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
Table 1D.—Capital Standard Federal Payment Rate
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Table 3A.—FY 2009 and 3-Year Average Hourly Wage for Urban Areas by CBSA
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Table 7A.—Medicare Prospective Payment System Selected Percentile Lengths of Stay: FY 2007 MedPAR Update—December 2007 GROUPER V25.0 MS–DRGs
Table 7B.—Medicare Prospective Payment System Selected Percentile Lengths of Stay: FY 2007 MedPAR Update—December 2007 GROUPER V26.0 MS–DRGs
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Table 9C.—Hospitals Redesignated as Rural under Section 1886(d)(8)(E) of the Act—FY 2009
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
Table 11.—Proposed FY 2009 MS–LTC–DRGs, Proposed Relative Weights, Proposed Geometric Average Length of Stay, and Proposed Short-Stay Outlier Threshold

TABLE 1A.—NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR

[69.7 Percent Labor Share/30.3 Percent Nonlabor Share if Wage Index Greater Than 1]

Full update (3.0 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