	20.6954	19.2053	22.2507	20.7150
140211	1.3317	1.0334	30.3286	31.4539	34.5893	32.1847
140213	1.2466	1.0334	31.6926	32.1031	33.3902	32.4246
140217	1.4736	1.0334	32.1277	32.9404	33.2151	32.8054
140223	1.4965	1.0334	31.7267	33.5083	34.6969	33.3189
140224	1.3728	1.0334	29.6181	31.2237	30.1050	30.3035
140228	1.4758	0.9862	27.9456	28.2855	28.7440	28.3351
140231	1.4738	1.0334	30.0236	34.8291	35.2199	33.3358
140233	1.6742	0.9862	29.7093	31.5168	32.3348	31.1982
140234	1.0951	0.8743	24.5476	25.7353	25.7647	25.3480
140239	1.5089	0.9862	31.1879	31.0918	33.7241	31.9840
140240	1.4543	1.0334	31.5637	32.7986	28.0966	30.7320
140242	1.5121	1.0334	34.6120	35.2351	36.6696	35.4606
140250	1.2451	1.0334	29.6305	31.2533	32.9392	31.3008
140251	1.3749	1.0334	28.0622	28.3598	29.5921	28.6552
140252	1.4509	1.0334	34.4268	35.8762	36.1503	35.4953
140258	1.5542	1.0334	34.2333	33.0093	34.5667	33.9309
140275	1.3633	0.8606	27.8186	28.5064	26.7377	27.6728
140276	1.9223	1.0334	31.6359	32.1048	32.7052	32.1538
140280	1.4877	0.8606	24.9401	26.6536	26.9815	26.2013
140281	1.7853	1.0334	33.3903	35.6589	37.5673	35.5869
140286	1.2031	1.0334	30.3237	32.0048	32.2227	31.5106
140288	1.4810	1.0334	31.5197	31.5944	32.5446	31.8981
140289	1.2801	0.8993	23.8452	25.6847	26.0851	25.2075
140290	1.3716	1.0334	31.8135	32.5247	35.9647	33.4767
140291	1.5227	1.0334	31.9052	33.8706	32.7857	32.8705
140292	1.1466	1.0334	28.5094	30.6917	32.4476	30.3851
140294	1.1034	0.8428	24.0750	26.1595	26.9772	25.8209
140300	1.1745	1.0334	35.1494	42.5240	37.1204	38.1961
140301	1.0712	1.0334	49.9507	39.4295	38.0581	40.7701
140303	2.1328	1.0334	29.6470	*	32.2920	30.8365
150001	1.1896	0.9827	28.9075	31.8089	32.9797	31.2747
150002	1.4747	1.0328	26.6222	27.6481	28.1057	27.6106
150003	1.5897	0.8960	26.7585	26.9771	29.0575	27.6017
150004	1.4569	1.0328	28.7336	30.9626	31.6781	30.3933
150005	1.2612	0.9827	29.5371	30.5367	31.6148	30.6086
150006	1.3702	0.9353	25.6265	27.1364	28.3389	27.0718
150007	1.4525	0.9254	29.4971	30.0500	31.0369	30.2270
150008	1.4479	1.0328	27.5703	27.0525	29.1473	27.9333
150009	1.4395	0.9238	25.4496	25.7616	26.1499	25.7891
150010	1.5221	0.9254	27.2272	28.4118	28.2599	27.9486
150011	1.3308	0.9707	25.3178	26.7686	27.7857	26.5785
150012	1.5537	0.9644	30.0348	31.2282	30.4819	30.5840
150015	1.3616	0.9320	28.0931	27.3811	30.1474	28.5072
150017	1.8267	0.9004	26.3973	26.3379	27.1249	26.6388
150018	1.5912	0.9353	27.3689	29.1137	30.0478	28.9018
150021	1.8098	0.9004	28.9196	30.0030	31.1140	30.0142
150022	1.0584	0.8637	23.1041	23.8971	26.8394	24.4351

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
150023	1.5869	0.9707	26.9095	27.7520	30.3560	28.3734
150024	1.4757	0.9827	28.1655	28.4170	30.6133	29.0364
150026	1.3515	0.9353	28.6517	30.4967	31.9378	30.4512
150029	1.3421	0.9644	28.7187	29.9307	29.7461	29.4587
150030	1.1963	0.9707	29.1493	29.3588	31.1964	29.9386
150033	1.4204	0.9827	28.6838	29.7744	33.1990	30.5371
150034	1.4624	1.0328	28.6429	28.0434	30.0027	28.9357
150035	1.5482	0.9320	26.9700	27.8904	29.2014	28.0374
150037	1.2521	0.9827	31.0935	29.0161	30.4623	30.1390
150038	1.1402	0.9827	29.3156	33.0112	31.9539	31.4556
150042	1.3656	0.8791	22.8786	25.1403	25.2440	24.4073
150044	1.4443	0.9238	25.2137	25.2685	25.9260	25.4830
150045	1.0453	0.9004	26.9818	27.5340	29.4308	27.9971
150046	1.5575	0.9130	24.5593	26.5876	27.6210	26.2766
150047	1.7059	0.9004	25.5194	25.8497	27.1835	26.1904
150048	1.4375	0.9583	27.1233	28.1525	29.5578	28.3255
150051	1.6111	0.9707	26.5655	28.9157	30.3742	28.6837
150056	1.9795	0.9827	28.8727	29.3500	30.5758	29.6152
150057	2.0656	0.9827	28.9529	30.3287	29.1268	29.4500
150058	1.6334	0.9644	29.1444	29.1255	31.7536	30.0001
150059	1.4852	0.9827	31.4987	31.3362	36.2553	33.0486
150061	1.1299	0.8479	21.3711	22.6746	23.2415	22.4414
150064	1.2404	0.8479	25.4987	28.7978	28.9419	27.8440
150065	1.2493	0.9707	27.9283	30.2053	30.8254	29.6617
150069	1.1831	0.9583	26.2028	26.0909	27.0720	26.4651
150072	1.1283	0.8584	21.2120	21.7644	23.0612	21.9963
150074	1.4309	0.9827	25.9321	28.5655	29.4124	28.0120
150075	1.1406	0.9004	25.1568	25.7245	26.5972	25.8595
150076	1.2974	0.9353	29.3249	30.1120	29.2703	29.5697
150082	1.5914	0.8525	28.3494	26.4544	28.1280	27.6224
150084	1.8344	0.9827	31.1720	33.1784	34.8522	33.0904
150086	1.2227	0.9583	25.1992	26.6745	27.2568	26.4089
150088	1.2980	0.9707	27.2103	29.1509	30.2378	28.8855
150089	1.5552	0.8479	24.7233	24.8045	26.7270	25.4200
150090	1.5584	1.0328	30.4835	30.6412	30.8754	30.6754
150091	1.1569	0.9004	30.4234	32.1627	33.0402	31.9030
150097	1.1855	0.9827	27.7468	29.1359	29.4776	28.7947
150100	1.6039	0.8525	25.7997	26.9724	27.6326	26.7725
150101	1.0840	0.9004	29.0301	30.5475	31.6018	30.3780
150102	1.0268	0.9320	25.7424	25.8742	25.4704	25.6892
150104	1.1443	0.9827	28.2552	28.7788	30.8970	29.3100
150109	1.5465	0.8960	25.3367	26.8464	28.7412	26.9892
150112	1.4960	0.9707	28.0068	29.8540	31.7711	29.8902
150113	1.2097	0.9707	24.7960	25.9814	26.9088	25.9097
150115	1.3474	0.8479	22.0747	22.5793	22.3560	22.3407
150125	1.5500	1.0328	27.6535	29.3596	31.2081	29.4320
150126	1.3476	1.0328	28.9454	29.4300	32.5356	30.2297
150128	1.4329	0.9827	28.7810	29.5008	31.1046	29.8290
150129	1.1906	0.9827	29.7398	31.4317	32.9621	31.3709
150132	***	*	27.6560	*	*	27.6560
150133	1.2148	0.9353	25.1322	24.2538	23.0651	24.1076
150134	***	*	26.3249	21.6740	27.3963	24.7453
150146	1.1296	0.9547	29.5256	30.3343	31.8743	30.6315
150147	1.4431	1.0328	27.2339	26.1646	28.9248	27.6245
150149	0.9337	0.8525	23.7026	24.9629	25.3324	24.7398
150150	1.3583	0.9004	27.0542	26.7700	26.5963	26.7808
150153	2.3079	0.9827	32.1022	35.0617	37.3920	35.1885
150154	2.4814	0.9827	29.8514	29.8894	30.5758	30.1310
150155	***	*	45.0121	*	*	45.0121
150156	***	*	25.9681	*	*	25.9681
150157	1.7719	0.9827	*	32.3106	32.9148	32.6153
150158	1.2495	0.9827	*	*	30.4337	30.4337
150159	***	*	*	*	27.5574	27.5574
150160	2.0971	0.9827	*	*	28.6108	28.6108
150161	1.6006	0.9827	*	*	*	*
150162	1.8254	0.9827	*	*	*	*
150163	1.0174	0.9238	*	*	*	*

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
150164	1.1402	0.9419	*	*	*	*
150165	1.3537	0.9320	*	*	*	*
150166	1.0260	0.9320	*	*	*	*
160001	1.2035	0.8881	24.5108	25.7255	25.8676	25.3903
160005	1.2221	0.8709	23.1034	24.7755	24.8586	24.2778
160008	1.0503	0.8709	22.1402	22.4758	24.1271	22.9093
160013	1.1826	0.8888	24.0956	24.4099	25.5144	24.6765
160016	1.5621	0.8881	24.5338	27.1460	26.6516	26.0785
160024	1.5070	0.9460	27.4158	29.3756	32.4228	29.7117
160028	1.3546	0.9360	27.8535	30.0576	29.8324	29.2977
160029	1.5290	0.9337	28.7324	30.6687	32.2010	30.5406
160030	1.4497	0.9457	28.7786	30.9415	30.4757	30.0901
160032	1.0815	0.8944	25.4662	26.2935	28.5629	26.7834
160033	1.6123	0.8709	26.5315	27.2060	27.4787	27.0636
160040	1.3560	0.9248	25.9032	26.8110	28.2966	27.0153
160045	1.6650	0.8746	26.6463	27.5289	28.1662	27.4620
160047	1.3438	0.9360	26.0227	28.1280	29.4261	27.7499
160057	1.3696	0.9107	25.1272	25.6274	27.7953	26.1996
160058	1.9928	0.9337	28.4167	28.9924	29.8956	29.1104
160064	1.5613	0.9248	28.7668	28.4209	33.6067	30.2004
160067	1.3956	0.9248	24.8137	26.0243	26.7671	25.8721
160069	1.5119	0.8709	27.4473	27.6157	28.4064	27.8032
160079	1.4505	0.8746	24.7372	26.1618	28.5014	26.4591
160080	1.2258	0.8709	25.8252	27.2370	27.8729	26.9717
160082	1.7394	0.9460	27.4718	28.7831	31.7482	29.3428
160083	1.6319	0.9460	27.3004	28.3921	29.9472	28.5559
160089	1.2114	0.9107	23.2149	23.2888	23.9184	23.4747
160101	1.1157	0.9460	25.0503	25.4740	26.8503	25.8119
160104	1.6343	0.8709	28.1891	29.8126	27.0516	28.2560
160110	1.4968	0.9248	26.6633	28.8134	29.9071	28.6042
160112	1.2363	0.8709	24.7957	25.2886	26.1706	25.4488
160117	1.3763	0.8709	25.4659	27.3927	24.3309	25.6596
160122	1.1372	0.8709	23.9177	24.4996	25.3176	24.5888
160124	1.1221	0.8709	22.5482	24.3063	25.5031	24.1100
160146	1.4330	0.8745	22.6949	24.8485	25.1816	24.2135
160147	1.2223	0.8881	28.6303	29.8992	33.6376	30.7344
160153	1.6977	0.8745	29.9378	30.6173	30.4338	30.3298
160155	2.0066	0.8709	*	*	*	*
170001	1.1220	0.8086	23.1260	23.8863	24.5932	23.8766
170006	1.3222	0.9351	24.2068	27.1033	28.3509	26.6135
170009	1.0785	0.9453	30.9025	29.6386	32.2817	30.9531
170010	1.2334	0.8086	23.9707	25.5573	28.1793	25.9458
170012	1.6303	0.8785	26.1367	27.1195	28.7852	27.3256
170013	1.7166	0.8785	25.2476	26.7124	28.3035	26.7042
170014	1.0389	0.9453	23.8135	24.2322	25.8151	24.6246
170016	1.5893	0.8873	25.8061	26.7536	28.6802	27.0793
170017	1.1359	0.8980	26.9657	27.2925	29.1445	27.8530
170020	1.5631	0.8785	23.2757	24.1149	25.0539	24.1602
170023	1.4632	0.8785	24.0561	23.9812	24.8758	24.3255
170027	1.4379	0.8086	23.1766	23.4037	24.1118	23.5721
170033	1.3317	0.8086	21.9709	24.1882	25.0393	23.6609
170039	0.9397	0.8980	26.9852	26.0952	23.5961	25.4102
170040	1.9332	0.9453	28.4458	30.2468	30.0807	29.6659
170049	1.5092	0.9453	25.2070	26.4086	31.8575	27.9185
170058	1.0992	0.8086	22.9210	26.5949	28.1316	25.7970
170068	1.2130	0.8885	23.0635	23.8812	23.8492	23.5912
170074	1.1942	0.8086	23.7829	23.0567	24.8855	23.9145
170075	0.8436	0.8086	19.7760	19.9351	21.1954	20.2943
170086	1.5732	0.8873	26.1362	26.3615	28.5234	27.0437
170094	0.9157	0.8086	21.5295	16.5136	17.1709	18.5438
170103	1.2784	0.8980	23.8042	24.2003	25.5653	24.5527
170104	1.4059	0.9453	26.2990	27.6211	29.5069	27.8074
170105	1.1156	0.8086	21.9606	22.7412	23.4317	22.7174
170109	1.0350	0.9453	23.1088	23.8515	29.0177	25.4500
170110	0.8962	0.8086	23.3260	23.9572	24.7910	24.0231
170114	0.5755	*	*	*	*	*
170120	1.3720	0.9351	22.0253	22.2805	23.5271	22.6059

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
170122	1.6975	0.8980	26.6605	28.7175	29.6314	28.2843
170123	1.6684	0.8980	27.6653	27.0843	28.7608	27.8479
170133	1.0196	0.9453	23.1226	25.2301	25.7108	24.7246
170137	1.3249	0.8086	24.7096	25.3395	26.8014	25.6444
170142	1.3711	0.8720	23.9527	24.6019	25.5550	24.7027
170145	1.0867	0.8086	23.2162	23.3967	25.3728	23.9852
170146	1.5002	0.9453	29.8858	29.0720	31.6994	30.2197
170147	***	*	22.4973	24.3268	21.4565	23.0046
170150	1.1410	0.8252	20.9448	19.6160	22.0251	20.8653
170166	1.0165	0.8086	21.0762	22.6968	24.1063	22.6638
170175	1.4832	0.8785	25.6281	26.7229	31.7582	28.0191
170176	1.5583	0.9453	27.2332	29.0735	30.1114	28.8494
170180	***	*	32.5010	*	*	32.5010
170182	1.4504	0.9453	27.3503	28.9710	30.3781	28.8971
170183	1.9858	0.8980	25.8340	26.1890	27.7178	26.5683
170185	1.2572	0.9453	27.8139	28.1780	29.3202	28.5075
170186	2.5220	0.8980	32.8392	30.2613	30.7638	31.2790
170187	1.6421	0.8086	22.8493	24.1461	24.6391	23.8933
170188	1.9852	0.9453	30.6844	32.2573	33.7221	32.2678
170190	1.0158	0.8720	22.9540	26.2625	27.3023	25.5425
170191	1.8259	0.8086	22.1197	24.3813	26.0279	24.3247
170192	1.7639	0.8980	26.2724	27.7421	30.9200	28.4741
170193	1.3485	0.8785	20.6821	24.8531	24.4126	22.9315
170194	1.2331	0.9453	29.9014	27.6989	28.1972	28.5250
170195	2.4249	0.9453	30.1001	29.5947	29.1763	29.5492
170196	2.4635	0.8980	*	32.1832	29.9641	30.9601
170197	2.3250	0.8980	*	*	*	*
170198	1.9320	0.8086	*	*	*	*
180001	1.3069	0.9590	27.6917	29.7423	29.9655	29.1412
180002	1.0662	0.8062	25.7862	26.5488	27.3339	26.5496
180004	1.0759	0.7837	22.0797	20.8805	22.0615	21.6721
180005	1.1460	0.8767	24.9779	25.6159	27.4304	26.0705
180007	1.5443	0.8950	25.7042	27.1924	26.9425	26.6126
180009	1.7525	0.9127	26.4101	27.3228	28.7030	27.5584
180010	1.8312	0.8950	25.6153	27.7600	28.1667	27.1559
180011	1.6281	0.8756	25.5463	24.9909	25.0355	25.1733
180012	1.4715	0.9123	25.6000	26.7279	27.2829	26.5352
180013	1.5001	0.9276	23.7075	24.8125	26.8088	25.0983
180016	1.2868	0.9245	24.8408	24.7091	26.9522	25.4644
180017	1.3104	0.8230	21.8885	21.9715	25.4164	23.1027
180018	1.3551	0.7837	20.9857	23.3035	23.9155	22.7447
180019	1.1134	0.7837	24.0283	24.6279	27.6787	25.4951
180020	1.0616	0.7837	24.6953	25.9975	26.8856	25.8897
180021	0.9634	0.7837	20.7950	22.0740	22.3752	21.7644
180024	1.1593	0.9123	31.1159	26.3532	26.9538	28.0398
180025	1.2308	0.9245	22.6897	28.5935	28.4153	26.7267
180027	1.2008	0.8302	20.8303	21.7639	23.3873	21.9095
180029	1.4670	0.8756	25.6479	26.1528	26.3892	26.0660
180035	1.4807	0.9590	31.0794	32.8461	34.0348	32.7266
180036	1.3287	0.9127	25.2972	25.6959	30.2621	27.0558
180037	***	*	26.3132	27.8506	33.1874	29.1431
180038	1.5441	0.8764	26.0440	26.9752	28.2413	27.1328
180040	1.8313	0.9245	27.9979	28.5162	30.2450	28.9050
180043	1.1741	0.7978	20.9326	20.6439	24.0566	21.9172
180044	1.5998	0.8767	24.4569	25.8060	25.7978	25.3776
180045	1.3277	0.9590	27.4732	29.4127	29.9346	28.9840
180046	1.0026	0.8950	27.1034	27.0962	28.5552	27.5846
180048	1.3531	0.9123	23.9230	24.3696	24.6786	24.3395
180049	1.4067	0.8756	22.4769	24.3699	23.5737	23.4731
180050	1.1306	0.7919	26.3604	25.9557	26.7714	26.3675
180051	1.2266	0.8302	23.5299	24.3916	25.2356	24.4156
180053	0.9909	0.7837	21.3044	22.1921	23.0290	22.2290
180056	1.1314	0.8531	24.3074	24.5326	26.3959	25.0679
180064	1.2227	0.8151	17.1009	20.1799	21.9508	19.7362
180066	1.1136	0.9276	22.2713	23.7860	24.9530	23.6732
180067	1.9454	0.8950	26.0238	27.9852	29.6029	27.9902
180069	1.0930	0.8767	26.3701	26.6714	27.6777	26.8870

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
180070	1.1929	0.8077	20.6741	20.2189	21.3693	20.7657
180078	1.0594	0.8767	27.6806	28.2762	29.2125	28.3867
180079	1.1477	0.8096	20.2100	23.6005	24.9898	22.8630
180080	1.2693	0.7889	21.5818	23.7788	25.2996	23.5872
180087	1.2269	0.7837	20.8841	22.0302	22.1044	21.6767
180088	1.7069	0.9245	28.0916	28.6107	30.7936	29.1743
180092	1.1677	0.8950	23.7909	23.7866	25.2884	24.3103
180093	1.6170	0.8131	20.5807	21.4392	22.3324	21.4596
180095	1.0117	0.7837	17.9146	21.5639	21.2154	20.0750
180101	1.3146	0.8950	27.4506	28.1621	28.8758	28.2013
180102	1.5042	0.8302	21.0896	25.2343	27.3887	24.3942
180103	2.0473	0.8950	28.4583	28.1734	29.7626	28.8044
180104	1.5676	0.8302	25.6157	25.9689	27.1274	26.2415
180105	0.9511	0.7837	21.6002	23.1917	24.3659	23.0870
180106	0.8902	0.7837	20.2884	20.7220	21.2265	20.7447
180115	0.9040	0.7837	20.5539	20.3089	22.7088	21.1833
180116	1.1839	0.8320	23.5354	25.8927	26.8836	25.4592
180117	0.9408	0.7837	22.8469	24.7378	24.9567	24.2081
180124	1.3223	0.9276	24.8292	25.4664	27.1341	25.8362
180127	1.3584	0.9123	24.6774	26.3947	28.3610	26.4554
180128	0.9392	0.7837	22.6056	23.8144	23.7770	23.4109
180130	1.6779	0.9245	27.8900	29.1712	29.6725	28.9399
180132	1.4346	0.8756	24.5105	25.3789	29.0546	26.3805
180138	1.1879	0.9245	28.1901	28.6871	29.2584	28.7287
180139	1.0065	0.7837	23.3569	24.7575	26.2434	24.7763
180141	1.8666	0.9245	25.3357	27.5912	28.7307	27.2557
180143	1.6777	0.8950	28.1924	30.8734	28.2122	29.0557
180144	***	*	29.5052	*	*	29.5052
180147	***	*	*	31.1615	*	31.1615
180148	***	*	*	30.1250	*	30.1250
180149	1.0087	0.7837	*	*	16.4909	16.4909
180150	1.8775	0.9245	*	*	*	*
190001	1.0903	0.7682	22.1394	22.1569	22.5328	22.2811
190002	1.5733	0.8438	23.3368	24.6984	25.9371	24.6300
190003	1.4214	0.8438	25.8294	26.7844	28.0895	26.9253
190004	1.5112	0.7870	25.3473	25.0803	24.6536	25.0228
190005	1.5223	0.9140	22.6029	24.2899	28.3303	24.2844
190006	1.2838	0.8438	22.7979	24.8836	25.2490	24.3632
190007	1.1753	0.7682	21.8205	23.1426	24.0527	23.0456
190008	1.7450	0.7870	24.6074	26.3638	27.2663	26.0087
190009	1.3606	0.8127	21.1005	24.0696	25.0269	23.3881
190011	1.0090	0.7961	21.4052	21.6991	21.9165	21.6827
190013	1.5563	0.7682	21.4573	23.7333	22.8372	22.6699
190014	1.2264	0.7682	22.7151	22.6405	24.5399	23.2756
190015	1.3070	0.9140	23.7789	25.1767	26.9572	25.3336
190017	1.4841	0.8438	24.5390	24.7537	25.5465	24.9732
190019	1.7201	0.8127	24.0468	25.4624	27.5462	25.7258
190020	1.2827	0.8142	22.1967	23.4602	24.2346	23.3365
190025	1.3344	0.7682	23.5007	24.5024	26.5944	24.8092
190026	1.6101	0.8127	23.7702	24.1556	25.3736	24.4572
190027	1.6236	0.7682	24.3006	26.7132	31.5026	27.4175
190034	1.2092	0.7871	20.7334	21.2130	22.9658	21.6044
190036	1.6604	0.9140	25.4164	25.6551	30.2172	26.9231
190037	***	*	19.4071	20.7271	28.0447	21.7538
190039	1.5115	0.9140	24.4386	25.4003	24.6075	24.8194
190040	1.4212	0.9140	28.6297	28.0169	28.2426	28.2870
190041	1.4648	0.8547	28.5376	28.0050	28.7683	28.4375
190044	1.2898	0.7943	20.9993	21.2604	22.2461	21.5123
190045	1.5439	0.9140	25.8238	27.1996	27.5854	26.9044
190046	1.4309	0.9140	23.8552	24.7370	*	24.2936
190050	1.1484	0.7726	21.0259	20.9142	22.7951	21.5828
190053	1.2074	0.7783	17.9788	18.5819	20.6282	19.0432
190054	1.3250	0.7767	23.1471	22.7011	23.5129	23.1218
190060	1.4709	0.7682	23.7393	22.6291	19.8899	21.9229
190064	1.6110	0.8142	23.1358	23.7298	26.9941	24.6370
190065	1.5904	0.8142	22.1880	23.1202	22.9847	22.7749
190078	1.0906	0.7869	22.2431	22.2346	25.6940	23.4396

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Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
190079	1.1812	0.9140	24.0985	23.8192	25.3327	24.4472
190081	0.8736	0.7682	20.0121	21.4510	20.4101	20.6028
190086	1.2760	0.7785	22.0610	22.2895	22.2837	22.2151
190088	1.1378	0.8547	23.8562	23.1638	24.7445	23.9122
190090	1.0338	0.7682	23.1241	24.3303	25.8607	24.3672
190098	1.7595	0.8547	25.6854	25.7449	27.5043	26.3126
190099	1.0153	0.7871	22.0610	23.2343	25.7481	23.6613
190102	1.5441	0.8438	27.3126	26.9700	28.3071	27.5010
190106	1.1415	0.8127	23.5376	26.6227	24.2755	24.7510
190111	1.6311	0.8547	25.5729	26.5722	27.3180	26.5044
190114	1.0602	0.7682	17.2678	19.1586	20.3639	18.9135
190115	1.2209	0.8547	28.2066	26.0797	26.0278	26.7727
190116	1.1880	0.7767	22.3710	23.4013	24.2156	23.3424
190118	0.9844	0.8547	22.8809	21.2580	22.6571	22.2425
190122	1.4015	0.8142	22.0072	22.2371	22.8671	22.4040
190124	***	*	26.0032	27.9484	28.6694	27.4838
190125	1.5711	0.7961	25.5463	24.8256	26.6254	25.6717
190128	1.0269	0.8142	28.3257	29.6682	31.1762	29.7845
190131	1.3325	0.8142	27.8465	28.6795	28.5938	28.3736
190133	0.9162	0.7784	18.2045	22.4311	23.9545	22.0666
190135	1.6174	0.9140	27.7540	30.5646	35.0524	30.2944
190140	0.9876	0.7717	18.9652	23.0485	23.6705	21.8176
190144	1.2672	0.8547	22.9181	23.7875	24.8858	23.8764
190145	0.9764	0.7772	19.9265	20.8579	21.3982	20.7221
190146	1.5575	0.9140	27.4824	28.7200	28.5963	28.2726
190151	0.9239	0.7682	18.7467	18.8391	20.6962	19.4061
190152	1.1740	0.9140	28.1334	30.8512	34.6485	30.9971
190158	***	*	26.4787	30.6450	21.9727	27.7355
190160	1.5637	0.7961	22.9325	24.7822	25.8632	24.4460
190161	1.0278	0.7682	22.6187	22.9035	23.8066	23.1213
190162	***	*	25.2953	*	*	25.2953
190164	1.1308	0.8127	25.2560	26.6207	27.7247	26.5855
190167	1.2763	0.8438	26.4669	25.3283	27.1969	26.3225
190175	1.2783	0.9140	26.0547	27.4256	30.5928	28.0066
190176	1.7856	0.9140	25.8826	26.2596	*	26.0715
190177	1.6464	0.9140	27.7792	28.2751	29.7229	28.5969
190182	***	*	27.1682	29.8656	30.7038	29.2917
190183	1.2357	0.7870	22.6928	22.0119	23.3452	22.7038
190184	0.9592	0.7785	24.9476	24.1626	22.6137	23.9160
190185	***	*	25.6394	28.9759	36.7292	29.7365
190190	0.9248	0.7843	24.3327	26.7043	27.5056	26.1460
190191	1.3760	0.8438	24.1923	26.1628	26.9649	25.7635
190196	0.9701	0.8438	24.0385	25.8472	27.7801	25.9541
190197	***	*	25.8071	26.4825	28.7026	26.9781
190199	1.1052	0.8142	27.3304	32.0194	36.7076	31.6410
190200	***	*	28.8173	27.4781	*	28.3200
190201	1.2572	0.7682	25.1010	24.4563	26.8537	25.4868
190202	1.5245	0.8142	27.6084	29.6612	*	28.6936
190203	***	*	28.1832	29.9753	*	29.0343
190204	1.4475	0.9140	28.1033	30.5140	32.9125	30.3814
190205	1.6677	0.8438	26.6832	28.2484	30.1674	28.3935
190206	2.0426	0.9140	26.7401	29.2371	32.0163	29.3053
190208	0.8467	0.7682	28.7308	27.9908	24.9395	26.8779
190218	1.0293	0.8547	26.7262	28.1039	26.5243	27.0954
190236	1.4591	0.8547	24.7142	26.4614	26.9046	26.0708
190241	2.2461	0.7870	25.2123	25.7906	26.5307	25.8664
190242	1.1726	0.8142	24.8461	25.0035	26.9715	25.6625
190245	1.6582	0.7961	25.5751	26.7642	26.4147	26.2436
190246	1.8467	0.7843	*	22.7833	31.7133	27.5712
190247	***	*	32.7499	*	*	32.7499
190248	***	*	23.2220	*	*	23.2220
190249	1.7284	0.8142	20.0468	25.2523	27.0954	23.4238
190250	2.1126	0.9140	31.5101	33.3302	32.8347	32.5070
190251	1.3045	0.8142	21.4464	23.8389	25.1576	23.4538
190252	***	*	23.6924	*	*	23.6924
190253	***	*	22.8060	23.8037	22.2212	23.0780
190254	***	*	32.9290	*	*	32.9290

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
190255	0.7692	0.8438	22.2412	16.1593	23.8013	20.1015
190256	0.8038	0.9140	*	25.9577	25.9352	25.9454
190257	1.6689	0.7785	*	26.5505	22.7493	24.6724
190258	***	*	31.3715	26.1141	25.1970	27.3097
190259	2.0814	0.8438	*	26.5084	27.5500	27.0088
190260	***	*	*	29.3947	33.6205	31.1711
190261	1.3897	0.7961	*	27.0441	25.4725	26.2680
190262	***	*	*	30.3719	*	30.3719
190263	2.3211	0.8438	*	26.4202	29.7034	28.0032
190264	***	*	*	26.5842	*	26.5842
190265	***	*	*	22.6231	30.9242	27.1318
190266	2.3213	0.8142	*	*	24.3790	24.3790
190267	1.3728	0.9140	*	*	24.2777	24.2777
190268	1.6840	0.8438	*	*	29.1407	29.1407
190270	1.8665	0.9140	*	*	*	*
190272	1.2748	0.8438	*	*	28.4541	28.4541
190273	1.7599	0.8142	*	*	*	*
190274	1.6077	0.9140	*	*	*	*
190275	1.3329	0.9140	*	*	*	*
190276	0.8985	0.8547	*	*	*	*
190277	0.8585	0.8069	*	*	*	*
200001	1.3378	1.0115	25.2542	26.3045	28.1124	26.5658
200002	1.1591	0.8609	25.7212	27.1151	33.2665	28.3561
200008	1.3906	0.9927	27.7137	29.1836	29.3519	28.7769
200009	1.9207	0.9927	30.7510	32.5812	35.0717	32.7319
200018	1.3207	0.8609	23.5632	22.5027	24.6780	23.5929
200019	1.2779	0.9927	25.6649	27.7896	28.3393	27.2843
200020	1.3255	1.0007	32.6436	34.0916	34.5740	33.7902
200021	1.2204	0.9927	27.1381	29.2054	28.7597	28.4046
200024	1.6748	0.9644	27.5410	29.7817	30.9932	29.4721
200025	1.1710	0.9927	26.3124	28.5750	29.3588	28.1289
200031	1.3018	0.8609	21.2370	22.2151	23.7539	22.4062
200032	1.1782	0.9075	26.3322	26.8993	27.2259	26.8277
200033	1.8241	1.0115	29.3108	31.7007	33.6270	31.6171
200034	1.3255	0.9644	27.0582	27.0103	28.0397	27.3625
200037	1.1982	0.8609	24.1732	24.9418	26.7798	25.3841
200039	1.2970	0.9644	25.1179	26.6409	28.8029	26.8816
200040	1.2039	0.9927	25.9893	27.8053	25.5506	26.3685
200041	1.2079	0.8609	24.9670	26.6777	27.5049	26.3961
200050	1.2398	1.0115	27.6825	29.5033	30.1456	29.1592
200052	1.1153	0.8609	22.5159	24.4204	25.6220	24.1936
200063	1.1834	0.8609	25.8623	27.9748	28.2184	27.3991
210001	1.3549	0.9460	28.2858	29.3471	31.2328	29.6476
210002	1.9987	0.9981	32.3005	33.7388	36.0222	34.1104
210003	1.6222	1.0670	34.1109	30.7334	28.2547	30.8148
210004	1.4250	1.1018	33.6056	31.7132	33.9015	33.0686
210005	1.2610	1.1018	28.9554	29.5835	32.4052	30.3394
210006	1.0725	0.9981	25.9005	27.3620	27.9844	27.0796
210007	1.7994	0.9981	31.8767	30.7124	31.4098	31.3077
210008	1.4105	0.9981	24.3341	28.8850	31.8512	28.2947
210009	1.6490	0.9981	27.7900	30.2661	31.8249	29.9840
210011	1.3847	0.9981	30.8575	31.0966	30.7517	30.9025
210012	1.5973	0.9981	30.3078	31.1778	32.5280	31.3781
210013	1.1768	0.9981	28.5328	28.9917	32.1151	29.7726
210015	1.2997	0.9981	29.9261	32.2774	31.6875	31.3239
210016	1.6120	1.1018	32.3506	33.5493	35.3218	33.6933
210017	1.2904	0.8795	25.1890	26.8592	26.6187	26.2235
210018	1.2011	1.1018	29.5533	29.6521	31.5431	30.2539
210019	1.7205	0.9194	27.3731	28.7844	30.5458	28.9499
210022	1.4645	1.1018	35.4727	37.3092	36.1806	36.3038
210023	1.4878	1.0060	32.1812	33.0212	34.1635	33.1583
210024	1.8236	0.9981	30.6359	32.9434	34.5523	32.7596
210025	1.2388	0.8795	23.8552	24.8570	23.5138	24.0665
210027	1.4130	0.8795	24.6343	24.4821	25.2106	24.7916
210028	1.0692	0.9307	26.3469	26.7462	28.5196	27.2373
210029	1.2751	0.9981	31.0266	31.8539	32.9078	31.9592
210030	1.1883	0.8795	26.9763	32.2033	29.1777	29.4507

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
210032	1.1828	1.0645	27.0727	27.9359	29.2770	28.1114
210033	1.1640	0.9981	28.5534	29.2504	28.4332	28.7353
210034	1.2631	0.9981	30.2908	32.3827	33.0382	31.9423
210035	1.3018	1.0670	28.6484	27.3901	30.6664	28.8614
210037	1.2037	0.8795	27.3287	27.8394	28.8691	28.0163
210038	1.1889	0.9981	29.8121	32.3206	31.1537	31.0730
210039	1.1193	1.0670	30.4991	32.4139	35.1146	32.6902
210040	1.2216	0.9981	28.3559	29.2390	31.0827	29.5738
210043	1.3058	1.0060	26.6524	32.6961	29.2744	29.4113
210044	1.3653	0.9981	29.7339	30.3349	31.5436	30.5467
210045	0.9952	0.9194	14.2223	16.3724	19.6097	16.8133
210048	1.3768	0.9981	27.5043	26.0650	29.2439	27.5592
210049	1.2275	0.9981	26.0900	27.0161	28.5947	27.3346
210051	1.2948	1.0670	29.8892	29.5219	30.7936	30.0807
210054	1.2558	1.0670	27.4328	27.7607	28.6884	27.9549
210055	1.2394	1.0670	30.6941	31.4905	30.1989	30.7527
210056	1.3104	0.9981	30.0810	32.3518	32.7755	31.8047
210057	1.3542	1.1018	31.6787	32.8299	33.7244	32.7501
210058	1.1208	0.9981	31.0873	31.1988	32.0642	31.4531
210060	1.2448	1.0670	27.1764	29.9626	32.5116	29.9224
210061	1.2566	0.8983	23.1645	25.0253	26.6822	25.0230
220001	1.2273	1.1338	30.6070	31.2316	32.0820	31.3057
220002	1.3729	1.1338	32.4356	33.6649	35.9738	34.0706
220006	***	*	30.7673	33.6438	*	32.1319
220008	1.2887	1.1338	31.3385	34.7924	35.8651	34.0329
220010	1.2326	1.1338	30.7804	32.0925	33.7364	32.2148
220011	1.1369	1.1338	34.7655	36.5640	39.1211	36.8964
220012	1.4655	1.2672	37.8763	39.7564	41.7040	39.8247
220015	1.2984	1.0343	29.6315	32.4903	35.2353	32.4365
220016	1.1282	1.0343	30.4813	32.5863	33.1404	32.0656
220017	1.3194	1.1994	31.6170	33.3020	34.6550	33.1982
220019	1.0429	1.1338	24.4009	25.7855	26.3006	25.5037
220020	1.1312	1.1338	28.5288	30.8458	32.1503	30.5508
220024	1.2349	1.0343	28.7342	31.9491	32.8073	31.1791
220025	1.0377	1.1338	25.6478	30.4369	27.6958	27.7639
220028	***	*	31.7122	39.3089	*	35.2808
220029	1.1472	1.1338	30.6935	31.6363	32.6767	31.6963
220030	1.1059	1.0343	26.8849	28.1347	29.3701	28.1501
220031	1.5532	1.1994	36.8477	38.9433	39.4182	38.4392
220033	1.1976	1.1338	31.8249	32.3495	34.6977	33.0203
220035	1.4173	1.1338	31.4470	34.8739	36.1775	35.0964
220036	1.5119	1.1994	33.1436	35.9124	37.7268	35.6257
220046	1.4449	1.0445	30.4460	31.4510	33.8585	31.9500
220049	1.2309	1.1338	30.4740	32.4652	35.1108	32.7132
220050	1.0897	1.0343	28.3434	29.5194	30.3160	29.4110
220051	1.3081	1.0199	30.2552	30.1022	32.8672	31.0914
220052	1.1432	1.1994	32.4130	32.3532	34.9126	33.2019
220058	1.0116	1.1338	25.7247	27.8893	30.0325	27.9127
220060	1.1603	1.1994	32.5477	34.7336	36.8641	34.7665
220062	0.6341	1.1338	25.0766	25.4224	27.3304	25.9567
220063	1.2647	1.1338	30.2866	32.9283	32.2417	31.8295
220065	1.2613	1.0343	27.6009	30.1103	32.3793	30.0468
220066	1.3284	1.0343	27.8073	29.9736	*	28.8792
220067	1.2302	1.1994	30.2222	32.4019	33.9807	32.2180
220070	1.1429	1.1338	33.1299	34.2598	35.6244	34.3611
220071	1.8365	1.1994	36.5065	37.4087	40.0281	38.0115
220073	1.1896	1.1338	34.2989	36.0289	37.4224	35.9320
220074 [4]	1.3507	1.1338	30.5607	31.4730	33.2051	31.7041
220B74 [4]	***	*	*	31.4731	33.2051	32.3862
220075	1.5438	1.1994	30.9175	32.2957	33.3538	32.1942
220076	***	*	27.5148	*	*	27.5148
220077	1.6655	1.0972	31.7325	34.0168	33.7563	33.1765
220080	1.1645	1.1338	29.9595	31.1268	33.1617	31.3799
220082	1.2899	1.1338	30.0611	30.8230	32.2105	31.0609
220083	1.0693	1.1994	34.5118	34.5969	35.2728	34.8205
220084	1.2134	1.1338	30.9527	31.6955	34.6254	32.3748
220086	1.7222	1.1994	34.2388	35.3451	36.2359	35.3173

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Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
220088	1.9446	1.1994	35.8255	34.7637	37.0808	35.9288
220089	***	*	32.6305	34.8205	*	33.7125
220090	1.2394	1.1338	32.9011	34.1963	35.8940	34.3697
220095	1.1576	1.1338	28.0673	30.8626	31.1619	30.0333
220098	1.1400	1.1338	30.5869	31.5403	30.6593	30.9378
220100	1.3072	1.1994	31.9859	34.6599	35.7276	34.1807
220101	1.2971	1.1338	35.3464	37.7809	36.0984	36.4336
220105	1.1814	1.1338	33.2625	34.4029	35.8155	34.5228
220108	1.1999	1.1994	32.6131	33.8854	35.6985	34.0752
220110	2.0011	1.1994	39.2167	40.7382	43.8401	41.3123
220111	1.2206	1.1994	33.6167	34.2498	35.6193	34.5167
220116	1.8714	1.1994	36.4149	38.8799	40.0952	38.4127
220119	1.1333	1.1994	30.9965	32.0863	33.7174	32.3365
220126	1.1806	1.1994	31.4882	32.6938	35.6250	33.2716
220133	***	*	29.4855	34.9182	*	32.1170
220135	1.3038	1.2672	36.0203	37.5189	38.7180	37.4435
220153	***	*	*	19.8085	17.9600	18.7803
220154	***	*	*	28.7898	*	28.7898
220162	1.5970	*	*	*	*	*
220163	1.6172	1.1338	34.4874	37.4968	39.4859	37.2285
220171	1.6935	1.1338	32.7414	35.9948	36.4545	35.0735
220174	1.1926	1.1338	30.0406	30.9503	32.9113	31.3266
220175	1.2681	*	*	*	34.1550	34.1550
220176	1.6474	1.1338	*	*	31.4195	31.4195
230002	1.3237	1.0113	32.9010	32.7578	33.9675	33.2532
230003	1.2416	0.9455	27.5824	28.4716	28.9871	28.3360
230004	1.7110	1.0227	29.3934	31.5136	33.4620	31.5262
230005	1.2402	0.9337	25.8768	27.7463	29.0625	27.5854
230013	1.3836	1.0052	24.6511	27.2075	28.6417	26.7586
230015	1.1593	0.9159	26.2782	27.2541	28.9588	27.5253
230017	1.6518	1.0910	31.8821	32.5396	36.8018	33.8177
230019	1.6077	1.0052	32.3401	34.3213	35.1415	33.9317
230020	1.7476	1.0113	28.5646	29.5324	29.9072	29.3527
230021	1.5495	1.0365	26.5659	28.6169	29.5397	28.2368
230022	1.2686	0.9652	25.6683	30.1195	25.7829	27.0325
230024	1.6538	1.0113	32.1483	32.5892	34.5253	33.1061
230029	1.6160	1.0052	32.3538	32.3845	33.1460	32.6277
230030	1.2847	0.8864	23.8082	25.1100	24.9719	24.6466
230031	1.3571	0.9972	29.7232	30.0120	30.8859	30.2337
230034	1.3764	0.8864	24.4845	24.4141	29.1079	25.8635
230035	1.1994	0.9305	24.8822	25.6715	25.7083	25.4572
230036	1.4140	0.9472	29.3754	29.9642	31.0922	30.1636
230037	1.3059	1.0113	28.9244	28.5311	28.8529	28.7691
230038	1.7649	0.9455	28.2012	29.1263	30.1019	29.1994
230040	1.1794	0.9305	25.5154	26.3190	27.2835	26.3819
230041	1.5803	0.9472	27.8853	27.9569	30.3060	28.7057
230046	1.9162	1.0444	31.6235	32.2924	33.5285	32.5197
230047	1.4494	1.0052	31.1771	31.7075	32.0225	31.6475
230053	1.6700	1.0113	32.5711	32.1566	33.5420	32.7704
230054	1.8803	0.9412	25.7591	26.3251	28.1223	26.7475
230055	1.2587	0.8864	27.4349	28.4787	28.1872	28.0393
230058	1.1167	0.8864	25.9291	27.3156	27.9625	27.0813
230059	1.5346	0.9455	27.9091	28.5875	28.3586	28.2947
230060	1.2934	0.8864	28.2874	27.0288	28.7744	28.0391
230065	***	*	32.6255	*	*	32.6255
230066	1.3058	1.0227	30.6184	30.2104	32.3459	31.0702
230069	1.1826	1.0810	30.2663	31.3406	31.9653	31.2223
230070	1.6502	0.9034	25.6778	26.8315	28.0349	26.8663
230071	0.9448	1.0052	28.3064	29.6728	28.2055	28.7253
230072	1.3622	0.9455	26.2838	27.4742	28.8006	27.5408
230075	1.3557	1.0086	28.2540	30.9525	32.1146	30.4322
230077	1.8799	1.0810	29.8538	30.5567	31.0097	30.4726
230078	1.1903	0.8864	25.6809	25.7232	27.0050	26.0991
230080	1.2607	0.9472	24.1573	24.5432	25.6193	24.7905
230081	1.2326	0.8864	24.7374	26.4337	27.8091	26.3288
230085	1.2326	1.0910	23.4959	25.4289	27.6459	25.5347
230089	1.3435	1.0113	31.0522	32.8450	32.2293	31.9436

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
230092	1.3964	1.0113	28.6829	29.3442	30.5399	29.5449
230093	1.2159	0.8922	25.5804	27.4463	27.0555	26.7238
230095	1.2754	0.9472	22.8681	25.1854	25.9196	24.6699
230096	1.1779	1.0365	30.6024	31.7399	27.7873	29.8976
230097	1.6913	0.9305	28.2526	29.8962	31.5152	29.8782
230099	1.2173	1.0113	29.0221	29.3720	28.7386	29.0351
230100	1.1914	0.8864	24.1881	25.2118	25.6583	25.0492
230101	1.1683	0.8864	25.4839	28.4372	28.8595	27.6204
230104[5]	1.5934	1.0113	32.4634	32.4125	34.0171	32.9570
230B04[5]	***	*	*	*	34.0171	34.0171
230105	1.7842	0.9472	32.4583	30.5515	32.1103	31.7057
230106	1.2381	0.9455	25.3243	27.8584	30.0195	27.7687
230108	1.1549	0.8864	20.2539	24.4337	25.7463	23.4436
230110	1.2539	0.8864	27.0040	25.7196	27.0263	26.5809
230117	1.8415	1.0910	32.7994	33.0602	33.9148	33.2761
230118	1.0095	0.8864	23.6110	24.8890	24.8631	24.4400
230119	1.4381	1.0113	30.7488	31.9696	33.2026	32.0127
230121	1.2621	0.9652	26.4940	26.8361	27.7495	27.0478
230130	1.6817	1.0052	30.1608	31.2744	32.5589	31.3612
230132	1.5413	1.1258	32.3939	35.5304	38.2428	35.3551
230133	1.4288	0.8864	23.9442	25.0647	25.8516	24.9772
230135	1.3171	1.0113	25.9583	23.6005	31.5185	26.7530
230141	1.6173	1.1258	31.6152	33.2553	36.3094	33.7170
230142	1.2688	1.0113	27.8377	29.7417	29.9882	29.2232
230144	1.8275	1.0444	*	*	*	*
230146	1.3735	1.0113	26.8156	27.2621	29.0197	27.7279
230151	1.3314	1.0052	27.4546	29.8366	28.6704	28.6311
230156	1.5950	1.0444	32.3755	33.9034	34.7840	33.7042
230165	1.5974	1.0113	29.6376	31.4242	32.2831	31.1343
230167	1.6088	0.9899	29.8071	31.0657	32.8063	31.2488
230174	1.3451	0.9455	30.0563	29.7488	31.2452	30.3405
230176	1.3115	1.0113	28.1498	28.9798	29.2664	28.8186
230180	1.1167	0.8864	26.0707	24.9696	24.6000	25.1971
230184	***	*	34.6295	*	*	34.6295
230190	***	*	30.7875	33.8229	33.6707	32.7904
230193	1.3561	0.9972	25.1626	26.4728	28.4624	26.7218
230195	1.4319	1.0052	29.5656	30.9702	32.5528	31.0477
230197	1.6021	1.1258	32.0063	33.7128	34.8039	33.5209
230204	1.4349	1.0052	31.5615	32.2882	30.1956	31.3391
230207	1.2451	1.0052	25.4268	25.1983	26.8215	25.8117
230208	1.2210	0.9305	23.7523	24.3476	25.2472	24.4569
230212	1.0426	1.0444	31.9818	32.8567	33.4362	32.7601
230216	1.4778	0.9972	29.0147	29.2061	28.9567	29.0586
230217	1.4015	1.0086	30.1136	31.9732	33.0815	31.7828
230222	1.4250	0.9472	29.9341	30.6482	32.4389	30.9827
230223	1.3052	1.0052	28.6745	29.8430	31.9496	30.1361
230227	1.4799	1.0052	30.8218	33.6716	34.2728	32.7518
230230	1.4804	0.9899	29.8763	31.1712	31.4931	30.8595
230236	1.5428	0.9455	31.3110	30.8556	31.9088	31.3744
230239	1.3021	0.8864	21.0814	22.1579	23.5448	22.2557
230241	1.1943	0.9972	27.6106	28.5516	30.0233	28.7406
230244	1.4607	1.0113	29.6283	30.0405	32.1407	30.6177
230254	1.4847	1.0052	29.2653	29.5874	31.2379	30.0646
230257	0.9794	1.0052	29.6712	30.6372	30.0667	30.1067
230259	1.2691	1.0444	27.4217	27.5982	27.9557	27.6540
230264	2.0641	1.0052	22.7768	28.5416	29.2178	26.4132
230269	1.4701	1.0052	31.3226	31.3800	34.2667	32.3991
230270	1.3480	1.0113	28.5372	28.8173	29.2388	28.8712
230273	1.4692	1.0113	31.9862	31.5396	32.5706	32.0372
230275	0.5428	0.9034	23.8104	25.2133	22.3717	23.7470
230277	1.4612	1.0052	29.8372	31.4023	32.2518	31.1889
230279	0.5480	1.0810	27.2816	27.9726	26.8539	27.3521
230283	***	*	33.5531	*	*	33.5531
230294	***	*	31.6195	*	*	31.6195
230295	***	*	27.1298	*	*	27.1298
230296	***	*	*	34.2107	*	34.2107
230297	1.6971	1.0052	*	*	*	*

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
230298	0.7864	1.0052	*	*	*	*
230300	3.3739	1.0052	*	*	*	*
230301	1.0374	1.0052	*	*	*	*
240001	1.5531	1.0997	33.1499	34.7673	37.2179	35.0462
240002	1.8744	1.0519	31.6000	33.1051	34.6345	33.1529
240004	1.5878	1.0997	32.7010	32.5777	33.5085	32.9298
240006	1.2147	1.0982	31.0777	33.4777	32.8229	32.4953
240010	1.9657	1.0982	33.4668	32.7261	35.9102	34.0521
240014	1.0726	1.0997	29.8905	30.7519	33.4476	31.3959
240017	***	*	24.3596	*	*	24.3596
240018	1.2598	0.9925	28.1432	29.4995	30.5632	29.4372
240019	1.0353	1.0519	33.7546	32.7052	34.2538	33.5836
240020	1.1144	1.0997	31.3874	33.2449	34.5686	33.0762
240022	1.0632	0.9120	26.1920	27.3137	28.5889	27.3645
240030	1.3950	1.0638	26.5508	27.1312	27.6584	27.1136
240036	1.6415	1.0997	32.7028	34.2980	37.2177	34.8308
240038	1.4964	1.0997	31.9891	33.0554	34.7330	33.2508
240040	1.0575	1.0519	27.5074	28.9009	30.0238	28.8059
240043	1.2453	0.9120	23.3489	24.0708	25.7420	24.4201
240044	1.0841	0.9745	25.0988	26.8681	28.5689	26.7906
240047	1.5230	1.0519	28.6406	29.7835	35.6742	31.1184
240050	1.0910	1.0997	27.5553	30.9805	33.7946	30.9171
240052	1.2031	0.9120	28.7206	29.4617	31.0917	29.7873
240053	1.5039	1.0997	31.4324	33.1148	34.4186	33.0264
240056	1.3585	1.0997	33.1728	34.0845	35.8580	34.4096
240057	1.7902	1.0997	30.7703	33.4713	34.8349	33.0717
240059	1.0937	1.0997	31.0911	32.4803	32.5938	32.0866
240061	1.8510	1.0982	33.1799	32.0828	34.6008	33.3406
240063	1.5799	1.0997	33.7895	35.2877	36.9798	35.4057
240064	1.1730	1.0401	34.3757	27.2407	29.9902	30.4614
240066	1.5245	1.0997	35.3441	36.0705	39.6582	37.0745
240069	1.1972	1.0997	29.3718	30.9719	31.1660	30.5144
240071	1.1037	1.0997	28.6950	31.7754	32.5442	30.9915
240075	1.1903	1.0638	27.5039	29.1171	30.3218	29.0129
240076	1.0213	1.0997	30.6936	33.1439	33.7939	32.5944
240078	1.6519	1.0997	32.5785	34.6118	36.1976	34.5440
240080	1.9537	1.0997	32.5725	34.8064	36.5363	34.6282
240084	1.1356	1.0519	26.5975	27.0995	29.0260	27.5332
240088	1.2998	1.0638	28.0603	29.1387	30.7223	29.3333
240093	1.4599	1.0997	27.2928	29.1717	30.4718	29.0677
240100	1.3409	0.9120	30.8391	31.5774	30.9460	31.1194
240101	1.1984	0.9120	25.6963	26.8849	28.5492	27.1176
240104	1.2063	1.0997	31.6511	35.0736	35.8816	34.3219
240106	1.6106	1.0997	30.5927	32.8156	33.9953	32.4894
240115	1.4822	1.0997	32.0107	33.5288	36.2755	33.9354
240117	1.1647	0.9647	24.5750	27.6950	29.0889	27.1230
240128	***	*	23.3334	*	*	23.3334
240132	1.2651	1.0997	32.1233	34.6191	36.4224	34.2571
240141	1.1039	1.0997	31.4468	32.8689	34.2453	32.8961
240166	1.1593	0.9120	27.6987	26.5328	26.1726	26.6670
240187	1.2972	1.0997	27.8844	29.1582	30.9633	29.4012
240196	0.8466	1.0997	31.5965	34.3743	35.0319	33.6757
240206	0.9236	1.4448	*	*	*	*
240207	1.2383	1.0997	32.5589	34.6792	36.4537	34.6384
240210	1.2823	1.0997	32.7123	34.4184	36.5922	34.6233
240211	1.0511	0.9932	22.5430	17.4044	16.6144	18.6322
240213	1.4161	1.0997	33.8680	35.7818	37.4575	35.7765
250001	1.9650	0.8095	23.5222	23.7773	24.3386	23.8768
250002	0.9549	0.7883	23.4063	25.4201	25.0335	24.6387
250004	1.7720	0.8909	24.7907	25.8722	24.8072	25.1647
250006	1.1563	0.8909	24.4282	25.9199	27.0493	25.8303
250007	1.2323	0.8898	24.8929	27.7665	29.3457	27.3747
250009	1.2588	0.8361	23.0352	23.4866	24.9100	23.8155
250010	1.0456	0.7653	21.4322	21.8665	22.7976	22.0351
250012	0.9464	0.9329	21.5540	23.4837	26.4108	23.6996
250015	1.1829	0.7653	22.0067	22.2803	22.3674	22.2133
250017	1.0987	0.7653	22.7660	33.6840	25.7397	26.7933

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
250018	0.8867	0.7653	17.1276	17.9025	19.1099	18.0552
250019	1.5607	0.8898	25.7376	26.2199	27.7207	26.5559
250020	1.0028	0.7653	22.1851	23.7245	23.1510	23.0478
250023	0.8728	0.8156	18.0108	18.5067	19.5072	18.7146
250025	1.1390	0.7653	22.5621	23.1738	23.0544	22.9290
250027	0.9541	0.7653	24.4937	26.9922	32.5430	27.8433
250031	1.3451	0.8095	24.8139	25.9189	26.7496	25.8093
250034	1.5368	0.8909	26.1887	26.7996	27.9267	26.9950
250035	0.8649	0.7653	20.1622	19.1038	20.5237	19.9107
250036	1.0485	0.8030	20.3625	19.7951	22.5661	20.8304
250038	0.9523	0.8095	22.2571	26.9621	30.7941	25.9485
250040	1.4898	0.8156	24.5962	27.3366	26.2250	26.0460
250042	1.2547	0.8909	25.6807	26.1190	27.4593	26.4125
250043	0.9847	0.7653	18.8979	20.8841	21.1254	20.3156
250044	1.0363	0.7883	24.0508	24.9199	26.1725	25.0759
250048	1.6491	0.8095	25.2092	24.7659	27.6318	25.8347
250049	0.8715	0.7653	19.1044	20.4775	24.2222	21.0940
250050	1.3084	0.7653	20.8084	21.1657	22.4407	21.4799
250051	0.8661	0.7653	14.3741	13.9532	14.1652	14.1687
250057	1.1739	0.7653	22.7601	24.3654	22.9665	23.3314
250058	1.2366	0.7653	19.2502	18.9970	19.6711	19.3080
250059	0.9358	0.7653	23.8997	26.7491	25.5976	25.3587
250060	0.8110	0.7653	28.1431	25.4779	27.0347	26.8919
250061	0.8867	0.7653	17.8267	18.7413	25.1493	20.4689
250067	1.0949	0.7653	23.1193	25.2189	23.8020	24.0644
250069	1.4416	0.8280	22.6353	22.4194	23.4494	22.8355
250072	1.6783	0.8095	25.8399	25.5337	27.5770	26.3178
250077	0.9717	0.7653	18.3735	19.0416	19.6329	19.0451
250078	1.5855	0.8156	22.1243	22.8430	23.9580	22.9829
250079	0.8932	0.7653	45.5166	43.0845	46.0338	44.8458
250081	1.3682	0.8280	23.9995	25.6808	24.8259	24.8305
250082	1.4127	0.8150	23.0287	23.5399	25.6206	24.1469
250084	1.2526	0.7653	19.6492	19.1604	19.5676	19.4638
250085	1.0182	0.7653	22.5513	24.2915	24.6743	23.8551
250093	1.1850	0.7653	23.0984	23.9128	26.4337	24.4984
250094	1.6982	0.8156	24.1422	24.7718	25.4215	24.7893
250095	1.0314	0.7653	21.7488	23.6140	25.9001	23.7842
250096	1.2042	0.8095	24.9187	26.3743	27.7270	26.3759
250097	1.4899	0.8146	21.8139	22.0211	22.7899	22.2472
250099	1.2725	0.8095	21.1269	21.5656	27.5739	23.2182
250100	1.5271	0.8280	25.6846	27.0286	27.5468	26.7620
250102	1.5947	0.8095	24.6652	25.4050	25.5308	25.2035
250104	1.4396	0.8280	23.4303	24.4311	25.3986	24.4448
250112	0.9616	0.7653	24.3069	26.3357	27.4138	26.0536
250117	1.1581	0.8156	22.2450	23.7337	24.5692	23.5009
250120	***	*	24.6370	26.6522	*	25.6905
250122	1.1272	0.7653	27.2795	27.4424	23.4884	26.0511
250123	1.3504	0.8898	26.6221	27.9058	29.8280	28.1116
250124	0.8367	0.8095	20.4394	20.5667	21.9411	20.9862
250125	1.3788	0.8898	27.5158	26.7687	32.7395	28.5834
250126	1.0192	0.9329	24.4126	25.0019	25.2582	24.9087
250127	0.8041	1.4448	*	*	*	*
250128	0.9631	0.8099	17.7624	21.7882	23.5915	21.3639
250134	0.9291	0.8095	22.2167	21.0211	22.0830	21.7636
250136	1.0279	0.8095	22.9468	25.2241	27.1454	25.0260
250138	1.3091	0.8095	24.3018	25.2642	27.3114	25.5721
250141	1.4795	0.9329	28.5922	30.5112	33.4397	31.0006
250149	0.8769	0.7653	16.8796	17.2268	17.0956	17.0712
250151	0.5535	0.7653	18.8846	22.8238	*	19.4286
250152	0.8224	0.8095	26.9334	26.4559	28.5527	27.2309
250155	***	*	22.5728	*	*	22.5728
250156	***	*	*	16.8659	*	16.8659
250157	***	*	*	29.6398	*	29.6398
250162	1.0520	0.8912	*	*	*	*
260001	1.6886	0.9704	27.9230	29.5271	31.1839	29.5270
260004	0.9098	0.8470	20.3217	21.3629	24.1888	22.1072
260005	1.5296	0.8986	27.7855	27.9477	31.1215	28.9388

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
260006	1.4493	0.8470	30.3440	27.3754	33.7767	30.5981
260009	1.2153	0.9444	24.2360	25.7546	26.6670	25.5689
260011	1.5894	0.9038	25.6387	27.5762	31.2590	28.1581
260015	1.0293	0.8470	24.6139	25.0640	25.0244	24.8950
260017	1.3008	0.8736	23.5713	25.0461	26.2612	24.9757
260020	1.7335	0.8986	27.4730	29.3080	30.9576	29.2687
260021	1.3073	0.8986	29.3646	32.6735	19.4693	25.9620
260022	1.3246	0.8738	23.3393	24.8713	25.9379	24.7192
260023	1.3719	0.8986	24.3192	25.4314	25.5884	25.1233
260024	1.1889	0.8470	19.4952	19.2199	20.7131	19.8199
260025	1.3981	0.8986	22.2451	24.0358	24.5032	23.6143
260027	1.6154	0.9444	26.3590	29.3811	31.0217	28.7832
260032	1.8506	0.8986	25.6763	27.4857	28.7163	27.3241
260034	1.0142	0.9444	25.0573	27.1685	28.7725	27.0780
260040	1.7140	0.8470	24.3938	25.9074	27.2449	25.8128
260047	1.4348	0.8470	25.4978	26.6343	27.2646	26.4797
260048	1.1808	0.9444	27.6117	28.1515	29.6955	28.5297
260050	1.1398	1.0267	25.0506	26.2346	27.8050	26.4419
260052	1.3065	0.8986	26.0052	27.6360	29.6982	27.7827
260057	1.0872	0.9444	20.9639	21.5925	23.8167	22.1481
260059	1.2943	0.8547	22.6922	22.3885	24.9630	23.3714
260061	1.1720	0.8470	22.4766	22.8589	23.6708	22.9805
260062	1.2709	0.9444	28.1661	28.4975	29.6135	28.7754
260064	1.3641	0.8470	22.2395	23.3498	21.4934	22.3902
260065	1.7935	0.8470	27.1014	29.3564	27.9224	28.1492
260068	1.7301	0.8470	26.0295	27.3475	28.1227	27.1642
260070	0.9682	0.8470	24.6331	21.9701	25.2991	24.0399
260074	1.2162	0.8470	25.6218	28.0468	28.6203	27.4572
260077	1.6229	0.8986	26.7466	27.6624	28.7183	27.7262
260078	1.2711	0.8470	20.1983	21.1539	23.1780	21.5534
260080	1.0066	0.8470	17.9107	18.6070	18.6804	18.3878
260081	1.4925	0.8986	28.1182	29.1890	32.3581	29.9070
260085	1.5513	0.9444	26.6718	28.0306	29.6492	28.1046
260091	1.4867	0.8986	28.0537	28.5473	30.1154	28.9182
260094	1.6133	0.8470	24.1473	23.8654	25.1476	24.3842
260095	1.3868	0.9444	24.2698	27.6196	29.9069	27.0422
260096	1.5240	0.9444	29.7312	30.7267	32.9353	31.1666
260097	1.1896	0.8770	25.0624	25.5634	27.3117	26.0306
260102	0.9841	0.9444	27.2145	26.7624	30.7667	28.2426
260104	1.5825	0.8986	28.6247	28.0235	29.6366	28.7794
260105	1.8539	0.8986	29.8848	29.4766	32.4075	30.5702
260107	***	*	25.8177	27.9710	29.7754	27.7676
260108	1.8291	0.8986	26.6374	27.0758	28.5633	27.4377
260110	1.6476	0.8470	24.7656	26.6030	28.0368	26.5197
260113	1.1410	0.8470	21.2072	21.8884	23.0810	22.0233
260115	1.2609	0.8986	23.1396	24.6389	25.5643	24.4735
260116	1.0435	0.8470	21.3503	20.7479	22.5593	21.5340
260119	1.2922	0.8470	27.9769	31.5490	31.4981	30.2546
260137	1.7457	0.9704	24.3273	27.6592	31.4059	27.8364
260138	1.8944	0.9444	30.4410	30.6284	31.7554	30.9538
260141	1.8592	0.8470	24.1555	25.5663	26.6672	25.5210
260142	1.0838	0.8470	21.5923	21.7609	22.8201	22.0857
260147	0.9526	0.8470	21.4235	22.1928	22.9670	22.1968
260159	***	*	22.6276	23.9515	24.3018	23.5847
260160	1.0612	0.8470	23.8257	25.5096	26.6702	25.4076
260162	1.4383	0.8986	27.0236	28.4660	30.5739	28.7100
260163	1.2130	0.8557	21.6408	21.5566	23.8630	22.3617
260166	1.2356	0.9444	29.1225	28.5858	29.5234	29.0824
260175	1.1172	0.9444	25.1817	24.6064	25.7060	25.1720
260176	1.7557	0.8986	29.3034	31.1056	30.6112	30.3581
260177	1.2272	0.9444	27.0185	28.7942	29.0786	28.3077
260178	1.9689	0.8470	25.4782	27.1201	26.9886	26.5981
260179	1.5286	0.8986	26.6069	28.3234	29.6937	28.2012
260180	1.5853	0.8986	28.2931	29.3820	30.7313	29.4593
260183	1.6733	0.8986	27.5577	29.2684	31.4894	29.4549
260186	1.4640	0.8470	26.9797	28.8610	29.1853	28.3616
260190	1.2175	0.9444	27.9137	30.5343	30.8981	29.7909

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
260191	1.4412	0.8986	24.6973	26.3244	27.8627	26.3553
260193	1.2305	0.9444	26.8922	28.1060	29.5416	28.1851
260195	1.2498	0.8470	22.6870	24.0411	25.0275	23.9191
260198	***	*	28.0021	27.2555	27.9073	27.7138
260200	1.2908	0.8986	28.2453	27.4784	30.3290	28.7369
260207	1.1540	0.8470	22.6109	22.9579	23.6383	23.1705
260209	1.1532	0.9038	25.0098	25.0749	26.4196	25.5826
260210	1.3929	0.8986	26.8745	30.5975	36.4040	30.6935
260211	1.4262	0.9444	40.9821	35.9113	37.1525	38.3586
260213	***	*	*	34.8953	*	34.8953
260214	1.2306	0.9444	*	*	31.0153	31.0153
260216	1.3065	0.9444	*	*	*	*
260218	0.8126	*	*	*	*	*
260219	1.3191	0.8986	*	*	*	*
260220	2.3259	*	*	*	*	*
270002	1.1469	0.8640	24.0534	25.2907	28.3363	25.9060
270003	1.2563	0.8679	28.8700	29.1938	28.0533	28.6560
270004	1.6239	0.9045	26.1319	26.6779	28.5851	27.1552
270011	1.0779	*	22.7061	24.4696	*	23.5588
270012	1.5992	0.8679	25.2914	26.5854	28.0655	26.6761
270014	1.8067	0.8992	25.8231	27.4811	28.2567	27.1793
270017	1.3001	0.8909	26.5404	27.4150	29.3524	27.7689
270023	1.5599	0.8909	25.5682	26.3076	28.1878	26.6584
270032	1.0422	0.8640	20.3469	20.4330	21.6349	20.8153
270049	1.7681	0.9045	27.1634	28.6880	29.8869	28.6461
270051	1.5064	0.8909	26.5621	24.9371	29.3917	26.9486
270057	1.2964	0.8640	25.5811	27.1838	28.3612	27.1309
270074	0.8884	1.4448	*	*	*	*
270081	1.0022	*	19.5612	20.0438	*	19.8033
270086	1.2443	0.8679	21.0808	20.7976	21.8997	21.2340
270087	1.3324	0.8640	25.9772	24.8022	24.9177	25.2095
280003	1.7687	0.9620	30.6124	30.1057	32.3760	30.9970
280009	1.8349	0.9336	27.0705	29.3634	28.1542	28.1942
280013	1.7183	0.9400	27.0250	27.9523	30.3102	28.4716
280020	1.6559	0.9620	27.3284	32.3896	29.4807	29.7217
280023	1.3206	0.9336	26.7980	29.5132	30.0701	28.7818
280030	1.9392	0.9400	29.5102	30.6991	31.8740	30.6841
280032	1.2928	0.9336	24.3995	24.7539	25.6529	24.9364
280040	1.5775	0.9400	28.7207	29.5276	30.7378	29.6445
280060	1.6610	0.9400	27.7496	30.3049	30.8594	29.5587
280061	1.4476	0.9223	26.0208	26.4824	28.9580	27.1706
280065	1.2542	0.9611	28.0581	28.0132	29.5456	28.5374
280077	1.3602	0.8841	27.0860	28.2206	29.9204	28.4615
280081	1.6812	0.9400	28.7464	31.1212	28.9675	29.5979
280105	1.2560	0.9400	27.8599	29.8488	30.0457	29.2896
280111	1.1718	0.8761	24.5617	27.4853	28.3536	26.8743
280119	0.8951	1.4448	*	*	*	*
280123	0.9698	0.8884	15.4047	22.2185	20.2745	18.6147
280125	1.5858	0.8761	22.1345	23.2900	24.7453	23.4399
280127	1.8312	0.9620	29.3684	25.6806	26.5628	26.9797
280128	2.7488	0.9620	28.5422	28.8734	27.1001	28.1534
280129	2.0416	0.9400	*	27.8793	27.9490	27.9189
280130	1.3820	0.9400	*	29.8588	29.9628	29.9161
290001	1.7753	1.0476	36.3129	35.5113	33.3287	34.9942
290002	0.8657	0.9837	17.3876	23.9348	22.7349	20.8853
290003	1.7934	1.1666	30.3373	32.8182	34.6402	32.6118
290005	1.4648	1.1666	28.3366	31.7107	34.2346	31.0980
290006	1.0851	1.0476	31.7301	31.9838	33.1563	32.3337
290007	1.7274	1.1666	38.1938	39.7323	41.2361	39.7802
290008	1.2072	0.9824	27.3019	31.1116	33.2436	30.5242
290009	1.6426	1.0476	36.2724	32.3348	34.0900	34.1940
290012	1.3313	1.1666	32.3966	35.7988	38.5049	35.5355
290019	1.4604	1.0476	29.3650	30.5964	32.2793	30.8005
290020	1.0227	0.9824	23.2103	27.6277	27.2889	25.9788
290021	1.6689	1.1666	32.7894	36.7310	36.8695	35.4886
290022	1.7132	1.1666	29.9717	33.5330	38.8235	33.9036
290027	0.8931	0.9824	23.9959	23.9818	29.1114	25.2225

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
290032	1.4391	1.0476	31.6711	34.6589	36.9148	34.3264
290039	1.5440	1.1666	32.1423	34.9622	34.6334	33.9791
290041	1.4922	1.1666	34.2436	37.6077	38.4409	36.9258
290042	***	*	*	22.4859	*	22.4859
290044	***	*	37.1662	*	*	37.1662
290045	1.6567	1.1666	33.1512	34.4584	38.3841	35.4482
290046	1.4029	1.1666	*	38.7966	38.3084	38.5269
290047	1.4035	1.1666	*	33.4695	35.6348	34.5601
290049	1.3302	1.0476	*	26.0725	33.4248	30.0551
290051	1.8934	1.0027	*	*	32.5253	32.5253
290052	1.1590	0.9824	*	*	*	*
290053	1.5711	1.1666	*	*	*	*
300001	1.4434	1.0807	29.2260	29.8145	31.0102	30.0651
300003	2.0357	1.0807	34.7900	37.0886	37.7215	36.5476
300005	1.3788	1.0807	27.8000	27.8431	28.7980	28.1664
300011	1.3319	1.0807	30.9403	31.8928	33.0771	31.9916
300012	1.3235	1.0807	30.4972	31.2655	33.0547	31.6597
300014	1.2318	1.0807	29.7667	29.1847	30.7717	29.9265
300017	1.2863	1.0807	29.9560	31.6699	33.4139	31.6768
300018	1.3172	1.0807	29.4270	31.7891	31.5012	30.9778
300019	1.2444	1.0807	27.5672	28.2287	28.3103	28.0672
300020	1.1991	1.0807	30.8491	30.9783	32.4635	31.4527
300023	1.4459	1.0807	31.0040	31.2726	32.3183	31.5692
300029	1.8204	1.0807	29.8117	31.4429	32.0012	31.1343
300034	1.8504	1.0807	30.7676	31.6880	33.5519	32.0214
310001	1.7571	1.2878	41.7460	39.3391	41.4917	40.8275
310002	1.7914	1.2693	37.9183	37.8652	37.9453	37.9105
310003	1.1900	1.2878	36.2346	39.0785	40.1509	38.5759
310005	1.3414	1.1440	32.1319	33.6311	34.7634	33.5607
310006	1.4339	1.2878	28.4771	28.7321	30.4276	29.2523
310008	1.3390	1.2878	32.6788	33.3172	34.3243	33.4553
310009	1.3656	1.2693	33.6940	33.6165	35.4592	34.2954
310010	1.2858	1.1313	33.9552	33.7009	36.0797	34.6164
310011	1.2607	1.1599	31.2907	34.3497	37.4820	34.3008
310012	1.5959	1.2878	38.3590	39.8568	41.9596	40.0664
310013	***	*	31.0447	35.6260	32.9465	33.1378
310014	1.8164	1.1221	30.0793	32.9016	36.5996	33.3018
310015	1.9106	1.2693	36.8818	39.2928	40.8200	39.0289
310016	1.3313	1.2878	35.6155	38.2740	41.0326	38.2707
310017	1.3644	1.2693	32.2434	35.7308	35.9780	34.6067
310018	1.1472	1.2693	30.3234	32.9704	32.6937	31.9526
310019	1.5510	1.2878	30.3518	30.6369	31.8909	30.9689
310020	1.5807	1.2878	33.5516	37.3372	38.4230	37.3143
310021	1.6495	1.1316	32.1929	31.6562	32.2042	32.0219
310022	1.3231	1.1221	30.4043	31.1951	32.8059	31.4436
310024	1.3886	1.1440	33.3415	33.8622	36.6897	34.6507
310025	1.4248	1.2878	34.3687	32.2630	32.1469	32.9318
310026	1.3243	1.2878	29.1588	30.1392	30.1294	29.8053
310027	1.4636	1.1440	29.7793	31.5967	34.6445	31.9780
310028	1.1907	1.1440	32.2977	33.9911	34.8312	33.7159
310029	1.7792	1.1221	32.9246	33.6695	35.2057	33.9510
310031	2.8606	1.1221	37.0668	39.3783	39.5882	38.6577
310032	1.3218	1.1221	30.7865	33.0258	35.2379	33.0201
310034	1.4121	1.1221	31.7012	32.7523	36.8586	33.7114
310037	1.4765	1.2878	38.5415	38.2865	40.4608	39.0092
310038	1.8931	1.2693	35.9190	36.3344	39.8671	37.3872
310039	1.2417	1.2693	31.4278	33.2100	32.6403	32.4242
310040	1.2573	1.2878	33.8535	37.7945	41.2219	37.4721
310041	1.3358	1.1221	32.8390	33.9799	35.1979	33.9784
310042	***	*	34.4986	*	*	34.4986
310044	1.3493	1.1313	31.9678	33.7614	33.5843	33.0824
310045	1.6491	1.2878	36.7862	38.4424	39.2064	38.1273
310047	1.3458	1.1666	34.1520	37.3695	37.7198	36.4657
310048	1.3736	1.1316	32.9681	33.9506	34.5223	33.8353
310050	1.2457	1.2693	29.1732	32.3686	37.9191	32.9302
310051	1.4905	1.1440	35.0121	38.1174	39.7645	37.6891
310052	1.3237	1.1221	32.5778	33.5849	36.5463	34.2544

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Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
310054	1.4134	1.2693	34.4431	36.9095	38.2409	36.5602
310057	1.4334	1.1221	31.1268	31.8933	34.2018	32.3544
310058	1.0541	1.2878	27.1555	30.4080	30.4416	29.4040
310060	1.2546	1.1221	27.3415	27.8242	27.9121	27.7048
310061	1.2219	1.1221	31.6648	39.0538	33.5561	34.7375
310063	1.3448	1.1440	31.9247	33.8519	38.1450	34.4537
310064	1.5372	1.1666	35.7607	38.6310	39.4132	38.0057
310069	1.2581	1.1221	31.7642	34.4669	35.1354	33.8309
310070	1.4555	1.2693	34.3225	36.3279	36.9963	35.8869
310073	1.7821	1.1221	32.6733	34.2858	36.9226	34.6721
310074	1.4656	1.2878	40.3494	39.6196	39.0709	39.6558
310075	1.4250	1.1221	31.5226	32.5338	33.5226	32.5111
310076	1.6465	1.2693	38.0643	37.5163	38.1641	37.9202
310077	***	*	34.6085	*	*	34.6085
310078	***	*	30.5761	*	*	30.5761
310081	1.2620	1.1221	30.1561	31.0699	31.7950	31.0154
310083	1.3189	1.2693	30.3580	31.9151	28.3385	30.1096
310084	1.2659	1.1221	33.5941	32.6051	34.9604	33.7173
310086	1.2615	1.1221	29.5566	29.8794	30.9445	30.1377
310088	1.1243	1.1666	29.9929	30.3552	31.2420	30.5505
310090	1.2372	1.1440	32.8191	33.4615	33.9146	33.3953
310091	1.1327	1.1221	29.3969	31.9762	35.2892	32.2224
310092	1.4052	1.1313	29.7958	32.7054	32.8408	31.7803
310093	1.2201	1.2693	29.1288	30.2860	32.3840	30.5687
310096	1.9372	1.2693	34.1524	35.0707	34.2007	34.4697
310105	1.1572	1.2878	30.1069	32.5672	32.0252	31.5545
310108	1.4030	1.2693	33.0172	34.5866	36.2821	34.6390
310110	1.3096	1.1313	33.2246	33.4809	35.6793	34.1565
310111	1.2536	1.1221	31.8393	34.8284	36.0727	34.2677
310112	1.3277	1.1221	31.2372	32.2676	34.5315	32.6218
310113	1.2425	1.1221	31.0436	33.6771	35.0222	33.3347
310115	1.3224	1.1221	29.5320	31.9208	32.1173	31.2475
310116	1.2972	1.2878	29.2748	29.8144	27.5857	28.8828
310118	1.3587	1.2878	31.1803	31.2296	32.8252	31.7711
310119	1.8782	1.2693	43.1238	41.5702	41.2971	41.9830
310120	1.0851	1.1440	29.2535	33.3861	35.1643	32.4707
310122	***	*	*	41.9029	*	41.9029
310123	***	*	*	37.1022	*	37.1022
310124	***	*	*	41.8827	*	41.8827
310125	***	*	*	36.2186	*	36.2186
310126	***	*	*	*	34.3166	34.3166
320001	1.6823	0.9499	29.6182	30.0077	31.4174	30.3597
320002	1.5341	1.0587	32.0477	33.1342	34.1580	33.1619
320003	1.1298	1.0207	27.6222	31.4473	31.5768	30.3534
320004	1.3299	0.8858	24.7803	26.2073	28.2392	26.4283
320005	1.4214	0.9295	24.7543	28.7893	25.2152	26.1577
320006	1.2584	0.9295	26.9080	28.0964	28.5156	27.8949
320009	1.5798	0.9499	32.0116	27.8084	31.3279	30.3184
320011	1.1519	0.9300	25.6693	27.9522	28.9931	27.5536
320013	1.1126	1.0207	22.8283	30.5865	31.2869	27.7697
320014	1.0864	0.8858	27.2806	28.7089	30.4781	28.8685
320016	1.1842	0.8858	25.0835	27.1492	26.6374	26.3150
320017	1.2575	0.9499	31.6357	33.3496	30.5759	31.7120
320018	1.5461	0.8882	26.5109	25.9248	28.3438	26.9103
320019	1.4058	0.9499	27.8067	35.0217	28.6731	30.2204
320021	1.6185	0.9499	26.9918	28.8504	30.4499	28.7977
320022	1.1799	0.8858	23.9595	25.3707	27.5132	25.6817
320030	1.0361	0.8858	21.0378	24.4497	25.5246	23.7752
320033	1.2183	1.0207	31.7114	30.1471	30.1829	30.6567
320037	1.2261	0.9499	24.9657	25.2876	27.8969	26.0664
320038	1.2596	0.8858	21.7022	32.7192	31.6504	29.0042
320057	0.9342	1.4430	*	*	*	*
320058	0.7891	1.4430	*	*	*	*
320059	0.9914	1.4430	*	*	*	*
320060	1.0159	1.4430	*	*	*	*
320061	1.0245	1.4430	*	*	*	*
320062	0.9174	1.4430	*	*	*	*

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
320063	1.3932	0.9273	25.0031	26.0104	27.4933	26.1576
320065	1.3072	0.9273	27.3163	25.7945	26.9113	26.6843
320067	0.8947	0.8858	24.9865	24.7025	25.4100	25.0450
320069	1.0782	0.8858	22.4128	23.9863	25.3134	23.9141
320070	0.9255	1.4430	*	*	*	*
320074	1.2421	0.9499	31.1333	28.4396	28.8072	29.1304
320079	1.2567	0.9499	26.1188	27.6877	31.5635	28.5357
320083	2.4454	0.9499	26.6921	29.5483	32.9443	29.7645
320084	0.9653	0.8858	17.5788	22.7706	24.2897	21.5109
320085	1.7562	0.8882	27.9944	27.4100	28.4513	27.9647
320086	1.4744	0.8858	*	*	*	*
320087	1.3725	1.0587	*	*	*	*
330002	1.5701	1.3043	30.9600	32.1956	34.7252	32.6020
330003	1.3545	0.8833	24.4326	25.2223	26.8348	25.5129
330004	1.3501	1.0709	28.0594	30.2236	30.3204	29.4839
330005	1.5906	0.9593	30.3200	31.5030	33.2828	31.7049
330006	1.2783	1.3043	33.6284	34.2001	36.3279	34.6900
330008	1.1757	0.9593	23.4429	25.2005	26.2131	24.9414
330009	1.3652	1.3043	36.2820	38.9166	41.3767	38.8011
330010	1.0125	0.8375	20.7476	19.7098	20.5800	20.3266
330011	1.3772	0.8721	25.1308	27.4747	26.8258	26.4851
330013	1.9475	0.8833	26.4578	26.8382	28.8015	27.3879
330014	1.3374	1.3043	42.1759	45.7619	46.3155	44.6761
330016	***	*	22.0493	23.0769	*	22.5738
330019	1.3063	1.3043	38.5368	39.7429	44.5627	40.8880
330023	1.5312	1.2855	35.9428	36.4736	37.5106	36.6960
330024	1.7996	1.3043	42.7691	43.2342	44.8034	43.6032
330025	1.0483	0.9593	21.2565	23.2424	24.2691	22.9268
330027	1.3943	1.2855	42.8000	45.1920	45.9531	44.5412
330028	1.5319	1.3043	36.6498	36.2901	38.0116	36.9910
330029	0.5241	0.9593	23.2039	24.0679	22.9321	23.3384
330030	1.1544	0.8911	24.6175	25.3454	25.5081	25.1586
330033	1.2323	0.8531	24.5510	24.8022	25.0205	24.7863
330036	1.2126	1.3043	29.1884	30.3757	30.4633	30.0049
330037	1.2293	0.8911	22.3689	21.9246	23.4904	22.5870
330041	1.3098	1.3043	37.4883	36.9934	37.1640	37.2203
330043	1.4593	1.2729	39.1643	38.8060	40.6059	39.5013
330044	1.3446	0.8721	26.5669	28.2293	28.2619	27.6916
330045	1.4086	1.2729	38.1269	40.0326	41.6537	39.9715
330046	1.3696	1.3043	50.3152	47.4975	52.2364	49.9699
330047	1.2132	0.8375	24.3932	24.9934	26.1791	25.2159
330049	1.4907	1.2694	29.8350	34.8585	34.9720	33.3441
330053	1.0857	0.8911	20.6272	21.8383	20.1297	20.8283
330055	1.5415	1.3043	41.5934	42.2007	44.2313	42.7264
330056	1.3947	1.3043	36.0136	38.8910	39.9628	38.2393
330057	1.6802	0.8833	26.4989	27.7121	30.1910	28.1436
330058	1.2665	0.8911	22.2524	22.6852	23.6285	22.8634
330059	1.5527	1.3043	41.7343	44.9162	45.3660	44.0375
330061	1.1594	1.3043	36.0587	37.8828	37.8620	37.2887
330064	1.2603	1.3043	38.0437	38.2332	41.5714	39.3164
330065	1.0618	0.9593	25.3043	24.4004	26.2272	25.3188
330066	1.2729	0.8833	29.1780	25.8174	27.2069	27.4291
330067	1.3961	1.2694	27.8900	29.2571	30.7516	29.2920
330072	1.3012	1.3043	37.8505	39.6996	41.4567	39.5848
330073	1.1090	0.8911	22.5592	23.4020	25.1380	23.7034
330074	1.1944	0.8911	22.6629	23.4576	23.1004	23.0807
330075	1.1190	0.9865	23.1592	24.2552	23.7516	23.7241
330078	1.4677	0.9593	25.8073	27.2870	27.6659	26.9471
330079	1.3733	0.8308	24.6054	24.9941	27.9464	25.8287
330080	1.1760	1.3043	39.1417	38.9405	40.2059	39.4431
330084	1.0851	0.8308	22.5573	25.6880	27.3430	25.1537
330085	1.1551	0.9471	25.3285	26.6235	27.1697	26.3813
330086	1.3189	1.3043	32.7675	35.5269	40.9743	36.5723
330088	1.0110	1.2729	34.0789	35.3871	35.9962	35.1584
330090	1.4588	0.9101	25.5351	26.8730	27.7287	26.7363
330091	1.3843	0.9593	25.9378	27.0040	28.3015	27.0881
330094	1.2631	0.9901	25.7116	26.9148	28.6203	27.1128

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
330096	1.1987	0.8308	22.7189	24.2422	24.7885	23.9177
330100	1.1185	1.3043	38.3333	39.6244	37.8618	38.6066
330101	1.8970	1.3043	40.1929	43.7944	45.5381	43.2279
330102	1.4096	0.9593	25.3879	26.6887	27.2523	26.4449
330103	1.2008	0.8351	22.8242	24.5585	25.4907	24.2904
330104	1.3423	1.3043	33.7537	35.1076	36.5857	35.1622
330106	1.6914	1.2855	43.8210	46.3657	48.2871	46.1844
330107	1.2407	1.2729	34.9047	35.7384	38.0246	36.2529
330108	1.1289	0.8347	23.2919	23.9368	25.3011	24.1893
330111	0.9674	0.9593	20.3473	40.4349	23.2125	25.3142
330115	1.1888	0.9865	25.2373	23.8235	24.3889	24.4744
330119	1.7304	1.3043	39.0528	42.2901	41.2326	40.8420
330125	1.7378	0.8911	27.2920	28.0584	29.4802	28.3192
330126	1.3038	1.2855	35.2257	36.5689	37.7797	36.5514
330127	1.3108	1.3043	45.3680	45.2993	45.2542	45.3069
330128	1.2304	1.3043	39.5197	41.7790	43.3424	41.5728
330132	1.1001	0.8439	21.0479	21.7648	22.1446	21.6691
330133	1.3704	1.3043	39.3837	38.5228	39.9011	39.2582
330135	1.2101	1.1586	27.9132	32.0525	33.2291	31.0896
330136	1.5320	0.9471	25.8531	26.6680	25.4193	25.9628
330140	1.7962	0.9865	27.6183	29.3461	31.1320	29.4083
330141	1.3202	1.2729	39.4701	39.3741	39.1699	39.3348
330144	0.9865	0.8362	22.9561	23.3874	24.9303	23.7658
330151	1.2083	0.8362	21.7665	19.7959	21.6335	21.0260
330152	1.3015	1.3043	37.6721	38.2079	39.5722	38.4999
330153	1.7175	0.8833	26.4386	28.4446	28.9924	27.9865
330154	1.6921	*	*	*	*	*
330157	1.3796	0.9471	26.5686	27.1432	29.7604	27.7881
330158	1.6713	1.3043	38.2033	41.7010	39.5913	39.8276
330159	1.3553	0.9865	28.2774	31.7835	33.8472	31.2089
330160	1.5503	1.3043	36.6208	37.1915	39.1048	37.6457
330162	1.3383	1.3043	34.9460	37.6226	38.7613	37.1390
330163	1.1132	0.9593	27.1933	28.3910	28.6229	28.0754
330164	1.4898	0.8911	27.7217	27.8746	29.8437	28.5199
330166	1.0613	0.8308	20.4680	20.7121	22.8498	21.3014
330167	1.6290	1.2855	36.7653	39.1251	39.1824	38.3281
330169	1.3998	1.3043	45.3774	46.4939	47.5367	46.4021
330171	***	*	30.4005	35.1577	*	32.5880
330175	1.1285	0.8568	23.8509	24.1005	26.7868	24.8937
330177	0.9936	0.8308	20.6338	22.9834	23.4294	22.3276
330180	1.1924	0.8833	24.3761	25.4170	26.8643	25.5779
330181	1.3033	1.2855	41.4104	43.0977	46.2154	43.5483
330182	2.2878	1.2855	40.9014	41.3033	42.7924	41.6641
330184	1.3645	1.3043	35.8102	39.0437	39.7213	38.2058
330185	1.2668	1.2729	36.3155	38.4002	39.6695	38.1531
330188	1.2402	0.9593	25.1153	27.5988	29.7302	27.4385
330189	1.2886	0.8833	22.3484	22.4383	25.8116	23.5448
330191	1.2850	0.8833	25.5656	26.4328	28.2938	26.8175
330193	1.4383	1.3043	39.9327	39.8910	40.0256	39.9494
330194	1.7941	1.3043	45.5639	46.8880	49.8845	47.4698
330195	1.7054	1.3043	39.7802	41.7885	43.3185	41.6774
330196	1.2884	1.3043	36.7178	38.2525	38.6925	37.9124
330197	1.1174	0.8308	26.8921	25.9872	26.5516	26.4718
330198	1.3922	1.2855	33.4930	34.8985	35.8688	34.8129
330199	1.1949	1.3043	38.6407	40.3948	39.4065	39.4834
330201	1.8000	1.3043	37.2064	42.6707	46.5096	42.1336
330202	1.4107	1.3043	37.4150	37.4158	38.7609	37.8756
330203	1.4153	0.9865	32.1207	34.0499	34.6499	33.6383
330204	1.4550	1.3043	39.6393	41.9953	39.5313	40.4252
330205	1.2337	1.1586	31.9510	33.9418	35.3766	33.7848
330208	1.1951	1.3043	32.1256	33.5287	37.1706	34.2436
330209	***	*	30.2038	*	*	30.2038
330211	1.0836	0.8308	24.4470	25.8752	24.9417	25.1105
330213	1.0678	0.8308	24.4049	27.4890	28.5365	26.7727
330214	1.8791	1.3043	41.8719	42.1339	43.2434	42.4360
330215	1.2792	0.8721	23.7361	23.9583	26.3964	24.6837
330218	1.0910	0.9865	26.9638	26.9982	28.4109	27.4690

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Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
330219	1.7127	0.9593	29.8889	32.5658	33.2132	31.8655
330221	1.3708	1.3043	39.2080	40.0514	42.5461	40.6770
330222	1.2774	0.8833	25.8507	27.7198	28.7835	27.5072
330223	0.9707	0.8308	23.3669	26.1264	27.1959	25.6000
330224	1.3100	1.0709	27.9231	29.1738	30.4765	29.2021
330225	1.2228	1.2855	32.3585	35.7651	32.9013	33.6812
330226	1.4002	0.8911	24.5646	24.8471	26.3674	25.2746
330229	1.2244	0.8420	21.9356	23.0577	23.9230	22.9668
330230	1.0278	1.3043	37.1298	38.6569	39.3870	38.3808
330231	1.1135	1.3043	40.6697	44.9422	48.9002	44.9236
330232	1.2072	0.8833	26.3313	27.4639	27.9601	27.2541
330233	1.5357	1.3043	47.3497	52.7070	40.8517	46.1530
330234	2.3425	1.3043	48.2306	49.3219	49.8754	49.1340
330235	1.1520	0.9471	27.7031	29.4346	30.8007	29.3076
330236	1.5494	1.3043	40.2386	42.8981	42.6166	41.9558
330238	1.2738	0.8911	21.7435	21.8386	23.3946	22.3482
330239	1.2402	0.8420	22.3854	23.1885	24.6380	23.4006
330240	1.4609	1.3043	43.5753	40.5001	41.6117	41.8580
330241	1.8409	0.9865	30.2304	32.7683	32.9148	32.0133
330242	1.3112	1.3043	37.4870	36.9015	38.7839	37.7206
330245	1.7745	0.8721	26.1811	27.4326	28.6678	27.4605
330246	1.3715	1.2729	37.1611	35.7416	35.9559	36.2356
330247	1.1834	1.3043	35.4980	39.0219	41.3428	38.4848
330249	1.3392	0.9865	25.3246	24.6091	26.9847	25.6366
330250	1.3845	0.9216	27.1606	29.0080	29.6168	28.6244
330259	1.5072	1.2855	35.1514	36.4788	39.0189	36.8295
330261	1.2365	1.3043	33.7834	40.2579	38.0192	37.2335
330263	1.0140	0.8308	23.8738	24.1333	24.2125	24.0872
330264	1.3203	1.1586	30.4701	31.0557	32.1770	31.4635
330265	1.2419	0.8911	21.6477	23.9081	22.7426	22.7616
330267	1.3921	1.3043	32.8541	34.9885	35.3884	34.4218
330268	0.9313	0.8308	25.3567	23.8793	23.9129	24.3479
330270	2.0758	1.3043	57.3596	55.2136	52.3126	54.6691
330273	1.3499	1.3043	37.0157	35.9298	39.7849	37.6016
330276	1.1594	0.8344	24.3300	26.0935	27.0432	25.8320
330277	1.2068	0.9101	26.4535	30.9053	30.8138	29.1290
330279	1.6224	0.9593	27.4539	29.6385	31.2369	29.4467
330285	1.9771	0.8911	30.1928	31.1235	31.9305	31.0944
330286	1.3514	1.2729	35.5895	37.6040	38.8533	37.3699
330290	1.6233	1.3043	39.4690	40.6933	39.8010	39.9779
330304	1.3053	1.3043	36.2845	37.3537	39.4605	37.8134
330306	1.4567	1.3043	36.3552	38.7713	39.0391	38.0888
330307	1.3412	0.9561	29.2529	29.5885	30.8103	29.9028
330314	***	*	26.2719	28.1788	22.6868	26.0606
330316	1.2398	1.3043	34.8567	37.1766	37.9320	36.6690
330331	1.2869	1.2855	39.8402	41.2694	44.1690	41.7977
330332	1.3105	1.2855	35.1646	37.0111	38.6906	36.9311
330338	***	*	37.7497	*	*	37.7497
330339	0.7634	0.8833	23.5786	24.3066	25.0041	24.2976
330340	1.2284	1.2729	37.9000	37.4161	38.4698	37.9265
330350	1.5260	1.3043	41.1339	44.4617	44.2368	43.3333
330353	1.2443	1.3043	45.9692	45.0977	46.0175	45.7015
330354	2.1246	*	*	*	*	*
330357	1.2886	1.3043	38.2286	40.3850	40.2097	39.5419
330372	1.2901	1.2855	36.1840	35.1297	37.0288	36.1053
330385	1.0504	1.3043	48.6175	49.0859	47.3989	48.3826
330386	1.3408	1.1461	29.9366	33.3216	32.9974	32.1005
330389	1.7338	1.3043	37.1862	39.6871	37.5883	38.1257
330390	1.2394	1.3043	36.3842	35.5562	38.7634	36.9285
330393	1.7385	1.2729	38.0619	39.2186	38.9295	38.7593
330394	1.6520	0.8721	27.3388	28.4597	28.8056	28.2126
330395	1.4204	1.3043	36.3921	37.5791	50.1276	40.5815
330396	1.3480	1.3043	37.4998	39.4904	39.1940	38.7397
330397	1.4094	1.3043	37.5682	41.4448	41.1659	39.9850
330399	1.1317	1.3043	34.7394	36.7626	39.8000	37.1071
330401	1.3519	1.2729	37.8559	40.4485	41.7804	40.0688
330403	0.9101	0.8911	25.5163	25.2937	28.7267	26.3688

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
330404	0.9366	1.3043	*	*	36.1044	36.1044
330405	0.9452	1.3043	*	*	35.2698	35.2698
330406	0.9450	0.8833	*	*	28.2727	28.2727
330407	0.9449	0.8833	*	*	*	*
340001	1.4870	0.9570	28.3988	29.5709	29.9082	29.3235
340002	1.7858	0.9192	28.4860	29.6622	30.7384	29.6332
340003	1.2344	0.8632	24.1602	26.0888	26.6393	25.6927
340004	1.4318	0.9096	26.6404	27.5283	27.9184	27.3734
340008	1.2672	0.9567	26.7443	27.7206	29.0639	27.8645
340010	1.3315	0.9557	27.2105	28.7544	29.5207	28.5197
340011	1.1738	0.8632	19.7441	22.0047	22.5138	21.4242
340012	1.2246	0.8632	23.2288	24.7576	24.9253	24.3215
340013	1.2360	0.9307	23.9492	26.3607	26.9137	25.7232
340014	1.6086	0.8984	27.4888	27.8384	29.5330	28.3119
340015	1.3956	0.9570	28.0585	28.3928	30.0958	28.8519
340016	1.3330	0.8632	25.6454	27.2365	27.9629	26.9654
340017	1.2759	0.9192	25.7780	27.5672	28.4845	27.2551
340020	1.1889	0.8788	26.4465	27.5473	28.3440	27.4399
340021	1.3379	0.9570	29.4864	29.3835	31.3610	30.1011
340023	1.3629	0.9307	26.4225	26.2716	27.6909	26.8311
340024	1.1349	0.8809	23.6638	26.4001	26.8984	25.6597
340025	1.2988	0.9192	23.5881	24.0101	25.2827	24.3044
340027	1.2181	0.9174	25.5973	26.3840	26.6506	26.2232
340028	1.5011	0.9923	28.0323	30.7591	31.9846	30.2233
340030	1.9766	0.9693	29.6630	30.4591	31.1985	30.4842
340032	1.4553	0.9570	26.5958	28.7636	29.2058	28.2291
340035	1.0979	0.8632	23.9669	24.6262	26.0827	24.8874
340036	1.3100	0.9685	27.2691	27.3860	29.0626	27.9422
340037	1.1218	0.8794	25.6262	29.0618	30.5346	28.5630
340038	1.2380	0.8885	22.4829	24.2111	26.2582	24.3742
340039	1.2806	0.9570	27.4457	27.8228	29.5042	28.2768
340040	1.9081	0.9346	27.6626	28.7434	30.1256	28.8796
340041	1.3315	0.8946	24.3595	26.8314	27.1270	26.1141
340042	1.2353	0.8632	25.0110	25.6349	27.0573	25.9214
340047	1.8051	0.8984	27.4022	28.4968	28.7600	28.2338
340049	1.7851	0.9693	30.6791	29.6826	31.5524	30.6567
340050	1.2008	0.9567	26.0365	27.5274	29.2266	27.6025
340051	1.1886	0.8794	23.9612	24.4561	25.4961	24.6507
340053	1.4900	0.9570	27.8577	28.9355	30.8320	29.2316
340055	1.2129	0.8946	26.0647	26.5752	29.0098	27.1555
340060	1.0621	0.9141	22.9097	25.1791	26.8366	24.9813
340061	1.7496	0.9693	27.0089	29.8574	31.2885	29.4140
340064	1.1205	0.8632	23.4233	23.9701	25.0796	24.1848
340068	1.2915	0.8632	22.6814	23.6757	24.7388	23.6999
340069	1.8414	0.9693	29.3439	31.4951	32.2147	31.0749
340070	1.2531	0.8984	25.3226	26.6546	27.7660	26.6186
340071	1.0621	0.9557	26.3921	27.9748	29.7321	28.0710
340072	1.1433	*	25.2493	24.1350	*	24.6895
340073	1.6527	0.9693	30.9849	31.6803	33.2859	32.0279
340075	1.2349	0.8946	25.1551	25.1438	26.8298	25.7432
340084	1.1236	0.9570	21.1363	23.1300	25.6868	23.2795
340085	1.1506	0.8882	26.5164	27.9572	29.1072	27.8491
340087	1.2341	0.8632	22.4287	25.4730	23.8343	23.9111
340090	1.3071	0.9685	26.4031	26.7428	28.3594	27.2234
340091	1.6022	0.9096	27.1285	28.8044	30.4345	28.8160
340096	1.2333	0.8882	24.9036	26.5438	26.5795	26.0408
340097	1.2431	0.8632	26.2228	29.8005	27.9788	27.9546
340098	1.4670	0.9570	28.2493	29.7180	31.3896	29.8226
340099	1.2912	0.8632	21.8564	23.9702	26.0062	24.0248
340104	0.7848	0.8794	16.1204	17.0165	19.9477	17.8305
340106	1.1406	0.8632	26.0892	26.1340	24.5134	25.5139
340107	1.1991	0.9068	24.1762	26.5626	27.3548	26.0750
340109	1.2448	0.8868	25.4464	26.6383	26.6462	26.2343
340113	1.9457	0.9570	28.5587	30.3841	32.3765	30.4662
340114	1.5304	0.9693	28.3222	28.1311	30.1188	28.8788
340115	1.6260	0.9693	26.7592	27.2781	28.0955	27.3861
340116	1.7476	0.8946	27.5881	29.3698	29.9425	28.9452

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
340119	1.2861	0.9570	25.6226	29.4470	27.2924	27.4283
340120	1.0708	0.8632	25.9134	25.5399	26.1449	25.8647
340121	1.0930	0.9087	23.1343	23.8854	25.1565	24.0798
340123	1.2779	0.9141	26.0637	28.5669	28.7125	27.7861
340124	***	*	22.2988	23.5480	25.7275	23.7126
340126	1.3283	0.9557	26.9866	28.2247	30.6880	28.6662
340127	1.1942	0.9693	26.4746	28.2161	28.8647	27.8604
340129	1.3110	0.9570	25.7976	26.7606	31.7833	27.9613
340130	1.3497	0.9570	26.1717	28.1594	29.5278	27.9862
340131	1.4690	0.9174	27.4750	28.8542	29.6545	28.6874
340132	1.2127	0.8632	23.5856	24.6162	25.3247	24.5295
340133	1.0197	0.8940	23.4678	24.8579	26.8831	25.1020
340137	***	*	22.1741	28.9672	27.0855	25.1884
340138	0.9092	0.9693	*	*	*	*
340141	1.6729	0.9087	29.3878	29.3171	29.3351	29.3465
340142	1.2123	0.8632	26.6886	27.7555	28.2393	27.5936
340143	1.5447	0.8946	28.0082	27.9777	29.3839	28.4856
340144	1.2183	0.9570	26.1865	27.0150	27.6523	26.9370
340145	1.2148	0.9570	25.8459	26.7482	28.0628	26.9029
340147	1.3027	0.9557	26.9162	28.2626	29.6936	28.3096
340148	1.5007	0.8984	25.3660	25.8325	27.9119	26.4048
340151	1.2153	0.8684	22.7736	23.2158	24.5768	23.5273
340153	1.9232	0.9570	27.6509	28.5979	29.8260	28.7235
340155	1.4750	0.9693	30.3443	30.9501	31.7547	31.0367
340156	0.8722	1.4446	*	*	*	*
340158	1.1294	0.9087	27.7816	27.6526	29.4088	28.3011
340159	1.2146	0.9693	24.2588	25.3108	28.1688	25.9712
340160	1.3520	0.8632	21.7923	23.4631	24.2003	23.1718
340166	1.3505	0.9570	27.1132	28.5395	29.9101	28.5234
340168	0.4196	0.9087	*	*	*	*
340171	1.1184	0.9570	27.8539	27.4701	31.1928	28.9088
340173	1.3301	0.9693	28.3502	30.2815	30.9813	29.9351
340177	***	*	26.7155	*	*	26.7155
340179	***	*	34.1895	*	*	34.1895
340182	***	*	27.8071	*	*	27.8071
340183	1.1992	0.9570	*	*	30.1224	30.1224
350002	1.8113	0.7336	22.4307	23.5869	23.6039	23.2267
350003	1.2133	0.7336	23.9639	24.9975	24.5802	24.5236
350006	1.5637	0.7336	21.2726	22.4626	23.4334	22.3834
350009	1.0718	0.8212	23.8681	24.5737	23.9783	24.1447
350010	1.0699	*	20.1290	20.4198	*	20.2749
350011	1.9136	0.8212	23.8400	24.1135	26.0184	24.6622
350014	0.9542	*	19.1684	17.5837	*	18.3437
350015	1.5991	0.7336	20.9046	21.3342	22.9107	21.7900
350017	1.2273	0.7336	22.4359	21.6187	24.0965	22.7331
350019	1.6984	0.7709	23.2018	24.9615	24.9880	24.4055
350030	0.9524	0.7336	20.2722	22.5976	23.1013	22.0048
350063	0.9136	1.4365	*	*	*	*
350064	0.7388	1.4365	*	*	*	*
350070	1.7656	0.8212	25.2365	26.2454	26.2850	25.9334
360001	1.4815	0.9581	25.8669	28.8623	30.1018	28.2801
360002	1.2851	0.8723	24.5155	25.4859	25.2198	25.0794
360003	1.7681	0.9581	28.9672	30.7812	31.8948	30.5710
360006	1.8125	0.9869	30.1363	30.9806	31.8259	31.0038
360008	1.3172	0.8759	26.2632	27.5683	28.0182	27.2862
360009	1.5509	0.9299	25.0007	27.0618	28.2407	26.7836
360010	1.2398	0.8784	23.7825	24.7352	25.5935	24.7214
360011	1.2808	0.9657	27.6036	31.5587	29.9864	29.6800
360012	1.3492	0.9869	30.1416	31.0526	31.9806	31.0579
360013	1.0853	0.9299	27.0893	29.8412	30.2383	29.0666
360014	1.1225	0.9657	27.1017	27.0743	28.1800	27.4862
360016	1.4873	0.9581	27.8031	29.6298	30.2164	29.2161
360017	1.6193	0.9869	29.8525	31.7081	33.2491	31.6157
360019	1.3267	0.9266	26.9178	27.2997	28.3226	27.5252
360020	1.5825	0.9266	23.6400	25.6328	27.6681	25.6284
360025	1.4547	0.9267	27.4533	27.1546	28.4754	27.6992
360026	1.3750	0.9321	25.5379	25.2945	27.5409	26.1280

