Federal Register

8–18–06 Friday
Vol. 71 No. 160 Aug. 18, 2006

Book 1 of 2 Books

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WHEN: Tuesday, September 12, 2006
9:00 a.m.–Noon

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Conference Room, Suite 700
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Washington, DC 20002

RESERVATIONS: (202) 741–6008

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DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2006–23884; Directorate Identifier 2006–CE–13–AD; Amendment 39–14726; AD 2006–17–05]

RIN 2120–AA64

Airworthiness Directives; Mitsubishi Heavy Industries MU–2B Series Airplanes

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule.

SUMMARY: The FAA adopts a new airworthiness directive (AD) for all Mitsubishi Heavy Industries (MHI) MU–2B series airplanes. This AD requires you to do flight checks of the rigging of the engine and propeller systems. This AD results from a recent safety evaluation that used a data-driven approach to evaluate the design, operation, and maintenance of the MU–2B series airplanes in order to determine their safety and define what steps, if any, are necessary for their safe operation. Part of that evaluation was the identification of unsafe conditions that exist or could develop on the affected type design airplanes. We are issuing this AD to detect and correct improper adjustment of the flight idle fuel flow setting. This condition, if uncorrected, could result in degraded performance and poor handling qualities with consequent loss of control of the airplane in certain situations.

DATES: This AD becomes effective on September 22, 2006.

As of September 22, 2006, the Director of the Federal Register approved the incorporation by reference of certain publications listed in the regulation.

ADDRESSES: To get the service information identified in this AD, contact Mitsubishi Heavy Industries America, Inc., 4951 Airport Parkway, Suite 800, Addison, Texas 75001; telephone: (972) 934–5480; facsimile: (972) 934–5488.

To view the AD docket, go to the Docket Management Facility; U.S. Department of Transportation, 400 Seventh Street, SW., Nassif Building, Room PL–401, Washington, DC 20590–0001 or on the Internet at *http://dms.dot.gov*. The docket number is FAA–2006–23884; Directorate Identifier 2006–CE–13–AD.

FOR FURTHER INFORMATION CONTACT: Rao Edupuganti, Aerospace Engineer, ASW–150, Fort Worth Aircraft Certification Office, 2601 Meacham Blvd., Fort Worth, Texas 76193; telephone: (817) 222–5284; facsimile: (817) 222–5960.

SUPPLEMENTARY INFORMATION:

Discussion

On April 21, 2006, we issued a proposal to amend part 39 of the Federal Aviation Regulations (14 CFR part 39) to include an AD that would apply to all Mitsubishi Heavy Industries (MHI) MU–2B series airplanes. This proposal was published in the **Federal Register** as a notice of proposed rulemaking (NPRM) on April 28, 2006 (71 FR 25117). The NPRM proposed to require you to do flight checks of the rigging of the engine and propeller systems.

Comments

We provided the public the opportunity to participate in developing this AD. The following presents the comments received on the proposal and FAA's response to each comment:

Comment Issue No. 1: Revise the Manufacturer Contact Information

Ralph Sorrells, Deputy General Manager of Mitsubishi Heavy Industries America, Inc., requests that we revise the manufacturer contact information from Mitsubishi Heavy Industries in Nagoya, Japan, to Mitsubishi Heavy Industries America, Inc. in Addison, Texas.

We agree with the commenter and will incorporate the change into this final rule AD action.

Comment Issue No. 2: Correct the Date of the Japanese AD

Ralph Sorrells, Deputy General Manager of Mitsubishi Heavy Industries America, Inc., requests that we correct the date of Japanese AD No. TCD 4890–98 from October 7, 1998, to November 4, 1998.

We agree with the commenter and will incorporate the change into this final rule AD action.

Comment Issue No. 3: Remove Long-Body Models From Table 1, Paragraph (c)(1)

The airplanes described in Table 1, paragraph (c)(1) are short-body airplanes. Models MU–2B–30, MU–2B–35, and MU–2B–36 are long-body airplanes.

Ralph Sorrells, Deputy General Manager of Mitsubishi Heavy Industries America, Inc., requests that we remove reference of the long-body airplanes from Table 1, paragraph (c)(1).

We agree with the commenter and will incorporate the change into this final rule AD action.

Comment Issue No. 4: Remove the Requirement to Have the Flight Check Done by Two Individuals

Richard W. Shine states that to require another pilot or mechanic to be on board in order to do the flight checks would require a specific flight just for that purpose. This requirement is unnecessarily burdensome and will add significant cost to their operation. The commenter states that he can and has successfully and safely performed the flight checks himself.

He requests that we remove the two-person flight check requirement.

We agree with the commenter that the flight checks required in paragraph (e) of the proposed AD can safely be conducted with one rated pilot. This procedure is consistent with the referenced service bulletin and current practices. We inadvertently added the requirement for two individuals to do this check.

We will incorporate the change into this final rule AD action and remove that requirement.

Comment Issue No. 5: Add Procedures for Checking the Flight Idle Fuel Flow on the Ground

Michael Machinski requests that we change the proposed AD to incorporate maintenance procedures for checking the flight idle fuel flow on the ground.

We do not agree with the commenter. Doing the flight idle flow check in flight is consistent with the referenced service

bulletins and current practices. The procedures in the service bulletins for doing this check have remained unchanged over the past 8 years.

Those procedures have proven to be good and acceptable; therefore, we are not changing the final rule AD action based on this comment.

Conclusion

We have carefully reviewed the available data and determined that air safety and the public interest require adopting the AD as proposed except for the changes above and minor editorial corrections. We have determined that these changes and minor corrections:

- Are consistent with the intent that was proposed in the NPRM for correcting the unsafe condition; and
- Do not add any additional burden upon the public than was already proposed in the NPRM.

Costs of Compliance

We estimate that this AD affects 397 airplanes in the U.S. registry.

We estimate the following costs to accomplish the initial flight check:

Labor cost	Parts cost	Total cost per airplane	Total cost on U.S. operators
1 work-hour × $80 per hour = $80	Not applicable	$80	$31,760

The FAA is committed to updating the aviation community of expected costs associated with the MU–2B series airplane safety evaluation conducted in 2005. As a result of that commitment, the accumulating expected costs of all ADs related to the MU–2B series airplane safety evaluation may be found in the Final Report section at the following Web site: *http://www.faa.gov/aircraft/air_cert/design_approvals/small_airplanes/cos/mu2_foia_reading_library/.*

Authority for this Rulemaking

Title 49 of the United States Code specifies the FAA's authority to issue rules on aviation safety. Subtitle I, Section 106 describes the authority of the FAA Administrator. Subtitle VII, Aviation Programs, describes in more detail the scope of the agency's authority.

We are issuing this rulemaking under the authority described in Subtitle VII, Part A, Subpart III, Section 44701, "General requirements." Under that section, Congress charges the FAA with promoting safe flight of civil aircraft in air commerce by prescribing regulations for practices, methods, and procedures the Administrator finds necessary for safety in air commerce. This regulation is within the scope of that authority because it addresses an unsafe condition that is likely to exist or develop on products identified in this AD.

Regulatory Findings

We have determined that this AD will not have federalism implications under Executive Order 13132. This AD will not have a substantial direct effect on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government.

For the reasons discussed above, I certify that this AD:

1. Is not a "significant regulatory action" under Executive Order 12866;
2. Is not a "significant rule" under the DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and
3. Will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

We prepared a summary of the costs to comply with this AD (and other information as included in the Regulatory Evaluation) and placed it in the AD Docket. You may get a copy of this summary by sending a request to us at the address listed under **ADDRESSES.** Include "Docket No. FAA–2006–23884; Directorate Identifier 2006–CE–13–AD" in your request.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

Adoption of the Amendment

■ Accordingly, under the authority delegated to me by the Administrator, the Federal Aviation Administration amends part 39 of the Federal Aviation Regulations (14 CFR part 39) as follows:

PART 39—AIRWORTHINESS DIRECTIVES

■ 1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

■ 2. FAA amends § 39.13 by adding a new AD to read as follows:

2006–17–05 Mitsubishi Heavy Industries: Amendment 39–14726; Docket No. FAA–2006–23884; Directorate Identifier 2006–CE–13–AD.

Effective Date

(a) This AD becomes effective on September 22, 2006.

Affected ADs

(b) None.

Applicability

(c) This AD affects the following airplane models and serial numbers that are certificated in any category:

TABLE 1.—APPLICABILITY

Type certificate	Models	Serial Nos.
(1) A2PC	MU–2B, MU–2B–10, MU–2B–15, MU–2B–20, MU–2B–25, and MU–2B–26.	008 through 312, 314 through 320, and 322 through 347.
(2) A2PC	MU–2B–30, MU–2B–35, and MU–2B–36	501 through 651, 653 through 660, and 662 through 696.
(3) A10SW	MU–2B–25, MU–2B–26, and MU–2B–26A, and MU–2B–40.	313SA, 321SA, and 348SA through 459SA.
(4) A10SW	MU–2B–35, MU–2B–36A, and MU–2B–60	652SA, 661SA, and 697SA through 1569SA.

Unsafe Condition

(d) This AD results from a recent safety evaluation that used a data-driven approach to analyze the design, operation, and maintenance of the MU–2B series airplanes in order to determine their safety and define what steps, if any, are necessary for their safe operation. Part of that evaluation was the identification of unsafe conditions that exist or could develop on the affected type design airplanes. The actions specified in this AD are intended to detect and correct improper adjustment of the flight idle fuel flow setting. The above issue, if uncorrected, could result in degraded performance and poor handling qualities with consequent loss of control of the airplane in certain situations.

Compliance

(e) To address this problem, you must do the following:

TABLE 2.—ACTIONS/COMPLIANCE/PROCEDURES

Actions	Compliance	Procedures
Do flight checks of the rigging of the engine and propeller systems and make any necessary corrections. The owner/operator holding at least a private pilot certificate as authorized by section 43.7 of the Federal Aviation Regulations (14 CFR 43.7) may do these actions. Make an entry into the aircraft logbook showing compliance with this portion of the AD in accordance with section 43.9 of the Federal Aviation Regulations (14 CFR 43.9).	Check within 100 hours time-in-service (TIS) after September 22, 2006 (the effective date of this AD), and repetitively thereafter at intervals not to exceed 100 hours TIS. If any corrections are necessary, make the corrections before further flight.	*For airplanes listed in TCDS A2PC:* Follow MHI MV–2 Service Bulletin No. 234, dated October 7, 1998. *For airplanes listed in TCDS A10SW:* Follow MHI MV–2 Service Bulletin No. 097/73–001, dated July 24, 1998.

Alternative Methods of Compliance (AMOCs)

(f) The Manager, Fort Worth ACO, FAA, ATTN: Rao Edupuganti, Aerospace Engineer, ASW–150, 2601 Meacham Blvd., Fort Worth, Texas 76193; telephone: (817) 222–5284; facsimile: (817) 222–5960, has the authority to approve AMOCs for this AD, if requested using the procedures found in 14 CFR 39.19.

Related Information

(g) Japan Civil Aviation Bureau Airworthiness Directive No. TCD 4890–98, dated November 4, 1998; and MHI MV–2 Service Bulletins No. 234, dated October 7, 1998; and No. 097/73–001, dated July 24, 1998, also address the subject of this AD.

Material Incorporated by Reference

(h) You must do the actions required by this AD following the instructions in Mitsubishi Heavy Industries MV–2 Service Bulletin No. 234, dated October 7, 1998; and Mitsubishi Heavy Industries MV–2 Service Bulletin No. 097/73–001, dated July 24, 1998. The Director of the Federal Register approved the incorporation by reference of this service bulletin in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. To get a copy of these service bulletins, contact Mitsubishi Heavy Industries America, Inc., 4951 Airport Parkway, Suite 800, Addison, Texas 75001; telephone: (972) 934–5480; facsimile: (972) 934–5488. To review copies of this service information, go to the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, go to: *http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html* or call (202) 741–6030. To view the AD docket, go to the Docket Management Facility; U.S. Department of Transportation, 400 Seventh Street, SW., Nassif Building, Room PL–401, Washington, DC 20590–0001 or on the Internet at *http://dms.dot.gov*. The docket number is FAA–2006–23884; Directorate Identifier 2006–CE–13–AD.

Issued in Kansas City, Missouri, on August 11, 2006.

John R. Colomy,

Acting Manager, Small Airplane Directorate, Aircraft Certification Service.

[FR Doc. E6–13554 Filed 8–17–06; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2006–23883; Directorate Identifier 2006–CE–12–AD; Amendment 39–14722; AD 2006–17–01]

RIN 2120–AA64

Airworthiness Directives; Mitsubishi Heavy Industries MU–2B Series Airplanes

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule.

SUMMARY: The FAA adopts a new airworthiness directive (AD) for all Mitsubishi Heavy Industries (MHI) MU–2B series airplanes. This AD requires you to incorporate power assurance charts into the Limitations Section of the Airplane Flight Manual (AFM), inspect the engine torque indication system, and recalibrate the torque pressure transducers as required. This AD results from a recent safety evaluation that used a data-driven approach to analyze the design, operation, and maintenance of the MU–2B series airplanes in order to determine their safety and define what steps, if any, are necessary for their safe operation. Part of that evaluation was the identification of unsafe conditions that exist or could develop on the affected type design airplanes. We are issuing this AD to detect and correct torque transducers that are out of calibration. The above issue, if uncorrected, could result in degraded performance and poor handling qualities with consequent loss of control of the airplane in certain situations.

DATES: This AD becomes effective on September 22, 2006.

As of September 22, 2006, the Director of the Federal Register approved the incorporation by reference of certain publications listed in the regulation.

ADDRESSES: To get the service information identified in this AD, contact Mitsubishi Heavy Industries America, Inc., 4951 Airport Parkway, Suite 800, Addison, Texas 75001; telephone: (972) 934–5480; facsimile: (972) 934–5488.

To view the AD docket, go to the Docket Management Facility; U.S. Department of Transportation, 400 Seventh Street, SW., Nassif Building, Room PL–401, Washington, DC 20590–0001 or on the Internet at *http://dms.dot.gov*. The docket number is FAA–2006–23883; Directorate Identifier 2006–CE–12–AD.

FOR FURTHER INFORMATION CONTACT: Rao Edupuganti, Aerospace Engineer, ASW–150, Fort Worth Aircraft Certification Office, 2601 Meacham Blvd., Fort Worth, Texas 76193; telephone: (817) 222–5284; facsimile: (817) 222–5960.

SUPPLEMENTARY INFORMATION:

Discussion

On April 21, 2006, we issued a proposal to amend part 39 of the Federal Aviation Regulations (14 CFR part 39) to include an AD that would apply to all

Mitsubishi Heavy Industries (MHI) MU–2B series airplanes. This proposal was published in the **Federal Register** as a notice of proposed rulemaking (NPRM) on April 28, 2006 (71 FR 25120). The NPRM proposed to detect and correct torque transducers that are out of calibration. The above issue, if uncorrected, could result in degraded performance and poor handling qualities with consequent loss of control of the airplane in certain situations.

Comments

We provided the public the opportunity to participate in developing this AD. The following presents the comments received on the proposal and FAA's response to each comment:

Comment Issue No. 1: Revise the Manufacturer Contact Information

Ralph Sorrells, Deputy General Manager of Mitsubishi Heavy Industries America, Inc., requests that we revise the manufacturer contact information from Mitsubishi Heavy Industries in Nagoya, Japan, to Mitsubishi Heavy Industries America, Inc. in Addison Texas.

We agree with the commenter and will incorporate the change into this final rule AD action.

Comment Issue No. 2: Correct the Date of the Japanese AD

Ralph Sorrells, Deputy General Manager of Mitsubishi Heavy Industries America, Inc., requests that we correct the date of Japanese AD No. TCD 4889–98 from October 7, 1998, to November 5, 1998.

We agree with the commenter and will incorporate the change into this final rule AD action.

Comment Issue No. 3: Remove Long-Body Models From Table 1, Paragraph (c)(1)

The airplanes described in Table 1, paragraph (c)(1) are short-body airplanes. Models MU–2B–30, MU–2B–35, and MU–2B–36 are long-body airplanes.

Ralph Sorrells, Deputy General Manager of Mitsubishi Heavy Industries America, Inc., requests that we remove reference of the long-body airplanes from Table 1, paragraph (c)(1).

We agree with the commenter and will incorporate the change into this final rule AD action.

Comment Issue No. 4: Add the Following Rows to TABLE 3.—AFM INSERTION PAGES:

Ralph Sorrells, Deputy General Manager of Mitsubishi Heavy Industries America, Inc., request that we add the following rows to TABLE 3.—AFM INSERTION PAGES:

MU–2B–25	AFM, Section 6, Revision 9, dated January 14, 1999	6–19
MU–2B–26	AFM, Section 6, Revision 9, dated January 14, 1999	6–19
MU–2B–35	AFM, Section 6, Revision 10, dated January 14, 1999	6–19

We agree with the commenter and will incorporate the change into this final rule AD action.

Conclusion

We have carefully reviewed the available data and determined that air safety and the public interest require adopting the AD as proposed except for the changes above and minor editorial corrections. We have determined that these changes and minor corrections:

- Are consistent with the intent that was proposed in the NPRM for correcting the unsafe condition; and
- Do not add any additional burden upon the public than was already proposed in the NPRM.

Costs of Compliance

We estimate that this AD affects 397 airplanes in the U.S. registry.

We estimate the following costs to accomplish the inspection:

Labor cost	Parts cost	Total cost per airplane	Total cost on U.S. operators
5 work-hours × $80 = $400	Not applicable	$400	$158,800

The FAA is committed to updating the aviation community of expected costs associated with the MU–2B series airplane safety evaluation conducted in 2005. As a result of that commitment, the accumulating expected costs of all ADs related to the MU–2B series airplane safety evaluation may be found in the Final Report section at the following Web site: *http://www.faa.gov/aircraft/air_cert/design_approvals/small_airplanes/cos/mu2_foia_reading_library/.*

Authority for This Rulemaking

Title 49 of the United States Code specifies the FAA's authority to issue rules on aviation safety. Subtitle I, Section 106 describes the authority of the FAA Administrator. Subtitle VII, Aviation Programs, describes in more detail the scope of the agency's authority.

We are issuing this rulemaking under the authority described in Subtitle VII, Part A, Subpart III, Section 44701, "General requirements." Under that section, Congress charges the FAA with promoting safe flight of civil aircraft in air commerce by prescribing regulations for practices, methods, and procedures the Administrator finds necessary for safety in air commerce. This regulation is within the scope of that authority because it addresses an unsafe condition that is likely to exist or develop on products identified in this AD.

Regulatory Findings

We have determined that this AD will not have federalism implications under Executive Order 13132. This AD will not have a substantial direct effect on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government.

For the reasons discussed above, I certify that this AD:

1. Is not a "significant regulatory action" under Executive Order 12866;
2. Is not a "significant rule" under the DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and
3. Will not have a significant economic impact, positive or negative, on a substantial number of small entities

under the criteria of the Regulatory Flexibility Act.

We prepared a summary of the costs to comply with this AD (and other information as included in the Regulatory Evaluation) and placed it in the AD Docket.

You may get a copy of this summary by sending a request to us at the address listed under **ADDRESSES.** Include "Docket No. FAA–2006–23883; Directorate Identifier 2006–CE–12–AD" in your request.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

Adoption of the Amendment

■ Accordingly, under the authority delegated to me by the Administrator, the Federal Aviation Administration amends part 39 of the Federal Aviation Regulations (14 CFR part 39) as follows:

PART 39—AIRWORTHINESS DIRECTIVES

■ 1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

■ 2. FAA amends § 39.13 by adding a new AD to read as follows:

2006–17–01 Mitsubishi Heavy Industries: Amendment 39–14722; Docket No. FAA–2006–23883; Directorate Identifier 2006–CE–12–AD.

Effective Date

(a) This AD becomes effective on September 22, 2006.

Affected ADs

(b) None.

Applicability

(c) This AD affects the following airplane models and serial numbers that are certificated in any category:

TABLE 1.—APPLICABILITY

Type certificate	Models	Serial Nos.
(1) A2PC	MU–2B, MU–2B–10, MU–2B–15, MU–2B–20, MU–2B–25, and MU–2B–26.	008 through 312, 314 through 320, and 322 through 347.
(2) A2PC	MU–2B–30, MU–2B–35, and MU–2B–36	501 through 651, 653 through 660, and 662 through 696.
(3) A10SW	MU–2B–25, MU–2B–26, MU–2B–26A, and MU–2B–40	313SA, 321SA, and 348SA through 459SA.
(4) A10SW	MU–2B–35, MU–2B–36, MU–2B–36A, and MU–2B–60	652SA, 661SA, and 697SA through 1569SA.

Unsafe Condition

(d) This AD is the result of a recent safety evaluation that used a data-driven approach to analyze the design, operation, and maintenance of the MU–2B series airplanes in order to determine their safety and define what steps, if any, are necessary for their safe operation. Part of that evaluation was the identification of unsafe conditions that exist or could develop on the affected type design airplanes. The actions specified in this AD are intended to detect and correct torque transducers that are out of calibration. The above issue, if uncorrected, could result in degraded performance and poor handling qualities and lead to loss of control of the airplane in certain situations.

Compliance

(e) To address this problem, you must do the following:

TABLE 2.—ACTIONS/COMPLIANCE/PROCEDURES

Actions	Compliance	Procedures
(1) Incorporate the following pages from the Airplane Flight Manual (AFM) charts listed in TABLE 3.—AFM INSERTION PAGES, paragraph (f) of this AD, into the Limitations Section of the FAA-approved AFM.	Within 100 hours time-in-service (TIS) after September 22, 2006 (the effective date of this AD).	The owner/operator holding at least a private pilot certificate as authorized by section 43.7 of the Federal Aviation Regulations (14 CFR 43.7) may do the flight manual changes requirement of this AD. Make an entry into the aircraft records showing compliance with this portion of the AD in accordance with section 43.9 of the Federal Aviation Regulations (14 CFR 43.9).
(2) Inspect the engine torque indication system and recalibrate the torque pressure transducers as required. This inspection requires the use of the power assurance charts referenced in paragraph (e)(1) of this AD and in TABLE 3, paragraph (f) of this AD.	Within 100 hours TIS after September 22, 2006 (the effective date of this AD).	(i) For airplanes listed in Type Certificate No. A2PC follow Mitsubishi Heavy Industries, Ltd. (MHI) MV–2 Service Bulletin No. 233A, dated January 14, 1999. (ii) For airplanes listed Type Certificate No. A10SW follow MHI Service Bulletin No. MV–2 095/77–002, dated July 15, 1998.

(f) Use the following power assurance charts when doing the ground check portion of the inspection required in paragraph (e)(2) of this AD.

TABLE 3.—AFM INSERTION PAGES

Model of airplane affected	Date and version of AFM	Page number from AFM
(i) MU–2B	AFM, Section 6, Revision 9, dated January 14, 1999	6–34.
(ii) MU–2B–15	AFM, Section 6, Revision 9, dated January 14, 1999	6–19.
(iii) MU–2B–20	AFM, Section 6, Revision 9, dated January 14, 1999	6–20.
(iv) MU–2B–25	AFM, Section 6, Reissued March 25, 1986; and	6–18 and 6–19
	AFM, Section 6, Revision 9, dated January 14, 1999	6–19.

TABLE 3.—AFM INSERTION PAGES—Continued

Model of airplane affected	Date and version of AFM	Page number from AFM
(v) MU–2B–26	AFM, Section 6, Reissued March 25, 1986; and	6–17 and 6–18
	AFM, Section 6, Revision 9, dated January 14, 1999	6–19.
(vi) MU–2B–26A	AFM, Section 6, Reissued March 25, 1986	6–17 and 6–18.
(vii) MU–2B–35	AFM, Section 6, Reissued March 25, 1986; and	6–18 and 6–19
	AFM, Section 6, Revision 9, dated January 14, 1999	6–19.
(viii) MU–2B–36A	AFM, Section 6, Reissued February 28, 1986	6–20 and 6–21.
(ix) MU–2B–40	AFM, Section 6, Reissued March 25, 1986	6–17 and 6–18.
(x) MU–2B–60	AFM, Section 6, Reissued September 24, 1985	6–19 and 6–20.
(xi) MU–2B–10	AFM, Section 6, Revision 9, dated January 14, 1999	6–19.
(xii) MU–2B–30	AFM, Section 6, Revision 10, dated January 14, 1999	6–19.
(xiii) MU–2B–36	AFM, Section 6, Revision 9, dated January 14, 1999	6–20.

Note: AFM, Section 6, Reissued March 25, 1986 (FAA-approved) TCDS A10SW. AFM, Section 6, Revision 9 and Revision 10, dated January 14, 1999 (JCAB-approved).

Alternative Methods of Compliance (AMOCs)

(g) The Manager, Fort Worth Aircraft Certification Office, FAA, ATTN: Rao Edupuganti, Aerospace Engineer, ASW–150, Fort Worth ACO, 2601 Meacham Blvd., Fort Worth, Texas 76193; telephone: (817) 222–5284; facsimile: (817) 222–5960, has the authority to approve AMOCs for this AD, if requested using the procedures found in 14 CFR 39.19.

Related Information

(h) Japan Civil Aviation Bureau Airworthiness Directive No. TCD 4889–98, dated November 5, 1998, also addresses the subject of this AD.

Material Incorporated by Reference

(i) You must do the actions required by this AD following the instructions in Mitsubishi Heavy Industries, Ltd. MV–2 Service Bulletins No. 233A, dated January 14, 1999; and No. 095/77–002, dated July 15, 1998. The Director of the Federal Register approved the incorporation by reference of this service bulletin in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. To get a copy of this service information, contact Mitsubishi Heavy Industries America, Inc., 4951 Airport Parkway, Suite 800, Addison, Texas 75001; telephone: (972) 934–5480; facsimile: (972) 934–5488. To review copies of this service information, go to the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, go to: *http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html* or call (202) 741–6030. To view the AD docket, go to the Docket Management Facility; U.S. Department of Transportation, 400 Seventh Street, SW., Nassif Building, Room PL–401, Washington, DC 20590–0001 or on the Internet at *http://dms.dot.gov*. The docket number is FAA–2006–23883; Directorate Identifier 2006–CE–12–AD.

Issued in Kansas City, Missouri, on August 9, 2006.

John R. Colomy,

Acting Manager, Small Airplane Directorate, Aircraft Certification Service.

[FR Doc. E6–13441 Filed 8–17–06; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2006–24253; Directorate Identifier 2006–CE–23–AD; Amendment 39–14723; AD 2006–17–02]

RIN 2120–AA64

Airworthiness Directives; GROB–WERKE GMBH & CO KG Model G102 ASTIR CS Sailplanes

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule.

SUMMARY: The FAA supersedes Airworthiness Directive (AD) 84–09–05, which applies to certain GROB–WERKE GMBH & CO KG (previously identified as BURKHART–GROB FLUGZEUGBAU INDUSTRIESTRABE) Model G102 ASTIR CS sailplanes. AD 84–09–05 requires you to install a modified spherical locking bolt and nut in the forward horizontal stabilizer connection to the vertical stabilizer and install new locking pins in the aft connecting plate for the horizontal stabilizer. Since we issued AD 84–09–05, fatigue cracks were found in the modified spherical locking bolt. Consequently, this AD requires you to replace the modified spherical locking bolt, the retaining pins (collar bolts), and associated hardware; add a life limit on the spherical locking bolt and the retaining pins; and repetitively inspect the front and rear horizontal stabilizer attachment. This AD results from mandatory continuing airworthiness information (MCAI) issued by the airworthiness authority for Germany. We are issuing this AD to prevent cracks in the spherical locking bolt, which could result in failure of the horizontal stabilizer connection. This failure could lead to loss of control.

DATES: This AD becomes effective on September 22, 2006.

As of September 22, 2006, the Director of the Federal Register approved the incorporation by reference of certain publications listed in the regulation.

ADDRESSES: For service information identified in this AD, contact GROB Luft-und Raumfahrt, Lettenbachstrasse 9, D–86874 Tussenhausen-Mattsies, Federal Republic of Germany; telephone: 011 49 8268 998139; fax: 011 49 8268 998200; e-mail: *productsupport@grob-aerospace.de*.

To view the AD docket, go to the Docket Management Facility, U.S. Department of Transportation, 400 Seventh Street, SW., Nassif Building, Room PL–401, Washington, DC 20590–0001 or on the Internet at *http://dms.dot.gov*. The docket number is FAA–2006–24253; Directorate Identifier 2006–CE–23–AD.

FOR FURTHER INFORMATION CONTACT: Gregory A. Davison, Aerospace Engineer, ACE–112, Small Airplane Directorate, 901 Locust, Room 301, Kansas City, Missouri 64106; telephone: (816) 329–4130; facsimile: (816) 329–4090.

SUPPLEMENTARY INFORMATION:

Discussion

On May 30, 2006, we issued a proposal to amend part 39 of the Federal Aviation Regulations (14 CFR part 39) to include an AD that would apply to certain GROB–WERKE GMBH & CO KG (previously identified as BURKHART–GROB FLUGZEUGBAU INDUSTRIESTRABE) Model G102 ASTIR CS sailplanes. This proposal was published in the **Federal Register** as a notice of proposed rulemaking (NPRM)

on June 6, 2006 (71 FR 32484). The NPRM proposed to supersede AD 84–09–05 with a new AD that would require you to do the following:

- Remove the existing spherical locking bolt, nut, retaining pins (collar bolts), self-locking nut, and the lock washer; and replace with a new spherical locking bolt, P/N 102–3500.21, that has revision letter "b" permanently marked on the bottom of the bolt, a new nut, P/N 102–3510.21, new retaining pins (collar bolts), P/N 102–2142.46, a new self-locking nut, P/N LN9348–M8, and a new lock washer, P/N DIN 6797–10,5PHR;
- Add a life limit on the new spherical locking bolt and the retaining pins; and
- Inspect (repetitively) the front and rear horizontal stabilizer attachment assembly after the initial replacements.

Comments

We provided the public the opportunity to participate in developing this AD. The following presents the comments received on the proposal and FAA's response to each comment:

Comment Issue No. 1: Address the Intent of the AD as It Affects Parts Manufacturer Approval (PMA) Alternatives to the Original Equipment Manufacturer (OEM) Part

The Modification and Replacement Parts Association (MARPA) provides comments to the mandatory continuing airworthiness information (MCAI) AD process pertaining to how the FAA addresses PMA parts. The commenter would like to see the FAA more fully address the intent of the AD as it affects PMA alternatives to the unsafe OEM part.

We acknowledge the need to ensure that unsafe parts are identified and addressed in MCAI-related ADs. For this AD, we use the phrase "or FAA-approved equivalent part number" to address the PMA issue. We are currently examining all aspects of this issue, including input from industry. Once we have made a final determination, we will consider how our policy regarding PMA parts in ADs needs to be revised. We consider that to delay this AD action would be inappropriate since we have determined that an unsafe condition exists and that replacement of certain parts must be accomplished to ensure continued safety.

We have not changed the final rule AD action based on this comment.

Conclusion

We have carefully reviewed the available data and determined that air safety and the public interest require adopting the AD as proposed except for minor editorial corrections. We have determined that these minor corrections:

- Are consistent with the intent that was proposed in the NPRM for correcting the unsafe condition; and
- Do not add any additional burden upon the public than was already proposed in the NPRM.

Differences Between This AD and the Service Information

The service information specifies using a 20X magnifying glass for doing the inspections. This AD specifies using a dye penetrant method and a 10X magnifying glass for doing the inspections. This difference is because 20X magnifiers are not readily available in the field.

The requirements of this AD take precedence over the provisions in the service information.

Costs of Compliance

We estimate that this AD will affect 56 sailplanes in the U.S. registry.

We estimate the following costs to do the replacements:

Labor cost	Parts cost	Total cost for each sailplane	Total cost on U.S. operators
2 work-hours × $80 per hour = $160	$253	$413	$23,128

We estimate the following costs to do each inspection:

Labor cost	Parts cost	Total cost for each sailplane	Total cost on U.S. operators
2 work-hours × $80 per hour = $160	Not applicable	$160	$8,960

Authority for This Rulemaking

Title 49 of the United States Code specifies the FAA's authority to issue rules on aviation safety. Subtitle I, Section 106 describes the authority of the FAA Administrator. Subtitle VII, Aviation Programs, describes in more detail the scope of the agency's authority.

We are issuing this rulemaking under the authority described in Subtitle VII, Part A, Subpart III, Section 44701, "General requirements." Under that section, Congress charges the FAA with promoting safe flight of civil aircraft in air commerce by prescribing regulations for practices, methods, and procedures the Administrator finds necessary for safety in air commerce. This regulation is within the scope of that authority because it addresses an unsafe condition that is likely to exist or develop on products identified in this AD.

Regulatory Findings

We have determined that this AD will not have federalism implications under Executive Order 13132. This AD will not have a substantial direct effect on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government.

For the reasons discussed above, I certify that this AD:

1. Is not a "significant regulatory action" under Executive Order 12866;
2. Is not a "significant rule" under the DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and
3. Will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

We prepared a summary of the costs to comply with this AD (and other information as included in the Regulatory Evaluation) and placed it in the AD Docket. You may get a copy of this summary by sending a request to us at the address listed under **ADDRESSES.** Include "Docket No. FAA–2006–24253;

Directorate Identifier 2006–CE–23–AD" in your request.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

Adoption of the Amendment

■ Accordingly, under the authority delegated to me by the Administrator, the Federal Aviation Administration amends part 39 of the Federal Aviation Regulations (14 CFR part 39) as follows:

PART 39—AIRWORTHINESS DIRECTIVES

■ 1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

■ 2. FAA amends § 39.13 by removing Airworthiness Directive (AD) 84–09–05, Amendment 39–4849, and adding the following new AD:

2006–17–02 GROB–WERKE GMBH & CO KG (previously identified as BURKHART–GROB FLUGZEUGBAU INDUSTRIESTRABE): Amendment 39–14723; Docket No. FAA–2006–24253; Directorate Identifier 2006–CE–23–AD.

Effective Date

(a) This AD becomes effective on September 22, 2006.

Affected ADs

(b) This AD supersedes 84–09–05, Amendment 39–4849.

Applicability

(c) This AD affects Model G102 ASTIR CS sailplanes, serial numbers 1001 through 1536; that are certificated in any category.

Unsafe Condition

(d) This AD results from mandatory continuing airworthiness information (MCAI) issued by the airworthiness authority for Germany. We are issuing this AD to prevent cracks in the spherical locking bolt, which could result in failure of the horizontal stabilizer connection. This failure could lead to loss of control.

Compliance

(e) To address this problem, you must do the following:

Actions	Compliance	Procedures
(1) Remove and replace as follows: (i) Remove the existing retaining pins (collar bolts) and the self-locking nut and replace with new retaining pins, part numbers (P/N) 102–2142.46, and self-locking nut, P/N LN9348–M8 (or FAA-approved equivalent part numbers), on the T-plate; (ii) Remove the existing spherical locking bolt and replace with a new spherical locking bolt, P/N 102–3500.21, that has revision letter "b" permanently marked on the bottom of the bolt (or FAA-approved equivalent part number). Return replaced spherical locking bolts, P/N 102–3500.21, to Grob Systems, Inc., Aircraft Division, 1070 Navajo Drive, Bluffton, Ohio 45817; (iii) Remove the existing nut and replace with a new nut, 102–3510.21 (or FAA-approved equivalent part number); and (iv) Remove the existing lock washer and replace with a new lock washer, P/N DIN 6797–10,5PHR (or FAA-approved equivalent part number)	Within the next 90 days after September 22, 2006 (the effective date of this AD), unless already done. After doing the replacements, the spherical locking bolt and the retaining pins have a life limit of 10 years and must be replaced at that time.	As specified in GROB Service Bulletin MSB306–38/1, dated November 28, 2005, following the Accomplishment Instructions in GROB Service Bulletin MSB306–38, dated February 12, 2004, and the Annual Inspection procedures on pages 7 and 8 of the Astir CS Maintenance Manual, Rev. 9, dated Nov. 2005.
(2) Using a dye-penetrant method along with a minimum 10X magnifying glass, repetitively inspect the front and rear horizontal stabilizer attachment assembly for excessive movement, cracks, and/or damage in the spherical locking bolt. This inspection method takes precedence over the procedures outlined in GROB Service Bulletin MSB306–38, dated February 12, 2004.	Initially inspect within the next 100 hours time-in-service (TIS) or at the next annual inspection after the replacement required in paragraph (e)(1) of this AD, whichever occurs first. Repetitively inspect thereafter at 12-month intervals or at intervals not to exceed 100 hours TIS, whichever occurs first.	As specified in GROB Service Bulletin MSB306–38/1, dated November 28, 2005, following the Accomplishment Instructions in GROB Service Bulletin MSB306–38, dated February 12, 2004, and the Annual Inspection procedures on pages 7 and 8 of the Astir CS Maintenance Manual, Rev. 9, dated Nov. 2005.
(3) If, during any inspection required in paragraph (e)(2) of this AD, you find excessive movement:		

Actions	Compliance	Procedures
(i) In the front horizontal stabilizer attachment, you must replace the spherical locking bolt with a new part.	Before further flight after each inspection required in paragraph (e)(2) of this AD. After each replacement, the spherical locking bolt and the retaining pins have a life limit of 10 years and must be replaced at that time.	As specified in GROB Service Bulletin MSB306–38/1, dated November 28, 2005, following the Accomplishment Instructions in GROB Service Bulletin MSB306–38, dated February 12, 2004, and the Annual Inspection procedures on pages 7 and 8 of the Astir CS Maintenance Manual, Rev. 9, dated Nov. 2005.
(ii) In the rear horizontal stabilizer attachment, you must replace the retaining pins with new parts		
(iii) In the front and rear horizontal stabilizer attachment after doing the replacement(s) required in paragraph (e)(3)(i) and (e)(3)(ii) of this AD, you must replace the bearings in the stabilizer spar web		
(4) If, during any inspection required in paragraph (e)(2) of this AD, you do not find excessive movement in the front and rear horizontal stabilizer attachment:		
(i) Inspect the spherical locking bolt for cracks and damage using a dye-penetrant method along with a minimum 10X magnifying glass	Before further flight after each inspection required in paragraph (e)(2) of this AD. After each replacement, the spherical locking bolt and the retaining pins have a life limit of 10 years and must be replaced at that time.	As specified in GROB Service Bulletin MSB306–38/1, dated November 28, 2005, following the Accomplishment Instructions in GROB Service Bulletin MSB306–38, dated February 12, 2004, and the Annual Inspection procedures on pages 7 and 8 of the Astir CS Maintenance Manual, Rev. 9, dated Nov. 2005.
(ii) If you find cracks or damage on the spherical locking bolt, during the inspection required in paragraph (e)(4)(i) of this AD, you must replace the bolt with a new bolt		
(5) Do not install any spherical locking bolt, P/N 102–3500.21 (or FAA-approved equivalent part number), that does not have revision letter "b" permanently marked on the bottom of the bolt.	As of September 22, 2006 (the effective date of this AD).	Not applicable.
(6) 14 CFR 21.303 allows for replacement parts through parts manufacturer approval (PMA). The phrase "or FAA-approved equivalent part number" in this AD is intended to signify those parts that are PMA parts approved through identicality to the design of the part under the type certificate and replacement parts to correct the unsafe condition under PMA (other than identicality). If parts are installed that are identical to the unsafe parts, then the corrective actions of the AD affect these parts also. In addition, equivalent replacement parts to correct the unsafe condition under PMA (other than identicality) may also be installed provided they meet current airworthiness standards, which include those actions cited in this AD.	Not applicable	Not applicable.

Note: During ground handling, it has been noted that a tendency exists for the ground crew to move these gliders by using the horizontal stabilizer as a lifting point. This practice may facilitate damage to the stabilizer assembly and should be avoided. See Caution note in GROB Service Bulletin MSB306–38, dated February 12, 2004.

Alternative Methods of Compliance (AMOCs)

(f) The Manager, Standards Office, Small Airplane Directorate, FAA, ATTN: Gregory A. Davison, Aerospace Engineer, ACE–112, Small Airplane Directorate, 901 Locust, Room 301, Kansas City, Missouri 64106; telephone: (816) 329–4130; facsimile: (816) 329–4090, has the authority to approve AMOCs for this AD, if requested using the procedures found in 14 CFR 39.19.

(g) AMOCs approved for AD 84–09–05 are not approved for this AD.

Related Information

(h) German AD Number D–2004–168, dated March 23, 2004, also addresses the subject of this AD.

Material Incorporated by Reference

(i) You must do the actions required by this AD following the instructions in GROB Service Bulletin MSB306–38, dated February 12, 2004, and GROB Service Bulletin MSB306–38/1, dated November 28, 2005. The Director of the Federal Register approved the incorporation by reference of this service bulletin in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. To get a copy of this service information, contact GROB Luft-und Raumfahrt, Lettenbachstrasse 9, D–86874 Tussenhausen-Mattsies, Federal Republic of Germany; telephone: 011 49 8268 998139; fax: 011 49 8268 998200; e-mail: *productsupport@grob-aerospace.de.* To review copies of this service information, go to the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, go to: *http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html* or call (202) 741–6030. To view the AD docket, go to the Docket Management Facility; U.S. Department of Transportation, 400 Seventh Street, SW., Nassif Building, Room PL–401, Washington, DC 20590–0001 or on the Internet at *http://*

dms.dot.gov. The docket number is FAA–2006–24253; Directorate Identifier 2006–CE–23–AD.

Issued in Kansas City, Missouri, on August 9, 2006.

John R. Colomy,

Acting Manager, Small Airplane Directorate, Aircraft Certification Service.

[FR Doc. E6–13439 Filed 8–17–06; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2006–23889; Directorate Identifier 2005–NM–252–AD; Amendment 39–14714; AD 2006–16–14]

RIN 2120–AA64

Airworthiness Directives; Airbus Model A318, A319, A320, and A321 Airplanes

AGENCY: Federal Aviation Administration (FAA), Department of Transportation (DOT).

ACTION: Final rule.

SUMMARY: The FAA is adopting a new airworthiness directive (AD) for certain Airbus Model A318, A319, A320, and A321 airplanes. This AD requires inspecting to determine the part number of the twin motor actuators, and related investigative and corrective actions if necessary. This AD results from a report of a low pressure valve of the twin motor actuator found partially open, although the valve detection system indicated that the valve was closed. Investigation revealed that the locating pin in the actuator was too short to engage with the valve slot, resulting in incorrect alignment of the actuator and the drive assembly, causing the valve to remain partially open. We are issuing this AD to ensure that, in the event of an engine fire, the valve actuator functions properly to block the fuel flow to the engine and prevent an uncontrollable fire.

DATES: This AD becomes effective September 22, 2006.

The Director of the Federal Register approved the incorporation by reference of certain publications listed in the AD as of September 22, 2006.

ADDRESSES: You may examine the AD docket on the Internet at *http://dms.dot.gov* or in person at the Docket Management Facility, U.S. Department of Transportation, 400 Seventh Street, SW., Nassif Building, Room PL–401, Washington, DC.

Contact Airbus, 1 Rond Point Maurice Bellonte, 31707 Blagnac Cedex, France, for service information identified in this AD.

FOR FURTHER INFORMATION CONTACT: Dan Rodina, Aerospace Engineer, International Branch, ANM–116, Transport Airplane Directorate, FAA, 1601 Lind Avenue, SW., Renton, Washington 98057–5356; telephone (425) 227–2125; fax (425) 227–1149.

SUPPLEMENTARY INFORMATION:

Examining the Docket

You may examine the AD docket on the Internet at *http://dms.dot.gov* or in person at the Docket Management Facility office between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The Docket Management Facility office (telephone (800) 647–5227) is located on the plaza level of the Nassif Building at the street address stated in the **ADDRESSES** section.

Discussion

The FAA issued a supplemental notice of proposed rulemaking (NPRM) to amend 14 CFR part 39 to include an AD that would apply to certain Airbus Model A318, A319, A320, and A321 airplanes. That supplemental NPRM was published in the **Federal Register** on May 18, 2006 (71 FR 28825). That supplemental NPRM proposed to require inspecting to determine the part number of the twin motor actuators, and related investigative and corrective actions if necessary. That supplemental NPRM also proposed to revise the original NPRM by expanding the applicability.

Comments

We provided the public the opportunity to participate in the development of this AD. We have considered the single comment received.

Request To Add Revised Service Information to Applicability Section

Airbus advises that the service bulletin specified in the supplemental NPRM has been revised. Airbus notes that Airbus Service Bulletin A320–28–1122, Revision 01, including Appendix 01, dated April 11, 2006 (the original issue of the service bulletin was referenced in the supplemental NPRM for accomplishing the specified actions), changes the recommended status of the original issue to mandatory in Revision 01.

We agree with Airbus. We have reviewed Revision 01 of the service bulletin and note that it does not necessitate additional work. We have revised paragraph (f) of the AD to reflect Revision 01 of the service bulletin. In addition, we have added a new paragraph (g) to this AD specifying that accomplishing the actions specified in paragraph (f) of the AD in accordance with the original issue of the service bulletin is considered to be an acceptable method of compliance. Subsequent paragraphs of the AD have been re-identified accordingly.

Conclusion

We have carefully reviewed the available data, including the comment received, and determined that air safety and the public interest require adopting the AD with the changes described previously. These changes will neither increase the economic burden on any operator nor increase the scope of the AD.

Costs of Compliance

This AD affects about 763 airplanes of U.S. registry. The inspection takes about 1 work hour per airplane, at an average labor rate of $80 per work hour. Based on these figures, the estimated cost of this AD on U.S. operators is $61,040, or $80 per airplane.

Authority for This Rulemaking

Title 49 of the United States Code specifies the FAA's authority to issue rules on aviation safety. Subtitle I, section 106, describes the authority of the FAA Administrator. Subtitle VII, Aviation Programs, describes in more detail the scope of the Agency's authority.

We are issuing this rulemaking under the authority described in subtitle VII, part A, subpart III, section 44701, "General requirements." Under that section, Congress charges the FAA with promoting safe flight of civil aircraft in air commerce by prescribing regulations for practices, methods, and procedures the Administrator finds necessary for safety in air commerce. This regulation is within the scope of that authority because it addresses an unsafe condition that is likely to exist or develop on products identified in this rulemaking action.

Regulatory Findings

We have determined that this AD will not have federalism implications under Executive Order 13132. This AD will not have a substantial direct effect on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government.

For the reasons discussed above, I certify that this AD:

(1) Is not a "significant regulatory action" under Executive Order 12866;

(2) Is not a "significant rule" under DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and

(3) Will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

We prepared a regulatory evaluation of the estimated costs to comply with this AD and placed it in the AD docket. See the **ADDRESSES** section for a location to examine the regulatory evaluation.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

Adoption of the Amendment

■ Accordingly, under the authority delegated to me by the Administrator, the FAA amends 14 CFR part 39 as follows:

PART 39—AIRWORTHINESS DIRECTIVES

■ 1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

■ 2. The Federal Aviation Administration (FAA) amends § 39.13 by adding the following new airworthiness directive (AD):

2006–16–14 Airbus: Amendment 39–14714. Docket No. FAA–2006–23889; Directorate Identifier 2005–NM–252–AD.

Effective Date

(a) This AD becomes effective September 22, 2006.

Affected ADs

(b) None.

Applicability

(c) This AD applies to Airbus Model A318, A319, A320, and A321 airplanes, certificated in any category, except airplanes having manufacturer serial numbers (MSN) 2155 and subsequent.

Unsafe Condition

(d) This AD results from a report of a low pressure valve of the twin motor actuator found partially open, although the valve detection system indicated that the valve was closed. Investigation revealed that the locating pin in the actuator was too short to engage with the valve slot, resulting in incorrect alignment of the actuator and the drive assembly, causing the valve to remain partially open. We are issuing this AD to ensure that, in the event of an engine fire, the valve actuator functions properly to block the fuel flow to the engine and prevent an uncontrollable fire.

Compliance

(e) You are responsible for having the actions required by this AD performed within the compliance times specified, unless the actions have already been done.

Inspection/Related Investigative and Corrective Actions

(f) Within 6,000 flight hours or 24 months after the effective date of this AD, whichever is first: Inspect to determine the part number (P/N) of the twin motor actuators in accordance with Airbus Service Bulletin A320–28–1122, Revision 01, including Appendix 01, dated April 11, 2006.

(1) For airplanes having any actuator with P/N FRH010041 or P/N FRH010034, no further action is required by this paragraph.

(2) For airplanes having any actuator with P/N HTE190001–2, where the actuator serial number is not identified in Appendix 01 of the service bulletin, no further action is required by this paragraph.

(3) For airplanes having any actuator with P/N HTE190001 or HTE190001–1, do all applicable related investigative and corrective actions before further flight, in accordance with the service bulletin.

(4) For airplanes have any actuator with P/N HTE190001–2, where the actuator serial number is identified in Appendix 01 of the service bulletin, do all applicable related investigative and corrective actions before further flight, in accordance with the service bulletin.

Note 1: Airbus Service Bulletin A320–28–1122, Revision 01, dated April 11, 2006, refers to FR–HiTEMP Service Bulletin HTE190001–28–003, dated March 30, 2004, as an additional source of service information for determining the P/N of the twin motor actuators and accomplishing any related investigative and corrective actions.

Acceptable for Compliance

(g) Accomplishment of the actions required by paragraph (f) of this AD before the effective date of this AD in accordance with Airbus Service Bulletin A320–28–1122, including Appendix 01, dated November 19, 2004, is acceptable for compliance with the requirements of that paragraph.

Parts Installation

(h) As of the effective date of this AD: No person may install an actuator with P/N HTE190001, HTE190001–1, or HTE190001–2, and a serial number identified in Appendix 01 of Airbus Service Bulletin A320–28–1122, Revision 01, dated April 11, 2006, on any airplane unless all applicable related investigative and corrective actions have been done in accordance with the requirements of paragraph (f)(3) of this AD.

Alternative Methods of Compliance (AMOCs)

(i)(1) The Manager, International Branch, ANM–116, Transport Airplane Directorate, FAA, has the authority to approve AMOCs for this AD, if requested in accordance with the procedures found in 14 CFR 39.19.

(2) Before using any AMOC approved in accordance with § 39.19 on any airplane to which the AMOC applies, notify the appropriate principal inspector in the FAA Flight Standards Certificate Holding District Office.

Related Information

(j) French airworthiness directive F–2005–189, dated November 23, 2005, also addresses the subject of this AD.

Material Incorporated by Reference

(k) You must use Airbus Service Bulletin A320–28–1122, Revision 01, including Appendix 01, dated April 11, 2006, to perform the actions that are required by this AD, unless the AD specifies otherwise. The Director of the Federal Register approved the incorporation by reference of this document in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. Contact Airbus, 1 Rond Point Maurice Bellonte, 31707 Blagnac Cedex, France, for a copy of this service information. You may review copies at the Docket Management Facility, U.S. Department of Transportation, 400 Seventh Street, SW., Room PL–401, Nassif Building, Washington, DC; on the Internet at *http://dms.dot.gov*; or at the National Archives and Records Administration (NARA). For information on the availability of this material at the NARA, call (202) 741–6030, or go to *http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.*

Issued in Renton, Washington, on August 3, 2006.

Ali Bahrami,

Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. E6–13445 Filed 8–17–06; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2006–23850; Directorate Identifier 2005–NM–126–AD; Amendment 39–14715; AD 2006–16–15]

RIN 2120–AA64

Airworthiness Directives; McDonnell Douglas Model MD–10–10F and MD–10–30F Airplanes and Model MD–11 and MD–11F Airplanes

AGENCY: Federal Aviation Administration (FAA), Department of Transportation (DOT).

ACTION: Final rule.

SUMMARY: The FAA is superseding an existing airworthiness directive (AD), which applies to certain McDonnell Douglas Model MD–11 series airplanes. That AD currently requires a revision of the airplane flight manual (AFM) to alert the flightcrew that both flight management computers (FMCs) must be installed and operational. That AD also requires an inspection to determine the serial number of the FMCs; and follow-

on corrective actions, if necessary, which terminate the AFM revision. That AD also requires an inspection to verify if a certain modification is on the identification plates of the FMCs; and applicable follow-on and corrective actions. This new AD requires installation of upgraded FMC software, which would terminate the existing AD. This new AD also adds airplanes to the applicability, including adding Model MD–10–10F and MD–10–30F airplanes. This AD results from a report that the FMC does not acknowledge the pre-set glareshield control panel (GCP) altitude when profile (PROF) mode is engaged in descent mode. We are issuing this AD to prevent the un-commanded descent of an airplane below the selected level-off altitude, which could result in an unacceptable reduction in the separation between the airplane and nearby air traffic or terrain.

DATES: This AD becomes effective September 22, 2006.

The Director of the Federal Register approved the incorporation by reference of certain publications listed in the AD as of September 22, 2006.

On November 26, 2001 (66 FR 53335, October 22, 2001), the Director of the Federal Register approved the incorporation by reference of McDonnell Douglas Service Bulletin MD11–34–085, Revision 01, dated September 20, 1999.

ADDRESSES: You may examine the AD docket on the Internet at *http://dms.dot.gov* or in person at the Docket Management Facility, U.S. Department of Transportation, 400 Seventh Street, SW., Nassif Building, Room PL–401, Washington, DC.

Contact Boeing Commercial Airplanes, Long Beach Division, 3855 Lakewood Boulevard, Long Beach, California 90846, Attention: Data and Service Management, Dept. C1–L5A (D800–0024), for service information identified in this AD.

FOR FURTHER INFORMATION CONTACT: Natalie Phan-Tran, Aerospace Engineer, Systems and Equipment Branch, ANM–130L, FAA, Los Angeles Aircraft Certification Office, 3960 Paramount Boulevard, Lakewood, California 90712–4137; telephone (562) 627–5343; fax (562) 627–5210.

SUPPLEMENTARY INFORMATION:

Examining the Docket

You may examine the airworthiness directive (AD) docket on the Internet at *http://dms.dot.gov* or in person at the Docket Management Facility office between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The Docket Management Facility office (telephone (800) 647–5227) is located on the plaza level of the Nassif Building at the street address stated in the **ADDRESSES** section.

Discussion

The FAA issued a notice of proposed rulemaking (NPRM) to amend 14 CFR part 39 to include an AD that supersedes AD 2001–21–05, amendment 39–12476 (66 FR 53335, October 22, 2001). The existing AD applies to certain McDonnell Douglas Model MD–11 series airplanes. That NPRM was published in the **Federal Register** on February 15, 2006 (71 FR 7880). That NPRM proposed to retain all requirements of AD 2001–21–05 and require installation of upgraded flight management computer (FMC) software, which would terminate the existing AD. That NPRM also proposed to add airplanes to the applicability, including adding Model MD–10–10F and MD–10–30F airplanes.

Comments

We provided the public the opportunity to participate in the development of this AD. We have considered the comments that have been received on the NPRM.

Support for NPRM

The Air Line Pilots Association supports the NPRM.

Request To Supersede AD 2001–21–05 and AD 2004–18–04

UPS requests that the NPRM be rewritten to supersede both AD 2001–21–05 and AD 2004–18–04, amendment 39–13782 (69 FR 53794, September 21, 2004), and allow compliance by installing FMCs part number (P/N) 4059050–921 in accordance with Boeing Service Bulletin MD11–34–129, dated September 22, 2004.

We acknowledge the commenter's request; however we do not agree that this AD should supersede both ADs. This AD is a supersedure of AD 2001–21–05 and does allow compliance by installing FMC P/N 4059050–921. As specified in paragraphs (j)(2), (j)(3), and (j)(4) of this AD, operators that install FMC P/N 4059050–921 must do so in accordance with Boeing Service Bulletin MD11–34–129, dated September 22, 2004, and as specified in paragraph (j) of this AD, doing the installation is terminating action for the requirements of paragraphs (f) through (i) of this AD (paragraphs (f) through (i) are a restatement of the requirements of AD 2001–21–05).

This AD does not supersede AD 2004–18–04 because that AD contains requirements for airplanes that are not in the applicability of this AD. AD 2004–18–04 is applicable to all McDonnell Douglas Model MD–10–10F, MD–10–30F, MD–11, MD–11F, and 717–200 airplanes. This AD is applicable only to certain Model MD–10–10F and MD–10–30F airplanes and all Model MD–11 and MD–11F airplanes. However, as specified in paragraph (n)(4) of this AD, doing the applicable software/hardware upgrades required by paragraph (j) or (k) of this AD is approved as an alternative method of compliance for the actions required by AD 2004–18–04. We have not revised this AD in this regard.

Request To Clarify That Airplanes Having FMC P/N 4059050–921 Installed Are Not Applicable to the NPRM

The same commenter requests that the NPRM be clarified to indicate that it is not effective for any airplanes that already have P/N 4059050–921 installed.

We disagree with the commenter that this AD is not applicable to airplanes that already have P/N 4059050–921 installed. This AD is applicable to all Model MD–11 and MD–11F airplanes and certain Model MD–10–10F and MD–10–30F airplanes and requires installation of upgraded FMC software. For Model MD–11 and MD–11F airplanes, installing P/N 4059050–921 is an acceptable method of compliance with paragraph (j) of this AD. As specified in paragraph (e) of this AD, if the actions have already been done, then operators are in compliance with the applicable requirements of this AD. We have not revised this AD in this regard.

Request To Clarify That Any FMC P/N 4059050–921 Is Acceptable Regardless of Origin

The same commenter requests that the NPRM be clarified to specify that any FMC P/N 4059050–921 is acceptable for compliance with the NPRM regardless of the origin of the part (original manufacture, factory conversion, or on-aircraft conversion).

We agree with the commenter that any FMC P/N 4059050–921 is acceptable for compliance. Paragraphs (j)(2), (j)(3), and (j)(4) of this AD specify installing FMC P/N 4059050–921 in accordance with the service information specified in those paragraphs. Any FMC P/N 4059050–921 regardless of its origin is acceptable provided it is installed in accordance with the service information. No change is necessary. If operators install P/N 4059050–921 in accordance with a method that is not specified in the service information identified in this AD, operators must

request approval of an alternate of method of compliance as specified in paragraph (n) of this AD.

Clarification of Service Bulletin Date

In the NPRM, we inadvertently referred to the date of Boeing Service Bulletin MD11–34–068, Revision 3, as April 6, 2004. The correct date is April 6, 2005. We have revised this AD accordingly.

Conclusion

We have carefully reviewed the available data, including the comments that have been submitted, and determined that air safety and the public interest require adopting the AD with the change described previously. We have determined that this change will neither increase the economic burden on any operator nor increase the scope of the AD.

Costs of Compliance

There are about 230 airplanes of the affected design in the worldwide fleet and about 117 U.S.-registered airplanes. The following table provides the estimated costs for U.S. operators to comply with this AD. The average labor rate per hour is $65.

ESTIMATED COSTS

Action	Work hours	Parts	Cost per airplane	Number of U.S.-registered airplanes	Fleet cost
Airplane Flight Manual Revision, Inspections and Software Installation (required by AD 2001–21–05)	2	$0	$130	59	$7,670
Upgrade Software/Hardware (new action)	2	0	130	117	15,210

Authority for This Rulemaking

Title 49 of the United States Code specifies the FAA's authority to issue rules on aviation safety. Subtitle I, Section 106, describes the authority of the FAA Administrator. Subtitle VII, Aviation Programs, describes in more detail the scope of the Agency's authority.

We are issuing this rulemaking under the authority described in Subtitle VII, Part A, Subpart III, Section 44701, "General requirements." Under that section, Congress charges the FAA with promoting safe flight of civil aircraft in air commerce by prescribing regulations for practices, methods, and procedures the Administrator finds necessary for safety in air commerce. This regulation is within the scope of that authority because it addresses an unsafe condition that is likely to exist or develop on products identified in this rulemaking action.

Regulatory Findings

We have determined that this AD will not have federalism implications under Executive Order 13132. This AD will not have a substantial direct effect on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government.

For the reasons discussed above, I certify that this AD:

(1) Is not a "significant regulatory action" under Executive Order 12866;

(2) Is not a "significant rule" under DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and

(3) Will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

We prepared a regulatory evaluation of the estimated costs to comply with this AD and placed it in the AD docket. See the **ADDRESSES** section for a location to examine the regulatory evaluation.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

Adoption of the Amendment

■ Accordingly, under the authority delegated to me by the Administrator, the FAA amends 14 CFR part 39 as follows:

PART 39—AIRWORTHINESS DIRECTIVES

■ 1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

■ 2. The Federal Aviation Administration (FAA) amends § 39.13 by removing amendment 39–12476 (66 FR 53335, October 22, 2001) and by adding the following new airworthiness directive (AD):

2006–16–15 McDonnell Douglas: Amendment 39–14715. Docket No. FAA–2006–23850; Directorate Identifier 2005–NM–126–AD.

Effective Date

(a) This AD becomes effective September 22, 2006.

Affected ADs

(b) This AD supersedes AD 2001–21–05.

Applicability

(c) This AD applies to McDonnell Douglas airplanes, as specified in paragraphs (c)(1) and (c)(2) of this AD, certificated in any category.

(1) Model MD–10–10F and MD–10–30F airplanes, as identified in Boeing Service Bulletin MD10–31–053, Revision 1, dated June 14, 2005.

(2) All Model MD–11 and MD–11F airplanes.

Unsafe Condition

(d) This AD results from a report that the flight management computer (FMC) does not acknowledge the pre-set glareshield control panel (GCP) altitude when profile (PROF) mode is engaged in descent mode. We are issuing this AD to prevent the uncommanded descent of an airplane below the selected level-off altitude, which could result in an unacceptable reduction in the separation between the airplane and nearby air traffic or terrain.

Compliance

(e) You are responsible for having the actions required by this AD performed within the compliance times specified, unless the actions have already been done.

Restatement of Requirements of AD 2001–21–05

Airplane Flight Manual (AFM) Revision

(f) For MD–11 and MD–11F airplanes having manufacturer's fuselage numbers 0447 through 0552 inclusive, and 0554 through 0621 inclusive: Within 5 days after May 20, 1998 (the effective date of AD 98–10–01, amendment 39–10512), revise Section 1, page 5–1, of the Limitations Section of the FAA-approved AFM to include the following statement. This may be accomplished by inserting a copy of this AD into the AFM.

"Prior to dispatch of the airplane, both Flight Management Computer 1 (FMC–1) and FMC–2 must be installed and operational."

Inspection

(g) For MD–11 and MD–11F airplanes having manufacturer's fuselage numbers 0447 through 0552 inclusive, and 0554 through 0621 inclusive: Within 90 days after November 26, 2001 (the effective date of AD 2001–21–05), do an inspection to verify that

modification "AS" is on the front and rear identification plates of FMC–1 and FMC–2, per McDonnell Douglas Service Bulletin MD11–34–085, Revision 01, dated September 20, 1999. After the inspection has been done, the AFM revision required by paragraph (f) of this AD may be removed from the AFM.

Condition 1 (Modification "AS" Is Installed)

(h) If modification "AS" is found installed during the inspection required by paragraph (g) of this AD, before further flight, do the actions specified in paragraphs (h)(1) and (h)(2) of this AD, per McDonnell Douglas Service Bulletin MD11–34–085, Revision 01, dated September 20, 1999.

(1) Do a test of the FMCs in the flight compartment to ensure that modification "AS" is operational, and do applicable corrective actions, if necessary. Both FMCs must have modification "AS" installed and pass the test before loading new software per paragraph (h)(2) of this AD.

(2) Install new software and reidentify FMC–1 and FMC–2 as part number (P/N) 4059050–912.

Note 1: McDonnell Douglas Service Bulletin MD11–34–085, Revision 01, dated September 20, 1999, references Honeywell Service Bulletin 4059050–34–6020, Revision 1, dated April 30, 1999, as an additional source of service information for the installation and reidentification requirements of paragraphs (h)(2) and (i)(2) of this AD.

Condition 2 (Modification "AS" Is Not Installed)

(i) If modification "AS" is NOT found installed during the inspection required by paragraph (g) of this AD, before further flight, do the actions specified in paragraphs (i)(1), (i)(2), and (i)(3) of this AD, per McDonnell Douglas Service Bulletin MD11–34–085, Revision 01, dated September 20, 1999.

(1) Remove FMC–1 and FMC–2.

(2) Install modification "AS" and new software, and reidentify FMC–1 and FMC–2 as P/N 4059050–912.

(3) Install modified and reidentified FMC–1 and FMC–2.

New Requirements of This AD

Upgrade Software/Hardware—Model MD–11 and MD–11F Airplanes

(j) For Model MD–11 and MD–11F airplanes: Within 18 months after the effective date of this AD, upgrade the FMC software, and hardware as applicable, by doing the applicable actions specified in paragraph (j)(1), (j)(2), (j)(3), or (j)(4) of this AD. Doing this upgrade terminates the requirements of paragraphs (f) through (i) of this AD.

(1) For airplanes on which FMC P/N 4059050–906 through –912 is installed: Install new software in the main avionics rack, and reidentify FMC–1 and FMC–2 as P/N 4059050–913, in accordance with the Accomplishment Instructions of Boeing Service Bulletin MD11–34–130, dated March 16, 2005.

Note 2: Boeing Service Bulletin MD11–34–130 refers to Honeywell Alert Service Bulletin 4059050–34–A6024, dated March 9, 2005, as an additional source of service information for doing the actions specified in paragraph (j)(1) of this AD.

(2) For airplanes on which FMC P/N 4059050–920 is installed: Install new software in the main avionics rack, and reidentify FMC–1 and FMC–2 as P/N 4059050–921, in accordance with the Accomplishment Instructions of Boeing Service Bulletin MD11–34–129, dated September 22, 2004.

Note 3: Boeing Service Bulletin MD11–34–129 refers to Honeywell Alert Service Bulletin 4059050–34–A6023, dated September 22, 2004, as an additional source of service information for doing the actions specified in paragraph (j)(2) of this AD.

(3) For airplanes on which FMC P/N 4059050–906 through -911 is installed: In lieu of doing the software upgrade specified in paragraph (j)(1) of this AD, install new hardware and software and reidentify FMC–1 and FMC–2 as P/N 4059050–921, by doing all the applicable actions specified in the Accomplishment Instructions of McDonnell Douglas Service Bulletin MD11–34–085, Revision 01, dated September 20, 1999; Boeing Service Bulletin MD11–34–068, Revision 3, dated April 6, 2005; and Boeing Service Bulletin MD11–34–129, dated September 22, 2004.

Note 4: McDonnell Douglas Service Bulletin MD11–34–085 references Honeywell Service Bulletin 4059050–34–6020, Revision 1, dated April 30, 1999; Boeing Service Bulletin MD11–34–068 references Honeywell Service Bulletin 4059050–34–0010, dated March 19, 2003; and Boeing Service Bulletin MD11–34–129 refers to Honeywell Alert Service Bulletin 4059050–34–A6023, dated September 22, 2004; as additional sources of service information for doing the actions specified in paragraph (j)(3) of this AD.

(4) For airplanes on which FMC P/N 4059050–912 is installed: In lieu of doing the software upgrade specified in paragraph (j)(1) of this AD, install new hardware and software and reidentify FMC–1 and FMC–2 as P/N 4059050–921, by doing all the applicable actions specified in the Accomplishment Instructions of Boeing Service Bulletin MD11–34–068, Revision 3, dated April 6, 2005; and Boeing Service Bulletin MD11–34–129, dated September 22, 2004.

Note 5: Boeing Service Bulletin MD11–34–068 references Honeywell Service Bulletin 4059050–34–0010, dated March 19, 2003; and Boeing Service Bulletin MD11–34–129 refers to Honeywell Alert Service Bulletin 4059050–34–A6023, dated September 22, 2004; as additional sources of service information for doing the actions specified in paragraph (j)(4) of this AD.

Upgrade Software—Model MD–10–10F and MD–10–30F Airplanes

(k) For Model MD–10–10F and MD–10–30F airplanes: Within 18 months after the effective date of this AD, install new software in the main avionics rack and reidentify the versatile integrated avionics (VIA) digital computer as P/N 4081580–903, in accordance with the Accomplishment Instructions of Boeing Service Bulletin MD10–31–053, Revision 1, dated June 14, 2005.

Note 6: Boeing Service Bulletin MD10–31–053 refers to Honeywell Alert Service Bulletin 4081580–31–A6002, dated January 14, 2005, as an additional source of service information for doing the actions specified in paragraph (k) of this AD.

Parts Installation

(l) For Model MD–11 and MD–11F airplanes: As of the effective date of this AD, no person may install an FMC, P/N 4059050–906 through –912, or –920, on any airplane; except as required by the actions specified in paragraphs (h), (i), and (j) of this AD.

(m) For MD–10–10F and MD–10–30F airplanes: As of the effective date of this AD, no person may install a VIA digital computer, P/N 4081580–901 or 4081580–902, on any airplane.

Alternative Methods of Compliance (AMOCs)

(n)(1) The Manager, Los Angeles Aircraft Certification Office, FAA, has the authority to approve AMOCs for this AD, if requested in accordance with the procedures found in 14 CFR 39.19.

(2) Before using any AMOC approved in accordance with § 39.19 on any airplane to which the AMOC applies, notify the appropriate principal inspector in the FAA Flight Standards Certificate Holding District Office.

(3) AMOCs approved previously in accordance with AD 2001–21–05 are approved as AMOCs for the corresponding provisions of paragraphs (f) through (i) of this AD.

(4) Doing the actions required by paragraph (j) or (k) of this AD, as applicable, is approved as an AMOC for the actions required by AD 2004–18–04, amendment 39–13782.

Material Incorporated by Reference

(o) You must use the applicable service bulletins listed in Table 1 of this AD to perform the actions that are required by this AD, unless the AD specifies otherwise.

TABLE 1.—ALL MATERIAL INCORPORATED BY REFERENCE

Service Bulletin	Revision level	Date
Boeing Service Bulletin MD10–31–053	1	June 14, 2005.
Boeing Service Bulletin MD11–34–068	3	April 6, 2005.

TABLE 1.—ALL MATERIAL INCORPORATED BY REFERENCE—Continued

Service Bulletin	Revision level	Date
Boeing Service Bulletin MD11–34–129	Original	September 22, 2004.
Boeing Service Bulletin MD11–34–130	Original	March 16, 2005.
McDonnell Douglas Service Bulletin MD11–34–085	01	September 20, 1999.

(1) The Director of the Federal Register approved the incorporation by reference of the documents listed in Table 2 of this AD in accordance with 5 U.S.C. 552(a) and 1 CFR part 51.

TABLE 2.—NEW MATERIAL INCORPORATED BY REFERENCE

Service Bulletin	Revision level	Date
Boeing Service Bulletin MD10–31–053	1	June 14, 2005.
Boeing Service Bulletin MD11–34–068	3	April 6, 2005.
Boeing Service Bulletin MD11–34–129	Original	September 22, 2004.
Boeing Service Bulletin MD11–34–130	Original	March 16, 2005.

(2) On November 26, 2001 (66 FR 53335, October 22, 2001), the Director of the Federal Register approved the incorporation by reference of McDonnell Douglas Service Bulletin MD11–34–085, Revision 01, dated September 20, 1999.

(3) Contact Boeing Commercial Airplanes, Long Beach Division, 3855 Lakewood Boulevard, Long Beach, California 90846, Attention: Data and Service Management, Dept. C1–L5A (D800–0024), for a copy of this service information. You may review copies at the Docket Management Facility, U.S. Department of Transportation, 400 Seventh Street, SW., Room PL–401, Nassif Building, Washington, DC; on the Internet at *http://dms.dot.gov;* or at the National Archives and Records Administration (NARA). For information on the availability of this material at the NARA, call (202) 741–6030, or go to *http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.*

Issued in Renton, Washington, on August 3, 2006.

Ali Bahrami,

Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. E6–13448 Filed 8–17–06; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2006–25262; Directorate Identifier 2006–CE–39–AD; Amendment 39–14725; AD 2006–17–04]

RIN 2120–AA64

Airworthiness Directives; The Cessna Aircraft Company Models 172R, 172S, 182T, T182T, 206H, and T206H Airplanes

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule; request for comments.

SUMMARY: The FAA is adopting a new airworthiness directive (AD) for certain The Cessna Aircraft Company (Cessna) Models 172R, 172S, 182T, T182T, 206H, and T206H airplanes. This AD requires you to inspect the two end fittings on each of the flexible fuel hoses located in the engine compartment for the correct torque values, and, if any incorrect torque values are found during the inspection, tighten the hose end fittings to the correct torque values. This AD results from one report of loose fuel hose connections to the fuel injector servo on a Cessna Model 172S airplane. We are issuing this AD to detect and correct any incorrect torque values of the end fittings of flexible fuel hoses in the engine compartment, which could result in the loss of fuel flow and fuel leakage. Loss of fuel flow could result in partial or complete loss of engine power and fuel leakage could result in an engine compartment fire.

DATES: This AD becomes effective on September 1, 2006.

As of September 1, 2006, the Director of the Federal Register approved the incorporation by reference of certain publications listed in the regulation.

We must receive any comments on this AD by October 17, 2006.

ADDRESSES: Use one of the following addresses to comment on this AD.

- *DOT Docket Web site:* Go to *http://dms.dot.gov* and follow the instructions for sending your comments electronically.
- *Government-wide rulemaking Web site:* Go to *http://www.regulations.gov* and follow the instructions for sending your comments electronically.
- *Mail:* Docket Management Facility; U.S. Department of Transportation, 400 Seventh Street, SW., Nassif Building, Room PL–401, Washington, DC 20590–0001.
- *Fax:* (202) 493–2251.
- *Hand Delivery:* Room PL–401 on the plaza level of the Nassif Building, 400 Seventh Street, SW., Washington, DC, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

To get the service information identified in this AD, contact The Cessna Aircraft Company, Product Support, P.O. Box 7706, Wichita, Kansas 67277–7706; telephone: (316) 517–5800; facsimile: (316) 942–9006.

To view the comments to this AD, go to *http://dms.dot.gov.* The docket number is FAA–2006–25262; Directorate Identifier 2006–CE–39–AD.

FOR FURTHER INFORMATION CONTACT: Jeff Janusz, Aerospace Engineer, FAA, Wichita ACO, 1801 Airport Road, Room 100, Wichita, Kansas 67209; telephone: (316) 946–4148; facsimile: (316) 946–4107.

SUPPLEMENTARY INFORMATION:

Discussion

We have received one report of loose fuel hose connections to the fuel injector servo on a Cessna Model 172S airplane.

This condition, if not corrected, could result in the loss of fuel flow and fuel leakage. Loss of fuel flow could result in partial or complete loss of engine power and fuel leakage could result in an engine compartment fire.

Relevant Service Information

We reviewed Cessna Service Bulletin No. SB06–71–02, dated June 19, 2006. The service information describes procedures for inspecting the two end

fittings on each of the flexible fuel hoses located in the engine compartment for the correct torque values, and, if any incorrect torque values are found during the inspection, tighten the hose end fittings to the correct torque values.

FAA's Determination and Requirements of This AD

We are issuing this AD because we evaluated all the information and determined the unsafe condition described previously is likely to exist or develop on other products of the same type design. This AD requires you to do the actions in the referenced service bulletin.

In preparing this rule, we contacted type clubs and aircraft operators to get technical information and information on operational and economic impacts. We did not receive any information through these contacts. If received, we would have included a discussion of any information that may have influenced this action in the rulemaking docket.

FAA's Determination of the Effective Date

Since an unsafe condition exists that requires the immediate adoption of this AD, we determined that notice and opportunity for public comment before issuing this AD are impracticable, and that good cause exists for making this amendment effective in fewer than 30 days.

Comments Invited

This AD is a final rule that involves requirements affecting flight safety, and we did not precede it by notice and an opportunity for public comment. We invite you to send any written relevant data, views, or arguments regarding this AD. Send your comments to an address listed under the **ADDRESSES** section. Include the docket number "FAA–2006–25262; Directorate Identifier 2006-CE–39-AD" at the beginning of your comments. We specifically invite comments on the overall regulatory, economic, environmental, and energy aspects of the AD. We will consider all comments received by the closing date and may amend the AD in light of those comments.

We will post all comments we receive, without change, to *http://dms.dot.gov,* including any personal information you provide. We will also post a report summarizing each substantive verbal contact we receive concerning this AD.

Authority for This Rulemaking

Title 49 of the United States Code specifies the FAA's authority to issue rules on aviation safety. Subtitle I, Section 106, describes the authority of the FAA Administrator. Subtitle VII, Aviation Programs, describes in more detail the scope of the Agency's authority.

We are issuing this rulemaking under the authority described in Subtitle VII, Part A, Subpart III, Section 44701, "General requirements." Under that section, Congress charges the FAA with promoting safe flight of civil aircraft in air commerce by prescribing regulations for practices, methods, and procedures the Administrator finds necessary for safety in air commerce. This regulation is within the scope of that authority because it addresses an unsafe condition that is likely to exist or develop on products identified in this rulemaking action.

Regulatory Findings

We determined that this AD will not have federalism implications under Executive Order 13132. This AD will not have a substantial direct effect on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government.

For the reasons discussed above, I certify that this AD:

(1) Is not a "significant regulatory action" under Executive Order 12866;

(2) Is not a "significant rule" under DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and

(3) Will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

We prepared a regulatory evaluation of the estimated costs to comply with this AD and placed it in the AD docket.

Examining the AD Docket

You may examine the AD docket that contains the AD, the regulatory evaluation, any comments received, and other information on the Internet at *http://dms.dot.gov;* or in person at the Docket Management Facility between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The Docket Office (telephone (800) 647–5227) is located at the street address stated in the **ADDRESSES** section. Comments will be available in the AD docket shortly after receipt.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

Adoption of the Amendment

■ Accordingly, under the authority delegated to me by the Administrator, the FAA proposes to amend 14 CFR part 39 as follows:

PART 39—AIRWORTHINESS DIRECTIVES

■ 1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

■ 2. The FAA amends § 39.13 by adding the following new airworthiness directive (AD):

2006–17–04 The Cessna Aircraft Company: Amendment 39–14725; Docket No. FAA–2006–25262; Directorate Identifier 2006–CE–39–AD.

Effective Date

(a) This AD becomes effective on September 1, 2006.

Affected ADs

(b) None.

Applicability

(c) This AD affects the following airplane models and serial numbers that are certificated in any category:

TABLE 1:—APPLICABILITY AND AIRPLANE GROUPS

Group	Model	Serial Nos.
(1) Group 1 Airplanes: All models *not* equipped with the Garmin G1000 System	(i) 172R	17281244 through 17281334.
	(ii) 172S	172S9809 through 172S10219.
	(iii) 182T	18281527 through 18281832.
	(iv) T182T	T18208381 through T18208583.
	(v) 206H	20608231 through 20608265.
	(vi) T206H	T20608515 through T20608635.
(2) Group 2 Airplanes: All models equipped with the Garmin G1000 System	(i) 172R	17281244 through 17281334.
	(ii) 172S	172S9809 through 172S10219.
	(iii) 182T	18281527 through 18281832.

TABLE 1.—APPLICABILITY AND AIRPLANE GROUPS—Continued

Group	Model	Serial Nos.
	(iv) T182T	T18208381 through T18208583.
	(v) 206H	20608231 through 20608265.
	(vi) T206H	T20608515 through T20608635.

Unsafe Condition

(d) This AD is the result of one report of loose fuel hose connections to the fuel injector servo on a Cessna Aircraft Company Model 172S airplane. We are issuing this AD to detect and correct any incorrect torque values of the end fittings of flexible fuel hoses in the engine compartment, which could result in the loss of fuel flow and fuel leakage. Loss of fuel flow could result in partial or complete loss of engine power and fuel leakage could result in an engine compartment fire.

Compliance

(e) *For Group 1 Airplanes not equipped with the Garmin G1000 System:* To address this problem, you must do the following:

TABLE 2.—ACTIONS, COMPLIANCE, AND PROCEDURES FOR GROUP 1 AIRPLANES

Actions	Compliance	Procedures
(1) Inspect the two end fittings on each of the following hoses in the engine compartment for the correct torque values. (i) Fuel strainer to engine fuel pump. (ii) Engine fuel pump to fuel injector server (except T206). (iii) T206 only: Engine fuel pump to the union at the aft vertical cooling baffle. (iv) T206 only: Union at the aft vertical cooling baffle to the fuel injector servo. (v) Fuel injector servo to fuel manifold valve (except turbo models). (vi) Turbo models only: Fuel injector servo to fuel flow transducer. (vii) Turbo models only: Fuel flow transducer to fuel manifold valve. (viii) Fuel injector servo return to firewall fitting.	Within the next 5 hours time-in-service (TIS) after September 1, 2006 (the effective date of this AD), on airplanes that have not had a 100-hour or annual inspection of the engine installation fuel hoses for security and tightness of the end fittings.	Follow Cessna Service Bulletin No. SB06–71–02, dated June 19, 2006.
(2) If any incorrect torque values are found during the inspection required by paragraph (e)(1) of this AD, clean and dry the threads of all fittings, and tighten the hose end fittings to the correct torque values as defined in Table 4.	Before further flight after the inspection required by paragraph (e)(1) of this AD, in which any incorrect torque values are found.	Follow Cessna Service Bulletin No. SB06–71–02, dated June 19, 2006.

(f) *For Group 2 Airplanes equipped with the Garmin G1000 System:* To address this problem, you must do the following:

TABLE 3.—ACTIONS, COMPLIANCE, AND PROCEDURES FOR GROUP 2 AIRPLANES

Actions	Compliance	Procedures
(1) Inspect the two end fittings on each of the following hoses in the engine compartment for the correct torque values. (i) Fuel strainer to engine fuel pump. (ii) Engine fuel pump to fuel injector servo (except T206). (iii) T206 only: Engine fuel pump to the union at the aft vertical cooling baffle.	Within the next 5 hours TIS after September 1, 2006 (the effective date of this AD), on airplanes that have not had a 100-hour or annual inspection of the engine installation fuel hoses for security and tightness of the end fittings.	Follow Cessna Service Bulletin No. SB06–71–02, dated June 19, 2006.

TABLE 3.—ACTIONS, COMPLIANCE, AND PROCEDURES FOR GROUP 2 AIRPLANES—Continued

Actions	Compliance	Procedures
(iv) T206 only: Union at the aft vertical cooling baffle to the fuel injector servo. (v) Fuel injector servo to fuel flow transducer. (vi) Fuel flow transducer to fuel manifold valve. (vii) Fuel injector servo return to firewall fitting.		
(2) If any incorrect torque values are found during the inspection required by paragraph (f)(1) of this AD, clean and dry the threads of all fittings, and tighten the hose end fittings to the correct torque values as defined in Table 4.	Before further flight after the inspection required by paragraph (f)(1) of this AD, in which any incorrect torque values are found.	Follow Cessna Service Bulletin No. SB06–71–02, dated June 19, 2006.

(g) Use the following table for the correct torque values to tighten the hose end fittings as required in paragraphs (e)(2) and (f)(2) of this AD:

TABLE 4.—TORQUE VALUES FOR HOSE END FITTINGS

Flare hex sizes in fractions of an inch	Hose size	Correct torque in inch-pounds	
		Minimum	Maximum
9/16	−4	135	150
11/16	−6	270	300
7/8	−8	450	500

Alternative Methods of Compliance (AMOCs)

(h) The Manager, Wichita Aircraft Certification Office (ACO), FAA, ATTN: Jeff Janusz, Aerospace Engineer, FAA, Wichita ACO, 1801 Airport Road, Room 100, Wichita, Kansas 67209; telephone: (316) 946–4148; facsimile: (316) 946–4107, has the authority to approve AMOCs for this AD, if requested using the procedures found in 14 CFR 39.19.

Material Incorporated by Reference

(i) You must do the actions required by this AD following the instructions in Cessna Service Bulletin No. SB06–71–02, dated June 19, 2006. The Director of the Federal Register approved the incorporation by reference of this service bulletin in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. To get a copy of this service information, contact The Cessna Aircraft Company, Product Support, P.O. Box 7706, Wichita, Kansas 67277–7706; telephone: (316) 517–5800; facsimile: (316) 942–9006. To review copies of this service information, go to the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, go to: *http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html* or call (202) 741–6030. To view the AD docket, go to the Docket Management Facility; U.S. Department of Transportation, 400 Seventh Street, SW., Nassif Building, Room PL–401, Washington, DC 20590–0001 or on the Internet at *http://dms.dot.gov*. The docket number is FAA–2006–25262; Directorate Identifier 2006–CE–39–AD.

Issued in Kansas City, Missouri, on August 9, 2006.

John R. Colomy,

Acting Manager, Small Airplane Directorate, Aircraft Certification Service.

[FR Doc. E6–13442 Filed 8–17–06; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2006–24641; Directorate Identifier 2006–CE–27–AD; Amendment 39–14724; AD 2006–17–03]

RIN 2120–AA64

Airworthiness Directives; Stemme GmbH & Co. KG Models S10, S10–V, and S10–VT Sailplanes

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule.

SUMMARY: The FAA adopts a new airworthiness directive (AD) for certain Stemme GmbH & Co. KG (Stemme) Models S10, S10–V, and S10–VT sailplanes. This AD requires you to inspect the connection between the aileron push-rod and the connecting shaft to determine if a safety washer is installed. If there is no safety washer installed, this AD requires you to modify the aileron control assembly. This AD results from mandatory continuing airworthiness information (MCAI) issued by the airworthiness authority for Germany. We are issuing this AD to prevent a loose bearing in the aileron control lever, which could result in separation of the aileron control system. Separation of the aileron control system could lead to loss of aileron control.

DATES: This AD becomes effective on September 22, 2006.

As of September 22, 2006, the Director of the Federal Register approved the incorporation by reference of certain publications listed in the regulation.

ADDRESSES: To get the service information identified in this AD, contact STEMME AG, Flugplatzstraβe F 2, Nr. 7, D–15344 Strausberg, Germany; telephone: + 49.33.41/36 12–0; facsimile: + 49.33.41/36 12–30; e-mail: *P.Ellwanger@stemme.de*.

To view the AD docket, go to the Docket Management Facility; U.S. Department of Transportation, 400 Seventh Street, SW., Nassif Building, Room PL–401, Washington, DC 20590–001 or on the Internet at *http://dms.dot.gov*. The docket number is FAA–2006–24641; Directorate Identifier 2006–CE–27–AD.

FOR FURTHER INFORMATION CONTACT: Gregory A. Davison, Aerospace

Engineer, ACE–112, Small Airplane Directorate, 901 Locust, Room 301, Kansas City, Missouri 64106; telephone: (816) 329–4130; facsimile: (816) 329–4090.

SUPPLEMENTARY INFORMATION:

Discussion

On May 24, 2006, we issued a proposal to amend part 39 of the Federal Aviation Regulations (14 CFR part 39) to include an AD that would apply to certain Stemme Models S10, S10–V, and S10–VT sailplanes. This proposal was published in the **Federal Register** as a notice of proposed rulemaking (NPRM) on June 2, 2006 (71 FR 31980). The NPRM proposed to require you to inspect the joint between the aileron control rod, part number (P/N) 10SQ–RMB, and the connecting shaft, P/N 10SQ–RMW, to determine if a safety washer is installed. If a safety washer is not installed, the NPRM proposed to require you to modify this area by replacing the joint bolt (P/N LN9037–06042), installing a safety washer (P/N D440–06), and installing washer (P/N 10M–282).

Comments

We provided the public the opportunity to participate in developing this AD. We received no comments on the proposal or on the determination of the cost to the public.

Conclusion

We have carefully reviewed the available data and determined that air safety and the public interest require adopting the AD as proposed except for minor editorial corrections. We have determined that these minor corrections:

- Are consistent with the intent that was proposed in the NPRM for correcting the unsafe condition; and
- Do not add any additional burden upon the public than was already proposed in the NPRM.

Costs of Compliance

We estimate that this AD will affect 105 sailplanes in the U.S. registry.

We estimate the following costs to do the inspection:

Labor cost	Parts cost	Total cost per sailplane	Total cost on U.S. operators
1 work-hour × $80 per hour = $80	N/A	$80	105 × $80 = $8,400

We estimate the following costs to do any necessary replacements that will be required based on the results of the inspection. We have no way of determining the number of sailplanes that may need this replacement:

Labor cost	Parts cost	Total cost per sailplane
2 work-hours × $80 per hour = $160	$30	$160 + $30 = $190

Authority for This Rulemaking

Title 49 of the United States Code specifies the FAA's authority to issue rules on aviation safety. Subtitle I, Section 106 describes the authority of the FAA Administrator. Subtitle VII, Aviation Programs, describes in more detail the scope of the agency's authority.

We are issuing this rulemaking under the authority described in Subtitle VII, Part A, Subpart III, Section 44701, "General requirements." Under that section, Congress charges the FAA with promoting safe flight of civil aircraft in air commerce by prescribing regulations for practices, methods, and procedures the Administrator finds necessary for safety in air commerce. This regulation is within the scope of that authority because it addresses an unsafe condition that is likely to exist or develop on products identified in this AD.

Regulatory Findings

We have determined that this AD will not have federalism implications under Executive Order 13132. This AD will not have a substantial direct effect on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government.

For the reasons discussed above, I certify that this AD:

1. Is not a "significant regulatory action" under Executive Order 12866;

2. Is not a "significant rule" under the DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and

3. Will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

We prepared a summary of the costs to comply with this AD (and other information as included in the Regulatory Evaluation) and placed it in the AD Docket. You may get a copy of this summary by sending a request to us at the address listed under **ADDRESSES**. Include "Docket No. FAA–2006–24641; Directorate Identifier 2006–CE–27–AD" in your request.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

Adoption of the Amendment

■ Accordingly, under the authority delegated to me by the Administrator, the Federal Aviation Administration amends part 39 of the Federal Aviation Regulations (14 CFR part 39) as follows:

PART 39—AIRWORTHINESS DIRECTIVES

■ 1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

■ 2. FAA amends § 39.13 by adding a new AD to read as follows:

2006–17–03 Stemme GmbH & Co. KG: Amendment 39–14724; Docket No. FAA–2006–24641; Directorate Identifier 2006–CE–27–AD.

Effective Date

(a) This AD becomes effective on September 22, 2006.

Affected ADs

(b) None.

(c) This AD affects the following sailplane models and serial numbers that are certificated in any category:

Model	Serial Nos.
S10	10–03 through 10–56.
S10–V	14–001 through 14–030 (including all converted versions 14–003M through 14–056M).
S10–VT	11–001 through 11–089.

Unsafe Condition

(d) This AD results from mandatory continuing airworthiness information (MCAI) issued by the airworthiness authority for Germany. We are issuing this AD to prevent a loose bearing in the aileron control lever, which could result in separation of the aileron control system. Separation of the aileron control system could lead to loss of aileron control.

Compliance

(e) To address this problem, you must do the following:

Actions	Compliance	Procedures
(1) Inspect the joint between the aileron control rod, part number (P/N) 10SQ–RMB (or FAA-approved equivalent part number), and the connecting shaft, P/N 10SQ–RMW (or FAA–approved equivalent part number), to determine if a safety washer, P/N DIN 440–06 (or FAA-approved equivalent part number), is installed.	Within the next 20 hours time-in-service after September 22, 2006 (the effective date of this AD).	Follow Stemme Service Bulletin Document Number: A31–10–069, Am.-Index 01.a, dated September 10, 2004
(2) If after the inspection required in paragraph (e)(1) of this AD, you can positively determine that a safety washer, P/N DIN 440–06 (or FAA-approved equivalent part number), is installed between the joint in the aileron control rod and the connecting shaft, no further action is required.	Not applicable	Not applicable
(3) If after the inspection required in paragraph (e)(1) of this AD, you cannot positively determine that a safety washer is installed between the joint in the aileron control rod and the connecting shaft, do the following. (i) Install a safety washer, P/N DIN 440–06 (or FAA-approved equivalent part number); (ii) Replace the existing bolt with bolt, P/N LN9037–06042 (or FAA-approved equivalent part number), from the modification kit; and (iii) Install washer, P/N 10M–282 (or FAA-approved equivalent part number)	Before further flight after the inspection required in paragraph (e)(1) of this AD.	Follow Stemme Service Bulletin Document Number: A31–10–069, Am.-Index 01.a, dated September 10, 2004.
(4) 14 CFR 21.303 allows for replacement parts through parts manufacturer approval (PMA). The phrase "or FAA-approved equivalent part number" in this AD is intended to signify those parts that are PMA parts approved through identicality to the design of the part under the type certificate and replacement parts to correct the unsafe condition under PMA (other than identicality). If parts are installed that are identical to the unsafe parts, then the corrective actions of the AD affect these parts also. In addition, equivalent replacement parts to correct the unsafe condition under PMA (other than identicality) may also be installed provided they meet current airworthiness standards, which include those actions cited in this AD.	Not applicable	Not applicable.

Alternative Methods of Compliance (AMOCs)

(f) The Manager, Standards Office, Small Airplane Directorate, FAA, ATTN: Gregory A. Davison, Aerospace Engineer, ACE–112, Small Airplane Directorate, 901 Locust, Room 301, Kansas City, Missouri 64106; telephone: (816) 329–4130; facsimile: (816) 329–4090, has the authority to approve AMOCs for this AD, if requested using the procedures found in 14 CFR 39.19.

Related Information

(g) German AD Number D–2004–443, dated September 27, 2004, addresses the subject of this AD.

Material Incorporated by Reference

(h) You must do the actions required by this AD following the instructions in Stemme Service Bulletin Document Number: A31–10–069, Am.-Index 01.a, dated September 10, 2004. The Director of the Federal Register approved the incorporation by reference of this service bulletin in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. To get a copy of this service information, contact STEMME AG, Flugplatzstraße F 2, Nr. 7, D–15344 Strausberg, Germany; telephone: + 49.33.41 / 36 12–0; facsimile: + 49.33.41 / 36 12–30. To review copies of this service information, go to the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, go to: *http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html* or call (202) 741–6030. To view the AD docket, go to the Docket Management Facility; U.S. Department of Transportation, 400 Seventh Street, SW., Nassif Building, Room PL–401, Washington, DC 20590–0001 or on the Internet at *http://dms.dot.gov*. The docket number is FAA–2006–24641; Directorate Identifier 2006–CE–27–AD.

Issued in Kansas City, Missouri, on August 9, 2006.

John R. Colomy,

Acting Manager, Small Airplane Directorate, Aircraft Certification Service.

[FR Doc. E6–13440 Filed 8–17–06; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. 2004–NE–05–AD; Amendment 39–14706; AD 2006–16–06]

RIN 2120–AA64

Airworthiness Directives; General Electric Company (GE) CF6–80 Series Turbofan Engines

AGENCY: Federal Aviation Administration (FAA), Department of Transportation (DOT).

ACTION: Final rule; request for comments.

SUMMARY: The FAA is superseding an existing airworthiness directive (AD) for GE CF6–80 series turbofan engines with certain stage 1 high-pressure turbine (HPT) rotor disks. That AD currently requires an initial inspection as a qualification for the mandatory rework procedures for certain disks, and repetitive inspections only for certain disks for which the rework procedures were not required. That action also requires reworking certain disks before further flight, and removes certain CF6–80E1 series disks from service. This AD requires the same actions but shortens the compliance schedule for HPT disks that have not been previously inspected using AD 2004–04–07, which this AD supersedes. This AD results from a recent report of an uncontained failure of a stage 1 HPT disk. We are issuing this AD to detect and prevent cracks in the bottoms of the dovetail slots that could propagate to failure of the disk and cause an uncontained engine failure.

DATES: Effective September 5, 2006. The Director of the Federal Register approved the incorporation by reference of certain publications listed in the regulations as of September 5, 2006. The Director of the Federal Register previously approved the incorporation by reference of certain other publications listed in the regulations as of March 12, 2004 (69 FR 8801, February 26, 2004).

We must receive any comments on this AD by October 17, 2006.

ADDRESSES: Use one of the following addresses to submit comments on this ad:

- By mail: Federal Aviation Administration (FAA), New England Region, Office of the Regional Counsel, Attention: Rules Docket No. 2004–NE–05–AD, 12 New England Executive Park, Burlington, MA 01803.
- By fax: (781) 238–7055.
- By e-mail: *9-ane-adcomment@faa.gov.*

Contact General Electric Company via Lockheed Martin Technology Services, 10525 Chester Road, Suite C, Cincinnati, Ohio 45215, telephone (513) 672–8400, fax (513) 672–8422, for the service information identified in this AD.

You may examine the AD docket, by appointment, at the FAA, New England Region, Office of the Regional Counsel, 12 New England Executive Park, Burlington, MA. You may examine the service information, by appointment, at the FAA, New England Region, Office of the Regional Counsel, 12 New England Executive Park, Burlington, MA.

FOR FURTHER INFORMATION CONTACT: James Lawrence, Aerospace Engineer, Engine Certification Office, FAA, Engine and Propeller Directorate, 12 New England Executive Park, Burlington, MA 01803; telephone: (781) 238–7176, fax: (781) 238–7199.

SUPPLEMENTARY INFORMATION: On February 13, 2004, we issued AD 2004–04–07, Amendment 39–13488 (69 FR 38; February 26, 2004). That AD requires an initial inspection as a qualification for the mandatory rework procedures for certain disks, and repetitive inspections only for certain disks for which the rework procedures were not required. That action also requires reworking certain disks before further flight. That AD was the result of the manufacturer's investigation and development of a rework procedure to chamfer the aft breakedge of the dovetail slot bottom to reduce stresses. That condition, if not corrected, could result in cracks in the bottoms of the dovetail slots that could propagate to failure of the disk and cause an uncontained engine failure.

Actions Since AD 2004–04–07 Was Issued

Since AD 2004–04–07 was issued, a CF6–80A turbofan engine, installed on a Boeing 767 airplane, experienced an uncontained stage 1 HPT disk failure on June 2, 2006. The disk failure resulted in a fire and significant damage to the airplane. The event occurred during an on-ground maintenance operation.

Relevant Service Information

We reviewed and approved the technical contents of the following GE Service Bulletins (SBs) and Alert Service Bulletin (ASB) that describe procedures for removing, inspecting, and reworking certain stage 1 HPT rotor disks:

- SB No. CF6–80E1 S/B 72–0251, dated January 22, 2004;
- SB No. CF6–80A S/B 72–0779, Revision 1, dated January 22, 2004;
- SB No. CF6–80A S/B 72–0788, Revision 3, dated July 20, 2006;
- SB No. CF6–80A S/B 72–0822, dated July 20, 2006;
- ASB No. CF6–80C2 S/B 72–A1026, Revision 2, dated January 22, 2004;
- SB No. CF6–80C2 S/B 72–1089, Revision 3, dated July 20, 2006;
- SB No. CF6–80C2 S/B 72–1217, dated July 20, 2006.

FAA's Determination and Requirements of This AD

The unsafe condition described previously is likely to exist or develop on other GE CF6–80 series turbofan engines of the same type design. This AD requires rework of the dovetail slot bottom of certain stage 1 rotor disks. The disks must pass an inspection to qualify for the rework. This AD also requires removal from service of certain disks for which the rework procedures were not previously required. This AD also tightens the compliance schedule for HPT disks that have not been previously inspected using AD 2004–04–07. Operators must use the compliance schedule carried forward from AD 2004–04–07 or the new compliance schedule below, whichever occurs first:

- For stage 1 HPT rotor disks with 9,000 or more cycles-since-new (CSN) on the effective date of this AD, within 250 cycles-in-service (CIS) after the effective date of this AD, or by March 31, 2007, whichever occurs first.
- For stage 1 HPT rotor disks with 6,900 or more but fewer than 9,000 CSN on the effective date of this AD, within 500 CIS after the effective date of this AD, or before accumulating 9,250 CSN, or by December 31, 2007, whichever occurs first.
- For stage 1 HPT rotor disk with fewer than 6,900 CSN on the effective date of this AD, before accumulating 7,400 CSN, or by December 31, 2008, whichever occurs first.

This AD also removes from service certain CF6–80E1 series disks. You must use the service information described previously to perform the actions required by this AD.

FAA's Determination of the Effective Date

Since an unsafe condition exists that requires the immediate adoption of this AD, we have found that notice and opportunity for public comment before issuing this AD are impracticable, and that good cause exists for making this amendment effective in less than 30 days.

Comments Invited

This AD is a final rule that involves requirements affecting flight safety and was not preceded by notice and an opportunity for public comment; however, we invite you to submit any written relevant data, views, or arguments regarding this AD. Send your comments to an address listed under **ADDRESSES**. Include "AD Docket No. 2004–NE–05–D" in the subject line of your comments. If you want us to acknowledge receipt of your mailed comments, send us a self-addressed, stamped postcard with the docket number written on it; we will date-stamp your postcard and mail it back to you. We specifically invite comments on the overall regulatory, economic, environmental, and energy aspects of the rule that might suggest a need to modify it. If a person contacts us verbally, and that contact relates to a substantive part of this AD, we will summarize the contact and place the summary in the docket. We will consider all comments received by the closing date and may amend the AD in light of those comments.

Examining the AD Docket

You may examine the AD Docket (including any comments and service information), by appointment, between 8 a.m. and 4:30 p.m., Monday through Friday, except Federal holidays. See **ADDRESSES** for the location.

Authority for This Rulemaking

Title 49 of the United States Code specifies the FAA's authority to issue rules on aviation safety. Subtitle I, section 106, describes the authority of the FAA Administrator. Subtitle VII, Aviation Programs, describes in more detail the scope of the Agency's authority.

We are issuing this rulemaking under the authority described in subtitle VII, part A, subpart III, section 44701, "General requirements." Under that section, Congress charges the FAA with promoting safe flight of civil aircraft in air commerce by prescribing regulations for practices, methods, and procedures the Administrator finds necessary for safety in air commerce. This regulation is within the scope of that authority because it addresses an unsafe condition that is likely to exist or develop on products identified in this rulemaking action.

Regulatory Findings

We have determined that this AD will not have federalism implications under Executive Order 13132. This AD will not have a substantial direct effect on the States, on the relationship between the National Government and the States, or on the distribution of power and responsibilities among the various levels of government.

For the reasons discussed above, I certify that the regulation:

1. Is not a "significant regulatory action" under Executive Order 12866;
2. Is not a "significant rule" under the DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and
3. Will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

We prepared a summary of the costs to comply with this AD and placed it in the AD Docket. You may get a copy of this summary by sending a request to us at the address listed under **ADDRESSES**. Include "AD Docket No. 2004–NE–05–AD" in your request.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

Adoption of the Amendment

■ Accordingly, under the authority delegated to me by the Administrator, the Federal Aviation Administration amends part 39 of the Federal Aviation Regulations (14 CFR part 39) as follows:

PART 39—AIRWORTHINESS DIRECTIVES

■ 1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

■ 2. The FAA amends § 39.13 by removing Amendment 39–13488 (69 FR 8801; February 26, 2004), and by adding a new airworthiness directive, Amendment 39–14706, to read as follows:

2006–16–06 General Electric Company: Amendment 39–14706. Docket No. 2004–NE–05–AD.

Effective Date

(a) This airworthiness directive (AD) becomes effective September 5, 2006.

Affected ADs

(b) This AD supersedes AD 2004–04–07 (69 FR 8801; February 26, 2004).

Applicability

(c) This AD applies to the General Electric Company (GE) CF6–80 turbofan engine models listed in the following Table 1:

TABLE 1.—APPLICABILITY MODELS, PART NUMBERS, AIRPLANES

Models	Stage 1 high pressure turbine (HPT) rotor disk part numbers (P/Ns)	Engines installed on but not limited to
CF6–80A, CF6–80A1, CF6–80A2, CF6–80A3 ..	9234M67G22/G24/G25/G26, 9362M58G02/G06/G07/G09, 9367M45G02/G04/G09.	Airbus A310 and Boeing 767 airplanes.
CF6–80C2A1, CF6–80C2A2, CF6–80C2A3, CF6–80C2A5, CF6–80C2A8, CF6–80C2A5F, CF6–80C2B1, CF6–80C2B2, CF6–80C2B4, CF6–80C2B6, CF6–80C2B1F, CF6–80C2B2F, CF6–80C2B4F, CF6–80C2B5F, CF6–80C2B6F, CF6–80C2B6FA, CF6–80C2B7F, CF6–80C2D1F.	1862M23G01, 9392M23G10/G12/G21, 1531M84G02/G06/G08/G10/G12.	Airbus A300, A310, Boeing 747, 767, and McDonnell Douglas MD11 airplanes.
CF6–80E1A2, CF6–80E1A4	1639M41P04	Airbus A330 airplanes.

These engines are installed on, but not limited to, the airplanes listed in Table 1 of this AD.

Unsafe Condition

(d) This AD results from a recent report of an uncontained failure of a stage 1 HPT disk. The actions specified in this AD are intended to detect and prevent cracks in the bottoms of the dovetail slots that could propagate to

failure of the disk and cause an uncontained engine failure.

Compliance

(e) You are responsible for having the actions required by this AD performed within the compliance times specified unless the actions have already been done.

CF6–80A, –80A1, –80A2, and –80A3 Engines

Stage 1 HPT Rotor Disks, P/N 9362M58G09, With Chamfered Breakedges

(f) At the next piece-part exposure, for stage 1 HPT rotor disks, P/N 9362M58G09, with serial numbers (SNs) listed in Table 2 of this AD, do the following, unless already done using superseded AD 2004–04–07:

TABLE 2.—SNs OF CF6–80A SERIES STAGE 1 HPT ROTOR DISK P/N 9362M58G09—WITH CHAMFERED BREAKEDGES

GWN03RD7
GWN03TKG
GWN03TKH
GWN03TKJ
GWN03W3M
GWN03W3N
GWN03W3R
GWN042J3
GWN04FW2
GWN04FW3
GWN04FW4

TABLE 2.—SNs OF CF6–80A SERIES STAGE 1 HPT ROTOR DISK P/N 9362M58G09—WITH CHAMFERED BREAKEDGES—Continued

GWN04FW5
GWN04H0M
GWN04HRA
GWN04HRD
GWN04HRE
GWN04HRF
GWN04HRG
GWN04HRH
GWN04K8N
GWN04M9J
GWN04M9K
GWN04M9L
GWN04M9M
GWN04M9R
GWN04M9T
GWN04M9W

(1) Visually inspect the rotor disks for the presence of a chamfer on the aft breakedges of the dovetail slot bottoms. Use paragraph 3.A. of GE Service Bulletin (SB) No. CF6–80A S/B 72–0822, dated July 20, 2006, to do the inspection.

(2) For disks that have the chamfered breakedges, re-mark, fluorescent penetrant inspect (FPI), and eddy current inspect (ECI) the rotor disk. Use paragraph 3.A.(1) of the Accomplishment Instructions of GE SB No. CF6–80A S/B 72–0822, dated July 20, 2006, to re-mark and inspect the rotor disk and remove from service as necessary.

(3) For disks that do not have the chamfered breakedges, remove the disk from service. Use paragraph 3.A(2) of the Accomplishment Instructions of GE SB No. CF6–80A S/B 72–0822, dated July 20, 2006.

Stage 1 HPT Rotor Disks, P/Ns 9234M67G22, G24, G25, G26, 9367M45G04, G09, 9362M58G02, G06, G07, and 9362M58G09 with SNs not listed in Table 2 of this AD

(g) For stage 1 HPT rotor disks, P/Ns 9234M67G22, G24, G25, G26, 9367M45G04, G09, 9362M58G02, G06, G07, and 9362M58G09 with SNs not listed in Table 2 of this AD, inspect, rework, and re-mark the disks using paragraphs 3.A.(1) through 3.A.(2) of Accomplishment Instructions of GE SB No. CF6–80A S/B 72–0788, Revision 3, dated July 20, 2006, at the following, unless already done using superseded AD 2004–04–07:

(1) For both new and used stage 1 HPT rotor disks not installed in engines, inspect, rework, re-mark, and remove from service as necessary before further flight.

(2) For stage 1 HPT rotor disks that have been inspected using any version of GE SB No. CF6–80A S/B 72–0779, inspect, rework, re-mark, and remove from service as necessary at the next Engine Shop Visit (ESV) using the compliance times in the following Table 3:

TABLE 3.—COMPLIANCE TIMES FOR INSPECTION AND REWORK OF CF6–80A SERIES STAGE 1 HPT ROTOR DISKS, P/NS 9234M67G22, G24, G25, G26, 9367M45G04, G09, 9362M58G02, G06, G07, AND 9362M58G09 WITH SNS NOT LISTED IN TABLE 2 OF THIS AD—PREVIOUSLY INSPECTED

Stage 1 HPT rotor disk cycles-since-last-inspection (CSLI) on March 12, 2004 (effective date of superseded AD 2004–04–07)	Compliance time for inspection and rework
(i) More than 1,500 CSLI	At the next ESV after March 12, 2004 (effective date of superseded AD 2004–04–07), but not to exceed 4,500 CSLI.
(ii) 1,500 CSLI or fewer	At the next ESV after March 12, 2004 (effective date of superseded AD 2004–04–07), but not to exceed 3,500 CSLI.

(3) For stage 1 HPT rotor disks which have not been inspected using any version of GE SB No. CF6–80A S/B 72–0779, inspect, rework, re-mark, and remove from service as necessary using the following Table 4 or Table 4A compliance times, whichever occurs first:

TABLE 4.—COMPLIANCE TIMES FOR INSPECTION AND REWORK OF CF6–80A SERIES STAGE 1 HPT ROTOR DISKS, P/NS 9234M67G22, G24, G25, G26, 9367M45G04, G09, 9362M58G02, G06, G07, AND 9362M58G09 WITH SNS NOT LISTED IN TABLE 2 OF THIS AD—NOT PREVIOUSLY INSPECTED

Stage 1 HPT rotor disk cycles-since-new (CSN) on the effective date of this AD	Compliance time for inspection and rework
(i) 9,000 or more CSN	Within 250 cycles-in-service (CIS) after the effective date of this AD, or by March 31, 2007, whichever occurs first.
(ii) 6,900 or more but fewer than 9,000 CSN	Within 500 CIS after the effective date of this AD, but before accumulating 9,250 CSN, or by December 31, 2007, whichever occurs first.
(iii) Fewer than 6,900 CSN	Before accumulating 7,400 CSN, or by December 31, 2008, whichever occurs first.

TABLE 4A.—COMPLIANCE TIMES FOR INSPECTION AND REWORK OF CF6–80A SERIES STAGE 1 HPT ROTOR DISKS, P/NS 9234M67G22, G24, G25, G26, 9367M45G04, G09, 9362M58G02, G06, G07, AND 9362M58G09 WITH SNS NOT LISTED IN TABLE 2 OF THIS AD—NOT PREVIOUSLY INSPECTED

Stage 1 HPT rotor disk CSN on March 12, 2004 (effective date of superseded AD 2004–04–07)	Compliance time for inspection and rework
(i) 10,000 or more CSN	At the next ESV or within 1,000 CIS after March 12, 2004 (effective date of superseded AD 2004–04–07), whichever occurs first.
(ii) 5,000 or more CSN but fewer than 10,000 CSN	At the next ESV or within 2,400 CIS after March 12, 2004 (effective date of superseded AD 2004–04–07), whichever occurs first, but before accumulating 11,000 CSN.
(iii) Fewer than 5,000 CSN	At the next ESV or within 3,500 CIS after March 12, 2004 (effective date of superseded AD 2004–04–07), whichever occurs first, but before accumulating 7,400 CSN.

Stage 1 HPT Rotor Disks, P/N 9367M45G02

(h) For stage 1 HPT rotor disks, P/N 9367M45G02, remove the disk from service at the following times:

(1) For stage 1 HPT rotor disks not installed in engines, remove from service before further flight.

(2) For stage 1 HPT rotor disks that have been inspected before the effective date of this AD using any version of GE SB No. CF6–80A S/B 72–0779, and had more than zero CSN at the time of that inspection, remove from service at next ESV.

(3) For stage 1 HPT rotor disks that have not been inspected, or were only inspected with zero CSN before the effective date of this AD using any version of GE SB No. CF6–80A S/B 72–0779, remove from service using the following Table 5 or Table 5A compliance times, whichever occurs first:

TABLE 5.—COMPLIANCE TIMES FOR REMOVAL OF CF6–80A SERIES STAGE 1 HPT ROTOR DISKS, P/N 9367M45G02—NOT PREVIOUSLY INSPECTED

Stage 1 HPT rotor disk CSN on the effective date of this AD	Compliance time for removal
(i) 9,000 or more CSN	Within 250 CIS after the effective date of this AD, or by March 31, 2007, whichever occurs first.
(ii) 6,900 or more but fewer than 9,000 CSN	Within 500 CIS after the effective date of this AD, but before accumulating 9,250 CSN, or by December 31, 2007, whichever occurs first.
(iii) Fewer than 6,900 CSN	Before accumulating 7,400 CSN, or by December 31, 2008, whichever occurs first.

TABLE 5A.—COMPLIANCE TIMES FOR REMOVAL OF CF6–80A SERIES STAGE 1 HPT ROTOR DISKS, P/N 9367M45G02—NOT PREVIOUSLY INSPECTED

Stage 1 HPT rotor disk CSN on March 12, 2004 (effective date of superseded AD 2004–04–07)	Compliance time for removal
(i) 10,000 or more CSN	At the next ESV or within 1,000 CIS after March 12, 2004 (effective date of superseded AD 2004–04–07), whichever occurs first.
(ii) 5,000 or more CSN but fewer than 10,000 CSN	At the next ESV or within 2,400 CIS after March 12, 2004 (effective date of superseded AD 2004–04–07), whichever occurs first, but before accumulating 11,000 CSN.
(iii) Fewer than 5,000 CSN	At the next ESV or within 3,500 CIS after March 12, 2004 (effective date of superseded AD 2004–04–07), whichever occurs first, but before accumulating 7,400 CSN.

CF6–80C2 Series Engines

Stage 1 HPT Rotor Disks, P/N 1531M84G10, With Chamfered Breakedges, Group 1

(i) At the next piece-part exposure, for stage 1 HPT rotor disks, P/N 1531M84G10, with SNs listed in Table 6 (Group 1) of this AD, do the following, unless already done using superseded AD 2004–04–07:

TABLE 6.—SNS OF CF6–80C2 SERIES STAGE 1 HPT ROTOR DISKS, P/N 1531M84G10, WITH CHAMFERED BREAKEDGES, GROUP 1

GWN03111
GWN03114
GWN031N2
GWN031N3
GWN031N4
GWN031N5
GWN031N6
GWN031N7
GWN031N8
GWN031N9
GWN031NA
GWN031NC
GWN032G1
GWN032G2
GWN032G3
GWN032G4
GWN032G5
GWN032G6
GWN032G7
GWN032G8
GWN032G9
GWN032GE
GWN0335P
GWN0335R
GWN033C5
GWN034KR
GWN034KT
GWN03501
GWN0350M
GWN0350N
GWN0350P

TABLE 6.—SNs OF CF6–80C2 SERIES STAGE 1 HPT ROTOR DISKS, P/N 1531M84G10, WITH CHAMFERED BREAKEDGES, GROUP 1—Continued

GWN0350R
GWN0350T
GWN0350W
GWN035M5
GWN035M6
GWN035M7
GWN035M8
GWN035M9
GWN035MA
GWN035MC
GWN035MD
GWN035TH
GWN035TJ
GWN035TK
GWN035TL
GWN035TM
GWN03699
GWN0369A
GWN0369C
GWN0369D
GWN0369E
GWN0369G
GWN0369H
GWN0369J
GWN036JG
GWN036JH
GWN036JJ
GWN036JK
GWN036JL
GWN036JM
GWN036JN
GWN03752
GWN03753
GWN03754
GWN03755
GWN03756
GWN03757
GWN03759
GWN0375A
GWN0375C
GWN0375D
GWN0375E
GWN037H2
GWN03981
GWN03982
GWN03983
GWN03984
GWN03985
GWN03986
GWN03987
GWN03988
GWN03989
GWN0398A
GWN0398C
GWN039PF
GWN039PG
GWN039PH
GWN039PJ
GWN039PK
GWN039PL
GWN039PM
GWN039PN
GWN03A4J
GWN03A4K
GWN03A4L
GWN03A4M
GWN03A4N
GWN03A4P
GWN03A4R
GWN03A4T
GWN03A4W

TABLE 6.—SNs OF CF6–80C2 SERIES STAGE 1 HPT ROTOR DISKS, P/N 1531M84G10, WITH CHAMFERED BREAKEDGES, GROUP 1—Continued

GWN03C12
GWN03C13
GWN03C14
GWN03CA0
GWN03DC9
GWN03DCA
GWN03DCC
GWN03DCD
GWN03DCE
GWN03DCF
GWN03DCG
GWN03DCH
GWN03DCJ
GWN03DCK
GWN03DCL
GWN03DCM
GWN03DCN
GWN03DCP
GWN03DCR
GWN03DME
GWN03DMF
GWN03ER7
GWN03ER8
GWN03ER9
GWN03ERA
GWN03FTN
GWN03FTP
GWN03FTR
GWN03FTT
GWN03FTW
GWN03FW0
GWN03H56
GWN03H57
GWN03H58
GWN03HTL
GWN03HTM
GWN03HTN
GWN03HTP
GWN03HTR
GWN03HTT
GWN03J8T
GWN03J8W
GWN03J91
GWN03J92
GWN03JNN
GWN03JNP
GWN03K3C
GWN03K3D
GWN03K3F
GWN03K3G
GWN03K3H
GWN03K3K
GWN03K3L
GWN03K3M
GWN03K3N
GWN03K3T
GWN03K3W
GWN03K40
GWN03K7R
GWN03KR1
GWN03KR3
GWN03KR4
GWN03KR6
GWN03KR7
GWN03KR8
GWN03KRC
GWN03L2D
GWN03L2E
GWN03L2F
GWN03LNF
GWN03LNJ

TABLE 6.—SNs OF CF6–80C2 SERIES STAGE 1 HPT ROTOR DISKS, P/N 1531M84G10, WITH CHAMFERED BREAKEDGES, GROUP 1—Continued

GWN03LNK
GWN03M88
GWN03M8C
GWN03M8E
GWN03M8J
GWN03M8K
GWN03NHN
GWN03NHP
GWN03NHR
GWN03R74
GWN03R76
GWN03R78
GWN03R7E
GWN03R7F
GWN03R9G
GWN03R9H
GWN03R9M
GWN03R9P
GWN03R9T
GWN03RA2
GWN03RA3
GWN03RA5
GWN03RA8
GWN03RPA
GWN03RPC
GWN03RPD
GWN04026
GWN0402A
GWN0402F
GWN0402L
GWN040R5
GWN04189
GWN0418A
GWN0418D
GWN0418E
GWN0418F
GWN0418H
GWN0418J
GWN0418L
GWN0418N
GWN0418R
GWN04366
GWN044DP
GWN0454H
GWN0454M
GWN0454N
GWN045T0
GWN045T2
GWN045T8
GWN045TD
GWN045TG
GWN04722
GWN04729
GWN047LK
GWN048CD
GWN048CF
GWN048CH
GWN048CJ
GWN048CK
GWN049GJ
GWN049M8
GWN049M9
GWN04AER
GWN04ALR
GWN04AM1
GWN04CGJ
GWN04CGN
GWN04CGT
GWN04CGW
GWN04CH3
GWN04CH5

TABLE 6.—SNs OF CF6–80C2 SERIES STAGE 1 HPT ROTOR DISKS, P/N 1531M84G10, WITH CHAMFERED BREAKEDGES, GROUP 1—Continued

GWN04CH8
GWN04CH9
GWN04D52
GWN04D54
GWN04D56
GWN04D57
GWN04D58
GWN04D59
GWN04DPW
GWN04E9K
GWN04E9L
GWN04E9M
GWN04EMA
GWN04EMK
GWN04EML
GWN04EMM
GWN04FTL
GWN04FTM
GWN04FTN

(1) Visually inspect the rotor disks for the presence of a chamfer on the aft breakedges of the dovetail slot bottoms. Use paragraph 3.A. of GE SB No. CF6–80C2 S/B 72–1217, dated July 20, 2006, to do the inspection.

(2) For disks that have the chamfered breakedges, re-mark, FPI, and ECI the rotor disk. Use paragraph 3.A.(1) of the Accomplishment Instructions of GE SB No. CF6–80C2 S/B 72–1217, dated July 20, 2006, to re-mark and inspect the rotor disk, and remove from service as necessary.

(3) For disks that do not have the chamfered breakedges, remove the disk from service. Use paragraph 3.A.(4) of the Accomplishment Instructions of GE SB No. CF6–80C2 S/B 72–1217, dated July 20, 2006.

CF6–80C2 Series Engines

Stage 1 HPT Rotor Disks, P/N 1531M84G10, With Chamfered Breakedges, Group 2

(j) For stage 1 HPT rotor disks, P/N 1531M84G10, with SNs listed in Table 6A of this AD, with chamfered breakedges, (Group 2):

(1) With more than 6,900 CSN, perform paragraphs (j)(3) through (j)(5) as applicable, at the next ESV, but within 500 CIS after the effective date of this AD, unless already done using superseded AD 2004–04–07.

(2) With 6,900 CSN or fewer, perform paragraphs (j)(3) through (j)(5) as applicable, at the next ESV, but before accumulating 7,400 CSN, unless already done using superseded AD 2004–04–07.

TABLE 6A.—SNs OF CF6–80C2 SERIES STAGE 1 HPT ROTOR DISKS, P/N 1531M84G10, WITH CHAMFERED BREAKEDGES, GROUP 2

GWN03J90
GWN03K3R
GWN03K6J
GWN03K7T
GWN03KR2
GWN03KR5
GWN03KRA
GWN03KRD

TABLE 6A.—SNs OF CF6–80C2 SERIES STAGE 1 HPT ROTOR DISKS, P/N 1531M84G10, WITH CHAMFERED BREAKEDGES, GROUP 2—Continued

GWN03M89
GWN03M8D
GWN03M8F
GWN03NHT
GWN03R73
GWN03R75
GWN03R77
GWN03R79
GWN03R7A
GWN03R7C
GWN03R7D
GWN03R7G
GWN03R7H
GWN03R9J
GWN03R9K
GWN03R9L
GWN03R9N
GWN03R9R
GWN03R9W
GWN03RA0
GWN03RA1
GWN03RA4
GWN03RA6
GWN03RA7
GWN03RP7
GWN03RP9
GWN03RPE
GWN03RPF
GWN03RPG
GWN04027
GWN04028
GWN04029
GWN0402E
GWN0402G
GWN0402H
GWN0402J
GWN0402K
GWN0402M
GWN0402N
GWN0402P
GWN0418C
GWN0418G
GWN0418K
GWN0418M
GWN0418P
GWN0418T
GWN0418W
GWN04190
GWN04191
GWN0454E
GWN0454F
GWN0454G
GWN0454J
GWN0454K
GWN0454L
GWN045T1
GWN045T3
GWN045T4
GWN045T5
GWN045T6
GWN045T7
GWN045T9
GWN045TA
GWN045TC
GWN045TE
GWN045TF
GWN045TH
GWN046F6
GWN046F7

TABLE 6A.—SNs OF CF6–80C2 SERIES STAGE 1 HPT ROTOR DISKS, P/N 1531M84G10, WITH CHAMFERED BREAKEDGES, GROUP 2—Continued

GWN046F8
GWN04726
GWN047LG
GWN047LH
GWN047LJ
GWN047LL
GWN048CG
GWN048CM
GWN048CN
GWN048CP
GWN048CR
GWN049GH
GWN049GK
GWN049JL
GWN049JM
GWN049M7
GWN04AEP
GWN04AET
GWN04ALT
GWN04ALW
GWN04AM0
GWN04AM2
GWN04AM3
GWN04AM4
GWN04CGL
GWN04CHA
GWN04CHC
GWN04D55
GWN04DR4
GWN04DR9
GWN04DRE
GWN04DRJ
GWN04E9N
GWN04EM5
GWN04F8N
GWN04F8P
GWN04FTJ

(3) Visually inspect the rotor disks for the presence of a chamfer on the aft breakedges of the dovetail slot bottoms. Use paragraph 3.A. of GE SB No. CF6–80C2 S/B 72–1217, dated July 20, 2006, to do the inspection.

(4) For disks that have the chamfered breakedges, re-mark, FPI, and ECI the rotor disk. Use paragraph 3.A.(2) of the Accomplishment Instructions of GE SB No. CF6–80C2 S/B 72–1217, dated July 20, 2006, to re-mark and inspect the rotor disk, and remove from service as necessary.

(5) For disks that do not have the chamfered breakedges, remove the disk from service. Use paragraph 3.A.(4) of the Accomplishment Instructions of GE SB No. CF6–80C2 S/B 72–1217, dated July 20, 2006.

CF6–80C2 Series Engines

Stage 1 HPT Rotor Disks, P/N 1531M84G12, With Chamfered Breakedges

(k) For stage 1 HPT rotor disks, P/N 1531M84G12, with SNs listed in Table 6B of this AD, with chamfered breakedges:

(1) With more than 6,900 CSN, perform paragraph (k)(3) at the next ESV, but not to exceed 500 cycles after the effective date of this AD.

(2) With 6,900 CSN or fewer, perform paragraph (k)(3) at the next ESV, but before accumulating 7,400 CSN.

TABLE 6B.—SNs OF CF6–80C2 SERIES STAGE 1 HPT ROTOR DISKS, P/N 1531M84G12, WITH CHAMFERED BREAKEDGES

GWN04CH6
GWN04G5H
GWN04M03

(3) FPI and ECI the rotor disk. Use paragraph 3.A.(3) of the Accomplishment Instructions of GE SB No. CF6–80C2 S/B 72–1217, dated July 20, 2006, to re-mark and inspect the rotor disk, and remove from service as necessary.

Stage 1 HPT Rotor Disks, P/Ns 9392M23G10, G12, G21, 1531M84G02, G06, G08, and 1531M84G10 with SNs not listed in Table 6 and Table 6A of this AD

(l) For stage 1 HPT rotor disks, P/Ns 9392M23G10, G12, G21, 1531M84G02, G06, G08, and 1531M84G10 with SNs not listed in Table 6 and Table 6A of this AD, inspect, rework, and re-mark the disks using paragraphs 3.A.(1) through 3.A.(2) of Accomplishment Instructions of GE SB No. CF6–80C2 S/B 72–1089, Revision 3, dated July 20, 2006, at the following, unless already done using superseded AD 2004–04–07:

(1) For both new and used stage 1 HPT rotor disks not installed in engines, inspect, rework, re-mark, and remove from service as necessary before further flight.

(2) For stage 1 HPT rotor disks that have been inspected before March 12, 2004 (effective date of superseded AD 2004–04–07) using GE ASB No. CF6–80C2 S/B 72–A1024, Revision 1, dated November 3, 2000, or any version of GE ASB No. CF6–80C2 S/B 72–A1026, inspect, rework, re-mark, and remove from service as necessary using the compliance times in the following Table 7:

TABLE 7.—COMPLIANCE TIMES FOR INSPECTION AND REWORK OF CF6–80C2 SERIES STAGE 1 HPT ROTOR DISKS, P/NS 9392M23G10, G12, G21, 1531M84G02, G06, G08, AND 1531M84G10 WITH SNS NOT LISTED IN TABLE 6 AND TABLE 6A OF THIS AD—PREVIOUSLY INSPECTED

Stage 1 HPT rotor disk cycles-since-last-inspection (CSLI) on March 12, 2004 (effective date of superseded AD 2004–04–07)	Compliance time for inspection and rework
(i) More than 1,500 CSLI	At the next ESV after March 12, 2004 (effective date of superseded AD 2004–04–07), but not to exceed 4,500 CSLI.
(ii) 1,500 CSLI or fewer	At the next ESV after March 12, 2004 (effective date of superseded AD 2004–04–07), but not to exceed 3,500 CSLI.

(3) For stage 1 HPT rotor disks that have not been inspected before March 12, 2004 (effective date of superseded AD 2004–04–07) using GE ASB No. CF6–80C2 S/B 72–A1024, Revision 1, dated November 3, 2000, or any version of GE ASB No. CF6–80C2 S/B 72–A1026, inspect, rework, re-mark, and remove from service as necessary using the following Table 8 or Table 8A compliance times, whichever occurs first:

TABLE 8.—COMPLIANCE TIMES FOR INSPECTION AND REWORK OF CF6–80C2 SERIES STAGE 1 HPT ROTOR DISKS, P/NS 9392M23G10, G12, G21, 1531M84G02, G06, G08, AND 1531M84G10 WITH SNS NOT LISTED IN TABLE 6 AND TABLE 6A OF THIS AD—NOT PREVIOUSLY INSPECTED

Stage 1 HPT rotor disk cycles-since-new (CSN) on the effective date of this AD	Compliance time for inspection and rework
(i) 9,000 or more CSN	Within 250 CIS after the effective date of this AD, or by March 31, 2007, whichever occurs first.
(ii) 6,900 or more but fewer than 9,000 CSN	Within 500 CIS after the effective date of this AD, but before accumulating 9,250 CSN, or by December 31, 2007, whichever occurs first.
(iii) Fewer than 6,900 CSN	Before accumulating 7,400 CSN, or by December 31, 2008, whichever occurs first.

TABLE 8A.—COMPLIANCE TIMES FOR INSPECTION AND REWORK OF CF6–80C2 SERIES STAGE 1 HPT ROTOR DISKS, NS 9392M23G10, G12, G21, 1531M84G02, G06, G08, AND 1531M84G10 WITH SNS NOT LISTED IN TABLE 6 AND TABLE 6A OF THIS AD—NOT PREVIOUSLY INSPECTED

Stage 1 HPT rotor disk CSN on March 12, 2004 (effective date of superseded AD 2004–04–07)	Compliance time for inspection and rework
(i) 10,000 or more CSN	At the next ESV or within 1,000 CIS after March 12, 2004 (effective date of superseded AD 2004–04–07), whichever occurs first.
(ii) 5,000 or more CSN but fewer than 10,000 CSN	At the next ESV or within 2,400 CIS after March 12, 2004 (effective date of superseded AD 2004–04–07), but before accumulating 11,000 CSN.
(iii) Fewer than 5,000 CSN	At the next ESV or within 3,500 CIS after March 12, 2004 (effective date of superseded AD 2004–04–07), whichever occurs first, but before accumulating 7,400 CSN.

Stage 1 HPT Rotor Disks, P/N 1862M23G01

(m) For stage 1 HPT rotor disk, P/N 1862M23G01, remove the disk from service at the following times:

(1) For stage 1 HPT rotor disks not installed in engines, remove from service as necessary before further flight.

(2) For stage 1 HPT rotor disks that have been inspected before March 12, 2004 (effective date of superseded AD 2004–04–07), using any version of GE ASB No. CF6–80C2 S/B 72–A1026, and had more than zero CSN at the time of that inspection, remove from service at next ESV.

(3) For stage 1 HPT rotor disks that have not been inspected, or were only inspected with zero CSN before March 12, 2004 (effective date of superseded AD 2004–04–07), using any version of GE ASB No. CF6–80C2 S/B 72–A1026, remove from service

using the following Table 9 or Table 9A compliance times, whichever occurs first:

TABLE 9.—COMPLIANCE TIMES FOR REMOVAL OF CF6–80C2 SERIES STAGE 1 HPT ROTOR DISKS, P/N 1862M23G01—NOT PREVIOUSLY INSPECTED

Stage 1 HPT rotor disk CSN on the effective date of this AD	Compliance time for removal
(i) 9,000 or more CSN	Within 250 CIS after the effective date of this AD, or by March 31, 2007, whichever occurs first.
(ii) 6,900 or more but fewer than 9,000 CSN	Within 500 CIS after the effective date of this AD, but before accumulating 9,250 CSN, or by December 31, 2007, whichever occurs first.
(iii) Fewer than 6,900 CSN	Before accumulating 7,400 CSN, or by December 31, 2008, whichever occurs first.

TABLE 9A.—COMPLIANCE TIMES FOR REMOVAL OF CF6–80C2 SERIES STAGE 1 HPT ROTOR DISKS, P/N 1862M23G01—NOT PREVIOUSLY INSPECTED

Stage 1 HPT rotor disk CSN on March 12, 2004 (effective date of superseded AD 2004–04–07)	Compliance time for removal
(i) 10,000 or more CSN	At the next ESV or within 1,000 CIS after March 12, 2004 (effective date of superseded AD 2004–04–07), whichever occurs first.
(ii) 5,000 or more CSN but fewer than 10,000 CSN	At the next ESV or within 2,400 CIS after March 12, 2004 (effective date of superseded AD 2004–04–07), whichever occurs first, but before accumulating 11,000 CSN.
(iii) Fewer than 5,000 CSN	At the next ESV or within 3,500 CIS after March 12, 2004 (effective date of superseded AD 2004–04–07), whichever occurs first, but before accumulating 7,400 CSN.

CF6–80E1A2, A4 Engines

Stage 1 HPT Rotor Disks, P/N 1639M41P04

(n) For stage 1 HPT rotor disks, P/N 1639M41P04, remove the rotor disks from service using paragraphs 3.A.(1) through 3.A.(2) of Accomplishment Instructions of GE SB No. CF6–80E1 S/B 72–0251, dated January 22, 2004, at the following times:

(1) For stage 1 HPT rotor disks currently in service, remove the disk using the compliance times in the following Table 10 or Table 10A compliance times, whichever occurs first:

TABLE 10.—COMPLIANCE TIMES FOR REMOVAL OF CF6–80E1 STAGE 1 HPT ROTOR DISKS, P/N 1639M41P04

Stage 1 HPT rotor disk CSN on the effective date of this AD	Compliance Time For Removal
(i) 9,000 or more CSN	Within 250 CIS after the effective date of this AD, or by March 31, 2007, whichever occurs first.
(ii) 6,900 or more but fewer than 9,000 CSN	Within 500 CIS after the effective date of this AD, but before accumulating 9,250 CSN, or by December 31, 2007, whichever occurs first.
(iii) Fewer than 6,900 CSN	Before accumulating 7,400 CSN, or by December 31, 2008, whichever occurs first.

TABLE 10A.—COMPLIANCE TIMES FOR REMOVAL OF CF6–80E1 STAGE 1 HPT ROTOR DISKS, P/N 1639M41P04

Stage 1 HPT rotor disk CSN on the March 12, 2004 (effective date of superseded AD 2004–04–07)	Compliance time for removal
(i) More than 10,000 CSN	At the next ESV or within 600 CIS after March 12, 2004 (effective date of superseded AD 2004–04–07), whichever occurs first.
(ii) More than 5,000 CSN but fewer than or equal to 10,000 CSN	At the next ESV or within 2,500 CIS after March 12, 2004 (effective date of superseded AD 2004–04–07), whichever occurs first, but before accumulating 10,600 CSN.
(iii) Fewer than or equal to 5,000 CSN	At the next ESV or within 3,500 CIS after March 12, 2004 (effective date of superseded AD 2004–04–07), whichever occurs first, but before accumulating 7,500 CSN.

(2) After March 12, 2004 (effective date of superseded AD 2004–04–07), do not install any stage 1 HPT rotor disk, P/N 1639M41P04, into any engine.

Definitions

(o) For the purpose of this AD, the following definitions apply:

(1) An engine shop visit (ESV) is when the engine is removed from an aircraft for maintenance and a major engine flange is disassembled. For stage 1 HPT rotor disks that have been inspected using any version of GE SB No. CF6–80A SB 72–0779 or any version of GE ASB No. CF6–80C2 ASB 72-A1026 or GE SB No. CF6–80C2 SB 72-A1024, Revision 1, dated November 3, 2000 or are listed in Table 6A or Table 6B, the following actions, either separately or in combination with each other, are not considered ESVs for the purpose of this AD:

(i) The removal of the upper compressor stator case solely for airfoil maintenance.

(ii) The module level inspection of the high-pressure compressor rotor 3–9 spool.

(iii) The replacement of stage 5 high-pressure compressor variable stator vane bushings or lever arms.

(2) Piece-part exposure is when according to the manufacturer's engine manual or other FAA-approved engine manual the stage 1 HPT rotor disk is considered completely disassembled.

Reporting Requirements

(p) Within five calendar days of the inspection, report the results of inspections that equal or exceed the reject criteria to: Engine Certification Office, FAA, Engine and Propeller Directorate, 12 New England Executive Park, Burlington, MA 01803; telephone (781) 238–7176; fax (781) 238–7199. Reporting requirements have been approved by the Office of Management and Budget and assigned OMB control number 2120–0056. Be sure to include the following information:

(1) Engine model in which the stage 1 HPT rotor disk was installed.

(2) Part Number.

(3) Serial Number.

(4) Part CSN.

(5) Part CSLI.

(6) Date and location where inspection was done.

(q) We request that you record the inspection information and results on GE Form 1653–1, entitled CF6–80A/80C Stage 1 HPT Disk Dovetail Slot Bottom Inspection. This form is available in any version of GE SB CF6–80A S/B 72–0779, or GE ASB CF6–80C2 S/B 72–A1026. We also request that a copy of the data be sent to GE Airline Support Engineering, General Electric Aircraft Engines, Customer Support Center, 1 Neumann Way, Mail Drop RM285, Cincinnati, OH 45215.

Alternative Methods of Compliance

(r) The manager, Engine Certification Office, has the authority to approve alternative methods of compliance for this AD if requested using the procedures found in 14 CFR 39.19.

Material Incorporated by Reference

(s) You must use the service information specified in Table 11 to perform the actions required by this AD. The Director of the Federal Register previously approved the incorporation by reference of General Electric Service Bulletins No. CF6–80E1 S/B 72–0251, dated January 22, 2004 and No. CF6–80A S/B 72–0779, Revision 1, dated January 22, 2004, and Alert Service Bulletin No. CF6–80C2 S/B 72–A1026, Revision 2, dated January 22, 2004, as of March 12, 2004 (69 FR 8801, February 26, 2004). The Director of the Federal Register approved the incorporation by reference of the other documents listed in Table 11 of this AD in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You can get a copy from General Electric Company via Lockheed Martin Technology Services, 10525 Chester Road, Suite C, Cincinnati, Ohio 45215, telephone (513) 672–8400, fax (513) 672–8422. You may review copies at the FAA, New England Region, Office of the Regional Counsel, 12 New England Executive Park, Burlington, MA; or at the Office of the Federal Register, 800 North Capitol Street, NW, Suite 700, Washington, DC. Table 11 follows:

TABLE 11.—INCORPORATION BY REFERENCE

Service Bulletin No.	Page	Revision	Date
GE SB No. CF6–80E1 S/B 72–0251 Total Pages: 4	All	Original	January 22, 2004.
GE SB No. CF6–80A S/B 72–0779 Total Pages: 34	ALL	1	January 22, 2004.
GE SB No. CF6–80A S/B 72–0788 Total Pages: 11	ALL	3	July 20, 2006.
GE ASB No. CF6–80C2 S/B 72–A1026 Total Pages: 38	ALL	2	January 22, 2004.
GE SB No. CF6–80C2 S/B 72–1089 Total Pages: 11	ALL	3	July 20, 2006.
GE SB No. CF6–80C2 S/B 72–1217 Total Pages: 12	ALL	Original	July 20, 2006.
GE SB No. CF6–80A S/B 72–0822 Total Pages: 10	ALL	Original	July 20, 2006.

Related Information

(t) GE ASB No. CF6–80C2 S/B 72–A1024, Revision 1, dated November 3, 2000 also pertains to the subject of this AD.

Issued in Burlington, Massachusetts, on August 10, 2006.

Francis A. Favara,

Manager, Engine and Propeller Directorate, Aircraft Certification Service.

[FR Doc. E6–13437 Filed 8–17–06; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2006–24366; Directorate Identifier 2006–NM–040–AD; Amendment 39–14716; AD 2006–16–16]

RIN 2120–AA64

Airworthiness Directives; Empresa Brasileira de Aeronautica S.A. (EMBRAER) Model EMB–135BJ Airplanes

AGENCY: Federal Aviation Administration (FAA), Department of Transportation (DOT).

ACTION: Final rule.

SUMMARY: The FAA is adopting a new airworthiness directive (AD) for certain EMBRAER Model EMB–135BJ airplanes. This AD requires inspecting for missing fire blocking material on the left- and right-hand partitions of the forward baggage compartment door; replacing the seal on both partitions; and performing corrective action if necessary. This AD results from a report indicating that certain airplanes were delivered with the fire blocking material missing and the seal improperly installed on the partitions of the forward baggage compartment door. We are issuing this AD to detect and correct such discrepancies on the forward baggage compartment partition, which, in the event of a fire in the baggage compartment, could result in smoke propagating into the main cabin.

DATES: This AD becomes effective September 22, 2006.

The Director of the Federal Register approved the incorporation by reference of a certain publication listed in the AD as of September 22, 2006.

ADDRESSES: You may examine the AD docket on the Internet at *http://dms.dot.gov* or in person at the Docket

Management Facility, U.S. Department of Transportation, 400 Seventh Street, SW., Nassif Building, Room PL–401, Washington, DC.

Contact Empresa Brasileira de Aeronautica S.A. (EMBRAER), P.O. Box 343—CEP 12.225, Sao Jose dos Campos—SP, Brazil, for service information identified in this AD.

FOR FURTHER INFORMATION CONTACT: Dan Rodina, Aerospace Engineer, International Branch, ANM–116, Transport Airplane Directorate, FAA, 1601 Lind Avenue, SW., Renton, Washington 98057–3356; telephone (425) 227–2125; fax (425) 227–1149.

SUPPLEMENTARY INFORMATION:

Examining the Docket

You may examine the airworthiness directive (AD) docket on the Internet at *http://dms.dot.gov* or in person at the Docket Management Facility office between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The Docket Management Facility office (telephone (800) 647–5227) is located on the plaza level of the Nassif Building at the street address stated in the **ADDRESSES** section.

Discussion

The FAA issued a notice of proposed rulemaking (NPRM) to amend 14 CFR part 39 to include an AD that would apply to certain EMBRAER Model EMB–135BJ airplanes. That NPRM was published in the **Federal Register** on April 11, 2006 (71 FR 18247). That NPRM proposed to require inspecting for missing fire blocking material on the left- and right-hand partitions of the forward baggage compartment door; replacing the seal on both partitions; and performing corrective action if necessary.

Comments

We provided the public the opportunity to participate in the development of this AD. We have considered the comments received.

Request To Add Revised Service Information to Applicability Section

The manufacturer, EMBRAER, advises that the service bulletin specified in the NPRM has been revised. EMBRAER notes that EMBRAER Service Bulletin 145LEG–25–0060, Revision 01, dated March 3, 2006, extends the compliance time to coincide with the Brazilian airworthiness directive and contains minor changes. EMBRAER asks that we add the revised service bulletin to the applicability section.

We agree with EMBRAER. We have reviewed Revision 01 of the service bulletin and note that it does not necessitate additional work. We have changed the applicability section of the AD to refer to Revision 01. We have also revised paragraph (f) of the AD to reflect the revised service bulletin. In addition, we have added a new paragraph (g) to this AD specifying that accomplishment of the actions specified in paragraph (f) of the AD in accordance with the original issue of the service bulletin is considered to be an acceptable method of compliance. Subsequent paragraphs of the AD have been re-identified accordingly.

Request To Change Terminology

EMBRAER also asks that the statement of the unsafe condition specified in the NPRM be changed to the following: "We are issuing this AD to detect and correct such discrepancies on the partitions of the forward baggage compartment partition, which, in the event of a fire in the baggage compartment, could result in smoke propagating into the main cabin." EMBRAER states that instead of the forward baggage compartment "door," the subject area should be named the forward baggage compartment "partition."

We agree with EMBRAER and have changed the terminology throughout the AD as follows: "We are issuing this AD to detect and correct such discrepancies on the forward baggage compartment partition, which, in the event of a fire in the baggage compartment, could result in smoke propagating into the main cabin."

Conclusion

We have carefully reviewed the available data, including the comments received, and determined that air safety and the public interest require adopting the AD with the changes described previously. These changes will neither increase the economic burden on any operator nor increase the scope of the AD.

Costs of Compliance

The following table provides the estimated costs for U.S. operators to comply with this AD.

ESTIMATED COSTS

Action	Work hours	Average labor rate per hour	Parts	Cost per airplane	Number of U.S.-registered airplanes	Fleet cost
Inspection	1	$80	None	$80	23	$1,840
Seal Replacement	7	$80	Minimal	$560	23	$12,880

Authority for This Rulemaking

Title 49 of the United States Code specifies the FAA's authority to issue rules on aviation safety. Subtitle I, Section 106, describes the authority of the FAA Administrator. Subtitle VII, Aviation Programs, describes in more detail the scope of the Agency's authority.

We are issuing this rulemaking under the authority described in Subtitle VII, Part A, Subpart III, Section 44701, "General requirements." Under that section, Congress charges the FAA with promoting safe flight of civil aircraft in air commerce by prescribing regulations for practices, methods, and procedures the Administrator finds necessary for safety in air commerce. This regulation is within the scope of that authority because it addresses an unsafe condition that is likely to exist or develop on products identified in this rulemaking action.

Regulatory Findings

We have determined that this AD will not have federalism implications under Executive Order 13132. This AD will not have a substantial direct effect on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government.

For the reasons discussed above, I certify that this AD:

(1) Is not a "significant regulatory action" under Executive Order 12866;

(2) Is not a "significant rule" under DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and

(3) Will not have a significant economic impact, positive or negative, on a substantial number of small entities

under the criteria of the Regulatory Flexibility Act.

We prepared a regulatory evaluation of the estimated costs to comply with this AD and placed it in the AD docket. See the **ADDRESSES** section for a location to examine the regulatory evaluation.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

Adoption of the Amendment

■ Accordingly, under the authority delegated to me by the Administrator, the FAA amends 14 CFR part 39 as follows:

PART 39—AIRWORTHINESS DIRECTIVES

■ 1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

■ 2. The Federal Aviation Administration (FAA) amends § 39.13 by adding the following new airworthiness directive (AD):

2006–16–16 Empresa Brasileira de Aeronautica S.A. (EMBRAER): Amendment 39–14716. FAA–2006–24366; Directorate Identifier 2006–NM–040–AD.

Effective Date

(a) This AD becomes effective September 22, 2006.

Affected ADs

(b) None.

Applicability

(c) This AD applies to EMBRAER Model EMB–135BJ airplanes, certificated in any category; as identified in EMBRAER Service Bulletin 145LEG–25–0060, Revision 01, dated March 3, 2006.

Unsafe Condition

(d) This AD results from a report indicating that certain airplanes were delivered with the fire blocking material missing and the seal improperly installed on the partitions of the forward baggage compartment door. We are issuing this AD to detect and correct such discrepancies on the forward baggage compartment partition, which, in the event of a fire in the baggage compartment, could result in smoke propagating into the main cabin.

Compliance

(e) You are responsible for having the actions required by this AD performed within the compliance times specified, unless the actions have already been done.

Inspection and Corrective Actions

(f) Within 24 months after the effective date of this AD: Do a general visual inspection for missing fire blocking material (an insulation blanket) on the left- and right-hand partitions of the forward baggage compartment door, replace the seal on both partitions with a new seal, and accomplish all applicable corrective actions, by doing all the actions specified in the Accomplishment Instructions of EMBRAER Service Bulletin 145LEG–25–0060, Revision 01, dated March 3, 2006. All applicable corrective actions must be done before further flight.

Note 1: For the purposes of this AD, a general visual inspection is: "A visual examination of an interior or exterior area, installation, or assembly to detect obvious damage, failure, or irregularity. This level of inspection is made from within touching distance unless otherwise specified. A mirror may be necessary to ensure visual access to all surfaces in the inspection area. This level of inspection is made under normally available lighting conditions such as daylight, hangar lighting, flashlight, or droplight and may require removal or opening of access panels or doors. Stands, ladders, or platforms may be required to gain proximity to the area being checked."

Acceptable for Compliance

(g) Accomplishment of the actions required by paragraph (f) of this AD before the effective date of this AD in accordance with EMBRAER Service Bulletin 145LEG–25–0060, dated November 18, 2005, is acceptable for compliance with the requirements of that paragraph.

Alternative Methods of Compliance (AMOCs)

(h)(1) The Manager, International Branch, ANM–116, Transport Airplane Directorate, FAA, has the authority to approve AMOCs for this AD, if requested in accordance with the procedures found in 14 CFR 39.19.

(2) Before using any AMOC approved in accordance with § 39.19 on any airplane to which the AMOC applies, notify the appropriate principal inspector in the FAA Flight Standards Certificate Holding District Office.

Related Information

(i) Brazilian airworthiness directive 2006–02–02, effective February 24, 2006, also addresses the subject of this AD.

Material Incorporated by Reference

(j) You must use EMBRAER Service Bulletin 145LEG–25–0060, Revision 01, dated March 3, 2006, to perform the actions that are required by this AD, unless the AD specifies otherwise. The Director of the Federal Register approved the incorporation by reference of this document in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. Contact Empresa Brasileira de Aeronautica S.A. (EMBRAER), P.O. Box 343—CEP 12.225, Sao Jose dos Campos—SP, Brazil, for a copy of this service information. You may review copies at the Docket Management Facility, U.S. Department of Transportation, 400 Seventh Street, SW., Room PL–401, Nassif Building, Washington, DC; on the Internet at *http://dms.dot.gov;* or at the National Archives and Records Administration (NARA). For information on the availability of this material at the NARA, call (202) 741–6030, or go to *http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.*

Issued in Renton, Washington, on August 3, 2006.

Ali Bahrami,

Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. E6–13449 Filed 8–17–06; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Docket No. FAA–2006–25499; Airspace Docket No. 06–ASW–09]

Modification of Class D Airspace, Modification to Class E; Clovis, NM

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Direct final rule; request for comments.

SUMMARY: This action modifies the Class D and the Class E airspace areas at Cannon AFB, Clovis, NM, to provide controlled airspace for Category (CAT) E aircraft performing a circling approach within Class D and Class E Airspace.

DATES: Effective 0901 UTC, November 23, 2006.

Comments for inclusion in the Rules Docket must be received on or before October 23, 2006.

ADDRESSES: Send comments on the rule to the Docket Management System, U.S. Department of Transportation, Room Plaza 401, 400 Seventh Street, SW., Washington, DC 20590–0001. You must identify the docket number, FAA–2006–25499/Airspace Docket No. 06–ASW–09, at the beginning of your comments. You may also submit comments on the Internet at the DOT docket Web site, *http://dms.dot.gov* or the government-wide Web site, *http://regulations.gov.* Anyone can find and read the comments received in this docket, including the name, address and any other personal information placed in the docket by a commenter. You may hand-deliver your comments and review the public docket containing any comments received and this Direct Final Rule in person at the Dockets Office between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The Docket Office (telephone 1–800–647–5527) is located on the plaza level of the Department of Transportation Nassif Building at the street address stated previously.

An informal docket may also be examined during normal business hours at the office of the Central Service Area,

System Support Group, Federal Aviation Administration, Southwest Region, 2601 Meacham Boulevard, Fort Worth, TX. Call the group manager, System Support Group, AJO–2C2, telephone (817) 222–5530; fax (817) 222–5981, to make arrangements for your visit.

FOR FURTHER INFORMATION CONTACT: Joseph R. Yadouga, Central, Service Area, System Support Group, Federal Aviation Administration, Southwest Region, Fort Worth, TX 76193–0530; telephone: (817) 222–5597.

SUPPLEMENTARY INFORMATION: This amendment to 14 CFR part 71 establishes a Class D airspace designation for an airspace area from the surface up to but not including 6,800 feet MSL at Cannon AFB, Clovis, NM, and will be published in paragraph 5000 of FAA Order 7400.9N, dated September 1, 2005, and effective September 16, 2005, which is incorporated by reference in 14 CFR 71.1.

This amendment to 14 CFR part 71 also modifies the Class E airspace area extending upward from the surface at Cannon AFB, Clovis, NM, and will be published in paragraph 6000 of FAA Order 7400.9N, dated September 1, 2005, and effective September 16, 2005, which is incorporated by reference in 14 CFR 71.1.

The Direct Final Rule Procedure

The FAA anticipates that this regulation will not result in an adverse or negative comment, and, therefore, issues it as a direct final rule. The FAA has determined that this regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current. Unless a written adverse or negative comment, or a written notice of intent to submit an adverse or negative comment is received within the comment period, the regulation will become effective on the date specified. After the close of the comment period, the FAA will publish a document in the **Federal Register** indicating that no adverse or negative comments were received and confirming the date on which the final rule will become effective. If the FAA does receive, within the comment period, an adverse or negative comment, or written notice of intent to submit such a comment, a document withdrawing the direct final rule will be published in the **Federal Register,** and a notice of proposed rulemaking may be published with a new comment period.

Comments Invited

Although this action is in the form of a direct final rule, and was not preceded by a notice of proposed rulemaking, interested persons are invited to comment on this rule by submitting such written data, views, or arguments as they may desire. Communications must identify both docket numbers. All communications received on or before the closing date for comments will be considered, and this rule may be amended or withdrawn in light of the comments received. Factual information that supports the commenter's ideas and suggestions is extremely helpful in evaluating the effectiveness of this action and determining whether additional rulemaking action would be needed.

Comments are specifically invited on the overall regulatory, economic, environmental, and energy aspects of the rule that might suggest a need to modify the rule. All comments submitted will be available, both before and after the closing date for comments, in the Rules Docket for examination by interested persons. A report that summarizes each FAA-public contact concerned with the substance of this action will be filed in the Rules Docket.

Agency Findings

This rule does not have federalism implications, as defined in Executive Order No. 13132, because it does not have a substantial direct effect on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government. Accordingly, the FAA has not consulted with State authorities prior to publication of this rule.

The FAA has determined that this regulation is noncontroversial and unlikely to result in adverse or negative comments. For the reasons discussed, I certify that this regulation (1) is not a "significant regulatory action" under Executive Order 12866; (2) is not a "significant rule" under Department of Transportation (DOT) Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and (3) does not warrant preparation of a Regulatory Evaluation as these routine matters will only affect air traffic procedures and air navigation. I certify that this rule will not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

Authority for This Rulemaking

The FAA authority to issue rules regarding aviation safety is found in Title 49 of the United States Code. Subtitle I, Section 106 describes the authority of the FAA Administrator. Subtitle VII, Aviation Programs, describes in more detail the scope of the agency's authority.

This rulemaking is promulgated under the authority described in Subtitle VII, Part A, Subpart 1, Section 4013, "Sovereignty and use of airspace." Under that section, the FAA is charged with developing plans and policy for use of the navigatable airspace and assigning by regulation or order the airspace necessary to ensure the safety of aircraft and the efficient use of airspace. The FAA may modify or revoke an assignment when required in the public interest. This regulation is within the scope of that authority because it is in the public interest to provide greater control of the airspace for the safety of aircraft operating in the vicinity of the newly established airport traffic control tower.

List of Subjects in 14 CFR Part 71

Airspace, Incorporation by reference, Navigation (air).

Adoption of the Amendment

■ Accordingly, pursuant to the authority delegated to me, the Federal Aviation Administration amends part 71 of the Federal Aviation Regulations (14 CFR part 71) as follows:

PART 71—DESIGNATION OF CLASS A, CLASS B, CLASS C, CLASS D, AND CLASS E AIRSPACE AREAS; AIRWAYS; ROUTES; AND REPORTING POINTS

■ 1. The authority citation for part 71 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40103, 40113, 40120; E.O. 10854, 24 FR 9565, 3 CFR, 1959–1963 Comp., p. 389.

§ 71.1 [Amended]

■ 2. The incorporation by reference in 14 CFR 71.1 of Federal Aviation Administration Order 7400.9N, Airspace Designations and Reporting Points, dated September 1, 2005, and effective September 16, 2005, is amended as follows:

Paragraph 5000 Class D Airspace Areas Extending Upward From the Surface of the Earth

* * * * *

ASW NM D Clovis, NM [Revised]

Cannon AFB, NM
Lat. 34°22′58″ N, Long. 103°19′20″ W

That airspace extending upward from the surface to and including 6,800 feet MSL within a 6-mile radius Cannon AFB. The Class D airspace area is effective during the

specific dates and times established in advance by the Notice to Airmen. The effective time will thereafter be continuously published in the Airport/Facility Directory.

Paragraph 6000 Class E Airspace Areas Extending Upward From the Surface of the Earth

* * * * *

ASW NM E Clovis, NM [Revised]

Cannon AFB, NM
Lat. 34° 22′58″ N, Long. 103°19′20″ W
Cannon ILS Localizer
Lat. 34°22′25″ N, Long. 103°20′09″ W
Cannon TACAN0
Lat. 34°22′51″ N, Long. 103°19′21″ W

That airspace extending upward from the surface within a 6-mile radius of Cannon AFB. The Class E airspace area is effective during the specific dates and times established in advance by the Notice to Airmen. The effective time will thereafter be continuous published in the Airport/Facility Directory.

* * * * *

Issued in Fort Worth, TX, on August 1, 2006.

Donald R. Smith,

System Support Group Manager, Central Service Area.

[FR Doc. 06–6910 Filed 8–17–06; 8:45am]

BILLING CODE 4910–13–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

21 CFR Part 172

[Docket No. 2002F–0316 (formerly 02F–0316)]

Food Additives Permitted for Direct Addition to Food for Human Consumption; Bacteriophage Preparation

AGENCY: Food and Drug Administration, HHS.

ACTION: Final rule.

SUMMARY: The Food and Drug Administration (FDA) is amending the food additive regulations to provide for the safe use of a bacteriophage preparation on ready-to-eat meat and poultry products as an antimicrobial agent against *Listeria monocytogenes*. This action is in response to a petition filed by Intralytix, Inc.

DATES: This rule is effective August 18, 2006. Submit written or electronic objections and requests for a hearing by September 18, 2006. See section VII of this document for information on the filing of objections. The Director of the Office of the Federal Register approves the incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51 of certain publications in new 21 CFR 172.785 as of August 18, 2006.

ADDRESSES: You may submit objections and requests for a hearing, identified by Docket No. 2002F–0316 (formerly 02F–0316), by any of the following methods:

Electronic Submissions

Submit electronic objections in the following ways:

- Federal eRulemaking Portal: *http://www.regulations.gov*. Follow the instructions for submitting comments.
- Agency Web site: *http://www.fda.gov/dockets/ecomments*. Follow the instructions for submitting comments on the agency Web site.

Written Submissions

Submit written objections in the following ways:

- FAX: 301–827–6870.
- Mail/Hand delivery/Courier [For paper, disk, or CD–ROM submissions]: Division of Dockets Management (HFA–305), Food and Drug Administration, 5630 Fishers Lane, rm. 1061, Rockville, MD 20852.

To ensure more timely processing of objections, FDA is no longer accepting objections submitted to the agency by e-mail. FDA encourages you to continue to submit electronic objections by using the Federal eRulemaking Portal or the agency Web site, as described in the *Electronic Submissions* portion of this paragraph.

Instructions: All submissions received must include the agency name and Docket No(s). and Regulatory Information Number (RIN) (if a RIN number has been assigned) for this rulemaking. All objections received will be posted without change to *http://www.fda.gov/ohrms/dockets/default.htm*, including any personal information provided. For detailed instructions on submitting objections, see the "Objections" heading of the **SUPPLEMENTARY INFORMATION** section of this document.

Docket: For access to the docket to read background documents or objections received, go to *http://www.fda.gov/ohrms/dockets/default.htm* and insert the docket number, found in brackets in the heading of this document, into the "Search" box and follow the prompts and/or go to the Division of Dockets Management, 5630 Fishers Lane, rm. 1061, Rockville, MD 20852.

FOR FURTHER INFORMATION CONTACT: Raphael A. Davy, Center for Food Safety and Applied Nutrition (HFS–265), Food and Drug Administration, 5100 Paint Branch Pkwy., College Park, MD 20740, 301–436–1272.

SUPPLEMENTARY INFORMATION:

I. Background

In a notice published in the **Federal Register** of July 22, 2002 (67 FR 47823), FDA announced that a food additive petition (FAP 2A4738) had been filed by Intralytix, Inc., c/o Lewis & Harrison, 122 C St. NW., suite 740, Washington, DC 20001, now represented by Keller & Heckman LLP, 1001 G St., NW., suite 500 West, Washington, DC 20001. The petition proposed to amend the food additive regulations to provide for the safe use of a mixture of bacteriophages[1] (phages) as an antimicrobial agent against *Listeria monocytogenes* (*L. monocytogenes*) on foods, including fresh meat, meat products, fresh poultry, and poultry products. On December 18, 2003, the petitioner amended the petition to limit the petitioned use to ready-to-eat (RTE) meat and poultry products only.[2]

The food additive consists of a mixture of equal proportions of six individually purified phages. The petitioner's rationale for incorporating multiple phages in one formulation is to minimize the possibility of *L. monocytogenes* developing a resistance to the additive. Each phage in the additive is specific against various *L. monocytogenes* strains, including those strains known to be associated with foodborne illness (e.g., *L. monocytogenes* strains, serotypes 1/2a, 4b and 1/2b). The phages are lytic[3] double-stranded DNA phages. The petitioner has characterized each phage with respect to physical properties and other appropriate identifying factors (e.g., host range, structural protein profile, and DNA sequence of complete genome[4]).

In the manufacturing process, each phage contained in the additive is separately produced using a strain of *L. monocytogenes* that can serve as a host to the specific phage. The host *L. monocytogenes* strain is first cultured in microbiological media and the specific phage is added to the culture when a specified cell density is achieved. After phage multiplication, which results in lysis (destruction) of host cells, the phage is purified by use of multiple filtration steps (to remove bacteria and their components). The six phages produced by this process are then

[1] Bacteriophages are viruses that infect bacteria only.

[2] Ready-to-eat products, as used in this final rule, are defined in 9 CFR 430.1.

[3] Lytic bacteriophages lyse (destroy) their host bacteria as a normal part of their life cycle without integrating into the host genome.

[4] Genome means the genetic content of a cell or virus.

blended in phosphate buffered saline solution to formulate the additive. The six phages contained in the additive have been deposited with the American Type Culture Collection[5] (ATCC).

The phage preparation will be used as an antimicrobial agent to control *L. monocytogenes* in the production of RTE meat and poultry products. The phage preparation is directly sprayed on the surface of the RTE food articles at a level of approximately 1 milliliter (mL) of the preparation per 500 square centimeters (cm^2) of food surface area just prior to packaging.

II. Determination of Safety

Under the general safety standard in section 409 of the Federal Food, Drug, and Cosmetic Act (the act) (21 U.S.C. 348), a food additive cannot be approved for a particular use unless a fair evaluation of the data available to FDA establishes that the additive is safe for that use. FDA's food additive regulations (21 CFR 170.3(i)) define safe as "a reasonable certainty in the minds of competent scientists that the substance is not harmful under the intended conditions of use."

In evaluating the safety of the petitioned substance, FDA considered the following factors in determining the safety of the proposed food additive use: (1) The safety of the six phages constituting the food additive; (2) the safety of potential residues from *L. monocytogenes* used in the manufacture of the food additive and the need for limits related to their levels; (3) whether undesirable genes are potentially carried by the food additive; and (4) the need for additional identity and safety specifications.

A. Safety of the Petitioned Use of the Phage Preparation

Phages infect only bacteria, rather than mammalian or plant cells.[6] Moreover, phages are ubiquitous and humans are routinely exposed to them at high levels through food, water, and the environment without adverse effect.[7] Phages also are a part of the normal microbial population of the humangut.[8] However, the petitioner's bacteriophages are specific to *L. monocytogenes* only. Therefore, FDA concludes that the food additive under consideration does not present a toxicological concern for use in food as proposed by the petitioner based upon the explanations provided in the following sections (Refs. 1 and 3).

B. Safety Evaluation of Potential Residue Components From L. monocytogenes

FDA considered the possibility that the proposed food additive may contain *L. monocytogenes* components as residues from use of the organism as host for phage multiplication in the manufacturing process. Such residues may include the toxin Listeriolysin O (LLO). Potential residues of *L. monocytogenes* other than LLO do not present a safety concern (Ref. 1). Based on our review of scientific literature on the pathogenicity of *L. monocytogenes* (Ref. 1), FDA finds that LLO is the only substance known to be toxic that may potentially be present as a residue in this food additive after the manufacturing process.

LLO was not detected in the finished food additive within the assay limits of detection of 5 hemolytic units[9] (HU)/ml, and the petitioner provided information on the purification process used in the production of the food additive as additional assurance that LLO would not be present at detectable levels in the finished food additive. Nevertheless, the agency has calculated a worst-case exposure to LLO from consumption of food products treated with the phage preparation. Assuming LLO is present at a maximum level of 5 HU/ml in the additive, the worst-case exposure to LLO for males aged 20 years or more that consume RTE foods treated with the additive at the maximum intended use level is 52 HU/person/day (HU/p/d) at the mean and 104 HU/p/d at the 90th percentile. Males aged 20 years or more represent the worst-case scenario because this population group consumes the highest amount of food intended to be treated with the additive (Ref. 2). In this safety evaluation, FDA reviewed all available information on the identity, toxicity, and the stability of LLO. Even if LLO were present at the level of 5 HU/ml, this level does not present a toxicological concern for the following reasons (Ref. 1):

1. Inactivation of LLO by Cholesterol

The toxicity of LLO has been shown to be significantly reduced (by as much as 200- to 2000-fold) following pre-incubation of LLO with added cholesterol *in vitro* (Ref. 1). Since the phage preparation will be used on meat and poultry products and these products normally contain significant (milligram) amounts of cholesterol, then any residual amounts of LLO at levels no greater than 5 HU/ml that may be present in the additive are likely to be inactivated by the cholesterol.

2. pH and LLO Activity

Studies show that LLO activity is lost or significantly decreased in acidic (low pH of less than 4) environments (Ref. 1). Residual amounts of LLO, if present, are likely to be inactivated by the low pH (less than 4) within the human stomach.

3. Inactivation of Orally Consumed LLO by Human Defense Mechanisms

In vivo studies demonstrate that both normal intestinal microflora and cell-mediated immunity reactions in the intestines inhibit LLO (Ref. 1). These defense mechanisms provide some protection against low incidental oral exposures to LLO (no greater than 5 HU/ml). Additionally, at these levels, LLO is expected to be rapidly and irreversibly degraded by proteolytic enzymes that may be presented in the diet or in the stomach. Thus, LLO at these residual levels would not pose a toxic threat to humans.

Considering all of the above factors, FDA concludes that potential residues of LLO that may be found in the food additive are negligible (5 HU/ml or less) and do not pose a safety concern for the use of the additive as an antimicrobial agent on RTE meat and poultry products.

Although LLO was not detected in the food additive, the agency concludes that a specification is necessary to ensure that LLO is not present in detectable amounts to ensure the purity and safe use of the petitioned food additive. Thus, the agency is including in this regulation a specification of not more than 5 HU/ml for LLO (the limit of detection for the method).

C. Undesirable Genes (Bacterial Toxin Genes) Potentially Carried by Phages

Lysogenic phages, as opposed to those that are lytic, have the capacity to integrate into the host genome and may facilitate transfer of toxin or drug resistance genes between bacterial cells. FDA has determined that the phages contained in the petitioned food additive are lytic based on the petitioner's information on host lysis

[5] ATCC is a nonprofit bioresource center that maintains deposits of bacteria and bacteriophages among other biological materials. Their primary mission is to acquire, authenticate, preserve, develop, and distribute biological material.

[6] T.D. Brock and M.T. Madigan, 1998, *Biology of Microorganisms*, 5th edition; Prentice-Hall, Inc., Inglewood Cliffs, NJ.

[7] Bergh, O., K.Y. Borsheim, G. Bratbak, and M. Heldal, 1989, High abundance of viruses found in aquatic environments, *Nature*, vol. 340 (10): 467–468.

[8] Breitbart et al., 2003; *Journal of Bacteriology* 185 (20): 6220–6223.

[9] 1 HU of LLO is equal to one nanogram of protein (as reported in Geoffroy, C. et al. 1987, Purification, Characterization, and Toxicity of the Sulfhydryl-Activated Hemolysin Listeriolysin O from *Listeria monocytogenes*, Infection and Immunity, vol. 55(7): pp. 1641–1646).

characteristics and on genomic analysis of each phage (Ref. 4). Therefore, FDA concludes that the use of this food additive would not result in the spread of toxin or drug genes.

D. The Need for Other Specifications

We are also including specifications for potency, absence of undesirable genes, phage titer[10], absence of *L. monocytogenes* and other microbiological pathogens, and total organic carbon (Ref. 2). These specifications ensure the identity and safe use of the additive.

III. Other Considerations

FDA recognizes that while this rule is issued under the authority of the Federal Food, Drug, and Cosmetic Act, use of the ingredient must also comply with the Federal Meat Inspection Act or the Poultry Products Inspection Act, which are administered by the U.S. Department of Agriculture (USDA). In particular, those statutes provide that the ingredient must be suitable for its intended use. FDA recognizes that there may be meat or poultry products considered RTE for which use of the additive may not be suitable within the meaning of those statutes. This regulation addresses only the safety standard under section 409 of the Federal Food, Drug, and Cosmetic Act and does not address requirements for suitability administered by the USDA.

IV. Conclusion

FDA reviewed data in the petition and other available relevant material to evaluate the safety of the use of a phage preparation as an antimicrobial agent against *L. monocytogenes* on RTE meat and poultry products. Based on this information, the agency concludes that the proposed use of the additive is safe. Therefore, the regulations in part 172 (21 CFR part 172) should be amended as set forth in this document.

In accordance with § 171.1(h) (21 CFR 171.1(h)), the petition and the documents that FDA considered and relied upon in reaching its decision to approve the petition are available for inspection at the Center for Food Safety and Applied Nutrition by appointment with the information contact person (see **FOR FURTHER INFORMATION CONTACT**). As provided in § 171.1(h), the agency will delete from the documents any materials that are not available for public disclosure before making the documents available for inspection.

[10] A term that refers to the number of phage particles per milliliter of phage solution.

V. Environmental Impact

The agency has previously considered the environmental effects of this rule as announced in the notice of filing for FAP 2A4738 (67 FR 47823). No new information or comments have been received that would affect the agency's previous determination that there is no significant impact on the human environment and that an environmental impact statement is not required.

VI. Paperwork Reduction Act of 1995

This final rule contains no collection of information. Therefore, clearance by the Office of Management and Budget under the Paperwork Reduction Act of 1995 is not required.

VII. Objections

Any person who will be adversely affected by this regulation may file with the Division of Dockets Management (see **ADDRESSES**) written or electronic objections. Each objection shall be separately numbered, and each numbered objection shall specify with particularity the provisions of the regulation to which objection is made and the grounds for the objection. Each numbered objection on which a hearing is requested shall specifically so state. Failure to request a hearing for any particular objection shall constitute a waiver of the right to a hearing on that objection. Each numbered objection for which a hearing is requested shall include a detailed description and analysis of the specific factual information intended to be presented in support of the objection in the event that a hearing is held. Failure to include such a description and analysis for any particular objection shall constitute a waiver of the right to a hearing on the objection. Three copies of all documents are to be submitted and are to be identified with the docket number found in brackets in the heading of this document. Any objections received in response to the regulation may be seen in the Division of Dockets Management between 9 a.m. and 4 p.m., Monday through Friday.

VIII. References

The following references have been placed on display in the Division of Dockets Management (see **ADDRESSES**) and may be seen by interested persons between 9 a.m. and 4 p.m., Monday through Friday.

1. Memorandum dated June 3, 2005, from Division of Petition Review, Toxicology Group I, Tina Walker, to Raphael Davy, DPR, entitled "Safety Review of LMP–102™ as an antimicrobial agent in ready-to-eat foods, fresh meat, meat products, fresh poultry, and poultry products."

2. Memorandum dated April 11, 2005, from Division of Petition Review, Chemistry Review Group, Hyoung Lee, to Regulatory Group II, R. Davy, entitled "FAP 2A4738 (MATS#1137 M 2.3), Petition for the use of LMP–102™—a mixture of several monoclonal bacteriophages as an antimicrobial agent in ready-to-eat meat and poultry, Submissions of 10/25/04, 1/18/05, 1/25/05, and 2/18/05."

3. Memorandum dated February 1, 2006, from Division of Petition Review, Toxicology Group I, Tina Walker, to Raphael Davy, DPR, entitled "Addendum to the June 3, 2005 Final Toxicology Memorandum: Additional toxicological evaluation of the potential allergenicity/immunotoxicity of the *Listera* bacteriophage, LMP–102™."

4. Memorandum dated June 1, 2005, from Division of Biotechnology and GRAS Notice Review, Negash Belay, to Raphael A. Davy, Division of Petition Review, entitled "Revised FAP 2A4738."

List of Subjects in 21 CFR Part 172

Food additives, Incorporation by reference, Reporting and recordkeeping requirements.

■ Therefore, under the Federal Food, Drug, and Cosmetic Act and under authority delegated to the Commissioner of Food and Drugs, 21 CFR part 172 is amended as follows:

PART 172—FOOD ADDITIVES PERMITTED FOR DIRECT ADDITION TO FOOD FOR HUMAN CONSUMPTION

■ 1. The authority citation for 21 CFR part 172 continues to read as follows:

Authority: 21 U.S.C. 321, 341, 342, 348, 371, 379e.

■ 2. Section 172.785 is added to subpart H to read as follows:

§ 172.785 *Listeria*-specific bacteriophage preparation.

The additive may be safely used as an antimicrobial agent specific for *Listeria monocytogenes* (*L. monocytogenes*) in accordance with the following conditions:

(a) *Identity.* (1) The additive consists of a mixture of equal proportions of six different individually purified lytic-type (lacking lysogenic activity) bacteriophages (phages) specific against *L. monocytogenes*.

(2) Each phage is deposited at, and assigned an identifying code by, a scientifically-recognized culture collection center, and is made available to FDA upon request.

(3) The additive is produced from one or more cell cultures of *L. monocytogenes* in a safe and suitable nutrient medium.

(b) *Specifications.*

(1) The additive achieves a positive lytic result ($OD_{600} \leq 0.06$) when tested

against any of the following *L. monocytogenes* isolates available from American Type Culture Collection (ATCC): ATCC 35152 (serogroup 1/2a), ATCC 19118 (serogroup 4b), and ATCC 15313 (serogroup 1/2b). The analytical method for determining the potency of the additive entitled "Determination of Potency of LMP–102™," dated October 9, 2003, and printed by Intralytix, Inc., is incorporated by reference. The Director of the Office of the Federal Register approves this incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain a copy from the Office of Food Additive Safety (HFS–200), Center for Food Safety and Applied Nutrition, Food and Drug Administration, 5100 Paint Branch Pkwy., College Park, MD 20740, or you may examine a copy at the Center for Food Safety and Applied Nutrition's Library, 5100 Paint Branch Pkwy., College Park, MD 20740, or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: *http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html*.

(2) The mean phage titer of each monophage in the additive is 1×10^9 plaque forming units (PFU)/ml. The analytical method for determining phage titer entitled "Method to Determine Lytic Activity/Phage Titer," dated November 6, 2001, and printed by Intralytix, Inc., is incorporated by reference. Copies are available at locations cited in paragraph (b)(1) of this section.

(3) The phages present in the preparation must not contain a functional portion of any of the toxin-encoding sequences described in 40 CFR 725.421(d). No sequences derived from genes encoding bacterial 16S ribosomal RNA are present in the complete genomic sequence of the phages.

(4) *L. monocytogenes* toxin, listeriolysin O (LLO), is not greater than 5 hemolytic units (HU)/ml. The analytical method for determining LLO entitled "Quantitation of Listeriolysin O Levels in LMP–102™," dated September 27, 2004, and printed by Intralytix, Inc., is incorporated by reference. Copies are available at locations cited in paragraph (b)(1) of this section.

(5) The additive is negative for *L. monocytogenes*. The modified version of the U.S. Department of Agriculture's method for determining *L. monocytogenes* entitled "LMP–102™ *Listeria monocytogenes* Sterility Testing," dated May 24, 2004, and printed by Intralytix, Inc., is incorporated by reference. Copies are available at locations cited in paragraph (b)(1) of this section.

(6) The additive is negative for gram-positive and gram-negative bacteria capable of growing in commonly used microbiological media (e.g., Luria-Bertani (LB) medium), including *Escherichia coli*, *Salmonella* species and coagulase-positive *Staphylococci*, as determined by the "Method to Determine Microbial Contamination," dated July 11, 2003, and printed by Intralytix, Inc., is incorporated by reference. Copies are available at locations cited in paragraph (b)(1) of this section.

(7) Total organic carbon (TOC) is less than or equal to 36 mg/kg. The analytical method for determining TOC entitled "Determination of Total Organic Carbon by Automated Analyzer," dated March 30, 2001, and printed by Intralytix, Inc., is incorporated by reference. Copies are available at locations cited in paragraph (b)(1) of this section.

(c) *Conditions of use.* The additive is used in accordance with current good manufacturing practice to control *L. monocytogenes* by direct application to meat and poultry products that comply with the ready-to-eat definition in 9 CFR 430.1. Current good manufacturing practice is consistent with direct spray application of the additive at a rate of approximately 1 mL of the additive per 500 cm^2 product surface area.

Dated: August 3, 2006.

Jeffrey Shuren,

Assistant Commissioner for Policy.

[FR Doc. E6–13621 Filed 8–17–06; 8:45 am]

BILLING CODE 4160–01–S

NATIONAL LABOR RELATIONS BOARD

29 CFR Part 100

Debt Collection Procedures

AGENCY: National Labor Relations Board (NLRB).

ACTION: Interim Rule with request for comments.

SUMMARY: The National Labor Relations Board (NLRB) is issuing interim regulations with a request for comments concerning the procedures used to collect debts that are owed to the NLRB. These interim regulations conform to the legislative changes enacted in the Debt Collection Improvement Act of 1996 (DCIA) and the amended procedures presented in the Federal Claims Collection Standards (FCCS) issued by the Department of the Treasury (Treasury) and the Department of Justice (DOJ). These regulations are intended to improve the NLRB's collection of debts owed to the United States.

DATES: This interim rule is effective on August 18, 2006. Comments must be received on or before October 17, 2006.

ADDRESSES: You may submit comments, identified by [RIN Number], by any of the following methods:

- *Mail:* For paper, disk, or CD–ROM submissions, mail to Lester A. Heltzer, Executive Secretary, 1099 14th Street NW., Room 11610, Washington, DC 20570.
- *E-mail: Lester.Heltzer@nlrb.gov.* Include [RIN Number] in the subject line of the message.
- *Fax:* Office of the Executive Secretary Fax Number: (202) 273–4270.

Instructions: All submissions received must include the NLRB's name and the Regulatory Information Number (RIN) for this rulemaking.

FOR FURTHER INFORMATION CONTACT: Lester A. Heltzer, Executive Secretary, National Labor Relations Board, Room 11610, 1099 14th Street, NW., Washington, DC 20570–0001, Telephone (202) 273–1067, e-mail address *Lester.Heltzer@nlrb.gov.*

SUPPLEMENTARY INFORMATION:

I. Background

On April 26, 1996, the Debt Collection Improvement Act (DCIA) of 1996 (Pub. L. 104–134) was enacted. This Act enhances the Federal Government's debt collection activities. The purposes of the Act are—

(1) To maximize collections of delinquent debts owed to the Government by ensuring quick action to enforce recovery of debts and the use of all appropriate collection tools,

(2) To minimize the costs of debt collection by consolidating related functions and activities and using interagency teams,

(3) To reduce losses arising from debt management activity by requiring proper screening of potential borrowers, aggressive monitoring of all accounts, and sharing of information within and among Federal agencies,

(4) To ensure that the public is fully informed of the Federal Government's debt collection policies and that debtors are aware of their obligations to repay amounts owed to the Federal Government,

(5) To ensure that debtors have all appropriate due process rights, including the ability to verify,

challenge, and compromise claims, and access to administrative appeals procedures that are both reasonable and protect the interests of the United States,

(6) To encourage agencies, when appropriate, to sell delinquent debt, particularly debts with underlying collateral, and

(7) To rely on the experience and expertise of private sector professionals to provide debt collection services to Federal agencies.

This act provides that any nontax debt or claim owed to the United States that has been delinquent for a period of 180 days shall be referred to the Department of the Treasury or a Treasury-designated collection center for appropriate action to collect or terminate collection of the claim or debt. The DCIA provides Treasury with new collection tools, including the authority to offset any Federal agency's payment to a vendor to satisfy that vendor's debt.

The Federal Claims Collection Standards (FCCS) (31 CFR Chapter IX parts 900, 901, 902, 903, and 904) were revised November 22, 2000 (65 FR 70390). The revised FCCS clarify and simplify Federal debt collection procedures and reflect changes under the DCIA of 1996 and the General Accounting Office Act of 1996. The revised FCCS reflect legislative changes to Federal debt collection procedures enacted under the DCIA of 1996, Public Law 104–134, 110 Stat. 1321–358, as part of the Omnibus Consolidated Recissions and Appropriations Act of 1996. The revised FCCS provide agencies with greater latitude to adopt agency-specific regulations, tailored to the legal and policy requirements applicable to various types of Federal debt, to maximize the effectiveness of Federal debt collection procedures.

Treasury and the DOJ published the revised FCCS as a joint final rule under Chapter IX, Title 31, Code of Federal Regulations. These regulations superseded the FCCS regulations codified at 4 CFR Chapter II parts 101–105.

The revised FCCS prescribe standards for Federal agency use in the administrative collection, offset, compromise, and suspension or termination of collection activity for civil claims for money, funds, or property as defined by 31 U.S.C. 3701(b), unless specific Federal agency statutes or regulations apply to such activities, or as provided for by Title 11 of the United States Code when the claims involve bankruptcy. The revised FCCS also prescribe standards for referring debts to the DOJ for litigation.

These regulations cover the collection of debts such as court costs, vendor overpayments, travel-related expenses, etc. However, currently, the majority of the debts owed to the NLRB are payroll debts owed by current or former employees, the collection of which are covered under 5 U.S.C. 5514.

II. Administrative Procedures Act

Because this rule involves rules of agency organization, procedure, or practice, no notice of proposed rulemaking is required under section 553 of the Administrative Procedures Act (5 U.S.C. 553). Nonetheless, this is an interim rulemaking, with a provision for a 60-day public comment period. The NLRB will review all comments received during the comment period and will consider any modifications that appear appropriate in adopting these rules as final.

III. Regulatory Flexibility Act

Because no notice of proposed rulemaking is required for procedural rules, the requirements of the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) pertaining to regulatory flexibility analysis do not apply to these rules. However, even if the Regulatory Flexibility Act were to apply, the NLRB certifies that this interim rule will not have a significant impact on small businesses, state and local governments and geographical regions, health, safety, and the environment.

IV. Small Business Regulatory Enforcement Fairness Act

Because the interim rule relates to agency procedure and practice, the NLRB has determined that the Congressional review provisions of the Small Business Regulatory Enforcement Fairness Act (5 U.S.C. 801 *et seq.*) do not apply.

V. Paperwork Reduction Act

This interim rule does not impose any reporting or record keeping requirements under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

List of Subjects in 29 CFR Part 100

Administrative practice and procedures, debt collection procedures.

■ For the reasons set forth in the preamble, the National Labor Relations Board amends 29 CFR part 100 to add Subpart F, Debt Collection Procedures.

PART 100—ADMINISTRATIVE REGULATIONS

■ 1. The authority citation for part 100 is revised to read as follows:

Authority: Section 6, National Labor Relations Act, as amended (29 U.S.C. 141, 156).

Subpart A is also issued under 5 U.S.C. 7301.

Subpart B is also issued under the Inspector General Act of 1976, as amended by the Inspector General Act Amendments of 1988, 5 U.S.C. ap3; 42 U.S.C. 2000e–16(a).

Subpart D is also issued under 28 U.S.C. 2672; 28 CFR part 14.

Subpart E is also issued under 29 U.S.C. 794.

Subpart F is also issued under 31 U.S.C. 3711 and 3716–3719, as amended, 31 CFR part 285, 31 CFR Chapter IX parts 900–904.

■ 2. Subpart F is added as follows:

Subpart F—Debt Collection Procedures

Sec.

Subpart F—Debt Collection Procesures

§ 100.601 Purpose and scope.

This part prescribes standards and procedures for officers and employees of the National Labor Relations Board (NLRB) who are responsible for the collection and disposition of certain debts owed to the United States, as further defined below. The authority for this part is the Federal Claims Collection Act of 1966; the Debt Collection Improvement Act of 1996; 31 U.S.C. 3711 and 3716 through 3719, as amended; The Federal Claims Collection Standards, 31 CFR Chapter IX parts 900–904; and Office of Management and Budget Circular A–

129. The activities covered include: the collection of claims of any amount; compromising claims; suspending or terminating the collection of claims; referring debts that are more than 180 days delinquent to the Department of the Treasury for collection action; and the referral of debts of more than $100,000 (exclusive of any interest and charges) to the Department of Justice for litigation.

§ 100.602 Definitions.

For the purpose of this subpart, the following definitions will apply:

Administrative Offset means withholding money payable by the United States Government (including money payable by the United States Government on behalf of a State Government) to, or held by the Government for, a person to satisfy a debt the person owes the United States Government.

Centralized offset means the offset of Federal payments through the Treasury Offset Program to collect debts that creditor agencies have certified pursuant to 31 U.S.C. 3716(c), 3720A(a) and applicable regulations. The term "centralized offset" includes the Treasury Offset Program's processing of offsets of Federal payments disbursed by disbursing officials other than the Department of the Treasury.

Claim or debt means an amount of money, funds, or property that has been determined by an agency official to be owed to the United States by a person, organization, or entity, except another Federal agency. For the purposes of *administrative offset* under 31 U.S.C. 3716, the terms *claim* and *debt* include an amount of money, funds, or property owed by a person to a State (including past-due support being enforced by a State), the District of Columbia, American Samoa, Guam, the United States Virgin Islands, the Commonwealth of the Northern Mariana Islands, or the Commonwealth of Puerto Rico.

Cross-servicing means that the Department of the Treasury or another debt collection center is taking appropriate debt collection action on behalf of one or more Federal agencies or a unit or sub-agency thereof.

Debtor means an individual, organization, group, association, partnership, or corporation indebted to the Unites States, or the person or entity with legal responsibility for assuming the debtor's obligation.

Delinquent refers to the status of a debt and means a debt has not been paid by the date specified in the initial written demand for payment or applicable contractual agreement with the NLRB, unless other satisfactory payment arrangements have been made by that date. If the debtor fails to satisfy obligations under a payment agreement with the NLRB after other payment arrangements have been made, the debt becomes a delinquent debt.

Payment in full means payment of the total debt due the United States, including any interest, penalty, and administrative costs of collection assessed against the debtor.

Recoupment is a special method for adjusting debts arising under the same transaction or occurrence. For example, obligations arising under the same contract generally are subject to recoupment.

§ 100.603 Debts that are covered.

(a) The procedures covered by this part generally apply to claims for payment or debts that:

(1) Result from certain internal management activities of the NLRB; or

(2) Are referred to the NLRB for collection.

(b) The procedures covered by this part do not apply to:

(1) A debt arising from, or ancillary to, any action undertaken by or on behalf of the NLRB or its General Counsel in furtherance of efforts to ensure compliance with the National Labor Relations Act, 29 U.S.C. 151 et seq., including but not limited to actions involving the collection of monies owed for back pay and/or other monetary remedies provided for in Board orders or ancillary court proceedings. (Regulations concerning the collection of these types of debts are found in 29 CFR part 102, subparts U and V.);

(2) A debt involving criminal actions of fraud, the presentation of a false claim, or misrepresentation on the part of the debtor or any other person having an interest in the claim;

(3) A debt based in whole or in part on conduct in violation of the antitrust laws;

(4) A debt under the Internal Revenue Code of 1986;

(5) A debt between Federal agencies. Federal agencies should attempt to resolve interagency claims by negotiation in accordance with Executive Order 12146 (3 GFR, 1980 Comp., pp. 409–412);

(6) A debt once it becomes subject to salary offset under 5 U.S.C. 5514; or

(7) A debt involving bankruptcy which is covered by Title 11 of the United States Code.

(c) Debts involving criminal actions of fraud, false claims, misrepresentation, or that violate antitrust laws will be promptly referred to the Department of Justice. Only the Department of Justice has the authority to compromise, suspend, or terminate collection activity on such debts. However, at its discretion, the Department of Justice may return a debt to the NLRB for further handling.

§ 100.604 Monetary limitations on NLRB's authority.

The NLRB's authority to compromise a debt or to suspend or terminate collection action on a debt covered by these procedures is limited by 31 U.S.C. 3711(a) to claims that:

(a) Have not been referred to another Federal Agency for further collection actions; and

(b) Do not exceed $100,000 (exclusive of any interest) or such higher amount as the Attorney General shall from time to time prescribe for purposes of compromise or suspension or termination of collection activity.

§ 100.605 Information collection requirements: OMB approval.

This part contains no information collection requirements, and, therefore, is not subject to the requirements of the Paperwork Reduction Act (44 U.S.C. 3501 et seq.).

§ 100.606 No private rights created.

(a) The failure of the NLRB to include in this part any provision of the Federal Claims Collection Standards (FCCS), 31 CFR Chapter IX parts 900–904, does not prevent the NLRB from applying these provisions.

(b) A debtor may not use the failure of the NLRB to comply with any provision of this part or of the FCCS as a defense.

§ 100.607 Form of payment.

These procedures are directed primarily at the recovery of money or, when a contractual basis exists, the NLRB may demand the return of specific property or the performance of specific services.

§ 100.608 Subdivision of claims or debts.

A debt may not be subdivided to avoid the monetary ceiling established by 31 U.S.C. 3711(a)(2) and 29 CFR 100.604.

§ 100.609 Administrative collection of claims.

The NLRB shall aggressively collect all claims or debts. These collection activities will be undertaken promptly and follow up action will be taken as appropriate in accordance with 31 CFR Chapter IX § 901.1.

§ 100.610 Written demand for payment.

(a) The NLRB will promptly make written demand upon the debtor for

payment of money or the return of specific property. The written demand for payment will be consistent with the requirements of 31 CFR Chapter IX § 901.2. The date by which payment is due to avoid any late charges will be 60 days from the date that the demand letter is mailed or hand-delivered.

(b) The failure to state in a letter of demand a matter described in 31 CFR Chapter IX § 901.2 is not a defense for a debtor and does not prevent the NLRB from proceeding with respect to that matter.

(c) When necessary, to protect the Government's interest, written demand may be preceded by other appropriate action, including immediate referral for litigation. It may be appropriate to contact a debtor or his representative or guarantor by other means (telephone, in person, etc.) to discuss prompt payment and/or the debtor's ability to repay the debt, and to inform the debtor of his rights and the effect of nonpayment or delayed payment.

(d) When the NLRB learns that a bankruptcy petition has been filed with respect to a debtor, the NLRB will cease collection action immediately unless it has been determined that the automatic stay imposed at the time of filing pursuant to 11 U.S.C. 362 has been lifted or is no longer in effect.

§ 100.611 Reporting claims or debts.

(a) In addition to assessing interest, penalties, and administrative costs pursuant to 31 CFR Chapter IX § 901.9, the NLRB may report a debt that has been delinquent for 90 days to a consumer reporting agency in accordance with the requirements of 31 U.S.C. 3711(e).

(b) The information the NLRB discloses to a consumer reporting agency is limited to—

(1) Information necessary to establish the identity of the individual debtor, including name, address, and taxpayer identification number;

(2) The amount, status, and history of the debt; and

(3) The NLRB activity under which the debt arose.

§ 100.612 Disputed claims or debts.

(a) A debtor who disputes a debt should provide the NLRB with an explanation as to why the debt is incorrect within 60 days from the date the initial demand letter was mailed or hand-delivered. The debtor may support the explanation by affidavits, canceled checks, or other relevant evidence.

(b) If the debtor's arguments appear to have merit, the NLRB may waive the interest period pursuant to 29 CFR 100.617(c) pending a final determination of the existence or the amount of the debt.

(c) The NLRB may investigate the facts concerning the dispute and, if deemed necessary, arrange for a conference at which the debtor may present evidence and any arguments in support of the debtor's position.

§ 100.613 Contracting for collection services.

The NLRB may contract for collection services in order to recover delinquent debts only if the debts are not subject to the DCIA requirement to transfer claims or debts to the Treasury for debt collection services, e.g., claims or debts less than 180 days delinquent. However, the NLRB retains the authority to resolve disputes, compromise claims, suspend or terminate collection action, and initiate enforced collection through litigation. When appropriate, the NLRB shall contract for collection services in accordance with guidance and standards contained in 31 CFR Chapter IX parts 900–904.

§ 100.614 Collection by administrative offset.

(a) *Application.* (1) The NLRB may administratively undertake collection by centralized offset on each claim that is liquidated or certain in amount in accordance with the guidance and standards in 31 CFR Chapter IX parts 900–904 and 5 U.S.C. 5514.

(2) This section does not apply to those debts described in 31 CFR Chapter IX § 901.3(a)(2).

(3) Unless otherwise provided for by contract or law, debts or payments that are not subject to administrative offset under 31 U.S.C. 3716 may be collected by administrative offset under the common law or other applicable statutory authority.

(4) Generally, administrative offset of payments under the authority of 31 U.S.C. 3716 may not be conducted more than 10 years after the Government's right to collect the claim or debt first accrued.

(b) *Mandatory Centralized Offset.* The NLRB is required to refer past due legally enforceable, nontax debts that are over 180 days delinquent to the Department of the Treasury for collection by centralized administrative offset. A debt is legally enforceable if there has been a final determination by the NLRB that the debt, in the amount stated, is due and there are no legal bars to collection action. Debts under this section will be referred and collected pursuant to procedures in 31 CFR Chapter IX § 901.3(b).

(c) *NLRB administrative offset.* The NLRB, in order to refer a delinquent debt to the Department of the Treasury for administrative offset, adopts the administrative offset procedures as prescribed by 31 CFR Chapter IX § 901.3.

(d) *Non-centralized administrative offset.* Generally, non-centralized administrative offsets are ad hoc case-by-case offsets that the NLRB would conduct at its own discretion, internally or in cooperation with the agency certifying or authorizing payments to the debtor. Non-centralized administrative offset is used when centralized administrative offset is not available or appropriate to collect past due legally enforceable, nontax delinquent debts. In these cases, the NLRB may make a request directly to a payment-authorizing agency to offset a payment due a debtor to collect a delinquent debt. The NLRB adopts the procedures in 31 CFR Chapter IX § 901.3(c) so that it may request the Department of the Treasury or any other payment authorizing agency to conduct a non-centralized administrative offset.

(e) *Requests to OPM to offset a debtor's anticipated or future benefit payments under the Civil Service Retirement and Disability Fund and the Federal Employees Retirement System.* Upon providing OPM written certification that a debtor has been afforded the procedures provided for in this section, the NLRB will request that OPM offset a debtor's anticipated or future benefit payments under the Civil Service Retirement and Disability Fund (Fund) in accordance with regulations codified at 5 CFR 831.1801–831.1808 and the Federal Employees Retirement System (System) in accordance with regulations codified at 5 CFR 845.401–845.408. Upon receipt of a request, OPM will identify and "flag" a debtor's account in anticipation of the time when the debtor requests or becomes eligible for payments from the Fund or System. This will satisfy any requirement that offset be initiated prior to the expiration of the time limitations referenced in 29 CFR 100.614(a)(4).

(f) *Review Requirements.* For purposes of this section, whenever the NLRB is required to afford a debtor a review within the Agency, the NLRB shall provide the debtor with a reasonable opportunity for a review of the record in accordance with 31 CFR Chapter IX § 901.3(e). The NLRB will provide the debtor with a reasonable opportunity for an oral hearing in accordance with 31 CFR 285.11(f) when the debtor requests reconsideration of the debt, and the NLRB determines that the question of the indebtedness cannot be resolved by review of the written record, for example, when the validity of the debt

turns on an issue of credibility or veracity.

§ 100.615 Authorities other than offset.

(a) *Administrative Wage Garnishment.* The NLRB is authorized to collect debts from a debtor's wages by means of administrative wage garnishment in accordance with the requirements of 31 U.S.C. 3720D and 31 CFR 285.11. This section adopts and incorporates all of the provisions of 31 CFR 285.11 concerning administrative wage garnishment, including the hearing procedures described in 31 CFR 285.11(f). The NLRB may use administrative wage garnishment to collect a delinquent debt unless the debtor is making timely payments under an agreement to pay the debt in installments.

(b) This section does not apply to Federal salary offset, the process by which the NLRB collects debts from the salaries of Federal employees.

§ 100.616 Payment collection.

(a) The NLRB shall make every effort to collect a claim in full before it becomes delinquent, but will consider arranging for payment in regular installments consistent with 31 CFR Chapter IX § 901.8 if the debtor furnishes satisfactory evidence that he is unable to pay the debt in one lump sum. Except for a claim described in 5 U.S.C. 5514, all installment payment arrangements must be in writing and require the payment of interest, penalties, and other administrative costs. If possible, the installment payments should be sufficient in size and frequency to liquidate the debt in three years or less.

(b) If a debt is paid in one lump sum after it becomes delinquent, the NLRB shall impose charges for interest, penalties, and administrative costs as specified in 31 CFR Chapter IX § 901.9.

(c) Payment of a debt must be made by check, electronic funds transfer, draft, or money order payable to the National Labor Relations Board. Payment should be made to the National Labor Relations Board, Finance Branch, 1099 14th Street, NW., Washington, DC 20570, unless payment is—

(1) Made pursuant to arrangements with the Department of Justice;

(2) Ordered by a Court of the United States; or

(3) Otherwise directed in any other part of this chapter.

§ 100.617 Interest, penalties, and administrative costs.

(a) Pursuant to 31 U.S.C. 3717, the NLRB shall assess interest, penalties, and administrative costs on debts owed to the United States Government. Interest, penalties, and administrative costs will be assessed in accordance with the provisions contained in 31 CFR Chapter IX § 901.9.

(b) The NLRB shall waive collection of interest on a debt or any portion of the debt that is paid in full within 30 days after the date on which the interest began to accrue.

(c) The NLRB may waive interest during a period a disputed debt is under investigation or review by the NLRB. However, this additional waiver is not automatic and must be requested before the expiration of the initial 30-day waiver period. The NLRB may grant the additional waiver only if it finds merit in the explanation the debtor has submitted.

(d) The NLRB may waive collection of interest, penalties, and administrative costs if it finds that one or more of the following conditions exist:

(1) The debtor is unable to pay any significant sum toward the debt within a reasonable period of time;

(2) Collection of interest, penalties, and administrative costs will jeopardize collection of the principal of the debt;

(3) The NLRB is unable to enforce collection in full within a reasonable period of time by enforced collection proceedings; or

(4) Collection is not in the best interest of the United States, including when an administrative offset or installment agreement is in effect.

(e) The NLRB is authorized to impose interest and related charges on debts not subject to 31 U.S.C. 3717, in accordance with common law.

§ 100.618 Bankruptcy claims.

When the NLRB learns that a bankruptcy petition has been filed by a debtor, before proceeding with further collection action, the NLRB will immediately seek legal advice from the NLRB's Office of Special Counsel concerning the impact of the Bankruptcy Code on any pending or contemplated collection activities. After seeking legal advice from the NLRB's Office of Special Counsel, the NLRB will take any necessary action in accordance with the provisions of 31 CFR Chapter IX § 901.2(h).

§ 100.619 When a debt may be compromised.

The NLRB may compromise a debt not in excess of the monetary limitation in accordance with 31 CFR Chapter IX part 902 if it has not been referred to the Department of Justice for litigation.

§ 100.620 Finality of a compromise.

An offer of compromise must be in writing and signed by the debtor. An offer of compromise that is accepted by the NLRB is final and conclusive on the debtor and on all officials, agencies, and courts of the United States, unless obtained by fraud, misrepresentation, the presentation of a false claim, or mutual mistake of fact.

§ 100.621 When collection action may be terminated or suspended.

The NLRB may suspend or terminate collection action on a claim not in excess of the monetary limitation of $100,000 or such other amount as the Attorney General may direct, exclusive of interest, penalties, and administrative costs, after deducting the amount of partial payments or collections, if any, in accordance with the standards and reasons set forth in 31 Chapter IX Part CFR part 903.

§ 100.622 Termination of collection action.

Before terminating collection activity, the NLRB will have pursued all appropriate means of collection and determined, based upon results of the collection activity, that the debt is uncollectible. Termination of collection activity ceases active collection of the debt. The termination of collection activity does not preclude the NLRB from retaining a record of the account for the purposes stated in 31 CFR Chapter IX §§ 903.3(b) and (c).

§ 100.623 Exception to termination.

If a debt meets the exceptions described in 31 CFR Chapter IX § 903.4, the NLRB may refer it for litigation even though termination of collection activity may otherwise be appropriate.

§ 100.624 Discharge of indebtedness; reporting requirements.

Before discharging a delinquent debt (also referred to as close out of a debt), the NLRB shall take all appropriate steps to collect the debt in accordance with 31 U.S.C. 3711(g), including, as applicable, administrative offset, tax refund offset, Federal salary offset, referral to the Treasury or Treasury-designated collection centers or private collection contractors, credit bureau reporting, wage garnishment, litigation, and foreclosure. Discharge of indebtedness is distinct from termination or suspension of collection activity and is governed by the Internal Revenue Code. When the NLRB determines that it will discharge a debt, it will do so in accordance with the provisions of 31 CFR Chapter IX § 903.5.

§ 100.625 Referral of a claim to the Department of Justice.

The NLRB shall promptly refer debts that are subject to aggressive collection activity and that cannot be

compromised, or debts on which collection activity cannot be suspended or terminated, to the Department of Justice for litigation. Debts shall be referred as early as possible, consistent with the standards contained if 31 CFR Chapter IX parts 900–904 and, in any event, well within the period for initiating timely lawsuits against the debtors. The NLRB will make every effort to refer delinquent debts to the Department of Justice within one year of the date such debts became delinquent.

Dated: Washington, DC, August 15, 2006.

By Direction of the Board.

Lester A. Heltzer,

Executive Secretary.

[FR Doc. E6–13688 Filed 8–17–06; 8:45 am]

BILLING CODE 7545–01–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 117

[CGD08–06–027]

Drawbridge Operation Regulations; Gulf Intracoastal Waterway, Galveston, TX

AGENCY: Coast Guard, DHS.

ACTION: Notice of temporary deviation from regulations.

SUMMARY: The Commander, Eighth Coast Guard District, has issued a temporary deviation from the regulation governing the operation of the Galveston Causeway Railroad Bascule Bridge across the Gulf Intracoastal Waterway, mile 357.2 west of Harvey Locks, at Galveston, Galveston County, Texas. This deviation provides for two (2) three-hour closures to conduct scheduled maintenance to the drawbridge.

DATES: This deviation is effective from 7 a.m. until 4 p.m. on Tuesday, August 29, 2006.

ADDRESSES: Materials referred to in this document are available for inspection or copying at the office of the Eighth Coast Guard District, Bridge Administration Branch, Hale Boggs Federal Building, Room 1313, 500 Poydras Street, New Orleans, Louisiana 70130–3310 between 7 a.m. and 3 p.m., Monday through Friday, except Federal holidays. The telephone number is (504) 671–2128. The Bridge Administration Branch of the Eighth Coast Guard District maintains the public docket for this temporary deviation.

FOR FURTHER INFORMATION CONTACT: David Frank, Bridge Administration Branch, telephone (504) 671–2129.

SUPPLEMENTARY INFORMATION: The Burlington Northern Railway Company has requested a temporary deviation in order to perform necessary maintenance on the rail joints of the Galveston Causeway Railroad Bascule Bridge across the Gulf Intracoastal Waterway, mile 357.2 west of Harvey Locks, at Galveston, Galveston County, Texas. The maintenance is essential for the continued safe operation of the railroad bridge. The bridge currently opens on signal in accordance with 33 CFR 117.5. This temporary deviation will allow the bridge to remain in the closed-to-navigation position from 7 a.m. until 10 a.m. and from 1 p.m. until 4 p.m. on Tuesday, August 29, 2006. This temporary deviation was originally published to occur on Wednesday, August 16, 2006; however, Burlington Northern Railway Company has requested to reschedule to Tuesday, August 29, 2006.

The bridge has a vertical clearance of 10 feet above mean high water in the closed-to-navigation position.

Navigation at the site of the bridge consists mainly of tows with barges and some recreational pleasure craft. Due to prior experience, as well as coordination with waterway users, it has been determined that this closure will not have a significant effect on these vessels. No alternate routes are available.

In accordance with 33 CFR 117.35(c), this work will be performed with all due speed in order to return the bridge to normal operation as soon as possible. This deviation from the operating regulations is authorized under 33 CFR 117.35.

Dated: August 8, 2006.

Marcus Redford,

Bridge Administrator.

[FR Doc. E6–13665 Filed 8–17–06; 8:45 am]

BILLING CODE 4910–15–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 138

[USCG–2005–21780]

RIN 1625–AA98

New Oil Pollution Limits of Liability for Vessels—Delaware River Protection Act of 2006 Amendment to the Oil Pollution Act of 1990

AGENCY: Coast Guard, DHS.

ACTION: Notice of policy.

SUMMARY: The Coast Guard announces the enactment of statutory changes that will affect the financial responsibility of vessel owners and operators for oil pollution from their vessels. The Delaware River Protection Act of 2006 amends limits of liability under the Oil Pollution Act of 1990 (OPA 90) for discharges and substantial threats of discharge of oil from vessels. This statutory change will also result in future changes to Coast Guard regulations related to proof of financial responsibility by vessel owners and operators for discharges of oil from vessels.

FOR FURTHER INFORMATION CONTACT: Mr. Benjamin White at 202–493–6863.

SUPPLEMENTARY INFORMATION:

Background and Purpose

The limits of liability for oil removal costs and damages that result from discharges or substantial threats of discharge of oil from vessels, under OPA 90 (33 U.S.C. 2704), were amended by the enactment of the Delaware River Protection Act of 2006 (the Act), title VI of the Coast Guard and Maritime Transportation Act of 2006 (Pub. L. 109–241). The purpose of this notice is—

1. To alert the public of the amended limits of liability for vessels;

2. To notify the public that existing Coast Guard regulations in 33 CFR part 138 entitled "Financial Responsibility for Water Pollution (Vessels)" remain in effect until amended; and

3. To notify the public that a rulemaking project will be initiated to amend the regulations in 33 CFR part 138 to reflect the amended liability limits.

The following table shows the original and amended limits of liability by vessel type:

Limits of Liability

If the vessel is a—	The original limit of liability limit was the greater of—	The amended limits of liability are the greater of—
Tank vessel greater than 3,000 gross tons with a single hull, double sides only, or double bottom only.	$1,200 per gross ton or $10,000,000	$3,000 per gross ton or $22,000,000.
Tank vessel less than or equal to 3,000 gross tons with a single hull, double sides only, or double bottom only.	$1,200 per gross ton or $2,000,000	$3,000 per gross ton or $6,000,000.
Tank vessel greater than 3,000 gross tons with a double hull.	$1,200 per gross ton or $10,000,000	$1,900 per gross ton or $16,000,000.
Tank vessel less than or equal to 3,000 gross tons with a double hull.	$1,200 per gross ton or $2,000,000	$1,900 per gross ton or $4,000,000.
Any vessel other than a tank vessel	$600 per gross ton or $500,000	$950 per gross ton or $800,000.

Vessel owners, operators and demise charterers that are responsible parties under OPA 90 are liable to the amended limits as follows—

- The amended limits for any tank vessel are effective for an oil discharge or substantial threat of discharge that occurs on or after October 9, 2006.
- The amended limits for any other vessel are effective for an oil discharge or substantial threat of discharge that occurs on or after July 11, 2006.

The changes to the limits of liability created by the Act will result in changes to the requirements for proof of financial responsibility found in the existing "Financial Responsibility for Water Pollution (Vessels)" regulations at 33 CFR part 138. In general, the responsible party for any vessel over 300 gross tons using any place subject to the jurisdiction of the United States, or any vessel using the waters of the exclusive economic zone to transship or lighter oil destined for a place subject to the jurisdiction of the United States, must establish and maintain evidence of financial responsibility (i.e., ability to pay) sufficient to meet the applicable liability limit.

The Coast Guard intends to make changes to existing regulations resulting from the Act. We anticipate initiating a rulemaking that will require vessel owners and operators to provide evidence of financial responsibility to the amended limits of liability, as described above, within 120 days after the final rule is published in the **Federal Register**. In the interim, the levels of financial responsibility enforceable by the Coast Guard are the total applicable amounts currently found at 33 CFR 138.80(f).

If you have any questions regarding this notice, please submit them to: Mr. Benjamin White, National Pollution Fund Center, 4200 Wilson Blvd., Suite 1000, Arlington, VA 22203.

Dated: July 31, 2006.

Jan P. Lane,

Director, National Pollution Funds Center.

[FR Doc. E6–12936 Filed 8–17–06; 8:45 am]

BILLING CODE 4910–15–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 165

[CGD09–06–146]

RIN 1625–AA00

Safety Zone; Celebrate Erie, Erie, PA

AGENCY: Coast Guard, DHS.

ACTION: Temporary Final Rule.

SUMMARY: The Coast Guard is establishing a temporary safety zone encompassing the navigable waters of Presque Isle Bay during the Celebrate Erie Fireworks on August 20, 2006. This safety zone is necessary to ensure the safety of spectators and vessels from the hazards associated with fireworks displays. This safety zone is intended to restrict vessel traffic from a portion of Presque Isle Bay, Erie, Pennsylvania.

DATES: This rule will be effective from 9:45 p.m. (local) until 10:30 p.m. (local) on August 20, 2006.

ADDRESSES: Documents indicated in this preamble as being available in the docket, are part of docket CGD09–06–146 and are available for inspection or copying at: U.S. Coast Guard Sector Buffalo, 1 Fuhrmann Blvd, Buffalo, New York 14203, between 8 a.m. (local) and 4 p.m. (local), Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: LT Tracy Wirth, U.S. Coast Guard Sector Buffalo, at (716) 843–9573.

SUPPLEMENTARY INFORMATION:

Regulatory Information

We did not publish a notice of proposed rulemaking (NPRM) for this regulation. Under 5 U.S.C. 553(b)(B), the Coast Guard finds that good cause exists for not publishing an NPRM. The permit application was not received in time to publish an NPRM followed by a final rule before the effective date.

Under 5 U.S.C. 553(d)(3), good cause exists for making this rule effective less than 30 days after publication in the **Federal Register.** Delaying this rule would be contrary to the public interest of ensuring the safety of spectators and vessels during this event, and immediate action is necessary to prevent possible loss of life or property. The Coast Guard has not received any complaints or negative comments previously with regard to this event.

Background and Purpose

Temporary safety zones are necessary to ensure the safety of vessels and spectators from the hazards associated with fireworks displays. Based on accidents that have occurred in other Captain of the Port zones and the explosive hazard of fireworks, the Captain of the Port Buffalo has determined fireworks launches in close proximity to watercraft pose significant risks to public safety and property. The likely combination of large numbers of recreational vessels, congested waterways, darkness punctuated by bright flashes of light, alcohol use, and debris falling into the water could easily result in serious injuries or fatalities. Establishing a safety zone to control vessel movement around the locations of the fireworks launch platforms will help ensure the safety of persons and property at these events and help minimize the associated risk.

Discussion of Rule

A temporary safety zone is necessary to ensure the safety of spectators and vessels during the setup, loading and launching of a fireworks display in conjunction with Celebrate Erie. The fireworks display will occur between 9:45 p.m. (local) and 10:30 p.m. (local) on August 20, 2006.

The safety zone consists of all navigable waters of Presque Isle Bay in

an 800-foot radius around a point at position: 42°08′20″ N, 080°05′29″ W, at the end of Dobbins Landing Pier, Erie, PA. (DATUM: NAD 83). The size of this zone was determined using the National Fire Prevention Association guidelines and local knowledge concerning wind, waves, and currents.

All persons and vessels must comply with the instructions of the Coast Guard Captain of the Port or the designated on-scene representative. Entry into, transiting, or anchoring within the safety zone is prohibited unless authorized by the Captain of the Port Buffalo or his designated on-scene representative. The Captain of the Port or his designated on-scene representative may be contacted via VHF Channel 16.

Regulatory Evaluation

This rule is not a "significant regulatory action" under section 3(f) of Executive Order 12866, Regulatory Planning and Review, and does not require an assessment of potential costs and benefits under section 6(a)(3) of that Order. The Office of Management and Budget has not reviewed it under that Order. It is not "significant" under the regulatory policies and procedures of the Department of Homeland Security (DHS). We expect the economic impact of this rule to be so minimal that a full Regulatory Evaluation under the regulatory policies and procedures of DHS is unnecessary.

This determination is based on the minimal time that vessels will be restricted from the zone and the zone is an area where the Coast Guard expects insignificant adverse impact to mariners from the zones' activation.

Small Entities

Under the Regulatory Flexibility Act (5 U.S.C. 601–612), we have considered whether this rule would have a significant impact on a substantial number of small entities. The term "small entities" comprises small businesses, not-for-profit organizations that are independently owned and operated and are not dominant in their fields, and governmental jurisdictions with populations of less than 50,000.

The Coast Guard certifies under 5 U.S.C. 605(b) that this rule would not have a significant economic impact on a substantial number of small entities.

This rule would affect the following entities, some of which might be small entities: The owners or operators of commercial vessels intending to transit a portion of Presque Isle Bay during the activated safety zone.

This safety zone will not have a significant economic impact on a substantial number of small entities for the following reasons: This safety zone is only in effect for a very limited duration from 9:45 p.m. (local) until 10:30 p.m. (local) on the day of the event. Vessel traffic can safely pass outside the safety zone during the event. In the event that this temporary safety zone affects shipping, commercial vessels may request permission from the Captain of the Port Buffalo to transit through the safety zone. The Coast Guard will give notice to the public via a Broadcast to Mariners that the regulation is in effect.

Assistance for Small Entities

Under section 213(a) of the Small Business Regulatory Enforcement Fairness Act of 1996 (Public Law 104–121), we offered to assist small entities in understanding this rule so that they can better evaluate its effects and participate in the rulemaking process.

Small businesses may send comments on actions of Federal employees who enforce, or otherwise determine compliance with, Federal regulations to the Small Business and Agriculture Regulatory Enforcement Ombudsman and the Regional Small Business Regulatory Fairness Boards. The Ombudsman evaluates these actions annually and rates each agency's responsiveness to small business. If you wish to comment on actions by employees of the Coast Guard, call 1–888–REG–FAIR (1–888–734–3247).

Collection of Information

This rule calls for no new collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3520).

Federalism

A rule has implications for federalism under Executive Order 13132, Federalism, if it has substantial direct effect on State or local governments and would either preempt State law or impose a substantial direct cost of compliance on them. We have analyzed this rule under Executive Order 13132 and have determined that this rule does not have implications for federalism under that Order.

Unfunded Mandates Reform Act

The Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1531–1538) requires Federal agencies to assess the effects of their discretionary regulatory actions. In particular, the Act addresses actions that may result in the expenditure by a State, local, or tribal government, in the aggregate, or by the private sector of $100,000,000 or more in any one year. Though this rule would not result in such expenditure, we do discuss the effects of this rule elsewhere in this preamble.

Taking of Private Property

This rule will not affect a taking of private property or otherwise have taking implications under Executive Order 12630, Governmental Actions and Interference with Constitutionally Protected Property Rights.

Civil Justice Reform

This rule meets applicable standards in sections 3(a) and 3(b)(2) of Executive Order 12988, Civil Justice Reform, to minimize litigation, eliminate ambiguity, and reduce burden.

Protection of Children

The Coast Guard has analyzed this rule under Executive Order 13045, Protection of Children from Environmental Health Risks and Safety Risks. This rule is not an economically significant rule and does not concern an environmental risk to health or risk to safety that may disproportionately affect children.

Indian Tribal Governments

This rule does not have tribal implications under Executive Order 13175, Consultation and Coordination with Indian Tribal Governments, because it does not have a substantial direct effect on one or more Indian tribes, on the relationship between the Federal Government and Indian tribes, or on the distribution of power and responsibilities between the Federal Government and Indian tribes.

Energy Effects

We have analyzed this rule under Executive Order 13211, Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use. We have determined that it is not a "significant energy action" under that order because it is not a "significant regulatory action" under Executive Order 12866 and is not likely to have a significant adverse effect on the supply, distribution, or use of energy. It has not been designated by the Administrator of the Office of Information and Regulatory Affairs as a significant energy action. Therefore, it does not require a Statement of energy effects under Executive Order 13211.

Technical Standards

The National Technology Transfer and Advancement Act (NTTAA) (15 U.S.C. 272 note) directs agencies to use voluntary consensus standards in their regulatory activities unless the agency provides Congress, through the Office of

Management and Budget, with an explanation of why using these standards would be inconsistent with applicable law or otherwise impractical. Voluntary consensus standards are technical standards (e.g., specifications of materials, performance, design, or operation; test methods; sampling procedure; and related management system practices) that are developed or adopted by voluntary consensus standards bodies.

This rule does not use technical standards. Therefore, we did not consider the use of voluntary consensus standards.

Environment

We have analyzed this rule under Commandant Instruction M16475.1D, which guides the Coast Guard in complying with the National Environmental Policy Act of 1969 (NEPA) (42 U.S.C. 4321–4370f), and have made a preliminary determination that there are no factors in this case that would limit the use of a categorical exclusion under section 2.B.2 of the Instruction. Therefore, we believe that this rule should be categorically excluded, under figure 2–1, paragraph (34)(g), of the Instruction, from further environmental documentation. This event establishes a safety zone therefore paragraph (34)(g) of the Instruction applies.

A final "Environmental Analysis Check List" is available in the docket where indicated under **ADDRESSES**. Comments on this section will be considered before we make the final decision on whether the rule should be categorically excluded from further environmental review. Energy Effects under Executive Order 13211.

List of Subjects in 33 CFR Part 165

Harbors, Marine safety, Navigation (water), Reporting and recordkeeping requirements, Security measures, Waterways.

■ For the reasons discussed in the preamble, the Coast Guard amends 33 CFR Part 165 as follows:

PART 165—REGULATED NAVIGATION AREAS AND LIMITED ACCESS AREAS

■ 1. The authority citation for part 165 continues to read as follows:

Authority: 33 U.S.C. 1226, 1231; 46 U.S.C. Chapter 701; 50 U.S.C. 191, 195; 33 CFR 1.05–1(g), 6.04–1, 6.04–6, and 160.5; Pub. L. 107–295, 116 Stat. 2064; Department of Homeland Security Delegation No. 0170.1.

■ 2. A new temporary § 165.T09–146 is added to read as follows:

§ 165.T09–146 Safety Zone; Celebrate Erie, Erie, PA.

(a) *Location.* The following area is a temporary safety zone: all navigable waters of Presque Isle Bay in an 800-foot radius around a point at position: 42°08′0″ N, 080°05′29″ W, at the end of Dobbins Landing Pier, Erie, PA. (DATUM: NAD 83).

(b) *Effective time and date.* This section is effective from 9:45 p.m. (local) until 10:30 p.m. (local) on August 20, 2006.

(c) *Regulations.* (1) In accordance with the general regulations in section 165.23 of this part, entry into, transiting, or anchoring within this safety zone is prohibited unless authorized by the Captain of the Port Buffalo, or his designated on-scene representative.

(2) This safety zone is closed to all vessel traffic, except as may be permitted by the Captain of the Port Buffalo or his designated on-scene representative.

(3) The "on-scene representative" of the Captain of the Port is any Coast Guard commissioned, warrant or petty officer who has been designated by the Captain of the Port to act on his behalf. The on-scene representative of the Captain of the Port will be aboard either a Coast Guard or Coast Guard Auxiliary vessel. The Captain of the Port or his designated on-scene representative may be contacted via VHF Channel 16.

(4) Vessel operators desiring to enter or operate within the safety zone shall contact the Captain of the Port Buffalo or his on-scene representative to obtain permission to do so. Vessel operators given permission to enter or operate in the safety zone must comply with all directions given to them by the Captain of the Port Buffalo or his on-scene representative.

Dated: August 8, 2006.

S. J. Ferguson,

Captain, U.S. Coast Guard, Captain of the Port Buffalo.

[FR Doc. E6–13678 Filed 8–17–06; 8:45 am]

BILLING CODE 4910–15–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 165

[CGD09–06–147]

RIN 1625–AA00

Safety Zone; March of Dimes Paddle Erie, Erie, PA

AGENCY: Coast Guard, DHS.

ACTION: Temporary Final Rule.

SUMMARY: The Coast Guard is establishing a temporary safety zone encompassing the navigable waters of the Presque Isle. Bay during the Kayak Event on August 26, 2006. This safety zone is necessary to ensure the safety of participants and spectators from the hazards associated with kayaks crossing a main shipping channel during the event. This safety zone is intended to restrict vessel traffic from a portion of Presque Isle Bay in Erie, PA.

DATES: This rule will be effective from 8 a.m. (local) until 12 p.m. (local) on August 26, 2006.

ADDRESSES: Documents indicated in this preamble as being available in the docket, are part of docket CGD09–06–147 and available for inspection or copying at: U.S. Coast Guard Sector Buffalo, 1 Fuhrmann Blvd, Buffalo, New York 14203, between 8 a.m. (local) and 4 p.m. (local), Monday through Friday, except federal holidays.

FOR FURTHER INFORMATION CONTACT: LT Tracy Wirth, U.S. Coast Guard Sector Buffalo, at (716) 843–9573.

SUPPLEMENTARY INFORMATION:

Regulatory Information

We did not publish a notice of proposed rulemaking (NPRM) for this regulation. Under 5 U.S.C. 553(b)(B), the Coast Guard finds that good cause exists for not publishing an NPRM. The permit application was not received in time to publish an NPRM followed by a final rule before the effective date.

Under 5 U.S.C. 553(d)(3), good cause exists for making this rule effective less than 30 days after publication in the **Federal Register**. Delaying this rule would be contrary to the public interest of ensuring the safety of spectators and vessels during this event, and immediate action is necessary to prevent possible loss of life or property. The Coast Guard has not received any complaints or negative comments previously with regard to this event.

Background and Purpose

Temporary safety zones are necessary to ensure the safety of participants from the hazards associated with kayak events. Based on accidents that have occurred in other Captain of the Port zones, the Captain of the Port Buffalo has determined kayak events in close proximity to watercraft pose significant risks to public safety and property. The likely combination of large numbers of recreational vessels and congested waterways could easily result in serious injuries or fatalities. Establishing a safety zone to control vessel movement around the location of the kayak events will help ensure the safety of persons

and property at these events and help minimize the associated risk.

Discussion of Rule

A temporary safety zone is necessary to ensure the safety of participants and spectators during the setup and while the kayak events are taking place in conjunction with the March of Dimes Paddle Erie. The kayak events will occur between 8 a.m. (local) until 12 p.m. (local) on August 26, 2006.

The safety zone consists of all navigable waters of Presque Isle Bay bounded by a line connecting the following sets of coordinates: 42°07′56″ N, 080°06′28″ W, then north to 42°09′09″ N, 080°06′37″ W, then southwest to 42°07′27″ N, 080°08′11″ W, then east to the point of origin, in Presque Isle Bay, Erie, PA. [DATUM: NAD 83]. The size of this zone was determined using the COTP approval of the race course including guidelines and local knowledge concerning wind, waves, and currents.

All persons and vessels must comply with the instructions of the Coast Guard Captain of the Port or the designated on-scene representative. Entry into, transiting, or anchoring within the safety zone is prohibited unless authorized by the Captain of the Port Buffalo or his designated on-scene representative. The Captain of the Port or his designated on-scene representative may be contacted via VHF Channel 16.

Regulatory Evaluation

This rule is not a "significant regulatory action" under section 3(f) of Executive Order 12866, Regulatory Planning and Review, and does not require an assessment of potential costs and benefits under section 6(a)(3) of that Order. The Office of Management and Budget has not reviewed it under that Order. It is not "significant" under the regulatory policies and procedures of the Department of Homeland Security (DHS). We expect the economic impact of this rule to be so minimal that a full Regulatory Evaluation under the regulatory policies and procedures of DHS is unnecessary.

This determination is based on the minimal time that vessels will be restricted from the zone and the zone is an area where the Coast Guard expects insignificant adverse impact to mariners from the zones' activation.

Small Entities

Under the Regulatory Flexibility Act (5 U.S.C. 601–612), we have considered whether this rule would have a significant impact on a substantial number of small entities. The term "small entities" comprises small businesses, not-for-profit organizations that are independently owned and operated and are not dominant in their fields, and governmental jurisdictions with populations of less than 50,000.

The Coast Guard certifies under 5 U.S.C. 605(b) that this rule will not have a significant economic impact on a substantial number of small entities.

This rule will affect the following entities, some of which might be small entities: The owners or operators of commercial vessels intending to transit a portion of Presque Isle Bay Lake during the activated safety zone.

This safety zone will not have a significant economic impact on a substantial number of small entities for the following reasons: This safety zone is only in effect for a very limited duration from 8 a.m. (local) until 12 p.m. (local) on the day of the event. Vessel traffic can safely pass outside the safety zone during the event. In the event that this temporary safety zone affects shipping, commercial vessels may request permission from the Captain of the Port Buffalo to transit through the safety zone. The Coast Guard will give notice to the public via a Broadcast to Mariners that the regulation is in effect.

Assistance for Small Entities

Under section 213(a) of the Small Business Regulatory Enforcement Fairness Act of 1996 (Pub. L. 104–121), we offered to assist small entities in understanding this rule so that they can better evaluate its effects and participate in the rulemaking process.

Small businesses may send comments on actions of Federal employees who enforce, or otherwise determine compliance with, Federal regulations to the Small Business and Agriculture Regulatory Enforcement Ombudsman and the Regional Small Business Regulatory Fairness Boards. The Ombudsman evaluates these actions annually and rates each agency's responsiveness to small business. If you wish to comment on actions by employees of the Coast Guard, call 1–888–REG–FAIR (1–888–734–3247).

Collection of Information

This rule calls for no new collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3520).

Federalism

A rule has implications for federalism under Executive Order 13132, Federalism, if it has substantial direct effect on State or local governments and would either preempt State law or impose a substantial direct cost of compliance on them. We have analyzed this rule under Executive Order 13132 and have determined that this rule does not have implications for federalism under that Order.

Unfunded Mandates Reform Act

The Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1531–1538) requires Federal agencies to assess the effects of their discretionary regulatory actions. In particular, the Act addresses actions that may result in the expenditure by a State, local, or tribal government, in the aggregate, or by the private sector of $100,000,000 or more in any one year. Though this rule would not result in such expenditure, we do discuss the effects of this rule elsewhere in this preamble.

Taking of Private Property

This rule will not affect a taking of private property or otherwise have taking implications under Executive Order 12630, Governmental Actions and Interference with Constitutionally Protected Property Rights.

Civil Justice Reform

This rule meets applicable standards in sections 3(a) and 3(b)(2) of Executive Order 12988, Civil Justice Reform, to minimize litigation, eliminate ambiguity, and reduce burden.

Protection of Children

The Coast Guard has analyzed this rule under Executive Order 13045, Protection of Children from Environmental Health Risks and Safety Risks. This rule is not an economically significant rule and does not concern an environmental risk to health or risk to safety that may disproportionately affect children.

Indian Tribal Governments

This rule does not have tribal implications under Executive Order 13175, Consultation and Coordination with Indian Tribal Governments, because it does not have a substantial direct effect on one or more Indian tribes, on the relationship between the Federal Government and Indian tribes, or on the distribution of power and responsibilities between the Federal Government and Indian tribes.

Energy Effects

We have analyzed this rule under Executive Order 13211, Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use. We have determined that it is not a "significant energy action" under that order because

it is not a "significant regulatory action" under Executive Order 12866 and is not likely to have a significant adverse effect on the supply, distribution, or use of energy. It has not been designated by the Administrator of the Office of Information and Regulatory Affairs as a significant energy action. Therefore, it does not require a Statement of energy effects under Executive Order 13211.

Technical Standards

The National Technology Transfer and Advancement Act (NTTAA) (15 U.S.C. 272 note) directs agencies to use voluntary consensus standards in their regulatory activities unless the agency provides Congress, through the Office of Management and Budget, with an explanation of why using these standards would be inconsistent with applicable law or otherwise impractical. Voluntary consensus standards are technical standards (e.g., specifications of materials, performance, design, or operation; test methods; sampling procedure; and related management system practices) that are developed or adopted by voluntary consensus standards bodies.

This rule does not use technical standards. Therefore, we did not consider the use of voluntary consensus standards.

Environment

We have analyzed this rule under Commandant Instruction M16475.1D, which guides the Coast Guard in complying with the National Environmental Policy Act of 1969 (NEPA) (42 U.S.C. 4321–4370f), and have made a preliminary determination that there are no factors in this case that would limit the use of a categorical exclusion under section 2.B.2 of the Instruction. Therefore, we believe that this rule should be categorically excluded, under figure 2–1, paragraph (34)(g), of the Instruction, from further environmental documentation. This event establishes a safety zone therefore paragraph (34)(g) of the Instruction applies.

A final "Environmental Analysis Check List" is available in the docket where indicated under **ADDRESSES**. Comments on this section will be considered before we make the final decision on whether the rule should be categorically excluded from further environmental review. Energy Effects under Executive Order 13211.

List of Subjects in 33 CFR Part 165

Harbors, Marine safety, Navigation (water), Reporting and recordkeeping requirements, Security measures, Waterways.

■ For the reasons discussed in the preamble, the Coast Guard amends 33 CFR part 165 as follows:

PART 165—REGULATED NAVIGATION AREAS AND LIMITED ACCESS AREAS

■ 1. The authority citation for part 165 continues to read as follows:

Authority: 33 U.S.C. 1226, 1231; 46 U.S.C. Chapter 701; 50 U.S.C. 191, 195; 33 CFR 1.05–1(g), 6.04–1, 6.04–6, and 160.5; Pub. L. 107–295, 116 Stat. 2064; Department of Homeland Security Delegation No. 0170.1.

■ 2. A new temporary § 165.T09–147 is added to read as follows:

§ 165.T09–147 Safety Zone; March of Dimes Paddle Erie, Erie, PA

(a) *Location.* The following area is a temporary safety zone: All navigable waters of Presque Isle Bay bounded by a line connecting the following sets of coordinates: 42°07′56″ N, 080°06′28″ W, then north to 42°09′09″ N, 080°06′37″ W, then southwest to 42°07′27″ N, 080°08′11″ W, then east to the point of origin, in Presque Isle Bay, Erie, PA. [DATUM: NAD 83].

(b) *Effective time and date.* This section is effective from 8 a.m. (local) until 12 p.m. (local) on August 26, 2006.

(c) *Regulations.* (1) In accordance with the general regulations in section 165.23 of this part, entry into, transiting, or anchoring within this safety zone is prohibited unless authorized by the Captain of the Port Buffalo, or his designated on-scene representative.

(2) This safety zone is closed to all vessel traffic, except as may be permitted by the Captain of the Port Buffalo or his designated on-scene representative.

(3) The "on-scene representative" of the Captain of the Port is any Coast Guard commissioned, warrant or petty officer who has been designated by the Captain of the Port to act on his behalf. The on-scene representative of the Captain of the Port will be aboard either a Coast Guard or Coast Guard Auxiliary vessel. The Captain of the Port or his designated on-scene representative may be contacted via VHF Channel 16.

(4) Vessel operators desiring to enter or operate within the safety zone must contact the Captain of the Port Buffalo or his on-scene representative to obtain permission to do so. Vessel operators given permission to enter or operate in the safety zone must comply with all directions given to them by the Captain of the Port Buffalo or his on-scene representative.

Dated: August 8, 2006.

S.J. Ferguson,

Captain, U.S. Coast Guard, Captain of the Port Buffalo.

[FR Doc. E6–13677 Filed 8–17–06; 8:45 am]

BILLING CODE 4910–15–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[EPA–R03–OAR–2006–0153; FRL–8211–1]

Approval and Promulgation of Air Quality Implementation Plans; Virginia; Revised Definition of "Volatile Organic Compound"

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: EPA is approving a State Implementation Plan (SIP) revision submitted by the Virginia Department of Environmental Quality. This revision amends Virginia regulations by updating the definition of "volatile organic compound". This action is being taken under the Clean Air Act (CAA or the Act).

DATES: *Effective Date:* This final rule is effective on September 18, 2006.

ADDRESSES: EPA has established a docket for this action under Docket ID Number EPA–R03–OAR–2006–0153. All documents in the docket are listed in the *www.regulations.gov* Web site. Although listed in the electronic docket, some information is not publicly available, i.e., confidential business information (CBI) or other information whose disclosure is restricted by statute. Certain other material, such as copyrighted material, is not placed on the Internet and will be publicly available only in hard copy form. Publicly available docket materials are available either electronically through *www.regulations.gov* or in hard copy for public inspection during normal business hours at the Air Protection Division, U.S. Environmental Protection Agency, Region III, 1650 Arch Street, Philadelphia, Pennsylvania 19103. Copies of the State submittal are available at the Virginia Department of Environmental Quality, 629 East Main Street, Richmond, Virginia, 23219.

FOR FURTHER INFORMATION CONTACT: Helene Drago, (215) 814–5796, or by e-mail at *drago.helene@epa.gov.*

SUPPLEMENTARY INFORMATION:

I. Background

On April 5, 2006 (71 FR 17050), EPA published a notice of proposed

rulemaking (NPR) for the Commonwealth of Virginia. The revision updated the definition of "volatile organic compound" found in Virginia Regulations. The NPR proposed approval of the updated definition of "volatile organic compound". The formal SIP revision was submitted by the Virginia Department of Environmental Quality on January 12, 2006 .

II. Summary of SIP Revision

On January 12, 2006, the Commonwealth submitted a SIP revision request which amends the definition of "volatile organic compound" found under 9 VAC 5–10–20. The amendment revises the definition of the term "volatile organic compound" to exclude four compounds that have been demonstrated to be less reactive: 1,1,1,2,2,3,3-heptafluoro-3-methoxy-propane, 3-ethoxy -1,1,1,2,3,4,4,5,5,6,6,6-dodecafluoro-2-(trifluoromethyl) hexane, 1,1,1,2,3,3,3-heptafluoropropane, and methyl formate. The definition of VOC has also been revised in order to partially exclude t-butyl acetate. The amendment states that the compound, t-butyl acetate, should be considered to be a VOC for record keeping, emissions reporting, photochemical dispersion modeling and inventory requirements that apply to VOCs and should be uniquely identified in emission reports, but it is not a VOC for purposes of VOC emission standards, emission limitations, or content requirements. This definition update is consistent with Federal regulations.

III. General Information Pertaining to SIP Submittals From the Commonwealth of Virginia

In 1995, Virginia adopted legislation that provides, subject to certain conditions, for an environmental assessment (audit) "privilege"' for voluntary compliance evaluations performed by a regulated entity. The legislation further addresses the relative burden of proof for parties either asserting the privilege or seeking disclosure of documents for which the privilege is claimed. Virginia's legislation also provides, subject to certain conditions, for a penalty waiver for violations of environmental laws when a regulated entity discovers such violations pursuant to a voluntary compliance evaluation and voluntarily discloses such violations to the Commonwealth and takes prompt and appropriate measures to remedy the violations. Virginia's Voluntary Environmental Assessment Privilege Law, Va. Code Sec. 10.1–1198, provides a privilege that protects from disclosure documents and information about the content of those documents that are the product of a voluntary environmental assessment. The Privilege Law does not extend to documents or information (1) that are generated or developed before the commencement of a voluntary environmental assessment; (2) that are prepared independently of the assessment process; (3) that demonstrate a clear, imminent and substantial danger to the public health or environment; or (4) that are required by law.

On January 12, 1998, the Commonwealth of Virginia Office of the Attorney General provided a legal opinion that states that the Privilege law, Va. Code Sec. 10.1–1198, precludes granting a privilege to documents and information "required by law," including documents and information "required by Federal law to maintain program delegation, authorization or approval," since Virginia must "enforce Federally authorized environmental programs in a manner that is no less stringent than their Federal counterparts * * *." The opinion concludes that "[r]egarding § 10.1–1198, therefore, documents or other information needed for civil or criminal enforcement under one of these programs could not be privileged because such documents and information are essential to pursuing enforcement in a manner required by Federal law to maintain program delegation, authorization or approval."

Virginia's Immunity law, Va. Code Sec. 10.1–1199, provides that "[t]o the extent consistent with requirements imposed by Federal law," any person making a voluntary disclosure of information to a state agency regarding a violation of an environmental statute, regulation, permit, or administrative order is granted immunity from administrative or civil penalty. The Attorney General's January 12, 1998 opinion states that the quoted language renders this statute inapplicable to enforcement of any Federally authorized programs, since "no immunity could be afforded from administrative, civil, or criminal penalties because granting such immunity would not be consistent with Federal law, which is one of the criteria for immunity."

Therefore, EPA has determined that Virginia's Privilege and Immunity statutes will not preclude the Commonwealth from enforcing its program consistent with the Federal requirements. In any event, because EPA has also determined that a state audit privilege and immunity law can affect only state enforcement and cannot have any impact on Federal enforcement authorities, EPA may at any time invoke its authority under the Clean Air Act, including, for example, sections 113, 167, 205, 211 or 213, to enforce the requirements or prohibitions of the state plan, independently of any state enforcement effort. In addition, citizen enforcement under section 304 of the Clean Air Act is likewise unaffected by this, or any, state audit privilege or immunity law.

Other specific requirements and the rationale for EPA's proposed action are explained in the NPR and will not be restated here. No public comments were received on the NPR.

IV. Final Action

EPA is approving the revision of the definition of "volatile organic compound" which was submitted on January 12, 2006 as a revision to the Virginia SIP.

V. Statutory and Executive Order Reviews

A. General Requirements

Under Executive Order 12866 (58 FR 51735, October 4, 1993), this action is not a "significant regulatory action" and therefore is not subject to review by the Office of Management and Budget. For this reason, this action is also not subject to Executive Order 13211, "Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use" (66 FR 28355, May 22, 2001). This action merely approves state law as meeting Federal requirements and imposes no additional requirements beyond those imposed by state law. Accordingly, the Administrator certifies that this rule will not have a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*). Because this rule approves pre-existing requirements under state law and does not impose any additional enforceable duty beyond that required by state law, it does not contain any unfunded mandate or significantly or uniquely affect small governments, as described in the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4). This rule also does not have tribal implications because it will not have a substantial direct effect on one or more Indian tribes, on the relationship between the Federal Government and Indian tribes, or on the distribution of power and responsibilities between the Federal Government and Indian tribes, as specified by Executive Order 13175 (65 FR 67249, November 9, 2000). This action also does not have Federalism implications because it does not have

substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government, as specified in Executive Order 13132 (64 FR 43255, August 10, 1999). This action merely approves a state rule implementing a Federal requirement, and does not alter the relationship or the distribution of power and responsibilities established in the Clean Air Act. This rule also is not subject to Executive Order 13045 "Protection of Children from Environmental Health Risks and Safety Risks" (62 FR 19885, April 23, 1997), because it is not economically significant.

In reviewing SIP submissions, EPA's role is to approve state choices, provided that they meet the criteria of the Clean Air Act. In this context, in the absence of a prior existing requirement for the State to use voluntary consensus standards (VCS), EPA has no authority to disapprove a SIP submission for failure to use VCS. It would thus be inconsistent with applicable law for EPA, when it reviews a SIP submission, to use VCS in place of a SIP submission that otherwise satisfies the provisions of the Clean Air Act. Thus, the requirements of section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) do not apply. This rule does not impose an information collection burden under the provisions of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

B. Submission to Congress and the Comptroller General

The Congressional Review Act, 5 U.S.C. 801 *et seq.*, as added by the Small Business Regulatory Enforcement Fairness Act of 1996, generally provides that before a rule may take effect, the agency promulgating the rule must submit a rule report, which includes a copy of the rule, to each House of the Congress and to the Comptroller General of the United States. EPA will submit a report containing this rule and other required information to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the United States prior to publication of the rule in the **Federal Register**. This rule is not a "major rule" as defined by 5 U.S.C. 804(2).

C. Petitions for Judicial Review

Under section 307(b)(1) of the Clean Air Act, petitions for judicial review of this action must be filed in the United States Court of Appeals for the appropriate circuit by October 17, 2006. Filing a petition for reconsideration by the Administrator of this final rule does not affect the finality of this rule for the purposes of judicial review nor does it extend the time within which a petition for judicial review may be filed, and shall not postpone the effectiveness of such rule or action. This action to approve revisions to the Virginia SIP that update the definition of "volatile organic compound" may not be challenged later in proceedings to enforce its requirements. (See section 307(b)(2)).

List of Subjects in 40 CFR Part 52

Environmental protection, Air pollution control, Reporting and recordkeeping requirements, Volatile organic compounds.

Dated: August 8, 2006.

Donald S. Welsh,

Regional Administrator, Region III.

■ 40 CFR part 52 is amended as follows:

PART 52—[AMENDED]

■ 1. The authority citation for part 52 continues to read as follows:

Authority: 42 U.S.C. 7401 *et seq.*

Subpart VV—Virginia

■ 2. In § 52.2420, the table in paragraph (c) is amended by adding an entry for Chapter 10, Section 5–10–20 after the five existing entries for 5–10–20 to read as follows:

§ 52.2420 Identification of plan.

* * * * *

(c) * * *

EPA-APPROVED VIRGINIA REGULATIONS AND STATUTES

State citation (9 VAC 5)	Title/subject	State effective date	EPA approval date	Explanation [former SIP citation]
	Chapter 10 General Definitions [Part I]			
*	*	*	*	*
5–10–20	Terms Defined	5/04/05	8/18/06 [Insert page number where the document begins].	Revised definition of "volatile organic compound".
*	*	*	*	*

[FR Doc. E6–13614 Filed 8–17–06; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[EPA–R03–OAR–2005–VA–0010; FRL–8211–2]

Approval and Promulgation of Air Quality Implementation Plans; Virginia; Amendments to Existing Regulation Provisions Concerning Maintenance, Nonattainment, and Prevention of Significant Deterioration Areas

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: EPA is approving State Implementation Plan (SIP) revisions submitted by the Commonwealth of Virginia. These revisions consist of amendments to state regulation provisions concerning maintenance, nonattainment, and prevention of significant deterioration (PSD) areas for incorporation into the Virginia SIP. EPA is approving these SIP revisions in accordance with the Clean Air Act (CAA or Act).

DATES: *Effective Date:* This final rule is effective on September 18, 2006.

ADDRESSES: EPA has established a docket for this action under Docket ID Number EPA–R03–OAR–2005–VA–

0010. All documents in the docket are listed in the *http://www.regulations.gov* Web site. Although listed in the electronic docket, some information is not publicly available, i.e., confidential business information (CBI) or other information whose disclosure is restricted by statute. Certain other material, such as copyrighted material, is not placed on the Internet and will be publicly available only in hard copy form. Publicly available docket materials are available either electronically through *http://www.regulations.gov* or in hard copy for public inspection during normal business hours at the Air Protection Division, U.S. Environmental Protection Agency, Region III, 1650 Arch Street, Philadelphia, Pennsylvania 19103. Copies of the State submittal are available at the Virginia Department of Environmental Quality, 629 East Main Street, Richmond, Virginia 23219.

FOR FURTHER INFORMATION CONTACT: Ellen Wentworth, (215) 814–2034, or by e-mail at *wentworth.ellen@epa.gov*.

SUPPLEMENTARY INFORMATION:

I. Background

On June 12, 2006 (71 FR 33669), EPA published a notice of proposed rulemaking (NPR) for the Commonwealth of Virginia. The NPR proposed approval of formal SIP revisions submitted by the Commonwealth of Virginia on August 15, August 17, August 19, September 28, and October 3, 2005. These SIP revisions consist of amendments to existing regulation provisions concerning maintenance, nonattainment, and PSD areas found in 9 VAC 5, Chapter 20 of Virginia's regulations for the Control and Abatement of Air Pollution.

II. Summary of SIP Revisions

The August 15, 2005 SIP revision amends 9 VAC 5–20–203, Maintenance areas, 9 VAC 5–20–204, Nonattainment areas, and 9 VAC 5–20–205, PSD areas, to reflect the redesignation of the Hampton Roads ozone nonattainment area to attainment of the 1-hour ozone national ambient air quality standards (NAAQS) (62 FR 34408, June 26, 1997).

The August 17, 2005 SIP revision amends 9 VAC 5–20–203, Maintenance areas, 9 VAC 5–20–204, Nonattainment areas, and 9 VAC 5–20–205, PSD areas, to reflect the redesignation of the Richmond ozone nonattainment area to attainment of the 1-hour ozone NAAQS (62 FR 61237, November 17, 1997).

The August 19, 2005 SIP revision amends 9 VAC 5–20–204, Nonattainment areas, and 9 VAC 5–20–205, PSD areas, to reflect the first repeal of the 1-hour ozone NAAQS (63 FR 31087, June 5, 1998), which removed the White Top Mountain area from the list of 1-hour ozone nonattainment areas and from the list of PSD areas. The White Top Mountain area was later reinstated as a rural transport (marginal) ozone nonattainment area under the 1-hour ozone standard on July 20, 2000 (65 FR 45182), as a result of a 1999 court decision challenging EPA's previous determinations on the applicability of the 1-hour ozone standard.

The September 28, 2005 SIP revision amends 9 VAC 5–20–204, Nonattainment areas, and 9 VAC 5–20–205, PSD areas, by incorporating the new 8-hour ozone nonattainment areas into the list of Virginia's nonattainment areas found in 9 VAC 5–20–204, and revising the list of PSD areas found in 9 VAC 5–20–205. Because the 1-hour ozone standard was revoked, effective June 15, 2005, the revision also adds a provision to 9 VAC 5–20–204, which removed the severe area program in the Northern Virginia ozone nonattainment area as the area was constituted under the 1-hour standard. Because the severe area program imposed more stringent requirements than those required under section 184 of the CAA in that area, Virginia did not need to have a separate new source review (NSR) program meeting the section 184 requirements.

EPA proposed approval of this revision (71 FR, 33670, June 12, 2006), contingent upon the Commonwealth of Virginia implementing the NSR program required under section 184 of the CAA in Virginia's portion of the Ozone Transport Region (OTR). On July 13, 2006 (71 FR 39570), EPA published a final rulemaking implementing the NSR program required under section 184 of the CAA in Virginia's portion of the OTR.

It should be noted that since the September 28, 2005 SIP revision submittal, EPA has redesignated the Fredericksburg (70 FR 76165, December 23, 2005) and Shenandoah National Park (71 FR 24, January 3, 2006) areas to attainment of the 8-hour ozone NAAQS.

Other specific requirements pertaining to 9 VAC 5, Chapter 20 of Virginia's regulations for the Control and Abatement of Air Pollution and the rationale for EPA's proposed action are explained in the NPR and will not be restated here. No public comments were received on the NPR.

III. General Information Pertaining to SIP Submittals From the Commonwealth of Virginia

In 1995, Virginia adopted legislation that provides, subject to certain conditions, for an environmental assessment (audit) "privilege'" for voluntary compliance evaluations performed by a regulated entity. The legislation further addresses the relative burden of proof for parties either asserting the privilege or seeking disclosure of documents for which the privilege is claimed. Virginia's legislation also provides, subject to certain conditions, for a penalty waiver for violations of environmental laws when a regulated entity discovers such violations pursuant to a voluntary compliance evaluation and voluntarily discloses such violations to the Commonwealth and takes prompt and appropriate measures to remedy the violations. Virginia's Voluntary Environmental Assessment Privilege Law, Va. Code Sec. 10.1–1198, provides a privilege that protects from disclosure documents and information about the content of those documents that are the product of a voluntary environmental assessment. The Privilege Law does not extend to documents or information (1) that are generated or developed before the commencement of a voluntary environmental assessment; (2) that are prepared independently of the assessment process; (3) that demonstrate a clear, imminent and substantial danger to the public health or environment; or (4) that are required by law.

On January 12, 1998, the Commonwealth of Virginia Office of the Attorney General provided a legal opinion that states that the Privilege law,Va. Code Sec. 10.1–1198, precludes granting a privilege to documents and information "required by law," including documents and information "required by Federal law to maintain program delegation, authorization or approval," since Virginia must "enforce Federally authorized environmental programs in a manner that is no less stringent than their Federal counterparts * * *." The opinion concludes that "[r]egarding (10.1–1198, therefore, documents or other information needed for civil or criminal enforcement under one of these programs could not be privileged because such documents and information are essential to pursuing enforcement in a manner required by Federal law to maintain program delegation, authorization or approval."

Virginia's Immunity law, Va. Code Sec. 10.1–1199, provides that "[t]o the extent consistent with requirements

imposed by Federal law," any person making a voluntary disclosure of information to a state agency regarding a violation of an environmental statute, regulation, permit, or administrative order is granted immunity from administrative or civil penalty. The Attorney General's January 12, 1998 opinion states that the quoted language renders this statute inapplicable to enforcement of any Federally authorized programs, since "no immunity could be afforded from administrative, civil, or criminal penalties because granting such immunity would not be consistent with Federal law, which is one of the criteria for immunity."

Therefore, EPA has determined that Virginia's Privilege and Immunity statutes will not preclude the Commonwealth from enforcing its program consistent with the Federal requirements. In any event, because EPA has also determined that a state audit privilege and immunity law can affect only state enforcement and cannot have any impact on Federal enforcement authorities, EPA may at any time invoke its authority under the Clean Air Act, including, for example, sections 113, 167, 205, 211 or 213, to enforce the requirements or prohibitions of the state plan, independently of any state enforcement effort. In addition, citizen enforcement under section 304 of the Clean Air Act is likewise unaffected by this, or any, state audit privilege or immunity law.

IV. Final Action

EPA is approving the amendments to existing regulations pertaining to nonattainment, maintenance, and PSD areas found in 9 VAC 5 Chapter 20, submitted on August 15, 17, 19, September 28, and October 3, 2005, as revisions to the Commonwealth of Virginia SIP.

V. Statutory and Executive Order Reviews

A. General Requirements

Under Executive Order 12866 (58 FR 51735, October 4, 1993), this action is not a "significant regulatory action" and therefore is not subject to review by the Office of Management and Budget. For this reason, this action is also not subject to Executive Order 13211, "Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use" (66 FR 28355, May 22, 2001). This action merely approves state law as meeting Federal requirements and imposes no additional requirements beyond those imposed by state law. Accordingly, the Administrator certifies that this rule will not have a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*). Because this rule approves pre-existing requirements under state law and does not impose any additional enforceable duty beyond that required by state law, it does not contain any unfunded mandate or significantly or uniquely affect small governments, as described in the Unfunded Mandates Reform Act of 1995 (Public Law 104–4). This rule also does not have tribal implications because it will not have a substantial direct effect on one or more Indian tribes, on the relationship between the Federal Government and Indian tribes, or on the distribution of power and responsibilities between the Federal Government and Indian tribes, as specified by Executive Order 13175 (65 FR 67249, November 9, 2000). This action also does not have Federalism implications because it does not have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government, as specified in Executive Order 13132 (64 FR 43255, August 10, 1999). This action merely approves a state rule implementing a Federal requirement, and does not alter the relationship or the distribution of power and responsibilities established in the Clean Air Act. This rule also is not subject to Executive Order 13045 (Protection of Children from Environmental Health Risks and Safety Risks((62 FR 19885, April 23, 1997), because it is not economically significant.

In reviewing SIP submissions, EPA's role is to approve state choices, provided that they meet the criteria of the Clean Air Act. In this context, in the absence of a prior existing requirement for the State to use voluntary consensus standards (VCS), EPA has no authority to disapprove a SIP submission for failure to use VCS. It would thus be inconsistent with applicable law for EPA, when it reviews a SIP submission, to use VCS in place of a SIP submission that otherwise satisfies the provisions of the Clean Air Act. Thus, the requirements of section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) do not apply. This rule does not impose an information collection burden under the provisions of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

B. Submission to Congress and the Comptroller General

The Congressional Review Act, 5 U.S.C. 801 *et seq.*, as added by the Small Business Regulatory Enforcement Fairness Act of 1996, generally provides that before a rule may take effect, the agency promulgating the rule must submit a rule report, which includes a copy of the rule, to each House of the Congress and to the Comptroller General of the United States. EPA will submit a report containing this rule and other required information to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the United States prior to publication of the rule in the **Federal Register**. This rule is not a 'major rule' as defined by 5 U.S.C. 804(2).

C. Petitions for Judicial Review

Under section 307(b)(1) of the Clean Air Act, petitions for judicial review of this action must be filed in the United States Court of Appeals for the appropriate circuit by October 17, 2006. Filing a petition for reconsideration by the Administrator of this final rule does not affect the finality of this rule for the purposes of judicial review nor does it extend the time within which a petition for judicial review may be filed, and shall not postpone the effectiveness of such rule or action. This action, approving amendments to Virginia's existing regulation provisions concerning maintenance, nonattainment, and PSD areas, may not be challenged later in proceedings to enforce its requirements. (See section 307(b)(2)).

List of Subjects in 40 CFR Part 52

Environmental protection, Air pollution control, Carbon monoxide, Nitrogen dioxide, Ozone, Reporting and recordkeeping requirements, Volatile organic compounds.

Dated: August 8, 2006.

Donald S. Welsh,

Regional Administrator, Region III.

■ 40 CFR part 52 is amended as follows:

PART 52—[AMENDED]

■ 1. The authority citation for part 52 continues to read as follows:

Authority: 42 U.S.C. 7401 *et seq.*

Subpart VV—Virginia

■ 2. In § 52.2420, the table in paragraph (c) is amended by revising the entries for Chapter 20, sections 5–20–203, 5–20–204, and 5–20–205 to read as follows:

§ 52.2420 Identification of plan. (c) * * *

* * * * *

EPA-APPROVED VIRGINIA REGULATIONS AND STATUTES

State citation (9 VAC 5)	Title/subject	State effective date	EPA approval date	Explanation [former SIP citation]
*	*	*	*	*
	Chapter 20 General Provisions [Part II]			
*	*	*	*	*
5–20–203	Air Quality Maintenance Areas (AQMA)	01/01/98, 04/01/98	08/18/06 [Insert page number where the document begins].	
5–20–204	Nonattainment Areas	01/01/98, 04/01/98, 01/01/99, 08/25/04, 01/12/05	08/18/06 [Insert page number where the document begins].	
5–20–205	Prevention of Significant Deterioration Areas	01/01/98, 04/01/98, 01/01/99, 08/25/04	08/18/06 [Insert page number where the document begins].	
*	*	*	*	*

[FR Doc. E6–13615 Filed 8–17–06; 8:45 am]
BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 300

[FRL–8210–9]

National Oil and Hazardous Substance Pollution Contingency Plan National Priorities List; Technical Correction

AGENCY: Environmental Protection Agency (EPA).

ACTION: Technical Correction of final partial deletion of the South Andover Salvage Yards Superfund Site from the National Priorities List.

SUMMARY: On September 15, 1998 (63 FR 49321), EPA published a "Notice of intent to delete Operable Unit 2 of the South Andover Salvage Yards site from the National Priorities List; request for comments," and on October 28, 1998 (63 FR 57608), a "Final Rule; notice of deletion for Operable Unit 2 of the South Andover Salvage Yards Superfund Site from the National Priorities List (NPL)." The EPA is publishing this Technical Correction to the October 28, 1998 final notice of deletion due to errors that were published in that notice and in the National Priorities List at 40 CFR part 300, Appendix B. After review of the final notice of deletion and the National Priorities List, EPA is publishing this Technical Correction today to change the word "removing" in the October 28, 1998 final notice of deletion to the word "revising" and to amend 40 CFR part 300, Appendix B by adding the South Andover Site, Andover, Minnesota, and inserting a "P" in the Notes (a) column for the South Andover Site, Andover, Minnesota. EPA will place a copy of the final partial deletion package in the site repositories.

DATES: *Effective Date:* This Technical Correction of the direct final action is effective as of August 18, 2006.

ADDRESSES: Comprehensive information on the Site, as well as the comments that were received during the comment period are available at: Don deBlasio, Community Involvement Coordinator, U.S. EPA , P19J, 77 W. Jackson, Chicago, IL, (312) 886–4360 or 1–800–621–8431.

FOR FURTHER INFORMATION CONTACT: Gladys Beard, State NPL Deletion Process Manager, U.S. EPA (SR–6J), 77 W. Jackson, Chicago, IL 60604, (312) 886–7253 or 1–800–621–8431.

SUPPLEMENTARY INFORMATION:

Information Repositories: Repositories have been established to provide detailed information concerning this decision at the following address: U.S. EPA Region V Library, 77 W. Jackson, Chicago, IL 60604, (312) 353–5821, Monday through Friday 8 a.m. to 4 p.m.; Andover City Hall, 1685 N. W. Crosstown Blvd., Andover, MN 55303.

List of Subjects in 40 CFR Part 300

Environmental protection, Air pollution control, Chemicals, Hazardous substances, Hazardous waste, Intergovernmental relations, Penalties, Reporting and recordkeeping requirements, Superfund, Water pollution control, Water supply.

Dated: August 9, 2006.

Norman Niedergang,

Acting Regional Administrator, EPA Region V.

■ For the reasons stated in the preamble, 40 CFR part 300 is amended as follows:

PART 300—[AMENDED]

■ 1. The authority citation for part 300 continues to read as follows:

Authority: 33 U.S.C. 1321(c)(2); 42 U.S.C. 9601–9657; E.O. 12777, 56 FR 54757, 3 CFR, 1991 Comp., p. 351; E.O. 12580, 52 FR 2923, 3 CFR, 1987 Comp., p. 193.

■ 2. Table 1 of Appendix B to part 300 is amended under Minnesota "MN" by adding the entry for "South Andover" to read as follows:

Appendix B to Part 300—National Priorities List

TABLE 1.—GENERAL SUPERFUND SECTION

State	Sitename	City/County	(Notes) [a]
*	*	*	*
MN	South Andover Site	Andover	P

TABLE 1.—GENERAL SUPERFUND SECTION—Continued

State	Sitename	City/County	(Notes) [a]
*	*	*	*

[a] * * *
P=Sites with partial deletion(s).

* * * * *

[FR Doc. E6–13611 Filed 8–17–06; 8:45 am]
BILLING CODE 6560–50–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

44 CFR Part 64

[Docket No. FEMA–7939]

Suspension of Community Eligibility

AGENCY: Mitigation Division, Federal Emergency Management Agency (FEMA), Department of Homeland Security.

ACTION: Final rule.

SUMMARY: This rule identifies communities, where the sale of flood insurance has been authorized under the National Flood Insurance Program (NFIP), that are scheduled for suspension on the effective dates listed within this rule because of noncompliance with the floodplain management requirements of the program. If FEMA receives documentation that the community has adopted the required floodplain management measures prior to the effective suspension date given in this rule, the suspension will not occur and a notice of this will be provided by publication in the **Federal Register** on a subsequent date.

DATES: *Effective Dates:* The effective date of each community's scheduled suspension is the third date ("Susp.") listed in the third column of the following tables.

ADDRESSES: If you want to determine whether a particular community was suspended on the suspension date, contact the appropriate FEMA Regional Office or the NFIP servicing contractor.

FOR FURTHER INFORMATION CONTACT: William H. Lesser, Mitigation Division, 500 C Street, SW., Washington, DC 20472, (202) 646–2807.

SUPPLEMENTARY INFORMATION: The NFIP enables property owners to purchase flood insurance which is generally not otherwise available. In return, communities agree to adopt and administer local floodplain management aimed at protecting lives and new construction from future flooding. Section 1315 of the National Flood Insurance Act of 1968, as amended, 42 U.S.C. 4022, prohibits flood insurance coverage as authorized under the NFIP, 42 U.S.C. 4001 et seq.; unless an appropriate public body adopts adequate floodplain management measures with effective enforcement measures. The communities listed in this document no longer meet that statutory requirement for compliance with program regulations, 44 CFR part 59 et seq. Accordingly, the communities will be suspended on the effective date in the third column. As of that date, flood insurance will no longer be available in the community. However, some of these communities may adopt and submit the required documentation of legally enforceable floodplain management measures after this rule is published but prior to the actual suspension date. These communities will not be suspended and will continue their eligibility for the sale of insurance. A notice withdrawing the suspension of the communities will be published in the **Federal Register**.

In addition, FEMA has identified the Special Flood Hazard Areas (SFHAs) in these communities by publishing a Flood Insurance Rate Map (FIRM). The date of the FIRM, if one has been published, is indicated in the fourth column of the table. No direct Federal financial assistance (except assistance pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act not in connection with a flood) may legally be provided for construction or acquisition of buildings in identified SFHAs for communities not participating in the NFIP and identified for more than a year, on FEMA's initial flood insurance map of the community as having flood-prone areas (section 202(a) of the Flood Disaster Protection Act of 1973, 42 U.S.C. 4106(a), as amended). This prohibition against certain types of Federal assistance becomes effective for the communities listed on the date shown in the last column. The Administrator finds that notice and public comment under 5 U.S.C. 553(b) are impracticable and unnecessary because communities listed in this final rule have been adequately notified.

Each community receives 6-month, 90-day, and 30-day notification letters addressed to the Chief Executive Officer stating that the community will be suspended unless the required floodplain management measures are met prior to the effective suspension date. Since these notifications were made, this final rule may take effect within less than 30 days.

National Environmental Policy Act. This rule is categorically excluded from the requirements of 44 CFR part 10, Environmental Considerations. No environmental impact assessment has been prepared.

Regulatory Flexibility Act. The Administrator has determined that this rule is exempt from the requirements of the Regulatory Flexibility Act because the National Flood Insurance Act of 1968, as amended, 42 U.S.C. 4022, prohibits flood insurance coverage unless an appropriate public body adopts adequate floodplain management measures with effective enforcement measures. The communities listed no longer comply with the statutory requirements, and after the effective date, flood insurance will no longer be available in the communities unless remedial action takes place.

Regulatory Classification. This final rule is not a significant regulatory action under the criteria of section 3(f) of Executive Order 12866 of September 30, 1993, Regulatory Planning and Review, 58 FR 51735.

Executive Order 13132, Federalism. This rule involves no policies that have federalism implications under Executive Order 13132.

Executive Order 12988, Civil Justice Reform. This rule meets the applicable standards of Executive Order 12988.

Paperwork Reduction Act. This rule does not involve any collection of information for purposes of the Paperwork Reduction Act, 44 U.S.C. 3501 et seq.

List of Subjects in 44 CFR Part 64

Flood insurance, Floodplains.

■ Accordingly, 44 CFR part 64 is amended as follows:

PART 64—[AMENDED]

■ 1. The authority citation for part 64 is revised to read as follows:

Authority: 42 U.S.C. 4001 *et seq.*; Reorganization Plan No. 3 of 1978, 3 CFR, 1978 Comp.; p. 329; E.O. 12127, 44 FR 19367, 3 CFR, 1979 Comp.; p. 376.

§ 64.6 [Amended]

The tables published under the authority of § 64.6 are amended as follows:

State/location	Community No.	Effective date authorization/cancellation of sale of flood insurance in community	Current effective map date	Date certain Federal assistance no longer available in SFHAs
Region II				
New Jersey:				
Bayonne, City of, Hudson County	340218	July 25, 1975, Emerg; August 15, 1983, Reg; August 16, 2006, Susp.	08/16/2006	08/16/2006.
Harrison, Town of, Hudson County	340221	March 17, 1976, Emerg; September 30, 1977, Reg; August 16, 2006, Susp.	do	Do.
Hoboken, City of, Hudson County	340222	April 22, 1975, Emerg; November 17, 1982, Reg; August 16, 2006, Susp.	do	Do.
Weehawken, Township of, Hudson County.	340228	August 6, 1975, Emerg; May 1, 1984, Reg; August 16, 2006, Susp.	do	Do.
Region III				
Pennsylvania:				
Armagh, Township of, Mifflin County	421879	February 6, 1976, Emerg; August 19, 1991, Reg; August 16, 2006, Susp.	do	Do.
Bratton, Township of, Mifflin County	421153	April 15, 1974, Emerg; December 15, 1978, Reg; August 16, 2006, Susp.	do	Do.
Brown, Township of, Mifflin County	420683	August 16, 1974, Emerg; August 19, 1991, Reg; August 16, 2006, Susp.	do	Do.
Burnham, Borough of, Mifflin County	420684	February 9, 1973, Emerg; February 15, 1978, Reg; August 16, 2006, Susp.	do	Do.
Decatur, Township of, Mifflin County	421880	December 2, 1975, Emerg; June 1, 1987, Reg; August 16, 2006, Susp.	do	Do.
Derry, Township of, Mifflin County	421168	April 26, 1974, Emerg; September 1, 1978, Reg; August 16, 2006, Susp.	do	Do.
Granville, Township of, Mifflin County	421134	March 12, 1974, Emerg; August 15, 1978, Reg; August 16, 2006, Susp.	do	Do.
Kistler, Borough of, Mifflin County	420686	July 28, 1975, Emerg; September 15, 1977, Reg; August 16, 2006, Susp.	do	Do.
Lewistown, Borough of, Mifflin County	420687	November 17, 1972, Emerg; August 15, 1978, Reg; August 16, 2006, Susp.	do	Do.
McVeytown, Borough of, Mifflin County	420688	May 20, 1975, Emerg; June 1, 1987, Reg; August 16, 2006, Susp.	do	Do.
Menno, Township of, Mifflin County	421881	March 8, 1985, Emerg; June 1, 1987, Reg; August 16, 2006, Susp.	do	Do.
Newtown Hamilton, Borough of, Mifflin County.	420689	January 30, 1974, Emerg; February 15, 1978, Reg; August 16, 2006, Susp.	do	Do.
Oliver, Township of, Mifflin County	421882	August 29, 1975, Emerg; September 17, 1980, Reg; August 16, 2006, Susp.	do	Do.
Union, Township of, Mifflin County	421883	August 7, 1975, Emerg; June 1, 1987, Reg; August 16, 2006, Susp.	do	Do.
Wayne, Township of, Mifflin County	421240	May 3, 1974, Emerg; March 2, 1981, Reg; August 16, 2006, Susp.	do	Do.
Region IV				
Kentucky:				
Cumberland, City of, Harlan County	210100	November 5, 1971, Emerg; March 15, 1977, Reg; August 16, 2006, Susp.	do	Do.
Harlan, City of, Harlan County	210102	October 29, 1971, Emerg; January 17, 1979, Reg; August 16, 2006, Susp.	do	Do.
Loyall, City of, Harlan County	215189	December 3, 1971, Emerg; April 6, 1973, Reg; August 16, 2006, Susp.	do	Do.
Lynch, City of, Harlan County	210104	January 14, 1975, Emerg; July 2, 1979, Reg; August 16, 2006, Susp.	do	Do.
Wallins Creek, City of, Harlan County	215192	December 7, 1971, Emerg; March 2, 1973, Reg; August 16, 2006, Susp.	do	Do.
Region VII				
Missouri: Monett, City of, Barry County	290023	September 23, 1974, Emerg; April 15, 1981, Reg; August 16, 2006, Susp.	do	Do.

*-do- =Ditto.
Code for reading third column: Emerg.—Emergency; Reg.—Regular; Susp.—Suspension.

Dated: August 10, 2006.

Michael K. Buckley,

Deputy Director, Mitigation Division, Federal Emergency Management Agency, Department of Homeland Security.

[FR Doc. E6–13613 Filed 8–17–06; 8:45 am]

BILLING CODE 9110–12–P

Proposed Rules

Federal Register
Vol. 71, No. 160
Friday, August 18, 2006

This section of the FEDERAL REGISTER contains notices to the public of the proposed issuance of rules and regulations. The purpose of these notices is to give interested persons an opportunity to participate in the rule making prior to the adoption of the final rules.

NUCLEAR REGULATORY COMMISSION

10 CFR Part 36

[Docket No. PRM–36–01]

American National Standards Institute N43.10 Committee; Denial of Petition for Rulemaking

AGENCY: U.S. Nuclear Regulatory Commission.

ACTION: Denial of petition for rulemaking.

SUMMARY: The U.S. Nuclear Regulatory Commission (NRC) is denying a petition for rulemaking (PRM–36–01) submitted by the American National Standards Institute N43.10 Committee. The petitioner requested that the NRC amend its regulations to provide relief from the requirements to have an operator present onsite whenever an irradiator is operated using an automatic product conveyor system and whenever product is moved into or out of the radiation room when an irradiator is operated in a batch mode. In addition, the petitioner requested relief from the requirement to have a person who has received training, described in the regulations, on how to respond to alarms onsite at a panoramic irradiator where static irradiations (no movement of the product) are occurring.

ADDRESSES: Copies of the petition for rulemaking, the public comments received, and NRC's letter to the petitioner may be examined at NRC Public Document Room, Public File Area Room O1F21, 11555 Rockville Pike, Rockville, MD. These documents also may be viewed and downloaded electronically via the rulemaking Web site.

The NRC maintains an Agencywide Document Access and Management System (ADAMS), which provides text and image files of NRC's public documents. These documents may be accessed through NRC's Public Electronic Reading Room on the Internet at *http://www.nrc.gov/reading-rm/adams.html*. If you do not have access to ADAMS, or if there are problems in accessing the documents located in ADAMS, contact the NRC's Public Document Room Reference staff at 1–800–397–4209, 301–415–4737, or by e-mail to: *pdr@nrc.gov*.

FOR FURTHER INFORMATION CONTACT: Thomas Young, Office of Nuclear Material Safety and Safeguards, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001, telephone: (301) 415–5795, e-mail: *tfy@nrc.gov*.

SUPPLEMENTARY INFORMATION:

The Petition

On September 15, 1998 (63 FR 49298), the NRC published a notice of receipt of a petition for rulemaking filed by the American National Standards Institute N43.10 Committee. The petitioner requested that NRC amend 10 CFR 36.65(a) and (b). *These regulations require that:*

(a) Both an irradiator operator and at least one other individual, who is trained on how to respond and prepared to promptly render or summon assistance if the access control alarm sounds, shall be present onsite:

(1) Whenever the irradiator is operated using an automatic product conveyor system; and

(2) Whenever the product is moved into or out of the radiation room when the irradiator is operated in a batch mode.

(b) At a panoramic irradiator at which static irradiations (no movement of the product) are occurring, a person who has received the training on how to respond to alarms described in § 36.51(g) must be onsite.

The petitioner suggested revisions to require that:

(1) The operator and at least one other trained individual would be present onsite whenever it is necessary to enter the radiation room;

(2) An individual trained to respond to alarms would be available and prepared to promptly attend to alarms, emergencies, or abnormal event conditions at any time the irradiator is operating;

(3) If the individual is not onsite, automatic means of communication would be provided from the irradiator control system to the individual and the irradiator control system would be secured from unauthorized access and the console key would be secured from removal from the control console when the individual is not onsite;

(4) Inspection and maintenance for operability of the automatic communication system be completed; and

(5) A definition be provided in 10 CFR 36.2 for the term, "onsite."

Currently a licensee is required to maintain adequate coverage on all shifts of a continuously operating panoramic irradiator facility. However, the petitioner believes that based on domestic and international operating experience with panoramic irradiators, there is no significant benefit to safety from having the operator and an additional trained individual onsite as opposed to an individual being available to respond promptly from an offsite location. The petitioner believes the current cost for a licensee to employ individuals for continuous operation of the facility has a substantial impact on the expense associated with conducting business. The petitioner believes that revising the requirements as suggested above would result in cost containment without a reduction in safety.

The petitioner believes that recent improvements in communications technology support the design of automated alert systems to provide offsite warning to an individual who could then respond through technologies such as pagers, cell and land-line telephones, remote process control monitoring, etc. The petitioner believes that remote response to alarms could require only slightly longer response time than if the responder were onsite.

In its supporting information, the petitioner recognizes that during emergencies and abnormal events, human intervention is required to evaluate the situation and determine whether actions need to be taken and what specific action is required. The petitioner believes this evaluation can take place remotely, between the irradiator and an individual offsite. The petitioner also supports its position by stating that European irradiators of similar design and characteristics to those in the United States have had no incidents that can be traced to the practice of unattended operations.

Public Comments on the Petition

The notice of receipt of petition for rulemaking invited interested persons to submit comments. The NRC received

one comment letter from the Manager of Technical Services, State of Ohio's Bureau of Radiation Protection. The commenter was generally in favor of granting the petition. However, the commenter noted that the problem with remote communication systems is that they are likely to fail or become overloaded under extreme conditions, although the probability of having two remote incidents (irradiator and communication systems) occurring at one time is highly improbable for the unattended operation of a panoramic irradiator. In addition, the commenter suggested that an onsite security guard or other non-operator personnel could be trained to summon assistance as required without needing the operator. The comments were considered in the development of the NRC's decision on this petition.

Reasons for Denial

The NRC is denying the petition for the following two reasons:

1. In February 1993, the NRC amended its regulations to add 10 CFR Part 36, "Licenses and Radiation Safety Requirements for Irradiators," to specify radiation safety requirements and licensing requirements for the use of licensed radioactive materials in irradiators. After the rule became effective, the NRC received numerous licensee event reports that described failures or non-functions of source mechanisms and related systems that needed intervention by personnel who had received training described in the regulations on how to respond to alarms. The information reported to the NRC from 1990 to 2006 about events at irradiator facilities indicates no reduction in the number of events or the nature of events. The NRC determined that the data on events do not support the petitioner's request or indicate that the requirements should be revised. Rather, the NRC continues to believe that there is a need for individuals to be onsite to evaluate and respond to such emergencies, as well as to ensure day-to-day radiation safety.

2. The NRC does not believe that reliance on an automated communication system to notify a remote human operator via an electronic mechanism provides the same level of safety as currently provided by an onsite operator and/or a second individual who is trained to respond to irradiator alarms. This issue was previously raised in comments on the proposed rule for 10 CFR Part 36. The Statements of Consideration (SOC) for the final rule (58 FR 7715; February 9, 1993) state that, for 10 CFR 36.65, "a considerable number of comments objected to the proposed requirements as excessive." A commenter suggested that an irradiator with an automatic conveyor system should be able to operate with only an operator present and an automatic telephone dialing device for responding to alarms. Another commenter suggested that the irradiator should be able to operate unattended but with an automatic telephone dialing device. The SOC state that the NRC did not accept either suggestion because the NRC believed that automatic conveyer systems have enough malfunctions to require that an operator be present at the site. In addition, the NRC believed that the operator should have some backup in case of problems.

The petitioner has not provided a sufficient basis from which to conclude that this NRC judgement is no longer correct. Specifically, no new information has been provided by the petitioner that would warrant revising the existing regulations. The existing NRC regulations provide the basis for reasonable assurance that the common defense and security and public health and safety are adequately protected.

For the reasons cited in this document, the NRC denies this petition.

Dated at Rockville, Maryland, this 4th day of August, 2006.

For the Nuclear Regulatory Commission.

Luis A. Reyes,

Executive Director for Operations.

[FR Doc. E6–13632 Filed 8–17–06; 8:45 am]

BILLING CODE 7590–01–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2006–25634; Directorate Identifier 2006–NM–143–AD]

RIN 2120–AA64

Airworthiness Directives; Airbus Model A300 Airplanes

AGENCY: Federal Aviation Administration (FAA), Department of Transportation (DOT).

ACTION: Notice of proposed rulemaking (NPRM).

SUMMARY: We propose to adopt a new airworthiness directive (AD) for the products listed above. This proposed AD results from mandatory continuing airworthiness information (MCAI) issued by an airworthiness authority of another country to identify and correct an unsafe condition on an aviation product. The proposed AD would require actions that are intended to address the unsafe condition described in the MCAI.

DATES: We must receive comments on this proposed AD by September 18, 2006.

ADDRESSES: Use one of the following addresses to comment on this proposed AD:

- *DOT Docket Web site:* Go to *http://dms.dot.gov* and follow the instructions for sending your comments electronically.
- *Government-wide rulemaking Web site:* Go to *http://www.regulations.gov* and follow the instructions for sending your comments electronically.
- *Mail:* Docket Management Facility; U.S. Department of Transportation, 400 Seventh Street, SW., Nassif Building, Room PL–401, Washington, DC 20590.
- *Fax:* (202) 493–2251.
- *Hand delivery:* Room PL–401 on the plaza level of the Nassif Building, 400 Seventh Street, SW., Washington, DC, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

For service information identified in the proposed AD, contact Airbus, 1 Rond Point Maurice Bellonte, 31707 Blagnac Cedex, France.

FOR FURTHER INFORMATION CONTACT: Tom Stafford, Aerospace Engineer, International Branch, ANM–116, FAA, Transport Airplane Directorate, 1601 Lind Avenue, SW., Renton, Washington 98055–4056; telephone (425) 227–1622; fax (425) 227–1149.

SUPPLEMENTARY INFORMATION:

Streamlined Issuance of AD

The FAA is implementing a new process for streamlining the issuance of ADs related to MCAI. We are prototyping this process and specifically request your comments on its use. You can find more information in FAA draft Order 8040.2, "Airworthiness Directive Process for Mandatory Continuing Airworthiness Information," which is currently open for comments at *http://www.faa.gov/aircraft/draft_docs.* This streamlined process will allow us to adopt MCAI safety requirements in a more efficient manner and will reduce safety risks to the public.

This process continues to follow all existing AD issuance processes to meet legal, economic, Administrative Procedure Act, and **Federal Register** requirements. We also continue to follow our technical decision-making processes in all aspects to meet our responsibilities to determine and correct unsafe conditions on U.S.-certificated products.

This proposed AD references the MCAI and related service information that we considered in forming the

engineering basis to correct the unsafe condition. The proposed AD contains text copied from the MCAI and for this reason might not follow our plain language principles.

The comment period for this proposed AD is open for 30 days to allow time for comments on both the process and the AD content. In the future, ADs using this process will have a 15-day comment period, because the airworthiness authority and manufacturer have already published the documents on which we based our decision, making a longer comment period unnecessary.

Comments Invited

We invite you to send any written data, views, or arguments regarding this proposed AD. Send your comments to an address listed under the **ADDRESSES** section. Include the docket number, Docket No. FAA–2006–25634; Directorate Identifier 2006–NM–143–AD at the beginning of your comments. We specifically invite comments on the overall regulatory, economic, environmental, and energy aspects of the proposed AD. We are also inviting comments, views, or arguments on the new MCAI process. We will consider all comments received by the closing date and may amend the proposed AD in light of those comments.

We will post all comments we receive, without change, to *http://dms.dot.gov*, including any personal information you provide. We will also post a report summarizing each substantive verbal contact we receive concerning this proposed AD.

Discussion

The Direction Générale de l'Aviation Civile (DGAC), which is the airworthiness authority for France, has issued French Airworthiness Directive F–2005–157, dated September 14, 2005 (referred to after this as "the MCAI"), to correct an unsafe condition for the specified products. The MCAI states that the refined study of an in-service event has evidenced the need to perform a periodic test of pitch trim system 2. In the conditions of overriding the automatic pitch torque limiter, the clutch of the pitch trim servo-motor 1 is opened so that electric pitch trim system 1 will disconnect. The question is pending about the availability of the system 2 and its capability to take over the pitch trim function, particularly during a go-around. Failure of pitch trim system 2 to deflect the trimmable horizontal stabilizer (THS) at maximum rate could result in loss of high-speed trim and consequent reduced controllability of the airplane. The MCAI renders mandatory a periodic test to ensure the availability of the pitch trim system 2 and its possibility to deflect the THS at high speed of trim. You may obtain further information by examining the MCAI in the docket.

Relevant Service Information

Airbus has issued Service Bulletin A300–22–0121, dated July 11, 2005. The actions described in this service information are intended to correct the unsafe condition identified in the MCAI.

FAA's Determination and Requirements of the Proposed AD

This product is manufactured outside the United States and is type certificated for operation in the United States under the provisions of section 21.29 of the Federal Aviation Regulations (14 CFR 21.29) and the applicable bilateral agreement. Pursuant to this bilateral airworthiness agreement, the State of Design's airworthiness authority has notified us of the unsafe condition described in the MCAI and service information referenced above. We have examined the airworthiness authority's findings, evaluated all pertinent information, and determined an unsafe condition exists and is likely to exist or develop on all products of this type design. We are issuing this proposed AD to correct the unsafe condition.

Differences Between the Proposed AD and the MCAI or Service Information

We have reviewed the MCAI and related service information and, in general, agree with their substance. But we might have found it necessary to use different words from those in the MCAI to ensure the AD is clear for U.S. operators and is enforceable in a U.S. court of law. In making these changes, we do not intend to differ substantively from the information provided in the MCAI and related service information.

We might also have proposed different actions in this AD from those in the MCAI in order to follow FAA policies. Any such differences are described in a separate paragraph of the proposed AD. These proposed requirements, if ultimately adopted, will take precedence over the actions copied from the MCAI.

Costs of Compliance

Based on the service information, we estimate that this proposed AD would affect about 29 products of U.S. registry. We also estimate that it would take about 1 work hour per product to do the periodic test and 3 work hours to do the repair and follow-on test, and that the average labor rate is $80 per work hour. Required parts would cost $0 per product. Where the service information lists required parts costs that are covered under warranty, we have assumed that there will be no change for these costs. As we do not control warranty coverage for affected parties, some parties may incur costs higher than estimated here. Based on these figures, we estimate the cost of the proposed AD on U.S. operators to be $2,320, or $80 per product.

Authority for This Rulemaking

Title 49 of the United States Code specifies FAA's authority to issue rules on aviation safety. Subtitle I, Section 106, describes the authority of the FAA Administrator. Subtitle VII, Aviation Programs, describes in more detail the scope of the Agency's authority.

We are issuing this rulemaking under the authority described in Subtitle VII, Part A, Subpart III, Section 44701, "General requirements." Under that section, Congress charges FAA with promoting safe flight of civil aircraft in air commerce by prescribing regulations for practices, methods, and procedures the Administrator finds necessary for safety in air commerce. This regulation is within the scope of that authority because it addresses an unsafe condition that is likely to exist or develop on products identified in this rulemaking action.

Regulatory Findings

We have determined that this proposed AD would not have federalism implications under Executive Order 13132. This proposed AD would not have a substantial direct effect on the States, on the relationship between the national Government and the States, or on the distribution of power and responsibilities among the various levels of government.

For the reasons discussed above, I certify that the proposed regulation:

1. Is not a "significant regulatory action" under Executive Order 12866;

2. Is not a "significant rule" under the DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and

3. Will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

We prepared a regulatory evaluation of the estimated costs to comply with this proposed AD and placed it in the AD docket.

Examining the AD Docket

You may examine the AD docket that contains the proposed AD, the regulatory evaluation, any comments

received, and other information on the Internet at *http://dms.dot.gov*; or in person at the Docket Management Facility between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The Docket Office (telephone (800) 647–5227) is located at the street address stated in the **ADDRESSES** section. Comments will be available in the AD docket shortly after receipt.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Safety.

The Proposed Amendment

Accordingly, under the authority delegated to me by the Administrator, the Federal Aviation Administration proposes to amend 14 CFR part 39 as follows:

PART 39—AIRWORTHINESS DIRECTIVES

1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

2. The FAA amends § 39.13 by adding the following new AD:

Airbus: Docket No. FAA–2006–25634; Directorate Identifier 2006–NM–143–AD.

Comments Due Date

(a) We must receive comments on this airworthiness directive (AD) by September 18, 2006.

Affected ADs

(b) None.

Applicability

(c) This AD applies to Airbus A300 aircraft, all certified models and all serial numbers, certificated in any category; except for Models A300 B4–203 and A300 B2–203 in forward facing crew cockpit certified configuration.

Reason

(d) The refined study of an in-service event has evidenced the need to perform a periodic test of pitch trim system 2. In the conditions of overriding the automatic pitch torque limiter, the clutch of the pitch trim servo-motor 1 is opened so that electric pitch trim system 1 will disconnect. The question is pending about the availability of the system 2 and its capability to take over the pitch trim function, particularly during a go-around. Failure of pitch trim system 2 to deflect the trimmable horizontal stabilizer (THS) at maximum rate could result in loss of high-speed trim and consequent reduced controllability of the airplane. For such reason, this AD renders mandatory a periodic test to ensure the availability of the pitch trim system 2 and its possibility to deflect the THS at high speed of trim.

Actions and Compliance

(e) Unless already done, do the following actions except as stated in paragraph (f) below:

(1) Within 250 flight hours after the effective date of this AD: Perform an operational test of pitch trim system 2 in high speed of trim configuration and if system 2 does not function as specified in the instructions of Airbus Service Bulletin A300–22–0121, dated July 11, 2005; before further flight, return the system to correct operating condition in accordance with the instructions of the service bulletin.

(2) The operational test, followed if necessary by the corrective action described in the paragraph above, is to be repeated at intervals not exceeding 1,000 flight hours in accordance with the instructions of Airbus Service Bulletin A300–22–0121, dated July 11, 2005.

FAA AD Difference

(f) When complying with this AD, do the following: Although the Accomplishment Instructions of the referenced service bulletin describes procedures for submitting certain information to the manufacturer, this AD does not include that requirement.

Other FAA AD Provisions

(g) The following provisions also apply to this AD:

(1) *Alternative Methods of Compliance (AMOCs):* The Manager, International Branch, ANM–116, Transport Airplane Directorate, FAA, ATTN: Tom Stafford, Aerospace Safety Engineer, International Branch, ANM–116, Transport Airplane Directorate, FAA, 1601 Lind Avenue, SW., Renton, Washington 98055–4056; telephone (425) 227–1622; fax (425) 227–1149; has the authority to approve AMOCs for this AD, if requested using the procedures found in 14 CFR 39.19.

(2) *Notification of Principal Inspector:* Before using any AMOC approved in accordance with 14 CFR 39.19 on any airplane to which the AMOC applies, notify the appropriate principal inspector in the FAA Flight Standards Certificate Holding District Office.

(3) *Return to Airworthiness:* When complying with this AD, perform FAA-approved corrective actions before returning the product to an airworthy condition.

Related Information

(h) This AD is related to MCAI French airworthiness directive F–2005–157, dated September 14, 2005, which references Airbus Service Bulletin A300–22–0121, dated July 11, 2005, for information on required actions.

Issued in Renton, Washington, on August 7, 2006.

Ali Bahrami,

Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. E6–13647 Filed 8–17–06; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2006–25609; Directorate Identifier 2005–NM–263–AD]

RIN 2120–AA64

Airworthiness Directives; Boeing Model 777–200 and –300 Series Airplanes Equipped With Rolls-Royce RB211–TRENT 800 Series Engines

AGENCY: Federal Aviation Administration (FAA), Department of Transportation (DOT).

ACTION: Notice of proposed rulemaking (NPRM).

SUMMARY: The FAA proposes to adopt a new airworthiness directive (AD) for certain Boeing Model 777–200 and –300 series airplanes. This proposed AD would require revising the airplane flight manual to provide the flightcrew with new ground procedures for shedding core ice during long taxi periods in freezing fog. For airplanes unable to perform the shedding procedure after prolonged taxiing in freezing fog, this proposed AD would require certain investigative and corrective actions. This proposed AD results from reports of engine surges and internal engine damage due to ice accumulation during extended idle thrust operation in ground fog icing conditions. We are proposing this AD to prevent internal engine damage due to ice accumulation and shedding, which could cause a shutdown of both engines, and result in loss of control of the airplane.

DATES: We must receive comments on this proposed AD by October 2, 2006.

ADDRESSES: Use one of the following addresses to submit comments on this proposed AD.

- *DOT Docket Web site:* Go to *http://dms.dot.gov* and follow the instructions for sending your comments electronically.
- *Government-wide rulemaking Web site:* Go to *http://www.regulations.gov* and follow the instructions for sending your comments electronically.
- *Mail:* Docket Management Facility, U.S. Department of Transportation, 400 Seventh Street, SW., Nassif Building, room PL–401, Washington, DC 20590.
- *Fax:* (202) 493–2251.
- *Hand Delivery:* Room PL–401 on the plaza level of the Nassif Building, 400 Seventh Street, SW., Washington, DC, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

Contact Boeing Commercial Airplanes, P.O. Box 3707, Seattle,

Washington 98124–2207, for the service information identified in this proposed AD.

FOR FURTHER INFORMATION CONTACT: Margaret Langsted, Aerospace Engineer, Propulsion Branch, ANM–140S, FAA, Seattle Aircraft Certification Office, 1601 Lind Avenue, SW., Renton, Washington 98055–4056; telephone (425) 917–6500; fax (425) 917–6590.

SUPPLEMENTARY INFORMATION:

Comments Invited

We invite you to submit any relevant written data, views, or arguments regarding this proposed AD. Send your comments to an address listed in the **ADDRESSES** section. Include the docket number "FAA–2006–25609; Directorate Identifier 2005–NM–263–AD" at the beginning of your comments. We specifically invite comments on the overall regulatory, economic, environmental, and energy aspects of the proposed AD. We will consider all comments received by the closing date and may amend the proposed AD in light of those comments.

We will post all comments we receive, without change, to *http://dms.dot.gov*, including any personal information you provide. We will also post a report summarizing each substantive verbal contact with FAA personnel concerning this proposed AD. Using the search function of that Web site, anyone can find and read the comments in any of our dockets, including the name of the individual who sent the comment (or signed the comment on behalf of an association, business, labor union, etc.). You may review DOT's complete Privacy Act Statement in the **Federal Register** published on April 11, 2000 (65 FR 19477–78), or you may visit *http://dms.dot.gov*.

Examining the Docket

You may examine the AD docket on the Internet at *http://dms.dot.gov*, or in person at the Docket Management Facility office between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The Docket Management Facility office (telephone (800) 647–5227) is located on the plaza level of the Nassif Building at the DOT street address stated in the **ADDRESSES** section. Comments will be available in the AD docket shortly after the Docket Management System receives them.

Discussion

We have received reports indicating that internal engine damage has occurred on certain Airbus Model A330–243, –341, –342, and –343 airplanes equipped with Rolls-Royce RB211 TRENT 700 engines. Investigations have revealed that the engines were damaged due to extended idle thrust operations in severe ground fog icing conditions in very low outside air temperatures and freezing fog. It was determined that sufficient ice built upon the stationary surfaces of the engine core and heat transfer from increasing the thrust for takeoff caused the ice to shed, which then impacted and damaged the blades of the compressor. Engine damage due to ice accumulation and shedding, if not corrected, could result in a dual engine shutdown and loss of control of the airplane.

Similar Engine Models

Boeing Model 777–200 and –300 series airplanes equipped with Rolls-Royce RB211 TRENT 800 engines have a similar compressor design to the Rolls-Royce RB211 TRENT 700 engines installed on certain Airbus Model A330–243, –341, –342, and –343 airplanes. Therefore, those Boeing Model 777–200 and –300 series airplanes equipped with Rolls-Royce RB211 TRENT 800 engines may be subject to the same unsafe condition.

FAA's Determination and Requirements of the Proposed AD

We have evaluated all pertinent information and identified an unsafe condition that is likely to exist or develop on other airplanes of this same type design. For this reason, we are proposing this AD, which would require revising the AFM to provide the flightcrew with new ground procedures for shedding core ice during long taxi periods in freezing fog as described previously. Additionally, we are proposing that, if takeoff is not accomplished during ground operations in freezing fog within 60 minutes total taxi time, before further flight, the engines must be manually de-iced in accordance with tasks 12–33–03–600–803 and 12–33–03–600–804 of Chapter 12–33–03 of the Airplane Maintenance Manual (AMM). We are also proposing to require that, if the core ice shedding procedure is not accomplished within 45 minutes total taxi time in freezing fog, but takeoff can be achieved within 60 minutes total taxi time, that a borescope inspection for damage to the engine compressors be accomplished within 10 flights of that takeoff. Any repair must be performed before further flight. One acceptable method of accomplishing the borescope inspection is specified in tasks 72–00–00–200–801 and 72–00–00–200–802 of the Boeing 777 Aircraft Maintenance Manual (AMM) Chapter 72.

Costs of Compliance

There are about 208 airplanes of the affected design in the worldwide fleet. This proposed AD would affect about 53 airplanes of U.S. registry. The proposed actions would take about 1 work hour per airplane, at an average labor rate of $80 per work hour. Based on these figures, the estimated cost of the proposed AD for U.S. operators is $4,240, or $80 per airplane.

Authority for This Rulemaking

Title 49 of the United States Code specifies the FAA's authority to issue rules on aviation safety. Subtitle I, Section 106, describes the authority of the FAA Administrator. Subtitle VII, Aviation Programs, describes in more detail the scope of the Agency's authority.

We are issuing this rulemaking under the authority described in Subtitle VII, Part A, Subpart III, Section 44701, "General requirements." Under that section, Congress charges the FAA with promoting safe flight of civil aircraft in air commerce by prescribing regulations for practices, methods, and procedures the Administrator finds necessary for safety in air commerce. This regulation is within the scope of that authority because it addresses an unsafe condition that is likely to exist or develop on products identified in this rulemaking action.

Regulatory Findings

We have determined that this proposed AD would not have federalism implications under Executive Order 13132. This proposed AD would not have a substantial direct effect on the States, on the relationship between the national Government and the States, or on the distribution of power and responsibilities among the various levels of government.

For the reasons discussed above, I certify that the proposed regulation:

1. Is not a "significant regulatory action" under Executive Order 12866;

2. Is not a "significant rule" under the DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and

3. Will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

We prepared a regulatory evaluation of the estimated costs to comply with this proposed AD and placed it in the AD docket. See the **ADDRESSES** section for a location to examine the regulatory evaluation.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Safety.

The Proposed Amendment

Accordingly, under the authority delegated to me by the Administrator, the FAA proposes to amend 14 CFR part 39 as follows:

PART 39—AIRWORTHINESS DIRECTIVES

1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

2. The Federal Aviation Administration (FAA) amends § 39.13 by adding the following new airworthiness directive (AD):

Boeing: Docket No. FAA–2006–25609; Directorate Identifier 2005–NM–263–AD.

Comments Due Date

(a) The FAA must receive comments on this AD action by October 2, 2006.

Affected ADs

(b) None.

Applicability

(c) This AD applies to Boeing Model 777–200 and –300 series airplanes, certificated in any category, equipped with Rolls-Royce RB211 TRENT 800 engines.

Unsafe Condition

(d) This AD results from reports of engine surges and internal engine damage due to ice accumulation during extended idle thrust operation in ground fog icing conditions. We are issuing this AD to prevent internal engine damage due to ice accumulation and shedding, which could cause a shutdown of both engines, and result in loss of control of the airplane.

Compliance

(e) You are responsible for having the actions required by this AD performed within the compliance times specified, unless the actions have already been done.

Airplane Flight Manual (AFM) Revision

(f) Within 14 days after the effective date of this AD, revise the Limitations Section of the Boeing Model 777 Airplane Flight Manual (AFM) to include the following statements. This may be done by inserting a copy of this AD in the AFM.

"GROUND OPERATIONS IN FREEZING FOG

When freezing fog is reported and

(a) the OAT is 0 degrees C to −6 degrees C then run up the engines to 50% N1 for 1 minute every 45 minutes taxi time, or

(b) the OAT is −7 degrees C to −13 degrees C then run up the engines to 59% N1 for 1 minute for every 45 minutes taxi time, or

(c) the OAT is colder than −13 degrees C and taxi time exceeds 45 minutes, there is no run-up procedure.

Regardless of temperature, if the core ice shedding procedure described above is not accomplished within 45 minutes total taxi time in freezing fog, but takeoff can be achieved within 60 minutes total taxi time in freezing fog, takeoff is permitted. A borescope inspection is required within 10 flights. If takeoff is not accomplished within 60 minutes total taxi time, then manually de-ice the engines."

(g) When a statement identical to that in paragraph (f) of this AD has been included in the general revisions of the AFM, the general revisions may be inserted into the AFM, and the copy of this AD may be removed from the AFM.

Inspection for Ice

(h) If takeoff is not accomplished in freezing fog within 60 minutes total taxi time, before further flight, perform an inspection for ice of the variable inlet guide vanes (VIGV's), in accordance with Task 12–33–03–200–801 of the Airplane Maintenance Manual (AMM); and inspect the low pressure compressor (fan) for ice after engine operation in freezing fog, in accordance with Task 12–33–03–200–802 of Chapter 12–33–03, dated May 5, 2006, of the AMM.

(1) If no ice is detected, the time already completed in freezing conditions can be reset to zero for subsequent operation.

(2) If any ice is detected, before further flight, manually de-ice the engine core inlet in accordance with Task 12–33–03–600–803, of Chapter 12–33–03 of the AMM, dated May 5, 2006, or manually de-ice the engine by parking the aircraft in a heated hanger in accordance with Task 12–33–03–600–804 of Chapter 12–33–03 of the AMM, dated May 5, 2006.

Borescope Inspection for Damage

(i) For airplanes on which the core ice shedding procedure is not accomplished within 45 minutes total taxi time, but that achieve takeoff within 60 minutes total taxi time in freezing fog, regardless of temperature during ground operations in freezing fog: Within 10 flight cycles after takeoff, perform a borescope inspection for damage of the compressor of both engines, in accordance with a method approved by the Manager, Seattle Aircraft Certification Office (ACO). One acceptable method of compliance is to perform the borescope inspection in accordance with Boeing Model 777 Aircraft Maintenance Manual (AMM), Section 72, tasks 72–00–00–200–801 and 72–00–00–200–802, both dated May 5, 2006. If any damage is detected, repair before further flight in accordance with the AMM.

Alternative Methods of Compliance (AMOCs)

(j)(1) The Manager, Seattle Aircraft Certification Office (ACO), FAA, has the authority to approve AMOCs for this AD, if requested in accordance with the procedures found in 14 CFR 39.19.

(2) Before using any AMOC approved in accordance with § 39.19 on any airplane to which the AMOC applies, notify the appropriate principal inspector in the FAA Flight Standards Certificate Holding District Office.

(3) An AMOC that provides an acceptable level of safety may be used for any repair required by this AD, if it is approved by an Authorized Representative for the Boeing Commercial Airplanes Delegation Option Authorization Organization who has been authorized by the Manager, Seattle ACO, to make those findings. For a repair method to be approved, the repair must meet the certification basis of the airplane, and the approval must specifically refer to this AD.

Issued in Renton, Washington, on August 8, 2006.

Ali Bahrami,

Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. E6–13649 Filed 8–17–06; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF EDUCATION

34 CFR Chapter VI

Office of Postsecondary Education; Notice of Negotiated Rulemaking for Programs Authorized Under Title IV of the Higher Education Act of 1965, as Amended

AGENCY: Department of Education.

ACTION: Notice of establishment of negotiated rulemaking committee.

SUMMARY: We announce our intention to establish up to four negotiated rulemaking committees to prepare proposed regulations under Title IV of the Higher Education Act of 1965, as amended (HEA). Each committee will include representatives of organizations or groups with interests that are significantly affected by the subject matter of the proposed regulations. We also announce a series of four regional hearings, as detailed in the DATES section of this notice, where interested parties can suggest issues that should be considered for action by the negotiating committees. In addition, we request nominations for individual negotiators who represent key stakeholder constituencies that are involved in the student financial assistance programs authorized under Title IV of the HEA to serve on these committees.

DATES: We must receive your nominations for negotiators to serve on the committees on or before November 9, 2006. (See dates, times, and locations of regional hearings under the **SUPPLEMENTARY INFORMATION** section of this notice.)

ADDRESSES: Please send your nominations for negotiators to Patty Chase, U.S. Department of Education, 1990 K Street, NW., Room 8050, Washington, DC 20006, or by fax to Patty Chase at (202) 502–7874. You may

also e-mail your nominations to: *Patty.Chase@ed.gov*. Those nominated will be notified via letter as to whether or not they have been selected as a negotiator as soon as the Department's review process is completed.

FOR FURTHER INFORMATION CONTACT: For information about the hearings and the nomination submission process: Patty Chase, U.S. Department of Education, 1990 K Street, NW., Room 8050, Washington, DC 20006. Telephone: (202) 502–7905.

For information about negotiated rulemaking in general: Wendy Macias, U.S. Department of Education, 1990 K Street, NW., Room 8017, Washington, DC 20006. Telephone (202) 502–7526. You may also e-mail your questions about negotiated rulemaking to: *Wendy.Macias@ed.gov*.

If you use a telecommunications device for the deaf (TDD), you may call the Federal Relay Service (FRS) at 1–800–877–8339.

Individuals with disabilities may obtain this document in an alternative format (e.g., Braille, large print, audiotape, or computer diskette) on request to the contact person listed in this section for information about the hearings and the nomination submission process.

SUPPLEMENTARY INFORMATION: Section 492 of the Higher Education Act of 1965, as amended (HEA), requires that, before publishing any proposed regulations to implement programs under Title IV of the HEA, the Secretary obtain public involvement in the development of the proposed regulations. After obtaining advice and recommendations from the public, the Secretary must use a negotiated rulemaking process to develop the proposed regulations.

We intend to develop proposed regulations by following the negotiated rulemaking procedures in section 492 of the HEA. We intend to select participants for the negotiated rulemaking committees from nominees of the organizations and groups that represent the interests significantly affected by the proposed regulations. To the extent possible, we will select from the nominees, individual negotiators who reflect the diversity among program participants, in accordance with section 492(b)(1) of the HEA.

Regulatory Issues

We intend to conduct negotiated rulemaking to develop proposed regulations for the new Academic Competitiveness Grant (ACG) and National Science and Mathematics Access to Retain Talent Grant (National SMART Grant) programs, which were added to Title IV of the HEA by the Higher Education Reconciliation Act of 2005 (HERA), Pub. L. 109–171. Interim final regulations for these programs, with an invitation to comment, were published in the **Federal Register** on July 3, 2006 (71 FR 37990). The interim final regulations will be used to administer these programs for the 2006–2007 award year. The Secretary may, for the 2007–2008 award year, amend the regulations, as appropriate, in response to comments received. The regulations for these programs that will be developed through negotiated rulemaking would be in effect for the third and subsequent years of implementation of these programs (that is, beginning July 1, 2008).

Additionally, we expect to conduct negotiated rulemaking on any modifications to the regulations governing the Title IV programs generally that may be suggested as a result of the final report from the Secretary's Commission on the Future of Higher Education. The Commission plans to issue its report by mid-September. Therefore, the regulatory negotiation process could be used, to the extent possible, to address any recommendations for reducing regulatory burden or improving the administration of the Department's programs authorized by Title IV of the HEA.

We also note that there are bills currently pending in Congress to reauthorize the HEA. If reauthorization of the HEA is completed prior to the first negotiating session, we will, to the extent practicable, also include on the negotiating agenda changes to the regulations that may be needed to reflect any new law that may be enacted.

We also expect to conduct negotiated rulemaking on other regulatory issues. These issues may include: issues raised by the public during the regional hearings; issues resulting from changes made by the HERA, other than those relating to the ACG/National SMART Grant programs; and items that have been identified by the Department as needed to improve program administration and accountability.

Structure of the Committees

We anticipate having up to four negotiating committees based upon the nature of the topics to be negotiated. Each of the following committees will be organized as necessary depending upon the comments received as a result of this notice. One negotiating committee will focus on issues related to the ACG and National SMART Grant programs. A second committee would address issues related to the Federal student loan programs authorized by Title IV, Parts B, D, and E of the HEA. A third committee would address other programmatic, institutional eligibility and general provisions issues. This committee could address issues related to HEA Title IV Parts A (except for ACG and National SMART Grants), C, G, and H (except Subpart 2), as well as HEA Title II, Section 208(b)(2). A fourth committee would address accreditation issues (Title IV, Part H, Subpart 2). Our goal is to establish committees that will allow significantly affected parties to be represented while keeping the committees' size manageable.

Nominations of individuals from coalitions of individuals and organizations representing the constituencies identified below are strongly encouraged. Moreover, the Department encourages nominations of individuals who are actively involved in administering the Federal programs that are the subject of these negotiated rulemaking sessions and who can represent the interests of groups that are significantly affected by the regulations. The committees may create subgroups on particular topics that would involve additional individuals who are not members of the committees. Individuals who are not selected as members of the committees will be able to attend the meetings, have access to the individuals representing their constituencies, and participate in informal working groups on various issues between the meetings. The committee meetings will be open to the public.

The Department has identified the constituencies listed below as having interests that are significantly affected by the subject matter of the negotiated rulemaking process. The Department anticipates that individuals representing each of these constituencies will participate as members of one or more of the negotiated rulemaking committees. These constituencies are:

Students; Legal assistance organizations that represent students; Financial aid administrators at institutions of higher education; Business officers and bursars at institutions of higher education; Institutional servicers (including collection agencies); Trustees; State higher education executive officers; Business and industry;

Institutions of higher education eligible to receive Federal assistance under Title III, Parts A and B and Title V of the HEA, which includes Historically Black Colleges and Universities, Hispanic-Serving Institutions, American Indian Tribally Controlled Colleges and Universities,

Alaska Native and Native Hawaiian-Serving Institutions, and other institutions with a substantial enrollment of needy students as defined in Title III of the HEA; Two-year public institutions of higher education; Four-year public institutions of higher education; Private, non-profit institutions of higher education; Private, for-profit institutions of higher education; Guaranty agencies and guaranty agency servicers (including collection agencies); Lenders, secondary markets, and loan servicers; and Accrediting Agencies.

In addition to these groups, the Department would like the following groups to be represented on the negotiating committee for the ACG and National SMART Grant program:

K–12 public schools, including charter schools; Governors; Private schools and home schooled students; Registrars; Admissions officers; Parent organizations; and Organizations related to National SMART Grant majors.

While an individual selected to represent a constituency may be a representative of a group, institution, or industry participant, the individual will be expected to represent the interests of the entire constituency on the committee and to confer with other individuals and representatives of groups within that constituency.

Nominations should include:

- The name of the nominee, the organization he or she works for, if any, and a description of the interests that he or she represents;
- Evidence of support from individuals or groups of the constituency that he or she will represent;
- The nominee's commitment that he or she will actively participate in good faith in the development of the proposed regulations; and
- The nominee's contact information, including address, phone number, fax number, and e-mail address.

Schedule for Negotiations

We anticipate that the negotiating committees will meet in the Washington, DC, area three times beginning in December 2006 and concluding no later than March 2007. The dates and locations of these meetings will be published in a subsequent notice in the **Federal Register**, as well as being posted on the Department's Web site at: *http://www.ed.gov/policy/highered/reg/hearulemaking/2006/index2006.html.*

We will post the schedule for negotiations on our Web site. Each committee will use electronic mail to exchange documents and discuss proposals between meetings. The schedule will allow sufficient time for us to provide the public with a 60-day comment period for the proposed regulations resulting from the negotiated rulemaking process and sufficient time to address any issues raised in the comment period, while meeting the November 1 statutory deadline for publishing student financial assistance final regulations.

Regional Hearings

We will hold four public regional hearings for interested parties to discuss the agenda for the negotiated rulemaking sessions. These hearings will be held on:

- September 19, 2006, at the University of California-Berkeley in Berkeley, California;
- October 5, 2006, at the Loyola University in Chicago, Illinois;
- November 2, 2006, at the Royal Pacific Hotel Conference Center in Orlando, Florida; and
- November 8, 2006, at the U.S. Department of Education in Washington, DC.

The regional hearings will be held from 9 a.m.–4 p.m. local time.

Individuals desiring to present comments at the hearings are encouraged to do so. It is likely that each participant choosing to make a statement will be limited to five minutes. Individuals interested in making oral statements will be able to sign up to make a statement beginning at 8:30 a.m. on the day of the hearing at the Department's regional hearing on-site registration table on a first-come, first-served basis. If additional time slots remain, individuals may be given additional time to speak. If no time slots remain, the Department has reserved one additional hour at the end of the day for people who were not able to register to speak. The amount of time available will depend upon the number of individuals who request reservations. Speakers may also submit written comments.

In addition, for anyone unable to attend any of the regional hearings, the Department will also accept written comments. You should send your comments to: Wendy Macias, U.S. Department of Education, P.O. Box 33184, Washington, DC 20033–3184. All comments must be received by November 9, 2006.

The regional hearing sites are accessible to individuals with disabilities. Persons needing an auxiliary aid or service to participate in the meeting (e.g., interpreting service, assistive listening device, or materials in alternative format), should notify the contact person for information about meetings listed under **FOR FURTHER INFORMATION CONTACT** in this notice in advance of the scheduled meeting date. Although we will attempt to meet any request we receive, we may not be able to make available the requested auxiliary aid or service because of insufficient time to arrange it. Further information on the regional hearing sites is available on *http://www.ed.gov/policy/highered/reg/hearulemaking/2006/index2006.html.*

Electronic Access to This Document

You may view this document, in text or Adobe Portable Document Format (PDF) on the Internet at the following site: *http://www.ed.gov/news/fedregister.*

To use PDF you must have Adobe Acrobat Reader, which is available free at this site. If you have questions about using PDF, call the U.S. Government Printing Office toll free at 1–888–293–6498; or in the Washington, DC area at (202) 512–1530.

Note: The official version of this document is the document published in the **Federal Register.** Free Internet access to the official edition of the **Federal Register** and the Code of Federal Regulations is available on GPO Access at: *http://www.gpoaccess.gov/nara/index.html.*

Program Authority: 20 U.S.C. 1098a.

Dated: August 15, 2006.

James F. Manning,

Acting Assistant Secretary for Postsecondary Education.

[FR Doc. E6–13642 Filed 8–17–06; 8:45 am]

BILLING CODE 4000–01–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 55

[OAR–2004–0091; FRL–8211–3]

Outer Continental Shelf Air Regulations Consistency Update for California

AGENCY: Environmental Protection Agency, EPA.

ACTION: Proposed rule—Consistency Update.

SUMMARY: EPA is proposing to update a portion of the Outer Continental Shelf ("OCS") Air Regulations. Requirements applying to OCS sources located within 25 miles of States' seaward boundaries must be updated periodically to remain consistent with the requirements of the corresponding onshore area ("COA"), as mandated by section 328(a)(1) of the Clean Air Act, as amended in 1990 ("the

Act"). The portion of the OCS air regulations that is being updated pertains to the requirements for OCS sources by the Ventura County Air Pollution Control District (Ventura County APCD). The intended effect of approving the OCS requirements for the Ventura County APCD is to regulate emissions from OCS sources in accordance with the requirements onshore. The change to the existing requirements discussed below is proposed to be incorporated by reference into the Code of Federal Regulations and is listed in the appendix to the OCS air regulations.

DATES: Any comments must arrive by September 18, 2006.

ADDRESSES: Submit comments, identified by docket number OAR–2004–0091, by one of the following methods: Federal eRulemaking Portal: *http://www.regulations.gov*. Follow the on-line instructions.

1. *E-mail: steckel.andrew@epa.gov.*

2. *Mail or deliver*: Andrew Steckel (Air–4), U.S. Environmental Protection Agency Region IX, 75 Hawthorne Street, San Francisco, CA 94105–3901.

Instructions: All comments will be included in the public docket without change and may be made available online at *http://www.regulations.gov,* including any personal information provided, unless the comment includes Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. Information that you consider CBI or otherwise protected should be clearly identified as such and should not be submitted through *http://www.regulations.gov* or e-mail. *http://www.regulations.gov* is an "anonymous access" system, and EPA will not know your identity or contact information unless you provide it in the body of your comment. If you send e-mail directly to EPA, your e-mail address will be automatically captured and included as part of the public comment. If EPA cannot read your comment due to technical difficulties and cannot contact you for clarification, EPA may not be able to consider your comment.

Docket: The index to the docket for this action is available electronically at *http://www.regulations.gov* and in hard copy at EPA Region IX, 75 Hawthorne Street, San Francisco, California. While all documents in the docket are listed in the index, some information may be publicly available only at the hard copy location (e.g., copyrighted material), and some may not be publicly available in either location (e.g., CBI). To inspect the hard copy materials, please schedule an appointment during normal business hours with the contact listed in the **FOR FURTHER INFORMATION CONTACT** section.

FOR FURTHER INFORMATION CONTACT: Cynthia Allen, Air Division (Air–4), U.S. EPA Region 9, 75 Hawthorne Street, San Francisco, CA 94105, (415) 947–4120, *allen.cynthia@epa.gov.*

SUPPLEMENTARY INFORMATION:

I. Background information

A. Why Is EPA Taking This Action?

On September 4, 1992, EPA promulgated 40 CFR part 55,[1] which established requirements to control air pollution from OCS sources in order to attain and maintain Federal and State ambient air quality standards and to comply with the provisions of part C of title I of the Act. Part 55 applies to all OCS sources offshore of the States except those located in the Gulf of Mexico west of 87.5 degrees longitude. Section 328 of the Act requires that for such sources located within 25 miles of a State's seaward boundary, the requirements shall be the same as would be applicable if the sources were located in the COA. Because the OCS requirements are based on onshore requirements, and onshore requirements may change, section 328(a)(1) requires that EPA update the OCS requirements as necessary to maintain consistency with onshore requirements.

Pursuant to §§ 55.12 of the OCS rule, consistency reviews will occur (1) at least annually; (2) upon receipt of a Notice of Intent under §§ 55.4; or (3) when a state or local agency submits a rule to EPA to be considered for incorporation by reference in part 55. This proposed action is being taken in response to the submittal of requirements submitted by the Ventura County APCD. Public comments received in writing within 30 days of publication of this document will be considered by EPA before publishing a final rule.

Section 328(a) of the Act requires that EPA establish requirements to control air pollution from OCS sources located within 25 miles of States' seaward boundaries that are the same as onshore requirements. To comply with this statutory mandate, EPA must incorporate applicable onshore rules into part 55 as they exist onshore. This limits EPA's flexibility in deciding which requirements will be incorporated into part 55 and prevents EPA from making substantive changes to the requirements it incorporates. As a result, EPA may be incorporating rules into part 55 that do not conform to all of EPA's state implementation plan (SIP) guidance or certain requirements of the Act. Consistency updates may result in the inclusion of state or local rules or regulations into part 55, even though the same rules may ultimately be disapproved for inclusion as part of the SIP. Inclusion in the OCS rule does not imply that a rule meets the requirements of the Act for SIP approval, nor does it imply that the rule will be approved by EPA for inclusion in the SIP.

II. EPA's Evaluation

A. What Criteria Were Used To Evaluate Rules Submitted To Update 40 CFR Part 55?

In updating 40 CFR part 55, EPA reviewed the rules submitted for inclusion in part 55 to ensure that they are rationally related to the attainment or maintenance of federal or state ambient air quality standards or part C of title I of the Act, that they are not designed expressly to prevent exploration and development of the OCS and that they are applicable to OCS sources. 40 CFR 55.1. EPA has also evaluated the rules to ensure they are not arbitrary or capricious. 40 CFR 55.12 (e). In addition, EPA has excluded administrative or procedural rules,[2] and requirements that regulate toxics which are not related to the attainment and maintenance of federal and state ambient air quality standards.

B. What Requirements Were Submitted To Update 40 CFR Part 55?

1. After review of the requirements submitted by the Ventura County APCD against the criteria set forth above and in 40 CFR part 55, EPA is proposing to make the following District requirements applicable to OCS sources:

[1] The reader may refer to the Notice of Proposed Rulemaking, December 5, 1991 (56 FR 63774), and the preamble to the final promulgated September 4, 1992 (57 FR 40792) for further background and information on the OCS regulation.

[2] Each COA which has been delegated the authority to implement and enforce part 55, will use its administrative and procedural rules as onshore. However, in those instances where EPA has not delegated authority to implement and enforce part 55, EPA will use its own administrative and procedural requirements to implement the substantive requirements. 40 CFR 55.14(c)(4).

Rule No.	Name	Adoption or amended date
11	Definitions for Regulation II	03/14/06
26	New Source Review—General	03/14/06
26.1	New Source Review—Definitions	03/14/06
26.2	New Source Review—Requirements	03/14/06
26.3	New Source Review—Exemptions	03/14/06
26.6	New Source Review—Calculations	03/14/06
29	Conditions on Permits	03/14/06

III. Administrative Requirements

A. Executive Order 12866, Regulatory Planning and Review

The Office of Management and Budget (OMB) has exempted this regulatory action from Executive Order 12866, entitled "Regulatory Planning and Review."

B. Paperwork Reduction Act

This rule does not impose an information collection burden under the provisions of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*)

C. Regulatory Flexibility Act

The Regulatory Flexibility Act (RFA) generally requires an agency to conduct a regulatory flexibility analysis of any rule subject to notice and comment rulemaking requirements unless the agency certifies that the rule will not have a significant economic impact on a substantial number of small entities. Small entities include small businesses, small not-for-profit enterprises, and small governmental jurisdictions.

This rule will not have a significant impact on a substantial number of small entities because SIP approvals under section 110 and subchapter I, part D of the Clean Air Act do not create any new requirements but simply approve requirements that the State is already imposing. Therefore, because the Federal SIP approval does not create any new requirements, I certify that this action will not have a significant economic impact on a substantial number of small entities.

Moreover, due to the nature of the Federal-State relationship under the Clean Air Act, preparation of flexibility analysis would constitute Federal inquiry into the economic reasonableness of state action. The Clean Air Act forbids EPA to base its actions concerning SIPs on such grounds. *Union Electric Co.*, v. *U.S. EPA*, 427 U.S. 246, 255–66 (1976); 42 U.S.C. 7410(a)(2).

D. Unfunded Mandates Reform Act

Under sections 202 of the Unfunded Mandates Reform Act of 1995 ("Unfunded Mandates Act"), signed into law on March 22, 1995, EPA must prepare a budgetary impact statement to accompany any proposed or final rule that includes a Federal mandate that may result in estimated costs to State, local, or tribal governments in the aggregate; or to the private sector, of $100 million or more. Under section 205, EPA must select the most cost-effective and least burdensome alternative that achieves the objectives of the rule and is consistent with statutory requirements. Section 203 requires EPA to establish a plan for informing and advising any small governments that may be significantly or uniquely impacted by the rule.

EPA has determined that the approval action promulgated does not include a Federal mandate that may result in estimated costs of $100 million or more to either State, local, or tribal governments in the aggregate, or to the private sector. This Federal action approves pre-existing requirements under State or local law, and imposes no new requirements. Accordingly, no additional costs to State, local, or tribal governments, or to the private sector, result from this action.

E. Executive Order 13132, Federalism

Federalism (64 FR 43255, August 10, 1999) revokes and replaces Executive Orders 12612 (Federalism) and 12875 (Enhancing the Intergovernmental Partnership). Executive Order 13132 requires EPA to develop an accountable process to ensure "meaningful and timely input by State and local officials in the development of regulatory policies that have federalism implications." "Policies that have federalism implications" is defined in the Executive Order to include regulations that have "substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government." Under Executive Order 13132, EPA may not issue a regulation that has federalism implications, that imposes substantial direct compliance costs, and that is not required by statute, unless the Federal Government provides the funds necessary to pay the direct compliance costs incurred by State and local governments, or EPA consults with State and local officials early in the process of developing the proposed regulation. EPA also may not issue a regulation that has federalism implications and that preempts State law unless the Agency consults with State and local officials early in the process of developing the proposed regulation.

This rule will not have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government, as specified in Executive Order 13132, because it merely approves a state rule implementing a federal standard, and does not alter the relationship or the distribution of power and responsibilities established in the Clean Air Act. Thus, the requirements of section 6 of the Executive Order do not apply to this rule.

F. Executive Order 13175, Coordination With Indian Tribal Governments

Executive Order 13175, entitled "Consultation and Coordination with Indian Tribal Governments" (65 FR 67249, November 9, 2000), requires EPA to develop an accountable process to ensure "meaningful and timely input by tribal officials in the development of regulatory policies that have tribal implications." This final rule does not have tribal implications, as specified in Executive Order 13175. It will not have substantial direct effects on tribal governments, on the relationship between the Federal Government and Indian tribes, or on the distribution of power and responsibilities between the Federal Government and Indian tribes. Thus, Executive Order 13175 does not apply to this rule.

G. Executive Order 13045, Protection of Children From Environmental Health Risks and Safety Risks

Protection of Children from Environmental Health Risks and Safety Risks (62 FR 19885, April 23, 1997), applies to any rule that: (1) Is

determined to be "economically significant" as defined under Executive Order 12866, and (2) concerns an environmental health or safety risk that EPA has reason to believe may have a disproportionate effect on children. If the regulatory action meets both criteria, the Agency must evaluate the environmental health or safety effects of the planned rule on children, and explain why the planned regulation is preferable to other potentially effective and reasonably feasible alternatives considered by the Agency.

This rule is not subject to Executive Order 13045 because it does not involve decisions intended to mitigate environmental health or safety risks.

H. Executive Order 13211, Actions That Significantly Affect Energy Supply, Distribution, or Use

This rule is not subject to Executive Order 13211, "Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use" (66 FR 28355, May 22, 2001) because it is not a significant regulatory action under Executive Order 12866.

I. National Technology Transfer and Advancement Act

Section 12 of the National Technology Transfer and Advancement Act (NTTAA) of 1995 requires Federal agencies to evaluate existing technical standards when developing a new regulation. To comply with NTTAA, EPA must consider and use "voluntary consensus standards "(VCS) if available and applicable when developing programs and policies unless doing so would be inconsistent with applicable law or otherwise impractical.

The EPA believes that VCS are inapplicable to this action. Today's action does not require the public to perform activities conducive to the use of VCS.

List of Subjects in 40 CFR Part 55

Environmental protection, Administrative practice and procedures, Air pollution control, Continental shelf, Intergovernmental relations, Nitrogen dioxide, Ozone, Particulate matter, Reporting and recordkeeping requirements, Sulfur oxides.

Dated: July 28, 2006.

Alexis Strauss,

Acting Regional Administrator, Region IX.

Title 40 Chapter I of the Code of Federal Regulations, is proposed to be amended as follows:

PART 55—[AMENDED]

1. The authority citation for part 55 continues to read as follows:

Authority: Section 328 of the Clean Air Act (42 U.S.C. 7401 *et seq.*) as amended by Public Law 101–549.

2. Section 55.14 is amended by revising paragraph (e)(3)(ii)(H) to read as follows:

§ 55.14 Requirements that apply to OCS sources located within 25 miles of States' seaward boundaries, by State.

* * * * *

(e) * * *

(3) * * *

(ii) * * *

(H) *Ventura County Air Pollution Control District Requirements Applicable to OCS Sources.*

* * * * *

Appendix A to Part 55—[Amended]

3. Appendix A to part 55 is amended by revising paragraph (b)(8) under the heading "California" to read as follows:

Appendix A to Part 55—Listing of State and Local Requirements Incorporated by Reference Into Part 55, by State

* * * * *

California

* * * * *

(b) * * *

(8) The following requirements are contained in Ventura County Air Pollution Control District Requirements Applicable to OCS Sources:

Rule 2	Definitions (Adopted 4/13/04).
Rule 5	Effective Date (Adopted 4/13/04).
Rule 6	Severability (Adopted 11/21/78).
Rule 7	Zone Boundaries (Adopted 6/14/77).
Rule 10	Permits Required (Adopted 4/13/04).
Rule 11	Definition for Regulation II (Adopted 3/14/06).
Rule 12	Application for Permits (Adopted 6/13/95).
Rule 13	Action on Applications for an Authority to Construct (Adopted 6/13/95).
Rule 14	Action on Applications for a Permit to Operate (Adopted 6/13/95).
Rule 15.1	Sampling and Testing Facilities (Adopted 10/12/93).
Rule 16	BACT Certification (Adopted 6/13/95).
Rule 19	Posting of Permits (Adopted 5/23/72).
Rule 20	Transfer of Permit (Adopted 5/23/72).
Rule 23	Exemptions from Permits (Revised 4/13/04).
Rule 24	Source Recordkeeping, Reporting, and Emission Statements (Adopted 9/15/92).
Rule 26	New Source Review (Adopted 3/14/06).
Rule 26.1	New Source Review—Definitions (Adopted 3/14/06).
Rule 26.2	New Source Review—Requirements (Adopted 3/14/06).
Rule 26.3	New Source Review—Exemptions (Adopted 3/14/06).
Rule 26.6	New Source Review—Calculations (Adopted 3/14/06).
Rule 26.8	New Source Review—Permit To Operate (Adopted 10/22/91).
Rule 26.10	New Source Review—PSD (Adopted 1/13/98).
Rule 26.11	New Source Review—ERC Evaluation At Time of Use (Adopted 5/14/02).
Rule 28	Revocation of Permits (Adopted 7/18/72).
Rule 29	Conditions on Permits (Adopted 3/14/06).
Rule 30	Permit Renewal (Adopted 4/13/04).
Rule 32	Breakdown Conditions: Emergency Variances, A., B.1., and D. only. (Adopted 2/20/79).
Rule 33	Part 70 Permits—General (Adopted 10/12/93).
Rule 33.1	Part 70 Permits—Definitions (Adopted 4/10/01).
Rule 33.2	Part 70 Permits—Application Contents (Adopted 4/10/01).
Rule 33.3	Part 70 Permits—Permit Content (Adopted 4/10/01).
Rule 33.4	Part 70 Permits—Operational Flexibility (Adopted 4/10/01).
Rule 33.5	Part 70 Permits—Time frames for Applications, Review and Issuance (Adopted 10/12/93).
Rule 33.6	Part 70 Permits—Permit Term and Permit Reissuance (Adopted 10/12/93).
Rule 33.7	Part 70 Permits—Notification (Adopted 4/10/01).
Rule 33.8	Part 70 Permits—Reopening of Permits (Adopted 10/12/93).

Rule 33.9	Part 70 Permits—Compliance Provisions (Adopted 4/10/01).
Rule 33.10	Part 70 Permits—General Rule 70 Permits (Adopted 10/12/93).
Rule 34	Acid Deposition Control (Adopted 3/14/95).
Rule 35	Elective Emission Limits (Adopted 11/12/96).
Rule 36	New Source Review—Hazardous Air Pollutants (Adopted 10/6/98).
Rule 42	Permit Fees (Adopted 4/12/05).
Rule 44	Exemption Evaluation Fee (Adopted 9/10/96).
Rule 45	Plan Fees (Adopted 6/19/90).
Rule 45.2	Asbestos Removal Fees (Adopted 8/4/92).
Rule 47	Source Test, Emission Monitor, and Call-Back Fees (Adopted 6/22/99).
Rule 50	Opacity (Adopted 4/13/04).
Rule 52	Particulate Matter-Concentration (Adopted 4/13/04).
Rule 53	Particulate Matter-Process Weight (Adopted 4/13/04).
Rule 54	Sulfur Compounds (Adopted 6/14/94).
Rule 56	Open Burning (Revised 11/11/03).
Rule 57	Incinerators (Adopted 1/11/05).
Rule 57.1	Particulate Matter Emissions From Fuel Burning Equipment (Adopted 1/11/05).
Rule 62.7	Asbestos—Demolition and Renovation (Adopted 6/16/92).
Rule 63	Separation and Combination of Emissions (Adopted 11/21/78).
Rule 64	Sulfur Content of Fuels (Adopted 4/13/99).
Rule 67	Vacuum Producing Devices (Adopted 7/5/83).
Rule 68	Carbon Monoxide (Adopted 4/13/04).
Rule 71	Crude Oil and Reactive Organic Compound Liquids (Adopted 12/13/94).
Rule 71.1	Crude Oil Production and Separation (Adopted 6/16/92).
Rule 71.2	Storage of Reactive Organic Compound Liquids (Adopted 9/26/89).
Rule 71.3	Transfer of Reactive Organic Compound Liquids (Adopted 6/16/92).
Rule 71.4	Petroleum Sumps, Pits, Ponds, and Well Cellars (Adopted 6/8/93).
Rule 71.5	Glycol Dehydrators (Adopted 12/13/94).
Rule 72	New Source Performance Standards (NSPS). (Adopted 9/13/05).
Rule 73	National Emission Standards for Hazardous Air Pollutants (NESHAPS). (Adopted 9/13/05).
Rule 74	Specific Source Standards (Adopted 7/6/76).
Rule 74.1	Abrasive Blasting (Adopted 11/12/91).
Rule 74.2	Architectural Coatings (Adopted 11/13/01).
Rule 74.6	Surface Cleaning and Degreasing (Revised 11/11/03—effective 7/1/04).
Rule 74.6.1	Batch Loaded Vapor Degreasers (Adopted 11/11/03—effective 7/1/04).
Rule 74.7	Fugitive Emissions of Reactive Organic Compounds at Petroleum Refineries and Chemical Plants (Adopted 10/10/95).
Rule 74.8	Refinery Vacuum Producing Systems, Waste-water Separators and Process Turnarounds (Adopted 7/5/83).
Rule 74.9	Stationary Internal Combustion Engines (Adopted 11/8/05).
Rule 74.10	Components at Crude Oil Production Facilities and Natural Gas Production and Processing Facilities (Adopted 3/10/98).
Rule 74.11	Natural Gas-Fired Residential Water Heaters Control of NO_X (Adopted 4/9/85).
Rule 74.11.1	Large Water Heaters and Small Boilers (Adopted 9/14/99).
Rule 74.12	Surface Coating of Metal Parts and Products (Adopted 11/11/03).
Rule 74.15	Boilers, Steam Generators and Process Heaters (Adopted 11/8/94).
Rule 74.15.1	Boilers, Steam Generators and Process Heaters (Adopted 6/13/00).
Rule 74.16	Oil Field Drilling Operations (Adopted 1/8/91).
Rule 74.20	Adhesives and Sealants (Adopted 1/11/05).
Rule 74.23	Stationary Gas Turbines (Adopted 1/08/02).
Rule 74.24	Marine Coating Operations (Revised 11/11/03).
Rule 74.24.1	Pleasure Craft Coating and Commercial Boatyard Operations (Adopted 1/08/02).
Rule 74.26	Crude Oil Storage Tank Degassing Operations (Adopted 11/8/94).
Rule 74.27	Gasoline and ROC Liquid Storage Tank Degassing Operations (Adopted 11/8/94).
Rule 74.28	Asphalt Roofing Operations (Adopted 5/10/94).
Rule 74.30	Wood Products Coatings (Revised 11/11/03).
Rule 75	Circumvention (Adopted 11/27/78).
Rule 101	Sampling and Testing Facilities (Adopted 5/23/72).
Rule 102	Source Tests (Adopted 4/13/04).
Rule 103	Continuous Monitoring Systems (Adopted 2/9/99).
Rule 154	Stage 1 Episode Actions (Adopted 9/17/91).
Rule 155	Stage 2 Episode Actions (Adopted 9/17/91).
Rule 156	Stage 3 Episode Actions (Adopted 9/17/91).
Rule 158	Source Abatement Plans (Adopted 9/17/91).
Rule 159	Traffic Abatement Procedures (Adopted 9/17/91).
Rule 220	General Conformity (Adopted 5/9/95).
Rule 230	Notice to Comply (Adopted 11/9/99).

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[FR Doc. E6–13620 Filed 8–17–06; 8:45 am]
BILLING CODE 6560–50–P

DEPARTMENT OF THE INTERIOR

Bureau of Reclamation

43 CFR Part 415

RIN 1006–AA50

Regulating Non-Contract Use of Colorado River Water in the Lower Basin

AGENCY: Bureau of Reclamation, Interior.

ACTION: Advance notice of proposed rulemaking.

SUMMARY: The Bureau of Reclamation (Reclamation) is providing advance notice and is seeking public input on its plans to develop a rule to address and reduce the use of Colorado River water in the lower Colorado River basin (Lower Basin) without a contract (Non-Contract Use). Reclamation believes that development of such a rule would help prevent Non-Contract Use from depleting the Colorado River and taking water from holders of Colorado River water entitlements. Reclamation intends that any rule would establish the procedure that Reclamation would follow in making determinations of potential Non-Contract Use including notice and administrative appeal procedures for those entities whose use of Colorado River water falls within the category of Non-Contract use.

DATES: Submit comments regarding whether a rule is needed and, what should be in any rule that is developed, to Reclamation at the address below on or before October 17, 2006.

ADDRESSES: You may submit comments identified by the number 1006–AA50, by any of the following methods:

—Federal rulemaking portal *http://www.regulations.gov*. Follow the instructions for submitting comments.
—E-mail: *proposedrule@lc.usbr.gov*.
—Fax: (702) 293–8042, attention: Ms. Margot Selig.
—Mail: Regional Director, Lower Colorado Region, Attention: Ms. Margot Selig, Bureau of Reclamation, P.O. Box 61470, Boulder City, NV 89006.

FOR FURTHER INFORMATION CONTACT: Ms. Margot Selig, telephone (702) 293–8192, or e-mail at *proposedrule@lc.usbr.gov*.

SUPPLEMENTARY INFORMATION: This section provides the public with information as to why Reclamation currently believes development of a Non-Contract use rule is appropriate at this time.

Legal System For Use of Colorado River Water in the Lower Basin: The Colorado River is a primary source of water for irrigation, municipal, and industrial uses in the Lower Basin within Arizona, California, and Nevada (the Lower Division States). Colorado River water is stored behind Hoover Dam, authorized by the Boulder Canyon Project Act of 1928 (BCPA), for delivery and beneficial use in the United States. In addition, water stored by Hoover Dam is released pursuant to the United States' 1944 Treaty with Mexico addressing use of the Colorado, Rio Grande, and Tijuana Rivers.

The BCPA requires any person in the United States using this water to have a contract for such water with the Secretary of the Interior (Secretary). The Regional Director of Reclamation's Lower Colorado Region (Regional Director) enters into water delivery contracts with water users in Arizona, California, and Nevada on behalf of the Secretary. A valid water delivery contract constitutes an authorization by the Secretary, or an entitlement, to divert and consume Colorado River water in the Lower Basin. In addition to water delivery contracts, other entitlements to use Colorado River water are based on a United States Supreme Court Decree in *Arizona* v. *California* (Supreme Court Decree) or federal reservations of water. An entitlement to use Colorado River water (Entitlement) specifies how much water may be used, the purpose for which the water may be used, and where the use may occur. Reclamation considers any diversion or consumptive use of Colorado River water without a contract or other form of Entitlement to be a Non-Contract Use.

The Supreme Court Decree requires Reclamation to account for all mainstem Colorado River water use in the Lower Basin. Pursuant to this requirement, Reclamation prepares and maintains complete, detailed, and accurate records of all known diversions, return flow, and consumptive use of Colorado River water in the Lower Basin on an annual basis. These accounting records include all diversions and use of Colorado River water in Arizona, California, and Nevada, whether or not currently authorized by a water delivery contract or other form of Entitlement. All reported Colorado River water use in a state—whether authorized by an entitlement or not—is required by the Supreme Court Decree to be accounted for against the amount of Colorado River water available in that state during that year.

Technical Issues Anticipated To Be Addressed by Rule: As part of the anticipated rule, Reclamation anticipates identifying technical considerations that Reclamation would use to determine if a particular entity is using Colorado River water. Reclamation's current assessment of the situation on the Colorado River is that most Non-Contract Use consists of water withdrawn from wells located within the hydraulically-connected aquifer of the Colorado River (River Aquifer) or from river pumps. The Supreme Court Decree specified that the consumptive use of Colorado River water in the Lower Basin includes water drawn from the mainstream by underground pumping.

At Reclamation's request the United States Geological Survey (USGS) has developed a technical method to identify wells that pump water that is replaced by Colorado River water. The method is based on the existence of a River Aquifer and an accounting surface within the River Aquifer. The accounting surface extends outward from the exterior boundary of the Colorado River floodplain until encountering a geologic barrier to groundwater flow. Several thousand wells are located within the River Aquifer. The USGS is performing a well inventory within the boundary of the River Aquifer to identify wells and river pumps that can potentially divert water that would be replaced by Colorado River water. As part of the anticipated rule, Reclamation would utilize this accounting surface to define the area within which Reclamation would apply the USGS method to determine whether water withdrawn from a well is replaced with Colorado River water. Reclamation would also evaluate whether unique hydrologic circumstances in some areas along the Colorado River would merit an exception to the USGS methodology.

Need for Rule To Regulate Non-Contract Use of Colorado River Water in the Lower Basin: Reclamation's goal in its management of the lower Colorado River is to ensure that all Colorado River water use is covered by an Entitlement and correctly accounted for within each Lower Division State's apportionment. Because each Lower Division State's apportionment of Colorado River water is a limited amount, Non-Contract Use harms that state's Entitlement holders by taking water the Entitlement holders otherwise could legally use. This fact leads Reclamation to conclude that the proposed rulemaking is necessary and appropriate. Reclamation believes that development of the proposed rule is

necessary for a number of reasons, including particularly (1) the fact that each Lower Division State is fully utilizing its respective apportionment and (2) the recent prolonged period of drought in the Colorado River Basin which has reduced water saved in the Colorado River reservoirs in recent years.

Reclamation anticipates that the rule would also address several other situations where Colorado River water use is not in accordance with an Entitlement, such as using more Colorado River water than is allowed by an Entitlement, using Colorado River water for a purpose the contract does not authorize, or using Colorado River water outside an approved service area for the Entitlement. Reclamation has authority to enforce its written contracts to prevent water use (i) in excess of an Entitlement, (ii) for a purpose not approved by the Entitlement, or (iii) outside the approved service area for the Entitlement. Reclamation anticipates proposing methods to modify the Entitlements to allow the current uses to continue with the approval of Reclamation or cease the use.

Reclamation's Current Assessment of Content of Proposed Rule: Reclamation believes that the proposed rule is needed to provide a framework for identifying and controlling Non-Contract Use. Pending review of public comments, Reclamation expects the proposed rule to:

1. Establish the methodology developed by the USGS as the tool that Reclamation will use to determine if a well pumps water that is replaced with Colorado River water;

2. Establish the criteria a water user must satisfy to demonstrate that his or her well does not pump water that is replaced with Colorado River water; and

3. Establish a process for a water user to appeal a finding that a well pumps water that would be replaced by Colorado River water.

The proposed rule is also anticipated to address Colorado River water use that is not in accordance with an Entitlement. Pending review of public comments, Reclamation expects the proposed rule to:

1. Document the process Reclamation will use to notify a water user if Reclamation makes an initial determination that the water user is using Colorado River water in a way that is not in accordance with an Entitlement.

2. Document the process a water user must follow to challenge the accuracy of the information on which Reclamation's preliminary determination is made.

In the proposed rule, Reclamation anticipates including provisions that would serve to legalize Non-Contract Use, where possible, by working with Non-Contract Users to obtain a legal right to use Colorado River water. Here are several options that Reclamation will consider:

1. Some water may be available under the three Lower Division States' apportionments.

(a) *Arizona:* Some Colorado River water may be available for allocation in Arizona. After Reclamation consults with Arizona Department of Water Resources (ADWR), some of Arizona's unobligated Colorado River water could be committed for use by Non-Contract Users in Arizona. A possible contract between ADWR and Reclamation may satisfy the contract requirement for multiple individual water users and eliminate the need for contracts between the United States and the individual Non-Contract water users.

(b) *California:* All Colorado River water available for use in California is already under permanent contract. However, a small amount of water is available for domestic use in California through the Lower Colorado Water Supply Project (LCWSP). Non-Contract Users in California who are eligible for domestic use in California and who wish to participate under the LCWSP would need to enter into a water delivery subcontract with the City of Needles. The City of Needles is the only entity authorized to enter into a standard form subcontract for delivery of this water supply to project beneficiaries.

(c) *Nevada:* All Colorado River water available for use in Nevada is already under permanent contract. Any commitment to recognize new uses of Colorado River water in Nevada would be subject to terms established by the Southern Nevada Water Authority (SNWA). SNWA has an existing Entitlement to the delivery and use of any Colorado River water not previously committed for use by other Nevada water users.

2. A water user may be able to acquire an Entitlement through an assignment, transfer, or lease from an existing Entitlement holder within that state. However, an assignment, transfer, or lease is not valid unless it is approved by Reclamation.

3. A water user may be able to obtain a right to use water as a customer of an existing contract holder. The place of water use must be included within the contract holder's service area and the inclusion must be approved by Reclamation.

4. A water user may be able to acquire a different source of water that is not hydraulically connected to the mainstream of the Colorado River.

Directives in the BCPA and the Supreme Court Decree provide that all delivery and use of Colorado River water must be under a valid contract or other form of entitlement with the United States. Implementation of the anticipated rule would protect Entitlement holders by documenting appropriate steps to terminate a Non-Contract Use. Thus, Reclamation anticipates that the proposed rule would provide that if Reclamation determines a water user is making a Non-Contract Use and the water user is unable to acquire a legal right to use Colorado River water, Reclamation would order that water user to cease the Non-Contract Use and pursue available legal options to stop the Non-Contract Use.

Submitting Comments

Reclamation's practice is to make comments, including names and home addresses of respondents, available for public review. Individual respondents may request that we withhold their home address from public disclosure, which we will honor to the extent allowable by law. There may be other circumstances in which we would withhold a respondent's identity from public disclosure, as allowable by law. If you wish us to withhold your name and/or address, you must state this prominently at the beginning of your comment. We will make all submissions from organizations or businesses, and from individuals identifying themselves as representatives or officials of organizations or businesses, available for public disclosure in their entirety.

If you comment via the Internet, please submit comments in plain text, using the characters available on a standard typewriter or computer keyboard. Avoid using special characters and any form of encryption. Please include your name and e-mail or postal address in your Internet message. If you do not receive a confirmation via e-mail that Reclamation has received your Internet message, please contact us directly at (702) 293–8192.

Dated: August 8, 2006.

Mark Limbaugh,

Assistant Secretary—Water and Science.

[FR Doc. E6–13687 Filed 8–17–06; 8:45 am]

BILLING CODE 4310–MN–P

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

50 CFR Part 17

Endangered and Threatened Wildlife and Plants; 90-Day Finding on a Petition To List 16 Insect Species From the Algodones Sand Dunes, Imperial County, CA, as Threatened or Endangered

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Notice of 90-day petition finding.

SUMMARY: We, the U.S. Fish and Wildlife Service (Service), announce a 90-day finding on a petition to list 16 insect species from the Algodones Sand Dunes, Imperial County, California, as threatened or endangered, under the Endangered Species Act of 1973, as amended. We find that the petition does not present substantial scientific or commercial information indicating that listing these species may be warranted. Therefore, we are not initiating a status review in response to this petition. We ask the public to submit to us any new information that becomes available concerning the status of these species or threats to them or their habitat at any time.

DATES: The finding announced in this document was made on August 18, 2006.

ADDRESSES: The complete file for this finding is available for public inspection, by appointment, during normal business hours at the Carlsbad Fish and Wildlife Office, U.S. Fish and Wildlife Service, 6010 Hidden Valley Road, Carlsbad, California 92011. Submit new information, materials, comments, or questions concerning these species to us at the address above.

FOR FURTHER INFORMATION CONTACT: Jim Bartel, Field Supervisor, Carlsbad Fish and Wildlife Office (see **ADDRESSES**); or 760–431–9440 (voice) or 760–431–9624 (fax).

SUPPLEMENTARY INFORMATION:

Background

Section 4(b)(3)(A) of the Endangered Species Act of 1973, as amended (Act) (16 U.S.C. 1531 et seq.), requires that the Service make a finding on whether a petition to list, delist, or reclassify a species presents substantial scientific or commercial information indicating that the petitioned action may be warranted. This finding is based on information contained in the petition and information otherwise available in our files at the time we make the determination. To the maximum extent practicable, we are to make this finding within 90 days of our receipt of the petition, and publish our notice of the finding promptly in the **Federal Register**.

In making this finding, we relied on information provided by the petitioners and otherwise available in our files at the time of the petition review. We also had access to California Department of Fish and Game's California Natural Diversity Database that we queried for all known records of each of the species that were identified in the petition for listing. We evaluated this information in accordance with our regulations at Title 50 of the Code of Federal Regulations (CFR), § 424.14(b). The process of making a 90-day finding under section 4(b)(3)(A) of the Act and § 424.14(b) of our regulations is based on a determination of whether the information in the petition meets the "substantial scientific information" threshold.

Our standard for substantial scientific or commercial information within the CFR with regard to a 90-day petition finding is "that amount of information that would lead a reasonable person to believe that the measure proposed in the petition may be warranted" (50 CFR 424.14(b)). If we find that the petition presents substantial scientific or commercial information, we are required to promptly commence a status review of the species.

On July 19, 2004, we received a formal petition dated July 19, 2004, from the Center for Biological Diversity, Public Employees for Environmental Responsibility, and the Sierra Club (the petitioners) to list two sand wasps (*Microbembix elegans*) and (*Stictiella villegasi*); two bees (*Perdita algodones* and *Perdita glamis*); one vespid (*Euparagia* n. sp.); two velvet ants (*Dasymutilla nocturna* and *Dasymutilla imperialis*); Algodones sand jewel beetle (*Lepismadora algodones*); Algodones white wax jewel beetle (*Prasinalia imperialis*); Algodones croton jewel beetle (*Agrilus harenus*); Hardy's dune beetle (*Anomala hardyorum*); a scarab beetle (*Cyclocephala wandae*); and four subspecies of Roth's dune weevil (*Trigonoscuta rothi rothi*, *Trigonoscuta rothi algodones*, *Trigonoscuta rothi imperialis*, and *Trigonoscuta rothi punctata*), hereafter referred to as the 16 insect species, as threatened or endangered species in accordance with section 4 of the Act. On September 24, 2004, we received a letter and additional supporting documentation for the petition to list 16 insect species associated with the Algodones Dunes from the Center for Biological Diversity.

The petitioners requested listing of 16 insect species they believe to be endemic to the Algodones Dunes. This same area is alternately referred to as the Imperial Sand Dunes or the Glamis Dunes, and other geographic names are used to refer to portions of it. The Algodones Dunes is a desert located in eastern Imperial County in southern California. It is the largest mass of sand dunes in California, covering more than 40 miles (mi) (64 kilometers (km)) long and averaging 5 mi (8 km) wide (BLM 2003, p. 5). Most of this area is public land managed by the Bureau of Land Management (about 92 percent), and the rest is either private, U.S. Military, or State of California land (BLM 2003, p. 20). Most of the Algodones Dunes is in California, but a small portion extends southward into Mexico.

The petitioners also requested designation of critical habitat for the 16 insect species concurrent with their listing. The petition clearly identified itself as a petition and included the requisite identification information for the petitioners, as required in 50 CFR 424.14(a). In an October 5, 2004, letter to the petitioners, we responded that we reviewed the petition for the 16 insect species and determined that an emergency listing was not warranted, and that due to court orders and settlement agreements for other listing actions that required nearly all of our listing funds for fiscal year 2005, we would not be able to otherwise address the petition to list the 16 insect species at that time.

On December 1, 2005, the Center for Biological Diversity filed a Complaint for Declaratory and Injunctive Relief in United States District Court for the Southern District of California (*Center for Biological Diversity* v. *Norton et al.*, No. 05 CV 1988 BEN (BLM)) challenging our failure to issue a 90-day finding on the petition to list the 16 insect species. On January 12, 2006, we reached an agreement with the plaintiffs to submit to the **Federal Register** a completed 90-day finding by August 7, 2006, and if substantial, to complete the 12-month finding by June 15, 2007. This notice constitutes the 90-day finding for the July 19, 2004 petition.

Regarding the petitioners' request to list the vespid wasp (*Euparagia* n. sp.), we note that this does not represent a listable taxonomic entity under our regulations. The petitioners only identified a genus, and to make a listing decision, a taxon must be described to at least the species level. With regard to the four petitioned subspecies of Roth's dune weevil (*Trigonoscuta rothi rothi*,

Trigonoscuta rothi algodones, *Trigonoscuta rothi imperialis*, and *Trigonoscuta rothi punctata*), we did find a published manuscript naming these subspecies (Pierce 1975, pp. 57, 73, and 74). However, Anderson (2002, p. 777) states that most of the taxa in the genus *Trigonoscuta* are of questionable validity and need reassessment. Because the petition did not provide any further substantiating evidence related to the taxonomy of these insects, we have determined that the petition does not provide substantial scientific information that the vespid wasp (*Euparagia* n. sp.) and the four subspecies of weevils (*Trigonoscuta rothi rothi*, *Trigonoscuta rothi algodones*, *Trigonoscuta rothi imperialis*, and *Trigonoscuta rothi punctata*) are scientifically accepted taxons. Under the Act, we can only list recognized invertebrate species and subspecies. Hence, the request to list *Euparagia* n. sp. and the four Trigonoscuta subspecies will not be further considered in this finding. Therefore, the remainder of this finding addresses the remaining 11 insect species identified in the petition.

Species Information

The following section is based on information in the petition and available to us at the time of petition review. Microbembix elegans, a sand wasp, was first described as a species by Griswold (1996) and is in the family Sphecidae. Species in the genus *Microbembix* are all found in North and South America and are recognized by their relatively small size and other features as described by Bohart and Horning (1971, p. 24). The male *M. elegans* is unique among *Microbembix* in the modifications to the middle and hind legs (Griswold 1996, p. 142). Males average 0.47 inches (in) (12 millimeters (mm)) long and females range from 0.35 to 0.39 in (9 to 10 mm) long (Griswold 1996, p 143). Habitat information is limited to the description of active slip faces within sand dune systems; all specimens have been found at the base of shrubs where detritus collects (Griswold 1996, p. 142). Abundance and population trend information is not available. Distribution knowledge is limited to two "populations" identified in the Algodones Dunes system in Imperial County, California (Griswold 1996, p. 142).

The other sand wasp, *Stictiella villegasi*, was first described by Bohart (1982, pp. 596–597) and is also in the family Sphecidae. Bohart (1982, p. 597) states the species can be recognized by its almost entirely yellow appearance and a combination of other specific physical characteristics. Males and females are approximately 0.47 in (12 mm) long (Bohart 1982, p. 596). Information on habitat use, abundance, and population trends is not available. All known collections of the species are from the Algodones Dunes system in Imperial County, California (Bohart 1982, p. 597).

Perdita algodones, a bee, was first described by Timberlake (1980, p. 26) and is in the family Andrenidae. The species ranges in length from 0.17 to 0.18 in (4.3 to 4.5 mm) and in width from 0.05 to 0.06 in (1.2 to 1.5 mm) (Timberlake 1980, p. 26). This species has a dark blue-green head and thorax, black abdomen, and "whitish" wings (Timberlake 1980, p. 26). Timberlake (1980, p. 26) provides a detailed description of distinguishing physical characteristics of this species and states that it was found in the vicinity of Glamis, in Imperial County, California. Information on habitat, abundance, and population trends is lacking. All known collections are from the vicinity of Glamis, in Imperial County, California (Timberlake 1980, p. 26).

The other bee, *Perdita glamis*, is also in the family Andrenidae and was described from the only two known specimens by Timberlake (1980, pp. 16 and 17). The physical dimensions as provided by Timberlake (1980, p. 17) are a length of 0.20 in (5 mm) and an abdomen width of 0.06 in (1.5 mm). The head and thorax are dark blue and the abdomen is "dusky" (Timberlake 1980, p. 17). Timberlake (1980, p. 17) provides a detailed description of distinguishing physical characteristics of this species and indicates it was discovered in the sand dunes area of Imperial County, California. Information on habitat, abundance, and population trends is lacking. All known collections of this species are from the vicinity of Glamis in Imperial County, California (Timberlake 1980; p. 17).

Dasymutilla nocturna, a velvet ant, is a wasp in the family Mutillidae. Female mutillids are hairy and wingless, resembling ants, while males have wings and fewer hairs (Foltz 2001, pp. 1–2). All mutillid wasp larvae are parasitic on other insects (Earthlife 2005, p. 1). Mickel (1928, pp. 279–281) first described *Dasymutilla nocturna* based on two female specimens and provided a detailed description of distinguishing physical characteristics. Females are dark mahogany red, and males are black. Body length given by Mickel (1928, p. 279 and 281) was 0.5 in (13 mm) for females, and 0.4 in (10 mm) for males. Manley (1999), who also collected this species, examined Mickel's (1928, pp. 279–281) specimens and compared them to specimens from other California desert region *Dasymutilla* species. Manley (1999, p. 21) synonymized the species *D. subhyalina* and some specimens of *D. paranocturna* with *D. nocturna* on the basis that: (1) All are nocturnal; (2) all share the same geographic range, the Colorado Desert; (3) numerous individuals have been collected at the same place and time; and (4) males were attracted to and tried to mate with caged females. Specific information on habitat use, abundance, and population trends is not available.

Although most *D. nocturna* specimens have been collected from the Algodones Dunes or nearby (Manley 1999, p. 20), current available scientific information does not support the hypothesis that this species is restricted to the Algodones Dunes. Manley (1999, p. 18) states that the specimen from which the synonymous taxon *D. paranocturna* was described (the holotype) was collected from Blythe, Riverside County, California (approximately 50 mi (80 km) north of the Algodones Dunes) and further states the holotype is "undoubtedly a specimen of *D. nocturna*." Manley (1999, p. 20) also mentioned a *D. nocturna* specimen he said was correctly identified, but it was labeled Preston, Nevada. Manley states that this was likely mislabeled because "* * * no other specimen of the species had been found within [683.5 mi] 1100 km of Preston, Nevada." However, expert wasp taxonomist Roy Snelling (2006) confirmed a wider species distribution, citing personally identified *D. nocturna* specimens collected from the town of Roll, in Pima County, Arizona; the town of Westmorland near the Salton Sea in Imperial County, California; and the village of Paredones, Baja California, Mexico, southwest of the Algodones Dunes. The towns of Roll in Arizona and Westmorland in California, and the village of Paredones in Baja California, Mexico, are approximately 75 mi (121 km), 19 mi (31 km), and 35 mi (56 km) from the Algodones Dunes, respectively. Based on this information, we do not believe that *D. nocturna* is endemic to the Algodones Dunes.

The other velvet ant, *Dasymutilla imperialis*, is also a wasp in the family Mutillidae. It was first described by Manley and Pitts (2004, pp. 646–648), who provide a detailed description of the species' distinguishing physical characteristics based on male specimens; no female specimens have been collected. The male is entirely black and the length is approximately 0.39 to 0.47 in (10 to 12 mm) (Manley and Pitts 2004, p. 646). Specific

information on habitat, abundance, and population trends is not available. All known collections are from the Algodones Dunes (Manley and Pitts 2004, p. 648) and extensive collecting in this area over many years has not yielded any additional specimens of this species (Manley and Pitts 2004, p. 649). Manley and Pitts (2004, pp. 646–649) do not discuss any searches of other sand dunes for this species.

The Algodones sand jewel beetle *Lepismadora algodones* is in the family Buprestidae. It was first described by Velten and Bellamy (1987, pp. 186, 188, and 190), who provide a detailed description of distinguishing physical characteristics of the species: it varies in length from 0.16 to 0.25 in (4.0 to 6.5 mm) and in width from 0.06 to 0.08 in (1.4 to 2.1 mm), with females generally larger than males. Color varies from cupreus (copper) to brassy green (Velten and Bellamy 1987, p. 190). Most specimens in association with the plant *Tiquilia plicata*, the species was observed feeding on flowers and foliage of *Tiquilia plicata*, or at rest on foliage or dead twigs on the soil surface (Velten and Bellamy 1987, p. 190). The petition provides information on habitat use, activity patterns, reproduction, and mortality that we were unable to confirm in any cited information sources or information in our files. Specific information on habitat use, abundance, and population trends of this species was not available. All known collections of the species are from the Algodones Dunes in Imperial County, California (Velten and Bellamy 1987, p. 190).

The Algodones white wax jewel beetle *Prasinalia imperialis* is also in the family Buprestidae. It was first described by Barr (1969, pp. 326–328), who provides the most detailed description of this species' distinguishing physical characteristics. It is most readily recognized by its coppery coloration. Male dimensions vary from 0.63 to 0.87 in (16.0 to 22.0 mm) in length, while females vary from 0.57 to 0.89 in (14.5 to 25.0 mm) in length (Nelson and Bellamy 1996, p. 899). Habitat information is limited to a host plant association and collection locations. Barr (1969, p. 328) and Nelson and Bellamy (1996, p. 899) note an association with the plant *Eriogonum deserticola*. Larvae develop in the roots and crown of *Eriogonum deserticola*, and adults have been observed feeding on the bark of live twigs of this plant (Nelson and Bellamy 1996, p. 899). Information on abundance and population trends is not available. All collections for this species are from sand dunes and nearby areas on the eastern slope of Imperial Valley in California (Barr 1969, p. 328; Nelson and Bellamy 1996, p. 899).

The Algodones Croton jewel beetle *Agrilus harenus* is another member of the family Buprestidae. This species was first described by Nelson (1994, pp. 261–262), who provides a detailed description of the physical characteristics of the species. Males are 0.18 to 0.27 in (4.5 to 6.9 mm) long, while females range from 0.19 to 0.27 in (4.8 to 6.9 mm) long (Nelson 1994, p. 263). The species has been collected in association with sand dune habitat, and all the adults were associated with Wiggin's croton (*Croton wigginsii*), the likely host plant (Nelson 1994, p. 263). Adults have been collected from mid-April to late September (Nelson 1994, p. 263). There is no information on abundance or population trends. All collections for this species were from the Algodones Dunes in Imperial County, California (Nelson 1994, p. 263).

Hardy's dune beetle *Anomala hardyorum* is a member of the family Scarabaeidae. This species was first described by Potts (1976, pp. 221–222), who provides a detailed description of the species' distinguishing physical characteristics. Members of this species have a light tan coloration with males ranging from 0.28 to 0.39 in (7 to 10 mm) in length, and females from 0.28 to 0.35 in (7 to 9 mm) (Potts 1976, pp. 223 and 224). The species has most often been found on north- or east-facing dune slip faces. There is no known association between adults and any plant species (Hardy and Andrews 1980, p. 14). Adults are known to be active at dusk (Hardy and Andrews 1980, p. 14). There are no quantified estimates of abundance or population trends and information on distribution is limited. Hardy and Andrews (1980, p. 38–39) provided a map of collection locations in the Algodones Dunes, and concluded that the Hardy's June beetle was widespread in the dune system (Hardy and Andrews 1980, p. 17). All known collections are from the Algodones Dunes in Imperial County, California (Potts 1976, p. 222; Hardy and Andrews 1980, p. 14).

The scarab beetle *Cyclocephala wandae* is also a member of the family Scarabaeidae. This scarab beetle was first described by Hardy (pp. 160–161), who provides a detailed description of the species' distinguishing physical characteristics. The beetle is light brown, similar to *Pseudocatalpa andrewsii*, and ranges in length from 0.26 to 0.30 in. (6.6 to 7.5 mm) (Hardy 1974, p. 160). We were not able to locate information on abundance, distribution, or population trends. Other than the fact that the species inhabits sand dunes (Hardy 1974, pp. 160–161; Andrews *et al.* 1979, p. 40) habitat use information is lacking, and distribution information is limited to known collections from the Algodones Dunes in Imperial County, California (Hardy 1974, p. 161; Andrews *et al.* 1979, p. 40).

Threats Analysis

Section 4 of the Act and its implementing regulations (50 CFR 424) set forth the procedures for adding species to the Federal List of Endangered and Threatened Wildlife and Plants. A species may be determined to be an endangered or threatened species due to one or more of the five factors described in section 4(a)(1) of the Act: (A) Present or threatened destruction, modification, or curtailment of habitat or range; (B) overutilization for commercial, recreational, scientific, or educational purposes; (C) disease or predation; (D) inadequacy of existing regulatory mechanisms; or (E) other natural or manmade factors affecting its continued existence. In making this 90-day finding, we evaluated whether threats to the 11 scientifically accepted taxons presented in the petition may pose a concern with respect to their survival, such that listing under the Act may be warranted. Our evaluation of these threats is presented below.

A. Present or Threatened Destruction, Modification, or Curtailment of the Species' Habitat or Range

The petitioners state that the 11 insect species are endemic to the Algodones Dunes system and are habitat specialists with restricted geographic ranges, making them more prone to extinction than more widespread species. The petitioners also cite statements by Hardy and Andrews (1976, p. 21) that Coleoptera species endemic to several California dune systems face possible extinction or population decline if habitat destruction by human activity continues or escalates. The petitioners further assert that the 11 petitioned insect species have no colonization source should their known populations be eliminated.

The petitioners state that several published studies have documented deleterious effects of Off-Road-Vehicles (ORVs) on desert arthropods, mammals, birds, amphibians, reptiles, and vegetation (Busack and Bury 1974; Hardy and Andrews 1976; Bury *et al.* 1977; Berry 1980; Bury and Luckenbach 1983; Luckenbach and Bury 1983; Schultz 1988; Brooks 1995; Stebbins 1995; Brooks 1999). The petitioners

indicate that Hardy and Andrews (1976) reported ORVs could damage sand dune surfaces and destroy pockets of accumulated vegetative material or crusted deposits, which may be larval nurseries for endemic insects. The petitioners cite Carpelan (1995) as stating that ORVs can eliminate "entire generations" by obliterating accumulated vegetable matter in which larvae develop; as well as the findings of Luckenbach and Bury (1983) that arthropod tracks (mostly beetle) were 24 times more abundant in control areas than they were in ORV-impacted areas. The petitioners also cite Luckenbach and Bury's (1983) overall study conclusion that ORV activities in the Algodones Dunes are highly detrimental to dune biota. The petitioners cite several studies that discuss loss of vegetative cover due to ORV activity (Bury *et al.* 1977; Berry 1980; Lathrop 1983; Luckenbach and Bury 1983) and assert any activities resulting in the decline of general plant cover and host plants would threaten survival of rare endemic insect species with highly restricted geographical ranges and highly specific habitat needs.

The petitioners discuss concerns for Andrews' dune scarab beetle (*Pseudocotalpa andrewsi*), including lack of proposed monitoring of this species and impacts from ORVs in areas where it was known to be most abundant. Please refer to the **Federal Register** notice at 71 FR 2644 for our 90-day finding on the petition to list the Andrews' dune scarab beetle species. The petitioners conclude that current and projected ORV use and lack of adequate management by the Bureau of Land Management (BLM) threaten the continued existence of this and other endemic Algodones Dunes species. The petitioners also mention the temporary ORV closures for portions of the Algodones Dunes to protect the Peirson's milk-vetch (*Astragalus magdalenae*) in effect since November 2000, which encompass about 49,000 acres (ac) (19,838 hectares (ha)) (65 FR 69324, November 16, 2000). The petitioners also describe proposed management for the Algodones Dunes under the BLM Draft 2002 Recreation Area Management Plan (RAMP), and how the RAMP would greatly increase the area open to ORVs compared to the current situation. The petitioners assert that if currently protected areas in the Algodones Dunes are re-opened to ORV traffic, and other areas supporting rare endemic insects are not also protected, then habitat for the petitioned insect species will be modified or destroyed and their ranges curtailed.

The petitioners do not provide any scientific or commercial information on the distribution, habitat use, abundance, or population status of any of the 11 insect species in the part of the dune system that includes the Yuma Dunes in southwestern Arizona and dunes within the Gran Desierto Altar in Sonora, Mexico.

Evaluation of Information in the Petition

Based on the distribution information previously presented for *D. nocturna*, we believe this species is not endemic to the Algodones Dunes. However, we acknowledge it is possible the other 10 insect species could be endemic to the Algodones Dunes. Information provided in the petition and in our files on distribution of the 10 insect species is very limited. This information indicates these insects have only been found in the Algodones Dunes, but no information provided with the petition or in our files indicates whether other potential dune habitats, such as the Yuma Dunes or dune systems within the 5,000 square mi (12,950 square km) area of the Gran Desierto de Altar, have been surveyed for the 10 insect species. Only two studies cited by the petitioners, Hardy and Andrews (1976) and Andrews *et al.* (1979), sampled more than one dune area in southern California, and they only surveyed for beetles. Andrews *et al.* (1979) does provide some evidence that the two petitioned scarab beetles (*Cyclocephala wandae* and *Anomala hardyorum*) are endemic to Algodones Dunes; out of the five dune systems sampled, they found these two species only at the Algodones Dunes. But their conclusions are limited to the five dune systems and do not include all dune systems in the southwestern United States and Mexico, where these two species could potentially occur. Hence, it is unclear how widely scientists have searched for these two insect species. Without comprehensive surveys throughout sand dunes areas of southern California, Arizona, and northern Mexico, our understanding of these species' distributions and ranges is incomplete. An apparent host-plant relationship has been documented for the three jewel beetle species (Barr 1969, page 328; Velten and Bellamy 1987, page 190; Nelson 1994, page 263), but beyond this and the association of all the petitioned species with sand dunes, habitat requirements for the three jewel beetle species are inconclusive. The host plants for the three jewel beetles species are not endemic to the Algodones dunes. *Tiquila plicata* ranges into Arizona and Nevada (Hickman 1996, p. 392), *E. deserticola* is also found in Arizona and northwest Sonora, Mexico (Hickman 1996, p. 870), and *C. wigginsii* is also found in Arizona and northwestern Mexico (Hickman 1996, p. 572). Also, the petition does not provide significant information on the abundance of the 11 insect species, nor does it provide any population trend information. Given the extreme paucity of information on distribution (for example, *D. nocturna*; Snelling 2006), habitat requirements, abundance, and population trends, it cannot be determined how rare these 11 species are, how restricted they are geographically, how specialized they are in their habitat requirements, or if they lack colonization sources if known populations are eliminated.

The petitioners cite Busack and Bury (1974), Hardy and Andrews (1976), Bury *et al.* (1977), Berry (1980), Bury and Luckenbach (1983), Luckenbach and Bury (1983), Schultz (1988), Brooks (1995), Stebbins (1995), and Brooks (1999) as reporting negative effects of ORVs on desert species. However, most of these studies reported effects of ORV activity on vegetative cover and vertebrates, not insects. Schultz (1988) reported some negative effects of ORV activity on riparian tiger beetle (Cicindelidae) habitat, but this work was not in a sand dune system, and it did not involve any of the 11 insect species. Only Bury and Luckenbach (1983) and Luchenbach and Bury (1983) provided Algodones Dunes arthropod information, and both discuss the same data. Luckenbach and Bury (1983, p. 275) reported "arthropod (mostly beetle) tracks were twenty-four times more abundant in control plots [not impacted by ORV use] than in ORV-impacted plots." However, this work was focused mostly on vegetation and vertebrates, and arthropod (invertebrate) data was not species-specific. Furthermore, the observed tracks may not have represented any of the petitioned insects and were only identified as "mostly beetles."

Although Griswold (1996, p. 142) states that the sand wasp *Microbembix elegans* may be threatened by ORV activity, he did not provide data to substantiate this claim. Griswold (1996, p. 142) also stated that, while areas where this species was found were open to ORV activity, they were not currently receiving a high level of disturbance. Similarly, Evans and Bellamy (2000, p. 184) provided a list of threats to beetle populations that includes ORV traffic but do not provide data to document beetle impacts. Despite the petitioners' claim that Hardy and Andrews (1976) concluded that ORVs could destroy areas in the Algodones Dunes with

pockets of accumulated vegetative material or crusted deposits, Hardy and Andrews (1976, p. 2) did not have any study sites in the Algodones Dunes. Hardy and Andrews (1976, p. 19) summarized ways in which ORV activity may adversely affect dune restricted or adapted insects, but they did not provide data to support these hypotheses. Andrews *et al.* (1979, pp. 4–9) provided inventories of five dune areas in California, including the Algodones Dunes. However, only beetle species were inventoried, only the two petitioned scarab beetles and Roth's dune weevil were collected, and no information was provided on the effects of ORVs on insect species. Carpelan (1995, pp. 275–283) provided information on sand dune ecosystems focused on dune stabilization and dune insect adaptation and speciation. However, Carpelan's (1995, pp. 276–277) work was largely derived from Hardy and Andrews (1976) beetle study, and expressed general concern about adverse effects of ORVs on invertebrates.

Because Andrews' dune scarab beetle was evaluated separately under another listing petition, discussion of this species in this petition finding has limited relevancy. However, the Andrews' dune scarab beetle does face similar possible threats in the same geographic area, and the petition for Andrews' dune scarab beetle lacked similar substantial information, for example, a lack of distribution information from dune systems in Mexico (71 FR 26444; May 5, 2006). We acknowledge that BLM management of the Algodones Dunes could potentially affect the 11 insect species, because BLM does permit ORV use in parts of this dune system. However, about 49,000 ac (19,838 ha) of BLM managed lands are under temporary ORV closure to protect the Peirson's milk-vetch (65 FR 69324; November 16, 2000). In addition, the North Algodones Dunes Wilderness Area, of which BLM manages about 26,000 ac (10,526 ha), is permanently closed to ORV activity (BLM 2003; p. 71). BLM manages 159,000 acres (64,372 hectares) of the Algodones Dunes (BLM 2003; p. 5) so about 47 percent of the BLM-managed lands in the Algodones Dunes are currently closed to ORV activity. These interim closures are still in effect. Current management of the Imperial Sand Dunes Recreation Area (ISDRA) is discussed under Factor D below.

We compared a map of the interim ORV closures with the map of Hardy's dune beetle distribution in the Algodones Dunes from Hardy and Andrews (1980; appendix map). This was the only one of the petitioned insect species for which we had a collection location map. Fifteen of the 20 locations where Hardy's dune beetle was found (Hardy and Andrews 1980; appendix map) occurred outside of interim closure areas. One interim closure area, which BLM designated as the Adaptive Management Area in the 2003 RAMP (BLM 2003), had multiple Hardy's dune beetle collection locations. With regard to ORV use this area is designated as "Limited" in the 2003 RAMP (BLM 2003; page 84). The Adaptive Management Area would be open to motor vehicle entry only from October 15 to March 31 of each year, and only by permit (BLM 2003). Biological resources and public use would be monitored, and BLM would adjust public use to conserve habitats and species of concern (BLM 2003; pp. 84–86). Also BLM (2003; page 84) indicates current visitor use of the Adaptive Management Area is low compared to the remainder of the ISDRA. In addition, more location records (Hardy and Andrews 1980; appendix map) fall within the North Algodones Dunes Wilderness Area permanently closed to ORVs, than within the Adaptive Management Area. Regardless of the potential for negative ORV impacts, there is no information in the petition documenting what the magnitude of ORV impacts would be to Hardy's dune beetle or any of the other petitioned insect species.

Information in the petition regarding impacts to the 11 insect species in the Algodones Dunes from ORV use is inadequate, incomplete, or nonexistent. Therefore, we find the petition does not provide substantial scientific or commercial information to document that ORV use may be a factor threatening the 11 insect species.

B. Overutilization for Commercial, Recreational, Scientific, or Educational Purposes

The petition does not provide any information pertaining to Factor B. We acknowledge that scientific collection of insect species will continue in the Algodones Dunes area, but we do not have any information indicating current levels of collecting activity will harm populations.

C. Disease or Predation

The petitioners state that natural predation and disease, including fungal pathogens, affects populations; however, specific data are not available. Since the petition does not provide any data on natural predation or disease for the 11 insect species, we find that the petition does not contain substantial scientific or commercial information to document disease or predation may be a factor that threaten the petitioned insect species.

D. Inadequacy of Existing Regulatory Mechanisms

The petitioners assert that inadequate existing regulatory mechanisms endanger the continued existence of the petitioned insect species of the Algodones Dunes. The petitioners claim administrative plans and legal requirements to monitor and conserve endemic insects have not been implemented by BLM, while ORV use in the Algodones Dunes has increased by an order of magnitude in the last 30 years, resulting in direct mortality of endemic insect species and loss of host plants. The petitioners state that current management plans allow ORV use in the majority of habitat supporting the rare endemic insects (94 percent of creosote scrub, 84 percent of psammophytic scrub, and 88 percent of microphyll woodland). They also claim that pending plans to open currently protected areas of the dune system to ORVs are one of the most immediate threats to the existence of these insects. The petitioners further assert that BLM has been aware of concerns regarding the adverse impacts of ORVs on endemic insect species on the dunes for at least 30 years. They cite work by Hardy and Andrews (1976) describing deleterious effects of ORV activity on sand dune insects and claim ORV impacts discussed in that report are relevant to the Algodones Dunes, while acknowledging that Hardy and Andrews (1976) study did not focus on this area. The petitioners additionally claim that published peer-reviewed scientific literature is replete with studies documenting serious negative impacts of ORVs on desert systems (see discussion under Factor A). They also assert ORV use throughout the Algodones Dunes continued unabated in sensitive habitat until BLM was sued and forced to implement interim closures to protect the threatened Peirson's milk-vetch and desert tortoise.

The petition notes three planning documents for the Algodones Dunes Wildlife Habitat Area addressed management of biological resources prior to BLM's 2002 Draft Environmental Impact Statement (DEIS) for managing the ISDRA. These include the 1972 Recreation Management Plan, the 1980 California Desert Conservation Area Plan, and the 1987 RAMP (BLM and CDFG 1987). According to the petitioners, the 1987 RAMP called for reduction in the proposed level of recreation development and dispersal of

intensive recreational use within Class I areas (an intensive-use category where the management objective is to enhance opportunities for ORV recreation). The 1987 RAMP also included the Algodones Dunes Wildlife Habitat Management Plan (HMP), implemented under the authority of the Sikes Act (16 U.S.C. 670a-670o). The petitioners state that the HMP mandated biennial surveys for Andrew's dune scarab beetle and action that should be taken to determine distribution and status of other endemic invertebrates. They further assert that permanent monitoring of endemic dune insects was mandated in the HMP, but surveys have not been conducted.

The petitioners quote statements in the DEIS (BLM 2002) about biology, distribution, and threats to Andrews' dune scarab beetle, Hardy's dune beetle, and Carlson's dune beetle (*Anomala carlsoni*). They also claim BLM's assessment (BLM 2002) of these three beetle species is inadequate and inaccurate given the information presented in their petition. The petitioners state the DEIS lists only five insect species as "known to occur or having the potential to occur" at Algodones Dunes, and BLM ignored nearly two dozen other endemic insects in this area for which scientific information is available. The petition notes the HMP mandated collection of demographic and distributional information would have provided data regarding population growth rates, survival, reproduction, and habitat use that would have been useful in developing the BLM management plan. The petitioners also state that no data were presented in the DEIS (BLM 2002) regarding distribution of endemic insect species in the Algodones Dunes, although such data are required before land-use decisions are made to ensure species are not jeopardized by Federal actions.

The petitioners state that, in light of known ORV impacts on endemic desert insects, regulatory mechanisms to protect these species should include permanent protection of habitats throughout the Algodones Dunes, including stringent enforcement closures. The petitioners also state all four 2002 DEIS alternatives would result in relaxed conservation measures compared to current levels of protection, including reopening thousands of acres currently protected from ORV use, and the DEIS specifically rejected an alternative that would have maintained the interim closures. According to the petitioners, three of the four alternatives in the DEIS (BLM 2002) would permit ORVs on 198,220 ac (80,251 ha), and only protect 27,695 ac (11,213 ha) which is already protected as designated wilderness. The petitioners included a table with the petition summarizing four 2002 DEIS allowed ORV activity level alternatives for three desert habitat types (creosote bush scrub, psammophytic scrub, and microphyll woodland). The information suggests that even the most protective alternative (Alternative 3) would allow ORV use in more than half the psammophytic scrub, one-third the creosote bush scrub, and one-fourth the microphyll woodland. The information also suggests that visitation rates by 2012 to 2013 are projected to increase 82 percent above the 1999 to 2000 levels, and sensitive dune habitats will be increasingly impacted.

Evaluation of Information in the Petition

We acknowledge that the 1980 California Desert Conservation Area Plan called for monitoring effects of vehicle use on wildlife habitats and populations, and identifying and protecting sensitive species in management decisions (BLM 1980, pp. 20 and 28). Also, the Algodones Dunes Wildlife HMP (BLM and CDFG 1987, pp. 16 and 18) had action items for determining distribution and status of endemic invertebrates, and biological resource trends of special management concern in relation to implementing resource allocation decisions. BLM has funded some inventory and status work on insects at the Algodones Dunes (Andrews *et al.* 1979; Hardy and Andrews 1980; Scarabaeus Associates 1991), but whether all the monitoring work outlined in historic management plans has been completed is unknown. Information on insect species in the Algodones Dunes is lacking, as previously discussed. We acknowledge that, if this information was available, it would better inform BLM management decisions.

The petitioners did not substantiate their claim that published peer-reviewed scientific literature is "replete" with studies documenting serious negative impacts of ORVs in desert systems. The petition cites primarily Busack and Bury (1974), Hardy and Andrews (1976), Bury *et al.* (1977), Berry (1980), Bury and Luckenbach (1983), Luckenbach and Bury (1983), Schultz (1988), Brooks (1995 and 1999), and Stebbins (1995), regarding this threat. We find these works to be credible sources, but only four investigated desert systems and were published as peer-reviewed scientific literature (Busack and Bury 1974; Luckenbach and Bury 1983; Brooks 1995 and 1999). The other references are either book chapters summarizing studies done by others, or agency reports. From our evaluation of the petition it appears that the petition overstated the amount of peer-reviewed scientific information regarding the effects of ORVs on desert systems.

Of the scientific peer-reviewed literature cited, only Luckenbach and Bury (1983) reported impacts to invertebrates. Luckenbach and Bury (1983) did study the Algodones Dunes, and reported "arthropod (mostly beetle) tracks were twenty-four times more abundant in control plots than in ORV impacted plots." However, Luckenbach and Bury's (1983) data was limited to the central dunes (near State Highway 78), and was not species-specific (observed tracks may not have included any of the petitioned species or reflect species abundance). Scarabeaus Associates' (1991) study was intended to investigate impacts of ORV use on Andrews' dune scarab beetle. However, results were inconclusive (Scarabeaus Associates 1991), partly because ORV use levels were not documented at sample sites for correlation with beetle abundance.

Regarding concerns expressed by petitioners, the final 2003 RAMP (BLM 2003) for the Imperial Sand Dunes Recreation Area does not address specific conservation, research, or monitoring of the insects identified in the petition. The only mention in the BLM 2003 RAMP of any of the insect species was for Hardy's dune beetle, recognizing this beetle is a "poorly known" BLM sensitive species (Issues, Concerns, and Opportunities section). The final 2003 RAMP utilizes the preferred alternative in the DEIS (Alternative 2, BLM 2002) referenced by petitioners. Under the final 2003 RAMP all-terrain vehicle, motorcycle, truck, and dune buggy ORV use will be prohibited in the 26,202-ac (10,608-ha) North Algodones Dunes Wilderness Management Area (BLM 2003; p. 71). This represents about 16 percent of the area of the ISDRA managed by BLM. It is true that interim vehicle use closure areas designated for the threatened Peirson's milk-vetch plant and desert tortoise (*Gopherus agassizii*) through legal stipulation (BLM 2002) would not be maintained (would be opened to ORV use) under the final 2003 RAMP (BLM 2003). However, these interim ORV closures are still in effect, and, as a result of a March 13, 2006 U.S. District Court ruling (*Center for Biological Diversity et al.* v. *Bureau of Land Management et al.* and *American Sand Association et al.*, No. C 03–02509 SI), BLM is not currently able to fully implement the 2003 RAMP. Therefore,

the petitioners' contention that implementation of the 2003 RAMP, which would then open currently closed areas to ORV use, poses an immediate threat to the 11 insect species is not accurate.

Regardless of the specific management and monitoring actions implemented by BLM at the Algodones Dunes, the central issue here is whether such management is inadequate because the associated ORV activity has or will adversely affect the 11 insect species such that listing may be warranted. Though the petitioners claim they "were unable to find a single study documenting positive or even neutral effects of ORVs," the petition does not contain substantial information that ORV activity adversely affects any of the 11 insect species. The final 2003 RAMP also specifies some positive management actions that would help conserve dune habitat and species, such as monitoring of ORV use and species and habitats of concern (BLM 2003; Appendix 1).

Because there is a lack of information on ORV effects on the 11 insect species and species-specific threats, there is no basis for finding existing regulatory protections are inadequate. Therefore, we find that the petition does not present substantial scientific or commercial information that lack of regulatory mechanisms may present a threat to any of the 11 insect species.

E. Other Natural or Manmade Factors Affecting the Species' Continued Existence

The petitioners state that pesticide use in agricultural areas of Imperial Valley may be having negative impacts on these species through pesticide drift into the Algodones Dunes. The petitioners also state that spraying programs for the curly top leafhopper virus are likely to directly impact the species. However, the petitioners do not provide data or cite published studies to support these claims. Additionally, no information provided in the petition or in our files indicates that direct mortality from ORV use currently threatens any of the petitioned insect species. Therefore, we find the petition does not contain substantial scientific or commercial information that other natural or manmade factors may be a factor threatening the continued existence of the petitioned insect species.

Finding

We evaluated each of the five listing factors individually, and because the threats to the 11 insect species are not mutually exclusive, we also evaluated the collective effect of these threats. The petition focused primarily on two listing factors: Factor A (the Present or Threatened Destruction, Modification, or Curtailment of the Species' Habitat or Range) and Factor D (Inadequacy of Existing Regulatory Mechanisms). More specifically, information in the petition suggests that ORV activity within the Algodones dunes has disturbed dune surfaces and underlying accumulated organic debris that could act as larval nurseries for endemic insects. Additionally, the petitioners assert any activities resulting in the decline of general plant cover and host plants would threaten survival of rare endemic insect species with highly restricted geographical ranges and highly specific habitat needs. However, the petition does not present specific information regarding impacts to any of the 11 insect species and we are not aware of specific information regarding the impacts of ORV activities on the 11 insect species.

Furthermore, the petition cites the inadequacy of mechanisms, specifically BLM management, as threatening the continued existence of the 16 insect species. Additionally, interim court-ordered closures are currently in effect in over 16 percent of the ISDRA; therefore, the petitioners' contention that implementation of the 2003 RAMP, which would open the currently closed areas to ORV use, poses an immediate threat to the 11 insect species is not accurate. However, the central issue is whether ORV activity will adversely affect the 11 insect species. As stated above, the petition did not present substantial information, nor are we aware of any information regarding the adverse effects of ORV on any of the 11 insect species.

We reviewed the petition and supporting information provided by the petitioners and evaluated that information in relation to other pertinent literature and information available at the time of the petition review. After this review and evaluation, we find (1) The vespid wasp (*Euparagia* n. sp.) is not a listable entity as defined by the Act since it is only identified by the petitioners to the genus level; (2) the petition does not provide substantial scientific information that the four subspecies of weevils (*Trigonoscuta rothi rothi*, *Trigonoscuta rothi algodones*, *Trigonoscuta rothi imperialis*, and *Trigonoscuta rothi punctata*) are scientifically accepted taxons; and (3) the petition does not present substantial scientific or commercial information to demonstrate listing the remaining 11 petitioned 16 insect species of the Algodones Dunes area as threatened or endangered may be warranted at this time. We encourage interested parties to continue gathering data that will assist with conservation of these species. Information regarding the 16 insect species may be submitted to the Field Supervisor, Carlsbad Fish and Wildlife Office (see **ADDRESSES** section) at any time.

References Cited

A complete list of all references cited herein is available, upon request, from the Carlsbad Fish and Wildlife Office (see **ADDRESSES**).

Author

The authors of this document are the staff of the Carlsbad Fish and Wildlife Office.

Authority

The authority for this action is the Endangered Species Act of 1973, as amended (16 U.S.C. 1531 *et seq.*).

Dated: August 1, 2006.

H. Dale Hall,

Director, U.S. Fish and Wildlife Service.

[FR Doc. E6–13109 Filed 8–17–06; 8:45 am]

BILLING CODE 4310–55–P

Notices

Federal Register
Vol. 71, No. 160
Friday, August 18, 2006

This section of the FEDERAL REGISTER contains documents other than rules or proposed rules that are applicable to the public. Notices of hearings and investigations, committee meetings, agency decisions and rulings, delegations of authority, filing of petitions and applications and agency statements of organization and functions are examples of documents appearing in this section.

COMMITTEE FOR PURCHASE FROM PEOPLE WHO ARE BLIND OR SEVERELY DISABLED

Procurement List Additions

AGENCY: Committee for Purchase From People Who Are Blind or Severely Disabled.

ACTION: Additions to Procurement List.

SUMMARY: This action adds to the Procurement List services to be furnished by nonprofit agencies employing persons who are blind or have other severe disabilities.

DATES: *Effective Date:* September 17, 2006.

ADDRESSES: Committee for Purchase From People Who Are Blind or Severely Disabled, Jefferson Plaza 2, Suite 10800, 1421 Jefferson Davis Highway, Arlington, Virginia 22202–3259.

FOR FURTHER INFORMATION CONTACT: Sheryl D. Kennerly, Telephone: (703) 603–7740, Fax: (703) 603–0655, or e-mail *SKennerly@jwod.gov*.

SUPPLEMENTARY INFORMATION: On June 23, 2006, the Committee for Purchase From People Who Are Blind or Severely Disabled published notice (71 FR 36061) of proposed additions to the Procurement List.

After consideration of the material presented to it concerning capability of qualified nonprofit agencies to provide the services and impact of the additions on the current or most recent contractors, the Committee has determined that the services listed below are suitable for procurement by the Federal Government under 41 U.S.C. 46–48c and 41 CFR 51–2.4.

Regulatory Flexibility Act Certification

I certify that the following action will not have a significant impact on a substantial number of small entities. The major factors considered for this certification were:

1. The action will not result in any additional reporting, recordkeeping or other compliance requirements for small entities other than the small organizations that will furnish the services to the Government.

2. The action will result in authorizing small entities to furnish the services to the Government.

3. There are no known regulatory alternatives which would accomplish the objectives of the Javits-Wagner-O'Day Act (41 U.S.C. 46–48c) in connection with the services proposed for addition to the Procurement List.

End of Certification

Accordingly, the following services are added to the Procurement:

Services

Service Type/Location: Administrative Services GSA, Federal Technology Service, 10304 Eaton Place, Fairfax, Virginia.
NPA: ServiceSource, Inc., Alexandria, Virginia.
Contracting Activity: GSA, Federal Technology Service, Ft. Huachuca, Arizona.

Service Type/Location: Laundry Service USDA, National Animal Disease Center, 2300 Dayton Avenue, Ames, Iowa.
NPA: Genesis Development, Jefferson, Iowa.
Contracting Activity: USDA, Agriculture Research Service, Peoria, Illinois.

Service Type/Location: Linen Exchange and Laundry Service 1st Medical Group Medical Treatment Facility (MTF), at the following locations: Langley AFB, Virginia, Main Facility—45 Pine Road, Dental Clinic—76 Nealy Avenue, Flight Medicine—Building 74, Physical Therapy—Building 267.
NPA: Louise W. Eggleston Center, Inc., Norfolk, Virginia.
Contracting Activity: 1st Contracting Squadron/LGCS, Langley AFB, Virginia.

This action does not affect current contracts awarded prior to the effective date of this addition or options that may be exercised under those contracts.

Sheryl D. Kennerly,

Director, Information Management.

[FR Doc. E6–13670 Filed 8–17–06; 8:45 am]

BILLING CODE 6353–01–P

COMMITTEE FOR PURCHASE FROM PEOPLE WHO ARE BLIND OR SEVERELY DISABLED

Procurement List; Proposed Additions and Deletions

AGENCY: Committee for Purchase From People Who Are Blind or Severely Disabled.

ACTION: Proposed Additions to and Deletions from Procurement List.

SUMMARY: The Committee is proposing to add to the Procurement List a product and services to be furnished by nonprofit agencies employing persons who are blind or have other severe disabilities, and to delete a product and a service previously furnished by such agencies.

Comments Must Be Received on or Before: September 17, 2006.

ADDRESSES: Committee for Purchase From People Who Are Blind or Severely Disabled, Jefferson Plaza 2, Suite 10800, 1421 Jefferson Davis Highway, Arlington, Virginia 22202–3259.

FOR FURTHER INFORMATION OR TO SUBMIT COMMENTS CONTACT: Sheryl D. Kennerly, Telephone: (703) 603–7740, Fax: (703) 603–0655, or e-mail *SKennerly@jwod.gov*.

SUPPLEMENTARY INFORMATION: This notice is published pursuant to 41 U.S.C 47(a)(2) and 41 CFR 51–2.3. Its purpose is to provide interested persons an opportunity to submit comments on the proposed actions.

Additions

If the Committee approves the proposed additions, the entities of the Federal Government identified in this notice for each product or service will be required to procure the product and service listed below from nonprofit agencies employing persons who are blind or have other severe disabilities.

Regulatory Flexibility Act Certification

I certify that the following action will not have a significant impact on a substantial number of small entities. The major factors considered for this certification were:

1. If approved, the action will not result in any additional reporting, recordkeeping or other compliance requirements for small entities other than the small organizations that will furnish the product and services to the Government.

2. If approved, the action will result in authorizing small entities to furnish the product and services to the Government.

3. There are no known regulatory alternatives which would accomplish the objectives of the Javits-Wagner-O'Day Act (41 U.S.C. 46–48c) in connection with the product and services proposed for addition to the Procurement List.

Comments on this certification are invited. Commenters should identify the statement(s) underlying the certification on which they are providing additional information.

End of Certification

The following product and services are proposed for addition to Procurement List for production by the nonprofit agencies listed:

Product

Product/NSN: Fluorescent Highlighter Set (GSA Global Supply only), 7520–01–383–7959.
NPA: San Antonio Lighthouse for the Blind, San Antonio, Texas.
Contracting Activity: Office Supplies & Paper Products Acquisition Center, New York, New York.

Services

Service Type/Location: Custodial Services, Port Isabel Detention Center, 27991 Buena Vista Road, Port Isabel, Texas.
NPA: Mavagi Enterprises, Inc., San Antonio, Texas.
Contracting Activity: DHS Immigration and Customs Enforcement, Dallas, Texas.
Service Type/Location: Full Food Service, Fort Drum, 45 West Street, Fort Drum, New York.
NPA: Jefferson County Chapter, NYSARC, Watertown, New York.
Contracting Activity: Army Contracting Agency, Fort Drum, New York.

Deletions

Regulatory Flexibility Act Certification

I certify that the following action will not have a significant impact on a substantial number of small entities. The major factors considered for this certification were:

1. If approved, the action may result in additional reporting, recordkeeping or other compliance requirements for small entities.

2. If approved, the action may result in authorizing small entities to furnish the product and service to the Government.

3. There are no known regulatory alternatives which would accomplish the objectives of the Javits-Wagner-O'Day Act (41 U.S.C. 46–48c) in connection with the product and service proposed for deletion from the Procurement List.

End of Certification

The following product and service are proposed for deletion from the Procurement List:

Products

Product/NSNs: Pad, Floor Polishing Machine
7910–00–985–6851
7910–00–985–6853
7910–00–985–6855
7910–00–985–6856
7910–00–985–6857
7910–00–985–6858
7910–00–985–6859
7910–00–985–6860
7910–00–985–6861
7910–00–985–6862
7910–00–985–6863
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7910–00–985–6870
7910–00–985–6871
7910–00–985–6872
7910–00–985–6873
7910–00–985–6874
7910–00–985–6875
7910–00–985–6876
7910–00–985–6800
NPA: Beacon Lighthouse, Inc., Wichita Falls, Texas.
Contracting Activity: GSA, Southwest Supply Center, Fort Worth, Texas.
Product/NSNs: Floor Scrubbing Machine Pad
7910–00–NIB–0021—Lime, 19 in. diam., High Speed
7910–00-NIB–0022—Lime, 21 in. diam., High Speed
7910–00–NIB–0023—Dark Green, 22 in. diam., High Speed
NPA: Beacon Lighthouse, Inc., Wichita Falls, Texas.
Contracting Activity: GSA, Southwest Supply Center, Fort Worth, Texas.

Service

Service Type/Location: Janitorial/Custodial, Military Traffic Management Command, 1312th Medium Port Command, Compton, California.
NPA: None currently authorized.
Contracting Activity: Department of the Army.

Sheryl D. Kennerly,

Director, Information Management.

[FR Doc. E6–13671 Filed 8–17–06; 8:45 am]

BILLING CODE 6353–01–P

COMMITTEE FOR PURCHASE FROM PEOPLE WHO ARE BLIND OR SEVERELY DISABLED

Correction of Notice of Addition

AGENCY: Committee for Purchase From People Who Are Blind or Severely Disabled.

ACTION: Correction to Notice of Additions to the Procurement List.

SUMMARY: In the document appearing on page 46187, FR Doc E6–13162, Procurement List Additions and Deletions, in the issue of August 11, 2006, in the third column, the Committee published addition of Grounds/Custodial Security Services, Lake Okeechobee and Outlying Areas, Army Corps of Engineers, Lake Okeechobee, Florida. Following the publication of this Notice, the Committee determined that the response to comments received in response to the **Federal Register** Notice of Proposed Addition had not been published in the August 11 Notice as required. The Committee therefore is publishing the Service again with the response to comments received. All other information remains the same.

DATES: *Effective Date:* September 10, 2006.

ADDRESSES: Committee for Purchase From People Who Are Blind or Severely Disabled, Jefferson Plaza 2, Suite 10800, 1421 Jefferson Davis Highway, Arlington, Virginia 22202–3259.

FOR FURTHER INFORMATION CONTACT: Sheryl D. Kennerly, Telephone: (703) 603–7740, Fax: (703) 603–0655, or e-mail *SKennerly@jwod.gov*.

Addition

Service Type/Location: Grounds/Custodial/Security Services, Lake Okeechobee and Outlying Areas, Army Corps of Engineers, Lake Okeechobee, Florida.
NPA: Gulfstream Goodwill Industries, Inc., West Palm Beach, Florida.
Contracting Activity: U.S. Army Corps of Engineers, Jacksonville, Florida.

The following material is in response to comments received on this proposed addition. This information was provided to the Committee for their consideration.

Comments were received from the current contractor, a subcontractor for the service, an employee of the subcontractor, and a frequent camper on parkland involved in this service. All these persons objected to addition of the service to the Procurement List.

The service to be performed by a nonprofit agency has been removed from the coverage of the current contract. The current contractor claimed that removal of these functions will result in a significant reduction in the contractor's revenue base and severely affect its financial stability, while making it less competitive to recover the revenue elsewhere.

The period for which the contractor submitted revenues to the Committee includes windfall revenues due to increased hurricane activity during that period. Removal of these windfalls reduces the estimated revenue loss attributable to the addition of the service to the Procurement List to a

level which the Committee does not normally consider to be an adverse impact on a contractor.

The subcontractor and its employee indicated that addition of the service to the Procurement List would have a serious economic impact on the company, its workers, and the depressed rural area where the service is performed. The nonprofit agency which will be performing the service will do some subcontracting, which could mitigate this economic impact. In addition, people with severe disabilities have an unemployment rate of approximately 70 percent, which exceeds the unemployment rate of the persons likely to be adversely affected by this addition to the Procurement List. Consequently, the affected persons are more likely than those who will be employed on the project to find other work. Given that circumstance, and the Committee's mission to create work for people with severe disabilities, the Committee believes that the employment benefits of adding this service to the Procurement List outweigh the possible disadvantages the addition may cause.

The subcontractor and its employee also raised several safety and technical issues concerning performance of the service by people with severe disabilities. They noted that some mowing must be done on a high levee with extremely steep sides and surrounded by deep canals, and other mowing is done in park areas filled with expensive recreational vehicles and other easily damaged obstacles, as the frequent camper also noted. The subcontractor employee asked if the nonprofit agency has any experience in doing this kind of work. The subcontractor implied that acquisition of the equipment needed to do the work would put a further strain on the national budget.

The nonprofit agency has several grounds maintenance and custodial contracts with the State of Florida, so they are familiar with this kind of work. They are in the process of obtaining the specialized equipment needed to do the work and hiring qualified personnel. The Government will not pay extra to allow the nonprofit agency to acquire this equipment, which includes enclosed cab tractors with built-in and included safety equipment. The nonprofit agency will conduct extensive safety and other training to assure the workers are fully capable of doing the work. More experienced workers will be used in the steeper areas, and the use of people with severe disabilities will be phased in to all facets of the work, which includes custodial and security as well as grounds maintenance services, to assure that all workers are able to do the work safely and efficiently, with little or no damage to persons or property.

After consideration of the material presented to it concerning capability of qualified nonprofit agencies to provide the products and impact of the additions on the current or most recent contractors, the Committee has determined that the service listed below is suitable for procurement by the Federal Government under 41 U.S.C. 46–48c and 41 CFR 51–2.4.

Sheryl D. Kennerly,

Director, Information Management.

[FR Doc. E6–13672 Filed 8–17–06; 8:45 am]

BILLING CODE 6353–01–P

DEPARTMENT OF COMMERCE

International Trade Administration

[C–427–819]

Final Results of Countervailing Duty Administrative Review: Low Enriched Uranium from France

AGENCY: Import Administration, International Trade Administration, Department of Commerce.

SUMMARY: On February 15, 2006, the Department of Commerce ("the Department") published in the **Federal Register** its preliminary results of administrative review of the countervailing duty ("CVD") order on low enriched uranium ("LEU") from France for the period January 1, 2004, through December 31, 2004 (*see Notice of Preliminary Results of Countervailing Duty Administrative Review: Low Enriched Uranium from France*, 71 FR 7924 (February 15, 2006) ("*LEU 2004 Preliminary Results*")). The Department has now completed the administrative review in accordance with section 751(a) of the Tariff Act of 1930, as amended ("the Act").

Based on our analysis of the comments received, the Department has not revised the net subsidy rate for Eurodif S.A. ("Eurodif")/Compagnie Generale Des Matieres Nucleaires ("COGEMA"), the producer/exporter of subject merchandise covered by this review. For further discussion of our analysis of the comments received for these final results, *see* the August 14, 2006, Issues and Decision Memorandum from Stephen J. Claeys, Deputy Assistant Secretary for Import Administration, to David M. Spooner, Assistant Secretary for Import Administration, concerning the Final Results of Countervailing Duty Administrative Review: Low Enriched Uranium from France ("LEU 2004 Decision Memorandum"). The final net subsidy rate for Eurodif/COGEMA is listed below in "Final Results of Review."

EFFECTIVE DATE: August 18, 2006.

FOR FURTHER INFORMATION CONTACT: Kristen Johnson, AD/CVD Operations, Office 3, Import Administration, U.S. Department of Commerce, Room 4014, 14th Street and Constitution Avenue, NW, Washington, DC 20230; telephone: (202) 482–4793.

SUPPLEMENTARY INFORMATION:

Background

On February 15, 2006, the Department published in the **Federal Register** the preliminary results for this review (*see LEU 2004 Preliminary Results*). We invited interested parties to comment on the results. On March 20, 2006, we received case briefs from petitioners[1] and Eurodif/COGEMA and the Government of France ("GOF"), the respondents. On March 23, 2006, and March 24, 2006, we received rebuttal briefs from respondents and petitioners, respectively. On May 2, 2006, the Department published in the **Federal Register** a notice of extension of the deadline for the final results of this administrative review. *See Low Enriched Uranium from France: Extension of Time Limit for Final Results of Countervailing Duty Administrative Review*, 71 FR 25813 (May 2, 2006).

Pursuant to 19 CFR 351.213(b), this review covers only those producers or exporters of the subject merchandise for which a review was specifically requested. Accordingly, this review covers only Eurodif/COGEMA. The review covers the period January 1, 2004, through December 31, 2004, and two programs.

Scope of the Order

The product covered by this order is all LEU. LEU is enriched uranium hexafluoride (UF_6) with a U_{235} product assay of less than 20 percent that has not been converted into another chemical form, such as UO_2, or fabricated into nuclear fuel assemblies, regardless of the means by which the LEU is produced (including LEU produced through the down–blending of highly enriched uranium).

Certain merchandise is outside the scope of this order. Specifically, this order does not cover enriched uranium hexafluoride with a U_{235} assay of 20

[1] Petitioners are the United States Enrichment Corporation ("USEC") and USEC Inc.

percent or greater, also known as highly enriched uranium. In addition, fabricated LEU is not covered by the scope of this order. For purposes of this order, fabricated uranium is defined as enriched uranium dioxide (UO_2), whether or not contained in nuclear fuel rods or assemblies. Natural uranium concentrates (U_3O_8) with a U_{235} concentration of no greater than 0.711 percent and natural uranium concentrates converted into uranium hexafluoride with a U_{235} concentration of no greater than 0.711 percent are not covered by the scope of this order.

Also excluded from this order is LEU owned by a foreign utility end–user and imported into the United States by or for such end–user solely for purposes of conversion by a U.S. fabricator into uranium dioxide (UO_2) and/or fabrication into fuel assemblies so long as the uranium dioxide and/or fuel assemblies deemed to incorporate such imported LEU (i) remain in the possession and control of the U.S. fabricator, the foreign end–user, or their designated transporter(s) while in U.S. customs territory, and (ii) are re–exported within eighteen (18) months of entry of the LEU for consumption by the end–user in a nuclear reactor outside the United States. Such entries must be accompanied by the certifications of the importer and end user.

The merchandise subject to this order is currently classifiable in the Harmonized Tariff Schedule of the United States ("HTSUS") at subheading 2844.20.0020. Subject merchandise may also enter under 2844.20.0030, 2844.20.0050, and 2844.40.00. Although the HTSUS subheadings are provided for convenience and customs purposes, the written description of the merchandise is dispositive.

Analysis of Comments Received

All issues raised in the case and rebuttal briefs by parties to this review are addressed in the LEU 2004 Decision Memorandum, which is hereby adopted by this notice. A list of the issues contained in that decision memorandum is attached to this notice as Appendix I. Parties can find a complete discussion of the issues raised in this review and the corresponding recommendations in that public memorandum, which is on file in the Central Records Unit, room B–099 of the Main Commerce Building. In addition, a complete copy of the LEU 2004 Decision Memorandum can be accessed directly on the World Wide Web at http://ia.ita.doc.gov/frn. The paper copy and electronic version of the decision memorandum are identical in content.

Final Results of Review

In accordance with section 705(c)(1)(B)(i) of the Act, we calculated an *ad valorem* subsidy rate for Eurodif/COGEMA. For the review period, we determine the net subsidy rate to be 5.06 percent *ad valorem*.

As discussed in Comment 4 of the LEU 2004 Decision Memorandum, we have been enjoined from liquidating entries of the subject merchandise. Therefore, we do not intend to issue liquidation instructions to U.S. Customs and Border Protection ("CBP") for entries made during the period January 1, 2004, through December 31, 2004, until such time as the injunctions, issued on June 24, 2002, November 1, 2004, and October 12, 2005, are lifted.

We will, however, instruct CBP, within 15 days of publication of the final results of this review, to collect cash deposits of estimated countervailing duties at 5.06 percent *ad valorem* of the f.o.b. price on all shipments of the subject merchandise from the reviewed entity, entered, or withdrawn from warehouse, for consumption on or after the date of publication of the final results.

We will also instruct CBP to continue to collect cash deposits for non–reviewed companies at the most recent company–specific rate applicable to the company. Accordingly, the cash deposit rate that will be applied to non–reviewed companies covered by this order will be the rate for that company established in the investigation. *See Amended Final Determination and Notice of Countervailing Duty Order: Low Enriched Uranium from France*, 67 FR 6689 (February 13, 2002). The "all others" rate shall apply to all non–reviewed companies until a review of a company assigned this rate is requested.

This notice also serves as a reminder to parties subject to administrative protective order ("APO") of their responsibility concerning the disposition of proprietary information disclosed under APO in accordance with 19 CFR 351.305(a)(3). Timely written notification of return/destruction of APO materials or conversion to judicial protective order is hereby requested. Failure to comply with the regulations and the terms of an APO is a sanctionable violation.

This administrative review and this notice are issued and published in accordance with section 751(a)(1) and 777(i)(1) of the Act.

Dated: August 14, 2006.

Joseph A. Spetrini,

Acting Assistant Secretary for Import Administration.

APPENDIX I—ISSUES AND DECISION MEMORANDUM

[FR Doc. E6–13683 Filed 8–17–06; 8:45 am]
BILLING CODE 3510–DS–S

DEPARTMENT OF COMMERCE

International Trade Administration

Mission Statement; Secretarial Business Development Mission to China; November 13–17, 2006

AGENCY: International Trade Administration, Department of Commerce.

ACTION: Notice.

I. Mission Description

Secretary of Commerce Carlos M. Gutierrez will lead a senior-level U.S. business delegation to Beijing and Shanghai, China, November 13–17, 2006, to promote U.S. exports to China's leading industry sectors.

The Mission will focus on assisting U.S. companies that are experienced exporters enter the Chinese market for the first time as well as assist U.S. companies operating in China increase their current level of exports. The Mission will help participating firms gain market information, make business and government contacts, solidify business strategies, and advance specific projects, all geared towards the goal of helping U.S. firms expand their exports to China. The Mission will include business-to-business matchmaking appointments with local companies, as well as meetings with key government officials, and American and local chambers of commerce. The Mission will additionally provide a platform for policy and commercial issues—including intellectual property rights protection, transparency, and rule-of-law—that U.S. companies face in the Chinese market. The delegation will be

comprised of U.S. firms representing a broad-cross section of U.S. industries with commercial interests in China.

Senior representatives of the U.S. Trade Development Agency (USTDA), the U.S. Export-Import Bank (Ex-Im), and the U.S. Small Business Administration (SBA), will be invited to participate, to provide information and counseling on their programs as they relate to the Chinese market.

II. Commercial Setting

China is the fastest-growing major market in the world. It is now the third-largest trading nation and America's third-largest trading partner. Total bilateral trade with the U.S. in 2005 was $243 billion. Total U.S. exports to China in 2005 were $41 billion, an increase of 19 percent over 2004. Through May 2006, U.S. exports have grown 37 percent over the same period last year. As America's fourth-largest export market, China provides excellent opportunities for U.S. companies in a number of industries. For instance, China's telecommunications products and services import market is estimated to exceed $20 billion this year. Other strong industry import markets include a $10 billion market for semiconductor equipment, water and wastewater treatment market of $8 billion, a $7 billion market for automotive components, and a medical equipment market that will exceed $4 billion this year. In addition, as one of the world's major energy users, China's power generation equipment import market is expected to surpass $5 billion in 2006. Other leading export sectors identified by the U.S. Embassy in China include, air traffic control, safety and security, mining, construction, education, and machinery.

While many U.S. companies have been extremely successful in China, some have struggled or failed. Huge opportunities exist in China, but the business environment in the country remains difficult. Major challenges include intellectual property rights violations, a lack of transparency in rules and regulations, and inadequate rule-of-law. Some U.S. companies, especially small and medium-sized companies, underestimate the difficulty of entering and succeeding in this market. The Mission is designed to assist U.S. companies to identify the opportunities and address the challenges.

III. Mission Goals

The Business Development Mission will assist U.S. businesses initiate or expand their exports to China's leading industry sectors by making business-to-business introductions, providing market access information, and providing access to government decision makers. The Mission aims to:

- Assist U.S. companies that are experienced exporters enter China for the first time;
- Assist U.S. companies already operating in China increase their business there;
- Address obstacles to trade with China, including transparency, intellectual property rights protection, and rule of law;
- Provide information on U.S. Government trade financing programs, through the inclusion of representatives from USTDA, Ex-Im and SBA.

IV. Mission Scenario

The Business Development Mission to China will include stops in Beijing and Shanghai. In each city, participants will:

- Meet with potential buyers, agents/distributors and partners;
- Meet with high-level government officials; and
- Attend briefings conducted by embassy officials on the economic and commercial climates.

Receptions and other business events will be organized to provide mission participants with further opportunities to speak with local business and government representatives, as well as U.S. business executives living and working in the region.

V. Timetable

November 12–17, 2006

Nov 12: Arrive Beijing.

Nov 13: Briefing on market conditions by U.S. Government officials. Briefing by AmCham members and official meetings.

Nov 14: Matchmaking with local companies and official meetings. Reception hosted by Ambassador.

Nov 15: Travel to Shanghai. Briefing on market conditions by U.S. Government officials and AmCham members. Official meetings.

Nov 16: Matchmaking with local companies. Reception hosted by Consul General.

Nov 17: Mission concludes.

VI. Criteria for Participants' Selection

The following criteria would apply to participant selection:

- Demonstrated export experience;
- Relevance of a company's business line to mission goals;
- Suitability of a company's products or services to the Chinese market and likelihood of a participating company increasing its exports to China within a year as a result of this mission;
- Timeliness of the company's signed application materials and participation agreement (including the participation fee)*;
- Target of 20 to 30 participating companies on the Mission;
- Rank/seniority of the designated company representative;
- Diversity of company size, type, location, demographics, and traditional under-representation in business;
- Provision of adequate information on the company's products and/or services, and the company's primary market objectives, in order to facilitate appropriate pre-qualification of company by embassy staff; and
- Certification that the company meets Departmental guidelines for participation. A company's products or services should be either produced in the United States, or, if not, marketed under the name of a U.S. firm and have at least fifty-one percent U.S. content.

The participation fee will be $8,500 per firm, which includes one representative. The fee for each additional firm representative is $3,000. The option to participate in the Mission is also being offered to U.S.-based firms in China or the region; the same fee structure applies. Expenses for travel, lodging, and incidentals will be the responsibility of each mission participant.

Any partisan political activities (including political contributions) of an applicant are entirely irrelevant to the selection process.

VII. Timeframe for Recruitment and Applications

Mission recruitment will be conducted in an open and public manner, including publication in the **Federal Register**, posting on the Commerce Department trade mission calendar (*http://www.ita.doc.gov/doctm/tmcal.html*) and other Internet Web sites, press releases to general and trade media, direct mail, broadcast fax, notices by industry trade associations and other multiplier groups, and publicity at industry meetings, symposia, conferences, and trade shows. The Commercial Service will explore and welcome outreach assistance from other interested organizations, including other U.S. Government agencies.

Applications for the Mission will be made available July 24, 2006 through September 14, 2006. Applications can be obtained from the U.S. Department of Commerce Office of Business Liaison

* Upon completion of the application submission and review process, companies that have been selected to participate will be required to complete a participation agreement and pay a participation fee.

(Phone: 202–482–1360, e-mail *chinamission@doc.gov*) or from the Mission Web site at *http://www.export.gov/chinamission*.

The application deadline is September 15, 2006. Completed applications should be submitted to the Office of Business Liaison. Applications received after September 15, 2006 will be considered only if space and scheduling constraints permit.

Domestic Contact Information: The Office of Business Liaison, Tel: 202–482–1360.

Patrick Kirwan,

Director, Trade Promotion Coordinating Committee Secretariat.

[FR Doc. E6–13772 Filed 8–17–06; 8:45 am]

BILLING CODE 3510–25–P

DEPARTMENT OF COMMERCE

National Institute of Standards and Technology (NIST)

Board of Overseers of the Malcolm Baldrige National Quality Award

AGENCY: National Institute of Standards and Technology, Department of Commerce.

ACTION: Request for nominations of members to serve on the Board of Overseers of the Malcolm Baldrige National Quality Award.

SUMMARY: NIST invites and requests nomination of individuals for appointment to Board of Overseers of the Malcolm Baldrige National Quality Award (Board). The terms of some of the members of the Board will soon expire. NIST will consider nominations received in response to this notice for appointment to the Committee, in addition to nominations already received.

DATES: Please submit nominations on or before September 5, 2006.

ADDRESSES: Please submit nominations to Harry Hertz, Director, National Quality Program, NIST, 100 Bureau Drive, Mail Stop 1020, Gaithersburg, MD 20899–1020. Nominations may also be submitted via FAX to 301–948–3716. Additional information regarding the Committee, including its charter, current membership list, and executive summary may be found on its electronic home page at: *http://www.quality.nist.gov*.

FOR FURTHER INFORMATION CONTACT: Harry Hertz, Director, National Quality Program and Designated Federal Official, NIST, 100 Bureau Drive, Mail Stop 1020, Gaithersburg, MD 20899–1020; telephone 301–975–2361; FAX—301–948–3716; or via e-mail at *harry.hertz@nist.gov*.

SUPPLEMENTARY INFORMATION:

I. Board of Overseers of the Malcolm Baldrige National Quality Award Information

The Board was established in accordance with 15 U.S.C. 3711a(d)(2)(B), pursuant to the Federal Advisory Committee Act (5 U.S.C. app. 2).

Objectives and Duties

1. The Board shall review the work of the private sector contractor(s), which assists the Director of the National Institute of Standards and Technology (NIST) in administering the Award. The Board will make such suggestions for the improvement of the Award process as it deems necessary.

2. The Board shall provide a written annual report on the results of Award activities to the Secretary of Commerce, along with its recommendations for the improvement of the Award process.

3. The Board will function solely as an advisory committee under the Federal Advisory Committee Act.

4. The Board will report to the Director of NIST and the Secretary of Commerce.

Membership

1. The Board will consist of approximately eleven members selected on a clear, standardized basis, in accordance with applicable Department of Commerce guidance, and for their preeminence in the field of quality management. There will be a balanced representation from U.S. service, manufacturing, education, health care industries, and the nonprofit sector including government. The Board will include members familiar with the quality improvement operations of organizations representing manufacturing, service, small business, education, health care, and the nonprofit sector. No employee of the Federal Government shall serve as a member of the Board of Overseers.

2. The Board will be appointed by the Secretary of Commerce and will serve at the discretion of the Secretary. The term of office of each Board member shall be three years. All terms will commence on March 1 and end on February 28 of the appropriate year.

Miscellaneous

1. Members of the Board shall serve without compensation, but may, upon request, be reimbursed travel expenses, including per diem, as authorized by 5 U.S.C. 5701 *et seq.*

2. The Board will meet twice annually, except that additional meetings may be called as deemed necessary by the NIST Director or by the Chairperson. Meetings are one day in duration.

3. Board meetings are open to the public. Board members do not have access to classified or proprietary information in connection with their Board duties.

II. Nomination Information

1. Nominations are sought from the private sector as described above.

2. Nominees should have established records of distinguished service and shall be familiar with the quality improvement operations of manufacturing companies, service companies, small businesses, education, and health care. The category (field of eminence) for which the candidate is qualified should be specified in the nomination letter. Nominations for a particular category should come from organizations or individuals within that category. A summary of the candidate's qualifications should be included with the nomination, including (where applicable) current or former service on Federal advisory boards and Federal employment. In addition, each nomination letter should state that the person agrees to the nomination, acknowledges the responsibilities of serving on the Board, and will actively participate in good faith in the tasks of the Board. Besides participation at meetings, it is desired that members be able to devote the equivalent of seven days between meetings to either developing or researching topics of potential interest, and so forth, in furtherance of their Board duties.

3. The Department of Commerce is committed to equal opportunity in the workplace and seeks a broad-based and diverse Board membership.

Dated: August 14, 2006.

James E. Hill,

Acting Deputy Director.

[FR Doc. E6–13675 Filed 8–17–06; 8:45 am]

BILLING CODE 3510–13–P

DEPARTMENT OF COMMERCE

National Institute of Standards and Technology (NIST)

Judges Panel of the Malcolm Baldrige National Quality Award

AGENCY: National Institute of Standards and Technology, Department of Commerce.

ACTION: Request for nominations of members to serve on the Judges Panel of

the Malcolm Baldrige National Quality Award.

SUMMARY: NIST invites and requests nomination of individuals for appointment to the Judges Panel of the Malcolm Baldrige National Quality Award (Judges Panel). The terms of some of the members of the Judges Panel will soon expire. NIST will consider nominations received in response to this notice for appointment to the Committee, in addition to nominations already received.

DATES: Please submit nominations on or before September 5, 2006.

ADDRESSES: Please submit nominations to Harry Hertz, Director, National Quality Program, NIST, 100 Bureau Drive, Mail Stop 1020, Gaithersburg, MD 20899–1020. Nominations may also be submitted via FAX to 301–948–3716. Additional information regarding the Committee, including its charter, current membership list, and executive summary may be found on its electronic home page at: *http://www.quality.nist.gov.*

FOR FURTHER INFORMATION CONTACT: Harry Hertz, Director, National Quality Program and Designated Federal Official, NIST, 100 Bureau Drive, Mail Stop 1020, Gaithersburg, MD 20899–1020; telephone 301–975–2361; FAX—301–948–3716; or via e-mail at *harry.hertz@nist.gov.*

SUPPLEMENTARY INFORMATION:

I. Judges Panel Information

The Judges Panel was established in accordance with 15 U.S.C. 3711a(d)(1), the Federal Advisory Committee Act (5 U.S.C. app.2), The Malcolm Baldrige National Quality Improvement Act of 1987 (Public Law 101–107).

Objectives and Duties

1. The Judges Panel will ensure the integrity of the Malcolm Baldrige National Quality Award selection process by reviewing the results of examiners' scoring of written applications, and then voting on which applicants merit site visits by examiners to verify the accuracy of quality improvements claimed by applicants.

2. The Judges Panel will ensure that individuals on site visit teams for the Award finalists have no conflict of interest with respect to the finalists. The Panel will also review recommendations from site visits, and recommend Award recipients.

3. The Judges Panel will function solely as an advisory body, and will comply with the provisions of the Federal Advisory Committee Act.

4. The Panel will report to the Director of NIST.

Membership

1. The Judges Panel is composed of at least nine, and not more than twelve, members selected on a clear, standardized basis, in accordance with applicable Department of Commerce guidance. There will be a balanced representation from U.S. service, manufacturing, education, health care industries, and the nonprofit sector including government. The Panel will include members familiar with the quality improvement operations of organizations representing manufacturing, service, small business, education, health care, and the nonprofit sector. No employee of the Federal Government shall serve as a member of the Judges Panel.

2. The Judges Panel will be appointed by the Secretary of Commerce and will serve at the discretion of the Secretary. The term of office of each Panel member shall be three years. All terms will commence on March 1 and end on February 28 of the appropriate year.

Miscellaneous

1. Members of the Judges Panel shall serve without compensation, but may, upon request, be reimbursed travel expenses, including per diem, as authorized by 5 U.S.C. 5701 *et seq.*

2. The Judges Panel will meet four times per year. Additional meetings may be called as deemed necessary by the NIST Director or by the Chairperson. Meetings are one to four days in duration. In addition, each Judge must attend an annual three-day Examiner training course.

3. Committee meetings are closed to the public pursuant to Section 10(d) of the Federal Advisory Committee Act, 5 U.S.C. app. 2, as amended by Section 5(c) of the Government in the Sunshine Act, Pub. L. 94–409, and in accordance with Section 552b(c)(4) of title 5, United States Code. Since the members of the Judges Panel examine records and discuss Award applicant data, the meeting is likely to disclose trade secrets and commercial or financial information obtained from a person may be privileged or confidential.

II. Nomination Information

1. Nominations are sought from all U.S. service and manufacturing industries, education, and health care as described above.

2. Nominees should have established records of distinguished service and shall be familiar with the quality improvement operations of manufacturing companies, service companies, small businesses, education and health care organizations. The category (field of eminence) for which the candidate is qualified should be specified in the nomination letter. Nominations for a particular category should come from organizations or individuals within that category. A summary of the candidate's qualifications should be included with the nomination, including (where applicable) current or former service on Federal advisory boards and Federal employment. In addition, each nomination letter should state that the person agrees to the nomination, acknowledge the responsibilities of serving on the Judges Panel, and will actively participate in good faith in the tasks of the Judges Panel. Besides participation at meetings, it is desired that members be able to devote the equivalent of seventeen days between meetings to either developing or researching topics of potential interest, reading Baldrige applications, and so forth, in furtherance of their Committee duties.

3. The Department of Commerce is committed to equal opportunity in the workplace and seeks a broad-based and diverse Judges Panel membership.

Dated: August 14, 2006.

James E. Hill,

Acting Deputy Director.

[FR Doc. E6–13676 Filed 8–17–06; 8:45 am]

BILLING CODE 3510–13–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

[I.D. 080306B]

Endangered Species; File No. 1572

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Notice; issuance of permit.

SUMMARY: Notice is hereby given that Amanda Southwood, Department of Biology and Marine Biology, University of North Carolina at Wilmington, 601 S. College Road, Wilmington, North Carolina 28403 has been issued a permit to take loggerhead (*Caretta caretta*), green (Chelonia mydas), and Kemp's ridley (*Lepidochelys kempii*) sea turtles for purposes of scientific research.

ADDRESSES: The permit and related documents are available for review upon written request or by appointment in the following office(s):

Permits, Conservation and Education Division, Office of Protected Resources,

NMFS, 1315 East-West Highway, Room 13705, Silver Spring, MD 20910; phone (301)713–2289; fax (301)427–2521; and

Southeast Region, NMFS, 263 13th Ave South, St. Petersburg, FL 33701; phone (727)824–5312; fax (727)824–5309.

FOR FURTHER INFORMATION CONTACT: Patrick Opay or Kate Swails, (301)713–2289.

SUPPLEMENTARY INFORMATION: On April 12, 2006, notice was published in the **Federal Register** (71 FR 18726) that a request for a scientific research permit to take loggerhead, green, and Kemp's ridley sea turtles had been submitted by the above-named individual. The requested permit has been issued under the authority of the Endangered Species Act of 1973, as amended (ESA; 16 U.S.C. 1531 *et seq.*) and the regulations governing the taking, importing, and exporting of endangered and threatened species (50 CFR parts 222–226).

The purpose of the research is to assess the physiological response of loggerhead, green, and Kemp's ridley sea turtles to entanglement in fishing gear, identify post-release mortality events, and integrate these data to assess the feasibility of using biochemical indices as predictors of post-release mortality. The research will also provide information on the movements of sea turtles utilizing the lower Cape Fear River, North Carolina. Researchers would annually capture up to 15 loggerhead, 25 green, and 5 Kemp's ridley sea turtles for a 3–year period using gillnets. Animals would be measured, weighed, blood sampled, passive integrated transponder tagged, satellite transmitter tagged, VHF tagged and tracked, have their cloacal body temperature taken, and be released. The level of post-release mortality of turtles that are part of the physiological stress portion of the research may be high and reach up to 30 percent (9 animals per year or 27 over the course of the permit, all species combined). The principal investigator believes that current fishery mortality estimates are too high; therefore the study is being permitted for one year to gain a better understanding of actual mortality levels. Research after year one is contingent on the results of the first year and will only be authorized if NMFS determines further research is warranted and can be justified.

Issuance of this permit, as required by the ESA, was based on a finding that such permit (1) was applied for in good faith, (2) will not operate to the disadvantage of any endangered or threatened species, and (3) is consistent with the purposes and policies set forth in section 2 of the ESA.

Dated: August 14, 2006.

P. Michael Payne,

Chief, Permits, Conservation and Education Division, Office of Protected Resources, National Marine Fisheries Service.

[FR Doc. E6–13692 Filed 8–17–06; 8:45 am]

BILLING CODE 3510–22–S

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

National Sea Grant Review Panel

AGENCY: National Oceanic and Atmospheric Administration, Commerce.

ACTION: Notice of public meeting.

SUMMARY: This notice sets forth the schedule and proposed agenda of a forthcoming meeting of the Sea Grant Review Panel. The meeting will have several purposes. Panel members will discuss and provide advice on the National Sea Grant College Program in the areas of program evaluation, strategic planning, education and extension, science and technology programs, and other matters as described below:

DATES: The announced meeting is scheduled for: Tuesday, August 29, 2006.

ADDRESSES: Conference Call. Public access is available at SSMC Bldg 3, ROOM # 12836, 1315 East-West Highway, Silver Spring, MD.

FOR FURTHER INFORMATION CONTACT: Mr. Joseph Brown, National Sea Grant College Program, National Oceanic and Atmospheric Administration, 1315 East-West Highway, Room 11717, Silver Spring, Maryland 20910, (301) 713–2438.

SUPPLEMENTARY INFORMATION: The Panel, which consists of a balanced representation from academia, industry, state government and citizens groups, was established in 1976 by Section 209 of the Sea Grant Improvement Act (Public Law 94–461, 33 U.S.C. 1128). The Panel advises the Secretary of Commerce and the Director of the National Sea Grant College Program with respect to operations under the Act, and such other matters as the Secretary refers to them for review and advice. The agenda for the meeting is as follows:

Wednesday, August 30, 2006—1 to 4 p.m.

Agenda

I. Old Business.
II. Sea Grant Staffing.
III. NRC Report.

This meeting will be open to the public.

Dated: August 11, 2006.

Mark Brown,

Acting Deputy Assistant Administrator, Office of Oceanic and Atmospheric Research.

[FR Doc. E6–13696 Filed 8–17–06; 8:45 am]

BILLING CODE 3510–KA–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

[I.D. 080306A]

Pacific Albacore Tuna Fisheries; Updating Annual Vessel List

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Notice.

SUMMARY: NMFS revises the methodology to create a vessel list at the beginning of each calendar year of vessels eligible to fish for albacore tuna in Canadian waters. The vessel list reverts to zero vessels on December 31 of each year, unless NMFS receives a notice for a vessel to be added to the list for the upcoming year, with the requisite information. This notice clarifies NMFS' original intention that the vessel list remain valid for a single calendar year. Revising the way the list is created and updating the list every year is intended to facilitate the United States' obligation to annually provide Canada a current list of U. S. vessels that are likely to fish albacore off the coast of Canada.

ADDRESSES: Submit requests to be added to the vessel list of those vessels desiring to fish in Canadian waters to:

- E-mail: *albacore.fish@noaa.gov.*
- Mail: Mark Helvey, Assistant Regional Administrator, Southwest Region, NMFS, 501 West Ocean Blvd., Suite 4200, Long Beach, CA 90802–4213.
- Phone: (562)980–4024.
- Fax: (562) 980–4047.

FOR FURTHER INFORMATION CONTACT: Mark Helvey, Southwest Region, NMFS, (562) 980–4040.

SUPPLEMENTARY INFORMATION: The 1981 Treaty Between the Government of the United States of America and the Government of Canada on Pacific Coast Albacore Tuna Vessels and Port Privileges (Treaty), as amended in 2002,

establishes a number of obligations for both countries to control reciprocal fishing in waters of one country by vessels of the other country. One obligation is that each country is required to annually provide to the other country a list of its fishing vessels which propose to fish for Pacific albacore tuna off the coast of the other county for each fishing season. As described in the 2004 final rule in 69 FR 31531, published on June 4, 2004, and at 50 CFR 300.172, the list is to include vessel and owner name, address, and phone number; USCG documentation number (or state registration if not documented); vessel operator (if different from the owner) and his or her address with phone number. Each U.S. vessel must be on the list for at least 7 days prior to engaging in fishing under the Treaty. This is intended to ensure that both countries have equal information as to eligible vessels, and U.S. and Canadian enforcement offices can obtain lists of eligible vessels that are up to date to facilitate enforcement. Vessel owners who wish their vessel to remain on or be added to the vessel list must contact NMFS at the **ADDRESSES** section listed above and provide the required information. NMFS will notify fishermen by a confirmation letter or email that they are on the vessel list.

This revision to procedures is necessary for NMFS to reconstruct the 2006 vessel list. Previous to the 2006 fishing season, NMFS did not require owners of any albacore fishing vessels that wanted their vessels to be on the list of U. S. vessels eligible to fish for albacore tuna in Canadian waters under the Treaty to contact NMFS. Instead, NMFS relied on a lengthy list created from information provided by industry that was not readily verifiable nor did it indicate to NMFS whether each vessel owner actually wished to be eligible to fish for albacore tuna in Canada for any given year. The result was that NMFS did not have an effective and efficient way of annually providing the Canadian government an updated vessel list of vessels owners who intended to fish for albacore tuna in Canada for a particular fishing season.

NMFS is undertaking rulemaking to clarify the requirements of 50 CFR 300.172.

Authority: 16 U.S.C. 1801 *et seq.*

Dated: August 11, 2006.

James P. Burgess,

Acting Director, Office of Sustainable Fisheries, National Marine Fisheries Service.

[FR Doc. E6–13693 Filed 8–17–06; 8:45 am]

BILLING CODE 3510–22–S

COMMODITY FUTURES TRADING COMMISSION

Sunshine Act Meetings

TIME AND DATE: 11 a.m., Friday, September 1, 2006.

PLACE: 1155 21st St., NW., Washington, DC, 9th Floor Commission Conference Room.

STATUS: Closed.

MATTERS TO BE CONSIDERED: Surveillance Matters.

FOR FURTHER INFORMATION CONTACT: Eileen A. Donovan, 202–418–5100.

Eileen A. Donovan,

Acting Secretary of the Commission.

[FR Doc. 06–7044 Filed 8–16–06; 11:50 am]

BILLING CODE 6351–01–M

COMMODITY FUTURES TRADING COMMISSION

Sunshine Act Meetings

TIME AND DATE: 11 a.m., Friday, September 8, 2006.

PLACE: 1155 21st St., NW., Washington, DC, 9th Floor Commission Conference Room.

STATUS: Closed.

MATTERS TO BE CONSIDERED: Surveillance Matters.

FOR FURTHER INFORMATION CONTACT: Eileen A. Donovan, 202–418–5100.

Eileen A. Donovan,

Acting Secretary of the Commission.

[FR Doc. 06–7045 Filed 8–16–06; 11:50 am]

BILLING CODE 6351–01–M

COMMODITY FUTURES TRADING COMMISSION

Sunshine Act Meetings

TIME AND DATE: 11 a.m., Friday, September 15, 2006.

PLACE: 1155 21st St., NW., Washington, DC, 9th Floor Commission Conference Room.

STATUS: Closed.

MATTERS TO BE CONSIDERED: Enforcement Matters.

FOR FURTHER INFORMATION CONTACT: Eileen A. Donovan, 202–418–5100.

Eileen A. Donovan,

Acting Secretary of the Commission.

[FR Doc. 06–7046 Filed 8–16–06; 11:51 am]

BILLING CODE 6351–01–M

COMMODITY FUTURES TRADING COMMISSION

Sunshine Act Meetings

TIME AND DATE: 11 a.m., Friday, September 22, 2006.

PLACE: 1155 21st St., NW., Washington, DC, 9th Floor Commission Conference Room.

STATUS: Closed.

MATTERS TO BE CONSIDERED: Surveillance Matters.

FOR FURTHER INFORMATION CONTACT: Eileen A. Donovan, 202–418–5100.

Eileen A. Donovan,

Acting Secretary of the Commission.

[FR Doc. 06–7047 Filed 8–16–06; 11:52 am]

BILLING CODE 6351–01–M

COMMODITY FUTURES TRADING COMMISSION

Sunshine Act Meetings

TIME AND DATE: 11 a.m., Friday, September 29, 2006.

PLACE: 1155 21st St., NW., Washington, DC, 9th Floor Commission Conference Room.

STATUS: Closed.

MATTERS TO BE CONSIDERED: Surveillance Matters.

FOR FURTHER INFORMATION CONTACT: Eileen A. Donovan, 202–418–5100.

Eileen A. Donovan,

Acting Secretary of the Commission.

[FR Doc. 06–7048 Filed 8–16–06; 11:52 am]

BILLING CODE 6351–01–M

DEPARTMENT OF DEFENSE

Office of the Secretary of Defense

[DOD–2006–OS–0181]

Privacy Act of 1974; Systems of Records

AGENCY: Defense Finance and Accounting Service.

ACTION: Notice To Amend a System of Records.

SUMMARY: The Defense Finance and Accounting Service proposes to amend a system of records notice to its existing inventory of record systems subject to the Privacy Act of 1974 (5 U.S.C. 552a), as amended.

DATES: This action will be effective without further notice on September 18, 2006 unless comments are received that would result in a contrary determination.

ADDRESSES: Send comments to Ms. Linda Krabbenhoft, Freedom of Information Act/Privacy Act Program Manager, Defense Finance and Accounting Service, Denver, 6760 E. Irvington Place, Denver, CO 80279–8000.

FOR FURTHER INFORMATION CONTACT: Ms Linda Krabbenhoft at (303) 676–6045.

SUPPLEMENTARY INFORMATION: The Defense Finance and Accounting Service notices for systems of records subject to the Privacy Act of 1974 (5 U.S.C. 552a), as amended, have been published in the **Federal Register** and are available from the address above.

The specific changes to the record system being amended are set forth below followed by the notice, as amended, published in its entirety. The proposed amendment is not within the purview of subsection (r) of the Privacy Act of 1974 (5 U.S.C. 552a), as amended, which requires the submission of a new or altered system report.

Dated: August 14, 2006.

C.R. Choate,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

T3020

SYSTEM NAME:

Living Disaster Recovery Planning System (LDRPS) (September 16, 1998, 63 FR 49553).

CHANGES:

* * * * *

SYSTEM LOCATION:

Delete entry and replace with the following "Defense Finance and Accounting Service—Indianapolis, 8899 East 56th Street, Indianapolis, IN 46249–1460. (Physical location of database and server.)

Defense Finance and Accounting Service—Denver, 6760 East Irvington Place, Denver, CO 80279–8000.

Defense Finance and Accounting Service—Columbus, 3990 East Broad Street, Columbus, OH 43218–2317.

Defense Finance and Accounting Service—Cleveland, 1240 East 9th Street, Cleveland, OH 44199–2056.

Defense Finance and Accounting Service—Kansas City, 1500 East 95th Street, Kansas City, MO 64197–0001."

* * * * *

STORAGE:

Delete entry and replace with "Records are stored on an Oracle database server at DFAS Indianapolis. Backup copies of the database are generated on a bi-monthly basis and distributed to the lead contingency planner at each DFAS location for use in the event of network unavailability during an emergency situation."

* * * * *

SYSTEM MANAGER(S) AND ADDRESS:

Delete entry and replace with "Director of Contingency Planning Division, Defense Finance and Accounting Service—Indianapolis, 8899 East 56th Street, Indianapolis, IN 46249–1460."

* * * * *

CONTESTING RECORD PROCEDURES:

Delete "Office of Corporate Communications" and replace with "Corporate Communications and Legislative Liaison."

* * * * *

T3020

SYSTEM NAME:

Living Disaster Recovery Planning System (LDRPS).

SYSTEM LOCATION:

Defense Finance and Accounting Service—Indianapolis, 8899 east 56th Street, Indianapolis, IN 46249–1460. (Physical location of database and server.)

Defense Finance and Accounting Service—Denver, 6760 East Irvington Place, Denver, CO 80279–8000.

Defense Finance and Accounting Service—Columbus, 3990 East Broad Street, Columbus, OH 43218–2317.

Defense Finance and Accounting Service—Cleveland, 1240 East 9th Street, Cleveland, OH 44199–2056.

Defense Finance and Accounting Service—Kansas City, 1500 East 95th Street, Kansas City, MO 64197–0001. Defense Finance and Accounting Service Headquarters, 1931 Jefferson Davis Highway, Arlington, VA 22240–5291.

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

All civilian and military individuals employed by the Defense Finance and Accounting Service; may also include civilian and military personnel of the Department of Defense and other Government agencies; may also include family members and other emergency points-of-contact; and contractor organizations.

CATEGORIES OF RECORDS IN THE SYSTEM:

Name, organization(s), assignment, office and home telephone number(s), grade/rank, military branch of service, position title, job series, disability information, and emergency point-of-contact name and telephone numbers.

AUTHORITY FOR MAINTENANCE OF THE SYSTEM:

5 U.S.C. 301, Departmental Regulations; DFAS Regulation 3020.26, Corporate Contingency Plan; and E.O. 9397 (SSN).

PURPOSE(S):

To provide DFAS with a standardized automated contingency planning process. Personal information in the system is used to publish organizational telephone directories/locators, recall personnel to place of duty when required, for use in emergency notification, and to perform relevant functions/requirements/actions consistent with managerial functions during an emergency/disaster.

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS AND THE PURPOSES OF SUCH USES:

In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act, these records or information contained therein may specifically be disclosed outside the DoD as a routine use permanent to 5 U.S.C. 552a(b)(3) as follows:

To Federal, state, or local governments or civic organizations during actual emergencies, exercises, or continuity of operation tests for the purpose of responding to emergency situations.

The DoD 'Blanket Routine Users' published at the beginning of the DFAS compilation of systems of records notices apply to this system.

POLICIES AND PRACTICES FOR STORING, RETRIEVING, ACCESSING, RETAINING, AND DISPOSING OF RECORDS IN THE SYSTEM:

STORAGE:

Records are stored on an Oracle database server at DFAS Indianapolis. Backup copies of the database are generated on a bi-monthly basis and distributed to the lead contingency planner at each DFAS location for use in the event of network unavailability during an emergency situation.

RETRIEVABILITY:

Retrieved by individual's name, by organization, and by employee ID (which is a combination of individual's first and last name).

SAFEGUARDS:

As a minimum, records are accessed by person(s) responsible for servicing and authorized to use the record system in performance of their official duties who are properly screened and cleared for need-to-know. Access to the system is controlled through User IDs and passwords.

RETENTION AND DISPOSAL:

Records are perpetual because individual records are deleted or added when the file is updated.

SYSTEM MANAGER(S) AND ADDRESS:

Director of Contingency Planning Division, Defense Finance and Accounting Service—Indianapolis, 8899 East 56th Street, Indianapolis, IN 46249–1460.

NOTIFICATION PROCEDURE:

Individuals seeking to determine whether information about themselves is contained in this system of records should address written inquiries to the Privacy Act Officer at the appropriate DFAS location.

Individual should furnish full name, current DFAS organization element, current work address, and work telephone number.

RECORD ACCESS PROCEDURES:

Individuals seeking access to information about themselves in this system of records should address written inquiries to the Privacy Act Officer at the appropriate DFAS location.

Individual should furnish full name, current DFAS organization element, current work address, and work telephone number.

CONTESTING RECORD PROCEDURES:

The DFAS rules for accessing records, for contesting contents and appealing initial agency determinations are published in DFAS Regulation 5400.11–R; 32 CFR part 324; or may be obtained from the Freedom of Information/ Privacy Act Program Manager, Corporate Communications and Legislative Liaison, 6760 E. Irvington Place, Denver, CO 80279–8000.

RECORD SOURCE CATEGORIES:

Information is obtained from record subject.

EXEMPTIONS CLAIMED FOR THE SYSTEM:

None.

[FR Doc. 06–7009 Filed 8–17–06; 8:45 am]

BILLING CODE 5001–06–M

DEPARTMENT OF DEFENSE

Department of the Army

Department of Defense (DoD) Task Force on Mental Health; Meeting

AGENCY: Department of the Army; DoD.

ACTION: Notice of meeting.

SUMMARY: In accordance with section 10(a)(2) of Public Law 92–463, The Federal Advisory Committee Act, announcement is made of the following meeting:

Name of Committee: DoD Task Force on Mental Health, a Subcommittee of the Armed Forces Epidemiological Board.

Dates: September 20, 2006 (Open Session), September 21, 2006 (Open Session).

Times: 8:30 a.m.–5 p.m. (September 20, 2006); 8:30 a.m.–11 a.m. (September 21, 2006).

Location: Howze Auditorium, Bldg. 33009, 7500 761st Tank Battalion Ave., Fort Hood, TX 76544–5008.

Agenda: The purpose of the meeting is to obtain, review, and evaluate information related to the Mental Health Task Force's congressionally-directed task of assessing the efficacy of mental health services provided to members of the Armed Forces by the Department of Defense. The Task Force members will receive briefings on topics related to mental health concerns among military service members and mental health care delivery. The Task Force will hold a "Town Hall Meeting" session to hear concerns from the Fort Hood community and conduct an executive working session.

For Further Information Contact: Colonel Roger Gibson, Executive Secretary, Armed Forces Epidemiological Board, Skyline Six, 5109 Leesburg Pike, Room 682, Falls Church, VA 22041–3258, (703) 681–8012/3.

Supplementary Information: Sessions on September 20, 2006 and September 21, 2006 will be open to the public in accordance with Section 552b(b) of Title 5, U.S.C., specifically subparagraph (1) thereof and Title 5, U.S.C., appendix 1, subsection 10(d). Open sessions of the meeting will be limited by space accommodations. Any interested person may attend, appear before or file statements with the Board at the time and in the manner permitted by the Board.

Brenda S. Bowen,

Army Federal Register Liaison Officer.

[FR Doc. 06–7006 Filed 8–17–06; 8:45 am]

BILLING CODE 3710–08–M

DEPARTMENT OF DEFENSE

Department of the Army

Armed Forces Epidemiological Board; Meeting

AGENCY: Department of the Army; DoD.

ACTION: Notice of meeting.

SUMMARY: In accordance with section 10(a)(2) of Public Law 92–463, The Federal Advisory Committee Act, announcement is made of the following meeting:

Name of Committee: Armed Forces Epidemiological Board (AFEB).

Dates: September 26, 2006 (Open meeting); September 27, 2006 (Open meeting);

Times: 8 a.m.–5 p.m. (September 26, 2006); 8 a.m.–5 p.m. (September 27, 2006).

Location: The United States Naval Academy, 121 Blake Road, Annapolis, MD 21402.

Agenda: The purpose of the meeting is to address pending and new Board issues; provide briefings for Board members on topics related to ongoing and new Board issues, conduct subcommittee meetings, and conduct an executive working session.

For Further Information Contact: Colonel Roger Gibson, Executive Secretary, Armed Forces Epidemiological Board, Skyline Six, 5109 Leesburg Pike, Room 682, Falls Church, VA 22041–3258, (703) 681–8012/3.

Supplementary Information: The entire sessions on September 26, 2006 and September 27, 2006 will be open to the public in accordance with Section 552b(b) of Title 5, U.S.C., specifically subparagraph (1) thereof and Title 5, U.S.C., appendix 1, subsection 10(d). Open sessions of the meeting will be limited by space accommodations. Any interested person may attend, appear before or file statements with the Board at the time and in the manner permitted by the Board.

Brenda S. Bowen,

Army Federal Register Liaison Officer.

[FR Doc. 06–7008 Filed 8–17–06; 8:45 am]

BILLING CODE 3710–08–M

DEPARTMENT OF DEFENSE

Department of the Army

Intent To Grant an Exclusive License of a U.S. Government-Owned Patent

AGENCY: Department of the Army, DoD.

ACTION: Notice.

SUMMARY: In accordance with 35 U.S.C. 209(e) and 37 CFR 404.7(a)(I)(i), announcement is made of the intent to grant an exclusive, royalty-bearing, revocable license to U.S. patent number 6,399,332 issued June 4, 2002 entitled "Bacterial Superantigen Vaccines," and U.S. patent number 6,713,284 issued March 30, 2004 entitled "Bacterial Superantigen Vaccines," and all pending foreign patents to Integrated Biotherapeutics, Inc. with its principal place of business at Frederick Innovative Technology Center, Rosenstock Hall, Frederick, MD 21702.

ADDRESSES: Commander, U.S. Army Medical Research and Materiel Command, ATTN: Command Judge Advocate, MCMR–JA, 504 Scott Street, Fort Detrick, Frederick, MD 21702–5012.

FOR FURTHER INFORMATION CONTACT: For patent issues, Ms. Elizabeth Arwine, Patent Attorney, (301) 619–7808. For licensing issues, Dr. Paul Mele, Office of Research & Technology Assessment, (301) 619–6664, both at telefax (301) 619–5034.

SUPPLEMENTARY INFORMATION: Anyone wishing to object to the grant of this license can file written objections along

with supporting evidence, if any, 15 days from the date of this publication. Written objections are to be filed with the Command Judge Advocate (see **ADDRESSES**).

Brenda S. Bowen,

Army Federal Register Liaison Officer.

[FR Doc. 06–7007 Filed 8–17–06; 8:45am]

BILLING CODE 3710–08–M

DEPARTMENT OF EDUCATION

Submission for OMB Review; Comment Request

AGENCY: Department of Education.

SUMMARY: The Secretary of Education requests comments on the Free Application for Federal Student Aid (FAFSA) that the Secretary proposes to use for the 2007–2008 award year. The FAFSA is completed by students and their families and the information submitted on the form is used to determine the students' eligibility and financial need for financial aid under the student financial assistance programs authorized under Title IV of the Higher Education Act of 1965, as amended, (Title IV, HEA Programs).

DATES: Interested persons are invited to submit comments on or before September 18, 2006.

ADDRESSES: Written comments should be addressed to Office of Information and Regulatory Affairs, Attention: Rachel Potter, Desk Officer, Department of Education, Office of Management and Budget, 725 17th Street, NW., Room 10222, New Executive Office Building, Washington, DC 20503 or faxed to (202) 395–6974.

In addition, interested persons can access this document on the Internet:

(1) Go to IFAP at *http://ifap.ed.gov*;

(2) Scroll down to "Publications";

(3) Click on "FAFSAs and Renewal FAFSAs";

(4) Click on "By 2007–2008 Award Year";

(5) Click on "Draft FAFSA Form/ Instructions".

Please note that the free Adobe Acrobat Reader software, version 4.0 or greater, is necessary to view this file. This software can be downloaded for free from Adobe's Web site: *http://www.adobe.com.*

SUPPLEMENTARY INFORMATION: The Secretary is publishing this request for comment under the Provisions of the Paperwork Reduction Act of 1995, 44 U.S.C. 3501 *et seq.* Under that Act, ED must obtain the review and approval of the Office of Management and Budget (OMB) before it may use a form to collect information. However, under procedure for obtaining approval from OMB, ED must first obtain public comment of the proposed form, and to obtain that comment, ED must publish this notice in the **Federal Register**.

FOR FURTHER INFORMATION CONTACT: E-mail address *ICDocketMgr@ed.gov.*

Section 483 of the Higher Education Act of 1965, as amended (HEA) requires the Secretary, "in cooperation with agencies and organizations involved in providing student financial assistance," to "produce, distribute and process free of charge a common financial reporting form to be used to determine the need and eligibility of a student for financial assistance * * *" under the Title IV, HEA Programs. This form is the FAFSA. In addition, Section 483 authorizes the Secretary to include non-financial data items that assist States in awarding State student financial assistance. On February 8, 2006, President Bush signed the Higher Education Reconciliation Act of 2005 (HERA), Pub. L. 109–171. The HERA made changes to the HEA that affect student eligibility and need analysis. The HERA changes impact the FAFSA in the following ways: (1) New questions are added for a student (and spouse) or a student and parents asking whether they received benefits from any of five means-tested Federal benefit programs in 2006. Receipt of means-tested Federal benefits during the preceding calendar year (2006 for the 2007–2008 award year) is an alternative to the current questions about whether the student or parent filed or was required to file an IRS 1040 Form as one of the criteria used to determine who qualifies for an automatic zero EFC or a simplified needs test. (2) A new dependency question is added to ensure that a member of the U.S. Armed Forces on active duty for other than training purposes is considered an independent student. (3) The question regarding a student's convictions for drug-related offences has been modified. A student is ineligible for Title IV, HEA financial assistance only if the conviction for a Federal or State offence involving the possession or sale of a controlled substance is for conduct that occurred during the period of enrollment for which the student was receiving Title IV, HEA financial assistance. The ineligibility period is provided in the HEA. (4) New instructions have been added to clarify that Coverdell savings accounts, 529 college savings plans, and the refund value of 529 or State prepaid tuition plans should be reported as an asset of the account owner (unless the owner is a dependent student). (5) In addition, the FAFSA instructs applicants to exclude the value of a small business that the family owns and controls and that has 100 or fewer full-time or full-time equivalent employees.

The following data elements were deleted from the first FAFSA draft published June 6, 2006, because of space constraints on the paper form: Questions 27 and 28 regarding the student's interest in student loans or work-study and questions 94–97 representing a fifth and sixth college choice. Question numbers refer to the 2006–2007 FAFSA.

Many comments received during the 60-day public comment period indicated that financial aid administrators require information about a student's interest in work-study or student loans to properly package and award Federal student aid. Therefore, the draft FAFSA has been revised to restore one question (number 26) allowing students to enter a code from the instructions and indicate their interest in work-study, student loans, both programs, or neither program. Additional revisions to the FAFSA draft are as follows: (1) The new dependency question number 54 that asks if the student is currently serving on active duty in the U.S. armed forces has been placed prior to question number 55 that asks if the student is a veteran, for a more logical flow. New instructions for responding to the active duty question have been added in the "Notes" section. (2) Questions about Federal benefits received by an independent student or spouse have been placed on page 4 as questions 92–96. A dependent student would report the receipt of Federal benefits in the parents' section, questions 71–75, as a member of the parents' household. (3) Instructions have been modified for reporting the receipt of benefits from Federal means-tested programs; for reporting investments; and for using tax returns with U.S. territories or freely associated states.

The Secretary requests comments on these proposed changes to wording, as well as suggestions for ways to further simplify the application for students, parents, and schools. In particular, the Secretary is interested in comments regarding the best manner in which to construct a simplified form for applicants who qualify for an automatic zero or simplified needs test EFC calculation, including applicants who now qualify based on receipt of benefits from a Federal means-tested benefit program.

In addition to comments requested above, to accommodate the requirements of the Paperwork Reduction Act, the Secretary is

interested in receiving comments with regard to the following matters: (1) Is this collection necessary to the proper functions of the Department, (2) Will this information be processed and used in a timely manner, (3) Is the estimate of burden accurate, (4) How might the Department enhance the quality, utility, and clarity of the information to be collected, and (5) How might the Department minimize the burden of this collection on the respondents, including through the use of information technology.

Dated: August 14, 2006.

Angela C. Arrington,

Leader, IC Clearance Official, Regulatory Information Management Services, Office of Management.

Federal Student Aid

Type of Review: Revision.
Title: Free Application for Federal Student Aid (FAFSA).
Frequency: Annually.
Affected Public: Individuals and families.
Annual Reporting and Recordkeeping Hour Burden:
Responses: 15,952,890.
Burden Hours: 7,666,352.
Abstract: The FAFSA collects identifying and financial information about a student applying for Title IV, HEA program funds. This information is used to calculate the student's expected family contribution, which is used to determine a student's financial need. The information is also used for determining a student's eligibility for grants and loans under the Title IV, HEA Programs. It is further used for determining a student's eligibility for State and institutional financial aid programs. Requests for copies of the proposed information collection request may be accessed from *http://edicsweb.ed.gov*, by selecting the "Browse Pending Collections" link and clicking on "Download attachments" to view. Written requests for information should be addressed to U.S. Department of Education, 400 Maryland Avenue, SW., Potomac Center, 9th Floor, Washington, DC 20202–4700. Requests may also be electronically mailed to *ICDocketMgr@ed.gov* or faxed to (202) 245–6623. Please specify the complete title of the information collection when making your request. Comments regarding burden and/or the collection activity requirements should be directed to the e-mail address *ICDocketMgr@ed.gov*. Individuals who use a telecommunications device for the deaf (TDD) may call the Federal Information Relay Service (FIRS) at 1–800–877–8339 between 8 a.m. and 8 p.m., Eastern time, Monday through Friday.

[FR Doc. E6–13619 Filed 8–17–06; 8:45 am]

BILLING CODE 4001–01–P

DEPARTMENT OF EDUCATION

Submission for OMB Review; Comment Request

AGENCY: Department of Education.

SUMMARY: The IC Clearance Official, Regulatory Information Management Services, Office of Management invites comments on the submission for OMB review as required by the Paperwork Reduction Act of 1995.

DATES: Interested persons are invited to submit comments on or before September 18, 2006.

ADDRESSES: Written comments should be addressed to the Office of Information and Regulatory Affairs, Attention: Rachel Potter, Desk Officer, Department of Education, Office of Management and Budget, 725 17th Street, NW., Room 10222, New Executive Office Building, Washington, DC 20503 or faxed to (202) 395–6974.

SUPPLEMENTARY INFORMATION: Section 3506 of the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35) requires that the Office of Management and Budget (OMB) provide interested Federal agencies and the public an early opportunity to comment on information collection requests. OMB may amend or waive the requirement for public consultation to the extent that public participation in the approval process would defeat the purpose of the information collection, violate State or Federal law, or substantially interfere with any agency's ability to perform its statutory obligations. The IC Clearance Official, Regulatory Information Management Services, Office of Management, publishes that notice containing proposed information collection requests prior to submission of these requests to OMB. Each proposed information collection, grouped by office, contains the following: (1) Type of review requested, e.g. new, revision, extension, existing or reinstatement; (2) Title; (3) Summary of the collection; (4) Description of the need for, and proposed use of, the information; (5) Respondents and frequency of collection; and (6) Reporting and/or Recordkeeping burden. OMB invites public comment.

Dated: August 15, 2006.

Angela C. Arrington,

IC Clearance Official, Regulatory Information Management Services, Office of Management.

Federal Student Aid

Type of Review: Extension.
Title: Lender's Request for Payment of Interest and Special Allowance—LaRS.
Frequency: Quarterly; Annually.
Affected Public: State, Local, or Tribal Gov't, SEAs or LEAs; Businesses or other for-profit.
Reporting and Recordkeeping Hour Burden:
Responses: 12,800.
Burden Hours: 31,200.
Abstract: The Lender's Request for Payment of Interest and Special Allowance—LaRS (ED Form 799) is used by approximately 3,200 lenders participating in the Title IV, PART B loan programs. The ED Form 799 is used to pay interest and special allowance to holders of the Part B loans; and to capture quarterly data from lender's loan portfolio for financial and budgetary projections.

Requests for copies of the information collection submission for OMB review may be accessed from *http://edicsweb.ed.gov*, by selecting the "Browse Pending Collections" link and by clicking on link number 3138. When you access the information collection, click on "Download Attachments" to view. Written requests for information should be addressed to U.S. Department of Education, 400 Maryland Avenue, SW., Potomac Center, 9th Floor, Washington, DC 20202–4700. Requests may also be electronically mailed to *ICDocketMgr@ed.gov* or faxed to 202–245–6623. Please specify the complete title of the information collection when making your request.

Comments regarding burden and/or the collection activity requirements should be electronically mailed to *ICDocketMgr@ed.gov*. Individuals who use a telecommunications device for the deaf (TDD) may call the Federal Information Relay Service (FIRS) at 1–800–877–8339.

[FR Doc. E6–13673 Filed 8–17–06; 8:45 am]

BILLING CODE 4000–01–P

DEPARTMENT OF EDUCATION

Submission for OMB Review; Comment Request

AGENCY: Department of Education.

SUMMARY: The IC Clearance Official, Regulatory Information Management Services, Office of Management invites comments on the submission for OMB review as required by the Paperwork Reduction Act of 1995.

DATES: Interested persons are invited to submit comments on or before September 18, 2006.

ADDRESSES: Written comments should be addressed to the Office of Information and Regulatory Affairs, Attention: Rachel Potter, Desk Officer, Department of Education, Office of Management and Budget, 725 17th Street, NW., Room 10222, New Executive Office Building, Washington, DC 20503 or faxed to (202) 395–6974.

SUPPLEMENTARY INFORMATION: Section 3506 of the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35) requires that the Office of Management and Budget (OMB) provide interested Federal agencies and the public an early opportunity to comment on information collection requests. OMB may amend or waive the requirement for public consultation to the extent that public participation in the approval process would defeat the purpose of the information collection, violate State or Federal law, or substantially interfere with any agency's ability to perform its statutory obligations. The IC Clearance Official, Regulatory Information Management Services, Office of Management, publishes that notice containing proposed information collection requests prior to submission of these requests to OMB. Each proposed information collection, grouped by office, contains the following: (1) Type of review requested, *e.g.* new, revision, extension, existing or reinstatement; (2) Title; (3) Summary of the collection; (4) Description of the need for, and proposed use of, the information; (5) Respondents and frequency of collection; and (6) Reporting and/or Recordkeeping burden. OMB invites public comment.

Dated: August 15, 2006.

Angela C. Arrington,

IC Clearance Official, Regulatory Information Management Services, Office of Management.

Office of Planning, Evaluation and Policy Development

Type of Review: New.

Title: Study of Education Data Systems and Decision Making.

Frequency: Annually.

Affected Public: State, Local, or Tribal Gov't, SEAs or LEAs; Federal Government.

Reporting and Recordkeeping Hour Burden:

Responses: 235.

Burden Hours: 223.

Abstract: The purpose of the study is to examine the prevalence, use, and outcomes of education data systems for accountability, assessment, and instructional purposes.

Requests for copies of the information collection submission for OMB review may be accessed from *http://edicsweb.ed.gov,* by selecting the "Browse Pending Collections" link and by clicking on link number 3139. When you access the information collection, click on "Download Attachments " to view. Written requests for information should be addressed to U.S. Department of Education, 400 Maryland Avenue, SW., Potomac Center, 9th Floor, Washington, DC 20202–4700. Requests may also be electronically mailed to *ICDocketMgr@ed.gov* or faxed to 202–245–6623. Please specify the complete title of the information collection when making your request.

Comments regarding burden and/or the collection activity requirements should be electronically mailed to *ICDocketMgr@ed.gov.* Individuals who use a telecommunications device for the deaf (TDD) may call the Federal Information Relay Service (FIRS) at 1–800–877–8339.

[FR Doc. E6–13674 Filed 8–17–06; 8:45 am]

BILLING CODE 4000–01–P

DEPARTMENT OF EDUCATION

[CFDA No. 84.938H]

Notice Announcing Availability of Funds and Application Deadline for Hurricane Education Recovery Awards Under Title II of the Emergency Supplemental Appropriations Act for Defense, the Global War on Terror and Hurricane Recovery, 2006 (Pub. L. 109–234)

AGENCY: Office of Postsecondary Education, Department of Education.

SUMMARY: Under the Emergency Supplemental Appropriations Act for Defense, the Global War on Terror and Hurricane Recovery, 2006 we will award funds to institutions of higher education, as defined in section 102 of the Higher Education Act of 1965, as amended (HEA), that are located in an area in which a major disaster was declared in accordance with section 401 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act related to hurricanes in the Gulf of Mexico in calendar year 2005, and that were forced to close, relocate, or significantly curtail their activities as a result of damage directly caused by the hurricanes. These Hurricane Education Recovery Awards can be used only to defray expenses, including expenses that would have been covered by revenue lost as a direct result of a hurricane, expenses already incurred, and construction expenses directly related to damage resulting from the hurricanes.

Pre-Application Deadline: September 1, 2006.

Application Deadline: September 19, 2006.

SUPPLEMENTARY INFORMATION: The Emergency Supplemental Appropriations Act for Defense, the Global War on Terror and Hurricane Recovery, 2006 (Pub. L. 109–234) provided $50 million for Hurricane Education Recovery Awards to assist institutions of higher education, as defined in section 102 of the HEA that are located in an area in which a major disaster was declared in accordance with section 401 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act related to hurricanes in the Gulf of Mexico in calendar year 2005, and that were forced to close, relocate, or significantly curtail their activities as a result of damage directly caused by the hurricanes. This area includes the States of Louisiana and Mississippi and certain counties in the States of Alabama, Florida, and Texas. A list of these counties is available at: *http://www.fema.gov/hazard/hurricane/hu_recovery.shtm.* These awards can only be used to defray expenses incurred by these institutions, including, but not limited to, expenses that would have been covered by revenue lost as a direct result of a hurricane, reimbursement for expenses already incurred, and construction expenses, directly related to damage resulting from the hurricanes.

The Emergency Supplemental Appropriations Act for Defense, the Global War on Terror and Hurricane Recovery, 2006 authorizes the Department to make these funds available based on criteria established by the Secretary. The Secretary establishes and will consider the following criteria in allocating these funds: expenses that would have been covered by revenues lost by the institution as a direct result of the hurricanes; expenses incurred by the institution in remedying the effects of the hurricanes; the costs of construction associated with physical damage caused by the hurricanes; any amount of any insurance settlement or other reimbursement received including from a Federal or other relief agency; and the number of Pell Grant recipients enrolled at the institution at any time during the 2005–06 award year. Institutions must include information responsive to each of these criteria in their applications.

Available Funds for Hurricane Education Recovery Awards: $50,000,000.

Period of Fund Availability: Institutions receiving Hurricane Education Recovery Awards must obligate the funds received by September 30, 2008. Funds being used for construction must be expended by September 30, 2010.

Waiver of Proposed Rulemaking: Under the Administrative Procedure Act (APA) (5 U.S.C. 553), and section 437 of the General Education Provisions Act (20 U.S.C. 1232), the Department generally offers interested parties the opportunity to comment on proposed program requirements. However, the Emergency Supplemental Appropriations Act for Defense, the Global War on Terror and Hurricane Recovery, 2006 (Pub. L. 109–234) specifically exempts criteria established by the Secretary for the award of funds under this program from the rulemaking requirements of the APA and GEPA.

Pre-Application Requirements: Institutions intending to submit an application for a Hurricane Education Recovery Award must first complete and submit a pre-application data information form from which institutional allotments will be calculated. Data forms and instructions can be downloaded from *http://www.ed.gov/OPE* (click on the Hurricane Education Recovery Awards link). Complete the form and fax it to David Johnson, Program Officer, Office of Postsecondary Education, at 202–502–7877 by the date established under Pre-Application Deadline. Within one week of the Pre-Application Deadline, the Department will calculate the applicant institution's allotment and e-mail the amount back to the contact person identified on the form. Institutions will then have until September 12, 2006 to submit their application and budget through the e-Application system.

Electronic Submission of Applications: Applications for Hurricane Education Recovery Awards—CFDA Number 84.938H must be submitted electronically using e-Application available through the Department's e-Grants system, accessible through the e-Grants portal page at: *http://e-grants.ed.gov*.

We will reject your application if you submit it in paper format unless, as described elsewhere in this section, you qualify for one of the exceptions to the electronic submission requirement *and* submit, no later than two weeks before the application deadline date, a written statement to the Department that you qualify for one of these exceptions. Further information regarding calculation of the date that is two weeks before the application deadline date is provided later in this section under *Exception to Electronic Submission Requirement.*

While completing your electronic application, you will be entering data online that will be saved into a database. You may not e-mail an electronic copy of a grant application to us.

Please note the following:

- You must complete the electronic submission of your grant application by 4:30 p.m., Washington, DC time, on the application deadline date. The e-Application system will not accept an application for this program after 4:30 p.m., Washington, DC time, on the application deadline date. Therefore, we strongly recommend that you do not wait until the application deadline date to begin the application process.
- The regular hours of operation of the e-Grants Web site are 6 a.m. Monday until 7 p.m. Wednesday; and 6 a.m. Thursday until midnight Saturday, Washington, DC time. Please note that the system is unavailable on Sundays, and between 7 p.m. on Wednesdays and 6 a.m. on Thursdays, Washington, DC time, for maintenance. Any modifications to these hours are posted on the e-Grants Web site.
- You will not receive additional point value because you submit your application in electronic format, nor will we penalize you if you qualify for an exception to the electronic submission requirement, as described elsewhere in this section, and submit your application in paper format.
- You must submit all documents electronically, including the Application title page (ED 424), Budget Information (ED 524), and all necessary assurances and certifications. You must attach any narrative sections of your application as files in a .DOC (document), .RTF (rich text), or .PDF (Portable Document) format. If you upload a file type other than the three file types specified above or submit a password protected file, we will not review that material.
- Your electronic application must comply with any page limit requirements described in this notice.
- Prior to submitting your electronic application, you may wish to print a copy of it for your records.
- After you electronically submit your application, you will receive an automatic acknowledgment that will include a PR/Award number (an identifying number unique to your application).
- Within three working days after submitting your electronic application, fax a signed copy of the application Title Page (Form No. ED 424) to the Application Control Center after following these steps:

(1) Print the application Program Title Page (ED 424) from e-Application.

(2) The applicant's Authorizing Representative must sign this form (ED 424).

(3) Place the PR/Award number in the upper right hand corner (Item 1) of the hard-copy signature page of the ED 424.

(4) Fax the signed ED 424 to the Application Control Center at (202) 245–6272.

- We may request that you provide us original signatures on other forms at a later date.

Application Deadline Date Extension in Case of e-Application System Unavailability: If you are prevented from electronically submitting your application on the application deadline date because the e-Application system is unavailable, we will grant you an extension of one business day to enable you to transmit your application electronically, by mail, or by hand delivery. We will grant this extension if—

(1) You are a registered user of e-Application and you have initiated an electronic application for this competition; and

(2)(a) The e-Application system is unavailable for 60 minutes or more between the hours of 8:30 a.m. and 3:30 p.m., Washington, DC time, on the application deadline date; or

(b) The e-Application system is unavailable for any period of time between 3:30 p.m. and 4:30 p.m., Washington, DC time, on the application deadline date.

We must acknowledge and confirm these periods of unavailability before granting you an extension. To request this extension or to confirm our acknowledgment of any system unavailability, you may contact either (1) the person listed elsewhere in this notice under **FOR FURTHER INFORMATION CONTACT** (see section VII. Agency Contact) or (2) the e-Grants help desk at 1–888–336–8930. If the system is down and therefore the application deadline is extended, an e-mail will be sent to all registered users who have initiated an e-Application. Extensions referred to in this section apply only to the unavailability of the Department's e-Application system.

Exception to Electronic Submission Requirement: You qualify for an exception to the electronic submission requirement, and may submit your application in paper format, if you are unable to submit an application through the e-Application system because—

- You do not have access to the Internet; or

• You do not have the capacity to upload large documents to the Department's e-Application system; *and*

• No later than two weeks before the application deadline date (14 calendar days or, if the fourteenth calendar day before the application deadline date falls on a Federal holiday, the next business day following the Federal holiday), you mail or fax a written statement to the Department, explaining which of the two grounds for an exception prevent you from using the Internet to submit your application. If you mail your written statement to the Department, it must be postmarked no later than two weeks before the application deadline date. If you fax your written statement to the Department, we must receive the faxed statement no later than two weeks before the application deadline date.

Address and mail or fax your statement to: David Johnson, Hurricane Education Recovery Awards, U.S. Department of Education, 1990 K Street, NW., Room 6155, Washington, DC 20006–8544. FAX: (202) 502–7877.

Your paper application must be submitted in accordance with the mail or hand delivery instructions described in this notice.

b. *Submission of Paper Applications by Mail.*

If you qualify for an exception to the electronic submission requirement, you may mail (through the U.S. Postal Service or a commercial carrier) your application to the Department. You must mail the original and two copies of your application, on or before the application deadline date, to the Department at the applicable following address:

By mail through the U.S. Postal Service: U.S. Department of Education, Application Control Center, Attention: (CFDA Number 84.938H), 400 Maryland Avenue, SW., Washington, DC 20202–4260. or

By mail through a commercial carrier: U.S. Department of Education, Application Control Center—Stop 4260, Attention: (CFDA Number 84.938H), 7100 Old Landover Road, Landover, MD 20785–1506.

Regardless of which address you use, you must show proof of mailing consisting of one of the following:

(1) A legibly dated U.S. Postal Service postmark,

(2) A legible mail receipt with the date of mailing stamped by the U.S. Postal Service,

(3) A dated shipping label, invoice, or receipt from a commercial carrier, or

(4) Any other proof of mailing acceptable to the Secretary of the U.S. Department of Education.

If you mail your application through the U.S. Postal Service, we do not accept either of the following as proof of mailing:

(1) A private metered postmark, or

(2) A mail receipt that is not dated by the U.S. Postal Service.

If your application is postmarked after the application deadline date, we will not consider your application.

Note: The U.S. Postal Service does not uniformly provide a dated postmark. Before relying on this method, you should check with your local post office.

c. *Submission of Paper Applications by Hand Delivery.*

If you qualify for an exception to the electronic submission requirement, you (or a courier service) may deliver your paper application to the Department by hand. You must deliver the original and two copies of your application, by hand, on or before the application deadline date, to the Department at the following address: U.S. Department of Education, Application Control Center, Attention: (CFDA Number 84.938H), 550 12th Street, SW., Room 7041, Potomac Center Plaza, Washington, DC 20202–4260.

The Application Control Center accepts hand deliveries daily between 8 a.m. and 4:30 p.m., Washington, DC time, except Saturdays, Sundays, and Federal holidays.

Note for Mail or Hand Delivery of Paper Applications: If you mail or hand deliver your application to the Department:

(1) You must indicate on the envelope and—if not provided by the Department—on the Hurricane Education Recovery Awards Title Page the CFDA number and suffix letter (84.938H of the competition under which you are submitting your application.

(2) The Application Control Center will mail a grant application receipt acknowledgment to you. If you do not receive the grant application receipt acknowledgment within 15 business days from the application deadline date, you should call the U.S. Department of Education Application Control Center at (202) 245–6288.

Electronic Access to This Document: You may view this document, as well as other Department of Education documents published in the **Federal Register**, in text or Adobe Portable Document Format (PDF) on the Internet at the following site: *http://www.ed.gov/news/fedregister.*

To use PDF you must have Adobe Acrobat Reader, which is available free at this site. If you have questions about using PDF, call the U.S. Government Printing Office (GPO), toll free, at 1–888–293–6498; or in the Washington, DC, area at (202) 512–1530.

Note: The official version of this document is the document published in the **Federal Register**. Free Internet access to the official edition of the **Federal Register** and the Code of Federal Regulations is available on GPO Access at: *http://www.gpoaccess.gov/nara/index.html.*

Program Authority: Division B, Title IV of Pub. L. 109–148; Title II of Pub. L. 109–234.

Dated: August 15, 2006.

James F. Manning,

Acting Assistant Secretary for Postsecondary Education.

[FR Doc. E6–13641 Filed 8–17–06; 8:45 am]

BILLING CODE 4000–01–P

DEPARTMENT OF EDUCATION

Office of Special Education and Rehabilitative Services Overview Information; Centers for Independent Living; Notice Inviting Applications for New Awards for Fiscal Year (FY) 2006

Catalog of Federal Domestic Assistance (CFDA) Number: 84.132A.

Dates: Applications Available: August 18, 2006. Deadline for Transmittal of Applications: September 18, 2006.

Eligible Applicants: To be eligible to apply, an applicant must—

(a) Be a consumer-controlled, community-based, cross-disability, nonresidential, private nonprofit agency;

(b) Have the power and authority to—

(1) Carry out the purpose of part C of title VII of the Rehabilitation Act of 1973, as amended (the Act) and perform the functions listed in section 725(b) and (c) of the Act and subparts F and G of 34 CFR part 366 within a community located within a State or in a bordering State; and

(2) Receive and administer—

(i) Funds under 34 CFR part 366;

(ii) Funds and contributions from private or public sources that may be used in support of a center for independent living (center); and

(iii) Funds from other public and private programs;

(c) Be able to plan, conduct, administer, and evaluate a center consistent with the standards and assurances in section 725(b) and (c) of the Act and subparts F and G of 34 CFR part 366;

(d) Either—

(1) Not currently be receiving funds under part C of chapter 1 of title VII of the Act; or

(2) Propose the expansion of an existing center through the establishment of a separate and complete center (except that the governing board of the existing center may serve as the governing board of the new center) at a different geographical location;

(e) Propose to serve one or more of the geographic areas that are identified as unserved or underserved by the State and territories listed under *Estimated Number of Awards*; and

(f) Submit appropriate documentation demonstrating that the establishment of a new center is consistent with the design for establishing a statewide network of centers in the State plan of the State or territory whose geographic area or areas the applicant proposes to serve.

Estimated Available Funds: $154,046.

Estimated Number of Awards: 1, distributed in the following manner:

States and territories	Estimated available funds	Estimated number of awards
American Samoa	$154,046	1

Note: The Department is not bound by any estimates in this notice.

Project Period: Up to 60 months.

Full Text of Announcement

I. Funding Opportunity Description

Purpose of Program: This program provides support for planning, conducting, administering, and evaluating centers that comply with the standards and assurances in section 725 of the Act, consistent with the design included in the State plan for establishing a statewide network of centers.

Program Authority: 29 U.S.C. 796f–1.

Applicable Regulations: (a) The Education Department General Administrative Regulations (EDGAR) in 34 CFR parts 74, 75, 77, 79, 80, 81, 82, 84, 85, and 97. (b) The regulations for this program in 34 CFR parts 364 and 366.

II. Award Information

Type of Award: Discretionary grants.

Estimated Available Funds: $154,046.

Estimated Number of Awards: 1, distributed in the following manner:

States and territories	Estimated available funds	Estimated number of awards
American Samoa	$154,046	1

Note: The Department is not bound by any estimates in this notice.

Project Period: Up to 60 months.

III. Eligibility Information

1. *Eligible Applicants:* To be eligible to apply, an applicant must—

(a) Be a consumer-controlled, community-based, cross-disability, nonresidential, private nonprofit agency;

(b) Have the power and authority to—

(1) Carry out the purpose of part C of title VII of the Act and perform the functions listed in section 725(b) and (c) of the Act and subparts F and G of 34 CFR part 366 within a community located within a State or in a bordering State; and

(2) Receive and administer—

(i) Funds under 34 CFR part 366;

(ii) Funds and contributions from private or public sources that may be used in support of a center; and

(iii) Funds from other public and private programs;

(c) Be able to plan, conduct, administer, and evaluate a center consistent with the standards and assurances in section 725(b) and (c) of the Act and subparts F and G of 34 CFR part 366;

(d) Either—

(1) Not currently be receiving funds under part C of chapter 1 of title VII of the Act; or

(2) Propose the expansion of an existing center through the establishment of a separate and complete center (except that the governing board of the existing center may serve as the governing board of the new center) at a different geographical location;

(e) Propose to serve one or more of the geographic areas that are identified as unserved or underserved by the States and territories listed under *Estimated Number of Awards;* and

(f) Submit appropriate documentation demonstrating that the establishment of a new center is consistent with the design for establishing a statewide network of centers in the State plan of the State or territory whose geographic area or areas the applicant proposes to serve.

2. *Cost Sharing or Matching:* This program does not involve cost sharing or matching.

IV. Application and Submission Information

1. *Address To Request Application Package:* Education Publications Center (ED Pubs), P.O. Box 1398, Jessup, MD 20794–1398. Telephone (toll free): 1–877–433–7827. FAX: (301) 470–1244. If you use a telecommunications device for the deaf (TDD), you may call (toll free): 1–877–576–7734. You may also contact ED Pubs at its Web site: *http://www.ed.gov/pubs/edpubs.html* or you may contact ED Pubs at its E-mail address: *edpubs@inet.ed.gov*.

If you request an application from ED Pubs, be sure to identify this competition as follows: CFDA number 84.132A.

Individuals with disabilities may obtain a copy of the application package in an alternative format (*e.g.*, Braille, large print, audiotape, or computer diskette) by contacting the Grants and Contracts Services Team, U.S. Department of Education, 400 Maryland Avenue, SW., Room 5075, Potomac Center Plaza, Washington, DC 20202–2550. Telephone: (202) 245–7363. If you use a telecommunications device for the deaf (TDD), you may call the Federal Relay Service (FRS) at 1–800–877–8339.

2. *Content and Form of Application Submission:* Requirements concerning the content of an application, together with the forms you must submit, are in the application package for this competition.

3. *Submission Dates and Times:* Applications Available: August 18, 2006. Deadline for Transmittal of Applications: September 18, 2006.

Applications for grants under this competition must be submitted electronically using the Grants.gov Apply site (*http://www.grants.gov*). For information (including dates and times) about how to submit your application electronically or by mail or hand delivery if you qualify for an exception

to the electronic submission requirement, please refer to section IV. 6. *Other Submission Requirements* in this notice.

We do not consider an application that does not comply with the deadline requirements.

4. *Intergovernmental Review:* This program is subject to Executive Order 12372 and the regulations in 34 CFR part 79. However, in order to ensure that these FY 2006 grants are made before September 30, 2006, the 60-day intergovernmental review period has been waived.

5. *Funding Restrictions:* We reference regulations outlining funding restrictions in the Applicable Regulations section of this notice.

6. *Other Submission Requirements:* Applications for grants under this competition must be submitted electronically unless you qualify for an exception to this requirement in accordance with the instructions in this section.

a. *Electronic Submission of Applications:* Applications for grants under the Centers for Independent Living program—CFDA Number 84.132A must be submitted electronically using the Grants.gov Apply site at: *http://www.grants.gov*. Through this site, you will be able to download a copy of the application package, complete it offline, and then upload and submit your application. You may not E-mail an electronic copy of a grant application to us.

We will reject your application if you submit it in paper format unless, as described elsewhere in this section, you qualify for one of the exceptions to the electronic submission requirement *and* submit, no later than two weeks before the application deadline date, a written statement to the Department that you qualify for one of these exceptions. Further information regarding calculation of the date that is two weeks before the application deadline date is provided later in this section under *Exception to Electronic Submission Requirement.*

You may access the electronic grant application for the Centers for Independent Living program at: *http://www.grants.gov*. You must search for the downloadable application package for this program by the CFDA number. Do not include the CFDA number's alpha suffix in your search.

Please note the following:

- When you enter the Grants.gov site, you will find information about submitting an application electronically through the site, as well as the hours of operation.
- Applications received by Grants.gov are time and date stamped. Your application must be fully uploaded and submitted, and must be date/time stamped by the Grants.gov system no later than 4:30 p.m., Washington, DC time, on the application deadline date. Except as otherwise noted in this section, we will not consider your application if it is date/time stamped by the Grants.gov system later than 4:30 p.m., Washington, DC time, on the application deadline date. When we retrieve your application from Grants.gov, we will notify you if we are rejecting your application because it was date/time stamped by the Grants.gov system after 4:30 p.m., Washington, DC time, on the application deadline date.
- The amount of time it can take to upload an application will vary depending on a variety of factors including the size of the application and the speed of your Internet connection. Therefore, we strongly recommend that you do not wait until the application deadline date to begin the submission process through Grants.gov
- You should review and follow the Education Submission Procedures for submitting an application through Grants.gov that are included in the application package for this competition to ensure that you submit your application in a timely manner to the Grants.gov system. You can also find the Education Submission Procedures pertaining to Grants.gov at *http://e-Grants.ed.gov/help/GrantsgovSubmissionProcedures.pdf.*
- To submit your application via Grants.gov, you must complete all the steps in the Grants.gov registration process (see *http://www.grants.gov/applicants/get_registered.jsp*). These steps include (1) registering your organization, (2) registering yourself as an Authorized Organization Representative (AOR), and (3) getting authorized as an AOR by your organization. Details on these steps are outlined in the Grants.gov 3-Step Registration Guide (*see http://www.grants.gov/section910/Grants.govRegistrationBrochure.pdf*). You also must provide on your application the same D–U–N–S Number used with this registration. Please note that the registration process may take five or more business days to complete, and you must have completed all registration steps to allow you to submit successfully an application via Grants.gov.
- You will not receive additional point value because you submit your application in electronic format, nor will we penalize you if you qualify for an exception to the electronic submission requirement, as described elsewhere in this section, and submit your application in paper format.
- You must submit all documents electronically, including all information typically included on the following forms: Application for Federal Assistance (SF 424), the Department of Education Supplemental Information for SF 424, Budget Information—Non-Construction Programs (ED 524), and all necessary assurance and certifications. Please note that two of these forms—the SF 424 and the Department of Education Supplemental Information for SF 424—have replaced the ED 424 (Application for Federal Education Assistance). You must attach any narrative sections of your application as files in a .DOC (document), .RTF (rich text), or .PDF (Portable Document) format. If you upload a file type other than the three file types specified above or submit a password protected file, we will not review that material.
- Your electronic application must comply with any page limit requirements described in this notice.
- After you electronically submit your application, you will receive an automatic acknowledgment from Grants.gov that contains a Grants.gov tracking number. The Department will retrieve your application from Grants.gov and send you a second confirmation by e-mail that will include a PR/Award number (an ED-specified identifying number unique to your application).
- We may request that you provide us original signatures on forms at a later date.

Application Deadline Date Extension in Case of Technical Issues with the Grants.gov System: If you are prevented from electronically submitting your application on the application deadline date because of technical problems with the Grants.gov system, we will grant you an extension until 4:30 p.m., Washington, DC time, the following business day to enable you to transmit your application electronically, or by hand delivery. You also may mail your application by following the mailing instructions as described elsewhere in this notice. If you submit an application after 4:30 p.m., Washington DC time, on the deadline date, please contact the person listed elsewhere in this notice under *For Further Information Contact*, and provide an explanation of the technical problem you experienced with Grants.gov, along with the Grants.gov Support Desk Case Number (if available). We will accept your application if we can confirm that a technical problem occurred with the

Grants.gov system and that that problem affected your ability to submit your application by 4:30 p.m., Washington, DC time, on the application deadline date. The Department will contact you after a determination is made on whether your application will be accepted.

Note: Extensions referred to in this section apply only to the unavailability of or technical problems with the Grants.gov system. We will not grant you an extension if you failed to fully register to submit your application to Grants.gov before the deadline date and time or if the technical problem you experienced is unrelated to the Grants.gov system.

Exception to Electronic Submission Requirement: You qualify for an exception to the electronic submission requirement, and may submit your application in paper format, if you are unable to submit an application through the Grants.gov system because—

- You do not have access to the Internet; or
- You do not have the capacity to upload large documents to the Grants.gov system;

and

- No later than two weeks before the application deadline date (14 calendar days or, if the fourteenth calendar day before the application deadline date falls on a Federal holiday, the next business day following the Federal holiday), you mail or fax a written statement to the Department, explaining which of the two grounds for an exception prevent you from using the Internet to submit your application. If you mail your written statement to the Department, it must be postmarked no later than two weeks before the application deadline date. If you fax your written statement to the Department, we must receive the faxed statement no later than two weeks before the application deadline date.

Address and mail or fax your statement to: Thomas Kelley, U.S. Department of Education, 400 Maryland Avenue, SW., Room 5055, Potomac Center Plaza, Washington, DC 20202–2800. FAX: (202) 245–7593.

Your paper application must be submitted in accordance with the mail or hand delivery instructions described in this notice.

Submission of Paper Applications By Mail: If you qualify for any exception to the electronic submission requirement, you may mail (through the U.S. Postal Service or a commercial carrier), your application to the Department. You must mail the original and two copies of your application, on or before the application deadline date, to the Department at the applicable following address:

By mail through the U.S. Postal Service:

U.S. Department of Education, Application Control Center, Attention: (CFDA Number 84.132A), 400 Maryland Avenue, SW., Washington, DC 20202–4260;

or

By mail through a commercial carrier:

U.S. Department of Education, Application Control Center—Stop 4260, Attention: (CFDA Number 84.132A), 7100 Old Landover Road, Landover, MD 20785–1506.

Regardless of which address you use, you must show proof of mailing consisting of one of the following:

(1) A legibly dated U.S. Postal Service postmark,

(2) A legible mail receipt with the date of mailing stamped by the U.S. Postal Service,

(3) A dated shipping label, invoice, or receipt from a commercial carrier, or

(4) Any other proof of mailing acceptable to the Secretary of the U.S. Department of Education.

If you mail your application through the U.S. Postal Service, we do not accept either of the following as proof of mailing:

(1) A private metered postmark, or

(2) A mail receipt that is not dated by the U.S. Postal Service.

If your application is postmarked after the application deadline date, we will not consider your application.

Note: The U.S. Postal Service does not uniformly provide a dated postmark. Before relying on this method, you should check with your local post office.

c. *Submission of Paper Applications by Hand Delivery.*

If you qualify for an exception to the electronic submission requirement, you (or a courier service) may deliver your paper application to the Department by hand. You must deliver the original and two copies of your application by hand, on or before the application deadline date, to the Department at the following address: U.S. Department of Education, Application Control Center, Attention: (CFDA Number 84.132A), 550 12th Street, SW., Room 7041, Potomac Center Plaza, Washington, DC 20202–4260.

The Application Control Center accepts hand deliveries daily between 8 a.m. and 4:30 p.m., Washington, DC time, except Saturdays, Sundays, and Federal holidays.

Note for Mail or Hand Delivery of Paper Applications: If you mail or hand deliver your application to the Department:

(1) You must indicate on the envelope and—if not provided by the Department—in the appropriate place on the SF 424 the CFDA number—and suffix letter, if any—of the competition under which you are submitting your application.

(2) The Application Control Center will mail a grant application receipt acknowledgment to you. If you do not receive the grant application receipt acknowledgment within 15 business days from the application deadline date, you should call the U.S. Department of Education Application Control Center at (202) 245–6288.

V. Application Review Information

1. *Selection Criteria:* The selection criteria for this competition are in 34 CFR 366.27.

2. *Review and Selection Process:* An additional factor we consider in selecting an application for an award is comments regarding the application, if any, by the State Independent Living Council in the State or territory in which the applicant is located.

VI. Award Administration Information

1. *Award Notices:* If your application is successful, we notify your U.S. Representative and U.S. Senators and send you a Grant Award Notification (GAN). We may also notify you informally.

If your application is not evaluated or not selected for funding, we notify you.

2. *Administrative and National Policy Requirements:* We identify administrative and national policy requirements in the application package and reference these and other requirements in the *Applicable Regulations* section of this notice.

We reference the regulations outlining the terms and conditions of an award in the *Applicable Regulations* section of this notice and include these and other specific conditions in the GAN. The GAN also incorporates your approved application as part of your binding commitments under the grant.

3. *Reporting:* At the end of your project period, you must submit a final performance report, including financial information, as directed by the Secretary. If you receive a multi-year award, you must submit an annual performance report that provides the most current performance and financial expenditure information as specified by the Secretary in 34 CFR 75.118.

4. *Performance Measures:* The Government Performance and Results Act of 1993 (GPRA) directs Federal departments and agencies to improve the effectiveness of their programs by engaging in strategic planning, setting outcome-related goals for programs, and measuring program results against those goals.

The goal of the Centers for Independent Living program is to promote and practice the independent living philosophy of consumer control of the center regarding decisionmaking, service delivery, management, and establishment of the policy and direction of the center; self-help and self-advocacy; development of peer relationships and peer role models; and the equal access of individuals with significant disabilities to society and to all services, programs, activities, resources, and facilities, whether public or private and regardless of the funding source.

In order to measure the success of one component of meeting this goal, each grantee is required to track the number of individuals who leave nursing homes and other institutions for community-based housing due to independent living services provided by the center. In annual performance reports, centers are required to provide information on the number of individuals requesting this service and the number of individuals who successfully relocated from institutionalized to community-based living.

VII. Agency Contact

For Further Information Contact: Thomas Kelley, U.S. Department of Education, 400 Maryland Avenue, SW., Room 5055, Potomac Center Plaza, Washington, DC 20202–2800. Telephone: (202) 245–7404.

If you use a telecommunications device for the deaf (TDD), you may call the Federal Relay Service (FRS) at 1–800–877–8339.

Individuals with disabilities may obtain this document in an alternative format (*e.g.*, Braille, large print, audiotape, or computer diskette) on request to the program contact person listed in this section.

VIII. Other Information

Electronic Access to This Document: You may view this document, as well as all other documents of this Department published in the **Federal Register**, in text or Adobe Portable Document Format (PDF) on the Internet at the following site: *http://www.ed.gov/news/fedregister.*

To use PDF you must have Adobe Acrobat Reader, which is available free at this site. If you have questions about using PDF, call the U.S. Government Printing Office (GPO), toll free, at 1–888–293–6498; or in the Washington, DC, area at (202) 512–1530.

Note: The official version of this document is the document published in the **Federal Register.** Free Internet access to the official edition of the **Federal Register** and the Code of Federal Regulations is available on GPO Access at: *http://www.gpoaccess.gov/nara/index.html.*

Dated: August 14, 2006.

John H. Hager,

Assistant Secretary for Special Education and Rehabilitative Services.

[FR Doc. E6–13648 Filed 8–17–06; 8:45 am]

BILLING CODE 4000–01–P

DEPARTMENT OF ENERGY

Office of Energy Efficiency and Renewable Energy

Federal Energy Management Program; Standard for Premium Energy Efficient Electric Motors for Federal Acquisition

AGENCY: Office of Energy Efficiency and Renewable Energy, Department of Energy (DOE).

ACTION: Notice of final determination.

SUMMARY: The Energy Policy Act of 2005 (EPAct 2005) requires that in the case of electric motors of 1 to 500 horsepower, Federal agencies shall select and purchase only premium efficient motors that meet a specification designated by the Secretary of Energy (Secretary). DOE today designates the specifications developed by the Federal Energy Management Program (FEMP) under Executive Order 13123 as the specification for premium efficient motors for purposes of Federal purchasing. The specifications in today's final standard are identical to those in a temporary standard published for public comment on February 14, 2006. This final standard is consistent with standards recommended by the National Electrical Manufacturers Association (NEMA), the Consortium for Energy Efficiency (CEE) and other energy efficiency groups.

DATES: The effective date of this notice is August 18, 2006.

FOR FURTHER INFORMATION CONTACT: Shelley Launey, U.S. Department of Energy, Office of Energy Efficiency and Renewable Energy, Federal Energy Management Program (FEMP), EE–2L, 1000 Independence Avenue, SW., Washington, DC 20585–0121, (202) 586–1573, e-mail: *Shelley Launey@ee.doe.gov,* or Chris Calamita, U.S. Department of Energy, Office of General Counsel, GC–72, 1000 Independence Avenue, SW., Washington, DC 20585–0103, (202) 586–9507, e-mail: *Christopher.Calamita@hq.doe.gov.*

SUPPLEMENTARY INFORMATION:

I. Background

Generally, section 104 of EPAct 2005 (Pub. L. 109–58; August 8, 2005) amends Part 3 of Title V of the National Energy Conservation Policy Act (NECPA) (codified at 42 U.S.C. 8251 *et seq.*) to require that Federal agencies procure only ENERGY STAR qualified products or FEMP-designated products. Section 104 also sets forth procurement requirements for specific products, including electric motors of 1 to 500 horsepower. Prior to enactment of EPAct 2005, similar provisions for energy-efficient Federal purchasing were established under Executive Order 13123, 64 FR 30849, 30851 (June 8, 1999). With respect to motors, in response to Executive Order 13123, FEMP worked with NEMA and CEE to establish efficiency criteria for low-voltage electric motors as a voluntary standard for Federal procurements.

Part of Title V of NECPA, as amended by section 104 of EPAct 2005 (42 U.S.C. 8259(b)) requires that in the case of electric motors of 1 to 500 horsepower, Federal agencies shall purchase only premium efficient motors that meet a specification [1] designated by the Secretary no later than 120 days after the date of enactment; EPAct 2005 was enacted on August 8, 2005. DOE published a temporary standard for premium efficient motors for purposes of Federal procurement for public comment on February 14, 2006 (71 FR 7749). On February 28, 2006, the **Federal Register** corrected two erroneous values in Table 1 that it unintentionally included in the temporary standard notice (71 FR 10097).

After consultation with NEMA and representatives of energy efficiency organizations participating in the CEE Motors Committee, and after careful evaluation of the public comments, DOE today designates as a standard for premium energy efficient motors rated from 1 to 500 HP for purposes of Federal procurement, the efficiency levels as set forth in Tables 1 and 2 included in this notice.

II. Response to Comments on Temporary Standard

DOE received one written comment from the Defense Logistics Agency (DLA) in response to the February notice. The DLA requested that the motor specification apply only to

[1] Although section 104 states that "agencies shall select only premium efficient motors that meet a standard designated by the Secretary," we note that section 104 establishes a procurement standard based on efficiency specifications for electric motors.

commercially available motors for general applications and not to those required for special combat or defense related applications. DOE notes that the statutory definition of products subject to today's procurement requirement specifically excludes energy consuming products or systems designed or procured for combat or combat-related missions. Additionally, DOE is clarifying in Section III of this notice that the final standard is for general purpose motors, as defined by 10 CFR 431.12. DLA also suggested that DOE incorporate by reference Table 12–12 of the NEMA Standard MG–1 because it cites both nominal and minimum efficiencies. Nominal efficiency is the level to which motors are tested; it is the efficiency level which manufacturers include on the product nameplate. In actual practice, efficiencies may vary slightly from the nominal value, but they must not fall below the minimum level specified by the manufacturer.

For procurement purposes, the nominal efficiency is appropriate because this is the certified value of the motor. Also, the nominal efficiency is the specification that appears on a motor nameplate and as such, is the specification most readily available to a purchaser. Because DLA did not provide any compelling need for minimum efficiencies, and because a single nominal efficiency level will make it easier for agencies to readily identify which motors can be purchased under today's procurement standard, DOE is using nominal efficiency values identical to those in the current specification for premium electric motors contained in Table 12–12 of NEMA standard MG–1 for the final standard contained here, but is not incorporating Table 12–12.

III. Discussion of Final Standard

Today's designation is for electric motors of 1 to 500 horsepower as specified in EPAct 2005, that are not designed or procured for combat or combat-related missions. Further, the requirement established in today's document applies only to the procurement of "general-purpose" motors as defined in 10 CFR 431.12. Some applications require definite-purpose, special-purpose, special frame, or special mounted polyphase induction motors. However, such motors are not general purpose motors as defined in 10 CFR 431.12. Special purpose motors are therefore not subject to the procurement requirement in this document. Even so, special purpose motors meeting the efficiency levels of this specification are often available and are recommended.

DOE has worked in conjunction with NEMA and CEE to ensure that purchasers will not be confused by multiple efficiency specifications. The efficiency levels in Tables 1 and 2 are identical to the NEMA Premium™ and CEE Premium Efficiency Motors efficiency criteria. Tables 1 and 2 can also be found on the DOE FEMP procurement Web site at *http://www.eere.energy.gov/femp/procurement/eep_emotors.cfm*, and the NEMA Web site at *http://www.nema.org/gov/energy/efficiency/premium/*. Motor efficiency is identified on the nameplate by "nominal" efficiency, which represents the average efficiency of a large population of motors of the same design. It is certified in accordance with NEMA MG 1–1998, "Motors and Generators," and IEEE 112 Test Method B.

By using common specifications for premium energy efficient motors, NEMA, CEE, and DOE have helped focus market demand by Federal buyers and utility company customers on a single standard for energy efficiency, thus providing a clear market signal in support of energy efficiency to manufacturers, suppliers, specifiers, and installers of electric motors.

FEMP will periodically review the DOE's motor efficiency standard and revise it as necessary, in consultation with industry and energy efficiency organizations, to reflect technology advances and/or changing market conditions.

Issued in Washington, DC, on August 8, 2006.

Alexander A. Karsner,

Assistant Secretary, Energy Efficiency and Renewable Energy.

TABLE 1.—NOMINAL EFFICIENCIES FOR INDUCTION MOTORS RATED 600 VOLTS OR LESS

[Random wound]

	Open drip-proof			Totally enclosed fan-cooled		
HP	6-pole	4-pole	2-pole	6-pole	4-pole	2-pole
1	82.5	85.5	*77.0	82.5	85.5	77.0
1.5	86.5	86.5	84.0	87.5	86.5	84.0
2	87.5	86.5	85.5	88.5	86.5	85.5
3	88.5	89.5	85.5	89.5	89.5	86.5
5	89.5	89.5	86.5	89.5	89.5	88.5
7.5	90.2	91.0	88.5	91.0	91.7	89.5
10	91.7	91.7	89.5	91.0	91.7	90.2
15	91.7	93.0	90.2	91.7	92.4	91.0
20	92.4	93.0	91.0	91.7	93.0	91.0
25	93.0	93.6	91.7	93.0	93.6	91.7
30	93.6	94.1	91.7	93.0	93.6	91.7
40	94.1	94.1	92.4	94.1	94.1	92.4
50	94.1	94.5	93.0	94.1	94.5	93.0
60	94.5	95.0	93.6	94.5	95.0	93.6
75	94.5	95.0	93.6	94.5	95.4	93.6
100	95.0	95.4	93.6	95.0	95.4	94.1
125	95.0	95.4	94.1	95.0	95.4	95.0
150	95.4	95.8	94.1	95.8	95.8	95.0
200	95.4	95.8	95.0	95.8	96.2	95.4
250	95.4	95.8	95.0	95.8	96.2	95.8
300	95.4	95.8	95.4	95.8	96.2	95.8
350	95.4	95.8	95.4	95.8	96.2	95.8
400	95.8	95.8	95.8	95.8	96.2	95.8
450	96.2	96.2	95.8	95.8	96.2	95.8
500	96.2	96.2	95.8	95.8	96.2	95.8

TABLE 2.—NOMINAL EFFICIENCIES FOR INDUCTION MOTORS RATED 5 KV OR LESS

[Form wound]

	Open drip-proof			Totally enclosed fan-cooled		
HP	6-pole	4-pole	2-pole	6-pole	4-pole	2-pole
250	95.0	95.0	94.5	95.0	95.0	95.0
300	95.0	95.0	94.5	95.0	95.0	95.0
350	95.0	95.0	94.5	95.0	95.0	95.0
400	95.0	95.0	94.5	95.0	95.0	95.0
450	95.0	95.0	94.5	95.0	95.0	95.0
500	95.0	95.0	94.5	95.0	95.0	95.0

[FR Doc. E6–13691 Filed 8–17–06; 8:45 am]
BILLING CODE 6450–01–P

DEPARTMENT OF ENERGY

Energy Information Administration

Agency Information Collection Activities: Submission for OMB Review; Comment Request

AGENCY: Energy Information Administration (EIA), Department of Energy (DOE).

ACTION: Agency Information Collection Activities: Submission for OMB Review; Comment Request.

SUMMARY: The EIA has submitted the DOE–887, "DOE Customer Surveys," to the Office of Management and Budget (OMB) for review and a three-year extension under section 3507(h)(1) of the Paperwork Reduction Act of 1995 (Pub. L. 104–13) (44 U.S.C. 3501 *et seq.*, at 3507(h)(1)).

DATES: Comments must be filed by September 18, 2006. If you anticipate that you will be submitting comments but find it difficult to do so within that period, you should contact the OMB Desk Officer for DOE listed below as soon as possible.

ADDRESSES: Send comments to John Asalone, OMB Desk Officer for DOE, Office of Information and Regulatory Affairs, Office of Management and Budget. To ensure receipt of the comments by the due date, submission by FAX at 202–395–7285 or e-mail to *John_A._Asalone@omb.eop.gov* is recommended. The mailing address is 726 Jackson Place, NW., Washington, DC 20503. The OMB DOE Desk Officer may be telephoned at (202) 395–4650. (A copy of your comments should also be provided to EIA's Statistics and Methods Group at the address below.)

FOR FURTHER INFORMATION CONTACT: Requests for additional information should be directed to Kara Norman. To ensure receipt of the comments by the due date, submission by FAX (202–287–1705) or e-mail (*kara.norman@eia.doe.gov*) is recommended. The mailing address is Statistics and Methods Group (EI–70), Forrestal Building, U.S. Department of Energy, Washington, DC 20585–0670. Kara Norman may be contacted by telephone at (202) 287–1902.

SUPPLEMENTARY INFORMATION: This section contains the following information about the energy information collection submitted to OMB for review: (1) The collection numbers and title; (2) the sponsor (i.e., the Department of Energy component (if OGC, spell out "Office of General Council"); (3) the current OMB docket number (if applicable); (4) the type of request (i.e., new, revision, extension, or reinstatement); (5) response obligation (i.e., mandatory, voluntary, or required to obtain or retain benefits); (6) a description of the need for and proposed use of the information; (7) a categorical description of the likely respondents; and (8) an estimate of the total annual reporting burden (i.e., the estimated number of likely respondents times the proposed frequency of response per year times the average hours per response (just the burden hours here—not the formula).

1. DOE–887, "DOE Customer Surveys".
2. Energy Information Administration.
3. OMB Number 1901–0302.
4. Three-year extension.
5. Voluntary.
6. DOE–887 will be used to contact users and beneficiaries of DOE products or other services to determine how DOE can better improve its services to meet their needs. Information is needed to make DOE products more effective, efficient, and responsive and at a lesser cost.
7. Respondents are users and beneficiaries of DOE products and services.
8. 12,500 hours (50,000 respondents times 1 response per year times .25 hours per response).

Please refer to the supporting statement as well as the proposed forms and instructions for more information about the purpose, who must report, when to report, where to submit, the elements to be reported, detailed instructions, provisions for confidentiality, and uses (including possible nonstatistical uses) of the information. For instructions on obtaining materials, see the "**FOR FURTHER INFORMATION CONTACT**" section.

Statutory Authority: Section 3507(h)(1) of the Paperwork Reduction Act of 1995 (Pub. L. 104–13) (44 U.S.C. 3501 *et seq.*, at 3507(h)(1))

Issued in Washington, DC, August 14, 2006.

Nancy Kirkendall,

Agency Clearance Officer, Energy Information Administration.

[FR Doc. E6–13689 Filed 8–17–06; 8:45 am]
BILLING CODE 6450–01–P

DEPARTMENT OF ENERGY

Energy Information Administration

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Energy Information Administration (EIA), Department of Energy (DOE).

ACTION: Agency Information Collection Activities: Proposed Collection; Comment Request.

SUMMARY: The EIA is soliciting comments on the proposed revisions to and three-year extension of the Oil and Gas Reserves System Surveys, Form EIA–23 "Annual Survey of Domestic Oil and Gas Reserves," Form EIA–23P, "Oil and Gas Well Operator List Update Report," and EIA–64A, "Annual Report of the Origin of Natural Gas Liquids Production".

DATES: Comments must be filed by October 17, 2006. If you anticipate difficulty in submitting comments within that period, contact the person listed below as soon as possible.

ADDRESSES: Send comments to Mr. Rafi Zeilnalpour at U.S. Department of Energy, Energy Information Administration, Reserves and Production Division, 1999 Bryan Street, Suite 1110, Dallas, Texas 75201–6801. To ensure receipt of the comments by the due date, submission by fax (214–7206155) or e-mail (*RAFI.ZEINALPOUR@EIA.DOE.GOV*) is recommended. Alternatively, Mr. Rafi Zeilnalpour may be contacted by telephone at (214–720–6191).

FOR FURTHER INFORMATION CONTACT: Requests for additional information or copies of any forms and instructions should be directed to Mr. Rafi Zeilnalpour at the address listed above.

SUPPLEMENTARY INFORMATION:

I. Background
II. Current Actions
III. Request for Comments

I. Background

The Federal Energy Administration Act of 1974 (Pub. L. 93–275, 15 U.S.C. 761 *et seq.*) and the DOE Organization Act (Pub. L. 95–91, 42 U.S.C. 7101 *et seq.*) require the EIA to carry out a centralized, comprehensive, and unified energy information program. This program collects, evaluates, assembles, analyzes, and disseminates information on energy resource reserves, production, demand, technology, and related economic and statistical information. This information is used to assess the adequacy of energy resources to meet near and longer term domestic demands.

The EIA, as part of its effort to comply with the Paperwork Reduction Act of 1995 (Pub. L. 104–13, 44 U.S.C. Chapter 35), provides the general public and other Federal agencies with opportunities to comment on collections of energy information conducted by or in conjunction with the EIA. Any comments received help the EIA to prepare data requests that maximize the utility of the information collected, and to assess the impact of collection requirements on the public. Also, the EIA will later seek approval by the Office of Management and Budget (OMB) under Section 3507(a) of the Paperwork Reduction Act of 1995.

Operators of crude oil and natural gas wells are the target respondents of Forms EIA–23 and EIA–23P. There are two versions of Form EIA–23. Large operators (those that produce 1.5 million barrels or more of crude oil or 15 billion cubic feet or more of natural gas per year) and intermediate operators (those that produce at least 400,000 barrels of crude oil or 2 billion cubic feet of natural gas per year, but less than large operators) file Form EIA–23L. Small operators (those that produce less than intermediate operators) file Form 23S. Respondents report volumes of crude oil, associated-dissolved natural gas, non-associated natural gas, lease condensate production, reserves and revisions to previous year reports, discoveries, extensions, sales, acquisitions, and non-producing reserves for each individual operated field without regard to interest ownership. (Individual field information is requested from large and intermediate operators; samples of small operators are requested to submit less detailed information.) The majority of small operators are not asked to report annually on Form EIA–23. The selected sample of small operators provide production and available reserves information for crude oil, total natural gas and lease condensate at a State or geographic subdivision level.

Form EIA–23P is a postcard form used to collect information on possible oil and gas well operators that may be included in future EIA–23 surveys. Information obtained from Form EIA–23P is used to confirm and/or update general operator information, primarily about small companies with which no contact has been made in the last few years.

Operators of natural gas plants are the target respondents of the Form EIA–64A. The volumes of natural gas processed, natural gas liquids produced, resultant shrinkage of the natural gas and natural gas used in processing are requested of all natural gas plant operators.

In response to Public Law 95–91 Section 657, estimates of U.S. oil and gas reserves are to be reported annually. Many U.S. government agencies have an interest in the definitions of proved oil and gas reserves and the quality, reliability and usefulness of estimates of reserves. Among these are the Energy Information Administration (EIA), Department of Energy; Minerals Management Service (MMS), Department of Interior; Internal Revenue Service (IRS), Department of the Treasury; and the Securities and Exchange Commission (SEC). Each of these organizations has specific purposes for collecting, using, or estimating proved reserves. The EIA has a congressional mandate to provide accurate annual estimates of U.S. proved crude oil, natural gas and natural gas liquids reserves and publishes an annual reserves report to meet this requirement. The MMS maintains estimates of proved reserves to carry out their responsibilities in leasing, collecting royalty payments and regulating the activities of oil and gas companies on Federal lands and water and is second only to the IRS in generating Federal revenue. For the IRS, proved reserves and occasionally probable reserves are an essential component of calculating taxes for companies owning or producing oil and gas. The SEC requires publicly traded petroleum companies to annually file a reserves statement as part of their 10–K filing. The basic purpose of the 10–K filing is to give the investing public a clear and reliable financial basis to assess the relative value, as a financial asset, of a company's reserves, especially in comparison to other similar oil and gas companies.

The Government also uses the resulting information to develop national and regional estimates of proved reserves of domestic crude oil, natural gas and natural gas liquids to facilitate national energy policy decisions. These estimates are essential to the development, implementation, and evaluation of energy policy and legislation. Data are used directly in the EIA annual publication, *U.S. Crude Oil, Natural Gas and Natural Gas Liquids Reserves,* and are incorporated into a number of other publications and analyses. Secondary publications that use the data include EIA's *Annual Energy Review, Annual Energy Outlook, Petroleum Supply Annual* and *Natural Gas Annual.*

II. Current Actions

This notice is a three-year extension of Form EIA–23, "Annual Survey of Domestic Oil and Gas Reserves", Form EIA–23P, "Oil and Gas Well Operator List Update Report" and Form EIA–64A, "Annual Report of the Origin of Natural Gas Liquids Production, and a small modification to Form EIA–23L.

Form EIA–23P will be extended without modification. Currently available reliable State and other sources will be used to confirm and/or update operator information thereby reducing the number of Form EIA–23P mail-outs and consequent burden on respondents. Form EIA–23S and Form EIA–64A will also be extended without modification. Maintaining the list of currently active gas plants will be aided by reliable State and other sources thereby reducing the number of needed contacts with plant operators.

Form EIA–23L will be extended with one minor modification. EIA is proposing that more detailed information be collected on the Form EIA–23L for those fields which are producing oil and/or natural gas from sources previously or currently classified as uneconomical or technically unrecoverable. (Such

sources are often generically identified as "nonconventional" resources). This will be accomplished by requesting respondents to use Box No. 5 (MMS Code) in Section 2.1 on the Form EIA–23L to identify specific types of hydrocarbon reservoirs or hydrocarbon deposits by using an additional set of codes. This procedure of adding codes to the existing list of Mineral Management Service Codes has been used successfully since Report Year 1989 to identify volumes of coalbed methane production (natural gas produced from a coal reservoir) and coalbed methane proved reserves (natural gas proved reserves in a coal reservoir) by showing the code CB in Box No. 5. The additional codes will include SH for shale reservoirs and CH for chalk reservoirs. Other reservoirs will be placed in five classes of successively lower permeability: PH, PM, PT, PV, and PU, corresponding respectively to high, medium, tight, very tight and ultra-tight permeability. Most reservoirs currently considered "conventional" would fall into classes PH and PM and most reservoirs currently classified as tight would fall into class PT. Reserves in class PV are comparatively low but they are increasing; currently there may be no proved reserves in class PU.

Some hydrocarbon deposits present special production problems not necessarily related to permeability and additional codes will be assigned. For example, ultra heavy oils and bitumens (oil sands) that typically have low gravity, high viscosity and do not flow at standard conditions would be designated by the code HV (high viscosity). Gas hydrates would be designated by the code GH and natural gas dissolved in subsurface brines would be designated by the code GB. Other categories may be added. No change in burden is anticipated by providing this information because the list of MMS codes which are currently reported in Box 5 is merely being expanded and no new data elements are being added to Form EIA–23L. The use of additional codes to identify new sources of production will provide valuable information of substantial analytical value.

III. Request for Comments

Prospective respondents and other interested parties should comment on the actions discussed in item II. The following guidelines are provided to assist in the preparation of comments. In providing comments, please indicate to which form(s) your comments apply.

General Issues

A. Is the proposed collection of information necessary for the proper performance of the functions of the agency and does the information have practical utility? Practical utility is defined as the actual usefulness of information to or for an agency, taking into account its accuracy, adequacy, reliability, timeliness, and the agency's ability to process the information it collects.

B. What enhancements can be made to the quality, utility, and clarity of the information to be collected?

As a Potential Respondent to the Request for Information

A. What actions could be taken to help ensure and maximize the quality, objectivity, utility, and integrity of the information to be collected?

B. Are the instructions and definitions clear and sufficient? If not, which instructions need clarification?

C. Can the information be submitted by the due date?

D. Public reporting burden for this collection is estimated as follows:

Form EIA–23S: 4 hours (small operators).

Form EIA–23L: 32 hours (intermediate operators); 160 hours (large operators).

Form EIA–23P: 15 minutes (all operators).

Form EIA–64A: 6 hours (natural gas plant operators).

The estimated burden includes the total time necessary to provide the requested information. In your opinion, how accurate is this estimate?

E. The agency estimates that the only cost to a respondent is for the time it will take to complete the collection. Will a respondent incur any start-up costs for reporting, or any recurring annual costs for operation, maintenance, and purchase of services associated with the information collection?

F. What additional actions could be taken to minimize the burden of this collection of information? Such actions may involve the use of automated, electronic, mechanical, or other technological collection techniques or other forms of information technology.

G. Does any other Federal, State, or local agency collect similar information? If so, specify the agency, the data element(s), and the methods of collection.

As a Potential User of the Information To Be Collected

A. What actions could be taken to help ensure and maximize the quality, objectivity, utility, and integrity of the information disseminated?

B. Is the information useful at the levels of detail to be collected?

C. For what purpose(s) would the information be used? Be specific.

D. Are there alternate sources for the information and are they useful? If so, what are their weaknesses and/or strengths?

Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval of the form. They also will become a matter of public record.

Statutory Authority: Section 3507(h)(1) of the Paperwork Reduction Act of 1995 (Pub. L. 104–13, 44 U.S.C. Chapter 35).

Issued in Washington, DC, August 14, 2006.

Nancy Kirkendall,

Energy Information Administration.

[FR Doc. E6–13694 Filed 8–17–06; 8:45 am]

BILLING CODE 6450–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. RP06–445–000]

ANR Pipeline Company; Notice of Proposed Changes in FERC Gas Tariff

August 1, 2006.

Take notice that on July 26, 2006, ANR Pipeline Company (ANR) tendered for filing as part of its FERC Gas Tariff, Second Revised Volume No. 1, the following tariff sheets to become effective on September 1, 2006:

First Revised Sheet No. 101C.01.
Second Revised Sheet No. 101D.

Any person desiring to intervene or to protest this filing must file in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211 and 385.214). Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a notice of intervention or motion to intervene, as appropriate. Such notices, motions, or protests must be filed in accordance with the provisions of Section 154.210 of the Commission's regulations (18 CFR 154.210). Anyone filing an intervention or protest must serve a copy of that document on the Applicant. Anyone filing an intervention or protest on or before the intervention or protest date need not serve motions to intervene or protests on persons other than the Applicant.

The Commission encourages electronic submission of protests and

interventions in lieu of paper using the "eFiling" link at *http://www.ferc.gov*. Persons unable to file electronically should submit an original and 14 copies of the protest or intervention to the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426.

This filing is accessible online at *http://www.ferc.gov*, using the "eLibrary" link and is available for review in the Commission's Public Reference Room in Washington, DC. There is an "eSubscription" link on the Web site that enables subscribers to receive e-mail notification when a document is added to a subscribed docket(s). For assistance with any FERC Online service, please e-mail *FERCOnlineSupport@ferc.gov*, or call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Magalie R. Salas,

Secretary.

[FR Doc. E6–13770 Filed 8–17–06; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. CP05–357–003]

Cheniere Creole Trail Pipeline, L.P.; Notice of Amendment

August 11, 2006.

Take notice that on August 4, 2006, Cheniere Creole Trail Pipeline, L.P. (Cheniere), 717 Texas Avenue, Suite 3100, Houston, Texas 77002, filed in Docket No. CP05–357–003, pursuant to section 7(c) of the Natural Gas Act and Part 157 of the Commission's regulations, an application to amend its certificate of public convenience and necessity issued in Docket Nos. CP05–357–000, et al., on June 15, 2006. Cheniere proposes to extend the Cheniere Creole Trail Pipeline by adding 18.1 miles of natural gas pipeline facilities with appurtenances to connect the previously-authorized Cheniere pipeline with the Cheniere Sabine Pass Pipeline system. Cheniere also requested authorization for certain accounting and rate treatment related to the subject pipeline, all as more fully set forth in the application.

The application is on file with the Commission and open for public inspection. This application is available for review at the Commission in the Public Reference Room or may be viewed on the Commission's Web site at *http://www.ferc.gov* using the "eLibrary" link. Enter the docket number excluding the last three digits in the docket number field to access the document. For assistance, please contact FERC Online Support at *FERCOnlineSupport@ferc.gov* or toll free at (866) 208–3676, or for TTY, contact (202) 502–8659.

Any questions regarding the application should be directed to Patricia Outtrim, Cheniere LNG, Inc., 717 Texas Avenue, Suite 3100, Houston, Texas 77002, (713) 659–1361 or Lisa Tonery, King & Spalding LLP, 1185 Avenue of the Americas, New York, NY 10036, (212) 556–2307.

There are two ways to become involved in the Commission's review of this project. First, any person wishing to obtain legal status by becoming a party to the proceedings for this project should, on or before the comment date listed below, file with the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426, a motion to intervene in accordance with the requirements of the Commission's Rules of Practice and Procedure (18 CFR 385.214 or 385.211) and the Regulations under the NGA (18 CFR 157.10). A person obtaining party status will be placed on the service list maintained by the Secretary of the Commission and will receive copies of all documents filed by the applicant and by all other parties. A party must submit 14 copies of this filing and all subsequent filings made with the Commission and must mail a copy of all filing to the applicant and to every other party in the proceeding. Only parties to the proceeding can ask for court review of Commission orders in the proceeding.

However, other persons do not have to intervene in order to have comments considered. The second way to participate is by filing with the Secretary of the Commission, as soon as possible, an original and two copies of comments in support of or in opposition to this project. The Commission will consider these comments in determining the appropriate action to be taken, but the filing of a comment alone will not serve to make the filer a party to the proceeding. The Commission's rules require that persons filing comments in opposition to this project provide copies of their protests only to the party or parties directly involved in the protest.

Persons who wish to comment only on the environmental review of this project, or in support of or in opposition to this project, should submit an original and two copies of their comments to the Secretary of the Commission. Environmental commenters will be placed on the Commission's environmental mailing list, will receive copies of the environmental documents, and will be notified of meetings associated with the Commission's environmental review process. Environmental commenters will not be required to serve copies of filed documents on all other parties. The Commission's rules require that persons filing comments in opposition to the project provide copies of their protests only to the applicant. However, the non-party commenters will not receive copies of all documents filed by other parties or issued by the Commission (except for the mailing of environmental documents issued by the Commission) and will not have the right to seek court review of the Commission's final order.

The Commission strongly encourages electronic filings of comments, protests, and interventions via the internet in lieu of paper. See 18 CFR 385.2001(a) (1) (iii) and the instructions on the Commission's Web site (*www.ferc.gov*) under the "e-Filing" link.

Comment Date: September 1, 2006.

Magalie R. Salas,

Secretary.

[FR Doc. E6–13625 Filed 8–17–06; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket Nos. EL04–134–005; EL05–15–007]

Entergy Texas Arkansas; Notice of Filing

August 14, 2006.

On June 27, 2006, East Texas Electric Cooperative, Inc. and Entergy Arkansas, Inc. (EAI) filed a settlement agreement in the above proceeding, resolving issues in dispute relating to EAI's Refund Report originally filed on January 23, 2006. By this notice, comments on the settlement agreement should be filed on or before August 28, 2006.

Magalie R. Salas,

Secretary.

[FR Doc. E6–13628 Filed 8–17–06; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. PR00–9–005]

GulfTerra Texas Pipeline, L.P.; Notice of Request for Reconsideration

August 1, 2006.

Take notice that on July 12, 2006, Enterprise Texas Pipeline L.P. (Enterprise Texas), successor to GulfTerra Texas Pipeline, L.P. filed a request for reconsideration based on changed circumstances and request for expedited consideration. Enterprise Texas requests reconsideration of the June 11, 2002 Order on Staff Panel, and the February 25, 2004 Order on Rehearing and Denying Late Intervention (collectively, the Unbundling Orders).

Any person desiring to participate in this rate proceeding must file a motion to intervene or to protest this filing must file in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211 and 385.214). Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a notice of intervention or motion to intervene, as appropriate. Such notices, motions, or protests must be filed on or before the date as indicated below. Anyone filing an intervention or protest must serve a copy of that document on the Applicant. Anyone filing an intervention or protest on or before the intervention or protest date need not serve motions to intervene or protests on persons other than the Applicant.

The Commission encourages electronic submission of protests and interventions in lieu of paper using the "eFiling" link at *http://www.ferc.gov.* Persons unable to file electronically should submit an original and 14 copies of the protest or intervention to the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426.

This filing is accessible online at *http://www.ferc.gov,* using the "eLibrary" link and is available for review in the Commission's Public Reference Room in Washington, DC. There is an "eSubscription" link on the Web site that enables subscribers to receive e-mail notification when a document is added to a subscribed docket(s). For assistance with any FERC Online service, please e-mail *FERCOnlineSupport@ferc.gov,* or call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Comment Date: August 8, 2006.

Magalie R. Salas,

Secretary.

[FR Doc. E6–13769 Filed 8–17–06; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket Nos. EL06–84–000]

Nevada Power Company, Inc.; Notice of Institution of Proceeding and Refund Effective Date

August 1, 2006.

On July 28, 2006, the Commission issued an order that instituted a proceeding in Docket No. EL06–84–000, pursuant to section 206 of the Federal Power Act (FPA), 16 U.S.C. 824e (2005), to provide a forum for Nevada Power Company to address its assertion that its projected native load needs justify a restriction on the rollover rights of its transmission customer, PacifiCorp. *Nevada Power Company,* 116 FERC ¶ 61,093 (2006).

The refund effective date in Docket No. EL06–84–000, established pursuant to section 206(b) of the FPA, will be the date of publication of this notice in the **Federal Register**.

Magalie R. Salas,

Secretary.

[FR Doc. E6–13764 Filed 8–17–06; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. RP06–448–000]

Northern Border Pipeline Company; Notice of Proposed Changes in FERC Gas Tariff

August 1, 2006.

Take notice that on July 27, 2006, Northern Border Pipeline Company (Northern Border) tendered for filing to become part of its FERC Gas Tariff, First Revised Volume No. 1, the following tariff sheets to become effective August 28, 2006:

Second Revised Sheet No. 186,
Second Revised Sheet No. 190,
Fourth Revised Sheet No. 191.

Any person desiring to intervene or to protest this filing must file in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211 and 385.214). Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a notice of intervention or motion to intervene, as appropriate. Such notices, motions, or protests must be filed in accordance with the provisions of Section 154.210 of the Commission's regulations (18 CFR 154.210). Anyone filing an intervention or protest must serve a copy of that document on the Applicant. Anyone filing an intervention or protest on or before the intervention or protest date need not serve motions to intervene or protests on persons other than the Applicant.

The Commission encourages electronic submission of protests and interventions in lieu of paper using the "eFiling" link at *http://www.ferc.gov.* Persons unable to file electronically should submit an original and 14 copies of the protest or intervention to the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426.

This filing is accessible on-line at *http://www.ferc.gov,* using the "eLibrary" link and is available for review in the Commission's Public Reference Room in Washington, DC. There is an "eSubscription" link on the Web site that enables subscribers to receive e-mail notification when a document is added to a subscribed docket(s). For assistance with any FERC Online service, please e-mail *FERCOnlineSupport@ferc.gov,* or call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Magalie R. Salas,

Secretary.

[FR Doc. E6–13758 Filed 8–17–06; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. RP06–446–000]

Northern Border Pipeline Company; Notice of Proposed Changes in FERC Gas Tariff

August 1, 2006.

Take notice that on July 27, 2006, Northern Border Pipeline Company (Northern Border) tendered for filing to become part of its FERC Gas Tariff, First Revised Volume No. 1, the following

tariff sheets to become effective April 30, 2006:

Fourteenth Revised Sheet No. 99A.
Fourth Revised Sheet No. 303A.

Any person desiring to intervene or to protest this filing must file in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211 and 385.214). Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a notice of intervention or motion to intervene, as appropriate. Such notices, motions, or protests must be filed in accordance with the provisions of Section 154.210 of the Commission's regulations (18 CFR 154.210). Anyone filing an intervention or protest must serve a copy of that document on the Applicant. Anyone filing an intervention or protest on or before the intervention or protest date need not serve motions to intervene or protests on persons other than the Applicant.

The Commission encourages electronic submission of protests and interventions in lieu of paper using the "eFiling" link at *http://www.ferc.gov*. Persons unable to file electronically should submit an original and 14 copies of the protest or intervention to the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426.

This filing is accessible online at *http://www.ferc.gov*, using the "eLibrary" link and is available for review in the Commission's Public Reference Room in Washington, D.C. There is an "eSubscription" link on the Web site that enables subscribers to receive e-mail notification when a document is added to a subscribed docket(s). For assistance with any FERC Online service, please e-mail *FERCOnlineSupport@ferc.gov*, or call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Magalie R. Salas,

Secretary.

[FR Doc. E6–13771 Filed 8–17–06; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. RP06–447–000]

Northern Border Pipeline Company; Notice of Proposed Changes in FERC Gas Tariff

August 1, 2006.

Take notice that on July 27, 2006, Northern Border Pipeline Company (Northern Border) tendered for filing as part of its FERC Gas Tariff, First Revised Volume No. 1, the following tariff sheets to become effective August 28, 2006:

Third Revised Sheet No. 434.
Eighth Revised Sheet No. 201.
Fourth Revised Sheet No. 436.
Seventh Revised Sheet No. 287.
Fourth Revised Sheet No. 443.
Sixth Revised Sheet No. 295.
Fourth Revised Sheet No. 457.
Seventh Revised Sheet No. 298.
Third Revised Sheet No. 461.
Eleventh Revised Sheet No. 300.
Second Revised Sheet No. 466.
Fifth Revised Sheet No. 405.
Third Revised Sheet No. 468.
Sixth Revised Sheet No. 407.
Third Revised Sheet No. 472.
Sixth Revised Sheet No. 423.
Third Revised Sheet No. 473.
Sixth Revised Sheet No. 425.
Second Revised Sheet No. 479.
Third Revised Sheet No. 429A.
Fourth Revised Sheet No. 484.
Third Revised Sheet No. 429C.
Second Revised Sheet No. 488.

Any person desiring to intervene or to protest this filing must file in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211 and 385.214). Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a notice of intervention or motion to intervene, as appropriate. Such notices, motions, or protests must be filed in accordance with the provisions of Section 154.210 of the Commission's regulations (18 CFR 154.210). Anyone filing an intervention or protest must serve a copy of that document on the Applicant. Anyone filing an intervention or protest on or before the intervention or protest date need not serve motions to intervene or protests on persons other than the Applicant.

The Commission encourages electronic submission of protests and interventions in lieu of paper using the "eFiling" link at *http://www.ferc.gov*. Persons unable to file electronically should submit an original and 14 copies of the protest or intervention to the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426.

This filing is accessible online at *http://www.ferc.gov*, using the "eLibrary" link and is available for review in the Commission's Public Reference Room in Washington, DC. There is an "eSubscription" link on the Web site that enables subscribers to receive e-mail notification when a document is added to a subscribed docket(s). For assistance with any FERC Online service, please e-mail *FERCOnlineSupport@ferc.gov*, or call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Magalie R. Salas,

Secretary.

[FR Doc. E6–13806 Filed 8–17–06; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. RP06–449–000]

Portland Natural Gas Transmission System; Notice of Proposed Changes in FERC Gas Tariff

August 1, 2006.

Take notice that on July 28, 2006, Portland Natural Gas Transmission System (PNGTS) tendered for filing as part of its FERC Gas Tariff, Second Revised Volume No. 1, Original Sheet No. 1, to become effective September 1, 2006.

PNGTS states that copies of the filing are being served on all jurisdictional customers and interested State commissions.

Any person desiring to intervene or to protest this filing must file in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211 and 385.214). Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a notice of intervention or motion to intervene, as appropriate. Such notices, motions, or protests must be filed in accordance with the provisions of § 154.210 of the Commission's regulations (18 CFR 154.210). Anyone filing an intervention or protest must serve a copy of that document on the Applicant. Anyone filing an intervention or protest on or before the intervention or protest date need not serve motions to intervene or

protests on persons other than the Applicant.

The Commission encourages electronic submission of protests and interventions in lieu of paper using the "eFiling" link at *http://www.ferc.gov*. Persons unable to file electronically should submit an original and 14 copies of the protest or intervention to the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426.

This filing is accessible online at *http://www.ferc.gov*, using the "eLibrary" link and is available for review in the Commission's Public Reference Room in Washington, DC. There is an "eSubscription" link on the Web site that enables subscribers to receive e-mail notification when a document is added to a subscribed docket(s). For assistance with any FERC Online service, please e-mail *FERCOnlineSupport@ferc.gov*, or call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Magalie R. Salas,

Secretary.

[FR Doc. E6–13759 Filed 8–17–06; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

Notice of Filing

August 1, 2006.

Regional Transmission Organizations.	RT01–99–000, RT01–99–001,RT01–99–002 and RT01–99–003.
Bangor Hydro-Electric Company, *et al.*	RT01–86–000, RT01–86–001 and RT01–86–002.
New York Independent System Operator, Inc., *et al.*	RT01–95–000, RT01–95–001 and RT01–95–002.
PJM Interconnection, L.L.C., *et al.*	RT01–2–000, RT01–2–001, RT01–2–002 and RT01–2–003.
PJM Interconnection, L.L.C	RT01–98–000.
ISO New England, Inc.	RT02–3–000.
New York Independent System Operator, Inc..	

Take notice that PJM Interconnection, L.L.C., New York Independent System Operator, Inc. and ISO New England, Inc. have posted on their Internet Web sites charts and information updating their progress on the resolution of ISO seams.

Any person desiring to file comments on this information should file with the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426, in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211 and 385.214). All such comments should be filed on or before the comment date. Comments may be filed electronically via the Internet in lieu of paper; see 18 CFR 385.2001(a)(1)(iii) and the instructions on the Commission's Web site under the "e-Filing" link. The Commission strongly encourages electronic filings.

Comment Date: August 22, 2006.

Magalie R. Salas,

Secretary.

[FR Doc. E6–13807 Filed 8–17–06; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket Nos. EL06–83–000]

Southwest Power Pool, Inc.; Notice of Institution of Proceeding and Refund Effective Date

August 1, 2006.

On July 28, 2006, the Commission issued an order that instituted a proceeding in Docket No. EL06–83–000, pursuant to section 206 of the Federal Power Act (FPA), 16 U.S.C. 824e (2005), to provide a forum for Southwest Power Pool (SPP) to address its assertions that its projected native load needs justify a restriction on the rollover rights of its transmission customer, Southwestern Public Service Company. *Southwest Power Pool, Inc.*, 116 FERC ¶ 61,092 (2006).

The refund effective date in Docket No. EL06–83–000, established pursuant to section 206(b) of the FPA, will be the date of publication of this notice in the **Federal Register**.

Magalie R. Salas,

Secretary.

[FR Doc. E6–13763 Filed 8–17–06; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. EL06–92–000]

Tri-County Electric Cooperative, Inc.; Xcel Energy Services Inc.; Southwestern Public Service Company; Notice of Petition for Declaratory Order

August 1, 2006.

Take notice that on July 28, 2006, Tri-County Electric Cooperative, Inc. (Tri-County), Xcel Energy Services Inc., and Southwestern Public Service Company (SPS) (collectively "Petitioners") filed a joint petition for declaratory order for a finding that: (i) SPS alone is subject to the Commission's jurisdiction under the Federal Power Act (FPA) and (ii) disclaiming jurisdiction over Tri-County in connection with the disposition by SPS of certain distribution assets to Tri-County. Alternatively, petitioners request that the Commission grant Tri-County waivers of otherwise applicable section of the FPA.

The Petitioners state that a copy was served upon the Kansas Corporation Commission, the Oklahoma Corporation Commission, and the Public Utility Commission of Texas.

Any person desiring to intervene or to protest this filing must file in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211, 385.214). Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a notice of intervention or motion to intervene, as appropriate. Such notices, motions, or protests must be filed on or before the comment date. On or before the comment date, it is not necessary to serve motions to intervene or protests on persons other than the Applicant.

The Commission encourages electronic submission of protests and interventions in lieu of paper using the "eFiling" link at *http://www.ferc.gov*. Persons unable to file electronically should submit an original and 14 copies of the protest or intervention to the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426.

This filing is accessible online at *http://www.ferc.gov*, using the "eLibrary" link and is available for review in the Commission's Public Reference Room in Washington, DC. There is an "eSubscription" link on the Web site that enables subscribers to

receive e-mail notification when a document is added to a subscribed docket(s). For assistance with any FERC Online service, please e-mail *FERCOnlineSupport@ferc.gov*, or call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Comment Date: 5 p.m. Eastern Time on August 28, 2006.

Magalie R. Salas,

Secretary.

[FR Doc. E6–13765 Filed 8–17–06; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. TS06–11–000]

Wabash Valley Power Association; Notice of Filing

August 1, 2006.

Take notice that on July 26, 2006, Wabash Valley Power Association (Wabash Valley) filed a request for exemption from Part 358.1(c) of the Commission's Regulations under Order No. 2004, standards of conduct requirements.

Wabash Valley states copies of the filing were served upon the public utility commissions in Illinois Michigan, Indiana, Ohio and Missouri.

Any person desiring to intervene or to protest this filing must file in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211, 385.214). Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a notice of intervention or motion to intervene, as appropriate. Such notices, motions, or protests must be filed on or before the comment date. Anyone filing a motion to intervene or protest must serve a copy of that document on the Applicant and all the parties in this proceeding.

The Commission encourages electronic submission of protests and interventions in lieu of paper using the "eFiling" link at *http://www.ferc.gov*. Persons unable to file electronically should submit an original and 14 copies of the protest or intervention to the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426.

This filing is accessible online at *http://www.ferc.gov*, using the "eLibrary" link and is available for review in the Commission's Public Reference Room in Washington, DC. There is an "eSubscription" link on the Web site that enables subscribers to receive e-mail notification when a document is added to a subscribed docket(s). For assistance with any FERC Online service, please e-mail *FERCOnlineSupport@ferc.gov*, or call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Comment Date: 5 p.m. Eastern Time on August 25, 2006.

Magalie R. Salas,

Secretary.

[FR Doc. E6–13808 Filed 8–17–06; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

Notice of Filings

August 14, 2006.

Take notice that the Commission received the following electric corporate filings:

Docket Numbers: EC06–151–000.

Applicants: Northern New England Energy Corp.

Description: Green Mountain Power Corp et al. submits an application for a merger and associated disposition of Commission-jurisdictional facilities pursuant to section 203 of the Federal Power Act.

Filed Date: 08/09/2006.

Accession Number: 20060811–0151.

Comment Date: 5 p.m. Eastern Time on Wednesday, August 30, 2006.

Take notice that the Commission received the following electric rate filings:

Docket Numbers: ER03–1088–002.

Applicants: Direct Energy Marketing Inc.

Description: Direct Energy Marketing, Inc submits its Triennial Updated Market Analysis, in compliance with FERC's 8/13/03 Order.

Filed Date: 08/10/2006.

Accession Number: 20060811–0222.

Comment Date: 5 p.m. Eastern Time on Thursday, August 31, 2006.

Docket Numbers: ER04–445–018; ER04–435–021; ER04–441–013; ER04–443–014.

Applicants: California Independent System Operator Corporation, Pacific Gas and Electric Company, San Diego Gas & Electric Company, and Southern California Edison Company.

Description: The California Independent System Operator Corp submits their filing in compliance with FERC's 7/12/06 Order.

Filed Date: 08/10/2006.

Accession Number: 20060811–0225.

Comment Date: 5 p.m. Eastern Time on Thursday, August 31, 2006.

Docket Numbers: ER06–700–003.

Applicants: California Independent System Operator Corporation.

Description: California Independent System Operator Corp submits an errata to its Supplemental Compliance Filing submitted on 8/9/06 to modify the ISO tariff.

Filed Date: 08/10/2006.

Accession Number: 20060811–0221.

Comment Date: 5 p.m. Eastern Time on Thursday, August 31, 2006.

Docket Numbers: ER06–1005–000.

Applicants: Avista Corporation.

Description: Avista Corporation dba Avista Utilities in response to FERC's correspondence on 7/13/06 withdrawing their 5/17/06 filing of a Service Agreement with Morgan Stanley Capital Group, Inc.

Filed Date: 08/09/2006.

Accession Number: 20060811–0162.

Comment Date: 5 p.m. Eastern Time on Wednesday, August 30, 2006.

Docket Numbers: ER06–1347–000.

Applicants: American Electric Power Services Corp.

Description: Indiana and Michigan Power Co submits an Original Interconnection and Local Delivery Service Agreement with the Town of Warren, Indiana.

Filed Date: 08/09/2006.

Accession Number: 20060810–0055.

Comment Date: 5 p.m. Eastern Time on Wednesday, August 30, 2006.

Docket Numbers: ER06–1348–000.

Applicants: Katmai Energy, LLC.

Description: Katmai Energy, LLC's petition for acceptance of initial rate schedule, FERC Electric Rate Schedule 1, granting certain blanket approvals, waiver and blanket authority.

Filed Date: 08/09/2006.

Accession Number: 20060811–0192.

Comment Date: 5 p.m. Eastern Time on Wednesday, August 30, 2006.

Docket Numbers: ER06–1349–000.

Applicants: Southwest Power Pool, Inc.

Description: Southwest Power Pool, Inc submits seven Executed Service Agreements for Firm Point-to-Point Transmission Service with Kansas Municipal Energy Agency.

Filed Date: 08/09/2006.

Accession Number: 20060811–0191.

Comment Date: 5 p.m. Eastern Time on Wednesday, August 30, 2006.

Docket Numbers: ER06–1350–000.

Applicants: Public Service Company of New Mexico.

Description: Public Service Company of New Mexico submits its First Revised FERC Electric Rate Schedule No. 86.

Filed Date: 08/10/2006.

Accession Number: 20060811–0194.

Comment Date: 5 p.m. Eastern Time on Thursday, August 31, 2006.

Any person desiring to intervene or to protest in any of the above proceedings must file in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211 and 385.214) on or before 5 p.m. Eastern time on the specified comment date. It is not necessary to separately intervene again in a subdocket related to a compliance filing if you have previously intervened in the same docket. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Anyone filing a motion to intervene or protest must serve a copy of that document on the Applicant. In reference to filings initiating a new proceeding, interventions or protests submitted on or before the comment deadline need not be served on persons other than the Applicant.

The Commission encourages electronic submission of protests and interventions in lieu of paper, using the FERC Online links at *http://www.ferc.gov.* To facilitate electronic service, persons with Internet access who will eFile a document and/or be listed as a contact for an intervenor must create and validate an eRegistration account using the eRegistration link. Select the eFiling link to log on and submit the intervention or protests.

Persons unable to file electronically should submit an original and 14 copies of the intervention or protest to the Federal Energy Regulatory Commission, 888 First St. NE., Washington, DC 20426.

The filings in the above proceedings are accessible in the Commission's eLibrary system by clicking on the appropriate link in the above list. They are also available for review in the Commission's Public Reference Room in Washington, DC. There is an eSubscription link on the Web site that enables subscribers to receive e-mail notification when a document is added to a subscribed docket(s). For assistance with any FERC Online service, please e-mail *FERCOnlineSupport@ferc.gov* or call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Magalie R. Salas,

Secretary.

[FR Doc. E6–13629 Filed 8–17–06; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Project No. 12629–000–Maine]

F & B Wood Corp.; Notice of Availability of Environmental Assessment

August 1, 2006.

In accordance with the National Environmental Policy Act of 1969 and the Federal Energy Regulatory Commission's regulations, 18 CFR part 380 (Order No. 486, 52 FR 47879), the Office of Energy Projects has reviewed the application for exemption from licensing for the Corriveau Project, to be located on the Swift River, near the town of Mexico, Oxford County, Maine, and has prepared an Environmental Assessment (EA). In the EA, Commission staff analyze the potential environmental impacts of the project and conclude that exempting the project from licensing, with appropriate environmental measures, would not constitute a major Federal action significantly affecting the quality of the human environment.

A copy of the EA is on file with the Commission and is available for public inspection. The EA may also be viewed on the Commission's Web site at *http://www.ferc.gov* using the "eLibrary" link. Enter the docket number excluding the last three digits in the docket number field to access the document. For assistance, contact FERC Online Support at *FERCOnlineSupport@ferc.gov* or toll-free at 1–866–208–3676, or for TTY, (202) 502–8659.

Any comments should be filed within 30 days from the issuance date of this notice, and should be addressed to the Secretary, Federal Energy Regulatory Commission, 888 First Street, NE., Room 1–A, Washington, DC 20426. Please affix "Corriveau Project No. 12629" to all comments. Comments may be filed electronically via Internet in lieu of paper. The Commission strongly encourages electronic filings. See 18 CFR 385.2001(a)(1)(iii) and the instructions on the Commission's Web site under the "eFiling" link. For further information, contact Michael Spencer at (202) 502–6093.

Magalie R. Salas,

Secretary.

[FR Doc. E6–13768 Filed 8–17–06; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. CP06–398–000]

MoBay Storage Hub, Inc.; Notice of Intent To Prepare an Environmental Assessment for the Proposed MoBay Storage Project and Request for Comments on Environmental Issues

August 1, 2006.

The staff of the Federal Energy Regulatory Commission (FERC or Commission) will prepare an environmental assessment (EA) that will discuss the environmental impacts of the MoBay Storage Project involving construction and operation of facilities by MoBay Storage Hub, Inc. (MoBay) in offshore Alabama waters and in Mobile County, Alabama.[1] These facilities would consist of injection/withdrawal storage wells, observation wells, various diameter offshore and onshore pipeline, two 8,500 horsepower (hp) offshore compressor units, one 37,880 hp onshore compressor station, and meter stations. This EA will be used by the Commission in its decisionmaking process to determine whether the project is in the public convenience and necessity.

If you are a landowner receiving this notice, you may be contacted by a pipeline company representative about the acquisition of an easement to construct, operate, and maintain the proposed facilities. The pipeline company would seek to negotiate a mutually acceptable agreement. However, if the project is approved by the Commission, that approval conveys with it the right of eminent domain. Therefore, if easement negotiations fail to produce an agreement, the pipeline company could initiate condemnation proceedings in accordance with State law.

A fact sheet prepared by the FERC entitled "An Interstate Natural Gas Facility on My Land? What Do I Need To Know?" was attached to the project notice Caledonia provided to landowners. This fact sheet addresses a number of typically asked questions, including the use of eminent domain and how to participate in the Commission's proceedings. It is available for viewing on the FERC Internet Web site (*http://www.ferc.gov*).

[1] MoBay's application was filed with the Commission under section 7 of the Natural Gas Act and part 157 of the Commission's regulations.

Summary of the Proposed Project

MoBay proposes to build and operate a high-deliverability, multi-cycle natural gas storage facility and appurtenant facilities in Mobile Bay in offshore Alabama waters and in Mobile County, Alabama, to provide a working gas capacity of approximately 50 billion cubic feet (BCF), and maximum daily injection and withdrawal capabilities of up to one BCF per day. The proposed storage facility would be converted from three offshore substantially-depleted natural gas reservoirs: the North Dauphin Island (NDI), Northwest Dauphin Island (NWDI), and Northeast Petit Bois (NEPB) fields.

MoBay seeks authority to construct and operate:

- 30 offshore injection and withdrawal wells supported by 10 caissons;
- 14 observation wells within the three reservoirs;
- two offshore 8,500 hp compressor units on the NDI platform;
- 7.4 miles of 8- to 16-inch-diameter offshore pipeline connecting the 30 wells to the NDI and NWDI platforms;
- 12.1 miles of 36-inch-diameter offshore pipeline from the NDI platform to the Bayou Coden Valve Station at landfall just east of the mouth of Bayou Coden at milepost 0.0;
- the 37,880 hp MoBay Compressor Station near the Gulfstream Compressor Station 410 on Rock Road in Mobile County, Alabama;
- the Gulfstream Interconnect, the Transco Interconnect, and the Gulf South Pipe Line Interconnect Meter Stations; and
- the Coden Valve at milepost 0.04.

MoBay requests certification by November 1, 2006, to enable commencement of construction in late 2006 for a targeted in-service date of October 1, 2007.

The location of the project facilities is shown in Appendix 1.[2]

Land Requirements for Construction

Construction of the proposed facilities would require disturbance of 14 acres of land offshore and 93 acres of land onshore (18 acres in extra workspaces and pipe yard) for a total of 107 acres. Following construction, 14 acres of offshore land and 33 acres of onshore land would be restored to previous use, leaving 60 acres of onshore land under permanent easement for operation. MoBay would use a 100-foot-wide construction ROW and a 75-foot-wide operational ROW for the onshore pipelines. MoBay would open a 5-foot-wide seafloor trench for offshore pipeline construction.

The EA Process

The National Environmental Policy Act (NEPA) requires the Commission to take into account the environmental impacts that could result from an action whenever it considers the issuance of a Certificate of Public Convenience and Necessity. NEPA also requires us to discover and address concerns the public may have about proposals. This process is referred to as "scoping". The main goal of the scoping process is to focus the analysis in the EA on the important environmental issues. By this Notice of Intent, the Commission staff requests public comments on the scope of the issues to address in the EA. All comments received are considered during the preparation of the EA. State and local government representatives are encouraged to notify their constituents of this proposed action and encourage them to comment on their areas of concern.

In the EA we[3] will discuss impacts that could occur as a result of the construction and operation of the proposed project under these general headings:

- Geology and soils;
- Water resources;
- Wetlands and fisheries;
- Vegetation and wildlife;
- Threatened and endangered species;
- Land use;
- Cultural resources;
- Air quality and noise;
- Reliability and safety, and
- Cumulative impacts.

We will also evaluate reasonable alternatives to the proposed project or portions of the project, and make recommendations on how to lessen or avoid impacts on the various resource areas.

Our independent analysis of the issues will be in the EA. Depending on the comments received during the scoping process, the EA may be published and mailed to Federal, State, and local agencies, public interest groups, interested individuals, affected landowners, newspapers, libraries, and the Commission's official service list for this proceeding. A comment period will be allotted for review if the EA is published. We will consider all comments on the EA before we make our recommendations to the Commission.

To ensure your comments are considered, please carefully follow the instructions in the public participation section below.

Currently Identified Environmental Issues

We have already identified several issues that we think deserve attention based on a preliminary review of the proposed facilities and the environmental information provided by MoBay. This preliminary list of issues may be changed based on your comments and our analysis.

- Open-cut crossing of three perennial waterways, including Bayou Jonas and Bayou Como;
- Disturbance of cypress trees associated with Jonas Bayou;
- Sedimentation in the Mississippi Sound from underwater pipeline and well installation;
- Disturbance of 102 acres of wetlands, including conversion of 35 acres of palustrine forested wetlands to emergent wetlands;
- Open-cut pipeline installation across 15 miles of the Intercoastal Waterway;
- Visual impacts of 10 injection/withdrawal well caissons and 14 observation well caissons;
- Crossing within 0.03 mile of Ralston Park at milepost 0.70;
- Crossing of the Dauphin Island-Bayou LaBatre Loop of the Alabama Coastal Birding Trail at milepost 1.12;
- Noise impacts to three noise sensitive areas (*i.e.* residences) located from 1,800 to 4,300 feet from the proposed MoBay Compressor Station.

Public Participation

You can make a difference by providing us with your specific comments or concerns about the project. By becoming a commentor, your concerns will be addressed in the EA and considered by the Commission. You should focus on the potential environmental effects of the proposal, alternatives to the proposal (including alternative locations/routes), and measures to avoid or lessen environmental impact. The more specific your comments, the more useful they will be. Please carefully follow these instructions to ensure that your comments are received in time and properly recorded:

- Send an original and two copies of your letter to: Magalie R. Salas,

[2] The appendices referenced in this notice are not being printed in the **Federal Register**. Copies of all appendices, other than Appendix 1 (maps), are available on the Commission's Web site at the "eLibrary" link or from the Commission's Public Reference Room, 888 First Street, NE., Washington, DC 20426, or call (202) 502–8371. For instructions on connecting to eLibrary refer to the last page of this notice. Copies of the appendices were sent to all those receiving this notice in the mail.

[3] "We", "us", and "our" refer to the environmental staff of the Office of Energy Projects (OEP).

Secretary, Federal Energy Regulatory Commission, 888 First St., NE., Room 1A, Washington, DC 20426.

• Label one copy of the comments for the attention of Gas 2.

• Reference Docket No. CP06–398–000.

• Mail your comments so that they will be received in Washington, DC on or before August 31, 2006.

Please note that we are continuing to experience delays in mail deliveries from the U.S. Postal Service. As a result, we will include all comments that we receive within a reasonable time frame in our environmental analysis of this project. However, the Commission strongly encourages electronic filing of any comments or interventions or protests to this proceeding. See 18 CFR 385.2001(a)(1)(iii) and the instructions on the Commission's Web site at *http://www.ferc.gov* under the "e-Filing" link and the link to the User's Guide. Before you can file comments you will need to create a free account which can be created online.

We may mail the EA for comment. If you are interested in receiving it, please return the Information Request (Appendix 4). If you do not return the Information Request, you will be taken off the mailing list.

Becoming an Intervenor

In addition to involvement in the EA scoping process, you may want to become an official party to the proceeding known as an "intervenor". Intervenors play a more formal role in the process. Among other things, intervenors have the right to receive copies of case-related Commission documents and filings by other intervenors. Likewise, each intervenor must send one electronic copy (using the Commission's eFiling system) or 14 paper copies of its filings to the Secretary of the Commission and must send a copy of its filings to all other parties on the Commission's service list for this proceeding. If you want to become an intervenor you must file a motion to intervene according to Rule 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.214) (see Appendix 2).[4] Only intervenors have the right to seek rehearing of the Commission's decision.

Affected landowners and parties with environmental concerns may be granted intervenor status upon showing good cause by stating that they have a clear and direct interest in this proceeding which would not be adequately represented by any other parties. You do not need intervenor status to have your environmental comments considered.

Environmental Mailing List

An effort is being made to send this notice to all individuals, organizations, and government entities interested in and/or potentially affected by the proposed project. This includes all landowners who are potential right-of-way grantors, whose property may be used temporarily for project purposes, or who own homes within distances defined in the Commission's regulations of certain aboveground facilities. By this notice we are also asking governmental agencies, especially those in Appendix 3, to express their interest in becoming cooperating agencies for the preparation of the EA.

Additional Information

Additional information about the project is available from the Commission's Office of External Affairs, at 1–866–208–FERC (3372) or on the FERC Internet website (*http://www.ferc.gov*) using the eLibrary link. Click on the eLibrary link, click on "General Search" and enter the docket number excluding the last three digits (*i.e.*, enter PF06–398) in the Docket Number field. Be sure you have selected an appropriate date range. For assistance, please contact FERC Online Support at *FERCOnlineSupport@ferc.gov* or toll free at 1–866–208–3676, or for TTY, contact (202) 502–8659. The eLibrary link also provides access to the texts of formal documents issued by the Commission, such as orders, notices, and rulemakings.

In addition, the Commission now offers a free service called eSubscription which allows you to keep track of all formal issuances and submittals in specific dockets. This can reduce the amount of time you spend researching proceedings by automatically providing you with notification of these filings, document summaries and direct links to the documents. Go to *http://www.ferc.gov/esubscribenow.htm*.

Finally, public meetings or site visits will be posted on the Commission's calendar located at *http://www.ferc.gov/EventCalendar/EventsList.aspx* along with other related information.

Magalie R. Salas,

Secretary.

[FR Doc. E6–13760 Filed 8–17–06; 8:45 am]

BILLING CODE 6717–01–P

[4] Interventions may also be filed electronically via the Internet in lieu of paper. See the previous discussion on filing comments electronically.

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

Notice of Application Tendered for Filing With the Commission, Establishing Procedural Schedule for Relicensing, and a Deadline for Submission of Final Amendments

August 14, 2006.

Take notice that the following hydroelectric application has been filed with the Commission and is available for public inspection.

a. *Type of Application:* New Major License.

b. *Project No.:* 659–014.

c. *Date Filed:* August 3, 2006.

d. *Applicant:* Crisp County Power Commission.

e. *Name of Project:* Lake Blackshear Hydroelectric Project.

f. *Location:* On the Flint River in Worth, Lee, Sumter, Dooly, and Crisp Counties, near Cordele, Georgia. The project does not occupy Federal lands.

g. *Filed Pursuant to:* Federal Power Act 16 U.S.C. 791 (a)–825(r).

h. *Applicant Contact:* Steve Rentfrow, General Manager, Crisp County Power Commission, 202 South 7th Street, Cordele, GA 31015, Phone: 229–273–3811.

i. *FERC Contact:* Lee Emery at 202–502–8379 or e-mail at *lee.emery@ferc.gov*.

j. *Cooperating agencies:* We are asking Federal, state, local, and tribal agencies with jurisdiction and/or special expertise with respect to environmental issues to cooperate with us in the preparation of the environmental document. Agencies who would like to request cooperating status should follow the instructions for filing such requests described in item k below. Cooperating agencies should note the Commission's policy that agencies that cooperate in the preparation of the environmental document cannot also intervene. *See,* 94 FERC ¶ 61,076 (2001).

k. *Deadline for filing requests for cooperating agency status:* October 2, 2006.

All documents (original and eight copies) should be filed with: Magalie R. Salas, Secretary, Federal Energy Regulatory Commission, 888 First Street, NE, Washington, DC 20426.

Requests for cooperating agency status may be filed electronically via the Internet in lieu of paper. The Commission strongly encourages electronic filings. See 18 CFR 385.2001(a)(1)(iii) and the instructions on the Commission's Web site (*http://www.ferc.gov*) under the "e-Filing" link.

l. This application has not been accepted for filing. We are not soliciting motions to intervene, protests, or final terms and conditions at this time.

m. *The existing Lake Blackshear Project consists of:* (1) A 402-foot-long, 46-foot-high gated spillway; (2) a 630-foot-long auxiliary spillway; (3) a 3,410-foot-long north embankment; (4) a 650-foot-long south embankment; (5) an 8,700-acre impoundment at a full pool elevation of 237 feet mean sea level; (6) a powerhouse containing four turbines with a total installed capacity of 15.2 MW; (7) a 1,400-foot-long, 46 kilovolt transmission line; and (8) appurtenant facilities.

n. A copy of the application is available for review at the Commission in the Public Reference Room or may be viewed on the Commission's Web site at *http://www.ferc.gov* using the "eLibrary" link. Enter the docket number excluding the last three digits in the docket number field to access the document. For assistance, contact FERC Online Support at *FERCOnlineSupport@ferc.gov* or toll-free at 1–866–208–3676, or for TTY, (202) 502–8659. A copy is also available for inspection and reproduction at the address in item h above.

You may also register online at *http://www.ferc.gov/docs-filing/esubscription.asp* to be notified via e-mail of new filings and issuances related to this or other pending projects. For assistance, contact FERC Online Support.

o. With this notice, we are initiating consultation with the Georgia State Historic Preservation Officer (SHPO), as required by section 106, National Historic Preservation Act, and the regulations of the Advisory Council on Historic Preservation, 36 CFR, at § 800.4.

p. *Procedural schedule and final amendments:* At this time we do not anticipate the need for preparing a draft environmental assessment (EA). Recipients will have 45 days to provide the Commission with any written comments on the EA. All comments filed with the Commission will be considered in the Order taking final action on the license applications. However, should substantive comments requiring re-analysis be received on the EA document, we would consider preparing a subsequent EA document. The application will be processed according to the following Hydro Licensing Schedule. Revisions to the schedule will be made as appropriate.

Issue Acceptance letter or Deficiency Letter and request Additional Information, if needed—November 2006

Notice soliciting final terms and conditions—March 2007

Notice of the Availability of the EA—October 2007

Ready for Commission's decision on the application February 2008

Final amendments to the application must be filed with the Commission no later than 30 days from the issuance date of the notice soliciting final terms and conditions.

Magalie R. Salas,

Secretary.

[FR Doc. E6–13627 Filed 8–17–06; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Project No. 2030–073]

Portland General Electric Company and the Confederated Tribes of the Warm Springs Reservation of Oregon; Notice Extending Comment Period

August 1, 2006.

This notice applies to the Pelton Round Butte Hydroelectric Project, FERC No. P–2030. The project is licensed to Portland General Electric Company and the Confederated Tribes of the Warm Springs Reservation of Oregon (licensees).

On July 3, 2006, the Commission issued a Notice of Application and Soliciting Comments, Motions to Intervene, and Protests for an application by the licensees for a shoreline management plan as required by article 428 of the project license. The notice established July 31, 2006, as the deadline for filing comments or motions. This notice extends the deadline to August 31, 2006.

If you have any questions regarding this notice, please call Lesley Kordella at (202) 502–6406.

Magalie R. Salas,

Secretary.

[FR Doc. E6–13767 Filed 8–17–06; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Project No. 1971–079]

Idaho Power Company, Idaho/Oregon; Notice of Intent To Hold Public Meetings

August 11, 2006.

In accordance with the National Environmental Policy Act of 1969 and the Federal Energy Regulatory Commission's (Commission) regulations, 18 CFR Part 380 (Order No. 486, 52 Fed. Reg. 47897), the Office of Energy Projects reviewed the application for license for the Hells Canyon Project (FERC No. 1971), located on the Snake River in Washington and Adams Counties, Idaho, and Wallowa and Baker Counties, Oregon, and issued a Draft Environmental Impact Statement (draft EIS) for the project on July 28, 2006.

Copies of the draft EIS are available for review at the Commission's Public Reference Branch, Room 2A, located at 888 First Street, N.E., Washington, DC 20426 or may be viewed on the Commission's Web site at *http://www.ferc.gov* under the e-Library link by entering the docket number, P–1971, in the e-Library docket number field. For assistance, e-mail FERC Online Support at *FERCOnlineSupport@ferc.gov* or call toll-free at 1–866–208–3676, or for TTY, (202) 502–8659.

You are invited to attend any or all of four public meetings that will be held to receive comments on the draft EIS. The time and location of the meetings are as follows:

Boise, ID

Date: September 7, 2006.
Time: 7 to 11 p.m. (MST).
Place: Doubletree Hotel Boise Riverside.
Address: 2900 Chinden Blvd., Boise, ID.

Date: September 8, 2006.
Time: 10 a.m. to 2 p.m. (MST).
Place: Doubletree Hotel Boise Riverside.
Address: 2900 Chinden Blvd., Boise, ID.

Halfway, OR

Date: September 11, 2006.
Time: 7 to 9 p.m. (MST).
Place: Lions Hall.
Address: Center Street, Halfway, OR.

Weiser, ID

Date: September 12, 2006.
Time: 7 to 9 p.m. (MST).

Place: Weiser Senior Center.

Address: 115 E. Main Street, Weiser, ID.

At these meetings, resource agency personnel and other interested persons will have the opportunity to provide oral and written comments and recommendations regarding the draft EIS. The meetings will be recorded by a court reporter, and all statements (verbal and written) will become part of the Commission's public record for the project. These meetings are posted on the Commission's calendar located at *http://www.ferc.gov/EventCalendar/EventsList.aspx* along with other related information.

Whether or not you attend one of these meetings, you are invited to submit written comments on the draft EIS. Comments should be filed with Magalie R. Salas, Secretary, Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426. All comments must be filed by October 3, 2006, and should reference Project No. 1971–079. Comments may be filed electronically via the Internet in lieu of paper. The Commission strongly encourages electronic filings. See 18 CFR 385.2001(a)(1)(iii) and instructions on the Commission's Web site at *http://www.ferc.gov* under the "e-Library" link.

The Commission staff will consider comments made on the draft EIS in preparing a final EIS for the project. Before the Commission makes a licensing decision, it will take into account all concerns relevant to the public interest. The final EIS will be part of the record from which the Commission will make its decision.

For further information, contact Alan Mitchnick at (202) 502–6074, *alan.mitchnick@ferc.gov*; or Emily Carter at (202) 502–6512, *emily.carter@ferc.gov*.

Magalie R. Salas,

Secretary.

[FR Doc. E6–13624 Filed 8–17–06; 8:45 am]

BILLING CODE 6717–01–P

ENVIRONMENTAL PROTECTION AGENCY

[EPA–HQ–OPPT–2006–0499; FRL–8072–6]

Agency Information Collection Activities; Proposed Collection; Comment Request; Voluntary Cover Sheet for TSCA Submissions; EPA ICR No. 1780.04, OMB Control No. 2070–0156

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act (PRA) (44 U.S.C. 3501 *et seq.*), this document announces that EPA is planning to submit a request to renew an existing approved Information Collection Request (ICR) to the Office of Management and Budget (OMB). This ICR, entitled: "Voluntary Cover Sheet for TSCA Submissions" and identified by EPA ICR No. 1780.04 and OMB Control No. 2070–0156, is scheduled to expire on June 30, 2007. Before submitting the ICR to OMB for review and approval, EPA is soliciting comments on specific aspects of the proposed information collection.

DATES: Comments must be received on or before October 17, 2006.

ADDRESSES: Submit your comments, identified by docket identification (ID) number EPA–HQ–OPPT–2006–0499, by one of the following methods:

- *http://www.regulations.gov.* Follow the on-line instructions for submitting comments.
- *E-mail: oppt.ncic@epa.gov.*
- *Mail*: Document Control Office (7407M), Office of Pollution Prevention and Toxics (OPPT), Environmental Protection Agency, 1200 Pennsylvania Ave., NW., Washington, DC 20460–0001.
- *Hand Delivery*: OPPT Document Control Office (DCO), EPA East Bldg., Rm. 6428, 1201 Constitution Ave., NW., Washington, DC. Attention: Docket ID number EPA–HQ–OPPT–2006–0499. The DCO is open from 8 a.m. to 4 p.m., Monday through Friday, excluding legal holidays. The telephone number for the DCO is (202) 564–8930. Such deliveries are only accepted during the Docket's normal hours of operation, and special arrangements should be made for deliveries of boxed information.

Instructions: Direct your comments to docket ID number EPA–HQ–OPPT–2006–0499. EPA's policy is that all comments received will be included in the public docket without change and may be made available on-line at *http://www.regulations.gov*, including any personal information provided, unless the comment includes information claimed to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. Do not submit information that you consider to be CBI or otherwise protected through regulations.gov or e-mail. The regulations.gov website is an "anonymous access" system, which means EPA will not know your identity or contact information unless you provide it in the body of your comment. If you send an e-mail comment directly to EPA without going through regulations.gov your e-mail address will be automatically captured and included as part of the comment that is placed in the public docket and made available on the Internet. If you submit an electronic comment, EPA recommends that you include your name and other contact information in the body of your comment and with any disk or CD ROM you submit. If EPA cannot read your comment due to technical difficulties and cannot contact you for clarification, EPA may not be able to consider your comment. Electronic files should avoid the use of special characters, any form of encryption, and be free of any defects or viruses. For additional information about EPA's public docket visit the EPA Docket Center homepage at *http://www.epa.gov/epahome/dockets.htm.*

FOR FURTHER INFORMATION CONTACT: *For general information contact*: Colby Lintner, Regulatory Coordinator, Environmental Assistance Division (7408M), Office of Pollution Prevention and Toxics, Environmental Protection Agency, 1200 Pennsylvania Ave., NW., Washington, DC 20460–0001; telephone number: (202) 554–1404; e-mail address: *TSCA-Hotline@epa.gov.*

For technical information contact: Ron Carlson, Information Management Division (7407M), Office of Pollution Prevention and Toxics, Environmental Protection Agency, 1200 Pennsylvania Ave., NW., Washington, DC 20460; telephone number: (202) 564–631; fax number: (202) 564–7480; e-mail address: *carlson.ron@epa.gov.*

SUPPLEMENTARY INFORMATION:

I. What Information is EPA Particularly Interested in?

Pursuant to section 3506(c)(2)(A) of the PRA, EPA specifically solicits comments and information to enable it to:

1. Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the Agency, including whether the information will have practical utility.

2. Evaluate the accuracy of the Agency's estimates of the burden of the proposed collection of information, including the validity of the methodology and assumptions used.

3. Enhance the quality, utility, and clarity of the information to be collected.

4. Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated electronic, mechanical, or other technological collection techniques or other forms of

information technology, e.g., permitting electronic submission of responses. In particular, EPA is requesting comments from very small businesses (those that employ less than 25) on examples of specific additional efforts that EPA could make to reduce the paperwork burden for very small businesses affected by this collection.

II. What Should I Consider when I Prepare My Comments for EPA?

You may find the following suggestions helpful for preparing your comments:

1. Explain your views as clearly as possible and provide specific examples.
2. Describe any assumptions that you used.
3. Provide copies of any technical information and/or data you used that support your views.
4. If you estimate potential burden or costs, explain how you arrived at the estimate that you provide.
5. Provide specific examples to illustrate your concerns.
6. Offer alternative ways to improve the collection activity.
7. Make sure to submit your comments by the deadline identified under **DATES**.
8. To ensure proper receipt by EPA, be sure to identify the docket ID number assigned to this action in the subject line on the first page of your response. You may also provide the name, date, and **Federal Register** citation.

III. What Information Collection Activity or ICR Does this Action Apply to?

Affected entities: Entities potentially affected by this action are companies that manufacture, process, use, import or distribute in commerce chemical substances that are subject to reporting requirements under sections 4, 8(d) or 8(e) of the Toxic Substances Control Act (TSCA), or are subject to voluntary reporting under the Voluntary Children's Chemical Evaluation Program (VCCEP).

Title: Voluntary Cover Sheet for TSCA Submissions.

ICR numbers: EPA ICR No. 1780.04, OMB Control No. 2070–0156.

ICR status: This ICR is currently scheduled to expire on June 30, 2007. An Agency may not conduct or sponsor, and a person is not required to respond to, a collection of information, unless it displays a currently valid OMB control number. The OMB control numbers for EPA's regulations in title 40 of the CFR, after appearing in the **Federal Register** when approved, are listed in 40 CFR part 9, are displayed either by publication in the **Federal Register** or by other appropriate means, such as on the related collection instrument or form, if applicable. The display of OMB control numbers in certain EPA regulations is consolidated in 40 CFR part 9.

Abstract: TSCA requires industry to submit information and studies for existing chemical substances under sections 4, 6, and 8, and requests voluntary submission of such information under the VCCEP. EPA typically receives thousands of such submissions each year; each submission represents on average three studies. In addition, EPA can impose specific Data Call-Ins on industry.

As a follow-up to industry experience with a 1994 TSCA Data Call-In, the Chemical Manufacturers Association (CMA), now known as the American Chemistry Council (ACC), the Specialty Organics Chemical Manufacturers Association (SOCMA), and the Chemical Industry Data Exchange (CIDX), in cooperation with EPA, took an interest in pursuing electronic transfer of TSCA summary data and of full submissions to EPA. In particular, ACC developed a standardized cover sheet for voluntary use by industry as a first step to an electronic future and to begin familiarizing companies with standard requirements and concepts of electronic transfer. This form is designed for voluntary use as a cover sheet for submissions of information under TSCA sections 4, 8(d), 8(e) and VCCEP. The cover sheet facilitates submission of information by displaying certain basic data elements, permitting EPA more easily to identify, log, track, distribute, review and index submissions, and to make information publicly available more rapidly and at reduced cost, to the mutual benefit of both the respondents and EPA.

Responses to the collection of information are voluntary. Respondents may claim all or part of a notice confidential. EPA will disclose information that is covered by a claim of confidentiality only to the extent permitted by, and in accordance with, the procedures in TSCA section 14 and 40 CFR part 2.

Burden statement: The annual public reporting and recordkeeping burden for this collection of information is estimated to average 0.5 hours per response. Burden means the total time, effort, or financial resources expended by persons to generate, maintain, retain, or disclose or provide information to or for a Federal Agency. This includes the time needed to review instructions; develop, acquire, install, and utilize technology and systems for the purposes of collecting, validating, and verifying information, processing and maintaining information, and disclosing and providing information; adjust the existing ways to comply with any previously applicable instructions and requirements which have subsequently changed; train personnel to be able to respond to a collection of information; search data sources; complete and review the collection of information; and transmit or otherwise disclose the information.

The ICR provides a detailed explanation of this estimate, which is only briefly summarized here:

Estimated total number of potential respondents: 1,206.

Frequency of response: On occasion.

Estimated total average number of responses for each respondent: 1.8.

Estimated total annual burden hours: 1,061.5 hours.

Estimated total annual costs: 52,779. This includes an estimated burden cost of 52,779 and an estimated cost of 0 for capital investment or maintenance and operational costs.

IV. Are There Changes in the Estimates from the Last Approval?

There is a decrease of 8,074.5 hours (from 9,136 hours to 1,061.5 hours) in the total estimated respondent burden compared with that identified in the ICR currently approved by OMB. This decrease reflects a decrease in the estimated number of submissions under TSCA sections 4, 8(d) and 8(e), offset by the estimated number of submissions under VCCEP, for which the Voluntary TSCA Cover Sheet could be used, in particular a substantial decrease in the estimated number of TSCA section 4 submissions. Since the use of the Voluntary TSCA Cover Sheet is a direct reflection of the number of submissions received under TSCA sections 4, 8(d), 8(e) and VCCEP, any change in the estimated numbers of submissions under those requirements will result in a parallel change in the burden hours associated with this information collection. The change is an adjustment.

V. What is the Next Step in the Process for this ICR?

EPA will consider the comments received and amend the ICR as appropriate. The final ICR package will then be submitted to OMB for review and approval pursuant to 5 CFR 1320.12. EPA will issue another **Federal Register** notice pursuant to 5 CFR 1320.5(a)(1)(iv) to announce the submission of the ICR to OMB and the opportunity to submit additional comments to OMB. If you have any questions about this ICR or the approval process, please contact the technical

person listed under **FOR FURTHER INFORMATION CONTACT**.

List of Subjects

Environmental protection, Reporting and recordkeeping requirements.

Dated: August 7, 2006.

James D. Gulliford,

Assistant Administrator, Office of Prevention, Pesticides and Toxic Substances.

[FR Doc. E6–13607 Filed 8–17–06; 8:45 am]

BILLING CODE 6560–50–S

ENVIRONMENTAL PROTECTION AGENCY

[EPA–HQ–OPPT–2003–0004; FRL–8087–7]

Access to Confidential Business Information by the National Institute for Occupational Safety and Health

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: EPA has authorized the National Institute for Occupational Safety and Health (NIOSH) access to information which has been submitted to EPA under all sections of the Toxic Substances Control Act (TSCA). Some of the information may be claimed or determined to be Confidential Business Information (CBI).

DATES: Access to the confidential data will occur no sooner than August 25, 2006.

FOR FURTHER INFORMATION CONTACT: *For general information contact*: Colby Lintner, Regulatory Coordinator, Environmental Assistance Division (7408M), Office of Pollution Prevention and Toxics, Environmental Protection Agency, 1200 Pennsylvania Ave., NW., Washington, DC 20460; telephone number: (202) 554–1404; e-mail address: *TSCA-Hotline@.epa.gov*.

For technical information contact: Scott M. Sherlock, TSCA Security Staff, Environmental Assistance Division (7408M), Office of Pollution Prevention and Toxics, Environmental Protection Agency, 1200 Pennsylvania Ave., NW., Washington, DC 20460; telephone number: (202) 564–8257; e-mail address: *sherlock.scott@epa.gov*.

SUPPLEMENTARY INFORMATION:

I. General Information

A. Does this Notice Apply to Me?

This action is directed to the public in general. This action may, however, be of interest to those persons who are or may be subject to TSCA reporting requirements. Since other entities may also be interested, the Agency has not attempted to describe all the specific entities that may be affected by this action. If you have any questions regarding the applicability of this action to a particular entity, consult the person listed under **FOR FURTHER INFORMATION CONTACT**.

B. How Can I Get Copies of this Document and Other Related Documents?

1. *Docket*. EPA has established an official public docket for this action under docket identification (ID) number EPA–HQ–OPPT–2003–0004. The official public docket consists of the documents specifically referenced in this action, any public comments received, and other information related to this action. Although a part of the official docket, the public docket does not include CBI or other information whose disclosure is restricted by statute. The official public docket is the collection of materials that is available for public viewing at the EPA Docket Center, Rm. B102-Reading Room, EPA West, 1301 Constitution Ave., NW., Washington, DC. The EPA Docket Center is open from 8:30 a.m. to 4:30 p.m., Monday through Friday, excluding legal holidays. The EPA Docket Center Reading Room telephone number is (202) 566–1744, and the telephone number for the OPPT Docket, which is located in EPA the Docket Center, is (202) 566–0280.

2. *Electronic access*. You may access this **Federal Register** document electronically through the EPA Internet under the "**Federal Register**" listings at *http://www.epa.gov/fedrgstr/*.

II. What Action is the Agency Taking?

NIOSH needs access to TSCA information, including CBI, in order to meet its obligations to conduct special research, experiments, and demonstrations relating to occupational safety and health as are necessary to explore new problems, including those created by new technology in occupational safety and health. Specifically, in response to its authorities and stakeholder requests, NIOSH is pursuing a nanotechnology research program including a strategic mix of laboratory studies, field studies, and support for extramural studies. To assist in these activities, NIOSH is seeking information on nano-substances and other materials in the possession of EPA.

EPA is issuing this notice to inform all submitters of information under all sections of TSCA that the Agency will be providing NIOSH access to these CBI materials on a need-to-know basis only. All access to TSCA CBI under this arrangement will take place at EPA Headquarters and the NIOSH Headquarters located at 4676 Columbia Parkway, Cincinnati, OH 45226.

Clearance for access to TSCA CBI under this arrangement may continue until August 1, 2016.

NIOSH personnel will be requried to sign non-disclosure agreements and be briefed on appropriate security procedures before they are permitted access to CBI.

List of Subjects

Environmental protection, Confidential business information.

Dated: August 7, 2006.

Brion Cook,

Director, Information Management Division, Office of Pollution Prevention and Toxics.

[FR Doc. 06–7004 Filed 8–17–06; 8:45 am]

BILLING CODE 6560–50–S

ENVIRONMENTAL PROTECTION AGENCY

[ER–FRL–6678–4]

Environmental Impact Statements and Regulations; Availability of EPA Comments

Availability of EPA comments prepared pursuant to the Environmental Review Process (ERP), under section 309 of the Clean Air Act and Section 102(2)(c) of the National Environmental Policy Act as amended. Requests for copies of EPA comments can be directed to the Office of Federal Activities at 202–564–7167.

An explanation of the ratings assigned to draft environmental impact statements (EISs) was published in FR dated April 7, 2006 (71 FR 17845).

Draft EISs

EIS No. 20060149, ERP No. D–AFS–L65509–WA, School Fire Salvage Recovery Project, Salvage Harvest Fire-Killed (dead) and Fire-Damaged (dying) Trees, Implementation, Pomeroy Ranger District, Umatilla National Forest, Columbia and Garfield Counties, WA.

Summary: EPA expressed environmental concerns about the potential for increased sediment delivery to streams, the potential for mass wasting from logging on steep slopes and the uncertainty associated with using the WEPP model to predict sediment loading to streams. Rating EC2.

EIS No. 20060150, ERP No. D–BLM–K65306–CA, Alturas Field Office Project, Resource Management Plan,

Implementation, Lassen, Modoc, Shasta, and Siskiyou Counties, CA.

Summary: EPA expressed environmental concerns about water quality/riparian impacts from livestock and roads, and the sustain ability of rangeland management under the preferred alternative. EPA recommended reductions in grazing in areas not meeting range health standards, and additional acreage designated for special management. Rating EC2.

EIS No. 20060237, ERP No. D–AFS–L65514–AK, Traitors Cove Timber Sale Project, Timber Harvest and Road Construction, Implementation, Revillagigedo Island, Ketchikan-Misty Fiords Ranger District, Tongas National Forest, AK.

Summary: EPA expressed concerns about cumulative impacts to the watershed from the proposed action, as well as, past actions. The Final EIS should include modifications or mitigation for these impacts. Rating EC1.

EIS No. 20060241, ERP No. D–AFS–L65516–WA, Olympic National Forest, Beyond Prevention: Site-Specific Invasive Plant Treatment Project, Implementation, Clallam, Grays Harbor, Jefferson and Mason Counties, WA.

Summary: EPA expressed environmental concerns about aquatic invasive plant infestations and how these would be treated to prevent deterioration of water quality. Rating EC1.

EIS No. 20060245, ERP No. D–FHW–E40807–SC, Interstate 73 Southern Project, Construction from I–95 to the Myrtle Beach Region, Funding, NPDES Permit, U.S. Coast Guard Permit, U.S. Army COE Section 404 Permit, Dillon, Horry and Marion Counties, SC.

Summary: EPA expressed environmental concerns about potential impacts to wetlands and the Little Pee Dee River Heritage Preserve as well as noise impacts and environmental justice issues. Potential indirect impacts to wildlife habitat acreage is also a concern. Rating EC1.

EIS No. 20060256, ERP No. D–AFS–K65312–CA, Pilgrim Vegetation Management Project, Proposes Commercial Thinning/Sanitation, Shasta-Trinity National Forest, Siskiyou County, CA.

Summary: EPA expressed concerns about human and non-target species exposure to Borax and the effects of the project on sensitive species. EPA recommended the project design include road improvements to address identified sedimentation and erosion concerns. Rating EC2.

EIS No. 20060257, ERP No. D–AFS–L61232–AK, Helicopter Access to Conduct Forest Inventory and Analysis (FIA) in Wilderness, Implementation, Tongas and Chugach National Forest, AK.

Summary: EPA does not object to the proposed project. Rating LO.

Final EISs

EIS No. 20060250, ERP No. F–FHW–E40798–NC, Greensboro-High Point Road (NC–1486–NC–4121) Improvements from U.S. 311 (I–74) to Hilltop Road (NC–1424), Funding, Cities of Greensboro and High Point, Town of Jamestown, Guilford County, NC.

Summary: EPA continues to have environmental concerns about the protection of surface water quality within the Randleman Reservoir watershed. EPA also has concerns regarding construction-related mobile source air toxic as well as impacts to migratory birds.

EIS No. 20060289, ERP No. F–AFS–L65509–WA, School Fire Salvage Recovery Project, Salvage Harvest Fire-Killed (dead) and Fire-Damaged (dying) Trees, Implementation, Pomeroy Ranger District, Umatilla National Forest, Columbia and Garfield Counties, WA.

Summary: EPA continues to express concerns about increased sediment in streams, mass wasting and uncertainties associated with using the WEPP model to predict sediment loading.

EIS No. 20060301, ERP No. F–NPS–L65491–ID, Minidoka Internment National Monument (Former Minidoka Relocation Center), General Management Plan, Implementation, Jerome County, ID.

Summary: No formal comment letter was sent to the preparing agency.

Dated: August 15, 2006.

Ken Mittelholtz,

Environmental Protection Specialist, Office of Federal Activities.

[FR Doc. E6–13663 Filed 8–17–06; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[ER–FRL–6678–3]

Environmental Impacts Statements; Notice of Availability

Responsible Agency: Office of Federal Activities, General Information (202) 564–7167 or *http://www.epa.gov/compliance/nepa/.*

Weekly receipt of Environmental Impact Statements

Filed 08/07/2006 through 08/11/2006. Pursuant to 40 CFR 1506.9.

EIS No. 20060335, Draft EIS, FHW, NH, Spaulding Turnpike Improvements Project, Reconstruction and Widening of a 3.5-mile Section from U.S. Route 4 and NH Route 16, U.S. Coast Guard Bridge Permit, NPDES Permit and U.S. Army COE Section 404 Permit, Town of Newington, City of Dover, Strafford and Rockingham Counties, NH, *Comment Period Ends:* 10/02/2006. *Contact:* William F. O'Donnell 603–228–3057 x 101.

EIS No. 20060336, Final EIS, NPS, CA, Non-Native Deer Management Plan of Axis Deer (Axis axis) and Fallow Deer (Dama dama), Implementation, Point Reyes National Seashore (PRNS) and Golden Gate National Recreation Area, Marin County, CA, *Wait Period Ends:* 09/18/2006, *Contact:* Natalie Gates 415–464–5189.

EIS No. 20060337, Draft Supplement, COE, FL, Lake Okeechobee Regulation Schedule Study, Updated Information on Operational Changes to the Current Water Control Plan, Caloosahatchee and St. Lucie River Estuaries, Lake Okeechobee, FL, *Comment Period Ends:* 10/02/2006, *Contact:* Yvonne Haberer 904–232–1701.

EIS No. 20060338, Draft Supplement, FHW, MT, U.S. 93 Highway Ninepipe/Ronan Improvement Project, from Dublin Gulch Road/Red Horn Road, Funding, Special-Use-Permit, NPDES Permit and U.S. Army COE Section 404 Permit, Lake County, MT, *Comment Period Ends:* 10/06/2006, *Contact:* Theodore Burch 406–449–5302.

EIS No. 20060339, Final EIS, FRA, 00, Adoption—Powder River Basin Expansion Project, Construction of New Rail Facilities, Finance Docket No. 33407 Dakota, Minnesota and Eastern Railroad, SD, WY and MN, *Wait Period Ends:* 09/18/2006, *Contact:* David Valenstein 202–493–6368.

Federal Railroad Administration has adopted the Surface Transportation Board's, FEIS #200010444 filed 11/20/2001 and FSEIS #20050553 file 12/30/2005. FRA was not a Cooperating Agency on the above FEIS. Under Section 1506.3(b) of the CEQ Regulations, the FEIS and FSEIS must be Recirculated for a 30-day Wait Period.

EIS No. 20060340, Draft EIS, AFS, 00, Custer National Forest Weed Management, To Implement Specific

Invasive Weed Treatments, Carbon, Stillwater, Sweetgrass, Park, Powder River, Rosebud and Carter Counties, MT and Harding County, SD, *Comment Period Ends:* 10/02/2006, *Contact:* Kim Reid 406–657–6205 x233.

EIS No. 20060341, Final EIS, AFS, ID, Three Basins Timber Sale Project, Proposal to Treat 760 Acres of Mature Forest, Implementation, Caribou-Targhee National Forest, Montpellier Ranger District, Bearlake and Caribou Counties, ID, *Wait Period Ends:* 09/18/2006, *Contact:* Robbin Redman 208–557–5821.

EIS No. 20060342, Draft EIS, FHW, WA, WA–520 Bridge Replacement and HOV Project, Replace WA–520's Portage Bay and Evergreen Point Bridges and Improve Roadway between I–5 in Seattle and Bellevue Way or 108th Avenue Northeast on the Eastside, U.S. Coast Guard Permit and U.S. Army COE Section 10 and 404 Permits, King County, WA, *Comment Period Ends:* 10/02/2006, *Contact:* Paul Krueger 206–381–6432.

EIS No. 20060343, Draft EIS, WPA, SD, White Wind Farm Project, Construct a Large Utility-Scale Wind-Powered Electric Energy Generating Facility, Sherman Township, Brookings County, SD, *Comment Period Ends:* 10/02/2006, *Contact:* Mark Wieringa 720–962–7448.

Amended Notices

EIS No. 20060265, Draft EIS, EPA, ND, Mandan, Hidatsa and Arikara (MHA) Nation's Proposed Clean Fuels Refinery Project, Construct and Operate a New 15,000 Barrel Per Day Clean Fuels Refinery and Grow Hay for Buffalo, Fort Berthold Indian Reservation, Ward County, ND, *Comment Period Ends:* 09/14/2006, *Contact:* Dana Allen 303–312–6870. This document is available on the Internet at: *http://www.epa.gov/region8/compliance/nepa.*

Revision of FR Notice Published 06/30/2006: Extending Comment Period from 08/29/2006 to 09/14/2006.

EIS No. 20060278, Draft EIS, NOA, 00, North Atlantic Right Whale Ship Strike Reduction Strategy, To Implement the Operational Measures to Reduce the Occurrence and Severity of Vessel Collisions with the Right Whale, Serious Injury and Deaths Resulting from Collisions with Vessels, *Comment Period Ends:* 10/05/2006, *Contact:* Stewart Harris 301–713–2322.

Revision of FR Notice Published 07/07/2006. Extending Comment Period from 09/05/2006 to 10/05/2006.

EIS No. 20060309, Draft EIS, NOA, 00, Pacific Coast Groundfish Fishery Management Plan, Proposed Acceptable Biological Catch and Optimum Yield Specifications and Management Measures for the 2007–2008 Pacific Coast Groundfish Fishery and Amendment 16–4 Rebuilding Plans for Seven Depleted Pacific Coast Groundfish Species, WA, OR and CA, *Comment Period Ends:* 09/11/2006, *Contact:* Robert Lohn 206–526–6150.

Revision of FR Notice Published 07/28/2006: Correction to Telephone Number.

Dated: August 15, 2006.

Ken Mittelholtz,

Environmental Protection Specialist, Office of Federal Activities.

[FR Doc. E6–13662 Filed 8–17–06; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[EPA–HQ–OPPT–2006–0301; FRL–8077–1]

National Advisory Committee for Acute Exposure Guideline Levels for Hazardous Substances; Notice of Public Meeting

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: A meeting of the National Advisory Committee for Acute Exposure Guideline Levels for Hazardous Substances (NAC/AEGL Committee) will be held from September 6–8, 2006, in Bethesda, MD. At this meeting, the NAC/AEGL Committee will address, as time permits, the various aspects of the acute toxicity and the development of Acute Exposure Guideline Levels (AEGLs) for the following chemicals: 1,2,3-Trimethylbenzene; 1,2,4-trimethylbenzene; 1,3,5-trimethylbenzene; 2-ethylhexyl chloroformate; benzyl chloroformate; chlorobenzene; dibromoethane; ethylbenzene; ethylene oxide; hexafluoropropylene; phenyl chloroformate; phenyl mercaptan; propargyl alcohol; tetrafluoroethylene; and trifluorochloroethylene.

DATES: A meeting of the NAC/AEGL Committee will be held from 10 a.m. to 5 p.m. on September 6, 2006, from 8:30 a.m. to 5:30 p.m. on September 7, 2006, and from 8 a.m. to 12:30 p.m. on September 8, 2006.

For information on access or services for individuals with disabilities and/or to request accommodation of a disability, please contact the Designated Federal Officer (DFO) listed under **FOR FURTHER INFORMATION CONTACT** at least 10 days prior to the meeting, to give EPA as much time as possible to process your request.

ADDRESSES: The meeting will be held at the Hyatt Regency Bethesda at 7400 Wisconsin Ave., Bethesda, MD (Bethesda Metro Stop).