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
360027	1.5168	0.9266	27.4454	28.2923	29.6304	28.4671
360029	1.1810	0.9267	24.3216	26.4208	27.8825	26.2449
360032	1.2265	0.8582	25.0034	25.9916	27.2621	26.0956
360035	1.6390	0.9869	30.0172	31.3181	31.2432	30.8528
360036	1.1944	0.9266	27.8343	29.3514	29.9390	29.0664
360037	1.5004	0.9266	29.0046	30.0446	30.6535	29.8835
360038	1.5826	0.9581	25.4274	31.0611	31.3759	29.1457
360039	1.4590	0.9657	23.9783	24.7873	25.8206	24.8982
360040	1.2069	0.8969	24.8569	25.5337	26.7437	25.7182
360041	1.4496	0.9266	26.1522	26.6755	28.4427	27.1150
360044	1.1770	0.8709	21.5619	24.3840	24.7681	23.5345
360046	1.2150	0.9581	25.4673	26.2417	28.2956	26.6958
360048	1.8237	0.9267	29.3415	29.4378	30.0370	29.6170
360049	***	*	26.2222	*	*	26.2222
360051	1.6897	0.9321	26.8501	28.1167	29.4411	28.1381
360052	1.5471	0.9321	26.2066	26.8806	28.4711	27.2049
360054	1.3413	0.8759	22.9359	24.8248	23.6593	23.7903
360055	1.4007	0.8931	27.3941	30.0143	31.4776	29.5863
360056	1.5488	0.9581	26.5318	30.3677	31.1802	29.4451
360058	1.1206	0.8582	23.8119	24.5003	25.9278	24.7681
360059	1.4695	0.9266	29.3624	30.6173	30.6279	30.2152
360062	1.5597	0.9869	31.7422	32.8893	32.8990	32.5514
360064	1.5123	0.8931	25.2336	27.7795	28.6078	27.1789
360065	1.2709	0.9266	28.0405	29.7155	31.5056	29.7621
360066	1.4332	0.9299	27.1436	29.7605	30.9636	29.2899
360068	1.8584	0.9267	26.2065	26.6933	28.6320	27.1929
360070	1.6693	0.8845	27.2389	27.8891	28.8717	27.9936
360071	1.1466	0.8617	23.4619	26.4081	25.7940	25.2133
360072	1.5262	0.9869	25.9589	27.2286	28.3666	27.2276
360074	1.2813	0.9267	25.8959	27.5328	27.9970	27.1581
360075	1.2013	0.9266	26.8925	26.1657	28.3916	27.1857
360076	1.5143	0.9581	28.1013	29.0148	29.2102	28.7968
360077	1.5018	0.9266	28.4449	28.0133	28.3010	28.2547
360078	1.2814	0.9266	25.7885	27.4689	27.3636	26.8573
360079	1.7270	0.9321	27.2437	30.1230	31.3114	29.5585
360080	1.1032	0.8582	21.4526	22.7020	21.8797	22.0297
360081	1.3032	0.9267	29.8366	29.5312	31.4274	30.2589
360082	1.3735	0.9266	29.2561	28.7925	30.5823	29.5279
360084	1.6319	0.8845	27.3917	28.5402	29.2435	28.4167
360085	2.0543	0.9869	31.5800	32.8502	33.1267	32.5905
360086	1.6514	0.9321	25.4218	27.3124	28.3559	27.0242
360087	1.4326	0.9266	29.6579	28.4185	28.6324	28.8850
360089	1.1327	0.8582	25.3465	25.5608	28.0769	26.2935
360090	1.4661	0.9267	29.0199	30.7530	29.2643	29.6802
360091	1.3415	0.9266	25.8657	27.6809	28.1671	27.2522
360092	1.2566	0.9869	25.4954	25.4055	28.0797	26.3112
360095	1.4803	0.9267	26.4635	29.3787	30.1514	28.6022
360096	1.1353	0.8582	25.9275	26.8653	27.9493	26.9250
360098	1.4304	0.9266	25.5973	26.6382	26.5824	26.3001
360100	1.3412	0.8845	25.4523	23.6167	25.8131	24.9650
360101	1.4779	0.9266	27.6030	29.7817	30.6609	29.3460
360107	1.1819	0.9267	24.6095	26.0534	26.8168	25.8586
360109	1.0429	0.8582	26.3131	30.1382	30.4624	28.9111
360112	1.8522	0.9267	30.5715	31.1356	32.4383	31.4039
360113	1.2805	0.9581	26.6556	30.2871	30.3893	29.0672
360115	1.3320	0.9266	25.9841	26.1821	26.8438	26.3395
360116	1.2122	0.9581	25.1717	26.4968	26.8619	26.2113
360118	1.4755	0.9295	27.3884	28.5643	29.9812	28.5726
360121	1.2872	0.9267	27.4442	28.3835	31.6755	29.0943
360123	1.4063	0.9266	27.1920	28.0334	28.5418	27.9298
360125	1.2052	0.8582	24.1388	25.9067	27.1761	25.6993
360130	1.5015	0.9266	25.6570	26.3986	28.1792	26.7600
360131	1.3679	0.8845	25.3719	26.6635	27.3408	26.4479
360132	1.3742	0.9581	27.7724	29.4070	29.8386	28.9945
360133	1.5965	0.9321	29.8684	31.7521	33.1791	31.6376
360134	1.7642	0.9581	27.7339	28.5141	29.9175	28.7663
360137	1.7064	0.9266	26.1250	27.6894	30.3093	28.0256

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
360141	1.6073	0.8931	29.7937	31.1778	31.9380	30.9580
360143	1.3047	0.9266	28.3057	26.9394	28.0681	27.7625
360144	1.3394	0.9266	28.2473	28.9177	29.6531	28.9566
360145	1.6504	0.9266	27.1908	28.1835	29.3247	28.2623
360147	1.2554	0.8582	25.5854	27.5548	29.2356	27.4482
360148	1.1785	0.8582	26.0837	26.3399	25.7446	26.0498
360150	1.3213	0.9266	25.1217	28.2561	27.8825	27.0949
360151	1.4719	0.8845	25.3780	26.5636	26.9664	26.3114
360152	1.5125	0.9869	29.9425	31.5377	33.3560	31.6190
360153	0.9954	0.8582	19.8499	20.2147	21.8404	20.6626
360155	1.4645	0.9266	26.9127	28.9521	28.8915	28.2820
360156	1.1512	0.8701	24.3281	25.0833	26.2253	25.2574
360159	1.3312	0.9657	29.1529	28.6174	29.0171	28.9284
360161	1.3364	0.8931	25.4433	27.0875	27.7406	26.7559
360163	1.8747	0.9581	28.9742	30.0724	31.2057	30.0774
360170	1.1878	0.9869	28.5474	29.5954	30.0025	29.4160
360172	1.3762	0.9266	27.5669	28.8283	30.2315	28.8817
360174	1.2862	0.9321	26.8586	28.3143	28.3749	27.8656
360175	1.2487	0.9657	28.1531	28.3054	29.7479	28.7375
360179	1.5492	0.9581	30.0311	29.8299	31.3518	30.4088
360180	2.3387	0.9266	29.6633	31.4342	32.0205	31.0895
360185	1.2624	0.8582	25.6800	26.1080	26.4201	26.0786
360187	1.4967	0.9321	24.9353	25.7600	27.3727	26.0387
360189	1.1420	0.9869	26.3756	27.5097	28.2736	27.4040
360192	1.3279	0.9266	26.4616	27.5991	29.1980	27.8031
360195	1.0799	0.9266	25.0922	27.6155	27.2619	26.6349
360197	1.1347	0.9657	28.7580	28.9207	28.5250	28.7314
360203	1.1898	0.8582	24.4433	25.3692	27.7551	25.8598
360210	1.2170	0.9869	28.2976	29.6476	31.8161	29.9477
360211	1.6076	0.8582	25.7053	26.5459	27.2721	26.4875
360212	1.3076	0.9266	25.6080	26.6976	28.5868	26.9659
360218	1.2246	0.9869	29.8662	30.0101	31.0690	30.3264
360230	1.5275	0.9266	28.8018	30.0661	30.5975	29.8409
360234	1.4185	0.9581	25.9360	31.0656	30.7904	29.2950
360236	1.3057	0.9581	25.6728	29.5321	29.9348	28.6891
360239	1.3536	0.9321	27.2939	30.7728	31.7919	29.9651
360241	***	*	23.0662	25.7290	25.8138	24.8236
360242	1.9535	*	*	*	*	*
360245	0.6344	0.9266	20.6504	20.3426	20.4587	20.4760
360247	0.4196	0.9869	19.3677	*	*	19.3677
360253	2.2617	0.9581	33.2371	34.3347	34.6849	34.0994
360259	1.2301	0.9267	25.9878	27.2902	28.0868	27.1587
360261	1.5079	0.9118	22.3614	25.6332	26.6241	24.8458
360262	1.2975	0.9267	28.6995	30.1559	31.5616	30.2316
360263	1.9432	0.9299	25.1652	25.4864	28.1657	26.3875
360264	***	*	36.0754	*	*	36.0754
360265	***	*	36.6265	*	*	36.6265
360266	2.1538	0.9869	*	31.7565	29.8358	30.6488
360267	***	*	*	34.0936	*	34.0936
360268	***	*	*	34.0526	*	34.0526
360269	1.7035	0.9581	*	24.8552	25.5163	25.2427
360270	1.1268	0.8582	*	*	28.8661	28.8661
360271	***	*	*	*	28.4331	28.4331
360272	***	*	*	*	38.0986	38.0986
360273	***	*	*	*	37.6617	37.6617
360274	1.5016	0.9321	*	*	*	*
360276	1.1341	0.8931	*	*	*	*
370001	1.6484	0.8652	26.0194	26.8884	28.4890	27.1483
370002	1.1271	0.8016	22.0476	23.6886	26.2488	23.9833
370004	1.1127	0.9349	26.7434	26.8521	28.2786	27.2955
370006	1.2372	0.8784	22.4802	23.9935	25.2294	23.8425
370007	1.0227	0.8016	19.4036	20.3706	21.1255	20.2911
370008	1.4408	0.8686	25.3352	26.6563	27.9923	26.6850
370011	1.0018	0.8686	21.9649	22.3391	23.1755	22.5131
370013	1.5415	0.8686	26.5364	27.2667	28.3486	27.4244
370014	1.0690	0.9291	25.9393	26.4488	28.8951	27.1129
370015	1.0296	0.8652	24.7547	25.5815	27.8050	26.1032

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
370016	1.5756	0.8686	26.7938	29.8284	30.4646	28.9272
370018	1.5016	0.8652	25.3573	24.6868	31.2325	27.0624
370019	1.1994	0.8016	22.0221	25.2814	26.7609	24.7201
370020	1.4065	0.8016	20.8723	22.7566	27.7807	23.6027
370022	1.1935	0.8016	24.6099	22.2289	26.4826	24.3184
370023	1.2804	0.8106	23.5170	24.0376	24.9575	24.1637
370025	1.3471	0.8652	23.9873	24.5547	24.8323	24.4542
370026	1.4489	0.8686	25.8428	25.5172	26.0190	25.7953
370028	1.9475	0.8686	27.8621	28.5619	29.9829	28.8114
370029	1.1365	0.8016	26.8508	28.5309	30.0133	28.4170
370030	1.0209	0.8652	24.1483	25.8212	26.0822	25.3421
370032	1.4768	0.8686	24.8626	26.2642	28.0726	26.3353
370034	1.2643	0.8016	19.5099	20.4106	23.2177	21.1222
370036	1.0929	0.8016	19.2318	19.8162	21.1549	20.1518
370037	1.6173	0.8686	24.9553	25.2350	26.8975	25.7110
370039	1.0375	0.8652	23.0254	23.5745	25.3412	23.9675
370040	0.9726	0.8016	22.8356	26.7395	19.7632	23.1713
370041	0.8769	0.8652	22.6731	22.9834	29.5069	24.8467
370047	1.4262	0.8686	24.1991	24.4766	27.8930	25.5715
370048	1.0294	0.8016	21.4543	22.0627	23.4845	22.3179
370049	1.3024	0.8686	23.8844	22.8755	24.2087	23.6440
370051	1.0519	0.8016	19.8329	19.3222	21.8711	20.3135
370054	1.2382	0.8016	22.4652	25.2142	23.4638	23.6682
370056	1.8723	0.8630	24.3986	25.5453	27.6169	25.8232
370057	1.0258	0.8652	19.8683	22.1337	23.1808	21.6643
370060	1.0456	0.8652	19.9025	23.3858	25.5560	22.9757
370065	1.0154	0.8112	21.2343	23.5815	24.0050	22.9087
370072	0.8329	0.8274	11.7942	13.0963	22.8589	14.5180
370078	1.5381	0.8652	27.8611	26.6972	30.4817	28.2974
370080	0.9489	0.8016	19.9595	22.4113	23.7218	22.0520
370083	0.9450	0.8067	19.2568	20.9878	21.9159	20.6845
370084	1.0056	0.8016	19.6230	20.7326	17.4201	19.1737
370089	1.4095	0.8016	20.6153	22.1523	22.0592	21.6429
370091	1.6019	0.8652	24.1438	25.8697	28.0464	26.0375
370093	1.6611	0.8686	26.0459	27.5356	26.7255	26.7691
370094	1.3751	0.8686	24.5555	26.5265	28.3484	26.4229
370097	1.2821	0.8630	26.3168	26.8138	28.0905	27.0817
370099	1.0542	0.8016	24.9971	26.7206	30.5425	27.4897
370100	0.9080	0.8116	17.9732	19.4002	20.6297	19.4038
370103	1.0407	0.8016	18.8933	19.4273	22.2665	20.0894
370105	2.0282	0.8686	26.7973	26.6399	30.5423	27.9853
370106	1.4171	0.8686	27.8979	28.5957	29.6782	28.7253
370112	0.9279	0.8016	16.0592	16.7888	19.0125	17.3058
370113	1.1274	0.8950	26.9720	26.4608	30.0045	27.8038
370114	1.5752	0.8652	23.0006	25.9841	27.3069	25.4424
370138	1.0937	0.8016	20.2528	22.1675	23.6337	21.8806
370139	0.9151	0.8016	19.4287	20.5156	21.0751	20.3636
370148	1.5372	0.8686	27.0904	28.1933	29.3428	28.2968
370149	1.3311	0.8686	23.3493	23.3423	23.0749	23.2542
370153	1.1065	0.8016	23.2778	24.1667	25.9232	24.4635
370156	1.0044	0.8137	25.2562	23.0104	22.7138	23.5680
370158	0.9394	0.8686	20.7641	21.5228	22.0059	21.4295
370166	0.8545	0.8652	25.1107	24.7251	26.3414	25.3950
370169	0.9454	0.8179	16.8252	16.6752	24.5386	19.7622
370170	0.9052	1.4446	*	*	*	*
370171	0.9693	1.4446	*	*	*	*
370172	0.8569	1.4704	*	*	*	*
370173	0.9838	1.4446	*	*	*	*
370174	0.9087	1.4446	*	*	*	*
370176	1.3084	0.8652	24.7655	24.9650	26.6672	25.4759
370178	0.9114	0.8016	16.0179	16.0747	15.5266	15.8654
370180	1.1405	1.4446	*	*	*	*
370183	0.9683	0.8652	24.7103	23.8419	30.3849	26.4222
370190	1.5039	0.8652	29.1568	34.6942	32.5630	32.3673
370192	1.9589	0.8686	27.6367	19.0638	19.1330	21.1807
370196	***	*	22.3498	20.8296	24.6968	22.8178
370199	0.9156	0.8686	23.3989	23.7412	23.9357	23.7085

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
370200	1.0572	0.8016	20.5175	21.7153	19.7049	20.6651
370201	1.7010	0.8686	23.8090	24.2364	25.5862	24.5320
370202	1.4934	0.8652	26.1132	25.7966	25.8246	25.9084
370203	1.9356	0.8686	22.8869	25.7770	30.3614	26.3098
370206	1.7577	0.8686	26.0353	27.5752	30.8129	28.1710
370210	2.1582	0.8652	23.3786	27.2111	25.7890	25.4309
370211	1.1931	0.8686	27.8737	28.6537	30.9637	29.3408
370212	1.8217	0.8686	19.1720	20.3495	20.0910	19.8981
370214	0.8902	0.8137	20.6217	21.0732	20.1491	20.5858
370215	2.3013	0.8686	31.5652	32.4087	32.0922	32.0514
370216	2.0050	0.8652	27.2429	25.8260	29.6639	27.5894
370217	***	*	26.8677	*	*	26.8677
370218	1.9640	0.8652	*	30.3445	23.7493	26.4612
370219	***	*	*	*	41.4373	41.4373
370220	2.3081	0.8686	*	*	21.3140	21.3140
370222	1.8753	0.8686	*	*	26.9158	26.9158
370223	0.8701	0.8686	*	*	24.0138	24.0138
370226	1.4674	0.8016	*	*	*	*
370227	0.9326	0.8652	*	*	*	*
370228	1.2387	0.8652	*	*	*	*
380001	1.2850	1.1204	29.5842	32.0770	33.8473	31.8553
380002	1.2143	1.0298	30.3385	31.5246	32.6801	31.5496
380004	1.6454	1.1204	32.6901	34.5432	36.1178	34.4710
380005	1.4198	1.0298	30.9087	33.2849	33.5739	32.5875
380007	1.9643	1.1204	33.9601	35.1697	36.4198	35.2082
380009	2.0934	1.1204	32.4016	34.5635	36.5661	34.5647
380010	***	*	34.4208	*	*	34.4208
380014	1.8838	1.1076	33.6078	33.1928	35.7074	34.1739
380017	1.7891	1.1204	34.2605	35.3734	37.0024	35.5661
380018	1.8551	1.0298	30.9923	31.8181	32.4859	31.7959
380020	1.4577	1.1157	29.6053	34.6183	35.7367	32.9979
380021	1.4597	1.1204	29.2164	32.6142	33.0611	31.5746
380022	1.3523	1.0572	30.1742	29.6224	30.9162	30.2422
380025	1.1973	1.1204	35.5084	36.4910	38.1479	36.7332
380027	1.3782	1.1157	26.4982	28.0247	31.4378	28.6431
380029	1.2617	1.0725	28.7994	29.4461	33.3348	30.6606
380033	1.7377	1.1157	33.4828	34.0094	36.0221	34.5420
380037	1.3322	1.1204	32.4033	32.7922	34.0301	33.1177
380038	1.2761	1.1204	34.5971	35.1105	35.0334	34.9145
380039	***	*	38.0989	*	*	38.0989
380040	1.4621	1.0298	31.2286	32.9081	34.4710	32.9570
380047	1.8056	1.1043	31.0584	32.8188	35.8144	33.3095
380050	1.4231	1.0298	27.1814	29.7329	31.3064	29.4427
380051	1.7594	1.1204	30.8891	32.8545	34.6659	32.8426
380052	1.2624	1.0298	25.6085	28.6119	27.7647	27.2628
380056	1.1073	1.0725	27.7253	29.1686	31.0190	29.2586
380060	1.4994	1.1204	32.0101	33.8863	35.1087	33.6769
380061	1.6390	1.1204	32.3699	34.5230	35.7630	34.2152
380071	1.3775	1.1204	31.7761	31.0901	31.6798	31.5133
380075	1.3482	1.0298	33.8962	31.6884	34.0174	33.2050
380081	***	*	26.8149	*	*	26.8149
380082	1.2966	1.1204	35.6708	35.7821	37.7239	36.4069
380089	1.3399	1.1204	34.6015	35.4850	36.9989	35.7198
380090	1.3418	1.1157	33.0990	35.5535	41.4499	36.7267
380091	1.4734	1.1204	39.9703	40.5066	38.4947	39.6719
380100	***	*	*	*	45.3849	45.3849
390001	1.5668	0.8342	23.6075	24.3251	25.4178	24.4575
390002	1.3393	0.8579	24.7867	25.0860	25.9811	25.2995
390003	1.2164	0.8342	23.3672	24.5099	26.2863	24.7251
390004	1.6088	0.9185	24.4068	25.2424	26.5037	25.3610
390006	1.9527	0.9185	26.8581	28.6926	30.9901	28.9685
390008	1.1400	0.8402	22.8042	22.6297	22.9409	22.7921
390009	1.8038	0.8708	26.7462	26.7234	28.7325	27.4264
390010	1.1889	0.8579	24.5785	24.8196	26.0951	25.1622
390011	***	*	21.4856	20.2291	*	20.8697
390012	1.1856	1.0992	30.7542	32.4856	34.1980	32.4294
390013	1.3619	0.9185	25.0037	26.2323	28.3024	26.5751

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Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
390016	1.2430	0.8559	23.2095	24.3488	26.1785	24.5413
390019	1.1210	0.9675	24.0538	25.7515	25.3173	24.9933
390022	***	*	30.3565	29.6308	*	29.9808
390023	1.2632	1.0992	35.4452	34.7787	36.2584	35.4918
390024	***	*	33.5186	38.8750	37.4780	36.5096
390025	0.4329	1.0992	19.1362	20.3878	*	19.7743
390026	1.3079	1.0992	31.8512	31.8309	36.0580	33.1365
390027	1.6538	1.0992	35.5692	39.2158	40.9084	38.5953
390028	1.5828	0.8579	27.1869	27.1451	29.6197	27.9531
390030	1.1870	0.8626	23.6063	24.6343	26.5661	24.9940
390031	1.2126	0.9204	26.2654	27.2033	26.1246	26.5387
390032	1.2693	0.8579	23.9466	24.5243	25.3739	24.6172
390035	1.1907	1.0992	28.4564	29.5417	27.2114	28.3541
390036	1.4853	0.8579	21.6358	24.4917	26.1934	24.0498
390037	1.4598	0.8579	25.4290	25.2296	27.0768	25.9180
390039	1.2528	0.8342	22.0208	23.2300	22.1517	22.4609
390041	1.3077	0.8579	22.9814	24.2257	25.1175	24.1286
390042	1.3624	0.8579	28.3633	28.0996	29.6193	28.7201
390043	1.1959	0.8342	23.2378	24.2087	24.3584	23.9394
390044	1.5562	1.0788	28.7758	29.4057	29.9946	29.4217
390045	1.4816	0.8342	23.9343	24.6495	25.8784	24.8306
390046	1.6617	0.9799	29.6574	30.5115	32.5260	30.9440
390048	1.1221	0.9185	28.5342	28.3152	28.4555	28.4340
390049	1.5809	0.9675	29.6121	30.7431	30.4709	30.2929
390050	2.0142	0.8579	27.2599	27.3481	29.6697	28.1208
390052	1.1476	0.8389	24.9510	25.1462	26.3688	25.5002
390054	***	*	24.4435	27.4805	27.5682	26.3435
390056	1.1124	0.8378	23.5077	23.5821	24.7026	23.9359
390057	1.3322	1.0992	29.7982	30.9198	31.0260	30.6011
390058	1.3063	0.9185	26.9546	27.7296	29.6597	28.1041
390061	1.5170	0.9799	29.1318	30.0597	30.9185	29.9889
390062	1.1231	0.8342	21.2999	21.0713	22.8844	21.7734
390063	1.8374	0.8708	26.4998	26.8381	28.3963	27.2925
390065	1.3159	1.1006	27.6249	29.5654	31.8827	29.7493
390066	1.3881	0.9185	25.9645	25.4407	29.0022	26.8307
390067	1.7872	0.9185	29.7234	30.6128	32.2862	30.8943
390068	1.3404	0.9799	26.7358	29.0962	29.6963	28.5413
390070	1.3523	1.0992	33.3185	34.4935	34.5477	34.1258
390071	1.0062	0.8342	24.6462	24.8467	26.3816	25.3085
390072	1.0663	0.8342	25.3029	26.2568	28.8131	26.7355
390073	1.6919	0.8342	25.7822	26.4083	27.0855	26.4996
390074	***	*	23.6500	25.4098	*	24.5222
390076	1.3189	1.0992	31.8500	32.7671	33.9877	32.8740
390079	1.8491	0.8560	22.5607	24.4452	26.0178	24.3375
390080	1.3943	1.0992	28.7063	29.2645	31.6193	29.8842
390081	1.2389	1.0992	31.7569	33.6247	36.4760	33.9941
390084	1.1285	0.8342	23.2039	24.3372	24.3181	23.9420
390086	1.5931	0.8342	23.5141	25.0992	24.7444	24.4724
390090	1.9186	0.8579	27.3528	27.0122	30.1231	28.1610
390091	1.1759	0.8559	21.7010	23.3562	23.2108	22.7618
390093	1.1913	0.8559	22.6082	22.6023	23.8837	23.0312
390095	1.1678	0.8342	22.6150	24.6290	25.3848	24.2111
390096	1.6015	1.0788	28.8258	28.6055	30.3896	29.2646
390097	1.2500	1.0992	26.1741	27.9858	28.1266	27.3784
390100	1.6431	0.9799	30.0132	30.0234	32.5896	30.9302
390101	1.2844	0.9666	23.1497	24.8377	27.3460	25.1596
390102	1.4773	0.8579	24.8369	24.4589	25.5321	24.9493
390103	***	*	20.5741	20.4446	*	20.5090
390104	1.1021	0.8342	19.2326	19.6630	20.4543	19.7621
390107	1.5861	0.8579	24.1159	24.6565	25.6775	24.8676
390108	1.1988	1.0992	27.8171	28.5928	34.3038	30.1995
390110	1.5950	0.8579	27.7311	25.3407	25.7142	26.1477
390111	2.1581	1.0992	34.2990	34.8756	38.6429	35.9670
390112	1.3266	0.8342	20.2380	21.5439	18.4179	19.9664
390113	1.3312	0.8559	23.3686	24.2593	24.8661	24.1707
390114	1.6377	0.8579	26.9620	27.9184	28.5319	27.8260
390115	1.4264	1.0992	29.6905	30.8063	32.5023	31.0518

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
390116	1.2605	1.0992	32.2513	33.2562	33.9272	33.1578
390117	1.1784	0.8344	20.7821	21.5038	22.2319	21.5356
390118	1.1738	0.8342	20.5614	21.8917	23.6529	22.0851
390119	1.2800	0.8342	23.0928	24.3245	25.3896	24.2630
390121	***	*	25.4826	*	*	25.4826
390122	1.1069	0.8395	23.1866	23.3220	24.6425	23.7140
390123	1.1993	1.0992	32.4528	34.0062	35.1219	33.8960
390125	1.2499	0.8364	22.4033	22.8816	24.0182	23.1230
390127	1.3561	1.0992	31.9091	33.6557	33.1200	32.8957
390128	1.2331	0.8579	24.1628	24.1390	25.1844	24.5037
390130	1.1985	0.8342	23.0592	23.2504	30.3208	25.3350
390131	1.3570	0.8579	23.0577	23.5783	27.7127	24.8832
390132	1.4504	1.0992	29.6396	31.1168	30.0723	30.2692
390133	1.7609	0.9675	31.1083	32.9812	33.0697	32.4255
390136	***	*	23.9813	*	*	23.9813
390137	1.4546	0.8342	24.2878	26.1457	26.9140	25.8031
390138	1.1966	0.9185	25.3410	27.4231	27.7549	26.8681
390139	1.3522	1.0992	34.1447	34.0836	36.4969	34.9221
390142	1.5286	1.0992	33.8224	34.5773	33.3491	33.9107
390145	1.5880	0.8579	24.6672	25.6980	26.9194	25.7780
390146	1.1823	0.8364	22.6752	25.1805	23.9869	23.9695
390147	1.3781	0.8579	26.8522	28.6606	29.0974	28.1881
390150	1.1119	0.8579	22.8228	22.7668	22.6473	22.7481
390151	1.3436	1.1006	29.9254	31.4067	31.8952	31.1171
390153	1.3705	1.0992	32.8234	33.2427	36.0259	34.1045
390154	1.2171	0.8342	22.8391	23.3559	23.9776	23.4008
390156	1.3593	1.0992	32.2688	32.8999	33.7034	32.9631
390157	1.3257	0.8579	21.5923	22.1112	23.0975	22.2734
390160	1.3326	0.8579	24.0208	22.9696	25.2027	24.0528
390162	1.5041	1.1449	35.5057	34.5809	35.1818	35.0918
390163	1.2454	0.8559	23.2055	22.8341	24.8747	23.6452
390164	2.1300	0.8579	26.3087	27.1950	29.7760	27.7684
390166	***	*	20.9272	23.3255	28.2160	23.9468
390168	1.4758	0.8579	26.1365	26.9816	27.3654	26.8304
390169	1.4118	0.8342	26.5514	26.2643	26.6049	26.4723
390173	1.2178	0.8342	23.9927	25.6455	27.6024	25.7719
390174	1.6824	1.0992	34.2069	34.8999	34.9029	34.6825
390176	1.1316	0.8579	23.9779	24.1247	12.3126	18.1769
390178	1.3247	0.8930	22.6006	23.1452	23.9151	23.2190
390179	1.4264	1.0992	28.0688	30.1219	31.5474	29.9836
390180	1.3926	1.0992	34.9832	35.5291	38.2969	36.3036
390181	***	*	25.9871	26.6021	27.8820	26.8191
390183	1.1452	0.8342	27.0122	27.8358	28.2196	27.6769
390184	1.0915	0.8579	22.7451	23.9736	23.9958	23.5369
390185	1.2586	0.9675	25.4256	27.1119	25.5306	25.9878
390189	1.1436	0.8342	22.6796	23.6215	23.4893	23.2864
390192	1.0388	0.8342	20.5459	23.6171	23.7948	22.6673
390194	1.2037	0.9675	27.5890	26.3152	23.7351	25.7636
390195	1.6565	1.0992	34.2980	34.5594	37.2471	35.3797
390196	1.6460	*	*	*	*	*
390197	1.4171	0.9675	26.8270	27.2455	28.1394	27.4100
390198	1.1294	0.8708	20.5979	20.4350	21.0850	20.7061
390199	1.1366	0.8342	22.3224	23.0046	24.5461	23.3008
390201	1.3518	0.9512	27.0054	27.3542	28.5649	27.6588
390203	1.5297	1.0992	29.4930	29.1370	30.7209	29.8038
390204	1.2911	1.0992	29.5251	30.7346	32.0218	30.7952
390211	1.2835	0.8930	25.1689	26.5052	27.7862	26.4993
390217	1.2278	0.8579	23.5879	24.1886	26.2690	24.6769
390219	1.3577	0.8579	25.4886	26.1196	26.3253	25.9698
390220	1.0888	1.0992	28.9128	30.7435	32.0869	30.6085
390222	1.2691	1.0992	30.9464	31.7361	32.3724	31.7085
390223	1.9836	1.0992	30.2523	34.3280	37.4105	33.8814
390225	1.1877	0.9799	27.5803	27.2555	26.3628	26.9591
390226	1.7135	1.0992	32.6658	32.6508	35.4653	33.6044
390228	1.3609	0.8579	23.9845	24.2242	25.5103	24.5893
390231	1.4014	1.0992	30.9339	32.8353	35.2285	33.0470
390233	1.3823	0.9666	25.6904	27.2597	28.3647	27.1364

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
390236	0.9818	0.8345	22.1144	23.1290	24.5566	23.2393
390237	1.5868	0.8342	27.4944	28.4337	29.0645	28.3719
390246	1.1777	*	25.1956	26.0179	*	25.6189
390256	1.9774	0.9185	28.0617	28.8970	28.5871	28.5302
390258	1.4533	1.0992	30.4142	31.7164	32.0531	31.4303
390263	1.5092	0.9675	28.5864	29.9850	31.7255	30.1997
390265	1.5374	0.8579	24.0675	25.0166	27.7776	25.6284
390266	1.1912	0.8930	20.8789	22.2228	23.0128	22.0423
390267	1.2760	0.8579	24.2428	24.8309	25.7553	24.9521
390268	1.4064	0.8810	25.6643	26.7342	28.4188	27.0040
390270	1.6183	0.8342	24.9510	26.5010	27.0286	26.2567
390272	0.6051	1.0992	*	*	32.9893	32.9893
390278	0.6005	1.0992	26.6664	28.6323	28.8290	28.0560
390285	1.4914	1.0992	36.7163	37.6669	38.4678	37.6177
390286	1.2124	1.0992	29.5281	31.3393	31.7320	30.8704
390287	***	*	39.3176	42.2401	*	40.3959
390288	***	*	30.9701	*	*	30.9701
390289	***	*	30.7583	*	*	30.7583
390290	1.8004	1.0992	38.3776	41.1426	47.7624	42.2989
390302	0.8675	1.0992	*	*	*	*
390303	***	*	27.5580	*	*	27.5580
390304	1.2958	1.0992	30.4832	32.1633	33.4111	32.1082
390305	***	*	*	29.3217	*	29.3217
390306	***	*	*	40.3789	*	40.3789
390307	2.0387	0.8930	*	24.5393	22.9455	23.6860
390308	***	*	*	36.1737	*	36.1737
390309	***	*	*	37.8924	*	37.8924
390310	***	*	*	44.3991	*	44.3991
390311	***	*	*	*	49.8990	49.8990
390312	1.2883	1.0992	*	*	51.3342	51.3342
390313	1.1642	0.9204	*	*	*	*
390314	1.9344	0.9675	*	*	*	*
390315	1.6395	0.8579	*	*	*	*
390316	1.6856	0.9518	*	*	*	*
390318	0.8280	0.9675	*	*	*	*
400001	1.3295	0.4404	13.9386	14.9151	15.4246	14.7738
400002	1.9377	0.4122	15.3833	12.9440	12.9793	13.6878
400003	1.3791	0.4122	13.9258	15.7906	14.6853	14.8161
400004	1.2115	0.4404	12.0923	12.5928	13.5193	12.7362
400005	1.2533	0.4404	10.3505	11.1152	11.7582	11.0789
400006	1.1625	0.4404	8.1841	8.1381	*	8.1610
400007	1.1605	0.4404	11.8203	12.0743	10.4935	11.4512
400009	0.9834	0.3137	9.3834	9.5114	10.1204	9.6757
400010	0.9051	0.3311	9.8132	10.7993	10.4202	10.3256
400011	1.1055	0.4404	9.6641	8.5503	9.4065	9.2136
400012	1.4864	0.4404	12.3362	10.1156	*	11.0797
400013	1.3650	0.4404	11.1414	11.4222	12.3068	11.6476
400014	1.3749	0.3896	10.5286	9.9395	12.3295	10.8952
400015	1.4718	0.4404	13.7043	22.2017	21.9216	18.9475
400016	1.4676	0.4404	16.6472	16.1931	17.9101	16.9079
400017	0.8958	0.4404	10.3123	9.9185	10.0587	10.0981
400018	1.1103	0.4404	11.9184	12.3942	13.1567	12.5002
400019	1.5158	0.4404	12.8380	14.7133	15.2358	14.0763
400021	1.3614	0.4648	14.4549	13.9217	14.9779	14.4495
400022	1.4439	0.4122	14.9089	15.3625	15.2119	15.1640
400024	0.8933	0.3896	10.8439	12.6226	13.7214	12.2509
400026	1.1373	0.3137	9.9262	7.1179	8.9063	8.4875
400028	1.1913	0.4122	11.3260	10.6711	9.6940	10.5465
400032	1.1451	0.4404	10.3736	10.7141	10.7841	10.6281
400044	1.4861	0.4122	14.6420	11.3551	12.1404	12.5283
400048	1.3035	0.3137	9.6416	9.6860	10.5172	9.9689
400061	2.2573	0.4404	18.1303	18.0093	17.4499	17.8500
400079	1.2280	0.3311	9.5296	10.4599	10.6123	10.2200
400087	1.3360	0.4404	11.0377	11.4162	12.0032	11.4590
400098	1.3491	0.4404	13.8034	13.7878	12.8752	13.4675
400102	1.1900	0.4404	10.5879	12.1761	12.1258	11.5565
400103	1.9297	0.3896	10.6971	11.7488	11.3309	11.2618

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
400104	1.2190	0.4404	11.4322	12.8404	12.6932	12.3296
400105	1.2578	0.4404	15.6626	16.9029	17.0458	16.5427
400106	1.1085	0.4404	13.4097	12.9272	14.8543	13.7089
400109	1.4302	0.4404	14.4386	14.8208	14.5707	14.6114
400110	1.2156	0.3358	11.1812	9.9278	10.8210	10.6067
400111	1.2130	0.3311	14.1718	10.2141	10.7888	11.5139
400112	1.2446	0.4404	10.1512	13.5177	11.2302	11.5795
400113	1.1764	0.4122	10.5305	10.9503	11.5947	11.0441
400114	1.1726	0.4404	10.1379	10.8913	11.6870	10.9257
400115	1.0815	0.4404	12.0713	9.6200	10.6805	10.8173
400117	1.1347	0.4404	9.5929	11.6258	12.1537	11.0019
400118	1.2649	0.4404	12.8692	12.7861	12.6196	12.7539
400120	1.3351	0.4404	13.4069	14.0817	14.5200	14.0199
400121	1.1129	0.4404	9.7427	9.1826	9.9712	9.6244
400122	1.8905	0.4404	8.9478	9.5814	10.0960	9.5553
400123	1.2353	0.3896	12.8317	12.5609	13.8597	13.0762
400124	2.6860	0.4404	17.2139	17.9140	19.1698	18.1028
400125	1.2073	0.4067	11.9787	13.5394	13.1075	12.8846
400126	1.2894	0.4648	14.1062	16.5726	*	15.3043
400127	2.0911	0.4404	17.8303	20.7775	*	19.5304
400128	1.0184	0.4404	*	12.3520	*	12.3520
410001	1.3144	1.1338	29.0877	30.0315	30.5848	29.9101
410004	1.3107	1.1338	29.4953	31.3023	35.2360	31.9950
410005	1.2724	1.1338	28.1141	31.4387	34.5807	31.2615
410006	1.3911	1.0669	30.1855	32.8456	33.5403	32.1894
410007	1.6113	1.1338	33.2896	32.0730	34.2549	33.1928
410008	1.3225	1.0669	30.9505	32.5889	33.5128	32.3511
410009	1.2374	1.0669	31.7300	32.8422	34.3405	32.9948
410010	1.1305	1.1338	32.0704	32.7379	34.8380	33.2523
410011	1.4882	1.1338	33.8781	30.1941	36.7639	33.5131
410012	1.5728	1.1338	33.6072	37.0299	35.5818	35.4055
410013	1.2045	1.1587	35.8075	41.0010	40.1823	38.9884
420002	1.5630	0.9561	29.5592	30.5111	31.2220	30.4468
420004	1.9671	0.9231	28.1455	28.9250	30.2325	29.1286
420005	1.1610	0.8609	25.0420	24.6968	26.5027	25.3750
420006	***	*	26.3293	27.7764	29.1383	27.7486
420007	1.6315	0.9294	26.8165	29.0901	28.9533	28.2944
420009	1.4114	0.9294	27.0147	29.9378	28.6625	28.5279
420010	1.1406	0.8609	25.1452	25.5710	26.5503	25.7612
420011	1.1778	0.9605	22.1787	25.5130	25.9543	24.5702
420015	1.3156	0.9605	24.1685	26.3499	27.4912	26.0287
420016	0.9672	0.8609	21.6266	22.5681	23.4313	22.5462
420018	1.8307	0.8984	25.6687	27.5563	29.0897	27.4853
420019	1.0990	0.8767	22.5489	25.4954	25.8113	24.4094
420020	1.3500	0.9231	28.4344	27.5000	29.2372	28.3934
420023	1.7169	0.9605	27.4589	28.9321	30.4471	28.9941
420026	1.8642	0.8984	27.8986	28.0647	29.5039	28.4725
420027	1.5767	0.9294	26.4472	28.5621	31.3772	28.7401
420030	1.3204	0.9231	27.8435	28.4433	30.3403	28.8720
420033	1.1839	0.9605	30.4162	31.1608	32.4244	31.3429
420036	1.2480	0.9557	23.8742	24.6505	26.3463	24.9665
420037	1.3390	0.9605	29.8321	30.9556	32.7083	31.1311
420038	1.2831	0.9605	24.6642	26.6435	27.1507	26.1466
420039	1.0529	0.9017	28.2220	26.5582	26.3100	26.9774
420043	1.1111	0.8766	24.0971	25.7951	25.8352	25.2415
420048	1.2885	0.8984	25.9610	26.9625	27.4313	26.8137
420049	1.2591	0.8683	26.0953	25.7060	28.0020	26.6253
420051	1.7106	0.8609	25.9056	26.4710	27.4172	26.6012
420053	1.2316	0.8644	23.2246	24.4793	25.5724	24.4361
420054	1.1106	0.8612	25.6779	25.6444	26.7888	26.0196
420055	1.0931	0.8609	24.0965	25.1738	25.3132	24.8604
420056	1.3487	0.8609	27.7250	28.4512	29.7763	28.7570
420057	1.2036	0.8609	24.9313	26.2489	25.6602	25.6193
420062	1.1026	0.9557	26.7467	25.9569	27.2249	26.6400
420064	1.2630	0.8683	24.3540	24.6507	25.0602	24.6890
420065	1.4161	0.9231	25.5483	26.8118	28.1872	26.8671
420066	0.9980	0.8609	25.1062	25.0932	*	25.0997

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
420067	1.3639	0.8827	25.8561	26.5658	27.7148	26.7379
420068	1.3759	0.9231	25.6857	27.7315	28.0296	27.1430
420069	1.2054	0.8609	22.3445	23.7494	24.4638	23.5595
420070	1.3136	0.8984	24.7899	27.5988	27.6406	26.7218
420071	1.4339	0.9294	25.2862	27.6371	28.1087	27.0462
420072	1.1634	0.8609	17.8019	21.6587	20.7707	19.9748
420073	1.3829	0.8984	25.5204	26.1120	28.2651	26.7147
420078	1.8607	0.9605	29.5135	30.9001	32.0165	30.8100
420079	1.5040	0.9231	27.5439	28.6374	30.5954	28.9420
420080	1.4321	0.8827	28.6060	31.5670	32.8693	30.8888
420082	1.5113	0.9597	31.2671	33.9874	34.8836	33.3515
420083	1.4528	0.9294	26.4932	28.9007	29.6565	28.4194
420085	1.5909	0.9074	27.8386	29.1127	29.9059	28.9688
420086	1.4584	0.8984	28.0485	27.9523	29.6321	28.5671
420087	1.8044	0.9231	25.4697	26.8409	28.4609	26.9052
420089	1.3777	0.9231	28.1855	29.5862	31.7347	29.8346
420091	1.4537	0.8609	26.0592	27.2520	27.9042	27.0840
420093	***	*	28.0765	33.0474	*	30.2237
420098	1.2041	0.8609	30.7532	27.1939	27.6701	28.2065
420099	***	*	*	30.3089	*	30.3089
420100	***	*	*	*	29.2958	29.2958
420101	1.2049	0.8609	*	*	33.1975	33.1975
420102	1.4677	0.9605	*	*	*	*
430005	1.3356	0.8428	22.4111	23.8694	25.4368	23.9203
430008	1.1161	0.8963	24.4277	26.0873	27.2262	25.9003
430012	1.3044	0.9262	24.0326	25.2030	27.0179	25.4023
430013	1.2029	0.9262	25.9828	27.0427	28.4945	27.1837
430014	1.4127	0.8428	26.8752	27.9288	28.9278	27.9157
430015	1.1983	0.8428	23.6296	26.5787	28.0396	26.1008
430016	1.5975	0.9379	28.9376	32.8765	31.1313	30.9581
430027	1.7417	0.9379	26.6044	27.5759	29.2595	27.8481
430048	1.2671	0.8557	24.1969	25.1715	25.6411	25.0133
430060	0.9444	0.8428	13.2618	*	*	13.2618
430064	0.9859	0.8428	18.3125	16.4916	17.7325	17.4427
430077	1.7222	0.9618	25.8572	27.2116	31.1926	28.0482
430081	0.9388	1.4448	*	*	*	*
430082	0.8463	1.4448	*	*	*	*
430083	0.8496	1.4448	*	*	*	*
430084	0.9068	1.4448	*	*	*	*
430085	0.8878	1.4448	*	*	*	*
430089	1.8588	0.8783	22.3335	23.2467	24.9033	23.5426
430090	1.6017	0.9379	26.4862	29.0197	32.7369	29.5038
430091	2.2308	0.9502	25.1105	24.7274	26.7238	25.5162
430092	1.8871	0.8428	21.6478	21.9197	23.2508	22.2946
430093	1.3555	0.9502	27.5326	26.0232	24.7398	26.0952
430094	1.7381	0.8557	22.9091	23.2894	23.6605	23.3062
430095	2.4765	0.9379	31.3409	32.2326	32.5850	32.0536
430096	1.9114	0.8428	21.6713	24.6041	24.9608	23.8070
440001	1.1662	0.7999	21.2398	21.5755	25.4844	22.7818
440002	1.7208	0.8886	25.7434	26.3802	26.9121	26.3584
440003	1.3386	0.9445	28.4862	28.3557	26.0107	27.4326
440006	1.4409	0.9445	29.7146	31.5533	31.7373	31.0128
440007	0.9815	0.8176	19.9754	18.8273	22.7570	20.4815
440008	0.9673	0.8339	23.2126	27.3732	26.8850	25.9985
440009	1.1674	0.7957	23.9279	23.8148	24.4410	24.0653
440010	0.9494	0.7957	19.3669	19.6231	20.2498	19.7446
440011	1.3656	0.7957	23.6154	23.6698	24.8292	24.0419
440012	1.5047	0.7964	24.0169	23.7871	24.9243	24.2664
440015	1.8290	0.7957	25.0430	26.0601	27.1580	26.0995
440016	1.0436	0.8101	23.0350	24.5812	25.2515	24.2770
440017	1.7685	0.7964	25.0588	24.6707	26.1800	25.3213
440018	1.1100	0.7999	23.2107	25.0780	24.5898	24.3284
440019	1.6911	0.7957	25.3592	25.2230	26.2435	25.5920
440020	1.0903	0.8614	24.0995	24.7785	27.5620	25.4792
440024	1.1324	0.8717	23.9745	24.7705	26.2519	25.0623
440025	1.1246	0.8611	22.5407	22.6571	24.0274	23.0928
440026	***	*	28.0349	26.8153	28.4597	27.7725

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
440029	1.4650	0.9445	30.1204	31.2310	31.4630	30.9557
440030	1.2893	0.8013	23.7670	22.2607	22.3131	22.8053
440031	1.1356	0.7976	20.8964	22.6790	22.0708	21.8517
440032	1.1644	0.7957	19.7150	21.0380	23.8016	21.5383
440033	1.0637	0.7984	21.1087	22.7991	23.9790	22.5856
440034	1.6302	0.7957	24.6994	25.5061	25.9124	25.3762
440035	1.3910	0.9252	25.9613	26.2451	27.9203	26.6992
440039	2.1051	0.9445	29.8611	30.1790	30.1901	30.0895
440040	0.9210	0.7957	20.8637	20.8817	21.1282	20.9641
440046	1.3069	0.9445	27.9539	29.7377	30.7314	29.5270
440047	0.9617	0.8295	21.7892	22.8323	25.2156	23.3140
440048	1.8071	0.9305	29.4789	29.3187	30.6710	29.8250
440049	1.6747	0.9305	26.4772	28.8742	29.8603	28.4462
440050	1.2834	0.7964	24.4616	24.9694	26.3815	25.3086
440051	0.9337	0.8039	23.9253	23.4866	23.6554	23.6741
440052	1.0032	0.7957	22.8016	22.6128	24.4075	23.2437
440053	1.2712	0.9445	27.1197	27.8180	30.3887	28.4325
440054	1.0962	0.7957	23.5137	23.7931	21.9638	23.0467
440056	1.2127	0.7957	22.7820	23.2313	24.0623	23.3523
440057	1.1032	0.7978	16.6346	17.2176	19.3540	17.6957
440058	1.2003	0.7957	24.3522	26.0706	29.1174	26.6028
440059	1.4855	0.9252	28.3565	27.9467	29.4514	28.5989
440060	1.1325	0.8339	24.1024	25.0795	26.5869	25.2908
440061	1.1295	0.7957	23.9678	23.7360	25.4125	24.3711
440063	1.6197	0.7999	24.2566	23.9644	26.0741	24.7976
440064	0.9999	0.8857	23.7176	26.1246	26.7947	25.5515
440065	1.2421	0.9445	24.6169	25.8536	25.6096	25.3745
440067	1.1905	0.7957	24.4772	24.6553	26.0852	25.0966
440068	1.1835	0.8717	24.8146	26.1071	27.9066	26.2722
440070	1.0014	0.8066	20.0938	21.9166	23.2223	21.7288
440072	1.0393	0.8886	23.9563	25.7089	26.1643	25.2966
440073	1.4453	0.9252	26.3570	27.6154	27.5114	27.1567
440081	1.1673	0.8009	20.7125	20.7688	21.9671	21.1573
440082	1.9913	0.9445	30.6115	32.2479	32.8913	31.8790
440083	0.9577	0.7957	25.6099	23.6356	25.7074	24.9682
440084	1.1762	0.7982	18.6043	18.8699	19.8938	19.1297
440091	1.7581	0.8857	26.5687	28.1989	28.9678	27.9314
440102	1.0796	0.7957	20.7363	21.6762	22.1103	21.5215
440104	1.7788	0.8857	26.5741	27.9756	28.0888	27.5200
440105	0.9119	0.7999	22.9372	22.7962	23.7139	23.1599
440109	1.0139	0.8027	20.8924	21.4629	22.5885	21.7090
440110	1.1221	0.7957	20.9179	22.5929	23.6262	22.5559
440111	1.2820	0.9445	29.0975	28.8453	29.7446	29.2213
440115	0.9684	0.8295	23.1409	23.7107	24.9776	23.9354
440120	1.4947	0.7957	25.7161	24.7572	26.0604	25.5176
440125	1.6557	0.7957	22.8097	23.6328	24.0920	23.4915
440130	1.1217	0.7957	23.9955	25.1262	26.3188	25.1413
440131	1.1784	0.9305	25.6666	26.9649	28.3153	26.9308
440132	1.2291	0.7957	23.9410	24.0708	29.3371	25.7508
440133	1.7069	0.9445	29.2829	29.6093	32.5699	30.4215
440135	0.6898	0.7957	28.1925	27.7037	27.2084	27.7046
440137	1.0639	0.8695	22.2538	22.9547	24.6130	23.2371
440141	0.9917	0.7957	24.2406	24.9917	24.8736	24.6802
440144	1.2549	0.9252	23.9241	25.2293	26.3207	25.2055
440147	***	*	33.1756	34.8199	36.6955	34.8975
440148	1.1236	0.9252	23.9810	22.6188	28.0703	24.8107
440150	1.4307	0.9445	28.1012	29.4381	30.5491	29.3876
440151	1.1663	0.9252	27.1729	28.2203	28.6580	27.9977
440152	2.0008	0.9305	27.1877	28.4612	29.0563	28.2859
440153	1.0509	0.7964	23.6473	24.9388	23.3772	23.9591
440156	1.6421	0.8857	27.7309	28.5645	30.5139	28.9635
440159	1.4818	0.9305	26.9098	25.8289	27.2779	26.6811
440161	1.9267	0.9445	28.7074	29.9894	31.0647	29.9300
440162	***	*	27.6837	24.8705	24.6410	25.6902
440166	***	*	35.3064	*	*	35.3064
440168	1.0456	0.9305	28.1215	29.4028	31.3312	29.7029
440173	1.4350	0.7957	23.1167	24.0621	23.1355	23.4173

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
440174	0.8828	0.8269	25.4829	26.2087	27.4573	26.4456
440175	1.0111	0.7957	24.4848	24.7869	26.7698	25.3295
440176	1.3339	0.7964	22.9631	23.7695	24.9405	23.9373
440180	1.3459	0.7984	24.9841	22.3070	24.3370	23.7701
440181	0.9020	0.8322	24.8857	25.9450	26.4759	25.8145
440182	0.9536	0.8101	24.3302	25.0111	24.9897	24.8044
440183	1.6228	0.9305	29.1982	30.6599	30.9900	30.2946
440184	1.1292	0.7999	24.5786	23.3970	26.9069	24.9779
440185	1.1883	0.8717	25.3817	26.7473	26.3958	26.1839
440186	0.9919	0.9445	27.3733	28.9124	28.2842	28.1940
440187	1.0974	0.7957	24.0723	25.8238	27.4029	25.7687
440189	1.4158	0.8452	28.2621	28.8974	30.5766	29.1873
440192	1.0765	0.9252	27.3917	29.6272	30.6519	29.2789
440193	1.3104	0.9445	24.3622	25.2124	25.9713	25.1845
440194	1.2925	0.9445	29.4706	30.8593	32.3002	30.9187
440197	1.3992	0.9445	29.4275	30.1184	31.4294	30.3064
440200	0.9829	0.9445	21.1860	23.8654	23.8295	22.9591
440203	***	*	23.7451	17.9041	*	20.6007
440217	1.3768	0.9305	28.8641	29.8888	31.6636	30.1328
440218	2.0116	0.9445	23.7257	18.7275	36.9244	25.9465
440222	1.0088	0.9305	28.4664	29.0062	30.5130	29.3485
440225	0.8097	0.7957	24.8328	27.8860	26.9656	26.4719
440226	1.5694	0.7957	26.5831	27.1348	28.3176	27.3318
440227	1.2974	0.9445	*	30.7785	31.9097	31.3743
440228	1.5738	0.9305	*	28.3687	29.5349	29.0087
450002	1.4448	0.8867	28.0936	28.8521	29.7157	28.8515
450005	1.2408	0.8595	24.4933	24.5405	27.3460	25.4548
450007	1.3344	0.8949	23.0026	23.9490	24.4625	23.8045
450008	1.3803	0.8855	24.4701	24.5965	24.4362	24.5017
450010	1.5960	0.9175	25.5503	25.5582	30.1022	27.0858
450011	1.6560	0.9193	26.7418	28.5329	29.9285	28.4349
450015	1.5911	0.9852	29.9193	29.4919	30.3151	29.9209
450018	1.5354	0.9925	30.2383	30.7852	31.3118	30.7838
450021	1.8903	0.9852	29.5658	31.3107	31.7338	30.8752
450023	1.4138	0.8153	25.4450	25.5346	25.1670	25.3821
450024	1.5693	0.8867	26.9113	28.2047	27.3787	27.5109
450028	1.5788	0.9226	29.1438	29.5792	29.5668	29.4314
450029	1.6143	0.8816	25.0602	26.9361	28.6442	26.7635
450031	1.4439	0.9852	29.0824	30.3542	29.2123	29.5392
450032	1.2547	0.8407	21.5084	25.5785	26.3146	24.2723
450033	1.5969	0.9226	29.2468	27.8680	29.7653	28.9230
450034	1.5308	0.8595	26.5313	27.6929	29.6291	28.1119
450035	1.5326	0.9925	28.0668	28.8049	30.3345	29.0806
450037	1.5845	0.8666	26.6207	28.3403	28.2594	27.7345
450039	1.5955	0.9852	26.7503	28.2081	29.8132	28.2727
450040	1.7553	0.8712	25.4734	26.8412	28.5453	26.9585
450042	1.7455	0.8703	26.6382	26.5429	27.6115	26.9555
450044	1.6959	0.9852	31.0381	29.4293	32.9897	31.1698
450046	1.5774	0.8494	24.8947	25.5903	27.2425	25.9770
450047	0.8561	0.9226	21.8824	23.8457	24.9663	23.5090
450051	1.9250	0.9852	28.8829	29.9038	30.3953	29.7565
450052	0.9850	0.8153	22.6448	23.0007	24.3959	23.3480
450054	1.7911	0.8855	27.5399	26.5599	30.2202	28.0403
450055	1.0449	0.8153	22.9245	23.6382	24.1423	23.5765
450056	1.6824	0.9521	28.3092	31.4971	32.0873	30.6432
450058	1.5743	0.8949	26.6926	26.9918	27.7297	27.1586
450059	1.2980	0.9024	26.8325	27.3856	28.5629	27.5865
450064	1.5113	0.9852	26.8355	28.2786	29.0474	28.0416
450068	2.0486	0.9925	29.5876	30.5001	32.0346	30.7379
450072	1.2155	0.9925	25.8619	27.1081	28.0902	27.0430
450073	0.8877	0.8153	26.9446	26.1567	22.2326	25.0645
450076	1.6904	*	*	*	*	*
450078	0.8999	0.8153	21.4716	20.0758	20.7809	20.7567
450079	1.6789	0.9852	30.2420	30.5968	36.8906	32.4452
450080	1.2493	0.8666	27.9191	26.2439	26.8091	27.0298
450082	1.1597	0.8153	23.9025	24.2018	25.5648	24.5569
450083	1.7529	0.8901	27.4955	32.6462	30.2031	29.9862

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
450085	1.0822	0.8153	24.3637	25.6440	26.3606	25.4425
450087	1.3998	0.9852	30.0095	31.2668	32.6536	31.3363
450090	1.2615	0.8803	21.3837	21.8839	22.7815	22.0412
450092	1.2126	0.8153	24.9917	26.2781	28.2267	26.4935
450096	***	*	26.5103	28.1902	*	27.3122
450097	1.4580	0.9925	29.0142	29.8734	31.9758	30.2412
450099	1.3019	0.8883	31.3495	31.7829	29.8469	30.9845
450101	1.6171	0.8703	25.4409	26.7457	28.4201	26.8726
450102	1.7083	0.8901	25.6318	26.4161	27.3343	26.4779
450104	1.1855	0.8949	24.6169	28.8063	27.7838	26.9841
450107	1.5806	0.8867	27.6064	27.8177	29.0310	28.1649
450108	1.1922	0.8949	21.6557	19.3245	22.4281	21.1092
450119	1.3181	0.9118	27.8027	31.1026	34.4129	30.7679
450121	***	*	29.1296	27.7472	*	28.4439
450123	1.3318	0.8595	24.9674	26.2469	24.0420	24.9404
450124	1.7511	0.9521	28.2571	30.9140	31.9772	30.4250
450126	1.3989	0.9925	29.3768	30.5540	32.0348	30.6758
450128	1.2318	0.9118	25.1122	26.3296	28.3156	26.5694
450130	1.1977	0.8949	24.3295	24.3842	26.9201	25.2414
450131	***	*	25.9494	*	*	25.9494
450132	1.6322	0.9425	30.1620	31.9981	31.1340	31.0941
450133	1.5320	0.9283	28.4647	30.0648	30.9597	29.8077
450135	1.6395	0.9852	27.8983	30.1385	30.7885	29.6276
450137	1.6679	0.9852	31.4950	31.9644	35.7749	33.2271
450143	1.0277	0.9521	23.4592	23.6834	24.4333	23.8654
450144	1.0083	0.8712	26.2881	29.2987	31.1551	28.7443
450147	1.4564	0.8153	24.3562	24.7221	26.3019	25.1662
450148	1.2241	0.9852	27.0894	29.6777	30.0530	28.8673
450151	***	*	23.9558	26.2011	22.8759	24.2772
450152	1.2565	0.8855	23.3428	23.1056	24.3424	23.6074
450154	1.3302	0.8153	21.7237	22.9357	24.2578	22.9598
450155	1.1251	0.8153	21.7604	24.8052	24.8768	23.6641
450162	1.3269	0.8712	33.3285	32.9317	33.7803	33.3236
450163	1.0627	0.8207	24.1267	24.7857	27.0963	25.3188
450165	1.1447	0.8949	28.6490	29.1839	30.2222	29.3460
450176	1.4003	0.9118	23.1284	24.4338	25.8569	24.4742
450177	1.0905	0.8153	23.7624	24.4064	26.0891	24.7683
450178	0.9986	0.9283	27.8405	27.1184	28.5998	27.8381
450184	1.5684	0.9925	28.5399	29.5940	30.9705	29.6894
450187	1.2150	0.9925	28.3243	27.7374	29.2737	28.4472
450188	0.9254	0.8153	23.0595	23.2280	24.6816	23.6817
450191	1.1258	0.9521	26.5863	28.3937	31.1321	28.6333
450192	1.1180	0.8424	24.1186	26.4722	26.9874	25.8921
450193	2.0321	0.9925	34.4545	36.4793	37.1873	36.0649
450194	1.2632	0.8366	22.9605	24.3531	30.4368	25.7167
450196	1.4595	0.9852	24.0161	23.4577	25.4820	24.2962
450200	1.6042	0.8195	23.5012	25.6413	27.9825	25.4502
450201	0.9730	0.8153	23.2510	23.2800	22.5445	22.9956
450203	1.2116	0.9684	26.5237	27.8795	28.0968	27.5107
450209	1.8278	0.8997	27.5668	30.6146	31.9858	29.9981
450210	1.0215	0.8304	21.8722	22.5736	22.9049	22.4486
450211	1.3455	0.8666	28.4581	28.3770	28.8471	28.5692
450213	1.7959	0.8949	25.9169	26.8566	28.0289	26.9446
450214	1.2281	0.9925	27.4357	27.9913	28.2247	27.8829
450219	0.9660	0.8153	21.9207	23.9636	24.7267	23.5184
450221	1.1119	0.8153	19.3793	21.3721	20.7113	20.5035
450222	1.6824	0.9925	30.0314	30.3801	31.9231	30.7843
450224	1.3283	0.8901	26.8302	28.4382	28.7921	28.0121
450229	1.6525	0.8408	24.4450	25.1370	26.8016	25.3958
450231	1.6726	0.8997	27.1674	26.9783	27.0533	27.0671
450234	1.0198	0.8153	20.6889	20.4659	21.6802	21.1358
450235	1.0077	0.8153	23.5212	21.8967	23.8005	23.0639
450236	1.1319	0.8542	23.5426	22.9622	24.5926	23.6934
450237	1.6540	0.8949	25.7939	30.5885	31.2172	28.9557
450239	0.9770	0.8855	21.2586	19.1359	18.4232	19.4675
450241	1.0252	0.8153	20.8732	21.3641	28.4948	23.5112
450243	1.0024	0.8153	15.4510	17.2966	19.0176	17.2995

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
450253	0.9321	0.9925	24.2435	24.1056	22.9919	23.7733
450270	1.2113	0.8424	15.2190	19.8180	12.9994	15.5383
450271	1.2778	0.9684	22.7035	24.1269	23.9525	23.6286
450272	1.2096	0.9521	26.2576	27.0521	29.0903	27.4843
450280	1.4612	0.9852	29.9730	31.6575	34.9324	32.1866
450283	1.0893	0.9852	22.7938	24.1754	28.2079	24.8171
450289	1.4524	0.9925	32.2645	32.6533	32.6122	32.5225
450292	1.2808	0.9852	26.3242	26.8110	29.0226	27.3779
450293	0.8910	0.8153	23.6413	24.0827	24.1552	23.9551
450296	1.0439	0.9925	30.4324	31.5596	33.4528	31.7845
450299	1.5997	0.9193	27.5797	28.4171	29.4576	28.5044
450306	0.9802	0.8408	21.4558	22.9486	22.6822	22.3403
450315	2.4335	0.9852	37.1721	*	31.4204	33.9617
450324	1.5212	0.9852	25.1633	26.6093	27.9889	26.5490
450330	1.2552	0.9925	26.0771	27.1100	27.7403	26.9930
450340	1.4092	0.8600	25.0344	25.6791	30.5228	26.9242
450346	1.4343	0.8595	23.6072	23.8720	24.8416	24.1224
450347	1.2208	0.9925	28.7667	30.7825	28.5780	29.3911
450348	1.0018	0.8153	21.6787	21.0484	22.6822	21.8120
450351	1.2791	0.9684	26.5388	29.2560	29.9580	28.5841
450352	1.1062	0.9852	26.2281	27.2983	27.6466	27.0615
450353	***	*	27.0248	27.9576	*	27.5079
450358	1.9716	0.9925	31.4926	32.5922	33.9078	32.6875
450369	0.9268	0.8153	19.9148	22.8525	24.1950	22.2632
450370	1.2579	0.8388	25.5834	26.3235	29.0806	27.0009
450372	1.4550	0.9852	30.8886	29.5022	30.9328	30.4453
450373	0.9144	0.8153	24.8286	27.0726	27.4243	26.4835
450378	1.3092	0.9925	30.3883	32.2278	33.0566	31.9025
450379	1.4002	0.9852	33.7521	35.3807	35.0613	34.7094
450388	1.7004	0.8949	27.4328	27.8155	29.5360	28.2774
450389	1.1714	0.9852	25.6732	26.9638	26.8481	26.4861
450393	0.7662	0.9852	21.9347	*	39.0250	28.4483
450395	1.0730	0.9925	27.5189	26.7743	28.4265	27.6022
450399	0.8925	0.8153	20.3528	22.1731	20.6300	21.0332
450400	1.0684	0.8153	23.6358	26.2871	29.5008	26.1110
450403	1.3192	0.9852	29.0359	29.8643	31.7040	30.2580
450411	1.0061	0.8153	20.9372	21.5746	21.7875	21.4276
450418	***	*	28.4362	*	*	28.4362
450419	1.3124	0.9852	31.9966	34.2427	34.9949	33.8163
450422	1.2786	0.9852	34.4331	31.3454	32.4640	32.6976
450424	1.3562	0.9925	28.2463	30.7228	29.8269	29.5962
450431	1.6067	0.9521	26.3263	27.3926	28.5263	27.4173
450438	1.1486	0.8388	27.8659	26.5223	27.7728	27.3852
450446	0.7131	0.9925	17.0691	17.2871	15.4631	16.6064
450447	1.3552	0.9852	25.4200	26.5238	28.3710	26.7880
450451	1.0753	0.8689	24.6201	26.5477	25.8824	25.6945
450460	0.9426	0.8206	22.4227	24.9870	25.2172	24.1531
450462	1.7253	0.9852	29.6069	30.1466	30.6488	30.1364
450465	1.1257	0.9925	26.2759	27.0835	28.1840	27.2041
450469	1.4624	0.9852	26.3262	26.3445	31.1333	27.8724
450475	1.1940	0.8666	23.0942	24.5176	24.7023	24.0834
450484	1.4990	0.8666	26.7242	28.3913	27.7774	27.6347
450488	1.1180	0.8666	22.3981	23.7985	24.9095	23.7092
450489	0.9839	0.8153	23.4806	25.2680	26.9542	25.1940
450497	0.9966	0.8528	22.0918	23.1860	23.0703	22.7799
450498	0.9829	0.8153	18.6563	20.2475	20.6876	19.8494
450508	1.4530	0.8666	28.4471	27.2850	29.1501	28.3018
450514	***	*	26.3704	27.3043	26.4002	26.6921
450518	1.4419	0.8595	28.1755	29.1322	27.5863	28.1826
450530	1.2667	0.9925	29.1349	29.9720	30.7727	29.9520
450537	1.5128	0.9852	27.7757	28.7448	30.9146	29.1361
450539	1.2202	0.8220	23.1829	24.2151	25.0188	24.1139
450547	0.9744	0.9852	23.7820	34.3349	25.4122	27.1653
450558	1.7678	0.8408	26.9407	28.0655	28.7729	27.9448
450563	1.5299	0.9852	30.8332	32.0507	32.6847	31.9164
450565	1.3270	0.9684	26.7942	28.1741	27.4760	27.4805
450571	1.6222	0.8600	25.2108	27.4605	26.5303	26.3740

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
450573	1.0770	0.8279	22.0797	22.1492	24.6744	22.9817
450578	0.9673	0.8153	22.5167	25.0498	25.2476	24.2617
450580	1.0515	0.8153	22.3886	23.9004	25.9872	23.9915
450584	1.0829	0.8153	20.5257	22.5204	23.6045	22.1623
450586	1.0201	0.8153	18.9107	20.6699	18.3294	19.3042
450587	1.2259	0.8153	23.1202	25.0174	25.9358	24.6518
450591	1.1895	0.9925	25.7031	27.1744	27.9847	26.9265
450596	1.1854	0.9684	27.4011	29.8462	31.6577	29.6788
450597	0.9963	0.8153	24.7853	24.2586	24.8439	24.6216
450604	1.3397	0.8153	24.4743	25.9133	29.1526	26.5819
450605	0.9810	0.8494	20.9276	23.9332	14.8030	19.8571
450610	1.5974	0.9925	27.7317	28.3713	30.5957	28.8793
450615	0.9986	0.8185	21.8442	24.1902	22.6324	22.8680
450617	1.5826	0.9925	28.0225	28.8323	30.2898	29.0536
450620	0.9635	0.8153	18.6183	20.3723	21.2530	20.0799
450630	1.5054	0.9925	29.1462	29.8431	31.7991	30.2292
450634	1.6203	0.9852	28.7312	30.3274	31.7983	30.2933
450638	1.5993	0.9925	30.6572	32.4911	33.3208	32.0988
450639	1.4598	0.9852	30.4019	32.6255	34.3727	32.4471
450641	0.9799	0.8528	19.4389	20.2483	21.7288	20.4546
450643	1.3367	0.8816	22.7355	24.4999	27.2517	24.7934
450644	1.5467	0.9925	29.7918	30.7815	31.6848	30.7914
450646	1.4527	0.8867	25.6313	26.8060	27.4611	26.6291
450647	1.8764	0.9852	30.6924	32.4236	34.0988	32.4013
450651	1.5358	0.9852	30.4484	31.9261	33.6467	32.0226
450653	1.1592	0.8153	25.2144	26.1756	26.5346	25.9882
450654	0.9049	0.8153	21.5002	22.5447	25.0736	23.0141
450656	1.4220	0.8666	25.5050	28.1493	29.7276	27.7366
450658	0.9793	0.8153	22.2293	24.7856	22.7086	23.2037
450659	1.4021	0.9925	31.5024	34.2380	34.2632	33.2709
450661	1.4614	0.9425	30.2610	30.0751	29.2361	29.8375
450662	1.6460	0.9226	29.0535	29.0532	30.9608	29.6825
450668	1.5414	0.8867	28.8635	30.6114	30.2059	29.8659
450669	1.2189	0.9852	27.9796	30.2374	32.1221	30.1382
450670	1.4361	0.9925	25.9638	26.4266	26.2942	26.2315
450672	1.8349	0.9852	30.1191	31.8420	33.0834	31.7654
450674	0.9478	0.9925	28.7101	29.8971	31.9284	30.1847
450675	1.4578	0.9852	28.9005	30.9562	32.6351	30.8652
450677	1.3166	0.9852	25.9555	27.2760	27.1594	26.8126
450678	1.4170	0.9852	31.1563	33.3386	33.5496	32.6557
450683	1.2015	0.9852	27.4925	21.1737	24.8430	24.2908
450684	1.2814	0.9925	29.3025	30.2139	31.2746	30.2639
450686	1.6149	0.8712	24.2331	25.8530	26.4851	25.5754
450688	1.2727	0.9852	26.8599	26.9897	29.4376	27.7076
450690	1.3408	0.8901	26.5528	26.1743	30.0569	27.4939
450694	1.1759	0.8153	23.9961	24.0031	27.0859	24.8819
450697	1.4748	0.8949	24.8667	26.4132	28.2983	26.4744
450698	0.9175	0.8280	20.0955	21.5742	23.3052	21.6138
450702	1.6153	0.8666	26.8384	26.3696	27.1300	26.7835
450709	1.4034	0.9925	26.8146	27.1077	31.3218	28.4257
450711	1.4823	0.9118	26.7472	27.5622	28.1016	27.5198
450713	1.5563	0.9521	28.8285	29.4980	30.4912	29.6225
450715	1.3146	0.9852	17.3991	17.0235	*	17.2098
450716	1.4070	0.9925	32.3960	33.7096	33.9898	33.3800
450718	1.4669	0.9521	27.3215	28.1560	29.7584	28.4466
450723	1.4494	0.9852	28.5103	30.1704	31.0456	29.9614
450730	1.3722	0.9852	31.3324	32.7293	32.8896	32.3004
450742	1.1754	0.9852	27.2023	30.0583	30.4185	29.2913
450743	1.4478	0.9852	28.3362	28.4736	29.5077	28.8191
450746	0.8780	0.8153	20.6343	22.7873	23.3483	22.2429
450747	1.1965	0.8901	23.8314	25.8175	28.3918	25.8472
450749	0.9371	0.8153	20.0487	22.1562	23.9271	21.9555
450751	***	*	18.7456	21.4223	*	20.1469
450754	0.9429	0.8153	22.1819	24.7797	22.8559	23.2191
450755	0.9660	0.8429	19.8988	22.2006	24.7427	22.1319
450758	***	*	28.7342	28.2803	28.3285	28.4884
450760	1.0061	0.8867	24.7489	25.1637	23.7138	24.5602

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Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
450766	2.0334	0.9852	30.8004	30.2341	31.2061	30.7524
450770	1.1706	0.9521	24.1647	24.3244	23.6084	24.0129
450771	1.7003	0.9852	30.7105	32.0500	32.4987	31.7652
450774	1.7600	0.9925	27.2080	25.7436	27.5052	26.8202
450775	1.3943	0.9925	28.1428	29.8230	31.6636	29.9048
450779	1.2842	0.9852	29.9674	31.8403	32.0748	31.3351
450780	2.5251	0.8949	26.7611	27.0084	28.5545	27.4508
450788	1.5291	0.8494	26.2840	28.3759	29.7646	28.1299
450795	1.1739	0.9925	25.2007	32.9803	43.8548	34.0292
450796	1.8173	0.8997	36.4073	37.6274	39.4710	37.9807
450797	1.2450	0.9925	24.8950	24.8598	26.0293	25.2371
450801	1.4989	0.8195	24.6328	23.6072	25.6368	24.6370
450803	1.2105	0.9925	28.9235	29.0106	28.7024	28.8861
450804	2.0345	0.9925	27.8775	29.1282	31.1869	29.4370
450808	1.8935	0.9521	21.9793	23.0312	29.6456	24.9240
450809	1.6551	0.9521	26.4223	27.3080	29.4671	27.7555
450811	1.7218	0.9118	27.2584	31.2208	31.7219	29.8931
450813	1.1338	0.8949	20.1710	22.9289	26.5793	23.2366
450820	1.4186	0.9925	31.4666	33.9030	34.7415	33.5465
450822	1.3260	0.9852	32.2968	32.2145	34.4032	32.9996
450824	2.6758	0.9521	31.2375	33.3653	31.8377	32.1641
450825	1.4768	0.9118	20.6457	25.1521	25.7993	23.7848
450827	1.4405	0.9175	23.7554	24.1984	24.3655	24.1145
450828	1.3774	0.8153	24.4740	24.8236	26.9546	25.5737
450829	***	*	20.6016	19.5842	*	20.0933
450830	1.0119	0.9283	28.5902	27.8005	28.4004	28.2670
450831	0.9180	0.9925	23.3880	23.9467	24.4124	23.8672
450832	1.3167	0.9925	26.5229	27.3290	28.1375	27.3874
450833	1.1878	0.9852	27.0133	27.9649	29.0241	28.0113
450834	1.6180	0.9193	20.9607	27.4844	26.7240	24.5166
450838	1.0772	0.8279	19.5754	18.9620	19.2941	19.2971
450839	0.9688	0.8153	25.8222	27.2199	27.5319	26.8415
450840	1.2996	0.9852	30.1743	32.2538	32.4135	31.6992
450841	1.9116	0.9226	20.9410	20.9424	24.4366	22.2249
450844	1.3797	0.9925	30.7887	33.7978	33.0727	32.7243
450845	1.8834	0.8867	29.4933	29.9265	28.5011	29.2842
450847	1.2564	0.9925	28.5548	29.7356	30.7409	29.7031
450848	1.2904	0.9925	29.5355	30.5546	31.1455	30.4213
450850	1.5769	0.9562	21.9266	31.9606	27.2645	26.5516
450851	2.3662	0.9852	32.6950	35.1102	32.8357	33.5034
450853	1.7353	0.9852	36.1169	37.1043	38.3572	37.3449
450854	***	*	27.1868	*	*	27.1868
450855	1.6258	0.9226	30.8855	32.6916	30.7321	31.4205
450856	2.0970	0.8949	39.0865	37.7362	35.4977	37.3569
450857	***	*	30.4632	*	*	30.4632
450860	1.8529	0.9925	24.0171	29.1075	33.3360	29.3070
450861	***	*	34.9290	*	*	34.9290
450862	1.5594	0.9925	31.2224	31.8095	33.7932	32.2128
450863	***	*	24.8825	*	*	24.8825
450864	2.1890	0.8901	23.3765	24.5049	25.3514	24.5415
450865	1.1032	0.9521	29.1763	29.9559	31.9179	30.4451
450866	***	*	15.2959	*	*	15.2959
450867	1.1589	0.9521	28.2289	29.5879	31.4926	29.7806
450868	1.7418	0.9425	27.9579	25.3486	27.7398	27.0759
450869	2.1455	0.9118	22.6253	26.1616	28.7406	27.5500
450870	***	*	37.4364	*	*	37.4364
450871	1.8768	0.9521	*	28.9150	32.3967	30.6337
450872	1.3756	0.9852	*	27.2833	31.7321	29.8421
450873	***	*	*	14.8821	*	14.8821
450874	1.6738	0.9852	*	34.6083	35.6817	35.2071
450875	1.7360	0.8997	*	23.2763	23.2949	23.2862
450876	1.9264	0.8712	*	28.4343	30.3498	29.4575
450877	1.4979	0.8867	*	26.1867	29.2330	27.6968
450878	2.5641	0.8949	*	31.6750	33.6233	32.6691
450879	1.3352	0.8816	*	35.5672	36.4836	36.0727
450880	1.5477	0.9852	*	35.9572	32.6680	34.0899
450881	***	*	*	24.5464	*	24.5464

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
450882	***	*	*	26.6910	*	26.6910
450883	2.4793	0.9852	*	35.2646	37.1500	36.2387
450884	1.0281	0.8715	*	27.8213	23.5791	25.5501
450885	1.4517	0.9852	*	34.1148	36.0926	35.1477
450886	1.5017	0.9852	*	*	30.1552	30.1552
450887	***	*	*	*	25.5574	25.5574
450888	1.7096	0.9708	*	*	28.5970	28.5970
450889	1.5530	0.9852	*	*	35.6125	35.6125
450890	1.8266	0.9852	*	*	32.1973	32.1973
450891	1.4143	0.9852	*	*	39.0842	39.0842
450892	***	*	*	*	39.5303	39.5303
450893	1.3909	0.9852	*	*	36.2633	36.2633
450894	1.7932	0.9852	*	*	25.9422	25.9422
450895	***	*	*	18.4142	*	18.4142
460001	1.8307	0.9075	28.7150	30.0040	*	29.3648
460003	1.5382	0.9271	31.4135	32.3427	29.6430	31.1480
460004	1.7729	0.9271	28.2040	29.6342	29.8751	29.2534
460005	1.5237	0.9271	25.0239	26.0731	29.4163	26.8371
460006	1.4480	0.9271	27.1392	28.3678	28.9633	28.1485
460007	1.3341	0.9228	27.1308	28.0035	29.1171	28.1204
460008	1.3382	0.9271	29.5907	31.5485	27.6886	29.5829
460009	1.9760	0.9271	27.2885	28.3836	29.4687	28.4457
460010	2.0995	0.9271	29.0063	30.4606	30.9793	30.1575
460011	1.3236	0.8395	24.4402	24.9677	26.5474	25.3370
460013	1.3909	0.9075	27.7381	29.2731	29.7232	28.9118
460014	1.1488	0.9271	28.2647	29.5963	30.6427	29.4780
460015	1.3542	0.8827	27.2506	29.1318	28.7993	28.4031
460017	1.5067	0.8778	24.3030	26.1589	28.7101	26.4243
460018	0.8937	0.8395	22.0517	22.8028	22.0916	22.3156
460019	1.1962	0.8395	24.3756	23.2202	25.1607	24.2508
460020	0.9177	*	18.5159	*	*	18.5159
460021	1.7949	1.1388	28.0291	29.5761	29.7373	29.2069
460023	1.2032	0.9075	26.9512	28.5884	28.9445	28.1975
460026	1.0634	0.9052	26.9295	27.9487	29.2757	28.0634
460030	1.1657	0.8395	23.5942	24.4218	26.8971	24.9667
460033	0.8711	0.8395	25.3422	26.6606	27.9090	26.6490
460035	0.9610	0.8395	20.6322	21.9115	23.8672	22.1202
460039	1.0970	0.8827	29.5651	30.4912	30.0656	30.0667
460041	1.3694	0.9271	26.4640	26.3807	26.7342	26.5286
460042	1.4973	0.9271	24.9454	26.8389	36.2868	28.7517
460043	0.9867	0.9075	28.2008	28.6668	29.5636	28.8137
460044	1.3270	0.9271	27.4928	28.7023	29.5056	28.5642
460047	1.6851	0.9271	28.2336	29.9990	30.9988	29.7618
460049	1.9801	0.9271	26.6702	28.4884	28.6251	27.9963
460051	1.4090	0.9271	27.0160	27.8841	28.1118	27.6918
460052	1.6516	0.9075	26.1629	27.1995	28.7433	27.4110
460054	1.6931	0.8827	24.9926	25.7870	26.3926	25.7328
460055	1.4742	0.9075	*	*	*	*
470001	1.2668	0.9297	28.3017	29.7540	32.2867	30.1248
470003	1.8776	0.9275	28.1137	30.1973	30.0513	29.4645
470005	1.3533	0.9275	30.7872	33.1981	33.9946	32.7064
470011	1.1581	0.9275	28.1330	29.6269	30.8723	29.5547
470012	1.2088	0.9275	26.0225	27.0751	29.8242	27.6835
470024	1.1462	0.9275	27.0394	26.6351	27.3091	26.9932
490001	1.0923	0.8061	23.2174	24.0368	24.6876	23.9910
490002	1.0162	0.8061	20.8609	21.7092	24.0666	22.0939
490004	1.2931	0.9449	27.1676	27.5890	28.8643	27.8908
490005	1.5720	1.0669	29.8215	30.5349	31.4889	30.6457
490007	2.0360	0.8869	27.6572	29.3098	30.7391	29.2722
490009	1.9926	0.9728	30.4722	28.4642	31.4238	30.0808
490011	1.5707	0.8869	26.4766	27.4764	28.8762	27.6271
490012	1.0101	0.8061	21.0605	22.9922	21.8319	21.9360
490013	1.3744	0.9694	24.7521	25.5560	27.3086	25.8824
490017	1.5021	0.8869	25.8216	27.5902	29.6761	27.7176
490018	1.3622	0.9449	26.2510	27.2644	27.8664	27.1379
490019	1.1503	1.0669	25.9885	25.8264	29.8874	27.1451
490020	1.2876	0.9203	27.3142	29.3468	30.5993	29.0707

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
490021	1.4622	0.8646	25.7938	27.0641	28.1233	26.9966
490022	1.4112	1.0669	32.2676	30.1203	31.7964	31.3740
490023	1.3297	1.0669	30.3416	30.9920	32.6291	31.3336
490024	1.6994	0.8889	26.1125	27.9689	29.0379	27.6964
490027	1.1143	0.8061	24.0288	23.0017	24.3832	23.7446
490032	1.9515	0.9203	25.2654	28.5897	28.0097	27.3514
490033	1.0967	1.0669	31.2922	31.8282	30.9894	31.3730
490037	1.2781	0.8061	24.7711	25.2859	26.2942	25.4675
490038	1.2238	0.8061	21.8509	22.6504	24.0844	22.8205
490040	1.5127	1.1017	32.6564	34.1841	35.6796	34.1603
490041	1.5635	0.8869	26.0897	27.1613	29.1224	27.4587
490042	1.3157	0.8750	24.4650	25.7333	26.6055	25.6256
490043	1.3375	1.1017	33.7096	35.8872	36.5934	35.4348
490044	1.4493	0.8869	23.3527	23.3793	24.1751	23.6463
490045	1.3427	1.0669	32.0937	30.3772	32.8751	31.7663
490046	1.5416	0.8869	26.6517	27.9604	29.3861	28.0339
490048	1.4333	0.8646	26.2828	27.0620	28.0302	27.1308
490050	1.5231	1.0669	31.3885	32.2993	31.1346	31.5946
490052	1.6678	0.8869	23.5973	25.0046	25.1956	24.5749
490053	1.1871	0.8061	23.3315	23.8004	24.6193	23.9160
490057	1.6362	0.8869	26.6898	27.4918	29.0678	27.7786
490059	1.6585	0.9203	27.3611	30.8669	32.1008	30.0791
490060	1.0194	0.8061	23.6113	24.3192	25.7752	24.5807
490063	1.8759	1.1017	31.3619	31.6069	34.1154	32.3880
490066	1.3873	0.8869	27.8250	29.5917	31.4281	29.7032
490067	1.2870	0.9203	24.9021	25.9497	26.7787	25.8584
490069	1.5365	0.9203	27.3181	29.1527	30.1463	28.8658
490071	1.4069	0.9203	29.7186	31.7061	33.7101	31.7115
490073	***	*	33.1829	34.5774	46.4178	36.1085
490075	1.3188	0.8483	25.2022	25.7323	27.3411	26.0795
490077	1.4181	0.9728	26.6806	28.1506	31.0002	28.6185
490079	1.2674	0.8985	25.3103	25.2340	24.2052	24.9039
490084	1.1427	0.8248	24.9007	25.7657	26.3132	25.6727
490088	1.0983	0.8646	24.1471	25.0619	26.0270	25.0928
490089	1.1018	0.8889	24.9438	25.9902	27.4562	26.1612
490090	1.0545	0.8061	25.1157	25.5418	27.0746	25.9182
490092	1.0775	0.8061	23.3439	25.7405	27.5268	25.4745
490093	1.5429	0.8869	25.6531	26.7886	28.7103	27.0735
490094	0.9727	0.9203	28.2165	28.9155	29.7975	28.9991
490097	1.0690	0.9203	26.5322	27.1470	27.4607	27.0696
490098	1.2889	0.8061	23.2782	25.1625	26.7140	25.0883
490101	1.4144	1.1017	31.2377	32.3695	32.9490	32.2107
490104	0.7712	0.9203	*	17.0548	19.0055	18.0437
490105	0.8355	0.8061	25.5329	26.3827	*	25.9379
490106	0.7733	0.8061	23.8334	25.7352	26.2318	25.2383
490107	1.4215	1.1017	32.2672	33.5430	35.0239	33.6804
490108	1.0546	0.8646	22.9076	23.3204	25.1884	23.8173
490109	0.9060	0.8869	22.7854	24.2296	21.6710	22.7835
490110	1.3576	0.8307	24.2887	24.9861	26.3071	25.2068
490111	1.1082	0.8061	22.1476	22.7336	26.4282	23.6179
490112	1.7315	0.9203	27.1932	29.0816	31.2526	29.1894
490113	1.2911	1.0669	31.8177	32.4547	34.7813	33.0718
490114	1.1439	0.8061	22.5255	22.1387	23.0526	22.5829
490115	1.2011	0.8061	22.4058	23.5718	23.2109	23.0488
490116	1.1712	0.8061	24.2258	24.3853	25.0343	24.5470
490117	1.1002	0.8061	19.6398	18.1138	20.3031	19.3436
490118	1.6337	0.9203	27.6749	29.0569	31.2383	29.3451
490119	1.3013	0.8869	26.5756	27.8866	29.5203	28.0191
490120	1.4551	0.8869	25.8795	25.9610	27.1973	26.3518
490122	1.5919	1.1017	32.0743	33.3719	35.2212	33.5744
490123	1.1435	0.8061	24.3490	24.2254	24.5997	24.3927
490126	1.1732	0.8061	23.6690	24.0908	25.3282	24.3545
490127	1.1178	0.8061	21.3735	23.5161	23.1390	22.6004
490130	1.2203	0.8869	23.9982	25.3352	25.9771	25.1170
490134	0.8323	0.8061	*	33.2405	31.1474	32.1153
490135	0.7518	0.8889	*	25.9998	27.2771	26.6418
490136	1.4451	0.9203	*	*	31.2889	31.2889

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
490138	1.9348	0.8646	*	*	*	*
500001	1.6024	1.1562	31.1605	33.0901	37.5297	33.7723
500002	1.3750	1.0164	27.6400	29.1448	30.1855	29.0190
500003	1.3968	1.1377	30.6939	32.1262	32.7960	31.8089
500005	1.8014	1.1562	33.5117	35.0997	36.0900	34.9342
500007	1.3520	1.1377	29.2869	30.5263	31.0289	30.3229
500008	1.9737	1.1562	32.6052	33.5666	34.7787	33.6731
500011	1.3817	1.1562	31.4514	32.6223	38.3960	33.9417
500012	1.7799	1.0164	30.0509	33.8101	33.1661	32.2294
500014	1.6593	1.1562	36.1380	36.5833	37.2677	36.6858
500015	1.4000	1.1562	34.5877	37.5724	40.8644	37.5957
500016	1.6703	1.1377	31.4905	32.9177	34.2801	32.9164
500019	1.2524	1.0295	30.5594	31.6242	33.8866	32.0653
500021	1.3071	1.1377	30.7927	32.4702	33.5572	32.3511
500024	1.7453	1.1462	32.6171	36.1647	37.4510	35.4266
500025	1.9117	1.1562	37.7952	40.6369	44.7077	41.0323
500026	1.4550	1.1562	32.8369	34.5881	35.5055	34.3334
500027	1.4942	1.1562	34.6164	39.2906	42.4941	38.7477
500030	1.6959	1.1395	32.4426	34.9174	36.7964	34.7347
500031	1.2671	1.1297	32.8833	33.2391	34.1649	33.4481
500033	1.2468	1.0164	30.6292	31.8891	32.6732	31.7837
500036	1.3290	1.0164	28.7096	30.5938	31.9136	30.4918
500037	1.0577	1.0164	28.1056	31.2654	29.1752	29.5198
500039	1.5629	1.1377	32.2245	33.5606	34.5710	33.5071
500041	1.4344	1.1186	30.3627	34.2017	36.9240	33.8434
500044	1.8913	1.0514	29.0214	31.0936	32.0719	30.6373
500049	1.3698	1.0164	27.7170	29.8189	30.8120	29.5153
500050	1.5082	1.1186	32.6751	33.7713	35.7229	34.0820
500051	1.7917	1.1562	32.5764	34.7610	36.4745	34.6036
500052	1.4632	1.1562	*	*	*	*
500053	1.2557	1.0164	28.2901	30.2811	28.5649	29.0318
500054	1.9737	1.0514	31.6595	32.5105	34.8088	32.9758
500058	1.6843	1.0164	30.7487	30.7034	32.6820	31.4274
500060	1.3541	1.1562	37.4869	38.7682	40.3002	38.8996
500064	1.8909	1.1562	31.6112	32.3581	34.7906	32.9459
500072	1.2605	1.0576	31.2000	32.5269	33.1128	32.3268
500077	1.4765	1.0514	31.6153	33.2223	34.3082	33.0354
500079	1.3733	1.1377	31.3280	32.5809	34.2468	32.6847
500084	1.2608	1.1562	30.2411	32.7883	33.3057	32.1164
500088	1.4739	1.1562	35.3770	36.7953	38.5166	36.8898
500108	1.6172	1.1377	31.8483	34.3872	35.8890	34.0321
500119	1.3809	1.0514	29.7028	31.2233	31.7102	30.8549
500124	1.4071	1.1562	32.3505	34.4790	36.3296	34.3958
500129	1.5755	1.1377	32.1102	34.4447	37.3169	34.6824
500134	0.5967	1.1562	27.2428	28.1374	28.9744	28.2246
500139	1.4903	1.1462	33.9739	34.6412	37.5682	35.2949
500141	1.2645	1.1562	31.3308	33.7532	34.2350	33.1511
500143	0.5889	1.1462	23.6766	25.3099	26.3882	25.1082
500148	1.2204	1.0164	26.4206	37.7830	24.6331	30.3555
500150	1.2775	1.1186	*	*	34.7828	34.7828
510001	1.9319	0.8569	25.2973	25.8693	26.7901	26.0184
510002	1.2681	0.8732	23.8921	23.7270	24.8834	24.1721
510006	1.3528	0.8631	24.9627	24.8777	26.6403	25.4772
510007	1.6750	0.9107	24.7264	27.1149	28.5769	26.8115
510008	1.3363	0.9253	26.3554	27.5241	27.4687	27.1395
510012	0.9584	0.7759	18.8984	20.8455	22.9026	20.8292
510013	1.1635	0.7635	22.7882	22.8779	22.9605	22.8737
510018	1.0730	0.8398	22.4597	23.1043	23.7726	23.1223
510022	1.8098	0.8398	26.9511	26.8328	27.6095	27.1376
510023	1.2565	0.8011	20.6435	21.0940	23.1446	21.6346
510024	1.7530	0.8569	25.5634	26.6621	31.1308	27.8371
510026	0.9848	0.7635	17.9908	19.2025	17.8264	18.3206
510029	1.2995	0.8398	22.7104	24.0872	25.3908	24.0179
510030	1.1499	0.7635	24.3936	24.2007	25.5580	24.7270
510031	1.4626	0.8398	23.2624	24.0237	26.7854	24.6110
510033	1.5988	0.8028	22.6189	24.0796	24.2824	23.6905
510038	1.0704	0.7635	20.6565	20.9180	21.7526	21.1101

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
510039	1.3740	0.7635	19.8751	20.4719	21.3807	20.5901
510046	1.3781	0.7795	22.1712	22.2935	24.7175	23.0443
510047	1.2053	0.8569	27.1214	27.6859	28.8777	27.9077
510048	1.1872	0.7635	18.8576	22.7930	23.6384	21.5406
510050	1.5377	0.8569	21.0772	21.9009	23.5780	22.1906
510053	1.0938	0.7635	22.3318	21.5338	22.6278	22.1640
510055	1.5578	0.9107	28.4615	29.4111	30.7366	29.5844
510058	1.3382	0.8028	23.9015	25.3248	24.8750	24.7020
510059	***	*	22.1435	20.8847	21.9025	21.6378
510062	1.2241	0.8398	26.2296	26.7066	27.7962	26.9089
510067	1.0951	0.7635	25.0437	25.2130	25.2231	25.1585
510070	1.2034	0.8398	23.5639	23.9742	25.4968	24.3383
510071	1.2818	0.7795	23.4508	23.2954	23.4542	23.4003
510072	1.0733	0.7635	20.5146	19.4370	20.2379	20.0443
510077	1.0382	0.8748	24.5010	25.9515	27.1603	25.8349
510082	1.1006	0.7635	19.9081	20.3279	21.1654	20.4929
510085	1.2021	0.8398	26.3877	26.2617	26.8122	26.4911
510086	1.0879	0.7635	19.8735	19.2606	20.1963	19.7687
510090	***	*	*	*	39.0764	39.0764
520002	1.3026	0.9823	27.7705	29.0501	31.9053	29.6240
520004	1.4018	0.9796	27.6530	28.9857	30.9192	29.2469
520008	1.5695	1.0182	30.7553	33.8057	33.6749	32.7716
520009	1.6546	0.9511	27.4044	28.8591	29.6272	28.6360
520011	1.2826	0.9511	26.6268	28.0224	29.5006	28.0213
520013	1.4977	1.0976	29.0018	30.1834	32.1701	30.5206
520017	1.1201	0.9599	28.4699	29.3278	31.0517	29.6386
520019	1.3503	0.9511	28.6971	29.8640	30.2175	29.6442
520021	1.3207	1.0315	28.4182	29.1129	29.7788	29.1139
520027	1.4430	1.0182	31.4284	32.4137	33.5809	32.5077
520028	1.3966	1.1014	26.7260	28.0813	29.4683	28.3047
520030	1.6874	0.9823	29.4678	30.5724	31.6785	30.5738
520033	1.2248	0.9511	28.0662	29.0236	30.2616	29.1742
520034	1.2622	0.9511	26.1094	26.8886	28.1800	27.0611
520035	1.3586	0.9587	27.3276	28.1048	29.4053	28.2938
520037	1.7405	0.9823	30.1799	32.2144	31.6795	31.3757
520038	1.2048	1.0182	29.3134	29.6339	30.5249	29.8341
520040	***	*	29.1262	31.2038	35.9633	32.0420
520041	1.0813	1.1232	23.5495	25.3764	26.1572	25.0721
520044	1.3626	0.9587	27.3685	28.2382	28.6601	28.1191
520045	1.5915	0.9511	27.3336	29.2556	30.0840	28.8905
520048	1.5102	0.9511	26.8080	29.1870	30.1468	28.5889
520049	2.0434	0.9511	26.9851	28.0936	29.4223	28.1983
520051	1.5346	1.0182	31.9949	31.5974	32.4111	32.0738
520057	1.1885	0.9704	27.7528	29.1158	31.3292	29.4114
520059	1.3571	1.0026	29.5801	30.4491	31.1783	30.4093
520060	***	*	24.8638	*	*	24.8638
520062	1.3331	1.0182	28.8510	32.8584	32.6992	31.5738
520063	1.1678	1.0182	29.0993	30.3391	31.5185	30.3770
520064	1.5219	1.0182	30.3225	31.5723	33.1248	31.5779
520066	1.4182	0.9824	29.2088	31.0644	31.6673	30.6304
520070	1.6950	0.9599	27.6771	28.2059	30.0451	28.7359
520071	1.2135	1.0026	30.0262	30.6930	31.5435	30.8053
520075	1.6946	0.9511	29.2920	30.1582	32.2755	30.5484
520076	1.2239	1.1014	27.3335	27.4423	26.8932	27.2252
520078	1.4666	1.0182	29.9837	31.6606	32.0179	31.1768
520083	1.7215	1.1232	30.8826	32.7728	34.7200	32.8276
520087	1.7126	0.9796	28.5810	30.5659	31.9747	30.3890
520088	1.3463	0.9523	30.7450	30.6657	30.7462	30.7187
520089	1.5744	1.1232	33.8793	33.4098	34.9331	34.0808
520091	1.2752	0.9511	25.4593	27.3442	28.7166	27.1741
520095	1.2282	0.9704	30.4216	32.0381	33.2399	31.9187
520096	1.3683	1.0026	27.8896	29.5985	28.5204	28.6435
520097	1.3252	0.9511	29.1479	29.9998	31.0204	30.0765
520098	2.0129	1.1232	32.5785	36.5776	38.0962	35.8078
520100	1.3329	0.9824	29.3243	29.9458	31.7748	30.3552
520102	1.1961	1.0026	29.1680	30.7990	31.5735	30.5379
520103	1.5575	1.0182	30.3165	32.6269	34.5620	32.5629

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2007; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2009; HOSPITAL AVERAGE HOURLY WAGES FOR FEDERAL FISCAL YEARS 2007 (2003 WAGE DATA), 2008 (2004 WAGE DATA) AND 2009 (2005 WAGE DATA); AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Case-mix index [2]	FY 2009 wage index	Average hourly wage FY 2007	Average hourly wage FY 2008	Average hourly wage FY 2009 [1]	Average hourly wage** (3 years)
520107	1.3439	0.9523	28.9878	29.4178	30.0343	29.4887
520109	1.0451	0.9511	24.7228	25.0697	25.9723	25.2667
520113	1.2659	0.9511	31.4708	33.3475	33.3023	32.7086
520116	1.2564	1.0026	27.9688	30.2156	31.6687	29.9794
520132	***	*	25.0006	27.3431	*	26.0481
520136	1.6351	1.0182	30.6522	32.1479	32.3480	31.6992
520138	1.8898	1.0182	30.8016	31.6581	32.5653	31.6762
520139	1.3351	1.0182	28.8870	30.4903	31.7060	30.3322
520140	***	*	31.0043	31.1315	*	31.0699
520152	***	*	29.7308	*	*	29.7308
520160	1.7768	0.9511	27.9548	29.5582	30.3037	29.2715
520170	1.4785	1.0182	30.4309	31.4710	31.7586	31.2272
520173	1.0888	*	29.2429	31.0599	*	30.1478
520177	1.5992	1.0182	31.4555	32.5714	33.1218	32.4064
520189	1.1684	1.0315	28.0014	29.0295	29.2212	28.7600
520193	1.7185	0.9511	27.8113	29.2007	29.4715	28.8651
520194	1.5801	1.0182	30.1668	31.4379	30.9993	30.8959
520195	0.6565	1.0182	36.3116	36.2900	41.6044	37.9667
520196	1.7736	0.9599	36.9266	31.1175	31.6125	32.7571
520197	***	*	*	30.1917	*	30.1917
520198	1.3572	0.9511	*	28.5975	29.9781	29.2918
520199	2.0438	1.0182	*	36.5699	37.0103	36.7943
520202	1.6509	0.9823	*	*	*	*
520203	2.9989	1.1232	*	*	*	*
530002	1.1984	0.9223	28.3063	29.2069	29.2407	28.9305
530006	1.2359	0.9223	27.2421	29.2104	30.3704	28.9041
530008	1.1650	0.9223	24.0090	26.5180	30.5992	27.0161
530009	0.9602	0.9223	24.6719	26.0490	27.0529	25.9191
530010	1.2145	0.9223	25.9852	27.4121	28.5518	27.3468
530011	1.1265	0.9223	27.8772	27.8613	31.1309	28.8654
530012	1.7040	0.9618	26.9582	28.7524	30.6085	28.7888
530014	1.5582	0.9611	26.7156	28.5469	29.6709	28.4442
530015	1.1779	0.9327	29.8310	29.8306	33.4886	31.0902
530017	0.9134	0.9223	29.8503	31.1105	25.8172	28.8536
530025	1.2876	0.9223	24.4392	29.4346	28.8951	27.4712
530032	1.0528	0.9223	23.9004	24.6580	25.4254	24.6844

[1] Based on salaries adjusted for occupational mix, according to the calculation in section III.D.2. of the preamble to this proposed rule.
[2] The case-mix index is based on the billed DRGs in the FY 2007 MedPAR file. It is not transfer adjusted.
[3] Provider 140010 is part of a multicampus provider (MCH) that is comprised of campuses that are located in two different CBSAs. The provider number with a "B" in the 4th position, 140B10, indicates the portion of the wage and hours of the MCH that is allocated to CBSA 29404; provider number 140010 indicates the portion of wages and hours of the MCH that is allocated to CBSA 16974.
[4] Provider 220074 is part of a multicampus provider (MCH) that is comprised of campuses that are located in two different CBSAs. The provider number with a "B" in the 4th position, 220B74, indicates the portion of the wage and hours of the MCH that is allocated to CBSA 14484; provider number 220074 indicates the portion of wages and hours of the MCH that is allocated to CBSA 39300.
[5] Provider 230104 is part of a multicampus provider (MCH) that is comprised of campuses that are located in two different CBSAs. The provider number with a "B" in the 4th position, 230B04, indicates the portion of the wage and hours of the MCH that is allocated to CBSA 47644; provider number 230104 indicates the portion of wages and hours of the MCH that is allocated to CBSA 19804.
*Denotes wage data not available for the provider for that year.
**Based on the sum of the salaries and hours computed for Federal FYs 2007, 2008, and 2009.
***Denotes MedPAR data not available for the provider for FY 2007.