FOR FURTHER INFORMATION CONTACT: *For general information contact*: Colby Lintner, Regulatory Coordinator, Environmental Assistance Division (7408M), Office of Pollution Prevention and Toxics, Environmental Protection Agency, 1200 Pennsylvania Ave., NW., Washington, DC 20460–0001; telephone number: (202) 554–1404; e-mail address:*TSCA-Hotline@epa.gov.*

For technical information contact: Paul S. Tobin, DFO, Economics, Exposure, and Technology Division (7406M), Office of Pollution Prevention and Toxics, 1200 Pennsylvania Ave., NW., Washington, DC 20460–0001; telephone number: (202) 564–8557; e-mail address: *tobin.paul@epa.gov.*

SUPPLEMENTARY INFORMATION:

I. General Information

A. Does this Action Apply to Me?

This action is directed to the public in general. This action may be of particular interest to anyone who may be affected if the AEGL values are adopted by government agencies for emergency planning, prevention, or response programs, such as EPA's Risk Management Program under the Clean Air Act and Amendments Section 112r. It is possible that other Federal agencies besides EPA, as well as State agencies and private organizations, may adopt the AEGL values for their programs. As such, the Agency has not attempted to describe all the specific entities that may be affected by this action. If you have any questions regarding the applicability of this action to a particular entity, consult the DFO listed under **FOR FURTHER INFORMATION CONTACT.**

B. How Can I Get Copies of this Document and Other Related Information?

1. *Docket.* EPA has established a docket for this action under docket identification (ID) number EPA–HQ–OPPT–2006–0301. Publicly available docket materials are available electronically at *http://www.regulations.gov* or in hard copy at the OPPT Docket, EPA Docket Center (EPA/DC), EPA West, Rm. B102, 1301 Constitution Ave., NW., Washington, DC. The EPA Docket Center Public Reading Room is open from 8:30 a.m. to 4:30 p.m., Monday through Friday,

excluding legal holidays. The telephone number for the Public Reading Room is (202) 566–1744, and the telephone number for the OPPT Docket is (202) 566–0280.

2. *Electronic access.* You may access this **Federal Register** document electronically through the EPA Internet under the "**Federal Register**" listings at *http://www.epa.gov/fedrgstr/.*

II. Meeting Procedures

For additional information on the scheduled meeting, the agenda of the NAC/AEGL Committee, or the submission of information on chemicals to be discussed at the meeting, contact the DFO listed under **FOR FURTHER INFORMATION CONTACT.**

The meeting of the NAC/AEGL Committee will be open to the public. Oral presentations or statements by interested parties will be limited to 10 minutes. Interested parties are encouraged to contact the DFO to schedule presentations before the NAC/AEGL Committee. Since seating for outside observers may be limited, those wishing to attend the meeting as observers are also encouraged to contact the DFO at the earliest possible date to ensure adequate seating arrangements. Inquiries regarding oral presentations and the submission of written statements or chemical-specific information should be directed to the DFO.

III. Future Meetings

Another meeting of the NAC/AEGL Committee is scheduled for December 2006.

List of Subjects

Environmental protection, Chemicals, Hazardous substances, Health.

Dated: August 11, 2006.

Charles M. Auer,

Director, Office of Pollution Prevention and Toxics.

[FR Doc. E6–13658 Filed 8–17–06; 8:45 am]

BILLING CODE 6560–50–S

ENVIRONMENTAL PROTECTION AGENCY

[EPA–HQ–OPP–2006–0489; FRL–8084–7]

Notice of Filing of Pesticide Petitions for Establishment or Amendment to Regulations for Residues of Pesticide Chemicals in or on Various Commodities

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: This notice announces the initial filing of pesticide petitions proposing the establishment of regulations for residuesof pendimethalin, N-(1-ethylpropyl)-3,4-dimethyl-2,6-dinitrobenzanamine and its 3,5-dinitrobenzyl alcohol metabolite (CL 202347) in or on wheat and alfalfa commodities.

DATES: Comments must be received on or before September 18, 2006.

ADDRESSES: Submit your comments, identified by docket identification (ID) number EPA–HQ–OPP–2006–0489 and pesticide petition number (PP), by one of the following methods:

- Federal eRulemaking Portal: *http://www.regulations.gov.* Follow the on-line instructions for submitting comments.
- *Mail*: Office of Pesticide Programs (OPP) Regulatory Public Docket (7502P), Environmental Protection Agency, 1200 Pennsylvania Ave., NW., Washington, DC 20460–0001.
- *Delivery*: OPP Regulatory Public Docket (7502P), Environmental Protection Agency, Rm. S-4400, One Potomac Yard (South Building), 2777 S. Crystal Drive, Arlington, VA. Deliveries are only accepted during the Docket's normal hours of operation (8:30 a.m. to 4 p.m., Monday through Friday, excluding legal holidays). Special arrangements should be made for deliveries of boxed information. The Docket telephone number is (703) 305–5805.

Instructions: Direct your comments to docket ID number EPA–HQ–OPP–2006–0489. EPA's policy is that all comments received will be included in the docket without change and may be made available on-line at *http://www.regulations.gov*, including any personal information provided, unless the comment includes information claimed to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. Do not submit information that you consider to be CBI or otherwise protected through regulations.gov or e-mail. The Federal regulations.gov website is an "anonymous access" system, which means EPA will not know your identity or contact information unless you provide it in the body of your comment. If you send an e-mail comment directly to EPA without going through regulations.gov, your e-mail address will be automatically captured and included as part of the comment that is placed in the docket and made available on the Internet. If you submit an electronic comment, EPA recommends that you include your name and other contact information in the body of your comment and with any disk or CD-ROM you submit. If EPA cannot read your comment due to technical difficulties and cannot contact you for clarification, EPA may not be able to consider your comment. Electronic files should avoid the use of special characters, any form of encryption, and be free of any defects or viruses.

Docket: All documents in the docket are listed in the docket index. Although listed in the index, some information is not publicly available, e.g., CBI or other information whose disclosure is restricted by statute. Certain other material, such as copyrighted material, is not placed on the Internet and will be publicly available only in hard copy form. Publicly available docket materials are available either in the electronic docket at *http://www.regulations.gov*, or, if only available in hard copy, at the OPP Regulatory Public Docket in Rm. S-4400, One Potomac Yard (South Building), 2777 S. Crystal Drive, Arlington, VA. The hours of operation of this Docket Facility are from 8:30 a.m. to 4 p.m., Monday through Friday, excluding legal holidays. The Docket telephone number is (703) 305–5805.

FOR FURTHER INFORMATION CONTACT: Jim Tompkins, Registration Division, (7505P), Office of Pesticide Programs, Environmental Protection Agency, 1200 Pennsylvania Ave., NW., Washington, DC 20460–0001; (703) 305–5697; e-mail: *tompkins.jim@epa.gov.*

SUPPLEMENTARY INFORMATION:

I. General Information

A. Does this Action Apply to Me?

You may be potentially affected by this action if you are an agricultural producer, food manufacturer, or pesticide manufacturer. Potentially affected entities may include, but are not limited to:

- Crop production (NAICS code 111).
- Animal production (NAICS code 112).
- Food manufacturing (NAICS code 311).
- Pesticide manufacturing (NAICS code 32532).

This listing is not intended to be exhaustive, but rather provides a guide for readers regarding entities likely to be affected by this action. Other types of entities not listed in this unit could also be affected. The North American Industrial Classification System (NAICS) codes have been provided to assist you and others in determining whether this action might apply to certain entities. If you have any questions regarding the applicability of this action to a particular entity, consult

the person listed at the end of the pesticide petition summary of interest.

B. What Should I Consider as I Prepare My Comments for EPA?

1. *Submitting CBI.* Do not submit this information to EPA through regulations.gov or e-mail. Clearly mark the part or all of the information that you claim to be CBI. For CBI information in a disk or CD ROM that you mail to EPA, mark the outside of the disk or CD ROM as CBI and then identify electronically within the disk or CD ROM the specific information that is claimed as CBI. In addition to one complete version of the comment that includes information claimed as CBI, a copy of the comment that does not contain the information claimed as CBI must be submitted for inclusion in the public docket. Information so marked will not be disclosed except in accordance with procedures set forth in 40 CFR part 2.

2. *Tips for preparing your comments.* When submitting comments, remember to:

i. Identify the document by docket number and other identifying information (subject heading, **Federal Register** date and page number).

ii. Follow directions. The Agency may ask you to respond to specific questions or organize comments by referencing a Code of Federal Regulations (CFR) part or section number.

iii. Explain why you agree or disagree; suggest alternatives and substitute language for your requested changes.

iv. Describe any assumptions and provide any technical information and/or data that you used.

v. If you estimate potential costs or burdens, explain how you arrived at your estimate in sufficient detail to allow for it to be reproduced.

vi. Provide specific examples to illustrate your concerns, and suggest alternatives.

vii. Explain your views as clearly as possible, avoiding the use of profanity or personal threats.

viii. Make sure to submit your comments by the comment period deadline identified.

II. What Action is the Agency Taking?

EPA is printing a summary of each pesticide petition received under section 408 of the Federal Food, Drug, and Cosmetic Act (FFDCA), 21 U.S.C. 346a, proposing the establishment or amendment of regulations in 40 CFR part 180 for residues of pesticide chemicals in or on various food commodities. EPA has determined that this pesticide petition contains data or information regarding the elements set forth in FFDCA section 408(d)(2); however, EPA has not fully evaluated the sufficiency of the submitted data at this time or whether the data support granting of the pesticide petition. Additional data may be needed before EPA rules on this pesticide petition.

Pursuant to 40 CFR 180.7(f), a summary of the petition included in this notice, prepared by the petitioner along with a description of the analytical method available for the detection and measurement of the pesticide chemical residues is available on EPA's Electronic Docket at *http://www.regulations.gov/*. To locate this information on the home page of EPA's Electronic Docket, select "Quick Search" and type the OPP docket ID number. Once the search has located the docket, clicking on the "Docket ID" will bring up a list of all documents in the docket for the pesticide including the petition summary.

New Tolerance

1. *PP 4F6870.* BASF Corporation, P.O. Box 13528, Research Triangle Park, NC 27709, proposes to establish a tolerance for residues of the herbicide pendimethalin, N-(1-ethylpropyl)-3,4-dimethyl-2,6-dinitrobenzanamine and its 3,5-dinitrobenzyl alcohol metabolite (CL 202347) in or on food commodities wheat, grain at 0.1 parts per million (ppm); wheat, forage and hay at 0.6 ppm; and wheat, straw at 0.3 ppm.

2. *PP 5F6961.* BASF Corporation proposes to establish a tolerance for residues of the herbicide pendimethalin, N-(1-ethylpropyl)-3,4-dimethyl-2,6-dinitrobenzanamine and its 3,5-dinitrobenzyl alcohol metabolite (CL 202347) in or on food commodities alfalfa, forage and hay at 3.0 ppm; and alfalfa, seed at 0.1 ppm.

In plants, the analytical method is aqueous organic solvent extraction, column clean up, and quantitation by gas chromatography (GC). The method has a limited quantitation (LOQ) of 0.05 ppm for pendimethalin and the CL 202347 alcohol metabolite.

List of Subjects

Environmental protection, Agricultural commodities, Feed additives, Food additives, Pesticides and pests, Reporting and recordkeeping requirements.

Dated: August 7, 2006.

Donald R. Stubbs,

Acting Director, Registration Division, Office of Pesticide Programs.

[FR Doc. E6–13657 Filed 8–17–06; 8:45 am]

BILLING CODE 6560–50–S

FEDERAL MARITIME COMMISSION

[Docket No: 06–08]

In the Matter of the Lawfulness of Unlicensed Persons Acting as Agents for Licensed Ocean Transportation Intermediaries; Notice of Filing of Petition for Declaratory Order

The Commission has received a document styled a Petition for Declaratory Order filed by Team Ocean Services, a licensed OTI. Team seeks a declaratory order affirming that OTIs may lawfully engage unlicensed persons to act as their agent subject to certain requirements as set out in the Petition. Specifically, Team Ocean Services requests that the Commission affirm that it is lawful for OTIs to engage unlicensed persons to act as their agents to perform OTI services, as those are defined in the Commission Rules and Regulations, provided that such agency arrangement meets the following requirements: (1) That it is based on express authority from the OTI contained in a contract; (2) That the contract clearly binds the agent to conduct business on behalf of the OTI principal within the parameters set forth in the contract, and (3) That the arrangement provides that the agent will remain under the control of the OTI principal in performing those activities.

Interested persons may obtain a copy of the petition on the Commission's Web site at *http://www.fmc.gov/reading/PetitionsActivity.asp* or at the Office of The Secretary, Federal Maritime Commission, 800 North Capitol Street, NW., Room 1046, Washington DC, 20573–0001. Interested persons may reply to the petition by submitting and original and 15 copies of the reply to the Secretary, at the above address, or e-mailing the reply to *secretary@fmc.gov* on or before Tuesday, October 10, 2006.

Bryant L. VanBrakle,

Secretary.

[FR Doc. E6–13634 Filed 8–17–06; 8:45 am]

BILLING CODE 6730–01–P

FEDERAL RESERVE SYSTEM

Change in Bank Control Notices; Acquisition of Shares of Bank or Bank Holding Companies

The notificants listed below have applied under the Change in Bank Control Act (12 U.S.C. 1817(j)) and § 225.41 of the Board's Regulation Y (12 CFR 225.41) to acquire a bank or bank holding company. The factors that are considered in acting on the notices are

set forth in paragraph 7 of the Act (12 U.S.C. 1817(j)(7)).

The notices are available for immediate inspection at the Federal Reserve Bank indicated. The notices also will be available for inspection at the office of the Board of Governors. Interested persons may express their views in writing to the Reserve Bank indicated for that notice or to the offices of the Board of Governors. Comments must be received not later than September 1, 2006.

A. Federal Reserve Bank of San Francisco (Tracy Basinger, Director, Regional and Community Bank Group) 101 Market Street, San Francisco, California 94105-1579:

1. Brett D. Barker Bank Stock Fund, Devere E. Barker Bank Stock Fund, and Jeffrey Barker Bank Stock Fund, Sparks, Nevada; to acquire voting shares of The Bank Holdings, and thereby indirectly acquire Nevada Security Bank, both of Reno, Nevada.

Board of Governors of the Federal Reserve System, August 14, 2006.

Robert deV. Frierson,

Deputy Secretary of the Board.

[FR Doc. E6–13605 Filed 8–17–06; 8:45 am]

BILLING CODE 6210–01–S

FEDERAL RESERVE SYSTEM

Change in Bank Control Notices; Acquisition of Shares of Bank or Bank Holding Companies

The notificants listed below have applied under the Change in Bank Control Act (12 U.S.C. 1817(j)) and § 225.41 of the Board's Regulation Y (12 CFR 225.41) to acquire a bank or bank holding company. The factors that are considered in acting on the notices are set forth in paragraph 7 of the Act (12 U.S.C. 1817(j)(7)).

The notices are available for immediate inspection at the Federal Reserve Bank indicated. The notices also will be available for inspection at the office of the Board of Governors. Interested persons may express their views in writing to the Reserve Bank indicated for that notice or to the offices of the Board of Governors. Comments must be received not later than September 5, 2006.

A. Federal Reserve Bank of Cleveland (Douglas A. Banks, Vice President) 1455 East Sixth Street, Cleveland, Ohio 44101-2566:

1. Union Bank and Trust Company, and Thomas Milton Hasse, both of Lincoln, Nebraska, as trustees of the Barbara Dunlap Yaltaghian Trust; to acquire voting shares of New Richmond Bancorporation, and thereby indirectly acquire voting shares of New Richmond National Bank, both of New Richmond, Ohio.

Board of Governors of the Federal Reserve System, August 15, 2006.

Robert deV. Frierson,

Deputy Secretary of the Board.

[FR Doc. E6–13655 Filed 8–17–06; 8:45 am]

BILLING CODE 6210–01–S

FEDERAL RESERVE SYSTEM

Formations of, Acquisitions by, and Mergers of Bank Holding Companies

The companies listed in this notice have applied to the Board for approval, pursuant to the Bank Holding Company Act of 1956 (12 U.S.C. 1841 *et seq.*) (BHC Act), Regulation Y (12 CFR Part 225), and all other applicable statutes and regulations to become a bank holding company and/or to acquire the assets or the ownership of, control of, or the power to vote shares of a bank or bank holding company and all of the banks and nonbanking companies owned by the bank holding company, including the companies listed below.

The applications listed below, as well as other related filings required by the Board, are available for immediate inspection at the Federal Reserve Bank indicated. The application also will be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing on the standards enumerated in the BHC Act (12 U.S.C. 1842(c)). If the proposal also involves the acquisition of a nonbanking company, the review also includes whether the acquisition of the nonbanking company complies with the standards in section 4 of the BHC Act (12 U.S.C. 1843). Unless otherwise noted, nonbanking activities will be conducted throughout the United States. Additional information on all bank holding companies may be obtained from the National Information Center website at *www.ffiec.gov/nic/*.

Unless otherwise noted, comments regarding each of these applications must be received at the Reserve Bank indicated or the offices of the Board of Governors not later than September 14, 2006.

A. Federal Reserve Bank of Cleveland (Douglas A. Banks, Vice President) 1455 East Sixth Street, Cleveland, Ohio 44101-2566:

1. SV Bancorp, Inc., Wyoming, Ohio; to become a bank holding company by acquiring 100 percent of the voting shares of Spring Valley Bank, Wyoming, Ohio.

B. Federal Reserve Bank of Atlanta (Andre Anderson, Vice President) 1000 Peachtree Street, N.E., Atlanta, Georgia 30309:

1. Regions Financial Corporation, Birmingham, Alabama; to merge with AmSouth Bancorporation, and thereby indirectly acquire AmSouth Bank, both of Birmingham, Alabama.

C. Federal Reserve Bank of Chicago (Patrick M. Wilder, Assistant Vice President) 230 South LaSalle Street, Chicago, Illinois 60690-1414:

1. Capitol Bancorp Limited and Capitol Development Bancorp Limited V, both of Lansing, Michigan; to acquire 51 percent of the voting shares of 1st Commerce Bank, North Las Vegas, Nevada (in organization).

2. The ShoreBank Corporation, Chicago, Illinois, to acquire 100 percent of the voting shares of Greater Chicago Bank, Bellwood, Illinois.

Board of Governors of the Federal Reserve System, August 15, 2006.

Robert deV. Frierson,

Deputy Secretary of the Board.

[FR Doc. E6–13654 Filed 8–17–06; 8:45 am]

BILLING CODE 6210–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Committee on Vital and Health Statistics: Meeting

Pursuant to the Federal Advisory Committee Act, the Department of Health and Human Services (HHS) announces the following advisory committee meeting.

Name: National Committee on Vital and Health Statistics (NCVHS), Ad Hoc Workgroup on the Nationwide Health Information Network (NHIN).

Time and Date: August 31, 2006—11 a.m.–3 p.m. Eastern Daylight Time.

Place: Conference Call; Toll Free—1–888–425–9978; Leader's Name and Pass code—Dr. Simon Cohn, NCVHS; USA Toll Number 1–210–234–8000.

Status: Open.

Purpose: The Workgroup will discuss its draft findings related to a "minimum but essential" list of functional requirements for a nationwide health information network.

Contact Person for More Information: Substantive program information as well as summaries of meetings and a roster of committee members may be obtained from Mary Jo Deering PhD., Lead Staff Person for the NCVHS Workgroup on the National Health Information Infrastructure, NCI Center for Strategic Dissemination and NCI Center for Bioinformatics, National Cancer Institute, National Institutes of Health, 6116 Executive Boulevard—Room 4087, Rockville, MD 20852, telephone (301) 594–8193, or Marjorie S. Greenberg, Executive Secretary, NCVHS, National Center for Health Statistics, Centers for Disease Control and Prevention, 3311 Toledo Road, Room 2402, Hyattsville,

Maryland 20782, telephone (301) 458–4245. Information also is available on the NCVHS home page of the HHS Web site: *http://www.ncvhs.hhs.gov/*, where an agenda for the meeting will be posted when available.

Should you require reasonable accommodation, please contact the CDC Office of Equal Employment Opportunity on (301) 458–4EEO (4336) as soon as possible.

Dated: August 10, 2006.

James Scanlon,

Deputy Assistant Secretary for Science and Data Policy, Office of the Assistant Secretary for Planning and Evaluation.

[FR Doc. 06–7023 Filed 8–17–06; 8:45 am]

BILLING CODE 4151–04–M

DEPARTMENT OF OF HEALTH AND HUMAN SERVICES

National Committee on Vital and Health Statistics: Meeting

Pursuant to the Federal Advisory Committee Act, the Department of Health and Human Services (HHS) announces the following advisory committee meeting.

Name: National Committee on Vital and Health Statistics (NCVHS) meeting jointly with the Board of Scientific Counselors of the National Center for Health Statistics, Centers for Disease Control and Prevention.

Time and Date: September 13, 2006 9 a.m.–3:50 p.m., September 14, 2006 9 a.m.–1:45 p.m.

Place: Hubert H. Humphrey Building, 200 Independence Avenue, SW., Room 705A, Washington, DC 20201.

Status: Open.

Purpose: At this meeting the Committee will hear presentations and hold discussions on several health data policy topics. On the morning of the first day the Committee will hear updates and status reports from the Department of various topics including activities of the HHS Data Council. They will review the full Committee retreat and the Executive Subcommittee meeting. They will discuss Subcommittee products. This discussion will continue in the afternoon followed by an update from the Healthcare Information Technology Standards panel.

On the morning of the second day the Committee will hear an update of Agency for Healthcare Quality and Research's quality indicator project, followed by reports from the NCVHS Subcommittees and Work Groups. This will be followed by the convening of the joint meeting with the Board of Scientific Counselors of the National Center for Health Statistics, Center for Disease Control and Prevention. The focus of the joint meeting will be on areas of common interests including new implications of confidentiality requirements in vital records for natality and mortality, re-engineering the vital statistics system and role of health information technology. This will be followed by a discussion of the process for future collaborations.

The times shown above are for the full Committee meeting. Subcommittee breakout sessions are scheduled for late in the afternoon of the first day and in the morning prior to the full Committee meeting on the second day. Agendas for these breakout sessions will be posted on the NCVHS Web site (URL below) when available.

Contact Person for More Information: Substantive program information as well as summaries of meetings and a roster of committee members may be obtained from Marjorie S. Greenberg, Executive Secretary, NCVHS, National Center for Health Statistics, Centers for Diseases Control and Prevention, 3311 Toledo Road, Room 2402, Hyattsville, Maryland 20782, telephone (301) 458–4245. Information also is available on the NCVHS home page of HHS Web site: *http://www.ncvhs.hhs.gov/*, where further information including an agenda will be posted when available.

Should you require reasonable accommodation, please contact the CDC Office of Equal Employment Opportunity on (301) 458–4EEO (4336) as soon as possible.

Dated: August 11, 2006.

James Scanlon,

Deputy Assistant Secretary for Planning and Evaluation (OSDP), Office of the Assistant Secretary for Planning and Evaluation.

[FR Doc. 06–7024 Filed 8–17–06; 8:45 am]

BILLING CODE 4151–05–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Submission for OMB Review; Comment Request

Title: Child Care and Development Fund Annual Aggregate Report.

OMB No.: 0970–0150.

Description: Section 658K of the Child Care and Development Block Grant Act of 1990 (Pub. L. 101–508, 42 U.S.C. 9858) requires that the States and the Territories submit annual aggregate data on the children and families receiving direct services under the Child Care and Development Fund. The implementing regulations for the statutorily required reporting are at 45 CFR 98.70. Annual aggregate reports include data elements represented in the ACF–800. The Administration for Children and Families (ACF) uses aggregate data to determine the scope, type, and methods of child care delivery. This provides ACF with the information necessary to make reports to Congress, address national child care needs, offer technical assistance to grantees, meet performance measures, and conduct research. Consistent with the statute and regulations, ACF requests extension of the ACF–800.

Respondents: States, the District of Columbia, and the Territories, including Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands.

ANNUAL BURDEN ESTIMATES

Instrument	Number of respondents	Number of responses per respondent	Average burden hours per response	Total burden hours
ACF–800	56	1	40	2,240

Estimated Total Annual Burden Hours: 2,240.

Additional Information: Copies of the proposed collection may be obtained by writing to the Administration for Children and Families, Office of Administration, Office of Information Services, 370 L'Enfant Promenade, SW., Washington, DC 20447, Attn: ACF Reports Clearance Officer. All requests should be identified by the title of the information collection. E-mail address: *infocollection@acf.hhs.gov.*

OMB Comment: OMB is required to make a decision concerning the collection of information between 30 and 60 days after publication of this document in the **Federal Register.** Therefore, a comment is best assured of having its full effect if OMB receives it within 30 days of publication. Written comments and recommendations for the proposed information collection should be sent directly to the following: Office of Management and Budget, Paperwork Reduction Project, 725 17th Street, NW., Washington, DC 20503, attn: Desk Officer for ACF, e-mail address: *Katherine_T._Astrich@omb.eop.gov.*

Dated: August 14, 2006.

Robert Sargis,

Reports Clearance Officer.

[FR Doc. 06–7013 Filed 8–17–06; 8:45 am]

BILLING CODE 4184–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Submission for OMB Review; Comment Request

Title: Early Head Start Research and Evaluation Project: 5th-Grade follow-Up.

OMB No.: 0970–0143.

Description: The Administration for Children and Families (ACF) within the Department of Health and Human Services (HHS) is requesting comments on plans to collect 5th-grade follow-up data on children recruited into the Early Head Start Research and Evaluation study. This study is being conducted to assess children and families when the children in the study will be 5th graders or attending the 6th year of their formal schooling. Because of the way children and families were initially recruited for the study, it will take three years to collect 5th-grade data from the full sample of children. About 30 percent of the sample will be 5th graders in spring 2007, 50 percent in spring 2008, and 20 percent in spring 2009. Data will be collected on a sample of approximately 1,900 children and families across all 17 of the Early Head Start research sites. Data collection will include a child assessment and a child interview, an interview with the child's primary caregiver (usually the child's mother), videotaping of mother-child interactions and a set of home observations, and a questionnaire to be completed by the child's 5th-grade teacher.

This data collection is necessitated by the mandates of the 1998 reauthorization of Head Start (Head Start Act, as amended, October 27, 1998, Section 649 (d) and (e)).

Respondents: Individuals or households.

Annual Burden Estimates

Instrument	Number of respondents	Number of responses per respondent	Average burden hours per response	Total burden hours
Year 1 (2007):				
Parent Interview	570	1	1.00	570
Child Assessment	570	1	1.16	661
Child Interview	570	1	0.25	143
Mother-Child Interaction	1,140	1	0.25	285
Teacher Questionnaire	570	1	0.50	285
Year 1 Total	3,420			1,944
Year 2 (2008):				
Parent Interview	950	1	1.00	950
Child Assessment	950	1	1.16	1,102
Child Interview	950	1	0.25	238
Mother-Child Interaction	1,900	1	0.25	475
Teacher Questionnaire	950	1	0.50	475
Year 2 Total	5,700			3,240
Year 3 (2009)				
Parent Interview	380	1	1.00	380
Child Assessment	380	1	1.16	441
Child Interview	380	1	0.25	95
Mother-Child Interaction	760	1	0.25	190
Teacher Questionnaire	380	1	0.50	190
Year 3 Total	2,280			1,296

Estimated Total Burden Hours: 6,480.

Additional Information: Copies of the proposed collection may be obtained by writing to the Administration for Children and Families, Office of Administration, Office of Information Services, 370 L'Enfant Promenade, SW., Washington, DC 20447, Attn: ACF Reports Clearance Officer. All requests should be identified by the title of the information collection. E-mail address: *infocollection@acf.hhs.gov.*

OMB Comment: OMB is required to make a decision concerning the collection of information between 30 and 60 days after publication of this document in the **Federal Register.** Therefore, a comment is best assured of having its full effect if OMB receives it within 30 days of publication. Written comments and recommendations for the proposed information collection should be sent directly to the following: Office of Management and Budget, Paperwork Reducing Project, 725 17th Street, NW., Washington, DC 20503, attn: Desk Officer for ACF, e-mail address: *Katherine_T._Astrich@omb.eop.gov.*

Dated: August 14, 2006.

Robert Sargis,

Reports Clearance Officer.

[FR Doc. 06–7014 Filed 8–17–06; 8:45 am]

BILLING CODE 4184–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Submission for OMB Review; Comment Request

Title: Objective Work Plan (OWP), Objective Progress Report (OPR) and Project Abstract.

OMB No. 0980–0204.

Description: The information collected by OWP is needed to properly administer and monitor the Administration for Native Americans (ANA) programs within the Administration for Children and Families (ACF). OWP assists applicants in describing their project's objectives

and activities, and also assists independent panel reviewers, ANA staff and the ANA Commissioner during the review and funding decision process. The information in OPR is being collected on a quarterly basis to monitor the performance of grantees and better gauge grantee progress. The standardized format will allow ANA to report results across all its program areas and flag grantees that may need additional training and/or technical assistance to successfully implement their projects.

The Project Abstract provides crucial information in a concise format that is utilized by applicants, independent reviewers, ANA staff and the ANA Commissioner.

Respondents: Tribal Govt., Native non-profits, Tribal Colleges & Universities.

Annual Burden Estimates

Instrument	Number of respondents	Number of responses per respondent	Average burden hours per response	Total burden hours
OWP	500	1	3	1,500
OPR	275	4	1	1,100
Project Abstract	500	1	.5	250

Estimated Total Annual Burden Hours: 2,850.

Additional Information: Copies of the proposed collection may be obtained by writing to the Administration for Children and Families, Office of Administration, Office of Information Services, 370 L'Enfant Promenade, SW., Washington, DC 20447, Attn: ACF Reports Clearance Officer. All requests should be identified by the title of the information collection. E-mail address: *infocollection@acf.hhs.gov.*

OMB Comment: OMB is required to make a decision concerning the collection of information between 30 and 60 days after publication of this document in the **Federal Register.** Therefore, a comment is best assured of having its full effect if OMB receives it within 30 days of publication. Written comments and recommendations for the proposed information collection should be sent directly to the following: Office of Management and Budget, Paperwork Reduction Project, 725 17th Street, NW., Washington, DC 20503, attn: Desk Officer for ACF, e-mail address: *Katherine_T._Astrich@omb.eop.gov.*

Dated: August 14, 2006.

Robert Sargis,

Reports Clearance Officer.

[FR Doc. 06–7015 Filed 8–17–06; 8:45 am]

BILLING CODE 4184–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Office Of Community Services; Community Economic Development Program

AGENCY: Office of Community Services, Administration for Children and Families (ACF), Department of Health and Human Services (HHS).

ACTION: Replacement Grant.

CFDA#: 93.570.

Legislative Authority: The Community Services Block Grant (CSBG) Act of 1981, as amended by section 680 (a)(2) of the Community Opportunities, Accountability, and Training and Educational Services Act of 1998.

Amount of Award: $663,263.00.

Project Period: September 30, 2005 to September 29, 2008.

SUMMARY: The purpose of the Community Economic Development (CED) grants is to create new employment and business development opportunities for low-income individuals. The Office of Community Services (OCS) awarded a $663,263 CED grant (Grant No. 90EE0720) to Hall Neighborhood House in Bridgeport, Connecticut, on September 29, 2005. Prior to the expenditure of any of the grant funds, the grantee informed OCS in a letter dated April 17, 2006, that it wished to "relinquish the management and operation of this program effective immediately." The letter stated the grantee's "current financial instability" as the reason for the action.

In an attempt not to lose the benefits for the community that were intended through the CED grant, OCS identified a possible replacement recipient: Action for Bridgeport Community Development, Inc (ABCD). The organization is being considered as a replacement recipient for the following reasons:

- ABCD is a previously successful CED grantee (grant #90EE0546).
- ABCD is headquartered approximately a mile and a half from the offices of Hall Neighborhood House (HNH) in Bridgeport, CT and will serve the same community. Also, ABCD and HNH have worked together in the past and reportedly have maintained a good working relationship.
- ABCD has a significantly sophisticated budget to manage this project effectively. (In 2003, the organization had gross receipts of approximately $20 million.).
- ABCD was recently selected by the Head Start Bureau to be the successor grantee of HNH's active Head Start grant.
- ACF Region I Administrator Hugh Galligan speaks highly of the performance of ABCD and has recommended that it be the replacement recipient.

OCS has received and reviewed an application from ABCD. Upon finding that the proposed project is significantly similar to the one chosen for funding through HNH, OCS has requested that ABCD be approved as the permanent replacement recipient for Grant No. 90EE0720.

FOR FURTHER INFORMATION CONTACT: Office of Community Services, 370 L'Enfant Promenade, SW., Washington, DC 20447, Thom Campbell—(202) 401–5483, *tcampbell@acf.hhs.gov.*

Dated: August 4, 2006.

Josephine B. Robinson,

Director, Office of Community Services.

[FR Doc. E6–13667 Filed 8–17–06; 8:45 am]

BILLING CODE 4184–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. 2006N–0081]

Agency Information Collection Activities; Announcement of Office of Management and Budget Approval; Prescription Drug Marketing Act of 1987

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing that a collection of information entitled "Prescription Drug Marketing Act of

1987" has been approved by the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995.

FOR FURTHER INFORMATION CONTACT: Liz Berbakos, Office of Management Programs (HFA–250), Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857, 301–827–1482.

SUPPLEMENTARY INFORMATION: In the **Federal Register** of June 2, 2006 (71 FR 32097), the agency announced that the proposed information collection had been submitted to OMB for review and clearance under 44 U.S.C. 3507. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. OMB has now approved the information collection and has assigned OMB control number 0910–0435. The approval expires on August 31, 2009. A copy of the supporting statement for this information collection is available on the Internet at *http://www.fda.gov/ohrms/dockets.*

Dated: August 10, 2006.

Jeffrey Shuren,

Assistant Commissioner for Policy.

[FR Doc. E6–13609 Filed 8–17–06; 8:45 am]

BILLING CODE 4160–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Cancer Institute; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4), and 552b(c)(6), as amended. The contract proposals and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the contract applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Cancer Institute Special Emphasis Panel—SBIR topic 207 (Phase II), "Multi-Purpose Radiophamaceutical Synthesis Platforms".

Date: September 5, 2006.

Time: 1 p.m. to 3 p.m.

Agenda: To review and evaluate contract proposals.

Place: National Institutes of Health, 6130 Executive Blvd., EPN/6053, Rockville, MD 20852, (Telephone Conference Call).

Contact Person: C. Michael Kerwin, PhD, MPH, Scientific Review Administrator, Special Review and Logistics Branch, Division of Extramural Activities, National Cancer Institute, NIH, 6116 Executive Boulevard, Room 8057, Bethesda, MD 20892–8329, (301) 496–7421, *kerwinm@mail.nih.gov.*

(Catalogue of Federal Domestic Assistance Program Nos. 93.392, Cancer Construction; 93.393, Cancer Cause and Prevention Research; 93.394, Cancer Detection and Diagnosis Research; 93.395, Cancer Treatment Research; 93.396, Cancer Biology Research; 93.397, Cancer Centers Support; 93.398, Cancer Research Manpower; 93.399, Cancer Control, National Institutes of Health, HHS)

Dated: August 14, 2006.

Anna Snouffer,

Acting Director, Office of Federal Advisory Committee Policy.

[FR Doc. 06–7016 Filed 8–17–06; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Cancer Institute; Notice of Closed Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following meetings.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Cancer Institute Special Emphasis Panel, Cancer Education and Cancer Development.

Date: September 25, 2006.

Time: 5:30 p.m. to 6:30 p.m.

Agenda: To review and evaluate grant applications.

Place: Double Tree Rockville, 1750 Rockville Pike, Rockville, MD 20852.

Contact Person: Jeannette F Korczak, PhD, Scientific Review Administrator, Review Training Resources Branch, Division of Extramural Activities, National Cancer Institute, NIH, 6116 Executive Blvd., Room 8115, Bethesda, MD 20892, 301–496–9767, *korczak@mail.nih.gov.*

Name of Committee: National Cancer Institute Initial Review Group, Subcommittee I—Career Development.

Date: September 26–27, 2006.

Time: 8 a.m. to 5 p.m.

Agenda: To review and evaluate grant applications.

Place: Holiday Inn Georgetown, 2101 Wisconsin Avenue, NW., Washington, DC 20007.

Contact Person: Robert Bird, PhD, Scientific Review Administrator, Resources and Training Review Branch, National Cancer Institute, National Institutes of Health, 6116 Executive Blvd., Room 8113, MSC 8328, Bethesda, MD 20892–8328, 301–496–7978, *birdr@mail.nih.gov.*

Name of Committee: National Cancer Institute Special Emphasis Panel, Prevention, Control and Population Sciences.

Date: September 27–29, 2006.

Time: 8 a.m. to 5 p.m.

Agenda: To review and evaluate grant applications.

Place: Hyatt Regency Bethesda, One Bethesda Metro Center, 7400 Wisconsin Avenue, Bethesda, MD 20814.

Contact Person: Hasnaa Shafik, MD, PhD, Scientific Review Administrator, Division of Extramural Activities, RPRB, National Cancer Institute, National Institutes of Health, 6116 Executive Blvd., Room 8037, Bethesda, MD 20892, (301) 451–4757, *shafikh@mail.nih.gov.*

Name of Committee: National Cancer Institute Special Emphasis Panel, Innovations in Cancer Sample Preparation, STTR, SBIR.

Date: October 4, 2006.

Time: 8 a.m. to 5 p.m.

Agenda: To review and evaluate grant applications.

Place: Bethesda North Marriott Hotel and Conf. Center, 5701 Marinelli Road, Bethesda North, MD 20852.

Contact Person: Gerald G. Lovinger, PhD, Scientific Review Administrator, Special Review and Logistics Branch, Division of Extramural Activities, National Cancer Institute, 6116 Executive Blvd., Room 8101, Bethesda, MD 20892–8329, 301/496–7987. *lovingeg@mail.nih.gov.*

Name of Committee: National Cancer Institute Special Emphasis Panel, Clinical Program Project Special Emphasis Panel.

Date: October 4–6, 2006.

Time: 8 a.m. to 5 p.m.

Agenda: To review and evaluate grant applications.

Place: Hilton, 8727 Colesville Road, Silver Spring, MD 20910.

Contact Person: Carol Lyman, PhD, Scientific Review Administrator, Division of Extramural Activities, National Cancer Institute, National Institutes of Health, 6116 Executive Blvd, Room 8119, Bethesda, MD 20892–8328, 301–451–4761, *lymanc@mail.nih.gov.*

Name of Committee: National Cancer Institute Special Emphasis Panel, Discovery and Development.

Date: October 4–6, 2006.

Time: 8 a.m. to 5 p.m.

Agenda: To review and evaluate grant applications.

Place: Hilton Silver Spring, 8727 Colesville Road, Silver Spring, MD 20910.

Contact Person: Peter J. Wirth, PhD, Scientific Review Administrator, Research Programs Review Branch, Division of Extramural Activities, National Cancer Institute, 6116 Executive Boulevard, Room 8131, Bethesda, MD 20892–8328, 301–496–7566, *pw2q@nih.gov*.

Name of Committee: National Cancer Institute Special Emphasis Panel, Small Animal Imaging Resource Program.

Date: October 12–13, 2006.

Time: 8 a.m. to 5 p.m.

Agenda: To review and evaluate grant applications.

Place: Bethesda Marriott Hotel & Resort, 5151 Pooks Hill Road, Bethesda, MD 20814.

Contact Person: Michael B. Small, PhD, Scientific Review Administrator, Research Programs Review Branch, Division of Extramural Activities, National Cancer Institute, National Institutes of Health, 6116 Executive Blvd., Room 8127, Bethesda, MD 20892–8328, 301–402–0996. *smallm@mail.nih.gov*.

Name of Committee: National Cancer Institute Special Emphasis Panel, Innovative Technologies for the Molecular Analysis of Cancer.

Date: October 25–26, 2006.

Time: 8 a.m. to 5 p.m.

Agenda: To review and evaluate grant applications.

Place: Crowne Plaza Hotel, 8777 Georgia Ave, Silver Spring, MD 20910.

Contact Person: Sherwood Githens, PhD, Scientific Review Administrator, Special Review and Logistics Branch, National Cancer Institute, Division of Extramural Activities, 6116 Executive Blvd., Room 8053, Bethesda, MD 20892, 301/435–1822, *githenss@mail.nih.gov*.

(Catalogue of Federal Domestic Assistance Program Nos. 93.392, Cancer Construction; 93.393, Cancer Cause and Prevention Research; 93.394, Cancer Detection and Diagnosis Research; 93.395, Cancer Treatment Research; 93.396, Cancer Biology Research; 93.397, Cancer Centers Support; 93.398, Cancer Research Manpower; 93.399, Cancer Control; National Institutes of Health, HHS)

Dated: August 14, 2006.

Anna Snouffer,

Acting Director, Office of Federal Advisory Committee Policy.

[FR Doc. 06–7017 Filed 8–17–06; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Cancer Institute; Notice of Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the meeting of the President's Cancer Panel.

The meeting will be open to the public as indicated below, with attendance limited to space available. Individuals who plan to attend and need special assistance, such as sign language interpretation or other reasonable accommodations, should notify the Contact Person listed below in advance of the meeting.

The meeting will be closed to the public in accordance with the provisions set forth in section 552b(c)(9)(B), Title 5 U.S.C., as amended, because the premature disclosure of information and the discussions would likely to significantly frustrate implementation of recommendations.

Name of Committee: President's Cancer Panel.

Date: September 11, 2006.

Open: September 11, 2006, 8 a.m.–4 p.m.

Agenda: Promoting Healthy Lifestyles to Reduce the Risk of Cancer.

Place: University of Minnesota Cancer Center, 425 East River Road, Room 450, Minneapolis, MN 55455.

Closed: September 11, 2006, 4:30 p.m.–6:30 p.m.

Agenda: The Panel will discuss the Promoting Healthy Lifestyles to Reduce the Risk of Cancer and discuss potential topics for the 2007/2008 series.

Place: Radisson Plaza Hotel, 35 South 7th Street, Minneapolis, MN 55402.

Contact Person: Abby Sandler, PhD, Executive Secretary, National Cancer Institute, National Institutes of Health, Building 6116, Room 212, 6116 Executive Boulevard, Bethesda, MD 20892, 301/451–9399.

Any interested person may file written comments with the committee by forwarding the comments to the Contact Person listed on this notice. The comments should include the name, address, telephone number and, when applicable, the business or professional affiliation of the interested person.

Information is also available on the Institute's/Center's home page: *deainfo.nci.nih.gov/advisory/pcp/pcp.htm*, where an agenda and any additional information for the meeting will be posted when available.

(Catalogue of Federal Domestic Assistance Program Nos. 93.392, Cancer Construction; 93.393, Cancer Cause and Prevention Research; 93.394, Cancer Detection and Diagnosis Research; 93.395, Cancer Treatment Research; 93.396, Cancer Biology Research; 93.397, Cancer Centers Support; 93.398, Cancer Research Manpower; 93.399, Cancer Control, National Institutes of Health, HHS)

Dated: August 14, 2006.

Anna Snouffer,

Acting Director, Office of Federal Advisory Committee Policy.

[FR Doc. 06–7021 Filed 8–17–06; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Center on Minority Health and Health Disparities; Notice of Meeting.

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of a meeting of the National Advisory Council on Minority Health and Health Disparities.

The meeting will be open to the public as indicated below, with attendance limited to space available. Individuals who plan to attend and need special assistance, such as sign language interpretation or other reasonable accommodation, should notify the Contact Person listed below in advance of the meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Advisory Council on Minority Health and Health Disparities.

Date: September 12, 2006.

Closed: 8:30 a.m. to 9:30 a.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Two Democracy Plaza, 6707 Democracy Boulevard, Suite 800, Bethesda, MD 20892.

Open: 9:30 a.m. to 5 p.m.

Agenda: The agenda will include Opening Remarks, Administrative Matters, Director's Report, NCMHD, Program Concept Clearance Report, Extramural Program Highlights, NHGRI Health Disparities Research Highlights, and other business of the Council.

Place: National Institutes of Health, Two Democracy Plaza, 6707 Democracy Boulevard, Suite 800, Bethesda, MD 20892.

Contact Person: Donna Brooks, Asst. Director for Administration, National Center on Minority Health and Health Disparities, National Institutes of Health, 6707 Democracy Blvd., Suite 800, Bethesda, MD 20892, 301–435–2135, *brooksd@ncmhd.nih.gov*.

Any interested person may file written comments with the committee by forwarding the statement to the Contact Person listed on this notice. The statement should include the name, address, telephone number and when applicable, the business or professional affiliation of the interested person.

Dated: August 11, 2006.

Anna Snouffer,

Acting Director, Office of Federal Advisory Committee Policy.

[FR Doc. 06–6999 Filed 8–17–06; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Eye Institute; Notice of Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of a meeting of the National Advisory Eye Council.

The meeting will be open to the public as indicated below, with attendance limited to space available. Individuals who plan to attend and need special assistance, such as sign language interpretation or other reasonable accommodations, should notify the Contact Person listed below in advance of the meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and/or contract proposals and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications and/or contract proposals, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Advisory Eye Council.

Date: September 14, 2006.

Closed: 8:30 a.m. to 12 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 5635 Fishers Lane, Terrace Level Conference Center, Bethesda, MD 20892.

Open: 2 p.m. to 5 p.m.

Agenda: Following opening remarks by the Director, NEI there will be presentations by the staff of the Institute and discussions concerning Institute programs.

Place: National Institutes of Health, 5635 Fishers Lane, Terrace Level Conference Center, Bethesda, MD 20892.

Contact Person: Lore Anne McNicol, PhD, Director, Division of Extramural Research, National Eye Institute, National Institutes of Health, Bethesda, MD 20892, (301) 451–2020.

Any interested person may file written comments with the committees by forwarding the statement to the Contact Person listed on this notice. The statement should include the name, address, telephone number and when applicable, the business or professional affiliation of the interested person.

Information is also available on the Institute's/Center's home page: *www.nei.nih.gov*, where an agenda and any additional information for the meeting will be posted when available.

(Catalogue of Federal Domestic Assistance Program Nos. 93.867, Vision Research, National Institutes of Health, HHS)

Dated: August 14, 2006.

Anna Snouffer,

Acting Director, Office of Federal Advisory Committee Policy.

[FR Doc. 06–7018 Filed 8–17–06; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Heart, Lung, and Blood Institute; Notice of Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of a meeting of the National Heart, Lung, and Blood Advisory Council.

The meeting will be open to the public as indicated below, with attendance limited to space available. Individuals who plan to attend and need special assistance, such as sign language interpretation or other reasonable accommodations, should notify the Contact Person listed below in advance of the meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Heart, Lung, and Blood Advisory Council.

Date: September 12, 2006.

Open: 8 a.m. to 12 p.m.

Agenda: Discussion of program policies and issues.

Place: National Institutes of Health, Building 31, 31 Center Drive, Bethesda, MD 20892.

Closed: 1 p.m. to 5 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Building 31, 31 Center Drive, Bethesda, MD 20892.

Contact Person: Deborah P. Beebe, Director, Division of Extramural Affairs, National Heart, Lung, and Blood Institute, National Institutes of Health, Two Rockledge Center, Room 7100, 6701 Rockledge Drive, Bethesda, MD 20892, 301–435–0260.

Any interested person may file written comments with the committee by forwarding the statement to the Contact Person listed on this notice. The statement should include the name, address, telephone number and when applicable, the business or professional affiliation of the interested person.

In the interest of security, NIH has instituted stringent procedures for entrance onto the NIH campus. All visitor vehicles, including taxicabs, hotel, and airport shuttles will be inspected before being allowed on campus. Visitors will be asked to show one form of identification (for example, a government-issued photo ID, driver's license, or passport) and to state the purpose of their visit.

Information is also available on the Institute's/Center's home page: *www.nhlbi.nih.gov/meetings/index.htm*, where an agenda and any additional information for the meeting will be posted when available.

(Catalogue of Federal Domestic Assistance Program Nos. 93.233, National Center for Sleep Disorders Research; 93.837, Heart and Vascular Diseases Research; 93.838, Lung Diseases Research; 93.839, Blood Diseases and Resources Research, National Institutes of Health, HHS)

Dated: August 11, 2006.

Anna Snouffer,

Acting Director, Office of Federal Advisory Committee Policy.

[FR Doc. 06–6998 Filed 8–17–06; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Dental & Craniofacial Research; Notice of Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of a meeting of the National Advisory Dental and Craniofacial Research Council.

The meeting will be open to the public as indicated below, with attendance limited to space available. Individuals who plan to attend and need special assistance, such as sign language interpretation or other reasonable accommodations, should notify the Contact Person listed below in advance of the meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and/or contract proposals and the

discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications and/or contract proposals, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Advisory Dental and Craniofacial Research Council.

Date: September 18, 2006.

Open: 8:30 a.m. to 11:30 a.m.

Agenda: Director's Report; Concept Clearances; OPASI Briefing, Deputy Director; Council Operating Procedures—Revisions.

Place: National Institutes of Health, Building 31, C Wing, 31 Center Drive, Conference Room 10, Bethesda, MD 20892.

Closed: 1 p.m. to 4:30 p.m.

Agenda: To review and evaluate grant applications and/or proposals.

Place: National Institutes of Health, Building 31, C Wing, 31 Center Drive, Conference Room 10, Bethesda, MD 20892.

Contact Person: Norman S. Braveman, PhD, Assistant to the Director, NIH–NIDCR, Building 31, RM. 5B55, Bethesda, MD 20892, 301–594–2089, NORMAN.BRAVEMAN@NIH.GOV.

Information is also available on the Institute's/Center's home page: *http://www.nidcr.nih.gov/about*, where an agenda and any additional information for the meeting will be posted when available.

(Catalogue of Federal Domestic Assistance Program Nos. 93.121, Oral Diseases and Disorders Research, National Institutes of Health, HHS)

Dated: August 10, 2006.

Anna Snouffer,

Acting Director, Office of Federal Advisory Committee Policy.

[FR Doc. 06–6995 Filed 8–17–06; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute on Deafness and Other Communication Disorders; Notice of Closed Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following meetings.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute on Deafness and Other Communication Disorders Special Emphasis Panel, Review Panel for Cochlear Implant Grants.

Date: September 26, 2006.

Time: 11 a.m. to 12 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 6120 Executive Blvd., Rockville, MD 20852, (Telephone Conference Call).

Contact Person: Melissa Stick, PhD, MPH, Chief, Scientific Review Branch, Scientific Review Branch, Division of Extramural Activities, NIDCD/NIH, 6120 Executive Blvd., Bethesda, MD 20892. 301–496–8683.

Name of Committee: National Institute on Deafness and Other Communication Disorders Special Emphasis Panel, Pre-Doctoral Summer Training Program in Auditory Research.

Date: October 3, 2006.

Time: 1 p.m. to 5 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 6120 Executive Blvd., Rockville, MD 20852. (Telephone Conference Call).

Contact Person: Stanley C. Oaks, PhD, Scientific Review Administrator, Division of Extramural Activities, NIDCD, NIH, Executive Plaza South, Room 400C, 6120 Executive Blvd—MSC 7180, Bethesda, MD 20892–7180. 301–496–8683. *so14s@nih.gov.*

(Catalogue of Federal Domestic Assistance Program Nos. 93.173, Biological Research Related to Deafness and Communicative Disorders, National Institutes of Health, HHS)

Dated: August 10, 2006.

Anna Snouffer,

Acting Director, Office of Federal Advisory Committee Policy.

[FR Doc. 06–6996 Filed 8–17–06; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of General Medical Sciences; Notice of Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of a meeting of the National Advisory General Medical Sciences Council.

The meeting will be open to the public as indicated below, with attendance limited to space available. Individuals who plan to attend and need special assistance, such as sign language interpretation or other reasonable accommodations, should notify the Contact Person listed below in advance of the meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and/or contract proposals and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications and/or contract proposals, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Advisory General Medical Sciences Council.

Date: September 14–15, 2006.

Closed: September 14, 2006, 8:30 a.m. to 5 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Natcher Building, Conference Rooms E1 & E2, 9000 Rockville Pike, Bethesda, MD 20852.

Open: September 15, 2006, 8:30 a.m. to adjournment.

Agenda: For the discussion of program policies and issues, opening remarks, report of the Director, NIGMS, and other business of the Council.

Place: National Institutes of Health, Natcher Building, Conference Rooms E1 & E2, 9000 Rockville Pike, Bethesda, MD 20852.

Contact Person: Ann A. Hagan, PhD, Associate Director for Extramural Activities, NIGMS, NIH, DHHS, 45 Center Drive, Room 2AN24H, MSC6200, Bethesda, MD 20892–6200. (301) 594–4499. *hagana@nigms.nih.gov.*

Any interested person may file written comments with the committee by forwarding the statement to the Contact Person listed on this notice. The statement should include the name, address, telephone number and when applicable, the business or professional affiliation of the interested person.

In the interest of security, NIH has instituted stringent procedures for entrance onto the NIH campus. all visitor vehicles, including taxicabs, hotel, and airport shuttles will be inspected before being allowed on campus. Visitors will be asked to show one form of identification (for example, a government-issued photo ID, driver's license, or passport) and to state the purpose of their visit.

Information is also available on the Institute's/Center's home page: *http://www.nigms.nih.gov/about/advisory_council.html,* where an agenda and any additional information for the meeting will be posted when available.

(Catalogue of Federal Domestic Assistance Program Nos. 93.375, Minority Biomedical Research Support; 93.821, Cell Biology and Biophysics Research; 93.859, Pharmacology, Physiology, and Biological Chemistry Research; 93.862, Genetics and Developmental Biology Research; 93.88, Minority Access to Research Careers; 93.96,

Special Minority Initiatives, National Institutes of Health, HHS)

Dated: August 10, 2006.

Anna Snouffer,

Acting Director, Office of Federal Advisory Committee Policy.

[FR Doc. 06–6997 Filed 8–17–06; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Allergy and Infectious Diseases; Notice of Closed Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following meetings.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute of Allergy and Infectious Diseases Special Emphasis Panel Innate Immunity: Role of TLR Signaling in Mounting an Immune Response.

Date: September 8, 2006.

Time: 12 p.m. to 3 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Rockledge 6700, 6700B Rockledge Drive, Room 3131, Bethesda, MD 20817, (Telephone Conference Call).

Contact Person: Katherine L. White, Scientific Review Administrator, Scientific Review Program, Division of Extramural Activities, National Institutes of Health/NIAID/DHHS, 6700B Rockledge Drive, MSC 7616, Bethesda, MD 20892, 301–435–1615, *kw174b@nih.gov.*

Name of Committee: National Institute of Allergy and Infectious Diseases Special Emphasis Panel Regulations of Signaling Pathways.

Date: September 13, 2006.

Time: 1:30 p.m. to 5:30 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Rockledge 6700, 6700B Rockledge Drive, Room 3258, Bethesda, MD 20817, (Telephone Conference Call).

Contact Person: Sujata Vijh, Scientific Review Administrator, Scientific Review Program, Division of Extramural Activities, NIAID/NIH/DHHS, 6700B Rockledge Drive, MSC 7616, Bethesda, MD 20892, 301–594–0985, *vijhs@niaid.nih.gov.*

(Catalogue of Federal Domestic Assistance Program Nos. 93.855, Allergy, Immunology, and Transplantation Research; 93.856, Microbiology and Infectious Diseases Research, National Institutes of Health, HHS)

Dated: August 11, 2006.

Anna Snouffer,

Acting Director, Office of Federal Advisory Committee Policy.

[FR Doc. 06–7000 Filed 8–17–06; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Diabetes and Digestive and Kidney Diseases; Notice of Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of meetings of the National Diabetes and Digestive and Kidney Diseases Advisory Council.

The meetings will be open to the public as indicated below, with attendance limited to space available. Individuals who plan to attend and need special assistance, such as sign language interpretation or other reasonable accommodations, should notify the Contact Person listed below in advance of the meeting.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Diabetes and Digestive and Kidney Diseases Advisory Council.

Date: September 20–21, 2006.

Open: September 20, 2006, 8:30 a.m. to 12:30 p.m.

Agenda: To present the Director's Report and other scientific presentations.

Place: National Institutes of Health, Building 31, 31 Center Drive, Conference Room 10, Bethesda, MD 20892.

Closed: September 21, 2006, 9:45 a.m. to 10:15 a.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Building 31, 31 Center Drive, Conference Room 10, Bethesda, MD 20892.

Open: September 21, 2006, 10:15 a.m. to 12 p.m.

Agenda: Continuation of the Director's Report and other scientific presentations.

Place: National Institutes of Health, Building 31, 31 Center Drive, Conference Room 10, Bethesda, MD 20892.

Contact Person: Brent B. Stanfield, PhD, Director, Division of Extramural Activities, National Institutes of Diabetes and Digestive and Kidney Diseases, 6707 Democracy Blvd. Room 715, MSC 5452, Bethesda, MD 20892, (301) 594–8843, *stanfibr@niddk.nih.gov.*

Name of Committee: National Diabetes and Digestive and Kidney Diseases Advisory Council, Diabetes, Endocrinology, and Metabolic Diseases Subcommittee.

Date: September 20–21, 2006.

Open: September 20, 2006, 1:30 p.m. to 5:30 p.m.

Agenda: To review Division's scientific and planning activities.

Place: National Institutes of Health, Building 31, 31 Center Drive, Conference Room 10, Bethesda, MD 20892.

Closed: September 21, 2006, 8 a.m. to 9:30 a.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Building 31, 31 Center Drive, Conference Room 10, Bethesda, MD 20892.

Contact Person: Brent B. Stanfield, PhD, Director, Division of Extramural Activities, National Institutes of Diabetes and Digestive and Kidney Diseases, 6707 Democracy Blvd. Room 715, MSC 5452, Bethesda, MD 20892, (301) 594–8843, *stanfibf@niddk.nih.gov.*

Name of Committee: National Diabetes and Digestive and Kidney Diseases Advisory Council, Digestive Diseases and Nutrition Subcommittee.

Date: September 20–21, 2006.

Open: September 20, 2006, 1:30 p.m. to 5:30 p.m.

Agenda: To review the Division's scientific and planning activities.

Place: National Institutes of Health, Building 31, 31 Center Drive, Conference Room 9A22, Bethesda, MD 20892.

Closed: September 21, 2006, 8 a.m. to 9:30 a.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Building 31, 31 Center Drive, Conference Room 9A22, Bethesda, MD 20892.

Contact Person: Brent B. Stanfield, PhD, Director, Division of Extramural Activities, National Institutes of Diabetes and Digestive and Kidney Diseases, 6707 Democracy Blvd., Room 715, 5452, Bethesda, MD 20892, (301) 594–8843, *stanfibr@niddk.nih.gov.*

Name of Committee: National Diabetes and Digestive and Kidney Diseases Advisory Council Kidney, Urologic, and Hematologic Diseases Subcommittee.

Date: September 20–21, 2006.

Open: September 20, 2006, 1:30 p.m. to 5:30 p.m.

Agenda: To review the Division's scientific and planning activities.

Place: National Institutes of Health, Building 31, 31 Center Drive, Conference Room 9A22, Bethesda, MD 20892.

Closed: September 21, 2006, 8 a.m. to 9:30 a.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Building 31, 31 Center Drive, Conference Room 9A22, Bethesda, MD 20892.

Contact Person: Brent B. Stanfield, PhD, Director, Division of Extramural Activities, National Institutes of Diabetes and Digestive and Kidney Diseases, 6707 Democracy Blvd., Room 715, 5452, Bethesda, MD 20892, (301) 594–8843, *stanfibr@niddk.nih.gov.*

Any interested person may file written comments with the committee by forwarding the statement to the Contact Person listed on this notice. The statement should include the name, address, telephone number and when applicable, the business or professional affiliation of the interested person.

In the interest of security, NIH has instituted stringent procedures for entrance onto the NIH campus. All visitor vehicles, including taxicabs, hotel, and airport shuttles will be inspected before being allowed on campus. Visitors will be asked to show one form of identification (for example, a government-issued photo ID, driver's license, or passport) and to state the purpose of their visit.

Information is also available on the Institute's/Center's home page: *www.niddk.nih.gov/fund/divisions/DEA/Council/coundesc.htm.*, where an agenda and any additional information for the meeting will be posted when available.

(Catalogue of Federal Domestic Assistance Program Nos. 93.847, Diabetes, Endocrinology and Metabolic Research; 93.848, Digestive Diseases and Nutrition Research; 93.849, Kidney Diseases, Urology and Hematology Research, National Institutes of Health, HHS)

Dated: August 14, 2006.

Anna Snouffer,

Acting Director, Office of Federal Advisory Committee Policy.

[FR Doc. 06–7019 Filed 8–17–06; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Child Health and Human Development; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The contract proposals and the discussion could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the contract proposals, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute of Child Health and Human Development Special Emphasis Panel; Drug Testing Facility.

Date: September 7, 2006.

Time: 12 p.m. to 2 p.m.

Agenda: To review and evaluate grant proposals.

Place: National Institutes of Health, 6100 Executive Boulevard, Room 5B01, Rockville, MD 20852, (Telephone Conference Call).

Contact Person: Hameed Khan, Scientific Review Administrator, Division of Scientific Review, National Institute of Child Health and Human Development, NIH, 6100 Executive Blvd., Room 5B01, Bethesda, MD 20892, (301) 435–6902, *khanh@mail.nih.gov.*

(Catalogue of Federal Domestic Assistance Program Nos. 93.864, Population Research; 93.865, Research for Mothers and Children; 93.929, Center for Medical Rehabilitation Research; 93.209, Contraception and Infertility Loan Repayment Program, National Institutes of Health, HHS)

Dated: August 14, 2006.

Anna Snouffer,

Acting Director, Office of Federal Advisory Committee Policy.

[FR Doc. 06–7022 Filed 8–17–06; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Office of the Director, National Institutes of Health; Notice of Meeting

Pursuant to section 10(a) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of a meeting of the Recombinant DNA Advisory Committee.

The meeting will be open to the public, with attendance limited to space available. Individuals who plan to attend and need special assistance, such as sign language interpretation or other reasonable accommodations, should notify the Contact Person listed below in advance of the meeting.

Name of Committee: Recombinant DNA Advisory Committee.

Date: September 20, 2006.

Time: 1 p.m. to 5 p.m.

Agenda: The Recombinant DNA Advisory Committee will review and discuss selected human gene transfer protocols as well as related data management activities.

Place: National Institutes of Health, Natcher Building, 45 Center Drive, Conference Room D, Bethesda, MD 20892.

Contact Person: Laurie Lewallen, Advisory Committee Coordinator, Office of Biotechnology Activities, National Institutes of Health, 6705 Rockledge Drive, Room 750, Bethesda, MD 20892–7985; 301–496–9838; *lewallla@od.nih.gov.*

Any interested person may file written comments with the committee forwarding the statement to the Contact Person listed on this notice. The statement should include the name, address, telephone number and when applicable, the business or professional affiliation of the interested person.

Information is also available on the Institute's/Center's home page: *http://www4.od.nih.gov/oba/*, where an agenda and any additional information for the meeting will be posted when available.

OMB's "Mandatory Information Requirements for Federal Assistance Program Announcements" (45 FR 39592, June 11, 1980) requires a statement concerning the official government programs contained in the Catalog of Federal Domestic Assistance. Normally NIH lists in its announcements the number and title of affected individual programs for the guidance of the public. Because the guidance in this notice covers virtually every NIH and Federal research program in which DNA recombinant molecule techniques could be used, it has been determined not to be cost effective or in the public interest to attempt to list these programs. Such a list would likely require several additional pages. In addition, NIH could not be certain that every Federal program would be included as many Federal agencies, as well as private organizations, both national and international, have elected to follow the NIH Guidelines. In lieu of the individual program listing, NIH invites readers to direct questions to the information address above about whether individual programs listed in the Catalog of Federal Domestic Assistance are affected.

(Catalogue of Federal Domestic Assistance Program Nos. 93.14, Intramural Research Training Award; 93.22, Clinical Research Loan Repayment Program for Individuals from Disadvantaged Backgrounds; 93.232, Loan Repayment Program for Research Generally; 93.39, Academic Research Enhancement Award; 93.936, NIH Acquired Immunodeficiency Syndrome Research Loan Repayment Program; 93.187, Undergraduate Scholarship Program for Individuals from Disadvantaged Backgrounds, National Institutes of Health, HHS)

Dated: August 14, 2006.

Anna Snouffer,

Acting Director, Office of Federal Advisory Committee Policy.

[FR Doc. 06–7020 Filed 8–17–06; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

[USCG–2006–25598]

Towing Safety Advisory Committee

AGENCY: Coast Guard, DHS.

ACTION: Notice of meetings.

SUMMARY: The Towing Safety Advisory Committee (TSAC) and its working groups will meet as required to discuss various issues relating to shallow-draft inland and coastal waterway navigation and towing safety. All meetings will be open to the public.

DATES: TSAC will meet on, Thursday, September 21, 2006, from 8 a.m. to 3 p.m. The working groups will meet on Wednesday, September 20, 2006, from 8 a.m. to 3 p.m. These meetings may close early if all business is finished. Written material for and requests to make oral presentations at the meetings should reach the Coast Guard on or before September 11, 2006. Requests to have a copy of your material distributed to each member of the Committee or working groups prior to the meetings should reach the Coast Guard on or before September 11, 2006.

ADDRESSES: TSAC will meet in Salons A & B, Hilton St. Louis Airport; 10330 Natural Bridge Road; St. Louis, MO 63134–3303. Guest rooms may be reserved by calling (800)–HILTONS or (314)–426–5500. In order to obtain the Government Rate, reservations must be made before September 5, 2006. Send written material and requests to make oral presentations to Mr. Gerald P. Miante, Assistant Executive Director, TSAC; U.S. Coast Guard Headquarters, G–PSO–1, Room 1210; 2100 Second Street, SW., Washington, DC 20593–0001. This notice and related documents are available on the Internet at *http://dms.dot.gov* under the docket number USCG–2006–25598.

FOR FURTHER INFORMATION CONTACT: Mr. Gerald P. Miante, Assistant Executive Director, TSAC; telephone (202) 372–1401, fax (202) 372–1926, or e-mail at: *gmiante@comdt.uscg.mil.*

SUPPLEMENTARY INFORMATION: Notice of these meetings is given under the Federal Advisory Committee Act, 5 U.S.C. App. 2 (Pub. L. 92–463, 86 Stat. 770, as amended).

Agenda of Committee Meeting

The agenda includes the following items:

(1) Comprehensive Report of the Towing Vessel Inspection Working Group;

(2) Status Report of the Licensing Implementation Working Group: an Approved Model Training Program for Wheelhouse Personnel;

(3) Update from the Working Group on Lessons Learned from the Review of the AV Kastner/Buchanan 14/SWIFT Collision and the MV Wally Roller Incident; and

(4) Discussions on the Transportation Worker Identification Credential (TWIC) and the Merchant Mariner Credential (MMC) Rulemakings.

Procedural

All meetings are open to the public. Please note that the meetings may close early if all business is finished. Members of the public may make oral presentations during the meetings. If you would like to make an oral presentation at a meeting, please notify the Assistant Executive Director no later than September 11, 2006. Written material for distribution at a meeting should reach the Coast Guard no later than September 11, 2006. If you would like a copy of your material distributed to each member of the Committee or Working Groups in advance of a meeting, please submit 20 copies to the Assistant Executive Director no later than September 11, 2006. You may also submit this material electronically to the e-mail address in **FOR FURTHER INFORMATION CONTACT**, no later than September 11, 2006. Also, at the Chair's discretion, members of the public may present comment at the end of the Public Meeting. Please understand that the Committee's schedule may be quite demanding and time for public comment may be limited.

Information on Services for Individuals With Disabilities

For information on facilities or services for individuals with disabilities or to request special assistance at the meetings, contact the Assistant Executive Director as soon as possible.

Dated: August 11, 2006.

J.G. Lantz,

Director of National and International Standards, Assistant Commandant for Prevention.

[FR Doc. E6–13666 Filed 8–17–06; 8:45 am]

BILLING CODE 4910–15–P

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR–5041–N–30]

Notice of Proposed Information Collection: Comment Request; Request for Occupied Conveyance

AGENCY: Office of the Assistant Secretary for Housing—Federal Housing Commissioner, HUD.

ACTION: Notice.

SUMMARY: The proposed information collection requirement described below will be submitted to the Office of Management and Budget (OMB) for review, as required by the Paperwork Reduction Act. The Department is soliciting public comments on the subject proposal.

DATES: *Comments Due Date:* October 17, 2006.

ADDRESSES: Interested persons are invited to submit comments regarding this proposal. Comments should refer to the proposal by name and/or OMB Control Number and should be sent to: Lillian Deitzer, Reports Management Officer, Department of Housing and Urban Development, 451 7th Street, SW., L'Enfant Plaza Building, Room 8003, Washington, DC 20410.

FOR FURTHER INFORMATION CONTACT: Laurie Maggiano, Acting Director, Office of Single Family Asset Management, U.S. Department of Housing and Urban Development, 451 7th Street, SW., Washington, DC 20410, telephone (202) 708–1672 (this is not a toll free number) for copies of the proposed forms and other available information.

SUPPLEMENTARY INFORMATION: The Department is submitting the proposed information collection to OMB for review, as required by the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35, as amended).

This Notice is soliciting comments from members of the public and affected agencies concerning the proposed collection of information to: (1) Evaluate whether the proposed collection is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility; (2) Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information; (3) Enhance the quality, utility, and clarity of the information to be collected; and (4) Minimize the burden of the collection of information on those who are to respond; including the use of appropriate automated collection techniques or other forms of information technology, *e.g.*, permitting electronic submission of responses.

This Notice also lists the following information:

Title of Proposal: Request for Occupied Conveyance.

OMB Control Number, if applicable: 2502–0268.

Description of the need for the information and proposed use: Prior to intended acquisition of property securing an FHA-insured mortgage; the mortgagee must notify the mortgagor and each head of household who is occupying a unit of the potential acquisition by HUD. The mortgagee informs the occupant of his/her rights and includes information necessary for the occupant to request to remain in the property. Occupants return the form HUD–9539 and supporting

documentation to the local HUD office within 20 days after receipt of the notice. The information is necessary for HUD to determine whether the occupant qualifies to remain in the property. An occupant who is accepted must execute a month-to-month lease.

Agency form numbers, if applicable: HUD–9539.

Estimation of the total numbers of hours needed to prepare the information collection including number of respondents, frequency of response, and hours of response: The estimated total number of burden hours needed to prepare the information collection is 21,125; the number of respondents is 12,750 generating approximately 74,750 annual responses; the frequency of response is on occasion; and the estimated time needed to prepare the response varies from 15 minutes to 30 minutes.

Status of the proposed information collection: This is an extension of a currently approved collection.

Authority: The Paperwork Reduction Act of 1995, 44 U.S.C., Chapter 35, as amended.

Dated: August 14, 2006.

Frank L. Davis,

General Deputy Assistant Secretary for Housing—Federal Housing Commissioner.

[FR Doc. E6–13606 Filed 8–17–06; 8:45 am]

BILLING CODE 4210–67–P

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR–5045–N–33]

Federal Property Suitable as Facilities To Assist the Homeless

AGENCY: Office of the Assistant Secretary for Community Planning and Development, HUD.

ACTION: Notice.

SUMMARY: This Notice identifies unutilized, underutilized, excess, and surplus Federal property reviewed by HUD for suitability for possible use to assist the homeless.

EFFECTIVE DATES: August 18, 2006.

FOR FURTHER INFORMATION CONTACT: Kathy Ezzell, Department of Housing and Urban Development, Room 7262, 451 Seventh Street, SW., Washington, DC 20410; telephone (202) 708–1234; TTY number for the hearing- and speech-impaired (202) 708–2565, (these telephone numbers are not toll-free), or call the toll-free Title V information line at 1–800–927–7588.

SUPPLEMENTARY INFORMATION: In accordance with the December 12, 1988 court order in *National Coalition for the Homeless* v. *Veterans Administration*, No. 88–2503–OG (D.D.C.), HUD publishes a Notice, on a weekly basis, identifying unutilized, underutilized, excess and surplus Federal buildings and real property that HUD has reviewed for suitability for use to assist the homeless. Today's Notice is for the purpose of announcing that no additional properties have been determined suitable or unsuitable this week.

Dated: August 10, 2006.

Mark R. Johnston,

Acting Deputy Assistant Secretary for Special Needs.

[FR Doc. 06–6934 Filed 8–17–06; 8:45 am]

BILLING CODE 4210–67–M

DEPARTMENT OF THE INTERIOR

Office of the Secretary

Exxon Valdez Oil Spill Trustee Council; Renewal of the Public Advisory Committee Charter

AGENCY: Office of the Secretary, Department of the Interior.

ACTION: Notice.

SUMMARY: This notice is published in accordance with 41 CFR part 102–3, subpart B, How Are Advisory Committees Established, Renewed, Reestablished, and Terminated. Following the recommendation and approval of the *Exxon Valdez* Oil Spill Trustee Council, the Secretary of the Interior hereby renews the *Exxon Valdez* Oil Spill Public Advisory Committee Charter to continue for approximately 2 years, to September 30, 2008.

FOR FURTHER INFORMATION CONTACT: Douglas Mutter, Department of the Interior, Office of Environmental Policy and Compliance, 1689 "C" Street, Room 119, Anchorage, Alaska, (907) 271–5011.

SUPPLEMENTARY INFORMATION: On March 24, 1989, the T/V/ *Exxon Valdez* ran aground on Bligh Reef in Prince William Sound in Alaska spilling approximately 11 million gallons of North Slope crude oil. Oil moved into the Gulf of Alaska, along the Kenai coast to Kodiak Island and the Alaska Peninsula—some 600 miles from Bligh Reef. Massive clean up and containment efforts were initiated and continued to 1992. On October 8, 1991, an agreement was approved by the United States District Court for the District of Alaska that settled claims of the United States and the State of Alaska against the Exxon Corporation and the Exxon Shipping Company for various criminal and civil violations. Under the civil settlement, Exxon agreed to pay to the governments $900 million over a period of 10 years. An additional 5-year period was established to possibly make additional claims.

The *Exxon Valdez* Oil Spill Trustee Council was established to manage the funds obtained from the civil settlement of the *Exxon Valdez* Oil Spill. The Trustee Council is composed of three State of Alaska trustees (Attorney General; Commissioner, Department of Environmental Conservation; and Commissioner, Department of Fish and Game) and three Federal representatives appointed by the Federal Trustees (Secretary, US Department of Agriculture; the Administrator of the National Oceanic and Atmospheric Administration; and the secretary, US Department of the Interior).

The Public Advisory Committee was created pursuant to Paragraph V.A.4 of the Memorandum of Agreement and Consent Decree entered into by the United States of America and the State of Alaska on August 27, 1991, and approved by the United States District Court for the District of Alaska in settlement of *United States of America* v. *State of Alaska*, Civil Action No. A91–081 CV. The Public Advisory Committee was originally chartered as the Public Advisory Group by the Secretary of the Interior on October 23, 1992, and functions solely as an advisory body, and in compliance with the provisions of the Federal Advisory Committee Act, as amended (5 U.S.C. App.).

The Public Advisory Committee was established to advise the Trustee Council, and began functioning in October 1992. The Public Advisory Committee consists of 15 members representing the following principal interests: sport hunting and fishing, conservation and environmental, public-at-large, recreation users, commercial tourism, local government, science/technical, subsistence, commercial fishing, aquaculture and mariculture, regional monitoring programs, tribal government, marine transportation, and Native landowners. Members are appointed to serve a 2-year term.

To carry out its advisory role, the Public Advisory Committee makes recommendations to, and advises, the Trustee Council in Alaska on the following matters:

All decisions related to injury assessment, restoration activities, or other use of natural resource damage recovery monies obtained by the governments, including all decisions regarding:

a. Planning, evaluation and allocation of available funds;

b. Planning, evaluation and conduct of injury assessment and restoration activities;

c. Planning, evaluation and conduct of long-term monitoring and research activities; and

d. Coordination of a, b, and c.

Trustee Council intentions regarding the importance of obtaining a diversity of viewpoints is stated in the *Public Advisory Committee Background and Guidelines*: "The Trustee Council intends that the Public Advisory Committee be established as an important component of the Council's public involvement process." The Council continues, stating their desire that "* * * a wide spectrum of views and interest are available for the Council to consider as it evaluates, develops, and implements restoration activities. It is the Council's intent that the diversity of interests and views held by the Public Advisory Committee members contribute to wide ranging discussions that will be of benefit to the Trustee Council."[2]

In order to ensure that a broad range of public viewpoints continues to be available to the Trustee Council, and in keeping with the settlement agreement, the continuation of the Public Advisory Committee for another 2-year period is recommended.

Dated: July 28, 2006.

Dirk Kempthorne,

Secretary of the Interior.

Certification

I hereby certify that the renewal of the Charter of the Public Advisory Committee, an advisory committee to make recommendations to and advise the *Exxon Valdez* Oil Spill Trustee Council in Alaska, is necessary and in the public interest in connection with the performance of duties mandated by the settlement of *United States* v. *State of Alaska*, No. A91–081 CV, and is in accordance with the Comprehensive Environmental Response, Compensation and Liability Act of 1980, as amended and supplemented.

Dated: July 28, 2006.

Dirk Kempthorne,

Secretary of the Interior.

[FR Doc. 06–7011 Filed 8–17–06; 8:45 am]

BILLING CODE 4310–RG–M

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

Final Comprehensive Conservation Plan/Environmental Impact Statement for the Sweetwater Marsh and South San Diego Bay Units of the San Diego Bay National Wildlife Refuge

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Notice of availability.

SUMMARY: The U.S. Fish and Wildlife Service (Service) announces that a Final Comprehensive Conservation Plan/ Environmental Impact Statement (Final CCP/EIS) for the Sweetwater Marsh and South San Diego Bay Units of the San Diego Bay National Wildlife Refuge is available for review. This Final CCP/EIS has been prepared pursuant to the National Environmental Policy Act of 1969 and is designed to address the Service's obligation under the National Wildlife Refuge System Administration Act of 1966, as amended by the National Wildlife Refuge System Improvement Act of 1997. The Final CCP/EIS describes the Service's proposal for managing these Refuge Units over the next 15 years.

DATES: A Record of Decision may be signed no sooner than 30 days after the publication of this notice (40 CFR 1506.10(b)(2)).

ADDRESSES: A copy of the Final CCP/ EIS, including Appendix P (Responses to Comments) is available on compact disk or in hard copy by writing to: Victoria Touchstone, Refuge Planner, San Diego National Wildlife Refuge Complex, 6010 Hidden Valley Road, Carlsbad, CA 92011 or by e-mailing *Victoria_Touchstone@fws.gov*. You may also access or download copies of the Final CCP/EIS and associated Appendices at the following Web site address: *http://sandiegorefuges.fws.gov*. Hard copies of the Final CCP/EIS are also available for viewing at the following locations:

- San Diego National Wildlife Refuge Complex, 6010 Hidden Valley Road, Carlsbad, CA;
- Tijuana Estuary Visitor Center, 301 Caspian Way, Imperial Beach, CA;
- Chula Vista Public Library, Civic Center Branch, 365 F Street, Chula Vista, CA and South Chula Vista Branch, 389 Orange Avenue, Chula Vista, CA;
- Coronado Public Library, 640 Orange Avenue, Coronado, CA;
- Imperial Beach Library, 810 Imperial Beach Boulevard, Imperial Beach, CA;
- National City Library, 200 East 12th Street, National City, CA; and
- City of San Diego, Central Library, Government Publications, 820 E Street and the Otay Mesa Branch Library, 3003 Coronado Avenue, San Diego, CA.

FOR MORE INFORMATION CONTACT: Victoria Touchstone, Refuge Planner, at the above street and e-mail address, or via telephone at (760) 431–9440 extension 349, or by fax at (760) 930–0256.

SUPPLEMENTARY INFORMATION: The National Wildlife Refuge System Administration Act of 1966, as amended by the National Wildlife Refuge System Improvement Act of 1997 (16 U.S.C. 668dd–668ee *et seq.*) requires the Service to develop a Comprehensive Conservation Plan (CCP) for each National Wildlife Refuge. The purpose for developing a CCP is to provide refuge managers with a 15-year strategy for achieving refuge purposes and contributing toward the mission of the National Wildlife Refuge System (Refuge System), consistent with sound principles of fish and wildlife science, conservation, legal mandates, and Service policies. In addition to outlining broad management direction for conserving wildlife and their habitats, the CCPs identify wildlife-dependent recreational opportunities available to the public, including opportunities for hunting, fishing, wildlife observation and photography, and environmental education and interpretation. The National Wildlife Refuge System Administration Act of 1966, as amended by the National Wildlife Refuge System Improvement Act of 1997, requires the Service to review and update these CCPs at least every 15 years. Revisions to the CCP will be prepared in accordance with the National Environmental Policy Act of 1969 (42 U.S.C. 4321–4370d).

The San Diego Bay National Wildlife Refuge is located approximately 10 miles north of the United States-Mexico border in southwestern San Diego County, California. Collectively, the two Refuge Units encompass approximately 2,620 acres of land and water in and around the south end of San Diego Bay. The coastal wetlands protected within this Refuge annually provide essential foraging and resting habitat for tens of thousands of migratory shorebirds and wintering waterfowl traveling along the Pacific Flyway.

The Sweetwater Marsh Unit was established as a National Wildlife Refuge in 1988. Encompassing approximately 316 acres, this Refuge was established to protect federally listed endangered and threatened

species. The coastal salt marsh and upland areas within the Sweetwater Marsh Unit support 6 federally listed species, including 3 listed birds that nest within the Unit, 1 State-listed endangered species, and 26 species of birds identified by the Service as Birds of Conservation Concern.

The South San Diego Bay Unit was established in 1999 as a unit of the San Diego National Wildlife Refuge for the purpose of protecting, managing, and restoring habitats for federally listed endangered and threatened species and migratory birds. The Service currently manages approximately 2,300 acres of the 3,940 acres included within the Unit's approved acquisition boundary. The majority of this management area is leased to the Service by the California State Lands Commission. Included within this Unit is the largest remaining expanse of intertidal mudflats in San Diego Bay. This and other habitats within the Unit support 5 federally listed endangered and threatened species, 1 State-listed endangered species, and 19 species of birds identified by the Service as Birds of Conservation Concern. Open water is the dominant habitat, followed by intertidal mudflats, disturbed uplands, salt marsh, and freshwater wetlands. The Unit includes an active commercial solar salt operation that is managed under a Special Use Permit. The salt pond levees provide important nesting habitat for a variety of colonial nesting seabirds, and the brine invertebrates present in some ponds provide foraging habitat for various migratory birds, including phalaropes and eared grebes.

The proposed action is to adopt and implement a CCP that best achieves the purposes for which the Refuge was established, furthers its vision and goals, contributes to the mission of the National Wildlife Refuge System, addresses significant issues and applicable mandates, and is consistent with the principles of sound fish and wildlife management. Implementing the CCP will enable the Refuge to fulfill its role in the conservation and management of fish and wildlife resources within the Pacific Flyway, including the conservation of important coastal wetlands, and to provide refuge visitors with opportunities to enjoy the Refuge's resources through high-quality opportunities for wildlife observation, environmental education, and environmental interpretation. A Predator Management Plan, prepared pursuant to the Service's endangered species management responsibilities, is also included in the CCP/EIS as a step-down plan. The predator management plan, which benefits the Federally listed endangered California least tern and light-footed clapper rail and the threatened western snowy plover, has been developed as a comprehensive wildlife damage control program that addresses a range of management actions from vegetation control and nesting habitat enhancement to non-lethal and lethal control of both mammalian and avian predators. Under this plan, the most effective, selective, and humane techniques available to deter or remove individual predators or species would be implemented.

This CCP will also satisfy a condition of the Public Agency Lease between the California State Lands Commission and the Service, requiring management and public access plans for the South San Diego Bay Unit, as well as fulfill the Service's obligation described in a Cooperative Agreement between the Service and the Unified Port of San Diego to prepare "a holistic habitat restoration plan" for a 1,035-acre portion of the existing salt ponds within the South San Diego Bay Unit.

The Service analyzed various alternatives for future management of the Refuge, including three alternatives for the Sweetwater Marsh Unit and four alternatives for the South San Diego Bay Unit. Sweetwater Marsh Unit, Alternative C, and South San Diego Bay Unit, Alternative D, have been identified as the Service's preferred alternatives.

Alternative C for the Sweetwater Marsh Unit would improve habitat quality and restore intertidal and upland habitats to support six Federally listed species, along with the Refuge's other plant and animal resources. The existing trail system on Gunpowder Point would be redesigned and new interpretive elements would be provided to better complement the existing environmental education programs supported by the Refuge.

Alternative D for the South San Diego Bay Unit would enhance nesting opportunities in and around the salt ponds for the California least tern, western snowy plover, and various other colonial seabirds; restore to native coastal habitats up to 410 acres of previous agricultural land in the Otay River floodplain; restore 650 acres of commercial solar salt ponds to tidal influence to support intertidal mudflat and coastal salt marsh habitats; and manage the water and salinity levels in an additional 275 acres of salt ponds. Opportunities for wildlife observation, photography, and environmental interpretation would be expanded; a pedestrian pathway would be constructed along the southern end of the Refuge to improve wildlife observation opportunities for Refuge visitors; and the other public uses (*i.e.*, fishing, environmental education, and boating) currently provided on the Refuge would be maintained.

The following substantive changes were made between the Draft and Final CCP/EIS:

1. We revised Appendix D (CCP Implementation) to clarify the phasing plan for restoration of the salt ponds under scenario 2 and to more clearly describe the step-down planning process for future restoration and enhancement proposals on the South San Diego Bay Unit.

2. We expanded the biological resources information provided in Chapter 3, Affected Environment, to address comments received during public review.

Public comments were requested, considered, and incorporated throughout the planning process. Public outreach included public meetings and workshops, planning update mailings, and **Federal Register** notices. Three previous notices were published in the **Federal Register** concerning the development of this CCP (65 FR 39172, June 23, 2000; 67 FR 19583, April 22, 2002; 70 FR 42359, July 22, 2005). During the public review and comment period for the Draft CCP/EIS, which occurred from July 22 to September 19, 2005, the Service received 38 written comments and four verbal comments. All substantive issues raised in these comments have been addressed through changes incorporated in the Final CCP/EIS and/or through responses to the comments, which are included in Appendix P, Responses to Comments, of the Final CCP/EIS.

Dated: August 11, 2006.

Ken McDermond,

Acting Manager, California/Nevada Operations, Sacramento, California.

[FR Doc. E6–13556 Filed 8–17–06; 8:45 am]

BILLING CODE 4310–55–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[MT–030–1320–EL, NDM 95104]

Notice of Competitive Coal Lease Sale, North Dakota

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice of competitive coal lease sale, lease application NDM 95104.

SUMMARY: Notice is hereby given that the United States Department of Interior (DOI), Bureau of Land Management (BLM), Montana State Office, will offer

coal reserves in the lands described below in Oliver County, North Dakota, hereinafter described as Federal coal lease application (LBA) NDM 95104 for competitive lease by sealed bid in accordance with the provisions for competitive lease sales in 43 CFR 22.2(a), and the Mineral Leasing Act of 1920, as amended and supplemented (30 U.S.C. 181 *et seq.*).

DATES: The lease sale will be held at 11 a.m., Tuesday, September 12, 2006. Sealed bids must be sent by certified mail, return receipt requested, or be hand delivered to the address indicated below, and must be received on or before 10 a.m., September 12, 2006.

ADDRESSES: The lease sale will be held in the BLM Montana State Office, 920 Conference Room, 5001 Southgate Drive, Billings, Montana 59101–4669. Sealed bids clearly marked "Sealed Bid for NDM 95104 Coal Sale-Not to be opened before 11 a.m., Tuesday, September 12, 2006" must be submitted to the Cashier, BLM Montana State Office, at the address given above. The cashier will issue a receipt for each hand delivered sealed bid.

FOR FURTHER INFORMATION CONTACT: Connie Schaff, Land Law Examiner, or Rebecca Spurgin, Coal Coordinator, at 406–896–5060 or 406–896–5080, respectively.

SUPPLEMENTARY INFORMATION: This sale is being held in response to a LBA filed by The BNI Coal, Ltd on September 29, 2005. All coal LBAs submitted to BLM for processing prior to November 7, 2005 are not subject to cost recovery on a case-by-case basis (See 43 CFR 3000.10(d)(1), 70 FR 58872, October 7, 2005). The Federal coal resource to be offered consists of all recoverable reserves in the following described lands:

T. 142 N., R. 84 W., 5th P. M.
Sec. 28: W½.

Containing approximately 320 acres in Oliver County, North Dakota.

The LBA's total recoverable coal reserves are estimated to be 8.3 million tons (averaging 15.3 feet in thickness) and the average overburden depth is 100 feet.

The estimated coal quality on an as-received basis is as follows:

BTU	6,765 BTU/lb.
Volatile Matter	25.73 %
Fixed Carbon	28.72 %
Moisture	38.46 %
Sulfur Content	0.91 %
Ash Content	7.09 %

The tracts will be leased to the qualified bidder of the highest cash amount, provided that the high bid meets or exceeds the BLM's pre-sale estimate of fair market value (FMV). No bid that is less than $100 per acre, or fraction thereof, will be considered. The DOI has established a minimum bid of $100 per acre or fraction thereof for Federal coal tracts. The minimum bid is not intended to represent FMV. The FMV will be determined by the Authorized Officer after the sale. In the event identical high sealed bids are received, the tying high bidders will be requested to submit follow-up bids until a high bid is received. All tie-breaking sealed-bids must be submitted within 15 minutes following the Sale Official's announcement at the sale that identical high bids have been received.

A lease issued as a result of this offering will provide for payment of an annual rental of $3 per acre, or fraction thereof; and a royalty payable to the United States of 12.5 percent of the value of coal mined by surface methods and 8.0 percent of the value of coal mined by underground methods. The value of the coal will be determined in accordance with 30 CFR 206.250.

Bidding instructions for the tracts offered and the terms and conditions of the proposed coal lease are included in the Detailed Statement of Lease Sale. Copies of the Detailed Statement and the proposed coal lease are available at the Montana State Office at the address given above. Casefile NDM 95104 is available for inspection at the Montana State Office during normal business hours at the address above.

Dated: July 12, 2006.

Glenwood F. Kerestes,

Acting Chief, Branch of Solid Minerals.

[FR Doc. E6–13608 Filed 8–17–06; 8:45 am]

BILLING CODE 4310–$$–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[WY–920–1320–EL, WYW172929]

Notice of Invitation for Coal Exploration License Application, Wyoming

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice of Invitation for Coal Exploration License Application, Jacobs Ranch Coal Company, WYW172929, Wyoming.

SUMMARY: Pursuant to section 2(b) of the Mineral Leasing Act of 1920, as amended by section 4 of the Federal Coal Leasing Amendments Act of 1976, 90 Stat. 1083, 30 U.S.C. 201(b), and to the regulations adopted as 43 Code of Federal Regulations (CFR) 3410, all interested qualified parties, as provided in 43 CFR 3472.1, are hereby invited to participate with Jacobs Ranch Coal Company on a pro rata cost sharing basis in a program for the exploration of coal deposits owned by the United States of America in the following-described lands in Campbell County, Wyoming:

T. 44 N., R. 70 W., 6th P.M., Wyoming,
Sec. 21: Lots 1 through 16;
T. 43 N., R. 71 W., 6th P.M., Wyoming,
Sec. 3: Lots 2, 5 through 19;
Sec. 4: Lots 5 through 20;
Sec. 5: Lots 5 through 20;
Sec. 6: Lots 8, 15, 16, 23;
T. 44 N., R. 71 W., 6th P.M., Wyoming,
Sec. 15: Lots 9 through 16;
Sec. 20: Lots 9, 10, 14, 15;
Sec. 21: Lots 1 through 16;
Sec. 22: Lots 1 through 16;
Sec. 27: Lots 1 through 16;
Sec. 28: Lots 1 through 16;
Sec. 29: Lots 1 through 15, SE¼SE¼,
Sec. 30: Lots 5, 12, 13, 20;
Sec. 31: Lots 5, 12, 13, 20;
Sec. 32: Lots 1 through 15, SW¼SE¼;
Sec. 33: Lots 1 through 15, NE¼SE¼;
Sec. 34: Lots 1 through 16;
Containing 9,260.58 acres, more or less.

DATES: Any party electing to participate in this exploration program must send written notice to both the Bureau of Land Management and Jacobs Ranch Coal Company, as provided in the **ADDRESSES** section below, no later than thirty days after publication of this invitation in the **Federal Register**.

ADDRESSES: Copies of the exploration plan are available for review during normal business hours in the following offices (serialized under number WYW172929): Bureau of Land Management, Wyoming State Office, 5353 Yellowstone Road, P.O. Box 1828, Cheyenne, WY 82003; and, Bureau of Land Management, Casper Field Office, 2987 Prospector Drive, Casper, WY 82604. The written notice should be sent to the following addresses: Jacobs Ranch Coal Company, c/o Rio Tinto Energy America, Attn: Tom Suchomel, Caller Box 3009, Gillette, WY 82717, and the Bureau of Land Management, Wyoming State Office, Branch of Solid Minerals, Attn: Mavis Love, P.O. Box 1828, Cheyenne, WY 82003.

SUPPLEMENTARY INFORMATION: All of the coal in the above-described land consists of unleased Federal coal within the Powder River Basin Known Coal Leasing Area. The purpose of the exploration program is to obtain supplemental geotechnical data from two previous drilling programs and to assist with the planning of future expansions to the Jacobs Ranch Mine. This notice of invitation will be published in The News-Record of Gillette, WY, once each week for two

consecutive weeks beginning the week of August 14, 2006, and in the **Federal Register**.

The foregoing is published in the **Federal Register** pursuant to 43 CFR 3410.2–1(c)(1).

Dated: July 28, 2006.

Alan Rabinoff,

Deputy State Director, Minerals and Lands.

[FR Doc. E6–13633 Filed 8–17–06; 8:45 am]

BILLING CODE 4310–22–P

DEPARTMENT OF THE INTERIOR

National Park Service

Plans of Operations and Environmental Assessments for Continuing Operations for Chesapeake Operating, Inc., and Pantera Energy Company, Lake Meredith National Recreation Area, Texas

AGENCY: National Park Service, Department of the Interior.

ACTION: Notice of Availability of Plans of Operations and Environmental Assessments for a 30-day Public Review at Lake Meredith National Recreation Area.

SUMMARY: Notice is hereby given in accordance with Section 9.52(b) of Title 36 of the Code of Federal Regulations, Part 9, Subpart B, of a Plan of Operations submitted by Chesapeake Operating, Inc., for continuing operations of the J.T. Sneed 103, H.I. Lea 101, and H.I. Lea R–1 natural gas wells and a Plan of Operations submitted by Pantera Energy Company for continuing operations of the Barnes State #1 and the Barnes State #1R natural gas wells in Lake Meredith National Recreation Area, Moore and Potter Counties, Texas. Additionally, the NPS has prepared Environmental Assessments for both of these proposals.

DATES: The above documents are available for public review and comment through September 18, 2006.

ADDRESSES: The Plans of Operations and Environmental Assessments are available for public review and comment in the Office of the Superintendent, Karren Brown, Lake Meredith National Recreation Area, 419 E. Broadway, Fritch, Texas. The documents are also available at the Planning, Environment and Public Comment Web site at *http://parkplanning.gov.*

FOR FURTHER INFORMATION CONTACT: Ms. Arlene Wimer, Environmental Protection Specialist, Division of Resource Management, Lake Meredith National Recreation Area, P.O. Box 1460, Fritch, Texas 79036, Telephone: 806–865–3874, ext. 35, e-mail at *Arlene_Wimer@nps.gov.*

SUPPLEMENTARY INFORMATION: If you wish to comment on the environmental assessment, you may mail comments to the name and address above or post comments online at *http://parkplanning.nps.gov/.* This environmental assessment will be on public review for 30 days. Our practice is to make comments, including names, home addresses, home phone numbers, and e-mail addresses of respondents, available for public review. Individual respondents may request that we withhold their names and/or home addresses, etc., but if you wish us to consider withholding this information you must state this prominently at the beginning of your comments. In addition, you must present a rationale for withholding this information. This rationale must demonstrate that disclosure would constitute a clearly unwarranted invasion of privacy. Unsupported assertions will not meet this burden. In the absence of exceptional, documentable circumstances, this information will be released. We will always make submissions from organizations or businesses, and from individuals identifying themselves as representatives of or officials of organizations or businesses, available for public inspection in their entirety.

Dated: July 17, 2006.

Karren Brown,

Superintendent, Lake Meredith National Recreation Area.

[FR Doc. E6–13685 Filed 8–17–06; 8:45 am]

BILLING CODE 4310–3A–P

DEPARTMENT OF THE INTERIOR

National Park Service

Notice of Inventory Completion: U.S. Department of the Interior, National Park Service, Western Archeological and Conservation Center, Tucson, AZ; Correction

AGENCY: National Park Service, Interior.

ACTION: Notice; correction.

Notice is here given in accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), 25 U.S.C. 3003, Sec (5), of the completion of an inventory of human remains and associated funerary objects in the possession of the U.S. Department of the Interior, National Park Service, Western Archeological and Conservation Center, Tucson, AZ. The human remains and cultural items were removed from sites along the Transwestern Pipeline Project in Arizona and New Mexico.

This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA, 25 U.S.C. 3003 (d)(3). The determinations in this notice are the sole responsibility of the Chief, Museum Collections Repository, Western Archeological and Conservation Center.

This notice corrects the number of human remains and associated funerary objects reported in a notice of inventory completion published in the **Federal Register** on January 8, 2002. The error was identified by tribal representatives during consultation regarding repatriation of the Native American human remains and associated funerary objects identified in the published notice.

In the **Federal Register** of January 8, 2002, FR Doc. 02–384, page 914, the following corrections are made-

The fourth paragraph is corrected by substituting the following paragraph:

In 1959–1960, human remains representing 14 individuals were recovered from 4 sites during legally authorized excavations under the direction of National Park Service archeologist Wesley L. Bliss. The four sites were located along a linear transect through Cibola and McKinley Counties, NM, and Apache County, AZ, as part of the Transwestern Pipeline Project. No known individuals were identified.

The fifth paragraph is corrected by substituting the following paragraph:

Human remains representing two individuals were recovered from the TRW PPL L-WR–32 site. The four associated funerary objects are a Puerco black-on-white bowl, a bowl and one box of sherds of the White Mound black-on white ceramic type, and an Escavada black-on-white seed jar. Diagnostic artifacts found associated with the burials indicate that the human remains were buried during the Basketmaker III-Pueblo I phases (A.D. 500–950).

The seventh paragraph is corrected by substituting the following paragraph:

Human remains representing two individuals were recovered from the TRW PPL L-WR–43 site. The one associated funerary object is a Puerco black-on-red bowl. The diagnostic artifact found associated with the burials indicates that the human remains were buried during the Pueblo III phase (A.D. 1250–1300).

The tenth paragraph is corrected by substituting the following paragraph:

The manager of the Western Archeological and Conservation Center has determined that, pursuant to 25

U.S.C. 3001 (9–10), the human remains described above represent the physical remains of 14 individuals of Native American ancestry. The manager of the Western Archeological and Conservation Center also has determined that, pursuant to 25 U.S.C. 3001 (3)(A), the 11 objects described above are reasonably believed to have been placed with or near individual human remains at the time of death or later as part of a death rite or ceremony. Lastly, the manager of the Western Archeological and Conservation Center has determined that, pursuant to 25 U.S.C. 3001 (2) there is a relationship of shared group identity that can be reasonably traced between the Native American human remains and associated funerary objects and the Hopi Tribe of Arizona; Pueblo of Acoma, New Mexico; Pueblo of Santa Ana, New Mexico; Pueblo of Zia, New Mexico; and Zuni Tribe of the Zuni Reservation, New Mexico.

Representatives of any other Indian tribe that believes itself to be culturally affiliated with the human remains and associated funerary objects should contact Dr. Stephanie H. Rodeffer, Chief, Museum Collections Repository, Western Archeological and Conservation Center, 255 N. Commerce Park Loop, Tucson, AZ 85745, telephone (520) 670–6501, before September 18, 2006. Repatriation of the human remains and associated funerary objects to the Hopi Tribe of Arizona; Pueblo of Acoma, New Mexico; Pueblo of Santa Ana, New Mexico; Pueblo of Zia, New Mexico; and Zuni Tribe of the Zuni Reservation, New Mexico may proceed after that date if no additional claimants come forward.

The Western Archeological and Conservation Center is responsible for notifying the Ak Chin Indian Community of the Maricopa (Ak Chin) Indian Reservation, Arizona; Gila River Indian Community of the Gila River Indian Reservation, Arizona; Hopi Tribe of Arizona; Pueblo of Acoma, New Mexico; Pueblo of Santa Ana, New Mexico; Pueblo of Zia, New Mexico; Salt River Pima-Maricopa Indian Community of the Salt River Reservation, Arizona; Tohono O'odham Nation of Arizona; and Zuni Tribe of the Zuni Reservation, New Mexico that this notice has been published.

Dated: August 15, 2006.

Sherry Hutt,

Manager, National NAGPRA Program.

[FR Doc. E6–13684 Filed 8–17–06; 8:45 am]

BILLING CODE 4312–50–S

DEPARTMENT OF THE INTERIOR

National Park Service

Notice of Inventory Completion: Pacific Lutheran University, Tacoma, WA

AGENCY: National Park Service, Interior.

ACTION: Notice.

Notice is here given in accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), 25 U.S.C. 3003, of the completion of an inventory of human remains and associated funerary objects in the possession of Pacific Lutheran University, Tacoma, WA. The human remains and associated funerary objects were removed from Walworth County, SD.

This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA, 25 U.S.C. 3003 (d)(3). The determinations in this notice are the sole responsibility of the museum, institution, or Federal agency that has control of the Native American human remains and associated funerary objects. The National Park Service is not responsible for the determinations in this notice.

A detailed assessment of the human remains was made by Pacific Lutheran University professional staff in consultation with representatives of the Cheyenne River Sioux Tribe of the Cheyenne River Reservation and Three Affiliated Tribes of the Fort Berthold Reservation, North Dakota.

In 1932, human remains representing a minimum of two individuals were removed from a site near the mouth of Swan Creek, north of the town of LeBeau, Walworth County, SD, by Dr. W.H. Over, curator of the museum of South Dakota State University at Vermillion, SD. Subsequently, South Dakota State University transferred the human remains and associated funerary objects to a private collector, Jens Knudsen, a biology professor at the Pacific Lutheran University. Mrs. Knudsen, the widow of Mr. Knudsen, transferred the human remains and associated funerary objects to Pacific Lutheran University. No known individuals were identified. The 56 associated funerary objects are 1 string of small beads, 3 sets of glass beads on sinew from a garment, 2 glass beads attached to leather, 7 loose glass beads, 1 mirror fragment, 16 stone "bird" points, 10 stone "thumb nail" scrapers, 1 stone knife, 1 stone graver, 1 lot of cloth and leather fragments, 4 thong shapers, 1 lot of "needle bones," 6 pottery sherds, 1 piece of carbonized corn, and 1 lot of red pigment.

Documentation that accompanied the collection from South Dakota State University indicates that the human remains and associated funerary objects were recovered from a site occupied by the "Ree" or Arikara Indians. The descendants of the Arikara are members of the Three Affiliated Tribes of the Fort Berthold Reservation, North Dakota.

Officials of Pacific Lutheran University have determined that, pursuant to 25 U.S.C. 3001 (9–10), the human remains described above represent the physical remains of two individuals of Native American ancestry. Officials of Pacific Lutheran University also have determined that, pursuant to 25 U.S.C. 3001 (3)(A), the 56 objects described above are reasonably believed to have been placed with or near individual human remains at the time of death or later as part of the death rite or ceremony. Lastly, officials of Pacific Lutheran University have determined that, pursuant to 25 U.S.C. 3001 (2), there is a relationship of shared group identity that can be reasonably traced between the Native American human remains and associated funerary objects and the Three Affiliated Tribes of the Fort Berthold Reservation, North Dakota.

Representatives of any other Indian tribe that believes itself to be culturally affiliated with the human remains should contact David R. Huelsbeck, Anthropology Department, Pacific Lutheran University, Tacoma, WA 98447, telephone (253) 535–7196, before September 18, 2006. Repatriation of the human remains and associated funerary objects to the Three Affiliated Tribes of the Fort Berthold Reservation, North Dakota may proceed after that date if no additional claimants come forward.

Pacific Lutheran University is responsible for notifying the Assiniboine and Sioux Tribes of the Fort Peck Indian Reservation, Montana; Cheyenne River Sioux Tribe of the Cheyenne River Reservation, South Dakota; Crow Creek Sioux Tribe of the Crow Creek Reservation, South Dakota; Lower Brule Sioux Tribe of the Lower Brule Reservation, South Dakota; Oglala Sioux Tribe of the Pine Ridge Reservation, South Dakota; Rosebud Sioux Tribe of the Rosebud Indian Reservation, South Dakota; Santee Sioux Nation, Nebraska; Standing Rock Sioux Tribe of North & South Dakota; and Three Affiliated Tribes of the Fort Berthold Reservation, North Dakota that this notice has been published.

Dated: July 7, 2006.

Sherry Hutt,

Manager, National NAGPRA Program.

[FR Doc. E6–13686 Filed 8–17–06; 8:45 am]

BILLING CODE 4312–50–S

DEPARTMENT OF THE INTERIOR

National Park Service

Notice of Intent to Repatriate a Cultural Item: Thomas Burke Memorial Washington State Museum, University of Washington, Seattle, WA

AGENCY: National Park Service, Interior.

ACTION: Notice.

Notice is here given in accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), 25 U.S.C. 3005, of the intent to repatriate a cultural item in the possession of the Thomas Burke Memorial Washington State Museum (Burke Museum), University of Washington, Seattle, WA, that meets the definition of "object of cultural patrimony" under 25 U.S.C. 3001.

This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA, 25 U.S.C. 3003 (d)(3). The determinations in this notice are the sole responsibility of the museum, institution, or Federal agency that has control of the cultural item. The National Park Service is not responsible for the determinations in this notice.

The cultural item is a large stone sculpture (Burke catalog #152), referred to by the Chilliwack community, which includes the Nooksack people, as the "Stone T'ixwelatsa." The sculpture has anthropomorphic and zoomorphic features carved and pecked into the stone. The head includes large eyes and an open mouth with exaggerated lips. The main body of the figure appears to be seated with flexed arms and legs. A ridge with six protruding grooves is present on the back of the figure, and a small circular depression is present on the top of the head. The figure weighs over 100 pounds.

According to Chilliwack and Nooksack oral history, T'ixwelatsa was a man turned into stone by the transformer Xa:ls. T'ixwelatsa was the first male ancestor of the Chilliwack community. The Chilliwack historically spoke a Nooksack related language. The Chilliwack share a common ancestry and cultural connection with the Nooksack. The sculpture is considered a transformation object that holds the spirit of T'ixwelatsa, and Xa:ls gave the transformed stone form to T'ixwelatsa's wife as the original caretaker. The stone T'ixwelatsa was placed in front of the longhouse and cared for by the descendants of T'ixwelatsa. At an unknown date, one of the subsequent caretakers married into the neighboring Sumas tribe and took the stone with her as part of her continuing caretaking responsibilities.

The cultural item is believed to have been removed from the Fraser Plains, near Sumas, Whatcom County, WA, in 1892. It was donated to the museum by the Young Naturalist Society (Burke Accn. # 190). At the time of removal from the Fraser Plains, the cultural item was considered inalienable by a single individual and was removed without the permission of the caretaker or Tixwelatsa's descendants.

The Nooksack Indian Tribe of Washington is considered a member of the broader Chilliwack community, which includes both American and Canadian Chilliwack communities. Ties between the Chilliwack communities were artificially divided by the creation of the United States and Canadian border in 1858. Despite this separation, the Nooksack continue to maintain a strong relationship with the Canadian Chilliwack community. The "Stone T'ixwelatsa" is culturally affiliated with the Nooksack Indian Tribe of Washington, as part of the Chilliwack community, based on religious, geographic, kinship, and oral history information presented by the tribe. Evidence submitted during consultation supports the central importance of this cultural item to the cultural identity of the Nooksack Indian Tribe of Washington and broader Chilliwack community. The cultural item is considered collective property of the Chilliwack community and serves as a significant part of the cultural model for education.

Officials of the Burke Museum have determined that, pursuant to 25 U.S.C. 3001 (3)(D), the cultural item described above has an ongoing historical, traditional, or cultural importance central to the Native American group or culture itself, rather than property owned by an individual. Officials of the Burke Museum also have determined that, pursuant to 25 U.S.C. 3001 (2), there is a relationship of shared group identity that can be reasonably traced between the object of cultural patrimony and the Nooksack Indian Tribe of Washington.

Representatives of any other Indian tribe that believes itself to be culturally affiliated with the object of cultural patrimony should contact Dr. Peter Lape, Burke Museum, Box 353010, Seattle, WA 98195, telephone (206) 685–2282, before September 18, 2006. Repatriation of the object of cultural patrimony to the Nooksack Indian Tribe of Washington may proceed after that date if no additional claimants come forward.

The Burke Museum is responsible for notifying the Nooksack Indian Tribe of Washington that this notice has been published.

Dated: July 24, 2006

Sherry Hutt,

Manager, National NAGPRA Program.

[FR Doc. E6–13690 Filed 8–17–06; 8:45 am]

BILLING CODE 4312–50–S

DEPARTMENT OF THE INTERIOR

National Park Service

Notice of Receipt of Application for Telecommunication Site

AGENCY: National Park Service, Glen Canyon National Recreation Area, Interior.

ACTION: Notice.

SUMMARY: (Authority: 47 U.S.C. 332 note (Telecommunications Act of 1996 section 704(c)); 16 U.S.C. 5; other applicable authorities and Director's Order 53) Glen Canyon National Recreation Area has received an application from Comment Four Corners, LLC, to install and operate a wireless (cellular) telephone system. The location of the proposed telecommunication site is at the Defiance House Lodge at Bullfrog, Utah.

DATES: Comments on this proposal can be mailed to the address shown below and must be received within 30 days of the publication of this notice in the **Federal Register**. Our practice is to make comments, including names, home addresses, home phone numbers, and email addresses of respondents, available for public review. Individual respondents may request that we withhold their names and/or home addresses, etc., but if you wish us to consider withholding this information you must state this prominently at the beginning of your comments. In addition, you must present a rationale for withholding this information. This rationale must demonstrate that disclosure would constitute a clearly unwarranted invasion of privacy. Unsupported assertions will not meet this burden. In the absence of exceptional, documentable circumstances, this information will be released. We will always make submissions from organizations or businesses, and from individuals identifying themselves as

representatives of or officials or organizations or businesses, available for public inspection in their entirety.

ADDRESSES: This documents is available for review at Glen Canyon NRA Headquarters, 691 Scenic View Drive, Page, AZ 86040, between the hours of 7 a.m. and 4 p.m.

FOR FURTHER INFORMATION CONTACT: Glen Canyon NRA, P.O. Box 1507, Page, AZ 86040, or by going to *http://planning.nps.gov.*

SUPPLEMENTARY INFORMATION: Currently, there is no cellular service in the Bullfrog Marina area, which receives over 200,000 visitors per year. The cellular antennas are to be installed on the exterior of the Defiance House Lodge. The Defiance House Lodge is a non-historic 48 room hotel in the Bullfrog developed area. The proposed site includes six 51 inch by 13 inch by 3 inch rectangular panel antennas mounted on the façcade of the Defiance House Lodge and a nearby ground mounted associated radio equipment shielded by a cedar privacy fence matching existing fencing. The antenna panels do not visibly protrude above the roofline of the lodge and are painted to match the lodge color scheme. Neither the antennas nor the associated equipment will have any adverse effects on the area's scenery or visual resources. The staff at Glen Canyon National Recreation Area has completed a review and analysis pursuant to the National Environmental Policy Act (NEPA), the National Historic Preservation Act, the Telecommunications Act of 1996, and National Park Service requirements, policy and regulations. The NEPA analysis has determined that there will not be any adverse effects on the park's natural or cultural resources resulting from this proposal; therefore, this project has been categorically excluded from further analysis under NEPA. Copies of the NEPA analysis will be available at Glen Canyon NRA, 691 Scenic View Drive, Page, AZ 86040, or can be requested by writing to Glen Canyon NRA, Attention Stan Burman, PO Box 1507, Page, AZ 86040, or by going to *http://parkplanning.nps.gov/*

Nancie E. Ames,

Deputy Superintendent.

[FR Doc. 06–7025 Filed 8–17–06; 8:45 am]

BILLING CODE 4312–EF–M

DEPARTMENT OF JUSTICE

Notice of Lodging of Consent Decree Under the Clean Air Act

Notice is hereby given that on August 11, 2006, a proposed decree in *United States* v. *A. Finkl & Sons Company,* Civil Action No. 06 C 4297, was lodged with the United States District Court for the Northern District of Illinois.

In this action the United States sought injunctive relief and civil penalties for violations of the New Source Performance Standards (NSPS) for Electric Arc Furnaces and Argon-Oxygen Decarburization Vessels at a steel forging plant owned and operated by A. Finkl & Sons Company (A. Finkl) at 2011 Southport Avenue in Chicago, Illinois. The consent decree will require A. Finkl to comply with all applicable requirements of the NSPS, including emission standards, operational and equipment standards, maintenance requirements, record-keeping and reporting requirements. A. Finkl will also submit to Illinois EPA an application for an amendment to its Title V permit to provide for compliance with the emission limitations and other requirements of the NSPS. Under the proposed consent decree, A. Finkl will pay a civil penalty of $75,000. In addition, A. Finkl will spend $620,000 to perform two supplemental environmental projects: (1) A. Finkl will install low NO_X burners on one of its gas fired furnaces at a cost of $545,000, resulting in an expected reduction of five tons per year in NO_X emissions; and (2) A. Finkl will spend $75,000 to retrofit 34 vehicles owned by the City of Chicago with diesel oxidation catalysts.

The Department of Justice will receive for a period of thirty (30) days from the date of this publication comments relating to the consent decree. Comments should be addressed to the Assistant Attorney General, Environmental and Natural Resources Division, P.O. Box 7611, U.S. Department of Justice, Washington, DC 20044–7611, and should refer to *United States* v. *A. Finkl & Sons Company,* Civil Action No. 06 C 4297, DOJ case Number 90–5–2–1–08203.

The consent decree may be examined at the Office of the United States Attorney, 219 S. Dearborn St., Chicago, Illinois, and at U.S. EPA Region 5, 77 W. Jackson Blvd., Chicago, Illinois. During the public comment period, the consent decree may also be examined on the following Department of Justice Web site: *http://www.usdoj.gov/enrd/Consent_Decrees.html.* A copy of the consent decree may also be obtained by mail from the Consent Decree Library, P.O. Box 7611, U.S. Department of Justice, Washington, DC 20044–7611, or by faxing or e-mailing a request to Tonia Fleetwood (*tonia.fleetwood@usdoj.gov*) fax no. (202) 514–0097, phone confirmation number (202) 514–1547. In requesting a copy from the Consent Decree Library, please enclose a check in the amount of $35.00, payable to the U.S. Treasury or, if by e-mail or fax, forward a check in that amount to the Consent Decree Library at the stated address.

William D. Brighton,

Assistant Chief, Environmental Enforcement Section, Environment and Natural Resources Division.

[FR Doc. 06–6993 Filed 8–17–06; 8:45 am]

BILLING CODE 4410–15–M

DEPARTMENT OF JUSTICE

Notice of Lodging of Two Consent Decrees Between the United States of America and Midland Refining Company, Inc., Clear Water Trucking Company, Inc., Rosann Harpster, and Lewis W. Williams Under the Comprehensive Environmental Response, Compensation, and Liability Act

Under 28 CFR 50.7, notice is hereby given that on July 10, 2006, two proposed Consent Decrees in the case of *United States* v. *Midland Refining Company, Inc., Clear Water Trucking Company, Inc., Rosann Harpster, and Lewis W. Williams, Jr.,* Civil Action No. 06–1200–JTM, has been lodged with the United States District Court for the District of Kansas.

The Complaint sought the recovery of costs incurred in connection with response actions taken by the United States Environmental Protection Agency at the 57th and North Broadway Superfund Site in Wichita, Kansas.

Under the terms of the first Consent Decree (the Midland Consent Decree), Midland Refining Company, Inc., Clear Water Trucking, Inc., and Rosann Harpster will make payments to the United States totaling $79,000. Under the terms of the second Consent Decree (the Williams Consent Decree), Lewis W. Williams, Jr. will make payments to the United States totaling $110,000.03, and will make additional payments of a percentage of the gross income derived from certain "Property" as defined in the Consent Decree. In exchange, the United States will provide a covenant not to sue and contribution protection to all of the Defendants.

The Department of Justice will receive for a period of thirty (30) days from the date of this publication comments

relating to the Consent Decrees. Comments should be addressed to the Assistant Attorney General, Environment and Natural Resources Division, P.O. Box 7611, U.S. Department of Justice, Washington, DC 20044–7611, and should refer to *United States* v. *Midland Refining Company, Inc., et al.*, Civil Action No. 06–1200–JTM (D. Kan.), D.J. Ref. 90–11–3–1737/1.

During the public comment period, the Consent Decrees may be examined on the following Department of Justice Web site: *http://www.usdoj.gov/enrd/open.html*. Copies of the Consent Decree may also be obtained by mail from the Consent Decree Library, P.O. Box 7611, U.S. Department of Justice, Washington, DC 20044–7611, or by faxing or e-mailing a request to Tonia Fleetwood (*tonia.fleetwood@usdoj.gov*), fax no. (202) 514–0097, phone confirmation number (202) 514–1547. In requesting a copy from the Consent Decree Library, please enclose a check in the amount of $6.75 for the Midland Consent Decree, in the amount of $8.50 for the Williams Consent Decree, or in the amount of $15.25 for both Consent Decrees (25 cents per page reproduction cost) payable to the United States Treasury.

Robert E. Maher, Jr.,

Assistant Section Chief, Environmental Enforcement Section, Environment and Natural Resources Division.

[FR Doc. 06–6992 Filed 8–17–06; 8:45 am]

BILLING CODE 4410–15–M

NUCLEAR REGULATORY COMMISSION

[Docket Nos. 50–498 and 50–499]

STP Nuclear Operating Company; Notice of Withdrawal of Application for Amendments to Facility Operating Licenses

The U.S. Nuclear Regulatory Commission (NRC/the Commission) has granted the request of STP Nuclear Operating Company (the licensee) to withdraw its August 2, 2004, application for the proposed amendments to Facility Operating License Nos. NPF–76 and NPF–80, for the South Texas Project (STP), Units 1 and 2, respectively, located in Matagorda County, Texas.

The purpose of the licensee's request for amendments was to allow implementation of a risk-informed process for determining the allowed outage times for STP's Technical Specifications.

The Commission had previously issued a Notice of Consideration of Issuance of Amendments published in the **Federal Register** on August 31, 2004 (69 FR 53112). However, by letter dated July 27, 2006, the NRC informed the licensee that the NRC would consider the proposed application for amendments to be withdrawn unless the licensee notified the NRC, by August 9, 2006, that our understanding was incorrect. Thus, the August 2, 2004, application for amendments is considered to be withdrawn by the licensee.

For further details with respect to this action, see the application for amendments dated August 2, 2004, and the NRC staff's letter dated July 27, 2006. Documents may be examined, and/or copied for a fee, at the NRC's Public Document Room (PDR), located at One White Flint North, Public File Area O1 F21, 11555 Rockville Pike (first floor), Rockville, Maryland. Publicly available records will be accessible electronically from the Agencywide Documents Access and Management Systems (ADAMS) Public Electronic Reading Room on the internet at the NRC Web site, *http://www.nrc.gov/reading-rm.html*. Persons who do not have access to ADAMS or who encounter problems in accessing the documents located in ADAMS should contact the NRC PDR Reference staff by telephone at 1–800–397–4209, or 301–415–4737, or by e-mail to *pdr@nrc.gov*.

Dated at Rockville, Maryland, this 10th day of August 2006.

For the Nuclear Regulatory Commission.

Mohan C. Thadani,

Senior Project Manager, Plant Licensing Branch IV, Division of Operating Reactor Licensing, Office of Nuclear Reactor Regulation.

[FR Doc. E6–13631 Filed 8–17–06; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

Regulatory Guide and Associated Review Plan; Withdrawal of Notice

AGENCY: Nuclear Regulatory Commission.

ACTION: Regulatory Guide and Associated Standard Review Plan Notice of Issuance and Availability: Withdrawal.

SUMMARY: The Nuclear Regulatory Commission (NRC) is withdrawing the notice of the issuance and availability of a Regulatory Guide for public comment (i.e., Regulatory Guide 1.200, Revision 1 and its associated Standard Review Plan). The NRC is taking this action because of the omission of information.

FOR FURTHER INFORMATION CONTACT: Mary Drouin, Office of Nuclear Regulatory Research, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001, telephone (301) 415–6675, e-mail *MXD@NRC.Gov*.

SUPPLEMENTARY INFORMATION: On August 10, 2006 (71 FN 45864), the NRC published a notice in the **Federal Register** stating that the Nuclear Regulatory Commission has issued for public comment a revision of a regulatory guide (and its associated Standard Review Plan), specifically Regulatory Guide 1.200, Revision 1, "An Approach for Determining the Technical Adequacy of Probabilistic Risk Assessment Results for Risk-Informed Activities," which provides guidance to licensees in determining the technical adequacy of a probabilistic risk analysis used in risk-informed, integrated decision-making process, and to endorse standards and industry guidance. Certain pertinent information was inadvertently omitted from the notice; therefore, the NRC is withdrawing the notice. The NRC will issue a corrected notice with a revised date for the review and comment period.

Dated at Rockville, MD, this 14th day of August 2006.

For the Nuclear Regulatory Commission.

Farouk Eltawila,

Director, Division of Risk Assessment and Special Projects, Office of Nuclear Regulatory Research.

[FR Doc. E6–13635 Filed 8–17–06; 8:45 am]

BILLING CODE 7590–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–54314; File No. SR–Amex–2006–27]

Self-Regulatory Organizations; American Stock Exchange LLC; Order Approving a Proposed Rule Change and Amendments No. 1 and 2 Thereto Relating to Interim Members

August 14, 2006.

I. Introduction

On March 23, 2006, the American Stock Exchange LLC ("Amex" or "Exchange") filed with the Securities and Exchange Commission ("Commission"), pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 ("Act")[1] and Rule 19b–4 thereunder,[2] a proposal to amend Amex Rule 353 to limit members and member organizations from allocating their seats

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

to interim members on the Floor of the Exchange for a maximum of fifteen aggregate days that may be used consecutively or non-consecutively for a one-year period beginning on the date of approval as an interim member ("approval date"). On June 15, 2006, Amex filed Amendment No. 1 to the proposed rule change and on June 27, 2006, Amex filed Amendment No. 2 to the proposed rule change. The proposed rule change, as amended, was published for comment in the **Federal Register** on July 13, 2006. The Commission received no comments regarding the proposal.[3] This order approves the proposed rule change, as amended.

II. Description of the Proposal

Currently, Amex Rule 353 permits unfettered temporary allocation of a membership to an interim member[4] on the Floor of the Exchange so long as the duration is no less than one day and no more than one year. The Exchange proposes to amend Amex Rule 353 to reduce the maximum number of days the member or member organization can allocate its membership to an interim member to fifteen days, which may be used by each interim member consecutively or non-consecutively for a one-year period beginning on the date of approval of such interim member by the Exchange. Upon approval of this proposed rule change by the Commission, (1) all interim members currently on seats will be able to use their fifteen day allocation for the duration of the year from the date on which they were approved for interim membership and (2) interim members that are subsequently approved will have a year beginning on their individual approval dates to use their fifteen day allocation.

If an interim member has exhausted the fifteen day period, even if this occurs prior to end of the one-year period, the member or member organization may regain interim membership status by designating another interim member, or redesignating the same interim member, to the seat by filing documents required by the Membership Services Department and paying the maintenance fee in accordance with Article VII, Section 1(g) of the Amex Constitution.[5]

In addition, the proposed rule change will (1) eliminate the $250 allocation fee in Article IV, Section 3(e) and Article VII, Section 1(g) of the Amex Constitution, which specify the fees associated with the Interim Member program, and all references thereto; (2) waive the $1,500 initiation fee associated with the transfer of a membership pursuant to a special transfer agreement[6] in Article IV, Section 1(f) and Article VII, Section 1(c) of the Amex Constitution for interim members who wish to lease a seat immediately following their allotted time as an interim member; (3) make clarifications in Amex Rule 353 and Article IV, Section 3(e) of the Amex Constitution that an interim member will become effective upon submission of the appropriate form to and approval by the Membership Services Department of the Exchange; and (4) make corresponding changes related to this proposed rule change to the Member Fee Schedule, which sets forth the fees that Amex charges its members.

III. Discussion

After careful consideration of the proposal, the Commission finds that the proposed rule change, as amended, is consistent with the requirements of the Act and the rules and regulations thereunder applicable to a national securities exchange[7] and, in particular, the requirements of Section 6 of the Act.[8] Specifically, the Commission finds that the proposed rule change is consistent with Section 6(b)(5) of the Act,[9] which requires, among other things, that the rules of a national securities exchange be designed to promote just and equitable principles of trade, to foster cooperation and coordination with persons engaged in regulating, clearing, settling, processing information with respect to, and facilitating transactions in securities, to remove impediments to and perfect the mechanism of a free and open market and a national market system and, in general, to protect investors and the public interest. Section 6(b)(5) of the Act[10] also requires that the rules of an exchange not be designed to permit unfair discrimination among customers, issuers, brokers, or dealers. In addition, the Commission believes that the proposal is consistent with Section 6(b)(4) of the Act,[11] in that the proposed rule change provides for the equitable allocation of reasonable dues, fees, and other charges among the Exchange's members and issuers and other persons using its facilities.

The Exchange believes that allowing unlimited allocation of temporary membership days to interim members lessens the value of memberships by essentially permitting individuals who do not own or lease seats to operate as members.[12] The Exchange believes that this circumvention of seat leasing and ownership increases the number of unleased seats and decreases the demand for a membership, thereby artificially lessening the value of the membership. However, the Exchange also believes that the Interim Member program has served a useful function on the Floor by providing members with protection in cases of illnesses or emergencies and coverage when vacation is taken. The Exchange believes that the proposed rule change adequately balances concerns over having adequate emergency coverage on the Floor and concerns over the devaluation of memberships. The Commission believes that is consistent with the Act for the Exchange to make the changes described above to limit the interim membership program to balance these concerns.

While some members may incur additional expense as a result of the proposed restrictions to the Interim Member program, the proposed rule change should also provide some economic relief to these members. For example, the elimination of the $250 allocation fee, which the Exchange charges each time an interim member is designated to a seat, should permit members to more effectively use the fifteen days for emergencies, illnesses, and vacations on a non-consecutive basis. Further, waiving the $1,500 initiation fee, which is charged whenever a member enters into a special transfer agreement, for those who wish to lease a seat immediately following their allotted time as an

[3] The comment period expired on August 3, 2006.

[4] An interim member is an individual, pre-qualified by the Exchange, who is designated by a member or member organization to temporarily use the membership for a specified period of time when the member is absent from the Trading Floor. Article IV, Section 3(e) of the Amex Constitution explicitly states that the designation of an interim member is "subject to and in accordance with such rules as may be adopted from time to time by the Board of Governors." Amex Rule 353 sets forth the specific requirements, rights, and limitations of interim members.

[5] The maintenance fee is a $1500 charge that is paid by a member or member organization annually to the Exchange in order to maintain interim member status. This proposal does not affect the amount of the maintenance fee.

[6] A special transfer agreement is an agreement between the owner of a regular or options principal membership and an individual who is authorized to use the membership for a specified period of time or until the occurrence of a specified event.

[7] In approving this proposed rule change, the Commission has considered the proposed rule's impact on efficiency, competition, and capital formation. 15 U.S.C. 78c(f).

[8] 15 U.S.C. 78f.

[9] 9 15 U.S.C. 78f(b)(5).

[10] *Id.*

[11] 15 U.S.C. 78f(b)(4).

[12] 12 The Exchange represents that if the proposed rule change had been implemented at the start of 2005, approximately half of the 21 interim members would have exhausted their fifteen aggregate days by the beginning of November.

interim member, will provide relief to members who encounter serious emergencies, as well as offer a financial incentive for interim members to enter into special transfer agreements.

IV. Conclusion

It is therefore ordered, pursuant to Section 19(b)(2) of the Act,[13] that the proposed rule change (SR–Amex–2006–27), as amended, is approved.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[14]

Nancy M. Morris,

Secretary.

[FR Doc. E6–13636 Filed 8–17–06; 8:45 am]

BILLING CODE 8010–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–54310; File No. SR–Amex–2006–71]

Self-Regulatory Organizations; American Stock Exchange LLC; Notice of Filing and Order Granting Accelerated Approval of Proposed Rule Change Relating to Floor Broker HandHeld Terminals

August 11, 2006.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 ("Act"),[1] and Rule 19b–4 thereunder,[2] notice is hereby given that on August 2, 2006, the American Stock Exchange LLC ("Amex" or "Exchange") filed with the Securities and Exchange Commission ("Commission") the proposed rule change as described in Items I and II below, which Items have been substantially prepared by the Exchange. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons and is approving the proposal on an accelerated basis.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange proposes to adopt Commentary .02 to Amex Rule 935—ANTE to clarify that floor brokers, when interacting with orders and quotes in the ANTE System, are required to use their handheld terminals.

The text of the proposed rule change is available on the Exchange's Web site at (*http://www.amex.com*), at the principal office of the Exchange, and at the Commission's Public Reference Room. The text of the proposed rule change is set forth below. Proposed new language is *italicized.*

Rule 935—ANTE. Allocation of Executed Contracts

(a)–(b) No Change.

Commentary

.01 No Change

.02 Floor brokers when interacting with orders and quotes in the ANTE system are required to use their handheld terminals.

* * * * *

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the Exchange included statements concerning the purpose of, and basis for, the proposed rule change. The text of these statements may be examined at the places specified in Item III below. The Exchange has prepared summaries, set forth in Sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and the Statutory Basis for, the Proposed Rule Change

1. Purpose

The Exchange proposes to add new Commentary .02 to Amex Rule 935—ANTE to clarify that Exchange floor brokers are required to use their handheld terminals when interacting with orders and quotes in accessing the Exchange's electronic options marketplace or "ANTE." The market depth at the Exchange in ANTE and the trading crowd may differ, due to the differences inherent in an automatic execution system and an auction market. With the recent approval and near-term implementation of a remote market maker program (*i.e.*, Remote Registered Options Traders ("RROTs") and Supplemental Registered Options Traders ("SROTs")),[3] as well as the "hybrid" market structure for options at the Exchange, a floor broker may receive different execution sizes based on whether the order is routed electronically or walked into the trading crowd. As a result, the Exchange believes that in order to maintain a fair and orderly market, a floor broker who desires to access the ANTE system should be required to use his or her handheld terminal.

In today's options marketplace, orders are increasingly routed to and executed on the Amex and the other options exchanges electronically. At the Exchange, the ANTE system provides for the automatic matching and execution of market and marketable limit orders within eligible size limit parameters (*i.e.*, the "auto-match size"). The auto-match size is the maximum order size that can be automatically matched with orders on the book or the disseminated quote. Orders for less than the auto-match size are automatically matched at the disseminated price up to the disseminated size. The ANTE system then allocates the executed contracts among the participants to the trade, pursuant to the algorithm set forth in Amex Rule 935--ANTE.

Floor brokers, in order to receive an ANTE allocation for transactions in ANTE, are required to use their handheld terminals so that the order trades against the ANTE Central Book. Floor brokers that execute orders in the trading crowd are accordingly outside the ANTE system. Therefore, the ANTE or electronic marketplace and the trading crowd may have different depth of market at any particular point in time. The Exchange believes that this is the nature of the "hybrid" market model that currently exists. As a result, a floor broker who desires to access the depth of market available in ANTE by interacting with orders and quotes, must submit his or her order through the handheld terminal. Working an order in the trading crowd does not access the depth of market that may exist in the ANTE system. In addition, the introduction of RROTs and SROTs further necessitates direct floor broker access to the ANTE market, since the specialist is unable to match a trade in the trading crowd with an RROT or SROT quote. Therefore, the Exchange proposes to adopt Commentary .02 to Amex Rule 935—ANTE to clarify that a floor broker accessing the electronic marketplace available through ANTE by interacting with orders and quotes must submit such order(s) via his or her handheld terminal.

2. Statutory Basis

The Exchange believes that the proposed rule change is consistent with Section 6(b) of the Act,[4] in general, and furthers the objectives of Section 6(b)(5) of the Act,[5] in particular, in that it is designed to prevent fraudulent and manipulative acts and practices, to

[13] 15 U.S.C. 78s(b)(2).

[14] 17 CFR 200.30–3(a)(12).

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] *See* Securities Exchange Act Release Nos. 53652 (April 13, 2006), 71 FR 20422 (April 20, 2006) and 53635 (April 12, 2006), 71 FR 20144 (April 19, 2006).

[4] 15 U.S.C. 78f(b).

[5] 15 U.S.C. 78f(b)(5).

promote just and equitable principles of trade, to remove impediments to and perfect the mechanisms of a free and open market and a national market system, and, in general, to protect investors and the public interest.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchanges believes that the proposed rule change does not impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants or Others

No written comments were solicited or received with respect to the proposed rule change.

III. Solicitation of Comments

Interested persons are invited to submit written data, views and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an e-mail to *rule-comments@sec.gov*. Please include File Number SR–Amex–2006–71 on the subject line.

Paper Comments

- Send paper comments in triplicate to Nancy M. Morris, Secretary, Securities and Exchange Commission, Station Place, 100 F Street, NE., Washington, DC 20549–1090.

All submissions should refer to File Number SR–Amex–2006–71. This file number should be included on the subject line if e-mail is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying in the Commission's Public Reference Room. Copies of such filing also will be available for inspection and copying at the principal office of the Amex. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–Amex–2006–71 and should be submitted on or before September 8, 2006.

IV. Commission's Findings and Order Granting Accelerated Approval of Proposed Rule Change

The Commission finds that the proposed rule change is consistent with the requirements of the Act and the rules and regulations thereunder applicable to a national securities exchange.[6] In particular, the Commission finds that the proposed rule change is consistent with Section 6(b)(5) of the Act,[7] which requires that an exchange have rules designed, among other things, to promote just and equitable principles of trade, to remove impediments to and perfect the mechanisms of a free and open market and a national market system, and, in general, to protect investors and the public interest. The Commission believes that the proposal should help to promote just and equitable principles of trade and remove impediments to and perfect the mechanisms of a free and open market by clarifying current requirements for floor broker access to the liquidity on ANTE, the Exchange's electronic options marketplace.

The Commission finds good cause for approving this proposed rule change before the thirtieth day after the publication of notice thereof in the **Federal Register** pursuant to Section 19(b)(2) of the Act.[8] The proposal does not raise any new or novel regulatory issues and merely codifies a current requirement for floor broker access to ANTE.

V. Conclusion

It is therefore ordered, pursuant to Section 19(b)(2) of the Act,[9] that the proposed rule change (SR–Amex–2006–71) is hereby approved on an accelerated basis.

[6] In approving this rule change, the Commission notes that it has considered the proposed rule's impact on efficiency, competition, and capital formation. *See* 15 U.S.C. 78c(f).

[7] 15 U.S.C. 78f(b)(5).

[8] 15 U.S.C. 78s(b)(2).

[9] 15 U.S.C. 78s(b)(2).

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[10]

Nancy M. Morris,

Secretary.

[FR Doc. E6–13637 Filed 8–17–06; 8:45 am]

BILLING CODE 8010–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–54311; File No. SR–CBOE–2005–103]

Self-Regulatory Organizations; Chicago Board Options Exchange, Incorporated; Notice of Filing of Proposed Rule Change and Amendment No. 1 Thereto To Amend CBOE Rules Relating to the Electronic Designated Primary Market Maker Program

August 11, 2006.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 ("Act")[1] and Rule 19b–4 thereunder,[2] notice is hereby given that on December 5, 2005, the Chicago Board Options Exchange, Incorporated ("CBOE" or "Exchange") filed with the Securities and Exchange Commission ("Commission") the proposed rule change as described in Items I, II and III below, which Items have been prepared by CBOE. On August 11, 2006, the Exchange filed Amendment No. 1 to the proposed rule change. The Commission is publishing this notice to solicit comments on the proposed rule change, as amended, from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange proposes to amend CBOE rules relating to the Electronic Designated Primary Market Maker ("e-DPM") Program. The text of the proposed rule change is set forth below. Proposed additions are in italics, and proposed deletions are in brackets.

* * * * *

Rule 8.92. Electronic DPM Program

(a)–(b) No change.

(c) Allocation of Option Classes. The Board of Directors or a committee designated by the Board of Directors shall grant e-DPMs allocations in option classes. Factors to be considered in granting allocations include performance, capacity, performance commitments, efficiency, competitiveness, and operational

[10] 17 CFR 200.30–3(a)(12).

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

factors. In addition, the following shall apply:

(i)–(iv) No change.

(v) An e-DPM may not be allocated an option class for which the e-DPM organization serves as DPM on the trading floor, [.]

(vi) The Exchange may remove any option class from the e-DPM Program at any time if certain factors no longer warrant its inclusion in the program. Factors to be considered in removing an option class include any of the following: Market share, number of exchanges trading the product, average daily trading volume, and liquidity in the product. The Exchange shall give prior notice of any removal of an option class to the e-DPMs trading in that option class.

(d)–(e) No change.

* * * * *

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, CBOE included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. CBOE has prepared summaries, set forth in Sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and the Statutory Basis for, the Proposed Rule Change

1. Purpose

CBOE's e-DPM Program was created, generally, to enhance the liquidity base of the CBOE Hybrid Trading System and to increase the Exchange's market share in overall options trading by allowing member organizations, e-DPMs, to operate remotely as competing DPMs in the same option classes.[3] The Exchange, through its designees, determines which option classes to include in the e-DPM Program and, accordingly, which classes to allocate to each respective e-DPM.[4]

This rule change proposes to clarify that the Exchange should also have the authority to remove any e-DPM option class from the e-DPM Program if certain factors no longer warrant the continued inclusion of that option class in the e-DPM Program. The factors used in making such a determination would relate to the option class itself and will include any of the following: (i) Market share, (ii) number of exchanges trading the product, (iii) average daily trading volume, and (iv) liquidity in the product. The Exchange will consider any one or all of these factors in determining whether to remove an option class from the e-DPM Program. Such factors will be considered by the Exchange in removing any option class(es) from the e-DPM Program, including those option classes that are the top classes trading on the Exchange and those option classes that are the bottom classes trading on the Exchange.[5] The ability to remove and limit the number of e-DPM option classes is necessary to further the competitive goals of the e-DPM Program.

The purpose of the e-DPM Program is to create, among other things, greater market share, volume and liquidity. For certain option classes that have been in the e-DPM Program, there may no longer be a need to have such option classes in the program since at the present time, those classes have consistently maintained a level of greater market share, higher volume and/or greater liquidity. In reviewing these factors, the Exchange may determine that such class(es) no longer need to be in the e-DPM Program and can therefore be removed from the e-DPM Program, since that class meets the levels that the Exchange deems appropriate. In addition, the Exchange may wish to remove an option class from the e-DPM Program for the opposite reason. Certain option classes that are in the e-DPM Program may not have increased in market share, volume and/or liquidity, or may have even gone down in total market share, volume and/or liquidity. Since being in the e-DPM Program did not increase these factors, the Exchange may wish to remove such option class(es) from the program since they have not benefited from being in the program. Prior to removing any option class from the e-DPM Program, the Exchange would notify the e-DPMs trading in that option class that such class is being removed from the program. Persons aggrieved by the removal of an option class from the e-DPM Program may appeal such decision to the Exchange's Appeals Committee pursuant to Chapter XIX of the rules of the Exchange.

By being able to review these proposed factors for all option classes in the e-DPM Program and in making a determination on whether an option class(es) should be included in the e-DPM Program, the Exchange believes it will have the flexibility to ultimately enhance the overall market share and volume of all option classes trading on the Exchange.

2. Statutory Basis

The Exchange believes that the proposal is consistent with Section 6(b) of the Act,[6] in general, and Sections 6(b)(5) and 6(b)(7) of the Act,[7] in particular, in that it is designed to promote just and equitable principles of trade and to remove impediments to and perfect the mechanism of a free and open market and a national market system, and provides a fair procedure for the limitation by the Exchange of any person with respect to access to services offered by the Exchange.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change will impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants or Others

The Exchange did not solicit or receive any written comments with respect to the proposed rule change.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Within 35 days of the date of publication of this notice in the **Federal Register** or within such longer period (i) as the Commission may designate up to 90 days of such date if it finds such longer period to be appropriate and publishes its reasons for so finding or (ii) as to which the self-regulatory organization consents, the Commission will:

A. By order approve the proposed rule change, or

B. institute proceedings to determine whether the proposed rule change should be disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

[3] *See* CBOE Rules 8.92 through 8.94 and Securities Exchange Act Release No. 50003 (July 12, 2004), 69 FR 43028 (July 19, 2004) (Order approving SR–CBOE–2004–24). e-DPMs operate remotely as specialists by entering bids and offers electronically from locations other than the trading floor.

[4] *Id.*

[5] Based on the National Average Daily Volume.

[6] 15 U.S.C. 78f(b).

[7] 15 U.S.C. 78f(b)(5) and 78f(b)(7).

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an e-mail to *rule-comments@sec.gov*. Please include File Number SR–CBOE–2005–103 on the subject line.

Paper Comments

- Send paper comments in triplicate to Nancy M. Morris, Secretary, Securities and Exchange Commission, Station Place, 100 F Street NE., Washington, DC 20549–1090.

All submissions should refer to File Number SR–CBOE–2005–103. This file number should be included on the subject line if e-mail is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying in the Commission's Public Reference Room. Copies of such filing also will be available for inspection and copying at the principal office of the Exchange. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–CBOE–2005–103 and should be submitted on or before September 8, 2006.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[8]

Nancy M. Morris,

Secretary.

[FR Doc. E6–13643 Filed 8–17–06; 8:45 am]

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[8] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–54301; File No. SR–CHX–2006–05]

Self-Regulatory Organizations; Chicago Stock Exchange, Inc,; Notice of Filing of a Proposed Rule Change and Amendment No. 1 Thereto to Implement a New Trading Model

August 10, 2006.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 ("Act"),[1] and Rule 19b–4 thereunder,[2] notice is hereby given that on February 2, 2006, the Chicago Stock Exchange, Inc. ("CHX" or "Exchange") filed with the Securities and Exchange Commission ("Commission") the proposed rule change as described in Items I, II, and III below, which Items have been prepared by the CHX. On August 10, 2006, the Exchange filed Amendment No. 1 to the proposed rule change.[3] The Commission is publishing this notice to solicit comments on the proposed rule change, as amended, from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The CHX proposes to amend its rules to implement a new trading model that provides the opportunity for entirely automated executions to occur within a central matching system accessible by all Exchange participants. The new model also would end the Exchange's operation of a physical trading floor and is intended to comply with the requirements of Regulation NMS ("Reg. NMS").[4] The text of this proposed rule change is available on the Exchange's Web site at *http://www.chx.com/rules/proposed_rules.htm*, in the Commission's Public Reference Room, and on the Commission's Web site at *http://www.sec.gov*.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the CHX included statements concerning the purpose of, and basis for, the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. The CHX has prepared summaries, set forth in Sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

Through this proposed rule change, the Exchange seeks to implement a new trading model that allows its participants to interact in a fully-automated matching system. In this model, the Exchange would no longer operate a physical trading floor where on-floor specialists, brokers and market makers seek execution of their orders. Instead, the Exchange would operate an automated system where its participants—from any location—could submit orders for immediate execution. The Exchange believes that this new model provides an opportunity for its participants and their customers to receive efficient, low-cost executions, while giving the Exchange enhanced capabilities for surveilling its participants' trading activities.

In this new model, the Exchange anticipates that most of its participants would continue to be "off-Exchange" order-sending firms that would simply send orders to the Matching System for execution. These firms would not be required to register with the Exchange to act in any specific capacity other than as trading participants.[5] The Exchange would, however, allow participant firms to register in two special categories—to operate as proprietary market makers on the Exchange or to act as institutional brokers. Market makers could choose to post two-sided quotations and trade for their proprietary accounts. Any customer order would be accepted off the Exchange and a market maker could then choose whether or not to enter the order in the Exchange's Matching System or submit the order to a different venue. In contrast, any customer orders accepted by institutional brokers would be deemed to be on the Exchange when accepted. These market makers and institutional brokers would operate on the Exchange, even if they are not physically located on a single trading floor.

Because the Exchange is taking this opportunity to modernize many of its long-standing procedures and rules, the implementation of the new trading model will result in changes to virtually

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] Amendment No. 1 replaces and supersedes the original filing in its entirety.

[4] 17 CFR 242.600, *et seq.*

[5] Since its demutualization in February 2005, the Exchange has not had "members." Instead, a broker-dealer that seeks to effect transactions directly on the Exchange must become an Exchange "participant."

every section of the Exchange's rule book. The most significant changes can be found in new CHX Article 20 of the Exchange's rules, which describes the operation of the Exchange's central matching system. CHX Article 16 details the new role of market makers on the Exchange, and CHX Article 17 describes the role and responsibilities of the Exchange's institutional brokers. Changes to other sections of the rules are designed to eliminate obsolete provisions—including those that relate to the operation of a physical trading floor—and to update other responsibilities to reflect the more automated trading that is the hallmark of the Exchange's new model. The Exchange has also made an effort to better organize the rules. After describing the provisions of new CHX Articles 20, 16 and 17, this submission will review each of the other sets of proposed rule changes beginning with CHX Article 1.[6]

a. The Matching System

The Exchange's Matching System would be the core facility of the Exchange. It would provide the only means for the display of orders and a central point for the execution of orders. On one hand, the Matching System is simply an extension of the operation of the Exchange's electronic book to all securities traded on the Exchange.[7] On the other hand, this Matching System would provide a much more robust platform for the interaction of orders than is possible on the Exchange today.

1. *Trading hours.* The Matching System would operate a regular trading session and a late trading session each day.[8] The regular trading session ordinarily would begin immediately after the primary market for a security opens its market and would end at 3 p.m. each day for all securities except specified exchange-traded funds, which would trade until 3:15 p.m.[9] The second trading session—the late trading session—would begin immediately after the close of the first session and would end at 3:30 p.m.[10] Two senior officers of the Exchange could decide to open the Exchange for trading if the primary market announces that it will not open or will open later than usual, or if the primary market has not opened within 15 minutes after its normal operating time.[11] Special rules apply to the trading hours for securities listed exclusively on the Exchange.[12]

2. *Access to the Matching System.* Exchange participants could route orders to the Matching System through any communications line approved by the Exchange.[13] To the extent that the Exchange participates in the Intermarket Trading System ("ITS") Plan or any other linkage plan, ITS commitments and other intermarket orders could be sent to the Matching System through those linkages.[14]

3. *Eligible orders—basic requirements.* The Exchange's Matching System would only accept day orders; orders designated good-till-canceled would not be accepted.[15] Similarly, except for immediate-or-cancel market orders or specially-designated cross orders, the Matching System would only accept limit orders and orders for regular-way settlement.[16] Orders could be submitted as round lots, odd lots or mixed lots, except that orders in securities that only trade in specific share size increments must be submitted only in those share sizes.[17]

Except for any types of cross and cross with size orders (described later in this filing), the Matching System would only accept orders that comply with the sub-penny requirements of Reg. NMS set out in Rule 612 [18] and that do not exceed any size and/or price limitations imposed by the Exchange to help eliminate erroneous transactions or orders and transactions that cannot be processed by the Exchange's systems.[19] Because cross and cross with size orders essentially are sub-penny executions (rather than orders), these transactions could be submitted to the Matching System in sub-penny increments down to $0.000001.[20] Importantly, however, the Matching System would not allow any type of cross or cross with size order (except a midpoint cross, a cross that executes at the midpoint of the NBBO or a cross with size) (i) Priced at or above $1.00, to execute at a price less than $.01 better than any order on the same side of the Matching System, or (ii) priced under $1.00, to execute at a price less than $.0001 better than any order on the same side of the Matching System.[21]

4. *Order types and conditions.* The Matching System would accept a wide variety of order types and conditions, which are set out in CHX Article 20, Rule 4(b). Some of the more routine order types would include immediate or cancel ("IOC") limit and market orders, fill or kill ("FOK") orders, sell short and short exempt orders, reserve size orders, time in force orders and cancel on halt orders.[22] As required by Reg. NMS, IOC

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[6] Throughout its rule book, the Exchange is replacing the Roman numerals currently used to identify each of its articles with an easier-to-understand Arabic number.

[7] *See* Securities Exchange Act Release No. 52094 (July 21, 2005), 70 FR 43913 (July 29, 2005) (approving the electronic book for the trading of securities not assigned to a specialist firm).

[8] *See* CHX Article 20, Rule 1(b).

[9] All times referenced in this filing are expressed in Central Time.

[10] These sessions are similar to the trading sessions that occur on the Exchange today, except that the late trading session in the new model (unlike the extended session under the current rules, in which the MAX system is not operational) would be a fully automated trading session. *See* CHX Article IX, Rule 10(b).

[11] *See* CHX Article 20, Rule 1, Interpretation and Policy .03. If these officers decide to open one or more NYSE-listed, Amex-listed or other listed securities (other than Nasdaq-listed securities) when the primary market for these securities is not trading, the Matching System will cancel all pending opening cross orders in affected securities and, at the opening time selected by these officers, will then accept all other orders and match them as provided by the Matching System rules. If these officers decide to open one or more Nasdaq-listed securities when the primary market for these securities is not trading, the Matching System will: (a) If the decision is made before 8:30 a.m., execute all opening cross orders in affected securities as if the primary market had opened and then accept all other orders and match them as provided by the Matching System rules; or (b) if the decision is made on or after 8:30 a.m., cancel all pending opening cross orders in affected securities and, at the opening time selected by the Exchange officers, then accept all other orders and match them as provided by the Matching System rules.

[12] *See* CHX Article 20, Rule 1, Interpretation and Policy .04 (confirming that the regular trading session for these securities would begin at 8:30 a.m. and end at 3:00 p.m.).

[13] *See* CHX Article 20, Rule 8(a)(1).

[14] *See* CHX Article 20, Rule 8(a)(2). So long as it is required by the OTC/UTP Plan, the Exchange would also provide telephonic access to NASD market makers. *See* CHX Article 20, Rule 8(a)(3).

[15] *See* CHX Article 20, Rule 4(a)(2).

[16] *See* CHX Article 20, Rules 4(a)(1), 4(a)(3) and 4(a)(7). A special type of order—a non-regular way cross order—could be submitted for execution and non-regular way settlement. *See* CHX Article 20, Rule 4(b)(15).

[17] *See* CHX Article 20, Rule 4(a)(4).

[18] 17 CFR 242.612.

[19] *See* CHX Article 20, Rule 4(a)(6). The Exchange intends to develop a set of parameters that would be used to identify orders that either appear to be erroneous (based on their relationship to current market conditions) or that exceed the Exchange's systems capabilities (such as orders priced higher than a very high dollar level or those for a very large number of shares). These orders would be rejected to permit the continued effective operation of the Matching System.

[20] *See* CHX Article 20, Rule 4(a)(7)(b), confirming that cross and cross with size orders can be submitted in sub-penny increments, whether the orders are priced less than or at or above $1.00. The Exchange represents that it understands that it will need to obtain exemptive relief from the requirements of Reg. NMS to permit these executions to occur and will work with Commission staff to obtain that relief.

[21] *See* CHX Article 20, Rule 4(a)(7)(b). The Exchange represents that it has imposed this requirement based on input from Commission staff that it is required for any market operated by a national securities exchange.

[22] *See* CHX Article 20, Rule 4(b)(12) (IOC orders); Rule 4(b)(13) (IOC market orders); Rule 4(b)(11) (FOK orders); Rule 4(b)(20) (sell short orders); Rule 4(b)(21) (short exempt orders); Rule 4(b)(19)

Continued

orders would be executed against any orders at or better than the Exchange's best bid or offer ("BBO"), including any reserve size or other undisplayed orders at or better than that price.[23] Reserve size orders would permit a participant to identify a portion of an order to be displayed and a portion that should remain undisplayed, and to provide an instruction that the displayed portion should be refreshed to the original display quantity whenever the displayed share size falls below a specific threshold.[24] Time in force orders would be eligible for execution within a specified time period, with any unexecuted balance to be immediately cancelled when this period expires.[25] Cancel on halt orders would be automatically cancelled by the Matching System if a trading halt or suspension is declared on the Exchange in that security.[26]

The Matching System also would accept several different types of cross transactions, including a basic cross, a cross with size, a cross with satisfy, a cross with yield, a midpoint cross, an opening cross and a non-regular way cross. A basic cross transaction would be an order to buy and sell the same security at a specific price that is better than the Exchange's displayed BBO and, where required by the ITS Plan, another linkage plan or Reg. NMS, equal to or better than the NBBO.[27] A cross with size would be a cross for at least 5,000 shares and for a value of $100,000 that is at a price equal to or better than the Exchange's displayed BBO (and, where required by the ITS Plan, another linkage plan, or Reg. NMS, equal to or better than the NBBO), where the size of the cross transaction is larger than the largest order displayed on the Exchange at that price.[28] A cross with satisfy is designed to provide a participant with an efficient mechanism for clearing out displayed orders in the Matching System that would otherwise have time priority (or displayed bids or offers in other market centers that would otherwise have price priority) and then effecting a cross transaction at that price.[29] A cross with yield is a similar order type, which would automatically yield interest on the buy, sell or either side of the order to any order already displayed in the Matching System at the same or better price.[30] And, finally, as their names suggest, an opening cross is a cross transaction that would be specifically designated to be executed at the opening price; a non-regular way cross would be designated for non-regular way settlement; and a midpoint cross would execute at the midpoint between the NBBO.[31]

The Matching System also would accept several order types that are specifically contemplated by Reg. NMS.[32] For example, the Matching System would accept benchmark orders which meet the requirements of Rule 611(b)(7) of Reg. NMS. Initially, the Exchange would limit submission of benchmark orders to the Exchange's institutional brokers.[33] The Matching

(reserve size orders); Rule 4(b)(22) (time in force orders); and Rule 4(b)(3) (cancel on halt orders).

[23] *See* CHX Article 20, Rules 4(b)(12) (IOC orders) and 4(b)(13) (IOC market orders).

[24] *See* CHX Article 20, Rule 4(b)(19).

[25] *See* CHX Article 20, Rule 4(b)(22). The Matching System initially would permit participants to identify any time period of a minute or a multiple of a minute as the "time in force" for a particular order. In later upgrades to the Matching System, participants would be allowed to identify an order's "time in force" in seconds.

[26] *See* CHX Article 20, Rule 4(b)(3).

[27] *See* CHX Article 20, Rule 4(b)(4). A cross may represent interest of one or more Exchange participants, trading for a proprietary account. This order or transaction type is already permitted in the Exchange's electronic book. *See* CHX Article XXA, Rule 2.

[28] *See* CHX Article 20, Rule 4(b)(6). A cross with size is already permitted in the Exchange's electronic book and is similar to the type of transaction that can take place on the Exchange's trading floor. *See* CHX Article XXA, Rule 2; CHX Article XX, Rule 23. The proposed definition of a cross with size transaction would reduce the required number of shares in the order to 5,000 shares from 25,000 shares, mirroring similar requirements in the floor trading rules of other markets. *See* Boston Stock Exchange Rules, Chapter II, Section 18; Philadelphia Stock Exchange Rule 126(h). At the same time, the definition would be changed to also require that a cross must have a value of $100,000. The Exchange represents that it has imposed this requirement based on input from Commission staff that it is required for any market operated by a national securities exchange and based on an assurance from Commission staff that all national securities exchanges would be required to impose a similar requirement. The proposed definition of a cross with size transaction also would confirm that this order could represent interest of one or more participants of the Exchange.

[29] *See* CHX Article 20, Rule 4(b)(5). With this order type, a participant would send: (A) An instruction to execute a cross transaction at a specific price; and (B) an instruction (i) To execute orders already displayed in the Matching System at their limit prices (up to a specified number of shares) against a specified party to the extent necessary to allow the cross transaction to occur and/or (ii) to route outbound orders or commitments to other market centers to the extent necessary to prevent an improper trade-through. If a cross with satisfy is sent with a share size that is too small to satisfy orders in the Matching System or bids or offers in other markets, as applicable, the order would be automatically cancelled. Once the satisfying execution has occurred (or, for orders or commitments sent to other market centers, those orders or commitments have been sent), the cross would be executed at a price that is better than the best bid or offer to be displayed in the Matching System and, for securities listed on NYSE, Amex and any exchange other than Nasdaq (and for Nasdaq-listed securities, when Reg. NMS is implemented in those issues), equal to or better than the NBBO.

A cross with satisfy may represent interest of one or more participants of the Exchange but, to the extent that it represents interest of the participant sending the order to the Matching System, the participant would not be eligible to satisfy existing bids or offers in the Matching System at a price that is better than the cross price and could only satisfy bids or offers in other markets at a price that is better than the cross price if the cross is for at least 10,000 shares or has a value of at least $200,000 (a "block size order") or is for the account of an institutional customer (as that term is defined in CHX Article 8, Rule 11, Interpretation and Policy .03) and the participant's customer has specifically agreed to that outcome.

[30] *See* CHX Article 20, Rule 4(b)(7). This order would have: (A) An instruction to execute a cross transaction at a specific price; and (B) an instruction to yield interest on the buy, sell or either side of the order (as specified in the order) to any order already displayed in the Matching System at the same or better price, to the extent necessary to allow the cross transaction to occur. The cross would be executed at a price that is better than the best bid or offer to be displayed in the Matching System and, for securities listed on NYSE, Amex and any exchange other than Nasdaq (and for Nasdaq-listed securities, when Reg. NMS is implemented in those issues), equal to or better than the NBBO.

[31] *See* CHX Article 20, Rule 4(b)(16) (opening cross); Rule 4(b)(15) (non-regular way cross); and Rule 4(b)(14) (midpoint cross). As described later in this submission, opening cross orders would execute immediately after the primary market opens in a security, at the opening price. For securities listed on NYSE, Amex and any exchange other than Nasdaq, the opening price would be the primary market opening price. For Nasdaq-listed securities (except in the case of an initial IPO), the opening price would be the midpoint of the first unlocked, uncrossed market that occurs on or after 8:30 a.m. For Nasdaq-listed securities on the date of an IPO, the opening price would be the Nasdaq opening price. Opening cross orders would not be accepted in securities exclusively listed on the Exchange and would not be accepted if any part of the sell side of the order is marked as a sell short order. A midpoint cross would be executed at the midpoint of the NBBO, but if the NBBO is locked at the time a midpoint cross is received, the midpoint cross would execute at the locked NBBO. If the NBBO is crossed at the time a midpoint cross is received, the midpoint cross would be automatically cancelled.

A non-regular way settlement cross would execute without regard to the NBBO or any other orders the Matching System and could represent the interest of one or more participants in the Exchange. Any non-regular way cross that is for cash settlement must be received by the Matching System by 2 p.m. or such other time that may be established by the Exchange and communicated to participants from time to time. The Matching System would not accept one-sided orders for non-regular way settlement. The only way to effect a non-regular way transaction within the Matching System would be through a non-regular way cross. Exchange participants currently may execute orders for non-regular way settlement, both on the floor of the Exchange and in the Exchange's electronic book. *See* CHX Article XX, Rule 9; CHX Article XXA, Rule 2(c)(5).

[32] These order types—and other expressly-identified provisions—take effect with the implementation of Rule 611 of Reg. NMS. 17 CFR 242.611. The Exchange will use February 5, 2007 (the "Trading Phase Date") as the effective date for these provisions. *See* Securities Exchange Act Release No. 53829 (May 18, 2006), 71 FR 30038 (May 24, 2006) (setting new compliance dates for Rules 610 and 611).

[33] The Exchange initially has limited the use of this order type to its institutional brokers to ensure that the Exchange can determine whether or not the requirements of Rule 611(b)(7) Reg. NMS have been

System would also accept BBO intermarket sweep orders ("BBO ISOs"), which would execute against orders at the Exchange's BBO, without regard to whether the execution would trade through another market's protected quotation.[34] If a BBO ISO is marked as "immediate or cancel," any remaining balance in the order would be automatically cancelled. If a BBO ISO is not marked as "immediate or cancel," any remaining balance in the order would be placed in the Matching System and displayed, without regard to whether that display would lock or cross another market center.[35] Two other Reg. NMS-related orders—an outbound ISO and a price-penetrating ISO—would also be accepted by the Exchange's Matching System.[36]

Finally, the Matching System would accept do-not-display and do not route orders. A do not route order, as its name implies, would be executed or displayed within the Matching System and could not be routed to another market center.[37] A do-not-display order would be an order, for at least 1,000 shares when entered, that should not be displayed in whole or in part, but that would remain eligible for execution within the Matching System.[38]

5. *Ranking of orders in the Matching System.* As described in CHX Article 20, Rule 8, all orders received by the Matching System would be ranked by price, time of receipt and, for round-lot orders, any display instructions received with the orders. Specifically, orders received by the Matching System would be ranked as follows:

a. *Orders that are eligible for display, as well as mixed-lot and odd lot orders.* Limit orders that are eligible to be displayed, including the displayed portion of reserve size orders, and all odd-lot and mixed-lot orders would be ranked together, at each price point, in time priority.[39]

b. *Orders that are displayed in part, where a portion is not displayed.* At each price point, the undisplayed portions of reserve size orders would be ranked together in time priority and would be ranked after any displayed orders (and any odd-lot and mixed-lot orders) at that price.

c. *Completely undisplayed orders.* Orders that are received with a do-not-display instruction would be ranked together, at each price point, in time priority and would be ranked after any other orders at that price.

Changes to an order's size or price, or its displayed portion, could impact its ranking within the Matching System. For example, when the displayed portion of a reserve size order is refreshed with new volume, the displayed portion of the order would receive a new ranking based on the time at which it was refreshed.[40] Similarly, if a participant increases the number of shares in a fully-displayed order, that order would receive a new ranking based on the time at which these shares were added to the order.[41] Any change in the price of an order would result in a new price and time ranking for the order, based on the time of the price change.[42] Finally, any change to the display instruction associated with an order would result in a new ranking for the order based on the time that the new instruction was received.[43]

6. *Display of orders within the Matching System.* All orders that are eligible for display would be immediately and publicly displayed through the processes set out in the appropriate transaction reporting plan for each security when they constitute the best round-lot bid or offer in the Matching System for that security. In addition, the Matching System would aggregate all shares, including odd-lot orders and the odd-lot portions of mixed-lot orders, at a single price point, and then round that total share amount down to the nearest round-lot amount for display purposes.[44] The undisplayed portion of a reserve size order and any other orders received with a do-not-display instruction would not be eligible for display.

The Exchange believes that its disseminated quotations would constitute automated quotations under the definition set out in Rule 600(b)(3) of Reg. NMS.[45] The Exchange's proposed rules confirm that each order submitted to the Matching System must be a firm order and cannot be identified as a "manual" quotation.[46]

7. *Opening of the regular trading session.* Immediately after the primary market opens, the Matching System would execute all opening cross orders, then start accepting and matching orders as provided in CHX Article 20, Rule 8(d).[47] If the primary market in a

met. *See* CHX Article 20, Rule 4(b)(2). A benchmark order may execute at any price, without regard to the protected NBBO and may represent interest of one or more Exchange participants.

[34] *See* CHX Article 20, Rule 4(b)(1). These orders are executed based on the premise that the participant routing the order to the Matching System has already satisfied the protected quotations of other market centers. *See* CHX Article 20, Rule 6(c)(3).

[35] These orders are displayed based on the premise that the participant routing the order to the Matching System has already satisfied the quotations of other markets so that the display of the order would not lock or cross those markets.

[36] An outbound ISO would allow an Exchange participant to ask the Exchange to execute an order on the Exchange without regard to the protected quotations at other markets while simultaneously routing ISOs to those other markets to execute against their protected quotations. *See* CHX Article 20, Rule 4(b)(17). A price-penetrating ISO would operate much like a basic ISO, except that it would allow a participant to execute through displayed and undisplayed interest, at multiple price points, on the Exchange. *See* CHX Article 20, Rule 4(b)(18).

[37] As further described in the section relating to the prevention of trade-throughs, a do not route order would be immediately cancelled if its execution would improperly trade through the ITS BBO or another market's protected quotations. Any types of cross, IOC or FOK orders would deemed to have been received with a "do not route" condition because these orders either are immediately executed in the Matching System or cancelled. *See* CHX Article 20, Rule 4(b)(10).

[38] *See* CHX Article 20, Rule 4(b)(9). A do-not-display order could receive that designation because a customer specifically instructed a participant not to display the order or because a participant decided that its own order should not be displayed. As described later in this submission, a do-not-display order would be ranked, at any given price point, behind displayed orders (and any odd-lot and mixed-lot orders at the price) and behind the undisplayed portions of any reserve size orders. These completely undisplayed orders would both allow a participant to fulfill a customer's instructions and to otherwise keep trading interest hidden, but to remain within the Matching System where the orders could be executed against inbound orders seeking liquidity.

[39] For the most part, executions in the Matching System would occur on a "share-for-share" basis, regardless of whether the incoming or resting orders were round-lot, mixed-lot or odd-lot orders. The one exception to this share-for-share matching is in the handling of ITS commitments or linkage plan orders, which would only be matched in round-lot increments, for the full amount of round-lot shares available at the price reflected in the NBBO. *See* CHX Article 20, Rule 8(e)(9). Any remaining portion of the ITS commitment or linkage plan order would then be automatically cancelled.

[40] *See* CHX Article 20, Rule 8(b)(4). Any remaining undisplayed portion of the order would continue to be ranked at the price and time at which it was originally received.

[41] *See* CHX Article 20, Rule 8(b)(5). Any reduction in the number of shares in an order, however, would not change its ranking within the Matching System.

[42] *Id.*

[43] *Id.*

[44] This aggregation and rounding process would apply for display purposes only; all orders would retain their rankings for execution purposes as described in CHX Article 20, Rule 8(b)(1) through (5). However, as noted in CHX Article 20, Rule 8(g), the Matching System would report each round-lot transaction that occurs within the Matching System, including executions of resting odd-lot orders that have been aggregated into one or more round-lots for display purposes, to the appropriate consolidated reporting system.

[45] As required by Rule 600(b)(3) of Reg. NMS in its definition of "automated quotations," the Exchange's Matching System is designed to accept IOC orders; to immediately and automatically execute an IOC order against the displayed BBO, up to its full size; to immediately and automatically cancel any unexecuted portion of the IOC order without routing the order elsewhere; to immediately and automatically transmit a response to the order-sending participant indicating the action taken on the order; and to immediately and automatically update the BBO to reflect any change that occurred as a result of the execution.

[46] *See* CHX Article 20, Rule 3(a).

[47] *See* CHX Article 20, Rule 8(d).

security other than a Nasdaq-listed security opens with a quote, but has not reported a trade for 30 seconds following the dissemination of the initial quote, the Matching System would cancel all opening cross orders, and then start accepting and matching all other orders.[48]

8. *Automated matching of orders.* With certain exceptions specifically set out in CHX Article 20, Rule 8(e), and subject to the provisions relating to the prevention of trade throughs that are set out in CHX Article 20, Rule 5, incoming orders would be matched against one or more orders in the Matching System, in the order of their ranking, at the price of each resting order, for the full amount of shares available at that price or for the size of the incoming order, if smaller.[49] If an order could not be immediately matched or matched in full when received (and it is not designated as an order type that should be immediately cancelled), it or its residual portion would be placed in the Matching System and ranked as described above.[50]

The following order types would be subject to specific executions within the Matching System:

a. *Benchmark orders.* Benchmark orders, which are cross transactions submitted by institutional brokers that meet the requirements of Rule 611(b)(7) of Reg. NMS, would execute at any price, without regard to the NBBO and may represent the interest of one or more participants of the Exchange.[51]

b. *Cross and cross with size orders.* Cross and cross with size orders would be automatically executed if they meet the requirements set out in Rule 4(b)(4) and (6) respectively, but would be immediately and automatically cancelled if they do not meet these requirements.[52]

c. *Cross with satisfy orders.* In executing this order type, the Matching System first would determine whether the order contains a share size that is sufficient to satisfy orders in the Matching System or bids or offers in other markets, as applicable. If this requirement is not met, the cross with satisfy would be automatically cancelled.[53]

If the order meets this requirement, the Matching System then would satisfy existing orders in the Matching System or send orders or commitments to other market centers to satisfy bids or offers, as necessary to prevent a trade-through and, before updating the Exchange's quotes, would execute the cross at a price that is better than the best bid or offer to be displayed in the Matching System and, for securities listed on NYSE, Amex or any other exchange other than Nasdaq (and for Nasdaq-listed securities, when Reg. NMS is implemented in those issues), equal to or better than the NBBO. In doing so, the Matching System would determine whether the Participant that sent the order to the Matching System is attempting to satisfy bids or offers in the Matching System at a price that is better than the cross price and, if so, would not allow those executions to occur, but would instead allocate the better prices to the customer, not to the Participant sending the order to the Matching System.

d. *Cross with yield orders.* When the customer order that is part of a cross with yield order is eligible for an immediate execution because it is at a price better than the currently displayed best bid or offer in the Matching System, the cross with yield order would be automatically executed by matching the participant as principal against the customer order; provided, however, that if there is any order already displayed in the Matching System at the same price as (or better than) the participant's interest, that order or those orders would be matched against the customer order in place of the participant's interest as necessary to exhaust the customer order interest.[54] If the customer order that is part of a cross with yield order is not eligible for an immediate execution because it is not better than the currently displayed bid or offer in the Matching System, the cross with yield order would be immediately and automatically cancelled.

e. *Midpoint cross.* A midpoint cross order would be immediately executed at the midpoint between the NBBO. If the NBBO is locked at the time the order is received, the midpoint cross would be executed at the locked market price, unless the order could be executed in subpenny increments. If the NBBO is crossed at the time the order is received, the midpoint cross would be immediately and automatically cancelled.[55]

f. *Non-regular way cross orders.* These orders would be automatically executed without regard to either the NBBO or any orders for regular way settlement that might be in the Matching System.[56]

g. *Sell short orders.* Sell short orders (including odd lot orders) would be displayed and executed only when permissible under the provisions of Rule 10a–1 ("Short Sale Rule") and Regulation SHO.[57] When a sell short order cannot be executed or displayed at its limit price under the provisions of the Short Sale Rule and Regulation SHO, the order would be automatically repriced (without violating its limit price) to the next available price at which it can be executed or displayed.[58]

h. *Do not display orders.* A do-not-display order would be executed as provided in CHX Rule 8(d), but would be immediately and automatically cancelled if, at any point, the order would prevent the execution of an inbound order because the do-not-display order has crossed the NBBO.[59]

i. *Inbound ITS commitment or linkage plan order.* An inbound ITS commitment or linkage plan order, if it is priced at or better than the current Exchange-displayed BBO (or if it is marked "market"), would be automatically matched, in round-lot increments, against the order(s) at the price reflected in the BBO (or at a better undisplayed price), for the full amount of round-lot shares available at that price, and any remaining portion of the ITS commitment or linkage plan order would be automatically cancelled.[60] An inbound ITS commitment marked as a "block" trade would be automatically matched, in round-lot increments, at the price reflected in the ITS commitment, against the order(s) in the Matching System, in regular price-time priority.

j. *Trades in locked markets.* Trades would continue to be executed in the Matching System when the NBBO is

[48] *Id.* This provision would apply only to securities other than Nasdaq-listed securities. As noted above, Nasdaq-listed securities would open based on the first unlocked, uncrossed market that occurs on or after 8:30 a.m.

[49] *See* CHX Article 20, Rule 8(d)(1).

[50] *See* CHX Article 20, Rule 8(d)(2). Orders that would be immediately cancelled, if not executed, include FOK orders and IOC limit and market orders. *See* CHX Article 20, Rules 4(b)(11) through (13).

[51] *See* CHX Article 20, Rule 8(e)(1) and Rule 4(b)(2). A benchmark order is defined in Rule 611(b)(7) of Reg. NMS as an order that is executed at a price that was not based, directly or indirectly, on the quoted price of the security at the time of execution and for which the material terms were not reasonably determinable at the time the commitment to execute the order was made.

[52] *See* CHX Article 20, Rule 8(e)(1).

[53] *See* CHX Article 20, Rule 8(e)(4).

[54] *See* CHX Article 20, Rule 8(e)(2).

[55] *See* CHX Article 20, Rule 4(b)(14).

[56] *See* CHX Article 20, Rule 4(b)(15).

[57] Because there is no exemption from the requirements of the Short Sale Rule or Reg. SHO for odd lots executed within a system such as the Matching System, odd lot orders would be treated as all other orders in determining whether they could be executed under the Short Sale Rule and Reg. SHO.

[58] *See* CHX Article 20, Rule 8(e)(5).

[59] *See* CHX Article 20, Rule 8(e)(6).

[60] *See* CHX Article 20, Rule 8(e)(7). The Exchange believes that this handling of ITS commitments and linkage plan orders is consistent with the ITS Plan and the current draft of the linkage plan that might replace the ITS Plan.

crossed; provided however, that (i) If the ITS Plan requires that the Matching System route the inbound order to another market for execution, the Matching System would do so or, if the order is marked "do not route," the Matching System would automatically cancel the order; and (ii) once Reg. NMS is implemented in a security, the Matching System would only execute orders in that security up to (but not beyond) the first uncrossed NBBO.[61]

9. *Prevention of trade-throughs and other order routing.* The Exchange's Matching System would prevent the execution of all or a part of an inbound order for at least a round lot if the execution would cause an improper trade-through of another ITS market or if, when Reg. NMS is implemented for a security, the execution of all or a part of the order would be improper under Reg. NMS Rule 611.[62] Inbound odd lot orders and odd lot crosses would be eligible for execution on the Exchange, even if they would trade through other markets' bids and offers.

If a participant has submitted a cross with satisfy or an outbound ISO order and its execution would cause an improper trade through, the Matching System would execute the order and simultaneously route commitments or orders to other markets to satisfy their protected quotes. In these situations, the Exchange's systems would determine when, how and where these orders (or commitments) should be routed to satisfy protected quotes. The Exchange would route these orders (or commitments), at the participant's election, either through the Intermarket Trading System (or any later linkage that supersedes ITS) or through the connectivity provided by a routing services provider with whom the Exchange has negotiated an agreement.

The Exchange will provide these routing services pursuant to the terms of three separate agreements, to the extent that they are applicable to a specific routing decision: (1) An agreement between the Exchange and each Participant on whose behalf orders will be routed ("Participant-Exchange Agreement"); (2) an agreement between each Participant and a specified third-party broker-dealer that will use its routing connectivity to other markets and serve as a "give-up" in those markets ("Give-Up Agreement"); and (3) an agreement between the Exchange and the specified third-party broker-dealer ("Routing Connectivity Agreement") pursuant to which the third-party broker-dealer agrees to provide routing connectivity to other markets and serve as a "give-up" for the Exchange's Participants in other markets. The Exchange will provide these routing services in compliance with its rules and with the provisions of the Act and the rules thereunder, including, but not limited to, the requirements of Sections 6(b)(4) and (5) of the Act that the rules of a national securities exchange provide for the equitable allocation of reasonable dues, fees and other charges among its members and issuers and other persons using its facilities, and not be designed to permit unfair discrimination between customers, issuers, brokers or dealers. The Routing Connectivity Agreement will include terms and conditions that enable the Exchange to comply with these obligations.

In addition to these routing services, the Exchange is developing a functionality that would, in all other situations where the execution of an inbound round lot order, in whole or in part, would cause a trade-through, (a) Route the order to another venue, according to each participant's instructions, or (b) if the order is marked "do not route," automatically cancel the order.[63] The Exchange plans to supplement this filing, or file a new rule submission, with respect to this functionality, as soon as possible.

The Exchange has developed an initial series of trade-through policies and procedures that describe how the Exchange will implement the provisions of Rule 611 of Reg. NMS.[64] These procedures describe the Exchange's clock synchronization practices, as well as its plans for applying the exceptions to Rule 611 of Reg. NMS.[65] Among other things, these procedures confirm that the Exchange would apply the self-help exception (and disregard another market's quotations for trade-through purposes) when that market has publicly announced that it is not disseminating automated quotations (but has not identified those quotes as manual); or when the Exchange has a reasonable basis for believing that the other market is experiencing systems problems and that market (a) Has not responded, within 30 seconds, to an Exchange inquiry seeking information about possible systems problems, or (b) has not confirmed, within two minutes after an Exchange inquiry, that it is not having systems problems.[66] These procedures also confirm that the Exchange automatically would place an appropriate modifier on trades executed pursuant to an exemption from, or exception to, Rule 611 of Reg. NMS in accordance with specifications approved by the operating committee of the relevant national market system plan for an NMS stock.[67]

The Exchange's initial trade-through policies also describe its plans for confirming that its own bids and offers qualify as automated quotations. Specifically, the Exchange would periodically (no less often than once every five seconds and no more often than once every second) send a test IOC order to the Matching System to determine whether the Exchange's Matching System accepts the order and would use automated monitoring systems to further measure the Matching System's handling of test IOC orders within the Matching System.[68] These

[61] *See* CHX Article 20, Rule 5, Interpretation and Policy .01(e).

[62] *See* CHX Article 20, Rule 5. At least initially, however, the Exchange would not apply the "flickering quote" exception to Rule 611 of Reg. NMS (Reg. NMS Rule 611(b)(8)) when determining whether or not the execution of the order would create an improper trade-through.

[63] There would be one exception to the general rule that an inbound "do not route" order would be cancelled if its execution would constitute an improper trade-through. If an undisplayed order is resting in the Matching System and the execution of an inbound order (that is not an IOC or FOK order) against the undisplayed resting order would cause an improper trade-through, the resting order would be cancelled to the extent necessary to allow the inbound order to be executed or quoted.

[64] *See* CHX Article 20, Rule 5, Interpretation and Policy .01. The Exchange will further define its policies in more detail over the next month or so.

[65] The Exchange's systems will routinely, throughout the trading day, use processes that capture the time reflected on the atomic clock operated by the National Institute of Standards and Technology and will automatically make adjustments to the time recorded in the Exchange's Matching System to ensure that the period between the two times does not exceed 500 milliseconds.

[66] *See* CHX Article 20, Rule 5, Interpretation and Policy .01(d). The Exchange would notify the other market of its use of the self-help exception by using appropriate technology made available for intermarket communications from time to time. The Exchange then would continue to apply this self-help exception until the other market has provided reasonable assurance to the Exchange (or to the public) that the problems have been corrected.

[67] *See* CHX Article 20, Rule 5, Interpretation and Policy .01(h). In addition, if an on-Exchange participant submits an outbound ISO order (consisting of an order to execute on the Exchange, coupled with outbound ISOs to execute against protected quotations of other markets), the Matching System will not execute the order on the Exchange until it either simultaneously routes ISOs to other markets or confirms that the participant submitting the order has simultaneously routed ISOs designed to execute against the full size of any other market's protected bid or offer, as required by Rule 600(b)(30) and Rule 611(b)(6) of Reg. NMS.

[68] These systems would review, in real time, the Matching System's handling of test IOC orders to determine whether, and within what time frame, (i) IOC orders are executed against the displayed quote, up to its full size; (ii) any unexecuted portion of the IOC order is cancelled; (iii) a confirmation of the action taken is generated and transmitted from the Matching System to the monitoring system (to serve as a proxy for a transmission to the order-sending firm); and (iv) the Matching System transmits a new bid or offer (as appropriate) to the

Continued

monitoring systems would provide immediate reports to other Exchange systems for further handling. If these systems receive a report that gives the Exchange reason to believe that it is not capable of displaying automated quotations, the Exchange would automatically and immediately append a "manual" identifier to the bids and offers it makes publicly available.[69] The Exchange would not remove this "manual" identifier until it has determined that its quotations qualify as automated quotations. It would then notify other markets that its quotations are automated to ensure that all markets recognize the Exchange's bids and offers as automated quotations.

10. *Locking and crossing quotations.* An order would not be displayed on the Exchange if its display would improperly lock or cross the ITS best bid or offer or, when Reg. NMS is implemented for a security, if its display would constitute a locking or crossing quotation.[70] These otherwise locking or crossing orders would either be routed to another appropriate market or, if designated as "do not route," would be automatically cancelled.

11. *Clearing the matching system.* To ensure that orders on the Exchange have an appropriate opportunity to interact with each other, institutional brokers ordinarily would be required to clear the Matching System before sending an order to another market for execution.[71] Any outbound ITS commitments that are seeking liquidity in another market—whether they represent agency or proprietary interest—would be required to first clear the displayed and undisplayed orders in the Exchange's Matching System before being sent through the ITS System. Outbound ITS commitments (or ISOs) that are being sent to another market to satisfy its displayed bid or offer, however, would not be required to clear the Exchange's Matching System before being sent to the other market.[72] Additionally, an institutional broker would not be required to clear the Matching System if the customer order that is being sent to another market could not be executed in the Matching System (*e.g.*, the order is a stop or stop limit order which has not yet been elected).[73]

12. *Trading halts.* Under the proposed rules, two senior officers of the Exchange would be authorized to suspend and restart trading within a trading session or to halt trading for the remainder of a trading session, in one or more securities, when the officials believe it is in the public interest.[74] If trading in one or more issues is suspended or halted, the Matching System would not accept any additional orders and would resume quoting and matching orders only after the end of the trading halt.[75] Because the Matching System would not be locked or crossed when trading is halted, and because it would not accept orders during the halt, the Matching System would be able to emerge from the halt without any special reopening process, by simply displaying its BBO and then accepting and matching orders as provided by the Matching System rules described above.

13. *Cancelling transactions/handling clearly erroneous transactions.* Under the proposed rules, participants that make a transaction in demonstrable error could agree to cancel and unwind the transaction, subject to the approval of the Exchange.[76] The Exchange also proposes to extend its current electronic book rule for the handling of clearly erroneous transactions, with a few minor changes, to the operation of the Matching System.[77] This rule would allow the Exchange to review, and potentially modify or cancel, executions where one party believes that the terms of the transaction were clearly erroneous when submitted. A related rule relating to systems disruptions and malfunctions would allow the Exchange to modify or cancel executions that result from a disruption or malfunction in the use or operation of the Matching System, or any communications system associated with the Matching System or when extraordinary market conditions or other circumstances exist in which the nullification or modification of transactions may be necessary for the maintenance of a fair and orderly market or the protection of investors and the public interest. The proposed rules set out procedures for each of these reviews, including specific means for participants to appeal the Exchange's decisions.[78]

14. *The late trading session.* The Exchange's Matching System would begin accepting orders for the late trading session immediately after the closing of the regular trading session.[79] Orders for the late trading session would be matched according to the same process used during the regular trading session. As noted above, the late trading session would end at 3:30 p.m.

b. Market Makers

The Exchange's proposed new trading model would allow participants to register to act as proprietary market makers on the Exchange. The provisions that would govern the activities of these

monitoring system (to serve as a proxy for a transmission to the appropriate securities information processor). *See* CHX Article 20, Rule 5, Interpretation and Policy .02(a).

[69] In the event that the Exchange's systems do not permit the Exchange to disseminate a "manual" identifier, the Exchange would announce that its quotes are manual over an appropriate functionality available for communications with other market centers. *See* CHX Article 20, Rule 5, Interpretation and Policy .02(b).

[70] *See* CHX Article 20, Rule 6(d).

[71] If a customer specifically requests otherwise, an institutional broker is not required to clear the Matching System. *See* CHX Article 20, Rule 7(a). Institutional brokers would be required to document any directives for special handling of orders under this rule. *See* CHX Article 20, Rule 7(b).

[72] *See* CHX Article 20, Rule 7(c).

[73] *See* CHX Article 20, Rule 7(d).

[74] *See* CHX Article 20, Rule 1(d). Under the Exchange's current rules, a trading halt could be declared by the chairman or vice chairman of the Exchange's Board of Directors, or by its president, with the prior approval of a director from a participant firm and a director from the trading floor. The Exchange believes that it no longer is appropriate or effective to require its directors to participate in the decisions to suspend or halt trading, particularly with the automated environment proposed by the new trading model and the fact that the Exchange will no longer be operating a trading floor.

[75] *See* CHX Article 20, Rule 1, Interpretation and Policy .02. Participants could cancel orders during the halt.

[76] *See* CHX Article 20, Rule 9.

[77] *See* CHX Article 20, Rule 10; *see also* CHX Article XXA, Rule 7 (the policy approved for use within the electronic book).

[78] For example, a participant seeking review of a "clearly erroneous" transaction would be required to notify the Exchange of the request immediately after the execution by telephone, and within 15 minutes after the execution in writing. The Exchange would promptly notify the other party to the transaction. Both parties then would be required to submit information relating to the disputed transaction, within specified time frames. After reviewing the transaction, an Exchange official would notify both parties of his or her decision, in writing; either party could appeal the decision to a subcommittee of the Exchange's Committee on Exchange Procedure and, if not satisfied, to the full Committee on Exchange Procedure. In making his or her decision, the Exchange official would consider the goals of maintaining a fair and orderly market and protecting investors and the public interest; if an Exchange official determines that a transaction was clearly erroneous, he or she would try to return the parties to the positions that they would have been in (or positions reasonably similar to those positions) if the error had not occurred. Similarly, in the event of a disruption or malfunction that impacts the operation or use of the Matching System (or in the event of extraordinary market conditions or other circumstances), an Exchange official could declare transactions void or modify transactions. Absent extraordinary circumstances, any Exchange action to void or modify transactions in this manner must be taken within 30 minutes of detection of the erroneous transaction, but in no event later than 2 p.m. on the trading day following the date of the trade at issue. The official would be required to notify each member involved in the transaction as soon as practicable after making any decision; decisions could be appealed using the procedure set out for the review of decisions addressing clearly erroneous transactions.

[79] *See* CHX Article 20, Rule 8(c)(2). Orders for the late trading session would not be allowed queue before the close of the regular trading session; they would only be accepted by the Exchange after the close of the regular trading session.

market makers are set out in the proposed rules in CHX Article 16. These proposed rules replace the current market maker rules contained in CHX Article XXXIV.

Under the proposed rules, a participant firm seeking to act as a market maker would be required to register with the Exchange.[80] Participant firms would be required to register as market makers; individual traders within those firms would be required to separately register as market maker traders.[81] The proposed rules specifically provide that a market maker that is a participant in the Exchange, but is not a member of another self-regulatory organization, would be permitted to trade only on a proprietary basis and would not be permitted to handle any agency orders on the Exchange.[82] More than one market maker could register in each security.[83]

A participant would register as a market maker by submitting an application to the Exchange, confirming its ability to comply with applicable rules and identifying the number of securities in which it seeks to make markets.[84] The Exchange would review each application and, using specific criteria, would determine whether or not the participant should be registered in that capacity.[85] The Exchange would notify each participant of the action taken with respect to its application and, if it denies a participant's registration request, would describe the reasons for that denial.[86] An unsuccessful applicant would be permitted to seek a review from that decision pursuant to the provisions of CHX Article 15.[87]

Under the proposed rules, once a firm's market maker registration is approved, the firm could select the securities in which it would act as market maker by notifying the Exchange.[88] The Exchange would require a firm to seek prior approval before acting as market maker in more than 500 securities and with respect to each increment of an additional 100 securities after that threshold is reached.[89] If a market maker drops a security from its selected list, that participant would not be allowed to trade that security again as market maker for 20 calendar days.[90]

A firm's registration as a market maker could be terminated voluntarily, by the market maker itself, or involuntarily, by the Exchange.[91] The proposed rules would allow market makers to voluntarily deregister by filing the appropriate form with the Exchange. As part of that process, a firm would be permitted to request temporary or partial deregistration as a market maker—and thus avoid the need to complete the registration process again—in specific circumstances that temporarily prevent a market maker from acting in that role.[92] Under the proposed rules, the Exchange could grant a request for temporary or partial deregistration for up to 60 days and could extend that period in its discretion. The proposed rules would allow the Exchange to suspend, terminate or limit a market maker's registration upon a determination of any substantial or continued failure by the participant to engage in dealings as required by CHX Article 16, Rule 8 or as set out in CHX Article 13.[93]

During the Exchange's regular trading session, a market maker would be required to engage in a course of dealings for its own account to assist in the maintenance, to the extent reasonably practicable, of fair and orderly markets on the Exchange. A market maker's responsibilities would specifically include: (1) Using automated systems to maintain a continuous two-sided quote, for at least a round-lot, in each of the securities in which it is registered; (2) maintaining adequate minimum capital; and (3) meeting specific quotation or trade requirements, with respect to its dealings on the Exchange, over the course of each calendar month.[94] A market maker's continuous two-sided quotes must be at prices which are reasonably related to the prevailing market price of the security.[95]

Market makers would have two other specific obligations. First, a market maker that is registered as a market maker solely on the Exchange and engages in other business activities (or that is affiliated with a broker or dealer that engages in other business activities) would be required to establish, and describe to the Exchange, information barriers that prevent the market maker

[80] *See* CHX Article 16, Rule 1(a). A participant would be not be considered to be acting as a market maker unless it was registered in that capacity and was in good standing.

[81] *See* CHX Article 16, Rule 1, Interpretation and Policy .01.

[82] *See* CHX Article 16, Rule 1, Interpretation and Policy .02.

[83] *See* CHX Article 16, Rule 3, Interpretation and Policy .03.

[84] *See* CHX Article 16, Rule 2(b).

[85] *See* CHX Article 16, Rule 3. In considering a participant's request for registration as a market maker, the Exchange would consider: (a) The participant's financial resources; (b) the participant's experience and demonstrated ability in making markets, including the depth and quality of the market quoted by the participant in other securities; (c) the participant's demonstrated ability to make markets in such a manner as to increase the order flow to the Exchange and, as a result, the competitiveness of its market with markets elsewhere; (d) the participant's disciplinary record, including its violations of Exchange rules, the rules of other SROs and Federal securities laws; (e) the participant's operational capability, including its ability to comply with the responsibilities set out in CHX Article 16, Rule 8; and (f) the overall best interests of the Exchange.

[86] *See* CHX Article 16, Rule 2(d).

[87] *See* CHX Article 16, Rule 2(d).

[88] *See* CHX Article 16, Rule 5. A market maker would be required to notify the Exchange of a decision to add or drop securities by 9 a.m. on the trading day preceding the date on which the change would take effect, unless the Exchange is able to accommodate a notification closer to the effective date. *Id.*

[89] *See* CHX Article 16, Rule 5, Interpretation and Policy .01. This process would allow the Exchange to evaluate a market maker's request, using the criteria in CHX Rule 3, to determine whether the firm appears capable of handling its market maker responsibilities in these additional issues.

[90] *See* CHX Article 16, Rule 5, Interpretation and Policy .02. This prohibition would not apply where a market maker has received approval to voluntarily deregister as a market maker under the provisions of CHX Article 16, Rule 6.

[91] *See* CHX Article 16, Rules 6 (voluntary deregistration) and 7 (involuntary deregistration). In addition, the Exchange would consider a firm to have deregistered if it is not trading any securities as a market maker (*i.e.*, it is not submitting bids or offers in the securities it has selected). *See* CHX Article 16, Rule 6. If a firm is deemed to have deregistered, it would be required to complete the registration process again before acting as a market maker on the Exchange.

[92] These reasons include software, hardware, connectivity or other problems that interfere with the market maker's ability to appropriately send bids or offers to the Exchange or otherwise act as market maker; legal or regulatory considerations that temporarily prevent the participant from acting as market maker; or other circumstances, including, but not limited to, those that are beyond a market maker's control, that interfere with the participant's ability to act as market maker. *See* CHX Article 16, Rule 6, Interpretation and Policy .01.

[93] CHX Article 13 contains the Exchange's rules and procedures relating to the suspension and reinstatement of a participant's ability to act as a participant and to retain its registration in a special capacity (such as a market maker).

[94] *See* CHX Article 16, Rule 8(a) through (c). Over the course of each calendar month, a market maker would be required to meet either of these requirements: (1) At least 5% of the total number of a market maker's principal bids or offers on the Exchange, in each quarter, for each of its assigned securities, must, when entered on the Exchange, be at the NBBO or improve the NBBO in a manner that attributes market data revenue to the Exchange under the terms of applicable national market system reporting plans; or (2) the shares traded by a market maker for its own account, for each of its assigned issues, must equal or exceed 1% of the total number of shares executed on the Exchange in that issue.

[95] *See* CHX Article 16, Rule 8, Interpretation and Policy .01. The proposed rules provide that, in most circumstances, a market maker's quotations should be priced no more than 10% away from the prevailing NBBO (as applicable) for securities priced under $1.00, 5% for securities priced between $1.00 and $50.00 and 3% for securities priced above $50.00. This quoting guidance is substantially similar to that currently provided by the Exchange's Market Regulation Department to participants (such as specialists and market makers) that have a quoting obligation on the Exchange.

from using material, non-public information or information about customer order flow in its trading activities.[96] And, second, a market maker would be required to record and, provide upon request, to the Exchange in an approved electronic format, its long or short position in a security as of the time that it initiates an order in that security on the Exchange.[97]

c. Institutional Brokers

Under the Exchange's proposed new trading model, any participant firm that acts as a broker in effecting transactions on the Exchange and for which the Exchange is the designated examining authority would be permitted to register with the Exchange as an institutional broker and to use Exchange systems for handling orders and reporting transactions.[98] Each individual that would be authorized to effect trades on behalf of the firm would be required to separately register as an institutional broker representative.[99] The Exchange anticipates that its existing floor brokers would register as institutional brokers in the new model. Importantly, although institutional brokers would operate as participants on the Exchange, they could trade from any location and would not effect transactions from a physical trading floor.[100]

Under the proposed rules, institutional brokers would be required to adhere to trading and business conduct rules that apply to participant firms generally and would be subject to specific obligations set out in CHX Article 17. Among other things, institutional brokers would be required to enter all orders received for execution on the Exchange into an automated system to provide an electronic record of their order handling practices; would be required to maintain separate accounts for handling agency transactions, principal transactions and transactions involving errors; and would be required to enter transactions into the appropriate accounts.[101] Institutional brokers would also be required to maintain required records of their trading activities, including records of their relationships with their customers.[102] Finally, institutional brokers would be required to use an electronic system, acceptable to the Exchange, for the handling of orders that integrates the institutional broker's on-Exchange trading activities with the Matching System and with its trading activities in other market centers.[103]

A customer order would be deemed to be on the Exchange when received by an institutional broker, but would not have priority in the Matching System until it is entered into that system. The proposed rules would also set out specific order handling obligations for institutional brokers.[104] Specifically, an institutional broker handling a market order would be required to use due diligence to execute the order at the best price or prices available.[105] Similarly, an institutional broker handling a limit order would be required to use due diligence to execute the order at or better than the limit price, if available. And, an institutional broker who has been given a not held order would be required to use brokerage judgment in the execution of the order, and if he exercises such judgment, would be relieved of all responsibility with respect to the time of the order's execution and the execution price or prices given to the order.[106] These proposed rules are similar to rules that relate to broker trading activities on at least one other market and are designed to establish a specific standard by which institutional broker order handling activities could be measured.[107]

The final new requirement under the proposed rules would require that brokers use reasonable efforts to report all transactions that are not effected through the Exchange's Matching System to the Exchange within 10 seconds after the trade occurs.[108] Although the Exchange anticipates that most executions by its institutional brokers would occur within the Matching System, the Exchange recognizes that its institutional brokers could, from time to time, execute orders outside of that system. To ensure that the Exchange and its institutional brokers can establish compliance with the trade-through provisions of the ITS Plan and Rule 610 of Reg. NMS, the Exchange is developing functionality in its Brokerplex system that would allow an institutional broker to electronically validate whether a trade would constitute a trade-through before the trade occurs and that would create an electronic record that that validation had taken place.[109] Because of the possibility that a broker trading on a proprietary basis against a customer order could use this functionality in a manner inconsistent with the broker's fiduciary obligations to the customer order, the proposed rules would require

[96] *See* CHX Article 16, Rule 9. At the time a participant becomes a market maker, the participant would be required to submit a written statement describing its plans for establishing and maintaining the required information barriers, including the internal controls that will be put in place to monitor the barriers' effectiveness. A market maker engaging in these other business activities would not be allowed to act as a market maker on the Exchange until the Exchange had approved the information barrier procedures.

[97] *See* CHX Article 16, Rule 10. The requirement to report information to the Exchange would apply only to market makers that are not NASD members. NASD members would provide this information directly to the NASD and would be subject to the NASD's oversight with respect to their trading activity.

[98] *See* CHX Article 17, Rule 1.

[99] *See* CHX Article 17, Rule 1, Interpretation and Policy .02. This requirement essentially tracks the current requirement that individual floor brokers separately register with the Exchange and take required examinations. *See* CHX Article VI, Rules 2 and 3.

[100] As noted above, the Exchange would not operate a physical trading floor in the new trading model. The Exchange anticipates that it would continue to allow participants to remain in their current locations within the trading floor space, paying current rent, through the end of the year, at which time the trading floor space would be more formally subleased to interested parties (including participants) for use as office or trading space. The Exchange believes that it would be appropriate to allow participants to remain in their current locations on the floor (and to pay the current rent for that space) during, and for a short time after, the transition to the new trading model so that firms that choose to relocate are not unnecessarily required to disrupt their operations by both a transition to a new trading model and a physical relocation.

[101] *See* CHX Article 17, Rule 3(a) and Rule 3(c). The requirement for entering orders into an electronic system to permit the Exchange to more readily surveil broker order handling activities has been approved and implemented. *See* CHX Article 11, Rule 3; Securities Exchange Act Release No. 53772 (May 8, 2006), 71 FR 27758 (May 12, 2006). In addition, although the Exchange's current rules do not specifically require brokers to maintain specific principal, agency and error accounts, the Exchange's Market Regulation Department has encouraged them to do so as a way to evidence their compliance with general order handling obligations.

[102] *See* CHX Article 17, Rule 3(f).

[103] *See* CHX Article 17, Rule 3(b).

[104] *See* CHX Article 17, Rule 3(d). An institutional broker generally would execute its customers' orders on an agency basis. If, however, an institutional broker believes it is in the best interests of its customer to execute an order on a principal basis, it must comply with the requirements of CHX Article 9, Rule 18. See CHX Article 17, Rule 3(d)(4).

[105] In handling a market order, an institutional broker could assign an appropriate limit price to the order and send it to the Matching System, could enter an IOC market order into the Matching System or could route the order to another market center after clearing the Exchange's Matching System.

[106] *See* CHX Article 17, Rule 3(d)(3).

[107] *See* NYSE Rule 123A.41–.44. The Exchange's Rules do not currently contain any specific order execution standards that apply to its brokers.

[108] *See* CHX Article 17, Rule 3(e). This provision would also require that an institutional broker mark as "SOLD" any trades reported after this time.

[109] *See* CHX Article 17, Rule 3, Interpretation and Policy .03. Other possible functionality might allow a broker to enter the details of a proposed cross transaction (such as its price, the number of shares and whether the sell side of the order is "short") into the Brokerplex system, which would send the cross to the Matching System for execution when it could be executed. The first type of functionality—to allow a broker to report a trade outside of the Matching System in a manner that is consistent with the NBBO and orders in the Matching System—is slated for roll-out to brokers in (or before) early October 2006.

a broker that pulls up the validation window to complete the required information and report the transaction (without cancelling out of the functionality) unless the broker mistakenly input the symbol for the wrong security or the transaction may be cancelled pursuant to the provisions set out in CHX Article 20, Rules 9, 10 and 11 (relating to cancellations of transactions, clearly erroneous transactions and systems disruptions and malfunctions).[110]

d. Other Rule Changes

1. *CHX Article 1. (Definitions and General Information).* Within this Article of the rules, the Exchange proposes to add new definitions for terms that are used elsewhere in the rules.[111] The Exchange also seeks to add two new sections—one new rule that lists and defines types of orders and conditions and one new rule that confirms that all times identified in the rules are Central Time unless otherwise indicated.[112]

2. *CHX Article 2. (Committees).* The proposed changes to this Article eliminate references to the Exchange's trading floor and to the Exchange's current Committee on Specialist Assignment and Evaluation.[113] Under the proposed new model, the Exchange would no longer have specialists who are responsible for handling orders in each issue and thus there is not a need to have a committee to assign securities and evaluate specialist performance. The proposed changes also would confirm that the Committee on Exchange Procedure would consist of not less than seven participants, without specifying the specialized roles in which those persons must serve.[114]

3. *CHX Article 3. (Participants).* The primary substantive changes in this Article are designed to streamline the process of obtaining a trading permit on the Exchange. Under the Exchange's current rules, the Exchange's staff makes a preliminary determination about an applicant's qualifications and then posts the applicant's name to permit other participants to submit any objections to that applicant's desire to trade on the Exchange. The Exchange believes that this posting process is not a necessary component of the application process—indeed, it appears to relate back to a time when information about a firm's prior business dealings might best be learned by talking with others in the business community. The electronic databases of information that are available today eliminate the need for this sort of process.[115]

There are three other groups of proposed changes within CHX Article 3. In CHX Rule 1, the Exchange seeks to eliminate the definitions that identify when a participant is engaging in a public securities business—these definitions do not relate to any particular requirement applicable to Exchange participants under the current rules. And, in CHX Rule 2, the Exchange proposes to replace references to "co-specialists," "floor brokers" and "registered market makers" with references to "institutional broker representatives" and "market maker traders," the terms used in CHX Articles 16 and 17 to refer to the individuals who would have special registration on the Exchange in the new model.

One final change to CHX Article 3 would create a more detailed limitation of liability provision that tracks similar provisions on other markets.[116] This provision would confirm that neither the Exchange, nor its affiliates, nor any of the directors, officers, committee members, officials, employees, contractors or agents of the Exchange or its affiliates would be liable to participants or persons associated with participants for any loss arising out of the use of the facilities, systems, services or equipment provided by the Exchange or for any loss associated with an interruption in, or in a failure or unavailability of, of any such facilities, systems, services or equipment, whether or not the loss resulted from negligence or other unintentional errors omissions or from any other cause within or without the Exchange's control.[117] The provision would also confirm that the Exchange makes no warranty as to results that might be obtained by persons using the Exchange's facilities or services or any data transmitted by or on behalf of the Exchange.[118] Other changes to this provision would bar a participant from instituting a legal proceeding against the Exchange, its affiliates or their directors, officer, committee members, officials, employees, contractors or agents for actions taken or omitted in connection with the official business of the Exchange, except to the extent that such actions or omissions constitute violations of the Federal securities laws for which a private right of action exists.[119]

4. *CHX Article 4. (Participant Firms).* In this Article, the Exchange seeks to eliminate references to its trading floor and to floor brokers.[120] It also proposes to change existing requirements relating to the nominees and voting designees named on trading permits to confirm that any person affiliated with a participant firm, not just a general partner of the firm, who is acting as an institutional broker representative or a market maker trader can be named as a nominee on a trading permit.[121] Similarly, the Exchange proposes to confirm that any officer of a participant firm can be named as voting designee, not just the firm's president or one of its

[110] *See* CHX Article 17, Rule 3, Interpretation and Policy .03.

[111] These newly-defined terms include "Act" and "Exchange Act," "Amex," "BBO," "CHX," "CHX Holdings," "institutional broker," "NBBO," "Nasdaq," "NYSE," "primary market," "Rule 10a–1 and Regulation SHO," "rules," and "Securities Act." The Exchange's BBO would be the best bid or offer displayed in the Exchange's Matching System. The NBBO would be described in reference to the definition used in Rule 600(b)(42) of Reg. NMS. The "primary market"—a term used largely to determine the execution price of opening cross orders—would mean, unless otherwise designated by the Exchange, the initial listing market for a security. References to the Exchange's Rules would include the rules of the Exchange that have been adopted by the Exchange's Board of Directors and that have either been approved by the Commission or become effective pursuant to Section 19(b)(3) of the Act. The Exchange proposes to delete the definitions of "floor" and to delete references to the trading floor from the "trading facilities" definition to reflect the fact that the Exchange will not be operating a physical trading floor in the new model.

[112] *See* CHX Article 1, Rules 2 and 3. The order types and conditions set out in Rule 2 primarily are those that are accepted by the Exchange's Matching System and described in CHX Article 20, Rule 4. A few new definitions were added to clarify basic information such as the definition of "odd lot," "round lot" and "mixed lot." *See* CHX Article 1, Rules 2(w) (odd lot), 2(cc) (round lot) and 2(r) (mixed lot).

[113] *See* CHX Article 2, Rule 5 (removing references to the trading floor and to the Committee on Specialist Assignment and Evaluation); Rule 6 (deleting the description of the role of the Committee on Specialist Assignment and Evaluation); and Rule 10 (deleting references to the Exchange's trading floor).

[114] *See* CHX Article 2, Rule 5 (removing a requirement that three of the Committee members be active on the Exchange's Floor as specialists, odd-lot dealers or floor brokers). The Exchange believes that, with its move the new trading model, it is no longer appropriate to mandate that Committee members trade in certain capacities and not others.

[115] *See* CHX Article 3, Rules 3 and 4. Other changes to the application process would confirm that, with the posting process eliminated, Exchange staff would make the initial determination on each application for a trading permit. These changes also would refer applicants to a new CHX Article, CHX Article 15, for a single set of procedures for seeking review of Exchange decisions, such as the denial of a trading permit.

[116] *See* ISE Rule 705(a) and CBOE Rule 6.7A.

[117] *See* the full text of this provision at CHX Article 3, Rule 8(a).

[118] *See* the full text of this provision at CHX Article 3, Rule 8(b).

[119] *See* CHX Article 3, Rule 8(c) for the complete text of this provision. Importantly, this last provision would not apply to appeals of disciplinary actions or other actions by the Exchange for which an appellate right is provided by the rules.

[120] *See* CHX Article 4, Rules 4 and 15.

[121] *See* CHX Article 4, Rule 13(b).

vice presidents.[122] These changes are designed to reflect the fact that participant firms are structured in various ways—some are partnerships and others are not—and that the Exchange is concerned with an individual's authority to act on behalf of the firm, not whether he or she fits into a narrowly selected job title or role.[123]

5. *CHX Article 5. (Access to the Exchange).* Under the Exchange's current rules, this Article (entitled "Admission to Floor—Communications") contains rules describing visitor and employee access to the trading floor, the making of announcements on the floor and the connections that can be made to and from the Exchange's trading floor.[124] Because the Exchange would not operate a physical trading floor in its new model, the Exchange proposes to delete these rules and to replace them with rules that contemplate remote access to the Exchange's automated trading systems. These proposed new rules would begin by requiring that participants have reasonable procedures to maintain the physical security of the equipment and systems used to access the Exchange and to maintain an updated list of the persons who can obtain access to the Exchange on the Participant's behalf.[125] Another rule would confirm that, as a condition of obtaining access to the Exchange, each participant agrees to pay Exchange fees, including fees associated with the routing of orders to other markets.[126]

One of the last proposed new rules in this Article would set out a structure through which Exchange participants could provide non-participant broker-dealers with access to the Exchange, through clearing arrangements or otherwise.[127] Under this proposed rule, this type of sponsored access could be provided so long as the participant sponsoring access (the "sponsoring participant"), the non-participant broker-dealer and the Exchange entered into appropriate agreements confirming basic information about the roles and responsibilities of the various parties. These agreements would confirm that: (1) All orders submitted by the non-participant broker-dealer, and any executions resulting from those orders, are binding in all respects on the sponsoring participant; (2) the sponsoring participant is responsible for all actions taken and fees incurred in connection with any order submitted or transaction executed by the non-participant broker-dealer; (3) in all matters relating to the non-participant's access to the Exchange and its use of Exchange facilities, the Exchange would communicate with the sponsoring participant and would not be required to communicate with the non-participant at any time; (4) the non-participant broker-dealer would have reasonable procedures to maintain the physical security of the equipment used to access the Exchange to prevent improper use of, or access to, the Exchange; and (5) the sponsoring participant would indemnify and hold the Exchange harmless from any liability, loss, claim or expense which the Exchange may incur in connection with the agreement. The Exchange believes that these provisions provide sufficient assurances to the Exchange, to other participants using the Exchange's facilities and to the non-participants themselves that non-participant broker-dealer access to the Exchange's facilities would be subject to the same standards and obligations that apply to participant access.[128]

The final proposed rule in this Article would permit an appeal from a Market Regulation Department decision to deny access to a participant (or a non-participant broker-dealer) under any of the rules in the Article. Any appeal from such a decision would be made pursuant to the procedures set out in CHX Article 15.[129]

6. *CHX Article 6. (Registration).* In this Article, the proposed rule changes would begin by confirming that individuals acting as institutional broker representatives and market maker traders would be required to register with the Exchange and successfully complete certain written examinations.[130] Other proposed changes would set out more specific obligations relating to notifications that would need to be made to the Exchange when a registered or associated person is terminated and would require participant firms to notify the Exchange of any firm-related event constituting a statutory disqualification.[131] Additional changes would update the firm supervision rules to require participants to identify the person(s) responsible for acting as supervisors; to recognize that supervisory authority could be delegated and to establish the mechanism for doing so; to provide that, in the absence of a specific designation, the firm's general partner(s), president, chief executive officer or other principal executive officer would be deemed to have supervisory responsibility; to require firms to meet, at least annually, with staff about compliance matters; and to require firms to establish internal controls to assure that appropriate supervision is being exercised.[132] Other changes would require that a participant opening a branch office file a Form BR with the Exchange (instead of Schedule E to Form BD) and confirm that a participant must retain records that identify the names of all persons who are designated as supervisory personnel (and the dates for which those designations are effective) for six years (the first two years in an easily accessible place). Finally, the changes in this Article would add a new rule relating to fingerprinting of Exchange staff and contractors and would incorporate two rules that currently occur elsewhere in the Exchange's rules.[133]

7. *CHX Article 7. (Financial Responsibility and Reporting).*[134] In this

[122] *See* CHX Article 4, Rule 13(c).

[123] Other proposed changes in this Article correct a misspelling (CHX Rule 4) and clarify that participants do not "own" trading permits, they "hold" them. (CHX Rule 13(a)).

[124] One of these provisions, CHX Rule 4, contains a new interpretation and policy that requires participants to provide specific information to the Exchange about connections to, and orders handled through, layoff vendors. The Exchange proposes to move this provision to CHX Article 11, its new Books and Records rule.

[125] *See* CHX Article 5, Rule 1.

[126] *See* CHX Article 5, Rule 2.

[127] *See* CHX Article 5, Rule 3.

[128] For example, because the sponsoring participant confirms that it is responsible for the non-participant's actions, the Exchange can enforce compliance with its rules through actions taken against the sponsoring participant. In addition, the non-participant (like a participant) would be required to use reasonable procedures to maintain the physical security of the equipment used to access the Exchange and the Exchange would communicate with the participant on all issues relating to the use of the Exchange's facilities.

[129] *See* CHX Article 5, Rule 4.

[130] *See* CHX Article 6, Rules 2(b)(7) and 3.

[131] *See* CHX Article 6, Rule 2(e)–(f) and Interpretations and Policies .03 and .04.

[132] *See* CHX Article 6, Rule 5(a) (various provisions relating to the designation of persons with supervisory authority) and 5(c) (internal controls and training). These obligations are similar to those required by other SROs and would ensure that the Exchange's participant firms are strengthening the work that they do to supervise their registered and associated persons.

[133] *See* CHX Article 6, Rule 10 (fingerprinting) and Rules 8 and 9 (formerly, CHX Article VIII, Rule 16 and CHX Article VIII, Rule 11). Under the proposed fingerprinting rule, the Exchange would conduct fingerprint-based criminal records checks of all prospective employees, as well as of independent contractors and temporary employees who are expected to have access to Exchange facilities for more than 10 days. The Exchange would similarly conduct checks of persons who would have access to premises controlled by CHX Holdings, when those premises are in the same building as Exchange facilities. This proposed rule would codify the Exchange's current practice of conducting these checks for prospective Exchange employees and would extend that practice to independent contractors and temporary workers who have more than fleeting access to Exchange facilities, as well as to other persons who have access to certain CHX Holdings premises.

[134] This Article previously was numbered CHX Article XI of the Exchange's Rules. The marked

Article, the proposed rule changes would delete references to requirements that current apply to specialist firms and incorporate three fee-related provisions that currently appear in other Articles.[135]

8. *CHX Article 8. (Business Conduct).* As noted above, as part of its new model filing, the Exchange has sought to better organize its rules. Although there were some minor organizational changes in earlier Articles, the proposed changes in CHX Article 8 are somewhat more extensive.[136] Importantly, though, CHX Article 8 does not contain any completely new rule provisions; indeed, eleven of the sixteen proposed rules in this CHX Article have not been changed at all.[137] Instead, the rules in this section were gathered from throughout the Exchange's rulebook and, with three exceptions discussed below, are not substantially modified.[138]

The existing version of CHX Article VIII, Rule 21 extensively details how one participant firm must coordinate with another participant in the transfer of customer accounts. Because the Exchange is not the designated examining authority for any firm that carries participant accounts, the Exchange believes that this detailed recitation of account transfer procedures is not a necessary component of its rules. Instead, the Exchange proposes to adopt, in CHX Article 8, Rule 10, rule language similar to that used by other markets that have similarly constrained examining responsibilities.[139] Also, the Exchange has proposed revisions to CHX Rule 16 that would make the text relating to its policy against harassment and other conduct rules applicable, once the Exchange no longer operates a trading floor, to conduct that occurs on Exchange premises, while conducting business on the Exchange or when interacting with Exchange staff who are conducting Exchange business.

The Exchange has proposed the deletion of several rules in the existing CHX Article VIII. As an initial matter, the Exchange seeks to delete CHX Article VIII, Rule 22 (Responsibility for Acts of Others), which identifies supervisory obligations that are much like those being added to CHX Article 6, Rule 5, as described above. Other provisions that would be deleted appear to be unnecessarily duplicative of existing Exchange authority or of provisions that are being retained or seem otherwise unnecessary for the regulation of the automated market which the Exchange will operate.[140]

9. *CHX Article 9. (General Trading Rules).* The Exchange proposes to reorganize CHX Article 9 in much the same manner as CHX Article 8.[141] The proposed changes to CHX Article 9 include only three new rules—relating to the reporting of transactions (including riskless principal transactions) and to the use of a customer's give-up.[142] Other provisions have been gathered from the text of the existing CHX Article IX and from other sections of the current rulebook and have been modified primarily to remove references to the Exchange's trading floor or to make other clarifications to the text.[143]

As in CHX Article VIII, the Exchange has proposed the deletion of rules that are obsolete; that appear to be unnecessarily duplicative of existing Exchange authority or of provisions that are being retained; or that seem otherwise unnecessary for the regulation of the automated market which the Exchange will operate. For example, the Exchange proposes to delete its existing general books and records rule (CHX Article IX, Rule 7) because it has been replaced by much more detailed provisions in CHX Article 11. Similarly, the existing rule relating to the business

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version of the rules in this submission compares the current CHX Article XI to the changes that would be made as part of the Exchange's new trading model, including the change in numbering. The provisions in current CHX Article VII have been moved to new CHX Article 13, as described below.

[135] The specialist-related provisions that would be deleted are shown in CHX Article 7, Rule 3. The three fee-related rules that would be added to this section—so that all fee-related provisions could be gathered as much as possible in one place—formerly were CHX Article XIV, Rules 1 (fixing and paying fees); 10 (failure to pay debts); and 11 (fees for participants in military service).

[136] To try to enhance a reader's ability to understand which rules the Exchange proposes to keep in force, the Exchange shows the reorganized rules as new text in the first section of Exhibit 5 and the existing rule text as deleted text in the second section of Exhibit 5. Some of these apparently deleted rules have not been completely removed; instead, they have been moved to other CHX Articles in the rulebook. *See* CHX Article VIII, Deleted Rules 3, 7, 9 and 17 (moved to CHX Article 9); Rules 8, 11 and 16 (moved to CHX Article 12); and Rule 23 and 24 (moved to new CHX Article 14).

[137] *See* CHX Article 8, Rules 2 (formerly Rule 12); 3 (formerly Rule 1); 4 (formerly Rule 5); 5 (formerly Rule 2); 8 (formerly Rule 18); 9 (formerly Rule 19); 11 (formerly Rule 25); 12 (formerly CHX Article XV, Rule 3); 13 (formerly CHX Article XIII); 14 (formerly CHX Article XXXIII) and 15 (formerly CHX Article XV, Rule 1).

[138] Small modifications include changes that would delete references to the trading floor, eliminate obsolete provisions or clarify wording. *See* CHX Article 8, Rule 1 (replacing the reference to "constitution" with a reference to the Exchange's "bylaws" and deleting the unnecessary word "Firm" in the first few words of the text); Rule 7 (eliminating references to non-participants on the trading floor and to employees of banks, insurance companies and other corporations); and Rule 8 (eliminating references to floor employees).

[139] *See* PCXE Rule 9.19.

[140] *See* e.g., CHX Article VIII, Rule 4 (Upsetting Market Equilibrium) and Rule 10 (Dealings on Market Price Fluctuations), which address issues similar to those set out in other Exchange rules, including CHX Article 9, Rule 11 (Price Manipulation). *See also* CHX Article VIII, Rule 8 (unnecessarily confirming that a participant, or a partner, officer, director or registered employee of a participant firm that is found guilty of conduct inconsistent with just and equitable principles of trade shall be expelled, suspended or disciplined).

[141] As above, the Exchange shows the reorganized rules as new text in the first section of Exhibit 5 and the existing rule text as deleted text in the second section of Exhibit 5.

[142] *See* CHX Article 9, Rules 13, 14 and 25. Proposed Rule 13 contains provisions that confirm that transactions on the Exchange may occur only in the Matching System or through an institutional broker and require institutional brokers to report all executions that occur on the Exchange (except for transactions that occur within the Matching System, because the Exchange has already stored information about those transactions). Proposed CHX Rule 14 sets out riskless principal trade reporting rules that are similar to those put in place by other markets and could be used by institutional brokers in their handling of customer orders. Most frequently, however, the Exchange anticipates that its institutional brokers would continue their current practice of acting on an agency, not riskless principal, basis when representing orders in other markets. Rule 14 confirms that the second, riskless principal leg of the riskless principal transaction is not required to clear the Matching System pursuant to CHX Article 20, Rule 7 and is not required to yield to orders otherwise resident on the Exchange.

[143] *See* CHX Article 9, Rules 1 (moved from CHX Article XX, Rule 1 and modified to state simply that the trading rules apply to trading on the Exchange); 2 (moved from CHX Article VIII, Rule 7 and modified to confirm that, even if not willful, a pattern or practice of rule violations may be considered conduct inconsistent with just and equitable principles of trade); 3 (moved from CHX Article XX, Rule 4 and modified to eliminate obsolete references to Exchange employees who are authorized to close contracts under the rule); 4 (moved from CHX Article IX, Rule 8); 5 (moved from CHX Article XX, Rule 6); 6 (moved from CHX Article XX, Rule 8 and modified to replace references to "bids and offers" with references to "orders"); 7 (moved from CHX Article XXVII, Rules 1 and 2); 8 (moved from CHX Article XX, Rule 3); 9 (moved from CHX Article VIII, Rule 3); 10 (moved from CHX Article XX, Rule 29); 11 (moved from CHX Article IX, Rule 6 and modified to confirm that the rule applies to both purchases and sales); 12 (moved from CHX Article IX, Rule 11); 16 (moved from CHX Article VIII, Rule 17); 17 (moved from CHX Article IX, Rule 5 and modified (i) To confirm that a participant may not execute an incoming order for its own account at a price less than a penny better than an unexecuted customer limit order that it is aware of or holding; (ii) to confirm that a participant will be deemed to be holding or aware of an unexecuted customer order when the order remains unexecuted in the Matching System; and (iii) to clarify that a participant will not violate this provision if it satisfies bids and offers in other markets at a price that is better than the cross price of a customer order, in accordance with the requirements for a "cross with satisfy" order); 18 (moved from CHX Article XX, Rule 31 and modified to remove references to public bidding and offering, as on the floor of the Exchange); 19 (moved from CHX Article IX, Rule 1); 20 (combined from CHX Article IX, Rules 2 and 9; CHX Article XX, Rule 32); 21 (moved from CHX Article IX, Rule 4); 22 (combined from CHX Article IX, Rule 15 and CHX Article XX, Rule 33; modified to eliminate references to the trading floor); 23 (moved from CHX Article IX, Rule 17); and 24 (moved from CHX Article VIII, Rule 9 and modified to eliminate the definition of "Act" because that definition is already contained in CHX Article 1 of the rules).

days and hours of the Exchange (CHX Article IX, Rule 10) would be replaced by the provisions of CHX Article 20, Rule 1, which contains information (including the operating hours) associated with the Matching System's trading sessions.[144]

10. *CHX Article 10. (Margins).* The Exchange proposes to delete, from this section of its rules, the provisions relating to any margin requirements for specialists.[145]

11. *CHX Article 11. (Books and Records).* This Article is an entirely new Article that would include the four primary books and records rule that apply to Exchange participants.[146] Two of these proposed rules contain provisions that already appear elsewhere in the Exchange's current rules.[147] One new rule—CHX Rule 2—would confirm that Exchange participants must make and preserve all books, accounts, records, memoranda and correspondence as required by applicable law, including Commission rules and Exchange rules. Another new rule—CHX Rule 1—would require that participants provide the Exchange with access to books and records and must furnish requested financial and transaction-related records to the Exchange upon request. The Exchange believes that these new rules bolster the Exchange's ability to perform its regulatory responsibilities.

12. *CHX Article 12. (Disciplinary Matters and Trial Proceedings).* The Exchange's proposal would make two primary changes to this CHX Article.[148] First, because the Exchange would not operate a trading floor in the new trading model, the proposal would eliminate the Exchange Procedure Committee's ability to take action against participants with respect to trading floor and other on-site decorum violations.[149] The proposal also would eliminate, from the Minor Rule Violation Plan, any rules that would otherwise be deleted by this proposal.[150]

13. *CHX Article 13. (Suspensions and Reinstatements).* In this Article, which previously was numbered CHX Article VII, the Exchange proposes one substantive change.[151] As an initial matter, the Exchange seeks to add new text that would allow the Exchange to use its emergency suspension authority whenever a participant firm that is registered as an institutional broker or market maker has failed to perform, or is failing to perform, any material responsibility imposed on the participant because of that role and, as a result, cannot be permitted to continue in business with safety to its customers or creditors or to the Exchange.[152] The Exchange believes that it is important to extend its suspension authority in this manner to allow the Exchange to address egregious circumstances that might arise because of an institutional broker's or market maker's failure to meet the obligations that arise because of its specialized role in the market.

14. *CHX Article 14. (Arbitration).* Under the Exchange's proposal, this Article would consist of Rules 23 and 24 from former CHX Article VIII. The Exchange does not propose any substantive changes to these provisions, although it has re-numbered provisions to make them somewhat more consistent with the other sets of rules.[153] Also, in Section 31 of Proposed CHX Rule 2, the Exchange has replaced a reference to an effective date that was "after 120 days have elapsed from the date of Commission approval of this Rule" with a reference to the appropriate specific date, January 5, 1990.

15. *CHX Article 15. (Hearings and Reviews).*[154] The Exchange currently has several disparate provisions that permit participants to seek review of an Exchange decision. These provisions often do not define the specifics associated with any hearing or review; they sometimes (but not always) permit further review by the Board. This new Article is designed to consolidate many of these provisions into one section that can be uniformly applied to Exchange decisions that do not involve disciplinary matters or appeals from arbitration decisions.[155]

Among other things, this new Article would provide details about requesting a hearing (which must be done within 30 days of the initial decision at issue, unless an extension of time is granted); the appointment of the hearing panel (which would be the entire Executive Committee, unless the Committee chooses to appoint a panel of five of its members to hear a matter); requesting extensions of time; submitting documents and witness lists (which ordinarily must be done at least 72 hours before the start of the hearing); the notice of hearing; the conduct of the hearing (during which all parties may be represented by counsel and the formal rules of evidence would not apply); the parameters of the decision that would be reached (for example, the decision would be in writing and ordinarily distributed within 90 days after the end of the hearing or the submission of post-hearing briefs, whichever is later); and seeking further review of the decision (which can be done by either party, within 30 days, or by the Board on its own motion).[156] Throughout these proposed rules, the Exchange has sought to provide a central set of rules for these hearings which is similar to, but more expansive than, the various provisions scattered throughout the existing rulebook.

16. *CHX Article 19. (ITS).* This Article contains the ITS-related rules applicable to the Exchange's participants. The Exchange has proposed only a few changes to these rules. The most substantive change to this section of the rulebook confirms that the Exchange's Matching System will accept and execute inbound ITS commitments on behalf of its participants.[157] This change recognizes the much more automated nature of the trading that will occur on the Exchange in the new trading model. Other proposed changes to the rules highlight the sections that will be deleted on the effective date of the NMS Linkage Plan among various exchanges—these sections include the

[144] Other rules that would be deleted include CHX Article IX, Rule 10B (containing an obsolete rule relating to a stop order ban based on a no-longer-existing NYSE rule on the same topic); Rule 12 (containing a broad prohibition on the circulation of rumors that seems to be focused on a floor-based trading environment) and Rule 16 (relating to floor trading).

[145] *See* CHX Article 10, Rule 3(c)(6).

[146] The provisions in current CHX Article XI have been moved to CHX Article 7 of the proposed set of rules.

[147] *See* Proposed CHX Rule 3 (incorporating text from CHX Article XX, Rule 24) and Proposed CHX Rule 4 (moved from CHX Article V, Rule 4).

[148] The Exchange has sought other changes to CHX Article 12, and to other Exchange rules, as part of a pending rule filing, SR–CHX–2005–06. When that proposal is approved, the Exchange will amend this submission, if necessary, to incorporate any changes arising from the other proposal.

[149] *See* CHX Article 12, deleted Rule 3.

[150] *See e.g.*, CHX Article 12, Rule 8(h) (proposed deletion of rules relating to the submission of the co-specialist survey, as well as failure to comply with decorum and open outcry requirements).

[151] The advertising requirements of CHX Article XIII have been moved to CHX Article 8, Rule 14.

[152] *See* CHX Article 13, Rule 2.

[153] The current provisions of CHX Article XIV ("Fiscal Policies") were either transferred to CHX Article 7 ("Financial Responsibility and Reporting") or would be deleted as no longer necessary in the new trading model.

[154] The current text of CHX Article XV ("Commissions") has either been moved to other CHX Articles (*e.g.*, CHX Article XV, Rule 5 has been moved to CHX Article 22) or it has been deleted.

[155] *See* CHX Article 15, Rule 1.

[156] *See* CHX Article 15, Rule 2 (submission of requests for hearing); Rule 3 (requests for hearings on emergency actions); Rule 4 (hearing panel); Rule 5 (extensions of time); Rule 6 (submissions of supporting materials); Rule 7 (notice of hearing); Rule 8 (conduct of hearing); Rule 9 (decision); and Rule 10 (seeking review of that decision).

[157] *See* CHX Article 19, Rule 1(b)(4). The proposed changes confirm that the Matching System will execute ITS commitments as set out in CHX Article 20 of the Exchange's rules.

provisions relating to the Preopening Application, the Locked Markets requirements and the Block Trade Policy.[158] Other changes to the ITS rules eliminate references to the Exchange's trading floor and to rules that are being deleted as part of the implementation of the new trading model.

17. *CHX Article 21. (Clearance and Settlement).* In this new Article, the Exchange seeks to incorporate all of the rules that it believes would be necessary in connection with the clearance and settlement of transactions in the new trading model. These rules have been gathered from various existing CHX Articles; the section does not include any entirely new rules, although a few rules have been modified to eliminate references to the trading floor.[159] Among other things, this proposed new Article would require participants to maintain accounts with a qualified clearing agency, or with another participant that has such an account, for the recording of transactions on the Exchange.[160] The proposed Article would also confirm that the Exchange may extend or postpone the time for performance of contracts when required by just and equitable principles of trade or to meet unusual conditions.[161]

18. *CHX Article 22. (Listing).* This Article is numbered CHX Article XXVIII in the Exchange's current rules.[162] The proposed changes in this section would delete references to the Exchange's specialist firms; correct a telephone number and a typographical error; eliminate references to the Exchange's trading floor; and more accurately describe the work done by Exchange staff in connection with its surveillance of trading in exclusively listed securities.[163] No other changes to the Exchange's listing rules are contemplated in connection with the proposed new trading model.

19. *Other deleted provisions.* In addition to the changes noted in the paragraphs above, the Exchange's new trading model proposal would also eliminate the following Articles from its rulebook: CHX Article XVI (Insurance as an Ancillary Activity); CHX Article XVII (Suspension and Termination of Special Floor Registration for Unsatisfactory Performance); CHX Article XX (Regular Trading Session); XXIII (Reclamations); XXIV (Lending Securities); XXV (Closing of Contracts); XXVI (Marking to the Market); CHX Article XXIX (Special Offerings); CHX Article XXX (Specialists); CHX Article XXXI (Odd-lots); CHX Article XXXII (Exchange Distribution Plan); XXXIV (registered Market Makers—Equity Floor); CHX Article XXXV (Secondary Trading Session); CHX Article XXXVI (Baskets); and CHX Article XXXVII (Chicago Match). Each of these sets of rules would no longer be necessary in the new trading model.[164]

e. Proposed Roll-Out of New Trading Model

The Exchange anticipates that it will be ready to begin implementing its new trading model in September 2006. Closer to the implementation date, the Exchange will notify participants of its detailed roll-out plans.

2. Statutory Basis

The Exchange believes that the proposed rule change is consistent with the requirements of the Act and the rules and regulations thereunder that are applicable to a national securities exchange, and, in particular, with the requirements of Section 6(b) of the Act.[165] In particular, the Exchange believes that the proposed rule change is consistent with Section 6(b)(5) of the Act,[166] because it would promote just and equitable principles of trade, remove impediments to, and perfect the mechanism of, a free and open market and a national market system, and, in general, protect investors and the public interest by permitting the Exchange to operate an efficient, automated market for the trading of securities.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule changes will impose any burden on competition.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants or Others

The Exchange has reviewed drafts of various sections of the proposed rule text, and the concept of the new trading model, with various participants. Although some participants provided varying levels of input, the Exchange did not solicit, nor did it receive, written comments with respect to this final version of the proposed rule change.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Within 35 days of the date of publication of this notice in the **Federal Register** or within such longer period (i) As the Commission may designate up to 90 days of such date if it finds such longer period to be appropriate and publishes its reasons for so finding or (ii) as to which the Exchange consents, the Commission will:

(A) By order approve such proposed rule change, or

(B) Institute proceedings to determine whether the proposed rule change should be disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and

[158] The Exchange will file a proposal, nearer the effective date of the NMS Linkage Plan, to formally propose the deletion of these sections.

[159] The Exchange has updated the definition of "registered clearing agency" to confirm that it means a clearing agency which is registered with the Commission pursuant to the provisions of Section 17(A)(b)(2) of the Act or has obtained from the Commission an exemption from registration granted specifically to allow the clearing agency to provide confirmation and affirmation services. *See* CHX Article 21, Rule 1, Interpretation and Policy .01.

[160] This rule—and a related rule relating to book-entry settlement—currently are found in CHX Article XXII, Rule 3 and CHX Article XXI, Rule 4 of the Exchange's rules.

[161] *See* CHX Article 21, Rule 3 (formerly, CHX Article XXII, Rule 1). As a final matter, this provision would allow the Exchange to continue to provide services, including back-office clearing work, for participants. *See* CHX Article 21, Rule 4 (formerly, CHX Article XXI, Rule 13).

[162] The markings in this Article compare the text of CHX Article XXVIII against the proposed rule changes. The rules contained in current CHX Article XXI, which relates to the contracts, tickets and comparisons, would either be moved to other sections of the proposed new trading model rules (*e.g.*, CHX Article XXI, Rules 4 and 13 have been moved to CHX Article 22) or would be deleted in the new trading model because the issues covered by this provision are the subject of clearing depository rules or agreements between participants and their clearing firms and/or a clearing depository.

[163] *See* CHX Rule 23(a) (correcting the omission of the roman numeral "I"); Interpretations and Policies to Rule 23 (clarifying the work of market surveillance; deleting references to specialists; and correcting a telephone number); and CHX Rule 26 (eliminating references to the Exchange's trading floor).

[164] A few of these Articles contain rules for trading sessions that have been already discontinued. The Exchange, for example, is not conducting a secondary trading session under the rules set out in CHX Article XXXV and is not using the Chicago Match system described in CHX Article XXXVII. One Article, CHX Article XX, contains the rules relating to the Exchange's operation of its MAX trading system, which will be replaced with the new model's Matching System. Other Articles relate to special registration categories—such as those for odd-lot dealers (CHX Article XXXI) or specialists (CHX Article XXX)—which are not part of the new trading model. Moreover, the Exchange does not currently intend to permit special offerings (CHX Article XXIX) or use the Exchange Distribution Plan (CHX Article XXXII) or the basket rules (CHX Article XXXVI) in the new model. Finally, some of the Articles that the Exchange proposes to delete appear to be more related to clearing and settlement or to back office processes (CHX Articles XXIII (Reclamations), XV (Closing of Contracts) and XXVI (Marking to the Market) and less related to the Exchange's on-going role as a market.

[165] 15 U.S.C. 78f(b).

[166] 15 U.S.C. 78f(b)(5).

arguments concerning the foregoing, including whether the proposed rule change, as amended, is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an e-mail to *rule-comments@sec.gov*. Please include File Number SR–CHX–2006–05 on the subject line.

Paper Comments

- Send paper comments in triplicate to Nancy M. Morris, Secretary, Securities and Exchange Commission, 100 F Street, NE., Washington, DC 20549–1090.

All submissions should refer to File Number SR–CHX–2006–05. This file number should be included on the subject line if e-mail is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying in the Commission's Public Reference Room. Copies of the filing also will be available for inspection and copying at the principal office of the Exchange. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–CHX–2006–05 and should be submitted on or before September 8, 2006.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[167]

Nancy M. Morris,

Secretary.

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[167] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–54313; File No. SR–NASD–2006–099]

Self-Regulatory Organizations; National Association of Securities Dealers, Inc.; Notice of Filing and Immediate Effectiveness of Proposed Rule Change Relating to Amendments to Procedures for the Exercise of Options

August 14, 2006.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (the "Act"),[1] and Rule 19b–4 thereunder,[2] notice is hereby given that on August 10, 2006, the National Association of Securities Dealers, Inc. ("NASD") filed with the Securities and Exchange Commission ("Commission") the proposed rule change as described in Items I, II, and III below, which Items have been prepared by NASD. NASD filed the proposal as a "non-controversial" proposed rule change pursuant to Section 19(b)(3)(A) of the Act,[3] and Rule 19b–4(f)(6) thereunder,[4] which renders the proposal effective upon filing with the Commission.[5] The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

NASD proposes to amend Rule 2860(b)(23) (Tendering Procedures for Exercise of Options) to: (1) Simplify the manner in which a Contrary Exercise Advice ("CEA") is submitted; (2) extend by one hour the cut-off time by which members must submit CEA notices; (3) add procedures for exercising a standardized equity option when a modified close of trading is announced; and (4) consolidate all provisions pertaining to the exercise of standardized options contracts into Rule 2860(b)(23) instead of having additional and overlapping provisions in Rule 11850 (Tendering Procedures for Exercise of Options) as it currently the case. The text of the proposed rule change is available at NASD, at the Commission, and at *www.nasd.com*.

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] 15 U.S.C. 78s(b)(3)(A).

[4] 17 CFR 240.19b–4(f)(6).

[5] NASD gave the Commission written notice of its intent to file the proposed rule change on June 16, 2006. *See* Rule 19b–4(f)(6)(iii). 17 CFR 240.19b–4(f)(6)(iii).

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, NASD included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. NASD has prepared summaries, set forth in Sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

NASD proposes to amend Rule 2860(b)(23) (Tendering Procedures for Exercise of Options) to conform to recent changes of the substantially similar rules of the Options Exchanges.[6] The proposed rule change presents no novel issues.

The proposed rule change simplifies the manner in which a Contrary Exercise Advice ("CEA") is submitted, extends by one hour the cut-off time by which members must submit CEA notices, and adds procedures for exercising a standardized equity option when a modified close of trading is announced. The proposed rule change also consolidates all provisions pertaining to the exercise of standardized options contracts into Rule 2860(b)(23) instead of having additional and overlapping provisions in Rule 11850 (Tendering Procedures for Exercise of Options) as is currently the case.

The provisions in Rule 2860(b)(23) apply only to members that are not also members of the exchange on which the option is listed and traded, so-called "access firms."[7] Inasmuch as access firms are not members of an options exchange, it is necessary that the NASD rule subject such firms and customers of such firms to the same requirements for CEAs as customers and firms that are members of an options exchange.

Currently, Rule 2860(b)(23)(A) generally requires that members cannot accept instructions to exercise a

[6] *See* Rule 980 of the American Stock Exchange; Rule 1042 of the Philadelphia Stock Exchange; Rule 6.24 of the NYSE Arca (formerly the PCX); Rule 11.1 and related Regulatory Circulars RG03–41 and RG 03–54 of the Chicago Board Options Exchange; Rule 1100 of the International Securities Exchange; and Chapter VII Section 1 of the Boston Options Exchange (collectively referred to as the "Options Exchanges").

[7] *See* Rule 2860(b)(1)(A)(ii).

standardized option from the account of any customer or any other member after 5:30 p.m. Eastern Time ("ET") on the business day immediately prior to the expiration date of an option contract. Rule 2860(b)(23)(A) also provides for an exception to this exercise cut-off time for specified reasons. Rule 2860(b)(23)(B) requires that members maintain records for each exercise instruction. Additional procedures with respect to the exercise of standardized options contracts that are not included in Rule 2860 are provided in Rule 11850 of the Uniform Practice Code and address The Options Clearing Corporation's ("OCC") exercise-by-exception procedures ("Ex-by-Ex"). The Ex-by-Ex procedures set forth in OCC Rule 805 provide for the automatic exercise of certain options that are in-the-money by a specified amount. Under the Ex-by-Ex procedures, option holders holding an option contract that is in-the-money by a requisite amount and who wish to have their contracts automatically exercised need to take no further action.

However, under OCC Rule 805, option holders who do not want their options automatically exercised or who want their options to be exercised under different parameters than that of the Ex-by-Ex procedure must file a CEA with a national options exchange of which they are a member or where the equity option is listed in accordance with Rule 11850 and instruct the OCC of their "contrary intention." Rule 11850 is designed, in part, to deter individuals from taking improper advantage of late breaking news by requiring evidence of an options holder's intention to exercise or not exercise expiring equity options via the submission of a CEA. Members satisfy the filing requirement by manually submitting a CEA form or by electronically submitting the CEA through OCC's electronic communications system.

If the OCC has waived the Ex-by-Ex procedures for an options class, a member is still required to submit a CEA if the member wants to exercise a standardized equity option that would not have been automatically exercised, or not to exercise a standardized equity option that would have been automatically exercised, had the Ex-by-Ex procedure been in effect.

The Ex-by-Ex procedures contained in the rules of Options Exchanges have recently been amended.[8] In addition, the Options Exchanges' rules contain provisions for exercising an equity option in the event of a modified close of trading. NASD proposes to (1) amend its rules to conform to the changes to the similar rules of the Options Exchanges, and (2) consolidate the provisions pertaining to the procedures for exercising standardized options set forth in Rule 11850 into Rule 2860(b)(23).

Specifically, Rule 2860(b)(23)(A)(i) would be amended to mirror the provisions of Rule 11850(a)(1) and provide that members may establish fixed procedures as to the latest time they will accept exercise instructions from customers for tender to the OCC.

Rule 2860(b)(23)(A)(ii) would be amended to integrate the provisions of Rule 11850(b)(1)(A) regarding the cut-off time to submit final exercise decisions. In addition, to conform to the similar amendments to the rules of the Options Exchanges, NASD proposes to extend the cut-off time to 6:30 p.m. ET for members to submit CEAs for customer accounts. NASD further proposes to allow members to submit CEAs for non-customer accounts by 6:30 p.m. ET, but only if such member employs an electronic procedure with time stamp recording for the submission of exercise instructions by options holders. Members would have to establish fixed procedures to ensure secure time stamps in connection with the utilization of the electronic stamp provision. If a member does not employ an electronic time stamp and appropriate procedures to ensure secure time stamps, the member would have to submit CEAs for non-customer accounts by 5:30 p.m. ET.

NASD believes that granting members additional time to submit CEAs or Advice Cancels is necessary to address a concern that a 5:30 p.m. ET cut-off time is problematic for customer accounts due to logistical difficulties in the time required to receive customer exercise instructions, and, subsequently, to process them through retail branch systems and back offices before submitting them. NASD believes that extending the cut-off times for CEAs and Advice Cancels for non-customer accounts, if electronically time stamped, is fair and provides for consistent regulation. NASD does not propose to extend the submission cut-off time for members that manually submit CEA and Advice Cancels due to difficulties involved in monitoring manual procedures.

Rule 2860(b)(23)(A)(iii) would be amended to incorporate the provisions of Rule 11850(b)(1)(A) regarding the Ex-by-Ex procedures together with conforming language and definitional changes to harmonize the rule with the rules of the Options Exchanges.

A new subparagraph (iv) would be added to Rule 2860(b)(23)(A) to parallel the provisions of Rule 11850(b)(1)(B) for cases in which the Ex-by-Ex procedure has been waived. New subparagraph (iv) also would track the amended rules of the Options Exchanges that provide that no CEA is required to be filed if the option holder does not wish to exercise the expiring standardized equity option.

Rule 2860(b)(23)(A)(v) would provide (as currently provided in Rule 11850(b)(1)(C)) that members that maintain proprietary or public customer positions in expiring standardized equity options must take necessary steps to ensure that final exercise decisions are properly indicated to the relevant national options exchange with respect to such positions. In addition, members that have accepted the responsibility to indicate final exercise decisions on behalf of another member also must take necessary steps to ensure that such decisions are properly indicated to the relevant national options exchange.

Rule 2860(b)(23)(A)(vi) would retain the provision (as currently provided in Rule 2860(b)(23)(A)(ii) and Rule 11850(b)(2)) that would allow members to make final exercise decisions after the exercise cut-off time, but before expiration of the standardized equity option subject to the same exceptions as Rule 11850 currently provides which are also consistent with the rules of the Options Exchanges.[9] Rule 2860(b)(23)(B) would also retain the requirements for reporting and record keeping obligations when a member relies on these exceptions as amended by incorporating provisions from Rule 11850(b)(3).

NASD also proposes to add to Rule 2860 a similar provision as found in the rules of the Options Exchanges that address when an options exchange or the OCC establishes a different exercise cut-off time.[10] Specifically, proposed Rule 2860(b)(23)(A)(vii) would apply when a different or modified close of trading is announced. In such cases, the

[8] *See* Securities Exchange Act Release Nos. 47885 (May 16, 2003), 68 FR 28309 (May 23, 2003) (SR–AMEX–2001–92) (approval order); 48639 (October 16, 2003), 68 FR 60764 (October 23, 2003) (SR–PHLX–2003–65); 48640 (October 16, 2003), 68 FR 60757 (October 23, 2003) (SR–PCX–2003–47); 49275 (February 18, 2004), 69 FR 8713 (February 25, 2004) (SR–CBOE–2003–47); 48505 (September 17, 2003), 68 FR 55680 (September 26, 2003) (SR–ISE–2003–20); and 49191 (February 4, 2004), 69 FR 7055 (February 12, 2004) (SR–BSE–2004–04).

[9] *See* Securities Exchange Act Release No. 35389 (February 16, 1995) 60 FR 10135 (February 23, 1995) (SR–NASD–94–78) regarding the Commission's approval of NASD's deletion of the exemption in Rule 11850 that applies "in the case of options contracts carried in an account maintained for another member in which only positions of customers of such other member are carried" in order to conform to the rules of the Options Exchanges.

[10] *See supra* note 6.

option exchange or the OCC would have forewarning of the event and would be required to provide notice of the change in the exercise cut-off time by 5:30 p.m. ET on the business day prior to the last trading day before expiration. Under such circumstances, the deadline for making a final decision to exercise or not exercise would be 1 hour and 28 minutes following the time announced for the close of trading on that day. With respect to the submission of a CEA by members, the cut-off time would be 2 hours and 28 minutes after the close of trading for customer accounts and non-customer accounts where the member firm employs an electronic procedure with time stamp for the submission of exercise instructions. Members that do not employ an electronic submission procedure for exercise instructions would be required to submit a CEA within 1 hour and 28 minutes after the close of trading for its non-customer accounts.

Proposed subparagraphs (viii), (ix) and (x) of Rule 2860(b)(23)(A), wholly incorporate the provisions of Rule 11850(b)(4) through (6), respectively. As noted above, Rule 2860(b)(23)(B) requiring recordkeeping of instructions would be retained and amended by incorporating provisions from Rule 11850(b)(3).

Finally, paragraphs (C) and (D) of Rule 2860(b)(23) govern the allocation of exercise assignment notices and delivery and payment, respectively. Rule 11850(c) and (d) of the Uniform Practice Code have the same provisions as Rule 2860(b)(23) with regard to these provisions. Accordingly, these provisions are deleted from Rule 11850 as they are covered in Rule 2860(b)(23)(C) and (D).

NASD believes that the proposed rule change is necessary to provide its members that are not members of an options exchange with the same treatment as members of the Options Exchanges. Furthermore, as noted above, the proposed rule change will streamline and simplify the NASD rules as well as harmonize NASD's rule with those of the Options Exchanges.

NASD has filed the proposed rule change for immediate effectiveness. NASD will announce the implementation date of the proposed rule change in a *Notice to Members* to be published no later than 60 days following the filing of the rule change with the Commission for immediate effectiveness. The implementation date will be 30 days after the date of the *Notice to Members*.

2. Statutory Basis

NASD believes that the proposed rule change is consistent with the provisions of Section 15A(b)(6) of the Act,[11] which requires, among other things, that NASD rules be designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, and, in general, to protect investors and the public interest. NASD believes the proposed rule change will streamline and simplify NASD rules by consolidating overlapping provisions. In addition, NASD believes the proposed rule change will promote consistent regulation by harmonizing NASD's rule with those of the Options Exchanges.

B. Self-Regulatory Organization's Statement on Burden on Competition

NASD does not believe that the proposed rule change will result in any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants or Others

Written comments were neither solicited nor received.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Because the foregoing proposed rule change does not: (i) Significantly affect the protection of investors or the public interest; (ii) impose any significant burden on competition; and (iii) become operative for 30 days from the date on which it was filed, or such shorter time as the Commission may designate if consistent with the protection of investors and the public interest, the proposed rule change has become effective pursuant to Section 19(b)(3)(A) of the Act [12] and Rule 10b–4(f)(6) thereunder.[13]

At any time within 60 days of the filing of such proposed rule change, the Commission may summarily abrogate such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an e-mail to *rule-comments@sec.gov*. Please include File Number SR–NASD–2006–099 on the subject line.

Paper Comments

- Send paper comments in triplicate to Nancy M. Morris, Secretary, Securities and Exchange Commission, Station Place, 100 F Street, NE., Washington, DC 20549–1090.

All submissions should refer to File Number SR–NASD–2006–099. This file number should be included on the subject line if e-mail is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying in the Commission's Public Reference Room. Copies of such filing also will be available for inspection and copying at the principal office of the NASD. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–NASD–2006–099 and should be submitted on or before September 8, 2006.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[14]

Nancy M. Morris,

Secretary.

[FR Doc. E6–13639 Filed 8–17–06; 8:45 am]

BILLING CODE 8010–01–P

[11] 15 U.S.C. 78*o*–3(b)(6).

[12] 15 U.S.C. 78s(b)(3)(A).

[13] 17 CFR 240.19b–4(f)(6).

[14] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–54306; File No. SR–OCC–2006–05]

Self-Regulatory Organizations; The Options Clearing Corporation; Notice of Filing of a Proposed Rule Change Relating to Expiration Date Exercise Procedures

August 11, 2006.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 ("Act"),[1] notice is hereby given that on April 26, 2006, The Options Clearing Corporation ("OCC") filed with the Securities and Exchange Commission ("Commission") the proposed rule change as described in Items I, II, and III below, which items have been prepared primarily by OCC. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The proposed rule change would amend Rule 805, which describes expiration date exercise procedures including exercise by exception processing.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, OCC included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. OCC has prepared summaries, set forth in sections (A), (B), and (C) below, of the most significant aspects of such statements.[2]

(A) Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

The proposed rule change would amend Rule 805, Expiration Date Exercise Procedure, to reduce the threshold amounts used to determine the equity options that are in the money for purposes of exercise by exception processing. A conforming change would also be made to Rule 1106, Open Positions, which concerns the treatment of open positions following the suspension of a clearing member.

OCC has for years maintained an "exercise by exception" procedure. Under that procedure, options that are in the money at expiration by more than a specified threshold amount are exercised automatically unless the clearing member carrying the position instructs otherwise. Equity options are determined to be in the money or not based on the difference between the exercise price and the closing price of the underlying equity interest on the last trading day before expiration. In September 2004, in order to streamline expiration processing, OCC reduced the threshold amounts for equity options from $.75 to $.25 in a clearing member's customers' account and from $.25 to $.15 in any other account (*i.e.*, firm and market makers' accounts).[3] This change, which was implemented at the request of the OCC Roundtable,[4] immediately yielded significant benefits to both OCC and clearing members as the time for submitting exercise instructions was reduced by one to three hours on an average expiration weekend.

Increasing options volumes in 2004 and 2005 prompted the OCC Roundtable to review the thresholds applied to equity options in an effort to further reduce operational risks and improve expiration processing. Initially, the Roundtable proposed that the threshold for all account types be set at $.01, but an OCC survey of clearing members found that while 65% of responding clearing members supported this change, 35% were against it. A second OCC survey determined that 75% of responding clearing members were in favor of a threshold change to $.05 for all account types and 25% were opposed to it. The Roundtable then requested that OCC establish $.05 as the threshold applicable to equity options exercises for all account types.

In response to this request, OCC analyzed equity options exercise information from the June 2004 through December 2005 expirations. OCC's analysis determined that 70% of equity option contracts carried in clearing members' customers' accounts that were in the money by the amount of $.05 to $.24 (*i.e.*, the change in the "in-the-money" amount represented by the proposed threshold) were exercised. OCC's analysis also determined that exercise activity in other account ranges supported the proposed threshold change.

OCC surveyed all clearing members to obtain their views and comments on the proposed change to $.05 as the threshold amount for equity options for all account types. Survey results demonstrated strong support across the membership for the change. Eighty-seven clearing members[5] responded to the survey with sixty-five clearing members (75 percent) in favor of the threshold change and 22 clearing members (25 percent) opposed. Clearing members supporting the change confirmed the Roundtable's view that it would significantly reduce the number of instructions they are required to input on expiration thereby shortening the timeframe for completing instructions to OCC.

OCC contacted each firm that opposed the threshold change. These firms are generally mid-size to small retail clearing members. Their opposition to the change reflected their principal concern about having to input more "do not exercise" instructions. Some indicated concerns about the need to educate customers and the possibility that commission costs could make an exercise unprofitable.[6] However, all of these firms agreed that they could adapt to the change if supported by the majority of clearing members. OCC further reviewed the positions carried by these firms and determined that, on average, they carry positions in fewer than 10 expiring series per expiration that are below the current threshold of $.25. This review led OCC to conclude that the threshold change would result in only a slight increase in processing time for these firms and that they would not be unduly burdened by its implementation.

OCC's survey of clearing members also asked firms to provide an estimate of the time needed to accommodate the threshold change based upon supplied time frames (e.g., 0–3 months or 4–6 months). The majority of firms indicated that they could complete the necessary systems development and customer notifications within six months. OCC contacted every firm that commented on the proposed time frames, and all expressed the view that their efforts would be completed in the six month time period.

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[1] 15 U.S.C. 78s(b)(1).

[2] The Commission has modified parts of these statements.

[3] Securities Exchange Act Release No. 50178 (August 10, 2004), 69 FR 51343 (August 18, 2004) [File No. SR–OCC–2004–04].

[4] The OCC Roundtable is an OCC sponsored advisory group comprised of representatives from OCC's participant exchanges, OCC, a cross-section of OCC clearing members, and industry service bureaus. The Roundtable considers operational improvements that may be made to increase efficiencies and lower costs in the options industry.

[5] OCC contacted clearing members that did not respond to its survey. These firms expressed no opinion on the matter.

[6] As noted, clearing members are able to instruct OCC not to exercise an expiring equity option.

The Roundtable has recommended that this change be implemented for the October 2006 expiration. OCC therefore requests that the Commission approve the proposed rule change with an effective date of October 1, 2006, and that the Commission authorize OCC to implement the threshold change thereafter based upon its assessment of clearing member readiness. OCC would provide at least ten days advance notice to clearing members of the effective date for the new threshold amounts by information memoranda and other forms of electronic notice such as e-mail. Additionally, OCC would allow clearing members additional time to complete preparations for the threshold change if necessary.

OCC believes that the proposed rule change is consistent with Section 17A of the Act because it facilitates the prompt and accurate processing of exercise information on expiration.

(B) Self-Regulatory Organization's Statement on Burden on Competition

OCC does not believe that the proposed rule change would impose any burden on competition.

(C) Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

Written comments were not and are not intended to be solicited with respect to the proposed rule change, and none have been received.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Within 35 days of the date of publication of this notice in the **Federal Register** or within such longer period (i) as the Commission may designate up to 90 days of such date if it finds such longer period to be appropriate and publishes its reasons for so finding, or (ii) as to which the self-regulatory organization consents, the Commission will:

(A) By order approve the proposed rule change, or

(B) Institute proceedings to determine whether the proposed rule change should be disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*) or
- Send an e-mail to *rule-comments@sec.gov*. Please include File Number SR–OCC–2006–05 on the subject line.

Paper Comments

- Send paper comments in triplicate to Nancy M. Morris, Secretary, Securities and Exchange Commission, 100 F Street, NE., Washington, DC 20549–1090.

All submissions should refer to File Number SR–OCC–2006–05. This file number should be included on the subject line if e-mail is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying in the Commission's Public Reference Section, 100 F Street, NE., Washington, DC 20549. Copies of such filing also will be available for inspection and copying at the principal office of OCC and on OCC's Web site at *www.optionsclearing.com*. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–OCC–2006–05 and should be submitted on or before September 8, 2006.

For the Commission by the Division of Market Regulation, pursuant to delegated authority.[7]

Nancy M. Morris,

Secretary.

[ER Doc. E6–13616 Filed 8–17–06; 8:45 am]

BILLING CODE 8010–01–P

[7] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–54305; File No. SR–OCC–2006–11]

Self-Regulatory Organizations; The Options Clearing Corporation; Notice of Filing and Immediate Effectiveness of a Proposed Rule Change Relating to Quarterly Options

August 11, 2006.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 ("Act"),[1] notice is hereby given that on June 23, 2006, The Options Clearing Corporation ("OCC") filed with the Securities and Exchange Commission ("Commission") the proposed rule change as described in Items I, II, and III below, which items have been prepared primarily by OCC. OCC filed the proposed rule change pursuant to Section 19(b)(3)(A) of the Act[2] whereby the proposal was effective upon filing with the Commission. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The proposed rule change would amend OCC's By-Laws and Rules to accommodate "quarterly options" (*i.e.*, a series of options or index options that expires on the last business day of the calendar quarter) which have been proposed for trading by the International Securities Exchange ("ISE").

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, OCC included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. OCC has prepared summaries, set forth in sections (A), (B), and (C) below, of the most significant aspects of such statements.[3]

(A) Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

Quarterly options in general have the same terms as conventional options

[1] 15 U.S.C. 78s(b)(1).

[2] 15 U.S.C. 78s(b)(3)(A)(ii).

[3] The Commission has modified parts of these statements.

except that (a) quarterly options expire on the last business day of a calendar quarter and (b) all quarterly index options would be settled based on the level of the underlying index at the close on the day of exercise ("P.M. Settled") rather than the level of the index at the opening on that day ("A.M. Settled"). In addition, certain modifications in exercise procedures are necessary to accommodate the business day expiration of quarterly options.

Because of concerns with quoting capacity, ISE filed and the Commission has approved a proposed rule change that allows ISE to list quarterly options under a pilot program that is limited both in duration and in the number of classes of quarterly options that may trade.[4] Specifically, for an initial one-year period following the first trade date ("Pilot Period") ISE would list series of quarterly options in (a) up to five options classes already listed on ISE that are either (i) index options or (ii) options on exchange traded funds and (b) options classes that are selected by any other exchanges that list quarterly options under a similar pilot program. If ISE decides to continue to list quarterly options at the end of the Pilot Period, ISE would have to file an additional rule filing with the Commission as well as a pilot program report analyzing a variety of data, including the impact of the pilot program on the capacity of ISE, the Options Price Reporting Authority, and market data vendors. If ISE decides to cease listing quarterly options at the end of the Pilot Period or if the Commission were to refuse to approve a rule change permitting quarterly options to continue to trade, ISE would not list any additional series and would permit only closing transactions in open series.

ISE notes in its filing that there is a risk of confusion with respect to quarterly options series and other options in the same class. The risk of confusion is lessened with respect to conventional options because those options cannot expire in the same week as quarterly options. However, short term options, which are one-week options that normally are listed on a Friday and expire on the next following Friday, could expire on the same day as quarterly options. In order to lessen the likelihood of confusion with respect to short term options and quarterly options in the same class, ISE will not list a series of short term options if that series would expire on the same date as a series of quarterly options in the same class.[5] Because of their differing expiration dates, quarterly options are not be fungible with conventional options or short term options.

Because quarterly options differ from conventional options and short term options only in their expiration date, the P.M. settlement feature of quarterly index options, and other modifications relating to business day expiration, quarterly options can be cleared and settled by OCC with relatively minor revisions to OCC's By-Laws and Rules. A new defined term for "quarterly options" is added to Article I of the By-Laws, and the definition of "expiration date" in that Article is amended to clarify that quarterly options do not expire on the same date as conventional options. Rules 801 and 805 are amended to include quarterly options among the exceptions to the general rule that options may not be exercised on the business day before their expiration date. Rules 801 and 1804 are amended to provide for the automatic exercise of quarterly index options when those options are in-the-money by a specified amount. Finally, a reference in Article XVII to "quarterly index expiration options" or "QIX," which are no longer traded, has been removed to avoid confusion. A conforming reference to short term options has been added to Rule 801(b) to provide clarity that such options on indexes are subject to automatic exercise, as presently provided in Rule 1804(c).

OCC believes that the proposed rule change is consistent with the purposes and requirements of Section 17A of the Act because it is designed to promote the prompt and accurate clearance and settlement of securities transactions, to foster cooperation and coordination with persons engaged in the clearance and settlement of securities transactions, to remove impediments to and perfect the mechanism of a national system for the prompt and accurate clearance and settlement of securities transactions, and, in general, to protect investors and the public interest. The proposed changes promote these objectives by applying to quarterly options the same basic governing principles that are applicable to other classes of options. The proposed changes are not inconsistent with the existing By-Laws and rules of OCC, including those proposed to be amended.

(B) Self-Regulatory Organization's Statement on Burden on Competition

OCC does not believe that the proposed rule change would impose any burden on competition.

(C) Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

Written comments were not and are not intended to be solicited with respect to the proposed rule change, and none have been received.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

The foregoing rule change has become effective pursuant to Section 19(b)(3)(A)(iii) of the Act[6] and Rule 19b–4(f)(4)[7] promulgated thereunder because the proposal effects a change in an existing service of OCC that (A) does not adversely affect the safeguarding of securities or funds in the custody or control of OCC or for which it is responsible and (B) does not significantly affect the respective rights or obligations of OCC or persons using the service. At any time within sixty days of the filing of the proposed rule change, the Commission may summarily abrogate such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form *(http://www.sec.gov/rules/sro.shtml)* or
- Send an e-mail to *rule-comments@sec.gov*. Please include File Number SR–OCC–2006–11 on the subject line.

Paper Comments

- Send paper comments in triplicate to Nancy M. Morris, Secretary, Securities and Exchange Commission, 100 F Street, NE., Washington, DC 20549–1090.

All submissions should refer to File Number SR–OCC–2006–11. This file

[4] Securities Exchange Act Release Nos. 53857 (June 1, 2006), 71 FR 31246 (May 24, 2006) and 54113 (July 7, 2006), 71 FR 39694 (July 13, 2006) [File No. SR–ISE–2006–24].

[5] Supplementary Material .02(b) to ISE Rule 2009.

[6] 15 U.S.C. 78s(b)(3)(A)(iii).

[7] 17 CFR 240.19b–4(f)(4).

number should be included on the subject line if e-mail is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site *(http://www.sec.gov/rules/sro.shtml)*. Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying in the Commission's Public Reference Section, 100 F Street, NE., Washington, DC 20549. Copies of such filing also will be available for inspection and copying at the principal office of OCC and on OCC's Web site at *www.optionsclearing.com*.

All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–OCC–2006–11 and should be submitted on or before September 8, 2006.

For the Commission by the Division of Market Regulation, pursuant to delegated authority.[8]

Nancy M. Morris,

Secretary.

[FR Doc. E6–13617 Filed 8–17–06; 8:45 am]

BILLING CODE 8010–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–54312; File No. SR–Phlx–2006–28]

Self-Regulatory Organizations; Philadelphia Stock Exchange, Inc.; Notice of Filing and Immediate Effectiveness of Proposed Rule Change and Amendments No. 1, 2, and 3 Thereto Relating to the Deletion of Obsolete Provisions from Exchange Rules

August 14, 2006.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 ("Act")[1], and Rule 19b–4[2] thereunder, notice is hereby given that on April 28, 2006, the Philadelphia Stock Exchange, Inc. ("Phlx" or "Exchange") filed with the Securities and Exchange Commission ("Commission") the proposed rule change as described in Items I and II below, which Items have been prepared by the Phlx. On June 15, 2006, July 19, 2006, and August 10, 2006, the Exchange filed Amendments No. 1,[3] 2,[4] and 3,[5] respectively. The Exchange has designated the proposed rule change, as amended, as constituting a non-controversial rule change under Rule 19b–4(f)(6) under the Act,[6] which renders the proposal effective upon filing with the Commission. The Commission is publishing this notice to solicit comments on the proposed rule change, as amended, from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Phlx proposes to amend various Exchange rules to delete obsolete provisions relating to trading systems and practices that are no longer in effect on the Exchange, particularly as the new options system, Phlx XL, replaced the old "AUTO–X" provisions.[7] The text of the proposed rule change, as amended, is available on the Exchange's Web site at *http://www.phlx.com*, at the Exchange's Office of the Secretary, and the Commission's Public Reference Room.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the Phlx included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. The Phlx has prepared summaries, set forth in Sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

The purpose of the proposed rule change is to delete provisions in the Exchange's rules that no longer apply because of technological advancements or obsolete trading practices. Specifically, the following amendments are proposed:

Quotation Size: The Phlx XL rules originally provided in Exchange Rule 1014(b) that electronic quotations submitted on Phlx XL could be submitted with a quotation size of fewer than 10 contracts for a specific period of time following the initial deployment of Phlx XL. The maximum time period during which such a quotation size was permitted was one year following the deployment of Phlx XL, after which all electronic quotations submitted on Phlx XL had to be for a size of at least 10 contracts. Because it has been more than one year since the initial deployment of Phlx XL, the rule is now obsolete. Quotations submitted on Phlx XL currently must have a size of at least 10 contracts. Additionally, quotations made by non-SQT ROTs in open outcry in response to a request for a market were originally permitted to quote with a size fewer than 10 contracts during this period. Non-SQT ROTs must now provide such quotations with a size of at least 10 contracts.

Continuous Open Outcry Quoting Obligation: Currently, Exchange Rule 1014(b)(ii)(E)(1)(C) describes the open outcry quoting obligation applicable to non-SQT ROTs in response to a request for a quote by a Floor Broker, specialist, Floor Official, or other ROT (including an SQT). The Exchange proposes to delete the portion of the rule that describes the minimum quote size for such a quotation during various phases of the rollout of Phlx XL. Because Phlx XL is now deployed floor-wide, and the rollout periods described in the rule have all expired, that portion of the rule is no longer necessary.

Definition of "Remainder of the Order": Currently, Exchange Rule 1014(g)(i)(A)(1) defines "Remainder of the Order" as, respecting non-Streaming Quote Options, the portion of an Initiating Order that remains following the allocation of contracts to customers that are on parity in accordance with Rule 1014(g)(i). The term "Remainder of the Order" is used in the Exchange's rules concerning the allocation of

[8] 17 CFR 200.30–3(a)(12).

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] Amendment No. 1 replaced the original filing in its entirety.

[4] Amendment No. 2 replaced the original filing and Amendment No. 1 in their entirety.

[5] Amendment No. 3 made clarifying changes to the rule text by retaining a description of Auto-X and clarifying that the term Auto-X is currently applied to include Book Match and Book Sweep in the Exchange's rules, including those rules concerning the engagement and disengagement of Auto-X.

[6] 17 CFR 240.19b–4(f)(6).

[7] In July 2004, the Exchange began trading equity options on Phlx XL, followed by index options in December 2004. Phlx XL was completely rolled out by February 2005, such that all options are now "Streaming Quote Options." *See* Securities Exchange Act Release No. 50100 (July 27, 2004), 69 FR 46612 (August 3, 2004) (SR–Phlx–2003–59).

contracts traded in open outcry and allocated in the crowd.[8] During the rollout period of Phlx XL, some options traded as "Streaming Quote Options" on the Phlx XL platform, while others continued to trade as "non-Streaming Quote Options." Currently, all options traded on the Exchange are traded on Phlx XL as "Streaming Quote Options." Exchange Rule 1014(g)(i)(A)(1) originally contemplated that non-Streaming Quote Options would generally be traded and allocated in open outcry. Thus, now that there are no longer any non-Streaming Quote Options, the Exchange proposes to amend Exchange Rule 1014(g)(i)(A)(1) such that the definition of "Remainder of the Order," in that sub-paragraph would apply only to transactions that are executed and allocated in open outcry by a participant other than the specialist.[9]

The term "Remainder of the Order" also appears in Exchange Rule 1014(g)(i)(A)(2) respecting orders that are executed manually by the specialist. Because the specialist is responsible as agent for limit orders on the limit order book, Exchange Rule 1014(g)(i)(A)(2) requires the specialist to allocate to customer orders, and next to off-floor broker-dealer limit order first. "Remainder of the Order" in this situation means the portion of the initiating order that after the specialist makes such an allocation. The Exchange is proposing a corresponding amendment to Options Floor Procedure Advice ("OFPA") B–6, Priority of Options Orders for Equity Options and Index Options by Account Type.

ROT Access: Prior to the deployment of Phlx XL, Exchange specialists and ROTs were permitted to submit price improving limit orders onto the limit order book electronically in non-Streaming Quote options. Specialists and ROTs that submitted such price-improving limit orders were entitled to receive a special allocation. The program, known as "ROT Access" and codified in Exchange Rule 1014(g)(i)(B), applied to options that did not trade on Phlx XL because it was, before Phlx XL, the only way for ROTs to enter trading interest independently and electronically. Currently, all options traded on the Exchange are traded on Phlx XL, thus obviating the need for ROT Access.[10]

Exchange Rule 1014(g)(i)(B) is therefore proposed to be deleted. The introductory phrase "[r]especting Streaming Quote Options" in Exchange Rule 1014(g)(i)(A)(2) and the caption "Assignment in Streaming Quote Options" in Exchange Rule 1014 Commentary .05(b) are deleted as unnecessary because all equity and index options now trade as Streaming Quote Options.

During the development and deployment of Phlx XL, the Exchange adopted Commentary .04 to Exchange Rule 1080, which among other things describes when Phlx XL would be deployed following Commission approval of the rules applicable to Phlx XL, and actions to be taken by the Exchange in the event that Phlx XL was not deployed for all options trading on the Exchange by April 30, 2005. Because Phlx XL was deployed for all options trading on the Exchange prior to April 30, 2005, these portions of Commentary .04 are moot and thus proposed to be deleted.

Assignment in Non-Streaming Quote Options: Exchange Rule 1014, Commentary .05(a) currently describes assignments in non-Streaming Quote Options. Because all options on the exchange currently trade on Phlx XL (and thus there are no non-Streaming Quote Options), Exchange Rule 1014, Commentary .05(a) is proposed to be deleted.

AUTO-X: Exchange Rule 1080(c) currently includes references to the antiquated notion of an artificial "AUTO-X guarantee" and a minimum and maximum guaranteed AUTO-X size. Because the Exchange's Phlx XL automatic execution features (Book Match [11] and Book Sweep [12]) currently provide for automatic executions up to the disseminated size (for which the responsible brokers or dealers that are quoting are firm), there is no longer an artificial "AUTO-X guarantee" for which the Exchange will provide automatic executions. Therefore, the Exchange proposes to delete the relevant sections of Rule 1080(c) discussing an artificial AUTO-X guarantee. In addition, the Options Committee's ability to restrict the use of AUTO-X and increase the size of eligible orders is being deleted, as automatic execution processes, Book Match and Book Sweep, are described in other parts of the rule.

Exchange Rule 1080(c)(iii)(A) currently describes the Exchange's "Book Sweep" automatic execution and Wheel allocation functionality respecting non-Streaming Quote Options. Because there are no longer any non-Streaming Quote Options and the Wheel is obsolete, the Exchange proposes to delete the current text of Exchange Rule 1080(c)(iii)(A). The current text of Exchange Rule 1080(c)(iii)(B) respecting the Book Sweep functionality applicable to Streaming Quote Options, which are allocated automatically pursuant to Exchange Rule 1014(g)(vii), and not on the "Wheel," would be retained and renumbered accordingly.

The Wheel: Prior to the floor-wide deployment of Phlx XL, contra-side participation for AUTO–X automatic execution in non-Streaming Quote Options rotated among Wheel participants (the specialist and ROTs signed onto the Wheel) in accordance with Exchange Rule 1080(g)(i)(A). Trades executed on the Wheel were allocated in accordance with the algorithm set forth in OFPA F–24. Because all options on the Exchange are traded on Phlx XL, and because the Wheel is no longer in use in the Exchange's trading system, Exchange Rule 1080(g)(i)(A) and OFPA F–24 are proposed to be deleted.

Additionally, Exchange Rule 1080(g)(i) currently provides that the contra-side to automatically executed orders may be a Wheel Participant. There are no longer any Wheel Participants on the Exchange; therefore the Exchange proposes to amend Exchange Rule 1080(g)(i) to provide that the contra-side to automatically executed orders may be an electronic quotation,[13] which reflects the current

[8] *See* Exchange Rule 1014(g)(v).

[9] The Exchange notes that both Streaming Quote Options and Non-Streaming Quote Options have been executed in open outcry since the initial deployment of Phlx XL.

[10] The Exchange notes that the proposed rule change would not affect the ability of a non-SQT ROT (*i.e.*, an on-floor Exchange ROT that does not submit electronic quotes) to place limit orders onto the limit order book via electronic interface.

[11] Book Match is an automatic execution feature of the Exchange's systems that automatically executes inbound marketable orders against limit orders on the book or specialist, RSQT and/or SQT electronic quotes ("electronic quotes") at the disseminated price where: (1) The Exchange's disseminated size includes limit orders on the book and/or electronic quotes at the disseminated price; and (2) the disseminated price is the National Best Bid or Offer. *See* Exchange Rule 1080(g)(i)(B).

[12] Book Sweep is an automatic execution feature of the Exchange's systems that, respecting non-Streaming Quote Options, allowed certain orders resting on the limit order book to be automatically executed when the bid or offer generated by the Exchange's system or by the specialist's proprietary quoting system locks (*i.e.*, $1.00 bid, $1.00 offer) or crosses (*i.e.*, $1.05 bid, $1.00 offer) the Exchange's best bid or offer in a particular series as established by an order on the limit order book. Orders in non-Streaming Quote Options executed by the Book Sweep feature were allocated among crowd participants participating on the Wheel. Book Sweep is being retained for Streaming Quote Options. *See* Exchange Rule 1080(c)(iii). Telephone conversation between Richard Rudolph, Vice President and Counsel, Exchange, and Terri Evans, Special Counsel, Division, Commission, on August 9, 2006 (clarifying that Book Sweep is being retained).

[13] *See supra* note 10.

system that has been in place for Streaming Quote Options since the deployment of Phlx XL. Finally, for accuracy, the Exchange proposes to delete the reference to AUTO–X from the title of Exchange Rule 1080(g).

Collective Crowd Quote/Firm Quotations: Exchange Rule 1080, Commentary .01(b)(ii) currently provides that, respecting non-Streaming Quote Options, specialists determine which model to select per option and may change models during the trading day, and that the specialist may, but is not required to (a) consult with and/or (b) agree with the trading crowd in setting these parameters or selecting a model, but the members of the trading crowd are not required to provide input in these decisions, and in all cases, the specialist has the responsibility and authority to make the final determination. Because all options on the Exchange trade on Phlx XL, and each Phlx XL participant submits independent quotations, the rule is obsolete and is proposed to be modified.[14]

Exchange Rule 1080, Commentary .01(c) states that with respect to non-Streaming Quote Options, the disseminated market (whether by Auto-Quote or specialized quote feed) is deemed to represent the quotations of all ROTs in that option unless a ROT has expressly indicated otherwise in a clear and audible manner, respecting either a specific series, the class or the option (specifying LEAPS), and with sufficient time for the specialist to take action to update the quote if necessary. Because there are no longer any non-Streaming Quote Options and there is no collective quote (rather, there are independent quotations), the Exchange proposes to modify Exchange Rule 1080, Commentary .01, to reflect that specialists, SQTs and RSQTs submit individual quotations. For the same reason, a similar modification concerning a collective quoting requirement is proposed to Exchange Rule 1082.

Disseminated Size: Exchange Rule 1082(a)(ii)(A) defines "disseminated size" as it applies to non-Streaming Quote Options. Because there are no longer any non-Streaming Quote Options, Exchange Rule 1082(a)(ii)(A) is proposed to be deleted. The phrase "[w]ith respect to non-Streaming Quote Options" is deleted from Exchange Rule 1082(b)(i) as obsolete.[15] The introductory phrases "respecting Streaming Quote Options" and "[w]ith respect to Streaming Quote Options" are deleted from Exchange Rule 1082(a)(ii)(B) and Exchange Rule 1082(b)(ii) respectively as unnecessary, since all equity and index options are now Streaming Quote Options.

The Exchange is proposing a corresponding amendment to OFPA F–7, Size of Exchange's Disseminated Bid or Offer.

Firm Quote Rule Citation: Exchange Rule 1082(a)(iii) currently provides that the term "SEC Quote Rule" shall mean Rule 11Ac1–1 under the Securities Exchange Act of 1934, as amended (the "Act"). Recently, Regulation NMS under the Act was promulgated, and the SEC Quote Rule was re-designated as Rule 602 of Regulation NMS.[16] The proposal would amend Rule 1082(a)(iii) accordingly.

Specified Disengagement Size: Commentary .07 to Exchange Rule 1080 contains references to the "specified disengagement size" that applied to the Exchange's "rapid fire" mechanism prior to the deployment of Phlx XL. Because that "rapid fire" program no longer exists and has been replaced with Exchange Rule 1093, Phlx XL Risk Monitor Mechanism,[17] Commentary .07 is proposed to be deleted.

2. Statutory Basis

The Exchange believes that its proposal is consistent with Section 6(b) of the Act,[18] in general, and furthers the objectives of Section 6(b)(5) of the Act,[19] in particular, in that it is designed to promote just and equitable principles of trade, to remove impediments to and perfect the mechanism of a free and open market and a national market system, and, in general, to protect investors and the public interest, by removing rule provisions which have become obsolete due to changes in technology, trading practices, or other changes that make such provisions obsolete. According to the Exchange, eliminating the obsolete provisions is in the public interest because it will eliminate possible confusion regarding the Exchange's current practices.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change will impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

Written comments were neither solicited nor received.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Because the foregoing rule change: (1) Does not significantly affect the protection of investors or the public interest; (2) does not impose any significant burden on competition; and (3) does not become operative for 30 days from the date on which it was filed, or such shorter time as the Commission may designate if consistent with the protection of investors and the public interest, the proposed rule change has become effective pursuant to Section 19(b)(3)(A) of the Act[20] and Rule 19b–4(f)(6) thereunder.[21]

The Exchange has requested that the Commission waive the 5-day pre-filing notice requirement[22] and the 30-day operative delay. The Commission has determined to waive the 5-day pre-filing notice requirement. Also, the Commission, consistent with the protection of investors and the public interest, has determined to waive the 30-day operative delay to allow the deletion of obsolete or unnecessary rules to take effect immediately, which should allow the Exchange to immediately reflect the currently applicable rules in its rule book. Accordingly, the Commission designates the proposal to be effective and operative upon filing with the Commission.[23] At any time within 60 days of the filing of such proposed rule change, the Commission may summarily abrogate such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors,

[14] Telephone conversation between Richard Rudolph, Vice President and Counsel, Exchange, and Terri Evans, Special Counsel, Division, Commission, on August 9, 2006 (clarifying that the rule is being modified and not deleted).

[15] The remaining text of Exchange Rule 1082(b) concerning the firm quote obligations of a responsible broker or dealer acting as agent on behalf of a limit order would be retained, since Floor Brokers still may represent limit orders in the crowd and would be the "responsible broker or dealer" in that situation.

[16] 17 CFR 242.602.

[17] *See* Securities Exchange Act Release No. 53166 (January 23, 2006) 71 FR 4625 (January 27, 2006) (SR–Phlx–2006–05).

[18] 15 U.S.C. 78f(b).

[19] 15 U.S.C. 78f(b)(5).

[20] 15 U.S.C. 78s(b)(3)(A).

[21] 17 CFR 240.19b–4(f)(6).

[22] Telephone conversation between Richard Rudolph, Vice President and Counsel, Exchange, and Terri Evans, Special Counsel, Division, Commission, on August 9, 2006.

[23] For purposes of waiving the operative date of this proposal, the Commission has considered the proposed rule's impact on efficiency, competition, and capital formation. 15 U.S.C. 78c(f).

or otherwise in furtherance of the purposes of the Act.[24]

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change, as amended, is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an e-mail to *rule-comments@sec.gov*. Please include File Number SR–Phlx–2006–28 on the subject line.

Paper Comments

- Send paper comments in triplicate to Nancy M. Morris, Secretary, Securities and Exchange Commission, 100 F Street, NE., Washington, DC 20549–1090.

All submissions should refer to File Number SR–Phlx–2006–28. This file number should be included on the subject line if e-mail is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change, as amended, that are filed with the Commission, and all written communications relating to the proposed rule change, as amended, between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying in the Commission's Public Reference Room. Copies of the filing also will be available for inspection and copying at the principal office of the Phlx. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–Phlx–2006–28 and should be submitted on or before September 8, 2006.

[24] For purposes of calculating the 60-day abrogation period, the Commission considers the proposed rule change, as amended, to have been filed on August 10, 2006, when Amendment No. 3 was filed.

[25] 17 CFR 200.30–3(a)(12).

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[25]

Nancy M. Morris,

Secretary.

[FR Doc. E6–13640 Filed 8–17–06; 8:45 am]

BILLING CODE 8010–01–P

SMALL BUSINESS ADMINISTRATION

[Disaster Declaration # 10565]

Alaska Disaster # AK–00005

AGENCY: U.S. Small Business Administration.

ACTION: Notice.

SUMMARY: This is a Notice of the Presidential declaration of a major disaster for Public Assistance Only for the State of Alaska (FEMA–1657–DR), dated 08/04/2006.

Incident: Snow melt and ice jam flooding.

Incident Period: 05/13/2006 through 05/30/2006.

Effective Date: 08/04/2006.

Physical Loan Application Deadline Date: 10/03/2006.

ADDRESSES: Submit completed loan applications to: U.S. Small Business Administration, National Processing and Disbursement Center, 14925 Kingsport Road, Fort Worth, TX 76155.

FOR FURTHER INFORMATION CONTACT: A. Escobar, Office of Disaster Assistance, U.S. Small Business Administration, 409 3rd Street, SW., Suite 6050, Washington, DC 20416.

SUPPLEMENTARY INFORMATION: Notice is hereby given that as a result of the President's major disaster declaration on 08/04/2006, applications for Private Non-Profit organizations that provide essential services of a governmental nature may file disaster loan applications at the address listed above or other locally announced locations.

The following areas have been determined to be adversely affected by the disaster:

Primary Areas: Lower Kuskokwim Regional Education Attendance Area, Lower Yukon Regional Education Attendance Area, Yukon-Koyukuk Regional Education Attendance Area.

The Interest Rates are:

	Percent
Other (including non-profit organizations) with credit available elsewhere	5.000
Businesses and non-profit organizations without credit available elsewhere	4.000

The number assigned to this disaster for physical damage is 10565.

(Catalog of Federal Domestic Assistance Number 59008).

Roger B. Garland,

Acting Associate Administrator for Disaster Assistance.

[FR Doc. E6–13645 Filed 8–17–06; 8:45 am]

BILLING CODE 8025–01–P

SMALL BUSINESS ADMINISTRATION

[Disaster Declaration #10557 and #10558]

Ohio Disaster Number OH–00007

AGENCY: U.S. Small Business Administration.

ACTION: Amendment 1.

SUMMARY: This is an amendment of the Presidential declaration of a major disaster for the State of Ohio (FEMA–1656–DR), dated 08/01/2006.

Incident: Severe Storms, Straight Line Winds, and Flooding.

Incident Period: 07/27/2006 and continuing through 08/04/2006.

Effective Date: 08/04/2006.

Physical Loan Application Deadline Date: 10/02/2006.

Eidl Loan Application Deadline Date: 05/01/2007.

ADDRESSES: Submit completed loan applications to: U.S. Small Business Administration, National Processing And Disbursement Center, 14925 Kingsport Road, Fort Worth, TX 76155.

FOR FURTHER INFORMATION CONTACT: A. Escobar, Office of Disaster Assistance, U.S. Small Business Administration, 409 3rd Street, SW., Suite 6050, Washington, DC 20416.

SUPPLEMENTARY INFORMATION: The notice of the President's major disaster declaration for the State of Ohio, dated 08/01/2006, is hereby amended to establish the incident period for this disaster as beginning 07/27/2006 and continuing through 08/04/2006.

All other information in the original declaration remains unchanged.

(Catalog of Federal Domestic Assistance Numbers 59002 and 59008)

Roger B. Garland,

Acting Associate Administrator for Disaster Assistance.

[FR Doc. E6–13646 Filed 8–17–06; 8:45 am]

BILLING CODE 8025–01–P

SMALL BUSINESS ADMINISTRATION

National Advisory Council; Public Meeting

The U.S. Small Business Administration (SBA) National

Advisory Council (NAC) will hold a public meeting on Thursday, September 7, 2006. The meeting will be held at the Wyndham New Orleans, Canal Place, 100 Rue Iberville, New Orleans, LA 70130. The purpose of the meeting is for the NAC members to provide expert advice, ideas and opinions on SBA programs and small business issues and discuss recent updates pertaining to the delivery of the Agency's programs and services. Information will be presented by members of the council or interested others.

Anyone wishing to attend or participate must contact Balbina Caldwell in writing, phone or e-mail, to be added to the agenda. Balbina Caldwell, Director, National Advisory Council, SBA Headquarters, 409 3rd Street SW., Washington DC 20416, phone (202) 205–6914, e-mail: *balbina.caldwell@sba.gov.*

For more information about the National Advisory Council, see our Web site at *http://www.sba.gov/nac/index.html.*

Sincerely,

Stephen D. Kong,

Acting General Counsel.

[FR Doc. E6–13650 Filed 8–17–06; 8:45 am]

BILLING CODE 8025–01–P

SMALL BUSINESS ADMINISTRATION

National Small Business Development Center Advisory Board; Public Meeting

The U.S. Small Business Administration (SBA), National Small Business Development Center (SBDC) Advisory Board will be hosting a public annual meeting on Thursday, September 14, 2006. The meeting will be held at the Hilton Americas Hotel, 1600 Lamar Street, Room 203, Houston, Texas 77011.

The purpose of the meeting is to introduce our new board members and to discuss Advisory Board matters that may be presented by members and the staff of the SBA. Anyone wishing to attend the meeting must contact Erika Fischer, Senior Program Analyst, U.S. Small Business Administration, Office of Small Business Development Centers, 409 3rd Street, SW., Washington, DC 20416, telephone (202) 205–7045 or fax (202) 481–0681.

Stephen D. Kong,

Acting General Counsel.

[FR Doc. E6–13644 Filed 8–17–06; 8:45 am]

BILLING CODE 8025–01–P

DEPARTMENT OF STATE

[Public Notice 5407]

Shipping Coordinating Committee; Notice of Meeting

The Shipping Coordinating Committee (SHC) will conduct an open meeting at 10 a.m. on Tuesday, August 29, 2006, in Room 4236 of the Department of Transportation Headquarters, 400 Seventh Street, SW., Washington, DC 20590–0001. The primary purpose of the meeting is to prepare for the Eleventh Session of the International Maritime Organization (IMO) Sub-Committee on Dangerous Goods, Solid Cargoes and Containers to be held at the International Coffee Organization Headquarters in London, England from September 11 to September 15, 2006.

The primary matters to be considered include:

—Amendments to the International Maritime Dangerous Goods (IMDG) Code and Supplements including harmonization of the IMDG Code with the United Nations Recommendations on the Transport of Dangerous Goods.
—Amendments to the Code of Safe Practice for Solid Bulk Cargoes (BC Code) including evaluation of properties of solid bulk cargos and mandatory application of the BC Code.
—Casualty and incident reports and analysis.
—Measures to enhance maritime security.
—Guidance on serious structural deficiencies in containers; reporting procedure on serious structural deficiencies.
—Review of the Code of Safety for Special Purpose Ships (SPS Code).
—Amendments to the Code of Safe Practice for Cargo Stowage and Securing (CSS Code).
—Revision of the guidelines for the Transport and Handling of Limited Amounts of Hazardous and Noxious Liquid Substances in Bulk on Offshore Support Vessels (LHNS) and the guidelines for the Design and Construction of Offshore Supply Vessels (OSV).
—Extension of the Code of Practice for the Safe Unloading and Loading of Bulk Carriers (BLU Code) to include grain.
—Guidance on providing safe working conditions for securing of containers.
—Review of the Recommendations on the Safe Use of Pesticides in Ships.
—Application of requirements for dangerous goods in packaged form in SOLAS and the 2000 High Speed Craft (HSC) Code.

Members of the public may attend the meeting up to the seating capacity of the room. Interested persons may seek information by writing: Mr. R.C. Bornhorst, U.S. Coast Guard (G–PSO–3), Room 1210, 2100 Second Street, SW., Washington, DC 20593–0001 or by calling (202) 372–1426.

Dated: August 9, 2006.

Margaret Hayes,

Executive Secretary, Shipping Coordinating Committee, Department of State.

[FR Doc. E6–13679 Filed 8–17–06; 8:45 am]

BILLING CODE 4710–09–P

DEPARTMENT OF STATE

[Public Notice 5425]

Shipping Coordinating Committee; Notice of Meeting

The Shipping Coordinating Committee (SHC) will conduct an open meeting at 9:30 a.m. on Tuesday, October 3, 2006, in Room 2415 of the United States Coast Guard Headquarters Building, 2100 2nd Street, SW., Washington, DC 20593–0001. The primary purpose of the meeting is to prepare for the 55th Session of the International Maritime Organization (IMO) Marine Environment Protection Committee (MEPC) to be held at IMO, Central Hall Westminster in London, England from October 9th to 13th, 2006.

The primary matters to be considered include:

—Harmful aquatic organisms in ballast water;
—Recycling of ships;
—Prevention of air pollution from ships;
—Consideration and adoption of amendments to mandatory instruments;
—Interpretation and amendments of MARPOL 73/78 and related instruments;
—Implementation of the International Convention on Oil Pollution Preparedness, Response and Cooperation (OPRC) Convention and the OPRC-Hazardous Noxious Substance (OPRC–HNS) Protocol and relevant conference resolutions;
—Identification and protection of Special Areas and Particularly Sensitive Sea Areas;
—Inadequacy of reception facilities;
—Reports of sub-committees;
—Work of other bodies;
—Status of Conventions;
—Harmful anti-fouling systems for ships;
—Promotion of implementation and enforcement of MARPOL 73/78 and related instruments;
—Follow-up to United Nations Conference on Environment and

Development (UNCED) and World Summit on Sustainable Development (WSSD);
—Technical co-operation programme;
—Future role of formal safety assessment and human element issues;
—Work program of the Committee and subsidiary bodies;
—Application of the Committees' Guidelines; and
—Consideration of the report of the Committee.

Please note that hard copies of documents associated with MEPC 55 will not be available at this meeting. Documents will be available in Adobe Acrobat format on CD–ROM. To request documents please write to the address provided below, or request documents via the following Internet link: *http://www.uscg.mil/hq/g-m/mso/MOMEPC.htm.*

Members of the public may attend this meeting up to the seating capacity of the room. Interested persons may seek information by writing to Lieutenant Heather St. Pierre, Commandant (G–PSO–4), U.S. Coast Guard Headquarters, 2100 Second Street, SW., Room 1601, Washington, DC 20593–0001 or by calling (202) 372–1432.

Dated: August 9, 2006.

Margaret Hayes,

Executive Secretary, Shipping Coordinating Committee, Department of State.

[FR Doc. E6–13681 Filed 8–17–06; 8:45 am]

BILLING CODE 4710–09–P

DEPARTMENT OF STATE

[Public Notice 5456]

Shipping Coordinating Committee; Notice of Meeting

The Working Group on Radiocommunications and Search and Rescue (COMSAR) of the Subcommittee on Safety of Life at Sea (SOLAS) will conduct open meetings at 9:30 a.m. on Thursday, October 5, November 9, December 7, 2006 and January 4, February 8, 2007. The meetings will be held in suite 1060 of the Radio Technical Commission for Maritime Services (RTCM), 1800 North Kent Street, Arlington, VA 22209. This meeting is to prepare for the Eleventh Session of the International Maritime Organization (IMO) SOLAS COMSAR Sub-Committee scheduled for the week of February 19–23, 2007 in London, England.

Members of the public may attend these meetings up to the seating capacity of the rooms. Interested persons may seek information, including meeting room numbers, by writing: Mr. Russell S. Levin, U.S. Coast Guard Headquarters, Commandant (CG–622), Jemal Building Room JR10–1216, 1900 Half Street, SW., Washington, DC 20593 or by sending Internet electronic mail to *rlevin@comdt.uscg.mil.*

Dated: August 9, 2006.

Margaret Hayes,

Executive Secretary, Shipping Coordinating Committee, Department of State.

[FR Doc. E6–13682 Filed 8–17–06; 8:45 am]

BILLING CODE 4710–09–P

DEPARTMENT OF STATE

[Public Notice 5517]

Receipt of Application for a Permit for Pipeline Facilities To Be Constructed and Maintained on the Borders of the United States

AGENCY: Department of State.