TABLE 3A.—FY 2009 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS BY CBSA

[*Based on the salaries and hours computed for Federal FYs 2007, 2008, and 2009]

CBSA code	Urban area	FY 2009 average hourly wage	3-Year average hourly wage
10180	Abilene, TX	27.1004	25.7723
10380	Aguadilla-Isabela-San Sebastián, PR	10.6709	10.7622
10420	Akron, OH	28.3319	26.9292
10500	Albany, GA	28.2617	27.2184
10580	Albany-Schenectady-Troy, NY	28.4655	27.2227
10740	Albuquerque, NM	30.6500	29.7201
10780	Alexandria, LA	26.1655	24.7913
10900	Allentown-Bethlehem-Easton, PA-NJ	31.2097	30.7425
11020	Altoona, PA	26.7060	25.9824

TABLE 3A.—FY 2009 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS BY CBSA—Continued

[*Based on the salaries and hours computed for Federal FYs 2007, 2008, and 2009]

CBSA code	Urban area	FY 2009 average hourly wage	3-Year average hourly wage
11100	Amarillo, TX	29.0008	28.2619
11180	Ames, IA	30.4757	30.0901
11260	Anchorage, AK	38.0798	36.6236
11300	Anderson, IN	28.7750	27.5948
11340	Anderson, SC	31.3772	28.7401
11460	Ann Arbor, MI	33.6572	32.6579
11500	Anniston-Oxford, AL	25.8029	24.6804
11540	Appleton, WI	30.0406	29.0241
11700	Asheville, NC	29.6273	28.5517
12020	Athens-Clarke County, GA	30.9008	29.8591
12060	Atlanta-Sandy Springs-Marietta, GA	31.4502	30.3269
12100	Atlantic City-Hammonton, NJ	38.0743	36.7794
12220	Auburn-Opelika, AL	24.3605	24.4407
12260	Augusta-Richmond County, GA-SC	30.9498	29.7603
12420	Austin-Round Rock, TX	30.6888	29.3079
12540	Bakersfield, CA	36.5786	34.6045
12580	Baltimore-Towson, MD	32.1655	30.9372
12620	Bangor, ME	32.5961	30.6397
12700	Barnstable Town, MA	40.8356	39.1326
12940	Baton Rouge, LA	26.2494	25.0384
12980	Battle Creek, MI	32.3508	30.7409
13020	Bay City, MI	30.3060	28.7057
13140	Beaumont-Port Arthur, TX	27.7045	26.7778
13380	Bellingham, WA	36.7964	34.7347
13460	Bend, OR	35.6036	33.2554
13644	Bethesda-Frederick-Gaithersburg, MD	33.9508	32.8571
13740	Billings, MT	29.1465	27.7805
13780	Binghamton, NY	28.1030	27.6136
13820	Birmingham-Hoover, AL	28.3138	27.3821
13900	Bismarck, ND	23.2350	22.4949
13980	Blacksburg-Christiansburg-Radford, VA	26.1759	25.2599
14020	Bloomington, IN	30.3742	28.6837
14060	Bloomington-Normal, IL	30.6807	29.0683
14260	Boise City-Nampa, ID	29.9365	29.1371
14484	Boston-Quincy, MA	38.6504	36.7387
14500	Boulder, CO	32.3079	31.3052
14540	Bowling Green, KY	26.8895	25.3106
14600	Bradenton-Sarasota-Venice, FL	31.5095	30.2345
14740	Bremerton-Silverdale, WA	34.5710	33.5071
14860	Bridgeport-Stamford-Norwalk, CT	42.0944	39.8678
15180	Brownsville-Harlingen, TX	29.7382	29.0319
15260	Brunswick, GA	32.6731	31.3350
15380	Buffalo-Niagara Falls, NY	30.9123	29.5833
15500	Burlington, NC	27.7660	26.6186
15540	Burlington-South Burlington, VT	29.6973	29.1460
15764	Cambridge-Newton-Framingham, MA	35.6990	34.3809
15804	Camden, NJ	34.1250	32.6476
15940	Canton-Massillon, OH	28.5297	27.6782
15980	Cape Coral-Fort Myers, FL	30.6869	29.4302
16180	Carson City, NV	32.3122	30.2124
16220	Casper, WY	30.6085	28.7888
16300	Cedar Rapids, IA	28.3050	27.0341
16580	Champaign-Urbana, IL	30.1432	29.1751
16620	Charleston, WV	27.1192	26.3071
16700	Charleston-North Charleston-Summerville, SC	29.7955	28.4097
16740	Charlotte-Gastonia-Concord, NC-SC	30.8456	29.4515
16820	Charlottesville, VA	31.3517	29.8273
16860	Chattanooga, TN-GA	28.6158	27.6439
16940	Cheyenne, WY	29.6709	28.4442
16974	Chicago-Naperville-Joliet, IL	33.3033	32.5973
17020	Chico, CA	35.0695	34.2761
17140	Cincinnati-Middletown, OH-KY-IN	30.9027	29.7285
17300	Clarksville, TN-KY	26.7544	25.7478
17420	Cleveland, TN	26.2909	25.3790
17460	Cleveland-Elyria-Mentor, OH	29.8896	28.9336
17660	Coeur d'Alene, ID	29.5998	28.7256
17780	College Station-Bryan, TX	29.6321	28.1756
17820	Colorado Springs, CO	31.4793	29.6470
17860	Columbia, MO	27.2133	26.2863

TABLE 3A.—FY 2009 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS BY CBSA—Continued

[*Based on the salaries and hours computed for Federal FYs 2007, 2008, and 2009]

CBSA code	Urban area	FY 2009 average hourly wage	3-Year average hourly wage
17900	Columbia, SC	28.9948	27.6672
17980	Columbus, GA-AL	29.2007	27.4844
18020	Columbus, IN	31.7711	29.8902
18140	Columbus, OH	31.8334	30.9635
18580	Corpus Christi, TX	27.3797	26.2260
18700	Corvallis, OR	35.7074	34.1739
19060	Cumberland, MD-WV	24.2686	24.3744
19124	Dallas-Plano-Irving, TX	31.7539	30.5827
19140	Dalton, GA	27.3868	26.8521
19180	Danville, IL	31.2955	29.5310
19260	Danville, VA	27.3411	26.0795
19340	Davenport-Moline-Rock Island, IA-IL	27.2010	26.8964
19380	Dayton, OH	30.0672	28.7100
19460	Decatur, AL	24.8584	24.2893
19500	Decatur, IL	26.3336	25.3091
19660	Deltona-Daytona Beach-Ormond Beach, FL	28.4632	27.8441
19740	Denver-Aurora, CO	34.1438	32.7970
19780	Des Moines-West Des Moines, IA	30.6173	28.7458
19804	Detroit-Livonia-Dearborn, MI	32.3846	31.4605
20020	Dothan, AL	24.8722	23.3546
20100	Dover, DE	34.3823	32.3013
20220	Dubuque, IA	26.5562	26.9190
20260	Duluth, MN-WI	33.8981	31.7842
20500	Durham, NC	31.2419	30.0944
20740	Eau Claire, WI	30.9902	29.6325
20764	Edison-New Brunswick, NJ	36.1487	34.5118
20940	El Centro, CA	29.1074	28.1129
21060	Elizabethtown, KY	27.2829	26.5352
21140	Elkhart-Goshen, IN	30.6988	29.4323
21300	Elmira, NY	26.8991	25.8564
21340	El Paso, TX	28.5812	28.1095
21500	Erie, PA	28.0896	26.9188
21660	Eugene-Springfield, OR	35.9675	34.2186
21780	Evansville, IN-KY	27.4904	26.7119
21820	Fairbanks, AK	36.1891	34.2975
21940	Fajardo, PR	13.1075	12.8846
22020	Fargo, ND-MN	26.0887	24.9864
22140	Farmington, NM	25.2152	26.1577
22180	Fayetteville, NC	31.9846	30.2233
22220	Fayetteville-Springdale-Rogers, AR-MO	29.4256	27.9239
22380	Flagstaff, AZ	37.5481	35.8798
22420	Flint, MI	36.2781	34.1503
22500	Florence, SC	27.3900	26.5639
22520	Florence-Muscle Shoals, AL	25.2619	24.0763
22540	Fond du Lac, WI	30.7462	30.7188
22660	Fort Collins-Loveland, CO	30.8219	29.2764
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL	31.6349	30.8485
22900	Fort Smith, AR-OK	25.2751	24.4937
23020	Fort Walton Beach-Crestview-Destin, FL	28.1059	26.8450
23060	Fort Wayne, IN	28.8955	28.1729
23104	Fort Worth-Arlington, TX	31.2137	29.8330
23420	Fresno, CA	35.7716	34.2816
23460	Gadsden, AL	25.7517	24.9688
23540	Gainesville, FL	30.4476	29.0940
23580	Gainesville, GA	30.0367	28.8932
23844	Gary, IN	30.0576	28.8628
24020	Glens Falls, NY	28.2938	26.8175
24140	Goldsboro, NC	29.5207	28.5197
24220	Grand Forks, ND-MN	24.9880	24.4055
24300	Grand Junction, CO	31.2200	29.9879
24340	Grand Rapids-Wyoming, MI	29.9037	29.1399
24500	Great Falls, MT	27.9340	26.5446
24540	Greeley, CO	32.4200	30.9988
24580	Green Bay, WI	30.6825	29.5078
24660	Greensboro-High Point, NC	29.4639	28.1363
24780	Greenville, NC	30.1256	28.8796
24860	Greenville-Mauldin-Easley, SC	31.0004	29.7649
25020	Guayama, PR	10.1106	09.6176
25060	Gulfport-Biloxi, MS	28.6731	27.0856

TABLE 3A.—FY 2009 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS BY CBSA—Continued

[*Based on the salaries and hours computed for Federal FYs 2007, 2008, and 2009]

CBSA code	Urban area	FY 2009 average hourly wage	3-Year average hourly wage
25180	Hagerstown-Martinsburg, MD-WV	29.8828	28.7638
25260	Hanford-Corcoran, CA	35.7293	33.4052
25420	Harrisburg-Carlisle, PA	29.4620	28.6481
25500	Harrisonburg, VA	28.8643	27.8908
25540	Hartford-West Hartford-East Hartford, CT	36.0188	34.1981
25620	Hattiesburg, MS	24.2839	23.4139
25860	Hickory-Lenoir-Morganton, NC	28.8353	27.7789
25980	[1] Hinesville-Fort Stewart, GA.		
26100	Holland-Grand Haven, MI	29.3296	28.2605
26180	Honolulu, HI	37.4061	34.9722
26300	Hot Springs, AR	29.4741	27.9457
26380	Houma-Bayou Cane-Thibodaux, LA	25.3740	24.7942
26420	Houston-Sugar Land-Baytown, TX	31.9906	30.9869
26580	Huntington-Ashland, WV-KY-OH	29.4107	27.7644
26620	Huntsville, AL	28.9607	27.8624
26820	Idaho Falls, ID	29.3359	28.2699
26900	Indianapolis-Carmel, IN	31.6890	30.3105
26980	Iowa City, IA	30.2168	29.3116
27060	Ithaca, NY	30.8103	29.9028
27100	Jackson, MI	30.5399	29.5811
27140	Jackson, MS	25.9122	24.9687
27180	Jackson, TN	27.3080	26.6865
27260	Jacksonville, FL	29.3541	28.3904
27340	Jacksonville, NC	27.0573	25.9214
27500	Janesville, WI	31.7184	30.5036
27620	Jefferson City, MO	29.1505	27.2519
27740	Johnson City, TN	25.8452	24.5939
27780	Johnstown, PA	25.9505	24.9881
27860	Jonesboro, AR	26.0204	24.6491
27900	Joplin, MO	31.3014	28.6510
28020	Kalamazoo-Portage, MI	35.1589	33.2912
28100	Kankakee-Bradley, IL	38.7329	33.0300
28140	Kansas City, MO-KS	30.4624	29.0579
28420	Kennewick-Pasco-Richland, WA	31.3630	30.6561
28660	Killeen-Temple-Fort Hood, TX	28.5417	26.9557
28700	Kingsport-Bristol-Bristol, TN-VA	25.3719	24.5154
28740	Kingston, NY	30.3965	29.3492
28940	Knoxville, TN	25.4214	24.8943
29020	Kokomo, IN	29.8433	29.2845
29100	La Crosse, WI-MN	31.6291	30.0294
29140	Lafayette, IN	28.8946	27.2885
29180	Lafayette, LA	27.2063	25.9638
29340	Lake Charles, LA	24.4720	24.0434
29404	Lake County-Kenosha County, IL-WI	33.4390	32.6639
29420	Lake Havasu City-Kingman, AZ	31.6370	29.6383
29460	Lakeland-Winter Haven, FL	28.1459	27.5004
29540	Lancaster, PA	31.0576	30.0449
29620	Lansing-East Lansing, MI	31.9010	30.9914
29700	Laredo, TX	28.4147	26.3095
29740	Las Cruces, NM	28.3851	27.2925
29820	Las Vegas-Paradise, NV	37.5945	35.4889
29940	Lawrence, KS	26.8014	25.6444
30020	Lawton, OK	27.8148	26.3376
30140	Lebanon, PA	29.0022	26.8307
30300	Lewiston, ID-WA	29.8774	29.0074
30340	Lewiston-Auburn, ME	30.0517	28.7720
30460	Lexington-Fayette, KY	28.8431	27.8163
30620	Lima, OH	29.9606	28.3617
30700	Lincoln, NE	31.0009	30.3915
30780	Little Rock-North Little Rock-Conway, AR	28.2114	28.2530
30860	Logan, UT-ID	28.3537	27.8958
30980	Longview, TX	27.3041	26.9355
31020	Longview, WA	36.9240	33.8434
31084	Los Angeles-Long Beach-Glendale, CA	38.9626	36.6108
31140	Louisville-Jefferson County, KY-IN	29.7925	28.3269
31180	Lubbock, TX	28.0803	26.7835
31340	Lynchburg, VA	27.7933	26.6660
31420	Macon, GA	31.6291	30.3409
31460	Madera, CA	26.7719	26.0576

TABLE 3A.—FY 2009 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS BY CBSA—Continued

[*Based on the salaries and hours computed for Federal FYs 2007, 2008, and 2009]

CBSA code	Urban area	FY 2009 average hourly wage	3-Year average hourly wage
31540	Madison, WI	36.2618	34.3945
31700	Manchester-Nashua, NH	33.0542	31.4821
31900	Mansfield, OH	29.9812	28.5726
32420	Mayagüez, PR	12.5555	11.7170
32580	McAllen-Edinburg-Mission, TX	29.3886	27.9884
32780	Medford, OR	33.0786	32.3223
32820	Memphis, TN-MS-AR	30.0626	28.8798
32900	Merced, CA	39.1381	36.7035
33124	Miami-Miami Beach-Kendall, FL	31.8599	30.6911
33140	Michigan City-La Porte, IN	29.1570	27.7380
33260	Midland, TX	30.8197	29.6993
33340	Milwaukee-Waukesha-West Allis, WI	32.8741	31.8085
33460	Minneapolis-St. Paul-Bloomington, MN-WI	35.4391	33.7580
33540	Missoula, MT	28.2291	26.9683
33660	Mobile, AL	25.1640	24.3569
33700	Modesto, CA	39.1156	36.9865
33740	Monroe, LA	25.6673	24.6843
33780	Monroe, MI	28.7386	29.0350
33860	Montgomery, AL	26.3999	25.1056
34060	Morgantown, WV	27.8745	26.4870
34100	Morristown, TN	23.5598	23.4073
34580	Mount Vernon-Anacortes, WA	32.2055	31.3429
34620	Muncie, IN	26.7339	25.4260
34740	Muskegon-Norton Shores, MI	32.9571	31.3172
34820	Myrtle Beach-North Myrtle Beach-Conway, SC	28.0263	27.0772
34900	Napa, CA	45.2771	42.3405
34940	Naples-Marco Island, FL	31.7163	30.5323
34980	Nashville-Davidson-Murfreesboro-Franklin, TN	30.5185	29.8356
35004	Nassau-Suffolk, NY	41.0210	39.8184
35084	Newark-Union, NJ-PA	37.3360	36.1271
35300	New Haven-Milford, CT	38.1842	37.0168
35380	New Orleans-Metairie-Kenner, LA	29.4715	27.1340
35644	New York-White Plains-Wayne, NY-NJ	42.0303	40.8866
35660	Niles-Benton Harbor, MI	29.3085	28.0264
35980	Norwich-New London, CT	36.8468	36.0398
36084	Oakland-Fremont-Hayward, CA	49.9560	47.7941
36100	Ocala, FL	27.4049	26.5357
36140	Ocean City, NJ	37.4820	34.3008
36220	Odessa, TX	30.3782	30.3247
36260	Ogden-Clearfield, UT	29.7855	28.2615
36420	Oklahoma City, OK	27.9928	27.1135
36500	Olympia, WA	37.0153	34.9710
36540	Omaha-Council Bluffs, NE-IA	30.2913	29.2081
36740	Orlando-Kissimmee, FL	29.6766	28.9783
36780	Oshkosh-Neenah, WI	30.0761	28.8544
36980	Owensboro, KY	28.2413	27.1328
37100	Oxnard-Thousand Oaks-Ventura, CA	36.9286	35.1055
37340	Palm Bay-Melbourne-Titusville, FL	30.3622	29.2690
37380	[2] Palm Coast, FL	28.3179	27.7197
37460	Panama City-Lynn Haven, FL	27.4719	25.9842
37620	Parkersburg-Marietta-Vienna, WV-OH	25.9281	25.2122
37700	Pascagoula, MS	25.8776	25.5012
37764	Peabody, MA	34.6216	32.8179
37860	Pensacola-Ferry Pass-Brent, FL	26.1506	24.9081
37900	Peoria, IL	29.1439	28.4392
37964	Philadelphia, PA	35.4610	33.9583
38060	Phoenix-Mesa-Scottsdale, AZ	33.0972	31.5810
38220	Pine Bluff, AR	26.6629	25.9270
38300	Pittsburgh, PA	27.6753	26.3759
38340	Pittsfield, MA	33.6590	31.7762
38540	Pocatello, ID	29.3360	28.3737
38660	Ponce, PR	13.2835	13.4725
38860	Portland-South Portland-Biddeford, ME	31.9890	30.7480
38900	Portland-Vancouver-Beaverton, OR-WA	36.1216	34.7569
38940	Port St. Lucie, FL	31.9898	30.8026
39100	Poughkeepsie-Newburgh-Middletown, NY	35.2679	33.9878
39140	Prescott, AZ	32.8634	30.9614
39300	Providence-New Bedford-Fall River, RI-MA	34.3817	33.0490
39340	Provo-Orem, UT	29.1600	28.8274

TABLE 3A.—FY 2009 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS BY CBSA—Continued

[*Based on the salaries and hours computed for Federal FYs 2007, 2008, and 2009]

CBSA code	Urban area	FY 2009 average hourly wage	3-Year average hourly wage
39380	Pueblo, CO	27.8188	26.8684
39460	Punta Gorda, FL	29.9874	29.4798
39540	Racine, WI	28.8930	28.8892
39580	Raleigh-Cary, NC	31.2156	30.0484
39660	Rapid City, SD	30.6204	27.7643
39740	Reading, PA	30.0875	29.3819
39820	Redding, CA	41.6249	39.4241
39900	Reno-Sparks, NV	33.7604	34.6330
40060	Richmond, VA	29.6609	28.3807
40140	Riverside-San Bernardino-Ontario, CA	36.2653	34.0181
40220	Roanoke, VA	28.6468	27.4630
40340	Rochester, MN	35.3899	33.7865
40380	Rochester, NY	28.7144	27.8099
40420	Rockford, IL	31.7824	30.6686
40484	Rockingham County-Strafford County, NH	31.9359	31.0988
40580	Rocky Mount, NC	29.2288	27.8751
40660	Rome, GA	31.2559	29.9017
40900	Sacramento-Arden-Arcade-Roseville, CA	41.9426	40.3835
40980	Saginaw-Saginaw Township North, MI	29.1128	28.2485
41060	St. Cloud, MN	37.2177	34.8308
41100	St. George, UT	29.7373	29.2069
41140	St. Joseph, MO-KS	33.7767	30.5981
41180	St. Louis, MO-IL	28.9842	27.8523
41420	Salem, OR	34.3369	32.4058
41500	Salinas, CA	47.9744	45.4050
41540	Salisbury, MD	29.6266	27.8982
41620	Salt Lake City, UT	29.8767	29.1422
41660	San Angelo, TX	27.7212	26.5502
41700	San Antonio, TX	28.8457	27.6665
41740	San Diego-Carlsbad-San Marcos, CA	36.2686	34.6834
41780	Sandusky, OH	28.4754	27.6992
41884	San Francisco-San Mateo-Redwood City, CA	48.5597	46.7826
41900	San Germán-Cabo Rojo, PR	14.9779	14.5348
41940	San Jose-Sunnyvale-Santa Clara, CA	51.2569	48.2592
41980	San Juan-Caguas-Guaynabo, PR	14.1930	13.8050
42020	San Luis Obispo-Paso Robles, CA	38.5623	36.3112
42044	Santa Ana-Anaheim-Irvine, CA	38.1247	35.9846
42060	Santa Barbara-Santa Maria-Goleta, CA	37.7124	35.1162
42100	Santa Cruz-Watsonville, CA	51.5525	48.3881
42140	Santa Fe, NM	34.1580	33.1619
42220	Santa Rosa-Petaluma, CA	49.2189	45.6081
42340	Savannah, GA	28.8176	27.8424
42540	Scranton-Wilkes-Barre, PA	26.5201	25.6648
42644	Seattle-Bellevue-Everett, WA	37.3352	35.3387
42680	Sebastian-Vero Beach, FL	30.7417	30.0442
43100	Sheboygan, WI	29.1159	28.0863
43300	Sherman-Denison, TX	29.9470	27.3065
43340	Shreveport-Bossier City, LA	27.5578	26.7863
43580	Sioux City, IA-NE-SD	28.3024	27.7781
43620	Sioux Falls, SD	30.2235	29.2197
43780	South Bend-Mishawaka, IN-MI	31.0993	30.1358
43900	Spartanburg, SC	29.1025	28.3525
44060	Spokane, WA	33.9523	32.3332
44100	Springfield, IL	29.4330	27.9091
44140	Springfield, MA	33.3312	31.8950
44180	Springfield, MO	27.3178	26.6919
44220	Springfield, OH	27.8315	26.5028
44300	State College, PA	28.4188	27.0040
44700	Stockton, CA	38.6087	36.4711
44940	Sumter, SC	27.6406	26.7218
45060	Syracuse, NY	31.7909	30.5763
45104	Tacoma, WA	35.9647	33.8969
45220	Tallahassee, FL	29.0061	27.8746
45300	Tampa-St. Petersburg-Clearwater, FL	28.9032	28.1723
45460	Terre Haute, IN	29.4437	27.6736
45500	Texarkana, TX-Texarkana, AR	26.4165	24.8363
45780	Toledo, OH	29.8934	28.9126
45820	Topeka, KS	28.5929	27.0599
45940	Trenton-Ewing, NJ	34.3697	33.3207

TABLE 3A.—FY 2009 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS BY CBSA—Continued

[*Based on the salaries and hours computed for Federal FYs 2007, 2008, and 2009]

CBSA code	Urban area	FY 2009 average hourly wage	3-Year average hourly wage
46060	Tucson, AZ	30.4264	29.2232
46140	Tulsa, OK	27.8831	26.3265
46220	Tuscaloosa, AL	28.0199	26.8295
46340	Tyler, TX	28.6912	27.8517
46540	Utica-Rome, NY	28.1040	27.1057
46660	Valdosta, GA	26.3052	25.6427
46700	Vallejo-Fairfield, CA	45.6926	44.8127
47020	Victoria, TX	25.6787	25.2869
47220	Vineland-Millville-Bridgeton, NJ	35.2379	33.0201
47260	Virginia Beach-Norfolk-Newport News, VA-NC	28.5838	27.2923
47300	Visalia-Porterville, CA	33.2020	31.5996
47380	Waco, TX	28.0515	26.9091
47580	Warner Robins, GA	30.5824	28.8902
47644	Warren-Troy-Farmington Hills, MI	32.1363	31.0932
47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	34.3840	33.3639
47940	Waterloo-Cedar Falls, IA	28.0510	26.9028
48140	Wausau, WI	31.6785	30.5738
48260	Weirton-Steubenville, WV-OH	25.8721	24.7386
48300	Wenatchee, WA	30.3614	31.9688
48424	West Palm Beach-Boca Raton-Boynton Beach, FL	31.1027	29.7030
48540	Wheeling, WV-OH	22.6472	21.8074
48620	Wichita, KS	28.9395	27.7964
48660	Wichita Falls, TX	29.5744	26.8201
48700	Williamsport, PA	25.8784	24.8306
48864	Wilmington, DE-MD-NJ	34.0940	32.8588
48900	Wilmington, NC	29.1370	29.0123
49020	Winchester, VA-WV	31.4889	30.6457
49180	Winston-Salem, NC	29.0508	28.2246
49340	Worcester, MA	35.2688	34.2006
49420	Yakima, WA	32.0317	30.9552
49500	Yauco, PR	10.8210	10.6067
49620	York-Hanover, PA	31.1804	29.5691
49660	Youngstown-Warren-Boardman, OH-PA	28.8065	27.5854
49700	Yuba City, CA	34.7445	32.8688
49740	Yuma, AZ	31.9135	30.1305

[1] This area has no average hourly wage because there are no short-term, acute care hospitals in the area.

[2] This is a new CBSA for FY 2008. To calculate the 3-year average hourly wage for this new area, we included the hospitals' data from their previous geographic location for FY 2006 and FY 2007.

TABLE 3B.—FY 2009 AND 3-YEAR* AVERAGE HOURLY WAGE FOR RURAL AREAS BY CBSA

[*Based on the sum of the salaries and hours computed for Federal FYs 2007, 2008, and 2009]

CBSA code	Nonurban area	FY 2009 average hourly wage	3-Year average hourly wage
01	Alabama	24.6411	23.6242
02	Alaska	38.4008	35.4138
03	Arizona	28.5407	27.4573
04	Arkansas	24.6204	23.3335
05	California	38.6569	35.9246
06	Colorado	30.0754	28.7842
07	Connecticut	36.4301	35.6330
08	Delaware	32.6029	30.8226
10	Florida	27.8797	26.8062
11	Georgia	25.2642	24.2873
12	Hawaii	36.0283	33.6508
13	Idaho	24.4380	24.1641
14	Illinois	27.1642	25.9705
15	Indiana	27.3432	26.4475
16	Iowa	28.1850	26.6791
17	Kansas	25.9806	24.8089
18	Kentucky	25.2536	24.2249
19	Louisiana	24.7667	23.6881
20	Maine	27.7429	26.2711
21	Maryland	28.3407	27.4609
22	Massachusetts		
23	Michigan	28.5656	27.6632

TABLE 3B.—FY 2009 AND 3-YEAR* AVERAGE HOURLY WAGE FOR RURAL AREAS BY CBSA—Continued

[*Based on the sum of the salaries and hours computed for Federal FYs 2007, 2008, and 2009]

CBSA code	Nonurban area	FY 2009 average hourly wage	3-Year average hourly wage
24	Minnesota	29.3894	28.3126
25	Mississippi	24.6569	23.9273
26	Missouri	26.3804	25.2174
27	Montana	27.8425	26.4700
28	Nebraska	28.0119	26.9486
29	Nevada	31.6580	29.6483
30	New Hampshire	33.2526	32.8237
31	New Jersey [1]		
32	New Mexico	28.5810	27.1089
33	New York	26.7717	25.8110
34	North Carolina	27.8184	26.7060
35	North Dakota	23.7299	22.7358
36	Ohio	27.6801	26.8138
37	Oklahoma	25.8341	24.3148
38	Oregon	33.1220	30.9016
39	Pennsylvania	26.9119	25.8178
40	Puerto Rico [1]		
41	Rhode Island [1]		
42	South Carolina	27.7889	26.8744
43	South Dakota	27.1581	25.8858
44	Tennessee	25.6634	24.6486
45	Texas	26.2796	25.3601
46	Utah	27.0526	25.6723
47	Vermont	32.0308	30.2935
49	Virginia	25.9700	24.9967
50	Washington	32.6127	31.5030
51	West Virginia	24.6596	23.6988
52	Wisconsin	30.7058	29.7224
53	Wyoming	29.7219	28.3175

[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 AND BY STATE—FY 2009

[Constituent counties are listed in Table 4E.]

CBSA Code	Urban area	State	Wage index	GAF
10180	Abilene, TX	TX	0.8408	0.8880
10380	Aguadilla-Isabela-San Sebastián, PR	PR	0.3311	0.4691
10420	Akron, OH	OH	0.8784	0.9150
10500	Albany, GA	GA	0.8770	0.9140
10580	Albany-Schenectady-Troy, NY	NY	0.8833	0.9185
10740	Albuquerque, NM	NM	0.9499	0.9654
10780	Alexandria, LA	LA	0.8127	0.8676
10900	Allentown-Bethlehem-Easton, PA-NJ	NJ	1.1221	1.0821
10900	Allentown-Bethlehem-Easton, PA-NJ	PA	0.9675	0.9776
11020	Altoona, PA	PA	0.8342	0.8833
11100	Amarillo, TX	TX	0.8997	0.9302
11180	Ames, IA	IA	0.9417	0.9597
11260	Anchorage, AK	AK	1.1884	1.1255
11300	Anderson, IN	IN	0.8923	0.9249
11340	Anderson, SC	SC	0.9721	0.9808
11460	Ann Arbor, MI	MI	1.0444	1.0302
11500	Anniston-Oxford, AL	AL	0.8007	0.8588
11540	Appleton, WI	WI	0.9511	0.9662
11700	Asheville, NC	NC	0.9192	0.9439
12020	Athens-Clarke County, GA	GA	0.9589	0.9717
12060	Atlanta-Sandy Springs-Marietta, GA	GA	0.9760	0.9835
12100	Atlantic City-Hammonton, NJ	NJ	1.1666	1.1113
12220	Auburn-Opelika, AL	AL	0.7647	0.8322
12260	Augusta-Richmond County, GA-SC	GA	0.9604	0.9727
12260	Augusta-Richmond County, GA-SC	SC	0.9589	0.9717
12420	Austin-Round Rock, TX	TX	0.9521	0.9669
12540	Bakersfield, CA	CA	1.1822	1.1214
12580	Baltimore-Towson, MD	MD	0.9981	0.9987
12620	Bangor, ME	ME	1.0115	1.0079

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA AND BY STATE—FY 2009—Continued

[Constituent counties are listed in Table 4E.]

CBSA Code	Urban area	State	Wage index	GAF
12700	Barnstable Town, MA	MA	1.2672	1.1761
12940	Baton Rouge, LA	LA	0.8142	0.8687
12980	Battle Creek, MI	MI	1.0039	1.0027
13020	Bay City, MI	MI	0.9472	0.9635
13140	Beaumont-Port Arthur, TX	TX	0.8595	0.9015
13380	Bellingham, WA	WA	1.1395	1.0935
13460	Bend, OR	OR	1.1043	1.0703
13644	Bethesda-Frederick-Gaithersburg, MD	MD	1.1018	1.0686
13740	Billings, MT	MT	0.9045	0.9336
13780	Binghamton, NY	NY	0.8721	0.9105
13820	Birmingham-Hoover, AL	AL	0.8786	0.9152
13900	Bismarck, ND	ND	0.7336	0.8088
13980	Blacksburg-Christiansburg-Radford, VA	VA	0.8122	0.8672
14020	Bloomington, IN	IN	0.9419	0.9598
14060	Bloomington-Normal, IL	IL	0.9520	0.9669
14260	Boise City-Nampa, ID	ID	0.9290	0.9508
14484	Boston-Quincy, MA	MA	1.1994	1.1326
14500	Boulder, CO	CO	0.9994	0.9996
14540	Bowling Green, KY	KY	0.8344	0.8834
14600	Bradenton-Sarasota-Venice, FL	FL	0.9757	0.9833
14740	Bremerton-Silverdale, WA	WA	1.0706	1.0478
14860	Bridgeport-Stamford-Norwalk, CT	CT	1.2591	1.1709
15180	Brownsville-Harlingen, TX	TX	0.9226	0.9463
15260	Brunswick, GA	GA	1.0139	1.0095
15380	Buffalo-Niagara Falls, NY	NY	0.9593	0.9719
15500	Burlington, NC	NC	0.8632	0.9042
15540	Burlington-South Burlington, VT	VT	0.9275	0.9498
15764	Cambridge-Newton-Framingham, MA	MA	1.1078	1.0726
15804	Camden, NJ	NJ	1.1221	1.0821
15940	Canton-Massillon, OH	OH	0.8845	0.9194
15980	Cape Coral-Fort Myers, FL	FL	0.9502	0.9656
16180	Carson City, NV	NV	1.0027	1.0018
16220	Casper, WY	WY	0.9618	0.9737
16300	Cedar Rapids, IA	IA	0.8746	0.9123
16580	Champaign-Urbana, IL	IL	0.9353	0.9552
16620	Charleston, WV	WV	0.8398	0.8873
16700	Charleston-North Charleston-Summerville, SC	SC	0.9231	0.9467
16740	Charlotte-Gastonia-Concord, NC-SC	NC	0.9570	0.9704
16740	Charlotte-Gastonia-Concord, NC-SC	SC	0.9557	0.9694
16820	Charlottesville, VA	VA	0.9728	0.9813
16860	Chattanooga, TN-GA	GA	0.8880	0.9219
16860	Chattanooga, TN-GA	TN	0.8857	0.9202
16940	Cheyenne, WY	WY	0.9223	0.9461
16974	Chicago-Naperville-Joliet, IL	IL	1.0334	1.0228
17020	Chico, CA	CA	1.1822	1.1214
17140	Cincinnati-Middletown, OH-KY-IN	IN	0.9583	0.9713
17140	Cincinnati-Middletown, OH-KY-IN	KY	0.9590	0.9717
17140	Cincinnati-Middletown, OH-KY-IN	OH	0.9581	0.9711
17300	Clarksville, TN-KY	KY	0.8302	0.8804
17300	Clarksville, TN-KY	TN	0.8280	0.8788
17420	Cleveland, TN	TN	0.8137	0.8683
17460	Cleveland-Elyria-Mentor, OH	OH	0.9266	0.9491
17660	Coeur d'Alene, ID	ID	0.9185	0.9434
17780	College Station-Bryan, TX	TX	0.9193	0.9440
17820	Colorado Springs, CO	CO	0.9738	0.9820
17860	Columbia, MO	MO	0.8470	0.8925
17900	Columbia, SC	SC	0.8984	0.9293
17980	Columbus, GA-AL	AL	0.9061	0.9347
17980	Columbus, GA-AL	GA	0.9061	0.9347
18020	Columbus, IN	IN	0.9852	0.9898
18140	Columbus, OH	OH	0.9869	0.9910
18580	Corpus Christi, TX	TX	0.8494	0.8942
18700	Corvallis, OR	OR	1.1076	1.0725
19060	Cumberland, MD-WV	MD	0.8795	0.9158
19060	Cumberland, MD-WV	WV	0.7635	0.8313
19124	Dallas-Plano-Irving, TX	TX	0.9852	0.9898
19140	Dalton, GA	GA	0.8499	0.8946
19180	Danville, IL	IL	0.9711	0.9801
19260	Danville, VA	VA	0.8483	0.8935

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA AND BY STATE—FY 2009—Continued

[Constituent counties are listed in Table 4E.]

CBSA Code	Urban area	State	Wage index	GAF
19340	Davenport-Moline-Rock Island, IA-IL	IL	0.8606	0.9023
19340	Davenport-Moline-Rock Island, IA-IL	IA	0.8709	0.9097
19380	Dayton, OH	OH	0.9321	0.9530
19460	Decatur, AL	AL	0.7714	0.8372
19500	Decatur, IL	IL	0.8428	0.8895
19660	Deltona-Daytona Beach-Ormond Beach, FL	FL	0.8814	0.9172
19740	Denver-Aurora, CO	CO	1.0561	1.0381
19780	Des Moines-West Des Moines, IA	IA	0.9460	0.9627
19804	Detroit-Livonia-Dearborn, MI	MI	1.0052	1.0036
20020	Dothan, AL	AL	0.7718	0.8375
20100	Dover, DE	DE	1.0669	1.0453
20220	Dubuque, IA	IA	0.8709	0.9097
20260	Duluth, MN-WI	MN	1.0519	1.0353
20260	Duluth, MN-WI	WI	1.0499	1.0339
20500	Durham, NC	NC	0.9693	0.9789
20740	Eau Claire, WI	WI	0.9599	0.9724
20764	Edison-New Brunswick, NJ	NJ	1.1221	1.0821
20940	El Centro, CA	CA	1.1822	1.1214
21060	Elizabethtown, KY	KY	0.8466	0.8922
21140	Elkhart-Goshen, IN	IN	0.9547	0.9688
21300	Elmira, NY	NY	0.8347	0.8836
21340	El Paso, TX	TX	0.8867	0.9210
21500	Erie, PA	PA	0.8708	0.9096
21660	Eugene-Springfield, OR	OR	1.1157	1.0779
21780	Evansville, IN-KY	IN	0.8525	0.8965
21780	Evansville, IN-KY	KY	0.8531	0.8969
21820	Fairbanks, AK	AK	1.1884	1.1255
21940	Fajardo, PR	PR	0.4067	0.5400
22020	Fargo, ND-MN	MN	0.9120	0.9389
22020	Fargo, ND-MN	ND	0.8212	0.8738
22140	Farmington, NM	NM	0.8858	0.9203
22180	Fayetteville, NC	NC	0.9923	0.9947
22220	Fayetteville-Springdale-Rogers, AR-MO	AR	0.9131	0.9396
22220	Fayetteville-Springdale-Rogers, AR-MO	MO	0.9123	0.9391
22380	Flagstaff, AZ	AZ	1.1652	1.1104
22420	Flint, MI	MI	1.1258	1.0845
22500	Florence, SC	SC	0.8609	0.9025
22520	Florence-Muscle Shoals, AL	AL	0.7883	0.8497
22540	Fond du Lac, WI	WI	0.9523	0.9671
22660	Fort Collins-Loveland, CO	CO	0.9581	0.9711
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL	FL	1.0025	1.0017
22900	Fort Smith, AR-OK	AR	0.7843	0.8467
22900	Fort Smith, AR-OK	OK	0.8016	0.8595
23020	Fort Walton Beach-Crestview-Destin, FL	FL	0.8703	0.9093
23060	Fort Wayne, IN	IN	0.9004	0.9307
23104	Fort Worth-Arlington, TX	TX	0.9684	0.9783
23420	Fresno, CA	CA	1.1822	1.1214
23460	Gadsden, AL	AL	0.7991	0.8576
23540	Gainesville, FL	FL	0.9427	0.9604
23580	Gainesville, GA	GA	0.9321	0.9530
23844	Gary, IN	IN	0.9320	0.9529
24020	Glens Falls, NY	NY	0.8780	0.9148
24140	Goldsboro, NC	NC	0.9159	0.9416
24220	Grand Forks, ND-MN	MN	0.9120	0.9389
24220	Grand Forks, ND-MN	ND	0.7709	0.8368
24300	Grand Junction, CO	CO	0.9925	0.9949
24340	Grand Rapids-Wyoming, MI	MI	0.9305	0.9519
24500	Great Falls, MT	MT	0.8679	0.9075
24540	Greeley, CO	CO	1.0028	1.0019
24580	Green Bay, WI	WI	0.9511	0.9662
24660	Greensboro-High Point, NC	NC	0.9141	0.9403
24780	Greenville, NC	NC	0.9346	0.9547
24860	Greenville-Mauldin-Easley, SC	SC	0.9605	0.9728
25020	Guayama, PR	PR	0.3137	0.4521
25060	Gulfport-Biloxi, MS	MS	0.8898	0.9232
25180	Hagerstown-Martinsburg, MD-WV	MD	0.9273	0.9496
25180	Hagerstown-Martinsburg, MD-WV	WV	0.9253	0.9482
25260	Hanford-Corcoran, CA	CA	1.1822	1.1214
25420	Harrisburg-Carlisle, PA	PA	0.9185	0.9434

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA AND BY STATE—FY 2009—Continued

[Constituent counties are listed in Table 4E.]

CBSA Code	Urban area	State	Wage index	GAF
25500	Harrisonburg, VA	VA	0.8956	0.9273
25540	Hartford-West Hartford-East Hartford, CT	CT	1.1897	1.1263
25620	Hattiesburg, MS	MS	0.7653	0.8326
25860	Hickory-Lenoir-Morganton, NC	NC	0.8946	0.9266
26100	Holland-Grand Haven, MI	MI	0.9101	0.9375
26180	Honolulu, HI	HI	1.1608	1.1075
26300	Hot Springs, AR	AR	0.9146	0.9407
26380	Houma-Bayou Cane-Thibodaux, LA	LA	0.7870	0.8487
26420	Houston-Sugar Land-Baytown, TX	TX	0.9925	0.9949
26580	Huntington-Ashland, WV-KY-OH	KY	0.9127	0.9394
26580	Huntington-Ashland, WV-KY-OH	OH	0.9118	0.9387
26580	Huntington-Ashland, WV-KY-OH	WV	0.9107	0.9380
26620	Huntsville, AL	AL	0.8987	0.9295
26820	Idaho Falls, ID	ID	0.9327	0.9534
26900	Indianapolis-Carmel, IN	IN	0.9827	0.9881
26980	Iowa City, IA	IA	0.9337	0.9541
27060	Ithaca, NY	NY	0.9561	0.9697
27100	Jackson, MI	MI	0.9477	0.9639
27140	Jackson, MS	MS	0.8095	0.8653
27180	Jackson, TN	TN	0.8452	0.8912
27260	Jacksonville, FL	FL	0.9092	0.9369
27340	Jacksonville, NC	NC	0.8632	0.9042
27500	Janesville, WI	WI	0.9824	0.9879
27620	Jefferson City, MO	MO	0.9038	0.9331
27740	Johnson City, TN	TN	0.7999	0.8582
27780	Johnstown, PA	PA	0.8342	0.8833
27860	Jonesboro, AR	AR	0.8291	0.8796
27900	Joplin, MO	MO	0.9704	0.9796
28020	Kalamazoo-Portage, MI	MI	1.0910	1.0615
28100	Kankakee-Bradley, IL	IL	1.2018	1.1341
28140	Kansas City, MO-KS	KS	0.9453	0.9622
28140	Kansas City, MO-KS	MO	0.9444	0.9616
28420	Kennewick-Pasco-Richland, WA	WA	1.0164	1.0112
28660	Killeen-Temple-Fort Hood, TX	TX	0.8855	0.9201
28700	Kingsport-Bristol-Bristol, TN-VA	TN	0.7957	0.8551
28700	Kingsport-Bristol-Bristol, TN-VA	VA	0.8061	0.8628
28740	Kingston, NY	NY	0.9433	0.9608
28940	Knoxville, TN	TN	0.7957	0.8551
29020	Kokomo, IN	IN	0.9254	0.9483
29100	La Crosse, WI-MN	MN	0.9815	0.9873
29100	La Crosse, WI-MN	WI	0.9796	0.9860
29140	Lafayette, IN	IN	0.8960	0.9276
29180	Lafayette, LA	LA	0.8438	0.8902
29340	Lake Charles, LA	LA	0.7682	0.8348
29404	Lake County-Kenosha County, IL-WI	IL	1.0376	1.0256
29404	Lake County-Kenosha County, IL-WI	WI	1.0357	1.0243
29420	Lake Havasu City-Kingman, AZ	AZ	0.9817	0.9874
29460	Lakeland-Winter Haven, FL	FL	0.8715	0.9101
29540	Lancaster, PA	PA	0.9799	0.9862
29620	Lansing-East Lansing, MI	MI	0.9899	0.9931
29700	Laredo, TX	TX	0.8816	0.9173
29740	Las Cruces, NM	NM	0.8858	0.9203
29820	Las Vegas-Paradise, NV	NV	1.1666	1.1113
29940	Lawrence, KS	KS	0.8317	0.8814
30020	Lawton, OK	OK	0.8630	0.9040
30140	Lebanon, PA	PA	0.8991	0.9298
30300	Lewiston, ID-WA	ID	0.9271	0.9495
30300	Lewiston, ID-WA	WA	1.0164	1.0112
30340	Lewiston-Auburn, ME	ME	0.9326	0.9533
30460	Lexington-Fayette, KY	KY	0.8950	0.9268
30620	Lima, OH	OH	0.9299	0.9514
30700	Lincoln, NE	NE	0.9620	0.9738
30780	Little Rock-North Little Rock-Conway, AR	AR	0.8754	0.9129
30860	Logan, UT-ID	ID	0.8827	0.9181
30860	Logan, UT-ID	UT	0.8827	0.9181
30980	Longview, TX	TX	0.8666	0.9066
31020	Longview, WA	WA	1.1434	1.0961
31084	Los Angeles-Long Beach-Glendale, CA	CA	1.1916	1.1275
31140	Louisville-Jefferson County, KY-IN	IN	0.9238	0.9472

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA AND BY STATE—FY 2009—Continued

[Constituent counties are listed in Table 4E.]

CBSA Code	Urban area	State	Wage index	GAF
31140	Louisville-Jefferson County, KY-IN	KY	0.9245	0.9477
31180	Lubbock, TX	TX	0.8712	0.9099
31340	Lynchburg, VA	VA	0.8646	0.9052
31420	Macon, GA	GA	0.9815	0.9873
31460	Madera, CA	CA	1.1822	1.1214
31540	Madison, WI	WI	1.1232	1.0828
31700	Manchester-Nashua, NH	NH	1.0807	1.0546
31900	Mansfield, OH	OH	0.9295	0.9512
32420	Mayagüez, PR	PR	0.3896	0.5244
32580	McAllen-Edinburg-Mission, TX	TX	0.9118	0.9387
32780	Medford, OR	OR	1.0298	1.0203
32820	Memphis, TN-MS-AR	AR	0.9329	0.9535
32820	Memphis, TN-MS-AR	MS	0.9329	0.9535
32820	Memphis, TN-MS-AR	TN	0.9305	0.9519
32900	Merced, CA	CA	1.1969	1.1310
33124	Miami-Miami Beach-Kendall, FL	FL	0.9865	0.9907
33140	Michigan City-La Porte, IN	IN	0.9041	0.9333
33260	Midland, TX	TX	0.9562	0.9698
33340	Milwaukee-Waukesha-West Allis, WI	WI	1.0182	1.0124
33460	Minneapolis-St. Paul-Bloomington, MN-WI	MN	1.0997	1.0672
33460	Minneapolis-St. Paul-Bloomington, MN-WI	WI	1.0976	1.0659
33540	Missoula, MT	MT	0.8909	0.9239
33660	Mobile, AL	AL	0.7809	0.8442
33700	Modesto, CA	CA	1.1963	1.1306
33740	Monroe, LA	LA	0.7961	0.8554
33780	Monroe, MI	MI	0.8918	0.9246
33860	Montgomery, AL	AL	0.8192	0.8723
34060	Morgantown, WV	WV	0.8631	0.9041
34100	Morristown, TN	TN	0.7957	0.8551
34580	Mount Vernon-Anacortes, WA	WA	1.0164	1.0112
34620	Muncie, IN	IN	0.8479	0.8932
34740	Muskegon-Norton Shores, MI	MI	1.0227	1.0155
34820	Myrtle Beach-North Myrtle Beach-Conway, SC	SC	0.8683	0.9078
34900	Napa, CA	CA	1.3847	1.2497
34940	Naples-Marco Island, FL	FL	0.9820	0.9876
34980	Nashville-Davidson-Murfreesboro-Franklin, TN	TN	0.9445	0.9617
35004	Nassau-Suffolk, NY	NY	1.2729	1.1797
35084	Newark-Union, NJ-PA	NJ	1.1440	1.0965
35084	Newark-Union, NJ-PA	PA	1.1574	1.1053
35300	New Haven-Milford, CT	CT	1.1897	1.1263
35380	New Orleans-Metairie-Kenner, LA	LA	0.9140	0.9403
35644	New York-White Plains-Wayne, NY-NJ	NJ	1.2878	1.1891
35644	New York-White Plains-Wayne, NY-NJ	NY	1.3043	1.1995
35660	Niles-Benton Harbor, MI	MI	0.9095	0.9371
35980	Norwich-New London, CT	CT	1.1897	1.1263
36084	Oakland-Fremont-Hayward, CA	CA	1.5278	1.3367
36100	Ocala, FL	FL	0.8633	0.9042
36140	Ocean City, NJ	NJ	1.1484	1.0994
36220	Odessa, TX	TX	0.9425	0.9603
36260	Ogden-Clearfield, UT	UT	0.9243	0.9475
36420	Oklahoma City, OK	OK	0.8686	0.9080
36500	Olympia, WA	WA	1.1462	1.0979
36540	Omaha-Council Bluffs, NE-IA	IA	0.9360	0.9557
36540	Omaha-Council Bluffs, NE-IA	NE	0.9400	0.9585
36740	Orlando-Kissimmee, FL	FL	0.9189	0.9437
36780	Oshkosh-Neenah, WI	WI	0.9511	0.9662
36980	Owensboro, KY	KY	0.8764	0.9136
37100	Oxnard-Thousand Oaks-Ventura, CA	CA	1.1822	1.1214
37340	Palm Bay-Melbourne-Titusville, FL	FL	0.9401	0.9586
37380	Palm Coast, FL	FL	0.8769	0.9140
37460	Panama City-Lynn Haven, FL	FL	0.8633	0.9042
37620	Parkersburg-Marietta-Vienna, WV-OH	OH	0.8582	0.9006
37620	Parkersburg-Marietta-Vienna, WV-OH	WV	0.8028	0.8603
37700	Pascagoula, MS	MS	0.8030	0.8605
37764	Peabody, MA	MA	1.0744	1.0504
37860	Pensacola-Ferry Pass-Brent, FL	FL	0.8633	0.9042
37900	Peoria, IL	IL	0.9043	0.9334
37964	Philadelphia, PA	PA	1.0992	1.0669
38060	Phoenix-Mesa-Scottsdale, AZ	AZ	1.0271	1.0185

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA AND BY STATE—FY 2009—Continued

[Constituent counties are listed in Table 4E.]

CBSA Code	Urban area	State	Wage index	GAF
38220	Pine Bluff, AR	AR	0.8274	0.8783
38300	Pittsburgh, PA	PA	0.8579	0.9004
38340	Pittsfield, MA	MA	1.0445	1.0303
38540	Pocatello, ID	ID	0.9103	0.9377
38660	Ponce, PR	PR	0.4122	0.5450
38860	Portland-South Portland-Biddeford, ME	ME	0.9927	0.9950
38900	Portland-Vancouver-Beaverton, OR-WA	OR	1.1204	1.0810
38900	Portland-Vancouver-Beaverton, OR-WA	WA	1.1186	1.0798
38940	Port St. Lucie, FL	FL	0.9905	0.9935
39100	Poughkeepsie-Newburgh-Middletown, NY	NY	1.0944	1.0637
39140	Prescott, AZ	AZ	1.0198	1.0135
39300	Providence-New Bedford-Fall River, RI-MA	MA	1.0669	1.0453
39300	Providence-New Bedford-Fall River, RI-MA	RI	1.0669	1.0453
39340	Provo-Orem, UT	UT	0.9052	0.9341
39380	Pueblo, CO	CO	0.9303	0.9517
39460	Punta Gorda, FL	FL	0.9286	0.9505
39540	Racine, WI	WI	0.9511	0.9662
39580	Raleigh-Cary, NC	NC	0.9685	0.9783
39660	Rapid City, SD	SD	0.9502	0.9656
39740	Reading, PA	PA	0.9327	0.9534
39820	Redding, CA	CA	1.2730	1.1797
39900	Reno-Sparks, NV	NV	1.0476	1.0324
40060	Richmond, VA	VA	0.9203	0.9447
40140	Riverside-San Bernardino-Ontario, CA	CA	1.1822	1.1214
40220	Roanoke, VA	VA	0.8889	0.9225
40340	Rochester, MN	MN	1.0982	1.0662
40380	Rochester, NY	NY	0.8911	0.9241
40420	Rockford, IL	IL	0.9862	0.9905
40484	Rockingham County-Strafford County, NH	NH	1.0807	1.0546
40580	Rocky Mount, NC	NC	0.9068	0.9352
40660	Rome, GA	GA	0.9699	0.9793
40900	Sacramento—Arden-Arcade—Roseville, CA	CA	1.2827	1.1859
40980	Saginaw-Saginaw Township North, MI	MI	0.9034	0.9328
41060	St. Cloud, MN	MN	1.1549	1.1036
41100	St. George, UT	UT	0.9228	0.9465
41140	St. Joseph, MO-KS	KS	1.0481	1.0327
41140	St. Joseph, MO-KS	MO	1.0472	1.0321
41180	St. Louis, MO-IL	IL	0.8993	0.9299
41180	St. Louis, MO-IL	MO	0.8986	0.9294
41420	Salem, OR	OR	1.0650	1.0441
41500	Salinas, CA	CA	1.4671	1.3001
41540	Salisbury, MD	MD	0.9194	0.9441
41620	Salt Lake City, UT	UT	0.9271	0.9495
41660	San Angelo, TX	TX	0.8600	0.9019
41700	San Antonio, TX	TX	0.8949	0.9268
41740	San Diego-Carlsbad-San Marcos, CA	CA	1.1822	1.1214
41780	Sandusky, OH	OH	0.8828	0.9182
41884	San Francisco-San Mateo-Redwood City, CA	CA	1.4879	1.3127
41900	San Germán-Cabo Rojo, PR	PR	0.4648	0.5918
41940	San Jose-Sunnyvale-Santa Clara, CA	CA	1.5758	1.3654
41980	San Juan-Caguas-Guaynabo, PR	PR	0.4404	0.5703
42020	San Luis Obispo-Paso Robles, CA	CA	1.1822	1.1214
42044	Santa Ana-Anaheim-Irvine, CA	CA	1.1822	1.1214
42060	Santa Barbara-Santa Maria-Goleta, CA	CA	1.1822	1.1214
42100	Santa Cruz-Watsonville, CA	CA	1.5766	1.3658
42140	Santa Fe, NM	NM	1.0587	1.0398
42220	Santa Rosa-Petaluma, CA	CA	1.5052	1.3232
42340	Savannah, GA	GA	0.8943	0.9264
42540	Scranton—Wilkes-Barre, PA	PA	0.8342	0.8833
42644	Seattle-Bellevue-Everett, WA	WA	1.1562	1.1045
42680	Sebastian-Vero Beach, FL	FL	0.9519	0.9668
43100	Sheboygan, WI	WI	0.9511	0.9662
43300	Sherman-Denison, TX	TX	0.9291	0.9509
43340	Shreveport-Bossier City, LA	LA	0.8547	0.8981
43580	Sioux City, IA-NE-SD	IA	0.8745	0.9123
43580	Sioux City, IA-NE-SD	NE	0.8783	0.9150
43580	Sioux City, IA-NE-SD	SD	0.8783	0.9150
43620	Sioux Falls, SD	SD	0.9379	0.9570
43780	South Bend-Mishawaka, IN-MI	IN	0.9644	0.9755

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS BY CBSA AND BY STATE—FY 2009—Continued

[Constituent counties are listed in Table 4E.]

CBSA Code	Urban area	State	Wage index	GAF
43780	South Bend-Mishawaka, IN-MI	MI	0.9651	0.9760
43900	Spartanburg, SC	SC	0.9017	0.9316
44060	Spokane, WA	WA	1.0514	1.0349
44100	Springfield, IL	IL	0.9133	0.9398
44140	Springfield, MA	MA	1.0343	1.0234
44180	Springfield, MO	MO	0.8470	0.8925
44220	Springfield, OH	OH	0.8629	0.9040
44300	State College, PA	PA	0.8810	0.9169
44700	Stockton, CA	CA	1.1822	1.1214
44940	Sumter, SC	SC	0.8609	0.9025
45060	Syracuse, NY	NY	0.9865	0.9907
45104	Tacoma, WA	WA	1.1137	1.0765
45220	Tallahassee, FL	FL	0.8981	0.9290
45300	Tampa-St. Petersburg-Clearwater, FL	FL	0.8993	0.9299
45460	Terre Haute, IN	IN	0.9130	0.9396
45500	Texarkana, TX-Texarkana, AR	AR	0.8197	0.8727
45500	Texarkana, TX-Texarkana, AR	TX	0.8195	0.8726
45780	Toledo, OH	OH	0.9267	0.9492
45820	Topeka, KS	KS	0.8873	0.9214
45940	Trenton-Ewing, NJ	NJ	1.1221	1.0821
46060	Tucson, AZ	AZ	0.9442	0.9614
46140	Tulsa, OK	OK	0.8652	0.9056
46220	Tuscaloosa, AL	AL	0.8695	0.9087
46340	Tyler, TX	TX	0.8901	0.9234
46540	Utica-Rome, NY	NY	0.8721	0.9105
46660	Valdosta, GA	GA	0.8163	0.8702
46700	Vallejo-Fairfield, CA	CA	1.3974	1.2575
47020	Victoria, TX	TX	0.8153	0.8695
47220	Vineland-Millville-Bridgeton, NJ	NJ	1.1221	1.0821
47260	Virginia Beach-Norfolk-Newport News, VA	NC	0.8868	0.9210
47260	Virginia Beach-Norfolk-Newport News, VA	VA	0.8869	0.9211
47300	Visalia-Porterville, CA	CA	1.1822	1.1214
47380	Waco, TX	TX	0.8703	0.9093
47580	Warner Robins, GA	GA	0.9490	0.9648
47644	Warren-Troy-Farmington-Hills, MI	MI	0.9972	0.9981
47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	DC	1.0670	1.0454
47894	Washington-Arlington-Alexandria DC-VA-MD-WV	MD	1.0670	1.0454
47894	Washington-Arlington-Alexandria DC-VA-MD-WV	VA	1.0669	1.0453
47894	Washington-Arlington-Alexandria DC-VA-MD-WV	WV	1.0647	1.0439
47940	Waterloo-Cedar Falls, IA	IA	0.9248	0.9479
48140	Wausau, WI	WI	0.9823	0.9878
48260	Weirton-Steubenville, WV-OH	OH	0.8582	0.9006
48260	Weirton-Steubenville, WV-OH	WV	0.8011	0.8591
48300	Wenatchee, WA	WA	1.0164	1.0112
48424	West Palm Beach-Boca Raton-Boynton Beach, FL	FL	0.9631	0.9746
48540	Wheeling, WV-OH	OH	0.8582	0.9006
48540	Wheeling, WV-OH	WV	0.7635	0.8313
48620	Wichita, KS	KS	0.8980	0.9290
48660	Wichita Falls, TX	TX	0.9175	0.9427
48700	Williamsport, PA	PA	0.8342	0.8833
48864	Wilmington, DE-MD-NJ	DE	1.0645	1.0437
48864	Wilmington, DE-MD-NJ	MD	1.0645	1.0437
48864	Wilmington, DE-MD-NJ	NJ	1.1221	1.0821
48900	Wilmington, NC	NC	0.9087	0.9365
49020	Winchester, VA-WV	VA	0.9771	0.9843
49020	Winchester, VA-WV	WV	0.9751	0.9829
49180	Winston-Salem, NC	NC	0.9096	0.9372
49340	Worcester, MA	MA	1.0945	1.0638
49420	Yakima, WA	WA	1.0164	1.0112
49500	Yauco, PR	PR	0.3358	0.4737
49620	York-Hanover, PA	PA	0.9666	0.9770
49660	Youngstown-Warren-Boardman, OH-PA	OH	0.8931	0.9255
49660	Youngstown-Warren-Boardman, OH-PA	PA	0.8930	0.9254
49700	Yuba City, CA	CA	1.1822	1.1214
49740	Yuma, AZ	AZ	0.9903	0.9933

TABLE 4B.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR RURAL AREAS BY CBSA AND BY STATE—FY 2009

CBSA code	Rural area	State	Wage index	GAF
01	Alabama	AL	0.7647	0.8322
02	Alaska	AK	1.1884	1.1255
03	Arizona	AZ	0.8857	0.9202
04	Arkansas	AR	0.7641	0.8317
05	California	CA	1.1822	1.1214
06	Colorado	CO	0.9303	0.9517
07	Connecticut	CT	1.1897	1.1263
08	Delaware	DE	1.0252	1.0172
10	Florida	FL	0.8633	0.9042
11	Georgia	GA	0.7840	0.8465
12	Hawaii	HI	1.1219	1.0820
13	Idaho	ID	0.7597	0.8284
14	Illinois	IL	0.8428	0.8895
15	Indiana	IN	0.8479	0.8932
16	Iowa	IA	0.8709	0.9097
17	Kansas	KS	0.8086	0.8646
18	Kentucky	KY	0.7837	0.8463
19	Louisiana	LA	0.7682	0.8348
20	Maine	ME	0.8609	0.9025
21	Maryland	MD	0.8795	0.9158
22	Massachusetts	MA	1.0199	1.0136
23	Michigan	MI	0.8864	0.9207
24	Minnesota	MN	0.9120	0.9389
25	Mississippi	MS	0.7653	0.8326
26	Missouri	MO	0.8470	0.8925
27	Montana	MT	0.8640	0.9047
28	Nebraska	NE	0.8761	0.9134
29	Nevada	NV	0.9824	0.9879
30	New Hampshire	NH	1.0807	1.0546
31	New Jersey [1]	NJ	1.1221	1.0821
32	New Mexico	NM	0.8858	0.9203
33	New York	NY	0.8308	0.8808
34	North Carolina	NC	0.8632	0.9042
35	North Dakota	ND	0.7336	0.8088
36	Ohio	OH	0.8582	0.9006
37	Oklahoma	OK	0.8016	0.8595
38	Oregon	OR	1.0298	1.0203
39	Pennsylvania	PA	0.8342	0.8833
40	Puerto Rico [1]	PR		
41	Rhode Island [1]	RI		
42	South Carolina	SC	0.8609	0.9025
43	South Dakota	SD	0.8428	0.8895
44	Tennessee	TN	0.7957	0.8551
45	Texas	TX	0.8153	0.8695
46	Utah	UT	0.8395	0.8871
47	Vermont	VT	0.9275	0.9498
49	Virginia	VA	0.8061	0.8628
50	Washington	WA	1.0164	1.0112
51	West Virginia	WV	0.7635	0.8313
52	Wisconsin	WI	0.9511	0.9662
53	Wyoming	WY	0.9223	0.9461

[1] All counties in the State or Territory are classified as urban. The New Jersey floor is imputed as specified in § 412.64(h)(4) and discussed in the FY 2005 IPPS final rule (69 FR 49109) and in section III.B.2 of the preamble of this proposed rule.

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED BY CBSA AND BY STATE—FY 2009

CBSA code	Area	State	Wage index	GAF
10420	Akron, OH	OH	0.8784	0.9150
10500	Albany, GA	AL	0.8397	0.8872
10500	Albany, GA	GA	0.8397	0.8872
10580	Albany-Schenectady-Troy, NY	NY	0.8833	0.9185
10740	Albuquerque, NM	NM	0.9295	0.9512
10780	Alexandria, LA	LA	0.8127	0.8676
10900	Allentown-Bethlehem-Easton, PA-NJ	PA	0.9675	0.9776
11100	Amarillo, TX	KS	0.8885	0.9222
11100	Amarillo, TX	TX	0.8883	0.9221

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED BY CBSA AND BY STATE—FY 2009—Continued

CBSA code	Area	State	Wage index	GAF
11180	Ames, IA	IA	0.8881	0.9219
11260	Anchorage, AK	AK	1.1884	1.1255
11460	Ann Arbor, MI	MI	1.0113	1.0077
12060	Atlanta-Sandy Springs-Marietta, GA	AL	0.9760	0.9835
12060	Atlanta-Sandy Springs-Marietta, GA	GA	0.9760	0.9835
12420	Austin-Round Rock, TX	TX	0.9521	0.9669
12620	Bangor, ME	ME	1.0115	1.0079
12940	Baton Rouge, LA	MS	0.8146	0.8690
13020	Bay City, MI	MI	0.9472	0.9635
13644	Bethesda-Frederick-Gaithersburg, MD	DC	1.1018	1.0686
13644	Bethesda-Frederick-Gaithersburg, MD	PA	1.1006	1.0678
13644	Bethesda-Frederick-Gaithersburg, MD	VA	1.1017	1.0686
13780	Binghamton, NY	PA	0.8560	0.8990
13820	Birmingham-Hoover, AL	AL	0.8786	0.9152
13900	Bismarck, ND	ND	0.7336	0.8088
13980	Blacksburg-Christiansburg-Radford, VA	WV	0.7795	0.8432
14020	Bloomington, IN	IN	0.8791	0.9155
14260	Boise City-Nampa, ID	ID	0.9100	0.9375
14260	Boise City-Nampa, ID	NV	0.9824	0.9879
14484	Boston-Quincy, MA	MA	1.1338	1.0898
14484	Boston-Quincy, MA	RI	1.1338	1.0898
14600	Bradenton-Sarasota-Venice, FL	FL	0.9648	0.9758
14740	Bremerton-Silverdale, WA	WA	1.0576	1.0391
14860	Bridgeport-Stamford-Norwalk, CT	NY	1.2694	1.1775
15380	Buffalo-Niagara Falls, NY	NY	0.9593	0.9719
15540	Burlington-South Burlington, VT	NY	0.9216	0.9456
15764	Cambridge-Newton-Framingham, MA	NH	1.0807	1.0546
16180	Carson City, NV	NV	0.9837	0.9888
16220	Casper, WY	SD	0.9618	0.9737
16580	Champaign-Urbana, IL	IL	0.8840	0.9190
16620	Charleston, WV	WV	0.8398	0.8873
16700	Charleston-North Charleston-Summerville, SC	SC	0.9231	0.9467
16740	Charlotte-Gastonia-Concord, NC-SC	NC	0.9570	0.9704
16740	Charlotte-Gastonia-Concord, NC-SC	SC	0.9557	0.9694
16820	Charlottesville, VA	VA	0.9449	0.9619
16860	Chattanooga, TN-GA	AL	0.8740	0.9119
16860	Chattanooga, TN-GA	GA	0.8740	0.9119
16860	Chattanooga, TN-GA	TN	0.8717	0.9103
16974	Chicago-Naperville-Joliet, IL	IL	1.0334	1.0228
16974	Chicago-Naperville-Joliet, IL	IN	1.0328	1.0223
16974	Chicago-Naperville-Joliet, IL	WI	1.0315	1.0215
17140	Cincinnati-Middletown, OH-KY-IN	IN	0.9583	0.9713
17140	Cincinnati-Middletown, OH-KY-IN	OH	0.9581	0.9711
17300	Clarksville, TN-KY	KY	0.8302	0.8804
17460	Cleveland-Elyria-Mentor, OH	OH	0.9266	0.9491
17660	Coeur d'Alene, ID	MT	0.8992	0.9298
17820	Colorado Springs, CO	CO	0.9738	0.9820
17860	Columbia, MO	MO	0.8470	0.8925
17900	Columbia, SC	SC	0.8984	0.9293
17980	Columbus, GA-AL	AL	0.8495	0.8943
17980	Columbus, GA-AL	GA	0.8495	0.8943
18140	Columbus, OH	OH	0.9657	0.9764
18700	Corvallis, OR	OR	1.0572	1.0388
19124	Dallas-Plano-Irving, TX	TX	0.9852	0.9898
19340	Davenport-Moline-Rock Island, IA-IL	IL	0.8606	0.9023
19340	Davenport-Moline-Rock Island, IA-IL	IA	0.8709	0.9097
19380	Dayton, OH	OH	0.9321	0.9530
19740	Denver-Aurora, CO	CO	1.0409	1.0278
19804	Detroit-Livonia-Dearborn, MI	MI	1.0052	1.0036
20100	Dover, DE	DE	1.0304	1.0207
20260	Duluth, MN-WI	MN	1.0401	1.0273
20500	Durham, NC	NC	0.9693	0.9789
20500	Durham, NC	VA	0.9694	0.9789
20764	Edison-New Brunswick, NJ	NJ	1.1221	1.0821
21060	Elizabethtown, KY	KY	0.8230	0.8751
21140	Elkhart-Goshen, IN	IN	0.9547	0.9688
21500	Erie, PA	NY	0.8420	0.8889
21660	Eugene-Springfield, OR	OR	1.1157	1.0779
21780	Evansville, IN-KY	IN	0.8479	0.8932
21780	Evansville, IN-KY	KY	0.8131	0.8679

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED BY CBSA AND BY STATE—FY 2009—Continued

CBSA code	Area	State	Wage index	GAF
22020	Fargo, ND-MN	ND	0.8212	0.8738
22020	Fargo, ND-MN	SD	0.8428	0.8895
22180	Fayetteville, NC	NC	0.9567	0.9701
22220	Fayetteville-Springdale-Rogers, AR-MO	AR	0.8952	0.9270
22220	Fayetteville-Springdale-Rogers, AR-MO	OK	0.8950	0.9268
22380	Flagstaff, AZ	AZ	1.1305	1.0876
22420	Flint, MI	MI	1.0810	1.0548
22520	Florence-Muscle Shoals, AL	AL	0.7883	0.8497
22520	Florence-Muscle Shoals, AL	MS	0.7883	0.8497
22540	Fond du Lac, WI	WI	0.9523	0.9671
22660	Fort Collins-Loveland, CO	CO	0.9581	0.9711
22744	Ft Lauderdale-Pompano Beach-Deerfield Beach, FL	FL	1.0025	1.0017
23020	Fort Walton Beach-Crestview-Destin, FL	FL	0.8633	0.9042
23060	Fort Wayne, IN	IN	0.9004	0.9307
23104	Fort Worth-Arlington, TX	TX	0.9684	0.9783
23540	Gainesville, FL	FL	0.9427	0.9604
23844	Gary, IN	IN	0.9320	0.9529
24300	Grand Junction, CO	CO	0.9925	0.9949
24340	Grand Rapids-Wyoming, MI	MI	0.9305	0.9519
24500	Great Falls, MT	MT	0.8679	0.9075
24540	Greeley, CO	NE	0.9611	0.9732
24540	Greeley, CO	WY	0.9611	0.9732
24580	Green Bay, WI	MI	0.9412	0.9594
24580	Green Bay, WI	WI	0.9511	0.9662
24660	Greensboro-High Point, NC	NC	0.8984	0.9293
24660	Greensboro-High Point, NC	VA	0.8985	0.9293
24780	Greenville, NC	NC	0.9174	0.9427
24860	Greenville-Mauldin-Easley, SC	NC	0.9307	0.9520
24860	Greenville-Mauldin-Easley, SC	SC	0.9294	0.9511
25060	Gulfport-Biloxi, MS	MS	0.8156	0.8697
25420	Harrisburg-Carlisle, PA	PA	0.9185	0.9434
25540	Hartford-West Hartford-East Hartford, CT	CT	1.1897	1.1263
25540	Hartford-West Hartford-East Hartford, CT	MA	1.0972	1.0656
25860	Hickory-Lenoir-Morganton, NC	NC	0.8794	0.9158
26180	Honolulu, HI	HI	1.1608	1.1075
26420	Houston-Sugar Land-Baytown, TX	TX	0.9925	0.9949
26580	Huntington-Ashland, WV-KY-OH	KY	0.8767	0.9138
26580	Huntington-Ashland, WV-KY-OH	OH	0.8759	0.9133
26580	Huntington-Ashland, WV-KY-OH	WV	0.8748	0.9125
26620	Huntsville, AL	AL	0.8636	0.9045
26620	Huntsville, AL	TN	0.8614	0.9029
26820	Idaho Falls, ID	ID	0.9327	0.9534
26820	Idaho Falls, ID	WY	0.9327	0.9534
26900	Indianapolis-Carmel, IN	IN	0.9707	0.9798
26980	Iowa City, IA	IA	0.9107	0.9380
27060	Ithaca, NY	NY	0.9101	0.9375
27140	Jackson, MS	MS	0.8095	0.8653
27180	Jackson, TN	MS	0.8361	0.8846
27180	Jackson, TN	TN	0.8339	0.8830
27260	Jacksonville, FL	FL	0.9092	0.9369
27260	Jacksonville, FL	GA	0.9112	0.9383
27620	Jefferson City, MO	MO	0.8736	0.9116
27780	Johnstown, PA	PA	0.8342	0.8833
27860	Jonesboro, AR	AR	0.8291	0.8796
27860	Jonesboro, AR	MO	0.8470	0.8925
27900	Joplin, MO	KS	0.9351	0.9551
27900	Joplin, MO	OK	0.9349	0.9549
28020	Kalamazoo-Portage, MI	MI	1.0365	1.0249
28140	Kansas City, MO-KS	MO	0.9444	0.9616
28420	Kennewick-Pasco-Richland, WA	ID	0.9560	0.9697
28420	Kennewick-Pasco-Richland, WA	WA	1.0164	1.0112
28700	Kingsport-Bristol-Bristol, TN-VA	KY	0.7919	0.8523
28700	Kingsport-Bristol-Bristol, TN-VA	TN	0.7957	0.8551
28940	Knoxville, TN	KY	0.7889	0.8501
28940	Knoxville, TN	TN	0.7957	0.8551
29180	Lafayette, LA	LA	0.8438	0.8902
29460	Lakeland-Winter Haven, FL	FL	0.8715	0.9101
29540	Lancaster, PA	PA	0.9799	0.9862
29620	Lansing-East Lansing, MI	MI	0.9652	0.9760
29820	Las Vegas-Paradise, NV	AZ	1.1388	1.0931

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED BY CBSA AND BY STATE—FY 2009—Continued

CBSA code	Area	State	Wage index	GAF
29820	Las Vegas-Paradise, NV	UT	1.1388	1.0931
30460	Lexington-Fayette, KY	KY	0.8756	0.9130
30620	Lima, OH	OH	0.9299	0.9514
30700	Lincoln, NE	NE	0.9336	0.9540
30780	Little Rock-North Little Rock-Conway, AR	AR	0.8650	0.9055
30860	Logan, UT-ID	UT	0.8827	0.9181
30980	Longview, TX	TX	0.8666	0.9066
31084	Los Angeles-Long Beach-Glendale, CA	CA	1.1822	1.1214
31140	Louisville-Jefferson County, KY-IN	KY	0.9123	0.9391
31340	Lynchburg, VA	VA	0.8646	0.9052
31420	Macon, GA	GA	0.9618	0.9737
31540	Madison, WI	WI	1.1014	1.0684
31700	Manchester-Nashua, NH	NH	1.0807	1.0546
32780	Medford, OR	OR	1.0298	1.0203
32820	Memphis, TN-MS-AR	AR	0.8909	0.9239
32820	Memphis, TN-MS-AR	MS	0.8909	0.9239
32820	Memphis, TN-MS-AR	TN	0.8886	0.9223
33124	Miami-Miami Beach-Kendall, FL	FL	0.9865	0.9907
33340	Milwaukee-Waukesha-West Allis, WI	WI	1.0026	1.0018
33460	Minneapolis-St. Paul-Bloomington, MN-WI	MN	1.0997	1.0672
33460	Minneapolis-St. Paul-Bloomington, MN-WI	WI	1.0976	1.0659
33540	Missoula, MT	MT	0.8909	0.9239
33700	Modesto, CA	CA	1.1963	1.1306
33740	Monroe, LA	AR	0.7789	0.8427
33740	Monroe, LA	LA	0.7785	0.8424
33860	Montgomery, AL	AL	0.8192	0.8723
34060	Morgantown, WV	WV	0.8631	0.9041
34740	Muskegon-Norton Shores, MI	MI	0.9455	0.9623
34820	Myrtle Beach-North Myrtle Beach-Conway, SC	NC	0.8632	0.9042
34820	Myrtle Beach-North Myrtle Beach-Conway, SC	SC	0.8609	0.9025
34980	Nashville-Davidson-Murfreesboro-Franklin, TN	KY	0.9276	0.9498
34980	Nashville-Davidson-Murfreesboro-Franklin, TN	TN	0.9252	0.9482
35004	Nassau-Suffolk, NY	CT	1.2038	1.1354
35084	Newark-Union, NJ-PA	NJ	1.1316	1.0884
35084	Newark-Union, NJ-PA	NY	1.1461	1.0979
35084	Newark-Union, NJ-PA	PA	1.1449	1.0971
35300	New Haven-Milford, CT	CT	1.1897	1.1263
35380	New Orleans-Metairie-Kenner, LA	LA	0.9140	0.9403
35644	New York-White Plains-Wayne, NY-NJ	CT	1.2391	1.1581
35644	New York-White Plains-Wayne, NY-NJ	NJ	1.2693	1.1774
35644	New York-White Plains-Wayne, NY-NJ	NY	1.2855	1.1877
35980	Norwich-New London, CT	RI	1.1587	1.1061
36084	Oakland-Fremont-Hayward, CA	CA	1.5278	1.3367
36140	Ocean City, NJ	DE	1.0909	1.0614
36220	Odessa, TX	NM	0.9273	0.9496
36220	Odessa, TX	TX	0.9283	0.9503
36420	Oklahoma City, OK	OK	0.8686	0.9080
36500	Olympia, WA	WA	1.1297	1.0871
36740	Orlando-Kissimmee, FL	FL	0.9073	0.9356
37460	Panama City-Lynn Haven, FL	AL	0.8322	0.8818
37700	Pascagoula, MS	AL	0.8030	0.8605
37764	Peabody, MA	NH	1.0807	1.0546
37860	Pensacola-Ferry Pass-Brent, FL	AL	0.8115	0.8667
37900	Peoria, IL	IL	0.9043	0.9334
37964	Philadelphia, PA	DE	1.0799	1.0540
37964	Philadelphia, PA	NJ	1.1221	1.0821
37964	Philadelphia, PA	PA	1.0788	1.0533
38220	Pine Bluff, AR	MS	0.8150	0.8693
38300	Pittsburgh, PA	OH	0.8582	0.9006
38300	Pittsburgh, PA	PA	0.8579	0.9004
38300	Pittsburgh, PA	WV	0.8569	0.8996
38340	Pittsfield, MA	NY	0.9901	0.9932
38340	Pittsfield, MA	VT	0.9275	0.9498
38860	Portland-South Portland-Biddeford, ME	ME	0.9644	0.9755
38900	Portland-Vancouver-Beaverton, OR-WA	OR	1.1204	1.0810
38900	Portland-Vancouver-Beaverton, OR-WA	WA	1.1186	1.0798
38940	Port St. Lucie, FL	FL	0.9741	0.9822
39100	Poughkeepsie-Newburgh-Middletown, NY	NY	1.0709	1.0480
39140	Prescott, AZ	AZ	1.0011	1.0008
39340	Provo-Orem, UT	UT	0.9052	0.9341

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED BY CBSA AND BY STATE—FY 2009—Continued

CBSA code	Area	State	Wage index	GAF
39580	Raleigh-Cary, NC	NC	0.9557	0.9694
39740	Reading, PA	PA	0.9204	0.9448
39820	Redding, CA	CA	1.2730	1.1797
39900	Reno-Sparks, NV	NV	1.0476	1.0324
40060	Richmond, VA	VA	0.9203	0.9447
40140	Riverside-San Bernardino-Ontario, CA	AZ	1.1254	1.0843
40220	Roanoke, VA	VA	0.8750	0.9126
40220	Roanoke, VA	WV	0.8732	0.9113
40380	Rochester, NY	NY	0.8911	0.9241
40420	Rockford, IL	IL	0.9756	0.9832
40484	Rockingham County-Strafford County, NH	ME	1.0007	1.0005
40660	Rome, GA	AL	0.9524	0.9672
40900	Sacramento—Arden-Arcade—Roseville, CA	CA	1.2710	1.1785
40980	Saginaw-Saginaw Township North, MI	MI	0.8864	0.9207
41060	St. Cloud, MN	MN	1.0638	1.0433
41100	St. George, UT	UT	0.9228	0.9465
41140	St. Joseph, MO-KS	MO	1.0267	1.0182
41180	St. Louis, MO-IL	IL	0.8993	0.9299
41180	St. Louis, MO-IL	MO	0.8986	0.9294
41620	Salt Lake City, UT	UT	0.9271	0.9495
41700	San Antonio, TX	TX	0.8949	0.9268
41884	San Francisco-San Mateo-Redwood City, CA	CA	1.4879	1.3127
41940	San Jose-Sunnyvale-Santa Clara, CA	CA	1.5758	1.3654
42044	Santa Ana-Anaheim-Irvine, CA	CA	1.1822	1.1214
42100	Santa Cruz-Watsonville, CA	CA	1.5766	1.3658
42140	Santa Fe, NM	NM	1.0207	1.0141
42220	Santa Rosa-Petaluma, CA	CA	1.4497	1.2896
42340	Savannah, GA	GA	0.8841	0.9191
42340	Savannah, GA	SC	0.8827	0.9181
42644	Seattle-Bellevue-Everett, WA	WA	1.1377	1.0924
43300	Sherman-Denison, TX	OK	0.9291	0.9509
43340	Shreveport-Bossier City, LA	LA	0.8547	0.8981
43580	Sioux City, IA-NE-SD	NE	0.8761	0.9134
43620	Sioux Falls, SD	SD	0.9262	0.9489
43780	South Bend-Mishawaka, IN-MI	IN	0.9353	0.9552
43900	Spartanburg, SC	SC	0.9017	0.9316
44060	Spokane, WA	ID	1.0315	1.0215
44180	Springfield, MO	AR	0.8477	0.8930
44180	Springfield, MO	MO	0.8470	0.8925
44940	Sumter, SC	SC	0.8609	0.9025
45060	Syracuse, NY	NY	0.9471	0.9635
45220	Tallahassee, FL	GA	0.8397	0.8872
45300	Tampa-St. Petersburg-Clearwater, FL	FL	0.8993	0.9299
45500	Texarkana, TX-Texarkana, AR	AR	0.8093	0.8651
45780	Toledo, OH	OH	0.9267	0.9492
45820	Topeka, KS	KS	0.8720	0.9105
46140	Tulsa, OK	OK	0.8652	0.9056
46220	Tuscaloosa, AL	MS	0.8280	0.8788
46340	Tyler, TX	TX	0.8901	0.9234
46700	Vallejo-Fairfield, CA	CA	1.3974	1.2575
47260	Virginia Beach-Norfolk-Newport News, VA	NC	0.8868	0.9210
47644	Warren-Troy-Farmington-Hills, MI	MI	0.9972	0.9981
47894	Washington-Arlington-Alexandria, DC-VA	VA	1.0669	1.0453
47940	Waterloo-Cedar Falls, IA	IA	0.9248	0.9479
48140	Wausau, WI	WI	0.9823	0.9878
48620	Wichita, KS	KS	0.8785	0.9151
48620	Wichita, KS	OK	0.8784	0.9150
48700	Williamsport, PA	PA	0.8342	0.8833
48864	Wilmington, DE-MD-NJ	DE	1.0645	1.0437
48864	Wilmington, DE-MD-NJ	NJ	1.1221	1.0821
48900	Wilmington, NC	SC	0.9074	0.9356
49180	Winston-Salem, NC	NC	0.9096	0.9372
49340	Worcester, MA	NH	1.0807	1.0546
49660	Youngstown-Warren-Boardman, OH-PA	OH	0.8582	0.9006
49660	Youngstown-Warren-Boardman, OH-PA	PA	0.8559	0.8989
04	Arkansas	LA	0.7682	0.8348
05	California	CA	1.1822	1.1214
10	Florida	FL	0.8633	0.9042
14	Illinois	IL	0.8428	0.8895
14	Illinois	KY	0.8320	0.8817

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED BY CBSA AND BY STATE—FY 2009—Continued

CBSA code	Area	State	Wage index	GAF
14	Illinois	MO	0.8470	0.8925
16	Iowa	MO	0.8738	0.9118
17	Kansas	KS	0.8086	0.8646
22	Massachusetts	MA	1.0199	1.0136
23	Michigan	MI	0.8864	0.9207
25	Mississippi	MS	0.7653	0.8326
26	Missouri	MO	0.8470	0.8925
30	New Hampshire	VT	0.9297	0.9513
33	New York	NY	0.8308	0.8808
34	North Carolina	TN	0.8611	0.9027
36	Ohio	OH	0.8582	0.9006
37	Oklahoma	OK	0.8016	0.8595
38	Oregon	OR	1.0298	1.0203
39	Pennsylvania	NY	0.8351	0.8839
39	Pennsylvania	PA	0.8342	0.8833
44	Tennessee	KY	0.7978	0.8567
44	Tennessee	TN	0.7957	0.8551
45	Texas	TX	0.8153	0.8695
49	Virginia	KY	0.8062	0.8628
49	Virginia	VA	0.8061	0.8628
50	Washington	WA	1.0164	1.0112
53	Wyoming	NE	0.9223	0.9461

TABLE 4D–1.—RURAL FLOOR BUDGET NEUTRALITY FACTORS—FY 2009

State	Rural floor budget neutrality ajustment factor
Alabama	1.00000
Alaska	0.99734
Arizona	1.00000
Arkansas	1.00000
California	0.98552
Colorado	0.99683
Connecticut	0.96390
Delaware	1.00000
Washington, DC	1.00000
Florida	0.99781
Georgia	1.00000
Hawaii	1.00000
Idaho	1.00000
Illinois	0.99993
Indiana	0.99928
Iowa	0.99572
Kansas	1.00000
Kentucky	1.00000
Louisiana	0.99945
Maine	1.00000
Maryland	

TABLE 4D–1.—RURAL FLOOR BUDGET NEUTRALITY FACTORS—FY 2009—Continued

State	Rural floor budget neutrality ajustment factor
Massachusetts	1.00000
Michigan	1.00000
Minnesota	1.00000
Mississippi	1.00000
Missouri	0.99910
Montana	1.00000
Nebraska	1.00000
Nevada	1.00000
New Hampshire	0.97787
New Jersey	0.98738
New Mexico	0.99875
New York	1.00000
North Carolina	0.99983
North Dakota	0.99424
Ohio	0.99906
Oklahoma	0.99983
Oregon	0.99955
Pennsylvania	0.99895
Puerto Rico	1.00000

TABLE 4D–1.—RURAL FLOOR BUDGET NEUTRALITY FACTORS—FY 2009—Continued

State	Rural floor budget neutrality ajustment factor
Rhode Island	1.00000
South Carolina	0.99840
South Dakota	1.00000
Tennessee	0.99741
Texas	0.99980
Utah	1.00000
Vermont	0.90100
Virginia	0.99991
Washington	0.99791
West Virginia	0.99782
Wisconsin	0.99809
Wyoming	1.00000

*Maryland hospitals, under section 1814(b)(3) of the Act, are waived from the IPPS ratesetting. Therefore, the rural floor budget neutrality adjustment does not apply.

**The rural floor budget neutrality factor for New Jersey is based on an imputed floor (see Table 4B).

TABLE 4D–2.—URBAN AREAS WITH HOSPITALS RECEIVING THE STATEWIDE RURAL FLOOR OR IMPUTED FLOOR WAGE INDEX—FY 2009

[*Only hospitals that are geographically located in the specified State receive the State's rural or imputed floor wage index.]

CBSA code	Urban area	State*	Rural or imputed floor wage index
10900	Allentown-Bethlehem-Easton, PA–NJ	NJ	1.1221
11020	Altoona, PA	PA	0.8342
11260	Anchorage, AK	AK	1.1884
11540	Appleton, WI	WI	0.9511
12220	Auburn-Opelika, AL	AL	0.7647
12540	Bakersfield, CA	CA	1.1822
13900	Bismarck, ND	ND	0.7336
15500	Burlington, NC	NC	0.8632

TABLE 4D–2.—URBAN AREAS WITH HOSPITALS RECEIVING THE STATEWIDE RURAL FLOOR OR IMPUTED FLOOR WAGE INDEX—FY 2009—Continued

[*Only hospitals that are geographically located in the specified State receive the State's rural or imputed floor wage index.]

CBSA code	Urban area	State *	Rural or imputed floor wage index
15540	Burlington-South Burlington, VT	VT	0.9275
15804	Camden, NJ	NJ	1.1221
16940	Cheyenne, WY	WY	0.9223
17020	Chico, CA	CA	1.1822
17860	Columbia, MO	MO	0.8470
19060	Cumberland, MD–WV	MD	0.8795
19060	Cumberland, MD–WV	WV	0.7635
19340	Davenport-Moline-Rock Island, IA–IL	IA	0.8709
19500	Decatur, IL	IL	0.8428
20220	Dubuque, IA	IA	0.8709
20764	Edison-New Brunswick, NJ	NJ	1.1221
20940	El Centro, CA	CA	1.1822
21820	Fairbanks, AK	AK	1.1884
22020	Fargo, ND–MN	MN	0.9120
22140	Farmington, NM	NM	0.8858
22500	Florence, SC	SC	0.8609
22900	Fort Smith, AR–OK	OK	0.8016
23420	Fresno, CA	CA	1.1822
24220	Grand Forks, ND–MN	MN	0.9120
24580	Green Bay, WI	WI	0.9511
25260	Hanford-Corcoran, CA	CA	1.1822
25540	Hartford-West Hartford-East Hartford, CT	CT	1.1897
25620	Hattiesburg, MS	MS	0.7653
27340	Jacksonville, NC	NC	0.8632
27780	Johnstown, PA	PA	0.8342
28420	Kennewick-Pasco-Richland, WA	WA	1.0164
28700	Kingsport-Bristol-Bristol, TN–VA	TN	0.7957
28700	Kingsport-Bristol-Bristol, TN–VA	VA	0.8061
28940	Knoxville, TN	TN	0.7957
29340	Lake Charles, LA	LA	0.7682
29740	Las Cruces, NM	NM	0.8858
30300	Lewiston, ID–WA	WA	1.0164
31460	Madera, CA	CA	1.1822
31700	Manchester-Nashua, NH	NH	1.0807
32780	Medford, OR	OR	1.0298
34100	Morristown, TN	TN	0.7957
34580	Mount Vernon-Anacortes, WA	WA	1.0164
34620	Muncie, IN	IN	0.8479
35300	New Haven-Milford, CT	CT	1.1897
35980	Norwich-New London, CT	CT	1.1897
36100	Ocala, FL	FL	0.8633
36780	Oshkosh-Neenah, WI	WI	0.9511
37100	Oxnard-Thousand Oaks-Ventura, CA	CA	1.1822
37460	Panama City-Lynn Haven, FL	FL	0.8633
37620	Parkersburg-Marietta-Vienna, WV–OH	OH	0.8582
37860	Pensacola-Ferry Pass-Brent, FL	FL	0.8633
39380	Pueblo, CO	CO	0.9303
39540	Racine, WI	WI	0.9511
40140	Riverside-San Bernardino-Ontario, CA	CA	1.1822
40484	Rockingham County-Strafford County, NH	NH	1.0807
41740	San Diego-Carlsbad-San Marcos, CA	CA	1.1822
42020	San Luis Obispo-Paso Robles, CA	CA	1.1822
42044	Santa Ana-Anaheim-Irvine, CA	CA	1.1822
42060	Santa Barbara-Santa Maria-Goleta, CA	CA	1.1822
42540	Scranton-Wilkes-Barre, PA	PA	0.8342
43100	Sheboygan, WI	WI	0.9511
44180	Springfield, MO	MO	0.8470
44700	Stockton, CA	CA	1.1822
44940	Sumter, SC	SC	0.8609
45940	Trenton-Ewing, NJ	NJ	1.1221
47020	Victoria, TX	TX	0.8153
47220	Vineland-Millville-Bridgeton, NJ	NJ	1.1221
47300	Visalia-Porterville, CA	CA	1.1822
48260	Weirton-Steubenville, WV–OH	OH	0.8582
48300	Wenatchee, WA	WA	1.0164
48540	Wheeling, WV–OH	OH	0.8582
48540	Wheeling, WV–OH	WV	0.7635
48700	Williamsport, PA	PA	0.8342
48864	Wilmington, DE–MD–NJ	NJ	1.1221

TABLE 4D–2.—URBAN AREAS WITH HOSPITALS RECEIVING THE STATEWIDE RURAL FLOOR OR IMPUTED FLOOR WAGE INDEX—FY 2009—Continued

[*Only hospitals that are geographically located in the specified State receive the State's rural or imputed floor wage index.]