The Department of State has received an application from TransCanada Keystone Pipeline, LP ("Keystone") for a Presidential permit, pursuant to Executive Order 11423 of August 16, 1968, as amended by Executive Order 12847 of May 17, 1993, and Executive Order 13284 of January 23, 2003 to construct, connect, operate, and maintain the Keystone Pipeline Project at the U.S.-Canadian border at Cavalier County, North Dakota, for the purpose of transporting Canadian crude oil production from the Western Canadian Sedimentary Basin ("WCSB") to existing terminals in Missouri, Illinois, and potentially, Oklahoma.

TransCanada Keystone Pipeline, LP, is a limited liability company, organized under the laws of the State of Delaware. Keystone is a wholly-owned subsidiary of TransCanada Oil Pipelines Inc., a Delaware Corporation, with its principal office located at 450 1st Street, SW., Calgary, Alberta, Canada, T2P 5H1. The proposed new pipeline would consist in the U.S. of 1,018 miles of 30-inch diameter pipeline and 55 miles of 24-inch diameter pipeline ("Keystone Mainline") from the U.S.-Canadian border at Cavalier County, North Dakota, to Patoka, Illinois. If the extension to Cushing, Oklahoma ("Cushing Extension") is constructed, it will consist of an additional 291 miles of 30-inch pipeline for a total of 1365 miles of pipeline. In Canada, the project would involve the sale to Keystone of an existing 530 mile, 34-inch diameter natural gas transmission pipeline currently owned by TransCanada Limited and conversion of that line to crude oil service. In addition, Keystone will construct 230 miles of pipeline from Hardisty to the converted line and an additional 62 miles of pipeline from the converted line to the U.S. border.

As required by E.O. 13337, the Department of State is circulating this application to concerned Federal agencies for comment.

DATES: Interested parties are invited to submit, in duplicate, comments relative to this proposal on or before September 18, 2006 to Elizabeth Orlando, Office of Environmental Policy, Department of State, Washington, DC 20520. The application and related documents that are part of the record to be considered by the Department of State in connection with this application are available for inspection in the Office of Environmental Policy during normal business hours.

FOR FURTHER INFORMATION CONTACT: Elizabeth Orlando, Office of Environmental Policy, Department of State, Washington, DC 20520, telephone 202–647–4284, facsimile 202–647–1052, E-mail *orlandoea2@state.gov.*

Dated: August 14, 2006.

John Thompson,

Acting Director, Office of Environmental Policy, U.S. Department of State.

[FR Doc. E6–13626 Filed 8–17–06; 8:45 am]

BILLING CODE 4710–07–P

DEPARTMENT OF TRANSPORTATION

Federal Highway Administration

Environmental Impact Statement; Smith County, TX

AGENCY: Federal Highway Administration (FHWA), DOT.

ACTION: Notice of intent.

SUMMARY: The FHWA is issuing this notice to advise the public that an environmental impact statement (EIS) will be prepared for the proposed U.S. Highway (U.S.) 69/Loop 49 North Lindale Reliever Route (LRR) project in Smith County, Texas.

FOR FURTHER INFORMATION CONTACT: Donald E. Davis, District Engineer, Federal Highway Administration—Texas Division, 300 E. 8th Street, Austin, Texas 78701, Telephone: 512–536–5960.

SUPPLEMENTARY INFORMATION: The FHWA, in cooperation with the Texas Department of Transportation (TxDOT), will prepare an environmental impact statement (EIS) for a proposal to construct a Lindale Reliever Route in Smith County, Texas. The proposed improvement would involve construction of a new location roadway

from the planned Loop 49 West/IH 20 interchange to connect with the existing U.S. 69 north of the City of Lindale, a roadway distance of approximately 5–6 miles.

The proposed Lindale Reliever Route would serve as a connector between Loop 49 and U.S. 69 and address safety, mobility, connectivity and capacity needs.

Alternatives under consideration include (1) taking no action (the no-build alternative), (2) constructing a proposed Lindale Reliever Route facility built to current highway standards, and (3) improvements to existing highways. The proposed facility will be evaluated as a toll road project. A Feasibility Study prepared in 2001 evaluated four corridor alternatives along new location right-of-way and a No-Build alternative, resulting in the identification of a recommended study corridor. Subsequent public involvement opportunities have identified additional study corridors. Evaluation of a reasonable number of alignment alternatives will be documented in the EIS, as well as the no-build and existing highway improvement alternatives, based on input from federal, state, and local agencies, as well as private organizations and concerned citizens.

The EIS will evaluate potential impacts from construction and operation of the proposed roadway including, but not limited to, the following: Impacts to residences and businesses, including potential relocations and displacements; transportation impacts (construction detours, construction traffic, and mobility improvement); air and noise impacts from construction equipment and operation of the roadway; social and economic impacts; impacts to cultural resources; water quality impacts from construction and roadway runoff; impacts related to tolling; and impacts to waters of the U.S. including wetlands from right-of-way encroachment.

Correspondence describing the proposed project and soliciting comments will be sent to appropriate federal, state, and local agencies, and to private organizations and citizens who have previously expressed interest in the proposal. TxDOT completed a Feasibility Study for the project in May 2001. In conjunction with the Feasibility Study, TxDOT developed a steering committee, provided project information at two public meetings, and met with interested stakeholders. An agency scoping meeting is anticipated to be held by TxDOT in September 2006 to coordinate and solicit agency representatives' input on project plans including the purpose and need and the range of alternatives, introduce project team members, obtain comments pertaining to the scope of the EIS, identify important issues, set goals, develop project schedule, and respond to questions. A continuing public involvement program will include a project mailing list, project newsletters, a public scoping meeting (public notice will be given of the time and place), and numerous informal meetings with interested citizens and stakeholders. In addition, a public hearing will be held after the publication of the Draft EIS. Public notice will be given of the time and place of the hearing. The Draft EIS will be available for public and agency review and comment prior to the public hearing.

To ensure that the full range of issues related to this proposed action are addressed and all significant issues identified, comments and suggestions are invited from all interested parties. Comments or questions concerning this proposed action and the EIS should be directed to the FHWA at the address provided above.

(Catalog of Federal Domestic Assistance Program Number 20.205, Highway Research Planning and Construction. The regulations implementing Executive Order 12373 regarding intergovernmental consultation on Federal programs and activities apply to this program.)

Donald E. Davis,

District Engineer.

[FR Doc. 06–7012 Filed 8–17–06; 8:45 am]

BILLING CODE 4910–22–M

DEPARTMENT OF TRANSPORTATION

Federal Railroad Administration

Adoption of Environmental Impact Statement, Participation in a Section 106 Programmatic Agreement, and Notice of Availability of Section 4(f)/303 Statement

AGENCY: Federal Railroad Administration (FRA), Department of Transportation (DOT).

ACTION: Adoption and Recirculation of Final Environmental Impact Statement and Final Supplemental Environmental Impact Statement; Participation as a Concurring Party to a Section 106 Programmatic Agreement; and Notice of Availability of a Draft Section 4(f)/303 Statement.

SUMMARY: FRA is issuing this notice to advise the public and interested agencies that FRA has decided to adopt the Environmental Impact Statement (EIS) and Supplemental Environmental Impact Statement (SEIS) issued by the Surface Transportation Board (STB) for construction and operation of a new rail line and related improvements by the Dakota, Minnesota and Eastern Railroad Corporation (DM&E). Under applicable regulations, FRA is allowed to adopt and recirculate the STB's Final EIS and Final SEIS as its own, since FRA's proposed action is substantially the same as the action covered by the STB's EISs. The FRA further announces the availability of a draft Section 4(f)/303 Statement prepared for the Project by the FRA pursuant to Section 4(f) of the Department of Transportation Act (49 U.S.C. § 303(c)). The draft Section 4(f)/303 Statement and STB's EISs are available and comments may be submitted as indicated below.

This project, known as the Powder River Basin Expansion Project (Project), would involve construction of approximately 280 miles of new rail line to reach the coal mines of Wyoming's Powder River Basin and reconstruction of another approximately 600 miles of DM&E's existing rail line that would allow operation of unit coal trains along the reconstructed route to and from the new line. The Project takes place in the States of Minnesota, South Dakota and Wyoming. The DM&E has applied to the FRA for a $2.3 billion loan under the Railroad Rehabilitation and Improvement Financing (RRIF) program to finance the Project.

DATES: Submit comments on the Final EIS, Final SEIS, or the draft Section 4(f)/303 Statement no later than October 10, 2006 to David Valenstein, Environmental Program Manager, at the address listed below.

ADDRESSES: The EIS documents and the draft Section 4(f)/303 Statement can be inspected at the FRA office at the address listed below. The draft Section 4(f)/303 Statement may be obtained from the FRA Web site at *http://www.fra.dot.gov* or by contacting the FRA. Additionally, the STB's Draft EIS, Final EIS, Draft SEIS and Final SEIS are available in electronic format on the STB Web site at *http://www.stb.dot.gov* under Environmental Matters, Key Cases, DM&E Links and one or more of the EISs may be viewed in 70 libraries in the Project area as listed on FRA's Web site.

FOR FURTHER INFORMATION CONTACT: David Valenstein, Environmental Program Manager; 1120 Vermont Avenue, NW.; Mail Stop 20; Washington, DC 20590; Phone (202) 493–6368.

SUPPLEMENTARY INFORMATION: The DM&E filed an application in 1998 with the STB for authority to construct and

operate the Project, which would involve construction of approximately 280 miles of new rail line to reach the coal mines of Wyoming's Powder River Basin. *See* STB Finance Docket No. 33407. Reconstruction of another approximately 600 miles of DM&E's existing rail lines would be required in conjunction with the new line construction to allow operation of unit coal trains along the reconstructed route to and from the new line. STB's National Environmental Policy Act (NEPA) review considered the impacts of both the new line construction and existing line reconstruction. The STB's Section of Environmental Analysis (SEA) prepared a Draft Environmental Impact Statement (DEIS) for the Project on September 27, 2000, provided a comment period from October 6, 2000 to March 6, 2001, and prepared a Final EIS on November 19, 2001. After litigation challenging the adequacy of the EIS, the court remanded the case back to the STB. *Mid States Coalition for Progress* v. *Surface Transportation Board*, 345 F.3d 520 (8th Cir. 2003). The STB subsequently issued a Draft SEIS on April 15, 2005, and a Final SEIS on December 30, 2005. On February 15, 2006, the STB issued a decision approving the construction and operation of the proposed project, subject to various environmental conditions and oversight. The STB issued the above-mentioned EISs with assistance from the following five cooperating agencies which had jurisdiction over various aspects of the Project: The U.S. Department of Agriculture, Forest Service; the U.S. Department of Interior, Bureau of Land Management; the U.S. Army Corps of Engineers; the U.S. Department of Interior, Bureau of Reclamation; and the U.S. Coast Guard. The FRA was not a cooperating agency because it had no involvement or jurisdiction over any aspect of the Project at that time.

Amendments to the RRIF program adopted in section 9003 of the Safe Accountable, Flexible, Efficient Transportation Equity Act: A Legacy for Users (Pub. L. 109–59, 119 Stat 1144) expanded the scope of the RRIF program and made other changes to the underlying statute and implementing regulations which, when taken together, made possible the DM&E RRIF application to finance the Project. The DM&E originally submitted a preliminary application for RRIF financing in late 2005 that contained several components, including the construction of a new rail line into the Powder River Basin (PRB), and the rehabilitation of several segments of its existing system. However, that application was subsequently replaced by two separate applications, one in February, 2006 for the PRB construction and another in March, 2006 for some rehabilitation work necessary for the west end of the DM&E rail system independent of the PRB project. Provision of a loan to the DM&E under the RRIF program requires FRA compliance with the requirements of the NEPA, Section 4(f) of the Department of Transportation Act, 49 U.S.C. 303(c), and FRA's Environmental Procedures [64 FR 28545, 28522 at § 12 (May 6, 1999)], see also 49 CFR 260.35.

FRA has conducted an independent review of the EIS and SEIS for the purpose of determining whether FRA could adopt these documents pursuant to 40 CFR 1506.3. FRA's review concluded that the action encompassed by the DM&E RRIF application is substantially the same as the action documented in the EIS and SEIS, that the EIS and SEIS adequately assess the environmental impacts associated with the Project and meet the standards of the Council on Environmental Quality (CEQ) NEPA Regulation (40 CFR parts 1500–1508), and that the EIS and SEIS can be adopted by the FRA. CEQ's regulations implementing NEPA strongly encourage agencies to reduce paperwork and duplication, 40 CFR 1500.4. One of the methods identified by CEQ to accomplish this goal is adopting the environmental documents prepared by other agencies in appropriate circumstances, 40 CFR 1500.4(n), 1500.5(h), and 1506.3. In instances where the actions covered by the original environmental impact statement and the proposed action are substantially the same, the agency adopting another agency's statement is not required to recirculate it except as a final statement, 40 CFR 1506.3(b).

In accordance with the Environmental Protection Agency's (EPA) requirements regarding the filing of EISs, FRA has provided the EPA with a notice of adoption and five copies of the STB's Final EIS and Final SEIS. EPA will publish a notice of availability of the Final EIS and SEIS in the **Federal Register** consistent with its usual practices. Because of the multi-volume size of the FEIS and SEIS and its continued availability in libraries in the affected States and on the STB's Web site, FRA is not republishing the document on its own. This would be costly, defeat CEQ's goals of reducing paperwork and duplication of effort, and be of little or no additional value to other agencies or the public. FRA has mailed a notification of FRA's adoption and where the EISs are available to persons and parties of record who have participated in the most recent phase of STB's EIS process.

Because the STB's EIS for the Project did not include an evaluation pursuant to Section 4(f) of the Department of Transportation Act (49 U.S.C. § 303(c)), the FRA, with assistance from an independent contractor, has prepared a separate draft Section 4(f)/303 Statement consistent with FRA procedures and posted it on FRA's Web site (*http://www.fra.dot.gov*). Comments on the draft section 4(f)/303 Statement may be forwarded to the FRA at the address listed above.

In adopting the STB EIS and issuing a draft 4(f)/303 Statement, the FRA finds that FRA's undertaking under Section 106 of the National Historic Preservation Act is substantially the same as the undertaking addressed by the STB and consequently FRA seeks to join, as a concurring party, the March 2003 Programmatic Agreement (PA) agreed to pursuant to Section 106 for the Project and included in the Draft SEIS as Appendix D. The PA was developed and executed by the STB, the DM&E, the Advisory Council on Historic Preservation, State Historic Preservation Officers, and other invited signatories in the affected States to coordinate additional evaluation and consultation regarding historic and cultural resources. FRA agrees with the area of potential effects, the level of effort for identification of historic properties, and the procedures to be followed for treatment of affected historic properties outlined in the PA. By joining as a concurring party, the FRA would be better able to require the applicant to comply with the PA as a condition of the FRA loan and permit continued FRA involvement in future decisions regarding historic resources should the FRA decide to approve the loan.

Accordingly, FRA has adopted the STB EIS and SEIS, is recirculating the Final EIS and Final SEIS, is seeking to join the PA, and has concluded that no supplement or additional environmental review beyond the Section 4(f)/303 Statement referenced herein is required to support the FRA's proposed action. FRA anticipates that a final Section 4(f)/303 Statement and Record of Decision will be issued after October 10, 2006.

Issued in Washington, DC on August 10, 2006.

Joseph H. Boardman,

Federal Railroad Administrator.

[FR Doc. E6–13531 Filed 8–17–06; 8:45 am]

BILLING CODE 4910–06–P

DEPARTMENT OF THE TREASURY

Submission for OMB Review; Comment Request

August 10, 2006.

The Department of the Treasury has submitted the following public information collection requirement(s) to OMB for review and clearance under the Paperwork Reduction Act of 1995, Public Law 104–13. Copies of the submission(s) may be obtained by calling the Treasury Bureau Clearance Officer listed. Comments regarding this information collection should be addressed to the OMB reviewer listed and to the Treasury Department Clearance Officer, Department of the Treasury, Room 11000, 1750 Pennsylvania Avenue, NW., Washington, DC 20220.

Dates: Written comments should be received on or before September 18, 2006 to be assured of consideration.

Internal Revenue Service (IRS)

OMB Number: 1545–0940.

Type of Review: Extension.

Title: Election of $10 Million Limitation on Exempt Small Issues of Industrial Development Bonds; Supplemental Capital Expenditure Statements.

Description: The regulation liberalizes the procedure by which the State or local government issuer of an exempt small issue of tax-exempt bonds elects the $10 million limitation upon the size of such issue and deletes the requirement to file certain supplemental capital expenditure statements.

Respondents: State, local, or tribal governments.

Estimated Total Burden Hours: 1,000 hours.

OMB Number: 1545–0217.

Type of Review: Extension.

Title: Possessions Corporation Tax Credit (Under Sections 936 and 30A), and Schedule P, Allocation of Income and Expenses Under Section 936(h)(5).

Form: 5735.

Description: Form 5735 is used to compute the possessions tax credit under sections 936 & 30A. Schedule P is used by corporations that elect to share the income or expenses with their affiliates. Each form provides the IRS with information to determine if the corporations have correctly computed the tax credit and the cost-share or profit-split method.

Respondents: Business and other for-profit institutions.

Estimated Total Burden Hours: 33,818 hours.

OMB Number: 1545–1816.

Type of Review: Extension.

Title: Disclosure of Returns and Return Information to Designee of Taxpayer.

Description: Regulation section 301.6103(c)–1 generally authorizes the IRS and its agents to disclose returns and return information to such person or persons as the taxpayer may designate in a written request for or consent to disclosure, or to any other person at the taxpayer's written or nonwritten request to the extent necessary to comply with a request for information or assistance made by the taxpayer to such other person. The regulation requires a taxpayer who wishes to authorize disclosure of his or her returns or return information to provide the IRS or its agents with certain information, such as information identifying.

Respondents: Individuals or Households.

Estimated Total Burden Hours: 800 hours.

OMB Number: 1545–1432.

Type of Review: Extension.

Title: Voluntary Customer Surveys to Implement E.O. 12862 Coordinated by the Corporate Planning and Performance Division on Behalf of All IRS Operations Functions.

Description: This is a generic clearance for an undefined number of customer satisfaction and opinion surveys and focus group interviews to be conducted over the next three years. Surveys and focus groups conducted under the generic clearance are used by the Internal Revenue Service to determine levels of customer satisfaction as well as determining issues that contribute to customer burden. This information will be used to make quality improvements to products and services.

Respondents: Business and other for-profit institutions.

Estimated Total Burden Hours: 50,000 hours.

OMB Number: 1545–1833.

Type of Review: Extension.

Title: Revenue Procedure 2003–37, Documentation Provisions for Certain Taxpayers Using the Fair Market Value Method of Interest Expense Apportionment.

Description: Revenue Procedure 2003–37 describes documentation and information a taxpayer that uses the fair market value method of apportionment of interest expense may prepare and make available to the Service upon request in order to establish the fair market value of the taxpayer's assets to the satisfaction of the Commissioner as required by Sec. 1.861–9T(g)(1)(iii). It also sets forth the procedures to be followed in the case of elections to use the fair market value method.

Respondents: Business and other for-profit institutions.

Estimated Total Burden Hours: 625 hours.

OMB Number: 1545–1190.

Type of Review: Extension.

Title: Like-Kind Exchanges.

Form: 8824.

Description: Form 8824 is used by individuals, partnerships, and other entities to report the exchange of business or investment property, and the deferral of gains from such transactions under section 1031. It is also used to report the deferral of gain under section 1043 by members of the executive branch of the Federal government.

Respondents: Individuals or households.

Estimated Total Burden Hours: 834,979 hours.

OMB Number: 1545–1069.

Type of Review: Extension.

Title: Certain Cash or Deferred Arrangements and Employee and Matching Contributions under Employee Plans: REG–108639–99 (NPRM) Retirement Plans; Cash or Deferred Arrangements.

Form: 8824.

Description: The IRS needs this information to insure compliance with sections 401(k), 401(m), and 4979 of the Internal Revenue Code. Certain additional taxes may be imposed if sections 401(k) and 401(m) are not complied with.

Respondents: Businesses or other for-profit institutions.

Estimated Total Burden Hours: 1,060,000 hours.

OMB Number: 1545–1020.

Type of Review: Extension.

Title: Allocation of Estimated Tax Payments to Beneficiaries.

Form: 1041–T.

Description: This form was developed to allow a trustee of a trust or an executor of an estate to make an election under IRC section 643(g) to allocate any payment of estimated tax to a beneficiary(ies). This form serves as a transmittal so that Service Center personnel can determine the correct amounts that are to be transferred from the fiduciary's account to the individual's account.

Respondents: Business or other for-profit institutions.

Estimated Total Burden Hours: 990 hours.

Clearance Officer: Glenn P. Kirkland, (202) 622–3428, Internal Revenue Service, Room 6516, 1111 Constitution Avenue, NW., Washington, DC 20224.

OMB Reviewer: Alexander T. Hunt, (202) 395–7316, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503.

Robert Dahl,

Treasury PRA Clearance Officer.

[FR Doc. E6–13610 Filed 8–17–06; 8:45 am]

BILLING CODE 4830–01–P

DEPARTMENT OF THE TREASURY

Submission for OMB Review; Comment Request

August 14, 2006.

The Department of Treasury has submitted the following public information collection requirement(s) to OMB for review and clearance under the Paperwork Reduction Act of 1995, Public Law 104–13. Copies of the submission(s) may be obtained by calling the Treasury Bureau Clearance Officer listed. Comments regarding this information collection should be addressed to the OMB reviewer listed and to the Treasury Department Clearance Officer, Department of the Treasury, Room 11000, 1750 Pennsylvania Avenue, NW., Washington, DC 20220.

Dates: Written comments should be received on or before September 18, 2006 to be assured of consideration.

Internal Revenue Service (IRS)

OMB Number: 1545–1556.

Type of Review: Extension.

Title: Source of Income From Sales of Inventory Partly From Sources Within a Possession of the United States; Also, Source of Income Derived From Certain Purchases From a Corporation Electing Section 936.

Description: The information requested in section 1.863–3(f)(6) is necessary for the Service to audit taxpayers' return to ensure taxpayers are properly determining the source of their income.

Respondents: Businesses or other for-profit institutions.

Estimated Total Burden Hours: 500 hours.

OMB Number: 1545–0976.

Type of Review: Extension.

Title: Estimated Tax on Unrelated Business Taxable Income for Tax-Exempt Organizations.

Form: 990–W.

Description: Form 990–W is used by tax-exempt trusts and tax-exempt corporations to figure estimated tax liability on unrelated business income and on investment income for private foundations and the amount of each installment payment. Form 990–W is a worksheet only. It is not required to be filed.

Respondents: Business and other for-profit institutions, and not-for-profit institutions.

Estimated Total Burden Hours: 387,392 hours.

OMB Number: 1545–0950.

Type of Review: Extension.

Title: Application for Enrollment To Practice Before the Internal Revenue Service.

Form: 23.

Description: Form 23 must be completed by those who desire to be enrolled to practice before the Internal Revenue Service. The information on the form will be used by the Director of Practice to determine the qualifications and eligibility of applicants for enrollment.

Respondents: Individuals or Households.

Estimated Total Burden Hours: 2,400 hours.

OMB Number: 1545–1444.

Type of Review: Revision.

Title: Empowerment Zone Employment Credit.

Form: 8844.

Description: Employers who hire employees who live and work in one of the 11 designated empowerment zones can receive a tax credit for the first $15,000 of wages paid to each employee. The credit is applicable from the date of designation through the year 2004.

Respondents: Individuals or Households.

Estimated Total Burden Hours: 365,904 hours.

OMB Number: 1545–1844.

Type of Review: Extension.

Title: Agreement To Mediate.

Form: 13369.

Description: Fast Track Mediation is a dispute resolution process designed to expedite case resolution. In order to avail themselves of this process, taxpayers and Compliance must complete the Agreement to Mediate once an examination or collection determination is made. Once signed by both parties, the Agreement to Mediate will be forwarded to Appeals to schedule a mediation session.

Respondents: Individuals or Households.

Estimated Total Burden Hours: 15 hours.

OMB Number: 1545–1690.

Type of Review: Extension.

Title: Notice 2000–28 Coal Exports.

Description: Notice 2000–28 provides guidance relating to the coal excise tax imposed by section 4121 of the Internal Revenue Code. The notice provides rules under the Code for making a nontaxable sale of coal for export or for obtaining a credit or refund when tax has been paid with respect to a nontaxable sale or coal for export.

Respondents: Business and other for-profit institutions.

Estimated Total Burden Hours: 400 hours.

OMB Number: 1545–0129.

Type of Review: Extension.

Title: U.S. Income Tax Return for Certain Political Organizations.

Form: 1120–POL.

Description: Certain political organizations file Form 1120–POL to report the tax imposed by section 527. The form is used to designate a principal business campaign committee that is subject to a lower rate of tax under section 527(h). IRS uses Form 1120–POL to determine if the proper tax was paid.

Respondents: Not-for-profit institutions.

Estimated Total Burden Hours: 239,150 hours.

OMB Number: 1545–0175.

Type of Review: Extension.

Title: Alternative Minimum Tax-Corporations.

Form: 4626.

Description: Form 4626 is used by corporations to calculate their alternative minimum tax.

Respondents: Businesses and other for-profit institutions.

Estimated Total Burden Hours: 2,596,800 hours.

Clearance Officer:

Glenn P. Kirkland, (202) 622–3428, Internal Revenue Service, Room 6516, 1111 Constitution Avenue, NW., Washington, DC 20224.

OMB Reviewer: Alexander T. Hunt, (202) 395–7316, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503.

Robert Dahl,

Treasury PRA Clearance Officer.

[FR Doc. E6–13612 Filed 8–17–06; 8:45 am],

BILLING CODE 4830–01–P

DEPARTMENT OF THE TREASURY

Open Meeting of the Financial Literacy and Education Commission

AGENCY: Departmental Offices, Treasury.

ACTION: Notice of open meeting.

SUMMARY: This notice announces a meeting of the Financial Literacy and Education Commission, established by the Financial Literacy and Education

Improvement Act (Title V of the Fair and Accurate Credit Transactions Act of 2003).

DATES: The ninth meeting of the Financial Literacy and Education Commission will be held on Tuesday, September 19, 2006, beginning at 2 p.m.

ADDRESSES: The Financial Literacy and Education Commission meeting will be held in the Cash Room at the Department of the Treasury, located at 1500 Pennsylvania Avenue, NW., Washington, DC. To be admitted to the Treasury building, attendees must RSVP by providing his or her name, organization, phone number, date of birth, Social Security number, and country of citizenship to the Department of the Treasury by e-mail at: *FLECrsvp@do.treas.gov*, or by telephone at: (202) 622–1783 (not a toll-free number) not later than 5 p.m. on Wednesday, September 13, 2006.

FOR FURTHER INFORMATION CONTACT: For additional information, contact Tom Kurek by e-mail at: *thomas.kurek@do.treas.gov* or by telephone at (202) 622–5770 (not a toll free number). Additional information regarding the Financial Literacy and Education Commission and the Department of the Treasury's Office of Financial Education may be obtained through the Office of Financial Education's Web site at: *http://www.treas.gov/financialeducation*.

SUPPLEMENTARY INFORMATION: The Financial Literacy and Education Improvement Act, which is Title V of the Fair and Accurate Credit Transactions Act of 2003 (the "FACT Act") (Pub. L. 108–159), established the Financial Literacy and Education Commission (the "Commission") to improve financial literacy and education of persons in the United States. The Commission is composed of the Secretary of the Treasury and the head of the Office of the Comptroller of the Currency; the Office of Thrift Supervision; the Federal Reserve; the Federal Deposit Insurance Corporation; the National Credit Union Administration; the Securities and Exchange Commission; the Departments of Education, Agriculture, Defense, Health and Human Services, Housing and Urban Development, Labor, and Veterans Affairs; the Federal Trade Commission; the General Services Administration; the Small Business Administration; the Social Security Administration; the Commodity Futures Trading Commission; and the Office of Personnel Management. The Commission is required to hold meetings that are open to the public every four months, with its first meeting occurring within 60 days of the enactment of the FACT Act. The FACT Act was enacted on December 4, 2003.

The ninth meeting of the Commission, which will be open to the public, will be held in the Cash Room at the Department of the Treasury, located at 1500 Pennsylvania Avenue, NW., Washington, DC. The room will accommodate 80 members of the public. Seating is available on a first-come basis. Participation in the discussion at the meeting will be limited to Commission members, their staffs, and special guest presenters.

Dated: August 9, 2006.

Dan Iannicola, Jr.,

Deputy Assistant Secretary for Financial Education.

[FR Doc. E6–13638 Filed 8–17–06; 8:45 am]

BILLING CODE 4810–37–P

DEPARTMENT OF THE TREASURY

Office of Thrift Supervision

Submission for OMB Review; Comment Request—Thrift Financial Report: Schedule DI

AGENCY: Office of Thrift Supervision (OTS), Treasury.

ACTION: Notice and request for comment.

SUMMARY: In accordance with the requirements of the Paperwork Reduction Act of 1995 (44 U.S.C. 3507), OTS may not conduct or sponsor, and the respondent is not required to respond to, an information collection unless it displays a currently valid OMB control number. On April 28, 2006, OTS requested public comment for 60 days (71 FR 25282) on proposed revisions to the Thrift Financial Report (TFR), which is currently an approved collection of information. The notice described regulatory reporting revisions proposed for the TFR: Schedule DI—Consolidated Deposit Information to become effective September 30, 2006, primarily in response to the increased levels of deposit insurance from $100,000 to $250,000 for retirement accounts provided by the Federal Deposit Insurance Corporation ("FDIC") Board of Directors on March 14, 2006, in interim rules effective April 1, 2006 (71 FR 14629), implementing certain provisions of the Federal Deposit Insurance Reform Act of 2005, ("Reform Act") (Pub. L. 109–171).

After considering the comments received, OTS has adopted the proposed revisions, with the exception of one proposed line item deletion, and is setting the effective date for the revisions at December 31, 2006. OTS is submitting the adopted revisions to OMB for review and approval.

DATES: Submit written comments on or before September 18, 2006. The regulatory reporting revisions described herein take effect December 31, 2006.

ADDRESSES: Send comments, referring to the collection by "1550–0023 (TFR Revisions—December 2006)", to OMB and OTS at these addresses: Office of Information and Regulatory Affairs, Attention: Desk Officer for OTS, U.S. Office of Management and Budget, 725—17th Street, NW., Room 10235, Washington, DC 20503, or by fax to (202) 395–6974; and Information Collection Comments, Chief Counsel's Office, Office of Thrift Supervision, 1700 G Street, NW., Washington, DC 20552, by fax to (202) 906–6518, or by e-mail to *infocollection.comments@ots.treas.gov*. OTS will post comments and the related index on the OTS Internet Site at *www.ots.treas.gov*. In addition, interested persons may inspect comments at the Public Reading Room, 1700 G Street, NW., by appointment. To make an appointment, call (202) 906–5922, send an e-mail to *public.info@ots.treas.gov*, or send a facsimile transmission to (202) 906–7755.

FOR FURTHER INFORMATION CONTACT: For further information or to obtain a copy of the submission to OMB, please contact Marilyn K. Burton, OTS Clearance Officer, at *marilyn.burton@ots.treas.gov*, (202) 906–6467, or facsimile number (202) 906–6518, Litigation Division, Chief Counsel's Office, Office of Thrift Supervision, 1700 G Street, NW., Washington, DC 20552.

You can obtain a copy of the December 2006 Thrift Financial Report form from the OTS Web site at *http://www.ots.treas.gov* or you may request it by electronic mail from *tfr.instructions@ots.treas.gov*. You can request additional information about this proposed information collection from James Caton, Director, Financial Monitoring and Analysis Division, (202) 906–5680, Office of Thrift Supervision, 1700 G Street, NW., Washington, DC 20552.

SUPPLEMENTARY INFORMATION: The effect of the proposed revisions to the reporting requirements of these information collections will vary from institution to institution, depending on the institution's involvement with the types of activities or transactions to which the proposed changes apply. OTS estimates that implementation of these reporting changes will result in a small

increase in the current reporting burden imposed by the TFR. The following burden estimates include the effect of the proposed revisions.

Title: Thrift Financial Report.

OMB Number: 1550–0023.

Form Number: OTS 1313.

Statutory Requirement: 12 U.S.C. 1464(v) imposes reporting requirements for savings associations. Except for selected items, these information collections are not given confidential treatment.

Type of Review: Revision of currently approved collections.

Affected Public: Savings associations.

Estimated Number of Respondents and Recordkeepers: 854.

Estimated Burden Hours per Respondent: 36.5 burden hours.

Estimated Frequency of Response: Quarterly.

Estimated Total Annual Burden: 124,684 burden hours.

Abstract: All OTS-regulated savings associations must comply with the information collections described in this notice. OTS collects this information each calendar quarter, or less frequently if so stated. OTS uses this information to monitor the condition, performance, and risk profile of individual institutions and systemic risk among groups of institutions and the industry as a whole. Except for selected items, these information collections are not given confidential treatment.

I. Background

On March 14, 2006, the FDIC Board of Directors approved interim final rules pursuant to the Reform Act that will raise the deposit insurance coverage on certain retirement accounts at a bank or savings institution to $250,000 from $100,000. The increase, which became effective on April 1, 2006, is the result of a new law increasing Federal deposit insurance coverage for the first time in more than 25 years. The basic insurance coverage for other deposit accounts for individuals, joint accountholders, businesses, government entities, and trusts—remains at $100,000.

Under the FDIC's new rules, up to $250,000 in deposit insurance will be provided to a depositor with money in a variety of retirement accounts, primarily traditional and Roth IRAs (Individual Retirement Accounts), at one insured institution. Other types of accounts included under the new deposit insurance limit are self-directed Keogh accounts, "457 Plan" accounts for state government employees, and employer-sponsored "defined contribution plan" accounts that are self-directed, which are primarily 401(k) accounts. In general, self-directed means the consumer chooses how and where the money is deposited.

In addition, the IRAs and other retirement accounts that will be protected under the new rules to $250,000 are insured separately from other accounts at the same institution that will continue to be insured up to at least $100,000. Additional information about deposit insurance is available at the FDIC's Web site, *http://www.fdic.gov.*

The new law also established a method by which the FDIC would consider an increase in the insurance limits on all deposit accounts (including retirement accounts) in the future, but only every five years starting in 2011. Any such increase would be based, in part, on inflation. Otherwise, accounts will continue to be insured as described above.

The new law also merged the Bank Insurance Fund and the Savings Association Insurance Fund into a new Deposit Insurance Fund.

As a result of these changes in deposit insurance for retirement accounts held at FDIC-insured depository institutions, OTS considered a range of potential information needs and identified those additions to the TFR that are believed to be most critical and relevant to OTS as it seeks to fulfill its supervisory responsibilities. At the same time, OTS identified certain existing TFR data that are no longer relevant or useful to warrant their continued collection. OTS believes that the reporting burden that would result from the new TFR items discussed in this proposal would increase only slightly due to the proposed elimination of a limited number of other TFR items. After savings associations make any necessary changes to their systems and records, OTS estimated that these deposit-related reporting changes would produce an average net increase of 0.4 hours per institution per year in the ongoing reporting burden of the TFR. Nevertheless, when viewing these proposed revisions to the TFR within a larger context, they are intended to maintain the effectiveness of the on- and off-site supervision activities of the OTS, which should help to control the overall regulatory burden on institutions.

II. Current Actions

OTS received comments on the April 2006 proposal from the American Bankers Association (ABA), a trade group whose members include savings associations. OTS also received a request from the Board of Governors of the Federal Reserve System to maintain line DI200, IRA/Keogh Accounts, for their use in monetary analysis.

OTS has considered these comments and has decided to proceed with the proposed changes to Schedule DI, but will not eliminate line DI200, IRA/Keogh Accounts. These changes will become effective on December 31, 2006. This decision is discussed below.

ABA expressed concern about the short amount of time for savings associations to implement the revisions. ABA urged OTS to delay the reporting revisions until the FDIC finalizes its interim rule on retirement deposit account insurance and savings associations have had time to make necessary systems changes. The ABA noted that the amount of time that institutions have to prepare for these reporting revisions is shorter than usual and indicated that thrift deposit records and systems do not clearly distinguish the types of retirement deposit accounts eligible for the higher insurance coverage from other accounts. It also asserted that there is uncertainty in the thrift industry as to which retirement deposit accounts are eligible for the higher insurance coverage. To address these concerns, OTS will set the effective date of these changes at December 31, 2006.

For the December 31, 2006, TFR, thrifts would be expected to have made appropriate systems changes to enable them to report reasonably accurate data on all types of retirement deposit accounts eligible for the $250,000 insurance coverage. Thrifts' deposit records and systems should enable them to report information on all retirement deposit accounts in these TFR items in accordance with the applicable instructions.

Dated: August 14, 2006.

Deborah Dakin,

Senior Deputy Chief Counsel, Regulations and Legislation Division.

[FR Doc. E6–13668 Filed 8–17–06; 8:45 am]

BILLING CODE 6720–01–P

DEPARTMENT OF VETERANS AFFAIRS

Veterans' Disability Benefits Commission; Notice of Meeting

The Department of Veterans Affairs (VA) gives notice under Public Law 92–463 (Federal Advisory Committee Act) that the Veterans' Disability Benefits Commission has scheduled a southern regional town hall meeting on Tuesday, September 5, 2006, from 7 p.m. until 9 p.m., at the Marriott Atlanta Century Center, 2000 Century Boulevard, NE.,

Atlanta, GA. The meeting is open to the public.

The purpose of the Commission is to carry out a study of the benefits under the laws of the United States that are provided to compensate and assist veterans and their survivors for disabilities and deaths attributable to military service.

The Commission is conducting the final of eight fact-finding, data-gathering site visits throughout the United States. The Atlanta area was selected based on criteria that included the concentration of veterans, active-duty service members and National Guard and Reserves, and the location of Veterans Benefits Administration, Veterans Health Administration, and Department of Defense (DoD) facilities, with particular interest in transition activities. The goal of this visit is to allow the commissioners the opportunity to tour local VA and DoD facilities; examine the processes in place which assist disabled veterans and service members, and survivors in their efforts to obtain benefits and to present these individuals and the general public with an opportunity to learn about the work of the Commission and to offer comments in face-to-face forums.

Interested person may attend and present oral statements to the Commission. Time for each oral presentation will be limited to five minutes or less, depending on the number of participants. Interested parties may provide written comments for review by the Commission prior the meeting, by e-mail to: *veterans@vetscommission.intranets.com* or by mail to: Mr. Ray Wilburn, Executive Director, Veterans' Disability Benefits Commission, 1101 Pennsylvania Avenue, NW., 5th Floor, Washington, DC 20004.

Dated: August 11, 2006.

By Direction of the Secretary.

E. Philip Riggin,

Committee Management Officer.

[FR Doc. 06–6991 Filed 8–17–06; 8:45 am]

BILLING CODE 8320–01–M

DEPARTMENT OF VETERANS AFFAIRS

Advisory Committee on the Readjustment of Veterans; Notice of Meeting

The Department of Veterans Affairs (VA) gives notice under Public Law 92–463 (Federal Advisory Committee Act) that a meeting of the Advisory Committee on the Readjustment of Veterans will be held on September 7–8, 2006, at The American Legion, Washington Office, at 1608 K Street, NW., Washington, DC from 8 a.m. to 4:30 p.m. each day. The meeting will be open to the public.

The purpose of the Committee is to review the post-war readjustment needs of veterans and to evaluate the availability and effectiveness of VA programs to meet these needs.

The agenda for September 7 will review the coordination of services between VA and the Department of Defense as this relates to ensuring a seamless transition for returning war veterans. The topics covered will include deployment-related problems faced by service members and their families, and Battlemind Training as developed by the Walter Reed Army Institute for Research.

On September 8 the Committee will be provided with an update on the current activities of the Readjustment Counseling Service Vet Center program to serve the veterans from Operation Enduring Freedom and Operation Iraqi Freedom. The agenda will also include a review of the partnership between VA and DOD in implementing the Post-Deployment Health Reassessment Program; strategic planning activities, and drafting recommendations for the Committee's next report to Congress.

No time will be allocated at this meeting for receiving oral presentations from the public. However, members of the public may direct written questions or submit prepared statements for review by the Committee in advance to Mr. Charles M. Flora, M.S.W., Designated Federal Officer, Readjustment Counseling Service, Department of Veterans Affairs (15), 810 Vermont Avenue, NW., Washington, DC 20420. Those who plan to attend or have questions concerning the meeting may contact Mr. Flora at (202) 273–8969 or *charles.flora@va.gov*.

Dated: August 9, 2006.

By Direction of the Secretary.

E. Philip Riggin,

Committee Management Officer.

[FR Doc. 06–6994 Filed 8–17–06; 8:45 am]

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Part II

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 409, 410, 412, et al.
Revision to Hospital Inpatient Prospective Payment Systems—2007 FY Occupational Mix Adjustment to Wage Index; Implementation; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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

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

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

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

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

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

SUMMARY: We are revising the Medicare hospital inpatient prospective payment systems (IPPS) for operating and capital-related costs to implement changes arising from our continuing experience with these systems, and to implement a number of changes made by the Deficit Reduction Act of 2005 (Pub. L. 109–171). In addition, in the Addendum to this final rule, we describe the changes to the amounts and factors used to determine the rates for Medicare hospital inpatient services for operating costs and capital-related costs. We also are setting forth rate-of-increase limits as well as policy changes for hospitals and hospital units excluded from the IPPS that are paid in full or in part on a reasonable cost basis subject to these limits. These changes are applicable to discharges occurring on or after October 1, 2006.

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

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

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

In addition, we are responding to public comments received on a proposed rule issued in the **Federal Register** on May 17, 2006 that proposed to revise the methodology for calculating the occupational mix adjustment to the wage index for the FY 2007 hospital inpatient prospective payment system by applying an adjustment to 100 percent of the wage index using new 2006 occupational mix survey data collected from hospitals.

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

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

DATES: *Effective Dates:* The provisions of these final rules are effective on October 1, 2006, with the exception of the provisions in § 412.8, § 414.802, and the procedures for withdrawing or terminating reclassifications established in section III.H.4. of the preamble. The provisions of § 412.8, § 414.802, and the procedures for withdrawing or terminating reclassifications established in section II.H.4. of the preamble are effective August 18, 2006. This rule is a major rule as defined in 5 U.S.C. 804(2). Pursuant to 5 U.S.C. 801(a)(1)(A), we are submitting a report to the Congress on this rule on August 1, 2006.

Comment Date: We will consider comments on the exclusion of CAP drugs from the ASP calculation (§ 414.802) as discussed in section XII. of the preamble of this final rule, if we receive them at one of the addresses provided below, no later than 5 p.m. on October 2, 2006.

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

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

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

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

2. *By regular mail.* You may mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1325–IFC4, P.O. Box 8011, Baltimore, MD 21244–1850.

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

3. *By express or overnight mail.* You may send written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1325–IFC4, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members. Room 445-G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201; or 7500 Security Boulevard, Baltimore, MD 21244–1850.

(Because access to the interior of the HHH Building is not readily available to

persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

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

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

FOR FURTHER INFORMATION CONTACT:

Marc Hartstein, (410) 786–4548, Operating Prospective Payment, Diagnosis-Related Groups (DRGs), Wage Index, Occupational Mix Adjustment, New Medical Services and Technology Add-On Payments, Hospital Geographic Reclassifications, Sole Community Hospital, Disproportionate Share Hospital, and Medicare-Dependent, Small Rural Hospital Issues.

Tzvi Hefter, (410) 786–4487, Capital Prospective Payment, Excluded Hospitals, Graduate Medical Education, Critical Access Hospitals, Long-Term Care (LTC)-DRGs, and Terms of Hospital Loans under Health Care Infrastructure Improvement Program Issues.

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

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

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

Frederick Grabau, (410) 786–0206, Services in Foreign Hospitals Issues.

Brian Reitz, (410) 786–5001, Obsolete Paper Claims Forms Issues.

Melinda Jones, (410) 786–7069, Loan Forgiveness Criteria for Health Care Infrastructure Improvement Program.

Corinne Axelrod, (410) 786–5620, Competitive Acquisition Program (CAP) for Part B Drugs Issues.

Angela Mason, (410) 786–7452, Payment for Covered Outpatient Drugs and Biologicals Issues.

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

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

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

Electronic Access

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Acronyms

AHA American Hospital Association
AHIMA American Health Information Management Association
AHRO Agency for Health Care Research and Quality
AMI Acute myocardial infarction
AOA American Osteopathic Association
APR DRG All Patient Refined Diagnosis-Related Group System
ASC Ambulatory surgical center
ASP Average sales price
AWP Average wholesale price
BBA Balanced Budget Act of 1997, Pub. L. 105–33
BBRA Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999, Pub. L. 106–113
BIPA Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Benefits Improvement and Protection Act of 2000, Pub. L. 106–554
BLS Bureau of Labor Statistics
AH Critical access hospital
AP Competitive Acquisition Program
CART CMS Abstraction & Reporting Tool
CBSAs Core-based statistical areas
CC Complication or comorbidity
CDAC Clinical Data Abstraction Center
CIPI Capital input price index
CPI Consumer price index
CMI Case-mix index
CMS Centers for Medicare & Medicaid Services
CMSA Consolidated Metropolitan Statistical Area
COBRA Consolidated Omnibus Reconciliation Act of 1985, Pub. L. 99–272
CPI Consumer price index
CRNA Certified registered nurse anesthetist
CY Calendar year
DRA Deficit Reduction Act of 2005, Pub. L. 109–171
DRG Diagnosis-related group
DSH Disproportionate share hospital
ECI Employment cost index
EMR Electronic medical record
EMTALA Emergency Medical Treatment and Labor Act of 1986, Pub. L. 99–272
FDA Food and Drug Administration
FFY Federal fiscal year
FIPS Federal information processing standards
FQHC Federally qualified health center
FTE Full-time equivalent
FY Fiscal year
GAAP Generally Accepted Accounting Principles
GAF Geographic Adjustment Factor
GME Graduate medical education
HCAHPS Hospital Consumer Assessment of Healthcare Providers and Systems
HCFA Health Care Financing Administration
HCRIS Hospital Cost Report Information System
HHA Home health agency
HHS Department of Health and Human Services
HIC -Health insurance card
HIPAA Health Insurance Portability and Accountability Act of 1996, Pub. L. 104–191
HIPC Health Information Policy Council
HIS Health information system
HIT Health information technology
HMO Health maintenance organization
HSA Health savings account
HSCRC Maryland Health Services Cost Review Commission

HSRV Hospital-specific relative value
HSRVcc Hospital-specific relative value cost center
HQA Hospital Quality Alliance
HQI Hospital Quality Initiative
HwH Hospital-within-a-hospital
ICD–9–CM International Classification of Diseases, Ninth Revision, Clinical Modification
ICD–10–PCS International Classification of Diseases, Tenth Edition, Procedure Coding System
ICU Intensive care unit
IHS Indian Health Service
IME Indirect medical education
IOM Institute of Medicine
IPF Inpatient psychiatric facility
IPPS Acute care hospital inpatient prospective payment system
IRF Inpatient rehabilitation facility
IRP Initial residency period
JCAHO Joint Commission on Accreditation of Healthcare Organizations
LAMCs Large area metropolitan counties
LTC-DRG Long-term care diagnosis-related group
LTCH Long-term care hospital
MCE Medicare Code Editor
MCO Managed care organization
MCV Major cardiovascular condition
MDC Major diagnostic category
MDH Medicare-dependent, small rural hospital
MedPAC Medicare Payment Advisory Commission
MedPAR Medicare Provider Analysis and Review File
MEI Medicare Economic Index
MGCRB Medicare Geographic Classification Review Board
MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108–173
MRHFP Medicare Rural Hospital Flexibility Program
MSA Metropolitan Statistical Area
NAICS North American Industrial Classification System
NCD National coverage determination
NCHS National Center for Health Statistics
NCQA National Committee for Quality Assurance
NCVHS National Committee on Vital and Health Statistics
NECMA New England County Metropolitan Areas
NICU Neonatal intensive care unit
NQF National Quality Forum
NTIS National Technical Information Service
NVHRI National Voluntary Hospital Reporting Initiative
OES Occupational employment statistics
OIG Office of the Inspector General
OMB Executive Office of Management and Budget
O.R. Operating room
OSCAR Online Survey Certification and Reporting (System)
PRM Provider Reimbursement Manual
PPI Producer price index
PMSAs Primary metropolitan statistical areas
PPS Prospective payment system
PRA Per resident amount
ProPAC Prospective Payment Assessment Commission
PRRB Provider Reimbursement Review Board
PS&R Provider Statistical and Reimbursement (System)
QIG Quality Improvement Group, CMS
QIO Quality Improvement Organization
RHC Rural health clinic
RHQDAPU Reporting hospital quality data for annual payment update
RNHCI Religious Nonmedical Health Care Institution
RRC Rural referral center
RUCAs Rural-urban commuting area codes
RY Rate year
SAF Standard Analytic File
SCH Sole community hospital
SFY State fiscal year
SIC Standard Industrial Classification
SNF Skilled nursing facility
SOCs Standard occupational classifications
SOM State Operations Manual
SSA Social Security Administration
SSI Supplemental Security Income
TAG Technical Advisory Group
TEFRA Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248
UHDDS Uniform hospital discharge data set

Table of Contents

I. Background

A. Summary

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

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

predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups (DRGs).

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

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

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

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

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

Although payments to most hospitals under the IPPS are made on the basis of the standardized amounts, some categories of hospitals are paid the higher of a hospital-specific rate based on their costs in a base year (the higher of FY 1982, FY 1987, FY 1996, or FY 2002) or the IPPS rate based on the standardized amount. For example, sole community hospitals (SCHs) are the sole source of care in their areas, and Medicare-dependent, small rural hospitals (MDHs) are a major source of care for Medicare beneficiaries in their areas. Both of these categories of hospitals are afforded special payment protection in order to maintain access to services for beneficiaries. (Through FY 2007, an MDH receives the IPPS rate plus 50 percent of the difference between the IPPS rate and its hospital-specific rate if the hospital-specific rate is higher than the IPPS rate. In addition, an MDH may not use FY 1996 as its base year for the hospital-specific rate. As discussed below, for discharges occurring on or after October 1, 2007, but before October 1, 2011, an MDH will receive the IPPS rate plus 75 percent of the difference between the IPPS rate and its hospital-specific rate, if the hospital-specific rate is higher than the IPPS rate.)

Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of inpatient hospital services "in accordance with a prospective payment system established by the Secretary." The basic methodology for determining capital prospective payments is set forth in our regulations at 42 CFR 412.308 and 412.312. Under the capital PPS, payments are adjusted by the same DRG for the case as they are under the operating IPPS. Capital PPS payments are also adjusted for IME and DSH, similar to the adjustments made under the operating IPPS. In addition, hospitals may receive outlier payments for those cases that have unusually high costs.

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

2. Hospitals and Hospital Units Excluded From the IPPS

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

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

a. Inpatient Rehabilitation Facilities (IRFs)

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

b. Long-Term Care Hospitals (LTCHs)

Under the authority of sections 123(a) and (c) of Pub. L. 106–113 and section 307(b)(1) of Pub. L. 106–554, LTCHs that do not meet the definition of "new" under § 412.23(e)(4) are being transitioned from being paid for inpatient hospital services based on a blend of reasonable cost-based reimbursement under section 1886(b) of the Act to 100 percent of the Federal rate during a 5-year period with cost reporting periods beginning on or after October 1, 2002. Those LTCHs that do not meet the definition of "new" may elect to be paid based on 100 percent of the Federal prospective payment rate instead of a blended payment in any year during the 5-year transition. For cost reporting periods beginning on or after October 1, 2006, LTCHs will be paid 100 percent of the Federal rate. The existing regulations governing payment under the LTCH PPS are located in 42 CFR Part 412, Subpart O.

c. Inpatient Psychiatric Facilities (IPFs)

Under the authority of sections 124(a) and (c) of Pub. L. 106–113, IPFs are paid under the IPF PPS. Under the IPF PPS, some IPFs are transitioning from being paid for inpatient hospital services based on a blend of reasonable cost-based payment to a Federal per diem

payment rate, effective for cost reporting periods beginning on or after January 1, 2005 (November 15, 2004 IPF PPS final rule (69 FR 66922) and May 9, 2006 IPF PPS final rule (71 FR 27040)). For cost reporting periods beginning on or after January 1, 2008, all IPFs will be paid 100 percent of the Federal per diem payment amount. The existing regulations governing payment under the IPF PPS are located in 42 CFR 412, Subpart N.

3. Critical Access Hospitals (CAHs)

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

4. Payments for Graduate Medical Education (GME)

Under section 1886(a)(4) of the Act, costs of approved educational activities are excluded from the operating costs of inpatient hospital services. Hospitals with approved graduate medical education (GME) programs are paid for the direct costs of GME in accordance with section 1886(h) of the Act; the amount of payment for direct GME costs for a cost reporting period is based on the hospital's number of residents in that period and the hospital's costs per resident in a base year. The existing regulations governing payments to the various types of hospitals are located in 42 CFR Part 413.

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

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

- Section 5001(a), which, effective for FY 2007 and subsequent years, allows for expansion of the requirements for hospital quality data reporting.
- Section 5003, which makes several changes to the MDH program. It extends special payment provisions, requires MDHs to use FY 2002 as their base year for determining whether use of their hospital-specific rate enhances payment (but permits them to continue to use either their 1982 or 1987 hospital-specific rate if using either of those rates results in higher payments), and removes the application of the 12-percent cap on the DSH payment adjustment factor for MDHs.
- Section 5004, which reduces certain allowable SNF bad debt payments by 30 percent. Payments for the bad debts of full-benefit, dual eligible individuals are not reduced.

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

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

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

After publication of the FY 2007 IPPS proposed rule, the United States Court of Appeals for the Second Circuit issued a decision in the Bellevue case that caused us to modify our proposals on the implementation of the occupational mix adjustment. As a result, we published a second proposed rule in the May 17, 2006 **Federal Register** that superseded the occupational mix proposals that had been made in the FY 2007 IPPS proposed rule (published April 25, 2006). The following is a summary of the major changes that we proposed to make and the issues that we addressed in the FY 2007 IPPS and FY 2007 Occupational Mix Adjustment to the Wage Index proposed rules:

1. DRG Reclassifications and Recalibrations of Relative Weights

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

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

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

2. Changes to the Hospital Wage Index

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

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

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

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

- The reporting of hospital quality data as a condition for receiving the full annual payment update increase.
- Changes in payments to SCHs and MDHs.

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

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

4. Changes to the PPS for Capital-Related Costs

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

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

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

6. Payments for Services Furnished Outside the United States

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

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

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

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

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

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

In the Addendum to the proposed rule, we set forth proposed changes to the amounts and factors for determining the FY 2007 prospective payment rates for operating costs and capital-related costs. We also proposed to establish the threshold amounts for outlier cases. In addition, we addressed the proposed update factors for determining the rate-of-increase limits for cost reporting periods beginning in FY 2007 for hospitals and hospital units excluded from the PPS.

10. Impact Analysis

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

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

In Appendix B of the proposed rule, as required by sections 1886(e)(4) and (e)(5) of the Act, we provided our recommendations of the appropriate percentage changes for FY 2007 for the following:

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

12. Discussion of Medicare Payment Advisory Commission Recommendations

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

13. Appendix C and Appendix D

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

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

We received over 2,300 timely items of correspondence containing multiple comments on the FY 2007 IPPS proposed rule. We also received over 100 timely items of correspondence on the FY 2007 Occupational Mix Adjustment to the Wage Index proposed rule. Summaries of the public comments and our responses to those comments are set forth under the appropriate heading.

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

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

We received seven timely items of correspondence on the interim final

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

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

On September 30, 2005, we published in the **Federal Register** (70 FR 57376) a proposed rule (CMS–1320–P) to establish the loan forgiveness criteria for qualifying hospitals who receive loans under the Health Care Infrastructure Improvement Program that was established under section 1016 of Pub. L. 108–173.

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

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

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

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

II. Changes to DRG Classifications and Relative Weights

A. Background

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

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

B. DRG Reclassifications

1. General

As discussed in section II.D. of the preamble to the FY 2007 IPPS proposed rule (71 FR 24030), for FY 2007, we are making only limited changes to the current DRG classifications that will be applicable to discharges occurring on or after October 1, 2006. We are limiting our changes because, as discussed in detail in section II.C. of the preamble to the proposed rule and to this final rule, we are focusing our efforts on addressing the recommendations made last year by MedPAC to refine the entire CMS DRG system by taking into account severity of illness and applying hospital-specific relative value (HSRV) weights to DRGs.

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

The process of forming the DRGs was begun by dividing all possible principal diagnoses into mutually exclusive principal diagnosis areas, referred to as Major Diagnostic Categories (MDCs). The MDCs were formed by physician panels as the first step toward ensuring that the DRGs would be clinically coherent. The diagnoses in each MDC correspond to a single organ system or etiology and, in general, are associated with a particular medical specialty. Thus, in order to maintain the requirement of clinical coherence, no final DRG could contain patients in different MDCs. Most MDCs are based on a particular organ system of the body. For example, MDC 6 is Diseases and Disorders of the Digestive System. This approach is used because clinical care is generally organized in accordance with the organ system affected. However, some MDCs are not constructed on this basis because they involve multiple organ systems (for example, MDC 22 (Burns)). For FY 2006, cases are assigned to one of 526 DRGs in 25 MDCs. The table below lists the 25 MDCs.

MAJOR DIAGNOSTIC CATEGORIES (MDCs)

1	Diseases and Disorders of the Nervous System.
2	Diseases and Disorders of the Eye.
3	Diseases and Disorders of the Ear, Nose, Mouth, and Throat.
4	Diseases and Disorders of the Respiratory System.
5	Diseases and Disorders of the Circulatory System.
6	Diseases and Disorders of the Digestive System.
7	Diseases and Disorders of the Hepatobiliary System and Pancreas.
8	Diseases and Disorders of the Musculoskeletal System and Connective Tissue.
9	Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast.
10	Endocrine, Nutritional and Metabolic Diseases and Disorders.
11	Diseases and Disorders of the Kidney and Urinary Tract.
12	Diseases and Disorders of the Male Reproductive System.
13	Diseases and Disorders of the Female Reproductive System.
14	Pregnancy, Childbirth, and the Puerperium.
15	Newborns and Other Neonates with Conditions Originating in the Perinatal Period.
16	Diseases and Disorders of the Blood and Blood Forming Organs and Immunological Disorders.

MAJOR DIAGNOSTIC CATEGORIES (MDCs)—Continued

17	Myeloproliferative Diseases and Disorders and Poorly Differentiated Neoplasms.
18	Infectious and Parasitic Diseases (Systemic or Unspecified Sites).
19	Mental Diseases and Disorders.
20	Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders.
21	Injuries, Poisonings, and Toxic Effects of Drugs.
22	Burns.
23	Factors Influencing Health Status and Other Contacts with Health Services.
24	Multiple Significant Trauma.
25	Human Immunodeficiency Virus Infections.

In general, cases are assigned to an MDC based on the patient's principal diagnosis before assignment to a DRG. However, for FY 2006, there are nine DRGs to which cases are directly assigned on the basis of ICD–9–CM procedure codes. These DRGs are for heart transplant or implant of heart assist systems, liver and/or intestinal transplants, bone marrow transplants, lung transplants, simultaneous pancreas/kidney transplants, pancreas transplants, and for tracheostomies. Cases are assigned to these DRGs before they are classified to an MDC. The table below lists the nine current pre-MDCs.

PRE-MAJOR DIAGNOSTIC CATEGORIES (PRE-MDCs)

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

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

Generally, nonsurgical procedures and minor surgical procedures that are not usually performed in an operating room are not treated as O.R. procedures. However, there are a few non-O.R. procedures that do affect DRG assignment for certain principal diagnoses. An example is extracorporeal shock wave lithotripsy for patients with a principal diagnosis of urinary stones.

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

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

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

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

The records for all Medicare hospital inpatient discharges are maintained in the Medicare Provider Analysis and Review (MedPAR) file. The data in this file are used to evaluate possible DRG classification changes and to recalibrate the DRG weights. However, in the July 30, 1999 IPPS final rule (64 FR 41500), we discussed a process for considering non-MedPAR data in the recalibration process. In order for us to consider using particular non-MedPAR data, we must have sufficient time to evaluate and test the data. The time necessary to do so depends upon the nature and quality of the non-MedPAR data submitted. Generally, however, a significant sample of the non-MedPAR

data should be submitted by mid-October for consideration in conjunction with the next year's proposed rule. This allows us time to test the data and make a preliminary assessment as to the feasibility of using the data. Subsequently, a complete database should be submitted by early December for consideration in conjunction with the next year's proposed rule.

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

2. Yearly Review for Making DRG Changes

Many of the changes to the DRG classifications are the result of specific issues brought to our attention by interested parties. We encourage individuals with concerns about DRG classifications to bring those concerns to our attention in a timely manner so they can be carefully considered for possible inclusion in the annual proposed rule Therefore, similar to the timetable for interested parties to submit non-MedPAR data for consideration in the DRG recalibration process, concerns about DRG classification issues should be brought to our attention no later than early December in order to be considered and possibly included in the next annual proposed rule updating the IPPS.

The actual process of forming the DRGs was, and continues to be, highly iterative, involving a combination of statistical results from test data combined with clinical judgment. For purposes of this final rule, in deciding whether to create a separate DRG, we consider whether the resource consumption and clinical characteristics of the patients with a given set of conditions are significantly different than the remaining patients in the existing DRG. We evaluate patient care costs using average charges and lengths of stay as proxies for costs and rely on the judgment of our medical officers to decide whether patients are clinically distinct or similar to other patients in the DRG. In evaluating resource costs, we consider both the absolute and percentage differences in average charges between the cases we are selecting for review and the remainder of cases in the DRG. We also consider variation in charges within these groups; that is, whether observed average differences are consistent across patients or attributable to cases that are extreme in terms of charges or length of stay, or both. Further, we also consider the number of patients who will have a given set of characteristics and generally prefer not to create a new DRG unless it will include a substantial number of cases.

C. Revisions to the DRG System Used Under the IPPS

1. MedPAC Recommendations

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

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

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

As we noted in the FY 2006 IPPS final rule, we had insufficient time to complete a thorough evaluation of these recommendations for full implementation in FY 2006. However, we did adopt severity-weighted cardiac DRGs in FY 2006 to address public comments on this issue and the specific concerns of MedPAC regarding cardiac surgery DRGs. We also indicated that we planned to further consider all of MedPAC's recommendations and thoroughly analyze options and their impacts on the various types of hospitals in the FY 2007 IPPS proposed rule. Following the publication of the FY 2006 IPPS final rule, we contracted with 3M Health Information Systems to assist us in performing this analysis.

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

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

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

incentives that Medicare payments may provide for the further development of specialty hospitals.

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

2. Refinement of the Relative Weight Calculation

MedPAC made two recommendations with respect to the DRG relative weight calculation. First, MedPAC recommended that CMS base the DRG relative weights on the estimated cost of providing care. Second, MedPAC recommended that CMS base the weights on the national average of hospitals' relative values in each DRG. Because both of these recommendations address the relative weight calculation, we are addressing them together. The work we have done to address these recommendations was discussed in detail in the proposed rule (71 FR 24006–24011).

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

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

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

In the proposed rule, we indicated several concerns about the methodology used by MedPAC. MedPAC's methodology to reduce hospital charges to cost is administratively burdensome, not only to develop, but also to maintain. First, MedPAC developed CCRs for individual hospitals at the most detailed department level. Specifically, in calculating costs as the basis for the relative weights, MedPAC applied hospital-specific CCRs from each provider's cost report to the line item charges on the claims that the hospital submitted during the same time period. This methodology required matching cost report data to claims data, and because cost report data take longer to compile and file, the method necessitates using older claims data to set relative weights. The most recent complete set of Medicare cost reports available to us is from FY 2003. Thus, if we were to model the exact approach used by MedPAC and use claims data for a matching year, we would be using claims data from FY 2003 instead of using FY 2005 claims data, as we would if we were to continue with our current methodology. In addition, MedPAC's hospital-specific approach required detailed cost center distinctions for each hospital that are difficult to define, map, and apply. This approach also required the use of the Standard Analytic File (SAF) because MedPAR data that we currently use to set DRG weights did not have the necessary level of detail. Using the SAF increases processing time and adds further complexity to the process of setting the relative weights.

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

As we explained in the FY 2007 IPPS proposed rule, we developed an alternative to MedPAC's approach that we believe achieves similar results in a more administratively feasible manner. This method involves developing hospital-specific charge relative weights at the cost center level and then scaling the weights to costs using the national cost center charge ratios developed from the cost report data. After studying Medicare cost report data, we established 10 cost center categories based upon broad hospital accounting definitions. In our cost center categories, there are 8 ancillary cost groups in addition to routine day costs and intensive care day costs, and each category represents at least 5 percent of the charges in the claims data. The specific cost report lines that contribute to each category and the corresponding charge lines from the MedPAR claims data are itemized in Table A below.

In the proposed rule, we stated that this alternative approach, which we labeled as the HSRV cost center (HSRVcc) methodology, has several advantages. First, the use of national average rather than hospital-specific CCRs avoids the complexity

encountered with cost center CCRs at the hospital level and allows us to retain more data for use in the relative weight calculation. In addition, the methodology eliminates the need to match claims to the time period of the CCRs, resulting in the ability to use more timely claims data. Furthermore, the alternative approach makes it more feasible to update the relative weights annually using a single methodology. We do not have to replicate the methodology once every 5 years and make adjustments based on changes in charges in the intervening years. The HSRVcc methodology is described in detail in the proposed rule (71 FR 24008 through 24011).

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

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

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

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

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

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

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

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

A few commenters stated that we made incorrect assumptions that may have resulted in new distortions to the relative weights. Specifically, the commenters stated that we were incorrect in applying the same CCR

across all hospitals for a given cost center and applying the same percent mix of services by cost center to all DRGs. The commenters recommended that we first convert charges to costs for each hospital and DRG, and then compute hospital-specific relative values. They stated that the reversal of the calculations in the HSRVcc methodology accommodates cost center mix and charge markup differences across hospitals and across DRGs.

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

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

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

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

In response to the concerns expressed regarding the CCR calculation, we proposed to establish the geometric mean CCRs using a hospital-weighted methodology because we believed that it served as an acceptable measure of central tendency. In addition, we proposed to trim the CCRs on the basis of 1.96 standard deviations since we were using national averages and thought a more stringent statistical trim would be appropriate. In response to comments, however, we have reconsidered our approach and have implemented the 3 standard deviation statistical trim supported by commenters. Further, we are also adopting the charge-weighted method of calculating CCRs, as we now believe it may be more appropriate to apply CCRs based on aggregate costs and charges among hospitals to the charges that are aggregated by DRG and used to set the relative weights.

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

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

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

using the average for all supplies and equipment.

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

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

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

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

Other commenters suggested that we also create separate cost centers for implantable devices and nursing. As noted in the comments, the MedPAR file does not contain the necessary detail to identify a separate cost center for implantable devices or nursing. In addition, we did not have enough time to evaluate whether it would be reasonable to utilize a nursing cost center in the methodology in the future. However, we anticipate undertaking further analysis of the relative weight methodology over the next year in conjunction with the research we are doing on charge compression to determine if additional cost centers are necessary.

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

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

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

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

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

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

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

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

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

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

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

(k) Lithotripsy is included in Radiology Services;

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

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

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

Response: We wish to clarify to the commenters that the charge description titles shown in the MedPAR charge description column in Table A were not meant to also be interpreted as the title for each of the cost report line items. That is, we were simply using Table A to illustrate the MedPAR charge groups and the cost report line numbers that were used to create the 10 proposed cost centers. To alleviate this confusion, we are revising Table A to show both the MedPAR charge titles and the titles of the cost report line items. In response to comments (j) and (l), we note that the cost report line item number 65 for ambulance was inadvertently listed twice in the proposed rule; line item 62, observation beds, was used in establishing the CCR for the other services category. Line 65 for ambulance was only used once in the actual other services CCR calculation. Line item 62 should have appeared in the "other services" cost center grouping printed in Table A in the proposed rule. We have corrected this error in the final version of Table A. In addition, in regards to comment (k) above, we have moved the lithotripsy charges from MedPAR to the "other services" cost center grouping and we have also

revised the CCR for "other services" to include the cost report line item 43 for radioisotopes, which was formerly included in the radiology CCR.

In response to the commenters' question regarding the inclusion of subscripted lines, when we calculated the CCRs for the proposed rule and subsequently for this final rule, we relied on a HCRIS data set that contains rolled-up cost report fields such that line items which are subscripted contain the total value for the line item and any subscripted lines below. Therefore, most subscripted lines were included in the proposed rule CCRs and continue to be included in the final rule CCR calculations. However, some subscripted line items are not rolled up and continue to have their own field on the HCRIS data set that we used to calculate the CCRs. Therefore, we are now including the cost report line item 6201 for observation beds, the cost report line item 6350 for Rural Health clinics and the cost report line item 6360 for Federally Qualified Health clinics in the other services CCR. Cost report line items 6350 and 6360 are only reported by provider-based Rural Health clinics and Federally Qualified Health clinics and are necessary in order to identify all incurred costs applicable to furnishing an observation bed prior to a decision to admit a patient to the hospital. Further, we are now including the cost report line item 68 for other reimbursement in the other services CCR, and we are including professional services charges from MedPAR in the other services charge grouping. In response to the commenters' requests that we show the revenue codes that comprise the MedPAR charges, we have also inserted an additional column in Table A that lists the revenue codes MedPAR groups into each charge field that we are using in the final 13 cost centers. The final version of Table A appears below:

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Cost Center Group Name (13 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field	Cost Report Line Description (Wksheet C Part 1 & Wksheet D-4	Cost from HCRIS (Wksheet C, Part 1, Column 5 and line number	Charges from HCRIS (Wksheet C, Part 1, Column 6 & 7 and line number	Medicare Charges from HCRIS (Wksheet D-4, Column & line number
Routine Days	Private Room Charges	011X and 014X	Adults & Pediatrics (General Routine Care)	C_1_C5_25	C_1_C6_25	D4_HOS_C2_25
	Semi-Private Room Charges	010X, 012X, 013X and 016X-019X			C_1_C7_25	D4_HOS_C2_26
	Ward Charges	015X				
Intensive Days	Intensive Care Charges	020X	Intensive Care Unit	C_1_C5_26	C_1_C6_26	D4_HOS_C2_26
					C_1_C7_26	
	Coronary Care Charges	021X	Coronary Care Unit	C_1_C5_27	C_1_C6_27	D4_HOS_C2_27
					C_1_C7_27	
			Burn Intensive Care Unit	C_1_C5_28	C_1_C6_28	D4_HOS_C2_28
					C_1_C7_28	
			Surgical Intensive Care Unit	C_1_C5_29	C_1_C6_29	D4_HOS_C2_29
					C_1_C7_29	
			Other Special Care Unit	C_1_C5_30	C_1_C6_30	D4_HOS_C2_30
					C_1_C7_30	
Drugs	Pharmacy Charges	025X, 026X and 063X	Intravenous Therapy	C_1_C5_48	C_1_C6_48	D4_HOS_C2_48
					C_1_C7_48	
			Drugs Charged To Patient	C_1_C5_56	C_1_C6_56	D4_HOS_C2_56
					C_1_C7_56	
Supplies and Equipment	Medical/Surgical Supply Charges	027X and 062X	Medical Supplies Charged to Patients	C_1_C5_55	C_1_C6_55	D4_HOS_C2_55
					C_1_C7_55	
	Durable Medical Equipment Charges	0290, 0291, 0292 and 0294-0299	DME-Rented	C_1_C5_66	C_1_C6_66	D4_HOS_C2_66

Cost Center Group Name (13 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field	Cost Report Line Description (Wksheet C Part 1 & Wksheet D-4	Cost from HCRIS (Wksheet C, Part 1, Column 5 and line number	Charges from HCRIS (Wksheet C, Part 1, Column 6 & 7 and line number	Medicare Charges from HCRIS (Wksheet D-4, Column & line number
					C_1_C7_66	
	Used Durable Medical Charges	0293	DME-Sold	C_1_C5_67	C_1_C6_67	D4_HOS_C2_67
					C_1_C7_67	
Therapy Services	Physical Therapy Charges	042X	Physical Therapy	C_1_C5_50	C_1_C6_50	D4_HOS_C2_50
					C_1_C7_50	
	Occupational Therapy Charges	043X	Occupational Therapy	C_1_C5_51	C_1_C6_51	D4_HOS_C2_51
					C_1_C7_51	
	Speech Pathology Charges	044X and 047X	Speech Pathology	C_1_C5_52	C_1_C6_52	D4_HOS_C2_52
					C_1_C7_52	
Inhalation Therapy	Inhalation Therapy Charges	041X and 046X	Respiratory Therapy	C_1_C5_49	C_1_C6_49	D4_HOS_C2_49
					C_1_C7_49	
Operating Room For all DRGs but Labor & Delivery	Operating Room Charges	036X, 071X and 072X	Operating Room	C_1_C5_37	C_1_C6_37	D4_HOS_C2_37
					C_1_C7_37	
			Recovery Room	C_1_C5_38	C_1_C6_38	D4_HOS_C2_38

Cost Center Group Name (13 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field		Cost Report Line Description (Wksheet C Part 1 & Wksheet D-4	Cost from HCRIS (Wksheet C, Part 1, Column 5 and line number	Charges from HCRIS (Wksheet C, Part 1, Column 6 & 7 and line number	Medicare Charges from HCRIS (Wksheet D-4, Column & line number
						C_1_C7_38	
Labor & Delivery **ONLY FOR THE 6 Labor & Delivery DRGs 370, 371, 372, 373, 374, 375**	Operating Room Charges	036X, 071X and 072X		Delivery Room and Labor Room	C_1_C5_39	C_1_C6_39 C_1_C7_39	D4_HOS_C2_39
	Clinic Charges	051X		Obstetrics Clinic	C_1_C5_63	C_1_C6_63 C_1_C7_63	D4_HOS_C2_63
Anesthesia	Anesthesia Charges	037X		Anesthesiology	C_1_C5_40	C_1_C6_40 C_1_C7_40	D4_HOS_C2_40
Cardiology	Cardiology Charges	048X and 073X		Electrocardiology	C_1_C5_53	C_1_C6_53 C_1_C7_53	D4_HOS_C2_53
				Electro-encephalography	C_1_C5_54	C_1_C6_54 C_1_C7_54	D4_HOS_C2_54
Laboratory	Laboratory Charges	030X, 031X, 074X and 075X		Laboratory	C_1_C5_44	C_1_C6_44	D4_HOS_C2_44

Cost Center Group Name (13 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field	Cost Report Line Description (Wksheet C Part 1 & Wksheet D-4	Cost from HCRIS (Wksheet C, Part 1, Column 5 and line number	Charges from HCRIS (Wksheet C, Part 1, Column 6 & 7 and line number	Medicare Charges from HCRIS (Wksheet D-4, Column & line number
					C_1_C7_44	
			PBP Clinic Laboratory Services	C_1_C5_45	C_1_C6_45	D4_HOS_C2_45
					C_1_C7_45	
Radiology	Radiology Charges	028X, 032X, 033X, 034X, 035X and 040X	Radiology - Diagnostic	C_1_C5_41	C_1_C6_41	D4_HOS_C2_41
					C_1_C7_41	
	MRI Charges	061X	Radiology - Therapeutic	C_1_C5_42	C_1_C6_42	D4_HOS_C2_42
Other Services	Lithotripsy Charge	079X	Radioisotope	C_1_C5_43	C_1_C6_43	D4_HOS_C2_43
					C_1_C7_43	
	Other Service Charge	0002-0099, 022X, 023X, 024X,052X,053X 055X-060X, 064X-070X, 076X-078X, 090X-095X and 099X	Whole Blood & Packed Blood Cells	C_1_C5_46	C_1_C6_46	D4_HOS_C2_46
					C_1_C7_46	
	Blood Charges	038X	Blood Storing Processing & Transfusing	C_1_C5_47	C_1_C6_47	D4_HOS_C2_47
					C_1_C7_47	
	Blood Administratio n Charges	039X	ASC (Non Distinct Part)	C_1_C5_58	C_1_C6_58	D4_HOS_C2_58
					C_1_C7_58	

Cost Center Group Name (13 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field	Cost Report Line Description (Wksheet C Part 1 & Wksheet D-4	Cost from HCRIS (Wksheet C, Part 1, Column 5 and line number	Charges from HCRIS (Wksheet C, Part 1, Column 6 & 7 and line number	Medicare Charges from HCRIS (Wksheet D-4, Column & line number
	Outpatient Service Charges	049X and 050X	Other Ancillary	C_1_C5_59	C_1_C6_59 C_1_C7_59	D4_HOS_C2_59
	Emergency Room Charges	045X	Clinic	C_1_C5_60	C_1_C6_60 C_1_C7_60	D4_HOS_C2_60
	Ambulance Charges	054X	Emergency	C_1_C5_61	C_1_C6_61 C_1_C7_61	D4_HOS_C2_61
	ESRD Revenue Setting Charges	080X and 082X-088X	Observation beds	C_1_C5_62	C_1_C6_62 C_1_C7_62	D4_HOS_C2_62
	Clinic Visit Charges (excluding Labor & Delivery DRGs)	051X	Observation beds	C_1_C5_6201	C_1_C6_6201 C_1_C7_6201	D4_HOS_C2_6201
			Rural Health Clinic	C_1_C5_6350	C_1_C6_6350 C_1_C7_6350	D4_HOS_C2_6350
	Professional Fees Charges	096X, 097X, and 098X	FQHC	C_1_C5_6360	C_1_C6_6360 C_1_C7_6360	D4_HOS_C2_6360
			Home Program Dialysis	C_1_C5_64	C_1_C6_64 C_1_C7_64	D4_HOS_C2_64

Cost Center Group Name (13 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field	Cost Report Line Description (Wksheet C Part 1 & Wksheet D-4	Cost from HCRIS (Wksheet C, Part 1, Column 5 and line number	Charges from HCRIS (Wksheet C, Part 1, Column 6 & 7 and line number	Medicare Charges from HCRIS (Wksheet D-4, Column & line number
			Ambulance	C_1_C5_65	C_1_C6_65	D4_HOS_C2_65
					C_1_C7_65	
			Other Reimbursable	C_1_C5_68	C_1_C6_68	D4_HOS_C2_68
					C_1_C7_68	

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

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

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

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

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

First, the commenters believed that CMS should address cost report accuracy. The commenters stated that because the cost reports have only been used for payment in limited circumstances (DSH, IME, outlier policy), hospitals have had little incentive to report accurately and completely for the services provided to Medicare beneficiaries. In addition, they claimed the cost reports do not contain the level of detail necessary to accurately determine costs at the DRG level. Instead, the cost report provides payments, costs, and some reimbursement totals by department or cost center. The commenters also advised that CMS perform additional auditing of the cost reports to ensure accuracy. The commenters were concerned that if CMS implements a cost-based weighting methodology, the DRG weights will be based on largely un-audited cost reports since approximately 15 percent of hospital cost reports are audited each year. They noted that MedPAC estimated that a full-scale audit could require 1,000 to 2,000 hours from a fiscal intermediary,

as well as additional time and resources from the hospital. In addition, a few commenters stated that CMS should only use final settled cost report data, not as-submitted data, in calculating DRG weights.

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

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

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

Response: With respect to the commenters' recommendation regarding the reporting of costs and charges for services, CMS requires hospitals to report their costs and charges through the cost report with sufficient specificity to support CMS' use of cost report data for monitoring and payment. Within generally accepted principles of cost accounting, CMS allows providers flexibility to accommodate the unique attributes of each institution's accounting systems. For example, providers must match the generally intended meaning of the line-item cost centers, both standard and non-standard, to the unique configuration of department and service categories used by each hospital's accounting system. Also, while the cost report provides a recommended basis of allocation for the general service cost centers, a provider is permitted, within specified guidelines, to use an alternative basis for a general service cost if it can support to its intermediary that the alternative is more accurate than the recommended basis. This approach creates internal consistency between a hospital's accounting system and the cost report but cannot guarantee the precise comparability of costs and charges for individual cost centers across institutions.

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

Despite the concerns raised in the comments, we believe that costs and charges are reported through the cost report with sufficient specificity to support CMS' use of cost report data to develop cost-based weights. The information we obtained from the cost report on the differing level of charge markups occurring between routine and ancillary hospital departments supports MedPAC's conclusions that the most profitable DRGs that are leading to the development of specialty hospitals are those that require a lot of ancillary services with high markups and low CCRs. To the extent that charge markups vary significantly between the various routine and ancillary hospital departments, we believe that there is a need to adjust charges to cost prior to setting the relative weights. We will continue to rely on the cost report to establish the CCRs that we are finalizing to use to adjust the DRG charges to costs.

However, we continue to be interested in receiving suggestions on ways that hospitals can uniformly and consistently report charges and costs related to all cost centers that also acknowledge the ubiquitous tradeoff between greater precision in developing CCRs and administrative burden

coupled with reduced flexibility in hospital accounting practices. Another issue to consider is the potential changes to the relative weights from undertaking efforts of this magnitude that will be costly for both CMS, its fiscal intermediaries and costly and burdensome to hospitals. Although we are not modifying the cost report or our cost report instructions at this time, we would be open to making improvements in the future.

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

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

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

Response: We appreciate the commenters concerns regarding the HSRVcc relative weight setting methodology we proposed and the large change in the relative weights that result from the application of this methodology. As we stated in the FY 2006 IPPS final rule, given the potential for significant redistribution in payments, the MedPAC recommendations should be studied extensively before any broad fundamental changes are made to the current system. In the proposed rule, we provided the results of such an extensive analysis and concluded that changes can be made to the relative weight methodology and the DRG system to improve payment accuracy. Although we agree that adopting a methodology that results in large changes in payment should not be adopted without careful study, we do not believe that the mere presence of such significant impacts invalidates the methodology. On the contrary, we believe large payment impacts may suggest there is a significant degree of distortion present in the current payment system. In our view, we believe that the changes to the IPPS should be evaluated based on whether they represent an improvement to the current system. MedPAC has studied the IPPS extensively and found that improvement can be found in payment accuracy from adopting its recommendations that are similar to those we proposed.[2]

While we acknowledge the need for further study and evaluation of the HSRVcc methodology, we continue to believe that the differential markups among departmental CCRs have introduced distortion into the charge-based relative weights. We note that MedPAC found that "the current payment system encourages community hospitals to allocate capital to profitable services such as cardiology and stimulates the formation of specialty hospitals that often focus on providing profitable services and tend to care for low-severity patients." [3] The information we obtained from the cost reports on the differing level of charge markups occurring between routine and ancillary hospital departments supports MedPAC's conclusions that the most profitable DRGs that are leading to the development of cardiac specialty hospitals are those that require a lot of ancillary services with high markups and low CCRs. We note that the proposed rule showed that these hospitals are almost exclusively affected by changes to the relative weight methodology providing further evidence of bias and distortion in the relative weights by setting them using hospital charges. To the extent that charge markups vary significantly between the various routine and ancillary hospital departments, we believe that there is a need to adjust charges to cost prior to setting the relative weights. Although it suggested refinements to CMS' proposal (all of which we have adopted in this final rule), we note that MedPAC found that the CMS proposals made great strides toward achieving the goal of improvements in payment accuracy.[4] Therefore, as discussed in section II. C., we are using the national average CCRs to adjust the cost center charges for each DRG to cost prior to setting the relative weights. While we acknowledge that no payment methodology can be perfect because DRG-specific costs cannot be determined, we believe the cost-based methodology we are finalizing in this rule represents a significant

[2] Medicare Payment Advisory Commission: Report to Congress on Physician-Owned Specialty Hospitals, March 2005, p. 37–38.

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

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

improvement over the current charge-based methodology for all of the reasons we specified above. Under the cost-based methodology in this final rule, we will increase payment for relatively underpaid cases and reduce payment for relatively overpaid cases. We believe this reform is badly needed to reduce the bias in the weights and make more appropriate payments for both medical and surgical DRGs.

In order to mitigate the impact of the changes in the relative weights, we are implementing the new cost-based weight methodology in a 3-year transition, where the weights in the first year will be set based on 33 percent of the cost-based weight and 67 percent of the charge based weight. We will continue to study the HSRVcc methodology, the potential effects of charge compression and ways in which we can better account for severity of illness within the DRG system in the coming year.

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

Comment: One commenter asserted that CMS published incorrect and deficient information about the HSRVcc methodology, its impact on hospitals, and the underlying data utilized in developing the proposed rule. Specifically, the commenter believed the HSRVcc methodology was flawed and therefore stated that the published impacts were inaccurate. The commenter believed that we failed to comply with the Federal Data Quality Act, and OMB, HHS, and CMS Guidelines which address the quality of the data used for policy development, in particular, meeting standards of utility, objectivity, integrity, and transparency and reproducibility. Because the commenter believed that we have violated these data quality standards, the public was deprived of the opportunity to submit meaningful comments, as required by the Administrative Procedure Act (APA). The commenter urged CMS to take the appropriate steps that would result in the withdrawal of the FY 2007 IPPS proposed rule and the publication of a new proposed rule.

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

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

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

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

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

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

Comment: One commenter asserted that the proposed changes to improve

payment accuracy and to provide payment equity between specialty and general hospitals do not address many of the differences between specialty and full-service hospitals. The commenter stated that hospitals should be reimbursed for the additional services that are required to operate a full-service hospital which are often unnecessary in a specialty hospital setting. The commenter acknowledged that CMS already provides some support to hospitals that serve a high percentage of Medicaid patients through disproportionate share payments. However, the commenter suggested that CMS also make add-on payments to the base DRG payment for expenses such as: operation of a full-service, 24-hour emergency department; operation of a trauma service, a burn unit, or other high cost medically necessary services; sponsoring ground and helicopter ambulance services; operation of 24-hour diagnostic services; provision of round the clock nursing services; and provision of other support services such as clinical pharmacists, nutritionists, case managers, and medical social workers. The commenter believed these add-on payments will encourage hospitals to maintain these services rather than promote specialty hospitals that may be able to operate at a lesser cost without some or all of these services.

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

Comment: A few commenters stated that although the DRG payment changes proposed by CMS seek to address the proliferation of physician-owned, limited service hospitals in response to recommendations by MedPAC, they do not believe that these payment changes alone will remove the inappropriate incentives created by physician self-referral to limited-service hospitals. They stated that physicians will still have the ability and incentive to refer financially attractive patients to facilities they own, avoid serving low-income patients, and encourage utilization of profitable services. The commenters urged CMS to examine the investment structures of physician-owned, limited service hospitals and to continue the moratorium on issuing new provider numbers to physician-owned, limited service hospitals until the agency's strategic plan has been developed and the Congress has had the opportunity to consider the agency's final report on the topic.

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

Comment: Many commenters stated that CMS's proposed HSRVcc methodology presented in the FY 2007 IPPS proposed rule failed to address issues of "charge compression." The commenters explained that "charge compression" describes the common billing practice of hospitals applying higher percentage markups on lower cost items and lower percentage markups on higher cost items. The commenters noted that MedPAC explained that hospitals may reduce the mark-ups for higher-cost items to avoid "sticker shock."[5] As discussed below, many commenters believed that, to the extent "charge compression" exists, the proposed HSRVcc methodology would lead to systematic differences between estimates of costs and Medicare's payments. Therefore, the commenters believed that the proposal failed to accomplish CMS's stated goal of setting the DRG weights based on accurate cost determinations. If the proposed methodology is implemented, several commenters believed hospitals that perform a large volume of procedures requiring relatively costly supplies/procedures would be severely and unfairly penalized through inappropriately reduced Medicare DRG payments. The treatments they provide would be less likely to be provided, and consequently, Medicare beneficiaries' access to care may be diminished. Therefore, the commenters stated that if CMS adopts a cost-based DRG weighting methodology, a more accurate measure of determining hospitals' actual costs must be developed.

Many commenters believed that "charge compression" is a concern because the proposed HSRVcc methodology uses a single CCR for a variety of items and services in a department. Specifically, under the proposed HSRVcc methodology, we proposed to aggregate hospital-level departmental charges into 10 cost centers for each DRG, and then apply national average cost-center level CCRs to determine estimated costs. The commenters asserted that because most hospitals do not apply the same uniform percentage mark-up when setting the charges of each item in the department, the proposed HSRVcc methodology underestimates the cost of relatively more expensive items (particularly devices and implants) and overestimates the cost of relatively less expensive items. The commenters believed that the use of a single CCR for a variety of different items results in a systematic distortion of the estimated costs, and consequently the DRG relative weights that are used in determining the IPPS payment rates. Specifically, many commenters stated that the HSRVcc methodology has a disproportionate adverse impact on DRGs that include implantable technologies and devices, and in some cases would result in Medicare reimbursement that is less than the actual cost of the device.

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

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

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

The commenters pointed out that the results of this research are consistent with previous analyses demonstrating "charge compression" in hospitals' billing patterns. The commenters also noted that this research was conducted exclusively on Medicare claims data, without supplementation with any external data. The commenters believed that this research demonstrates that an adjustment for "charge compression" is possible. They further asserted that the research provides a solid analytical basis for a specific adjustment. The commenters advocated that we use the coefficients from this regression analysis to develop a "data-driven" adjustment to the CCRs for the supplies and equipment to address the distortion caused by "charge compression."

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

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

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

Response: We appreciate the commenters' concerns regarding charge compression and its impact on the relative weight calculations under the proposed HSRVcc methodology. We are interested in further studying the analytic technique suggested in the comments of using a regression analysis to identify adjustments that could be made to the CCRs to account for charge compression. We note that the Hogan study's regression model was only applied to expensive medical supplies and devices and was not applied uniformly to develop potential adjustments that could be made to costs and charges across all revenue and cost centers that could potentially be subject to charge compression. If such a model were to be applied, we believe further analysis would have to be undertaken to determine whether it should apply to all costs and revenue centers. At this time, we intend to research whether a rigorous model should allow an adjustment for "charge compression" to the extent it exists. Accordingly, we have engaged a contractor to undertake a study on charge compression and review the statistical models provided to us by the commenters. To the extent that we find "charge compression" exists, we will further study potential models that could adjust for it so we can develop more accurate systems of cost-based weights to better reflect the relative costs of the different types of services provided under the IPPS. As suggested in the comments, we plan to fully involve appropriate stakeholders in future analysis of this issue to the extent feasible. Before implementing such an adjustment, we would fully describe our analysis and a potential proposed adjustment as part of the IPPS proposed rule for FY 2008.

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

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

In addition, we note that in order to mitigate the impact of adopting a revised methodology for calculating DRG weights, we are standardizing charges for MedPAR claims using the same methodology we have used in past years, rather than using the HSRV methodology. However, as discussed in detail in section II.E. of this preamble to the final rule, we are adopting our proposal to adjust charges to account for costs prior to establishing DRG weights. However, we anticipate undertaking further analysis of the hospital-specific methodology over the next year in conjunction with the research we are doing on charge compression. If our analysis suggests that an adjustment for charge compression should be applied and/or that the hospital-specific methodology will result in relative

weights that more closely approximate the relative costs of care, we will propose further changes for FY 2008. In the interim, we are further mitigating the potential payment effects from the changes to the DRG relative weights by adopting a 3-year transition of the relative weights. During the first year of the transition, the relative weights will be based on a blend of 33 percent of the cost-based weights and 67 percent of the charge weights. In the second year of the transition, the relative weights will be based on a blend of 33 percent of the charge weights and 67 percent of the cost-based weights. In the third year of the transition, the relative weights will be based on 100 percent of the cost-based weights.

3. Refinement of DRGs Based on Severity of Illness

For purposes of the following discussions, the term "CMS DRGs" means the DRG system we currently use under the IPPS; the term "APR DRGs" means the severity DRG system designed by 3M Health Information Systems that currently is used by the State of Maryland; and the term "consolidated severity-adjusted DRGs (CS DRGs)" means the DRG system based on a consolidated version of the APR DRGs (as described in detail below). We discussed the CS DRGs in the FY 2007 IPPS proposed rule and solicited public comments on whether there are alternative DRG systems that could result in better recognition of severity than the CS DRGs we were proposing. As we made clear in the proposed rule, there are still further changes that are important to make to the CS DRG system before it is ready for adoption. In the remainder of this final rule, "CS DRGs" refers to the DRG system we analyzed and proposed for adoption in FY 2008. However, as we indicate below, we received a number of public comments about the proposed CS DRGs, potential alternatives, and a number of other issues related to our proposal. Below we summarize those comments, respond to the comments, and present our plans for adopting a severity-adjusted DRG system for FY 2008.

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

After publication of the FY 2006 IPPS final rule, CMS contracted with 3M Health Information Systems to further analyze the MedPAC recommendations in support of our consideration of possible changes to the IPPS for FY 2007. Under one task of this contract, 3M Health Information Systems analyzed the feasibility of using a revised DRG system under the IPPS that is modeled on the APR DRGs Version 23 to better recognize severity of illness. The APR DRGs have been used successfully as the basis of Belgium's hospital prospective global budgeting system since 2002. The State of Maryland began using APR DRGs as the basis of its all-payer hospital payment system in July 2005. More than a third of the hospitals in the United States are already using APR DRG software to analyze comparative hospital performance. Many major health information system vendors have integrated this system into their products. Several State agencies utilize the APR DRGs for the public dissemination of comparative hospital performance reports. APR DRGs have been widely applied in policy and health services research. In addition to being used in research by MedPAC, the APR DRGs also contain a separate measure of risk of mortality that is used in the Quality Indicators of the Agency for Healthcare Research and Quality, the Premier Hospital Quality Incentive Demonstration discussed in section IV.B. of this preamble, and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) hospital accreditation survey process (Shared Visions-New Pathways).

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

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

The CMS DRG and APR DRG systems have a similar basic structure. There are 25 MDCs in both systems. The DRG assignments for both systems are based on the reporting of ICD–9–CM diagnosis and procedure codes. Both DRG systems are composed of a base DRG that describes the reason for hospital admission and a subdivision of the base DRG based on other patient attributes that affect the care of the patient. For surgical patients, the base DRG is defined based on the type of procedure performed. For medical patients, the base DRG is defined based on the principal diagnosis. In Version 23.0 of the CMS DRG system, there are 367 base DRGs and 526 total DRGs. In Version 23 of the APR DRG system, there are 314 base DRGs and 1,258 total APR DRGs. Some of the base DRGs in the two systems are virtually identical. For example, there is no significant difference between the base DRG under both systems for medical treatment of congestive heart failure. For other base DRGs, there are substantial differences. For example, in the CMS DRG system, there are two base DRGs for appendectomy (simple and complex); in the APR DRG system, there is only one base DRG for appendectomy (the relative complexity of the patient is addressed in the subsequent subdivision of the base DRG into severity of illness subclasses).

The focus of the CMS DRGs is on complexity. Complexity is defined as the relative volume and types of diagnostic, therapeutic, and bed services required for the treatment of a particular illness. Thus, the focus of payment in the CMS DRG system reflects the relative resource use needed by the patient in one DRG group compared to another. Resource use is generally correlated with severity of illness but intensive resource use does not necessarily indicate a high level of severity in every case. It is possible that some patients will be resource-intensive and require high-cost services even though they are less severely ill than other patients. The CMS DRG system subdivides the base DRGs using age and the presence of a secondary diagnosis that represents a CC. The age subdivisions primarily relate to pediatric patients (those who are less than 18 years of age). Patients are assigned to the CC subgroup if they have at least one secondary diagnosis that is considered a CC. The diagnoses that are designated as CCs are the same across all base DRGs. The subdivisions of the base CMS DRGs are not uniform: Some base DRGs have no subdivision; some base DRGs have a two-way subdivision based on the presence of a CC; and other base DRGs have a three-way subdivision based on a pediatric subdivision followed by a CC subdivision of the adult patients. In addition, some base DRGs in MDC 5 (Diseases and Disorders of the Circulatory System) have a subdivision based on the presence of a major cardiovascular condition or complex diagnosis.

The APR DRG system subdivides the base DRGs by adding four severity of

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

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

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

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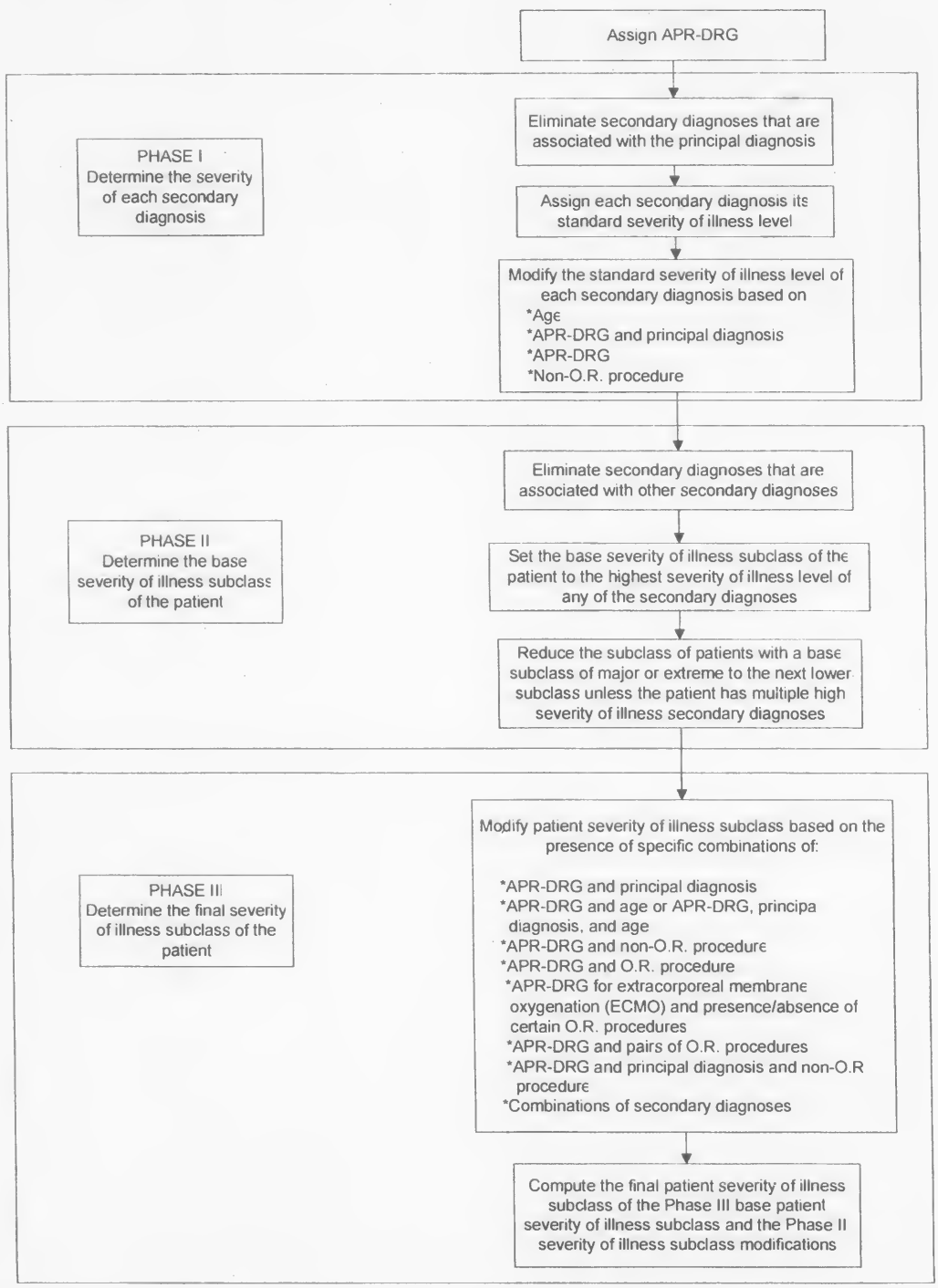
Diagram--Three Phase Process for Determining Patient Severity of Illness



Under the CMS DRG system, a patient is assigned to the DRG with CC if there is at least one secondary diagnosis present that is a CC. There is no recognition of the impact of multiple CCs. Under the APR DRG system, high severity of illness is primarily determined by the interaction of multiple diseases. Under the CMS DRG

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

The CMS DRG structure makes some DRG modifications difficult to accommodate. For example, high severity diseases that occur in low volume are difficult to accommodate because the only choice is to form a separate base DRG with relatively few patients. Such an approach could lead to a proliferation of low-volume DRGs. Alternatively, these cases may be included in DRGs with other patients that are dissimilar clinically or in costs. Requests for new base DRGs formed on the use of a specific technology may also be difficult to accommodate. Base DRGs formed based on the use of a specific technology would result in the payment weight for the DRG being dominated by the price set by the manufacturer for the technology.

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

Section 1886(d)(4) of the Act specifies that the Secretary must adjust the classifications and weighting factors at least annually to reflect changes in treatment patterns, technology, and other factors that may change the relative use of hospital resources. Therefore, we believe a method of recognizing technologies that represent increased complexity, but not necessarily greater severity of illness, should be included in the system. We plan to develop criteria for determining when it is appropriate to recognize increased complexity in the structure of the DRG system and how these criteria interact with the existing statutory provisions for new technology add-on payments. In the FY 2007 IPPS proposed rule, we invited public comments on this particular issue.

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

Comment: Some commenters strongly supported including the complication codes (996.00–999.9) when assigning a patient to a severity-adjusted DRG because the codes represent pre-existing or predictably higher risks upon admission for difficult patients who are typically referred to regional centers. The commenters stated that failure to do so will create new incentives for adverse admission selection and underpay hospitals that treat difficult patients. The commenters stated that the 996 codes include some complications that should never be paid (for example, wrong site surgery and instruments left in the patient). However, the commenters indicated that these kinds of complications likely constitute less than one-half of one percent of all complications and revising the DRG system so that all 996 codes are not paid will provide incentives to hospitals to avoid admitting patients that are at high risk because of a pre-existing condition or other circumstance. Another commenter stated that all infections should be removed as complicating conditions under the DRG system.

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

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

TABLE B.—COMPARISON OF THE CMS DRG SYSTEM AND THE APR DRG SYSTEM

Element	CMS DRG System	APR DRG System
Number of base DRGs	367	314
Total number of DRGs	526	1,258
Number of CC (severity) subclasses	2	4

TABLE B.—COMPARISON OF THE CMS DRG SYSTEM AND THE APR DRG SYSTEM—Continued

Element	CMS DRG System	APR DRG System
Multiple CCs recognized	No	Yes.
CC assignment specific to base DRG	No	Yes.
Logic of CC subdivision	Presence or absence	18-step process.
Logic of MDC assignment	Principal diagnosis	Principal diagnosis with rerouting.
Death used in DRG definitions	Yes	No.
Data requirements	Hospital claims	Hospital claims.

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

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

Case 2: The patient receives a secondary diagnosis of an ulcer of anus and rectum and an additional secondary diagnosis of unspecified intestinal obstruction (ICD–9–CM diagnosis code 560.9). Under the CMS DRG system, the patient is assigned to DRG 148 (Major Small and Large Bowel Procedures With CC). Under the APR DRG system, the patient is assigned to base DRG 221 and the severity of illness subclass increases to 2 (moderate).

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

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

TABLE C.—EXAMPLE OF SAMPLE CASES ASSIGNED UNDER THE CMS DRG SYSTEM AND UNDER THE APR DRG SYSTEM

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

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

b. CS DRGs for Use in the IPPS

APR DRGs were developed to encompass all-payer patient populations. As a result, we found that, for the Medicare population, some of the APR DRGs have very low volume. MedPAC noted that the larger number of DRGs under a severity-weighted system might mean that CMS would be faced with establishing weights in many categories that have few cases and, thus, potentially creating unstable estimates. While volume is an important consideration in evaluating any potential consolidation of APR DRGs for use under the IPPS, we believe that hospital resource use and clinical interpretability also need to be taken into consideration. For example, any consolidation of severity of illness subclasses within a base DRG should be restricted to contiguous severity of illness subclasses. Thus, it would not be reasonable clinically to combine severity of illness subclasses 1 and 4 solely because both consist of low-volume cases. We analyzed consolidating APR DRGs by either combining the base DRGs or the severity of illness subclasses within a base DRG. For consolidation across base APR DRGs, we considered patient volume, similarity of hospital charges across all four severity of illness subclasses and

clinical similarity of the base APR DRGs. For consolidations of severity of illness subclasses within a base DRG, we considered patient volume and the similarity of hospital charges between severity of illness subclasses. In considering how to consolidate severity of illness subclasses, we believed it was important to use uniform criteria across all DRGs to avoid creating confusing and difficult to interpret results. That is, we were concerned about inconsistencies in the number of severity levels across different DRGs.

The objective to simultaneously take into consideration patient volume and average charges often produced conflict. Table D below contains the overall patient volume and average charge by APR DRG severity of illness subclass. While severity of illness subclass 4 (extreme) has the lowest patient volume of 5.80 percent, we found that the dramatically different average charges between severity of illness subclass 3 (major) and subclass 4 (extreme) patients of approximately $32,426 and $81,952, respectively, would make it difficult to consolidate severity of illness subclass 3 and 4 patients. Conversely, we found that, while the average charge difference between severity of illness subclass 1 (minor) and 2 (moderate) patients was much smaller, of approximately $17,649 and $20,021, respectively, the majority of patient volume (68.08 percent) is in these two subclasses. Thus, low patient volume and small average charge differences rarely coincided.

TABLE D.—OVERALL AVERAGE CHARGES AND PATIENT VOLUME BY APR DRG SEVERITY OF ILLNESS SUBCLASS

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

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

We reviewed the patient volume and average charges across APR DRGs and found that medical cases assigned severity of illness subclass 4 within an MDC have similar average charges. We observed the same pattern in average charges across severity of illness subclass 4 surgical patients within an MDC. The data suggest that, in cases with a severity of illness of subclass 4, the severity of the cases had more impact on hospital resource use than the reason for admission (that is, the base APR DRG within an MDC). Thus, we believe that, within each MDC, the severity of illness subclass 4 medical and surgical patients, respectively, could be consolidated into a single group.

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

TABLE E.—SUMMARY STATISTICS FOR SURGICAL CASES WITH SEVERITY OF ILLNESS SUBCLASS 4 IN MDC 11

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

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

of illness subclass 4 groups was reduced from 262 to 69.

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

The Medicare patient volume in MDC 15 was very low, allowing for a more aggressive consolidation. For MDC 15, we consolidated 28 base APR DRGs into 7 base CS DRGs. For each of the 7 consolidated base MDC 15 DRGs, we combined severity of illness subclasses 1 and 2 into one DRG and severity of illness subclass 3 and 4 into another DRG. This consolidation reduced the total number of MDC 15 DRGs from 112 in the APR DRG system to 14 CS DRGs.

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

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

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

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

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

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

Appendix D of the FY 2007 IPPS proposed rule (71 FR 24433) showed the crosswalk of each CS DRG to its respective APR DRG. We numbered the DRGs sequentially and incorporated the severity of illness subclass into the DRG

description. However, within the range of sequential numbers used for an MDC, we retained some unused numbers to allow for future DRG expansion. By using a three-digit number for the CS DRGs, we also avoid the need for reprogramming of computer systems that would be necessary to accommodate a change from the current three-digit DRG number to separate fields for the base CS DRG number and the severity of illness subclass.

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

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

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

- Some patients in need of ventricular assist devices (VAD) are currently paid in the same group as heart transplant patients using the CMS DRGs. Other heart assist devices are assigned to DRG 525 (Other Heart Assist Implant). These patients will be paid in the same group as implantable cardiac defibrillator patients under the CS DRGs. The commenters noted that it is possible that payment for these kinds of cases could decline by more than 70 percent under the proposed rule. The commenter believed that the assignment under the CS DRGs will not recognize higher resources associated with treating VAD patients relative to those in need of implantable cardiac defibrillators.
- Bare metal and drug-eluting coronary stents would be assigned to the same CS DRG eliminating the distinction currently made for these two different kinds of stents in the CMS DRGs. The commenters noted that CMS created separate DRGs for drug eluting and bare metal stents to recognize the higher costs of drug eluting stents.
- Defibrillator device replacement cases are currently assigned to DRG 551 (Permanent Cardiac Pacemaker Implant With Major Cardiovascular Diagnoses or AICD Lead or Generator). The commenters were concerned that these cases would be assigned to the DRGs for Permanent Cardiac Pacemaker Implant With & W/O AMI, Heart Failure or Shock and the cases would revert back to classification based on presence or absence of heart failure, AMI, or shock, rather than an MCV.
- Patients receiving tPA thrombolytic therapy for stroke are currently assigned to DRG 559 (Acute Ischemic Stroke With Use of a Thrombolytic Agent). CMS revised the DRGs in FY 2006 to provide a separate DRG for stroke patients being treated with a reperfusion agent. According to the commenter, these patients will be paid in the same group with all stroke cases under CS DRGs undoing the change that CMS made in FY 2006 according to the commenter.
- In FY 2006, CMS created separate DRGs for the revision of hip or knee replacement (DRG 545, Revision of Hip or Knee Replacement) to distinguish the higher resources associated with revisions from original replacements. Under CS DRGs, these cases would be assigned to the same group as the original replacement (bilateral or single) of the specific joint. The commenters were concerned that CMS' proposal to adopt cCS DRGs will undo a proposal that it adopted just 1 year ago.
- Combined anterior/posterior spinal fusion cases are currently assigned to DRG 496 (Combined Anterior/Posterior Spinal Fusion). This procedure requires two separate incisions and turning the patient over during surgery. The commenter expressed concern that under the CS DRG system, these cases would be paid in the same group as all spinal fusions and the new DRGs would not recognize higher costs associated with treating these patients.
- The APR DRG and CS DRG systems do not have DRGs for lung transplants alone or combined kidney/pancreas transplants. The commenter suggested that there should be separate DRGs for these transplants in addition to liver/intestinal transplants. The commenter indicated that lung transplants alone have lower costs and should not be in the same DRG as combined transplants.

Response: In the vast majority of clinical situations, severity of illness and treatment complexity are directly related and are therefore addressed in the CS DRGs. As discussed in the proposed rule, there are a number of clinical situations, primarily related to the use of specific technologies, in which low severity patients receive care with high treatment complexity and cost. We acknowledge that further refinements are needed to the proposed CS DRG system before it will be ready for adoption. In the FY 2007 IPPS proposed rule, we noted a number of concerns we had with adopting the CS DRGs in FY 2007 (71 FR 24027). Among them was our concern that we might need additional time to refine the CS DRGs to better account for complexity as well as severity. The commenters have brought some important issues to our attention that we believe should be carefully considered before we adopt the CS DRGs. We will consider these issues if we were to make further modifications to the CS DRGs and propose adopting them for FY 2008. However, as we indicate elsewhere in this final rule, we have engaged a contractor to assist us with completing an evaluation of alternative DRG systems that may better recognize severity than the current CMS DRGs and meet other criteria that would make them suitable to adopt for purposes of payment under the IPPS. We expect to complete this evaluation of alternative DRG systems quickly this fall as part of moving forward on adopting a revised DRG system that better recognizes severity in the IPPS rulemaking for FY 2008. It is possible that some of the alternatives that we evaluate for better recognizing severity in the DRGs will be based on the current CMS DRGs. If we were to develop a clinical severity concept that uses the current CMS DRGs as the starting point, it is possible that the issues raised by the commenters will no longer be a concern. If, however, we were to propose adopting the CS DRGs for FY 2008, we would consider the issues raised by the commenters as we make further refinements to this DRG

system so it accounts for complexity as well as severity as a proxy for relative resource use.

Comment: One commenter suggested a way of accounting for therapeutic complexity when assigning a patient under the CS DRGs. The commenter indicated that the patient should be assigned to a severity of illness subclass based on whether they received a separately identifiable technology that provides a clinical benefit and results in significantly higher case costs independent of severity level relative to the base DRG. The commenter also recommended that complexity levels be superimposed on the proposed severity of illness levels, such that either severity or complexity, or a combination of the two, would increase the classification of a case. The classifications would be defined as severity of illness or complexity (1–4).

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

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

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

Comment: Some commenters stated concerns with merging of dissimilar patient groups in the CS DRG system. Combining clinically dissimilar groups across the severity dimension has the potential to render the groups far less clinically meaningful. It is anticipated that such groups would have to be restructured frequently as treatment patterns change for primarily very ill patients. Some commenters stated that it seems that more categories may have been consolidated than necessary, giving up clinical and statistical homogeneity unnecessarily. It was noted that this is especially important if the CS DRGs are envisioned as part of the basis for evolving efforts towards value-based purchasing where such measures as post-admission complications and readmissions need to be evaluated on a risk-adjusted basis. An alternative approach was suggested to keep the patient groups separate from a classification perspective, but merge from a payment analysis perspective.

Response: As discussed above, the CS DRGs are based on the APR DRG system. The APR DRG system is comprised of 314 base DRGs, which are divided into four severity of illness subclasses. We believe that the APR DRG greatly improve recognition of resource use and clinical similarity of patients. However, in our analysis of the APR DRG system, we observed that cases assigned severity of illness subclass 4 within an MDC have similar average charges. Furthermore, our clinical consultants frequently considered the severity of illness subclass 4 patients across DRGs within an MDC to have a closer clinical resemblance than to lower severity patients in their respective DRGs because, in severely ill patients, comorbidities have a greater impact on severity than the reason for admisssion. Treatment patterns will evolve for these multiple comorbidities leading to severity level 4 (sepsis, shock, acute renal failure, among others). However, to the extent that these multiple comorbidities will change (for example, better treatment of septic shock so that this occurs less frequently) they should do so equally across all patients within an MDC. With respect to the comment about maintaining more DRG groups for purposes other than payment under the IPPS, we proposed to adopt the CS DRGs only for Medicare inpatient hospital payment. We chose to consolidate the APR DRGs to increase administrative simplicity, minimize the impact on existing claim processing systems, and avoid having multiple DRGs with low case volumes and similar weights. The commenter's suggestion would essentially result in many more DRGs having exactly the same weight. Therefore, we do not see a need to adopt the commenter's suggestion. However, a hospital or any other entity can use an alternative patient classification system for the other purposes suggested in the comment.

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

In addition, another commenter stated that private health insurance company contracts use the CMS DRG relative weights as the payment basis for inpatient services delivered to members under private health insurance plans. The commenter stated that because these contracts are typically negotiated based on a fairly static assumption of CMS DRGs (including classification and weights), the proposed redistribution will disrupt virtually every contract because of the varying services

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

[7] Ibid, page 41.

consumed by members covered under private health insurance. The commenter urged CMS to provide a greater lead time in implementing changes to the DRG system and relative weight methodology to allow health insurers more time to model the impact of the methodological changes to their hospital contracts.

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

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

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

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

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

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

Response: We did not propose any changes to the DRG classifications systems used under the IPF PPS or the LTCH PPS in the IPPS proposed rule. However, we acknowledge that these PPSs use the IPPS DRG classifications to make payment determinations. Furthermore, we note that the refinements we are adopting to the current CMS DRG system to better recognize severity (which are discussed in detail in section II.C.7. of this final rule) will be applicable under the IPF PPS and LTCH PPS, just as past annual updates to the IPPS DRG classifications). We will need to consider whether corresponding changes need to be made to these other payment systems once final decisions are made about how DRG classification will occur under the IPPS in the future. Payment rate and policy changes to the IPF PPS and LTCH PPS went into effect for RY 2007 on July 1, 2006. These PPSs are using the Version 23 IPPS GROUPER for the first 3 months of RY 2007 (July 2006 through September 2006). Consistent with the IPPS, the IPF PPS will use Version 24 of the IPPS GROUPER, effective October 1, 2006. No further changes will be made to the IPF PPS until next July. Under the LTCH PPS, changes to the LTC–DRGs were proposed for FY 2007, based on the proposed Version 24 IPPS GROUPER (71 FR 24049 through 24068), and changes to the LTC–DRGs that will be effective October 1, 2006, based on the finalized Version 24 IPPS GROUPER (presented in this final rule) are discussed in section II.F. of the preamble of this final rule. Any changes to the DRG classification systems for these prospective payment systems would be undertaken through notice and comment rulemaking in their respective proposed rules.

Comment: One commenter stated that it was not clear how the judgment was made for the MDC 11 severity subclass 4 example shown that these average charge values were sufficiently similar to consolidate. The commenter suggested that CMS provide further information about the criteria and considerations it used to judge categories as low volume and potentially unstable and to judge the mean charges (or costs) as sufficiently similar to warrant consolidation. One commenter expressed concern about the consolidations related to obstetrics and psychiatric care services.

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

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

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

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

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

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

- *Validation.* The commenters indicated that it is unclear whether there is a need for a new patient classification system. The commenters stated that the implication of moving from a resource-based system to a severity-based payment system must be more fully explored and understood. They indicated that CMS provided no analysis that shows that the proposed changes result in an improved hospital payment system compared to the existing DRG system or APR DRGs.
- *Budget neutrality adjustment.* The commenter indicated that the proposed rule did not address an adjustment for improved documentation and coding or even a methodology for determining one. The commenter suggested that CMS not apply an adjustment for more comprehensive documentation and coding that increases perceived but not real case mix until there is evidence that one is needed. The commenter requested that CMS monitor actual changes in coding and documentation practices associated with implementation of inpatient payment reforms to determine if any base payment adjustments are needed rather than adjust payments in anticipation of such changes.
- *Availability of the GROUPER.* Many commenters stated that the proprietary nature and lack of transparency of the proposed CS DRG GROUPER are concerns. The current DRG GROUPER logic has been in the public domain since the inception of IPPS. Without the new GROUPER logic, the commenters believed that it is virtually impossible for anyone to thoroughly analyze the system and comment. The commenters urged that CMS make any new classification system widely available to the public on the same terms as the current DRG system. Some commenters stated that CMS should provide the GROUPER for the CS DRGs and open a new public comment period. Several commenters were concerned about the cost of the GROUPER if the CS DRGs were implemented.
- *Too few diagnoses and procedures considered.* The commenters are concerned that the current CMS GROUPER does not use all diagnosis and procedures that affect a patient's severity of illness and/or the resources utilized. The commenters believed that the number of secondary diagnoses may be an important factor in determining differences in patient characteristics.

Response: With respect to the comment about the need for a new patient classification system, the proposed rule noted that we modeled the CS DRGs and observed a 12-percent increase in the explanatory power (or R-square statistic) of the DRG system to explain hospital charges. That is, we found more uniformity among hospital total charges within the CS DRGs than we did with Medicare's current DRG system (71 FR 24027). Thus, we believe that there is clear evidence that improvements can be made to the current DRG system that will reduce heterogeneity among patients within a given DRG. While this statistic indicates that the current CMS DRG system can be refined to improve payment accuracy, we agree that it does not necessarily mean we should adopt the system we proposed. As suggested by the commenters, there are a number of other evaluation criteria that we need to consider before deciding whether to adopt the CS DRGs or a potential alternative. We describe these criteria in more detail below. With respect to the comments about a budget neutrality adjustment to account for potential improvements in documentation and coding, we discuss the comments and our responses on this issue more fully in the next section of this final rule. The comment about the availability of the GROUPER is related to a number of detailed comments we received about the potential for Medicare to adopt a proprietary DRG system. We have provided a more detailed description of these comments and our responses below. With respect to the comment about fully utilizing all of the diagnosis and procedure codes submitted on the claim, we note that CMS does not process codes submitted electronically on the 837i electronic format beyond the first 9 diagnosis codes and the first 6 procedure codes. While HIPAA requires CMS to accept up to 25 ICD–9–CM diagnosis and procedure codes on the HIPAA 837i electronic format, it does not require that CMS process that many diagnosis and procedure codes. As suggested by the commenters, there may be value in retaining additional data on patient conditions that would result from expanding Medicare's data system so it can accommodate additional diagnosis and procedure codes. We will consider this issue while we contemplate refinements to our DRG system to better recognize patient severity. However, extensive lead time is required to allow for modifications to our internal and contractors' electronic systems in order to process and store this additional information. We are unable to move forward with this recommendation without carefully evaluating implementation issues. One

issue that we expect to consider in deciding whether to adopt such a major systems change is how frequently information beyond the ninth diagnosis code and sixth procedure code affects DRG assignment. Given the cost of an infrastructure change to accommodate this request, we want to be certain that there are sufficient benefits to justify the costs. Again, we will continue to carefully evaluate this request to expand the process capacity of our systems.

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

Response: As explained above, we are not adopting the HSRVcc methodology for FY 2007 because of our concerns about the interaction of charge compression with the hospital-specific portion of the cost weight methodology. Instead, we are setting relative weights based on the estimated cost of the DRGs where cost is determined by applying the national average CCRs to the standardized charges for each DRG in each of the 13 cost centers. In general, when we consider whether to further distinguish types of cases within a DRG in order to create a new DRG or to reassign these cases to a different DRG, we are comparing cases that are clinically similar. Therefore, it is possible or even likely that these cases will be using the same mix of routine and ancillary services and the results of the analysis will be similar whether the cases are compared based on average costs or charges. That is, the cases will be using services that have comparable charge markups over costs and the analysis will produce the same conclusion whether the comparison between cases is based on costs or charges. The major differences between cost and charge weights will occur when comparing across clinically dissimilar services that use a different mix of routine and ancillary services with variable markups. For this reason, we believe that we can continue to do our initial evaluation of potential DRG changes using average charges. Given the complexity associated with developing cost-based weights, we believe our preliminary analysis for evaluating whether to make a DRG change should use charges as a proxy for costs. However, we will consider the commenters' suggestion and, to the extent feasible, consider whether it is possible to evaluate potential DRG changes using costs as well as charges.

Comment: Numerous comments expressed concerns about the use of a proprietary DRG classification system. The commenters indicated that the current DRG GROUPER logic has been in the public domain since the inception of the IPPS. Many commenters noted that the source code, logic and documentation for the current DRG system can be purchased through the National Technical Information Service. The commenters stressed the importance of maintaining transparency within the DRG system (that is, any new DRG system should be available to the public on the same terms as the current one). The commenters stated that any methodology used for the Medicare GROUPER must not be based on a proprietary system. One commenter questioned how future DRG refinements would be made if the underlying system is owned by 3M.

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

Several commenters stated that if CS DRGs are adopted and the GROUPER remains proprietary, they would be limited in their ability to educate and assist hospitals in use of the new system. One commenter indicated that the current 3M product is proprietary and not available in the public domain for hospitals or their software vendors who develop and support their patient account billing and case management software. The commenter also stated that it does not have any access to the underlying codes, conditions and edits utilized by 3M with its product and as a result could not accurately comment on the interaction between severity and complexity associated with individual claims in contrast to resource consumption. The commenter stated that, although hospitals are not required to have a GROUPER, hospitals that hold compliance as a top priority rely on a grouper/encoder to ensure that claims meet all edits prior to submission.

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

Another commenter stated that it offered software that hospitals and health plans utilize in managing the billing, coding, and payment for inpatient hospital services under the DRGs. The development of software related to Medicare's DRG system by private companies is possible only because the current DRG methodology is available in the public domain. The commenter also noted that the public can obtain full access to the details underlying the CMS DRG system by purchasing information and software from the National Technical Information Service for a nominal charge in a timely manner well in advance of the implementation of changes. The commenter noted the information was available to all of the public simultaneously and no company

currently has a competitive advantage in producing DRG products. The commenter added that CMS currently engages in an open and comprehensive discussion about the structure of the DRG methodology through a variety of mechanisms including notices published in the **Federal Register**. CMS releases sufficient detail about its methodology in electronic formats to enable providers, health plans, and vendors to develop and validate their own computer programs. The commenter expressed concern that unfettered access to the underpinnings of the DRG system would not continue to be available under the CMS proposal to adopt CS DRGs. The commenter suggested the following criteria that a new DRG system should meet in order to be adopted by Medicare:

- Software distribution comparable to what is currently made available, which includes:
- GROUPER source code which produces all pertinent return information;
- All underlying tables that drive the GROUPER with documentation;
- A complete set of test cases to validate the functioning of the software;
- Complete system and user documentation;
- Contact people who can and will respond to questions in a timely fashion;
- The right to redistribute the methodology to business partners and consultants;
- The right to translate source code to other technology environments and to integrate it into other systems;
- Pre-releases of software and documentation well in advance of planned implementations; and
- An open inclusive process for considering future enhancements.

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

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

- Provider Specific File.
- Impact file for IPPS FY 2007 Proposed Rule.
- CCRs and Weighting Factors.
- DRG Relative Weights.
- CS DRG HSRVcc relative weights.
- CAH List for FY 2007 Proposed Rule.

In addition to this information, we made available for purchase both the FY 2004 and FY 2005 MedPAR data that were used in simulating the policies in the IPPS proposed rule. We also discussed the proposed rule in at least two national teleconferences that were open to the public. One of these calls was a Special Hospital Open Door call that was scheduled for 1 and 1½ hours and was completely devoted to explaining the IPPS proposed rule and answering questions from the public. There were over 1,100 calls into this national teleconference. Finally, we were able to provide access to a Web tool on 3M's Web site that would allow an end user to build case examples using the proposed CS DRGs. While the commenters are correct that these case examples could only be analyzed one at a time, the tool did provide a detailed explanation of how the severity of illness was assigned and the demographic and diagnostic information that went into that determination. Further, other information about the CS DRGs and APR DRGs were available at that Web site, including access to the APR DRG definitions manual.

We acknowledge the many comments suggesting that the logic of Medicare's DRG system should continue to remain in the public domain as it has since the inception of PPS. We also acknowledge the commenters' concern about the impact of moving to a proprietary system and the potential for limiting public access to the underlying GROUPER logic relative to the current CMS DRGs. We note that the issues associated with using a proprietary DRG system were well illustrated in a public comment that we received from the Maryland Health Services Cost Review Commission (HSCRC). Maryland adopted the APR DRGs in June 2004. The commenter noted that "despite the advance notice, a number of hospitals had not acquired the APR DRG GROUPER until near the time for full implementation to begin. In addition to acquiring the GROUPER, hospitals had to deal with issues of integrating the GROUPER with other hospital systems, which was at times difficult with proprietary systems." The commenter further noted that Maryland has 47 acute care hospitals and "moving the nation's entire hospital industry to a new system in a short period is likely to be much more difficult." The commenter indicated that "CMS has the opportunity to avoid some of the transition issues the HSCRC faced by placing the CS DRG logic in the public domain or by requiring open licensing of the GROUPER at reasonable rates." The commenter noted that consultants and vendors to hospitals have struggled to obtain access to the GROUPER as they advised their clients.

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

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

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

Two commenters proposed alternative severity of illness systems to the APR DRG system. One commenter suggested that we use the Refined DRG (RDRG) severity of illness system which is supported by Health Systems Consultants, Inc, that contains 1,274 groups with 350 base DRGs. The commenter explained that each of the medical base DRGs is divided into three severity classes and each of the surgical base DRGs is divided into four severity

classes. In addition, there are neonate groups based on birth weight, seven DRGs that do not have severity classes and an early death group in each MDC created to remove low outliers according to the commenter. The commenter noted that the research for the RDRG system was undertaken between 1986 and 1989 under a Health Care Financing Administration (now CMS) cooperative agreement. The commenter indicated that the RDRG system has been updated annually using the current CMS complications and comorbidities list since 1989. Solucient, LLC has also used the previous HCFA DRG severity work to develop a risk adjusted DRG system which they refer to as Refined Diagnosis Related Group (R–DRG). Solucient also reports that they have updated their system annually with ICD–9–CM code changes. Another commenter noted that HSS/Ingenix has developed an all-payer severity-adjusted DRG system (APS–DRGs) which contains 1,130 case-mix cells with 376 consolidated DRGs plus 2 error categories. The commenter indicated that, outside of MDC 15, all consolidated DRGs are divided uniformly into three severity levels. The commenter also indicated that the number of severity levels within MDC 15 depends upon the consolidated DRG in the APS–DRG system.

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

Response: The approach suggested in the comments to incorporating severity measures into the current CMS DRG system may be a viable option that we will evaluate in the coming year. With respect to the comment that we undertake demonstration projects to study alternative ways of better recognizing severity in the DRG system, we are concerned that such an endeavor could not be completed in time for FY 2008 implementation. We believe it is very important to make improvements to the DRG system to better recognize severity rapidly and there are a number of different ways that improvements in payment accuracy can be achieved without undertaking a lengthy demonstration project. As suggested by the commenters, much research has already been completed on alternative DRG systems. We believe it is likely that at least one of these systems (or potentially a system that we develop ourselves based on our own prior research) will be suitable to achieve our goal of improvements in payment accuracy by FY2008. We are currently in the process of engaging a research contractor to evaluate the 3M Severity of Illness DRG products along with the other DRG severity systems that have come to our attention during the comment process.

As indicated above, we will use public access to the system as an important element in evaluating whether each system can be adopted by Medicare. With respect to the CS DRGs and potentially the other systems described in the public comments, there may be licensing issues. We proposed to use the CS DRGs beginning in FY 2008. While they were developed under a contract with the Federal government, the CS DRGs are essentially a variant of the APR DRGs that are copyrighted by 3M. The APS–DRGs are a proprietary product owned by HSS/Ingenix, a division of United Health Care. However, HSS/Ingenix has indicated that, should we decide to adopt their product, it would make its DRG system available to the public under the same terms as the current CMS DRGs (that is, the source code, logic and documentation can be purchased through the National Technical Information Service). The RDRG system is supported by Health Systems Consultants.

There are other issues of note with respect to the DRG systems mentioned in the comments and Medicare's efforts to adopt a DRG system that better recognizes severity. In the late 1980's, CMS (then HCFA) funded a Yale University contract for the development of refined severity DRGs. The severity DRGs developed under this contract formed the basis for most of the severity DRG systems available today, including the Ingenix APS–DRGs, the 3M APR DRGs, the Health Systems Consultants RDRGs and the Australian government's AR–DRGs. In the mid-1990's, CMS (then HCFA) also adapted the Yale system and developed a potential severity DRG system, which was described in the Health Care Financing Review.[8] Although the APR DRGs have departed from the Yale approach to a greater extent than have the other systems, both the 3M product and the APS–DRGs were derived from the 1989 Yale severity system that is in the public domain. Given that the Yale system is in the public domain and CMS considered adopting a severity DRG system based on it in the mid 1990's, we will also consider updating our prior work part of our initiative to identify and implement a severity DRG system for use by Medicare in FY 2008. Consistent with the sentiment expressed in the public comments, this option would have the advantage of using the current DRGs as a starting point and retaining the benefit of the many DRG decisions we have made in recent years. The DRG system we considered in the mid-1990's used a base DRG with 3 levels of severity depending upon whether the patient had no CC, a CC, or a major CC. During this past winter, CMS began a comprehensive review of over 13,000 diagnosis codes to determine whether they should be classified as CCs when present as a secondary diagnosis. Under this option, we could continue this review of the CC list, classifying them into one of the three categories described above in conjunction with updating the severity DRG system that we considered in mid-1990's.

c. Changes to CMI From a New DRG System

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

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

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

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

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

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

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

We believe that adoption of CS DRGs would create a risk of increased aggregate levels of payment as a result of increased documentation and coding. MedPAC notes that "refinements in DRG definitions have sometimes led to substantial unwarranted increases in payments to hospitals, reflecting more complete reporting of patients' diagnoses and procedures." MedPAC further notes that "refinements to the DRG definitions and weights would substantially strengthen providers' incentives to accurately report patients' comorbidities and complications." To address this issue, MedPAC recommended that the Secretary "project the likely effect of reporting improvements on total payments and make an offsetting adjustment to the national average base payment amounts." [10]

The Secretary has broad discretion under section 1886(d)(3)(A)(vi) of the Act to adjust the standardized amount so as to eliminate the effect of changes in coding or classification of discharges that do not reflect real changes in case-mix. While we modeled the changes to the DRG system and relative weights for the proposed rule to ensure budget neutrality, we are concerned that the large increase in the number of DRGs will provide opportunities for hospitals to do more accurate documentation and coding of information contained in the medical record. Coding that has no effect on payment under the current DRG system may result in a case being assigned to a higher paid DRG under a system that better recognizes severity. Thus, more accurate and complete documentation and coding may occur under a DRG system that better recognizes severity because it will result in higher payments than the current CMS DRGs. In the FY2007 IPPS proposed rule, we solicited comments on this issue.

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

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

Comment: Several commenters expressed concern that the proposed rule did not provide any type of analysis to justify or support the need for an adjustment to the IPPS rates for anticipated changes in case mix from a new DRG system. These commenters noted that CMS did not provide a specific adjustment amount in the proposed rule. The commenters stated their view that it is the responsibility of CMS to provide adequate notice and the opportunity for meaningful public comments in response to such a specific proposal before any adjustment can be applied. One commenter recognized that CMS is authorized to make adjustments for changes in coding that are likely to occur. However, absent strong evidence, they urged CMS to avoid making negative adjustments to the standardized amount for anticipated increases in case mix. Another commenter provided two suggestions to CMS. The first suggestion was for CMS to share its thought process on how the standardized amount would be adjusted and allow the public an opportunity to provide comments on this basic set of criteria. The second suggestion was that CMS should make a commitment to adjust future base payment levels if it is determined that the initial adjustment projections are inaccurate. Another commenter stated that any adjustment to the standardized amount in an attempt to account for increased documentation and coding is unnecessary and unwarranted. The commenter asserted that it is virtually impossible to objectively distinguish real changes in case mix from those that occur due to improved coding and documentation. This commenter stated claims are coded using the official coding guidelines that are the same regardless of the DRG system being used. Another commenter requested that CMS not overestimate the growth in CMI as a result of improved coding. This commenter asserted there are many needs for accurate data collection in a hospital setting and coders do not stop reviewing a medical record after locating the first CC that assigns the patient to a higher weighted DRG. The commenter maintained that several hospitals ask coders to assign codes to many of the non-invasive procedures that do not affect DRG assignment. This same commenter also stated they believe the increase in CMI will not be as significant as CMS anticipates.

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

The commenter also indicated that case mix growth exceeded four percent for the State's hospitals on average, as they began to prepare for the full transition to APR DRGs. Case mix growth in this current fiscal year is about the same. As such, the State has established a policy for FY 2006, limiting the amount of case mix growth experienced for each hospital until the coding patterns become stable. In addition, an appeals process for hospitals with services that generate rising case mix growth due to complexity has also been established.

Response: We appreciate the commenters' concerns and feedback regarding potential adjustments to the national standardized amount to account for improvements in documentation and coding that may cause the case-mix index to increase absent real case-mix growth. The commenters are correct that we did not propose a specific adjustment for improved documentation and coding. As stated in the proposed rule, we were soliciting comments on the possibility of changes in the case mix index as a result of the increase in the number of DRGs within the proposed CS DRGs. We will continue to analyze this issue as we evaluate alternative DRG systems that may better recognize severity of illness for implementation in FY 2008. We

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

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

acknowledge the commenters' request to provide an opportunity for public comment before CMS adopts a specific adjustment to the standardized amounts for improved documentation and coding. As stated earlier, we intend to propose further changes to better recognize severity in the DRG system for FY 2008. If we decide to make an adjustment to the standardized amount to account for improvements in documentation and coding, we will provide the specific level adjustment and the data and analysis underlying it in a proposed rule that will allow for an opportunity for public comment.

We disagree with the commenters that suggested there is no need for an adjustment to the IPPS standardized amounts to account for improvements in documentation that increase case mix and, therefore, payments. As presented above and in the proposed rule, Medicare's experience since the original inception of the IPPS and long-standing research provide substantiation that improvements in documentation and coding that increase case-mix and payment will occur when the opportunity arises through the expansion of the DRG system. Further, the comment representing the State of Maryland made clear that when CS DRGs "are used for reimbursement, hospitals have the financial incentive to improve their clinical documentation and to code administrative records more completely." [11] MedPAC also noted that "adopting our recommended refinements to the DRG definitions and weights would substantially strengthen providers' incentives to accurately report patients' comorbidities and complications." [12]

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

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

4. Effect of CS DRGs on the Outlier Threshold

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

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

Using FY 2004 Medicare charge data, 3M Health Information Systems simulated the effect of adopting CS DRGs in conjunction with HSRVcc weights (described) on the FY 2006 outlier threshold using the same estimation parameters used by CMS in the FY 2006 final rule (that is, the charge inflation factor of 14.94 percent) (70 FR 47494). Under these assumptions, 3M Health Information Systems estimated that the outlier threshold would be reduced from $23,600 under the current system to $18,758 under the CS DRGs with HSRVcc weights. By increasing the number of DRGs to better recognize severity, the DRG system itself would provide better recognition for cases that are currently paid as outliers. That is, many cases that are high-cost outlier cases under the current DRG system would be paid using a severity of illness subclass 3 or 4 under the CS DRGs and could potentially be paid as nonoutlier cases.

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

Response: We will consider further the application of the postacute care transfer payment policy as we make changes to the DRG system. With respect to outliers, we discussed this issue in the proposed rule. We noted that better recognition of severity in the

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

[12] MedPAC, p. 42.

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

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

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

5. Impact of Refinement of DRG System on Payments

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

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

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

DRG	Title	Proposed rule (percent)	Final rule (w/o transition) (percent)	Final rule (with transition) (percent)
14 ...	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION	3.8	1.8	0.6
75 ...	MAJOR CHEST PROCEDURES	1.4	0.0	0.0
76 ...	OTHER RESP SYSTEM O.R. PROCEDURES W CC	−3.4	−1.7	−0.6
79 ...	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	7.6	2.0	0.7
87 ...	PULMONARY EDEMA & RESPIRATORY FAILURE	10.9	0.0	0.0
88 ...	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	8.3	1.8	0.6
89 ...	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	9.7	2.1	0.7
104	CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W CARD CATH	−11.0	−3.1	−1.0
105	CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W/O CARD CATH	−7.2	−2.3	−0.8
110	MAJOR CARDIOVASCULAR PROCEDURES W CC	−5.4	−3.3	−1.1
113	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE	5.0	3.4	1.1
121	CIRCULATORY DISORDERS W AMI & MAJOR COMP, DISCHARGED ALIVE	4.7	0.7	0.2
124	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG	−19.7	−9.3	−3.1
125	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG	−28.9	−14.6	−4.9
127	HEART FAILURE & SHOCK	2.8	3.7	1.2
138	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	2.7	2.5	0.8
143	CHEST PAIN	−10.5	−6.2	−2.1
144	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	4.2	2.2	0.7
174	G.I. HEMORRHAGE W CC	11.2	2.9	1.0
182	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC	5.6	−1.1	−0.4
188	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	5.7	1.0	0.3
210	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC	3.8	2.2	0.7
277	CELLULITIS AGE >17 W CC	15.2	9.1	3.0
296	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	10.6	5.3	1.8
316	RENAL FAILURE	8.3	3.7	1.2
320	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	10.9	5.3	1.8
493	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	−4.0	−4.6	−1.5
497	SPINAL FUSION EXCEPT CERVICAL W CC	−13.4	0.5	0.2
515	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH	−20.6	0.3	0.1
541	ECMO OR TRACH W MV 96+HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R..	3.6	−2.9	−1.0
542	TRACH W MV 96+HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	8.4	−0.8	−0.3
544	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY	−3.7	2.6	0.9
545	REVISION OF HIP OR KNEE REPLACEMENT	−5.8	1.8	0.6

DRG	Title	Proposed rule (percent)	Final rule (w/o transition) (percent)	Final rule (with transition) (percent)
547	CORONARY BYPASS W CARDIAC CATH W MAJOR CV DX	−8.9	−5.5	−1.8
548	CORONARY BYPASS W CARDIAC CATH W/O MAJOR CV DX	−11.9	−6.2	−2.1
550	CORONARY BYPASS W/O CARDIAC CATH W/O MAJOR CV DX	−5.8	−3.8	−1.3
551	PERMANENT CARDIAC PACEMAKER IMPL W MAJ CV DX OR AICD LEAD OR GNRTR.	−13.0	1.3	0.4
552	OTHER PERMANENT CARDIAC PACEMAKER IMPLANT W/O MAJOR CV DX	−15.0	1.0	0.3
553	OTHER VASCULAR PROCEDURES W CC W MAJOR CV DX	−5.8	−0.5	−0.2
554	OTHER VASCULAR PROCEDURES W CC W/O MAJOR CV DX	−6.5	−1.4	−0.5
556	PERCUTANEOUS CARDIOVASC PROC W NON-DRUG-ELUTING STENT W/O MAJ CV DX.	−34.9	−16.2	−5.4
557	PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W MAJOR CV DX.	−25.5	−10.4	−3.5
558	PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W/O MAJ CV DX.	−34.5	−13.8	−4.6

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

COMPARISON OF THE NUMBER OF DRGS EXPERIENCING PERCENT GAINS/LOSSES IN RELATIVE WEIGHTS IN THE PROPOSED RULE RELATIVE TO THE FINAL RULE TRANSITION

Percent change in DRG weight	Proposed rule	Final rule (with transition)
More than −10%	32	0
Between −5 and −10%	42	1
Between −1 and −5%	49	78
Between −1 and +1%	42	308
Between 1% and 5%	111	130
Between 5% and 10%	97	12
More than +10%	153	7

COMPARISON OF THE NUMBER OF HOSPITALS EXPERIENCING PERCENT GAINS/LOSSES IN CASE-MIX INDEX IN THE PROPOSED RULE RELATIVE TO THE FINAL RULE TRANSITION

Percent change in case-mix index	Proposed rule	Final rule (with transition)
More than −10%	40	0
Between −5 and −10%	103	0
Between −1 and −5%	597	30
Between −1 and +1%	416	2,067
Between 1% and 5%	1493	1,450
Between 5% and 10%	794	28
More than +10%	79	20

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

	Proposed rule Column 1	Severity changes in DRGs	Severity DRG changes & cost weights (with transition)
All hospitals	0.0	0.0	0.0
By Geographic Location:			
Urban hospitals	−0.3	0.0	0.0

	Proposed rule Column 1	Severity changes in DRGs	Severity DRG changes & cost weights (with transition)
Large urban areas (populations over 1 million)	0.1	0.0	0.1
Other urban areas (populations of 1 million or fewer)	−0.9	0.0	−0.2
Rural hospitals	2.7	−0.1	0.2
Bed Size (Urban):			
0–99 beds	0.5	0.3	0.1
100–199 beds	1.8	0.0	0.3
200–299 beds	0.0	−0.1	−0.1
300–499 beds	−1.1	0.0	0.1
500 or more beds	−1.5	0.0	−0.2
Bed Size (Rural):			
0–49 beds	5.5	−0.1	0.3
50–99 beds	4.3	−0.2	0.3
100–149 beds	2.8	−0.2	0.2
150–199 beds	1.0	0.1	0.1
200 or more beds	−0.2	−0.2	−0.2
Urban by Region:			
New England	0.3	0.3	0.1
Middle Atlantic	0.1	0.0	0.2
South Atlantic	−0.7	−0.1	−0.2
East North Central	−0.4	0.0	0.0
East South Central	−0.8	−0.2	−0.3
West North Central	−1.4	0.1	−0.2
West South Central	−0.7	0.0	−0.1
Mountain	−1.4	0.2	−0.1
Pacific	0.6	−0.1	0.2
Puerto Rico	3.3	−0.4	0.1
Rural by Region:			
New England	1.8	0.1	0.5
Middle Atlantic	2.8	0.0	0.4
South Atlantic	3.4	−0.3	0.2
East North Central	1.9	−0.1	0.1
East South Central	2.9	0.0	0.0
West North Central	1.7	−0.1	0.1
West South Central	3.5	−0.2	0.1
Mountain	2.4	−0.1	0.2
Pacific	3.5	−0.4	0.3
By Payment Classification:			
Urban hospitals	−0.3	0.0	0.0
Large urban areas (populations over 1 million)	0.1	0.0	0.1
Other urban areas (populations of 1 million or fewer)	−0.9	0.0	−0.2
Rural areas	2.6	−0.1	0.2
Teaching Status:			
Non–teaching	1.1	0.0	0.2
Fewer than 100 Residents	−0.8	−0.1	−0.1
100 or more Residents	−0.8	0.0	−0.2
Urban DSH:			
Non–DSH	−1.1	0.1	0.0
100 or more beds	−0.2	−0.1	0.0
Less than 100 beds	3.5	0.1	0.4
Rural DSH:			
SCH	4.2	−0.2	0.2
RRC	1.3	−0.1	0.0
Other Rural:			
100 or more beds	4.2	0.1	0.3
Less than 100 beds	5.5	−0.1	0.2
Urban teaching and DSH:			
Both teaching and DSH	−0.6	0.0	−0.1
Teaching and no DSH	−1.7	0.1	−0.1
No teaching and DSH	1.1	0.0	0.2
No teaching and no DSH	−1.0	0.1	0.0
Rural Hospital Types:			
RRC	4.8	0.1	0.3
SCH	0.9	0.0	0.0
MDH	3.9	−0.3	0.2
SCH and RRC	5.1	−0.1	0.4
MDH and RRC	1.0	−0.3	0.0
Type of Ownership:			
Voluntary	−0.3	0.0	0.0
Proprietary	0.2	0.0	0.1
Government	1.3	0.0	0.0

	Proposed rule Column 1	Severity changes in DRGs	Severity DRG changes & cost weights (with transition)
Medicare Utilization as a Percent of Inpatient Days:			
0–25	2.7	0.2	0.3
25–50	−0.5	0.0	0.0
50–65	0.3	−0.1	0.0
Over 65	0.3	0.0	−0.1
Hospitals Reclassified by the Medicare Geographic Classification Review Board:			
FY 2005 Reclassifications:.			
Urban Hospitals Reclassified by the Medicare Geographic Classification Review Board:			
First Half FY 2007 Reclassifications	−0.5	0.1	0.0
Urban Nonreclassified, First Half FY 2007	−0.3	0.0	0.0
All Urban Hospitals Reclassified Second Half FY 2007	−0.3	0.0	0.0
Urban Nonreclassified Hospitals Second Half FY 2007	−0.3	0.0	0.0
All Rural Hospitals Reclassified Second Half FY 2007	1.6	−0.1	0.1
Rural Nonreclassified Hospitals Second Half FY 2007	4.5	−0.1	0.3
All Section 401 Reclassified Hospitals	2.9	−0.1	0.2
Other Reclassified Hospitals (Section 1886(d)(8)(B))	4.6	−0.2	0.4
Section 508 Hospitals	−0.5	−0.1	0.0
Cardic Specialty Hospitals	−11.2	0.0	−2.3

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

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

Response: Because of the long lead time to develop the methodology and our proposed rule, we used the FY 2004 MedPAR data to calculate HSRVcc weights and model the CS DRGs for purposes of the analysis shown on pages 24007–24011, 24020–24026 of the FY 2007 IPPS proposed rule (71 FR24007–24011, 24020–24026). At the time we were developing provisions of the proposed rule, FY 2005 MedPAR data were unavailable to us. Given the public interest in prompt publication of the rule, we decided not to replicate all of the analysis that we provided in section II.C. of the proposed rule based on the FY 2004 data once the new FY 2005 data became available to us. We believed delaying publication of the proposed rule to revise our analysis so all of the payment impacts were shown based on FY 2005 data was not in the public interest. Once we developed the methodology and the analysis for the proposed rule, we calculated the relative weights using the HSRVcc methodology that we were proposing to adopt for FY 2007 using the FY 2005 MedPAR. We modeled the HSRVcc relative weights using the FY 2005 MedPAR because we would be using these data to calculate actual relative weights that would be used to determine FY 2007 hospital payments. We believed it was important to model our FY 2007 proposal as closely to how payments would be determined to provide the most meaningful opportunity for public comment. For purposes of providing the payment impacts shown on pages 24028–24030 and the Appendix A—Regulatory Impact Analysis (71 FR24404) and the methodological description shown on pages 24044–24049 of the proposed rule, we used FY 2005 MedPAR data. We disagree with the commenters that providing separate analyses using 2 years of data makes it more difficult to understand and assess the payment impacts. Rather, we believe that providing these analyses makes it easier to understand how relative weights will change solely as a result of updating the data.

Comment: MedPAC was pleased that CMS proposed three of MedPAC's four recommended changes to the IPPS system. However, the MedPAC expressed concern the proposal not to implement the severity changes until FY 2008. They stated that it is important to correct for differences in patients' severity concurrently with the corrections for charging distortions. MedPAC believed that all of the proposed policy changes to the IPPS should happen concurrently. MedPAC stated that failure to adopt all of the changes would leave some payment distortions in place, thereby continuing to favor some kinds of patients over others. According to MedPAC, adopting all of the policies would create the most accurate payments and prevent hospitals from facing unjustified shifts in their payments that may occur under partial adoption of the payment reforms. MedPAC stated that concerns about giving hospitals time to adapt to the changes may be better managed by implementing all changes in FY 2007 and then giving hospitals a transition period. Another commenter asked that CMS implement both of these proposed changes in FY 2007 for the following reasons:

- MedPAC's analysis revealed significant inaccuracy in the current payment system and recommended implementation of both the new severity-refined DRGs and a revised method for the weights at the same time.
- It is inequitable to remove the subsidy provided by the overpayments for cardiac and orthopedic surgery prior to correcting the underpayments for the most severely ill patients.
- It is not reasonable to ask that some hospitals experience financial losses from implementing the new weights this year if implementing severity would offset some or all of these losses. To stagger implementation will cause providers to experience unnecessary payment fluctuation between FY 2007 and FY 2008.

The commenter further added that a delay is not beneficial to taxpayers as hospitals will have more time to up-code and increase their Medicare payments. Many commenters agreed with MedPAC that the cost weights and severity-adjusted DRGs should be implemented simultaneously. However, these commenters suggested implementation no sooner than FY 2008 to limit sharp fluctuations in payments

to hospitals from year to year. Many commenters opposed a two-step implementation, whereby CMS would implement cost-based weights in one year and a new DRG system to better account for patient severity in a subsequent year. They noted that each of these two major reforms significantly redistributes payments, often in off-setting directions. They stated that large swings in payments between the two reforms would create unnecessary volatility and have a profound impact on hospitals' ability to plan effectively, especially for necessary major medical equipment purchases and other capital expenditures. Therefore, they recommended that CMS implement both cost-based weights and severity-adjusted DRGs concurrently. While some commenters urged CMS to implement both payment reforms concurrently in FY 2007, other commenters advised delaying until at least FY 2008 to allow enough time to improve the proposed methodologies and underlying cost data to ensure accuracy of payments. Some commenters stated that the cost-based weights methodology should be implemented after the severity adjusted DRG methodology.

Response: Although we are not adopting the CS DRGs this year, we agree that it is important to smooth the transition for our current DRG system to a more accurate payment system. As indicated above, we have decided to adopt traditional cost-based weights for FY 2007 without the HSRV part of the methodology and we are making refinements that will create 20 new CMS DRGs, modify 32 others across 13 different clinical areas involving 1,666,476 cases that would improve the CMS DRG system's recognition of severity of illness for FY 2007. We believe it is appropriate to take steps toward transitioning the IPPS to a severity based DRG system for FY 2007 by applying some of the severity logic from our proposal to the CMS DRGs where appropriate. By revising the CMS DRGs, we are offering hospitals an interim step toward severity DRGs. Hospitals would be able to take advantage of the improved recognition of severity within the context of the more familiar CMS DRGs. This interim step affords us the opportunity to adopt some of the more basic components of a severity DRG system, such as specific splits in DRGs that lead to groups with greater resource utilization.

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

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

Comment: One commenter stated that the annual impact of the changes to the proposed CS DRG system will reduce payments for its institution by an additional $2.7 million per year. The commenter suggested that community, not for profit hospitals be exempt from these proposed changes as this is not the group of hospitals that were the intended target of these changes. One commenter stated that the efforts to address issues identified in the MedPAC report should begin and end with the specialty hospital subset and should not occur in conjunction with payment systems at large for all other hospital facilities.

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

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

For these reasons, we believe these changes should apply to all hospitals paid using the IPPS, regardless of

whether a hospital is a specialty hospital or a rural referral center. We have made significant changes to our proposal and the impacts shown in this final rule may be very different for an individual hospital than those we showed in the proposed rule. The impact on any specific hospital will depend on the types of cases it treats.

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

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

Comment: One commenter stated that the best estimates on a hospital specific basis, of the incremental effects on payment of CMS' changes to the DRG system should be published in the FY 2007 IPPS final rule. The commenter also suggested that CMS release impact files by hospitals far in advance of any implementation.

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

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

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

Comment: Some commenters encouraged CMS to review the cost/benefit of implementing the cost-based weight methodology and a severity-adjusted DRG system in conjunction with changes to the CMS UB04 claim form and the adoption of ICD–10–CM. The commenters suggested that implementing these changes simultaneously could help alleviate the additional cost of multiple system upgrades both for the hospital and the fiscal intermediaries. Some commenters stated that CMS should conduct a single independent study to determine the impact that implementation of this methodology will have on coding and billing productivity or hospital cash flow. Some commenters stated that implementing the significant DRG changes proposed by CMS is only a temporary solution until a more refined DRG system can be adopted with more specific clinical classification systems such as ICD–10–CM and ICD–10–PCS that will be capable of fully recognizing a patient's severity of illness and the services provided to treat that condition.

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

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

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

Comment: Several commenters stated that the reasons CMS gave in the proposed rule for not implementing CS DRGs for FY 2007 are valid. The commenters stated that they are all the

more valid because hospitals now would have less time to prepare if CMS were to implement its proposed severity adjusted DRGs this October 1.

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

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

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

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

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

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

Another commenter was also concerned about MedPAC's recommendation to adjust the DRGs to account for the prevalence of high-cost cases. The commenter explained that reducing the relative weights to finance the outlier pool will adversely affect payment for hospitals specializing in the most complex patients. Hospitals may be discouraged from developing the capacity to treat high cost outliers and responding to the needs of their community according to the commenter. Meanwhile, the commenter suggested that hospitals that have the capacity to treat the highest cost and most complex cases may abandon such an infrastructure because it will be too costly to maintain.

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

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

One commenter was concerned that CMS provided only "minimal" analysis of the effect of the DRG refinements on the outlier threshold. Noting that the 5.1 percent set aside for outlier payments could be significantly reduced with the adoption of severity DRG refinements, the commenter believed that implementation of severity DRGs is premature until the Secretary determines whether statutory changes are needed to determine the percentage of total IPPS payments that should be made as outliers.

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

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

6. Conclusions

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

transition period while we plan further improvements to the IPPS for FY 2008.

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

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

Therefore, while we proposed to adopt the CS DRGs in FY 2008, we were considering whether to make more limited changes to the current DRG system to better recognize severity of illness in FY 2007. In the FY 2006 IPPS final rule (70 FR 47474 through 47478), we took steps to better recognize severity of illness among cardiovascular patients. For all DRGs except cardiac DRGs, we currently distinguish between more and less complex cases based on the presence or absence of a CC. However, the diagnoses that we designate as CCs are the same across all base DRGs. Because the CC list is not dependent on the patient's underlying condition, CCs may not accurately recognize severity in a given case. The changes we made in FY 2006 to the cardiac DRGs significantly improved recognition of severity between patients by distinguishing between more and less severe cases based on the presence or absence of a MCV. In the proposed rule, we indicated that we were considering whether a similar approach applied to other DRGs would improve payment.

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

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

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

[13] Ibid, p. 26.

relative weights that takes costs into account. We have revised the CCRs that we used to develop cost-based weights based on the public comments. Although they do not show the same differentials indicated in the proposed rule, they continue to support MedPAC's conclusion that a system based on charges pays too much for some types of cases and pays too little for others. As indicated above, we summarized hospital-level cost and charge information to 2 routine and 11 ancillary departmental cost centers and found that national average routine cost center CCRs ranged from 50 percent (intensive care unit days) to 56 percent (routine days), while ancillary cost center CCRs ranged from 16 percent (anesthesiology) to 46 percent (labor and delivery room).

MedPAC also found that relative profitability ratios were higher among cardiovascular surgical DRGs than the medical DRGs.[14] We believe the relative profitability of the surgical cardiovascular DRGs has been an important factor in the development of specialty heart hospitals. Our payment impact analysis indicates that this issue will be addressed by adopting cost-based weights. Moving from the current system of charge-based weights to cost-based weights increases payment in the medical DRGs relative to the surgical DRGs. We expected this result, given that routine costs will generally account for a higher proportion of total costs in the medical DRGs than in the surgical DRGs. In the proposed rule, we estimated that all of our combined changes would, on average, increase the medical DRG weights by approximately 7.3 percent while reducing the surgical DRG weights by approximately 6.9 percent. Implementing the cost-based weights without utilizing the HSRV standardization method under the 3-year transition period where the weights for FY 2007 will be based on 33 percent of the cost-based weight and 67 percent of the charge weight will lessen the effects of redistribution between medical and surgical DRGs. In this final rule, we estimate that the increase in the average medical DRG weight will be 0.9 percent and that the decrease in the average surgical DRG weight will be 1.2 percent. The pattern of increasing medical weights and decreasing surgical weights still holds true. However, by adopting the cost based weights in a transition period, we are mitigating the larger swings in payments that our proposed policies adopted in full would have caused.

[14] Ibid, p. 29.

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

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

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

[15] Ibid, p. 37.

[16] Ibid, p.37.

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

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

Therefore, for the reasons indicated above, we are not adopting the CS DRGs for FY 2007. However, we are creating 20 new CMS DRGs and modifying 32 others across 13 different clinical areas involving 1,666,476 cases that would improve the CMS DRG system's recognition of severity of illness for FY 2007. Furthermore, as discussed earlier, we have engaged a contractor to assist us with evaluating alternative DRG systems that were raised as potential alternatives to the 3M Severity of Illness DRG products in the public comments. Finally, we will consider the review that we have undertaken of the 13,000 codes on the CC list as part of making further refinements to the current CMS DRGs to better recognize severity of illness based on the work that CMS (then HCFA) did in the mid-1990's to adopt severity DRGs. Again, we expect to complete this work in time for proposing changes to the DRG system to better recognize severity of illness by FY 2008.

7. Severity Refinements to CMS DRGs

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

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

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

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

We began our review by focusing on the cardiac and orthopedic DRGs because of our concerns that cardiac, orthopedic, and surgical hospitals have taken advantage of opportunities in the DRG system to specialize in the least complex and most profitable inpatient cases. However, with respect to orthopedic and surgical specialty hospitals, we considered that they have very small inpatient volume and the issues that are leading to their creation are generally unrelated to profit opportunities in the IPPS. Although we did review the orthopedic DRGs, we generally did not find opportunities within the current DRG system to make further refinements for severity of illness. We were also unable to find a strong basis to subdivide further most of the cardiovascular DRGs. In last year's IPPS rule, we already made significant changes to the DRG system to better account for severity of illness in the DRGs frequently performed by cardiac hospitals. As mentioned earlier, this DRG change involved splitting some cardiac DRGs based on the presence or absence of an MCV. We then conducted a comparison of the base DRGs in the CMS DRG system and proposed CS DRGs. We analyzed data to identify specific CMS DRGs with wide ranges in charges that had been subdivided or in other ways modified under the proposed CS DRGs. As stated earlier, this process did not allow CMS to use the more sophisticated logic involved in the proposed CS DRGs to differentiate groups with greater severity. However, we were able to identify a group of DRGs that could be created to better align our payments based on severity of illness. We used our own analysis along with specific recommendations received during the comment period to develop further severity refinements to the current DRGs.

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

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

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

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

(1) Nervous System Infection Except Viral Meningitis

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

nervous system. The CS DRGs divided these cases in order to better recognize severity. The codes which describe bacterial infection and tuberculosis are listed below.

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

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

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

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

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

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

Diagnosis code	DRG 560 diagnosis code titles
003.21	Salmonella meningitis.
013.00	Tuberculous meningitis, unspecified examination.
013.01	Tuberculous meningitis, bacteriological or histological examination not done.
013.02	Tuberculous meningitis, bacteriological or histological examination results unknown (at present).
013.03	Tuberculous meningitis, tubercle bacilli found (in sputum) by microscopy.
013.04	Tuberculous meningitis, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
013.05	Tuberculous meningitis, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
013.06	Tuberculous meningitis, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
013.10	Tuberculoma of meninges, unspecified examination.
013.11	Tuberculoma of meninges, bacteriological or histological examination not done.
013.12	Tuberculoma of meninges, bacteriological or histological examination results unknown (at present).
013.13	Tuberculoma of meninges, tubercle bacilli found (in sputum) by microscopy.
013.14	Tuberculoma of meninges, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
013.15	Tuberculoma of meninges, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
013.16	Tuberculoma of meninges, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
013.20	Tuberculoma of brain, unspecified examination.
013.21	Tuberculoma of brain, bacteriological or histological examination not done.
013.22	Tuberculoma of brain, bacteriological or histological examination results unknown (at present).
013.23	Tuberculoma of brain, tubercle bacilli found (in sputum) by microscopy.
013.24	Tuberculoma of brain, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
013.25	Tuberculoma of brain, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
013.26	Tuberculoma of brain, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
013.30	Tuberculous abscess of brain, unspecified examination.
013.31	Tuberculous abscess of brain, bacteriological or histological examination not done.
013.32	Tuberculous abscess of brain, bacteriological or histological examination results unknown (at present).
013.33	Tuberculous abscess of brain, tubercle bacilli found (in sputum) by microscopy.
013.34	Tuberculous abscess of brain, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
013.35	Tuberculous abscess of brain, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
013.36	Tuberculous abscess of brain, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
013.40	Tuberculoma of spinal cord, unspecified examination.
013.41	Tuberculoma of spinal cord, bacteriological or histological examination not done.
013.42	Tuberculoma of spinal cord, bacteriological or histological examination results unknown (at present).
013.43	Tuberculoma of spinal cord, tubercle bacilli found (in sputum) by microscopy.
013.44	Tuberculoma of spinal cord, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
013.45	Tuberculoma of spinal cord, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
013.46	Tuberculoma of spinal cord, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
013.50	Tuberculous abscess of spinal cord, unspecified examination.
013.51	Tuberculous abscess of spinal cord, bacteriological or histological examination not done.
013.52	Tuberculous abscess of spinal cord, bacteriological or histological examination results unknown (at present).
013.53	Tuberculous abscess of spinal cord, tubercle bacilli found (in sputum) by microscopy.
013.54	Tuberculous abscess of spinal cord, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.

Diagnosis code	DRG 560 diagnosis code titles
013.55	Tuberculous abscess of spinal cord, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
013.56	Tuberculous abscess of spinal cord, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
013.60	Tuberculous encephalitis or myelitis, unspecified examination.
013.61	Tuberculous encephalitis or myelitis, bacteriological or histological examination not done.
013.62	Tuberculous encephalitis or myelitis, bacteriological or histological examination results unknown (at present).
013.63	Tuberculous encephalitis or myelitis, tubercle bacilli found (in sputum) by microscopy.
013.64	Tuberculous encephalitis or myelitis, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
013.65	Tuberculous encephalitis or myelitis, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
013.66	Tuberculous encephalitis or myelitis, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
013.80	Other specified tuberculosis of central nervous system, unspecified examination.
013.81	Other specified tuberculosis of central nervous system, bacteriological or histological examination not done.
013.82	Other specified tuberculosis of central nervous system, bacteriological or histological examination results unknown (at present).
013.83	Other specified tuberculosis of central nervous system, tubercle bacilli found (in sputum) by microscopy.
013.84	Other specified tuberculosis of central nervous system, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
013.85	Other specified tuberculosis of central nervous system, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
013.86	Other specified tuberculosis of central nervous system, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
013.90	Unspecified tuberculosis of central nervous system, unspecified examination.
013.91	Unspecified tuberculosis of central nervous system, bacteriological or histological examination not done.
013.92	Unspecified tuberculosis of central nervous system, bacteriological or histological examination results unknown (at present).
013.93	Unspecified tuberculosis of central nervous system, tubercle bacilli found (in sputum) by microscopy.
013.94	Unspecified tuberculosis of central nervous system, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
013.95	Unspecified tuberculosis of central nervous system, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
013.96	Unspecified tuberculosis of central nervous system, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
036.0	Meningococcal meningitis.
036.1	Meningococcal encephalitis.
098.82	Gonococcal meningitis.
320.0	Hemophilus meningitis.
320.1	Pneumococcal meningitis.
320.2	Streptococcal meningitis.
320.3	Staphylococcal meningitis.
320.7	Meningitis in other bacterial diseases classified elsewhere.
320.81	Anaerobic meningitis.
320.82	Meningitis due to gram-negative bacteria, not elsewhere classified.
320.89	Meningitis due to other specified bacteria.
320.9	Meningitis due to unspecified bacterium.
324.0	Intracranial abscess.
324.1	Intraspinal abscess.
324.9	Intracranial and intraspinal abscess of unspecified site.
357.0	Acute infective polyneuritis.

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

Diagnosis code	DRG 561 diagnosis code titles
006.5	Amebic brain abscess.
045.00	Acute paralytic poliomyelitis specified as bulbar, unspecified type of poliovirus.
045.01	Acute paralytic poliomyelitis specified as bulbar, poliovirus type i.
045.02	Acute paralytic poliomyelitis specified as bulbar, poliovirus type ii.
045.03	Acute paralytic poliomyelitis specified as bulbar, poliovirus type iii.
045.10	Acute poliomyelitis with other paralysis, unspecified type of poliovirus.
045.11	Acute poliomyelitis with other paralysis, poliovirus type i.
045.12	Acute poliomyelitis with other paralysis, poliovirus type ii.
045.13	Acute poliomyelitis with other paralysis, poliovirus type iii.
045.90	Unspecified acute poliomyelitis, unspecified type poliovirus.
045.91	Unspecified acute poliomyelitis, poliovirus type i.
045.92	Unspecified acute poliomyelitis, poliovirus type ii.
045.93	Unspecified acute poliomyelitis, poliovirus type iii.
049.8	Other specified non-arthropod-borne viral diseases of central nervous system.

Diagnosis code	DRG 561 diagnosis code titles
049.9	Unspecified non-arthropod-borne viral diseases of central nervous system.
052.0	Postvaricella encephalitis.
052.2	Postvaricella myelitis.
053.14	Herpes zoster myelitis.
054.3	Herpetic meningoencephalitis.
054.74	Herpes simplex myelitis.
055.0	Postmeasles encephalitis.
056.01	Encephalomyelitis due to rubella.
056.09	Rubella with other neurological complications.
062.0	Japanese encephalitis.
062.1	Western equine encephalitis.
062.2	Eastern equine encephalitis.
062.3	St. Louis encephalitis.
062.4	Australian encephalitis.
062.5	California virus encephalitis.
062.8	Other specified mosquito-borne viral encephalitis.
062.9	Mosquito-borne viral encephalitis, unspecified.
063.0	Russian spring-summer (taiga) encephalitis.
063.1	Louping ill.
063.2	Central European encephalitis.
063.8	Other specified tick-borne viral encephalitis.
063.9	Tick-borne viral encephalitis, unspecified.
064	Viral encephalitis transmitted by other and unspecified arthropods.
066.2	Venezuelan equine fever.
071	Rabies.
072.2	Mumps encephalitis.
090.40	Juvenile neurosyphilis, unspecified.
090.41	Congenital syphilitic encephalitis.
090.42	Congenital syphilitic meningitis.
090.49	Other juvenile neurosyphilis.
091.81	Acute syphilitic meningitis (secondary).
094.2	Syphilitic meningitis.
094.3	Asymptomatic neurosyphilis.
094.81	Syphilitic encephalitis.
100.81	Leptospiral meningitis (aseptic).
100.89	Other specified leptospiral infections.
112.83	Candidal meningitis.
114.2	Coccidioidal meningitis.
115.01	Histoplasma capsulatum meningitis.
115.11	Histoplasma duboisii meningitis.
115.91	Histoplasmosis meningitis, unspecified.
130.0	Meningoencephalitis due to toxoplasmosis.
321.0	Cryptococcal meningitis.
321.1	Meningitis in other fungal diseases.
321.2	Meningitis due to viruses not elsewhere classified.
321.3	Meningitis due to trypanosomiasis.
321.4	Meningitis in sarcoidosis.
321.8	Meningitis due to other nonbacterial organisms classified elsewhere.
322.0	Nonpyogenic meningitis.
322.1	Eosinophilic meningitis.
322.2	Chronic meningitis.
322.9	Meningitis, unspecified.
323.01	Encephalitis and encephalomyelitis in viral diseases classified elsewhere.
323.02	Myelitis in viral diseases classified elsewhere.
323.1	Encephalitis, myelitis, and encephalomyelitis in rickettsial diseases classified elsewhere.
323.2	Encephalitis, myelitis, and encephalomyelitis in protozoal diseases classified elsewhere.
323.41	Other encephalitis and encephalomyelitis due to infection classified elsewhere.
323.42	Other myelitis due to infection classified elsewhere.
323.51	Encephalitis and encephalomyelitis following immunization procedures.
323.52	Myelitis following immunization procedures.
323.61	Infectious acute disseminated encephalomyelitis (ADEM).
323.62	Other postinfectious encephalitis and encephalomyelitis.
323.63	Postinfectious myelitis.
323.81	Other causes of encephalitis and encephalomyelitis.
323.82	Other causes of myelitis.
323.9	Unspecified causes of encephalitis, myelitis, and encephalomyelitis.
341.20	Acute (transverse) myelitis NOS.
341.21	Acute (transverse) myelitis in conditions classified elsewhere.
341.22	Idiopathic transverse myelitis.

(2) Seizure and Headache

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

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

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

Response: Under both the APR DRGs and our proposed CS DRGs, seizure and headache cases are assigned to separate DRGs while these cases are grouped together in the CMS DRGs. Both severity DRG systems recognize different levels of severity for these two groups of patients. Our medical advisors found that seizure and headache patients are clinically different, with seizure patients having a higher level of severity. We also analyzed data for patients with seizures versus those who are admitted with headaches and found that seizure cases have higher average charges than headaches. We did not have enough cases to analyze potential DRG changes for DRG 26. As the chart below shows, seizure patients age greater than 17 have average charges of $17,125 with CC and $10,540 without CC. Headache patients greater than 17 years of age have average charges of $11,618. The data did not support creating a split for headache patients greater than 17 years with and without CC. The difference in average charges for these groups was only $2,596 ($12,591 with CC as compared to $9,995 for those without a CC).

DRGs 24, 25, and 26

DRG	Number of cases	Average length of stay	Average charges
24	60,186	4.67	$16,403.55
25	25,816	3.13	10,419.00
26	21	4.05	17,396.43

Seizures Age >17 With and Without CC

DRG	Number of cases	Average length of stay	Average charges
With CC	50,605	4.8	$17,125.19
Without CC	20,065	3.1	10,540.27

Headaches > 17

DRG	Average length of stay	Average charges
15,332	3.4	$11,618.15

Headaches >17 With and Without CC

DRG	Number of cases	Average length of stay	Average charges
With CC	9,581	3.7	$12,591,92
Without CC	5,751	2.9	9,995.85

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

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

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

We are creating the following three new DRGs:

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

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

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

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

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

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

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

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

Medical patients who are treated with mechanical ventilation for respiratory failure are currently assigned to DRG 475 (Respiratory System Diagnosis with Ventilator Support). This DRG includes patients who are on a mechanical ventilator for only a few hours as well as patients who are on mechanical ventilation for several days. The proposed CS DRGs divide these patients into two groups, those on ventilator support for 96 or more hours and those on ventilator support for less than 96 hours. The CS DRGs recognize the difference in severity between these two groups of patients. Our medical advisors agree that medical patients who are treated with mechanical ventilation for respiratory failure for 96 or more hours in most cases are more severely ill than patients who are treated with mechanical ventilation for fewer than 96 hours. A review of these cases illustrates a significant difference in average charges for patients on ventilator support for 96 or more hours which supports the greater severity of these patients. The chart below shows that patients on ventilator support for 96 or more hours have average charges of $83,058 compared to $38,300 for patients on ventilator support for less than 96 hours, a difference of $44,758 in charges. The following chart summarizes these data.

DRG 475 RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT

DRG	Number of cases	Average length of stay	Average charges
DRG 475	114,199	10.64	$55,873.15
DRG 475 with Ventilator Support 96+ Hours	44,836	15.30	83,058.24
DRG 475 with Ventilator Support <96 Hours	69,363	7.64	38,300.81

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

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

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

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

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

96.70 (Continuous mechanical ventilation of unspecified duration).

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

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

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

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

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

- CMS DRG 174 (G.I. Hemorrhage with CC).
- CMS DRG 175 (G.I. Hemorrhage without CC).
- CMS DRG 182 (Esophagitis, Gastroenteritis & Miscellaneous Digestive Disorders Age >17 with CC).
- CMS DRG 183 (Esophagitis, Gastroenteritis & Miscellaneous Digestive Disorders Age >17 without CC).
- CMS DRG 184 (Esophagitis, Gastroenteritis & Miscellaneous Digestive Disorders Age 0–17).
- CMS DRG 188 (Digestive System Diagnoses Age >17 with CC).
- CMS DRG 189 (Digestive System Diagnoses Age >17 without CC).
- CMS DRG 190 (Digestive System Diagnoses Age 0–17).

DRGS 174, 175, 182, 183, 184, 188, 189, AND 190

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

MAJOR ESOPHAGEAL DISORDERS

Number of cases	Average length of stay	Average charges
10,633	4.7	$18,410.30

MAJOR GASTROINTESTINAL AND PERITONEAL INFECTIONS

Number of cases	Average length of stay	Average charges
41,736	6.9	$20,861.06

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

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

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

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

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

Diagnosis code	Major esophageal disorders diagnosis code titles
001.0	Cholera due to vibrio cholerae.
001.1	Cholera due to vibrio cholerae el tor.
001.9	Cholera, unspecified.
003.0	Salmonella gastroenteritis.
004.0	Shigella dysenteriae.
004.1	Shigella flexneri.
004.2	Shigella boydii.
004.3	Shigella sonnei.
004.8	Other specified shigella infections.
004.9	Shigellosis, unspecified.
005.0	Staphylococcal food poisoning.
005.2	Food poisoning due to clostridium perfringens (c. welchii).
005.3	Food poisoning due to other clostridia.
005.4	Food poisoning due to vibrio parahaemolyticus.
005.81	Food poisoning due to vibrio vulnificus.
005.89	Other bacterial food poisoning.
006.0	Acute amebic dysentery without mention of abscess.
006.1	Chronic intestinal amebiasis without mention of abscess.
006.2	Amebic nondysenteric colitis.
007.0	Balantidiasis.
007.1	Giardiasis.

Diagnosis code	Major esophageal disorders diagnosis code titles
007.2	Coccidiosis.
007.3	Intestinal trichomoniasis.
007.4	Cryptosporidiosis.
007.5	Cyclosporiasis.
007.8	Other specified protozoal intestinal diseases.
007.9	Unspecified protozoal intestinal disease.
008.00	Intestinal infection due to e. coli, unspecified.
008.01	Intestinal infection due to enteropathogenic e. coli.
008.02	Intestinal infection due to enterotoxigenic e. coli.
008.03	Intestinal infection due to enteroinvasive e. coli.
008.04	Intestinal infection due to enterohemorrhagic e. coli.
008.09	Intestinal infection due to other intestinal e. coli infections.
008.1	Intestinal infection due to arizona group of paracolon bacilli.
008.2	Intestinal infection due to aerobacter aerogenes.
008.3	Intestinal infection due to proteus (mirabilis) (morganii).
008.41	Intestinal infection due to staphylococcus.
008.42	Intestinal infection due to pseudomonas.
008.43	Intestinal infection due to campylobacter.
008.44	Intestinal infection due to yersinia enterocolitica.
008.45	Intestinal infection due to clostridium difficile.
008.46	Intestinal infection due to other anaerobes.
008.47	Intestinal infection due to other gram-negative bacteria.
008.49	Intestinal infection due to other organisms.
008.5	Bacterial enteritis, unspecified.
4.00	Tuberculous peritonitis, unspecified examination.
014.01	Tuberculous peritonitis, bacteriological or histological examination not done.
014.02	Tuberculous peritonitis, bacteriological or histological examination results unknown (at present).
014.03	Tuberculous peritonitis, tubercle bacilli found (in sputum) by microscopy.
014.04	Tuberculous peritonitis, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
014.05	Tuberculous peritonitis, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
014.06	Tuberculous peritonitis, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
014.80	Other tuberculosis of intestines and mesenteric glands, unspecified examination.
014.81	Other tuberculosis of intestines and mesenteric glands, bacteriological or histological examination not done.
014.82	Other tuberculosis of intestines and mesenteric glands, bacteriological or histological examination results unknown (at present).
014.83	Other tuberculosis of intestines and mesenteric glands, tubercle bacilli found (in sputum) by microscopy.
014.84	Other tuberculosis of intestines and mesenteric glands, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
014.85	Other tuberculosis of intestines and mesenteric glands, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically.
014.86	Other tuberculosis of intestines and mesenteric glands, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods (inoculation of animals).
021.1	Enteric tularemia.
022.2	Gastrointestinal anthrax.
032.83	Diphtheritic peritonitis.
039.2	Abdominal actinomycotic infection.
095.2	Syphilitic peritonitis.
098.86	Gonococcal peritonitis.
123.1	Cysticercosis.
123.5	Sparganosis (larval diphyllobothriasis).
123.6	Hymenolepiasis.
123.8	Other specified cestode infection.
123.9	Cestode infection, unspecified.
126.0	Ancylostomiasis due to ancylostoma duodenale.
126.1	Necatoriasis due to necator americanus.
126.2	Ancylostomiasis due to ancylostoma braziliense.
126.3	Ancylostomiasis due to ancylostoma ceylanicum.
126.8	Other specified ancylostoma.
126.9	Ancylostomiasis and necatoriasis, unspecified.
540.0	Acute appendicitis with generalized peritonitis.
540.1	Acute appendicitis with peritoneal abscess.
567.0	Peritonitis in infectious diseases classified elsewhere.
567.1	Pneumococcal peritonitis.
567.21	Peritonitis (acute) generalized.
567.22	Peritoneal abscess.
567.23	Spontaneous bacterial peritonitis.
567.29	Other suppurative peritonitis.
567.31	Psoas muscle abscess.
567.38	Other retroperitoneal abscess.
7.39	Other retroperitoneal infections.
567.89	Other specified peritonitis.
567.9	Unspecified peritonitis.
569.5	Abscess of intestine.

(2) Principal or Secondary Diagnosis of Major Gastrointestinal Diagnosis

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

We then examined DRGs 148 and 149 (Major Small & Large Bowel Procedures with and without CC, respectively) and DRGs 154 through 156 (Stomach, Esophageal & Duodenal Procedures Age >17 with and without CC and Age 0–17, respectively) when these Major Gastrointestinal Diagnoses were present as either a principal or secondary diagnosis. In general, these Major Gastrointestinal Diagnoses represent or are associated with the reason for performing the surgical procedure in DRGs 148 and 149 and DRGs 154 through 156 and are the most serious diagnoses that necessitate surgery. As the following tables illustrate, the presence of these Major Gastrointestinal Diagnoses identifies patients with a higher level of severity. The presence of these Major Gastrointestinal Diagnoses leads to significantly higher average charges for these two groups of surgical patients, particularly for cases currently assigned to DRGs 148 and 154 which are the surgical procedures that include the presence of a CC. The surgical patients with Major Gastrointestinal Diagnoses would not only be considered to have a greater level of severity and be more expensive, they would also be assigned to the surgical DRG that includes a CC. The tables below show that patients in DRG 148 with a Major Gastrointestinal Diagnosis have average charges of $70,001.16 compared to average charges of $43,809.03 when a Major Gastrointestinal Diagnosis is not present. The difference in charges for cases in DRG 149 was not as great. The difference in average charges was $29,103.84 for DRG 149 when a Major Gastrointestinal Diagnosis was present and $23,077.84 when it was not. The number of cases with a Major Gastrointestinal Diagnosis was significantly larger for DRG 148 (58,153 cases compared to only 1,822 in DRG 149). Similar findings occur for DRGs 154, 155, and 156. Cases with a Major Gastrointestinal Diagnosis occur with significantly greater numbers in DRG 154 (9,924 compared to only 357 in DRG 155 and none in DRG 156). The average charges for cases with a Major Gastrointestinal Diagnosis were $84,270.92 for DRG 154, and only $29,193.81 for DRG 155.

DRGs 148, 149, 154, 155, AND 156

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

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

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

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

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

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

Diagnosis code	Principal or secondary diagnosis—major gastrointestinal diagnosis diagnosis code title
008.41	Intestinal infection due to staphylococcus.
008.42	Intestinal infection due to pseudomonas.
008.43	Intestinal infection due to campylobacter.
008.45	Intestinal infection due to clostridium difficile.
008.46	Intestinal infection due to other anaerobes.
008.49	Intestinal infection due to other organisms.
014.04	Tuberculous peritonitis, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture.
098.86	Gonococcal peritonitis.

Diagnosis code	Principal or secondary diagnosis—major gastrointestinal diagnosis diagnosis code title
456.0	Esophageal varices with bleeding.
456.20	Esophageal varices in diseases classified elsewhere, with bleeding.
530.21	Ulcer of esophagus with bleeding.
530.4	Perforation of esophagus.
530.7	Gastroesophageal laceration-hemorrhage syndrome.
530.84	Tracheoesophageal fistula.
531.00	Acute gastric ulcer with hemorrhage, without mention of obstruction.
531.21	Acute gastric ulcer with hemorrhage and perforation, with obstruction.
531.40	Chronic or unspecified gastric ulcer with hemorrhage, without mention of obstruction.
531.41	Chronic or unspecified gastric ulcer with hemorrhage, with obstruction.
531.50	Chronic or unspecified gastric ulcer with perforation, without mention of obstruction.
531.60	Chronic or unspecified gastric ulcer with hemorrhage and perforation, without mention of obstruction.
531.91	Gastric ulcer, unspecified as acute or chronic, without mention of hemorrhage or perforation, with obstruction.
532.00	Acute duodenal ulcer with hemorrhage, without mention of obstruction.
532.10	Acute duodenal ulcer with perforation, without mention of obstruction.
532.11	Acute duodenal ulcer with perforation, with obstruction.
532.20	Acute duodenal ulcer with hemorrhage and perforation, without mention of obstruction.
532.31	Acute duodenal ulcer without mention of hemorrhage or perforation, with obstruction.
532.40	Chronic or unspecified duodenal ulcer with hemorrhage, without mention of obstruction.
532.41	Chronic or unspecified duodenal ulcer with hemorrhage, with obstruction.
532.50	Chronic or unspecified duodenal ulcer with perforation, without mention of obstruction.
532.60	Chronic or unspecified duodenal ulcer with hemorrhage and perforation, without mention of obstruction.
533.00	Acute peptic ulcer of unspecified site with hemorrhage, without mention of obstruction.
533.10	Acute peptic ulcer of unspecified site with perforation, without mention of obstruction.
533.21	Acute peptic ulcer of unspecified site with hemorrhage and perforation, with obstruction.
533.40	Chronic or unspecified peptic ulcer of unspecified site with hemorrhage, without mention of obstruction.
533.41	Chronic or unspecified peptic ulcer of unspecified site with hemorrhage, with obstruction.
533.50	Chronic or unspecified peptic ulcer of unspecified site with perforation, without mention of obstruction.
533.51	Chronic or unspecified peptic ulcer of unspecified site with perforation, with obstruction.
533.60	Chronic or unspecified peptic ulcer of unspecified site with hemorrhage and perforation, without mention of obstruction.
533.91	Peptic ulcer of unspecified site, unspecified as acute or chronic, without mention of hemorrhage or perforation, with obstruction.
534.00	Acute gastrojejunal ulcer with hemorrhage, without mention of obstruction.
534.40	Chronic or unspecified gastrojejunal ulcer with hemorrhage, without mention of obstruction.
534.41	Chronic or unspecified gastrojejunal ulcer, with hemorrhage, with obstruction.
534.50	Chronic or unspecified gastrojejunal ulcer with perforation, without mention of obstruction.
534.51	Chronic or unspecified gastrojejunal ulcer with perforation, with obstruction.
534.91	Gastrojejunal ulcer, unspecified as acute or chronic, without mention of hemorrhage or perforation, with obstruction.
535.01	Acute gastritis with hemorrhage.
535.11	Atrophic gastritis with hemorrhage.
535.21	Gastric mucosal hypertrophy with hemorrhage.
535.31	Alcoholic gastritis with hemorrhage.
535.41	Other specified gastritis with hemorrhage.
535.51	Unspecified gastritis and gastroduodenitis with hemorrhage.
535.61	Duodenitis with hemorrhage.
537.3	Other obstruction of duodenum.
537.83	Angiodysplasia of stomach and duodenum with hemorrhage.
540.0	Acute appendicitis with generalized peritonitis.
540.1	Acute appendicitis with peritoneal abscess.
550.00	Unilateral or unspecified inguinal hernia, with gangrene.
550.01	Recurrent unilateral or unspecified inguinal hernia, with gangrene.
550.02	Bilateral inguinal hernia, with gangrene.
551.00	Unilateral or unspecified femoral hernia with gangrene.
551.1	Umbilical hernia with gangrene.
551.20	Unspecified ventral hernia with gangrene.
551.21	Incisional ventral hernia, with gangrene.
551.29	Other ventral hernia with gangrene.
551.3	Diaphragmatic hernia with gangrene.
551.8	Hernia of other specified sites, with gangrene.
551.9	Hernia of unspecified site, with gangrene.
557.0	Acute vascular insufficiency of intestine.
557.1	Chronic vascular insufficiency of intestine.
557.9	Unspecified vascular insufficiency of intestine.
560.0	Intussusception.
560.2	Volvulus.
560.31	Gallstone ileus.
560.81	Intestinal or peritoneal adhesions with obstruction (postoperative) (postinfection).
560.89	Other specified intestinal obstruction.
560.9	Unspecified intestinal obstruction.
562.02	Diverticulosis of small intestine with hemorrhage.
562.03	Diverticulitis of small intestine with hemorrhage.
562.12	Diverticulosis of colon with hemorrhage.
562.13	Diverticulitis of colon with hemorrhage.
564.7	Megacolon, other than hirschsprung's.

Diagnosis code	Principal or secondary diagnosis—major gastrointestinal diagnosis diagnosis code title
567.0	Peritonitis in infectious diseases classified elsewhere.
567.1	Pneumococcal peritonitis.
567.21	Peritonitis (acute) generalized.
567.22	Peritoneal abscess.
567.23	Spontaneous bacterial peritonitis.
567.29	Other suppurative peritonitis.
567.31	Psoas muscle abscess.
567.38	Other retroperitoneal abscess.
567.39	Other retroperitoneal infections.
567.81	Choleperitonitis.
567.9	Unspecified peritonitis.
568.81	Hemoperitoneum (nontraumatic).
569.5	Abscess of intestine.
569.83	Perforation of intestine.
569.85	Angiodysplasia of intestine with hemorrhage.
578.0	Hematemesis.
750.3	Congenital tracheoesophageal fistula, esophageal atresia and stenosis.
863.30	Injury to small intestine, unspecified site, with open wound into cavity.
863.31	Injury to duodenum with open wound into cavity.
863.39	Other injury to small intestine with open wound into cavity.
863.50	Injury to colon, unspecified site, with open wound into cavity.
863.51	Injury to ascending (right) colon with open wound into cavity.
863.52	Injury to transverse colon with open wound into cavity.
863.53	Injury to descending (left) colon with open wound into cavity.
863.54	Injury to sigmoid colon with open wound into cavity.
863.55	Injury to rectum with open wound into cavity.
863.59	Other injury to colon and rectum with open wound into cavity.
863.90	Injury to gastrointestinal tract, unspecified site, with open wound into cavity.
863.95	Injury to appendix with open wound into cavity.
863.99	Injury to other and unspecified gastrointestinal sites with open wound into cavity.
868.13	Injury to peritoneum with open wound into cavity.
947.3	Burn of gastrointestinal tract.

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

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

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

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

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

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

MAJOR BLADDER PROCEDURES

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

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

- DRG 303 (Kidney, Ureter & Major Bladder Procedures for Neoplasm).
- DRG 304 (Kidney, Ureter & Major Bladder Procedures for Non-Neoplasm with CC)
- DRG 305 (Kidney, Ureter & Major Bladder Procedures for Non-Neoplasm without CC)
- DRG 308 (Minor Bladder Procedures with CC)
- DRG 309 (Minor Bladder Procedures without CC)

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

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

MAJOR BLADDER PROCEDURES

Number of cases	Average length of stay	Average charges
6,354	10.8	$53,434.93

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

We are renaming the following three DRGs:

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

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

MAJOR BLADDER PROCEDURES

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

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

Under our proposed CS DRGs, major hematological and immunological diagnoses were found to identify cases with a higher level of severity. They are assigned to a single DRG under the CS DRGs. The diagnoses considered to be major hematological and immunological diagnoses include the following conditions:

Diagnosis code	Major hematological and immunological code titles
279.11	Digeorge's syndrome.
279.12	Wiskott-aldrich syndrome.
279.13	Nezelof's syndrome.
279.19	Other deficiency of cell-mediated immunity.
279.2	Combined immunity deficiency.
283.0	Autoimmune hemolytic anemias.

Diagnosis code	Major hematological and immunological code titles
283.10	Non-autoimmune hemolytic anemia, unspecified.
283.19	Other non-autoimmune hemolytic anemias.
283.2	Hemoglobinuria due to hemolysis from external causes.
283.9	Acquired hemolytic anemia, unspecified.
284.8	Other specified aplastic anemias.
284.9	Aplastic anemia, unspecified.
288.1	Functional disorders of polymorphonuclear neutrophils.
288.2	Genetic anomalies of leukocytes.
996.85	Complications of transplanted bone marrow.

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

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

Our medical advisors agree that major hematological and immunological disorders are found in patients with significantly greater levels of severity and are different from other conditions in the four DRGs where they are assigned. Our data analysis shows that major hematological and immunological diseases identify patients with significantly greater levels of severity. They are more resource intensive than other conditions assigned to these four DRGs. Cases with major hematological and immunological conditions had average charges of $21,276 compared to $11,066 to $18,791 for the other conditions where these cases are currently assigned. Most of the nonhematological and immunological cases (96,557) are assigned to DRG 395 and have an average charge of $12,977.

DRGs 395, 396, 398, AND 399

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

MAJOR HEMATOLOGICAL DIAGNOSIS EXCLUDING SICKLE CELL CRISIS & COAGULATION DISORDERS

Number of cases	Average length of stay	Average charges
25,087	5.6	$21,276.25

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

Diagnosis code	Major hematological and immunological code titles
279.11	Digeorge's syndrome.
279.12	Wiskott-aldrich syndrome.
279.13	Nezelof's syndrome.
279.19	Other deficiency of cell-mediated immunity.
279.2	Combined immunity deficiency.
283.0	Autoimmune hemolytic anemias.
283.10	Non-autoimmune hemolytic anemia, unspecified.
283.19	Other non-autoimmune hemolytic anemias.
283.2	Hemoglobinuria due to hemolysis from external causes.
283.9	Acquired hemolytic anemia, unspecified.
284.01*	Constitutional red blood cell aplasia.
284.09*	Other constitutional aplastic anemia.
284.8	Other specified aplastic anemias.
284.9	Aplastic anemia, unspecified.
288.00*	Neutropenia, unspecified.

Diagnosis code	Major hematological and immunological code titles
288.01*	Congenital neutropenia.
288.02*	Cyclic neutropenia.
288.03*	Drug induced neutropenia.
288.04*	Neutropenia due to infection.
288.09*	Other neutropenia.
288.1	Functional disorders of polymorphonuclear neutrophils.
288.2	Genetic anomalies of leukocytes.
996.85	Complications of transplanted bone marrow.

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

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

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

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

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

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

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

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

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

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

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

g. Severe Sepsis

Comment: As an alternative to the proposed CS DRGs, commenters recommended a new DRG to identify patients with severe sepsis associated with respiratory failure requiring mechanical ventilation. One commenter suggested using an approach to better recognize severity of illness that is similar to the change CMS implemented in the FYa2006 final rule for major cardiovascular conditions (MCVs). This approach involved examining the MCVs which could be present as either a principal or secondary diagnosis leading to greater severity of illness and resource consumption. Another option suggested by two commenters involved modifying DRGa416 (Septicemia Age >17) so that it would be split based on mechanical ventilation greater than 96 hours (code 96.72). The commenter stated that patients on mechanical ventilation for greater than 96 hours have a greater severity of illness than do those who are not on mechanical ventilation for 96 or more hours. Another commenter recommended considering mechanical ventilation as a pre-MDC DRG on the basis of the mechanical ventilation greater than 96 hours procedure code (96.72) to better recognize patients with a greater severity level. This commenter also provided an option to add systemic infections (038.x) as an acceptable principal diagnosis for DRG 475 when reported in conjunction with mechanical ventilation or tracheostomy. One commenter maintained that the clinical reason to address a new DRG for severe sepsis is related to proper recognition and treatment for this group of patients with a greater degree of severity. This commenter stated clinicians are getting better at understanding the importance of early recognition and treatment. As sepsis presents with organ dysfunction, treatments must be prompt or mortality rapidly increases according to the commenter.

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

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

The data clearly show that DRG 416 septicemia patients who are on mechanical ventilation for 96 or more hours have a significantly greater severity of illness level and use greater resources than do other patients in DRG 416. Those patients on mechanical ventilation for 96 or more hours had average charges of $94,994 compared to $25,709 for other patients in DRG 416. We found no cases in DRG 417 with patients who reported mechanical ventilation for 96 or more hours. Therefore, we agree with the commenters that patients in DRG 416 who are on long term mechanical ventilation of 96 or more hours have greater severity of illness and use significantly greater resources. These patients should be assigned to a separate DRG to better reflect their higher severity level. Because we have no data on patients in DRG 417, we are not modifying that DRG at this time. Because the data on DRG 416 are compelling, we are deleting DRG 416 and splitting these cases into two new DRGs based on whether or not the patient is on mechanical ventilation for 96 or more hours. These two new DRGs are as follows:

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

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

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

D. Changes to Specific DRG Classifications

1. Pre-MDCs

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

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

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

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

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

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

episode will continue to be assigned to DRG 103.

b. Pancreas Transplants

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

Medicare coverage of pancreas transplants alone is limited to transplants in those facilities that are Medicare-approved for kidney transplantation. A listing of approved transplant centers can be found at: *http://www.cms.hhs.gov/ESRDGeneralInformation/02_Data.asp#TopOfPage*. The CMS NCD includes several criteria for the coverage of pancreas transplants alone, including having a diagnosis of Type I diabetes. (We refer readers to section 260.3 of the Medicare National Coverage Manual for the entire language of the NCD.)

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

Because the April 2006 Medicare final decision memorandum stated that the performance of pancreas transplants alone is reasonable and necessary for Medicare beneficiaries in limited circumstances, the logic for the determination of patient case assignment to DRG 513 in the FY 2006 GROUPER program needs to be modified to remove the requirement that patients also have kidney disease. Therefore, because the NCD was finalized, we are modifying DRG 513 to consist of the following logic: List A (the diabetes codes) of the required principal or secondary diagnosis codes remains the same, as does the required operating room procedures (codes 52.80 (Pancreatic transplant NOS), and 52.82, (Homotransplant of pancreas)). List B is removed from the logic; the following codes will no longer be required as a principal or secondary diagnosis:

- 403.01, Hypertensive kidney disease, malignant, with chronic kidney disease
- 403.11, Hypertensive kidney disease, benign, with chronic kidney disease
- 403.91, Hypertensive kidney disease, unspecified, with chronic kidney disease
- 404.02, Hypertensive heart and kidney disease, malignant, with chronic kidney disease
- 404.03, Hypertensive heart and kidney disease, malignant, with heart failure and chronic kidney disease
- 404.12, Hypertensive heart and kidney disease, benign, with chronic kidney disease
- 404.13, Hypertensive heart and kidney disease, benign, with heart failure and chronic kidney disease
- 404.92, Hypertensive heart and kidney disease, unspecified, with chronic kidney disease
- 404.93, Hypertensive heart and kidney disease, unspecified, with heart failure and chronic kidney disease
- 585.1, Chronic kidney disease, Stage I
- 585.2, Chronic kidney disease, Stage II (mild)
- 585.3, Chronic kidney disease, Stage III (moderate)
- 585.4, Chronic kidney disease, Stage IV (severe)
- 585.5, Chronic kidney disease, Stage V
- 585.6, End stage renal disease
- 585.9, Chronic kidney disease, unspecified
- V42.0, Organ or tissue replaced by transplant, kidney
- V43.89, Organ or tissue replaced by other means, other organ or tissue, other

We note that DRG 513 remains in the pre-MDC hierarchy.

Comment: Five commenters supported the proposed coding changes to DRG 513 and the MCE.

Response: We appreciate the support of the commenters. Accordingly, as the NCD for pancreas transplants alone was approved, in this final rule, we are adopting the changes as described above to DRG 513 and the MCE logic.

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

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

Deep-brain stimulation (DBS) is designed to deliver electrical stimulation to the subthalamic nucleus or internal globus pallidus to ameliorate symptoms caused by abnormal neurotransmitter levels that lead to abnormal cell-to-cell electrical impulses in Parkinson's disease and essential tremor. DBS implants for essential tremor are unilateral, with neurostimulation leads on one side of the brain. DBS implants for Parkinson's disease are bilateral, requiring implantation of neurostimulation leads in both the left and right sides of the brain.

The implantation of a full DBS system requires two types of procedures. First, surgeons implant leads containing electrodes into the targeted sections of the brain where neurostimulation therapy is to be delivered. Second, a neurostimulator pulse generator is implanted in the pectoral region and extensions from the neurostimulator pulse generator are then tunneled under the skin along the neck and connected with the proximal ends of the leads implanted in the brain. Hospitals stage the two procedures required for a full-system DBS implant.

In FY 2005, to better account for these two types of procedures, we revised procedure code 02.93 (Implantation or replacement of intracranial neurostimulator lead(s)) for the lead placement and created three new procedures codes for the pulse generator: 86.94 (Insertion or replacement of single array neurostimulator pulse generator); 86.95 (Insertion or replacement of dual array neurostimulator pulse generator); and 86.96 (Insertion or replacement of other neurostimulator pulse generator). We published the new procedure codes and revised procedure code titles in Tables 6B and 6F of the FY 2005 IPPS final rule (69 FR 49627 and 49641).

In FY 2006, we made further refinements to the pulse generator codes to identify rechargeable pulse generators. We published the new procedure codes and revised procedure code titles in Tables 6B and 6F of the FY 2006 IPPS final rule (70 FR 47637

and 47639). The current list of pulse generators codes are:

- 86.94 (Insertion or replacement of single array neurostimulator pulse generator, not specified as rechargeable);
- 86.95 (Insertion or replacement of dual array neurostimulator pulse generator, not specified as rechargeable);
- 86.96 (Insertion or replacement of other neurostimulator pulse generator);
- 86.97 (Insertion or replacement of single array neurostimulator rechargeable generator); and
- 86.98 (Insertion or replacement of dual array neurostimulator rechargeable generator).

Kinetra® is an implantable dual array neurostimulator pulse generator that is approved for a new technology add-on payment through FYA2006. For more information about the new technology add-on payment, please refer to section II.G.3.a. of this preamble.

Medtronic, the manufacturer of Kinetra®, argues that the new technology add-on payment provision is designed to recognize the higher costs of new medical innovations for the initial period the technology is available on the market, and until the associated costs and charges related to the technology are available in the MedPAR database and can be used to recalibrate the DRG weights. Medtronic also argues that, once a technology is no longer eligible for new technology add-on payments, the new technology add-on payment provision is designed to support the reclassification of the technology to other clinically coherent DRGs with comparable resource costs.

With the conclusion of the new technology add-on payment, Medtronic is concerned that Kinetra® will be inadequately paid in DRG 1 (Craniotomy Age >17 With CC) or DRG 2 (Craniotomy Age >17 Without CC) under MDC 1. Medtronic recommended that CMS reassign the full-system Kinetra® implants to DRG 543 (Craniotomy with Implant of Chemo Agent or Acute Complex CNS Principal Diagnosis) under MDC 1. To accommodate this recommendation, procedure codes 02.93 and 86.95 would have to be reassigned to DRG 543 and the title for DRG 543 would have to be revised to "Craniotomy with Implantation of Major Device or Acute Complex CNS Principal Diagnosis." Medtronic argued that DRG 543 would be a "clinically-consistent DRG that more appropriately reflects the resource utilization associated with full-system [deep brain stimulation] procedures." Medtronic also emphasized that its proposal would only apply to full-system Kinetra® implants when both the leads and generators are implanted during a single inpatient stay and procedure codes 02.93 and 86.95 both appear on the claim. Medtronic believes the current DRG assignment is appropriate for partial system implants.

Medtronic provided an analysis of FY 2004 MedPAR data. Procedure code 86.95 was not created until FY 2005 so Medtronic used procedure codes 02.93 and 86.09 (Other incision of skin and subcutaneous tissue) to identify the full system. It identified 193 cases assigned to DRG 1 with average charges of approximately $69,155, and 532 cases assigned to DRG 2 with average charges of approximately $56,113.

In the FY 2007 IPPS proposed rule we indicated that we have reviewed the latest data for the full-system DBS implants assigned to DRG 1 or DRG 2 in the FY 2005 MedPAR file. We identified cases with procedure codes 02.93 and 86.95 for full-system dual array cases. We also identified cases with reported codes 02.93 and 86.96 for those full-system cases where the type of pulse generator was not specified. The following table displays our results:

DRG	Number of cases	Average length of stay	Average charges
DRG 1—All Cases	23,037	9.61	$55,494
DRG 1—Cases with 02.93 and 86.95 (Kinetra®)	51	5.18	73,020
DRG 1—Cases with 02.93 and 86.96 (Unspecified)	101	4.86	53,356
DRG 2—All Cases	9,707	4.41	32,791
DRG 2—Cases with 02.93 and 86.95 (Kinetra®)	146	2.40	59,414
DRG 2—Cases with 02.93 and 86.96 (Unspecified)	249	2.12	47,047
DRG 543—All cases	5,192	11.71	71,138

These data showed that approximately one-quarter of the full-system dual array neurostimulator pulse generator cases are assigned to DRG 1 and approximately three-quarters of these cases are assigned to DRG 2. In both DRGs, the average length of stay was shorter for the full-system array neurostimulator pulse generator cases than for all other cases. However, the average charges for the full-system dual array neurostimulator pulse generator cases are approximately $18,000 and $27,000 higher than the average charges for DRGs 1 and 2, respectively. The average charges for these cases in DRG 1 are comparable to those for DRG 543. However, the more commonly occurring cases in DRG 2 have average charges that are less than those in DRG 543 by nearly $12,000. We reviewed all of the procedures that will result in a case being assigned to DRGs 1 and 2. Unlike the full-system DBS implants, we believe for most of the cases assigned to these DRGs, there will be no device cost to the hospital. For this reason, we believe the higher average charges and lower length of stay for cases involving full-system dual array neurostimulator pulse generators are likely accounted for by the cost of the device. While it is possible that the cost of the device itself will make the full-system DBS implants more expensive than other cases in the DRG, the hospital's charge markup may also explain the higher charges but lower average length of stay. As indicated in section II.G.3.a. of this final rule, the national average CCR for medical equipment and supplies is approximately 34 percent. Thus, the actual cost to the hospital of the case including the full-system dual array neurostimulator pulse generator may be much lower than the charges would suggest.

With respect to whether the cost of the technology itself, absent a charge markup, makes the case more expensive, in the FY 2007 IPPS proposed rule, we stated that we intended to address this issue as we make further refinements to the DRG system to address severity of illness as discussed in section II.C. of this preamble.

Comment: Several commenters opposed CMS' proposed decision to retain the current assignment of implantable dual array neurostimulator pulse generator cases in DRGs 1 and 2. Several commenters stated that CMS should recognize the higher resources associated with this technology and reassign implantable dual array neurostimulator pulse generator cases to DRG 543. Two commenters disagreed

with CMS' statements that markups associated with Kinetra® may overstate the total charges of the implant procedure. Medtronic submitted information on charge compression in which the company contends that it conclusively finds the hospital charge markups for implantable devices are in fact significantly lower than for other, lower cost supplies and equipment. Medtronic and one other commenter argued that the total charges found in the FY 2005 MedPAR data associated with implantable dual array neurostimulator pulse generator procedures may be understated relative to other procedures in DRG 1, DRG 2 and DRG 543 and that reassignment of this technology to DRG 543 is fully warranted. The commenters stated that the implementation of the CS DRGs should be deferred to at least FY 2008 and not be a factor in CMS' decision to make DRG reassignments this year.

Response: With regard to the issue of charge compression, we are studying this issue in our effort to improve payment accuracy in the IPPS. The average charges for the 51 cases in DRG 1 where the patient received a dual array neurostimulator are $17,426 or 31 percent higher than the rest of the cases in DRG 1. The average charges are comparable to those for DRG 543 ($73,020 for dual array neurostimulator cases and $71,138 for DRG 543).

The average charges for the 146 cases in DRG 2 are $26,623 or 81 percent higher than the rest of the cases in DRG 2 and only $12,000 less than the average charges for DRG 543. Based on these data, we believe that the dual array neurostimulator cases will be more accurately paid in DRG 543 than DRGs 1 and 2. We will be implementing this change to the DRG assignment for the full-system dual array neurostimulator cases for FY 2007. Implantable dual array neurostimulator pulse generator procedure cases reported with ICD–9–CM procedure codes 02.93 and 86.95 will be reassigned to DRG 543. We are changing the DRG title for DRG 543 to "Craniotomy With Major Device Implant or Acute Complex CNS Principal Diagnosis."

b. Carotid Artery Stents

Background: Stroke is the third leading cause of death in the United States and the leading cause of serious, long-term disability. Approximately 70 percent of all strokes occur in people age 65 and older. The carotid artery, located in the neck, is the principal artery supplying the head and neck with blood. Accumulation of plaque in the carotid artery can lead to stroke either by decreasing the blood flow to the brain or by the plaque breaking free and lodging in the brain or other arteries leading to the head. The percutaneous transluminal angioplasty (PTA) procedure involves inflating a balloon-like device in the narrowed section of the carotid artery to reopen the vessel. A carotid stent is then deployed in the artery to prevent the vessel from closing or restenosing. A distal filter device (embolic protection device) may also be present, which is intended to prevent pieces of plaque from entering the bloodstream.

Effective July 1, 2001, Medicare covered PTA of the carotid artery concurrent with carotid stent placement when furnished in accordance with the FDA-approved protocols governing Category B Investigational Device Exemption (IDE) clinical trials. PTA of the carotid artery, when provided solely for the purpose of carotid artery dilation concurrent with carotid stent placement, was considered to be a reasonable and necessary service only when provided in the context of such clinical trials and, therefore, was considered a covered service for the purposes of those trials. Performance of PTA in the carotid artery when used to treat obstructive lesions outside of approved protocols governing Category B IDE clinical trials remained noncovered until the release of the October 12, 2004 NCD for PTA of the carotid artery in post-approval studies. This decision extended coverage of PTA in the carotid artery concurrent with placement of an FDA-approved carotid stent for an FDA-approved indication when furnished in accordance with the FDA-approved protocols governing post-approval studies. On March 17, 2005, CMS released an NCD that extended coverage to patients at high risk for carotid endarterectomy (CEA) who also have symptomatic carotid artery stenosis ≥70 percent. Procedures must be performed in CMS-approved facilities and with FDA-approved carotid artery stent(s) with distal embolic protection. (Section 20.7 of the NCD manual which discusses this decision may be viewed at the Web site: *http://www.cms.hhs.gov/manuals/downloads/ncd103c1_Part1.pdf.*

Placement of a carotid artery stent in patients who have had a disabling stroke (modified Rankin scale ≥3) is excluded from coverage.

We established codes for carotid artery stent procedures for use with discharges occurring on or after October 1, 2004, for inpatients who were enrolled in an FDA-approved clinical trial and who were using on-label FDA-approved stents and embolic protection devices. These codes are as follows:

- 00.61 (Percutaneous angioplasty or atherectomy of precerebral (extracranial vessel(s)); and
- 00.63 (Percutaneous insertion of carotid artery stent(s)).

We assigned procedure code 00.61 to four MDCs and seven DRGs. The most likely clinical scenario is that in which cases are assigned to MDC 1 (Diseases and Disorders of the Nervous System) in DRGs 533 (Extracranial Procedures with CC) and 534 (Extracranial Procedures without CC). Other DRG assignments can be found in Table 6B of the Addendum to the FY 2005 IPPS final rule (69 FR 49624). Code 00.63 is not considered a procedure code itself and should be used in combination with code 00.61.

Based on the results of evaluation of PTA and carotid stents for our FY 2006 final rule (70 FR 47300, August 12, 2005), we did not find sufficient evidence to warrant a DRG change at that time.

We again reviewed the PTA and insertion of a carotid stent(s) for the FY 2007 proposed rule, as manufacturer representatives suggested that we assign all carotid stenting cases to DRG 533 only, bypassing DRG 534. As we indicated in the FY 2007 IPPS proposed rule (71 FR 24032), we reviewed the FY 2005 MedPAR data on all cases in DRGs 533 and 534 and on those cases containing code 00.61 in combination with 00.63. The following table displays those results:

DRG	Number of cases	Average length of stay (Days)	Average charges
DRG 533—All cases	44,031	3.65	$26,376
DRG 533 with codes 00.61 and 00.63 reported	2,400	2.94	33,344
DRG 533 with code 00.61 and without 00.63	99	5.95	46,591
DRG 534—All cases	40,381	1.72	17,196
DRG 534 with codes 00.61 and 00.63 reported	2,056	1.52	25,000

DRG	Number of cases	Average length of stay (Days)	Average charges
DRG 534 with code 00.61 and without 00.63	55	2.31	27,895

We found that 5.5 and 5.1 percent of the cases in DRGs 533 and 534, respectively, involved placement of a carotid artery stent. In DRG 533, the average length of stay was 19.4 percent shorter for the carotid stenting cases than for all other cases. In DRG 534, the average length of stay was 11.6 percent shorter for the carotid stenting cases than for all other cases. However, the average charges for the carotid stent cases were higher by $6,968 in DRG 533 and $7,804 in DRG 534. We reviewed all of the procedures that would result in a case being assigned to DRGs 533 and 534. Unlike the carotid artery stent placements, we believe that, for most of the other cases assigned to these DRGs, there will be no device cost to the hospital. For this reason, we believe the higher average charges and lower length of stay for the cases involving carotid artery stents could be accounted for by the cost of the device. We discussed the possibility that the cost of the device itself makes the stent cases more expensive than other cases in the DRG, and that the hospital's charge markup may also explain the higher charges but lower average length of stay. We also suggested that we intended to address this issue as we make further refinements to the CS DRG system previously described. The use of a carotid stent or stents may increase complexity and resource use even though the patient is not necessarily more severely ill. We indicated that we believed that the CS DRG system we proposed would need to be further refined to assign cases based on complexity as well as severity to account for technologies such as carotid stents that increase costs. For this reason, we did not propose a change to the current DRG assignment for these cases.

Comment: More than a dozen commenters addressed this topic. State hospital associations, in particular, were unanimous in their recommendation that all carotid stenting cases should immediately be assigned only to DRG 533, bypassing DRG 534 entirely. The commenters suggested this solution to increase payments to hospitals in order that the higher costs associated with carotid stents are recognized within the existing DRG system.

Response: We are opposed to this suggestion. The DRGs comprise a native structure of the types of patients within each DRG category. Further, this structure is based on an organizing principle. For example, cases in DRGs 533 and 534 are organized on the principle of surgical approach (extracranial procedures) as well as the presence or absence of CCs. To ignore the structure of the DRG solely for the purpose of increasing payment would set an unwelcome precedent for defining all of the other DRGs in the system.

Comment: Several commenters mentioned that, while CMS suggested that the higher average charges and lower lengths of stay for cases involving carotid artery stents are likely accounted for by the cost of the device, CMS provided no evidence to support this assertion.

Response: The average length of stay for patients in DRGs 533 and 534 with the placement of carotid stent(s) are 19.4 and 11.6 percent shorter than the other patients assigned to DRGs 533 and 534, respectively. Therefore, a long length of stay is not the reason for the higher average charges. We based our assertion on the contribution of the cost of the device to the total cost of the patients in these DRGs compared to other cases in the DRG with longer lengths of stay. We note that the next comment suggests that our analysis is correct that the higher charges for the carotid artery stent cases relative to other cases in the DRG are, in part, associated with higher supply costs.

Comment: One commenter suggested that CMS create a new pair of DRGs with and without MCVs until the adequacy of payment under the severity adjustment methodology is fully assessed. This commenter noted that, while length of stay and operating room costs are lower for carotid stenting, supply and radiology charges associated with the stent and the angiography are higher, resulting in higher overall costs for carotid stenting.

Response: While we recognize the creativity of this approach, we note that the MCVs are applicable to cases in MDC 5 (Diseases and Disorders of the Circulatory System), while DRGs 533 and 534 are in MDC 1 (Diseases and Disorders of the Nervous System). Such an approach for MDC 1 might have merit, but we would want to evaluate the entire MDC thoroughly before creating such a list of complicating diagnoses. We will further consider this concept as we evaluate severity DRG systems for adoption in FY 2008.

Comment: One commenter, while urging CMS to reconsider our decision not to assign all carotid cases to DRG 533, noted that the current National Coverage Determination on CAS [Carotid Artery Stenting] very clearly states that only those patients who are at high risk for [open] surgery due to the presence of a detailed list of complications or comorbidities are eligible for carotid artery stenting. Therefore, by CMS' own characterization, all patients undergoing carotid artery stenting have complications and comorbidities and should be assigned to DRG 533.

Response: This assumption is theoretically correct. However, the detailed list of comorbidities or anatomical risk factors that are required to support the surgeon's decision to perform carotid stenting instead of a carotid endarterectomy is not the same as the CMS list of CCs. For example, amaurosis fugax, code 362.34 (Transient arterial occlusion) is recognized as a risk factor which would justify carotid stenting, but is not recognized by the CMS GROUPER as a diagnosis defined as a CC.

Comment: Several commenters suggested that CMS create two new DRGs for the carotid stent cases.

Response: We note that the number of procedures has increased from the data reported in the FY 2006 IPPS final rule (70 FR 47300), thus indicating acceptance of this procedure by the medical community as a main-stream surgical alternative. In FY 2006, as the specific codes for carotid stenting had only been in use since October 1, 2004, we used the existing codes 39.50 (Angioplasty or atherectomy of other noncoronary vessel(s)) and 39.90 (Insertion of non-drug-eluting peripheral vessel stent(s)), in combination with principal diagnosis code 433.10 (Occlusion and stenosis of carotid artery, without mention of cerebral infarction) as a proxy for the number of cases involved in clinical trials. In DRG 533, we had 1,586 cases with the proxy codes reported, and in DRG 534, there were 1,397 cases. In FY 2005, the patients represented 3.5 percent and 3.3 percent of all cases in DRGs 533 and 534, respectively. That figure has now climbed to 2,400 cases

and 2,056 cases, and 5.5 percent and 5.1 percent, respectively.

In addition, the difference in the average charges are 26 percent higher for carotid artery stent cases in DRG 533 than for the average charges in all cases in that DRG, and 45 percent higher using the same parameters for DRG 534. We believe these data are compelling enough to warrant creation of a new DRG.

Accordingly, we are creating DRG 583 (Carotid Artery Stent Procedure). This DRG will be located in MDC 1, and will be hierarchically ordered above DRGs 533 and 534. DRG 583 will contain two procedure codes. Code 00.61 will determine the DRG, and will be combined with code 00.63. Both codes must be reported in order for cases to be assigned to this DRG.

We are not splitting this DRG based on the presence or absence of a CC as suggested by the commenters. One criterion for splitting a DRG based on the presence or the absence of a CC is that it must have an impact of at least $40 million. In this situation, the overall average of the charges for all cases in DRGs 533 and 534 is $30,193. We then subtracted the actual average charges for only the carotid stent cases in both DRGs 533 and 534, and multiplied that figure by the actual number of cases. For DRG 533 and DRG 534, we estimate an impact of approximately $10 million each. Added together, the total impact would be $20 million, falling short of our threshold of a $40 million impact to create a CC/non-CC split. Therefore, we are not creating a CC/non-CC split in the DRG for carotid artery stenting at this time.

We reiterate that coverage of the carotid artery stent procedure is limited to patients at risk of developing a stroke due to narrowing or stenosis of the carotid artery. Diagnosis code 433.10 (Occlusion and stenosis of carotid artery without mention of cerebral infarction) should be used to identify the site of the procedure in the carotid artery. If it is necessary to identify bilateral occlusion or stenosis, diagnosis code 433.30 (Occlusion and stenosis of multiple and bilateral arteries without mention of cerebral infarction) may also be used. These codes should be used together, as code 433.30 contains arterial sites that are not currently covered for Medicare patients. Reporting of code 433.30 alone will cause the case to fail the editing system at the fiscal intermediary, and the case could be denied.

Inclusion of the fifth digit of "1" (with cerebral infarction) with either 433.1x or 433.3x will cause the claim to be rejected.

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

a. Insertion of Epicardial Leads for Defibrillator Devices

As we indicated in the FY 2007 IPPS proposed rule (71 FR 24033), we received a comment indicating that a change in coding advice for the insertion of epicardial leads for CRT–D defibrillator devices affects DRG assignment. The commenter noted that the Third Quarter 2005 issue of the American Hospital Association's publication *Coding Clinic for ICD–9–CM* instructs coders to assign code 37.74 (Insertion or replacement of epicardial lead [electrode] into atrium) for pacemaker or defibrillator leads inserted through use of a thoracotomy into the epicardium. While the use of code 37.74 is standard coding practice for pacemakers, the advice is new for defibrillators. This coding advice was discussed at the ICD–9–CM Coordination and Maintenance Committee meeting held on September 29 and 30, 2005. Participants at the Committee meeting proposed modifications for the code category 37.7 (insertion, revision, replacement, and removal of pacemaker leads; insertion of temporary pacemaker system; and revision of cardiac device pocket). These modifications involved expanding the category so that the codes for leads would no longer be restricted to pacemakers. This change would guide coders to use code 37.74 for the insertion of epicardial leads for both defibrillators and pacemakers for the ICD–9–CM and will become effective on October 1, 2006.

The commenter indicated that this coding advice would restrict some defibrillator cases from being assigned to the defibrillator DRGs. Specifically, the commenter expressed concerns about the DRG logic for the following DRGs:

- DRG 515 (Cardiac Defibrillator Implant without Cardiac Catheter)
- DRG 535 (Cardiac Defibrillator Implant with Cardiac Catheter with AMI/Heart Failure/Shock)
- DRG 536 (Cardiac Defibrillator Implant with Cardiac Catheter without AMI/Heart Failure/Shock)

Cases are assigned to one of these three DRGs when a total defibrillator system, including both the device and one or more leads, is implanted. The implant could be represented by the ICD–9–CM codes for the total system, that is, code 00.51 (Implantation of cardiac resynchronization defibrillator, total system [CRT–D]) or code 37.94 (Implantation or replacement of automatic cardioverter/defibrillator, total system [AICD]). Cases can also be assigned to DRGs 515, 535, and 536 when a combination of a device and a lead code is reported. The following combinations of defibrillator device and lead codes are present in the current DRG logic:

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

A DRG logic issue has arisen concerning the instruction to use code 37.74 for epicardial leads inserted with CRT–D defibrillators. The new combination of a defibrillator device with an epicardial lead (code 37.74) is not included in DRGs 515, 535, and 536. The commenter recommended that the following combinations be added to DRGs 515, 535, and 536 so that all types of defibrillator device and lead combinations would be included: code 37.74 and code 00.54; code 37.74 and code 37.96; and code 37.74 and code 37.98.

We agree that these three combinations should be added to the list of combination codes included in DRGs 515, 535, and 536. This change would result in all combinations of defibrillator devices and leads being assigned to one of the defibrillator DRGs. Therefore, in the FY 2007 IPPS proposed rule, we proposed to add these three combinations to the list of procedure combinations under DRGs 515, 535, and 536.

Comment: A number of commenters supported adding the new combinations of defibrillator devices with the epicardial leads to DRGs 515, 535, and 536. One commenter stated that this change would bring the DRGs into

alignment with the change in coding advice to assign code 37.74 in conjunction with implantation of CRT–D defibrillators.

Response: We appreciate the support of commenters and agree that this change would bring the DRGs into alignment with the change in coding advice.

In this final rule, we are adding the following combinations of device and lead codes to DRGs 515, 535, and 536: code 37.74 and code 00.54; code 37.74 and code 37.96; and code 37.74 and code 37.98.

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

In the FY 2006 IPPS final rule (70 FR 47289 and 47474 through 47479), we addressed a comment we had received in response to the FY 2006 proposed rule which noted that section 507(c) of Pub. L. 108–173 required MedPAC to conduct a study to determine how the DRG system should be updated to better reflect the cost of delivering care in a hospital setting. The commenter noted that MedPAC reported that the "cardiac surgery DRGs have high relative profitability ratios." While the commenter acknowledged that it may take time to conduct and complete a thorough evaluation of the MedPAC payment recommendations for all DRGs, the commenter strongly encouraged CMS to revise the cardiac DRGs through patient severity refinement as part of the IPPS final rule effective for FY 2006.

In response to this comment, we performed an extensive review of the cardiovascular DRGs in MDC 5, particularly those DRGs that were commonly billed by specialty hospitals. We observed that there was some overlap between the lists of cardiovascular complications and complex diagnoses and that these lists were already used to segregate patients into DRGs that used greater resources. Because the hospital industry already was familiar with the major complication and complex diagnosis lists used within the cardiovascular DRGs, we began our analysis with these two overlapping lists.

The two lists were originally developed for the current DRG system because they contained conditions that could have an impact on the resources needed to treat a patient with cardiovascular complications. Many of the conditions were cardiovascular diagnoses and, therefore, would be classified to MDC 5. However, we determined that some of the diagnoses were not cardiovascular, but would still have an impact on a patient with cardiovascular complications. The conditions that were not cardiovascular diagnoses were not assigned to MDC 5 if they were the principal diagnosis.

We reviewed the conditions on the two overlapping lists and identified conditions that we believed would lead to a more complicated patient stay requiring greater resource use. We referred to these conditions as "major cardiovascular conditions (MCVs)." The MCVs could be present as either a principal diagnosis or a secondary diagnosis and lead to greater resource consumption. The complete list of MCVs was published in the FY 2006 IPPS final rule (70 FR 47477 and 47478).

In the FY 2006 IPPS final rule, we also adopted new DRGs 547 through 558, effective October 1, 2005 (70 FR 47475 and 47476). However, we emphasized that the refinements to the DRGs were being taken as an interim step to better recognize severity in the DRG system for FY 2006 until we could complete a more comprehensive analysis of the APR DRG system and the CC list as part of a complete analysis of the MedPAC recommendations that we planned to perform for FY 2007 (and which was addressed in section II.C. of the preamble of the FY 2007 proposed rule).

Since publication of the FY 2006 IPPS final rule, we have received a question from a commenter as to why we did not apply the MCV list to the following defibrillator DRGs: 515, 535, and 536. The commenter noted that the pacemaker DRGs were revised using the MCV list, but the defibrillator DRGs were not.

As noted above, for FY 2006, we created new DRGs 546 through 558 to identify cases with more costly and severely ill patients as an interim step to evaluating severity DRGs. We analyzed for the first time last year data on cases within MDC 5 and presented data that showed significant difference for patients in certain DRGs based on the presence or absence of an MCV. This split did not work for the defibrillator DRGs, as we could not identify groups with significantly different resource use. For instance, splitting DRG 515 based on the presence of an MCV would lead to two groups with differences in charges of only $3,430 ($89,341 for those with an MCV and $85,911 for those without an MCV). In the data we displayed in the FY 2006 IPPS final rule, the differences for DRGs selected for an MCV split ranged from $10,319 to $21,035. Splitting DRG 515 based on an MCV would produce a difference in charges of only 10.1 percent as compared to differences of 28.7 to 47.7 percent for DRGs 547 through 558. Therefore, the data did not support including DRG 515 among those split based on the presence or absence of an MCV. Similar results were found when DRG 536 was split by an MCV. There was only an 8.1 percent difference in charges between the two groups. We also identified other problems with splitting DRG 535 based on the presence or absence of an MCV. Some of the codes a claim must include for the case to be grouped to DRG 535 under our current system are also codes on the MCV list. Therefore, applying the MCV list to DRG 535 would result in all cases being assigned to the DRG with an MCV and none to the DRG without an MCV. For these reasons, we did not subdivide DRGs 515, 535, and 536 based on the presence or absence of an MCV.

In the FY 2007 IPPS proposed rule, we indicated that we had decided not to propose additional refinements of the DRGs based on MCVs for FY 2007 because of our efforts to propose a broader refinement of the DRG system, as discussed in detail in section II.C. of the proposed rule. However, as discussed further in section II.C. of the preamble of the proposed rule, we solicited comments on whether it would be appropriate in FY 2007 to apply a clinical severity concept to an expanded set of DRGs, similar to the approach we used in FY 2006 to refine cardiac DRGs based on the presence or absence of an MCV.

Comment: Commenters agreed with the recommendation that we not subdivide DRGs 515, 535, and 536 based on MCV. However, one commenter expressed concerns about how the current DRGs were achieving their goal of identifying patients with greater severity of illness. Other commenters opposed the proposal to delay refining defibrillator DRGs based on MCVs. These commenters believed it was appropriate for CMS to apply a clinical severity concept similar to the approach used in FY 2006 to refine cardiac DRGs to an expanded set of DRGS (for example, defibrillator DRGs) based on the presence or absence of an MCV.

Response: We agree with the commenters who suggested that our goal should be to reform the Medicare DRG system to develop a better means of capturing severity of illness and complexity. As discussed in section II.C. of the preamble of the proposed rule, we solicited comments on whether it would be appropriate in FY 2007 to apply a clinical severity concept to an expanded set of DRGs, similar to the approach we used in FY 2006 to refine cardiac DRGs based on the presence or absence of an MCV. As discussed in section II.C.7., we are implementing revisions to the

current DRGs to better recognize severity of illness. However, the analysis we have performed to this point does not support splitting defibrillator DRGs based on the presence or absence of an MCV. As stated earlier, simply applying the MCVs to the defibrillator DRGs in DRGs 515, 535, and 536 would not lead to significant improvements for DRG 515. Applying the MCV list to DRG 535 would result in all cases being assigned to the DRG with an MCV and none to the DRG without an MCV. For these reasons, we did not subdivide DRGs 515, 535, and 536 based on the presence or absence of an MCV.

While we did not find additional severity improvements for defibrillator cases, we will continue to study this area and look for further improvements.

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

a. Hip and Knee Replacements

In the FY 2006 final rule (70 FR 47303), we deleted DRG 209 (Major Joint and Limb Reattachment Procedures of Lower Extremity) and created new DRGs 544 (Major Joint Replacement or Reattachment of Lower Extremity) and 545 (Revision of Hip or Knee Replacement) to help resolve payment issues for hospitals that perform revisions of joint replacements because we found revisions of joint replacements to be significantly more resource intensive than original hip and knee replacements. DRG 544 includes the following code assignments:

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

DRG 545 includes the following procedure code assignments:

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

In the FY 2006 IPPS final rule (70 FR 47305), we indicated that the American Association of Orthopaedic Surgeons had requested that, once we receive claims data using the two DRG procedure code assignments, we closely examine data from the use of the codes under the two DRGs to determine if future additional DRG modifications are needed.

After publication of the FY 2006 IPPS final rule, a number of hospitals and coding personnel advised us that the DRG logic for DRG 471 (Bilateral or Multiple Major Joint Procedures of Lower Extremity), which utilizes the new and revised hip and knee procedure codes under DRGs 544 and 545, also includes codes that describe procedures that are not bilateral or that do not involve multiple major joints. DRG 471 was developed to include cases where major joint procedures such as revisions or replacements were performed either bilaterally or on two joints of one lower extremity. We changed the logic for DRG 471 last year for the first time when we added the new and revised codes. The commenters indicated that, by adding the more detailed codes that do not include total revisions or replacements to the list of major joint procedures to DRG 471, we are assigning cases to DRG 471 that do not have bilateral or multiple joint procedures. For example, when a hospital reports a code for revision of the tibial component (code 00.81) and patellar component of the right knee (code 00.83), the current DRG logic assigns the case to DRG 471. The commenters indicated that this code assignment is incorrect because only one joint has undergone surgery, but two components were used. One commenter indicated that ICD–9–CM does not identify left/right laterality. Therefore, it is difficult to use the current coding structure to determine if procedures are performed on the same leg or on both legs. The commenters raised a concern about whether CMS intended to pay hospitals using DRG 471 for procedures performed on one joint. The commenters indicated that the DRG assignments for these codes would also make future data analysis misleading. The commenters recommended removing codes from DRG 471 that do not specifically identify bilateral or multiple joint procedures.

We agree that the new and revised joint procedure codes should not be assigned to DRG 471 unless they include bilateral and multiple joints. Therefore, in the FY 2007 IPPS proposed rule (71 FR 24035), we proposed to remove the following codes from DRG 471:

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

The proposed revised DRG 471 would then contain only the following codes:

- 00.70, Revision of hip replacement, both acetabular and femoral components
- 00.80, Revision of knee replacement, total (all components)
- 81.51, Total hip replacement
- 81.52, Partial hip replacement
- 81.54, Total knee replacement
- 81.56, Total ankle replacement

We proposed to assign the codes removed from DRG 471 (codes 00.71, 00.72, 00.73, 00.81, 00.82, 00.83, 00.84, 81.53, and 81.55) to DRG 545 when used either alone or in combination. This list of codes removed from DRG 471 and added to DRG 545 includes partial revisions of the knee and hip as well as unspecified joint procedures such as code 81.55 where it is not clear if the revision is total or partial.

Comment: Several comments supported our proposals to remove codes 00.71, 00.72, 00.73, 00.81, 00.82, 00.83, 00.84, 81.53, and 81.55 from the combinations assigned to DRG 471 and assign cases with these codes to DRG 545. The commenters agreed that these codes should be removed from DRG 471 because they do not represent bilateral and multiple joint revisions or replacements.

Response: We appreciate the commenters support to remove codes 00.71, 00.72, 00.73, 00.81, 00.82, 00.83, 00.84, 81.53, and 81.55 from the combinations assigned to DRG 471. These cases will be assigned to DRG 545.

We are finalizing the changes to DRG 471 and DRG 545 that we proposed.

Further, as we indicated in the proposed rule, we plan to perform extensive data analysis on the new and revised joint procedure codes as we receive billing data to determine if future refinements of these DRGs are needed. In addition, as indicated in section II.C. of the preamble of the proposed rule, we are planning in the future to adopt a revised DRG system for the IPPS that addresses severity of illness. We encouraged commenters to evaluate how the new and revised joint procedures should be addressed in such a revised system. We received comments indicating that the CS DRGs that we proposed do not distinguish between patients receiving an original joint replacement from a revision. As we indicate elsewhere in this final rule, we will evaluate these issues as we develop our plans for adopting a revised DRG system that addresses severity of illness.

b. Spinal Fusion

In the FY 2006 IPPS final rule (70 FR 47307), we created new DRG 546 (Spinal Fusions Except Cervical with Curvature of the Spine or Malignancy). DRG 546 is composed of all noncervical spinal fusions previously assigned to DRGs 497 (Spinal Fusion Except Cervical with CC) and 498 (Spinal Fusion Except Cervical without CC) that have a principal or secondary diagnosis of curvature of the spine or a principal diagnosis of a malignancy. The principal diagnosis codes that lead to DRG 546 assignment are the following:

- 170.2, Malignant neoplasm of vertebral column, excluding sacrum and coccyx
- 198.5, Secondary malignant neoplasm of bone and bone marrow
- 213.2, Benign neoplasm of bone and articular cartilage; vertebral column, excluding sacrum and coccyx
- 238.0, Neoplasm of uncertain behavior of other and unspecified sites and tissues; Bone and articular cartilage
- 239.2, Neoplasms of unspecified nature; bone, soft tissue, and skin
- 732.0, Juvenile osteochondrosis of spine
- 733.13, Pathologic fracture of vertebrae
- 737.0, Adolescent postural kyphosis
- 737.10, Kyphosis (acquired) (postural)
- 737.11, Kyphosis due to radiation
- 737.12, Kyphosis, postlaminectomy
- 737.19, Kyphosis (acquired), other
- 737.20, Lordosis (acquired) (postural)
- 737.21, Lordosis, postlaminectomy
- 737.22, Other postsurgical lordosis
- 737.29, Lordosis (acquired), other
- 737.30, Scoliosis [and kyphoscoliosis], idiopathic
- 737.31, Resolving infantile idiopathic scoliosis
- 737.32, Progressive infantile idiopathic scoliosis
- 737.33, Scoliosis due to radiation
- 737.34, Thoracogenic scoliosis
- 737.39, Other kyphoscoliosis and scoliosis
- 737.8, Other curvatures of spine
- 737.9, Unspecified curvature of spine
- 754.2, Congenital scoliosis
- 756.51, Osteogenesis imperfecta

The secondary diagnoses that will lead to DRG 546 assignment are:

- 737.40, Curvature of spine, unspecified
- 737.41, Curvature of spine associated with other conditions, kyphosis
- 737.42, Curvature of spine associated with other conditions, lordosis
- 737.43, Curvature of spine associated with other conditions, scoliosis

After publication of the FY 2006 IPPS final rule, we received a comment stating that creating new DRG 546 was insufficient to address clinical severity and resource differences among spinal fusion cases that involve fusing multiple levels of the spine. Specifically, the commenter suggested that the spinal fusion DRGs be further modified to incorporate Bone Morphogenic Protein (BMP), code 84.52 (Insertion of recombinant bone morphogenetic protein). The commenter also suggested that CMS apply a clinical severity concept to all back and spine surgical cases similar to the approach that we used for the MCVs to refine the cardiac DRGs in the final rule for FY 2006. The commenter recommended recognizing additional conditions that reflect higher resource needs, regardless of whether they are principal or secondary diagnoses. The commenter also suggested that the spine DRGs be further subdivided based on the use of specific spinal devices such as artificial discs. These changes would entail the creation of 10 new spine DRGs in addition to other changes requested.

Response: We agree that it is important to recognize severity when classifying patients into specific DRGs. In response to recommendations made by MedPAC last year that are discussed in section II.C. of this final rule, we are conducting a comprehensive analysis of the entire DRG system to determine whether to undertake significant reform to better recognize severity of illness. At this time, we believe it is premature to develop a severity adjustment for spine surgeries while we are considering a more systematic approach to capturing severity of illness across all DRGs. We also believe it would be premature to make revisions to DRG 546 because this DRG was created on October 1, 2005, and we do not yet have data to analyze its impact. Given the number of innovations occurring in spinal surgery over the last several years (for example, artificial spinal disc prostheses, kyphoplasty, and vertebroplasty), we agree that additional analysis of the spine DRGs would be warranted if we were to continue with the current DRG system and not adopt CS DRGs. However, as discussed above, in the FY 2007 IPPS proposed rule, we proposed to develop a severity-adjusted DRG system. For this reason, we are not further researching this issue for FY 2007. However, in the proposed rule, we encouraged commenters to examine the proposed CS DRG system described in section II.C. of the preamble of the proposed rule to determine whether there is a better recognition of severity of illness and resource use in that system.

Comment: One commenter stated that it was premature to consider splitting the spinal fusion DRGs into potentially up to 10 new DRGs at this time. The commenter stated there is a need for additional data analysis prior to recommending new DRGs.

Response: We agree with the commenter that it is premature to consider splitting the spinal fusion DRGs into as many as 10 new DRGs. We will continue to study this area. In the meantime, we will not modify the spinal fusion DRGs for October 1, 2006.

c. CHARITE™ Spinal Disc Replacement Device

CHARITE™ is a prosthetic intervertebral disc. On October 26, 2004, the FDA approved the CHARITE™ Artificial Disc for single level spinal arthroplasty in skeletally mature patients with degenerative disc disease between L4 and S1. On October 1, 2004, we created new procedure codes for the insertion of spinal disc prostheses (codes 84.60 through 84.69). We provided the DRG assignments for these new codes in Table 6B of the FY 2005 IPPS proposed rule (69 FR 28673). We received comments on the FY 2005 proposed rule recommending that we change the assignments for these codes from DRG 499 (Back and Neck Procedures Except Spinal Fusion With CC) and DRG 500 (Back and Neck Procedures Except Spinal Fusion Without CC) to the DRGs for spinal fusion, DRG 497 (Spinal Fusion Except Cervical With CC) and DRG 498 (Spinal Fusion Except Cervical Without CC) for procedures on the lumbar spine and to

DRGs 519 and 520 for procedures on the cervical spine. In the FY 2005 IPPS final rule (69 FR 48938, August 11, 2004), we indicated that DRGs 497 and 498 are limited to spinal fusion procedures. Because the surgery involving the CHARITE™ Artificial Disc is not a spinal fusion, we decided not to include this procedure in these DRGs. However, we stated that we would continue to analyze this issue and solicited further public comments on the DRG assignment for spinal disc prostheses.

In the FY 2006 final rule (70 FR 47353, August 12, 2005), we noted that, if a product meets all of the criteria for Medicare to pay for the product as a new technology under section 1886(d)(5)(K) of the Act, there is a clear preference expressed in the statute for us to assign the technology to a DRG based on similar clinical or anatomical characteristics or costs. However, for FY 2006, we did not find that the CHARITE™ Artificial Disc met the substantial clinical improvement criterion and, thus, did not qualify as a new technology. Consequently, we did not address the DRG classification request made under the authority of this provision of the Act.

However, we did evaluate whether to reassign the CHARITE™ Artificial Disc to different DRGs using the Secretary's authority under section 1886(d)(4) of the Act (70 FR 47308, August 12, 2005). We indicated that we did not have Medicare charge information to evaluate DRG changes for cases involving an implant of a prosthetic intervertebral disc like the CHARITE™ and did not make a change in its DRG assignments. We stated that we would consider whether changes to the DRG assignments for the CHARITE™ Artificial Disc were warranted for FY 2007, once we had information from Medicare's data system that would assist us in evaluating the costs of these patients.

As we discussed in the FY 2007 IPPS proposed rule (71 FR 24036), we received correspondence regarding the DRG assignments for the CHARITE™ Artificial Disc, code 84.65 (Insertion of total spinal disc prosthesis, lumbosacral). The commenter had previously submitted an application for the CHARITE™ Artificial Disc for new technology add-on payments for FY 2006 and had requested a reassignment of cases involving CHARITE™ implantation to DRGs 497 and 498. The commenter asked that we examine claims data for FY 2005 and reassign procedure code 84.65 from DRGs 499 and 500 into DRGs 497 and 498. The commenter again stated the view that cases with the CHARITE™ Artificial Disc reflect comparable resource use and similar clinical indications as do those in DRGs 497 and 498. If CMS were to reject reassignment of the CHARITE™ Artificial Disc to DRGs 497 and 498, the commenter suggested creating two separate DRGs for lumbar disc replacements.

On February 15, 2006, we posted a proposed national coverage determination (NCD) on the CMS Web site seeking public comment on our proposed finding that the evidence is not adequate to conclude that lumbar artificial disc replacement with the CHARITE™ Artificial Disc is reasonable and necessary. The proposed NCD stated that lumbar artificial disc replacement with the CHARITE™ Artificial Disc is generally not indicated in patients over 60 years old. Further, it stated that there is insufficient evidence among either the aged or disabled Medicare population to make a reasonable and necessary determination for coverage. With an NCD pending to make spinal arthroplasty with the CHARITE™ Artificial Disc noncovered, we indicated in the FY 2007 IPPS proposed rule that we did not believe it was appropriate at that time to reassign procedure code 84.65 from DRGs 499 and 500 to DRGs 497 and 498.

After considering the public comments and additional evidence received, we made a final NCD on May 16, 2006, that Medicare would not cover the CHARITE™ Artificial Disc for the Medicare population over 60 years of age. For Medicare beneficiaries 60 years of age and under, local Medicare contractors have the discretion to determine coverage for lumbar artificial disc replacement procedures involving the CHARITE™ Artificial Disc. The final NCD can be found at: *http://www.cms.hhs.gov/mcd/viewncd.asp:ncd_;id-150.10&ncd_version1&basket=ncd%3A150%2E10%3A1%3ALumbar+Artificial+Disc+Replacement%280ADR%29.*

Comment: Some commenters agreed with our proposed decision not to reassign CHARITE™ Artificial Disc at this time to the spinal fusion DRGs. Other commenters disagreed with our proposal not to move code 84.65 (CHARITE™) from DRGs 499 and 500 to DRGs 497 and 498. One commenter noted that the national noncoverage determination for the CHARITE™ Artificial Disc only applies to patients over 60 years of age. The commenter further noted that local Medicare carriers have the discretion to make coverage decisions for Medicare beneficiaries who are under 60 years of age. The commenter stated that patients who receive the CHARITE™ Artificial Disc are candidates for a fusion procedure involving an anterior surgical approach. The commenter goes on to state that the CHARITE™ Artificial Disc is an alternative therapy to spinal fusion for patients with similar diagnoses. The commenter supplied data from FY 2005 MedPAR file in support of its request for a DRG change. These data included 54 cases that were assigned to DRGs 499 and 500. The 23 cases in DRG 499 had mean charges of $61,750, while the 31 cases assigned to DRG 500 had mean charges of $53,802. These data compare to mean charges of $26,974 for all cases in DRG 499 and $17,731 for all cases in DRG 500. The commenter reported mean charges of $71,581 for DRG 497 and $55,489 for DRG 498. The commenter stated that the 54 CHARITE™ cases are more similar in average charges to all cases in DRGs 497 and 498 than to DRGs 499 and 500.

Response: We agree with the commenter that it is not appropriate to consider a DRG revision at this time for the CHARITE™ Artificial Disc, given the recent decision to limit coverage for surgical procedures involving this device. Although we have reviewed the Medicare charge data, we are concerned that there are a very small number of cases for patients under 60 years of age who have received the CHARITE™ Artificial Disc. We believe it appropriate to base the decision on a DRG change on charge data only on the population for which the procedure is covered. We have an extremely small number of cases for patients under 60 on which to base such a decision. For this reason, we do not believe it is appropriate to modify the DRGs at this time for CHARITE™ cases.

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

In FYs 2005 and 2006, we considered requests for the creation of a separate DRG for the diagnosis of severe sepsis. Severe sepsis is described by ICD–9–CM code 995.92 (Systemic inflammatory response syndrome due to infection with organ dysfunction). Patients admitted with sepsis as a principal diagnosis currently are assigned to DRG 416 (Septicemia Age > 17) and DRG 417 (Septicemia Age 0–17) in MDC 18 (Infectious and Parasitic Diseases (Systemic or Unspecified Sites)). The commenter requested that all cases in which severe sepsis is present on admission, as well as those cases in which it develops after admission (which are currently classified elsewhere), be included in this new DRG. In both FY 2005 and FY 2006 (69 FR 48975 and 70 FR 47309), we did not believe the current clinical definition of

severe sepsis was specific enough to identify a meaningful cohort of patients in terms of clinical coherence and resource utilization to warrant a separate DRG. Sepsis is found across hundreds of medical and surgical DRGs, and the term "organ dysfunction" implicates numerous currently existing diagnosis codes. While we recognize that Medicare beneficiaries with severe sepsis are quite ill and require extensive hospital resources, in the past we have not found that they can be identified adequately to justify removing them from all of the other DRGs in which they appear. For this reason, we did not create a new DRG for severe sepsis for FY 2005 or FY 2006. We indicated that we would continue to work with National Center for Health Statistics (NCHS) to improve the codes so that our data on these patients improve. We also indicated that we would continue to examine data on these patients as we consider future modifications.

For the FY 2007 IPPS proposed rule, we again received a request to consider creating a separate DRG for patients diagnosed with severe sepsis (71 FR 24037). The information and data available to us from hospital bills with respect to identifying patients with severe sepsis have not changed since last year. However, the NCHS discussed modifications to the current ICD–9–CM diagnosis codes for systemic inflammatory response syndrome (SIRS), codes 995.91 through 995.94 (which include severe sepsis) at the September 29–30, 2005 ICD–9–CM Coordination and Maintenance Committee meeting. During the meeting, it became clear that there is still confusion surrounding the use of these codes. As a result of the meeting and the comments received, the Committee made modifications to the set of SIRS codes. These modifications are reflected in Table 6E, Revised Diagnosis Code Titles, of the Addendum to this final rule.

We believe that implementation of the modified SIRS diagnosis codes and the updated coding guidelines over the next year could begin the process of improving data for this group of patients. The desired outcome is to be able to better evaluate Medicare beneficiaries with severe sepsis with regard to their clinical coherence, resource utilization, and charges. Therefore, in the FY 2007 IPPS proposed rule, we did not propose to create a new DRG for severe sepsis for FY 2007.

Comment: Numerous commenters asked for changes to the current sepsis classification. The commenters agreed that coding of systemic inflammatory response syndrome (SIRS), sepsis, septicemia, severe sepsis, and septic shock has been confusing to the provider community in the last few years. Specifically, one commenter stated coding guidelines have been revised based on clinical definitions, which in turn has affected the DRG classification for sepsis. Another commenter referenced the ICD–9–CM Code Book tabular section and the American Hospital Association's (AHA) fourth quarter (4Q) 2003 Coding Clinic, "for patients with severe sepsis, the code for the systemic infection (038.x) or trauma should be sequenced first, followed by either code 995.92 (Systemic Inflammatory Response Syndrome due to infectious process with organ dysfunction) or code 995.94 (Systemic inflammatory response syndrome due to noninfectious process with organ dysfunction). Codes for the specific organ dysfunction should also be assigned." The commenter stated that as a result of this coding guideline, respiratory failure cannot be sequenced as the principal diagnosis because it is considered an organ dysfunction of the patient's sepsis. However, reverting sequencing instructions would be confusing and again disrupt the data according to some of the commenters. As a result, many commenters stated that a new DRG for severe sepsis is not appropriate due to the inconsistent data.

Response: We agree that there has been a great deal of confusion in the coding and sequencing of cases with severe sepsis and SIRS. The commenters are correct that the coding directives lead cases with severe sepsis that are on mechanical ventilation for respiratory failure to be assigned to DRG 416 (Septicemia Age >17) and DRG 417 (Septicemia Age 0 >17) instead of DRG 475 (Respiratory System Diagnosis with Ventilator Support). As stated in the proposed rule, we have continued to work with NCHS to improve the codes so that our data on these patients improve. We believe that implementation of the modified SIRS diagnosis codes and the updated coding guidelines over the next year will further improve the coding of this subset of patients.

Comment: One commenter presented its analysis of the MedPAR data and again requested the creation of two new DRGS for severe sepsis, one medical and one surgical. The other option suggested by the commenter was to split DRGs 415 and 416 into DRGs with and without severe sepsis cases. The commenter expressed concern that, while there has been some confusion over the use of the SIRS family of codes (995.90–995.94) over the past three years, the confusion has been mainly associated with the other codes and not the severe sepsis code (995.92). The commenter provided information concerning the definition of severe sepsis and its adoption following a 1992 consensus panel of the American College of Chest Physicians and the Society of Critical Care Medicine. According to the commenter, the panel defined severe sepsis as a systemic inflammatory response to infection that leads to acute organ dysfunction. The commenter noted this definition has been used successfully to identify thousands of patients with severe sepsis and in more than 30 large-scale clinical trials. The commenter also stated severe sepsis cases are clinically coherent with a common underlying problem (SIRS) leading to complications (acute organ dysfunction) and are managed similarly, receiving advanced life support in intensive care units. The commenter also provided examples to demonstrate how clinical coherence leads to resource use coherence.

Response: We appreciate the commenter's analysis of the data. As stated above, there has been significant confusion over the use of the sepsis codes. While the definition may be well understood among the individuals involved with the clinical trials, there has been uncertainty in the application of the codes as evidenced by repeated discussions at the ICD–9–CM Coordination and Maintenance Committee meetings and comments received in response to the proposed rule. We note that the National Center for Health Statistics has revised the sepsis and systemic inflammatory response syndrome codes in response to suggestions made at the Committee meetings. These revisions are shown in Table 6E of the Addendum to this final rule and will go into effect on October 1, 2006 (codes 995.91 through 995.94). We did not propose a new DRG for severe sepsis for FY 2007 in the proposed rule due to the data inconsistencies and difficulty expressed with properly assigning the sepsis codes, among other reasons cited previously.

In the FY 2007 IPPS proposed rule, we also solicited comments on the proposal we were considering to adopt a CS DRG system. We noted it is possible that the proposed system would better recognize the extensive resources that hospitals use to treat patients with severe sepsis. We encouraged commenters to examine the proposed system and provide comments. The comments and responses on this proposal are discussed in section II.C of this final rule.

Therefore, in this FY 2007 final rule we are not creating new DRGs for medical or surgical severe sepsis cases as requested by the commenter.

6. Medicare Code Editor (MCE) Changes

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

For FY 2007, we proposed to make several changes to the MCE edits (71 FR 24038 and 24039). We received one comment on this topic. As a result of new and modified codes approved after the annual spring ICD–9–CM Coordination and Maintenance meeting, we make changes to the MCE. In the past, in both the IPPS proposed and final rules, we only provided the list of changes to the MCE in the IPPS that were brought to our attention after the prior year's final rule. We historically have not listed the changes we have made to the MCE as a result of the new and modified codes approved after the annual spring ICD–9–CM Coordination and Maintenance meeting. These changes are approved too late in the rulemaking schedule for inclusion in the proposed rule. Furthermore, although our MCE policies have been described in our proposed and final rules, we have not provided the detail of each new or modified diagnosis and procedure code edit in the final rule. However, in response to a public comment and in the interest of making the IPPS more transparent, we are including in this final rule a comprehensive list of all the changes to the MCE edits for the next fiscal year as a result of coding changes.

a. Edit: Newborn Diagnoses

We proposed to add code 780.92 (Excessive crying of infant (baby)) to the "Newborn Diagnoses" edit in the MCE. This edit is structured for patients with an age of "0". In the Tabular portion of the ICD–9–CM diagnosis codes, the "excludes" note at code 780.92 states that this code "excludes excessive crying of child, adolescent or adult" and sends the coder to code 780.95 (Other excessive crying. (The new title of this code, shown on Table 6E of the Addendum to this final rule is "Excessive crying of child, adolescent, or adult".) To make a conforming change, we also proposed that code 780.92 be removed from the "Pediatric Diagnoses—Age 0 Through 17" edit.

We did not receive any public comments on the proposed edit and, therefore, are adopting it as final.

In addition, there were diagnosis codes discussed at the March 2006 ICD–9–CM Coordination and Maintenance meeting that were approved too late in the rulemaking schedule for inclusion in the proposed rule. Therefore, the following ICD–9–CM diagnosis codes are added to the "Newborn Diagnosis" MCE edit for FY 2007:

- 768.7, Hypoxic-ischemic encephalopathy (HIE)
- 770.87, Respiratory arrest of newborn
- 770.88, Hypoxemia of newborn
- 775.81, Other acidosis of newborn
- 775.89, Other neonatal endocrine and metabolic disturbances
- 779.85, Cardiac arrest of newborn

Because diagnosis code 775.8 (Other transitory neonatal endocrine and metabolic disturbances) was expanded to the fifth-digit level, this code is being deleted from the Newborn Diagnosis edit.

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

We are adding the following new diagnosis codes to the edit for diagnosis for pediatrics—age 0–17 years old:

- V85.51, Body Mass Index, pediatric, less than 5th percentile for age
- V85.52, Body Mass Index, pediatric, 5th percentile to less than 85th percentile for age
- V85.53, Body Mass Index, pediatric, 85th percentile to less than 95th percentile for age
- V85.54, Body Mass Index, pediatric, greater than or equal to 95th percentile for age

c. Edit: Maternity Diagnoses—Age 12 through 55

We are adding the following new codes to the edit for maternity diagnoses—age 12 through 55:

- 649.00, Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable
- 649.01, Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition
- 649.02, Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication
- 649.03, Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication
- 649.04, Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication
- 649.10, Obesity complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable
- 649.11, Obesity complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition
- 649.12, Obesity complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication
- 649.13, Obesity complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication
- 649.14, Obesity complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication
- 649.20, Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable
- 649.21, Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition
- 649.22, Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication
- 649.23, Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication
- 649.24, Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication
- 649.30, Coagulation defects complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable
- 649.31, Coagulation defects complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition
- 649.32, Coagulation defects complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication
- 649.33, Coagulation defects complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication
- 649.34, Coagulation defects complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication
- 649.40, Epilepsy complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable

- 649.41, Epilepsy complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition
- 649.42, Epilepsy complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication
- 649.43, Epilepsy complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication
- 649.44, Epilepsy complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication
- 649.50, Spotting complicating pregnancy unspecified as to episode of care or not applicable
- 649.51, Spotting complicating pregnancy delivered, with or without mention of antepartum condition
- 649.53, Spotting complicating pregnancy antepartum condition or complication
- 649.60, Uterine size date discrepancy, unspecified as to episode of care or not applicable
- 649.61, Uterine size date discrepancy, delivered, with or without mention of antepartum condition
- 649.62, Uterine size date discrepancy, delivered, with mention of postpartum complication
- 649.63, Uterine size date discrepancy, antepartum condition or complication
- 649.64, Uterine size date discrepancy, postpartum condition or complication

d. Edit: Diagnoses Allowed for Females Only

The following codes are now invalid codes, as shown in Table 6C of the Addendum to the FY 2007 IPPS proposed rule and this final rule. In the FY 2007 IPPS proposed rule, we proposed to remove them from the "Diagnosis Allowed for Females Only" edit in the MCE.

- 616.8, Other specified inflammatory diseases of cervix, vagina, and vulva
- 629.8, Other specified disorders of female genital organs

Codes 616.8 and 629.8 have been expanded to the fifth-digit level. Therefore, we proposed to place the following expanded codes in the "Diagnoses Allowed for Females Only" edit.

- 616.81, Mucositis (ulcerative) of cervix, vagina, and vulva
- 616.89, Other inflammatory disease of cervix, vagina, and vulva
- 629.81, Habitual aborter without current pregnancy
- 629.89, Other specified disorders of female genital organs

The following two codes have revised descriptions (as shown in Table 6E of the Addendum to this final rule) which specify gender. Therefore, we proposed to add them to "Diagnoses Allowed for Females Only" edit.

- V26.31, Testing of female for genetic disease carrier status
- V26.32, Other genetic testing of female

We did not receive any public comments on the proposed changes to this edit. Therefore, we are adopting the changes as final.

In addition, we are adding the following new ICD–9–CM codes to this edit:

- 618.84, Cervical stump prolapse
- 629.29, Other female genital mutilation status
- 649.00, Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable
- 649.01, Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition
- 649.02, Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication
- 649.03, Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication
- 649.04, Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication
- 649.10, Obesity complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable
- 649.11, Obesity complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition
- 649.12, Obesity complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication
- 649.13, Obesity complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication
- 649.14, Obesity complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication
- 649.20, Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable
- 649.21, Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition
- 649.22, Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication
- 649.23, Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication
- 649.24, Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication
- 649.30, Coagulation defects complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable
- 649.31, Coagulation defects complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition
- 649.32, Coagulation defects complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication
- 649.33, Coagulation defects complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication
- 649.34, Coagulation defects complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication
- 649.40, Epilepsy complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable
- 649.41, Epilepsy complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition
- 649.42, Epilepsy complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication
- 649.43, Epilepsy complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication
- 649.44, Epilepsy complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication
- 649.50, Spotting complicating pregnancy unspecified as to episode of care or not applicable
- 649.51, Spotting complicating pregnancy delivered, with or without mention of antepartum condition
- 649.53, Spotting complicating pregnancy antepartum condition or complication
- 649.60, Uterine size date discrepancy, unspecified as to episode of care or not applicable
- 649.61, Uterine size date discrepancy, delivered, with or without mention of antepartum condition

- 649.62, Uterine size date discrepancy, delivered, with mention of postpartum complication
- 649.63, Uterine size date discrepancy, antepartum condition or complication
- 649.64, Uterine size date discrepancy, postpartum condition or complication
- 795.06, Papanicolaou smear of cervix with cytologic evidence of malignancy
- 795.82, Elevated cancer antigen 125 [CA 125]

e. Edit: Diagnoses Allowed for Males Only

Code 608.2 (Torsion of testis) is now an invalid code (as shown in Table 6C of the Addendum to the proposed rule and this final rule). Therefore, we proposed to remove it from the "Diagnoses Allowed for Males Only" edit. This code has been expanded to the fifth-digit level. We proposed to place the following expanded codes in the "Diagnoses Allowed for Males Only" edit:

- 608.20, Torsion of testis, unspecified
- 608.21, Extravaginal torsion of spermatic cord
- 608.22 Intravaginal torsion of spermatic cord
- 608.23, Torsion of appendix testis
- 608.24, Torsion of appendix epididymis

The following codes have been created effective for FY 2007 and are gender specific. Therefore, we proposed to add them to the "Diagnosis Allowed for Males Only" edit.

- V26.34, Testing of male for genetic disease carrier status
- V26.35, Encounter for testing of male partner of habitual aborter
- V26.39, Other genetic testing of male

We did not receive any public comments on our proposed changes to this edit. Therefore, we are adopting the changes as final.

f. Edit: Procedures Allowed for Females Only

The following new codes are added to the list of female procedures:

- 68.41, Laparoscopic total abdominal hysterectomy
- 68.49, Other and unspecified total abdominal hysterectomy
- 68.61, Laparoscopic radical abdominal hysterectomy
- 68.69, Other and unspecified radical abdominal hysterectomy
- 68.71, Laparoscopic radical vaginal hysterectomy [LRVH]
- 68.79, Other and unspecified radical vaginal hysterectomy

In addition, the following codes were expanded to the fourth digit and, therefore, are removed from this edit:

- 68.4, Total abdominal hysterectomy
- 68.6, Radical abdominal hysterectomy
- 68.7, Radical vaginal hysterectomy

g. Edit: Manifestations Not Allowed as Principal Diagnosis

We proposed to add the following codes to the "Manifestations Not Allowed as Principal Diagnosis" edit in the MCE:

- 362.03, Nonproliferative diabetic retinopathy, NOS
- 362.04, Mild nonproliferative diabetic retinopathy
- 362.05, Moderate nonproliferative diabetic retinopathy
- 362.06, Severe nonproliferative diabetic retinopathy
- 362.07, Diabetic macular edema.

We did not receive any public comments concerning this proposed change. Therefore, we are adopting the above proposed changes as final.

In addition, we are adding the following new codes to this edit:

- 284.2, Myelophthisis
- 289.83, Myelofibrosis
- 323.01, Encephalitis and encephalomyelitis in viral diseases classified elsewhere
- 323.02, Myelitis in viral diseases classified elsewhere
- 323.41, Other encephalitis and encephalomyelitis due to infection classified elsewhere
- 323.42, Other myelitis due to infection classified elsewhere
- 323.61, Infectious acute disseminated encephalomyelitis (ADEM)
- 323.62, Other postinfectious encephalitis and encephalomyelitis
- 323.63, Postinfectious myelitis
- 323.71, Toxic encephalitis and encephalomyelitis
- 323.72, Toxic myelitis
- 341.21, Acute (transverse) myelitis in conditions classified elsewhere

The following codes have been expanded to the fifth-digit level of specificity, which results in making the four-digit code invalid. Therefore, these codes are removed from the manifestation edit:

- 323.0, Encephalitis in viral diseases classified elsewhere
- 323.4, Other encephalitis due to infection classified elsewhere
- 323.6, Postinfectious encephalitis
- 323.7, Toxic encephalitis

In the proposed rule, we had suggested we would remove code 525.10 (Acquired absence of teeth, unspecified) from this edit in the MCE. However, all codes in subcategory 525.1 (Loss of teeth due to trauma, extraction, or periodontal disease) are considered manifestation codes. Therefore, we are retracting this proposal, and are leaving code 525.10 in this edit.

h. Edit: Nonspecific Principal Diagnosis

We proposed to add the following codes to the "Nonspecific Principal Diagnosis" edit in the MCE:

- 255.10, Hyperaldosteronism, unspecified
- 323.9, Unspecified causes of encephalitis, myelitis, and encephalomyelitis
- 770.10, Fetal and newborn aspiration, unspecified.
- 780.31, Febrile convulsions (simple), unspecified

Codes 255.10, 323.9, and 780.31 appear on Table 6E, Revised Diagnosis Codes, and are being included in this edit because of their revised descriptions. Code 770.10 was inadvertently left off this list for FY 2006 when the code was created.

We did not receive any public comments on the proposed changes to this edit. Therefore, we are adopting the proposed changes as final. In addition, we are adding the following codes to this edit:

- 238.75, Myelodysplastic syndrome, unspecified
- 276.50, Volume depletion NOS
- 277.30, Amyloidosis, unspecified
- 288.00, Neutropenia, unspecified
- 288.50, Leukocytopenia, unspecified
- 288.60, Leukocytosis, unspecified
- 341.20, Acute (transverse) myelitis NOS
- 379.60, Inflammation (infection) of postprocedural bleb, unspecified
- 523.30, Aggressive periodontitis, unspecified
- 523.40, Chronic periodontitis, unspecified
- 525.60, Unspecified unsatisfactory restoration of tooth
- 528.00, Stomatitis and mucositis, unspecified
- 608.20, Torsion of testis, unspecified
- 649.00, Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable
- 649.10, Obesity complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable
- 649.20, Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable
- 649.30, Coagulation defects complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable

- 649.40, Epilepsy complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable
- 649.50, Spotting complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable
- 649.60, Uterine size date discrepancy, unspecified as to episode of care or not applicable
- 958.90, Compartment syndrome, unspecified
- 995.20, Unspecified adverse effect of unspecified drug, medicinal and biological substance
- 995.22, Unspecified adverse effect of anesthesia
- 995.23, Unspecified adverse effect of insulin
- 995.29, Unspecified adverse effect of other drug, medicinal and biological substance

We are removing the following codes from this edit:

- 362.03, Nonproliferative diabetic retinopathy NOS
- 525.10, Acquired absence of teeth, unspecified
- 793.9, Other nonspecific abnormal findings on radiological and other examinations of body structure

Comment: Two commenters suggested that the expanded code (793.99, Other nonspecific abnormal findings on radiological and other examinations of body structure) be added back into this edit.

Response: We will not act on those suggestions at this time, as we believe that code 739.9 should not originally have been in the edit as it is more like an "other" code than a "nonspecific" code.

i. Edit: Unacceptable Principal Diagnosis

Most V-codes describe an individual's health status, but these codes are not usually a current illness or injury. Therefore, most V-codes are included in the "Unacceptable Principal Diagnosis" edit. The following codes became invalid (as shown in Table 6C of the Addendum to the proposed rule and this final rule) for FY 2007, and we proposed to remove them from this edit:

- V18.5, Family history, digestive disorders
- V58.3, Attention to surgical dressings and sutures
- V72.1, Examination of ears and hearing

The following V-codes represent either fifth-digit extensions of the above codes, or new codes that were created effective October 1, 2006 (Table 6A of the Addendum to the proposed rule and this final rule). Therefore, we proposed to add the following codes to the "Unacceptable Principal Diagnosis" edit:

- V18.51, Family history, colonic polyps
- V18.59, Family history, other digestive disorders
- V26.34, Testing of male for genetic disease carrier status
- V26.35, Encounter for testing of male partner of habitual aborter
- V26.39, Other genetic testing of male
- V45.86, Bariatric surgery status
- V58.30, Encounter for change or removal of nonsurgical wound dressing
- V58.31, Encounter for change or removal of surgical wound dressing
- V58.32, Encounter for removal of sutures
- V72.11, Encounter for hearing examination following failed hearing screening
- V72.19, Other examination of ears and hearing
- V82.71, Screening for genetic disease carrier status
- V82.79, Other genetic screening
- V85.51, Body mass index, pediatric, less than 5th percentile for age
- V85.52, Body mass index, pediatric, 5th percentile to less than 85th percentile for age
- V85.53, Body mass index, pediatric, 85th percentile to less than 95th percentile for age
- V85.54, Body mass index, pediatric, greater than or equal to 95th percentile for age
- V86.0, Estrogen receptor positive status [ER+]
- V86.1, Estrogen receptor negative status [ER−]

We did not receive any public comments on these proposed edits. Therefore, we are adopting the proposed changes as final.

j. Edit: Nonspecific O.R. Procedures

We proposed to remove code 00.29 (Intravascular imaging unspecified vessel(s)) from the "Nonspecific O.R. Procedure" edit in the MCE. This code was erroneously placed in this edit; it is not considered an O.R. procedure.

We did not receive any public comments on these proposed edits. Therefore, we are adopting the proposed changes as final.

In addition, we are removing code 68.39 (Other subtotal abdominal hysterectomy) from this edit. Code 68.39 is not a nonspecific code, it is considered other, and was originally included in this edit in error.

k. Edit: Noncovered Procedures

Under the proposed changes to DRG 513 (Pancreas Transplant) under the Pre-MDCs described in section II.D.1. of the preamble of the FY 2007 IPPS proposed rule, a patient must have a history of medically uncontrollable, insulin-dependent diabetes mellitus, that is, Type I diabetes mellitus. Therefore, to conform the "Noncovered Procedures" Edit in the MCE to these proposed changes, we proposed to revise Diagnosis List 1 in this edit to include only the following codes:

- 250.01, Diabetes mellitus without mention of complication, type I [juvenile type], not stated as uncontrolled
- 250.03, Diabetes mellitus without mention of complication, type I [juvenile type], uncontrolled
- 250.11, Diabetes with ketoacidosis, type I [juvenile type], not stated as uncontrolled
- 250.13, Diabetes with ketoacidosis, type I [juvenile type], uncontrolled
- 250.21, Diabetes with hyperosmolarity, type I [juvenile type], not stated as uncontrolled
- 250.23, Diabetes with hyperosmolarity, type I [juvenile type], uncontrolled
- 250.31, Diabetes with other coma, type I [juvenile type], not stated as uncontrolled
- 250.33, Diabetes with other coma, type I [juvenile type], uncontrolled
- 250.41, Diabetes with renal manifestations, type I [juvenile type], not stated as uncontrolled
- 250.43, Diabetes with renal manifestations, type I [juvenile type], uncontrolled
- 250.51, Diabetes with ophthalmic manifestations, type I [juvenile type], not stated as uncontrolled
- 250.53, Diabetes with ophthalmic manifestations, type I [juvenile type], uncontrolled
- 250.61, Diabetes with neurological manifestations, type I [juvenile type], not stated as uncontrolled
- 250.63, Diabetes with neurological manifestations, type I [juvenile type], uncontrolled
- 250.71, Diabetes with peripheral circulatory disorders, type I [juvenile type], not stated as uncontrolled
- 250.73, Diabetes with peripheral circulatory disorders, type I [juvenile type], uncontrolled
- 250.81, Diabetes with other specified manifestations, type I [juvenile type], not stated as uncontrolled
- 250.83, Diabetes with other specified manifestations, type I [juvenile type], uncontrolled
- 250.91, Diabetes with unspecified complication, type I [juvenile type], not stated as uncontrolled
- 250.93, Diabetes with unspecified complication, type I [juvenile type], uncontrolled

In addition, we proposed to remove Diagnosis List 2 from the "Noncovered Procedures" edit, which is comprised of the following codes:

- 403.01, Hypertensive kidney disease, malignant, with chronic kidney disease
- 403.11, Hypertensive kidney disease, benign, with chronic kidney disease
- 403.91, Hypertensive kidney disease, unspecified, with chronic kidney disease
- 404.02, Hypertensive heart and kidney disease, malignant, with chronic kidney disease
- 404.03, Hypertensive heart and kidney disease, malignant, with heart failure and chronic kidney disease
- 404.12, Hypertensive heart and kidney disease, benign, with chronic kidney disease
- 404.13, Hypertensive heart and kidney disease, benign, with heart failure and chronic kidney disease
- 404.92, Hypertensive heart and kidney disease, unspecified, with chronic kidney disease
- 404.93, Hypertensive heart and kidney disease, unspecified, with heart failure and chronic kidney disease
- 585.1, Chronic kidney disease, Stage I
- 585.2, Chronic kidney disease, Stage II (mild)
- 585.3, Chronic kidney disease, Stage III (moderate)
- 585.4, Chronic kidney disease, Stage IV (severe)
- 585.5, Chronic kidney disease, Stage V
- 585.6, End stage renal disease
- 585.9, Chronic kidney disease, unspecified
- V42.0, Organ or tissue replaced by transplant, kidney
- V43.89, Organ or tissue replaced by other means, other organ or tissue, other

All of the comments we received regarding this proposal were favorable. Therefore, we are adopting the above changes as final.

Lumbar Artificial Disc: CMS has found that lumbar artificial disc replacement (LADR) with the Charite™ lumbar artificial disc is not reasonable and necessary for the Medicare population over 60 years of age. Therefore, we issued a national noncoverage determination for LADR with the Charite™ lumbar artificial disc for Medicare patients over 60 years of age. For Medicare beneficiaries 60 years of age and under, there is no national coverage determination, leaving such determinations to be made on a local basis. The coverage decision memo can be viewed on the CMS Web site at *http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=170.*

To conform to this decision, procedure code 84.65 (Insertion of total spinal disc prosthesis, lumbosacral) is put on the Non-Covered Procedure edit except when the patient is 60 years of age or less. The logic will be as follows:

84.65, Insertion of total spinal disc prosthesis, lumbosacral
AND
Age <=61

l. Edit: Bilateral Procedure

We proposed to remove the following codes from the Bilateral Procedure edit, as these are adjunct codes. They are not O.R. codes recognized by the GROUPER as procedures, and the edit was created in error last year.

- 00.74, Hip replacement bearing surface, metal-on-polyethylene
- 00.75, Hip replacement bearing surface, metal-on-metal
- 00.76, Hip replacement bearing surface, ceramic-on-ceramic

We did not receive any public comments on these proposed edits. Therefore, we are adopting the proposed changes as final.

In addition, we are deleting the following joint revision codes from this edit, as they should not have been added last year.

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

7. Surgical Hierarchies

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

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

A surgical class can be composed of one or more DRGs. For example, in MDC 11, the surgical class "kidney transplant" consists of a single DRG (DRG 302) and the class "kidney, ureter and major bladder procedures" consists of three DRGs (DRGs 303, 304, and 305). Consequently, in many cases, the surgical hierarchy has an impact on more than one DRG. The methodology for determining the most resource-intensive surgical class involves weighting the average resources for each DRG by frequency to determine the weighted average resources for each surgical class. For example, assume surgical class A includes DRGs 1 and 2 and surgical class B includes DRGs 3, 4, and 5. Assume also that the average charge of DRG 1 is higher than that of DRG 3, but the average charges of DRGs 4 and 5 are higher than the average charge of DRG 2. To determine whether surgical class A should be higher or lower than surgical class B in the surgical hierarchy, we would weight the average charge of each DRG in the class by frequency (that is, by the number of cases in the DRG) to determine average resource consumption for the surgical class. The surgical classes would then be ordered from the class with the highest average resource utilization to that with the lowest, with the exception of "other O.R. procedures" as discussed below.

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

We note that, notwithstanding the foregoing discussion, there are a few instances when a surgical class with a lower average charge is ordered above a surgical class with a higher average charge. For example, the "other O.R. procedures" surgical class is uniformly ordered last in the surgical hierarchy of each MDC in which it occurs, regardless of the fact that the average charge for the

DRG or DRGs in that surgical class may be higher than that for other surgical classes in the MDC. The "other O.R. procedures" class is a group of procedures that are only infrequently related to the diagnoses in the MDC, but are still occasionally performed on patients in the MDC with these diagnoses. Therefore, assignment to these surgical classes should only occur if no other surgical class more closely related to the diagnoses in the MDC is appropriate.

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

Based on the preliminary recalibration of the DRGs, in the FY 2007 IPPS proposed rule (71 FR 24039), we proposed to revise the surgical hierarchy for Pre-MDCs, MDC 1 (Diseases and Disorders of the Nervous System), MDC 2 (Diseases and Disorders of the Eye), MDC 3 (Diseases and Disorders of the Ear, Nose, Mouth, and Throat), MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue), MDC 10 (Endocrine, Nutritional and Metabolic Diseases and Disorders), and MDC 13 (Diseases and Disorders of the Female Reproductive System) as follows:

In Pre-MDCs, we proposed to reorder DRG 481 (Bone Marrow Transplant) above DRG 513 (Pancreas Transplant).

In MDC 1, we proposed to reorder DRGs 531-532 (Spinal Procedures, With CC and Without CC, respectively) above DRGs 529-530 (Ventricular Shunt Procedures, With CC and Without CC, respectively).

In MDC 2, we proposed to reorder DRG 42 (Intraocular Procedures Except Retina, Iris and Lens) above DRG 36 (Retinal Procedures).

In MDC 3, we proposed to reorder DRGs 168-169 (Mouth Procedures, With CC and Without CC, respectively) above DRG 57 (T&A Procedures, Except Tonsillectomy and/or Adenoidectomy Only, Age > 17) and DRG 58 (T&A Procedures, Except Tonsillectomy and/or Adenoidectomy Only, Age 0–17).

In MDC 8, we proposed to reorder DRG 213 (Amputation for Musculoskeletal System and Connective Tissue Disorders) above DRG 216 (Biopsies of Musculoskeletal System and Connective Tissue).

In MDC 10, we proposed to reorder DRG 285 (Amputation of Lower Limb for Endocrine, Nutritional and Metabolic Diseases and Disorders) above DRG 288 (O.R. Procedures for Obesity).

In MDC 13, we proposed to reorder DRG 363 (D&C, Conization and Radio-Implant, for Malignancy) and DRG 364 (D&C, Conization and Radio-Implant, Except for Malignancy) above DRG 360 (Vagina, Cervix, and Vulva Procedures).

We did not receive any public comments on the proposed changes to the surgical hierarchy described above. Based on a test of the proposed revisions using the March 2006 update of the FY 2005 MedPAR file and the revised GROUPER software, we found that the revisions are still supported by the data. Therefore, we are incorporating these proposed revisions to the surgical hierarchy as final for FY 2007. In addition, because, in this final rule, we are deleting 8 DRGs and creating 20 new DRGs as discussed under section II.D.7. of this preamble, we are reordering the following DRGs in MDC 1 (Diseases and disorders of the Nervous System), MDC 6 (Diseases and Disorders of the Digestive System), MDC 11 (Diseases and Disorders of the Kidney and urinary Tract), and MDC 18 (Infectious and Parasitic Diseases (Systemic or Unspecified Sites)):

- In MDC 1, we are reordering DRG 577 (Carotid Artery Stent Procedure) above DRG 533 (Extracranial Procedures With CC).
- In MDC 6, we are reordering DRGs 567 and 568 (Stomach, Esophageal and Duodenal Procedures Age >17 With CC With and Without Major GI Diagnoses, respectively) above DRG 155 (Stomach, Esophageal and Duodenal Procedures Age >17 Without CC);
- In MDC 6, we are reordering DRGs 569-570 (Major Small and Large Bowel Procedures With CC With and Without Major GI Diagnoses, respectively) above DRG 149 (Major Small and Large Bowel Procedures Without CC).
- In MDC 11, we are reordering DRG 573 (Major Bladder Procedures) above DRG 303 (Kidney, Ureter and Major Bladder Procedures for Neoplasm).
- In MDC 18, we are reordering DRG 578 (Infections and Parasite Diseases With O.R. Procedure) above DRG 579 (Postoperative or Post-Traumatic Infections With O.R. Procedure).

8. Refinement of Complications and Comorbidities (CC) List

a. Background

As indicated earlier in this preamble, under the IPPS DRG classification system, we have developed a standard list of diagnoses that are considered complications or comorbidities (CCs). Historically, we developed this list using physician panels that classified each diagnosis code based on whether the diagnosis, when present as a secondary condition, would be considered a substantial complication or comorbidity. A substantial complication or comorbidity was defined as a condition that, because of its presence with a specific principal diagnosis, would cause an increase in the length of stay by at least 1 day in at least 75 percent of the patients.

b. Comprehensive Review of the CC List

In previous years, we have made changes to the standard list of CCs, either by adding new CCs or deleting CCs already on the list, but we have never conducted a comprehensive review of the list. Given the long period of time that had elapsed since the original CC list was developed, the incremental nature of changes to it, and changes in the way inpatient care is delivered, and in partial response to recommendations in MedPAC's March 2005 Report to Congress on Physician-Owned Specialty Hospitals, for the FY 2006 IPPS final rule, we reviewed the 121-paired DRGs that were split on the presence or absence of a CC among the 3,285 diagnosis codes on the CC list. We presented the results of that review and summarized public comments that we received in the FY 2006 proposed rule on the review results in the FY 2006 IPPS final rule (70 FR 47313 through 47315). Further analysis of the CC list and refinement to recognize the effects of differences in severity of illness among patients is discussed in section II.C. of the preamble of the proposed rule as part of our efforts to develop a CSDRG system for use in the IPPS.

During this past winter, CMS began a comprehensive review of over 13,000 diagnosis codes to determine whether they should be classified as CCs when present as a secondary diagnosis. Although we did not complete this review because of the work we did to develop the CS DRGs, we are considering whether to continue our analysis of the CC list as part of an effort to develop and adopt a severity DRG system that is in the public domain for FY 2008. As we explained in more detail above, we may update the work we did to develop a severity DRG system in the mid-1990s that classified patients into a base DRG that was further subdivided based on three levels of severity depending upon whether the patient had no CC, a CC, or a major CC in conjunction with continuing our review of the CC list.

c. CC Exclusions List for FY 2007

In the September 1, 1987 final notice (52 FR 33143) concerning changes to the DRG classification system, we modified the GROUPER logic so that certain diagnoses included on the standard list of CCs would not be considered valid CCs in combination with a particular principal diagnosis. We created the CC Exclusions List for the following reasons: (1) To preclude coding of CCs for closely related conditions; (2) to preclude duplicative or inconsistent coding from being treated as CCs; and (3) to ensure that cases are appropriately classified between the complicated and uncomplicated DRGs in a pair. As we indicated above, we developed a list of diagnoses, using physician panels, to include those diagnoses that, when present as a secondary condition, would be considered a substantial complication or comorbidity. In previous years, we have made changes to the list of CCs, either by adding new CCs or deleting CCs already on the list. We did not propose to delete any of the diagnosis codes on the CC list for FY 2007.

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

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

The creation of the CC Exclusions List was a major project involving hundreds of codes. We have continued to review the remaining CCs to identify additional exclusions and to remove diagnoses from the master list that have been shown not to meet the definition of a CC.[17]

As we proposed, we are making limited revisions to the CC Exclusions List to take into account the changes that will be made in the ICD–9–CM diagnosis coding system effective October 1, 2006. (See section II.D.10. of this preamble for a discussion of ICD–9–CM changes.) We are making these changes in accordance with the principles established when we created the CC Exclusions List in 1987.

Tables 6G and 6H in the Addendum to this final rule contain the revisions to the CC Exclusions List that will be effective for discharges occurring on or after October 1, 2006. Each table shows the principal diagnoses with changes to the excluded CCs. Each of these principal diagnoses is shown with an asterisk, and the additions or deletions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.

CCs that are added to the list are in Table 6G—Additions to the CC Exclusions List. Beginning with discharges on or after October 1, 2006, the indented diagnoses will not be recognized by the GROUPER as valid CCs for the asterisked principal diagnosis.

CCs that are deleted from the list are in Table 6H—Deletions from the CC Exclusions List. Beginning with discharges on or after October 1, 2006, the indented diagnoses will be recognized by the GROUPER as valid CCs for the asterisked principal diagnosis.

Copies of the original CC Exclusions List applicable to FY 1988 can be obtained from the National Technical Information Service (NTIS) of the Department of Commerce. It is available in hard copy for $152.50 plus shipping and handling. A request for the FY 1988 CC Exclusions List (which should include the identification accession number (PB) 88–133970) should be made to the following address: National Technical Information Service, United States Department of Commerce, 5285 Port Royal Road, Springfield, VA 22161; or by calling (800) 553–6847.

Users should be aware of the fact that all revisions to the CC Exclusions List (FYs 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2001, 2002, 2003, 2004, 2005, and 2006) and those in Tables 6G and 6H of this final rule for FY 2007 must be incorporated into the list purchased from NTIS in order to obtain the CC Exclusions List applicable for discharges occurring on or after October 1, 2006. (Note: There was no CC Exclusions List in FY 2000 because we did not make changes to the ICD–9–CM codes for FY 2000.)

Alternatively, the complete documentation of the GROUPER logic, including the current CC Exclusions List, is available from 3M/Health Information Systems (HIS), which, under contract with CMS, is responsible for updating and maintaining the GROUPER program. The current DRG Definitions Manual, Version 23.0, is available for $225.00, which includes $15.00 for shipping and handling. Version 24.0 of this manual, which will include the final FY 2007 DRG changes, will be available in hard copy for $250.00. Version 24.0 of the manual is also available on a CD for $200.00; a combination hard copy and CD is available for $400.00. These manuals may be obtained by writing 3M/HIS at the following address: 100 Barnes Road, Wallingford, CT 06492; or by calling (203) 949–0303. Please specify the revision or revisions requested.

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

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

DRGs 468, 476, and 477 are reserved for those cases in which none of the O.R. procedures performed are related to the principal diagnosis. These DRGs are intended to capture atypical cases, that is, those cases not occurring with sufficient frequency to represent a distinct, recognizable clinical group. DRG 476 is assigned to those discharges

[17] See the FY 1989 final rule (53 FR 38485, September 30, 1988), for the revision made for the discharges occurring in FY 1989; the FY 1990 final rule (54 FR 36552, September 1, 1989), for the FY 1990 revision; the FY 1991 final rule (55 FR 36126, September 4, 1990), for the FY 1991 revision; the FY 1992 final rule (56 FR 43209, August 30, 1991) for the FY 1992 revision; the FY 1993 final rule (57 FR 39753, September 1, 1992), for the FY 1993 revision; the FY 1994 final rule (58 FR 46278, September 1, 1993), for the FY 1994 revisions; the FY 1995 final rule (59 FR 45334; September 1, 1994), for the FY 1995 revisions; the FY 1996 final rule (60 FR 45782, September 1, 1995), for the FY 1996 revisions; the FY 1997 final rule (61 FR 46171, August 30, 1996), for the FY 1997 revisions; the FY 1998 final rule (62 FR 45966, August 29, 1997) for the FY 1998 revisions; the FY 1999 final rule (63 FR 40954, July 31, 1998), for the FY 1999 revisions; the FY 2001 final rule (65 FR 47064, August 1, 2000), for the FY 2001 revisions; the FY 2002 final rule (66 FR 39851, August 1, 2001), for the FY 2002 revisions; the FY 2003 final rule (67 FR 49998, August 1, 2002), for the FY 2003 revisions; the FY 2004 final rule (68 FR 45364, August 1, 2003), for the FY 2004 revisions; the FY 2005 final rule (69 FR 49848, August 11, 2004), for the FY 2005 revisions; and the FY 2006 final rule (70 FR 47640, August 12, 2005), for the FY 2006 revisions. In the FY 2000 final rule (64 FR 41420, July 30, 1999), we did not modify the CC Exclusions List because we did not make any changes to the ICD–9–CM codes for FY 2000.

in which one or more of the following prostatic procedures are performed and are unrelated to the principal diagnosis:

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

All remaining O.R. procedures are assigned to DRGs 468 and 477, with DRG 477 assigned to those discharges in which the only procedures performed are nonextensive procedures that are unrelated to the principal diagnosis.[18]

For FY 2007, we did not propose to change the procedures assigned among these DRGs. We did not receive any comments on our proposal and, therefore, are adopting it as final.

[18] The original list of the ICD–9–CM procedure codes for the procedures we consider nonextensive procedures, if performed with an unrelated principal diagnosis, was published in Table 6C in section IV of the Addendum to the FY 1989 final rule (53 FR 38591). As part of the FY 1991 final rule (55 FR 361.35), the FY 1992 final rule (56 FR 43212), the FY 1993 final rule (57 FR 23625), the FY 1994 final rule (58 FR 46279), the FY 1995 final rule (59 FR 45336), the FY 1996 final rule (60 FR 45783), the FY 1997 final rule (61 FR 46173), and the FY 1998 final rule (62 FR 45981), we moved several other procedures from DRG 468 to DRG 477, and some procedures from DRG 477 to DRG 468. No procedures were moved in FY 1999, as noted in the final rule (63 FR 40962); in FY 2000 (64 FR 41496); in FY 2001 (65 FR 47064); or in FY 2002 (66 FR 39852). In the FY 2003 final rule (67 FR 49999) we did not move any procedures from DRG 477. However, we did move procedure codes from DRG 468 and placed them in more clinically coherent DRGs. In the FY 2004 final rule (68 FR 45365), we moved several procedures from DRG 468 to DRGs 476 and 477 because the procedures are nonextensive. In the FY 2005 final rule (69 FR 48950), we moved one procedure from DRG 468 to 477. In addition, we added several existing procedures to DRGs 476 and 477. In FY 2006 (70 FR 47317), we moved one procedure from DRG 468 and assigned it to DRG 477. In FY 2007, we moved one procedure from DRG 468 and assigned it to DRGs 479, 553, and 554.

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

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

We identify those procedures occurring in conjunction with certain principal diagnoses with sufficient frequency to justify adding them to one of the surgical DRGs for the MDC in which the diagnosis falls. Based on this year's review, as proposed, we are not removing any procedures from DRG 477 with assignment to one of the surgical DRGs. We did not receive any comments on our proposal, and, therefore, there will be no change to DRG 477.

However, we did receive a comment regarding DRG 468 after the publication of the proposed rule. The comment addressed advances in treatment technology for hypertension and noted that two procedure codes cause cases to be assigned to DRG 468 instead of more appropriately to DRGs in MDC 5. Therefore, we are moving the following two codes into MDC 5, DRG 479 (Other Vascular Procedures without CC), and paired DRGs 553 and 554 (Other Vascular Procedures with CC with and without Major CV Diagnosis, respectively):

- 04.92, Implantation or replacement of peripheral neurostimulator lead(s)
- 86.96, Insertion or replacement of other neurostimulator pulse generator

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

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

We did not propose to move any procedure codes from DRG 476 to DRGs 468 or 477, or from DRG 477 to DRGs 468 or 476 for FY 2007. We did not receive any public comments on our proposal and; therefore, are adopting it as final.

c. Adding Diagnosis or Procedure Codes to MDCs

Based on our review this year, as we proposed, we are not adding any diagnosis codes to MDCs for FY 2007. We did not receive any public comments on our proposal and, therefore, are adopting it as final.

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

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

The Official Version of the ICD–9–CM contains the list of valid diagnosis and procedure codes. (The Official Version of the ICD–9–CM is available from the Government Printing Office on CD–ROM for $25.00 by calling (202) 512–1800.) The Official Version of the ICD–9–CM is no longer available in printed manual form from the Federal Government; it is only available on CD–ROM. Users who need a paper version are referred to one of the many products available from publishing houses.

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

Tabular List and *Alphabetic Index for Procedures*.

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

The Committee presented proposals for coding changes for implementation in FY 2007 at a public meeting held on September 29–30, 2005, and finalized the coding changes after consideration of comments received at the meetings and in writing by December 2, 2005. Those coding changes were announced in the FY 2007 IPPS proposed rule and are listed in Tables 6A through 6F in the Addendum to this final rule. The Committee held its 2006 meeting on March 23–24, 2006. Proposed new codes for which there was a consensus of public support and for which complete tabular and indexing changes can be made by May 2006 will be included in the October 1, 2006 update to ICD–9–CM. Code revisions that were discussed at the March 23–24, 2006 Committee meeting could not be finalized in time to include them in the FY 2007 IPPS proposed rule. These additional codes are included in Tables 6A through 6F of this final rule and are marked with an asterisk (*).

Copies of the minutes of the procedure codes discussions at the Committee's September 29–30, 2005 meeting can be obtained from the CMS Web site: *http://cms.hhs.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp*. The minutes of the diagnosis codes discussions at the September 29–30, 2005 meeting are found at: *http://www.cdc.gov/nchs/icd9.htm*. Paper copies of these minutes are no longer available and the mailing list has been discontinued. These Web sites also provide detailed information about the Committee, including information on requesting a new code, attending a Committee meeting, and timeline requirements and meeting dates.

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

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

The ICD–9–CM code changes that have been approved will become effective October 1, 2006. The new ICD–9–CM codes are listed, along with their DRG classifications, in Tables 6A and 6B (New Diagnosis Codes and New Procedure Codes, respectively) in the Addendum to this proposed rule. As we stated above, the code numbers and their titles were presented for public comment at the ICD–9–CM Coordination and Maintenance Committee meetings. Both oral and written comments were considered before the codes were approved. In the FY 2007 IPPS proposed rule, we only solicited comments on the proposed classification of these new codes.

Comment: One commenter expressed concern about the DRG assignment for codes 629.81 (Habitual aborter without current pregnancy) and 629.89 (Other specified disorders of female genital organs). The commenter indicated that CMS proposed to assign both codes to DRG 368 (Infections, Female Reproductive System) within MDC–18. The commenter posited that CMS may have erred in listing the DRG assignment as DRG 368 and instead intended to assign the code to DRG 369 (Menstrual and Other Female Reproductive System Disorders) since these conditions are not infections.

Response: We agree with the commenter that codes 629.81 and 629.89 do not represent infections and should not be assigned to DRG 368 within MDC 18. They should instead be assigned to DRG 369 as the commenter suggested. Therefore, we are changing the DRG assignment for codes 629.81 and 629.89 from DRG 368 to DRG 369. This change is shown in Table 6A of the Addendum to this final rule.

Comment: One commenter asked whether the footnotes for codes 995.20 through 995.29 in Table 6A of the Addendum to the proposed rule was in error. The commenter stated that the predecessor code, 995.2 (Unspecified adverse effect of drug, medicinal and biological substance) is considered a secondary diagnosis of a "major problem" diagnosis that will assign a patient to DRGs 387 (Prematurity with Major Problems) and DRG 389 (Full–Term Neonate with Major Problems) when present only as a secondary diagnosis. However, the commenter added, the footnote on the expanded codes 995.20 through 995.29 lists them as principal or secondary diagnoses that will assign a patient to DRGs 387 and 389 for neonates with major problems. The specific codes are as follows:

- 995.20 (Unspecified adverse effect of unspecified drug, medicinal and biological substance)
- 995.21 (Arthus phenomenon)
- 995.22 (Unspecified adverse effect of anesthesia)
- 995.23 (Unspecified adverse effect of insulin)
- 995.27 (Other drug allergy)
- 995.29 (Unspecified adverse effect of other drug, medicinal and biological substance)

Response: The commenter is correct that we made an error in the footnote. The predecessor code 995.2 when present as a secondary diagnosis, will be a major problem that assigns the patient to DRGs 387 and 389. The footnote should have indicated codes 995.20 through 995.29 will only assign patients DRGs 387 and 389 when present as a secondary diagnosis. We have corrected the footnote in Table 6A of the Addendum to this final rule.

For codes that have been replaced by new or expanded codes, the corresponding new or expanded diagnosis codes are included in Table 6A. New procedure codes are shown in Table 6B. Diagnosis codes that have been replaced by expanded codes or other codes or have been deleted are in Table 6C (Invalid Diagnosis Codes). These invalid diagnosis codes will not be recognized by the GROUPER beginning with discharges occurring on or after October 1, 2006. Table 6D contains invalid procedure codes. These invalid procedure codes will not be recognized by the GROUPER beginning with discharges occurring on or after October 1, 2006. Revisions to diagnosis code titles are in Table 6E (Revised Diagnosis Code Titles), which also includes the DRG assignments for these revised codes. Table 6F includes revised procedure code titles for FY–2007.

In the September 7, 2001 final rule implementing the IPPS new technology add-on payments (66 FR 46906), we indicated we would attempt to include proposals for procedure codes that

would describe new technology discussed and approved at the April meeting as part of the code revisions effective the following October. As stated previously, ICD–9–CM codes discussed at the March 23–24, 2006 Committee meeting that received consensus and that were finalized by May 2006, are included in Tables 6A through 6F of the Addendum to this final rule.

Section 503(a) of Pub. L. 108–173 included a requirement for updating ICD–9–CM codes twice a year instead of a single update on October 1 of each year. This requirement was included as part of the amendments to the Act relating to recognition of new technology under the IPPS. Section 503(a) amended section 1886(d)(5)(K) of the Act by adding a clause (vii) which states that the "Secretary shall provide for the addition of new diagnosis and procedure codes in April 1 of each year, but the addition of such codes shall not require the Secretary to adjust the payment (or diagnosis–related group classification) * * * until the fiscal year that begins after such date." This requirement improves the recognition of new technologies under the IPPS system by providing information on these new technologies at an earlier date. Data will be available 6 months earlier than would be possible with updates occurring only once a year on October 1.

While section 1886(d)(5)(K)(vii) of the Act states that the addition of new diagnosis and procedure codes on April 1 of each year shall not require the Secretary to adjust the payment, or DRG classification, under section 1886(d) of the Act until the fiscal year that begins after such date, we have to update the DRG software and other systems in order to recognize and accept the new codes. We also publicize the code changes and the need for a mid-year systems update by providers to capture the new codes. Hospitals also have to obtain the new code books and encoder updates, and make other system changes in order to capture and report the new codes.

The ICD–9–CM Coordination and Maintenance Committee holds its meetings in the spring and fall in order to update the codes and the applicable payment and reporting systems by October 1 of each year. Items are placed on the agenda for the ICD–9–CM Coordination and Maintenance Committee meeting if the request is received at least 2 months prior to the meeting. This requirement allows time for staff to review and research the coding issues and prepare material for discussion at the meeting. It also allows time for the topic to be publicized in meeting announcements in the **Federal Register** as well as on the CMS Web site. The public decides whether or not to attend the meeting based on the topics listed on the agenda. Final decisions on code title revisions are currently made by March 1 so that these titles can be included in the IPPS proposed rule. A complete addendum describing details of all changes to ICD–9–CM, both tabular and index, is publicized on CMS and NCHS Web pages in May of each year. Publishers of coding books and software use this information to modify their products that are used by health care providers. This 5-month time period has proved to be necessary for hospitals and other providers to update their systems.

A discussion of this timeline and the need for changes are included in the December 4–5, 2005 ICD–9–CM Coordination and Maintenance Committee minutes. The public agreed that there was a need to hold the fall meetings earlier, in September or October, in order to meet the new implementation dates. The public provided comment that additional time would be needed to update hospital systems and obtain new code books and coding software. There was considerable concern expressed about the impact this new April update would have on providers.

In the FY 2005 IPPS final rule, we implemented section 1886(d)(5)(K)(vii) of the Act, as added by section 503(a) of Pub. L. 108–173, by developing a mechanism for approving, in time for the April update, diagnosis and procedure code revisions needed to describe new technologies and medical services for purposes of the new technology add-on payment process. We also established the following process for making these determinations. Topics considered during the Fall ICD–9–CM Coordination and Maintenance Committee meeting are considered for an April 1 update if a strong and convincing case is made by the requester at the Committee's public meeting. The request must identify the reason why a new code is needed in April for purposes of the new technology process. The participants at the meeting and those reviewing the Committee meeting summary report are provided the opportunity to comment on this expedited request. All other topics are considered for the October 1 update. Participants at the Committee meeting are encouraged to comment on all such requests. There were no requests for an expedited April 1, 2006 implementation of an ICD–9–CM code at the September 29–30, 2005 Committee meeting. Therefore, there were no new ICD–9–CM codes implemented on April 1, 2006.

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

Current addendum and code title information is published on the CMS Web page at: *www.cms.hhs.gov/icd9ProviderDiagnosticCodes/01_overview.asp#TopofPage.* Information on ICD–9–CM diagnosis codes, along with the Official ICD–9–CM Coding Guidelines, can be found on the Web page at: *www.cdc.gov/nchs/icd9.htm.* Information on new, revised, and deleted ICD–9–CM codes is also provided to the AHA for publication in the *Coding Clinic for ICD–9–CM.* AHA also distributes information to publishers and software vendors.

CMS also sends copies of all ICD–9–CM coding changes to its contractors for use in updating their systems and providing education to providers.

These same means of disseminating information on new, revised, and deleted ICD–9–CM codes will be used to notify providers, publishers, software vendors, contractors, and others of any changes to the ICD–9–CM codes that are implemented in April. The code titles are adopted as part of the ICD–9–CM Coordination and Maintenance Committee process. Thus, although we publish the code titles in the IPPS proposed and final rules, they are not subject to comment in the proposed or final rules. We will continue to publish the October code updates in this manner within the IPPS proposed and final rules. For codes that are implemented in April, we will assign the new procedure code to the same DRG in which its predecessor code was assigned so there will be no DRG impact as far as DRG assignment. This mapping was specified by section 1886(d)(5)(K)(vii) of the Act as added by section 503(a) of Pub. L. 108–173. Any midyear coding updates will be available through the Web sites indicated above and through the *Coding Clinic for ICD–9–CM.* Publishers and software vendors currently obtain code changes through these sources in order

to update their code books and software systems. We will strive to have the April 1 updates available through these Web sites 5 months prior to implementation (that is, early November of the previous year), as is the case for the October 1 updates.

Comment: Many commenters recommended that the Secretary use the regulatory process to replace ICD–9–CM with ICD–10–CM and ICD–10–PCS expeditiously. Several commenters indicated that the April 2005 ICD–9–CM Coordination and Maintenance Committee meeting included discussions of limiting the creation of new procedure codes in order to allow the classification system to last at least 2 more years. ICD–9–CM procedure code categories 00 and 17 were created to identify a diverse group of procedures and interventions affecting all body systems. The commenters stressed that the establishment of these code categories represented a deviation from the normal structure of ICD–9–CM and was a stopgap measure to accommodate new technology when there are no other codes available in the corresponding body system chapters (for example, musculoskeletal system and circulatory system). The commenters indicated that category 00 is now full, and the ICD–9–CM Coordination and Maintenance Committee is considering proposals for codes in category 17. The commenters stated that at the April Coordination and Maintenance meeting a proposal was presented that would in effect leave only 80 codes available in the new category 17. The commenters stated that in recent years, as many as 50 new procedure codes have been created in a single year. The commenters strongly recommended that the Secretary use the regulatory process to implement ICD–10–CM and ICD–10–PCS in place of ICD–9–CM expeditiously.

Several commenters indicated that limitations with ICD–9–CM make data collected with these codes less precise. The commenters stated that systems such as the CS DRGs could make use of the more detailed information in ICD–10–CM and ICD–10–PCS to group claims more accurately and better identify differences in severity and complexity. Similar comments were received from a number of other individuals.

Response: We agree that it is important to have an accurate and precise coding system. The Department will continue to study whether to adopt ICD–10–CM. In the interim, we continue to update both ICD–9–CM and ICD–10–PCS.

Comment: A number of commenters expressed concern that only nine diagnosis codes and six procedure codes are processed by Medicare. The commenters recommended that CMS modify its systems so that the number of diagnoses codes processed would increase from 9 to 25 and the number of procedures processed would increase from 6 to 25. The commenters stated that hospitals submit claims to CMS in electronic format, and that the HIPAA compliant electronic transaction standard, HIPAA 837i, allows up to 25 diagnoses and 25 procedures. The commenters stated that CMS does not require its fiscal intermediaries to process codes beyond the first nine diagnosis codes and six procedure codes. The commenters indicated that complex classification systems such as the proposed CS DRGs could make use of the information in these additional codes to better classify the patients.

One commenter stated that an incremental step in working towards a refined DRG system is to have CMS systems process 25 diagnosis and procedure codes.

Response: The commenters are correct that CMS does not process codes submitted electronically on the 837i electronic format beyond the first 9 diagnosis codes and first 6 procedure codes. While HIPAA requires CMS to accept up to 25 ICD–9–CM diagnosis and procedure codes on the HIPAA 837i electronic format, it does not require that CMS process that many diagnosis and procedure codes.

As suggested by the commenters, there is value in retaining additional data on patient conditions that would result from expanding Medicare's data system so it can accommodate additional diagnosis and procedure codes. We have been considering this issue while we contemplated refinements to our DRG system to better recognize patient severity of illness. However, extensive lead time is required to allow for modifications to our internal and contractors' electronic systems in order to process and store this additional information. We are unable to move forward with this recommendation without carefully evaluating implementation issues. We will continue to carefully evaluate this request to expand the process capacity of our systems.

Comment: One commenter expressed concern about the process involved with updating the ICD–9–CM Coding Guidelines. The guidelines are updated by the cooperating parties of ICD–9–CM, including representatives from the Centers for Disease and Prevention Control (CDC), CMS, the AHA, and the AHIMA. The commenter complimented CMS staff for becoming more "provider friendly" and using such tools as the open door forum to involve providers in policy discussions. The commenter requested that some of the coding guideline discussions be held in an open meeting so that providers could give input.

Response: We agree with the commenter that it is important to involve the provider community in activities involving the updating of ICD–9–CM codes and guidelines. The Department utilizes the ICD–9–CM Coordination and Maintenance Committee to discuss proposed changes to the coding system. At times, this Committee also addresses coding guidelines that affect code selection. The current process of approving new and revised coding guidelines involves approval by all four cooperating parties. It is our understanding that AHA and AHIMA actively seek input from their members on coding issues. AHA and AHIMA use this input when they are voting on coding issue to be published in the AHA's *Coding Clinic for ICD–9–CM* and on coding guidelines. We will refer these concerns to the cooperating parties so that they may discuss improvements which could be made in obtaining providers' input into coding guidelines. We will also welcome recommendations on specific coding guideline issues that providers wish to be included in future agendas of the ICD–9–CM Coordination and Maintenance Committee. The Committee recently discussed coding guidelines for septicemia. We will continue to work with the provider community to offer a public forum for discussion of ICD–9–CM code revisions and guidelines.

11. Other Issues

a. Chronic Kidney Disease

Comment: Two commenters expressed concern regarding the revised diagnosis codes for chronic kidney disease and their DRG assignments which appeared in Table 6E of the Addendum to the proposed rule. The following codes were identified as being classified to DRGs 331, 332, and 333 (Other kidney and urinary tract diagnoses with and without CC, and age 0–17, respectively) in MDC 11 (Diseases and Disorders of the Kidney and Urinary Tract):

- 403.00 (Hypertensive chronic kidney disease, malignant, with chronic kidney disease stage I through stage IV, or unspecified)
- 403.10 (Hypertensive chronic kidney disease, benign, with chronic kidney disease stage I through stage IV, or unspecified)

• 403.90 (Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage I through stage IV, or unspecified)

The commenters stated that revisions made to these three codes will go into effect October 1. These changes would add the concept of chronic kidney disease to the three codes. Therefore, these three codes should be assigned to the same DRGs as other codes for chronic kidney disease. The codes with chronic kidney disease are assigned to DRGs 315 (Other kidney and urinary tract procedures) and 316 (Renal failure) and not to DRGs 331 through 333 where they were proposed.

Response: The commenters are correct. The three codes listed above were modified to include the concept of chronic kidney disease. As such, they should be assigned to DRG 315 (Other Kidney and Urinary Tract Procedures) and DRG 316 (Renal Failure) (and not to DRGs 331 through 333. We have made these changes in Table 6E of the Addendum to this final rule. Therefore, we will assign codes 403.00, 403.10, and 403.90 to DRG 315–316.

b. Bronchial Valve

Comment: Two commenters that manufacture minimally invasive surgical therapies for patients with chronic obstructive pulmonary disease addressed the establishment of a new code for the insertion of a bronchial valve. This topic was discussed at the March 23–24, 2006 meeting of the ICD–9–CM Coordination and Maintenance Committee. (A complete summary report of the meeting including handouts can be found at: *http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp#TopofPage.*) CMS created a new code for endoscopic insertion of a bronchial valve: code 33.71 (Endoscopic insertion or replacement of bronchial valve(s)). The new code is listed in Table 6B of the Addendum to this final rule. The predecessor codes that are currently used for this procedure are:

• 33.22, Fiber-optic bronchoscopy
• 96.05, Other intubation of respiratory tract

The commenters expressed support for the creation of the new code, but requested that the code not be assigned to the same DRG as its predecessor codes. The predecessor codes are assigned to a medical DRG if the patient is admitted with a respiratory diagnosis. If the patient is admitted with a history of malignancy, the patient would be assigned to DRG 412 (History of Malignancy with Endoscopy). The commenters requested that code 33.71 be assigned to DRG 75 (Major Chest Procedure). Although the commenters acknowledged that CMS has no data on which to evaluate this request, they recommended that CMS use a combination of the diagnosis of air leaks and treatment with scarification as a proxy for cases that receive a bronchial valve. The commenters stated that these patients are clinically similar and can be expected to have similar resource intensity to patients that would receive an endobronchial insertion or replacement of bronchial valves.

The commenters undertook their own data analysis using the FY 2005 MedPAR file. They used the following diagnosis procedure codes to identify the proxy patients:

• 512.0, Spontaneous tension pneumothorax
• 512.8, Other spontaneous pneumothorax
• 34.6, Scarification of the pleura

Using these codes, the companies identified 490 patients which were assigned to DRG 75. These patients had average charges of $56,711 as compared to $49,698 for all patients in DRG 75. The commenters stated that, although the resource utilization for scarification (and by inference, valve implantation) appears to be higher than the average for DRG 75, they believed it would still be reasonable to initially assign code 33.71 to DRG 75 until actual cost data can be gathered using the new procedure code.

Response: We do not agree that the endoscopic insertion of a bronchial valve is clinically similar to scarification of the pleura. The commenters themselves indicate that insertion of the bronchial valve is a minimally invasive procedure. Scarification of the pleura is a significantly invasive procedure. Furthermore, the bronchial valves are inserted into patients admitted with chronic obstructive pulmonary disease, not spontaneous pneumothorax. Therefore, we do not agree with using the pneumothorax diagnoses as a proxy for patients who will receive the bronchial valve.

The bronchial valve code 33.71 will go into effect on October 1, 2006. At this time, we have no information that suggests we should assign this new code to a DRG that is different than the predecessor codes. For this reason, we are classifying code 33.71, Endoscopic insertion or replacement of bronchial valve(s) as a nonoperating room procedure that will be assigned to DRG 412. This classification is listed in Table 6B of the Addendum to this final rule. Once we receive data using the new code, we will evaluate this issue further.

c. Female Reproductive System Reconstruction Procedures

Comment: One commenter recommended that CMS consider revising the current procedure code assignments for DRG 356 (Female Reproductive System Reconstructive Procedures) under MDC 13 (Diseases and Disorders of the Female Reproduction System) to better reflect the clinical coherence of those procedures that are specific to maintaining reproductive health. The proposal suggested by the commenter would distinguish procedures that are intended to ensure the reproductive function of a woman from urinary conditions that cause discomfort and emptying the bladder. The commenter suggested revising DRG 356 to limit it to procedures that are specific to maintaining reproductive health while creating four new DRGs that would be clinically similar for procedures performed to repair pelvic floor defects which cause urinary incontinence. The commenter stated these new DRGs would be timely with the procedure code proposal they are planning to present at the September 28–29, 2006 ICD–9–CM Coordination and Maintenance Committee meeting.

Response: We appreciate the commenter's recommendation to create four new DRGs in order to recognize the clinical coherence of procedures specific to maintaining reproductive health. There are two aspects to the commenter's proposal. The first part of the proposal would limit DRG 356 to procedures that are intended to maintain reproductive health. The second part of the commenter's proposal would create four new DRGs for repairing pelvic floor defects that create urinary incontinence. These four new DRGs would consist of two new DRG pairs (each split based on whether or not the patient has a CC) that would separate patients based on whether or not they had a graft procedure.

The commenter provided no data to support its proposal. Further, two of the four new DRGs being requested by the commenter would be based on new and revised procedure codes that have not yet been proposed or created. Therefore, we are unable to evaluate the request at this time. We may consider this proposal further in the future if the ICD–9–CM Coordination and Maintenance Committee creates the new codes being requested by the commenter and further data are made available for review.

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

In recent years, there have been several field actions and recalls with regard to failure of implantable cardiac defibrillators (ICDs) and pacemakers. In many of these cases, the manufacturers have offered replacement devices without cost to the hospital or credit for the device being replaced if the patient required a more expensive device. In some circumstances, manufacturers have also offered, through a warranty package, to pay specified amounts for unreimbursed expenses to persons who had replacement devices implanted. In addition, we believe that incidental device failures that are covered by manufacturer warranties occur routinely. While we understand that some device malfunctions may be inevitable as medical technology grows increasingly sophisticated, we believe that early recognition of problems would reduce the number of people with the potential to be adversely affected by these device problems. The medical community needs heightened and early awareness of patterns of device failures, voluntary field actions, and recalls so that it can take appropriate action to care for Medicare beneficiaries. Systematic efforts must be undertaken by all interested and involved parties, including manufacturers, insurers, and the medical community, to ensure that device problems are recognized and addressed as early as possible so that people's health is protected and high quality medical care is provided. We are taking several steps to assist in the early recognition and analysis of patterns of device problems to minimize the potential for harmful device-related effects on the health of Medicare patients and the public in general.

In recent years, CMS has recognized the importance of data collection as a condition of Medicare coverage for selected services. In 2005, CMS issued a National Coverage Determination (NCD) that expanded coverage of ICDs and also required registry participation when the devices were implanted for certain clinical indications. The NCD included this requirement in order to ensure that the care received by Medicare beneficiaries was reasonable and necessary and, therefore, appropriately reimbursed. Presently, the American College of Cardiology—National Cardiovascular Data Registry (ACC–NCDR) collects these data and maintains the registry.

In addition to ensuring appropriate payment of claims, collection, and ongoing analysis of ICD implantation, data can facilitate public health response in the event of future device recalls. The systematic recording of device manufacturer and model number can enhance patient and provider notification. Analysis of registry data may uncover patterns in complication rates (for example, device malfunction, device related infection, or early battery depletion) associated with particular devices that signify the need for a more specific investigation. Patterns found in registry data may identify problems earlier than the currently available mechanisms, which do not systematically collect such detailed information surrounding procedures.

We encourage the medical community to work to develop additional registries for implantable devices, so that timely and comprehensive information is available regarding devices, recipients of those devices, and their health status and outcomes. While participation in an ICD registry is required as a condition of coverage for ICD implantation for certain clinical conditions, we believe that the potential benefits of registries extend well beyond their application in Medicare's specific NCDs. As medical technology continues to advance swiftly, data collection regarding the short and long term outcomes of new technologies, and especially concerning implanted devices that may remain in the bodies of patients for their lifetimes, will be essential to the timely recognition of any specific problems and patterns of complications. This information will facilitate early interventions to mitigate harm and improve the quality and efficiency of health care services.

Moreover, data from registries may help further the development of high quality, evidence-based clinical practice guidelines for the care of patients who may receive device-intensive procedures. In turn, widespread use of evidence-based guidelines may reduce variation in medical practice, leading to improved personal and public health. Registry information may also contribute to the development of more comprehensive and refined quality metrics that may be used to systematically assess and then improve the safety and quality of health care. Such improvements in the quality of care that result in better personal health will require the sustained commitment of industry, payers, health care providers, and others towards that goal, along with excellent and open communication and rapid systemwide responses in a comprehensive effort to protect and enhance the health of the public. We look forward to further discussions with the public about new strategies to recognize device problems early and how to definitively address them, in order to minimize both the harmful health effects and increased health care costs that may result.

In addition, we believe that the routine identification of Medicare claims for certain device implantation procedures in situations where a payment adjustment is appropriate may enhance the medical community's recognition of device problems, potentially leading to more timely improvements in device technologies. This systematic approach, where hospitals identify and then appropriately report selected services when devices are replaced without cost to the hospital or with full credit to the hospital for the cost of the replaced device, should provide comprehensive information regarding the hospital experiences of Medicare patients with certain devices that are being replaced. Because Medicare patients are common recipients of implanted devices, this claims information may be particularly helpful in identifying patterns of device problems early in their natural history so that appropriate strategies to reduce future problems may be developed.

In addition to our concern for the public health, we also have a fiduciary responsibility to the Medicare Trust Fund to ensure that Medicare pays only for covered services. Therefore, we believe that we need to consider whether it is appropriate to reduce the Medicare payment in cases in which an implanted device is replaced without cost to the hospital or with full credit for the removed device. Such a proposal could cover certain devices for which credit for the replaced device is given or which are replaced as a result of or pursuant to a warranty, field action, voluntary recall, involuntary recall, and certain devices which are provided free of charge. It could provide for a reduction in the IPPS payment when we determine that the device is replaced without cost to the provider or beneficiary or when the provider receives full credit for the cost of a replaced device. We will need to develop a methodology to determine the amount of the reduction to the otherwise payable IPPS payment. We believe that this is appropriate because in these cases the full cost of the replaced device is not incurred and, therefore, we believe that an adjustment to the payment is necessary to remove the cost of the device.

E. Recalibration of DRG Weights

In the FY 2007 IPPS proposed rule, we proposed to change the DRG

recalibration process methodology for FY 2007 to move to an HSRV weighting method as discussed in section II.C.2. of the preamble to the proposed rule (71 FR 24044). For FY 2006 and years prior, we have recalibrated the DRG weights based on charge data for Medicare discharges using the most current charge information available (for example, the FY 2005 MedPAR file would have been used for FY 2007). Our thorough analysis of the March 2005 MedPAC recommendations regarding refinement of the DRG system used for the IPPS (see discussion of the MedPAC recommendations in section II.C.2. of this preamble) has shown that using gross charges as a basis for setting the DRG weights has introduced bias into the weighting process. Specifically, hospitals that are systematically more expensive than others (that is, teaching hospitals and specialty hospitals) tend to treat certain cases more commonly than others, causing the weights for these cases to be artificially high. In addition, hospitals may mark up their charges for routine days, intensive care days, and various ancillary services by different percentages. This practice of differential markups among hospital cost centers may also introduce bias into the weights. For instance, we have observed that ancillary service cost centers generally have higher charge markups than routine services. Thus, the charge-based relative weight methodology may result in higher weights for DRGs that use more ancillary services relative to DRGs that use more routine services than would occur under a system where the weights are based on costs.

As discussed in section II.C.2. of the preamble of the proposed rule, based on our study of the MedPAC recommendations, we developed an alternative methodology for recalibrating the DRG weights. This proposed method is discussed in detail beginning on 71 FR 24044. The proposed method involved applying the HSRV methodology at the cost center level (HSRVcc) to remove the bias introduced by hospital characteristics (that is, teaching, disproportionate share, location, and size, among others) and then scaling the weights to costs using national cost center CCRs derived from cost report data. However, in response to comments discussed in section II.C.2 of this final rule, we have postponed the implementation of the HSRV methodology in order to further study its effects and have subsequently revised the methodology for setting relative weights based on cost. Further, we are adopting the cost relative weights under a 3-year transition period such that in FY 2007, year one of the transition, the relative weights will be a blend of 33 percent of the relative cost weight and 67 percent of the relative charge weight. In year two, the relative weights will be based on 67 percent of the relative cost weight and 33 percent of the relative charge weight and in year three, the relative weights will be 100 percent cost based.

In developing the final system of weights, we used two data sources: Claims data and cost report data. As in previous years, the claims data source is the MedPAR file. This file is based on fully coded diagnostic and procedure data for all Medicare inpatient hospital bills. The FY 2005 MedPAR data used in this proposed rule include discharges occurring on October 1, 2004, through September 30, 2005, based on bills received by CMS through March 31, 2006, from all hospitals subject to the IPPS and short-term acute care hospitals in Maryland (which are under a waiver from the IPPS under section 1814(b)(3) of the Act). The FY 2005 MedPAR file used in calculating the relative weights includes data for approximately 12,238,146 Medicare discharges. Discharges for Medicare beneficiaries enrolled in a Medicare+Choice managed care plan are excluded from this analysis. The data exclude CAHs, including hospitals that subsequently became CAHs after the period from which the data were taken. The second data source used in the cost relative weight methodology are the FY 2004 Medicare cost report data files from HCRIS, which represents the most recent full set of cost report data available. We used the March 31, 2006 update of the HCRIS cost report files for FY 2004 in setting the final relative cost based weights.

Because we are implementing the relative weights on a transitional basis it is necessary to calculate both charge based and cost based relative weights. The charge-based methodology used to calculate the DRG relative weights from the MedPAR data is the same methodology that was in place for FY 2006 and was applied as follows:

- To the extent possible, all the claims were regrouped using the FY 2007 DRG classification revisions discussed in section II.D. of this preamble.
- The transplant cases that were used to establish the relative weight for heart and heart-lung, liver and/or intestinal, and lung transplants (DRGs 103, 480, and 495) were limited to those Medicare-approved transplant centers that have cases in the FY 2005 MedPAR file. (Medicare coverage for heart, heart-lung, liver and/or intestinal, and lung transplants is limited to those facilities that have received approval from CMS as transplant centers.)
- Organ acquisition costs for kidney, heart, heart-lung, liver, lung, pancreas, and intestinal (or multivisceral organs) transplants continue to be paid on a reasonable cost basis. Because these acquisition costs are paid separately from the prospective payment rate, it was necessary to subtract the acquisition charges from the total charges on each transplant bill that showed acquisition charges before computing the average charge for the DRG and before eliminating statistical outliers.
- Total charges were standardized to remove the effects of differences in area wage levels, indirect medical education and disproportionate share payments, and, for hospitals in Alaska and Hawaii, the applicable cost-of-living adjustment.
- The average standardized charge per DRG was calculated by summing the standardized total charges for all cases in the DRG and dividing that amount by the number of cases classified in the DRG. A transfer case was counted as a fraction of a case based on the ratio of its transfer payment under the per diem payment methodology to the full DRG payment for non-transfer cases. That is, a transfer case receiving payment under the transfer methodology equal to half of what the case would receive as a non-transfer would be counted as 0.5 of a total case.
- Statistical outliers were eliminated by removing all cases that were beyond 3.0 standard deviations from the mean of the log distribution of both the charges per case and the charges per day for each DRG.
- The average charge for each DRG was then recomputed (excluding the statistical outliers) and divided by the national average standardized charge per case to determine the relative weight.

The new charge-based weights were then normalized by an adjustment factor of 1.49338 so that the average case weight after recalibration was equal to the average case weight before recalibration. This normalization adjustment is intended to ensure that recalibration by itself neither increases nor decreases total payments under the IPPS as required by section 1886(d)(4)(C)(iii) of the Act. We note that due to the decision in *Bellevue Hosp. Center* v. *Leavitt*, in which the Court of Appeals for the Second Circuit (the Court) ordered CMS to apply the occupational mix adjustment to 100 percent of the wage index effective for FY 2007 (see section III.C. of this final

rule for more details of this Court decision), we are unable to finalize the FY 2007 wage index data at this time. Since we are relying on the wage index data as one of the standardizing factors that we use in calculating both the charge-based and the cost-based relative weights that are blended to set the FY 2007 transitional relative weights, we will recalculate the FY 2007 relative weights when the wage data becomes available and will publish these recalculated relative weights in a subsequent **Federal Register** notice prior to October 1, 2006.

The methodology we used to calculate the DRG cost-based weights from the FY 2005 MedPAR claims data and FY 2004 Medicare cost report data is as follows:

- To the extent possible, all the claims were regrouped using the FY 2007 DRG classification revisions discussed in section II.D. of this preamble.
- The transplant cases that were used to establish the relative weight for heart and heart-lung, liver and/or intestinal, and lung transplants (DRGs 103, 480, and 495) were limited to those Medicare-approved transplant centers that have cases in the FY 2005 MedPAR file. (Medicare coverage for heart, heart-lung, liver and/or intestinal, and lung transplants is limited to those facilities that have received approval from CMS as transplant centers.)
- Organ acquisition costs for kidney, heart, heart-lung, liver, lung, pancreas, and intestinal (or multivisceral organs) transplants continue to be paid on a reasonable cost basis. Because these acquisition costs are paid separately from the prospective payment rate, it is necessary to subtract the acquisition charges from the total charges on each transplant bill that showed acquisition charges before computing the average cost for each DRG and before eliminating statistical outliers.
- Claims with total charges or total length of stay less than or equal to zero were dropped. Claims that had an amount in the total charge field that differed by more than $10.00 from the sum of the routine day charges, intensive care charges, pharmacy charges, special equipment charges, therapy services charges, operating room charges, cardiology charges, laboratory charges, radiology charges, other service charges, labor and delivery charges, inhalation therapy charges and anesthesia charges were also dropped. At least 94 percent of the providers in the MedPAR file had charges for 10 of the 13 cost centers. Claims for providers that did not have charges greater than zero for at least 10 of the 13 cost centers were dropped.
- Statistical outliers were eliminated by removing all cases that were beyond 3.0 standard deviations from the mean of the log distribution of both the total charges per case and the total charges per day for each DRG.

Once the MedPAR data were trimmed and the statistical outliers were removed, the charges for each of the 13 cost groups for each claim were standardized to remove the effects of differences in area wage levels, indirect medical education and disproportionate share payments, and for hospitals in Alaska and Hawaii, the applicable cost-of-living adjustment. Charges were then summed by DRG for each of the 13 cost groups such that each DRG had 13 standardized charge totals. These charges were then adjusted to cost by applying the national average CCRs developed from the FY 2004 cost report data.

The 13 cost centers that we used in the DRG cost calculation are shown in the following table. In addition, the table shows the lines on the cost report that we used to create the national cost center CCRs that we used to adjust the DRG charges to cost:

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Cost Center Group Name (13 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field	Cost Report Line Description (Wksheet C Part 1 & Wksheet D-4	Cost from HCRIS (Wksheet C, Part 1, Column 5 and line number	Charges from HCRIS (Wksheet C, Part 1, Column 6 & 7 and line number	Medicare Charges from HCRIS (Wksheet D-4, Column & line number
Routine Days	Private Room Charges	011X and 014X	Adults & Pediatrics (General Routine Care)	C_1_C5_25	C_1_C6_25	D4_HOS_C2_25
	Semi-Private Room Charges	010X, 012X, 013X and 016X-019X			C_1_C7_25	D4_HOS_C2_26
	Ward Charges	015X				
Intensive Days	Intensive Care Charges	020X	Intensive Care Unit	C_1_C5_26	C_1_C6_26	D4_HOS_C2_26
					C_1_C7_26	
	Coronary Care Charges	021X	Coronary Care Unit	C_1_C5_27	C_1_C6_27	D4_HOS_C2_27
					C_1_C7_27	
			Burn Intensive Care Unit	C_1_C5_28	C_1_C6_28	D4_HOS_C2_28
					C_1_C7_28	
			Surgical Intensive Care Unit	C_1_C5_29	C_1_C6_29	D4_HOS_C2_29
					C_1_C7_29	
			Other Special Care Unit	C_1_C5_30	C_1_C6_30	D4_HOS_C2_30
					C_1_C7_30	
Drugs	Pharmacy Charges	025X, 026X and 063X	Intravenous Therapy	C_1_C5_48	C_1_C6_48	D4_HOS_C2_48
					C_1_C7_48	
			Drugs Charged To Patient	C_1_C5_56	C_1_C6_56	D4_HOS_C2_56
					C_1_C7_56	
Supplies and Equipment	Medical/Surgical Supply Charges	027X and 062X	Medical Supplies Charged to Patients	C_1_C5_55	C_1_C6_55	D4_HOS_C2_55
					C_1_C7_55	
	Durable Medical Equipment Charges	0290, 0291, 0292 and 0294-0299	DME-Rented	C_1_C5_66	C_1_C6_66	D4_HOS_C2_66
					C_1_C7_66	

Cost Center Group Name (13 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field		Cost Report Line Description (Wksheet C Part 1 & Wksheet D-4	Cost from HCRIS (Wksheet C, Part 1, Column 5 and line number	Charges from HCRIS (Wksheet C, Part 1, Column 6 & 7 and line number	Medicare Charges from HCRIS (Wksheet D-4, Column & line number
	Used Durable Medical Charges	0293		DME-Sold	C_1_C5_67	C_1_C6_67 C_1_C7_67	D4_HOS_C2_67
Therapy Services	Physical Therapy Charges	042X		Physical Therapy	C_1_C5_50	C_1_C6_50 C_1_C7_50	D4_HOS_C2_50
	Occupational Therapy Charges	043X		Occupational Therapy	C_1_C5_51	C_1_C6_51 C_1_C7_51	D4_HOS_C2_51
	Speech Pathology Charges	044X and 047X		Speech Pathology	C_1_C5_52	C_1_C6_52 C_1_C7_52	D4_HOS_C2_52
Inhalation Therapy	Inhalation Therapy Charges	041X and 046X		Respiratory Therapy	C_1_C5_49	C_1_C6_49 C_1_C7_49	D4_HOS_C2_49
Operating Room For all DRGs but Labor & Delivery	Operating Room Charges	036X, 071X and 072X		Operating Room	C_1_C5_37	C_1_C6_37 C_1_C7_37	D4_HOS_C2_37
				Recovery Room	C_1_C5_38	C_1_C6_38 C_1_C7_38	D4_HOS_C2_38

Cost Center Group Name (13 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field		Cost Report Line Description (Wksheet C Part 1 & Wksheet D-4	Cost from HCRIS (Wksheet C, Part 1, Column 5 and line number	Charges from HCRIS (Wksheet C, Part 1, Column 6 & 7 and line number	Medicare Charges from HCRIS (Wksheet D-4, Column & line number
Labor & Delivery **ONLY FOR THE 6 Labor & Delivery DRGs**	Operating Room Charges	036X, 071X and 072X		Delivery Room and Labor Room	C_1_C5_39	C_1_C6_39 C_1_C7_39	D4_HOS_C2_39
370, 371, 372, 373, 374, 375	Clinic Charges	051X		Obstetrics Clinic	C_1_C5_63	C_1_C6_63 C_1_C7_63	D4_HOS_C2_63
Anesthesia	Anesthesia Charges	037X		Anesthesiology	C_1_C5_40	C_1_C6_40 C_1_C7_40	D4_HOS_C2_40
Cardiology	Cardiology Charges	048X and 073X		Electrocardiology	C_1_C5_53	C_1_C6_53 C_1_C7_53	D4_HOS_C2_53
				Electro-encephalography	C_1_C5_54	C_1_C6_54 C_1_C7_54	D4_HOS_C2_54
Laboratory	Laboratory Charges	030X, 031X, 074X and 075X		Laboratory	C_1_C5_44	C_1_C6_44 C_1_C7_44	D4_HOS_C2_44

Cost Center Group Name (13 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field	Cost Report Line Description (Wksheet C Part 1 & Wksheet D-4	Cost from HCRIS (Wksheet C, Part 1, Column 5 and line number	Charges from HCRIS (Wksheet C, Part 1, Column 6 & 7 and line number	Medicare Charges from HCRIS (Wksheet D-4, Column & line number
			PBP Clinic Laboratory Services	C_1_C5_45	C_1_C6_45 C_1_C7_45	D4_HOS_C2_45
Radiology	Radiology Charges	028X, 032X, 033X, 034X, 035X and 040X	Radiology - Diagnostic	C_1_C5_41	C_1_C6_41 C_1_C7_41	D4_HOS_C2_41
	MRI Charges	061X	Radiology - Theraputic	C_1_C5_42	C_1_C6_42	D4_HOS_C2_42
Other Services	Lithotripsy Charge	079X	Radioisotope	C_1_C5_43	C_1_C6_43 C_1_C7_43	D4_HOS_C2_43
	Other Service Charge	0002-0099, 022X, 023X, 024X,052X,053X 055X-060X, 064X-070X, 076X-078X, 090X-095X and 099X	Whole Blood & Packed Blood Cells	C_1_C5_46	C_1_C6_46 C_1_C7_46	D4_HOS_C2_46
	Blood Charges	038X	Blood Storing Processing & Transfusing	C_1_C5_47	C_1_C6_47 C_1_C7_47	D4_HOS_C2_47
	Blood Administratio n Charges	039X	ASC (Non Distinct Part)	C_1_C5_58	C_1_C6_58 C_1_C7_58	D4_HOS_C2_58
	Outpatient Service Charges	049X and 050X	Other Ancillary	C_1_C5_59	C_1_C6_59	D4_HOS_C2_59

Cost Center Group Name (13 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field		Cost Report Line Description (Wksheet C Part 1 & Wksheet D-4	Cost from HCRIS (Wksheet C, Part 1, Column 5 and line number	Charges from HCRIS (Wksheet C, Part 1, Column 6 & 7 and line number	Medicare Charges from HCRIS (Wksheet D-4, Column & line number
						C_1_C7_59	
	Emergency Room Charges	045X		Clinic	C_1_C5_60	C_1_C6_60	D4_HOS_C2_60
						C_1_C7_60	
	Ambulance Charges	054X		Emergency	C_1_C5_61	C_1_C6_61	D4_HOS_C2_61
						C_1_C7_61	
	ESRD Revenue Setting Charges	080X and 082X-088X		Observation beds	C_1_C5_62	C_1_C6_62	D4_HOS_C2_62
						C_1_C7_62	
	Clinic Visit Charges (excluding Labor & Delivery DRGs)	051X		Observation beds	C_1_C5_6201	C_1_C6_6201	D4_HOS_C2_6201
						C_1_C7_6201	
				Rural Health Clinic	C_1_C5_6350	C_1_C6_6350	D4_HOS_C2_6350
	Professional Fees Charges	096X, 097X, and 098X				C_1_C7_6350	
				FQHC	C_1_C5_6360	C_1_C6_6360	D4_HOS_C2_6360
						C_1_C7_6360	
				Home Program Dialysis	C_1_C5_64	C_1_C6_64	D4_HOS_C2_64
						C_1_C7_64	
				Ambulance	C_1_C5_65	C_1_C6_65	D4_HOS_C2_65

Cost Center Group Name (13 total)	MedPAR Charge Field	Revenue Codes contained in MedPAR Charge Field		Cost Report Line Description (Wksheet C Part 1 & Wksheet D-4	Cost from HCRIS (Wksheet C, Part 1, Column 5 and line number	Charges from HCRIS (Wksheet C, Part 1, Column 6 & 7 and line number	Medicare Charges from HCRIS (Wksheet D-4, Column & line number
						C_1_C7_65	
				Other Reimbursable	C_1_C5_68	C_1_C6_68	D4_HOS_C2_68
						C_1_C7_68	

We developed the national average CCRs as follows:

Taking the FY 2004 cost report data, we removed CAHs, Indian Health Service hospitals, all-inclusive rate hospitals, and cost reports that represented time periods of less than 1 year (365 days). We included hospitals located in Maryland as we are including their charges in our claims database. We then created CCRs for each provider for each cost center (see prior table for line items used in the calculations) and removed any CCRs that were greater than 10 or less than .01. In response to a comment from MedPAC discussed in section II.C.1. of this preamble, we normalized the departmental CCRs by dividing the CCR for each department by the total CCR for the hospital for the purpose of trimming the data. We then took the logs of all of the normalized cost center CCRs and removed any cost center CCRs where the log of the cost center CCR was greater or less than the mean log plus/minus 3 times the standard deviation for the log of that cost center CCR. In the proposed rule we had used a trim of 1.96 times the standard deviation. However, in response to comments as discussed in section II C. of this preamble, we have subsequently revised our trim to 3 standard deviations as commenters stated that this less stringent trim appropriately retains more providers in the database. Once the cost report data were trimmed, we calculated a Medicare specific CCR, again in response to a comment from MedPAC as discussed in section II.C. of this preamble. The Medicare specific CCR was determined by taking the Medicare charges for each line item from worksheet D Part 4 and deriving the Medicare specific costs by applying the hospital-specific departmental CCRs to the Medicare specific charges for each line item from worksheet D Part 4. Once each hospital's Medicare specific costs were established, we summed the total Medicare specific costs and divided by the sum of the total Medicare specific charges to produce national average, charge weighted CCRs. In the proposed rule, we used hospital-specific CCRs, but in response to comments as discussed in section II C. of this preamble, we have revised our methodology to use charge-weighted CCRs in establishing the national average CCRs.

After we multiplied the total charges for each DRG in each of the 13 cost centers by the corresponding national average CCR, we summed the 13 "costs" across each DRG to produce a total standardized cost for the DRG. The average standardized cost for each DRG was then computed as the total standardized cost for the DRG divided by the transfer adjusted case count for the DRG. The average cost for each DRG was then divided by the national average standardized cost per case to determine the relative weight.

The new cost-based weights were then normalized by an adjustment factor of 1.49338 so that the average case weight after recalibration was equal to the average case weight before recalibration. This normalization adjustment is intended to ensure that recalibration by itself neither increases nor decreases total payments under the IPPS as required by section 1886(d)(4)(C)(iii) of the Act.

When we recalibrated the DRG weights for previous years, we set a threshold of 10 cases as the minimum number of cases required to compute a reasonable weight. We used that same case threshold in recalibrating the DRG weights for FY 2007. Using the FY 2005 MedPAR data set, there are 40 DRGs that contain fewer than 10 cases. In FY 2006, we computed weights for low volume DRGs by adjusting the FY 2005 weights of these low volume DRGs by the percentage change in the average weight of the cases in other DRGs. Because we believe that we do not have sufficient MedPAR data to set accurate and stable HSRVcc weights for these low-volume DRGs, we proposed to assign them the weights of similar DRGs for which we have more complete data and solicited comment on this proposal. The crosswalk table we proposed is shown in the FY 2007 IPPS proposed rule (71 FR 24048).

Comment: One commenter stated that we should not assign weights based on other DRGs but should instead supplement our current data the data from other sources so that we can set weights for these DRGs based on actual cases.

Response: Because we are implementing cost based weights in a transition phase and because we intend to study the DRGs and relative weight methodologies during the coming year we have reconsidered our proposal to assign low volume DRGs the weights of other DRGS for FY 2007 and are reverting to our previous method of updating the prior year's weight for these DRGs by the percentage change in the average weight of the cases in the other DRGs. We may consider supplementing our MedPAR data with additional claims data in the future.

Section 1886(d)(4)(C)(iii) of the Act requires that, beginning with FY 1991, reclassification and recalibration changes be made in a manner that assures that the aggregate payments are neither greater than nor less than the aggregate payments that would have been made without the changes. Although normalization is intended to achieve this effect, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate

payments to hospitals because payments to hospitals are affected by factors other than average case weight. Therefore, as we have done in past years, and as discussed in section II.A.4.a. of the Addendum to this final rule, we are making a budget neutrality adjustment to ensure that the requirement of section 1886(d)(4)(C)(iii) of the Act is met.

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

1. Background

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

In the past, the annual update to the IPPS DRGs has been based on the annual revisions to the ICD–9–CM codes and was effective each October 1. As discussed in the FY 2006 IPPS final rule (70 FR 47323 through 47341) and in the Rate Year (RY) 2007 LTCH PPS final rule (71 FR 27803 through 27809), with the implementation of section 503(a) of Pub. L. 108–173, there is the possibility that one feature of the GROUPER software program may be updated twice during a Federal fiscal year (October 1 and April 1) as required by the statute for the IPPS. Section 503(a) of Pub. L. 108–173 amended section 1886(d)(5)(K) of the Act by adding a new clause (vii) which states that "the Secretary shall provide for the addition of new diagnosis and procedure codes in [sic] April 1 of each year, but the addition of such codes shall not require the Secretary to adjust the payment (or diagnosis-related group classification) * * * until the fiscal year that begins after such date." This requirement improves the recognition of new technologies under the IPPS by accounting for those ICD–9–CM codes in the MedPAR claims data at an earlier date. In implementing the statutory change, the agency has provided that ICD–9–CM diagnosis and procedure codes for new medical technology may be created and added to existing DRGs in the middle of the Federal fiscal year on April 1. However, this policy change will have no effect on the LTC–DRG relative weights, which will continue to be updated only once a year (October 1), nor will there be any impact on Medicare payments under the LTCH PPS. The use of the ICD–9–CM code set is also compliant with the current requirements of the Transactions and Code Sets Standards regulations at 45 CFR Parts 160 and 162, promulgated in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. 104–191.

As we explained in the RY 2007 LTCH PPS final rule (71 FR 27805 through 27809), in the health care industry, historically annual changes to the ICD–9–CM codes were effective for discharges occurring on or after October 1 each year. Thus, the manual and electronic versions of the GROUPER software, which are based on the ICD–9–CM codes, were also revised annually and effective for discharges occurring on or after October 1 each year. As noted above, the patient classification system used under the LTCH PPS (LTC–DRGs) is based on the patient classification system used under the IPPS (CMS DRGs), which historically had been updated annually and is effective for discharges occurring on or after October 1 through September 30 each year. As also mentioned above, the ICD–9–CM coding update process was revised as a result of implementing section 503(a) of Pub. L. 108–173, which includes a requirement for updating diagnosis and procedure codes as often as twice a year instead of the current process of annual updates on October 1 of each year (as discussed in greater detail in section II.D.10. of the preamble of this final rule). The agency uses the ICD–9–CM codes as its code set for diagnoses and procedures. Therefore, the ICD–9–CM codes currently used under both the IPPS and LTCH PPS may be updated as often as twice a year. This requirement is included as part of the amendments to the Act relating to recognition of new medical technology under the IPPS.

Despite the fact that aspects of the GROUPER software may be updated to recognize any new technology ICD–9–CM codes, as discussed most recently in the RY 2007 LTCH PPS final rule (71 FR 27805 through 27808), there will be no impact on either LTC–DRG assignments or payments under the LTCH PPS at that time. That is, changes to the LTC–DRGs (such as the creation or deletion of LTC–DRGs) and the relative weights will continue to be updated in the manner and timing (October 1) as they are now. As noted above and as described in the RY 2007 LTCH PPS final rule (71 FR 27805 through 27809), updates to the GROUPER for both the IPPS and the LTCH PPS (with respect to relative weights and the creation or deletion of DRGs) are made in the annual IPPS proposed and final rules and are effective each October 1. We also explained that because we do not publish a midyear IPPS rule, any April 1 code updates will not be published in a midyear IPPS rule. Rather, we will assign any new diagnosis or procedure codes to the same DRG in which its predecessor code was assigned, so that there will be no impact on the DRG assignments (as also discussed in section II.D.10. of this preamble). Any coding updates will be available through the Web sites provided in section II.D.10. of this preamble and through the *Coding Clinic for ICD–9–CM*. Publishers and software vendors currently obtain code changes through these sources in order to update their code books and software system. If new codes are implemented on April 1, revised code books and software systems, including the GROUPER software program, will be necessary because we must use current ICD–9–CM codes. Therefore, for purposes of the LTCH PPS, because each ICD–9–CM code must be included in the GROUPER algorithm to classify each case into a LTC–DRG, the GROUPER software program used under the LTCH PPS would need to be revised to accommodate any new codes.

In implementing section 503(a) of Pub. L. 108–173, there will only be an April 1 update if new technology codes are requested and approved. We note that any new codes created for April 1 implementation will be limited to those diagnosis and procedure code revisions primarily needed to describe new technologies and medical services. However, we reiterate that the process of discussing updates to the ICD–9–CM has been an open process through the ICD–9–CM Coordination and Maintenance Committee since 1995. Requestors will be given the opportunity to present the merits for a new code and make a clear and convincing case for the need to update ICD–9–CM codes for purposes of the IPPS new technology add-on payment process through an April 1 update (as also discussed in section II.D.10. of this preamble).

However, as we discussed in the RY 2007 LTCH PPS final rule (71 FR 27805

through 27809), at the September 29–30, 2005 ICD–9–CM Coordination and Maintenance Committee meeting, there were no requests for an April 1, 2006 implementation of ICD–9–CM codes, and, therefore, the next update to the ICD–9–CM coding system would not occur until October 1, 2006 (FY 2007). Presently, as there were no coding changes suggested for an April 1, 2006 update, the ICD–9–CM coding set implemented on October 1, 2005, will continue through September 30, 2006 (FY 2006). The update to the ICD–9–CM coding system for FY 2007 is discussed above in section II.D.10. of this preamble. Accordingly, in this final rule, as discussed in greater detail below, we are revising the LTC–DRG classifications and relative weights, to be effective October 1,2006 through September 30, 2007 (FY 2007). Furthermore, we will notify LTCHs of any revisions to the GROUPER software used under the IPPS and the LTCH PPS that will be implemented April 1, 2007. The LTC–DRGs and relative weights for FY 2007 in this final rule are based on the IPPS DRGs (GROUPER Version 24.0) discussed in section II.B. of the preamble to this final rule.

Comment: Two commenters urged us to consolidate rulemaking for the LTCH PPS into one annual cycle rather than setting the payment rates and policy changes on a July 1 through June 30 rate year but making changes to the LTC–DRGs and relative weights based on the Federal fiscal year, October 1 through September 30. Both commenters noted that this situation has caused management and planning difficulty for some LTCHs. One of the commenters, whose LTCH has a June 1 through May 31 fiscal year, emphasizes the difficulties in "estimating the impact of changes in case weights as part of the final rule" associated with the hospital IPPS.

One commenter noted that other Medicare provider types only experience one routine annual adjustment to their respective PPSs and that it is not reasonable to expect the LTCH provider community to comment on the reasonableness of a proposed payment level in February when "that payment level is subject to change in a second rulemaking proposed in April or May of the same year." This commenter suggested that, commencing with FY 2008, all LTCH PPS rulemaking should occur on the same schedule as it does under the IPPS, which would maintain the established cycle for the update of the LTC–DRGs and relative weights. The same commenter further suggested that, should CMS make this change in the rulemaking schedule, for the first year only, CMS should establish a 3-month (July through September) and 12-month (October through September) update factor to the Federal rate.

Response: In the LTCH RY 2004 final rule (68 FR 34122), we revised our regulations at § 412.535, which established a LTCH PPS rate year with a July 1 effective date for the annual update of the Federal payment rate and associated payment policies while also maintaining an October 1 implementation date for the update of the LTC–DRG patient classification system and associated weighting factors. In changing the effective date of the annual LTCH PPS rate year update and the resulting publication dates of the proposed and final regulations for the LTCH PPS, we stated that this shift in the schedule would promote "administrative feasibility and efficiency" by avoiding concurrent rulemaking and publication with the IPPS final rule. We also noted that although section 1886(e)(5)(A) of the Act required that, for the IPPS, the proposed rule be published in the **Federal Register** "not later than the April 1 before each fiscal year; and the final rule, not later than the August 1 before such fiscal year," no similar requirement is imposed on the LTCH PPS and that we believed that this schedule change was well within the considerable discretion that Congress afforded the Secretary in the implementation of the LTCH PPS (68 FR 34125 through 34128). We maintained at that time, and we continue to believe, that this change to the LTCH rate year annual rulemaking schedule was not unduly burdensome for the LTCH industry because we had not added any requirements that LTCHs maintain payment systems or coding software in order to be paid under the LTCH PPS, although we understood that it was common for many hospitals, consultants, and industry associations to do so.

With regard to the commenter who described a LTCH with a fiscal year beginning on June 1, we would also reiterate what we stated in the FY 2004 final rule that "since the start of cost reporting periods for many LTCHs, as well as acute care hospitals, have not generally coincided with the October starting date of the Federal fiscal year, those hospitals that choose to have their own payment software are very familiar with the virtually seamless routine of inputting new numbers to their existing systems when a final rule is published" (68 FR 34127).

Therefore, we continue to believe that there is no significant administrative burden imposed on the LTCH industry by the establishment of the July 1 through June 30 rate year for the annual payment rate update under the LTCH PPS while still maintaining the October 1 through September 30 update of the LTC–DRGs and relative weights which are linked to the annual update of the diagnosis and procedure code set (ICD–9–CM) currently adopted by the DHHS and the IPPS DRGs and relative weights.

However, two commenters also stated that the separate rule-making cycles cause difficulty in "estimating the impact of changes in case weights," which will be published in April or May, when commenting on the payment rates published in the LTCH PPS proposed rule in the preceding January or February. From the volume of correspondence that we receive from LTCH associations and their consultants, some of which include detailed analyses of CMS data, we do not believe that our annual publication in the IPPS proposed rule of the proposed updates of the LTC–DRGs and corresponding relative weights (which are derived solely from the best available LTCH MedPAR claims data) prohibits the public from assessing the impact such proposed changes would have if finalized. In fact, in their specific comments on the proposed FY 2007 LTC–DRG relative weights (discussed in greater detail below), several commenters presented analyses of the combined effect of the policy changes established in the RY 2007 LTCH PPS final rule, effective July 1, 2007 (for example, revisions to the short-stay outlier policy), and the proposed changes to the LTC–DRGs and relative weights for FY 2007. Furthermore, the comments received on the policies presented in the LTCH PPS RY 2007 proposed rule, a number of which contained detailed data evaluations, demonstrated the availability as well as the ability of the public to analyze the proposed policy changes using the most recent LTCH MedPAR claims data. Therefore, we do not believe that our present publication schedule deprives industry stakeholders of the opportunity to submit meaningful comments on proposed changes to payment levels when we are establishing the payment rates and associated policy under the LTCH PPS, even though changes to the LTC–DRG weights are proposed in a separate notice of proposed rulemaking.

Given the considerable discretion granted to the Secretary under the BBRA of 1999 and the BIPA of 2000 to develop the LTCH PPS, we may revisit the rulemaking schedule for the LTCH PPS in the future. If a revision to the schedule is proposed, the public will have the opportunity to submit

comments on any proposed change to the schedule during the rulemaking process.

2. Changes in the LTC–DRG Classifications

a. Background

Section 123 of Pub. L. 106–113 specifically requires that the agency implement a PPS for LTCHs that is a per discharge system with a DRG-based patient classification system reflecting the differences in patient resources and costs in LTCHs. Section 307(b)(1) of Pub. L. 106–554 modified the requirements of section 123 of Pub. L. 106–113 by specifically requiring that the Secretary examine "the feasibility and the impact of basing payment under such a system [the LTCH PPS] on the use of existing (or refined) hospital diagnosis-related groups (DRGs) that have been modified to account for different resource use of long-term care hospital patients as well as the use of the most recently available hospital discharge data."

In accordance with section 307(b)(1) of Pub. L. 106–554 and § 412.515 of our existing regulations, the LTCH PPS uses information from LTCH patient records to classify patient cases into distinct LTC–DRGs based on clinical characteristics and expected resource needs. The LTC–DRGs used as the patient classification component of the LTCH PPS correspond to the DRGs under the IPPS for acute care hospitals. Thus, in this final rule, we are using the IPPS GROUPER Version 24.0 for FY 2007 to process LTCH PPS claims for LTCH discharges occurring from October 1, 2006, through September 30, 2007. The changes to the CMS–DRG classification system used under the IPPS for FY 2007 (GROUPER Version 24.0) are discussed in section II.D. of the preamble to this final rule.

We note that, as we discuss in section II.C.6. of the preamble to this final rule, MedPAC, in its 2005 Report to Congress on Physician-Owned Specialty Hospitals, recommended that CMS, among other things, refine the current DRGs under the IPPS to more fully capture differences in severity of illness among patients. As we also discuss in that same section, in evaluating the MedPAC recommendation for the IPPS, we are evaluating the APR DRG GROUPER used by MedPAC in its analysis. Based on this analysis, we concur with MedPAC that the modified version of the APR DRGs would account more completely for differences in severity of illness and associated costs among hospitals. However, as we made clear in the proposed rule and reiterate in section II.C.6. of the preamble of this final rule, there are still further changes that are important to make to the CS DRG system before it is ready for adoption. At this time, we are not adopting a new severity-adjusted DRG system, such as the APR DRGs or a modified version of the APR DRGs, under the IPPS, as discussed in greater detail in section II.C.6. of the preamble of this final rule. However, we are refining the current CMS–DRG system by creating 20 new CMS DRGs and modifying 32 others across 13 different clinical areas involving 1,666,476 cases that would improve the CMS DRG system's recognition of severity of illness for FY 2007. We note that the LTCH PPS uses the same patient classification system (DRGs) as the IPPS. That is, the patient classification system used under the LTCH PPS (LTC DRGs) is based on the patient classification system used under the IPPS (CMS DRGs), which historically had been updated annually and is effective for discharges occurring on or after October 1 through September 30 each year. As such, the updates to the CMS DRG classification system used under the IPPS for FY 2007 (GROUPER Version 24.0), discussed in section II.D. of the preamble to this final rule, will also be updates that apply under the LTCH PPS.

Under the LTCH PPS, we determine relative weights for each of the DRGs to account for the difference in resource use by patients exhibiting the case complexity and multiple medical problems characteristic of LTCH patients. In a departure from the IPPS, as we discussed in the August 30, 2002 LTCH PPS final rule (67 FR 55985), which implemented the LTCH PPS, and the FY 2006 IPPS final rule (70 FR 47324), we use low-volume quintiles in determining the LTC–DRG relative weights for LTC–DRGs with less than 25 LTCH cases, because LTCHs do not typically treat the full range of diagnoses as do acute care hospitals. Specifically, we group those low-volume LTC–DRGs (that is, LTC–DRGs with fewer than 25 cases) into 5 quintiles based on average charge per discharge. (A listing of the composition of low-volume quintiles for the FY 2006 LTC–DRGs (based on FY 2004 MedPAR data) appears in section II.G.3. of the FY 2006 IPPS final rule (70 FR 47325 through 47332).) We also adjust for cases in which the stay at the LTCH is less than or equal to five-sixths of the geometric average length of stay; that is, short-stay outlier cases (§ 412.529), as discussed below in section II.F.4. of this preamble.

b. Patient Classifications Into DRGs

Generally, under the LTCH PPS, Medicare payment is made at a predetermined specific rate for each discharge; that is, payment varies by the LTC–DRG to which a beneficiary's stay is assigned. Just as cases are classified into DRGs for acute care hospitals under the IPPS (see section II.B. of this preamble), cases are classified into LTC–DRGs for payment under the LTCH PPS based on the principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay, as well as age, sex, and discharge status of the patient. The diagnosis and procedure information is reported by the hospital using the ICD–9–CM codes.

As discussed in section II.B. of this preamble, the CMS–DRGs are organized into 25 major diagnostic categories (MDCs), most of which are based on a particular organ system of the body; the remainder involve multiple organ systems (such as MDC 22, Burns). Accordingly, the principal diagnosis determines MDC assignment. Within most MDCs, cases are then divided into surgical DRGs and medical DRGs. Some surgical and medical DRGs are further differentiated based on the presence or absence of CCs. (See section II.B. of this preamble for further discussion of surgical DRGs and medical DRGs.)

Because the assignment of a case to a particular LTC–DRG will determine the amount that is paid for the case, it is important that the coding is accurate. As used under the IPPS, classifications and terminology used under the LTCH PPS are consistent with the ICD–9–CM and the Uniform Hospital Discharge Data Set (UHDDS), as recommended to the Secretary by the National Committee on Vital and Health Statistics ("Uniform Hospital Discharge Data: Minimum Data Set, National Center for Health Statistics, April 1980") and as revised in 1984 by the Health Information Policy Council (HIPC) of the U.S. Department of Health and Human Services. We point out again that the ICD–9–CM coding terminology and the definitions of principal and other diagnoses of the UHDDS are consistent with the requirements of the Transactions and Code Sets Standards under HIPAA (45 CFR Parts 160 and 162).

The emphasis on the need for proper coding cannot be overstated. Inappropriate coding of cases can adversely affect the uniformity of cases in each LTC–DRG and produce inappropriate weighting factors at recalibration and result in inappropriate payments under the LTCH PPS. LTCHs are to follow the same coding guidelines used by acute care hospitals to ensure

accuracy and consistency in coding practices. There will be only one LTC–DRG assigned per long-term care hospitalization; it will be assigned at the time of discharge of the patient. Therefore, it is mandatory that the coders continue to report the same principal diagnosis on all claims and include all diagnosis codes for conditions that coexist at the time of admission, for conditions that are subsequently developed, or for conditions that affect the treatment received. Similarly, all procedures performed in a LTCH, or paid for under arrangements by a LTCH, during that stay are to be reported on each claim.

Upon the discharge of the patient from a LTCH, the LTCH must assign appropriate diagnosis and procedure codes from the ICD–9–CM. Completed claim forms are to be submitted electronically to the LTCH's Medicare fiscal intermediary. Medicare fiscal intermediaries enter the clinical and demographic information into their claims processing systems and subject this information to a series of automated screening processes called the Medicare Code Editor (MCE). These screens are designed to identify cases that require further review before assignment into a LTC–DRG can be made.

After screening through the MCE, each LTCH claim will be classified into the appropriate LTC–DRG by the Medicare LTCH GROUPER. The LTCH GROUPER is specialized computer software and is the same GROUPER used under the IPPS. After the LTC–DRG is assigned, the Medicare fiscal intermediary determines the prospective payment by using the Medicare LTCH PPS PRICER program, which accounts for LTCH hospital-specific adjustments and payment rates. As provided for under the IPPS, we provide an opportunity for the LTCH to review the LTC–DRG assignments made by the fiscal intermediary and to submit additional information, if necessary. within a specified timeframe (§ 412.513(c)).

The LTCH GROUPER is used both to classify past cases in order to measure relative hospital resource consumption to establish the LTC–DRG weights and to classify current cases for purposes of determining payment. The records for all Medicare hospital inpatient discharges are maintained in the MedPAR file. The data in this file are used to evaluate possible DRG classification changes and to recalibrate the DRG weights during our annual update (as discussed in section II.E. of this preamble). The LTC–DRG relative weights are based on data for the population of LTCH discharges, reflecting the fact that LTCH patients represent a different patient-mix than patients in short-term acute care hospitals.

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

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

As we stated in the August 30, 2002 LTCH PPS final rule (67 FR 55981), one of the primary goals for the implementation of the LTCH PPS is to pay each LTCH an appropriate amount for the efficient delivery of care to Medicare patients. The system must be able to account adequately for each LTCH's case-mix in order to ensure both fair distribution of Medicare payments and access to adequate care for those Medicare patients whose care is more costly. To accomplish these goals, we adjust the LTCH PPS standard Federal prospective payment system rate by the applicable LTC–DRG relative weight in determining payment to LTCHs for each case. Under the LTCH PPS, relative weights for each LTC–DRG are a primary element used to account for the variations in cost per discharge and resource utilization among the payment groups (§ 412.515). To ensure that Medicare patients classified to each LTC–DRG have access to an appropriate level of services and to encourage efficiency, we calculate a relative weight for each LTC–DRG that represents the resources needed by an average inpatient LTCH case in that LTC–DRG. For example, cases in a LTC–DRG with a relative weight of 2 will, on average, cost twice as much as cases in a LTC–DRG with a weight of 1.

b. Data

In the FY 2007 IPPS proposed rule (71 FR 24052), to calculate the proposed LTC–DRG relative weights for FY 2007, we obtained total Medicare allowable charges from FY 2005 Medicare LTCH bill data from the December 2005 update of the MedPAR file, which were the best available data at that time, and we used the proposed Version 24.0 of the CMS GROUPER used under the IPPS (as discussed in that same proposed rule) to classify cases. In that same proposed rule, we also proposed that if more recent data were available, we would use that data and the finalized Version 24.0 of the CMS GROUPER (used under the IPPS) to determine the final LTC–DRG relative weights for FY 2007. Accordingly, to calculate the final LTC–DRG relative weights for FY 2007 in this final rule, we obtained total Medicare allowable charges from FY 2005 Medicare hospital bill data from the March 2006 update of the MedPAR file (which are the most recent available data), and used the final Version 24.0 of the CMS GROUPER used under the IPPS (as discussed in section II.B. of this preamble) to classify cases.

We also stated in the FY 2007 IPPS proposed rule (71 FR 24052), as we discussed in the FY 2006 IPPS final rule (70 FR 47325), we have excluded the data from LTCHs that are all-inclusive rate providers and LTCHs that are reimbursed in accordance with demonstration projects authorized under section 402(a) of Pub. L. 90–248 as amended. Therefore, consistent with the proposed rule, in the development of the FY 2007 LTC–DRG relative weights in this final rule, we have excluded the data of the 19 all-inclusive rate providers and the 3 LTCHs that are paid in accordance with demonstration projects that had claims in the FY 2005 MedPAR file.

c. Hospital-Specific Relative Value Methodology

By nature, LTCHs often specialize in certain areas, such as ventilator-dependent patients and rehabilitation and wound care. Some case types (DRGs) may be treated, to a large extent, in hospitals that have, from a perspective of charges, relatively high (or low) charges. This nonarbitrary distribution of cases with relatively high (or low) charges in specific LTC–DRGs has the potential to inappropriately distort the measure of average charges. To account for the fact that cases may not be randomly distributed across LTCHs, we use a hospital-specific relative value (HSRV) method to calculate the LTC–DRG relative weights instead of the methodology used to determine the DRG relative weights under the IPPS described in section II.E. of this preamble. We believe this method will remove this hospital-specific source of bias in measuring LTCH average charges. Specifically, we reduce the impact of the variation in charges across providers on any particular LTC–DRG relative weight by converting each LTCH's charge for a case to a relative value based on that LTCH's average charge.

Under the HSRV method, we standardize charges for each LTCH by converting its charges for each case to hospital-specific relative charge values and then adjusting those values for the LTCH's case-mix. The adjustment for case-mix is needed to rescale the hospital-specific relative charge values (which, by definition, average 1.0 for each LTCH). The average relative weight for a LTCH is its case-mix, so it is reasonable to scale each LTCH's average

relative charge value by its case-mix. In this way, each LTCH's relative charge value is adjusted by its case-mix to an average that reflects the complexity of the cases it treats relative to the complexity of the cases treated by all other LTCHs (the average case-mix of all LTCHs).

In accordance with the methodology established under § 412.523, as implemented in the August 30, 2002 LTCH PPS final rule (67 FR 55989 through 55991), we standardize charges for each case by first dividing the adjusted charge for the case (adjusted for short-stay outliers under § 412.529 as described in section II.F.4. (step 3) of this preamble) by the average adjusted charge for all cases at the LTCH in which the case was treated. Short-stay outliers under § 412.529 are cases with a length of stay that is less than or equal to five-sixths the average length of stay of the LTC–DRG. The average adjusted charge reflects the average intensity of the health care services delivered by a particular LTCH and the average cost level of that LTCH. The resulting ratio is multiplied by that LTCH's case-mix index to determine the standardized charge for the case.

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

d. Low-Volume LTC–DRGs

In order to account for LTC–DRGs with low-volume (that is, with fewer than 25 LTCH cases), in accordance with the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 55984), we group those "low-volume LTC–DRGs" (that is, DRGs that contained between 1 and 24 cases annually) into one of five categories (quintiles) based on average charges, for the purposes of determining relative weights. Consistent with the FY 2007 IPPS proposed rule (71 FR 24052 and 24053), we will continue to employ this treatment of low-volume LTC–DRGs in determining the FY 2007 LTC–DRG relative weights using the best available LTCH data in this final rule. In that same proposed rule, using LTCH cases from the December 2005 update of the FY 2005 MedPAR file, we identified 173 LTC–DRGs that contained between 1 and 24 cases. As noted above, we also proposed that if more recent data were available, we would use that data and the finalized Version 24.0 of the CMS GROUPER (used under the IPPS) to determine the final LTC–DRG relative weights for FY 2007. Accordingly, for this final rule, using LTCH cases from the March 2006 update of the FY 2005 MedPAR file, we identified 180 LTC–DRGs that contained between 1 and 24 cases. This list of LTC–DRGs was then divided into one of the 5 low-volume quintiles, each containing 36 LTC–DRGs (180/5 = 36). In accordance with our established methodology, as we proposed, we then make an assignment to a specific low-volume quintile by sorting the low-volume LTC–DRGs in ascending order by average charge. For this final rule, this results in an assignment to a specific low-volume quintile of the sorted 180 low-volume LTC–DRGs by ascending order by average charge. For this final rule, based on LTCH claims data from the March 2006 update of the FY 2005 MedPAR file and the finalized Version 24.0 of the CMS GROUPER, the number of low-volume LTC–DRGs is evenly divisible by five (that is, the number of low-volume quintile used to determine the LTC–DRG relative weights). Consequently, for this final rule, it was not necessary to employ our established methodology to determine which low-volume quintile would receive the additional LTC–DRG(s) if the number of low-volume LTC–DRGs had not been evenly divisible by five. However, if the number of LTC–DRGs with less than 25 LTCH cases for this final rule had not evenly divisible by five, we would have employed our established methodology that compares the average charge of the low-volume LTC–DRGs, to determine which low-volume quintile would receive the additional LTC–DRG, as presented in greater detail in the FY 2007 IPPS proposed rule (71 FR 24053). Because, for this final rule, the number of LTC–DRGs with less than 25 LTCH cases was evenly divisible by five, to determine the composition of the low-volume quintiles, in accordance with our established methodology, as was proposed, we sorted the 180 low-volume LTC–DRGs in ascending order, and grouped the first fifth (1st through 36th) of low-volume LTC–DRGs (with the lowest average charge) into Quintile 1; the next fifth (37th through 72nd) of low-volume LTC–DRGs were into Quintile 2; and so on until the last fifth (145th through 180th) of low-volume LTC–DRGs (with the highest average charge) were grouped into Quintile 5.

In order to determine the relative weights for the LTC–DRGs with low volume for FY 2007, as was proposed, in accordance with the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 55984), in this final rule, we used the five low-volume quintiles described above. The composition of each of the five low-volume quintiles shown in the chart below was used in determining the LTC–DRG relative weights for FY 2007. As was proposed, for this final rule, we determined a relative weight and (geometric) average length of stay for each of the five low-volume quintiles using the formula that we apply to the regular LTC–DRGs (25 or more cases), as described below in section II.F.4. of this preamble. We assigned the same relative weight and average length of stay to each of the LTC–DRGs that make up that low-volume quintile. We note that, as this system is dynamic, it is possible that the number and specific type of LTC–DRGs with a low volume of LTCH cases will vary in the future. We use the best available claims data in the MedPAR file to identify low-volume LTC–DRGs and to calculate the relative weights based on our methodology.

COMPOSITION OF LOW-VOLUME QUINTILES FOR FY 2007

LTC–DRG	Description
Quintile 1	
29	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC.

COMPOSITION OF LOW-VOLUME QUINTILES FOR FY 2007—Continued

LTC–DRG	Description
31	CONCUSSION AGE >17 W CC.
45	NEUROLOGICAL EYE DISORDERS.
65	DYSEQUILIBRIUM.
69	OTITIS MEDIA & URI AGE >17 W/O CC.
83	MAJOR CHEST TRAUMA W CC.
93	INTERSTITIAL LUNG DISEASE W/O CC.
102	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC.
125	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG.
129	CARDIAC ARREST, UNEXPLAINED.
136	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC.
140	ANGINA PECTORIS.
143	CHEST PAIN.
160	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC.
181	G.I. OBSTRUCTION W/O CC.
183	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC.
208	DISORDERS OF THE BILIARY TRACT W/O CC.
224	SHOULDER, ELBOW OR FOREARM PROC, EXC MAJOR JOINT PROC, W/O CC.
237	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH.
241	CONNECTIVE TISSUE DISORDERS W/O CC.
250	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC.
254	FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE >17 W/O CC.
273	MAJOR SKIN DISORDERS W/O CC.
323	URINARY STONES W CC, &/OR ESW LITHOTRIPSY.
324	URINARY STONES W/O CC.
332	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC.
335	MAJOR MALE PELVIC PROCEDURES W/O CC.
347	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC.
367	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC.
383	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS.
399	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC.
425	ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION.
432	OTHER MENTAL DISORDER DIAGNOSES.
509	FULL THICKNESS BURN W/O SKIN GRFT OR INH INJ W/O CC OR SIG TRAUMA.
511	NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA.
523	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W/O CC.
	Quintile 2
8	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC.
11	NERVOUS SYSTEM NEOPLASMS W/O CC.
17	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC.
46	OTHER DISORDERS OF THE EYE AGE >17 W CC.
77	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC.
117	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT.
122	CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE.
128	DEEP VEIN THROMBOPHLEBITIS.
133	ATHEROSCLEROSIS W/O CC.
139	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC.
173	DIGESTIVE MALIGNANCY W/O CC.
175	G.I. HEMORRHAGE W/O CC.
177	UNCOMPLICATED PEPTIC ULCER W CC.
189	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC.
246	NON-SPECIFIC ARTHROPATHIES.
261	BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION.
276	NON-MALIGNANT BREAST DISORDERS.
281	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC.
284	MINOR SKIN DISORDERS W/O CC.
295	DIABETES AGE 0–35.
301	ENDOCRINE DISORDERS W/O CC.
325	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC.
348	BENIGN PROSTATIC HYPERTROPHY W CC.
419	FEVER OF UNKNOWN ORIGIN AGE >17 W CC.
420	FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC.
427	NEUROSES EXCEPT DEPRESSIVE.
431	CHILDHOOD MENTAL DISORDERS.
441	HAND PROCEDURES FOR INJURIES.
445	TRAUMATIC INJURY AGE >17 W/O CC.
447	ALLERGIC REACTIONS AGE >17.
450	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC.
479	OTHER VASCULAR PROCEDURES W/O CC.
492	CHEMO W ACUTE LEUKEMIA AS SDX OR W USE OF HIGH DOSE CHEMO AGENT.
521	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC.

COMPOSITION OF LOW-VOLUME QUINTILES FOR FY 2007—Continued

LTC–DRG	Description
524	TRANSIENT ISCHEMIA.
563	SEIZURE AGE >17 W/O CC.
	Quintile 3
21	VIRAL MENINGITIS.
22	HYPERTENSIVE ENCEPHALOPATHY.
44	ACUTE MAJOR EYE INFECTIONS.
67	EPIGLOTTITIS.
72	NASAL TRAUMA & DEFORMITY.
97*	BRONCHITIS & ASTHMA AGE >17 W/O CC.
100	RESPIRATORY SIGNS & SYMPTOMS W/O CC.
118	CARDIAC PACEMAKER DEVICE REPLACEMENT.
119	VEIN LIGATION & STRIPPING.
142*	SYNCOPE & COLLAPSE W/O CC.
157	ANAL & STOMAL PROCEDURES W CC.
171	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC.
199	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY.
206*	DISORDERS OF LIVER EXCEPT MALIG, CIRR, ALC HEPA W/O CC.
227	SOFT TISSUE PROCEDURES W/O CC.
228	MAJOR THUMB OR JOINT PROC, OR OTH HAND OR WRIST PROC W CC.
235	FRACTURES OF FEMUR.
259	SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC.
266	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC.
270	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC.
299	INBORN ERRORS OF METABOLISM.
312	URETHRAL PROCEDURES, AGE >17 W CC.
338	TESTES PROCEDURES, FOR MALIGNANCY.
339	TESTES PROCEDURES, NON-MALIGNANCY AGE >17.
344	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY.
346	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC.
369	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS.
404	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC.
414	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC.
449	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC.
454	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC.
467	OTHER FACTORS INFLUENCING HEALTH STATUS.
486	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA.
502	KNEE PROCEDURES W PDX OF INFECTION W/O CC.
532	SPINAL PROCEDURES W/O CC.
555	PERCUTANEOUS CARDIOVASCULAR PROC W MAJOR CV DX.
	Quintile 4
55	MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES.
63	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES.
95*	PNEUMOTHORAX W/O CC.
110	MAJOR CARDIOVASCULAR PROCEDURES W CC.
124	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG.
193	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC.
197	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC.
223	MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC.
262	BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY.
268	SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES.
288	O.R. PROCEDURES FOR OBESITY.
304	KIDNEY AND URETER PROCEDURES FOR NON-NEOPLASM W CC.
306	PROSTATECTOMY W CC.
308	MINOR BLADDER PROCEDURES W CC.
310	TRANSURETHRAL PROCEDURES W CC.
336	TRANSURETHRAL PROSTATECTOMY W CC.
345	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY.
365	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES.
376	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE.
394	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS.
401	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC.
408	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC.
487	OTHER MULTIPLE SIGNIFICANT TRAUMA.
488	HIV W EXTENSIVE O.R. PROCEDURE.
493	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC.
496	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION.
500	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC.
503	KNEE PROCEDURES W/O PDX OF INFECTION.

COMPOSITION OF LOW-VOLUME QUINTILES FOR FY 2007—Continued

LTC–DRG	Description
506	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA.
515	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH.
519	CERVICAL SPINAL FUSION W CC.
533	EXTRACRANIAL PROCEDURES W CC.
538	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXCEPT HIP & FEMUR W/O CC.
539	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W CC.
552	OTHER PERMANENT CARDIAC PACEMAKER IMPLANT W/O MAJOR CV DX PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W MAJOR CV.
557	DX.
	Quintile 5
1	CRANIOTOMY AGE >17 W CC.
146	RECTAL RESECTION W CC.
150	PERITONEAL ADHESIOLYSIS W CC.
152	MINOR SMALL & LARGE BOWEL PROCEDURES W CC.
159	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC.
168	MOUTH PROCEDURES W CC.
191	PANCREAS, LIVER & SHUNT PROCEDURES W CC.
195	CHOLECYSTECTOMY W C.D.E. W CC.
200	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY.
218	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W CC.
230	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR.
232	ARTHROSCOPY.
257	TOTAL MASTECTOMY FOR MALIGNANCY W CC.
293*	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC.
341	PENIS PROCEDURES.
406	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W CC.
424	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS.
471	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY.
476	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.
482	TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES.
491	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY.
497	SPINAL FUSION EXCEPT CERVICAL W CC.
499	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC.
504	EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV 96+ HRS W SKIN GRAFT.
505	EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV 96+ HRS W/O SKIN GRAFT.
529	VENTRICULAR SHUNT PROCEDURES W CC.
531	SPINAL PROCEDURES W CC.
535	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK.
543	CRANIOTOMY W MAJOR DEVICE IMPLANT OR ACUTE COMPLEX CNS PDX.
544	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY.
545	REVISION OF HIP OR KNEE REPLACEMENT.
567	STOMACH, ESOPHAGEAL & DUODENAL PROC AGE >17 W CC W MAJOR GI DX.
568	STOMACH, ESOPHAGEAL & DUODENAL PROC AGE >17 W CC W/O MAJOR GI DX.
569	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC W MAJOR GI DX.
570	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC W/O MAJOR GI DX.
573	MAJOR BLADDER PROCEDURES.

*One of the original 180 low-volume LTC–DRGs initially assigned to this low-volume quintile; removed from this low-volume quintile in addressing nonmonotonicity (see step 5 below)..

We note that we will continue to monitor the volume (that is, the number of LTCH cases) in these low-volume quintiles to ensure that our quintile assignment results in appropriate payment for such cases and does not result in an unintended financial incentive for LTCHs to inappropriately admit these types of cases.

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

As we noted previously, as was proposed, the FY 2007 LTC–DRG relative weights in this final rule are determined in accordance with the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 55989 through 55991). In summary, LTCH cases must be grouped in the appropriate LTC–DRG, while taking into account the low-volume LTC–DRGs as described above, before the FY 2007 LTC–DRG relative weights can be determined. After grouping the cases in the appropriate LTC–DRG, we calculated the relative weights for FY 2007 in this final rule by first removing statistical outliers and cases with a length of stay of 7 days or less, as discussed in greater detail below. Next, we adjusted the number of cases in each LTC–DRG for the effect of short-stay outlier cases under § 412.529, as also discussed in greater detail below. The short-stay adjusted discharges and corresponding charges are used to calculate "relative adjusted weights" in each LTC–DRG using the HSRV method described above.

Below we discuss in detail the steps for calculating the FY 2007 LTC–DRG relative weights in this final rule. These steps are the same as the ones we presented in the FY 2007 IPPS proposed rule for calculating the proposed FY 2007 LTC–DRG relative weights. We note that, as we stated above in section II.F.3.b. of this preamble, we have excluded the data of all-inclusive rate LTCHs and LTCHs that are paid in accordance with demonstration projects that had claims in the FY 2005 MedPAR file.

Step 1—Remove statistical outliers:

The first step in the calculation of the FY 2007 LTC–DRG relative weights, as was proposed, is to remove statistical outlier cases. We define statistical outliers as cases that are outside of 3.0 standard deviations from the mean of the log distribution of both charges per case and the charges per day for each LTC–DRG. These statistical outliers are removed prior to calculating the relative weights. As noted above, we believe that they may represent aberrations in the data that distort the measure of average resource use. Including those LTCH cases in the calculation of the relative weights could result in an inaccurate relative weight that does not truly reflect relative resource use among the LTC–DRGs.

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

The FY 2007 LTC–DRG relative weights reflect the average of resources used on representative cases of a specific type. Generally, cases with a length of stay of 7 days or less do not belong in a LTCH because these stays do not fully receive or benefit from treatment that is typical in a LTCH stay, and full resources are often not used in the earlier stages of admission to a LTCH. As explained above, if we were to include stays of 7 days or less in the computation of the FY 2007 LTC–DRG relative weights, the value of many relative weights would decrease and, therefore, payments would decrease to a level that may no longer be appropriate.

We do not believe that it would be appropriate to compromise the integrity of the payment determination for those LTCH cases that actually benefit from and receive a full course of treatment at a LTCH, in order to include data from these very short-stays. Thus, as explained above, in determining the FY 2007 LTC–DRG relative weights in this final rule, as was proposed, we remove LTCH cases with a length of stay of 7 days or less.

Step 3—Adjust charges for the effects of short-stay outliers.

After removing cases with a length of stay of 7 days or less, we are left with cases that have a length of stay of greater than or equal to 8 days. The next step in the calculation of the FY 2007 LTC–DRG relative weights is to adjust each LTCH's charges per discharge for those remaining cases for the effects of short-stay outliers as defined in § 412.529(a). (However, we note that even if a case was removed in Step 2 (that is, cases with a length of stay of 7 days or less), it was paid as a short-stay outlier if its length of stay was less than or equal to five-sixths of the average length of stay of the LTC–DRG, in accordance with § 412.529.)

We make this adjustment by counting a short-stay outlier as a fraction of a discharge based on the ratio of the length of stay of the case to the average length of stay for the LTC–DRG for nonshort-stay outlier cases. This has the effect of proportionately reducing the impact of the lower charges for the short-stay outlier cases in calculating the average charge for the LTC–DRG. This process produces the same result as if the actual charges per discharge of a short-stay outlier case were adjusted to what they would have been had the patient's length of stay been equal to the average length of stay of the LTC–DRG.

As we explained in the FY 2007 IPPS proposed rule (71 FR 24059), counting short-stay outlier cases as full discharges with no adjustment in determining the LTC–DRG relative weights would lower the LTC–DRG relative weight for affected LTC–DRGs because the relatively lower charges of the short-stay outlier cases would bring down the average charge for all cases within a proposed LTC–DRG. This would result in an "underpayment" for nonshort-stay outlier cases and an "overpayment" for short-stay outlier cases. Therefore, in this final rule, as was proposed, we adjust for short-stay outlier cases under § 412.529 in this manner because it results in more appropriate payments for all LTCH cases.

Step 4—Calculate the FY 2007 LTC–DRG relative weights on an iterative basis.

The process of calculating the LTC–DRG relative weights using the HSRV methodology is iterative. First, for each LTCH case, we calculate a hospital-specific relative charge value by dividing the short-stay outlier adjusted charge per discharge (see step 3) of the LTCH case (after removing the statistical outliers (see step 1)) and LTCH cases with a length of stay of 7 days or less (see step 2) by the average charge per discharge for the LTCH in which the case occurred. The resulting ratio is then multiplied by the LTCH's case-mix index to produce an adjusted hospital-specific relative charge value for the case. An initial case-mix index value of 1.0 is used for each LTCH.

For each LTC–DRG, the FY 2007 LTC–DRG relative weight is calculated by dividing the average of the adjusted hospital-specific relative charge values (from above) for the LTC–DRG by the overall average hospital-specific relative charge value across all cases for all LTCHs. Using these recalculated LTC–DRG relative weights, each LTCH's average relative weight for all of its cases (case-mix) is calculated by dividing the sum of all the LTCH's LTC–DRG relative weights by its total number of cases. The LTCHs' hospital-specific relative charge values above are multiplied by these hospital-specific case-mix indexes. These hospital-specific case-mix adjusted relative charge values are then used to calculate a new set of LTC–DRG relative weights across all LTCHs. In this final rule, as was proposed, this iterative process is continued until there is convergence between the weights produced at adjacent steps, for example, when the maximum difference is less than 0.0001.

Step 5—Adjust the FY 2007 LTC–DRG relative weights to account for nonmonotonically increasing relative weights.

As explained in section II.B. of this preamble, the FY 2007 CMS DRGs, on which the FY 2007 LTC–DRGs are based, contain "pairs" that are differentiated based on the presence or absence of CCs. The LTC–DRGs with CCs are defined by certain secondary diagnoses not related to or inherently a part of the disease process identified by the principal diagnosis, but the presence of additional diagnoses does not automatically generate a CC. As we discussed in the FY 2006 IPPS final rule (70 FR 47336), the value of monotonically increasing relative weights rises as the resource use increases (for example, from uncomplicated to more complicated). The presence of CCs in a LTC–DRG means that cases classified into a "without CC" LTC–DRG are expected to have lower resource use (and lower costs). In other words, resource use (and costs) are expected to decrease across "with CC/without CC" pairs of LTC–DRGs.

For a case to be assigned to a LTC–DRG with CCs, more coded information is called for (that is, at least one relevant secondary diagnosis), than for a case to be assigned to a LTC–DRG "without CCs" (which is based on only one principal diagnosis and no relevant secondary diagnoses). Currently, the LTCH claims data include both accurately coded cases without complications and cases that have complications (and cost more), but were not coded completely. Both types of cases are grouped to a LTC–DRG "without CCs" when only the principal diagnosis was coded. Since the LTCH PPS was only implemented for cost reporting periods beginning on or after October 1, 2002 (FY 2003), and LTCHs were previously paid under cost-based reimbursement, which is not based on patient diagnoses, coding by LTCHs for

these cases may not have been as detailed as possible.

Thus, in developing the FY 2003 LTC–DRG relative weights for the LTCH PPS based on FY 2001 claims data, as we discussed in the August 30, 2002 LTCH PPS final rule (67 FR 55990), we found on occasion that the data suggested that cases classified to the LTC–DRG "with CCs" of a "with CC/without CC" pair had a lower average charge than the corresponding LTC–DRG "without CCs." Similarly, as discussed in the FY 2006 IPPS final rule (70 FR 47336 through 47337), based on FY 2004 claims data, we also found on occasion that the data suggested that cases classified to the LTC–DRG "with CCs" of a "with CC/without CC" pair have a lower average charge than the corresponding LTC–DRG "without CCs" for the FY 2006 LTC–DRG relative weights.

We believe this anomaly may be due to coding that may not have fully reflected all comorbidities that were present. Specifically, LTCHs may have failed to code relevant secondary diagnoses, which resulted in cases that actually had CCs being classified into a "without CC" LTC–DRG. It would not be appropriate to pay a lower amount for the "with CC" LTC–DRG because, in general, cases classified into a "with CC" LTC–DRG are expected to have higher resource use (and higher cost) as discussed above. Therefore, previously when we determined the LTC–DRG relative weights in accordance with the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 55990) when we implanted the LTCH PPS, we grouped both the cases "with CCs" and "without CCs" together for the purpose of calculating the LTC–DRG relative weights. As we stated in that same final rule, we will continue to employ this methodology to account for nonmonotonically increasing relative weights until we have adequate data to calculate appropriate separate weights for these anomalous LTC–DRG pairs. We expect that, as was the case when we first implemented the IPPS, in most instances, this problem will be self-correcting, as LTCHs submit more completely coded data in the future.

There are three types of "with CC" and "without CC" pairs that could be nonmonotonic; that is, where the "without CC" LTC–DRG would have a higher average charge than the "with CC" LTC–DRG. For this final rule, using the LTCH cases in the March 2006 update of the FY 2005 MedPAR file (the most recent and complete data available at this time), we identified one of the three types of nonmonotonic LTC–DRG pairs. As we stated in the August 30, 2002 LTCH PPS final rule (67 FR 55990), we believe this anomaly may be due to coding inaccuracies and expect that, as was the case when we first implemented the acute care hospital IPPS, this problem will be self-correcting, as LTCHs submit more completely coded data in the future.

The first category of nonmonotonically increasing relative weights for LTC–DRG pairs "with and without CCs" contains one pair of LTC–DRGs in which both the LTC–DRG "with CCs" and the LTC–DRG "without CCs" had 25 or more LTCH cases and, therefore, did not fall into one of the 5 low-volume quintiles. For those nonmonotonic LTC–DRG pairs, based on our established methodology (67 FR 55983 through 55990), we combined the LTCH cases and computed a new relative weight based on the case-weighted average of the combined LTCH cases of the LTC–DRGs. The case-weighted average charge is determined by dividing the total charges for all LTCH cases by the total number of LTCH cases for the combined LTC–DRG. This new relative weight is then assigned to both of the LTC–DRGs in the pair. In this final rule, for FY 2007, there were no LTC–DRGs that fell into this category.

The second category of nonmonotonically increasing relative weights for LTC–DRG pairs "with and without CCs" consists of one pair of LTC–DRGs that has fewer than 25 cases, and each LTC–DRG is grouped to different low-volume quintiles in which the "without CC" LTC–DRG is in a higher-weighted low-volume quintile than the "with CC" LTC–DRG. For those pairs, based on our established methodology, we combine the LTCH cases and determine the case-weighted average charge for all LTCH cases. The case-weighted average charge is determined by dividing the total charges for all LTCH cases by the total number of LTCH cases for the combined LTC–DRG. Based on the case-weighted average LTCH charge, we determine within which low-volume quintile the "combined LTC–DRG" is grouped. Both LTC–DRGs in the pair are then grouped into the same low-volume quintile, thus having the same relative weight. In this final rule, for FY 2007, there were no LTC–DRGs that fell into this category.

The third category of nonmonotonically increasing relative weights for LTC–DRG pairs "with and without CCs" consists of one pair of LTC–DRGs where one of the LTC–DRGs has fewer than 25 LTCH cases and is grouped to a low-volume quintile and the other LTC–DRG has 25 or more LTCH cases and has its own LTC–DRG relative weight, and the LTC–DRG "without CCs" has the higher relative weight. Based on our established methodology, as proposed, we removed the low-volume LTC–DRG from the low-volume quintile and combined it with the other LTC–DRG for the computation of a new relative weight for each of these LTC–DRGs. This new relative weight is assigned to both LTC–DRGs, so they each have the same relative weight. In this final rule, for FY 2007, 5 "pairs" of LTC–DRGs fall into this category: LTC–DRGs 94 and 95; LTC–DRGs 96 and 97; LTC–DRGs 141 and 142; LTC–DRGs 205 and 206; and LTC–DRGs 292 and 293.

Step 6—Determine a FY 2007 LTC–DRG relative weight for LTC–DRGs with no LTCH cases.

As we stated above, in this final rule, as we proposed we determine the relative weight for each LTC–DRG using total Medicare allowable charges reported in the March 2006 update of the FY 2005 MedPAR file. Of the 538 LTC–DRGs for FY 2007, we identified 183 LTC–DRGs for which there were no LTCH cases in the database. That is, based on data from the FY 2005 MedPAR file used in this final rule, no patients who would have been classified to those LTC–DRGs were treated in LTCHs during FY 2005 and, therefore, no charge data were reported for those LTC–DRGs. Thus, in the process of determining the LTC–DRG relative weights, we are unable to determine weights for these 183 LTC–DRGs using the methodology described in Steps 1 through 5 above. However, because patients with a number of the diagnoses under these LTC–DRGs may be treated at LTCHs beginning in FY 2007, as was proposed, for this final rule, we assigned relative weights to each of the 183 "no volume" LTC–DRGs based on clinical similarity and relative costliness to one of the remaining 355 (538 - 183 = 355) LTC–DRGs for which we are able to determine relative weights, based on FY 2005 LTCH claims data. As there are currently no LTCH cases in these "no volume" LTC–DRGs, as proposed, we determined relative weights for the 183 LTC–DRGs with no LTCH cases in the FY 2005 MedPAR file used in this final rule by grouping them to the appropriate low-volume quintile. This methodology is consistent with our methodology used in determining relative weights to account for the low-volume LTC–DRGs described above.

As was proposed, for this final rule, our methodology for determining the relative weights for the "no volume" LTC–DRGs is as follows: We crosswalk the no volume LTC–DRGs by matching them to other similar LTC–DRGs for

which there were LTCH cases in the FY 2005 MedPAR file based on clinical similarity and intensity of use of resources as determined by care provided during the period of time surrounding surgery, surgical approach (if applicable), length of time of surgical procedure, postoperative care, and length of stay. We assigned the relative weight for the applicable low-volume quintile to the no volume LTC–DRG if the LTC–DRG to which it is crosswalked is grouped to one of the low-volume quintiles. If the LTC–DRG to which the no volume LTC–DRG is crosswalked is not one of the LTC–DRGs to be grouped to one of the low-volume quintiles, we compared the relative weight of the LTC–DRG to which the no volume LTC–DRG is crosswalked to the relative weights of each of the five quintiles and we assigned the no volume LTC–DRG the relative weight of the low-volume quintile with the closest weight. For this final rule, a list of the no volume FY 2007 LTC–DRGs and the FY 2007 LTC–DRG to which it is crosswalked in order to determine the appropriate low-volume quintile for the assignment of a relative weight for FY 2007 is shown in the chart below.

NO VOLUME LTC-DRG CROSSWALK AND QUINTILE ASSIGNMENT FOR FY 2007

LTC–DRG	Description	Cross-walked LTC–DRG	Low-volume quintile assignment
2	CRANIOTOMY AGE >17 W/O CC	1	Quintile 5.
3	CRANIOTOMY AGE 0–17	1	Quintile 5.
6	CARPAL TUNNEL RELEASE	237	Quintile 1.
26	SEIZURE & HEADACHE AGE 0–17	563	Quintile 2.
30	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0–17	29	Quintile 1.
32	CONCUSSION AGE >17 W/O CC	31	Quintile 1.
33	CONCUSSION AGE 0–17	31	Quintile 1.
36	RETINAL PROCEDURES	46	Quintile 2.
37	ORBITAL PROCEDURES	46	Quintile 2.
38	PRIMARY IRIS PROCEDURES	46	Quintile 2.
39	LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	46	Quintile 2.
40	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	46	Quintile 2.
41	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0–17	46	Quintile 2.
42	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	46	Quintile 2.
43	HYPHEMA	45	Quintile 1.
47	OTHER DISORDERS OF THE EYE AGE >17 W/O CC	45	Quintile 1.
48	OTHER DISORDERS OF THE EYE AGE 0–17	45	Quintile 1.
49	MAJOR HEAD & NECK PROCEDURES	64	Quintile 4.
50	SIALOADENECTOMY	63	Quintile 4.
51	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	63	Quintile 4.
52	CLEFT LIP & PALATE REPAIR	63	Quintile 4.
53	SINUS & MASTOID PROCEDURES AGE >17	63	Quintile 4.
54	SINUS & MASTOID PROCEDURES AGE 0–17	63	Quintile 4.
56	RHINOPLASTY	63	Quintile 4.
57	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	69	Quintile 1.
58	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17	69	Quintile 1.
59	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	69	Quintile 1.
60	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17	69	Quintile 1.
61	MYRINGOTOMY W TUBE INSERTION AGE >17	69	Quintile 1.
62	MYRINGOTOMY W TUBE INSERTION AGE 0–17	69	Quintile 1.
66	EPISTAXIS	69	Quintile 1.
70	OTITIS MEDIA & URI AGE 0–17	69	Quintile 1.
71	LARYNGOTRACHEITIS	97	Quintile 2.
74	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0–17	69	Quintile 1.
81	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0–17	69	Quintile 1.
84	MAJOR CHEST TRAUMA W/O CC	93	Quintile 1.
86	PLEURAL EFFUSION W/O CC	102	Quintile 1.
91	SIMPLE PNEUMONIA & PLEURISY AGE 0–17	90	Quintile 2.
98	BRONCHITIS & ASTHMA AGE 0–17	97	Quintile 2.
104	CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W CARDIAC CATH	110	Quintile 4.
105	CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W/O CARDIAC CATH	110	Quintile 4.
106	CORONARY BYPASS W PTCA	110	Quintile 4.
108	OTHER CARDIOTHORACIC PROCEDURES	110	Quintile 4.
111	MAJOR CARDIOVASCULAR PROCEDURES W/O CC	110	Quintile 4.
137	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0–17	136	Quintile 1.
147	RECTAL RESECTION W/O CC	171	Quintile 3.
149	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	176	Quintile 3.
151	PERITONEAL ADHESIOLYSIS W/O CC	160	Quintile 1.
153	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	152	Quintile 5.
155	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC	567	Quintile 5.
156	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0–17	567	Quintile 5.
158	ANAL & STOMAL PROCEDURES W/O CC	157	Quintile 3.
161	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC	160	Quintile 1.
162	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC	160	Quintile 1.
163	HERNIA PROCEDURES AGE 0–17	160	Quintile 1.
164	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	171	Quintile 3.
165	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	171	Quintile 3.

NO VOLUME LTC-DRG CROSSWALK AND QUINTILE ASSIGNMENT FOR FY 2007—Continued

LTC–DRG	Description	Cross-walked LTC–DRG	Low-volume quintile assignment
166	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	171	Quintile 3.
167	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	171	Quintile 3.
169	MOUTH PROCEDURES W/O CC	185	Quintile 2.
178	UNCOMPLICATED PEPTIC ULCER W/O CC	160	Quintile 1.
184	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0–17	183	Quintile 1.
186	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0–17	185	Quintile 2.
187	DENTAL EXTRACTIONS & RESTORATIONS	185	Quintile 2.
190	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0–17	189	Quintile 2.
192	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	191	Quintile 5.
194	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC	193	Quintile 4.
196	CHOLECYSTECTOMY W C.D.E. W/O CC	197	Quintile 4.
198	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC	197	Quintile 4.
211	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC	210	Quintile 5.
212	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0–17	210	Quintile 5.
219	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W/O CC	210	Quintile 5.
220	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE 0–17	218	Quintile 5.
229	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	237	Quintile 1.
234	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC	237	Quintile 1.
251	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17.W/O CC	237	Quintile 1.
252	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0–17	253	Quintile 2.
255	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE 0–17	253	Quintile 2.
258	TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	274	Quintile 3.
260	SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	274	Quintile 3.
267	PERIANAL & PILONIDAL PROCEDURES	270	Quintile 3.
275	MALIGNANT BREAST DISORDERS W/O CC	274	Quintile 3.
279	CELLULITIS AGE 0–17	273	Quintile 1.
282	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0–17	281	Quintile 2.
286	ADRENAL & PITUITARY PROCEDURES	292	Quintile 4.
289	PARATHYROID PROCEDURES	63	Quintile 4.
290	THYROID PROCEDURES	63	Quintile 4.
291	THYROGLOSSAL PROCEDURES	63	Quintile 4.
298	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0–17	297	Quintile 1.
303	KIDNEY AND URETER PROCEDURES FOR NEOPLASM	318	Quintile 3.
305	KIDNEY AND URETER PROCEDURES FOR NON-NEOPLASM W/O CC	318	Quintile 3.
307	PROSTATECTOMY W/O CC	306	Quintile 4.
309	MINOR BLADDER PROCEDURES W/O CC	308	Quintile 4.
311	TRANSURETHRAL PROCEDURES W/O CC	310	Quintile 4.
313	URETHRAL PROCEDURES, AGE >17 W/O CC	312	Quintile 3.
314	URETHRAL PROCEDURES, AGE 0–17	312	Quintile 3.
319	KIDNEY & URINARY TRACT NEOPLASMS W/O CC	318	Quintile 3.
322	KIDNEY & URINARY TRACT INFECTIONS AGE 0–17	321	Quintile 1.
326	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC	321	Quintile 1.
327	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0–17	321	Quintile 1.
328	URETHRAL STRICTURE AGE >17 W CC	325	Quintile 2.
329	URETHRAL STRICTURE AGE >17 W/O CC	325	Quintile 2.
330	URETHRAL STRICTURE AGE 0–17	325	Quintile 2.
333	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0–17	332	Quintile 1.
334	MAJOR MALE PELVIC PROCEDURES W CC	335	Quintile 1.
337	TRANSURETHRAL PROSTATECTOMY W/O CC	306	Quintile 4.
340	TESTES PROCEDURES, NON-MALIGNANCY AGE 0–17	339	Quintile 3.
342	CIRCUMCISION AGE >17	339	Quintile 3.
343	CIRCUMCISION AGE 0–17	339	Quintile 3.
349	BENIGN PROSTATIC HYPERTROPHY W/O CC	339	Quintile 3.
351	STERILIZATION, MALE	339	Quintile 3.
353	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY	365	Quintile 4.
354	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	365	Quintile 4.
355	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC	365	Quintile 4.
356	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	365	Quintile 4.
357	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY	365	Quintile 4.
358	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	365	Quintile 4.
359	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	365	Quintile 4.
360	VAGINA, CERVIX & VULVA PROCEDURES	365	Quintile 4.
361	LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	383	Quintile 1.
362	ENDOSCOPIC TUBAL INTERRUPTION	383	Quintile 1.
363	D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	383	Quintile 1.
364	D&C, CONIZATION EXCEPT FOR MALIGNANCY	383	Quintile 1.
370	CESAREAN SECTION W CC	383	Quintile 1.
371	CESAREAN SECTION W/O CC	383	Quintile 1.
372	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	383	Quintile 1.
373	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	383	Quintile 1.

NO VOLUME LTC-DRG CROSSWALK AND QUINTILE ASSIGNMENT FOR FY 2007—Continued

LTC–DRG	Description	Cross-walked LTC–DRG	Low-volume quintile assignment
374	VAGINAL DELIVERY W STERILIZATION &/OR D&C	383	Quintile 1.
375	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	383	Quintile 1.
377	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	383	Quintile 1.
378	ECTOPIC PREGNANCY	383	Quintile 1.
379	THREATENED ABORTION	383	Quintile 1.
380	ABORTION W/O D&C	383	Quintile 1.
381	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	383	Quintile 1.
382	FALSE LABOR	383	Quintile 1.
384	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	383	Quintile 1.
385	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	383	Quintile 1.
386	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	383	Quintile 1.
387	PREMATURITY W MAJOR PROBLEMS	383	Quintile 1.
388	PREMATURITY W/O MAJOR PROBLEMS	383	Quintile 1.
389	FULL TERM NEONATE W MAJOR PROBLEMS	383	Quintile 1.
390	NEONATE W OTHER SIGNIFICANT PROBLEMS	383	Quintile 1.
391	NORMAL NEWBORN	383	Quintile 1.
392	SPLENECTOMY AGE >17	197	Quintile 4.
393	SPLENECTOMY AGE 0–17	197	Quintile 4.
396	RED BLOOD CELL DISORDERS AGE 0–17	399	Quintile 1.
402	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC	395	Quintile 2.
405	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0–17	404	Quintile 3.
407	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC	408	Quintile 4.
411	HISTORY OF MALIGNANCY W/O ENDOSCOPY	173	Quintile 2.
412	HISTORY OF MALIGNANCY W ENDOSCOPY	173	Quintile 2.
417	SEPTICEMIA AGE 0–17	576	Quintile 3.
422	VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0–17	426	Quintile 1.
433	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	523	Quintile 1.
443	OTHER O.R. PROCEDURES FOR INJURIES W/O CC	445	Quintile 2.
446	TRAUMATIC INJURY AGE 0–17	445	Quintile 2.
448	ALLERGIC REACTIONS AGE 0–17	447	Quintile 2.
451	POISONING & TOXIC EFFECTS OF DRUGS AGE 0–17	449	Quintile 3.
455	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC	449	Quintile 3.
481	BONE MARROW TRANSPLANT	394	Quintile 4.
484	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	1	Quintile 5.
485	LIMB REATTACHMENT, HIP & FEMUR PROC FOR MULTIPLE SIGNIFICANT TRAUMA	487	Quintile 4.
494	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	493	Quintile 4.
498	SPINAL FUSION EXCEPT CERVICAL W/O CC	497	Quintile 5.
507	FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA	511	Quintile 1.
518	PERCUTANEOUS CARDIOVASC PROC W/O CORONARY ARTERY STENT OR AMI	125	Quintile 1.
520	CERVICAL SPINAL FUSION W/O CC	497	Quintile 5.
522	ALCOHOL/DRUG ABUSE OR DEPENDENCE W REHABILITATION THERAPY W/O CC	521	Quintile 2.
525	OTHER HEART ASSIST SYSTEM IMPLANT	468	Quintile 5.
528	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE	1	Quintile 5.
530	VENTRICULAR SHUNT PROCEDURES W/O CC	529	Quintile 5.
534	EXTRACRANIAL PROCEDURES W/O CC	500	Quintile 4.
536	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK	517	Quintile 4.
540	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W/O CC	399	Quintile 1.
546	SPINAL FUSION EXC CERV WITH CURVATURE OF THE SPINE OR MALIG	499	Quintile 5.
547	CORONARY BYPASS W CARDIAC CATH W MAJOR CV DX	517	Quintile 4.
548	CORONARY BYPASS W CARDIAC CATH W/O MAJOR CV DX	517	Quintile 4.
549	CORONARY BYPASS W/O CARDIAC CATH W MAJOR CV DX	517	Quintile 4.
550	CORONARY BYPASS W/O CARDIAC CATH W/O MAJOR CV DX	517	Quintile 4.
556	PERCUTANEOUS CARDIOVASC PROC W NON-DRUG-ELUTING STENT W/O MAJ CV DX.	125	Quintile 1.
558	PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W/O MAJ CV DX.	125	Quintile 1.
559	ACUTE ISCHEMIC STROKE WITH USE OF THROMBOLYTIC AGENT	16	Quintile 3.
577	CAROTID ARTERY STENT PROCEDURE	533	Quintile 4

To illustrate this methodology for determining the relative weights for the 183 LTC–DRGs with no LTCH cases, we are providing the following examples, which refer to the no volume LTC–DRGs crosswalk information for FY 2007 provided in the chart above.

Example 1: There were no cases in the FY 2005 MedPAR file used for this final rule for LTC–DRG 3 (Craniotomy Age 0–17). Since the procedure is similar in resource use and the length and complexity of the procedures and the length of stay are similar, we determined that LTC–DRG 1 (Craniotomy Age >17 with CC), which is assigned to low-volume Quintile 5 for the purpose of determining the FY 2007 relative weights, would display similar clinical and resource use. Therefore, we assigned the same relative weight of LTC–DRG 1 of 1.6835 (Quintile 5) for

FY 2007 (Table 11 in the Addendum to this final rule) to LTC–DRG 3.

Example 2: There were no LTCH cases in the FY 2005 MedPAR file used in this final rule for LTC–DRG 91 (Simple Pneumonia and Pleurisy Age 0–17). Since the severity of illness in patients with pneumonia and pleurisy is similar in patients regardless of age, we determined that LTC–DRG 90 (Simple Pneumonia and Pleurisy Age >17 Without CC) would display similar clinical and resource use characteristics and have a similar length of stay to LTC–DRG 91. There were over 25 cases in LTC–DRG 90 in the FY 2005 MedPAR file data used determining the FY 2007 LTC–DRG relative weights in this final rule. Therefore, it would not be assigned to a low-volume quintile for the purpose of determining the LTC–DRG relative weights. However, under our established methodology, LTC–DRG 91, with no LTCH cases, would need to be grouped to a low-volume quintile. We determined that the low-volume quintile with the closest weight to LTC–DRG 90 (0.4958) (refer to Table 11 in the Addendum to this final rule) would be low-volume Quintile 2 (0.5594) (refer to Table 11 in the Addendum to this final rule). Therefore, we assigned LTC–DRG 91 a relative weight of 0.5694 for FY 2007. We note that we will continue to monitor the volume (that is, the number of LTCH cases) that have few or no LTCH cases to ensure that our no volume LTC–DRG crosswalking and relative weight assignment results in appropriate payments for such cases and does not result in an unintended financial incentive for LTCHs to inappropriately admit these types of cases.

Furthermore, as was proposed, we are establishing LTC–DRG relative weights of 0.0000 for heart, kidney, liver, lung, pancreas, and simultaneous pancreas/kidney transplants (LTC–DRGs 103, 302, 480, 495, 512, and 513, respectively) for FY 2007 in this final rule because Medicare will only cover these procedures if they are performed at a hospital that has been certified for the specific procedures by Medicare and presently no LTCH has been so certified. Based on our research, we found that most LTCHs only perform minor surgeries, such as minor small and large bowel procedures, to the extent any surgeries are performed at all. Given the extensive criteria that must be met to become certified as a transplant center for Medicare, we believe it is unlikely that any LTCHs would become certified as a transplant center. In fact, in the nearly 20 years since the implementation of the IPPS, there has never been a LTCH that even expressed an interest in becoming a transplant center.

However, if in the future a LTCH applies for certification as a Medicare-approved transplant center, we believe that the application and approval procedure would allow sufficient time for us to determine appropriate weights for the LTC–DRGs affected. At the present time, we would only include these six transplant LTC–DRGs in the GROUPER program for administrative purposes. Because we use the same GROUPER program for LTCHs as is used under the IPPS, removing these LTC–DRGs would be administratively burdensome.

Again, we note that, as this system is dynamic, it is entirely possible that the number of LTC–DRGs with a zero volume of LTCH cases based on the system will vary in the future. We used the best most recent available claims data in the MedPAR file to identify zero volume LTC–DRGs and to determine the relative weights in this final rule.

Table 11 in the Addendum to this final rule lists the LTC–DRGs and their respective relative weights, geometric mean length of stay, and five-sixths of the geometric mean length of stay (to assist in the determination of short-stay outlier payments under § 412.529) for FY 2007.

We also wish to point out that in section VI.A.5. of the preamble of this rule, we discuss our revision to the regulations for grandfathered HwHs, grandfathered hospital satellite facilities, and grandfathered satellite units at §§ 412.22(f), 412.22(h), and 412.25(e), respectively. In addition, in section VI.A.6. of the preamble of this final rule, we discuss our revision and clarification to the existing policies governing the determination of LTCHs' CCRs and the reconciliation of high-cost and short-stay outlier payments under the LTCH PPS based on the proposal presented in the FY 2007 IPPS proposed rule (71 FR 24126 through 24135).

5. Summary of Public Comments and Departmental Responses

Comment: Numerous commenters opposed the proposed changes in the LTC–DRG weights, which they noted would result in an approximately 1.4 percent decrease in estimate aggregate payments to LTCHs. Several of the commenters noted that LTCHs had been subject to a number of "significant Medicare payment reductions in recent years," including an estimated 4.2 percent reduction as a result of the reweighting of the LTC–DRGs for FY 2006; a zero update (as opposed to a 3.4 percent market-basket increase) in the Federal rate for RY 2007; an estimated 3.7 percent decrease caused by the revised short-stay outlier payment policy for RY 2007; and, most recently, the estimated 1.4 percent reduction as a result of the proposed reclassification and reweighting of the LTC–DRGs for FY 2007. The commenters maintained that the cumulative effect of these established and proposed Medicare payment reductions is not sustainable for the LTCH industry and will cause much "volatility" for LTCH providers, and also restrict access to LTCHs for patients.

One commenter provided a chart that indicated that if CMS finalizes the proposed LTC–DRG relative weights, LTCH industry-wide margins would approximate 0 percent. Another commenter, an association that represents large LTCH chains, urged CMS to postpone implementation of the proposed FY 2007 reweighting of the LTC–DRGs until an analysis of the impact of this change on payment adequacy, as well as other payment changes established for RY 2007, is conducted.

Response: While we understand the commenters' concerns with the estimated decrease of 1.4 percent in LTCH PPS payments as a result of the proposed changes in the LTC–DRGs, and relative weights for FY 2007, we did not propose any changes in the methodology used to determine the proposed recalibration of the LTC–DRG relative weights for FY 2007. (We note that based on the final LTCH–DRG relative weights for FY 2007 the estimate is a 1.3 percent decrease.) The proposed update to the LTC–DRG relative weights for FY 2007 is based on the proposed Version 24.0 of the CMS GROUPER (including the proposed changes in the DRG classifications relative weights and geometric mean length of stay) and FY 2005 LTCH claims data. For this final rule, we used updated data as described previously. In the FY 2003 final rule for the LTCH PPS, which first implemented the payment system, we described in great detail, the methodology for the development of the LTC–DRG relative weights, and we have reiterated these steps in every subsequent rulemaking cycle. (When we revised our regulations at § 412.535, establishing the LTCH PPS rate year, while still publishing the LTC–DRG updates on the Federal fiscal year (October through September) cycle, we continued to include a brief write-up of our LTC–DRG update methodology in the annual LTCH PPS proposed and final rules and a comprehensive description of the policy in the annual IPPS proposed and final rules (67 FR 55984–55995; 68 FR

34131–34132; 69 FR 25681; 69 FR 48989–48999; 70 FR 24177–24178; 70 FR 37323–37341; and 71 FR 27808).) There has been no methodological change in the way in which the LTC–DRG relative weights are computed since the implementation of the LTCH PPS. The annual determination of the LTC–DRG relative weights is data-driven; that is, based on claims data in the most current MedPAR files which are derived from patient bills submitted by LTCHs.

We agree with the commenters who noted that the LTCH industry has indeed been impacted by significant changes since the start of the LTCH PPS for FY 2003. Since we first established the LTCH PPS, the unadjusted Federal payment rate, which began at $34,956.15, increased to $38,086.64 for RY 2006. (The zero percent update finalized in the RY 2007 LTCH PPS final rule (71 FR 27798) resulted in the stabilization of this amount for RY 2007.) From RY 2005 to RY 2006, there was a 5.7 percent increase in estimated aggregate LTCH PPS payments (70 FR 24217). The average Medicare payment per case for FY 2003 was reported at $26,751, while, for RY 2006, it was estimated to be $33,208, which is an increase of over 24 percent. Significantly, there was a 13.8 percent increase in estimated Medicare payments to LTCHs in RY 2005 alone. The results of the first 2 years of this "volatility" were aggregate industry margins estimated at 7.8 percent for FY 2003, and for FY 2004, preliminary cost report data revealed an estimated average Medicare margin of 12.7 percent, as stated in the RY 2007 LTCH PPS final rule (71 FR 27819).

The commenters noted the Medicare payment reductions in recent years, including the estimated 4.2 percent reduction for FY 2006 due to the recalibration of the LTC–DRG weights and the estimated 1.4 percent decrease in aggregate LTCH PPS payments due to the proposed update to the LTC–DRG relative weights for FY 2007. As noted above, the decrease in average case-mix based on the proposed LTC–DRG relative weights for FY 2007 as compared to FY 2006, as well as the decrease in average case-mix from FY 2006 as compared to FY 2005, which were estimated to result in an aggregate estimated decrease in LTCH PPS payments, were data driven. For this final rule they remain data driven as well. In the FY 2006 IPPS proposed rule (70 FR 23667), we noted that we continued to observe a significant increase of relatively lower charge cases being assigned to LTC–DRGs with higher relative weights in the prior year. The addition of these lower charge cases resulted in a decrease in many of the LTC–DRG relative weights from FY 2005 to FY 2006. This decrease in many of the LTC–DRG relative weights, in turn, resulted in an estimated decrease in LTCH PPS payments from FY 2005 to FY 2006. As we explained in that same rule, contributing to this increased number of relatively lower charge cases being assigned to LTC–DRGs with higher relative weights in the prior year were improvements in coding practices, which are typically found when moving from a reasonable cost-based payment system to a PPS.

Our analyses of data from the March 2005 update of the FY 2004 MedPAR files, which were used to calculate the FY 2006 LTC–DRG relative weights, and the most recent update of the FY 2005 MedPAR files which were used to determine the proposed and final FY 2007 LTC–DRG relative weights continue to show an increase of relatively lower charge cases being assigned to LTC–DRGs with higher relative weights in the prior year. As we explained in the FY 2006 IPPS final rule (70 FR 47335) and the FY 2007 IPPS proposed rule (71 FR 24413), the impact of including cases with relatively lower charges into LTC–DRGs that had a relatively higher relative weight in the previous fiscal year's GROUPER is a decrease in the average relative weight for those LTC–DRGs, which, in turn, may result in an estimated aggregate decrease in LTCH PPS payments.

The commenters also mentioned the zero update to the RY 2007 standard Federal rate as one of the "significant Medicare payment reductions in recent years." In the RY 2007 LTCH PPS final rule (71 FR 27819 through 27827), we explained our rationale for establishing a zero percent update to the standard Federal rate for the 2007 LTCH PPS rate year, which was based on the most recent estimate in the Rehabilitation, Psychiatric and Long-Term Care (RPL) market basket offset by an adjustment for changes in coding practices that are unrelated to case mix, rather than solely using the most recent estimate of the RPL market basket to update the RY 2006 Federal rate. This market basket offset resulted from a number of factors that included our ongoing monitoring activities, which prompted us to examine the changes in LTCHs' patient case-mix index and margins since the inception of the LTCH PPS for FY 2003 (67 FR 56014).

First, we noted that there has been tremendous growth in the number of LTCHs reimbursed by Medicare. Specifically, the number of LTCHs almost doubled from approximately 200 LTCHs in FY 2003 to 378 LTCHs at the start of FY 2005. In addition, Medicare spending for LTCHs has also grown rapidly, as noted in MedPAC's June 2004 Report to Congress (page 122). Rapid increases in LTCH growth and Medicare spending under the LTCH PPS, in conjunction with the fact that over 98 percent of LTCHs are currently paid based fully on the Federal rate (rather than choosing to be paid under a blend of the reasonable cost-based (TEFRA) payment amount and the LTCH PPS Federal rate payment amount), prompted us to examine changes in LTCHs' patient case-mix index and margins under the LTCH PPS. We believed the zero percent update factor for RY 2007, which was based on the most recent estimate of the RPL market basket at that time, adjusted to account for coding changes, was supported by our findings regarding the case-mix index, Medicare margins, and patient census based on the most recent complete LTCH data.

As we explained in considerable detail in the RY 2007 final rule for the LTCH PPS (71 FR 27818 through 27824), a LTCH's case-mix index is defined as the case-weighted average LTC–DRG relative weight for all its discharges in a given period. Changes in the case-mix index consist of two components: "real" case-mix index changes and "apparent" case-mix index changes. Real case-mix index increase is defined as the increase in the average LTC–DRG relative weights resulting from the hospital's treatment of more resource intensive patients. Apparent case-mix index increase is defined as the increase in computed case-mix index that is due to changes in coding practices (including better documentation of the medical record by physicians and more complete coding of the medical record by coders). Observed case-mix index increase is defined as real case-mix index increase plus the apparent case-mix index increase.

If LTCH patients have more costly impairments, lower functional status, or increased comorbidities, and thus require more resources in the LTCH, we consider this a real change in case-mix. Conversely, if LTCH patients have the same impairments, functional status, and comorbidities but are coded differently resulting in higher payment, we consider this an apparent change in case-mix. We believe that changes in payment rates should accurately reflect changes in LTCHs' true cost of treating patients (real case-mix index increase), and should not be influenced by changes in coding practices (apparent case-mix index increase). Apparent case-mix index increase results in a case

being grouped to a LTC–DRG with a higher weight than it would be without such changes in coding practices, which results in a higher payment to the LTCH that does not necessarily reflect the true cost of treating the patient. Therefore, in the RY 2007 LTCH PPS final rule (71 FR 27798) under the broad discretionary authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of the BIPA to include appropriate adjustments, including updates, in the establishment of the LTCH PPS, we revised the annual update to the LTCH PPS standard Federal rate set forth at § 412.523(a)(2) for the 2007 LTCH PPS rate year to adjust the payment amount for LTCH inpatient hospital services to eliminate the effect of coding or classification changes that do not reflect real changes in LTCHs' case-mix.

Our determination to specifically provide a zero update resulted from data analysis by 3M Health Information Systems (3M) regarding changes in case-mix and coding since the implementation of the LTCH PPS, based on the most recently available data, which compared FY 2003 LTCH claims data from the first year of implementation of the PPS with FY 2004 LTCH claims data, and also looked at FY 2001 claims data (generated prior to the implementation of the LTCH PPS). (The FY 2001 data was the same LTCH claims data used to develop the LTCH PPS.) The analysis indicated, among other things, that the average annual case-mix index increase from FY 2001 to FY 2003 was 2.75 percent. Since coding of diagnoses was not a factor in determining payments under the former reasonable cost-based (TEFRA) payment system, and since payments were not directly tied to diagnosis codes, there was no incentive for LTCHs to attempt to influence payments through changes in coding practices. Therefore, it was reasonable to assume that the observed 2.75 percent change in case-mix in the years prior to the implementation of the LTCH PPS represent the value for the real case-mix index increase (that is, we assumed that the 2.75 percent increase in case-mix is due to treatment of more resource intensive patients, rather than to improvements in documentation or more complete coding of the medical record during this period). Using the average annual 2.75 percent observed case-mix index increase as a baseline, we separated the computed case-mix index increase between FY 2003 and FY 2004 into the real case-mix index increase, which is based on the treatment of more resource intensive patients, and the apparent case-mix index increase, due to improvements in documentation and coding practices.

As we stated in the RY 2007 LTCH PPS final rule (71 FR 27820), the calculated observed case-mix index increase between FY 2003 and FY 2004 was 6.75 percent. Assuming that the real case-mix index increase observed (on average) from FY 2001 to FY 2003 remained relatively constant into FY 2004, then the difference of 4.0 percent (6.75 percent minus 2.75 percent) represented the apparent case-mix index increase that was due to improvements in documentation and coding. This was considerably higher than the 0.34 percent behavioral offset originally estimated by the CMS Office of the Actuary, which was used in the development of the FY 2003 LTCH PPS standard Federal rate (67 FR 56033). Therefore, we believed that it was appropriate that the market basket be offset by an adjustment to account for changes in coding practices that do not reflect changes in real case mix. This adjustment was implemented to ensure that the LTCH PPS payment rates continue to reflect, as closely as possible, the true costs of treating LTCH patients. It was our intent that such an adjustment to the most recent estimate of the LTCH PPS market basket would eliminate the effect of coding or classification changes that did not reflect real changes in LTCHs' case-mix in prior years.

Regarding the impact of the revised short-stay outlier policy on Medicare payments to LTCHs, we continue to believe that the revisions we established to the short-stay outlier payment adjustments in the RY 2007 LTCH PPS final rule were highly appropriate and that they provide fair and reasonable payment for short-stay patients in LTCHs, which are required to meet the same certification criteria as short-term acute care hospitals set forth in section 1861(e) of the Act and generally have an average length of stay of greater than 25 days. Therefore, our present policy under the short-stay outlier policy at § 412.529, effective for discharges beginning on or after July 1, 2006, is to base Medicare payment on the least of 100 percent of the estimated costs of the discharge, 120 percent of the LTC–DRG per diem payment amount multiplied by the length of stay, the full LTC–DRG payment, or a LTCH PPS payment based on a blend of the IPPS-comparable per diem payment amount (capped at the full IPPS comparable payment amount) and a payment based on 120 percent of the LTC–DRG per diem amount.

We believe that this finalized policy clearly demonstrates our rationale, which is that as the length of a short-stay outlier case increases, the case begins to resemble a more "typical" LTCH stay as defined under section 1886(d)(1)(B)(IV)(I) of the Act and envisioned by the statutes authorizing the establishment of the LTCH PPS. Furthermore, the estimated 3.7 percent decrease in payments cited by the commenters will only have an impact on payments to those LTCHs that continue to admit a large number of very short-stay patients. We believe that the previous short-stay outlier policy, under which Medicare paid the least of 120 percent of the estimated cost of the case, 120 percent of the per diem LTC–DRG multiplied by the length of stay, or the full LTC–DRG, inadvertently provided an incentive for a LTCH to inappropriately admit patients who could otherwise have been treated in acute care hospitals and paid for under the IPPS. Therefore, we believe the provisions of the short-stay outlier policy that were finalized in the RY 2007 LTCH PPS final rule (71 FR 27845 through 27872) will result in fair and equitable payment for short-stay patients at LTCHs.

In response to the commenter who provided a chart that indicated industry-wide margins of approximately zero percent because of the proposed changes in the LTC–DRG relative weights that are anticipated to result from the 1.4 percent payment reduction, we continue to believe that our case-mix analysis (case-mix index) and Medicare margins analysis are sound. In the RY 2007 final rule for the LTCH PPS, we calculated "revenue-weighted" Medicare margins, which are the sum of hospital inpatient Medicare revenue (payments) minus the sum of hospital inpatient Medicare expenses (costs) divided by the sum of hospital inpatient Medicare revenue (payments). This margin analysis, which is also utilized by MedPAC in its analyses, is used to evaluate the overall financial status of LTCHs in general. In our analysis of the latest available LTCH data, we found that LTCH Medicare margins for FY 2003 (the first year of the LTCH PPS) were 7.8 percent, and preliminary data for FY 2004 based on the most recent HCRIS data revealed an even higher Medicare margin of 12.7 percent. Moreover, our analysis of LTCHs' payments and costs per discharge based on the latest available cost report data supports our adjustment to account for changes in coding practices that do not reflect changes in real case mix because it shows that, while payments (revenue) increased approximately 15 percent from FY 2002 to FY 2003, costs

(expenses) per discharge increased by only 8 percent for the same period.

Thus, payments to LTCHs from FY 2002 to FY 2003 increased almost twice as much as the increase of costs for the same period. We also noted that even though we established a zero update to the Federal payment rate for RY 2007, we continue to believe that, based on the sizeable Medicare margins among LTCHs, the standard rate for the RY 2007 LTCH PPS will not affect beneficiary access to LTCH services because LTCHs will continue to be paid adequately to reflect the cost of resources needed to treat Medicare beneficiaries. We also note that MedPAC's March 2006 Report to Congress on Medicare Payment Policy included similar data on margins and, based on its indepth evaluation of payment adequacy for LTCHs for 2006, MedPAC recommended that there be no update to the LTCH PPS Federal rate for RY 2007.

In addition, we do not believe that it would be appropriate to "postpone implementation" of the proposed reweighting of the LTC–DRGs pending an analysis of the impact on LTCH payment adequacy of this change, as well as other payment changes established for LTCHs for RY 2007. The annual recalibration of the LTC–DRG relative weights, which is based on patient data, is one of the cornerstones of all prospective payment systems. To reiterate, we believe that the policies finalized for RY 2007, including the zero percent update to the standard Federal rate and the payment adjustment for short-stay outlier cases, do not provide any impediment to the ability of LTCHs to continue to maintain the quality or the availability of appropriately delivered LTCH services to Medicare beneficiaries.

Comment: Several comments questioned the methodology that we used that distinguishes between payment "reductions" resulting from the zero update to the standard Federal rate finalized in the RY 2007 LTCH PPS final rule and payment reductions resulting from the proposed reweighting of the LTC–DRGs for FY 2007. One commenter asserted that CMS has utilized the same rationale as a basis to propose to reduce the FY 2007 LTC–DRG relative weights that were used to apply a zero percent update in the RY 2007 LTCH PPS final rule. The commenters believed CMS has double-counted the same phenomenon.

Another commenter stated that, because the LTC–DRG relative weights are not updated in a budget-neutral manner, through the annual recalibration of the weights, the LTC–DRG system will "self-correct over time" without the need for any lowering of the Federal payment rate. The commenter believed that this non-budget neutral weight recalibration will continue to correct for the case-mix creep until coding improvement reaches a plateau, at which point annual case-mix variation will reflect actual variations in case-mix intensity. Citing our justification of "apparent" as opposed to real case-mix increase based on FY 2004 LTCH data for the zero percent update to the Federal rate for RY 2007, the commenter believed that CMS has overpenalized LTCHs by a net 4.2 percent. The commenter recommended that CMS work with the industry to establish an update system that eliminates the possibility of "over reduction" due to case-mix creep by one of the following options: implementing a budget neutral recalibration system and address case-mix creep through the update; or alternatively, maintaining the current non-budget neutral weight recalibration system but foregoing any future Federal rate update reduction for case-mix creep.

Response: The commenters have expressed concern that, if we finalize the proposed change in the FY 2007 LTC–DRG relative weights, the change would result in an estimated 1.4 percent decrease in payments. Because we have already finalized the zero update to the RY 2007 standard Federal rate, the commenters believe we will have reduced payments to LTCHs twice for the same phenomenon. We would like to remind the commenters that the "zero percent" update to the Federal rate for RY 2007 did not reduce LTCH PPS payments from their previous level. Instead, the Federal rate remained at $38,086.04 from RY 2006 to RY 2007. Furthermore, we disagree and do not believe that LTCHs are being penalized twice, once through adjustment of the standard Federal rate and again due to the proposed and finalized recalibration of the LTC–DRG relative weights for FY 2007.

In the LTCH PPS RY 2007 final rule, we addressed a similar allegation by commenters that we were "unfairly penalizing" LTCHs twice in proposing the zero percent update to the standard Federal rate as a remedy for inappropriate Medicare payments to LTCHs resulting from "case-mix creep" (that is, the "apparent" case-mix index increase) between FYs 2003 and 2004. At that time, several commenters stated that CMS had already corrected any coding issues from FY 2004 by the annual recalibration of the LTC–DRGs for FY 2006 based on case-mix changes from FYs 2003 and 2004, which resulted in an estimated decrease of 4.2 percent in payments to LTCHs.

In the RY 2007 LTCH PPS final rule (71 FR 27882), we presented the explanation of the distinction between the annual reweighting of the LTC–DRGs, which we expect to result in appropriate payments for the forthcoming fiscal year's LTCH discharges, and determinations regarding the appropriate application of adjustments to the market basket increase applied to the standard Federal rate which was established to account for payments made in a prior year that were based on improved coding rather than increased patient severity (71 FR 27821). At that time, we reviewed the discussion in the FY 2006 IPPS final rule (70 FR 47701–47702) in which we estimated that a payment reduction of −4.2 percent would result from the FY 2006 recalibration of the LTC–DRG relative weights, which were based on LTCH claims data from the FY 2004 MedPAR file. We stated "* * * [t]hus FY 2004 LTCH claims data, which reflected improved coding, were used to determine the LTC–DRG relative weights used to pay LTCH PPS discharges occurring during FY 2006. While it is true that the reweighting of the LTC–DRGs using FY 2004 LTCH claims served to update the relative weights based on actual claims data in each LTC–DRG, which also reflects coding improvements that occurred in FY 2004, the recalibration of LTC–DRG weights only corrects for any coding improvement for the purpose of making accurate LTCH PPS payments in FY 2006." (71 FR 27822)

However, annual recalibration does not serve to account for payments that were made based on improved coding (rather than patient severity) in prior years. The case-mix adjustment to the market basket in determining the RY 2007 Federal rate is meant to reduce current payments to account for the increase payments that occurred in FY 2004 that resulted from the CMI increase that is attributable to "case-mix" creep in that year 71 FR 27822).

We also explained the rationale and computations underlying our update for RY 2007 in that same final rule: "In the RY 2007 LTCH PPS proposed rule, we proposed to offset the market basket by an amount equal to the increase in case mix that was due solely to improved documentation and coding rather than changes in real case mix. At the time of the proposed rule, that increase was within rounding error of the market basket, and therefore resulted in a proposed Federal rate for RY 2007 that was equal to the RY 2006 Federal rate, and not a reduction to the RY 2006

Federal rate." (71 FR 27821). Therefore, this policy determination regarding the market basket increase of zero percent for RY 2007 was based on changes in the LTCHs' case-mix indices in conjunction with a broader analysis of trends in the LTCH industry (noted most recently by MedPAC in the Commission's March 2006 Report to the Congress (page 211)) and in particular, driven by a detailed analysis of LTCH margins since the implementation of the LTCH PPS. As we stated in that same final rule, we believe that, in determining the Federal rate update for RY 2007, it is appropriate to apply an adjustment to the most recent estimate of the LTCH PPS market basket to eliminate the effects of coding and classification changes that do not reflect changes in real case-mix. This adjustment is necessary to account for prior year payments that were made based on improved coding practices (rather than increased patient severity) (71 FR 27821). Furthermore, we note that FY 2004 LTCH claims data were used to determine the adjustment to the market basket to account for changes in coding practices in establishing the zero percent update to the Federal rate for RY 2007, while FY 2005 LTCH claims data were used to determine the proposed and final FY 2007 LTC–DRG relative weights. Because LTCH claims data from different years were used to determine the two adjustments noted by the commenters, we further disagree that we "double counted the same phenomenon."

Regarding our margins analysis, based on data from the LTCHs' cost reports received as of December 31, 2005, updated LTCH margins analysis for the LTCH PPS RY 2007 final rule continued to show high Medicare margins among LTCHs since the implementation of the LTCH PPS in FY 2003. As noted in the RY 2007 LTCH PPS final rule, "[w]e calculated 'revenue-weighted' Medicare margins, which are the sum of hospital inpatient Medicare revenue (payments) minus the sum of hospital inpatient Medicare expenses (costs) divided by the sum of hospital inpatient Medicare revenue (payments). This margin calculation, also utilized by MedPAC in its analyses, is used to evaluate the overall financial status of LTCHs in general. In an analysis of the latest available LTCH cost reports, we found that LTCH Medicare margins for FY 2003 (the first year of the LTCH PPS) were 7.8 percent and preliminary cost report data for FY 2004 based on the most recent update to the cost report data in HCRIS reveal an even higher Medicare margin of 12.7 percent. For periods prior to the implementation of the LTCH PPS (that is, FY 1999 through FY 2002), we found that aggregate Medicare margins ranged between a minimum of −2.3 percent in FY 2000, and a maximum of 1.5 percent in FY 2002." (71 FR 27823).

We wish to emphasize that, as we specified in the RY 2007 LTCH PPS proposed rule, the large observed increase in LTCH case-mix was not accompanied by a corresponding increase in Medicare costs. This was consistent with our belief expressed earlier that a significant part of this observed increase in case-mix was "apparent" and not "real." In conjunction with an increase in real case-mix (that is, patient severity), we would have expected to see a significant increase in costs per discharge, even taking into account LTCH operating efficiencies, to pay for the resources needed to treat sicker patients. Consistent with MedPAC's most recent research discussed in its March 2006 Report to Congress (section 4C), our margins analysis indicated that, in spite of the estimated real increase in case-mix (severity of patients), payments to LTCHs under the LTCH PPS are generally more than adequate to cover the Medicare costs of the inpatient hospital services provided to LTCH patients.

Therefore, for the reasons discussed above, we disagree with the commenters who believe that we "double counted the same phenomenon." To summarize, the purpose of the adjustment to the market basket which was to account for changes in coding practices that resulted in a zero percent update to the Federal rate for RY 2007 and the changes in payments that will result from the proposed and final reweighting of the LTC–DRGs are different. Specifically, the objective of our adjustment to the standard Federal rate update for RY 2007 was to adjust payments to account for prior year payments made by the Medicare program that were due to changes in coding practices, that did not reflect actual costs of beneficiary care. However, the annual recalibration of the relative weights for LTC–DRGs reflects the variation in coding practices and charges from the previous year and it helps ensure that the LTC–DRG relative weights in the upcoming fiscal year will result in appropriate payments to LTCHs for the resources they expend to treat patients. This was the case for FY 2006, when LTC–DRG relative weight recalibrations were estimated to result in a payment decrease of 4.2 percent and it was also the case for the estimated 1.4 percent decrease based on the proposed LTC–DRG relative weights for FY 2007. It is also the case for the estimated 1.3 percent decrease in this final rule due to the recalibration of the LTC–DRG relative weights.

Therefore, in response to the commenter who presented an "either/or" scenario suggesting that we should adjust payments based on case-mix variation through the present (that is, not budget neutral) recalibration of the LTC–DRG relative weights but forego any future Federal rate update for case-mix creep, or we should address "case-mix creep" through the annual update in the Federal rate but implement a budget neutral recalibration system, we do not believe that this approach is appropriate, given that, as discussed in greater detail above, the purposes of the case-mix adjustments in each context are distinct. It is possible that if coding practices stabilize and reach "a plateau," as one of the commenters suggested, and case-mix variation only reflects real variations in case-mix intensity, the "self-correcting" mechanism of the annual recalibrations of LTC–DRG relative weights may be a reliable indication of actual costs at LTCHs by DRG. However, we emphasize that there is a distinct difference between the payment adjustments that could result from data-driven determinations that we consider, as described earlier, when we promulgate our policy regarding the annual application of the market basket update to the standard Federal rate and the data-driven effects of the recalibration of the LTC–DRG relative weights. Moreover, we do not believe that the zero update to the standard Federal rate implemented for RY 2007, which was intended to adjust for payments that were reflective of payments that were made based on improved coding rather than patient severity in 2004, and the reweighting of the relative weights for the LTC–DRGs, which would only address making appropriate payments for FY 2007, have resulted in an "over reduction" of payments to LTCHs, or overpenalized the LTCH industry.

As we have stated most recently in the RY 2007 LTCH PPS final rule, we discussed a potential framework to update payments to LTCHs that would account for appropriate factors that affect efficient delivery of services and care to Medicare beneficiaries (71 FR 27818), and we have solicited comments on the presentation of a model for such a framework presented in Appendix A of that final rule. Presently, however, in the absence of a more comprehensive update framework, we believe that it is necessary and appropriate for us to evaluate the need of applying an

adjustment to the full market-basket increase, based upon the best available data and policy considerations. Similarly, we believe it is appropriate to update the LTC–DRG relative weights based on the latest available data because the more recent data ensure that the LTC DRG relative weights for FY 2007 best reflect the resources actually used in the treatment of LTCH patients.

Comment: Several commenters discussed the impact of policies that we proposed under the IPPS for short-term, acute care hospitals (that is, the adoption of severity-adjusted DRGs; and the implementation of HSRVcc (cost-based weights) methodology for calibration of DRG weights) in their evaluation of the proposed 1.4 decrease in the LTC–DRG payments based on the proposed LTC–DRG changes for FY 2007. Both commenters urged us not to implement the proposed LTC–DRG relative weights because they believe that the discussion of the severity-adjusted DRGs in the proposed rule emphasized the fact that the LTC–DRG classifications, as they currently exist, do not accurately capture the full measure of severity for LTCH patients.

One commenter commissioned a study by the Lewin Group that utilized claims data from the FY 2005 MedPAR file and cost report data from FY 2003 to simulate the HSRVcc methodology set forth in the proposed rule. The commenter stated that the result was that, rather than a estimated 1.4 percent payment reduction, the HSRVcc method of determining LTC–DRG relative weights resulted in an estimated 1.5 percent increase in LTCH PPS payments. The commenter added that this indicates that there can be reasonable differences as to what is the most accurate method of establishing relative weights under PPSs and that the Secretary should adjust the LTC–DRG weights this year on a budget-neutral basis, thus eliminating the estimated 1.4 percent decrease based on the proposed LTC–DRG relative weights. The commenter recommended that, although the authorizing legislation contemplates that CMS use the most recently available LTC–DRG weights for an annual update, the Secretary could use his broad authority to modify the LTC–DRG payments, as appropriate, and in order to accurately reflect current LTCH patient care. The commenter believed that the FY 2006 LTC–DRG relative weights should be maintained for FY 2007 because they more accurately account for the expected resources to be used by LTCH patients in FY 2007.

Another commenter noted that, based on the discussion in the FY 2007 proposed rule, CMS believes that severity-adjusted DRGs would improve the accuracy of the DRG system under the IPPS, and consequently, the commenter believed that, for FY 2008, severity-adjusted LTC–DRGs could be considered because they may better account for differences in severity of illnesses and associated costs across hospitals. This commenter further stated that higher weighted LTC–DRGs (and the LTCHs that treat them) are more vulnerable to the payment reductions proposed for FY 2007 based on proposed LTC–DRG relative weights because payment rates for higher acuity LTCH patients will be diluted by the FY 2005 upcoding of many lower severity cases to the higher weighted DRGs. In addition, the commenter pointed to the revised short-stay outlier policy established in the RY 2007 LTCH PPS final rule which, they believe, is intended to reduce the number of lower-acuity patients being treated in LTCHs, and stated that those LTCH patients that are not short-stay outlier cases will be more typical of LTCH patients and, therefore, have higher acuity. The same commenter also mentioned that the FY 2005 data that are being proposed to be used to reweight the LTC–DRGs for FY 2007 represent a system "still in flux" because the system is still transitioning to full payment under the LTCH PPS and only a portion of each case is being paid based on LTC–DRGs. For these reasons, the commenter urged CMS to postpone further LTC–DRG rate reductions and instead recommended that CMS address coding improvements comprehensively in FY 2008 under the LTCH PPS in the context of the improved severity measures proposed under the IPPS for FY 2008 (or earlier).

Response: We understand that the commenters are concerned with the 1.4 percent decrease in estimated aggregated LTCH PPS payments for FY 2007 due to the proposed reweighting of the LTC–DRGs. We also understand that the commenters believe that the adoption of a severity-adjusted patient classification system under the LTCH PPS applied to the LTC–DRGs and the use of cost-based weights (HSRVcc) methodology could result in a different estimated aggregate payment change for FY 2007. However, as we discussed in greater detail below, we do not agree that the FY 2006 relative weights would more accurately represent resource use by LTCH patients for FY 2007 and that it would be necessary or appropriate to postpone the finalization of the annual reweighting of the LTC–DRGs. The current (FY 2006) LTC–DRG relative weights were determined based on FY 2004 LTCH claims data from the MedPAR files. For FY 2007, we proposed to use our existing relative weight methodology (established when the LTCH PPS was implemented for FY 2003) and FY 2005 LTCH claims data from the MEDPAR files to recalibrate the LTC–DRG relative weights, as these were currently the most recent complete LTCH claims data. As was proposed, for this final rule, we are using the March 2006 update of the FY 2005 MedPAR files because this is currently the most recent and complete LTCH claims data. We believe that the FY 2005 data are the best LTCH data available that reflect LTCHs' current treatment practice and coding patterns. Therefore, because the FY 2005 LTCH claims data better reflects current LTCH behavior than the FY 2004 LTCH claims data that was used to determine the FY 2006 LTC–DRG relative weights, we believe that using this updated (FY 2005) LTCH claims data with our existing relative weight methodology will result in LTC–DRG relative weights for FY 2007 that will best reflect the resources actually utilized by LTCHs in treating their Medicare patients.

With respect to the accuracy of the current LTCH–DRG system, we note the following. For FY 2003, we decided to adopt the current LTC–DRG system stating, "the LTC–CMS–DRG system is a system that is familiar to hospitals because it is based on the current DRG system under the acute care hospital inpatient prospective payment system. We believe that the familiarity of the LTC–CMS–DRG model may best facilitate the transition from the reasonable cost-based system to the prospective payment system as well as providing continuity in payment methodology across related sites of care (for example, an acute care hospitalization for a patient with a chronic condition)" (67 FR 55966). However, we have noted that we believed that there may be significant advantages in the use of severity-adjusted LTC–DRGs. In fact, when we were developing the LTCH PPS for FY 2003, we seriously considered using a specially modified version of the APR–DRGs (67 FR 55966–55967). At that time, we stated:

"The LTC–APR–DRGs, a condensed version of 3M's all-patient refined DRGs (APR–DRGs) for acute care hospitals, was developed by 3M Health Information Systems, for exclusive use in LTCHs. The LTC–APR–DRG system was designed to reflect the clinical characteristics of LTCH patients. This case-mix classification model contains 26 base LTC–APR–DRGs, subdivided by 4 severity of illness levels to yield 104 classification levels. In this system, the

patient's secondary diagnoses, their interaction, and their clinical impact on the primary diagnosis determine the severity level assigned to each of the 26 LTC–APR–DRGs" (67 FR 55966).

When we decided to use the same patient classification system as the IPPS, following a comprehensive analysis of both the LTC–APR–DRGs and the existing DRG system (modified by the use of quintiles for low volume DRGs) for the particular purposes of patient classification at LTCHs, we indicated that we believed that either classification system would result in appropriate payments for LTCHs under the PPS. However, we noted several issues to consider concerning the LTC–APR–DRG system, including—

"* * * its complexity, its clinical subjectivity, and its utility as it relates to other Medicare prospective payment systems. The LTC–APR–DRG model provides a clinical description of the population of LTCHs, patients exhibiting a range of severity of illness with multiple comorbidities as indicated by secondary diagnoses. The clinical interaction of the primary diagnosis with these comorbidities determines the severity level of the primary diagnoses, resulting in the final assignment to a LTC–APR–DRG by the GROUPER software designed for this system" (67 FR 55966).

We further noted that "* * * determining whether particular comorbidities increase the cost of a case for a LTCH patient is complicated by the nature of the clinical characteristics of these patients. More specifically, many LTCH patients have numerous conditions that may not all be relevant to the cost of care for a particular discharge. Although the patient actually has a specific condition, including this condition among secondary diagnoses coded under the LTC–APR–DRG system may assign an inaccurate severity level to the primary diagnosis and result in inappropriate LTC–APR–DRG payment. We also believe that reliance on existing comorbidity information submitted on LTCH bills could result in significant variation in the assignment of the specific LTC–APR–DRGs" (67 FR 55967).

We concluded our explanation in the FY 2003 final rule for the LTCH PPS by stating that "[e]ven though we are using LTC–DRGs in the LTCH prospective payment system in this final rule, we may have the opportunity to propose a severity-adjusted patient classification for LTCHs in the future, particularly if the acute care hospital inpatient prospective payment system moves in this direction" (67 FR 55967). As we noted in the FY 2007 IPPS proposed rule, if and when a severity-adjusted patient classification system is adopted under the IPPS, we would need to consider whether to propose revisions to the patient classification system used under the LTCH PPS. Any proposed changes to the patient classification system would be done through notice and comment rulemaking (71 FR 24051). Subsequently, in 2005, MedPAC recommended we refine the entire inpatient acute care CMS DRG system to take into account severity of illness and apply HSRV weights to DRGs. However, we believe that it is advantageous to the LTCH community to wait for CMS to first finalize its policies regarding any refinements to the DRG system for the IPPS so that we can fully analyze what the effects of such changes would be on LTCH PPS payments. To the extent any changes for severity-adjusted DRGs for the IPPS system have been finalized, an analysis could then be performed to determine whether it is appropriate to propose the same severity-adjusted patient classification for LTCHs. As we stated in the FY 2007 IPPS proposed rule:

"At that time, we would need to consider whether to propose revisions to the patient classification system under the LTCH PPS. Any proposed changes to the patient classification system would be done through notice and comment rulemaking" (71 FR 24051).

The commenters cited the virtues of the severity-adjusted DRGs and one commenter commissioned the above described study to assess the validity of our proposed update to the LTC–DRG relative weights for FY 2007. In response to these comments, we reiterate that, while we understand that applying the severity-adjusted DRGs under the LTCH PPS could have an impact on setting relative weights used in determining LTCH PPS payments, we would consider their use in the LTCH PPS after we evaluate any DRG refinements for the IPPS, as noted above.

We note that while severity-adjusted DRGs had been proposed under the IPPS system for FY 2008 (or earlier), we did not propose to revise the current patient classification system used under the LTC PPS. Because, as we explained above, we believe any refinement due to severity-adjusted DRGs for the IPPS system would need to be evaluated to determine whether it is *appropriate* to use the same severity-adjusted DRGs for LTCHs, we will, at that time, take into consideration such issues as the impact of treating higher acuity patients.

We have noted that some commenters believe it is not appropriate that LTCHs be impacted by decreasing payments because of the upcoding of lower acuity patients to higher weighted LTC–DRGs, as discussed in the previous responses. However, as we discussed in the FY 2007 IPPS proposed rule (71 FR 24413), many of the LTC–DRG relative weights proposed for FY 2007 are lower than the current (FY 2006) LTC–DRG relative weight because based on the latest available LTCH claims data, we continue to observe an increase in the number of relatively lower charge cases being assigned to LTC–DRGs with higher relative weights in prior years. As explained previously, we believe that using updated (FY 2005) LTCH claims data will result in LTC–DRG relative weights for FY 2007 that best reflect the resources actually utilized by LTCHs in treating their Medicare patients and thereby act to ensure appropriate LTCH PPS payments in FY 2007. The commenter is correct in noting that it was our intention, when we revised the short-stay outlier policy described above, to reduce the number or type of short-stay patients being treated in LTCHs that do not utilize the resources of "typical" LTCHs. Many of these very short stay cases require more appropriate treatment at another hospital setting, such as an acute care hospital. Therefore, we are not convinced that reducing the number of short stay patients treated at LTCHs will necessarily result in higher LTC–DRG weights in all LTC–DRGs or even in higher weighted LTC–DRGs.

Moreover, since the implementation of the LTCH PPS in FY 2003, we have accounted for very short-stay and short-stay outliers cases in our LTC–DRG relative weight methodology. Specifically, we have removed cases with a length of stay of 7 days or less because we believed that they could "significantly bias payments against inlier cases" (67 FR 55989). In addition, the methodology includes a step to adjust charges for the effects of short-stay outliers by "counting a short-stay outlier as a fraction of a discharge based on the ratio of the length of stay of the case to the average length of stay for the LTC–DRG." Without this adjustment, we maintained at that time that we believed that "the relatively lower charges of the short-stay outlier cases bring down the average charge for all cases within a LTC–DRG * * * [and] result in an 'underpayment' to nonshort-stay outlier cases * * *" (67 FR 55990). Therefore, we do not believe that the changes that we have made in the short-stay outlier policy in the RY 2007 LTCH PPS final rule will affect the DRG weights because our methodology has

always accounted for this potential effect so that a reduction in short-stay outlier cases will not necessarily result in a significant change to the DRG weights.

During the previous 4 years, while we phased in to full payments under the LTCH PPS, we have reweighted the LTC–DRGs, with the result that for the first year, there was an estimated negligible increase in average payments based upon the reweighting of the LTC–DRGs (FY 2004 + 0.4 percent) and a negligible decrease in estimated payments based on the LTC–DRG update in FY 2005 (FY 2005, −0.5 percent). For the subsequent 2 years, there were decreases (FY 2006, −4.2 percent; proposed FY 2007, −1.4 percent). Although the LTCH PPS has been evolving, we believe that using the updated (FY 2005) LTCH claims data with our existing relative weight methodology will result in LTC–DRG relative weights for FY 2007 that will best reflect the resources actually utilized by LTCHs in treating its Medicare patients since the FY 2005 data is the best LTCH data available that reflects LTCHs' current treatment practice and coding patterns. Therefore, we do not find it either necessary or appropriate to postpone the FY 2007 update of the LTC–DRG relative weights until we consider the adoption of a classification system with "improved severity measures."

Comment: Numerous commenters suggested that CMS forgo the proposed approximately 1.4 percent decrease in estimated aggregate LTCH PPS payments and, instead, establish a policy of budget neutrality for the annual updates of the LTC–DRG relative weights. The commenters believed a policy of budget neutrality would mitigate the estimated LTCH PPS payment reductions that CMS estimates would result from the proposed changes to the LTC–DRGs and relative weights for FY 2007. MedPAC also endorsed adopting a policy of budget neutrality for the annual recalibration of the LTC–DRG weights and noted that the adoption of the budget neutrality process that CMS uses in recalibrating the annual weights for the IPPS for the LTCH would avoid the estimated decrease in payments of 1.4 percent for FY 2007.

One commenter asserted that the absence of a budget neutrality adjustment for the annual recalibration of the LTC–DRGs provides a negative incentive for efficiency, because assigning cases that appropriately use fewer hospital resources to a particular LTC–DRG will result in a lower weight for that LTC–DRG. Therefore, the commenter urged CMS not to implement the proposed reweighting for FY 2007 prior to a full analysis of the impact of the proposed reweighting along with other payment policy changes provided in the RY 2007 LTCH PPS on the overall adequacy of payments to LTCHs. In addition, the commenters expressed eagerness to review the recommendations currently under development by RTI International for patient and facility criteria for LTCHs. Several commenters further suggested that no additional reimbursement reductions under the LTCH PPS should be imposed until the RTI report is complete and the industry works with CMS to implement its findings.

Response: We understand that the commenters are concerned with the estimated decrease in payments under LTCH PPS based upon the changes in the LTC DRGs and relative weights proposed for FY 2007. However, as discussed above, we are not postponing the proposed FY 2007 reclassification and recalibration of the LTC–DRGs. In addition, the payment policies that were finalized in the RY 2007 LTCH PPS final rule, such as the zero update to the standard Federal rate and the revised short-stay outlier policy, will be effective for LTCH discharges beginning on July 1, 2007, as established in that rule.

We further acknowledge that the commenters and also MedPAC are urging us to establish a budget neutrality requirement for the annual reclassification and recalibration of the LTC–DRGs so that, in future years, the LTCH PPS would avoid an estimated decrease in aggregate payments such as the estimated 1.3 percent based on the LTC–DRG weights that we are finalizing for FY 2007.

In the responses to comments addressed above, we have noted several reasons for the annual fluctuations in LTC–DRG relative weights that resulted in an estimated increase in aggregate payments for FY 2004, a negligible estimated decrease in aggregate payments for FY 2005, and decreases in aggregate payments for FYs 2006 and 2007. We reiterate that the LTCH PPS has existed since FY 2003, and we believe that several factors are occurring that affect the changes to the relative weights, including actual improvements in coding so that cases are appropriately assigned to LTC–DRGs. Each year, we recalibrate the LTC–DRG relative weights based on the most recent available LTCH claims data, which reflect current LTCH patient mix and coding practices. The annual recalibration of the LTC–DRG relative weights to which LTCH cases are assigned will appropriately reflect more or less resource use than the previous year's LTC–DRG relative weights.

We understand the concerns expressed by the commenters regarding this fiscal year's estimated decrease in payments based upon the proposed (and finalized) FY 2007 reweighting of the LTC–DRGs. However, we remind the commenters that establishing a budget-neutrality policy for the LTC–DRG weights would have precluded the increase in payments that occurred during FY 2004 as well as any increase that an analysis of future data may warrant.

Under the IPPS, there is a statutory requirement in section 1886(d)(4)(C)(iii) of the Act that requires that, beginning with FY 1991, reclassification and recalibration changes be made in a manner that assures that the aggregate payments are neither greater than nor less than the aggregate payments that would have been made without the changes. However, there is no statutory or regulatory requirement that the annual update to the LTC–DRG classifications and relative weights be done in a budget neutral manner. In addition, after FY 2003, the year that the LTCH PPS was implemented, there was no statutory requirement for budget neutrality for any component of the LTCH PPS.

However, as we have already noted, the LTCH PPS, having been first implemented for cost reporting periods beginning on or after the start of FY 2003, will soon end its transition period and payment will be based solely on the Federal rate with cost reporting periods beginning in FY 2007. In the RY 2007 LTCH PPS final rule, we provided that we would reevaluate all payment adjustments that were originally considered for the LTCH PPS prior to its implementation and also determine the appropriateness of a one-time prospective adjustment to the standard Federal rate (§ 412.523(d)(3)) so that the effect of any significant differences between actual payments and estimated payments for the first year of the LTCH PPS would not be perpetuated in the PPS for future years. Given the considerable discretion granted to the Secretary under the BBRA of 1999 and the BIPA of 2000 to develop the LTCH PPS, it is possible, however, that at the same time, the Secretary would consider using his broad authority to establish a policy of budget neutrality for the annual update of the LTC–DRG classifications and relative weights. As noted above, currently the best available LTCH data (FY 2005) are from the second full year of the PPS, and LTCHs

may still be modifying their behavior to the change in payment methodology. If, upon reevaluation of our payment policies based on future LTCH data as the data become available, we find that it would be appropriate to propose making the updates to the LTC–DRGs and relative weights in a budget neutral manner, the public will have the opportunity to submit comments on any proposed change during the rulemaking process.

The commenters mentioned their eagerness to review the recommendations currently being developed by RTI regarding the feasibility of patient and facility level admissions criteria for LTCHs. We anticipate that RTI will submit its final report and recommendations during RY 2007. We place considerable importance on RTI's work, and we will encourage a dialogue with the public based on the report. We note that, while we believe the report will have a substantial impact on future Medicare policy for LTCHs, we still believe that the retention of many of the specific payment adjustment features of the LTCH PPS presently in place and the development of additional or revised adjustments may still be both necessary and appropriate for purposes of protecting the integrity of the Medicare trust fund.

Comment: Several commenters believed that the changes to the LTC–DRG relative weights will have a more significant impact on high case-mix providers than on low-case mix providers. One commenter referred to a LTCH which, as a high acuity provider, will experience an approximate 5 percent drop in total case mix index. This commenter requested that CMS make a weighted average calculation available when it publishes the impacts of changes in the relative weights. The commenter further suggested that CMS produce an impact statement focusing on changes across all DRGs that will enable providers to understand the impacts on their individual LTCHs.

Response: We believe we published a comprehensive description of the impact of the reweighting of the LTC–DRGs for FY 2007 in the proposed rule (71 FR 24413). Specifically, in section VII, Effects of Other Proposed Policy Changes, in subsection A, under the heading, Effects of LTC–DRG Reclassifications and Relative Weights for LTCHs, we included a detailed analysis of the impact that would result from our proposals.

In that section, we stated: "When we compared the GROUPER Version 23.0 (FY 2006) LTC–DRG relative weights to the proposed GROUPER Version 24.0 (FY 2007) proposed LTC–DRG relative weights, we found that approximately 62 percent of the LTC–DRGs would have a higher relative weight under Version 23.0, while the remaining approximately 38 percent of the LTC–DRGs would have a higher relative weight under Version 24.0. We also found that, based on FY 2005 LTCH cases, the GROUPER Version 23.0 LTC–DRG relative weights were, on average, approximately 3.1 percent higher than the proposed GROUPER Version 24.0 LTC–DRG relative weights. In addition, based on an analysis of the most recent available LTCH claims data from the FY 2005 MedPAR file, we continue to observe that the average proposed LTC–DRG relative weight decreases due to an increase of relatively lower charge cases being assigned to LTC–DRGs with higher relative weights in the prior year.

Contributing to this increase in these relatively lower charge cases being assigned to proposed LTC–DRGs with higher relative weights in the prior year are improvements in coding practices, which are typical when moving from a reasonable cost-based payment system to a PPS. The impact of including additional cases with relatively lower charges in LTC–DRGs that had a relatively higher relative weight in the GROUPER Version 23.0 (FY 2006) is a decrease in the average relative weight for those LTC–DRGs in the proposed GROUPER Version 24.0. As noted above in section II.F. of the preamble to this proposed rule, LTCHs are a specialized provider type that typically do not treat a broad spectrum of patients in their facilities with many different diagnoses. While there are 526 valid proposed GROUPER Version 24.0 LTC–DRGs, 191 LTC–DRGs have no LTCH cases. In addition, another 173 LTC–DRGs are categorized as 'low volume' (that is, have less than 25 cases annually). Consequently, only about 162 LTC–DRGs are used by most LTCHs on a 'regular basis' (that is, nationally LTCHs discharge, in total, an average of 25 or more of these cases annually).

Of these 162 LTC–DRGs that are used on a regular basis, we found that approximately 60 percent of the LTC–DRGs would have higher relative weights under GROUPER Version 23.0 in comparison to proposed GROUPER Version 24.0, and the remaining 40 percent of the 162 LTC–DRGs that are used on a 'regular basis' would have higher relative weights under proposed GROUPER Version 24 in comparison to GROUPER Version 23.0. In addition, about 25 percent of the 162 LTC–DRGs that are used on a 'regular basis' would experience a decrease in the average charge per case as compared to the average charge per case in that DRG based on FY 2004 data, which generally results in a lower relative weight. Moreover, of the 162 LTC–DRGs that are used on a 'regular basis,' approximately 63 percent of those LTC–DRGs would experience a change in the average charge per case from FY 2004 LTCH data as compared to FY 2005 LTCH data that is less than the increase in overall average LTCH charges across all LTC–DRGs from FY 2004 to FY 2005 of about 8.3 percent. Accordingly, those LTC–DRGs would also have a proposed reduction in their relative weight as compared to the relative weight in FY 2006. For those LTC–DRGs in which the average charge within the LTC–DRG increase is less than 8.3 percent, the proposed relative weights for those LTC–DRGs would decrease because the average charge for each of those LTC–DRGs is being divided by a larger number (that is, the average charge across all LTC–DRGs). For the reasons discussed above, we believe that the proposed changes in the LTC–DRG relative weights, which include a significant number of LTC–DRGs with lower proposed relative weights, would result in approximately a 1.4 percent decrease in estimated aggregate LTCH PPS payments" (71 FR 24413).

The above paragraphs, published in the FY 2007 IPPS proposed rule, clearly indicated the impact of the reweighting of the LTC–DRGs. All of the impact percentages listed are "weighted averages," as was the proposed estimated 1.4 percent decrease in aggregate LTCH PPS payments. That is, all LTCH cases in the December 2005 update of the FY 2005 MedPAR file were used to determine the LTC–DRG impact figures presented in the FY 2007 IPPS proposed rule. Therefore, the latest data on the types of patients treated across all LTCHs were used to determine the impact and not just the proposed changes to the LTC–DRG weights. The proposed and final FY 2007 reweighting of the LTC–DRGs may indeed have a more significant impact on a high acuity provider because many of the proposed and final LTC–DRG weights in relatively high weighted LTC–DRGs would decrease compared to their current values. However, we also note that Medicare payments for several of the highest acuity LTC–DRGs have yielded substantial margins. For example, an analysis of MedPAR data from FY 2004 indicated that, for LTC–DRG 475 (Ventilator Support) with a relative weight of 2.1358 for FY 2004, average aggregate (dollar weighted) margins for all providers was 21.09 percent, and for LTC–DRG 87 (Pulmonary Edema/Respiratory

Support) with a relative weight of 1.6513 for FY 2004, average aggregate margins were 26.93 percent. Even for cases requiring somewhat less resource intensity, such as LTC–DRG 416 (Septicemia) with a relative weight of 0.9191 for FY 2004, which is also one of the diagnoses most frequently found in LTCHs, the aggregate margin is 11.54 percent and for LTC–DRG 249 (After Care Musculoskeletal) with a relative weight of 0.7829 for FY 2004, the margin is 9.69 percent. Therefore, we believe that the reweighting of the LTC–DRGs for FY 2007, even for those high-acuity providers who experience a more significant impact, should not impede the efficient and effective delivery of care to Medicare beneficiaries, because, as described above, several of the highest-acuity LTC–DRGs have yielded substantial margins. Furthermore, even though the recalibration of the LTC–DRG relative weights will result in a decrease in the relative weight for some high-acuity LTC–DRGs, because the recalibration is based on the most recent available LTCH claims data (FY 2005), it ensures the most accurate payments for FY 2007 based on current LTCH treatment and coding practices.

In response to the commenter who requested impacts that reflected a weighted average calculation, as noted above, the impact of the proposed changes to the LTC–DRGs for FY 2007 presented in the FY 2007 IPPS proposed rule (71 FR 24413) are based on a weighted average calculation. That is, all FY 2005 LTCH cases in the December 2005 update of the MedPAR data were used to determine the impact figures presented in the proposed rule. This means that only the proposed changes to the relative weights for LTC–DRGs that had LTCH cases in those DRGs based on the FY 2005 LTCH data contributed to the impact. This continues to be true for the impact of the final LTC_DRG weights which are based on the most recent update of the FY 2005 MedPAR data. It also means that, for example, LTCH cases in LTC–DRG 475 represent approximately 12 percent of all LTCH cases in FY 2005 and therefore, 12 percent of the impact presented in the proposed rule was due to the proposed change in the LTC–DRG weight for LTC–DRG 475. We believe that the commenter may have mistakenly believed that we measured the impact of the proposed LTC–DRG changes based on the changes proposed for each LTC–DRG without accounting for the volume of LTCH cases treated in each LTC–DRG. In addition, we note that if a provider is eager to determine the specific impact of the annual proposed LTC–DRG reweighting on an individual LTCH or a particular weight, the provider needs only to compare an application of the LTC–DRG weights published in the previous year's final rule (Table 11) of its cases to the proposed LTC–DRG relative weights that are published in the current year's proposed rule (Table 11; 71 FR 24395–24403) as applied to the same set of cases.

Comment: Several commenters maintained that the proposed 1.4 percent decrease in aggregate payments to LTCHs due to the proposed LTC–DRG reclassification and recalibration for FY 2007, in addition to payment cuts established for RY 2007 represent a "misinterpretation" of MedPAC's recommendation in its March 2006 Report to the Congress for a zero update for LTCHs. MedPAC cited Medicare margins for 2004 of 9.0 for the LTCH industry and projected 7.8 percent margins for 2006, but the commenters believed that these projections did not factor in the impact of the "25 percent policy" for co-located LTCHs or the estimated payment reductions associated with the revised short-stay outlier policy.

Response: As we have noted elsewhere in earlier responses to comments, the estimated 1.4 percent decrease aggregate in LTCH PPS payments due to the proposed LTC–DRG reclassification and recalibration for FY 2007 is a data-driven result of the annual recalibration of the relative weights for LTC–DRGs based on the latest available LTCH claims data from the MedPAR files (FY 2005). Therefore, for FY 2007, based on the updated LTC–DRGs classifications and relative weights, estimated payments to LTCHs will be 1.3 percent less than they would have been based on the prior fiscal year's (that is, FY 2006) classifications and relative weights for the same LTCH cases. Similarly, LTCH claims data from the FY 2006 MedPAR files will be used to determine the proposed LTC–DRG relative weights for FY 2008, and the resulting aggregate LTCH PPS payments, absent a regulatory or statutory change implementing recalibration of relative weights in a budget neutral manner, may either decrease or increase, based upon the FY 2006 data and DRG classification changes. In setting the annual relative weights for the LTC–DRG system for FY 2007, we have followed the requirements established with the implementation of the LTCH PPS in FY 2003 (67 FR 55984–55995). Although the proposed recalibrated LTC–DRG relative weights were estimated to result in 1.4 percent decrease in LTCH PPS payments for FY 2007 (and based on final policies established in this final rule, the updated LTC–DRGs for FY 2007 are estimated to result in a 1.3 percent decrease in aggregate LTCH PPS payments for FY 2007, as noted above), we do not believe that this adjustment is relevant to MedPAC's recommendation for the zero percent update to the LTCH PPS Federal rate for RY 2007.

The annual LTC-DRG update is separate from the Federal rate update; specifically, their purposes are different and independent. The standard Federal base rate is an estimate of the national average cost per case which is adjusted by the LTC-DRG relative weights to reflect the resource consumption of the particular case; that is, a case with a relative weight of 2.0 is twice as costly/uses twice the resources as a case with a relative weight of 1.0. The LTC-DRG relative weights are recalibrated annually based on the most recent available LTCH data to reflect resources used by LTCHs in treating each type of case. The update to the Federal rate is to adjust the Federal rate to account for various adjustments to that rate, including inflation.

MedPAC's data analysis, in its March 2006 Report to the Congress, indicated that the average Medicare margin for LTCHs was 9.0 percent for FY 2005 and was projected at 7.8 percent for 2006. (As we stated in our RY 2007 LTCH PPS final rule, MedPAC also noted that "LTCH HwHs were found to have higher margins than freestanding LTCHs in RY 2005" (71 FR 27823).) Based on its analysis, MedPAC stated that "* * * evidence from the indicators we have examined suggests that LTCHs can accommodate the cost of caring for Medicare beneficiaries in 2007 without an increase in the base rate" (p. 218). Consistent with MedPAC's recommendation, after incorporating an adjustment to account for changes in coding practices that did not reflect "real" case-mix, we finalized a zero percent update for FY 2007 (71 FR 27819). As stated earlier, this adjustment is not a function of, or related to, the update to the relative weights for LTC–DRGs.

The commenters' also reference the 25-percent threshold payment adjustment for co-located LTCHs (§ 412.534) established beginning in FY 2005 and the newly revised short stay outlier payment policy (§ 412.529) beginning in RY 2007. We believe that the commenters are seeking to connect these adjustments, which are also estimated to result in a decrease in aggregate LTCH PPS payments in the absence of a change in admission

practices by LTCHs to the estimated impact of the updated LTC–DRG relative weights. However, the policies cited by the commenters are not related to the impact of the updating of the LTCH–DRG relative weights, but each independently, furthers the goal of establishing fair and reasonable Medicare payments under the LTCH PPS.

The HwH "25 percent rule," that is, the special payment provisions for LTCH HwHs and satellites, was established at § 412.534 in the FY 2005 IPPS final rule. Under that policy, we provide a payment adjustment for those patients discharged from co-located LTCHs (that is, HwHs and satellites) admitted from host hospitals that exceeded a specified threshold percentage (in most cases, 25 percent). Medicare patients who reach high-cost outlier status in the host hospital are excluded from the count of the percentage of patients admitted directly from the host. As we discussed in the FY 2005 IPPS final rule, when we implemented the "25 percent rule," we were unable to estimate the impact of this policy because we anticipated behavioral changes by both the host and the co-located LTCHs resulting from the provision that exempted high-cost outliers from the percentage threshold calculation (69 FR 49771).

MedPAC further addressed this issue in the March 2006 Report, where it noted that it "* * * cannot foresee how HwHs/ behavior will change in response to this rule. CMS has discussed scenarios (CMS 2005). For example, patients admitted to an HwHs from the host hospital after becoming an outlier are not counted in the limit, thus HwHs may admit more outlier cases under this rule. Alternatively, host hospitals may discharge fewer patients to their HwHs because of constraints from the 25 percent rule, in which case HwHs' volume might fall. In cities where there is another LTCH, an acute care hospital might discharge patients to a different long-term care hospital than the one on its grounds. The Office of Inspector General or the QIOs may want to monitor acute care hospitals' and HwHs' behavior in response to the 25 percent rule. Because we have no evidence of how HwHs will react, we have not modeled margins incorporating this policy change." (p. 218)

Because the policy at § 412.534 exempts patients admitted from the host hospital if they had already achieved high-cost outlier status under the IPPS, from the LTCHs' percentage threshold calculation (as noted above), we believe that even with some adjustments resulting in a decrease in payments to some co-located LTCHs, Medicare payments to co-located LTCHs on average will continue to exceed the Medicare costs of the inpatient hospital services provided to its patients, even with a zero percent update to the Federal rate for RY 2007 (71 FR 27823). Furthermore, we believe that the 25-percent threshold policy and the short stay outlier payment revision that that we have established, first for co-located LTCHs at § 412.534 for FY 2004 and the revisions to the short-stay outlier policies at § 412.529 that we finalized for RY 2007, each have a firm and consistent basis in our general policy considerations under the LTCH PPS.

As we noted in the RY 2007 final rule for the LTCH PPS, we do not believe that the change to the short-stay outlier policy will result in an adverse impact on LTCHs. As a result of the change to the short-stay outlier payment formula, we believe that LTCHs will have an incentive to significantly reduce the number of very short-stay cases that they admit. We believe that, by paying appropriately for short-stay outlier cases and by removing the financial incentive for LTCHs to admit those very short stay cases that could otherwise receive appropriate treatment at an acute care hospital (and paid under the IPPS), LTCHs will change their admission patterns for these patients. We further believe that payment decreases to LTCHs resulting from this policy would only occur if LTCHs were to continue to admit the same number of short-stay outlier patients with very short lengths of stay. We believe this policy is needed to assure that payments for short-stay outlier cases are appropriate.

Therefore, we disagree with the commenter that we have "misinterpreted" MedPAC's recommendation of a zero percent update for 2007 in our proposed update to the LTC-DRGs for FY 2007. We maintain that the rationale for each of the policy features mentioned by the commenter, when evaluated independently, is clear and reasonable. In addition, they are independent of the DRG recalibration that occurs every year based on an established formula. We strongly disagree with the allegations that their implementation represents a "misinterpretation" of MedPAC's margin analysis and recommendation (discussed above) in the March 2006 Report to the Congress. As discussed above, this update is not based on MedPAC's analysis and we believe that updating the LTC–DRG relative weights for FY 2007 based on FY 2005 LTCH claims data will result in more appropriate LTCH PPS payments since the relative resource intensity of each LTC–DRG (that is, the relative weight) will be determined from the most recent available LTCH data (FY 2005) reflecting LTCHs' current practice and treatment patterns.

Comment: Several commenters, including MedPAC, recommended that we adopt severity-adjusted DRGs as the patient classification system for the LTCH PPS. In particular, MedPAC analyzed FY 2004 CMS LTCH data using both standardized charges and standardized hospital-specific costs (removing the effect of local wages) using Version 23 (FY 2006) of the GROUPER and stated that, on a preliminary basis, CS DRGs are relatively homogeneous in resource use for the kinds of cases treated in LTCHs. They believed that this indicates that the CS DRGs proposed for IPPS hospitals may also "be promising for LTCHs."

Response: We are aware of the heightened interest in severity-adjusted DRGs by the provider community, and in section II.C.6.of this final rule, we discuss the revisions that we are making to the DRG classifications structure for the IPPS and our expectations for adopting severity adjustments for DRGs under the IPPS in FY 2008. We appreciate the data analysis that MedPAC produced to demonstrate the potential utility of CS DRGs for classifying patients being treated in LTCHs. It is possible that the modified version of the APR DRGs or another severity-adjusted patient classification system may account for differences in severity of illness and associated costs among hospitals. In section II.C. of this preamble, we discuss the issues that we are dealing with respect to the adoption of a severity adjusted DRG system. Once we have addressed those issues under the IPPS, we would need to consider whether it is appropriate to propose similar revisions to the patient classification system under the LTCH PPS. As stated in the FY 2007 IPPS proposed rule, we would emphasize that any proposed changes to the patient classification system for LTCHs would be done through notice and comment rulemaking.

G. Add-On Payments for New Services and Technologies

1. Background

Sections 1886(d)(5)(K) and (L) of the Act establish a process of identifying and ensuring adequate payment for new medical services and technologies (sometimes collectively referred to in this section as "new technologies") under the IPPS. Section 1886(d)(5)(K)(vi) of the Act specifies

that a medical service or technology will be considered new if it meets criteria established by the Secretary after notice and opportunity for public comment. Section 1886(d)(5)(K)(ii)(I) of the Act specifies that the process must apply to a new medical service or technology if, "based on the estimated costs incurred with respect to discharges involving such service or technology, the DRG prospective payment rate otherwise applicable to such discharges under this subsection is inadequate."

The regulations implementing this provision establish three criteria for new medical services and technologies to receive an additional payment. First, § 412.87(b)(2) defines when a specific medical service or technology will be considered new for purposes of new medical service or technology add-on payments. The statutory provision contemplated the special payment treatment for new medical services or technologies until such time as data are available to reflect the cost of the technology in the DRG weights through recalibration. There is a lag of 2 to 3 years from the point a new medical service or technology is first introduced on the market and when data reflecting the use of the medical service or technology are used to calculate the DRG weights. For example, data from discharges occurring during FY 2005 are used to calculate the FY 2007 DRG weights in this final rule. Section 412.87(b)(2) provides that a "medical service or technology may be considered new within 2 or 3 years after the point at which data begin to become available reflecting the ICD–9–CM code assigned to the new medical service or technology (depending on when a new code is assigned and data on the new medical service or technology become available for DRG recalibration). After CMS has recalibrated the DRGs, based on available data, to reflect the costs of an otherwise new medical service or technology, the medical service or technology will no longer be considered 'new' under the criterion for this section."

The 2-year to 3-year period during which a medical service or technology can be considered new would ordinarily begin with FDA approval, unless there was some documented delay in bringing the product onto the market after that approval (for instance, component production or drug production had been postponed until FDA approval due to shelf life concerns or manufacturing issues). After the DRGs have been recalibrated to reflect the costs of an otherwise new medical service or technology, the special add-on payment for new medical services or technology ceases (§ 412.87(b)(2)). For example, an approved new technology that received FDA approval in October 2005 and entered the market at that time may be eligible to receive add-on payments as a new technology until FY 2008 (discharges occurring before October 1, 2007), when data reflecting the costs of the technology would be used to recalibrate the DRG weights. Because the FY 2008 DRG weights will be calculated using FY 2006 MedPAR data, the costs of such a new technology would likely be reflected in the FY 2008 DRG weights.

Section 412.87(b)(3) further provides that, to receive special payment treatment, new medical services or technologies must be inadequately paid otherwise under the DRG system. To assess whether technologies would be inadequately paid under the DRGs, we establish thresholds to evaluate applicants for new technology add-on payments. In the FY 2004 IPPS final rule (68 FR 45385, August 1, 2003), we established the threshold at the geometric mean standardized charge for all cases in the DRG plus 75 percent of 1 standard deviation above the geometric mean standardized charge (based on the logarithmic values of the charges and transformed back to charges) for all cases in the DRG to which the new medical service or technology is assigned (or the case-weighted average of all relevant DRGs, if the new medical service or technology occurs in many different DRGs). Table 10 in the Addendum to the FY 2004 IPPS final rule (68 FR 45648) listed the qualifying threshold by DRG, based on the discharge data that we used to calculate the FY 2004 DRG weights.

However, section 503(b)(1) of Pub. L. 108–173 amended section 1886(d)(5)(K)(ii)(I) of the Act to provide for "applying a threshold * * * that is the lesser of 75 percent of the standardized amount (increased to reflect the difference between cost and charges) or 75 percent of 1 standard deviation for the diagnosis-related group involved." The provisions of section 503(b)(1) apply to classification for fiscal years beginning with FY 2005. We updated Table 10 from the **Federal Register** document that corrected the FY 2004 final rule (68 FR 57753, October 6, 2003), which contained the thresholds that we used to evaluate applications for new service or technology add-on payments for FY 2005, using the section 503(b)(1) measures stated above, and posted these new thresholds on our Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/08_newtech.asp*. In the FY 2005 IPPS final rule (in Table 10 of the Addendum), we included the final thresholds that were being used to evaluate applicants for new technology add-on payments for FY 2006. (Refer to section IV.D. of the preamble to the FY 2005 IPPS final rule (69 FR 49084, August 11, 2004) for a discussion of a revision of the regulations to incorporate the change made by section 503(b)(1) of Pub. L. 108–173.) Table 10 of the Addendum to the FY 2006 final rule (70 FR 47680) contained the final thresholds that are being used to evaluate applications for new technology add-on payments for FY 2007.

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

The new medical service or technology add-on payment policy provides additional payments for cases with high costs involving eligible new medical services or technologies while preserving some of the incentives under the average-based payment system. The payment mechanism is based on the cost to hospitals for the new medical service or technology. Under § 412.88, Medicare pays a marginal cost factor of 50 percent for the costs of a new medical service or technology in excess of the full DRG payment. If the actual costs of a new medical service or technology case exceed the DRG payment by more than the 50-percent marginal cost factor of the new medical service or technology, Medicare payment is limited to the DRG payment plus 50 percent of the estimated costs of the new technology.

The report language accompanying section 533 of Pub. L. 106–554 indicated Congressional intent that the Secretary implement the new mechanism on a budget neutral basis (H.R. Conf. Rep. No. 106–1033, 106th Cong., 2nd Sess. at 897 (2000)). Section 1886(d)(4)(C)(iii) of the Act requires that the adjustments to annual DRG classifications and relative weights must be made in a manner that ensures that aggregate payments to hospitals are not affected. Therefore, in the past, we accounted for projected payments under the new medical

service and technology provision during the upcoming fiscal year at the same time we estimated the payment effect of changes to the DRG classifications and recalibration. The impact of additional payments under this provision was then included in the budget neutrality factor, which was applied to the standardized amounts and the hospital-specific amounts.

Section 1886(d)(5)(K)(ii)(III) of the Act, as amended by section 503(d)(2) of Pub. L. 108–173, provides that there shall be no reduction or adjustment in aggregate payments under the IPPS due to add-on payments for new medical services and technologies. Therefore, add-on payments for new medical services or technologies for FY 2005 and later years have not been budget neutral.

Applicants for add-on payments for new medical services or technologies for FY 2008 must submit a formal request, including a full description of the clinical applications of the medical service or technology and the results of any clinical evaluations demonstrating that the new medical service or technology represents a substantial clinical improvement, along with a significant sample of data to demonstrate the medical service or technology meets the high-cost threshold, no later than October 15. 2006. Applicants must submit a complete database no later than December 30, 2006. Complete application information, along with final deadlines for submitting a full application, will be available at our Web site: *http://www.cms.hhs.gov/AcuteInpatientPPS/08_newtech.asp*. To allow interested parties to identify the new medical services or technologies under review before the publication of the proposed rule for FY 2008, the Web site will also list the tracking forms completed by each applicant.

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

Section 1886(d)(5)(K)(viii) of the Act, as amended by section 503(b)(2) of Pub. L. 108–173, provides for a mechanism for public input before publication of a notice of proposed rulemaking regarding whether a medical service or technology represents a substantial clinical improvement or advancement. The process for evaluating new medical service and technology applications requires the Secretary to—

- Provide, before publication of a proposed rule, for public input regarding whether a new service or technology represents an advance in medical technology that substantially improves the diagnosis or treatment of Medicare beneficiaries.
- Make public and periodically update a list of the services and technologies for which applications for add-on payments are pending.
- Accept comments, recommendations, and data from the public regarding whether a service or technology represents a substantial clinical improvement.
- Provide, before publication of a proposed rule, for a meeting at which organizations representing hospitals, physicians, manufacturers, and any other interested party may present comments, recommendations, and data regarding whether a new service or technology represents a substantial clinical improvement to the clinical staff of CMS.

In order to provide an opportunity for public input regarding add-on payments for new medical services and technologies for FY 2007 before publication of the FY 2007 IPPS proposed rule, we published a notice in the **Federal Register** on December 23, 2005 (70 FR 76315) and held a town hall meeting at the CMS Headquarters Office in Baltimore, MD, on February 16, 2006. In the announcement notice for the meeting, we stated that the opinions and alternatives provided during the meeting would assist us in our evaluations of applications by allowing public discussions of the substantial clinical improvement criterion for each of the FY 2007 new medical service and technology add-on payment applications before the publication of the FY 2007 IPPS proposed rule.

Approximately 35 participants registered and attended the town hall meeting in person, while additional participants listened over an open telephone line. The participants focused on presenting data on the substantial clinical improvement aspect of their products, as well as the need for additional payments to ensure access to Medicare beneficiaries. In addition, we received written comments regarding the substantial clinical improvement criterion for the applicants. We considered these comments in our evaluation of each new application for FY 2007 in the proposed rule and in this final rule. We have summarized these comments or, if applicable, indicated that no comments were received, at the end of the discussion of the individual applications.

We received two general comments about application of the newness and substantial clinical improvement criteria.

Comment: One commenter encouraged CMS to amend the definition of substantial clinical improvement for the IPPS new technology provision to conform to the OPPS definition of substantial clinical improvement used in 2001. Specifically, AdvaMed requested that after "decreased pain, bleeding, or other quantifiable symptom," CMS should insert the following language: "such as convenience, durability, ease of operation or make other improvements in quality of life."

Response: We believe we addressed this concern in the FY 2006 IPPS final rule (70 FR 47360). We use similar standards to evaluate substantial clinical improvement in the IPPS and OPPS and, in both systems, we employ identical language to explain and elaborate on the kinds of considerations that are taken into account in determining whether a new technology represents a substantial clinical improvement. We do not believe a change to the regulations text is necessary.

Comment: One commenter suggested that CMS should not use "substantial similarity" to evaluate newness without also determining whether the product is a substantial clinical improvement. The commenter argued that CMS is applying a concept that is not defined in regulations. If CMS applies the concept as part of determining whether a product is new without evaluating substantial clinical improvement, the commenter recommended that CMS should define substantial similarity through notice and comment rulemaking.

Response: We addressed this comment in the FY 2006 IPPS final rule (70 FR 47350 through 47351). We refer readers to that final rule for a detailed response to this comment.

Section 1886(d)(5)(K)(ix) of the Act, as added by section 503(c) of Pub. L. 108–173, requires that, before establishing any add-on payment for a new medical service or technology, the Secretary shall seek to identify one or more DRGs associated with the new technology, based on similar clinical or anatomical characteristics and the costs of the technology and assign the new technology into a DRG where the average costs of care most closely approximate the costs of care using the new technology. No add-on payment will be made if the new technology is assigned to a DRG that most closely approximates its costs.

At the time an application for new technology add-on payments is submitted, the DRGs associated with the new technology are identified. We only determine that a new DRG assignment is necessary or a new technology add-on

payment is appropriate when the payment under these currently assigned DRGs is not adequate and the technology otherwise meets the newness, cost, and substantial clinical improvement criteria.

In this final rule, we evaluate whether new technology add-on payments will continue in FY 2007 for the three technologies that currently receive such payments. In addition, we present our evaluations of three applications for add-on payments in FY 2007.

Comment: One commenter stated that section 503 of Pub. L. 108–173 provided new funding for new technology add-on payments by no longer requiring that these payments be budget neutral. The commenter stated that this provision was enacted to ensure that the IPPS would better account for new drugs, devices, and services. However, the commenter believed that CMS continues to resist approval of new technologies and considers only a few technologies a year for add-on payments.

Another commenter called upon CMS to be more willing to indicate its preliminary views regarding whether a new technology application meets the criteria for add-on payments in the proposed rule. The commenter expressed particular concern that CMS had not given a strong indication of whether any of the initial new technology applications would meet the substantial clinical improvement criterion and noted that doing so would enhance stakeholder dialogue with CMS on the evaluation of the new technology criteria during the comment period.

Another commenter believed that CMS' definition of new technology is contrary to the statute. The commenter explained that CMS uses the FDA approval date to determine newness while the statute clearly requires that new technology add-on payments begin on the date an ICD–9–CM code is issued. The commenter urged CMS to use the date an ICD–9–CM code is issued to determine whether a technology is new instead of the FDA approval date.

Response: With respect to the comment that CMS resists approval of new technologies and considers only a few technologies a year for add-on payments, we note that we encourage companies with new-technologies that believe that they may meet the new technology criteria to apply for add-on payments. In our view, we have not resisted approving new technologies or been overly stringent in our application of the criteria. Our review of new technology focuses on the merits of the application and the requirements under the statute. The experience of our review process indicates that a significant number of new technologies have met the criteria. In fact, we have approved over 50 percent (6 of 11) of applications where we had to apply judgment about whether the technology met the criteria for an add-on payment. From FY 2003 to FY 2006, we received a total of 25 applications, but only 21 were unique (four applicants applied twice in subsequent years for the same technology). Of the applications that we received, 8 were already beyond the timeline to be considered new, 1 had not received FDA approval, and 1 did not meet the cost criterion. In our view, we denied these applications using objective criteria and without having to apply any subjective judgment. Of the remaining 11 applications, 6 were approved for new technology add-on payment, while the other 5 were not approved because we determined that these applications were not substantially different from older technologies or did not meet the substantial clinical improvement criterion. Therefore, to date, we have approved over 50 percent of applications where we needed to apply judgment about whether a new technology met the criteria for an add-on payment. These statistics obviously reflect the recent experience of new technology applications, and, depending on the ability of applications to meet the criteria in the future, will likely change. We note that the merits of each application determine whether it should be approved. The aggregate statistics reflect the ability of applicants to satisfy the criteria, and should not be construed as a measure of the appropriateness of the review process. We also note that over the years, the cost criterion has been lowered, giving applicants a lower threshold to meet the cost criterion. We encourage and welcome additional applications in future years so that we can continue to make payments for those technologies that meet the criteria and warrant new technology add-on payments.

With respect to the comment that CMS should be more willing to indicate our preliminary views regarding whether a new technology meets the criteria for an add-on payment, we provided our initial concerns regarding the two pending applications in the proposed rule. For the C-Port® System, we described our concerns about both the newness ("various forms of surgical staples and clips have been used for more than a decade in a wide range of surgical procedures") and substantial clinical improvement ("the applicant submitted evidence suggesting that device does not always produce reliable anastomoses") criteria and also indicated that the device appears to meet the cost threshold (71 FR 24071). Similarly, for the X STOP Interspinous Process Decompression System, we indicated our belief that "the device satisfies the newness and cost threshold criteria" and described our concerns about substantial clinical improvement (71 FR 24072). As a result of information provided in the proposed rule, the applicants were afforded the opportunity to address the specific concerns we raised. For example, the applicant for the C-Port® system was able to address our concerns about similarity to predicate devices to allow us to determine that the device meets the newness criterion. Similarly, the applicant for X STOP was able to address the concerns we raised in the proposed rule about whether the device meets the substantial clinical improvement criterion during the comment period.

Finally, with respect to the comment that CMS should use the issuance of an ICD–9–CM code as the date on which "newness" would begin, we have addressed this issue several times before, including in the FY 2005 IPPS final rule (69 FR 49002) and the FY 2006 IPPS final rule (70 FR 47343).

Comment: One commenter proposed that CMS allow manufacturers to apply for a new technology add-on payment on an ongoing basis and recommended that the agency issue quarterly updates announcing the approval of new technology add-on payments, similar to the outpatient setting.

Response: Section 1886(d)(5)(K)(i) of the Act requires that new technology add-on payments be established after notice and opportunity for public comments (in the publication required by subsection (e)(5) for a fiscal year or otherwise). In addition, pursuant to section 1886(d)(5)(K)(viii) of the Act, we are also required to hold an annual town hall meeting prior to the IPPS proposed rule to obtain public input about whether a new technology meets the substantial clinical improvement criterion. Given the requirements in the statute, it is not feasible to process applications on a quarterly basis.

Comment: Some commenters expressed disappointment that CMS has not increased the payment rate for new technology add-on payments from a maximum of 50 percent to a maximum of 80 percent of the marginal cost factor of the new medical service or technology, consistent with the outlier payment methodology. The commenters stated that increasing the marginal cost factor from 50 percent to 80 percent

would offer some stability and consistency for hospitals thus enabling hospitals to more easily provide their patients access to new technologies.

Other commenters noted that CMS has approved so few technologies for new technology add-on payments that it would make more sense to compensate hospitals with a full add-on payment by paying on a cost basis using the average sales price plus six percent for FDA approved drugs and biologicals and list price plus a percentage for devices. The commenters believed that such a payment methodology would ensure that, "providers recoup their costs, Medicare pays a fair rate, and that payment is harmonized across treatment settings." Finally, one commenter requested that CMS provide clear guidance and greater transparency as to how determinations of newness will be made for a technology that already has an ICD–9–CM code but is later approved by the FDA for a new indication.

Response: We did not propose any changes to the marginal cost factor in the proposed rule. Furthermore, we continue to believe that a 50-percent marginal cost factor is appropriate for the reasons described in detail in the new technology final rule (66 FR 46919, September 7, 2001).

Also, we have already discussed the situation in which a technology is described under an existing ICD–9–CM code, but subsequently receives approval for a new indication from the FDA. That discussion can be found in the September 7, 2001 new technology final rule (66 FR 46915) and in the FY 2005 IPPS final rule (69 FR 49011) concerning InFUSE® Bone Graft for tibia fractures.

Comment: Several commenters stated that CMS did not address how the proposed changes to the DRGs would affect new technology add-on payments. Another commenter stated that it is essential that CMS maintain new technology add-on payments for FY 2007 and beyond. Another commenter recommended that CMS broaden the new technology criteria to ensure that new technologies are accounted for within a cost-based DRG system.

Response: Although we are adopting a system of cost relative weights in this final rule (section III.C. of this preamble), we will continue to apply the cost criterion using standardized charges consistent with the statute. The statute requires that we apply "a threshold specified by the Secretary that is the lesser of 75 percent of the standardized payment amount (increased to reflect the difference between costs and charges) or 75 percent of one standard deviation for the diagnosis-related group involved." Changes to the DRG system to better recognize severity in the DRG will also have no effect on our application of the new technology criteria. Any changes to the DRG system will merely result in us calculating different thresholds for the revised DRGs. In addition, once a technology is approved for new technology add-on payments, we will continue to use the ICD–9–CM code to identify the technology for determining when new technology add-on payments are appropriate.

Finally, section 1886(d)(5)(K) and (L) of the Act establishes a process of identifying and ensuring adequate payment for new medical services and technologies. Because no changes have been made to this section of the statute, we will continue to make new technology add-on payments for FY 2007 and beyond for those technologies that meet the criteria.

Comment: One commenter recommended that, because CMS proposed to implement a cost-based weight DRG system, CMS should reconsider whether applicants for FY 2007 new technology add-on payments meet the cost criterion based on a revised data set.

Response: As stated above, Table 10 of the Addendum to the FY 2006 IPPS final rule (70 FR 47680) contained the final thresholds that are being used to evaluate applications for new technology add-on payments for FY 2007. We use the thresholds contained in Table 10 that were published in the previous year's final rule (that is, FY 2006) to determine whether a technology is inadequately paid for the next fiscal year (that is, FY 2007). We publish Table 10 in the proposed rule in order to give the public notice and the opportunity to submit comments before we finalize the thresholds in the final rule. Also, it is necessary for applicants to have the thresholds from Table 10 during the application process so that both the applicants and CMS can establish if the applicant's technology meets the cost criterion. Further, as we note above, we believe that the statute requires us to establish the cost thresholds using charges.

Comment: One commenter noted that section 503 of Pub. L. 108–173 included a provision to expand the inpatient new technology add-on payment to include a broader range of technologies. The commenter added that this legislation was made to ensure that adequate payments were made to hospitals until hospital charges include the costs for these technologies. The commenter explained that CMS' narrow interpretation has created a situation where few, if any, products can qualify for new technology add-on payments and a process that is opaque and thus, costly, especially for small companies, to apply for add-on payments. The commenter requested that CMS provide greater opportunity for technologies to qualify for add-on payments to ensure patient access to new technologies as Congress intended.

Response: Section 503 of Pub. L. 108–173 amended the law to: (1) require that we establish diagnosis and procedure codes annually on April 1 as well as October 1; (2) change the application of the cost threshold; (3) require a process for obtaining public input on new technology applications prior to the proposed rule; and (4) eliminate the budget neutrality requirement for new technology add-on payments. We believe that we have implemented section 503 as Congress intended.

As we discussed in the FY 2006 IPPS final rule (70 FR 47344), we do not believe that our criteria present an inordinately cumbersome burden for small companies that want to apply for new technology add-on payments. We have received applications for FY 2007 from relatively small companies compared to some of the companies that have applied in the past. Further, we have already been approached by other small companies seeking new technology add-on payments for FY 2008. We encourage potential applicants to contact us before their technology is available on the market if they have questions about the new technology application process.

Comment: One commenter requested that it be given the opportunity to work closely with CMS to help refine the regulatory framework under which CMS evaluates new innovative treatments for Medicare beneficiaries. The commenter suggested ideas such as creating a pathway for small companies under FDA review to elect to meet with CMS to discuss coverage, payment, and coding issues. In addition, the commenter recommended that CMS establish a committee and annual public workshop to assist emerging technologies and small companies with the new technology add-on payment process.

Response: We have been committed to providing ample opportunity for applicants and other interested parties to make their views known to us throughout the application process, at the annual public meeting, and during the comment period on the proposed rule. We encourage interested parties to contact CMS staff for more information about the new technology add-on application process. Interested parties

may contact Tiffany Swygert at (410) 786–4642 or Michael Treitel at (410) 786–4552.

Comment: One commenter requested that CMS broaden the definition of substantial clinical improvement. The commenter explained that, in the outpatient setting, CMS views as a separate factor "improvements in the medical technology itself that are so significant that we may wish to recognize them for separate payment even though they do not directly result in substantial clinical improvements." For example, technological advancements may result in improvement of a product's "convenience, durability [or] ease of operation such as the strength of materials, increased battery life, [and] miniaturization." The commenter suggested that CMS could recognize these additional improvements along with others when evaluating substantial clinical improvement in the inpatient setting.

Response: The commenter's specific reference to language that was included in the November 2, 2001 OPPS final rule was taken out of context. The language quoted above by the commenter from that OPPS final rule stated that CMS "may," under the OPPS, recognize technologies for separate payment even though they do not directly result in substantial clinical improvements. To date, under the OPPS, we have only applied the explicit substantial clinical improvement criteria to pass-through device category applications. In the OPPS context, CMS has not found any applications for technologies "that are so significant that we may wish to recognize them for separate payment (as opposed to packaged payments) even though they do not result in substantial clinical improvements" (67 FR 66783). In fact, the historical OPPS experience has indicated that, in general, highly significant advances in medical technology from characteristics such as longer battery life commonly result in substantial clinical improvements that may be appropriately evaluated according to the substantial clinical improvement criteria alone. We have not made a determination to apply these standards within the IPPS. However, as noted in the FY 2005 IPPS final rule (69 FR 49021), we will continue to consider whether to employ specific factors such as those identified for the OPPS in the IPPS.

Comment: One commenter urged CMS not to use the FDA section 510(k) approval process as a bar to a determination of meeting the newness criterion because the "predicate" devices identified through the section 510(k) approval process are not necessarily substantially similar to the new technology; rather the approval indicates that the new device is at least as safe and effective as its predicate(s).

Response: We appreciate the commenter's concern and agree that the mere existence of a predicate device(s) identified in the FDA section 510(k) approval process should not automatically preclude a product from meeting the newness criterion. Although we may consider the predicate devices that are listed in the FDA section 510(k) approval, we will evaluate whether a new technology is substantially similar to existing products on a case-by-case basis. We refer readers to the discussion in the FY 2006 final rule (70 FR 47350–47352) for more detailed information on substantial similarity.

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

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

Medtronic, Inc. submitted an application for approval of the Kinetra® implantable neurostimulator device for new technology add-on payments for FY 2005. In the IPPS final rule for FY 2005 (69 FR 49019, August 11, 2004), we approved Kinetra® for new technology add-on payments.

As noted above, the period for which technologies are eligible to receive new technology add-on payments is 2 to 3 years after the product becomes available on the market and data reflecting the cost of the technology are reflected in the DRG weights. This technology received FDA approval on December 16, 2003. Therefore, the technology will be beyond the 2- to 3-year period during which it can be considered new during FY 2007. Therefore, we proposed in the FY 2007 IPPS proposed rule (71 FR 24070), to discontinue add-on payments for the Kinetra® rechargeable, implantable neurostimulator device for FY 2007.

The manufacturer submitted a request that we consider a higher-paying DRG assignment for dual array neurostimulator pulse generator cases. We have taken this request into consideration and have reviewed the FY 2005 Medicare charge data for cases that use implantable neurostimulator for deep brain stimulation. Our findings and a full discussion of this issue can be found in section II.D.2.a. of the preamble of this final rule.

Comment: A number of commenters were concerned that the expiration of the new technology add-on payment for Kinetra® will lead to inadequate payments for full system Kinetra® implants. One commenter requested that CMS reconsider its decision to end payments for the Kinetra® implantable neurostimulator. Other commenters thanked CMS for its efforts in granting add-on payments for the Kinetra® during the last 2 years.

Response: As noted above, the Kinetra® technology will be beyond the 2-year to 3-year period during which it can be considered new during FY 2007. Therefore, we are finalizing our proposal from the FY 2007 IPPS proposed rule (71 FR 24070) to discontinue add-on payments for the Kinetra® rechargeable implantable neurostimulator for FY 2007.

b. Endovascular Graft Repair of the Thoracic Aorta

W. L. Gore & Associates, Inc. submitted an application for consideration of its Endovascular Graft Repair of the Thoracic Aorta (GORE TAG) for new technology add-on payments for FY 2006. The manufacturer argued that endovascular stent-grafting of the descending thoracic aorta provides a less invasive alternative to the traditional open surgical approach required for the management of descending thoracic aortic aneurysms. The GORE TAG device is a tubular stent-graft mounted on a catheter-based delivery system, and it replaces the synthetic graft normally sutured in place during open surgery. The device was initially identified using ICD–9–CM procedure code 39.79 (Other endovascular repair (of aneurysm) of other vessels). The applicant also requested a unique ICD–9–CM procedure code. As noted in Table 6B of the FY 2006 IPPS final rule (70 FR 47637), new procedure code 39.73 (Endovascular implantation of graft in thoracic aorta) was assigned to this technology.

In the FY 2006 IPPS final rule (70 FR 47356), we approved the GORE TAG device for new technology add-on payment for FY 2006. We noted that any substantially similar device that is FDA-approved before or during FY 2006 that uses the same ICD–9–CM procedure code as GORE TAG and is assigned to the same DRGs as those approved for new technology add-on payments may also receive the new technology add-on payment associated with this technology in FY 2006.

FDA approved GORE TAG on March 23, 2005. The technology remains within the 2- to 3-year period during which it can be considered new. Therefore, as we proposed (71 FR 24070), we are continuing add-on

payments for the endovascular graft repair of the thoracic aorta for FY 2007.

Comment: Some commenters supported our proposal to continue new technology add-on payments for GORE TAG for FY 2007.

Response: We thank the commenters for their support and, as noted above, we are continuing new technology add-on payments for GORE TAG for FY 2007.

c. Restore® Rechargeable Implantable Neurostimulator

Medtronic Neurological submitted an application for new technology add-on payments for its Restore® Rechargeable Implantable Neurostimulator for FY 2006. The Restore® Rechargeable Implantable Neurostimulator is designed to deliver electrical stimulation to the spinal cord to block the sensation of pain. The technology standard for neurostimulators uses internal sealed batteries as the power source to generate the electrical current. These internal batteries have finite lives, and require replacement when their power has been completely discharged. According to the manufacturer, the Restore® Rechargeable Implantable Neurostimulator "represents the next generation of neurostimulator technology, allowing the physician to set the voltage parameters in such a way that fully meets the patient's requirements to achieve adequate pain relief without fear of premature depletion of the battery." The applicant stated that the expected life of the Restore® rechargeable battery is 9 years, compared to an average life of 3 years for conventional neurostimulator batteries. We approved new technology add-on payments for all rechargeable, implantable neurostimulators for FY 2006. Cases involving these devices, made by any manufacturer, are identified by the presence of newly created ICD–9–CM code 86.98 (Insertion or replacement of dual array rechargeable neurostimulator pulse generator).

As noted above, the period for which technologies are eligible to receive new technology add-on payments is 2 to 3 years after the product becomes available on the market and data reflecting the cost of the technology are reflected in the DRG weights. The FDA approved the Restore® Rechargeable Implantable Neurostimulator in 2005. However, as noted above and in the FY 2006 IPPS final rule (70 FR 47358), at least one similar product was approved by the FDA as early as April 2004. Nevertheless, consistent with current policy (70 FR 47362) and decisions for prior products (that is, bone morphogenetic products and CRT–D devices), as we proposed (71 FR 24070 through 24071), we are continuing new technology add-on payments for rechargeable, implantable neurostimulators in FY 2007 because the product will be beyond the 3-year period only in the latter 6 months of the fiscal year.

Comment: Some commenters supported our decision to continue add-on payments for the Restore® Rechargeable Implantable Neurostimulator.

Response: We appreciate the commenters' support and as noted above, we are continuing new technology add-on payments for Restore® Rechargeable Implantable Neurostimulator for FY 2007.

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

a. C-Port® Distal Anastomosis System

Cardica, Inc. submitted an application for new technology add-on payments for FY 2007 for its Cardica C-Port® Distal Anastomosis System. The manufacturer stated that the C-Port® System is indicated for all patients requiring a vein as a conduit during a coronary bypass operation for bypassing a coronary artery stenosis or occlusion. The manufacturer contended that the C-Port® System is specifically designed to create a reliable and consistent end-to-side anastomosis between a conduit, such as a venous graft, and a small arterial vessel during the bypass surgery. The device consists of eight stainless steel clips and a delivery system. Once the vein graft has been loaded into the device and the device positioned against the target vessel, the anastomosis is created by pushing a single button. Cardica, Inc. stated the main purpose of the device is to replace a conventional hand-sewn, distal anastomosis with an automated, compliant, mechanical anastomosis.

We received the following public comments at the new technology town hall meeting regarding whether this technology meets the substantial clinical improvement criteria:

Comment: The manufacturer argued that this technology meets the substantial clinical improvement criterion because:

- It achieves higher patency rates at 6 months compared to conventional hand-sewn anastomoses.
- Use of the device will result in less surgeon-to-surgeon variability in the quality of the anastomosis compared to hand sewing.
- The device leads to reduced operative time.
- The product allows for the creation of an anastomosis during minimally invasive surgery.

In addition, we received written comments expressing support for approval of new technology add-on payments for the C-Port® System. These commenters noted that—

- The device allows the anastomosis to be completed quickly, reducing patient complications during surgery from ischemia.
- The device will allow for smaller incisions during heart surgery and physicians will not have to position their hands in the chest cavity in order to hand-sew the anastomosis.
- The rapidly deployed anastomosis clamp provides patients with a surgical alternative where one would otherwise not be available due to the comorbidities associated with the more invasive CABG procedures.

Response: We appreciate the time and effort the applicant took to present at the town hall meeting. We indicated in the proposed rule that we would consider the information presented in the written comments and at the town hall meeting, and invoted interested parties to submit objective data that would support the assertions presented above by the commenters.

The C-Port® System was granted section 510(k) approval from the FDA on November 10, 2005. While the device appeared to meet the criteria for being considered new based on its FDA approval date, we were concerned that various forms of surgical staples and clips have been used for more than a decade in a wide range of surgical procedures. In fact, the FDA found that the C-Port® System "is substantially equivalent to the predicate devices with regard to indications, device characteristics, method of use, labeling and materials." Thus, given its similarity to other devices currently on the market, we were concerned that the C-Port® System may not qualify as new. In the FY 2007 IPPS proposed rule, we solicited specific comments on whether this device is new and how it could be distinguished from predicate devices that perform the same or a similar function.

We received the following public comments in response to the proposed rule.

Comment: The manufacturer commented that the C-Port® System meets the newness criterion for the following reasons:

- The FDA section 510(k) approval process identifies predicate devices as having "a similar, not necessarily identical use and function."

• There is no other "fully-integrated anastomotic system cleared by the FDA for the creation of an anastomosis between a blood vessel graft and a target coronary artery." There are no "clip or staple-based automated distal coronary anastomotic devices such as [C-Port®] approved by the FDA." The manufacturer argued that while the devices they identified in the FDA section 510(k) approval process are similar to C-Port® system, none of them are identical.

• C-Port® was FDA approved in November 2005, thus enabling the device to still qualify as new based on its FDA approval date.

• There is no clinical precedence for the use of a stapling device in creating distal coronary anastomoses, and there are no ICD–9 CM codes for stapling devices—the lack of the procedure code means that CMS does not have charge data for C-Port® and that the device's costs are not reflected in the current DRG weights.

• CMS approved Kinetra® in 2004 and stated that the Kinetra® device was not "significantly different in terms of how it achieves its desired clinical results from its predecessor Soletra®." The manufacturer believed that the approval of Kinetra® sets precedence for C-Port® approval.

Response: We appreciate the manufacturer's clarification of the questions we posed in the proposed rule about whether the C-Port® would meet the newness criterion. The additional information submitted has allowed us to determine that the C-Port® meets the newness criterion.

In response to the commenter's statement about Kinetra®, we indicated that Soletra® and Kinetra® achieve the desired clinical result through the same stimulation mechanism. However, we did not find Soletra® and Kinetra® to be substantially similar products. We noted that Soletra® controls symptoms only on one side of a patient's body, while Kinetra® provides bilateral control of neurological symptoms through a single device. We determined in the FY 2005 IPPS final rule (69 FR 49019) that Kinetra® represented a substantial clinical improvement over the previous Soletra® device.

In the proposed rule, we also noted that there is currently no ICD–9–CM code used to identify how the anastomosis is performed. The surgical technique used to graft the bypass to the arterial vessel is part of the surgical procedure itself and is not separately identified in our current coding structure. Although there is not an explicit code to identify C-Port®, the hospital's charge for the device will be included on its bill. The hospital is permitted to charge for all items and services it furnishes irrespective of whether a particular item is identified by an explicit ICD–9–CM code. The charges included on hospital bills for the device will be part of the relative weight calculation 2 years later (that is, FY 2005 hospital charge data are used to set the FY 2007 relative weights).

Comment: The manufacturer of C-Port® urged CMS to differentiate between "distinct procedures involving the creation of anastomosis" by creating the following codes: (a) Anastomosis, manual; and (b) anastomosis, automated, using single or multiple clip array deployment technology. The manufacturer commented that a new code should be created for C-Port® because the C-Port® Distal Anastomosis procedure is not a typical part of the bypass procedure code and the use of the C-Port® system requires training and proctoring for physicians and OR staff to use the equipment because the C-Port® system comprises new steps and preparation in the bypass procedure. Finally, the manufacturer stated that CMS set a precedent for the creation of a new code by creating a code for a drug-eluting stent even though ICD–9–CM procedure codes already existed for stent procedures and by creating a new code to distinguish single versus dual channel-pulse generator devices (Kinetra® by Medtronic).

Response: While the use of the C-Port® device may represent a difference in technique of creating a distal anastomosis, we do not agree that it is a distinct procedure. Historically, we have subdivided procedures involving the insertion of specific devices that are designed to achieve a specific therapeutic purpose, but we have not assigned a code for specific tools used to perform surgery. Kinetra®, a stent and a pacemaker, is an example of a device that is implanted in a patient to treat an illness that is appropriately assigned a code. To date, we have not used a code to identify a specific type of surgical tool such as a scalpel, saw, or clamp. Similarly, we view C-Port® as a surgical tool (albeit far more sophisticated or innovative than those just mentioned) that should also not be recognized by its own ICD–9–CM code.

The applicant made several arguments in support of the device meeting the cost criterion. Cardica, Inc. estimated that the cost of each device will be approximately $1,200. The applicant assumed a hospital markup of 100 percent, with an average use of 2.5 C-Port® devices per case. Therefore, it estimated that the total average charge per patient will be $6,000. The C-Port® System would be used when a coronary artery bypass graft is performed. Thus, we assessed whether it meets the cost criterion in relation to the threshold for DRGs 106 (Coronary Bypass with Percutaneous Transluminal Coronary Angioplasty), 547 (Coronary Bypass with Cardiac Catheter with Major CV Diagnosis), 548 (Coronary Bypass with Cardiac Catheter without Major CV Diagnosis), 549 (Coronary Bypass without Cardiac Catheter with Major CV Diagnosis), and 550 (Coronary Bypass without Cardiac Catheter without Major CV Diagnosis). We note that the data analysis for this technology is slightly unusual, as the DRGs to which the technology would have been assigned in FY 2005 (the MedPAR data we are currently using) are DRGs 107 and 109. These DRGs were terminated in FY 2006, and 4 new coronary bypass DRGs were created for these cases (DRGs 547, 548, 549, and 550). The manufacturer provided estimates showing a case-weighted threshold for DRGs 106, 547, 548, 549 and 550 of $75,373. The applicant projected a 20-percent market penetration for the device in FY 2007 or its use in approximately 23,000 cases across the 5 DRGs. The applicant submitted data showing average standardized charges for cases using the C-Port® System of $80,887. Therefore, the applicant argued that the device meets the cost threshold for a new technology add-on payment. Our internal data analysis of the technology, using the FY 2005 MedPAR data and Table 10 thresholds for FY 2005, shows a case-weighted threshold of $68,416. We identified cases using coronary bypass procedure codes 36.10, 36.11, 36.12, 36.13 and 36.14, and concluded that the case-weighted average standardized charge for these bypass cases was $79,394. Thus, our internal data also suggested that the device meets the cost threshold.

As we discussed in the proposed rule, the applicant made several arguments in support of the device meeting the substantial clinical improvement criterion. The manufacturer argued that the C-Port® creates a reliable and fully compliant end-to-side anastomosis between a vein graft and a coronary artery, in less time than is required to create a hand-sewn distal anastomosis. The applicant also stated that the C-Port® System integrates deployment of the anastomotic clips and creation of the arteriotomy, thus enabling deployment to occur without occlusion of blood flow through the target vessel. However, we note that the applicant submitted evidence suggesting that the device does not always produce reliable

anastomoses; specifically, a study of 130 patients receiving 132 devices reported 13 incomplete anastomoses in 12 patients, and the study also noted that additional manual stitches were required in the majority of the patients studied. Therefore, we were concerned that these studies suggested that the C-Port® System may not represent a substantial clinical improvement over the traditional hand-sewn technique. At the town hall meeting, the applicant noted that these results were associated with inexperience preparing the target vessel, vein thickness assessment, proper device alignment and anastomosis site selection rather than problems with the device itself. The applicant believed that these problems will become infrequent as surgeons have more experience with the device. In the FY 2007 IPPS proposed rule, we solicited further information from commenters that would suggest how the product meets the substantial clinical improvement criterion.

We received the following comment in response to the proposed rule.

Comment: The manufacturer submitted the following comments to be considered in our evaluation of whether C-Port® met the substantial clinical improvement criterion:

- Intraoperative anastomotic failures with the hand-sewn technique occur in approximately 10 percent of patients. Falk, et al., evaluated vein graft patency using a meta-analysis of 28 published studies with over 28,000 grafts and found that occlusion within 30 days occurs in about 12 percent of vein grafts while occlusion within 6 months occurs in 20 percent.
- The C-Port® device may mitigate some of the negative factors found in hand-sewn anastomoses that impact vein graft patency. Post-operative vein graft patency rates using the hand-sewn technique were 88 percent at 30 days and 80 percent at 6 months (data obtained from historical controls); whereas patency rates using the C-Port® device were 99 percent at discharge and 96 percent at 6 months.
- In the greater than 1-year followup group, none of the patients in the pivotal C-Port® study required a reintervention.
- The "10 percent failure rate" cited in a C-Port® publication referred to a failure in surgeons using the device (due to lack of experience using it), not a failure of the device itself.

Response: We are concerned that information presented by the applicant does not demonstrate that this technology is a sufficient improvement over hand-sewing the distal anastomosis. Although patency rates using the C-Port® device were reportedly higher than those found using the hand-sewn technique (99 percent at discharge and 96 percent at 6 months compared to 88 percent at 30 days and 80 percent at 6 months), we also found that the data on the hand-sewn patency rates was derived from a meta-analysis of over 28,000 bypass grafts to different coronary vessels, many of which may have been comparatively poor candidates for bypass grafting, suggesting a possible selection bias in the arteries in the C-Port® study. We believe that a clinical study demonstrating substantial clinical improvement in outcomes is necessary for this technology because the comparison is of the CABG procedure using the C-Port® device to the hand-sewn technique. In some cases, our approval of a technology was based on a clinical assessment that at least one of the criteria for evaluating substantial clinical improvement listed in the new technology final rule (66 FR 46914) was met. For example, our approval of the Restore rechargeable neurostimulator was based on evidence that showed it decreased the "rate of subsequent * * * therapeutic interventions" by avoiding a surgery to replace a battery. Similarly, we approved GORE TAG because it "offers a treatment option for patient population unresponsive to, or ineligible for, currently available treatments." In these cases, we were less reliant on a clinical study to demonstrate improvement over an existing technology than our clinical judgment that the product achieved its intended purposes which itself is a substantial clinical improvement. With C-Port® or with a hand-sewn anastomosis, the treatment is the same (a CABG for coronary artery vessel disease). Thus, clinical studies demonstrating an improvement in CABG outcomes using the C-Port® device relative to the hand-sewn technique are critical to approving the device for new technology add-on payments.

Given the relatively high rates of success of both the hand sewn and the automated technique, we were not able to determine that the C-Port® device is a substantial clinical improvement over the traditional hand-sewn technique. Accordingly, after consideration of the comments received, we are not approving the C-Port® Distal Anastomosis System for FY 2007 new technology add-on payment.

There are several potential criteria listed in the new technology final rule that C-Port® could potentially meet. For instance, it is possible that C-Port® will reduce recovery time or lead to more rapid beneficial resolution of the disease process treatment. Given the potential benefits of C-Port®, it is likely that we would approve the technology for add-on payments with a study that more definitively demonstrates substantial clinical improvement. For instance, our main concern with the study presented was that the control group and the study population used to demonstrate substantial clinical improvement may not have been directly comparable. If there was a study that showed similar improvements in patency rates between the control group and a study population where the patients were directly comparable in their coronary artery vessel disease, we believe it would be more likely to demonstrate that the substantial clinical improvement criterion was met.

b. NovoSeven® for Intracerebral Hemorrhage

The Pinnacle Health Group in conjunction with Novo Nordisk Inc. (the manufacturer) submitted an application for new technology add-on payments for FY 2007 for NovoSeven® for Intracerebral Hemorrhage. However, the applicant withdrew its application for new technology add-on payment on June 07, 2006.

We received the following public comments regarding this application for new technology add-on payments in response to the FY 2007 IPPS proposed rule.

Comment: One commenter supported approving new technology add-on payments for NovoSeven®. The commenter believed that the availability of an add-on payment would help facilitate patient access to this important and costly therapy.

Response: We appreciate the commenter's response to the proposed rule. We note that, during the comment period, the applicant withdrew its application from consideration for new technology add-on payments for FY 2007.

We appreciate the applicant for its submittal of an application for new technology add-on payments and encourage a resubmission of an application upon FDA approval of its technology.

c. X STOP Interspinous Process Decompression System

St. Francis Medical Technologies submitted an application for new technology add-on payments for the X STOP Interspinous Process Decompression System for FY 2007. Lumbar spinal stenosis describes a condition that occurs when the spaces between bones in the spine become

narrowed due to arthritis and other age-related conditions. This narrowing, or stenosis, causes nerves coming from the spinal cord to be compressed, thereby causing symptoms including pain, numbness, and weakness. It particularly causes symptoms when the spine is in extension, as occurs when a patient stands fully upright or leans back. The X STOP device is inserted between the spinous processes of adjacent vertebrae in order to provide a minimally invasive alternative to conservative treatment (exercise and physical therapy) and invasive surgery (spinal fusion). It works by limiting the spine extension that compresses the nerve roots while still preserving as much motion as possible. The device is inserted in a relatively simple, primarily outpatient procedure using local anesthesia. However, in some circumstances, the physician may prefer to admit the patient for an inpatient stay. The manufacturer described the device as providing "a new minimally invasive, stand-alone alternative treatment for lumbar spinal stenosis."

The X STOP Interspinous Process Decompression system received pre-market approval from the FDA on November 21, 2005. The device is currently described by ICD–9–CM code 84.58 (Implantation of Interspinous process decompression device) (excluding: fusion of spine (codes 81.00 through 81.08, and 81.30 through 81.39)). This ICD–9–CM code went into effect on October 1, 2005.

The manufacturer provided data in support of the device meeting the cost threshold criterion. The applicant stated that there would be an average of 1.6 units used per case. Each unit costs $5,500; therefore, the technology is expected to cost $8,800 per case. The device is currently assigned to DRGs 499 (Back and Neck Procedures Except Spinal Fusion with CC) and 500 (Back and Neck Procedures Except Spinal Fusion without CC). The manufacturer projected that there would be approximately 424 patients eligible to receive the device in DRG 499 in FY 2007, while there may be approximately 1,700 patients who receive the device in DRG 500. The manufacturer also provided data for cases involved in the clinical trials. The average standardized charge for the cases in FY 2004 was $24,065. The weighted threshold for DRGs 499 and 500 is $20,096. However, the manufacturer argued that because significantly less than 20 percent of patients receiving the X STOP experienced complications or had comorbidities, the threshold should be calculated by estimating that 20 percent of patients would be assigned to DRG 499 and 80 percent would to DRG 500. The manufacturer stated in its application that, using this methodology, the applicable threshold should be $19,796. Using either calculation, it appears that the technology meets the cost threshold for new technology add-on payments.

The applicant also submitted information in support of its claim of meeting the substantial clinical improvement criterion. The manufacturer stated that the X STOP device is placed between the spinous processes to limit extension of the symptomatic level(s), yet allowing flexion, axial rotation, and lateral bending (that is, the device limits pressure on the spinal nerves and the resulting pain symptoms when the patient is in an upright position or leans backward while also preserving the patient's ability to turn side-to-side, bend forward, and to turn to either side). The applicant contended that this technology provides an alternative with improved clinical outcomes to conservative and surgical treatments. The manufacturer further stated that the device may offer a new alternative to lumbar spinal decompression procedures such as laminectomy and laminotomy. Additional information included in the application suggested that the device preserves spinal motion and is superior to a spinal decompression procedure that requires concomitant fusion (with or without instrumentation). The applicant argued that the advantages over spinal decompression include reduced risk, shorter hospital stay, and earlier improvement in pain and function. The manufacturer further contended that disease progression at adjacent levels is minimal following X STOP implantation compared to the known risk associated with surgical decompression and concomitant fusion. The applicant stated that the X STOP is comparable to traditional surgical decompression of lumbar spinal stenosis with respect to improved quality of life postoperatively. According to the applicant, the device provides advantages over nonoperative care, including better symptom relief, improved function, and increased patient satisfaction.

We received the following public comments through the new technology town hall meeting process regarding this application for add-on payments.

Comment: The applicant asserted that the X STOP Interspinous Process Decompression system has the following advantages:

- It retains spinal anatomy and all spinal structures.
- The device allows for increased function and less pain after implantation as evidenced by radiographic measures that showed increases in the spinal canal area by 18 percent, diameter by 9 percent, and subarticular diameter (the route that the nerves exit the spine) by 50 percent. In lateral view: area increased by 25 percent and width by 41 percent.
- The X STOP is a reversible procedure that causes no damage to facets or disks.
- The device allows for a treatment option for patients that cannot undergo surgeries with general anesthesia.
- The rate of complications associated with implantation of the device is below 1 percent.

Response: In the proposed rule, we indicated that we would evaluate these assertions as we further considered this application for new technology add-on payments for the final rule. We also noted that the study that the applicant summarized at the town hall meeting for the X STOP used a randomized study that targeted lumbar spinal stenosis patients with mild to moderate symptoms. The control group did not require operative care. In the proposed rule, we solicited information from the comments that demonstrates how the study populations showed substantial clinical improvement compared to the control group.

We believe that the device satisfies the newness and cost threshold criteria for new technology add-on payments. However, in the FY 2007 IPPS proposed rule, we expressed our concern that the information included with the application may raise issues about substantial clinical improvement. During the FDA approval process, the Center for Devices and Radiological Health (CDRH) Advisory Panel voted against premarket approval (PMA) in August 2004 because of concerns about proper patient selection as well as the lack of objective endpoints, especially radiographic endpoints. The Panel also mentioned the overall low clinical efficacy rate in the study population. The device subsequently received PMA approval, but only on the condition that it be used in the context of a long term (5 year) follow-up study. In the proposed rule, we solicited information from commenters that addressed the concerns raised by the CDRH Advisory Panel or other information bearing on the issue of whether this product meets the substantial clinical improvement criterion.

We note that the town hall meeting produced contradictory information regarding whether this procedure is generally performed in inpatient or

outpatient settings. The presenter indicated that over 90 percent of his patients were treated as outpatients. The manufacturer noted that 90 percent of non-U.S. patients and approximately two-thirds of U.S. patients since FDA approval have been treated in inpatient settings. While the setting where the procedure is typically performed has no bearing on whether the product represents a substantial clinical improvement, we noted that we believe the physician should select the most appropriate site to perform the procedure based on the clinical needs of the patient.

We received the following comments in response to the FY 2007 IPPS proposed rule.

Comment: The manufacturer commented that the contradictory information we noted in the proposed rule about whether the procedure in general performed in the outpatient or inpatient setting was likely the result of the presenter at the town hall meeting misspeaking when he said that the device was used in the outpatient setting about 90 percent of the time. Although the device may be used with local anesthesia, the manufacturer predicted that many clinicians attending to Medicare patients will choose general anesthesia and will use the procedure in an inpatient setting. The manufacturer stated that the X STOP device is currently used in the inpatient setting about 90 percent of the time.

Response: We appreciate the commenter's clarification of this point. As we indicated in the proposed rule, the site of service has no bearing on whether we will determine the technology to be a substantial clinical improvement. However, given the similarity in the criteria we apply in the two settings for determining substantial clinical improvement, we note that a decision to approve a device for inpatient new technology add-on payment may have implications for outpatient new technology pass-through payment.

Comment: In response to our request for additional information supporting that the X STOP device meets the substantial clinical improvement criterion, the manufacturer reiterated many of the comments that it submitted through the new technology town hall meeting process. Mainly, the commenter stated that X STOP offers an alternative to surgery that is associated with fewer and less severe complications, is a reversible procedure, and offers a faster recovery time than more invasive surgery. The commenter also stated that X STOP meets the criterion when compared to other disease management modalities for lumbar spinal stenosis patients, as evidenced by symptom relief, physical functioning, treatment satisfaction, and health-related quality of life, and that use of X STOP results in—

- Comparable treatment efficacy when compared to laminectomy
- Lower rates of intraoperative complications compared to surgical decompression with or without concomitant fusion
- Lower reoperation rates for unresolved stenosis systems compared to other surgical treatments.

In addition, the manufacturer stated that it addressed the issues that the Advisory Panel to the FDA cited as reasons for voting against approving X STOP. Those issues were in regards to proper patient selection, a lack of objective endpoints, especially radiographic endpoints and an overall low clinical efficacy rate in the study population. The manufacturer claimed that it addressed the concerns of the Advisory Panel by submitting additional data and analyses to the FDA that—

- Identified patients with LSS and moderately impaired physical function at baseline as the appropriate indication.
- Supplemented "the showing of the mechanism of effect on the spine in cadavers with in vivo clinical radiographic data."
- Addressed the issue of low clinical efficacy rates, by showing that the success rates using X STOP were comparable to those of more invasive procedures that are covered by Medicare.

The manufacturer further noted that the Advisory Panel wrote in its Summary of Safety and Effectiveness document that "the X STOP device met the primary clinical study endpoint for success, exceeding the success rate of the control in every statistical analysis." Finally, the manufacturer noted that the FDA requirement that X STOP's approval was conditioned on a 5-year followup study was not uncommon for spinal implant devices and that, over the past 10 years, all nine spinal implant FDA approvals have had similar conditional requirements. The manufacturer also commented that CMS approved the INFUSE Bone Graft device and noted that the FDA required a 6-year followup study as a condition of its approval of that device.

Several commenters who were individual physicians who have had experience using the X STOP device indicated that X STOP provides an alternative to more invasive surgery such as a laminectomy after conservative treatment has failed. All of the commenters supported approving the device for new technology add-on payment. In addition to commenters' support that the device is minimally invasive and has short operative and recovery time, some of the commenters mentioned other positive outcomes that the X STOP procedure—

- Increases foraminal height and produces minimal reversal of the lordosis, as measured by post operative x-rays;
- Reduced the pain reported by patients by half in some cases;
- Provided alleviation of neurogenic claudication symptoms; and
- Benefited patients with significant comorbidities, including cardiothoracic problems, specifically chronic obstructive pulmonary disease or coronary artery disease

In addition, some commenters noted that the X STOP device can very easily be implanted in the outpatient setting (assuming appropriate patient-selection), thus allowing high inpatient costs to be avoided.

Response: We appreciate the commenters' submittal of comments in support of X STOP. With respect to substantial clinical improvement, we continue to be concerned that the FDA Advisory Panel noted the overall low clinical efficacy rate in the study population and only approved the technology conditional on a 5 year followup study. Nevertheless, we note that the FDA did approve the technology, meaning that it is safe and effective (that is, it achieves its intended purpose). Further, we note that the applicant was able to address the FDA concern about lack of objective endpoints by the showing of the mechanism of effect on the spine in cadavers with in vivo clinical radiographic data. That is, the applicant was able to show that the X STOP device limits spine extension that compresses the nerve. Thus, we believe that the technology has promise for providing a less invasive alternative to procedures such as laminectomy or fusion for patients that have failed conservative treatment (exercise, physical therapy and medication). The X STOP system represents a new level of treatment on the continuum of care for patients with lumbar spinal stenosis that previously did not exist.

Accordingly, after consideration of the comments received, we are approving the X STOP Interspinous Process Decompression System for new technology add-on payment for FY 2007. However, we remain interested in seeing whether the clinical evidence from the 5-year followup study required by the FDA demonstrates that X STOP

continues to be effective. Cases involving X STOP will be identified by ICD–9–CM code 84.58 (Implantation of interspinous process decompression device). These cases are generally included in DRG 499 (Back and Neck Procedures Except Spinal Fusion with CC) and DRG 500 (Back and Neck Procedures Except Spinal Fusion without CC). As noted in the proposed rule, the manufacturer submitted data to support its estimated cost per case involving the X STOP procedure of $8,800. Accordingly, we are finalizing a maximum add-on payment of $4,400 for cases that involve this technology.

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

Table 10 of the IPPS proposed and final rules contains the cost thresholds that are used to determine whether a technology meets the criteria for new technology add-on payments. We are publishing an interim Table 10 in this final rule. We use the national adjusted operating standardized amounts in calculating the cost threshold. As noted in section III. and in the Addendum to this final rule, the final national adjusted operating standardized amounts will be published subsequent to this final rule when the wage index and budget neutrality factors are finalized for FY 2007. Therefore, we will also publish a revised version of Table 10, containing the final thresholds for FY 2008 between August 1 and October 1.

III. Changes to the Hospital Wage Index

A. Background

Section 1886(d)(3)(E) of the Act requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." In accordance with the broad discretion conferred under the Act, we currently define hospital labor market areas based on the definitions of statistical areas established by the Office of Management and Budget (OMB). A discussion of the FY 2007 hospital wage index based on the statistical areas, including OMB's revised definitions of Metropolitan Areas, appears under section III.B. of this preamble.

Beginning October 1, 1993, section 1886(d)(3)(E) of the Act requires that we update the wage index annually. Furthermore, this section provides that the Secretary base the update on a survey of wages and wage-related costs of short-term, acute care hospitals. The survey must exclude the wages and wage-related costs incurred in furnishing skilled nursing services. This provision also requires us to make any updates or adjustments to the wage index in a manner that ensures that aggregate payments to hospitals are not affected by the change in the wage index. The adjustment for FY 2007 is discussed in section II.B. of the Addendum to this final rule.

As discussed below in section III.G. of this preamble, we also take into account the geographic reclassification of hospitals in accordance with sections 1886(d)(8)(B) and 1886(d)(10) of the Act when calculating the wage index. Under section 1886(d)(8)(D) of the Act, the Secretary is required to adjust the standardized amounts so as to ensure that aggregate payments under the IPPS after implementation of the provisions of sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act are equal to the aggregate prospective payments that would have been made absent these provisions. The budget neutrality adjustment for FY 2007 is discussed in section II.A.4.b. of the Addendum to this final rule.

Section 1886(d)(3)(E) of the Act also provides for the collection of data every 3 years on the occupational mix of employees for short-term, acute care hospitals participating in the Medicare program, in order to construct an occupational mix adjustment to the wage index. A discussion of the occupational mix adjustment that we are applying beginning October 1, 2006 (the FY 2007 wage index) appears under section III.C. of this preamble.

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

The wage index is calculated and assigned to hospitals on the basis of the labor market area in which the hospital is located. In accordance with the broad discretion under section 1886(d)(3)(E) of the Act, beginning with FY 2005, we define hospital labor market areas based on the Core-Based Statistical Areas (CBSAs) established by OMB and announced in December 2003 (69 FR 49027). OMB defines a CBSA, beginning in 2003, as "a geographic entity associated with at least one core of 10,000 or more population, plus adjacent territory that has a high degree of social and economic integration with the core as measured by commuting ties." The standards designate and define two categories of CBSAs: Metropolitan Statistical Areas (MSAs) and Micropolitan Statistical Areas (65 FR 82235).

According to OMB, MSAs are based on urbanized areas of 50,000 or more population, and Micropolitan Statistical Areas (referred to in this discussion as Micropolitan Areas) are based on urban clusters with a population of at least 10,000 but less than 50,000. Counties that do not fall within CBSAs are deemed "Outside CBSAs." In the past, OMB defined MSAs around areas with a minimum core population of 50,000, and smaller areas were "Outside MSAs."

The general concept of the CBSAs is that of an area containing a recognized population nucleus and adjacent communities that have a high degree of integration with that nucleus. The purpose of the standards is to provide nationally consistent definitions for collecting, tabulating, and publishing Federal statistics for a set of geographic areas. CBSAs include adjacent counties that have a minimum of 25 percent commuting to the central counties of the area. (This is an increase over the minimum commuting threshold of 15 percent for outlying counties applied in the previous MSA definition.) We consider CBSAs that are MSAs to be urban, and CBSAs that are Micropolitan Statistical Areas as well as areas outside of CBSAs to be rural. In addition, where an MSA has been divided into Metropolitan Division to comprise the labor market areas for purposes of calculating the wage index (69 FR 49029).

The revised CBSAs established by OMB comprised MSAs and Micropolitan Areas based on Census 2000 data. (A copy of the announcement may be obtained at the following Internet address: *http://www.whitehouse.gov/omb/bulletins/fy04/b04–03.html.*) The revised definitions recognize 49 MSAs and 565 Micropolitan Areas, and extensively changed the composition of many of the MSAs that existed prior to the revisions.

The revised area designations resulted in a higher wage index for some areas and a lower wage index for others. Further, some hospitals that were previously classified as urban are now in rural areas. Given the significant payment impacts upon some hospitals because of these changes, we provided a transition period to the new labor market areas in the FY 2005 IPPS final rule (69 FR 49027 through 49034). As part of that transition, we allowed urban hospitals that became rural under the new definitions to maintain their assignment to the MSA where they were previously located for the 3-year period of FY 2005, FY 2006, and FY 2007.

Specifically, these hospitals were assigned the wage index of the urban area to which they previously belonged. (For purposes of the wage index computation, the wage data of these hospitals remained assigned to the statewide rural area in which they are located.) The hospitals receiving this transition will not be considered urban hospitals; rather, they will maintain their status as rural hospitals. Thus, the hospital would not be eligible, for example, for a large urban add-on payment under the capital PPS. In other words, it is the wage index, but not the urban or rural status, of these hospitals that is being affected by this transition. The higher wage indices that these hospitals are receiving are also being taken into consideration in determining whether they qualify for the out-migration adjustment discussed in section III.I. of this preamble and the amount of any adjustment.

FY 2007 will be the third year of this transition period. We will continue to assign the wage index for the urban area in which the hospital was previously located through FY 2007. In order to ensure this provision remains budget neutral, we will continue to adjust the standardized amount by a transition budget neutrality factor to account for these hospitals. Doing so is consistent with the requirement of section 1886(d)(3)(E) of the Act that any "adjustments or updates [to the adjustment for different area wage levels] * * * shall be made in a manner that assures that aggregate payments * * * are not greater or less than those that would have been made in the year without such adjustment."

Beginning in FY 2008, these hospitals will receive their statewide rural wage index, although they will be eligible to apply for reclassification by the MGCRB both during this transition period and in subsequent years. These hospitals will be considered rural for reclassification purposes.

Consistent with the FY 2005 and FY 2006 IPPS final rules, as we did beginning in FY 2006, for FY 2007 we are providing that hospitals receive 100 percent of their wage index based upon the CBSA configurations. Specifically, we will determine for each hospital a wage index for FY 2007 employing wage index data from FY 2003 hospital cost reports and using the CBSA labor market definitions.

C. Occupational Mix Adjustment to the FY 2007 Wage Index

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

Comment: Some commenters expressed concern about the occupational mix adjustment relative to the proposed implementation of changes to the DRG system. A few stated that the purpose of the occupational mix adjustment is to ensure that hospitals are not paid through both the wage index and the resource-based DRG system for the additional resources needed for certain procedures. The commenters suggested that the occupational mix adjustment is not necessary if a robust severity-adjusted DRG system is implemented. Other commenters indicated that CMS should consider deferring the implementation of the proposed hospital-specific cost weighting methodology and severity DRGs until at least FY 2008 to alleviate the burden on hospitals that will be negatively affected by a redistribution of Medicare payments under the new occupational mix adjustment.

Response: We remind the commenters that an occupational mix adjustment to the wage index is required under section 1886(d)(3)(E) of the Act. Although we understand the commenters' concerns that some hospitals may be negatively affected by the new occupational mix adjustment, we also believe that it is important for us to move forward with implementing changes in the DRG system that would recognize that some more complex cases may require a higher DRG payment because the services are provided by more highly skilled workers.

Comment: A few commenters opposed the occupational mix adjustment. One commenter believed that the initial application of the occupational mix adjustment had unintended results, benefiting fewer rural hospitals and more large urban hospitals than anticipated. The commenter stated that this problem has been compounded by the additional pressure from the decision in *Bellevue Hosp. Center* v. *Leavitt*, 443 F.3d 163 (2nd Cir. 2006), and, therefore, recommended that CMS approach Congress about repealing the mandate for the occupational mix adjustment. Another commenter indicated that the occupational mix survey is confusing and burdensome to hospitals.

Response: As held in *Bellevue Hosp. Center* v. *Leavitt*, 443 F.3d 163 (2nd Cir. 2006), adjusting the wage index for occupational mix is required by Congress. Therefore, commenters who believe that the occupational mix should be eliminated would need to approach the Congress with such concerns. As for the initial application of the occupational mix, we believe the unexpected outcomes may have been due to a combination of factors, including the newness of the survey and changing trends in hospital employment. We have modified the survey for 2006, and these modifications should reduce the risk of reporting and measurement errors. These modifications are based largely on suggestions we received from MedPAC and the hospital community. We understand the commenter's concern that completing the survey causes a burden to hospitals; however, the statute requires us to collect data on occupational mix every 3 years. In response to similar concerns expressed for the 2003 survey, we streamlined the 2006 survey and clarified the instructions in an effort to reduce the burden. We will continue to work with hospitals and associations to explore ways to improve the survey to ensure the accuracy of the occupational mix adjustment while reducing the reporting burden for hospitals.

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

In our initial FY 2007 IPPS proposed rule (71 FR 23996), we discussed our proposals for calculating the proposed FY 2007 occupational mix adjustment. We proposed to use the same CMS Wage Index Occupational Mix Survey and Bureau of Labor Statistics (BLS) data that we used for the FY 2005 and FY 2006 wage indices, with a few exceptions. We also proposed to adjust 10 percent of the FY 2007 wage index by a factor reflecting occupational mix. However on April 3, 2006, in *Bellevue Hosp. Center* v. *Leavitt*, 443 F.3d 163 (2nd Cir. 2006) the Court of Appeals for the Second Circuit (the Court) ordered CMS to apply the occupational mix adjustment to 100 percent of the wage index effective for FY 2007. The Court ordered CMS to "immediately * * * collect data that are sufficiently robust to permit full application of the

occupational mix adjustment." The Court also ordered that all "data collection and measurement and any other preparations necessary for full application be completed by September 30, 2006, at which time the agency is to immediately apply the adjustment in full." For more information, we refer the readers to *Bellevue Hosp. Center* v. *Leavitt*, 443 F.3d 163, 179 (2nd Cir. 2006).

To comply with the Court's order, on April 21, 2006, we issued a Joint-Signature Memorandum (JSM–06412) to all Medicare fiscal intermediaries announcing our plans to collect new occupational mix data from hospitals. The Joint-Signature Memorandum is available on the CMS Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS*. Click on "Wage Index Files" and the link is titled: *2006 Occupational Mix Survey—Interim Data Collection—CMS Memo to Fiscal Intermediaries*.

On May 17, 2006, we also published in the **Federal Register** (71 FR 28644) a second proposed rule that proposed to revise the methodology for calculating the occupational mix adjustment by applying the occupational mix adjustment to 100 percent of the wage index using the new occupational mix data collected from hospitals. The second proposed rule also proposed to modify hospitals' procedures for withdrawing requests to reclassify for the FY 2007 wage index and for supplementing the FY 2008 reclassification application with official data used to develop the FY 2007 wage index. In addition, we proposed to replace in full the descriptions of the data and methodology that would be used in calculating the occupational mix adjustment discussed in the initial FY 2007 IPPS proposed rule.

As stated earlier, section 1886(d)(3)(E) of the Act requires us to conduct a new survey at least once every 3 years. On October 14, 2005, we published a notice in the **Federal Register** (70 FR 60092) proposing to use a new survey, the 2006 Medicare Wage Index Occupational Mix Survey (the 2006 survey) to apply an occupational mix adjustment to the FY 2008 wage index. In the proposed 2006 survey, we included several modifications based on the comments and recommendations we received on the 2003 survey, including (1) allowing hospitals to report their own average hourly wage rather than using BLS data; (2) extending the prospective survey period; and (3) reducing the number of occupational categories but refining the subcategories for registered nurses.

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

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

The revised 2006 survey provides for the collection of hospital-specific wages and hours data, a 6-month prospective reporting period (that is, January 1, 2006, through June 30, 2006), the transfer of each general service category that comprised less than 4 percent of total hospital employees in the 2003 survey to the "all other occupations" category (the revised survey focuses only on the mix of nursing occupations), additional clarification of the definitions for the occupational categories, an expansion of the registered nurse category to include functional subcategories, and the exclusion of average hourly rate data associated with advance practice nurses.

The 2006 survey includes only two general occupational categories: Nursing and "all other occupations." The nursing category has four subcategories: registered nurses, licensed practical nurses, aides, orderlies, attendants, and medical assistants. The registered nurse subcategory includes two functional subcategories: management personnel and staff nurses or clinicians. As indicated above, the 2006 survey provides for a 6-month data collection period, from January 1, 2006 through June 30, 2006. However, we allowed flexibility for the reporting period begin and end dates to accommodate some hospitals' bi-weekly payroll and reporting systems. That is, the 6-month reporting period must begin on or after December 25, 2005, and must end before July 9, 2006.

To comply with the order of the court in *Bellevue Hosp. Center* v. *Leavitt*, as discussed above, we proposed to collect new survey data, instead of using the 2003 survey data proposed in the FY 2007 IPPS proposed rule, to calculate the occupational mix adjustment for the FY 2007 wage index. Because hospitals were already collecting data for the revised 2006 survey, we proposed to use the first 3 months of that data (that is, from January 1, 2006, through March 31, 2006) to calculate the FY 2007 occupational mix adjustment. In order to allow sufficient time for hospitals, fiscal intermediaries, and CMS to collect, review, and correct the new data, and for CMS to perform required analyses and apply the new data in calculating the FY 2007 occupational mix adjustment, we determined that it would be impossible for us to apply the full 6 months of data by October 1, 2006.

Comment: Several commenters stated that hospitals were sometimes unsure of the placement of certain employees on the survey. For example, hospitals were uncertain as to the category that would include surgical technicians and paramedics who are employed by the hospital and who usually work in the emergency department. The commenters urged CMS to evaluate where these employees should be placed on the survey for future collections.

The commenters also stated that they agreed with CMS' efforts to ensure consistent reporting by specifying the cost centers for collecting nursing personnel data. They agreed that the cost centers included on the survey are where the majority of nurses are employed within hospitals. The commenters added that the use of the cost centers significantly reduces the burden for hospitals by allowing them to focus on only the listed cost centers. However, the commenters urged CMS to consider refining the list of cost centers for future collections. The commenters advised that every hospital has a different method for attributing costs to cost centers; therefore, some hospitals may have a few cost centers that contain a significant number of nursing personnel that were not included in the current survey.

The commenters recommended that CMS work with the hospital community to explore potential changes to the survey occupational categories and cost centers. Even if they are warranted, the commenters suggested that CMS should not make any changes to the ongoing survey collection, as it would

necessitate the resubmission of the 1st quarter 2006 data to ensure that both 1st and 2nd quarters could be used for the FY 2008 and the FY 2009 occupational mix adjustment.

Response: We appreciate the assistance we have already received from the hospital community in developing the 2006 occupational mix survey. On May 25, 2006, in response to questions from hospitals and associations, we distributed supplemental instructions to the intermediaries, hospitals (via the intermediaries), and national hospital associations (and posted the instructions on our Web site) to clarify the placement of nursing and nonnursing personnel on the occupational mix survey. We will continue to work with MedPAC and the hospital community to determine if changes to the occupational categories and cost centers included on the survey are reasonable and necessary for future collections. We agree with not changing the instructions for the 2006 survey. As the commenters indicated, to change the survey with the 1st quarter data collection already completed would require substantial rework on the part of hospitals, fiscal intermediaries, and CMS.

Comment: A few commenters expressed concern that hospitals in States with mandatory nurse-staffing ratios for inpatient facilities and hospitals that use higher levels of registered nurses to improve the quality of care will be adversely affected by the occupational mix adjustment. One commenter stated that the current survey is designed to benefit parts of the country that make greater use of lesser skilled nurses and allied health professionals, and to reduce payment in areas that make greater use of registered nurses in nursing positions. The commenter speculated that the occupational mix adjustment will likely reduce the payments for its hospitals, thus reducing the quality of care they can provide to Medicare beneficiaries.

Another commenter indicated that the wage index and occupational mix adjustments penalize hospitals that invest in quality and efficiency at the same time that Congress is trying to improve quality and efficiency under the Medicare program. The commenter stated that the effect of these adjustments on hospitals that use higher levels of registered nurses reduces or eliminates the annual Medicare inflation increase provided to address the increasing costs these hospitals incur. The commenter further indicated that this reduction would not be a savings to the program, but rather it would be a redistribution of Medicare payments to hospitals that have not been as efficient or as focused on improving the quality of care.

Response: As stated earlier, the statute requires implementation of an occupational mix adjustment to the wage index. In addition, the purpose of the occupational mix adjustment is to control the effect of a hospital's employment mix on its average hourly wage for the wage index. The adjustment standardizes the employment mix for hospitals so that the wage index more accurately compares wage rates among labor market areas for a constant mix of labor. As the commenters noted, the occupational mix adjustment would lower the wage index for an area employing a mix of more highly paid and skilled labor than the national average. Although we understand the commenters' concerns regarding the effect of the occupational mix on their areas' Medicare payments, we disagree that the wage index and occupational mix adjustments penalize hospitals that invest in quality and efficiency. We note that CMS is moving toward adoption of a severity-based DRG system that will better recognize severity of illness and provide improved payments to those hospitals that need more highly skilled labor to care for more severely ill patients. Even under the current system, the labor costs incurred by hospitals that provide more highly skilled services are currently reflected in the hospital's DRG payments and illustrated through a higher case mix index. Reflecting the costs associated with more highly skilled labor in both the case mix and the wage index is essentially counting them twice.

To comply with the order of the court in *Bellevue Hosp. Center* v. *Leavitt*, as a final policy, we are adopting our proposal to use the new 1st quarter 2006 survey data to calculate the occupational mix adjustment for the FY 2007 wage index.

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

The Joint-Signature Memorandum (JSM–06412) that we issued on April 21, 2006, instructed all fiscal intermediaries to immediately alert the hospitals they service to the changes in the schedule for submitting the occupational mix data files.

The Joint-Signature Memorandum provided hospitals and fiscal intermediaries with the revised schedule for the occupational mix survey data that would be used in the FY 2007 wage index. The schedule included deadlines for—

- Hospitals to submit occupational mix data. The deadline was June 1, 2006.
- Fiscal intermediary review of the submitted data. The deadline was June 22, 2006.
- Availability of the submitted data on the CMS Web site. The deadline was June 29, 2006.
- Hospitals to submit requests to their fiscal intermediaries for corrections to their interim occupational mix data. The deadline was July 13, 2006.
- Fiscal intermediaries to submit corrected interim occupational mix survey data for the January 1, 2006, through March 31, 2006 period. The deadline was July 27, 2006.

We noted that it was critical that hospitals provide information according to the dates provided in the schedule in order to be able to appeal any disputed calculations at a later point to the Provider Review Reimbursement Board (PRRB). The final deadline for the fiscal intermediaries to make occupational mix data available to CMS was July 27, 2006. These data would reflect fiscal intermediary review and the resolution of any errors or adjustments between the hospitals and fiscal intermediary. Once these data are available on the CMS Web site, changes to a hospital's occupational mix data would be allowed only in those very limited situations involving an error by the fiscal intermediary or CMS that the hospital could not have known about before its review of the final occupational mix data file. Specifically, neither the fiscal intermediary nor CMS would approve the following types of requests:

- Requests for occupational mix data corrections that were submitted too late to be included in the data transmitted to CMS by fiscal intermediaries on or before July 27, 2006.
- Requests for correction of errors that were not, but could have been, identified during the hospital's review of the June 29, 2006 occupational mix file.

Verified corrections to the occupational mix received by the fiscal intermediaries and CMS (that is, by July 13, 2006) would be incorporated into the final wage index for FY 2007, to be effective October 1, 2006.

We created the process described above to resolve all substantive occupational mix correction disputes before we finalize the wage and occupational mix data for the FY 2007 payment rates. Accordingly, hospitals that did not meet the procedural deadlines set forth above will not be

afforded a later opportunity to submit occupational mix data corrections or to dispute the fiscal intermediary's decision with respect to requested changes. Specifically, our policy is that hospitals that do not meet the procedural deadlines set forth above will not be permitted to challenge later, before the PRRB, the failure of CMS to make a requested data revision. (See *W.A. Foote Memorial Hospital* v. *Shalala,* No. 99–CV–75202–DT (E.D. Mich.2001) and *Palisades General Hospital* v. *Thompson,* No. 99–1230 (D.D.C. 2003)). We also refer the reader to the FY 2000 IPPS final rule (64 FR 41513) for a discussion of the parameters for appealing to the PRRB for wage index data corrections.

We believe the occupational mix data correction process described above provided hospitals with the opportunity to bring errors in their occupational mix data to the fiscal intermediary's attention.

Because hospitals had access to the final occupational mix data by June 29, 2006, we believe they had the opportunity to detect any data entry or tabulation errors made by the fiscal intermediary or CMS before the development and publication of the final FY 2007 wage index and the implementation of the FY 2007 wage index on October 1, 2006. We believe that if hospitals availed themselves of the opportunities afforded to provide and make corrections to the occupational mix data, the wage index implemented on October 1, 2006, will be accurate. In the event that errors are identified by hospitals and brought to our attention after July 13, 2006, we will only make mid-year changes to the wage index in accordance with § 412.64(k). For a detailed discussion, see section III.J. of this preamble.

Comment: One commenter stated that the 6-month reporting period for the 2006 survey, originally planned for the FY 2008 wage index, is an improvement over the 2003 survey process. However, the commenter urged CMS to initiate a survey with a full-year reporting period for the FY 2009 wage index.

Response: We appreciate the commenter's recognition of our efforts to improve the occupational mix survey process. We also appreciate the commenter's suggestion for expanding the survey reporting period to a full year for the FY 2009 wage index. While we appreciate the willingness expressed in the comment to collect a complete year of data in order to achieve more accurate survey results, we note that hospitals are currently obligated to collect data for the period April 1, 2006, to June 30, 2006, by August 31 in order for us to use 6 months of data to apply the occupational mix adjustment for FY 2008. If we were to use a full year of 2006 survey data to apply an occupational mix adjustment for FY 2009, hospitals would have to submit data for the last 6 months of calendar year 2006. Hospitals have already been required to submit occupational mix survey data for two different 3-month periods in 2006. At this time, we believe it would be burdensome to require a third occupational mix data collection from hospitals for 2006 in order to apply the adjustment based on a full year of data for FY 2009. We also note that collecting a full year of calendar year 2007 data, from January 1, 2007, through December 31, 2007, would not provide enough time for a thorough review and correction period before the FY 2009 proposed rule would be published in April 2008. Our normal wage index review and correction process before the proposed rule publication begins in early October and ends in late February. This would mean that hospitals and intermediaries would have only approximately 2 months, from January to late February, to review and correct a year's worth of occupational mix data. We believe that such an abbreviated review and correction period would not be in the hospitals' best interest. However, we will consider expanding the survey reporting period to a full year for a future collection.

Comment: Some commenters expressed concern that the 3-month survey period for FY 2007 will lead to inaccurate results for several reasons: Having no advance notice of the expedited data collection; some hospitals had not yet begun, or had just begun, to plan for the 2006 survey data collection and had little or no resources available to complete the survey for all or part of the 3-month time period; the new survey, though improved over the previous survey, is more complicated and requires more effort to complete; due to the short timeframe for developing and submitting the data (4 months), some normal review processes had to be eliminated by hospitals; not enough time was allowed for the types of corrections that can be made during the annual wage index survey process; due to the infrequent collection of the occupational mix data, many hospitals may underestimate its importance; there was not enough time for hospital groups to review the data for individual hospitals in the area, a process that often raises questions that leads to more accurate data.

Response: We understand the commenters' concerns about the potential for inaccurate occupational mix survey data to be used due to the abbreviated data collection and reporting periods. However, CMS has established a process that we believe will maximize the opportunity for accurate occupational mix data to be used to adjust area wage indices. Hospitals were required to submit occupational mix survey data to their fiscal intermediaries by June 1, 2006. CMS provided fiscal intermediaries with a desk review program to assist in identifying erroneous or aberrant data. Fiscal intermediaries then had 3 weeks (or until June 22) to review the data and submit it to CMS. CMS made the occupational mix survey data available on the CMS Web site on June 29 to facilitate review by hospitals, fiscal intermediaries, and others. The June 29 posting of occupational survey data resulted in hospitals, State hospital associations, wage index consultants, and others identifying errors and other aberrant data. These parties then initiated action to correct the occupational mix survey data by the July 13 deadline. While there is no additional time available to correct the survey data for the FY 2007 wage index, we will, however, allow hospitals to submit any additional revisions and corrections to both 3-month periods of data for the FY 2008 wage index. We strongly encourage hospitals to take full advantage of the FY 2008 wage index correction process. Hospitals will be notified early in the Fall of 2006 regarding the revision/correction process for the FY 2008 wage index for both the cost report wage data and the 2006 occupational mix survey data.

3. Calculation of the Occupational Mix Adjustment

In the May 17, 2006 proposed rule, we proposed a series of steps to be used in calculating the FY 2007 occupational mix adjustment factor. In this final rule, we are adopting the proposed steps with one minor exception. In response to comments (discussed below), we have made an adjustment to step 7 so that the percentage of worker salaries attributable to the nursing category is based on salaries and not on hours. For 2007, we will calculate the occupational mix adjustment factor using the following steps:

Step 1—For each hospital, determine the percentage of the total nursing category attributable to a nursing subcategory by dividing the nursing subcategory hours by the total nursing category's hours (registered nurse management personnel and registered nurse staff nurses or clinicians are treated as separate nursing

subcategories). Repeat this computation for each of the five nursing subcategories: Registered nurse management personnel, registered nurse staff nurses or clinicians, licensed practical nurses; nursing aides, orderlies, and attendants; and medical assistants.

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

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

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

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

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

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

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

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

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

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

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

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

Step 11—To compute the occupational mix adjusted wage index, divide each area's occupational mix adjusted average hourly wage (Step 9) by the national occupational mix adjusted average hourly wage (Step 10).

Step 12—To compute the Puerto Rico specific occupational mix adjusted wage index, follow Steps 1 through 11 above.

Comment: MedPAC and a few other commenters noted that Step 7 of CMS' proposed calculation for the occupational mix adjustment uses the occupational mix survey's paid hours to determine the portion of the salaries and wage-related costs to adjust for occupational mix (that is, the total nursing portion) and the portion to remain unadjusted (that is, the all other occupations portion). One of the commenters stated that this approach was reasonable using the 2003 survey data because hospital-specific paid salaries data were not collected. However, the commenter also noted that the actual share of wages for either the nursing category or the all other occupations category could differ using an allocation that is based on paid hours compared to paid salaries. The commenters suggested that, since the 2006 survey provides for the collection of paid salaries data, CMS should use paid salaries instead of paid hours to more accurately determine the wage costs that should be adjusted for occupational mix and those that should not.

Response: As discussed above, we evaluated the commenters' recommendation and agree that it is reasonable to use the occupational mix survey salaries instead of hours in computing the portion of a hospital's salaries and wage-related costs to adjust for occupational mix and the portion to remain unadjusted. Accordingly, we revised Step 7 of the final calculation for the occupational mix adjustment to reflect this change.

We received no other comments on the steps used in calculating the occupational mix adjustment. As a final policy, we are adopting the proposed calculation, with the change to Step 7, for the occupational mix adjustment to the FY 2007 wage index. Also, to comply with the order of the court in *Bellevue Hosp. Center* v. *Leavitt*, we will apply this adjustment to 100 percent of the wage index.

The table below is an illustrative example of the final occupational mix adjustment. (**Note**: We have revised this example from that included in the proposed rule to reflect the change in step 7 discussed above. We have added an additional column for provider occupational mix salaries and the Provider Percent by Total is determined by dividing the hospital's total nurse salaries (and separately, Total All Other Salaries) by Total Employee Salaries.

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Example of Occupational Mix Adjustment

Hospital A								
			Step 1	Step 2	Step 3	Step 5	Step 6	in Step 7
	Provider Occupational Mix Hours	Provider Occupational Mix Salaries	Provider % by Subcategory	National AHWs by Subcategory	Provider Adjusted AHW	National Adjusted Nurse AHW	Nurse Occupational Mix Adjustment Factor	Provider % by Total
RN Mngt	202,387.00	$780,640.00	9.84%	$50.00	$4.92			
RN Staff	1,439,742.00	$17,345,123.00	70.00%	$30.00	$21.00			
LPNs	67,860.00	$404,822.00	3.30%	$20.00	$0.66			
Nurse Aides	259,177.00	$1,762,579.00	12.60%	$13.00	$1.64			
Medical Assistants	87,622.00	$577,045.00	4.26%	$12.00	$0.51			
Total Nurse Hours and Salaries	2,056,788.00	$20,870,209.00			$28.73	$27.00	0.9398	52.40%
ALLOTHER	5,000,000.00	$18,957,010.00			Step 4			47.60%
TOTAL	7,056,788.00	$39,827,219.00						
Wage Data from Cost Report								
Wages (From S-3, Parts II and III)	$83,312,942.55							
Hours (From S-3, Parts II and III)	3,836,299.60							
Hospital A Unadjusted AHW	$21.72							
Nurse Occupational Mix Wages	$41,030,019	Step 7						
All Other Unadjusted Occupational Mix Wages	$39,655,400	Step 7						
Total Occupational Mix Wages	$80,685,419	Step 8						

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

Because the occupational mix adjustment is required by statute, all hospitals that are subject to payments under the IPPS, or any hospital that would be subject to the IPPS if not granted a waiver, must complete the occupational mix survey, unless the hospital has no associated cost report wage data that are included in the FY 2007 wage index.

For the FY 2005 and FY 2006 final wage indices, we used the unadjusted wage data for hospitals that did not submit occupational mix survey data. For calculation purposes, this equates to applying the national nursing mix to the wage data for these hospitals, because hospitals having the same mix as the Nation would have an occupational mix adjustment factor equaling 1.0000. However, an adjustment may not be equitable in situations where the hospital has a higher or lower than average occupational mix than the Nation as a whole. If the hospital's occupational mix is higher than the average for the nation as a whole, hospitals in other areas are disadvantaged by the hospital not providing occupational mix information. If the hospital's occupational mix is lower than the average for the Nation as a whole, other hospitals in the same geographic area would be disadvantaged by the hospital not providing the information.

In the FY 2005 and FY 2006 IPPS final rules (69 FR 49035 and 70 FR 47368), we noted that we would revisit this matter with subsequent collections of the occupational mix data. In the May 17, 2006 proposed rule, for the FY 2007 wage index, we proposed to use one of four options for treating the occupational mix data for nonresponsive hospitals: (1) Assign the hospital an occupational mix adjustment factor of 1.0000 as we did for FY 2005 and FY 2006; (2) assign the hospital the average occupational mix adjustment factor for its labor market area; (3) assign the hospital the lowest occupational mix adjustment factor for its labor market area; or (4) assign the hospital the average occupational mix factor for similar hospitals, based on factors such as, geographic location, bed size, teaching versus non-teaching status and case mix. We requested comments on these or other alternatives for equitably addressing the situation of hospitals that are not responsive to the occupational mix survey.

Comment: A majority of the commenters believed that, in order for the wage index to be computed accurately, it is critical for all IPPS hospitals to complete the occupational mix survey. Many of the commenters suggested that CMS should penalize hospitals that did not submit a survey. However, the commenters indicated that no hospitals should be penalized for not completing the survey for the 1st quarter of FY 2006 (to be used in calculating the FY 2007 wage index) because of the short notification and timeframe for the collection of that data. Some suggested future penalties such as a 1 to 2 percent reduction in the hospital's wage index value or a set percentage of the standardized amount, whichever is administratively feasible. However, the commenters also suggested that any penalty should be hospital-specific and should not affect the wage index amounts for other hospitals in the area. Commenters suggested that CMS should first calculate the area wage index using proxy data for a nonresponsive hospital's occupational mix adjustment, and then CMS should assess a penalty on its wage index value or national standardized amount.

The commenters supported all of the ideas we raised in the proposed rule except option 3. Commenters unanimously opposed assigning the hospital the lowest occupational mix adjustment factor for its labor market area, because they believed this option would have the most negative impact on other hospitals in the labor market area. MedPAC recommended option 4, to assign the hospital the average occupational mix factor for similar hospitals, based on factors such as, geographic location, bed size, teaching versus nonteaching status and case-mix. MedPAC suggested other factors that CMS should consider, such as share of ICU days and types of services offered. Some commenters recommended an option that we did not describe. These commenters recommended that CMS substitute data from the previous 2003 survey for hospitals that did not submit 2006 survey data for the FY 2007 wage index. Alternatively, several commenters recommended that CMS could substitute the national average hourly wage (that is, option 1, an occupational mix adjustment of 1.0000) for nonresponsive hospitals in calculating an area's wage index, while others favored option 2 because it would have the least affect on the labor market area. One commenter recommended assigning the lower of the hospital's occupational mix adjustment in FY 2006 or the average for the hospital's labor market in FY 2007. The commenter believed that the best proxy for a hospital's missing FY 2007 data is its FY 2006 occupational mix adjustment, even though there was a change in the formula to calculate the FY 2007 adjustment. The commenter stated that CMS should provide an exception for an exogenous event affecting all hospitals in the labor market area. In this scenario, the commenter recommended using the average FY 2007 adjustment.

Response: We agree with the commenters that hospitals that did not respond to the occupational mix survey should not benefit from the participation of others. We also agree that, due to the unusual circumstances of the Court's order and the short timeframe that hospitals were provided for completing and submitting their data, it would not be fair to apply a penalty to nonresponsive hospitals for the 2007 wage index. However, we believe that section 1886(d)(5)(I)(i) of the Act provides us with the authority to penalize hospitals that do not submit occupational mix survey data. That section authorizes us to provide for exceptions and adjustments to the payment amounts under IPPS as the Secretary deems appropriate. We will give serious consideration to applying a hospital-specific penalty such as those suggested by the commenters if a hospital does not comply with regulations requiring submission of occupational mix survey data in future years. We will address this issue in the FY 2008 IPPS proposed rule.

Regarding the treatment of data for nonresponsive hospitals, we have chosen not to adopt option 3, because it would be punitive to other hospitals in the area that submitted occupational mix data. We also have not chosen option 1 because it does not provide an incentive for hospitals to respond if they have a higher mix of employees than the national average. We will not use data from the 2003 survey, as some commenters suggested, because the 2007 wage index, we believe, should be exclusively based on the newly collected data. In addition, there was concern about the sufficient robustness of such data to support 100 percent adjustments. We also do not believe it would be entirely feasible, for 2007, to implement MedPAC's recommendation, option 4, due to the wide range of parameters that could be used for developing proxies for the missing hospitals and the fact that the exact set of such parameters was not subject to comment. So many variables might be of relevance that our selection of any particular variables might be subject to controversy, and hospitals may wish to have an opportunity to comment on the exact variables that would be used. MedPAC's recommendation to add more variables to further refine the analysis

could be so limiting as to result in few or no hospitals to use for comparison.

For the FY 2007 wage index, we have adopted option 2—using the average occupational mix adjustment for the labor market area. We believe this option would have the least impact on the wage index for other hospitals in the area and does not have the disadvantages of the options discussed above. Although we believe this option is the best of the ones we considered for nonresponsive hospitals for FY 2007, we reserve the right to apply a different approach in future years, including potentially penalizing nonresponsive hospitals. If there is only one hospital in the labor market area, and that hospital failed to submit occupational mix data, or, if there are no hospitals in the labor market area, we would apply the national occupational mix factor of 1.0000 in calculating the area's FY 2007 occupational mix adjusted wage index.

Comment: Some commenters recommended that CMS allow hospitals that failed to submit their 1st quarter data by June 1, 2006, to submit that data when the 2nd quarter data is due (that is, by August 31, 2006). The commenters also suggested that CMS allow hospitals that submitted their 1st quarter data by June 1, an opportunity to correct that data when the 2nd quarter data are due. The commenters indicated that allowing hospitals to submit the data at this time would improve the survey response rate and eliminate the need for penalties for hospitals that would otherwise be nonresponsive and improve the accuracy of the data for the FY 2008 and the FY 2009 occupational mix adjustment.

Response: We agree with the commenters. Hospitals that did not submit occupational mix data for the 1st quarter of 2006 will be permitted to submit 1st and 2nd quarter data by August 31. We included the 1st quarter data for some hospitals that submitted survey data after June 1. However, submissions that were received too late to include in the FY 2007 occupational mix adjustment will be included in the desk review process for the occupational mix adjustment for the FY 2008 wage index. As we previously mentioned, we will also allow hospitals an opportunity to revise both their 1st quarter and 2nd quarter 2006 occupational mix data for the FY 2008 wage index. Further, we stated that we will notify hospitals early in the Fall of 2006 regarding the revision/correction process for the FY 2008 wage index for both the cost report wage data and the 2006 occupational mix survey data.

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

The FY 2007 wage index values (effective for hospital discharges occurring on or after October 1, 2006, and before October 1, 2007) that will be published separately from this final rule will be based on the data collected from the Medicare cost reports submitted by hospitals for cost reporting periods beginning in FY 2003 (the FY 2006 wage index was based on FY 2002 wage data).

The FY 2007 wage index will include the following categories of data associated with costs paid under the IPPS (as well as outpatient costs):

- Salaries and hours from short-term, acute care hospitals (including paid lunch hours and hours associated with military leave and jury duty).
- Home office costs and hours.
- Certain contract labor costs and hours (which includes direct patient care, certain top management, pharmacy, laboratory, and nonteaching physician Part A services).
- Wage-related costs, including pensions and other deferred compensation costs.

Consistent with the wage index methodology for FY 2006, the final wage index for FY 2007 also will exclude the direct and overhead salaries and hours for services not subject to IPPS payment, such as SNF services, home health services, costs related to GME (teaching physicians and residents) and certified registered nurse anesthetists (CRNAs), and other subprovider components that are not paid under the IPPS. The final FY 2007 wage index also will exclude the salaries, hours, and wage-related costs of hospital-based rural health clinics (RHCs), and Federally qualified health centers (FQHCs) because Medicare pays for these costs outside of the IPPS (68 FR 45395). In addition, salaries, hours, and wage-related costs of CAHs will be excluded from the wage index, for the reasons explained in the FY 2004 IPPS final rule (68 FR 45397).

Data collected for the IPPS wage index are also currently used to calculate wage indices applicable to other providers, such as SNFs, home health agencies, and hospices. In addition, they are used for prospective payments to IRFs, IPFs, and LTCHs, and for hospital outpatient services. We note that, in the IPPS rules, we do not address comments pertaining to the wage indices for non-IPPS providers. Such comments should be made in response to separate proposed rules for those providers.

Comment: Several commenters addressed CMS' policy of excluding data from CAHs when computing the wage index. They stated that, as of FY 2007, 1,191 CAHs (representing approximately 24 percent of all IPPS hospitals in FY 2000, and approximately 55 percent of all rural hospitals in FY 2000) have been removed from the wage index. The commenters indicated that CAHs have lower average hourly wages than the typical IPPS hospital and eliminating their data from the wage index overstates the national average hourly wage by an estimated 0.707 percent. They added that increases in the national average hourly wage, in turn, are offset with the application of a negative budget neutrality adjustment, which understates IPPS operating payments according to the commenters. The commenters believed that the artificial increase in the national average hourly wage has lowered the budget neutrality adjustment by an estimated $1.52 billion over 5 years (2003–2007). The commenters stated that CMS should apply a one-time positive budget neutrality adjustment in FY 2007 to compensate for the prior underpayments. They did not believe similar future adjustments would be necessary because very few hospitals are expected "to convert to CAH status now that the necessary provider designation is no longer an option."

Other commenters asked that CMS use estimated CAH wage data to compute the FY 2007 wage index, and that an occupational mix factor of 1.0000 be assigned to these hospitals. The commenters noted that MedPAC has recommended that CAH data be included in the wage index, at least in computing the national average hourly wage. The commenters asserted that because CAHs in rural areas still compete with rural IPPS hospitals for scarce resources, their data should be included in the wage index.

Commenters also requested that CMS obtain wage data from CAHs and subject that data to the same rigorous review by the fiscal intermediaries as is done for IPPS hospitals. Another commenter suggested that an alternative to including the CAHs in wage index would be to not factor in any increases in the national average hourly wage that are attributable to the removal of CAHs' wage data.

Response: In the August 1, 2003 final rule (68 FR 45397–8), we explained the reasons for our decision to remove CAH data from the wage index immediately upon conversion to CAH status, even if the hospital was paid under the IPPS during the cost reporting period used in calculating the current fiscal year's wage index. The primary reason for excluding CAHs from the wage index was that

they are a separate provider type and are unique compared to other short term, acute care hospitals with respect to factors such as their location and bed size. We discussed the payment impact, mentioning the substantial negative impact CAHs typically have on the wage indexes in the areas where they are located, and the minimal impact they have on other areas. We also stated that we would not be holding other hospitals' payments harmless for this change, consistent with our general wage index policy.

As the commenters indicated, in the FY 2006 IPPS final rule, we addressed a comment from MedPAC recommending that data from CAHs be included in the wage index (70 FR 47370). MedPAC had recommended that CMS begin collecting wage data from CAHs in 2005. Although we agree with MedPAC that CAHs have recently become more similar to other rural hospitals, in structure, location, and services provided, largely due to changes in the CAH statute resulting from section 405 of Pub. L. 108–173 (MMA), the wage index must be based on data from "subsection (d)," short-term, acute care hospitals, consistent with section 1886(d)(3)(E) of the Act. Therefore, we cannot use any wage data collected from CAHs in the IPPS wage index. Because Pub. L. 108–173 was enacted at the end of calendar year 2003, it would not affect the wage index at least until FY 2008, which would be computed from cost reporting periods beginning in FY 2004. Accordingly, we continue to believe that it has been prudent policy to remove the wage data for hospitals that later became CAHs from the wage index.

We do not believe that the elimination of these data has resulted in an overstated national average hourly wage, nor has the budget neutrality adjustment been inappropriately reduced. The national average hourly wage appropriately reflects only those wages paid by IPPS hospitals. To determine the budget neutrality adjustment for FY 2007, we equate IPPS payments using the FY 2006 and FY 2007 wage indices using FY 2005 MedPAR data that excludes any hospitals that became CAHs as of February 17, 2006. The calculation excludes CAHs from the determination of IPPS payments using both the FY 2006 and FY 2007 wage indices so the budget neutrality adjustment reflects only information from IPPS hospitals and is not overstated. Consequently, we will not apply a one-time positive budget neutrality adjustment in FY 2007.

E. Verification of Worksheet S–3 Wage Data

The wage data for the final FY 2007 wage index will be obtained from Worksheet S–3, Parts II and III of the FY 2003 Medicare cost reports. Instructions for completing the Worksheet S–3, Parts II and III are in the Provider Reimbursement Manual, Part I, sections 3605.2 and 3605.3. The data file used to construct the wage index will include FY 2003 data submitted to us as of June 28, 2006. As in past years, we will perform an intensive review of the wage data, mostly through the use of edits designed to identify aberrant data.

We asked our fiscal intermediaries to revise or verify data elements that resulted in specific edit failures. While some of the edits failures were resolved, we did remove the wage data of some hospitals from the final FY 2007 wage index. For the final FY 2007 wage index in this final rule, we removed the data for 229 hospitals from our database: 189 hospitals designated as CAHs by 7 or more days prior to the posting of the preliminary February public use file, and 30 hospitals were low Medicare utilization hospitals or failed edits that could not be corrected because the hospitals terminated the program or changed ownership. In addition, we removed the wage data for 10 hospitals with incomplete or inaccurate data resulting in zero or negative, or otherwise aberrant, average hourly wages. As a result, the final FY 2007 wage index is calculated based on FY 2003 wage data from 3,570 hospitals.

In constructing the final FY 2007 wage index, we will include the wage data for facilities that were IPPS hospitals in FY 2003, even for those facilities that have since terminated their participation in the program as hospitals, as long as those data do not fail any of our edits for reasonableness. We believe that including the wage data for these hospitals is, in general, appropriate to reflect the economic conditions in the various labor market areas during the relevant past period. However, we exclude the wage data for CAHs as discussed in 68 FR 45397.

Section 4410 of Pub. L. 105–33 provides that, for the purposes of section 1886(d)(3)(E) of the Act, for discharges occurring on or after October 1, 1997, the area wage index applicable to any hospital that is located in an urban area of a State may not be less than the area wage index applicable to hospitals located in rural areas in the State. This provision is commonly referred to as the "rural floor." In the August 11, 2004 IPPS final rule (69 FR 49109), we discussed situations where a State has only urban areas and no geographically rural areas, or a State has geographically rural areas but no IPPS hospitals are located in those rural areas. As a result, these States did not have rural IPPS hospitals from which to compute and apply a "rural floor." In that final rule, we developed a policy for imputing a "rural floor" for these States, effective for the FYs 2005, 2006, and 2007 wage indices, so that a "rural floor" could be applicable to IPPS urban hospitals in those States in the same manner that a "rural floor" is applicable to IPPS urban hospitals in States that have IPPS rural hospitals. We revised the regulations at § 412.64(h) to describe the methodology for computing the imputed "rural floors" for these States and to define an all-urban State. Specifically, § 412.64(h)(5) defines an all-urban State as "a State with no rural areas * * * or a State in which there are no hospitals classified as rural. A State with rural areas and with hospitals reclassified as rural under § 412.103 is not an all-urban State."

We have received questions as to what area wage index CMS would apply in the instance where a new rural IPPS hospital opens in a State that has an imputed "rural floor" because it has rural areas but had no hospitals classified as rural. In addition, we have been asked whether a new IPPS hospital could submit its wages and hours data to be used in computing the wage index, even though the hospital did not file a cost report as an IPPS provider for the cost report base year that is used in calculating that wage index.

A new hospital can be an entirely new facility that did not exist before, or it can be a hospital that participated in Medicare under a previous provider number, but has acquired a new Medicare provider number (such as when a CAH converts to IPPS status, or vice versa). As a new IPPS hospital (in this case, rural), the hospital would not yet have filed any wages and hours data on a Medicare cost report. Even in the situation where a new IPPS hospital previously participated in Medicare as a non-IPPS provider, wages and hours data collected as a non-IPPS provider would not be suitable for calculating an IPPS wage index because section 1886(d)(3)(E) of the Act specifies that the wage index must be based on data from "subsection (d)" hospitals. Thus, CMS could not include wages and hours from a period during which a hospital was not an IPPS provider. Furthermore, even once the hospital files its first Medicare cost report under the new IPPS provider number, that first cost report is not used in computing the wage index for the hospital's geographic

area until 4 years later (for example, we use the 2003 data to compute the wage index for FY 2007). Therefore, if a new rural IPPS hospital opens in a State that has an imputed "rural floor" and has rural areas, for FY 2007, the hospital would receive the imputed "rural floor" as its wage index. The imputed rural floor is set to expire on September 30, 2007. However, we expect that we would address the 2008 implications for a new rural hospital that is the only rural hospital in the State in the FY 2008 proposed rule.

Comment: Two commenters stated that CMS' above policy conflicts with the policy of excluding the wage data of IPPS hospitals that convert to CAH status. The commenters also asserted that in the years before the hospital's own wage data is used, the rural hospital will be paid at the imputed rural floor, which they contend is unrelated to the hospital's own labor market costs. The commenters also asserted that if the new rural hospital's average hourly wage is greater than the imputed rural floor, the hospital would suffer underpayments until its index could be based upon its own wage data. One commenter suggested that, at least for CAHs converting to IPPS status, CMS should use wage data filed by the hospital when it was a CAH.

The commenters urged CMS to include the wage data of a new rural IPPS hospital in the wage index "as soon as a full year's cost report with the hospital operating as a PPS hospital is available."

Response: We disagree with the commenters. Our consistent policy is that new hospitals must first develop their wage data and have it reviewed by our fiscal intermediaries prior to the wage data being included in the wage index. The submission and review process requires a 4-year period, in order to allow time for all hospitals to complete and submit their wage data for the fiscal year, for the fiscal intermediaries to review the data, for the fiscal intermediaries to present the results of their review to hospitals, for hospitals to review any potential errors in the wage index files, for us to resolve any disputes between the fiscal intermediary and the hospital, and finally, for the final wage indices to be calculated and published in advance of the fiscal year. For a discussion of the wage data review and correction process, refer to section III.J. of this preamble. This policy applies to all new hospitals, not just rural hospitals. Although a new rural IPPS hospital that previously was a CAH may be willing to provide CMS with wage data from the period during which it was a CAH, the wage index must be based on data from IPPS hospitals, consistent with section 1886(d)(3)(E) of the Act. A CAH is not an IPPS hospital; thus, we cannot include the hospital's wages and hours from the period during which it was a CAH. Indeed, even if a CAH previously existed as an IPPS hospital (that is, it previously was an IPPS hospital, converted to CAH status, and then converted back to IPPS status), its historical wage data would have been submitted from years prior to the cost reports used to calculate the FY 2007 wage index (that is, the FY 2003 cost reports). If a CAH converts back to IPPS status in FY 2007, there would be no wage data for the FY 2007 wage index because such a provider did not file Medicare cost reports as an IPPS provider in FY 2003.

We recognize, as one commenter pointed out that in the past we have noted the importance of including "all" available wage data in the wage index calculation. However, our past statements to this effect were discussing the inclusion of all IPPS hospital wage data, not data from non-IPPS hospitals. In the FY 2003 IPPS final rule (67 FR 50023), we discussed our policy of including data from IPPS hospitals that have since closed. We stated that such data should be included because, "any hospital that is in operation during the data collection period used to calculated the wage index should be included in the database, since the hospital's data reflect conditions occurring in that labor market area during the period surveyed." Our statement, however, was directed at the inclusion of IPPS hospital data—not the inclusion of data from hospitals that were not IPPS hospitals during the data collection period. As stated earlier, section 1886(d)(3)(E) of the Act requires the wage index to be based upon a survey of "subsection (d) hospitals."

Lastly, we think it is false logic to state that our policy excluding data from hospitals that become CAHs necessarily requires inclusion of data from hospitals that switch from CAH status to IPPS status. As stated in the FY 2003 IPPS final rule, we exclude hospitals that convert to CAH status because our analysis showed that the wage data for these hospitals, in general, are significantly different from other short-term hospitals (68 FR 45397). CAHs that convert to IPPS status, in contrast, could not, under the statute, be included in the wage index survey because they are not IPPS hospitals at the time of the survey.

Comment: A few commenters recommended that CMS propose now to extend the imputed rural floor to coincide with the rural floor established under section 4410 of Pub. L. 105–33, in order to place all 50 states on a level playing field.

Response: As stated above, our policy for imputing a "rural floor" is effective for the FYs 2005, 2006, and 2007 wage indices. We will determine the appropriateness of extending that policy beyond FY 2007 and state our proposal in the FY 2008 proposed rule. Commenters will be have sufficient time during the FY 2008 IPPS comment period to assess and comment on such a proposal.

Comment: One commenter suggested that CMS should select one national contractor as part of the Medicare Administrative Contractor (MAC) bidding process (provided for under section 1847A of the Act as added by section 911 of Pub. L. 108-173) to do wage index reviews. The commenter believed that the use of the MAC process to solicit a single "national" contractor would ensure that the wage data and occupational mix data reviews are handled consistently and accurately, so that all hospitals are subject to the same policy interpretations. The commenter noted the importance of the wage index in determining Medicare payments to hospitals and indicated that any variation among contractors in the handling of hospitals' wage index data could be detrimental to hospitals in certain geographic regions. The commenter also stated that the inclusion of a 100 percent occupational mix adjustment intensifies the need for a contractor approach going forward.

Response: We appreciate the suggestion and will consider it as we develop our program acquisition strategies.

F. Computation of the FY 2007 Unadjusted Wage Index

The method used to compute the FY 2007 wage index without an occupational mix adjustment follows:

Step 1—As noted above, we based the FY 2007 wage index on wage data reported on the FY 2003 Medicare cost reports. We gathered data from each of the non-Federal, short-term, acute care hospitals for which data were reported on the Worksheet S–3, Parts II and III of the Medicare cost report for the hospital's cost reporting period beginning on or after October 1, 2002, and before October 1, 2003. In addition, we include data from some hospitals that had cost reporting periods beginning before October 2002 and reported a cost reporting period covering all of FY 2003. These data are included because no other data from these hospitals would be available for

the cost reporting period described above, and because particular labor market areas might be affected due to the omission of these hospitals. However, we generally describe these wage data as FY 2003 data. We note that, if a hospital had more than one cost reporting period beginning during FY 2003 (for example, a hospital had two short cost reporting periods beginning on or after October 1, 2002, and before October 1, 2003), we include wage data from only one of the cost reporting periods, the longer, in the wage index calculation. If there was more than one cost reporting period and the periods were equal in length, we include the wage data from the later period in the wage index calculation.

Step 2—Salaries—The method used to compute a hospital's average hourly wage excludes certain costs that are not paid under the IPPS. In calculating a hospital's average salaries plus wage-related costs, we subtract from Line 1 (total salaries) the GME and CRNA costs reported on Lines 2, 4.01, 6, and 6.01, the Part B salaries reported on Lines 3, 5 and 5.01, home office salaries reported on Line 7, and exclude salaries reported on Lines 8 and 8.01 (that is, direct salaries attributable to SNF services, home health services, and other subprovider components not subject to the IPPS). We also subtract from Line 1 the salaries for which no hours were reported. To determine total salaries plus wage-related costs, we add to the net hospital salaries the costs of contract labor for direct patient care, certain top management, pharmacy, laboratory, and nonteaching physician Part A services (Lines 9 and 10), home office salaries and wage-related costs reported by the hospital on Lines 11 and 12, and nonexuded area wage-related costs (Lines 13, 14, and 18).

We note that contract labor and home office salaries for which no corresponding hours are reported are not included. In addition, wage-related costs for nonteaching physician Part A employees (Line 18) are excluded if no corresponding salaries are reported for those employees on Line 4.

Step 3—Hours—With the exception of wage-related costs, for which there are no associated hours, we compute total hours using the same methods as described for salaries in Step 2.

Step 4—For each hospital reporting both total overhead salaries and total overhead hours greater than zero, we then allocate overhead costs to areas of the hospital excluded from the wage index calculation. First, we determine the ratio of excluded area hours (sum of Lines 8 and 8.01 of Worksheet S–3, Part II) to revised total hours (Line 1 minus the sum of Part II, Lines 2, 3, 4.01, 5, 5.01, 6, 6.01, 7, and Part III, Line 13 of Worksheet S–3). We then compute the amounts of overhead salaries and hours to be allocated to excluded areas by multiplying the above ratio by the total overhead salaries and hours reported on Line 13 of Worksheet S–3, Part III. Next, we compute the amounts of overhead wage-related costs to be allocated to excluded areas using three steps: (1) We determine the ratio of overhead hours (Part III, Line 13) to revised hours (Line 1 minus the sum of Lines 2, 3, 4.01, 5, 5.01, 6, 6.01, 7, 8, and 8.01); (2) we compute overhead wage-related costs by multiplying the overhead hours ratio by wage-related costs reported on Part II, Lines 13, 14, and 18; and (3) we multiply the computed overhead wage-related costs by the above excluded area hours ratio. Finally, we subtract the computed overhead salaries, wage-related costs, and hours associated with excluded areas from the total salaries (plus wage-related costs) and hours derived in Steps 2 and 3.

Step 5—For each hospital, we adjust the total salaries plus wage-related costs to a common period to determine total adjusted salaries plus wage-related costs. To make the wage adjustment, we estimate the percentage change in the employment cost index (ECI) for compensation for each 30-day increment from October 14, 2002, through April 15, 2004, for private industry hospital workers from the BLS' *Compensation and Working Conditions*. We use the ECI because it reflects the price increase associated with total compensation (salaries plus fringes) rather than just the increase in salaries. In addition, the ECI includes managers as well as other hospital workers. This methodology to compute the monthly update factors uses actual quarterly ECI data and assures that the update factors match the actual quarterly and annual percent changes. The factors used to adjust the hospital's data were based on the midpoint of the cost reporting period, as indicated below.

MIDPOINT OF COST REPORTING PERIOD

After	Before	Adjustment factor
10/14/2002	11/15/2002	1.06058
11/14/2002	12/15/2002	1.05679
12/14/2002	01/15/2003	1.05304
01/14/2003	02/15/2003	1.04915
02/14/2003	03/15/2003	1.04513
03/14/2003	04/15/2003	1.04108
04/14/2003	05/15/2003	1.03713
05/14/2003	06/15/2003	1.03325
06/14/2003	07/15/2003	1.02948
07/14/2003	08/15/2003	1.02584
08/14/2003	09/15/2003	1.02231
09/14/2003	10/15/2003	1.01878
10/14/2003	11/15/2003	1.01510
11/14/2003	12/15/2003	1.01127
12/14/2003	01/15/2004	1.00743
01/14/2004	02/15/2004	1.00367
02/14/2004	03/15/2004	1.00000
03/14/2004	04/15/2004	0.99644

For example, the midpoint of a cost reporting period beginning January 1, 2003, and ending December 31, 2003, is June 30, 2003. An adjustment factor of 1.02948 would be applied to the wages of a hospital with such a cost reporting period. In addition, for the data for any cost reporting period that began in FY 2003 and covered a period of less than 360 days or more than 370 days, we annualize the data to reflect a 1-year cost report. Dividing the data by the number of days in the cost report and then multiplying the results by 365 accomplishes annualization.

Step 6—Each hospital is assigned to its appropriate urban or rural labor market area before any reclassifications under section 1886(d)(8)(B), section 1886(d)(8)(E), or section 1886(d)(10) of the Act. Within each urban or rural labor market area, we add the total adjusted salaries plus wage-related costs obtained in Step 5 for all hospitals in that area to determine the total adjusted salaries plus wage-related costs for the labor market area.

Step 7—We divide the total adjusted salaries plus wage-related costs obtained under both methods in Step 6 by the sum of the corresponding total hours (from Step 4) for all hospitals in each labor market area to determine an average hourly wage for the area.

Step 8—We add the total adjusted salaries plus wage-related costs obtained in Step 5 for all hospitals in the Nation and then divide the sum by the national sum of total hours from Step 4 to arrive at a national average hourly wage. Using the data as described above, the national average hourly wage is $29.6521.

Step 9—For each urban or rural labor market area, we calculate the hospital wage index value, unadjusted for occupational mix, by dividing the area average hourly wage obtained in Step 7 by the national average hourly wage computed in Step 8.

Step 10—Following the process set forth above, we develop a separate Puerto Rico-specific wage index for purposes of adjusting the Puerto Rico standardized amounts. (The national Puerto Rico standardized amount is

adjusted by a wage index calculated for all Puerto Rico labor market areas based on the national average hourly wage as described above.) We add the total adjusted salaries plus wage-related costs (as calculated in Step 5) for all hospitals in Puerto Rico and divided the sum by the total hours for Puerto Rico (as calculated in Step 4) to arrive at an overall average hourly wage of $13.0915 for Puerto Rico. For each labor market area in Puerto Rico, we calculate the Puerto Rico-specific wage index value by dividing the area average hourly wage (as calculated in Step 7) by the overall Puerto Rico average hourly wage.

Step 11—Section 4410 of Pub. L. 105–33 provides that, for discharges on or after October 1, 1997, the area wage index applicable to any hospital that is located in an urban area of a State may not be less than the area wage index applicable to hospitals located in rural areas in that State. (For all-urban States, we establish an imputed floor (69 FR 49109). Furthermore, this wage index floor is to be implemented in such a manner as to ensure that aggregate IPPS payments are not greater or less than those that would have been made in the year if this section did not apply. For FY 2007, the areas affected by this provision, after the occupational mix adjustment is applied, will be by a footnote in Tables 4A–1 and 4A–2 that are to be published separate from this final rule.

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

For the final FY 2005 and FY 2006 wage indices, we used a blend of the occupational mix adjusted wage index and the unadjusted wage index. Specifically, we adjusted 10 percent of the FY 2005 and FY 2006 wage index adjustment factor by a factor reflecting occupational mix. We refer readers to the FY 2005 IPPS final rule at 69 FR 49052 and the FY 2006 IPPS final rule at 70 FR 47376 for a detailed discussion of the blended wage index.

As discussed in section III.C. of this preamble, for FY 2007, we are applying the occupational mix adjustment to 100 percent of the FY 2007 wage index. We will calculate the occupational mix adjustment using the first 3 months of the 2006 survey data, using the methodology described in section III.C. of this preamble.

Comment: One commenter suggested that, for the FY 2007 wage index, CMS should apply the *Bellevue Hosp. Center* v. *Leavitt* decision only to hospitals in the Second Circuit, and not on a nationwide basis. For States outside the Second Circuit, the commenter recommended that CMS apply the occupational mix adjustment at 10 percent, as it did in FYs 2005 and 2006. The commenter noted that there is a CMS (then HCFA) precedent for applying a court's order to only hospitals in the States in the Circuit where the decision was rendered, citing HCFA Ruling 97–2, pertaining to the inclusion of "eligible but unpaid" Medicaid days in the DSH calculation.

Response: The commenter did not address whether the 10-percent adjustment would use the new 2006 occupational mix survey data or the prior 2003 data. Therefore, it is not clear how the commenter is suggesting we apply the policy. Nevertheless, we believe the most appropriate policy is to apply the occupational mix adjustment uniformly nationwide, using the same survey data and a 100 percent adjustment for all hospitals. It is important to keep in mind that the occupational mix adjustment is an adjustment to the wage index factor that represents the ratio of a labor market area's average hourly wage to the national average hourly wage. DSH adjustments, in contrast, are not based upon individual hospital information compared to a national average. If we were to use separate sets of data depending upon geographic location, hospitals located in the Second Circuit would be compared to one national benchmark, whereas hospitals located elsewhere would be compared to a different one. We believe such a policy would undermine the calculation of the wage index that is a relative measure of differences in area wage levels that uses a uniform national baseline for purposes of comparison. In addition, we note that the New York labor market area includes counties located both inside and outside of the Second Circuit. The New York-White Plains-Wayne, NY–NJ CBSA includes three New Jersey Counties: Bergen, Hudson, and Passaic Counties. These counties are located in the Third Circuit, not the Second Circuit. Therefore, applying the *Bellevue Hosp. Center* v. *Leavitt* decision only in the Second Circuit would result in two area wage index values for the New York labor market area, adding further complexity to the wage index calculation.