CBSA code	Urban area	State *	Rural or imputed floor wage index
49420	Yakima, WA	WA	1.0164
49700	Yuba City, CA	CA	1.1822

TABLE 4E.—URBAN CBSAS AND CONSTITUENT COUNTIES—FY 2009

CBSA code	Urban area (constituent counties)
10180	Abilene, TX
	Callahan County, TX
	Jones County, TX
	Taylor County, TX
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
10420	Akron, OH
	Portage County, OH
	Summit County, OH
10500	Albany, GA
	Baker County, GA
	Dougherty County, GA
	Lee County, GA
	Terrell County, GA
	Worth County, GA
10580	Albany-Schenectady-Troy, NY
	Albany County, NY
	Rensselaer County, NY
	Saratoga County, NY
	Schenectady County, NY
	Schoharie County, NY
10740	Albuquerque, NM
	Bernalillo County, NM
	Sandoval County, NM
	Torrance County, NM
	Valencia County, NM
10780	Alexandria, LA
	Grant Parish, LA
	Rapides Parish, LA
10900	Allentown-Bethlehem-Easton, PA-NJ
	Warren County, NJ
	Carbon County, PA
	Lehigh County, PA
	Northampton County, PA
11020	Altoona, PA
	Blair County, PA
11100	Amarillo, TX
	Armstrong County, TX
	Carson County, TX
	Potter County, TX
	Randall County, TX
11180	Ames, IA
	Story County, IA
11260	Anchorage, AK
	Anchorage Municipality, AK
	Matanuska-SusitnaBorough, AK
11300	Anderson, IN
	Madison County, IN
11340	Anderson, SC

TABLE 4E.—URBAN CBSAS AND CONSTITUENT COUNTIES—FY 2009—Continued

CBSA code	Urban area (constituent counties)
	Anderson County, SC
11460	Ann Arbor, MI
	Washtenaw County, MI
11500	Anniston-Oxford, AL
	Calhoun County, AL
11540	Appleton, WI
	Calumet County, WI
	Outagamie County, WI
11700	Asheville, NC
	Buncombe County, NC
	Haywood County, NC
	Henderson County, NC
	Madison County, NC
12020	Athens-Clarke County, GA
	Clarke County, GA
	Madison County, GA
	Oconee County, GA
	Oglethorpe County, GA
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
12100	Atlantic City-Hammonton, NJ
	Atlantic County, NJ
	Hammonton County, NJ
12220	Auburn-Opelika, AL
	Lee County, AL
12260	Augusta-Richmond County, GA-SC
	Burke County, GA
	Columbia County, GA
	McDuffie County, GA

TABLE 4E.—URBAN CBSAS AND CONSTITUENT COUNTIES—FY 2009—Continued

CBSA code	Urban area (constituent counties)
	Richmond County, GA
	Aiken County, SC
	Edgefield County, SC
12420	[1] Austin-Round Rock, TX
	Bastrop County, TX
	Caldwell County, TX
	Hays County, TX
	Travis County, TX
	Williamson County, TX
12540	Bakersfield, CA
	Kern County, CA
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
12620	Bangor, ME
	Penobscot County, ME
12700	Barnstable Town, MA
	Barnstable County, MA
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
12980	Battle Creek, MI
	Calhoun County, MI
13020	Bay City, MI
	Bay County, MI
13140	Beaumont-Port Arthur, TX
	Hardin County, TX
	Jefferson County, TX
	Orange County, TX
13380	Bellingham, WA
	Whatcom County, WA
13460	Bend, OR
	Deschutes County, OR
13644	[1] Bethesda-Frederick-Gaithersburg, MD
	Frederick County, MD
	Montgomery County, MD
13740	Billings, MT
	Carbon County, MT
	Yellowstone County, MT
13780	Binghamton, NY
	Broome County, NY
	Tioga County, NY
13820	[1] Birmingham-Hoover, AL
	Bibb County, AL
	Blount County, AL

TABLE 4E.—URBAN CBSAS AND CONSTITUENT COUNTIES—FY 2009—Continued

CBSA code	Urban area (constituent counties)
	Chilton County, AL
	Jefferson County, AL
	St. Clair County, AL
	Shelby County, AL
	Walker County, AL
13900	Bismarck, ND
	Burleigh County, ND
	Morton County, ND
13980	Blacksburg-Christiansburg-Radford, VA
	Giles County, VA
	Montgomery County, VA
	Pulaski County, VA
	Radford City, VA
14020	Bloomington, IN
	Greene County, IN
	Monroe County, IN
	Owen County, IN
14060	Bloomington-Normal, IL
	McLean County, IL
14260	Boise City-Nampa, ID
	Ada County, ID
	Boise County, ID
	Canyon County, ID
	Gem County, ID
	Owyhee County, ID
14484	[1] Boston-Quincy, MA
	Norfolk County, MA
	Plymouth County, MA
	Suffolk County, MA
14500	Boulder, CO
	Boulder County, CO
14540	Bowling Green, KY
	Edmonson County, KY
	Warren County, KY
14600	Bradenton-Sarasota-Venice, FL
	Bradenton County, FL
	Manatee County, FL
	Sarasota County, FL
14740	Bremerton-Silverdale, WA
	Kitsap County, WA
14860	Bridgeport-Stamford-Norwalk, CT
	Fairfield County, CT
15180	Brownsville-Harlingen, TX
	Cameron County, TX
15260	Brunswick, GA
	Brantley County, GA
	Glynn County, GA
	McIntosh County, GA
15380	[1] Buffalo-Niagara Falls, NY
	Erie County, NY
	Niagara County, NY
15500	Burlington, NC
	Alamance County, NC
15540	Burlington-South Burlington, VT
	Chittenden County, VT
	Franklin County, VT
	Grand Isle County, VT
15764	[1] Cambridge-Newton-Framingham, MA
	Middlesex County, MA
15804	[1] Camden, NJ
	Burlington County, NJ
	Camden County, NJ
	Gloucester County, NJ
15940	Canton-Massillon, OH
	Carroll County, OH
	Stark County, OH

TABLE 4E.—URBAN CBSAS AND CONSTITUENT COUNTIES—FY 2009—Continued

CBSA code	Urban area (constituent counties)
15980	Cape Coral-Fort Myers, FL
	Lee County, FL
16180	Carson City, NV
	Carson City, NV
16220	Casper, WY
	Natrona County, WY
16300	Cedar Rapids, IA
	Benton County, IA
	Jones County, IA
	Linn County, IA
16580	Champaign-Urbana, IL
	Champaign County, IL
	Ford County, IL
	Piatt County, IL
16620	Charleston, WV
	Boone County, WV
	Clay County, WV
	Kanawha County, WV
	Lincoln County, WV
	Putnam County, WV
16700	Charleston-North Charleston-Summerville, SC
	Berkeley County, SC
	Charleston County, SC
	Dorchester County, SC
	Summerville County, SC
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
16820	Charlottesville, VA
	Albemarle County, VA
	Fluvanna County, VA
	Greene County, VA
	Nelson County, VA
	Charlottesville City, VA
16860	Chattanooga, TN-GA
	Catoosa County, GA
	Dade County, GA
	Walker County, GA
	Hamilton County, TN
	Marion County, TN
	Sequatchie County, TN
16940	Cheyenne, WY
	Laramie County, WY
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
17020	Chico, CA
	Butte County, CA
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

TABLE 4E.—URBAN CBSAS AND CONSTITUENT COUNTIES—FY 2009—Continued

CBSA code	Urban area (constituent counties)
	Grant County, KY
	Kenton County, KY
	Pendleton County, KY
	Brown County, OH
	Butler County, OH
	Clermont County, OH
	Hamilton County, OH
	Warren County, OH
17300	Clarksville, TN-KY
	Christian County, KY
	Trigg County, KY
	Montgomery County, TN
	Stewart County, TN
17420	Cleveland, TN
	Bradley County, TN
	Polk County, TN
17460	[1] Cleveland-Elyria-Mentor, OH
	Cuyahoga County, OH
	Geauga County, OH
	Lake County, OH
	Lorain County, OH
	Medina County, OH
17660	Coeur d'Alene, ID
	Kootenai County, ID
17780	College Station-Bryan, TX
	Brazos County, TX
	Burleson County, TX
	Robertson County, TX
17820	Colorado Springs, CO
	El Paso County, CO
	Teller County, CO
17860	Columbia, MO
	Boone County, MO
	Howard County, MO
17900	Columbia, SC
	Calhoun County, SC
	Fairfield County, SC
	Kershaw County, SC
	Lexington County, SC
	Richland County, SC
	Saluda County, SC
17980	Columbus, GA-AL
	Russell County, AL
	Chattahoochee County, GA
	Harris County, GA
	Marion County, GA
	Muscogee County, GA
18020	Columbus, IN
	Bartholomew County, IN
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
18580	Corpus Christi, TX
	Aransas County, TX
	Nueces County, TX
	San Patricio County, TX
18700	Corvallis, OR
	Benton County, OR
19060	Cumberland, MD-WV
	Allegany County, MD
	Mineral County, WV
19124	[1] Dallas-Plano-Irving, TX
	Collin County, TX

TABLE 4E.—URBAN CBSAS AND CONSTITUENT COUNTIES—FY 2009—Continued

CBSA code	Urban area (constituent counties)
	Dallas County, TX
	Delta County, TX
	Denton County, TX
	Ellis County, TX
	Hunt County, TX
	Kaufman County, TX
	Rockwall County, TX
19140	Dalton, GA
	Murray County, GA
	Whitfield County, GA
19180	Danville, IL
	Vermilion County, IL
19260	Danville, VA
	Pittsylvania County, VA
	Danville City, VA
19340	Davenport-Moline-Rock Island, IA-IL
	Henry County, IL
	Mercer County, IL
	Rock Island County, IL
	Scott County, IA
19380	Dayton, OH
	Greene County, OH
	Miami County, OH
	Montgomery County, OH
	Preble County, OH
19460	Decatur, AL
	Lawrence County, AL
	Morgan County, AL
19500	Decatur, IL
	Macon County, IL
19660	Deltona-Daytona Beach-Ormond Beach, FL
	Volusia County, FL
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
19780	Des Moines-West Des Moines, IA
	Dallas County, IA
	Guthrie County, IA
	Madison County, IA
	Polk County, IA
	Warren County, IA
19804	[1] Detroit-Livonia-Dearborn, MI
	Wayne County, MI
20020	Dothan, AL
	Geneva County, AL
	Henry County, AL
	Houston County, AL
20100	Dover, DE
	Kent County, DE
20220	Dubuque, IA
	Dubuque County, IA
20260	Duluth, MN-WI
	Carlton County, MN
	St. Louis County, MN
	Douglas County, WI
20500	Durham, NC
	Chatham County, NC
	Durham County, NC
	Orange County, NC
	Person County, NC
20740	Eau Claire, WI
	Chippewa County, WI
	Eau Claire County, WI
20764	[1] Edison-New Brunswick, NJ
	Middlesex County, NJ
	Monmouth County, NJ
	New Brunswick County, NJ
	Ocean County, NJ
	Somerset County, NJ
20940	El Centro, CA
	Imperial County, CA
21060	Elizabethtown, KY
	Hardin County, KY
	Larue County, KY
21140	Elkhart-Goshen, IN
	Elkhart County, IN
21300	Elmira, NY
	Chemung County, NY
21340	El Paso, TX
	El Paso County, TX
21500	Erie, PA
	Erie County, PA
21660	Eugene-Springfield, OR
	Lane County, OR
21780	Evansville, IN-KY
	Gibson County, IN
	Posey County, IN
	Vanderburgh County, IN
	Warrick County, IN
	Henderson County, KY
	Webster County, KY
21820	Fairbanks, AK
	Fairbanks North Star Borough, AK
21940	Fajardo, PR
	Ceiba Municipio, PR
	Fajardo Municipio, PR
	Luquillo Municipio, PR
22020	Fargo, ND-MN
	Clay County, MN
	Cass County, ND
22140	Farmington, NM
	San Juan County, NM
22180	Fayetteville, NC
	Cumberland County, NC
	Hoke County, NC
22220	Fayetteville-Springdale-Rogers, AR-MO
	Benton County, AR
	Madison County, AR
	Washington County, AR
	McDonald County, MO
22380	Flagstaff, AZ
	Coconino County, AZ
22420	Flint, MI
	Genesee County, MI
22500	Florence, SC
	Darlington County, SC
	Florence County, SC
22520	Florence-Muscle Shoals, AL
	Colbert County, AL
	Lauderdale County, AL
22540	Fond du Lac, WI
	Fond du Lac County, WI
22660	Fort Collins-Loveland, CO
	Larimer County, CO
22744	[1] Fort Lauderdale-Pompano Beach-Deerfield Beach, FL
	Broward County, FL
22900	Fort Smith, AR-OK
	Crawford County, AR
	Franklin County, AR
	Sebastian County, AR
	Le Flore County, OK
	Sequoyah County, OK
23020	Fort Walton Beach-Crestview-Destin, FL
	Okaloosa County, FL
23060	Fort Wayne, IN
	Allen County, IN
	Wells County, IN
	Whitley County, IN
23104	[1] Fort Worth-Arlington, TX
	Johnson County, TX
	Parker County, TX
	Tarrant County, TX
	Wise County, TX
23420	Fresno, CA
	Fresno County, CA
23460	Gadsden, AL
	Etowah County, AL
23540	Gainesville, FL
	Alachua County, FL
	Gilchrist County, FL
23580	Gainesville, GA
	Hall County, GA
23844	Gary, IN
	Jasper County, IN
	Lake County, IN
	Newton County, IN
	Porter County, IN
24020	Glens Falls, NY
	Warren County, NY
	Washington County, NY
24140	Goldsboro, NC
	Wayne County, NC
24220	Grand Forks, ND-MN
	Polk County, MN
	Grand Forks County, ND
24300	Grand Junction, CO
	Mesa County, CO
24340	Grand Rapids-Wyoming, MI
	Barry County, MI
	Ionia County, MI
	Kent County, MI
	Newaygo County, MI
24500	Great Falls, MT
	Cascade County, MT
24540	Greeley, CO
	Weld County, CO
24580	Green Bay, WI
	Brown County, WI
	Kewaunee County, WI
	Oconto County, WI
24660	Greensboro-High Point, NC
	Guilford County, NC
	Randolph County, NC
	Rockingham County, NC
24780	Greenville, NC
	Greene County, NC
	Pitt County, NC
24860	Greenville-Mauldin-Easley, SC
	Greenville County, SC
	Laurens County, SC
	Pickens County, SC

TABLE 4E.—URBAN CBSAS AND CONSTITUENT COUNTIES—FY 2009—Continued

CBSA code	Urban area (constituent counties)
25020	Guayama, PR
	Arroyo Municipio, PR
	Guayama Municipio, PR
	Patillas Municipio, PR
25060	Gulfport-Biloxi, MS
	Hancock County, MS
	Harrison County, MS
	Stone County, MS
25180	Hagerstown-Martinsburg, MD-WV
	Washington County, MD
	Berkeley County, WV
	Morgan County, WV
25260	Hanford-Corcoran, CA
	Kings County, CA
25420	Harrisburg-Carlisle, PA
	Cumberland County, PA
	Dauphin County, PA
	Perry County, PA
25500	Harrisonburg, VA
	Rockingham County, VA
	Harrisonburg City, VA
25540	[1] Hartford-West Hartford-East
	Hartford, CT
	Hartford County, CT
	Middlesex County, CT
	Tolland County, CT
25620	Hattiesburg, MS
	Forrest County, MS
	Lamar County, MS
	Perry County, MS
25860	Hickory-Lenoir-Morganton, NC
	Alexander County, NC
	Burke County, NC
	Caldwell County, NC
	Catawba County, NC
25980	Hinesville-Fort Stewart, GA
	Liberty County, GA
	Long County, GA
26100	Holland-Grand Haven, MI
	Ottawa County, MI
26180	Honolulu, HI
	Honolulu County, HI
26300	Hot Springs, AR
	Garland County, AR
26380	Houma-Bayou Cane-Thibodaux, LA
	Lafourche Parish, LA
	Terrebonne Parish, LA
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
26580	Huntington-Ashland, WV-KY-OH
	Boyd County, KY
	Greenup County, KY
	Lawrence County, OH
	Cabell County, WV
	Wayne County, WV
26620	Huntsville, AL
	Limestone County, AL
	Madison County, AL
26820	Idaho Falls, ID
	Bonneville County, ID
	Jefferson County, ID
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
26980	Iowa City, IA
	Johnson County, IA
	Washington County, IA
27060	Ithaca, NY
	Tompkins County, NY
27100	Jackson, MI
	Jackson County, MI
27140	Jackson, MS
	Copiah County, MS
	Hinds County, MS
	Madison County, MS
	Rankin County, MS
	Simpson County, MS
27180	Jackson, TN
	Chester County, TN
	Madison County, TN
27260	[1] Jacksonville, FL
	Baker County, FL
	Clay County, FL
	Duval County, FL
	Nassau County, FL
	St. Johns County, FL
27340	Jacksonville, NC
	Onslow County, NC
27500	Janesville, WI
	Rock County, WI
27620	Jefferson City, MO
	Callaway County, MO
	Cole County, MO
	Moniteau County, MO
	Osage County, MO
27740	Johnson City, TN
	Carter County, TN
	Unicoi County, TN
	Washington County, TN
27780	Johnstown, PA
	Cambria County, PA
27860	Jonesboro, AR
	Craighead County, AR
	Poinsett County, AR
27900	Joplin, MO
	Jasper County, MO
	Newton County, MO
28020	Kalamazoo-Portage, MI
	Kalamazoo County, MI
	Van Buren County, MI
28100	Kankakee-Bradley, IL
	Kankakee County, IL
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
28420	Kennewick-Pasco-Richland, WA
	Benton County, WA
	Franklin County, WA
28660	Killeen-Temple-Fort Hood, TX
	Bell County, TX
	Coryell County, TX
	Lampasas County, TX
28700	Kingsport-Bristol-Bristol, TN-VA
	Hawkins County, TN
	Sullivan County, TN
	Bristol City, VA
	Scott County, VA
	Washington County, VA
28740	Kingston, NY
	Ulster County, NY
28940	Knoxville, TN
	Anderson County, TN
	Blount County, TN
	Knox County, TN
	Loudon County, TN
	Union County, TN
29020	Kokomo, IN
	Howard County, IN
	Tipton County, IN
29100	La Crosse, WI-MN
	Houston County, MN
	La Crosse County, WI
29140	Lafayette, IN
	Benton County, IN
	Carroll County, IN
	Tippecanoe County, IN
29180	Lafayette, LA
	Lafayette Parish, LA
	St. Martin Parish, LA
29340	Lake Charles, LA
	Calcasieu Parish, LA
	Cameron Parish, LA
29404	Lake County-Kenosha County, IL-WI
	Lake County, IL
	Kenosha County, WI
29420	Lake Havasu City-Kingman, AZ
	Mohave County, AZ
29460	Lakeland-Winter Haven, FL
	Polk County, FL
	Winter Haven County, FL
29540	Lancaster, PA
	Lancaster County, PA
29620	Lansing-East Lansing, MI
	Clinton County, MI
	Eaton County, MI
	Ingham County, MI
29700	Laredo, TX
	Webb County, TX
29740	Las Cruces, NM
	Dona Ana County, NM
29820	[1] Las Vegas-Paradise, NV
	Clark County, NV
29940	Lawrence, KS

TABLE 4E.—URBAN CBSAS AND CONSTITUENT COUNTIES—FY 2009—Continued

CBSA code	Urban area (constituent counties)
	Douglas County, KS
30020	Lawton, OK
	Comanche County, OK
30140	Lebanon, PA
	Lebanon County, PA
30300	Lewiston, ID-WA
	Nez Perce County, ID
	Asotin County, WA
30340	Lewiston-Auburn, ME
	Androscoggin County, ME
30460	Lexington-Fayette, KY
	Bourbon County, KY
	Clark County, KY
	Fayette County, KY
	Jessamine County, KY
	Scott County, KY
	Woodford County, KY
30620	Lima, OH
	Allen County, OH
30700	Lincoln, NE
	Lancaster County, NE
	Seward County, NE
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
30860	Logan, UT-ID
	Franklin County, ID
	Cache County, UT
30980	Longview, TX
	Gregg County, TX
	Rusk County, TX
	Upshur County, TX
31020	Longview, WA
	Cowlitz County, WA
31084	[1] Los Angeles-Long Beach-Glendale, CA
	Los Angeles County, CA
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
31180	Lubbock, TX
	Crosby County, TX
	Lubbock County, TX
31340	Lynchburg, VA
	Amherst County, VA
	Appomattox County, VA
	Bedford County, VA
	Campbell County, VA
	Bedford City, VA
	Lynchburg City, VA
31420	Macon, GA
	Bibb County, GA

TABLE 4E.—URBAN CBSAS AND CONSTITUENT COUNTIES—FY 2009—Continued

CBSA code	Urban area (constituent counties)
	Crawford County, GA
	Jones County, GA
	Monroe County, GA
	Twiggs County, GA
31460	Madera, CA
	Madera County, CA
31540	Madison, WI
	Columbia County, WI
	Dane County, WI
	Iowa County, WI
31700	Manchester-Nashua, NH
	Hillsborough County, NH
31900	Mansfield, OH
	Richland County, OH
32420	Mayagüez, PR
	Hormigueros Municipio, PR
	Mayagüez Municipio, PR
32580	McAllen-Edinburg-Mission, TX
	Hidalgo County, TX
32780	Medford, OR
	Jackson County, OR
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
32900	Merced, CA
	Merced County, CA
33124	[1] Miami-Miami Beach-Kendall, FL
	Miami-Dade County, FL
33140	Michigan City-La Porte, IN
	LaPorte County, IN
33260	Midland, TX
	Midland County, TX
33340	[1] Milwaukee-Waukesha-West Allis, WI
	Milwaukee County, WI
	Ozaukee County, WI
	Washington County, WI
	Waukesha County, WI
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
33540	Missoula, MT
	Missoula County, MT
33660	Mobile, AL
	Mobile County, AL
33700	Modesto, CA
	Stanislaus County, CA
33740	Monroe, LA
	Ouachita Parish, LA
	Union Parish, LA
33780	Monroe, MI

TABLE 4E.—URBAN CBSAS AND CONSTITUENT COUNTIES—FY 2009—Continued

CBSA code	Urban area (constituent counties)
	Monroe County, MI
33860	Montgomery, AL
	Autauga County, AL
	Elmore County, AL
	Lowndes County, AL
	Montgomery County, AL
34060	Morgantown, WV
	Monongalia County, WV
	Preston County, WV
34100	Morristown, TN
	Grainger County, TN
	Hamblen County, TN
	Jefferson County, TN
34580	Mount Vernon-Anacortes, WA
	Skagit County, WA
34620	Muncie, IN
	Delaware County, IN
34740	Muskegon-Norton Shores, MI
	Muskegon County, MI
34820	Myrtle Beach-North Myrtle Beach-Conway, SC
	Horry County, SC
34900	Napa, CA
	Napa County, CA
34940	Naples-Marco Island, FL
	Collier County, FL
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
35004	[1] Nassau-Suffolk, NY
	Nassau County, NY
	Suffolk County, NY
35084	[1] Newark-Union, NJ-PA
	Essex County, NJ
	Hunterdon County, NJ
	Morris County, NJ
	Sussex County, NJ
	Union County, NJ
	Pike County, PA
35300	New Haven-Milford, CT
	New Haven County, CT
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
35644	[1] New York-White Plains-Wayne, NY-NJ
	Bergen County, NJ
	Hudson County, NJ
	Passaic County, NJ
	Bronx County, NY
	Kings County, NY

TABLE 4E.—URBAN CBSAS AND CONSTITUENT COUNTIES—FY 2009—Continued

CBSA code	Urban area (constituent counties)
	New York County, NY
	Putnam County, NY
	Queens County, NY
	Richmond County, NY
	Rockland County, NY
	Westchester County, NY
35660	Niles-Benton Harbor, MI
	Berrien County, MI
35980	Norwich-New London, CT
	New London County, CT
36084	[1] Oakland-Fremont-Hayward, CA
	Alameda County, CA
	Contra Costa County, CA
36100	Ocala, FL
	Marion County, FL
36140	Ocean City, NJ
	Cape May County, NJ
36220	Odessa, TX
	Ector County, TX
36260	Ogden-Clearfield, UT
	Davis County, UT
	Morgan County, UT
	Weber County, UT
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
36500	Olympia, WA
	Thurston County, WA
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
36740	[1] Orlando-Kissimmee, FL
	Lake County, FL
	Orange County, FL
	Osceola County, FL
	Seminole County, FL
36780	Oshkosh-Neenah, WI
	Winnebago County, WI
36980	Owensboro, KY
	Daviess County, KY
	Hancock County, KY
	McLean County, KY
37100	Oxnard-Thousand Oaks-Ventura, CA
	Ventura County, CA
37340	Palm Bay-Melbourne-Titusville, FL
	Brevard County, FL
37380	Palm Coast, FL
	Flager County, FL
37460	Panama City-Lynn Haven, FL
	Bay County, FL
37620	Parkersburg-Marietta-Vienna, WV-OH
	Washington County, OH
	Pleasants County, WV
	Wirt County, WV
	Wood County, WV
37700	Pascagoula, MS
	George County, MS
	Jackson County, MS
37764	Peabody, MA
	Essex County, MA
37860	Pensacola-Ferry Pass-Brent, FL
	Escambia County, FL
	Santa Rosa County, FL
37900	Peoria, IL
	Marshall County, IL
	Peoria County, IL
	Stark County, IL
	Tazewell County, IL
	Woodford County, IL
37964	[1] Philadelphia, PA
	Bucks County, PA
	Chester County, PA
	Delaware County, PA
	Montgomery County, PA
	Philadelphia County, PA
38060	[1] Phoenix-Mesa-Scottsdale, AZ
	Maricopa County, AZ
	Pinal County, AZ
38220	Pine Bluff, AR
	Cleveland County, AR
	Jefferson County, AR
	Lincoln County, AR
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
38340	Pittsfield, MA
	Berkshire County, MA
38540	Pocatello, ID
	Bannock County, ID
	Power County, ID
38660	Ponce, PR
	Juana Díaz Municipio, PR
	Ponce Municipio, PR
	Villalba Municipio, PR
38860	Portland-South Portland-Biddeford, ME
	Cumberland County, ME
	Sagadahoc County, ME
	York County, ME
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
38940	Port St. Lucie, FL
	Martin County, FL
	St. Lucie County, FL
39100	Poughkeepsie-Newburgh-Middletown, NY
	Dutchess County, NY
	Orange County, NY
39140	Prescott, AZ
	Yavapai County, AZ
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
39340	Provo-Orem, UT
	Juab County, UT
	Utah County, UT
39380	Pueblo, CO
	Pueblo County, CO
39460	Punta Gorda, FL
	Charlotte County, FL
39540	Racine, WI
	Racine County, WI
39580	Raleigh-Cary, NC
	Franklin County, NC
	Johnston County, NC
	Wake County, NC
39660	Rapid City, SD
	Meade County, SD
	Pennington County, SD
39740	Reading, PA
	Berks County, PA
39820	Redding, CA
	Shasta County, CA
39900	Reno-Sparks, NV
	Storey County, NV
	Washoe County, NV
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
40140	[1] Riverside-San Bernardino-Ontario, CA
	Riverside County, CA
	San Bernardino County, CA
40220	Roanoke, VA
	Botetourt County, VA
	Craig County, VA
	Franklin County, VA
	Roanoke County, VA
	Roanoke City, VA
	Salem City, VA
40340	Rochester, MN
	Dodge County, MN
	Olmsted County, MN
	Wabasha County, MN
40380	[1] Rochester, NY
	Livingston County, NY
	Monroe County, NY
	Ontario County, NY

TABLE 4E.—URBAN CBSAS AND CONSTITUENT COUNTIES—FY 2009—Continued

CBSA code	Urban area (constituent counties)
	Orleans County, NY
	Wayne County, NY
40420	Rockford, IL
	Boone County, IL
	Winnebago County, IL
40484	Rockingham County-Strafford County, NH
	Rockingham County, NH
	Strafford County, NH
40580	Rocky Mount, NC
	Edgecombe County, NC
	Nash County, NC
40660	Rome, GA
	Floyd County, GA
40900	[1] Sacramento—Arden-Arcade—Roseville, CA
	El Dorado County, CA
	Placer County, CA
	Sacramento County, CA
	Yolo County, CA
40980	Saginaw-Saginaw Township North, MI
	Saginaw County, MI
41060	St. Cloud, MN
	Benton County, MN
	Stearns County, MN
41100	St. George, UT
	Washington County, UT
41140	St. Joseph, MO-KS
	Doniphan County, KS
	Andrew County, MO
	Buchanan County, MO
	DeKalb County, MO
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
41420	Salem, OR
	Marion County, OR
	Polk County, OR
41500	Salinas, CA
	Monterey County, CA
41540	Salisbury, MD
	Somerset County, MD
	Wicomico County, MD
41620	Salt Lake City, UT
	Salt Lake County, UT
	Summit County, UT
	Tooele County, UT
41660	San Angelo, TX
	Irion County, TX
	Tom Green County, TX
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
41740	[1] San Diego-Carlsbad-San Marcos, CA
	San Diego County, CA
41780	Sandusky, OH
	Erie County, OH
41884	[1] San Francisco-San Mateo-Redwood City, CA
	Marin County, CA
	San Francisco County, CA
	San Mateo County, CA
41900	San Germán-Cabo Rojo, PR
	Cabo Rojo Municipio, PR
	Lajas Municipio, PR
	Sabana Grande Municipio, PR
	San Germán Municipio, PR
41940	[1] San Jose-Sunnyvale-Santa Clara, CA
	San Benito County, CA
	Santa Clara County, CA
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
42020	San Luis Obispo-Paso Robles, CA
	San Luis Obispo County, CA
42044	[1] Santa Ana-Anaheim-Irvine, CA
	Orange County, CA
42060	Santa Barbara-Santa Maria-Goleta, CA
	Santa Barbara County, CA
42100	Santa Cruz-Watsonville, CA
	Santa Cruz County, CA
42140	Santa Fe, NM
	Santa Fe County, NM
42220	Santa Rosa-Petaluma, CA
	Sonoma County, CA
42340	Savannah, GA
	Bryan County, GA
	Chatham County, GA
	Effingham County, GA
42540	Scranton—Wilkes-Barre, PA
	Lackawanna County, PA
	Luzerne County, PA
	Wyoming County, PA
42644	[1] Seattle-Bellevue-Everett, WA
	King County, WA
	Snohomish County, WA
42680	Sebastian-Vero Beach, FL
	Indian River County, FL
43100	Sheboygan, WI
	Sheboygan County, WI
43300	Sherman-Denison, TX
	Grayson County, TX
43340	Shreveport-Bossier City, LA
	Bossier Parish, LA
	Caddo Parish, LA
	De Soto Parish, LA
43580	Sioux City, IA-NE-SD
	Woodbury County, IA
	Dakota County, NE
	Dixon County, NE
	Union County, SD
43620	Sioux Falls, SD
	Lincoln County, SD
	McCook County, SD
	Minnehaha County, SD
	Turner County, SD
43780	South Bend-Mishawaka, IN-MI
	St. Joseph County, IN
	Cass County, MI
43900	Spartanburg, SC
	Spartanburg County, SC
44060	Spokane, WA
	Spokane County, WA
44100	Springfield, IL
	Menard County, IL
	Sangamon County, IL
44140	Springfield, MA
	Franklin County, MA
	Hampden County, MA
	Hampshire County, MA
44180	Springfield, MO
	Christian County, MO
	Dallas County, MO
	Greene County, MO
	Polk County, MO
	Webster County, MO
44220	Springfield, OH
	Clark County, OH
44300	State College, PA
	Centre County, PA

TABLE 4E.—URBAN CBSAS AND CONSTITUENT COUNTIES—FY 2009—Continued

CBSA code	Urban area (constituent counties)
44700	Stockton, CA
	San Joaquin County, CA
44940	Sumter, SC
	Sumter County, SC
45060	Syracuse, NY
	Madison County, NY
	Onondaga County, NY
	Oswego County, NY
45104	Tacoma, WA
	Pierce County, WA
45220	Tallahassee, FL
	Gadsden County, FL
	Jefferson County, FL
	Leon County, FL
	Wakulla County, FL
45300	[1] Tampa-St. Petersburg-Clearwater, FL
	Hernando County, FL
	Hillsborough County, FL
	Pasco County, FL
	Pinellas County, FL
45460	Terre Haute, IN
	Clay County, IN
	Sullivan County, IN
	Vermillion County, IN
	Vigo County, IN
45500	Texarkana, TX-Texarkana, AR
	Miller County, AR
	Bowie County, TX
45780	Toledo, OH
	Fulton County, OH
	Lucas County, OH
	Ottawa County, OH
	Wood County, OH
45820	Topeka, KS
	Jackson County, KS
	Jefferson County, KS
	Osage County, KS
	Shawnee County, KS
	Wabaunsee County, KS
45940	Trenton-Ewing, NJ
	Mercer County, NJ
46060	Tucson, AZ
	Pima County, AZ
46140	Tulsa, OK
	Creek County, OK
	Okmulgee County, OK
	Osage County, OK
	Pawnee County, OK
	Rogers County, OK
	Tulsa County, OK
	Wagoner County, OK
46220	Tuscaloosa, AL
	Greene County, AL
	Hale County, AL
	Tuscaloosa County, AL
46340	Tyler, TX
	Smith County, TX
46540	Utica-Rome, NY
	Herkimer County, NY
	Oneida County, NY
46660	Valdosta, GA
	Brooks County, GA
	Echols County, GA
	Lanier County, GA
	Lowndes County, GA
46700	Vallejo-Fairfield, CA
	Solano County, CA
47020	Victoria, TX
	Calhoun County, TX
	Goliad County, TX
	Victoria County, TX
47220	Vineland-Millville-Bridgeton, NJ
	Cumberland County, NJ
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
47300	Visalia-Porterville, CA
	Tulare County, CA
47380	Waco, TX
	McLennan County, TX
47580	Warner Robins, GA
	Houston County, GA
47644	[1] Warren-Troy-Farmington Hills, MI
	Lapeer County, MI
	Livingston County, MI
	Macomb County, MI
	Oakland County, MI
	St. Clair County, MI
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
47940	Waterloo-Cedar Falls, IA
	Black Hawk County, IA
	Bremer County, IA
	Grundy County, IA
48140	Wausau, WI
	Marathon County, WI
48260	Weirton-Steubenville, WV-OH
	Jefferson County, OH
	Brooke County, WV
	Hancock County, WV
48300	Wenatchee, WA
	Chelan County, WA
	Douglas County, WA
48424	[1] West Palm Beach-Boca Raton-Boynton Beach, FL
	Palm Beach County, FL
48540	Wheeling, WV-OH
	Belmont County, OH
	Marshall County, WV
	Ohio County, WV
48620	Wichita, KS
	Butler County, KS
	Harvey County, KS
	Sedgwick County, KS
	Sumner County, KS
48660	Wichita Falls, TX
	Archer County, TX
	Clay County, TX
	Wichita County, TX
48700	Williamsport, PA
	Lycoming County, PA
48864	Wilmington, DE-MD-NJ
	New Castle County, DE
	Cecil County, MD
	Salem County, NJ
48900	Wilmington, NC
	Brunswick County, NC
	New Hanover County, NC
	Pender County, NC
49020	Winchester, VA-WV
	Frederick County, VA
	Winchester City, VA
	Hampshire County, WV
49180	Winston-Salem, NC
	Davie County, NC
	Forsyth County, NC
	Stokes County, NC
	Yadkin County, NC
49340	Worcester, MA
	Worcester County, MA
49420	Yakima, WA
	Yakima County, WA
49500	Yauco, PR
	Guánica Municipio, PR
	Guayanilla Municipio, PR
	Peñuelas Municipio, PR
	Yauco Municipio, PR
49620	York-Hanover, PA
	York County, PA
49660	Youngstown-Warren-Boardman, OH-PA
	Mahoning County, OH
	Trumbull County, OH
	Mercer County, PA
49700	Yuba City, CA
	Sutter County, CA
	Yuba County, CA
49740	Yuma, AZ
	Yuma County, AZ

[1] Large urban area.

TABLE 4F.—PUERTO RICO WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) BY CBSA—FY 2009

[Note: The rural floor budget neutrality adjustment is not applicable to the Puerto Rico-specific wage index.]

CBSA code	Area	Wage index	GAF	Wage index—re-classified hospitals	GAF—re-classified hospitals
10380	Aguadilla-Isabela-San Sebastián, PR	0.7845	0.8469		
21940	Fajardo, PR	0.9572	0.9705		
25020	Guayama, PR	0.7472	0.8191		
32420	Mayagüez, PR	0.9236	0.9470		
38660	Ponce, PR	0.9757	0.9833		
41900	San Germán-Cabo Rojo, PR	1.0864	1.0584		
41980	San Juan-Caguas-Guaynabo, PR	1.0348	1.0237		
49500	Yauco, PR	0.7969	0.8560		

The following list represents all hospitals that are eligible to have their wage index increased by the out-migration adjustment listed in this table. Hospitals cannot receive the out-migration adjustment if they are reclassified under section 1886(d)(10) of the Act or redesignated under section 1886(d)(8)(B) of the Act. Hospitals that have already been reclassified under section 1886(d)(10) of the Act or redesignated under section 1886(d)(8)(B) of the Act are designated with an asterisk. We will automatically assume that hospitals that have already been reclassified under section 1886(d)(10) of the Act or redesignated under section 1886(d)(8)(B) of the Act wish to retain their reclassification/redesignation status and waive the application of the out-migration adjustment. Section 1886(d)(10) hospitals that wish to receive the out-migration adjustment, rather than their reclassification, should follow the termination/withdrawal procedures specified in 42 CFR 412.273 and section III.I.3. of the preamble of this proposed rule. Otherwise, they will be deemed to have waived the out-migration adjustment. Hospitals redesignated under section 1886(d)(8)(B) of the Act will be deemed to have waived the out-migration adjustment, unless they explicitly notify CMS that they elected to receive the out-migration adjustment instead within 45 days from the publication of this proposed rule. These notifications should be sent to the following address: Centers for Medicare and Medicaid Services, Center for Medicare Management, Attn.: Wage Index Adjustment Waivers, Division of Acute Care, Room C4–08–06, 7500 Security Boulevard, Baltimore, MD 21244–1850.

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2009

Provider No.	Reclassified for FY 2009	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
010021		0.0030	DALE	01220
010022	*	0.1128	CHEROKEE	01090
010025	*	0.0235	CHAMBERS	01080
010027		0.0015	COFFEE	01150
010029	*	0.0289	LEE	01400
010032		0.0325	RANDOLPH	01550
010035	*	0.0254	CULLMAN	01210
010038		0.0047	CALHOUN	01070
010040		0.0061	ETOWAH	01270
010045		0.0222	FAYETTE	01280
010046		0.0061	ETOWAH	01270
010047		0.0127	BUTLER	01060
010049		0.0015	COFFEE	01150
010052	*	0.0103	TALLAPOOSA	01610
010054	*	0.0092	MORGAN	01510
010059	*	0.0069	LAWRENCE	01390
010061	*	0.0542	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		0.0215	BULLOCK	01050
010125		0.0476	WINSTON	01660
010128		0.0046	CLARKE	01120
010129		0.0134	BALDWIN	01010
010138		0.0066	SUMTER	01590
010143	*	0.0254	CULLMAN	01210
010146		0.0047	CALHOUN	01070

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2009—Continued

Provider No.	Reclassified for FY 2009	Out-migration adjustment	Qualifying county name	County code
010150	*	0.0127	BUTLER	01060
010158	*	0.0023	FRANKLIN	01290
010164	*	0.0211	TALLADEGA	01600
030067		0.0298	LAPAZ	03055
040014	*	0.0199	WHITE	04720
040019	*	0.0258	ST. FRANCIS	04610
040039	*	0.0172	GREENE	04270
040047		0.0117	RANDOLPH	04600
040067		0.0007	COLUMBIA	04130
040071	*	0.0149	JEFFERSON	04340
040076	*	0.1000	HOT SPRING	04290
040081		0.0357	PIKE	04540
050002		0.0010	ALAMEDA	05000
050007		0.0146	SAN MATEO	05510
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
050069	*	0.0020	ORANGE	05400
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
050089	*	0.0017	SAN BERNARDINO	05460
050090	*	0.0058	SONOMA	05590
050099	*	0.0017	SAN BERNARDINO	05460
050101	*	0.0171	SOLANO	05580
050113		0.0146	SAN MATEO	05510
050118	*	0.0132	SAN JOAQUIN	05490
050122		0.0132	SAN JOAQUIN	05490
050129	*	0.0017	SAN BERNARDINO	05460
050133	*	0.0178	YUBA	05680
050136	*	0.0058	SONOMA	05590
050140	*	0.0017	SAN BERNARDINO	05460
050150	*	0.0342	NEVADA	05390
050152		0.0026	SAN FRANCISCO	05480
050167		0.0132	SAN JOAQUIN	05490
050168	*	0.0020	ORANGE	05400
050173	*	0.0020	ORANGE	05400
050174	*	0.0058	SONOMA	05590
050193	*	0.0020	ORANGE	05400
050194	*	0.0052	SANTA CRUZ	05540
050195		0.0010	ALAMEDA	05000
050197	*	0.0146	SAN MATEO	05510
050211		0.0010	ALAMEDA	05000
050224	*	0.0020	ORANGE	05400
050226	*	0.0020	ORANGE	05400
050228		0.0026	SAN FRANCISCO	05480
050230	*	0.0020	ORANGE	05400
050232		0.0103	SAN LUIS OBISPO	05500
050242	*	0.0052	SANTA CRUZ	05540
050245	*	0.0017	SAN BERNARDINO	05460
050264		0.0010	ALAMEDA	05000
050272	*	0.0017	SAN BERNARDINO	05460
050279	*	0.0017	SAN BERNARDINO	05460
050283		0.0010	ALAMEDA	05000
050289		0.0146	SAN MATEO	05510
050291	*	0.0058	SONOMA	05590
050298		0.0017	SAN BERNARDINO	05460
050300	*	0.0017	SAN BERNARDINO	05460
050305		0.0010	ALAMEDA	05000
050313		0.0132	SAN JOAQUIN	05490
050320		0.0010	ALAMEDA	05000
050325		0.0033	TUOLUMNE	05650
050327	*	0.0017	SAN BERNARDINO	05460

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2009—Continued

Provider No.	Reclassified for FY 2009	Out-migration adjustment	Qualifying county name	County code
050335	*	0.0033	TUOLUMNE	05650
050336		0.0132	SAN JOAQUIN	05490
050348	*	0.0020	ORANGE	05400
050366		0.0015	CALAVERAS	05040
050367	*	0.0171	SOLANO	05580
050385	*	0.0058	SONOMA	05590
050407		0.0026	SAN FRANCISCO	05480
050426	*	0.0020	ORANGE	05400
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
050517	*	0.0017	SAN BERNARDINO	05460
050526	*	0.0020	ORANGE	05400
050528	*	0.0233	MERCED	05340
050541	*	0.0146	SAN MATEO	05510
050543	*	0.0020	ORANGE	05400
050547	*	0.0058	SONOMA	05590
050548	*	0.0020	ORANGE	05400
050551	*	0.0020	ORANGE	05400
050567	*	0.0020	ORANGE	05400
050570	*	0.0020	ORANGE	05400
050580	*	0.0020	ORANGE	05400
050584		0.0017	SAN BERNARDINO	05460
050586	*	0.0017	SAN BERNARDINO	05460
050589	*	0.0020	ORANGE	05400
050603	*	0.0020	ORANGE	05400
050609	*	0.0020	ORANGE	05400
050618	*	0.0017	SAN BERNARDINO	05460
050633		0.0103	SAN LUIS OBISPO	05500
050667	*	0.0180	NAPA	05380
050668		0.0026	SAN FRANCISCO	05480
050678	*	0.0020	ORANGE	05400
050680	*	0.0171	SOLANO	05580
050690	*	0.0058	SONOMA	05590
050693	*	0.0020	ORANGE	05400
050714		0.0052	SANTA CRUZ	05540
050720	*	0.0020	ORANGE	05400
050744	*	0.0020	ORANGE	05400
050745	*	0.0020	ORANGE	05400
050746	*	0.0020	ORANGE	05400
050747	*	0.0020	ORANGE	05400
050748		0.0132	SAN JOAQUIN	05490
050754		0.0146	SAN MATEO	05510
050758	*	0.0017	SAN BERNARDINO	05460
060001		0.0042	WELD	06610
060003	*	0.0069	BOULDER	06060
060010		0.0153	LARIMER	06340
060027	*	0.0069	BOULDER	06060
060030		0.0153	LARIMER	06340
060103	*	0.0069	BOULDER	06060
060116	*	0.0069	BOULDER	06060
060119		0.0153	LARIMER	06340
070006	*	0.0045	FAIRFIELD	07000
070010	*	0.0045	FAIRFIELD	07000
070018	*	0.0045	FAIRFIELD	07000
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

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2009—Continued

Provider No.	Reclassified for FY 2009	Out-migration adjustment	Qualifying county name	County code
100077	*	0.0028	CHARLOTTE	10070
100081	*	0.0022	WALTON	10650
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
100292	*	0.0022	WALTON	10650
110023	*	0.0416	GORDON	11500
110029	*	0.0052	HALL	11550
110040	*	0.1455	JACKSON	11610
110041	*	0.0623	HABERSHAM	11540
110100		0.0790	JEFFERSON	11620
110101		0.0067	COOK	11311
110142		0.0185	EVANS	11441
110146	*	0.0805	CAMDEN	11170
110150	*	0.0227	BALDWIN	11030
110187	*	0.0643	LUMPKIN	11701
110189	*	0.0066	FANNIN	11450
110190		0.0241	MACON	11710
110205		0.0507	GILMER	11471
130003	*	0.0235	NEZ PERCE	13340
130024		0.0675	BONNER	13080
130049	*	0.0319	KOOTENAI	13270
130066		0.0319	KOOTENAI	13270
130067	*	0.0725	BINGHAM	13050
140001		0.0369	FULTON	14370
140026		0.0315	LA SALLE	14580
140043	*	0.0056	WHITESIDE	14988
140058	*	0.0126	MORGAN	14770
140110	*	0.0315	LA SALLE	14580
140116		0.0007	MC HENRY	14640
140160	*	0.0332	STEPHENSON	14970
140161		0.0168	LIVINGSTON	14610
140167	*	0.0632	IROQUOIS	14460
140176		0.0007	MC HENRY	14640
140234		0.0315	LA SALLE	14580
150006	*	0.0113	LA PORTE	15450
150015	*	0.0113	LA PORTE	15450
150022		0.0158	MONTGOMERY	15530
150030	*	0.0192	HENRY	15320
150072		0.0105	CASS	15080
150076	*	0.0215	MARSHALL	15490
150088	*	0.0111	MADISON	15470
150091	*	0.0050	HUNTINGTON	15340
150102	*	0.0108	STARKE	15740
150113	*	0.0111	MADISON	15470
150133	*	0.0193	KOSCIUSKO	15420
150146	*	0.0319	NOBLE	15560
160013		0.0179	MUSCATINE	16690
160030		0.0040	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		0.0240	GRAYSON	18420
180079		0.0259	HARRISON	18480
190003	*	0.0085	IBERIA	19220
190015	*	0.0243	TANGIPAHOA	19520
190017	*	0.0187	ST. LANDRY	19480
190034		0.0189	VERMILION	19560
190044		0.0261	ACADIA	19000
190050		0.0044	BEAUREGARD	19050
190053		0.0101	JEFFERSON DAVIS	19260

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2009—Continued

Provider No.	Reclassified for FY 2009	Out-migration adjustment	Qualifying county name	County code
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	*	0.0102	ALLEN	19010
190116		0.0085	MOREHOUSE	19330
190133		0.0102	ALLEN	19010
190140		0.0035	FRANKLIN	19200
190144	*	0.0387	WEBSTER	19590
190145		0.0090	LA SALLE	19290
190184	*	0.0161	CALDWELL	19100
190190		0.0161	CALDWELL	19100
190191	*	0.0187	ST. LANDRY	19480
190246		0.0161	CALDWELL	19100
190257	*	0.0061	LINCOLN	19300
190277		0.0387	WEBSTER	19590
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
210043		0.0079	ANNE ARUNDEL	21010
210061		0.0188	WORCESTER	21230
220001	*	0.0067	WORCESTER	22170
220002	*	0.0271	MIDDLESEX	22090
220010	*	0.0355	ESSEX	22040
220011	*	0.0271	MIDDLESEX	22090
220019	*	0.0067	WORCESTER	22170
220025	*	0.0067	WORCESTER	22170
220029	*	0.0355	ESSEX	22040
220033	*	0.0355	ESSEX	22040
220035	*	0.0355	ESSEX	22040
220049	*	0.0271	MIDDLESEX	22090
220058	*	0.0067	WORCESTER	22170
220062	*	0.0067	WORCESTER	22170
220063	*	0.0271	MIDDLESEX	22090
220070	*	0.0271	MIDDLESEX	22090
220080	*	0.0355	ESSEX	22040
220082	*	0.0271	MIDDLESEX	22090
220084	*	0.0271	MIDDLESEX	22090
220090	*	0.0067	WORCESTER	22170
220095	*	0.0067	WORCESTER	22170
220098	*	0.0271	MIDDLESEX	22090
220101	*	0.0271	MIDDLESEX	22090
220105	*	0.0271	MIDDLESEX	22090
220163	*	0.0067	WORCESTER	22170
220171	*	0.0271	MIDDLESEX	22090
220174	*	0.0355	ESSEX	22040
220176	*	0.0067	WORCESTER	22170
230003	*	0.0220	OTTAWA	23690
230005		0.0473	LENAWEE	23450
230013	*	0.0025	OAKLAND	23620
230015		0.0295	ST. JOSEPH	23740
230019	*	0.0025	OAKLAND	23620
230021	*	0.0101	BERRIEN	23100
230022	*	0.0212	BRANCH	23110
230029	*	0.0025	OAKLAND	23620
230035	*	0.0095	MONTCALM	23580
230037	*	0.0210	HILLSDALE	23290
230047	*	0.0021	MACOMB	23490
230069	*	0.0210	LIVINGSTON	23460
230071	*	0.0025	OAKLAND	23620
230072	*	0.0220	OTTAWA	23690
230075		0.0047	CALHOUN	23120
230078	*	0.0101	BERRIEN	23100
230092	*	0.0223	JACKSON	23370
230093		0.0058	MECOSTA	23530
230096	*	0.0295	ST. JOSEPH	23740

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2009—Continued

Provider No.	Reclassified for FY 2009	Out-migration adjustment	Qualifying county name	County code
230099	*	0.0231	MONROE	23570
230121	*	0.0678	SHIAWASSEE	23770
230130	*	0.0025	OAKLAND	23620
230151	*	0.0025	OAKLAND	23620
230174	*	0.0220	OTTAWA	23690
230195	*	0.0021	MACOMB	23490
230204	*	0.0021	MACOMB	23490
230207	*	0.0025	OAKLAND	23620
230208	*	0.0095	MONTCALM	23580
230217		0.0047	CALHOUN	23120
230222	*	0.0035	MIDLAND	23550
230223	*	0.0025	OAKLAND	23620
230227	*	0.0021	MACOMB	23490
230254	*	0.0025	OAKLAND	23620
230257	*	0.0021	MACOMB	23490
230264	*	0.0021	MACOMB	23490
230269	*	0.0025	OAKLAND	23620
230277	*	0.0025	OAKLAND	23620
230279	*	0.0210	LIVINGSTON	23460
230301	*	0.0025	OAKLAND	23620
240018		0.0805	GOODHUE	24240
240044		0.0625	WINONA	24840
240064	*	0.0134	ITASCA	24300
240069	*	0.0267	STEELE	24730
240071	*	0.0385	RICE	24650
240117		0.0527	MOWER	24490
240211		0.0812	PINE	24570
250023	*	0.0541	PEARL RIVER	25540
250040	*	0.0021	JACKSON	25290
250117	*	0.0541	PEARL RIVER	25540
250128		0.0446	PANOLA	25530
250162		0.0014	HANCOCK	25220
260059		0.0077	LACLEDE	26520
260064	*	0.0089	AUDRAIN	26030
260097		0.0300	JOHNSON	26500
260116	*	0.0087	ST. FRANCOIS	26930
260163		0.0087	ST. FRANCOIS	26930
280077		0.0080	DODGE	28260
280123		0.0123	GAGE	28330
290002	*	0.0277	LYON	29090
300011	*	0.0069	HILLSBOROUGH	30050
300012	*	0.0069	HILLSBOROUGH	30050
300017	*	0.0102	ROCKINGHAM	30070
300020	*	0.0069	HILLSBOROUGH	30050
300023	*	0.0102	ROCKINGHAM	30070
300029	*	0.0102	ROCKINGHAM	30070
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
310015	*	0.0203	MORRIS	31300
310017	*	0.0203	MORRIS	31300
310018	*	0.0268	ESSEX	31200
310021	*	0.0092	MERCER	31260
310031	*	0.0153	BURLINGTON	31150
310038	*	0.0209	MIDDLESEX	31270
310039	*	0.0209	MIDDLESEX	31270
310044		0.0092	MERCER	31260
310050	*	0.0203	MORRIS	31300
310054	*	0.0268	ESSEX	31200
310057	*	0.0153	BURLINGTON	31150
310061	*	0.0153	BURLINGTON	31150
310069	*	0.0096	SALEM	31340
310070	*	0.0209	MIDDLESEX	31270
310076	*	0.0268	ESSEX	31200
310083	*	0.0268	ESSEX	31200
310091	*	0.0096	SALEM	31340
310092		0.0092	MERCER	31260
310093	*	0.0268	ESSEX	31200
310096	*	0.0268	ESSEX	31200

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2009—Continued

Provider No.	Reclassified for FY 2009	Out-migration adjustment	Qualifying county name	County code
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	*	0.0126	WYOMING	33900
330010		0.0067	MONTGOMERY	33380
330027	*	0.0123	NASSAU	33400
330033		0.0223	CHENANGO	33080
330047		0.0067	MONTGOMERY	33380
330073	*	0.0151	GENESEE	33290
330094	*	0.0503	COLUMBIA	33200
330103	*	0.0131	CATTARAUGUS	33040
330106	*	0.0123	NASSAU	33400
330126	*	0.0642	ORANGE	33540
330132		0.0131	CATTARAUGUS	33040
330135		0.0642	ORANGE	33540
330144		0.0054	STEUBEN	33690
330151		0.0054	STEUBEN	33690
330167	*	0.0123	NASSAU	33400
330175		0.0260	CORTLAND	33210
330181	*	0.0123	NASSAU	33400
330182	*	0.0123	NASSAU	33400
330191	*	0.0017	WARREN	33750
330198	*	0.0123	NASSAU	33400
330205		0.0642	ORANGE	33540
330224	*	0.0633	ULSTER	33740
330225	*	0.0123	NASSAU	33400
330235	*	0.0306	CAYUGA	33050
330259	*	0.0123	NASSAU	33400
330264		0.0642	ORANGE	33540
330276		0.0036	FULTON	33280
330277	*	0.0054	STEUBEN	33690
330331	*	0.0123	NASSAU	33400
330332	*	0.0123	NASSAU	33400
330372	*	0.0123	NASSAU	33400
330386	*	0.0745	SULLIVAN	33710
340020		0.0156	LEE	34520
340021	*	0.0162	CLEVELAND	34220
340024		0.0177	SAMPSON	34810
340027	*	0.0128	LENOIR	34530
340037		0.0162	CLEVELAND	34220
340038		0.0253	BEAUFORT	34060
340039	*	0.0101	IREDELL	34480
340068	*	0.0087	COLUMBUS	34230
340069	*	0.0015	WAKE	34910
340070	*	0.0395	ALAMANCE	34000
340071	*	0.0226	HARNETT	34420
340073	*	0.0015	WAKE	34910
340085		0.0250	DAVIDSON	34280
340096		0.0250	DAVIDSON	34280
340104		0.0162	CLEVELAND	34220
340114	*	0.0015	WAKE	34910
340126	*	0.0100	WILSON	34970
340129	*	0.0101	IREDELL	34480
340133		0.0308	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		0.0141	ASHLAND	36020
360010	*	0.0074	TUSCARAWAS	36800
360013	*	0.0135	SHELBY	36760
360025	*	0.0077	ERIE	36220
360036	*	0.0126	WAYNE	36860
360040		0.0387	KNOX	36430
360044		0.0127	DARKE	36190

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2009—Continued

Provider No.	Reclassified for FY 2009	Out-migration adjustment	Qualifying county name	County code
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	*	0.0133	ASHTABULA	36030
360156		0.0119	SANDUSKY	36730
360175	*	0.0183	CLINTON	36130
360185	*	0.0071	COLUMBIANA	36140
360187	*	0.0186	CLARK	36110
360245	*	0.0133	ASHTABULA	36030
370014	*	0.0361	BRYAN	37060
370015	*	0.0366	MAYES	37480
370023		0.0090	STEPHENS	37680
370065		0.0096	CRAIG	37170
370072		0.0258	LATIMER	37380
370083		0.0051	PUSHMATAHA	37630
370100		0.0100	CHOCTAW	37110
370149	*	0.0302	POTTAWATOMIE	37620
370156		0.0121	GARVIN	37240
370169		0.0163	MCINTOSH	37450
370172		0.0258	LATIMER	37380
370214		0.0121	GARVIN	37240
380022	*	0.0067	LINN	38210
380029		0.0075	MARION	38230
380051	*	0.0075	MARION	38230
380056		0.0075	MARION	38230
390008		0.0060	LAWRENCE	39450
390016	*	0.0060	LAWRENCE	39450
390030		0.0284	SCHUYLKILL	39650
390031	*	0.0284	SCHUYLKILL	39650
390044	*	0.0191	BERKS	39110
390052		0.0047	CLEARFIELD	39230
390056		0.0036	HUNTINGDON	39380
390065	*	0.0532	ADAMS	39000
390066	*	0.0372	LEBANON	39460
390079	*	0.0003	BRADFORD	39130
390086	*	0.0047	CLEARFIELD	39230
390096	*	0.0191	BERKS	39110
390110	*	0.0003	CAMBRIA	39160
390113	*	0.0053	CRAWFORD	39260
390117		0.0002	BEDFORD	39100
390122		0.0053	CRAWFORD	39260
390125		0.0022	WAYNE	39760
390130	*	0.0003	CAMBRIA	39160
390138	*	0.0218	FRANKLIN	39350
390146		0.0022	WARREN	39740
390150	*	0.0031	GREENE	39370
390151	*	0.0218	FRANKLIN	39350
390162	*	0.0200	NORTHAMPTON	39590
390183	*	0.0284	SCHUYLKILL	39650
390201		0.1170	MONROE	39550
390236		0.0003	BRADFORD	39130
390313	*	0.0284	SCHUYLKILL	39650
390316		0.0191	BERKS	39110
420002		0.0004	YORK	42450
420007	*	0.0027	SPARTANBURG	42410
420009	*	0.0113	OCONEE	42360
420019		0.0158	CHESTER	42110
420020	*	0.0007	GEORGETOWN	42210
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
420053		0.0035	NEWBERRY	42350
420054		0.0003	MARLBORO	42340
420062	*	0.0109	CHESTERFIELD	42120
420068	*	0.0027	ORANGEBURG	42370
420069	*	0.0052	CLARENDON	42130
420070	*	0.0052	SUMTER	42420

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2009—Continued

Provider No.	Reclassified for FY 2009	Out-migration adjustment	Qualifying county name	County code
420082		0.0008	AIKEN	42010
420083	*	0.0027	SPARTANBURG	42410
420098	*	0.0007	GEORGETOWN	42210
430008		0.0535	BROOKINGS	43050
430048		0.0129	LAWRENCE	43400
430094		0.0129	LAWRENCE	43400
440007		0.0219	COFFEE	44150
440008	*	0.0449	HENDERSON	44380
440012		0.0007	SULLIVAN	44810
440016		0.0144	CARROLL	44080
440017		0.0007	SULLIVAN	44810
440024	*	0.0230	BRADLEY	44050
440025	*	0.0007	GREENE	44290
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
440050		0.0007	GREENE	44290
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
440176		0.0007	SULLIVAN	44810
440180		0.0027	CAMPBELL	44060
440181		0.0365	HARDEMAN	44340
440182		0.0144	CARROLL	44080
440185	*	0.0230	BRADLEY	44050
450032		0.0254	HARRISON	45620
450039	*	0.0024	TARRANT	45910
450052	*	0.0276	BOSQUE	45160
450059		0.0075	COMAL	45320
450064	*	0.0024	TARRANT	45910
450087	*	0.0024	TARRANT	45910
450090		0.0650	COOKE	45340
450099	*	0.0145	GRAY	45563
450135	*	0.0024	TARRANT	45910
450137	*	0.0024	TARRANT	45910
450144		0.0559	ANDREWS	45010
450163		0.0054	KLEBERG	45743
450192		0.0271	HILL	45651
450194		0.0213	CHEROKEE	45281
450210		0.0151	PANOLA	45842
450224	*	0.0195	WOOD	45974
450236		0.0389	HOPKINS	45654
450270		0.0271	HILL	45651
450283	*	0.0653	VAN ZANDT	45947
450324	*	0.0132	GRAYSON	45564
450347	*	0.0370	WALKER	45949
450348	*	0.0059	FALLS	45500
450370		0.0235	COLORADO	45312
450389	*	0.0618	HENDERSON	45640
450393	*	0.0132	GRAYSON	45564
450395	*	0.0441	POLK	45850
450419	*	0.0024	TARRANT	45910
450438		0.0235	COLORADO	45312
450451		0.0536	SOMERVELL	45893
450460		0.0053	TYLER	45942
450469	*	0.0132	GRAYSON	45564
450497		0.0375	MONTAGUE	45800
450539		0.0067	HALE	45582

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2009—Continued

Provider No.	Reclassified for FY 2009	Out-migration adjustment	Qualifying county name	County code
450547	*	0.0195	WOOD	45974
450563	*	0.0024	TARRANT	45910
450565	*	0.0486	PALO PINTO	45841
450573		0.0126	JASPER	45690
450596	*	0.0743	HOOD	45653
450615		0.0032	CASS	45260
450639	*	0.0024	TARRANT	45910
450641		0.0375	MONTAGUE	45800
450672	*	0.0024	TARRANT	45910
450675	*	0.0024	TARRANT	45910
450677	*	0.0024	TARRANT	45910
450698		0.0127	LAMB	45751
450747	*	0.0126	ANDERSON	45000
450755		0.0276	HOCKLEY	45652
450770	*	0.0182	MILAM	45795
450779	*	0.0024	TARRANT	45910
450813	*	0.0126	ANDERSON	45000
450838		0.0126	JASPER	45690
450872	*	0.0024	TARRANT	45910
450880	*	0.0024	TARRANT	45910
450884		0.0049	UPSHUR	45943
450886	*	0.0024	TARRANT	45910
450888		0.0024	TARRANT	45910
460001		0.0023	UTAH	46240
460013		0.0023	UTAH	46240
460017		0.0383	BOX ELDER	46010
460023		0.0023	UTAH	46240
460039	*	0.0383	BOX ELDER	46010
460043		0.0023	UTAH	46240
460052		0.0023	UTAH	46240
460055		0.0023	UTAH	46240
490019	*	0.1088	CULPEPER	49230
490084		0.0187	ESSEX	49280
490110		0.0185	MONTGOMERY	49600
500003	*	0.0166	SKAGIT	50280
500007	*	0.0166	SKAGIT	50280
500019		0.0131	LEWIS	50200
500039	*	0.0094	KITSAP	50170
500041	*	0.0020	COWLITZ	50070
510012		0.0124	MASON	51260
510018	*	0.0188	JACKSON	51170
510047	*	0.0269	MARION	51240
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
670015		0.0024	TARRANT	45910
670023		0.0024	TARRANT	45910

TABLE 5.—LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS–DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY

MS–DRG	FY 2009 proposed rule post-acute DRG	FY 2009 proposed 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.	23.4061	29.1	40.2
002	No	No	PRE	SURG	Heart transplant or implant of heart assist system w/o MCC.	12.8956	18.4	24.7

TABLE 5.—LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS–DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

MS–DRG	FY 2009 proposed rule post-acute DRG	FY 2009 proposed rule special pay DRG	MDC	Type	MS–DRG title	Weights	Geometric mean LOS	Arithmetic mean LOS
003	Yes	No	PRE	SURG	ECMO or trach w MV 96+ hrs or PDX exc face, mouth & neck w maj O.R.	18.3635	32.5	39.6
004	Yes	No	PRE	SURG	Trach w MV 96+ hrs or PDX exc face, mouth & neck w/o maj O.R..	11.1684	23.5	28.8
005	No	No	PRE	SURG	Liver transplant w MCC or intestinal transplant.	10.7436	15.9	21.2
006	No	No	PRE	SURG	Liver transplant w/o MCC	4.8292	8.9	10.2
007	No	No	PRE	SURG	Lung transplant	9.7325	15.9	19.7
008	No	No	PRE	SURG	Simultaneous pancreas/kidney transplant.	4.8917	10.1	11.9
009	No	No	PRE	SURG	Bone marrow transplant	6.6398	18.2	21.9
010	No	No	PRE	SURG	Pancreas transplant	3.7508	9.1	10.8
011	No	No	PRE	SURG	Tracheostomy for face,mouth & neck diagnoses w MCC.	4.8900	13.1	16.7
012	No	No	PRE	SURG	Tracheostomy for face,mouth & neck diagnoses w CC.	3.0563	8.9	10.7
013	No	No	PRE	SURG	Tracheostomy for face,mouth & neck diagnoses w/o CC/MCC.	1.9057	5.9	6.9
020	No	No	01	SURG	Intracranial vascular procedures w PDX hemorrhage w MCC.	8.3276	14.8	18.4
021	No	No	01	SURG	Intracranial vascular procedures w PDX hemorrhage w CC.	6.3534	13.7	15.4
022	No	No	01	SURG	Intracranial vascular procedures w PDX hemorrhage w/o CC/MCC.	4.2072	7.6	9.4
023	No	No	01	SURG	Cranio w major dev impl/acute complex CNS PDX w MCC or chemo implant.	5.0763	8.9	12.7
024	No	No	01	SURG	Cranio w major dev impl/acute complex CNS PDX w/o MCC.	3.4757	6.3	9.0
025	Yes	No	01	SURG	Craniotomy & endovascular intracranial procedures w MCC.	5.0324	9.9	13.0
026	Yes	No	01	SURG	Craniotomy & endovascular intracranial procedures w CC.	3.0107	6.5	8.2
027	Yes	No	01	SURG	Craniotomy & endovascular intracranial procedures w/o CC/MCC.	2.1083	3.5	4.5
028	Yes	Yes	01	SURG	Spinal procedures w MCC	5.1853	10.7	14.3
029	Yes	Yes	01	SURG	Spinal procedures w CC or spinal neurostimulators.	2.7949	5.1	7.1
030	Yes	Yes	01	SURG	Spinal procedures w/o CC/MCC	1.5395	2.8	3.7
031	Yes	No	01	SURG	Ventricular shunt procedures w MCC	4.3899	9.4	13.1
032	Yes	No	01	SURG	Ventricular shunt procedures w CC	1.9471	4.0	6.0
033	Yes	No	01	SURG	Ventricular shunt procedures w/o CC/MCC.	1.3334	2.3	3.0
034	No	No	01	SURG	Carotid artery stent procedure w MCC	3.2182	4.6	7.2
035	No	No	01	SURG	Carotid artery stent procedure w CC	2.0258	2.1	3.3
036	No	No	01	SURG	Carotid artery stent procedure w/o CC/MCC.	1.5706	1.3	1.6
037	No	No	01	SURG	Extracranial procedures w MCC	3.0208	5.9	8.5
038	No	No	01	SURG	Extracranial procedures w CC	1.5585	2.5	3.8
039	No	No	01	SURG	Extracranial procedures w/o CC/MCC	1.0057	1.5	1.8
040	Yes	Yes	01	SURG	Periph/cranial nerve & other nerv syst proc w MCC.	3.9691	9.7	13.3
041	Yes	Yes	01	SURG	Periph/cranial nerve & other nerv syst proc w CC or periph neurostim.	2.1517	5.3	7.2
042	Yes	Yes	01	SURG	Periph/cranial nerve & other nerv syst proc w/o CC/MCC.	1.6771	2.5	3.6
052	No	No	01	MED	Spinal disorders & injuries w CC/MCC	1.6271	4.9	6.7
053	No	No	01	MED	Spinal disorders & injuries w/o CC/MCC.	0.8617	3.2	4.0
054	Yes	No	01	MED	Nervous system neoplasms w MCC	1.5844	5.2	7.0
055	Yes	No	01	MED	Nervous system neoplasms w/o MCC	1.0781	3.8	5.1
056	Yes	No	01	MED	Degenerative nervous system disorders w MCC.	1.6311	5.7	7.8
057	Yes	No	01	MED	Degenerative nervous system disorders w/o MCC.	0.8755	3.9	5.0

TABLE 5.—LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS–DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

MS–DRG	FY 2009 proposed rule post-acute DRG	FY 2009 proposed rule special pay DRG	MDC	Type	MS–DRG title	Weights	Geometric mean LOS	Arithmetic mean LOS
058	No	No	01	MED	Multiple sclerosis & cerebellar ataxia w MCC.	1.5373	5.7	7.6
059	No	No	01	MED	Multiple sclerosis & cerebellar ataxia w CC.	0.9404	4.2	5.1
060	No	No	01	MED	Multiple sclerosis & cerebellar ataxia w/o CC/MCC.	0.6978	3.4	4.0
061	No	No	01	MED	Acute ischemic stroke w use of thrombolytic agent w MCC.	2.8759	6.8	8.9
062	No	No	01	MED	Acute ischemic stroke w use of thrombolytic agent w CC.	1.9505	5.3	6.3
063	No	No	01	MED	Acute ischemic stroke w use of thrombolytic agent w/o CC/MCC.	1.5168	3.9	4.5
064	Yes	No	01	MED	Intracranial hemorrhage or cerebral infarction w MCC.	1.8446	5.5	7.5
065	Yes	No	01	MED	Intracranial hemorrhage or cerebral infarction w CC.	1.1748	4.3	5.2
066	Yes	No	01	MED	Intracranial hemorrhage or cerebral infarction w/o CC/MCC.	0.8426	3.1	3.7
067	No	No	01	MED	Nonspecific cva & precerebral occlusion w/o infarct w MCC.	1.3899	4.4	5.8
068	No	No	01	MED	Nonspecific cva & precerebral occlusion w/o infarct w/o MCC.	0.8449	2.7	3.4
069	No	No	01	MED	Transient ischemia	0.7143	2.4	3.0
070	Yes	No	01	MED	Nonspecific cerebrovascular disorders w MCC.	1.8241	6.0	7.9
071	Yes	No	01	MED	Nonspecific cerebrovascular disorders w CC.	1.1307	4.4	5.6
072	Yes	No	01	MED	Nonspecific cerebrovascular disorders w/o CC/MCC.	0.7629	2.8	3.5
073	No	No	01	MED	Cranial & peripheral nerve disorders w MCC.	1.3037	4.7	6.2
074	No	No	01	MED	Cranial & peripheral nerve disorders w/o MCC.	0.8406	3.4	4.3
075	No	No	01	MED	Viral meningitis w CC/MCC	1.6738	5.7	7.3
076	No	No	01	MED	Viral meningitis w/o CC/MCC	0.8544	3.4	4.1
077	No	No	01	MED	Hypertensive encephalopathy w MCC	1.6225	5.2	6.7
078	No	No	01	MED	Hypertensive encephalopathy w CC	1.0050	3.6	4.4
079	No	No	01	MED	Hypertensive encephalopathy w/o CC/MCC.	0.7377	2.8	3.4
080	No	No	01	MED	Nontraumatic stupor & coma w MCC	1.1007	3.8	5.1
081	No	No	01	MED	Nontraumatic stupor & coma w/o MCC.	0.7094	2.7	3.5
082	No	No	01	MED	Traumatic stupor & coma, coma >1 hr w MCC.	2.0177	3.7	6.4
083	No	No	01	MED	Traumatic stupor & coma, coma >1 hr w CC.	1.3027	3.7	5.0
084	No	No	01	MED	Traumatic stupor & coma, coma >1 hr w/o CC/MCC.	0.8720	2.4	3.1
085	Yes	No	01	MED	Traumatic stupor & coma, coma <1 hr w MCC.	2.0942	5.5	7.6
086	Yes	No	01	MED	Traumatic stupor & coma, coma <1 hr w CC.	1.2049	3.9	5.0
087	Yes	No	01	MED	Traumatic stupor & coma, coma <1 hr w/o CC/MCC.	0.8008	2.6	3.3
088	No	No	01	MED	Concussion w MCC	1.5774	4.2	5.9
089	No	No	01	MED	Concussion w CC	0.9162	3.0	3.8
090	No	No	01	MED	Concussion w/o CC/MCC	0.6736	2.0	2.5
091	Yes	No	01	MED	Other disorders of nervous system w MCC.	1.5641	4.6	6.4
092	Yes	No	01	MED	Other disorders of nervous system w CC.	0.9195	3.5	4.5
093	Yes	No	01	MED	Other disorders of nervous system w/o CC/MCC.	0.6753	2.6	3.2
094	No	No	01	MED	Bacterial & tuberculous infections of nervous system w MCC.	3.3477	9.2	11.9
095	No	No	01	MED	Bacterial & tuberculous infections of nervous system w CC.	2.1934	6.9	8.6

TABLE 5.—LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS–DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

MS–DRG	FY 2009 proposed rule post-acute DRG	FY 2009 proposed rule special pay DRG	MDC	Type	MS–DRG title	Weights	Geometric mean LOS	Arithmetic mean LOS
096	No	No	01	MED	Bacterial & tuberculous infections of nervous system w/o CC/MCC.	1.8297	5.0	6.2
097	No	No	01	MED	Non-bacterial infect of nervous sys exc viral meningitis w MCC.	3.2101	9.9	12.6
098	No	No	01	MED	Non-bacterial infect of nervous sys exc viral meningitis w CC.	1.8564	6.8	8.4
099	No	No	01	MED	Non-bacterial infect of nervous sys exc viral meningitis w/o CC/MCC.	1.2533	4.6	5.9
100	Yes	No	01	MED	Seizures w MCC	1.5064	4.7	6.4
101	Yes	No	01	MED	Seizures w/o MCC	0.7594	2.9	3.7
102	No	No	01	MED	Headaches w MCC	0.9594	3.3	4.5
103	No	No	01	MED	Headaches w/o MCC	0.6224	2.5	3.1
113	No	No	02	SURG	Orbital procedures w CC/MCC	1.5656	3.8	5.6
114	No	No	02	SURG	Orbital procedures w/o CC/MCC	0.8313	1.9	2.6
115	No	No	02	SURG	Extraocular procedures except orbit	1.0625	3.3	4.3
116	No	No	02	SURG	Intraocular procedures w CC/MCC	1.1338	2.6	4.1
117	No	No	02	SURG	Intraocular procedures w/o CC/MCC	0.6699	1.6	2.2
121	No	No	02	MED	Acute major eye infections w CC/MCC	0.9556	4.4	5.5
122	No	No	02	MED	Acute major eye infections w/o CC/MCC.	0.6127	3.4	4.0
123	No	No	02	MED	Neurological eye disorders	0.6840	2.3	2.9
124	No	No	02	MED	Other disorders of the eye w MCC	1.0620	3.9	5.3
125	No	No	02	MED	Other disorders of the eye w/o MCC	0.6660	2.8	3.5
129	No	No	03	SURG	Major head & neck procedures w CC/MCC or major device.	2.0147	3.7	5.2
130	No	No	03	SURG	Major head & neck procedures w/o CC/MCC.	1.1588	2.4	2.9
131	No	No	03	SURG	Cranial/facial procedures w CC/MCC	1.9768	4.0	5.7
132	No	No	03	SURG	Cranial/facial procedures w/o CC/MCC.	1.1041	2.1	2.7
133	No	No	03	SURG	Other ear, nose, mouth & throat O.R. procedures w CC/MCC.	1.5491	3.6	5.3
134	No	No	03	SURG	Other ear, nose, mouth & throat O.R. procedures w/o CC/MCC.	0.8243	1.7	2.2
135	No	No	03	SURG	Sinus & mastoid procedures w CC/MCC.	1.6842	3.8	5.8
136	No	No	03	SURG	Sinus & mastoid procedures w/o CC/MCC.	0.9023	1.7	2.3
137	No	No	03	SURG	Mouth procedures w CC/MCC	1.2668	3.8	5.4
138	No	No	03	SURG	Mouth procedures w/o CC/MCC	0.7368	1.9	2.5
139	No	No	03	SURG	Salivary gland procedures	0.8176	1.4	1.8
146	No	No	03	MED	Ear, nose, mouth & throat malignancy w MCC.	2.0489	6.7	9.4
147	No	No	03	MED	Ear, nose, mouth & throat malignancy w CC.	1.2486	4.3	6.1
148	No	No	03	MED	Ear, nose, mouth & throat malignancy w/o CC/MCC.	0.8181	2.7	3.8
149	No	No	03	MED	Dysequilibrium	0.6086	2.2	2.7
150	No	No	03	MED	Epistaxis w MCC	1.2243	3.7	5.2
151	No	No	03	MED	Epistaxis w/o MCC	0.6018	2.3	2.9
152	No	No	03	MED	Otitis media & URI w MCC	0.8976	3.4	4.5
153	No	No	03	MED	Otitis media & URI w/o MCC	0.5948	2.6	3.2
154	No	No	03	MED	Other ear, nose, mouth & throat diagnoses w MCC.	1.3768	4.6	6.3
155	No	No	03	MED	Other ear, nose, mouth & throat diagnoses w CC.	0.8779	3.5	4.4
156	No	No	03	MED	Other ear, nose, mouth & throat diagnoses w/o CC/MCC.	0.6306	2.5	3.2
157	No	No	03	MED	Dental & oral diseases w MCC	1.4793	4.7	6.7
158	No	No	03	MED	Dental & oral diseases w CC	0.8615	3.4	4.5
159	No	No	03	MED	Dental & oral diseases w/o CC/MCC	0.5952	2.4	3.1
163	Yes	No	04	SURG	Major chest procedures w MCC	4.9951	12.2	14.9
164	Yes	No	04	SURG	Major chest procedures w CC	2.5982	6.7	8.1
165	Yes	No	04	SURG	Major chest procedures w/o CC/MCC	1.8086	4.3	5.1
166	Yes	No	04	SURG	Other resp system O.R. procedures w MCC.	3.6865	10.0	12.9

TABLE 5.—LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS–DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

MS–DRG	FY 2009 proposed rule post-acute DRG	FY 2009 proposed rule special pay DRG	MDC	Type	MS–DRG title	Weights	Geometric mean LOS	Arithmetic mean LOS
167	Yes	No	04	SURG	Other resp system O.R. procedures w CC.	2.0256	6.3	8.0
168	Yes	No	04	SURG	Other resp system O.R. procedures w/o CC/MCC.	1.3443	3.9	5.3
175	Yes	No	04	MED	Pulmonary embolism w MCC	1.5777	6.0	7.3
176	Yes	No	04	MED	Pulmonary embolism w/o MCC	1.0696	4.6	5.3
177	Yes	No	04	MED	Respiratory infections & inflammations w MCC.	2.0391	7.2	9.1
178	Yes	No	04	MED	Respiratory infections & inflammations w CC.	1.4979	6.0	7.4
179	Yes	No	04	MED	Respiratory infections & inflammations w/o CC/MCC.	1.0409	4.6	5.6
180	No	No	04	MED	Respiratory neoplasms w MCC	1.6938	6.0	7.9
181	No	No	04	MED	Respiratory neoplasms w CC	1.2293	4.5	5.9
182	No	No	04	MED	Respiratory neoplasms w/o CC/MCC	0.8712	3.2	4.2
183	No	No	04	MED	Major chest trauma w MCC	1.5304	5.8	7.2
184	No	No	04	MED	Major chest trauma w CC	0.9405	3.8	4.6
185	No	No	04	MED	Major chest trauma w/o CC/MCC	0.6755	2.9	3.4
186	Yes	No	04	MED	Pleural effusion w MCC	1.6200	5.7	7.4
187	Yes	No	04	MED	Pleural effusion w CC	1.0940	4.1	5.3
188	Yes	No	04	MED	Pleural effusion w/o CC/MCC	0.8121	3.1	4.0
189	No	No	04	MED	Pulmonary edema & respiratory failure	1.3473	4.8	6.1
190	Yes	No	04	MED	Chronic obstructive pulmonary disease w MCC.	1.3004	5.0	6.3
191	Yes	No	04	MED	Chronic obstructive pulmonary disease w CC.	0.9734	4.1	5.0
192	Yes	No	04	MED	Chronic obstructive pulmonary disease w/o CC/MCC.	0.7239	3.3	4.0
193	Yes	No	04	MED	Simple pneumonia & pleurisy w MCC	1.4303	5.4	6.8
194	Yes	No	04	MED	Simple pneumonia & pleurisy w CC	1.0041	4.4	5.3
195	Yes	No	04	MED	Simple pneumonia & pleurisy w/o CC/MCC.	0.7301	3.5	4.1
196	Yes	No	04	MED	Interstitial lung disease w MCC	1.6006	5.9	7.4
197	Yes	No	04	MED	Interstitial lung disease w CC	1.0973	4.4	5.4
198	Yes	No	04	MED	Interstitial lung disease w/o CC/MCC	0.8158	3.3	4.1
199	No	No	04	MED	Pneumothorax w MCC	1.7383	6.4	8.3
200	No	No	04	MED	Pneumothorax w CC	1.0118	3.9	5.1
201	No	No	04	MED	Pneumothorax w/o CC/MCC	0.7399	3.1	4.1
202	No	No	04	MED	Bronchitis & asthma w CC/MCC	0.8135	3.5	4.4
203	No	No	04	MED	Bronchitis & asthma w/o CC/MCC	0.5938	2.8	3.4
204	No	No	04	MED	Respiratory signs & symptoms	0.6533	2.2	2.9
205	Yes	No	04	MED	Other respiratory system diagnoses w MCC.	1.2427	4.0	5.5
206	Yes	No	04	MED	Other respiratory system diagnoses w/o MCC.	0.7266	2.7	3.4
207	Yes	No	04	MED	Respiratory system diagnosis w ventilator support 96+ hours.	5.1153	12.8	15.1
208	No	No	04	MED	Respiratory system diagnosis w ventilator support <96 hours.	2.1827	5.2	7.2
215	No	No	05	SURG	Other heart assist system implant	12.3351	7.8	14.2
216	Yes	No	05	SURG	Cardiac valve & oth maj cardiothoracic proc w card cath w MCC.	1..1072	15.7	18.4
217	Yes	No	05	SURG	Cardiac valve & oth maj cardiothoracic proc w card cath w CC.	7.0028	10.9	12.3
218	Yes	No	05	SURG	Cardiac valve & oth maj cardiothoracic proc w card cath w/o CC/MCC.	5.4355	8.4	9.1
219	Yes	Yes	05	SURG	Cardiac valve & oth maj cardiothoracic proc w/o card cath w MCC.	8.0764	11.5	14.0
220	Yes	Yes	05	SURG	Cardiac valve & oth maj cardiothoracic proc w/o card cath w CC.	5.3066	7.7	8.6

TABLE 5.—LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS–DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

MS–DRG	FY 2009 proposed rule post-acute DRG	FY 2009 proposed rule special pay DRG	MDC	Type	MS–DRG title	Weights	Geometric mean LOS	Arithmetic mean LOS
221	Yes	Yes	05	SURG	Cardiac valve & oth maj cardiothoracic proc w/o card cath w/o CC/MCC.	4.4089	6.0	6.4
222	No	No	05	SURG	Cardiac defib implant w cardiac cath w AMI/HF/shock w MCC.	8.6586	10.7	13.1
223	No	No	05	SURG	Cardiac defib implant w cardiac cath w AMI/HF/shock w/o MCC.	6.3035	4.6	6.3
224	No	No	05	SURG	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w MCC.	7.9767	9.2	11.4
225	No	No	05	SURG	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w/o MCC.	5.9123	4.5	5.6
226	No	No	05	SURG	Cardiac defibrillator implant w/o cardiac cath w MCC.	6.7278	6.2	9.3
227	No	No	05	SURG	Cardiac defibrillator implant w/o cardiac cath w/o MCC.	5.0145	1.8	2.8
228	Yes	No	05	SURG	Other cardiothoracic procedures w MCC.	7.8191	12.1	14.7
229	Yes	No	05	SURG	Other cardiothoracic procedures w CC	5.0358	7.9	9.1
230	Yes	No	05	SURG	Other cardiothoracic procedures w/o CC/MCC.	4.0677	5.6	6.5
231	No	No	05	SURG	Coronary bypass w PTCA w MCC	7.6801	11.2	13.3
232	No	No	05	SURG	Coronary bypass w PTCA w/o MCC	5.5460	8.3	9.2
233	Yes	No	05	SURG	Coronary bypass w cardiac cath w MCC.	7.0378	12.4	14.2
234	Yes	No	05	SURG	Coronary bypass w cardiac cath w/o MCC.	4.6193	8.3	8.9
235	Yes	No	05	SURG	Coronary bypass w/o cardiac cath w MCC.	5.6992	9.5	11.2
236	Yes	No	05	SURG	Coronary bypass w/o cardiac cath w/o MCC.	3.6122	6.1	6.6
237	No	No	05	SURG	Major cardiovasc procedures w MCC or thoracic aortic aneurysm repair.	5.0881	7.5	10.8
238	No	No	05	SURG	Major cardiovasc procedures w/o MCC.	2.8962	3.2	4.6
239	Yes	No	05	SURG	Amputation for circ sys disorders exc upper limb & toe w MCC.	4.4798	12.0	15.3
240	Yes	No	05	SURG	Amputation for circ sys disorders exc upper limb & toe w CC.	2.6706	8.3	10.4
241	Yes	No	05	SURG	Amputation for circ sys disorders exc upper limb & toe w/o CC/MCC.	1.5740	5.6	6.8
242	Yes	No	05	SURG	Permanent cardiac pacemaker implant w MCC.	3.7041	6.7	8.8
243	Yes	No	05	SURG	Permanent cardiac pacemaker implant w CC.	2.5934	3.8	5.1
244	Yes	No	05	SURG	Permanent cardiac pacemaker implant w/o CC/MCC.	2.0098	2.2	2.9
245	No	No	05	SURG	AICD generator procedures	4.0022	2.1	3.2
246	No	No	05	SURG	Perc cardiovasc proc w drug-eluting stent w MCC or 4+ vessels/stents.	3.1498	3.6	5.3
247	No	No	05	SURG	Perc cardiovasc proc w drug-eluting stent w/o MCC.	1.9134	1.7	2.2
248	No	No	05	SURG	Perc cardiovasc proc w non-drug-eluting stent w MCC or 4+ ves/stents.	2.8065	4.2	6.0
249	No	No	05	SURG	Perc cardiovasc proc w non-drug-eluting stent w/o MCC.	1.6397	1.9	2.5
250	No	No	05	SURG	Perc cardiovasc proc w/o coronary artery stent w MCC.	2.9923	5.4	7.8
251	No	No	05	SURG	Perc cardiovasc proc w/o coronary artery stent w/o MCC.	1.6023	2.1	2.8
252	No	No	05	SURG	Other vascular procedures w MCC	2.9526	5.5	8.5
253	No	No	05	SURG	Other vascular procedures w CC	2.2593	4.2	6.0
254	No	No	05	SURG	Other vascular procedures w/o CC/MCC.	1.5485	2.0	2.7
255	Yes	No	05	SURG	Upper limb & toe amputation for circ system disorders w MCC.	2.4040	7.1	9.7

TABLE 5.—LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS–DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

MS–DRG	FY 2009 proposed rule post-acute DRG	FY 2009 proposed rule special pay DRG	MDC	Type	MS–DRG title	Weights	Geometric mean LOS	Arithmetic mean LOS
256	Yes	No	05	SURG	Upper limb & toe amputation for circ system disorders w CC.	1.5895	5.8	7.5
257	Yes	No	05	SURG	Upper limb & toe amputation for circ system disorders w/o CC/MCC.	1.0216	3.6	4.8
258	No	No	05	SURG	Cardiac pacemaker device replacement w MCC.	2.8434	5.4	7.4
259	No	No	05	SURG	Cardiac pacemaker device replacement w/o MCC.	1.6944	2.0	2.8
260	No	No	05	SURG	Cardiac pacemaker revision except device replacement w MCC.	3.4221	8.1	11.2
261	No	No	05	SURG	Cardiac pacemaker revision except device replacement w CC.	1.4398	3.0	4.2
262	No	No	05	SURG	Cardiac pacemaker revision except device replacement w/o CC/MCC.	1.0173	2.0	2.6
263	No	No	05	SURG	Vein ligation & stripping	1.5392	3.4	5.4
264	Yes	No	05	SURG	Other circulatory system O.R. procedures.	2.5265	5.8	8.9
265	No	No	05	SURG	AICD lead procedures	2.2140	2.2	3.5
280	Yes	No	05	MED	Acute myocardial infarction, discharged alive w MCC.	1.9395	5.8	7.3
281	Yes	No	05	MED	Acute myocardial infarction, discharged alive w CC.	1.2210	3.9	4.8
282	Yes	No	05	MED	Acute myocardial infarction, discharged alive w/o CC/MCC.	0.8698	2.6	3.2
283	No	No	05	MED	Acute myocardial infarction, expired w MCC.	1.6979	3.4	5.5
284	No	No	05	MED	Acute myocardial infarction, expired w CC.	0.9130	2.2	3.2
285	No	No	05	MED	Acute myocardial infarction, expired w/o CC/MCC.	0.6059	1.7	2.2
286	No	No	05	MED	Circulatory disorders except AMI, w card cath w MCC.	1.9745	5.2	6.9
287	No	No	05	MED	Circulatory disorders except AMI, w card cath w/o MCC.	1.0225	2.4	3.1
288	Yes	No	05	MED	Acute & subacute endocarditis w MCC.	3.0720	9.2	11.8
289	Yes	No	05	MED	Acute & subacute endocarditis w CC	1.9524	7.0	8.7
290	Yes	No	05	MED	Acute & subacute endocarditis w/o CC/MCC.	1.4507	5.2	6.5
291	Yes	No	05	MED	Heart failure & shock w MCC	1.4576	5.0	6.5
292	Yes	No	05	MED	Heart failure & shock w CC	1.0053	4.1	5.0
293	Yes	No	05	MED	Heart failure & shock w/o CC/MCC	0.7205	3.1	3.7
294	No	No	05	MED	Deep vein thrombophlebitis w CC/MCC.	0.9564	4.6	5.5
295	No	No	05	MED	Deep vein thrombophlebitis w/o CC/MCC.	0.6347	3.7	4.3
296	No	No	05	MED	Cardiac arrest, unexplained w MCC	1.1910	1.9	3.0
297	No	No	05	MED	Cardiac arrest, unexplained w CC	0.6502	1.4	1.8
298	No	No	05	MED	Cardiac arrest, unexplained w/o CC/MCC.	0.4438	1.1	1.3
299	Yes	No	05	MED	Peripheral vascular disorders w MCC	1.4326	5.0	6.7
300	Yes	No	05	MED	Peripheral vascular disorders w CC	0.9245	4.1	5.0
301	Yes	No	05	MED	Peripheral vascular disorders w/o CC/MCC.	0.6580	3.0	3.7
302	No	No	05	MED	Atherosclerosis w MCC	1.0307	3.2	4.4
303	No	No	05	MED	Atherosclerosis w/o MCC	0.5666	2.0	2.5
304	No	No	05	MED	Hypertension w MCC	1.0808	3.9	5.2
305	No	No	05	MED	Hypertension w/o MCC	0.5900	2.3	2.9
306	No	No	05	MED	Cardiac congenital & valvular disorders w MCC.	1.5655	4.4	6.3
307	No	No	05	MED	Cardiac congenital & valvular disorders w/o MCC.	0.7476	2.7	3.4
308	No	No	05	MED	Cardiac arrhythmia & conduction disorders w MCC.	1.2981	4.1	5.5
309	No	No	05	MED	Cardiac arrhythmia & conduction disorders w CC.	0.8320	3.1	3.9

TABLE 5.—LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS–DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

MS–DRG	FY 2009 proposed rule post-acute DRG	FY 2009 proposed rule special pay DRG	MDC	Type	MS–DRG title	Weights	Geometric mean LOS	Arithmetic mean LOS
310	No	No	05	MED	Cardiac arrhythmia & conduction disorders w/o CC/MCC.	0.5829	2.3	2.8
311	No	No	05	MED	Angina pectoris	0.4969	1.9	2.3
312	No	No	05	MED	Syncope & collapse	0.7082	2.5	3.1
313	No	No	05	MED	Chest pain	0.5312	1.7	2.1
314	Yes	No	05	MED	Other circulatory system diagnoses w MCC.	1.7517	5.0	7.0
315	Yes	No	05	MED	Other circulatory system diagnoses w CC.	0.9922	3.5	4.6
316	Yes	No	05	MED	Other circulatory system diagnoses w/o CC/MCC.	0.6513	2.4	3.0
326	Yes	No	06	SURG	Stomach, esophageal & duodenal proc w MCC.	5.8025	13.2	17.1
327	Yes	No	06	SURG	Stomach, esophageal & duodenal proc w CC.	2.8389	7.8	10.1
328	Yes	No	06	SURG	Stomach, esophageal & duodenal proc w/o CC/MCC.	1.4576	3.2	4.4
329	Yes	No	06	SURG	Major small & large bowel procedures w MCC.	5.1793	12.8	16.0
330	Yes	No	06	SURG	Major small & large bowel procedures w CC.	2.5644	8.3	9.7
331	Yes	No	06	SURG	Major small & large bowel procedures w/o CC/MCC.	1.6250	5.2	5.9
332	Yes	No	06	SURG	Rectal resection w MCC	4.5358	12.0	14.3
333	Yes	No	06	SURG	Rectal resection w CC	2.4487	7.7	8.8
334	Yes	No	06	SURG	Rectal resection w/o CC/MCC	1.6247	4.7	5.5
335	Yes	No	06	SURG	Peritoneal adhesiolysis w MCC	4.0903	11.6	14.1
336	Yes	No	06	SURG	Peritoneal adhesiolysis w CC	2.2387	7.5	9.1
337	Yes	No	06	SURG	Peritoneal adhesiolysis w/o CC/MCC	1.4519	4.4	5.6
338	No	No	06	SURG	Appendectomy w complicated principal diag w MCC.	3.1787	8.8	10.7
339	No	No	06	SURG	Appendectomy w complicated principal diag w CC.	1.8625	6.0	7.0
340	No	No	06	SURG	Appendectomy w complicated principal diag w/o CC/MCC.	1.2267	3.5	4.2
341	No	No	06	SURG	Appendectomy w/o complicated principal diag w MCC.	2.1659	5.3	7.1
342	No	No	06	SURG	Appendectomy w/o complicated principal diag w CC.	1.3154	3.2	4.1
343	No	No	06	SURG	Appendectomy w/o complicated principal diag w/o CC/MCC.	0.9067	1.8	2.2
344	No	No	06	SURG	Minor small & large bowel procedures w MCC.	3.0822	9.2	11.8
345	No	No	06	SURG	Minor small & large bowel procedures w CC.	1.6391	6.2	7.2
346	No	No	06	SURG	Minor small & large bowel procedures w/o CC/MCC.	1.1869	4.4	4.9
347	No	No	06	SURG	Anal & stomal procedures w MCC	2.1823	6.4	8.8
348	No	No	06	SURG	Anal & stomal procedures w CC	1.2860	4.4	5.7
349	No	No	06	SURG	Anal & stomal procedures w/o CC/MCC.	0.7681	2.4	3.1
350	No	No	06	SURG	Inguinal & femoral hernia procedures w MCC.	2.2486	5.8	8.0
351	No	No	06	SURG	Inguinal & femoral hernia procedures w CC.	1.2638	3.4	4.6
352	No	No	06	SURG	Inguinal & femoral hernia procedures w/o CC/MCC.	0.8131	2.0	2.5
353	No	No	06	SURG	Hernia procedures except inguinal & femoral w MCC.	2.4935	6.4	8.4
354	No	No	06	SURG	Hernia procedures except inguinal & femoral w CC.	1.4046	4.0	5.1
355	No	No	06	SURG	Hernia procedures except inguinal & femoral w/o CC/MCC.	0.9675	2.4	2.9
356	Yes	No	06	SURG	Other digestive system O.R. procedures w MCC.	3.8574	9.5	12.9
357	Yes	No	06	SURG	Other digestive system O.R. procedures w CC.	2.1703	6.2	8.1

TABLE 5.—LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS–DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

MS–DRG	FY 2009 proposed rule post-acute DRG	FY 2009 proposed rule special pay DRG	MDC	Type	MS–DRG title	Weights	Geometric mean LOS	Arithmetic mean LOS
358	Yes	No	06	SURG	Other digestive system O.R. procedures w/o CC/MCC.	1.3493	3.3	4.5
368	No	No	06	MED	Major esophageal disorders w MCC	1.6184	5.1	6.6
369	No	No	06	MED	Major esophageal disorders w CC	1.0703	3.8	4.7
370	No	No	06	MED	Major esophageal disorders w/o CC/MCC.	0.7835	2.8	3.4
371	Yes	No	06	MED	Major gastrointestinal disorders & peritoneal infections w MCC.	1.9062	6.7	8.7
372	Yes	No	06	MED	Major gastrointestinal disorders & peritoneal infections w CC.	1.3025	5.6	6.9
373	Yes	No	06	MED	Major gastrointestinal disorders & peritoneal infections w/o CC/MCC.	0.8646	4.2	4.9
374	Yes	No	06	MED	Digestive malignancy w MCC	1.9057	6.3	8.6
375	Yes	No	06	MED	Digestive malignancy w CC	1.2523	4.6	6.0
376	Yes	No	06	MED	Digestive malignancy w/o CC/MCC	0.8820	3.2	4.2
377	Yes	No	06	MED	G.I. hemorrhage w MCC	1.6069	4.9	6.4
378	Yes	No	06	MED	G.I. hemorrhage w CC	1.0048	3.7	4.4
379	Yes	No	06	MED	G.I. hemorrhage w/o CC/MCC	0.7567	2.9	3.4
380	Yes	No	06	MED	Complicated peptic ulcer w MCC	1.7995	5.6	7.3
381	Yes	No	06	MED	Complicated peptic ulcer w CC	1.1138	4.2	5.2
382	Yes	No	06	MED	Complicated peptic ulcer w/o CC/MCC	0.8208	3.1	3.7
383	No	No	06	MED	Uncomplicated peptic ulcer w MCC	1.1789	4.4	5.5
384	No	No	06	MED	Uncomplicated peptic ulcer w/o MCC	0.7818	3.1	3.7
385	No	No	06	MED	Inflammatory bowel disease w MCC	1.8541	6.5	8.8
386	No	No	06	MED	Inflammatory bowel disease w CC	1.0601	4.5	5.7
387	No	No	06	MED	Inflammatory bowel disease w/o CC/MCC.	0.7746	3.5	4.3
388	Yes	No	06	MED	G.I. obstruction w MCC	1.5392	5.5	7.3
389	Yes	No	06	MED	G.I. obstruction w CC	0.9244	4.0	5.0
390	Yes	No	06	MED	G.I. obstruction w/o CC/MCC	0.6333	3.0	3.6
391	No	No	06	MED	Esophagitis, gastroent & misc digest disorders w MCC.	1.0810	3.9	5.2
392	No	No	06	MED	Esophagitis, gastroent & misc digest disorders w/o MCC.	0.6685	2.8	3.5
393	No	No	06	MED	Other digestive system diagnoses w MCC.	1.5367	4.9	6.9
394	No	No	06	MED	Other digestive system diagnoses w CC.	0.9489	3.8	4.8
395	No	No	06	MED	Other digestive system diagnoses w/o CC/MCC.	0.6745	2.6	3.3
405	Yes	No	07	SURG	Pancreas, liver & shunt procedures w MCC.	5.6481	12.4	17.0
406	Yes	No	07	SURG	Pancreas, liver & shunt procedures w CC.	2.7895	7.0	9.2
407	Yes	No	07	SURG	Pancreas, liver & shunt procedures w/o CC/MCC.	1.8411	4.2	5.5
408	No	No	07	SURG	Biliary tract proc except only cholecyst w or w/o c.d.e. w MCC.	4.2539	12.1	15.0
409	No	No	07	SURG	Biliary tract proc except only cholecyst w or w/o c.d.e. w CC.	2.5819	8.3	9.8
410	No	No	07	SURG	Biliary tract proc except only cholecyst w or w/o c.d.e. w/o CC/MCC.	1.6374	5.4	6.5
411	No	No	07	SURG	Cholecystectomy w c.d.e. w MCC	3.7602	10.4	12.4
412	No	No	07	SURG	Cholecystectomy w c.d.e. w CC	2.3633	7.5	8.6
413	No	No	07	SURG	Cholecystectomy w c.d.e. w/o CC/MCC.	1.6896	5.0	5.9
414	Yes	No	07	SURG	Cholecystectomy except by laparoscope w/o c.d.e. w MCC.	3.5777	9.7	11.7
415	Yes	No	07	SURG	Cholecystectomy except by laparoscope w/o c.d.e. w CC.	2.0372	6.5	7.6
416	Yes	No	07	SURG	Cholecystectomy except by laparoscope w/o c.d.e. w/o CC/MCC.	1.3290	4.1	4.8
417	No	No	07	SURG	Laparoscopic cholecystectomy w/o c.d.e. w MCC.	2.4851	6.5	8.4
418	No	No	07	SURG	Laparoscopic cholecystectomy w/o c.d.e. w CC.	1.6541	4.5	5.6

TABLE 5.—LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS–DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

MS–DRG	FY 2009 proposed rule post-acute DRG	FY 2009 proposed rule special pay DRG	MDC	Type	MS–DRG title	Weights	Geometric mean LOS	Arithmetic mean LOS
419	No	No	07	SURG	Laparoscopic cholecystectomy w/o c.d.e. w/o CC/MCC.	1.1296	2.5	3.2
420	No	No	07	SURG	Hepatobiliary diagnostic procedures w MCC.	4.0976	9.9	13.7
421	No	No	07	SURG	Hepatobiliary diagnostic procedures w CC.	1.8978	5.6	7.7
422	No	No	07	SURG	Hepatobiliary diagnostic procedures w/o CC/MCC.	1.2275	3.2	4.4
423	No	No	07	SURG	Other hepatobiliary or pancreas O.R. procedures w MCC.	4.5535	11.8	15.9
424	No	No	07	SURG	Other hepatobiliary or pancreas O.R. procedures w CC.	2.5159	7.9	10.4
425	No	No	07	SURG	Other hepatobiliary or pancreas O.R. procedures w/o CC/MCC.	1.3760	4.0	5.4
432	No	No	07	MED	Cirrhosis & alcoholic hepatitis w MCC	1.6776	5.2	7.0
433	No	No	07	MED	Cirrhosis & alcoholic hepatitis w CC	0.9378	3.8	4.9
434	No	No	07	MED	Cirrhosis & alcoholic hepatitis w/o CC/MCC.	0.6551	2.9	3.7
435	No	No	07	MED	Malignancy of hepatobiliary system or pancreas w MCC.	1.7117	5.7	7.6
436	No	No	07	MED	Malignancy of hepatobiliary system or pancreas w CC.	1.1892	4.5	5.8
437	No	No	07	MED	Malignancy of hepatobiliary system or pancreas w/o CC/MCC.	0.9506	3.2	4.3
438	No	No	07	MED	Disorders of pancreas except malignancy w MCC.	1.6992	5.5	7.5
439	No	No	07	MED	Disorders of pancreas except malignancy w CC.	1.0223	4.2	5.3
440	No	No	07	MED	Disorders of pancreas except malignancy w/o CC/MCC.	0.6963	3.2	3.8
441	Yes	No	07	MED	Disorders of liver except malig, cirr, alc hepa w MCC.	1.6580	5.1	7.0
442	Yes	No	07	MED	Disorders of liver except malig, cirr, alc hepa w CC.	0.9825	3.9	5.1
443	Yes	No	07	MED	Disorders of liver except malig, cirr, alc hepa w/o CC/MCC.	0.6945	3.0	3.8
444	No	No	07	MED	Disorders of the biliary tract w MCC	1.5579	5.0	6.6
445	No	No	07	MED	Disorders of the biliary tract w CC	1.0375	3.8	4.7
446	No	No	07	MED	Disorders of the biliary tract w/o CC/MCC.	0.7225	2.6	3.3
453	No	No	08	SURG	Combined anterior/posterior spinal fusion w MCC.	9.8724	12.0	15.7
454	No	No	08	SURG	Combined anterior/posterior spinal fusion w CC.	7.0370	6.5	8.0
455	No	No	08	SURG	Combined anterior/posterior spinal fusion w/o CC/MCC.	5.1744	3.7	4.4
456	No	No	08	SURG	Spinal fus exc cerv w spinal curv/malig/infec or 9+ fus w MCC.	8.5225	11.6	14.7
457	No	No	08	SURG	Spinal fus exc cerv w spinal curv/malig/infec or 9+ fus w CC.	5.6672	6.2	7.5
458	No	No	08	SURG	Spinal fus exc cerv w spinal curv/malig/infec or 9+ fus w/o CC/MCC.	4.7056	4.0	4.5
459	Yes	No	08	SURG	Spinal fusion except cervical w MCC	5.9847	7.6	9.4
460	Yes	No	08	SURG	Spinal fusion except cervical w/o MCC	3.5746	3.6	4.2
461	No	No	08	SURG	Bilateral or multiple major joint procs of lower extremity w MCC.	4.5636	6.8	8.4
462	No	No	08	SURG	Bilateral or multiple major joint procs of lower extremity w/o MCC.	3.1564	3.9	4.2
463	Yes	No	08	SURG	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w MCC.	4.6669	12.0	16.6
464	Yes	No	08	SURG	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w CC.	2.6117	7.7	10.2
465	Yes	No	08	SURG	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w/o CC/MCC.	1.4955	4.4	5.9
466	Yes	No	08	SURG	Revision of hip or knee replacement w MCC.	4.5564	7.4	9.2

TABLE 5.—LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS–DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

MS–DRG	FY 2009 proposed rule post-acute DRG	FY 2009 proposed rule special pay DRG	MDC	Type	MS–DRG title	Weights	Geometric mean LOS	Arithmetic mean LOS
467	Yes	No	08	SURG	Revision of hip or knee replacement w CC.	3.0720	4.8	5.5
468	Yes	No	08	SURG	Revision of hip or knee replacement w/o CC/MCC.	2.4597	3.6	3.9
469	Yes	No	08	SURG	Major joint replacement or reattachment of lower extremity w MCC.	3.2979	6.9	8.2
470	Yes	No	08	SURG	Major joint replacement or reattachment of lower extremity w/o MCC.	2.0144	3.6	3.9
471	No	No	08	SURG	Cervical spinal fusion w MCC	4.4277	7.0	9.8
472	No	No	08	SURG	Cervical spinal fusion w CC	2.6200	2.8	4.1
473	No	No	08	SURG	Cervical spinal fusion w/o CC/MCC	1.9213	1.6	2.0
474	Yes	No	08	SURG	Amputation for musculoskeletal sys & conn tissue dis w MCC.	3.4435	9.5	12.6
475	Yes	No	08	SURG	Amputation for musculoskeletal sys & conn tissue dis w CC.	1.9768	6.5	8.4
476	Yes	No	08	SURG	Amputation for musculoskeletal sys & conn tissue dis w/o CC/MCC.	1.1001	3.7	4.8
477	Yes	Yes	08	SURG	Biopsies of musculoskeletal system & connective tissue w MCC.	3.2545	8.9	11.9
478	Yes	Yes	08	SURG	Biopsies of musculoskeletal system & connective tissue w CC.	2.1266	4.6	6.6
479	Yes	Yes	08	SURG	Biopsies of musculoskeletal system & connective tissue w/o CC/MCC.	1.4779	1.9	2.8
480	Yes	Yes	08	SURG	Hip & femur procedures except major joint w MCC.	2.9050	7.8	9.3
481	Yes	Yes	08	SURG	Hip & femur procedures except major joint w CC.	1.8204	5.4	5.9
482	Yes	Yes	08	SURG	Hip & femur procedures except major joint w/o CC/MCC.	1.4976	4.5	4.8
483	Yes	No	08	SURG	Major joint & limb reattachment proc of upper extremity w CC/MCC.	2.2601	3.4	4.2
484	Yes	No	08	SURG	Major joint & limb reattachment proc of upper extremity w/o CC/MCC.	1.7535	2.1	2.4
485	No	No	08	SURG	Knee procedures w pdx of infection w MCC.	3.3033	9.8	12.1
486	No	No	08	SURG	Knee procedures w pdx of infection w CC.	2.1664	6.8	8.0
487	No	No	08	SURG	Knee procedures w pdx of infection w/o CC/MCC.	1.5507	4.9	5.7
488	Yes	No	08	SURG	Knee procedures w/o pdx of infection w CC/MCC.	1.6836	4.1	5.2
489	Yes	No	08	SURG	Knee procedures w/o pdx of infection w/o CC/MCC.	1.1604	2.6	3.0
490	No	No	08	SURG	Back & neck proc exc spinal fusion w CC/MCC or disc device/neurostim.	1.7221	3.0	4.3
491	No	No	08	SURG	Back & neck proc exc spinal fusion w/o CC/MCC.	0.9413	1.8	2.2
492	Yes	Yes	08	SURG	Lower extrem & humer proc except hip,foot,femur w MCC.	2.7705	6.8	8.5
493	Yes	Yes	08	SURG	Lower extrem & humer proc except hip,foot,femur w CC.	1.7631	4.3	5.3
494	Yes	Yes	08	SURG	Lower extrem & humer proc except hip,foot,femur w/o CC/MCC.	1.2385	2.8	3.4
495	Yes	No	08	SURG	Local excision & removal int fix devices exc hip & femur w MCC.	3.1782	8.1	11.0
496	Yes	No	08	SURG	Local excision & removal int fix devices exc hip & femur w CC.	1.7775	4.6	6.0
497	Yes	No	08	SURG	Local excision & removal int fix devices exc hip & femur w/o CC/MCC.	1.1277	2.3	3.0
498	No	No	08	SURG	Local excision & removal int fix devices of hip & femur w CC/MCC.	2.0274	5.5	7.9
499	No	No	08	SURG	Local excision & removal int fix devices of hip & femur w/o CC/MCC.	0.9097	2.3	3.0
500	Yes	Yes	08	SURG	Soft tissue procedures w MCC	2.8423	7.8	10.8
501	Yes	Yes	08	SURG	Soft tissue procedures w CC	1.4718	4.5	6.0
502	Yes	Yes	08	SURG	Soft tissue procedures w/o CC/MCC	0.9585	2.3	2.9
503	No	No	08	SURG	Foot procedures w MCC	2.3059	7.2	9.5

TABLE 5.—LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS–DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

MS–DRG	FY 2009 proposed rule post-acute DRG	FY 2009 proposed rule special pay DRG	MDC	Type	MS–DRG title	Weights	Geometric mean LOS	Arithmetic mean LOS
504	No	No	08	SURG	Foot procedures w CC	1.4725	5.1	6.5
505	No	No	08	SURG	Foot procedures w/o CC/MCC	0.9882	2.6	3.4
506	No	No	08	SURG	Major thumb or joint procedures	1.0286	2.5	3.4
507	No	No	08	SURG	Major shoulder or elbow joint procedures w CC/MCC.	1.7188	3.7	5.1
508	No	No	08	SURG	Major shoulder or elbow joint procedures w/o CC/MCC.	1.1156	1.7	2.1
509	No	No	08	SURG	Arthroscopy	1.1762	2.0	3.1
510	Yes	No	08	SURG	Shoulder,elbow or forearm proc, exc major joint proc w MCC.	1.9973	4.9	6.4
511	Yes	No	08	SURG	Shoulder,elbow or forearm proc, exc major joint proc w CC.	1.3434	3.2	4.0
512	Yes	No	08	SURG	Shoulder,elbow or forearm proc, exc major joint proc w/o CC/MCC.	0.9533	1.8	2.2
513	No	No	08	SURG	Hand or wrist proc, except major thumb or joint proc w CC/MCC.	1.2813	3.6	5.0
514	No	No	08	SURG	Hand or wrist proc, except major thumb or joint proc w/o CC/MCC.	0.8067	2.1	2.8
515	Yes	Yes	08	SURG	Other musculoskelet sys & conn tiss O.R. proc w MCC.	3.0601	7.9	10.4
516	Yes	Yes	08	SURG	Other musculoskelet sys & conn tiss O.R. proc w CC.	1.8073	4.5	6.0
517	Yes	Yes	08	SURG	Other musculoskelet sys & conn tiss O.R. proc w/o CC/MCC.	1.3326	2.1	3.0
533	Yes	No	08	MED	Fractures of femur w MCC	1.4207	4.8	6.7
534	Yes	No	08	MED	Fractures of femur w/o MCC	0.7318	3.3	4.0
535	Yes	No	08	MED	Fractures of hip & pelvis w MCC	1.3327	4.8	6.2
536	Yes	No	08	MED	Fractures of hip & pelvis w/o MCC	0.6934	3.4	3.9
537	No	No	08	MED	Sprains, strains, & dislocations of hip, pelvis & thigh w CC/MCC.	0.8871	3.6	4.5
538	No	No	08	MED	Sprains, strains, & dislocations of hip, pelvis & thigh w/o CC/MCC.	0.5787	2.7	3.2
539	Yes	No	08	MED	Osteomyelitis w MCC	2.0097	7.5	9.7
540	Yes	No	08	MED	Osteomyelitis w CC	1.3457	5.7	7.1
541	Yes	No	08	MED	Osteomyelitis w/o CC/MCC	0.9285	4.2	5.4
542	Yes	No	08	MED	Pathological fractures & musculoskelet & conn tiss malig w MCC.	1.8953	6.7	8.8
543	Yes	No	08	MED	Pathological fractures & musculoskelet & conn tiss malig w CC.	1.1263	4.8	5.9
544	Yes	No	08	MED	Pathological fractures & musculoskelet & conn tiss malig w/o CC/MCC.	0.7672	3.7	4.4
545	Yes	No	08	MED	Connective tissue disorders w MCC	2.3477	6.5	9.1
546	Yes	No	08	MED	Connective tissue disorders w CC	1.0951	4.4	5.5
547	Yes	No	08	MED	Connective tissue disorders w/o CC/MCC.	0.7224	3.1	3.8
548	No	No	08	MED	Septic arthritis w MCC	1.8776	6.7	8.9
549	No	No	08	MED	Septic arthritis w CC	1.1590	5.1	6.4
550	No	No	08	MED	Septic arthritis w/o CC/MCC	0.8006	3.7	4.5
551	Yes	No	08	MED	Medical back problems w MCC	1.5261	5.4	7.1
552	Yes	No	08	MED	Medical back problems w/o MCC	0.7623	3.4	4.1
553	No	No	08	MED	Bone diseases & arthropathies w MCC.	1.0978	4.7	6.0
554	No	No	08	MED	Bone diseases & arthropathies w/o MCC.	0.6305	3.0	3.7
555	No	No	08	MED	Signs & symptoms of musculoskeletal system & conn tissue w MCC.	1.0014	3.6	4.8
556	No	No	08	MED	Signs & symptoms of musculoskeletal system & conn tissue w/o MCC.	0.5738	2.5	3.1
557	Yes	No	08	MED	Tendonitis, myositis & bursitis w MCC	1.4264	5.2	6.6
558	Yes	No	08	MED	Tendonitis, myositis & bursitis w/o MCC.	0.8009	3.5	4.3
559	Yes	No	08	MED	Aftercare, musculoskeletal system & connective tissue w MCC.	1.7085	5.3	7.6

TABLE 5.—LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS–DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