Comment: One commenter believed that section 1886(d)(6) of the Act requires CMS to publish its actual wage tables and other factors by August 1. The commenter also cited the Balanced Budget Act of 1997 (BBA), Pub. L. 105–33, under which Congress moved the deadline in section 1886(d)(6) of the Act from September 1 to August 1. The commenter contended that Congress would not have needed to move the deadline if the final data were not to be published as of August 1.

Response: The relevant language of section 1886(d)(6)of the Act states: "The Secretary shall provide for publication in the **Federal Register**, on or before August 1 before each fiscal year * * * of a description of the methodology and data used in computing the adjusted DRG prospective payment rates under this subsection." We believe the plain language of section 1886(d)(6) of the Act requires merely a description of the data and methodology that are used to compute the IPPS rates and does not require actual publication of the rates.

With respect to the comments about the statutory change that moved the deadline for the IPPS rule from September 1 to August 1, section 4644 of the BBA was an amendment to conform section 1886(h)(6) of the Act to the requirements of the Congressional Review Act. The Congressional Review Act does not allow a major rule to go into effect for 60-days unless there is an act of Congress allowing the rule to go into effect earlier. The publication date in section 1886(d)(6) of the Act was changed accordingly so that the IPPS final rule could take effect no sooner than 60 days after publication, or by the beginning of the Federal fiscal year on October 1 without Congress having to act. However, Congress did not alter section 1886(d)(6) of the Act with respect to the information that is to be included in the final rule. We agree with the commenter that it is our usual practice to publish the wage tables and other factors along with the final rule consistent with 42 CFR 412.8. However, due to our implementation of the *Bellevue Hosp. Center* v. *Leavitt* decision, it is not possible to follow this procedure for FY 2007. In the proposed rule, we explained our intent to post the FY 2007 occupational mix adjusted wage index tables and related impacts on the CMS Web site after we publish the FY 2007 IPPS final rule, and in advance of October 1, 2006 (71 FR 28652). We have modified 42 CFR 412.8 accordingly. The change we are making to § 412.8 is a procedural rule that we are making effective upon publication.

Comment: A few commenters expressed concern that the new occupational mix adjustment may have a negative impact on some hospitals, and they would not know how they are affected until the final FY 2007 wage index tables are published. Some commenters recommended that CMS allow hospitals more time to review their data, comment on the survey results, and make adjustments and/or

revisions to their occupational mix survey data. One commenter requested that CMS publish the occupational mix regulations and data as an interim final rule with a full 60-day comment period so that providers will have an opportunity to comment further. Another commenter urged CMS to consider either delaying the implementation of the occupational mix adjustment, or consider allowing retroactive correction to any errors discovered after October 1. A few commenters recommended that CMS use its discretionary authority to "smooth out" the impact of this change on adversely affected hospitals and apply a multiyear transition of the occupational mix survey data.

Response: As we indicated above, while we understand the commenters' concerns about the potential for inaccurate occupational mix survey data to be used due to the abbreviated data collection and reporting periods, we believe we have established a review and correction process that is intended to minimize errors. We cannot delay the implementation of, or transition in, the occupational mix adjustment for the FY 2007 wage index because the Second Circuit Court required that all "data collection and measurement and any other preparations necessary for full application should be complete by September 30, 2006, at which time we instruct the agency to immediately apply the adjustment in full." Also, we believe that the 30-day comment period after the May 17, 2006 publication of the amended FY 2007 IPPS proposed rule provided ample opportunity for the public to comment on the new occupational mix survey data and adjustment for the FY 2007 wage index. Hospitals are usually afforded 60 days to comment on the entire IPPS rule. In addition, we cannot allow retroactive changes to the FY 2007 wage index for errors discovered after October 1, 2006, unless a hospital's correction request meets the strict criteria of § 412.64(k)(1) of our existing regulations (also see section III.J. of this preamble). However, as previously mentioned, we will allow hospitals an additional opportunity to revise both their 1st quarter and 2nd quarter 2006 occupational mix data for the FY 2008 wage index.

Comment: One commenter recommended that CMS publish the corrected 1st quarter 2006 survey data as a public use file prior to the publication of the final FY 2007 wage index tables.

Response: Intermediaries are required to transmit the corrected 1st quarter 2006 survey data to CMS by July 27, 2007. Unfortunately, due to our short timeframe after July 27 for reviewing the survey data and computing, analyzing, and publishing the final FY 2007 occupational mix adjusted wage index, we cannot publish the corrected 1st quarter survey data before we publish final FY 2007 wage index tables.

The final wage index values for FY 2007 (except those for hospitals receiving wage index adjustments under section 505 of Pub. L. 108–173) will be included in Tables 4A–1, 4A–2, 4B, 4C–1, 4C–2, and 4F that are to be posted on our Web site and published in a **Federal Register** notice subsequent to this final rule.

Tables 3A and 3B in the separate issuance will list the 3-year average hourly wage for each labor market area before the redesignation of hospitals, using the wages included in the calculation for the FYs 2005, 2006, 2007 wage indices. Table 3A in the separate issuance will list these data for urban areas and Table 3B in the separate issuance will list these data for rural areas. In addition, Table 2 in the separate issuance will include the adjusted average hourly wage for each hospital from the FY 2001 and FY 2002 cost reporting periods, as well as the FY 2003 period used to calculate the FY 2007 wage index. The 3-year averages will be calculated by dividing the sum of the dollars (adjusted to a common reporting period using the method described previously) across all 3 years, by the sum of the hours. If a hospital is missing data for any of the previous years, its average hourly wage for the 3-year period will be calculated based on the data available during that period.

The final wage index values in Tables 4A–1, 4A–2, 4B, 4C–1, 4C–2, and 4F and the average hourly wages in Tables 2, 3A, and 3B to be posted on our Web site and published in a subsequent **Federal Register** notice will include the occupational mix adjustment.

H. Revisions to the Wage Index Based on Hospital Redesignations

1. General

Under section 1886(d)(10) of the Act, the Medicare Geographic Classification Review Board (MGCRB) considers applications by hospitals for geographic reclassification for purposes of payment under the IPPS. Hospitals must apply to the MGCRB to reclassify by September 1 of the year preceding the year during which reclassification is sought. Generally, hospitals must be proximate to the labor market area to which they are seeking reclassification and must demonstrate characteristics similar to hospitals located in that area. The MGCRB issues its decisions by the end of February for reclassifications that become effective for the following fiscal year (beginning October 1). The regulations applicable to reclassifications by the MGCRB are located in §§ 412.230 through 412.280.

Section 1886(d)(10)(D)(v) of the Act provides that, beginning with FY 2001, a MGCRB decision on a hospital reclassification for purposes of the wage index is effective for 3 fiscal years, unless the hospital elects to terminate the reclassification. Section 1886(d)(10)(D)(vi) of the Act provides that the MGCRB must use the 3 most recent years' average hourly wage data in evaluating a hospital's reclassification application for FY 2003 and any succeeding fiscal year.

Section 304(b) of Pub. L. 106–554 provides that the Secretary must establish a mechanism under which a statewide entity may apply to have all of the geographic areas in the State treated as a single geographic area for purposes of computing and applying a single wage index, for reclassifications beginning in FY 2003. The implementing regulations for this provision are located at § 412.235.

Section 1886(d)(8)(B) of the Act requires the Secretary to treat a hospital located in a rural county adjacent to one or more urban areas as being located in the MSA to which the greatest number of workers in the county commute, if the rural county would otherwise be considered part of an urban area under the standards for designating MSAs and if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or counties of all contiguous MSAs. In light of the new CBSA definitions and the Census 2000 data that we implemented for FY 2005 (69 FR 49027), we undertook to identify those counties meeting these criteria. The eligible counties are identified under section III.H.4. of this preamble.

2. Effects of Reclassification/Redesignation

Section 1886(d)(8)(C) of the Act provides that the application of the wage index to redesignated hospitals is dependent on the hypothetical impact that the wage data from these hospitals would have on the wage index value for the area to which they have been redesignated. These requirements for determining the wage index values for redesignated hospitals is applicable both to the hospitals located in rural counties deemed urban under section 1886(d)(8)(B) of the Act and hospitals

that were reclassified as a result of the MGCRB decisions under section 1886(d)(10) of the Act. In compliance with section 1886(d)(8)(C) of the Act, as well as with the rules CMS has established by regulation, the wage index values were determined by considering the following:

- If including the wage data for the redesignated hospitals would reduce the wage index value for the area to which the hospitals are redesignated by 1 percentage point or less, the area wage index value determined exclusive of the wage data for the redesignated hospitals applies to the redesignated hospitals.
- If including the wage data for the redesignated hospitals reduces the wage index value for the area to which the hospitals are redesignated by more than 1 percentage point, the area wage index determined inclusive of the wage data for the redesignated hospitals (the combined wage index value) applies to the redesignated hospitals.
- If including the wage data for the redesignated hospitals increases the wage index value for the urban area to which the hospitals are redesignated, both the area and the redesignated hospitals receive the combined wage index value. Otherwise, the hospitals located in the urban area receive a wage index excluding the wage data of hospitals redesignated into the area.
- The wage data for a reclassified urban hospital is included in both the wage index calculation of the area to which the hospital is reclassified (subject to the rules described above) and the wage index calculation of the urban area where the hospital is physically located.
- Rural areas whose wage index values would be reduced by excluding the wage data for hospitals that have been redesignated to another area continue to have their wage index values calculated as if no redesignation had occurred (otherwise, redesignated rural hospitals are excluded from the calculation of the rural wage index).
- The wage index value for a redesignated rural hospital cannot be reduced below the wage index value for the rural areas of the State in which the hospital is located.
- In cases where urban hospitals have reclassified to rural areas under 42 CFR 412.103, the urban hospital wage data are: (a) Included in the rural wage index calculation, unless doing so would reduce the rural wage index; and (b) included in the urban area where the hospital is physically located.

3. FY 2007 MGCRB Reclassifications

Under section 1886(d)(10) of the Act, the MGCRB considers applications by hospitals for geographic reclassification for purposes of payment under the IPPS. The specific procedures and rules that apply to the geographic reclassification process are outlined in § 412.230 through § 412.280.

In the FY 2007 IPPS proposed rule (71 FR 24377), we identified hospitals that have reclassifications effective in FY 2007. As specified in § 412.273, hospitals that have been reclassified by the MGCRB are permitted to withdraw an application for reclassification or terminate an existing 3-year reclassification for FY 2007. The request must be received by the MGCRB within 45 days of publication of the IPPS proposed rule.

However, as a result of our compliance with the *Bellevue Hosp. Center* v. *Leavitt* court decision, as discussed earlier, we will be recalculating wage indices using new occupational mix data and applying the occupational mix to 100 percent of the wage index. Wage tables in the IPPS proposed rule did not include the new survey data, nor did they adjust 100 percent for occupational mix. Thus, the data that hospitals might have used to make withdrawal or termination decisions are obsolete. The necessary data (including wage indices and out-migration adjustments) hospitals generally utilize in evaluating whether to withdraw or terminate a reclassification will not be available until after this IPPS final rule has been published. Therefore, in the May 17, 2006 proposed rule (71 FR 28650), in this limited circumstance, we suspended the 45-day deadline and have established the new procedure described below to withdraw from or terminate reclassifications for FY 2007. Some hospitals may have adhered to the established process and notified the MGCRB of their decision to withdraw or terminate a reclassification, in accordance with § 412.273, before publication of that proposed rule.

Because hospitals made these decisions based on information in the FY 2007 IPPS proposed rule that is now obsolete, in the May 17, 2006 proposed rule, we proposed that the MGCRB not act on these withdrawal or termination requests. Instead, we have applied the following procedures for withdrawal and termination determinations for all hospital reclassifications for FY 2007. We will make reclassification withdrawal and termination determinations based on what we perceive would be most advantageous to the hospital. We will use our best efforts to determine what would provide the hospital with the highest possible wage index. Specifically, we will choose among: section 508 reclassifications, section 1886(d)(10) reclassifications, section 505 out-migration adjustments, and certain other changes to the wage index (for example, the special exceptions policy explained in the FY 2005 IPPS rule (69 FR 49105) or Lugar status if we determine that it is in the hospital's best interest to waive the Lugar/section 1886(d)(8)(B) redesignation in order to receive the section 505 out-migration adjustment).

We also will make the final occupational mix adjusted wage indices and out-migration adjustments and our interim decisions on hospital reclassifications available to the public in the **Federal Register** and on the CMS Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp* after August 1, 2006, and before October 1, 2006. We will allow hospitals a 30-day period from the date the final data and our interim decisions are made available on the Web site to notify CMS in writing, with a copy to the MGCRB, of whether they wish to reverse the reclassification decision made by CMS or to choose another reclassification for which they are eligible. We will make every effort to provide the final data before September 1, 2006, so that the 30-day period to make these determinations will end before October 1, 2006, and no retroactive adjustments will be necessary. Requests to reverse a decision made by CMS must be received, in writing, no later 30 days after the date are made available on the CMS Web site at the following:

Division of Acute Care, C4–08–06, 7500 Security Boulevard, Baltimore, MD 21244, Attn: Marianne Myers;

AND a copy to

Medicare Geographic Classification Review Board, 2520 Lord Baltimore Drive, Suite L, Baltimore, MD 21244–2670.

Prior to FY 2004, hospitals had been able to apply to be reclassified for purposes of either the wage index or the standardized amount. Section 401 of Pub. L. 108–173 established that all hospitals will be paid on the basis of the large urban standardized amount, beginning with FY 2004. Consequently, all hospitals are paid on the basis of the same standardized amount, which made such reclassifications moot. Although there could still be some benefit in terms of payments for some hospitals under the DSH payment adjustment for operating IPPS, section 402 of Pub. L. 108–173 equalized DSH payment adjustments for rural and urban hospitals, with the exception that the rural DSH adjustment is capped at 12 percent (except that rural referral centers and, effective for discharges

occurring on or after October 1, 2006, MDHs have no cap). (A detailed discussion of this application appears in section IV.I. of the preamble of the FY 2005 IPPS final rule (69 FR 49085). The exclusion of MDHs from the 12 percent DSH cap under Pub. L. 109–171 is discussed under section IV.F.4. of this preamble.)

Comment: Several commenters asked CMS to clarify its position on withdrawing reclassifications as well as the timeframe of submitting applications for geographic reclassification.

Response: The normal timetable of 45 days after the publication of the proposed rule for hospitals to withdraw or terminate a reclassification under section 508 of Pub. L. 108–173, section 1886(d)(10) of the Act, or section 1886(d)(8)(B) of the Act (in order to receive a section 505 out-migration adjustment) does not apply for FY 2007. For this reason, any withdrawal or termination requests submitted to the MGCRB and/or CMS following publication of the FY 2007 IPPS proposed rule are not reflected in the reclassification tables shown in this final rule.

We will make best efforts to give each hospital the highest FY 2007 wage index after reviewing applicable data using the 100 percent occupational adjusted wage index. Hospitals will have 15 days from the display date of this final rule to notify us of whether, in the absence of viewing the final 100 percent occupational mix-adjusted wage index data, they wish to choose a particular wage index for which they are eligible (such as to definitively maintain a reclassification that they received or to definitively terminate or withdraw from a reclassification). Written requests to maintain, terminate, or withdraw a reclassification, in the absence of viewing the final wage tables, must be *received* at the following address no later than 5 p.m. EDT 15 days from the date this final rule appears on public display at the Office of the Federal Register:

Division of Acute Care, C4–08–06, 7500 Security Boulevard, Baltimore, MD 21244, Attn: Marianne Myers.

If we do not receive notice from the hospital within such 15-day timeframe, we will make determinations for the hospital using our best efforts to determine what we believe results in the highest wage index for the hospital. If applicable, we will give the hospital its home wage index with the out-migration adjustment, if that option results in the highest wage index. In some cases, we may determine that it is most advantageous for a hospital to terminate its Lugar/section 1886(d)(8)(B) reclassification in order to receive the out-migration adjustment. Because this termination would result in the hospital losing urban status, we will separately publish a table identifying these hospitals that move from Lugar/urban status to rural status with the out-migration adjustment. For section 508 hospital individual reclassifications, we may make half-year terminations/withdrawals on behalf of hospitals, using the procedures identified in our proposed rule. That is, for a section 508 hospital that applied for an individual reclassification under section 1886(d)(10), we would give the section 508 hospital the higher of its home wage index, section 508 or 1886(d)(10) wage index for the first half of the year. For the second half of the year, we would give the section 508 hospital the higher of its home wage index or its section 1886(d)(10) reclassification. (However, in no case could such a hospital receive its home wage indes for the first half of the year and its MGCRB reclassification for the second half, or vice versa. For group reclassifications, we will apply the higher of the home wage index or the section 1886(d)(10) reclassification for the entire year. For group reclassifications that include a section 508 hospital, we will apply the decision that was on the MGCRB application for groups that followed the procedural rules (that is, the group either: (1) Withdrew from its section 1886(d)(10) reclassification for the first half of FY 2007 and will only receive a second half FY 2007 section 1886(d)(10) reclassification; or (2) the group is reclassified under section 1886(d)(10) of the Act for the entire year and the section 508 hospital withdraws from its section 508 reclassification for the first half of the FY 2007) unless the group informs us differently after publication of the final occupational mix adjusted wage indices. Groups that include a section 508 hospital will be able to make decisions as a group, separately for the first and second half of the year. Thus, the group may decide to withdraw a section 1886(d)(10) reclassification that would be applicable only for the second half of FY 2007. Again, however, in no case could a group whose 508 hospital chose to waive its 508 reclassification (and therefore accept the MGCRB reclassification for the first half of FY 2007) withdraw its MGCRB reclassification for the first half of the year, but not the second (or vice versa).

We acknowledge that hospitals may base withdrawal/termination decisions on factors other than simply what results in the highest wage index for the upcoming fiscal year. For this reason, we will allow a hospital to change a decision that is made by CMS on its behalf. Hospitals should note that we will not recalculate the wage indices or budget neutrality factors after the final notice announcing the FY 2007 occupational mix adjusted wage indices. That is, we will not further recalculate the wage indices or standardized amounts based on hospital decisions that further revise decisions made by CMS on the hospitals' behalf.

We will post the final occupational mix adjusted wage indices, out-migration adjustments, and our interim decisions on hospital reclassification on the CMS Web site, as discussed above, sometime after August 1, 2006, and before October 1, 2006. We will post the same tables on the CMS Web site that appear in the **Federal Register** final notice of the occupational mix adjusted wage indices to be published after August 1, 2006 and before October 1, 2006. Hospitals will be able to determine the reclassification decision applied on their behalf by reviewing Tables 9A through 9C for hospitals that are reclassified under section 1886(d)(8)(B) of the Act, section 508 of Pub. L. 108–173, or section 1886(d)(10) of the Act. The applicable wage index for these hospitals will be found on Table 2. If a hospital is not listed in Tables 9A through 9C, CMS will have made a decision not to reclassify the hospital and its home wage index will apply, including the effect of the out-migration adjustment, will be found in Table 2. The applicable out-migration adjustment for the hospital will be found in Table 4J. As indicated above, we will separately publish a table identifying hospitals that we move from Lugar/urban status to rural status with the out-migration adjustment in Table 9D. Hospitals will have 30 days after the data are placed on the CMS Web site to submit, in writing, whether they wish to revise the decision made on their behalf by CMS. Written requests to revise a decision made on behalf of a hospital by CMS must be *received* by CMS no later than 5 p.m. EDT, with a copy sent to the MGCRB, within 30 days from the date the information appears on the CMS Web site at *http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp* at the following addresses:

Division of Acute Care, C4–08–06, 7500 Security Boulevard, Baltimore, MD 21244, Attn: Marianne Myers;

AND a copy to

Medicare Geographic Classification Review Board, 2520 Lord Baltimore Drive, Suite L, Baltimore, MD 21244–2670.

If a hospital fails to notify CMS that it is revising a determination made on its behalf within 30 days from the date the information appears on the CMS Web site, the interim decision made by CMS on the hospital's behalf will be final for FY 2007. Therefore, if CMS makes a decision on a hospital's behalf to terminate or withdraw a reclassification and the hospital does not reverse or modify CMS's decision, we will deem the hospital's reclassification is withdrawn or terminated. Once CMS's decision on the hospital's behalf is in effect, it will be treated in the same manner as if the hospital(s) had made the reclassification decision on its own. Thus, for example, because a hospital cannot have overlapping reclassifications, if we decide a hospital should accept a FY 2007 through 2009 reclassification, any reclassification the hospital previously had for FY 2006 through 2008 would be permanently terminated.

Section 1886(d)(10)(C)(ii) of the Act indicates that a hospital requesting a change in geographic classification for a FY must submit its application to the MGCRB no later than the first day of the 13-month period ending on September 30 of the preceding fiscal year. Thus, the statute requires that FY 2008 reclassification applications be submitted to the MGCRB no later than September 1, 2006. Hospitals must submit applications for geographic reclassification for FY 2008 by September 1, 2006. However, because the 3-year average hourly wage of hospitals for the FY 2007 final rule will not be available by the September 1, 2006 deadline for submitting FY 2008 geographic reclassification applications, we will allow hospitals to supplement incomplete reclassification applications with the official data used to develop the FY 2007 wage index after filing their initial application. As indicated above, the 3-year average hourly wage information that will be necessary for FY 2008 reclassification applications will be available subsequent to this final rule after August 1, and before October 1, 2006. The information will be available on the CMS Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp* and then accessing the page titled "MGCRB Reclassification Data for FY 2008 Applications." Applications and other information about MGCRB reclassifications may be obtained via the CMS Internet Web site at: *http://www.cms.hhs.gov/mgcrb/*, or by calling the MGCRB at (410) 786–1174. The mailing address of the MGCRB is: 2520 Lord Baltimore Drive, Suite L, Baltimore, MD 21244–2670.

Comment: Several commenters requested a revision in the geographic reclassification rules so that in the future the occupational mix adjusted average hourly wage data is used as a point of comparison for eligibility. The commenters believed this change would make reclassification decisions consistent with the new basis for the wage index. The commenters also suggested that hospitals should not be allowed to apply for reclassification if they do not provide complete occupational mix data.

Response: Section 1886(d)(10)(D)(vi) of the Act requires the MGCRB to use the 3-year average of the average hourly wage data from the most recently published hospital wage survey data, as well as the preceding 2 fiscal years' published surveys. Because our published surveys of wage data include adjustments for occupational mix (10 percent in FYs 2005 and 2006 and 100 percent in FY 2007), the MGCRB uses mix-adjusted wage indices in making reclassification decisions. Therefore, for FY 2008 reclassification applications, the MGCRB will use the average of the average hourly wages for FYs 2005 through 2007. These data will be based on an occupational mix adjustment of 10 percent for FY 2005 and FY 2006 and 100 percent for FY 2007.

With respect to the comment about precluding hospitals that did not submit occupational mix survey data from reclassifying, we believe that due to the unusual circumstances of the Court's order and the short timeframe that hospitals were provided for completing and submitting their data, it would not be fair to apply a penalty to non-responsive hospitals for the 2008 reclassification applications. However, as indicated earlier, we will give serious consideration to applying some sort of penalty in the future if a hospital does not comply with regulations requiring submission of occupational mix survey data.

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

Applications for FY 2008 reclassifications are due to the MGCRB by September 1, 2006. We note that this deadline also applies for canceling a previous wage index reclassification withdrawal or termination under § 412.273(d). As we noted in the FY 2007 IPPS proposed rule (71 FR 24083), applications and other information about MGCRB reclassifications may be obtained, beginning in mid-July 2006, on the CMS Web site at: *http://www.cms.hhs.gov/mgcrb/*, or by calling the MGCRB at (410) 786–1174.

The MGCRB, in evaluating a hospital's request for reclassification for FY 2008 for the wage index, must utilize the official data used to develop the FY 2007 wage index. The wage data used to support the hospital's wage comparisons must be from the CMS hospital wage survey. Generally, the source for these data is the IPPS final rule to be published on or before August 1, 2006. However, as we stated earlier, the wage tables identifying the 3-year average hourly wage of hospitals will not be available in time to include them in this FY 2007 IPPS final rule. Therefore, we will make the data available subsequent to August 1, 2006, but before October 1, 2006.

Section 1886(d)(10)(C)(ii) of the Act indicates that a hospital requesting a change in geographic classification for a FY must submit its application to the MGCRB not later than the first day of the 13-month period ending on September 30 of the preceding FY. Thus, the statute requires that FY 2008 reclassification applications be submitted to the MGCRB by no later than September 1, 2006. For this reason, hospitals must file an FY 2008 reclassification application by the September 1, 2006 deadline even though the average hourly wage data used to develop the final FY 2007 wage indices will not yet be available. We note that, under § 412.256(c), the MGCRB must review applications and notify the hospital if it determines that the application is incomplete. We are also allowing hospitals 30 days from the date the final wage data is posted on the CMS Web site to request to cancel a withdrawal or termination in order to reinstate its reclassification for FY 2008 or FY 2009, or both fiscal years. Requests to cancel a withdrawal or termination in order to reinstate a hospital's reclassification for FY 2008 or FY 2009, or both fiscal years, should be forwarded to the following addresses:

Medicare Geographic Classification Review Board, 2520 Lord Baltimore Drive, Suite L, Baltimore, MD 21244–2670;

AND a copy to

Division of Acute Care, C4–08–06, 7500 Security Boulevard, Baltimore, MD 21244, Attn: Marianne Myers.

As outlined in § 412.256(c)(2), hospitals with incomplete applications have the opportunity to request that the MGCRB grant a hospital that has submitted an application by September 1, 2006, an extension beyond September 1, 2006, to complete its application. Thus, while hospitals must file an application for reclassification to the

MGCRB by September 1, 2006, they will be able to supplement the reclassification application with official data used to develop the FY 2007 wage index after filing their initial application. We are providing that hospitals file a supplement to the reclassification application with official data used to develop the FY 2007 wage index no later than 30 days after the data are made available on the CMS Web site. These same rules will apply to canceling a withdrawal or termination of a geographic reclassification.

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

Beginning October 1, 1988, section 1886(d)(8)(B) of the Act required us to treat a hospital located in a rural county adjacent to one or more urban areas as being located in the MSA if certain criteria were met. Prior to FY 2005, the rule was that a rural county adjacent to one or more urban areas would be treated as being located in the MSA to which the greatest number of workers in the county commute, if the rural county would otherwise be considered part of an urban area under the standards published in the **Federal Register** on January 3, 1980 (45 FR 956) for designating MSAs (and New England County Metropolitan Areas (NECMAs)), and if the commuting rates used in determining outlying counties (or, for New England, similar recognized areas) were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or counties of *all* contiguous MSAs (or NECMAs). Hospitals that met the criteria using the January 3, 1980 version of these OMB standards were deemed urban for purposes of the standardized amounts and for purposes of assigning the wage data index.

Effective beginning FY 2005, we use OMB's 2000 CBSA standards and the Census 2000 data to identify counties qualifying for redesignation under section 1886(d)(8)(B) for the purpose of assigning the wage index to the urban area. We provided the chart below with the listing of the rural counties designated as urban under section 1886(d)(8)(B) of the Act in the FY 2007 IPPS proposed rule. For discharges occurring on or after October 1, 2006, hospitals located in the first column of this chart will be redesignated for purposes of using the wage index of the urban area listed in the second column.

The following table is subject to revision if CMS decides it is most advantageous for a county to waive its county Lugar status in order for a hospital within that county to receive a section 505 out-migration adjustment.

RURAL COUNTIES REDESIGNATED AS URBAN UNDER SECTION 1886(D)(8)(B) OF THE ACT

[Based on CBSAs and Census 2000 data]

Rural County	CBSA
Cherokee, AL	Rome, GA.
Macon, AL	Auburn-Opelika, AL.
Talladega, AL	Anniston-Oxford, AL.
Hot Springs, AR	Hot Springs, AR.
Windham, CT	Hartford-West Hartford-East Hartford, CT.
Bradford, FL	Gainesville, FL.
Flagler, FL	Deltona-Daytona Beach-Ormond Beach, FL.
Hendry, FL	West Palm Beach-Boca Raton-Boynton, FL.
Levy, FL	Gainesville, FL.
Walton, FL	Fort Walton Beach-Crestview-Destin, FL.
Banks, GA	Gainesville, GA.
Chattooga, GA	Chattanooga, TN-GA.
Jackson, GA	Atlanta-Sandy Springs-Marietta, GA.
Lumpkin, GA	Atlanta-Sandy Springs-Marietta, GA.
Morgan, GA	Atlanta-Sandy Springs-Marietta, GA.
Peach, GA	Macon, GA.
Polk, GA	Atlanta-Sandy Springs-Marietta, GA.
Talbot, GA	Columbus, GA-AL.
Bingham, ID	Idaho Falls, ID.
Christian, IL	Springfield, IL.
DeWitt, IL	Bloomington-Normal, IL.
Iroquois, IL	Kankakee-Bradley, IL.
Logan, IL	Springfield, IL.
Mason, IL	Peoria, IL.
Ogle, IL	Rockford, IL.
Clinton, IN	Lafayette, IN.
Henry, IN	Indianapolis-Carmel, IN.
Spencer, IN	Evansville, IN-KY.
Starke, IN	Gary, IN.
Warren, IN	Lafayette, IN.
Boone, IA	Ames, IA.
Buchanan, IA	Waterloo-Cedar Falls, IA.
Cedar, IA	Iowa City, IA.
Allen, KY	Bowling Green, KY.
Assumption Parish, LA	Baton Rouge, LA.
St. James Parish, LA	Baton Rouge, LA.
Allegan, MI	Holland-Grand Haven, MI.
Montcalm, MI	Grand Rapids-Wyoming, MI.
Oceana, MI	Muskegon-Norton Shores, MI.
Shiawassee, MI	Lansing-East Lansing, MI.
Tuscola, MI	Saginaw-Saginaw Township North, MI.
Fillmore, MN	Rochester, MN.
Dade, MO	Springfield, MO.

RURAL COUNTIES REDESIGNATED AS URBAN UNDER SECTION 1886(D)(8)(B) OF THE ACT—Continued

[Based on CBSAs and Census 2000 data]

Rural County	CBSA
Pearl River, MS	Gulfport-Biloxi, MS.
Caswell, NC	Burlington, NC.
Granville, NC	Durham, NC.
Harnett, NC	Raleigh-Cary, NC.
Lincoln, NC	Charlotte-Gastonia-Concord, NC-SC.
Polk, NC	Spartanburg, NC.
Los Alamos, NM	Santa Fe, NM.
Lyon, NV	Carson City, NV.
Cayuga, NY	Syracuse, NY.
Columbia, NY	Albany-Schenectady-Troy, NY.
Genesee, NY	Rochester, NY.
Greene, NY	Albany-Schenectady-Troy, NY.
Schuyler, NY	Ithaca, NY.
Sullivan, NY	Poughkeepsie-Newburgh-Middletown, NY.
Wyoming, NY	Buffalo-Niagara Falls, NY.
Ashtabula, OH	Cleveland-Elyria-Mentor, OH.
Champaign, OH	Springfield, OH.
Columbiana, OH	Youngstown-Warren-Boardman, OH-PA.
Cotton, OK	Lawton, OK.
Linn, OR	Corvallis, OR.
Adams, PA	York-Hanover, PA.
Clinton, PA	Williamsport, PA.
Greene, PA	Pittsburgh, PA.
Monroe, PA	Allentown-Bethlehem-Easton, PA-NJ.
Schuylkill, PA	Reading, PA.
Susquehanna, PA	Binghamton, NY.
Clarendon, SC	Sumter, SC.
Lee, SC	Sumter, SG.
Oconee, SC	Greenville, SC.
Union, SC	Spartanburg, SC.
Meigs, TN	Cleveland, TN.
Bosque, TX	Waco, TX.
Falls, TX	Waco, TX.
Fannin, TX	Dallas-Plano-Irving, TX.
Grimes, TX	College Station-Bryan, TX.
Harrison, TX	Longview, TX.
Henderson, TX	Dallas-Plano-Irving, TX.
Milam, TX	Austin-Round Rock, TX.
Van Zandt, TX	Dallas-Plano-Irving, TX.
Willacy, TX	Brownsville-Harlingen, TX.
Buckingham, VA	Charlottesville, VA.
Floyd, VA	Blacksburg-Christiansburg-Radford, VA.
Middlesex, VA	Virginia Beach-Norfolk-Newport News, VA.
Page, VA	Harrisonburg, VA.
Shenandoah, VA	Winchester, VA–WV.
Island, WA	Seattle-Bellevue-Everett, WA.
Mason, WA	Olympia, WA.
Wahkiakum, WA	Longview, WA.
Jackson, WV	Charleston, WV.
Roane, WV	Charleston, WV.
Green, WI	Madison, WI.
Green Lake, WI	Fond du Lac, WI.
Jefferson, WI	Milwaukee-Waukesha-West Allis, WI.
Walworth, WI	Milwaukee-Waukesha-West Allis, WI.

As in the past, hospitals redesignated under section 1886(d)(8)(B) of the Act are also eligible to be reclassified to a different area by the MGCRB. Affected hospitals are permitted to compare the reclassified wage index for the labor market area in Tables 4C–1 and 4C–2 into which they have been reclassified by the MGCRB to the wage index for the area to which they are redesignated under section 1886(d)(8)(B) of the Act once the final wage index data are posted on the CMS Web site.

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

Under section 508 of Pub. L. 108–173, a qualifying hospital could appeal the wage index classification otherwise applicable to the hospital and apply for reclassification to another area of the State in which the hospital is located (or, at the discretion of the Secretary, to an area within a contiguous State). We implemented this process through notices published in the **Federal Register** on January 6, 2004 (69 FR 661), and February 13, 2004 (69 FR 7340). Such reclassifications are applicable to discharges occurring during the 3-year period beginning April 1, 2004, and ending March 31, 2007. Under section 508(b), reclassifications under this process do not affect the wage index computation for any area or for any

other hospital and cannot be effected in a budget neutral manner.

Some hospitals currently receiving a section 508 reclassification are eligible to reclassify to that same area under the standard reclassification process as a result of the new labor market definitions that we adopted for FY 2005. The governing regulations indicate that "if a hospital is already reclassified to a given geographic area for wage index purposes for a 3-year period, and submits an application to the same area for either the second or third year of the 3-year period, that application will not be approved." However in the FY 2006 IPPS final rule (70 FR 47382), we stated that hospitals that indicated in their FY 2007 MGCRB applications that they agreed to waive their section 508 reclassification for the first 6 months of FY 2007 if they were granted a 3-year reclassification under the traditional MGCRB process will not be subject to the rule cited above. Thus, in applying for a 3-year MGCRB reclassification beginning in FY 2007, hospitals that are already reclassified to the same area under section 508 should have indicated in their MGCRB reclassification requests that if they receive the MGCRB reclassification, they would forfeit the section 508 reclassification for the first 6 months of FY 2007.

Under 1886(d)(10)(D)(v) of the Act, CMS has the authority to "establish procedures" under which a hospital may elect to terminate a reclassification before the end of a 3-year period. In the FY 2006 IPPS final rule (70 FR 47382), we discussed our decision to exercise this authority to establish a procedural rule for section 508 hospitals to retain their section 508 reclassification through its expiration on March 31, 2007, and reclassify under the regulations at 42 CFR Part 412, Subpart L, for the second half of FY 2007. We provided further detail above on how we will apply decisions regarding section 508 reclassifications in the context of the *Bellevue Hosp. Center* v. *Leavitt* court decision. Again, we will select the reclassification option that provides the highest wage index for the hospital and will give the hospital 30 days to revise the decision made on its behalf by CMS. We refer readers to the discussion above for further details about how section 508 hospitals that have applied for an individual reclassification and hospitals groups that include a section 508 hospital can revise a CMS decision.

We will apply a similar rule for purposes of the out-migration adjustment for FY 2007 discussed in section III.I. of this preamble. The statute states that a hospital cannot receive an out-migration adjustment if it is reclassified under section 1886(d)(10) of the Act. Therefore, eligible hospitals that are not reclassified during any part of FY 2007 will, by default, receive an out-migration adjustment during that time period. If the hospital is reclassified for all of FY 2007, the hospital will be ineligible for the out-migration adjustment. If a hospital has a half fiscal year reclassification, the hospital will be eligible for the out-migration adjustment for the portion of the fiscal year that it is not reclassified.

The procedural rules described in the FY 2006 IPPS final rule were intended to address specific circumstances where individual and group reclassifications involve a section 508 hospital. The rules were designed to recognize the special circumstances of section 508 hospital reclassifications ending mid-year during FY 2007 and were intended to provide flexibility in our regulations that would allow previously approved reclassifications to continue through March 31, 2007, and new reclassifications to begin April 1, 2007, upon the conclusion of the section 508 reclassifications. As we indicated in the proposed rule, we have received questions about the application of these special procedural rules to non-section 508 hospitals that are part of group applications that previously were awarded an individual reclassification that continues into FY 2007. These hospitals are concerned that the procedural rules imply that such prior reclassification would be terminated beginning October 1, 2006, because the rules specify that "the remainder of the group receives the home wage index" for the period October 1, 2006, through March 31, 2007, if the group reclassification application specified that the section 1886(d)(10) group reclassification would not begin until April 1, 2007. We did not specifically contemplate preexisting individual reclassifications when we drafted the special procedural rules for group reclassifications that involve section 508 hospitals. However, we did not intend to adopt a less favorable policy for non-section 508 hospitals in a group with a pending individual geographic reclassification than we did for section 508 hospitals. Thus, we clarified our procedural rule with respect to non-section 508 hospitals with preexisting individual reclassifications that are part of group reclassifications that include a section 508 hospital. For the first half of FY 2007, we intend to either apply (a) the area wage index where the hospital is physically located if there is no reclassification pending, or (b) the hospital's individual reclassification wage index if the hospital was part of a group awarded a group reclassification and the group followed the procedural rules for postponing reclassification until April 1, 2007. However, once the hospital begins its new section 1886(d)(10) reclassification for the period April 1, 2007, through September 30, 2009, any prior reclassifications are permanently terminated, consistent with 42 CFR 412.274(b)(2)(ii). We are also reiterating that the special procedural rules that we have adopted for half fiscal year reclassifications and terminations are intended only to address the special circumstances created by section 508 of Pub. L. 108–173 with respect to reclassifications beginning and ending mid-way through a fiscal year. These special procedural rules do not change any of the permanent provisions currently in effect with respect to reclassifications under subpart L of 42 CFR Part 412.

We show the reclassifications effective under the one-time appeal process in tentative Table 9B in the Addendum to this final rule. All section 1886(d)(10) reclassifications are listed in tentative Table 9A in the Addendum to this final rule.

Comment: Many commenters stated their appreciation and support of CMS' flexibility relating to the expiration of section 508 and in facilitating the transition between the end of section 508 and reclassifications occurring under section 1886(d)(10) of the Act.

Response: We thank the commenters for their support.

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

Under the procedural rules described under section III.H.6. of this preamble, different wage indices may be in effect for the first 6 months and the second 6 months of FY 2007. Specifically, there may be different wage indices in effect for the first and second half of FY 2007 due to the special circumstances of section 508 reclassifications ending in the middle of a fiscal year and half of FY 2007 geographic reclassifications under section 1886(d)(10) beginning on April 1, 2007. This unique circumstance will not change as a result of the *Bellevue Hosp. Center* v. *Leavitt* court decision.

The half fiscal year section 1886(d)(10) reclassifications present issues related to the calculation of the reclassified wage indices and reclassification budget neutrality factor. Section 1886(d)(8)(C) of the Act provides requirements for determining

the wage index values for both hospitals located in rural counties deemed urban under section 1886(d)(8)(B) of the Act and hospitals that were reclassified as a result of the MGCRB decisions under section 1886(d)(10) of the Act. As provided in the statute, we are required to calculate a separate wage index for hospitals reclassified to an area if including the wage data for the reclassified hospitals would reduce the area wage index by more than 1 percent. We proposed to issue two separate reclassified wage indices for affected areas (one effective from October 1, 2006, through March 31, 2007, and a second reclassified wage index effective April 1, 2007, through September 30, 2007). The reclassified wage indices will be calculated based on the wage data for hospitals reclassified to the area in the respective half of the fiscal year. We only received public comments supporting this proposal.

The half fiscal year reclassifications also have implications for budget neutrality. The overall effect of geographic reclassification is required by section 1886(d)(8)(D) of the Act to be budget neutral. We apply an adjustment to the IPPS standardized amounts to ensure that the effects of geographic reclassification are budget neutral. We proposed calculating one budget neutrality adjustment that reflects the average of the adjustments required for first and second half fiscal year reclassifications, respectively, as discussed in section II.A.4.b. of the Addendum to this final rule. We only received public comments supporting this proposal.

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

In accordance with the broad discretion under section 1886(d)(13) of the Act, as added by section 505 of Pub. L. 108–173, beginning with FY 2005, we established a process to make adjustments to the hospital wage index based on commuting patterns of hospital employees. The process, outlined in the FY 2005 IPPS final rule (69 FR 49061), provides for an increase in the wage index for hospitals located in certain counties that have a relatively high percentage of hospital employees who reside in the county but work in a different county (or counties) with a higher wage index. Such adjustments to the wage index are effective for 3 years, unless a hospital requests to waive the application of the adjustment. A county will not lose its status as a qualifying county due to wage index changes during the 3-year period, and counties will receive the same wage index increase for those 3 years. However, a county that qualifies in any given year may no longer qualify after the 3-year period, or it may qualify but receive a different adjustment to the wage index level. Hospitals that receive this adjustment to their wage index are not eligible for reclassification under section 1886(d)(8) or section 1886(d)(10) of the Act. Adjustments under this provision are not subject to the budget neutrality requirements under section 1886(d)(3)(E) of the Act.

Hospitals located in counties that qualify for the wage index adjustment are to receive an increase in the wage index that is equal to the average of the differences between the wage indices of the labor market area(s) with higher wage indices and the wage index of the resident county, weighted by the overall percentage of hospital workers residing in the qualifying county who are employed in any labor market area with a higher wage index. We employ the pre-reclassified wage indices in making these calculations.

In the FY 2007 IPPS proposed rule (71 FR 24264 through 24272), in the Out-Migration Adjustment table, Table 4J, we identified hospitals located in qualifying counties. Table 4J also listed the proposed adjustments calculated for qualifying hospitals. Hospitals that newly qualified for the adjustment in FY 2005 or FY 2006 are eligible to receive the same adjustment in FY 2007. In the FY 2007 IPPS proposed rule, we determined county eligibility based on a 10 percent occupational mix adjustment to the wage index. However, under the May 17, 2006 proposed rule discussed in section III.C. of this preamble, for FY 2007 we are applying the occupational mix adjustment to 100 percent of the FY 2007 wage index. Therefore, we must reevaluate which counties are newly eligible for the out-migration adjustment in FY 2007 using the 100 percent occupational mix adjusted wage index data. We will publish an updated version of Table 4J showing eligible hospitals and their corresponding wage index adjustments on the CMS Web site after we publish this IPPS final rule, and in advance of October 1, 2006, using the procedures discussed in section III.H.of this preamble. We will use the same formula described in the FY 2005 final rule (69 FR 49064) to calculate the out-migration adjustment.

The adjustments calculated for qualifying hospitals will be listed in the revised Table 4J that will be issued separately from this final rule. These adjustments will be effective for each county for a period of 3 fiscal years. Hospitals that received the adjustment in FY 2006 will be eligible to retain that same adjustment for FY 2007. For hospitals in newly qualified counties, adjustments to the wage index are effective for 3 years, beginning with discharges occurring on or after October 1, 2006.

As previously noted, hospitals receiving the wage index adjustment under section 1886(d)(13)(F) of the Act are not eligible for reclassification under sections 1886(d)(8) or (d)(10) of the Act, or under section 508 of Pub. L. 108–173, unless they waive such out-migration adjustment. As announced in the FYs 2005 and 2006 final rules, hospitals redesignated under section 1886(d)(8) of the Act or reclassified under section 1886(d)(10) of the Act or under section 508 of Pub. L. 108-173 will be deemed to have chosen to retain their redesignation or reclassification, unless they explicitly notified CMS that they elected to receive the out-migration adjustment instead within 45 days from the publication of the FY 2007 proposed rule.

As previously noted, hospitals receiving the wage index adjustment under section 1886(d)(13)(F) of the Act are not eligible for reclassification under sections 1886(d)(8) or (d)(10) of the Act, or under section 508 of Pub. L. 108–173, unless they waive such out-migration adjustment. Ordinarily, our rule is to presume that a hospital wishes to retain its reclassification, unless it notifies us within 45 days of the proposed rule that it wishes to receive the out-migration adjustment in lieu of the reclassification. However, for FY 2007, as stated earlier, we will be making reclassification withdrawal and termination decisions on behalf of hospitals. Thus, the ordinary 45-day rule would not apply in FY 2007. Rather, hospitals will have 15 days from the display date of this final rule to notify us of whether, in the absence of viewing the final 100 percent occupational mix-adjusted wage index data, they wish to choose a particular wage index for which they are eligible (such as to definitively maintain a reclassification which they received or to definitively terminate or withdraw from a reclassification). Otherwise, we will make withdrawal and termination decisions on behalf of the hospital (including a decision as to whether to accept an out-migration adjustment instead of a reclassification), and the hospital will then have 30 days to reverse or modify our decision, as applicable.

J. Process for Requests for Wage Index Data Corrections

In the FY 2005 IPPS final rule (68 FR 27194), we revised the process and

timetable for application for development of the wage index, beginning with the FY 2005 wage index. The preliminary and unaudited wage index data for FY 2007 were made available on October 7, 2005, through the Internet on the CMS Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS*. In a memorandum dated October 7, 2005, we instructed all Medicare fiscal intermediaries to inform the IPPS hospitals they service of the availability of the wage index data files and the process and timeframe for requesting revisions (including the specific deadlines listed below). We instructed the fiscal intermediaries to advise hospitals that these data are also made available directly through their representative hospital organizations.

If a hospital wished to request a change to its data as shown in the October 7, 2005 wage index data files, the hospital was to submit corrections along with complete, detailed supporting documentation to its fiscal intermediary by December 5, 2005. Hospitals were notified of this deadline and of all other possible deadlines and requirements, including the requirement to review and verify their data as posted on the preliminary wage index data file on the Internet, through the October 7, 2005 memorandum referenced above.

The fiscal intermediaries notified the hospitals by mid-February 2006 of any changes to the wage index data as a result of the desk reviews and the resolution of the hospitals' early December 2005 change requests. The fiscal intermediaries also submitted the revised data to CMS by mid-February 2006. CMS published the proposed wage index PUFs that included hospitals' revised wage data on February 24, 2006. Also, in a memorandum dated February 14, 2006, we instructed fiscal intermediaries to notify all hospitals regarding the availability of the proposed wage index PUFs and the criteria and process for requesting corrections and revisions to the wage index data. Hospitals had until March 13, 2006, to submit requests to the fiscal intermediaries for reconsideration of adjustments made by the fiscal intermediaries as a result of the desk review, and to correct errors due to CMS's or the fiscal intermediary's mishandling of the wage index data. Hospitals were also required to submit sufficient documentation to support their requests.

After reviewing requested changes submitted by hospitals, fiscal intermediaries transmitted any additional revisions resulting from the hospitals' reconsideration requests by April 14, 2006. The deadline for a hospital to request CMS intervention in cases where the hospital disagreed with the fiscal intermediary's policy interpretations was April 21, 2006.

Hospitals were also instructed to examine Table 2 in the Addendum to the proposed rule. Table 2 contained each hospital's adjusted average hourly wage used to construct the wage index values for the past 3 years, including the FY 2003 data used to construct the proposed FY 2007 wage index. We noted that the hospital average hourly wages shown in Table 2 only reflected changes made to a hospital's data and transmitted to CMS by March 1, 2006..

As discussed in section III.C. of this preamble, on May 17, 2006, we published in the **Federal Register** (71 FR 28644) a proposed rule that proposed to revise the methodology for calculating the occupational mix adjustment by applying the occupational mix adjustment to 100 percent of the wage index using the new 2006 occupational mix data. In section III.C.2 of this preamble, we discussed in detail the timeline and process for collecting, reviewing, and correcting the FY 2006 occupational mix survey data. The 1st quarter 2006 occupational mix data PUF was released on June 29, 2006, to hospital associations and the public on the Internet at *http://www.cms.hhs.gov/AcuteInpatientPPS*. The release of this file superseded any and all of the 2003 occupational mix survey data that we had previously published and proposed to use for the FY 2007 wage index. Hospitals had until July 13 to submit to the intermediaries their requests for corrections to the new 2006 survey data. Intermediaries were to submit all corrected occupational mix data to CMS by July 27, 2007. Also, as discussed in section III.C., the occupational mix data could not be finalized in time to include in this final rule, so we are releasing the final occupational mix adjusted wage index data and tables after the publication of this final rule, but before October 1, 2006.

Because hospitals had access to the final occupational mix data by June 29, 2006, we believe they had the opportunity to detect any data entry or tabulation errors made by the fiscal intermediary or CMS before the development and publication of the final FY 2007 wage index and the implementation of the FY 2007 wage index on October 1, 2006. We believe that if hospitals availed themselves of the opportunities afforded to provide and make corrections to the occupational mix data, the wage index implemented on October 1, 2006, will be accurate. In the extent that errors are identified by hospitals and brought to our attention after July 13, 2006, we will only make mid-year changes to the wage index in accordance with § 412.64(k) (see below for a detailed discussion).

The final Worksheet S–3 wage data PUF was released in May 2006 to hospital associations and the public on the Internet at *http://www.cms.hhs.gov/AcuteInpatientPPS* (hereon, referred to as the May 2006 PUF). The May 2006 PUF was made available solely for the limited purpose of identifying any potential errors made by CMS or the fiscal intermediary in the entry of the final Worksheet S–3 wage data that result from the correction process described above (revisions submitted to CMS by the fiscal intermediaries by April 14, 2006). If, after reviewing the May 2006 PUF, a hospital believed that its Worksheet S–3 wage data were incorrect due to a fiscal intermediary or CMS error in the entry or tabulation of the final data, the hospital was to send a letter to both its fiscal intermediary and CMS outlining why the hospital believed an error existed and to provide all supporting information, including relevant dates (for example, when it first became aware of the error). CMS and the fiscal intermediaries were to receive these requests no later than June 12, 2006. (We note that the June 12, 2006 date was revised from the June 9, 2006 date originally specified in the October 7, 2005 letter to hospitals.) Requests mailed to CMS were to be sent to: Centers for Medicare & Medicaid Services, Center for Medicare Management, Attention: Wage Index Team, Division of Acute Care, C4–08–06, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Each request also was to be sent to the fiscal intermediary. The fiscal intermediary was to review requests upon receipt and contact CMS immediately to discuss its findings.

After the release of the May 2006 PUF, changes to the hospital Worksheet S–3 wage data were only to be made in those very limited situations involving an error by the fiscal intermediary or CMS that the hospital could not have known about before its review of the final wage data file. Specifically, neither the intermediary nor CMS would approve the following types of requests:

- Requests for Worksheet S–3 wage data corrections that were submitted too late to be included in the data transmitted to CMS by fiscal intermediaries on or before April 14, 2006.
- Requests for correction of errors that were not, but could have been, identified during the hospital's review

of the February 24, 2006 wage index data file.

• Requests to revisit factual determinations or policy interpretations made by the fiscal intermediary or CMS during the wage index data correction process.

Verified corrections to the Worksheet S–3 wage data received timely by CMS and the fiscal intermediaries (that is, by June 12, 2006) are incorporated into the final wage index and will be reflected in the FY 2007 final wage index tables that will be published in a separate issuance after the publication of this final rule.

We created the processes described above to resolve all substantive wage index data correction disputes before we finalize the wage and occupational mix data for the FY 2007 payment rates. Accordingly, hospitals that did not meet the procedural deadlines set forth above will not be afforded a later opportunity to submit wage index data corrections or to dispute the fiscal intermediary's decision with respect to requested changes. Specifically, our policy is that hospitals that did not meet the procedural deadlines set forth above will not be permitted to challenge later, before the Provider Reimbursement Review Board, the failure of CMS to make a requested data revision. (See *W. A. Foote Memorial Hospital* v. *Shalala*, No. 99–CV–75202–DT (E.D. Mich. 2001) and *Palisades General Hospital* v. *Thompson*, No. 99–1230 (D.D.C. 2003.) We refer the reader also to the FY 2000 final rule (64 FR 41513) for a discussion of the parameters for appealing to the Provider Reimbursement Review Board for wage index data corrections.

We believe the wage index data correction process described above provides hospitals with sufficient opportunity to bring errors in their wage index data to the fiscal intermediaries' attention. Nevertheless, in the event that errors are identified by hospitals and brought to our attention after June 12, 2006, for Worksheet S–3 wage data, or after July 13, 2006, for the 1st quarter 2006 occupational mix data, we retain the right to make midyear changes to the wage index under very limited circumstances.

Specifically, in accordance with § 412.64(k)(1) of our existing regulations, we make midyear corrections to the wage index for an area only if a hospital can show that: (1) The fiscal intermediary or CMS made an error in tabulating its data; and (2) the requesting hospital could not have known about the error or did not have an opportunity to correct the error, before the beginning of the fiscal year. For purposes of this provision, "before the beginning of the fiscal year" means by the June deadline for making corrections to the wage data for the following fiscal year's wage index. With regard to the FY 2007 wage index, this means by June 12 for Worksheet S–3 wage data and by July 13 for 1st quarter 2006 occupational mix data. This provision is not available to a hospital seeking to revise another hospital's data that may be affecting the requesting hospital's wage index for the labor market area. As indicated earlier, since CMS makes the wage data available to a hospital on the CMS Web site prior to publishing both the proposed and final IPPS rules, and the fiscal intermediaries notify hospitals directly of any wage data changes after completing their desk reviews, we do not expect that midyear corrections would be necessary. However, under our current policy, if the correction of a data error changes the wage index value for an area, the revised wage index value will be effective prospectively from the date the correction is made.

In the FY 2006 IPPS final rule (70 FR 47385), we revised § 412.64(k)(2) to specify that, effective on October 1, 2005, that is beginning with the FY 2006 wage index, a change to the wage index can be made retroactive to the beginning of the Federal fiscal year only when: (1) The fiscal intermediary or CMS made an error in tabulating data used for the wage index calculation; (2) the hospital knew about the error and requested that the fiscal intermediary and CMS correct the error using the established process and within the established schedule for requesting corrections to the wage index data, before the beginning of the fiscal year for the applicable IPPS update (that is, for the FY 2007 wage index, by the June 12, 2006 deadline for Worksheet S–3 data and the July 13, 2006 deadline for 1st quarter 2006 occupational mix data); and (3) CMS agreed that the fiscal intermediary or CMS made an error in tabulating the hospital's wage index data and the wage index should be corrected.

In those circumstances where a hospital requests a correction to its wage index data before CMS calculates the final wage index (that is, for the FY 2007 wage index, by the June 12, 2006 deadline for Worksheet S–3 wage data and the July 13, 2006 deadline for 1st quarter 2006 occupational mix data), and CMS acknowledges that the error in the hospital's wage data was caused by CMS's or the fiscal intermediary's mishandling of the data, we believe that the hospital should not be penalized by our delay in publishing or implementing the correction. As with our current policy, we indicated that the provision is not available to a hospital seeking to revise another hospital's data. In addition, the provision cannot be used to correct prior years' wage index data; it can only be used for the current Federal fiscal year. In other situations, we continue to believe that it is appropriate to make corrections prospectively only. We note that, as with prospective changes to the wage index, the final retroactive correction will be made irrespective of whether the change increases or decreases a hospital's payment rate. In addition, we note that the policy of retroactive adjustment will still apply in those instances where a judicial decision reverses a CMS denial of a hospital's wage index data revision request.

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

Section 1886(d)(3)(E) of the Act directs the Secretary to adjust the proportion of the national prospective payment system base payment rates that are attributable to wages and wage-related costs by a factor that reflects the relative differences in labor costs among geographic areas. It also directs the Secretary to estimate from time to time the proportion of hospital costs that are labor-related: "The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs of the DRG prospective payment rates * * *" We refer to the portion of hospital costs attributable to wages and wage-related costs as the labor-related share. The labor-related share of the prospective payment rate is adjusted by an index of relative labor costs, which is referred to as the wage index.

Section 403 of Pub. L. 108–173 amended section 1886(d)(3)(E) of the Act to provide that the Secretary must employ 62 percent as the labor-related share unless this "would result in lower payments to a hospital than would otherwise be made." However, this provision of Pub. L. 108–173 did not change the legal requirement that the Secretary estimate "from time to time" the proportion of hospitals" costs that are "attributable to wages and wage-related costs." We believe that this reflected Congressional intent that hospitals receive payment based on either a 62-percent labor-related share, or the labor-related share estimated from time to time by the Secretary, depending on which labor-related share resulted in a higher payment.

We have continued our research into the assumptions employed in calculating the labor-related share. Our research involves analyzing the compensation share separately for urban

and rural hospitals, using regression analysis to determine the proportion of costs influenced by the area wage index, and exploring alternative methodologies to determine whether all or only a portion of professional fees and nonlabor intensive services should be considered labor-related.

In the FY 2006 IPPS final rule (70 FR 47392), we presented our analysis and conclusions regarding the frequency and methodology for updating the labor-related share for FY 2006. We also recalculated a labor-related share of 69.731 percent, using the FY 2002-based PPS market basket for discharges occurring on or after October 1, 2005. In addition, we implemented this revised and rebased labor-related share in a budget neutral manner, but consistent with section 1886(d)(3)(E) of the Act, we did not take into account the additional payments that would be made as a result of hospitals with a wage index less than or equal to 1.0 being paid using a labor-related share lower than the labor-related share of hospitals with a wage index greater than 1.0.

The labor-related share is used to determine the proportion of the national PPS base payment rate to which the area wage index is applied. In this final rule, we are not making any changes to the national average proportion of operating costs that are attributable to wages and salaries, fringe benefits, professional fees, contract labor, and labor intensive services. Therefore, we are continuing to use a labor-related share of 69.731 percent for discharges occurring on or after October 1, 2006. Tables 1A and 1B which will be issued as part of a document separate from this final rule, as discussed in section III.C. of this final rule, will reflect this labor-related share. We note that section 403 of Pub. L. 108–173 amended sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act to provide that the Secretary must employ 62 percent as the labor-related share unless this employment "would result in lower payments to a hospital than would otherwise be made."

We also are continuing to use a labor-related share for the Puerto Rico-specific standardized amounts of 58.7 percent for discharges occurring on or after October 1, 2006. Consistent with our methodology for determining the national labor-related share, we added the Puerto Rico-specific relative weights for wages and salaries, fringe benefits, contract labor, nonmedical professional fees, and other labor-intensive services to determine the labor-related share. Puerto Rico hospitals are paid based on 75 percent of the national standardized amounts and 25 percent of the Puerto Rico-specific standardized amounts. For Puerto Rico hospitals, the national labor-related share will always be 62 percent because the wage index for all Puerto Rico hospitals is less than 1.0. A Puerto Rico-specific wage index is applied to the Puerto Rico-specific portion of payments to the hospitals. The labor-related share of a hospital's Puerto Rico-specific rate will be either 62 percent or the Puerto Rico-specific labor-related share depending on which results in higher payments to the hospital. If the hospital has a Puerto Rico-specific wage index of greater than 1.0, we will set the hospital's rates using a labor-related share of 62 percent for the 25 percent portion of the hospital's payment determined by the Puerto Rico standardized amounts because this amount will result in higher payments. Conversely, a hospital with a Puerto Rico-specific wage index of less than 1.0 will be paid using the Puerto Rico-specific labor-related share of 58.7 percent of the Puerto Rico-specific rates because the lower labor-related share will result in higher payments. The Puerto Rico labor-related share of 58.7 percent for FY 2007 will be reflected in the Table 1C of the separately issued document referenced under sections III.C. and III.H. of this preamble.

Comment: One commenter suggested that, for hospitals with a wage index greater than one, CMS should use the FY 1992-based labor share of 71.1 percent rather than continue to use the FY 2002-based IPPS labor share of 69.7 percent.

Response: The labor-related share is used to determine the proportion of the national PPS based payment rate to which the area wage index is applied. For IPPS, the labor share remains constant until the market basket is rebased. As discussed in the August 12, 2005 IPPS final rule (70 FR 47393), the labor-related share for the FY 2002-based market basket was calculated by adding the relative weights of the labor-related operating cost categories of that market basket. These cost categories are: wages and salaries, fringe benefits, professional fees, contract labor, and labor-intensive services. Their relative weights were derived from the FY 2002 Medicare cost reports, which represented the most recent and complete data available when the FY 2002-based market basket was developed.

A return to the considerably older FY 1992-based labor share, where the relative weights were determined using FY 1992 Medicare cost reports, would mean relying on outdated information and thus is not optimal.

Finally, although the wage index and the labor-related share are interrelated regarding final payments, it is important to note that the labor-related share is calculated completely independently of the wage index. For these reasons, we will continue to use a labor-related share of 69.731 percent for discharges occurring on or after October 1, 2006.

L. Proxy for the Hospital Market Basket

In the FY 2006 IPPS final rule (70 FR 47387), we changed the base year cost structure for the IPPS hospital index for the hospital market basket for operating costs from FY 1997 to FY 2002. As discussed in that final rule, the IPPS hospital index primarily uses the BLS data as price proxies, which are grouped in one of the three BLS categories. The categories are Producer Price Indexes (PPIs), Consumer Price Indexes (CPIs), and Employment Cost Indexes (ECIs), discussed in detail in the FY 2006 IPPS final rule (70 FR 47388 through 47391). We evaluate the price proxies using the criteria of reliability, timeliness, availability, and relevance. The PPIs, CPIs, and ECIs selected by us and used for this final rule meet these criteria as described in the FY 2006 IPPS final rule. We believe they continue to be the best measures of price changes for the cost categories.

Beginning April 2006 with the publication of March 2006 data, the BLS' ECI will use a different classification system, the North American Industrial Classification System (NAICS), instead of the Standard Industrial Codes (SIC), which will no longer exist. We have consistently used the ECI as the data source for our wages and salaries and other price proxies in the IPPS market basket and are not making any changes to the usage at this time. However, we did solicit comments in the IPPS proposed rule on our continued use of the BLS ECI data in light of the BLS change in system usage to the NAICS-based ECI. CMS received no comments on use of the BLS ECI data. As the SIC-based ECIs no longer exist, we will therefore adopt the proposed policy of using the BLS NAICS-based ECIs to replace the SIC-based ECIs as price proxies in the market basket.

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

A. Reporting of Hospital Quality Data for Annual Hospital Payment Update (§ 412.64(d)(2))

1. Background

Section 5001(a) of the Deficit Reduction Act of 2005, Pub. L. 109–171 (DRA) sets out new requirements for the Reporting Hospital Quality Data for

Annual Payment Update (RHQDAPU) program. The RHQDAPU program was established to implement section 501(b) of Pub. L. 108–173 (MMA). It builds on our ongoing voluntary Hospital Quality Initiative which is intended to empower consumers with quality of care information to make more informed decisions about their health care while also encouraging hospitals and clinicians to improve the quality of care.

Section 5001(a) of Pub. L. 109–171 revises the mechanism used to update the standardized amount for payment for hospital inpatient operating costs. New sections 1886(b)(3)(B)(viii)(I) and (II) of the Act provide that the payment update for FY 2007 and each subsequent fiscal year will be reduced by 2.0 percentage points for any "subsection (d) hospital" that does not submit certain quality data in a form and manner, and at a time, specified by the Secretary.

New sections 1886(b)(3)(B)(viii)(III) and (IV) of the Act require that we expand the "starter set" of 10 quality measures that we have used since 2003. Specifically, the Secretary is required to expand, consistent with the provisions of section 5001(a) of Pub. L. 109–171, the set of measures that the Secretary determines to be appropriate for the measurement of the quality of care furnished by hospitals in inpatient settings. In expanding these measures, section 1886(b)(3)(B)(viii)(IV) of the Act provides that we must begin to adopt the baseline set of performance measures as set forth in a 2005 report issued by the Institute of Medicine (IOM) of the National Academy of Sciences under section 238(b) of Pub. L. 108–173,[19] effective for payments beginning with FY 2007. The IOM measures include the Hospital Quality Alliance (HQA) measures (the HQA is a public-private collaboration to improve the quality of care provided by the nation's hospitals by measuring and publicly reporting on that care), the HCAHPS® patient perspective survey, and three structural measures. The structural measures included in the IOM report are: "(1) Implementation of computerized provider order entry for prescriptions, (2) staffing of intensive care units with intensivists, and (3) evidence-based hospital referrals. These measures originate from the Leapfrog Group's original "three leaps," and are part of the [National Quality Forum's] 30 safe practices."

[19] Institute of Medicine, "Performance Measurement: Accelerating Improvement," December 1, 2005, available at *http://www.iom.edu/CMS/3809/19805/31310.aspx.*

New sections 1886(b)(3)(B)(viii)(V) and (VI) of the Act require that, effective for payments beginning with FY 2008, we add other quality measures that reflect consensus among affected parties, and provide the Secretary with the discretion to replace any quality measures or indicators in appropriate cases, such as where all hospitals are effectively in compliance with a measure, or the measures or indicators have been subsequently shown to not represent the best clinical practice. Thus, the Secretary has broad discretion to replace measures on the basis that they are not appropriate.

New section 1886(b)(3)(B)(viii)(VII) of the Act requires that we establish procedures for making quality data available to the public after ensuring that a hospital has the opportunity to review, in advance, its data that are to be made public. In addition, this section requires that we report quality measures of process, structure, outcome, patients' perspective on care, efficiency, and costs of care that relate to services furnished in inpatient settings on the CMS Web site.

Like the provisions of section 501(b) of Pub. L. 108–173, the provisions of section 5001(a) of Pub. L. 109–171 do not apply to hospitals and hospital units excluded from the IPPS, or to payments to hospitals under other prospective payment systems such as the hospital outpatient PPS. New section 1886(b)(3)(B)(viii)(I) of the Act also provides that any reduction will apply only with respect to the fiscal year involved, and will not be taken into account for computing the applicable percentage increase for a subsequent fiscal year.

Initially, section 1886(b)(3)(B)(vii) of the Act provided for a reduction of 0.4 percentage points to the update percentage increase for each of FYs 2005 through 2007 for any "subsection (d) hospital" that did not submit data on the starter set of 10 quality measures established by the Secretary of Health and Human Services as of November 1, 2003. Section 5001(a) of Pub. L. 109–171 limits the 0.4 percentage point reduction to FY 2005 and FY 2006, and establishes a 2.0 percentage point reduction for FY 2007 and subsequent fiscal years.

The starter set of 10 quality measures we established as of November 1, 2003 are:

Heart Attack (Acute Myocardial Infarction)

- Was aspirin given to the patient upon arrival to the hospital?
- Was aspirin prescribed when the patient was discharged?
- Was a beta-blocker given to the patient upon arrival to the hospital?
- Was a beta-blocker prescribed when the patient was discharged?
- Was an ACE inhibitor given for the patient with heart failure?

Heart Failure (HF)

- Did the patient get an assessment of his or her heart function?
- Was an ACE inhibitor given to the patient?

Pneumonia (PNE)

- Was an antibiotic given to the patient in a timely way?
- Had the patient received a pneumococcal vaccination?
- Was the patient's oxygen level assessed?

We adopted these measures after the Secretary of HHS initiated a partnership with several collaborators intended to promote hospital quality improvement and public reporting of hospital quality information. These collaborators included the American Hospital Association, the Federation of American Hospitals, the Association of American Medical Colleges, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the National Quality Forum (NQF), the American Medical Association, the Consumer-Purchaser Disclosure Project, the American Association of Retired Persons, the American Federation of Labor-Congress of Industrial Organizations, the Agency for Healthcare Research and Quality (AHRQ), as well as CMS, Quality Improvement Organizations (QIOs), and others.

This collaboration, originally known as the National Voluntary Hospital Reporting Initiative, is now known as the HQA. Hospital data are submitted through the QualityNet Exchange secure Web site (*www.qnetexchange.org*). This Web site meets or exceeds all current Health Insurance Portability and Accountability Act requirements. Data from this initiative were initially used to populate the Hospital Compare Web site, *www.hospitalcompare.hhs.gov*. This Web site assists beneficiaries and the general public by providing information on hospital quality of care for consumers who need to select a hospital. It further serves to encourage consumers to work with their doctors and hospitals to discuss the quality of care they provide to patients, thereby providing an additional incentive to improve the quality of that care.

This starter set of 10 quality measures, all of which have been endorsed by the NQF, is a subset of measures currently collected for the JCAHO as part of its

certification program. NQF is a voluntary consensus standard-setting organization established to standardize health care quality measurement and reporting through its consensus development process We chose these 10 quality measures in order to collect data that will: (1) provide useful and valid information about hospital quality to the public; (2) provide hospitals with a sense of predictability about public reporting expectations; (3) begin to standardize data and data collection mechanisms; and (4) foster hospital quality improvement. Most hospitals have participated in the HQA, and are continuing to submit data to the QIO Clinical Warehouse. Since the HQA released the starter set of 10 quality measures, it has continued to release additional quality measures, and has released 11 additional NQF-endorsed quality measures to date. Many HQA-participating hospitals have been voluntarily reporting on these additional quality measures, although only the starter set of 10 quality measures were subject to potential reductions in hospitals' annual payment update percentages under section 501(b) of Pub. L. 108–173.

To implement section 501(b) of Pub. L. 108–173, we created the RHQDAPU program. Originally, the program set out the form, manner, and timeframes for hospitals to submit data regarding the starter set of 10 quality measures. For the FY 2005 payment update, we permitted hospitals to withdraw from the RHQDAPU program at any time up to August 1, 2004. Hospitals that withdrew from the program did not receive the full payment update and, instead, received a reduction of 0.4 percentage points in their payment update. We did not establish a deadline for withdrawal for the FY 2006 payment update.

For FY 2006, in order to receive a full payment update, hospitals were required to continuously submit to the QIO Clinical Warehouse abstracted data regarding the starter set of 10 quality measures each calendar quarter according to the schedule found on the QualityNet Exchange Web site. New participants were required to submit these data using the same schedule, starting with the quarter they began discharging patients. The data for each quarter had to be submitted on time and pass all of the edits and consistency checks required in the QIO Clinical Warehouse. Hospitals that did not treat a condition or that had very few discharges were not penalized, and they received the full payment update if they submitted appropriate data on each of the 10 quality measures that they treated for patients who were discharged during the reporting periods.

2. New Procedures for Hospital Reporting of Quality Data

a. Two Percentage Point Reduction

In the FY 2007 IPPS proposed rule (71 FR 24091), we proposed to amend our regulations at § 412.64(d)(2) to reflect the 2.0 percentage point reduction in the payment update for FY 2007 and subsequent fiscal years for hospitals that do not comply with requirements for reporting quality data as provided for under section 5001(a) of Pub. L. 109–171.

Comment: One commenter stated that the increase from a 0.4 percentage point reduction in the annual payment update to a 2.0 percentage point reduction was too great and that this increase could cause some small hospitals to close.

Response: The increase from a 0.4 percentage point reduction to a 2.0 percentage point reduction is mandated by section 1886(b)(3)(B)(viii)(I) of the Act.

Comment: One commenter asked if the 2.0 percentage point reduction in the market basket update would ever apply retroactively.

Response: The amount of the reduction and the payment update to which a reduction applies are governed by statute. Section 1886(b)(3)(B)(viii)(I) of the Act requires a 2.0 percentage point reduction for FY 2007 "and each subsequent fiscal year." Section 1886(b)(3)(B)(viii)(I) also provides that the 2.0 percentage point reduction "shall apply only to the fiscal year involved." Therefore, the 2.0 percentage point reduction will not affect the annual payment update for a hospital for any fiscal year prior to FY 2007.

b. New Procedures

We also revised the RHQDAPU program's procedures to reflect our experience with this program and to implement section 5001(a) of Pub. L. 109–171, including the new requirement for the reporting of an expanded set of quality measures. In addition to publication in this final rule, all revised procedures will be added to the "Reporting Hospital Quality Data for Annual Payment Update Reference Checklist" section of the QualityNet Exchange Web site. This checklist also contains all of the forms to be completed by hospitals participating in the program. In order to participate in the hospital reporting initiative, hospitals must follow these steps:

- Identify a QualityNet Exchange Administrator who follows the registration process and submits the information through the QIO. This must be done regardless of whether the hospital uses a vendor for transmission of data.
- Complete the revised "Reporting Hospital Quality Data for Annual Payment Update Notice of Participation" form. All hospitals must send this form to their QIO, no later than August 15, 2006. In addition, before participating hospitals initially begin reporting data, they must register with the QualityNet Exchange, regardless of the method used for submitting data. Although, we proposed that this form be submitted by August 1, 2006, we have chosen to extend the due date to August 15, 2006 to provide hospitals with additional time to notify their QIOs regarding their intent to participate. We received no comments on this proposal.
- Continue to collect data for all 10 "starter set" quality measures (or begin collecting such data, if newly participating in the program), and submit the data to the QIO Clinical Warehouse either using the CMS Abstraction & Reporting Tool (CART), the JCAHO ORYX® Core Measures Performance Measurement System, or another third-party vendor tool that has met the measurement specification requirements for data transmission to QualityNet Exchange. The QIO Clinical Warehouse will submit the data to CMS on behalf of the hospitals. The submission will be done through QualityNet Exchange. Because the information in the QIO Clinical Warehouse is considered QIO information, it is subject to the stringent QIO confidentiality regulations in 42 CFR Part 480. We proposed that hospitals continue to submit data regarding the starter set of 10 quality measures because the existing data submission schedule that we will use for the FY 2007 update relies on discharges that occurred in calendar year (CY) 2005. Because the first three quarters of CY 2005 data already have been submitted, we did not propose to require hospitals to submit any additional CY 2005 data to address the new quality measures. However, we again note that many hospitals have been providing data on these additional measures since they were first included in the HQA set, although these measures did not affect hospitals' annual payment adjustment under the RHQDAPU program implementing section 501(b) of Pub. L. 108–173.
- For the FY 2007 update, we proposed that hospitals also would be required to complete and return a written form on which they pledge to submit data on the set of expanded

quality measures starting with discharges that occur in CY 2006. The proposed 21 quality measures which we included in the proposed rule are part of the HQA-released measures that the 2005 IOM report recommended we use as expanded "starter" measures, and they include the 10 measures that we originally adopted for the RHQDAPU program. As discussed above, new section 1886(b)(3)(B)(viii)(IV) of the Act requires us to begin to adopt the baseline set of performance measures set forth in the 2005 IOM report effective for payments beginning with FY 2007. We proposed that hospitals would be required to submit data on the expanded measures to the QIO Clinical Warehouse beginning with discharges that occur in the first calendar quarter of 2006 (January through March discharges). We also stated that the deadline for hospitals to submit their data for first calendar quarter of 2006 would be August 15, 2007.

Comment: Over 100 commenters opposed our proposal that hospitals submit data using the expanded quality measures for discharges occurring in calendar year 2006. Even though data for the first calendar quarter of 2006 are not required to be submitted until August 15, 2006, commenters stated that using the first calendar quarter as a starting date for submissions would create a hardship for hospitals, and require that their staff re-review records. Commenters recommended that the expanded measure set be used for future reviews only, and that all changes made to reporting should be done with a future effective date. Most of the commenters recommended that we require hospitals to begin reporting using the expanded quality measures starting with discharges occurring in the third calendar quarter of 2006.

Response: After careful review and consideration of the operational issues raised by commenters, CMS has decided to modify the starting quarter for hospital reporting of the expanded 21 quality measures. In reviewing this matter, we recognized that hospitals who concurrently abstract data may have been required to reabstract data from records that had already been completed. Others would have the burden of reconsidering the additional data elements after the timeframe for which they are preparing to submit data. Given the goal of improving quality through public reporting in an efficient manner that does not create undue burden, CMS believes it is appropriate in this instance to modify the starting quarter for the expanded measures. Therefore, hospitals will now be required to submit data on the specified expanded set of 21 quality measures to the QIO Clinical Data Warehouse beginning with discharges that occur in the third calendar quarter of 2006 (July through September discharges). The deadline for hospitals to submit this data for third calendar quarter of 2006 is February 15, 2007. The measures that are part of this expanded measure set are described below.

Comment: Several commenters stated that not all hospitals are currently submitting data on the expanded measure set. These commenters noted that hospitals that do not currently submit data using the expanded measure set may need to hire and train new staff to handle the new increased data abstraction requirements that we proposed to implement in the proposed rule. Some of these commenters suggested that reporting data on the expanded measure set should start with January 2007 discharges in order to allow hospitals additional time to make the necessary changes for the extra work.

Response: Although hospitals are not currently required to submit data on the full set of 21 quality measures identified in the proposed rule, many of them are already submitting these data on a voluntary basis under the HQA initiative. As noted in our response to the previous set of comments, we have modified our proposal in response to concerns expressed by commenters. Hospitals will now be required to submit data on a specified expanded set of measures to the QIO Clinical Data Warehouse beginning with discharges that occur in the third calendar quarter of 2006 (July through September discharges). The deadline for hospitals to submit this data for third quarter 2006 is February 15, 2007. We believe that this will provide adequate additional time for hospitals to hire or train staff regarding the expanded quality measures.

Comment: One commenter expressed concern that the proposed rule requires hospitals to start collecting data on the expanded quality measures immediately.

Response: As indicated above, we have modified our original proposal to ease the hospitals' transition to reporting using the expanded quality measures. For the expanded measures reporting requirement, hospitals will now be required to pledge to submit data on the expanded measures beginning with discharges that occur in the third calendar quarter of 2006 (July through September discharges). Hospitals are given 4½ months following the last day of a discharge quarter to submit accurate data into the QIO Clinical Data Warehouse. Therefore, under our revised policy, we believe that hospitals will have sufficient time to plan when they will begin to collect data on the expanded quality measures.

We would also like to note that we have taken steps to ensure that the burden on hospitals to submit data on the expanded measures is as minimal as possible. For example, in addition to being described in this rule, all of the measures that must be reported, including the 11 newly required measures, are also described in the "Specifications Manual for National Hospital Quality Measures," which is a manual that is jointly issued and maintained by CMS and JCAHO. The manual contains all of the specifications, data definitions, data collection rules and algorithms related to all 21 measures (the 10 RHQDAPU PROGRAM measures and the 11 measures that are being voluntarily reported under the HQA initiative). All specifications for each of these measures as used by CMS for the RHQDAPU program are identical to, or "aligned" with, those used by JCAHO. The CMS and JCAHO alignment results in a single standardized process for the reporting of measures that is accepted by both CMS and JCAHO. In an effort to reduce the reporting burden on hospitals, CMS and the JCAHO work together to refine the data collection process for hospitals for the purposes of validation, public reporting, and the RHQDAPU program. Additionally, CMS and JCAHO have agreed to release all documents associated with data collection at a minimum of 120 days prior to implementation.

Comment: One commenter stated that the time frames for data collection in the proposed rule do not provide hospitals the opportunity to change or correct mistakes.

Response: The current data submission timeframe is designed to provide sufficient time for hospitals to meet all reporting requirements. Hospitals are given 4½ months following the last day of a discharge quarter to submit accurate data into the QIO Clinical Data Warehouse. We believe that this is a sufficient timeframe for the vendor, hospital, QIO or other interested party to identify data errors and submit corrections in advance of the data submission deadline. Additionally, abstractions can begin as early during the quarter as the day the patient is actually admitted. As such, hospitals actually have up to 3 months in addition to the 4½ months following the last day of the discharge quarter to collect and submit data. In

addition, under § 482.24 of our regulations, all elements of the medical record (for example, documentation) are required to be complete within 30 days following discharge, so we believe that hospitals have adequate time for the record abstraction and submission.

To ensure that data submission problems are recognized and corrected early, we encourage hospitals to submit their data continuously or to conduct test transmissions prior to the quarterly posted data transmission deadlines. Testing transmissions ensures that hospitals' computer systems are equipped with the proper software and configuration required to successfully transmit data through QualityNet Exchange Web site. We note that it is a hospital's responsibility to ensure that its data are submitted successfully to the QIO Clinical Data Warehouse. To make it easier for hospitals to verify whether their data were successfully submitted, the QualityNet Exchange Web site has a function that enables hospitals to run reports during test transmissions and after final transmission of data that indicate which records were successfully submitted, with and without errors, and/or which data were rejected by the warehouse. We recommend that hospitals run these reports following each submission of data. Submitting test files early also allows hospitals to check the reports to identify and change or correct mistakes.

Comment: Two commenters stated that the retrospective way that data are reviewed does not offer sufficient opportunity to quickly correct a problem in the hospital setting. One commenter recommended that abstracting occur concurrently with discharge, thereby preventing discharge if additional clinical requirements need to be met. The commenter suggested that a real-time data system be developed to capture this information. The system would alert health care providers when clinical requirements have not been met so that hospitals can remedy these requirements prior to discharging the patient. The commenter also suggested that CMS sponsor a demonstration project for this activity. It would give CMS the opportunity to lead the way for improved technology dissemination in hospitals.

Response: As we discussed in our discussion of value-based purchasing in the FY 2007 IPPS proposed rule (71 FR 24098), one of the challenges we face is minimizing the length of time between our receipt of, and our ability to provide feedback to hospitals on, the data they submit. We agree that hospitals also face this same issue with data they collect. CMS encourages hospitals to take steps toward the adoption of electronic medical records (EMRs) that will allow for the reporting of clinical quality data. In general, whether to abstract on a concurrent or on a retrospective basis is a hospital's decision, although we recognize there may be a necessary period of retrospective abstraction due to the implementation of new measures. We do not believe that a demonstration project is needed.

Comment: Several commenters noted that expanding the measure set retroactively will require hospitals to re-negotiate contracts with their vendors.

Response: We disagree that our proposal to require hospitals to submit data beginning with first quarter 2006 discharges would have expanded the measure set retroactively. However, as noted above, in response to the comments we received, we will require that hospitals begin using the expanded measure set for submissions due February 15, 2007 relating to discharges occurring in the third calendar quarter of 2006. We believe that this change will afford hospitals adequate notice to prepare for reporting using the expanded quality measures. CMS provides information in a manner that is timely for purposes of meeting the requirements outlined. CMS does not comment on the contractual arrangements between private parties such as hospitals and their vendors. CMS will continue to work with all to assist with their timely performance, but this issue remains a private contractual arrangement between those parties. As an alternative, CMS also provides the CART tool to ensure that hospitals may timely meet its requirements for the annual payment update.

Comment: Sixteen commenters requested that CMS consider publishing the proposal to expand the set of measures at least one full year prior to the start of the fiscal year to which the proposal would apply. Seven other commenters requested a 6-month to 1-year lead-time to prepare for reporting additional quality measures adopted by the Secretary as part of the RHQDAPU program.

Response: We have used the rulemaking process to adopt new quality measures under the RHQDAPU program, and we believe that this process provides sufficient notice for hospitals to comply for the annual payment update. We also note that all of the measures we have adopted to date for reporting under the RHQDAPU program were previously reported by many hospitals under other voluntary reporting initiatives.

Comment: One commenter suggested that CMS publicly release a list of the hospitals that do not meet quality reporting requirements each year. This would allow the affected hospitals to know immediately that they are not in compliance with quality reporting.

Response: Hospitals that met the current CMS requirements for quality data reporting and received their full annual payment update (APU) for FY 2006 are listed on *www.qualitynet.org.* In the future, QualityNet will display a list of those hospitals receiving their full APU for FY 2007. CMS currently does not have a system in place for individually notifying hospitals that fail to meet the RHQDAPU program requirements. CMS is currently considering how to inform those hospitals that do not receive their full annual payment update for FY 2007.

c. Expanded Quality Measures

In the FY 2007 IPPS proposed rule (71 FR 24093), we listed 21 proposed quality measures, including the 10 "starter set" measures and 11 new measures. The expanded set of measures includes:

Heart Attack (Acute Myocardial Infarction)

- Aspirin at arrival
- Aspirin prescribed at discharge
- ACE inhibitor (ACE–I) or Angiotensin Receptor Blocker (ARBs) for left ventricular systolic dysfunction
- Beta blocker at arrival
- Beta blocker prescribed at discharge
- Thrombolytic agent received within 30 minutes of hospital arrival
- Percutaneous Coronary Intervention (PCI) received within 120 minutes of hospital arrival
- Adult smoking cessation advice/ counseling

Heart Failure (HF)

- Left ventricular function assessment
- ACE inhibitor (ACE–I) or Angiotensin Receptor Blocker (ARBs) for left ventricular systolic dysfunction
- Discharge instructions
- Adult smoking cessation advice/ counseling

Pneumonia (PNE)

- Initial antibiotic received within 4 hours of hospital arrival
- Oxygenation assessment
- Pneumococcal vaccination status
- Blood culture performed before first antibiotic received in hospital
- Adult smoking cessation advice/ counseling
- Appropriate initial antibiotic selection
- Influenza vaccination status

Surgical Care Improvement Project (SCIP)—Named SIP for Discharges Prior to July 2006 (3Q06)

- Prophylactic antibiotic received within 1 hour prior to surgical incision
- Prophylactic antibiotics discontinued within 24 hours after surgery end time

Comment: Six commenters fully supported the progress CMS has made on the identification and reporting of quality measures.

Response: CMS appreciates the comments and looks forward to continued support for this effort.

Comment: One commenter suggested that, with regard to hospital acquired infections, CMS make it clear that process measures are an interim step prior to the reporting in the near future of the actual rates of common hospital acquired infections.

Response: CMS believes that the information obtained from both process and outcome measures (an example of which would be the rates of common hospital acquired infections) are important and complementary in stimulating the system changes necessary for quality improvement. With regard to nosocomial or hospital-acquired infections, we appreciate the comment and would note that the NQF is currently evaluating measures of hospital acquired infections with the goal of endorsing a set of measures by 2007. The NQF is a voluntary consensus standard-setting organization established to standardize healthcare quality measurement and reporting, for its review and endorsement through its consensus development process. In addition, we are working with the Centers for Disease Control (CDC) and the AHRQ, two government agencies that collaborate with CMS on the SCIP on ways to further reduce surgical complications and infections and improve the kinds of information collected related to this goal.

Comment: One commenter urged CMS to recognize new technology promptly and appropriately to ensure that measures do not provide incentives for hospitals to keep older technologies in place after they are outdated.

Response: CMS is constantly reviewing the medical literature and maintains technical expert panels and consultants for its performance measure sets so that its measures remain up to date with current technologies. Additionally, we have regular conference calls with the relevant specialty societies, such as the American College of Surgeons, the American Society of Anesthesiologists, and the Association of periOperative Registered Nurses), to obtain their input on new evidence and changing best practices that might warrant a change to our performance measures.

Comment: One commenter stated that in small hospitals, one person may be responsible for many jobs. In this situation, the commenter felt that submitting data regarding more measures was very redundant.

Response: For each of the conditions (such as pneumonia) for which we adopt measures, the measures focus on individual aspects of care that are considered standard for every patient. The addition of measures represents a more comprehensive view of the quality of services provided to each patient. We believe that additional information from the added measures will contribute to quality improvement in patient care.

Comment: Twenty-four commenters stated that their hospitals do not currently collect data for the surgical infection prevention (SIP) measures. They contend that the FY 2007 IPPS proposed rule's requirement that they establish a procedure for abstracting and collecting these measures for first quarter 2006 would be very burdensome for hospitals. Many of the commenters requested a delay in the implementation of the collection of SIP measures until third calendar quarter of 2006. Another commenter noted that the hospital's data collecting vendor would require additional funds to collect and process data to support the SIP measure data collection for January and February of 2006.

Response: As noted above, in this final rule we have revised the implementation date for hospital reporting using the expanded quality measures (including the SIP/SCIP measures) so that reporting will begin starting with discharges occurring in the third calendar quarter of 2006. We also note that submitting data via vendors is not the only route available to hospitals. Currently hospitals have available to them three mechanisms by which to submit data into the QIO Clinical Warehouse. It is the hospital's choice which mechanism it will utilize to report its data. The following data reporting mechanisms are available to hospitals:

- Quality Improvement Organization Program (QIO)—CMS makes available to hospitals data reporting assistance via QIOs. QIOs provide technical assistance to hospitals as they report data, and if need be will report the data on behalf of the hospital.
- Self reporting—Hospitals can report their own data. All data collection, including SIP/SCIP can be accomplished by using the CMS Abstraction & Reporting Tool (CART). This application tool is available at no charge to hospitals or other organizations.
- JCAHO vendor—A hospital may authorize a JCAHO Performance Measurement System (PMS) vendor that has met the CMS measurement specifications to transmit data into the QIO Clinical Warehouse on its behalf.

These reporting mechanisms are also described on the QualityNet Exchange Web site (*www.qualitynet.org*).

Comment: Nine commenters noted that the data requirement for SCIP would result in unplanned costs to hospitals including the hiring of additional abstractors, additional training, and additional medical assistance to pull the pertinent charts.

Response: Under section 5001(a) of Pub. L. 109–171, we are required to begin to adopt the baseline set of performance measures as set forth in the 2005 IOM report, which include the SIP/SCIP measures. In considering which of these measures we would adopt for the RHQDAPU program, we weighed the burden for the hospital to report additional quality data for the measure against the benefits of addressing recognized gaps in quality and providing beneficiaries with useful information on the quality of hospital care. We believe that the SIP/SCIP measures strike the appropriate relative balance of interests.

That balance is appropriate and valuable on three levels given the potential improvements in surgical site infections that can occur through proper antibiotic use. It is estimated that over half of the 127,000 surgical site infections that are contracted by Medicare beneficiaries were preventable (Best, WR, Khuri SF, et al.; Identifying Patient Preoperative Risk Factors and Postoperative Adverse Events in Administrative Databases: Results from the Department of Veterans Affairs National Surgical Quality Improvement Program. J Am Coll Surg 2002;194:257–266. 2002 by the American College of Surgeons).

SCIP measures are designed as a framework to help hospitals organize and coordinate care. Evidence has shown that when hospitals change their internal systems to reliably deliver the care mandated in the SCIP measures, they are more efficient and safer for patients. For example, a nationwide collaborative dedicated to improve the processes of care outlined in the proposed SCIP Infection measures demonstrated a significant reduction in surgical site infection (Dellinger EP, Hausmann SM, et al., Hospitals collaborate to decrease surgical site

infections. Am J Surg. 2005 Jul;190(1):9–15.). And reliable processes of care aimed at assuring the correct deep venous thrombosis prevention as outlined in the proposed SCIP VTE measures "markedly reduced" the rates of these complications in patients at risk (Kucher, N, Koo S, et al.; Electronic Alerts to Prevent Venous Thromboembolism among Hospitalized Patients N Engl J Med 2005;352:969–77).

Comment: One commenter stated that the sample size for SCIP for large hospitals will be onerous for these facilities. The commenter requested that the sample size be calculated using the entire organization's activity rather than each specialty. Under this approach, hospitals could decide on an individual basis if they want to drill down for more information.

Response: Specialty-specific sample sizes are required to provide more precise measures by specialty. Much of the existing research about antibiotic administration is specialty-specific, and the exclusion criteria and process measure rates differ by specialty. The increased sample size is necessary to incorporate these specialty-specific differences into hospital-level estimates of antibiotic administration.

The SCIP sample is designed to provide precise hospital level measures for all SCIP measures, including the SCIP Infection 1 and 3 measures included in this rule. CMS believes that the SCIP specialty-specific sample is designed to produce precise measures for the entire SCIP expanded measure set.

Comment: One commenter agreed with the inclusion of the SIP measures. This commenter believed that there was not sufficient information provided by the two measures alone. The commenter urged CMS to include SIP–2 in the measures.

Response: We agree with the commenter. CMS will evaluate how we can include SIP 2 (SCIP 2), appropriate selection of prophylactic antibiotics, in the future.

Comment: One commenter recommended that CMS review the way some of the indicators are measured. Two commenters recommended that quality measures should conform to clinically appropriate care established by peer-reviewed literature or professional consensus. One commenter suggested that there needs to be a more scientific method when setting up indicators.

Response: We believe that the quality measures in this rule and on Hospital Compare have a strong evidence base and represent technical guidelines from relevant stakeholder societies such as the American College of Cardiology and the American Heart Association. They are maintained by CMS working with the JCAHO through ongoing assessments of changes in the clinical literature, evaluation of trends in performance, and review by technical experts. In addition, all measures currently being reported, as well as those that we are adopting in this rule, have been endorsed by the NQF, a national consensus body whose mission is to identify a common set of standardized evidence-based measures for quality reporting. Detailed specifications for each of the measures, including information concerning the underlying literature and clinical evidence that led to their endorsement and adoption, are included in the *Specifications Manual for National Hospital Quality Measures*, at *www.qualitynet.org*.

Comment: Two commenters stated that financial incentives must allow sufficient flexibility to meet the unique needs of individual patients, and not encourage hospitals to avoid the most difficult cases.

Response: As noted in our response to the previous commenter, we have adopted evidence-based quality measures which have been endorsed by the NQF. There is no question that any payment system potentially contains incentives for unintended consequences that may be counter to the intent of those who design the system. We share the commenters' concern regarding this issue and will consider it as we monitor the impact of hospitals reporting data to receive the full market basket update under section 5001(a) of Pub. L. 109–171, and as we develop our plan for implementing a value-based purchasing, under section 5001(b) of Pub. L. 109–171.

Comment: Eight commenters stated payment for 2007 will be reduced by 2.0 percentage points for performance indicators that have a track record of poor reliability, such as the working diagnosis of pneumonia. The commenters noted that some hospitals resort to answering working diagnosis for pneumonia as a "yes" for all pneumonia charts regardless of actual documentation, since the penalty is disproportionately more severe if the no answer is found to be incorrect. The commenters noted that a couple of mismatches on the "no" response to working diagnosis can drive the hospitals to the brink of losing 2.0 percentage points of their annual payment update.

Response: The working diagnosis element is only one of over 15 elements in a single episode of care that is used to calculate the pneumonia measures. Many of the hospitals that failed quarterly validation due to submitting inaccurate pneumonia elements did not submit additional elements used in the calculation of pneumonia measures and validation score. All hospitals are able to submit all elements potentially used to calculate validation scores, and we encourage hospitals to submit all of these elements to improve their likelihood to pass quarterly validation.

Comment: Two commenters recommended that for future measure development, CMS select measures only from those used by the HQA for public reporting.

Response: CMS strongly values its participation in the HQA, which was established as a public-private collaboration to promote voluntary hospital public reporting on quality of care. Led by representatives of the hospital industry, with membership that includes consumer groups, unions, purchasers, providers, health plans and government, accrediting and standard-setting organizations, the HQA has been instrumental in helping to identify and find common ground among the diverse interests of these stakeholders. Congress recognized the HQA's role when it included the "starter set" of 10 measures, first identified by the HQA for reporting on Hospital Compare, in the Pub. L. 108–173 RHQDAPU program provisions (section 501(b)). As we now implement section 5001(a) of Pub. L. 109–171 and expand the measure set for FY 2007 and beyond, we are asking hospitals to report on the 21 HQA-approved measures. In addition, HQA has strongly supported the development and use of the HCAHPS tool for assessment of patient experience with care. We expect to continue to work closely with the HQA in our future efforts, as well.

In addition, we expect to add HCAHPS® measures to the RHQDAPU program's reporting set as soon as feasible. The HCAHPS® survey is designed to make "apples to apples" comparisons of patients" perspectives on hospital care including communications with doctors, communications with nurses, responsiveness of hospital staff, cleanliness and quietness of the hospital, pain control, communication about medicines, and discharge information.

Comment: One commenter requested a clear definition for antibiotic administration time. In the commenter's opinion, the current standard requiring that no longer than one-hour pass between the administration of the antibiotic and the making of a surgical

incision does not have adequate clinical support.

Response: The performance measures that we have adopted for the RHQDAPU program, including the timing of prophylactic antibiotic administration prior to surgery, are evidence-based, consensus-derived measures. The measurement specifications each of these measures includes the supporting evidence basis for the measure, and can be found in the *Specifications Manual for National Hospital Quality Measures, at www.qualitynet.org.* In addition, as part of our routine maintenance review of the measures, we monitor any changes in the medical literature that would require modification of the measures.

Comment: One commenter suggested "retiring" the oxygenation assessment measure. New section 1886(b)(3)(B)(viii)(VI) of the Act specifies that CMS has the ability to replace measures "where all hospitals are effectively in compliance." The commenter noted that the average performance on this measure is 99 percent and that retiring this measure would be a signal to hospitals that CMS is willing to reduce the burden of data collection as the set evolves.

Response: The commenter's points are well taken. The oxygenation measure was previously endorsed by the NQF. The NQF has recently initiated a "maintenance" review of all of its previously-endorsed pulmonary care measures, including the oxygenation measure, under which process these measures will be reevaluated by panels of experts and health care stakeholders (including CMS) to determine their continuing technical merit. CMS will defer its decision on the oxygenation measure until after this group has completed its deliberations.

Comment: Several commenters stated that the measures recommended by the Leapfrog Group (computerized provider order entry, intensive care intensivists, and evidence-based hospital referrals) and included in the 2005 IOM report do not meet the quality measure standards necessary for inclusion in CMS' national quality measurement initiatives. In addition, commenters noted that rural hospitals have not previously been asked to comply with these measures. These commenters believe that it would be unwise for CMS to adopt these measures. Another commenter wrote in support of the use of such structural measures. This commenter noted, however, that in terms of burden on hospitals, such programs span multiple years, must be approved on an annual basis, and require board approval. They also require significant financial resources, human resources, and time to develop and implement. The commenter stated that requiring such programs, which present a challenge to either fund or risk reduction in payment, would not appear to be reasonable. For example, the commenter stated that the phased-approach implementation of computerized provider order entry for prescriptions (CPOE) for its facility is projected to be completed by 2009 with an estimated cost of up to $2 million.

Response: We thank the commenters for their input. For FY 2007, we are not proposing that hospitals submit data on the three structural measures recommended by the three Leapfrog Group and included in the 2005 IOM report. However, as we continue to expand the set of measures on which hospitals report, we will consider whether to include these measures, as well as other structural measures and will bear the commenters' observations in mind.

Comment: Several commenters agreed that measures selected should be those that are endorsed by NQF and aligned with JCAHO's reporting requirements. The commenters also proposed that methods for maintaining measures be developed and implemented. Since medical knowledge continues to evolve, the science behind clinical practice guidelines must be monitored for changing evidence that previously accepted clinical practices no longer define the best care. Without this important step, measures cannot continue to evaluate best quality of care delivered to patients. The commenters proposed that CMS create a plan, including method and frequency for monitoring new evidence that impacts established measures, in addition to monitoring for adjustments needed to improve their implementation.

Response: We agree with the commenters. CMS continuously monitors new evidence and works with panels of experts, as well as with the relevant specialty societies and other groups that develop practice guidelines, to assure that the measures are up to date, and to verify that measures reflect best clinical practice. In addition, we work with JCAHO experts to assure that the detailed specifications and instructions for collection of data used to calculate the rates reflects the most up to date information about medications, coding, and other issues.

Comment: A commenter suggested that as new measures are added and mandated for public reporting, payment should not be based on simply the indicator percentage, but should also include the percentage change of improvement or the quarters of sustained improvement. The commenter stated that data collected based on such process improvement would be test data until the processes being measured were stable. Just as indicators are tested and validated, process improvement provides data that is test data. Transparency of data reporting connected to payment needs to allow a test period for data to not "count" toward payment.

Response: The commenter has made several important suggestions that are relevant to our ongoing deliberations about measures for both reporting quality data and for value-based payment systems (discussed more fully in section IV.B. of this preamble). In proposing that CMS consider measures that highlight improvement over time, rather than just performance during a single time period, the commenter has offered an important suggestion that addresses our goal of identifying a set of measures that will support sustained quality improvement. We also raised this issue in the 2007 IPPS proposed rule in our discussion of value-based purchasing (71 FR 24098). As we consider further expansion of the measure set, we will consider this suggestion, as well as the commenter's suggestion that hospitals be given the opportunity to "test" the reporting of new measures before they are included in any payment incentive arrangement.

Comment: Three commenters strongly urged CMS to adopt measures identified in the 2005 IOM report as well as consider and adopt as many additional NQF-endorsed measures as can be feasibly collected, for example:

Outcomes

- 30-day heart failure mortality
- 30-day heart attack mortality
- Failure to rescue

Complications

- Urinary catheter-associated infection rate
- Central line-associated blood stream infection rate
- Ventilator associated pneumonia rate

Clinical

- Surgery patients with recommended venous thromboembolism prophylaxis ordered
- Surgery patients who received appropriate venous thromboembolism prophylaxis within 24 hours prior to surgery to 24 hours after surgery

Response: We appreciate the specific recommendations of the commenters and will consider them as we look to expand the set of measures.

Comment: One commenter recommended that CMS continue to work to ensure the accuracy of the information posted on the Hospital Compare Web site. The methodology adopted should be fully transparent to all stakeholders to clearly assess hospital-level reliability. The commenter recommended that we also engage representatives from the research, provider, and consumer communities to obtain input on the different potential methodologies and their impact on data validity, accuracy, and completeness.

Response: We agree with the commenter. The integrity of the information posted on the Web site depends on the accuracy of the underlying data. In the 2007 IPPS proposed rule, we solicited input on proposed revisions to our methodology, and CMS remains open to advice and suggestions concerning how to continue to improve its processes to assess and assure hospital-level reliability.

Comment: Two commenters urged CMS to include outcome measures based on the best available science and consensus, rather than permanently focus on the process measures that it has adopted. Ultimately, consumers want to see the results of hospital practices, that is, whether the processes measured actually yield higher quality care as indicated by results, such as better mortality rates and fewer infections.

Response: We appreciate the specific recommendations of the commenter and will consider them as we look to further expand the set of measures. We are particularly interested in considering measures that have been endorsed by consensus building entities such as the NQF that take into account the issues of validity, reliability, impact and feasibility of the measures and involve a wide array of stakeholders. We also anticipate issuing a rulemaking in the near future that would propose to adopt a number of outcome measures, which may include 30-day post-admission mortality rates for patients with acute myocardial infarction and heart failure

Comment: Two commenters requested that, as we consider new measures, we involve all stakeholders in the process.

Response: CMS agrees with the commenter that stakeholder input is an essential part of the measure selection process. CMS receives input from stakeholders through multiple vehicles such as the NQF, the HQA and the notice and comment rulemaking process. CMS remains committed to the goal of including stakeholders in the process.

Comment: One commenter suggested that because CMS makes its hospital quality data public, the data should be risk adjusted, and technical standards should be applied to the data to assure fair treatment of hospitals.

Response: The set of measures currently reported on Hospital Compare are process measures for which no risk adjustment is needed, since they are constructed to reflect the proportion of cases in which a patient received the care that is appropriate for his or her clinical needs. The measures are constructed to exclude cases for which an intervention would not be appropriate. We expect that, as we consider whether to expand the set of measures to include outcome measures, we will need to address concerns about risk-adjustment and patient-mix.

Comment: Two commenters suggested that CMS develop measures that examine quality and costs of care within and across settings over time. A commenter also recommended allowing variation in the implementation of new measures due to variability across the country.

Response: We appreciate the recommendations of the commenters. As we work to expand the set of measures that hospitals report under the RHQDAPU program, we will consider such issues as how to assess care coordination both within and across hospitals and health care providers, as well as how to account for expected and unexpected variations in performance across providers.

Comment: One commenter expressed concern about the negative effects of requiring hospitals to report measures when it is actually the physician who orders the care. This particularly happens in the case of small rural hospitals. This commenter indicated that the hospital should not be responsible for physician mistakes.

Response: Hospitals cannot abrogate their responsibility for the care that is practiced at their own facilities. Given that virtually all significant treatment decisions are initiated with a physician's order, this argument would absolve hospitals of virtually all responsibility for quality and safety.

Comment: One commenter recommended addressing the alignment of physician and hospital indicators. If alignment is not possible, the commenter recommended that we have physician-driven indicators that apply to physicians only.

Response: CMS is working collectively with the hospital and physician communities to improve the overall quality of health care for Americans. As part of this effort, CMS to use a common focus on quality by clinicians and providers to achieve improvement in the quality of healthcare. One example of this is the Surgical Care Improvement Project (SCIP). The use of metrics that focus on surgical quality from both the physician and provider perspective offer the best opportunity to improve the surgical quality of care. In addition, CMS launched a Physician Voluntary Reporting Program (PVRP) that incorporated indicators that will align physician interests with hospitals. More information on PVRP can be found at *www.cms.hhs.gov/pvrp.*

d. HCAHPS® Survey

As recommended in the IOM report, we will be implementing the HCAHPS® survey in October 2006 as a part of the HQA. HCAHPS® is designed to make "apples to apples" comparisons of patients" perspectives on hospital care including communications with doctors, communications with nurses, responsiveness of hospital staff, cleanliness and quietness of the hospital, pain control, communication about medicines, and discharge information. More information on this survey can be found on our Web site: *www.cms.hhs.gov/HospitalQualityInits/downloads/HospitalHCAHPSFactSheet200512.pdf.* We intend to report the first three quarters of these survey data in late 2007 on the Web site: *www.hospitalcompare.hhs.gov.* HCAHPS® was endorsed by the NQF in May 2005. However, we did not propose to include HCAHPS® as a part of the revised FY 2007 "Reporting Hospital Quality Data for Annual Payment Update Notice of Participation" form.

We believe that the procedures and expanded measure set that we proposed to adopt in the FY 2007 IPPS proposed rule meets the requirement of section 1886(b)(3)(B)(viii)(IV) of the Act that, "for payments beginning with fiscal year 2007, in expanding the number of measures, under subclause (III), the Secretary shall begin to adopt" the 2005 IOM report's set of baseline measures. Section 1886(b)(3)(B)(viii)(III) of the Act states that we must expand, for FY 2007 and each subsequent fiscal year, the set of measures that the Secretary determines to be "appropriate" for the measurement of the quality of care furnished by hospitals in inpatient settings beyond the original quality measures that applied in FY 2005 and FY 2006.

We believe that the statute gives the Secretary the discretion to choose what "begin to adopt" should involve in FY 2007 and the number of additional

measures, if any that would be "appropriate" during this time. In proposing our revised procedures, designing the methods that hospitals will use to report during FY 2007, establishing a set of expanded measures based on the 2005 IOM report, and revising RHQDAPU program materials, we believe that we have met the statutory requirements. We will continue to explore the feasibility of adopting additional measures for purposes of the FY 2008 update, including the HCAHPS® survey described in the IOM report and other measures that reflect consensus among affected parties, as required by new sections 1886(b)(3)(B)(viii)(III) through (V) of the Act.

Comment: One commenter expressed support for the HCAHPS® initiative, but requested that CMS make the survey available in languages other than English and Spanish. The commenter noted that in areas with diverse patient populations such as New York City, hospitals will not be able to conduct the survey adequately in only two languages.

Response: The HCAHPS® survey is currently available only in English and Spanish. We intend to solicit comments from participating hospitals and survey vendors regarding additional languages for HCAHPS®. This information can be submitted to our HCAHPS mailbox, *CMSHOSPITALCAHPS@cms.hhs.gov*. Based on the information we receive, we will establish priorities for HCAHPS® translation into additional languages.

Comment: One commenter recommended that we offer hospitals sufficient time to incorporate the HCAHPS® measures into their care protocols. The commenter suggested that we establish an implementation schedule that provides for sufficient time for hospitals to become familiar with data submission, and instructions explaining how to use the tool for feedback. The commenter noted that such an approach would allow for development of more accurate data.

Response: We agree that hospitals and survey vendors must become familiar with the HCAHPS® instrument, data collection, and data submission procedures prior to participation in the national implementation of the survey. To this end, CMS offered free training to hospitals and survey vendors in February and April of this year. Additionally, to gain experience in all aspects of the survey, hospitals that will participate in the national implementation of HCAHPS® in October 2006 were required to take part in a "dry run" of the survey in April, May, or June of this year. Data submitted to CMS from this dry run will not be publicly reported. CMS is planning to offer additional training and dry run opportunities for hospitals that will join the HCAHPS® initiative after October 2006.

Comment: One commenter recommended that the following question be added to the HCAHPS® patient survey proposed for October 2006, "Did you get an infection while you were in the hospital or after any surgery or other procedure?" The commenter stated that most patients would know about the existence of an infection, and this would be a more precise way to identify significant problems than more general and subjective HCAHPS® questions, such as questions that address the "cleanliness and quietness of the hospital."

Response: We appreciate this suggestion, but at this time we are not planning to add new items to the current version of the HCAHPS® survey (which can be found on *www.hcahpsonline.org*)) based on our evaluation of the survey and on comments we received on the survey in response to multiple **Federal Register** notices that we published (for example, 68 FR 5889, 68 FR 38346, 68 FR 68087, and 70 FR 67476). However, we will keep this suggestion in mind for future versions of the survey.

Comment: Two commenters stated that for FY 2008, CMS needs to more than merely explore the feasibility of adopting additional measures for FY 2008 update. There should be a substantial expansion of measures for hospitals to obtain the FY 2008 annual update. The commenters agreed with the Consumer-Purchaser Disclosure Project recommendations that CMS adopt the additional measures identified in the 2005 IOM report (HCAHPS® and three structural measures), as well as consider and adopt a number of other NQF-endorsed measures.

Response: We note that in addition to the expanded measure set that we are adopting in this rule, we will begin national implementation of the HCAHPS® survey in October 2006. We also anticipate further expanding the measure set for FY 2008 and will consider adopting other NQF-endorsed measures at that time.

Comment: A commenter suggested that CMS identify and develop, in collaboration with the long-term care hospital (LTCH) industry, appropriate quality measurement indicators and begin collecting and public reporting results across providers.

Response: At this time, we are not working on developing measures for the long term care hospital setting. However we will consider, in the future, the commenter's suggestions regarding the collection of quality measures from long term care hospitals. HCAHPS® has been developed for use by short-term, acute-care hospitals, which encompasses all hospitals that are eligible to submit clinical measures for public reporting. At this time, other types of hospitals, including LTCHs, are not eligible to participate in HCAHPS®. CMS will, in the future, consider whether and how an HCAHPS® survey could be re-designed for appropriate use by other types of hospitals, including LTCHs.

Comment: Several commenters stated that there is no "no-cost" alternative to using a vendor to participate in HCAHPS®, unlike the situation of the collection of clinical chart abstraction data. They noted that this presented a significant burden to hospitals that will have no alternative to using commercial vendors to satisfy a Federal mandate. In addition, the commenters stated that a substantial number of hospitals do not currently conduct a patient experience survey and that the Federal government has committed only to providing the interface to upload data to QualityNet Exchange. Some commenters suggested that it would be helpful if we provided clear and concise guidance on HCAHPS® sampling.

Response: From the inception of the survey, CMS has been attentive to the costs to hospitals that participate in HCAHPS®. HCAHPS® has been designed to allow a hospital to either conduct the survey on its own, or to conduct the survey through the use of a survey vendor. A hospital that elects to self-administer HCAHPS® must meet a series of minimum survey requirements related to prior survey experience, capacity to conduct HCAHPS®, and its ability to satisfy quality control procedures. In addition, HCAHPS® was designed to be compatible with a range of popular survey practices. It is made available in four modes of administration (mail, telephone, mail with telephone follow-up, or active IVR), and can be implemented as a stand-alone survey, or integrated within an ongoing patient survey. Because of the nature of the HCAHPS®, the tool developed for HCAHPS® is different from the CART tool. However, CMS has designed an HCAHPS® on-line tool that allows hospitals that self-administer the survey to enter and upload the survey data into the QualityNet Exchange data base. There is no charge for use of the HCAHPS® on-line tool.

Further, in February and April 2006 CMS offered free training on participation in the HCAHPS® survey.

Among its topics, this training included detailed instruction on sampling. Additional iterations of this training program are currently being planned. CMS also provides readily available guidance on sampling and other HCAHPS® issues through its *HCAHPSonline.org* help desk. In addition, QualityNet Exchange maintains a help desk that provides assistance on matters related to submission to the HCAHPS® data warehouse. All of these services are available free of charge.

An independent study of the benefits and costs of HCAHPS® estimated that the average cost of HCAHPS® collected as a separate survey to be between $3,300 and $4,575 per hospital. The cost of combining HCAHPS® with an existing hospital survey would be about $978 per hospital (Abt Associates Inc.: *Costs and Benefits of HCAHPS,* October 5, 2005). Additionally, hospitals have the option to use a survey vendor or conduct HCAHPS® on their own if they have prior survey experience.

e. Data Submission

For the FY 2007 update, we specify that hospitals must submit complete data regarding the quality measures in accordance with the joint CMS/JCAHO sampling requirements located on the QualityNet Exchange Web site. These requirements specify that hospitals must submit a random sample or complete population of cases for each of three topics (acute myocardial infarction, heart failure, and pneumonia) covered by the starter set of 10 quality measures. Hospitals are expected to continuously meet these sampling requirements for the starter set of 10 quality measures for discharges in each quarter.

We do not anticipate significant additional burden on hospitals regarding the starter set of 10 quality measures or the anticipated 21 clinical quality measures because all JCAHO-accredited hospitals are currently required to adhere to these sampling requirements in acute myocardial infarction, heart failure, pneumonia, and surgical infection prevention for accreditation and core measure reporting purposes.

Comment: One commenter suggested that CMS consider a methodology that would allow resubmission of data in cases where incorrect data has been identified by the submitting provider, while still maintaining the integrity of the data validation process for payment purposes. The commenter suggested that this could be accomplished through the use of two databases. One database would be frozen once the final submission deadline for a quarter has passed to be used for Clinical Data Abstraction Center (CDAC) validation. However, if the providers discovered errors in its data submission after the quarterly deadline, it would be able to use a second database to submit updated data. The commenter believed that this would improve the data available on Hospital Compare.

Response: We believe that the commenter's suggestion that we create two separate databases has the potential to maintain the integrity of the validation process as well as to improve the quality of the publicly reported data. We will review the methodology and take this suggestion into consideration.

Comment: One commenter requested that CMS create meaningful and useful reports that would be available to vendors after data submission is complete each quarter. The reports should identify actionable steps that hospitals are required to take to make sure they successfully submit data for the RHQDAPU program. CMS should also modify the current Failure and Success Reports so that any data elements needed to populate or calculate measures reported for the annual payment update can be identified as a critical error and result in the rejection of the record. The hospital should be able to download the entire report, without having to download it into several reports.

Response: CMS thanks the commenter for the suggestions on how to improve the reports. The following reports are currently available to hospitals and vendors:

Title of report	Vendor access	Provider access
QIO Clinical Warehouse Import Detail by Provider—Provides case import status into warehouse; options for queries include topic, upload status, discharge dates, types of messages (critical, informational and measures) and various sort options.	X	X
QIO Clinical Warehouse Import Detail by Error Code—Provides case import status into warehouse; options for queries include topic, upload status, discharge dates and various sort options.	X	X
QIO Clinical Warehouse Submission Summary—Case submission summary	X	X
Case Status Summary Report—Includes measure inclusion status and reason for exclusion	Based on hospital authorization	X
Measure Status Summary Report—Summary of number of cases indicated per quality measure for cases accepted into the QIO Clinical Warehouse.	Based on hospital authorization	X

CMS is currently reviewing the data submission reports and considering modifications to improve and enhance the existing feedback reports. In the interim, we released two additional reports in June 2006 to provide more detailed information to hospitals.

- QIO Clinical Warehouse Measure Status by Category: this report will provide information by measure to include total cases as well as the number of cases by measure category (A–E).
- QIO Clinical Warehouse Measure Status by Case; this report will provide by measure for each case whether the case was eligible for the denominator, passed the measure (numerator), was excluded from measure calculation and the reason for exclusion.

CMS and its contractors routinely conduct training to provide additional assistance concerning how to access and utilize QualityNet Exchange Reports. Information on these trainings can be found on QualityNet Exchange Web site.

Comment: Two commenters requested that corporate owners and vendors have access to QualityNet reports about their specific hospitals, and believe that these reports should not be provided only to hospitals. The commenters stated that having access to these reports will allow hospitals to discern whether errors in data transmission have occurred and whether data should be resubmitted before the deadline.

Response: Hospitals have had the ability to grant third parties such as health care systems and vendors permission to access select QualityNet Exchange Reports since December 2004 through QualityNet Exchange Self-Serve. Health care system users and vendors obtain permission to access hospital reports by completing a QualityNet registration form and submitting the form to the QualityNet help desk. The QualityNet help desk will process the registration form. When

a QualityNet user account is assigned, the health care system or vendor user can then request access to reports through the QualityNet Self Serve. The healthcare system's or vendor's report request is then sent to the hospital for report access approval. Detailed instructions for using QualityNet Exchange Self-Serve are available in Chapter 2, Section 2 of the User Guide located on *www.QualityNet.org.*

Comment: One commenter opposed CMS' intent to develop measures specifications and a system or mechanism to accept data without converting it into XML.

Response: CMS does not intend to develop measures specifications and a system or mechanism to accept data without converting it into XML. Our intent is to continue to utilize the XML format for file submissions.

Comment: Four commenters disagreed with CMS' opinion that no additional burden would be placed on hospitals. The commenters noted that JCAHO participating hospitals are not required to submit the data regarding all 21 measures found in the proposed rule. Therefore, it would be an additional burden on the hospitals to have to submit more measures than are required by the current JCAHO requirements.

Response: We acknowledge this concern, but we are required by new section 1886(b)(3)(B)(viii)(IV) of the Act to begin to adopt the measures as specified in the 2005 IOM report. We believe that the measures we have selected are appropriate because we believe these quality measures will: (1) Provide useful and valid information about hospital quality to the public; (2) provide hospitals with a sense of predictability about public reporting expectations; (3) begin to standardize data and data collection mechanisms; and (4) foster hospital quality improvement.

We have also taken steps to ensure that the burden on hospitals is as minimal as possible. First, while some hospitals report through JCAHO vendors, we make available the CART tool for reporting on all of the measures in the expanded measures set, at no additional cost to the hospital. Second, our data analysis indicates that although hospitals are not currently required to submit data regarding the 21 measures identified in the proposed rule, many of them are already submitting these data as part of our HQA voluntary reporting initiative. Many hospitals have participated in the HQA, and are continuing to submit data to the QIO Clinical Warehouse. Many HQA-participating hospitals have been voluntarily reporting on the additional quality measures

Comment: One commenter stated that the additional requirements for reporting are too burdensome for rural hospitals. The commenter noted that additional resources required for this work takes away from time the staff can provide for actual care and that the costs associated with submitting the additional measures are too prohibitive for rural hospitals.

Response: Although we acknowledge that the additional reporting requirements will potentially require hospitals to begin collecting data that they have not, to date, been collecting, this potential burden must be weighed against the goals of improving quality of care and meeting the needs of patients. As we stated in response to a previous comment above, we have taken a series of steps to minimize the burden for all hospitals.

Comment: One commenter stated that the QUEST system does not provide consistent answers to questions about abstraction. This commenter stated that there are flaws in the current system. Therefore, the commenter stated that payment should not be based on this system.

Response: The QUEST system is the question and answer system that is available on the internet at QualityNet.org. Questions can be submitted by anyone and they are answered by CMS or its contractors. CMS is working to improve the QUEST system. New processes have been implemented in order to avoid inconsistent answers to questions about abstraction. However, payment is not based on the QUEST system, but is based on compliance with the full set of RHAQDAPU requirements. The primary source for abstraction clarification is the Specifications Manual for National Hospital Quality Measures, available on the QualityNet Exchange Web site.

f. RHQDAPU Program Withdrawal and Chart Validation Requirements

For the FY 2007 update, hospitals may withdraw from the revised RHQDAPU program at any time up to August 1, 2006. If a hospital withdraws from the program, it will receive a 2.0 percentage point reduction in its payment update.

For the FY 2007 update, and until further notice, we will continue to require that hospitals meet the chart validation requirements that we implemented in the FY 2006 IPPS final rule. There were no chart-audit validation criteria in place for FY 2005. Based upon our experience with the FY 2005 submissions and our requirement for reliable and validated data, in the FY 2006 IPPS final rule, we discussed additional requirements that we had established for the data that hospitals were required to submit in order to receive the full FY 2006 payment update (70 FR 47421 and 47422). These requirements, as well as additional information on validation requirements, will continue and are being placed on the QualityNet Exchange Web site.

For the FY 2007 payment update, and until further notice, hospitals must pass our validation requirement of a minimum of 80 percent reliability, based upon our chart-audit validation process, for the first three quarters of data from CY 2005. These data were due to the QIO Clinical Warehouse by July 15, 2005 (first quarter CY 2005 discharges), November 15, 2005 (second quarter CY 2005 discharges), and February 15, 2006 (third quarter CY 2005 discharges).

We use confidence intervals to determine if a hospital has achieved an 80-percent reliability aggregated over the three quarters. The use of confidence intervals allows us to establish an appropriate range below the 80-percent reliability threshold that demonstrates a sufficient level of reliability to allow the data to still be considered validated. We estimate the percent reliability based upon a review of five charts, and then calculate the upper 95-percent confidence limit for that estimate. If this upper limit is above the required 80-percent reliability, the hospital data are considered validated.

We are using the design-specific estimate of the variance for the confidence interval calculation, which, in this case, is a stratified single stage cluster sample, with unequal cluster sizes. (For reference, see Cochran, William G.: Sampling Techniques, John Wiley & Sons, New York, chapter 3, section 3.12 (1977); and Kish, Leslie.: Survey Sampling, John Wiley & Sons, New York, chapter 3, section 3.3 (1964).) Each quarter is treated as a stratum for variance estimation purposes.

We use a two-step process to determine if a hospital is submitting valid data. In the first step, we calculate the percent agreement for all of the variables submitted in all of the charts. If a hospital falls below the 80-percent cutoff, we restrict the comparison to those variables associated with the starter set of 10 quality measures. We recalculate the percent agreement and the estimated 95-percent confidence interval and again compare to the 80-percent cutoff point. If a hospital passes under this restricted set of variables, the hospital is considered to be submitting

valid data for purposes of the RHQDAPU program.

Comment: Four commenters recommended that CMS consider a validation process that would focus more resources on those hospitals that are having difficulty in passing the validation thresholds on a consistent basis.

Response: QIOs, on behalf of CMS, work to assist hospitals with all aspects of hospital reporting activity. QIOs are available to provide training and assistance to those hospitals experiencing difficulty passing the validation thresholds. This training and assistance is designed to improve the validation scores of hospitals with failing validation scores through better performance measurement techniques and medical record documentation.

Comment: One commenter recommended using an alternative method of data validation and suggested that we use the monthly data points of each clinical measure instead of relying on chart abstraction. Under this methodology, a monthly data point that exceeds three (3) standard deviations would be considered an outlier.

Response: The current validation methodology measures abstraction accuracy of hospital submitted data elements, and thereby measures the accuracy of reported data. The suggested alternative methodology is designed to identify outlier measures at the aggregate hospital level, and does not identify the specific source of errors. CMS believes that its current validation methodology more accurately measures abstraction accuracy at the element level for the RHQDAPU program.

Comment: One commenter stated that it is incongruent to require results from the first three quarters of 2005 for validation with an effective date of the final rule that is after the data submissions.

Response: Section 1886(b)(3)(B)(viii)(I) of the Act requires an annual determination of payment eligibility, and we believe that we can make accurate payment determinations based on three quarters of validated data. In order to make timely payments to hospitals under the IPPS during FY 2007, we need to complete our payment determinations prior to the start of FY 2007 that is, prior to October 1, 2006. Data submitted in connection with discharges that occurred during the first three quarters of 2005 constitute the most current data that we can use to make our payment determination for FY 2007.

Comment: Two commenters suggested that if we are going to increase the penalties for failure, there needs to be more timely feedback allowing organizations to correct their submission errors. These commenters recommended that the validation process take into account at least 6 quarters of data to allow for learning and to accommodate the constant changes in the specifications.

Response: We use quarterly validation results in order to make a single annual determination. The first three quarters of 2005 constitute the complete set of most currently available data to determine FY 2007 payment eligibility by September 1, 2006. We believe that using three quarters of data is sufficient to allow us to make accurate payment assessments. We will continue to review whether using additional quarters of data can improve the reliability of hospital results under the RHQDAPU program. In addition, as we noted in response to an earlier comment, hospitals and their vendors can use test transmissions in order to identify problems before the submission deadlines. Also, in an effort to reduce hospital burdens, CMS and JCAHO have agreed to release aligned measure changes 120-days prior to their implementation. This allows both hospitals and vendors adequate time to prepare for those changes prior to implementation. However, hospitals are responsible for ensuring that their vendors submit accurate and timely data. It is the responsibility of each vendor, and ultimately of the hospital, to adhere to the requirements listed in the specifications manual for the set discharge time period.

Comment: One commenter recommended a provision to allow CMS and the hospital to have the flexibility to meet 2 of 3, or 3 of 4 quarters. This would provide some assurance that if and when the processes break down, hospitals are not unilaterally punished while providing quality care.

Response: The 3 quarter validation determination is designed to provide a single overall estimate of hospital abstraction accuracy over the entire period. This single overall estimate pools the quarterly samples to increase the overall reliability of the abstraction accuracy estimate for that period. The expectation is that hospitals will abstract and submit cases every quarter with consistency. The entire period would not be reflected if hospitals are allowed the flexibility to meet 2 of 3, or 3 of 4 quarters. To utilize fewer quarters decreases the overall reliability of the abstraction accuracy estimate.

Comment: One commenter suggested that the annual payment update not be tied to validation until the JCAHO and CMS have aligned the measures, resulting in making the guidelines clear and consistent.

Response: As of July 1, 2004 discharges, all data elements within the 10-starter set were CMS and JCAHO aligned. As of January 1, 2005 discharges, all data elements for the expanded 21 measure set were aligned. The changes are designed to keep the measures current with the accepted evidence base of medical research, and to improve the clarity and reliability of the abstraction instructions. CMS and its contractors have and will continue to work diligently to ensure that alignment issues do not affect a hospital's eligibility for receiving the full annual payment update.

Comment: One commenter requested that hospitals not be held responsible when data processing and communication errors, under the control of CMS or that occur as a result of actions of its contractors, cause a failure in validation.

Response: When a hospital reports data processing and communication errors, the errors are thoroughly researched. CMS has not held a hospital responsible for data processing and communication errors that were clearly under the control of CMS or its contractors. However, CMS does hold the hospital responsible for its own errors in data processing and communication. If the error is by the hospital's contracted vendor, the hospital is held responsible.

Under the standard appeal process, all hospitals are given the detailed results of CDAC reabstraction along with their estimated percent reliability and the upper bound of the 95-percent confidence interval. If a hospital does not meet the required 80-percent threshold, the hospital has 10 working days to appeal these results to its QIO. The QIO will review the appeal with the hospital and make a final determination on the appeal. The QIO receives from the hospital the element or elements that are to be evaluated during the appeal process, along with the hospital's rationale for the difference between the hospital's abstraction and the CDAC reabstraction. In this validation appeal process, the QIO reviews the appeal using the medical record to evaluate the data elements that are being appealed. This process allows for an independent review and is designed to find coding errors on the part of abstractors. QIO appeal decisions are based on the data that the hospital submitted to the QIO Clinical Warehouse. The QIO has 20 calendar days to make a final decision. The QIO can either uphold or reverse the CDAC validation decision. If the QIO does not agree with the hospital's

appeal, the original results stand. However, if the QIO agrees with the hospital, new validation results are calculated and provided to the hospital through the usual processes. This validation appeal process is described in detail at the QualityNet Exchange Web site.

Comment: Twelve commenters recommended expanding the appeal process to include any indicator, regardless of whether the overall validation score for the hospitals is at or above 80 percent. The commenters believed that this would allow hospitals the opportunity for improvement. The commenters also felt that this was significant due to the aggregations of validation results for multiple quarters, and for the resolution of discrepancies between the hospital and the CDAC.

Response: Currently the appeals process is only available to those hospitals that had an overall reliability rate of less than 80 percent for the quarter. However, CMS encourages all hospitals to use their validation results as a tool for improving abstraction accuracy.

Comment: Seventeen commenters urged CMS to review, on a case-by-case basis, any instance in which a hospital's payment would be put in jeopardy as a result of the validation process. These commenters did not feel that the validation process is reliable enough to warrant a hospital losing its update due to faulty validation. If a hospital has made a good faith effort to submit valid data, one commenter felt that the hospital should receive its update regardless of whether the data are deemed accurate enough for display.

Response: CMS believes that the current validation process provides a reliable estimate of abstraction accuracy on an annual basis. CMS and its contractors work closely with the CDAC regarding issues that are raised by hospitals about the validation processes. If a hospital identifies an issue where it believes that its validation score is incorrect, CMS conducts a comprehensive review. We work diligently to ensure that validation issues do not impact eligibility for receiving the full market basket update.

Comment: Two commenters requested that hospitals receive more time to file validation appeals. One commenter suggested increasing the time for filing validation appeals from 10 days to 30 days.

Response: The current time frame for a hospital to file an appeal is 10 business days after the results are posted to QualityNet Exchange. The hospital is notified by electronic mail when its validation results are posted so it receives the information quickly, and it has the full 10 business days to review and appeal the results. The QIO then has an additional 20 calendar days to review and respond to this appeal by forwarding the information to the CDAC or upholding the CDAC decision while providing education to the hospital. CMS believes this is adequate time to file an appeal. The current validation and appeal process can extend as much as 6–9 months beyond the last day of a discharge quarter. To extend the time allowed to file appeals would further lengthen this time for hospitals to receive final results.

Comment: One commenter recommended that we use an impartial party to decide appeals. The commenter felt that the CDAC should not be responsible for both the abstraction as well as reabstraction if there is an appeal.

Response: All data successfully submitted into the QIO Clinical Data Warehouse are subject to the hospital data validation process. The CDAC reabstraction process that occurs during the appeal is a very objective process. Both the hospitals and the CDAC abstract the records using the same guidelines, the Specifications Manual for National Hospital Quality Measures. The hospital's abstraction is compared to the CDAC's reabstraction in order to determine mismatches and the validation score. A hospital that scores at least 80 percent overall for the quarter is considered to be supplying valid data for that quarter. A hospital that scores less than 80 percent overall for the quarter has the opportunity to file an appeal with its QIO. The hospital must supply to the QIO the rationale for the appeal and the QIO will review a copy of the same record the CDAC completed during its reabstraction. The QIO will then determine the final outcome of the appeal. The QIO has the final say in appeal decisions.

Comment: One commenter expressed several concerns with the validation process.

- The method that is used to construct the numerator and denominator on the summary report is unclear.

Response: We are unsure specifically which numerator & denominator the commenter is referring to. If we interpret the comment correctly, the commenter is referring to the Submission Feedback report. The denominator in the summary report refers to the number of elements in the sampled records used to calculate the measures, and the numerator refers to the number of correctly abstracted elements in the sampled records used to calculate the measures. Two measure lists are used to determine the denominator list of elements, one list for the ten starter set measures versus the second list for the expanded measure set. We believe that the documentation regarding these reports, available on the QualtyNet.org Web site, provides clear explanation of how the numerator and denominator are determined.

- CMS does not accept documentation from hospitals after the validation results have been published.

Response: Although we do not accept documentation from hospitals after the validation results have been published, we do have several safeguards in place to prevent this from happening. The CDAC works diligently with the QIOs and CMS to ensure that the requirements for hospital reporting of quality data are efficiently and effectively being addressed. We have devoted a great deal of resources to ensuring that the CDAC process, including the receipt of documentation, is consistent, reliable and accurate. Due in part to our adherence to the fixed time schedule in the hospital data validation process, and for security purposes, the CDAC utilizes an in-house system to track and monitor the end-to-end processing of each medical record request from hospitals. The CDAC also relies on external contractors like Federal Express or the U.S. Postal Service (within HIPAA guidelines) with their tracking systems to ship and track medical records. The CDAC goes so far as to contact each provider when all requested medical records are not received.

- Hospitals have failed validation due to the CDAC not receiving all materials, although the hospital verified that all of the materials were sent in a timely manner.

Response: CMS has several safeguards in place to prevent this from happening. The CDAC works diligently with QIOs and CMS to ensure that the requirements of the QIO program are efficiently and effectively being met. We have devoted a great deal of resources to ensuring that the CDAC process is consistent, reliable and accurate. Due in part to our adherence to the fixed time schedule in the hospital data validation process, and for security purposes, the CDAC utilizes an in-house system to track and monitor the end-to-end processing of each medical record request from hospitals. The CDAC also relies on external contractors like Federal Express or the U.S. Postal Service (within HIPAA guidelines) with their tracking systems to ship and track medical records. The CDAC goes so far as to contact each provider when all

requested medical records are not received.

• There is no information to verify the reliability of abstraction.

Response: Hospitals that score below 80 percent are able to appeal abstraction results, and these results are documented. If the hospital believes that it scored below 80 percent due to an abstraction error on the part of the CDAC, there is an appropriate process by which the hospital can appeal the validation results.

• For most hospitals, the sample size is too small to determine condition-specific indicator accuracy.

Response: The validation sample is designed to provide overall quarterly feedback on abstraction accuracy and to provide an annual estimate for payment eligibility determination. However, hospitals can use several quarters' validation results to estimate condition-specific accuracy.

In reviewing the hospital data, we will combine the samples for first quarter, second quarter, and third quarter (15 cases) into a single stratified sample to determine whether the 80-percent reliability level is met. This gives us the greatest accuracy when estimating the reliability level. The confidence interval approach accounts for the variation in coding among the five charts pulled each quarter and for the entire year around the overall hospital mean score (on all individual data elements compared). The closer each case's reliability score is to the hospital mean score, the tighter the confidence interval established for that hospital. A hospital may code each chart equally inaccurately, achieve a tight confidence interval, and not pass, even though its overall score is just below the passing threshold (75 percent, for example). A hospital with more variation among charts will achieve a broader confidence interval, which may allow it to pass, even though some charts score very low and others score very high.

We believe we have adopted the most suitable statistical tests for the hospital data we are trying to validate. In the FY 2007 IPPS proposed rule, we solicited comments from hospitals on this passing threshold, the confidence interval, and the sampling approach (71 FR 24094). Based on analytical results from FY 2006, we found confidence intervals using only five charts widely varied in size. As a result of these findings, we decided to combine multiple quarters of validation samples into a single stratified sample to shrink and/or decrease the variation and produce a more reliable estimate of abstraction reliability to determine if any changes in our methodology are required. We will make any necessary revisions to the sampling methodology and the statistical approach through manual issuances and other guidance to hospitals.

Comment: Several commenters objected to our validation process. They indicated that this process places a large burden on hospitals working with vendors that require the submission of 100 percent of the hospitals' cases. Additionally, this process will not provide timely feedback, and will only add to the burden of receiving untimely feedback while attempting to continue abstraction. Two commenters expressed concern about the accuracy of the validation process due to large fluctuations in the data dictionary guidelines. One of the commenters suggested that any modifications to the technical process should be published 120 days before the effective/implementation date and that the parameters of the validation process should be stated explicitly and documented. Several commenters suggested that hospitals should be notified about any validation rule changes at least 120 days before abstraction and that any validation process should not penalize hospitals for technical data issues.

Response: The current validation process of 5 charts per quarter is designed to provide hospitals, regardless of size, with an estimate of their abstraction accuracy. The quarterly interval is designed to minimize abstraction burden by coinciding with required submission requirements for JCAHO-accredited hospitals. Non-JCAHO accredited hospitals also need periodic feedback about their abstraction accuracy for quality improvement, and the current process is designed to provide this feedback. As noted above, CMS and JCAHO have agreed to release documents at a minimum of 120 days before implementation. All manuals contain data file submission requirements and programming formats for each quarter. Hospitals are encouraged to be aware of the release schedule and to ensure the proper Specifications Manual (data dictionary) is being used for the discharge time period specified. We will explore modifying the release date of updated Specifications Manuals to provide additional time to hospitals and vendors to incorporate these modifications.

Comment: Three commenters did not believe the validation process of using 5 charts over 4 patient populations is statistically reliable. The commenters recommended that we use 4 quarters of data to increase the number of charts. A commenter also recommended that we use as many as 25 charts.

Response: As we noted above, although we will consider using additional quarters of data, we believe that the current 3 quarters stratified sample provides sufficiently reliable results. The abstraction accuracy estimate is an element level estimate, and the chart is considered a cluster of elements. Each quarterly validation sample generally contains 50 to 100 elements clustered in 5 charts. Analysis of previous quarters of submitted data indicates that the clustering effect increases sampling variability by a relatively small proportion. However, the increase in sampling variability is so small that the sample still produces reliable validation rate estimates. The median hospital standard error using the three quarter stratified sample was about 3 percent.

Time limitations prevent us from using 2005 fourth quarter calendar year discharges for purposes of making the FY 2007 annual payment determination, since the scheduled completion date of appeals would not occur until after the September 1, 2006 scheduled release date of the list of hospitals receiving full payment update. However, we will consider using 4 quarters of validation results (that is, fourth quarter 2005 through third quarter 2006) for the FY 2008 determination. Additionally, CMS factored cost, burden, and precision of the validation results in determining the current validation sampling methodology. The goal of the chart audit validation process is to ensure that the hospital is abstracting and submitting accurate data. In order to calculate quality measures, which are used to determine the standard of care, complete and accurate data are necessary.

Comment: Eight commenters stated that hospitals may be negatively affected by the way CMS will determine the 80 percent reliability. The stratified sampling method could result in a passing score for the first two quarters, but may result in an overall failure rating based on the results of the third quarter.

Response: The stratified sampling method is designed to produce a single estimate of abstraction accuracy using three combined quarters of validation results. CMS uses three quarters' results to provide a reliable estimate of sustained abstraction accuracy. Combining results from multiple quarters improves the reliability of the estimate, since it is possible that abstraction accuracy varies widely from quarter to quarter. Thus, it is possible

that one or two quarterly validation samples achieve a passing score above 80percent, but a single quarterly validation score below 80 percent would drop the three combined quarter score below 80 percent. It is the weight of cases for a particular quarter that determines how much impact a single quarter will have on the overall reliability calculation. However, the aggregate approach improves the ability to accurately calculate the reliability of data submissions.

g. Data Validation and Attestation

For the FY 2007 update, we will revise and post up-to-date confidence interval information on the QualityNet Exchange Web site explaining the application of the confidence interval to the overall validation results. The data are being validated at several levels. There are consistency and internal edit checks to ensure the integrity of the submitted data; there are external edit checks to verify expectations about the volume of the data received.

In the FY 2007 proposed IPPS rule, we proposed that hospitals attest to the completeness and accuracy of the data submitted to the QIO Clinical Warehouse in order to improve aspects of the validation checks (71 FR 24094). In order to meet this requirement, for each quarter, hospitals will have to verify the completeness and accuracy, including the volume, of the data submitted. We plan to provide additional information to explain the data completeness requirement as well as provide the relevant form to be completed on the QualityNet Exchange Web site.

Comment: One commenter supported the requirement for hospitals to attest to the validity of their data. One commenter also suggested requiring hospitals to not only attest to the data, but to also subject a small number of hospitals to a random audit. Another commenter felt there are still significant issues with the completeness and adherence to sampling requirements.

Response: CMS appreciates the commenter's support for the attestation requirement and strives to continually improve the accuracy and reliability of the hospital quality data. In addition to the attestation requirement, CMS is currently studying the need, cost, and feasibility of alternative methods for assessing submission completeness and adherence to sampling requirements, including on-site random audits.

Comment: One commenter did not want the hospital attestations to become too burdensome. The commenter recommended that if the attestation can be a part of the review period, the QualityNet Exchange Administrator should be allowed to review the data in the preview period, and electronically sign for its accuracy. At a minimum, the attestations should be able to be delivered electronically.

Response: We welcome this suggestion, and agree that the electronic attestation would increase efficiency and lessen the burden for hospitals. We will investigate aspects, such as operational and legal requirements for attestation pertaining to electronic submission.

Comment: One commenter requested that CMS establish and communicate to the field which quarters will be used in the calculation of the validation threshold. The commenter believes that CMS should provide notice to RHQDAPU program eligible hospitals which quarters will be included in the annual payment update prior to the beginning of the rulemaking process each year.

Response: CMS is aware of and understands the commenters concerns in regards to the calculation of the validation threshold. However, we believe that the appropriate way to announce the quarters for which data must be submitted under the program is to announce them as part of the rulemaking process.

h. Public Display and Reconsideration Procedures

We will continue to display quality information for public viewing as required by new section 1886(b)(3)(B)(viii)(VII) of the Act. Before we display this information, hospitals will be permitted to review their information as we have it recorded.

For hospitals that CMS has determined do not meet the RHQDAPU program requirements for the applicable fiscal year who wish to appeal this determination, the appeals process set forth in 42 CFR Part 405, Subpart R (a Provider Reimbursement Review Board (PRRB) appeal) applies. However, in the FY 2007 IPPS proposed rule (71 FR 24095) we noted that we believe it may be appropriate to establish a structured reconsideration process to precede the PRRB appeal for FY 2008 and subsequent fiscal years.

Currently, a hospital may submit a letter setting out its reasons for requesting that we reconsider our decision that the hospital did not meet the RHQDAPU program requirements. We proposed to continue this process for FY 2007 RHQDAPU program decisions (71 FR 24095). However, we proposed to establish a deadline of November 1, 2006, for hospitals to make such requests related to the FY 2007 RHQDAPU program decisions, which will give hospitals a minimum of 30 days to submit reconsideration requests from the dates that the decisions are made public. Further, we proposed that the November 1, 2006 deadline also would apply to FY 2005 and FY 2006 RHQDAPU program decisions and that a November 1 deadline would apply in all future fiscal years. CMS will officially respond to the letters submitted by hospitals.

Further, we sought public comment specifically on the need for a more structured reconsideration process to precede any PRRB appeal for FY 2008 and subsequent fiscal years (71 FR 24095). We also sought comment on what such a process would entail. For example, we noted that such a process, if established, could include—

- A limited time, such as 30 days from the public release of the decision, for requesting a reconsideration;
- Who in a hospital organization can request such a reconsideration and be notified of its outcome;
- The specific factors that CMS will consider in such a reconsideration, such as an inability to submit data timely due to CMS systems failures;
- Specific requirements for submitting a reconsideration request, such as a written request for reconsideration specifically stating all reasons and factors, including specific data elements, why the hospital believes it did meet the RHQDAPU program requirements;
- Specific CMS components that would participate in the reconsideration process; and
- The timeframe, such as 60 days, for CMS to provide its reconsideration decision to the hospital.

We also solicited comments on the reasons for not establishing such a reconsideration process.

Comment: One commenter recommended a structured reconsideration process for FY 2007 RHQDAPU program decisions. This commenter supported reconsideration predicated on a written request specifically stating all reasons and factors why a hospital believes it did not meet the RHQDAPU program requirements. The commenter agreed with the deadline of November 1 for RHQDAPU program decisions, and a maximum of 60 days for a CMS response to the reconsideration.

Response: We are pleased that the commenter supports reconsideration predicated on a written request stating all reasons and factors for a hospital not meeting the RHQDAPU program requirements and concurs with the timeframes we proposed. We expect to

move forward with establishing a structured reconsideration process for future RHQDAPU program decisions.

Comment: Three commenters stated that the PRRB may not be the best review mechanism for appeals. A commenter suggested that CEOs should be able to submit their appeals in writing, stating all reasons and facts and that CMS should then establish a pre-PRRB review panel that does not involve any of the individuals who make the original determination. If the pre-PRRB review panel renders a decision against the hospital, the hospital can then go before the PRRB for a review.

Response: We are pleased that the commenter supports reconsideration predicated on a written request stating all reasons and factors for a hospital not meeting the RHQDAPU program requirements. We expect to move forward with establishing a structured reconsideration process for future RHQDAPU program decisions. We will examine the feasibility of using a panel structure that does not include individuals involved in the original determination. However, because of the highly technical nature of this process, it may be necessary to consult with those individuals due to their specialized expertise.

Comment: Three commenters supported establishing a process that could consider the reasons why a hospital did not meet the RHQDAPU program requirements. A commenter suggested that QIOs could be very helpful in developing and administering a reconsideration process.

Response: We appreciate these comments and will consider the suggestion that QIOs have a role in a reconsideration process as we begin to implement the reconsideration process for FY 2007 and subsequent fiscal years.

i. Conclusion

After consideration of the public comments received, because the change in the percentage point reduction from 0.4 percentage points to 2.0 percentage points is required by section 1886(b)(3)(B)(viii)(I) of the Act, we are adopting as final, without modification, the proposed changes to § 412.64(d) of our regulations.

After careful consideration of the public comments received, we are adopting as final the expanded quality measures we proposed.

In response to public comments, we will require that reporting of the expanded quality measures begin with discharges occurring on or after the third calendar quarter of 2006 (July through September discharges). The deadline for hospitals to submit data for this quarter will be February 15, 2007. We are also setting the deadline for hospitals to complete and send the revised "Reporting Hospital Quality Data for Annual Payment Update Notice of Participation" form to their respective QIO, no later than August 15, 2006. With these modifications, after careful consideration of the public comments received, we are adopting these procedures as final.

3. Electronic Medical Records

In the FY 2006 IPPS final rule, we encouraged hospitals to take steps toward the adoption of electronic medical records (EMRs) that will allow for reporting of clinical quality data from the EMRs directly to a CMS data repository (70 FR 47420). We intend to begin working toward creating measures specifications and a system or mechanism, or both, that will accept the data directly without requiring the transfer of the raw data into an XML file as is currently done. The Department continues to work cooperatively with other Federal agencies in the development of Federal health architecture data standards. We encouraged hospitals that are developing systems to conform them to both industry standards and, when developed, the Federal Health Architecture Data standards, and to ensure that the data necessary for quality measures are captured. Ideally, such systems will also provide point-of-care decision support that enables high levels of performance on the measures. Hospitals using EMRs to produce data on quality measures will be held to the same performance expectations as hospitals not using EMRs.

Due to the low volume of comments we received on this issue in response to the FY 2006 proposed IPPS rule, in the proposed IPPS rule for FY 2007 (71 FR 24095), we again invited comments on these requirements and options. In section IV.B.6. of the preamble to the FY 2007 IPPS proposed rule, we also invited comments on the potential role of effective, interoperable health information on technology in value-based purchasing.

Comment: Most of the comments that were submitted on the adoption of electronic health records in the hospital settings focused on:

- HIT associated cost implication for hospitals.
- The time frame for implementation should be at least a 10-year window, to allow hospitals to obtain the financial and technical support needed for this initiative.
- CMS statutory authority to encourage the use and adoption of HIT without new legislation.
- Support for the initiative but recommended that CMS develop partnerships with affected parties to ensure its successful development.

Response: After consideration of the public comments received, we will continue to pursue the adoption of electronic health records for the reporting of hospital quality data. In addition, for the future we will take all comments submitted under consideration as we move forward.

B. Value-Based Purchasing

1. Introduction

CMS has undertaken a number of activities to improve the quality and efficiency of care delivered to Medicare beneficiaries. Currently, there are several different fee-for-service payment systems under Medicare that are used to pay health professionals and other providers based on the number and complexity of services provided to patients. In general, all providers to which a specific Medicare payment system applies receive the same amount for a service, regardless of its quality or efficiency. As a result, Medicare's payment systems can direct more resources to hospitals that deliver care that is not of the highest quality or include unnecessary services (for example, duplicative tests and services or services to treat avoidable complications). Therefore, we are examining the concept of "value-based purchasing," which may use a range of incentives to achieve identified quality and efficiency goals, as a means of promoting better quality of care and more effective resource use in the Medicare payment systems. In considering the concept of value-based purchasing, we are working closely with stakeholder partners, including health professionals and providers. In the FY 2007 IPPS proposed rule (71 FR 24095), we sought public comment on value-based purchasing as related specifically to hospitals.

We discussed CMS' and Congress' initial steps toward hospital value-based purchasing, which include the Premier Hospital Quality Incentive Demonstration, the RHQDAPU program authorized by section 501(b) of Pub. L. 108–173 (MMA), and the extended and expanded RHQDAPU program authorized by section 5001(a) of Pub. L. 109–171 (DRA). (The RHQDAPU program was also discussed in section IV.A. of the preamble to the proposed rule.) In addition, we discussed the issues that must be considered in

developing a plan to implement a value-based purchasing plan beginning with FY 2009 for Medicare payments for subsection (d) hospitals. This plan is required by section 5001(b) of Pub. L. 109–171. For each of the required planning issues (measures, data infrastructure, incentives), we discussed CMS' activities to date and solicited comments on outstanding policy questions. Next, we discussed options for implementation of section 5001(c) of Pub. L. 109–171, which authorizes quality adjustment to DRG payments for certain conditions that were not present on hospital admission. We solicited input about detailed design considerations related to each of these issues and the advantages and disadvantages of possible approaches to planning and implementing hospital value-based purchasing.

Finally, we discussed and invited comments on how to encourage hospitals to effectively use health information technology to improve efficiency, processes, and health care outcomes, through, for example, adopting interoperable health information technology.

2. Premier Hospital Quality Incentive Demonstration

One of the ways in which CMS is testing innovative potential approaches to improving quality is through demonstrations and pilot projects. The demonstration most relevant to hospitals is the Premier Hospital Quality Incentive Demonstration. Premier, Inc., a nationwide alliance of not-for-profit hospitals, submitted an unsolicited proposal for consideration by CMS.[20] We have partnered with Premier to conduct a demonstration that is designed to test whether the quality of inpatient care for Medicare beneficiaries improves when financial incentives are provided. Under the demonstration, about 270 hospitals are voluntarily providing data on 34 quality measures related to 5 clinical conditions: heart attack, heart failure, pneumonia, coronary artery bypass graft, and hip and knee replacements.

Using the quality measures, CMS identifies hospitals with the highest quality performance in each of the five clinical areas. Hospitals scoring in the top 10 percent in each clinical area receive a 2-percent bonus payment in addition to the regular Medicare DRG payment for the measured condition. Hospitals in the second highest 10 percent receive a 1-percent bonus payment. In the third year of the demonstration, some hospitals that do not achieve absolute improvements above the demonstration's first year composite score baseline (the lowest 20 percent) for that condition will have their DRG payments reduced by 1 or 2 percent, depending on how far their performance is below the baseline.

Following the first year of the demonstration (FY 2004), CMS awarded a total of $8.85 million to participating hospitals in the top two deciles for each clinical area. In the aggregate, quality of care improved in all five clinical areas that were measured. Preliminary information from the second year of the demonstration indicates that quality is continuing to improve, particularly for the poorest performing hospitals. Additional information on the Premier Hospital Quality Incentive Demonstration is available on the CMS Web site at: *http://www.cms.hhs.gov/HospitalQualityInits/35_HospitalPremier.asp.*

3. RHQDAPU Program

We believe that the acts of collecting and submitting performance data and of publicly reporting comparative information about hospital performance seem to be a strong incentive to encourage hospital accountability. Measurement and reporting can help focus the attention of hospitals and consumers on specific goals and on hospitals' performance relative to those goals.

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

Since 2003, we have operated the Hospital Quality Initiative,[21] which is designed to stimulate improvements in hospital care by standardizing hospital performance measures and data transmission to ensure that all payers, hospitals, and oversight and accrediting entities use the same measures when publicly reporting on hospital performance. Section 501(b) of Pub. L. 108–173 authorized us to link the collection of data for an initial starter set of 10 quality measures to the Medicare annual update of the standardized payment amount for hospital inpatient operating costs (also known as the RHQDAPU program). For FYs 2005 and 2006, hospitals that met the RHQDAPU program's requirements received the full annual payment update to their inpatient operating costs, while hospitals that did not comply received an update that was reduced by 0.4 percentage points. For FY 2005, virtually every hospital in the country that was eligible to participate submitted data (98.3 percent), and approximately 96 percent of all participating hospitals met the requirements to receive the full update. The data regarding the starter set of 10 quality measures as well as additional, voluntarily-reported data on other quality measures, are available to the public through the Hospital Compare Web site at: *http://www.hospitalcompare.hhs.gov.*

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

As discussed in section IV.A. of the FY 2007 IPPS proposed rule (71 FR 24091), for FY 2007 and each subsequent year, section 5001(a) of Pub. L. 109–171 amended section 1886(b)(3)(B) of the Act and made changes to the program established under section 501(b) of Pub. L. 108–173. These changes require us to expand the number of measures for which data must be submitted, and to change the percentage point reduction in the annual payment update from 0.4 percentage points to 2.0 percentage points for subsection (d) hospitals that do not report the required quality measures in a form and manner, and at a time, specified by the Secretary. Effective for payments beginning with FY 2007, new section 1886(b)(3)(B)(viii)(IV) of the Act requires the Secretary to begin to adopt the expanded set of performance measures set forth in the IOM's 2005 report entitled, "Performance Measurement: Accelerating Improvement."[22] Those measures include the HQA measures, the HCAHPS® patient perspective survey, and three structural measures.[23] Effective for payments beginning with FY 2008, the Secretary must add other measures that reflect consensus among affected parties and may replace existing measures as appropriate. New section 1886(b)(3)(B)(viii)(VII) of the Act requires the Secretary to establish procedures for making hospital quality data on these measures available to the public. We discuss our responses to

[20] The Premier Hospital Quality Incentive Demonstration was authorized under section 402 of Pub. L. 90–248, Social Security Amendments of 1967 (42 U.S.C. 1395b–1). This section authorizes certain types of demonstration projects that waive compliance with the regular payment methods used in the Medicare program.

[21] For more information about CMS' Hospital Quality Initiative, see *http://www.cms.hhs.gov/HospitalQualityInits/.*

[22] Institute of Medicine, "Performance Measurement: Accelerating Improvement," December 1, 2005, available at *http://www.iom.edu/CMS/3809/19805/31310.aspx.*

[23] The three structural measures are: (1) Computerized provider order entry; (2) intensive care intensivists; and (3) evidence-based hospital referrals.

public comments on these requirements in section IV.A. of this preamble.

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

Section 5001(b) of Pub. L. 109–171 requires us to develop a plan to implement hospital value-based purchasing beginning with FY 2009. The plan must consider the following issues: (a) The ongoing development, selection, and modification process for measures of quality and efficiency in hospital inpatient settings; (b) the reporting, collection, and validation of quality data; (c) the structure of payment adjustments, including the determination of thresholds of improvements in quality that would substantiate a payment adjustment, the size of such payments, and the sources of funding for the payments; and (d) the disclosure of information on hospital performance. Section 5001(b) of Pub. L. 109–171 also calls for us to consult with affected parties and to consider relevant demonstrations in developing the plan. Each of these issues (measure development and refinement, data infrastructure, incentives, and public reporting) is discussed below, along with our activities to date and outstanding policy questions.

In the FY 2007 IPPS proposed rule (71 FR 24097), we sought comments on these issue areas and outstanding policy questions. We received 50 items of correspondence, which included 37 comments from hospitals and health care systems, including the American Hospital Association and many State hospital associations, the Federation of American Hospitals, the National Association of Public Hospitals, the Association of American Medical Colleges, and the Catholic Health Association. From the purchaser and consumer perspectives, we received comments from The Leapfrog Group, the National Business Coalition on Health, the Consumer-Purchaser Disclosure Project, the National Breast Cancer Coalition Fund, and Consumers Union. The medical device and information technology industries also provided comments.

As a preliminary matter, almost half of all commenters also made recommendations on the process for developing the Medicare value-based purchasing plan. The AHA, the State hospital associations, the Voluntary Hospital Association, and the Federation of American Hospitals all stressed that the HQA be the foundation for planning. Several other commenters noted the value of an iterative process, with multiple opportunities for public comment to build consensus.

We present a summary of the comments by major issue area below and our response.

a. Measure Development and Refinement

As we explore the potential connections between performance measurement and incentives, we would like to better understand how to develop valid, meaningful, current performance measures that are aligned with other hospital measurement activities, and an enterprise for development, validation, consensus building, and maintenance of these measures. In addition, before measures could be used to compare the relative quality or cost of care provided by hospitals, we believe that the information would need to be appropriately adjusted to account for relevant differences among hospitals and among their patients. The availability of appropriate measures on which consensus might be achieved depends on the state of the art of research on measure development.

We believe that it is desirable for performance measures to be based on appropriate evidence, effectively related to desired outcomes, derived in a transparent fashion involving consultation with experts and affected hospitals, and routinely updated. MedPAC's 2005 Report to Congress [24] stated that measures should be evidence-based; that collecting and analyzing data should not be unduly burdensome for the provider or for CMS; that risk adjustment should be sufficient to deter providers from avoiding patients who might lower performance scores; that most providers should be able to improve on the measures; that measures should apply to a broad range of care and providers; that measures should capture aspects of care that are under the control of the providers being measured; and that areas of care being measured should be those needing improvement.

The IOM's December 2005 report, "Performance Measurement: Accelerating Improvement" [25] recommended that measure sets should build on the work of key public- and private-sector organizations; that national performance measures that have been approved through ongoing consensus processes led by major stakeholder groups are an appropriate starting point; that the limited scope of current measures should be broadened to address efficiency, equity, and patient-centeredness; that quality, costs, and outcomes of care should be measured over longer time intervals; and that measures be applicable to more than one setting so that providers can share accountability for a patient's care (pp. 8–11).

The plan for hospital value-based purchasing mandated by Pub. L. 109–171 must address the ongoing development, selection, and modification process for measures of quality and efficiency in hospital inpatient settings. We have worked collaboratively in defining consistent, meaningful performance measures for hospitals and other providers for a number of years. The efforts of CMS and its stakeholder partners to develop standardized performance measures increase the likelihood that the measures will be valid, reliable, and widely accepted as viable indicators of performance. Standardized measures also reduce the burden for hospitals that would otherwise have to report different measures to multiple entities, such as accrediting bodies and State agencies.

CMS and the HQA (which includes representatives from consumers, hospitals, health professionals, purchasers, and accreditation organizations) collectively selected a starter set of 10 consensus-derived quality measures for public reporting, which was incorporated into the RHQDAPU program authorized by section 501(b) of Pub. L. 108–173. (See section IV.A. of the preamble to the FY 2007 IPPS proposed rule (71 FR 24091) for a detailed discussion of the RHQDAPU program.) The measures were endorsed by the NQF, a nonprofit voluntary organization that represents a broad range of health care stakeholders and endorses consensus-based national performance standards. CMS has also worked with the JCAHO to align hospital performance measures that we share in common, thereby reducing hospitals' reporting burden.

In April and September 2005, CMS and the HQA identified additional NQF-endorsed measures of hospital performance. In section IV.A. of the preamble to the FY 2007 IPPS proposed rule (71 FR 24093), we listed these measures and proposed to require hospital reporting on these measures under an expanded version of the RHQDAPU program authorized by section 5001(a) of Pub. L. 109–171. These measures are discussed in more

[24] Medicare Payment Advisory Commission: Report to Congress: Medicare Payment Policy, March 2005, pp. 186–187, available at: *http://www.medpac.gov/publications/generic_report_display.cfm?report_type_id=1&sid=2&subid=0.*

[25] Institute of Medicine, "Performance Measurement: Accelerating Improvement," December 1, 2005, available at *http://www.iom.edu/CMS/3809/19805/31310.aspx.*

detail on the CMS Web site at: *http://www.cms.hhs.gov/HospitalQualityInits/downloads/HospitalHQA2004_2007200512.pdf*. In this final rule, we have included the 20 NQF-endorsed measures currently reported on our Hospital Compare Web site, as well as two additional NQF-endorsed measures, as requirements for hospital reporting under the FY 2007 RHQDAPU program.

Two additional outcome measures (30-day mortality for heart attack and heart failure) have been endorsed by the NQF for public reporting. Further, in October 2006, we will be implementing the HCAHPS® survey of inpatient perceptions of their hospital care experiences, with the intention that an aggregate HCAHPS® measure will become a publicly reported performance measure. HCAHPS® was endorsed by the NQF in May 2005. Beyond these, we could also consider including additional measures from the Surgical Care Improvement Project, measures relating to a hospital's use of information technology that result in improved patient outcomes, implementation of data standards, and preventable readmissions as quality reporting measures under the RHQDAPU program or the hospital value-based purchasing program.

Comment: Virtually all of the commenters discussed the measures issues. The commenters focused on three major topics: (1) The use of quality versus efficiency measures, (2) the use of process versus outcome measures, and (3) the importance of including measures that capture aspects of care from the patient experience, including access, respect, and disparities/differences experienced by patients of different races and ethnic backgrounds.

From the perspective of virtually all provider associations, the hospital value-based purchasing program should focus on evidence-based process measures. The majority of commenters also believed that, for now, measures should focus solely on quality and that measures of efficiency are premature. Several commenters also stressed that the goal of the program should be to improve overall quality of care, rather than to decrease costs.

Commenters from the medical device industry raised the concern that a reliance on process measures when assessing efficiency could inhibit access to new technologies and urged that risk-adjusted outcome measures be used instead. Two provider associations urged that payment systems must ensure that evolving and improved technologies continue to be available to all patients and that efficiency measures not inhibit the adoption of new quality-enhancing technologies.

Commenters representing the purchaser and consumer perspectives stressed the importance of including measures that reflect quality, efficiency, equity, patient experience, and structure and urged that all measures be nationally endorsed, scientifically valid, risk-adjusted, and regularly updated. Several consumer groups and safety net providers also noted the importance of including measures that could capture disparities in care experienced by patients of different races and ethnic backgrounds. On a related note, the Association of American Medical Colleges and safety net providers emphasized the importance of assuring a level playing field to account for differences among types of hospitals and patient demographics.

Several commenters noted that developing measures is a public good and that substantial funding should be provided to support the development of consumer-relevant measures to fill existing gaps, especially for measures of efficiency and equity.

Several commenters supported including measures from the Surgical Care Improvement Program (SCIP) because surgical wounds and infections are among the most common and harmful hospital-acquired infections.

Regarding information technology, the response was mixed. Some commenters supported the inclusion of measures that would encourage IT adoption, while others noted the obstacle of ongoing issues with current health IT standards.

b. Data Infrastructure

Implementing measures on which to base a value-based purchasing system would require an infrastructure that could collect appropriate information from hospitals, store and aggregate it as necessary, and prepare it for use in determining appropriate incentives. Hospitals would likely need to be able to generate appropriate data as input for calculation of the measures. For some measures, data that hospitals already submit with claims for payment or for some other administrative purpose may be sufficient. For other measures, hospitals might need to provide information regarding their structure and resources or about the specifics of medical care provided to patients or the outcomes of that care. For that information, hospitals may need special software to assist with data collection and secure channels by which they can transmit data. In the FY 2007 IPPS proposed rule, we solicited comments on how to develop an infrastructure that would facilitate the efficient transmission and storage of data, and especially, as discussed in sections IV.A.3. and IV.B.6. of the preamble to that proposed rule (71 FR 24095, 24100). We especially solicited comments on how electronic medical and health record systems could help improve care and be integrated into or facilitate the data collection process.

We did not receive any comments specific to this issue.

Implementation would require communication channels and data warehouses with sufficient capacity and flexibility to acquire and store data from hospitals. We are considering how we might validate the submitted data, determine incentives based on that data, and transmit these values to Medicare's fiscal intermediaries. The potential infrastructure would need to be extremely secure and afford the most privacy protection permitted by law. It would also need to minimize the burden of data collection and transmission on providers. It would need to be accurate, efficient, and cost-effective for CMS to administer.

The plan for hospital value-based purchasing mandated by Pub. L. 109–171 must address the reporting, collection, and validation of quality data. Over the past few years, we have developed a data collection and reporting infrastructure for the RHQDAPU program that can transmit performance measurement data via secure channels for its submission, storage, analysis, validation, and reporting. Specifically, to facilitate data collection, we have developed the CART software to assist hospitals in the collection of clinical and administrative data used to measure performance improvement. CART, which is provided to hospitals free of charge, is a powerful application that hospitals and their designees can use to abstract clinical data needed for performance measurement from medical records. This tool was designed and developed by CMS with input from the JCAHO and the Medicare QIOs. We have also developed the QualityNet Exchange system for secure transmission of data to the QIO Clinical Warehouse. *QNetExchange.org* is the CMS-approved Web site for secure communications and data exchange between two or more of the following: Hospitals, performance measurement system vendors, end stage renal disease networks and facilities, QIOs, and CMS.

For data warehousing, we have a claims warehouse for Medicare Part A data, which maintains the claims for the most recent 42 months. We also have a QIO Clinical Warehouse that currently

contains information on the starter set of 10 quality measures collected under the RHQDAPU program, as well as additional voluntarily reported measures. We must assess the validity of the RHQDAPU information because of its use for quality improvement, public reporting, and determining hospitals' annual payment updates under the RHQDAPU program. Validation activities assess the reliability of the data that a hospital has submitted, as evidenced by the consistency between a hospital's abstraction and reabstraction by an independent party.

We are currently using a contractor, the CDAC, to carry out the validation process under the RHQDAPU program. Hospitals are required to submit certain quality data to the QIO Clinical Warehouse within 4.5 months of the end of each quarterly reporting period. The steps in the validation process are: (1) Check for duplicates; (2) draw a sample; (3) obtain copies of medical records; (4) request and complete CDAC abstraction; (5) post results on QualityNet Exchange for hospitals' review; and (6) resolve validation appeals. In the FY 2007 IPPS proposed rule (71 FR 24098), we sought comments on how the data submission and validation processes that we currently use for the RHQDAPU program might be adaptable to a hospital value-based purchasing program.

We did not receive any comments specific to this issue.

One of the key challenges we face in considering implementation of hospital value-based purchasing is minimizing the length of time between our receipt of data and our ability to provide feedback to hospitals on the data. Some of the hospitals that are participating in the RHQDAPU program and the Premier Hospital Quality Incentive Demonstration have asked for more timely feedback on their performance. We recognize that a long delay between the provision of services and feedback about the quality of those services may impede both improvement efforts and a hospital's motivation to improve. The current lag time between the end of the quarterly reporting period and the availability of performance feedback under the RHQDAPU program is approximately 9 months. Hospitals have 4.5 months to complete their paper medical records and to submit information to the QIO Clinical Warehouse, which roughly coincides with JCAHO's timeline for submission of data to their ORYX® Core Measure Performance Measurement System. Another 4.5 months are required to accomplish the steps in the validation process.

We are considering options to decrease the overall length of time between our receipt of data and our ability to provide feedback to hospitals, and we are interested in comments on these options. First, we are considering whether more frequent data submissions, such as monthly submissions, would decrease the time between the provision of services and feedback about the quality of those services. We are aware that some hospitals and their vendors already submit quality data on a monthly basis to JCAHO. However, unless we reduced the sample size per reporting period, the process of validating each month the same number of records that are currently validated each quarter would increase costs significantly. On the other hand, if we reduced the sample size per reporting period, the monthly numbers might be too small to provide for adequate validation. Second, we could shorten the data submission period, which is a significant source of lag time. This option would require hospitals to submit information to the data warehouse more quickly, which could increase the possibility that hospitals would submit less complete data. In addition, this option would require coordination with JCAHO to keep submission timelines congruent, which reduces hospitals' reporting burden. Third, we could eliminate the validation appeals process, which would reduce the lag time by up to 2 months. Fourth, we could create an expanded role for the third party vendors that assist hospitals with submitting quality data to CMS and JCAHO. For example, CMS could certify third party vendors to also provide standardized validation services and quick performance feedback to their hospital customers.

Comment: Approximately half of the commenters' responses included comments specific to data issues. The commenters addressed two issues in particular: (1) The data challenges confronted by small hospitals and (2) the timeliness of feedback versus the burden of submission.

A quarter of commenters raised the special challenges confronted by small, in particular rural, hospitals because of the small sample sizes they often encounter for many measures and the volatility and instability in measure results under these circumstances.

Regarding timeliness and the lag time between reporting and feedback, commenters from different stakeholder groups had opposing perspectives. Provider commenters were concerned that monthly reporting would be extremely burdensome, while purchaser and consumer advocate commenters suggested that monthly submission could improve the timeliness of data. All commenters stressed the importance of data validation. Consumers Union stressed that validation is critical and need not increase the time lag. It recommended the use of rolling publication of data with quarterly updates. Two commenters endorsed the concept that the data submission and validation processes could be streamlined through use of electronic health records (EHRs), which could also provide an incentive for adoption of EHRs. The Federation of American Hospitals found none of the options presented in the proposed IPPS rule for reducing the lag time between submission and feedback to be acceptable.

Several commenters mentioned the benefits of augmenting billing forms with clinical data elements and cited the approach of the Pennsylvania Healthcare Cost Containment Council.

c. Incentive Methodology

While measurement of the quality of care and of resources use may be advantageous in itself, we are considering whether and what kind of incentives can further improve outcomes. The potential design of incentives in a value-based purchasing system presents many choices. The implementation plan for hospital value-based purchasing mandated by Pub. L. 109–171 must address the structure of payment adjustments, including the determination of thresholds of improvements in quality that would substantiate a payment adjustment, the size of such payments, and the sources of funding for the value-based payments. In the FY 2007 IPPS proposed rule (71 FR 24098), we sought comments on the merits of and alternatives to all of the approaches to the design of a value-based purchasing methodology that are discussed below.

(1) How should incentives be structured?

A number of options exist for the structure of potential incentives. The incentive methodology could include differential incentives depending on whether hospitals exceed a particular standard of performance. To reflect expectations of continued improvement among hospitals, the standard could be raised in predictable steps over time. Alternatively, incentives could be structured to reward hospitals that improve from a baseline level of performance. These approaches could be combined to develop an incentive

methodology that includes both attaining benchmarks and improving care.

Comment: Approximately half of the commenters responded to at least one of the questions on incentives, and comments varied widely on these issues. Most commenters saw the combination of incentives to reward continuous improvement over time and incentives for attainment of specific benchmarks as most desirable. However, there was disagreement about the value of absolute benchmarks. Several commenters favored developing a fixed standard, rewarding hospitals that meet or exceed the standard, and when the majority achieves this standard, either raising the standard or selecting another measure with a fixed standard. They commented that the bar should be high enough to serve as an effective target, but not so high as to become attainable by only a small number of providers. By contrast, one commenter believed that a fixed benchmark discourages hospitals, particularly small and rural hospitals, because it might not reflect their unique circumstances.

Almost half of all commenters emphasized the importance of aligning hospital and physician incentives so that everyone will be working toward the same goals of improving quality and providing appropriate care.

(2) What level of incentive is needed?

Value-based purchasing incentives should be targeted to that level needed to achieve a desired level of performance. Our experience with implementing section 501(b) of Pub. L. 108–173 indicates that a targeted incentive, coupled with active management by CMS, can encourage reporting on quality measures. Nearly every eligible hospital has been willing and able to submit the required data in order to receive the full payment update under the RHQDAPU program. Similarly, our experience with the Premier Hospital Quality Incentive Demonstration indicates that a 1 or 2 percent bonus, coupled with potential reductions for poor performance, may stimulate improvement. Further experience in ascertaining how hospitals respond to incentives will be important for examining incentives over time.

Comment: A number of commenters across the stakeholder spectrum responded that the annual IPPS update is proving to be a sufficient incentive to encourage virtually all hospitals to participate in the RHQDAPU program and that the current level of a 1–2 percent incentive is appropriate. Commenters noted that an additional portion of the update could be made conditional upon achieving specified performance goals.

Many provider commenters stated that a system of rewards should increase payments or reduce regulatory burden for successful providers and urged that incentives involving penalties should not be used because the basic level of DRG payment does not now cover costs for more than one-third of hospitals. Several provider commenters suggested that rewards should be large enough to cover the costs of implementing process changes and to allow for reinvestment in quality improvement efforts. One provider commenter also urged that incentive structures should be gradual to avoid "cliff" effects in either rewards or penalties.

(3) What should be the source of incentives?

The President's FY 2007 Budget indicates support for identifying and testing "budget-neutral incentives that will stimulate Medicare providers to improve performance on quality and efficiency measures." [26] We do not believe that providing additional aggregate funding to finance performance-based incentives is either supportable or necessary. One approach might be to examine how we could identify and apply measurable savings achieved by reducing care that is unnecessary or otherwise inappropriate. For example, we may examine possibilities of improving care coordination, whether this could produce measurable savings, and whether some of the savings generated in one payment system could be used for incentives in another, as long as these reforms do not provide inappropriate incentives to stop providing necessary care. For instance, appropriate quality of care and effective resource use in hospitals and other institutional providers might generate savings that could be used for incentives for both physicians and facilities.

Comment: Several hospital association and individual provider commenters suggested that savings from improved care coordination could be a source of funding for incentives and recommended studying whether savings generated in one payment system could be used for payments in another setting.

One commenter noted the importance of assuring that funds designated for rewards be fully allocated to hospitals and urged that a program designed to reward improving quality should not become an arbitrary cost-cutting mechanism.

The budget-neutral shared savings approach currently used in the Leapfrog Hospital Rewards Program was cited by several commenters as a model worth considering, though the commenters noted that savings are harder to identify in the Medicare DRG-based system than in the commercial per diem systems where the Leapfrog Program is currently operating.

(4) What should the form of incentives be?

Potential approaches for incentives include making an add-on payment to the base payment for individual inpatient hospital services or providing periodic, lump-sum payments on a monthly, quarterly, or annual basis. Under the RHQDAPU program, hospitals that do not submit the required data receive a decrease in the standardized payment amount made for all inpatient operating costs for the applicable fiscal year. In a hospital value-based purchasing system, per-service payments might be made only in connection with the services directly associated with the particular measure for which the hospital achieved a good result. Alternatively, lump-sum payments might be made on a periodic basis to hospitals that achieve particular performance targets. The preferable approach may depend on operational concerns, the strength of incentive effects, and other aspects of the design. In the FY 2007 IPPS proposed rule (71 FR 24099), we sought comments on this issue.

Comment: We received three comments on this issue, and all commenters favored periodic lump-sum payments over other options.

(5) What should the timing of incentives be in relation to performance?

Any value-based purchasing system should seek a balance between rewarding desired performance close to when it occurs and ensuring the accuracy of both performance measurement and incentives. Given the lag times for collecting and reviewing different types of data, some measures may be calculated quickly after the period of performance, while data lag times for other measures may be longer. For instance, structural measures could affect incentives soon after they are collected. Other measures that are based on experience over a time interval may require some time for measured events to manifest. An example of this type of measure would be the rate of mortality within 30 days of hospitalization.

[26] Budget of the United States Government, Fiscal Year 2007, available at: *http://www.whitehouse.gov/omb/budget/fy2007/.*

We did not receive any comments specific to this issue.

(6) How should we develop composite scores?

Encouraging improved performance could be facilitated by valid and reliable methods to aggregate performance data into single composite scores. Composite scoring may also improve consumer understanding of complex performance indicators by combining measures of many dimensions of care into a single score. One example of a composite scoring methodology that we used for the Premier Hospital Quality Incentive Demonstration (discussed in detail above) is a modification of the "opportunity model," which can be used to address individual weighting, missing data, and sensitivity to case volumes. For example, a hospital that has few or no cases for a particular dimension of care could receive a low score, yet that measure is equally weighted with others in the composite. Under the opportunity model, a composite may be developed for a disease category by dividing the total number of successful interventions by the total number of opportunities for the same targeted interventions. Some of the advantages of the opportunity model are that individual measures are weighted by the volume of opportunities for the associated intervention for a particular hospital; missing values for a particular aspect of care provided by an individual hospital would not prevent that hospital from being represented in a public report; and composite measures may easily accommodate the addition of individual measures.

The "appropriate care measure" (ACM) is another composite scoring methodology, which we used in connection with the QIOs. The ACM scoring methodology is patient-centric. For a hospital to receive credit for treating a patient well, the hospital must have met the standard for every measure applicable to that patient's condition. There are also a number of proprietary composite measures, such as those used by Solucient, Healthgrades, CareScience, and *U.S. News & World Report*. In the FY 2007 IPPS proposed rule (71 FR 24099), we solicited comments on the use of composite scoring for hospital value-based purchasing and on the various composite scoring methodologies.

Comment: Five commenters supported the use of the "opportunity model." No comments were received regarding the "appropriate care model."

Several commenters urged that further research and consumer testing be done around the development and display of measure composites. Several other commenters urged that while composites are useful, they should not be the only information available; instead, information should be presented in various ways, including composite scores, individual scores making up the composite, statistics supporting the score, and graphics.

Value-based purchasing methods are still under development, and anticipating their potential effects on the health care system is difficult. We understand that unintended consequences may result from the implementation of these methods. We believe that we will need to assess incentives and evaluate their effects so that we can revise them quickly as we learn more about their impact on hospitals and on inpatient hospital services provided to Medicare beneficiaries.

We did not receive any comments specific to this issue.

d. Public Reporting

The plan for hospital value-based purchasing mandated by Pub. L. 109–171 must address the public disclosure of information on hospital performance. CMS currently provides public reporting of quality information through the "Compare" Web sites for hospitals, nursing homes, home health agencies, and dialysis facilities.[27] The Compare Web sites provide comparative quality information to consumers and others to help guide choices and drive improvements in the quality of care delivered in these settings. Besides providing Medicare beneficiaries and their health professionals with information to assist them in making informed health care decisions, public reporting of comparative performance data also provides information that is useful to health care consumers who are not Medicare beneficiaries. For example, a consumer who has a Health Savings Account can access CMS' Hospital Compare Web site to gather comparative quality information to assist in choosing a high quality hospital. CMS is contributing to the Administration's Consumer-Directed Health Care Initiative by working with our private- and public-sector partners to make health care information more transparent and available to consumers than ever before. (Refer to section IV.M. of the preamble to the FY 2007 IPPS proposed rule (71 FR 24120) for more information.) In the FY 2007 IPPS proposed rule (71 FR 24100), we sought comments on how we can further stimulate public reporting to increase the transparency and meaningfulness of healthcare performance information.

Comment: Five commenters made recommendations regarding public reporting. One commenter stressed that informed decision-making about performance cannot occur if reported costs are divorced from information about quality. A second commenter noted the importance of providing a formal appeals process for providers that disagree with their performance ratings. Consumers Union urged CMS to use multiple approaches to get consumers more engaged in using quality information, suggesting that Hospital Compare be promoted continuously, that tools be developed to support comparisons in different ways, and that information on Hospital Compare to be updated more frequently than once a year to be relevant to the patient and fair to the hospital.

Response: We thank all commenters for their thoughtful and valuable input. We will use these comments to inform our design of the plan for Medicare hospital value-based purchasing, as mandated by Pub. L. 109–171. This rulemaking process is the first opportunity for the public to be involved in our planning process. We will also be hosting public listening sessions in 2007 to receive public input on drafts of the plan. We encourage your participation in those listening sessions.

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

Medicare's IPPS encourages hospitals to treat patients efficiently. Hospitals receive the same DRG payment for stays that vary in length. In many cases, complications acquired in the hospital do not generate higher payments than the hospital would otherwise receive for other cases in the same DRG. To this extent, the IPPS does encourage hospitals to manage their patients well and to avoid complications, when possible. However, complications, such as infections, acquired in the hospital can trigger higher payments in two ways. First, the treatment of complications can increase the cost of hospital stays enough to generate outlier payments. However, the outlier payment methodology requires that hospitals experience large losses on outlier cases (in FY 2006, hospitals must lose $23,600 before a case qualifies for outlier payments, and the hospital

[27] See CMS' Hospital Compare Web site, available at: *http://www.hospitalcompare.hhs.gov/;* Nursing Home Compare Web site, avaialble at: *http://www.medicare.gov/NHCompare;* Home Health Compare Web site, avaialble at: *http://www.medicare.gov/HHCompare/Home.asp;* Dialysis Facility Compare Web site, available at: *http://www.medicare.gov/Dialysis.*

would then only receive 80 percent of its costs above the outlier threshold). Second, there are about 121 sets of DRGs that split based on the presence or absence of a complication or comorbidity (CC). The CC DRG in each pair would generate a higher Medicare payment. If an infection acquired during the beneficiary's hospital stay is one of the conditions on the CC list, the result may be a higher payment to the hospital under a CC DRG. (See section II.C. of the FY 2007 IPPS proposed rule (71 FR 24006) for a detailed discussion of proposed DRG reforms.)

Section 5001(c) of Pub. L. 109–171 requires the Secretary to identify, by October 1, 2007, at least two conditions that are (a) high cost or high volume or both, (b) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines. For discharges occurring on or after October 1, 2008, hospitals would not receive additional payment for cases in which one of the selected conditions was not present on admission. That is, the case would be paid as though the secondary diagnosis was not present. Section 5001(c) provides that we can revise the list of conditions from time to time, as long as it contains at least two conditions. Section 5001(c) also requires hospitals to submit the secondary diagnoses that are present at admission when reporting payment information for discharges on or after October 1, 2007. In the FY 2007 IPPS proposed rule (71 FR 24100), we sought input about which conditions and which evidence-based guidelines should be selected.

We received 44 comments on this section from hospitals and health care systems, provider associations, consumer groups, purchasers, medical device manufacturers, information technology companies, and health care research organizations.

Comment: The majority of commenters addressed conceptual issues concerning the selection, measurement, and prevention of hospital-acquired infections. While most of the commenters focused on broad factors CMS should consider, some of the commenters included specific recommendations of conditions for possible inclusion in the payment changes. We found these comments very helpful and constructive, and we look forward to further input as we work towards implementation of this section. In the following discussion, we present a summary of the major themes of the commenters and list the specific hospital-acquired complications presented in the comments.

Many commenters encouraged CMS to engage in a collaborative discussion with relevant experts in designing, evaluating, and implementing this section. The commenters urged CMS to include individuals with expertise in infection control and prevention, as well as representatives from the provider community, in this discussion.

Nearly half of the commenters expressed concern about the difficulty in distinguishing between hospital-acquired and community-acquired infections. Multiple commenters indicated that community-acquired infections often cannot be diagnosed on admission and thus would not be included as secondary diagnoses at the time of admission. These commenters indicated that it would be costly and inefficient to attempt to diagnose all community-acquired infections at the time of admission. The commenters requested that CMS provide technical guidance to assist providers in distinguishing between hospital and community-acquired infections.

Many commenters discussed the statutory requirement for hospitals to submit information regarding secondary diagnoses present on admission beginning FY 2008. Some commenters supported this requirement and suggested that it would better enable CMS and health care providers to more accurately differentiate between comorbidities and hospital-acquired complications. MedPAC, in particular, noted that this requirement was recommended in its March 2005 Report to Congress and indicated that this information is important to Medicare's value-based purchasing efforts. Other commenters suggested that CMS delay implementation of this provision, given the significant payment changes contained in the FY 2007 IPPS proposed rule.

Many commenters, including States, health care associations, and health care providers with experience in hospital-acquired infection prevention, cautioned us about potential problems with relying on secondary diagnosis codes to identify hospital-acquired complications. These commenters indicated that secondary diagnosis codes may be an inaccurate method for identifying true hospital-acquired complications. Some of the commenters referred to research showing a wide discrepancy between hospital-acquired infections identified through claims data and hospital-acquired infections identified through active surveillance and/or chart review. According to the commenters, this research found that active surveillance conducted by trained infection control practitioners was the most accurate method for identifying hospital-acquired infections. The commenters also noted that there is currently no standardized and validated method for using claims data to identify hospital-acquired infections.

A number of commenters expressed concerns about the data coding requirements for this payment change. They asked for detailed guidance from CMS to help them identify and document hospital-acquired complications. The commenters also noted that there are currently no standard definitions or guidance to code the present on admission indicator. In addition, there was concern that the current system of bill coding does not support a present on admission indicator and that future versions of the bill coding systems may not be implemented in time to meet the data reporting requirements for this payment change. The commenters also urged CMS to allow adequate time for hospitals to implement the necessary changes to their billing and coding systems and to conduct appropriate staff training.

Almost half of the commenters expressed concern that not all hospital-acquired infections are preventable. In particular, the commenters noted that sicker and more complex patients are at greater risk for hospital-acquired infections and complications. The commenters urged CMS to use discretion in implementing this section to ensure that the program does not punish hospitals taking care of sicker and more complex patients.

To address this issue, many of the commenters suggested that CMS include standardized infection-prevention process measures, in addition to outcome measures of hospital-acquired infections. The commenters proposed that hospitals should not be penalized if they follow evidence-based infection prevention measures. Specifically, a number of commenters referenced the Surgical Care Improvement Program (SCIP) and suggested that CMS build on this initiative. These commenters recommended that CMS include exceptions to the payment changes for cases in which the hospital performed evidence-based infection-prevention measures.

Some commenters proposed that CMS expand the scope of the payment changes beyond the statutory minimum of two conditions. They noted that the death, injury, and cost of hospital-acquired infections are too high to limit this provision to only two conditions. Commenters also recommended that

CMS annually select additional hospital-acquired complications for the payment change.

Conversely, a number of commenters proposed that CMS initially begin with limited demonstrations to test CMS" methodology before nationwide implementation. The commenters specifically mentioned the Michigan Hospital Association Keystone Center, the Pittsburgh Regional Health Initiative, and the Maryland Patient Safety Center as possible models. In addition, several commenters suggested that CMS work with states that currently collect information on diagnoses present on admission.

A commenter recommended that CMS include appropriate consumer protections to prevent providers from billing patients for the non-reimbursed costs of the hospital-acquired complications and to prevent hospitals from selectively avoiding patients perceived at risk for complications.

In addition to the broad conceptual suggestions, some commenters recommended specific conditions for possible inclusion in the payment changes. The specific conditions mentioned in the comments are listed below:

- *Surgical site infections.* Some commenters recommended including surgical site infections because of their high frequency and cost. Commenters also noted that evidence-based measures to prevent the occurrence of these infections are currently measured and reported as part of SCIP. Many commenters suggested that CMS work with SCIP partners to identify appropriate post-surgical hospital-acquired infections for possible inclusion in the payment changes. Other commenters expressed concern that administrative data may not be a reliable source for identifying surgical site infections. Commenters also cautioned that surgical site infections often do not manifest and thus cannot be diagnosed until after the patient has been discharged from the hospital.
- *Ventilator-associated pneumonia.* Commenters also mentioned ventilator-associated pneumonia as a possible condition for inclusion in the payment changes because this condition is currently measured and reported through SCIP. Other commenters recommended against this condition due to the subjective and labor-intensive nature of defining the diagnosis.
- *Catheter-associated bloodstream infections.* Commenters recommended catheter-associated bloodstream infections, including central line infections, as possible conditions. Commenters noted that these infections are currently reported through SCIP.
- *Urinary tract infections.* One commenter recommended nosocomial urinary tract infection for possible inclusion in the payment change. Another commenter argued against this condition because it has limited impact on patient mortality and morbidity.
- *Pressure ulcers.* Multiple commenters suggested that CMS consider pressure ulcers as an alternative to hospital-acquired infections.
- *Hospital falls.* Several commenters suggested that CMS consider hospital falls as an alternative to hospital-acquired infections.
- *Deep vein thromboses.* Commenters also suggested that CMS consider deep vein thromboses as an alternative to hospital-acquired infections.

Response: We would like to express our gratitude to all of the commenters for their thoughtful and helpful recommendations. We will carefully consider their views as we move toward implementing this section. CMS will be working closely with our colleagues at the Centers for Disease Control and Prevention over the coming months to select appropriate conditions to propose for implementation. We anticipate that the next opportunity for formal public comment will be the FY 2008 IPPS proposed rule-making, which will be published in spring of 2007. We encourage the public to comment on our proposal at that time.

6. Promoting Effective Use of Health Information Technology

We recognize the potential for health information technology (HIT) to facilitate improvements in the quality and efficiency of health care services. One recent RAND study found that broad adoption of electronic health records could save more than $81 billion annually and, at the same time, improve quality of care.[28] The largest potential savings that the study identified was in the hospital setting because of shorter hospital stays promoted by better coordinated care; less nursing time spent on administrative tasks; better use of medications in hospitals; and better utilization of drugs, laboratory services, and radiology services in hospital outpatient settings. The study also identified potential quality gains through enhanced patient safety, decision support tools for evidence-based medicine, and reminder mechanisms for screening and preventive care. Despite such large potential benefits, the study found that only about 20 to 25 percent of hospitals have adopted HIT systems.

It is important to note the caveats to the RAND study. The projected savings are across the health care sector, and any Federal savings would be a reduced percentage. In addition, there are significant assumptions made in the RAND study. National savings are projected in some cases based on one or two small studies. Also, the study assumes patient compliance, in the form of participation in disease management programs and following medical advice. For these reasons, extreme caution should be used in interpreting these results.

There are some mixed signals about the potential of HIT to reduce costs. Some studies have indicated that HIT adoption does not necessarily lead to lower costs and improved quality. In addition, some industry experts have stated that factors such as an aging population, medical advances, and increasing provider expenses would offset any projected savings.

In his 2004 State of the Union Address, President Bush announced a plan to ensure that most Americans have electronic health records within 10 years.[29] One part of this plan involves developing voluntary standards and promoting the adoption of interoperable HIT systems that use these standards. The 2007 Budget states that "The Administration supports the adoption of health information technology (IT) as a normal cost of doing business to ensure patients receive high quality care."

Over the past several years, CMS has undertaken several activities to promote the adoption and effective use of HIT in coordination with other Federal agencies and with the Office of the National Coordinator for Health Information Technology. One of those activities is promotion of data standards for clinical information, as well as for claims and administrative data. In addition, through our 8th Scope of Work contract with the QIOs, we are offering assistance to hospitals on how to adopt and redesign care processes to effectively use HIT to improve the quality of care for Medicare beneficiaries, including computerized physician order entry (CPOE) and bar coding systems. In section IV.A.3. of the FY 2007 IPPS proposed rule (71 FR

[28] RAND News Release: Rand Study Says Computerizing Medical Records Could Save $81 Billion Annually and Improve the Quality of Medical Care, September 14, 2005, available at: *http://rand.org/news.press.05/09.14.html.*

[29] Transforming Health Care: The President's Health Information Technology Plan, available at: *http://www.whitehouse.gov/infocus/technology/economic_policy200404/chap3.html.*

24095), we again invited comments on streamlining the submission of clinical quality data by using standards-based electronic medical records. (We used the term "electronic medical records" in section IV.A.3. instead of the term "electronic health records" that is used in this section in order to maintain consistency with our request for comments in the FY 2006 IPPS final rule.) Finally, our Premier Hospital Quality Incentive Demonstration provides additional financial payments for hospitals that achieve improvements in quality, which effective HIT systems can facilitate.

We are considering the role of interoperable HIT systems in increasing the quality of hospital services while avoiding unnecessary costs. As noted above, the Administration supports the adoption of HIT as a normal cost of doing business. Whereas payments under the IPPS do not vary depending on the adoption and use of HIT, hospitals that leverage HIT to provide better quality services may more efficiently reap the reward of any resulting cost savings. In addition, the adoption and use of HIT may contribute to improved processes and outcomes of care, including shortened hospital stays and the avoidance of adverse drug reactions.

In the preamble to the FY 2007 IPPS proposed rule (71 FR 24101), we sought comments on our statutory authority to encourage the adoption and use of HIT. We also sought comments on the appropriate role of HIT in any value-based purchasing program, beyond the intrinsic incentives of the IPPS, to provide efficient care, encourage the avoidance of unnecessary costs, and increase quality of care. In addition, we sought comments on promotion of the use of effective HIT through hospital conditions of participation (CoPs), perhaps by adding a requirement that hospitals use HIT that is compliant with and certified in its use of the HIT standards adopted by the Secretary. We anticipate that the American Health Information Community will provide advice to the Secretary on these issues.

We received 30 comments on this section. Below is a summary of the comments addressing: (1) CMS" statutory authority to encourage adoption of effective health information technology (HIT); (2) the role that HIT should play in value-based purchasing; and (3) whether CMS should promote the adoption of effective HIT through our CoPs. In addition to these areas in which we sought comments, we also received several comments on the challenges of implementing HIT, which were particularly focused on overcoming the high cost of implementation. We conclude the summary with additional commenter input on the adoption and use of HIT.

Comment: Seven comments addressed our statutory authority to encourage adoption and use of HIT. Two of the seven commenters stated that the HHS has the authority to encourage adoption of HIT. Those commenters referred to the Hill Burton Act, the Medicare Modernization Act, the Deficit Reduction Act, and the FY 2006 Health and Human Services Appropriations Act as bases for our statutory authority. Other commenters stated that we do not have the authority to encourage adoption and use of HIT. Those commenters pointed out the need for legislation to specifically authorize support for HIT implementation.

Nineteen commenters addressed the role of HIT in a value-based purchasing program. Only 2 of the 19 commenters stated that HIT should be directly tied to value-based purchasing. An overwhelming majority of the commenters believed that HIT funding should not be tied to value-based purchasing; rather those commenters stated that HIT implementation should be tied to increases in hospital payment. However, nearly all of the commenters agreed that use of effective HIT could increase health care quality, efficiency, patient safety, and care coordination. A few commenters recognized that HIT will likely reduce the burden of reporting to a value-based purchasing system.

We received 14 comments on the promotion of HIT through our CoPs. Of those comments, only three were in favor of including HIT in the CoPs. Of these comments, only three were in favor of including adoption of certified, interoperable HIT in the CoPs. The majority of commenters opposed this proposal and termed such a requirement a potential "unfunded mandate."

There were a total of 19 comments addressing the high costs associated with HIT implementation. Commenters identified cost as the greatest barrier to HIT implementation and stated that the short term benefits do not justify the costs. Several commenters noted that HIT is a public good and felt strongly that funding for HIT implementation should be provided through government loan guarantees and grants. Two commenters felt that safety-net hospitals should be the primary beneficiaries of any federal funding for HIT. One commenter observed that the governments of other countries funds HIT. Nine commenters observed that the proposed rule failed to recognize that a major finding of the RAND study was that HIT investments accrue more to the payers and purchasers than to hospitals and health systems, which the commenters believed indicates that purchasers and plans should make a greater share of investment in HIT.

We received 11 comments addressing the challenges of HIT implementation beyond costs. Many of the commenters noted that HIT adoption takes careful planning and requires many internal workflow process changes. Several comments addressed the variation in health care delivery systems and the vastly different needs for HIT across systems, as well as vastly differing abilities to accomplish HIT implementation. Many felt strongly that inoperability standards must precede implementation.

Several thoughtful ideas were addressed by a small proportion of commenters. Two commenters felt that until HIT is fully implemented, hospitals should be required to report a unique identifier for each coded procedure, capture referring and ordering providers for each procedure, record vital signs at presentation, include any do not resuscitate (DNR) orders, and record time of admission. Along the same lines, another commenter felt that until HIT is in place, hospitals should be required to notify dialysis facilities via phone, fax, or e-mail, when a kidney failure patient is admitted.

Response: We thank all commenters for their thoughtful and valuable discussion of the issues. In the HIT section of the preamble to the proposed rule, we recognized the potential for effective HIT to facilitate improvements in the quality and efficiency of health care services. We also pointed out CMS' promotion of the adoption and effective use of HIT in coordination with other Federal agencies and the Office of the National Coordinator of Health Information Technology. Here, we will discuss three areas that we are emphasizing to promote the effective use of HIT, in light of the comments we received: (1) Value-based purchasing, (2) the e-prescribing rule, and (3) infrastructure and interoperability standards. We believe that these activities will address the barriers to HIT implementation that were presented by the commenters and will increase the benefits of HIT adoption relative to the costs.

We continue our work toward the implementation of value-based purchasing payment system reforms because we believe that, among other advantages, value-based purchasing can encourage hospitals to invest in activities , such as effective HIT, that

have the potential to improve quality and decrease unnecessary costs. However, linking a portion of Medicare payments to valid measures of quality and effective use of resources could give hospitals more direct incentives to implement innovative ideas and approaches that may result in improved value of care. We agree with the commenters that noted that the use of effective HIT could increase quality, efficiency, patient safety, and care coordination. We also agree with the commenters that noted that effective use of HIT can be used to decrease the burden of reporting to value-based purchasing programs. However, we disagree with the commenters that recommended direct government funding of HIT. As stated in the President's 2007 Budget, "the Administration supports the adoption of [HIT] as a normal cost of doing business to ensure patients receive high quality care."

Commenters noted that multiple stakeholders in the health care system, including purchasers and payers, benefit from provider adoption and use of effective HIT and should share in the cost. CMS and OIG are in the process of issuing final rules to allow hospitals and other health care providers under some circumstances to donate electronic prescribing and electronic health records technology to physicians and others without running afoul of the Stark (physician self-referral) and anti-kickback statutes. We believe that these rules will facilitate the adoption of HIT by physicians and other health care providers who might otherwise have been unable or unwilling to invest in the technology. We also believe that these regulatory changes will help to stimulate the adoption of effective HIT, and that, as HIT use spreads, the benefits relative to the costs of implementation may increase for all stakeholders.

The majority of commenters pointed out that the current lack of HIT infrastructure, including lack of interoperability standards, is a major obstacle to adoption and effective use of HIT. To address the lack of infrastructure, the Secretary has undertaken a national strategy that calls for Federal agencies to collaborate with private stakeholders in the development of architecture, standards, certification processes, and methods of governance to facilitate the adoption of effective HIT. In September 2005, the Secretary selected 16 commissioners to serve on the American Health Information Community (AHIC), which is a federally chartered collaborative forum of private and public interests charged with advising the Secretary on how to make health information digital and interoperable. The goals of the Community include immediate access to vital medical information at the point of care, privacy protection, better data for research, and overall cost savings. The work of the Community has been divided among four workgroups: (1) the Electronic Health Records Workgroup, (2) the Chronic Care Workgroup, (3) the Consumer Empowerment Workgroup, and (4) the Biosurveillance Workgroup. The AHIC Workgroups have made recommendations, as their initial "breakthroughs," pertaining to: an electronic medication summary and registration history; secure messaging capabilities for individuals with chronic disease; biosurveillance monitoring; and, through secure means, broadening the availability and access to current and historical laboratory results and interpretations. More information about the Community is available at: *http://www.hhs.gov/healthit/ahic.html.*

In conclusion, we are not adopting at this time our proposal to require adoption of certified, interoperable HIT as a Medicare CoP. Rather, we are reserving judgment on the imposition of such a requirement and will continue to research the feasibility of doing so. We may revisit this issue in the FY 2008 IPPS proposed rule or in another rulemaking proceeding.

C. Sole Community Hospitals (SCHs) (§ 412.92) and Medicare-Dependent, Small Rural Hospitals (MDHs) (§ 412.108)

1. Background

Under the IPPS, special payment protections are provided to a sole community hospital (SCH). Section 1886(d)(5)(D)(iii) of the Act defines an SCH as a hospital that, by reason of factors such as isolated location, weather conditions, travel conditions, absence of other like hospitals (as determined by the Secretary), or historical designation by the Secretary as an essential access community hospital, is the sole source of inpatient hospital services reasonably available to Medicare beneficiaries. The regulations that set forth the criteria that a hospital must meet to be classified as an SCH are located in § 412.92.

Under the IPPS, separate special payment protections also are provided to a Medicare-dependent, small rural hospital (MDH). Section 1886(d)(5)(G)(iv) of the Act defines an MDH as a hospital that is located in a rural area, has not more than 100 beds, is not an SCH, and that has a high percentage of Medicare discharges (not less than 60 percent in its 1987 cost reporting year or in 2 of its most recent 3 audited and settled Medicare cost reporting years). The regulations that set forth the criteria that a hospital must meet to be classified as an MDH are located in § 412.108.

Although SCHs and MDHs are paid under special payment methodologies, they are section 1886(d) hospitals. Like all section 1886(d) IPPS hospitals, SCHs and MDHs are paid for their discharges based on the DRG weights calculated under section 1886(d)(4) of the Act.

Effective with hospital cost reporting periods beginning on or after October 1, 2000, section 1886(d)(5)(D)(i) of the Act (as amended by section 6003(e) of Pub. L. 101–239) and section 1886(b)(3)(I) of the Act (as added by section 405 of Pub. L. 106–113 and further amended by section 213 of Pub. L. 106–554), provide that SCHs are paid based on whichever of the following rates yields the greatest aggregate payment to the hospital for the cost reporting period:

- The Federal rate applicable to the hospital;
- The updated hospital-specific rate based on FY 1982 costs per discharge;
- The updated hospital-specific rate based on FY 1987 costs per discharge; or
- The updated hospital-specific rate based on FY 1996 costs per discharge.

For purposes of payment to SCHs for which the FY 1996 hospital-specific rate yields the greatest aggregate payment, payments for discharges during FYs 2001, 2002, and 2003 were based on a blend of the FY 1996 hospital-specific rate and the greater of the Federal rate or the updated FY 1982 or FY 1987 hospital-specific rate. For discharges during FY 2004 and subsequent fiscal years, payments based on the FY 1996 hospital-specific rate are 100 percent of the updated FY 1996 hospital-specific rate.

For each cost reporting period, the fiscal intermediary determines which of the payment options will yield the highest rate of payment to the SCH. Payments are automatically made at the highest rate using the best data available at the time the fiscal intermediary makes the determination. However, it may not be possible for the fiscal intermediary to determine in advance precisely which of the rates will yield the highest payment by year's end. In many instances, it is not possible to forecast the outlier payments, the amount of the DSH adjustment, or the IME adjustment, all of which are applicable only to payments based on the Federal rate. The fiscal intermediary makes a final adjustment at the close of the cost reporting period after it

determines precisely which of the payment rates would yield the highest payment to the hospital.

If an SCH disagrees with the fiscal intermediary's determination regarding the final amount of program payment to which it is entitled, it has the right to appeal the fiscal intermediary's decision in accordance with the procedures set forth in Subpart R of Part 405, which concern provider payment determinations and appeals.

Through and including FY 2006, under section 1886(d)(5)(G) of the Act, MDHs are paid based on the Federal national rate or, if higher, the Federal national rate plus 50 percent of the difference between the Federal national rate and the updated hospital-specific rate based on FY 1982 or FY 1987 costs per discharge, whichever is higher. However, section 5003 of Pub. L. 109–171 (DRA) modified these rules for discharges occurring on or after October 1, 2006. Section 5003(c) changed the 50-percent adjustment to 75 percent. Section 5003(b) requires that an MDH use the 2002 cost reporting year as its base year (that is, the FY 2002 hospital-specific rate), if that use results in a higher payment. An MDH does not have the option to use its FY 1996 hospital-specific rate. We discussed our proposed changes to implement section 5003 of the DRA in section IV.C.4 of the preamble to the FY 2007 IPPS proposed rule (71 FR 24104).

2. Volume Decrease Adjustment for SCHs and MDHs

Section 1886(d)(5)(D)(ii) of the Act requires that the Secretary make a payment adjustment to an SCH that experiences a decrease of more than 5 percent in its total number of inpatient discharges from one cost reporting period to the next, if the circumstances leading to the decline in discharges were beyond the SCH's control. Section 1886(d)(5)(G)(iii) of the Act requires that the Secretary make a payment adjustment to an MDH that experiences a decrease of more than 5 percent in its total number of inpatient discharges from one cost reporting period to the next, if the circumstances leading to the decline in discharges were beyond the MDH's control. These adjustments were designed to compensate an SCH or MDH for the fixed costs it incurs in the year following the reduction in discharges (this is, the second year), which it may be unable to reduce. Such costs include the maintenance of necessary core staff and services. Our records indicate that three to four SCHs/MDHs request this adjustment each year.

However, we believe that not all staff costs can be considered fixed costs. Using a standardized formula specified by us, the SCH or MDH must demonstrate that it appropriately adjusted the number of staff in inpatient areas of the hospital based on the decrease in the number of inpatient days. This formula examines nursing staff in particular. If an SCH or MDH has an excess number of nursing staff, the cost of maintaining those staff members is deducted from the total adjustment. One exception to this policy is that no SCH or MDH may reduce its number of staff to a level below what is required by State or local law. In other words, an SCH or MDH will not be penalized for maintaining a level of staff that is consistent with State or local requirements.

The process for determining the amount of the volume decrease adjustment can be found in section 2810.1 of the Provider Reimbursement Manual. Fiscal intermediaries are responsible for establishing whether an SCH or MDH is eligible for a volume decrease adjustment and, if so, the amount of the adjustment. To qualify for this adjustment, the SCH or MDH must demonstrate that: (a) A 5 percent or more decrease of total discharges has occurred; and (b) the circumstance that caused the decrease in discharges was beyond the control of the hospital. Once the fiscal intermediary has established that the SCH or MDH satisfies these two requirements, it will calculate the adjustment. The adjustment amount is determined by subtracting the second year's DRG payment from the lesser of: (a) The second year's costs minus any adjustment for excess staff; or (b) the previous year's costs multiplied by the appropriate IPPS update factor minus any adjustment for excess staff. The SCH or MDH receives the difference in a lump-sum payment.

The adjustment for excess staff is currently broken into two parts: the routine acute care area (excluding intensive care unit areas) excess staff adjustment and the intensive care unit excess staff adjustment. (For purposes of this section of the preamble, any subsequent references to the routine acute care area of an SCH or MDH refer to the routine acute care area excluding any intensive care unit areas.) In order to determine whether or not the hospital is appropriately staffing its routine acute care and its intensive care unit area, the fiscal intermediary compares the hospital's actual number of nursing staff in each area with the staffing of like-size hospitals in the same census region. Currently, fiscal intermediaries obtain average nurse staffing data from the American Hospital Association's HAS/Monitrend Data Book. (More information on the HAS/Monitrend Data Book follows.) If a hospital employs more than the reported average number of nurses in the routine acute care or intensive care unit area for hospitals of its size and census region, the fiscal intermediary reduces the amount of the adjustment by the cost of maintaining the additional staff. The amount of the reduction is calculated by multiplying the actual number of nursing staff above the reported average by the average nurse salary for that hospital as reported on the Medicare cost report. The complete process for determining the amount of the adjustment can be found at section 2810.1 of the Provider Reimbursement Manual.

Representatives from several SCH and MDH hospitals have contacted CMS with concerns regarding the current use of the HAS/Monitrend data for determining the volume decrease adjustment for SCHs and MDHs. Because the most recent HAS/Monitrend Data Book was published in 1989 and is no longer updated, the hospitals expressed concern that the information in the publication is too outdated for current use. Therefore, in the FY 2007 IPPS proposed rule (71 FR 24102), we presented for public comment a new methodology for calculating the adjustment for excess staff.

a. HAS/Monitrend Data

From the mid-1960's to 1989, the Healthcare Administrative Services Division of the American Hospital Association (AHA) published biannually the HAS/Monitrend Data Book, a collection of aggregate hospital statistics. Hospitals completed surveys based on 6 months of data; these data were categorized into one of five bed-size groups and into one of nine census regions. The bed size groups were 0–49, 50–99, 100–199, 200–399, and 400 or more beds. The census regions include: (1) New England (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont); (2) Middle Atlantic (New Jersey, New York, and Pennsylvania); (3) South Atlantic (Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, and West Virginia); (4) East North Central (Illinois, Indiana, Michigan, Ohio, and Wisconsin); (5) East South Central (Alabama, Kentucky, Mississippi, and Tennessee); (6) West North Central (Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, and South Dakota); (7) West South Central (Arkansas, Louisiana, Oklahoma, and Texas); (8) Mountain (Arizona, Colorado, Idaho, Montana, Nevada, New

Mexico, Utah, and Wyoming); and (9) Pacific (Alaska, California, Hawaii, Oregon, and Washington).

The survey collected data on nearly 400 items pertaining to utilization, resource allocation, departmental productivity, departmental direct expenses, and staffing. In order for aggregate data to be published for a category, at least three hospitals in the same census region and bed-size group had to have responded to the survey. For the final 1989 publication, 996 acute care hospitals completed the survey. CMS has used the HAS/Monitrend Data Book since 1984 to determine the volume decrease adjustment for SCHs; the data also have been used for the volume decrease adjustment for MDHs since 1990. In particular, CMS has used the HAS/Monitrend data on the number of paid nursing hours per patient day ("paid hours/patient day") in both the general acute care area ("Medical and Surgical Units") and the intensive care unit ("Med & Surg Intensive Care Unit"). More information on the HAS/Monitrend Data Book is available from the American Hospital Association, 840 North Lake Shore Drive, Chicago, Illinois 60611.

b. HAS/Monitrend Data Book Replacement Alternative

In the FY 2007 IPPS proposed rule (71 FR 24102), we proposed an alternative method for determining an SCH's or MDH's target number of core staff using data from the Medicare cost report and the occupational mix survey. However, this methodology would only establish one combined average number of nursing hours per patient day for both the inpatient routine care and the intensive care unit areas. We proposed to use the Medicare cost report and occupational mix survey data beginning with requests for adjustments for FY 2008 cost reports. We invited comments from the public on this proposal.

(1) Occupational Mix Survey

As discussed in the FY 2007 IPPS proposed rule (71 FR 24075), the CMS occupational mix survey collects from each hospital data on the mix of employees in the areas of the hospital payable under the IPPS for a limited number of hospital occupational categories. For the 2006 survey, these categories include registered nurses, licensed practical nurses, aides, orderlies, attendants, and medical assistants. The registered nurse subcategory includes two functional subcategories: management personnel and staff nurses or clinicians. For example, hospitals may choose to employ different combinations of registered nurses, licensed practical nurses, and nurses' aides for the purpose of providing nursing care to their patients. The varying labor costs associated with these choices reflect hospital management decisions rather than geographic differences in the costs of labor. The data collected on the survey are used to adjust hospitals' wage data to account for each hospital's mix within the general occupational categories. Hospitals completed the first occupational mix survey using FY 2003 data. A second survey will be completed this year (FY 2006).

Under the proposed method, we would calculate the nursing hours per inpatient day for each SCH or MDH by dividing the number of paid nursing hours (for registered nurses, licensed practical nurses, and nursing aides) reported on the occupational mix survey by the number of inpatient days reported on the Medicare cost report. The results would be grouped into the same bed-size groups and census regions as the HAS/Monitrend Data Book. CMS would publish the mean number of nursing hours per patient day for each census region and bed-size group in the **Federal Register**. (We proposed to include licensed practical nurse and nursing aide hours as well as registered nurse hours to reflect the various levels of nursing staff employed by hospitals to provide direct patient care.)

The results that would be published in the **Federal Register** would be the target number of core nursing hours per patient day. For purposes of the volume decrease adjustment, the published data would be utilized in the same way as the HAS/Monitrend data: The fiscal intermediary would multiply the SCH's or MDH's number of inpatient days by the applicable published hours per patient day. This figure would be divided by the average number of worked hours per year per nurse (for example, 2,080 for a standard 40-hour week). The result would be the target number of core nursing staff for the particular SCH or MDH. If necessary, the cost of any excess staff (number of FTEs that exceed the published number) would be removed from the second year's costs or, if applicable, the previous year's costs multiplied by the IPPS update factor when determining the volume decrease adjustment. Because we would consider registered nurses, licensed practical nurses, and nursing aides, the fiscal intermediary would calculate the excess staff adjustment by multiplying the number of excess staff by the average salary among the three groups, taking into account how many registered nurses, licensed practical nurses, and nursing aides work at the facility. (For instance, if the hospital's average salary for a registered nurse is $50,000 and the hospital's average salary for a licensed practical nurse is $30,000 and the hospital employs 5 registered nurses, 3 licensed practical nurses, and no nursing aides, the calculated average salary would be $42,500 for one FTE $(((5 \times \$50{,}000) + (3 \times \$30{,}000))/8 = \$42{,}500)$.

We proposed to use the results of the FY 2006 occupational mix survey and begin applying the proposed methodology for adjustments resulting from a decrease in discharges between FYs 2007 to 2008. Because the occupational mix survey is conducted once every 3 years, we would update the data set every 3 years. We proposed to use the FY 2006 survey results and not to utilize the FY 2003 survey results to take into account comments we received in response to the first set of results from the occupational mix survey, and to ensure that hospitals have had some experience with the occupational mix survey before it is used in determining these adjustments. Because we have used the HAS/Monitrend data for so many years, we stated our belief that it was appropriate to continue to use these data for one more year and wait for the results of the FY 2006 survey. We stated that this would give hospitals an opportunity to have some experience with the occupational mix survey before it is used in these adjustments, and would allow us to compare the data from the FY 2006 occupational mix survey with the data reported in the 2003 survey, if necessary. However, for purposes of describing how we would implement this methodology, we applied the proposed calculation to the FY 2003 occupational mix survey data. While we did not propose to use the FY 2003 data, we stated our belief that it was the best data available at the time to help explain our proposed methodology.

To calculate the results below, we merged the FY 2003 occupational mix survey results into the FY 2003 cost report file. We eliminated all observations for non-IPPS providers, providers who failed to complete the occupational mix survey, and providers for which provider numbers, bed counts and/or day counts were missing. We also only included providers with 12 months' worth of data. This resulted in a pool of approximately 3,541 providers.

For each provider in this pool, we calculated the number of nursing hours by adding the number of registered nurse, license practical nurse, and nursing aide hours reported on the occupational mix survey. We divided

the result of this calculation by the total number of inpatient days reported on the cost report to determine the number of nursing hours per patient day.

For purposes of calculating the census regional averages for the various bed-size groups, we proposed to only include observations that fall within 3 standard deviations of the mean of all observations, thus removing potential outliers in the data. Below are the results of this calculation.

We realize that, in the chart, some results may appear to be anomalous (for example, 0–49 beds for census regions 4, 6, and 8). We believe a small number of outlier data may have skewed the mean, which was the basis for identifying data within 3 standard deviations to include in the calculations. Therefore, we solicited comments on whether we should consider another method for determining the appropriateness of using available data in calculating the average number of nursing hours per patient day. For instance, in this case, the results are based on the inclusion of data within 3 standard deviations of the mean. Alternatively, we stated that we could use another measure of central tendency.

PAID NURSING HOURS PER PATIENT DAY

Number of beds	Census region								
	1	2	3	4	5	6	7	8	9
0–49	16.38	8.33	19.26	30.76	11.72	26.70	20.50	31.00	17.39
50–99	13.71	11.07	15.66	17.37	13.69	15.53	12.51	16.63	16.11
100–199	11.98	10.99	14.38	13.44	11.93	17.03	13.91	14.33	13.32
200–399	12.40	12.19	14.19	13.00	10.57	16.20	11.35	14.06	15.33
400 or more	13.32	9.42	12.77	15.39	9.51	19.70	12.36	17.64	13.32

(2) American Hospital Association Annual Hospital Survey

In the process of evaluating different sources of data to replace the HAS/Monitrend Data Book, we considered using the results of the AHA's Annual Hospital Survey. This survey includes over 700 data fields that cover facilities and services, utilization, finances, and staffing. On average, 6,000 hospitals complete the survey each year. Section E of the Annual Survey Database includes total facility staffing data. FTE counts are available for registered nurses, practical and vocational nurses, nursing assistive personnel, and other personnel. However, FTEs in outpatient areas, excluded units, and nursing home units within the hospital are also included in the aggregated FTE counts. It is not possible to separately identify how many of the total reported nursing FTEs are attributable to the general acute care facility and how many to a distinct part unit or outpatient facility. Due to varying staffing needs in distinct part units and outpatient areas, in the proposed rule we stated our belief that it would be best for any calculation of average staffing for the inpatient acute care area to consist of data solely from the inpatient acute care area of the hospital. In the FY 2007 IPPS proposed rule (71 FR 24104), we requested comments on this issue.

We received 16 public comments on our proposal.

Comment: Many commenters believed that it is not appropriate to use the FY 2006 occupational mix survey for making determinations under the volume decrease adjustment. The commenters believed the FY 2006 occupational mix survey consists of unreliable data due to the rushed nature of the collection. The commenters suggested that CMS use the AHA Annual Survey data to determine nursing levels per patient day. One commenter expressed concern that the data from the occupational mix survey and the hospital cost report data were not for the same time period and that annualizing the data from the occupational mix survey may distort the data. Another commenter noted that the occupational mix survey collects data from ancillary areas similar to the AHA Annual Survey data and, therefore, use of either data source would result in a similar calculation. One commenter recommended that CMS work with the AHA to develop a new survey tool to collect this information. In the interim, the commenter recommended continuing to use the latest HAS Monitrend data.

One commenter suggested that CMS no longer require fiscal intermediaries to compare a hospital's nursing staff per patient day with other hospitals of like size in the same area. Rather, the commenter suggested that fiscal intermediaries should be able to evaluate a hospital's individual needs and circumstances. The commenter also suggested that CMS only consider registered nurse and licensed practical nurse hours and eliminate nursing aide hours from the calculation. The commenter further suggested that CMS compare SCHs and MDHs to a smaller sample than the current census regions; for instance, CMS could compare hospitals in the same State.

Response: We do not agree with the commenters who stated that the occupational mix survey results are unreliable. The data is supplied solely by hospitals, and because this is the second time hospitals have completed the survey, we believe they are familiar with the requirements and are providing accurate information. In addition, although the collection may have been more hurried in 2006 due to the *Bellevue* decision, as explained in section III.C. of this preamble, hospitals had opportunities to review, validate and correct their occupational mix data. For 2006, the occupational mix collection will include three months of data. Therefore, it will be necessary to annualize the data to reflect staffing levels for a one year period. We do not believe this distorts an individual hospital's average staffing levels throughout the year unless the hospital experiences a unique event that either greatly increases or reduces hospital utilization and/or the hospital's ability to recruit and maintain staff. However, it is for this reason that we require a minimum number of hospitals in each bed-size/census group to have reported staffing data before calculating an average for that category. We believe that by combining the results of at least three hospitals of like size in an area, we reduce the chance of unique events affecting individual hospitals distorting the averages.

As previously mentioned, we stated in the proposed rule that it would be best to collect nursing data from only the inpatient, acute care portion of the hospital and that this would be a justification for using occupational mix survey data. However, in this final rule, we are correcting this statement, since the occupational mix survey—like the wage survey—collects data on both the

inpatient and outpatient areas of the hospital. Also, it is our understanding that hospital nursing staff may, and often do, rotate between the inpatient and outpatient areas of the hospital as necessary. In addition, inpatients often utilize services in the outpatient (or ancillary) areas of the hospital. Given that the occupational mix survey collects data on both outpatient and inpatient areas of the hospital, and given that most commenters stated that they preferred to use the AHA Annual Survey data and not the occupational mix data, our final policy will be to allow an SCH or MDH that has experienced a 5 percent or greater reduction in the number of discharges from one cost reporting period to the next the option of using either the AHA Annual Survey results or the occupational mix data to compare the number of hospital's core staff with other like-sized hospitals in its geographic area.

We recognize that the AHA data includes staffing data from distinct part units and skilled nursing facilities. While it is possible to identify which hospitals have skilled nursing facilities, it is not possible to distinguish between those hospitals with distinct part units and those without. Our data indicate that there are currently 1230 hospital-based skilled nursing facilities. If we eliminated all hospitals with skilled nursing facilities from the pool of comparison hospitals that responded to the FY 2004 AHA Annual Survey, roughly 3,000 hospitals would remain. We believe this is a sufficient number of hospitals with which to calculate staffing averages and our final policy will be that when using the AHA Annual Survey, we will eliminate hospitals with hospital-based skilled nursing facilities. Also, consistent with the HAS/Monitrend Databook, we will only calculate the average number of nursing staff for a bed-size/census group if there are data available for three or more hospitals.

In order to account for staff in the distinct part units, we would include in the patient day count the number of inpatient days from these units. While this may still lower the average number of staff per patient day, as discussed in more detail later in this section, a hospital may decide whether this data most closely resembles its staffing or whether the HAS/Monitrend data or occupational mix data better represents hospitals in its bed-size/census group. In light of this, we do not believe it is necessary for the AHA to develop a new survey tool to collect staffing information for purposes of this adjustment.

In response to the commenter who suggested that the fiscal intermediaries take into account the individual circumstances of each SCH/MDH that experiences a decrease in discharges, we note that the commenter failed to suggest how this may be achieved. In light of our goal of maintaining a uniform standard for calculating the amount of the volume decrease adjustments, we believe that it is more appropriate for the fiscal intermediaries to utilize either the same or comparable data sources for all hospitals. The AHA Annual Survey, occupational mix survey, and HAS/Monitrend Databook offer this standard. We note, however, that the AHA Annual Survey, the occupational mix survey and the HAS/Monitrend Databook are not identical data sources, as described above. Therefore, fiscal intermediaries and hospitals should work together to determine which data source best represents the staffing needs of the hospital. In addition, the fiscal intermediaries must consider any minimum staffing requirement set by the State. If the average number of nursing hours per patient day for a bed-size/census group is below the State's minimum staffing requirement, the fiscal intermediaries may not reduce the amount of a hospital's volume decrease adjustment to reflect a core number of nursing staff below what is required by law. In addition, we are continuing to employ the census areas defined by the AHA in the HAS/Monitrend Databook. The larger size of the census areas ensures that a sufficient number of hospitals respond in every bed-size category for each census region.

We have considered the commenter's statement that we should only consider registered nurse and licensed practical nurse staff when computing the number of nursing staff per patient day. However, we believe that nursing aides play an integral part in the delivery of nursing care and, therefore, should be considered part of the hospital's nursing staff for purposes of this determination. Therefore, we will continue to calculate the average number of reported registered nurse, licensed practical nurse, and nursing aide hours per patient day. As previously noted, the registered nurse, licensed practical nurse, and nursing aide FTEs in the AHA Annual Survey data include employees from outpatient areas and distinct part units of the hospital. Therefore, the fiscal intermediaries will include SCH or MDH registered nurse, licensed practical nurse, and nursing aide FTEs for all areas of the hospital, including any distinct part units, when conducting the comparison.

We had proposed to use the results of the 2006 occupational mix survey but not until FY 2008. At that time, we were not aware that we would have the results of the FY 2006 survey available to use for adjustments for decreases in discharges occurring in 2006. However, due to the shortened collection period necessitated by the decision in *Bellevue Hospital Center* v. *Leavitt*, these data will now be available for use for volume decrease adjustments for decreases in discharges between the 2005 and 2006 cost reporting periods. These data will be updated every 3 years. The results of the FY 2006 survey may be used for volume decrease adjustment calculations for decreases in discharges occurring during the 2006, 2007 and 2008 cost reporting periods.

After consideration of the public comments received, we are finalizing a policy to allow SCHs and MDHs the option of using the results of (1) the occupational mix survey, (2) the AHA Annual Survey, or (3) the HAS/Monitrend Databook for purposes of determining the amount of the volume decrease adjustment for any open adjustment requests. Beginning with adjustment requests for decreases in discharges occurring beginning with 2007, the amount of the volume decrease adjustment will be based on either the AHA Annual Survey or the occupational mix survey results. Therefore a SCH or MDH that has experienced a decrease in discharges in 2007 as compared to 2006 will no longer be permitted to use the HAS/Monitrend Databook results to calculate the amount of the volume decrease adjustment.

If the SCH/MDH opts to use the results of the occupational mix survey, the fiscal intermediaries will determine the SCH's or MDH's total hospital nursing staff per inpatient day for the year of the volume decrease and compare that figure to the number published for the hospital's census area and bed-size division. As described in the FY 2007 proposed rule, we will calculate the average number of nursing hours per patient day for all IPPS hospitals that responded to the occupational mix survey. We will begin by annualizing the results. We will then divide this figure by the number of inpatient days reported on the hospital cost report. At this point, we will eliminate results that fall outside three standard deviations of the mean in order to eliminate any potential outlier data. Hospitals will then be grouped by bed-size and census area and the average number of nursing hours per patient day will be calculated. We will post the

results of the occupational mix survey grouped by census division and bed-size group on the CMS Web site. Core staffing results and salaries will be compared to the salaries reported for *both* the inpatient and outpatient areas of the hospital.

In place of the occupational mix survey results (or the HAS/Monitrend Databook, which may be used only for open adjustment requests) hospitals may also opt to use the AHA Annual Survey results. Where available, these AHA Annual Survey Results may be used for all open adjustment requests, as well as for requests involving decreases experienced in 2007 or thereafter. Currently, the AHA has published the annual results including the FY 2004 survey. Fiscal intermediaries will use the survey results from the year in which the decrease occurred. For instance, if a hospital experiences a decrease between its 2002 and 2003 cost reporting periods, the fiscal intermediaries will compare the hospital's 2003 staffing with the results of the FY 2003 AHA Annual Survey. We will calculate the results of the Annual Survey in a similar method to the occupational mix survey (eliminating from our data-set any hospitals with hospital-based SNFs). We will begin by multiplying the number of reported nurse FTEs by 2080 to derive the number of nursing hours per year (based on a 40 hour work week). We will then divide this number by the total number of inpatient days, including inpatient days from distinct part units, as reported on the hospital cost report. We will then eliminate all providers with results outside of three standard deviations from the mean. The hospitals will then be grouped by bed-size and census area and the average number of nursing hours per patient day will be calculated for each category. If the hospital chooses to use the results of the AHA Annual Survey, the fiscal intermediary will include the hospital's number of nursing staff in the distinct part units, as well as distinct part unit inpatient days, in the determination. Bed-size groups will also be determined based on the total number of beds in the inpatient areas and distinct part units as reported on the hospital cost report. We will post the results of the Annual Survey grouped by census division and bed-size group on the CMS Web site. If a particular year is unavailable on the Web site or there are no results for a particular bed-size/census group, the fiscal intermediaries may contact CMS for the data.

If the fiscal intermediary determines that the SCH or MDH has a disproportionately high number of staff on a per inpatient day basis as compared to area hospitals, the fiscal intermediary will modify the amount of the adjustment to reflect the cost of the excess staff. As stated above, because we are including registered nurses, licensed practical nurses, and nursing aides in this determination, the fiscal intermediary will calculate the excess staff adjustment by multiplying the number of excess staff by the average weighted salary among the three groups, taking into account the number of registered nurses, licensed practical nurses, and nursing aides at the facility.

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

Under § 412.92(b)(3) and § 412.108(b)(4) respectively, once a facility has been designated as an SCH or MDH, the classification remains in effect without need for reapproval unless there is a change in the hospital's circumstances. Currently, the regulations do not contain an explicit requirement that an SCH report to CMS or the fiscal intermediary a change in circumstances that would affect its status as an SCH. Likewise, the current regulations for MDHs do not contain an explicit requirement that an MDH report to CMS or the fiscal intermediary a change in the circumstances affecting its MDH status. However, the fiscal intermediary is required to evaluate on an ongoing basis whether a hospital continues to qualify for MDH status.

We have become aware of several hospitals that have been paid based on SCH or MDH status even after the original circumstances that led to the respective classification changed. In the FY 2007 IPPS proposed rule (71 FR 24104), we proposed to amend § 412.92(b)(3) for SCHs and § 412.108(b)(4) for MDHs to require an SCH or MDH to report to its appropriate CMS Regional Office when the circumstances under which the hospital was approved for SCH or MDH status have changed. The CMS Regional Office would then determine whether the SCH or MDH continues to meet the criteria for classification under § 412.92 or § 412.108. If an SCH or MDH no longer meets these criteria, the CMS Regional Office would issue a letter canceling the classification within 30 days of its determination. If the circumstances affecting a hospital's SCH or MDH classification change and the hospital does not disclose the information to the CMS Regional Office, CMS would cancel the hospital's SCH or MDH designation effective on the earliest discernable date on which the fiscal intermediary can determine that the hospital no longer met the criteria for classification.

For MDHs, this reporting requirement is in addition to the fiscal intermediary's ongoing evaluations of whether a hospital continues to qualify for MDH status as set out in our existing regulations at § 412.108(b)(5).

We received 41 comments on this proposal.

Comment: Most commenters agreed that hospitals that no longer meet the qualification criteria for either SCH or MDH status should not continue to be paid as SCHs or MDHs. However, several commenters disagreed with the proposed requirement that an SCH or MDH notify the CMS Regional Office when any change in the circumstances that led to their classification occurs. They contended that the fiscal intermediary should be responsible for monitoring such conditions. One commenter argued that hospitals should not be required to report changes they cannot control, such as the building of new roads or hospitals.

Another commenter noted that some of the criteria are very difficult for hospitals to monitor, such as patient stays at other hospitals in the area. The commenter stated that to monitor these criteria would impose a tremendous administrative burden on SCHs and MDHs.

One commenter suggested that if CMS is to require that an SCH or MDH report on changes in the circumstances that led to its classification, the circumstances required to be reported be limited to those for which the hospital has readily available data, such as the opening of a new hospital within an SCH's mileage criterion. One commenter suggested that CMS not finalize any reporting requirement for SCHs or MDHs.

Response: We understand that some criteria may be difficult for hospitals to monitor. However, because a hospital cannot control the changes in circumstances should not imply that the hospital not be required to report changes of which it becomes aware. We agree with the commenters who suggested that certain criteria may be excessively burdensome for a hospital to monitor because they do not have ready access to the necessary data. For instance, we recognize that a hospital may not have the resources available to determine what percentage of patients in their service area has been admitted to other facilities in that area. For this reason, CMS often provides this data to hospitals seeking initial SCH classification. Therefore, we are modifying the change to the regulations to specify that SCHs will only be

expected to report changes that would effect the distance between it and another like-hospital, its geographic classification status (urban/rural), the number of beds (if the SCH was eligible under § 412.92(a)(1)(ii)), and travel time between itself and a like-provider. For instance, an SCH would be expected to report the opening of a new hospital or road, whether its geographic classification changed from rural to urban, and/or an increase in the number of beds at the hospital if the SCH was eligible under § 412.92(a)(1)(ii). An MDH would only be required to report if there is a change to the number of beds in the facility that increase the bed count to more than 100 and/or if its geographic classification changed from rural to urban. We will not expect an SCH or MDH to have knowledge of other factors that could affect SCH or MDH status. However, if it is subsequently shown that the hospital had knowledge of those factors, we would terminate SCH or MDH status as of the date the hospital became aware of the event. For example, we would not expect an SCH to be aware of the conversion of a nearby CAH to a short term acute care hospital. However, if there is documentation clearly indicating that the SCH had prior knowledge of the CAH's conversion and the converted hospital is located within the mileage criterion precluding SCH status, we will rescind the SCH designation to the time when the documentation indicates the SCH became aware of the conversion. The SCH/MDH must report any changes of which it becomes aware that affect SCH or MDH status within 30 days of the event occurring. We are updating the regulations text at § 412.92 and § 412.108 to reflect these requirements.

We are also modifying the proposed change to the regulations to require that an SCH or MDH report any changes to the fiscal intermediary and not the regional office. Fiscal intermediaries are responsible for accepting and reviewing applications for SCH and MDH designations. Therefore, we believe it is appropriate for all documentation to continue to be sent to the fiscal intermediary. The fiscal intermediary will forward the information submitted by the SCH or the MDH and its recommendation to the appropriate regional office.

Comment: Several commenters disagreed with the proposal to "retroactively" withdraw SCH or MDH classification if it could be expected that the hospital was aware of a change in the circumstances that led to its classification but did not report those changes to the fiscal intermediary. The commenters noted that such a change in reimbursement could be financially devastating to a hospital and recommended that CMS develop a prospective process for withdrawing the hospital's special payment status. One commenter suggested that an SCH or MDH in such a position lose their status immediately, but not retroactively. Several commenters requested clarification of how far back CMS would retroactively terminate SCH or MDH status.

Response: As explained earlier, we have modified the proposal to withdraw SCH or MDH status when the provider was expected to be aware of limited changes in circumstances that caused the provider to be no longer eligible for such designation or when documentation shows that an SCH or MDH was aware of a change outside of those listed in the revised regulations at § 412.92(b)(3)(ii) and § 412.108(b)(4)(ii) that would affect its classification and did not report these changes to the fiscal intermediary. In those circumstances, we believe it is appropriate to withdraw the special payment rate effective with the date the change occurred or, with respect to changes that an SCH or MDH is not required to report, when the provider becomes aware of the event. However, we understand the need to establish a limit to how far back CMS may rescind SCH or MDH status. We believe that withdrawal of the classification status falls within the framework of the reopening rules at 42 CFR 405.1885. Accordingly, we will withdraw such status for cost reporting periods that are within the 3-year reopening period. Therefore, if the triggering event (as noted in the revised regulations) changes the circumstances under which the SCH or the MDH received such designation occurs within the three-year reopening period, under the reopening rules, we will withdraw the SCH or MDH designation for those periods. If the event occurred prior to the 3-year reopening period, we will only withdraw SCH or MDH designation for those cost reporting periods subject to the reopening period.

Comment: Several commenters expressed concern that an SCH or MDH would be penalized for a change in circumstances even if it were unaware of such a change.

Response: If an SCH or an MDH is not expected to be aware of a change in circumstances, they will not be penalized if one has occurred and it is not reported. We acknowledge the commenter's concern and as noted above revised the regulations to take his concern into account. If due to the change in circumstances the SCH or the MDH is out of compliance with the criteria for classification and the change was not one of those specifically listed above and the SCH or MDH was not previously aware of the change, the provider's status will be terminated 30 days after the Regional Office has determined that the provider no longer meets the criteria for classification.

Comment: Several commenters disagreed with the termination of SCH or MDH status within 30 days of the determination that the hospital no longer met the qualifications for such status. One commenter suggested that CMS continue to pay the provider as an SCH or MDH for either 6 months or to the end of the cost reporting period, whichever comes later. Several commenters suggested that CMS extend the period to 12 months. One commenter requested that CMS only finalize these policies for future SCHs and MDHs, in effect grandfathering all current SCHs and MDHs.

Response: We do not agree that an SCH or an MDH that no longer meets the eligibility requirements for such designation should continue to receive enhanced payments. Currently, when the Regional Office determines that an SCH or MDH no longer meets the classification criteria, it issues a letter informing the provider that in 30 days the SCH or MDH status will terminate. As noted above, we will only terminate the provider's status 30 days after the Regional Office has determined that the provider no longer meets the criteria for classification if due to a change in circumstances the SCH or the MDH is out of compliance with the criteria for classification and the change was not one of those specifically listed above and the SCH or MDH was not previously aware of the change.

Comment; One commenter requested that CMS retain the current grandfathering provision for SCHs that permits any hospital that was an SCH as of December 19, 1989 to maintain that status despite any change of circumstances.

Response: Section 6003(e)(1) of Pub. L. 101–239 modified the criteria for being eligible for SCH status by reducing the number of miles between providers from 50 to 35 and by requiring the Secretary to establish a criterion that takes into consideration the travel time between two providers. Section 6003(e)(3) of Pub. L. 101–239 exempted hospitals that already had SCH status from meeting either of these requirements. In other words, any hospital that was an SCH in 1989 is protected under this grandfathering provision from the mileage criterion and whether or not it meets the criterion for

classification concerning travel time at § 412.92(a)(3). However, we note that this grandfathering provision is limited to these two circumstances. Hospitals with SCH designation in effect prior to 1989 can lose SCH status if they fail to meet any of the other eligibility criteria.

Comment: One commenter suggested that CMS use this rule to change the regulation at § 412.92(a)(1)(i), which requires that no more than 25 percent of residents who become hospital inpatients or 25 percent of Medicare beneficiaries who become hospital inpatients in the hospital's service area are admitted to other like hospitals within a 35-mile radius, or, if larger, the hospital's service area. The commenter suggested that CMS require that either an SCH initially meet this requirement but later meet a lower threshold or that the SCH be required to demonstrate compliance in two out of the three most recent cost reporting periods.

Response: We believe that this comment falls outside the scope of the proposed change in policy. However, we will keep this comment in mind when evaluating SCH policy in the future.

Comment: Several commenters requested that CMS revise the definition of "like hospital," especially in response to the growing number of specialty hospitals. Several commenters recommended that CMS not consider a specialty hospital to be a "like hospital" for purposes of determining eligibility and compliance with SCH criteria. One commenter expressed concern that the policy of considering any hospital whose number of inpatient days from units or wards generally payable under the IPPS is 8 percent or more of the total number of inpatient days from units or wards generally payable under the IPPS at the SCH a "like hospital" is arbitrary and should be reviewed. The commenter suggested that CMS increase the 8-percent threshold to at least 10 percent. Another commenter requested that CMS allow SCHs to retain its status even if a like hospital opens in its service area as long as the SCH's case mix index exceeds those of the like hospitals.

Response: While we understand the commenters' concerns, we believe that this comment is outside of the scope of the proposed policy change. However, we will keep this comment in mind when evaluating SCH policy in the future. In the meantime, we refer commenters to the discussion of "like hospital" in the preamble of the FY 2003 IPPS final rule (67 FR 50053–56). As we noted in that preamble, our goal for defining "like hospital" was to strike a balance between the need to ensure that SCHs do not lose their special status due to specialty hospitals opening nearby and the need to ensure that only hospitals that are the sole source of short-term acute hospitals services for their community qualify as SCHs. We originally proposed to consider any hospital that overlapped on 3 percent of more of services rendered to be considered a like hospital. However, in response to the public comments received, we finalized a definition of "like hospital" as a hospital paid under the IPPS with 8 percent or more of the total number of inpatient days as the SCH.

After consideration of the public comments received, we are finalizing a change to the regulations to specify that SCHs and MDHs will be required to report to the fiscal intermediary specific changes it becomes aware of that would affect the criteria under which it was eligible for such designation. For an SCH, the changes are as follows: distance between it and another like hospital, its geographic classification status (urban/rural), the number of beds if the SCH was eligible under § 412.92(a)(1)(ii), and the travel time between itself and a like-provider. An MDH will be required to report if there is a change to the number of beds in the facility that increase the bed count to more than 100 and/or if its geographic classification changed from rural to urban.

4. Payment Changes for MDHs Under the DRA of 2005 (§ 412.79, § 412.90(j) and § 412.108)

a. Background

Under § 412.108(a) of our regulations, in order to be classified as an MDH, a hospital must: (1) Be located in a rural area (as defined in 42 CFR Part 412, Subpart D); (2) have 100 or fewer beds (as defined at § 412.105(b)) during the cost reporting period; (3) must not be classified as an SCH (as defined in § 412.92); and (4) have no less than 60 percent of its inpatient days or discharges attributable to inpatients receiving Medicare Part A benefits during either its cost reporting period beginning in FY 1987, or in two of the last three of its audited cost reports that have been settled.

MDHs have been eligible for a series of special payment rates under the IPPS. Section 6003(f) of Pub. L. 101–239 created the first IPPS special payment methodology for MDHs. Effective for cost reporting periods beginning on or after April 1, 1990, and ending on or before March 31, 1993, an MDH was paid based on whichever of the following rates yielded the greatest aggregate payment for the cost reporting period:

- The Federal payment rate applicable to the MDH;
- The MDH's updated hospital-specific rate based on its FY 1982 base period costs per discharge; or
- The MDH's updated hospital-specific rate based on its FY 1987 base period costs per discharge.

Section 13501(e)(1) Pub. L. 103–66 extended the MDH payment provisions through 1994 and provided that, for discharges occurring after March 31, 1993, if an MDH's applicable hospital-specific rate exceeded the Federal payment rate, the additional payment was limited to 50 percent of the amount by which the applicable updated hospital-specific rate exceeded the Federal rate. These provisions expired effective for cost reporting periods beginning on or after October 1, 1994.

Section 4204(a)(3) of Pub. L. 105–33 amended sections 1886(d)(5)(G)(i) and (d)(5)(G)(ii)(II) of the Act to reinstate these special MDH payment provisions, including the 50-percent limitation, for cost reporting periods "beginning on or after October 1, 1997, and before October 1, 2001." Section 321(b)(1) of Pub. L. 106-113 made a technical amendment to these provisions of the Act (which describes the time periods for which some of the special payment provisions apply and the time periods during which a hospital may be considered an MDH under section 1886(d)(1)(G)(iv) of the Act) by striking the language "beginning on or after October 1, 1997, and before October 1, 2001" and replacing it with "discharges occurring on or after October 1, 1997, and before October 1, 2001". This change was made effective as if included in Pub. L. 105-33. Pub. L. 106–113 also provided for a 5-year extension of the MDH special payment provisions. Section 404(a) of that law further amended sections 1886(d)(1)(G)(i) and (d)(1)(G)(ii)(II) of the Act by striking the phrase "and before October 1, 2001" and inserting the phrase "and before October 1, 2006".

Section 5003(a) of Pub. L. 109–171 (DRA of 2005) amended the MDH special payment provisions in the Act. It amended section 1886(d)(5)(G) of the Act and made a conforming amendment under section 1886(b)(3)(D) of the Act to provide for another 5-year extension of the special MDH payment methodology. Under this extension, a revised special MDH payment methodology will apply for discharges occurring on or after October 1, 2006, and before October 1, 2011.

As stated earlier, MDHs currently are paid using whichever rate yields the

greatest aggregate payment: the Federal payment rate or, if higher, the Federal payment rate plus 50 percent of the difference between the Federal payment rate and the updated hospital-specific rate based on FY 1982 or FY 1987 base period costs per discharge.

Section 5003(b) of Pub. L. 109–171 provides that, for discharges occurring on or after October 1, 2006, and before October 1, 2011, an MDH's updated hospital-specific rate will be the FY 2002 base period costs per discharges if the FY 2002 based hospital-specific rate results in a payment increase. In cases where no payment increase results from using FY 2002 hospital-specific rate, an MDH will continue to be paid based on the higher of its updated FY 1982 or FY 1987 hospital-specific rates, if using one of those rates results in a payment higher than that under the Federal payment rate. (Unlike an SCH, an MDH does not have the option of using its updated FY 1996 hospital-specific rate.)

Under section 5003(c) of Pub. L. 109–171, for discharges occurring on or after October 1, 2006, and before October 1, 2011, if an MDH's applicable hospital-specific rate exceeded the Federal payment rate, the additional payment is limited to 75 percent (as opposed to the previous 50 percent) of the amount by which the applicable updated hospital-specific rate exceeded the Federal rate.

Section 5003(d) of Pub. L. 109–171 enhances the DSH adjustment for MDHs for discharges occurring on or after October 1, 2006. Further discussion concerning the implementation of this provision can be found in section IV.F.4. of the preamble to the FY 2007 IPPS final rule.

b. Regulation Changes

In this FY 2007 IPPS final rule, we are amending our regulations to implement section 5003(a) through (c) of Pub. L. 109–171. We are adding a new § 412.79 that describes how we will compute and update the MDH hospital-specific rate based on its FY 2002 base period. In addition, we are revising § 412.90(j) to reflect the extension of the MDH special payment provisions to discharges occurring before October 1, 2011. We also are amending § 412.108 by revising paragraph (a) and adding a new paragraph (c)(2)(iii) to reflect the changes to the special payment methodology effective for discharges occurring on or after October 1, 2006, and before October 1, 2011.

Comment: One commenter pointed out that the proposed language in the new § 412.79(a) in the proposed rule differs from the language provided in section 5003 of the statute. That is, the proposed regulatory language reads "ending on or before October 1, 2001"; however, the commenter believed it should read "beginning on or after October 1, 2001" as specified in the statute.

Response: We agree with the commenter that the regulatory language should mirror the statutory language and are making the appropriate changes to the regulatory language in this final rule.

Comment: One commenter supported the proposed changes made as well as CMS' timely implementation of the provisions from the DRA of 2005.

Response: We appreciate the commenter's support.

We received no other comments on these proposed changes. Therefore, we are adopting the proposed changes to the regulations as final, with the indicated change to the regulatory text to reflect the FY 2002 base period statutory language.

In addition, as we proposed, in this FY 2007 IPPS final rule, as a part of the amendments to § 412.90(j) and § 412.108(a), we are making two technical corrections. Section 412.90(j) describes when an MDH may receive a special payment adjustments, while § 412.108(a) discusses the definition of an MDH. Each of these sections now refers to "cost reporting periods beginning on or after April 1, 1990 and before October 1, 1994, or beginning on or after October 1, 1997 and before October 1, 2006". However, as noted above, sections 1886(d)(5)(G)(i) and (d)(5)(G)(ii)(II) of the Act, the provisions of the Act from which these time periods were drawn, were amended by Pub. L. 106–113. Sections 321(b)(1) and 404(a) of Pub. L. 106–113 amended sections 1886(d)(5)(G)(i) and (d)(5)(ii)(II) of the Act so that the phrase in each section "beginning on or after October 1, 1997, and before October 1, 2001" was replaced with the phrase "discharges occurring on or after October 1, 1997, and before October 1, 2006". (Section 5003(a)(1) of Pub. L. 109–171 changed the ending date in these provisions from "before October 1, 2006" to "before October 1, 2011".)

Therefore, we are removing the incorrect phrase "beginning on or after October 1, 1997" from each of these regulations and inserting the phrase, "discharges occurring on or after October 1, 1997", to conform the regulations to the statute.

We did not receive any public comments on these technical changes.

5. Technical Change

As we proposed, in this final rule, we are correcting the spelling of the word "adjustment" in paragraph (b)(2)(iv) of § 412.92, by changing it to "adjustment".

We did not receive any public comments on this technical change.

D. Rural Referral Centers (§ 412.96)

Under the authority of section 1886(d)(5)(C)(i) of the Act, the regulations at § 412.96 set forth the criteria that a hospital must meet in order to qualify under the IPPS as a rural referral center. For discharges occurring before October 1, 1994, rural referral centers received the benefit of payment based on the other urban standardized amount rather than the rural standardized amount. Although the other urban and rural standardized amounts are the same for discharges occurring on or after October 1, 1994, rural referral centers continue to receive special treatment under both the DSH payment adjustment and the criteria for geographic reclassification.

Section 402 of Pub. L. 108–173 raised the DSH adjustment for other rural hospitals with less than 500 beds and rural referral centers. Other rural hospitals with less than 500 beds are subject to a 12-percent cap on DSH payments. Rural referral centers are not subject to the 12 percent cap on DSH payments that is applicable to other rural hospitals (with the exception of rural hospitals with 500 or more beds). Rural referral centers are not subject to the proximity criteria when applying for geographic reclassification, and they do not have to meet the requirement that a hospital's average hourly wage must exceed 106 percent of the average hourly wage of the labor market area where the hospital is located.

Section 4202(b) of Pub. L. 105–33 states, in part, "[a]ny hospital classified as a rural referral center by the Secretary * * * for fiscal year 1991 shall be classified as such a rural referral center for fiscal year 1998 and each subsequent year." In the August 29, 1997 final rule with comment period (62 FR 45999), we also reinstated rural referral center status for all hospitals that lost the status due to triennial review or MGCRB reclassification, but not to hospitals that lost rural referral center status because they were now urban for all purposes because of the OMB designation of their geographic area as urban. However, subsequently, in the August 1, 2000 final rule (65 FR 47089), we indicated that we were revisiting that decision. Specifically, we stated that we would permit hospitals that previously qualified as a rural referral center and lost their status due to OMB redesignation of the county in which they are located from rural to urban to be reinstated as a rural referral center.

Otherwise, a hospital seeking rural referral center status must satisfy the applicable criteria. We used the definitions of "urban" and "rural" specified in Subpart D of 42 CFR Part 412.

One of the criteria under which a hospital may qualify as a rural referral center is to have 275 or more beds available for use (§ 412.96(b)(1)(ii)). A rural hospital that does not meet the bed size requirement can qualify as a rural referral center if the hospital meets two mandatory prerequisites (a minimum CMI and a minimum number of discharges) and at least one of three optional criteria (relating to specialty composition of medical staff, source of inpatients, or referral volume) (§ 412.96(c)(1) through (c)(5)). (See also the September 30, 1988 **Federal Register** (53 FR 38513).) With respect to the two mandatory prerequisites, a hospital may be classified as a rural referral center if—

- The hospital's CMI is at least equal to the lower of the median CMI for urban hospitals in its census region, excluding hospitals with approved teaching programs, or the median CMI for all urban hospitals nationally; and
- The hospital's number of discharges is at least 5,000 per year, or, if fewer, the median number of discharges for urban hospitals in the census region in which the hospital is located. (The number of discharges criterion for an osteopathic hospital is at least 3,000 discharges per year, as specified in section 1886(d)(5)(C)(i) of the Act.)

1. Case-Mix Index

Section 412.96(c)(1) provides that CMS will establish updated national and regional CMI values in each year's annual notice of prospective payment rates for purposes of determining rural referral center status. The methodology we use to determine the national and regional CMI values is set forth in regulations at § 412.96(c)(1)(ii). The national median CMI value for FY 2007 includes all urban hospitals nationwide, and the regional values for FY 2007 are the median values of urban hospitals within each census region, excluding those hospitals with approved teaching programs (that is, those hospitals receiving indirect medical education payments as provided in § 412.105(f)). These values are based on discharges occurring during FY 2005 (October 1, 2004 through September 30, 2005) and include bills posted to CMS' records through March 2006.

In the FY 2007 IPPS proposed rule (71 FR 24106), we proposed that, in addition to meeting other criteria, if they are to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 2006, rural hospitals with fewer than 275 beds must have a CMI value for FY 2005 that is at least—

- 1.3365; or
- The median CMI value (not transfer-adjusted) for urban hospitals (excluding hospitals with approved teaching programs as identified in § 412.105(f)) calculated by CMS for the census region in which the hospital is located. (See the table set forth in the proposed FY 2007 IPPS proposed rule at 71 FR 24106.)

Based on the latest data available (FY 2005 bills received through March 2006), in addition to meeting other criteria, if they are to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 2006, rural hospitals with fewer than 275 beds must have a CMI value for FY 2005 that is at least—

- 1.3132; or
- The median CMI value (not transfer-adjusted) for urban hospitals (excluding hospitals with approved teaching programs as identified in § 412.105(f)) calculated by CMS for the census region in which the hospital is located.

The final median CMI values by region are set forth in the following table:

Region	Case-mix index value
1. New England (CT, ME, MA, NH, RI, VT)	1.2313
2. Middle Atlantic (PA, NJ, NY)	1.2619
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.3252
4. East North Central (IL, IN, MI, OH, WI)	1.3118
5. East South Central (AL, KY, MS, TN)	1.2926
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.2344
7. West South Central (AR, LA, OK, TX)	1.3872
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.3877
9. Pacific (AK, CA, HI, OR, WA)	1.3366

Hospitals seeking to qualify as rural referral centers or those wishing to know how their CMI value compares to the criteria should obtain hospital-specific CMI values (not transfer-adjusted) from their fiscal intermediaries. Data are available on the Provider Statistical and Reimbursement (PS&R) System. In keeping with our policy on discharges, these CMI values are computed based on all Medicare patient discharges subject to the IPPS DRG-based payment.

2. Discharges

Section 412.96(c)(2)(i) provides that CMS will set forth the national and regional numbers of discharges in each year's annual notice of prospective payment rates for purposes of determining rural referral center status. As specified in section 1886(d)(5)(C)(ii) of the Act, the national standard is set at 5,000 discharges. In the FY 2007 IPPS proposed rule (71 FR 24106), we proposed to update the regional standards based on discharges for urban hospitals' cost reporting periods that began during FY 2003 (that is, October 1, 2002 through September 30, 2003), which is the latest available cost report data we had at that time.

Therefore, in the FY 2007 IPPS proposed rule (71 FR 24106), we proposed that, in addition to meeting other criteria, a hospital, if it is to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 2006, must have as the number of discharges for its cost reporting period that began during FY 2003 a figure that is at least—

- 5,000 (3,000 for an osteopathic hospital); or
- The median number of discharges for urban hospitals in the census region in which the hospital is located. (See the table set forth in the FY 2007 IPPS proposed rule at 71 FR 24106.)

Based on the latest discharge data available at this time, that is, for cost reporting periods that began during FY 2003, the final median number of discharges for urban hospitals by census region area are as follows:

Region	Number of discharges
1. New England (CT, ME, MA, NH, RI, VT)	7,366
2. Middle Atlantic (PA, NJ, NY)	10,307
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	10,546
4. East North Central (IL, IN, MI, OH, WI)	9,200
5. East South Central (AL, KY, MS, TN)	7,519
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	7,441
7. West South Central (AR, LA, OK, TX)	7,239
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	10,419
9. Pacific (AK, CA, HI, OR, WA)	7,965

We note that the median number of discharges for hospitals in each census region is greater than the national standard of 5,000 discharges. Therefore, 5,000 discharges is the minimum criterion for all hospitals.

We reiterate that if an osteopathic hospital is to qualify for rural referral

center status for cost reporting periods beginning on or after October 1, 2006, the hospital would be required to have at least 3,000 discharges for its cost reporting period that began during FY 2003.

Comment: Commenters indicated the case-mix index values that are used as criteria for rural referral center status have been fluctuating significantly in the past few years (2005 through 2007), where they had been relatively stable in prior years. They questioned the methodology used to calculate the values.

Response: While we agree that there have been changes in the case-mix index values over the past few years, in our view, they have not been significant. The methodology for determining the case-mix index values for rural referral center status has not changed. The FY 2007 final case-mix index values are based on a more complete file than the proposed values and are more in line with the prior year's values. Although the methodology for calculating the indices has not changed, in response to the commenters' concerns, we will continue to evaluate whether there are other factors that would cause the observed shift in the values.

Comment: One commenter recommended that CMS clarify the last sentence of the "Case-Mix Index" section which states that "In keeping with our policy on discharges, these case-mix index values are computed based on all Medicare patient discharges subject to DRG-based payment." The commenter believed it would be inappropriate to include discharges paid under the LTC DRG payment system. The commenter recommended that, assuming that discharges paid under the LTC DRG-based payment system are excluded, this sentence should be changed to specify "under the inpatient PPS DRG-based payment system."

Response: We agree with the commenter and have revised the preamble language in this final rule. The sentence now states, "In keeping with our policy on discharges, these case-mix index values are computed based on all Medicare patient discharges subject to the IPPS DRG-based payment."

Comment: Two commenters addressed the issue of which cost reporting period is to be used to determine the number of discharges of a hospital applying for initial rural referral center status. One commenter referenced 42 CFR 412.96(c)(2)(ii), which states that an osteopathic hospital applying for rural referral center status "must have at least 3,000 discharges during its most recently completed cost reporting period to meet the number of discharges criterion." This commenter believed that the preamble language in the proposed rule should be corrected to reflect the use of the hospital's most recently completed cost reporting period, rather than a cost reporting period specified by a fiscal year. The second commenter expressed an opposite view and stated that the cost reporting period specified by a fiscal year in the rule should apply and not the "most recently completed cost reporting period" specified in the regulations.

Response: We have considered this issue and have decided to clarify the regulations to be consistent with our longstanding practice as well as the policy we proposed in the FY 2007 IPPS proposed rule of using the same cost reporting period used to develop the regional medians. In this way, we derive the regional medians (to which the hospital's discharges may be compared) as well as the hospital's own discharge data using the same time period. Because we use the FY 2003 data for developing the regional medians, we will also use this data for determining the hospital's own discharges. This is in keeping with our longstanding and consistent policy of publishing in our preamble a specific cost reporting period that we consider to have the latest available cost report data at the time of publication of the rule. We have made technical revisions to § 412.96 to reflect our proposed policy. The language at § 412.96(c)(2)(i) will now state, "the hospital's cost reporting period that began during the same fiscal year as the cost reporting periods used to compute the regional median discharges under paragraph (i) of this section." We are also making similar revisions to the references to "the hospital's most recently completed cost reporting period" in § 412.96(c)(2)(ii) and 412.96(i)(3). In addition, in § 412.96(c)(2)(ii), we are deleting the last sentence that references "the triennial review."

E. Indirect Medical Education (IME) Adjustment (§ 412.105)

1. Background

Section 1886(d)(5)(B) of the Act provides that prospective payment hospitals that have residents in an approved graduate medical education (GME) program receive an additional payment to reflect the higher indirect patient care costs of teaching hospitals relative to nonteaching hospitals. The regulations regarding the calculation of this additional payment, known as the indirect medical education (IME) adjustment, are located at § 412.105.

The Balanced Budget Act of 1997 (Pub. L. 105–33) established a limit on the number of allopathic and osteopathic residents that a hospital may include in its full-time equivalent (FTE) resident count for direct GME and IME payment purposes. Under section 1886(h)(4)(F) of the Act, a hospital's unweighted FTE count of residents may not exceed the hospital's unweighted FTE count for its most recent cost reporting period ending on or before December 31, 1996. Under section 1886(d)(5)(B)(v) of the Act, the limit on the FTE resident count for IME purposes is effective for discharges occurring on or after October 1, 1997. A similar limit is effective for direct GME purposes for cost reporting periods beginning on or after October 1, 1997.

2. IME Adjustment Factor for FY 2007

The IME adjustment to the DRG payment is based in part on the applicable IME adjustment factor. The IME adjustment factor is calculated using a hospital's ratio of residents to beds, which is represented as r, and a formula multiplier, which is represented as c, in the following equation: $c \times [\{1 + r\}^{.405} - 1]$. The formula is traditionally described in terms of a certain percentage increase in payment for every 10-percent increase in the resident-to-bed ratio.

Section 502(a) of Pub. L. 108–173 modified the formula multiplier (c) to be used in the calculation of the IME adjustment. Prior to the enactment of Pub. L. 108–173, the formula multiplier was fixed at 1.35 for discharges occurring during FY 2003 and thereafter. Section 502(a) modified the formula multiplier beginning midway through FY 2004 and provided for a new schedule of formula multipliers for FY 2005 and thereafter. In the FY 2005 IPPS rule, we announced the schedule of formula multipliers to be used in the calculation of the IME adjustment and incorporated the schedule in our regulations at § 412.105(d)(3)(viii) through (d)(3)(xii). In the FY 2007 IPPS proposed rule (71 FR 24107), we specified that for any discharges occurring during FY 2007, the statutorily mandated formula multiplier is 1.32. Previously, for FY 2007, the mandated formula multiplier was 1.42. We estimate that application of the mandated formula multiplier for FY 2007 will result in an increase of 5.35 percent in IME payment for every approximately 10-percent increase in the resident-to-bed ratio.

Comment: While acknowledging that the formula multiplier for FY 2007 is mandated in law, several commenters expressed opposition to the reduced

IME payment resulting from the application of the formula multiplier.

Response: As noted by the commenters, the schedule of formula multipliers to be used in the calculation of the IME adjustment is mandated in law. In this rule, we are simply reiterating that, for any discharges occurring during FY 2007, the formula multiplier is 1.32.

3. Technical Change to Revise Cross-Reference

In the FY 2007 IPPS proposed rule (71 FR 24107), we proposed to revise the cross-references included in paragraph (f)(1)(ii)(C) of § 412.105 that specify the criteria for counting FTE residents who spend time in nonprovider settings for IME payment adjustment purposes. Currently, this paragraph only cites the criteria set forth in §§ 413.78(c) or 413.78(d). We should have also cited the provisions of § 413.78(e), which state that the time residents spend in nonprovider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs may be included in determining the number of FTE residents in the calculation of a hospital's resident count if other applicable conditions specified in paragraph (e) are met.

We did not receive any specific public comments on the proposed addition of a cross-reference to § 413.78(e) to § 412.105(f)(1)(ii)(C) and are therefore adopting it as final without modification.

We note that in sections IV.H.2.,3.,4., and 5. of the FY 2007 IPPS proposed rule (71 FR 24111), we discussed other policy changes and clarifications to the methodology for counting FTE residents for the purposes of direct GME payments, which also would be applicable to IME payments. We respond to public comments received on those proposals below in the specified sections.

F. Payment Adjustment for Disproportionate Share Hospitals (DSHs) (§ 412.106)

1. Background

Section 1886(d)(5)(F) of the Act provides for additional payments to subsection (d) hospitals that serve a disproportionate share of low-income patients. The Act specifies two methods for a hospital to qualify for the Medicare disproportionate share hospital (DSH) adjustment. Under the first method, hospitals that are located in an urban area and have 100 or more beds may receive a DSH payment adjustment if the hospital can demonstrate that, during its cost reporting period, more than 30 percent of its net inpatient care revenues are derived from State and local government payments for care furnished to indigent patients. These hospitals are commonly known as "Pickle hospitals." The second method, which is also the most commonly used method for a hospital to qualify, is based on a complex statutory formula under which payment adjustments are based on the level of the hospital's DSH patient percentage, which is the sum of two fractions: the "Medicare fraction" and the "Medicaid fraction." The Medicare fraction is computed by dividing the number of patient days that are furnished to patients who were entitled to both Medicare Part A and Supplemental Security Income (SSI) benefits by the total number of patient days furnished to patients entitled to benefits under Medicare Part A. The Medicaid fraction is computed by dividing the number of patient days furnished to patients who, for those days, were eligible for Medicaid but were not entitled to benefits under Medicare Part A by the number of total hospital patient days in the same period.

$$\text{DSH Patient Percentage} = \frac{\text{Medicare, SSI Days}}{\text{Total Medicare Days}} + \frac{\text{Medicaid, Non-Medicare Days}}{\text{Total Patient Days}}$$

2. Technical Corrections

In the FY 2007 IPPS proposed rule (71 FR 24108), we proposed to make a technical correction to § 412.106(a)(1)(iii) to reflect the statutory requirement at section 1886(d)(8)(E) of the Act that, as of January 1, 2000, hospitals reclassified under § 412.103 are considered rural for purposes of this DSH regulation. We also proposed to correct the regulation to eliminate the reference to § 412.62(f). These corrections reflect current policy and already-existing statutory requirements.

We did not receive any public comments regarding the proposed corrections to § 412.106(a)(1)(iii) to reflect the statutory requirement that section 1886(d)(8)(E) of the Act that hospitals reclassified under § 412.103 are considered rural for purposes of this DSH regulation and to eliminate the reference to § 412.62(f). Therefore, we are adopting the corrections as final without modification.

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

In an interim final rule published in the **Federal Register** on June 13, 2001 (66 FR 32174 and 32194) (which was finalized in the **Federal Register** on August 1, 2001 (66 FR 39827)), we incorporated into our regulations at § 412.106(d)(2) the provisions of section 211(b) of Pub. L. 106–554. Section 211(b) amended section 1886(d)(5)(F) of the Act to revise the calculation of the disproportionate share percentage adjustment for hospitals affected by the revised DSH qualifying threshold percentages specified in section 211(a) of Pub. L. 106–554. When the section 211 changes were incorporated into the Code of Federal Regulations at § 412.106(d)(2), the regulation text at § 412.106(d)(2)(v) was inadvertently deleted during the transcribing of the new text into the existing regulations. Section 412.106(d)(2)(v) specifies the payment adjustment factors for hospitals that meet the following criteria under § 412.106(c)(2) for discharges occurring on or after April 1, 1990, and before October 1, 1991, and on or after October 1, 1991: Hospitals located in an urban area, that have 100 or more beds, and that can demonstrate that, during their cost reporting period, more than 30 percent of their net inpatient care revenues are derived from State and local government payments for care furnished to indigent patients.

In the FY 2007 IPPS proposed rule (71 FR 24108), we proposed to reinstate the inadvertently deleted text of § 412.106(d)(2)(v). We noted that this is a correction to the regulations; we did not propose to change the payment adjustment factors for hospitals that meet the criteria under § 412.106(c)(2).

We did not receive any public comments on this proposal and are, therefore, adopting it as final without modifications.

4. Enhanced DSH Adjustment for MDHs

The DSH adjustment factor for most categories of hospitals is capped at 12 percent. Urban hospitals with more than 100 beds, rural hospitals with more than 500 beds, and rural referral centers, are exempt from this cap.

Section 5003(d) of Pub. L. 109–171 (DRA of 2005) amended section 1886(d)(5)(F) of the Act to revise the DSH payment adjustment factor for MDHs, effective for discharges occurring on or after October 1, 2006. Specifically, section 5003(d) amended section 1886(d)(5)(F)(xiv)(II) of the Act to exclude MDHs from the 12-percent DSH adjustment factor cap.

For all discharges occurring on or after October 1, 2006, the fiscal intermediary will not apply the cap when calculating the DSH payments. These payments will be subject to revision upon final settlement of the cost reporting period. We note that this change will not affect the calculation of the disproportionate patient percentage.

In the FY 2007 IPPS proposed rule (71 FR 24108), we proposed to amend the regulations at § 412.106 to include this provision under proposed new paragraph (d)(2)(iv)(D).

We did not receive any public comments of the proposed addition of § 412.106(d)(2)(iv)(D) to our regulations to reflect the revision to section 1886(d)(5)(F)(xiv)(II) of the Act made by section 5003 of Pub. L. 109–171. Therefore, we are adopting the proposed revision as final.

G. Geographic Reclassifications (§§ 412.103, 412.230, and 412.234)

1. Background

With the creation of the MGCRB, beginning in FY 1991, under section 1886(d)(10) of the Act, hospitals could request reclassification from one geographic location to another for the purpose of using the other area's standardized amount for inpatient operating costs or the wage index value, or both (September 6, 1990 interim final rule with comment period (55 FR 36754), June 4, 1991 final rule with comment period (56 FR 25458), and June 4, 1992 proposed rule (57 FR 23631)). As a result of legislative changes under section 402(b) of Pub. L. 108–7, section 402 of Pub. L. 108–89, and section 401 of Pub. L. 108–173, the standardized amount reclassification criterion for large urban and other areas is no longer necessary or appropriate and has been removed from our reclassification policy. We implemented this policy in the FY 2005 IPPS final rule (69 FR 49103). As a result, hospitals can request reclassification for the purposes of the wage index only and not the standardized amount. Implementing regulations in Subpart L of 42 CFR Part 412 (§§ 412.230 et seq.) set forth criteria and conditions for reclassifications for purposes of the wage index from rural to urban, rural to rural, or from an urban area to another urban area, with special rules for SCHs and rural referral centers.

Under section 1886(d)(8)(E) of the Act, an urban hospital may file an application to be treated as being located in a rural area if certain conditions are met. The regulations implementing this provision are located under § 412.103.

Effective with reclassifications for FY 2003, section 1886(d)(10)(D)(vi)(II) of the Act provides that the MGCRB must use the average of the 3 years of hourly wage data from the most recently published data for the hospital when evaluating a hospital's request for reclassification. The regulations at § 412.230(d)(2)(ii) stipulate that the wage data are taken from the CMS hospital wage survey used to construct the wage index in effect for prospective payment purposes. To evaluate applications for wage index reclassifications for FY 2007, the MGCRB used the 3-year average hourly wages published in Table 2 of the August 12, 2005 IPPS final rule (70 FR 47508). These average hourly wages are taken from data used to calculate the wage indexes for FY 2004, FY 2005, and FY 2006, based on cost reporting periods beginning during FY 2000, FY 2001, and FY 2002, respectively.

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

Under section 508 of Pub. L. 108–173, a qualifying hospital could appeal the wage index classification otherwise applicable to the hospital and apply for reclassification to another area of the State in which the hospital is located (or, at the discretion of the Secretary, to an area within a contiguous State). Such reclassifications are applicable to discharges occurring during the 3-year period beginning April 1, 2004, and ending March 31, 2007. Under section 508(b), reclassifications under this process do not affect the wage index computation for any area or for any other hospital and cannot be achieved in a budget neutral manner.

Some hospitals currently receiving a section 508 reclassification are eligible to reclassify to that same area under the standard reclassification process as a result of the new labor market definitions that we adopted for FY 2005. In applying for a 3-year MGCRB reclassification beginning in FY 2007, hospitals that are already reclassified to the same area under section 508 should have indicated in their MGCRB reclassification requests that if they receive the MGCRB reclassification, they would forfeit the section 508 reclassification for the first 6 months of FY 2007.

We refer readers to section III.H. of this preamble for a discussion of our updated procedural rules established under section 1886(d)(10)(D)(v) of the Act in which a section 508 hospital may retain its section 508 reclassification through its expiration on March 31, 2007, and accept a reclassification approved by the MGCRB for the second half of FY 2007 (April 1, 2007, through September 30, 2007). We also clarified the procedural rules for an already individually reclassified hospital that is part of a group that includes a section 508 hospital. For nonsection 508 hospitals in a group with a pending individual geographic reclassification, we will apply one of the following for the first half of FY 2007: (a) The area wage index where the hospital is physically located if there is no reclassification pending, or (b) the hospital's individual reclassification wage index if the hospital was part of a group awarded a group reclassification and the group followed the procedural rules for postponing reclassification until April 1, 2007. Final Table 9B will include a final list of section 508 reclassifications for the 1st half of FY 2007 and will be included in a subsequent **Federal Register** notice as well as posted to the CMS Web site after August 1, 2006, and before October 1, 2006.

3. Multicampus Hospitals (§ 412.230(d)(2)(iii))

Subsequent to the publication of the FY 2005 IPPS final rule, we became aware of a situation in which, as a result of the new labor market areas implemented in FY 2005 for the IPPS, a multicampus hospital previously located in a single MSA is now located in more than one CBSA. Under our existing policy, a multi-campus hospital with campuses located in the same labor market area receives a single wage index. However, if the campuses are located in more than one labor market area, payment for each discharge is determined using the wage index value for the MSA (or Metropolitan Divisions, where applicable) in which the campus of the hospital is located. Prior to FY 2006, the criteria for a hospital being reclassified to another wage area by the MGCRB did not address the circumstances under which a single campus of a multicampus hospital may seek reclassification. The regulations

require that a hospital provide data from the CMS hospital wage survey for the average hourly wage comparison that is used to support a request for reclassification. Because a multicampus hospital is required to report data for the entire hospital on a single cost report, there is no wage survey data for the individual hospital campus that can be used in a reclassification application.

In the FY 2006 IPPS final rule (70 FR 47444 through 47446 and 47487), we modified the reclassification rules at § 412.230(d)(2)(iii) to allow campuses of multicampus hospitals located in separate wage index areas to support a reclassification application to an area where another campus is located using the average hourly (composite) wage data submitted on the cost report for the entire multi-campus hospital as its hospital-specific data. This special rule applies for reclassification applications for FY 2006, FY 2007, and FY 2008 and will not be in effect for FY 2009 reclassification requests and beyond. Because reclassification applications to the MGCRB for FY 2009 must be filed in September 2007, or 1 month before the effective date of the FY 2008 IPPS rule, we addressed whether to extend the special rule for multicampus hospitals beyond FY 2008 in this FY 2007 final rule. In the FY 2006 IPPS final rule, we indicated that we would continue to explore options that would allow individual campuses of multi-campus hospitals to submit wage data necessary for geographic reclassification and also monitor the number of multi-campus hospitals affected by this provision (70 FR 47445 and 47446).

After reviewing this situation further, we are finalizing our proposed policy. Beginning with FY 2009 reclassifications, we will no longer allow a campus of a multicampus hospital to use the average hourly wage the entire hospital system to support its reclassification application. Because a cost report is filed for an entire hospital, the campus would have to obtain a separate provider number and be treated for Medicare payment purposes as an independent entity in order to be able to provide wage data for the specific campus. If a hospital were to make a change in FY 2007 to its organizational structure to provide campus specific data to support a reclassification application, the earliest fiscal year that the campus would be eligible to reclassify would be FY 2012 because the cost report data that are used for geographic reclassification precede the payment year by 5 years (that is, FY 2003 cost report data will be used to determine the FY 2008 geographic reclassifications).

To our knowledge, only one hospital has used the special rule for multicampus hospitals. This hospital has since joined a successful FY 2007 urban county group reclassification application to the same area to which it was approved under the multicampus hospital rule. Thus, this hospital is no longer required to meet the multicampus hospital rule. Given that there is only one hospital that has used this rule and this hospital was able to reclassify under the normal reclassification rules, we believe the special reclassification rule that applies to multi-campus hospitals is no longer needed. We proposed in the FY 2007 IPPS proposed rule, to not extend the special rule beyond FY 2008. After considering comments (discussed below) we have decided to adopt the proposal not to extend the multicampus rule beyond 2008. For reclassification requests for FY 2009 and thereafter, a campus of a multicampus hospital would be required to obtain a separate provider number in order to provide the required wage data from the CMS hospital wage survey for the average hourly wage comparison in its MGCRB reclassification application.

Comment: Several commenters requested that CMS continue to allow multi-campus hospitals to use the average hourly wage for the entire hospital system as its wage data to support a reclassification application to an area where another one of the campuses is located. One commenter argued that, once the new census data are available, there may be more hospitals in need of the provision. Two commenters asked CMS to retain the provision because they believed eliminating the multi-campus hospital rule will preclude both reclassifications of groups from areas where one of the hospital campuses is located as well as a campus of a multicampus provider from reclassifying as an individual hospital. These commenters argued that the multicampus hospital rule is necessary in order for an individual campus of a multi-campus hospital to provide wage data to join a group reclassification. Given how few hospitals are expected to use this option, the commenters asked that CMS extend the current rule for at least 5 more years.

Response: The next decennial census is in 2010. Using past experience as a guide, we would not be developing new labor market areas based on the decennial census until FY 2014 or FY 2015 and it is unknown whether such a special rule will be needed at that time. We do not believe a special time limited rule that was intended to give us time to address the particular circumstances of a situation should be retained for nearly 10 more years merely on the possibility that it will be needed. We can reconsider whether to reestablish this special rule if necessary when OMB publishes new MSA definitions following the 2010 Census. Further, as stated in the proposed rule, we believe that hospitals should have to support an individual reclassification application with their own data.

With respect to the comments about group reclassifications, we believe the commenters misunderstand our current rules on reclassification. We are not changing these already existing rules, under which a satellite campus of a multicampus hospital located in a CBSA different from the main hospital would not be required to provide campus-specific wage data in order to join the group and for the MGCRB to approve a group reclassification application. (When a campus of a multicampus hospital joins a group reclassification, the group uses average hourly wage information for the county that was used to develop the wage index for the labor market area. These data do not include wage information for an individual campus of a multicampus hospital.) As we stated in the proposed rule, a campus of a multicampus hospital can join a group reclassification under our normal rules (71 FR 24109). That is, the special rule for multicampus hospitals would not be needed when a campus of a multicampus hospital joins a group reclassification application. As we allow for new hospitals that are part of group reclassifications, an individual campus of a multicampus hospital may join a group reclassification under 42 CFR 412.234 without having to provide campus-specific wage data. The rationale for this policy was explained in the proposed rule and is the same for both new hospitals and individual campuses of multicampus hospitals that join group reclassifications (71 FR 24110).

After consideration of the public comments received, we are not making any further changes in this final rule to our policy relating to multicampus hospitals.

4. Urban Group Hospital Reclassifications (§ 412.234(a)(3)(iii))

Section 412.234(a)(3)(iii) of the regulations sets forth criteria for urban hospitals to be reclassified as a group for FY 2007 and thereafter. Under these criteria, "hospitals located in counties that are in the same Combined Statistical Area (CSA) (under the MSA definitions announced by the OMB on June 6, 2003) as the urban area to which

they seek redesignation qualify as meeting the proximity requirement for reclassification to the urban area to which they seek redesignation."

Last year, several commenters brought to our attention that, while the CSA standard allows for urban county group reclassifications in large urban areas throughout the United States (including 10 of the 11 CBSAs containing Metropolitan Divisions), the CSA standard precludes urban county group reclassifications between three Metropolitan Divisions within one CBSA in Florida. They urged us to modify our policy to also allow hospitals located in counties that are in the same CBSA (in the case of Metropolitan Divisions) as the area to which they seek redesignation to be considered to have met the proximity requirement. We agree with the commenter's proposed modification. The proximity standard for group reclassifications is intended to allow all of a county's hospitals to reclassify to an adjacent area where there is sufficient economic integration that there can be an expectation that both areas are competing in a similar labor market area. We believe there is sufficient economic integration between Metropolitan Divisions within a CBSA that urban county reclassifications within a CBSA or a CSA should be permitted. A CBSA, as defined by the OMB, is a "geographic entity associated with at least one core of 10,000 or more population, plus adjacent territory that has a high degree of social and economic integration with the core as measured by commuting ties."

Therefore, in the FY 2007 IPPS proposed rule (71 FR 24110), we proposed to revise § 412.234(a)(3) by adding a new paragraph (iv) to expand the proximity criteria to allow urban county groups to apply for reclassification to another area within the same CBSA. We proposed to require that, beginning with FY 2008, hospitals must be located in counties that are in the same CSA or CBSA (under the MSA definitions announced by OMB on June 6, 2003) as the urban area to which they seek redesignation to qualify as meeting the proximity requirement for reclassification to the urban area to which they seek redesignation.

Comment: Several commenters supported CMS' proposal to allow hospitals located in counties that are in the same CBSA as the county in which they seek redesignation to be considered to have met the proximity requirement for an urban county group reclassification. These commenters indicated that use of the CBSA criteria appropriately recognizes economic integration among different metropolitan divisions for purposes of applying the proximity standard within the urban county group reclassification regulations. Commenters further indicated that the new proximity criteria should be applied retroactively and be effective for urban group reclassifications beginning on October 1, 2006 (as opposed to October 1, 2007) under specified circumstances.

Response: We appreciate the commenters' support for our proposed change to the regulations, but we do not believe the changes should be made retroactively. The IPPS system, including any wage indices associated with a hospital's geographic classification or reclassification is a prospective system. In addition, under section 1886(d)(10) of the Act, the MGCRB makes decisions about reclassifications, not CMS. Applications for reclassifications for a fiscal year are required to be submitted in September, 13 months before the reclassification would go into effect (for example, a reclassification application for FY 2007 would have had to be submitted by September 2005). Reclassification decisions issued through the statutory process are final and binding and are not subject to judicial review. Making a reclassification criterion retroactive would interfere with the prospective nature of the MGCRB reclassification decisions, and we believe would conflict with the prospective nature of the entire IPPS system. In addition, it could require a recalculation of the budget neutrality adjustment required by section 1886(d)(8)(C) of the Act. Modifying the FY 2006 reclassification budget neutrality adjustment for all hospitals nationwide, we believe would not be feasible at this late date.

After consideration of the public comments received, we are adopting as final, without modification, the proposed revision to § 412.234(a)(3) to add a new paragraph (iv) to expand the proximity criteria to allow urban county groups to apply for reclassification to another area within the same CBSA.

5. Effect of Change of Ownership on Urban County Group Reclassifications (§§ 412.230, 412.234, and 489.18)

We have received questions asking for clarification of our policy regarding whether newly constructed hospitals and hospitals that do not accept assignment of the previous owner's provider agreement can join an urban county group reclassification.

The Medicare regulations at § 412.230 require that, for individual hospital reclassifications, a hospital must provide a weighted 3-year average of its average hourly wages using data from the CMS hospital wage survey used to construct the wage index in effect for prospective payment purposes. Section 489.18(c) of the regulations provides that, when there is a change of ownership, the existing provider agreement will automatically be assigned to the new owner when there is a change of ownership as defined in the rules. Section 412.230(d)(2)(iv) of the regulations specifies that, in situations where a hospital becomes a new provider and the existing hospital's provider agreement is not assigned under § 489.18, the wage data associated with the previous hospital's provider number will not be used in calculating the new hospital's 3-year average hourly wage. This policy is consistent with how we treat hospitals whose ownership has changed for other Medicare payment purposes. The regulations also state that once a new hospital has accumulated at least 1 year of wage data using survey data from the CMS hospital wage survey used to determine the wage index, it is eligible to apply for reclassification on the basis of those data.

While the regulations preclude a new provider from individually reclassifying until the hospital accumulates at least 1 year of wage data from the CMS hospital wage survey used to determine the wage index, a new provider may join a group reclassification under § 412.234. Under § 412.234, all hospitals in an urban county must apply for redesignation as a group. If we did not permit a new hospital to join group reclassifications, all hospitals in the county would not be part of the reclassification application and the urban county group would be precluded from reclassifying for 3 years until the new hospital accumulated at least 1 year of wage data. We believe it would be inequitable to preclude a group reclassification merely because there was one newly constructed hospital or one hospital in the county changed ownership and did not accept the prior owner's provider agreement. Alternatively, we believe that allowing group applications without a new hospital would be inconsistent with our regulations and unfair to new hospitals because it would put them at a competitive disadvantage with other hospitals in the county. Because such reclassifications are effective for 3 years, a new hospital that was not allowed to join a group reclassification would have to accept a lower wage index than all other hospitals in the county with which it competes for labor for up to 3 years.

Comment: One commenter suggested that where there is already an approved

group reclassification, the new provider should be automatically granted the wage index of all the other hospitals in the county. Alternatively, the commenter suggested that the Secretary could use the broad authority provided in the statute to grant an urban county group reclassification already in progress to a new hospital in the same county.

Response: There is currently no provision that allows a hospital to join a county-wide group reclassification already in effect. The existing regulations at § 412.234 provide that all hospitals in an urban county must apply for redesignation as a group. The MGCRB decision applies to only those hospitals listed on the application. However, it is possible that the urban county group can apply for another reclassification to a different area with the new provider.

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

In the FY 2006 IPPS final rule (70 FR 47448), we presented a commenter's concern about the special circumstances of a hospital located in a single hospital MSA surrounded by rural counties in relation to the wage index and the rules governing geographic reclassification. The commenter stated that an isolated hospital in a single hospital MSA is at a competitive disadvantage because the rural hospitals that surround the hospital have been reclassified to higher wage index areas or have been designated as rural referral centers, SCHs, MDHs, or CAHs. The urban hospital is ineligible for reclassification to a higher wage index area either as an individual hospital or as part of a group under the existing regulations. The commenter emphasized that this concern is especially significant given the fact that an isolated hospital in a single hospital MSA is the only hospital in its urban area, and, therefore, has an even greater obligation to the communities it serves.

The commenter advocated a change to the urban county group reclassification regulations whereby a hospital in a single hospital MSA surrounded by rural counties would be able to reclassify to the closest urban area that is part of a CSA located in the same State as the hospital. We did not adopt this suggested policy for FY 2006 because we did not believe it would be prudent to adopt the suggested policy in a final rule without first soliciting public comment. In the FY 2007 IPPS proposed rule, we solicited comments on this issue.

Comment: Commenters supported allowing a hospital that is the only hospital in its MSA to reclassify to the closest urban area that is part of a CSA located in the same State, when the hospitals in surrounding areas have all been reclassified to and/or are located in areas that receive wage index reimbursement significantly higher than the surrounding hospitals' actual wages. Without this reclassification, the commenters indicated that the hospital must continually work to keep wages competitive, purchase new technology, and provide services needed by Medicare beneficiaries in its community. The commenters also stated that a single hospital in an urban county must offer a broad range of services to meet the needs of the Medicare beneficiaries in its large service area, while potentially competing with hospitals that offer fewer services yet receive increased reimbursement due to their ability to reclassify. Some commenters also recommended that proximity criteria should focus more on competition as demonstrated through economic connection, rather than location. The commenters argued that there is an anomaly in the reclassification rules that allows a reclassified hospital to receive a wage index that is higher than its own average hourly wage. Such a hospital has an advantage relative to its competitors in the single hospital MSA by being able to take the excess revenue and invest in technology and services. One commenter stated that making an exception for the hospital addressed here would be an unnecessary expansion of the geographic reclassification provisions. The commenter indicated that it was not unsympathetic to the situation described of a hospital that is surrounded by rural hospitals that have all received special payment status. The commenter opposed allowing the hospital to reclassify to a distant area but indicated that it might support some accommodation that was particularized to this situation.

Response: We disagree with the notion that receiving a higher wage index than a hospital's own average hourly wage is an anomaly of reclassification. The wage index represents an average of all hospitals in a labor market area. Using the commenter's logic, such an "anomaly" would not be limited to reclassification. It would also be a feature of the wage index in a labor market area with multiple hospitals. Some hospitals would have higher wages than the labor market area average, and others, lower. The only policy option for addressing such a concern would be to have a hospital-specific wage index. We believe such an option would not be permitted under the section 1886(d)(3)(E) of the Act, which requires us to adjust IPPS rates for "area differences in hospital wage levels" to reflect the "relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." The statute clearly directs the Secretary to use area, and not hospital-specific, differences in wage levels in creating the wage index.

We believe that allowing hospitals in single hospital MSAs surrounded by rural counties to reclassify to the closest urban area that is part of a CSA located in the same State as the hospital would be an unnecessary expansion of the geographic reclassification provisions. If we adopted the commenters' change to the reclassification provisions, we would be allowing a hospital group to reclassify to a labor market area that is farther away from, rather than closer to, urban market areas. Such a change would be inconsistent with the geographic reclassification regulations that require a hospital to demonstrate proximity to the area where it requests reclassification. For individual hospital reclassifications, the proximity requirement is demonstrated by either meeting a mileage requirement or showing that at least 50 percent of the hospital's employees reside in the area to which it wishes to reclassify. For group reclassifications, the proximity requirement is met if the county demonstrates that it is adjacent to the area where it is seeking reclassification and has a sufficient degree of economic integration to suggest that both areas compete for the same labor. The commenter's approach would allow a hospital to reclassify to a labor market that is more than 75 miles away from the requested area. In general, we believe it is highly unlikely that two areas more than 75 miles apart compete for the same labor.

In accord with the comment from a national hospital association, we agree that the geographic reclassification rules should not be revised to accommodate this situation. However, as suggested in the comment, we considered an accommodation to address the particular circumstances of this situation. In this situation, a number of the surrounding hospitals benefit from being an MDH, SCH, or RRC. There are also two hospitals within approximately 35 miles of the hospital in the single hospital urban area that do not receive special payment under these provisions but receive a special wage index under

section 508 of Pub. L. 108–173. Therefore, the hospital in the single hospital urban area has neighboring hospitals that either receive special payment provisions such as RRC and SCH status or benefit from the special circumstances of section 508 that provided them with temporary higher wage indices. The section 508 reclassifications were special one-time reclassification provisions that permitted certain hospitals to reclassify that ordinarily would not be able to. Thus, the reclassification of the two neighboring hospitals, in conjunction with the special payment of the other surrounding hospitals, represents a situation that would not ordinarily occur under our reclassification of labor market area rules. Due to the combination of these factors and the unique circumstances surrounding the section 508 reclassifications, we are invoking our special exceptions and adjustment authority under section 1886(d)(5)(I)(i) of the Act for this situation. The special exceptions and adjustment authority authorizes us to provide "for such other exceptions and adjustments to [IPPS] payment amounts * * * as the Secretary deems appropriate." We believe it is appropriate in these circumstances to give the hospital in the single hospital urban area the same wage index as the nearby 508 hospitals until the expiration of the provision on March 31, 2007. We note that in somewhat analogous circumstances, we used the special exceptions authority to address hospitals co-located with other hospitals that received a special temporary wage index increase. In that case, a special exception was granted where individual hospitals were part of a failed group application, where a significant proportion of the group (one-third) was able to otherwise reclassify, and where the hospitals that did reclassify received wage indices at least 10 percent higher than the wage index of the MSA where the hospital was located (69 FR 49105).

Comment: One commenter indicated that when competing hospitals are geographically located in two separate MSAs they may experience large differences in their wage indices, thus leading to reimbursement differentials. The commenter stated that a hospital in a single hospital MSA could not rectify its situation simply by increasing labor compensation, thereby resulting in a higher hospital-specific wage index, because the wage index is based on wage data from 3 years earlier and, in addition, the wage index is only paid on the labor-related share of the standardized amount. Thus, the commenter concluded, a hospital could not receive dollar-for-dollar returns on its own labor costs for any particular year, even though it receives a wage index based on its own wage data.

Response: We disagree with the commenter's suggestion that the use of MSAs do not provide a sound basis for identifying hospital labor market areas. As noted in the FY 2005 IPPS final rule (69 FR 29027), exhaustive research has been completed since the mid-1990's on use of alternatives to using MSA definitions for inpatient hospital labor market. While individual hospitals may sometimes be disadvantaged by the use of OMB statistical area definitions for the Medicare IPPS labor market areas, there has been no consensus among interested parties that there are any better alternatives. Dividing the country into geographic areas used to determine wage indices, as is required by section 1886(d)(3)(E) of the Act, will necessarily result in different wage indices across different labor market areas. The commenter is correct that hospitals can neither change the proportion of their payment that is adjusted by the wage index nor shorten the period between when hospitals pay wages to their employees and when those wages are used in determining the wage index. However, these circumstances are not unique to hospitals in single-hospital MSAs. All hospitals experience a delay between the date hospital wage costs are incurred and the date those costs are used to determine the wage index. Similarly, all hospitals are paid based upon a set labor-related share.

Commenters: provided the following suggestions for revising the reclassification rules for single hospital MSAs:

- Exempt the hospital from the requirement that its wages be at least 108 percent of the average hourly wage of all other hospitals in its area, since a single hospital alone in its MSA could not, by definition, meet this test.
- Combine single hospital areas with neighboring MSAs, for the same reasons CMS treated micropolitan areas as rural when it adopted new labor market areas in FY 2005.
- Allow urban hospitals that qualify to be SCHs or rural referral centers other than being located in a rural area to reclassify using the special rules that apply to hospitals with such a status.

Response: We are not adopting any of the above recommendations in this final rule. We do not believe the reclassification rules should be modified to abolish the 108 percent test in the case of a hospital in a single-hospital MSA. The 108-percent test exists precisely to create a specific threshold for reclassifying and to ensure that a reclassifying hospital's own wages are significantly higher than the wages used in calculating the index of its home area. Allowing a hospital receiving 100 percent of its area wages to be exempt from this test, we believe, could potentially undermine the 108-percent test for all hospitals, and we are not certain how we would distinguish between a hospital with wages at, for example, 105 or 107 percent of its area wages and the single hospital with a wage index at 100 percent of its area wages. We note that section 1886(d)(10)(D)(i)(I) of the Act specifically directs us to include in our reclassification guidelines "guidelines for comparing wages * * * in the area in which the hospital is classified."

We also disagree with the suggestion that we should combine adjacent urban areas into one labor market area where one of the MSAs has a single hospital. As we indicated above, the MSAs have consistently been used by CMS to designate geographic areas and there has been no consensus among interested parties in favor of any alternatives. Combining MSAs could also potentially disadvantage hospitals in the urban area with multiple hospitals. For the same reason, we also disagree with the suggestion of the commenter that indicated a hospital that meets all of the requirements to be an SCH or a rural referral centers except rural status should be able to take advantage of the special reclassification provisions that apply to hospitals with these designations. As rural hospitals, these hospitals are afforded advantages that do not apply to urban hospitals. Congress has repeatedly recognized the special circumstances of rural hospitals. For example, Congress, in section 1886(d)(10)(D)(iii) of the Act, exempted rural referral centers from certain wage comparison rules used in reclassification.

Finally, hospitals in single hospital MSAs already have another reclassification option available where the 108-percent test does not need to be met. A hospital in a single hospital MSA can apply to an adjacent area using the group reclassification rules. Under these rules, the hospital must be located in a county that is in the same CSA or CBSA as the urban area where they are seeking reclassification. The CSA and CBSA requirement is intended to identify economic integration among different areas. To be part of an optional CSA, the OMB standard requires that there be at least a 15-percent employment interchange between the areas (25 percent for CBSAs). We do not see a need to exempt a hospital in a single

hospital MSA from wage data comparison because it can apply to an adjacent MSA within the same CSA using the group reclassification rules without having to meet the 108-percent test. If a hospital in a single hospital MSA cannot meet group reclassification criteria because of the CSA standard, it means there is not a sufficient degree of employment interchange to suggest that the areas compete for the same labor.

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

In this final rule, we are also invoking our special exceptions and adjustment authority under section 1886(d)(5)(I)(i) of the Act to adjust the wage index of a hospital group that failed to reclassify on the basis of incomplete OMB guidance for FY 2007 only. The hospital group in question timely applied to the MGCRB for geographic reclassification. On December 5, 2005, the OMB issued a bulletin, Bulletin 06–01, listing the MSAs that comprise various CSAs throughout the country. The bulletin did not include the hospital group's county as being part of the CSA to which the group sought reclassification. CMS regulations at 42 CFR 412.234 require a group to be in the same CSA as the urban area to which it seeks reclassification. Thus, the MGCRB properly denied the hospital group's request.

However, subsequent to the MGCRB denial, the OMB corrected its December 5, 2005 bulletin. On April 25, 2006 and then again on May 26, 2006, OMB issued correction bulletins stating that it had omitted from Bulletin 06–01 certain MSAs that should have been part of the CSA listing. The correction bulletin resulted in the hospital group becoming part of the same CSA as the urban area to which it had sought reclassification. However, by the time OMB issued its correction, the deadline for appealing the MGCRB denial to the Administrator (15 days from the date of the MGCRB decision) under 42 CFR 412.276(a) had passed. In addition, the time for the Administrator to issue a decision on his or her own motion (105 days following the issuance of an MGCRB decision) had also expired. As provided under § 412.276(b), MGCRB decisions are final and binding unless reviewed and changed by the Administrator.

Four other hospital groups were affected by OMB's correction bulletin(s). However, all of these groups were able to receive a positive determination by the Administrator. In one case, the Administrator was able to toll the timeframe for deciding the group's appeal under § 412.278(f)(2)(i). In the other three cases, the Administrator affirmed the MGCRB's decision but then amended the decision on May 30 within the 15 days allotted under § 412.278(g)(2).

The special exceptions and adjustment authority authorizes us to provide "for such other exceptions and adjustments to [IPPS] payment amounts * * * as the Secretary deems appropriate." We believe it is appropriate in these circumstances to adjust the hospital group's wage index to reflect the reclassification it would have received had OMB's initial CSA listing been complete. First, of the five hospital groups affected by the OMB bulletin(s), four were granted reclassifications under the procedures for Administrator review. Only the remaining hospital group was unable to reclassify because the deadline for the Administrator discretionary review expired on May 17, 2006, and the OMB did not issue its correction bulletin until May 26, 2006. The circumstances of the five cases are identical in that each was denied reclassification by the MGCRB by virtue of not meeting the CSA standard that was later corrected by OMB. We believe it would be inequitable for the one remaining hospital group to be the only group of the five similarly situated not to benefit from the correction of the errors to OMB Bulletin 06–01. Second, the MGCRB's decision was based upon an incomplete OMB listing. We do not believe the hospital group should experience an adverse determination solely on the basis of OMB omissions. Third, OMB issued its correction only 9 days after expiration of the discretionary review period for the Administrator to take review. Taken in conjunction, we believe that these three factors, the reclassification of all other similarly situated hospital groups; the governmental omission; and the closeness in time between OMB's correction and the expiration of the Administrator discretionary review period, support a special adjustment. We note that we are not retroactively granting a reclassification to the hospital group in question. Rather, we will adjust payment to reflect the wage index it would have received (for example, we will give the hospital group that wage index for hospitals reclassified to the requested area). The hospitals in the group will not receive the section 505 out-migration adjustment in FY 2007.

Finally, we note that the hospital group in question may reapply for geographic reclassification to the same area for the period FY 2008 through FY 2010. As specified in section III.H. of the preamble of this final rule, the deadline for FY 2008 reclassification applications is September 1, 2006. We encourage hospitals to closely review the special instructions provided in section III.H. of this preamble elsewhere in this final rule affecting the procedures for applying for reclassification for FY 2008, considering the unique circumstances of occupational mix wage adjusted average hourly wages not being available until after August 1 and prior to October 1.

H. Payment for Direct Graduate Medical Education

1. Background

Section 1886(h) of the Act, as added by section 9202 of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (Pub. L. 99–272) and implemented in regulations at existing §§ 413.75 through 413.83, establishes a methodology for determining payments to hospitals for the costs of approved graduate medical education (GME) programs. Section 1886(h)(2) of the Act, as added by COBRA, sets forth a methodology for the determination of a hospital-specific, base-period per resident amount (PRA) that is calculated by dividing a hospital's allowable costs of GME for a base period by its number of residents in the base period. The base period is, for most hospitals, the hospital's cost reporting period beginning in FY 1984 (that is, the period beginning between October 1, 1983, through September 30, 1984). Medicare direct GME payments are calculated by multiplying the PRA times the weighted number of full-time equivalent (FTE) residents working in all areas of the hospital (and nonhospital sites, when applicable), and the hospital's Medicare share of total inpatient days. The base year PRA is updated each year for inflation. However, as specified in section 1886(h)(2)(D)(ii) of the Act, for cost reporting periods beginning on or after October 1, 1993, through September 30, 1995, each hospital-specific PRA for the previous cost reporting period is not updated for inflation for any FTE residents who are not either a primary care or an obstetrics and gynecology resident. As a result, hospitals that train primary care and obstetrics and gynecology residents, as well as nonprimary care residents in FY 1994 or FY 1995, have two separate PRAs: one for primary care and obstetrics and gynecology residents and one for nonprimary care residents.

Pub. L. 106–113 amended section 1886(h)(2) of the Act, effective October 1, 2000, to establish a methodology for the use of a national average PRA in computing direct GME payments for

cost reporting periods beginning on or after October 1, 2000. Specifically, Pub. L. 106–113 established a "floor" for FY 2001 such that a hospital-specific PRA should not be less than 70 percent of the locality-adjusted national average PRA. In addition, it established a "ceiling" that froze or limited the annual inflation adjustment to a hospital-specific PRA if the PRA exceeded 140 percent of the locality-adjusted national average PRA. Section 511 of Pub. L. 106–554 increased the "floor" established by Pub. L. 106–113 to equal 85 percent of the locality-adjusted national average PRA for PRAs in existence in FY 2002. Existing regulations at § 413.77(d)(2)(iii) specify that, for purposes of calculating direct GME payments, each hospital-specific PRA is compared to the floor (for FY 2001 and FY 2002) and the ceiling (for FY 2001 through 2013) to determine whether a hospital-specific PRA should be revised. We note that, under existing regulations at § 413.77(c), if a hospital-specific PRA for FY 2001 or FY 2002 is revised due to application of the floor PRA, the revised PRA is the starting point for the PRA in future years, subject to the annual inflation adjustment and any other applicable adjustments.

Section 1886(h)(4)(F) of the Act established caps on the number of allopathic and osteopathic residents that hospitals may count for purposes of calculating direct GME payments. For most hospitals, the caps were the number of allopathic and osteopathic FTE residents training in the hospital's most recent cost reporting period ending on or before December 31, 1996. Section 422 of Pub. L. 108–173 added section 1886(h)(7) of the Act which provided for one-time reductions to the resident caps of teaching hospitals that were training a number of FTE residents below their cap in a reference period, and authorized a one-time "redistribution" of FTE resident slots to hospitals that could demonstrate a likelihood of using the additional resident slots within the first three cost reporting periods beginning on or after July 1, 2005.

2. Determination of Weighted Average Per Resident Amounts (PRAs) for Merged Teaching Hospitals (§ 413.77)

As stated in the background section above, in accordance with section 1886(h) of the Act, Medicare pays teaching hospitals for the direct costs of GME based on the per resident direct GME costs in a base year. For most hospitals, the base year is FY 1984 (cost reporting periods beginning between October 1, 1983, and September 30, 1984). Although section 1886(h) of the Act provides for the establishment of a PRA for a hospital that trained residents in the 1984 base year, the statute does not address how to treat the PRA(s) of teaching hospitals that subsequently merge.

Our policy has always been that when two or more teaching hospitals merge, we determine a weighted average PRA for the surviving merged hospital using direct GME costs and resident data from the base year cost report for each teaching hospital involved in the merger. This policy was detailed in Questions and Answers on Medicare GME Payments issued on November 8, 1990: "[When] two hospitals merge * * * the merged hospital's per resident amount * * * [is] based on the weighted average of the per resident amounts of both hospitals." We believe this is an equitable way to determine a PRA for the surviving merged hospital because it is based on the relative costs and sizes of the GME training programs in the respective facilities. Moreover, we believe this policy minimizes the role Medicare GME payments play in the choice of the surviving hospital entity. For example, there is no incentive to choose the surviving hospital based in part on the hospitals' relative PRAs.

To calculate the weighted average PRA for the merged entity, the fiscal intermediary begins by determining the base year PRAs and the base year FTE resident counts of the hospitals that merge. The weighted average PRA is calculated by adding the product of each hospital's base year PRA and its base year FTE resident count, and dividing that number by the total number of the base year FTE residents for those hospitals.

When our current methodology was first established for calculating the new PRA for a merged hospital, we adopted a policy to use base year PRAs and FTE resident counts. It was appropriate and workable to use data from the PRA base year because the base year data (usually for the 1984 fiscal year) associated with the hospital-specific PRAs were easily accessible. However, these data are now often over 20 years old and it has become administratively burdensome for both CMS and the fiscal intermediaries to access base year information in calculating the weighted average of the PRAs for merged hospitals.

In addition to it being administratively burdensome to use base year cost report data, where a hospital has two PRAs (one for primary care and obstetrics and gynecology residents and another for nonprimary care residents), these two PRAs are not being taken into account in developing the weighted average PRA for the merged hospital. As discussed earlier, hospitals that were training nonprimary care residents in FYs 1994 and 1995 have a separate nonprimary care PRA because there was no update for inflation applied to the PRA for nonprimary care residents in those years (§ 413.77(c)(2)). Accordingly, many teaching hospitals currently have two PRAs: one for primary care and obstetrics and gynecology residents and one for all other residents. (Hospitals that first train residents after FY 1995 would only have a single PRA, even if they train both primary care residents and nonprimary care residents.) Because the current methodology for calculating the weighted average PRA for a merged teaching hospital is based solely on data from the PRA base year (which is usually prior to the years during which the PRAs were not adjusted for inflation to reflect nonprimary care residents), this methodology does not take into account that the merged hospitals may currently have more than one PRA.

In the FY 2007 IPPS proposed rule (71 FR 24111 through 24113), we proposed, effective for cost reporting periods beginning on or after October 1, 2006, rather than using the direct GME FTE resident count and PRA from hospitals' base year cost reports, to simplify and revise the weighted average PRA methodology for determining a merged teaching hospital's PRA by using FTE resident data and PRA data from the most recently settled cost reports of the merging hospitals. We believe it is less administratively burdensome to use these data because these data are more recent and, therefore, more accessible. In addition, these data would reflect both a primary care and obstetrics and gynecology PRA and, if applicable, a nonprimary care PRA.

We noted that, prior to FY 2003, our policy for calculating the PRA for a new teaching hospital was to calculate the PRA based on the lower of the new teaching hospital's actual cost per resident in its base period or a weighted average of all the PRAs of existing teaching hospitals in the same geographic wage area, as that term is used under the prospective payment system (existing § 413.77(e)(1)). (For ease of discussion, we refer to a hospital that did not participate in Medicare or that did not have any approved medical residency training programs during the period beginning between October 1, 1983, through September 30, 1984, and has since commenced participating in Medicare and begun training residents in an approved program, as a "new teaching hospital.") The weighted average PRA of teaching hospitals within a particular geographic wage area

was determined using the base year PRA and the base year FTE resident count of each respective teaching hospital within the geographic wage area. However, as discussed in the August 1, 2002 IPPS final rule (67 FR 50067) effective October 1, 2002, we revised our policy to use PRAs and FTE resident data from the *most recently settled* cost reports of teaching hospitals in the same CBSA as the new teaching hospitals, rather than data from the 1984 base year (existing § 413.77(e)(1)(ii)(B)). We revised this policy for establishing PRAs for new teaching hospitals because it is less administratively burdensome to use data from the hospitals' most recently settled cost reports and because the more recent data takes into account that hospitals have a primary care PRA and a nonprimary care PRA. In the FY 2007 IPPS proposed rule, we proposed a similar policy revision for establishing a merged teaching hospital's PRA.

We proposed that the fiscal intermediaries would use the following steps to calculate the weighted average PRA for the merged teaching hospital:

Step 1: Identify the primary care and obstetrics and gynecology FTE resident count, the nonprimary care FTE resident count for hospitals with two PRAs, or the single FTE resident count for hospitals with a single PRA, for each teaching hospital involved in the merger. (Use the sum of the FTE resident counts from Line 3.07, Line 3.08, and Line 3.11 of the hospital's most recently settled Medicare cost report, CMS 2552–96, Worksheet E–3, Part IV.)

Step 2: Identify the PRAs (either a hospital's primary care and obstetrics and gynecology PRA and nonprimary care PRA or, if applicable, a hospital's single PRA) from the most recently settled cost report for each hospital involved in the merger, and update the PRAs using the CPI–U inflation factor to coincide with the fiscal year end of the surviving teaching hospital. For example, if the surviving teaching hospital's fiscal year end is December 31, 2006, and the most recently settled cost report of the teaching hospital(s) involved in the merger is June 30, 2003, the PRAs from this cost report would be updated for inflation to December 31, 2006.

Step 3: Calculate the weighted average PRA for the single merged hospital using the PRAs and FTE resident counts from Step 1 and Step 2. For each teaching hospital in the merger:

(a) For hospitals with two PRAs, multiply the primary care PRA by the number of primary care and obstetrics and gynecology FTE residents.

(b) For hospitals with two PRAs, multiply the nonprimary care PRA by the number of nonprimary care FTE residents.

(c) For hospitals with a single PRA, multiple the single PRA by the hospital's total number of FTE residents.

(d) Add the products from applicable Steps 3(a), (b), and (c) for all teaching hospitals that merged.

(e) Add the number of FTE residents from Step 1 for all hospitals.

(f) Divide the sum from Step 3(d) by the sum from Step 3(e). The result is the weighted average PRA for the merged hospital.

As mentioned above, many hospitals currently have two PRAs, one for primary care residents and another for nonprimary care residents. An advantage to using data from the most recently settled cost reports of the hospitals involved in a merger is that the two PRAs are taken into account in determining the weighted average PRA for the merged hospital. Because two PRAs would be taken into account under this proposal, we considered whether a primary care PRA and a nonprimary care PRA should, therefore, be determined for the merged hospital. Although it would be possible to determine and retain two PRAs for a merged hospital when one or more hospitals involved in the merger had two PRAs, we did not propose to do so. We proposed that a single PRA also be determined for the merged hospital in this situation because it is more administratively straightforward for the fiscal intermediaries and the merged hospitals and since the merged hospital itself was not in existence in the years that the two PRAs were established (FY 1994 and FY 1995), we do not believe it is necessary to retain the two PRAs. Furthermore, because the two existing pre-merger PRAs are taken into account when establishing the single PRA for the merged hospital, and the statutory provision that resulted in the creation of two PRAs has no continuing effect (because the updates were prohibited only for FY 1994 and FY 1995), we see no compelling reason to continue to carry two PRAs for a merged hospital.

The following was presented as an example of how to calculate a weighted average PRA under the proposed revised methodology:

Example: Assume that Hospital A, Hospital B, and Hospital C merge and Hospital B with a fiscal year end of December 31, 2006, is the surviving hospital. In their respective most recently settled cost reports, Hospital A has 200 primary care and obstetrics and gynecology FTE residents and 150 nonprimary care FTE residents, and Hospital B has 50 primary care and obstetrics and gynecology FTE residents and 60 nonprimary care FTE residents. Hospital C became a teaching hospital in 2000 and has 25 FTE residents. After updating the primary care and nonprimary care PRAs for inflation by the CPI–U to December 31, 2006, Hospital A has a primary care PRA of $120,000 and a nonprimary care PRA of $115,000, Hospital B has a primary care PRA of $100,000 and a nonprimary care PRA of $97,000, and Hospital C has a single PRA of $90,000.

(a) Primary care:

Hospital A: $120,000 × 200 FTEs = $24,000,000

Hospital B: $100,000 × 50 FTEs = $5,000,000

(b) Nonprimary care:

Hospital A: $115,000 × 150 FTEs = $17,250,000

Hospital B: $97,000 × 60 FTEs = $5,820,000

(c) Single PRA: Hospital C: $90,000 × 25 FTEs = $2,250,000

(d) $24,000,000 + $5,000,000 + $17,250,000 + $5,820,000 + $2,250,000 = $54,320,000

(e) 200 + 50 + 150 + 60 + 25 = 485 total FTEs

(f) $54,320,000/485 FTEs = $112,000, the weighted average of the hospitals involved in the merger for fiscal year end December 31, 2006.

Comment: One commenter commended our proposal to revise the weighted average PRA methodology for determining a merged teaching hospital's PRA by using direct GME FTE resident data and PRA data from the most recently settled cost reports of the merging hospitals. However, the commenter suggested that because a teaching hospital's reimbursement is calculated using the hospital's rolling average FTE count, and not the hospital's current year FTE count, the rolling average FTE count of merging hospitals (Lines 3.16 and 3.22 of Worksheet E–3, Part IV) should be used to determine a merged teaching hospital's PRA. The commenter also pointed out that a new teaching hospital's FTE count only appears on Lines 3.16 and 3.22 and in the case where one of the hospitals involved in a merger is a new teaching hospital, if CMS were to use the current year FTE counts, the new teaching hospital's PRA would not be taken into account in the weighted average PRA determination for the merged hospital.

Response: We appreciate the commenter's support for the proposed policy revision; however, we disagree with the commenter's suggestion. The intent of the policy revision is to ease

the administrative burden for hospitals and fiscal intermediaries by using more accessible cost reporting data for determining a merged hospital's weighted average PRA. We do not believe it is appropriate to change which FTE counts are used to make a PRA determination for a merged hospital. While it is true that the statute requires that direct GME payment be determined based on a 3-year rolling average of the hospital's FTE counts, that provision is intended by Congress to moderate the impact of year-to-year changes in hospitals' FTE counts. However, to calculate a weighted PRA for merging teaching hospitals, we believe it is appropriate to weight each hospital's PRA based on the FTE resident count for each hospital's current year. We do agree with the commenter that in the case of a merger that involves a new teaching hospital or an existing teaching hospital which, in accordance with 42 CFR 413.79(d)(5), included residents in "new teaching programs" on Lines 3.16 and/or 3.22 of Worksheet E–3, Part IV; the merged hospital's weighted average PRA will be computed by including the "new teaching program" FTE residents from those lines.

Comment: One commenter suggested that a separate primary care PRA and nonprimary care PRA be determined for a merged hospital. The commenter believed that because most existing teaching hospitals currently have two PRAs, it would be appropriate to determine two PRAs for a merged teaching hospital as well. In addition, the commenter believed that determining one PRA for a merged hospital might result in inaccurate reimbursement should the surviving hospital's mix of primary and nonprimary care residents or programs change significantly.

Response: Although we initially proposed to determine a single PRA for the merged hospital, after considering this comment, we are convinced that it is appropriate to determine two PRAs for a merged teaching hospital. Although we do not believe the determination of a single PRA for a merged hospital would necessarily result in "inaccurate reimbursement," we do recognize the commenter's point that the application of a single PRA for a merged hospital would be inconsistent with the application of two PRAs for most other teaching hospitals (typically, a lower one for residents in nonprimary care specialties), and could produce some unintended incentives. Specifically, we recognize that the two PRAs have the continuing effect of discouraging shifts from primary care and obstetrics and gynecology programs to nonprimary care programs. Therefore, we are revising the steps for calculating the weighted average PRAs for a merged teaching hospital. The following steps should be used by fiscal intermediaries to calculate the primary care weighted average PRA for a merged teaching hospital for mergers that occur on or after October 1, 2006:

Step 1: From the most recently settled cost report of each hospital involved in the merger, identify the primary care and obstetrics and gynecology FTE resident count (Line 3.07 and "new program" residents from Line 3.22 of Worksheet E–3, Part IV).

Step 2: From the most recently settled cost report of each hospital involved in the merger, identify the hospital's primary care and obstetrics and gynecology PRA (or a hospital's single PRA when applicable). Update the hospitals' PRAs to the midpoint of the surviving provider's cost reports that precede the cost report in which the merger occurs using a special CPI–U inflation factor obtained from the CMS Central Office. All of the merging hospitals' PRAs should be updated to coincide with the surviving hospital's fiscal year end for the cost reporting period prior to the merger. (For example, if the surviving teaching hospital's cost reporting period fiscal year end prior to the merger is December 31, 2006, and the most recently settled cost report of the teaching hospital(s) involved in the merger is June 30, 2003, the PRAs from this cost report would be updated for inflation to December 31, 2006).

Step 3: Calculate the weighted average primary care PRA for the merged hospital using the PRAs and FTE resident counts from Steps 1 and 2.

(a) For hospitals with two PRAs, multiply the primary care PRA by the number of primary care and obstetrics and gynecology FTE residents.

(b) For hospitals with a single PRA, multiply the single PRA by the number of primary care FTE residents.

(c) Add the products from each hospital from Steps 3(a) and (b).

(d) Add the number of FTE residents from each hospital from Step 1.

(e) Divide the sum from Step 3(c) by the sum from Step 3(d). The result is the weighted average primary care PRA for the merged hospital.

Fiscal intermediaries will follow these same steps to calculate the weighted average nonprimary care PRA for a merged teaching hospital. For the weighted average nonprimary care PRA, the merging hospitals' nonprimary care FTE counts (Lines 3.08 and 3.11 and "new program" residents on Line 3.22 from Worksheet E–3, Part IV) and nonprimary care PRAs (or a single PRA for a hospital with one PRA) should be used.

Comment: One commenter requested that CMS provide a detailed example that includes the merger date and the fiscal year ends for each merging hospital's cost report.

Response: The following is a detailed example of how a weighted average primary care PRA would be determined for a merged hospital. The changes to the proposed policy revision discussed previously have been incorporated into this example.

Example: Assume that Hospital A, Hospital B, and Hospital C will merge on February 1, 2007. On their most recently settled cost reports, Hospital A has 200 primary care and obstetrics and gynecology FTE residents, Hospital B has 50 primary care and obstetrics and gynecology FTE residents, and Hospital C has 10 primary care and obstetrics and gynecology FTE residents. The surviving hospital is Hospital C whose fiscal year end prior to the merger is December 31, 2006. Hospital A's and Hospital B's most recently settled cost report is September 30, 2002 and Hospital C's most recently settled cost report is December 31, 2003. Since Hospital C is the surviving provider and Hospitals A and B have fiscal year ends (that is, September 30, 2006) that differ from the fiscal year end of Hospital C (that is, December 31, 2006), Hospitals A and B's PRAs must be made concurrent with the PRA of Hospital C for fiscal year end December 31, 2006. The fiscal intermediary should contact the CMS Central Office for special update factors and for instructions on making the PRAs concurrent. Additional special update factors will be necessary to determine the direct GME payment, pre-merger and post-merger, as indicated in response to the next comment. After updating the PRAs for inflation by the appropriate CPI–U update factor to December 31, 2006, Hospital A has a primary care PRA of $120,000, Hospital B has a primary care PRA of $100,000, and Hospital C has a single PRA of $90,000.

(a) Hospital A: $120,000 × 200 FTEs = $24,000,000

Hospital B: $100,000 × 50 FTEs = $5,000,000

(b) Hospital C: $90,000 × 10 FTEs = $900,000

(c) $24,000,000 + $5,000,000 + 900,000 = $29,900,000

(d) 200 + 50 + 10 = 260 total FTEs

(e) $29,900,000/260 FTEs = $115,000, the weighted average primary care PRA for Hospital C, the surviving hospital, effective February 1, 2007, the date of

the merger. The weighted average nonprimary care PRA would be calculated using the merging hospitals' nonprimary care FTE counts and nonprimary care PRAs (or single PRA for Hospital C).

Comment: One commenter requested clarification on how CMS would treat a merger that occurs in the middle of the surviving hospital's cost reporting period. More specifically, the commenter questioned whether, in such a situation, the surviving hospital would have two PRAs, a pre-merger PRA and post-merger PRA.

Response: In the case described by the commenter, the surviving hospital would indeed be reimbursed with two sets of PRAs, a set of pre-merger PRAs and a set of post-merger PRAs. To calculate the direct GME payment for the surviving hospital for the cost reporting period in which the merger occurred, the fiscal intermediary performs a series of off-the-cost-report calculations, treating the pre-merger and post-merger periods of the surviving hospital's cost reporting period as if they are two short cost reporting periods. The fiscal intermediary would first calculate the direct GME reimbursement for the surviving hospital for the portion of the cost reporting period prior to the merger using only the surviving hospital's FTEs and PRA(s) and Medicare utilization rate. Second, the fiscal intermediary would calculate the surviving hospital's post-merger direct GME reimbursement using the weighted average PRA(s) updated with special CPI–U factors, a combined rolling average FTE count reflecting the merged hospitals' FTEs, and a combined Medicare utilization rate reflecting the portion of the cost reporting period after the merger. Then the fiscal intermediary would add the pre-merger and post-merger payments to determine the surviving hospital's total reimbursement for that cost reporting period. (Note that, although not the topic of this discussion, similar pre-merger and post-merger calculations are done for the resident-to-bed ratio for IME purposes as well).

Comment: One commenter believed that varying methodologies have been used in the past to determine the PRA for a merged teaching hospital and that our statement in the proposed rule that CMS' policy "has always been that when two or more teaching hospitals merge, we determine a weighted average PRA for the surviving merged hospital" is inaccurate. The commenter further believed that the reference to the 1990 GME Questions and Answers is poor evidence that CMS' current policy is to determine a weighted average PRA for the surviving merged hospital. Finally, the commenter believed that CMS should promulgate a policy that gives latitude to a merged hospital to have a PRA determined that takes into consideration the surviving hospital's post-merger operations. The commenter suggested that CMS adopt a policy that provides a merged hospital the option of having its PRA determined as the weighted average PRA or the surviving provider's PRA.

Response: We disagree with the commenter's assertion that varying policies have been used in the past to determine the PRA for a merged hospital. In addition to the 1990 Questions and Answers on Medicare GME Payments, we have consistently expressed our policy to determine a weighted average PRA for a merged hospital. For example, our policy was clearly cited in the May 12, 1998 **Federal Register** (63 FR 26239) in which we state that "in implementing the COBRA 1985 provision establishing a hospital-specific per resident amount in the situation of a merger, we have calculated the revised per resident amount for the merged hospital using an FTE weighted average of each of the respective hospital's per resident amount which is part of the merger." We have worked with numerous fiscal intermediaries in determining weighted average PRAs for merged hospitals and are unaware of any instance that a weighted average PRA was not determined for a merged hospital.

Our current policy, as revised by this final rule, applies prospectively for cost reporting periods beginning on or after October 1, 2006. Our main concern in making these clarifications and changes to our policy is to adopt a policy that can be applied consistently and that recognizes the nature of a merger of hospital entities. We believe it is appropriate to adopt a policy that takes into account each of the various merging hospitals' preexisting, statutorily established PRAs. We have adopted a policy under which the PRA(s) determined for a merged hospital is based on the weighted average of the different merging hospitals' PRAs precisely because it takes all of the merging hospitals' PRAs into account. We do not believe it is appropriate to provide a merged hospital the option of adopting the surviving hospital's PRA instead of the average weighted PRA because, aside from the fact that such a policy would ignore the fact that the merger is a result of multiple hospitals with individual PRAs joining together, such a policy could inappropriately provide an incentive to choose the surviving hospital based on which surviving hospital's PRA would yield the highest reimbursement.

Comment: Several commenters requested that this policy revision be included as a provision in the regulatory text of § 413.77, the regulation that deals with the determination of PRAs.

Response: We agree with the commenters. In this final rule, we are revising § 413.77 by adding a new paragraph (h) to reflect the policy on determining the PRA for the surviving hospital when multiple hospitals merge, effective October 1, 2006.

3. Determination of Per Resident Amounts (PRAs) for New Teaching Hospitals (§ 413.77(e))

As we discussed earlier in the background portion of this section, the hospital-specific, base-period PRA used in the payment methodology for determining Medicare direct GME payments is calculated by dividing a hospital's allowable direct costs of GME in a base period by its number of residents in that base period. In the case of a hospital that did not train residents in its FY 1984 cost reporting period, a PRA is determined by comparing and taking the lower of a PRA based on direct GME costs and FTE residents in a base year or the updated weighted mean value of PRAs of all hospitals located in the same geographic wage area. For ease of discussion, we refer to a hospital that did not participate in Medicare or have any approved medical residency training programs during the base period beginning between October 1, 1983, through September 30, 1984, and has since commenced participating in Medicare and begun training residents in an approved program, as a "new teaching hospital." A new teaching hospital's PRA is established by using the lower of its hospital-specific PRA based on the actual allowable direct GME costs and FTE residents during a base period as defined in § 413.77(e) or the updated weighted mean value of PRAs of other teaching hospitals in the same geographic area.

Existing regulations at § 413.77(e) specify that the base year for establishing a PRA for a new teaching hospital is the first cost reporting period in which the new teaching hospital participates in Medicare and the residents are on duty during the first month of that period. If the new teaching hospital begins training residents but does not have residents on duty during the first month of the first cost reporting period in which training occurs, the new teaching hospital is paid on a reasonable cost basis under § 413.77(e) for any GME costs incurred

by that hospital during that period. The intent of this policy for new teaching hospitals is to make a more accurate determination of a PRA based on the hospital's per resident direct GME costs in a cost reporting period in which GME costs have been incurred for that entire period. As we noted in a response to comments in a final rule published in the **Federal Register** on September 29, 1989 (54 FR 40310), we believe that where the new teaching hospital's cost reporting period begins on a date other than July 1 (the beginning of the academic year), for example, October 1 or January 1, the cost reporting period that includes costs and resident counts from the first year of the training program may not be reflective of the actual average costs per resident of the program because the full complement of residents might not be on duty, and those that are on duty might be receiving a salary for as few as 1 or 2 months of the cost reporting period. In the usual case, training in the program would continue into the following cost reporting period and residents would thus be on duty in the first month of this next cost reporting period. Consequently, our existing regulations at § 413.77(e)(1) specify that the PRA is to be determined by using the cost and resident data from the first cost reporting period during which residents are training in the first month of the cost reporting period.

It has come to our attention that, in rare instances, it is possible for a new teaching hospital, either through happenstance or by purposeful gaming of the policy, to continue to be reimbursed for direct GME costs on a reasonable cost basis even beyond the first cost reporting period during which residents begin training at the hospital as long as no residents are on duty at the new teaching hospital in the first month of the subsequent cost reporting period(s). We believe this scenario is contrary to the statutory intent of section 1886(h) of the Act, which instructs that instead of payment on a reasonable cost basis, the Secretary is to determine and base direct GME payments on a PRA for each hospital with a residency program. For that reason, in the FY 2007 IPPS proposed rule (71 FR 24113), we proposed to revise § 413.77(e)(1) and (e)(1)(i) to provide that we will make a PRA determination even where residents are not on duty in the first month of a cost reporting period but where residents began training at the hospital in the prior cost reporting period. We proposed that, effective for cost reporting periods beginning on or after October 1, 2006, if a new teaching hospital begins training residents in a cost reporting period beginning on or after October 1, 2006, and no residents are on duty during the first month of that period, the fiscal intermediary establishes a PRA for the hospital using the lesser of: (1) The cost and resident data from the cost reporting period immediately following the one for which GME training at the hospital was first reported (that is, the base period); or (2) the updated weighted mean value of PRAs of all hospitals located in the same geographic wage area. We note that, as with existing policy, the base year need not be a full cost reporting year.

Comment: One commenter noted that CMS should clarify that the PRA will be based on "the lesser of" the cost and resident data from the cost report, or the updated weighted mean value of PRAs of all hospitals located in the same geographic wage area.

Response: We agree with the commenter and have revised the language in the preamble of this final rule accordingly.

After consideration of the public comments received, we are adopting as final, without modifications, the proposed changes to § 413.77(e)(1) and (e)(1)(i) to provide that "effective for cost reporting periods beginning on or after October 1, 2006, if a new teaching hospital does not have residents on duty during the first month of that period, the PRA will be determined using information from the cost reporting period immediately following the cost reporting period during which the hospital participates in Medicare and residents began training at the hospital even if the residents are not on duty during the first month of that period."

4. Requirements for Counting and Appropriate Documentation of FTE Residents: Clarification (§§ 412.105(f), 413.75(d), 413.78(b) and (e), 413.80, and 413.81)

Despite the fact that current policies concerning the counting of FTE residents for IME and direct GME payment purposes have been in effect since October 1985, we continue to receive questions on the proper counting and appropriate documentation for FTE residents for IME and direct GME payment purposes. As a result of these continuing questions, in the FY 2007 IPPS proposed rule (71 FR 24113), we included a clarification of policies that apply in determining hospitals' FTE resident counts for Medicare GME payment purposes.

In the existing regulations at § 413.78(b) for direct GME payments, we specify that no individual may be counted as more than one FTE, and that a hospital cannot claim the time spent by residents training at another hospital. Therefore, if a resident spends time training in more than one hospital, the residents counts as a partial FTE based on the portion of time the resident trains at the hospital (and a nonhospital setting if the hospital meets the requirements of § 413.78(e)) to the total time worked. (The same provisions apply to part-time residents as specified in § 413.78(b)). A similar policy exists at § 412.105(f)(1)(ii) and (iii) for purposes of counting FTE residents for IME payment purposes. As we have explained in previous **Federal Register** documents (55 FR 36064 and 67 FR 50077), these policies apply even when a hospital actually incurs the cost of training the resident(s) at *another* hospital(s). For example, during a cost reporting year, a full-time resident trains at Hospital A for 6 months and trains at Hospital B for 6 months. Hospital A is paying the salary and fringe benefits of the resident for the entire year. In this case, each hospital would only count 0.5 of an FTE at the most for that resident. Hospital A would *not* be able to count the entire FTE for that resident, regardless of the fact that it incurred all of the training costs for the resident during that training year.

We also have become aware of issues that have arisen due to a hospital's failure to document the number of FTE residents claimed on its cost report. Proper documentation is required so that Medicare fiscal intermediaries can determine where and when a resident(s) is training and to allow the fiscal intermediary to make payment to the hospital based on the time the resident(s) spends at the hospital, which may be a percentage of the total time trained. A rotation schedule is the primary documentation that can be used to support the direct GME and IME resident counts but other similar documentation may be acceptable. The following is a situation about which we learned that illustrates how inadequate documentation resulted in inappropriate counting of FTEs. Two hospitals, Hospital C and D, were "associated" with each other, with residents training at both hospitals. However, instead of differentiating between the number of FTEs and the actual amount of time spent at each hospital, Hospitals C and D split the FTEs 50/50. Since, in reality, the number of residents actually training at each hospital differed, splitting the FTE

count 50/50 resulted in inappropriate payment to both hospitals. Hospitals are not permitted to decide among themselves how their FTEs will be counted. A hospital may not count a greater number of FTE residents than is actually training at the hospital (or its nonhospital sites) during the year. Each hospital must have documentation which demonstrates, for the entire cost reporting period, the amount of time that the resident trained at the hospital and, if applicable, a nonhospital site. Furthermore, to the extent that residents train in nonhospital sites, the hospital claiming the FTEs in the nonhospital site must meet the requirements at § 413.78(e).

Situations such as the one described above involving Hospital C and Hospital D are particularly harmful when one or more of the hospitals involved incorrectly reported FTEs in the cost reporting period used to establish one or more of the hospitals' FTE resident caps, and as a result, the caps were established incorrectly. Unless the incorrect caps can be revised pursuant to our regulations regarding review and revision of agency determinations, those caps must be applied to the hospital(s) in future years. For instance, we have learned of situations where a hospital's FTE resident caps were established incorrectly a number of years earlier and, due to administrative finality of settled cost reports, can no longer be adjusted. However, going forward, that cap will be applied to the hospital's count of FTEs, which must reflect the number of FTE residents actually training in the hospital (or in nonhospital sites where applicable).

In order to ensure that FTEs are being properly counted, hospitals are required to furnish specific documentation to support the number of FTE residents included in the hospital's FTE count. Section 413.75(d) specifies the requirements concerning documentation of FTE residents. Proper documentation must include the following information: The name and social security number of the resident; the type of residency program in which the individual participates and the number of years the resident has completed in all types of residency programs; the dates the resident is assigned to the hospital and any hospital-based providers (similar to the rotation schedule); the dates the resident is assigned to other hospitals, or other freestanding providers, and any nonprovider setting during the cost reporting period, if any; and the name of the employer paying the resident's salary. In addition, the documentation should include the name of the medical, osteopathic, dental, or podiatric school from which the resident graduated and the date of graduation, and whether the resident is a foreign medical graduate, including documentation concerning whether the resident has satisfied the regulatory requirements for foreign medical graduates at § 413.80. The information must be certified by an official of the hospital and, if different, an official responsible for administering the residency program. Again, proper documentation on where and when a FTE resident is training during a cost reporting period is essential in order for the hospital to receive direct GME and IME payments based on the correct number of FTE resident(s). Inaccurate, incomplete, or inappropriate documentation will lead to Medicare disallowing certain FTE residents from being counted for purposes of direct GME and IME payments. We note that we are *not* expanding or making any changes to current policy for proper documentation of FTEs. Rather, we are clarifying the existing regulations concerning proper counting and documentation of FTEs.

Comment: Several commenters noted that the issue of proper documentation has been a frequent topic of discussion between teaching hospitals and fiscal intermediaries and that concerns involving the "lack of uniform standards" for documentation, burdens related to "duplicative documentation requests," and matters pertaining to the "Medicare audit process" have been communicated to the CMS central office. Several commenters asserted that the Medicare Intern and Resident Information System (IRIS) is used by many teaching hospitals as a means of documentation and verification of FTE resident rotations and counts. One commenter noted further that since teaching hospitals and fiscal intermediaries use the IRIS "* * *as the key reporting tool for resident information * * *" CMS should contribute further resources and consideration to maintaining the IRIS and ensuring that the program itself and its technical support systems are "state-of-the-art." Specifically, the commenter stated that because CMS is the agency responsible for the management of the Medicare program, it has the responsibility to update the IRIS so that it is a "user-friendly" tool for teaching hospitals. In addition, the commenter noted that because the IRIS has not recently been updated, teaching hospitals have had to rely on private software in order to use the IRIS. The commenter stated that it is inappropriate that teaching hospitals have had to rely on private software to make the IRIS work. The commenter suggested that CMS form an IRIS task force comprised of "* * * CMS policy staff, CMS audit staff, and industry and intermediary representation * * *" to attend to concerns involving the IRIS.

Response: We believe that § 413.75(d) clearly specifies the documentation that is required to allow a hospital to count FTE residents for Medicare payment purposes. However, we encourage hospitals and fiscal intermediaries to contact CMS with questions they have about proper documentation. With regards to the use of the IRIS in determining a hospital's FTE resident count and as a source for documentation purposes, we note that currently the IRIS does not contain all of the specific documentation requirements cited under § 413.75(d) and § 412.105(f)(1). Furthermore, the IRIS does not serve as the evidence/documentation that supports the accuracy of the FTE resident counts reported in the cost report, which is the subject of section IV.H.4. of this preamble. The hospitals prepare the IRIS using actual records (for example, rotation schedules or similar documentation) that could be proper evidence/documentation to support the accuracy of the FTE resident counts reported in the cost report. In addition, we are aware that, for whatever reasons, the FTE resident counts computed using the IRIS information do not always match the FTE resident counts reported in the related cost reports. Thus, the IRIS is not, in itself, a sufficient mechanism for hospitals to meet their obligation to furnish information required under § 413.75(d) to support the FTE resident counts reported in the cost report. We emphasize that rotation schedules or other similar documentation should stand as the primary evidence to support hospitals' FTE resident counts. Regarding the commenter's assertion that it is inappropriate that teaching hospitals have had to rely on a private software program for IRIS use, we note that CMS does not mandate that fiscal intermediaries purchase separate software packages to supplement the IRIS. Where the hospitals or the fiscal intermediaries utilize a private software program for the IRIS, those fiscal intermediaries can use the IRIS in conjunction with the rotation schedule or similar documentation as an audit tool to identify duplicates, that is, the counting of the same resident by more than one hospital.

Comment: One commenter noted that in order for hospitals and intermediaries to determine proper GME reimbursement improved guidance and reporting systems are necessary, and

that, without better guidance, mistakes will continue to be made by hospitals and intermediaries. Furthermore, the commenter stated that in order to maintain a cost effective policy, GME payment policy should be evaluated from time to time "* * * to determine operational efficiency and effectiveness." The commenter stated that maintaining a cost effective approach includes limiting disagreements between teaching hospitals and fiscal intermediaries which requires that Medicare direct hospitals and fiscal intermediaries, "* * * on the spirit and intent of the law." The commenter stated that, although the law imparts that payment be rooted in rules of nongovernmental organizations, "* * * such as the American Council of Graduate Medical Education (ACGME) and American Board of Medical Specialties (ABMS)," the rules of these organizations "* * * are not enforced rigidly and do not have the force of the law." The commenter understands that policy cannot cover every issue but stated that "* * * financial auditors will not allow a situation unless it is specifically addressed in regulation and other directives."

The commenter asserted that, "improper payment is usually due to the intermediaries' lack of knowledge about a policy or misunderstanding about the GME rules and, [t]o remedy the fact that intermediaries are not well versed in many of the basic principles required for GME audit work, there is a need for Medicare GME payment specialists." In addition, the commenter stated that hospitals must deal with inconsistencies from year to year due to different auditors and the auditors' requirements for documentation. The commenter further stated that Medicare policies established to adhere with the law are instituted without an adequate understanding of how teaching programs and hospitals function. The commenter asserted that it is time to provide further guidance to fiscal intermediaries and hospitals on. Medicare GME payment policy and one way CMS could provide further guidance is to revise the Provider Reimbursement Review Manual (PRM) instead of issuing instructions through multiple **Federal Register**s.

In addition, the commenter stated that a cost effective measure to take to correctly count FTE residents would be to modify the IRIS because the system currently does not incorporate sufficient information to meet the regulatory requirement to report all training locations for an individual resident, and only identifies a range of dates where some FTE time is counted for the same resident by more than one hospital. Furthermore, the commenter stated that fiscal intermediaries interpret software limitations as the need for hospitals to provide supplementary documentation. The commenter noted that "[i]n practice, neither the intermediary nor the hospitals have followed the regulatory requirement to report all training locations of a resident" and therefore recommended that "* * * CMS clarify that hospitals must obtain a report from the entity sponsoring the training program that lists each resident's training location." Furthermore, the commenter asserted that "[t]he intermediary's level of acceptable documents has been increasingly stringent * * *" and that there have been occasions where disallowances have occurred because the submitted documentation did not meet individual intermediary requirements. The commenter also provided other examples of situations where auditors have disallowed FTE residents.

Response: We acknowledge that the PRM should be revised and updated to incorporate current GME policies. However, we disagree with the commenters' assertion that not enough guidance is provided to teaching hospitals concerning Medicare's GME payment policies. In addition to clarifying policy through public Q&As and **Federal Register**s, we meet with teaching hospitals and intermediaries on hospital-specific issues and with associations representing teaching hospitals in order to clarify GME policy. We urge hospitals and fiscal intermediaries to contact us regarding questions they have about appropriate documentation. With regards to the use of the IRIS in determining a hospital's FTE resident count, we note that the IRIS is only intended to serve as an audit tool to help identify duplicates and does not contain all of the specific documentation requirements listed under § 413.75(d) and § 412.105(f)(1) and, therefore, additional documentation is required. As previously mentioned, the fact that the IRIS does not meet the regulatory provision to report all training locations for an individual resident is not the only reason that the IRIS cannot serve as the evidence/documentation to support the accuracy of the FTE resident counts reported in the cost report. Modification of the IRIS would not eliminate the need for auditable evidence to support the cost report and the information included in the IRIS. We specified in the preamble background and the previous response in this section that CMS considers the rotation schedules or similar documentation as the primary evidence to support the FTE resident counts. In response to the commenter's recommendation that sponsoring institutions submit documentation listing residents' training locations, the rotation schedules are prepared by the Director of the GME program of the sponsoring institution. These types of rotation schedules should be used by the hospital to determine the cost report FTE resident counts and be furnished by the hospital to the fiscal intermediary when requested for audit purposes.

Comment: One commenter noted that the documentation submitted in accordance with § 413.75(d) needs to be certified by an official of the hospital or by an official responsible for administering the residency program. The commenter was unclear as to what exactly needs to be certified, and in what format, and asked if submission and certification of the IRIS report meets the certification requirement.

Response: The IRIS report does not contain all the information listed in § 413.75(d) or § 412.105(f)(1). Therefore, in itself, it does not meet all the requirements of these sections regardless of whether it is certified or not. Therefore, in addition to submitting the IRIS report, the hospital must submit the other documentation elements specified in § 413.75(d), and those must be certified by a hospital or GME program official.

Comment: One commenter expressed concern over the policies regarding the proper counting of FTE residents. Specifically, the commenter expressed dismay that a hospital can count resident training time for GME payment purposes when the resident rotates to a nonhospital site but not when a resident is training at another hospital even if the teaching hospital is incurring all the training costs of that resident at that other hospital. The commenter noted that this policy is particularly detrimental to emergency medicine. The commenter stated that the Accreditation Council for Graduate Medical Education (ACGME) sets forth a required case volume for residency training in emergency medicine and that this volume requirement limits the number of rural emergency medical residency training programs. The commenter noted that in an effort to provide residents in emergency medicine with experience in rural practice, attempts have been made to expand training to rural hospitals. The commenter noted that since few small rural hospitals "* * * want to undertake the burden of becoming teaching hospitals in their

own right * * *," the major teaching hospitals have continued to pay the costs of those residents training at the rural hospitals. The commenter stated that the current policy opposes efforts of governmental agencies to increase training in rural areas and further stated that more residency program directors would make rural training available if they were permitted to continue to count residents that were rotating to rural hospitals. The commenter urged CMS to change its policy to allow payment to the primary teaching institution for resident time spent in rural hospitals in situations where it is not economically feasible for the rural hospital to become a teaching hospital.

Response: We agree that efforts should be made to ensure that residency training is occurring at rural facilities so that residents are prepared to work in these environments upon completion of their residency training programs. However, we do not believe that it is consistent with the requirements at sections 1886(d)(5)(B)(IV) and 1886(h)(4)(E) of the Social Security Act to expand the policy to allow hospitals to count residents training at rural hospitals even if the hospital seeking to count the resident is paying the cost of training for those residents rotating to the rural hospital. In addition, section 1886(h)(4)(B) of the Social Security Act requires that the regulations take into account individuals who serve as residents simultaneously in more than one hospital. Therefore, we believe that the statute contemplates allowing a hospital to count only those residents actually training in that hospital. We do not believe it is appropriate for the "primary" teaching hospital to include time spent by residents at other hospitals in its FTE count, even when the "primary" teaching hospital is incurring the costs of training the residents.

Comment: One commenter stated that fiscal intermediaries may be using the IRPs set forth in the August 30, 1996 **Federal Register**. The commenter noted that in the August 30, 1996 **Federal Register**, CMS set an IRP of 2 years for podiatry residency programs. The commenter noted, however, that since at least 2003, the Council on Podiatric Medical Education (CPME) has stated that there exists both a 2-year podiatric medicine and surgery-24 program and a 3-year podiatric medicine and surgery-36 program. The commenter requested that all intermediaries use the most recent information regarding the length of the relevant training programs as set forth by the relevant accrediting organizations, in this case the CPME.

Response: We did not propose any changes in policy regarding IRPs in the FY 2007 IPPS proposed rule. We consider this comment out of the scope of the proposed rule. Therefore, we are not responding to this comment at this time.

5. Resident Time Spent in Nonpatient Care Activities as Part of Approved Residency Programs (§§ 413.9 and 413.78(a))

In section IV.H.4. of this preamble, we discussed the importance of properly documenting where and when residents are training in a particular hospital or nonhospital site, in order for that hospital to count those FTE residents for purposes of direct GME and IME payment. In addition, it is important for hospitals to be able to document the activities in which residents are engaged because there are certain activities that are not allowable for direct GME or IME payment purposes, even though those activities may be performed as part of an approved residency program. Specifically, it has come to our attention that there may be some confusion in the provider community as to whether the time that residents spend in nonpatient care activities that are part of the approved residency program may be counted for the purpose of direct GME and IME payments. We have most recently received questions as to whether the time residents spend in nonhospital sites in didactic activities such as journal clubs or classroom lectures may be included in determining the allowable FTE resident counts. To respond to these inquiries and to resolve any confusion, in the FY 2007 IPPS proposed rule (71 FR 24114 and 24115), we included a clarification of our policy concerning the counting of time spent in nonpatient care activities for the purpose of direct GME and IME payments in both hospital and nonhospital settings.

With respect to training in nonhospital settings, the time that residents spend in nonpatient care activities as part of an approved program, including didactic activities, cannot be included in a hospital's direct GME or IME FTE resident count. This longstanding policy is based on the statutory requirements for counting FTE residents training in nonhospital sites. For the purpose of direct GME payments, providers have been allowed since July 1, 1987, to count the time residents spend training in nonhospital sites under certain conditions. Section 1886(h)(4)(E) of the Act specifies that the implementing regulations concerning computation of direct GME for training in nonhospital sites "shall provide that *only time spent in activities relating to patient care* shall be counted and that all the time so spent by a resident under an approved medical residency training program shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs all, or substantially all, of the costs for the training program in that setting" (emphasis added).

For IME payment purposes, hospitals were first allowed to count the time residents spend training in nonhospital sites for discharges occurring on or after October 1, 1997. Section 1886(d)(5)(B)(iv) of the Act was amended by Pub. L. 105–33 in 1997 to provide that "all the time spent by an intern or resident *in patient care activities* under an approved medical residency program at an entity in a nonhospital setting shall be counted towards the determination of full-time equivalency if the hospital incurs all, or substantially all, of the costs for the training program in that setting" (emphasis added).

We understand that, as part of an approved medical residency program, residents are often required to participate in didactic and "scholarly" activities such as educational conferences, journal clubs, and seminars. Some of these activities may take place in nonhospital sites, such as freestanding clinics or physicians' offices, or in conference rooms at nonhospital settings. In implementing section 1886(h)(4)(E) of the Act for direct GME payment purposes, we specifically stated that "only time spent in activities relating to patient care may be counted [in nonhospital sites]" (54 FR 40292, September 29, 1989). In 1998, when we implemented the statute allowing FTE residents to be counted in nonhospital sites for IME, we reiterated that a hospital may only count resident training time "in nonhospital sites for indirect and direct GME, respectively, if the resident is involved in patient care" (63 FR 40986, July 31, 1998). While we have not explicitly defined in regulations "patient care activities," we have applied the plain meaning of that term. In addition, we note that the scope of the term "patient care" had been well-established in the Medicare program even prior to issuance of the first rules on counting FTE residents for purposes of direct GME and IME payments. For example, prior to the IPPS, acute care hospitals were paid by Medicare for inpatient services based on their reasonable operating costs, or costs relating to the provision of reasonable and necessary "patient care." The

longstanding regulation at 42 CFR 413.9, entitled "Costs related to patient care," states that "all payments to providers of services must be based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries." Thus, the scope of costs recognized as reasonable under Medicare had been limited to those relating to "patient care," or to those relating to covered services for the care of beneficiaries. Although the agency appears to have made a conflicting statement in a letter directed to a particular individual implying that didactic time spent in nonhospital settings could be counted for direct GME and IME, that statement was inaccurate. We have applied and continue to apply the plain meaning of the statutory terms "patient care activities" and "activities relating to patient care" in the context of approved GME programs. That is, the plain meaning of patient care activities would certainly not encompass didactic activities. Rather, the plain meaning refers to the care and treatment of particular patients, or to services for which a physician or other practitioner may bill. Time spent by residents in such patient care activities may be counted for direct GME and IME payment purposes in the nonhospital site. Time spent by residents in other activities in the nonhospital site that do not involve the care and treatment of particular patients, such as didactic or "scholarly" activities, is not allowable for direct GME and IME payment purposes.

We note that there is a difference in the rules for counting FTE resident time for IME and direct GME payments when residents are training in a hospital. For direct GME payment purposes, under § 413.78(a), "residents in an approved program working in all areas of the hospital complex may be counted." As explained in the September 29, 1989 **Federal Register** document (54 FR 40286), the hospital complex consists of the hospital and the hospital-based providers and subproviders. Therefore, the distinction between patient care activities and nonpatient care activities is not relevant to direct GME FTE count determinations when the residents are training in the hospital complex. However, for IME payment purposes, consistent with the regulations at § 413.9, only time spent in patient care activities in the hospital may be counted. It has been our longstanding policy that, regardless of the site of training, "* * * we do not include residents in the IME count to the extent that the residents are not involved in furnishing patient care * * *" (66 FR 39897, August 1, 2001).

Comment: Many commenters took issue with CMS's "clarification" that FTE resident time spent in didactic activities while training in the hospital could not be counted for purposes of IME payment, and while training in a nonhospital site could not be counted for either direct GME or IME payments. The commenters urged CMS to "revert" to the position expressed in a letter in 1999, and questioned whether, in light of that 1999 letter, CMS is actually "clarifying" its policy rather than changing existing policy. One commenter suggested that to "avoid challenges" to CMS's policy, a definition of "patient care activities" should be promulgated under the Administrative Procedures Act (APA). Another commenter argued that it is "improper" for CMS to exclude nonpatient care time from the IME count for fiscal years prior to 2001 (as the April 25, 2006 proposed rule would) because CMS did not enact regulations requiring the exclusion of nonpatient care activities from the IME count until 2001. The commenter observed that in the April 25, 2006 proposed rule, as in the 2001 rule (66 FR 39898), CMS stated that the rule excluding nonpatient care time from the IME count was "longstanding" policy and applies to periods prior to 2001. The commenter asserted that it is inappropriate for the agency to apply the policy expressed in the April 25, 2006 proposed rule retroactively (as was done in 2001) because it "amends the agency's policy prior to 2001 without notice and comment rulemaking as required by the APA." Another commenter noted that, as justification for CMS's "longstanding policy" concerning patient care activities, CMS quoted from the August 1, 2001 final rule (66 FR 39897) which states that "we do not include residents in the IME count to the extent that the residents are not involved in furnishing patient care * * *." The commenter stated that CMS "failed" to include the remainder of the text, which states "but are instead engaged exclusively in research." The commenter argued that the excluded phrase indicates that CMS only meant to exclude research activities that are not patient-related from the IME count, and that "nowhere is the word 'didactic' ever mentioned."

Response: We disagree with the commenters' assertion that the provision in the proposed rule concerning the time residents spend in nonpatient care activities is a change in policy, rather than a clarification of existing policy. With respect to residency training occurring in nonhospital settings, in the April 25, 2006 proposed rule (71 FR 24115), we enumerated several examples to illustrate that the requirement for residents to spend time in patient care activities is fundamental to including the FTE resident time in the count for direct GME and IME purposes. Specifically, in implementing section 1886(h)(4)(E) of the Act, which allows hospitals to count time spent by residents training in nonhospital sites for direct GME payment purposes under certain circumstances including that the resident time be spent in activities related to patient care, we reiterated that "only time spent in activities relating to patient care may be counted" (54 FR 40292, September 29, 1989). In 1998, when we implemented section 1886(d)(5)(B)(iv), which first allowed hospitals to count time spent by residents in nonhospital sites for purposes of IME under certain conditions including that the resident time be spent in patient care activities, we reiterated that a hospital may only count resident training time "in nonhospital sites for indirect and direct GME, respectively, if the resident is involved in patient care" (63 FR 40986, July 31, 1998). In addition, we noted in the April 25, 2006 proposed rule that the scope of the term "patient care" had been well-established in the Medicare program even prior to issuance of the first rules on counting FTE residents for purposes of direct GME and IME payments.

While we have not explicitly defined "patient care activities" in regulations, we have consistently used the plain meaning of that term. This is the case despite the agency's erroneous response to a question on this issue in a September 24, 1999 letter. The commenters refer to this 1999 letter to support their argument that the "clarification" in the proposed rule demonstrates that CMS has changed its position since 1999. In the September 24, 1999 letter, CMS (then HCFA) wrote:

"HCFA interprets the phrase 'patient care activities' broadly to include any patient care oriented activities that are part of the residency program. * * * [T]his can include resident participation in "(1) the direct delivery of patient care, such as clinical rounds, discussions, and conferences, and (2) scholarly activities, such as educational seminars, classroom lectures, research conferences, patient care related research as part of the residency program, and presentations of papers and research results to fellow residents, medical students, and faculty."

As we stated in the April 25, 2006 proposed rule (71 FR 24115), in this

September 24, 1999 letter, we inaccurately stated our interpretation of the phrase "patient care activities," implying that didactic time spent in nonhospital settings could be counted for direct GME and IME purposes. While there is no explanation of the phrase "patient care activities" in the conference report language accompanying the change in the laws allowing the counting of FTE residents in nonhospital sites in 1987 for direct GME and in 1997 for IME, we believe that Congress intended to limit in some meaningful way the types of activities for which FTE resident time could be counted in the nonhospital setting. If the term "patient care" in the statutory phrase "only time spent in activities relating to patient care" (section 1886(h)(4)(E) of the Act) was to be interpreted as broadly as suggested in the agency's September 24, 1999 letter, there would be virtually no limit to the types of activities that could be counted, rendering the entire phrase, and particularly, the word "only," meaningless. If Congress had desired that all FTE time as part of an approved program be counted in nonhospital sites, then it need not have added the limiting language concerning patient care. It could have stated simply that time spent in an approved program at a nonhospital site should be counted. We do not believe that Congress would have included a superfluous phrase in the statute. As the commenters point out, CMS had not defined the term "patient care" prior to the enactment of either of the statutory provisions in 1987 and 1997. Therefore, we believe that when Congress used the term "patient care", it meant to give the term its plain meaning. Such a plain meaning of the statutory language is in direct conflict with the exceedingly broad definition of "patient care activities" articulated in the September 24, 1999 letter. We do not believe it would be appropriate to adopt a broad definition of patient care activities as was expressed in the 1999 letter when that definition would conflict with the plain meaning of a limiting phrase in the statute—to the extent that it would give little or no meaning to the statutory phrase. Moreover, we believe it would be particularly inappropriate to adopt such a broad construction when the definition has not been promulgated through notice and comment rulemaking, but rather, expressed in a single letter directed to a single individual.

We also question whether the provider community would actually have relied as heavily as commenters suggest on the September 24, 1999 letter when it was clearly directed to a single attorney in response to his specific inquiry, and not to a broader audience, nor was it (nor any similar guidance) disseminated by the Agency to its fiscal intermediaries. Furthermore, although we believe that the letter responding to this attorney contained an inartful and incorrect expression of the policy concerning nonpatient care activities, we do not believe that expression should be used to permit the indiscriminate inclusion of FTE resident time spent in nonpatient care activities in nonhospital sites.

With respect to residency training in the hospital, our policy limiting the IME count to only time spent in patient care activities is rooted in the creation and the purpose of the IME adjustment. The IME adjustment is a payment to a teaching hospital for its higher costs of patient care. Before Congress passed the 1983 law that included the IME adjustment in the IPPS, the Secretary submitted a report to Congress in 1982 that (in part) explained that, "the indirect costs of graduate medical education are higher patient care costs incurred by hospitals with medical education programs" (Report to Congress required by the Tax Equity and Fiscal Responsibility Act of 1982, December 1982, pp. 48–49, italics emphasis added). Similarly, in passing the IPPS legislation in 1983, the House Committee on Ways and Means acknowledged the link between higher patient care costs and teaching hospitals, and noted that the IME adjustment was important due to concerns about whether the PPS could adequately account for factors such as the severity of illness of patients utilizing the more specialized treatment programs at teaching hospitals. Thus, the reasons for the IME adjustment enumerated by Congress and by the Secretary are directly linked to the involvement of residents in patient care. The August 1, 2001 final rule (66 FR 39897) also lists discussions in other Federal Register notices in the 1980s that clearly state that the indirect costs of medical education are the additional operating costs that teaching hospitals incur in furnishing patient care. We reiterated this longstanding policy in the August 1, 2001 final rule and stated that, "* * * consistent with the purpose of IME payments and general Medicare reimbursement principles, in determining the FTE count with respect to the IME adjustment, it has been our longstanding policy that we do not include residents to the extent that the residents are not involved in patient care [but are instead engaged exclusively in research]" (66 FR 39897). One of the commenters stated that, in the discussion in the April 25, 2006 proposed rule (71 FR 24115), "CMS failed to include the remainder of the text which states 'but are instead engaged exclusively in research.' These excluded words put in context what CMS was trying to convey in that rule—that in terms of research activities, only those that are patient-related may be counted. Nowhere is the word 'didactic' ever mentioned." We did not include the remainder of that text in the proposed rule because the focus of the discussion in the proposed rule was on didactic activities, not research. However, we reiterate that, just as residents engaged in activities that are exclusively research are not engaged in patient care activities, and are not included in the IME count in the hospital, residents in the hospital engaged in didactic, nonpatient care activities are also not counted for the purpose of IME.

Comment: Several commenters pointed to what they believe is an "inconsistency of logic" concerning CMS' position regarding the time that may be included in the resident count at nonhospital settings, and the policy concerning the time for which a hospital must incur the costs relating to a teaching physician in those settings. On the one hand, CMS argues that in order for hospitals to receive direct GME and IME payments relating to residents training in nonhospital settings, the hospital must pay for the costs of the time spent by teaching physicians in educating residents, even when the activities are not associated with patient care. On the other hand, CMS precludes hospitals from counting FTE resident time not spent in patient care activities. According to the commenters, these "conflicting positions" where the hospitals must pay for costs of training time that they cannot count for purposes of direct GME and IME payments will result in confusion in the provider community.

Response: We are aware of what the commenter views as a paradox in the requirements concerning the time that residents train in nonhospital settings. Nevertheless, the statute clearly requires that hospitals must incur "all, or substantially all, of the costs for the training program" in the nonhospital setting in order to count any FTE residents training at a nonhospital site for IME and direct GME purposes (§ 1886(d)(5)(B)(iv) and § 1886(h)(4)(E) of the Act). The definition of "all or substantially all of the costs for the training program in the nonhospital

site" at § 413.75(b) is consistent with what CMS (and previously HCFA) has always considered to be "direct costs" of a GME program, inlcuding "the residents' salaries and fringe benefits * * * and the portion of the cost of teaching physicians' salaries and fringe benefits attributable to direct GME." The direct costs of GME associated with teaching physicians were historically paid for under Part A of the Medicare Trust Fund, while payment for billable, patient care services provided by residents supervised by teaching physicians are generally paid under Medicare Part B. Therefore, the costs associated with patient care activities in which the teaching physicians are involved are not included in the direct costs of the GME program. Yet, in allowing hospitals to count FTE residents training in nonhospital sites, the statutory provision regarding direct GME also states that "only time spent in activities relating to patient care shall be counted * * *" (§ 1886(h)(4)(E) of the Act). Similarly, the statutory provision regarding IME states, "all the time spent by an intern or resident in patient care activities * * * shall be counted * * *" (§ 1886(d)(5)(B)(iv)). Consequently, hospitals are not permitted to count a portion of the FTE resident time (that is, the nonpatient care time) even though they must incur the training program costs associated with that time.

Comment: Several commenters stated that the IME and direct GME statute pertaining to nonhospital sites supports the counting of didactic activities, and that Congress wanted to encourage, not limit, residency training in nonhospital sites. The commenters believe that the reference to "patient care activities" in the IME and direct GME nonhospital statutes refers generally to patient care settings, such as physicians' offices and other ambulatory care sites. One commenter cited the statutory language as the reason why hospitals exclude extended periods of time spent exclusively in "bench" research outside of the hospital, or time spent by preventive medicine residents in state and local public health departments from the IME and direct GME FTE counts, since these activities do not involve "patient care." Another commenter implied that didactic time in nonhospital sites is allowed for IME purposes since the conference agreement accompanying the legislative language in the BBA states, "The conference agreement includes new permission for hospitals to rotate residents through nonhospital settings, which include primarily ambulatory care settings, *without reduction indirect medical education funds*" (emphasis added). Commenters also stated that Congress was "well aware" that residency training involves didactic components, and Congressional actions in both COBRA 1986 (enacting the direct GME nonhospital site provision) and BBA 1997 (enacting the IME nonhospital site provision) make it clear that Medicare would allow hospitals to count time spent in nonhospital sites for purposes of direct GME and IME.

Response: We believe the commenters have erroneously concluded that because Congress desired to encourage increased residency training in nonhospital sites, the nonhospital IME and direct GME statutes must, therefore, also support the counting of FTE residents engaged in didactic activities in nonhospital sites. In fact, despite the lack of an explicit explanation of what was intended by the term "patient care activities," when the Conference committee report language is viewed in conjunction with the statute, we believe the obvious and correct conclusion is that Congress wanted to encourage more training in nonhospital settings, but only for the purpose of increasing patient care training in outpatient, ambulatory settings. This Congressional intent is evident in the legislative history of both the direct GME and the IME provisions on nonhospital settings. First, legislative history associated with passage of the direct GME provision (as part of Pub. L. 99–509) indicates that "[s]ince it is difficult to find sufficient other sources of funding [other than hospitals and Medicare] for the costs of such training, [that is, training in freestanding primary care settings such as family practice clinics or ambulatory surgery centers] assignments to these settings are discouraged [under the pre-enactment payment scheme]. It is the Committee's view that training in these settings is desirable, because of the growing trend to treat more patients out of the inpatient hospital setting and because of the encouragement it gives to primary care." (Emphasis added.) (H.R. Rep. No. 99–727, 99th Cong., 1st Sess., 70 (1986).) Thus, from the start of the provision allowing hospitals to count FTE resident training in nonprovider sites, we believe Congress intended to create a monetary incentive (or remove the disincentive) for hospitals to rotate residents from the hospital to the nonhospital settings for the purpose of treating patients in those ambulatory settings, *not* for the purpose of spending time in didactic activities in those settings. We believe this is the reason why Congress specifically added the "patient care activities" requirement to the direct GME (and later, the IME) statute. Similarly, in the Conference committee report accompanying the provision of Pub. L. 105–33 on counting resident training time in nonhospital settings for IME, Congress stated that "[t]he conference agreement includes new permission for hospitals to rotate residents through nonhospital settings, without reduction in indirect medical education funds" (emphasis added, H.R. Conf. Rep. No. 105–217, 105th Cong., 1st Sess., 817 (1997).) We believe that by the phrase "without reduction in indirect medical education funds," Congress intended that when hospitals send residents to nonhospital sites for training, the IME payments relating to those FTE residents would not cease; that is, the hospitals would continue to receive IME, in addition to the direct GME payments they were already receiving when residents rotate from the hospitals to nonhospital settings. Furthermore, as we stated in the August 1, 2003 final rule in the context of redistribution of cost and community support principles (68 FR 45436), legislative intent becomes even more evident when the nature of the IME adjustment is considered. Because the IME adjustment is a payment for patient care costs that is made for each Medicare discharge from the areas subject to the IPPS in a teaching hospital, "the authorization by Congress for IME payments relating to nonhospital services while residents are training at nonhospital sites would be absurd if not viewed as an incentive to transfer existing residency training from the hospital to the nonhospital setting" (68 FR 45436). Given the nature of IME as a patient care payment, surely Congress would not have made IME payments available for training in nonhospital settings to encourage movement of didactic training from the hospital to nonhospital sites. To the contrary, we believe Congress clearly intended to encourage hospitals to shift only residency training that involves patient care activities from the hospital to outpatient ambulatory settings.

Comment: One commenter alleged that, "in a very misleading fashion in the proposed rule, CMS does not quote the entire section of the relevant portion of the Medicare statute, which reads in full:

"Counting Time Spent in Outpatient Settings. Such rules shall provide that only time spent in activities relating to patient care shall be counted and that all the time so spent by a resident under an approved medical residency training program shall be counted toward the determination of full-time equivalency, without regard to the setting in which

the activities are performed, if the hospital incurs all, or substantially all, of the costs for the training in that setting." (Emphasis added). Section 1886(h)(4)(E) of the Social Security Act."

The commenter argued that Congress and CMS are well aware of the language that can be used to describe care directly provided to individual patients; that is "direct patient care." The commenter included a list of mostly regulatory (and 2 statutory) cites where the term "direct patient care" is used and noted that the statutory language regarding GME does not use the term "direct patient care," but rather, uses the much broader language of "activities relating to patient care." Further, the law states that "all the time so spent by a resident under an approved medical residency training program shall be counted * * * without regard to the setting in which the activities are performed" (emphasis added.) The commenter added that Medicare regulations also define "direct medical and surgical services" of physicians in a teaching setting as "services to individual beneficiaries that are either personally furnished by a physician or furnished by a resident under the supervision of a physician in a teaching hospital * * *" (42 CFR 415.152), and that in all these situations, the idea of "direct patient care" can be more narrowly defined than "activities relating to patient care."

Response: It appears that the commenter has overlooked the paragraph on page 24115 of the April 25, 2006 proposed rule where we did, in fact, quote the entire section of the statutory language pertaining to direct GME payments for nonhospital training. We also believe the statutory language is intended to be read differently from the way the commenter has suggested, resulting in a significantly different policy. Specifically, the commenter quotes and emphasizes the statute as follows: "*all the time* so spent by a resident under an approved medical residency training program shall be counted * * * without regard to the setting in which the activities are performed * * *" The commenter uses this language to suggest that CMS must allow the time spent in didactic activities in nonhospital sites. However, we believe the correct reading of the statute in its entirety is:

"Such rules shall provide that *only* time spent in activities relating to patient care shall be counted and that *all the time so spent* by a resident * * * shall be counted toward the determination of full-time equivalency, without regard to the setting in which the activities are performed * * *" (§ 1886(h)(4)(E) of the Act).

In other words, only a *subset* of the time that residents spend in nonhospital settings can be counted. Specifically, *only all of the time so spent* in activities relating to patient care can be counted, *not* necessarily all of the time spent training in the nonhospital site. Similarly, the IME statute states, "*all the time spent by an intern or resident in patient care activities* * * * shall be counted * * *" (§ 1886(d)(5)(B)(iv) of the Act). Furthermore, as we stated in response to previous comments, if "patient care" in the phrase "only time spent in activities relating to patient care" (section 1886(h)(4)(E) of the Act) is interpreted as broadly as suggested by the commenter, there would be virtually no limit to the types of activities that could be counted, rendering the entire phrase, and particularly the word "only," meaningless. In addition, we note that the definition of "direct medical and surgical services" at § 415.152 of regulations relating to physicians in a teaching setting is consistent with our definition of the plain meaning of "patient care activities." Just as the definition of "direct medical and surgical services" refers to services to individual beneficiaries that are either personally furnished by a physician or furnished by a resident under the supervision of a physician, our definition of "patient care activities" refers to the care and treatment of particular patients, or to services for which a physician or other practitioner may bill. Therefore, the terms "direct medical and surgical services" and "direct patient care" are, for all intents and purposes, synonymous with the phrase "patient care activities."

Comment: We received many comments expressing strong opposition to the clarification in the proposed rule, some of which were quite passionate and included ominous predictions of the dire consequences of such a policy on GME programs. Generally, commenters urged that we rescind the provision in the proposed rule, on the grounds that there is a very close connection between the didactic activities that residents engage in and the delivery of patient care. They argued that with the exception of extended periods of time spent doing "bench research" which is excluded from the IME count, every activity that the residents are engaged in is integral to patient care activities. The commenters argued that there is no distinction between patient care and other activities in which residents participate during their residency training. Rather, the distinction is more appropriate when comparing undergraduate medical training and post-graduate residency training. The commenters noted that the emphasis in medical school is didactic education, while the focus in residency training is patient care delivery, with continued didactic education in the context of furnishing patient care. The commenters argued that the didactic activities are an important part of the ACGME's required curriculum since it is now widely recognized that physicians should be competent in "medical knowledge about established and evolving biomedical, clinical, and cognate * * * sciences and the application of this knowledge to patient care" (ACGME Institutional Requirements, III(E)(1)(b)). Several other commenters pointed out that the ACGME competencies are intended to address "exactly what the IOM has criticized our training professions for," and therefore, didactic sessions are necessary to improve the quality of residency education. These commenters stated that their program (family medicine) currently evaluates their residents "in all these competencies as a continuing quality improvement process during patient care" (emphasis in the original). Commenters representing osteopathic residency programs stated that all osteopathic training programs are required to teach certain core competencies by 2006. Another commenter stated that, in an effort to improve the residents' skills in delivering patient care, the teaching physician "looks for every opportunity, in whatever physical setting for the 'teachable moment' to review a critical point or two to hone the learner's skills." Commenters also asserted that most didactic activities are relatively short, and residents often continue to have direct patient care responsibilities during the didactic time, and are often paged to respond to emergencies or to tend to their assigned patients during scheduled didactic periods. They noted generally that current patients are often used as a springboard for discussions at lectures, and it would be extremely difficult to track when the "patient care" ends and the didactic time begins. In addition, residents are required to attend simulation programs, which prepare them for "real-time" patient care experiences using advanced technologies. A commenter urged CMS to promote and encourage investment in such technologies and activities that are intended to improve the quality of patient care, rather than "create reimbursement disincentives for institutions that may be struggling to

afford it." Many commenters indicated that if CMS finalized this rule, teaching faculty "will be caught up in the productivity race with no time for" valuable discussions with their residents, at a time when family physicians need to be "exceptionally well trained" in order to meet the needs of underserved, vulnerable patient population who need chronic disease management. The commenters warned that CMS's proposal "lowers the standards of care for Medicare patients" and is "dangerous for our current and our future patients." One commenter asked that we reconsider rule changes that will "rob Peter to pay Paul," while another commenter urged that we "please [do] not allow anything to occur that might reduce the attractiveness" of medical school graduates pursuing primary care specialties. One commenter added that with the recent loss of funding for primary care education in Title VII of the Public Health Act, this ruling could "literally spell the end of primary care practice in the United States." Another commenter asked if "perhaps [CMS] could refocus [its] efforts toward educating doctors instead of spending so much of [its] time identifying new ways of withholding funding." We also received a comment that stated that reimbursement for direct GME and IME is "sufficiently restricted" by limits on increases to per resident amounts (PRAs) and FTE resident caps, and there is no need to impose additional "burdensome recordkeeping requirements with the sole apparent intent of further reducing such payments."

Response: We are sympathetic to the commenters' arguments that the didactic activities in which the residents are required to participate contribute to the development of more highly skilled, proficient, well-rounded clinicians, and we are not in any way minimizing the importance of such activities, nor are we advocating a position that would deny *all* GME payments for these activities. However, we note that Medicare GME payments were never intended to cover the *total* costs of medical education, as is evidenced most obviously by the fact that direct GME payments are based on Medicare's share of the costs of training an FTE resident. Rather, we are merely distinguishing between activities that concern the treatment and diagnosis of particular patients (that is, patient care), and activities that are didactic in nature (that is, not patient care), as this distinction is necessary to ensure that Medicare funds for medical education are paid appropriately. Direct GME has historically been considered to be the payment for the direct costs of education. Accordingly, the direct educational costs incurred by a hospital in providing didactic activities are more appropriately paid for via the direct GME payment. We note that the methodology used to determine hospitals' base year direct GME PRAs included the allowable costs and FTE time of didactic activities occurring within the hospital complex. The IME adjustment serves an entirely different purpose. Specifically, the IME adjustment is a payment under the IPPS to recognize the higher operating costs that teaching hospitals incur in furnishing patient care; it is intended to pay a teaching hospital for those additional indirect patient care costs, not the direct costs associated with didactic learning.

Furthermore, while we do not dispute that didactic activities are essential to and integrated with the residents' patient care experience, this does *not* mean that the didactic activities are patient care activities. In addition, the didactic activities are not an insignificant portion of a resident's training. These activities are required by the accrediting organizations, and are necessary for board certification, and therefore, even though it may not be an unusual occurrence for a resident to be called out of a conference to tend to a patient care emergency, the resident surely must satisfy his/her minimum requirements of didactic training over the course of the entire academic year. A random search on the internet of individual hospitals' program requirements revealed that many programs schedule didactic activities for their residents of an hour or more in length every single day. In fact, many comments we received were from commenters who included detailed descriptions of the nonpatient care activities in which their residents are required to participate. We are also aware of rotations that are administrative or didactic in nature that are more lengthy (for example, 2 weeks or 6 weeks), but are scheduled less frequently. Such rotations are surely not patient care. Therefore, we are not convinced by the commenters' arguments that since didactic time is frequently integrated with patient care activities, it is patient care and, therefore, the time should be allowed for IME purposes in the hospital, and for direct GME and IME purposes in the nonhospital site.

Comment: One commenter noted that direct GME and IME payments are based on allowable "full-time equivalent" (FTE) counts, and that the regulations do not specify the number of hours that comprise one FTE. Rather, the regulations for IME state that "full-time equivalent status is based on the total time necessary to fill a residency slot" (§ 412.105(f)(1)(iii)(A)), and the direct GME regulations have a similar requirement (42 CFR § 413.78(a)).

Response: The commenter is correct that a hospital's allowable FTE count is "based on the total time necessary to fill a residency slot" (§ 412.105(f)(1)(iii)(A). As the regulations state, the concept of the total time necessary to fill a residency slot is used to determine the part-time or full-time status of the resident. If it is determined that the resident is not working the number of hours necessary to fill a residency slot (between all the resident's hospital and nonhospital training sites), the resident would be considered part-time, and the proportion of total time the resident is working in all training sites would be adjusted accordingly. For purposes of determining a hospital's count of FTE residents, the important word in the regulatory phrase is "based." That is, the starting point (denominator) for determining the allowable FTE count is the total time necessary to fill a residency slot. However, the hospital must then subtract (from the numerator) all nonallowable training time, such as time spent at other providers, time spent in IPPS-excluded distinct part units (for IME), didactic activities (for IME), and so on. Thus, while a hospital's allowable FTE count is certainly "based" on the total time necessary to fill a resident slot, the total time is often greater than the FTE time a particular hospital is permitted to count for IME and direct GME payment purposes.

Comment: One commenter noted that the average resident's workweek is 80 hours, and if CMS were to count an FTE resident for GME purposes based on a 40 hour workweek as is done for the Medicare IPPS wage index, the exclusion of didactic activities would not affect the overall FTE count.

Response: The total number of hours recorded as worked by residents for the purpose of the wage index adjustment to the IPPS represents a compromise, and is irrelevant in the context of determining the FTE resident count for GME payment. Historically, the actual number of hours worked by residents (often more than 80 hours per week) was included in the average hourly wages of hospitals used to compute the wage index. However, teaching hospitals argued that the excessive number of resident hours relative to the hours worked by other employees skewed their average hourly wage

downward, and placed them at a disadvantage relative to non-teaching hospitals. Therefore, CMS (then HCFA) determined that it would be appropriate to count interns and residents for wage index purposes based on a 40-hour workweek. Thus, the 40-hour workweek actually benefited teaching hospitals for wage index purposes. In any case, beginning with the FY 2000 wage index (which was based on cost reporting periods starting on or after October 1, 1995 and ending on or before September 30, 1996), the wages and hours of interns and residents were phased out of the wage index, since Medicare payments for the salaries and fringe benefits of interns and residents are made by Medicare through the direct GME payment (based on the PRA), and not the IPPS. (Beginning with the FY 2003 wage index (cost reporting periods beginning on or after October 1, 1999), we removed 100 percent of the interns' and residents' wage data from the wage index). For purposes of determining what portion of an FTE resident a hospital may count for a resident that is training at the hospital (after first determining whether the resident is a part-time or full-time resident based on the total necessary to fill the residency slot), it is important and necessary to first determine the actual total time worked by the resident. Accordingly, if 80 hours per week is established as the total time necessary to fill the residency slot, and if a resident works an 80-hour week and works 40 hours per week at each of two hospitals, each hospital would count no more than one half of an FTE for the resident. The FTE determination for that resident cannot be based on 40 hours, since that would result in both hospitals counting the same resident as a full FTE. Thus, in calculating the FTE count, it would be inappropriate to compare the time spent in patient care activities to a 40 hour week and not to the total time worked by the resident.

Comment: Some commenters asserted that just as the direct GME statute for residency training in the hospital does not include a reference to patient care, and therefore, all training in the hospital is countable for direct GME, the IME statute for hospital training also does not refer to patient care, and therefore, all the training in the hospital should be counted for IME too. One commenter asserted that the proposed rule is *"ultra vires"* and is therefore, "unconstitutional" because the IME statute for training in the hospital does not exclude time spent in nonpatient care activities, and that the IME adjustment is only the "best proxy" for teaching hospitals' increased training costs—it was not intended to measure the "actual costs" of training residents. The commenter argued that the Congress did not "intend that CMS parse apart or exclude certain time" from the FTE count, and doing so is beyond the scope of the agency's authority. Another comment stated that "we are unaware of any Medicare directive that distinguishes patient care activity in a hospital and nonhospital site." One commenter stated that he is "not aware that the fiscal intermediaries made disallowances for educational activities when calculating hospitals' PRAs in the 1984 base year." The commenter also refers to the 1990 Q&As issued by CMS (then HCFA) to the CMS Regional Offices and the fiscal intermediaries for use in computing the base year PRAs, and argues that "CMS makes numerous references to educational activities as allowable costs and does not once specify that these costs and the associated resident time were to be carved out if the activity took place in the nonhospital setting." The commenter quoted part of a response (to one of the 1990 Q&As) which stated, "If the hospital, rather than the related school, directly incurs the costs associated with these educational activities, they should be recognized as allowable graduate medical education costs and included in the per resident amount."

Another commenter noted that the provisions at section 2120 of the Provider Reimbursement Manual, Part I, titled *Reimbursement for Costs of Interns and Residents*, which described the cost method of reimbursement for GME programs, do not distinguish between training types or training location, and therefore, Medicare allowed costs of residents when they trained in didactic activities in nonhospital locations.

Commenters also argued that CMS's "overly rigid" interpretation of "patient care activities" ignores CMS's longstanding definition of "costs related to patient care," which is the basis for much of CMS's analysis, because educational activities like conferences and seminars for hospital employees have always been allowable costs under Medicare, and therefore, should be allowed for purposes of the IME as well. [see PRM–I, chapter 21, sections 2108.1, 2128, 2136.1, 2138.1, 2138.2, 2144.4, and 2144.6]. Another commenter contended that to exclude didactic time from the IME calculation would be inconsistent with Congress's purpose in instituting the IME adjustment. Congress's reason for enacting this provision was to address factors that contribute to the higher costs incurred by teaching hospitals, such as more acutely ill patients, more specialized treatments, and the additional costs associated with training residents such as the ordering of additional tests and extra staffing demands. The commenter argued that during the time the residents are involved in didactic activities, "these costs are in no way reduced," since the "patients remain just as ill as they were before, the hospital continues with its resident-related inefficiencies, the hospital continues to provide specialized services, and the services are just as intense. Thus, all of the costs that the IME adjustment is intended to compensate continue unabated no matter what the resident is doing."

Other commenters quoted the Committee report language accompanying the PPS legislation, which stated that purpose of the IME adjustment was to address "serious doubts about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents * * * the adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals (emphasis added, U.S. House of Representatives, 1983)."

In light of this Committee report language, the commenter believed that the language in the proposed rule defining the "plain meaning" of patient care as related to the care and treatment of a specific patient or to services for which physicians can bill is "patently incorrect."

Response: After reading the numerous comments challenging CMS' position that only the time spent by residents in patient care activities in the hospital may be counted for IME purposes, it has become apparent to us that there actually has been a good deal of confusion in the teaching hospital community regarding our longstanding policy with respect to IME and patient care activities. Nevertheless, we do believe that the commenters are misconstruing and confusing CMS' position on, and the purpose for, the direct GME payments and IME payments, respectively. By including a provision in the April 25, 2006 proposed rule clarifying our position on the time residents spend in nonpatient care activities, we were (and still are) distinguishing between activities that concern the treatment and diagnosis of

particular patients (that is, patient care), and activities that are didactic in nature (that is not patient care), as this distinction is necessary to ensure that Medicare funds for medical education are paid appropriately. As stated in response to a previous comment, historically, direct GME has been considered to be a payment for the direct costs of education. The conference report accompanying the original Medicare legislation (Pub. L. 89–97) stated:

"Many hospitals engage in substantial educational activities, including the training of medical students, internship and residency programs, the training of nurses, and the training of various paramedical personnel. Educational activities enhance the quality of care in an institution and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees as well as compensation of teachers and other costs) should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program" (S. Rep. No. 404, 89th Cong., 1st Sess. 36 (1965); H.R. No. 213, 89th Cong., 1st Sess. 32 (1965)).

Accordingly, educational activities of hospital employees, particularly those in "formally organized or planned programs of study" as they were described in the original regulations first published on November 22, 1966 (31 FR 14814, and 20 CFR 405.421) (later redesignated as 42 CFR 405.421 on September 30, 1977 and as 42 CFR 413.85 on September 30, 1986)), were recognized as Medicare-allowable costs and implicitly included in the definition of "costs related to patient care" at 42 CFR 413.9. These specific payments for medical education activities were the basis for what later evolved into the direct GME payments, as established by Section 9202 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. 99–272). That is, direct GME (and also, payments for approved nursing and allied health education programs under 42 CFR 413.85) is a payment for education because it explicitly pays hospitals for the direct costs of these formally organized programs, such as the stipends of trainees and teachers. Additionally, as early as 1971, Chapter 4 of the Provider Reimbursement Manual, Part I, stated that "any costs of usual patient care" are excluded from the definition of approved educational activities (Section 404.2 of the PRM-I). Clearly, the early medical education payments, in which current direct GME payments are rooted, were not intended to be a payment for caring for patients, but rather were (and are still today) payments to hospitals for education costs. Medicare made then, and still makes, payments for usual patient care as part of the hospital's operating costs and as direct payment to hospital-based physicians under Medicare Part B. Therefore, to the extent that residents engage in nonpatient care didactic activities as part of their approved programs, the costs of those didactic activities are allowed and paid by Medicare through the direct GME payment, based on the PRA. The commenter is indeed correct that the costs of didactic activities were included as allowable costs by the fiscal intermediaries when determining the base year PRAs. However, the commenter should not conclude that didactic activities that occurred outside of the hospital were included in the determination of the PRAs. Under Medicare's previous reasonable cost method of payment for approved medical education activities, any costs incurred by a hospital for resident training that took place outside of the hospital setting were not allowable costs to that hospital (66 FR 3371). In establishing PRAs, fiscal intermediaries used a count of FTE residents for the 1984 base period that reflected "the average number of FTE residents working in the health care complex during the GME base period" (54 FR 40299). Section 9314 of Pub. L. 99–509 changed the law to allow resident time spent training in nonhospital settings to be counted for the first time for purposes of direct GME payments on and after July 1, 1987. Furthermore, regarding the specific language from the 1990 Q&As quoted by the commenter, neither that question, nor the answer provided by CMS (then HCFA) gives any indication of *where* the educational activities took place. Therefore, the fact that CMS stated that the costs of educational activities incurred directly by a hospital are included in the PRA does *not* mean that the costs incurred by a hospital for all educational activities are allowable, regardless of the location in which they occurred. Similarly, just because the FTE time associated with certain costs is allowable (according to the statute) does not mean that the costs of a particular activity are necessarily allowable. Certainly, if the Congress had not changed the law in 1987 to allow residents training in nonhospital settings to be counted (for direct GME purposes), then even the time spent in direct patient care activities in nonhospital sites would not be allowed to be counted by a hospital. The relevant point, however, is that educational costs incurred by a hospital in providing didactic activities to residents in approved programs are paid by Medicare via the direct GME payment, which is a payment for costs of education.

The purpose of the IME adjustment is different from that of direct GME in that it is designed to adjust the IPPS payment to teaching hospitals for the higher operating costs they incur in furnishing patient care. It is intended to pay a teaching hospital for those additional patient care costs that are an indirect result of the presence of the teaching program at the hospital, and not the direct costs associated with didactic learning. Although the commenters argue that didactic activities have long been recognized by CMS as "related to patient care," despite the fact that none of these activities involves the "care and treatment of individual patients" or "services for which a physician or other practitioner may bill," we believe that because IME is a payment specifically for patient care costs, the regulations and subregulatory guidance concerning "costs related to patient care" are not sufficient for determining what actually constitutes patient care and is therefore, an activity for which FTE resident time in the hospital may be counted for IME. As stated in response to a previous comment, with respect to residency training in the hospital, our policy limiting the IME count to only time spent in patient care activities is rooted in the creation and the purpose of the IME adjustment. Before Congress passed the 1983 law that included the IPPS and an IME adjustment, the Secretary submitted a report to Congress in 1982 that (in part) explained that, "the indirect costs of graduate medical education are higher patient care costs incurred by hospitals with medical education programs" (Report to Congress required by the Tax Equity and Fiscal Responsibility Act of 1982, December 1982, pp. 48–49, italics emphasis added). Similarly, in passing the IPPS legislation in 1983, the House Committee on Ways and Means acknowledged the link between higher patient care costs of teaching hospitals, and noted that the IME adjustment was important due to—

"* * * serious doubts about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of

residents * * * the adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals (U.S. House of Representatives, 1983)."

Essentially, Congress listed two reasons for the IME adjustment, similar to those stated in the Secretary's 1982 report: (1) Teaching hospitals typically offer more technologically advanced treatments to their patients, and therefore, patients who are sicker and need more sophisticated treatment are more likely to go to teaching hospitals, and (2) the presence of inefficiencies associated with teaching residents resulting from the additional tests or procedures ordered by residents and the demands put on physicians who supervise, and staff that support, the residents. That is, because teaching hospitals attract sicker patients, they incur higher costs in caring for those sicker patients—whether due to additional tests ordered by residents or more intensive treatments provided in an educational setting. The Secretary and Congress recognized that the learning process in which the residents are engaged results in more intensive, and therefore more costly, treatment. Thus, the purpose of the IME adjustment is clearly limited to the unique characteristics and conditions of teaching hospitals that directly relate to the delivery of patient care.[30] Since the purpose of the IME adjustment is rooted in patient care, there is a clear and compelling reason to limit the FTE resident time that can be counted for IME to time spent by residents in patient care; that is, in the care and the treatment of particular patients, or in furnishing services for which a physician or practitioner may bill.

Commenters argued that during the time the residents are involved in didactic activities, higher costs incurred by teaching hospitals "are in no way reduced," and emphasized the language in the Committee report describing the purpose of the IME adjustment as addressing (in part), "* * * the additional costs associated with the teaching of residents." To address these comments, we refer to the August 1, 2001 final rule (66 FR 39898), in which we reiterated our policy that IME is a payment for patient care, and we also included an example from that rule to illustrate how the FTE resident count for IME should be determined in a manner that would properly reimburse a hospital with residents that are engaged in non-patient care research activities. Although the discussion in the August 1, 2001 **Federal Register** focused on research, this example is useful for this discussion on nonpatient care didactic activities. In the example (66 FR 39898), a hospital has 20 FTE residents who were furnishing patient care in the areas of the hospital subject to the PPS, and 4 FTE residents engaged exclusively in research. We stated that the IME payment to the hospital should reflect the additional operating costs resulting from those 20 FTE residents delivering patient care, and would not include the 4 FTEs engaged exclusively in research, as those 4 FTE residents did not contribute to the hospital's higher operating costs. While it may be that the existence of the research activities did contribute in some marginal way to the higher operating costs of the hospital, for instance, by attracting more severely ill or uninsured patients to the hospital for non-research treatment, those residents engaged exclusively in research are not involved in and do not contribute to more intensive or inefficient patient care, and therefore, their presence does not result in higher allowable operating costs. We believe the same holds true for the time residents spend in didactic activities—during this time, the residents are not participating in or contributing to more intensive or inefficient patient care. Moreover, we believe that it is the combination of the factors enumerated by the Secretary and Congress as the reasons for the IME adjustment that contribute to the higher operating costs of teaching hospitals. We believe the Congress' reference to "additional costs associated with the teaching of residents" refers to the presence of inefficiencies associated with teaching residents resulting from the additional tests or procedures ordered by residents and the demands put on physicians who supervise, and staff that support, the residents; and not to costs associated with research or didactic activities. Since direct GME payments are made to teaching hospitals to cover the explicit educational costs of training residents, we do not believe Congress intended for the IME adjustment to duplicate those educational payments. In fact, it first became evident that an adjustment to payments for teaching hospitals was necessary, in addition to the cost-based GME payments, after 1972 when Congress instituted what became known as the "section 223" limits to hospitals' routine operating costs. Since the agency's analyses showed that the section 223 cost limits adversely impacted teaching hospitals, a calculation based on a regression formula was computed to adjust the routine operating cost limits of teaching hospitals. Consequently, the IME adjustment was instituted to address the higher patient care costs not sufficiently compensated under the cost limits, and later the DRG system. In the example above, the inclusion of the four FTE residents engaged in nonpatient care research in the resident count for IME would vastly overcompensate the hospital for any marginal contribution to operating costs resulting from the presence of those FTE residents. Similarly, a resident that is participating in a seminar or a conference is not contributing to the higher patient care costs of the hospital. Thus, although it would be appropriate to count such nonpatient care time in calculating direct GME payments, it would not be appropriate to count that time for purposes of the IME adjustment. Accordingly, we believe it is appropriate and fully consistent with Congressional intent to apply the plain meaning of the term "patient care activities" and to limit the FTE resident count to time spent in patient care activities for IME for training in the hospital, and for both IME and direct GME for training in nonhospital sites. That is, only time spent in the care and treatment of particular patients, or in providing services for which a physician or other practitioner may bill, may be counted.

Comment: One commenter said that independent research activity rotations were included in the allowable FTE count used to determine hospitals' direct GME base year PRAs. The commenter said that these research electives, which are part of the ACGME approved program, "may happen at the hospital's medical library" or "may happen at home at the resident's study desk," but "all of it has been included in the FTEs used to calculate the PRA amount." The commenter suggested that, by the clarification in the April 25, 2006 proposed rule, CMS is adopting a "change in accounting method," and that, therefore, CMS should consider adopting a change in the PRAs for hospitals that "exclude these newly excluded" FTEs.

Response: We believe the commenter is confusing our policy of including the

[30] Similarly, to the extent that the higher costs are caused by other factors such as a greater relative share of medically complex or indigent patients, the IPPS includes payments in the form of the outlier and disproportionate share hospital (DSH) adjustments to specifically compensate for those costs. (Health Care Financing Review, Winter 1992, Vol. 14, No. 2, p. 69, and Health Care Financing Review, Spring 1990, Vol. 11, No. 3, pp. 31–41).Therefore, the additional indirect medical education costs that remain after controlling for outlier and DSH payments are the essentially the higher patient care costs resulting from the presence and involvement of residents in patient care.

FTE time spent in research activities in the denominator of the PRA calculation, and, in the FTE count in years subsequent to the PRA base year, our policy of excluding the costs of research activities from the numerator of the PRA. As we explained in the September 29, 1989 **Federal Register** and again in the August 1, 2001 **Federal Register** (66 FR 39898 through 39899), each hospital's PRA is determined by taking the hospital's total allowable graduate medical education costs (which do not include costs allocated to the nursery cost center, research, and other nonreimbursable cost centers) in a base year and dividing the costs by the number of FTE residents working in all areas of the hospital complex in the base year (§ 413.77(a)(1)(i)). In the case of research and other nonreimbursable cost centers, costs were excluded from the PRA calculation because they were nonreimbursable in the base year, consistent with longstanding Medicare policy on Medicare cost reimbursement to teaching hospitals. Ideally, residents participating in research electives would also have been excluded from the base year FTE count used in the PRA calculation. However, for a number of hospitals, the FTE count for the base year did include residents engaged in such research because the 1984 base year information available from hospitals when the PRAs were determined in 1990 did not consistently distinguish between residents involved in furnishing patient care services and residents engaged in nonpatient care research. The inclusion of such additional FTEs in the denominator of the PRA calculation lowered the PRAs for these hospitals.

In order to avoid disadvantaging these hospitals, in making direct GME payments for a given year, we included and continue to include residents engaged in nonpatient care research in the direct GME FTE count both in the base year PRA calculation and in the FTE count in subsequent payment year calculations. This policy was adopted to "offset" the effects of the inclusion of such FTE residents in the denominator of the direct GME PRA calculation (no such "offset" is warranted in the context of IME). Thus, there has been no "change in accounting method," and it is not necessary to consider changing the PRAs of hospitals that exclude independent research rotations, as the commenter suggests. Furthermore, because the nonreimburseable costs were excluded in calculating the PRA, the end result is that the direct GME payment does not encompass the costs of residents engaged exclusively in research. Therefore, as with the IME payment, Medicare is not and has not been reimbursing teaching hospitals under direct GME for costs the hospital incurs associated with resident time spent in nonpatient care research.

Comment: One commenter disputed CMS' policy to exclude nonpatient care time from the IME count on the grounds that the IME statute states that "the Secretary shall provide for an additional payment amount for subsection (d) hospitals with indirect costs of medical education, in an amount computed in the same manner as the adjustment for such costs under regulations (in effect as of January 1, 1983) * * *" (section 1886(d)(5)(B) of the Act). The commenter maintained that because the regulations in effect as of January 1, 1983, did not exclude nonpatient care activities from the IME count, the plain meaning of the statute requires that this time continue to be included in the IME resident count.

Response: The exclusion of time spent in nonpatient care activities from the IME count is longstanding CMS policy, and consistent with the rules in effect as of January 1, 1983. The statute implementing the IME adjustment at section 1886(d)(5)(B) of the Act requires that, "[t]he Secretary shall provide for an additional payment amount for subsection (d) hospitals with indirect costs of medical education in an amount computed in the same manner as the adjustment for such costs under regulations (in effect as of January 1, 1983) * * *").

For the initial analysis of the operating costs of teaching hospitals versus non-teaching hospitals that was used to develop the IME adjustment, while analysts could distinguish between allowable and non-allowable costs, they did not have a method to consistently and accurately isolate all the time spent by residents in nonpatient care activities. Therefore, no consideration was given to where the residents were training in the hospital or what the residents were doing (that is, patient care or other activities). Prior to the implementation of the IPPS, under the reasonable cost system of reimbursement, the concept of an "FTE resident" had little, if any, relevance. Thus, for this analysis, an "FTE" simply distinguished between a resident that was employed at the hospital on a full-time basis and a resident that was employed at the hospital only part-time. Accordingly, while only allowable costs were considered in the analysis, the time spent by residents in non-reimbursable activities or areas of the hospital was not excluded from the analysis.

The April 1, 1980 **Federal Register** implementing the initial IME adjustment specified simplistic requirements for hospitals to report FTE residents to the fiscal intermediaries for purposes of receiving the IME adjustment to their cost limits, consistent with the relatively crude resident counts CMS used in computing the IME adjustment (45 FR 21484). The rules in effect as of January 1, 1983 concerning determining the resident count for IME required, in part, that only residents in approved programs could be counted (47 FR 43310 (September 30, 1982)). Once the IPPS was effective, CMS took certain steps to modify the rules concerning FTE resident counts for the resident-to-bed ratio to more appropriately adapt the IME adjustment to the new prospective payment methodology under which only inpatient operating costs were reimbursed. (Other types of costs, such as direct GME and outpatient hospital costs were specifically excluded from payment under the IPPS, and continued to be paid under existing mechanisms.) A distinction was drawn, for payment purposes, between the acute inpatient hospital (subject to the IPPS), and distinct part units and hospitals not paid under the IPPS. Since reasonable cost payments to these "IPPS excluded" providers and units already included the indirect costs of medical education, in order to avoid a "double" payment that would result from counting residents in those IPPS-excluded settings, CMS clarified in regulations that the IPPS IME adjustment does not apply to any hospitals or distinct part units not paid under the PPS, and consequently, both the number of beds and the time spent by residents in those areas could not be included in the resident-to-bed ratio (48 FR 39844). The agency modified the rules for counting FTE residents and hospital beds for purposes of the IME adjustment so that the adjustment would be more closely tailored to reflect the higher allowable patient care costs of teaching hospitals under the prospective payment system for inpatient acute care hospitals.

In the September 3, 1985 final rule, CMS responded to comments regarding its proposal to exclude FTE resident time spent in outpatient departments from the numerator of the resident-to-bed ratio. CMS had proposed this exclusion "because outpatient departments also are not subject to the prospective payment system and because the additional operating costs of outpatient departments associated with interns and residents are already recognized through reasonable cost

reimbursement for hospital services furnished to outpatients" (50 FR 35681 through 35682). The commenters stated that CMS was required to count residents training in outpatient departments since section 1886(d)(5)(B) of the Act requires that the IME adjustment be "computed in the same manner" as set forth in the regulations on January 1, 1983. The commenters further argued that in the September 1, 1983 interim final rule, CMS said that residents in outpatient departments would be counted so as to avoid "altering only one element of the variable and failing to maintain comparability between the methodology used for developing the adjustment factors and subsequently standardizing hospital costs based on that factor" (48 FR 39778).

In response to those comments, CMS stated that the agency believed that in excluding residents training in the outpatient departments from the FTE count, it was computing the adjustment "in the same manner" as previously, since the adjustment continued to be based on a resident-to-bed ratio. CMS noted that, although the statute purports to refer to regulations in effect on January 1, 1983, there were no specific regulations in effect on that date, and, although the September 30, 1982 **Federal Register** (47 FR 43310) contained a description of the method to be used, the agency believed that "Congress, in enacting the prospective payment system, intended that the methodology in effect be adopted rather than the entire description published in that notice" (emphasis added). CMS further noted that the agency had already made changes to the methodology for counting interns and residents in the January 3, 1984 and August 31, 1984 final rules (the latter in response to a provision in Pub. L. 98–369) to "adapt the previous system to the prospective payment system more effectively." (In fact, the Agency had also made changes in the September 1, 1983 **Federal Register** (48 FR 39844) to exclude FTE training time in distinct part units that are excluded from the PPS). We noted that, in response to the refinements the agency made in 1983 and 1984 to the rules for counting residents for purposes of the IME adjustment, Congress could have made adjustments to the IME multiplier, but chose not to do so even though it passed legislation (Pub. L. 98–369) dealing specifically with indirect medical education payments. In response to comments, the agency observed that "the current [IME] adjustment itself is no longer entirely consistent with the original factor" (50 FR 35682). We concluded that, "if the deletion of time furnishing services to outpatients, which decreases the count of interns and residents, invalidates the indirect medical education adjustment, it should follow that the expansion of programs that took place since the current factor was developed also should have invalidated the adjustment. However, especially since Congress did not mandate that the factor be recalculated, we believe that if there are, as here, overriding concerns, the revision to the method of counting interns and residents is justified" (50 FR 35682).

We acknowledge that soon after publication of this rule, Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA) (Pub. L. 99–272) on April 7, 1986, which included a provision (section 9104(a)) that addressed the agency's regulation, and required that time spent by residents training in outpatient departments "will continue to be counted for purposes of determining the indirect teaching adjustment" (See 51 FR 16773, May 6, 1986). We note further, however, that although Congress addressed CMS's rule on excluding time spent in outpatient departments, Congress could have, but did not, also address the agency's regulations concerning the exclusion of training time in distinct part psychiatric and rehabilitation units. Congress has considered and taken legislative action with respect to the IME adjustment many times since 1986, but has not found it necessary to modify the agency's policies with respect to the counting of FTE residents for IME purposes. We do not believe that we are obligated to adhere rigidly to the rudimentary methodology of counting FTE residents for IME purposes that was in effect prior to and in the early days of the IPPS. Rather, since the IME adjustment is a payment for additional patient care costs, we believe there is a clear and compelling reason to limit the FTE resident time counted for IME purposes to the time spent by residents in the care and the treatment of particular patients, or to services for which a physician or other practitioner may bill.

Comment: One commenter argued that CMS' position in the April 25, 2006 proposed rule that nonpatient care activities must be excluded from the IME FTE count "flies in the face of" the United States District Court's decision in *Riverside Methodist Hospital* v. *Thompson*, Case No. C2–02–94 (S.D. Ohio 2003). In *Riverside*, the hospital appealed the fiscal intermediary's disallowance of time spent in the hospital in journal clubs and seminars from the IME FTE count. In that decision, the Court ruled "1) that the 2001 rule excluding nonpatient care time from the FTE count must not apply retroactively and 2) that resident time spent on nonpatient care activities should be included in the IME FTE count." The commenter contended that CMS' position in the proposed rule is "an unconstitutional attempt to use the regulatory process to overturn the decision of an Article III court." Another commenter claimed that the Court in *Riverside* affirmed Congress' intent that the IME adjustment should compensate teaching hospitals for more than just the direct costs of residents' involvement in patient care because those higher operating costs are difficult to separately identify and measure precisely. The commenter quoted part of the ruling in the *Riverside* case: "It is precisely because the indirect costs cannot be adequately itemized and quantified that Congress devised a formula based on the degree of teaching intensity in a particular hospital, as a substitution for any other method of reimbursing such costs. If Congress had believed that the indirect medical education costs of a teaching hospital could be separately identified and quantified, and that higher direct patient care costs could be so determined from the hospital's records, then *Congress could easily have qualified its formula for reimbursement to restrict the number of FTE residents to a number based only on hours that residents spent providing 'patient care.' It obviously did not do so*".

Response: The first commenter is correct that the Court in the *Riverside* case ruled to reverse the fiscal intermediary's disallowance of time spent by the hospital's residents in nonpatient care activities from the IME FTE count. We respect and will give full effect to that Court's decision. However, we do not read that decision to restrict the Secretary's discretion to promulgate regulations on the issues litigated in that case. Although we acknowledge the Court's recognition that the statute did not specify that the IME formula be based only on hours spent in providing patient care, we believe, as explained above, that such a limitation is appropriate and in accordance with the purpose of the IME payment, as well as Congressional intent, under the IPPS. It is also noteworthy that Congress has not acted to modify the agency's policies with respect to counting FTE residents even though Congress has recently enacted several provisions relating to IME and direct GME in the MMA. We

would also note that the cost report at issue in the Riverside case was from Fiscal Year 1996, which is clear evidence that the agency's policy to disallow the time spent in nonpatient care activities from the IME FTE count in the hospital is, indeed, longstanding.

Comment: Many commenters voiced their concern that if CMS were to "inappropriately" require that all didactic activities must be excluded for IME purposes in the hospital, and for direct GME and IME purposes in the nonhospital sites, it would result in a "quagmire of administrative difficulties," and enormously increase teaching hospitals' documentation burdens. It would mean a "sea change" for many hospitals, as rotation schedules are often weekly or monthly, and vary widely not only from hospital to hospital, but also from program to program. Especially for very large teaching hospitals, reporting residents' activities in hour-long increments is "literally not achievable." One commenter alleged that CMS's "nefarious" separation of patient care time from didactic activities which "devolve[s] to discussions of particular patients seems a capricious exercise in futility." With respect to training in nonhospital settings, one commenter warned that CMS' proposal would have a "chilling effect" on training outside the hospital. The commenter believed that hospitals will be "forced to demand" that nonhospital sites closely monitor the portion of time that is spent in nonpatient care activities, which may be difficult to distinguish from the patient care activities. The commenter believed that physicians will refuse to supervise residents in nonhospital sites if the documentation requirements become too burdensome, which would "frustrate" Congress' intent in enacting the IME nonhospital site payment provision. Another commenter expressed concern that CMS' "short-sighted" approach "penalizes" hospital-based residency programs that provide their residents with nonhospital training experiences, "exacerbating other recent CMS policy changes that disadvantage training programs conducted outside the hospital."

Response: We have carefully considered the comments, and we recognize that providing hour-by-hour schedules for, in some cases, more than 1,000 residents, could be a daunting task. We would point out, however, that nowhere in the preamble discussion of the April 25, 2006 proposed rule did we explicitly require hourly rotation schedules. We did say that "it is important for hospitals to be able to document the activities in which residents are engaged because there are certain activities that are not allowable for direct GME or IME payment purposes, even though those activities may be performed as part of an approved residency program" (71 FR 24114). Although we need to ensure that Medicare payments are paid accurately, it is not our desire to impose unreasonably complicated and time-consuming recordkeeping requirements. It has always been the general practice of fiscal intermediaries to use rotation schedules as the primary source of documentation to determine whether residents' time is allowable for IME and direct GME payment purposes. However, we are sympathetic to the fact that up to this point, hospitals have been inconsistent in their reporting of nonpatient care activities, either because of confusion surrounding our FTE-counting policy, or because of differing approaches to developing and maintaining rotation schedules. Therefore, we believe it is appropriate from an administrative perspective to distinguish between the treatment of cost reports for cost reporting periods beginning prior to October 1, 2006, and cost reporting periods starting on or after October 1, 2006, with respect to documentation requirements. Prospectively, (for cost reporting periods beginning on or after October 1, 2006), to ensure consistent reporting by hospitals and auditing by fiscal intermediaries, we believe it is appropriate to require all teaching hospitals to document residents' time at some minimum level of detail. Specifically, for cost reporting periods beginning on or after October 1, 2006, for training occurring either in the hospital or in nonhospital settings, we are instituting a "one workday" threshold for documentation purposes. That is, we are not requiring that hospitals overhaul their current rotation schedules, nor are we mandating that rotation schedules be in one-day increments. Rather, if a resident's workday consists entirely of scheduled didactic activities and no scheduled patient care activities (for example, no care and treatment of individual patients, or no services which are billable) then, for documentation purposes, that workday must *not* be recorded as "patient care" (or, as occurring in a patient care unit such as ICU or Pediatrics, etc.). Instead that workday must be identified as nonpatient care and the time must be subtracted from the allowable FTE count (for IME if the training occurred within the hospital complex, and for both IME and direct GME if the training occurred in a nonhospital site). In other words, as long as an *entire* workday is *not* scheduled for didactic activities, then for documentation purposes, that day may be recorded as spent in patient care activities. For example, if a hospital maintains rotation schedules in monthly blocks for each resident in a particular program, and if a resident that is otherwise assigned to the Coronary Care Unit (CCU) for the month of January was scheduled to attend an all day conference on January 10 and not to participate in any planned patient care activities on that day, then the hospital must note on the rotation schedule that it submits to the fiscal intermediary that this resident was not in "patient care" on January 10. The hospital would subtract that time from the resident's allowable IME and/or direct GME FTE count accordingly. We believe this "one workday" approach to documentation of residents' time is an appropriate administrative measure that will assist our fiscal intermediaries in enforcing the policy concerning time spent in nonpatient care activities for cost reporting periods starting on or after October 1, 2006, while not overburdening hospitals with excessively detailed recordkeeping requirements. However, our policy continues to be that only time spent in patient care activities may be counted for IME purposes in the hospital complex, and for direct GME and IME purposes in nonhospital sites. Accordingly, we are amending § 413.75(b) to add a definition of the term "patient care activities" which means, "the care and treatment of particular patients, including services for which a physician or other practitioner may bill." (We note that in the proposed rule, we defined patient care activities as "the care and treatment of particular patients or services for which a physician or other practitioner may bill" (emphasis added). In this final rule, we are changing the word "or" to "including," because we did not mean to imply that the phrase "the care and treatment of particular patients" and "services for which a physician or other practitioner may bill" are mutually exclusive. Rather, services that are billable are a subset of the more general category of activities involving the "care and treatment of particular patients," and are indicative of patient care delivery). In addition, we are amending the IME regulations at § 412.105(f)(1)(iii) to add a paragraph (C) to state that "In order to be counted, a resident must be spending time in patient care activities, as defined in § 413.75(b)."

Comment: One commenter requested that if CMS decides to implement the policy expressed in the proposed rule, CMS should clarify that "only planned activities expressly undertaken to meet programmatic requirements should be included as part of the approved residency program." The commenter was concerned that without such a clarification, CMS may interpret "spontaneous" encounters at nonhospital settings (such as unplanned lunch meetings with a teaching physician and a resident where they "happen" to discuss a medical topic) as nonpatient care time. Another commenter listed several residency training scenarios that he believed would need further clarification with respect to whether the time could be counted for IME and/or direct GME purposes, if CMS's policy is finalized. The scenarios included the time that a resident is called out of a conference to care for a patient, lunch time lectures, and requires courses of study or activities that the resident may complete at home or at a faculty member's home.

Response: As we stated in response to the previous comment, as long as an *entire* workday is *not* scheduled for didactic activities, then for documentation purposes, that day may be recorded as spent in patient care activities. Of course, activities must be part of the approved residency training program in order to be counted for IME and direct GME payment purposes and a resident must be training within the hospital complex or in a nonhospital site. If a hospital documents that time was spent studying at a resident's or a teaching physician's home, this time is not permitted to be included in the IME count because it is not time spent in patient care, nor is it permitted to be included in the direct GME count because it did not take place in the hospital complex.

Comment: One commenter stated that if CMS decides to implement the policy in the proposed rule in some form (although the commenter believed CMS shouldn't), then the final policy would represent a change that must be modified formally through the process of notice and comment rulemaking, and therefore, should only apply prospectively for rotations beginning on or after July 1, 2007.

Response: Although we recognize that there has been some misapprehension of our policies among the teaching hospital community, in particular with respect to the counting of FTE residents training in the hospital for purposes of IME, the only change we are making to current policy is the "one workday" approach to identifying nonpatient care time spent by residents. We do not believe it is necessary to wait until July 1, 2007, to implement our recordkeeping policy. We believe that an effective date stated above, for cost reporting periods beginning on or after October 1, 2006, provides hospitals with sufficient time to either modify their rotation schedules to reflect the "one workday" approach or to find other comparable documentation that can be used by the fiscal intermediaries in auditing cost reports.

Comment: A commenter said that it is unclear how CMS intends to exclude nonpatient care time for cost reporting purposes; that is, just from the time allowable as part of a hospital's resident count (that is, the numerator), or from the total time worked (in all locations) by the resident (that is, the denominator). The commenter observed that the statute quoted by CMS in the proposed rule states that "only time spent in activities relating to patient care shall be counted" (emphasis added, section 1886(h)(4)(E) of the Act). The commenter believed that to be "counted", the time appears both in the allowable time claimed by the hospital and the total time worked by the resident in a given year, and conversely, if the activities do not relate to patient care, then the time should not be counted either as allowable time or as part of the total time worked. The commenter requested that CMS specify that these activities are not to be included at all in IRIS, either as allowable or unallowable, so as not to dilute the total resident count that may be claimed by all of the hospitals training the resident.

Response: The effect of the commenter's request would be to ignore portions of training time spent by residents in approved residency training programs with the result that, in total, less than a full-time equivalent resident would be counted. We do not believe such a policy would be appropriate or comport with Congressional intent. Section 1886(h)(4)(A) of the Act states that, "The Secretary shall establish rules consistent with this paragraph for the computation of the number full-time equivalent residents in an approved medical residency training program" and the remainder of the subsection is replete with references to "full-time equivalent" residents. Accordingly, the regulations at § 412.105(f)(1)(iii)(A) for IME and § 413.78(b) for direct GME indicate that, in computing the FTE count of a hospital, for each resident, the denominator consists of the total time necessary to fill a residency slot, which constitutes full-time equivalent status. Full-time equivalent status, in turn, is based upon the total amount of training time necessary to fulfill the requirements of the approved medical residency training program in a given academic year. Therefore, the denominator must consist of the *total* time worked by a resident throughout the academic year in activities that are part of the approved program, whether or not the time is permitted to be counted for IME or direct GME payment purposes. As stated in response to a previous comment, the starting point (denominator) for determining the allowable FTE count is the total time necessary to fill a residency slot consistent with the requirements of the approved residency program. However, the hospital must then subtract all non-allowable training time, such as time spent at other providers, time spent in IPPS-excluded distinct part units, nonpatient care activities (for example, research, didactic time), and so on, and only include the allowable time in the numerator. Thus, while a hospital's allowable FTE count is certainly "based" on the total time necessary to fill a resident slot that total time is often greater than the FTE time a particular hospital is permitted to count for payment purposes. Furthermore, certainly no FTE resident time that is outside the scope of the approved program would be included in either the numerator or the denominator of the FTE computation.

Comment: A commenter noted that CMS uses the definition of "hospital complex" as explained in the September 29, 1989 **Federal Register** to determine which residents may be included in a hospital's direct GME count. Specifically, the September 29, 1989 **Federal Register** (54 FR 40286) states that the hospital complex consists of the hospital and hospital-based providers and subproviders. The commenter observed that CMS's regulations concerning the requirements for provider-based status are at § 413.65, and stated that it is their understanding that if a facility qualifies as provider-based under these regulations, the facility will be considered part of the hospital complex. The commenter requested that the connection between "hospital complex" and "provider-based" be clarified in the final rule, since the September 29, 1989 **Federal Register** seems to imply that only facilities such as SNFs and HHAs (facilities that bill Medicare and have direct patient care activities) can qualify as provider-based. The commenter noted that, for example, a separate building where only research is conducted may qualify for provider-

based status and should be included as part of the hospital complex.

Response: The commenter is correct that the regulations that would be used to determine if a facility is part of the hospital complex (that is, provider-based) for direct GME purposes, are at § 413.65. As the commenter pointed out, it may be necessary to determine for direct GME purposes if a facility in which no patient care is provided is "provider-based," even though a provider-based determination would not otherwise be made for such a facility. The example mentioned by the commenter of a separate building in which only research is conducted would be an instance where it would be appropriate for the fiscal intermediary to use the criteria at § 413.65 to determine if a facility is part of the hospital complex for direct GME purposes. Thus, training that occurs in facilities that meet the provider-based criteria at § 413.65 is training "in the hospital", and training that occurs in facilities that do *not* meet the provider-based criteria is training "in nonhospital settings," (and, of course, in the case of the training in nonhospital settings, the hospital must meet certain requirements in order to count any FTE resident training time spent in that setting).

Comment: Some commenters urged CMS not to distinguish between direct GME and IME payments based on hospital versus nonhospital locations. One commenter argued that "geography" is irrelevant, particularly in the era of telephone and Internet communications. Another commenter believed that distinctions between provider-based versus freestanding practices or medical school facilities are "founded on legal, structural, or financial issuances." The commenter stated that hospital and nonhospital locations might be "across the hall or on the next floor from each other" with no difference between the patient care and learning experiences in each place. The commenter believed that CMS has recently distinguished between these sites for reimbursement purposes based solely on who is bearing "all or substantially all" of the costs of the residency program, which has created "confusion, complexity, and controversy" in the provider community. Further "clarifications" of payment based on location or on type of activity are "unnecessary and onerous."

Response: We understand that it is quite common for hospitals, especially large academic medical centers, to be located on the same campus as a medical school, where the buildings are very closely situated or even connected, and the facilities are often shared. However, as the commenter indicated, hospitals, nonhospital sites, and medical schools are structured separately for legal and financial purposes, and are recognized independently for state licensing and Medicare cost reporting purposes. To put it simply, a hospital is not a medical school, and a medical school is not a hospital. As we stated in response to the previous comment, the criteria to be used in determining if a facility is provider-based are in the regulations at § 413.65. Facilities that meet the provider-based criteria are part of the hospital, and facilities that do not meet the provider-based criteria are nonhospital sites, even if they are located on the same campus as the hospital. Additionally, while there is no requirement that hospitals incur the costs of residents training in a hospital in order for those residents to be counted for IME and direct GME purposes, hospitals are required by statute (not merely by CMS regulations, as the commenter implies) to incur "all, or substantially all of the costs" of a residency training program in a nonhospital site (such as a medical school) in order to count any of the resident FTE training time spent in those nonhospital sites for IME and direct GME purposes. Similarly, the statutes for IME and direct GME clearly indicate that only training in patient care activities may be counted in the nonhospital sites. Since the statute makes these distinctions, we do not believe we have created "unnecessary" and "confusing" distinctions between where the residents are training, or the type of activities in which the residents are engaged.

Comment: Many comments from members of an academy of family medicine in a particular State indicated that they were informed that "CMS is considering the disallowance of faculty development activity in the calculation of IME and DME reimbursement." Some of the activities they listed as being at risk included development, review, and delivery of curriculum, scholarly activities such as written publications and faculty development conferences, resident evaluation, faculty training, and alumni evaluation and research. The commenters were concerned that future physicians cannot be properly trained "without support for the educational aspects of their experience." Another group of commenters, also teaching faculty for family medicine programs, stated that they were attracted to a profession in family medicine because "the community recognized the value of experience and academic inquiry to the well-being of our communities and the training of future physicians." These teaching physicians stated that less than one-third of their academic time is compensated, and if funding for their work on program development, clinical research, writing critical reviews, and evaluating resident performance is reduced, then they may find it necessary to return to full time clinical practice, since the "thought of being told by a program that [we] will need to see more patients to pay for the time [we are] developing and delivering curriculum will be unacceptable." The commenters concluded by wishing CMS "the best of luck" if CMS implements this rule, and stated that they would not continue as faculty members. Another commenter cautioned that "with every additional burden placed" on residency training by CMS or the ACGME, more valuable teaching physicians will be lost.

Response: It appears the commenters have confused the time that residents in approved programs spend in nonpatient care activities, with the time that teaching faculty spend in nonpatient care activities. While the direct GME payments, through the PRAs, do compensate teaching hospitals for the portion of the teaching physicians' salaries and fringe benefits attributable to GME activities, only the FTE time of residents participating in approved programs is included in the hospital's FTE resident count for both IME and direct GME. Accordingly, the activities listed by the commenters in which teaching faculty engage either on behalf of, or independent of, the residents they supervise are not affected by the rule that only time spent by residents in patient care activities may be counted for IME purposes in the hospital, and for IME and direct GME purposes in the nonhospital sites.

Comment: One commenter, a hospital system, said that their understanding, which has been "reaffirmed time and again by our annual fiscal intermediary audits," is that, with respect to direct GME, time spent in a nonpatient care activity, "no matter where it took place (on site or off), was allowed to be counted if that activity was needed for Board certification." The commenter stated that it seems CMS "largely agrees" with this position "If the nonpatient care activities occur on site, but doesn't if the activity is offsite" (emphasis included in the original). The commenter believes this is "illogical" considering that the hospital continues to bear the direct costs of the resident in either case. The commenter concluded that, although they were commenting on the implications for

direct GME, "at least for IME, [CMS's] position is consistent—nonpatient care activities are not allowed whether one is on site OR offsite" (emphasis included in the original).

Response: As we indicated in response to a previous comment, although our position with respect to IME and FTE time spent in nonpatient care activities is a longstanding policy as we explained in greater detail above, it has become apparent to us that there actually has been significant confusion regarding this policy in the teaching hospital community. Our policy has been to apply the plain meaning of the term "patient care activities," which means that, even if the nonpatient care activities that occur in nonhospital sites count toward Board certification (that is, they are part of the approved program), such time must not be included in the direct GME or IME count. With respect to training in the hospital, resident time spent training in didactic activities that are part of an approved program can be counted for direct GME purposes, but not for IME. It makes no difference whether the hospital is paying the residents" salaries when the training occurs in the hospital complex; whether a hospital incurs the costs for the residents it trains in the hospital is irrelevant for purposes of both IME and direct GME. The requirement to incur the costs of the residency training program only applies in the instances where hospitals wish to count FTE residents that are training in nonhospital settings. In that case, the hospital must incur all or substantially all of the costs of the training program in the nonhospital site (and meet certain other requirements) in order to count any FTE residents training in that site.

In summary, we are finalizing the clarification of our policy that only time spent in patient care activities may be counted for IME purposes in the hospital complex and for direct GME and IME purposes in nonhospital sites. We are amending § 413.75(b) to add a definition of the term "patient care activities" which means, "the care and treatment of particular patients, including services for which a physician or other practitioner may bill." In addition, we are amending the IME regulations at § 412.105(f)(1)(iii) to add a paragraph (C) to state that "In order to be counted, a resident must be spending time in patient care activities, as defined in § 413.75(b)." We are also making conforming changes to the regulations text at § 412.105(f)(1)(iii)(C), and § 413.78(c)(1), (d)(1), and (e)(1) for residency training in nonhospital settings. Lastly for cost reporting periods beginning on or after October 1, 2006, we are implementing a "one workday" approach to documentation of residents' time, where, if a resident's workday consists entirely of scheduled nonpatient care activities, that workday must be identified as nonpatient care time and must be subtracted from the allowable FTE count (for IME, if the training occurred in the hospital complex, and for both IME and direct GME, if the training occurred in a nonhospital site).

6. Medicare GME Affiliated Groups: Technical Changes to Regulations

In the FY 2005 IPPS final rule (69 FR 49112 and 49254 through 49265), we redesignated the contents of § 413.86 (which contained the regulations governing Medicare payment for direct GME) as §§ 413.75 through 413.83 and made corresponding cross-reference changes in the text of these regulations. We have discovered that under the definition of "Medicare GME affiliated group" under § 413.75(b), we incorrectly cited the cross-reference to the rotation requirements for GME affiliated groups in paragraphs (1), (2), and (3), as "§ 413.79(g)(2)". In the FY 2007 IPPS proposed rule (71 FR 24115), we proposed to correct the cross-reference for the rotation requirements in paragraphs (2) and (3) of the definition to read "§ 413.79(f)(2)".

We did not receive any public comments on this proposed technical change and, therefore, are adopting it as final.

In the FY 2006 IPPS final rule (70 FR 47457 and 47489), we made additional changes to certain sections of the GME redesignated regulations to correct cross-references to other parts of 42 CFR Chapter IV relating to the definitions of the "urban" and "rural" location of a hospital. In one of the corrections, in paragraph (1) under the definition of "Medicare GME affiliated group" under § 413.75(b), we inadvertently dropped the language in that paragraph relating to the rotational requirements for these groups, including the incorrect cross-reference to § 413.79(g)(2). In the FY 2007 IPPS proposed rule (71 FR 24115), we proposed to correct the language of paragraph (1) under the definition of "Medicare GME affiliated group" under § 413.75(b) by adding the dropped language and correcting the cross-reference to read "§ 413.79(f)(2)."

We did not receive any public comments on this proposed technical change and, therefore, are adopting it as final.

In the FY 2006 IPPS final rule (70 FR 47454 and 47489), we revised § 413.79(e)(1)(iv) to provide that a new urban teaching hospital that qualifies for an adjustment to its FTE cap for a newly approved program may enter into a Medicare GME affiliation agreement, but only if the resulting adjustments to its direct GME and IME caps are "positive adjustments." We specified in the preamble of that final rule that this provision is effective for affiliation agreements entered into on or after October 1, 2005. However, we inadvertently did not include this effective date in the regulation text. In the FY 2007 IPPS proposed rule (71 FR 24115 and 24116), we proposed to revise § 413.79(e)(1)(iv) to include the effective date as part of the text of that section.

In addition, we proposed to correct a cross-reference in the introductory text of paragraph (f) of § 413.79 relating to Medicare GME affiliated groups. The cross-reference to "paragraph (e)(3)" of § 413.79 should read "paragraph (d)" of that section. This proposed change is necessary to accurately cite the reference to our rules regarding the 3-year rolling average.

We did not receive any public comments on the proposed technical change and cross-reference change and, therefore, are adopting them as final.

I. Payment for the Costs of Nursing and Allied Health Education Activities: Clarification (§ 413.85)

In addition to direct GME and IME payments to hospitals for the direct and indirect costs incurred for their graduate medical education programs in medicine, osteopathy, dentistry, and podiatry, Medicare makes payments to hospitals for two other categories of education-related costs for which different payment policies apply:

- Approved nursing and allied health education programs operated by the hospital. The costs of these programs are excluded from the definition of inpatient hospital operating costs and are not included in the calculation of the per discharge payment rates for hospitals paid under the IPPS, or in the calculation of payments to hospitals and hospital units excluded from the IPPS that are subject to the rate-of-increase ceiling. These costs are separately identified and "passed through" (that is, paid separately, on a reasonable cost basis).
- All other costs that can be categorized as educational programs and activities (for example, continuing education, on the job training, or seminars). These costs are considered to be part of the hospitals' normal operating costs and payment for these costs is included in the per discharge payment amount for hospitals subject to the IPPS, the IRF PPS, or the LTCH PPS

and the prospective per diem payment amount for facilities under the IPF PPS. Similarly, these costs are considered to be part of the hospitals' normal operating costs and are included as reasonable costs that are subject to the TEFRA rate-of-increase limits applicable to hospitals that continue to receive payments subject to those limits, including cancer and children's hospitals.

Regulations governing payment for the costs of approved and allied health education activities are located at 42 CFR 413.85.

In the FY 2004 IPPS final rule (68 FR 45429), we revised the regulations at § 413.85(h)(3) to further clarify the difference between provider-operated and continuing education programs. We revised the regulations to state that, effective October 1, 2003, programs in which employees participate that do not lead to the ability to practice and begin employment in a nursing or allied health specialty are also treated as normal operating costs. We now realize that when we revised § 413.85(h)(3) to include this clarification, we inadvertently did not specify that the provision was applicable to trainees as well as employees. In the preamble of the FY 2004 IPPS final rule, we stated that because § 413.85(h)(3) refers to education that will not lead to the ability to practice and *begin* employment, we intended the provisions to apply not only to employees but to trainees as well. Therefore, in the FY 2007 IPPS proposed rule (71 FF 24116), we proposed to make a technical change to § 413.85(h)(3) to make it applicable to both employees and trainees. We proposed this technical change to clarify that the educational activities in which employees or trainees participate, but that do not lead to the ability to practice and begin employment in a nursing or allied health specialty, are treated as normal operating costs. We noted that we did not propose to expand or make any changes to the current payment policy for nursing and allied health education activities; rather, we merely proposed to clarify the language of the existing regulations.

Comment: One commenter requested that, in response to CMS'' clarification of the regulations pertaining to normal operating costs, CMS make "* * * a regulation revision to reflect that trainees are included in the normal operation costs to avoid confusion."

Response: We agree with the commenter and note that as we proposed, we are revising the regulations at § 413.85(h)(3) to read: Educational seminars, workshops, and continuing education programs in which the employees *or trainees* participate that enhance the quality of medical care or operating efficiency of the provider and, effective October 1, 2003, do not lead to the ability to practice and begin employment in a nursing or allied health specialty.

In this final rule, we are adopting as final, without modifications, the proposed technical change to § 413.85(h)(3) to make it applicable to both employees and trainees.

J. Hospital Emergency Services Under EMTALA (§ 489.24)

1. Background

Sections 1866(a)(1)(I), 1866(a)(1)(N), and 1867 of the Act impose specific obligations on certain Medicare-participating hospitals and CAHs. (Throughout this section of this proposed rule, when we reference the obligation of a "hospital" under these sections of the Act and in our regulations, we mean to include CAHs as well.) These obligations concern individuals who come to a hospital emergency department and request examination or treatment for medical conditions, and apply to all of these individuals, regardless of whether they are beneficiaries of any program under the Act.

The statutory provisions cited above are frequently referred to as the Emergency Medical Treatment and Labor Act (EMTALA), also known as the patient antidumping statute. EMTALA was passed in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. 99–272. Congress enacted these antidumping provisions in the Social Security Act to ensure that individuals with emergency medical conditions are not denied essential lifesaving services because of a perceived inability to pay.

Under section 1866(a)(1)(I)(i) of the Act, a hospital that fails to fulfill its EMTALA obligations under these provisions may be liable for termination of its Medicare provider agreement, which would result in loss of all Medicare and Medicaid payments.

Section 1867 of the Act sets forth requirements for medical screening examinations for individuals who come to the hospital and request examination or treatment for a medical condition. The section further provides that if a hospital finds that such an individual has an emergency condition, it is obligated to provide that individual with either necessary stabilizing treatment or an appropriate transfer to another medical facility where stabilization can occur.

The EMTALA statute also outlines the obligation of hospitals to receive appropriate transfers from other hospitals. Section 1867(g) of the Act states that a participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires these specialized capabilities or facilities if the hospital has the capacity to treat the individual.

The regulations implementing section 1867 of the Act are found at 42 CFR 489.24.

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

Section 945 of Pub. L. 108–173 (MMA) required the Secretary to establish a Technical Advisory Group (TAG) to provide the Secretary with advice concerning issues related to EMTALA regulations and implementation. Section 945 of Pub. L. 108–173 further required that the EMTALA TAG be composed of 19 members, including the Administrator of CMS, the Inspector General of HHS, hospital representatives and physicians representing various specialties, patient representatives, and representatives of organizations involved in EMTALA enforcement.

The EMTALA TAG was first established in 2005 and held three meetings during that year. At each of its meetings, the EMTALA TAG heard testimony from representatives of physician groups, hospital associations, and others regarding EMTALA issues and concerns. As explained more fully below in sections IV.K.3. and 4. of this preamble, in the FY 2007 IPPS proposed rule (71 FR 24116 through 24118) we proposed to revise the EMTALA regulations at § 489.24 based on the recommendations adopted and forwarded to the Secretary by the EMTALA TAG.

3. Definition of "Labor"

As noted in the background portion of this section, the EMTALA statute and regulations require that if an individual comes to a hospital emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital is obligated to provide that individual with an appropriate medical screening examination within the capability of the hospital. If the individual is found to have an emergency medical condition, the hospital is obligated by EMTALA to

provide either necessary stabilizing treatment or an appropriate transfer to another medical facility where stabilization can occur.

Section 489.24(b) of the regulations defines the key terms used in the section. The term "emergency medical condition" is defined as—

"A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions, that there is inadequate time to effect a safe transfer to another hospital before delivery; or that transfer may pose a threat to the health and safety of the woman or the unborn child."

This definition closely follows the definition of "emergency medical condition" in section 1867(e)(1) of the Act with the exception that the regulation text further expands on "acute symptoms of sufficient severity" by including "psychiatric disturbances and/or symptoms of substance abuse" in addition to severe pain. In recognition of the fact that this definition gives special consideration to women in labor, the term "labor" is itself defined, in paragraph (b) of § 489.24, to mean "the process of childbirth beginning with the latent or early phases of labor and continuing through the delivery of the placenta." The definition further states: "A woman experiencing contractions is in true labor unless a physician certifies that, after a reasonable period of observation, the woman is in false labor." A woman found to be in false labor is considered not to have an emergency medical condition and that finding thus means that the hospital has no further EMTALA obligation to her.

The CMS interpretative guidelines used by State surveyors in EMTALA investigations provide that once an individual has presented to a hospital seeking emergency care, the determination as to whether an emergency medical condition exists is made by the examining physician(s) or other qualified medical person(s) actually caring for the individual at the treating facility. The guidelines further provide that the medical screening examination must be conducted by one or more individuals who are determined to be qualified by the hospital bylaws or rules and regulations and who meet the hospital condition of participation in 42 CFR 482.55 regarding emergency services personnel and direction. (Of course, these individuals would not be expected or permitted to perform any screening functions other than those which they are allowed to perform under State scope of practice laws.) However, consistent with the definition of "labor" at § 489.24(b), the guidelines also state that if a qualified medical person other than a physician determines that a woman is in false labor, a physician must certify the diagnosis. The guidelines permit this certification to be made based either on actual examination of the patient or on a telephone consultation with the qualified medical person who actually examined the patient. (Medicare State Operations Manual, Appendix V—Interpretive Guidelines—Responsibility of Participating Hospitals in Emergency Cases, TAG A–406.)

At its meeting held on June 15–17, 2005, the EMTALA TAG heard testimony from representatives of both physician and nonphysician professional societies regarding the competence of practitioners other than physicians to certify false labor. In particular, a representative of the American College of Nurse-Midwives stated that the current requirement that allows only a physician to certify false labor is overly restrictive and does not adequately recognize the training and competence of certified nurse-midwives. Testimony was also presented by the American College of Obstetricians and Gynecologists, which recommended amending the EMTALA regulations to allow certified nurse-midwives and other qualified medical persons to determine whether a woman is in false labor.

After extensive consideration of the issue, the members of the EMTALA TAG voted to recommend to the Secretary that the definition of "labor" at § 489.24(b) be amended to permit certified nurse-midwives and other qualified medical personnel to certify false labor. The TAG recommended deleting the second sentence, which states that a woman experiencing contractions is in true labor unless a physician certifies that, after a reasonable time of observation, the woman is in false labor.

We agree with the TAG's recommendation that other health care practitioners besides physicians should be allowed to certify false labor, and believe that the recommendation is consistent with CMS' current policy regarding who may conduct medical screening examinations. However, we do not believe such a change can be best accomplished by simply deleting the second sentence of the current definition of "labor" in the existing regulations because doing so would also remove the explicit statement that a woman experiencing contractions is in labor unless she has been found to be in false labor. To achieve the principal objective of the EMTALA TAG recommendation without compromising the protections of EMTALA for women having contractions, in the FY 2007 IPPS proposed rule, we proposed to modify the definition of "labor" in § 489.24(b) by revising the second sentence of that definition to state that a woman experiencing contractions is in true labor unless a physician, certified nurse-midwife, or other qualified medical person acting within his or her scope of practice as defined in hospital medical staff bylaws and State law, certifies that, after a reasonable time of observation, the woman is in false labor. The effect of this change would be to have a single, uniform policy on the personnel who are authorized to make a determination as to whether an individual has an emergency medical condition.

Comment: Several commenters expressed approval of the proposed change to the regulations to allow nonphysician practitioners to certify when a woman is in false labor, pursuant to State law and hospital bylaws. The commenters stated that this change to the regulations would provide hospitals greater flexibility in staffing and help ensure access to necessary services.

Response: We appreciate the commenters' support for this change to the regulations and have kept their remarks in mind while finalizing this proposal.

Comment: One commenter disagreed with the proposed change to the regulations. The commenter stated that one cause of higher rates of premature labor and malformed and malpresented neonates in the United States than among other industrialized nations is the use of nurses for labor and delivery services. The commenter recommended that CMS not only continue to require that a physician determine when a woman is in false labor but also that such physician be specialized in obstetrics.

Response: While we understand this commenter's concerns, the commenter has not provided evidence to support the allegation that there is a higher rate of premature labor and malformed and malpresented neonates in the United

States than other industrialized nations. Nor has the commenter demonstrated that the problems as cited are directly linked to nonphysician practitioners' involvement in labor and delivery services. Therefore, we are not modifying the proposed change based on this comment.

Comment: One commenter expressed approval of the concept of allowing practitioners other than physicians to certify false labor, but objected to the use of the phrase "qualified medical person" in § 489.24(b) to describe the kind of individual who may perform this function. The commenter stated that use of the term "medical" could suggest, incorrectly, that only a physician could certify false labor. The commenter recommended that the term used be "other qualified health care professional".

Response: The term "qualified medical person" is used in section 1867(c)(1)(A)(ii) of the Act and in current regulations at § 489.24 (e)(1)(C). Both statutory and regulatory usages of this term make reference to a "qualified medical person" as an individual other than a physician who is authorized to sign a certificate outlining the risks and benefits of transfer in the absence of a physician. Thus, we do not believe the language in our proposed revision will be misleading. However, we will keep the commenter's concern in mind as we draft conforming revisions to the EMTALA program instructions and other issuances, to make it clear that a qualified medical person need not be (and in fact will not be) a physician.

After consideration of the public comments received, we are adopting as final, without modifications, the proposed change in the definition of "labor" in § 489.24(b).

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

Section 489.24(b) of the regulations outlines when a hospital will be considered to be a hospital with a "dedicated emergency department" and makes it clear that only a hospital with a dedicated emergency department has an EMTALA responsibility with respect to an individual for whom no appropriate transfer is sought but who comes to the hospital seeking examination or treatment for a medical condition. However, it has come to CMS' attention that our policy regarding the application of EMTALA to hospitals that have specialized capabilities but are without dedicated emergency departments may be less well understood as it relates to individuals for whom an appropriate transfer is sought.

It has been CMS' longstanding policy that any Medicare-participating hospital with a specialized capability must, in accordance with section 1867(g) of the Act, accept, within the capacity of the hospital, an appropriate transfer from a requesting hospital. This policy has been applied to hospitals without regard to whether they have dedicated emergency departments. In fact, in the past, CMS has taken enforcement actions against hospitals with specialized capabilities that failed to accept appropriate transfers under EMTALA when the hospitals had the capacity to treat the transferred individuals.

At its meeting held on October 26–28, 2005, the EMTALA TAG heard testimony from representatives of physician groups, hospital associations, and others regarding EMTALA compliance by specialty hospitals that typically do not have dedicated emergency departments. After extensive consideration and discussion of the issues raised and views presented, the members of the EMTALA TAG voted to recommend to the Secretary that hospitals with specialized capabilities (as defined in § 489.24(f) of the regulation) that do not have a dedicated emergency department be bound by the same responsibility to accept an appropriate transfer under EMTALA as hospitals with a dedicated emergency department.

We agree with the EMTALA TAG's assessment. We believe that the recommendation is consistent with CMS' current policy and highlights the need to clarify CMS' policy regarding hospitals with specialized capabilities. Therefore, in the FY 2007 IPPS proposed rule (71 FR 24118), we proposed to modify the regulations at § 489.24(f) to specifically indicate that any participating hospital with specialized capabilities or facilities, even if it does not have a dedicated emergency department, may not refuse to accept an appropriate transfer if the hospital has the capacity to treat the individual. We noted that the proposed revision does not reflect any change in current CMS policy. We further noted that the revision would not require hospitals without dedicated emergency departments to open dedicated emergency departments nor would it impose any EMTALA obligations on those hospitals with respect to individuals who come to the hospital as their initial point of entry into the medical system seeking a medical screening examination or treatment for a medical condition. Although the proposed revision sought only to clarify, rather than change, current policy, we nevertheless, solicited comments on what effect, if any, commenters believe the proposed clarification might have on EMTALA compliance and patient health and safety.

Comment: Several commenters expressed approval of the proposed change to the regulations to clarify that hospitals with specialized capabilities have an obligation under EMTALA to accept appropriate transfers within their capabilities whether or not the hospital has a dedicated emergency department, including all physician-owned limited service facilities.

Response: We appreciate the commenters' support for this change to the regulations and have kept their remarks in mind while finalizing this proposal.

Comment: Several commenters requested that CMS provide additional guidance on the definition of "specialized capabilities or facilities."

Response: We refer these commenters to the regulations at § 489.24(f) for a partial list of specialized capabilities or facilities. These include, but are not limited to, burn units, shock-trauma units, neonatal intensive care units, and certain referral centers. We recognize that this list is not exhaustive and would include physician-owned limited service facilities with special capabilities. We also would note that the EMTALA TAG is currently considering whether the definition of "specialized capabilities" should be further revised. However, no expansion of the list of specialized facilities or capabilities was specifically proposed in the proposed rule published on April 25, 2006. In view of this fact and in consideration of the fact that the EMTALA TAG may make recommendations relating to this issue, we have decided not to make any further revision to the list of examples noted above. However, we will consider carefully any recommendations made by the EMTALA TAG on the issue and may propose changes in the future.

Comment: Several commenters asked CMS to emphasize that all physician-owned limited service facilities are required to maintain adequate on-call panels to comply with the Medicare hospital conditions of participation. In addition, the commenters requested that CMS require these hospitals to have preexisting transfer agreements with any community hospital to which it may send patients for emergency services. Two commenters suggested that the Secretary establish the terms of such agreements. The commenters recommended three issues to be

addressed in the agreements: Procedures for an appropriate transfer for patients not covered under EMTALA; continuity of care; and support for maintaining full-time emergency capacity at the community hospital, including on-call coverage. The commenters also requested that CMS require physicians who practice at such hospitals to participate in on-call panels at the community hospitals with which their hospital has a transfer agreement.

Response: While physician-owned limited service hospitals certainly are required to maintain compliance with the hospital conditions of participation, those regulations set forth in 42 CFR Part 482 do not include an explicit on-call requirement. Thus, we are not including a revision in this final rule to include the specific change requested by the commenter. However, we note that the conditions of participation relating to a hospital's governing body at § 482.12(c)(3) requires that all Medicare-participating hospitals have a doctor of medicine or osteopathy either on duty or on call at all times. In addition, the governing body condition of participation and the condition of participation for medical staff found at § 482.22 include various other requirements that make the hospital governing body and medical staff accountable for providing adequate physician services for hospital patients. These requirements also apply to physician-owned limited service facilities, including those that do not operate emergency departments, on the same basis as to community and other hospitals.

In general, we believe the comments concerning transfer agreements are outside the scope of the proposed change to the regulations. In addition, the terms of transfer agreements between hospitals are decided upon by the individual hospitals party to the agreement. However, we will refer these comments to the EMTALA TAG for further consideration, and may propose some further change in Medicare regulations on these topics in the future if they are warranted.

5. Clarification of Reference to "Referral Centers"

The language of the existing regulations at § 489.24(f) duplicates the language of section 1867(g) of the Act in that it identifies, as an example of a hospital with specialized capabilities, "(with respect to rural areas) regional referral centers identified by the Secretary in regulation)". Because the term "regional referral centers" is not used elsewhere in the Medicare regulations, it is unclear whether the reference is to referral centers as defined in 42 CFR 412.96, which must be located in rural areas and meet other criteria spelled out in that section, or to any facilities that are located in rural areas and accept patients on referral. To maintain consistency in the Medicare regulations and avoid confusion as to which facilities are considered to have specialized capabilities for purposes of EMTALA, in the FY 2007 IPPS proposed rule (71 FR 24118), we proposed to amend § 489.24 by clarifying that "regional referral centers" are those centers meeting the requirements of § 412.96.

We did not receive any public comments on this clarification and, therefore, are adopting, as final without modification, the amendment to § 489.24 to clarify that "regional referral centers" are those centers meeting the requirements of § 412.96.

K. Other Technical Changes

1. Cross-Reference Correction in Regulations on Limitations on Beneficiary Charges (§ 412.42)

In the FY 2007 IPPS proposed rule (71 Fr 24118), we proposed to amend § 412.42 to correct an obsolete cross-reference. Paragraph (d) of § 412.42 contains a cross-reference to "§ 405.310(k)." This section was redesignated as § 411.15(k) in 1989 (54 FR 41737, October 11, 1989). We proposed to amend paragraph (d) of § 412.42 to delete the obsolete cross-reference and insert the correct cross-reference.

We did not receive any public comments on this proposed cross-reference change and are, therefore, adopting it as final.

2. Cross-Reference Corrections in Regulations on Payment Denials Based on Admissions and Quality Reviews (§ 412.48)

In the FY 2007 IPPS proposed rule (71 FR 24118), we proposed to amend § 412.48 to correct an obsolete cross-reference. Paragraph (b) of § 412.48 contains a cross-reference to "§§ 405.330 through 405.332". Section 405.330 was redesignated as § 411.400, and § 405.332 was redesignated as § 411.402 in 1989 (54 FR 41746, October 11, 1989). (There was no § 405.331.) We proposed to amend paragraph (b) of § 412.48 to delete the obsolete cross-references and to insert the correct cross-references.

We did not receive any public comments on this proposed cross-reference change and are, therefore, adopting it as final.

3. Cross-Reference Correction in Regulations on Outlier Payments (§ 412.84)

On June 9, 2003, we published a final rule in the **Federal Register** (68 FR 34494) that amended the portion of the hospital IPPS regulations that sets out the methodology for determining payments for extraordinarily high-cost cases (outliers). We changed the methodology because we concluded that, in certain cases, hospitals were dramatically and inappropriately increasing charges, thereby inflating CCRs, resulting in overestimation of these hospitals' costs per case, a critical factor in determining outlier payments.

As a part of these methodology changes, we required that outlier payments be reconciled using a hospital's settled cost report for the cost reporting year in which the outlier discharge occurred. This approach meant that there would be some delay in computing the final outlier payment. To address this issue, we added § 412.84(m), which provided that reconciled outlier payments would be adjusted to account for the time value of any underpayments or overpayments.

We inadvertently included in paragraph (m) of § 412.84 a cross-reference to paragraph (h)(3) of § 412.84. The cross-reference should be to paragraph (i)(4), which sets out the requirement for reconciling outlier payments when the cost report for the year in which the discharge occurred is settled. In the FY 2007 IPPS proposed rule (71 FR 24118 and 24119), we proposed to amend paragraph (m) of § 412.84 to correct the cross-reference to read "paragraph (i)(4)" of § 412.84.

We did not receive any public comments on this proposed cross-reference change and are, therefore, adopting it as final.

4. Removing References to Two Paper Claims Forms

Section 1862(a)(22) of the Act generally requires electronic submission of initial Medicare claims requesting payment for items and services. Section 1862(h) of the Act provides for limited exceptions when paper claims still may be used. Our existing regulations at 42 CFR 424.32 set out the requirements for submitting electronic and paper claims for payment, as well as when the exceptions apply and paper forms still may be used. Our existing regulations at paragraph (b) of § 424.32 list six forms that are to be used for submitting paper claims.

We have evaluated the use of two of these forms, Form CMS–1490U (Request for Medicare Payment by Organization)

and Form CMS–1491 (Request for Medicare Payment—Ambulance). We found that these forms have limited use, we would incur expensive costs in redesigning these forms to comply with other reporting requirements, and that an alternate form is available to claim payments. For these reasons, we intend to no longer use these forms. Therefore, in the FY 2007 IPPS proposed rule (71 FR 24119), we proposed to remove the references to these forms from paragraph (b) of § 424.32.

Form CMS–1490U is a paper claim form used by employers, unions, employer-employee organizations that pay physicians and suppliers for their services to employees, group practice prepayment plans, and health maintenance organizations. Form CMS–1490U is used to claim payment from carriers for bills already paid by these entities. We concluded that this form should no longer be used for several reasons. It is duplicative of Form CMS–1500 (Health Insurance Claim Form), which also may be used to claim payment for these services. We have encouraged suppliers to submit their paper claims using the Form CMS–1500. Unlike Form CMS–1500, Form CMS–1490U cannot accommodate an additional reporting requirement, the National Provider Identifier (NPI), without an expensive redesign. Finally, according to our records, relatively few suppliers currently use the form. The CMS component that supplies blank copies of this form for users reported that, between 2002 and 2005, only 2,550 copies of Form CMS–1490U were ordered by carriers. A 2005 survey of Part B carriers indicated that requests for the form are very low and that receipts of the form vary from very few to none.

Form CMS–1491 is a paper claim form used by ambulance suppliers to apply for payment for ambulance services. We concluded that this form should no longer be used for several reasons. It also is duplicative of Form CMS–1500, which also may be used to claim payment for ambulance services. In addition, we have encouraged suppliers to submit their paper ambulance claims using the Form CMS–1500. Unlike Form CMS–1500, Form CMS–1491 cannot accommodate the NPI without an expensive redesign and usage of this form is low. A recent survey of carriers, initiated by Joint Signature Memorandum RO–2324, Request for Information Concerning the CMS–1491, issued October 30, 2003, from the Centers for Medicare Management, was conducted to ascertain the usage of Form CMS–1491. The results of the survey showed that fewer than 2 percent (1.71 percent) of all suppliers of ambulance services currently use the Form CMS–1491. CMS received approximately 240,000 ambulance claims using Form CMS–1491 during the period from October 1, 2002, to September 30, 2003. These data were used for the most recent OMB renewal under the Paperwork Reduction Act. Since the last OMB renewal approval in 2001, CMS has printed a total of 1,620,000 forms at a cost of $42,890.

We did not receive any public comments on our proposal. Therefore, we are adopting, as final without modification, the proposed removal of the references to the identified forms from paragraph (b) of § 424.32.

L. Rural Community Hospital Demonstration Program

In accordance with the requirements of section 410A(a) of Pub. L. 108–173, the Secretary has established a 5-year demonstration program (beginning with selected hospitals' first cost reporting period beginning on or after October 1, 2004) to test the feasibility and advisability of establishing "rural community hospitals" for Medicare payment purposes for covered inpatient hospital services furnished to Medicare beneficiaries. A rural community hospital, as defined in section 410A(f)(1), is a hospital that:

- Is located in a rural area (as defined in section 1886(d)(2)(D) of the Act) or is treated as being located in a rural area under section 1886(d)(8)(E) of the Act;
- Has fewer than 51 beds (excluding beds in a distinct part psychiatric or rehabilitation unit) as reported in its most recent cost report;
- Provides 24-hour emergency care services; and
- Is not designated or eligible for designation as a CAH.

As we indicated in the FY 2005 IPPS final rule (69 FR 49078), in accordance with sections 410A(a)(2) and (a)(4) of Pub. L.108–173 and using 2002 data from the U.S. Census Bureau, we identified 10 States with the lowest population density from which to select hospitals: Alaska, Idaho, Montana, Nebraska, Nevada, New Mexico, North Dakota, South Dakota, Utah, and Wyoming (Source: U.S. Census Bureau Statistical Abstract of the United States: 2003). Nine rural community hospitals located within these States are currently participating in the demonstration program for FY 2007. (Of the 13 hospitals that participated in the first 2 years of the demonstration program, 4 hospitals located in Nebraska have withdrawn from the program; they have become CAHs.)

Under the demonstration program, participating hospitals are paid the reasonable costs of providing covered inpatient hospital services (other than services furnished by a psychiatric or rehabilitation unit of a hospital that is a distinct part), applicable for discharges occurring in the first cost reporting period beginning on or after the October 1, 2004, implementation date of the demonstration program. Payments to the participating hospitals will be the lesser amount of the reasonable cost or a target amount in subsequent cost reporting periods. The target amount in the second cost reporting period is defined as the reasonable costs of providing covered inpatient hospital services in the first cost reporting period, increased by the inpatient prospective payment update factor (as defined in section 1886(b)(3)(B) of the Act) for that particular cost reporting period. The target amount in subsequent cost reporting periods is defined as the preceding cost reporting period's target amount, increased by the inpatient prospective payment update factor (as defined in section 1886(b)(3)(B) of the Act) for that particular cost reporting period.

Covered inpatient hospital services are inpatient hospital services (defined in section 1861(b) of the Act), and include extended care services furnished under an agreement under section 1883 of the Act.

Section 410A of Pub. L. 108–173 requires that "in conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented." Generally, when CMS implements a demonstration program on a budget neutral basis, the demonstration program is budget neutral in its own terms; in other words, the aggregate payments to the participating providers do not exceed the amount that would be paid to those same providers in the absence of the demonstration program. This form of budget neutrality is viable when, by changing payments or aligning incentives to improve overall efficiency, or both, a demonstration program may reduce the use of some services or eliminate the need for others, resulting in reduced expenditures for the demonstration program's participants. These reduced expenditures offset increased payments elsewhere under the demonstration program, thus ensuring that the demonstration program as a whole is budget neutral or

yields savings. However, the small scale of this demonstration program, in conjunction with the payment methodology, makes it extremely unlikely that this demonstration program could be viable under the usual form of budget neutrality. Specifically, cost-based payments to the nine participating small rural hospitals are likely to increase Medicare outlays without producing any offsetting reduction in Medicare expenditures elsewhere. Therefore, a rural community hospital's participation in this demonstration program is unlikely to yield benefits to the participant if budget neutrality were to be implemented by reducing other payments for these providers.

In order to achieve budget neutrality for this demonstration program for FY 2007, we are adjusting the national inpatient PPS rates by an amount sufficient to account for the added costs of this demonstration program. We are applying budget neutrality across the payment system as a whole rather than merely across the participants in this demonstration program. As we discussed in the FY 2005 and FY 2006 IPPS final rules (69 FR 49183 and 70 FR 47462), we believe that the language of the statutory budget neutrality requirements permits the agency to implement the budget neutrality provision in this manner. For FY 2007, using cost report data for FY 2003, adjusted to account for the increased estimated costs for the remaining nine participating hospitals, we estimate that the adjusted amount would be $9,197,870. This estimated adjusted amount reflects the estimated difference between the participating hospitals' costs and the IPPS payment based on data from the hospitals' cost reports. We discuss the payment rate adjustment that will be required to ensure the budget neutrality of the demonstration program for FY 2007 in section II.A.4. of the Addendum to this final rule.

We did not receive any public comments on the provisions of the demonstration program discussed in the proposed rule.

M. Health Care Information Transparency Initiative

The United States faces a dilemma in health care. Although the rate of increase in health care spending slowed last year, costs are still growing at an unsustainable rate. The United States spends $1.9 trillion on health care, or 16 percent of the gross domestic product (GDP). By 2015, projections are that health care will consume 20 percent of the GDP. The Medicare program alone consumes 3.4 percent of the GDP; by 2040, it will consume 8.1 percent of the GDP, and by 2070, 14 percent of the GDP.

Part of the reason health care costs are rising so quickly is that most consumers of health care—the patients—are frequently not aware of the actual cost of their care. Health insurance shields them from the full cost of services, and they have only limited information about the quality and costs of their care. Consequently, consumers do not have the incentive or means to carefully shop for providers offering the best value. Thus, providers of care are not subject to the competitive pressures that exist in other markets for offering quality services at the best possible price. Reducing the rate of increase in health care prices and avoiding health services of little value could help to stem the growth in health care spending, and potentially translate into fewer individuals who are unable to afford health insurance. Part of the President's health care agenda is to expand Health Savings Accounts (HSAs), which would provide consumers with greater financial incentives to compare providers in terms of price and quality, and choose those that offer the best value.

In order to exercise such choices, consumers must have accessible and useful information on price and quality of health care items and services. Typically, health care providers do not publicly quote or publish their prices. Moreover, list prices, or charges, generally differ from the actual prices negotiated and paid by different health plans. Thus, even if consumers were financially motivated to shop for the best price, it would be very difficult at the current time for them to access usable information.

Similarly, individuals have very little information available to them about the quality of care that they receive. Although there are preliminary steps underway to rectify that fact, including the hospital quality reporting initiative in which a significant number of acute care hospitals are participating (see sections IV.A and IV.B of this preamble), those data are nascent and consumers lack sufficient information on which to base a judgment about where to receive care based on quality of care.

For these reasons, in the FY 2007 IPPS proposed rule (71 FR 24120), we announced that the Department intends to launch a major health care information transparency initiative in 2006. This effort will build on steps already taken by CMS to make quality and price information available. For example, we currently collect quality information and publish it through the CMS Hospital Compare Web site, which we reference in other parts of this final rule. We also make available unprecedented information on the prices of drugs to beneficiaries in the Medicare prescription drug plan for each pharmacy in the United States.

In the FY 2007 IPPS proposed rule, we also stated that we intend to take further steps to collect and publish useful information on quality and cost. The Department intends to identify several regions in the United States where health care costs are high, and where there is significant interest in reducing health care costs and improving health care quality. The Department will use its leadership role in health care policy to help lead change in those areas.

The Secretary also has significant regulatory authority as well. In the FY 2007 IPPS proposed rule, we solicited comments on several proposals that the Secretary might adopt to increase the transparency of quality and pricing information, and how this can be used to attenuate the growth in health care costs. In addition, we solicited comments from the public on additional ways that we could use our regulatory authority to enhance transparency of quality and pricing information.

In the FY 2007 IPPS proposed rule, we addressed several possibilities that we believe exist. First, we could publish a list of hospital charges either for every region of the country or for selected regions of the country. In addition, we could publish the rates that Medicare actually pays to a particular hospital for every DRG or for selected DRGs that could be adjusted to take into account the hospital's labor market area, teaching hospital status, and DSH status. Some might argue that publishing these payment rates does not provide meaningful information to consumers because Medicare payment rates are not set by the market, but rather by a statutory payment formula. In addition, providing information on hospital payments only does not disclose the true cost of an episode of care because it would not take into account the cost of physician services, laboratory tests, and other procedures that go along with hospital charges. On the other hand, Medicare payment rates may provide a helpful benchmark, especially for uninsured individuals, to determine whether the charges they see on a hospital bill bear any relationship to what third-party fee-for-service payors pay to the hospital.

A second option would be for the Secretary to use his authority to establish conditions of participation for

hospitals to propose a rule that relates to charges for uninsured patients. For example, the conditions of participation could include a requirement that hospitals post their prices and/or post their policies regarding discounts or other assistance for uninsured patients.

Yet another alternative to posting Medicare DRG payment rates would be to make publicly available the total Medicare payments for an episode of care. For example, one of the most common inpatient hospital procedures under the Medicare program (based on total dollars spent) is hip replacement surgery. Under this proposal, we could make publicly available the expected total payment for an episode of care for hip replacement surgery, including the inpatient hospital stay, physician payments (including the surgeon and the anesthesiologist), and payments for post-acute care services such as services provided in an IRF, SNF, or LTCH. In the proposed rule, we indicated that we are currently assessing methods for making such information available and were seeking comments on how to do so as quickly and effectively as possible.

We solicited comment on any ways in which the Department can encourage transparency in health care quality and pricing whether through its leadership on voluntary initiatives or through regulatory requirements. We also sought comment on the Department's statutory authority to impose such requirements. We indicated that discussion of particular options in the proposed rule should not be taken as an indication that the Department will adopt any of these proposals. Rather, the proposals were included to foster comment on possible options to promote the aims of transparency of quality and pricing information and the Department's authority and ability potentially to implement these options. We indicated that the Department is anxious to receive comments on any of these proposals, or on other options that may be available that the Department could adopt either through voluntary initiatives or through its regulatory authority.

Thirty-eight commenters made more than a hundred specific comments on the transparency discussion in the FY 2007 IPPS proposed rule. We received comments from providers, practitioners, and their representatives or associations, including hospital associations, physician associations, and organizations representing other health care professionals, as well as the medical device industry. We also received comments from organizations that promote quality measures in health care, from employers, and from health care-related companies. We found these comments to be extremely helpful and constructive as we seek to promote transparency in the health care system.

Listed below are the eight issue areas related to transparency that we identified in the comments and which generated the greatest number of comments:

- Features of transparency;
- Types of pricing information;
- Leadership/stakeholder participation;
- Medicare Conditions of Participation;
- Limited effectiveness of transparency efforts to address uninsured and safety net providers;
- Physician-identifiable Medicare claims data;
- Concerns regarding the June 1, 2006 posting of payment information on the 30 common elective procedures by DRG; and
- The link between value-based purchasing and making the health care system more transparent.

Comment: The majority of commenters provided comments on what types of transparency features would be important to consumers with the end goal of providing consumers with meaningful, easily accessible information for health care decision-making. Many commenters suggested conducting research on what information consumers would want. For example, ease of use and ease of access to posted price information (which may include a web-based tool), common definitions and language to describe pricing information, and offering explanations of the potential sources of variation in price are features that numerous commenters identified. They also noted that the integration of price and quality information is critical and that price should only be one consideration in consumers' decision-making process. Several commenters highlighted the importance of a feasible approach to implementation, specifically highlighting the complexity of hospital pricing. One commenter noted that physician ownership in specialty hospitals should be transparent to the public. One commenter suggested that transparency should promote the continuum of care. Finally, several commenters noted that promoting the use of health information technology as well as further developing quality measurements are important factors in advancing transparency.

Response: We agree that it is important to understand what information beneficiaries want, how they use the information, whom beneficiaries consult in making decisions, and the needs of different types of users of information. Particularly with regard to Medicare beneficiaries—many of whom face challenges in accessing and understanding information—CMS has strived to provide information on quality in a way that is accessible and meaningful to beneficiaries and to those who assist beneficiaries in making health care decisions. CMS and AHRQ have sponsored research in this area and will continue to examine these issues. We will continue to improve the web-based tools currently in use (such as Hospital Compare and Nursing Home Compare), and will continue to explore other means of improving our ability to disseminate information and means of encouraging the use of available information.

We recognize the complexities involved in attempting to present pricing information in an accurate and useful manner that is accessible for the intended users. We agree that in making health care decisions, consumers must have access to both cost and quality information and that information must be available across the continuum of care. Consumers also must have access to other types of information that may be considered relevant when they are making decisions about their health care. While CMS has recently begun releasing information on Medicare payments to hospitals by procedure, and we plan to make pricing information available for other types of providers and practitioners, we recognize that an education effort is required to enable the best use of pricing information. Similarly, from the provider and practitioner point of view, there are many complexities involved in the reporting of information on price and quality. We agree that standardizing terminology and greater use of health information technology would support transparency by reducing reporting burdens. The ideal is to design a system that is feasible and accomplishes its intended goals in the most efficient manner possible.

Comment: We received a significant number of comments on what types of pricing information should be made publicly available based on reliable claims data. Many commenters recommended making both hospital charges and out-of-pocket costs available, and several commenters recommended this as a Federal requirement. However, some commenters cautioned against using hospital charges since they do not reflect consumers' expected costs. Commenters noted that it is important to help consumers understand that there

are price variations that reflect factors such as additional payments to fund teaching and research missions, caring for the under- and uninsured, and other costs. Several commenters noted the importance of measuring costs and quality across settings and over appropriate timeframes using evidence-based protocols. One commenter recommended displaying CCRs. Another commenter recommended reporting national average charges for certain common procedures. One commenter noted that the cost of nursing care is not shown as a separate cost to patients. One commenter noted that costs of supplies and services should be transparent as well. With regard to possible studies of costs in areas of the country where there are relatively high health care costs, one commenter recommended that a studied region be homogenous, but heterogeneous outside of the study area.

Response: As mentioned previously, we recognize the complexities involved in attempting to present pricing information in an accurate and useful manner that is accessible for the intended users. As also noted above, we agree that in making health care decisions, consumers must have access to both cost and quality information, as well as other information that may be considered relevant when consumers are making decisions about their health care. As noted above, while CMS has recently begun to release information on Medicare payments to hospitals by procedure as well as the number of procedures performed by the hospital, and we plan to make pricing information available for other types of providers and practitioners, we recognize that an education effort is required to enable the best use of pricing information. Consumers must take into account the many factors noted by commenters which are components of the prices that consumers (or insurers) will pay for care. For example, consumers may want to know the costs of all the services they received in an episode-of-care when determining the total costs for a course of treatment. Similarly, with an episode-of-care approach, consumers also may want information about the quality of care at each point in the continuum of care when multiple providers and practitioners are involved.

With regard to beneficiary out-of-pocket costs, the current pricing tools available to Medicare beneficiaries—the Medicare Personal Plan Finder and the tools beneficiaries use in evaluating Part D drug plans—are intended to give beneficiaries important, accurate information about their expected out-of-pocket costs when faced with various choices. At the same time, we believe it is desirable for consumers to know how much their insurer—or the Medicare program (and therefore taxpayers)—is paying for a person's care. The cost of care to the primary payer should be a factor when a person is attempting to make judicious decisions about his or her health care.

Comment: A considerable number of commenters addressed the importance of leadership and stakeholder participation in efforts to bring greater transparency to the health care system. Many commenters noted the success of existing public-private partnerships and recommended that CMS continue to build on these partnerships. Many commenters recommended that the further expansion of hospital quality information should be accomplished through the Hospital Quality Alliance. Also, commenters noted that the AHRQ is best suited to conduct research on what consumers want in helping them with health care purchasing decisions. Several commenters suggested collaborative efforts though workshops. Several commenters recommended a hospital-led effort to create consumer-friendly pricing language. One commenter suggested that insurance companies are best positioned to be advisors to patients and to provide information on the expected costs for an entire episode of care. One commenter supported a hospital-led effort in making transparent information available to consumers, rather than a government-led initiative.

Response: The views of many of the commenters are consistent with CMS' current practices in the development and dissemination of quality measures for Medicare beneficiaries, and are consistent with our future direction with respect to transparency in providing price and quality information. Many of the tools and measures that CMS currently uses in providing information on quality have been developed through public-private collaborations. CMS has used a collaborative approach for many years, and CMS actively participates in efforts such as the Hospital Quality Alliance, the Ambulatory Care Quality Alliance, the National Committee on Quality Assurance, the National Quality Forum, and numerous other organizations whose mission is to improve the quality of health care by making valid, reliable information available to providers and consumers. In particular, CMS is supporting pilot programs in Boston, Indianapolis, Minneapolis-St. Paul, Wisconsin, Phoenix, and California, in conjunction with the Hospital Quality Alliance and Ambulatory Care Quality Alliance, to identify and implement effective ways of providing better information on quality and improving quality. As the commenters noted, the AHRQ is a leader in this arena, and CMS will continue to work with AHRQ to ensure that there is continuing progress in providing information on quality. A broad, collaborative approach to the development and dissemination of information also promotes improvement in the usefulness of the information and improvement in the mechanisms of dissemination.

As noted above, we agree that it is important to understand the information needs of Medicare beneficiaries, and we will continue to examine that issue as it pertains to beneficiaries. As more information on quality continues to be made available, and as pricing information becomes more commonly available, we need to understand whether the new information and the manner in which it is disseminated is effectively serving the needs of beneficiaries and the needs of other individuals and entities that assist beneficiaries in their decisionmaking processes.

Comment: Several commenters opposed the option which suggested that we modify the Medicare conditions of participation to require hospitals to post price information on assistance programs for the uninsured. Commenters noted that hospitals provide community financial assistance to the uninsured in their service areas based on local patient demographics and the local poverty level. They believe that as patient demographics and poverty levels vary from community to community, so must charity care policies. One commenter noted that without Congressional action, CMS does not have the authority to require hospitals to produce price information unrelated to Federal program beneficiaries. This commenter also advocated that CMS allow the current hospital pricing marketplace, that includes the provision of charity care to the uninsured, to continue to operate without Federal interference.

Response: Although we are not adopting our proposal to amend the Medicare conditions of participation to require hospitals to post price information, including information on assistance programs for the uninsured at this time, we have not abandoned the idea and may consider it in the future. As noted in the FY 2007 IPPS proposed rule, we are considering several options to achieve greater transparency in the health care system. We agree that any transparency policy must take into

consideration the current programs operated by hospitals across the country to provide financial assistance to the uninsured and the variances in the patient demographics that are addressed by these programs. However, we believe that providing true cost transparency in the health care system will require making available price information across populations through public-private collaboratives, such as the AQA pilots. We appreciate the current efforts of the hospital and insurance industries to work with CMS towards greater transparency in the health care system.

Comment: Two commenters suggested that pricing transparency will not address the problem of the uninsured and will have a marginal impact on costs. Specifically, the commenters argued that the complexity of, and variances in, hospital charge structures make price comparisons among hospitals nearly impossible; and therefore posting hospital-specific charges will not accomplish CMS' transparency goals. Rather the commenters stated that CMS should work with Congress to expand Medicaid and other safety net programs. Alternatively, the commenters supported the expansion of CMS' current efforts to report national average charges for certain common procedures, as this information would allow patients to encourage their local hospitals to align their charges with national averages. The commenters also noted that for the privately insured, the relevant financial information is the amount that is the patient's responsibility.

Response: We believe by increasing the transparency of health care costs and providing cost and quality information to consumers to make better-informed health care choices, overall costs to the health care system should decrease and the quality of care will improve. Greater health care efficiency is critical for the long-term sustainability of the health care system, including the ability to deliver care to the uninsured population. As we continue to develop policies to support transparency in the health care system, CMS is committed to ensuring that the needs of the uninsured population and the safety net providers that serve them are addressed.

Comment: Three commenters recommended the release of physician-identifiable Medicare claims data (fully protecting patient privacy), to allow for better quality and efficiency performance reporting.

Response: Those making this comment suggest that releasing physician-identifiable Medicare claims data to the public would increase the scope and breadth of performance measures. CMS is firmly committed to increasing the scope and breadth of performance measures in all settings of care in which Medicare patients receive care. Specifically, in this regulation, CMS is requiring hospitals to report on a broader set of quality measures to receive the full payment update. We agree that physician-identifiable claims are an important source of information and are evaluating the potential to use physician-identifiable Medicare claims in this initiative.

Comment: One commenter noted that the June 1, 2006 CMS posting of payment information on the 30 common elective procedures by diagnosis-related group (DRG) does not include information on the quality of care delivered within each specific DRG.

Response: We agree that both quality and cost information must be used to assess the value of health care. We disagree with the commenter's view that CMS is not releasing information for beneficiaries on both quality and cost on the same conditions. Many of the patients who would receive care for the high-utilization condition for which payment information has been posted would be the same patients whose care would be assessed for Hospital Compare quality measures. Further, the HQA surgical measures would apply to some of the surgical procedures for which payment information was posted. Many quality measures, such as the Hospital Consumer Assessment of Healthcare Providers and Systems Survey® (HCAHPS®), are not specific to certain procedures and may be just as important to beneficiaries and other consumers as condition-specific clinical measures. Other information included in the posting, such as how many patients a hospital treats for a certain condition, also adds to the information that people can use to make better decisions on their care.

Comment: Several commenters supported the link between value-based purchasing and making the health care system more transparent.

Response: We agree that financial incentives can be a powerful tool to encourage quality improvement. Almost all hospitals chose to report and improve on certain quality measures when Congress determined that reporting them should be a condition of receiving the full payment update for inpatient care. Further, the initial results from the Premier Hospital Quality Incentive Demonstration show that participating hospitals, on average, improved on the quality measures upon which they were assessed for purposes of receiving a payment bonus. In addition to these efforts, CMS has embarked on a variety of initiatives that use public reporting to provide useful information to beneficiaries and to improve the quality and value of care. Payers, beneficiaries, and providers share a common interest in having consumers make informed health care decisions. Providers who deliver high quality services at a lower cost than others should be given the opportunity to be publicly acknowledged for their efforts.

V. Changes to the PPS for Capital-Related Costs

A. Background

Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of inpatient acute hospital services "in accordance with a PPS established by the Secretary." Under the statute, the Secretary has broad authority in establishing and implementing the PPS for hospital inpatient capital-related costs. We initially implemented the PPS for capital-related costs in the August 30, 1991 IPPS final rule (56 FR 43358), in which we established a 10-year transition period to change the payment methodology for Medicare hospital inpatient capital-related costs from a reasonable cost-based methodology to a prospective methodology (based fully on the Federal rate).

Federal fiscal year (FFY) 2001 was the last year of the 10-year transition period established to phase in the PPS for hospital inpatient capital-related costs. For cost reporting periods beginning in FY 2002, capital PPS payments are based solely on the Federal rate for most acute care hospitals (other than certain new hospitals and hospitals receiving certain exception payments). The basic methodology for determining capital prospective payments using the Federal rate is set forth in § 412.312. For the purpose of calculating payments for each discharge, the standard Federal rate is adjusted as follows:

(Standard Federal Rate) × (DRG Weight) × (Geographic Adjustment Factor (GAF)) × (Large Urban Add-on, if applicable) × (COLA for hospitals located in Alaska and Hawaii) × (1 + Capital DSH Adjustment Factor + Capital IME Adjustment Factor, if applicable).

Hospitals also may receive outlier payments for those cases that qualify under the threshold established for each fiscal year as specified in § 412.312(c) of the regulations.

The regulations at § 412.348(f) provide that a hospital may request an additional payment if the hospital

incurs unanticipated capital expenditures in excess of $5 million due to extraordinary circumstances beyond the hospital's control. This policy was originally established for hospitals during the 10-year transition period, but as we discussed in the August 1, 2002 IPPS final rule (67 FR 50102), we revised the regulations at § 412.312 to specify that payments for extraordinary circumstances are also made for cost reporting periods after the transition period (that is, cost reporting periods beginning on or after October 1, 2001). Additional information on the exception payment for extraordinary circumstances in § 412.348(f) can be found in the FY 2005 IPPS final rule (69 FR 49185 and 49186).

During the transition period, under §§ 412.348(b) through (e), eligible hospitals could receive regular exception payments. These exception payments guaranteed a hospital a minimum payment percentage of its Medicare allowable capital-related costs depending on the class of hospital (§ 412.348(c)), but were available only during the 10-year transition period. After the end of the transition period, eligible hospitals can no longer receive this exception payment. However, even after the transition period, eligible hospitals receive additional payments under the special exceptions provisions at § 412.348(g), which guarantees all eligible hospitals a minimum payment of 70 percent of its Medicare allowable capital-related costs provided that special exceptions payments do not exceed 10 percent of total capital IPPS payments. Special exceptions payments may be made only for the 10 years from the cost reporting year in which the hospital completes its qualifying project, and the hospital must have completed the project no later than the hospital's cost reporting period beginning before October 1, 2001. Thus, an eligible hospital may receive special exceptions payments for up to 10 years beyond the end of the capital PPS transition period. Hospitals eligible for special exceptions payments were required to submit documentation to the intermediary indicating the completion date of their project. (For more detailed information regarding the special exceptions policy under § 412.348(g), refer to the August 1, 2001 IPPS final rule (66 FR 39911 through 39914) and the August 1, 2002 IPPS final rule (67 FR 50102).)

Under the PPS for capital-related costs, § 412.300(b) of the regulations defines a new hospital as a hospital that has operated (under current or previous ownership) for less than 2 years. (For more detailed information, see the August 30, 1991 final rule (56 FR 43418).) During the 10-year transition period, a new hospital was exempt from the capital PPS for its first 2 years of operation and was paid 85 percent of its reasonable costs during that period. Originally, this provision was effective only through the transition period and, therefore, ended with cost reporting periods beginning in FY 2002. Because we believe that special protection to new hospitals is also appropriate even after the transition period, as discussed in the August 1, 2002 IPPS final rule (67 FR 50101), we revised the regulations at § 412.304(c)(2) to provide that, for cost reporting periods beginning on or after October 1, 2002, a new hospital (defined under § 412.300(b)) is paid 85 percent of its Medicare allowable capital-related costs through its first 2 years of operation, unless the new hospital elects to receive fully prospective payment based on 100 percent of the Federal rate. (Refer to the August 1, 2001 IPPS final rule (66 FR 39910) for a detailed discussion of the statutory basis for the system, the development and evolution of the system, the methodology used to determine capital-related payments to hospitals both during and after the transition period, and the policy for providing exception payments.)

Section 412.374 provides for the use of a blended payment amount for prospective payments for capital-related costs to hospitals located in Puerto Rico. Accordingly, under the capital PPS, we compute a separate payment rate specific to Puerto Rico hospitals using the same methodology used to compute the national Federal rate for capital-related costs. In general, hospitals located in Puerto Rico are paid a blend of the applicable capital PPS Puerto Rico rate and the applicable capital PPS Federal rate.

Prior to FY 1998, hospitals in Puerto Rico were paid a blended capital PPS rate that consisted of 75 percent of the capital PPS Puerto Rico specific rate and 25 percent of the capital PPS Federal rate. However, effective October 1, 1997 (FY 1998), in conjunction with the change to the operating PPS blend percentage for Puerto Rico hospitals required by section 4406 of Pub. L. 105–33, we revised the methodology for computing capital PPS payments to hospitals in Puerto Rico to be based on a blend of 50 percent of the capital PPS Puerto Rico rate and 50 percent of the capital PPS Federal rate. Similarly, in conjunction with the change in operating PPS payments to hospitals in Puerto Rico for FY 2005 required by section 504 of Pub. L. 108–173, we again revised the methodology for computing capital PPS payments to hospitals in Puerto Rico to be based on a blend of 25 percent of the capital PPS Puerto Rico rate and 75 percent of the capital PPS Federal rate effective for discharges occurring on or after October 1, 2004.

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

In the FY 2007 IPPS proposed rule (71 FR 24122), we proposed technical changes to §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment. These changes were proposed to reflect our historic policy that hospitals reclassified as rural under § 412.103 also are considered rural under the capital PPS. Since the genesis of the capital PPS in FY 1992, the same geographic classifications used under the operating PPS also have been used under the capital PPS.

These changes and clarifications are necessary because we inadvertently made an error when we updated our capital PPS regulations to incorporate OMB's new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005. In the FY 2005 IPPS final rule (69 FR 49187 through 49188), in order to incorporate the new CBSA designations and the provisions of the newly established § 412.64, which incorporated the CBSA-based geographic classifications, we revised § 412.316(b) and § 412.320 to specify that, effective for discharges occurring on or after October 1, 2004, the capital PPS payment adjustments are based on the geographic classifications under § 412.64. However, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

We believe that this error must be corrected in order to maintain our historic policy for treating urban-to-rural hospital reclassifications under the operating PPS the same for purposes of the capital PPS. Therefore, we proposed to specify under §§ 412.316(b)(2) and (b)(3) and 412.320(a)(1)(ii) and (a)(1)(iii) that, for discharges on or after October 1, 2006, hospitals that are reclassified from urban to rural under § 412.103 would be considered rural.

We did not receive any public comments on our proposal. Therefore, we are adopting as final, without modification, the proposed changes to §§ 412.316(b)(2) and (b)(3) and 412.320(a)(1)(ii) and (a)(1)(iii) which specify that, for discharges on or after October 1, 2006, hospitals that are

reclassified from urban to rural under § 412.103 would be considered rural.

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

In the FY 2007 IPPS proposed rule (71 FR 24122) we proposed to make technical corrections to the regulations under paragraphs (a) and (c) of § 412.316. Specifically, we proposed to make a technical change under § 412.316(a) to correct the cross-reference to "§ 412.63(k)" to clarify that the same wage index that applies to hospitals under the operating PPS is used to determine the geographic adjustment factor (GAF) under the capital PPS. We proposed to cross-refer instead to subpart D of Part 412 to capture the applicable requirements in their entirety.

We did not receive any public comments on our proposal. Therefore, we are adopting as final without modification the proposed technical change under § 412.316(a) to correct the cross-reference to "§ 412.63(k)" to clarify that the same wage index that applies to hospitals under the operating PPS is used to determine the geographic adjustment factor (GAF) under the capital PPS. We cross-refer instead to subpart D of Part 412 to capture the applicable requirements in their entirety. This technical correction does not change any current payment policies because the regulation, as written, makes clear that the GAF adjustment for local cost variation under the capital PPS is based on a hospital's operating PPS wage index value. Thus, the same payment policies that are in effect prior to FY 2007 (that is, the GAF is based on a hospital's operating PPS wage index value) will continue in effect for FY 2007 and beyond; the only change in the regulation is a correction of the erroneous cross-reference.

In addition, we proposed to make a technical correction under § 412.316(c) to correct the cross-reference to "§ 412.115" to clarify that, for hospitals located in Alaska and Hawaii, the same COLA factor that applies to these hospitals under the operating PPS is used to determine the COLA factor under the capital PPS. The existing regulation erroneously references the COLA factor used to determine payment under § 412.115, which is not related to the operating PPS COLA factor or any other payment factors. Again, we proposed to cross-refer instead to subpart D of Part 412 to capture the applicable requirements in their entirety.

We did not receive any public comments on this proposal. Therefore, we are adopting as final, without modification, the proposed technical correction. This technical correction does not change any current payment policy; rather it makes clear that the capital PPS COLA factor is based on the hospital's COLA factor under the operating PPS. This technical correction reflects our historic policy that the COLA factor under the capital PPS is based on the hospital's operating PPS COLA factor, which is how the capital PPS COLA factor has been determined since the implementation of the capital PPS in FY 1992. Thus, the same payment policy that has been in effect prior to FY 2007 (that is, the use of the operating PPS COLA factor as shown in the table in section II.B.2 of the Addendum of this final rule in determining a hospital's capital PPS COLA factor) will continue to be in effect for FY 2007 and beyond; the only change in the regulation is a correction of the erroneous cross-reference.

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

A. Payments to Excluded Hospitals and Hospital Units (§ 413.40)

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

Historically, hospitals and hospital units excluded from the prospective payment system received payment for inpatient hospital services they furnished on the basis of reasonable costs, subject to a rate-of-increase ceiling. An annual per discharge limit (the target amount as defined in § 413.40(a)) was set for each hospital or hospital unit based on the hospital's own cost experience in its base year. The target amount was multiplied by the Medicare discharges and applied as an aggregate upper limit (the ceiling as defined in § 413.40(a)) on total inpatient operating costs for a hospital's cost reporting period. Prior to October 1, 1997, these payment provisions applied consistently to all categories of excluded providers (rehabilitation hospitals and units (now referred to as IRFs), psychiatric hospitals and units (now referred to as IPFs), LTCHs, children's hospitals, and cancer hospitals).

Payment for children's hospitals and cancer hospitals that are excluded from the IPPS continues to be subject to the rate-of-increase ceiling based on the hospital's own historical cost experience. (We note that, in accordance with § 403.752(a) of the regulations, RNHCIs are also subject to the rate-of-increase limits established under § 413.40 of the regulations.) For IRFs, IPFs, and LTCHs, reasonable cost payment provisions changed significantly for cost reporting periods beginning on or after October 1, 1997.

Section 1886(b)(3)(H) of the Act established caps on the target amounts for cost reporting periods beginning on or after October 1, 1997, through September 30, 2002, for certain existing hospitals and hospital units excluded from the IPPS. Section 413.40(c)(4)(iii) of the implementing regulations states that "In the case of a psychiatric hospital or unit, rehabilitation hospital or unit, or long-term care hospital, the target amount is the lower of amounts specified in paragraph (c)(4)(iii)(A) or (c)(4)(iii)(B) of this section." Accordingly, in general, for "existing" IPFs, IRFs, or LTCHs for the applicable 5-year period, the target amount is the lower of: The hospital-specific target amount (§ 413.40(c)(4)(iii)(A)) or the 75th percentile cap (§ 413.40(c)(4)(iii)(B)).

For cost reporting periods beginning on or after October 1, 2002, all IRFs are paid 100 percent of the adjusted Federal rate under the IRF PPS. Therefore, an IRF, considered "existing" under section 1886(b)(3)(H) of the Act would have no portion of its payment subject to § 413.40(c)(4)(ii) of the regulations for cost reporting periods beginning on or after October 1, 2002.

For cost reporting periods beginning on or after October 1, 2002, to the extent an IPF or LTCH has all or a portion of its payment determined under reasonable cost principles, the target amounts for the reasonable cost-based portion of the payment are determined in accordance with section 1886(b)(3)(A)(ii) of the Act and the regulations at § 413.40(c)(4)(ii). Section 413.40(c)(4)(ii) states, "Subject to the provisions of [§ 413.40] paragraph (c)(4)(iii) of this section, for subsequent cost reporting periods, the target amount equals the hospital's target amount for the previous cost reporting period increased by the update factor for the subject cost reporting period unless the provisions of [§ 413.40] paragraph (c)(5)(ii) of this section apply." Thus, because § 413.40(c)(4)(ii) indicates that the provisions of that paragraph are subject to the provisions of § 413.40(c)(4)(iii), which are applicable only for cost reporting periods beginning on or after October 1, 1997, through September 30, 2002, the target amount for FY 2003 was determined by updating the target amount for FY 2002 by the applicable update factor. For example, if a provider was paid the cap amount in FY 2002, the target amount for FY 2003 would be the amount paid in FY 2002, updated to FY 2003 (that is, the target amount from the previous year increased by the applicable update

factor). As discussed below, IRFs, IPFs, and LTCHs are now paid under separate PPSs, although some are subject to transition payment provisions.

In addition, a new method of determining the payment amount for "new" excluded providers for cost reporting periods beginning on or after October 1, 1997. Section 413.40(f)(2)(ii) of the implementing regulations states that, "* * * the amount of payment for a new psychiatric hospital or unit, a new rehabilitation hospital or unit, or a new long term care hospital that was not paid and excluded prior to October 1, 1997, is the lower of the hospital's net inpatient operating cost per case or 110 percent of the nation median of the target amounts for the class of excluded hospitals and units (psychiatric, rehabilitation, long-term care) as adjusted for the difference in wage levels and updated to the first cost reporting period in which the hospital receives payment. The second cost reporting period is subject to the same target amount as the first cost reporting period." For the third cost reporting period, the target amount determined for the preceding cost reporting period is updated to the third cost reporting period. (See § 413.40(c)(4)(v).)

The 110 percent of the national median payment limits for new providers under TEFRA (§ 413.40(f)(2)(ii)) do not apply to those IPFs or LTCHs, whose first cost reporting period begins on or after the date the particular class of hospitals implemented their respective PPS because they are paid 100 percent of their Federal PPS rate. IRFs are paid 100 percent of the Federal rate under the IRF PPS for cost reporting periods beginning on or after October 1, 2002. Therefore, the 110 percent of the median payment limitations are not applicable to IRFs for cost reporting periods beginning on or after that date.

2. Separate PPS for IRFs

Section 1886(j) of the Act, as added by section 4421(a) of Pub. L. 105–33, provided for a phase-in of a case-mix adjusted PPS for inpatient hospital services furnished by IRFs for cost reporting periods beginning on or after October 1, 2000, and before October 1, 2002, with payments based entirely on the adjusted Federal prospective payment for cost reporting periods beginning on or after October 1, 2002. Section 1886(j) of the Act was amended by section 125 of Pub. L. 106–113 to require the Secretary to use a discharge as the payment unit under the PPS for inpatient hospital services furnished by IRFs and to establish classes of patient discharges by functional-related groups. Section 305 of Pub. L. 106–554 further amended section 1886(j) of the Act to allow IRFs, subject to the blend methodology, to elect to be paid the full Federal prospective payment rather than the transitional period payments specified in the Act.

On August 7, 2001, we issued a final rule in the **Federal Register** (66 FR 41316) establishing the PPS for IRFs, effective for cost reporting periods beginning on or after January 1, 2002. There was a transition period for cost reporting periods beginning on or after January 1, 2002, and ending before October 1, 2002. For cost reporting periods beginning on or after October 1, 2002, payments are based entirely on the adjusted Federal prospective payment rate determined under the IRF PPS.

3. Separate PPS for LTCHs

In accordance with the requirements of section 123 of Pub. L. 106–113, as modified by section 307(b) of Pub. L. 106–554, we established a per discharge, DRG-based PPS for LTCHs as described in section 1886(d)(1)(B)(iv) of the Act for cost reporting periods beginning on or after October 1, 2002, in a final rule issued on August 30, 2002 (67 FR 55954). The LTCH PPS uses information from LTCH hospital patient records to classify patients into distinct LTC–DRGs based on clinical characteristics and expected resource needs. Separate payments are calculated for each LTC–DRG with additional adjustments applied.

On May 7, 2004, we issued in the **Federal Register** a final rule (69 FR 25673) that updated the payment rates for the LTCH PPS and made policy changes effective for a new LTCH PPS rate year of July 1, 2004 through June 30, 2005. For the LTCH PPS rate year of July 1, 2005 through June 30, 2006, we issued in the **Federal Register** a final rule (70 FR 24168) that further updated the payment rates and made policy changes. For the LTCH PPS rate year of July 1, 2006 through June 30, 2007, we issued in the **Federal Register** a final rule (71 FR 27798) that further updated the payment rates, discussed the LTC–DRG classifications and relative weights which remain linked to the inpatient DRG system, and made several policy changes. The 5-year period for LTCHs to transition from a PPS payment consisting of a blend of reasonable cost-based reimbursement and the adjusted Federal prospective payment rate to a payment based on 100 percent of the Federal prospective rate ends with cost reporting periods beginning on or after October 1, 2005, and before October 1, 2006. LTCHs with cost reporting periods beginning on or after October 1, 2006, are paid entirely on the adjusted Federal prospective payment rate.

4. Separate PPS for IPFs

In accordance with section 124 of the BBRA and section 405(g)(2) of Pub. L. 108–173, we established a PPS for inpatient hospital services furnished in IPFs. On November 15, 2004, we issued in the **Federal Register** a final rule (69 FR 66922) that established the IPF PPS, effective for IPF cost reporting periods beginning on or after January 1, 2005. Under the final rule, we compute a Federal per diem base rate to be paid to all IPFs for inpatient psychiatric services based on the sum of the average routine operating, ancillary, and capital costs for each patient day of psychiatric care in an IPF, adjusted for budget neutrality. The Federal per diem base rate is adjusted to reflect certain patient characteristics, including age, specified DRGs, selected high-cost comorbidities, days of the stay, and certain facility characteristics, including a wage index adjustment, rural location, indirect teaching costs, the presence of a full-service emergency department, and COLAs for IPFs located in Alaska and Hawaii. We have established a 3-year transition period during which IPFs whose first cost reporting periods began before January 1, 2005, will be paid based on a blend of reasonable cost-based payment and IPF PPS payments. For cost reporting periods beginning on or after January 1, 2008, all IPFs will be paid 100 percent of the Federal per diem payment amount.

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

Existing regulations at 42 CFR 412.22(e) define a hospital-within-a-hospital (HwH) as a hospital that occupies space in a building also used by another hospital, or in one or more separate buildings located on the same campus as buildings used by another hospital. In order to be paid as an excluded hospital, an HwH is required to demonstrate compliance with requirements at § 412.22(e)(1) through (e)(3), as applicable, which were established to create operational and organizational separateness between the HwH and the host hospital with which it is co-located.

The existing regulations at § 412.22(h), relating to satellite facilities of hospitals excluded from the IPPS, define a satellite facility as a part of a hospital that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital.

Section 412.25(e), relating to satellite facilities of excluded hospital units, defines a satellite facility as a part of a hospital unit that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital.

There are significant similarities between the definition of a satellite facility and the definition of an HwH as it relates to their co-location with other Medicare hospital-level providers (hosts). There are also similarities in our policy concerns with the potential for patient-shifting (and its consequences for the Medicare program) between the co-located entities and their hosts. Regarding HwHs and satellite facilities, particularly LTCH HwHs and satellite facilities of LTCHs, which were the original entities that we regulated beginning with FY 1995, we have repeatedly expressed our concerns (for example, in the FY 2005 IPPS final rule (69 FR 49191)) that an HwH's or a satellite facility's "configuration could result in patient admission, treatment, and discharge patterns that are guided more by attempts to maximize Medicare payments than by patient welfare." (69 FR 48916 and 49191). We further believe that "the unregulated linking of an IPPS hospital and a hospital excluded from the IPPS could lead to two Medicare payments for what was essentially one episode of patient care." (69 FR 48916 and 49191). Therefore, we established "separateness and control" criteria to govern these relationships with host hospitals, at § 412.22(e) for HwHs, and at §§ 412.22(h) and 412.25(e) for satellite facilities of excluded hospitals and satellite facilities of hospital units, respectively. Moreover, for HwHs and satellite facilities, we provided for the "grandfathering" of existing facilities, thereby exempting those that were in existence prior to the establishment of the "separateness and control" requirements from compliance with the criteria. At § 412.22(f), we provided for the grandfathering of HwHs that were in existence on or before September 30, 1995, as long as the hospital continues to operate under the same terms and conditions. We also provided for grandfathering HwHs that changed the terms and conditions under which they operated between September 30, 1995 and before October 1, 2003, but subsequently continued to operate under the terms and conditions in effect on September 30, 2003. At § 412.22(h)(3) and (h)(4) we grandfathered satellite facilities that were part of a hospital, that were in existence on September 30, 1999, and that met certain other conditions. Further, at § 412.25(e)(3) and (e)(4), we grandfathered satellite facilities that were part of a hospital unit, were in existence on September 30, 1999, and that met certain other conditions. The purpose of our grandfathering certain existing HwHs and satellites was to reflect reliance interests and settled expectations that existed on the part of these facilities at the time the separateness and control requirements were created.

The regulations addressing "separateness and control" policies for each of the above types of entities are presently not entirely uniform. This situation has arisen, in part, because the policies were implemented at different times and also because there are differences among the types of entities. (For example, in the FY 2003 IPPS final rule (67 FR 49982 and 50105), we included a detailed discussion of the "performance of basic functions" test utilized for HwHs and how this test was not applicable to satellite facilities.) There are also differences between specific features of the grandfathering provisions for HwHs and satellite facilities, despite the fact that, as noted above, the intent of each of the grandfathering provisions was the same (for HwHs at § 412.22(f), for satellite facilities of hospitals at § 412.22(h)(3)(i) and (h)(4), and for satellite facilities of hospital units at § 412.25(e)(3) and (e)(4)). The regulations exempt certain HwHs and satellite facilities from compliance with the "separateness and control" criteria governing the relationships with their host hospitals as long as they continue to operate under the same "terms and conditions," including the number of beds and square footage considered to be part of the hospital or satellite facility as of the date that they were grandfathered.

This particular policy was adopted because we believed that those entities that were designated as grandfathered, versus those that were required to meet the "separateness and control" requirements, should not be permitted to alter their operations from the "snapshot in time" taken when they were grandfathered and thus benefit even more from this status. In other words, we believed that grandfathered facilities received a benefit not enjoyed by nongrandfathered facilities—namely, they were free from compliance with the "separateness and control" regulations and we did not want to allow these entities to realize additional economic advantages by expansion that would increase their Medicare payments by virtue of their grandfathered status. Furthermore, it has been our policy that if a grandfathered HwH or satellite facility of the HwH chooses not to operate under the same terms and conditions in effect as of its grandfathering, it could still be paid under the applicable excluded hospital payment system if it changed its relationship with its host to the extent that it has come into compliance with the applicable "separateness and control" requirements. In addition, our rationale for the separateness and control requirements (and limiting the grandfathering provision) was to prevent abusive gaming of the Medicare payment system by co-located hospitals.

Because the underlying rationale for the grandfathering policies for both HwHs and satellite facilities of HwHs is the same, upon review of these various provisions, we believe that, where appropriate, the grandfathering provisions should be consistent. Under the authority of section 1871(a)(1) of the Act, which authorizes the Secretary to prescribe such regulations as may be necessary to carry out the administration of the Medicare program, in the FY 2007 IPPS proposed rule (71 FR 24124) we proposed the following revisions to make the policies consistent. We proposed to revise the HwH provision at § 412.22(f) to include an exception to the requirement that a grandfathered HwH be operated under the terms and conditions in effect on October 1, 2003, that corresponds to the existing exceptions for satellite facilities of hospitals and for satellite facilities of hospital units at § 412.22(h)(4) and 412.25(e)(4), respectively. (As provided in § 412.22(f), the original September 30, 1995, "snapshot in time" date for grandfathered HwHs was extended to hospitals that changed the terms and conditions under which they operated between September 30, 1995, and before October 1, 2003, in the FY 2004 IPPS final rule (68 FR 45462).) Specifically, we proposed a corresponding change to the HwH grandfathering provision at § 412.22(f)(3) that would allow for increases or decreases in square footage, or decreases in the number of beds of the HwH that are needed for specific circumstances beyond the control of the facility. We proposed to specify that increases or decreases in square footage or decreases in the number of beds that are required because of the relocation of a facility to permit construction or renovation necessary for compliance with Federal, State, or local law affecting the physical facility or because of catastrophic events such as fires, floods, earthquakes, or tornadoes. (64 FR 14535) We also proposed to add a

provision for grandfathered hospital satellites and satellites of units at § 412.22(h)(5) and § 412.25(e)(5) respectively, allowing a decrease in square footage or numbers of beds for consistency with the proposed regulations for grandfathered HwHs at § 412.22(f)(3)(i) and we proposed to amend § 412.22(h)(4)(i) to mirror to the language in § 412.25(e)(4)(i).

The comments we received on our proposals, and our responses, are set forth below.

Comment: All of the commenters, including commenters representing grandfathered HwHs, including grandfathered LTCHs, children's hospitals, a cancer hospital, and an IRF, hospital associations, legislators, and industry consultants, endorsed our reexamination of the existing restrictions on grandfathered HwHs changing the "terms and conditions" under which they operate. A number of commenters questioned whether or not HwHs would lose their grandfathered status if they were required by Federal, State, or local law, or catastrophic events to increase or decrease their square footage or to decrease their number of beds in ways that did not involve relocations of the facilities. Two commenters described hypothetical situations that could result in a need for an increase in square footage for the grandfathered HwH such as the following: Making necessary repairs to the existing physical plant that are now governed by building standards established by the American Institute of Architects (AIA) or the Americans with Disabilities Act (ADA) since the facility was established (and now required by law); compliance with privacy and security requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA); or meeting fire or safety codes that were not in existence when the facility was built. The commenters requested that CMS clarify its grandfathering policies in light of such scenarios.

Response: We thank the commenters for their support for our proposals. After reviewing the comments, we agree that there are indeed situations not related to the relocation of a facility that could make it necessary to add or reduce square footage, or decrease the number of beds in a grandfathered facility. Moreover, after consideration of this concern and of the comments we received on our proposals, and for the reasons summarized below, and in accordance with our authority in section 1871(a)(1) of the Act we have decided to revise our regulations on grandfathering of HwHs, satellites of IPPS-excluded hospitals, and satellites of IPPS-excluded hospital units to allow these facilities more flexibility to adjust their square footage upward or downward or to decrease their number of beds. Specifically, in this final rule, for cost reporting periods beginning on or after October 1, 2006, we are revising the regulations in §§ 412.22(f)(3)(applicable to HwHs), 412.22(h)(4)(applicable to satellites of IPPS-excluded hospitals), and 412.25(e)(4)(applicable to satellites of IPPS-excluded units) to allow these facilities to increase or decrease the square footage of the facility or to decrease the number of beds in the facility without affecting the facility's grandfathered status. Under the final rule, such changes could be undertaken for any reason and would not be limited to situations involving changes in Federal, State, or local laws or catastrophic events. Such changes also would not be limited to cases in which a facility must be relocated. Therefore, we have not finalized our proposed provisions that specified such exceptions for HwHs, and in the case of satellites hospitals, we have restored the existing terminology of § 412.22(h)(4) for cost reporting periods beginning before October 1, 2006. This is the case because under our finalized policy, which is effective for cost periods beginning on or after October 1, 2006, as discussed in detail below, we are not restricting grandfathered HwHs at § 412.22(h)(3) and grandfathered satellites at 412.22(h)(5) from increasing or decreasing their square footage or decreasing their number of beds. As discussed elsewhere in these responses, even though grandfathered satellite units will also be permitted to increase or decrease their square footage or decrease their number of beds at § 412.25(e), such facilities are subject to the existing regulations regarding changes in size of excluded units unless the change in size is necessitated by relocation of the unit to permit construction or renovation necessary for compliance with a law affecting the physical facility or because of catastrophic event.

As noted above, in establishing grandfathering provisions generally, we intended to protect certain existing hospitals and satellite facilities from "the potentially adverse impact of recent, more specific regulations that we now believe to be essential to the goals of the Medicare program" (68 FR 45463). However, they were not intended to establish a separate class of providers. Moreover, it was our intention that our "snapshot in time" policy prevented grandfathered entities that were advantaged more than their nongrandfathered peer facilities as a result of their protected status from realizing additional benefits by changing their "terms and conditions" in ways that could increase their Medicare reimbursement. It also helps prevent the program abuse associated with co-located facilities that may result from patient shifting whereby Medicare makes two separate payments for what is essentially a single episode of care.

Recently, several grandfathered LTCH HwHs and satellite facilities questioned whether a *decrease* in their square footage or their number of beds would result in negating their grandfathered status, because compliance with each of the above cited grandfathering provisions requires that they continue to operate under the *same* terms and conditions, including the number of beds and square footage considered to be part of the hospital, the satellite facility, or the hospital unit in effect on the day that the grandfathering policy was implemented. We also have been urged to modify our policies to allow these grandfathered entities to increase in square footage and number of beds without requiring compliance with the "separateness and control"policies discussed above. Clearly, under existing regulations, an increase or a decrease in square footage or number of beds would result in a loss of status as a grandfathered HwH or hospital satellite facility (unless § 412.22(h)(4) or § 412.25(b)(3) applies) because the existing regulations prohibit any change in the terms and conditions of operation, as described above.

As stated above, under our broad authority in section 1871(a)(1) of the Act, we have now decided to revise the regulations in §§ 412.22(f) (applicable to HwHs), 412.22(h)(4) and (h)(5) (applicable to satellites of IPPS-excluded hospitals) and 412.25(e)(4) and (e)(5) (applicable to satellites of IPPS-excluded units) to allow these facilities for cost reporting periods beginning on or after October 1, 2006, to increase or decrease the square footage of the facility or to decrease the number of beds in the facility at any time without affecting the facility's grandfathered status.

We made this decision following a review of public comments on our proposed rule, as summarized below. In reaching this decision, we recognize that allowing increases in the square footage of those grandfathered facilities could, in some cases, increase their reimbursement under Federal health insurance programs administered by CMS. For example, any increase in the square footage of a grandfathered facility

could result in increased operating costs. Therefore, an increase in square footage in a grandfathered HwH that is paid for services to Medicare beneficiaries under the TEFRA system could lead to an increase in Medicare payments. We recognize that this result is not fully consistent with our objective of not allowing a grandfathered facility to make changes that would lead to increased costs to the Medicare program. However, we believe it is necessary to weigh the importance of this objective against the need, described by many of those whose comments are summarized below, for hospitals and other grandfathered facilities to have the flexibility to upgrade their facilities and services to incorporate new technology or additional services to meet patient needs or to comply with applicable new laws. After considering these two competing objectives in relation to one another, we concluded that allowing increases in square footage is justified even though in a very limited number of cases (as explained below), it may result in some additional cost to the Medicare program.

We note that with the exception of children's and cancer hospitals, the only IPPS-excluded facilities are IRFs, IPFs, and LTCHs. The payment methodologies applicable to IRFs, IPFs, and LTCHs use prospectively determined rates, so that payments to an individual facility are not affected by increases in the square footage of that facility. Children's and cancer hospitals are paid through the use of a TEFRA system under which increases in the square footage of a facility would increase the facility's Medicare payments. However, there is only one grandfathered cancer HwH and only three grandfathered children's HwHs. For this reason, we believe that the total Medicare cost increases, if any, will be very small.

Comment: Several commenters requested that we establish a policy that would enable them to maintain their grandfathered status while also being permitted to increase square footage to accommodate advancements in patient care, and improvements in medical technology that have evolved since they were grandfathered, and that would also permit expansion for administrative or nonpatient related care activities. The comments focused on each facility's need for additional space (square footage) which would allow them the ability to expand to accommodate dialysis, rehabilitation, telemetry, and hyperbaric services, isolation areas, and additional diagnostic equipment which are essential in order to maintain high quality patient services. A number of commenters also noted that their needs for additional space for administrative activities, professional instruction, and computer hardware had grown since they were grandfathered. These commenters argued that such expansions of square footage are essential in order to efficiently deliver the highest quality care to Medicare beneficiaries and, furthermore, would not result in any increased costs to the Medicare program.

Several of the commenters asserted that the legislative intent of section 4417(a) of the BBA of 1997, which established grandfathering for those LTCH HwHs that were certified to participate in the Medicare program on or before September 30, 1995, and that were co-located with another hospital, was to protect these hospitals and not limit their functioning. These commenters maintained that Congress did not intend for a grandfathered HwH to lose the ability to participate in the Medicare program as a hospital excluded from the IPPS if they added beds or increased square footage in order to better serve Medicare beneficiaries. Another commenter stated that the issue of how Medicaid payments might be impacted by grandfathering of certain LTCHs was not contemplated by the grandfathering provision in the BBA of 1997, and asks CMS to clarify the application of the HwH rules to an excluded hospital's participation in the Medicaid program.

Response: When we established the basic grandfathering requirements for HwHs, we had two objectives. As we have noted above, we believed the grandfathering provision enacted by Congress reflected a legitimate interest in protecting certain existing hospitals that were co-located with other hospitals from "the potentially adverse impact of recent, more specific regulations that we now believe to be essential to the goals of the Medicare program" (68 FR 45463). The grandfathering provisions are an exception to the separateness and control requirements that reflect reliance interests and settled expectations that existed at the time the rule was set into place. Grandfathering provisions for these facilities allowed existing HwHs to continue to be paid outside of the IPPS, despite the fact that, among other factors, they did not demonstrate operational or organizational separateness between these grandfathered entities and their host hospitals. However, the second objective was to ensure that these entities would not make changes that would lead to increased costs to the Medicare program or that could encourage inappropriate patient shifting by co-located hospitals. This particular policy was adopted because we believed that those entities that were designated as grandfathered should not be permitted to alter their operations from the "snapshot in time" taken when they were grandfathered and thus benefit even more from this status than those facilities that were required to meet the "separateness and control" requirements. As noted above, an HwH could change its terms and conditions under which it operates after September 39, 1995 but before October 1, 2003, after which time its terms and conditions may not further change. (See FY 2004 IPPS final rule (68 FR 45462).) In other words, we believed that grandfathered facilities received a benefit not enjoyed by nongrandfathered facilities—namely, they were free from compliance with the "separateness and control" regulations and we did not want to allow these entities to realize additional economic advantages by expansion that could increase Medicare payments by virtue of their grandfathered status.

With respect to section 4417(a) of the BBA, we believe its purpose was to protect LTCH HwHs that existed prior to September 30, 1995, from losing their IPPS excluded status because they failed to meet the separateness and control requirements recently promulgated by the Secretary. We do not believe that it is reasonable to assume that by creating a limited exception for these hospitals, Congress was immunizing these facilities from any further regulation by the Secretary as to their growth and financial impact on the Medicare program. We do not believe Congress was establishing a separate class of providers. Furthermore, contrary to commenter's assertions, grandfathered facilities continue to remain free to add beds or square footage at any time, as long as they meet the separation and control requirements outlined in these regulations. Consequently, it is inaccurate to suggest that a grandfathered HwH would lose its ability to participate in the Medicare program as an excluded hospital if it increases the number of beds or square footage since complying with the separateness and control requirements remains an option for these facilities.

In response to the comments stating that the issue of Medicaid payments is not contemplated by the grandfathering provision in the BBA of 1997 and asking us to clarify the application of the HwH rules to an excluded hospital's participation in the Medicaid program, we note that the grandfathering rules'

impact on the Medicaid payments to a hospital, to the extent there is an impact, will depend on the particular payment methodology adopted by the State in its State Medicaid plan. In general, if a State pays grandfathered HwHs under a predetermined prospective rate which is unaffected by changes in square footage, then individual hospitals would not be directly affected by increases or decreases in their square footage. By contrast, if the State were to pay grandfathered HwHs under the TEFRA system used by Medicare or under another cost-based system, payment could be directly affected by changes in square footage. With respect to changes in the numbers of beds, to the extent a hospital seeks to increase its number of beds because it is already operating at or near its State licensed and Medicare-certified bed capacity, increasing the number of beds would lead to a proportionate increase in utilization and payment. We believe that it is appropriate to consider the impact of revisions in Medicare policy on the Medicaid payment system.

We continue to believe that it is entirely reasonable and appropriate for to us regulate the growth of HwHs that have been otherwise favored by exemptions from the more rigorous "separateness and control" provisions that we have implemented for non-grandfathered co-located providers. We also note that the issue here, namely our reexamination of our grandfathering policies, is an exception to a general rule to permit reliance on expectations that existed at the time the rule was put in place. However, we do understand that, in order to provide the highest level of patient care, any hospital will have to respond to advancements in patient care, some of which may involve the introduction of new technology requiring an increased need for space, such as new imaging equipment or the installation of a hyperbaric chamber. We also understand that a hospital may also have reasonable need to create additional administrative space for a number of reasons, among which are instructional space, updated computer hardware, and record storage.

We believe that these commenters have presented cogent arguments for our reconsideration of the preclusion against a grandfathered HwH expanding square footage. We have evaluated the impact on the Medicare program of allowing an increase in square footage for grandfathered HwHs and have determined that we believe that such a policy change will not result in additional Medicare payments to those grandfathered HwHs that are paid under the excluded hospital PPSs (LTCH, IRF, and IPF). For those grandfathered HwHs that are still reimbursed under the TEFRA payment system (that is, certain cancer and children's hospitals) square footage is used to allocate certain costs, so there may be a corresponding increase in Medicare payment for those costs. However, we believe (as we discuss in greater detail below) that because there is only one grandfathered cancer HwH and three grandfathered children's HwHs, the increased costs will be "*de minimus*" and we see no reason, therefore, to distinguish them from other grandfathered HwHs in a way that might discourage them from making necessary and appropriate changes to their facilities that would result in increases in their square footage. Therefore, we believe the de minimus costs to the Medicare program associated with increases in square footage are outweighed by the benefits associated with advancements in technology and other patient care enhancements that may be achieved through changes to hospital facilities that concurrently increase the square footage of the facilities. Even though it is likely that any increase in the square footage of a hospital or satellite paid under the TEFRA system will increase the costs upon which Medicare payment is based, certain improvements, such as the adoption of new technology or modernization of a physical facility, may also result in reduced operating costs that partially or entirely offset any cost increases.

Therefore, in this final rule, we are revising the policy that we proposed at § 412.22(f)(3) to specify that a grandfathered HwH may increase or decrease its square footage or decrease its number of beds, or both, without affecting its exception from the "separateness and control" requirements for HwHs at § 412.22(e). However, as explained below, we continue to believe that an increase in the number of beds, which could have a much more significant impact on the level of payments to the facility under the Medicare programs, is a change to the facility that should be a basis for terminating its grandfathered status. This policy will be effective for cost reporting periods beginning on or after October 1, 2006. Although we considered allowing increases in square footage to situations involving new technology or new laws affecting hospitals' physical facilities, we concluded that such a policy would be overly prescriptive and that its enforcement would not be cost effective in light of the limited increases in Medicare spending we expect to result from this change. Thus, we have not included any provision restricting the reasons for which such changes may be made.

In the interest of consistent treatment of HwHs, hospital satellite facilities (as defined in § 412.22(h)), and satellite facilities of units (as defined in section 412.25(e)(1)), and because similar considerations underlie our policies with respect to each type of grandfathered facility, we are also applying this policy to satellites, effective for cost reporting periods beginning on or after October 1, 2006. To accomplish these changes, we are revising §§ 412.22(f), 412.22(h), and 412.25(e) as set forth below.

In the case of facilities that are satellites of IPPS-excluded units, we note that there are existing rules in § 412.25(b)(1) and (2) which govern changes in the square footage and number of beds in an IPPS-excluded unit and where applicable, the regulations that we are finalizing for the increase or decrease in square footage of the decrease in number or beds of a grandfathered satellite unit will be subject to these rules. Section 412.25(b)(1) permits increases in the square footage or number of beds of a unit to be made only at the start of a cost reporting period. However, as we have discussed previously, in these finalized revisions of our grandfathering policy, while we are allowing for an increase in square footage of grandfathered satellite units, we are not allowing these facilities to increase their number of beds. Therefore, we specify in § 412.25(e)(5)(i), a grandfathered unit structured as a satellite facility may only increase in square footage at the beginning of a cost reporting period. Further, existing regulations for excluded hospitals at § 412.25(b)(2) permit reductions in the square footage or number of beds of a unit to be made only with 30 days' advance written notice to the fiscal intermediary and CMS, requires maintenance of sufficient information to accurately determine costs, and specifies that reductions in the number of beds or square footage considered to be part of an excluded unit made during a cost reporting period must remain in effect for the remainder of that period. Since our finalized policy at § 412.25(e)(5)(i) allows for *both* reductions in square footage or bed number for grandfathered satellite units, under circumstance other than those specified at § 412.25(e)(4) we are requiring that any such decreases by these facilities be subject to existing regulations for units of excluded hospitals at 412.25(b)(2). We believe

that these requirements are reasonable and necessary because changes in the square footage or a decrease in the number of beds in a satellite of a unit may affect the bed size or square footage of the facility of which it is a part. We believe this requirement is needed to avoid confusion and provide for equitable and consistent treatment of all excluded units.

However, under existing regulations at 412.25(e)(4), a grandfathered satellite of a unit would be able to increase or decrease its square footage or decrease its number of beds at any time, for purposes of relocation of the facility to permit construction or renovation necessary for compliance with changes in the law affecting the physical facility, or because of catastrophic events.

Comment: Several commenters stated that if the proposed revisions allowing for a decrease in square footage, but not an increase, were finalized, their grandfathered HwHs would face the very onerous choice of either not making necessary operational or clinical improvements to their facilities or of having to disrupt longstanding favorable relationships with the administration of their host hospital.

Response: As we have stated above, under the policy in this final rule, we are not attempting to prescribe the reasons for which changes in the square footage of grandfathered HwHs and satellites may be made. We believe this approach will give the hospitals and satellites the flexibility they need to increase or decrease square footage in response to technological innovation, changes in hospital practice patterns, shifts in the types of services required by the hospital's or satellite's patients, and other factors relevant to the operation of the facilities, without having to alter their historic relationship with their host hospital.

Comment: One commenter stated that our proposed regulations indicated a new flexibility to our implementation of grandfathering rules for HwHs but found no logic in why we would allow certain changes in "terms and conditions" but not others.

Response: Although we are making significant changes to the proposed revisions of our grandfathering policy for HwHs and satellite facilities in this final rule, as noted throughout these responses, we believe that the rationale underlying our determinations is quite apparent. We are permitting grandfathered HwHs and satellite facilities an increase in square footage because we believe that there have been significant clinical advances, some of which are detailed elsewhere in these responses, reasonably requiring a hospital to increase its physical space in order to accommodate new equipment or treatment modalities so that it could continue it to offer the highest level of medical care to its patients. We could also envision circumstances under which changing administrative or otherwise nonclinical needs could require additional space, and we have noted that we understand that an increase in square footage by those HwHs and satellite facilities paid under the TEFRA system may result in a de minimus increase in Medicare costs. However, we do not believe that any of these changes require the establishment of additional beds. Because the number of beds is directly related to hospital capacity, adding bed capacity will significantly increase costs to the Medicare program across all excluded providers. This case is unlike that of an increase in square footage because square footage increases would increase Medicare spending only for services of those hospitals paid under the TEFRA system. By contrast, increasing the bed capacity of a grandfathered HwH or unit would allow increased utilization not only in TEFRA facilities but in HwHs and satellites paid under the prospective payment systems applicable to IRFs, IPFs, and LTCHs. To the extent that any of these systems provides a higher level of payment for certain services than the IPPS, allowing bed size increases by grandfathered facilities might lead to the shifting of utilization from less expensive to more expensive settings, thereby inappropriately increasing Medicare spending.

Furthermore, a significant increase in the number of beds could dramatically alter the size and character of the facility, thereby defeating one of the primary purposes of grandfathering which was, as noted above, to capture the "snapshot in time" for the grandfathered facility. By allowing existing co-located facilities (HwHs or satellite facilities) to continue to function as they had been, we were enabling these facilities to continue to function as they were, without having to make the organizational and operating changes necessary for compliance with our separateness and control policies. Therefore, in answer to the commenter, we believe that our rationale for the changes that we are finalizing to the grandfathering regulations is apparent. We are permitting changes that relate directly to the quality of patient care and services and we are not allowing changes that we believe could substantially and inappropriately increase costs to the Medicare program. In addition, we note that we have never adopted a policy that would preclude one of these facilities from changing other terms and conditions under which it operates, including its bed size. We would only require that such a facility begin to comply with the separateness and control requirements.

Comment: Several hospitals requested that we allow them to increase their bed numbers. One commenter, a children's hospital, noted that it wanted to establish mental health beds for children and adolescents. Another commenter suggested alternatives to our preclusion of increase in bed size for grandfathered HwHs: that CMS allow a "modest" increase in beds equivalent to those permitted during the 18-month moratorium established by Congress in section 507 of Pub. L. 108–173 for physician-owned specialty hospitals or if the grandfathered HwH admitted a "de minimus" percentage (for example, 10 percent or less) of patients from its host. This commenter and one other commenter, a grandfathered LTCH co-located with an IRF from which the commenter stated that the LTCH receives a minimum of admissions, suggested that CMS establish another exemption from the bed size increase preclusion of the grandfathering regulations if the inpatient facility with which the grandfathered HwH is co-located is not an acute care hospital, but rather is an IRF or an IPF or if the HwH is located on a campus of the host acute care hospital but is not physically co-located with an acute care hospital. The commenters believed that this particular exemption is reasonable because, in the view of the commenter, our most significant concern regarding HwHs is inappropriate shifting of patients from a host acute care hospital to a LTCH HwH.

Response: In considering these comments, we believe it is important to recall that grandfathered HwHs, as well as satellite facilities, are organized and operated in ways that make them unable to meet the minimal tests of separateness and control applicable to nongrandfathered facilities, so that they effectively function as units of their host facilities. Because of this, we continue to believe that, in grandfathering HwHs and satellites facilities, we have conferred a significant advantage on them as compared to like facilities that are required to meet our "separateness and control" requirements and are closely monitored. Therefore, although we are finalizing regulations that will allow grandfathered HwHs and satellite facilities the ability to increase their square footage, we are not allowing grandfathered facilities an increase in the number of beds because such an

increase would result in unjustifiable additional payments to the grandfathered HwH and inappropriate additional costs to the Medicare program.

With respect to the childrens' hospital that indicated that it wanted to be able to add additional beds to its hospital in order to establish mental health beds for children and adolescents, we note the following. First, grandfathered HwHs are not precluded from increasing the number of beds, and in fact, they may do so at any time, so long as they comply with the separateness and control requirements. In addition, the fiscal intermediary for the grandfathered childrens' HwHs that commented on this issue has indicated that based upon the hospital's average inpatient census figures, there appear to be sufficient beds available at the hospital to establish inpatient mental health services for children and adolescents without adding additional beds.

In response to the commenter's suggestions of either allowing a "modest" increase in bed numbers equivalent to that permitted for physician-owned specialty hospitals under Pub. L. 108–173 or of 10 percent, or allowing an increase in bed numbers if the grandfathered HwH was only admitting a "de minimus" percentage of patients from its host, we do not believe that allowing any increase in the number of beds for a grandfathered HwH is either necessary or appropriate. We also do not believe that it is appropriate to establish a distinction between grandfathered HwHs depending upon the hospital category of the host, as did the commenters referring to a LTCH HwH that is co-located with an IRF. Nor do we believe that it would be appropriate to broaden this commenter's suggested exemption to grandfathered HwHs that are on the campus of an acute care hospital but are physically co-located with IRFs or IPFs. Our intent in establishing the grandfathering provisions for HwHs and satellite facilities was never to establish separate classes of grandfathered providers. Rather, it was to protect settled expectations that existed at the time that the grandfathering rules were put in place. In addition, in each of these configurations, an increase in bed size could result in a significant increase in Medicare utilization and payment and given the close integration between a grandfathered HwH or satellite and its host hospital, we believe the potential for inappropriate Medicare spending increases exists.

As discussed above, although the original "separateness and control" regulations focused on the particular configuration of an acute care host being paid under the IPPS and a LTCH being paid under the TEFRA system (59 FR 45389 through 45393), the regulations were extended for FY 1998 (62 FR 46014) to include all hospitals excluded from the IPPS and not just those that were co-located with an acute care hospital. (In the FY 1999 IPPS final rule, among other rules, we established "separateness and control" requirements for satellites (65 FR 41532 through 41535)). Thus, contrary to the commenter's assertion, our concern with HwHs is not limited to an acute care hospital co-located with a LTCH HwH.). Despite the fact that the LTCH HwH commenter received very few patients from its host IRF, we do not believe that the behavior of one grandfathered HwH can be generalized to indicate the behavior of an entire LTCH industry or the behavior of all grandfathered facilities. Although we endorse the behavior that the commenter describes, we do not believe that it is necessary or appropriate to establish an additional exemption that would allow a grandfathered HwH that is already advantaged by not having to comply with "separateness and control" regulations to expand its number of beds solely because it is not "gaming" the system but rather it is functioning within accepted Medicare policies and procedures.

Comment: One commenter asked us to clarify whether CMS would permit a grandfathered HwH that reduced its size and bed number from the number that it had at the time at which it had been grandfathered to return to that original size and bed number at a future time without threatening its grandfathered status. A number of commenters asked CMS to specify that grandfathered HwHs would be able to add or discontinue direct patient care services in the same manner as any other hospital and whether the scope and amount of those services would be limited to those that were in place when the HwH was grandfathered. Specifically, commenters asked whether a grandfathered HwH could provide outpatient services or establish provider based services.

Response: After considering the question raised by the first commenter, we have decided to adopt a policy under which a grandfathered HwH that reduced its bed number from the point at which it had been grandfathered would be permitted to return at a future time to the number of Medicare-certified beds that existed at the time it was grandfathered, as governed either by § 412.22(f)(1) or (f)(2), without threatening its grandfathered status. Specifically, we are revising § 412.22(f)(3) to provide that if a hospital decreases its number of beds below the number of beds considered to be part of the hospital on September 30, 1995, it may subsequently increase the number of beds at any time as long as the resulting total number of beds considered to be part of the hospital does not exceed the number in effect on September 30, 1995 (for hospitals that continue to operate under the same terms and conditions in effect on that date, as described in § 412.22(f)(1)) or the number in effect on September 30, 2003, as described in § 412.22(f)(1) (for hospitals that changed the terms and conditions under which they operated after September 30, 1995 but before October 1, 2003), as described in § 412.22(f)(2). We are including similar changes in § 412.22(h)(4) (applicable to satellites of IPPS-excluded hospitals) and § 412.25(h)(4) (applicable to satellites of IPPS-excluded units). We believe this policy is consistent with our stated intent to allow hospitals that were in existence prior to the implementation of the HwH or the satellite rules to continue to operate under the same terms and conditions they had operated under at the time those provisions were implemented. Allowing a hospital that had decreased its number of beds below the number it had as of the date of the implementation of the HwH and satellite provisions to increase its number of beds up to the level it had on the implementation date, allows the hospital to maintain its original "terms and conditions". These changes, like the rest of our revisions to sections 412.22 and 412.25, will be effective for cost reporting periods beginning on or after October 1, 2006.

In response to the question as to whether a grandfathered HwH could provide outpatient services or establish provider-based services, we wish to note that the statutory provisions of section 1886(d)(1)(B) of the Act govern Medicare payment for inpatient hospital services of hospitals and units that are excluded from the IPPS. Our HwH regulations at § 412.22 address the relationship between an inpatient acute care hospital payable under the IPPS and an inpatient hospital that is excluded from the IPPS that are co-located. For this reason, our HwH regulations, including the exemption for grandfathered facilities, only address space used for inpatient services and this would also be true for satellite facilities. As has always been the case, an HwH or satellite facility would be able to discontinue or to initiate *noninpatient* services, including onsite

or offsite outpatient hospital services without compromising its grandfathered status. Such changes in scope of outpatient services or the establishment of provider-based departments would of course have to be done in compliance with other applicable regulations, such as 42 CFR 413.65 governing provider-based status for facilities or organizations.

Comment: Several commenters urged CMS to make an exception for grandfathered children's hospitals and allow them to expand square footage and also bed numbers without any deleterious impact on their status as hospitals certified by Medicare as exempt from the IPPS. The commenters noted that there are only three grandfathered children's hospitals. One commenter emphasized that, as opposed to other excluded HwHs, children's hospitals do not serve a Medicare population, because very few beneficiaries are children. Therefore, any expansion that CMS allows for the three grandfathered facilities would not lead to increased Medicare costs. Although these HwHs do not treat a significant number of Medicare beneficiaries, however, the commenters emphasize that loss of the Medicare exclusion from the IPPS would have a significant and negative impact on their Medicaid reimbursements as well as on their ability to receive funds to train residents under the Federal CHGME. The commenters believed that, despite the fact that each of the children's hospitals are major Medicaid providers, the number of beds in a facility has no bearing on whether or not a patient is deemed Medicaid eligible. Furthermore, they added, since Federal funding for State Medicaid disproportionate share hospital payments is capped, if these hospitals are allowed to grow, such growth would not cause the Federal portion of Medicaid to exceed the caps. The commenters claimed that there is no benefit to Medicare from applying the prohibition against growth or increase in bed numbers to children's hospitals; rather, they believe that there would be significant harm to these hospitals and to their community if they had to choose one of the three alternatives open to them: not expanding to serve their communities; losing their Medicare IPPS-exempt status; or altering their administrative and medical governance with regard to their co-located hospital, which would pose significant legal, operational, and financial barriers.

This commenter further asserted that the three reasons why CMS has established special regulations for grandfathered HwHs are not germane for children's hospitals, that is, "to prevent proliferation of LTCHs that function as units of host acute care hospitals; to prevent the avoidance of TEFRA target rates; and to avoid two Medicare payments for one episode of care." The commenter also asserted the following points: there is no proliferation of children's hospitals; children are admitted directly to their facilities and do not spend time in the acute care hospital, so there are no issues about two hospital payments for one spell of illness; and the three grandfathered children's HwHs have not reorganized since they were established at least 30 years ago, long before this category was recognized for payment purposes by CMS.

Some commenters stated that CMS has established a precedent of treating children's hospitals differently from other excluded hospital types in establishing our regulations at § 412.22(i), which exempted children's hospitals from the general policy that disallowed excluded hospitals with satellite facilities that were in existence prior to October 1, 1997, from expanding their total bed numbers (the sum of the beds in the hospital and the satellite) beyond the number that they had on October 1, 1997. These commenters further maintained that CMS has stated that it believes that the grandfathering regulations for satellite regulations and grandfathering regulations for HwHs should be consistent and that, specifically, the satellite regulations at § 412.22(h)(2)(i) exempt children's hospitals from the limitation on bed number expansion to which other excluded hospital satellites are subject. Therefore, the commenter requested that CMS provide the same exception for grandfathered children's HwH and allow expansion in the number of beds without compromising their grandfathered status.

Response: The commenters have urged us to establish a policy that would distinguish grandfathered children's HwHs from the other categories of grandfathered HwHs and allow them to expand both in square footage and in number of beds. We understand the commenters' statements that, although the facilities do not serve a significant Medicare population and hence there would be little or no additional costs to the Medicare program should they be permitted to expand, their continued status as hospitals excluded from the IPPS under Medicare is important to them because it might enhance their ability to obtain higher Medicaid payment or more for CHGME.

As we have noted above, we are finalizing a policy for all grandfathered excluded HwHs that would allow them to increase or decrease their square footage without compromising their status of IPPS-excluded hospitals or their grandfathered status and this policy would also be applicable to the three grandfathered children's HwHs. We are making this change because we believe that the commenters have presented cogent arguments regarding their facility's need to physically expand in order to accommodate new medical equipment and services as well as to meet new administrative needs in order to continue to deliver high quality medical care. However, we have stated that we are not allowing grandfathered HwHs to increase their number of beds without compromising their grandfathered status. The commenters claimed that children's HwHs treat few Medicare beneficiaries, and therefore there would be no significant additional costs to the Medicare system should they be allowed to increase their bed numbers. Because a change allowing children's HwHs to keep grandfathered status while increasing their number of beds would not significantly increase Medicare spending but would increase Medicaid payments to the hospitals, these hospitals recommend that such a change be made.

We considered this comment carefully but do not find it persuasive. As stated above, a key objective of revising our HwH and satellite grandfathering regulations is to provide a high degree of uniformity and consistency for all grandfathered IPPS-excluded facilities. We do not believe it would be consistent with this objective if we were to single out a particular type of excluded facility for special, more favorable treatment simply because the patient population treated by the hospital typically includes very few Medicare patients. (In addition, even though Medicare payment amounts might not increase in this circumstance, we find it important to maintain a high level of credibility in the Medicare system because it is typically used as a reference for Medicaid payments.) We also do not believe the absence of adverse Medicare cost impact is a sufficient reason for making a change to national Medicare policy solely in order to increase Medicaid payments to a select class of hospitals. In this context, we note under Medicaid, the States are not bound to follow Medicare payment rules for children's hospitals, but instead have considerable flexibility to modify their individual State plans to provide the level of payments for services that will best meet the needs of Medicaid recipients in the particular

State. To the extent additional payment under Medicaid is appropriate in a State, we believe provision for it should be made through the State Medicaid plan rather than by a national Medicare change affecting all States. Moreover, as we have noted, our data reveal that the there presently is no shortage of bed capacity for the three grandfathered children's HwHs, but that, on the contrary, all three are operating below the licensed bed capacity under State law. Thus, it appears that the current number of beds in these hospitals is adequate. Further, we wish to emphasize that grandfathered facilities remain free at any time to increase their number of beds so long as the applicable separateness and control regulations are met.

In regard to the comment that CMS should allow grandfathered children's HwHs to increase their bed size without losing their grandfathered status because CMS has established a precedent for special treatment of children's hospitals through the regulations at § 412.22(h)(2)(i), which exempt children's hospitals from the satellite restrictions applicable to certain other types of IPPS-excluded hospitals, we believe this comment reflects a misunderstanding of the scope and purpose of § 412.22(h)(2)(i).

To respond fully to this comment, it will be necessary to review the background of § 412.22(h)(2)(i). Under the BBA of 1997, certain types of hospitals and hospital units which were first excluded from the IPPS for a cost reporting period beginning on or after October 1, 1997 were paid under lower TEFRA ceilings than hospitals and units that were excluded from the IPPS for a cost reporting period beginning before that date (64 FR 41533). Following enactment of this provision, CMS became aware of some interest by existing hospitals in establishing satellite units in new locations that would function in much the same way as new hospitals, but would qualify for payment under the higher TEFRA ceilings applicable to previously-excluded hospitals. To prevent satellite facilities of this type from being used to circumvent the BBA provision, we added new regulatory requirements, in § 412.22(h)(2)(i). Under those requirements, an IPPS-excluded hospital's number of beds, including both beds at the main campus and beds at any satellite locations, could not exceed the hospital's number of beds on the last day of its last cost reporting period beginning before October 1, 1997. As noted earlier, the lower TEFRA ceilings imposed by the BBA applied only to certain types of hospitals, specifically long-term care, psychiatric, and rehabilitation hospitals. They did not apply to children's hospitals. In determining the scope of section 412.22(h)(2)(i), therefore, we decided not to impose the satellite restrictions on children's hospitals because those new children's hospitals were not subject to the new, lower TEFRA ceilings and therefore would have no incentive to attempt to evade them.

In other words, the inapplicability of § 412.22(h)(2)(i) to children's hospitals does not reflect any decision by CMS to provide special, favorable treatment for children's hospitals by excluding them from a restriction that would otherwise apply to them. On the contrary, it simply reflects a policy decision by CMS that a regulation designed to prevent a particular abusive practice should not be applied to those hospitals that would not have an incentive to engage in that practice.

(Although not raised by any commenter, a question might arise as to why CMS did not exempt cancer hospitals from the bed size restriction since they, like children's hospitals, were not subject to the lower TEFRA ceilings imposed by the BBA. The legislative provision under which cancer hospitals are excluded from the IPPS at section 1886(d)(1)(B)(v)(I), (II) and (III)] limits cancer hospital status to those specified hospitals. These provisions effectively prevent the recognition of new cancer hospitals. We were concerned that this provision might create an incentive for the opening of new satellites in an attempt to circumvent the restriction inherent in the legislative provision, which would be an abusive practice of the same type as using satellites to evade the BBA provisions. To counter the incentive that might exist for such a practice, cancer hospitals have not been excluded from the scope of § 412.22(h)(2)(i).)

We also would address the commenter's specific assertions that children's hospitals should not be subject to general restrictions on growth that we have established for grandfathered HwHs and satellite facilities because of the following reasons: there is no proliferation of children's hospitals; children are admitted directly to their facilities and do not spend time in acute care hospitals; the three grandfathered children's HwHs have not reorganized since they were established at least 30 years ago, long before this category was established for payment purposes by CMS. Although these assertions may be accurate, we do not believe that they are germane to the issue of the revisions of the regulations for grandfathered HwHs and satellite.

In this final rule, we are finalizing policies that revise the preclusion on changing "terms and conditions" and will allow grandfathered HwHs and satellite facilities to decrease their square footage or bed numbers and also to increase their square footage. As discussed above, expansion in square footage of the three grandfathered children's HwHs, could result in increased costs to the Medicare program, since children's hospitals are paid for under the TEFRA system. We have determined, however, that the increased costs will be "de minimus" and we believe that such costs to the Medicare program associated with increases in square footage are outweighed by the benefits associated with advancements in technology and other patient care enhancements that may be achieved through changes to hospital facilities that concurrently increase the square footage of the facilities.

Comment: One commenter representing a cancer hospital, which the commenter identifies as the only grandfathered hospital in this provider category, stated that limiting the growth of this cancer hospital is inequitable and punitive since it is the only cancer hospital being affected. The commenter stated that the regulatory criteria have ensured that there will be no future hospitals in this category developed and, therefore, our concerns about the negative impact of HwH growth on the Medicare system has no policy rationale in this case. The commenter urged CMS to exempt this cancer hospital from the growth restrictions for grandfathered HwHs.

Response: We do not agree that the grandfathering provision for HwHs in existence before September 30, 1995, is "inequitable or punitive." Although we understand that the specific statutory provision at section 1886(d)(1)(B)(v) of the Act and the regulatory criteria at § 412.23(f) make it unlikely that there will be additional cancer HwHs established, we reiterate that our grandfathering policy for HwHs was not established in order to limit HwH growth. Our goal, as noted above, was to enable hospitals excluded from the IPPS that were co-located prior to the recognition of HwHs as an entity to continue in their present arrangement with their "host" hospital without having to comply with the regulatory framework that we were establishing for HwHs. Because we were giving these hospitals a significant advantage, we believe that it was reasonable and equitable to put restrictions on their

growth unless they elected to comply with the HwH regulations at § 412.22(e). As we have indicated previously, grandfathered facilities remain free at any time to increase their beds so long as they comply with separateness and control requirements.

Based on our reconsideration of our proposed policy, at this time we are finalizing regulations at § 412.22(f)(3) that allow grandfathered HwHs to increase in square footage because we believe that there have been significant clinical advances, some of which are detailed elsewhere in these responses, reasonably requiring a hospital to physically expand in order to accommodate new equipment or treatment modalities that would enable it to continue to offer the highest level medical care to its patients. We could also envision that circumstances under which changing administrative or otherwise non-clinical needs could require additional space. However, we emphasize that we do not believe that any of these changes require the establishment of additional beds. Therefore, although the commenter's hospital will be permitted to increase its square footage, we are not establishing an exemption for a grandfathered cancer HwH from the limitation on increasing the number of beds.

After consideration of the public comments received, we are revising § 412.22(f)(3) and (h)(5) and § 412.25(c)(4) of the regulations to state that grandfathered HwHs and satellites will be permitted to decrease their square footage or number of beds, or both or increase their square footage without compromising their grandfathered status. This policy is effective for cost reporting periods beginning on or after October 1, 2006.

Because grandfathered HwHs or grandfathered satellite facilities may be co-located with an acute care hospital or may be co-located with another excluded hospital (69 FR 49198), we want to emphasize that under our policy revisions described above, where the HwH or satellite facility decreases its number of beds or square footage, there could be an impact on the host hospital if the hospital is also a PPS-exempt hospital and is also exempted because of grandfathering from compliance with the "separateness and control" requirements. (Because excluded hospitals are prohibited from having excluded hospital units under § 412.25(a)(1)(ii), this discussion is limited to HwHs and satellite facilities of hospitals.) For example, if grandfathered HwH "A" is co-located with another hospital excluded from the IPPS, hospital "B" (which is a rehabilitation hospital), a decrease in the number of beds in hospital "A" could impact the grandfathered status of hospital "B" if hospital "B" absorbed the extra beds. In such a case, if the determination were made that hospital "B" would expand, in order to maintain status as an excluded hospital, hospital "B" would then have to meet the applicable "separateness and control" requirements at § 412.22(e).

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

a. Background

In the June 9, 2003 IPPS high-cost outlier final rule (68 FR 34498), we made revisions to our policies concerning the determination of LTCHs' CCRs and the reconciliation of high-cost and short-stay outlier payments under the LTCH PPS. As we stated in that final rule, (68 FR 34507), because the LTCH PPS high-cost outlier and short-stay outlier policies are modeled after the IPPS outlier policy, we believe they are susceptible to the same payment vulnerabilities and, therefore, merited revision.

We revised our regulations to specify that fiscal intermediaries will use either the most recent settled cost report or the most recent tentative settled cost report, whichever is from the later cost reporting period, because we believe that a hospital has the ability to inappropriately increase its outlier payments during the time lag between the current charges and the CCR from the settled cost report, through dramatic charge increases. Using either the most recent settled cost report or the most recent tentative settled cost report, whichever is from the later cost reporting period, in many cases, reduces the time lag for updating CCRs by a year or more.

We also revised the regulations to specify that, in the event more recent charge data indicate that an alternative CCR would be more appropriate, CMS has the authority to direct the fiscal intermediary to change the LTCH's CCR to reflect the change evidenced by the more recent data. We made this change because even the later (that is, most recent) CCRs calculated from the tentatively settled cost reports would overestimate costs for hospitals that have continued to increase charges much faster than costs during the time between the tentatively settled cost report and the time when the claim is processed. In addition, we further revised the regulations to allow a hospital to contact its fiscal intermediary to request that its otherwise applicable CCR be changed if the LTCH presents substantial evidence that its CCR is inaccurate (68 FR 34497 and 34506 through 34508).

Also in the June 9, 2003 final rule (68 FR 34499 through 34500 and 34506 through 34507), we revised the regulations to specify that a fiscal intermediary may use a statewide average CCR if it is unable to determine an accurate CCR in one of three circumstances discussed in greater detail below. We made this revision because we noted that as hospitals raise their charges faster than their costs increase, over time their CCRs will decline. If hospitals continue to increase charges at a faster rate than their costs increase over a long period of time, or if they increase charges at extreme rates, their CCRs may fall below the range considered reasonable and, under our former policy, fiscal intermediaries would, in most cases, assign a statewide average CCR. These statewide averages are generally considerably higher than the threshold. Therefore, prior to the change in the regulations, these hospitals benefited from an artificially high ratio being applied to their already high charges. Furthermore, hospitals could continue to increase charges faster than costs, without any further downward adjustment to their CCR.

In addition, in the June 9, 2003 final rule (68 FR 34500 through 34502 and 34506 through 34508), we added a provision to our regulations to provide that outlier payments would become subject to reconciliation when hospitals' cost reports are settled. We noted that we had become increasingly aware that some hospitals had taken advantage of the former outlier policy by increasing their charges at extremely high rates, knowing that there would be a time lag before their CCRs would be adjusted to reflect the higher charges. We believed that even the revisions to the regulations described above would not completely eliminate all such opportunity. We explained that we believed that a hospital would still be able to dramatically increase its charges by far above the rate-of-increase in costs during any given year.

In the RY 2007 LTCH PPS proposed rule (71 FR 4648, 4674 through 4676, and 4690 through 4692), we discussed our current methodology for determining hospitals' CCRs under the LTCH PPS high-cost and short-stay outlier policies, and we presented proposals to refine our methodology for determining the annual CCR ceiling and statewide average CCRs. In that same proposed rule, we also discussed our

existing policy for the reconciliation of LTCH PPS high-cost and short-stay outlier payments, along with our proposal to codify in Subpart O of 42 CFR Part 412 those policies, including proposed modifications and editorial clarifications to those existing policies.

In that RY 2007 LTCH PPS proposed rule, we proposed that the proposed revisions to the policies governing the determination of LTCHs' CCRs and the reconciliation of high-cost and short-stay outlier payments would be effective October 1, 2006, noting that historically, annual updates to LTCH CCR ceiling and statewide average CCRs have been effective on October 1. In addition, our proposal stated that the LTCH CCR ceiling and statewide average CCRs that would be effective October 1, 2006, would be presented in the annual IPPS proposed and final rules.

As we stated in both the RY 2007 LTCH PPS final rule (71 FR 27832 through 27833 and 27871) and the FY 2007 IPPS proposed rule (71 FR 24127), we received a few specific comments on this portion of the RY 2007 LTCH PPS proposed rule concerning the proposed changes to the policies governing the determination of LTCHs' CCRs. As mentioned below, one commenter in this final rule supported our proposal. Several other commenters referenced one of the specific comments raised by another commenter on the proposed changes to the methodology for determining LTCH CCRs in their own comments on the RY 2007 LTCH PPS proposed rule. In addition, a commenter on the RY 2007 LTCH PPS proposed rule included a synopsis of our proposed changes concerning the determination of LTCHs' CCRs. Based on the commenter's synopsis of the proposed changes, we believe that the commenters clearly understood the nature and purpose of the proposed changes. However, the commenter pointed out that, in the RY 2007 LTCH PPS proposed rule, we did not provide an analysis of the effect of this proposed change, nor did we provide an example of the new CCR values under this proposed methodology. Another commenter did not "object in concept to the proposed combination of [IPPS] operating and capital cost-to-charge ratios" (to compute a "total" CCR for each IPPS hospital by adding together each hospital's operating CCR and its capital CCR) from which to compute the LTCH CCR ceiling and applicable statewide average CCRs. However, the commenter also pointed out that we did not provide any impact data and requested that we defer adoption of that proposed change until such data are provided for comment.

Therefore, in light of the comments referenced above, we proposed in the FY 2007 IPPS proposed rule (71 FR 24126 through 24135) the same changes to the policies governing the determination of LTCHs' CCRs and the reconciliation of high-cost and short-stay outlier payments that we proposed in the RY 2007 LTCH PPS proposed rule. We included in the FY 2007 IPPS proposed rule the values of the proposed LTCH CCR ceiling and the proposed statewide average LTCH CCRs that would be effective October 1, 2006, based on our proposed policy changes, along with the values of the proposed LTCH CCRs that would be determined under our current methodology. We also indicated that we would respond further to any comments received on the proposed changes to the policies governing the determination of LTCHs' CCRs and the reconciliation of LTCH PPS high-cost outlier and short-stay payments presented in the FY 2007 IPPS proposed rule in the FY 2007 IPPS final rule that will be published this summer. We received two public comments concerning the proposed changes to the policies governing the determination of LTCHs' CCRs and the reconciliation of LTCH high-cost outlier and short-stay payments presented in the FY 2007 IPPS proposed rule (71 FR 24125 through 24136). As discussed in greater detail below in this section, in this final rule, we are finalizing the proposed changes to the policies governing the determination of LTCHs' CCRs and the reconciliation of LTCH high-cost outlier and short-stay payments as proposed. In the RY 2007 LTCH PPS final rule (71 FR 27871), we revised the short-stay outlier payment formula based on the existing regulatory language at § 412.529(c) concerning the determination of LTCH CCRs and the reconciliation of short-stay outlier payments since we did not finalize any changes to our policy regarding the determination of LTCHs' CCRs and the reconciliation of LTCH PPS short-stay outlier payments in that LTCH PPS final rule.

In that same final rule, we noted that, to the extent the policy changes we proposed in the FY 2007 IPPS proposed rule regarding the determination of LTCHs' CCRs and the reconciliation of short-stay outlier payments are implemented, we may need to make conforming changes to the regulatory language in § 412.529 in the FY 2007 IPPS final rule to ensure that any such changes are consistent with (and do not contradict) the changes we made to § 412.529 in the RY 2007 LTCH PPS final rule. Accordingly, in adopting the proposed changes to the regulations regarding the determination of LTCHs' CCRs and the reconciliation of outlier payments in this final rule, we are making conforming changes to the regulatory language in § 412.529 as necessary based on the changes to the short-stay outlier policy at § 412.529 established in the RY 2007 LTCH PPS proposed rule (71 FR 27899 through 27900).

Comment: One commenter supported our proposed changes to the methodology for determining LTCH CCRs and LTCH PPS outlier reconciliation. The commenter was particularly appreciative of the impact analysis presented in the FY 2007 IPPS proposed rule.

Response: We appreciate the commenter's support and are pleased that our impact analysis was able to assist in the understanding of our proposal.

b. High-Cost Outliers

Under the broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of BIPA, when we implemented the LTCH PPS, we established an adjustment for additional payments for outlier cases that have extraordinarily high-costs relative to the costs of most discharges at § 412.525(a). Providing additional payments for outliers strongly improves the accuracy of the LTCH PPS in determining resource costs at the patient level and hospital level. Specifically, under § 412.525(a), we make outlier payments for any discharge if the estimated cost of the case exceeds the adjusted LTCH PPS payment for the LTC–DRG plus a fixed-loss amount. Under the LTCH PPS high-cost outlier policy, the LTCH's loss is limited to the fixed-loss amount and a fixed percentage of costs above the marginal cost factor. We calculate the estimated cost of a case by multiplying the overall hospital CCR by the Medicare allowable covered charge. In accordance with § 412.525(a)(3), we pay outlier cases 80 percent of the difference between the estimated cost of the patient case and the outlier threshold (the sum of the adjusted Federal prospective payment for the LTC–DRG and the fixed-loss amount).

c. Short-Stay Outliers

When we implemented the LTCH PPS, under § 412.529, we established a special payment policy for short-stay outlier cases, that is, LTCH PPS cases with a length of stay that is less than or equal to five-sixths of the geometric average length of stay for each LTC–DRG. Generally, LTCHs are defined by

statute as having an average length of stay of greater than 25 days. We believe that a short-stay outlier payment adjustment results in more appropriate payments, because these cases most likely would not receive a full course of a LTCH-level of treatment in such a short period of time and a full LTC–DRG payment may not always be appropriate. A short-stay outlier is defined at § 412.529(a) as a LTCH discharge with a length of stay of up to and including five-sixths the geometric average length of stay for the LTC–DRG. Under the short-stay outlier policy at § 412.529(c)(1), for LTCH PPS discharges occurring before July 1, 2006, in general, we adjust the per discharge payment under the LTCH PPS by the least of 120 percent of the estimated cost of the case, 120 percent of the LTC–DRG specific per diem amount, or the full LTC–DRG payment. Under the short-stay outlier policy at § 412.529(c)(2), for LTCH PPS discharges occurring on or after July 1, 2006, in general, we adjust the per discharge payment under the LTCH PPS by the least of 100 percent of the estimated cost of the case, 120 percent of the LTC–DRG specific per diem amount, the full LTC–DRG payment, or a blend of an amount comparable to the IPPS per diem amount (capped at the full IPPS comparable amount) and the 120 percent of the LTC–DRG specific amount (71 FR 27899). Consistent with the LTCH PPS high-cost outlier policy, we calculate the estimated cost of a case by multiplying the overall hospital CCR by the Medicare allowable covered charges.

d. CCR Ceiling

Under the LTCH PPS, a single prospective payment per discharge is made for both inpatient operating and capital-related costs. Therefore, we compute a single "overall" LTCH-specific CCR based on the sum of LTCH operating and capital-related costs (as described in Chapter 3, section 150.24, of the Medicare Claims Processing Manual (CMS Pub. 100–4)) as compared to total charges. A LTCH's CCR is calculated by dividing its total Medicare costs (that is, the sum of its operating and capital inpatient routine and ancillary costs) by its total Medicare charges (that is, the sum of its operating and capital inpatient routine and ancillary charges). (Instructions regarding the changes established in the June 9, 2003 IPPS high-cost outlier final rule for both LTCHs and IPPS hospitals can be found in Program Transmittal A–03–058 (Change Request 2785; July 3, 2003).)

Under our current policy, a LTCH is assigned the applicable statewide average CCR instead of using its CCR computed from data in its most recent (settled or tentatively settled) cost report if, among other things, the LTCH's CCR is found to be in excess of the applicable maximum CCR threshold. The applicable maximum CCR threshold is the combined IPPS operating and capital CCR ceiling. For instance, for FY 2006, under the current policy, the IPPS operating CCR ceiling is 1.254 and the IPPS capital CCR ceiling is 0.169 (70 FR 47496). Therefore, under our current policy, the combined operating and capital CCR ceiling is 1.423 (1.254 + 0.169 = 1.423) as specified in Program Transmittal 692 (Change Request 4046, September 30, 2005).

These ceilings represent 3.0 standard deviations from the mean of the log distribution of operating and capital cost-to-charge ratios for all IPPS hospitals. As we explained in the June 9, 2003 final rule (68 FR 34507), LTCH CCRs above this threshold are most likely due to faulty data reporting or entry, and, therefore, these CCRs should not be used to identify and make payments for outlier cases. Such data are clearly errors and should not be relied upon. (There are also other circumstances, discussed below, when we use a statewide CCR instead of a LTCH-specific CCR.)

Under the current methodology, we determine a "combined" statewide average CCR for LTCHs located in rural areas of a State that accounts for operating and capital costs and charges and a "combined" statewide average CCR for LTCHs located in urban areas of a State that accounts for operating and capital-related costs and charges. In order to calculate a combined statewide average CCR under our current methodology, we first calculate separate statewide average operating CCRs and capital CCRs. Under the IPPS, two statewide average operating CCRs are computed for each State: a statewide average CCR for rural areas and a statewide average CCR for urban areas. One statewide average capital CCR is computed for each State (applicable to both urban and rural areas). We use the same capital CCR for urban and rural areas because capital costs are the same regardless of geographic location. (Below we discuss our proposed revisions to this methodology, which we are adopting as final in this final rule.)

As we explained in the RY 2006 LTCH PPS final rule (70 FR 24192), we believe it is appropriate to use the combined IPPS operating and capital CCR ceiling and the applicable combined IPPS statewide average urban and rural CCRs in determining LTCHs' CCRs because LTCHs' cost and charge structures are similar to that of IPPS acute care hospitals. For instance, LTCHs are certified as acute care hospitals, as set forth in section 1861(e) of the Act, to participate as a hospital in the Medicare program, and these hospitals, in general, are paid as LTCHs only because their Medicare average length of stay is greater than 25 days (§ 412.23(e)). Furthermore, as also explained in that same final rule, prior to qualifying as a LTCH under § 412.23(e)(2)(i), a hospital generally is paid as an acute care hospital under the IPPS during the period in which it demonstrates that it has an average length of stay of greater than 25 days. In addition, because there are less than 400 LTCHs, and they are unevenly geographically distributed throughout the United States, there may not be sufficient LTCH CCR data to determine an appropriate LTCH PPS CCR ceiling using LTCH data.

Because LTCHs have a single "total" CCR (rather than separate operating and capital CCRs), under the broad authority of section 123 of the BBRA and section 307(b)(1) of BIPA, in the FY 2007 IPPS proposed rule (71 FR 24128 through 24129 and 24132 through 24133), we proposed to revise our regulations for high-cost outliers and short-stay outliers (§§ 412.525(a)(4) and 412.529(c)(5), respectively) to specify that, for discharges occurring on or after October 1, 2006, if a LTCH's CCR is in excess of the LTCH CCR ceiling (which would be calculated as 3 standard deviations above the corresponding national geometric mean total CCR (established and published annually by CMS)), the fiscal intermediary may use a statewide average CCR (also established annually by CMS and discussed in more detail below). (We also proposed a change in our methodology for calculating the applicable statewide average CCRs under the LTCH PPS, which we are finalizing in this final rule, as discussed in greater detail below.)

Specifically, for purposes of determining a LTCH's CCR under the LTCH PPS high-cost and short-stay outlier policies at §§ 412.525(a)(4) and 412.529 respectively, for discharges occurring on or after October 1, 2006, we proposed that we would determine the single "total" CCR ceiling, based on IPPS CCR data, by first calculating the total (that is, operating and capital) IPPS CCR for each hospital and then determining the average total CCR for all IPPS hospitals. For example, if an IPPS hospital's operating CCR is 0.432 and its capital CCR is 0.027, its total CCR would be 0.459 (0.432 + 0.027 = 0.459).

This calculation would be repeated for all IPPS hospitals in order to determine a total CCR for all IPPS hospitals. Next, the total IPPS CCR would be used to determine the average total IPPS CCR and standard deviation across all IPPS hospitals. The LTCH CCR ceiling would then be established at 3 standard deviations from the national geometric mean total IPPS CCR, rather than determining the LTCH total CCR ceiling as we do under our current policy by adding the separate IPPS operating CCR and capital CCR ceilings, which are each separately determined at 3 standard deviations from the average operating IPPS CCR and average capital IPPS CCR, respectively.

Under this proposed policy, we would use the same IPPS CCR data that we currently use to annually determine the separate IPPS operating CCR and capital CCR ceilings (that we add together under our current policy to determine the annual CCR ceiling for LTCHs) to compute IPPS hospital-specific total CCRs that would be used to determine the single LTCH total CCR ceiling. We believe that determining a LTCH CCR ceiling based on IPPS total (operating and capital-related) Medicare costs and charges rather than adding the separate IPPS CCR ceilings determined from operating CCRs and capital CCRs, respectively, would be more consistent with the LTCH PPS single payment, which does not differentiate payments between operating and capital-related costs. We noted that we still believe that it is appropriate to continue to use IPPS data to determine the annual LTCH CCR ceiling.

We also explained in both the RY 2007 LTCH PPS proposed rule (71 FR 4675) and the FY 2007 IPPS proposed rule (71 FR 24129), that these proposed revisions to our policy concerning the determination of the annual LTCH CCR ceiling would be effective for discharges occurring on or after October 1, 2006, rather than July 1, 2006. We proposed this approach because we proposed to continue to use the same IPPS data used to determine the individual IPPS operating and capital CCR ceilings established and published annually in the IPPS proposed and final rules. Because both the separate IPPS operating and capital CCRs ceilings and the new LTCH "total" CCR ceiling would be determined using the same data, we believe it would be administratively expedient to continue to establish the LTCH CCR ceiling to be effective for discharges occurring on or after October 1 of each year. (As stated previously, this is consistent with our current policy, where the LTCH CCR ceiling is updated annually on October 1.) Therefore, under this proposal, the public would continue to consult the annual IPPS proposed and final rules for changes to the LTCH CCR ceiling that would be effective for discharges occurring on or after October 1. Under this proposal, the current LTCH CCR ceiling established for discharges occurring on or after October 1, 2005, in the FY 2006 IPPS final rule would remain in effect for discharges occurring on or before September 30, 2006.

Comment: One commenter questioned why CMS' proposal concerning LTCH CCRs did not utilize a floor for applying the statewide average similar to using a ceiling. The commenter explained that even though a hospital could increase payment by increasing its charges, if a hospital has a historically low CCR, then it should be assigned the statewide average.

Response: As discussed in the June 9, 2003 outlier final rule (68 FR 34494 and 34507), we no longer assign the statewide average when a hospital's CCR falls below a minimum CCR threshold or "floor," as we believe a LTCH could arbitrarily increase its charges in order to maximize outlier payments. Even though this increase in charges should result in a lower CCR in the future (due to the time lag in cost report settlement), a floor would result in a LTCH being assigned the statewide average CCR. This would result in inappropriately higher outlier payments because in order to avoid making excessive outlier payments, under both our current policy and the proposed LTCH CCR policy, we apply the LTCH's actual CCR no matter how low the hospital's CCR falls. This policy for LTCHs is consistent with the policy we have adopted under the IPPS.

Under both our current policy and the proposed LTCH CCR policy, we apply a CCR maximum threshold or "ceiling" for those hospitals beyond three standard deviations of the national mean CCR to address what we believe is questionable data. As we explained in the FY 2007 IPPS proposed rule (71 FR 24127), CCRs above this threshold are most likely due to faulty data reporting or entry, and, therefore, these CCRs should not be used to identify and make payments for outlier cases. Such data are likely errors and should not be relied upon, and therefore, we assign the hospital the statewide average CCR. We note that, if a hospital has a historically low CCR, then a consistent pattern of a low CCR suggests that this CCR is reflective of their actual ratio of costs to charges as opposed to an instance of the data being aberrant. Therefore, we believe application of the statewide average CCR is not necessary. While it is possible that this low CCR may be based on questionable data, under both our current policy and the proposed LTCH CCR policy, a hospital may request its fiscal intermediary to use a different (higher or lower) CCR based on substantial evidence presented by the hospital.

We did not remove the ceiling similar to removing the floor, as the vulnerability of a hospital gaming the outlier payment system applies to hospitals raising their charges, thus lowering their CCR and then receiving the statewide average (if a floor was in place). Hospitals with high CCRs reflect costs that are high or exceed their charges, which is uncommon. Therefore, as stated above, we believe if a hospital does cross the ceiling, it is likely due to an error and we assign the statewide average. However, as noted above, a hospital may request its fiscal intermediary to use a different (higher or lower) CCR based on substantial evidence presented by the hospital even if a hospital's CCR is above the ceiling. Therefore, consistent with our current CCR policy, the applicable statewide average CCR will only be assigned when a LTCH's CCR exceeds the maximum CCR threshold (ceiling) determined as three standard deviations of the national mean total CCR (as described above), and not when it falls below the minimum threshold (floor).

We received no other comments and after consideration of the public comments received, we are adopting as final, without modification, the policy proposed in the proposed rule. Accordingly, in this final rule, under the broad authority of section 123 of the BBRA and section 307(b)(1) of BIPA, we are establishing under the LTCH PPS high-cost outlier policy at § 412.525(a)(4)(iv)(C)(*2*) and the LTCH PPS short-stay outlier policy at § 412.529(c)(3)(iv)(C)(*2*), that the fiscal intermediary may use a statewide CCR if it is unable to determine an accurate CCR for a LTCH if, amoung other things, a LTCHs' CCR is in excess of 3 standard deviations above the corresponding national geometric mean cost-to-charge ratio. Furthermore, §§ 412.525(a)(4)(iv)(C)(*2*) and 412.529(c)(3)(iv)(C)(*2*) specify that CMS will establish and publish this mean annually. As discussed above, as proposed, for discharges occurring on or after October 1, 2006, the LTCH total CCR ceiling will be calculated as three standard deviations above the corresponding national geometric mean total CCR, which will be determined based on IPPS CCR data, by first calculating the total (that is, operating and capital) IPPS CCR for each hospital

and then determining the average total IPPS CCR for all hospitals. As noted in the FY 2007 IPPS proposed rule (71 FR 24129) and reiterated above, consistent with our current policy, the LTCH total CCR ceiling will be updated annually and will be effective for discharges occurring on or after October 1 of each year. Therefore, the public should continue to consult the annual IPPS proposed and final rules for changes to the LTCH CCR ceiling that would be effective for discharges occurring on or after October 1.

In the FY 2007 IPPS proposed rule, based on IPPS total CCR data from the December 2005 update to the Provider-Specific File, we proposed a total CCR ceiling of 1.313 under the LTCH PPS that would be effective October 1, 2006. Furthermore, in the FY 2007 IPPS proposed rule, we proposed that, if more recent data are available, we would use those data to determine the final total CCR ceiling under the LTCH PPS for FY 2007 using the proposed methodology described above. Based on the latest available data (data from the March 2006 update to the Provider-Specific File), for this final rule, the CCR ceiling under our proposed methodology would be 1.321.

The LTCH CCR ceiling determined under our current "combined" methodology using the most recent data would result in a slightly higher LTCH CCR ceiling (that is, 1.26 + 0.154 = 1.414) for FY 2007 compared to the "total" CCR ceiling of 1.321 for FY 2007 calculated using our new methodology. However, based on CCRs from the March 2006 update of the Provider-Specific File, there are no LTCHs that have a CCR that is greater than the ceiling of 1.321 (the highest LTCH CCR in the current database of 392 LTCHs is 1.27).

e. Statewide Average CCRs

In addition to being authorized to assign the applicable statewide average CCR to a LTCH whose CCR is above the ceiling, the fiscal intermediary may use the applicable statewide average CCR in other circumstances. In the June 9, 2003 IPPS high-cost outlier final rule, we also established our current policy that the fiscal intermediary may use the applicable statewide average CCR for LTCHs for whom data with which to calculate a CCR are not available (for example, missing or faulty data) or for new LTCHs that have not yet submitted their first Medicare cost report. For this purpose, a "new" LTCH is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with § 489.18.

We note that, consistent with our current policy, either CMS or the LTCH may request the use of a different (higher or lower) CCR based on substantial evidence that such a CCR more accurately reflects the LTCH's actual costs and charges. This applies to new LTCHs (as defined above) as well. For instance, CMS may determine that the applicable statewide average CCR should not be applied to hospitals that convert from acute care IPPS hospitals to LTCHs and receive new LTCH provider numbers. Rather, the cost and charge data from the IPPS hospitals' cost reports (even if they are for more or less than a 12-month cost reporting period) would be used to determine the LTCH's CCR.

In addition to proposing to revise our methodology for determining the annual CCR ceiling under the LTCH PPS for discharges occurring on or after October 1, 2006, under the broad authority of section 123 of the BBRA and section 307(b)(1) of BIPA, in the FY 2007 proposed rule (71 FR 24131 through 24134), we proposed to revise our regulations for high-cost outliers and short-stay outliers (§§ 412.525(a)(4) and 412.529(c)(5), respectively) for discharges occurring on or after October 1, 2006, to codify in Subpart O of 42 CFR Part 412 the remaining LTCH PPS outlier policy changes that were established in the June 9, 2003 IPPS high-cost outlier final rule (68 FR 34506 through 34513), including proposed modifications and editorial clarifications to those existing policies established in that final rule, which are discussed in greater detail below in this section. We proposed these additional revisions to §§ 412.525(a)(4) and 412.529(c)(5) because we believe that making these revisions would more precisely describe the application of those policies as they relate to the determination of LTCH CCRs and because these proposed changes would be consistent with the proposed changes to the calculation of the LTCH CCR ceiling discussed above in this section.

Specifically, we proposed to specify under the LTCH PPS high-cost outlier policy at § 412.525(a)(4) and the LTCH PPS short-stay outlier policy at § 412.529 that the fiscal intermediary may use a statewide average CCR, which would be established annually by CMS, if it is unable to determine an accurate CCR for a LTCH in one of the following three circumstances: (1) new LTCHs that have not yet submitted their first Medicare cost report (for this purpose, consistent with current policy, a new LTCH would be defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with § 489.18); (2) LTCHs whose CCR is in excess of the LTCH CCR ceiling; and (3) other LTCHs for whom data with which to calculate a CCR are not available (for example, missing or faulty data). (Other sources of data that the fiscal intermediary may consider in determining a LTCH's CCR included data from a different cost reporting period for the LTCH, data from the cost reporting period preceding the period in which the hospital began to be paid as a LTCH (that is, the period of at least 6 months that it was paid as a short-term acute care hospital), or data from other comparable LTCHs, such as LTCHs in the same chain or in the same region.)

We did not receive any public comments on our proposal. Therefore, in this final rule, we are adopting as final, without modification, our proposed policy. Accordingly, under the broad authority of section 123 of the BBRA and section 307(b)(1) of BIPA, in this final rule, we are establishing §§ 412.525(a)(4)(iv)(C)(*1*) through (*3*) and 412.529(c)(3)(iv)(C)(*1*) through (*3*), which specify that the fiscal intermediary may use a statewide average CCR if it is unable to determine an accurate CCR for a LTCH in one of the following three circumstances: (1) new LTCHs that have not yet submitted their first Medicare cost report (for this purpose, consistent with current policy, a new LTCH would be defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with § 489.18; (2) LTCHs whose CCR is in excess of the LTCH CCR ceiling; and (3) other LTCHs for whom data with which to calculate a CCR are not available (for example, missing or faulty data). (Other sources of data that the fiscal intermediary may consider in determining a LTCH's CCR included data from a different cost reporting period for the LTCH, data from the cost reporting period preceding the period in which the hospital began to be paid as a LTCH (that is, the period of at least 6 months that it was paid as a short-term acute care hospital), or data from other comparable LTCHs, such as LTCHs in the same chain or in the same region.) These regulations further specify that the statewide average CCRs used under the LTCH PPS, as described in greater detail below, will be established annually by CMS.

Also, in the FY 2007 IPPS proposed rule (71 FR 24130 through 24131 and 24133 through 24134) we described our existing methodology for calculating the combined statewide average CCR for rural and urban LTCHs. Under the proposed LTCH PPS high-cost outlier policy at § 412.525(a)(4) and the

proposed LTCH PPS short-stay outlier policy at § 412.529 for discharges occurring on or after October 1, 2006, we proposed to compute statewide average CCRs for use under the LTCH PPS in a manner similar to the way we proposed to compute LTCH PPS CCR ceilings. Specifically, under this proposed policy, we would use the same IPPS CCR data that we currently use to annually establish the separate IPPS operating and capital statewide CCRs to compute statewide average total CCRs. Below we outline our proposed methodology for calculating the total statewide average CCR for a rural LTCH:

Step 1: Calculate the total CCR for each rural IPPS hospital by adding together its operating CCR and its capital CCR.

Step 2: Calculate the weighted average total CCR for all rural IPPS hospitals in the State (as shown in the third column of Table 8C of the Addendum to the FY 2007 IPPS proposed rule). This same proposed methodology would be applied when determining the "total" statewide average CCR for LTCHs located in urban areas, except that we would replace "rural IPPS hospitals" with "urban IPPS hospitals" in Steps 1 and 2. Under this proposal, the underlying data, that is, the IPPS CCRs, would remain the same. (We note that the weighted average total CCR for all urban IPPS hospitals in the State is shown in the second column of Table 8C of the Addendum to this final rule and the weighted average total CCR for all rural IPPS hospitals in the State is shown in the third column of Table 8C of the Addendum to this final rule, based on the policies finalized in this final rule as discussed below.)

We also proposed that these statewide average "total" (operating and capital) CCRs that would be used under the LTCH PPS would continue to be published annually in the IPPS proposed and final rules, and, therefore, the public would continue to consult the annual IPPS proposed and final rules for changes to the applicable statewide average total CCRs that would be effective for discharges occurring on or after October 1. Under this proposal, the current applicable statewide average operating and capital CCRs, established for discharges occurring on or after October 1, 2005, would remain in effect for discharges occurring on or before September 30, 2006. Our rationale for proposing to establish statewide average "total" CCRs (as described above in this section) based on IPPS data under the proposed revisions to the high-cost outlier policy at § 412.525(a)(4) and short-stay outlier policy at § 412.529 is the same as the one stated above for proposing to use IPPS data to determine a "total" LTCH CCR ceiling.

We did not receive any public comments on our proposed changes. Therefore, we are adopting them as final without modification. Accordingly, under the broad authority of section 123 of the BBRA and section 307(b)(1) of BIPA, in this final rule, under §§ 412.525(a)(4)(iv)(C) and 412.529(c)(3)(iv)(C), as proposed and as described above, for discharges occurring on or after October 1, 2006, the applicable LTCH statewide average total CCRs will be determined based on IPPS CCR data in a manner similar to the way we will be computing the LTCH PPS CCR ceiling, as discussed above. As also noted in the FY 2007 IPPS proposed rule (71 FR 24129 and 24134) and reiterated above, consistent with our policy, the LTCH PPS statewide average total CCRs will be updated annually and will be effective for discharges occurring on or after October 1 of each year. Therefore, the public should continue to consult the annual IPPS proposed and final rules for changes to the LTCH PPS statewide average total CCRs that would be effective for discharges occurring on or after October 1.

We also proposed to determine the urban and rural statewide average total CCRs for Maryland LTCHs paid under the LTCH PPS using, as a proxy, the national average total CCR for urban IPPS hospitals and the national average total CCR for rural IPPS hospitals, respectively (71 FR 24130 through 24131 and 24134). As we explained in the FY 2007 IPPS proposed rule, we proposed this proxy because we believe that the CCR data on the Provider-Specific File for Maryland hospitals may not be accurate. This is because acute care hospitals in Maryland are operating under a waiver of Medicare's ratesetting methodologies for inpatient and outpatient services under the authorities of sections 1814(b)(3) and 1833(a)(2) of the Act. The State's Health Services Cost Review Commission (HSCRC) is the regulatory body that establishes hospital-specific rates for all hospital services in Maryland.

Because all Maryland short-term acute care hospitals are paid based on the hospital-specific rates set by the HSCRC rather than under the IPPS, CCRs are not required to determine their Medicare payments (as they are for other acute care hospitals that are not governed under the waiver at sections 1814(b)(3) and 1833(a)(2) of the Act, and who are reimbursed for their treatment of Medicare patients under the IPPS). Therefore, CCRs in the Provider-Specific File for Maryland acute care hospitals, for the most part, are missing (because they are not used for payment). Those CCRs that are inputted into the Provider-Specific File for Maryland acute care hospitals by the fiscal intermediary are most likely unaudited because they are not used for making payments. For all these reasons, we are concerned that CCRs for Medicare acute care hospitals located in Maryland that are in the Provider-Specific File may not be reliable. Therefore, we believe that they should not be used as proxies for setting the statewide average total CCRs for Maryland LTCHs.

As we discussed in the FY 2007 IPPS proposed rule (71 FR 24130 and 24134), we believe it would be more appropriate to establish statewide average total CCRs for Maryland LTCHs based on national average total CCRs of IPPS hospitals that were audited by fiscal intermediaries. Therefore, we proposed to establish statewide average total CCRs for Maryland LTCHs based on the national average total CCRs of all IPPS hospitals because we believe that the average of the CCRs of all the IPPS hospitals across the country that were audited by fiscal intermediaries would be based on sufficient rigorous complete data that would be a representative proxy for the ratio of costs-to-charges of LTCHs in Maryland that are subject to LTCH PPS. (We note that, under our proposal, the fiscal intermediary may assign the statewide average CCR in one of three circumstances (that is, "new" LTCHs, as defined above; LTCHs with a CCR that is in excess of the LTCH ceiling; and LTCHs with unavailable data, as discussed above).) We solicited comments or suggestions for an alternative proxy statewide average CCR to use for LTCHs that are located in Maryland and are paid under the LTCH PPS in the FY 2007 IPPS proposed rule. We did not receive any public comments on our proposal or any alternative proxy statewide average CCR to use for LTCHs that are located in Maryland and are paid under the LTCH PPS. Therefore, under the broad authority of section 123 of the BBRA and section 307(b)(1) of BIPA, we are adopting our proposed methodology for determining the statewide average CCR for Maryland under the LTCH PPS as final without modification.

In the FY 2007 IPPS proposed rule (71 FR 24130 and 24134) we stated that, if more recent data are available for the final rule, we would use those data to determine the final LTCH PPS statewide average CCRs for FY 2007 using the proposed methodology describe above that we are adopting as final in this final rule. Therefore, in this final rule, based on the most recent complete IPPS total

CCR data from the March 2006 update of the Provider-Specific File, the final LTCH PPS statewide average total CCRs for urban and rural hospitals that will be effective October 1, 2006, are presented in Table 8C of the Addendum to this final rule. (As was proposed, we note that for this final rule, as is the case under the IPPS, all areas in the District of Columbia, New Jersey, Puerto Rico, and Rhode Island are classified as urban, and therefore there are no rural statewide average total CCRs listed for those jurisdictions in Table 8C of the Addendum to this final rule. As was proposed, we also note that for this final rule, as is the case under the IPPS, although Massachusetts has areas that are designated as rural, there are no short-term acute care IPPS hospitals or LTCHs located in those areas as of March 2006, and therefore there are no rural statewide average total CCR listed for rural Massachusetts in Table 8C of the Addendum of this final rule.)

Comparing the statewide average "total" CCRs in Table 8C of the Addendum to this final rule to the "combined" statewide average CCRs that would have been calculated using our existing methodology shows that the changes to our methodology for determining LTCH statewide average CCRs results in only minor changes in the average CCR for each State. In particular, the largest decrease in a statewide average CCR (with the exception of Maryland, as discussed above) will be in urban Wyoming (−0.7 percent). However, there is currently only 1 LTCH located in Wyoming. The largest increase in a statewide average CCR will be in urban District of Columbia (0.7 percent), and there are currently only 2 LTCHs located in the District of Columbia.

f. Data Used to Determine a CCR

Similar to our current policy, in the FY 2007 IPPS proposed rule (71 FR 24131 and 24134), we also proposed to specify under our proposed revision to the LTCH PPS high-cost outlier policy at § 412.525(a)(4) and the LTCH PPS short-stay outlier policy at § 412.529 that, for discharges occurring on or after October 1, 2006, the CCR applied at the time a claim is processed would be based on either the most recently settled cost report or the most recent tentatively settled cost report, whichever is from the latest cost reporting period. Furthermore, in the same proposed rule, we proposed under the LTCH PPS high-cost outlier policy at § 412.525(a)(4) and the LTCH PPS short-stay outlier policy at § 412.529 to state that CMS may specify an alternative to the CCR computed from the most recently settled cost report or the most recent tentatively settled cost report, whichever is later (under proposed §§ 412.525(a)(4)(iv)(B) and 412.529(c)(3)(iv)(B)), or a hospital may also request that the fiscal intermediary use a different (higher or lower) CCR based on substantial evidence presented by the hospital. These proposed revisions to our policy for determining a LTCH's CCR for discharges occurring on or after October 1, 2006, under the proposed revisions to the LTCH PPS high-cost and short-stay outlier policies, described above, are similar to our existing policy established in the June 9, 2003 IPPS high-cost outlier final rule (68 FR 34506 through 34513). In addition, we proposed a technical correction to existing § 412.525(a)(3) to change the plural reference from cost-to-charge "ratios" to the singular reference to a cost-to-charge "ratio" because, under the LTCH PPS, a single (total) CCR is computed for LTCHs.

We did not receive any comment on our proposal. Therefore, we are adopting as final without modification the proposed policy changes. Accordingly, under the broad authority of section 123 of the BBRA and section 307(b)(1) of BIPA, in this final rule, we are establishing under §§ 412.525(a)(4)(iv)(B) and 412.529(c)(3)(iv) that, for discharges occurring on or after October 1, 2006, the CCR applied at the time a claim is processed will be based on either the most recently settled cost report or the most recent tentatively settled cost report, whichever is from the latest cost reporting period. Under the broad authority of section 123 of the BBRA and section 307(b)(1) of BIPA, we are also establishing at §§ 412.525(a)(4)(iv)(A) and 412.529(c)(3)(iv)(A) that, for discharges occurring on or after October 1, 2006, CMS may specify an alternative to the CCR computed under new §§ 412.525(a)(4)(iv)(B) and 412.529(c)(3)(iv)(B) (that is, computed from the most recently settled cost report or the most recent tentatively settled cost report, whichever is later), or a hospital may also request that the fiscal intermediary use a different (higher or lower) CCR based on substantial evidence presented by the hospital. In addition, as proposed, under the broad authority of section 123 of the BBRA and section 307(b)(1) of BIPA, we are revising § 412.525(a)(3) to change the plural reference from cost-to-charge "ratios" to the singular reference to a cost-to-charge "ratio" in this final rule.

g. Reconciliation of Outlier Payments Upon Cost Report Settlement

In the June 9, 2003 IPPS high-cost outlier final rule (68 FR 34508 through 34512), we established our policy for LTCHs that effective with LTCH PPS discharges occurring on or after August 8, 2003, any reconciliation of outlier payments will be based upon the actual CCR computed from the costs and charges incurred in the period during which the discharge occurs. In that same final rule, we also established our current policy that for discharges occurring on or after August 8, 2003, at the time of any reconciliation, outlier payments may be adjusted to account for the time value of any underpayments or overpayments based upon a widely available index to be established in advance by the Secretary and will be applied from the midpoint of the cost reporting period to the date of reconciliation. Additional information on the administration of the reconciliation process under the IPPS is provided in Program Transmittal 707 (Change Request 3966, October 12, 2005). We note that, in addition to the changes to the high-cost outlier and short-stay outlier policies presented in this final rule, we are currently developing additional instructions on the administration of the existing reconciliation process under the LTCH PPS that would be similar to the IPPS reconciliation process.

In the FY 2007 IPPS proposed rule (71 FR 24131 and 24134), for discharges occurring on or after October 1, 2006, we proposed to codify into the LTCH PPS section of the regulations (Subpart O of 42 CFR Part 412) the provisions governing the determination of LTCHs' CCRs, including proposed modifications and editorial clarifications to our existing methodology for determining the annual LTCH CCR ceiling and applicable statewide average CCRs under the LTCH PPS. In addition, in that same proposed rule, under the broad authority of section 123 of the BBRA and section 307(b)(1) of BIPA, we proposed to revise §§ 412.525(a)(4), and 412.529(c)(3) for discharges occurring on or after October 1, 2006, to codify in Subpart O of 42 CFR Part 412 the provisions discussed above concerning the reconciliation of LTCH PPS outlier payments, including proposed editorial clarifications discussed in greater detail below in this section, that would more precisely describe the application of those policies. We proposed the additional revisions to §§ 412.525(a)(4) and 412.529(c)(3) concerning the reconciliation of outlier payments, which are discussed in greater detail

below in this section, because these proposed changes would be consistent with the proposed changes to the calculation of the LTCH CCR ceiling discussed above.

Specifically, we proposed under the LTCH PPS high-cost outlier policy at § 412.525(a)(4) and the LTCH PPS short-stay outlier policy at § 412.529, similar to our current policy, to specify that, for discharges occurring on or after October 1, 2006, any reconciliation of outlier payments would be based on the CCR calculated based on a ratio of costs to charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled. In addition, we proposed under the LTCH PPS high-cost outlier policy at § 412.525(a)(4)and the LTCH PPS short-stay outlier policy at § 412.529, similar to our current policy, to specify that, for discharges occurring on or after October 1, 2006, at the time of any reconciliation, outlier payments may be adjusted to account for the time value of any underpayments or overpayments. Consistent with our current policy, we also proposed that such an adjustment would be based upon a widely available index to be established in advance by the Secretary and would be applied from the midpoint of the cost reporting period to the date of reconciliation. As we discussed in the FY 2007 IPPS proposed rule (71 FR 24131 and 24134), we proposed to make these additions to §§ 412.525(a)(4) and 412.529 because we believe that such proposed changes reinforce the concept that the LTCH PPS has a single payment rate for inpatient operating and capital-related costs (as discussed in greater detail previously), and because we believe it would be more appropriate and administratively simpler to include all of the regulatory provisions concerning the determination of LTCH PPS (high-cost and short-stay) outlier payments applicable under the LTCH PPS regulations in Subpart O of 42 CFR Part 412.

We did not receive any public comments on the proposed changes regarding the reconciliation of LTCH PPS outlier payments upon cost report settlement. Therefore, under the broad authority of section 123 of the BBRA and section 307(b)(1) of BIPA, we are adopting as final, without modification, the proposed changes to the regulations at § 412.525(a)(4)(iv)(D) through (E) for LTCH PPS high-cost outliers and § 412.529(c)(3)(iv)(D) through (E) for LTCH PPS short-stay outliers regarding the methodology for determining LTCH CCRs and LTCH PPS outlier reconciliation.

7. Technical Corrections Relating to LTCHs

In the FY 2007 IPPS proposed rule (71 FR 24135), we proposed to make the following technical changes to various sections of the regulations relating to LTCHs to update or correct cross-references or to include inadvertently omitted provisions: a. In the following sections, we proposed to correct several incorrect cross-references in the existing regulations:

- In § 412.505(b)(1), we proposed to change the cross-reference "§ 412.22(e) and (h)(5)" to the phrase "§ 412.22(e)(3) and (h)(6), if applicable".
- In § 412.508(c)(3), we proposed to change the cross-reference "§ 1001.301" to "§ 1001.201."
- In § 412.541(b)(2)(i), we proposed to change the cross-reference "§ 412.533(b)" to "§ 412.533(a)(5) and § 412.533(c)" to correctly refer to the provisions on the determination of the LTCH PPS rates.

b. We proposed to revise § 412.511 to change the cross-reference "§ 412.22(e) and (h)(5)" to the phrase "§ 412.22(e)(3) and (h)(6)" and to clarify the requirement that LTCHs must meet under §§ 412.22(e)(3) and (h)(6) to report co-location status as part of its overall reporting requirements.

c. We proposed to revise § 412.525(d) by adding new paragraphs (d)(3) and (d)(4) to specify two additional payment adjustments to the per discharge payments under the LTCH PPS that were inadvertently omitted; that is, the special payment under the onsite transfer and readmission policy at § 412.532 and the special payment provisions for LTCH HwHs and satellites of LTCHs at § 412.534.

d. We proposed to revise § 412.532(a)(2) to correct the cross-reference to the definition of a satellite facility by changing "§ 412.22(f)" to "§ 412.22(h)". In addition, we proposed to revise paragraph (b) of § 412.532 to include satellite facilities and SNFs as part of the definition of entities that may be "co-located" or "onsite" with a hospital. In existing § 412.532(a)(2) and (a)(3), we include satellite facilities and SNFs, respectively, within the onsite provider payment policy as entities that may be co-located with a LTCH, but omitted to mention them in § 412.532(b) as being included when we defined "co-located or onsite" facilities. We proposed to conform § 412.532(b) to include their mention.

We did not receive any public comments on these technical changes and, therefore, are adopting them as final without modification.

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

As stated earlier, on November 15, 2004, we published in the **Federal Register** the final rule establishing a PPS for IPFs (69 FR 66922). As a part of that rule, we amended the authority citations for 42 CFR Parts 412 and 413 to include references to section 124 of Pub. L. 106–113. Section 124 directed us to take various actions regarding a per diem PPS for IPFs. We included incorrect cross-references to the United States Statutes at Large citation for this provision. We proposed to amend the authority citations for Parts 412 and 413 by removing the incorrect cross-reference to "113 Stat. 1515" and inserting the correct cross-reference "113 Stat. 1501A–332".

We did not receive any public comments on the proposed cross-reference correction and, therefore, are adopting it as final without modification.

9. Report of Adjustment (Exceptions) Payments

Section 4419(b) of Pub. L. 105–33 requires the Secretary to publish annually in the **Federal Register** a report describing the total amount of adjustment payments made to excluded hospitals and units, by reason of section 1886(b)(4) of the Act, during the previous fiscal year.

The process of requesting, adjudicating, and awarding an adjustment payment is likely to occur over a 2-year period or longer. First, an excluded hospital or excluded unit of a hospital must file its cost report for a fiscal year with its fiscal intermediary within 5 months after the close of its cost reporting period in accordance with § 413.24(f)(2). The fiscal intermediary then reviews the cost report and issues a Notice of Program Reimbursement (NPR) within approximately 2 months after the filing of the cost report. If the hospital's operating costs are in excess of the ceiling, the hospital may file a request for an adjustment payment within 180 days from the date of the NPR. The fiscal intermediary, or CMS, depending on the type of adjustment requested, then reviews the request and determines if an adjustment payment is warranted. This determination is often not made until more than 6 months after the date the request is filed. However, in an attempt to provide interested parties with data on the most recent adjustments for which we do have data, we are publishing data on adjustment payments that were processed by the

fiscal intermediary or CMS during FY 2005.

The table below includes the most recent data available from the fiscal intermediaries and CMS on adjustment payments that were adjudicated during FY 2005. As indicated above, the adjustments made during FY 2005 only pertain to cost reporting periods ending in years prior to FY 2004. Total adjustment payments awarded to excluded hospitals and units during FY 2005 are $21,362,945. The table depicts for each class of hospitals, in the aggregate, the number of adjustment requests adjudicated, the excess operating cost over ceiling, and the amount of the adjustment payments.

Class of hospital	Number	Excess cost over ceiling	Adjustment payments
Rehabilitation	12	$ 4,753,618	$1,352,043
Psychiatric	34	27,408,956	18,362,262
Long-Term Care	2	2,147,623	1,485,380
Children's	—	—	—
Cancer	—	—	—
Religious Nonmedical. Health Care Institution	3	383,951	163,260

B. Critical Access Hospitals (CAHs)

1. Background

Section 1820 of the Act provides for the establishment of Medicare Rural Hospital Flexibility Programs (MRHFPs), under which individual States may designate certain facilities as critical access hospitals (CAHs). Facilities that are so designated and meet the CAH conditions of participation under 42 CFR Part 485, Subpart F, will be certified as CAHs by CMS. Regulations governing payments to CAHs for services to Medicare beneficiaries are located in 42 CFR Part 413.

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

Under section 1820(c)(2)(B)(i) of the Act, a CAH is required to be located more than a 35-mile drive (or in the case of mountainous terrain or only secondary roads, a 15-mile drive) from a hospital or another CAH, unless the CAH is certified by the State as a necessary provider of health care services to residents in the area. Section 405(h) of Pub. L. 108-173 amended section 1820(c)(2)(B)(i)(II) of the Act by adding language that terminated a State's authority to waive the location requirement for a CAH by designating the CAH as a necessary provider, effective January 1, 2006. As a result of this amendment, as of January 1, 2006, States are no longer able to designate CAH status based upon a determination that an entity is a necessary provider of health care. However, section 405(h) of Pub. L. 108–173 also included a grandfathering provision for CAHs that are certified as necessary providers prior to January 1, 2006. Under this provision, a CAH that is designated as a necessary provider in its State's rural health plan prior to January 1, 2006, is permitted to maintain its necessary provider designation.

The regulations that specify the location requirements for CAHs described above are set forth at 42 CFR 485.610(c). To implement the amendment made by section 405(h) of Pub. L. 108–173, we published a final rule in the **Federal Register** on August 11, 2004 (69 FR 49271) to revise the regulations under paragraph (c) of § 485.610. In that revision, we inadvertently included an erroneous date: In the second sentence of paragraph (c), we stated that a CAH that is designated as a necessary provider as of October 1, 2006, will maintain its necessary provider designation after October 1, 2006. Although a correction notice was published in the **Federal Register** on October 7, 2004 (69 FR 60252), the notice corrected only the second citation of the date in that paragraph. As a result, the second sentence of § 485.610(c) continues to state, incorrectly, that a CAH that is designated as a necessary provider as of October 1, 2006, will maintain its necessary provider designation as of January 1, 2006.

To avoid further confusion, and to ensure that the regulations implementing the CAH location requirement under section 1820(c)(2)(B)(i)(II) of the Act specify that requirement accurately, we proposed to revise the second sentence of § 485.610(c) to state that a CAH that was designated as a necessary provider on or before December 31, 2005, will maintain its necessary provider designation as of January 1, 2006. We note that this change would merely correct the previous error and does not reflect any change in our policy as to how the statutory provision is implemented.

Comment: A number of commenters raised issues concerning the interpretative guidelines that we issued relating to implementation of the CAH necessary provider provision.

Response: These interpretative guidelines were developed after the FY 2005 IPPS final rule was published. We consider the comments that we received to be outside the scope of the May 12, 2006 proposed rule and, therefore, are not responding to them in this final rule. However, we are considering these comments as part of our ongoing policy review efforts and will take appropriate action if warranted.

In this final rule, we are adopting as final, without modification, the revision to the second sentence of § 412.610(c) described above.

VII. Payment for Services Furnished Outside the United States

A. Background

Section 1862(a)(4) of the Act generally prohibits payment under Medicare for items and services furnished outside the United States. Under sections 1861(x) and 210(i) of the Act, "United States" is defined to include the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, and America Samoa. Furthermore, under Pub. L. 94–241, "those laws which provide Federal services and financial assistance programs" apply to the Northern Mariana Islands to the same extent as they do to Guam. In addition, we have interpreted the term "United States" as including U.S. territorial waters. We consider shipboard services furnished in a port of the United States or within 6 hours before arrival at, or departure from, a port of the United States to be furnished in the United States territorial waters (54 FR 41723). Therefore, in our regulations at § 411.9(a), we define the United States to include the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, and for purposes of services furnished on board ship, the territorial waters

adjoining the land areas of the United States. This general prohibition has exceptions, under which payment may be made for inpatient hospital services, emergency inpatient hospital services, and for physician and ambulance services associated with these hospital services that are furnished outside the United States.

Payment may be made for inpatient hospital services if a Medicare beneficiary who is a United States resident received these services at a hospital located outside of the United States that either was closer to, or was substantially more accessible from, the beneficiary's residence than the nearest United States hospital that was adequately equipped and available to treat the beneficiary. Payment may be made for emergency inpatient hospital services if a beneficiary was in the United States (or in Canada while traveling between Alaska and another State without unreasonable delay and by the most direct route) when the emergency arose, and the hospital located outside the United States was closer to, or substantially more accessible from, the place where the emergency arose than the nearest available adequately equipped hospital within the United States. Payment may be made for physician and ambulance services furnished in connection with these inpatient and emergency inpatient hospital services. Our existing regulations that implement these statutory provisions are located at 42 CFR 409.3, 409.5, 410.14, 410.66, 411.9, 413.74 and Subparts G and H of Part 424.

B. Proposed Clarification of Regulations

Services that fall under these exceptions typically are furnished in Canada or Mexico. However, in accordance with section 1814(f) of the Act and the definition of the term "United States" (42 CFR 411.9(a)), it is permissible for Medicare to pay for services furnished in foreign countries other than Canada and Mexico. For example, if a Medicare beneficiary who is in Guam needed emergency inpatient hospital services and the nearest available hospital adequately equipped to treat that beneficiary was located in the Philippines, Medicare payment would be permitted for the services.

Several of our existing regulations (§§ 409.3, 409.5, 410.66, and 413.74) specifically refer to services furnished in Canada and Mexico and do not indicate that it is permissible for Medicare payment to be made for services furnished in other foreign countries. The references in these sections also are more limited than the provisions of 42 CFR Part 424, Subpart H, the portion of our regulations that addresses treatment furnished in a foreign country. Therefore, in the FY 2007 IPPS proposed rule (71 FR 24136), we proposed to amend those regulations that refer to Canada and Mexico in order to conform them to the Act and to our other regulations addressing these situations.

Comment: Commenters indicated that they believed additional clarification of the proposed revisions on payment for services outside the United States may be necessary to avoid confusion. Specifically, they noted that the example cited in the preamble states: if a Medicare beneficiary who is in Guam needed emergency inpatient hospital services and the nearest available hospital adequately equipped was located in the Philippines, Medicare payment would be permitted for the services. The commenters indicated that this statement and the proposed accompanying changes to the regulations raise several questions. First, does it matter that the beneficiary happens to be in Guam, or is there an expectation that the beneficiary resides in Guam? Second, does it matter if the beneficiary is in a United States Territory (that is, Guam), or would payment be permitted for services furnished to a beneficiary who was in another foreign country? Finally, what is the applicability of these provisions to a beneficiary who maintains residence outside the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, or American Samoa?