MS–DRG	FY 2009 proposed rule post-acute DRG	FY 2009 proposed rule special pay DRG	MDC	Type	MS–DRG title	Weights	Geometric mean LOS	Arithmetic mean LOS
560	Yes	No	08	MED	Aftercare, musculoskeletal system & connective tissue w CC.	0.9491	3.6	4.7
561	Yes	No	08	MED	Aftercare, musculoskeletal system & connective tissue w/o CC/MCC.	0.5794	2.1	2.8
562	Yes	No	08	MED	Fx, sprn, strn & disl except femur, hip, pelvis & thigh w MCC.	1.3933	4.9	6.4
563	Yes	No	08	MED	Fx, sprn, strn & disl except femur, hip, pelvis & thigh w/o MCC.	0.6749	3.1	3.7
564	No	No	08	MED	Other musculoskeletal sys & connective tissue diagnoses w MCC.	1.4053	5.2	7.0
565	No	No	08	MED	Other musculoskeletal sys & connective tissue diagnoses w CC.	0.8848	3.9	5.0
566	No	No	08	MED	Other musculoskeletal sys & connective tissue diagnoses w/o CC/MCC.	0.6673	3.0	3.7
573	Yes	No	09	SURG	Skin graft &/or debrid for skn ulcer or cellulitis w MCC.	3.1703	9.6	13.1
574	Yes	No	09	SURG	Skin graft &/or debrid for skn ulcer or cellulitis w CC.	1.9362	7.1	9.3
575	Yes	No	09	SURG	Skin graft &/or debrid for skn ulcer or cellulitis w/o CC/MCC.	1.1176	4.7	5.9
576	No	No	09	SURG	Skin graft &/or debrid exc for skin ulcer or cellulitis w MCC.	3.4522	8.4	13.0
577	No	No	09	SURG	Skin graft &/or debrid exc for skin ulcer or cellulitis w CC.	1.5788	4.2	6.1
578	No	No	09	SURG	Skin graft &/or debrid exc for skin ulcer or cellulitis w/o CC/MCC.	0.9803	2.4	3.3
579	Yes	No	09	SURG	Other skin, subcut tiss & breast proc w MCC.	2.7821	7.8	10.7
580	Yes	No	09	SURG	Other skin, subcut tiss & breast proc w CC.	1.4093	3.7	5.5
581	Yes	No	09	SURG	Other skin, subcut tiss & breast proc w/o CC/MCC.	0.8606	1.9	2.6
582	No	No	09	SURG	Mastectomy for malignancy w CC/MCC.	0.9682	2.1	2.8
583	No	No	09	SURG	Mastectomy for malignancy w/o CC/MCC.	0.7498	1.6	1.8
584	No	No	09	SURG	Breast biopsy, local excision & other breast procedures w CC/MCC.	1.4344	4.0	6.0
585	No	No	09	SURG	Breast biopsy, local excision & other breast procedures w/o CC/MCC.	0.7995	1.7	2.2
592	Yes	No	09	MED	Skin ulcers w MCC	1.7469	6.6	8.9
593	Yes	No	09	MED	Skin ulcers w CC	1.1021	5.2	6.4
594	Yes	No	09	MED	Skin ulcers w/o CC/MCC	0.7871	4.1	5.1
595	No	No	09	MED	Major skin disorders w MCC	1.8159	6.2	8.3
596	No	No	09	MED	Major skin disorders w/o MCC	0.8200	3.8	4.8
597	No	No	09	MED	Malignant breast disorders w MCC	1.6001	5.9	8.2
598	No	No	09	MED	Malignant breast disorders w CC	1.0812	4.3	5.7
599	No	No	09	MED	Malignant breast disorders w/o CC/MCC.	0.7309	2.7	3.7
600	No	No	09	MED	Non-malignant breast disorders w CC/MCC.	0.9433	4.1	5.1
601	No	No	09	MED	Non-malignant breast disorders w/o CC/MCC.	0.6539	3.1	3.9
602	Yes	No	09	MED	Cellulitis w MCC	1.3980	5.5	7.0
603	Yes	No	09	MED	Cellulitis w/o MCC	0.7988	3.9	4.7
604	No	No	09	MED	Trauma to the skin, subcut tiss & breast w MCC.	1.1875	4.3	5.7
605	No	No	09	MED	Trauma to the skin, subcut tiss & breast w/o MCC.	0.6739	2.8	3.5
606	No	No	09	MED	Minor skin disorders w MCC	1.2415	4.4	6.3
607	No	No	09	MED	Minor skin disorders w/o MCC	0.6434	2.9	3.8
614	No	No	10	SURG	Adrenal & pituitary procedures w CC/MCC.	2.5046	5.1	7.0
615	No	No	10	SURG	Adrenal & pituitary procedures w/o CC/MCC.	1.3782	2.7	3.2
616	Yes	No	10	SURG	Amputat of lower limb for endocrine, nutrit, & metabol dis w MCC.	4.6284	13.3	16.9

TABLE 5.—LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS–DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

MS–DRG	FY 2009 proposed rule post-acute DRG	FY 2009 proposed rule special pay DRG	MDC	Type	MS–DRG title	Weights	Geometric mean LOS	Arithmetic mean LOS
617	Yes	No	10	SURG	Amputat of lower limb for endocrine, nutrit, & metabol dis w CC.	2.0940	7.0	8.8
618	Yes	No	10	SURG	Amputat of lower limb for endocrine, nutrit, & metabol dis w/o CC/MCC.	1.3234	5.1	6.4
619	No	No	10	SURG	O.R. procedures for obesity w MCC	3.3383	5.2	8.2
620	No	No	10	SURG	O.R. procedures for obesity w CC	1.8739	2.9	3.7
621	No	No	10	SURG	O.R. procedures for obesity w/o CC/MCC.	1.4269	1.9	2.2
622	Yes	No	10	SURG	Skin grafts & wound debrid for endoc, nutrit & metab dis w MCC.	3.1268	9.4	13.2
623	Yes	No	10	SURG	Skin grafts & wound debrid for endoc, nutrit & metab dis w CC.	1.8728	6.7	8.6
624	Yes	No	10	SURG	Skin grafts & wound debrid for endoc, nutrit & metab dis w/o CC/MCC.	1.0877	4.8	6.0
625	No	No	10	SURG	Thyroid, parathyroid & thyroglossal procedures w MCC.	2.1260	4.7	7.1
626	No	No	10	SURG	Thyroid, parathyroid & thyroglossal procedures w CC.	1.1284	2.1	3.1
627	No	No	10	SURG	Thyroid, parathyroid & thyroglossal procedures w/o CC/MCC.	0.7378	1.3	1.5
628	Yes	No	10	SURG	Other endocrine, nutrit & metab O.R. proc w MCC.	3.2732	7.5	11.2
629	Yes	No	10	SURG	Other endocrine, nutrit & metab O.R. proc w CC.	2.2931	6.9	8.7
630	Yes	No	10	SURG	Other endocrine, nutrit & metab O.R. proc w/o CC/MCC.	1.5069	4.0	5.5
637	Yes	No	10	MED	Diabetes w MCC	1.3538	4.5	6.1
638	Yes	No	10	MED	Diabetes w CC	0.8135	3.4	4.3
639	Yes	No	10	MED	Diabetes w/o CC/MCC	0.5577	2.5	3.0
640	Yes	No	10	MED	Nutritional & misc metabolic disorders w MCC.	1.1105	3.9	5.4
641	Yes	No	10	MED	Nutritional & misc metabolic disorders w/o MCC.	0.6798	3.1	3.8
642	No	No	10	MED	Inborn errors of metabolism	1.0169	3.7	5.2
643	Yes	No	10	MED	Endocrine disorders w MCC	1.6408	5.8	7.6
644	Yes	No	10	MED	Endocrine disorders w CC	1.0437	4.4	5.5
645	Yes	No	10	MED	Endocrine disorders w/o CC/MCC	0.7164	3.1	3.9
652	No	No	11	SURG	Kidney transplant	2.9787	6.6	7.8
653	Yes	No	11	SURG	Major bladder procedures w MCC	5.8091	13.6	16.9
654	Yes	No	11	SURG	Major bladder procedures w CC	2.9531	8.7	9.9
655	Yes	No	11	SURG	Major bladder procedures w/o CC/MCC.	2.0241	5.7	6.5
656	No	No	11	SURG	Kidney & ureter procedures for neoplasm w MCC.	3.2762	8.0	10.1
657	No	No	11	SURG	Kidney & ureter procedures for neoplasm w CC.	1.8655	5.0	6.0
658	No	No	11	SURG	Kidney & ureter procedures for neoplasm w/o CC/MCC.	1.3790	3.3	3.7
659	Yes	No	11	SURG	Kidney & ureter procedures for non-neoplasm w MCC.	3.3225	8.0	11.2
660	Yes	No	11	SURG	Kidney & ureter procedures for non-neoplasm w CC.	1.8913	4.8	6.5
661	Yes	No	11	SURG	Kidney & ureter procedures for non-neoplasm w/o CC/MCC.	1.2600	2.6	3.3
662	No	No	11	SURG	Minor bladder procedures w MCC	2.7078	7.4	10.3
663	No	No	11	SURG	Minor bladder procedures w CC	1.4443	3.7	5.3
664	No	No	11	SURG	Minor bladder procedures w/o CC/MCC.	0.9940	1.6	2.1
665	No	No	11	SURG	Prostatectomy w MCC	2.5635	8.2	11.1
666	No	No	11	SURG	Prostatectomy w CC	1.5553	4.3	6.4
667	No	No	11	SURG	Prostatectomy w/o CC/MCC	0.8259	2.1	2.9
668	No	No	11	SURG	Transurethral procedures w MCC	2.2348	6.2	8.5
669	No	No	11	SURG	Transurethral procedures w CC	1.2049	3.1	4.4
670	No	No	11	SURG	Transurethral procedures w/o CC/MCC.	0.7672	1.9	2.5
671	No	No	11	SURG	Urethral procedures w CC/MCC	1.4136	4.1	5.9
672	No	No	11	SURG	Urethral procedures w/o CC/MCC	0.7962	1.9	2.5

TABLE 5.—LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS–DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

MS–DRG	FY 2009 proposed rule post-acute DRG	FY 2009 proposed rule special pay DRG	MDC	Type	MS–DRG title	Weights	Geometric mean LOS	Arithmetic mean LOS
673	No	No	11	SURG	Other kidney & urinary tract procedures w MCC.	2.7645	5.8	9.7
674	No	No	11	SURG	Other kidney & urinary tract procedures w CC.	2.1527	4.6	7.2
675	No	No	11	SURG	Other kidney & urinary tract procedures w/o CC/MCC.	1.3137	1.5	2.1
682	Yes	No	11	MED	Renal failure w MCC	1.6374	5.2	7.2
683	Yes	No	11	MED	Renal failure w CC	1.1270	4.5	5.7
684	Yes	No	11	MED	Renal failure w/o CC/MCC	0.7278	3.2	3.9
685	No	No	11	MED	Admit for renal dialysis	0.8578	2.5	3.5
686	No	No	11	MED	Kidney & urinary tract neoplasms w MCC.	1.6240	5.6	7.6
687	No	No	11	MED	Kidney & urinary tract neoplasms w CC.	1.0719	4.1	5.4
688	No	No	11	MED	Kidney & urinary tract neoplasms w/o CC/MCC.	0.6816	2.5	3.3
689	Yes	No	11	MED	Kidney & urinary tract infections w MCC.	1.2271	4.9	6.2
690	Yes	No	11	MED	Kidney & urinary tract infections w/o MCC.	0.7559	3.5	4.2
691	No	No	11	MED	Urinary stones w esw lithotripsy w CC/MCC.	1.4503	2.9	4.0
692	No	No	11	MED	Urinary stones w esw lithotripsy w/o CC/MCC.	1.1528	1.9	2.4
693	No	No	11	MED	Urinary stones w/o esw lithotripsy w MCC.	1.1915	3.6	4.8
694	No	No	11	MED	Urinary stones w/o esw lithotripsy w/o MCC.	0.6573	2.0	2.6
695	No	No	11	MED	Kidney & urinary tract signs & symptoms w MCC.	1.1723	4.2	5.5
696	No	No	11	MED	Kidney & urinary tract signs & symptoms w/o MCC.	0.6308	2.6	3.3
697	No	No	11	MED	Urethral stricture	0.6938	2.4	3.1
698	Yes	No	11	MED	Other kidney & urinary tract diagnoses w MCC.	1.4719	5.0	6.7
699	Yes	No	11	MED	Other kidney & urinary tract diagnoses w CC.	0.9700	3.7	4.8
700	Yes	No	11	MED	Other kidney & urinary tract diagnoses w/o CC/MCC.	0.6813	2.8	3.6
707	No	No	12	SURG	Major male pelvic procedures w CC/MCC.	1.6265	3.4	4.4
708	No	No	12	SURG	Major male pelvic procedures w/o CC/MCC.	1.1839	1.8	2.1
709	No	No	12	SURG	Penis procedures w CC/MCC	1.8803	3.8	6.5
710	No	No	12	SURG	Penis procedures w/o CC/MCC	1.2586	1.4	1.8
711	No	No	12	SURG	Testes procedures w CC/MCC	2.0318	5.5	8.2
712	No	No	12	SURG	Testes procedures w/o CC/MCC	0.8077	2.2	3.0
713	No	No	12	SURG	Transurethral prostatectomy w CC/MCC.	1.1188	2.9	4.2
714	No	No	12	SURG	Transurethral prostatectomy w/o CC/MCC.	0.6333	1.7	1.9
715	No	No	12	SURG	Other male reproductive system O.R. proc for malignancy w CC/MCC.	1.7120	3.9	6.3
716	No	No	12	SURG	Other male reproductive system O.R. proc for malignancy w/o CC/MCC.	0.9713	1.2	1.4
717	No	No	12	SURG	Other male reproductive system O.R. proc exc malignancy w CC/MCC.	1.8091	5.1	7.2
718	No	No	12	SURG	Other male reproductive system O.R. proc exc malignancy w/o CC/MCC.	0.7849	2.2	2.8
722	No	No	12	MED	Malignancy, male reproductive system w MCC.	1.5588	5.7	7.6
723	No	No	12	MED	Malignancy, male reproductive system w CC.	0.9901	4.1	5.3
724	No	No	12	MED	Malignancy, male reproductive system w/o CC/MCC.	0.6006	2.4	3.2
725	No	No	12	MED	Benign prostatic hypertrophy w MCC	1.0462	4.2	5.5

TABLE 5.—LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS–DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

MS–DRG	FY 2009 proposed rule post-acute DRG	FY 2009 proposed rule special pay DRG	MDC	Type	MS–DRG title	Weights	Geometric mean LOS	Arithmetic mean LOS
726	No	No	12	MED	Benign prostatic hypertrophy w/o MCC.	0.6675	2.7	3.5
727	No	No	12	MED	Inflammation of the male reproductive system w MCC.	1.3016	5.0	6.4
728	No	No	12	MED	Inflammation of the male reproductive system w/o MCC.	0.6911	3.3	4.0
729	No	No	12	MED	Other male reproductive system diagnoses w CC/MCC.	1.0993	4.0	5.6
730	No	No	12	MED	Other male reproductive system diagnoses w/o CC/MCC.	0.5963	2.4	3.1
734	No	No	13	SURG	Pelvic evisceration, rad hysterectomy & rad vulvectomy w CC/MCC.	2.3505	6.0	8.0
735	No	No	13	SURG	Pelvic evisceration, rad hysterectomy & rad vulvectomy w/o CC/MCC.	1.1311	2.9	3.4
736	No	No	13	SURG	Uterine & adnexa proc for ovarian or adnexal malignancy w MCC.	4.1736	11.2	13.8
737	No	No	13	SURG	Uterine & adnexa proc for ovarian or adnexal malignancy w CC.	1.9577	6.0	7.2
738	No	No	13	SURG	Uterine & adnexa proc for ovarian or adnexal malignancy w/o CC/MCC.	1.1577	3.5	3.9
739	No	No	13	SURG	Uterine, adnexa proc for non-ovarian/adnexal malig w MCC.	3.0131	7.8	10.2
740	No	No	13	SURG	Uterine, adnexa proc for non-ovarian/adnexal malig w CC.	1.4661	4.3	5.2
741	No	No	13	SURG	Uterine, adnexa proc for non-ovarian/adnexal malig w/o CC/MCC.	1.0021	2.7	3.0
742	No	No	13	SURG	Uterine & adnexa proc for non-malignancy w CC/MCC.	1.3433	3.5	4.5
743	No	No	13	SURG	Uterine & adnexa proc for non-malignancy w/o CC/MCC.	0.8469	2.0	2.3
744	No	No	13	SURG	D&C, conization, laparoscopy & tubal interruption w CC/MCC.	1.3918	4.1	5.8
745	No	No	13	SURG	D&C, conization, laparoscopy & tubal interruption w/o CC/MCC.	0.7460	2.1	2.6
746	No	No	13	SURG	Vagina, cervix & vulva procedures w CC/MCC.	1.2662	3.0	4.2
747	No	No	13	SURG	Vagina, cervix & vulva procedures w/o CC/MCC.	0.8403	1.6	1.9
748	No	No	13	SURG	Female reproductive system reconstructive procedures.	0.8193	1.5	1.7
749	No	No	13	SURG	Other female reproductive system O.R. procedures w CC/MCC.	2.4919	6.7	9.3
750	No	No	13	SURG	Other female reproductive system O.R. procedures w/o CC/MCC.	0.9660	2.5	3.1
754	No	No	13	MED	Malignancy, female reproductive system w MCC.	1.7520	6.2	8.3
755	No	No	13	MED	Malignancy, female reproductive system w CC.	1.0769	4.3	5.7
756	No	No	13	MED	Malignancy, female reproductive system w/o CC/MCC.	0.6327	2.5	3.1
757	No	No	13	MED	Infections, female reproductive system w MCC.	1.5775	6.5	8.1
758	No	No	13	MED	Infections, female reproductive system w CC.	1.0621	4.9	6.1
759	No	No	13	MED	Infections, female reproductive system w/o CC/MCC.	0.7646	3.6	4.5
760	No	No	13	MED	Menstrual & other female reproductive system disorders w CC/MCC.	0.7917	3.0	4.0
761	No	No	13	MED	Menstrual & other female reproductive system disorders w/o CC/MCC.	0.5008	1.9	2.4
765	No	No	14	SURG	Cesarean section w CC/MCC	1.0606	4.0	5.0
766	No	No	14	SURG	Cesarean section w/o CC/MCC	0.7486	3.0	3.2
767	No	No	14	SURG	Vaginal delivery w sterilization &/or D&C.	0.9741	2.6	3.4
768	No	No	14	SURG	Vaginal delivery w O.R. proc except steril &/or D&C.	1.7321	0.0	0.0

TABLE 5.—LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS–DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

MS–DRG	FY 2009 proposed rule post-acute DRG	FY 2009 proposed rule special pay DRG	MDC	Type	MS–DRG title	Weights	Geometric mean LOS	Arithmetic mean LOS
769	No	No	14	SURG	Postpartum & post abortion diagnoses w O.R. procedure.	1.2935	3.2	4.6
770	No	No	14	SURG	Abortion w D&C, aspiration curettage or hysterotomy.	0.6677	1.6	2.2
774	No	No	14	MED	Vaginal delivery w complicating diagnoses.	0.6571	2.6	3.2
775	No	No	14	MED	Vaginal delivery w/o complicating diagnoses.	0.4830	2.0	2.2
776	No	No	14	MED	Postpartum & post abortion diagnoses w/o O.R. procedure.	0.6192	2.5	3.3
777	No	No	14	MED	Ectopic pregnancy	0.7721	1.9	2.2
778	No	No	14	MED	Threatened abortion	0.4373	2.0	3.0
779	No	No	14	MED	Abortion w/o D&C	0.4871	1.6	2.1
780	No	No	14	MED	False labor	0.1962	1.3	1.5
781	No	No	14	MED	Other antepartum diagnoses w medical complications.	0.6154	2.6	3.8
782	No	No	14	MED	Other antepartum diagnoses w/o medical complications.	0.3926	1.7	2.5
789	No	No	15	MED	Neonates, died or transferred to another acute care facility.	1.4227	0.0	0.0
790	No	No	15	MED	Extreme immaturity or respiratory distress syndrome, neonate.	4.6916	0.0	0.0
791	No	No	15	MED	Prematurity w major problems	3.2042	0.0	0.0
792	No	No	15	MED	Prematurity w/o major problems	1.9334	0.0	0.0
793	No	No	15	MED	Full term neonate w major problems	3.2914	0.0	0.0
794	No	No	15	MED	Neonate w other significant problems	1.1650	0.0	0.0
795	No	No	15	MED	Normal newborn	0.1577	0.0	0.0
799	No	No	16	SURG	Splenectomy w MCC	4.7602	10.8	14.1
800	No	No	16	SURG	Splenectomy w CC	2.5819	6.2	7.9
801	No	No	16	SURG	Splenectomy w/o CC/MCC	1.6484	3.8	4.9
802	No	No	16	SURG	Other O.R. proc of the blood & blood forming organs w MCC.	3.3539	8.9	12.2
803	No	No	16	SURG	Other O.R. proc of the blood & blood forming organs w CC.	1.7689	4.7	6.7
804	No	No	16	SURG	Other O.R. proc of the blood & blood forming organs w/o CC/MCC.	1.0613	2.5	3.4
808	No	No	16	MED	Major hematol/immun diag exc sickle cell crisis & coagul w MCC.	1.9850	6.3	8.2
809	No	No	16	MED	Major hematol/immun diag exc sickle cell crisis & coagul w CC.	1.1737	4.2	5.3
810	No	No	16	MED	Major hematol/immun diag exc sickle cell crisis & coagul w/o CC/MCC.	0.8957	3.2	4.0
811	No	No	16	MED	Red blood cell disorders w MCC	1.2742	4.0	5.7
812	No	No	16	MED	Red blood cell disorders w/o MCC	0.7629	2.8	3.7
813	No	No	16	MED	Coagulation disorders	1.3556	3.7	5.1
814	No	No	16	MED	Reticuloendothelial & immunity disorders w MCC.	1.4932	5.0	6.7
815	No	No	16	MED	Reticuloendothelial & immunity disorders w CC.	0.9973	3.8	5.0
816	No	No	16	MED	Reticuloendothelial & immunity disorders w/o CC/MCC.	0.6989	2.8	3.5
820	No	No	17	SURG	Lymphoma & leukemia w major O.R. procedure w MCC.	5.6401	13.3	17.7
821	No	No	17	SURG	Lymphoma & leukemia w major O.R. procedure w CC.	2.2489	5.5	7.9
822	No	No	17	SURG	Lymphoma & leukemia w major O.R. procedure w/o CC/MCC.	1.2399	2.6	3.5
823	No	No	17	SURG	Lymphoma & non-acute leukemia w other O.R. proc w MCC.	4.0990	12.1	15.4
824	No	No	17	SURG	Lymphoma & non-acute leukemia w other O.R. proc w CC.	2.1791	6.6	8.7
825	No	No	17	SURG	Lymphoma & non-acute leukemia w other O.R. proc w/o CC/MCC.	1.2059	3.0	4.3
826	No	No	17	SURG	Myeloprolif disord or poorly diff neopl w maj O.R. proc w MCC.	4.6385	11.1	15.0
827	No	No	17	SURG	Myeloprolif disord or poorly diff neopl w maj O.R. proc w CC.	2.2759	5.9	8.0

TABLE 5.—LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS–DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

MS–DRG	FY 2009 proposed rule post-acute DRG	FY 2009 proposed rule special pay DRG	MDC	Type	MS–DRG title	Weights	Geometric mean LOS	Arithmetic mean LOS
828	No	No	17	SURG	Myeloprolif disord or poorly diff neopl w maj O.R. proc w/o CC/MCC.	1.3050	3.0	3.8
829	No	No	17	SURG	Myeloprolif disord or poorly diff neopl w other O.R. proc w CC/MCC.	2.8972	7.0	10.7
830	No	No	17	SURG	Myeloprolif disord or poorly diff neopl w other O.R. proc w/o CC/MCC.	1.0802	2.5	3.7
834	No	No	17	MED	Acute leukemia w/o major O.R. procedure w MCC.	4.5854	9.5	15.5
835	No	No	17	MED	Acute leukemia w/o major O.R. procedure w CC.	2.5840	6.2	10.4
836	No	No	17	MED	Acute leukemia w/o major O.R. procedure w/o CC/MCC.	1.2085	3.4	5.2
837	No	No	17	MED	Chemo w acute leukemia as sdx or w high dose chemo agent w MCC.	6.4047	17.6	23.1
838	No	No	17	MED	Chemo w acute leukemia as sdx w CC or high dose chemo agent.	2.9669	7.9	12.3
839	No	No	17	MED	Chemo w acute leukemia as sdx w/o CC/MCC.	1.4181	5.0	6.4
840	Yes	No	17	MED	Lymphoma & non-acute leukemia w MCC.	2.6031	7.7	10.4
841	Yes	No	17	MED	Lymphoma & non-acute leukemia w CC.	1.5529	5.2	6.9
842	Yes	No	17	MED	Lymphoma & non-acute leukemia w/o CC/MCC.	1.0261	3.4	4.6
843	No	No	17	MED	Other myeloprolif dis or poorly diff neopl diag w MCC.	1.8203	6.1	8.5
844	No	No	17	MED	Other myeloprolif dis or poorly diff neopl diag w CC.	1.2030	4.6	6.1
845	No	No	17	MED	Other myeloprolif dis or poorly diff neopl diag w/o CC/MCC.	0.8143	3.3	4.3
846	No	No	17	MED	Chemotherapy w/o acute leukemia as secondary diagnosis w MCC.	2.1299	5.8	8.4
847	No	No	17	MED	Chemotherapy w/o acute leukemia as secondary diagnosis w CC.	0.9436	2.7	3.4
848	No	No	17	MED	Chemotherapy w/o acute leukemia as secondary diagnosis w/o CC/MCC.	0.7995	2.5	3.1
849	No	No	17	MED	Radiotherapy	1.2021	4.4	6.0
853	Yes	No	18	SURG	Infectious & parasitic diseases w O.R. procedure w MCC.	5.4286	12.7	16.7
854	Yes	No	18	SURG	Infectious & parasitic diseases w O.R. procedure w CC.	2.9171	9.1	11.1
855	Yes	No	18	SURG	Infectious & parasitic diseases w O.R. procedure w/o CC/MCC.	1.8093	5.6	7.0
856	Yes	No	18	SURG	Postoperative or post-traumatic infections w O.R. proc w MCC.	4.7315	11.5	15.4
857	Yes	No	18	SURG	Postoperative or post-traumatic infections w O.R. proc w CC.	2.0472	6.6	8.5
858	Yes	No	18	SURG	Postoperative or post-traumatic infections w O.R. proc w/o CC/MCC.	1.3563	4.5	5.7
862	Yes	No	18	MED	Postoperative & post-traumatic infections w MCC.	1.9123	6.1	8.2
863	Yes	No	18	MED	Postoperative & post-traumatic infections w/o MCC.	0.9575	4.2	5.2
864	No	No	18	MED	Fever of unknown origin	0.8224	3.2	4.1
865	No	No	18	MED	Viral illness w MCC	1.4950	4.7	6.7
866	No	No	18	MED	Viral illness w/o MCC	0.6673	2.8	3.5
867	Yes	No	18	MED	Other infectious & parasitic diseases diagnoses w MCC.	2.3423	7.0	9.6
868	Yes	No	18	MED	Other infectious & parasitic diseases diagnoses w CC.	1.0761	4.5	5.8
869	Yes	No	18	MED	Other infectious & parasitic diseases diagnoses w/o CC/MCC.	0.7628	3.5	4.3
870	Yes	No	18	MED	Septicemia or severe sepsis w MV 96+ hours.	5.7422	12.9	15.5
871	Yes	No	18	MED	Septicemia or severe sepsis w/o MV 96+ hours w MCC.	1.8211	5.5	7.5

TABLE 5.—LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS–DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

MS–DRG	FY 2009 proposed rule post-acute DRG	FY 2009 proposed rule special pay DRG	MDC	Type	MS–DRG title	Weights	Geometric mean LOS	Arithmetic mean LOS
872	Yes	No	18	MED	Septicemia or severe sepsis w/o MV 96+ hours w/o MCC.	1.1188	4.7	5.7
876	No	No	19	SURG	O.R. procedure w principal diagnoses of mental illness.	2.4279	7.8	11.9
880	No	No	19	MED	Acute adjustment reaction & psychosocial dysfunction.	0.5867	2.4	3.2
881	No	No	19	MED	Depressive neuroses	0.5784	3.1	4.2
882	No	No	19	MED	Neuroses except depressive	0.6086	3.1	4.4
883	No	No	19	MED	Disorders of personality & impulse control.	1.0102	4.4	7.4
884	Yes	No	19	MED	Organic disturbances & mental retardation.	0.8923	4.1	5.5
885	No	No	19	MED	Psychoses	0.8380	5.5	7.6
886	No	No	19	MED	Behavioral & developmental disorders	0.7479	4.0	6.1
887	No	No	19	MED	Other mental disorder diagnoses	0.7275	3.0	4.6
894	No	No	20	MED	Alcohol/drug abuse or dependence, left ama.	0.3842	2.1	3.0
895	No	No	20	MED	Alcohol/drug abuse or dependence w rehabilitation therapy.	0.8727	8.1	10.5
896	Yes	No	20	MED	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC.	1.3787	4.8	6.6
897	Yes	No	20	MED	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC.	0.6152	3.3	4.1
901	No	No	21	SURG	Wound debridements for injuries w MCC.	3.8708	9.9	15.1
902	No	No	21	SURG	Wound debridements for injuries w CC.	1.6889	5.5	7.7
903	No	No	21	SURG	Wound debridements for injuries w/o CC/MCC.	0.9976	3.4	4.6
904	No	No	21	SURG	Skin grafts for injuries w CC/MCC	2.9204	7.0	11.2
905	No	No	21	SURG	Skin grafts for injuries w/o CC/MCC	1.1156	3.4	4.7
906	No	No	21	SURG	Hand procedures for injuries	0.9941	2.1	3.1
907	Yes	No	21	SURG	Other O.R. procedures for injuries w MCC.	3.6871	8.0	11.6
908	Yes	No	21	SURG	Other O.R. procedures for injuries w CC.	1.9162	4.9	6.8
909	Yes	No	21	SURG	Other O.R. procedures for injuries w/o CC/MCC.	1.1372	2.7	3.6
913	No	No	21	MED	Traumatic injury w MCC	1.2246	4.2	5.7
914	No	No	21	MED	Traumatic injury w/o MCC	0.6625	2.7	3.4
915	No	No	21	MED	Allergic reactions w MCC	1.2354	3.3	4.7
916	No	No	21	MED	Allergic reactions w/o MCC	0.4409	1.7	2.1
917	Yes	No	21	MED	Poisoning & toxic effects of drugs w MCC.	1.4143	3.7	5.2
918	Yes	No	21	MED	Poisoning & toxic effects of drugs w/o MCC.	0.5809	2.1	2.7
919	No	No	21	MED	Complications of treatment w MCC	1.5200	4.5	6.4
920	No	No	21	MED	Complications of treatment w CC	0.9220	3.3	4.4
921	No	No	21	MED	Complications of treatment w/o CC/MCC.	0.6097	2.3	3.0
922	No	No	21	MED	Other injury, poisoning & toxic effect diag w MCC.	1.3580	4.1	6.0
923	No	No	21	MED	Other injury, poisoning & toxic effect diag w/o MCC.	0.6142	2.4	3.2
927	No	No	22	SURG	Extensive burns or full thickness burns w MV 96+ hrs w skin graft.	14.0060	23.4	31.1
928	No	No	22	SURG	Full thickness burn w skin graft or inhal inj w CC/MCC.	5.0621	11.7	16.0
929	No	No	22	SURG	Full thickness burn w skin graft or inhal inj w/o CC/MCC.	2.1574	5.3	7.7
933	No	No	22	MED	Extensive burns or full thickness burns w MV 96+ hrs w/o skin graft.	2.1246	2.3	4.3
934	No	No	22	MED	Full thickness burn w/o skin grft or inhal inj.	1.2949	4.4	6.2
935	No	No	22	MED	Non-extensive burns	1.2209	3.6	5.4
939	No	No	23	SURG	O.R. proc w diagnoses of other contact w health services w MCC.	2.6570	6.6	10.1

TABLE 5.—LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS–DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

MS–DRG	FY 2009 proposed rule post-acute DRG	FY 2009 proposed rule special pay DRG	MDC	Type	MS–DRG title	Weights	Geometric mean LOS	Arithmetic mean LOS
940	No	No	23	SURG	O.R. proc w diagnoses of other contact w health services w CC.	1.6379	3.6	5.4
941	No	No	23	SURG	O.R. proc w diagnoses of other contact w health services w/o CC/MCC.	1.0782	2.1	2.7
945	Yes	No	23	MED	Rehabilitation w CC/MCC	1.2869	8.6	10.5
946	Yes	No	23	MED	Rehabilitation w/o CC/MCC	1.0861	6.9	7.9
947	Yes	No	23	MED	Signs & symptoms w MCC	1.0525	3.8	5.0
948	Yes	No	23	MED	Signs & symptoms w/o MCC	0.6473	2.8	3.5
949	No	No	23	MED	Aftercare w CC/MCC	0.7925	2.6	4.1
950	No	No	23	MED	Aftercare w/o CC/MCC	0.5548	2.4	3.5
951	No	No	23	MED	Other factors influencing health status	0.7442	2.2	4.7
955	No	No	24	SURG	Craniotomy for multiple significant trauma.	5.0969	8.6	12.3
956	Yes	No	24	SURG	Limb reattachment, hip & femur proc for multiple significant trauma.	3.5263	7.6	9.3
957	No	No	24	SURG	Other O.R. procedures for multiple significant trauma w MCC.	6.0787	10.2	14.9
958	No	No	24	SURG	Other O.R. procedures for multiple significant trauma w CC.	3.6129	8.0	10.4
959	No	No	24	SURG	Other O.R. procedures for multiple significant trauma w/o CC/MCC.	2.3808	4.9	6.3
963	No	No	24	MED	Other multiple significant trauma w MCC.	2.8713	6.7	9.5
964	No	No	24	MED	Other multiple significant trauma w CC.	1.6024	4.9	6.2
965	No	No	24	MED	Other multiple significant trauma w/o CC/MCC.	0.9832	3.4	4.1
969	No	No	25	SURG	HIV w extensive O.R. procedure w MCC.	5.3749	12.9	18.8
970	No	No	25	SURG	HIV w extensive O.R. procedure w/o MCC.	2.4892	6.5	9.8
974	No	No	25	MED	HIV w major related condition w MCC	2.5595	7.3	10.4
975	No	No	25	MED	HIV w major related condition w CC	1.3571	5.3	7.0
976	No	No	25	MED	HIV w major related condition w/o CC/MCC.	0.8910	3.8	4.9
977	No	No	25	MED	HIV w or w/o other related condition	1.0965	3.9	5.3
981	Yes	No		SURG	Extensive O.R. procedure unrelated to principal diagnosis w MCC.	5.0175	11.7	15.1
982	Yes	No		SURG	Extensive O.R. procedure unrelated to principal diagnosis w CC.	3.0780	7.5	9.7
983	Yes	No		SURG	Extensive O.R. procedure unrelated to principal diagnosis w/o CC/MCC.	1.9959	3.9	5.4
984	No	No		SURG	Prostatic O.R. procedure unrelated to principal diagnosis w MCC.	3.3256	11.8	14.6
985	No	No		SURG	Prostatic O.R. procedure unrelated to principal diagnosis w CC.	2.2113	7.3	9.7
986	No	No		SURG	Prostatic O.R. procedure unrelated to principal diagnosis w/o CC/MCC.	1.2767	3.5	5.3
987	Yes	No		SURG	Non-extensive O.R. proc unrelated to principal diagnosis w MCC.	3.4336	9.8	13.0
988	Yes	No		SURG	Non-extensive O.R. proc unrelated to principal diagnosis w CC.	1.8752	5.8	7.8
989	Yes	No		SURG	Non-extensive O.R. proc unrelated to principal diagnosis w/o CC/MCC.	1.1032	2.9	4.1
998	No	No		**	Principal diagnosis invalid as discharge diagnosis.	0.0000	0.0	0.0
999	No	No		**	Ungroupable	0.0000	0.0	0.0

MS–DRGs 998 and 999 contain cases that could not be assigned to valid DRGs.

NOTE: If there is no value in either the geometric mean length of stay or the arithmetic mean length of stay columns, the volume of cases is insufficient to obtain a meaningful computation of these statistics.

TABLE 6A.—NEW DIAGNOSIS CODES

Diagnosis code	Description	CC	MDC	MS–DRG
046.11	Variant Creutzfeldt-Jakob disease	CC	01	056, 057
046.19	Other and unspecified Creutzfeldt-Jakob disease	CC	01	056, 057
046.71	Gerstmann-Sträussler-Scheinker syndrome	CC	01	056, 057
			25	974, 975, 976
046.72	Fatal familial insomnia	CC	01	056, 057
			25	974, 975, 976
046.79	Other and unspecified prion disease of central nervous system	CC	01	056, 057
			25	974, 975, 976
051.01	Cowpox	N	18	865, 866
051.02	Vaccinia not from vaccination	N	18	865, 866
059.00	Orthopoxvirus infection, unspecified	N	18	865, 866
059.01	Monkeypox	CC	18	865, 866
059.09	Other orthopoxvirus infections	N	18	865, 866
059.10	Parapoxvirus infection, unspecified	N	18	865, 866
059.11	Bovine stomatitis	N	18	865, 866
059.12	Sealpox	N	18	865, 866
059.19	Other parapoxvirus infections	N	18	865, 866
059.21	Tanapox	CC	18	865, 866
059.22	Yaba monkey tumor virus	N	18	865, 866
059.29	Yatapoxvirus infection, unspecified	N	18	865, 866
059.8	Other poxvirus infections	N	18	865, 866
059.9	Poxvirus infections, unspecified	N	18	865, 866
078.12	Plantar wart	N	09	606, 607
136.21	Specific infection due to acanthamoeba	N	18	867, 868, 869
136.29	Other specific infections by free-living amebae	CC	18	867, 868, 869
199.2	Malignant neoplasm associated with transplant organ	CC	17	843, 844, 845
203.02	Multiple myeloma, in relapse	CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
203.12	Plasma cell leukemia, in relapse	CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
203.82	Other immunoproliferative neoplasms, in relapse	CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
204.02	Acute lymphoid leukemia, in relapse	CC	17	820, 821, 822, 834, 835, 836, 837 [1], 838 [1], 839 [1]
204.12	Chronic lymphoid leukemia, in relapse	CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
204.22	Subacute lymphoid leukemia, in relapse	CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
204.82	Other lymphoid leukemia, in relapse	CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
204.92	Unspecified lymphoid leukemia, in relapse	CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
205.02	Acute myeloid leukemia, in relapse	CC	17	820, 821, 822, 834, 835, 836, 837 [1], 838 [1], 839 [1]
205.12	Chronic myeloid leukemia, in relapse	CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
205.22	Subacute myeloid leukemia, in relapse	CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
205.32	Myeloid sarcoma, in relapse	CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
205.82	Other myeloid leukemia, in relapse	CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
205.92	Unspecified myeloid leukemia, in relapse	CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	MS–DRG
206.02	Acute monocytic leukemia, in relapse	CC	17	820, 821, 822, 834, 835, 836, 837 [1], 838 [1], 839 [1]
206.12	Chronic monocytic leukemia, in relapse	CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
206.22	Subacute monocytic leukemia, in relapse	CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
206.82	Other monocytic leukemia, in relapse	CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
206.92	Unspecified monocytic leukemia, in relapse	CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
207.02	Acute erythremia and erythroleukemia, in relapse	CC	17	820, 821, 822, 834, 835, 836, 837 [1], 838 [1], 839 [1]
207.12	Chronic erythremia, in relapse	CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
207.22	Megakaryocytic leukemia, in relapse	CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
207.82	Other specified leukemia, in relapse	CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
208.02	Acute leukemia of unspecified cell type, in relapse	CC	17	820, 821, 822, 834, 835, 836, 837 [1], 838 [1], 839 [1]
208.12	Chronic leukemia of unspecified cell type, in relapse	CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
208.22	Subacute leukemia of unspecified cell type, in relapse	CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
208.82	Other leukemia of unspecified cell type, in relapse	CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
208.92	Unspecified leukemia, in relapse	CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
209.00	Malignant carcinoid tumor of the small intestine, unspecified portion	CC	06	374, 375, 376
209.01	Malignant carcinoid tumor of the duodenum	CC	06	374, 375, 376
209.02	Malignant carcinoid tumor of the jejunum	CC	06	374, 375, 376
209.03	Malignant carcinoid tumor of the ileum	CC	06	374, 375, 376
209.10	Malignant carcinoid tumor of the large intestine, unspecified portion	CC	06	374, 375, 376
209.11	Malignant carcinoid tumor of the appendix	CC	06	338, 339, 340, 374, 375, 376
209.12	Malignant carcinoid tumor of the cecum	CC	06	374, 375, 376
209.13	Malignant carcinoid tumor of the ascending colon	CC	06	374, 375, 376
209.14	Malignant carcinoid tumor of the transverse colon	CC	06	374, 375, 376
209.15	Malignant carcinoid tumor of the descending colon	CC	06	374, 375, 376
209.16	Malignant carcinoid tumor of the sigmoid colon	CC	06	374, 375, 376
209.17	Malignant carcinoid tumor of the rectum	CC	06	374, 375, 376
209.20	Malignant carcinoid tumor of unknown primary site	CC	17	843, 844, 845
209.21	Malignant carcinoid tumor of the bronchus and lung	CC	04	180, 181, 182
209.22	Malignant carcinoid tumor of the thymus	CC	17	843, 844, 845
209.23	Malignant carcinoid tumor of the stomach	CC	06	374, 375, 376
209.24	Malignant carcinoid tumor of the kidney	CC	11	656, 657, 658, 686, 687, 688
209.25	Malignant carcinoid tumor of foregut, not otherwise specified	CC	06	374, 375, 376
209.26	Malignant carcinoid tumor of midgut, not otherwise specified	CC	06	374, 375, 376
209.27	Malignant carcinoid tumor of hindgut, not otherwise specified	CC	06	374, 375, 376
209.29	Malignant carcinoid tumor of other sites	CC	17	843, 844, 845
209.30	Malignant poorly differentiated neuroendocrine carcinoma, any site	CC	17	843, 844, 845
209.40	Benign carcinoid tumor of the small intestine, unspecified portion	N	06	393, 394, 395
209.41	Benign carcinoid tumor of the duodenum	N	06	393, 394, 395

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	MS–DRG
209.42	Benign carcinoid tumor of the jejunum	N	06	393, 394, 395
209.43	Benign carcinoid tumor of the ileum	N	06	393, 394, 395
209.50	Benign carcinoid tumor of the large intestine, unspecified portion	N	06	393, 394, 395
209.51	Benign carcinoid tumor of the appendix	N	06	393, 394, 395
209.52	Benign carcinoid tumor of the cecum	N	06	393, 394, 395
209.53	Benign carcinoid tumor of the ascending colon	N	06	393, 394, 395
209.54	Benign carcinoid tumor of the transverse colon	N	06	393, 394, 395
209.55	Benign carcinoid tumor of the descending colon	N	06	393, 394, 395
209.56	Benign carcinoid tumor of the sigmoid colon	N	06	393, 394, 395
209.57	Benign carcinoid tumor of the rectum	N	06	393, 394, 395
209.60	Benign carcinoid tumor of unknown primary site	N	17	843, 844, 845
209.61	Benign carcinoid tumor of the bronchus and lung	N	04	180, 181, 182
209.62	Benign carcinoid tumor of the thymus	N	16	814, 815, 816
209.63	Benign carcinoid tumor of the stomach	N	06	393, 394, 395
209.64	Benign carcinoid tumor of the kidney	N	11	656, 657, 658, 686, 687, 688
209.65	Benign carcinoid tumor of foregut, not otherwise specified	N	06	393, 394, 395
209.66	Benign carcinoid tumor of midgut, not otherwise specified	N	06	393, 394, 395
209.67	Benign carcinoid tumor of hindgut, not otherwise specified	N	06	393, 394, 395
209.69	Benign carcinoid tumor of other sites	N	17	843, 844, 845
238.77	Post-transplant lymphoproliferative disorder (PTLD)	CC	21	919, 920, 921
249.00	Secondary diabetes mellitus without mention of complication, not stated as uncontrolled, or unspecified.	N	PRE 10	008, 010 637, 638, 639
249.01	Secondary diabetes mellitus without mention of complication, uncontrolled	N	PRE 10	008, 010 637, 638, 639
249.10	Secondary diabetes mellitus with ketoacidosis, not stated as uncontrolled, or unspecified	MCC	PRE 10	008, 010 637, 638, 639
249.11	Secondary diabetes mellitus with ketoacidosis, uncontrolled	MCC	PRE 10	008, 010 637, 638, 639,
249.20	Secondary diabetes mellitus with hyperosmolarity, not stated as uncontrolled, or unspecified	MCC	PRE 10	008, 010 637, 638, 639
249.21	Secondary diabetes mellitus with hyperosmolarity, uncontrolled	MCC	PRE 10	008, 010 637, 638, 639
249.30	Secondary diabetes mellitus with other coma, not stated as uncontrolled, or unspecified	MCC	PRE 10	008, 010 637, 638, 639
249.31	Secondary diabetes mellitus with other coma, uncontrolled	MCC	PRE 10	008, 010 637, 638, 639
249.40	Secondary diabetes mellitus with renal manifestations, not stated as uncontrolled, or unspecified.	N	PRE 11	008, 010 698, 699, 700
249.41	Secondary diabetes mellitus with renal manifestations, uncontrolled	N	PRE 11	008, 010 698, 699, 700
249.50	Secondary diabetes mellitus with ophthalmic manifestations, not stated as uncontrolled, or unspecified.	N	PRE 02	008, 010 124, 125
249.51	Secondary diabetes mellitus with ophthalmic manifestations, uncontrolled	N	PRE 02	008, 010 124, 125
249.60	Secondary diabetes mellitus with neurological manifestations, not stated as uncontrolled, or unspecified.	N	PRE 01	008, 010 073, 074
249.61	Secondary diabetes mellitus with neurological manifestations, uncontrolled	N	PRE 01	008, 010 073, 074
249.70	Secondary diabetes mellitus with peripheral circulatory disorders, not stated as uncontrolled, or unspecified.	N	PRE 05	008, 010 299, 300, 301
249.71	Secondary diabetes mellitus with peripheral circulatory disorders, uncontrolled	N	PRE 05	008, 010 299, 300, 301
249.80	Secondary diabetes mellitus with other specified manifestations, not stated as uncontrolled, or unspecified.	N	PRE 10	008, 010 637, 638, 639
249.81	Secondary diabetes mellitus with other specified manifestations, uncontrolled	N	PRE 10	008, 010 637, 638, 639
249.90	Secondary diabetes mellitus with unspecified complication, not stated as uncontrolled, or unspecified.	N	PRE 10	008, 010 637, 638, 639
249.91	Secondary diabetes mellitus with unspecified complication, uncontrolled	N	PRE 10	008, 010 637, 638, 639
259.50	Androgen insensitivity, unspecified	N	10	643, 644, 645
259.51	Androgen insensitivity syndrome	N	10	643, 644, 645
259.52	Partial androgen insensitivity	N	10	643, 644, 645
275.5	Hungry bone syndrome	N	10	640, 641
279.50	Graft-versus-host disease, unspecified	CC	16	808, 809, 810
279.51	Acute graft-versus-host disease	CC	16	808, 809, 810
279.52	Chronic graft-versus-host disease	CC	16	808, 809, 810
279.53	Acute on chronic graft-versus-host disease	CC	16	808, 809, 810
289.84	Heparin-induced thrombocytopenia (HIT)	N	15 16	791[2], 793[2] 813

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	MS–DRG
			25	977
337.00	Idiopathic peripheral autonomic neuropathy, unspecified	N	01	073, 074
337.01	Carotid sinus syndrome	N	01	073, 074
337.09	Other idiopathic peripheral autonomic neuropathy	N	01	073, 074
339.00	Cluster headache syndrome, unspecified	N	01	102, 103
339.01	Episodic cluster headache	N	01	102, 103
339.02	Chronic cluster headache	N	01	102, 103
339.03	Episodic paroxysmal hemicrania	N	01	102, 103
339.04	Chronic paroxysmal hemicrania	N	01	102, 103
339.05	Short lasting unilateral neuralgiform headache with conjunctival injection and tearing	N	01	102, 103
339.09	Other trigeminal autonomic cephalgias	N	01	102, 103
339.10	Tension type headache, unspecified	N	01	102, 103
339.11	Episodic tension type headache	N	01	102, 103
339.12	Chronic tension type headache	N	01	102, 103
339.20	Post-traumatic headache, unspecified	N	01	102, 103
339.21	Acute post-traumatic headache	N	01	102, 103
339.22	Chronic post-traumatic headache	N	01	102, 103
339.3	Drug induced headache, not elsewhere classified	N	01	102, 103
339.41	Hemicrania continua	N	01	102, 103
339.42	New daily persistent headache	N	01	102, 103
339.43	Primary thunderclap headache	N	01	102, 103
339.44	Other complicated headache syndrome	N	01	102, 103
339.81	Hypnic headache	N	01	102, 103
339.82	Headache associated with sexual activity	N	01	102, 103
339.83	Primary cough headache	N	01	102, 103
339.84	Primary exertional headache	N	01	102, 103
339.85	Primary stabbing headache	N	01	102, 103
339.89	Other headache syndromes	N	01	102, 103
346.02	Migraine with aura, without mention of intractable migraine with status migrainosus	N	01	102, 103
346.03	Migraine with aura, with intractable migraine, so stated, with status migrainosus	N	01	102, 103
346.12	Migraine without aura, without mention of intractable migraine with status migrainosus	N	01	102, 103
346.13	Migraine without aura, with intractable migraine, so stated, with status migrainosus	N	01	102, 103
346.22	Variants of migraine, not elsewhere classified, without mention of intractable migraine with status migrainosus.	N	01	102, 103
346.23	Variants of migraine, not elsewhere classified, with intractable migraine, so stated, with status migrainosus.	N	01	102, 103
346.30	Hemiplegic migraine, without mention of intractable migraine without mention of status migrainosus.	N	01	102, 103
346.31	Hemiplegic migraine, with intractable migraine, so stated, without mention of status migrainosus.	N	01	102, 103
346.32	Hemiplegic migraine, without mention of intractable migraine with status migrainosus	N	01	102, 103
346.33	Hemiplegic migraine, with intractable migraine, so stated, with status migrainosus	N	01	102, 103
346.40	Menstrual migraine, without mention of intractable migraine without mention of status migrainosus.	N	01	102, 103
346.41	Menstrual migraine, with intractable migraine, so stated, without mention of status migrainosus.	N	01	102, 103
346.42	Menstrual migraine, without mention of intractable migraine with status migrainosus	N	01	102, 103
346.43	Menstrual migraine, with intractable migraine, so stated, with status migrainosus	N	01	102, 103
346.50	Persistent migraine aura without cerebral infarction, without mention of intractable migraine without mention of status migrainosus.	N	01	102, 103
346.51	Persistent migraine aura without cerebral infarction, with intractable migraine, so stated, without mention of status migrainosus.	N	01	102, 103
346.52	Persistent migraine aura without cerebral infarction, without mention of intractable migraine with status migrainosus.	N	01	102, 103
346.53	Persistent migraine aura without cerebral infarction, with intractable migraine, so stated, with status migrainosus.	N	01	102, 103
346.60	Persistent migraine aura with cerebral infarction, without mention of intractable migraine without mention of status migrainosus.	CC	01	102, 103
346.61	Persistent migraine aura with cerebral infarction, with intractable migraine, so stated, without mention of status migrainosus.	CC	01	102, 103
346.62	Persistent migraine aura with cerebral infarction, without mention of intractable migraine with status migrainosus.	CC	01	102, 103
346.63	Persistent migraine aura with cerebral infarction, with intractable migraine, so stated, with status migrainosus.	CC	01	102, 103
346.70	Chronic migraine without aura, without mention of intractable migraine without mention of status migrainosus.	N	01	102, 103
346.71	Chronic migraine without aura, with intractable migraine, so stated, without mention of status migrainosus.	N	01	102, 103
346.72	Chronic migraine without aura, without mention of intractable migraine with status migrainosus.	N	01	102, 103
346.73	Chronic migraine without aura, with intractable migraine, so stated, with status migrainosus	N	01	102, 103

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	MS–DRG
346.82	Other forms of migraine, without mention of intractable migraine with status migrainosus	N	01	102, 103
346.83	Other forms of migraine, with intractable migraine, so stated, with status migrainosus	N	01	102, 103
362.20	Retinopathy of prematurity, unspecified	N	02	124, 125
362.22	Retinopathy of prematurity, stage 0	N	02	124, 125
362.23	Retinopathy of prematurity, stage 1	N	02	124, 125
362.24	Retinopathy of prematurity, stage 2	N	02	124, 125
362.25	Retinopathy of prematurity, stage 3	N	02	124, 125
362.26	Retinopathy of prematurity, stage 4	N	02	124, 125
362.27	Retinopathy of prematurity, stage 5	N	02	124, 125
364.82	Plateau iris syndrome	N	02	124, 125
372.34	Pingueculitis	N	02	124, 125
414.3	Coronary atherosclerosis due to lipid rich plaque	N	05	302, 303
511.81	Malignant pleural effusion	CC	04	180, 181, 182
511.89	Other specified forms of effusion, except tuberculous	CC	04	186, 187, 188
			15	791 [2], 793 [2]
569.44	Dysplasia of anus	N	06	393, 394, 395
571.42	Autoimmune hepatitis	N	07	441, 442, 443
599.70	Hematuria, unspecified	N	11	695, 696
			15	791 [2], 793 [2]
599.71	Gross hematuria	N	11	695, 696
			15	791 [2], 793 [2]
599.72	Microscopic hematuria	N	11	695, 696
			15	791 [2], 793 [2]
611.81	Ptosis of breast	N	09	600, 601
611.82	Hypoplasia of breast	N	09	600, 601
611.83	Capsular contracture of breast implant	N	09	600, 601
611.89	Other specified disorders of breast	N	09	600, 601
612.0	Deformity of reconstructed breast	N	09	600, 601
612.1	Disproportion of reconstructed breast	N	09	600, 601
625.70	Vulvodynia, unspecified	N	13	742, 743, 760, 761
625.71	Vulvar vestibulitis	N	13	742, 743, 757, 758, 759
625.79	Other vulvodynia	N	13	742, 743, 760, 761
649.70	Cervical shortening, unspecified as to episode of care or not applicable	CC	14	998
649.71	Cervical shortening, delivered, with or without mention of antepartum condition	CC	14	765, 766, 767, 768, 774, 775
649.73	Cervical shortening, antepartum condition or complication	CC	14	781, 782
678.00	Fetal hematologic conditions, unspecified as to episode of care or not applicable	N	14	998
678.01	Fetal hematologic conditions, delivered, with or without mention of antepartum condition	N	14	765, 766, 767, 768, 774, 775
678.03	Fetal hematologic conditions, antepartum condition or complication	N	14	781, 782
678.10	Fetal conjoined twins, unspecified as to episode of care or not applicable	N	14	998
678.11	Fetal conjoined twins, delivered, with or without mention of antepartum condition	N	14	765, 766, 767, 768, 774, 775
678.13	Fetal conjoined twins, antepartum condition or complication	N	14	781, 782
679.00	Maternal complications from in utero procedure, unspecified as to episode of care or not applicable.	N	14	765, 766, 767, 768, 774, 775
679.01	Maternal complications from in utero procedure, delivered, with or without mention of antepartum condition.	N	14	765, 766, 767, 768, 774
679.02	Maternal complications from in utero procedure, delivered, with mention of postpartum complication.	N	14	765, 766, 767, 768, 774
679.03	Maternal complications from in utero procedure, antepartum condition or complication	N	14	781, 782
679.04	Maternal complications from in utero procedure, postpartum condition or complication	N	14	769, 776
679.10	Fetal complications from in utero procedures, unspecified as to episode of care or not applicable.	N	14	998
679.11	Fetal complications from in utero procedures, delivered, with or without mention of antepartum condition.	N	14	765, 766, 767, 768, 774, 775
679.12	Fetal complications from in utero procedures, delivered, with mention of postpartum complication.	N	14	765, 766, 767, 768, 774, 775
679.13	Fetal complications from in utero procedures, antepartum condition or complication	N	14	781, 782
679.14	Fetal complications from in utero procedures, postpartum condition or complication	N	14	769, 776
695.10	Erythema multiforme, unspecified	N	09	595, 596
695.11	Erythema multiforme minor	N	09	595, 596
695.12	Erythema multiforme major	CC	09	595, 596
695.13	Stevens-Johnson syndrome	CC	09	595, 596
695.14	Stevens-Johnson syndrome-toxic epidermal necrolysis overlap syndrome	CC	09	595, 596
695.15	Toxic epidermal necrolysis	CC	09	595, 596
695.19	Other erythema multiforme	N	09	595, 596
695.50	Exfoliation due to erythematous condition involving less than 10 percent of body surface	N	09	606, 607

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	MS–DRG
695.51	Exfoliation due to erythematous condition involving 10–19 percent of body surface	N	09	606, 607
695.52	Exfoliation due to erythematous condition involving 20–29 percent of body surface	N	09	606, 607
695.53	Exfoliation due to erythematous condition involving 30–39 percent of body surface	CC	09	606, 607
695.54	Exfoliation due to erythematous condition involving 40–49 percent of body surface	CC	09	606, 607
695.55	Exfoliation due to erythematous condition involving 50–59 percent of body surface	CC	09	606, 607
695.56	Exfoliation due to erythematous condition involving 60–69 percent of body surface	CC	09	606, 607
695.57	Exfoliation due to erythematous condition involving 70–79 percent of body surface	CC	09	606, 607
695.58	Exfoliation due to erythematous condition involving 80–89 percent of body surface	CC	09	606, 607
695.59	Exfoliation due to erythematous condition involving 90 percent or more of body surface	CC	09	606, 607
707.20	Pressure ulcer, unspecified stage	N	09	573, 574, 575, 592, 593, 594
707.21	Pressure ulcer, stage I	N	09	573, 574, 575, 592, 593, 594
707.22	Pressure ulcer, stage II	N	09	573, 574, 575, 592, 593, 594
707.23	Pressure ulcer, stage III	MCC [3]	09	573, 574, 575, 592, 593, 594
707.24	Pressure ulcer, stage IV	MCC [3]	09	573, 574, 575, 592, 593, 594
729.90	Disorders of soft tissue, unspecified	N	08	555, 556
729.91	Post-traumatic seroma	N	08	555, 556
729.92	Nontraumatic hematoma of soft tissue	N	08	555, 556
729.99	Other disorders of soft tissue	N	08	555, 556
760.61	Newborn affected by amniocentesis	N	15	794
760.62	Newborn affected by other in utero procedure	N	15	794
760.63	Newborn affected by other surgical operations on mother during pregnancy	N	15	794
760.64	Newborn affected by previous surgical procedure on mother not associated with pregnancy	N	15	794
777.50	Necrotizing enterocolitis in newborn, unspecified	MCC	15	791 [4], 793 [4]
777.51	Stage I necrotizing enterocolitis in newborn	MCC	15	791 [4], 793 [4]
777.52	Stage II necrotizing enterocolitis in newborn	MCC	15	791 [4], 793 [4]
777.53	Stage III necrotizing enterocolitis in newborn	MCC	15	791 [4], 793 [4]
780.72	Functional quadriplegia	MCC	01	052, 053
788.91	Functional urinary incontinence	N	11	695, 696
788.99	Other symptoms involving urinary system	N	11	695, 696
795.07	Satisfactory cervical smear but lacking transformation zone	N	13	742, 743, 760, 761
795.10	Abnormal glandular Papanicolaou smear of vagina	N	13	742, 743, 760, 761
795.11	Papanicolaou smear of vagina with atypical squamous cells of undetermined significance (ASC–US).	N	13	742, 743, 760, 761
795.12	Papanicolaou smear of vagina with atypical squamous cells cannot exclude high grade squamous intraepithelial lesion (ASC–H).	N	13	742, 743, 760, 761
795.13	Papanicolaou smear of vagina with low grade squamous intraepithelial lesion (LGSIL)	N	13	742, 743, 760, 761
795.14	Papanicolaou smear of vagina with high grade squamous intraepithelial lesion (HGSIL)	N	13	742, 743, 760, 761
795.15	Vaginal high risk human papillomavirus (HPV) DNA test positive	N	13	742, 743, 760, 761
795.16	Papanicolaou smear of vagina with cytologic evidence of malignancy	N	13	742, 743, 760, 761
795.18	Unsatisfactory vaginal cytology smear	N	13	742, 743, 760, 761
795.19	Other abnormal Papanicolaou smear of vagina and vaginal HPV	N	13	742, 743, 760, 761
796.70	Abnormal glandular Papanicolaou smear of anus	N	06	393, 394, 395
796.71	Papanicolaou smear of anus with atypical squamous cells of undetermined significance (ASC–US).	N	06	393, 394, 395
796.72	Papanicolaou smear of anus with atypical squamous cells cannot exclude high grade squamous intraepithelial lesion (ASC–H).	N	06	393, 394, 395
796.73	Papanicolaou smear of anus with low grade squamous intraepithelial lesion (LGSIL)	N	06	393, 394, 395
796.74	Papanicolaou smear of anus with high grade squamous intraepithelial lesion (HGSIL)	N	06	393, 394, 395
796.75	Anal high risk human papillomavirus (HPV) DNA test positive	N	06	393, 394, 395
796.76	Papanicolaou smear of anus with cytologic evidence of malignancy	N	06	393, 394, 395
796.77	Satisfactory anal smear but lacking transformation zone	N	06	393, 394, 395
796.78	Unsatisfactory anal cytology smear	N	06	393, 394, 395
796.79	Other abnormal Papanicolaou smear of anus and anal HPV	N	06	393, 394, 395
997.31	Ventilator associated pneumonia	CC	04 15	205, 206 791 [2], 793 [2]
997.39	Other respiratory complications	CC	04 15	205, 206 791 [2], 793 [2]
998.30	Disruption of wound, unspecified	CC	21	919, 920, 921

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	MS–DRG
998.33	Disruption of traumatic wound repair	CC	21	919, 920, 921
999.81	Extravasation of vesicant chemotherapy	CC	05	314, 315, 316
			15	791[2], 793[2]
999.82	Extravasation of other vesicant agent	CC	05	314, 315, 316
			15	791[2], 793[2]
999.88	Other infusion reaction	N	05	314, 315, 316
			15	791[2], 793[2]
999.89	Other transfusion reaction	N	15	791[2], 793[2]
			16	811, 812
V07.51	Prophylactic use of selective estrogen receptor modulators (SERMs)	N	23	951
V07.52	Prophylactic use of aromatase inhibitors	N	23	951
V07.59	Prophylactic use of other agents affecting estrogen receptors and estrogen levels	N	23	951
V13.51	Personal history of pathologic fracture	N	23	951
V13.52	Personal history of stress fracture	N	23	951
V13.59	Personal history of other musculoskeletal disorders	N	23	951
V15.21	Personal history of undergoing in utero procedure during pregnancy	N	23	951
V15.22	Personal history of undergoing in utero procedure while a fetus	N	23	951
V15.29	Personal history of surgery to other organs	N	23	951
V15.51	Personal history of traumatic fracture	N	23	951
V15.59	Personal history of other injury	N	23	951
V23.85	Pregnancy resulting from assisted reproductive technology	N	14	998
V23.86	Pregnancy with history of in utero procedure during previous pregnancy	N	14	998
V28.81	Encounter for fetal anatomic survey	N	23	951
V28.82	Encounter for screening for risk of pre-term labor	N	23	951
V28.89	Other specified antenatal screening	N	23	951
V45.11	Renal dialysis status	N	23	951
V45.12	Noncompliance with renal dialysis	N	23	951
V45.87	Transplanted organ removal status	N	23	951
V46.3	Wheelchair dependence	N	23	951
V51.0	Encounter for breast reconstruction following mastectomy	N	09	606, 607
V51.8	Other aftercare involving the use of plastic surgery	N	09	606, 607
V87.01	Contact with and (suspected) exposure to arsenic	N	23	951
V87.09	Contact with and (suspected) exposure to other hazardous metals	N	23	951
V87.11	Contact with and (suspected) exposure to aromatic amines	N	23	951
V87.12	Contact with and (suspected) exposure to benzene	N	23	951
V87.19	Contact with and (suspected) exposure to other hazardous aromatic compounds	N	23	951
V87.2	Contact with and (suspected) exposure to other potentially hazardous chemicals	N	23	951
V87.31	Contact with and (suspected) exposure to mold	N	23	951
V87.39	Contact with and (suspected) exposure to other potentially hazardous substances	N	23	951
V87.41	Personal history of antineoplastic chemotherapy	N	23	949, 950
V87.42	Personal history of monoclonal drug therapy	N	23	949, 950
V87.49	Personal history of other drug therapy	N	23	949, 950
V88.01	Acquired absence of both cervix and uterus	N	13	742, 743, 760, 761
V88.02	Acquired absence of uterus with remaining cervical stump	N	13	742, 743, 760, 761
V88.03	Acquired absence of cervix with remaining uterus	N	13	742, 743, 760, 761
V89.01	Suspected problem with amniotic cavity and membrane not found	N	23	951
V89.02	Suspected placental problem not found	N	23	951
V89.03	Suspected fetal anomaly not found	N	23	951
V89.04	Suspected problem with fetal growth not found	N	23	951
V89.05	Suspected cervical shortening not found	N	23	951
V89.09	Other suspected maternal and fetal condition not found	N	23	951

[1] Secondary diagnosis of acute leukemia
[2] Secondary diagnosis of major problem.
[3] The pressure ulcer site specific codes (707.00–707.09) will be non-CCs. The pressure ulcer stage III and IV codes will be classified as MCCs.
[4] Principal or secondary diagnosis of major problem.

TABLE 6B.—NEW PROCEDURE CODES

Procedure code	Description	O.R.	MDC	MS–DRG
00.49	SuperSaturated oxygen therapy	N.		
00.58	Insertion of intra-aneurysm sac pressure monitoring device (intraoperative)	N.		
00.59	Intravascular pressure measurement of coronary arteries	N.		
00.67	Intravascular pressure measurement of intrathoracic arteries	N.		
00.68	Intravascular pressure measurement of peripheral arteries	N.		
00.69	Intravascular pressure measurement, other specified and unspecified vessels	N.		

TABLE 6B.—NEW PROCEDURE CODES—Continued

Procedure code	Description	O.R.	MDC	MS–DRG
17.11	Laparoscopic repair of direct inguinal hernia with graft or prosthesis	Y	06	350, 351, 352
17.12	Laparoscopic repair of indirect inguinal hernia with graft or prosthesis	Y	06	350, 351, 352
17.13	Laparoscopic repair of inguinal hernia with graft or prosthesis, not otherwise specified	Y	06	350, 351, 352
17.21	Laparoscopic bilateral repair of direct inguinal hernia with graft or prosthesis	Y	06	350, 351, 352
17.22	Laparoscopic bilateral repair of indirect inguinal hernia with graft or prosthesis	Y	06	350, 351, 352
17.23	Laparoscopic bilateral repair of inguinal hernia, one direct and one indirect, with graft or prosthesis.	Y	06	350, 351, 352
17.24	Laparoscopic bilateral repair of inguinal hernia with graft or prosthesis, not otherwise specified.	Y	06	350, 351, 352
17.31	Laparoscopic multiple segmental resection of large intestine	Y	06	329, 330, 331
			17	820, 821, 822, 826, 827, 828
			21	907, 908, 909
			24	957, 958, 959
17.32	Laparoscopic cecectomy	Y	05	264
			06	329, 330, 331
			21	907, 908, 909
			24	957, 958, 959
17.33	Laparoscopic right hemicolectomy	Y	05	264
			06	329, 330, 331
			17	820, 821, 822, 826, 827, 828
			21	907, 908, 909
			24	957, 958, 959
17.34	Laparoscopic resection of transverse colon	Y	05	264
			06	329, 330, 331
			17	820, 821, 822, 826, 827, 828
			21	907, 908, 909
			24	957, 958, 959
17.35	Laparoscopic left hemicolectomy	Y	05	264
			06	329, 330, 331
			10	628, 629, 630
			17	820, 821, 822, 826, 827, 828
			21	907, 908, 909
			24	957, 958, 959
17.36	Laparoscopic sigmoidectomy	Y	06	329, 330, 331
			17	820, 821, 822, 826, 827, 828
			21	907, 908, 909
			24	957, 958, 959
17.39	Other laparoscopic partial excision of large intestine	Y	05	264
			06	329, 330, 331
			17	820, 821, 822, 826, 827, 828
			21	907, 908, 909
			24	957, 958, 959
37.36	Excision or destruction of left atrial appendage (LAA)	N.		
37.55	Removal of internal biventricular heart replacement system	Y	PRE	001, 002
			05	237, 238
38.23	Intravascular spectroscopy	N.		
45.81	Laparoscopic total intra-abdominal colectomy	Y	05	264
			06	329, 330, 331
			17	820, 821, 822, 826, 827, 828
			21	907, 908, 909
			24	957, 958, 959
45.82	Open total intra-abdominal colectomy	Y	05	264
			06	329, 330, 331
			17	820, 821, 822, 826, 827, 828
			21	907, 908, 909
			24	957, 958, 959
45.83	Other and unspecified total intra-abdominal colectomy	Y	05	264
			06	329, 330, 331
			17	820, 821, 822, 826, 827, 828
			21	907, 908, 909
			24	957, 958, 959
48.40	Pull-through resection of rectum, not otherwise specified	Y	06	332, 333, 334

TABLE 6B.—NEW PROCEDURE CODES—Continued

Procedure code	Description	O.R.	MDC	MS–DRG
			17	820, 821, 822, 826, 827, 828
			21	907, 908, 909
			24	957, 958, 959
48.42	Laparoscopic pull-through resection of rectum	Y	06	332, 333, 334
			17	820, 821, 822, 826, 827, 828
			21	907, 908, 909
			24	957, 958, 959
48.43	Open pull-through resection of rectum	Y	06	332, 333, 334
			17	820, 821, 822, 826, 827, 828
			21	907, 908, 909
			24	957, 958, 959
48.50	Abdominoperineal resection of the rectum, not otherwise specified	Y	06	332, 333, 334
			17	820, 821, 822, 826, 827, 828
			21	907, 908, 909
			24	957, 958, 959
48.51	Laparoscopic abdominoperineal resection of the rectum	Y	06	332, 333, 334
			17	820, 821, 822, 826, 827, 828
			21	907, 908, 909
			24	957, 958, 959
48.52	Open abdominoperineal resection of the rectum	Y	06	332, 333, 334
			17	820, 821, 822, 826, 827, 828
			21	907, 908, 909
			24	957, 958, 959
48.59	Other abdominoperineal resection of the rectum	Y	06	332, 333, 334
			17	820, 821, 822, 826, 827, 828
			21	907, 908, 909
			24	957, 958, 959
53.42	Laparoscopic repair of umbilical hernia with graft or prosthesis	Y	06	353, 354, 355
53.43	Other laparoscopic umbilical herniorrhaphy	Y	06	353, 354, 355
			21	907, 908, 909
			24	957, 958, 959
53.62	Laparoscopic incisional hernia repair with graft or prosthesis	Y	06	353, 354, 355
			21	907, 908, 909
			24	957, 958, 959
53.63	Other laparoscopic repair of other hernia of anterior abdominal wall with graft or prosthesis	Y	06	353, 354, 355
53.71	Laparoscopic repair of diaphragmatic hernia, abdominal approach	Y	04	163, 164, 165
			06	326, 327, 328
			21	907, 908, 909
			24	957, 958, 959
53.72	Other and open repair of diaphragmatic hernia, abdominal approach	Y	04	163, 164, 165
			06	326, 327, 328
			21	907, 908, 909
			24	957, 958, 959
53.75	Repair of diaphragmatic hernia, abdominal approach, not otherwise specified	Y	04	163, 164, 165
			06	326, 327, 328
			21	907, 908, 909
			24	957, 958, 959
53.83	Laparoscopic repair of diaphragmatic hernia, with thoracic approach	Y	04	163, 164, 165
			06	326, 327, 328
			21	907, 908, 909
			24	957, 958, 959
53.84	Other and open repair of diaphragmatic hernia, with thoracic approach	Y	04	163, 164, 165
			06	326, 327, 328
			21	907, 908, 909
			24	957, 958, 959
80.53	Repair of the anulus fibrosus with graft or prosthesis	Y	01	028, 029, 030
			08	490, 491
			17	820, 821, 822, 826, 827, 828
			21	907, 908, 909
			24	957, 958, 959
80.54	Other and unspecified repair of the anulus fibrosus	Y	01	028, 029, 030
			08	490, 491
			17	820, 821, 822, 826, 827, 828

TABLE 6B.—NEW PROCEDURE CODES—Continued

Procedure code	Description	O.R.	MDC	MS–DRG
			21	907, 908, 909
			24	957, 958, 959

TABLE 6C.—INVALID DIAGNOSIS CODES

Diagnosis code	Description	CC	MDC	MS–DRG
046.1	Jakob-Creutzfeldt disease	CC	01	056, 057
051.0	Cowpox	N	18	865, 866
136.2	Specific infections by free-living amebae	MCC	18	867, 868, 869
259.5	Androgen insensitivity syndrome	N	10	643, 644, 645
337.0	Idiopathic peripheral autonomic neuropathy	CC	01	073, 074
511.8	Other specified forms of pleural effusion, except tuberculous	MCC	04	186, 187, 188
			15	791 [1], 793 [1]
599.7	Hematuria	N	11	695, 696
			15	791 [1], 793 [1]
611.8	Other specified disorders of breast	N	09	600, 601
695.1	Erythema multiforme	CC	09	595, 596
729.9	Other and unspecified disorders of soft tissue	N	08	555, 556
760.6	Surgical operation on mother	N	15	794
777.5	Necrotizing enterocolitis in fetus or newborn	MCC	15	791 [2], 793 [2]
788.9	Other symptoms involving urinary system	N	11	695, 696
795.1	Nonspecific abnormal Papanicolaou smear of other site	N	04	180, 181, 182
997.3	Respiratory complications	CC	04	205, 206
			15	791 [1], 793 [1]
999.8	Other transfusion reaction	CC	15	791 [1], 793 [1]
			16	811, 812
V13.5	Personal history of other musculoskeletal disorders	N	23	951
V15.2	Personal history of surgery to other major organs	N	23	951
V15.5	Personal history of injury	N	23	951
V28.8	Encounter for other specified antenatal screening	N	23	951
V45.1	Renal dialysis status	N	23	951
V51	Aftercare involving the use of plastic surgery	N	09	606, 607

[1] Principal or secondary diagnosis of major problem.
[2] Principal or secondary diagnosis of major problem.

TABLE 6D.—INVALID PROCEDURE CODES

Procedure code	Description	O.R.	MDC	MS–DRG
			.....	
45.8	Total intra-abdominal colectomy	Y	05	264
			06	329, 330, 331
			17	820, 821, 822, 826, 827, 828
			21	907, 908, 909
			24	957, 958, 959
48.5	Abdominoperineal resection of rectum	Y	06	332, 333, 334
			17	820, 821, 822, 826, 827, 828
			21	907, 908, 909
			24	957, 958, 959
53.7	Repair of diaphragmatic hernia, abdominal approach	Y	04	163, 164, 165
			06	326, 327, 328
			21	907, 908, 909
			24	957, 958, 959

TABLE 6E.—REVISED DIAGNOSIS CODE TITLES

Diagnosis code	Description	CC	MDC	MS–DRG
203.00	Multiple myeloma, without mention of having achieved remission	CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842

TABLE 6E.—REVISED DIAGNOSIS CODE TITLES—Continued

Diagnosis code	Description	CC	MDC	MS–DRG
203.10	Plasma cell leukemia, without mention of having achieved remission	CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
203.80	Other immunoproliferative neoplasms, without mention of having achieved remission	CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
204.00	Acute lymphoid leukemia, without mention of having achieved remission	CC	17	820, 821, 822, 834, 835, 836, 837 [1], 838 [1], 839 [1]
204.10	Chronic lymphoid leukemia, without mention of having achieved remission	CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
204.20	Subacute lymphoid leukemia, without mention of having achieved remission	CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
204.80	Other lymphoid leukemia, without mention of having achieved remission	CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
204.90	Unspecified lymphoid leukemia, without mention of having achieved remission	CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
205.00	Acute myeloid leukemia, without mention of having achieved remission	CC	17	820, 821, 822, 834, 835, 836, 837 [1], 838 [1], 839 [1]
205.10	Chronic myeloid leukemia, without mention of having achieved remission	CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
205.20	Subacute myeloid leukemia, without mention of having achieved remission	CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
205.30	Myeloid sarcoma, without mention of having achieved remission	CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
205.80	Other myeloid leukemia, without mention of having achieved remission	CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
205.90	Unspecified myeloid leukemia, without mention of having achieved remission	CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
206.00	Acute monocytic leukemia, without mention of having achieved remission	CC	17	820, 821, 822, 834, 835, 836, 837 [1], 838 [1], 839 [1]
206.10	Chronic monocytic leukemia, without mention of having achieved remission	CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
206.20	Subacute monocytic leukemia, without mention of having achieved remission	CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
206.80	Other monocytic leukemia, without mention of having achieved remission	CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
206.90	Unspecified monocytic leukemia, without mention of having achieved remission	CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
207.00	Acute erythremia and erythroleukemia, without mention of having achieved remission	CC	17	820, 821, 822, 834, 835, 836, 837 [1], 838 [1], 839 [1]
207.10	Chronic erythremia, without mention of having achieved remission	CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
207.20	Megakaryocytic leukemia, without mention of having achieved remission	CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
207.80	Other specified leukemia, without mention of having achieved remission	CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842

TABLE 6E.—REVISED DIAGNOSIS CODE TITLES—Continued

Diagnosis code	Description	CC	MDC	MS–DRG
208.00	Acute leukemia of unspecified cell type, without mention of having achieved remission	CC	17	820, 821, 822, 834, 835, 836, 837 [1], 838 [1], 839 [1]
208.10	Chronic leukemia of unspecified cell type, without mention of having achieved remission	CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
208.20	Subacute leukemia of unspecified cell type, without mention of having achieved remission	CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
208.80	Other leukemia of unspecified cell type, without mention of having achieved remission	CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
208.90	Unspecified leukemia, without mention of having achieved remission	CC	17	820, 821, 822, 823, 824, 825, 840, 841, 842
346.00	Migraine with aura, without mention of intractable migraine without mention of status migrainosus.	N	01	102, 103
346.01	Migraine with aura, with intractable migraine, so stated, without mention of status migrainosus.	N	01	102, 103
346.10	Migraine without aura, without mention of intractable migraine without mention of status migrainosus.	N	01	102, 103
346.11	Migraine without aura, with intractable migraine, so stated, without mention of status migrainosus.	N	01	102, 103
346.20	Variants of migraine, not elsewhere classified, without mention of intractable migraine without mention of status migrainosus.	N	01	102, 103
346.21	Variants of migraine, not elsewhere classified, with intractable migraine, so stated, without mention of status migrainosus.	N	01	102, 103
346.80	Other forms of migraine, without mention of intractable migraine without mention of status migrainosus.	N	01	102, 103
346.81	Other forms of migraine, with intractable migraine, so stated, without mention of status migrainosus.	N	01	102, 103
386.00	Ménière's disease, unspecified	N	03	149
386.01	Active Ménière's disease, cochleovestibular	N	03	149
386.02	Active Ménière's disease, cochlear	N	03	149
386.03	Active Ménière's disease, vestibular	N	03	149
386.04	Inactive Ménière's disease	N	03	149
707.00	Pressure ulcer, unspecified site	N [2]	09	573, 574, 575, 592, 593, 594
707.01	Pressure ulcer, elbow	N [2]	09	573, 574, 575, 592, 593, 594
707.02	Pressure ulcer, upper back	N [2]	09	573, 574, 575, 592, 593, 594
707.03	Pressure ulcer, lower back	N [2]	09	573, 574, 575, 592, 593, 594
707.04	Pressure ulcer, hip	N [2]	09	573, 574, 575, 592, 593, 594
707.05	Pressure ulcer, buttock	N [2]	09	573, 574, 575, 592, 593, 594
707.06	Pressure ulcer, ankle	N [2]	09	573, 574, 575, 592, 593, 594
707.07	Pressure ulcer, heel	N [2]	09	573, 574, 575, 592, 593, 594
707.09	Pressure ulcer, other site	N [2]	09	573, 574, 575, 592, 593, 594
776.9	Unspecified hematological disorder specific to newborn	N	15	794
795.08	Unsatisfactory cervical cytology smear	N	13	742, 743, 760, 761
998.31	Disruption of internal operation (surgical) wound	CC	21	919, 920, 921
V28.3	Encounter for routine screening for malformation using ultrasonics	N	23	951
V45.71	Acquired absence of breast and nipple	N	23	951

[1] Secondary diagnosis of acute leukemia.

[2] The pressure ulcer site specific codes (707.00–707.09) will be non-CCs. The pressure ulcer stage III and IV codes will be classified as MCCs.

TABLE 6F.—REVISED PROCEDURE CODE TITLES

Procedure code	Description	O.R.	MDC	MS–DRG
37.52	Implantation of internal biventricular heart replacement system	Y	PRE	001 [1], 002 [1]
37.53	Replacement or repair of thoracic unit of (total) replacement heart system	Y	05	215
37.54	Replacement or repair of other implantable component of (total) replacement heart system	Y	05	215
45.71	Open and other multiple segmental resection of large intestine	Y	06	329, 330, 331
			17	820, 821, 822, 826, 827, 828
			21	907, 908, 909
			24	957, 958, 959
45.72	Open and other cecectomy	Y	05	264
			06	329, 330, 331
			21	907, 908, 909
			24	957, 958, 959
45.73	Open and other right hemicolectomy	Y	05	264
			06	329, 330, 331
			17	820, 821, 822, 826, 827, 828
			21	907, 908, 909
			24	957, 958, 959
45.74	Open and other resection of transverse colon	Y	05	264
			06	329, 330, 331
			17	820, 821, 822, 826, 827, 828
			21	907, 908, 909
			24	957, 958, 959
45.75	Open and other left hemicolectomy	Y	05	264
			06	329, 330, 331
			10	628, 629, 630
			17	820, 821, 822, 826, 827, 828
			21	907, 908, 909
			24	957, 958, 959
45.76	Open and other sigmoidectomy	Y	06	329, 330, 331
			17	820, 821, 822, 826, 827, 828
			21	907, 908, 909
			24	957, 958, 959
45.79	Other and unspecified partial excision of large intestine	Y	05	264
			06	329, 330, 331
			17	820, 821, 822, 826, 827, 828
			21	907, 908, 909
			24	957, 958, 959
53.01	Other and open repair of direct inguinal hernia	Y	06	350, 351, 352
53.02	Other and open repair of indirect inguinal hernia	Y	06	350, 351, 352
53.03	Other and open repair of direct inguinal hernia with graft or prosthesis	Y	06	350, 351, 352
53.04	Other and open repair of indirect inguinal hernia with graft or prosthesis	Y	06	350, 351, 352
53.11	Other and open bilateral repair of direct inguinal hernia	Y	06	350, 351, 352
53.12	Other and open bilateral repair of indirect inguinal hernia	Y	06	350, 351, 352
53.13	Other and open bilateral repair of inguinal hernia, one direct and one indirect	Y	06	350, 351, 352
53.14	Other and open bilateral repair of direct inguinal hernia with graft or prosthesis	Y	06	350, 351, 352
53.15	Other and open bilateral repair of indirect inguinal hernia with graft or prosthesis	Y	06	350, 351, 352
53.16	Other and open bilateral repair of inguinal hernia, one direct and one indirect, with graft or prosthesis.	Y	06	350, 351, 352
53.41	Other and open repair of umbilical hernia with graft or prosthesis	Y	06	353, 354, 355
53.49	Other open umbilical herniorrhaphy	Y	06	353, 354, 355
			21	907, 908, 909
			24	957, 958, 959
53.61	Other open incisional hernia repair with graft or prosthesis	Y	06	353, 354, 355
			21	907, 908, 909
			24	957, 958, 959
53.69	Other and open repair of other hernia of anterior abdominal wall with graft or prosthesis	Y	06	353, 354, 355
81.65	Percutaneous vertebroplasty	Y	08	515, 516, 517
			21	907, 908, 909
			24	957, 958, 959
81.66	Percutaneous vertebral augmentation	Y	08	515, 516, 517
			21	907, 908, 909
			24	957, 958, 959

[1] Note MS–DRG change.

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY: FY 2007 MEDPAR UPDATE—DECEMBER 2007 GROUPER V25.0 MS–DRGS

MS-DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
1	655	40.2107	12	17	31	51	83
2	287	24.7456	9	12	17	28	48
3	23,205	39.6406	16	22	32	48	68
4	21,267	28.8412	11	17	24	35	49
5	635	21.1717	7	10	15	26	42
6	229	10.2576	6	7	9	12	17
7	356	19.6517	8	10	15	22	38
8	483	11.9337	6	7	9	13	20
9	1,346	21.9725	8	16	20	25	35
10	163	10.7791	6	7	8	11	19
11	1,264	16.7302	6	9	13	20	30
12	1,907	10.6754	4	6	9	13	18
13	1,268	6.9267	3	4	6	8	11
20	885	18.3525	6	10	17	24	32
21	530	15.4472	8	11	14	19	25
22	212	9.3726	2	6	9	12	15
23	3,730	12.6794	2	5	10	17	25
24	2,092	9.0263	1	4	8	12	18
25	8,697	13.0331	4	6	10	17	25
26	11,781	8.2206	2	4	7	11	15
27	13,695	4.5403	1	2	4	6	9
28	1,666	14.3055	4	7	11	18	27
29	3,070	7.1091	1	3	6	9	14
30	3,398	3.7310	1	1	3	5	7
31	1,024	13.1377	3	6	10	18	27
32	2,780	5.9781	1	2	4	8	14
33	3,623	3.0395	1	1	2	4	6
34	765	7.2261	1	2	5	9	15
35	2,239	3.2823	1	1	2	4	8
36	6,947	1.5949	1	1	1	2	3
37	4,841	8.5478	2	3	7	11	17
38	14,146	3.7666	1	1	2	5	9
39	51,927	1.8278	1	1	1	2	3
40	4,766	13.3479	3	6	10	17	25
41	7,573	7.2006	1	3	6	9	14
42	4,859	3.6300	1	1	2	5	8
52	1,163	6.7395	2	3	5	8	14
53	587	4.0102	1	2	3	5	7
54	5,240	6.9504	2	3	5	9	14
55	16,289	5.0708	1	2	4	6	10
56	8,250	7.7668	2	3	6	9	14
57	47,224	4.9743	2	3	4	6	9
58	736	7.5978	2	4	6	9	15
59	2,752	5.1432	2	3	4	6	9
60	4,068	3.9668	2	2	4	5	7
61	1,586	8.9426	2	4	7	11	17
62	2,464	6.2683	3	4	5	8	11
63	1,323	4.5110	2	3	4	6	8
64	55,734	7.4669	2	3	6	10	15
65	105,000	5.2179	2	3	4	6	9
66	89,325	3.7141	1	2	3	5	7
67	1,397	5.8232	2	3	5	7	11
68	11,402	3.4467	1	2	3	4	6
69	101,817	2.9920	1	2	2	4	5
70	7,341	7.8574	2	4	6	10	15
71	9,526	5.5568	2	3	4	7	10
72	5,739	3.5389	1	2	3	4	7
73	9,223	6.2394	2	3	5	8	12
74	31,500	4.3070	1	2	3	5	8
75	1,238	7.3021	2	4	6	9	14
76	873	4.1340	2	2	4	5	7
77	1,211	6.6821	2	3	5	9	12
78	1,405	4.4157	2	2	4	6	8
79	931	3.3845	1	2	3	4	6
80	1,861	5.1016	1	2	4	6	10
81	7,124	3.5267	1	2	3	4	6
82	1,757	6.4087	1	1	4	9	15
83	2,049	4.9551	1	2	4	7	10
84	2,769	3.1268	1	1	2	4	6
85	5,879	7.6399	2	3	6	10	15

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY: FY 2007 MEDPAR UPDATE—DECEMBER 2007 GROUPER V25.0 MS–DRGS—Continued

MS-DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
86	11,469	5.0021	1	3	4	6	9
87	12,958	3.2740	1	2	3	4	6
88	711	5.8748	1	3	4	7	12
89	2,733	3.7603	1	2	3	5	7
90	3,089	2.5494	1	1	2	3	5
91	7,605	6.3657	2	3	5	8	13
92	16,265	4.4647	1	2	4	6	8
93	16,121	3.2188	1	2	3	4	6
94	1,473	11.8547	4	6	10	15	22
95	1,030	8.6359	3	5	7	11	15
96	757	6.1744	2	4	6	8	11
97	1,192	12.6023	4	7	11	16	23
98	1,005	8.3522	3	5	7	10	15
99	641	5.8752	2	3	5	8	11
100	16,989	6.3526	2	3	5	8	12
101	56,991	3.6950	1	2	3	5	7
102	1,080	4.5306	1	2	3	6	9
103	13,735	3.1270	1	2	2	4	6
113	525	5.5981	1	2	4	8	12
114	555	2.6090	1	1	2	3	5
115	1,046	4.3222	1	2	4	5	7
116	546	4.0678	1	1	2	5	8
117	996	2.1596	1	1	1	2	3
121	542	5.4576	2	3	4	7	10
122	617	4.0454	2	2	3	5	7
123	2,785	2.8747	1	2	2	4	5
124	749	5.2697	1	2	4	7	10
125	4,661	3.5134	1	2	3	4	7
129	1,353	5.1803	1	2	4	6	11
130	1,073	2.9385	1	1	2	4	6
131	929	5.7492	1	2	4	8	12
132	886	2.6501	1	1	2	3	5
133	1,981	5.3296	1	2	4	7	11
134	3,362	2.2329	1	1	1	3	4
135	352	5.8295	1	2	4	8	12
136	472	2.3305	1	1	1	3	5
137	773	5.4062	1	2	4	7	11
138	886	2.5237	1	1	2	3	5
139	1,490	1.8456	1	1	1	2	3
146	674	9.4466	2	4	7	12	19
147	1,364	6.1320	1	2	4	8	12
148	847	3.8040	1	1	3	5	8
149	38,817	2.7185	1	1	2	3	5
150	949	5.1981	1	2	4	6	10
151	6,810	2.8921	1	1	2	4	5
152	1,726	4.4571	1	2	3	5	8
153	11,433	3.2168	1	2	3	4	6
154	1,899	6.3381	2	3	5	8	12
155	4,471	4.4187	1	2	4	6	8
156	4,819	3.1731	1	2	3	4	6
157	1,044	6.6542	1	3	5	8	14
158	3,219	4.5281	1	2	3	6	9
159	2,355	3.0522	1	1	2	4	6
163	13,614	14.9476	5	8	13	19	27
164	17,887	8.0977	3	5	7	10	15
165	13,805	5.1442	2	3	5	6	9
166	20,549	12.9161	4	7	10	16	24
167	20,520	7.9756	2	4	7	10	15
168	5,467	5.2532	1	2	4	7	10
175	12,682	7.2650	3	4	6	9	12
176	41,338	5.3283	2	3	5	7	9
177	63,750	9.1032	3	5	7	12	17
178	70,831	7.3794	3	4	6	9	13
179	26,087	5.5654	2	3	5	7	10
180	22,324	7.9001	2	4	6	10	15
181	30,220	5.9078	2	3	5	8	11
182	5,446	4.1761	1	2	3	5	8
183	1,856	7.2338	2	4	6	9	13
184	4,320	4.5829	2	3	4	6	8
185	2,506	3.4066	1	2	3	4	6

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY: FY 2007 MEDPAR UPDATE—DECEMBER 2007 GROUPER V25.0 MS–DRGS—Continued

MS-DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
186	9,239	7.4006	2	4	6	9	14
187	10,028	5.3216	2	3	4	7	10
188	5,014	3.9928	1	2	3	5	8
189	113,067	6.1459	2	3	5	8	11
190	58,781	6.2972	2	3	5	8	12
191	118,162	5.0156	2	3	4	6	9
192	184,764	3.9705	1	2	3	5	7
193	87,315	6.7517	2	4	6	8	12
194	253,950	5.2660	2	3	4	7	9
195	133,231	4.0792	2	2	4	5	7
196	5,388	7.3537	3	4	6	9	14
197	6,796	5.3899	2	3	4	7	10
198	4,616	4.0804	1	2	3	5	7
199	3,208	8.3030	2	4	7	11	16
200	8,382	5.0894	1	2	4	7	10
201	3,467	4.0580	1	2	3	5	8
202	29,252	4.3530	1	2	4	5	8
203	36,870	3.3859	1	2	3	4	6
204	25,669	2.8746	1	1	2	4	5
205	5,848	5.5050	1	2	4	7	10
206	21,532	3.4393	1	2	3	4	6
207	39,505	15.0709	6	9	13	18	25
208	76,444	7.2241	1	3	6	10	14
215	141	14.1844	1	3	9	17	31
216	8,616	18.3713	8	11	16	23	31
217	7,236	12.3046	6	8	11	15	20
218	2,554	9.0568	5	6	8	11	14
219	10,525	13.9944	6	8	11	17	26
220	13,928	8.5619	5	6	7	10	14
221	7,032	6.4428	4	5	6	7	10
222	2,771	13.0949	5	7	11	17	23
223	5,080	6.2701	1	3	5	8	12
224	1,911	11.3673	4	6	9	14	21
225	5,076	5.6420	2	3	5	7	10
226	7,064	9.3342	1	3	7	12	19
227	42,807	2.8263	1	1	1	3	7
228	2,974	14.7078	6	8	13	18	26
229	3,596	9.1096	4	6	8	11	15
230	1,566	6.4757	3	4	6	8	11
231	1,446	13.3811	6	8	11	17	24
232	1,515	9.1868	5	7	8	11	14
233	16,254	14.1787	7	9	12	17	24
234	34,309	8.9262	5	6	8	11	13
235	9,629	11.2185	5	7	9	14	20
236	30,065	6.6177	4	5	6	8	10
237	22,384	10.8073	2	5	9	14	21
238	42,226	4.6444	1	2	3	6	9
239	13,307	15.3499	5	8	12	19	29
240	11,658	10.3695	3	5	8	13	19
241	2,680	6.7634	3	4	6	8	12
242	17,519	8.7738	3	4	7	11	17
243	36,074	5.0924	1	2	4	7	10
244	62,706	2.9268	1	1	2	4	6
245	5,887	3.3061	1	1	2	4	7
246	28,818	5.3370	1	2	4	7	12
247	188,884	2.1674	1	1	1	3	4
248	13,847	5.9831	1	2	4	8	12
249	69,978	2.4966	1	1	2	3	5
250	6,762	7.7798	1	3	6	10	16
251	41,707	2.8343	1	1	2	4	6
252	45,567	8.5378	1	3	6	11	18
253	44,910	6.0144	1	2	5	8	13
254	53,360	2.7299	1	1	2	3	6
255	2,521	9.6942	2	4	8	12	18
256	3,425	7.4762	2	4	6	9	13
257	705	4.8482	1	2	4	7	10
258	686	7.3761	2	3	6	9	14
259	7,302	2.8020	1	1	2	4	6
260	1,549	11.2214	3	5	8	14	22
261	3,522	4.2127	1	1	3	6	9

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY: FY 2007 MEDPAR UPDATE—DECEMBER 2007 GROUPER V25.0 MS–DRGS—Continued

MS-DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
262	3,531	2.5902	1	1	2	3	6
263	652	5.4126	1	1	3	7	13
264	28,273	8.8998	1	3	6	11	19
280	63,593	7.3381	2	4	6	9	13
281	53,704	4.8075	2	3	4	6	9
282	54,305	3.2480	1	2	3	4	6
283	14,888	5.4547	1	1	3	7	13
284	4,139	3.2341	1	1	2	4	7
285	2,803	2.2112	1	1	1	3	5
286	23,695	6.9333	2	3	5	9	14
287	158,158	3.1457	1	1	2	4	6
288	2,953	11.7541	4	6	9	14	22
289	1,357	8.6610	3	5	7	11	15
290	473	6.4947	2	4	5	8	11
291	187,597	6.4926	2	3	5	8	12
292	204,514	4.9936	2	3	4	6	9
293	196,441	3.6816	1	2	3	5	6
294	1,415	5.5611	2	3	5	7	9
295	1,343	4.3291	2	3	4	6	7
296	1,917	3.0303	1	1	1	3	7
297	791	1.8217	1	1	1	2	3
298	602	1.3040	1	1	1	1	2
299	17,750	6.6518	2	3	5	8	12
300	44,551	5.0493	2	3	4	6	9
301	36,994	3.6992	1	2	3	5	7
302	7,587	4.3756	1	2	3	5	8
303	70,544	2.5315	1	1	2	3	5
304	2,086	5.1942	1	2	4	7	10
305	35,079	2.8628	1	1	2	4	5
306	1,515	6.2964	1	3	4	8	12
307	6,344	3.4455	1	2	3	4	6
308	35,699	5.5438	1	2	4	7	11
309	79,311	3.9373	1	2	3	5	7
310	158,556	2.7530	1	1	2	4	5
311	21,034	2.3089	1	1	2	3	4
312	165,835	3.1053	1	2	2	4	6
313	211,391	2.1067	1	1	2	3	4
314	61,613	7.0205	2	3	5	9	14
315	29,960	4.6041	1	2	4	6	9
316	17,966	2.9978	1	1	2	4	6
326	11,226	17.1201	6	9	14	21	32
327	10,457	10.0519	3	5	8	13	18
328	8,865	4.3610	1	2	3	6	9
329	48,110	15.9561	6	9	13	20	29
330	63,624	9.7138	4	6	8	12	17
331	28,171	5.8793	3	4	5	7	9
332	1,823	14.3489	6	8	12	18	25
333	5,922	8.8349	4	6	8	10	15
334	3,719	5.5052	2	4	5	7	9
335	7,182	14.0778	5	8	12	18	25
336	12,448	9.0917	3	5	8	11	16
337	8,570	5.5883	1	3	5	8	10
338	1,501	10.7082	4	6	9	13	19
339	3,163	7.0452	3	4	6	9	12
340	3,558	4.1521	2	2	4	5	7
341	878	7.1287	2	3	5	9	14
342	2,544	4.1395	1	2	3	5	8
343	6,975	2.1792	1	1	2	3	4
344	936	11.7575	4	6	9	15	22
345	2,914	7.2447	3	4	6	9	12
346	2,759	4.9467	2	3	5	6	8
347	1,625	8.8166	2	4	7	11	17
348	4,164	5.7366	2	3	5	7	11
349	5,155	3.0795	1	1	2	4	6
350	1,756	7.9897	2	3	6	10	16
351	4,287	4.5573	1	2	4	6	9
352	8,183	2.4793	1	1	2	3	5
353	3,165	8.4051	2	4	7	11	16
354	8,420	5.0816	2	3	4	6	9
355	15,316	2.8995	1	1	2	4	5

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY: FY 2007 MEDPAR UPDATE—DECEMBER 2007 GROUPER V25.0 MS–DRGS—Continued

MS-DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
356	8,335	12.9146	3	6	10	16	25
357	7,801	8.1406	2	4	6	10	16
358	2,477	4.4719	1	2	4	6	9
368	3,566	6.5979	2	3	5	8	13
369	5,248	4.7487	2	3	4	6	9
370	3,554	3.3995	1	2	3	4	6
371	24,371	8.7488	3	4	7	11	17
372	27,061	6.8532	3	4	6	8	12
373	15,249	4.9382	2	3	4	6	8
374	9,039	8.5759	2	4	7	11	16
375	18,945	6.0287	2	3	5	8	12
376	4,279	4.1837	1	2	3	5	8
377	51,556	6.3806	2	3	5	8	12
378	110,340	4.4472	2	3	4	5	8
379	92,136	3.4088	1	2	3	4	6
380	3,020	7.2738	2	3	6	9	14
381	5,293	5.1734	2	3	4	6	9
382	4,492	3.6814	1	2	3	5	7
383	1,223	5.5200	2	3	4	7	10
384	8,080	3.7490	1	2	3	5	7
385	1,996	8.8191	3	4	6	11	18
386	7,126	5.6996	2	3	5	7	10
387	5,033	4.2935	1	2	4	5	8
388	18,540	7.3159	2	3	6	9	14
389	45,795	5.0160	2	3	4	6	9
390	46,426	3.5522	1	2	3	4	6
391	44,299	5.2367	1	2	4	6	10
392	282,071	3.4889	1	2	3	4	6
393	23,253	6.8917	2	3	5	8	14
394	45,853	4.8196	1	2	4	6	9
395	24,740	3.3344	1	2	3	4	6
405	3,963	17.0056	5	8	13	21	34
406	5,300	9.1566	2	5	7	11	18
407	2,115	5.4851	1	3	5	7	10
408	1,548	14.9961	6	8	12	18	28
409	1,737	9.8290	4	6	8	12	18
410	598	6.5033	2	4	6	8	11
411	956	12.4069	5	7	10	15	22
412	955	8.5696	4	6	8	11	14
413	756	5.9272	2	4	5	7	10
414	5,241	11.7296	5	7	10	14	21
415	6,127	7.6236	3	5	7	9	13
416	5,328	4.8281	2	3	4	6	8
417	16,444	8.3803	3	4	7	10	16
418	27,075	5.6341	2	3	5	7	10
419	35,887	3.1911	1	1	3	4	6
420	766	13.6606	3	6	10	17	26
421	1,054	7.6879	2	3	6	10	16
422	327	4.3609	1	2	4	6	8
423	1,542	15.8599	4	7	12	20	32
424	894	10.4172	3	5	8	14	20
425	125	5.3760	1	2	4	7	10
432	15,140	6.9542	2	3	5	9	14
433	9,672	4.8719	1	2	4	6	9
434	877	3.6933	1	2	3	5	6
435	12,111	7.5614	2	3	6	10	15
436	13,158	5.8396	2	3	5	8	11
437	3,887	4.2529	1	2	3	6	8
438	14,063	7.5128	2	3	5	9	15
439	24,364	5.3275	2	3	4	7	10
440	25,670	3.8103	1	2	3	5	7
441	13,335	7.0467	2	3	5	9	14
442	14,144	5.1103	2	2	4	6	9
443	6,544	3.7796	1	2	3	5	7
444	12,898	6.6243	2	3	5	8	13
445	16,794	4.7264	1	2	4	6	9
446	15,932	3.2658	1	2	3	4	6
453	948	15.6561	5	7	12	19	29
454	1,771	8.0237	3	4	6	10	14
455	1,969	4.4307	1	3	4	5	7

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY: FY 2007 MEDPAR UPDATE—DECEMBER 2007 GROUPER V25.0 MS–DRGS—Continued

MS-DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
456	946	14.7061	5	7	11	19	28
457	2,413	7.4836	3	4	6	9	13
458	1,609	4.5438	2	3	4	6	7
459	3,508	9.4478	4	5	7	11	17
460	51,883	4.2180	2	3	4	5	7
461	1,018	8.4342	3	5	6	9	14
462	13,194	4.2178	3	3	4	5	6
463	5,054	16.5693	5	7	12	20	33
464	5,839	10.2197	3	5	8	12	20
465	2,398	5.8661	1	3	5	7	11
466	4,072	9.1717	3	5	7	11	16
467	14,331	5.4882	3	3	4	6	9
468	21,133	3.9306	2	3	3	4	6
469	30,532	8.2006	3	5	7	10	14
470	405,204	3.9281	3	3	3	4	6
471	2,283	9.7946	2	4	7	13	20
472	6,954	4.0913	1	1	3	5	9
473	22,875	1.9623	1	1	1	2	4
474	2,918	12.6453	4	6	10	15	24
475	3,277	8.3946	3	4	7	11	15
476	1,589	4.7885	1	2	4	6	9
477	2,582	11.8548	3	6	9	15	22
478	8,562	6.6119	1	3	6	9	13
479	11,424	2.8188	1	1	1	4	7
480	26,724	9.2958	4	5	8	11	16
481	72,123	5.9291	3	4	5	7	9
482	48,111	4.8427	3	4	4	6	7
483	7,100	4.2093	2	2	3	5	8
484	17,842	2.4311	1	2	2	3	4
485	1,183	12.1116	4	6	10	15	22
486	2,186	8.0425	3	5	7	10	14
487	1,312	5.6715	3	3	5	7	9
488	2,495	5.2236	2	3	4	6	10
489	5,763	3.0465	1	2	3	4	5
490	22,971	4.3437	1	1	3	5	9
491	52,406	2.2104	1	1	2	3	4
492	5,217	8.5338	3	5	7	11	15
493	16,900	5.2509	2	3	4	6	9
494	29,166	3.3992	1	2	3	4	6
495	1,970	10.9609	3	5	8	14	21
496	5,555	5.9802	2	3	5	7	11
497	6,632	3.0054	1	1	2	4	6
498	1,163	7.8865	2	3	6	10	16
499	1,110	2.9757	1	1	2	4	6
500	1,503	10.8283	3	5	8	14	21
501	3,873	5.9700	2	3	5	8	12
502	6,452	2.9416	1	1	2	4	6
503	833	9.4586	3	5	7	11	17
504	2,162	6.4510	2	3	6	8	12
505	3,004	3.3832	1	2	3	4	6
506	810	3.4074	1	1	2	4	7
507	836	5.1459	1	2	4	6	10
508	2,481	2.0512	1	1	1	2	3
509	627	3.1100	1	1	2	3	7
510	973	6.4070	2	3	5	8	12
511	3,926	3.9758	1	2	3	5	7
512	10,961	2.1581	1	1	2	3	4
513	1,052	5.0266	1	2	4	6	10
514	1,006	2.8191	1	1	2	3	6
515	3,818	10.4445	3	5	8	13	20
516	11,280	5.9870	1	3	5	8	11
517	17,523	3.0079	1	1	2	4	7
533	822	6.6861	2	3	5	8	12
534	3,392	4.0292	1	2	3	5	7
535	6,990	6.2365	2	3	5	8	12
536	33,661	3.9328	2	3	3	5	7
537	665	4.4722	2	3	4	5	8
538	1,056	3.2197	1	2	3	4	6
539	3,417	9.7085	3	5	8	12	17
540	4,016	7.1257	3	4	6	8	13

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY: FY 2007 MEDPAR UPDATE—DECEMBER 2007 GROUPER V25.0 MS–DRGS—Continued

MS-DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
541	1,618	5.3745	2	3	4	7	9
542	5,709	8.7758	3	4	7	11	17
543	17,012	5.9463	2	3	5	7	11
544	10,798	4.4077	2	3	4	5	8
545	4,079	9.0924	2	4	6	11	19
546	5,577	5.5338	2	3	4	7	10
547	4,533	3.8083	1	2	3	5	7
548	580	8.9379	3	4	7	11	17
549	1,110	6.3874	2	3	5	8	12
550	858	4.4545	2	2	4	6	8
551	10,066	7.1058	2	3	6	9	14
552	85,179	4.1225	1	2	3	5	7
553	3,076	5.9620	2	3	5	7	11
554	19,173	3.6913	1	2	3	5	7
555	2,013	4.8405	1	2	4	6	9
556	18,639	3.1089	1	2	3	4	6
557	3,646	6.6100	2	3	5	8	12
558	15,089	4.2586	2	2	4	5	7
559	1,815	7.5444	2	3	6	9	15
560	4,319	4.7217	1	2	4	6	9
561	7,107	2.7680	1	1	2	3	5
562	5,458	6.3674	2	3	5	8	12
563	36,267	3.7016	1	2	3	4	6
564	1,661	6.9934	2	3	5	9	13
565	3,311	4.9795	2	3	4	6	9
566	2,624	3.6825	1	2	3	5	7
573	5,477	13.0933	4	6	9	16	26
574	11,123	9.3248	3	5	7	11	17
575	5,462	5.8521	2	3	5	7	11
576	547	12.9506	2	4	9	17	28
577	2,228	6.1104	1	2	4	8	13
578	3,054	3.3062	1	1	2	4	7
579	3,511	10.6830	3	5	8	14	21
580	10,711	5.5084	1	2	4	7	12
581	12,142	2.6146	1	1	2	3	6
582	5,337	2.8943	1	1	2	3	5
583	8,748	1.8056	1	1	1	2	3
584	668	5.9850	1	2	4	8	13
585	1,469	2.2321	1	1	1	2	4
592	4,178	8.8712	3	4	7	10	16
593	12,304	6.4415	2	3	5	8	11
594	2,751	5.0593	2	3	4	6	9
595	1,112	8.3327	2	4	6	10	16
596	5,308	4.7600	1	2	4	6	8
597	458	8.2009	2	3	6	10	16
598	1,400	5.7243	2	3	4	7	11
599	306	3.7320	1	1	3	4	6
600	682	5.0513	2	3	4	7	9
601	884	3.8541	1	2	3	5	7
602	22,088	7.0278	2	4	6	9	13
603	130,121	4.7073	2	3	4	6	8
604	2,660	5.6590	1	3	4	7	11
605	22,097	3.4622	1	2	3	4	6
606	1,350	6.3422	1	3	4	7	12
607	7,168	3.7913	1	2	3	5	7
614	1,457	7.0336	2	3	5	8	14
615	1,546	3.1572	1	2	3	4	5
616	1,091	16.9432	6	9	13	20	31
617	6,718	8.7904	3	5	7	11	15
618	258	6.3605	2	3	6	8	11
619	696	8.2011	2	3	5	9	18
620	2,186	3.6780	1	2	3	4	7
621	7,848	2.1617	1	1	2	3	4
622	1,112	13.1574	3	6	9	16	24
623	3,077	8.5707	3	4	7	10	15
624	383	6.0261	2	3	5	7	10
625	1,274	7.0879	1	2	5	9	15
626	2,538	3.1233	1	1	2	3	7
627	14,026	1.5172	1	1	1	2	2
628	3,366	11.1851	2	4	8	14	23

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY: FY 2007 MEDPAR UPDATE—DECEMBER 2007 GROUPER V25.0 MS–DRGS—Continued

MS-DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
629	4,160	8.7418	3	5	7	11	16
630	534	5.5281	1	2	4	7	11
637	17,104	6.0581	2	3	5	7	12
638	42,581	4.2659	1	2	3	5	8
639	38,312	3.0382	1	2	2	4	5
640	60,806	5.4332	1	2	4	7	11
641	201,324	3.8256	1	2	3	5	7
642	1,492	5.1810	1	2	4	6	9
643	5,176	7.6103	2	4	6	9	14
644	11,788	5.4597	2	3	4	7	10
645	8,179	3.8912	1	2	3	5	7
652	10,067	7.7888	4	5	6	9	13
653	1,697	16.8981	7	9	13	21	31
654	3,452	9.8624	5	7	8	11	16
655	1,633	6.5150	3	5	7	8	10
656	3,918	10.1146	4	5	8	12	19
657	7,422	5.9603	3	4	5	7	10
658	8,271	3.7356	2	2	3	5	6
659	4,658	11.2003	3	5	8	14	22
660	7,594	6.5146	2	3	5	8	13
661	4,260	3.2758	1	2	3	4	6
662	949	10.2740	2	4	8	14	20
663	2,054	5.2639	1	2	4	7	11
664	4,390	2.1223	1	1	1	2	4
665	654	11.0627	3	5	9	14	21
666	2,092	6.3595	1	2	4	9	14
667	3,616	2.8695	1	1	2	3	6
668	3,833	8.5265	2	4	7	11	16
669	12,746	4.4236	1	2	3	6	9
670	11,687	2.5131	1	1	2	3	5
671	808	5.9468	1	2	4	8	12
672	943	2.5302	1	1	2	3	5
673	12,542	9.7323	1	3	7	13	21
674	11,715	7.1905	1	2	5	9	15
675	7,824	2.0675	1	1	1	2	4
682	82,091	7.1569	2	3	5	9	14
683	132,320	5.6544	2	3	5	7	10
684	44,932	3.8913	1	2	3	5	7
685	2,331	3.4822	1	1	2	4	7
686	1,597	7.5717	2	3	6	9	15
687	3,261	5.3502	1	3	4	7	10
688	1,073	3.2591	1	1	2	4	6
689	55,995	6.2004	2	3	5	8	11
690	198,101	4.2356	2	2	4	5	7
691	821	3.9586	1	2	3	5	8
692	491	2.3992	1	1	2	3	5
693	2,429	4.8345	1	2	4	6	10
694	18,000	2.5778	1	1	2	3	5
695	975	5.5251	1	3	4	7	11
696	10,518	3.2901	1	2	3	4	6
697	592	3.1115	1	1	2	4	6
698	23,320	6.6546	2	3	5	8	13
699	24,207	4.8302	1	2	4	6	9
700	12,279	3.5497	1	2	3	4	7
707	5,979	4.4131	1	2	3	5	8
708	18,063	2.1475	1	1	2	3	4
709	762	6.5341	1	2	4	8	15
710	1,831	1.7739	1	1	1	2	3
711	790	8.1684	1	3	6	10	16
712	705	3.0496	1	1	2	4	7
713	10,252	4.1916	1	2	3	5	9
714	28,797	1.9430	1	1	2	2	3
715	531	6.2806	1	2	4	8	13
716	1,273	1.4289	1	1	1	1	2
717	703	7.2319	2	3	5	9	14
718	589	2.7640	1	1	2	3	5
722	745	7.5852	2	3	6	10	14
723	1,949	5.2678	1	3	4	7	10
724	578	3.1522	1	1	2	4	6
725	755	5.5007	2	3	4	7	10

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY: FY 2007 MEDPAR UPDATE—DECEMBER 2007 GROUPER V25.0 MS–DRGS—Continued

MS-DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
726	3,716	3.4739	1	2	3	4	6
727	1,294	6.3995	2	3	5	8	12
728	6,158	4.0404	1	2	3	5	7
729	591	5.5736	1	2	4	7	10
730	471	3.0786	1	1	2	4	6
734	1,362	7.9941	3	4	6	9	15
735	1,130	3.3602	1	2	3	4	5
736	854	13.7752	5	7	11	17	25
737	3,293	7.1786	3	4	6	8	13
738	863	3.8714	2	3	3	5	6
739	1,013	10.1955	3	5	8	12	20
740	4,326	5.2305	2	3	4	6	9
741	6,014	2.9940	1	2	3	4	5
742	10,950	4.5175	2	2	3	5	8
743	32,325	2.2608	1	2	2	3	3
744	1,520	5.8355	1	2	4	7	12
745	1,694	2.5738	1	1	2	3	5
746	2,634	4.2134	1	2	3	5	8
747	10,409	1.8856	1	1	2	2	3
748	19,857	1.7358	1	1	1	2	3
749	982	9.3401	2	4	7	12	19
750	435	3.1103	1	1	2	4	6
754	978	8.3395	2	4	7	11	16
755	2,933	5.6870	2	3	4	7	11
756	677	3.1359	1	1	2	4	6
757	1,393	8.1436	3	4	6	10	16
758	1,605	6.0536	2	3	5	7	11
759	1,239	4.4722	2	2	4	5	8
760	1,700	3.9594	1	2	3	5	8
761	1,749	2.4351	1	1	2	3	5
765	2,754	5.0359	2	3	4	5	7
766	2,686	3.1601	2	2	3	4	4
767	132	3.3712	2	2	2	3	5
768	6	3.5000	1	2	3	6	6
769	98	4.6224	1	2	3	6	11
770	202	2.2277	1	1	1	2	5
774	1,506	3.1886	2	2	2	3	5
775	5,768	2.2394	1	2	2	3	3
776	511	3.3112	1	2	2	4	7
777	206	2.2136	1	1	2	3	4
778	474	3.0127	1	1	2	3	5
779	110	2.1182	1	1	1	2	3
780	40	1.4500	1	1	1	1	3
781	3,017	3.7630	1	1	2	4	7
782	171	2.4971	1	1	1	2	4
790	1	25.0000	125	125	125	125	125
799	566	14.0583	5	7	11	18	26
800	705	7.8610	3	4	6	9	15
801	557	4.9336	2	2	4	6	9
802	765	12.2706	3	5	9	15	25
803	1,070	6.6738	1	3	5	8	14
804	987	3.4215	1	1	3	4	6
808	6,088	8.2467	3	4	6	10	16
809	12,869	5.3247	2	3	4	7	10
810	2,786	4.0337	1	2	3	5	7
811	21,404	5.6912	1	2	4	7	11
812	89,951	3.7401	1	2	3	5	7
813	14,232	5.1669	1	2	4	6	10
814	1,554	6.7368	2	3	5	8	13
815	3,297	4.9706	1	2	4	6	9
816	2,147	3.5198	1	2	3	4	7
820	1,299	17.7229	5	8	14	23	34
821	2,474	7.8646	1	3	6	10	16
822	1,893	3.5288	1	1	3	4	7
823	2,178	15.4385	5	8	12	20	29
824	2,974	8.7492	2	4	7	11	17
825	1,748	4.3084	1	1	3	6	9
826	524	15.0401	4	7	11	19	29
827	1,254	7.9793	2	4	6	10	16
828	799	3.7722	1	2	3	5	7

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY: FY 2007 MEDPAR UPDATE—DECEMBER 2007 GROUPER V25.0 MS–DRGS—Continued

MS-DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
829	1,171	10.6576	2	4	7	13	22
830	521	3.7179	1	1	2	4	8
834	4,028	15.4615	2	4	10	23	36
835	2,703	10.4351	2	3	6	12	28
836	1,622	5.1843	1	2	3	6	10
837	1,043	23.1419	5	10	23	31	42
838	1,320	12.2629	3	4	6	21	29
839	1,467	6.4104	3	4	5	6	10
840	9,659	10.4408	3	5	8	13	21
841	10,035	6.9221	2	3	5	9	13
842	5,310	4.5563	1	2	4	6	9
843	1,350	8.5222	2	4	6	10	17
844	2,412	6.0987	2	3	5	8	12
845	804	4.3022	1	2	3	6	8
846	2,113	8.4179	2	3	5	10	18
847	23,862	3.3508	1	2	3	4	6
848	1,723	3.1294	1	1	3	4	5
849	1,477	5.9709	2	3	5	6	12
853	34,852	16.6669	5	8	13	21	30
854	6,643	11.1072	4	6	9	14	20
855	459	7.0261	2	4	6	9	13
856	5,892	15.3839	4	7	12	19	30
857	9,614	8.4628	3	4	7	10	16
858	3,246	5.6741	2	3	5	7	10
862	7,929	8.1778	2	4	6	10	16
863	21,420	5.1976	2	3	4	7	9
864	18,946	4.0639	1	2	3	5	7
865	1,705	6.7009	2	3	4	8	14
866	8,182	3.5351	1	2	3	4	7
867	5,062	9.6254	2	4	7	12	19
868	2,641	5.7819	2	3	4	7	11
869	1,103	4.3128	2	2	4	5	7
870	21,199	15.4758	6	9	13	19	27
871	216,384	7.4839	2	3	6	10	14
872	90,892	5.7138	2	3	5	7	10
876	857	11.9498	2	5	9	14	24
880	9,282	3.1518	1	1	2	4	6
881	4,623	4.1888	1	2	3	5	8
882	1,556	4.4274	1	2	3	6	9
883	757	7.3725	1	2	4	8	15
884	19,006	5.4936	2	3	4	6	10
885	80,806	7.6211	2	3	6	9	14
886	404	6.0767	1	2	4	7	12
887	393	4.6209	1	2	3	5	8
894	4,369	2.9528	1	1	2	3	4
895	6,958	10.4997	3	4	6	7	9
896	5,490	6.6087	2	3	5	8	13
897	36,053	4.0582	1	2	3	5	6
901	924	15.0693	3	6	10	18	30
902	2,031	7.7371	2	3	6	9	16
903	1,500	4.5680	1	2	4	6	9
904	1,047	11.2178	2	4	7	13	23
905	811	4.6523	1	2	4	6	8
906	712	3.1657	1	1	2	4	6
907	8,462	11.6494	2	5	8	14	23
908	8,319	6.7682	2	3	5	8	13
909	5,447	3.6367	1	1	3	5	7
913	804	5.6629	1	3	4	7	12
914	6,609	3.4330	1	2	3	4	6
915	1,078	4.7356	1	2	3	6	9
916	5,508	2.1044	1	1	2	3	4
917	15,775	5.1645	1	2	4	6	11
918	35,653	2.7260	1	1	2	3	5
919	11,089	6.3723	2	3	5	8	13
920	13,970	4.3608	1	2	3	5	8
921	9,423	2.9687	1	1	2	4	6
922	1,047	5.9933	1	2	4	7	12
923	3,952	3.2338	1	1	2	4	6
927	211	31.1374	7	15	26	41	60
928	818	15.9694	4	7	12	21	31

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY: FY 2007 MEDPAR UPDATE—DECEMBER 2007 GROUPER V25.0 MS–DRGS—Continued

MS-DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
929	438	7.6872	1	3	6	10	16
933	139	4.3453	1	1	1	4	8
934	659	6.1988	1	3	5	8	12
935	2,201	5.4330	1	2	4	7	11
939	671	10.0611	2	4	7	13	20
940	1,320	5.4220	1	2	4	7	12
941	1,707	2.7299	1	1	2	3	5
945	6,244	10.4947	4	6	8	12	15
946	3,055	7.8628	3	5	6	7	8
947	9,715	5.0101	1	2	4	6	10
948	47,722	3.4806	1	2	3	4	6
949	632	4.1092	1	1	2	4	6
950	387	3.4858	1	1	2	4	5
951	940	4.6436	1	1	2	3	6
955	443	12.2822	2	5	10	16	26
956	3,975	9.2896	4	5	7	11	17
957	1,311	14.8795	2	7	12	19	28
958	1,146	10.4031	3	6	8	13	19
959	286	6.2413	2	3	5	8	11
963	1,586	9.5214	2	4	8	13	19
964	2,573	6.2274	2	3	5	8	11
965	1,071	4.1391	1	2	3	5	7
969	639	18.8279	4	8	14	22	36
970	136	9.8309	2	3	7	12	17
974	5,920	10.3723	2	4	8	13	21
975	4,674	7.0148	2	3	5	9	13
976	2,617	4.9308	2	2	4	6	8
977	4,565	5.2931	1	2	4	6	10
981	25,479	15.1488	5	8	12	19	28
982	18,329	9.7455	3	5	8	12	18
983	6,112	5.3613	1	2	4	7	11
984	671	14.6811	5	8	13	18	25
985	903	9.6512	2	5	8	13	18
986	731	5.3338	1	2	3	7	12
987	8,240	13.0089	4	6	10	16	24
988	11,583	7.8090	2	3	6	10	15
989	5,796	4.1046	1	1	3	6	9
	11,387,276						

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY: FY 2007 MEDPAR UPDATE—DECEMBER 2007 GROUPER V26.0 MS–DRGS

MS–DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
1	655	40.2107	12	17	31	51	83
2	287	24.7456	9	12	17	28	48
3	23,205	39.6406	16	22	32	48	68
4	21,267	28.8412	11	17	24	35	49
5	635	21.1717	7	10	15	26	42
6	229	10.2576	6	7	9	12	17
7	356	19.6517	8	10	15	22	38
8	483	11.9337	6	7	9	13	20
9	1,346	21.9725	8	16	20	25	35
10	163	10.7791	6	7	8	11	19
11	1,264	16.7302	6	9	13	20	30
12	1,907	10.6754	4	6	9	13	18
13	1,268	6.9267	3	4	6	8	11
20	885	18.3525	6	10	17	24	32
21	530	15.4472	8	11	14	19	25
22	212	9.3726	2	6	9	12	15
23	3,730	12.6794	2	5	10	17	25
24	2,092	9.0263	1	4	8	12	18
25	8,697	13.0331	4	6	10	17	25
26	11,781	8.2206	2	4	7	11	15

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY: FY 2007 MEDPAR UPDATE—DECEMBER 2007 GROUPER V26.0 MS–DRGS—Continued

MS–DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
27	13,695	4.5403	1	2	4	6	9
28	1,666	14.3055	4	7	11	18	27
29	3,070	7.1091	1	3	6	9	14
30	3,398	3.7310	1	1	3	5	7
31	1,024	13.1377	3	6	10	18	27
32	2,780	5.9781	1	2	4	8	14
33	3,623	3.0395	1	1	2	4	6
34	765	7.2261	1	2	5	9	15
35	2,239	3.2823	1	1	2	4	8
36	6,947	1.5949	1	1	1	2	3
37	4,841	8.5478	2	3	7	11	17
38	14,146	3.7666	1	1	2	5	9
39	51,927	1.8278	1	1	1	2	3
40	4,765	13.3490	3	6	10	17	25
41	7,573	7.2006	1	3	6	9	14
42	4,859	3.6300	1	1	2	5	8
52	1,163	6.7395	2	3	5	8	14
53	587	4.0102	1	2	3	5	7
54	5,240	6.9504	2	3	5	9	14
55	16,289	5.0708	1	2	4	6	10
56	8,250	7.7668	2	3	6	9	14
57	47,224	4.9743	2	3	4	6	9
58	736	7.5978	2	4	6	9	15
59	2,752	5.1432	2	3	4	6	9
60	4,068	3.9668	2	2	4	5	7
61	1,586	8.9426	2	4	7	11	17
62	2,464	6.2683	3	4	5	8	11
63	1,323	4.5110	2	3	4	6	8
64	55,734	7.4669	2	3	6	10	15
65	105,000	5.2179	2	3	4	6	9
66	89,325	3.7141	1	2	3	5	7
67	1,397	5.8232	2	3	5	7	11
68	11,402	3.4467	1	2	3	4	6
69	101,817	2.9920	1	2	2	4	5
70	7,341	7.8574	2	4	6	10	15
71	9,526	5.5568	2	3	4	7	10
72	5,739	3.5389	1	2	3	4	7
73	9,223	6.2394	2	3	5	8	12
74	31,500	4.3070	1	2	3	5	8
75	1,238	7.3021	2	4	6	9	14
76	873	4.1340	2	2	4	5	7
77	1,211	6.6821	2	3	5	9	12
78	1,405	4.4157	2	2	4	6	8
79	931	3.3845	1	2	3	4	6
80	1,861	5.1016	1	2	4	6	10
81	7,124	3.5267	1	2	3	4	6
82	1,757	6.4087	1	1	4	9	15
83	2,049	4.9551	1	2	4	7	10
84	2,769	3.1268	1	1	2	4	6
85	5,879	7.6399	2	3	6	10	15
86	11,468	5.0024	1	3	4	6	9
87	12,958	3.2740	1	2	3	4	6
88	711	5.8748	1	3	4	7	12
89	2,733	3.7603	1	2	3	5	7
90	3,089	2.5494	1	1	2	3	5
91	7,605	6.3657	2	3	5	8	13
92	16,265	4.4647	1	2	4	6	8
93	16,121	3.2188	1	2	3	4	6
94	1,473	11.8547	4	6	10	15	22
95	1,030	8.6359	3	5	7	11	15
96	757	6.1744	2	4	6	8	11
97	1,192	12.6023	4	7	11	16	23
98	1,005	8.3522	3	5	7	10	15
99	641	5.8752	2	3	5	8	11
100	16,989	6.3526	2	3	5	8	12
101	56,991	3.6950	1	2	3	5	7
102	1,080	4.5306	1	2	3	6	9
103	13,735	3.1270	1	2	2	4	6
113	525	5.5981	1	2	4	8	12
114	555	2.6090	1	1	2	3	5

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY: FY 2007 MEDPAR UPDATE—DECEMBER 2007 GROUPER V26.0 MS–DRGS—Continued

MS–DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
115	1,046	4.3222	1	2	4	5	7
116	546	4.0678	1	1	2	5	8
117	996	2.1596	1	1	1	2	3
121	542	5.4576	2	3	4	7	10
122	617	4.0454	2	2	3	5	7
123	2,785	2.8747	1	2	2	4	5
124	749	5.2697	1	2	4	7	10
125	4,661	3.5134	1	2	3	4	7
129	1,353	5.1803	1	2	4	6	11
130	1,073	2.9385	1	1	2	4	6
131	929	5.7492	1	2	4	8	12
132	886	2.6501	1	1	2	3	5
133	1,981	5.3296	1	2	4	7	11
134	3,362	2.2329	1	1	1	3	4
135	352	5.8295	1	2	4	8	12
136	472	2.3305	1	1	1	3	5
137	773	5.4062	1	2	4	7	11
138	886	2.5237	1	1	2	3	5
139	1,490	1.8456	1	1	1	2	3
146	674	9.4466	2	4	7	12	19
147	1,364	6.1320	1	2	4	8	12
148	847	3.8040	1	1	3	5	8
149	38,817	2.7185	1	1	2	3	5
150	949	5.1981	1	2	4	6	10
151	6,810	2.8921	1	1	2	4	5
152	1,726	4.4571	1	2	3	5	8
153	11,433	3.2168	1	2	3	4	6
154	1,899	6.3381	2	3	5	8	12
155	4,471	4.4187	1	2	4	6	8
156	4,819	3.1731	1	2	3	4	6
157	1,044	6.6542	1	3	5	8	14
158	3,219	4.5281	1	2	3	6	9
159	2,355	3.0522	1	1	2	4	6
163	13,614	14.9476	5	8	13	19	27
164	17,887	8.0977	3	5	7	10	15
165	13,805	5.1442	2	3	5	6	9
166	20,549	12.9161	4	7	10	16	24
167	20,520	7.9756	2	4	7	10	15
168	5,467	5.2532	1	2	4	7	10
175	12,682	7.2650	3	4	6	9	12
176	41,338	5.3283	2	3	5	7	9
177	63,750	9.1032	3	5	7	12	17
178	70,831	7.3794	3	4	6	9	13
179	26,087	5.5654	2	3	5	7	10
180	22,324	7.9001	2	4	6	10	15
181	30,220	5.9078	2	3	5	8	11
182	5,446	4.1761	1	2	3	5	8
183	1,856	7.2338	2	4	6	9	13
184	4,320	4.5829	2	3	4	6	8
185	2,506	3.4066	1	2	3	4	6
186	9,239	7.4006	2	4	6	9	14
187	10,028	5.3216	2	3	4	7	10
188	5,014	3.9928	1	2	3	5	8
189	113,067	6.1459	2	3	5	8	11
190	58,781	6.2972	2	3	5	8	12
191	118,162	5.0156	2	3	4	6	9
192	184,764	3.9705	1	2	3	5	7
193	87,315	6.7517	2	4	6	8	12
194	253,950	5.2660	2	3	4	7	9
195	133,231	4.0792	2	2	4	5	7
196	5,388	7.3537	3	4	6	9	14
197	6,796	5.3899	2	3	4	7	10
198	4,616	4.0804	1	2	3	5	7
199	3,208	8.3030	2	4	7	11	16
200	8,382	5.0894	1	2	4	7	10
201	3,467	4.0580	1	2	3	5	8
202	29,252	4.3530	1	2	4	5	8
203	36,870	3.3859	1	2	3	4	6
204	25,669	2.8746	1	1	2	4	5
205	5,848	5.5050	1	2	4	7	10

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY: FY 2007 MEDPAR UPDATE—DECEMBER 2007 GROUPER V26.0 MS–DRGS—Continued

MS–DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
206	21,532	3.4393	1	2	3	4	6
207	39,505	15.0709	6	9	13	18	25
208	76,444	7.2241	1	3	6	10	14
215	141	14.1844	1	3	9	17	31
216	8,616	18.3713	8	11	16	23	31
217	7,236	12.3046	6	8	11	15	20
218	2,554	9.0568	5	6	8	11	14
219	10,525	13.9944	6	8	11	17	26
220	13,928	8.5619	5	6	7	10	14
221	7,032	6.4428	4	5	6	7	10
222	2,771	13.0949	5	7	11	17	23
223	5,080	6.2701	1	3	5	8	12
224	1,911	11.3673	4	6	9	14	21
225	5,076	5.6420	2	3	5	7	10
226	7,064	9.3342	1	3	7	12	19
227	42,807	2.8263	1	1	1	3	7
228	2,974	14.7078	6	8	13	18	26
229	3,596	9.1096	4	6	8	11	15
230	1,566	6.4757	3	4	6	8	11
231	1,446	13.3811	6	8	11	17	24
232	1,515	9.1868	5	7	8	11	14
233	16,254	14.1787	7	9	12	17	24
234	34,309	8.9262	5	6	8	11	13
235	9,629	11.2185	5	7	9	14	20
236	30,065	6.6177	4	5	6	8	10
237	22,384	10.8073	2	5	9	14	21
238	42,226	4.6444	1	2	3	6	9
239	13,307	15.3499	5	8	12	19	29
240	11,658	10.3695	3	5	8	13	19
241	2,680	6.7634	3	4	6	8	12
242	17,519	8.7738	3	4	7	11	17
243	36,074	5.0924	1	2	4	7	10
244	62,706	2.9268	1	1	2	4	6
245	3,930	3.2237	1	1	2	4	7
246	28,818	5.3370	1	2	4	7	12
247	188,884	2.1674	1	1	1	3	4
248	13,847	5.9831	1	2	4	8	12
249	69,978	2.4966	1	1	2	3	5
250	6,762	7.7798	1	3	6	10	16
251	41,707	2.8343	1	1	2	4	6
252	45,567	8.5378	1	3	6	11	18
253	44,910	6.0144	1	2	5	8	13
254	53,360	2.7299	1	1	2	3	6
255	2,521	9.6942	2	4	8	12	18
256	3,425	7.4762	2	4	6	9	13
257	705	4.8482	1	2	4	7	10
258	686	7.3761	2	3	6	9	14
259	7,302	2.8020	1	1	2	4	6
260	1,549	11.2214	3	5	8	14	22
261	3,522	4.2127	1	1	3	6	9
262	3,531	2.5902	1	1	2	3	6
263	652	5.4126	1	1	3	7	13
264	28,273	8.8998	1	3	6	11	19
265	1,957	3.4716	1	1	2	4	8
280	63,593	7.3381	2	4	6	9	13
281	53,704	4.8075	2	3	4	6	9
282	54,305	3.2480	1	2	3	4	6
283	14,888	5.4547	1	1	3	7	13
284	4,139	3.2341	1	1	2	4	7
285	2,803	2.2112	1	1	1	3	5
286	23,695	6.9333	2	3	5	9	14
287	158,158	3.1457	1	1	2	4	6
288	2,953	11.7541	4	6	9	14	22
289	1,357	8.6610	3	5	7	11	15
290	473	6.4947	2	4	5	8	11
291	187,597	6.4926	2	3	5	8	12
292	204,514	4.9936	2	3	4	6	9
293	196,441	3.6816	1	2	3	5	6
294	1,415	5.5611	2	3	5	7	9
295	1,343	4.3291	2	3	4	6	7

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY: FY 2007 MEDPAR UPDATE—DECEMBER 2007 GROUPER V26.0 MS–DRGS—Continued

MS–DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
296	1,917	3.0303	1	1	1	3	7
297	791	1.8217	1	1	1	2	3
298	602	1.3040	1	1	1	1	2
299	17,750	6.6518	2	3	5	8	12
300	44,551	5.0493	2	3	4	6	9
301	36,994	3.6992	1	2	3	5	7
302	7,587	4.3756	1	2	3	5	8
303	70,544	2.5315	1	1	2	3	5
304	2,086	5.1942	1	2	4	7	10
305	35,079	2.8628	1	1	2	4	5
306	1,515	6.2964	1	3	4	8	12
307	6,344	3.4455	1	2	3	4	6
308	35,699	5.5438	1	2	4	7	11
309	79,311	3.9373	1	2	3	5	7
310	158,556	2.7530	1	1	2	4	5
311	21,034	2.3089	1	1	2	3	4
312	165,835	3.1053	1	2	2	4	6
313	211,391	2.1067	1	1	2	3	4
314	61,613	7.0205	2	3	5	9	14
315	29,960	4.6041	1	2	4	6	9
316	17,966	2.9978	1	1	2	4	6
326	11,226	17.1201	6	9	14	21	32
327	10,457	10.0519	3	5	8	13	18
328	8,865	4.3610	1	2	3	6	9
329	48,110	15.9561	6	9	13	20	29
330	63,624	9.7138	4	6	8	12	17
331	28,171	5.8793	3	4	5	7	9
332	1,823	14.3489	6	8	12	18	25
333	5,922	8.8349	4	6	8	10	15
334	3,719	5.5052	2	4	5	7	9
335	7,182	14.0778	5	8	12	18	25
336	12,448	9.0917	3	5	8	11	16
337	8,570	5.5883	1	3	5	8	10
338	1,501	10.7082	4	6	9	13	19
339	3,163	7.0452	3	4	6	9	12
340	3,558	4.1521	2	2	4	5	7
341	878	7.1287	2	3	5	9	14
342	2,544	4.1395	1	2	3	5	8
343	6,975	2.1792	1	1	2	3	4
344	936	11.7575	4	6	9	15	22
345	2,914	7.2447	3	4	6	9	12
346	2,759	4.9467	2	3	5	6	8
347	1,625	8.8166	2	4	7	11	17
348	4,164	5.7366	2	3	5	7	11
349	5,155	3.0795	1	1	2	4	6
350	1,756	7.9897	2	3	6	10	16
351	4,287	4.5573	1	2	4	6	9
352	8,183	2.4793	1	1	2	3	5
353	3,165	8.4051	2	4	7	11	16
354	8,420	5.0816	2	3	4	6	9
355	15,316	2.8995	1	1	2	4	5
356	8,334	12.9144	3	6	10	16	25
357	7,801	8.1406	2	4	6	10	16
358	2,477	4.4719	1	2	4	6	9
368	3,566	6.5979	2	3	5	8	13
369	5,248	4.7487	2	3	4	6	9
370	3,554	3.3995	1	2	3	4	6
371	24,371	8.7488	3	4	7	11	17
372	27,061	6.8532	3	4	6	8	12
373	15,249	4.9382	2	3	4	6	8
374	9,039	8.5759	2	4	7	11	16
375	18,945	6.0287	2	3	5	8	12
376	4,279	4.1837	1	2	3	5	8
377	51,556	6.3806	2	3	5	8	12
378	110,340	4.4472	2	3	4	5	8
379	92,136	3.4088	1	2	3	4	6
380	3,020	7.2738	2	3	6	9	14
381	5,293	5.1734	2	3	4	6	9
382	4,492	3.6814	1	2	3	5	7
383	1,223	5.5200	2	3	4	7	10

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY: FY 2007 MEDPAR UPDATE—DECEMBER 2007 GROUPER V26.0 MS–DRGS—Continued

MS–DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
384	8,080	3.7490	1	2	3	5	7
385	1,996	8.8191	3	4	6	11	18
386	7,126	5.6996	2	3	5	7	10
387	5,033	4.2935	1	2	4	5	8
388	18,540	7.3159	2	3	6	9	14
389	45,795	5.0160	2	3	4	6	9
390	46,426	3.5522	1	2	3	4	6
391	44,299	5.2367	1	2	4	6	10
392	282,071	3.4889	1	2	3	4	6
393	23,253	6.8917	2	3	5	8	14
394	45,853	4.8196	1	2	4	6	9
395	24,740	3.3344	1	2	3	4	6
405	3,963	17.0056	5	8	13	21	34
406	5,300	9.1566	2	5	7	11	18
407	2,115	5.4851	1	3	5	7	10
408	1,548	14.9961	6	8	12	18	28
409	1,737	9.8290	4	6	8	12	18
410	598	6.5033	2	4	6	8	11
411	956	12.4069	5	7	10	15	22
412	955	8.5696	4	6	8	11	14
413	756	5.9272	2	4	5	7	10
414	5,241	11.7296	5	7	10	14	21
415	6,127	7.6236	3	5	7	9	13
416	5,328	4.8281	2	3	4	6	8
417	16,444	8.3803	3	4	7	10	16
418	27,075	5.6341	2	3	5	7	10
419	35,887	3.1911	1	1	3	4	6
420	766	13.6606	3	6	10	17	26
421	1,054	7.6879	2	3	6	10	16
422	327	4.3609	1	2	4	6	8
423	1,542	15.8599	4	7	12	20	32
424	894	10.4172	3	5	8	14	20
425	125	5.3760	1	2	4	7	10
432	15,140	6.9542	2	3	5	9	14
433	9,672	4.8719	1	2	4	6	9
434	877	3.6933	1	2	3	5	6
435	12,111	7.5614	2	3	6	10	15
436	13,158	5.8396	2	3	5	8	11
437	3,887	4.2529	1	2	3	6	8
438	14,063	7.5128	2	3	5	9	15
439	24,364	5.3275	2	3	4	7	10
440	25,670	3.8103	1	2	3	5	7
441	13,335	7.0467	2	3	5	9	14
442	14,144	5.1103	2	2	4	6	9
443	6,544	3.7796	1	2	3	5	7
444	12,898	6.6243	2	3	5	8	13
445	16,794	4.7264	1	2	4	6	9
446	15,932	3.2658	1	2	3	4	6
453	948	15.6561	5	7	12	19	29
454	1,771	8.0237	3	4	6	10	14
455	1,969	4.4307	1	3	4	5	7
456	946	14.7061	5	7	11	19	28
457	2,413	7.4836	3	4	6	9	13
458	1,609	4.5438	2	3	4	6	7
459	3,508	9.4478	4	5	7	11	17
460	51,883	4.2180	2	3	4	5	7
461	1,018	8.4342	3	5	6	9	14
462	13,194	4.2178	3	3	4	5	6
463	5,052	16.5713	5	7	12	20	33
464	5,838	10.2205	3	5	8	12	20
465	2,398	5.8661	1	3	5	7	11
466	4,072	9.1717	3	5	7	11	16
467	14,331	5.4882	3	3	4	6	9
468	21,133	3.9306	2	3	3	4	6
469	30,531	8.2004	3	5	7	10	14
470	405,204	3.9281	3	3	3	4	6
471	2,283	9.7946	2	4	7	13	20
472	6,954	4.0913	1	1	3	5	9
473	22,875	1.9623	1	1	1	2	4
474	2,918	12.6453	4	6	10	15	24

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY: FY 2007 MEDPAR UPDATE—DECEMBER 2007 GROUPER V26.0 MS–DRGS—Continued

MS–DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
475	3,277	8.3946	3	4	7	11	15
476	1,589	4.7885	1	2	4	6	9
477	2,582	11.8548	3	6	9	15	22
478	8,562	6.6119	1	3	6	9	13
479	11,424	2.8188	1	1	1	4	7
480	26,724	9.2958	4	5	8	11	16
481	72,123	5.9291	3	4	5	7	9
482	48,111	4.8427	3	4	4	6	7
483	7,100	4.2093	2	2	3	5	8
484	17,842	2.4311	1	2	2	3	4
485	1,183	12.1116	4	6	10	15	22
486	2,186	8.0425	3	5	7	10	14
487	1,312	5.6715	3	3	5	7	9
488	2,495	5.2236	2	3	4	6	10
489	5,763	3.0465	1	2	3	4	5
490	22,971	4.3437	1	1	3	5	9
491	52,406	2.2104	1	1	2	3	4
492	5,216	8.5299	3	5	7	11	15
493	16,899	5.2510	2	3	4	6	9
494	29,166	3.3992	1	2	3	4	6
495	1,970	10.9609	3	5	8	14	21
496	5,555	5.9802	2	3	5	7	11
497	6,632	3.0054	1	1	2	4	6
498	1,163	7.8865	2	3	6	10	16
499	1,110	2.9757	1	1	2	4	6
500	1,502	10.8309	3	5	8	14	21
501	3,872	5.9698	2	3	5	8	12
502	6,452	2.9416	1	1	2	4	6
503	833	9.4586	3	5	7	11	17
504	2,162	6.4510	2	3	6	8	12
505	3,004	3.3832	1	2	3	4	6
506	810	3.4074	1	1	2	4	7
507	836	5.1459	1	2	4	6	10
508	2,481	2.0512	1	1	1	2	3
509	627	3.1100	1	1	2	3	7
510	973	6.4070	2	3	5	8	12
511	3,926	3.9758	1	2	3	5	7
512	10,961	2.1581	1	1	2	3	4
513	1,052	5.0266	1	2	4	6	10
514	1,006	2.8191	1	1	2	3	6
515	3,818	10.4445	3	5	8	13	20
516	11,280	5.9870	1	3	5	8	11
517	17,523	3.0079	1	1	2	4	7
533	822	6.6861	2	3	5	8	12
534	3,392	4.0292	1	2	3	5	7
535	6,990	6.2365	2	3	5	8	12
536	33,661	3.9328	2	3	3	5	7
537	665	4.4722	2	3	4	5	8
538	1,056	3.2197	1	2	3	4	6
539	3,417	9.7085	3	5	8	12	17
540	4,016	7.1257	3	4	6	8	13
541	1,618	5.3745	2	3	4	7	9
542	5,709	8.7758	3	4	7	11	17
543	17,012	5.9463	2	3	5	7	11
544	10,798	4.4077	2	3	4	5	8
545	4,079	9.0924	2	4	6	11	19
546	5,577	5.5338	2	3	4	7	10
547	4,533	3.8083	1	2	3	5	7
548	580	8.9379	3	4	7	11	17
549	1,110	6.3874	2	3	5	8	12
550	858	4.4545	2	2	4	6	8
551	10,066	7.1058	2	3	6	9	14
552	85,179	4.1225	1	2	3	5	7
553	3,076	5.9620	2	3	5	7	11
554	19,173	3.6913	1	2	3	5	7
555	2,013	4.8405	1	2	4	6	9
556	18,639	3.1089	1	2	3	4	6
557	3,646	6.6100	2	3	5	8	12
558	15,089	4.2586	2	2	4	5	7
559	1,815	7.5444	2	3	6	9	15

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY: FY 2007 MEDPAR UPDATE—DECEMBER 2007 GROUPER V26.0 MS–DRGS—Continued

MS–DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
560	4,319	4.7217	1	2	4	6	9
561	7,107	2.7680	1	1	2	3	5
562	5,458	6.3674	2	3	5	8	12
563	36,267	3.7016	1	2	3	4	6
564	1,661	6.9934	2	3	5	9	13
565	3,311	4.9795	2	3	4	6	9
566	2,624	3.6825	1	2	3	5	7
573	5,477	13.0933	4	6	9	16	26
574	11,123	9.3248	3	5	7	11	17
575	5,462	5.8521	2	3	5	7	11
576	547	12.9506	2	4	9	17	28
577	2,228	6.1104	1	2	4	8	13
578	3,054	3.3062	1	1	2	4	7
579	3,511	10.6830	3	5	8	14	21
580	10,711	5.5084	1	2	4	7	12
581	12,142	2.6146	1	1	2	3	6
582	5,337	2.8943	1	1	2	3	5
583	8,748	1.8056	1	1	1	2	3
584	668	5.9850	1	2	4	8	13
585	1,469	2.2321	1	1	1	2	4
592	4,178	8.8712	3	4	7	10	16
593	12,304	6.4415	2	3	5	8	11
594	2,751	5.0593	2	3	4	6	9
595	1,112	8.3327	2	4	6	10	16
596	5,308	4.7600	1	2	4	6	8
597	458	8.2009	2	3	6	10	16
598	1,400	5.7243	2	3	4	7	11
599	306	3.7320	1	1	3	4	6
600	682	5.0513	2	3	4	7	9
601	884	3.8541	1	2	3	5	7
602	22,088	7.0278	2	4	6	9	13
603	130,121	4.7073	2	3	4	6	8
604	2,660	5.6590	1	3	4	7	11
605	22,097	3.4622	1	2	3	4	6
606	1,350	6.3422	1	3	4	7	12
607	7,168	3.7913	1	2	3	5	7
614	1,457	7.0336	2	3	5	8	14
615	1,546	3.1572	1	2	3	4	5
616	1,091	16.9432	6	9	13	20	31
617	6,718	8.7904	3	5	7	11	15
618	258	6.3605	2	3	6	8	11
619	696	8.2011	2	3	5	9	18
620	2,186	3.6780	1	2	3	4	7
621	7,848	2.1617	1	1	2	3	4
622	1,112	13.1574	3	6	9	16	24
623	3,077	8.5707	3	4	7	10	15
624	383	6.0261	2	3	5	7	10
625	1,274	7.0879	1	2	5	9	15
626	2,538	3.1233	1	1	2	3	7
627	14,026	1.5172	1	1	1	2	2
628	3,366	11.1851	2	4	8	14	23
629	4,160	8.7418	3	5	7	11	16
630	534	5.5281	1	2	4	7	11
637	17,104	6.0581	2	3	5	7	12
638	42,581	4.2659	1	2	3	5	8
639	38,312	3.0382	1	2	2	4	5
640	60,806	5.4332	1	2	4	7	11
641	201,324	3.8256	1	2	3	5	7
642	1,492	5.1810	1	2	4	6	9
643	5,176	7.6103	2	4	6	9	14
644	11,788	5.4597	2	3	4	7	10
645	8,179	3.8912	1	2	3	5	7
652	10,067	7.7888	4	5	6	9	13
653	1,697	16.8981	7	9	13	21	31
654	3,452	9.8624	5	7	8	11	16
655	1,633	6.5150	3	5	7	8	10
656	3,918	10.1146	4	5	8	12	19
657	7,422	5.9603	3	4	5	7	10
658	8,271	3.7356	2	2	3	5	6
659	4,658	11.2003	3	5	8	14	22

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY: FY 2007 MEDPAR UPDATE—DECEMBER 2007 GROUPER V26.0 MS–DRGS—Continued

MS–DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
660	7,594	6.5146	2	3	5	8	13
661	4,260	3.2758	1	2	3	4	6
662	949	10.2740	2	4	8	14	20
663	2,054	5.2639	1	2	4	7	11
664	4,390	2.1223	1	1	1	2	4
665	654	11.0627	3	5	9	14	21
666	2,092	6.3595	1	2	4	9	14
667	3,616	2.8695	1	1	2	3	6
668	3,833	8.5265	2	4	7	11	16
669	12,746	4.4236	1	2	3	6	9
670	11,687	2.5131	1	1	2	3	5
671	808	5.9468	1	2	4	8	12
672	943	2.5302	1	1	2	3	5
673	12,542	9.7323	1	3	7	13	21
674	11,715	7.1905	1	2	5	9	15
675	7,824	2.0675	1	1	1	2	4
682	82,091	7.1569	2	3	5	9	14
683	132,320	5.6544	2	3	5	7	10
684	44,932	3.8913	1	2	3	5	7
685	2,331	3.4822	1	1	2	4	7
686	1,597	7.5717	2	3	6	9	15
687	3,261	5.3502	1	3	4	7	10
688	1,073	3.2591	1	1	2	4	6
689	55,995	6.2004	2	3	5	8	11
690	198,101	4.2356	2	2	4	5	7
691	821	3.9586	1	2	3	5	8
692	491	2.3992	1	1	2	3	5
693	2,429	4.8345	1	2	4	6	10
694	18,000	2.5778	1	1	2	3	5
695	975	5.5251	1	3	4	7	11
696	10,518	3.2901	1	2	3	4	6
697	592	3.1115	1	1	2	4	6
698	23,320	6.6546	2	3	5	8	13
699	24,207	4.8302	1	2	4	6	9
700	12,279	3.5497	1	2	3	4	7
707	5,979	4.4131	1	2	3	5	8
708	18,063	2.1475	1	1	2	3	4
709	762	6.5341	1	2	4	8	15
710	1,831	1.7739	1	1	1	2	3
711	790	8.1684	1	3	6	10	16
712	705	3.0496	1	1	2	4	7
713	10,252	4.1916	1	2	3	5	9
714	28,797	1.9430	1	1	2	2	3
715	531	6.2806	1	2	4	8	13
716	1,273	1.4289	1	1	1	1	2
717	703	7.2319	2	3	5	9	14
718	589	2.7640	1	1	2	3	5
722	745	7.5852	2	3	6	10	14
723	1,949	5.2678	1	3	4	7	10
724	578	3.1522	1	1	2	4	6
725	755	5.5007	2	3	4	7	10
726	3,716	3.4739	1	2	3	4	6
727	1,294	6.3995	2	3	5	8	12
728	6,158	4.0404	1	2	3	5	7
729	591	5.5736	1	2	4	7	10
730	471	3.0786	1	1	2	4	6
734	1,362	7.9941	3	4	6	9	15
735	1,130	3.3602	1	2	3	4	5
736	854	13.7752	5	7	11	17	25
737	3,293	7.1786	3	4	6	8	13
738	863	3.8714	2	3	3	5	6
739	1,013	10.1955	3	5	8	12	20
740	4,326	5.2305	2	3	4	6	9
741	6,014	2.9940	1	2	3	4	5
742	10,950	4.5175	2	2	3	5	8
743	32,325	2.2608	1	2	2	3	3
744	1,520	5.8355	1	2	4	7	12
745	1,694	2.5738	1	1	2	3	5
746	2,634	4.2134	1	2	3	5	8
747	10,409	1.8856	1	1	2	2	3

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY: FY 2007 MEDPAR UPDATE—DECEMBER 2007 GROUPER V26.0 MS–DRGS—Continued

MS–DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
748	19,857	1.7358	1	1	1	2	3
749	982	9.3401	2	4	7	12	19
750	435	3.1103	1	1	2	4	6
754	978	8.3395	2	4	7	11	16
755	2,933	5.6870	2	3	4	7	11
756	677	3.1359	1	1	2	4	6
757	1,393	8.1436	3	4	6	10	16
758	1,605	6.0536	2	3	5	7	11
759	1,239	4.4722	2	2	4	5	8
760	1,700	3.9594	1	2	3	5	8
761	1,749	2.4351	1	1	2	3	5
765	2,754	5.0359	2	3	4	5	7
766	2,686	3.1601	2	2	3	4	4
767	132	3.3712	2	2	2	3	5
768	6	3.5000	1	2	3	6	6
769	98	4.6224	1	2	3	6	11
770	202	2.2277	1	1	1	2	5
774	1,506	3.1886	2	2	2	3	5
775	5,768	2.2394	1	2	2	3	3
776	511	3.3112	1	2	2	4	7
777	206	2.2136	1	1	2	3	4
778	474	3.0127	1	1	2	3	5
779	110	2.1182	1	1	1	2	3
780	40	1.4500	1	1	1	1	3
781	3,017	3.7630	1	1	2	4	7
782	171	2.4971	1	1	1	2	4
790	1	25.0000	125	125	125	125	125
799	566	14.0583	5	7	11	18	26
800	705	7.8610	3	4	6	9	15
801	557	4.9336	2	2	4	6	9
802	765	12.2706	3	5	9	15	25
803	1,070	6.6738	1	3	5	8	14
804	987	3.4215	1	1	3	4	6
808	6,088	8.2467	3	4	6	10	16
809	12,869	5.3247	2	3	4	7	10
810	2,786	4.0337	1	2	3	5	7
811	21,404	5.6912	1	2	4	7	11
812	89,951	3.7401	1	2	3	5	7
813	14,232	5.1669	1	2	4	6	10
814	1,554	6.7368	2	3	5	8	13
815	3,297	4.9706	1	2	4	6	9
816	2,147	3.5198	1	2	3	4	7
820	1,299	17.7229	5	8	14	23	34
821	2,474	7.8646	1	3	6	10	16
822	1,893	3.5288	1	1	3	4	7
823	2,178	15.4385	5	8	12	20	29
824	2,974	8.7492	2	4	7	11	17
825	1,748	4.3084	1	1	3	6	9
826	524	15.0401	4	7	11	19	29
827	1,254	7.9793	2	4	6	10	16
828	799	3.7722	1	2	3	5	7
829	1,171	10.6576	2	4	7	13	22
830	521	3.7179	1	1	2	4	8
834	4,028	15.4615	2	4	10	23	36
835	2,703	10.4351	2	3	6	12	28
836	1,622	5.1843	1	2	3	6	10
837	1,043	23.1419	5	10	23	31	42
838	1,320	12.2629	3	4	6	21	29
839	1,467	6.4104	3	4	5	6	10
840	9,659	10.4408	3	5	8	13	21
841	10,035	6.9221	2	3	5	9	13
842	5,310	4.5563	1	2	4	6	9
843	1,350	8.5222	2	4	6	10	17
844	2,412	6.0987	2	3	5	8	12
845	804	4.3022	1	2	3	6	8
846	2,113	8.4179	2	3	5	10	18
847	23,862	3.3508	1	2	3	4	6
848	1,723	3.1294	1	1	3	4	5
849	1,477	5.9709	2	3	5	6	12
853	34,852	16.6669	5	8	13	21	30

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY: FY 2007 MEDPAR UPDATE—DECEMBER 2007 GROUPER V26.0 MS–DRGS—Continued

MS–DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
854	6,643	11.1072	4	6	9	14	20
855	459	7.0261	2	4	6	9	13
856	5,892	15.3839	4	7	12	19	30
857	9,614	8.4628	3	4	7	10	16
858	3,246	5.6741	2	3	5	7	10
862	7,929	8.1778	2	4	6	10	16
863	21,420	5.1976	2	3	4	7	9
864	18,946	4.0639	1	2	3	5	7
865	1,705	6.7009	2	3	4	8	14
866	8,182	3.5351	1	2	3	4	7
867	5,062	9.6254	2	4	7	12	19
868	2,641	5.7819	2	3	4	7	11
869	1,103	4.3128	2	2	4	5	7
870	21,199	15.4758	6	9	13	19	27
871	216,384	7.4839	2	3	6	10	14
872	90,892	5.7138	2	3	5	7	10
876	857	11.9498	2	5	9	14	24
880	9,282	3.1518	1	1	2	4	6
881	4,623	4.1888	1	2	3	5	8
882	1,556	4.4274	1	2	3	6	9
883	757	7.3725	1	2	4	8	15
884	19,006	5.4936	2	3	4	6	10
885	80,806	7.6211	2	3	6	9	14
886	404	6.0767	1	2	4	7	12
887	393	4.6209	1	2	3	5	8
894	4,369	2.9528	1	1	2	3	4
895	6,958	10.4997	3	4	6	7	9
896	5,490	6.6087	2	3	5	8	13
897	36,053	4.0582	1	2	3	5	6
901	924	15.0693	3	6	10	18	30
902	2,031	7.7371	2	3	6	9	16
903	1,500	4.5680	1	2	4	6	9
904	1,046	11.2237	2	4	7	13	23
905	811	4.6523	1	2	4	6	8
906	710	3.1451	1	1	2	4	6
907	8,461	11.6506	2	5	8	14	23
908	8,319	6.7682	2	3	5	8	13
909	5,447	3.6367	1	1	3	5	7
913	804	5.6629	1	3	4	7	12
914	6,609	3.4330	1	2	3	4	6
915	1,078	4.7356	1	2	3	6	9
916	5,508	2.1044	1	1	2	3	4
917	15,775	5.1645	1	2	4	6	11
918	35,653	2.7260	1	1	2	3	5
919	11,089	6.3723	2	3	5	8	13
920	13,970	4.3608	1	2	3	5	8
921	9,423	2.9687	1	1	2	4	6
922	1,047	5.9933	1	2	4	7	12
923	3,952	3.2338	1	1	2	4	6
927	211	31.1374	7	15	26	41	60
928	818	15.9694	4	7	12	21	31
929	438	7.6872	1	3	6	10	16
933	139	4.3453	1	1	1	4	8
934	659	6.1988	1	3	5	8	12
935	2,201	5.4330	1	2	4	7	11
939	671	10.0611	2	4	7	13	20
940	1,320	5.4220	1	2	4	7	12
941	1,707	2.7299	1	1	2	3	5
945	6,244	10.4947	4	6	8	12	15
946	3,055	7.8628	3	5	6	7	8
947	9,715	5.0101	1	2	4	6	10
948	47,722	3.4806	1	2	3	4	6
949	632	4.1092	1	1	2	4	6
950	387	3.4858	1	1	2	4	5
951	940	4.6436	1	1	2	3	6
955	444	12.2658	2	5	10	16	26
956	3,976	9.2912	4	5	7	11	17
957	1,318	14.8566	2	7	12	19	28
958	1,147	10.4080	3	6	8	13	19
959	291	6.2921	2	3	5	8	11

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY: FY 2007 MEDPAR UPDATE—DECEMBER 2007 GROUPER V26.0 MS–DRGS—Continued

MS–DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
963	1,586	9.5214	2	4	8	13	19
964	2,573	6.2274	2	3	5	8	11
965	1,072	4.1371	1	2	3	5	7
969	639	18.8279	4	8	14	22	36
970	136	9.8309	2	3	7	12	17
974	5,920	10.3723	2	4	8	13	21
975	4,674	7.0148	2	3	5	9	13
976	2,617	4.9308	2	2	4	6	8
977	4,565	5.2931	1	2	4	6	10
981	25,478	15.1488	5	8	12	19	28
982	18,329	9.7455	3	5	8	12	18
983	6,112	5.3613	1	2	4	7	11
984	671	14.6811	5	8	13	18	25
985	903	9.6512	2	5	8	13	18
986	731	5.3338	1	2	3	7	12
987	8,240	13.0089	4	6	10	16	24
988	11,583	7.8090	2	3	6	10	15
989	5,796	4.1046	1	1	3	6	9
	11,387,276						

TABLE 8A.—PROPOSED STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS—MARCH 2008

State	Urban	Rural
Alabama	0.261	0.33
Alaska	0.401	0.745
Arizona	0.288	0.418
Arkansas	0.32	0.368
California	0.225	0.303
Colorado	0.281	0.437
Connecticut	0.399	0.528
Delaware	0.495	0.513
District of Columbia *	0.345	
Florida	0.238	0.281
Georgia	0.329	0.39
Hawaii	0.382	0.453
Idaho	0.468	0.534
Illinois	0.305	0.395
Indiana	0.39	0.466
Iowa	0.357	0.444
Kansas	0.288	0.424
Kentucky	0.37	0.371
Louisiana	0.299	0.353
Maine	0.498	0.462
Maryland	0.726	0.793
Massachusetts *	0.471	
Michigan	0.364	0.462
Minnesota	0.391	0.53
Mississippi	0.302	0.355
Missouri	0.33	0.399
Montana	0.422	0.465
Nebraska	0.335	0.46
Nevada	0.22	0.478
New Hampshire	0.457	0.427
New Jersey *	0.178	
New Mexico	0.377	0.36
New York	0.346	0.522
North Carolina	0.402	0.396
North Dakota	0.428	0.457
Ohio	0.338	0.522
Oklahoma	0.293	0.383
Oregon	0.452	0.415
Pennsylvania	0.267	0.413
Puerto Rico *	0.474	
Rhode Island *	0.388	

TABLE 8A.—PROPOSED STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS—MARCH 2008—Continued

State	Urban	Rural
South Carolina	0.284	0.301
South Dakota	0.335	0.43
Tennessee	0.297	0.371
Texas	0.257	0.342
Utah	0.414	0.572
Vermont	0.543	0.619
Virginia	0.358	0.357
Washington	0.385	0.443
West Virginia	0.471	0.462
Wisconsin	0.425	0.458
Wyoming	0.431	0.562

* All counties in the State or Territory are classified as urban, with the exception of Massachusetts, which has areas designated as rural. However, no short-term acute care IPPS hospitals are located in those areas as of March 2008.

TABLE 8B.—PROPOSED STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS—MARCH 2008

State	Ratio
Alabama	0.024
Alaska	0.036
Arizona	0.023
Arkansas	0.025
California	0.015
Colorado	0.028
Connecticut	0.028
Delaware	0.035
District of Columbia	0.022
Florida	0.022
Georgia	0.028
Hawaii	0.03
Idaho	0.038
Illinois	0.026
Indiana	0.037

TABLE 8B.—PROPOSED STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS—MARCH 2008—Continued

State	Ratio
Iowa	0.028
Kansas	0.03
Kentucky	0.029
Louisiana	0.026
Maine	0.03
Maryland	0.058
Massachusetts	0.031
Michigan	0.03
Minnesota	0.028
Mississippi	0.027
Missouri	0.029
Montana	0.034
Nebraska	0.039
Nevada	0.021
New Hampshire	0.032
New Jersey	0.013
New Mexico	0.032
New York	0.026
North Carolina	0.032
North Dakota	0.037
Ohio	0.028
Oklahoma	0.026
Oregon	0.031
Pennsylvania	0.022
Puerto Rico	0.042
Rhode Island	0.02
South Carolina	0.024
South Dakota	0.032
Tennessee	0.03
Texas	0.026
Utah	0.032
Vermont	0.045
Virginia	0.036
Washington	0.03
West Virginia	0.034
Wisconsin	0.037
Wyoming	0.044

TABLE 8C.—PROPOSED STATEWIDE AVERAGE TOTAL COST-TO-CHARGE RATIOS FOR LTCHS—MARCH 2008

State	Urban	Rural
Alabama	0.279	0.36
Alaska	0.432	0.806
Arizona	0.311	0.448
Arkansas	0.343	0.401
California	0.238	0.322
Colorado	0.307	0.479
Connecticut	0.426	0.576
Delaware	0.529	0.551
District of Columbia *	0.368	.....
Florida	0.259	0.311
Georgia	0.355	0.424
Hawaii	0.411	0.487
Idaho	0.506	0.576
Illinois	0.33	0.427
Indiana	0.426	0.507
Iowa	0.381	0.483
Kansas	0.314	0.463
Kentucky	0.398	0.401
Louisiana	0.325	0.38
Maine	0.529	0.49
Maryland ***	0.34	0.434
Massachusetts **	0.502	.....
Michigan	0.393	0.497
Minnesota	0.418	0.569
Mississippi	0.328	0.384
Missouri	0.357	0.438
Montana	0.453	0.505
Nebraska	0.371	0.505
Nevada	0.24	0.539
New Hampshire	0.489	0.459
New Jersey **	0.19	.....
New Mexico	0.408	0.394
New York	0.372	0.558
North Carolina	0.434	0.431
North Dakota	0.461	0.505
Ohio	0.365	0.563
Oklahoma	0.318	0.414
Oregon	0.484	0.444
Pennsylvania	0.287	0.443
Puerto Rico **	0.514	.....
Rhode Island **	0.408	.....
South Carolina	0.308	0.327
South Dakota	0.365	0.466
Tennessee	0.326	0.406
Texas	0.282	0.374
Utah	0.445	0.622
Vermont	0.594	0.657
Virginia	0.393	0.398
Washington	0.414	0.473
West Virginia	0.505	0.496
Wisconsin	0.462	0.497
Wyoming	0.467	0.616

* 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 March 2008.

** National average IPPS total cost-to-charge ratios, as discussed in section VI.E. of this proposed rule.

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS—FY 2009

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
010001	20020	10500	
010005	01	26620	
010009	19460	26620	
010010	01	13820	
010012	01	40660	
010022	01	12060	
010025	01	17980	
010029	12220	17980	
010035	01	13820	
010052	01	33860	
010054	19460	26620	
010055	20020	37460	
010059	19460	26620	
010061	01	16860	
010065	01	13820	
010083	01	37860	
010085	19460	26620	
010090	33660	37700	
010100	01	37860	
010101	01	13820	
010102	01	33860	
010118	01	33860	
010126	01	33860	
010143	01	26620	
010150	01	33860	
010158	01	22520	
010164	01	13820	
020008	02	11260	
030007	39140	22380	LUGAR
030033	03	22380	
030055	29420	39140	
030069	29420	40140	
030101	29420	29820	
040014	04	30780	
040017	04	22220	
040019	04	32820	
040020	27860	32820	
040027	04	44180	
040039	04	27860	
040041	04	30780	
040069	04	32820	
040071	38220	30780	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS—FY 2009—Continued

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
040076	04	30780	LUGAR
040078	26300	30780	
040080	04	27860	
040085	04	32820	
040088	04	33740	
040091	04	45500	
040119	04	30780	
050006	05	39820	
050009	34900	46700	
050013	34900	46700	
050014	05	40900	
050022	40140	42044	
050038	41940	42100	
050042	05	39820	
050046	37100	31084	
050054	40140	42044	
050069	42044	31084	
050071	41940	42100	
050073	46700	36084	
050076	41884	36084	
050082	37100	31084	
050089	40140	31084	
050090	42220	41884	
050099	40140	31084	
050101	46700	36084	
050102	40140	42044	
050118	44700	33700	
050125	41940	42100	
050129	40140	31084	
050131	41884	36084	
050133	49700	40900	
050136	42220	41884	
050140	40140	31084	
050150	05	40900	
050153	41940	42100	
050159	37100	31084	
050168	42044	31084	
050173	42044	31084	
050174	42220	41884	
050188	41940	42100	
050193	42044	31084	
050194	42100	41940	
050197	41884	41940	
050224	42044	31084	
050226	42044	31084	
050230	42044	31084	
050236	37100	31084	
050242	42100	41940	
050243	40140	42044	
050245	40140	31084	
050272	40140	31084	
050279	40140	31084	
050291	42220	41884	
050292	40140	42044	
050300	40140	31084	
050301	05	42220	
050308	41940	42100	
050327	40140	31084	
050329	40140	42044	
050335	05	33700	
050348	42044	31084	
050360	41884	36084	
050367	46700	36084	
050380	41940	42100	
050385	42220	41884	
050390	40140	42044	
050394	37100	31084	
050423	40140	42044	
050426	42044	31084	
050441	41940	42100	
050476	05	42220	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS—FY 2009—Continued

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
050494	05	40900	
050510	41884	36084	
050517	40140	31084	
050526	42044	31084	
050534	40140	42044	
050541	41884	41940	
050543	42044	31084	
050547	42220	41884	
050548	42044	31084	
050549	37100	31084	
050551	42044	31084	
050567	42044	31084	
050570	42044	31084	
050573	40140	42044	
050580	42044	31084	
050586	40140	31084	
050589	42044	31084	
050603	42044	31084	
050604	41940	42100	
050609	42044	31084	
050616	37100	31084	
050662	41940	42100	
050667	34900	46700	
050678	42044	31084	
050680	46700	36084	
050684	40140	42044	
050686	40140	42044	
050688	41940	42100	
050690	42220	41884	
050693	42044	31084	
050694	40140	42044	
050701	40140	42044	
050709	40140	31084	
050720	42044	31084	
050744	42044	31084	
050745	42044	31084	
050746	42044	31084	
050747	42044	31084	
050749	37100	31084	
050758	40140	31084	
060003	14500	19740	
060012	39380	17820	
060023	24300	19740	
060027	14500	19740	
060031	17820	19740	
060049	06	22660	
060075	06	24300	
060096	06	19740	
060103	14500	19740	
060116	14500	19740	
070001	35300	35004	
070003	07	25540	LUGAR
070004	07	25540	
070005	35300	35004	
070006	14860	35644	
070010	14860	35644	
070011	07	25540	
070015	07	35644	
070016	35300	35004	
070017	35300	35004	
070018	14860	35644	
070019	35300	35004	
070022	35300	35004	
070028	14860	35644	
070031	35300	35004	
070033	14860	35644	
070034	14860	35644	
070036	25540	35300	
070038	35300	35004	
070039	35300	35004	
080001	48864	37964	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS—FY 2009—Continued

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
080003	48864	37964	
080004	20100	48864	
080006	08	20100	
080007	08	36140	
090001	47894	13644	
090004	47894	13644	
090011	47894	13644	
100002	48424	22744	
100014	19660	36740	
100017	19660	36740	
100022	33124	22744	
100023	10	36740	
100024	10	33124	
100045	19660	36740	
100047	39460	14600	
100049	10	29460	
100068	19660	36740	
100072	19660	36740	
100077	39460	14600	
100080	48424	22744	
100081	10	23020	LUGAR
100105	42680	38940	
100109	10	36740	
100130	48424	22744	
100139	10	23540	LUGAR
100150	10	33124	
100156	10	23540	
100157	29460	45300	
100160	10	33124	
100168	48424	22744	
100176	48424	22744	
100217	42680	38940	
100232	10	27260	
100234	48424	22744	
100236	39460	14600	
100249	10	45300	
100252	10	38940	
100253	48424	22744	
100258	48424	22744	
100268	48424	22744	
100269	48424	22744	
100275	48424	22744	
100287	48424	22744	
100288	48424	22744	
100292	10	23020	LUGAR
110001	19140	16860	
110002	11	12060	
110016	11	17980	
110023	11	12060	
110029	23580	12060	
110038	11	45220	
110040	11	12060	LUGAR
110041	11	12060	
110054	40660	12060	
110069	47580	31420	
110075	11	42340	
110095	11	10500	
110112	11	10500	
110121	11	45220	
110122	46660	45220	
110125	11	31420	
110128	11	42340	
110146	11	27260	
110150	11	12060	
110153	47580	31420	
110168	40660	12060	
110187	11	12060	LUGAR
110189	11	12060	
120028	12	26180	
130002	13	14260	
130003	30300	28420	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS—FY 2009—Continued

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
130049	17660	44060	
130067	13	26820	LUGAR
140012	14	16974	
140015	14	41180	
140032	14	41180	
140034	14	41180	
140040	14	37900	
140043	14	19340	
140046	14	41180	
140058	14	41180	
140064	14	37900	
140084	29404	16974	
140100	29404	16974	
140110	14	16974	
140130	29404	16974	
140135	19500	16580	
140143	14	16974	
140155	28100	16974	
140160	14	40420	
140164	14	41180	
140186	28100	16974	
140202	29404	16974	
140291	29404	16974	
150002	23844	16974	
150004	23844	16974	
150006	33140	43780	
150008	23844	16974	
150011	15	26900	
150015	33140	23844	
150018	21140	43780	
150023	45460	26900	
150026	21140	43780	
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	43780	
150146	15	21140	
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	
170068	17	11100	
170120	17	27900	
170142	17	45820	
170175	17	48620	
170190	17	45820	
170193	17	48620	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS—FY 2009—Continued

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
180002	18	49	
180005	18	26580	
180011	18	30460	
180012	21060	31140	
180013	14540	34980	
180017	18	21060	
180024	18	31140	
180027	18	17300	
180029	18	30460	
180043	18	44	
180044	18	26580	
180048	18	31140	
180049	18	30460	
180050	18	28700	
180066	18	34980	
180069	18	26580	
180078	18	26580	
180080	18	28940	
180093	18	21780	
180102	18	17300	
180104	18	17300	
180116	18	14	
180124	14540	34980	
180127	18	31140	
180132	18	30460	
190003	19	29180	
190015	19	35380	
190017	19	29180	
190086	19	33740	
190088	19	43340	
190106	19	10780	
190144	19	43340	
190164	19	10780	
190167	19	29180	
190184	19	33740	
190191	19	29180	
190208	19	04	
190218	19	43340	
190257	19	33740	
200020	38860	40484	
200024	30340	38860	
200034	30340	38860	
200039	20	38860	
200050	20	12620	
220001	49340	14484	
220002	15764	14484	
220008	39300	14484	
220010	37764	14484	
220011	15764	14484	
220019	49340	14484	
220020	39300	14484	
220025	49340	14484	
220029	37764	14484	
220033	37764	14484	
220035	37764	14484	
220049	15764	14484	
220058	49340	14484	
220062	49340	14484	
220063	15764	14484	
220070	15764	14484	
220073	39300	14484	
220074	39300	14484	
220077	44140	25540	
220080	37764	14484	
220082	15764	14484	
220084	15764	14484	
220090	49340	14484	
220095	49340	14484	
220098	15764	14484	
220101	15764	14484	
220105	15764	14484	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS—FY 2009—Continued

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
220163	49340	14484	
220171	15764	14484	
220174	37764	14484	
220175	15764	14484	
220176	49340	14484	
230002	19804	11460	
230003	26100	34740	
230013	47644	19804	
230019	47644	19804	
230020	19804	11460	
230021	35660	28020	
230022	23	29620	
230024	19804	11460	
230029	47644	19804	
230030	23	40980	
230035	23	24340	LUGAR
230036	23	13020	
230037	23	11460	
230038	24340	34740	
230047	47644	19804	
230053	19804	11460	
230054	23	24580	
230059	24340	34740	
230069	47644	22420	
230071	47644	19804	
230072	26100	34740	
230077	40980	22420	
230080	23	13020	
230089	19804	11460	
230092	27100	11460	
230095	23	13020	
230096	23	28020	
230097	23	24340	
230099	33780	11460	
230104	19804	11460	
23B104	47644	19804	
230105	23	13020	
230106	24340	34740	
230119	19804	11460	
230121	23	29620	LUGAR
230130	47644	19804	
230135	19804	11460	
230142	19804	11460	
230146	19804	11460	
230151	47644	19804	
230165	19804	11460	
230174	26100	34740	
230176	19804	11460	
230195	47644	19804	
230204	47644	19804	
230207	47644	19804	
230208	23	24340	LUGAR
230222	23	13020	
230223	47644	19804	
230227	47644	19804	
230236	24340	34740	
230244	19804	11460	
230254	47644	19804	
230257	47644	19804	
230264	47644	19804	
230269	47644	19804	
230270	19804	11460	
230273	19804	11460	
230277	47644	19804	
230279	47644	22420	
230301	47644	19804	
240030	24	41060	
240036	41060	33460	
240064	24	20260	
240069	24	33460	
240071	24	33460	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS—FY 2009—Continued

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
240075	24	41060	
240088	24	41060	
240093	24	33460	
240187	24	33460	
250002	25	22520	
250004	25	32820	
250006	25	32820	
250009	25	27180	
250023	25	25060	LUGAR
250031	25	27140	
250034	25	32820	
250040	37700	25060	
250042	25	32820	
250044	25	22520	
250069	25	46220	
250078	25620	25060	
250081	25	46220	
250082	25	38220	
250094	25620	25060	
250097	25	12940	
250099	25	27140	
250100	25	46220	
250104	25	46220	
250117	25	25060	LUGAR
260009	26	28140	
260015	26	27860	
260017	26	27620	
260022	26	16	
260025	26	41180	
260050	26	41140	
260064	26	17860	
260074	26	17860	
260094	26	44180	
260110	26	44180	
260113	26	14	
260116	26	14	
260119	26	27860	
260175	26	28140	
260183	26	41180	
260186	26	44180	
270003	27	24500	
270014	33540	17660	
270017	27	33540	
270051	27	33540	
280009	28	30700	
280023	28	30700	
280032	28	30700	
280061	28	53	
280065	28	24540	
280125	28	43580	
290002	29	16180	LUGAR
290006	29	39900	
290008	29	14260	
290019	16180	39900	
300001	30	31700	
300011	31700	49340	
300012	31700	49340	
300017	40484	37764	
300019	30	15764	
300020	31700	49340	
300023	40484	37764	
300029	40484	37764	
300034	31700	49340	
310002	35084	35644	
310009	35084	35644	
310014	15804	37964	
310015	35084	35644	
310017	35084	35644	
310018	35084	35644	
310021	45940	35084	
310022	15804	37964	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS—FY 2009—Continued

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
310029	15804	37964	
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	
310086	15804	37964	
310093	35084	35644	
310096	35084	35644	
310108	20764	35644	
310119	35084	35644	
320003	32	42140	
320005	22140	10740	
320006	32	10740	
320013	32	42140	
320033	32	42140	LUGAR
320063	32	36220	
320065	32	36220	
330004	28740	39100	
330008	33	15380	LUGAR
330023	39100	35644	
330027	35004	35644	
330049	39100	14860	
330067	39100	14860	
330073	33	40380	LUGAR
330085	33	45060	
330090	21300	27060	
330094	33	38340	
330103	33	39	
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	22180	
340010	24140	39580	
340013	34	24860	
340014	49180	24660	
340015	34	16740	
340021	34	16740	
340023	11700	24860	
340027	34	24780	
340039	34	16740	
340047	49180	24660	
340050	34	22180	
340051	34	25860	
340068	34	34820	
340069	39580	20500	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS—FY 2009—Continued

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
340070	15500	24660	
340071	34	39580	LUGAR
340073	39580	20500	
340091	24660	49180	
340109	34	47260	
340114	39580	20500	
340115	34	20500	
340126	34	39580	
340127	34	20500	LUGAR
340129	34	16740	
340131	34	24780	
340138	39580	20500	
340144	34	16740	
340145	34	16740	LUGAR
340147	40580	39580	
340148	49180	24660	
340173	39580	20500	
350003	35	13900	
350006	35	13900	
350009	35	22020	
360008	36	26580	
360010	36	10420	
360011	36	18140	
360013	36	30620	
360014	36	18140	
360019	10420	17460	
360020	10420	17460	
360025	41780	45780	
360027	10420	17460	
360036	36	17460	
360039	36	18140	
360054	36	26580	
360065	36	17460	
360078	10420	17460	
360086	44220	19380	
360095	36	45780	
360096	36	49660	LUGAR
360107	36	45780	
360121	36	45780	
360150	10420	17460	
360159	36	18140	
360175	36	18140	
360185	36	49660	LUGAR
360187	44220	19380	
360197	36	18140	
360211	48260	38300	
360245	36	17460	LUGAR
360253	19380	17140	
370004	37	27900	
370006	37	48620	
370014	37	43300	
370015	37	46140	
370016	37	36420	
370018	37	46140	
370025	37	46140	
370026	37	36420	
370030	37	46140	
370047	37	36420	
370049	37	36420	
370113	37	22220	
370149	37	36420	
380001	38	38900	
380022	38	18700	LUGAR
380027	38	21660	
380050	38	32780	
380051	41420	38900	
380090	38	21660	
390006	39	25420	
390013	39	25420	
390016	39	49660	
390031	39	39740	LUGAR

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS—FY 2009—Continued

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
390044	39740	37964	
390046	49620	29540	
390048	39	25420	
390065	39	13644	
390066	30140	25420	
390071	39	48700	LUGAR
390079	39	13780	
390086	39	27780	
390091	39	49660	
390093	39	49660	
390096	39740	37964	
390110	27780	38300	
390113	39	49660	
390138	39	25420	
390150	39	38300	LUGAR
390151	39	13644	
390162	10900	35084	
390163	38300	49660	
390185	42540	10900	
390313	39	39740	LUGAR
410001	39300	14484	
410004	39300	14484	
410005	39300	14484	
410007	39300	14484	
410010	39300	14484	
410011	39300	14484	
410012	39300	14484	
410013	39300	35980	
420007	43900	24860	
420009	42	24860	LUGAR
420020	42	16700	
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
420070	44940	17900	
420071	42	24860	
420080	42	42340	
420083	43900	24860	
420085	34820	48900	
420098	42	34820	
430012	43	43620	
430013	43	43620	
430014	43	22020	
430077	39660	16220	
440002	27180	32820	
440008	44	27180	
440020	44	26620	
440024	17420	16860	
440025	44	34	
440035	17300	34980	
440056	34100	28940	
440059	44	34980	
440060	44	27180	
440067	34100	28700	
440068	44	16860	
440072	44	32820	
440073	44	34980	
440144	44	34980	
440148	44	34980	
440151	44	34980	
440185	17420	16860	
440192	44	34980	
450007	45	41700	
450039	23104	19124	
450064	23104	19124	
450080	45	30980	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS—FY 2009—Continued

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
450087	23104	19124	
450099	45	11100	
450133	33260	36220	
450135	23104	19124	
450137	23104	19124	
450148	23104	19124	
450178	45	36220	
450187	45	26420	
450196	45	19124	
450211	45	30980	
450214	45	26420	
450224	45	46340	
450283	45	19124	LUGAR
450324	43300	19124	
450347	45	26420	
450351	45	23104	
450389	45	19124	LUGAR
450393	43300	19124	
450395	45	26420	
450419	23104	19124	
450447	45	19124	
450465	45	26420	
450469	43300	19124	
450484	45	30980	
450508	45	30980	
450547	45	19124	
450563	23104	19124	
450565	45	23104	
450596	45	23104	
450639	23104	19124	
450656	45	30980	
450672	23104	19124	
450675	23104	19124	
450677	23104	19124	
450747	45	46340	
450770	45	12420	LUGAR
450779	23104	19124	
450813	45	41700	
450830	45	36220	
450872	23104	19124	
450880	23104	19124	
450886	23104	19124	
460004	36260	41620	
460005	36260	41620	
460007	46	41100	
460021	41100	29820	
460026	46	39340	
460039	46	30860	
460041	36260	41620	
460042	36260	41620	
470001	47	30	
470012	47	38340	
490004	25500	16820	
490005	49020	47894	
490013	49	20500	
490018	49	16820	
490019	49	47894	
490040	47894	13644	
490042	13980	40220	
490043	47894	13644	
490048	40220	31340	
490063	47894	13644	
490079	49	24660	
490097	49	40060	
490101	47894	13644	
490107	47894	13644	
490122	47894	13644	
500002	50	28420	
500003	34580	42644	
500007	34580	42644	
500016	48300	42644	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS—FY 2009—Continued

Provider No.	Geographic CBSA	Reclassified CBSA	LUGAR
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
510024	34060	38300	
510046	51	13980	
510047	51	38300	
510050	48540	38300	
510062	51	16620	
510070	51	16620	
510071	51	13980	
510077	51	26580	
520002	52	48140	
520013	20740	33460	
520021	29404	16974	
520028	52	31540	LUGAR
520037	52	48140	
520059	39540	33340	
520071	52	33340	LUGAR
520076	52	31540	
520096	39540	33340	
520102	52	33340	LUGAR
520107	52	22540	
520113	52	24580	
520116	52	33340	LUGAR
520189	29404	16974	
530014	16940	24540	
530015	53	26820	

TABLE 9C.—HOSPITALS REDESIGNATED AS RURAL UNDER SECTION 1886(D)(8)(E) OF THE ACT—FY 2009

Provider No.	Geographic CBSA	Redesignated rural area
050192	23420	05
050528	32900	05
050618	40140	05
100048	37860	10
100118	37380	10
100134	27260	10
140167	14	14
170137	29940	17
220051	38340	22
230078	35660	23
250017	25	25
260006	41140	26
260047	27620	26
260195	44180	26
330268	10580	33
360125	36	36
370054	36420	37
380040	13460	38
390130	27780	39
390183	39	39
440135	34980	44
450052	45	45
450078	10180	45
450243	10180	45

TABLE 9C.—HOSPITALS REDESIGNATED AS RURAL UNDER SECTION 1886(D)(8)(E) OF THE ACT—FY 2009—Continued

Provider No.	Geographic CBSA	Redesignated rural area
450348	45	45
490116	13980	49
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)—MARCH 2008 [1]

MS–DRG	Number of cases	Threshold
1	655	$345,754
2	287	202,892

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)—MARCH 2008 [1]—Continued

MS–DRG	Number of cases	Threshold
3	23,338	258,756
4	21,431	156,815
5	634	172,190
6	228	95,919
7	356	167,452
8	482	96,343
9	1,345	104,341
10	163	77,500
11	1,266	77,654
12	1,909	55,617
13	1,274	39,624
20	887	149,490
21	532	115,973
22	212	81,500
23	3,741	88,473
24	2,103	62,851

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)—MARCH 2008 [1]—Continued

MS–DRG	Number of cases	Threshold
25	8,713	82,504
26	11,796	56,523
27	13,711	44,491
28	1,670	80,242
29	3,085	50,231
30	3,425	32,616
31	1,024	67,618
32	2,785	38,809
33	3,621	31,322
34	764	60,605
35	2,238	44,518
36	6,915	38,592
37	4,842	55,045
38	14,152	35,529
39	51,945	25,865
40	4,769	62,151
41	7,588	41,971
42	4,869	36,094
52	1,167	32,407
53	593	22,313
54	5,257	31,973
55	16,334	26,860
56	8,269	29,873
57	47,422	19,707
58	742	29,625
59	2,761	22,941
60	4,080	17,346
61	1,591	55,734
62	2,466	44,297
63	1,327	38,685
64	55,842	35,590
65	105,150	28,434
66	89,467	21,616
67	1,406	31,006
68	11,458	23,218
69	102,005	18,938
70	7,347	34,967
71	9,531	27,718
72	5,746	20,092
73	9,230	28,411
74	31,583	21,471
75	1,240	35,756
76	874	23,183
77	1,214	34,334
78	1,405	25,703
79	931	19,435
80	1,870	26,205
81	7,158	17,937
82	1,764	36,630
83	2,056	30,149
84	2,784	22,390
85	5,896	37,019
86	11,488	27,925
87	13,005	19,836
88	712	31,870
89	2,740	23,572
90	3,094	17,953
91	7,628	30,627
92	16,286	22,388

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)—MARCH 2008 [1]—Continued

MS–DRG	Number of cases	Threshold
93	16,162	17,182
94	1,476	57,294
95	1,034	44,072
96	761	37,723
97	1,195	56,725
98	1,007	38,018
99	642	30,539
100	17,058	30,273
101	57,248	19,211
102	1,086	24,512
103	13,854	16,849
113	527	33,475
114	562	20,755
115	1,060	26,332
116	566	26,098
117	1,140	16,472
121	549	22,487
122	623	14,246
123	2,789	18,857
124	753	25,197
125	4,693	16,936
129	1,359	40,771
130	1,074	29,912
131	933	39,603
132	889	28,315
133	1,988	32,709
134	3,379	21,267
135	353	36,814
136	474	24,169
137	775	29,030
138	891	18,731
139	1,498	20,992
146	680	36,795
147	1,369	27,392
148	860	20,935
149	38,942	16,006
150	955	25,517
151	6,839	13,767
152	1,735	21,825
153	11,517	15,282
154	1,906	28,847
155	4,498	21,959
156	4,851	16,219
157	1,048	29,382
158	3,229	21,572
159	2,376	15,149
163	13,622	83,366
164	17,895	50,966
165	13,816	40,520
166	20,575	60,767
167	20,538	42,190
168	5,478	32,296
175	12,686	34,823
176	41,375	26,341
177	63,876	38,177
178	71,036	31,805
179	26,205	25,015
180	22,369	34,979
181	30,299	28,647

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)—MARCH 2008 [1]—Continued

MS–DRG	Number of cases	Threshold
182	5,485	22,812
183	1,858	32,624
184	4,329	23,386
185	2,521	16,595
186	9,254	33,122
187	10,047	27,117
188	5,031	20,564
189	113,197	30,640
190	58,935	28,961
191	118,443	24,100
192	185,468	18,078
193	87,659	30,876
194	254,760	24,785
195	134,022	18,110
196	5,396	32,914
197	6,822	27,198
198	4,650	20,752
199	3,215	34,978
200	8,396	25,022
201	3,475	17,803
202	29,397	20,216
203	37,161	14,886
204	25,777	17,542
205	5,872	27,528
206	21,625	18,717
207	39,614	87,097
208	76,655	43,557
215	143	173,781
216	8,640	168,323
217	7,240	124,423
218	2,557	104,181
219	10,538	136,802
220	13,938	99,436
221	7,039	87,477
222	2,772	156,334
223	5,081	119,825
224	1,912	145,014
225	5,074	113,498
226	7,067	118,743
227	42,758	93,475
228	2,975	132,326
229	3,599	95,382
230	1,568	80,590
231	1,445	149,264
232	1,516	114,499
233	16,267	125,690
234	34,348	93,360
235	9,634	99,860
236	30,093	73,812
237	22,441	88,481
238	42,307	57,831
239	13,331	62,725
240	11,688	43,263
241	2,679	32,205
242	17,530	66,838
243	36,091	52,897
244	62,665	44,466
245	3,943	73,686
246	28,838	67,069

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)—MARCH 2008 [1]—Continued

MS–DRG	Number of cases	Threshold
247	188,816	48,746
248	13,859	60,786
249	70,027	44,038
250	6,790	59,714
251	41,777	41,857
252	45,667	51,697
253	44,988	46,446
254	53,543	37,335
255	2,525	40,724
256	3,453	31,694
257	707	23,510
258	688	53,299
259	7,314	38,081
260	1,553	56,280
261	3,525	31,484
262	3,531	25,624
263	656	30,621
264	28,327	41,945
265	1,959	42,694
280	63,744	37,477
281	53,825	29,595
282	54,438	22,672
283	14,927	32,787
284	4,145	24,166
285	2,811	16,215
286	23,714	42,608
287	158,325	29,592
288	2,964	50,314
289	1,357	37,277
290	480	31,429
291	188,057	30,477
292	205,085	23,997
293	197,247	17,506
294	1,417	22,037
295	1,346	14,125
296	1,917	28,779
297	793	17,798
298	603	12,266
299	17,830	29,028
300	44,700	21,461
301	37,174	15,572
302	7,607	24,792
303	70,815	14,928
304	2,098	25,698
305	35,311	15,266
306	1,521	29,058
307	6,371	18,574
308	35,795	28,398
309	79,510	20,681
310	158,993	14,833
311	21,229	13,279
312	166,359	18,189
313	212,358	14,841
314	61,733	32,156
315	30,052	24,173
316	18,076	16,573
326	11,247	90,510
327	10,467	52,332
328	8,878	34,042

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)—MARCH 2008 [1]—Continued

MS–DRG	Number of cases	Threshold
329	48,192	83,718
330	63,720	49,785
331	28,246	37,251
332	1,828	76,442
333	5,926	48,536
334	3,736	36,301
335	7,186	70,724
336	12,464	45,785
337	8,586	34,468
338	1,501	60,013
339	3,167	42,250
340	3,566	31,529
341	882	45,033
342	2,548	33,808
343	6,990	24,135
344	933	54,766
345	2,919	36,119
346	2,766	28,030
347	1,628	40,240
348	4,174	30,100
349	5,178	19,260
350	1,760	42,667
351	4,293	30,824
352	8,211	20,507
353	3,172	47,221
354	8,433	33,349
355	15,386	23,911
356	8,357	61,777
357	7,827	42,844
358	2,484	32,598
368	3,570	34,021
369	5,250	26,848
370	3,562	20,098
371	24,424	34,233
372	27,117	28,743
373	15,293	20,505
374	9,082	35,802
375	19,032	28,329
376	4,321	22,907
377	51,664	32,372
378	110,502	24,239
379	92,325	18,668
380	3,027	35,357
381	5,304	27,876
382	4,499	21,070
383	1,227	29,549
384	8,101	21,207
385	1,998	34,976
386	7,139	26,903
387	5,041	20,238
388	18,589	31,113
389	45,899	23,260
390	46,538	16,397
391	44,419	26,016
392	282,973	17,753
393	23,327	30,889
394	45,966	23,957
395	24,872	17,482
405	3,972	86,374

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)—MARCH 2008 [1]—Continued

MS–DRG	Number of cases	Threshold
406	5,304	52,360
407	2,120	39,348
408	1,549	71,677
409	1,737	50,663
410	601	36,877
411	957	69,221
412	961	51,066
413	760	39,922
414	5,248	62,853
415	6,133	43,331
416	5,338	32,604
417	16,454	49,649
418	27,098	39,258
419	35,942	29,790
420	768	66,342
421	1,057	39,447
422	331	31,257
423	1,545	71,874
424	897	47,509
425	126	32,981
432	15,201	33,045
433	9,723	23,926
434	898	17,085
435	12,164	34,878
436	13,203	28,443
437	3,911	25,366
438	14,096	33,587
439	24,418	26,852
440	25,766	18,781
441	13,382	31,516
442	14,214	24,098
443	6,593	17,782
444	12,947	33,108
445	16,870	27,464
446	16,037	19,832
453	950	165,424
454	1,778	121,032
455	1,988	93,297
456	947	144,023
457	2,416	98,535
458	1,617	82,249
459	3,516	97,638
460	52,310	66,514
461	1,018	82,048
462	13,179	63,047
463	5,060	60,604
464	5,853	43,476
465	2,416	31,714
466	4,073	74,467
467	14,326	57,869
468	21,140	49,618
469	30,544	59,370
470	405,849	44,493
471	2,288	77,861
472	7,009	52,304
473	23,109	42,971
474	2,925	51,927
475	3,287	37,186
476	1,595	25,620

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)—MARCH 2008 [1]—Continued

MS–DRG	Number of cases	Threshold
477	2,589	58,272
478	8,575	45,067
479	11,457	35,879
480	26,755	53,624
481	72,188	40,303
482	48,187	34,632
483	7,107	47,684
484	17,896	40,860
485	1,183	60,074
486	2,189	44,942
487	1,312	36,049
488	2,501	35,530
489	5,791	27,889
490	23,080	37,310
491	52,938	23,744
492	5,221	51,439
493	16,933	38,816
494	29,231	29,960
495	1,974	52,628
496	5,569	37,148
497	6,672	28,169
498	1,167	38,115
499	1,113	22,378
500	1,503	47,316
501	3,878	32,847
502	6,482	23,489
503	833	42,531
504	2,172	32,702
505	3,036	24,287
506	815	25,704
507	838	37,099
508	2,506	27,713
509	627	28,236
510	974	40,828
511	3,932	32,904
512	11,002	23,803
513	1,053	30,121
514	1,014	20,124
515	3,820	54,024
516	11,287	39,608
517	17,603	32,537
533	825	27,647
534	3,414	16,259
535	7,007	27,756
536	33,727	15,479
537	667	21,443
538	1,059	13,756
539	3,448	35,081
540	4,046	28,706
541	1,658	21,628
542	5,723	34,804
543	17,041	26,766
544	10,817	18,081
545	4,093	36,357
546	5,587	26,110
547	4,571	17,948
548	585	33,933
549	1,120	26,761
550	865	18,763
551	10,077	30,882
552	85,429	18,705
553	3,084	25,449
554	19,284	15,035
555	2,025	23,819
556	18,715	14,407
557	3,658	29,996
558	15,153	19,455
559	1,816	30,350
560	4,334	21,234
561	7,125	13,644
562	5,476	28,172
563	36,406	15,527
564	1,667	28,585
565	3,334	21,320
566	2,646	16,029
573	5,490	45,601
574	11,156	34,288
575	5,477	25,545
576	549	51,383
577	2,233	32,911
578	3,065	24,256
579	3,521	45,095
580	10,746	31,153
581	12,188	22,362
582	5,347	24,362
583	8,780	19,177
584	670	31,432
585	1,499	20,658
592	4,197	31,149
593	12,368	23,904
594	2,786	17,143
595	1,119	31,375
596	5,334	19,449
597	465	30,971
598	1,413	25,450
599	321	18,124
600	686	22,523
601	893	15,565
602	22,195	28,410
603	130,827	18,332
604	2,679	26,853
605	22,207	16,438
606	1,358	25,667
607	7,223	15,152
614	1,460	47,701
615	1,550	34,632
616	1,091	65,719
617	6,743	38,652
618	262	29,334
619	696	56,060
620	2,183	41,545
621	7,840	34,898
622	1,113	43,197
623	3,081	34,355
624	387	24,651
625	1,276	41,939
626	2,544	28,873
627	14,040	19,271
628	3,371	53,828
629	4,183	42,434
630	539	33,189
637	17,173	28,050
638	42,846	19,293
639	38,599	13,546
640	61,027	25,018
641	202,068	16,467
642	1,522	23,787
643	5,194	31,972
644	11,834	25,437
645	8,221	17,977
652	10,083	61,353
653	1,697	89,458
654	3,458	56,337
655	1,633	42,874
656	3,922	58,696
657	7,428	41,203
658	8,291	33,644
659	4,668	53,703
660	7,609	38,883
661	4,273	31,713
662	952	45,713
663	2,064	31,902
664	4,406	24,778
665	656	47,408
666	2,094	32,797
667	3,632	20,211
668	3,838	42,144
669	12,767	30,048
670	11,721	19,264
671	809	31,091
672	945	19,988
673	12,591	45,199
674	11,735	41,821
675	7,841	34,014
682	82,356	31,292
683	132,588	26,544
684	45,085	17,817
685	2,328	19,847
686	1,603	31,947
687	3,266	26,251
688	1,084	18,135
689	56,256	27,047
690	198,999	18,127
691	819	33,914
692	492	26,929
693	2,431	28,697
694	18,046	18,013
695	981	25,865
696	10,563	15,132
697	594	17,528
698	23,391	29,470
699	24,279	23,424
700	12,340	16,877
707	5,984	37,222
708	18,084	30,416
709	765	35,528
710	1,845	29,560

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)—MARCH 2008 [1]—Continued

MS–DRG	Number of cases	Threshold
711	792	37,675
712	710	20,316
713	10,272	26,996
714	28,875	15,559
715	532	36,052
716	1,275	29,420
717	705	34,114
718	589	19,293
722	754	30,816
723	1,970	24,740
724	586	15,657
725	759	24,606
726	3,733	16,368
727	1,300	27,843
728	6,194	17,130
729	592	25,442
730	471	14,723
734	1,364	44,272
735	1,133	28,372
736	856	73,117
737	3,302	41,614
738	866	28,882
739	1,015	53,269
740	4,338	34,448
741	6,033	24,839
742	10,977	31,971
743	32,430	21,234
744	1,527	30,774
745	1,700	20,207
746	2,643	30,028
747	10,434	21,235
748	19,915	20,564
749	982	45,119
750	437	24,771
754	986	33,562
755	2,954	25,879
756	687	16,172
757	1,398	32,870
758	1,612	26,363
759	1,244	19,100
760	1,708	19,562
761	1,773	13,249
765	2,773	20,365
766	2,692	13,836
767	133	18,724
769	98	28,990
770	203	16,249
774	1,517	12,327
775	5,784	8,750
776	513	15,047
777	209	20,244
778	475	8,942
779	112	11,223
780	41	3,917
781	3,040	13,218
782	175	8,623
799	566	82,467
800	705	50,685
801	556	37,382

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)—MARCH 2008 [1]—Continued

MS–DRG	Number of cases	Threshold
802	764	53,613
803	1,071	36,134
804	995	27,223
808	6,092	37,130
809	12,879	27,509
810	2,801	22,786
811	21,482	26,846
812	90,369	18,397
813	14,238	27,095
814	1,564	30,406
815	3,315	25,805
816	2,154	18,432
820	1,301	89,835
821	2,478	43,777
822	1,894	30,581
823	2,182	69,584
824	2,976	44,341
825	1,756	30,652
826	524	76,715
827	1,256	44,122
828	802	32,076
829	1,175	47,921
830	524	28,158
834	4,031	58,295
835	2,707	37,287
836	1,623	25,573
837	1,044	96,925
838	1,321	47,431
839	1,466	30,443
840	9,683	43,346
841	10,060	32,240
842	5,341	25,445
843	1,354	34,538
844	2,414	27,673
845	811	21,496
846	2,117	38,966
847	23,925	26,844
848	1,725	23,146
849	1,478	29,110
853	34,961	80,838
854	6,662	52,593
855	459	38,661
856	5,904	65,124
857	9,631	37,513
858	3,258	30,272
862	7,955	34,329
863	21,482	22,129
864	19,034	20,781
865	1,707	29,217
866	8,201	17,149
867	5,076	38,916
868	2,659	25,425
869	1,139	18,507
870	21,356	94,830
871	216,894	35,333
872	91,026	27,030
876	860	42,167
880	9,304	15,133
881	4,658	12,046

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)—MARCH 2008 [1]—Continued

MS–DRG	Number of cases	Threshold
882	1,558	12,634
883	758	17,971
884	19,126	19,197
885	81,314	15,242
886	407	13,905
887	399	16,694
894	4,798	7,599
895	10,278	12,773
896	5,570	26,933
897	38,298	13,086
901	926	54,456
902	2,036	33,188
903	1,508	23,579
904	1,047	43,056
905	812	26,185
906	716	24,257
907	8,469	56,134
908	8,340	36,960
909	5,470	27,977
913	807	27,237
914	6,655	16,360
915	1,080	26,134
916	5,527	10,518
917	15,818	29,720
918	35,758	14,390
919	11,106	30,394
920	14,005	22,313
921	9,462	14,923
922	1,055	28,288
923	3,976	15,419
927	213	182,484
928	819	65,145
929	440	37,218
933	145	31,568
934	663	24,756
935	2,220	22,937
939	673	46,257
940	1,322	33,961
941	1,720	26,932
945	6,687	20,290
946	4,359	15,730
947	9,751	24,756
948	47,916	15,920
949	682	18,328
950	420	12,682
951	951	15,279
955	449	87,860
956	3,984	57,503
957	1,325	101,860
958	1,156	67,071
959	295	47,759
963	1,592	50,127
964	2,581	34,357
965	1,077	25,020
969	644	78,213
970	138	45,746
974	5,952	41,989
975	4,710	29,607
976	2,654	22,430

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)—MARCH 2008 [1]—Continued

MS–DRG	Number of cases	Threshold
977	4,633	25,054
981	25,506	78,693
982	18,355	55,049
983	6,144	40,105
984	671	59,501

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)—MARCH 2008 [1]—Continued

MS–DRG	Number of cases	Threshold
985	904	42,990
986	732	29,607
987	8,256	55,744
988	11,611	37,995
989	5,817	27,744

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)—MARCH 2008 [1]—Continued

MS–DRG	Number of cases	Threshold
999	26	15,387

[1] Cases taken from the FY 2007 MedPAR file; MS–DRGs are from GROUPER Version 26.0.

TABLE 11.—PROPOSED FY 2009 MS–LTC–DRGS, PROPOSED RELATIVE WEIGHTS, PROPOSED GEOMETRIC AVERAGE LENGTH OF STAY, AND PROPOSED SHORT-STAY OUTLIER THRESHOLD

Proposed MS–LTC–DRG	Proposed base MS–LTC–DRG	Proposed MS–LTC–DRG title	FY 2007 LTCH cases	Proposed relative weight	Proposed geometric average length of stay	Proposed short-stay outlier (SSO) threshold [1]
1	1	Heart transplant or implant of heart assist system w MCC	0	0.0000	0.0	0.0
2	1	Heart transplant or implant of heart assist system w/o MCC.	0	0.0000	0.0	0.0
3	3	ECMO or trach w MV 96+ hrs or PDX exc face, mouth & neck w maj O.R..	286	4.5889	66.5	55.4
4	4	Trach w MV 96+ hrs or PDX exc face, mouth & neck w/o maj O.R..	1,201	2.9992	44.4	37.0
5	5	Liver transplant w MCC or intestinal transplant	0	0.0000	0.0	0.0
6	5	Liver transplant w/o MCC	0	0.0000	0.0	0.0
7	7	Lung transplant	0	0.0000	0.0	0.0
8	8	Simultaneous pancreas/kidney transplant	0	0.0000	0.0	0.0
9	9	Bone marrow transplant	0	1.2617	31.5	26.3
10	10	Pancreas transplant	0	0.0000	0.0	0.0
11	11	Tracheostomy for face, mouth & neck diagnoses w MCC	1	1.7509	37.9	31.6
12	11	Tracheostomy for face, mouth & neck diagnoses w CC	1	1.7509	37.9	31.6
13	11	Tracheostomy for face, mouth & neck diagnoses w/o CC/MCC.	0	1.7509	37.9	31.6
20	20	Intracranial vascular procedures w PDX hemorrhage w MCC.	0	1.7509	37.9	31.6
21	20	Intracranial vascular procedures w PDX hemorrhage w CC.	0	1.7509	37.9	31.6
22	20	Intracranial vascular procedures w PDX hemorrhage w/o CC/MCC.	0	1.7509	37.9	31.6
23	23	Craniotomy w major device implant or acute complex CNS PDX w MCC*.	2	1.2617	31.5	26.3
24	23	Craniotomy w major device implant or acute complex CNS PDX w/o MCC*.	1	1.2617	31.5	26.3
25	25	Craniotomy & endovascular intracranial procedures w MCC.	1	1.7509	37.9	31.6
26	25	Craniotomy & endovascular intracranial procedures w CC	3	1.7509	37.9	31.6
27	25	Craniotomy & endovascular intracranial procedures w/o CC/MCC.	1	0.8596	25.2	21.0
28	28	Spinal procedures w MCC	11	1.2617	31.5	26.3
29	28	Spinal procedures w CC	9	1.2617	31.5	26.3
30	28	Spinal procedures w/o CC/MCC	1	1.2617	31.5	26.3
31	31	Ventricular shunt procedures w MCC	5	1.7509	37.9	31.6
32	31	Ventricular shunt procedures w CC	1	1.7509	37.9	31.6
33	31	Ventricular shunt procedures w/o CC/MCC	0	1.7509	37.9	31.6
34	34	Carotid artery stent procedure w MCC	0	1.2617	31.5	26.3
35	34	Carotid artery stent procedurew CC	0	1.2617	31.5	26.3
36	34	Carotid artery stent procedure w/o CC/MCC	0	1.2617	31.5	26.3
37	37	Extracranial procedures w MCC	7	1.2617	31.5	26.3
38	37	Extracranial procedures w CC*	6	1.2617	31.5	26.3
39	37	Extracranial procedures w/o CC/MCC	0	1.2617	31.5	26.3

TABLE 11.—PROPOSED FY 2009 MS–LTC–DRGS, PROPOSED RELATIVE WEIGHTS, PROPOSED GEOMETRIC AVERAGE LENGTH OF STAY, AND PROPOSED SHORT-STAY OUTLIER THRESHOLD—Continued

Proposed MS–LTC–DRG	Proposed base MS–LTC–DRG	Proposed MS–LTC–DRG title	FY 2007 LTCH cases	Proposed relative weight	Proposed geometric average length of stay	Proposed short-stay outlier (SSO) threshold [1]
40	40	Periph & cranial nerve & other nerv syst proc w MCC	143	1.2451	34.8	29.0
41	40	Periph & cranial nerve & other nerv syst proc w CC	87	1.0890	34.5	28.8
42	40	Periph & cranial nerve & other nerv syst proc w/o CC/MCC*.	6	1.0890	34.5	28.8
52	52	Spinal disorders & injuries w CC/MCC	83	0.9943	31.3	26.1
53	52	Spinal disorders & injuries w/o CC/MCC	7	0.8596	25.2	21.0
54	54	Nervous system neoplasms w MCC	31	1.0109	26.7	22.3
55	54	Nervous system neoplasms w/o MCC	50	0.6542	21.6	18.0
56	56	Degenerative nervous system disorders w MCC	1,180	0.8022	25.3	21.1
57	56	Degenerative nervous system disorders w/o MCC	1,945	0.6033	24.0	20.0
58	58	Multiple sclerosis & cerebellar ataxia w MCC	19	0.8596	25.2	21.0
59	58	Multiple sclerosis & cerebellar ataxia w CC	23	0.6327	21.6	18.0
60	58	Multiple sclerosis & cerebellar ataxia w/o CC/MCC	10	0.6327	21.6	18.0
61	61	Acute ischemic stroke w use of thrombolytic agent w MCC	0	0.8823	23.5	19.6
62	61	Acute ischemic stroke w use of thrombolytic agent w CC	0	0.5770	22.8	19.0
63	61	Acute ischemic stroke w use of thrombolytic agent w/o CC/MCC.	0	0.4824	19.6	16.3
64	64	Intracranial hemorrhage or cerebral infarction w MCC	107	0.7831	24.5	20.4
65	64	Intracranial hemorrhage or cerebral infarction w CC	67	0.6217	24.0	20.0
66	64	Intracranial hemorrhage or cerebral infarction w/o CC/MCC.	24	0.4824	19.6	16.3
67	67	Nonspecific cva & precerebral occlusion w/o infarct w MCC.	4	0.4824	19.6	16.3
68	67	Nonspecific cva & precerebral occlusion w/o infarct w/o MCC.	4	0.4824	19.6	16.3
69	69	Transient ischemia	13	0.4824	19.6	16.3
70	70	Nonspecific cerebrovascular disorders w MCC	87	0.8823	23.5	19.6
71	70	Nonspecific cerebrovascular disorders w CC	52	0.5770	22.8	19.0
72	70	Nonspecific cerebrovascular disorders w/o CC/MCC	8	0.4824	19.6	16.3
73	73	Cranial & peripheral nerve disorders w MCC	116	0.8910	24.6	20.5
74	73	Cranial & peripheral nerve disorders w/o MCC	173	0.6057	23.1	19.3
75	75	Viral meningitis w CC/MCC	15	0.6327	21.6	18.0
76	75	Viral meningitis w/o CC/MCC	0	0.6327	21.6	18.0
77	77	Hypertensive encephalopathy w MCC	4	1.2617	31.5	26.3
78	77	Hypertensive encephalopathy w CC	1	0.6327	21.6	18.0
79	77	Hypertensive encephalopathy w/o CC/MCC	1	0.4824	19.6	16.3
80	80	Nontraumatic stupor & coma w MCC	47	0.7859	29.2	24.3
81	80	Nontraumatic stupor & coma w/o MCC	110	0.7028	28.2	23.5
82	82	Traumatic stupor & coma, coma >1 hr w MCC	9	0.8596	25.2	21.0
83	82	Traumatic stupor & coma, coma >1 hr w CC	12	0.6327	21.6	18.0
84	82	Traumatic stupor & coma, coma >1 hr w/o CC/MCC	3	0.6327	21.6	18.0
85	85	Traumatic stupor & coma, coma <1 hr w MCC	78	0.8652	26.1	21.8
86	85	Traumatic stupor & coma, coma <1 hr w CC	81	0.6630	24.1	20.1
87	85	Traumatic stupor & coma, coma <1 hr w/o CC/MCC	15	0.4824	19.6	16.3
88	88	Concussion w MCC	0	0.4824	19.6	16.3
89	88	Concussion w CC	1	0.4824	19.6	16.3
90	88	Concussion w/o CC/MCC	0	0.4824	19.6	16.3
91	91	Other disorders of nervous system w MCC	218	0.9248	25.9	21.6
92	91	Other disorders of nervous system w CC	138	0.6661	25.0	20.8
93	91	Other disorders of nervous system w/o CC/MCC	43	0.6046	22.0	18.3
94	94	Bacterial & tuberculous infections of nervous system w MCC.	203	1.0466	29.2	24.3
95	94	Bacterial & tuberculous infections of nervous system w CC.	106	0.9763	28.9	24.1
96	94	Bacterial & tuberculous infections of nervous system w/o CC/MCC.	31	0.7559	27.6	23.0
97	97	Non-bacterial infect of nervous sys exc viral meningitis w MCC.	48	1.0415	26.0	21.7
98	97	Non-bacterial infect of nervous sys exc viral meningitis w CC.	22	0.8596	25.2	21.0
99	97	Non-bacterial infect of nervous sys exc viral meningitis w/o CC/MCC.	6	0.6327	21.6	18.0
100	100	Seizures w MCC	47	0.6380	21.8	18.2
101	100	Seizures w/o MCC	55	0.6132	25.4	21.2
102	102	Headaches w MCC	9	0.6327	21.6	18.0
103	102	Headaches w/o MCC	4	0.6327	21.6	18.0
113	113	Orbital procedures w CC/MCC	1	0.8596	25.2	21.0

TABLE 11.—PROPOSED FY 2009 MS–LTC–DRGS, PROPOSED RELATIVE WEIGHTS, PROPOSED GEOMETRIC AVERAGE LENGTH OF STAY, AND PROPOSED SHORT-STAY OUTLIER THRESHOLD—Continued

Proposed MS–LTC–DRG	Proposed base MS–LTC–DRG	Proposed MS–LTC–DRG title	FY 2007 LTCH cases	Proposed relative weight	Proposed geometric average length of stay	Proposed short-stay outlier (SSO) threshold [1]
114	113	Orbital procedures w/o CC/MCC	0	0.8596	25.2	21.0
115	115	Extraocular procedures except orbit	0	0.4824	19.6	16.3
116	116	Intraocular procedures w CC/MCC	1	0.8596	25.2	21.0
117	116	Intraocular procedures w/o CC/MCC	0	0.4824	19.6	16.3
121	121	Acute major eye infections w CC/MCC	10	0.6327	21.6	18.0
122	121	Acute major eye infections w/o CC/MCC	1	0.6327	21.6	18.0
123	123	Neurological eye disorders	0	0.4824	19.6	16.3
124	124	Other disorders of the eye w MCC	2	0.6327	21.6	18.0
125	124	Other disorders of the eye w/o MCC	8	0.4824	19.6	16.3
129	129	Major head & neck procedures w CC/MCC or major device.	0	1.3344	30.2	25.2
130	129	Major head & neck procedures w/o CC/MCC	0	0.4824	19.6	16.3
131	131	Cranial/facial procedures w CC/MCC	0	1.7509	37.9	31.6
132	131	Cranial/facial procedures w/o CC/MCC	1	1.7509	37.9	31.6
133	133	Other ear, nose, mouth & throat O.R. procedures w CC/MCC.	10	1.2617	31.5	26.3
134	133	Other ear, nose, mouth & throat O.R. procedures w/o CC/MCC.	0	1.2617	31.5	26.3
135	135	Sinus & mastoid procedures w CC/MCC	2	0.4824	19.6	16.3
136	135	Sinus & mastoid procedures w/o CC/MCC*	1	0.4824	19.6	16.3
137	137	Mouth procedures w CC/MCC	1	1.7509	37.9	31.6
138	137	Mouth procedures w/o CC/MCC	0	1.7509	37.9	31.6
139	139	Salivary gland procedures	0	1.7509	37.9	31.6
146	146	Ear, nose, mouth & throat malignancy w MCC	40	1.3344	30.2	25.2
147	146	Ear, nose, mouth & throat malignancy w CC	26	0.9930	22.4	18.7
148	146	Ear, nose, mouth & throat malignancy w/o CC/MCC	6	0.4824	19.6	16.3
149	149	Dysequilibrium	11	0.4824	19.6	16.3
150	150	Epistaxis w MCC	0	0.8596	25.2	21.0
151	150	Epistaxis w/o MCC	0	0.6327	21.6	18.0
152	152	Otitis media & URI w MCC	9	0.8596	25.2	21.0
153	152	Otitis media & URI w/o MCC	23	0.6327	21.6	18.0
154	154	Nasal trauma & deformity w MCC	50	0.7707	22.0	18.3
155	154	Nasal trauma & deformity w CC	47	0.7011	21.1	17.6
156	154	Nasal trauma & deformity w/o CC/MCC	13	0.6327	21.6	18.0
157	157	Dental & Oral Diseases w MCC	12	0.6327	21.6	18.0
158	157	Dental & Oral Diseases w CC	21	0.6327	21.6	18.0
159	157	Dental & Oral Diseases w/o CC/MCC	5	0.4824	19.6	16.3
163	163	Major chest procedures w MCC	45	2.5063	33.5	27.9
164	163	Major chest procedures w CC	6	1.2617	31.5	26.3
165	163	Major chest procedures w/o CC/MCC	1	0.8596	25.2	21.0
166	166	Other resp system O.R. procedures w MCC	1,506	2.4992	41.8	34.8
167	166	Other resp system O.R. procedures w CC	211	1.8587	36.2	30.2
168	166	Other resp system O.R. procedures w/o CC/MCC	8	0.8596	25.2	21.0
175	175	Pulmonary embolism w MCC	128	0.6640	21.9	18.3
176	175	Pulmonary embolism w/o MCC	139	0.5479	20.0	16.7
177	177	Respiratory infections & inflammations w MCC	3,181	0.8784	22.8	19.0
178	177	Respiratory infections & inflammations w CC	2,334	0.7414	22.1	18.4
179	177	Respiratory infections & inflammations w/o CC/MCC	394	0.6225	19.4	16.2
180	180	Respiratory neoplasms w MCC	149	0.7975	20.9	17.4
181	180	Respiratory neoplasms w CC	109	0.6255	18.7	15.6
182	180	Respiratory neoplasms w/o CC/MCC*	11	0.6255	18.7	15.6
183	183	Major chest trauma w MCC	1	0.4824	19.6	16.3
184	183	Major chest trauma w CC	2	0.4824	19.6	16.3
185	183	Major chest trauma w/o CC/MCC	1	0.4824	19.6	16.3
186	186	Pleural effusion w MCC	121	0.7576	20.5	17.1
187	186	Pleural effusion w CC	60	0.6176	20.5	17.1
188	186	Pleural effusion w/o CC/MCC*	15	0.6176	20.5	17.1
189	189	Pulmonary edema & respiratory failure	6,586	0.9608	23.9	19.9
190	190	Chronic obstructive pulmonary disease w MCC	1,652	0.7477	20.5	17.1
191	190	Chronic obstructive pulmonary disease w CC	1,343	0.6220	19.4	16.2
192	190	Chronic obstructive pulmonary disease w/o CC/MCC	764	0.5358	17.3	14.4
193	193	Simple pneumonia & pleurisy w MCC	1,805	0.7698	21.6	18.0
194	193	Simple pneumonia & pleurisy w CC	2,026	0.6368	20.1	16.8
195	193	Simple pneumonia & pleurisy w/o CC/MCC	382	0.5374	17.4	14.5
196	196	Interstitial lung disease w MCC	110	0.7122	20.1	16.8
197	196	Interstitial lung disease w CC	85	0.5716	17.6	14.7
198	196	Interstitial lung disease w/o CC/MCC	40	0.5059	15.9	13.3

TABLE 11.—PROPOSED FY 2009 MS–LTC–DRGS, PROPOSED RELATIVE WEIGHTS, PROPOSED GEOMETRIC AVERAGE LENGTH OF STAY, AND PROPOSED SHORT-STAY OUTLIER THRESHOLD—Continued

Proposed MS–LTC–DRG	Proposed base MS–LTC–DRG	Proposed MS–LTC–DRG title	FY 2007 LTCH cases	Proposed relative weight	Proposed geometric average length of stay	Proposed short-stay outlier (SSO) threshold [1]
199	199	Pneumothorax w MCC	49	0.7639	21.8	18.2
200	199	Pneumothorax w CC	32	0.5906	17.8	14.8
201	199	Pneumothorax w/o CC/MCC	5	0.4824	19.6	16.3
202	202	Bronchitis & asthma w CC/MCC	88	0.6509	19.6	16.3
203	202	Bronchitis & asthma w/o CC/MCC	21	0.6327	21.6	18.0
204	204	Respiratory signs & symptoms	233	0.8315	22.8	19.0
205	205	Other respiratory system diagnoses w MCC	324	0.8236	22.3	18.6
206	205	Other respiratory system diagnoses w/o MCC	171	0.7182	21.5	17.9
207	207	Respiratory system diagnosis w ventilator support 96+ hours.	13,186	2.0793	34.5	28.8
208	208	Respiratory system diagnosis w ventilator support <96 hours.	1,452	1.1752	23.6	19.7
215	215	Other heart assist system implant	0	0.8596	25.2	21.0
216	216	Cardiac valve & oth maj cardiothoracic proc w card cath w MMCC.	0	1.2617	31.5	26.3
217	216	Cardiac valve & oth maj cardiothoracic proc w card cath w MCC.	0	0.8596	25.2	21.0
218	216	Cardiac valve & oth maj cardiothoracic proc w card cath w/o CC/MMCC.	0	0.8596	25.2	21.0
219	219	Cardiac valve & oth maj cardiothoracic proc w/o card cath w MMCC.	0	1.2617	31.5	26.3
220	219	Cardiac valve & oth maj cardiothoracic proc w/o card cath w MCC.	0	0.8596	25.2	21.0
221	219	Cardiac valve & oth maj cardiothoracic proc w/o card cath w/o CC/MCC.	0	0.8596	25.2	21.0
222	222	Cardiac defib implant w cardiac cath w AMI/HF/shock w MMCC.	0	1.7509	37.9	31.6
223	222	Cardiac defib implant w cardiac cath w AMI/HF/shock w/o MMCC.	0	1.7509	37.9	31.6
224	224	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w MMCC.	0	1.7509	37.9	31.6
225	224	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w/o MMCC.	0	1.7509	37.9	31.6
226	226	Cardiac defibrillator implant w/o cardiac cath w MMCC	11	1.7509	37.9	31.6
227	226	Cardiac defibrillator implant w/o cardiac cath w/o MMCC	9	1.7509	37.9	31.6
228	228	Other cardiothoracic procedures w MMCC	0	1.4637	33.3	27.8
229	228	Other cardiothoracic procedures w MCC	0	1.2121	28.9	24.1
230	228	Other cardiothoracic procedures w/o CC/MMCC	0	0.6327	21.6	18.0
231	231	Coronary bypass w PTCA w MMCC	0	1.2617	31.5	26.3
232	231	Coronary bypass w PTCA w/o MMCC	0	0.8596	25.2	21.0
233	233	Coronary bypass w cardiac cath w MMCC	0	1.2617	31.5	26.3
234	233	Coronary bypass w cardiac cath w/o MMCC	0	0.8596	25.2	21.0
235	235	Coronary bypass w/o cardiac cath w MMCC	0	1.2617	31.5	26.3
236	235	Coronary bypass w/o cardiac cath w/o MMCC	0	0.8596	25.2	21.0
237	237	Major cardiovascular procedures w MMCC	7	1.2617	31.5	26.3
238	237	Major cardiovascular procedures w/o MMCC	2	0.8596	25.2	21.0
239	239	Amputation for circ sys disorders exc upper limb & toe w MMCC.	163	1.5067	36.6	30.5
240	239	Amputation for circ sys disorders exc upper limb & toe w MCC.	83	1.1559	34.1	28.4
241	239	Amputation for circ sys disorders exc upper limb & toe w/o CC/MMCC.	10	0.8596	25.2	21.0
242	242	Permanent cardiac pacemaker implant w MCC*	12	1.7509	37.9	31.6
243	242	Permanent cardiac pacemaker implant w MCC	5	1.7509	37.9	31.6
244	242	Permanent cardiac pacemaker implant w/o CC/MMCC	1	1.7509	37.9	31.6
245	245	AICD generator procedures	0	1.7509	37.9	31.6
246	246	Percutaneous cardiovascular proc w drug-eluting stent w MMCC.	3	1.2617	31.5	26.3
247	246	Percutaneous cardiovascular proc w drug-eluting stent w/o MMCC.	1	1.2617	31.5	26.3
248	248	Percutaneous cardiovasc proc w non-drug-eluting stent w MMCC.	2	1.2617	31.5	26.3
249	248	Percutaneous cardiovasc proc w non-drug-eluting stent w/o MCC*.	1	1.2617	31.5	26.3
250	250	Perc cardiovasc proc w/o coronary artery stent or AMI w MMCC.	3	1.7509	37.9	31.6

TABLE 11.—PROPOSED FY 2009 MS–LTC–DRGS, PROPOSED RELATIVE WEIGHTS, PROPOSED GEOMETRIC AVERAGE LENGTH OF STAY, AND PROPOSED SHORT-STAY OUTLIER THRESHOLD—Continued

Proposed MS–LTC–DRG	Proposed base MS–LTC–DRG	Proposed MS–LTC–DRG title	FY 2007 LTCH cases	Proposed relative weight	Proposed geometric average length of stay	Proposed short-stay outlier (SSO) threshold [1]
251	250	Perc cardiovasc proc w/o coronary artery stent or AMI w/o MMCC.	0	1.7509	37.9	31.6
252	252	Other vascular procedures w MMCC	134	1.4637	33.3	27.8
253	252	Other vascular procedures w MCC	51	1.2121	28.9	24.1
254	252	Other vascular procedures w/o CC/MMCC	3	0.6327	21.6	18.0
255	255	Upper limb & toe amputation for circ system disorders w MMCC.	61	1.2589	33.8	28.2
256	255	Upper limb & toe amputation for circ system disorders w MCC.	42	0.9416	30.0	25.0
257	255	Upper limb & toe amputation for circ system disorders w/o CC/MMCC.	1	0.4824	19.6	16.3
258	258	Cardiac pacemaker device replacement w MMCC	0	1.2617	31.5	26.3
259	258	Cardiac pacemaker device replacement w/o MMCC	1	1.2617	31.5	26.3
260	260	Cardiac pacemaker revision except device replacement w MMCC.	2	1.2617	31.5	26.3
261	260	Cardiac pacemaker revision except device replacement w CC*.	1	0.8596	25.2	21.0
262	260	Cardiac pacemaker revision except device replacement w/o CC/MCC*.	1	0.8596	25.2	21.0
263	263	Vein ligation & stripping	3	0.4824	19.6	16.3
264	264	Other circulatory system O.R. procedures	608	1.0954	31.1	25.9
265	265	AICD lead procedures	0	1.2617	31.5	26.3
280	280	Circulatory disorders w AMI, discharged alive w MMCC	259	0.7832	23.0	19.2
281	280	Circulatory disorders w AMI, discharged alive w MCC	110	0.5772	20.6	17.2
282	280	Circulatory disorders w AMI, discharged alive w/o CC/MMCC.	35	0.5060	19.9	16.6
283	283	Circulatory disorders w AMI, expired w MMCC	56	0.7924	16.1	13.4
284	283	Circulatory disorders w AMI, expired w CC*	17	0.7924	16.1	13.4
285	283	Circulatory disorders w AMI, expired w/o CC/MMCC	0	0.7924	16.1	13.4
286	286	Circulatory disorders except AMI, w card cath w MMCC	8	1.2617	31.5	26.3
287	286	Circulatory disorders except AMI, w card cath w/o MMCC	9	0.8596	25.2	21.0
288	288	Acute & subacute endocarditis w MMCC	594	1.0060	26.1	21.8
289	288	Acute & subacute endocarditis w MCC	217	0.7920	26.1	21.8
290	288	Acute & subacute endocarditis w/o CC/MMCC	48	0.6873	24.3	20.3
291	291	Heart failure & shock w MMCC	1,728	0.7727	21.9	18.3
292	291	Heart failure & shock w MCC	901	0.6294	21.2	17.7
293	291	Heart failure & shock w/o CC/MMCC	362	0.5168	18.8	15.7
294	294	Deep vein thrombophlebitis w CC/MMCC	6	0.6327	21.6	18.0
295	294	Deep vein thrombophlebitis w/o CC/MMCC	0	0.6327	21.6	18.0
296	296	Cardiac arrest, unexplained w MMCC	0	0.7924	16.1	13.4
297	296	Cardiac arrest, unexplained w MCC	0	0.7924	16.1	13.4
298	296	Cardiac arrest, unexplained w/o CC/MMCC	0	0.7924	16.1	13.4
299	299	Peripheral vascular disorders w MMCC	587	0.7804	23.4	19.5
300	299	Peripheral vascular disorders w MCC	751	0.5847	22.0	18.3
301	299	Peripheral vascular disorders w/o CC/MMCC	78	0.5385	20.3	16.9
302	302	Atherosclerosis w MMCC	59	0.7597	21.8	18.2
303	302	Atherosclerosis w/o MMCC	61	0.5692	20.1	16.8
304	304	Hypertension w MMCC	6	0.4824	19.6	16.3
305	304	Hypertension w/o MMCC	15	0.4824	19.6	16.3
306	306	Cardiac congenital & valvular disorders w MMCC	59	0.8224	22.7	18.9
307	306	Cardiac congenital & valvular disorders w/o MMCC	38	0.7367	22.9	19.1
308	308	Cardiac arrhythmia & conduction disorders w MMCC	96	0.8384	25.0	20.8
309	308	Cardiac arrhythmia & conduction disorders w MCC	107	0.5679	20.8	17.3
310	308	Cardiac arrhythmia & conduction disorders w/o CC/MCC	36	0.4590	19.4	16.2
311	311	Angina pectoris	7	0.4824	19.6	16.3
312	312	Syncope & collapse	58	0.5083	19.7	16.4
313	313	Chest pain	6	0.4824	19.6	16.3
314	314	Other circulatory system diagnoses w MMCC	1,305	0.8758	22.9	19.1
315	314	Other circulatory system diagnoses w MCC	285	0.6575	21.0	17.5
316	314	Other circulatory system diagnoses w/o CC/MMCC	72	0.6026	21.0	17.5
326	326	Stomach, esophageal & duodenal proc w MMCC	19	1.7509	37.9	31.6
327	326	Stomach, esophageal & duodenal proc w MCC	3	1.2617	31.5	26.3
328	326	Stomach, esophageal & duodenal proc w/o CC/MCC*	1	1.2617	31.5	26.3
329	329	Major small & large bowel procedures w MMCC	31	2.2757	41.8	34.8
330	329	Major small & large bowel procedures w MCC	12	1.7509	37.9	31.6
331	329	Major small & large bowel procedures w/o CC/MMCC	1	1.7509	37.9	31.6
332	332	Rectal resection w MMCC	0	1.6757	34.2	28.5

TABLE 11.—PROPOSED FY 2009 MS–LTC–DRGS, PROPOSED RELATIVE WEIGHTS, PROPOSED GEOMETRIC AVERAGE LENGTH OF STAY, AND PROPOSED SHORT-STAY OUTLIER THRESHOLD—Continued

Proposed MS–LTC–DRG	Proposed base MS–LTC–DRG	Proposed MS–LTC–DRG title	FY 2007 LTCH cases	Proposed relative weight	Proposed geometric average length of stay	Proposed short-stay outlier (SSO) threshold [1]
333	332	Rectal resection w MCC	0	1.1606	30.0	25.0
334	332	Rectal resection w/o CC/MMCC	0	1.1606	30.0	25.0
335	335	Peritoneal adhesiolysis w MMCC	6	1.7509	37.9	31.6
336	335	Peritoneal adhesiolysis w MCC	0	1.7509	37.9	31.6
337	335	Peritoneal adhesiolysis w/o CC/MMCC	0	1.7509	37.9	31.6
338	338	Appendectomy w complicated principal diag w MMCC	0	0.9726	25.1	20.9
339	338	Appendectomy w complicated principal diag w MCC	0	0.7768	23.2	19.3
340	338	Appendectomy w complicated principal diag w/o CC/MMCC.	0	0.5958	19.6	16.3
341	341	Appendectomy w/o complicated principal diag w MMCC	0	0.9726	25.1	20.9
342	341	Appendectomy w/o complicated principal diag w MCC	0	0.7768	23.2	19.3
343	341	Appendectomy w/o complicated principal diag w/o CC/MMCC.	0	0.5958	19.6	16.3
344	344	Minor small & large bowel procedures w MMCC	5	1.7509	37.9	31.6
345	344	Minor small & large bowel procedures w MCC	0	1.7509	37.9	31.6
346	344	Minor small & large bowel procedures w/o CC/MMCC	0	1.7509	37.9	31.6
347	347	Anal & stomal procedures w MMCC	3	1.7509	37.9	31.6
348	347	Anal & stomal procedures w MCC	3	1.2617	31.5	26.3
349	347	Anal & stomal procedures w/o CC/MMCC	0	1.2617	31.5	26.3
350	350	Inguinal & femoral hernia procedures w MMCC	0	1.2617	31.5	26.3
351	350	Inguinal & femoral hernia procedures w MCC	0	1.2617	31.5	26.3
352	350	Inguinal & femoral hernia procedures w/o CC/MMCC	0	1.2617	31.5	26.3
353	353	Hernia procedures except inguinal & femoral w MMCC	1	1.7509	37.9	31.6
354	353	Hernia procedures except inguinal & femoral w MCC	1	0.6327	21.6	18.0
355	353	Hernia procedures except inguinal & femoral w/o CC/MMCC.	0	0.6327	21.6	18.0
356	356	Other digestive system O.R. procedures w MMCC	141	1.6757	34.2	28.5
357	356	Other digestive system O.R. procedures w MCC	36	1.1606	30.0	25.0
358	356	Other digestive system O.R. procedures w/o CC/MCC*	4	1.1606	30.0	25.0
368	368	Major esophageal disorders w MMCC	26	0.9161	21.1	17.6
369	368	Major esophageal disorders w MCC	14	0.8596	25.2	21.0
370	368	Major esophageal disorders w/o CC/MMCC	4	0.8596	25.2	21.0
371	371	Major gastrointestinal disorders & peritoneal infections w MMCC.	722	0.9726	25.1	20.9
372	371	Major gastrointestinal disorders & peritoneal infections w MCC.	350	0.7768	23.2	19.3
373	371	Major gastrointestinal disorders & peritoneal infections w/o CC/MCC.	68	0.5958	19.6	16.3
374	374	Digestive malignancy w MMCC	96	0.9011	21.5	17.9
375	374	Digestive malignancy w MCC	90	0.7804	23.4	19.5
376	374	Digestive malignancy w/o CC/MMCC	3	0.6327	21.6	18.0
377	377	G.I. hemorrhage w MMCC	90	0.8200	23.8	19.8
378	377	G.I. hemorrhage w MCC	53	0.6902	23.8	19.8
379	377	G.I. hemorrhage w/o CC/MMCC	18	0.6327	21.6	18.0
380	380	Complicated peptic ulcer w MMCC	22	0.8596	25.2	21.0
381	380	Complicated peptic ulcer w MCC	17	0.6327	21.6	18.0
382	380	Complicated peptic ulcer w/o CC/MMCC	5	0.4824	19.6	16.3
383	383	Uncomplicated peptic ulcer w MMCC	0	0.8596	25.2	21.0
384	383	Uncomplicated peptic ulcer w/o MMCC	7	0.8596	25.2	21.0
385	385	Inflammatory bowel disease w MMCC	36	0.8076	23.3	19.4
386	385	Inflammatory bowel disease w MCC	37	0.7126	23.1	19.3
387	385	Inflammatory bowel disease w/o CC/MMCC	5	0.4824	19.6	16.3
388	388	G.I. obstruction w MMCC	213	0.9486	22.5	18.8
389	388	G.I. obstruction w MCC	97	0.7302	20.9	17.4
390	388	G.I. obstruction w/o CC/MMCC	17	0.6327	21.6	18.0
391	391	Esophagitis, gastroent & misc digest disorders w MMCC	255	0.7914	21.9	18.3
392	391	Esophagitis, gastroent & misc digest disorders w/o MMCC	292	0.6568	21.0	17.5
393	393	Other digestive system diagnoses w MMCC	779	1.0684	25.7	21.4
394	393	Other digestive system diagnoses w MCC	449	0.7872	22.6	18.8
395	393	Other digestive system diagnoses w/o CC/MMCC	33	0.5783	22.1	18.4
405	405	Pancreas, liver & shunt procedures w MMCC	10	1.2617	31.5	26.3
406	405	Pancreas, liver & shunt procedures w CC*	2	1.2617	31.5	26.3
407	405	Pancreas, liver & shunt procedures w/o CC/MMCC	0	1.2617	31.5	26.3
408	408	Biliary tract proc except only cholecyst w or w/o c.d.e. w MMCC.	0	0.6327	21.6	18.0
409	408	Biliary tract proc except only cholecyst w or w/o c.d.e. w MCC.	1	0.6327	21.6	18.0

TABLE 11.—PROPOSED FY 2009 MS–LTC–DRGS, PROPOSED RELATIVE WEIGHTS, PROPOSED GEOMETRIC AVERAGE LENGTH OF STAY, AND PROPOSED SHORT-STAY OUTLIER THRESHOLD—Continued

Proposed MS–LTC–DRG	Proposed base MS–LTC–DRG	Proposed MS–LTC–DRG title	FY 2007 LTCH cases	Proposed relative weight	Proposed geometric average length of stay	Proposed short-stay outlier (SSO) threshold [1]
410	408	Biliary tract proc except only cholecyst w or w/o c.d.e. w/o CC/MMCC.	0	0.6327	21.6	18.0
411	411	Cholecystectomy w c.d.e. w MMCC	1	1.7509	37.9	31.6
412	411	Cholecystectomy w c.d.e. w MCC	0	1.7509	37.9	31.6
413	411	Cholecystectomy w c.d.e. w/o CC/MMCC	0	1.7509	37.9	31.6
414	414	Cholecystectomy except by laparoscope w/o c.d.e. w MMCC.	2	1.7509	37.9	31.6
415	414	Cholecystectomy except by laparoscope w/o c.d.e. w MCC.	3	1.7509	37.9	31.6
416	414	Cholecystectomy except by laparoscope w/o c.d.e. w/o CC/MMCC.	0	1.7509	37.9	31.6
417	417	Laparoscopic cholecystectomy w/o c.d.e. w MCC*	11	1.7509	37.9	31.6
418	417	Laparoscopic cholecystectomy w/o c.d.e. w MCC	5	1.7509	37.9	31.6
419	417	Laparoscopic cholecystectomy w/o c.d.e. w/o CC/MMCC	0	1.7509	37.9	31.6
420	420	Hepatobiliary diagnostic procedures w MMCC	0	0.8596	25.2	21.0
421	420	Hepatobiliary diagnostic procedures w MCC	0	0.8596	25.2	21.0
422	420	Hepatobiliary diagnostic procedures w/o CC/MMCC	0	0.8596	25.2	21.0
423	423	Other hepatobiliary or pancreas O.R. procedures w MMCC.	23	1.7509	37.9	31.6
424	423	Other hepatobiliary or pancreas O.R. procedures w MCC	2	0.8596	25.2	21.0
425	423	Other hepatobiliary or pancreas O.R. procedures w/o CC/MMCC.	0	0.8596	25.2	21.0
432	432	Cirrhosis & alcoholic hepatitis w MMCC	73	0.6977	20.9	17.4
433	432	Cirrhosis & alcoholic hepatitis w MCC	24	0.6327	21.6	18.0
434	432	Cirrhosis & alcoholic hepatitis w/o CC/MMCC	0	0.6327	21.6	18.0
435	435	Malignancy of hepatobiliary system or pancreas w MMCC	53	0.8340	22.0	18.3
436	435	Malignancy of hepatobiliary system or pancreas w MCC	26	0.4904	17.2	14.3
437	435	Malignancy of hepatobiliary system or pancreas w/o CC/MMCC.	4	0.4824	19.6	16.3
438	438	Disorders of pancreas except malignancy w MMCC	243	1.0807	23.5	19.6
439	438	Disorders of pancreas except malignancy w MCC	144	0.7533	22.0	18.3
440	438	Disorders of pancreas except malignancy w/o CC/MMCC	24	0.6327	21.6	18.0
441	441	Disorders of liver except malig,cirr,alc hepa w MMCC	123	0.8206	23.1	19.3
442	441	Disorders of liver except malig,cirr,alc hepa w MCC	62	0.7145	21.7	18.1
443	441	Disorders of liver except malig,cirr,alc hepa w/o CC/MMCC.	14	0.4824	19.6	16.3
444	444	Disorders of the biliary tract w MMCC	104	0.8334	22.7	18.9
445	444	Disorders of the biliary tract w MCC	35	0.6140	20.7	17.3
446	444	Disorders of the biliary tract w/o CC/MCC*	8	0.6140	20.7	17.3
453	453	Combined anterior/posterior spinal fusion w MMCC	0	1.7509	37.9	31.6
454	453	Combined anterior/posterior spinal fusion w MCC	0	1.7509	37.9	31.6
455	453	Combined anterior/posterior spinal fusion w/o CC/MMCC	0	1.7509	37.9	31.6
456	456	Spinal fusion exc cerv w spinal curv, malig or 9+ fusions w MMCC.	1	1.7509	37.9	31.6
457	456	Spinal fusion exc cerv w spinal curv, malig or 9+ fusions w MCC.	3	1.7509	37.9	31.6
458	456	Spinal fusion exc cerv w spinal curv, malig or 9+ fusions w/o CC/MMCC.	0	1.7509	37.9	31.6
459	459	Spinal fusion except cervical w MMCC	1	1.7509	37.9	31.6
460	459	Spinal fusion except cervical w/o MMCC	0	1.7509	37.9	31.6
461	461	Bilateral or multiple major joint procs of lower extremity w MMCC.	0	1.7509	37.9	31.6
462	461	Bilateral or multiple major joint procs of lower extremity w/o MMCC.	0	0.8596	25.2	21.0
463	463	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w MMCC.	526	1.4126	38.7	32.3
464	463	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w MCC.	311	1.0643	34.0	28.3
465	463	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w/o CC/MCC.	61	0.9863	34.0	28.3
466	466	Revision of hip or knee replacement w MMCC	3	1.2617	31.5	26.3
467	466	Revision of hip or knee replacement w MCC	4	1.2617	31.5	26.3
468	466	Revision of hip or knee replacement w/o CC/MMCC	1	0.4824	19.6	16.3
469	469	Major joint replacement or reattachment of lower extremity w MCC*.	3	1.7509	37.9	31.6
470	469	Major joint replacement or reattachment of lower extremity w/o MMCC.	3	1.7509	37.9	31.6

TABLE 11.—PROPOSED FY 2009 MS–LTC–DRGS, PROPOSED RELATIVE WEIGHTS, PROPOSED GEOMETRIC AVERAGE LENGTH OF STAY, AND PROPOSED SHORT-STAY OUTLIER THRESHOLD—Continued

Proposed MS–LTC–DRG	Proposed base MS–LTC–DRG	Proposed MS–LTC–DRG title	FY 2007 LTCH cases	Proposed relative weight	Proposed geometric average length of stay	Proposed short-stay outlier (SSO) threshold [1]
471	471	Cervical spinal fusion w MMCC	2	0.8596	25.2	21.0
472	471	Cervical spinal fusion w MCC	1	0.8596	25.2	21.0
473	471	Cervical spinal fusion w/o CC/MMCC	0	0.8596	25.2	21.0
474	474	Amputation for musculoskeletal sys & conn tissue dis w MMCC.	91	1.5642	38.4	32.0
475	474	Amputation for musculoskeletal sys & conn tissue dis w MCC.	67	1.1116	33.9	28.3
476	474	Amputation for musculoskeletal sys & conn tissue dis w/o CC/MMCC.	4	0.8596	25.2	21.0
477	477	Biopsies of musculoskeletal system & connective tissue w MMCC.	22	1.7509	37.9	31.6
478	477	Biopsies of musculoskeletal system & connective tissue w MCC.	12	1.2617	31.5	26.3
479	477	Biopsies of musculoskeletal system & connective tissue w/o CC/MMCC.	0	1.2617	31.5	26.3
480	480	Hip & femur procedures except major joint w MMCC	21	1.7509	37.9	31.6
481	480	Hip & femur procedures except major joint w MCC	11	1.2617	31.5	26.3
482	480	Hip & femur procedures except major joint w/o CC/MMCC	2	0.8596	25.2	21.0
483	483	Major joint & limb reattachment proc of upper extremity w CC/MMCC.	0	1.7509	37.9	31.6
484	483	Major joint & limb reattachment proc of upper extremity w/o CC/MMCC.	0	0.8596	25.2	21.0
485	485	Knee procedures w pdx of infection w MMCC	10	1.2617	31.5	26.3
486	485	Knee procedures w pdx of infection w MCC	10	1.2617	31.5	26.3
487	485	Knee procedures w pdx of infection w/o CC/MCC*	2	1.2617	31.5	26.3
488	488	Knee procedures w/o pdx of infection w CC/MMCC	1	1.7509	37.9	31.6
489	488	Knee procedures w/o pdx of infection w/o CC/MMCC	1	0.6327	21.6	18.0
490	490	Back & neck procedures except spinal fusion w CC/MCC or disc devices.	8	1.2617	31.5	26.3
491	490	Back & neck procedures except spinal fusion w/o CC/MMCC.	0	1.2617	31.5	26.3
492	492	Lower extrem & humer proc except hip, foot, femur w MMCC.	10	1.2617	31.5	26.3
493	492	Lower extrem & humer proc except hip, foot, femur w MCC.	10	1.2617	31.5	26.3
494	492	Lower extrem & humer proc except hip, foot, femur w/o CC/MMCC.	1	0.8596	25.2	21.0
495	495	Local excision & removal int fix devices exc hip & femur w MMCC.	42	1.2616	36.9	30.8
496	495	Local excision & removal int fix devices exc hip & femur w CC*.	20	1.2616	36.9	30.8
497	495	Local excision & removal int fix devices exc hip & femur w/o CC/MCC*.	5	1.2616	36.9	30.8
498	498	Local excision & removal int fix devices of hip & femur w CC/MCC.	9	1.7509	37.9	31.6
499	498	Local excision & removal int fix devices of hip & femur w/o CC/MCC.	0	1.7509	37.9	31.6
500	500	Soft tissue procedures w MMCC	68	1.3427	36.7	30.6
501	500	Soft tissue procedures w MCC	28	1.0746	33.3	27.8
502	500	Soft tissue procedures w/o CC/MMCC	4	0.8596	25.2	21.0
503	503	Foot procedures w MMCC	15	1.2617	31.5	26.3
504	503	Foot procedures w MCC	22	0.8596	25.2	21.0
505	503	Foot procedures w/o CC/MMCC	3	0.8596	25.2	21.0
506	506	Major thumb or joint procedures	0	1.2617	31.5	26.3
507	507	Major shoulder or elbow joint procedures w CC/MMCC	1	1.7509	37.9	31.6
508	507	Major shoulder or elbow joint procedures w/o CC/MMCC	0	1.7509	37.9	31.6
509	509	Arthroscopy	0	0.8596	25.2	21.0
510	510	Shoulder, elbow or forearm proc, exc major joint proc w MCC*.	1	0.8596	25.2	21.0
511	510	Shoulder, elbow or forearm proc, exc major joint proc w CC*.	2	0.8596	25.2	21.0
512	510	Shoulder, elbow or forearm proc, exc major joint proc w/o CC/MCC.	0	0.8596	25.2	21.0
513	513	Hand or wrist proc, except major thumb or joint proc w CC/MMCC.	6	1.2617	31.5	26.3
514	513	Hand or wrist proc, except major thumb or joint proc w/o CC/MCC*.	1	1.2617	31.5	26.3

TABLE 11.—PROPOSED FY 2009 MS–LTC–DRGS, PROPOSED RELATIVE WEIGHTS, PROPOSED GEOMETRIC AVERAGE LENGTH OF STAY, AND PROPOSED SHORT-STAY OUTLIER THRESHOLD—Continued

Proposed MS–LTC–DRG	Proposed base MS–LTC–DRG	Proposed MS–LTC–DRG title	FY 2007 LTCH cases	Proposed relative weight	Proposed geometric average length of stay	Proposed short-stay outlier (SSO) threshold [1]
515	515	Other musculoskelet sys & conn tiss O.R. proc w MMCC	60	1.3728	31.5	26.3
516	515	Other musculoskelet sys & conn tiss O.R. proc w MCC	27	0.9133	28.0	23.3
517	515	Other musculoskelet sys & conn tiss O.R. proc w/o CC/MMCC.	0	0.9133	28.0	23.3
533	533	Fractures of femur w MMCC	3	0.6327	21.6	18.0
534	533	Fractures of femur w/o MMCC	6	0.6327	21.6	18.0
535	535	Fractures of hip & pelvis w MMCC	16	0.8596	25.2	21.0
536	535	Fractures of hip & pelvis w/o MMCC	25	0.6130	26.9	22.4
537	537	Sprains, strains, & dislocations of hip, pelvis & thigh w CC/MMCC.	1	0.4824	19.6	16.3
538	537	Sprains, strains, & dislocations of hip, pelvis & thigh w/o CC/MCC.	0	0.4824	19.6	16.3
539	539	Osteomyelitis w MMCC	1,317	0.9928	30.2	25.2
540	539	Osteomyelitis w MCC	848	0.7632	27.6	23.0
541	539	Osteomyelitis w/o CC/MMCC	227	0.6901	27.1	22.6
542	542	Pathological fractures & musculoskelet & conn tiss malig w MMCC.	23	0.8596	25.2	21.0
543	542	Pathological fractures & musculoskelet & conn tiss malig w MCC.	42	0.5682	20.5	17.1
544	542	Pathological fractures & musculoskelet & conn tiss malig w/o CC/MMCC.	17	0.4824	19.6	16.3
545	545	Connective tissue disorders w MMCC	50	0.9093	23.5	19.6
546	545	Connective tissue disorders w MCC	38	0.8478	25.5	21.3
547	545	Connective tissue disorders w/o CC/MMCC	5	0.4824	19.6	16.3
548	548	Septic arthritis w MMCC	172	0.8843	26.1	21.8
549	548	Septic arthritis w MCC	200	0.7080	26.9	22.4
550	548	Septic arthritis w/o CC/MMCC	73	0.6067	24.2	20.2
551	551	Medical back problems w MMCC	83	0.8867	26.5	22.1
552	551	Medical back problems w/o MMCC	156	0.6146	24.2	20.2
553	553	Bone diseases & arthropathies w MMCC	15	0.6327	21.6	18.0
554	553	Bone diseases & arthropathies w/o MMCC	59	0.5022	21.3	17.8
555	555	Signs & symptoms of musculoskeletal system & conn tissue w MMCC.	3	0.8596	25.2	21.0
556	555	Signs & symptoms of musculoskeletal system & conn tissue w/o MCC.	8	0.4824	19.6	16.3
557	557	Tendonitis, myositis & bursitis w MMCC	84	0.8284	24.6	20.5
558	557	Tendonitis, myositis & bursitis w/o MMCC	134	0.6519	23.0	19.2
559	559	Aftercare, musculoskeletal system & connective tissue w MMCC.	1,368	0.8146	26.1	21.8
560	559	Aftercare, musculoskeletal system & connective tissue w MCC.	1,613	0.6469	24.7	20.6
561	559	Aftercare, musculoskeletal system & connective tissue w/o CC/MMCC.	730	0.5579	22.8	19.0
562	562	Fx, sprn, strn & disl except femur, hip, pelvis & thigh w MMCC.	5	0.8596	25.2	21.0
563	562	Fx, sprn, strn & disl except femur, hip, pelvis & thigh w/o MMCC.	9	0.4824	19.6	16.3
564	564	Other musculoskeletal sys & connective tissue diagnoses w MMCC.	307	0.8803	24.2	20.2
565	564	Other musculoskeletal sys & connective tissue diagnoses w MCC.	199	0.6473	22.7	18.9
566	564	Other musculoskeletal sys & connective tissue diagnoses w/o CC/MMCC.	60	0.6236	22.5	18.8
573	573	Skin graft &/or debrid for skn ulcer or cellulitis w MMCC	1,814	1.3944	38.2	31.8
574	573	Skin graft &/or debrid for skn ulcer or cellulitis w MCC	1,761	1.0779	36.0	30.0
575	573	Skin graft &/or debrid for skn ulcer or cellulitis w/o CC/MMCC.	200	0.9033	30.1	25.1
576	576	Skin graft &/or debrid exc for skin ulcer or cellulitis w MMCC.	27	1.7840	37.6	31.3
577	576	Skin graft &/or debrid exc for skin ulcer or cellulitis w MCC	28	0.8093	27.3	22.8
578	576	Skin graft &/or debrid exc for skin ulcer or cellulitis w/o CC/MMCC.	11	0.6327	21.6	18.0
579	579	Other skin, subcut tiss & breast proc w MMCC	476	1.3648	36.5	30.4
580	579	Other skin, subcut tiss & breast proc w MCC	398	1.0585	33.5	27.9
581	579	Other skin, subcut tiss & breast proc w/o CC/MMCC	34	0.8032	30.1	25.1
582	582	Mastectomy for malignancy w CC/MMCC	1	1.7509	37.9	31.6
583	582	Mastectomy for malignancy w/o CC/MMCC	0	1.7509	37.9	31.6

TABLE 11.—PROPOSED FY 2009 MS–LTC–DRGS, PROPOSED RELATIVE WEIGHTS, PROPOSED GEOMETRIC AVERAGE LENGTH OF STAY, AND PROPOSED SHORT-STAY OUTLIER THRESHOLD—Continued

Proposed MS–LTC–DRG	Proposed base MS–LTC–DRG	Proposed MS–LTC–DRG title	FY 2007 LTCH cases	Proposed relative weight	Proposed geometric average length of stay	Proposed short-stay outlier (SSO) threshold [1]
584	584	Breast biopsy, local excision & other breast procedures w CC/MMCC.	2	0.6327	21.6	18.0
585	584	Breast biopsy, local excision & other breast procedures w/o CC/MMCC.	0	0.6327	21.6	18.0
592	592	Skin ulcers w MMCC	3,044	0.9490	27.0	22.5
593	592	Skin ulcers w MCC	2,805	0.7171	26.1	21.8
594	592	Skin ulcers w/o CC/MMCC	435	0.6109	24.8	20.7
595	595	Major skin disorders w MMCC	28	0.8138	25.3	21.1
596	595	Major skin disorders w/o MMCC	39	0.6547	22.4	18.7
597	597	Malignant breast disorders w MMCC	7	1.2617	31.5	26.3
598	597	Malignant breast disorders w MCC	7	0.8596	25.2	21.0
599	597	Malignant breast disorders w/o CC/MCC*	1	0.8596	25.2	21.0
600	600	Non-malignant breast disorders w CC/MMCC	17	0.8596	25.2	21.0
601	600	Non-malignant breast disorders w/o CC/MMCC	6	0.4824	19.6	16.3
602	602	Cellulitis w MMCC	829	0.6963	21.7	18.1
603	602	Cellulitis w/o MMCC	1,634	0.5333	19.9	16.6
604	604	Trauma to the skin, subcut tiss & breast w MMCC	29	0.8236	24.4	20.3
605	604	Trauma to the skin, subcut tiss & breast w/o MMCC	53	0.6053	23.8	19.8
606	606	Minor skin disorders w MMCC	63	0.8273	24.5	20.4
607	606	Minor skin disorders w/o MMCC	93	0.5599	20.7	17.3
614	614	Adrenal & pituitary procedures w CC/MMCC	0	1.0449	32.5	27.1
615	614	Adrenal & pituitary procedures w/o CC/MMCC	0	0.8596	25.2	21.0
616	616	Amputat of lower limb for endocrine, nutrit,& metabol dis w MMCC.	70	1.4804	38.4	32.0
617	616	Amputat of lower limb for endocrine, nutrit,& metabol dis w MCC.	132	1.1478	33.1	27.6
618	616	Amputat of lower limb for endocrine, nutrit,& metabol dis w/o CC/MMCC.	2	0.4824	19.6	16.3
619	619	O.R. procedures for obesity w MMCC	1	1.7509	37.9	31.6
620	619	O.R. procedures for obesity w MCC	0	1.7509	37.9	31.6
621	619	O.R. procedures for obesity w/o CC/MMCC	0	1.7509	37.9	31.6
622	622	Skin grafts & wound debrid for endoc, nutrit & metab dis w MCC.	171	1.2978	35.7	29.8
623	622	Skin grafts & wound debrid for endoc, nutrit & metab dis w MCC.	357	1.0065	30.9	25.8
624	622	Skin grafts & wound debrid for endoc, nutrit & metab dis w/o CC/MMCC.	21	0.6327	21.6	18.0
625	625	Thyroid, parathyroid & thyroglossal procedures w MMCC	1	1.2617	31.5	26.3
626	625	Thyroid, parathyroid & thyroglossal procedures w MCC	1	0.8596	25.2	21.0
627	625	Thyroid, parathyroid & thyroglossal procedures w/o CC/MMCC.	0	0.8596	25.2	21.0
628	628	Other endocrine, nutrit & metab O.R. proc w MMCC	48	1.3769	32.3	26.9
629	628	Other endocrine, nutrit & metab O.R. proc w MCC	110	1.0449	32.5	27.1
630	628	Other endocrine, nutrit & metab O.R. proc w/o CC/MMCC	2	0.8596	25.2	21.0
637	637	Diabetes w MMCC	421	0.9264	26.6	22.2
638	637	Diabetes w MCC	1,052	0.6950	24.5	20.4
639	637	Diabetes w/o CC/MMCC	71	0.5777	20.8	17.3
640	640	Nutritional & misc metabolic disorders w MMCC	638	0.8424	23.1	19.3
641	640	Nutritional & misc metabolic disorders w/o MMCC	548	0.6217	21.5	17.9
642	642	Inborn errors of metabolism	5	0.4824	19.6	16.3
643	643	Endocrine disorders w MMCC	30	0.6833	24.0	20.0
644	643	Endocrine disorders w MCC	28	0.5393	21.1	17.6
645	643	Endocrine disorders w/o CC/MCC	1	0.4824	19.6	16.3
652	652	Kidney transplant	0	0.0000	0.0	0.0
653	653	Major bladder procedures w MCC	2	1.7509	37.9	31.6
654	653	Major bladder procedures w MCC	0	1.7509	37.9	31.6
655	653	Major bladder procedures w/o CC/MMCC	0	1.7509	37.9	31.6
656	656	Kidney & ureter procedures for neoplasm w MMCC	1	1.7509	37.9	31.6
657	656	Kidney & ureter procedures forneoplasm w MCC	0	1.7509	37.9	31.6
658	656	Kidney & ureter procedures for neoplasm w/o CC/MMCC	0	1.7509	37.9	31.6
659	659	Kidney & ureter procedures for non-neoplasm w MMCC	6	1.2617	31.5	26.3
660	659	Kidney & ureter procedures for non-neoplasm w MCC	6	1.2617	31.5	26.3
661	659	Kidney & ureter procedures for non-neoplasm w/o CC/MMCC.	1	0.6327	21.6	18.0
662	662	Minor bladder procedures w MMCC	2	1.7509	37.9	31.6
663	662	Minor bladder procedures w MCC	2	0.6327	21.6	18.0
664	662	Minor bladder procedures w/o CC/MCC	0	0.6327	21.6	18.0

TABLE 11.—PROPOSED FY 2009 MS–LTC–DRGS, PROPOSED RELATIVE WEIGHTS, PROPOSED GEOMETRIC AVERAGE LENGTH OF STAY, AND PROPOSED SHORT-STAY OUTLIER THRESHOLD—Continued

Proposed MS–LTC–DRG	Proposed base MS–LTC–DRG	Proposed MS–LTC–DRG title	FY 2007 LTCH cases	Proposed relative weight	Proposed geometric average length of stay	Proposed short-stay outlier (SSO) threshold [1]
665	665	Prostatectomy w MCC*	2	0.8596	25.2	21.0
666	665	Prostatectomy w CC*	1	0.8596	25.2	21.0
667	665	Prostatectomy w/o CC/MMCC	0	0.8596	25.2	21.0
668	668	Transurethral procedures w MMCC	4	0.8596	25.2	21.0
669	668	Transurethral procedures w MCC	3	0.6327	21.6	18.0
670	668	Transurethral procedures w/o CC/MMCC	0	0.6327	21.6	18.0
671	671	Urethral procedures w CC/MMCC	1	0.6327	21.6	18.0
672	671	Urethral procedures w/o CC/MMCC	0	0.6327	21.6	18.0
673	673	Other kidney & urinary tract procedures w MMCC	227	1.4418	33.8	28.2
674	673	Other kidney & urinary tract procedures w MCC	67	1.1430	29.1	24.3
675	673	Other kidney & urinary tract procedures w/o CC/MMCC	0	1.1430	29.1	24.3
682	682	Renal failure w MMCC	1,458	0.8945	23.8	19.8
683	682	Renal failure w MCC	713	0.7478	22.8	19.0
684	682	Renal failure w/o CC/MMCC	91	0.6647	20.6	17.2
685	685	Admit for renal dialysis	32	0.8341	25.1	20.9
686	686	Kidney & urinary tract neoplasms w MMCC	15	0.8596	25.2	21.0
687	686	Kidney & urinary tract neoplasms w MCC	18	0.8596	25.2	21.0
688	686	Kidney & urinary tract neoplasms w/o CC/MMCC	3	0.6327	21.6	18.0
689	689	Kidney & urinary tract infections w MMCC	868	0.6712	22.6	18.8
690	689	Kidney & urinary tract infections w/o MMCC	782	0.5266	20.5	17.1
691	691	Urinary stones w esw lithotripsy w CC/MMCC	0	0.4824	19.6	16.3
692	691	Urinary stones w esw lithotripsy w/o CC/MMCC	0	0.4824	19.6	16.3
693	693	Urinary stones w/o esw lithotripsy w MMCC	3	0.8596	25.2	21.0
694	693	Urinary stones w/ot esw lithotripsy w/o MMCC	5	0.4824	19.6	16.3
695	695	Kidney & urinary tract signs & symptoms w MMCC	4	1.2617	31.5	26.3
696	695	Kidney & urinary tract signs & symptoms w/o MMCC	7	0.6327	21.6	18.0
697	697	Urethral stricture	0	0.6327	21.6	18.0
698	698	Other kidney & urinary tract diagnoses w MMCC	285	0.9527	23.5	19.6
699	698	Other kidney & urinary tract diagnoses w MCC	142	0.6606	22.0	18.3
700	698	Other kidney & urinary tract diagnoses w/o CC/MMCC	33	0.5695	21.1	17.6
707	707	Major male pelvic procedures w CC/MMCC	0	1.2617	31.5	26.3
708	707	Major male pelvic procedures w/o CC/MMCC	0	0.6327	21.6	18.0
709	709	Penis procedures w CC/MMCC	15	1.7509	37.9	31.6
710	709	Penis procedures w/o CC/MMCC	0	1.7509	37.9	31.6
711	711	Testes procedures w CC/MMCC	6	1.2617	31.5	26.3
712	711	Testes procedures w/o CC/MMCC	0	1.2617	31.5	26.3
713	713	Transurethral prostatectomy w CC/MMCC	2	1.7509	37.9	31.6
714	713	Transurethral prostatectomy w/o CC/MMCC	0	1.7509	37.9	31.6
715	715	Other male reproductive system O.R. proc for malignancy w CC/MMCC.	0	1.2617	31.5	26.3
716	715	Other male reproductive system O.R. proc for malignancy w/o CC/MMCC.	0	1.2617	31.5	26.3
717	717	Other male reproductive system O.R. proc exc malignancy w CC/MMCC.	11	1.2617	31.5	26.3
718	717	Other male reproductive system O.R. proc exc malignancy w/o CC/MMCC.	0	1.2617	31.5	26.3
722	722	Malignancy, male reproductive system w MMCC	15	0.6327	21.6	18.0
723	722	Malignancy, male reproductive system w MCC	15	0.4824	19.6	16.3
724	722	Malignancy, male reproductive system w/o CC/MMCC	0	0.4824	19.6	16.3
725	725	Benign prostatic hypertrophy w MMCC	1	0.8596	25.2	21.0
726	725	Benign prostatic hypertrophy w/o MMCC	2	0.4824	19.6	16.3
727	727	Inflammation of the male reproductive system w MMCC	27	0.7907	23.1	19.3
728	727	Inflammation of the male reproductive system w/o MMCC	51	0.5259	20.4	17.0
729	729	Other male reproductive system diagnoses w CC/MMCC	49	0.8878	26.2	21.8
730	729	Other male reproductive system diagnoses w/o CC/MMCC	8	0.4824	19.6	16.3
734	734	Pelvic evisceration, rad hysterectomy & rad vulvectomy w CC/MMCC.	0	1.2617	31.5	26.3
735	734	Pelvic evisceration, rad hysterectomy & rad vulvectomy w/o CC/MMCC.	0	1.2617	31.5	26.3
736	736	Uterine & adnexa proc for ovarian or adnexal malignancy w MMCC.	0	1.2617	31.5	26.3
737	736	Uterine & adnexa proc for ovarian or adnexal malignancy w MCC.	0	0.8596	25.2	21.0
738	736	Uterine & adnexa proc for ovarian or adnexal malignancy w/o CC/MMCC.	0	0.4824	19.6	16.3
739	739	Uterine,adnexa proc for non-ovarian/adnexal malig w MMCC.	1	1.2617	31.5	26.3

TABLE 11.—PROPOSED FY 2009 MS–LTC–DRGS, PROPOSED RELATIVE WEIGHTS, PROPOSED GEOMETRIC AVERAGE LENGTH OF STAY, AND PROPOSED SHORT-STAY OUTLIER THRESHOLD—Continued

Proposed MS–LTC–DRG	Proposed base MS–LTC–DRG	Proposed MS–LTC–DRG title	FY 2007 LTCH cases	Proposed relative weight	Proposed geometric average length of stay	Proposed short-stay outlier (SSO) threshold [1]
740	739	Uterine,adnexa proc for non-ovarian/adnexal malig w MCC.	0	1.2617	31.5	26.3
741	739	Uterine,adnexa proc for non-ovarian/adnexal malig w/o CC/MMCC.	0	1.2617	31.5	26.3
742	742	Uterine & adnexa proc for non-malignancy w CC/MMCC	0	0.8596	25.2	21.0
743	742	Uterine & adnexa proc for non-malignancy w/o CC/MMCC	0	0.4824	19.6	16.3
744	744	D&C, conization, laparascopy & tubal interruption w CC/MMCC.	1	0.8596	25.2	21.0
745	744	D&C, conization, laparascopy & tubal interruption w/o CC/MMCC.	0	0.8596	25.2	21.0
746	746	Vagina, cervix & vulva procedures w CC/MMCC	1	1.7509	37.9	31.6
747	746	Vagina, cervix & vulva procedures w/o CC/MMCC	0	1.7509	37.9	31.6
748	748	Female reproductive system reconstructive procedures	0	1.2617	31.5	26.3
749	749	Other female reproductive system O.R. procedures w CC/MMCC.	4	1.2617	31.5	26.3
750	749	Other female reproductive system O.R. procedures w/o CC/MMCC.	0	1.2617	31.5	26.3
754	754	Malignancy, female reproductive system w MMCC	22	1.2617	31.5	26.3
755	754	Malignancy, female reproductive system w MCC	21	0.8596	25.2	21.0
756	754	Malignancy, female reproductive system w/o CC/MMCC	1	0.4824	19.6	16.3
757	757	Infections, female reproductive system w MCC*	52	0.7580	23.7	19.8
758	757	Infections, female reproductive system w CC*	27	0.7580	23.7	19.8
759	757	Infections, female reproductive system w/o CC/MCC*	5	0.7580	23.7	19.8
760	760	Menstrual & other female reproductive system disorders w CC/MMCC.	0	0.8596	25.2	21.0
761	760	Menstrual & other female reproductive system disorders w/o CC/MMCC.	0	0.8596	25.2	21.0
765	765	Cesarean section w CC/MMCC	0	0.8596	25.2	21.0
766	765	Cesarean section w/o CC/MMCC	0	0.8596	25.2	21.0
767	767	Vaginal delivery w sterilization &/or D&C	0	0.8596	25.2	21.0
768	768	Vaginal delivery w O.R. proc except steril &/or D&C	0	0.8596	25.2	21.0
769	769	Postpartum & post abortion diagnoses w O.R. procedure	0	0.8596	25.2	21.0
770	770	Abortion w D&C, aspiration curettage or hysterotomy	0	0.8596	25.2	21.0
774	774	Vaginal delivery w complicating diagnoses	0	0.8596	25.2	21.0
775	775	Vaginal delivery w/o complicating diagnoses	0	0.8596	25.2	21.0
776	776	Postpartum & post abortion diagnoses w/o O.R. procedure	0	0.8596	25.2	21.0
777	777	Ectopic pregnancy	0	0.8596	25.2	21.0
778	778	Threatened abortion	0	0.7580	23.7	19.8
779	779	Abortion w/o D&C	0	0.7580	23.7	19.8
780	780	False labor	0	0.7580	23.7	19.8
781	781	Other antepartum diagnoses w medical complications	1	0.4824	19.6	16.3
782	782	Other antepartum diagnoses w/o medical complications	0	0.4824	19.6	16.3
789	789	Neonates, died or transferred to another acute care facility	0	0.4824	19.6	16.3
790	790	Extreme immaturity or respiratory distress syndrome, neonate.	0	0.4824	19.6	16.3
791	791	Prematurity w major problems	0	0.4824	19.6	16.3
792	792	Prematurity w/o major problems	0	0.4824	19.6	16.3
793	793	Full term neonate w major problems	0	0.4824	19.6	16.3
794	794	Neonate w other significant problems	0	0.4824	19.6	16.3
795	795	Normal newborn	0	0.4824	19.6	16.3
799	799	Splenectomy w MCC	0	0.8596	25.2	21.0
800	799	Splenectomy w CC	1	0.8596	25.2	21.0
801	799	Splenectomy w/o CC/MMCC	0	0.8596	25.2	21.0
802	802	Other O.R. proc of the blood & blood forming organs w MMCC.	4	1.2617	31.5	26.3
803	802	Other O.R. proc of the blood & blood forming organs w MCC.	0	1.2617	31.5	26.3
804	802	Other O.R. proc of the blood & blood forming organs w/o CC/MMCC.	0	1.2617	31.5	26.3
808	808	Major hematol/immun diag exc sickle cell crisis & coagul w MMCC.	17	1.2617	31.5	26.3
809	808	Major hematol/immun diag exc sickle cell crisis & coagul w MCC.	11	0.8596	25.2	21.0
810	808	Major hematol/immun diag exc sickle cell crisis & coagul w/o CC/MMCC.	1	0.4824	19.6	16.3
811	811	Red blood cell disorders w MMCC	43	0.7905	22.8	19.0
812	811	Red blood cell disorders w/o MMCC	58	0.5349	20.4	17.0

TABLE 11.—PROPOSED FY 2009 MS–LTC–DRGS, PROPOSED RELATIVE WEIGHTS, PROPOSED GEOMETRIC AVERAGE LENGTH OF STAY, AND PROPOSED SHORT-STAY OUTLIER THRESHOLD—Continued

Proposed MS–LTC–DRG	Proposed base MS–LTC–DRG	Proposed MS–LTC–DRG title	FY 2007 LTCH cases	Proposed relative weight	Proposed geometric average length of stay	Proposed short-stay outlier (SSO) threshold [1]
813	813	Coagulation disorders	55	0.8402	23.2	19.3
814	814	Reticuloendothelial & immunity disorders w MMCC	16	0.8596	25.2	21.0
815	814	Reticuloendothelial & immunity disorders w MCC	7	0.6327	21.6	18.0
816	814	Reticuloendothelial & immunity disorders w/o CC/MMCC	1	0.4824	19.6	16.3
820	820	Lymphoma & leukemia w major O.R. procedure w MMCC	0	1.2617	31.5	26.3
821	820	Lymphoma & leukemia w major O.R. procedure w MCC	0	0.8596	25.2	21.0
822	820	Lymphoma & leukemia w major O.R. procedure w/o CC/MMCC.	0	0.8596	25.2	21.0
823	823	Lymphoma & non-acute leukemia w other O.R. proc w MMCC.	11	1.2617	31.5	26.3
824	823	Lymphoma & non-acute leukemia w other O.R. proc w MCC.	4	0.8596	25.2	21.0
825	823	Lymphoma & non-acute leukemia w other O.R. proc w/o CC/MMCC.	0	0.8596	25.2	21.0
826	826	Myeloprolif disord or poorly diff neopl w maj O.R. proc w MMCC.	1	1.7509	37.9	31.6
827	826	Myeloprolif disord or poorly diff neopl w maj O.R. proc w MCC.	1	1.7509	37.9	31.6
828	826	Myeloprolif disord or poorly diff neopl w maj O.R. proc w/o CC/MMCC.	0	1.7509	37.9	31.6
829	829	Myeloprolif disord or poorly diff neopl w other O.R. proc w CC/MMCC.	7	1.7509	37.9	31.6
830	829	Myeloprolif disord or poorly diff neopl w other O.R. proc w/o CC/MMCC.	0	1.7509	37.9	31.6
834	834	Acute leukemia w/o major O.R. procedure w MMCC	14	0.8596	25.2	21.0
835	834	Acute leukemia w/o major O.R. procedure w CC*	14	0.8596	25.2	21.0
836	834	Acute leukemia w/o major O.R. procedure w/o CC/MCC*	2	0.8596	25.2	21.0
837	837	Chemo w acute leukemia as sdx or w high dose chemo agent w MMCC.	0	1.7509	37.9	31.6
838	837	Chemo w acute leukemia as sdx or w high dose chemo agent w MCC.	0	1.7509	37.9	31.6
839	837	Chemo w acute leukemia as sdx or w high dose chemo agent w/o CC/MMCC.	0	1.7509	37.9	31.6
840	840	Lymphoma & non-acute leukemia w MMCC	133	0.9227	23.1	19.3
841	840	Lymphoma & non-acute leukemia w MCC	63	0.7247	19.7	16.4
842	840	Lymphoma & non-acute leukemia w/o CC/MMCC	7	0.6327	21.6	18.0
843	843	Other myeloprolif dis or poorly diff neopl diag w MMCC	20	0.8596	25.2	21.0
844	843	Other myeloprolif dis or poorly diff neopl diag w MCC	11	0.6327	21.6	18.0
845	843	Other myeloprolif dis or poorly diff neopl diag w/o CC/MMCC.	3	0.6327	21.6	18.0
846	846	Chemotherapy w/o acute leukemia as secondary diagnosis w MMCC.	49	1.4778	30.0	25.0
847	846	Chemotherapy w/o acute leukemia as secondary diagnosis w MCC.	43	1.0877	23.8	19.8
848	846	Chemotherapy w/o acute leukemia as secondary diagnosis w/o CC/MMCC.	0	1.0877	23.8	19.8
849	849	Radiotherapy	141	0.7949	21.6	18.0
853	853	Infectious & parasitic diseases w O.R. procedure w MMCC.	837	1.7864	37.3	31.1
854	853	Infectious & parasitic diseases w O.R. procedure w MCC	104	1.1703	33.0	27.5
855	853	Infectious & parasitic diseases w O.R. procedure w/o CC/MCC*.	5	1.1703	33.0	27.5
856	856	Postoperative or post-traumatic infections w O.R. proc w MMCC.	301	1.5591	36.7	30.6
857	856	Postoperative or post-traumatic infections w O.R. proc w MCC.	213	1.0707	32.6	27.2
858	856	Postoperative or post-traumatic infections w O.R. proc w/o CC/MMCC.	32	0.8943	26.8	22.3
862	862	Postoperative & post-traumatic infections w MMCC	1,163	0.9629	25.3	21.1
863	862	Postoperative & post-traumatic infections w/o MMCC	1,231	0.7018	23.8	19.8
864	864	Fever of unknown origin	11	0.4824	19.6	16.3
865	865	Viral illness w MMCC	36	0.7998	22.2	18.5
866	865	Viral illness w/o MMCC	14	0.6327	21.6	18.0
867	867	Other infectious & parasitic diseases diagnoses w MMCC	357	1.1296	23.4	19.5
868	867	Other infectious & parasitic diseases diagnoses w MCC	86	0.7458	22.6	18.8
869	867	Other infectious & parasitic diseases diagnoses w/o CC/MMCC.	7	0.4824	19.6	16.3

TABLE 11.—PROPOSED FY 2009 MS–LTC–DRGS, PROPOSED RELATIVE WEIGHTS, PROPOSED GEOMETRIC AVERAGE LENGTH OF STAY, AND PROPOSED SHORT-STAY OUTLIER THRESHOLD—Continued

Proposed MS–LTC–DRG	Proposed base MS–LTC–DRG	Proposed MS–LTC–DRG title	FY 2007 LTCH cases	Proposed relative weight	Proposed geometric average length of stay	Proposed short-stay outlier (SSO) threshold [1]
870	870	Septicemia w MV 96+ hours	894	2.2127	33.0	27.5
871	871	Septicemia w/o MV 96+ hours w MMCC	4,507	0.8713	23.4	19.5
872	871	Septicemia w/o MV 96+ hours w/o MMCC	1,608	0.6584	21.8	18.2
876	876	O.R. procedure w principal diagnoses of mental illness	12	0.6327	21.6	18.0
880	880	Acute adjustment reaction & psychosocial dysfunction	11	0.4824	19.6	16.3
881	881	Depressive neuroses	14	0.6327	21.6	18.0
882	882	Neuroses except depressive	16	0.4824	19.6	16.3
883	883	Disorders of personality & impulse control	12	0.8596	25.2	21.0
884	884	Organic disturbances & mental retardation	146	0.5159	25.4	21.2
885	885	Psychoses	1,218	0.4206	23.9	19.9
886	886	Behavioral & developmental disorders	18	0.4824	19.6	16.3
887	887	Other mental disorder diagnoses	0	0.6327	21.6	18.0
894	894	Alcohol/drug abuse or dependence, left ama	0	0.6327	21.6	18.0
895	895	Alcohol/drug abuse or dependence w rehabilitation therapy.	2	0.4824	19.6	16.3
896	896	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MMCC.	7	1.2617	31.5	26.3
897	896	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MMCC.	17	0.4824	19.6	16.3
901	901	Wound debridements for injuries w MMCC	217	1.5251	35.9	29.9
902	901	Wound debridements for injuries w MCC	129	1.0552	30.1	25.1
903	901	Wound debridements for injuries w/o CC/MMCC	23	0.8596	25.2	21.0
904	904	Skin grafts for injuries w CC/MMCC	78	1.3404	35.6	29.7
905	904	Skin grafts for injuries w/o CC/MMCC	6	0.8596	25.2	21.0
906	906	Hand procedures for injuries	1	1.7509	37.9	31.6
907	907	Other O.R. procedures for injuries w MMCC	91	1.6273	37.5	31.3
908	907	Other O.R. procedures for injuries w MCC	63	1.1167	34.0	28.3
909	907	Other O.R. procedures for injuries w/o CC/MCC*	6	1.1167	34.0	28.3
913	913	Traumatic injury w MMCC	37	0.7480	24.8	20.7
914	913	Traumatic injury w/o MMCC	66	0.6073	21.8	18.2
915	915	Allergic reactions w MMCC	0	0.4824	19.6	16.3
916	915	Allergic reactions w/o MMCC	0	0.4824	19.6	16.3
917	917	Poisoning & toxic effects of drugs w MMCC	8	0.4824	19.6	16.3
918	917	Poisoning & toxic effects of drugs w/o MMCC	9	0.4824	19.6	16.3
919	919	Complications of treatment w MMCC	1,235	1.0924	26.9	22.4
920	919	Complications of treatment w MCC	841	0.8582	26.0	21.7
921	919	Complications of treatment w/o CC/MMCC	117	0.6163	20.1	16.8
922	922	Other injury, poisoning & toxic effect diag w MMCC	7	0.8596	25.2	21.0
923	922	Other injury, poisoning & toxic effect diag w/o MMCC	11	0.6327	21.6	18.0
927	927	Extensive burns or full thickness burns w MV 96+ hrs w skin graft.	1	1.7509	37.9	31.6
928	928	Full thickness burn w skin graft or inhal inj w CC/MMCC	9	1.2617	31.5	26.3
929	928	Full thickness burn w skin graft or inhal inj w/o CC/MMCC	2	0.6327	21.6	18.0
933	933	Extensive burns or full thickness burns w MV 96+ hrs w/o skin graft.	10	1.2617	31.5	26.3
934	934	Full thickness burn w/o skin grft or inhal inj	40	0.7755	24.2	20.2
935	935	Non-extensive burns	46	0.7815	24.5	20.4
939	939	O.R. proc w diagnoses of other contact w health services w MCC.	267	1.3463	34.1	28.4
940	939	O.R. proc w diagnoses of other contact w health services w MCC.	135	0.9993	30.6	25.5
941	939	O.R. proc w diagnoses of other contact w health services w/o CC/MMCC.	15	0.8596	25.2	21.0
945	945	Rehabilitation w CC/MMCC	2,220	0.6154	22.1	18.4
946	945	Rehabilitation w/o CC/MMCC	428	0.4311	18.9	15.8
947	947	Signs & symptoms w MMCC	57	0.6548	22.2	18.5
948	947	Signs & symptoms w/o MMCC	69	0.5737	22.2	18.5
949	949	Aftercare w CC/MMCC	3,802	0.7034	22.5	18.8
950	949	Aftercare w/o CC/MMCC	546	0.5002	19.2	16.0
951	951	Other factors influencing health status	28	1.2726	27.0	22.5
955	955	Craniotomy for multiple significant trauma	0	1.7509	37.9	31.6
956	956	Limb reattachment, hip & femur proc for multiple significant trauma.	0	0.8596	25.2	21.0
957	957	Other O.R. procedures for multiple significant trauma w MMCC.	1	1.2617	31.5	26.3
958	957	Other O.R. procedures for multiple significant trauma w MCC.	1	0.4824	19.6	16.3

TABLE 11.—PROPOSED FY 2009 MS–LTC–DRGS, PROPOSED RELATIVE WEIGHTS, PROPOSED GEOMETRIC AVERAGE LENGTH OF STAY, AND PROPOSED SHORT-STAY OUTLIER THRESHOLD—Continued

Proposed MS–LTC–DRG	Proposed base MS–LTC–DRG	Proposed MS–LTC–DRG title	FY 2007 LTCH cases	Proposed relative weight	Proposed geometric average length of stay	Proposed short-stay outlier (SSO) threshold [1]
959	957	Other O.R. procedures for multiple significant trauma w/o CC/MMCC.	0	0.4824	19.6	16.3
963	963	Other multiple significant trauma w MMCC	15	0.8596	25.2	21.0
964	963	Other multiple significant trauma w MCC	5	0.6327	21.6	18.0
965	963	Other multiple significant trauma w/o CC/MMCC	3	0.4824	19.6	16.3
969	969	HIV w extensive O.R. procedure w MMCC	13	1.2617	31.5	26.3
970	969	HIV w extensive O.R. procedure w/o MCC*	3	1.2617	31.5	26.3
974	974	HIV w major related condition w MMCC	196	1.0056	21.9	18.3
975	974	HIV w major related condition w MCC	85	0.6433	18.3	15.3
976	974	HIV w major related condition w/o CC/MMCC	16	0.6327	21.6	18.0
977	977	HIV w or w/o other related condition	45	0.6975	19.0	15.8
981	981	Extensive O.R. procedure unrelated to principal diagnosis w MMCC.	1,143	2.3516	43.1	35.9
982	981	Extensive O.R. procedure unrelated to principal diagnosis w MCC.	290	1.4645	35.2	29.3
983	981	Extensive O.R. procedure unrelated to principal diagnosis w/o CC/MMCC.	26	1.1662	31.9	26.6
984	984	Prostatic O.R. procedure unrelated to principal diagnosis w MMCC.	16	1.2617	31.5	26.3
985	984	Prostatic O.R. procedure unrelated to principal diagnosis w MCC.	9	1.2617	31.5	26.3
986	984	Prostatic O.R. procedure unrelated to principal diagnosis w/o CC/MMCC.	0	1.2617	31.5	26.3
987	987	Non-extensive O.R. proc unrelated to principal diagnosis w MMCC.	419	1.7561	36.4	30.3
988	987	Non-extensive O.R. proc unrelated to principal diagnosis w MCC.	218	1.1596	33.9	28.3
989	987	Non-extensive O.R. proc unrelated to principal diagnosis w/o CC/MMCC.	10	0.8596	25.2	21.0
998	998	Ungroupable	0	0.0000	0.0	0.0
999	999	Principal diagnosis invalid as discharge diagnosis	0	0.0000	0.0	0.0

[1] The proposed SSO Threshold is calculated as 5/6th of the geometric average length of stay of the proposed MS–LTC–DRG (as specified at § 412.529 in conjunction with § 412.503).

* In determining the proposed MS–LTC–DRG relative weights, these proposed MS–LTC–DRGs were adjusted for nonmonotonicity as discussed in section II.I.4. (step 6) of the preamble of this proposed rule.

Appendix A—Regulatory Impact Analysis

I. Overall Impact

We have examined the impacts of this proposed rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review) and the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), Executive Order 13132 on Federalism, and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Order 12866 (as amended by Executive Order 13258) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year).

We have determined that this proposed rule is a major rule as defined in 5 U.S.C. 804(2). We estimate that the proposed changes for FY 2009 operating and capital payments would 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 proposed rule, would result in an approximate $4 billion increase in FY 2009 operating and capital payments. Our impact estimate includes the −0.9 percent adjustment for documentation and coding changes to the IPPS standardized amounts and capital Federal rates for FY 2009 in accordance with section 7 of Pub. L. 110–90. For purposes of the impact analysis, we also assume an additional 1.8 percent increase in case-mix between FY 2008 and FY 2009 because we believe the adoption of the MS–DRGs will result in case-mix growth due to documentation and coding changes that do not reflect real changes in patient severity of illness. The estimates of IPPS operating payments do not reflect any changes in hospital admissions or real case-mix intensity, which would also affect overall payment changes.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small government jurisdictions. Most hospitals and most other providers and suppliers are considered to be small entities, either by being nonprofit organizations or by meeting the Small Business Administration definition of a small business (having revenues of $31.5 million or less in any 1 year). (For details on the latest standards for heath care providers, we refer readers to page 33 of the Table of Small Business Size Standards at the Small Business Administration Web site at: *http://www.sba.gov/services/contractingopportunities/sizestandardstopics/tableofsize/index.html*.) For purposes of the RFA, all hospitals and other providers and suppliers are considered to be small entities. Individuals and States are not included in the definition of a small entity. We believe that this proposed rule would have a significant impact on small entities as explained in this Appendix. Because we acknowledge that many of the affected entities are small entities, the analysis discussed throughout the preamble of this proposed rule constitutes our initial regulatory flexibility analysis. Therefore, we are soliciting comments on our estimates and analysis of the impact of the proposed rule on those small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact

analysis for any proposed 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 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we now define a small rural hospital as a hospital that is located outside of an urban area and has fewer than 100 beds. Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent urban area. Thus, for purposes of the IPPS, we continue to classify these hospitals as urban hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately $130 million. This proposed rule will not mandate any requirements for State, local, or tribal governments, nor will it affect private sector costs.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. As stated above, this proposed rule 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 proposed rule is consistent with the regulatory philosophy and principles identified in Executive Order 12866, the RFA, and section 1102(b) of the Act. The proposed rule would 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 proposed changes in this proposed rule would 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 proposed changes would 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 proposed policy changes, as well as statutory changes effective for FY 2009, on various hospital groups. We estimate the effects of individual proposed policy changes by estimating payments per case while holding all other payment policies constant. We use the best data available, but, generally, we do not attempt to make adjustments for future changes in such variables as admissions, lengths of stay, or case-mix. However, in the FY 2008 IPPS final rule, we indicated that we believe that implementation of the MS–DRGs would lead to increases in case-mix that do not reflect actual increases in patients' severity of illness as a result of more comprehensive documentation and coding. As explained in section II.D. of the preamble of this proposed rule, the FY 2008 IPPS final rule with comment period established a documentation and coding adjustment of −1.2 percent for FY 2008, −1.8 percent for FY 2009, and −1.8 percent for FY 2010 to maintain budget neutrality for the transition to the MS DRGs. Subsequently, Congress enacted Pub. L. 110–90. Section 7 of Public L. 110–90 reduced the IPPS documentation and coding adjustment from −1.2 percent to −0.6 percent for FY 2008 and from −1.8 percent to −0.9 percent for FY 2009. Following enactment of Pub. L. 110–90, we revised the FY 2008 standardized amounts (as well as other affected payment factors and thresholds) to reflect the −0.6 percent FY 2008 documentation and coding adjustment. The proposed FY 2009 IPPS national standardized amount included in this proposed rule reflects the documentation and coding adjustment of −0.9 percent for FY 2009. While we have adopted the statutorily mandated documentation and coding adjustments for payment purposes, we continue to believe that an increase in case-mix of 1.8 percent between FY 2008 and FY 2009 is likely as a result of the adoption of the MS DRGs. The impacts shown below illustrate the impact of the FY 2009 IPPS changes on hospital operating payments, including the −0.9 percent FY 2009 documentation and coding adjustment to the IPPS national standardized amounts, both prior to and following the expected 1.8 percent growth in case-mix between FY 2008 and FY 2009. As we have done in the previous rules, we are soliciting 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 March 2008, there are 3,528 IPPS hospitals to be included in our analysis. This represents about 58 percent of all Medicare-participating hospitals. The majority of this impact analysis focuses on this set of hospitals. There are also approximately 1,311 CAHs. These small, limited service hospitals are paid on the basis of reasonable costs rather than under the IPPS. There are also 1,219 specialty hospitals and 2,291 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 are not included in this proposed rule. There is also a separate rule to update and make changes to the LTCH PPS for its current July 1 through June 30 rate year (RY). However, we have traditionally used the IPPS rule to update the LTCH patient classifications and relative weights because the LTCH PPS uses the same DRGs as the IPPS, resulting in the LTCH relative weights being reclassified and recalibrated according to the same schedule as the IPPS (that is, for each Federal fiscal year). The impacts of our policy changes on LTCHs, where applicable, are discussed below. (We note that, as discussed in section II.I. of the preamble of this proposed rule, in the RY 2009 LTCH PPS proposed rule 73 FR 5351 through 5352), we proposed to move the annual LTCH PPS RY update (currently effective July 1) to be effective October 1 through September 30 (the Federal fiscal year) each year beginning October 1, 2009. Under this proposal, RY 2009 would be extended 3 months, such that RY 2009 would be the 15-month period of July 1, 2008 through September 30, 2009.)

V. Effects on Excluded Hospitals and Hospital Units

As of March 2008, there were 1,219 hospitals excluded from the IPPS. Of these 1,219 hospitals, 314 IPFs, 78 children's hospitals, 11 cancer hospitals, and 19 RNHCIs are either being paid on a reasonable cost basis or have a portion of the PPS payment based on reasonable cost principles subject to the rate-of-increase ceiling under § 413.40. The remaining providers, 221 IRFs, 394 LTCHs, and 182 IPFs, are paid 100 percent of the Federal prospective rate under the IRF PPS and the LTCH PPS, respectively, or 100 percent of the Federal per diem amount under the IPF PPS. As stated above, IRFs and IPFs are not affected by this proposed rule. The impacts of the changes to LTCHs are discussed separately below. In addition, there are 1,319 IPFs co-located in hospitals otherwise subject to the IPPS, 788 of which are paid on a blend of the IPF PPS per diem payment and the reasonable cost-based payment. The remaining 531 IPF units are paid 100 percent of the Federal amount under the IPF PPS. There are 972 IRFs (paid under the IRF PPS) co-located in hospitals otherwise subject to the IPPS.

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 2009. For these hospitals

(cancer and children's hospitals), consistent with section 1886(b)(3)(B)(ii) of the Act, we are proposing an update that is the percentage increase in the FY 2009 IPPS operating market basket, which is estimated to be 3.0 percent, based on Global Insights, Inc.'s 2008 first 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 proposed update is the percentage increase in the FY 2009 IPPS operating market basket increase, which is estimated to be 3.0 percent, based on Global Insight, Inc.'s 2008 first quarter forecast of the IPPS operating market basket increase.

The final rule implementing the IPF PPS (69 FR 66922) established a 3-year transition to the IPF PPS during which some providers received a blend of the IPF PPS per diem payment and the TEFRA reasonable cost-based payment. This transitional period for a blended payment amount for IPFs ended for cost reporting periods that began on or after January 1, 2008. Because the reasonable cost-based amount is zero percent for cost reporting periods beginning during CY 2008, no IPF will have a portion of its PPS payment that is based in part on reasonable cost subject to the rate-of-increase ceiling during FY 2009. Thus, there is no longer a need for an update factor for IPFs' TEFRA target amount for FY 2009 and thereafter.

The impact on excluded hospitals and hospital units of the proposed 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 Proposed Policy Changes Under the IPPS for Operating Costs

A. Basis and Methodology of Estimates

In this proposed rule, we are announcing proposed 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 2009 operating payments will increase 4.1 percent compared to FY 2008, largely due to the statutorily mandated update to the IPPS rates. This amount also reflects the −0.9 percent FY 2009 documentation and coding adjustment to the IPPS national standardized amounts and our assumption of an additional 1.8 percent increase in case-mix between FY 2008 and FY 2009 as a result of improvements in documentation and coding that do not represent real increases in underlying resource demands and patient acuity due to the adoption of the MS–DRGs. The impacts do not illustrate changes in hospital admissions or real case-mix intensity, which will also affect overall payment changes.

We have prepared separate impact analyses of the changes to each system. This section deals with changes to the operating prospective payment system. Our payment simulation model relies on the most recent available data to enable us to estimate the impacts on payments per case of certain changes in this proposed rule. However, there are other changes for which we do not have data available that would allow us to estimate the payment impacts using this model. For those changes, we have attempted to predict the payment impacts based upon our experience and other more limited data.

The data used in developing the quantitative analyses of changes in payments per case presented below are taken from the FY 2007 MedPAR file and the most current Provider-Specific File that is used for payment purposes. Although the analyses of the changes to the operating PPS do not incorporate cost data, data from the most recently available hospital cost report were used to categorize hospitals. Our analysis has several qualifications. First, in this analysis, we do not make adjustments for future changes in such variables as admissions, lengths of stay, or underlying growth in real case-mix. Second, due to the interdependent nature of the IPPS payment components, it is very difficult to precisely quantify the impact associated with each change. Third, we use various sources for the data used to categorize hospitals in the tables. In some cases, particularly the number of beds, there is a fair degree of variation in the data from different sources. We have attempted to construct these variables with the best available source overall. However, for individual hospitals, some miscategorizations are possible.

Using cases from the FY 2007 MedPAR file, we simulated payments under the operating IPPS given various combinations of payment parameters. Any short-term, acute care hospitals not paid under the IPPS (Indian Health Service hospitals and hospitals in Maryland) were excluded from the simulations. The impact of payments under the capital IPPS, or the impact of payments for costs other than inpatient operating costs, are not analyzed in this section. Estimated payment impacts of FY 2009 changes to the capital IPPS are discussed in section VIII. of this Appendix.

The changes discussed separately below are the following:

- The effects of the annual reclassification of diagnoses and procedures, full implementation of the MS–DRG system and 100 percent cost-based DRG relative weights,
- The effects of the changes in hospitals' wage index values reflecting wage data from hospitals' cost reporting periods beginning during FY 2005, compared to the FY 2004 wage data.
- The effects of the recalibration of the DRG relative weights as required by section 1886(d)(4)(C) of the Act, including the wage and recalibration budget neutrality factors.
- The effects of geographic reclassifications by the MGCRB that will be effective in FY 2009.
- The effects of the proposal to apply the rural floor budget neutrality adjustment at the State level, redistributing payments within the State, rather than adjusting payments to hospitals in other States.
- The effects of the proposal to apply the imputed rural floor budget neutrality adjustment to the wage index at the State-level, rather than applying it to the standardized amount at the national level.
- 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 the proposed FY 2009 policies relative to payments based on FY 2008 policies.

To illustrate the impacts of the proposed FY 2009 changes, our analysis begins with a FY 2008 baseline simulation model using: the proposed FY 2009 update of 3.0 percent; the FY 2008 DRG GROUPER (Version 25.0); the most current CBSA designations for hospitals based on OMB's MSA definitions; the FY 2008 wage index; and no MGCRB reclassifications. Outlier payments are set at 5.1 percent of total operating DRG and outlier payments.

Section 1886(b)(3)(B)(viii) of the Act, as added by section 5001(a) of 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, 186 providers did not receive the full market basket rate-of-increase for FY 2008 because they failed the quality data submission process. For purposes of the simulations shown below, we modeled the proposed payment changes for FY 2009 using a reduced update for these 186 hospitals. However, we do not have enough information to determine which hospitals will not receive the full market basket rate-of-increase for FY 2009 at this time.

Each policy change, statutorily or otherwise, is then added incrementally to

this baseline, finally arriving at an FY 2009 model incorporating all of the proposed changes. This simulation allows us to isolate the effects of each proposed change.

Our final comparison illustrates the proposed percent change in payments per case from FY 2008 to FY 2009. Three factors not discussed separately have significant impacts here. The first is the update to the standardized amount. In accordance with section 1886(b)(3)(B)(i) of the Act, we are updating the standardized amounts for FY 2009 using the most recently forecasted hospital market basket increase for FY 2009 of 3.0 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 1.0 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 3.0 percent.

A second significant factor that affects the proposed changes in hospitals' payments per case from FY 2008 to FY 2009 is the change in a hospital's geographic reclassification status from one year to the next. That is, payments may be reduced for hospitals reclassified in FY 2008 that are no longer reclassified in FY 2009. Conversely, payments may increase for hospitals not reclassified in FY 2008 that are reclassified in FY 2009. 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 2008 will be 4.8 percent of total DRG payments. When the FY 2008 final rule was published, we projected FY 2008 outlier payments would be 5.1 percent of total DRG plus outlier payments; the average standardized amounts were offset correspondingly. The effects of the lower than expected outlier payments during FY 2009 (as discussed in the Addendum to this proposed rule) are reflected in the analyses below comparing our current estimates of FY 2008 payments per case to estimated FY 2009 payments per case (with outlier payments projected to equal 5.1 percent of total DRG payments).

B. Analysis of Table I

Table I displays the results of our analysis of the proposed changes for FY 2009. The table categorizes hospitals by various geographic and special payment consideration groups to illustrate the varying impacts on different types of hospitals. The top row of the table shows the overall impact on the 3,528 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 2,542 hospitals located in urban areas included in our analysis. Among these, there are 1,402 hospitals located in large urban areas (populations over 1 million), and 1,140 hospitals in other urban areas (populations of 1 million or fewer). In addition, there are 986 hospitals in rural areas. The next two groupings are by bed-size categories, shown separately for urban and rural hospitals. The final groupings by geographic location are by census divisions, also shown separately for urban and rural hospitals.

The second part of Table I shows hospital groups based on hospitals' FY 2009 payment classifications, including any reclassifications under section 1886(d)(10) of the Act. For example, the rows labeled urban, large urban, other urban, and rural show that the 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 2,584, 1,424, 1,160 and 944, respectively.

The next three groupings examine the impacts of the proposed 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 2,485 nonteaching hospitals in our analysis, 805 teaching hospitals with fewer than 100 residents, and 238 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 proposed changes on rural hospitals by special payment groups (SCHs, RRCs, and MDHs). There were 197 RRCs, 355 SCHs, 156 MDHs, 102 hospitals that are both SCHs and RRCs, and 12 hospitals that are both an MDH and an RRC.

The next series of groupings are based on the type of ownership and the hospital's Medicare utilization expressed as a percent of total patient days. These data were taken from the FY 2005 Medicare cost reports.

The next two groupings concern the geographic reclassification status of hospitals. The first grouping displays all urban hospitals that were reclassified by the MGCRB for FY 2009. The second grouping shows the MGCRB rural reclassifications. The final category shows the impact of the proposed policy changes on the 20 cardiac specialty hospitals in our analysis.

TABLE I.—IMPACT ANALYSIS OF PROPOSED CHANGES FOR FY 2009

	Number of hospitals [1]	Proposed FY 2009 cost based DRG Weights & MS–DRG changes [2]	Proposed FY 2009 wage data [3]	Proposed FY 2009 DRG, rel. wts. and wage index changes [4]	FY 2009 MGCRB Reclassifications [5]	Application of proposed rural floor and imputed rural floor, including proposed within state budget neutrality [6]	Proposed FY 2009 out-migration adjustment [7]	All proposed FY 2009 changes w/CMI adjustment prior to estimated CMI growth [8]	All proposed FY 2009 changes w/CMI adjustment and estimated CMI growth [9]
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
All Hospitals	3,528	0.1	−0.1	0	0	0	0	2.3	4.1
By Geographic Location:									
Urban hospitals	2,542	0.2	−0.1	0.1	−0.2	0	0	2.4	4.2
Large urban areas	1,402	0.5	−0.1	0.3	−0.4	−0.1	0	2.6	4.4
Other urban areas	1,140	0	0	−0.1	−0.1	0.1	0	2.2	3.9
Rural hospitals	986	−1	0	−1.1	2.1	−0.1	0.1	1.5	3.3
Bed Size (Urban):									
0–99 beds	643	−0.7	−0.1	−0.8	−0.4	0.1	0	1.6	3.4
100–199 beds	829	0.1	0	0	−0.1	0.1	0	2.2	4
200–299 beds	483	0.2	0	0.2	−0.2	−0.1	0	2.4	4.2
300–499 beds	411	0.3	0	0.3	−0.2	0	0	2.6	4.3
500 or more beds	176	0.5	−0.3	0.1	−0.3	0	0	2.5	4.3
Bed Size (Rural):									
0–49 beds	338	−2.3	0.1	−2.3	0.6	0	0.2	0.7	2.5
50–99 beds	373	−1.2	0	−1.3	1.1	−0.1	0.2	1.2	3
100–149 beds	166	−0.9	0.1	−0.8	2.5	0	0.1	1.5	3.3
150–199 beds	67	−0.6	−0.1	−0.8	3	−0.1	0	2	3.8

TABLE I.—IMPACT ANALYSIS OF PROPOSED CHANGES FOR FY 2009—Continued

	Number of hospitals [1]	Proposed FY 2009 cost based DRG Weights & MS–DRG changes [2]	Proposed FY 2009 wage data [3]	Proposed FY 2009 DRG, rel. wts. and wage index changes [4]	FY 2009 MGCRB Reclassifications [5]	Application of proposed rural floor and imputed rural floor, including proposed within state budget neutrality [6]	Proposed FY 2009 out-migration adjustment [7]	All proposed FY 2009 changes w/CMI adjustment prior to estimated CMI growth [8]	All proposed FY 2009 changes w/CMI adjustment and estimated CMI growth [9]
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
200 or more beds	42	−0.3	−0.1	−0.4	3.2	−0.1	0	2.1	3.9
Urban by Region:									
New England	121	0	0	−0.1	0.5	0.1	0	1.2	3
Middle Atlantic	348	0	−0.5	−0.5	0.1	0	0	1.2	3
South Atlantic	385	0.4	−0.3	0.1	−0.4	0	0	2.7	4.4
East North Central	394	0.5	−0.5	−0.1	−0.4	0	0	2.4	4.1
East South Central	163	−0.1	−0.2	−0.2	−0.2	0	0	2.4	4.2
West North Central	157	−0.1	0.2	0.1	−0.7	0	0	2.8	4.5
West South Central	371	0.4	0	0.3	−0.6	0	0	2.9	4.7
Mountain	157	0.3	0.1	0.5	−0.2	0	0	3.2	5
Pacific	393	0.4	0.9	1.2	−0.2	0	0	3.4	5.2
Puerto Rico	53	−0.2	−0.7	−0.9	−0.7	0	0	1.4	3.2
Rural by Region:									
New England	23	−0.8	−0.4	−1.3	2.4	−0.9	0	0.6	2.3
Middle Atlantic	70	−0.9	−0.1	−1.1	2	0	0.1	1.3	3.1
South Atlantic	172	−0.6	−0.1	−0.7	2.2	0	0.1	1.9	3.7
East North Central	121	−0.9	−0.3	−1.3	1.6	0	0.1	1.4	3.2
East South Central	176	−1.3	−0.1	−1.4	2.7	0	0.1	1.6	3.4
West North Central	113	−0.9	0.1	−0.8	1.7	0	0.1	1.6	3.4
West South Central	200	−1.7	0.5	−1.3	2.5	0	0.1	1.3	3.1
Mountain	75	−0.9	0	−1	0.5	0	0.1	1.2	3.1
Pacific	36	−0.7	0.6	−0.2	1.8	−0.3	0	1.8	3.6
By Payment Classification:									
Urban hospitals	2,584	0.2	−0.1	0.1	−0.2	0	0	2.4	4.2
Large urban areas	1,424	0.4	−0.1	0.3	−0.4	−0.1	0	2.6	4.4
Other urban areas	1,160	0	0	−0.1	0	0.1	0	2.2	3.9
Rural areas	944	−1	0	−1.1	2	−0.1	0.1	1.5	3.3
Teaching Status:									
Nonteaching	2,485	−0.2	0	−0.2	0.3	0	0	2.2	4
Fewer than 100 residents	805	0.2	0	0.1	−0.2	0	0	2.4	4.2
100 or more residents	238	0.5	−0.3	0.2	−0.3	0	0	2.5	4.2
Urban DSH:									
Non-DSH	838	−0.3	−0.2	−0.4	−0.1	0	0	1.8	3.6
100 or more beds	1,534	0.4	−0.1	0.3	−0.3	0	0	2.6	4.3
Less than 100 beds	354	−0.7	0	−0.8	0	0	0	1.6	3.4
Rural DSH:									
SCH	389	−1.5	0	−1.5	0.4	0	0.1	1.5	3.3
RRC	206	−0.6	0	−0.6	3.4	−0.1	0	1.9	3.7
100 or more beds	39	−0.8	0	−0.9	1.3	0	0.4	1.3	3.1
Less than 100 beds	168	−1.7	0	−1.8	1.3	0	0.3	0.6	2.4
Urban teaching and DSH:									
Both teaching and DSH	811	0.4	−0.1	0.3	−0.4	0	0	2.5	4.3
Teaching and no DSH	172	−0.1	−0.2	−0.3	0	0	0	1.8	3.6
No teaching and DSH	1,077	0.2	0	0.2	0	0.1	0	2.5	4.3
No teaching and no DSH	524	−0.2	−0.2	−0.4	−0.3	0	0	1.9	3.7
Special Hospital Types:									
RRC	197	−0.4	−0.1	−0.4	3.2	0	0	2.3	4.1
SCH	355	−1.3	0.1	−1.3	0.4	0	0.1	1.2	3
MDH	156	−1.8	0.1	−1.8	0.5	0	0.2	2	3.8
SCH and RRC	102	−0.5	0.1	−0.5	1.7	0	0	2.2	4.1
MDH and RRC	12	−1.3	0.1	−1.3	0.9	−0.3	0	1	2.8
Type of Ownership:									
Voluntary	2,027	0.1	−0.1	0	0	0	0	2.3	4
Proprietary	827	0	0	−0.1	0	−0.1	0	2.4	4.1
Government	587	0.1	−0.1	0	0.1	0.1	0	2.6	4.4
Medicare Utilization as a Percent of Inpatient Days:									
0–25	255	0.8	−0.1	0.7	−0.4	−0.2	0	3.2	4.9
25–50	1,350	0.3	0	0.3	−0.3	0	0	2.7	4.4
50–65	1,431	−0.1	−0.2	−0.3	0.4	0.1	0	1.9	3.7
Over 65	392	−0.8	−0.2	−1	0.5	0	0.1	1.2	3
FY 2009 Reclassifications by the Medicare Geographic Classification Review Board:									
All Reclassified Hospitals	805	0	0	0	2	−0.1	0	2.1	3.8
Non-Reclassified Hospitals	2,723	0.2	−0.1	0	−0.7	0	0	2.4	4.2
Urban Hospitals Reclassified	445	0.2	0	0.2	1.5	−0.2	0	2.1	3.9
Urban Nonreclassified, FY 2009	2,075	0.3	−0.1	0.1	−0.7	0.1	0	2.5	4.3
All Rural Hospitals Reclassified Full Year FY 2009	360	−0.7	0	−0.7	3.3	−0	0	1.8	3.7
Rural Nonreclassified Hospitals Full Year FY 2009	565	−1.5	−0	−1.6	−0.4	−0.1	0.3	1	2.8

TABLE I.—IMPACT ANALYSIS OF PROPOSED CHANGES FOR FY 2009—Continued

	Number of hospitals [1]	Proposed FY 2009 cost based DRG Weights & MS–DRG changes [2]	Proposed FY 2009 wage data [3]	Proposed FY 2009 DRG, rel. wts. and wage index changes [4]	FY 2009 MGCRB Reclassifications [5]	Application of proposed rural floor and imputed rural floor, including proposed within state budget neutrality [6]	Proposed FY 2009 out-migration adjustment [7]	All proposed FY 2009 changes w/CMI adjustment prior to estimated CMI growth [8]	All proposed FY 2009 changes w/CMI adjustment and estimated CMI growth [9]
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
All Section 401 Reclassified Hospitals	29	−1.3	−0.2	−1.6	0.6	0	0	1.6	3.5
Other Reclassified Hospitals (Section 1886(d)(8)(B))	61	−1	−0.2	−1.3	3.2	−0.2	0.1	1	2.8
Specialty Hospitals									
Cardiac specialty Hospitals	20	−2.2	−0.1	−2.4	−0.7	0.1	0	0	1.8

[1] Because data necessary to classify some hospitals by category were missing, the total number of hospitals in each category may not equal the national total. Discharge data are from FY 2007, and hospital cost report data are from reporting periods beginning in FY 2006 and FY 2005.

[2] This column displays the payment impact of the changes to the V26 GROUPER and the recalibration of the DRG weights based on FY 2007 MedPAR data in accordance with section 1886(d)(4)(C)(iii) of the Act.

[3] This column displays the payment impact of updating the wage index data to the FY 2005 cost report data.

[4] This column displays the combined payment impact of the changes in column 2 and column 3 and the budget neutrality factors for DRG and wage index changes in accordance with section 1886(d)(4)(C)(iii) of the Act and section 1886(d)(3)(E) of the Act.

[5] Shown here are the effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB). The effects demonstrate the FY 2009 payment impact of going from no reclassifications to the reclassifications scheduled to be in effect for FY 2008. Reclassification for prior years has no bearing on the payment impacts shown here. This column reflects the geographic budget neutrality factor of 0.992333.

[6] This column displays the effects of the rural floor and the imputed rural floor, including the proposal to apply the budget neutrality adjustment within State.

[7] 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.

[8] This column shows changes in payments from FY 2008 to FY 2009, including the proposed FY 2009 −0.9 percent documentation and coding adjustment, but not the projected 1.8 percent increase in case-mix expected to occur in FY 2009 due to improvements in documentation and coding. It incorporates all of the changes displayed in Columns 4, 5, 6, 7 (the changes displayed in Columns 2 and 3 are included in Column 4). It also reflects the impact of the FY 2009 update, and changes in hospitals' reclassification status in FY 2009 compared to FY 2008.

[9] This column shows changes in payments from FY 2008 to FY 2009 including the proposed FY 2009 −0.9 percent documentation and coding adjustment and the projected 1.8 percent increase in case-mix expected to occur in FY 2009 due to improvements in documentation and coding. It incorporates all of the changes displayed in Columns 4, 5, 6, 7, 8 (the changes displayed in Columns 2 and 3 are included in Column 4). It also reflects the impact of the FY 2008 update, and changes in hospitals' reclassification status in FY 2009 compared to FY 2008. The sum of these impacts may be different from the percentage changes shown here due to rounding and interactive effects.

C. Effects of the Proposed Changes to the MS–DRG Reclassifications and Relative Cost-Based Weights (Column 2)

In Column 2 of Table I, we present the effects of the DRG reclassifications, as discussed in section II. of the preamble to this proposed rule. Section 1886(d)(4)(C)(i) of the Act requires us annually to make appropriate classification changes in order to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources.

As discussed in the preamble of this proposed rule, the FY2009 DRG relative weights will be 100 percent cost-based and 100 percent MS–DRGs, thus completing our three year transition to cost-based relative weights and our two year transition to MS–DRGs. For FY 2009, the MS–DRGs are calculated using the FY2007 MedPAR data grouped to the Version 26.0 (FY2009) DRGs. The proposed 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 proposed rule. In previous years, this column would also reflect the effects of the recalibration budget neutrality factor that is applied to the hospital-specific rates and the Puerto Rico-specific standardized amount. However, for this proposed rule, we show the effects of the recalibration budget neutrality factor of 0.998700 in column 4. We note that, consistent with section 1886(d)(4)(C)(iii) of the Act, we are applying a budget neutrality factor to the national standardized amounts to ensure that the overall payment impact of the DRG changes (combined with the wage index changes) is budget neutral. This proposed wage and recalibration budget neutrality factor of 0.99525 is applied to payments in Column 4 and not Column 2.

The proposed 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 proposed changes in this column will increase payments by 0.1 percent. However, as stated earlier, the proposed changes shown in this column are combined with revisions to the wage index, and the budget neutrality adjustments made for these changes are shown in column 4. Thus, the impact after accounting only for budget neutrality for proposed changes to the DRG relative weights and classification is somewhat lower than the figures shown in this column (approximately 0.1 percent).

D. Effects of Proposed Wage Index Changes (Column 3)

Section 1886(d)(3)(E) of the Act requires that, beginning October 1, 1993, we annually update the wage data used to calculate the wage index. In accordance with this requirement, the wage index for FY 2009 is based on data submitted for hospital cost reporting periods beginning on or after October 1, 2004 and before October 1, 2005. The estimated impact of the proposed wage data on hospital payments is isolated in Column 3 by holding the other payment parameters constant in this simulation. That is, Column 3 shows the percentage changes in payments when going from a model using the FY 2008 wage index, based on FY 2004 wage data and having a 100-percent occupational mix adjustment applied, to a model using the FY 2009 pre-reclassification wage index, also having a 100-percent occupational mix adjustment applied, based on FY 2005 wage data (while holding other payment parameters such as use of the version 26.0 DRG grouper constant). The wage data collected on the FY 2005 cost report include overhead costs for contract labor that were not collected on FY 2004 and earlier cost reports. The impacts below incorporate the effects of the FY 2005 wage data collected on hospital cost reports, including additional overhead costs for contract labor compared to the wage data from FY 2004 cost reports that were used to calculate the FY 2008 wage index.

Column 3 shows the impacts of updating the wage data using FY 2004 cost reports. Overall, the new wage data will lead to a −0.1 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 urban Pacific region, which experiences a 0.9 percent increase before applying an adjustment for budget neutrality. The largest decline from updating the wage data is seen in Puerto Rico (0.7 percent decrease).

In looking at the wage data itself, the national average hourly wage increased 4.2 percent compared to FY 2008. Therefore, the only manner in which to maintain or exceed

the previous year's wage index was to match or exceed the national 4.2 percent increase in average hourly wage. Of the 3,457 hospitals with wage data for both FYs 2008 and 2009, 1,707, or 49.4 percent, experienced an average hourly wage increase of 4.2 percent or more.

The following chart compares the shifts in wage index values for hospitals for FY 2009 relative to FY 2008. Among urban hospitals, 32 will experience an increase of more than 5 percent and less than 10 percent and 5 will experience an increase of more than 10 percent. Among rural hospitals, none will experience an increase of more than 5 percent and less than 10 percent, and none will experience an increase of more than 10 percent. However, 972 rural hospitals will experience increases or decreases of less than 5 percent, while 2,420 urban hospitals will experience increases or decreases of less than 5 percent. Eighteen urban hospitals will experience decreases in their wage index values of more than 5 percent and less than 10 percent. Ten urban hospitals will experience decreases in their wage index values of greater than 10 percent. No rural hospitals will experience decreases of more than 5 percent. These figures reflect changes in the wage index which is an adjustment to either 69.7 percent or 62 percent of a hospital's standardized amount depending upon whether its wage index is greater than 1.0 or less than or equal to 1.0. Therefore, these figures are illustrating a somewhat larger change in the wage index than would occur to the hospital's total payment.

The following chart shows the projected impact for urban and rural hospitals.

Percentage change in area wage index values	Number of hospitals	
	Urban	Rural
Increase more than 10 percent	5	0
Increase more than 5 percent and less than 10 percent	32	0
Increase or decrease less than 5 percent	2,420	972
Decrease more than 5 percent and less than 10 percent	18	0
Decrease more than 10 percent	10	0

E. Combined Effects of Proposed MS–DRG and Wage Index Changes (Column 4)

Section 1886(d)(4)(C)(iii) of the Act requires that changes to MS–DRG reclassifications and the relative weights cannot increase or decrease aggregate payments. In addition, section 1886(d)(3)(E) of the Act specifies that any updates or adjustments to the wage index are to be budget neutral. As noted in the Addendum to this proposed rule, in determining the budget neutrality factor, we equated simulated aggregate payments for FY 2008 and FY 2009 using the FY 2007 Medicare utilization data after applying the changes to the DRG relative weights and the wage index.

We computed a wage and MS–DRG recalibration budget neutrality factor of 0.999525 (which is applied to the national standardized amounts) and a recalibration budget neutrality factor 0.998700 (which is applied to the hospital-specific rates and the Puerto Rico-specific standardized amount). The 0.0 percent impact for all hospitals demonstrates that the proposed MS–DRG and wage changes, in combination with the budget neutrality factor, are budget neutral. In Table I, the combined overall impacts of the effects of both the MS–DRG reclassifications and the updated wage index are shown in Column 4. The estimated changes shown in this column reflect the combined effects of the changes in Columns 2 and 3 and the budget neutrality factors discussed previously.

We estimate that the combined impact of the proposed changes to the relative weights and DRGs and the updated wage data with budget neutrality applied will increase payments to hospitals located in large urban areas (populations over 1 million) by approximately 0.3. These proposed changes would generally increase payments to hospitals in all urban areas (0.1 percent) and large teaching hospitals (0.2 percent). Rural hospitals will generally experience a decrease in payments (−1.1 percent). Among the rural hospital categories, rural hospitals with less than 50 beds will experience the greatest decline in payment (−2.3 percent) primarily due to the changes to MS–DRGs and the relative cost weights.

F. Effects of MGCRB Reclassifications (Column 5)

Our impact analysis to this point has assumed hospitals are paid on the basis of their actual geographic location (with the exception of ongoing policies that provide that certain hospitals receive payments on other bases than where they are geographically located). The proposed changes in Column 5 reflect the per case payment impact of moving from this baseline to a simulation incorporating the MGCRB decisions for FY 2009 which affect hospitals' wage index area assignments.

By 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 2009 geographic reclassifications.

The overall effect of geographic reclassification is required by section 1886(d)(8)(D) of the Act to be budget neutral. Therefore, we are proposing to apply an adjustment of 0.992333 to ensure that the effects of the section 1886(d)(10) reclassifications are budget neutral. (See section II.A. of the Addendum to this proposed rule.) Geographic reclassification generally benefits hospitals in rural areas. We estimate that geographic reclassification will increase payments to rural hospitals by an average of 2.1 percent.

G. Effects of the Proposed Rural Floor and Imputed Rural Floor, Including the Proposed Application of Budget Neutrality at the State Level (Column 6)

As discussed in section III.B. of the preamble of this FY 2009 proposed rule, 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. In FY 2008, we changed how we applied budget neutrality to the rural floor. Rather than applying a budget neutrality adjustment to the standardized amount, a uniform budget neutrality adjustment is applied to the wage index. For FY 2009, we are proposing to apply the rural floor budget neutrality adjustment at the State level, which would redistribute payments within the State rather than across all other providers within the Nation.

Furthermore, 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 the FY 2008 IPPS final rule with comment period (72 FR 47321), we finalized our rule to extend the imputed rural floor for 1 additional year. In this proposed rule, we are proposing to extend the imputed rural floor for an additional 3 years through FY 2011. Furthermore, consistent with our proposal to apply the rural floor budget neutrality adjustment at the State level, we are proposing to apply the imputed rural floor budget neutrality adjustment to the wage index at the State level.

Column 6 shows the projected impact of the rural floor and the imputed rural floor, including the proposed application of the budget neutrality adjustment at the State level. The column compares the post-reclassification FY 2009 wage index of providers before the rural floor adjustment and the post-reclassification FY 2009 wage index of providers with the rural floor and

imputed rural floor adjustment. Only urban hospitals can benefit from the rural floor provision. Because the provision is budget neutral, in prior years, all other hospitals (that is, all rural hospitals and those urban hospitals to which the adjustment is not made) had experienced a decrease in payments due to the budget neutrality adjustment applied nationally. However, under this proposal, States that have no hospitals receiving a rural floor wage index would no longer have a negative budget neutrality adjustment applied to their wage indices. Conversely, all hospitals in States with hospitals receiving a rural floor would have their wage indices downwardly adjusted to achieve budget neutrality within the State.

We project that, in aggregate, rural hospitals will experience a 0.1 percent decrease in payments. We project hospitals located in other urban areas (populations of 1 million or fewer) will experience a 0.1 percent increase in payments because the rural floor adjustment applies to urban hospitals. Rural New England hospitals can expect the greatest decrease in payment by 0.9 percent because hospitals in Vermont will receive a rural floor budget neutrality adjustment of 0.901 or a reduction of approximately 10 percent, and hospitals in Connecticut will receive a rural floor budget neutrality adjustment of 0.9639 or a reduction of approximately 4 percent. New Jersey, which is the only State that benefits from the imputed rural floor, is expected to receive a rural floor budget neutrality adjustment of 0.987838 or a reduction of approximately 1.2 percent.

The table that appears in section III B.2.b. of the preamble of this proposed rule shows how payments would change, at the State level, if we moved from our current policy of applying rural floor budget neutrality at the national level to our proposed policy to apply the rural floor budget neutrality within the State. The table shows that, under our current policy of applying budget neutrality at the national level, States that do not have any hospitals receiving the rural floor wage index would expect a decrease in payments because, in order to maintain budget neutrality nationally, these hospitals have to pay for the hospitals in other States that do receive a rural floor. For example, States such as Arizona, New York, and Rhode Island, which do not have hospitals receiving a rural floor, would expect to lose 0.2 percent in payments under a national rural floor budget neutrality adjustment. However, under our proposed policy to apply rural floor budget neutrality within each State, States that do not have hospitals receiving a floor would see an increase in payments (compared with our current policy of applying budget neutrality at the national level) because they would no longer have their wage indexes adjusted to maintain budget neutrality. However, all hospitals in States with hospitals receiving a rural floor would expect a decrease in their payments in order to achieve budget neutrality within their States (that is, the wage indices for hospitals in that State would be decreased in order to make the additional payments to hospitals in that State receiving the rural floor). Therefore, compared with our current policy of applying budget neutrality at the national level, States such as Arizona, New York, and Rhode Island could expect payment increases of 0.3 percent under a rural floor budget neutrality applied at the State level, while States such as California and Connecticut, which have several hospitals that benefit from the rural floor, could expect decreases in payments by 0.8 percent and 2.2 percent, respectively.

H. Effects of the Proposed Wage Index Adjustment for Out-Migration (Column 7)

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 2009 relative to no adjustment at all. We included these additional payments to providers in the impact table shown above, and we estimate the impact of these providers receiving the out-migration increase to be approximately $20 million.

I. Effects of All Proposed Changes With CMI Adjustment Prior to Estimated Growth (Column 8)

Column 8 compares our estimate of payments per case between FY 2008 and FY 2009 with all changes reflected in this proposed rule for FY 2009, including a −0.9 percent documentation and coding adjustment to the FY 2009 national standardized amounts to account for anticipated improvements in documentation and coding that are expected to increase case-mix. We generally apply an adjustment to the DRGs to ensure budget neutrality assuming constant utilization. However, in the FY 2008 IPPS final rule with comment period, we indicated that we believe that the adoption of MS–DRGs would lead to increases in case-mix as a result of improved documentation and coding. In the FY 2008 IPPS final rule with comment period, we had finalized a policy to apply a documentation and coding adjustment to the standardized amount of −1.2 percent for FY 2008, −1.8 percent for FY 2009, and −1.8 percent for FY 2010 to offset the expected increase in case-mix and achieve budget neutrality. However, in compliance with section 7 of Pub. L. 110–90, we reduced the documentation and coding adjustment to −0.6 percent for FY 2008. In accordance with section 7 of Pub. L. 110–90, for FY 2009, we are applying a documentation and coding adjustment of −0.9 percent to the FY 2009 national standardized amounts (in addition to the −0.6 percent adjustment made for FY 2008). We are not proposing to apply the documentation and coding adjustment to the FY 2009 hospital-specific rates and the FY 2009 Puerto Rico-specific standardized amount. However, we continue to believe that case-mix growth of an additional 1.8 percent compared to FY 2008 is likely to occur across all hospitals as a result of improvements in documentation and coding.

Column 8 illustrates the total payment change for FY 2009 compared to FY 2008, taking into account the −0.9 percent FY 2009 documentation and coding adjustment but not the projected 1.8 percent case-mix increase itself. Therefore, this column illustrates a total payment change that is less than what is anticipated to occur.

J. Effects of All Proposed Changes With CMI Adjustment and Estimated Growth (Column 9)

Column 9 compares our estimate of payments per case between FY 2008 and FY 2009, incorporating all changes reflected in this proposed rule for FY 2009 (including statutory changes). This column includes the FY 2009 documentation and coding adjustment of −0.9 percent and the projected 1.8 percent increase in case-mix from improved documentation and coding (with the 1.8 percent case-mix increase assumed to occur equally across all hospitals).

Column 9 reflects the impact of all FY 2009 changes relative to FY 2008, including those shown in Columns 2 through 7. The average increase for all hospitals is approximately 4.1 percent. This increase includes the effects of the 3.0 percent market basket update. It also reflects the 0.3 percentage point difference between the projected outlier payments in FY 2008 (5.1 percent of total DRG payments) and the current estimate of the percentage of actual outlier payments in FY 2008 (4.8 percent), as described in the introduction to this Appendix and the Addendum to this proposed rule. As a result, payments are projected to be 0.3 percentage points lower in FY 2008 than originally estimated, resulting in a 0.3 percentage point greater increase for FY 2009 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. There might also be interactive effects among the various factors comprising the payment system that we are not able to isolate. For these reasons, the values in Column 9 may not equal the product of the percentage changes described above.

The overall change in payments per case for hospitals in FY 2009 is proposed to increase by 4.1 percent. Hospitals in urban areas will experience an estimated 4.2 percent increase in payments per case compared to FY 2008. Hospitals in large urban areas will experience an estimated 4.4 percent increase and hospitals in other urban areas will experience an estimated 3.9 percent increase in payments per case in FY 2008. Hospital payments per case in rural areas are estimated to increase 3.3 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 and wage data) and 5.0 percent in the Mountain region (mostly due to MS–DRGs). The smallest urban increase is estimated at 3.0 percent in the Middle Atlantic and New England regions.

Among the rural regions in Column 9, the providers in the New England region experience the smallest increase in payments (2.3 percent) primarily due to the State-specific rural floor budget neutrality adjustment. The South Atlantic and Pacific regions will have the highest increases among rural regions, with 3.7 percent and 3.6 percent estimated increases, respectively. Again, increases in rural areas are generally less than the national average due to the adoption of MS–DRGs.

Among special categories of rural hospitals in Column 9, the SCH and RRC providers will receive an estimated increase in payments of 4.1 percent, and the MDH and RRCs will experience an estimated increase in payments by 2.8 percent.

Urban hospitals reclassified for FY 2009 are anticipated to receive an increase of 3.9 percent, while urban hospitals that are not reclassified for FY 2009 are expected to receive an increase of 4.3 percent. Rural hospitals reclassifying for FY 2009 are anticipated to receive a 3.7 percent payment increase and rural hospitals that are not reclassifying are estimated to receive a payment increase of 2.8 percent.

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

For FY 2009, we are continuing to apply the volume adjustment criteria we specified in the FY 2005 IPPS final rule (69 FR 49099). We expect that three providers will receive the low-volume adjustment for FY 2009. We estimate the impact of these providers receiving the additional 25-percent payment increase to be approximately $2,300.

L. Impact Analysis of Table II

Table II presents the projected impact of the proposed changes for FY 2009 for urban and rural hospitals and for the different categories of hospitals shown in Table I. It compares the estimated payments per case for FY 2008 with the proposed average estimated payments per case for FY 2009, as calculated under our models. Thus, this table presents, in terms of the average dollar amounts paid per discharge, the combined effects of the proposed changes presented in Table I. The proposed percentage changes shown in the last column of Table II equal the proposed percentage changes in average payments from Column 9 of Table I.

TABLE II.—IMPACT ANALYSIS OF PROPOSED CHANGES FOR FY 2009 OPERATING PROSPECTIVE PAYMENT SYSTEM

[Payments per case]

	Number of hospitals	Average FY 2008 payment per case [1]	Average proposed FY 2009 payment per case [1]	All proposed FY 2009 changes
	(1)	(2)	(3)	(4)
All hospitals	3,528	$9,144	$9,519	4.1
By Geographic Location:				
Urban hospitals	2,542	9,571	9,972	4.2
Large urban areas (populations over 1 million)	1,402	10,045	10,484	4.4
Other urban areas (populations of 1 million or fewer)	1,140	9,000	9,355	3.9
Rural hospitals	986	6,683	6,905	3.3
Bed Size (Urban):				
0–99 beds	643	7,283	7,533	3.4
100–199 beds	829	8,103	8,428	4
200–299 beds	483	8,985	9,363	4.2
300–499 beds	411	10,046	10,482	4.3
500 or more beds	176	11,875	12,382	4.3
Bed Size (Rural):				
0–49 beds	338	5,509	5,644	2.5
50–99 beds	373	6,097	6,279	3
100–149 beds	166	6,660	6,884	3.4
150–199 beds	67	7,467	7,752	3.8
200 or more beds	42	8,361	8,686	3.9
Urban by Region:				
New England	121	9,935	10,230	3
Middle Atlantic	348	10,440	10,752	3
South Atlantic	385	9,025	9,427	4.5
East North Central	394	9,065	9,440	4.1
East South Central	163	8,681	9,044	4.2
West North Central	157	9,140	9,555	4.5
West South Central	371	9,043	9,466	4.7
Mountain	157	9,571	10,051	5
Pacific	393	11,614	12,219	5.2
Puerto Rico	53	4,706	4,857	3.2
Rural by Region:				
New England	23	9,051	9,263	2.3
Middle Atlantic	70	6,912	7,124	3.1
South Atlantic	172	6,529	6,773	3.7
East North Central	121	6,872	7,093	3.2
East South Central	176	6,263	6,474	3.4
West North Central	113	6,886	7,119	3.4
West South Central	200	6,088	6,276	3.1
Mountain	75	6,802	7,010	3.1
Pacific	36	8,162	8,455	3.6
By Payment Classification:				
Urban hospitals	2,584	9,549	9,948	4.2
Large urban areas (populations over 1 million)	1,424	10,026	10,464	4.4
Other urban areas (populations of 1 million or fewer)	1,160	8,975	9,328	3.9

TABLE II.—IMPACT ANALYSIS OF PROPOSED CHANGES FOR FY 2009 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Payments per case]

	Number of hospitals	Average FY 2008 payment per case [1]	Average proposed FY 2009 payment per case [1]	All proposed FY 2009 changes
	(1)	(2)	(3)	(4)
Rural areas	944	6,716	6,941	3.3
Teaching Status:				
Non-teaching	2,485	7,716	8,023	4
Fewer than 100 Residents	805	9,193	9,577	4.2
100 or more Residents	238	13,392	13,951	4.2
Urban DSH:				
Non-DSH	838	8,118	8,409	3.6
100 or more beds	1,534	10,062	10,498	4.3
Less than 100 beds	354	6,792	7,022	3.4
Rural DSH:				
SCH	389	6,093	6,293	3.3
RRC	206	7,465	7,740	3.7
100 or more beds	39	6,110	6,299	3.1
Less than 100 beds	168	5,451	5,580	2.4
Urban teaching and DSH:				
Both teaching and DSH	811	10,986	11,457	4.3
Teaching and no DSH	172	8,885	9,201	3.6
No teaching and DSH	1,077	8,283	8,644	4.4
No teaching and no DSH	524	7,796	8,083	3.7
Rural Hospital Types:				
RRC	197	7,783	8,100	4.1
SCH	355	6,564	6,764	3
MDH	156	5,757	5,975	3.8
SCH and RRC	102	7,901	8,223	4.1
MDH and RRC	12	7,303	7,510	2.8
Type of Ownership:				
Voluntary	2,027	9,252	9,625	4
Proprietary	827	8,424	8,772	4.1
Government	587	9,440	9,853	4.4
Medicare Utilization as a Percent of Inpatient Days:				
0–25	255	13,112	13,751	4.9
25–50	1,350	10,344	10,801	4.4
50–65	1,431	7,950	8,245	3.7
Over 65	392	7,033	7,245	3
Hospitals Reclassified by the Medicare Geographic Classification Review Board: FY 2009 Reclassifications:				
All Reclassified Hospitals FY 2009	805	8,803	9,141	3.8
All Non-Reclassified Hospitals FY 2009	2,723	9,264	9,651	4.2
Urban Reclassified Hospitals FY 2009:	445	9,547	9,921	3.9
Urban Non-reclassified Hospitals FY 2009:	2,075	9,586	9,994	4.3
Rural Reclassified Hospitals FY 2009:	360	7,240	7,505	3.7
Rural Nonreclassified Hospitals FY 2009:	565	5,870	6,033	2.8
All Section 401 Reclassified Hospitals:	29	7,555	7,816	3.5
Other Reclassified Hospitals (Section 1886(d)(8)(B))	61	6,534	6,716	2.8
Specialty Hospitals:				
Cardiac Specialty Hospitals	20	10,894	11,085	1.8

[1] These payment amounts per case do not reflect any estimates of annual case-mix increase.

VII. Effects of Other Proposed Policy Changes

In addition to those policy changes discussed above that we are able to model using our IPPS payment simulation model, we are proposing to make various other changes in this proposed rule. Generally, we have limited or no specific data available with which to estimate the impacts of these proposed changes. Our estimates of the likely impacts associated with these other proposed changes are discussed below.

A. Effects of Proposed Policy on HACs, Including Infections

In section II.F. of the preamble of this proposed rule, we discuss our implementation of section 5001(c) of Pub. L. 109–171, which requires the Secretary to identify conditions that (1) are high cost, high volume, or both, (2) result in the assignment of a case to a MS–DRG that has a higher payment when present as a secondary diagnosis, and (3) could reasonably have been prevented through application of evidence-based guidelines. For discharges occurring on or after October 1, 2008, hospitals will not receive additional payment for cases in which one of the selected conditions was not present on admission. 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 MS–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 one or more of the selected conditions are the only secondary diagnosis or diagnoses present on the claim that will lead to higher payment. Therefore, if at least one 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. Medicare beneficiaries will generally have multiple secondary diagnoses during a hospital stay, such that beneficiaries having one MCC or CC will frequently have additional conditions that also will generate higher payment. Therefore, in only a small percentage of the cases will the beneficiary have only one secondary diagnosis that would lead to higher payment.

The section 5001(c) payment provision will go into effect on October 1, 2008. Our savings estimate for the next 5 fiscal years from this provision has changed from our savings estimate published in the FY 2008 IPPS final rule with comment period because of the potential addition to the list of selected HACs for FY 2009 of the nine conditions considered in section II.F. of this proposed rule. We had estimated a savings of $20 million per year from this provision for the eight conditions we originally selected in the FY 2008 IPPS final rule with comment period (72 FR 48168). We now estimate that this provision will save $50 million per year for the first 3 years beginning October 1, 2008. Beginning in FY 2012, we estimate a savings of $60 million per year as a result of this provision. Our savings estimates for the next 5 fiscal years are shown below:

Year	Savings (in millions)
FY 2009	$50
FY 2010	50
FY 2011	50
FY 2012	60
FY 2013	60

B. Effects of Proposed MS–LTC–DRG Reclassifications and Relative Weights for LTCHs

In section II.I. of the preamble to this proposed rule, we discuss the proposed MS–LTC–DRGs (proposed Version 26.0 of the GROUPER) and development of the proposed relative weights for use under the LTCH PPS for FY 2009. We also discuss that when we adopted the new severity adjusted MS–LTC–DRG patient classification system under the LTCH PPS in the FY 2008 IPPS final rule with comment, we implemented a 2-year transition, in which the MS–LTC–DRG relative weights for FY 2009 would be based completely on the MS–LTC–DRG patient classification system (and no longer based in part on the former LTC–DRG patient classification system). Consistent with the requirement at § 412.517 established in the RY 2008 LTCH PPS final rule (72 FR 26880 through 26884), the proposed annual update to the classification and relative weights under the LTCH PPS for RY 2009 was done in a budget neutral manner, such that estimated aggregate LTCH PPS payments would be unaffected; that is, they would be neither greater than nor less than the estimated aggregate LTCH PPS payments that would have been made without the MS–LTC–DRG classification and relative weight changes. To achieve budget neutrality under § 412.517, in determining the proposed FY 2009 MS–LTC–DRG relative weights, we applied a factor of 1.038266 in the first step of the budget neutrality process (normalization), and we applied a budget neutrality factor of 0.9965 after normalization (see section II.I.4. (step 7) of the preamble of this proposed rule). These proposed factors that were applied to maintain budget neutrality were based on the most recent available LTCH claims data (FY 2007 MedPAR files) for the 387 LTCHs in our database. Consistent with the budget neutrality requirement under § 412.517, we estimate that with the proposed changes to the MS–LTC–DRG classifications and relative weights for FY 2009, there would be no change in aggregate LTCH PPS payments. In applying the budget neutrality adjustment described above, we assumed constant utilization.

C. Effects of Proposed Policy Change Relating to New Medical Service and Technology Add-On Payments

In section II.J. of the preamble to this proposed rule, we discuss proposed add-on payments for new medical services and technologies. As explained in that section, add-on payments for new technology under section 1886(d)(5)(K) of the Act are not required to be budget neutral. As discussed in section II.J.4. of this proposed rule, we have yet to determine whether any of the four applications we received will meet the criteria for new technology add-on payments for FY 2009. Consequently, it is premature to estimate the potential payment impact in FY 2009 of any potential new technology add-on payments for FY 2009. There are no technologies receiving new technology add-on payment in FY 2008. Therefore, at this time, we estimate that Medicare's new technology add-on payments would remain unchanged in FY 2009 compared to FY 2008. If any of the four applicants are found to be eligible for new technology add-on payments for FY 2009 in the final rule, we would discuss the estimated payment impact for FY 2009 in that final rule.

D. Effects of Proposed Policy Regarding Postacute Care Transfers to Home Health Services

In section IV.A. of the preamble to this proposed rule, we noted that, under current regulations, the postacute care transfer policy applies to acute care discharges for which home health care (for a related condition) begins within 3 days of the discharge from an acute care hospital where the patient was discharged from the hospital prior to the geometric mean length of stay for a ''qualified'' MS–DRG. In that section, we discussed the reasons why we believe that the 3-day timeframe is no longer an appropriate threshold under the postacute care transfer policy. We discussed our rationale for extending the timeframe from within 3 days to within 7 days. Accordingly, we proposed to revise the timeframe in our regulations to within 7 days of discharge to home under a written plan for the provision of home health services, effective with discharges occurring on or after October 1, 2008.

To estimate the impact of this proposal, we used acute care hospital claims from the FY 2005 MedPAR file and searched for claims with a discharge destination code of ''01'' (Discharged to Home or Self-Care (Routine Discharge)) or ''06'' (Discharged/Transferred to Home under Care of Organized Home Health Service Organization in Anticipation of Covered Skilled Care). We then matched the acute care hospital MedPAR claims with HHA final action claims for 2005, using beneficiary identification numbers. We then compared the hospital discharge date with the home health admission date and determined a distribution by the difference in these two dates. We found that, for those patients for whom home health services began within 60 days of hospital discharge, in 6.7 percent of the cases, the services began on days 4 through day 7 after the acute care hospital discharge. We estimate that applying the proposed change to the hospital postacute care transfer policy would reduce Medicare payments to acute care inpatient hospitals by approximately $330 million over 5 years. For FY 2009, we estimate that Medicare payments would be reduced by approximately $50 million.

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

In section IV.B. of the preamble of this proposed rule, we discuss the requirements for hospitals to report quality data in order for hospitals to receive the full annual hospital payment update for FY 2009 and FY 2010. There are an estimated 186 hospitals in this analysis that may not receive the full market basket update for FY 2009. Most of these hospitals are either small rural or small urban hospitals. However, at this time, information is not available to determine the hospitals that do not meet the requirements for the full hospital market increase for FY 2009.

We also note that, for the FY 2009 payment update, hospitals must pass our validation requirement of a minimum of 80 percent reliability, based upon our chart-audit validation process, for the four quarters of data from FY 2007. These data were due to the QIO Clinical Warehouse by May 15, 2007 (fourth quarter CY 2006 discharges), August 15, 2007 (first quarter CY 2007 discharges), November 15, 2007 (second quarter CY 2007 discharges), and February 15, 2008 (third quarter CY 2007 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 proposed rule, we are proposing to provide additional validation criteria to ensure that the quality data being sent to CMS are accurate. The requirement of 5 charts per

hospital will result in approximately 21,500 charts per quarter total submitted to the agency. We reimburse hospitals for the cost of sending charts to the Clinical Data Abstraction Center (CDAC) at the rate of 12 cents per page for copying and approximately $4.00 per chart for postage. Our experience shows that the average chart received at the CDAC is approximately 150 pages. Thus, the agency will have expenditures of approximately $597,600 per quarter to collect the charts. Given that we reimburse for the data collection effort, we believe that a requirement for five charts per hospital per quarter represents a minimal burden to the participating hospital.

F. Effects of Proposed Policy Change to Methodology for Computing Core Staffing Factors for Volume Decrease Adjustment for SCHs and MDHs

In section IV.D. of the preamble of this proposed rule, we discuss a change to the methodology we would use to compute the average nursing staff factors (nursing hours per patient days) for the volume decrease adjustment for SCHs and MDHs. If certain requirements are met, this adjustment may be made if the hospital's total discharges decrease by more than 5 percent from one cost reporting period to the next. We do not believe this proposed change would have any significant impact on Medicare payments to these hospitals.

G. Effects of Proposed Clarification of Policy for Collection of Risk Adjustment Data From MA Organizations

In section IV.H. of the preamble of this proposed rule, we discuss our proposed revision of our regulations to clarify that CMS has the authority to require MA organizations to submit encounter data for each item and service provided to an MA plan enrollee. The proposed revision also would clarify that CMS will determine the formats for submitting encounter data, which may be more abbreviated than those used for the Medicare fee-for-service claims data submission process. At this time, we have not yet determined an approach for submission of the encounter data. Therefore, we are not in a position to determine the extent to which the cost impact of submitting encounter data would differ from the current costs to MA organizations of submitting risk adjustment data.

H. Effects of Proposed Policy Changes Relating to Hospital Emergency Services Under EMTALA

In section IV.I. of the preamble of this proposed rule, we are proposing to clarify our policy regarding the applicability of EMTALA to hospital inpatients. We are proposing to amend the regulations to state that when an individual covered by EMTALA was admitted as an inpatient and remains unstabilized with an emergency medical condition, a receiving hospital with specialized capabilities has an EMTALA obligation to accept that individual, assuming that the transfer of the individual is an appropriate transfer and the participating hospital with specialized capabilities has the capacity to treat the individual. In addition, we are proposing two changes relating to the requirements for on-call physicians in hospital emergency departments. We are proposing to delete the provision relating to maintaining a list of on-call physicians from the regulations referring to EMTALA at § 489.24(j)(1) because a provision addressing the on-call physician list is already included in the regulations relating to provider agreements at § 489.20(r)(2). We are proposing to incorporate the language of § 489.24(j)(1) as replacement language for the existing § 489.20(r)(2) and amend the regulatory language to make it more consistent with the statutory language found at section 1866(a)(1)(I)(iii) of the Act, which refers to hospital CoPs and the requirement to maintain an on-call list. These proposed changes would make the regulations consistent with the statutory basis for maintaining an on-call list. In addition, we are proposing to amend our regulations to provide that hospitals may comply with the on-call list requirement by participating in a formal community call plan so long as the plan includes a number of elements that are specified in the preamble to the proposed rule. Lastly, we are proposing to make a technical change to the regulations to conform them to the statutory language found in the Pandemic and All-Hazards Preparedness Act. These proposals do not include any substantive new requirements. Although hospitals choosing to participate in a community call arrangement will be required to devise a formal community call plan, such a plan would increase a hospital's flexibility in meeting its on-call requirements. We are estimating no impact on Medicare expenditures and no significant impact on hospitals with emergency departments.

I. Effects of Implementation of Rural Community Hospital Demonstration Program

In section IV.K. of the preamble to this proposed rule, we discuss our implementation of section 410A of Pub. L. 108–173 that required the Secretary to establish a demonstration that will modify reimbursement for inpatient services for up to 15 small rural hospitals. Section 410A(c)(2) requires that ''in conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.'' There are currently nine hospitals participating in the demonstration. We are currently conducting a solicitation for up to six additional hospitals to participate in the demonstration program.

As discussed in section IV.K. of the preamble to this proposed rule, we are satisfying this requirement by adjusting national IPPS rates by a factor that is sufficient to account for the added costs of this demonstration. We estimate that the average additional annual payment for FY 2009 that would be made to each participating hospital under the demonstration would be approximately $2,134,123. 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. As an estimate for the 15 hospitals that may participate, the total annual impact of the demonstration program for FY 2009 is projected to be $32,011,849. (In the final rule, we should know the exact number of hospitals participating in the demonstration program and would revise our estimates accordingly.) 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 Proposed Policy Changes Relating to Payments to Hospitals-Within-Hospitals

In section VI.F. of the preamble of this proposed rule, we discuss our proposed policy change to allow a HwH that cannot meet the criteria in regulations for a separate governing body solely because it is a State hospital occupying space with another State hospital or located on the same campus as another State hospital and both hospitals are under the same governing authority, or the governing authority of a third entity that controls both State hospitals, to nevertheless qualify for an exclusion from the IPPS if the hospital meets other applicable criteria for HwHs in the regulations and the specified proposed criteria in this proposed rule. We are only aware of one hospital that would be allowed qualify for exclusion from the IPPS under the proposed criteria and to expand its bed size under the proposed provisions. Because any expansion would occur at some point in the future, we are unable to quantify the impact of this proposed change.

K. Effects of Proposed Policy Changes Relating to Requirements for Disclosure of Physician Ownership in Hospitals

In section VII. of the preamble of this proposed rule, we discuss our proposals concerning (1) the definition of a physician-owned hospital; (2) the requirement that physician-owned hospitals disclose the ownership to patients; and (3) the requirement that all hospitals and CAHs must furnish written notice to their patients at the beginning of their hospital stay or outpatient visit if a physician is not present in the hospital 24 hours per day, 7 days per week, and that the notice must indicate how the hospital will meet the medical needs of any patient who develops an emergency medical condition at a time when there is no physician present in the hospital. The definition and the above requirements were implemented in the FY 2008 IPPS final rule with comment period (72 FR 47387 and 47391).

In this proposed rule, we are proposing to revise the definition of a physician-owned hospital at § 489.3 to include hospitals that have an ownership or investment interests by a physician and/or by an immediate family member of a physician. (The existing definition refers to an ownership or investment interest by a physician only, and not to an ownership or investment interest by an immediate family member.) We are also proposing to except from the definition of physician-owned hospital those hospitals that do not have at least one physician owner/investor or immediate family member

owner/investor who refers patients to the hospital. We believe that the proposed changes to the definition of physician-owned hospital would result in no more than a de minimis increase in the number of hospitals that are subject to the disclosure requirements applicable to physician-owned hospitals. We believe that there would be very few hospitals that would now meet the definition of physician-owned hospital, if we adopt our proposal to include immediate family members within the group of owners or investors that cause a hospital to be considered physician-owned, that did not already meet the definition. That is, we believe there are very few hospitals for which an immediate family member of a physician, but not the physician himself or herself, or any other physician, has an ownership or investment interest. Moreover, to the extent that such hospitals exist, that is, hospitals that have no physician owner/investors but which have owners/investors who are immediate family members of one or more physicians, such hospitals would not be subject to the disclosure requirement if we adopt our proposed exception to the definition of a physician-owned hospital for those hospitals that do not have at least one referring physician whose immediate family member is an owner/investor. Also, if we adopt this proposed exception to the definition of physician-owned hospital, the number of hospitals that now are subject to the disclosure requirement may be reduced slightly as we understand that there are some hospitals that have no referring physician owner/investors but rather have physician owner/investors who have retired from the practice of medicine. Thus, if both our proposed changes to the definition of physician-owned hospital are adopted, the net result may be no change, or a minimal increase or decrease in the number of hospitals that are subject to the disclosure requirement. Finally, if our proposal to change the definition of physician-owned hospital is adopted to encompass immediate family members, some hospitals that already meet the definition based on the presence of physician owner/investors may have to amend their list of physician owner/investors to add immediate family members, which we believe would be a minimal burden.

We are proposing to clarify that the list of the hospital's owners or investors who are physicians or immediate family members of physicians must be provided to the patient at the time the request for the list is made by or on behalf of the patient. We note that hospitals are already currently required to furnish the list of physician owners or investors and, thus, we believe that the impact of stipulating a timeframe for furnishing the list is negligible.

We are proposing to require all hospitals to require that all physician owners who also are members of the hospital's medical staff to agree, as a condition of continued medical staff membership or admitting privileges, to disclose, in writing, to all patients they refer to the hospital any ownership or investment interest that is held by themselves or by an immediate family member (as defined in § 411.351). Disclosure would be required at the time the referral is made. Both hospitals and physicians would participate in the disclosure process. We believe this proposal would have a small effect on physician-owned hospitals to the extent that it may require them to change their bylaws or make similar changes.

We do not anticipate that our proposals in section VII. of the preamble of this proposed rule would have a significant economic impact on a substantial number of physicians, other health care providers and suppliers, or the Medicare or Medicaid programs and their beneficiaries. Specifically, we believe that this proposed rule would affect mostly hospitals, physicians, and beneficiaries. The proposed changes concerning both the definition of a physician-owned hospital and the disclosure of physician ownership in hospitals are consistent with the physician self-referral statute and regulations as well as the current practices of most hospitals. Thus, our proposed requirement that the list of physician owners be provided to the patient at the time the request for the list is made by or on behalf of the patient would present a negligible economic impact on the hospital. Similarly, the cost borne by individual physicians to implement these provisions would be limited to a one-time cost associated with developing a disclosure notice that would be shared with patients at the time the referral is made in addition to the negligible time associated with providing the list to the patient and maintaining a copy of the notice in the patient's medical record.

We are also proposing to provide authority for CMS to terminate the Medicare provider agreement of any hospital that fails to furnish the required written notice that a physician is not available 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 there is no physician present in the hospital. We believe that the cost borne by hospitals to implement this proposal would be limited to a one-time cost associated with completing minor revisions to the hospital's policies and procedures to comply with the requirements of its Medicare provider agreement. Most hospitals have standard procedures to satisfy CMS by correcting deficiencies (such as the failure to furnish notice of physician ownership in the hospital to patients) before action is taken by CMS to terminate the Medicare provider agreement.

Overall, we believe that beneficiaries would be positively impacted by these provisions. Specifically, disclosure of physician ownership or investment interests equips patients to make informed decisions about where they elect to receive care. Our proposals make no significant changes that have the potential to impede patient access to health care facilities and services. In fact, we believe that our proposals would help minimize anti-competitive behavior that can affect the decision as to where a beneficiary receives health care services and possibly the quality of the services furnished.

L. Effects of Proposed Changes Relating to Physician Self-Referral Provisions

In section VIII. of the preamble of this proposed rule, we discuss our proposals pertaining to physician self-referral provisions, including: stand in the shoes, period of disallowance, and reporting of financial relationships between hospitals and physicians. We do not anticipate that our proposals would have a significant impact on physicians, other health care providers and suppliers, or the Medicare or Medicaid programs and their beneficiaries.

With respect to the proposals to modify the physician ''stand in the shoes'' provisions, we do not anticipate that entities that include one or more physician organizations would find it necessary to restructure their organizational relationships. We believe that if either of our alternative approaches is adopted, compliance with the ''stand in the shoes'' provisions would be made easier by simplifying the required analysis of arrangements in which a physician organization is interposed between the referring physician and the entity furnishing DHS. In addition to our proposals concerning the physician ''stand in the shoes'' provisions, we are making an entity ''stand in the shoes'' proposal, whereby an entity that furnishes DHS would be deemed to stand in the shoes of an organization in which it has a 100-percent ownership interest and would be deemed to have the same compensation arrangements with the same parties and on the same terms as does the organization that it owns. We believe that the entity stand in the shoes proposal may result in more financial relationships between entities and physicians being subject to the physician self-referral provisions, but we are unable to quantify at this time the possible increase or determine the effect of the proposal on the referral patterns or organization structures of DHS entities and their wholly-owned organizations. Rather, we welcome public comments on these issues.

Our proposal pertaining to the period of disallowance is a codification of what we believe is existing law and reflects what we believe most entities furnishing DHS are already following. Therefore, we do not anticipate a significant economic impact on the industry.

M. Effects of Proposed Changes Relating to Reporting of Financial Relationships Between Hospitals and Physicians

As discussed in section IX. of the preamble to this proposed rule, we are proposing to require that 500 hospitals furnish information concerning their financial relationships with their physicians. The financial relationships include ownership and investment interests and compensation arrangements. We are proposing that this information be submitted in a collection of information instrument that CMS has developed—the ''DFRR,'' which is included in Appendix C to this proposed rule. We are unable to quantify the number of physicians who have ownership and investment interests and compensation arrangements with hospitals. Even if we assume that the 500 hospitals have a substantial number of financial relationships with physicians, we believe that, in general, the economic impact on these hospitals would not be substantial. Because we are proposing that the DFRR be completed by hospitals and that the

physician information requested in the DFRR will be on file at the hospital, we believe there should be negligible, if any, impact upon physicians or other health care providers or suppliers. Specifically, we believe that the cost to complete the DFRR for each hospital would be approximately $1,550, and the total cost burden for the industry would be approximately $775,000.

We expect that this proposed rule may result in savings to the Medicare program by minimizing anti-competitive business arrangements as well as financial incentives that encourage overutilization. In addition, to the extent that we determine that any arrangements are noncompliant with the physician self-referral statute and regulations, there may be monies returned to the Medicare Trust Fund. We cannot gauge with any certainty the extent of these savings to the Medicare program at this time. Finally, we do not anticipate any financial burden on beneficiaries or impact on beneficiary access to medically necessary services because the completion of the DFRR would be conducted by hospitals.

VIII. Effects of Proposed 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 proposed rule, with the 10-year transition period ending with hospital cost reporting periods beginning on or after October 1, 2001 (FY 2002), beginning in FY 2002 capital prospective payment system payments for most hospitals are based solely on the capital Federal rate. Therefore, we no longer include information on obligated capital costs or projections of old capital costs and new capital costs, which were factors needed to calculate payments during the transition period, for our impact analysis.

The basic methodology for determining a capital PPS payment is set forth at § 412.312. The basic methodology for calculating capital IPPS payments in FY 2009 would be as follows: (Standard Federal Rate) × (DRG weight) × (GAF) × (COLA for hospitals located in Alaska and Hawaii) × (1 + Disproportionate Share Adjustment Factor + IME Adjustment Factor, if applicable).

We note that, in accordance with § 412.322(c), the IME adjustment factor for FY 2009 is equal to half of the current adjustment, as discussed in section V.B.2. of the preamble of this proposed rule. In addition, hospitals may also receive outlier payments for those cases that qualify under the threshold established for each fiscal year.

The data used in developing the impact analysis presented below are taken from the December 2007 update of the FY 2007 MedPAR file and the December 2007 update of the Provider-Specific File that is used for payment purposes. Although the analyses of the proposed changes to the capital prospective payment system do not incorporate cost data, we used the December 2007 update of the most recently available hospital cost report data (FYs 2005 and 2006) to categorize hospitals. Our analysis has several qualifications. We use the best data available and make assumptions about case-mix and beneficiary enrollment as described below. In addition, as discussed in section III. of the Addendum to this proposed rule, as we established for FY 2008, we are proposing to adjust the national capital rate to account for improvements in documentation and coding under the MS–DRGs in FY 2009. (As discussed in section III.A.6. of the Addendum to this proposed rule, we are not proposing to adjust the Puerto Rico specific capital rate to account for improvements in documentation and coding under the MS–DRGs in FY 2009.) Furthermore, due to the interdependent nature of the IPPS, it is very difficult to precisely quantify the impact associated with each proposed 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 December 2007 update of the FY 2007 MedPAR file, we simulated payments under the capital PPS for FY 2008 and FY 2009 for a comparison of total payments per case. Any short-term, acute care hospitals not paid under the general IPPS (Indian Health Service hospitals and hospitals in Maryland) are excluded from the simulations.

As we explain in section III.A. of the Addendum to this proposed rule, payments are no longer made under the regular exceptions provision under §§ 412.348(b) through (e). Therefore, we no longer use the actuarial capital cost model (described in Appendix B of the August 1, 2001 proposed rule (66 FR 40099)). We modeled payments for each hospital by multiplying the capital Federal rate by the GAF and the hospital's case-mix. We then added estimated payments for indirect medical education (which are reduced by 50 percent in FY 2009 in accordance with § 412.322(c), as discussed in section V.B.2. of the preamble of this proposed rule), disproportionate share, and outliers, if applicable. For purposes of this impact analysis, the model includes the following assumptions:

- We estimate that the Medicare case-mix index will increase by 1.0 percent in both FYs 2008 and 2009. (We note that this does not reflect the expected growth in case-mix due to improvement in documentation and coding under the MS–DRGs, as discussed below.)
- We estimate that the Medicare discharges will be 13.2 million in FY 2008 and 13.3 million in FY 2009 for an approximately 0.4 percent increase from FY 2008 to FY 2009.
- The capital Federal rate was updated beginning in FY 1996 by an analytical framework that considers changes in the prices associated with capital-related costs and adjustments to account for forecast error, changes in the case-mix index, allowable changes in intensity, and other factors. As discussed in section VIII. of the preamble and section III.A.2.1. of the Addendum to this proposed rule, the proposed FY–2009 update is 0.7 percent.
- In addition to the proposed FY 2009 update factor, the proposed FY 2009 capital Federal rate was calculated based on a proposed GAF/DRG budget neutrality factor of 1.0007, a proposed outlier adjustment factor of 0.9427, and a proposed exceptions adjustment factor of 0.9998.
- For FY 2009, as discussed in section III.A. of the Addendum to this proposed rule, the proposed FY 2009 national capital rate was further adjusted by a factor to account for anticipated improvements in documentation and coding that are expected to increase case-mix under the MS–DRGs. In the FY 2008 IPPS final rule with comment period (72 FR 47186), we established adjustments to the IPPS rates based on the Office of the Actuary projected case-mix growth resulting from improved documentation and coding of 1.2 percent for FY 2008, 1.8 percent for FY 2009, and 1.8 percent for FY 2010. However, we reduced the documentation and coding adjustment to –0.6 percent for FY 2008, and for FY 2009, we are proposing to apply an adjustment of 0.9 percent, consistent with section 7 of Pub. L. 110–90. As noted above and as discussed in section III.A.6. of the Addendum to this proposed rule, we are not proposing to adjust the Puerto Rico-specific capital rate to account for improvements in documentation and coding under the MS–DRGs in FY 2009.

B. Results

We used the actuarial model described above to estimate the potential impact of our proposed changes for FY 2009 on total capital payments per case, using a universe of 3,528 hospitals. As described above, the individual hospital payment parameters are taken from the best available data, including the December 2007 update of the FY 2007 MedPAR file, the December 2007 update to the PSF, and the most recent cost report data from the December 2007 update of HCRIS. In Table III, we present a comparison of total payments per case for FY 2008 compared to proposed FY 2009 based on the proposed FY 2009 payment policies. Column 2 shows estimates of payments per case under our model for FY 2008. Column 3 shows estimates of payments per case under our model for FY 2009. Column 4 shows the total percentage change in payments from FY 2008 to FY 2009. The change represented in Column 4 includes the proposed 0.7 percent update to the capital Federal rate, other changes in the adjustments to the capital Federal rate (for example, the 50 percent reduction to the teaching adjustment for FY

2009), and the additional 0.9 percent reduction to the national capital rate to account for improvements in documentation and coding (or other changes in coding that do not reflect real changes in case-mix) for implementation of the MS–DRGs. Consistent with the impact analysis for the proposed policy changes under the IPPS for operating costs in section VI. of this Appendix, for purposes of this impact analysis, we also assume a 1.8 percent increase in case-mix growth for FY 2009, as determined by the Office of the Actuary, because we believe the adoption of the MS–DRG will result in case-mix growth due to documentation and coding changes that do not reflect real changes in patient severity of illness. The comparisons are provided by: (1) Geographic location; (2) region; and (3) payment classification.

The simulation results show that, on average, capital payments per case in FY 2009 can be expected to remain about the same as capital payments per case in FY 2008. The proposed capital rate for FY 2009 would decrease 1.14 percent as compared to the FY 2008 capital rate, and the proposed changes to the GAFs are expected to result in a slight decrease (0.3 percent) in capital payments. In addition, the 50 percent reduction to the teaching adjustment in FY 2009 will also result in a decrease in capital payments from FY 2008 as compared to FY 2009. Countering these factors is the projected case-mix growth as a result of improved documentation and coding (discussed above) as well as an estimated increase in outlier payments in FY 2008 as compared to FY 2009. The net result of these changes is an estimated 0.0 percent change in capital payments per discharge from FY 2008 to FY 2009 for all hospitals (as shown below in Table III).

The results of our comparisons by geographic location and by region are consistent with the results we expected with the decrease to the teaching adjustment in FY 2009 (§ 412.522(c)). The geographic comparison shows that all urban hospitals are expected to experience no change in capital IPPS payments per case in FY 2009 as compared to FY 2008, while hospitals in large urban areas are expected to experience a slight decrease (0.3 percent) in capital IPPS payments per case in FY 2009 as compared to FY 2008. Capital IPPS payments per case for rural hospitals are expected to increase 0.5 percent. These differences in payments per case by geographic location are mostly due to the decrease in the teaching adjustment. Because teaching hospitals generally tend to be located in urban or large urban areas, we would expect that the 50 percent decrease in the teaching adjustment for FY 2009 would have a more significant impact on hospitals in those areas than those hospitals located in rural areas.

Most regions are estimated to experience an increase in total capital payments per case from FY 2008 to FY 2009. These increases vary by region and range from a 1.9 percent increase in the Pacific urban and West South Central urban regions to a 0.1 percent increase in the East North Central urban region. Two urban regions are projected to experience a relatively larger decrease in capital payments, with the difference mostly due to proposed changes in the GAFs and the 50 percent reduction in the teaching adjustment for FY 2009: −2.7 percent in the Middle Atlantic urban region and −3.6 percent in the New England urban region. The East North Central urban region is also expected to experience a decrease of 0.1 percent in capital payments in FY 2009 as compared to FY 2008, mostly due to proposed changes in the GAFs. There are two rural regions that expected to experience a decrease in total capital payments per case: A −4.5 percent decrease in the New England rural region and a −1.0 percent decrease in the Middle Atlantic rural region. Again, for these two rural regions, the projected decrease in capital payments is mostly due to proposed changes in the GAF, as well as a smaller than average increase in changes payments due to the adoption of the MS–DRGs.

By type of ownership, voluntary and government hospitals are estimated to experience a decrease of 0.2 percent and 0.8 percent, respectively. The projected decrease in capital payments per case is primarily due to the 50 percent teaching adjustment reduction for FY 2009. Proprietary hospitals are estimated to experience an increase in capital payments per case of 1.6 percent. This estimated increase in capital payments is mostly due to a smaller than average decrease in payments resulting from the 50 percent teaching adjustment reduction for FY 2009.

Section 1886(d)(10) of the Act established the MGCRB. Before FY 2005, hospitals could apply to the MGCRB for reclassification for purposes of the standardized amount, wage index, or both. Section 401(c) of 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 2009. Reclassification for wage index purposes also affects the GAFs because that factor is constructed from the hospital wage index.

To present the effects of the hospitals being reclassified for FY 2009, we show the average capital payments per case for reclassified hospitals for FY 2008. Urban reclassified hospitals are expected to have the largest decrease in capital payments of 0.4 percent, while rural reclassified hospitals are expected to have the largest increase in capital payments of 1.0 percent. Urban nonreclassified hospitals are not expected to experience any change in capital payment from FY 2008 to FY 2009, while rural nonreclassified hospitals are expected to experience a slight decrease in capital payments of 0.3 percent. The projected changes in capital payments for rural hospitals are mainly due to the proposed changes to the GAF (including the proposal to apply the rural floor budget neutrality at a State level). The projected changes in capital payments for urban hospitals are mainly due to the 50 percent reduction in the teaching adjustment in FY 2009.

TABLE III.—COMPARISON OF TOTAL CAPITAL PAYMENTS PER CASE

[FY 2008 payments compared to FY 2009 payments]

	Number of hospitals	Average FY 2008 payments/case	Average FY 2009 payments/case	Change
By Geographic Location:				
All hospitals	3,528	757	757	0.0
Large urban areas (populations over 1 million)	1,402	834	831	−0.3
Other urban areas (populations of 1 million or fewer)	1,140	752	754	0.3
Rural areas	986	528	531	0.5
Urban hospitals	2,542	796	796	0.0
0–99 beds	643	632	642	1.6
100–199 beds	829	684	692	1.1
200–299 beds	483	752	758	0.8
300–499 beds	411	829	827	−0.3
500 or more beds	176	973	957	−1.7
Rural hospitals	986	528	531	0.5
0–49 beds	338	429	427	−0.5
50–99 beds	373	485	487	0.4
100–149 beds	166	532	537	1.0
150–199 beds	67	586	595	1.4
200 or more beds	42	652	652	0.0
By Region:				

TABLE III.—COMPARISON OF TOTAL CAPITAL PAYMENTS PER CASE—Continued

[FY 2008 payments compared to FY 2009 payments]

	Number of hospitals	Average FY 2008 payments/case	Average FY 2009 payments/case	Change
Urban by Region	2,542	796	796	0.0
New England	121	835	805	−3.6
Middle Atlantic	348	858	835	−2.7
South Atlantic	385	755	763	1.1
East North Central	394	777	770	−0.9
East South Central	163	719	727	1.2
West North Central	157	777	779	0.2
West South Central	371	747	761	1.9
Mountain	157	807	822	1.8
Pacific	393	925	943	1.9
Puerto Rico	53	367	368	0.3
Rural by Region	986	528	531	0.5
New England	23	706	675	−4.5
Middle Atlantic	70	543	537	−1.0
South Atlantic	172	516	524	1.5
East North Central	121	555	555	0.1
East South Central	176	480	484	0.9
West North Central	113	560	567	1.1
West South Central	200	479	483	0.8
Mountain	75	533	539	1.2
Pacific	36	650	660	1.6
By Payment Classification:				
All hospitals	3,528	757	757	0.0
Large urban areas (populations over 1 million)	1,424	832	830	−0.3
Other urban areas (populations of 1 million or fewer)	1,160	750	752	0.3
Rural areas	944	528	531	0.6
Teaching Status:				
Non-teaching	2,484	643	657	2.1
Fewer than 100 Residents	805	765	769	0.5
100 or more Residents	238	1,085	1,037	−4.4
Urban DSH:				
100 or more beds	1,534	823	820	−0.3
Less than 100 beds	354	567	573	1.2
Rural DSH:				
Sole Community (SCH/EACH)	389	467	469	0.4
Referral Center (RRC/EACH)	206	584	589	0.8
Other Rural:				
100 or more beds	39	489	493	0.8
Less than 100 beds	168	438	438	0.1
Urban teaching and DSH:				
Both teaching and DSH	811	896	881	−1.6
Teaching and no DSH	172	784	777	−0.8
No teaching and DSH	1,077	683	700	2.5
No teaching and no DSH	524	702	716	2.0
Rural Hospital Types:				
Non special status hospitals	2,459	800	799	−0.1
RRC/EACH	63	700	714	2.0
SCH/EACH	36	654	659	0.8
Medicare-dependent hospitals (MDH)	11	457	456	−0.2
SCH, RRC and EACH	15	751	776	3.4
Hospitals Reclassified by the Medicare Geographic Classification Review Board:				
FY 2009 Reclassifications:				
All Urban Reclassified	445	802	799	−0.4
All Urban Non-Reclassified	2,075	796	796	0.0
All Rural Reclassified	360	573	579	1.0
All Rural Non-Reclassified	565	459	458	−0.3
Other Reclassified Hospitals (Section 1886(d)(8)(B))	54	535	538	0.5
Type of Ownership:				
Voluntary	2,027	770	769	−0.2
Proprietary	827	699	710	1.6
Government	587	752	746	−0.8
Medicare Utilization as a Percent of Inpatient Days:				
0–25	255	998	971	−2.8
25–50	1,350	847	843	−0.5
50–65	1,431	671	677	0.9
Over 65	392	598	601	0.5

IX. Alternatives Considered

This proposed rule contains a range of proposed policies. The preamble of this proposed rule provides descriptions of the statutory provisions that are addressed, identifies those proposed policies when discretion has been exercised, and presents rationale for our decisions and, where relevant, alternatives that were considered.

X. Overall Conclusion

The changes we are proposing in this proposed rule will affect all classes of hospitals. Some hospitals are expected to experience significant gains and others less significant gains, but overall hospitals are projected to experience positive updates in IPPS payments in FY 2009. Table I of section VI. of this Appendix demonstrates the estimated distributional impact of the IPPS budget neutrality requirements for proposed MS–DRG and wage index changes, and for the wage index reclassifications under the MGCRB. Table I also shows an overall increase of 4.1 percent in operating payments. We estimate operating payments to increase by $3.96 billion. This accounts for the projected savings associated with the postacute care transfer policy proposal and the HACs policy, which each have an estimated savings of $50 million. In addition, this estimate includes the hospital reporting of quality data program costs ($2.39 million) and all proposed operating payment policies as described in section VII. of this Appendix. Capital payments are estimated to increase by 0.0 percent per case, as shown in Table III of section VIII. of this Appendix. Therefore, we project that the increase in capital payments in FY 2009 compared to FY 2008 is negligible ($6 million). The proposed operating and capital payments should result in a net increase of $3.967 billion to IPPS providers. The discussions presented in the previous pages, in combination with the rest of this proposed rule, constitute a regulatory impact analysis.

XI. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehousegov/omb/circulars/a004/a-4.pdf),* in Table IV below, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this proposed rule. This table provides our best estimate of the increase in Medicare payments to providers as a result of the proposed changes to the IPPS presented in this proposed rule. All expenditures are classified as transfers to Medicare providers.

TABLE IV.—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES FROM FY 2008 TO FY 2009

Category	Transfers
Annualized Monetized Transfers	$3.967 Billion.
From Whom to Whom	Federal Government to IPPS Medicare Providers.
Total	$3.967 Billion.

XII. Executive Order 12866

In accordance with the provisions of Executive Order 12866, the Office of Management and Budget reviewed this proposed rule.

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

I. Background

Section 1886(e)(4)(A) of the Act requires that the Secretary, taking into consideration the recommendations of the MedPAC, recommend update factors for inpatient hospital services for each fiscal year that take into account the amounts necessary for the efficient and effective delivery of medically appropriate and necessary care and high quality care. Under section 1886(e)(5)(B) of the Act, we are required to publish update factors recommended by the Secretary in the proposed and final IPPS rules, respectively. Accordingly, this Appendix provides the recommendations for the update factors for the IPPS national standardized amount, the Puerto Rico-specific standardized amount, the hospital-specific rates for SCHs and MDHs, and the rate-of-increase limits for hospitals and hospital units excluded from the IPPS, as well as LTCHS, IPFs, and IRFs. We also discuss our response to MedPAC's recommended update factors for inpatient hospital services.

II. Inpatient Hospital Update for FY 2009

Section 1886(b)(3)(B)(i)(XX) of the Act, as amended by section 5001(a) of Pub. L. 109–171, sets the FY 2009 percentage increase in the operating cost standardized amount equal to the rate-of-increase in the hospital market basket for IPPS hospitals in all areas, subject to the hospital submitting quality information under rules established by the Secretary in accordance with 1886(b)(3)(B)(viii) of the Act. For hospitals that do not provide these data, the update is equal to the market basket percentage increase less 2.0 percentage points. Consistent with current law, based on Global Insight, Inc.'s first quarter 2008 forecast of the FY 2009 market basket increase, we are estimating that the FY 2009 update to the standardized amount will be 3.0 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, we are estimating that the update to the standardized amount will be 1.0 percent (that is, the current estimate of the market basket rate-of-increase minus 2.0 percentage points).

Section 1886(d)(9)(C)(1) of the Act is the basis for determining the percentage increase to the Puerto Rico-specific standardized amount. For FY 2009, we are applying the full rate-of-increase in the hospital market basket for IPPS hospitals to the Puerto Rico-specific standardized amount. Therefore, the update to the Puerto Rico-specific standardized amount is estimated to be 3.0 percent.

Section 1886(b)(3)(B)(iv) of the Act sets the FY 2009 percentage increase in the hospital-specific rates applicable to SCHs and MDHs equal to the rate set forth in section 1886(b)(3)(B)(i) of the Act (that is, the same update factor as for all other hospitals subject to the IPPS, or the rate-of-increase in the market basket). Therefore, the update to the hospital-specific rates applicable to SCHs and MDHs is estimated to be 3.0 or 1.0 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 proposing a rate-of-increase percentage to the reasonable cost portion for FY 2009 for LTCHs to be used under § 413.40. In addition, section 124 of 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) are paid under a blended methodology for cost reporting periods beginning on or after January 1, 2005, and before January 1, 2008. For cost reporting periods beginning on or after January 1, 2008, existing IPFs are paid based on 100 percent of the Federal per diem rate. Therefore, because no portion of the existing IPFs prospective payments will be based on reasonable cost concepts for cost reporting periods beginning on or after

January 1, 2008, we are not proposing a rate-of-increase percentage to the reasonable cost portion for FY 2009 for IPFs to be used under § 412.426(c). New IPFs are paid based on 100 percent of the Federal per diem payment amount.

Currently, children's hospitals, cancer hospitals, and RNHCIs are the remaining three types of hospitals still reimbursed under the reasonable cost methodology. We are providing our current estimate of the FY 2009 IPPS operating market basket percentage increase (3.0 percent) to update the target limits for children's hospitals, cancer hospitals, and RNHCIs.

Effective for cost reporting periods beginning on or after October 1, 2002, LTCHs have been paid under the LTCH PPS. Additionally, for cost reporting periods beginning on or after October 1, 2006, no portion of a LTCH's PPS payments can be based on reasonable cost concepts. Consequently, there is no need to propose to update the target limit under § 413.40 effective October 1, 2008, for LTCHs.

In the RY 2009 LTCH PPS proposed rule (73 FR 5361 through 5362), we proposed an update of 2.6 percent to the LTCH PPS Federal rate for RY 2009, which is based on a proposed market basket increase of 3.5 percent and a proposed adjustment of 0.9 percent to account for the increase in case-mix in a prior year that resulted from changes in coding practices rather than an increase in patient severity. The proposed market basket of 3.5 percent used in determining this proposed update factor is based on our proposal in the LTCH proposed rule to extend the LTCH RY 2009 by 3 months (a total of 15 months instead of 12 months) through September 30, 2009. (A full discussion of the reasons for this proposed extension of RY 2009 can be found in the RY 2009 LTCH PPS proposed rule (73 FR 5351 through 5353).) However, if we were not proposing to extend the 2009 LTCH PPS rate year by 3 months, we would have proposed a market basket update of 3.1 percent for a 12-month RY 2009 offset by the proposed adjustment of 0.9 percent to account for the increase in case-mix in a prior year that resulted from changes in coding practices rather than an increase in patient severity.

Effective for cost reporting periods beginning on or after January 1, 2005, IPFs are paid under the IPF PPS. IPF PPS payments are based on a Federal per diem rate that is derived from the sum of the average routine operating, ancillary, and capital costs for each patient day of psychiatric care in an IPF, adjusted for budget neutrality. For cost reporting periods beginning on or after January 1, 2005, and before January 1, 2008, existing IPFs (those not defined as ''new'' under § 412.426(c)) are paid based on a blend of the reasonable cost-based PPS payments and the Federal per diem base rate. For cost reporting periods beginning on or after January 1, 2008, existing IPFs are paid based on 100 percent of the Federal per diem rate. Consequently, there is no need to propose to update the target limit under § 412.426(c) effective October 1, 2008, for IPFs.

IRFs are paid under the IRF PPS for cost reporting periods beginning on or after January 1, 2002. For cost reporting periods beginning on or after October 1, 2002 (FY 2003), and thereafter, the Federal prospective payments to IRFs are based on 100 percent of the adjusted Federal IRF prospective payment amount, updated annually (69 FR 45721). Section 1886(j)(3)(C) of the Act, as amended by section 115 of Pub. L. 110–173 sets the FY 2009 IRF PPS update factor equal to 0 percent. Thus, we are not applying an update (market basket) to the IRF PPS rates for FY 2009.

III. Secretary's Recommendation

MedPAC is recommending an inpatient hospital update equal to the market basket rate of increase for FY 2009. MedPAC's rationale for this update recommendation is described in more detail below. Based on the FY 2009 President's Budget, we are recommending an update to the standardized amount of 0 percent. We are recommending that this same update factor apply to SCHs and MDHs.

Section 1886(d)(9)(C)(1) of the Act is the basis for determining the percentage increase to the Puerto Rico-specific standardized amount. For FY 2009, we are applying the full rate-of-increase in the hospital market basket for IPPS hospitals to the Puerto Rico-specific standardized amount. Therefore, the update to the Puerto Rico-specific standardized amount is estimated to be 3.0 percent.

In addition to making a recommendation for IPPS hospitals, in accordance with section 1886(e)(4)(A) of the Act, we are also recommending update factors for all other types of hospitals. Consistent with the President's Budget, we are recommending an update based on the IPPS market basket increase for children's hospitals, cancer hospitals, and RNHCIs of 0 percent. As mentioned above, for cost reporting periods beginning on or after January 1, 2008, existing IPFs are paid based on 100 percent of the Federal per diem rate (and are no longer paid a blend of the reasonable cost-based PPS payments and the Federal per diem base rate). Consequently, we are no longer recommending an update factor for the portion of the payment that is based on reasonable costs. Consistent with the President's Budget, based on Global Insight, Inc.'s first quarter 2008 forecast of the RPL market basket increase, we are recommending an update to the IPF PPS Federal rate for RY 2009 of 3.2 percent for the Federal per diem payment amount.

In the RY 2009 LTCH PPS proposed rule (73 FR 5361 through 5362), we proposed an update of 2.6 percent to the LTCH PPS Federal rate for RY 2009, which is based on a proposed market basket increase of 3.5 percent and a proposed adjustment of 0.9 percent to account for the increase in case-mix in a prior year that resulted from changes in coding practices rather than an increase in patient severity. The proposed market basket of 3.5 percent used in determining this proposed update factor is based on our proposal in the LTCH proposed rule to extend the LTCH RY 2009 by 3 months (a total of 15 months instead of 12 months) through September 30, 2009. (A full discussion on the reasons for this proposed extension of RY 2009 can be found in the RY 2009 LTCH PPS proposed rule (73 FR 5351 through 5353).) However, if we were not proposing to extend the 2009 LTCH PPS rate year by 3 months, we would have proposed a market basket update for a 12 month RY 2009 of 3.1 percent in determining the proposed update factor for RY 2009 offset by the proposed adjustment of 0.9 percent to account for the increase in case-mix in a prior year that resulted from changes in coding practices rather than an increase in patient severity.

Finally, consistent with the President's FY 2009 Budget, we are recommending a zero percent update to the IRF PPS Federal rate for FY 2009. This recommendation is consistent with the zero percent increase factor specified in section 1886(j)(3)(C) of the Act, as amended by section 115 of Pub. L. 110–173.

IV. MedPAC Recommendation for Assessing Payment Adequacy and Updating Payments in Traditional Medicare

In its March 2008 Report to Congress, MedPAC assessed the adequacy of current payments and costs, and the relationship between payments and an appropriate cost base, utilizing an established methodology used by MedPAC in the past several years.

MedPAC recommended an update to the hospital inpatient rates equal to the increase in the hospital market basket in FY 2009, concurrent with implementation of a quality incentive program. Similar to last year, MedPAC also recommended that CMS put pressure on hospitals to control their costs rather than accommodate the current rate of cost growth, which is, in part, caused by a lack of pressure from private payers.

MedPAC noted that indicators of payment adequacy are almost uniformly positive. MedPAC expects Medicare margins to remain low in 2008. At the same time though, MedPAC's analysis finds that hospitals with low non-Medicare profit margins have below average standardized costs and most of these facilities have positive overall Medicare margins.

Response: Similar to our response last year, we agree with MedPAC that hospitals should control costs rather than accommodate the current rate of growth. An update equal to less than the market basket will motivate hospitals to control their costs, consistent with MedPAC's recommendation. As MedPAC noted, the lack of financial pressure at certain hospitals can lead to higher costs and in turn bring down the overall Medicare margin for the industry.

As discussed in section II of the preamble of this proposed rule, CMS implemented the MS–DRGs in FY 2008 to better account for severity of illness under the IPPS, and is basing the DRG weights on costs rather than charges. We continue to believe that these refinements will better match Medicare payment of the cost of care and provide incentives for hospitals to be more efficient in controlling costs.

We note that, because the operating and capital prospective payment systems remain separate, we are proposing to continue to use separate updates for operating and capital payments. The proposed update to the

capital rate is discussed in section III of the Addendum to this proposed rule.

Appendix C—Disclosure of Financial Relationship Report (DFRR) Form

Disclosure of Financial Relationship Report (DFRR)

Requirement

Completion of the Disclosure of Financial Relationship Report (DFRR or Report) is required under section 1877(f) of the Social Security Act. The Report must be completed, certified by the appropriate officer of the hospital, and received by CMS within 60 days of the date that appears on the cover letter or e-mail transmission. Pursuant to 42 CFR 411.361(f), failure to timely submit the requested information concerning an entity's ownership, investment, and compensation arrangements may result in civil monetary penalties of up to $10,000 for each day beyond the deadline established for disclosure.

Please be advised that the results from the DFRR may be shared with other Federal agencies and with Congressional committees, as permitted or mandated by law. We intend to protect from public disclosure, to the fullest extent permitted by Exemptions 4 and 6 of the Freedom of Information Act, 5 U.S.C. 552(b)(4) and (6), any confidential business information and any individual-specific information collected. We note that CMS is prevented by the Trade Secrets Act, 18 U.S.C. 1905, from releasing confidential business information, except as authorized by law.

Information collected from each hospital will be analyzed separately to determine whether the financial relationships are in compliance with the physician self-referral laws and implementing regulations. At this time, we do not plan to aggregate data.

Exception to Mandatory Reporting

An entity that furnishes 20 or fewer Part A and/or Part B services during a calendar year is excepted from this reporting requirement pursuant to 42 CFR 411.361(b). If you believe that the hospital qualifies for this exception:

- The Chief Executive Officer, Chief Financial Officer, or a comparable officer of the Hospital must certify in writing that the hospital furnishes 20 or fewer Part A and/or Part B services during a calendar year.
- The certification statement must read as follows: ''I, (insert name), hereby certify that, to the best of my knowledge and belief, (insert name of Hospital) furnishes 20 or fewer Part A and/or Part B services during a calendar year. Therefore the hospital is relying on the exception in 42 CFR 411.361(b) and will not be reporting financial relationship data concerning the facility.'' The certification statement must be signed and dated, and include the title of the signatory.
- If the hospital or entity qualifies for the exception at 42 CFR 411.361(b), please mail the original and one copy of the signed certification statement to: Physician Self-Referral, Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Mailstop C4–25–02, Baltimore, Maryland 21244–1850. In addition, we request, but do not require, that you e-mail a PDF or other electronically scanned version of the document to *HOSPITALDISCLOSURE@cms.hhs.gov*. In the subject line, please include the title ''Exception to Disclosure Report.''

General Instructions for DFRR

- The requested disclosures on Worksheets 1 through 6 pertain only to hospitals with physician ownership or investment. For purposes of this Report, ownership is synonymous with investment.
- For any question pertaining to the financial relationship between a physician and the Hospital or entity or individual, ''physician'' shall include each immediate family member of the physician, as defined in 42 CFR 411.351.
- The terms, ''physician-owner'' and ''physician-investor'' are used interchangeably throughout this report.
- Please provide the physician's last name, first name, and Medicare National Provider Identifier (NPI). Only for those physicians who have not yet received an NPI, may the physician's Unique Physician Identification Number (UPIN) be submitted instead. We will not accept a hospital created identifier (for example, Physician 1, Physician 2, etc.).
- Where supporting documentation or an explanation is requested, please include the name of the physician-owner or physician-investor, and his/her NPI.
- Supplemental documents should be provided only when specifically requested on a worksheet. Supporting documentation should be organized and clearly labeled to reference the relevant worksheet. Please include only information that responds to the question asked; extraneous information should not be included. For example, if only a few pages of a large document are responsive to a question, please only submit those relevant pages.
- If a particular question does not apply to the hospital, please type ''N/A.''
- If sufficient rows are not provided, please save the Excel spreadsheet, insert the necessary number of additional rows, and print a copy of the revised Excel spreadsheet.
- Upon completion of the entire DFRR, please verify all information presented (including the totals for the respective fields or columns) and return an original and one copy to: Physician Self-Referral, Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Mailstop C4–25–02, Baltimore, Maryland 21244–1850. CMS also requests, but does not require, that a PDF or other electronically scanned version of the DFRR and accompanying documentation be sent to *HOSPITALDISCLOSURE@cms.hhs.gov*.
- Please enter all date fields in the following format: MM/DD/YY. For example, ''March 31, 2006'' must be entered as follows: 03/31/06.

Report Contents

The attached report consists of the following spreadsheets:

- Cover Sheet—(Certification Page)
- Worksheet 1—Hospital Characteristics
- Worksheet 2—Direct Ownership in Hospital
- Worksheet 3—Indirect Ownership in Hospital
- Worksheet 4—Payments Made to Hospital by Direct Owners
- Worksheet 5—Payments Made to Hospital by Indirect Owners
- Worksheet 6—Investment Reconciliation
- Worksheet 7—Compensation Arrangements—Rentals, Personal Service Arrangements, and Recruitment (See 42 CFR 411.357)
- Worksheet 8—Other Types of Compensation Arrangements (See 42 CFR 411.357)

Key Terms

1. Additional Purchases: Stocks purchased after initial or starting investment. Report the total cost and number of additional shares of stock purchased.
2. Assessments: Any cost or fee required and paid by any investor of the hospital. These fees usually do not involve any basis or change in the owner's investment in the facility.
3. Back-up Guarantee: Physician-owner's risk of loss or liability related to the ownership of his or her stock is guaranteed by another entity. If the borrower has problems in repayment, the payment is guaranteed by a third party.
4. Basis of Stock/Shares: The cost of the stock at the end of the cost reporting period(s) ending in 2006.
5. Capital Calls: Each investor is asked/required to put additional capital in the company. Depending on the structure of the call, if no additional shares are issued, the basis (cost) of the investor's stock will increase, or if additional shares are issued, the number of the investor's shares will increase.
6. Compilation of Financial Statements: A compilation presents information in the form of financial statements that are the representation of management without expressing assurances.
7. Direct Ownership or Investment Interest: Direct ownership or investment interest is defined at 42 CFR 411.354(a)(2).
8. Disproportionate Guarantee by Physician Investor: Physician investor's risk of loss or liability related to the ownership of his/her stock is guaranteed by the corporate investor in a disproportionate percentage to the percentage of stock owned by that physician investor (i.e.: Physician investor owns 40% of the stock of a hospital, but assumes risk of loss or liability equal to 20%.)
9. Fair Market Value: Fair market value is defined at 42 CFR 411.351.
10. Hospital: Hospital is synonymous with operating entity (that is, the corporation or legal entity through which the hospital operates).
11. Immediate family member: An immediate family member means: Husband or wife; birth or adoptive parent, child, or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law; grandparent or grandchild; and spouse of a grandparent or grandchild. 42 CFR 411.351.
12. Indirect Ownership or Investment Interest: An indirect ownership or investment interest is defined at 42 CFR 411.354(b)(5).

13. Internally prepared: Internally prepared financial statements are prepared by employees of the hospital, and are used mostly to monitor the hospital's performance.

14. Loan Guarantees: A situation when the borrower's liability is collateralized by a third party.

15. NPI: Medicare National Provider Identifier.

16. Other Capital Assessments: Report only if shares of stock are involved. Fees assessed should not be reported.

17. Relinquishments or Sales: For each share of stock that is sold during the cost reporting period(s) in 2006, report the dollar amount of the sale and the number of shares sold.

18. Reporting Period: The reporting period refers to any cost reporting period(s) ending in 2006.

19. Return of Capital Dividends: A distribution that is not paid out of the earnings and profits of the company. This distribution reduces the basis of the stock.

20. Review of Financial Statements: A review of financial statements is an engagement that results in an accountant's opinion that expresses less assurance than that of a certified audit, but more than a compilation. Typically this involves limited auditing, testing, analytical procedures, and/or inquiries.

21. Stock/share: These terms are used interchangeably throughout the worksheets.

22. Stock Dividends: Stock dividends are distributions made by a corporation of its own stock.

Worksheet 1—Hospital Characteristics

- Please include month, date, and year for the beginning and end of your cost reporting period(s).

Worksheet 2—Direct Ownership in Hospital

- Identify the class of stock (if applicable) and list all owners of that class within the same grouping on the Worksheet.
- If the direct owner is the physician, enter ''Self'' in Column B.
- If the direct owner is not the physician, please write the individual's name in Column A and in Column B indicate his/her relationship to the physician and give the physician's name.
- The basis of the stock/shares is the cost of the stock at the end of the cost reporting period(s) ending in 2006. This amount should equal Worksheet 6, Column B, Line 18.
- One hundred percent of ownership should be identified for each individual class of stock.

Worksheet 3—Indirect Ownership in Hospital

- Report only indirect ownership interests of physicians and immediate family members on this Worksheet.
- In Column A, identify each entity with ownership in the hospital and identify the type of entity in Column B. The entity's percentage of direct ownership should be listed in Column C.
- List each investor-owner of the group entity in Column D. Indicate if the investor-owner is a physician. If the investor-owner is an immediate family member, please indicate the relationship to, and name of the physician to whom the investor-owner is related.
- Column E should indicate each investor-owner's percentage ownership in the entity at the end of the cost reporting period(s) in 2006, with the number of shares owned (if applicable) listed in Column F. Each type of share owned (if applicable) should be listed individually with the type of stock labeled in Column G.
- To calculate the percent of indirect ownership in Column H for each investor-owner of the entity, multiply the percentage in Column C by the percentage in Column E.

Worksheet 4—Payments Made to Hospital by Direct Owners

- Report only payments to the hospital by direct physician-owners and immediate family member owners on this Worksheet.
- Complete one line for each payment made by a physician-owner related to his or her investment interest, including, but not limited to: Initial investments, assessments, capital calls, and loan guarantees. If necessary, please insert additional lines.
- In Column B, indicate ''Self'' if the physician is the direct owner. If the direct owner is not the physician, please list the direct owner's name in Column A and in Column B, indicate the immediate family member's relationship to the physician and give the physician's name.
- Do not group payments under one physician name, but rather use a separate line for each type of payment made by a physician.

Worksheet 5—Payments Made to Hospital by Indirect Owners

- Report only payments made by indirect physician-owners and immediate family member owners on this Worksheet.
- Complete one line for each payment made by an entity related to an investment interest, including, but not limited to: Initial investments, assessments, capital calls, and loan guarantees. If necessary, please insert additional lines.
- List the name of the indirect ownership entity in Column A. In Column B, list the names of individuals that compose that entity, placing only one person per line and indicating his or her status, i.e. ''Self'' for physician, or ''IFM'' for immediate family member.
- For immediate family members, enter the relationship to and name of, the physician family member in Column C.
- Do not group payments under one entity name, but rather use a separate line for each type of payment made by an entity.

Worksheet 6—Investment Reconciliation

- Please *complete* a separate Worksheet for each physician-owner or immediate family member owner.
- Please provide the owner's Social Security Number (SSN) or NPI as appropriate.
- If a physician owns more than one class of stock/equity, a separate worksheet must be completed for each class of stock/equity.
- Line 10, Column A—The begin date must be the start of the cost reporting period(s) that end(s) in 2006. That is, for a cost reporting period of July 1, 2005 to June 30, 2006, the begin date is 07/01/05.
- Line 10, Columns B, C, and D must reflect the physician-owner's total investment for the class of stock/equity described, as of the beginning of the period being evaluated (all cost period(s) ending in 2006).
- Lines 11 through 17, Columns B, C, and D must reflect any and all changes to the physician-owner's stock/equity during the period being evaluated, so that line 18 reflects the owner's total investment at the end of the period.
- Line 17 must reflect all other capital assessments that occurred during the cost reporting period(s) ending in 2006.
- Line 18, Column A—The end date must be the end date of the cost reporting period(s) that end(s) in 2006. That is, for a cost reporting period of July 1, 2005 to June 30, 2006, the end date is 06/30/06.
- Line 18, Column B—The amount entered here should be equal to the amount listed on Worksheet 2, Column C for each class of stock for each physician owner.

Worksheet 7—Compensation Arrangements—Rentals, Personal Service Arrangements, and Recruitment (See 42 CFR 411.357)

- For all physicians who had one or more of the compensation arrangements listed in columns A through D list the physician's complete name in the first column, the physician's NPI, and insert either a Y or N as to whether the physician is an owner/investor of the hospital. In addition, please insert the applicable number of compensation arrangements in each respective column.
- For those compensation arrangements listed in columns A through D, include not just those that you believe fit within an exception in 42 CFR 411.357, but those that are implicated by the referenced exception.
- The information requested in columns A and B must include compensation arrangements that occur in either direction (i.e., rentals to/from physicians).
- Please indicate in the appropriate column *the number of compensation arrangements* that pertain to the physician for the reporting period(s) ending in 2006.
- Note that each Column A–D that is filled in with a number requires the submission of supporting documentation for each compensation arrangement. With the exception of uniform personal service arrangements, please submit a copy of the written agreement(s) that were in effect during the reporting period(s) ending in 2006.
- *Personal Service Arrangements (PSA—Column C)*
  - For each physician listed, please indicate the number of PSAs in effect for the cost reporting period(s) ending in 2006.
  - In the next column indicate if the physician used a uniform PSA prepared by the hospital. We consider a PSA to be uniform if all of the elements present in the arrangements are materially the same. Only one copy of the uniform PSA should be included in the supplemental materials. The

one copy will satisfy the supporting documentation requirement for all physicians who entered into a uniform PSA with the hospital.

○ Indicate whether or not the hospital has a signed copy of this agreement on file for this physician in the next sub-column with a Y or N.

○ If the physician had a non-uniform PSA in effect for the cost reporting period(s) ending in 2006, please indicate this on the Worksheet and provide a copy of the PSA with the supplemental materials for this Worksheet.

Worksheet 8—Other Types of Compensation Arrangements (See 42 CFR 411.357)

- This Worksheet addresses other compensation arrangements exceptions that are found at 42 CFR 411.357.
- Please note that you may be required to furnish an explanation or additional documentation depending on the answer to each question.
- Submit only the information that is necessary to answer the question by removing extraneous documentation where possible.

Questions

Questions regarding these instructions may be directed to: *DFRR-Questions@cms.hhs.gov*.

BILLING CODE 4120–01–P

Centers for Medicare & Medicaid Services

Disclosure of Financial Relationships Report ("DFRR")

Section 1877(f) of the Social Security Act authorizes the Secretary to collect, in such form, manner, and at such times as the Secretary shall specify, "information concerning [an] entity's ownership, investment and compensation arrangements, including" (1) the covered items and services furnished by the provider or supplier; and (2) the names and unique physician identification numbers (UPINs) of all physicians (or their immediate family members) with an ownership or investment interest, or compensation arrangement. The implementing regulation, 42 C.F.R. § 411.361, states that CMS and OIG may require entities to submit information concerning their reportable financial relationships (any ownership or investment interest, or compensation arrangement) with a physician (or his or her immediate family member).

In accordance with its authority under the statute and regulations, CMS is requiring that certain hospitals provide information concerning their ownership, investment and compensation arrangements by completing the Disclosure of Financial Relationships Report ("DFRR" or "Report").

Please send, in paper format, the original and one copy of the complete DFRR (which consists of the signed certification statement, all applicable worksheets, and all accompanying documentation) to: Physician Self-Referral, Centers for Medicare & Medicaid Services, 7500 Security Blvd., Mailstop C4-25-02, Baltimore, Maryland 21244-1850. (We also ask, but do not require, that you send an electronic version of the completed worksheets to HOSPITALDISCLOSURE@cms.hhs.gov.). The complete DFRR (hard copy) must be received by us no later than 60 days from the date that appears on the cover letter or e-mail transmission to you. Section 1877(g) of the Social Security Act provides that failure to disclose timely the information sought can result in civil monetary penalties of up to $10,000 for each day beyond the deadline established for disclosure. Questions concerning the mandatory Disclosure of Financial Relationships Report may be sent to:

DFRR-Questions@cms.hhs.gov

Certification Statement

I hereby certify that the attached responses to this Section 1877(f) Disclosure of Financial Relationships Report, filed on behalf of (insert Medicare Provider name) _____(insert Medicare Provider Number)_____ are true and correct to the best of my belief and knowledge.

_____
Signature

_____
Printed name

_____
Date

_____
Title *

* The certification must be signed by the Chief Executive Officer (CEO), Chief Financial Officer (CFO), or comparable officer of the hospital

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-XXXX**. The time required to complete this information collection is estimated to average 6 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Exception from Reporting Requirement

An entity that furnishes a total (Part A and Part B combined) of 20 or fewer Medicare services during a calendar year is excepted from this reporting requirement pursuant to 42 C.F.R. § 411.361(b). If you believe that you are excepted from this requirement, please have the CEO, CFO, or a comparable officer of the Hospital, certify in writing that your hospital furnishes 20 or fewer Part A and Part B services during a calendar year in the certification statement below.

Please send the completed and signed certification to: Physician Self-Referral, Centers for Medicare & Medicaid Services, 7500 Security Blvd., Mailstop C4-25-02, Baltimore, Maryland 21244-1850. In addition, please email an electronic copy of the certification to HOSPITALDISCLOSURE@cms.hhs.gov. In the subject matter line please insert the title, "Exception to Disclosure Report". Questions concerning the mandatory disclosure of financial relationships may be sent to:

DFRR-Questions@cms.hhs.gov

Certification Statement

I hereby certify that, to the best of my knowledge and belief (insert Hospital name), _____, (insert Provider Number), _____furnishes 20 or fewer Part A and Part B services during a calendar year. Thus, we are invoking the exception at 42 C.F.R. § 411.362(b) and will not be reporting financial relationship data concerning our facility.

_____
Signature

_____
Printed name

_____
Date

_____
Title *

* The certification must be signed by the Chief Executive Officer (CEO), Chief Financial Officer (CFO), or comparable officer of the hospital.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-XXXX**. The time required to complete this information collection is estimated to average 6 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

PLEASE READ ALL INSTRUCTIONS PRIOR TO COMPLETING THIS WORKSHEET AND FURNISH REQUIRED DOCUMENTATION

Worksheet 1
Hospital Characteristics

1 Hospital Legal Name 2 Medicare Provider Number
3 Hospital d/b/a Name 4 Medicare Participation Date (mm/dd/yy)
5 Address (1)
6 Address (2)
7 City 8 State 9 Zip
10 Cost Reporting Period(s) (Ending in 2006) (Begin) (End)
11 Ownership type Corp LP Not for Profit
LLC LLP Other (Specify): _____
12 Within the cost reporting period(s) ending in 2006, were there one or more individual physicians (including immediate family members) who had (1) a direct ownership or investment interest in the hospital (e.g., through stock issued in the physician's or immediate family member's name), and/or (2) an indirect ownership or investment interest in the hospital (e.g., through stock issued in the name of an entity such as a group practice or LLC or corporation in which the physician or immediate family member had an ownership interest)?

YES (Complete all worksheets)
NO (Complete worksheets 7 and 8)

13 Number of Licensed Beds

14 Provide the hospital's separate independently audited financial statements with footnotes and supplementary information. If not available, submit the financial statements that have been reviewed, but if not available, submit financial statements that have been compiled, but if not available, submit the financial statements that have been internally prepared. Indicate whether the submitted financial statements have been independently audited, reviewed, compiled, or internally prepared. The statements must be for the cost reporting period(s) ending in 2006.

15 Is there any type of limitation of liability (regardless of source) on any physician's (or immediate family member's) investment (e.g., a stop loss agreement)?

YES (Submit documentation and include the physician's name and NPI (or UPIN, if the physician has no NPI). I immediate family member, submit name and SSN. If no documentation exists, submit written description of arrangement and indicate that no documentation exists.

PLEASE READ ALL INSTRUCTIONS PRIOR TO COMPLETING THIS WORKSHEET AND FURNISH REQUIRED DOCUMENTATION

Worksheet 2

Direct Ownership in Hospital

	A	B	C	D
	Identify all Owners by Class of Stock	**Self / Relationship (if Immediate Family Member)**	**Basis of Stock/Shares (in Dollars)**	**Percent Ownership in Hospital**
	Example--Class A Stock			
	John M. Doe 123-34-5678	Self	$25,000	25.00%
	Alice Doe	Wife, John M. Doe	$25,000	25.00%
	Group Practice #1	N/A	$50,000	50.00%
	Total		$100,000	100.00%
Class _____:				
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	Total		_____	100.00%

Class _____:

Total			100.00%

Class _____:

Total			100.00%

PLEASE READ ALL INSTRUCTIONS PRIOR TO COMPLETING THIS WORKSHEET AND FURNISH REQUIRED DOCUMENTATION

Worksheet 3

Indirect Ownership in Hospital

	A	B	C	D	E	F	G	H
	Name of Entity	**Type of Entity**	**Entity's Direct Ownership %**	**Composition of Entity**	**% Ownership of Entity**	**Number of Shares Owned**	**Class of Stock/Shared**	**Percent of Indirect Ownership**
Ex .1	Group Practice A	Group Practice	50%	John Doe (physician)	50%	2000	Class A	25.00%
				Bob Brown (physician)	30%	1200	Class A	15.00%
				Susan Brown (Wife) Bob Brown	20%	800	Class A	10.00%
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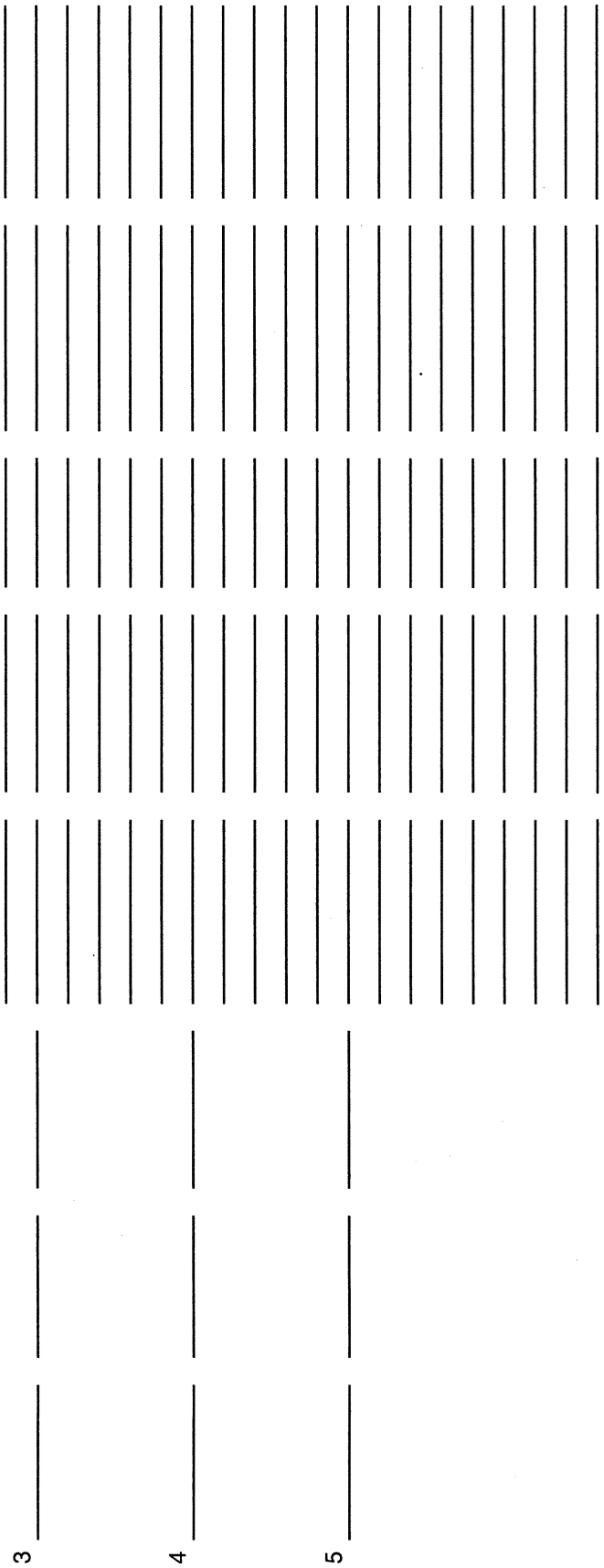
2								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PLEASE READ ALL INSTRUCTIONS PRIOR TO COMPLETING THIS WORKSHEET AND FURNISH REQUIRED DOCUMENTATION

Worksheet 4

Payments Made to Hospital by Direct Owners

List all payments made by physician-owners to the hospital based on or related to their direct investment interest, including, but not limited to, initial investments, assessments, capital calls, and loan guarantees:

	A	B	C	D	E	F
	Name of Physician	**Self / Relationship (if Immediate Family Member)**	**NPI**	**Date**	**Type of Payment**	**Amount**
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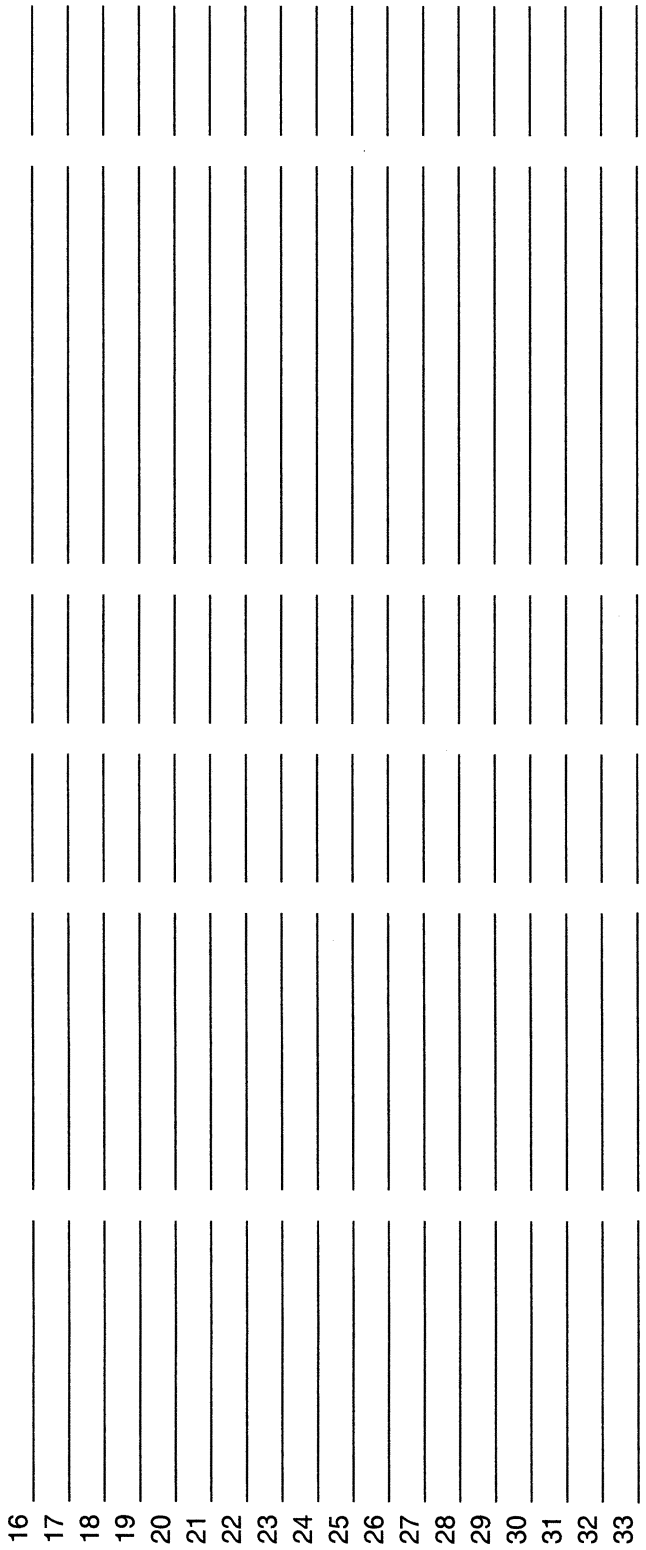
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PLEASE READ ALL INSTRUCTIONS PRIOR TO COMPLETING THIS WORKSHEET AND FURNISH REQUIRED DOCUMENTATION

Worksheet 5

Payments Made to Hospital by Indirect Owners

List all payments made by physician-owners to the hospital based on or related to their indirect investment interest, including, but not limited to, initial investments, assessments, capital calls, and loan guarantees:

	A	B	C	D	E	F	G
	Name of Entity:	**Composition of Entity and Classification**	**Self / Relationship (if Immediate Family Member)**	**NPI**	**Date**	**Type of Payment**	**Amount**
	Example -- Group Practice 1	John Doe (Physician) Bob Brown (Physician) Susan Brown (IFM)	Self Self Wife, Bob Brown				
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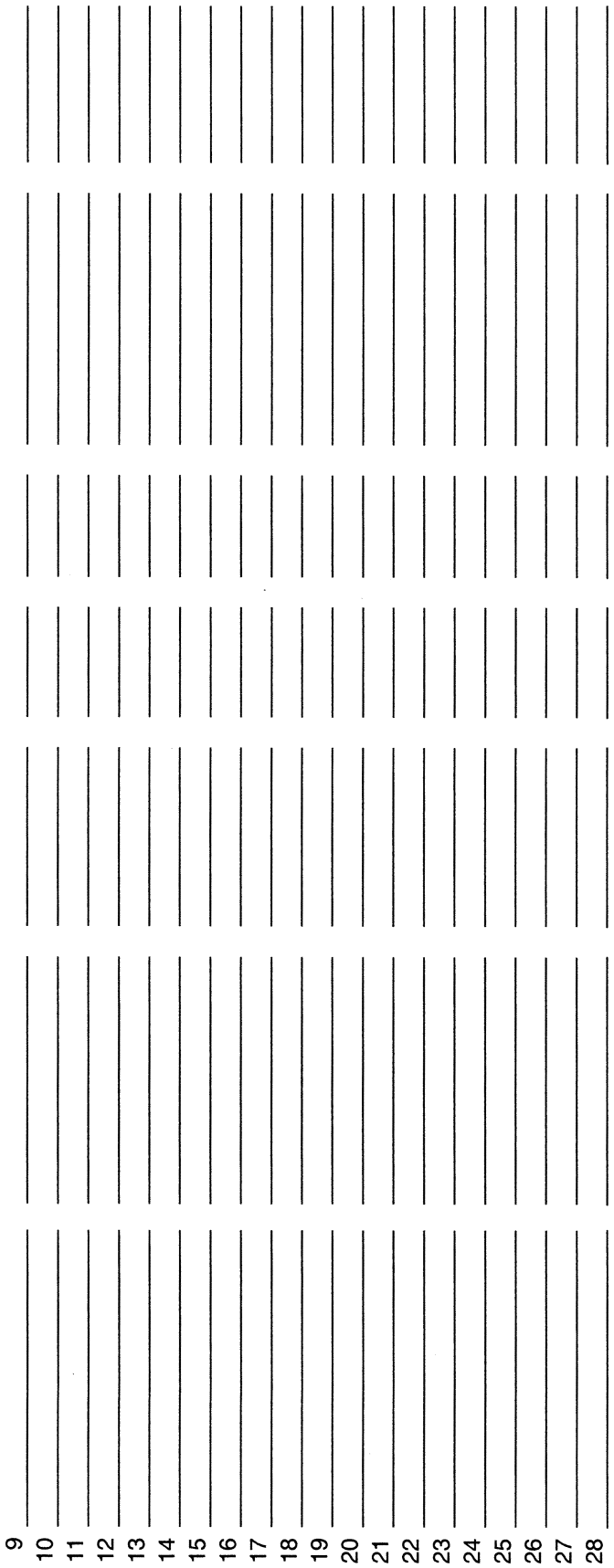
7							
8							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PLEASE READ ALL INSTRUCTIONS PRIOR TO COMPLETING THIS WORKSHEET AND FURNISH REQUIRED DOCUMENTATION

Worksheet 6

Investment Reconciliation

1 Name _____ 2 Owner: 3 Identification #

4 Address (1) _____ ☐ Individual Physician NPI: _____

5 Address (2) _____ ☐ Immediate Family SSN: _____

6 City _____ 7 State _____ 8 Zip _____ (Phys. Name _____)

9 **Class of Stock/Equity:** _____

	A Begin Date			B Dollar Amt		C # of Shares		D Cost per Share
10	_____ (mm/dd/yy)	Initial or Starting Investment $		_____		_____		_____
11		Additional Purchases	+		+	_____	+	_____
12		Stock Dividends			+	_____	+	_____
13		Stock Splits			+	_____	+	_____
14		Relinquishments or Sales	-	_____	-		-	
15		Return of Capital Dividends	-	_____			-	_____
16		Capital Calls	+	_____			+	_____
17		Other Capital Assessments (not fees) Explain: _____	+	_____	+		+	_____
18	_____ (mm/dd/06)	Investment at Cost Report Period Ending in 2006	$	_____	=	_____	=	_____

19 Is the physician-owner's risk of loss or liability limited or eliminated by agreement or understanding with any other party? (e.g., a stop-loss agreement, back-up guarantee, or disproportionate guarantee by physician investor).

☐ YES ☐ NO (If yes, complete line 20)

20 If Line 19 is yes, describe in detail here:

_____

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PLEASE READ ALL INSTRUCTIONS PRIOR TO COMPLETING THIS WORKSHEET AND FURNISH REQUIRED DOCUMENTATION

Worksheet 7

Compensation Arrangements -- Rentals, Personal Service Arrangements, and Recruitment (See 42 C.F.R. § 411.357)

			A	B	C			D
Physician Name	Physician NPI	Owner/Investor? Yes/No	Rental of Office Space§ 411.357(a)	Rental of Equipment §411.357(b)	Personal Service Arrangement* §411.357(d)			Physician Recruitment §411.357(e)
					# of PSAs	Uniform Y/N	Signed Y/N	

For each box completed with a number above, include a copy of the written agreement between the physician(s) and the hospital in force during the period ending in 2006.

***See full instructions for the PSA exception.**

PLEASE READ ALL INSTRUCTIONS PRIOR TO COMPLETING THIS WORKSHEET AND FURNISH REQUIRED DOCUMENTATION

Worksheet 8

Other Types of Compensation Arrangements (see 42 C.F.R. § 411357)

1 Were there any isolated transactions with a physician, such as one-time sale of property or sale of a practice (42 C.F.R. § 411.357(f))?

☐ YES ☐ NO

If yes, was the transaction consistent with fair market value?

☐ YES ☐ NO

If NO, attach an explanation. The explanation should include the physician's name and National Provider Identifier.

2 Was there any remuneration paid to a physician that did not relate to a designated health service (42 C.F.R. §411.357(g))

☐ YES ☐ NO

3 Were there any payments made by a physician to the hospital as compensation for any item or service not previously covered in this Report (42 C.F.R. § 411.357(i)?

☐ YES ☐ NO

If Yes, attach an explanation. The explanation should include the physician's name and National Provider Identifier.

4 Were there any charitable donations made by a physician to the hospital § 411.357(j)?

☐ YES ☐ NO

If Yes, attach an explanation. The explanation should include the physician's name and National Provider Identifier.

5 Were there any non-monetary compensation and/or medical staff incidental benefits granted to a physician that exceeded published limits (42 C.F.R. § 411.357 (k) & (m)?

☐ YES ☐ NO

If Yes, attach an explanation. The explanation should include the physician's name and National Provider Identifier.

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