Further, the commenters believed that CMS should evaluate the safety concerns of beneficiaries living outside the United States, but in close proximity to hospitals accredited by Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in foreign countries. They stated that these beneficiaries are forced to travel great distances to reach hospitals in the U.S., sometimes at great risk to their health, while adequately equipped, accredited hospitals are immediately available to meet their health care needs.

Response: If a Medicare beneficiary is in Guam (or any other U.S. Territory) and an emergency arises that results in the beneficiary receiving emergency inpatient services from a foreign hospital, Medicare may pay for such services irrespective of whether the beneficiary is a resident of Guam (or any other U.S. Territory). That is, section 1814(f)(2) of the Act and 42 CFR 424.122 do not require that a beneficiary be a resident of Guam (or any other U.S. Territory where an emergency occurs) in order for Medicare to pay for those services. Because section 1814(f)(2) of the Act and our regulations at § 424.122 already directly address when Medicare payment may be made for emergency inpatient services furnished in foreign hospitals, it is unnecessary to outline those provisions again in 42 CFR 409.3, 409.5, 410.66, and 413.74 of the regulations.

With respect to the question concerning Medicare beneficiaries who maintain their residence outside the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, or the Northern Mariana Islands as we noted above, section 1814(f)(2) of the Act and § 424.122 of the regulations do not require that a beneficiary be a resident of Guam (or any other U.S. Territory where an emergency occurs) in order for Medicare to pay for emergency inpatient services that a Medicare beneficiary receives from a foreign hospital. However, section 1814(f)(1) of the Act and § 424.123 of the regulations require that, in order for payment to be made for nonemergency inpatient hospital services that a Medicare beneficiary receives at a hospital located outside the United States, the beneficiary must be a U.S. resident who received these nonemergency services at a hospital located outside of the United States that either was closer to, or was substantially more accessible from, the beneficiary's residence than the nearest U.S. hospital that was adequately equipped and available to treat the beneficiary.

With respect to beneficiaries who are forced to travel great distances to reach hospitals in the United States, although we are concerned about the health and safety of Medicare beneficiaries, CMS does not have the legal authority to expand upon the foreign services for which Medicare may make payment, because Medicare law prohibits payment for items and services furnished outside the United States, except for certain limited services (see sections 1814(f) and 1862(a)(4) of the Act).

After consideration of the public comments received, we are adopting as final, without modification, the amendments to our existing regulations regarding services furnished outside the United States described above.

In the FY 2007 IPPS proposed rule, we also proposed to make some related technical changes. In §§ 409.3(e) and 424.123(c)(2), we proposed to change the references from the Joint Commission on Accreditation of Hospitals (JCAH) to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the

current name of that organization. In § 424.121(c), we proposed to change the obsolete cross-reference from § 405.313 to the correct cross-reference, § 411.9.

We did not receive any public comments on these technical changes. Therefore, we are adopting as final, without modification, the technical changes to §§ 409.3(e), 424.123(c)(2), and 424.121(c) described above.

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

Section 1886(a)(4) of the Act excludes the costs of administering blood clotting factors to inpatients with hemophilia from the definition of "operating costs of inpatient hospital services." Section 6011(b) of Pub. L. 101–239 states that the Secretary of Health and Human Services shall determine the payment amount made to hospitals under Medicare Part A for the costs of administering blood clotting factors to individuals with hemophilia by multiplying a predetermined price per unit of blood clotting factor by the number of units provided to the individual. The regulations governing payment for blood clotting factors furnished to hospital inpatients and for payment for the furnishing fee are located in §§ 412.2(f)(8) and 412.115(b).

In FY 2005, we made payments for blood clotting factors furnished to inpatients at 95 percent of average wholesale price (AWP), consistent with the rates then paid under section 1842(o) of the Act for Medicare Part B drugs (including blood clotting factor furnished to beneficiaries who are not inpatients).

Section 303 of Pub. L. 108–173 added section 1847A to the Act. Effective January 1, 2005, this section requires that almost all Medicare Part B drugs not paid on a cost or prospective basis be paid at 106 percent of average sales price (ASP), while section 1842(o)(5) of the Act provides for a Medicare Part B payment of a furnishing fee for blood clotting factor. On November 15, 2004, we published regulations in the **Federal Register** (69 FR 66310 through 66319) that implemented the provisions of section 1847A of the Act. These regulations are codified at Subpart K of Part 414 and § 410.63, respectively.

The furnishing fee is updated each calendar year as specified by section 1842(o)(5) of the Act. The furnishing fee for clotting factor for years after CY 2005 is equal to the fee for the previous year increased by the percentage increase in the consumer price index (CPI) for medical care for the 12-month period ending with June of the previous year. This requirement is set forth in our regulations at § 410.63.

In the FY 2006 IPPS final rule (70 FR 47473), we amended our regulations at §§ 412.2(f)(8) and 412.115(b) to state that, for discharges occurring on or after October 1, 2005, we make payment for blood clotting factor administered to hospital inpatients using the Medicare Part B payment amounts for blood clotting factor as determined under Subpart K of 42 CFR Part 414 and for the furnishing fee as determined under § 410.63.

On November 21, 2005, we issued regulations in the **Federal Register** (70 FR 70225) updating the furnishing fee payment amount for CY 2006. We announced that the increase in the CPI for medical care for the 12 months ending June 30, 2005 was 4.2 percent. Consequently, the furnishing fee for CY 2006, initially established effective January 1, 2005, at $0.14 per unit of clotting factor, for CY 2006 was set at $0.146 per individual unit (I.U.) for blood clotting factor. We indicated in the preamble to that rule that while "the furnishing fee payment rate is calculated at 3 digits, the actual amount paid to providers and suppliers is rounded to 2 digits."

The fiscal intermediaries continue to use the Medicare Part B Drug Pricing File to make payments for blood clotting factor. The furnishing fee is included in the ASP price per unit sent with the Medicare Part B Drug Pricing File that is updated annually. By using the Medicare Part B Drug Pricing File, Medicare will be making consistent payments for blood clotting factor provided to inpatients and outpatients. For further updates on pricing, we refer readers to the Medicare Part B drug pricing regulations.

Comment: Two commenters addressed the blood clotting policy in response to the proposed rule. One commenter supported CMS in its quest for a uniform approach for drug payment. Both commenters recommended that CMS continue to provide the additional payment for blood clotting factor administered to hemophiliac inpatients in the future even if severity-adjusted DRGs are implemented.

Response: We appreciate the commenters' support. The blood clotting factor policy will remain unchanged even if there are changes to the DRG system. CMS will continue to provide the additional payment for blood clotting factor administered to hemophilia inpatients. As we stated in our proposed rule (79 FR 24136) and restated in this final rule, by fiscal intermediaries utilizing the Medicare Part B Drug Pricing File, Medicare will be making consistent payments for blood clotting factor provided to inpatients and outpatients. For further updates on pricing, readers should refer to the Medicare Part B drug pricing regulations.

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

A. Background

Under section 1861(v)(1) of the Act and § 413.89 of our existing regulations, Medicare may pay some or all of the uncollectible deductible and coinsurance amounts to those entities paid under a reasonable cost payment methodology that are eligible to receive payment for bad debt. Under our existing regulations, Medicare generally pays 100 percent of allowable bad debt amounts to most entities eligible to receive bad debt payment, including SNFs, CAHs, rural health clinics, federally qualified health clinics, community mental health clinics, health maintenance organizations reimbursed on a cost basis, competitive medical plans, and health care prepayment plans. To determine if bad debt amounts are allowable, the requirements at § 413.89 and the Provider Reimbursement Manual (PRM) (CMS Pub. 15 Part 1, Chapter 3) must be met.

However, under section 1861(v)(1)(T)(iv) of the Act and our existing regulations, Medicare payments for allowable bad debt amounts for hospitals are reduced by 30 percent. Moreover, under our existing regulations, Medicare does not pay for bad debt amounts arising from anesthetists' services paid under a fee schedule (§ 413.89(i)). In addition, although Medicare pays end-stage renal disease (ESRD) facilities 100 percent of allowable bad debt claims, these payments are capped at facilities' unrecovered cost (§ 413.178 of the regulations).

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

Section 5004 of Pub. L. 109–171 (DRA of 2005) amended section 1861(v)(1) of the Act to mandate that, for cost reporting periods beginning on or after October 1, 2005, Medicare payments to SNFs for certain allowable bad debt amounts be reduced. Specifically, for Medicare beneficiaries who are not dual eligible individuals (as defined in section 1935(c)(6)(A)(ii) of the Act), allowable bad debt amounts attributable to the coinsurance amounts under the Medicare program are reduced by 30 percent (deductibles are not applicable to patients in SNFs). Allowable bad debt

amounts for Medicare beneficiaries who are dual eligible individuals (as defined in section 1935(c)(6)(A)(ii) of the Act) will continue to be paid at 100 percent.

C. Proposed Regulation Changes

In the FY 2007 IPPS proposed rule (71 FR 24137), we proposed to conform the Medicare regulations under § 413.89 to the provisions of section 5004 of Pub. L. 109–171. Specifically, we proposed to revise paragraph (h) by redesignating the existing contents as paragraph (h)(1) and add a new paragraph (h)(2) to reflect this payment limitation. We proposed to include in paragraph (h)(2) a cross-reference to the definition of "full-benefit dual eligible individual" found at § 423.772 of our regulations. In addition, we proposed to revise § 413.89(a) to add a cross-reference to the existing limitations on payments to hospitals and the proposed new limitations on payments to SNFs found in paragraph (h), and to correct the cross-reference to the exception for payments for bad debts arising from anesthetists' services paid under a fee schedule from "paragraph (h)" to "paragraph (i)."

Comment: One commenter expressed concern that under the proposed definition of a "full benefit dual eligible individual" found at § 423.772 of our regulations, SNFs will not only have to document that the patient is eligible for both Medicare and Medicaid services but also will now have to document that the patient has coverage under a prescription drug plan under Part D of Title XVIII of the Act or under an MA–PD plan under Part C of Title XVIII of the Act. The commenter stated that the additional documentation will increase the burden on SNFs to provide documentation.

Response: After reviewing the legislative background associated with section 5004 of Pub. L. 109–171, we determined that it was not the Congress' intent to reduce bad debt payments to SNFs for individuals who are eligible for both Medicare and Medicaid, also known as dual eligible individuals. Section 5004 defines "dual eligible individuals" as individuals who are entitled to benefits under Part A of Medicare and are described in section 1935(c)(6)(A)(ii) of the Act.

The definition of a "full-benefit dual eligible individual" at section 1935(c)(6)(A) of the Act is codified at § 423.772 of the regulations. Specifically, section 1935(c)(6)(A) of the Act defines a "full-benefit dual eligible individual" in terms of both clause (i) and (ii). Section 1935(c)(6)(A)(i) of the Act (and paragraph (1) under the definition of "full-benefit dual eligible individual" at § 423.772) states that the individual must have coverage for the month for covered Part D drugs under a prescription drug plan under Part D of Title XVUIII of the Act or under an MA–PD plan under Part C of title XVIII of the Act. Section 1935(c)(6)(A)(ii) of the Act (and paragraph (2) under the definition of "full-benefit dual eligible individual" at § 423.772) states the individual must be determined eligible by the State for medical assistance for full benefits under Title XIX of the Act under section 1902(a)(10)(A) or section 1902(a)(10)(C), by reason of section 1902(f) of the Act, or under any other category of eligibility for medical assistance for full benefits under Title XIX of the Act. Clearly, the Congress did not include the criterion at section 1935(c)(6)(A)(i) of the Act (and, thus, paragraph (1) under the definition of "full-benefit dual eligible individual" at § 423.772) for defining dual eligible individuals to determine the applicability of the reduction of bad debt payments under section 5004 of Pub. L. 109–171.

Accordingly, for this final rule, we are revising the proposed regulation text at new § 413.89(h)(2) to better conform with the language of the statute by defining a dual eligible individual as an individual who is entitled to benefits under Part A of Medicare and is determined eligible by the State for medical assistance under title XIX as described under paragraph (2) of the definition of a full-benefit dual eligible individual at § 423.772. We believe that this revision addresses the concerns expressed by the commenter.

Comment: One commenter stated that, in April 2006, CMS issued revisions to the freestanding SNF Medicare cost reporting Form 2540–96 and instructions to implement the provisions of section 5004 of Pub. L. 109–171 but has not issued similar revisions to the hospital-based (distinct part) SNF Medicare cost reporting Form 2552–96. The commenter requested that CMS clarify whether the provisions of section 5004 will or will not apply to both freestanding and hospital-based SNFs.

Response: Section 5004 of Pub. L. 109–171 applies to both freestanding and hospital-based SNFs. We are currently preparing revisions to the hospital-based SNF Medicare cost reporting Form 2552–96 and instructions to implement the provisions of section 5004. We anticipate that the revisions will be issued in a Transmittal to the Provider Reimbursement Manual—Part 2 (Pub. #15–2) prior to the publication of this final rule.

After consideration of the public comments received, we are adopting as final, with one modification, the amendments needed to conform our regulations to the provisions of section 5004 of Pub. L. 109–171, and to add and correct the cross-references, as described above.

X. MedPAC Recommendations

We are required by section 1886(e)(4)(B) of the Act to respond to MedPAC's IPPS recommendations in our annual proposed IPPS rule. We have reviewed MedPAC's March 2006 "Report to the Congress: Medicare Payment Policy" and have given it careful consideration in conjunction with the proposed policies set forth in this document. MedPAC's Recommendation 2A states that "The Congress should increase payment rates for the acute inpatient and outpatient prospective payment systems in 2007 by the projected increase in the hospital market basket index less half of the Commission's expectation for productivity growth." This recommendation is discussed in Appendix B to this final rule.

In section II.C. of the preamble of this final rule, we further address MedPAC's 2005 recommendations included in Recommendation 1 in the March 2005 Report to Congress on Physician-Owned Specialty Hospitals as well as Recommendation 3, which recommended that the Secretary implement MedPAC's recommended policies over a transition period. The recommendations in Recommendation 1 relate to refining the DRGs used under the IPPS to more fully capture differences in severity of illness among patients; basing the DRG relative weights on the estimated cost of providing care rather than on charges; and basing the weights on the national average of hospitals" relative values in each DRG. In section II.E. of the preamble to this final rule, we also further address Recommendation 2 of the March 2005 Report on Physician-Owned Specialty Hospitals, which recommended adjusting the DRG relative weights to account for differences in the prevalence of high-cost outlier cases.

For further information relating specifically to the MedPAC reports or to obtain a copy of the reports, contact MedPAC at (202) 653–7220, or visit MedPAC's Web site at: *www.medpac.gov.*

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

A. Background

Section 1016 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) (Pub. L. 108–173) amended the Act to add section 1897, which establishes the Health Care Infrastructure Improvement Program. Section 1897 of the Act authorizes the Secretary to establish a loan program that provides loans to qualifying hospitals for payment of the capital costs of eligible projects. Section 1897(d) of the Act specifies that an eligible project is a project of a qualifying hospital that is designed to improve the health care infrastructure of the hospital, including construction, renovation, or other capital improvements. Section 1897(b) of the Act requires the Secretary to establish the application process, the terms and conditions, and other requirements for the loan program. The statute was subsequently amended by section 6045 of the Emergency Supplemental Appropriations Act for Defense, the Global War on Terror, and Tsunami Relief, 2005 (the Tsunami Relief Act of 2005) (Pub. L. 109–13) to also provide that any determination made by the Secretary under section 1897 of the Act is not subject to any administrative or judicial review.

Section 1897(c)(2) of the Act defines a "qualifying hospital" as a hospital or entity that is engaged in research in the causes, prevention, and treatment of cancer; and is designated as a cancer center by the National Cancer Institute (NCI) or is designated by the State legislature as the official cancer institute of the State and such designation by the State legislature occurred prior to December 8, 2003. Section 1897(c)(3) of the Act, as added by Pub. L. 109–13, specifies that an "entity" has the same meaning as specified in section 501(c)(3) of the Internal Revenue Code of 1986 and is exempt from tax under section 501(a) of the Code; has at least one existing memorandum of understanding or affiliation agreement with a hospital located in the State in which the entity is located; and retains clinical outpatient treatment for cancer on site as well as laboratory research and education and outreach for cancer in the same facility. Section 1897(c)(3) of the Act is effective as if included in the enactment of Pub. L. 108–173.

Section 1897(f) of the Act provides that the Secretary may forgive a loan provided to a qualifying hospital, under terms and conditions that are analogous to the loan forgiveness provision for student loans under part D of title IV of the Higher Education Act of 1965 (20 U.S.C.1087a *et seq.*). However, the Secretary must condition such forgiveness on the establishment by the hospital of (1) an outreach program for cancer prevention, early diagnosis, and treatment that provides services to a substantial majority of the residents of the State or region, including residents of rural areas; (2) an outreach program for cancer prevention, early diagnosis, and treatment that provides services to multiple Indian tribes; and (3) unique research resources (such as population databases), or an affiliation with an entity that has unique research resources.

In addition, section 1897(h) of the Act requires the Secretary to submit to Congress within 4 years after enactment of Pub. L. 108–173 a report on the projects for which loans are provided under section 1897 of the Act and a recommendation as to whether the Congress should authorize the Secretary to continue loans under this section beyond FY 2008.

Prior to the enactment of Pub. L. 109–13, section 1897(g) (1) of the Act provided for the appropriation of $200,000,000 to carry out the loan program. The funds allocated for the loan program are to remain available during the period beginning on July 1, 2004, and ending on September 30, 2008. However, the Congress rescinded $58,000,000, through Pub. L. 109–13, leaving $142,000,000 available for the loan program. Section 1897(g) of the Act also states that, of the $142,000,000, not more than $2,000,000 can be used for the administration of the loan program for each fiscal year from FY 2004 through FY 2008). (We note that no administrative funding was used in FY 2004.)

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

On September 30, 2005, we published two rules in the **Federal Register** (an interim final rule with comment period (70 FR 57368) and a proposed rule (70 FR 57376)) to establish the loan program to improve certain hospital infrastructure, including capital improvement, as provided for under the Health Care Infrastructure Improvement Program established under section 1897 of the Act. In the September 30, 2005 interim final rule with comment period, we set forth, under a new 42 CFR Chapter IV, Subchapter H, Part 505, the Federal regulations established by the Secretary governing requirements for qualifying hospitals or entities, the application process, and the criteria and conditions for selecting eligible projects under the loan program. In the September 30, 2005 proposed rule, we proposed to establish the loan forgiveness criteria for qualifying hospitals that receive loans under the Health Care Infrastructure Improvement Program.

C. Provisions of the Interim Final Rule With Comment Period

1. Loan Qualifying Criteria (§§ 505.3, 505.5(a), and 505.11)

In order to receive a loan under the Health Care Infrastructure Improvement Program, an applicant must meet the statutory definition of a qualifying hospital as defined in sections 1897(c)(2) and (c)(3) of the Act. We incorporated these definitions in the regulations at § 505.3.

We specified in the regulations at § 505.11 that a qualifying hospital must submit an application to CMS by a specified date to request a loan for the capital costs of an eligible project. We specified the requirements and procedures for submittal of the application.

In § 505.5(a), we provided that the capital costs for which a qualifying hospital may obtain a loan are limited to the reasonable costs incurred by the hospital, and capitalized on the Medicare cost report, for any facility or item of equipment that it has acquired the possession or use of at the time the loan funding is awarded.

2. Selection Criteria (§ 505.5(b) and (c))

We established the criteria under which qualifying hospitals are prioritized for the loan program. We specified that we prioritize applicants that meet the following conditions:

(a) The hospital is located in a State that, based on population density, is defined as a rural State.

(2) The hospital is located in a State with multiple Indian tribes.

We indicated that CMS will send written notice to qualifying hospitals that have been selected to participate in the loan program.

3. Terms of the Loan (§§ 505.7 and 505.9)

Under the terms of the loan program, we specified that we require an authorized official of each qualifying hospital to execute a promissory note, loan agreement, or any other approved form that we may designate, to ensure compliance with the terms of the loan program. In the interim final rule, we

indicated that each loan recipient receives a lump sum distribution for which payment of principal and interest is deferred for 60 months beginning with the day of official notification to the qualifying hospital of loan award. The loan repayment period is 20 years. (However, as discussed in section XI.B. of this preamble, in the September 30, 2005 proposed rule, we further proposed forgiveness criteria for loans, as directed by the statute.)

In accordance with the loan criteria, the loan recipient must agree to make payments every month for 20 years until the loan, including interest, is repaid. A loan recipient may make full prepayment or partial prepayment without paying any prepayment charge. When a prepayment is made, the qualifying hospital must provide CMS with written notice.

Furthermore, the loan recipient must agree that the provisions of a loan under section 1897 of the Act does not—

- Relieve the hospital of any obligation to obtain any required State or local permit or approval with respect to the project;
- Limit the right of any unit of State or local government to approve or regulate any rate of return on private equity invested in the project; or
- Otherwise supersede any State or local law (including any regulation) applicable to the construction or operation of the project.

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

We received seven public comments on the September 30, 2005 interim final rule.

Comment: In general, commenters expressed concern that many qualifying hospitals providing cancer care to rural areas and Native populations throughout the country may not qualify to participate in the loan program since the regulatory criteria require that qualifying hospitals be located in one of the ten states listed. Moreover, one commenter was concerned that CMS may have misconstrued Congressional intent in establishing the selection criteria based on the statutory terms for loan forgiveness. The commenter noted that the proposed selection criteria relied on location and population rather than the merits of the application in order to award loans. Some commenters expressed concern that the selection criteria were too restrictive because preference was conferred to the 10 least populated states with the greatest numbers of Indian tribes in the country. Some commenters suggested that CMS expand the selection criteria to allow all qualifying hospitals that serve rural and Indian tribe populations to be considered for loan funds. In addition, one commenter suggested that in order to maximize the benefit to a greater number of applicants, CMS limit the amount of available loan funds to $10 million per State.

Response: The statute instructs the Secretary to establish criteria for selecting among qualifying hospitals that apply for a loan under this section. The criteria are to consider the extent to which the project for which the loan is sought is nationally or regionally significant, in terms of expanding or improving the healthcare infrastructure of the United States or the region or in terms of the medical benefit that the project will have. Section 1897 of the Act also provides for loan forgiveness and, in setting conditions for loan forgiveness, requires that qualifying hospitals establish certain outreach programs that include rural areas and Indian tribe populations. Therefore, we continue to believe it is appropriate to prioritize qualifying hospitals for purposes of making loans to qualifying hospitals based on rural and Indian tribe criteria as previously discussed in the interim final rule. We stated in the interim final rule that, "Since the statute outlines specific criteria in which to forgive loans, we believe that it is consistent with the Congressional intent to give priority to qualifying hospitals that meet at least some of the statutory conditions for loan forgiveness when selecting qualifying hospitals for the loan program" (70 FR 57369). We note that there are many outstanding hospitals providing cancer care in the country and we believe the selection criteria will allow us to select from applicants that both demonstrate merit and meet the priorities that are indicated in the statutory language for this loan program.

In response to the comment regarding State limits on available loan funds, we disagree that a $10 million limit per State would be in the best interests of qualifying hospitals. Section 1897(d) of the Act directs that loan funds are to be used for qualifying projects, defined in statute as "designed to improve the healthcare infrastructure of the hospital, including construction, renovation, or other capital improvements." We note that construction, renovation, or other capital improvement projects for qualifying hospitals providing cancer care are likely to be costly and require large expenditures. We believe limiting the loan amount to a total of $10 million for all applicants within a State could inadvertently cause some qualifying hospitals to receive insufficient funding for their eligible project. Insufficient funding may also hinder a qualifying hospital's ability to establish the outreach programs and unique research resources that are required for loan forgiveness and intended to benefit the community through the qualifying hospital's participation in this loan program.

Comment: One commenter noted that the statutory language did not limit qualifying hospitals to entities that file cost reports and suggested that the regulations be modified to allow a state university/cancer research center that is not an entity described at section 501(c)(3) of the Internal Revenue Code of 1986, but that meets all other requirements, to be considered a qualifying hospital under this loan program. In addition, the commenter asked why CMS proposed that a qualifying hospital that had not acquired the possession and use of assets which it intends as a qualifying project under this loan program must have entered into a contractual obligation for those projects before December 8, 2003, the date of enactment of Pub. L. 108–173.

Response: We are not requiring that qualifying hospitals be entities that file cost reports. Since CMS is administering the program, we believe that it is appropriate to apply our reasonable cost methodology to determine the capital costs of an eligible project where applicable. We note that it is the statute that defines qualifying hospitals to include an entity described at section 501(c)(3) of the Internal Revenue Code of 1986 and not a definition established through regulations. Finally, we believe it is appropriate to specify a deadline for which qualifying hospitals must have had a written commitment of assets intended as eligible projects. A deadline allows CMS to make a determination that the requested loan amount is reasonable and appropriate for the eligible project. Without a deadline we would not be able to determine the parameters of the eligible project. We chose December 8, 2003, because that was the date Pub. L. 108–173 was enacted.

5. Provisions of This Final Rule

This final rule finalizes the provisions set forth in the September 30, 2005 interim final rule with comment, without modification.

D. Proposed Rule on Forgiveness of Indebtedness

In the September 30, 2005 proposed rule, we proposed to establish the loan forgiveness criteria for qualifying hospitals that are selected to participate

in the loan program under the Health Care Infrastructure Improvement Program.

1. Conditions for Loan Forgiveness (§ 505.13)

As specified in section 1897(f) of the Act, we proposed to forgive a loan provided to a qualifying hospital under terms and conditions that are analogous to the loan forgiveness provision for student loans under part D of title IV of the Higher Education Act of 1965 (20 U.S.C. 1087a et seq.). The student loan program specifies that in order to be eligible for loan forgiveness, borrowers are required to satisfy certain conditions, such as completing a service obligation that satisfies certain terms and conditions as determined by the Secretary. Therefore, we proposed that, to fulfill the service obligation, borrowers must meet the loan forgiveness conditions based on the provisions of section 1897(f) of the Act. Section 1897(f) of the Act provides that the Secretary shall condition such forgiveness on the establishment by the hospital of (1) an outreach program for cancer prevention, early diagnosis, and treatment that provides services to a substantial majority of the residents of a State or region, including residents of rural areas; (2) an outreach program for cancer prevention, early diagnosis, and treatment that provides services to multiple Indian tribes; and (3) unique research resources (such as population databases), or an affiliation with an entity that has unique research resources.

In addition, we proposed that the qualifying hospital must submit a written request for loan forgiveness to CMS by the effective date of the final rule (that is, October 1, 2006).

2. Plan Criteria for Meeting the Conditions for Loan Forgiveness (§ 505.15)

In the September 30, 2005 proposed rule, we proposed to specify the loan forgiveness criteria under three domains, as outlined in section XI.C.1 of this preamble, that are consistent with the sections 1897(f)(A), (f)(B), and (f)(C) of the Act: (a) Domain 1—Outreach program for cancer prevention, early diagnosis, and treatment that provides services to a substantial majority of the residents of a State or region, including residents of rural areas; (b) Domain 2—Outreach program for cancer prevention, early diagnosis, and treatment that provides services to multiple Indian tribes; and (c) Domain 3—Unique research resources (such as population databases), or an affiliation with an entity that has unique research resources.

Specifically, we proposed to add §§ 505.13, 505.15, and 505.17 to provide that the qualifying hospital must designate in its plan to CMS—

- The population(s) for which it would target its outreach programs.
- Sufficient detail to clearly describe how it would designate its targeted populations and that the populations designated should be in accordance with the provisions of the statute.
- A detailed description of how it would identify the cancer types that it is targeting.
- A detailed description of the approaches it would be conducting or implementing, including the reasons why the intervention approaches were selected and why they may make a difference in improving cancer care for the targeted population.
- Improvement goals for the prevention, early diagnosis, and treatment, for each cancer type identified in its outreach programs.
- At least one measure (for example, either an outcome measure or a process measure) used to track its progress in achieving the goals it has established for each area of prevention, early diagnosis, and treatment, for each cancer type identified in its plan.
- A description of how it would establish or maintain existing unique research resources or how it would establish or maintain existing unique research resources or an affiliation with another entity that has unique research resources.

We proposed at § 505.13(c) that the qualifying hospital must submit to CMS by the timeframe specified by the Secretary the following: (1) A written request for loan forgiveness; (2) a plan describing how the qualifying hospital would establish, implement or maintain existing outreach programs for its targeted populations; and (3) how it would establish or maintain existing unique research resources or an affiliation with an entity that has unique research resources over the loan deferment period. We proposed to make that timeframe 60 days after the publication of the final rule.

In proposed § 505.3, we proposed to define "outreach programs" as formal cancer programs for teaching, diagnostic screening, therapy or treatment, prevention, or interventions to enhance the health and knowledge of their designated population(s). Likewise, we proposed to define "unique research resources" as resources that are used for the purpose of discovering or testing options related to the causes, prevention, and treatment of cancer.

We invited specific public comments on the type of information that must be included in the plan and the timeframe for a qualifying hospital to submit its plan to CMS. We also solicited comments on whether we should provide more specific criteria for the qualifying hospital to use in defining its targeted populations.

We believed that 60 days after the final rule publication date is reasonable time for qualifying hospitals intending to apply for loan forgiveness to prepare and submit their initial plan, since the loan deferment period is up to 60 months after notification of acceptance in the program and the qualifying hospital would be assessed on its performance during the loan deferment period.

Furthermore, we believed that requiring the qualifying hospitals to submit a plan in which they would determine the targeted population, the types of cancers (that is, the cancer types to be considered), goals for improving prevention, diagnosis, and treatment, and the measures to track their progress in reaching the goals provides flexibility to the qualifying hospitals as they develop, implement, or maintain their outreach programs.

We also believed that it is appropriate to request this level of detail from the qualifying hospitals because section 1897(h) of the Act requires the Secretary to submit a report to the Congress before fiscal year 2008. The report must indicate the projects for which loans are provided under this section and recommend whether the Congress should authorize the Secretary to continue loans under this section beyond fiscal year 2008. Receiving this information from the qualifying hospitals is necessary for the Secretary to make a fully informed recommendation to the Congress.

Under § 505.17, we proposed that the qualifying hospital must submit annual progress reports to CMS describing its progress in achieving its plan or any changes to the initial plan and a final annual report at least 6 months before the end of the 60-month loan deferment period.

Further, we proposed under § 505.19 that, if a qualifying hospital meets the conditions, plan criteria, and reporting requirements for loan forgiveness specified in § 505.13, § 505.15, and § 505.17, the loan would be forgiven. We proposed that if the loan is forgiven, we would send written notification for the loan forgiveness approval to the loan recipient at least 90 days before the end of the loan deferment period. If the loan recipient does not meet the conditions, plan criteria, or reporting requirements

for the loan forgiveness specified in § 505.13, § 505.15, and § 505.17, we proposed that we would send written notification for the denial of the loan forgiveness.

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

We received one public comment on the September 30, 2005 proposed rule.

Comment: One commenter suggested that the proposed loan deferment period of 60 months, during which the qualifying hospital is to establish outreach programs and unique research resources in accordance with the statutory conditions for loan forgiveness, is unnecessarily and excessively protracted. The commenter noted that the statute does not dictate the duration of the loan deferment period and that the statutory conditions for loan forgiveness can and should be accomplished with appropriate speed. The commenter urged CMS to shorten the deferment period, suggesting that 36 months is sufficient time for qualifying hospitals to satisfy the statutory conditions for loan forgiveness. In fact, the commenter believed that the most meaningful steps toward satisfaction of the conditions for loan forgiveness should be accomplished within the first twelve months of the program. The commenter noted that the shortened time period would spur qualifying hospitals to establish the outreach programs and unique research resources more quickly thereby maximizing the benefit to the community and making the most out of the funding.

Response: The proposed loan deferment period of 60 months was intended to ensure that qualifying hospitals had sufficient time to establish the outreach programs and unique research resources to achieve loan forgiveness. In the proposed rule, we specifically requested comments from the public regarding the timeframe in order to assess whether the proposed period was appropriate. We appreciate the commenter's input that it is possible to establish the outreach programs and unique research resources as specified in the proposed rule within 36 months and possibly as early as 12 months, the shortest timeframe for which the commenter suggested the most meaningful steps could be accomplished. While the commenter suggested that 36 months is sufficient time for qualifying hospitals to satisfy the statutory conditions for loan forgiveness, we find that the commenter's additional argument that delaying loan forgiveness could inadvertently and unnecessarily delay providing intended benefits to the public to be compelling. Therefore, considering that a qualifying hospital may be well on the way to satisfying the conditions for loan forgiveness within 12 months, and in order to motivate loan recipients intending to strive for loan forgiveness to provide this benefit to the public as soon as feasible, we are changing the time period in which a qualifying hospital may be assessed and approved for loan forgiveness to as early as 12 months from the date that CMS notifies the qualifying hospital of the award of the loan. We note that, while 60 months was likely an overestimate of the time needed to satisfy the terms for loan forgiveness, we are reluctant to limit all qualifying hospitals to 12 months to accomplish the initiatives required for loan forgiveness based on the submission of one comment. Therefore, we believe it is more appropriate to provide for consideration of loan forgiveness as early as 12 months from the date CMS notifies the qualifying hospital of the awarding of the loan and require that all evaluations for loan forgiveness must conclude no later than 60 months from the date CMS notifies the qualifying hospital of the awarding of the loan.

4. Provisions of the Final Rule

We are adopting as final the proposed changes to § 505.3 and the addition of §§ 505.13 and 505.15, with only minor editorial changes. To accommodate the option in which qualifying hospitals may establish the outreach programs and unique research resources to achieve loan forgiveness as early as 12 months after loan notification, we are modifying § 505.17(b) as proposed to specify that CMS will use the annual report to assess the qualifying hospital's loan forgiveness status and if the annual report shows that the qualifying hospital has fulfilled the conditions, plan criteria, and reporting requirements for loan forgiveness specified in §§ 505.13, 505.15, and § 505.17, CMS will notify the qualifying hospital in writing that the loan is forgiven. We note that at § 505.17(c), we specify that the qualifying hospital's final annual report is due to CMS at least 6 months before the end of the loan deferment period specified in § 505.7(b). We are also modifying § 505.19 to specify that CMS will send a written notification of approval for loan forgiveness to the qualifying hospital by the earlier of (1) 30 days from the date of receipt of the annual report that shows the qualifying hospital has satisfied the requirements for loan forgiveness; or (2) 90 days before the end of the loan deferment period defined in § 505.7(b).

E. Statutory Requirements for Issuance of Regulations

Section 902 of Pub. L. 108–173 (MMA) amended section 1871(a) of the Act and requires the Secretary, in consultation with the Director of the Office of Management and Budget, to establish and publish timelines for the publication of Medicare final regulations based on the previous publication of a Medicare proposed or interim final regulation. Section 902 of the MMA also states that the timelines for these regulations may vary but shall not exceed 3 years after publication of the preceding proposed or interim final regulation except under exceptional circumstances.

This final rule finalizes provisions set forth in the September 30, 2005 interim final rule with comment (70 FR 57368) and the September 30, 2005 proposed rule (70 FR 57376). In addition, this final rule is being published within the 3-year time limit imposed by section 902 of the MMA. Therefore, we believe that the final rule is in accordance with the Congress' intent to ensure timely publication of final regulations.

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

[If you choose to comment on issues in this section, please include the caption "Exclusion of CAP from the ASP Calculation" at the beginning of your comments.]

A. Background

1. Average Sales Price (ASP)

Section 303(c) of Pub. L. 108–173 (the MMA) revised the drug payment methodology by creating a new pricing system based on the ASP of a drug or biological. Effective January 2005, Medicare pays for the vast majority of Part B covered drugs and biologicals using a drug payment methodology based on the ASP. (Please note that information on covered outpatient drugs and biologicals can be found at: *http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/*.) In accordance with sections 1847A and 1927(b)(3)(A) of the Act, manufacturers submit the ASP data for their products to us on a quarterly basis, at the 11-digit National Drug Code (NDC) level.

These data include each manufacturer's total sales (in dollars) and number of units of a drug to all purchasers in the United States in a calendar quarter (excluding certain sales exempted by statute), with limited

exceptions, and other data elements pertaining to the NDC. The sales price is net of discounts such as volume discounts, prompt pay discounts, cash discounts, free goods that are contingent on any purchase requirement, chargebacks, and rebates (other than rebates under section 1927 of the Act). The Medicare payment rate is based on 106 percent of the ASP, less applicable deductible and coinsurance amounts, and is updated quarterly.

2. Competitive Acquisition Program (CAP)

Section 303(d) of Pub. L. 108–173 added a new section 1847B to the Act. This section provides for an alternative payment methodology to the ASP for certain Part B covered drugs and biologicals that are not paid on a cost or prospective payment basis by establishing a CAP for the acquisition of and payment for competitively-biddable Part B covered drugs and biologicals. This program began on July 1, 2006. Physicians now have a choice between—(1) obtaining these drugs from approved CAP vendors; and (2) acquiring and billing for Part B covered drugs under the ASP system. In the March 4, 2005 **Federal Register** (70 FR 10746), we proposed regulations to establish provisions for acquiring and billing for drugs and biologicals through the CAP . (Please note that information on the CAP can be found at: *http://www.cms.hhs.gov/CompetitiveAcquisforBios/.*)

3. Regulatory History

In response to the March 4, 2005 proposed rule, many commenters requested clarification about whether the prices determined under the CAP are taken into account in computing the ASP under section 1847A of the Act. Most commenters recommended that purchases made under the CAP be excluded from the ASP calculation. However, one commenter suggested that, because the CAP was not included in the list of sales that are exempt from the ASP calculation set forth in section 1847A(c)(2) of the Act, prices under the CAP could not be excluded. In our July 6, 2005 interim final rule with comment period (70 FR 39022), we responded that because the CAP was not included in the section 1847A(c)(2) of the Act list of sales that are exempt from the ASP calculation, we believed that sales to vendors made under the CAP must be included in the ASP.

Commenters on the July 6, 2005 interim final rule with comment period reiterated their objections to including purchases made by vendors under the CAP in the ASP calculations. These commenters requested that we change our interpretation of our statutory authority. Several commenters provided detailed legal arguments supporting the exclusion of purchases by vendors made under the CAP from the calculation of ASP.

Some commenters stated that we could use our demonstration authority to exclude CAP prices from ASP. Other commenters took the position that we could use our authority to establish CAP drug categories to establish a category of drugs and biologicals that would be excluded from the ASP calculation. Several commenters stated that sales to approved CAP vendors should be considered excluded from the determination of "best price" under section 1927(c)(1)(C) of the Act. These commenters maintained that by virtue of this exclusion, prices of CAP drugs and biologicals could be excluded from the calculation of ASP. One commenter contended that sales to CAP vendors are excluded from best price because CAP vendors do not fit squarely into the list of entities contained in the definition of "best price" in section 1927(c)(1)(C)(i) of the Act. Another commenter suggested that approved CAP vendors, as Medicare contractors, should be considered Federal purchasers exempt from the determination of best price under sections 1927(c)(1)(C)(i)(I) through (II) of the Act.

Finally, several commenters stated that the intent of Congress was to create two different and separate structures, with separate pricing, in order to provide physicians with a choice of programs. These commenters referenced the language contained in sections 1847A(a)(2) and 1847B(a)(1)(A) of the Act in support of their contentions. Section 1847A(a)(2) of the Act states that section 1847A "shall not apply in the case of a physician who elects under subsection (a)(1)(A)(ii) of section 1847B for that section to apply instead of this section for the payment for drugs and biologicals." Section 1847B(a)(1)(A) of the Act states that "this section shall not apply in the case of a physician who elects section 1847A to apply." These commenters stated that this language, which is contained in both the ASP and CAP statutory provisions, clearly indicates that Congress intended the two programs to operate independently. These commenters asserted that as independent programs, the pricing methodologies under ASP and the CAP should not be linked. These commenters further believed that including CAP prices in the calculation of ASP would undermine the CAP program by virtually eliminating any incentive that a manufacturer might have to offer discounts to CAP vendors.

In response to the comments that we received on this issue, we revisited our analysis of our statutory authority. In the November 21, 2005 **Federal Register** (70 FR 70477), we published an interim final rule with comment in which we stated that we did not find entirely persuasive the commenters' arguments regarding demonstration authority, best price, or the definition of categories as a legal basis for revising our interpretation. However, we recognized the commenters' concerns about the effect of including CAP prices in the calculation of ASP and agreed that the best outcome for both the ASP methodology and the CAP programs would be one in which prices under CAP did not affect payment amounts under the ASP methodology. In addition, we found compelling the commenters' statements about the separation of the ASP and CAP programs and that the two programs are intended to be alternatives to each other. We acknowledged the possibility that Congress intended the programs to be completely independent of each other.

Therefore, as a result of our reassessment, and in accordance with our statutory authority, including our authority under section 1847A(b)(2)(B) of the Act to establish methods for counting units, we decided to exclude, for the initial 3-year contract period under the CAP, units of CAP drugs that are administered to beneficiaries by participating CAP physicians. We revised § 414.802 (definition of unit) to reflect the exclusion of units of CAP drugs administered to beneficiaries by participating CAP physicians. We further stated that we intend to examine the effect of this exclusion and, if necessary, revisit our decision at the end of the initial 3-year period of the CAP. We also clarified that manufacturers must exclude rebates and lagged price concessions attributable to units of CAP drugs administered to a beneficiary by a participating CAP physician when using the estimation methodology specified in § 414.804.

On April 21, 2006, we announced the selection of the approved CAP vendor for the initial phase of the CAP. The approved CAP vendor is required to provide manufacturers, upon request, with information necessary to determine which sales to the approved CAP vendor are sales of CAP drugs that are excluded from the ASP calculation.

We did not receive any timely comments on the November 21, 2005 interim final rule with comment period. In a March 3, 2006 **Federal Register**

notice (71 FR 10975), we published a PRA notice soliciting comment on our proposed modification of the OMB-approved ASP information collection requirements, regarding the collection of the number of CAP units excluded from the ASP calculation. In response to this notice, a commenter stated that, in certifying the accuracy of the submitted ASP data, manufacturers must rely on approved CAP vendors to provide the number of units of CAP drugs that are administered to beneficiaries by participating CAP physicians. The commenter noted that CAP vendors are the only entities with direct information on CAP units sold. Because of this circumstance, the commenter believed that the requirement to exclude units of CAP drugs administered to beneficiaries by participating CAP physicians places the manufacturer in the untenable position of reporting ASP and certifying reports of ASP based on second-hand information. Further, the commenter noted that manufacturers may not have timely access to this information and they cannot independently confirm its accuracy. The commenter suggested that we consider an alternative approach.

B. Regulation Change

Existing § 414.802 requires that, during the first 3 years of the CAP, the method for counting units excludes units of CAP drugs (as defined in § 414.902) administered to a beneficiary by a participating CAP physician (as defined in § 414.902). As a result of comments received on our March 3, 2006 PRA notice and our ongoing work with manufacturers, we learned that manufacturers were concerned that they would have difficulty obtaining the information necessary to accurately exclude CAP units (as currently defined in § 414.802) from the ASP calculation. We have reexamined our current definition of unit based on the manufacturers concerns.

After reexamination of the issues, we have determined that we did not fully consider that the current definition of unit may have unintended results. For example, an unintended result occurs when, as permitted by the statute in certain emergency situations under the CAP, the participating CAP physician administers a drug from his or her stock and orders a replacement from the approved CAP vendor. Our existing regulations specify a unit qualifies as a CAP unit when it is administered to a beneficiary by a participating CAP physician. However, in this instance, the drug that was administered was obtained outside the CAP, and the drug supplied by the approved CAP vendor was not administered to the beneficiary. Therefore, under our current definition of "unit," under the CAP, the manufacturer could not exclude the units of CAP drugs that participating CAP physicians obtain from approved CAP vendors in accordance with the resupply provisions of § 414.906(e).

This result would have the effect of inappropriately including the sales of units of CAP drugs in the ASP calculation. Moreover, this result is inconsistent with our intended policy. In addition, requiring manufacturers to track administration of units of CAP drugs that approved CAP vendors supply to participating CAP physicians to resupply the physician's stock (in order to determine whether such drugs are ever administered to a Medicare beneficiary for purposes of excluding them from the calculation of ASP) would be burdensome for manufacturers and participating CAP physicians. These burdens are caused by the fact that manufacturers would have to rely on data from the participating CAP physicians to identify such units. However, our regulations and CAP participation agreement do not require participating CAP physicians to track the administration of drugs from their private stock.

Our decision to exclude CAP units from the ASP was based on our concerns about the effect of including CAP prices in the calculation of ASP. The decision also was based on our belief that the best outcome for both the ASP methodology and the CAP programs would be one in which prices under CAP did not affect payment amounts under the ASP methodology. To remedy this unintended result and to better effectuate our intent in excluding CAP units, we are revising the definition of "unit" at § 414.802 for ASP purposes during the first 3 years of the CAP. We are persuaded by the commenters and by our review of the current regulation that: (1) the current definition of unit does not achieve the policy goal of establishing methods of counting units so that the payment amounts under the ASP methodology are not affected by the CAP; and (2) an alternative definition of unit will be significantly less burdensome on manufacturer, CAP vendors, and participating CAP physicians.

Therefore, as a result of our reexamination, and in accordance with our authority under section 1847A(b)(2)(B) of the Act to establish methods for counting units, we have decided to revise our definition of "unit" in our regulations to exclude, for the initial 3-year contract period under the CAP, units of CAP drugs sold to an approved CAP vendor for use under the CAP. We note that the revised definition is consistent with suggestions made by commenters in response to the March 4, 2005 proposed rule. Many commenters suggested that "sales to" or "purchases by" approved CAP vendors be excluded from the calculation of ASP. However, we are clarifying, that only those units of CAP drugs sold to an approved CAP vendor for use under the CAP are excluded from the calculation of ASP.

In implementing this revised definition of unit, it is our intent to facilitate the start up of the CAP and reduce complexities and burdens associated with identifying units of CAP drugs excluded from the calculation of ASP. We believe the revised definition of unit establishes a method for counting units so that the payment amounts under the ASP methodology are not affected by the CAP. Further, we believe that manufacturers can more readily verify excluded units of CAP drugs in accordance with the revised definition.

Manufacturers must continue to exclude rebates and lagged price concessions attributable to units of CAP drugs sold to approved CAP vendors for use under the CAP.

We welcome comments on the exclusion of CAP drug units from the calculation of the ASP. We also seek comments on accounting for this exclusion when estimating lagged price concessions. We will address comments received in a subsequent **Federal Register** document.

After the initial 3-year period of the CAP, we will evaluate the impact on approved CAP vendors, manufacturers, and others of excluding units sold to approved CAP vendors for use under the CAP from the calculation of ASP. If there appears to be a reason not to continue to exclude units of CAP drugs sold to approved CAP vendors for use under the CAP from the calculation of ASP, we will undertake rulemaking to describe our findings and conclusions and to seek public comment.

XIII. Other Required Information

A. Requests for Data From the Public

In order to respond promptly to public requests for data related to the prospective payment system, we have established a process under which commenters can gain access to raw data on an expedited basis. Generally, the data are available in computer tape or cartridge format; however, some files are available on diskette as well as on the Internet at: *http://www.cms.hhs.gov/providers/hipps*. In the FY 2007 IPPS proposed rule (71 FR 24137 through 24139), we published a list of data files

that are available for purchase from CMS or that may be downloaded from the Internet without charge.

B. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comment on the following issues:

•The need for the information collection and its usefulness in carrying out the proper functions of our agency.

•The accuracy of our estimate of the information collection burden.

•The quality, utility, and clarity of the information to be collected.

•Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

The following information collection requirements are included in this final rule and their associated burdens are subject to the PRA:

Section 412.64 Federal Rates for Inpatient Operating Costs for Federal Fiscal Year 2005 and Subsequent Fiscal Years (Reporting of Hospital Quality Data for Annual Hospital Payment Update)

In the FY 2007 IPPS proposed rule (71 FR 23996), we outlined the requirements for this section and we are restating those requirements and burden estimates as part of this final rule. Section 412.64(d)(2) requires hospitals, in order to qualify for the full annual market basket update, to submit quality data on a quarterly basis to CMS, as specified by CMS.

As discussed in the section IV.A. of this preamble, section 5001(a) of Pub. L. 109–171 sets forth new requirements for the Reporting of Hospital Quality Data for Annual Payment Update (RHQDAPU) program. New sections 1886(b)(3)(B)(viii)(III) and (IV) of the Act require that we expand the "starter" set of 10 measures that we currently use. In accordance with section 238(b) of Pub. L. 108–173, effective for all payments beginning with FY 2007, the set of measures will expand from 10 to 21 measures, as we adopt the baseline set of performance measures set forth in a 2005 report issued by the Institute of Medicine (IOM) of the National Academy of Sciences.

The burden estimate has been updated based on increased number of collected measures and the anticipated levels of participation by hospitals. We estimate that there will be approximately 3,700 respondents per year. Of this number, approximately 3,100 hospitals are JCAHO accredited and are currently collected measures and submitting data to the JCAHO on a quarterly basis. Of the JCAHO accredited hospitals, approximately 1,080 are collecting the same measures CMS will be collecting for public reporting and there is no additional burden for these hospitals. Approximately 1,940 of the JCAHO-accredited hospitals will need to collect SCIP in addition to the data already collected for maintaining JCAHO accreditation. Approximately 60 accredited hospitals do not submit for the three starter set topics and must begin collecting and submitting data on all four topics. In addition, there are approximately 600 hospitals that do not participate in the JCAHO accreditation process. These non-JCAHO hospitals will have the additional burden of collecting data on all four topics.

For JCAHO hospitals, we estimate it will take 25 hours per quarter per topic for collection. We expect the burden for hospitals to total 238,560 hours per year, including time allotted for overhead. For non-JCAHO accredited hospitals, we estimate the burden to be 246,000 hours per year including overhead. The total number of burden hours for all hospitals is 485,560 hours. The number of respondents will vary according to the level of voluntary participation. One hundred percent of the data may be collected electronically. There will be no additional burden placed on hospitals that submit this data in response to section 5001(b) of Pub. L. 109–171.

We are revising this collection to include the burden associated with the collection of the additional quality measures. However, the burden associated with the requirements under § 412.64(d) is currently approved under OMB Number 0938–0918, with an expiration date of December 31, 2008.

Section 412.92 Special Treatment: Sole Community Hospitals

In the FY 2007 proposed rule (71 FR 23996), we outlined the requirements for § 412.92. We are restating those requirements and burden estimates as part of this final rule. Section 412.92(b)(3) requires an approved sole community hospital (SCH) to notify the appropriate fiscal intermediary of any change which would affect its classification as an SCH.

The burden associated with this requirement is the time and effort it would take for the SCH to provide such notification to the fiscal intermediary. We estimate that on an annual basis it would take an SCH 1 hour to provide notification. While this requirement is subject to the PRA, we believe the requirement is exempt because it impacts less than 10 SCHs.

Section 412.108 Special Treatment: Medicare-Dependent, Small Rural Hospitals

In the FY 2007 IPPS proposed rule (71 FR 23996), we outlined the requirements for this section. We are restating those requirements and burden estimates as part of this final rule. Section 412.108(b)(4) requires an approved MDH to notify the appropriate fiscal intermediary of any change which would affect its status as an MDH.

The burden associated with this requirement is the time and effort it would take for the MDH to provide such notification to the fiscal intermediary. We estimate that on an annual basis it would take an MDH 1 hour to provide notification. While this requirement is subject to the PRA, we believe the requirement is exempt because it impacts less than 10 MDHs.

Section 412.525 Adjustments to the Federal Prospective Payment

In the RY 2007 LTCH PPS proposed rule (71 FR 4648), we outlined the collection of information requirements associated with § 412.525 and we are restating those requirements and burden estimates as part of this final rule. Section 412.525(a)(4)(iv)(A) states that CMS may specify an alternative to the cost-to-charge ratio otherwise applicable under paragraph (a)(4)(iv)(B) of this section. In addition, a hospital may also request that its fiscal intermediary use a different (higher or lower) CCR based on substantial evidence provided by the hospital.

The burden associated with this requirement is the time and effort necessary for a hospital to gather, process, and submit the necessary documentation to its fiscal intermediary to substantiate its request for the use of a different CCR by its fiscal intermediary. For example, necessary documentation, as stipulated by CMS and the fiscal intermediary, may include but not be limited to financial records documenting the hospital's cost and charges.

The estimated burden for this requirement is 8 hours per hospital. Therefore, we estimate that it would require 80 annual hours (8 hours x 10

facilities), to comply with this requirement.

We initiated the OMB approval process by publishing a 60-day **Federal Register** notice on July 21, 2006 (71 FR 41448).

Section 412.529 Special Payment Provision for Short-Stay Outliers

In the RY 2007 LTCH PPS proposed rule (71 FR 4648), we also outlined the collection of information requirements associated with § 412.529 and we are restating these requirements and burden estimates as part of this final rule. Section 412.529(c)(4)(iv)(A) states that CMS may specify an alternative to the CCR otherwise applicable under paragraph (c)(4)(iv)(B) of this section. In addition, a hospital may also request that its FI use a different (higher or lower) CCR based on substantial evidence provided by the hospital.

The burden associated with this requirement is the time and effort necessary for a hospital to gather, process, and submit the necessary documentation to its fiscal intermediary to substantiate its request for the use of a different CCR by its fiscal intermediary. For example, necessary documentation, as stipulated by CMS and the fiscal itnermediary, may include but not be limited to financial records documenting the hospital's cost and charges.

The estimated burden for this requirement is 8 hours per hospital. Therefore, we estimate that it would require 80 annual hours (8 hours x 10 facilities), to comply with this requirement.

We initiated the OMB approval process by publishing a 60-day **Federal Register** notice on July 21, 2006 (71 FR 41448).

Section 505.13 Conditions for Loan Forgiveness

In the September 30, 2005 **Federal Register** (70 FR 57376), we published a proposed rule that outlined the requirements for § 505.13 and we are restating those requirements and evaluation of the burden as part of this final rule. Section 505.13(d) requires a hospital seeking loan forgiveness to submit to CMS, within the timeframe specified by the Secretary, a written request for loan forgiveness and a loan forgiveness plan that meets the criteria specified in § 505.15.

The burden associated with this requirement is the time and effort needed to draft and submit the written request of forgiveness and the time and effort to develop and submit a loan forgiveness plan. While these requirements are subject to the PRA, we believe they are exempt as defined in 5 CFR 1320.3(c)(4). These requirements will impact less than 10 hospitals.

This final rule imposes collection of information requirements as outlined in the regulation text and specified above. However, this final rule also makes reference to several associated information collections that are not discussed in the regulation text. The following is a discussion of these collections, which have received the Office of Management and Budget's (OMB) approval:

Occupational Mix Adjustment to the FY 2007 Index (Hospital Wage Index Occupational Mix Survey)

As stated in section III.C. and III.G. of this preamble, for FY 2007 in order to comply with the Bellevue decision, CMS will base the occupational mix adjustment on data collected from the 2006 survey. CMS submitted a revised information collection request to the Office of Management and Budget (OMB) that contained the existing burden and the additional burden associated with collecting new occupational mix data from hospitals to determine the occupational mix adjustment by September 30, 2006.

The burden associated with this information collection request is the time and effort required to collect and submit the data in the Hospital Wage Index Occupational Mix Survey to CMS. While this burden is subject to the PRA, it is already approved under OMB control number 0938–0907, with an expiration date of May 31, 2009.

Revisions to the Wage Index Based on Hospital Redesignations (Medicare Geographic Classification Review Board)

As noted in section III.H of this preamble, section 1886(d)(10) of the Act established the MGCRB, an entity that has the authority to accept IPPS hospital applications requesting geographic reclassification for wage index or standardized payment amounts and to issue decisions on these requests. It is important for CMS to ensure the accuracy of the MGCRB decisions and remain apprised of potential payment impacts. Our regulations at § 412.256 require a hospital to submit a copy of its MGCRB application to CMS.

The burden associated with this requirement is the time and effort associated with a hospital compiling and submitting a copy of its MGCRB application to CMS. While this requirement is subject to the PRA, it is currently approved under OMB control number 0938–0573, with an expiration date of November 30, 2008.

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

Section XII.A.1 of this preamble provides background information pertaining to the use of the average sales price (ASP) as the basis for our drug payment methodology. In accordance with section 1847A of the Act, most Medicare Part B covered drugs and biologicals not paid on a cost or prospective payment basis are paid based on the average sales price of the drug or biological, beginning in CY 2005. The ASP data reporting requirements are specified in Section 1927 of the Act. The reported ASP data are used to establish the Medicare payment amounts.

Section XII.A.2 and XII.A.3 of this preamble discuss the ASP payment methodology, the CAP for certain Part B covered drugs, and the regulatory history of ASP and CAP. The CAP program began on July 1, 2006. The program provides physicians with a choice between obtaining Part B covered drugs from approved CAP vendors, or acquiring and billing for Part B drugs under the ASP system.

As discussed in a November 21, 2005 (70 FR 70478) interim final rule with comment period and a March 3, 2006 (71 FR 10975) 30-day PRA **Federal Register** notice, the collection of ASP data imposes information collection requirements on the public. The burden associated with ASP information collection requirements is the time and effort required by manufacturers of Medicare Part B drugs and biologicals to prepare and submit the required data to CMS. While these requirements are subject to the PRA, they are currently approved under OMB control number 0938–0921, with an expiration date of May 31, 2009.

As required by section 3504(h) of the Paperwork Reduction Act of 1995, we have submitted a copy of this document to the Office of Management and Budget (OMB) for its review of these information collection requirements.

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

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on the proposed rule. The notice of proposed rulemaking includes a reference to the legal authority under which the rule is proposed, and the terms and substances of the proposed rule or a description of the subjects and

issues involved. This procedure can be waived, however, if an agency finds good cause that a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued.

We find good cause to waive the requirement for publication of a notice of proposed rulemaking and public comment for the provisions of section XII. of this preamble on the grounds that it is necessary to implement this change immediately in order to ensure that a more accurate, and less burdensome, implementation of our policy is in place in time for it to be effective for the next ASP reporting period. We believe that revising the definition of "unit" as described in this rule will best ensure that the payment amounts under the ASP methodology are not affected by the CAP, consistent with our stated policy. Without an immediate revision to the definition of "unit," the regulation requires a level of complexity in determining how to exclude CAP prices that we did not intend and places unintended burdens on participating CAP physicians. Further, unless the revised definition of "unit" is implemented immediately, it would not be effective in time for manufacturers to accurately exclude units of CAP drugs sold to approved CAP vendors for use under the CAP during the third calendar quarter of 2006 and certify their reports.

We also ordinarily provide a 60-day delay in the effective date of the provisions of a rule in accordance with the Administrative Procedure Act, which normally requires a 30-day delay in the effective date of a final rule, and the Congressional Review Act, which requires a 60-day delay in the effective date of a major rule. However, we can waive the delay in effective date if the Secretary finds, for good cause, that the delay is impracticable, unnecessary or contrary to the public interest, and incorporates a statement of the finding and the reasons in the rule issued (5 U.S.C. 553(d)(3); 5 U.S.C. 808(2)).

We find that good cause exists to waive the 60-day delay in effectiveness for the provisions of section XII. of this preamble and § 414.802 so that these portions of this rule take effect immediately upon publication in the **Federal Register**. Unless the revised definition of "unit" is implemented immediately, it would not be effective in time for manufacturers to accurately exclude units of CAP drugs sold to approved CAP vendors for use under the CAP during the third calendar quarter of 2006. As noted above, a delay in implementation of this refinement would impose costs burdens on manufacturers and participating CAP physicians that we did not intend. Further, without this refinement, manufacturers may be unable to certify the accuracy of their ASPs. Because manufactures must certify their ASPs, this refinement must be in place before the beginning of the next ASP reporting period. For these reasons, we find good cause to waive the 60-day delay in the effective date and these regulations will be effective on August 18, 2006.

Moreover, in section II.c.iv. of the Addendum to this final rule, we discuss a technical correction that we are making to remove the second sentence from § 412.116(e) of our regulations. We find it unnecessary to undertake notice-and-comment rulemaking with respect to removing this sentence because this correction merely removes a sentence that previously was struck from our regulations, but was inadvertently reinstated. We note that this change to the regulations underwent notice-and-comment rulemaking when it was initially removed from the regulations (68 FR 34515). Thus, because the public already had opportunity to comment on this policy, additional comment would be unnecessary.

D. Response to Comments

Because of the large number of comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments on the CAP ASP provisions we receive by the date and time specified in the "**DATES**" section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

List of Subjects

42 CFR Part 409

Health Facilities, Medicare.

42 CFR Part 410

Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Rural areas, X-rays.

42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 414

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 424

Emergency medical services, Health facilities, Health professions, Medicare.

42 CFR Part 485

Grant programs—health, Health facilities, Medicaid, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 489

Health facilities, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 505

Administrative practice and procedure, Health facilities, Loan programs, Infrastructure improvement program, Reporting and recordkeeping, and Rural areas.

■ For the reasons stated in the preamble of this final rule, the Centers for Medicare & Medicaid Services is amending 42 CFR Chapter IV as follows:

PART 409—HOSPITAL INSURANCE BENEFITS

■ 1. The authority citation for part 409 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

■ 2. Section 409.3 is amended by revising paragraph (e) under the definition of "Qualified hospital" to read as follows:

§ 409.3 Definitions.

* * * * *

Qualified hospital means a facility that—* * *

(e) If it is a foreign hospital, is licensed, or approved as meeting the standard for licensing, by the appropriate foreign licensing agency, and for purposes of furnishing nonemergency services to U.S. residents, is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or by a foreign program under standards that CMS finds to be equivalent to those of JCAHO.

■ 3. Section 409.5 is revised to read as follows:

§ 409.5 General description of benefits.

Hospital insurance (Part A of Medicare) helps pay for inpatient hospital or inpatient CAH services and posthospital SNF care. It also pays for

home health services and hospice care. There are limitations on the number of days of care that Medicare can pay for and there are deductible and coinsurance amounts for which the beneficiary is responsible. For each type of service, certain conditions must be met as specified in the pertinent sections of this subpart and in part 418 of this chapter regarding hospice care. Conditions for payment of emergency inpatient services furnished by a nonparticipating U.S. hospital and for services furnished in a foreign country are set forth in subparts G and H of part 424 of this chapter.

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

■ 4. The authority citation for part 410 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

■ 5. Section 410.66 is revised to read as follows:

§ 410.66 Emergency outpatient services furnished by a nonparticipating hospital and services furnished in a foreign country.

Conditions for payment of emergency inpatient services furnished by a nonparticipating U.S. hospital and for services furnished in a foreign country are set forth in subparts G and H of part 424 of this chapter.

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

■ 6. The authority citation for part 412 is revised to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh), and sec. 124 of Pub. L. 106–113 (113 Stat. 1501A–332).

■ 7. Section 412.8 is amended by—
■ a. Revising paragraph (b)(2).
■ b. Adding a new paragraph (c).

The revision and addition read as follows:

§ 412.8 Publication of schedules for determining prospective payment rates.

* * * * *

(b) * * *

(2) Except as provided in paragraph (c) of this section, CMS publishes a **Federal Register** document setting forth final methods, amounts, and factors for determining inpatient prospective payment rates not later than the August 1 before the Federal fiscal year in which the rates would apply.

(c) *Publication schedule for FY 2007.* For FY 2007, not later than August 1, 2006, CMS publishes a **Federal Register** document setting forth a description of the methodology and data used in computing the inpatient prospective payment rates for that year.

■ 8. Section 412.22 is amended by—
■ a. Revising the introductory text of paragraph (f).
■ b. Adding a new paragraph (f)(3).
■ c. Revising paragraph (h)(1).
■ d. In paragraph (h)(2), removing the phrase "(h)(3), (h)(6), and (h)(7) of this section" and adding the phrase "(h)(3), (h)(4), (h)(5), (h)(7), and (h)(8) of this section" in its place.
■ e. Redesignating paragraphs (h)(5), (h)(6), and (h)(7) as paragraphs (h)(6), (h)(7), and (h)(8), respectively.
■ f. Revising paragraph (h)(3).
■ g. Revising paragraph (h)(4).
■ h. Adding a new paragraph (h)(5).
■ i. In newly redesignated paragraph (h)(6), removing the phrase "(h)(1) through (h)(4) of this section" and adding the phrase "(h)(1) through (h)(5) of this section" in its place.

The revisions and addition read as follows:

§ 412.22 Excluded hospitals and hospital units: General rules.

* * * * *

(f) *Applicotion for certoin hospitals.* Except as provided in paragraph (f)(3) of this section, if a hospital was excluded from the prospective payment systems under the provisions of this section on or before September 30, 1995, and at that time occupied space in a building also used by another hospital, or in one or more buildings located on the same campus as buildings used by another hospital, the criteria in paragraph (e) of this section do not apply to the hospital as long as the hospital—

* * * * *

(3) For cost reporting periods beginning on or after October 1, 2006, in applying the provisions of paragraph (f)(1) or (f)(2) of this section, any hospital that was excluded from the prospective payment systems under the provisions of this section on or before September 30, 1995, and at that time occupied space in a building also used by another hospital, or in one or more buildings located on the same campus as buildings used by another hospital may increase or decrease the square footage or decrease the number of beds considered to be part of the hospital at any time without affecting the provisions of paragraph (f)(1) or (f)(2) of this section.

(i) If a hospital to which the provisions of paragraph (f)(1) of this section applies decreases its number of beds below the number of beds considered to be part of the hospital on September 30, 1995, it may subsequently increase the number of beds at any time as long as the resulting total number of beds considered to be part of the hospital does not exceed the number of beds at the hospital on September 30, 1995.

(ii) If a hospital to which the provisions of paragraph (f)(2) of this section applies decreases its number of beds below the number of beds considered to be part of the hospital on September 30, 2003, it may subsequently increase the number of beds at any time as long as the resulting total number of beds considered to be part of the hospital does not exceed the number of beds at the hospital on September 30, 2003.

* * * * *

(h) *Sotellite facilities.* (1) For purposes of paragraphs (h)(2) through (h)(5) of this section, a satellite facility is a part of a hospital that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital.

* * * * *

(3) Except as provided in paragraphs (h)(4) and (h)(5) of this section, the provisions of paragraph (h)(2) of this section do not apply to—

* * * * *

(4) For cost reporting periods beginning before October 1, 2006, in applying the provisions of paragraph (h)(3) of this section, any hospital structured as a satellite facility on September 30, 1999, may increase or decrease the square footage of the satellite facility or may decrease the number of beds in the satellite facility if these changes are made necessary by relocation of a facility—

(i) To permit construction or renovation necessary for compliance with changes in Federal, State, or local law; or

(ii) Because of catastrophic events such as fires, floods, earthquakes, or tornadoes.

(5) For cost reporting periods beginning on or after October 1, 2006, in applying the provisions of paragraph (h)(3) of this section—

(i) Any hospital structured as a satellite facility on September 30, 1999, may increase or decrease the square footage or decrease the number of beds considered to be part of the satellite facility at any time without affecting the provisions of paragraph (h)(3) of this section; and

(ii) If the satellite facility decreases its number of beds below the number of beds considered to be part of the satellite facility on September 30, 1999,

it may subsequently increase the number of beds at any time as long as the resulting total number of beds considered to be part of the satellite facility does not exceed the number of beds at the satellite facility on September 30, 1999.

* * * * *

■ 9. Section 412.25 is amended by—

■ a. In paragraph (e) introductory text, remove the cross-reference "paragraph (e)(2) and (e)(4)" and add the cross-reference "paragraph (e)(2) and (e)(5)" in its place.

■ b. In paragraph (e)(2) introductory text, remove the cross-reference "paragraph (e)(3) and (e)(5)" and add the cross-reference "paragraph (e)(3) and (e)(6)" in its place.

■ c. Revising paragraph (e)(3).

■ d. Revising paragraph (e)(4) introductory text.

■ e. Redesignating paragraph (e)(5) as (e)(6).

■ f. Adding a new paragraph (e)(5).

The revisions and addition read as follows:

§ 412.25 Excluded hospital units: Common requirements.

* * * * *

(e) * * *

(3) Except as specified in paragraphs (e)(4) and (e)(5) of this section, the provisions of paragraph (e)(2) of this section do not apply to any unit structured as a satellite facility on September 30, 1999, and excluded from the prospective payment systems on that date, to the extent the unit continues operating under the same terms and conditions, including the number of beds and square footage considered to be part of the unit at the satellite facility on September 30, 1999.

(4) In applying the provisions of paragraph (e)(3) of this section, any unit structured as a satellite facility on September 30, 1999, may increase or decrease the square footage of the satellite facility or may decrease the number of beds in the satellite facility considered to be part of the satellite facility at any time, if these changes are made by the relocation of a facility—

* * * * *

(5) For cost reporting periods beginning on or after October 1, 2006, in applying the provisions of paragraph (e)(3) of this section—

(i) Any unit structured as a satellite facility on September 30, 1999, may increase the square footage of the unit only at the beginning of a cost reporting period or decrease the square footage or number of beds considered to be part of the satellite facility subject to the provisions of paragraph (b)(2) of this section, without affecting the provisions of paragraph (e)(3) of this section; and

(ii) If the unit structured as a satellite facility decreases its number of beds below the number of beds considered to be part of the satellite facility on September 30, 1999, subject to the provisions of paragraph (b)(2) of this section, it may subsequently increase the number of beds at the beginning or a cost reporting period as long as the resulting total number of beds considered to be part of the satellite facility does not exceed the number of beds at the satellite facility on September 30, 1999.

* * * * *

§ 412.42 [Amended]

■ 10. In paragraph (d) of § 412.42, the cross-reference "§ 405.310(k)" is removed, and the cross-reference "§ 411.15(k)" is added in its place.

§ 412.48 [Amended]

■ 11. In paragraph (b) of § 412.48, the cross-reference "§§ 405.330 through 405.332" is removed and the cross-reference "§ 411.400 and § 411.402" is added in its place.

■ 12. Section 412.64 is amended by—

■ a. Revising paragraph (d)(2).

■ b. Adding a new paragraph (h)(6).

The revision and addition read as follows:

§ 412.64 Federal rates for inpatient operating costs for Federal fiscal year 2005 and subsequent fiscal years.

* * * * *

(d) * * *

(2)(i) In the case of a "subsection (d) hospital," as defined under section 1886(d)(1)(B) of the Act, that does not submit quality data on a quarterly basis to CMS, in the form and manner specified by CMS, the applicable percentage change specified in paragraph (d)(1) of this section is reduced—

(A) For fiscal years 2005 and 2006, by 0.4 percentage points; and

(B) For fiscal year 2007 and subsequent fiscal years, by 2.0 percentage points.

(ii) Any reduction of the percentage change will apply only to the fiscal year involved and will not be taken into account in computing the applicable percentage change for a subsequent fiscal year.

* * * * *

(h) * * *

(6) If a new rural hospital that is subject to the hospital inpatient prospective payment system opens in a State that has an imputed rural floor and has rural areas, CMS uses the imputed floor as the hospital's wage index until the hospital's first cost report as an inpatient prospective payment system provider is contemporaneous with the cost reporting period being used to develop a given fiscal year's wage index.

* * * * *

■ 13. A new § 412.79 is added to Subpart E to read as follows:

§ 412.79 Determination of the hospital-specific rate for inpatient operating costs for Medicare-dependent, small rural hospitals based on a Federal fiscal year 2002 base period.

(a) *Base-period costs*—(1) *General rule.* Except as provided in paragraph (a)(2) of this section, for each MDH, the intermediary determines the MDH's Medicare Part A allowable inpatient operating costs, as described in § 412.2(c), for the 12-month or longer cost reporting period beginning on or after October 1, 2001, and before October 1, 2002.

(2) *Exceptions.* (i) If the MDH's last cost reporting period beginning before October 1, 2002, is for less than 12 months, the base period is the MDH's most recent 12-month or longer cost reporting period beginning before that short cost reporting period.

(ii) If the MDH does not have a cost reporting period beginning on or after October 1, 2001, and before October 1, 2002, and does have a cost reporting period beginning on or after October 1, 2000, and before October 1, 2001, that cost reporting period is the base period unless the cost reporting is for less than 12 months. In that case, the base period is the MDH's most recent 12-month or longer cost reporting period beginning before that short cost reporting period.

(b) *Costs on a per discharge basis.* The intermediary determines the MDH's average base-period operating cost per discharge by dividing the total operating costs by the number of discharges in the base period. For purposes of this section, a transfer as described in § 412.4(b) is considered to be a discharge.

(c) *Case-mix adjustment.* The intermediary divides the average base-period cost per discharge by the MDH's case-mix index for the base period.

(d) *Updating base period costs.* For purposes of determining the updated base-period costs for cost reporting periods beginning in Federal fiscal year 2002, the update factor is determined using the methodology set forth in § 412.73(c)(14) and (c)(15).

(e) *DRG adjustment.* The applicable hospital-specific cost per discharge is multiplied by the appropriate DRG weighting factor to determine the hospital-specific base payment amount

(target amount) for a particular covered discharge.

(f) *Notice of hospital-specific rate.* The intermediary furnishes the MDH a notice of its hospital-specific rate which contains a statement of the hospital's Medicare Part A allowable inpatient operating costs. number of Medicare discharges, and case-mix index adjustment factor used to determine the hospital's cost per discharge for the Federal fiscal year 2002 base period.

(g) *Right to administrative and judicial review.* An intermediary's determination of the hospital-specific rate for a hospital is subject to administrative and judicial review. Review is available to an MDH upon receipt of the notice of the hospital-specific rate. The notice is treated as a final intermediary determination of the amount of program reimbursement for purposes of subpart R of Part 405 of this chapter, governing provider reimbursement determinations and appeals.

(h) *Modification of hospital-specific rate.* (1) The intermediary recalculates the hospital-specific rate to reflect the following:

(i) Any modifications that are determined as a result of administrative or judicial review of the hospital-specific rate determinations; or

(ii) Any additional costs that are recognized as allowable costs for the MDH's base period as a result of administrative or judicial review of the base-period notice of amount of program reimbursement.

(2) With respect to either the hospital-specific rate determination or the amount of program reimbursement determination, the actions taken on administrative or judicial review that provide a basis for recalculations of the hospital-specific rate include the following:

(i) A reopening and revision of the MDH's base-period notice of amount of program reimbursement under §§ 405.1885 through 405.1889 of this chapter.

(ii) A prehearing order or finding issued during the provider payment appeals process by the appropriate reviewing authority under § 405.1821 or § 405.1853 of this chapter that resolved a matter at issue in the MDH's base-period notice of amount of program reimbursement.

(iii) An affirmation, modification, or reversal of a Provider Reimbursement Review Board decision by the Administrator of CMS under § 405.1875 of this chapter that resolved a matter at issue in the hospital's base-period notice of amount of program reimbursement.

(iv) An administrative or judicial review decision under §§ 405.1831, 405.1871, or 405.1877 of this chapter that is final and no longer subject to review under applicable law or regulations by a higher reviewing authority, and that resolved a matter at issue in the hospital's base-period notice of amount of program reimbursement.

(v) A final, nonappealable court judgment relating to the base-period costs.

(3) The adjustments to the hospital-specific rate made under paragraphs (h)(1) and (2) of this section are effective retroactively to the time of the intermediary's initial determination of the rate.

(i) *Maintaining budget neutrality.* CMS makes an adjustment to the hospital-specific rate to ensure that changes to the DRG classifications and recalibrations of the DRG relative weights are made in a manner so that aggregate payments to section 1886(d) hospitals are not affected.

§ 412.84 [Amended]

■ 14. In paragraph (m) of § 412.84, the cross-reference "paragraph (h)(3)" is removed and the cross-reference "paragraph (i)(4)" is added in its place.

■ 15. Section 412.90 is amended by revising paragraph (j) to read as follows:

§ 412.90 General rules.

* * * * *

(j) *Medicare-dependent, small rural hospitals.* For cost reporting periods beginning on or after April 1, 1990, and before October 1, 1994, and for discharges occurring on or after October 1, 1997, and before October 1, 2011, CMS adjusts the prospective payment rates for inpatient operating costs determined under subparts D and E of this part if a hospital is classified as a Medicare-dependent, small rural hospital.

* * * * *

■ 16. Section 412.92 is amended by—

■ a. In paragraph (b)(2)(iv) of § 412.92, the word "djustment" is removed and the word "adjustment" is added in its place.

■ b. Revising paragraph (b)(3) to read as follows:

§ 412.92 Special treatment: Sole community hospitals.

* * * * *

(b) * * *

(3) *Duration of classification.*

(i) An approved classification as a sole community hospital remains in effect without need for reapproval unless there is a change in the circumstances under which the classification was approved. An approved sole community hospital must notify the fiscal intermediary if any change that is specified in paragraph (b)(3)(ii) of this section occurs. If CMS determines that a sole community hospital failed to comply with this requirement, CMS will cancel the hospital's classification as a sole community hospital effective with the date that the hospital no longer met the criteria for such classification, consistent with the provisions of § 405.1885 of this chapter.

(ii) A sole community hospital must report the following to the fiscal intermediary within 30 days of the event:

(A) The opening of a new hospital in its service area.

(B) The opening of a new road between itself and a like provider within 35 miles.

(C) An increase in the number of beds to more than 50 if the hospital qualifies as a sole community hospital under paragraph (a)(1)(ii) of this section.

(D) Its geographic classification changes.

(E) Any changes to the driving conditions that result in a decrease in the amount of travel time between itself and a like provider if the hospital qualifies as a sole community hospital under paragraph (a)(3) of this section.

(iii) A sole community hospital must report to the fiscal intermediary if it becomes aware of any change that would affect its classification as a sole community hospital beyond the events listed in paragraph (b)(3)(ii) of this section within 30 days of the event. If CMS determines that a sole community hospital has failed to comply with this requirement, CMS will cancel the hospital's classification as a sole community hospital effective with the date the hospital became aware of the event that resulted in the sole community hospital no longer meeting the criteria for such classification, consistent with the provisions of § 405.1885 of this chapter.

* * * * *

■ 17. Section 412.96 is amended by—

■ a. Revising paragraph (c)(2)(i) introductory text.

■ b. Revising paragraph (c)(2)(ii).

■ c. Revising paragraph (i)(3).

The revisions read as follows:

§ 412.96 Special Treatment: Referral centers.

* * * * *

(c) * * *

(2) *Number of discharges.* (i) CMS sets forth the national and regional number of discharges in each year's annual notice of prospective payment rates

published under § 412.8(b). The methodology CMS uses to calculate these criteria is described in paragraph (i) of this section. Except as provided in paragraph (c)(2)(ii) of this section for an osteopathic hospital, for the hospital's cost reporting period that began during the same fiscal year as the cost reporting periods used to compute the regional median discharges under paragraph (i) of this section, its number of discharges (not including discharges from units excluded from the prospective payments system under subpart B of this part or from newborn units) is at least equal to—

* * * * *

(ii) For cost reporting periods beginning on or after January 1, 1986, an osteopathic hospital, recognized by the American Osteopathic Healthcare Association (or any successor organization), that is located in a rural area must have at least 3,000 discharges during its cost reporting period that began during the same fiscal year as the cost reporting periods used to compute the regional median discharges under paragraph (i) of this section to meet the number of discharges criterion.

* * * * *

(i) * * *

(3) *Annual notice.* CMS sets forth the national and regional criteria in the annual notice of prospective payment rates published under § 412.8(b). These criteria are compared to an applying hospital's number of discharges for the same cost reporting period used to develop the regional criteria in this section in determining if the hospital qualifies for referral center status for cost reporting periods beginning on or after October 1 of the Federal fiscal year to which the notice applies.

■ 18. Section 412.105 is amended by—

■ a. Revising paragraph (f)(1)(ii)(C).

■ b. Adding a new paragraph (f)(1)(iii)(C).

The addition reads as follows:

§ 412.105 Special treatment: Hospitals that incur indirect costs for graduate medical education programs.

* * * * *

(f) * * *

(1) * * *

(ii) * * *

(C) Effective for discharges occurring on or after October 1, 1997, the time spent by a resident in a nonhospital setting in patient care activities, as defined in § 413.75(b) of this subchapter, under an approved medical residency training program is counted towards the determination of full-time equivalency if the criteria set forth in § 413.78(c), § 413.78(d), or § 413.78(e) of this subchapter, as applicable, are met.

(iii) * * *

(C) In order to be counted, a resident must be spending time in patient care activities, as defined in § 413.75(b) of this subchapter.

* * * * *

■ 19. Section 412.106 is amended by—

■ a. Revising paragraph (a)(1)(iii).

■ b. Republishing the introductory text of paragraph (d)(2)(iv).

■ c. Revising paragraph (d)(2)(iv)(C)(3).

■ d. Adding a new paragraph (d)(2)(iv)(D).

■ e. Adding a new paragraph (d)(2)(v).

The revision and additions read as follows:

§ 412.106 Special treatment: Hospitals that serve a disproportionate share of low-income patients.

(a) * * *

(1) * * *

(iii) The hospital's location, in an urban or rural area, is determined in accordance with the definitions in § 412.64, except that a reclassification that results from an urban hospital reclassified as rural as set forth in § 412.103 is classified as rural.

* * * * *

(d) * * *

(2) * * *

(iv) If the hospital meets the criteria of paragraph (c)(1)(iv) of this section—

* * * * *

(C) * * *

(*3*) Except as provided in paragraph (d)(2)(iv)(D) of this section, the maximum payment adjustment factor is 12 percent.

(D) Effective for discharges occurring on or after October 1, 2006, for a hospital that is classified as a Medicare-dependent, small rural hospital under § 412.108, the payment adjustment factor limitation specified in paragraph (d)(2)(iv)(C)(3) does not apply.

(v) If the hospital meets the criteria of paragraph (c)(2) of this section, the payment adjustment factor is as follows:

(A) 30 percent for discharges occurring on or after April 1, 1990, and before October 1, 1991.

(B) 35 percent for discharges occurring on or after October 1, 1991.

* * * * *

■ 20. Section 412.108 is amended by—

■ a. Revising paragraph (a)(1) introductory text.

■ b. Revising paragraph (b)(4).

■ c. Adding a new paragraph (c)(2)(iii).

The revisions and addition read as follows:

§ 412.108 Special Treatment: Medicare-dependent, small rural hospitals.

(a) *Criteria for classification as a Medicare-dependent, small rural hospital.* (1) *General considerations.* For cost reporting periods beginning on or after April 1, 1990, and ending before October 1, 1994, or for discharges occurring on or after October 1, 1997, and before October 1, 2011, a hospital is classified as a Medicare-dependent, small rural hospital if it is located in a rural area (as defined in subpart D of this part) and meets all of the following conditions:

* * * * *

(b) * * *

(4) A determination of MDH status made by the fiscal intermediary is effective 30 days after the date the fiscal intermediary provides written notification to the hospital. An approved MDH status determination remains in effect unless there is a change in the circumstances under which the status was approved.

(i) An approved MDH must notify the fiscal intermediary if any change occurs that is specified in paragraph (b)(4)(ii) of this section occurs. If CMS determines that an MDH failed to comply with this requirement, CMS will cancel the hospital's classification as an MDH effective with the date that the hospital no longer met the criteria for such status, consistent with the provisions of § 405.1885 of this chapter.

(ii) An MDH must report the following to the fiscal intermediary within 30 days of the event:

(A) The number of beds increases to more than 100.

(B) Its geographic classification changes.

(iii) An MDH must report to the fiscal intermediary if it becomes aware of any change that would affect its classification as an MDH beyond the events listed in paragraph (b)(4)(ii) of this section within 30 days of the event. If CMS determines that an MDH has failed to comply with this requirement, CMS will cancel the hospital's classification as an MDH effective with the date the hospital became aware of the event that resulted in the MDH no longer meeting the criteria for such classification, consistent with the provisions of § 405.1885 of this chapter.

* * * * *

(c) * * *

(2) * * *

(iii) For discharges occurring during cost reporting periods (or portions thereof) beginning on or after October 1, 2006, and before October 1, 2011, 75 percent of the amount that the Federal rate determined under paragraph (c)(1) of this section is exceeded by the highest of the following:

(A) The hospital-specific rate as determined under § 412.73.

(B) The hospital-specific rate as determined under § 412.75.

(C) The hospital-specific rate as determined under § 412.79.

* * * * *

§ 412.116 [Amended]

■ 21. In § 412.116(e), the second sentence is removed.

■ 22. Section 412.234 is amended by—

■ a. In paragraph (a)(3)(ii), removing the term "fiscal year" and adding the term "Federal fiscal year" in its place.

■ b. Revising paragraph (a)(3)(iii).

■ c. Adding a new paragraph (a)(3)(iv).

The revisions and addition read as follows:

§ 412.234 Criteria for all hospitals in an urban county seeking redesignation to another urban area.

(a) * * *

(3) * * *

(iii) For Federal fiscal year 2007, hospitals located in counties that are in the same Combined Statistical Area (CSA) (under the MSA definitions announced by the OMB on June 6, 2003) as the urban area to which they seek redesignation qualify as meeting the proximity requirement for reclassification to the urban area to which they seek redesignation.

(iv) For Federal fiscal year 2008 and thereafter, hospitals located in counties that are in the same Combined Statistical Area (CSA) or Core-Based Statistical Area (CBSA) (under the MSA definitions announced by the OMB on June 6, 2003) as the urban area to which they seek redesignation qualify as meeting the proximity requirements for reclassification to the urban area to which they seek redesignation.

* * * * *

■ 23. Section 412.316 is amended by—

■ a. Revising paragraph (a).

■ b. Revising paragraph (b)(2).

■ c. Adding a new paragraph (b)(3).

■ d. Revising paragraph (c).

The revisions and addition read as follows:

§ 412.316 Geographic adjustment factors.

(a) *Local cost variation.* CMS adjusts for local cost variation based on the hospital wage index value that is applicable to the hospital under subpart D of this part. The adjustment factor equals the hospital wage index value applicable to the hospital raised to the .6848 power and is applied to 100 percent of the Federal rate.

(b) * * *

(2) For discharges occurring on or after October 1, 2004, the definition of large urban area under § 412.63(c)(6) continues to be in effect for purposes of the payment adjustment under this section, based on the geographic classification under § 412.64, except as provided for in paragraph (b)(3) of this section.

(3) For purposes of this section, the geographic classifications specified under § 412.64 apply, except that, effective for discharges occurring on or after October 1, 2006, for an urban hospital that is reclassified as rural as set forth in § 412.103, the geographic classification is rural.

(c) *Cost-of-living adjustment.* CMS provides an additional payment to a hospital located in Alaska and Hawaii equal to [0.3152 x (the cost-of-living adjustment factor used to determine payments under subpart D of this part—1)] percent.

24. Section 412.320 is amended by—

■ a. Revising paragraph (a)(1)(ii).

■ b. Adding a new paragraph (a)(1)(iii).

The revision and addition read as follows:

§ 412.320 Disproportionate share adjustment factor.

(a) * * *

(1) * * *

(ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64, except as provided for in paragraph (a)(1)(iii) of this section.

(iii) For purposes of this section, the geographic classifications specified under § 412.64 apply, except that, effective for discharges occurring on or after October 1, 2006, for an urban hospital that is reclassified as rural as set forth in § 412.103, the geographic classification is rural.

* * * * *

■ 25. Section 412.505 is amended by revising paragraph (b)(1) to read as follows:

§ 412.505 Conditions for payment under the prospective payment system for long-term care hospitals.

* * * * *

(b) *General requirements.* (1) Effective for cost reporting periods beginning on or after October 1, 2002, a long-term care hospital must meet the conditions for payment of this section, § 412.22(e)(3) and (h)(6), if applicable, and § 412.507 through § 412.511 to receive payment under the prospective payment system described in this subpart for inpatient hospital services furnished to Medicare beneficiaries.

* * * * *

§ 412.508 [Amended]

■ 26. In paragraph (c)(3) of § 412.508, the cross-reference "§ 1001.301" is removed and the cross-reference "1001.201" is added in its place.

■ 27. Section 412.511 is revised to read as follows:

§ 412.511 Reporting and recordkeeping requirements.

A long-term care hospital participating in the prospective payment system under this subpart must meet the requirement of §§ 412.22(e)(3) and 412.22(h)(6) to report co-located status, if applicable, and the recordkeeping and cost reporting requirements of §§ 413.20 and 413.24 of this subchapter.

■ 28. Section 412.525 is amended by—

■ a. Revising paragraph (a)(3).

■ b. Revising paragraph (a)(4)(ii).

■ c. Revising paragraph (a)(4)(iii).

■ d. Adding a new paragraph (a)(4)(iv).

■ e. Adding a new paragraph (d)(3).

■ f. Adding a new paragraph (d)(4).

The revisions and additions read as follows:

§ 412.525 Adjustments to the Federal prospective payment.

(a) * * *

(3) The additional payment equals 80 percent of the difference between the estimated cost of the patient's care (determined by multiplying the hospital-specific cost-to-charge ratio by the Medicare allowable covered charge) and the sum of the adjusted LTCH PPS Federal prospective payment and the fixed-loss amount.

(4) * * *

(ii) For discharges occurring on or after August 8, 2003, and before October 1, 2006, high-cost outlier payments are subject to the provisions of § 412.84(i)(1), (i)(3), and (i)(4) and (m) for adjustments of cost-to-charge ratios.

(iii) For discharges occurring on or after October 1, 2003, and before October 1, 2006, high-cost outlier payments are subject to the provisions of § 412.84(i)(2) for adjustments to cost-to-charge ratios.

(iv) For discharges occurring on or after October 1, 2006, high-cost outlier payments are subject to the following provisions:

(A) CMS may specify an alternative to the cost-to-charge ratio otherwise applicable under paragraph (a)(4)(iv)(B) of this section. A hospital may also request that its fiscal intermediary use a different (higher or lower) cost-to-charge ratio based on substantial evidence presented by the hospital. A request must be approved by the CMS Regional Office.

(B) The cost-to-charge ratio applied at the time a claim is processed is based

on either the most recent settled cost report or the most recent tentatively settled cost report, whichever is from the latest cost reporting period.

(C) The fiscal intermediary may use a statewide average cost-to-charge ratio, which CMS establishes annually, if it is unable to determine an accurate cost-to-charge ratio for a hospital in one of the following circumstances:

(*1*) A new hospital that has not yet submitted its first Medicare cost report. (For this purpose, a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with § 489.18 of this chapter.)

(*2*) A hospital whose cost-to-charge ratio is in excess of 3 standard deviations above the corresponding national geometric mean cost-to-charge ratio. CMS establishes and publishes this mean annually.

(*3*) Any other hospital for which data to calculate a cost-to-charge ratio are not available.

(D) Any reconciliation of outlier payments is based on the cost-to-charge ratio calculated based on a ratio of costs to charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled.

(E) At the time of any reconciliation under paragraph (a)(4)(iv)(D) of this section, outlier payments may be adjusted to account for the time value of any underpayments or overpayments. Any adjustment is based upon a widely available index to be established in advance by the Secretary, and is applied from the midpoint of the cost reporting period to the date of reconciliation.

* * * * *

(d) * * *

(3) Patients who are transferred to onsite providers and readmitted to a long-term care hospital, as provided for in § 412.532.

(4) Long-term care hospitals-within-hospitals and satellites of long-term care hospitals as provided in § 412.534.

■ 29. Section 412.529 is amended by revising paragraph (c)(3) to read as follows:

§ 412.529 Special payment provision for short-stay outliers.

* * * * *

(c) * * *

(3)(i) For discharges occurring on or after October 1, 2002, and before August 8, 2003, no reconciliations are made to short-stay outlier payments upon cost report settlement to account for differences between cost-to-charge ratio and the actual cost-to-charge ratio of the case.

(ii) For discharges occurring on or after August 8, 2003, and before October 1, 2006, short-stay outlier payments are subject to the provisions of § 412.84(i)(1), (i)(3), and (i)(4) and (m) for adjustments of cost-to-charge ratios.

(iii) For discharges occurring on or after October 1, 2003, and before October 1, 2006, short-stay outlier payments are subject to the provisions of § 412.84(i)(2) for adjustments to cost-to-charge ratios.

(iv) For discharges occurring on or after October 1, 2006, short-stay outlier payments are subject to the following provisions:

(A) CMS may specify an alternative to the cost-to-charge ratio otherwise applicable under paragraph (c)(3)(iv)(B) of this section. A hospital may also request that its fiscal intermediary use a different (higher or lower) cost-to-charge ratio based on substantial evidence presented by the hospital. This request must be approved by the CMS Regional Office.

(B) The cost-to-charge ratio applied at the time a claim is processed is based on either the most recent settled cost report or the most recent tentatively settled cost report, whichever is from the latest cost reporting period.

(C) The fiscal intermediary may use a statewide average cost-to-charge ratio, which CMS establishes annually, if it is unable to determine an accurate cost-to-charge ratio for a hospital in one of the following circumstances:

(*1*) A new hospital that has not yet submitted its first Medicare cost report. (For this purpose, a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with § 489.18 of this chapter.)

(*2*) A hospital whose cost-to-charge ratio is in excess of 3 standard deviations above the corresponding national geometric mean. CMS establishes and publishes this mean annually.

(*3*) Any other hospital for which data to calculate a cost-to-charge ratio are not available.

(D) Any reconciliation of outlier payments is based on the cost-to-charge ratio calculated based on a ratio of costs to charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled.

(E) At the time of any reconciliation under paragraph (c)(3)(iv)(D) of this section, outlier payments may be adjusted to account for the time value of any underpayments or overpayments. Any adjustment is based upon a widely available index to be established in advance by the Secretary, and is applied from the midpoint of the cost reporting period to the date of reconciliation.

■ 30. Section 412.532 is amended by—

■ a. Revising paragraph (a)(2).

■ b. Revising paragraph (b).

The revisions read as follows:

§ 412.532 Special payment provisions for patients who are transferred to onsite providers and readmitted to a long-term care hospital.

(a) * * *

(2) A satellite facility, as defined in § 412.22(h), that is co-located with the long-term care hospital.

* * * * *

(b) As used in this section, "co-located" or "onsite" facility means a hospital, satellite facility, unit, or SNF that occupies space in a building also used by another hospital or unit or in one or more buildings on the same campus, as defined in § 413.65(a)(2) of this subchapter, as buildings used by another hospital or unit.

* * * * *

§ 412.541 [Amended]

■ 31. In § 412.541, paragraph (b)(2)(i), remove the cross-reference "§ 412.533(b)" and add in its place "§ 412.533(a)(5) and § 412.533(c)".

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

■ 32. The authority citation for part 413 is revised to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1861(v), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395d(d), 1395f(b), 1395g, 1395l(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww); and sec. 124 of Pub. L. 106–133 (113 Stat. 1501A–332).

■ 33. Section 413.74 is amended by revising paragraph (a) to read as follows:

§ 413.74 Payment to a foreign hospital.

(a) *Principle.* Section 1814(f) of the Act provides for the payment of emergency and nonemergency inpatient hospitals services furnished by foreign hospitals to Medicare beneficiaries. Subpart H of part 424 of this chapter, together with this section, specifies the conditions for payment.

* * * * *

■ 34. Section 413.75 is amended by—

■ a. In paragraph (b), revising paragraph (1) under the definition of "Medicare GME affiliated group".

■ b. In paragraph (b), removing the cross-reference "§ 413.79(g)(2)" under paragraph (2) of the definition of "Medicare GME affiliated group" and adding the cross-reference "§ 413.79(f)(2)" in its place.
■ c. In paragraph (b), removing the cross-reference "§ 413.79(g)(2)" under paragraph (3) of the definition of "Medicare GME affiliated group" and adding the cross-reference "§ 413.79(f)(2)" in its place.
■ d. In paragraph (b), adding in alphabetical order the definition of "Patient care activities".

The addition and revision read as follows:

§ 413.75 Direct GME payments: General requirements.

* * * * *

(b) * * *

Medicare GME affiliated group means—

(1) Two or more hospitals that are located in the same urban or rural area (as those terms are defined in subpart D of Part 412 of this subchapter) or in a contiguous area and meet the rotation requirements in § 413.79(f)(2).

* * * * *

Patient care activities means the care and treatment of particular patients, including services for which a physician or other practitioner may bill.

* * * * *

■ 35. Section 413.77 is amended by—
■ a. Revising paragraph (e)(1) introductory text.
■ b. Revising paragraph (e)(1)(i).
■ c. Adding a new paragraph (h).

The revisions and addition read as follows:

§ 413.77 Direct GME payments: Determination of per resident amounts.

* * * * *

(e) *Exceptions*—(1) *Base period for certain hospitals.* If a hospital did not have any approved medical residency training programs or did not participate in Medicare during the base period, but either condition changes in a cost reporting period beginning on or after July 1, 1985, the fiscal intermediary establishes a per resident amount for the hospital using the information from the first cost reporting period during which the hospital participates in Medicare and the residents are on duty during the first month of that period. Effective for cost reporting periods beginning on or after October 1, 2006, if a hospital did not have any approved medical residency training programs or did not participate in Medicare during the base period, but either condition changes in a cost reporting period beginning on or after October 1, 2006, and the residents are not on duty during the first month of that period, the fiscal intermediary establishes a per resident amount for the hospital using the information from the first cost reporting period immediately following the cost reporting period during which the hospital participates in Medicare and residents began training at the hospital. The per resident amount is based on the lower of the amount specified in paragraph (e)(1)(i) or paragraph (e)(1)(ii) of this section, subject to the provisions of paragraph (e)(1)(iii) of this section. Any GME costs incurred by the hospital during the cost reporting period prior to the base period used for calculating the PRA are reimbursed on a reasonable cost basis.

(i) The hospital's actual cost per resident incurred in connection with the GME program(s) based on the cost and resident data from the hospital's base year cost reporting period as established in paragraph (e)(1) of this section.

* * * * *

(h) *Hospital mergers.* Effective for cost reporting periods beginning on or after October 1, 2006, when multiple hospitals merge, a primary care and obstetrics and gynecology weighted average per resident amount and a nonprimary care weighted average per resident amount is calculated, if applicable, for the surviving hospital, using FTE resident data and per resident amount data from the most recently settled cost reports of the respective hospitals prior to the merger.

■ 36. Section 413.78 is amended by—
■ a. Revising paragraph (c)(1).
■ b. Revising paragraph (d)(1).
■ c. Revising paragraph (e)(1).

The revisions read as follows:

§ 413.78 Direct GME payments: Determinations of the total number of FTE residents.

* * * * *

(c) * * *

(1) The resident spends his or her time in patient care activities, as defined in § 413.75(b).

* * * * *

(d) * * *

(1) The resident spends his or her time in patient care activities, as defined in § 413.75(b).

(e) * * *

(1) The resident spends his or her time in patient care activities, as defined in § 413.75(b).

* * * * *

■ 37. Section 413.79 is amended by—
■ a. Revising paragraph (e)(1)(iv).
■ b. In the introductory text of paragraph (f), removing the cross-reference "paragraph (e)(3) of this section" and adding the cross-reference "paragraph (d) of this section" in its place.

The revision reads as follows:

§ 413.79 Direct GME payments: Determination of the weighted number of FTE residents.

* * * * *

(e) * * *

(1) * * *

(iv) Effective for affiliation agreements entered into on or after October 1, 2005, an urban hospital that qualifies for an adjustment to its FTE cap under paragraph (e)(1) of this section is permitted to be part of a Medicare GME affiliated group for purposes of establishing an aggregate FTE cap only if the adjustment that results from the affiliation is an increase to the urban hospital's FTE cap.

* * * * *

■ 38. Section 413.85 is amended by revising paragraph (h)(3) to read as follows:

§ 413.85 Costs of approved nursing and allied health education activities.

* * * * *

(h) * * *

(3) Educational seminars, workshops, and continuing education programs in which the employees or trainees participate that enhance the quality of medical care or operating efficiency of the provider and, effective October 1, 2003, do not lead to the ability to practice and begin employment in a nursing or allied health specialty.

* * * * *

■ 39. Section 413.89 is amended by—
■ a. Revising paragraph (a).
■ b. Revising paragraph (h).

The revisions read as follows:

§ 413.89 Bad debts, charity, and courtesy allowances.

(a) *Principle.* Bad debts, charity, and courtesy allowances are deductions from revenue and are not to be included in allowable cost. However, subject to the limitations described under paragraph (h) of this section and the exception for anesthetists' services described under paragraph (i) of this section, bad debts attributable to the deductibles and coinsurance amounts are reimbursable under the program.

* * * * *

(h) *Limitations on bad debts.* (1) *Hospitals.* In determining reasonable costs for hospitals, the amount of bad debt otherwise treated as allowable costs (as defined in paragraph (e) of this section) is reduced—

(i) For cost reporting periods beginning during fiscal year 1998, by 25 percent;

(ii) For cost reporting periods beginning during fiscal year 1999, by 40 percent;

(iii) For cost reporting periods beginning during fiscal year 2000, by 45 percent; and

(iv) For cost reporting periods beginning during a subsequent fiscal year, by 30 percent.

(2) *Skilled nursing facilities.* For cost reporting periods beginning during fiscal year 2006 or during a subsequent fiscal year, the amount of skilled nursing facility bad debts for coinsurance otherwise treated as allowable costs (as defined in paragraph (e) of this section) for services furnished to a patient who is not a dual eligible individual is reduced by 30 percent. A dual eligible individual is defined for this section as an individual that is entitled to benefits under Part A of Medicare and is determined eligible by the State for medical assistance under Title XIX of the Act as described under paragraph (2) of the definition of a "full-benefit dual eligible individual" at § 423.772 of this chapter.

* * * * *

PART 414—PAYMENT FOR PART B MEDICAL AND OTHER HEALTH SERVICES

■ 40. The authority citation for part 414 continues to read as follows:

Authority: Secs. 1102, 1871, and 1881(b)(1) of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395rr(b)(1)).

■ 41. Section 414.802 is amended by revising the definition of "unit" to read as follows:

§ 414.802 Definitions.

* * * * *

Unit means the product represented by the 11-digit National Drug Code. During the first 3 years of the CAP (as defined in § 414.902), the method of counting units excludes units of CAP drugs (as defined in § 414.902) sold to an approved CAP vendor (as defined in § 414.902) for use under the CAP (as defined in § 414.902).

PART 424—CONDITIONS FOR MEDICARE PAYMENT

■ 42. The authority citation for part 424 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

§ 424.32 [Amended]

■ 43. In § 424.32, in paragraph (b), the phrase "CMS–1490U—Request for Medicare Payment by Organization. (For use by an organization requesting payment for medical services.)" is removed and the phrase "CMS–1491—Request for Medicare Payment—Ambulance. (For use by an organization requesting payment for ambulance services.)" is removed.

§ 424.121 [Amended]

■ 44. In § 424.121, paragraph (c) is amended by removing the cross-reference "§ 405.313" and adding the cross-reference "§ 411.9" in its place.

■ 45. Section 424.123 is amended by revising paragraph (c)(2) to read as follows:

§ 424.123 Conditions for payment for nonemergency inpatient hospital services furnished by a hospital closer to the individual's residence.

* * * * *

(c) * * *

(2) Accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or accredited or approved by a program of the country where it is located under standards the CMS finds to be essentially equivalent to those of the JCAHO.

* * * * *

PART 485—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

■ 46. The authority citation for part 485 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

§ 485.610 [Amended]

■ 47. In paragraph (c) of § 485.610, the phrase "as of October 1, 2006" is removed and the phrase "on or before December 31, 2005" is added in its place.

PART 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

■ 48. The authority citation for part 489 continues to read as follows:

Authority: Secs. 1102, 1819, 1861, 1864(m), 1866, 1869, and 1871 of the Social Security Act (42 U.S.C. 1302, 1395i–3, 1395x, 1395aa(m), 1395cc, 1395ff, and 1395hh).

■ 49. Section 489.24 is amended by—

■ a. Revising the definition of "Labor" under paragraph (b).

■ b. Revising paragraph (f).

The revisions read as follows:

§ 489.24 Special responsibilities of Medicare hospitals in emergency cases.

* * * * *

(b) * * *

Labor means the process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta. A woman experiencing contractions is in true labor unless a physician, certified nurse-midwife, or other qualified medical person acting within his or her scope of practice as defined in hospital medical staff bylaws and State law, certifies that, after a reasonable time of observation, the woman is in false labor.

* * * * *

(f) *Recipient hospital responsibilities.* A participating hospital that has specialized capabilities or facilities (including, but not limited to, facilities such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers, which, for purposes of this subpart, means hospitals meeting the requirements of referral centers found at § 412.96 of this chapter) may not refuse to accept from a referring hospital within the boundaries of the United States an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual. This requirement applies to any participating hospital with specialized capabilities, regardless of whether the hospital has a dedicated emergency department.

* * * * *

SUBCHAPTER H—HEALTH CARE INFRASTRUCTURE IMPROVEMENT PROGRAM

PART 505—ESTABLISHMENT OF THE HEALTH CARE INFRASTRUCTURE IMPROVEMENT PROGRAM

■ 50. The authority citation for part 505 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C 1302 and 1395hh).

■ 51. In § 505.3, the introductory text is republished and definitions of "Outreach programs" and "Unique research resources" are added in alphabetical order to read as follows:

§ 505.3 Definitions.

For purposes of this subpart, the following definitions apply:

* * * * *

Outreach programs mean formal cancer programs for teaching, diagnostic screening, therapy or treatment, prevention, or interventions to enhance the health and knowledge of their designated population(s).

* * * * *

Unique research resources means resources that are used for the purpose of discovering or testing options related

to the causes, prevention, and treatment of cancer.

■ 52. A new Subpart B, containing §§ 505.13, 505.15, 505.17, and 505.19, is added to Part 505 to read as follows:

Subpart B—Forgiveness of Indebtedness

Secs.

Subpart B—Forgiveness of Indebtedness

§ 505.13 Conditions for loan forgiveness.

The Secretary may forgive a loan provided under this part if the qualifying hospital—

(a) Has been selected to participate in the loan program specified in § 505.5(c).

(b) Has established the following in accordance with a plan that meets the criteria specified in § 505.15:

(1) An outreach program for cancer prevention, early diagnosis, and treatment that provides services to a substantial majority of the residents of a State or region, including residents of rural areas;

(2) An outreach program for cancer prevention, early diagnosis, and treatment that provides services to multiple Indian tribes; and

(3) Unique research resources (such as population databases) or an affiliation with an entity that has unique research resources.

(c) Submits to CMS, within the timeframe specified by the Secretary, a—

(1) Written request for loan forgiveness; and

(2) Loan forgiveness plan that meets the criteria specified in § 505.15 of this subpart.

§ 505.15 Plan criteria for meeting the conditions for loan forgiveness.

The qualifying hospital requesting loan forgiveness must submit to CMS a plan specifying how it will develop, implement, or maintain an existing outreach program for cancer prevention, early diagnosis, and treatment for a substantial majority of the residents of a State or region, including residents of rural areas and for multiple Indian tribes and specifying how the qualifying hospital will establish or maintain existing unique research resources or an affiliation with an entity that has unique research resources.

(a) *Outreach programs.* The initial plan must specify how the hospital will establish or develop, implement, or maintain existing outreach programs. The plan must—

(1) Address cancer prevention for cancers that are prevalent in the designated populations or cancers that are targeted by the qualifying hospital, interventions, and goals for decreasing the targeted cancer rates during the loan deferment program; and

(2) Address early diagnosis of cancers that are prevalent in the designated populations or cancers that are targeted by the qualifying hospital, interventions, and goals for improving early diagnosis rates for the targeted cancer(s) during the loan deferment period;

(3) Address cancer treatment for cancers that are prevalent in the designated populations or cancers that are targeted by the qualifying hospital, interventions, and goals for improving cancer treatment rates for the targeted cancer(s) during the loan deferment; and

(4) Identify the measures that will be used to determine the qualifying hospital's annual progress in meeting the initial goals specified in paragraphs (a)(1) through (a)(3) of this section.

(b) *Unique research resources.* The plan must specify how the qualifying hospital will establish or maintain existing unique research resources or an affiliation with an entity that has unique research resources.

§ 505.17 Reporting requirements for meeting the conditions for loan forgiveness.

(a) *Annual reporting requirements.* On an annual basis, beginning one year from the date that CMS notified the qualifying hospital of the loan award, the qualifying hospital must submit a report to CMS that updates the plan specified in § 505.15 by—

(1) Describing the qualifying hospital's progress in meeting its initial plan goals;

(2) Describing any changes to the qualifying hospital's initial plan goals; and

(3) Including at least one measure used to track the qualifying hospital's progress in meeting its plan goals.

(b) *Review of annual reports.* CMS will review each qualifying hospital's annual report to provide the hospital with feedback regarding its loan forgiveness status. If CMS determines that the annual report shows that the qualifying hospital has fulfilled the conditions, plan criteria, and reporting requirements for loan forgiveness specified in §§ 505.13, 505.15, and § 505.17, CMS will notify the qualifying hospital in writing that the loan is forgiven.

(c) *Final annual reporting requirements.* A qualifying hospital must submit its final report to CMS at least 6 months before the end of the loan deferment period specified in § 505.7(b).

§ 505.19 Approval or denial of loan forgiveness.

(a) *Approval of loan forgiveness.* If CMS determines that a qualifying hospital has met the conditions, plan criteria, and reporting requirements for loan forgiveness specified in § 505.13, § 505.15, and § 505.17, CMS will send a written notification of approval for loan forgiveness to the qualifying hospital by the earlier of—

(1) 30 days from the date of receipt of the annual report that shows the qualifying hospital has satisfied the requirements for loan forgiveness; or

(2) 90 days before the end of the loan deferment period defined in § 505.7(b).

(b) *Denial of loan forgiveness.* If CMS determines that a qualifying hospital has not met the conditions, plan criteria, or reporting requirements for loan forgiveness specified in § 505.13, § 505.15, or § 505.17 of this part, CMS will send a written notification of denial of loan forgiveness to the qualifying hospital at least 30 days before the end of the loan deferment period defined in § 505.7(b).

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: July 27, 2006.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Dated: July 31, 2006.

Michael O. Leavitt,

Secretary.

[Editorial Note: The following Addendum and appendixes will not appear in the Code of Federal Regulations.]

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

I. Summary and Background

Due to the unusual circumstances imposed by the order of the Court of Appeals for the Second Circuit in the decision in *Bellevue Hospital Center* v. *Leavitt,* discussed in detail in section III.C. of the preamble of this final rule, we are not able to provide the final FY 2007 occupational mix adjusted wage index tables, payment rates, or impacts in this final rule. Because the wage data affect the calculation of the outlier threshold as well as the outlier offset and budget neutrality factors that are

applied to the standardized amounts, we are only able to provide tentative figures at this time. These tentative amounts will be revised once the occupational mix adjusted wage index is finalized. Subsequent to this final rule, we will publish a **Federal Register** document listing the final standardized amounts, outlier offsets, and budget neutrality factors that are effective October 1, 2006 for FY 2007. The final data also will be published on the CMS Web site.

In this Addendum, we are setting forth a final description of the methods and data we are using to determine the prospective payment rates for Medicare hospital inpatient operating costs and Medicare hospital inpatient capital-related costs. We are also setting forth the final rate-of-increase percentages for updating the target amounts for hospitals and hospital units excluded from the IPPS. We note that, because hospitals excluded from the IPPS are paid on a cost basis (and not by the IPPS), these hospitals are not affected by the tentative figures for standardized amounts, offsets, and budget neutrality factors. Therefore, in this final rule, we are finalizing the rate-of-increase percentages for updating the target amounts for hospitals and hospital units excluded from the IPPS that are effective October 1, 2006.

In general, except for SCHs, MDHs, and hospitals located in Puerto Rico, each hospital's payment per discharge under the IPPS is based on 100 percent of the Federal national rate, which is based on the national adjusted standardized amount. This amount reflects the national average hospital cost per case from a base year, updated for inflation.

SCHs are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal national rate; the updated hospital-specific rate based on FY 1982 costs per discharge; the updated hospital-specific rate based on FY 1987 costs per discharge; or the updated hospital-specific rate based on FY 1996 costs per discharge.

Under section 1886(d)(5)(G) of the Act, MDHs historically have been paid based on the Federal national rate or, if higher, the Federal national rate plus 50 percent of the difference between the Federal national rate and the updated hospital-specific rate based on FY 1982 or FY 1987 costs per discharge, whichever is higher. (MDHs did not have the option to use their FY 1996 hospital-specific rate.) Section 5003(a)(1) of Pub. L. 109–171 extended and modified the MDH special payment provision which was previously set to expire on October 1, 2006, to discharges occurring on or after October 1, 2006, but before October 1, 2011. Under section 5003(b) of Pub. L. 109–171, if the change results in an increase to its target amount, an MDH must rebase its hospital-specific rates to its FY 2002 cost report. In addition, under section 5003(c) of Pub. L. 109–171, MDHs will now be paid based on the Federal national rate or, if higher, the Federal national rate plus 75 percent of the difference between the Federal national rate and the updated hospital-specific rate. Further, based upon section 5003(d) of Pub. L. 109–171, MDHs will no longer be subject to the 12-percent cap on their DSH payment adjustment factor.

For hospitals in Puerto Rico, the payment per discharge is based on the sum of 25 percent of a Puerto Rico rate that reflects base year average costs per case of Puerto Rico hospitals and 75 percent of the Federal national rate. (See section II.D.3. of this Addendum for a complete description.)

As discussed below in section II. of this Addendum, we are making changes in the determination of the prospective payment rates for Medicare inpatient operating costs for FY 2007. In section III. of this Addendum, we discuss our changes for determining the prospective payment rates for Medicare inpatient capital-related costs for FY 2007. Section IV. of this Addendum sets forth our final changes for determining the rate-of-increase limits for hospitals excluded from the IPPS for FY 2007. Section V. of this Addendum sets forth policies on payment for blood clotting factors administered to hemophilia inpatients. The tables to which we refer in the preamble of this final rule are presented in section VI. of this Addendum of this final rule. Some of these tables are based upon tentative data, and the final tables will be presented in a separate document that will be published on the CMS Web site, as well as in the **Federal Register** after publication of this final rule but prior to October 1, 2006.

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

The basic methodology for determining prospective payment rates for hospital inpatient operating costs for FY 2005 and subsequent fiscal years is set forth at § 412.64. The basic methodology for determining the prospective payment rates for hospital inpatient operating costs for hospitals located in Puerto Rico for FY 2005 and subsequent fiscal years is set forth at §§ 412.211 and 412.212. Below we discuss the factors used for determining the prospective payment rates.

In summary, the tentative standardized amounts set forth in Tables 1A, 1B, 1C, and 1D of section VI. of this Addendum reflect—

- Equalization of the standardized amounts for urban and other areas at the level computed for large urban hospitals during FY 2004 and onward, as provided for under section 1886(d)(3)(A)(iv) of the Act, updated by the applicable percentage increase required under sections 1886(b)(3)(B)(i)(XX) and 1886(b)(3)(B)(viii) of the Act.
- The labor-related share that is applied to the tentative standardized amounts and tentative Puerto Rico-specific standardized amounts to give the hospital the highest payment, as provided for under sections 1886(d)(3)(E), and 1886(d)(9)(C)(iv) of the Act.
- Final updates of 3.4 percent for all areas (that is, the full market basket percentage increase of 3.4 percent), as required by section 1886(b)(3)(B)(i)(XX) of the Act, as amended by section 5001(a)(1) of Pub. L. 109–171, and reflecting the requirements of section 1886(b)(3)(B)(viii) of the Act, as added by section 5001(a)(3) of Pub. L. 109–171, to reduce the applicable percentage increase by 2.0 percentage points for a hospital that fails to submit data, in a form and manner specified by the Secretary, relating to the quality of inpatient care furnished by the hospital.
- An adjustment to ensure the DRG recalibration, as provided for under section 1886(d)(4)(C)(iii) of the Act, by applying a final budget neutrality adjustment factor to the standardized amount.
- An adjustment to ensure the wage index update and changes are budget neutral, as provided for under section 1886(d)(3)(E) of the Act.
- An adjustment to ensure the effects of the special transition measures adopted in relation to the implementation of new labor market areas are budget neutral.
- An adjustment to ensure the effects of geographic reclassification are budget neutral, as provided for in section 1886(d)(8)(D) of the Act, by removing the FY 2006 budget neutrality factor and applying a revised factor.
- An adjustment to remove the FY 2006 outlier offset and apply an offset for FY 2007.
- An adjustment to ensure the effects of the rural community hospital demonstration required under section 410A of Pub. L. 108–173 are budget neutral, as required under section 410A(c)(2) of Pub. L. 108–173.

A. Calculation of the Tentative Adjusted Standardized Amount

1. Standardization of Base-Year Costs or Target Amounts

In general, the national standardized amount is based on per discharge averages of adjusted hospital costs from a base period (section 1886(d)(2)(A) of the Act) or, for Puerto Rico, adjusted target amounts from a base period (section 1886(d)(9)(B)(i) of the Act), updated and otherwise adjusted in accordance with the provisions of section 1886(d) of the Act. The September 1, 1983 interim final rule (48 FR 39763) contained a detailed explanation of how base-year cost data (from cost reporting periods ending during FY 1981) were established in the initial development of standardized amounts for the IPPS. The September 1, 1987 final rule (52 FR 33043 and 33066) contains a detailed explanation of how the target amounts were determined, and how they are used in computing the Puerto Rico rates.

Sections 1886(d)(2)(B) and (d)(2)(C) of the Act require us to update base-year per discharge costs for FY 1984 and then standardize the cost data in order to remove the effects of certain sources of cost variations among hospitals. These effects include case-mix, differences in area wage levels, cost-of-living adjustments for Alaska and Hawaii, indirect medical education costs, and costs to hospitals serving a disproportionate share of low-income patients.

In accordance with section 1886(d)(3)(E) of the Act, the Secretary estimates, from time-to-time, the proportion of hospitals' costs that are attributable to wages and wage-related costs. In general, the standardized amount is divided into labor-related and nonlabor-related amounts; only the proportion considered the labor-related amount is adjusted by the wage index. Section 1886(d)(3)(E) of the Act requires that 62 percent of the standardized amount be adjusted by the wage index, unless doing so would result in lower payments to a hospital than would otherwise be made. (Section 1886(d)(9)(C)(iv)(II) of the Act extends this provision to the labor-related share for hospitals located in Puerto Rico.)

For FY 2007, we are not changing the national and Puerto Rico-specific labor-related and nonlabor-related shares from the percentages established for FY 2006. Therefore, the labor-related share will continue to be 69.7 percent for the national standardized amounts and 58.7 percent for the Puerto Rico specific standardized amount. Consistent with section 1886(d)(3)(E) of the Act, we are applying the wage index to a labor-related share of 62 percent for all non-Puerto Rico hospitals whose wage indexes are less than or equal to 1.0000. For all non-Puerto Rico hospitals whose wage indices are greater than 1.0000, we are applying the wage index to a labor share of 69.7 percent of the national standardized amount. For a Puerto Rico hospital, we will apply a labor share of 58.7 percent if its Puerto Rico-specific wage index is less than or equal to 1.0000. For Puerto Rico hospitals whose Puerto Rico-specific wage index values are greater than 1.0000, we will apply a labor share of 62 percent.

The tentative standardized amounts appear in Table 1A, 1B, and 1C of the Addendum to this final rule.

Comment: Several commenters recommended that CMS raise the labor share from 69.7 percent to the previous level of 71.1 percent for hospitals with a wage index greater than one. The commenters explained that a reduced labor share has a negative impact and severe financial strain on their hospitals.

Response: We thank the commenters for their comments. We refer the commenters to the FY 2006 final rule (70 FR 47392–47396) where a full discussion (including comments and responses) on the labor share percentage can be found. As we indicated, our analysis in last year's rule showed that the labor-related share should equal 69.7 percent nationally based on the latest available data.

2. Computing the Tentative Average Standardized Amount

Section 1886(d)(3)(A)(iv) of the Act requires that, beginning with FY 2004 and thereafter, an equal standardized amount is to be computed for all hospitals at the level computed for large urban hospitals during FY 2003, updated by the applicable percentage update. Section 1886(d)(9)(A) of the Act equalizes the Puerto Rico-specific urban and rural area rates. Accordingly, we will calculate FY 2007 national and Puerto Rico standardized amounts, irrespective of whether a hospital is located in an urban or rural location.

3. Updating the Tentative Average Standardized Amount

In accordance with section 1886(d)(3)(A)(iv)(II) of the Act, we are updating the equalized standardized amount for FY 2007 by the full estimated market basket percentage increase for hospitals in all areas, as specified in section 1886(b)(3)(B)(i)(XX) of the Act, as amended by section 5001(a)(1) of Pub. L. 109–171. The percentage change in the market basket reflects the average change in the price of goods and services purchased by hospitals to furnish inpatient care. The most recent forecast of the hospital market basket increase for FY 2007 is 3.4 percent. Thus, for FY 2007, the update to the average standardized amount is 3.4 percent for hospitals in all areas.

Section 1886(b)(3)(B) of the Act specifies the mechanism used to update the standardized amount for payment for inpatient hospital operating costs. Section 1886(b)(3)(B)(viii) of the Act, as added by section 5001(a)(3) of Pub. L. 109–171, provides for a reduction of 2.0 percentage points to the update percentage increase (also known as the market basket update) for FY 2007 and each subsequent fiscal year for any "subsection (d) hospital" that does not submit quality data as discussed in section IV.A. of the preamble of this final rule. The tentative standardized amounts in Tables 1A through 1C of section VI. of this Addendum reflect these differential amounts.

Although the update factors for FY 2007 are set by law, we are required by section 1886(e)(4) of the Act to recommend, taking into account MedPAC's recommendations, appropriate update factors for FY 2007 for both IPPS hospitals and hospitals and hospital units excluded from the IPPS. Our recommendation on the update factors (which is required by sections 1886(e)(4)(A) and (e)(5)(A) of the Act) is set forth in Appendix B of this final rule.

We note that the occupational mix wage index data will have no affect on the market basket increase factor of 3.4 percent. Therefore, the update factors of 3.4 and 1.4 percent are final and not tentative. These update factors (3.4 and 1.4 percent) are one element that will be used to determine the FY 2007 standardized amounts. Other factors, such as the outlier offset and budget neutrality adjustments for wage index and reclassification that are applied to the standardized amounts, are yet to be determined pending the calculation of the occupational mix adjustment. The market basket increase of 3.4 percent is based on the second quarter forecast of the hospital market basket increase by the Office of the Actuary (as discussed in Appendix B of this final rule).

4. Other Adjustments to the Average Standardized Amount

As in the past, we are adjusting the FY 2007 standardized amount to remove the effects of the FY 2006 geographic reclassifications and outlier payments before applying the FY 2007 updates. We then apply budget neutrality offsets

for outliers and geographic reclassifications to the standardized amount based on FY 2007 payment policies.

We do not remove the prior year's budget neutrality adjustments for reclassification and recalibration of the DRG weights and for updated wage data because, in accordance with sections 1886(d)(4)(C)(iii) and 1886(d)(3)(E) of the Act, estimated aggregate payments after the changes in the DRG relative weights and wage index should equal estimated aggregate payments prior to the changes. If we removed the prior year adjustment, we would not satisfy these conditions.

Budget neutrality is determined by comparing aggregate IPPS payments before and after making the changes that are required to be budget neutral (for example, reclassifying and recalibrating the DRGs, updating the wage data, and geographic reclassifications). We include outlier payments in the simulations because they may be affected by changes in these parameters.

We are also adjusting the standardized amount this year by an estimated amount to ensure that aggregate IPPS payments do not exceed the amount of payments that would have been made in the absence of the rural community hospital demonstration required under section 410A of Pub. L. 108–173. This demonstration is required to be budget neutral under section 410A(c)(2) of Pub. L. 108–173.

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

Section 1886(d)(4)(C)(iii) of the Act specifies that, beginning in FY 1991, the annual DRG reclassification and recalibration of the relative weights must be made in a manner that ensures that aggregate payments to hospitals are not affected. As discussed in section II. of the preamble of this final rule, we normalized the recalibrated DRG weights by an adjustment factor, so that the average case weight after recalibration is equal to the average case weight prior to recalibration. However, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals because payments to hospitals are affected by factors other than average case weight. Therefore, as we have done in past years, we are making a budget neutrality adjustment to ensure that the requirement of section 1886(d)(4)(C)(iii) of the Act is met.

As noted above, due to the decision of the *Bellevue* court, we are unable to finalize the wage data used in establishing the FY 2007 IPPS payment factors at this time. We use the wage data to standardize the charges when recalibrating the DRG weights, and therefore, we will recalculate the final DRG weights when the occupational mix adjusted wage data become available. Since the DRG relative weights are not yet final, at this time we are only able to provide the tentative DRG reclassification and recalibration budget neutrality adjustment. Subsequent to this final rule and prior to October 1, 2006, the recalculated DRG weights and the final DRG reclassification and recalibration budget neutrality adjustment will be published in a **Federal Register** notice.

Section 1886(d)(3)(E) of the Act requires us to update the hospital wage index on an annual basis beginning October 1, 1993. This provision also requires us to make any updates or adjustments to the wage index in a manner that ensures that aggregate payments to hospitals are not affected by the change in the wage index. For FY 2007, we are adjusting 100 percent of the wage index factor for occupational mix. We describe the occupational mix adjustment in section III.C. of the preamble to this final rule. However, the data to compute the 100 percent occupational mix adjustment are not available to us at this time. Although section 1886(d)(3)(E) of the Act requires us to update the wage index on a budget neutral basis, we cannot include the effects of the occupational mix adjustment on the wage index in our budget neutrality calculations at this time. Therefore, the budget neutrality adjustment to the standardized amounts that we calculated below is tentative pending the calculation of the occupational mix adjusted wage indices that will be provided on the CMS Web site and in a **Federal Register** notice prior to October 1.

In FY 2005, those urban hospitals that became rural under the new labor market area definitions were assigned the wage index of the urban area in which they were located under the previous labor market definitions for a 3-year period of FY 2005, FY 2006, and FY 2007. Because we are in the third year of this 3-year transition, we are adjusting the standardized amounts for FY 2007 to ensure budget neutrality for this policy. We discuss this adjustment in section III.B. of the preamble to this final rule. Again, the adjustment for this factor will be affected by the occupational mix adjusted wage indices that will be recalculated prior to October 1. For this reason, the adjustment for previously urban hospitals that become rural under the new labor market area definitions is tentative pending final calculation of the occupational mix adjusted wage indices.

Section 4410 of Pub. L. 105–33 provides that, for discharges on or after October 1, 1997, the area wage index applicable to any hospital that is not located in a rural area may not be less than the area wage index applicable to hospitals located in rural areas in that State. This provision is required by section 4410(b) of Pub. L. 105–33 to be budget neutral. Therefore, we include the effects of this provision in our calculation of the wage update budget neutrality factor. As discussed in the FY 2006 IPPS final rule (70 FR 47493), FY 2007 is the third and final year of the 3-year provision that uses an imputed wage index floor for States that have no rural areas and States that have geographic rural areas, but that have no hospitals actually classified as rural. We are also adjusting for the effects of this provision in our calculation of the wage update budget neutrality factor. This figure will also be updated pending calculation of the occupational mix adjusted wage indices.

To comply with the requirement that DRG reclassification and recalibration of the relative weights and the updated wage index be budget neutral, we used FY 2005 discharge data to simulate payments and compared aggregate payments using the FY 2006 relative weights and wage indexes to aggregate payments using the FY 2007 relative weights and wage indexes. The same methodology was used for the FY 2006 budget neutrality adjustment.

Based on this comparison, we computed a tentative budget neutrality adjustment factor equal to 0.997030. We also are adjusting the Puerto Rico-specific standardized amount for the effect of DRG reclassification and recalibration. We computed a tentative budget neutrality adjustment factor for the Puerto Rico-specific standardized amount equal to 0.997968. These budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the FY 2006 budget neutrality adjustments. In addition, as discussed in section IV.E. of the preamble to this final rule, we are applying the same tentative DRG reclassification and recalibration budget neutrality factor of 0.997968 to the hospital-specific rates that are to be effective for cost reporting periods beginning on or after October 1, 2006.

Using the same data, we calculated a tentative transition budget neutrality

adjustment to account for the "hold harmless" policy under which urban hospitals that became rural under the new labor market area definitions were assigned the wage index of the urban area in which they were located under the previous labor market area definitions for a 3-year period of FY 2005, FY 2006, and FY 2007. Using the pre-reclassified wage index, we simulated payments under the new labor market area definitions and compared them to simulated payments under the "hold harmless" policy. Based on this comparison, we computed a tentative transition budget neutrality adjustment of 0.999605.

Comment: Several commenters addressed CMS" policy of excluding data from CAHs when computing the wage index. The commenters believed that the artificial increase in the national average hourly wage has lowered the budget neutrality adjustment by an estimated $1.52 billion over 5 years (2003 through 2007). The commenters stated that CMS should apply a one-time positive budget neutrality adjustment in FY 2007 to compensate for the prior underpayments. They did not believe similar future adjustments would be necessary since very few hospitals are expected "to convert to CAH status now that the necessary provider designation is no longer an option."

Response: We do not believe that the elimination of these data has resulted in an overstated national average hourly wage, nor has the budget neutrality adjustment been inappropriately reduced. Section 1886(d)(3)(E) of the Act requires that wage index adjustments be made in a manner that assures that aggregate payments in a fiscal year are not greater or less than those that would have been made without the wage index adjustment. We calculate the budget neutrality adjustment for the wage index by comparing simulated payments under our current wage index adjustment policies with simulated payments with no wage index adjustment. Our current policy is to exclude CAH data from our calculation of the IPPS wage index, so we believe this policy should be taken into account when we calculate the budget neutrality adjustment for the wage index. Consequently, we will not apply a one-time positive budget neutrality adjustment in FY 2007. We note that a full discussion on the wage index can be found in section III. of the preamble to this final rule.

b. Reclassified Hospitals—Tentative Budget Neutrality Adjustment

Section 1886(d)(8)(B) of the Act provides that, effective with discharges occurring on or after October 1, 1988, certain rural hospitals are deemed urban. In addition, section 1886(d)(10) of the Act provides for the reclassification of hospitals based on determinations by the MGCRB. Under section 1886(d)(10) of the Act, a hospital may be reclassified for purposes of the wage index.

Under section 1886(d)(8)(D) of the Act, the Secretary is required to adjust the standardized amount to ensure that aggregate payments under the IPPS after implementation of the provisions of sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act are equal to the aggregate prospective payments that would have been made absent these provisions. We note that neither the wage index reclassifications provided under section 508 of Pub. L. 108–173 nor the wage index adjustments provided under section 1886(d)(13) of the Act are budget neutral. Section 508(b) of Pub. L. 108–173 provides that the wage index reclassifications approved under section 508(a) of Pub. L. 108–173 "shall not be effected in a budget neutral manner." Section 1886(d)(13)(H) of the Act similarly provides that any increase in a wage index under section 1886(d)(13) shall not be taken into account "in applying any budget neutrality adjustment with respect to such index" under section 1886(d)(8)(D) of the Act. To calculate the tentative budget neutrality factor, we used FY 2005 discharge data to simulate payments, and compared total IPPS payments prior to any reclassifications under sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act to total IPPS payments after such reclassifications. Based on these simulations, we calculated a tentative adjustment factor of 0.991850 to ensure that the effects of this reclassification are budget neutral.

The tentative adjustment factor is applied to the standardized amount after removing the effects of the FY 2006 budget neutrality adjustment factor. We note that the FY 2007 tentative adjustment reflects FY 2007 wage index reclassifications approved by the MGCRB or the Administrator, and the effects of MGCRB reclassifications approved in FY 2005 and FY 2006 (section 1886(d)(10)(D)(v) of the Act makes wage index reclassifications effective for 3 years). As we note earlier in this final rule, CMS will make a FY 2007 reclassification determination for a hospital based on what we believe will be most advantageous to the hospital using the fully occupational mix adjusted wage index. We will calculate the final budget neutrality adjustments for geographic reclassification subsequent to this final rule, but prior to October 1, and will make this information available with the occupational mix adjusted wage indices and final IPPS rates.

c. Outliers

Section 1886(d)(5)(A) of the Act provides for payments in addition to the basic prospective payments for "outlier" cases involving extraordinarily high costs. To qualify for outlier payments, a case must have costs greater than the sum of the prospective payment rate for the DRG, any IME and DSH payments, any new technology add-on payments, and the "outlier threshold" or "fixed loss" amount (a dollar amount by which the costs of a case must exceed payments in order to qualify for an outlier payment). We refer to the sum of the prospective payment rate for the DRG, any IME and DSH payments, any new technology add-on payments, and the outlier threshold as the outlier "fixed-loss cost threshold." To determine whether the costs of a case exceed the fixed-loss cost threshold, a hospital's CCR is applied to the total covered charges for the case to convert the charges to costs. Payments for eligible cases are then made based on a marginal cost factor, which is a percentage of the costs above the fixed-loss cost threshold. The marginal cost factor for FY 2007 is 80 percent, the same marginal cost factor we have used since FY 1995 (59 FR 45367).

In accordance with section 1886(d)(5)(A)(iv) of the Act, outlier payments for any year are projected to be not less than 5 percent nor more than 6 percent of total operating DRG payments plus outlier payments. Section 1886(d)(3)(B) of the Act requires the Secretary to reduce the average standardized amount by a factor to account for the estimated proportion of total DRG payments made to outlier cases. Similarly, section 1886(d)(9)(B)(iv) of the Act requires the Secretary to reduce the average standardized amount applicable to hospitals in Puerto Rico to account for the estimated proportion of total DRG payments made to outlier cases. More information on outlier payments may be found on the CMS Web site at *http://www.cms.hhs.gov/AcuteInpatientPPS/04_outlier.asp#TopOfPage.*

i. FY 2007 tentative outlier fixed-loss cost threshold.

As stated above, the wage index tables, rates, and impacts will not be final in this final rule because we are yet

to determine occupational mix adjusted wage indices. Therefore, we are only able to provide tentative standardized amounts, relative weights, offsets, and budget neutrality factors in this final rule. Once we have the final occupational mix data, we will recalculate these amounts to reflect the final occupational mix adjusted wage indices. The same circumstances apply to the outlier threshold. Without final wage index data, final standardized amounts, final offsets and final budget neutrality factors, we are only able to provide a tentative fixed loss outlier threshold in this final rule. Subsequent to this final rule, we will publish a final fixed loss outlier threshold that will be effective for discharges on and after October 1, 2006 for FY 2007. However, in this final rule, we are adopting as final the methodology we will use to calculate the final outlier fixed-loss cost threshold.

For FY 2007, we proposed to use the same methodology used for FY 2006 (70 FR 47493) to calculate the outlier threshold. As we have done in the past, to calculate the proposed FY 2007 outlier threshold, we simulated payments by applying FY 2007 rates and policies using cases from the FY 2005 MedPAR files. Therefore, in order to determine the FY 2007 outlier threshold, we inflate the charges on the MedPAR claims by 2 years, from FY 2005 to FY 2007.

In certain years in the past, we have inflated MedPAR claims by calculating a 2-year average annual rate-of-change in charges-per-case using the charge data for the two most recent years for which we had relatively complete MedPAR data. As discussed in the FY 2006 IPPS final rule (70 FR 47494), however, we believe that charge data from FY 2003 may be distorted due to the atypically high rate of hospital charge inflation during FY 2003. Therefore, we are not inflating charges using a 2-year average annual rate-of-change from FY 2003 to FY 2004 and FY 2004 to FY 2005.

Instead, we proposed to continue using a refined methodology that takes into account the lower inflation in hospital charges that is occurring as a result of the outlier final rule (68 FR 34494), which changed our methodology for determining outlier payments by implementing the use of more current and accurate CCRs. Our refined methodology uses more recent data that reflects the rate-of-change in hospital charges under the new outlier policy. Specifically, we proposed to establish the FY 2007 outlier threshold as follows: Using the latest data available, we would calculate the 1-year average annualized rate-of-change in charges-per-case from the last quarter of FY 2004 in combination with the first quarter of FY 2005 (July 1, 2004 through December 31, 2004) to the last quarter of FY 2005 in combination with the first quarter of FY 2006 (July 1, 2005 through December 31, 2005). This rate of change was 7.57 percent (1.0757) or 15.15 percent (1.1515) over 2 years.

As we have done in the past, we proposed to establish the FY 2007 outlier threshold using hospital CCRs from the March 2006 update to the Provider-Specific File—the most recent available at the time of this final rule. This file includes CCRs that reflect implementation of the changes to the policy for determining the applicable CCRs that became effective August 8, 2003 (68 FR 34494).

Using this methodology, we proposed to establish an outlier fixed-loss cost threshold for FY 2007 equal to the prospective payment rate for the DRG, plus any IME and DSH payments, and any add-on payments for new technology, plus $25,530.

We noted that the case-weighted national average CCR declined by approximately 1 percent from the March 2005 to the March 2006 update of the Provider-Specific File. Hospital charges continue to increase at a steady rate of growth between 7 and 8 percent over each of the last 2 years, resulting in a decline to the CCRs that are used to compute the outlier threshold. Using lower CCRs from the March 2006 Provider-Specific File, in combination with the FY 2005 MedPAR claims and inflated charges, contributes to a higher outlier threshold for FY 2007 compared to FY 2006.

As we did in establishing the FY 2006 outlier threshold (70 FR 47494), in our projection of FY 2007 outlier payments, we proposed not to make an adjustment for the possibility that hospitals' CCRs and outlier payments may be reconciled upon cost report settlement. We stated that we continue to believe that, due to the policy implemented in the June 9, 2003 outlier final rule, CCRs will no longer fluctuate significantly and, therefore, few hospitals will actually have these ratios reconciled upon cost report settlement. In addition, it is difficult to predict which specific hospitals will have CCRs and outlier payments reconciled in their cost reports in any given year. We also noted that reconciliation occurs because hospitals' actual CCRs for the cost reporting period are different than the interim CCRs used to calculate outlier payments when a bill is processed. Our simulations assume that CCRs accurately measure hospital costs and, therefore, are more indicative of post-reconciliation than pre-reconciliation outlier payments. As a result, we proposed to continue to omit any assumptions about the effects of reconciliation from the outlier threshold calculation.

Comment: Many commenters, including two major hospital associations, were concerned that the proposed outlier threshold for FY 2007 remains too high and CMS will have removed over $300 million from the IPPS rates that were not paid back as outliers. The commenters noted that total estimated outlier payments in FY 2004 and FY 2005 were well under the 5.1 percent target. As a result, the commenters recommended further refining the outlier methodology so that, in their view, it will be more likely that CMS projects a threshold that meets the 5.1 target. The commenters explained that aside from inflating the claim charges, CMS should also use an adjustment factor to project CCRs. The commenters believed that the use of more than one indicator will make the threshold calculation more reliable and accurate.

The commenters used data from the March 31, 2006 HCRIS update to determine hospitals' CCRs (instead of using CCRs from the PSF per CMS's methodology). The commenters accounted for a nine month time lag from the end of a cost reporting period until the fiscal intermediary is able to update the CCR to project the CCRs expected to be used for outlier calculations in FY 2007. The commenters then calculated a cost inflation factor of 5.69 percent by determining the 2002–2004 aggregate annual rate of increase in cost per discharge. The commenters used this cost inflation factor along with CMS' charge inflation factor of 7.57 percent to project CCRs. These projected CCRs were applied to projected FY 2007 charges to simulate the determination of costs for FY 2007 outlier payments. Using this methodology, the commenters determined and recommended an outlier threshold of $24,000 that they assert would result in 5.1 percent outlier payments. The commenters also indicated that CMS would have paid 5.1 percent of total IPPS payments as outliers in FY 2006 using a threshold of $21,275 instead of $23,600. In addition, the commenters asserted that CMS removed a total of $3 billion more from the IPPS rates than it spent on outlier payments over FY 2004, 2005, and 2006. Therefore, the commenters urged CMS to adopt a better methodology of projecting the

CCRs, regardless of the DRG refinements being adopted for FY 2007.

One commenter argued that using CMS' previous methodology with costs instead of charges resulted in an outlier threshold of $23,055 for FY 2007 that would be more likely to result in 5.1 percent of total IPPS payments being paid as outliers. Using a methodology with costs and data from HCRIS (to determine hospital CCRs), the commenter computed a threshold of $22,645. The commenter asserted that projections using a cost threshold for FY 2004–2006 would have been much closer to the ultimate threshold needed to achieve the 5.1 percent target. Because the commenter believed there is now 3 years of data demonstrating that a cost methodology is a better predictor of the threshold, the commenter recommended that CMS adopt a threshold of $22,645.

MedPAC also commented that CMS should adjust the outlier methodology and apply an adjustment to project CCRs. MedPAC explained that using CCRs that are too high will overstate costs resulting in a fixed loss threshold that is too high. Therefore, MedPAC recommended that CMS project the average costs and charge per case to project hospitals' CCRs using the charge inflation factor already determined by CMS and the cost inflation factor using the market basket when projecting the CCRs.

Another commenter stated that it is inappropriate to use a methodology that ignores cost inflation. The commenter argued that the threshold is a "cost outlier threshold" and therefore an adjustment for cost should be incorporated into the outlier threshold methodology.

One commenter asked CMS to strongly reconsider the increase to the outlier threshold and implement a reduction that is consistent with the trends for FY 2005 and FY 2006 in outlier payments. Another commenter recommended that CMS calculate what the outlier threshold would need to be for the current fiscal year (2006) to enable outlier payments to meet the 5.1 percent target and apply that threshold for FY 2007.

Response: As the commenters noted, the outlier thresholds we have projected in the last several years have resulted in payments below the 5.1 percent target. However, we have been hesitant to change our model because, in the early years of this decade, outlier payments were significantly higher than the 5.1 percent target we projected because the charging practices of some hospitals resulted in overestimation of hospitals' cost-per-case. However, now that data for later years in which charging practices were stabilized are available, after careful consideration, we agree that a refinement to the proposed methodology to account for the rate of change in the relationship between costs and charges would likely increase the precision of our model and we believe this would be an appropriate refinement to adopt in determining the FY 2007 outlier threshold.

For FY 2007, we are using the same methodology we proposed, except that we are using more recent data to determine the charge inflation factor (as explained below). In addition, we are applying an adjustment factor to the CCRs to account for cost and charge inflation (as explained below). As we proposed, for this final rule, we simulated payments by applying FY 2007 rates and policies using cases from the FY 2005 MedPAR files. Therefore, as stated above, in order to determine the FY 2007 outlier threshold, we inflated the charges on the MedPAR claims by 2 years, from FY 2005 to FY 2007.

As noted above, the commenters supported our charge inflation methodology. Therefore, using the most recent data available (updated from the proposed rule), we calculated the 1-year average annualized rate-of-change in charges-per-case from the first quarter of FY 2005 in combination with the second quarter of FY 2005 (October 1, 2004 through March 31, 2005) to the first quarter of FY 2006 in combination with the second quarter of FY 2006 (October 1, 2005 through March 31, 2006). This rate of change was 7.9 percent (1.079) or 16.42 percent (1.1642) over 2 years.

As we have done in the past, we are establishing the FY 2007 outlier threshold using hospital CCRs from the March 2006 update to the Provider-Specific File—the most recent data available at the time of this final rule.

However, as noted above, many commenters believe an adjustment to the CCRs would be appropriate in projecting a threshold that meets the 5.1 percent target. The commenters referenced above used cost report data from HCRIS and applied a cost inflation factor based on the annual rate of increase in the cost per discharge from 2002 through 2004. However, we still believe the best source of hospital's operating and capital CCRs are those that come from the Provider-Specific File. As noted in the FY 2006 final rule (70 FR 47495), fiscal intermediaries will determine actual outlier payment amounts using some of the same CCRs that are in the March 2006 PSF. Fiscal intermediaries will begin using an updated CCR to calculate the outlier payments for a hospital only after a more recent cost report of the hospital has been tentatively settled. Nevertheless, we now agree with the commenters that it is appropriate to apply an adjustment factor to the CCRs so that the CCRs we are using in our simulation more closely reflect the CCRs that will be used in FY 2007.

We worked with our actuarial office in deriving the methodology described below to develop the CCR adjustment factor. Specifically, we used the operating cost per discharge increase in combination with the final updated market basket increase determined by Global Insight, Inc., as well as the charge inflation factor described above to estimate the adjustment to the CCRs. By using the market basket rate-of-increase and the increase in the average cost per discharge from hospital cost reports, we are using two different measures of cost inflation. For FY 2007, we determined the adjustment by taking the percentage increase in the operating costs per discharge from FY 2003 to FY 2004 (1.0645) from the cost report and dividing it by the final market basket increase from FY 2004 (1.039) We repeated this calculation for 2 prior years to determine the 3-year average of the rate of adjusted change in costs between the market basket rate-of-increase and the increase in cost per case from the cost report (FY 2001 to FY 2002 percentage increase of operating costs per discharge of 1.0836 divided by FY 2002 final market basket increase of 1.04, FY 2002 to FY 2003 percentage increase of operating costs per discharge of 1.0698 divided by FY 2003 final market basket increase of 1.04). For FY 2007, we averaged the differentials calculated for FY 2002, FY 2003, and FY 2004 which resulted in a mean ratio of 1.0327. We multiplied the 3-year average of 1.0327 by the 2005 market basket percentage increase of 1.0420, which resulted in an operating cost inflation factor of 7.61 percent or 1.0761. We then divided the operating cost inflation factor by the 1-year average change in charges (1.079) and applied an adjustment factor of 0.9973 to the operating CCRs from the Provider-Specific File.

We believe it is appropriate to apply only a one year adjustment factor to the CCRs. On average, it takes approximately 9 months for fiscal intermediaries to tentatively settle a cost report from the fiscal year end of a hospital's cost reporting period. The average "age" of hospitals' CCRs from the time the fiscal intermediary inserts the CCR in the PSF until the beginning of FY 2007 is approximately 1 year. Therefore, as stated above, we believe a

one year adjustment to the CCRs is appropriate.

We used the same methodology for the capital CCRs and applied an adjustment factor of 0.9574 (cost inflation factor of 1.0303 divided by a charge inflation factor of 1.0761) to the capital CCRs. We are using the same charge inflation factor for the capital CCRs that was used for the operating CCRs. The charge inflation factor is based on the overall billed charges and therefore we believe it is appropriate to apply the charge factor to both the operating and capital CCRs.

We believe this calculation of an adjustment to the CCRs is more accurate and stable than the commenters' methodology because it takes into account the costs per discharge and the market basket percentage increase when determining a cost adjustment factor.

Using this methodology, we are establishing a tentative outlier fixed-loss cost threshold for FY 2007 equal to the prospective payment rate for the DRG, plus any IME and DSH payments, and any add-on payments for new technology, plus $24,475. The tentative outlier threshold that we calculated for this final rule is $1,055 lower than the $25,530 threshold from the proposed rule. We anticipate that a threshold based on the methodology above will reach the target of 5.1 percent. We note that, in this final rule, we are adopting this methodology to compute the final outlier fixed-loss cost threshold for FY 2007, although the final dollar amount of the outlier threshold will be published in a subsequent **Federal Register** document.

We also note, that the case-weighted national average CCR declined by approximately an additional 1 percent from the December 2005 to the March 2006 update of the Provider-Specific File. We further reduced the CCRs by applying an adjustment to reflect the differential increase between costs and charges. As noted above, using lower CCRs from the March 2006 Provider-Specific File, in combination with the FY 2005 MedPAR claims and inflated charges, contributes to a lower outlier threshold for FY 2007 in this final rule compared to the proposed rule.

Finally, charges are a key influence over outlier payments. Therefore, we continue to believe it is appropriate to use a methodology based on charges instead of costs. Please refer to our response to a similar comment in the FY 2006 final rule (70 FR 47495) for a more detailed discussion of this issue.

Comment: One commenter suggested that CMS consider making mid-year adjustments to the outlier threshold if it appears that outlier payments are going to be significantly above or below the 5.1 percent target. The commenter believed that a mid-year adjustment would aid CMS in reaching the 5.1 percent target irrespective of the methodology CMS uses to determine the threshold. However, the commenter did note that a mid-year correction will be of less need if CMS were to adopt a methodology based on cost or the CMS model that projects CCRs. Another commenter recommended that CMS evaluate the practicality and effects of a correction error similar to the update forecast error adjustment used in recommending an update for the market basket rate of increase.

One commenter urged CMS to publicly account for the amount of unspent outlier payments over the last 3 years and to establish a policy whereby the unspent money is returned to the base rate for inpatient spending.

Response: We appreciate the commenters suggestions for improving payment accuracy for outliers. However, we have already responded to similar comments in the FY 2006 final rule (70 FR 47495).

Furthermore, we believe that a policy whereby the standardized amounts would be adjusted to reflect differences between the 5.1 percent removed from the rates and the amounts actually paid as outliers would be inconsistent with the purpose of the statute relating to outlier payments and the prospective payment system. Section 1886(d)(3)(B) of the Act requires that we reduce the standardized amounts by a factor equal to the proportion of outlier payments "as estimated by the Secretary." Therefore, we believe that the statute does not contemplate adjustments to the standardized amounts in an upcoming year because actual outlier payments in past years were more or less than we had estimated.

Comment: One commenter was concerned that CMS has not met the 5.1 percent target in previous years and suggested that CMS project the outlier threshold at 5.5 percent of total payments to ensure it meets the 5.1 percent target.

Another commenter was concerned about the impact that the DRG refinement will have on outlier payments. The commenter recommended that CMS maintain the threshold at $23,600 for FY 2007 while hospitals adjust to the other PPS payment changes that will occur.

One commenter supported eliminating outlier payments in its entirety and recommended a more equitable approach by simply increasing the standardized amounts by 5.1 percent. The commenter explained that this method would remove the ability to game the system and would be more desirable to deserving providers that do not abuse the system.

Response: As noted above, section 1886(d)(5)(A)(iv) of the Act requires outlier payments to be not less than 5 percent nor more than 6 percent of total estimated or projected payments. Therefore, we cannot eliminate outlier payments as suggested by one commenter or set a threshold that is based on the current fiscal year for the coming fiscal year. Although we are refining the DRGs, the statute requires us to set an outlier threshold so that estimated total outlier payments are between 5 and 6 percent of total IPPS payments. If we failed to project a new outlier threshold for FY 2007, but rather simply continued to use the outlier threshold for FY 2006, we would not meet the mandate of the statute.

We also note that we project outlier payments at 5.1 percent to ensure that we offset the minimum amount necessary from the standardized amounts to meet our statutory obligation. Although CMS could legally project an outlier threshold so that 5.5 percent of total IPPS payments are paid as outliers, the law would also require us to remove 5.5 percent from the standardized amounts to finance the outlier pool, which would reduce funds available for typical cases. As a result, we believe setting the outlier threshold so that 5.1 percent of total IPPS payments are paid as outliers is more equitable to all hospitals, as less money is withdrawn from the standardized amounts due to the outlier offset and it allows proportionally greater payment for typical cases. Therefore, we are adopting as final our proposal to set the outlier threshold so that 5.1 percent of estimated total IPPS payments are paid as outliers.

ii. Other changes concerning outliers.

As stated in the FY 1994 IPPS final rule (58 FR 46348, September 1, 1993), we establish outlier thresholds that are applicable to both hospital inpatient operating costs and hospital inpatient capital-related costs. When we modeled the combined operating and capital outlier payments, we found that using a common set of thresholds resulted in a lower percentage of outlier payments for capital-related costs than for operating costs. We project that the thresholds for FY 2007 will result in outlier payments equal to 5.1 percent of operating DRG payments and 4.87 percent of capital payments based on the Federal rate.

In accordance with section 1886(d)(3)(B) of the Act, we are reducing the FY 2007 standardized amount by the same percentage to

account for the projected proportion of payments paid to outliers.

The tentative outlier adjustment factors that will be applied to the standardized amount for FY 2007 are as follows:

	Operating standardized amounts	Capital federal rate
National	0.948966	0.956763
Puerto Rico	0.967415	0.967670

We are applying the tentative outlier adjustment factors to the tentative FY 2007 rates after removing the effects of the FY 2006 outlier adjustment factors on the standardized amount.

To determine whether a case qualifies for outlier payments, we apply hospital-specific CCRs to the total covered charges for the case. Operating and capital costs for the case are calculated separately by applying separate operating and capital CCRs. These costs are then combined and compared with the outlier fixed-loss cost threshold.

The outlier final rule (68 FR 34494) eliminated the application of the statewide average CCRs for hospitals whose CCRs fall below 3 standard deviations from the national mean CCR. However, for those hospitals for which the fiscal intermediary computes operating CCRs greater than 1.26 or capital CCRs greater than 0.154, or hospitals for whom the fiscal intermediary is unable to calculate a CCR (as described at § 412.84(i)(3) of our regulations), we are still using statewide average CCRs to determine whether a hospital qualifies for outlier payments.[31] Table 8A in section VI. of this Addendum contains the statewide average operating CCRs for urban hospitals and for rural hospitals for which the fiscal intermediary is unable to compute a hospital-specific CCR within the above range. Effective for discharges occurring on or after October 1, 2006, these statewide average ratios will replace the ratios published in the IPPS final rule for FY 2006 (70 FR 47672). Table 8B in section VI. of this Addendum contains the comparable statewide average capital CCRs. Again, the CCRs in Tables 8A and 8B will be used during FY 2007 when hospital-specific CCRs based on the latest settled cost report are either not available or are outside the range noted above. For an explanation of Table 8C, please see section VI. of this Addendum.

We finally note that we published a manual update (Change Request 3966) to outliers on October 12, 2005. The manual update covered an array of topics, including CCRs, reconciliation, and the time value of money. To download and view the manual update, please visit *http://www.cms.hhs.gov/transmittals/downloads/R707CP.pdf.*

iii. FY 2005 and FY 2006 outlier payments.

In the FY 2006 IPPS final rule (70 FR 47496), we stated that, based on available data, we estimated that actual FY 2005 outlier payments would be approximately 4.1 percent of actual total DRG payments. This estimate was computed based on simulations using the FY 2004 MedPAR file (discharge data for FY 2004 bills). That is, the estimate of actual outlier payments did not reflect actual FY 2005 bills, but instead reflected the application of FY 2005 rates and policies to available FY 2004 bills.

Our current estimate, using available FY 2005 bills, is that actual outlier payments for FY 2005 were approximately 3.96 percent of actual total DRG payments. Thus, the data indicate that, for FY 2005, the percentage of actual outlier payments relative to actual total payments is lower than we projected before FY 2005 (and, thus, is less than the percentage by which we reduced the standardized amounts for FY 2005). We note that, for FY 2006, the outlier threshold was lowered to $23,600 compared to $25,800 for FY 2005. The outlier threshold was lower in FY 2006 than FY 2005 as a result of slower growth in hospital charge inflation following implementation of the outlier final rule that went into effect on August 9, 2003. Nevertheless, consistent with the policy and statutory interpretation we have maintained since the inception of the IPPS, we do not plan to make retroactive adjustments to outlier payments to ensure that total outlier payments for FY 2005 are equal to 5.1 percent of total DRG payments.

We currently estimate that actual outlier payments for FY 2006 will be approximately 4.62 percent of actual total DRG payments, 0.48 percentage points lower than the 5.1 percent we projected in setting the outlier policies for FY 2006. This estimate is based on simulations using the FY 2005 MedPAR file (discharge data for FY 2005 bills). We used these data to calculate an estimate of the actual outlier percentage for FY 2006 by applying FY 2006 rates and policies, including an outlier threshold of $23,600 to available FY 2005 bills. Even though we are estimating payments below the 5.1 percent threshold for FY 2006, our simulations using FY 2005 Medicare data show consistent levels of charge inflation and a need to increase the threshold for FY 2007 to ensure that 5.1 percent of total IPPS payments are paid as outliers.

iv. Technical changes.

Subpart F of Part 412 of the existing regulations discusses payment for outlier cases and special payment for new technology. We have become aware of an inadvertent mistake in § 412.84(m). Currently, § 412.84(m) discusses the application of the time value of money when a hospital's outlier payments are reconciled. When referencing reconciliation, the section mistakenly references paragraph (h)(3) instead of paragraph (i)(4). We received no comments on this change and therefore are finalizing our proposal to revise § 412.84(m) to reference the current policy under paragraph (i)(4).

In addition, in the June 9, 2003 outlier final rule, we amended § 412.116(e) to remove the second sentence, which stated that payments for outliers "are made based on submitted bills and represent final payment." It was necessary to remove this sentence, as we added a provision to the regulations that provides that outlier payments are subject to reconciliation when hospitals' cost reports are settled. In the FY 2004 IPPS final rule (68 FR 45393), we again amended § 412.116(e) to provide that new technology add-on payments are made on a case-by-case basis, rather than on an interim basis. However, it has come to our attention that, in the FY 2004 IPPS final rule, we inadvertently reinserted the sentence that we had struck in the June 9, 2003 outlier final rule. We never intended to reinsert this sentence, and our policy since the implementation of the outlier final rule has always been the same (that outlier payments are subject to reconciliation when hospitals' cost reports are settled). Therefore, in order to correct the regulations to reflect our current policy, we are removing the second sentence from § 412.116(e). Although we did not propose this technical correction, as further discussed in section XIII.C. of this final rule, we find it unnecessary to undertake notice and comment rulemaking with respect to this technical correction.

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

Section 410A of Pub. L. 108–173 requires the Secretary to establish a demonstration that will modify reimbursement for inpatient services for up to 15 small rural hospitals. Section 410A(c)(2) of Pub. L. 108–173 requires that "in conducting the demonstration

[31] These figures represent 3.0 standard deviations from the mean of the log distribution of CCRs for all hospitals.

program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented." As discussed in section IV.M. of the preamble to this final rule, we are satisfying this requirement by adjusting national IPPS rates by a factor that is sufficient to account for the added costs of this demonstration. We estimate that the average additional annual payment that will be made to each participating hospital under the demonstration will be approximately $1,021,985. We based this estimate on the recent historical experience of the difference between inpatient cost and payment for hospitals that are participating in the demonstration. For 9 participating hospitals, the total annual impact of the demonstration program is estimated to be $9,197,870. The required tentative adjustment to the Federal rate used in calculating Medicare inpatient prospective payments as a result of the demonstration is 0.999905.

In order to achieve budget neutrality, we are adjusting the tentative national IPPS rates by a tentative amount sufficient to account for the added costs of this demonstration. In other words, we are applying budget neutrality across the payment system as a whole rather than merely across the participants of this demonstration. We believe that the language of the statutory budget neutrality requirement permits the agency to implement the budget neutrality provision in this manner. The statutory language requires that "aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration * * * was not implemented," but does not identify the range across which aggregate payments must be held equal.

5. Tentative FY 2007 Standardized Amount

The tentative adjusted standardized amount is divided into labor-related and nonlabor-related portions. Tables 1A and 1B in section VI. of this Addendum contain the tentative national standardized amount that we are applying to all hospitals, except hospitals in Puerto Rico. The tentative Puerto Rico-specific amounts are shown in Table 1C. The tentative amounts shown in Tables 1A and 1B differ only in that the labor-related share applied to the tentative standardized amounts in Table 1A is 69.7 percent, and the labor-related share applied to the tentative standardized amounts in Table 1B is 62 percent. In accordance with sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act, we are applying the labor-related share of 62 percent, unless the application of that percentage would result in lower payments to a hospital than would otherwise be made. The effect of this application is that the labor-related share of the tentative standardized amount is 62 percent for all hospitals (other than those in Puerto Rico) whose wage indexes are less than or equal to 1.0000.

In addition, Tables 1A and 1B include tentative standardized amounts reflecting the full 3.4 percent update for FY 2007, and tentative standardized amounts reflecting the 2.0 percentage point reduction to the update (a 1.4 percent update) applicable for hospitals that fail to submit quality data consistent with section 1886(b)(3)(B)(viii) of the Act.

We note that in this final rule we are not supplying a table that illustrates the changes from the FY 2006 national average standardized amount. Because we are only setting the standardized amounts tentatively, we do not believe it is appropriate to include this table in this final rule. However, we will publish a table in the subsequent notice to this final rule that details the calculation of the final standardized amounts.

Under section 1886(d)(9)(A)(ii) of the Act, the Federal portion of the Puerto Rico payment rate is based on the discharge-weighted average of the national large urban standardized amount (this tentative amount is set forth in Table 1A). The tentative labor-related and nonlabor-related portions of the national average standardized amounts for Puerto Rico hospitals for FY 2007 are set forth in Table 1C of section VI. of this Addendum. This table also includes the tentative Puerto Rico standardized amounts. The labor-related share applied to the tentative Puerto Rico specific standardized amount is 58.7 percent, or 62 percent, depending on which is more advantageous to the hospital. (Section 1886(d)(9)(C)(iv) of the Act, as amended by section 403(b) of Pub. L. 108–173, provides that the labor-related share for hospitals in Puerto Rico will be 62 percent, unless the application of that percentage would result in lower payments to the hospital.)

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

Tables 1A through 1C, as set forth in section VI. of this Addendum, contain the tentative labor-related and tentative nonlabor-related shares of the standardized amount that we are using to calculate the prospective payment rates for hospitals located in the 50 States, the District of Columbia, and Puerto Rico for FY 2007. This section addresses two types of adjustments to the tentative standardized amounts that are made in determining the prospective payment rates as described in this Addendum.

1. Tentative Adjustment for Area Wage Levels

Sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act require that we make an adjustment to the labor-related portion of the national and Puerto Rico prospective payment rates, respectively, to account for area differences in hospital wage levels. This adjustment is made by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. In section III. of the preamble to this final rule, we discuss the data and methodology for the FY 2007 wage index. We note that because the occupational mix adjusted wage index data will not be finalized until after this final rule, we will not be publishing Tables 4A–1, 4A–2, 4B, 4C–1, 4C–2, and 4F in this final rule. However, we will publish these tables in the **Federal Register** and on the CMS Web site once all the data is finalized and prior to October 1, 2006.

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

Section 1886(d)(5)(H) of the Act authorizes an adjustment to take into account the unique circumstances of hospitals in Alaska and Hawaii. Higher labor-related costs for these two States are taken into account in the adjustment for area wages described above. For FY 2007, we are adjusting the payments for hospitals in Alaska and Hawaii by multiplying the nonlabor-related portion of the standardized amount by the appropriate adjustment factor contained in the table below.

TABLE OF COST-OF-LIVING ADJUSTMENT FACTORS: ALASKA AND HAWAII HOSPITALS

Area	Cost of living adjustment factor
Alaska—All areas	1.25
Hawaii:	
County of Honolulu	1.25
County of Hawaii	1.165
County of Kauai	1.2325
County of Maui	1.2375
County of Kalawao	1.2375

(The above factors are based on data obtained from the U.S. Office of Personnel Management.)

C. DRG Relative Weights

As discussed in section II. of the preamble of this final rule, we have developed a classification system for all hospital discharges, assigning them into DRGs, and have developed relative weights for each DRG that reflect the resource utilization of cases in each DRG relative to Medicare cases in other DRGs. Table 5 of section VI. of this Addendum contains the relative weights that we are using for discharges occurring in FY 2007. These factors have been recalibrated as explained in section II. of the preamble of this final rule.

D. Calculation of the Prospective Payment Rates

General Formula for Calculation of Prospective Payment Rates for FY 2007

In general, the operating prospective payment rate for all hospitals paid under the IPPS located outside of Puerto Rico, except SCHs and MDHs, for FY 2007 equals the Federal rate.

The prospective payment rate for SCHs for FY 2007 equals the higher of the applicable Federal rate or the hospital-specific rate as described below. The prospective payment rate for MDHs for FY 2007 equals the higher of the Federal rate, or the Federal rate plus 75 percent of the difference between the Federal rate and the hospital-specific rate as described below. The prospective payment rate for Puerto Rico for FY 2007 equals 25 percent of the Puerto Rico rate plus 75 percent of the applicable national rate.

As noted above, we are not able to provide the final FY 2007 occupational mix adjusted wage index tables. Although Tables 4A–1, 4A–2, 4B, 4C–1, and 4C–2 will be published on the CMS Web site and in a subsequent **Federal Register** document to this final rule, any reference to these tables below refers to these future tables.

1. Federal Rate

The Federal rate is determined as follows:

Step 1—Select the appropriate average standardized amount considering the applicable wage index and whether the hospital has submitted qualifying quality data (full update for qualifying hospitals, update minus 2.0 percentage points for nonqualifying hospitals).

Step 2—Multiply the labor-related portion of the standardized amount by the applicable wage index for the geographic area in which the hospital is located or the area to which the hospital is reclassified.

Step 3—For hospitals in Alaska and Hawaii, multiply the nonlabor-related portion of the standardized amount by the appropriate cost-of-living adjustment factor.

Step 4—Add the amount from Step 2 and the nonlabor-related portion of the standardized amount (adjusted, if appropriate, under Step 3).

Step 5—Multiply the final amount from Step 4 by the relative weight corresponding to the appropriate DRG (see Table 5 of section VI. of this Addendum).

The Federal rate as determined in Step 5 may then be further adjusted if the hospital qualifies for either the IME or DSH adjustment. In addition, for hospitals that qualify for a low-volume payment adjustment under section 1886(d)(12) of the Act, the payment in Step 5 would be increased by 25 percent.

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

a. Calculation of Hospital-Specific Rate

Section 1886(b)(3)(C) of the Act provides that SCHs are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal rate; the updated hospital-specific rate based on FY 1982 costs per discharge; the updated hospital-specific rate based on FY 1987 costs per discharge; or the updated hospital-specific rate based on FY 1996 costs per discharge.

As discussed previously, MDHs are required to rebase their hospital-specific rates to their FY 2002 cost reports if doing so results in higher payments. In addition, effective for discharges occurring on or after October 1, 2006, MDHs are to be paid based on the Federal national rate or, if higher, the Federal national rate plus 75 percent (changed from 50 percent) of the difference between the Federal national rate and the greater of the updated hospital-specific rates based on either FY 1982, FY 1987 or FY 2002 costs per discharge. Further, MDHs will no longer be subject to the 12-percent cap on their DSH payment adjustment factor.

Hospital-specific rates have been determined for each of these hospitals based on the FY 1982 costs per discharge, the FY 1987 costs per discharge, or, for SCHs, the FY 1996 costs per discharge and for MDHs, the FY 2002 cost per discharge. For a more detailed discussion of the calculation of the hospital-specific rates, we refer the reader to the FY 1984 IPPS interim final rule (48 FR 39772); the April 20, 1990 final rule with comment (55 FR 15150); the FY 1991 IPPS final rule (55 FR 35994); and the FY 2001 IPPS final rule (65 FR 47082). In addition, for both SCHs and MDHs, the hospital-specific rate is adjusted by the budget neutrality adjustment factor as discussed in section IV.C. of the preamble to this final rule. The resulting rate will be used in determining the payment rate an SCH or MDH will receive for its discharges beginning on or after October 1, 2006.

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

We are increasing the hospital-specific rates by 3.4 percent (the hospital market basket percentage increase) for SCHs and MDHs for FY 2007. Section 1886(b)(3)(C)(iv) of the Act provides that the update factor applicable to the hospital-specific rates for SCHs is equal to the update factor provided under section 1886(b)(3)(B)(iv) of the Act, which, for SCHs in FY 2007, is the market basket rate-of-increase. Section 1886(b)(3)(D) of the Act provides that the update factor applicable to the hospital-specific rates for MDHs also equals the update factor provided under section 1886(b)(3)(B)(iv) of the Act, which, for FY 2007, is the market basket rate-of-increase.

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

Section 1886(d)(9)(E)(iv) of the Act provides that, effective for discharges occurring on or after October 1, 2004, hospitals located in Puerto Rico are paid based on a blend of 75 percent of the national prospective payment rate and 25 percent of the Puerto Rico-specific rate.

a. Puerto Rico Rate

The Puerto Rico prospective payment rate is determined as follows:

Step 1—Select the appropriate average standardized amount considering the applicable wage index (see Table 1C).

Step 2—Multiply the labor-related portion of the standardized amount by the appropriate Puerto Rico-specific wage index.

Step 3—Add the amount from Step 2 and the nonlabor-related portion of the standardized amount.

Step 4—Multiply the amount from Step 3 by the appropriate DRG relative weight (see Table 5 of section IV. of the Addendum).

Step 5—Multiply the result in Step 4 by 25 percent.

b. National Rate

The national prospective payment rate is determined as follows:

Step 1—Select the appropriate average standardized amount considering the applicable wage index.

Step 2—Multiply the labor-related portion of the standardized amount by the applicable wage index for the geographic area in which the hospital is located or the area to which the hospital is reclassified.

Step 3—Add the amount from Step 2 and the nonlabor-related portion of the national average standardized amount.

Step 4—Multiply the amount from Step 3 by the appropriate DRG relative weight (see Table 5 of section VI. of the Addendum).

Step 5—Multiply the result in Step 4 by 75 percent.

The sum of the Puerto Rico rate and the national rate computed above equals the prospective payment for a given discharge for a hospital located in Puerto Rico. This rate may then be further adjusted if the hospital qualifies for either the IME or DSH adjustment.

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

The PPS for acute care hospital inpatient capital-related costs was implemented for cost reporting periods beginning on or after October 1, 1991. Effective with that cost reporting period, hospitals were paid during a 10-year transition period (which extended through FY 2001) to change the payment methodology for Medicare acute care hospital inpatient capital-related costs from a reasonable cost-based methodology to a prospective methodology (based fully on the Federal rate).

The basic methodology for determining Federal capital prospective rates is set forth in regulations at §§ 412.308 through 412.352. Below we discuss the factors that we are using to determine the tentative capital Federal rate for FY 2007, which will be effective for discharges occurring on or after October 1, 2006. As discussed in section I. of the Addendum of this final rule, we are not able to provide the final FY 2007 capital Federal prospective rates in this rule due to requirements imposed by the Second Circuit Court's order regarding wage index information as collected for the inpatient Federal rates. This affects the Federal capital payment rates, as well, because wage index information is used to determine the GAF/DRG budget neutrality factor, the GAF, and outlier adjustment factor that are used in arriving at the capital Federal rates. We are providing tentative amounts, where applicable, as proxies for these rates and factors until the occupational mix adjusted wage index is finalized. Subsequent to this final rule, we will publish in a **Federal Register** document a listing the capital Federal rates, offsets and budget neutrality factors that are effective October 1, 2006 for FY 2007.

The 10-year transition period ended with hospital cost reporting periods beginning on or after October 1, 2001 (FY 2002). Therefore, for cost reporting periods beginning in FY 2002, all hospitals (except "new" hospitals under § 412.304(c)(2)) are paid based on 100 percent of the capital Federal rate. For FY 1992, we computed the standard Federal payment rate for capital-related costs under the IPPS by updating the FY 1989 Medicare inpatient capital cost per case by an actuarial estimate of the increase in Medicare inpatient capital costs per case. Each year after FY 1992, we update the capital standard Federal rate, as provided at § 412.308(c)(1), to account for capital input price increases and other factors. The regulations at § 412.308(c)(2) provide that the capital Federal rate is adjusted annually by a factor equal to the estimated proportion of outlier payments under the capital Federal rate to total capital payments under the capital Federal rate. In addition, § 412.308(c)(3) requires that the capital Federal rate be reduced by an adjustment factor equal to the estimated proportion of payments for (regular and special) exceptions under § 412.348. Section 412.308(c)(4)(ii) requires that the capital standard Federal rate be adjusted so that the effects of the annual DRG reclassification and the recalibration of DRG weights and changes in the geographic adjustment factor are budget neutral.

For FYs 1992 through 1995, § 412.352 required that the capital Federal rate also be adjusted by a budget neutrality factor so that aggregate payments for inpatient hospital capital costs were projected to equal 90 percent of the payments that would have been made for capital-related costs on a reasonable cost basis during the fiscal year. That provision expired in FY 1996. Section 412.308(b)(2) describes the 7.4 percent reduction to the capital rate that was made in FY 1994, and § 412.308(b)(3) describes the 0.28 percent reduction to the capital rate made in FY 1996 as a result of the revised policy of paying for transfers. In FY 1998, we implemented section 4402 of Pub. L. 105-33, which required that, for discharges occurring on or after October 1, 1997, and before October 1, 2002, the unadjusted capital standard Federal rate is reduced by 17.78 percent. As we discussed in the FY 2003 IPPS final rule (67 FR 50102) and implemented in § 412.308(b)(6), a small part of that reduction was restored effective October 1, 2002.

To determine the appropriate budget neutrality adjustment factor and the regular exceptions payment adjustment during the 10-year transition period, we developed a dynamic model of Medicare inpatient capital-related costs; that is, a model that projected changes in Medicare inpatient capital-related costs over time. With the expiration of the budget neutrality provision, the capital cost model was only used to estimate the regular exceptions payment adjustment and other factors during the transition period. As we explained in the FY 2002 IPPS final rule (66 FR 39911), beginning in FY 2002, an adjustment for regular exception payments is no longer necessary because regular exception payments were only made for cost reporting periods beginning on or after October 1, 1991, and before October 1, 2001 (see § 412.348(b)). Because payments are no longer being made under the regular exception policy effective with cost reporting periods beginning in FY 2002, we no longer use the capital cost model. The capital cost model and its application during the transition period are described in Appendix B of the FY 2002 IPPS final rule (66 FR 40099).

Section 412.374 provides for the use of a blended payment system for payments to Puerto Rico hospitals under the PPS for acute care hospital inpatient capital-related costs. Accordingly, under the capital PPS, we compute a separate payment rate specific to Puerto Rico hospitals using the same methodology used to compute the national Federal rate for capital-related costs. In accordance with section 1886(d)(9)(A) of the Act, under the PPS for acute care hospital operating costs, hospitals located in Puerto Rico are paid for operating costs under a special payment formula. Prior to FY 1998, hospitals in Puerto Rico were paid a blended operating rate that consisted of 75 percent of the applicable standardized amount specific to Puerto Rico hospitals and 25 percent of the applicable national average standardized amount. Similarly, prior to FY 1998, hospitals in Puerto Rico were paid a blended capital rate that consisted of 75 percent of the applicable capital Puerto Rico-specific rate and 25 percent of the applicable capital Federal rate. However, effective October 1, 1997, in accordance with section 4406 of Pub. L. 105–33, operating payments to hospitals in Puerto Rico were revised to be based on a blend of 50 percent of the applicable standardized amount specific to Puerto

Rico hospitals and 50 percent of the applicable national average standardized amount. In conjunction with this change to the operating blend percentage, effective with discharges occurring on or after October 1, 1997, we also revised the methodology for computing capital payments to hospitals in Puerto Rico to be based on a blend of 50 percent of the Puerto Rico capital rate and 50 percent of the capital Federal rate.

As we discussed in the FY 2005 IPPS final rule (69 FR 49185), section 504 of Pub. L. 108–173 increased the national portion of the operating IPPS payments for Puerto Rico hospitals from 50 percent to 62.5 percent and decreased the Puerto Rico portion of the operating IPPS payments from 50 percent to 37.5 percent for discharges occurring on or after April 1, 2004 through September 30, 2004 (see the March 26, 2004 One-Time Notification (Change Request 3158)). In addition, section 504 of Pub. L. 108-173 provided that the national portion of operating IPPS payments for Puerto Rico hospitals is equal to 75 percent and the Puerto Rico portion of operating IPPS payments is equal to 25 percent for discharges occurring on or after October 1, 2004. Consistent with that change in operating IPPS payments to hospitals in Puerto Rico, for FY 2005 (as we discussed in the FY 2005 IPPS final rule), we revised the methodology for computing capital payments to hospitals located in Puerto Rico to be based on a blend of 25 percent of the Puerto Rico capital rate and 75 percent of the capital Federal rate for discharges occurring on or after October 1, 2004.

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

In the FY 2006 IPPS final rule (70 FR 47503), we established a capital Federal rate of $420.65 for FY 2006. In the discussion that follows, we explain the factors that we are using to determine the tentative FY 2007 capital Federal rate. In particular, we explain why the tentative FY 2007 capital Federal rate will increase approximately 1.60 percent compared to the FY 2006 capital Federal rate. However, we estimate aggregate capital payments will decrease by 0.2 percent during this same period. This decrease is due to a decrease in the estimated total number of Medicare fee-for-service discharges for FY 2007 as compared to the estimated total number of Medicare fee-for-service discharges in FY 2006. We are estimating a decrease in Medicare fee-for-service discharges in FY 2007 as compared to FY 2006, in part because we are projecting an increase in beneficiary Medicare managed care enrollment as a result of the implementation of several provisions of Pub. L. 108–173. Therefore, although we are projecting that capital PPS payments per discharge will increase slightly from FY 2006 to FY 2007, we project that aggregate capital PPS payments will decrease for the same period.

Total payments to hospitals under the IPPS are relatively unaffected by changes in the capital prospective payments. Because capital payments constitute about 10 percent of hospital payments, a 1-percent change in the capital Federal rate yields only about 0.1 percent change in actual payments to hospitals. As noted above, aggregate payments under the capital IPPS are estimated to decrease slightly in FY 2007 compared to FY 2006.

1. Projected Capital Standard Federal Rate Update

a. Description of the Update Framework

Under § 412.308(c)(1), the capital standard Federal rate is updated on the basis of an analytical framework that takes into account changes in a capital input price index (CIPI) and several other policy adjustment factors. Specifically, we have adjusted the projected CIPI rate-of-increase as appropriate each year for case-mix index-related changes, for intensity, and for errors in previous CIPI forecasts. The update factor for FY 2007 under that framework is 1.10 percent based on the best data available at this time. The update factor is based on a projected 1.1 percent increase in the CIPI, a 0.0 percent adjustment for intensity, a 0.0 percent adjustment for case-mix, a 0.0 percent adjustment for the FY 2005 DRG reclassification and recalibration, and a forecast error correction of 0.0 percent. As discussed below in section III.C. of this Addendum, we believe that the CIPI is the most appropriate input price index for capital costs to measure capital price changes in a given year. We also explain the basis for the FY 2007 CIPI projection in that same section of this Addendum. Below we describe the policy adjustments that have been applied.

The case-mix index is the measure of the average DRG weight for cases paid under the IPPS. Because the DRG weight determines the prospective payment for each case, any percentage increase in the case-mix index corresponds to an equal percentage increase in hospital payments.

The case-mix index can change for any of several reasons:

- The average resource use of Medicare patients changes ("real" case-mix change);
- Changes in hospital coding of patient records result in higher weight DRG assignments ("coding effects"); and
- The annual DRG reclassification and recalibration changes may not be budget neutral ("reclassification effect").

We define real case-mix change as actual changes in the mix (and resource requirements) of Medicare patients as opposed to changes in coding behavior that result in assignment of cases to higher weighted DRGs but do not reflect higher resource requirements. The capital update framework includes the same case-mix index adjustment used in the former operating IPPS update framework (as discussed in the May 18, 2005 IPPS proposed rule for FY 2005 (69 FR 28816)). (We are no longer using an update framework in making a recommendation for updating the operating IPPS standardized amounts as discussed in section II, of Appendix B in the FY 2006 IPPS final rule (70 FR 47707)).

For FY 2007, we are projecting a 1.0 percent total increase in the case-mix index. We estimate that the real case-mix increase will also equal 1.0 percent in FY 2007. The net adjustment for change in case-mix is the difference between the projected increase in case-mix and the projected total increase in case-mix. Therefore, the net adjustment for case-mix change in FY 2007 is 0.0 percentage points.

The capital update framework also contains an adjustment for the effects of DRG reclassification and recalibration. This adjustment is intended to remove the effect on total payments of prior year changes to the DRG classifications and relative weights, in order to retain budget neutrality for all case-mix index-related changes other than those due to patient severity. Due to the lag time in the availability of data, there is a 2-year lag in data used to determine the adjustment for the effects of DRG reclassification and recalibration. For example, we are adjusting for the effects of the FY 2005 DRG reclassification and recalibration as part of our update for FY 2007. We estimate that FY 2005 DRG reclassification and recalibration will result in a 0.0 percent change in the case-mix when compared with the case-mix index that would have resulted if we had not made the reclassification and recalibration changes to the DRGs. Therefore, we are making a 0.0 percent adjustment for DRG reclassification and recalibration in the update for FY 2007 to maintain budget neutrality.

The capital update framework also contains an adjustment for forecast error. The input price index forecast is based on historical trends and relationships ascertainable at the time the update factor is established for the upcoming year. In any given year, there may be unanticipated price fluctuations that may result in differences between the actual increase in prices and the forecast used in calculating the update factors. In setting a prospective payment rate under the framework, we make an adjustment for forecast error only if our estimate of the change in the capital input price index for any year is off by 0.25 percentage points or more. There is a 2-year lag between the forecast and the measurement of the forecast error. A forecast error of 0.1 percentage point was calculated for the FY 2005 update. That is, current historical data indicate that the forecasted FY 2005 CIPI used in calculating the FY 2005 update factor (0.7 percent) slightly understated the actual realized price increases (0.8 percent) by 0.1 percentage point. This slight underprediction was mostly due to the incorporation of newly available source data for fixed asset prices into the market basket. However, because this estimation of the change in the CIPI is less than 0.25 percentage points, it is not reflected in the update recommended under this framework. Therefore, we are making a 0.0 percent adjustment for forecast error in the update for FY 2007.

Under the capital IPPS update framework, we also make an adjustment for changes in intensity. We calculate this adjustment using the same methodology and data that were used in the framework used in the past under the operating IPPS. The intensity factor for the operating update framework reflects how hospital services are utilized to produce the final product, that is, the discharge. This component accounts for changes in the use of quality-enhancing services, for changes in within-DRG severity, and for expected modification of practice patterns to remove noncost-effective services.

We calculate case-mix constant intensity as the change in total charges per admission, adjusted for price level changes (the CPI for hospital and related services) and changes in real case-mix. The use of total charges in the calculation of the intensity factor makes it a total intensity factor; that is, charges for capital services are already built into the calculation of the factor. Therefore, we have incorporated the intensity adjustment from the operating update framework into the capital update framework. Without reliable estimates of the proportions of the overall annual intensity increases that are due, respectively, to ineffective practice patterns and to the combination of quality-enhancing new technologies and within-DRG complexity, we assume, as in the operating update framework, that one-half of the annual increase is due to each of these factors. The capital update framework thus provides an add-on to the input price index rate of increase of one-half of the estimated annual increase in intensity, to allow for within-DRG severity increases and the adoption of quality-enhancing technology.

We have developed a Medicare-specific intensity measure based on a 5-year average. Past studies of case-mix change by the RAND Corporation (Has DRG Creep Crept Up? Decomposing the Case Mix Index Change Between 1987 and 1988" by G. M. Carter, J. P. Newhouse, and D. A. Relles, R–4098–HCFA/ProPAC (1991)) suggest that real case-mix change was not dependent on total change, but was usually a fairly steady 1.0 to 1.4 percent per year. We use 1.4 percent as the upper bound because the RAND study did not take into account that hospitals may have induced doctors to document medical records more completely in order to improve payment.

We calculate case-mix constant intensity as the change in total charges per admission, adjusted for price level changes (the CPI for hospital and related services), and changes in real case-mix. As we noted above, in accordance with § 412.308(c)(1)(ii), we began updating the capital standard Federal rate in FY 1996 using an update framework that takes into account, among other things, allowable changes in the intensity of hospital services. For FYs 1996 through 2001, we found that case-mix constant intensity was declining and we established a 0.0 percent adjustment for intensity in each of those years. For FYs 2002 and 2003, we found that case-mix constant intensity was increasing and we established a 0.3 percent adjustment and 1.0 percent adjustment for intensity, respectively. For FYs 2004 and 2005, we found that the charge data appeared to be skewed (as discussed in greater detail below) and we established a 0.0 percent adjustment in each of those years. Furthermore, we stated that we would continue to apply a 0.0 percent adjustment for intensity until any increase in charges can be tied to intensity rather than attempts to maximize outlier payments.

As noted above, our intensity measure is based on a 5-year average, and therefore, the intensity adjustment for FY 2007 is based on data from the 5-year period FY 2001 through FY 2005. We found a dramatic increase in hospital charges for each of those 5 years without a corresponding increase in the hospital case-mix index. These findings are similar to the considerable increase in hospitals' charges, which we found when we were determining the intensity factor in the FY 2004, FY 2005 and FY 2006 update recommendations as discussed in the FY 2004 IPPS final rule (68 FR 45482), the FY 2005 IPPS final rule (69 FR 49285) and the FY 2006 IPPS final rule (70 FR 47500), respectively. If hospitals were treating new or different types of cases, which would result in an appropriate increase in charges per discharge, then we would expect hospitals' case-mix to increase proportionally.

As we discussed in the FY 2006 IPPS final rule (70 FR 47500), because our intensity calculation relies heavily upon charge data and we believe that these charge data may be inappropriately skewed, we established a 0.0 percent adjustment for intensity for FY 2006.

On June 9, 2003, we published revisions to our outlier policy for determining the additional payment for extraordinarily high-cost cases (68 FR 34494 through 34515). These revised policies were effective on August 8, 2003, and October 1, 2003. While it does appear that a response to these policy changes is beginning to occur, that is, the change in charges for FYs 2004 and 2005 are somewhat less than the previous 4 years, they still show a significant annual increase in charges without a corresponding increase in hospital case-mix. The increase in charges in FY 2004, for example, is approximately 12 percent, which, while less than the increase in the previous 3 years, is still much higher than increases in years prior to FY 2001. In addition, this approximate 12-percent increase in charges for FY 2004 significantly exceeds the case-mix increase for the same period. Based on the approximate 12-percent increase in charges for FY 2004, we believe residual effects of hospitals' charge practices prior to the implementation of the outlier policy revisions established in the June 9, 2003 final rule continue to appear in the data because hospitals may not have had enough time to adopt changes in their behavior in response to the new outlier policy. Thus, we believe that the FY 2004 and FY 2005 charge data may still be skewed. Because the intensity adjustment is based on a 5-year average, and although the new outlier policy was generally effective in FY 2004, we believe it still will be several years before all the effects of hospitals attempting to maximize outlier

payments are removed from the intensity calculation. Therefore, as proposed, we are making a 0.0 percent adjustment for intensity for FY 2007. In the past (FYs 1996 through 2001) when we found intensity to be declining, we believed a zero (rather than negative) intensity adjustment was appropriate. Similarly, we believe that it is appropriate to apply a zero intensity adjustment for FY 2007 until any increase in charges can be tied to intensity rather than to attempts to maximize outlier payments.

Above, we described the basis of the components used to develop the 1.1 percent capital update factor for FY 2007 as shown in the table below.

CMS FY 2007 UPDATE FACTOR TO THE CAPITAL FEDERAL RATE

Capital Input Price Index	1.1
Intensity	0.0
Case-Mix Adjustment Factors:	
Real Across DRG Change	1.0
Projected Case-Mix Change	−1.0
Subtotal	0.0
Effect of FY 2005 Reclassification and Recalibration	0.0
Forecast Error Correction	0.0
Total Update	1.1

b. Comparison of CMS and MedPAC Update Recommendation

In the past, MedPAC has included update recommendations for capital PPS in a Report to Congress. In its March 2006 Report to Congress, MedPAC did not make an update recommendation for capital PPS payments for FY 2007. However, in that same report, MedPAC made an update recommendation for hospital inpatient and outpatient services (page 46). MedPAC reviews inpatient and outpatient services together because they are so closely interrelated. For FY 2007, MedPAC recommended an increase in the payment rate for the operating IPPS by the projected increase in the hospital market basket index, less half of MedPAC's expectation for productivity growth (or 0.45 percent, based on its assessment of beneficiaries' access to care and changes in hospital capacity, volume of services, access to capital, quality of care, and the relationship of Medicare payments and hospitals' costs.) In addition, MedPAC recommended combining the annual rate update with an incentive payment policy for quality. (MedPAC's Report to the Congress: Medicare Payment Policy, March 2006, Section 2A.)

2. Outlier Payment Adjustment Factor

Section 412.312(c) establishes a unified outlier methodology for inpatient operating and inpatient capital-related costs. A single set of thresholds is used to identify outlier cases for both inpatient operating and inpatient capital-related payments. Section 412.308(c)(2) provides that the standard Federal rate for inpatient capital-related costs be reduced by an adjustment factor equal to the estimated proportion of capital-related outlier payments to total inpatient capital-related PPS payments. The outlier thresholds are set so that operating outlier payments are projected to be 5.1 percent of total operating DRG payments.

In the FY 2006 IPPS final rule (70 FR 47501), we estimated that outlier payments for capital would equal 4.85 percent of inpatient capital-related payments based on the capital Federal rate in FY 2006. Based on the tentative thresholds as set forth in section II.A.4.c. of this Addendum, we estimate that tentative outlier payments for capital-related costs would equal 4.32 percent for inpatient capital-related payments based on the tentative Federal rate in FY 2007. Therefore, we are applying a tentative outlier adjustment factor of 0.9568 to the tentative capital Federal rate. Thus, we estimate that the percentage of capital outlier payments to total capital standard payments for FY 2007 will be slightly lower than the percentages for FY 2006.

The outlier reduction factors are not built permanently into the capital rates; that is, they are not applied cumulatively in determining the capital Federal rate. The tentative FY 2007 outlier adjustment of 0.9568 is a 0.56 percent change from the FY 2006 outlier adjustment of 0.9515. Therefore, the net change in the tentative outlier adjustment to the tentative capital Federal rate for FY 2007 is 1.0056 (0.9568/0.9915). Thus, the outlier adjustment increases the tentative FY 2007 capital Federal rate by 0.56 percent compared with the FY 2006 outlier adjustment.

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

Section 412.308(c)(4)(ii) requires that the capital Federal rate be adjusted so that aggregate payments for the fiscal year based on the capital Federal rate after any changes resulting from the annual DRG reclassification and recalibration and changes in the GAF are projected to equal aggregate payments that would have been made on the basis of the capital Federal rate without such changes. Because we implemented a separate GAF for Puerto Rico, we apply separate budget neutrality adjustments for the national GAF and the Puerto Rico GAF. We apply the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. Separate adjustments were unnecessary for FY 1998 and earlier because the GAF for Puerto Rico was implemented in FY 1998.

In the past, we used the actuarial capital cost model (described in Appendix B of the FY 2002 IPPS final rule (66 FR 40099)) to estimate the aggregate payments that would have been made on the basis of the capital Federal rate with and without changes in the DRG classifications and weights and in the GAF to compute the adjustment required to maintain budget neutrality for changes in DRG weights and in the GAF. During the transition period, the capital cost model was also used to estimate the regular exception payment adjustment factor. As we explain in section III.A.4. of this Addendum, beginning in FY 2002, an adjustment for regular exception payments is no longer necessary. Therefore, we are no longer using the capital cost model. Instead, we are using historical data based on hospitals' actual cost experiences to determine the exceptions payment adjustment factor for special exceptions payments.

To determine the tentative factors for FY 2007, we compared (separately for the national capital rate and the Puerto Rico capital rate) estimated aggregate capital Federal rate payments based on the FY 2006 DRG relative weights and the FY 2006 GAF to estimated aggregate capital Federal rate payments based on the FY 2007 relative weights and the tentative FY 2007 GAF. As we established in the FY 2006 IPPS final rule (70 FR 47503), the budget neutrality factors were 0.9920 for the national capital rate and 0.9959 for the Puerto Rico capital rate. In making the comparison, we set the exceptions reduction factor to 1.00. To achieve budget neutrality for the changes in the national GAF, based on calculations using updated data, we are applying a tentative incremental budget neutrality adjustment of 1.0003 for FY 2007 to the previous cumulative FY 2006 adjustments of 0.9920, yielding a tentative adjustment of 0.9923, through FY 2007 (calculations done on unrounded numbers). For the Puerto Rico GAF, we are applying a tentative incremental budget neutrality

adjustment of 1.0021 for FY 2007 to the previous cumulative FY 2006 adjustment of 0.9959, yielding a tentative cumulative adjustment of 0.9980 through FY 2007.

We then compared estimated aggregate capital Federal rate payments based on the FY 2006 DRG relative weights and the FY 2006 GAF to estimated aggregate capital Federal rate payments based on the FY 2007 DRG relative weights and the tentative FY 2007 GAF. The incremental adjustment for DRG classifications and changes in relative weights is 0.9992 both nationally and for Puerto Rico. The cumulative adjustments for DRG classifications and changes in relative weights and for changes in the tentative GAF through FY 2007 are 0.9914 nationally and 0.9972 for Puerto Rico. The following table summarizes the adjustment factors for each fiscal year:

BUDGET NEUTRALITY ADJUSTMENT FOR DRG RECLASSIFICATIONS AND RECALIBRATION AND THE GEOGRAPHIC ADJUSTMENT FACTORS

Fiscal year	National				Puerto Rico			
	Incremental adjustment				Incremental adjustment			
	Geographic adjustment factor	DRG reclassifications and recalibration	Combined	Cumulative	Geographic adjustment factor	DRG reclassifications and recalibration	Combined	Cumulative
1992				1.00000				
1993			0.99800	0.99800				
1994			1.00531	1.00330				
1995			0.99980	1.00310				
1996			0.99940	1.00250				
1997			0.99873	1.00123				
1998			0.99892	1.00015				1.00000
1999	0.99944	1.00335	1.00279	1.00294	0.99898	1.00335	1.00233	1.00233
2000	0.99857	0.99991	0.99848	1.00142	0.99910	0.99991	0.99901	1.00134
2001[1]	0.99782	1.00009	0.99791	0.99933	1.00365	1.00009	1.00374	1.00508
2001[2]	[3]0.99771	[3]1.00009	[3]0.99780	0.99922	[3]1.00365	[3]1.00009	[3]1.00374	1.00508
2002	[4]0.99666	[4]0.99668	[4]0.99335	0.99268	[4]0.98991	[4]0.99668	[4]0.99662	0.99164
2003[5]	0.99915	0.99662	0.99577	0.98848	1.00809	0.99662	1.00468	0.99628
2003[6]	[7]0.99896	[7]0.99662	[7]0.99558	0.98830	1.00809	0.99662	1.00468	0.99628
2004[8]	[9]1.00175	[9]1.00081	[9]1.00256	0.99083	1.00028	1.00081	1.00109	0.99736
2004[10]	[9]1.00164	[9]1.00081	[9]1.00245	0.99072	1.00028	1.00081	1.00109	0.99736
2005[11]	[12]0.99967	1.00094	[12]1.00061	0.99137	0.99115	1.00094	0.99208	0.98946
2005[13]	[12]0.99946	1.00094	[12]1.00040	0.99117	0.99115	1.00094	0.99208	0.98946
2006	[14]1.00185	0.99892	[14]1.00076	0.99198	1.00762	0.99892	1.00653	0.99592
2007	[15]1.00029	0.999[15]	[15]0.99943	[15]0.99142	[15]1.00213	0.99915	[15]1.00128	[15]0.99719

[1] Factors effective for the first half of FY 2001 (October 2000 through March 2001).
[2] Factors effective for the second half of FY 2001 (April 2001 through September 2001).
[3] Incremental factors are applied to FY 2000 cumulative factors.
[4] Incremental factors are applied to the cumulative factors for the first half of FY 2001.
[5] Factors effective for the first half of FY 2003 (October 2002 through March 2003).
[6] Factors effective for the second half of FY 2003 (April 2003 through September 2003).
[7] Incremental factors are applied to FY 2002 cumulative factors.
[8] Factors effective for the first half of FY 2004 (October 2003 through March 2004).
[9] Incremental factors are applied to the cumulative factors for the second half of FY 2003.
[10] Factors effective for the second half of FY 2004 (April 2004 through September 2004).
[11] Factors effective for the first quarter of FY 2005 (September 2004 through December 2004).
[12] Incremental factors are applied to average of the cumulative factors for the first half (October 1, 2003 through March 31, 2004) and second half (April 1, 2004 through September 30, 2004) of FY 2004.
[13] Factors effective for the last three quarters of FY 2005 (January 2005 through September 2005).
[14] Incremental factors are applied to average of the cumulative factors for 2005.
[15] Tentative factors for FY 2007, as discussed above in section III. of this Addendum.

The methodology used to determine the recalibration and geographic (DRG/GAF) budget neutrality adjustment factor is similar to that used in establishing budget neutrality adjustments under the PPS for operating costs. One difference is that, under the operating PPS, the budget neutrality adjustments for the effect of geographic reclassifications are determined separately from the effects of other changes in the hospital wage index and the DRG relative weights. Under the capital PPS, there is a single DRG/GAF budget neutrality adjustment factor (the national capital rate and the Puerto Rico capital rate are determined separately) for changes in the GAF (including geographic reclassification) and the DRG relative weights. In addition, there is no adjustment for the effects that geographic reclassification has on the other payment parameters, such as the payments for serving low-income patients, indirect medical education payments, or the large urban add-on payments.

In the FY 2006 IPPS final rule (70 FR 47503), we calculated a GAF/DRG budget neutrality factor of 1.0008 for FY 2006. For FY 2007, we are establishing a tentative GAF/DRG budget neutrality factor of 0.9994. The GAF/DRG budget neutrality factors are built permanently into the capital rates; that is, they are applied cumulatively in determining the capital Federal rate. This follows from the requirement that estimated aggregate payments each year be no more or less than they would have been in the absence of the annual DRG reclassification and recalibration and changes in the GAF. The tentative incremental change in the adjustment from FY 2006 to FY 2007 is 0.9994. The tentative cumulative change in the capital Federal rate due to this adjustment is 0.9914 (the product of the incremental factors for FYs 1993 though 2006 and the tentative incremental factor of 0.9994 for FY 2007). (We note that averages of the incremental factors that were in effect during FYs 2005 and 2006, respectively, were used in the calculation of the tentative cumulative adjustment of 0.9994 for FY 2007.)

This factor accounts for DRG reclassifications and recalibration and for changes in the GAF. It also incorporates the effects on the tentative GAF of FY 2007 geographic reclassification decisions made by the MGCRB compared to FY 2006 decisions. However, it does not account for changes in payments due to changes in the DSH and IME adjustment factors or in the large urban add-on.

4. Exceptions Payment Adjustment Factor

Section 412.308(c)(3) requires that the capital standard Federal rate be reduced by an adjustment factor equal to the estimated proportion of additional payments for both regular exceptions and special exceptions under § 412.348 relative to total capital PPS payments. In estimating the proportion of regular exception payments to total capital PPS payments during the transition period, we used the actuarial capital cost model originally developed for determining budget neutrality (described in Appendix B of the FY 2002 IPPS final rule (66 FR 40099)) to determine the exceptions payment adjustment factor, which was applied to both the Federal and hospital-specific capital rates.

An adjustment for regular exception payments is no longer necessary in determining the FY 2007 capital Federal rate because, in accordance with § 412.348(b), regular exception payments were only made for cost reporting periods beginning on or after October 1, 1991 and before October 1, 2001. Accordingly, as we explained in the FY 2002 IPPS final rule (66 FR 39949), in FY 2002 and subsequent fiscal years, no payments will be made under the regular exceptions provision. However, in accordance with § 412.308(c), we still need to compute a budget neutrality adjustment for special exception payments under § 412.348(g). We describe our methodology for determining the exceptions adjustment used in calculating the FY 2007 capital Federal rate below.

Under the special exceptions provision specified at § 412.348(g)(1), eligible hospitals include SCHs, urban hospitals with at least 100 beds that have a disproportionate share percentage of at least 20.2 percent or qualify for DSH payments under § 412.106(c)(2), and hospitals with a combined Medicare and Medicaid inpatient utilization of at least 70 percent. An eligible hospital may receive special exceptions payments if it meets: (1) A project need requirement as described at § 412.348(g)(2), which, in the case of certain urban hospitals, includes an excess capacity test as described at § 412.348(g)(4); (2) an age of assets test as described at § 412.348(g)(3); and (3) a project size requirement as described at § 412.348(g)(5).

Based on information compiled from our fiscal intermediaries, six hospitals have qualified for special exceptions payments under § 412.348(g). Because we have cost reports ending in FY 2005 for all of these hospitals, we calculated the adjustment based on actual cost experience. Using data from cost reports ending in FY 2005 from the December 2005 update of the HCRIS data, we divided the capital special exceptions payment amounts for the six hospitals that qualified for special exceptions by the total capital PPS payment amounts (including special exception payments) for all hospitals. Based on the data from cost reports ending in FY 2005, this ratio is rounded to 0.0003. Because we have not received all cost reports ending in FY 2005, we also divided the FY 2005 special exceptions payments by the total capital PPS payment amounts for all hospitals with cost reports ending in FY 2004. This ratio also rounds to 0.0003. Because special exceptions are budget neutral, we are offsetting the tentative capital Federal rate by 0.03 percent for special exceptions payments for FY 2007. Therefore, the exceptions adjustment factor is equal to 0.9997 (1—0.0003) to account for special exceptions payments in FY 2007.

In the FY 2006 IPPS final rule (70 FR 47503), we estimated that total (special) exceptions payments for FY 2006 would equal 0.03 percent of aggregate payments based on the capital Federal rate. Therefore, we applied an exceptions adjustment factor of 0.9997 (1—0.0003) in determining the FY 2006 capital Federal rate. As we stated above, we estimate that exceptions payments in FY 2007 will equal 0.03 percent of aggregate payments based on the tentative FY 2007 capital Federal rate. Therefore, we are applying an exceptions payment adjustment factor of 0.9997 to the capital Federal rate for FY 2007. The exceptions adjustment factor for FY 2007 is the same as the factor used in determining the FY 2006 capital Federal rate in the FY 2006 IPPS final rule (70 FR 47503). The exceptions reduction factors are not built permanently into the capital rates; that is, the factors are not applied cumulatively in determining the capital Federal rate. Therefore, the net change in the exceptions adjustment factor used in determining the tentative FY 2007 capital Federal rate is 1.0000 (0.9997/0.9997).

5. Capital Standard Federal Rate for FY 2007

In the FY 2006 IPPS final rule (70 FR 47503), we established a capital Federal rate of $420.65 for FY 2006. In this final rule, we are establishing a tentative capital Federal rate of $427.38 for FY 2007. The tentative capital Federal rate for FY 2007 was calculated as follows:

- The FY 2007 update factor is 1.0110; that is, the update is 1.1 percent.

- The tentative FY 2007 budget neutrality adjustment factor that is applied to the capital standard Federal payment rate for changes in the DRG relative weights and in the GAF is 0.9994.
- The tentative FY 2007 outlier adjustment factor is 0.9568.
- The FY 2007 (special) exceptions payment adjustment factor is 0.9997.

Because the tentative capital Federal rate has already been adjusted for differences in case-mix, wages, cost-of-living, indirect medical education costs, and payments to hospitals serving a disproportionate share of low-income patients, we are not making additional adjustments in the capital standard Federal rate for these factors, other than the tentative budget neutrality factor for changes in the DRG relative weights and the GAF.

We are providing a chart that shows how each of the factors and adjustments for FY 2007 affected the computation of the tentative FY 2007 capital Federal rate in comparison to the average FY 2006 capital Federal rate. The FY 2007 update factor has the effect of increasing the tentative capital Federal rate by 1.1 percent compared to the average FY 2006 Federal rate. The tentative GAF/DRG budget neutrality factor has the effect of decreasing the tentative capital Federal rate by 0.06 percent. The tentative FY 2007 outlier adjustment factor has the effect of increasing the tentative capital Federal rate by 0.56 percent compared to the average FY 2006 capital Federal rate. The FY 2007 exceptions payment adjustment factor remains unchanged from the FY 2006 exceptions payment adjustment factor, and therefore, has a 0.0 percent net effect on the tentative FY 2007 capital Federal rate. The combined effect of all the changes is to tentatively increase the capital Federal rate by 1.6 percent compared to the average FY 2006 capital Federal rate.

COMPARISON OF FACTORS AND ADJUSTMENTS: FY 2006 CAPITAL FEDERAL RATE AND FY 2007 CAPITAL FEDERAL RATE

	FY 2006	FY 2007	Change	Percent change
Update Factor [1]	1.0080	1.0110	1.0110	1.10
GAF/DRG Adjustment Factor [1]	1.0008	[3] 0.9994	0.9994	−0.06
Outlier Adjustment Factor [2]	0.9515	[3] 0.9568	1.0056	0.56
Exceptions Adjustment Factor [2]	0.9997	0.9997	0.0000	0.00
Capital Federal Rate	$420.65	[3] $427.38	1.0160	1.60

[1] The update factor and the GAF/DRG budget neutrality factors are built permanently into the capital rates. Thus, for example, the incremental change from FY 2006 to FY 2007 resulting from the application of the tentative 0.9994 GAF/DRG budget neutrality factor for FY 2007 is 0.9994.

[2] The outlier reduction factor and the exceptions adjustment factor are not built permanently into the capital rates; that is, these factors are not applied cumulatively in determining the capital rates. Thus, for example, the net change resulting from the application of the tentative FY 2007 outlier adjustment factor would be 0.9568/0.9515, or 1.0056.

[3] Tentative factors for FY 2007, as discussed above in section III. of this Addendum.

We are also providing a chart that shows how the tentative final FY 2007 capital Federal rate differs from the proposed FY 2007 capital Federal rate presented in the FY 2007 IPPS proposed rule (71 FR 24158–24159).

COMPARISON OF FACTORS AND ADJUSTMENTS: PROPOSED FY 2007 CAPITAL FEDERAL RATE AND TENTATIVE FINAL FY 2007 CAPITAL FEDERAL RATE

	Proposed FY 2007	Final FY 2007	Change	Percent change
Update factor	1.0080	1.0110	1.0030	0.30
GAF/DRG Adjustment Factor	1.0012	*0.9994	0.9982	−0.18
Outlier Adjustment Factor	0.9513	*0.9568	1.0058	0.58
Exceptions Adjustment Factor	0.9997	0.9997	0.0000	0.00
Capital Federal Rate	$424.42	*$427.38	1.0070	0.70

*Tentative factors for FY 2007, as discussed above in section III. of this Addendum.

6. Special Capital Rate for Puerto Rico Hospitals

Section 412.374 provides for the use of a blended payment system for payments to Puerto Rico hospitals under the PPS for acute care hospital inpatient capital-related costs. Accordingly, under the capital PPS, we compute a separate payment rate specific to Puerto Rico hospitals using the same methodology used to compute the national Federal rate for capital-related costs. Under the broad authority of section 1886(g) of the Act, as discussed in section VI. of the preamble of this final rule, beginning with discharges occurring on or after October 1, 2004, capital payments to hospitals in Puerto Rico are based on a blend of 25 percent of the Puerto Rico capital rate and 75 percent of the capital Federal rate. The Puerto Rico capital rate is derived from the costs of Puerto Rico hospitals only, while the capital Federal rate is derived from the costs of all acute care hospitals participating in the IPPS (including Puerto Rico).

To adjust hospitals' capital payments for geographic variations in capital costs, we apply a GAF to both portions of the blended capital rate. The GAF is calculated using the operating IPPS wage index and varies, depending on the labor market area or rural area in which the hospital is located. We use the Puerto Rico wage index to determine the GAF for the Puerto Rico part of the capital-blended rate and the national wage index to determine the GAF for the national part of the blended capital rate.

Because we implemented a separate GAF for Puerto Rico in FY 1998, we also apply separate budget neutrality adjustments for the national GAF and for the Puerto Rico GAF. However, we apply the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. As we stated above in section III.A.4. of this Addendum, for Puerto Rico, the tentative GAF budget neutrality factor is 1.0021, while the DRG adjustment is 0.9992, for a

combined tentative cumulative adjustment of 0.9972.

In computing the payment for a particular Puerto Rico hospital, the Puerto Rico portion of the capital rate (25 percent) is multiplied by the Puerto Rico-specific GAF for the labor market area in which the hospital is located, and the national portion of the capital rate (75 percent) is multiplied by the national GAF for the labor market area in which the hospital is located (which is computed from national data for all hospitals in the United States and Puerto Rico). In FY 1998, we implemented a 17.78 percent reduction to the Puerto Rico capital rate as a result of Pub. L. 105–33. In FY 2003, a small part of that reduction was restored.

For FY 2006, before application of the GAF, the special capital rate for Puerto Rico hospitals was $201.93 for discharges occurring on or after October 1, 2005 through September 30, 2006. With the changes we are making to the factors used to determine the capital rate, the tentative FY 2007 special capital rate for Puerto Rico is $203.13.

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

Because the 10-year capital PPS transition period ended in FY 2001, all hospitals (except "new" hospitals under § 412.324(b) and under § 412.304(c)(2)) are paid based on 100 percent of the capital Federal rate in FY 2006. The applicable capital Federal rate was determined by making adjustments as follows:

- For outliers, by dividing the capital standard Federal rate by the outlier reduction factor for that fiscal year; and
- For the payment adjustments applicable to the hospital, by multiplying the hospital's GAF, disproportionate share adjustment factor, and IME adjustment factor, when appropriate.

For purposes of calculating payments for each discharge during FY 2007, the capital standard Federal rate is adjusted as follows: (Standard Federal Rate) × (DRG weight) × (GAF) × (Large Urban Add-on, if applicable) × (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.

Hospitals also may receive outlier payments for those cases that qualify under the thresholds established for each fiscal year. Section 412.312(c) provides for a single set of thresholds to identify outlier cases for both inpatient operating and inpatient capital-related payments. The tentative outlier thresholds for FY 2007 are in section II.A.4.c. of this Addendum. For FY 2007, a case qualifies as a cost outlier if the cost for the case plus the IME and DSH payments is greater than the prospective payment rate for the DRG plus the tentative fixed-loss amount of $24,475.

An eligible hospital may also qualify for a special exceptions payment under § 412.348(g) for up through the 10th year beyond the end of the capital transition period if it meets: (1) A project need requirement described at § 412.348(g)(2), which in the case of certain urban hospitals includes an excess capacity test as described at § 412.348(g)(4); and (2) a project size requirement as described at § 412.348(g)(5). Eligible hospitals include SCHs, urban hospitals with at least 100 beds that have a DSH patient percentage of at least 20.2 percent or qualify for DSH payments under § 412.106(c)(2), and hospitals that have a combined Medicare and Medicaid inpatient utilization of at least 70 percent. Under § 412.348(g)(8), the amount of a special exceptions payment is determined by comparing the cumulative payments made to the hospital under the capital PPS to the cumulative minimum payment level. This amount is offset by: (1) Any amount by which a hospital's cumulative capital payments exceed its cumulative minimum payment levels applicable under the regular exceptions process for cost reporting periods beginning during which the hospital has been subject to the capital PPS; and (2) any amount by which a hospital's current year operating and capital payments (excluding 75 percent of operating DSH payments) exceed its operating and capital costs. Under § 412.348(g)(6), the minimum payment level is 70 percent for all eligible hospitals.

During the transition period, new hospitals (as defined under § 412.300) were exempt from the capital PPS for their first 2 years of operation and were paid 85 percent of their reasonable costs during that period. Effective with the third year of operation through the remainder of the transition period, under § 412.324(b), we paid the hospitals under the appropriate transition methodology (if the hold-harmless methodology were applicable, the hold-harmless payment for assets in use during the base period would extend for 8 years, even if the hold-harmless payments extend beyond the normal transition period).

Under § 412.304(c)(2), for cost reporting periods beginning on or after October 1, 2002, we pay a new hospital 85 percent of its reasonable costs during the first 2 years of operation unless it elects to receive payment based on 100 percent of the capital Federal rate. Effective with the third year of operation, we pay the hospital based on 100 percent of the capital Federal rate (that is, the same methodology used to pay all other hospitals subject to the capital PPS).

C. Capital Input Price Index

1. Background

Like the operating input price index, the capital input price index (CIPI) is a fixed-weight price index that measures the price changes associated with capital costs during a given year. The CIPI differs from the operating input price index in one important aspect—the CIPI reflects the vintage nature of capital, which is the acquisition and use of capital over time. Capital expenses in any given year are determined by the stock of capital in that year (that is, capital that remains on hand from all current and prior capital acquisitions). An index measuring capital price changes needs to reflect this vintage nature of capital. Therefore, the CIPI was developed to capture the vintage nature of capital by using a weighted-average of past capital purchase prices up to and including the current year.

We periodically update the base year for the operating and capital input prices to reflect the changing composition of inputs for operating and capital expenses. The CIPI was last rebased to FY 2002 in the FY 2006 IPPS final rule (70 FR 47387).

2. Forecast of the CIPI for FY 2007

Based on the latest forecast by Global Insight, Inc. (second quarter of 2006), we are forecasting the CIPI to increase 1.1 percent in FY 2007. This reflects a projected 1.7 percent increase in vintage-weighted depreciation prices (building and fixed equipment, and movable equipment) and a 3.1 percent increase in other capital expense prices in FY 2007, partially offset by a 2.1 percent decline in vintage-weighted interest expenses in FY 2007. The weighted average of these three factors produces the 1.1 percent increase for the CIPI as a whole in FY 2007.

The CIPI forecast of 1.1 percent is higher than the CIPI forecast of 0.8 percent that appeared in the proposed rule. This is mainly due to a change in the forecast of vintage-weighted depreciation prices from a 1.4 percent to a 1.7 percent increase and a change in vintage-weighted interest expenses from a 2.3 to a 2.1 percent decline. The change in the forecast for depreciation

prices reflects the incorporation of newly available source data for fixed asset prices into the market basket, while the change in the forecast for interest expenses reflects the incorporation of recent increases in interest rates.

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

A. Payments to Existing Excluded Hospitals and Units

As discussed in section VI. of the preamble of this final rule, the inpatient operating costs of children's hospitals and cancer hospitals that are excluded from the IPPS are paid on the basis of reasonable cost subject to the rate-of-increase ceiling established under the authority of sections 1886(b)(3)(A)(i) and (ii) of the Act and § 413.40 of the regulations. The ceiling is based on a target amount per discharge under TEFRA. In addition, in accordance with § 403.752(a) of the regulations, RNHCIs also are paid under § 413.40 which uses section 1886(b)(3)(B)(ii) of the Act to update the percentage increase in the rate of increase limits. The most recent projected forecast of the market basket percentage increase for FY 2007 for children's hospitals, cancer hospitals, and RNHCIs using the IPPS market basket (70 FR 47396 through 47405) is 3.4 percent (the same as we proposed).

LTCHs, rehabilitation hospitals and units, and psychiatric hospitals and units, historically, were excluded from the IPPS and subject to the rate-of-increase limits under § 413.40, as well. However, prospective payment systems have been developed for each of the three types of hospitals, and each kind of hospital is currently paid under its own PPS, either at 100 percent of the Federal rate or according to a transition period methodology, if applicable. (For more detailed discussion of these payment methodologies, see 69 FR 49190; 69 FR 66922; 68 FR 45674; and 67 FR 55954.)

For cost reporting periods beginning on or after October 1, 2002, to the extent a LTCH or a psychiatric hospital or unit has all or a portion of its payment determined under reasonable cost principles, the target amounts for the reasonable cost-based portion of the blended payment are determined in accordance with sections 1886(b)(3)(A)(i) and 1886(b)(3)(B)(ii) of the Act and the regulations at § 413.40(c)(4)(ii). Section 413.40(c)(4)(ii) states, "Subject to the provisions of [§ 413.40], paragraph (c)(4)(iii) of this section, for subsequent cost reporting periods, the target amount equals the hospital's target amount for the previous cost reporting period increased by the update factor for the subject cost reporting period, unless the provisions of [§ 413.40] paragraph (c)(5)(ii) of this section apply." Thus, because § 413.40(c)(4)(ii) indicates that the provisions of that paragraph are subject to the provisions of § 413.40(c)(4)(iii), which are applicable only for cost reporting periods beginning on or after October 1, 1997 through September 30, 2002, the target amount for FY 2003 is determined by updating the target amount for FY 2002 by the applicable update factor. For example, if a provider was paid the cap amount for FY 2002 (§ 413.40(c)(4)(iii)), the target amount for FY 2003 would be the amount paid in FY 2002, updated to FY 2003 (that is, the target amount from the previous year increased by the applicable update factor).

Effective for cost reporting periods beginning on or after October 1, 2002, IRFs are paid 100 percent of the adjusted Federal prospective payment rate under the IRP PPS.

Effective for cost reporting periods beginning on or after October 1, 2002, LTCHs also are no longer paid on a reasonable cost basis, but are paid under a LTCH DRG-based PPS. In implementing the LTCH PPS, an existing LTCH (that is, not defined as new under § 412.23(e)(4)) could have elected to be paid based on 100 percent of the standard Federal prospective payment rate during the transition period. However, we also established a 5-year transition period from reasonable cost-based payments (subject to the TEFRA limit) to fully Federal prospective payment amounts during which an existing LTCH could receive a PPS-blended payment consisting of two payment components—one based on reasonable cost under the TEFRA payment system, and the other based on the standard Federal prospective payment rate.

Effective for cost reporting periods that will begin on or after October 1, 2006, the LTCHs that receive payment based on a blended payment amount will no longer receive a portion of their payment that is based, in part, on reasonable cost subject to the rate-of-increase ceiling under § 413.40. This is because, in accordance with § 412.533, LTCHs are paid 100 percent of the adjusted Federal prospective payment amount and zero percent of the amount calculated under reasonable cost principles for cost reporting periods beginning on or after October 1, 2006.

As part of the PPS for existing IPFs, we have established a 3-year transition period during which existing IPFs will be paid based on a blend of reasonable cost-based payment (subject to the TEFRA limit) and the prospective per diem payment rate. IPFs that are paid under a blended methodology will have the reasonable cost-based portion of their payment subject to a hospital target amount. The most recent projected forecast of the market basket percentage increase for FY 2007 for the reasonable cost-based portion of an IPF's payment using the excluded hospital market basket (70 FR 47396 through 47405) is 3.4 percent. For cost reporting periods beginning on or after January 1, 2008, IPFs will be paid 100 percent of the Federal prospective per diem amount.

The market basket percentage increases for FY 2007 are made by CMS' Office of the Actuary and reflect the average change in the price of goods and services purchased by hospitals to furnish inpatient hospital care. They are based on the best available data. As discussed in section III.L. of the preamble of this FY 2006 IPPS final rule, we use the IPPS market basket for children's hospitals, cancer hospitals, and RNHCIs, and the excluded hospital market basket for LTCHs, and IPFs for the reasonable cost portion of its payment to the extent a portion of its PPS payment is based on reasonable costs. We did not propose any changes to our method of calculating the hospital market basket for IPPS or for excluded hospitals for FY 2007. Consistent with our current methodology of calculating the hospital market basket for IPPS and excluded hospitals, we use updated data for our final rule to the extent it is available. As we indicated above, based on updated data, the projected IPPS market basket increase is 3.4 percent (the same as we proposed) and the projected excluded hospital market basket increase is 3.4 percent (as opposed to 3.6 percent in the proposed rule) for FY 2007.

B. New Excluded Hospitals and Units

Section 1886(b)(7) of the Act established a payment methodology for new (cost reporting periods beginning on or after October 1, 1997) rehabilitation hospitals and units, psychiatric hospitals and units, and LTCHs. For the first two 12-month cost reporting periods, payment was based on the lower of the hospital's net inpatient operating costs or 110 percent of the national median of target amounts for the particular class of hospital for FY 1996, updated to the applicable cost reporting period, and adjusted for differences in area wage levels. Consequently, beginning with the FY 1998 IPPS final rule, we published

annually in the **Federal Register**, the updated 110 percent median of the wage-neutral national target amounts, divided into the labor and nonlabor-related share, for each of the three classes of providers affected by the payment limitation. As explained in the FY 2006 IPPS final rule (70 FR 47466 through 47467), the charts containing the updated 110 percent median payment amount information are no longer needed and are discontinued.

V. Payment for Blood Clotting Factor Administered to Inpatient With Hemophilia

As discussed in section VIII. of the preamble to this final rule, in the FY 2006 IPPS final rule (70 FR 47473), we amended our regulations at §§ 412.2(f)(8) and 412.115(b) to state that, for discharges occurring on or after October 1, 2005, we make payment for blood clotting factor administered to hospital inpatients using the Medicare Part B payment amounts for blood clotting factor as determined under Subpart K of 48 CFR Part 414 and for the furnished fee as determined under § 410.63.

In accordance with § 410.63(c)(2) and our November 21, 2005 regulations (70 FR 70225), the furnishing fee for blood clotting factor for CY 2006 was determined to be $0.146 per individual unit (I.U.). Although the furnishing fee payment rate is calculated at 3 digits, the actual amount paid to providers and suppliers is rounded to 2 digits. In section VIII of the preamble to this final rule, we are providing that fiscal intermediaries continue to make payment amounts for blood clotting factor administered to hemophilia inpatients using the Medicare Part B payment amounts determined under Subpart K of 42 CFR Part 414 and that payment amounts for the furnishing fee for the blood clotting factor be calculated at 3 digits, currently at $0.146 per I.U. of blood clotting factor.

The fiscal intermediaries continue to use the Medicare Part B Drug Pricing File to make payments for blood clotting factors. The furnishing fee is included in the ASP price per unit sent with the Medicare Part B Drug Pricing File that is updated quarterly. By using the Medicare Part B Drug Pricing File, Medicare will be making consistent payments for blood clotting factor provided to inpatients and outpatients. For further updates on pricing, we refer reader to the Medicare Part B drug pricing regulations.

VI. Tables

This section includes a majority of the tables referred to throughout the preamble to this final rule and in this Addendum.

The following tables, which contain data relating to the FY 2007 wage indices and the hospital reclassifications and payment amounts for operating and capital-related costs that are affected by the new occupational mix survey data discussed in section III.C. of this final rule, will be published on the CMS Web site and in a subsequent **Federal Register** notice between August 1 and October 1, 2006.

Table 2—Hospital Case-Mix Indexes for Discharges Occurring in Federal Fiscal Year 2005; Hospital Wage Indexes for Federal Fiscal Year 2007; Hospital Average Hourly Wage for Federal Fiscal Years 2005 (2001 Wage Data), 2006 (2002 Wage Data), and 2007 (2003 Wage Data); Wage Indexes and 3-Year Average of Hospital Average Hourly Wages
Table 3A—FY 2007 and 3-Year Average Hourly Wage for Urban Areas by CBSA
Table 3B—FY 2007 and 3-Year Average Hourly Wage for Rural Areas by CBSA
Table 4A–1—Wage Index and Capital Geographic Adjustment Factor (GAF) for Urban Areas by CBSA—FY 2007
Table 4A–2—Wage Index and Capital Geographic Adjustment Factor (GAF) for Certain Urban Areas by CBSA for the Period April 1 through September 30, 2007
Table 4B—Wage Index and Capital Geographic Adjustment Factor (GAF) for Rural Areas by CBSA—FY 2007
Table 4C–1—Wage Index and Capital Geographic Adjustment Factor (GAF) for Hospitals That Are Reclassified by CBSA—FY 2007
Table 4C–2—Wage Index and Capital Geographic Adjustment Factor (GAF) for Certain Hospitals That Are Reclassified by CBSA for the Period April 1 through September 30, 2007
Table 4F—Puerto Rico Wage Index and Capital Geographic Adjustment Factor (GAF) by CBSA—FY 2007

The following tables are included in this final rule as tentative tables and do not reflect decisions that are yet to be made by CMS pending the final calculation of the occupational mix adjusted wage index. Additional information appears with each table. Revised tables reflecting CMS' decisions on behalf of hospitals using occupational mix adjusted wage indices will be published on the CMS Web site, as well as in a subsequent **Federal Register** notice between August 1 and October 1, 2006.

Table 1A—National Adjusted Operating Standardized Amounts, Labor/Nonlabor (69.7 Percent Labor Share/30.3 Percent Nonlabor Share if Wage Index Is Greater Than 1)
Table 1B—National Adjusted Operating Standardized Amounts, Labor/Nonlabor (62 Percent Labor Share/38 Percent Nonlabor Share if Wage Index Is Less Than or Equal To 1)
Table 1C—Adjusted Operating Standardized Amounts for Puerto Rico, Labor/Nonlabor
Table 1D—Capital Standard Federal Payment Rate
Table 4J—Out-Migration Adjustment—FY 2007
Table 5—List of Diagnosis-Related Groups (DRGs), Relative Weighting Factors, and Geometric and Arithmetic Mean Length of Stay (LOS)
Table 9A—Hospital Reclassifications and Redesignations by Individual Hospitals and CBSA for FY 2007
Table 9B—Hospital Reclassifications and Redesignations by Individual Hospital Under Section 508 of Pub. L. 108–173 for FY 2007
Table 9C—Hospitals Redesignated as Rural under Section 1886(d)(8)(E) of the Act for FY 2007
Table 10—Tentative Geometric Mean Plus the Lesser of .75 of the National Adjusted Operating Standardized Payment Amount (Increased to Reflect the Difference Between Costs and Charges) or .75 of One Standard Deviation of Mean Charges by Diagnosis-Related Group (DRG)—July 2006

The following tables are final and not subject to revision based on the final calculation of the occupational mix adjusted wage index.

Table 6A—New Diagnosis Codes
Table 6B—New Procedure Codes
Table 6C—Invalid Diagnosis Codes
Table 6D—Invalid Procedure Codes
Table 6E—Revised Diagnosis Code Titles
Table 6F—Revised Procedure Code Titles
Table 6G—Additions to the CC Exclusions List
Table 6H—Deletions from the CC Exclusions List
Table 7A—Medicare Prospective Payment System Selected Percentile Lengths of Stay: FY 2005 MedPAR Update March 2006 GROUPER V23.0
Table 7B—Medicare Prospective Payment System Selected Percentile Lengths of Stay: FY 2005 MedPAR Update March 2006 GROUPER V24.0
Table 8A—Statewide Average Operating Cost-to-Charge Ratios—July 2006
Table 8B—Statewide Average Capital Cost-to-Charge Ratios—July 2006
Table 8C—Statewide Average Total Cost-to-Charge Ratios for LTCHs—July 2006
Table 11—FY 2007 LTC–DRGs, Relative Weights, Geometric Average Length of Stay, and 5/6ths of the Geometric Average Length of Stay

TABLE 1A.—NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, 69.7 PERCENT LABOR SHARE/30.3 PERCENT NONLABOR SHARE IF WAGE INDEX GREATER THAN 1

Full Update (3.4 percent)	*Note: Subsequent to this final rule, we will publish the final standardized amounts based on the final occupational mix adjustment.
Tentative Labor Related Share: $3,400.13*	
Tentative Nonlabor Related Share: $1,478.10*	
Reduced Update (1.4 percent)	*Note: Subsequent to this final rule, we will publish the final standardized amounts based on the final occupational mix adjustment.
Tentative Labor Related Share: $3,334.36*	
Tentative Nonlabor Related Share: $1,449.51*	

TABLE 1B.—NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, 62 PERCENT LABOR SHARE/38 PERCENT NONLABOR SHARE IF WAGE INDEX LESS THAN OR EQUAL TO 1

Full Update (3.4 percent)	*Note: Subsequent to this final rule, we will publish the final standardized amounts based on the final occupational mix adjustment.
Tentative Labor Related Share: $3,024.51*	
Tentative Nonlabor Related Share: $1,853.72*	
Reduced Update (1.4 percent)	*Note: Subsequent to this final rule, we will publish the final standardized amounts based on the final occupational mix adjustment.
Tentative Labor Related Share: $2,966.00*	
Tentative Nonlabor Related Share: $1,817.87*	

TABLE 1C.—ADJUSTED OPERATING STANDARDIZED AMOUNTS FOR PUERTO RICO, LABOR/NONLABOR

Rates if wage index greater than one (National)	*Note: Subsequent to this final rule, we will publish the final standardized amounts based on the final occupational mix adjustment.
Tentative Labor Related Share: $3,400.13*	
Tentative Nonlabor Related Share: $1,478.10*	
Rates if wage index greater than one (Puerto Rico)	*Note: Subsequent to this final rule, we will publish the final standardized amounts based on the final occupational mix adjustment.
Tentative Labor Related Share: $1,436.25*	
Tentative Nonlabor Related Share: $880.28*	
Rates if wage index less than one (National)	*Note: Subsequent to this final rule, we will publish the final standardized amounts based on the final occupational mix adjustment.
Tentative Labor Related Share: $3,024.51*	
Tentative Nonlabor Related Share: $1,853.72*	
Rates if wage index less than one (Puerto Rico)	*Note: Subsequent to this final rule, we will publish the final standardized amounts based on the final occupational mix adjustment.
Tentative Labor Related Share: $1,359.80*	
Tentative Nonlabor Related Share: $956.72*	

TABLE 1D.—CAPITAL STANDARD FEDERAL PAYMENT RATE

National	*Note: Subsequent to this final rule, we will publish the final standardized amounts based on the final occupational mix adjustment.
Tentative Capital Payment Rate: $427.38*	
Puerto Rico	*Note: Subsequent to this final rule, we will publish the final standardized amounts based on the final occupational mix adjustment.
Tentative Capital Payment Rate: $203.13*	

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TABLE 4J.--OUT-MIGRATION ADJUSTMENT --FY 2007

The following list represents all hospitals located in counties that became newly eligible in FY 2005 or FY 2006 to have their wage index increased by the out-migration adjustment listed in this table. Hospitals cannot receive the out-migration adjustment if they are reclassified under section 1886(d)(10) of the Act, reclassified under section 508 of Pub. L. 108-173, or redesignated under section 1886(d)(8) of the Act. If a hospital has a half fiscal year reclassification, the hospital will be eligible for the out-migration adjustment for the portion of the fiscal year that it is not reclassified. Hospitals that have already been reclassified under section 1886(d)(10) of the Act, reclassified under section 508 of Pub. L. 108-173, or redesignated under section 1886(d)(8) of the Act for any portion of the fiscal year are designated with an asterisk. It is important to note that Table 4J is a tentative table and the asterisked information reflects the latest information available to CMS regarding MGCRB and Administrator reclassification decisions for FY 2007. It does not reflect any potential withdrawal decisions yet to be made by CMS or the hospitals. This table also does not reflect any additional hospitals located in counties that may newly qualify for the adjustment in FY 2007. We must reevaluate which counties are newly eligible for the out-migration adjustment in FY 2007 using the 100 percent occupational mix adjusted wage index data. A revised Table 4J reflecting CMS decisions on behalf of hospitals using occupational mix adjusted wage indices will be published in a subsequent **Federal Register** notice between August 1 and October 1, 2006. The subsequent **Federal Register** notice will also contain tables listing all interim reclassification/redesignations. Hospitals will then have 30 days from the date data appears on the CMS Web site to determine whether to submit a request to withdraw the reclassification/redesignation shown in such tables and receive the out-migration adjustment instead. Unless we are notified within 30 days of the data appearing on the CMS Web site, we will automatically assume that hospitals reclassified under section 1886(d)(10) of the Act, reclassified under section 508 of Pub. L. 108-173, or redesignated under section 1886(d)(8) of the Act wish to retain their reclassification/redesignation status and waive the application of the out-migration adjustment. Hospitals are not required to provide CMS with any type of formal notification that they wish to remain reclassified/redesignated.

Provider Number	Reclassified between 10/1/06 and 3/31/07	Reclassified between 4/1/07 and 9/30/07	Out-migration Adjustment	Qualifying County Name
010005	*	*	0.0259	MARSHALL
010008	*	*	0.0212	CRENSHAW
010009	*	*	0.0092	MORGAN
010010			0.0259	MARSHALL
010012	*	*	0.0205	DE KALB
010022	*	*	0.0714	CHEROKEE
010025	*	*	0.0235	CHAMBERS
010029	*	*	0.0107	LEE
010035	*	*	0.0375	CULLMAN
010038			0.0062	CALHOUN
010045	*	*	0.016	FAYETTE

Provider Number	Reclassified between 10/1/06 and 3/31/07	Reclassified between 4/1/07 and 9/30/07	Out-migration Adjustment	Qualifying County Name
010005	*	*	0.0259	MARSHALL
010008	*	*	0.0212	CRENSHAW
010009	*	*	0.0092	MORGAN
010010			0.0259	MARSHALL
010012	*	*	0.0205	DE KALB
010022	*	*	0.0714	CHEROKEE
010025	*	*	0.0235	CHAMBERS
010029	*	*	0.0107	LEE
010035	*	*	0.0375	CULLMAN
010038			0.0062	CALHOUN
010045	*	*	0.016	FAYETTE
010047			0.0155	BUTLER
010054	*	*	0.0092	MORGAN
010061			0.0506	JACKSON
010078			0.0062	CALHOUN
010083	*	*	0.0121	BALDWIN
010085	*	*	0.0092	MORGAN
010100	*	*	0.0121	BALDWIN
010101	*	*	0.031	TALLADEGA
010109			0.0451	PICKENS
010129			0.0121	BALDWIN
010143	*	*	0.0375	CULLMAN
010146			0.0062	CALHOUN
010150	*	*	0.0155	BUTLER
010158	*	*	0.0093	FRANKLIN
010164	*	*	0.031	TALLADEGA
040014	*	*	0.0159	WHITE
040019	*	*	0.0697	ST. FRANCIS
040047	*	*	0.009	RANDOLPH
040069	*	*	0.014	MISSISSIPPI
040071	*	*	0.0026	JEFFERSON
040076	*	*	0.1075	HOT SPRING
040100	*	*	0.0159	WHITE
050008			0.0026	SAN FRANCISCO
050009	*	*	0.0478	NAPA
050013	*	*	0.0478	NAPA
050014	*	*	0.0131	AMADOR
050016			0.0103	SAN LUIS OBISPO
050042	*	*	0.0219	TEHAMA
050046		*	0.0156	VENTURA
050047			0.0026	SAN FRANCISCO
050055			0.0026	SAN FRANCISCO
050065	*	*	0.0029	ORANGE
050069	*	*	0.0029	ORANGE
050073	*	*	0.0269	SOLANO
050076	*	*	0.0026	SAN FRANCISCO
050082		*	0.0156	VENTURA
050084			0.0555	SAN JOAQUIN
050089	*	*	0.0152	SAN BERNARDINO
050090	*	*	0.0308	SONOMA
050099	*	*	0.0152	SAN BERNARDINO
050101	*	*	0.0269	SOLANO
050117			0.0463	MERCED
050118	*	*	0.0555	SAN JOAQUIN
050122			0.0555	SAN JOAQUIN
050129	*	*	0.0152	SAN BERNARDINO
050133			0.017	YUBA

Provider Number	Reclassified between 10/1/06 and 3/31/07	Reclassified between 4/1/07 and 9/30/07	Out-migration Adjustment	Qualifying County Name
050136	*	*	0.0308	SONOMA
050140	*	*	0.0152	SAN BERNARDINO
050150	*	*	0.0316	NEVADA
050152			0.0026	SAN FRANCISCO
050159		*	0.0156	VENTURA
050167			0.0555	SAN JOAQUIN
050168	*	*	0.0029	ORANGE
050173	*	*	0.0029	ORANGE
050174	*	*	0.0308	SONOMA
050193	*	*	0.0029	ORANGE
050224	*	*	0.0029	ORANGE
050226	*	*	0.0029	ORANGE
050228	*	*	0.0026	SAN FRANCISCO
050230	*	*	0.0029	ORANGE
050232			0.0103	SAN LUIS OBISPO
050236		*	0.0156	VENTURA
050245	*	*	0.0152	SAN BERNARDINO
050272	*	*	0.0152	SAN BERNARDINO
050279	*	*	0.0152	SAN BERNARDINO
050291	*	*	0.0308	SONOMA
050298	*	*	0.0152	SAN BERNARDINO
050300	*	*	0.0152	SAN BERNARDINO
050313			0.0555	SAN JOAQUIN
050325			0.0176	TUOLUMNE
050327	*	*	0.0152	SAN BERNARDINO
050335			0.0176	TUOLUMNE
050336			0.0555	SAN JOAQUIN
050348	*	*	0.0029	ORANGE
050367	*	*	0.0269	SOLANO
050385	*	*	0.0308	SONOMA
050394		*	0.0156	VENTURA
050407			0.0026	SAN FRANCISCO
050426	*	*	0.0029	ORANGE
050444			0.0463	MERCED
050454			0.0026	SAN FRANCISCO
050457			0.0026	SAN FRANCISCO
050469	*	*	0.0152	SAN BERNARDINO
050476			0.0257	LAKE
050494	*		0.0316	NEVADA
050506			0.0103	SAN LUIS OBISPO
050517	*	*	0.0152	SAN BERNARDINO
050526	*	*	0.0029	ORANGE
050528	*	*	0.0463	MERCED
050535	*	*	0.0029	ORANGE
050543	*	*	0.0029	ORANGE
050547	*	*	0.0308	SONOMA

Provider Number	Reclassified between 10/1/06 and 3/31/07	Reclassified between 4/1/07 and 9/30/07	Out-migration Adjustment	Qualifying County Name
050548	*	*	0.0029	ORANGE
050549		*	0.0156	VENTURA
050550	*	*	0.0029	ORANGE
050551	*	*	0.0029	ORANGE
050567	*	*	0.0029	ORANGE
050568			0.0062	MADERA
050570	*	*	0.0029	ORANGE
050580	*	*	0.0029	ORANGE
050584	*	*	0.0152	SAN BERNARDINO
050585	*	*	0.0029	ORANGE
050586	*	*	0.0152	SAN BERNARDINO
050589	*	*	0.0029	ORANGE
050592	*	*	0.0029	ORANGE
050594	*	*	0.0029	ORANGE
050603	*	*	0.0029	ORANGE
050609	*	*	0.0029	ORANGE
050616		*	0.0156	VENTURA
050618	*	*	0.0152	SAN BERNARDINO
050633			0.0103	SAN LUIS OBISPO
050667	*	*	0.0478	NAPA
050668			0.0026	SAN FRANCISCO
050678	*	*	0.0029	ORANGE
050680	*	*	0.0269	SOLANO
050690	*	*	0.0308	SONOMA
050693	*	*	0.0029	ORANGE
050695			0.0555	SAN JOAQUIN
050720	*	*	0.0029	ORANGE
050728	*	*	0.0308	SONOMA
050744			0.0029	ORANGE
050745			0.0029	ORANGE
050746			0.0029	ORANGE
050747			0.0029	ORANGE
050749		*	0.0156	VENTURA
060001	*	*	0.0294	WELD
060003	*	*	0.0203	BOULDER
060027	*	*	0.0203	BOULDER
060103	*	*	0.0203	BOULDER
060116			0.0203	BOULDER
070003	*	*	0.0009	WINDHAM
070006	*	*	0.0047	FAIRFIELD
070010	*	*	0.0047	FAIRFIELD
070018	*	*	0.0047	FAIRFIELD
070020			0.0073	MIDDLESEX
070021	*	*	0.0009	WINDHAM
070028	*	*	0.0047	FAIRFIELD
070033	*	*	0.0047	FAIRFIELD

Provider Number	Reclassified between 10/1/06 and 3/31/07	Reclassified between 4/1/07 and 9/30/07	Out-migration Adjustment	Qualifying County Name
070034	*	*	0.0047	FAIRFIELD
080001			0.0063	NEW CASTLE
080003			0.0063	NEW CASTLE
100014			0.0118	VOLUSIA
100017			0.0118	VOLUSIA
100045	*	*	0.0118	VOLUSIA
100047			0.0021	CHARLOTTE
100062			0.006	MARION
100068			0.0118	VOLUSIA
100072			0.0118	VOLUSIA
100077			0.0021	CHARLOTTE
100102			0.0125	COLUMBIA
100118	*	*	0.0398	FLAGLER
100156			0.0125	COLUMBIA
100175			0.0231	DE SOTO
100212			0.006	MARION
100232	*	*	0.0347	PUTNAM
100236			0.0021	CHARLOTTE
100252	*	*	0.0233	OKEECHOBEE
100290			0.0582	SUMTER
110023	*	*	0.05	GORDON
110027			0.0387	FRANKLIN
110029	*	*	0.0063	HALL
110041	*	*	0.0777	HABERSHAM
110069	*	*	0.0474	HOUSTON
110124			0.0428	WAYNE
110150	*	*	0.0261	BALDWIN
110153	*	*	0.0474	HOUSTON
110187	*	*	0.1172	LUMPKIN
110189	*	*	0.0031	FANNIN
110190			0.0182	MACON
110205	*	*	0.0779	GILMER
130003	*	*	0.0095	NEZ PERCE
130024			0.0275	BONNER
130049	*	*	0.0349	KOOTENAI
130066			0.0349	KOOTENAI
140012	*	*	0.022	LEE
140026			0.0346	LA SALLE
140033	*	*	0.0147	LAKE
140043	*	*	0.0046	WHITESIDE
140058	*	*	0.0081	MORGAN
140084	*	*	0.0147	LAKE
140100	*	*	0.0147	LAKE
140110	*	*	0.0346	LA SALLE
140130	*	*	0.0147	LAKE
140155	*	*	0.0027	KANKAKEE

Provider Number	Reclassified between 10/1/06 and 3/31/07	Reclassified between 4/1/07 and 9/30/07	Out-migration Adjustment	Qualifying County Name
140160	*	*	0.0286	STEPHENSON
140161	*	*	0.0138	LIVINGSTON
140186	*	*	0.0027	KANKAKEE
140202	*	*	0.0147	LAKE
140205			0.0163	BOONE
140234	*	*	0.0346	LA SALLE
140291	*	*	0.0147	LAKE
150022			0.0249	MONTGOMERY
150030	*	*	0.0201	HENRY
150035			0.0083	PORTER
150045			0.0416	DE KALB
150065	*	*	0.0139	JACKSON
150076	*	*	0.0189	MARSHALL
150088	*	*	0.0196	MADISON
150091			0.0573	HUNTINGTON
150102	*	*	0.016	STARKE
150113	*	*	0.0196	MADISON
150122	*	*	0.0199	RIPLEY
160013			0.0218	MUSCATINE
160030			0.004	STORY
160032			0.0272	JASPER
160080	*	*	0.0049	CLINTON
170137	*	*	0.0336	DOUGLAS
180012	*	*	0.0083	HARDIN
180066	*	*	0.0567	LOGAN
180127	*	*	0.0352	FRANKLIN
180128			0.0282	LAWRENCE
190001	*	*	0.0645	WASHINGTON
190003	*	*	0.0107	IBERIA
190015	*	*	0.0401	TANGIPAHOA
190017			0.0235	ST. LANDRY
190054			0.0107	IBERIA
190078			0.0235	ST. LANDRY
190088			0.0705	WEBSTER
190099	*	*	0.039	AVOYELLES
190106	*	*	0.0238	ALLEN
190133			0.0238	ALLEN
190144			0.0705	WEBSTER
190184			0.0161	CALDWELL
190190			0.0161	CALDWELL
190191	*	*	0.0235	ST. LANDRY
190246			0.0161	CALDWELL
200002			0.0129	LINCOLN
200024	*	*	0.0071	ANDROSCOGGIN
200032			0.0466	OXFORD
200034	*	*	0.0071	ANDROSCOGGIN

Provider Number	Reclassified between 10/1/06 and 3/31/07	Reclassified between 4/1/07 and 9/30/07	Out-migration Adjustment	Qualifying County Name
200050	*	*	0.014	HANCOCK
210001			0.0129	WASHINGTON
210004			0.004	MONTGOMERY
210016			0.004	MONTGOMERY
210018			0.004	MONTGOMERY
210022			0.004	MONTGOMERY
210023			0.0209	ANNE ARUNDEL
210028			0.0512	ST. MARYS
210043			0.0209	ANNE ARUNDEL
210048			0.0287	HOWARD
210057			0.004	MONTGOMERY
220001	*	*	0.0056	WORCESTER
220002	*	*	0.0249	MIDDLESEX
220010	*	*	0.0306	ESSEX
220011	*	*	0.0249	MIDDLESEX
220019	*	*	0.0056	WORCESTER
220025	*	*	0.0056	WORCESTER
220028	*	*	0.0056	WORCESTER
220029	*	*	0.0306	ESSEX
220033	*	*	0.0306	ESSEX
220035	*	*	0.0306	ESSEX
220049	*	*	0.0249	MIDDLESEX
220058	*	*	0.0056	WORCESTER
220062	*	*	0.0056	WORCESTER
220063	*	*	0.0249	MIDDLESEX
220070	*	*	0.0249	MIDDLESEX
220080	*	*	0.0306	ESSEX
220082	*	*	0.0249	MIDDLESEX
220084	*	*	0.0249	MIDDLESEX
220089			0.0249	MIDDLESEX
220090	*	*	0.0056	WORCESTER
220095	*	*	0.0056	WORCESTER
220098	*	*	0.0249	MIDDLESEX
220101	*	*	0.0249	MIDDLESEX
220105	*	*	0.0249	MIDDLESEX
220163	*	*	0.0056	WORCESTER
220171	*	*	0.0249	MIDDLESEX
220174	*	*	0.0306	ESSEX
220176			0.0056	WORCESTER
230003	*	*	0.0035	OTTAWA
230013	*	*	0.0091	OAKLAND
230015			0.0359	ST. JOSEPH
230019	*	*	0.0091	OAKLAND
230021			0.0136	BERRIEN
230022	*	*	0.0113	BRANCH
230029	*	*	0.0091	OAKLAND

Provider Number	Reclassified between 10/1/06 and 3/31/07	Reclassified between 4/1/07 and 9/30/07	Out-migration Adjustment	Qualifying County Name
230037	*	*	0.0178	HILLSDALE
230041			0.0099	BAY
230047	*	*	0.0082	MACOMB
230069	*	*	0.0487	LIVINGSTON
230071	*	*	0.0091	OAKLAND
230072	*	*	0.0035	OTTAWA
230075			0.0145	CALHOUN
230078	*	*	0.0136	BERRIEN
230092	*	*	0.0389	JACKSON
230093	*	*	0.0079	MECOSTA
230096	*	*	0.0359	ST. JOSEPH
230099	*	*	0.0339	MONROE
230106	*		0.003	NEWAYGO
230121	*	*	0.0691	SHIAWASSEE
230130	*	*	0.0091	OAKLAND
230151	*	*	0.0091	OAKLAND
230174	*	*	0.0035	OTTAWA
230195	*	*	0.0082	MACOMB
230204	*	*	0.0082	MACOMB
230207	*	*	0.0091	OAKLAND
230217	*	*	0.0145	CALHOUN
230222			0.0228	MIDLAND
230223	*	*	0.0091	OAKLAND
230227	*	*	0.0082	MACOMB
230254	*	*	0.0091	OAKLAND
230257	*	*	0.0082	MACOMB
230264	*	*	0.0082	MACOMB
230269	*	*	0.0091	OAKLAND
230277	*	*	0.0091	OAKLAND
230279	*	*	0.0487	LIVINGSTON
240018	*	*	0.1196	GOODHUE
240044			0.0868	WINONA
240064	*	*	0.0138	ITASCA
240069	*	*	0.0419	STEELE
240071	*	*	0.0454	RICE
240187	*	*	0.0506	MC LEOD
240211	*	*	0.0705	PINE
250040	*	*	0.0294	JACKSON
260011	*	*	0.0007	COLE
260047	*	*	0.0007	COLE
260074	*	*	0.0158	RANDOLPH
260097			0.0425	JOHNSON
280077	*	*	0.0089	DODGE
280123			0.0137	GAGE
290019	*	*	0.0026	CARSON CITY
290049			0.0026	CARSON CITY

Provider Number	Reclassified between 10/1/06 and 3/31/07	Reclassified between 4/1/07 and 9/30/07	Out-migration Adjustment	Qualifying County Name
290051			0.0026	CARSON CITY
300011	*	*	0.0069	HILLSBOROUGH
300012	*	*	0.0069	HILLSBOROUGH
300017	*	*	0.0361	ROCKINGHAM
300020	*	*	0.0069	HILLSBOROUGH
300023	*	*	0.0361	ROCKINGHAM
300029	*	*	0.0361	ROCKINGHAM
300034	*	*	0.0069	HILLSBOROUGH
310002	*	*	0.0351	ESSEX
310009	*	*	0.0351	ESSEX
310010			0.0092	MERCER
310011			0.0115	CAPE MAY
310013	*	*	0.0351	ESSEX
310018	*	*	0.0351	ESSEX
310021	*	*	0.0092	MERCER
310038	*	*	0.035	MIDDLESEX
310039	*	*	0.035	MIDDLESEX
310044			0.0092	MERCER
310054	*	*	0.0351	ESSEX
310070	*	*	0.035	MIDDLESEX
310076	*	*	0.0351	ESSEX
310083	*	*	0.0351	ESSEX
310092			0.0092	MERCER
310093	*	*	0.0351	ESSEX
310096	*	*	0.0351	ESSEX
310108	*	*	0.035	MIDDLESEX
310110			0.0092	MERCER
310119	*	*	0.0351	ESSEX
310123			0.0351	ESSEX
310124			0.035	MIDDLESEX
320003			0.0629	SAN MIGUEL
320011			0.0442	RIO ARRIBA
320018			0.0063	DONA ANA
320085			0.0063	DONA ANA
330004	*	*	0.0959	ULSTER
330008	*	*	0.047	WYOMING
330027	*	*	0.0137	NASSAU
330094	*	*	0.0778	COLUMBIA
330106	*	*	0.0137	NASSAU
330126	*		0.056	ORANGE
330135	*		0.056	ORANGE
330167		*	0.0137	NASSAU
330181		*	0.0137	NASSAU
330182	*	*	0.0137	NASSAU
330191	*	*	0.0026	WARREN
330198		*	0.0137	NASSAU

Provider Number	Reclassified between 10/1/06 and 3/31/07	Reclassified between 4/1/07 and 9/30/07	Out-migration Adjustment	Qualifying County Name
330205	*		0.056	ORANGE
330224	*	*	0.0959	ULSTER
330225		*	0.0137	NASSAU
330235	*	*	0.027	CAYUGA
330259		*	0.0137	NASSAU
330264	*		0.056	ORANGE
330276			0.0063	FULTON
330331		*	0.0137	NASSAU
330332		*	0.0137	NASSAU
330372		*	0.0137	NASSAU
330386	*	*	0.1139	SULLIVAN
340015			0.0267	ROWAN
340020			0.0207	LEE
340021	*	*	0.0216	CLEVELAND
340037			0.0216	CLEVELAND
340039	*	*	0.0144	IREDELL
340069	*	*	0.0053	WAKE
340070	*	*	0.0448	ALAMANCE
340073	*	*	0.0053	WAKE
340085			0.0377	DAVIDSON
340096			0.0377	DAVIDSON
340104			0.0216	CLEVELAND
340114	*	*	0.0053	WAKE
340126	*	*	0.0161	WILSON
340127	*	*	0.0961	GRANVILLE
340129	*	*	0.0144	IREDELL
340133			0.0308	MARTIN
340138	*	*	0.0053	WAKE
340144	*	*	0.0144	IREDELL
340145	*	*	0.0563	LINCOLN
340173	*	*	0.0053	WAKE
360013	*	*	0.0166	SHELBY
360025	*	*	0.0087	ERIE
360036	*	*	0.0263	WAYNE
360065	*	*	0.0141	HURON
360070			0.0028	STARK
360078	*	*	0.0159	PORTAGE
360084	*	*	0.0028	STARK
360086	*	*	0.0168	CLARK
360095	*	*	0.0087	HANCOCK
360100			0.0028	STARK
360107	*	*	0.0213	SANDUSKY
360131			0.0028	STARK
360151			0.0028	STARK
360156			0.0213	SANDUSKY
360175	*	*	0.0159	CLINTON

Provider Number	Reclassified between 10/1/06 and 3/31/07	Reclassified between 4/1/07 and 9/30/07	Out-migration Adjustment	Qualifying County Name
360187	*	*	0.0168	CLARK
360197	*	*	0.0092	LOGAN
360270			0.012	DEFIANCE
370004	*	*	0.0193	OTTAWA
370014	*	*	0.0831	BRYAN
370015	*	*	0.0463	MAYES
370023			0.0084	STEPHENS
370065			0.0121	CRAIG
370113	*	*	0.0205	DELAWARE
370149			0.0356	POTTAWATOMIE
370219			0.0356	POTTAWATOMIE
380002			0.013	JOSEPHINE
380022	*	*	0.0201	LINN
380029			0.0075	MARION
380051			0.0075	MARION
380056			0.0075	MARION
390011			0.0012	CAMBRIA
390044	*	*	0.02	BERKS
390046	*	*	0.0098	YORK
390056			0.0042	HUNTINGDON
390065	*	*	0.0501	ADAMS
390066	*	*	0.0259	LEBANON
390096	*	*	0.02	BERKS
390101			0.0098	YORK
390110	*	*	0.0012	CAMBRIA
390130			0.0012	CAMBRIA
390138	*	*	0.0325	FRANKLIN
390146			0.0053	WARREN
390150	*	*	0.0206	GREENE
390151	*	*	0.0325	FRANKLIN
390162			0.02	NORTHAMPTON
390201	*	*	0.1127	MONROE
390233			0.0098	YORK
420007	*	*	0.0001	SPARTANBURG
420020	*	*	0.0035	GEORGETOWN
420027	*	*	0.021	ANDERSON
420030	*	*	0.0103	COLLETON
420039	*	*	0.0153	UNION
420043			0.0177	CHEROKEE
420068	*	*	0.0097	ORANGEBURG
420070	*	*	0.0101	SUMTER
420083	*	*	0.0001	SPARTANBURG
420098			0.0035	GEORGETOWN
440008	*	*	0.0663	HENDERSON
440024	*	*	0.0387	BRADLEY
440030			0.0056	HAMBLEN

Provider Number	Reclassified between 10/1/06 and 3/31/07	Reclassified between 4/1/07 and 9/30/07	Out-migration Adjustment	Qualifying County Name
440035	*	*	0.0441	MONTGOMERY
440047			0.0499	GIBSON
440056	*	*	0.0321	JEFFERSON
440060	*	*	0.0499	GIBSON
440063			0.0011	WASHINGTON
440067	*	*	0.0056	HAMBLEN
440073	*	*	0.0513	MAURY
440105			0.0011	WASHINGTON
440115			0.0499	GIBSON
440148	*	*	0.0568	DE KALB
440153			0.0007	COCKE
440174			0.0372	HAYWOOD
440181			0.0407	HARDEMAN
440184			0.0011	WASHINGTON
440185	*	*	0.0387	BRADLEY
450032	*	*	0.0416	HARRISON
450039	*	*	0.0097	TARRANT
450059	*	*	0.0073	COMAL
450064	*	*	0.0097	TARRANT
450087	*	*	0.0097	TARRANT
450099	*	*	0.018	GRAY
450121	*	*	0.0097	TARRANT
450135	*	*	0.0097	TARRANT
450137	*	*	0.0097	TARRANT
450144	*	*	0.0573	ANDREWS
450163			0.0134	KLEBERG
450187	*	*	0.0264	WASHINGTON
450194	*	*	0.0328	CHEROKEE
450214	*	*	0.0368	WHARTON
450224	*	*	0.0411	WOOD
450347	*	*	0.0427	WALKER
450370			0.0258	COLORADO
450389	*	*	0.0881	HENDERSON
450395	*	*	0.0484	POLK
450419	*	*	0.0097	TARRANT
450438	*	*	0.0258	COLORADO
450447	*	*	0.0358	NAVARRO
450451	*	*	0.0551	SOMERVELL
450465			0.0435	MATAGORDA
450547	*	*	0.0411	WOOD
450563	*	*	0.0097	TARRANT
450565			0.0486	PALO PINTO
450596			0.0808	HOOD
450597			0.0077	DE WITT
450639	*	*	0.0097	TARRANT
450672	*	*	0.0097	TARRANT

Provider Number	Reclassified between 10/1/06 and 3/31/07	Reclassified between 4/1/07 and 9/30/07	Out-migration Adjustment	Qualifying County Name
450675	*	*	0.0097	TARRANT
450677	*	*	0.0097	TARRANT
450694	*	*	0.0368	WHARTON
450747	*	*	0.0195	ANDERSON
450755	*	*	0.0484	HOCKLEY
450779	*	*	0.0097	TARRANT
450813	*	*	0.0195	ANDERSON
450872	*	*	0.0097	TARRANT
450880	*	*	0.0097	TARRANT
450886			0.0097	TARRANT
450888			0.0097	TARRANT
460017			0.0392	BOX ELDER
460039	*	*	0.0392	BOX ELDER
490019			0.124	CULPEPER
490038			0.0022	SMYTH
490084			0.0167	ESSEX
490105	*	*	0.0022	SMYTH
490110			0.0082	MONTGOMERY
500003	*	*	0.0208	SKAGIT
500007			0.0208	SKAGIT
500019			0.0213	LEWIS
500021	*	*	0.0055	PIERCE
500024	*	*	0.0023	THURSTON
500039	*	*	0.0174	KITSAP
500041	*	*	0.0118	COWLITZ
500079	*	*	0.0055	PIERCE
500108	*	*	0.0055	PIERCE
500129	*	*	0.0055	PIERCE
500139	*	*	0.0023	THURSTON
500143	*	*	0.0023	THURSTON
510018	*	*	0.0209	JACKSON
510039			0.0112	OHIO
510047	*	*	0.0275	MARION
510050			0.0112	OHIO
510077	*	*	0.0021	MINGO
520028	*	*	0.0157	GREEN
520035			0.0077	SHEBOYGAN
520044			0.0077	SHEBOYGAN
520057			0.0118	SAUK
520059	*	*	0.02	RACINE
520071	*	*	0.0239	JEFFERSON
520095	*	*	0.0118	SAUK
520096	*	*	0.02	RACINE
520102	*	*	0.0298	WALWORTH
520116	*	*	0.0239	JEFFERSON
520132			0.0077	SHEBOYGAN

Note: The following Table 5 is a tentative table. The final Table 5 will be published in a subsequent **Federal Register** notice.

BILLING CODE 4120–01–P

TABLE 5.-- LIST OF DIAGNOSIS-RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)

DRG	FY 07 Final Rule Post-Acute Care DRG	FY 07 Final Rule Special Pay DRG	MDC	TYPE	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
1	Yes	No	01	SURG	CRANIOTOMY AGE >17 W CC	3.4574	7.3	9.8
2	Yes	No	01	SURG	CRANIOTOMY AGE >17 W/O CC	1.9490	3.4	4.4
3	No	No	01	SURG *	CRANIOTOMY AGE 0-17	2.0113	8.8	11.0
4	No	No	01	SURG	NO LONGER VALID	0.0000	0.0	0.0
5	No	No	01	SURG	NO LONGER VALID	0.0000	0.0	0.0
6	No	No	01	SURG	CARPAL TUNNEL RELEASE	0.7915	2.1	3.1
7	Yes	Yes	01	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC	2.6576	6.5	9.4
8	Yes	Yes	01	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC	1.5943	2.0	2.8
9	No	No	01	MED	SPINAL DISORDERS & INJURIES	1.3619	4.4	6.2
10	Yes	No	01	MED	NERVOUS SYSTEM NEOPLASMS W CC	1.2544	4.6	6.0
11	Yes	No	01	MED	NERVOUS SYSTEM NEOPLASMS W/O CC	0.8577	2.7	3.6
12	Yes	No	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS	0.9324	4.3	5.5
13	Yes	No	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	0.8543	4.0	4.9
14	Yes	No	01	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION	1.2110	4.3	5.5
15	Yes	No	01	MED	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT	0.9446	3.1	4.1
16	Yes	No	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	1.3552	5.0	6.4
17	Yes	No	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	0.7140	2.4	3.1
18	Yes	No	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W CC	1.0043	4.1	5.2
19	Yes	No	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	0.7198	2.7	3.4
20	No	No	01	MED	NO LONGER VALID	0.0000	0.0	0.0
21	No	No	01	MED	VIRAL MENINGITIS	1.4131	4.7	6.2
22	No	No	01	MED	HYPERTENSIVE ENCEPHALOPATHY	1.1638	3.9	5.0
23	No	No	01	MED	NONTRAUMATIC STUPOR & COMA	0.7970	3.0	3.9
24	No	No	01	MED	NO LONGER VALID	0.0000	0.0	0.0
25	No	No	01	MED	NO LONGER VALID	0.0000	0.0	0.0

DRG	FY 07 Final Rule Post-Acute Care DRG	FY 07 Final Rule Special Pay DRG	MDC	TYPE	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
26	No	No	01	MED	SEIZURE & HEADACHE AGE 0-17	1.0022	2.7	3.8
27	No	No	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR	1.3491	3.1	4.8
28	Yes	No	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W CC	1.3343	4.2	5.7
29	Yes	No	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC	0.7395	2.6	3.2
30	No	No	01	MED *	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0-17	0.3402	*	*
31	No	No	01	MED	CONCUSSION AGE >17 W CC	0.9792	3.0	3.9
32	No	No	01	MED	CONCUSSION AGE >17 W/O CC	0.6386	1.9	2.3
33	No	No	01	MED *	CONCUSSION AGE 0-17	0.2136	*	*
34	Yes	No	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W CC	1.0165	3.6	4.8
35	Yes	No	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	0.6584	2.5	3.1
36	No	No	02	SURG	RETINAL PROCEDURES	0.8042	1.4	1.8
37	No	No	02	SURG	ORBITAL PROCEDURES	1.2028	2.7	4.1
38	No	No	02	SURG	PRIMARY IRIS PROCEDURES	0.6191	2.2	2.8
39	No	No	02	SURG	LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	0.6422	1.5	2.0
40	No	No	02	SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	1.0277	3.0	4.1
41	No	No	02	SURG *	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17	0.3462	*	*
42	No	No	02	SURG	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	0.7670	1.7	2.4
43	No	No	02	MED	HYPHEMA	0.6168	2.4	3.0
44	No	No	02	MED	ACUTE MAJOR EYE INFECTIONS	0.7164	3.8	4.8
45	No	No	02	MED	NEUROLOGICAL EYE DISORDERS	0.7438	2.5	3.0
46	No	No	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W CC	0.7903	3.2	4.2
47	No	No	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W/O CC	0.5515	2.4	3.0
48	No	No	02	MED *	OTHER DISORDERS OF THE EYE AGE 0-17	0.3050	*	*
49	No	No	03	SURG	MAJOR HEAD & NECK PROCEDURES	1.6654	3.2	4.5
50	No	No	03	SURG	SIALOADENECTOMY	0.8801	1.5	1.9
51	No	No	03	SURG	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	0.8789	1.9	2.7
52	No	No	03	SURG	CLEFT LIP & PALATE REPAIR	0.6502	1.3	1.5
53	No	No	03	SURG	SINUS & MASTOID PROCEDURES AGE >17	1.3532	2.5	4.0
54	No	No	03	SURG *	SINUS & MASTOID PROCEDURES AGE 0-17	0.4944	*	*

DRG	FY 07 Final Rule Post-Acute Care DRG	FY 07 Final Rule Special Pay DRG	MDC	TYPE	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
55	No	No	03	SURG	MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES	0.9649	1.9	2.9
56	No	No	03	SURG	RHINOPLASTY	0.8933	1.9	2.7
57	No	No	03	SURG	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	0.9965	2.1	3.2
58	No	No	03	SURG *	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	0.2807	*	*
59	No	No	03	SURG	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	0.6831	1.8	2.4
60	No	No	03	SURG *	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	0.2137	1.4	1.7
61	No	No	03	SURG	MYRINGOTOMY W TUBE INSERTION AGE >17	1.5991	3.7	6.1
62	No	No	03	SURG *	MYRINGOTOMY W TUBE INSERTION AGE 0-17	0.3027	1.3	1.5
63	No	No	03	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES	1.3933	3.0	4.6
64	No	No	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY	1.2496	4.2	6.2
65	No	No	03	MED	DYSEQUILIBRIUM	0.6155	2.3	2.8
66	No	No	03	MED	EPISTAXIS	0.6279	2.4	3.1
67	No	No	03	MED	EPIGLOTTITIS	0.8244	2.8	3.7
68	No	No	03	MED	OTITIS MEDIA & URI AGE >17 W CC	0.6614	3.1	3.8
69	No	No	03	MED	OTITIS MEDIA & URI AGE >17 W/O CC	0.4920	2.5	3.0
70	No	No	03	MED	OTITIS MEDIA & URI AGE 0-17	0.3556	2.1	2.4
71	No	No	03	MED	LARYNGOTRACHEITIS	0.7755	3.4	4.4
72	No	No	03	MED	NASAL TRAUMA & DEFORMITY	0.7749	2.6	3.3
73	Yes	No	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17	0.8502	3.3	4.3
74	No	No	03	MED *	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0-17	0.3441	3.3	3.3
75	Yes	No	04	SURG	MAJOR CHEST PROCEDURES	3.0340	7.4	9.7
76	Yes	No	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.8356	8.2	10.7
77	Yes	No	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	1.1894	3.3	4.5
78	Yes	No	04	MED	PULMONARY EMBOLISM	1.2364	5.3	6.2
79	Yes	No	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	1.6262	6.7	8.3
80	Yes	No	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC	0.8949	4.3	5.3
81	No	No	04	MED *	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0-17	1.5579	5.2	6.2
82	Yes	No	04	MED	RESPIRATORY NEOPLASMS	1.4114	5.1	6.8

DRG	FY 07 Final Rule Post-Acute Care DRG	FY 07 Final Rule Special Pay DRG	MDC	TYPE	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
83	Yes	No	04	MED	MAJOR CHEST TRAUMA W CC	1.0306	4.2	5.3
84	Yes	No	04	MED	MAJOR CHEST TRAUMA W/O CC	0.6028	2.6	3.1
85	Yes	No	04	MED	PLEURAL EFFUSION W CC	1.2457	4.7	6.2
86	Yes	No	04	MED	PLEURAL EFFUSION W/O CC	0.7124	2.7	3.5
87	No	No	04	MED	PULMONARY EDEMA & RESPIRATORY FAILURE	1.3835	4.9	6.4
88	No	No	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	0.8884	3.9	4.9
89	Yes	No	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	1.0376	4.6	5.6
90	Yes	No	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	0.6155	3.2	3.7
91	No	No	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE 0-17	0.5608	2.5	3.4
92	Yes	No	04	MED	INTERSTITIAL LUNG DISEASE W CC	1.1977	4.8	6.0
93	Yes	No	04	MED	INTERSTITIAL LUNG DISEASE W/O CC	0.7445	3.0	3.8
94	No	No	04	MED	PNEUMOTHORAX W CC	1.1474	4.5	5.9
95	No	No	04	MED	PNEUMOTHORAX W/O CC	0.5880	2.7	3.4
96	No	No	04	MED	BRONCHITIS & ASTHMA AGE >17 W CC	0.7355	3.5	4.3
97	No	No	04	MED	BRONCHITIS & ASTHMA AGE >17 W/O CC	0.5431	2.8	3.4
98	No	No	04	MED	BRONCHITIS & ASTHMA AGE 0-17	0.5837	2.8	3.1
99	No	No	04	MED	RESPIRATORY SIGNS & SYMPTOMS W CC	0.7155	2.4	3.1
100	No	No	04	MED	RESPIRATORY SIGNS & SYMPTOMS W/O CC	0.5409	1.7	2.1
101	Yes	No	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	0.8614	3.2	4.2
102	Yes	No	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	0.5625	2.0	2.5
103	No	No	PRE	SURG	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM	18.8897	22.2	35.4
104	Yes	No	05	SURG	CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W CARD CATH	8.2784	12.8	15.1
105	Yes	No	05	SURG	CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W/O CARD CATH	6.0509	8.4	10.2
106	No	No	05	SURG	CORONARY BYPASS W PTCA	6.7434	9.3	10.9
107	No	No	05	SURG	NO LONGER VALID	0.0000	0.0	0.0
108	Yes	No	05	SURG	OTHER CARDIOTHORACIC PROCEDURES	5.7539	8.8	10.9
109	No	No	05	SURG	NO LONGER VALID	0.0000	0.0	0.0
110	No	No	05	SURG	MAJOR CARDIOVASCULAR PROCEDURES W CC	3.8050	5.4	8.1

DRG	FY 07 Final Rule Post-Acute Care DRG	FY 07 Final Rule Special Pay DRG	MDC	TYPE	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
111	No	No	05	SURG	MAJOR CARDIOVASCULAR PROCEDURES W/O CC	2.4890	2.3	3.1
112	No	No	05	SURG	NO LONGER VALID	0.0000	0.0	0.0
113	Yes	No	05	SURG	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE	3.2627	10.8	13.7
114	Yes	No	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	1.7522	6.6	8.7
115	No	No	05	SURG	NO LONGER VALID	0.0000	0.0	0.0
116	No	No	05	SURG	NO LONGER VALID	0.0000	0.0	0.0
117	No	No	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT	1.3693	2.7	4.3
118	No	No	05	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT	1.6689	2.0	3.0
119	No	No	05	SURG	VEIN LIGATION & STRIPPING	1.4512	3.3	5.4
120	Yes	No	05	SURG	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	2.4145	6.0	9.2
121	Yes	No	05	MED	CIRCULATORY DISORDERS W AMI & MAJOR COMP, DISCHARGED ALIVE	1.6161	5.2	6.5
122	No	No	05	MED	CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE	0.9626	2.7	3.4
123	No	No	05	MED	CIRCULATORY DISORDERS W AMI, EXPIRED	1.4884	2.9	4.7
124	No	No	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG	1.4098	3.3	4.4
125	No	No	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG	1.0537	2.1	2.7
126	Yes	No	05	MED	ACUTE & SUBACUTE ENDOCARDITIS	2.6622	9.0	11.3
127	Yes	No	05	MED	HEART FAILURE & SHOCK	1.0485	4.1	5.1
128	No	No	05	MED	DEEP VEIN THROMBOPHLEBITIS	0.7499	4.3	5.2
129	No	No	05	MED	CARDIAC ARREST, UNEXPLAINED	1.0103	1.6	2.5
130	Yes	No	05	MED	PERIPHERAL VASCULAR DISORDERS W CC	0.9709	4.3	5.5
131	Yes	No	05	MED	PERIPHERAL VASCULAR DISORDERS W/O CC	0.5755	3.1	3.7
132	No	No	05	MED	ATHEROSCLEROSIS W CC	0.6318	2.2	2.8
133	No	No	05	MED	ATHEROSCLEROSIS W/O CC	0.5482	1.8	2.1
134	No	No	05	MED	HYPERTENSION	0.6193	2.5	3.1
135	No	No	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC	0.9404	3.3	4.3

DRG	FY 07 Final Rule Post-Acute Care DRG	FY 07 Final Rule Special Pay DRG	MDC	TYPE	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
136	No	No	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC	0.6572	2.1	2.7
137	No	No	05	MED *	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0-17	0.8393	*	*
138	No	No	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	0.8363	3.0	3.9
139	No	No	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	0.5297	2.0	2.4
140	No	No	05	MED	ANGINA PECTORIS	0.5044	1.9	2.4
141	No	No	05	MED	SYNCOPE & COLLAPSE W CC	0.7627	2.7	3.4
142	No	No	05	MED	SYNCOPE & COLLAPSE W/O CC	0.6003	2.1	2.5
143	No	No	05	MED	CHEST PAIN	0.5635	1.7	2.1
144	Yes	No	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	1.3365	4.2	5.9
145	Yes	No	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	0.5838	2.0	2.6
146	Yes	No	06	SURG	RECTAL RESECTION W CC	2.7392	8.4	9.9
147	Yes	No	06	SURG	RECTAL RESECTION W/O CC	1.5121	4.9	5.6
148	No	No	06	SURG	NO LONGER VALID	0.0000	0.0	0.0
149	Yes	No	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.4364	5.1	5.7
150	Yes	No	06	SURG	PERITONEAL ADHESIOLYSIS W CC	2.7852	8.7	10.8
151	Yes	No	06	SURG	PERITONEAL ADHESIOLYSIS W/O CC	1.2867	4.0	5.0
152	No	No	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.8876	6.5	7.9
153	No	No	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.0973	4.4	4.9
154	No	No	06	SURG	NO LONGER VALID	0.0000	0.0	0.0
155	Yes	No	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC	1.2959	3.0	4.0
156	No	No	06	SURG *	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0-17	0.8644	8.9	9.3
157	Yes	No	06	SURG	ANAL & STOMAL PROCEDURES W CC	1.3421	4.1	5.7
158	Yes	No	06	SURG	ANAL & STOMAL PROCEDURES W/O CC	0.6588	2.1	2.7
159	No	No	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC	1.4316	3.7	5.1
160	No	No	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC	0.8676	2.2	2.7
161	No	No	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC	1.2405	3.2	4.5

DRG	FY 07 Final Rule Post-Acute Care DRG	FY 07 Final Rule Special Pay DRG	MDC	TYPE	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
162	No	No	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC	0.6918	1.7	2.1
163	No	No	06	SURG *	HERNIA PROCEDURES AGE 0-17	0.6809	2.0	2.4
164	No	No	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	2.1484	6.4	7.7
165	No	No	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	1.1853	3.4	4.0
166	No	No	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	1.4020	3.2	4.3
167	No	No	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	0.9001	1.8	2.1
168	No	No	03	SURG	MOUTH PROCEDURES W CC	1.2829	3.3	4.8
169	No	No	03	SURG	MOUTH PROCEDURES W/O CC	0.7682	1.8	2.3
170	Yes	No	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	2.9902	7.8	10.9
171	Yes	No	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC	1.2243	3.1	4.2
172	Yes	No	06	MED	DIGESTIVE MALIGNANCY W CC	1.4280	5.1	6.9
173	Yes	No	06	MED	DIGESTIVE MALIGNANCY W/O CC	0.7645	2.7	3.6
174	No	No	06	MED	G.I. HEMORRHAGE W CC	1.0295	3.8	4.7
175	No	No	06	MED	G.I. HEMORRHAGE W/O CC	0.5806	2.4	2.9
176	Yes	No	06	MED	COMPLICATED PEPTIC ULCER	1.1269	4.0	5.1
177	No	No	06	MED	UNCOMPLICATED PEPTIC ULCER W CC	0.9347	3.6	4.4
178	No	No	06	MED	UNCOMPLICATED PEPTIC ULCER W/O CC	0.6911	2.6	3.1
179	No	No	06	MED	INFLAMMATORY BOWEL DISEASE	1.0814	4.5	5.8
180	Yes	No	06	MED	G.I. OBSTRUCTION W CC	0.9925	4.1	5.3
181	Yes	No	06	MED	G.I. OBSTRUCTION W/O CC	0.5784	2.8	3.3
182	No	No	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC	0.7855	3.2	4.1
183	No	No	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC	0.5847	2.3	2.8
184	No	No	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0-17	0.6196	2.5	3.7
185	No	No	03	MED	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17	0.8883	3.3	4.5
186	No	No	03	MED *	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0-17	0.3294	2.6	3.1
187	No	No	03	MED	DENTAL EXTRACTIONS & RESTORATIONS	0.8425	3.1	4.2

DRG	FY 07 Final Rule Post-Acute Care DRG	FY 07 Final Rule Special Pay DRG	MDC	TYPE	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
188	Yes	No	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	1.0922	4.0	5.4
189	Yes	No	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	0.5913	2.4	3.0
190	No	No	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17	0.6336	2.3	3.0
191	Yes	No	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W CC	3.9330	8.8	12.5
192	Yes	No	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	1.6747	4.2	5.5
193	No	No	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC	3.3813	10.1	12.6
194	No	No	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC	1.5875	5.4	6.4
195	No	No	07	SURG	CHOLECYSTECTOMY W C.D.E. W CC	3.0519	8.8	10.6
196	No	No	07	SURG	CHOLECYSTECTOMY W C.D.E. W/O CC	1.5458	4.6	5.4
197	Yes	No	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	2.5503	7.4	9.1
198	Yes	No	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC	1.1793	3.7	4.3
199	No	No	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	2.2333	6.4	9.0
200	No	No	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY	2.8319	6.5	10.3
201	No	No	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES	3.7826	10.0	13.6
202	No	No	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS	1.3383	4.6	6.2
203	No	No	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	1.3632	4.8	6.5
204	No	No	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	1.0989	4.1	5.4
205	Yes	No	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC	1.2005	4.4	5.9
206	Yes	No	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC	0.7288	3.0	3.8
207	No	No	07	MED	DISORDERS OF THE BILIARY TRACT W CC	1.1824	4.1	5.3
208	No	No	07	MED	DISORDERS OF THE BILIARY TRACT W/O CC	0.6875	2.4	3.0
209	No	No	08	SURG	NO LONGER VALID	0.0000	0.0	0.0
210	Yes	Yes	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC	1.9021	5.9	6.7

DRG	FY 07 Final Rule Post-Acute Care DRG	FY 07 Final Rule Special Pay DRG	MDC	TYPE	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
211	Yes	Yes	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC	1.2936	4.3	4.6
212	No	No	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17	0.9192	2.2	2.5
213	Yes	No	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS	2.1167	7.1	9.6
214	No	No	08	SURG	NO LONGER VALID	0.0000	0.0	0.0
215	No	No	08	SURG	NO LONGER VALID	0.0000	0.0	0.0
216	Yes	No	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	1.8776	3.1	5.4
217	Yes	No	08	SURG	WND DEBRID & SKN GRFT EXCEPT HAND,FOR MUSCSKELET & CONN TISS DIS	3.0479	9.0	12.9
218	Yes	No	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W CC	1.7057	4.4	5.5
219	Yes	No	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W/O CC	1.1034	2.7	3.2
220	No	No	08	SURG *	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE 0-17	0.5988	2.6	4.0
221	No	No	08	SURG	NO LONGER VALID	0.0000	0.0	0.0
222	No	No	08	SURG	NO LONGER VALID	0.0000	0.0	0.0
223	No	No	08	SURG	MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC	1.1727	2.4	3.3
224	No	No	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC, W/O CC	0.8582	1.6	1.9
225	Yes	No	08	SURG	FOOT PROCEDURES	1.2775	3.8	5.4
226	Yes	No	08	SURG	SOFT TISSUE PROCEDURES W CC	1.6305	4.6	6.5
227	Yes	No	08	SURG	SOFT TISSUE PROCEDURES W/O CC	0.8615	2.1	2.6
228	No	No	08	SURG	MAJOR THUMB OR JOINT PROC,OR OTH HAND OR WRIST PROC W CC	1.1538	2.9	4.2
229	No	No	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	0.7217	2.0	2.5
230	No	No	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR	1.3375	3.6	5.4
231	No	No	08	SURG	NO LONGER VALID	0.0000	0.0	0.0
232	No	No	08	SURG	ARTHROSCOPY	0.9721	1.9	2.7
233	Yes	Yes	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	1.9028	4.3	6.4
234	Yes	Yes	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC	1.2580	1.9	2.7
235	Yes	No	08	MED	FRACTURES OF FEMUR	0.8214	3.8	4.9

DRG	FY 07 Final Rule Post-Acute Care DRG	FY 07 Final Rule Special Pay DRG	MDC	TYPE	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
236	Yes	No	08	MED	FRACTURES OF HIP & PELVIS	0.7685	3.8	4.6
237	No	No	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH	0.6569	3.0	3.8
238	Yes	No	08	MED	OSTEOMYELITIS	1.4081	6.5	8.4
239	Yes	No	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY	1.1194	4.9	6.2
240	Yes	No	08	MED	CONNECTIVE TISSUE DISORDERS W CC	1.3782	4.9	6.5
241	Yes	No	08	MED	CONNECTIVE TISSUE DISORDERS W/O CC	0.6637	3.0	3.7
242	No	No	08	MED	SEPTIC ARTHRITIS	1.1006	5.1	6.6
243	No	No	08	MED	MEDICAL BACK PROBLEMS	0.7967	3.6	4.5
244	Yes	No	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W CC	0.7390	3.6	4.5
245	Yes	No	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	0.4941	2.5	3.1
246	No	No	08	MED	NON-SPECIFIC ARTHROPATHIES	0.6312	2.8	3.6
247	No	No	08	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE	0.5932	2.6	3.3
248	No	No	08	MED	TENDONITIS, MYOSITIS & BURSITIS	0.8873	3.8	4.8
249	No	No	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	0.7501	2.8	4.0
250	Yes	No	08	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC	0.7223	3.2	3.9
251	Yes	No	08	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC	0.5119	2.3	2.8
252	No	No	08	MED *	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0-17	0.2600	*	*
253	Yes	No	08	MED	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W CC	0.8175	3.8	4.6
254	Yes	No	08	MED	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W/O CC	0.4974	2.6	3.1
255	No	No	08	MED *	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE 0-17	0.3028	*	*
256	Yes	No	08	MED	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	0.8715	3.9	5.0
257	No	No	09	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W CC	0.9123	2.0	2.6

DRG	FY 07 Final Rule Post-Acute Care DRG	FY 07 Final Rule Special Pay DRG	MDC	TYPE	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
258	No	No	09	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.7137	1.5	1.7
259	No	No	09	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC	1.0057	1.8	2.8
260	No	No	09	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.6812	1.2	1.4
261	No	No	09	SURG	BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION	0.9527	1.6	2.2
262	No	No	09	SURG	BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY	0.9647	3.2	4.6
263	Yes	No	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	2.1206	8.3	11.1
264	Yes	No	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC	1.0990	4.9	6.5
265	Yes	No	09	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC	1.6950	4.2	6.7
266	Yes	No	09	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC	0.9141	2.2	3.1
267	No	No	09	SURG	PERIANAL & PILONIDAL PROCEDURES	0.9444	2.9	4.2
268	No	No	09	SURG	SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES	1.2209	2.4	3.6
269	Yes	No	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.7923	6.0	8.3
270	Yes	No	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC	0.8211	2.7	3.6
271	Yes	No	09	MED	SKIN ULCERS	1.0752	5.6	7.1
272	Yes	No	09	MED	MAJOR SKIN DISORDERS W CC	1.0312	4.5	5.9
273	Yes	No	09	MED	MAJOR SKIN DISORDERS W/O CC	0.5861	3.0	3.7
274	No	No	09	MED	MALIGNANT BREAST DISORDERS W CC	1.1327	4.5	6.2
275	No	No	09	MED	MALIGNANT BREAST DISORDERS W/O CC	0.5925	2.4	3.3
276	No	No	09	MED	NON-MALIGANT BREAST DISORDERS	0.7422	3.6	4.6
277	Yes	No	09	MED	CELLULITIS AGE >17 W CC	0.8950	4.5	5.5
278	Yes	No	09	MED	CELLULITIS AGE >17 W/O CC	0.5644	3.4	4.0
279	No	No	09	MED *	CELLULITIS AGE 0-17	0.7922	3.2	3.7
280	Yes	No	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC	0.7716	3.2	4.0
281	Yes	No	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC	0.5206	2.3	2.8
282	No	No	09	MED *	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0-17	0.2633	*	*

DRG	FY 07 Final Rule Post-Acute Care DRG	FY 07 Final Rule Special Pay DRG	MDC	TYPE	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
283	Yes	No	09	MED	MINOR SKIN DISORDERS W CC	0.7603	3.4	4.6
284	Yes	No	09	MED	MINOR SKIN DISORDERS W/O CC	0.4585	2.3	2.9
285	Yes	No	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DISORDERS	2.1773	8.1	10.3
286	No	No	10	SURG	ADRENAL & PITUITARY PROCEDURES	1.9074	3.8	5.2
287	Yes	No	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS	1.9509	7.6	9.9
288	No	No	10	SURG	O.R. PROCEDURES FOR OBESITY	1.9136	2.9	3.7
289	No	No	10	SURG	PARATHYROID PROCEDURES	0.9232	1.6	2.4
290	No	No	10	SURG	THYROID PROCEDURES	0.8811	1.5	2.0
291	No	No	10	SURG	THYROGLOSSAL PROCEDURES	0.5837	1.3	1.5
292	Yes	No	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	2.6914	7.3	10.2
293	Yes	No	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	1.3891	3.5	4.8
294	Yes	No	10	MED	DIABETES AGE >35	0.7861	3.3	4.3
295	No	No	10	MED	DIABETES AGE 0-35	0.7652	2.8	3.7
296	Yes	No	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	0.8334	3.6	4.7
297	Yes	No	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC	0.5090	2.5	3.0
298	No	No	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0-17	0.5753	2.5	3.5
299	No	No	10	MED	INBORN ERRORS OF METABOLISM	1.0480	3.8	5.1
300	Yes	No	10	MED	ENDOCRINE DISORDERS W CC	1.1175	4.6	5.9
301	Yes	No	10	MED	ENDOCRINE DISORDERS W/O CC	0.6208	2.7	3.4
302	No	No	11	SURG	KIDNEY TRANSPLANT	3.1125	6.7	7.9
303	No	No	11	SURG	KIDNEY,URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM	1.9755	5.0	6.3
304	Yes	No	11	SURG	KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC	2.3454	5.8	8.3
305	Yes	No	11	SURG	KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC	1.1521	2.5	3.0
306	No	No	11	SURG	PROSTATECTOMY W CC	1.3360	3.6	5.6
307	No	No	11	SURG	PROSTATECTOMY W/O CC	0.6414	1.7	2.0
308	No	No	11	SURG	MINOR BLADDER PROCEDURES W CC	1.4570	3.3	5.3
309	No	No	11	SURG	MINOR BLADDER PROCEDURES W/O CC	0.9018	1.4	1.7

DRG	FY 07 Final Rule Post-Acute Care DRG	FY 07 Final Rule Special Pay DRG	MDC	TYPE	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
310	No	No	11	SURG	TRANSURETHRAL PROCEDURES W CC	1.2129	3.1	4.5
311	No	No	11	SURG	TRANSURETHRAL PROCEDURES W/O CC	0.6543	1.5	1.9
312	No	No	11	SURG	URETHRAL PROCEDURES, AGE >17 W CC	1.1767	3.3	4.9
313	No	No	11	SURG	URETHRAL PROCEDURES, AGE >17 W/O CC	0.7454	1.8	2.4
314	No	No	11	SURG *	URETHRAL PROCEDURES, AGE 0-17	0.5076	29.4	89.0
315	No	No	11	SURG	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	2.1139	3.7	6.8
316	Yes	No	11	MED	RENAL FAILURE	1.2596	4.8	6.3
317	No	No	11	MED	ADMIT FOR RENAL DIALYSIS	0.8067	2.4	3.5
318	No	No	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W CC	1.2348	4.4	6.0
319	No	No	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W/O CC	0.6066	1.9	2.6
320	Yes	No	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	0.8766	4.1	5.1
321	Yes	No	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	0.5793	3.0	3.6
322	No	No	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE 0-17	0.6171	3.1	3.6
323	No	No	11	MED	URINARY STONES W CC, &/OR ESW LITHOTRIPSY	0.8266	2.3	3.1
324	No	No	11	MED	URINARY STONES W/O CC	0.5059	1.6	1.8
325	No	No	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC	0.6901	2.9	3.7
326	No	No	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC	0.4540	2.1	2.6
327	No	No	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0-17	0.2115	1.8	2.0
328	No	No	11	MED	URETHRAL STRICTURE AGE >17 W CC	0.7276	2.6	3.4
329	No	No	11	MED	URETHRAL STRICTURE AGE >17 W/O CC	0.5212	1.4	1.7
330	No	No	11	MED *	URETHRAL STRICTURE AGE 0-17	0.3268	*	*
331	Yes	No	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC	1.0958	4.2	5.5
332	Yes	No	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC	0.6256	2.4	3.1
333	No	No	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0-17	1.0207	3.7	5.4
334	No	No	12	SURG	MAJOR MALE PELVIC PROCEDURES W CC	1.4176	3.3	4.0
335	No	No	12	SURG	MAJOR MALE PELVIC PROCEDURES W/O CC	1.1139	2.2	2.5

DRG	FY 07 Final Rule Post-Acute Care DRG	FY 07 Final Rule Special Pay DRG	MDC	TYPE	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
336	No	No	12	SURG	TRANSURETHRAL PROSTATECTOMY W CC	0.8570	2.4	3.2
337	No	No	12	SURG	TRANSURETHRAL PROSTATECTOMY W/O CC	0.5869	1.6	1.8
338	No	No	12	SURG	TESTES PROCEDURES, FOR MALIGNANCY	1.3786	3.8	5.8
339	No	No	12	SURG	TESTES PROCEDURES, NON-MALIGNANCY AGE >17	1.2550	3.3	5.2
340	No	No	12	SURG *	TESTES PROCEDURES, NON-MALIGNANCY AGE 0-17	0.2904	*	*
341	No	No	12	SURG	PENIS PROCEDURES	1.3394	1.9	3.2
342	No	No	12	SURG	CIRCUMCISION AGE >17	0.8117	2.3	3.0
343	No	No	12	SURG *	CIRCUMCISION AGE 0-17	0.1579	*	*
344	No	No	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY	1.2119	1.7	2.7
345	No	No	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY	1.3011	3.4	5.4
346	No	No	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC	1.0720	4.5	5.9
347	No	No	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC	0.5399	2.0	2.7
348	No	No	12	MED	BENIGN PROSTATIC HYPERTROPHY W CC	0.7434	3.1	4.0
349	No	No	12	MED	BENIGN PROSTATIC HYPERTROPHY W/O CC	0.4607	2.1	2.6
350	No	No	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	0.7762	3.6	4.5
351	No	No	12	MED *	STERILIZATION, MALE	0.2422	*	*
352	No	No	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	0.7822	3.0	4.2
353	No	No	13	SURG	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY	1.8122	4.5	6.0
354	No	No	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	1.4947	4.5	5.6
355	No	No	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC	0.9058	2.8	3.0
356	No	No	13	SURG	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	0.7571	1.6	1.9
357	No	No	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY	2.2244	6.4	8.0
358	No	No	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	1.1414	3.1	3.9

DRG	FY 07 Final Rule Post-Acute Care DRG	FY 07 Final Rule Special Pay DRG	MDC	TYPE	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
359	No	No	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	0.8052	2.1	2.3
360	No	No	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES	0.8808	2.0	2.5
361	No	No	13	SURG	LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	1.0637	2.1	3.0
362	No	No	13	SURG *	ENDOSCOPIC TUBAL INTERRUPTION	0.3096	1.0	1.0
363	No	No	13	SURG	D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	1.0996	2.9	4.2
364	No	No	13	SURG	D&C, CONIZATION EXCEPT FOR MALIGNANCY	0.8911	2.7	3.8
365	No	No	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	2.0516	5.3	7.9
366	No	No	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	1.2461	4.6	6.3
367	No	No	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	0.5876	2.3	3.1
368	No	No	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	1.1640	5.0	6.4
369	No	No	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	0.6577	2.5	3.3
370	No	No	14	SURG	CESAREAN SECTION W CC	0.9008	4.1	5.0
371	No	No	14	SURG	CESAREAN SECTION W/O CC	0.6568	3.1	3.4
372	No	No	14	MED	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	0.5654	2.7	3.4
373	No	No	14	MED	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	0.3912	2.1	2.3
374	No	No	14	SURG	VAGINAL DELIVERY W STERILIZATION &/OR D&C	0.6517	2.4	3.0
375	No	No	14	SURG	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	1.1244	4.0	6.2
376	No	No	14	MED	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	0.6173	2.5	3.3
377	No	No	14	SURG	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	1.2520	3.2	4.5
378	No	No	14	MED	ECTOPIC PREGNANCY	0.7182	1.8	2.2
379	No	No	14	MED	THREATENED ABORTION	0.4135	2.2	3.3
380	No	No	14	MED	ABORTION W/O D&C	0.4408	1.5	2.0
381	No	No	14	SURG	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	0.7091	1.7	2.4
382	No	No	14	MED	FALSE LABOR	0.1814	1.3	1.5
383	No	No	14	MED	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	0.5102	2.6	3.6
384	No	No	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	0.3792	1.7	2.6

DRG	FY 07 Final Rule Post-Acute Care DRG	FY 07 Final Rule Special Pay DRG	MDC	TYPE	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
385	No	No	15	MED *	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	1.4107	*	*
386	No	No	15	MED *	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	4.6519	*	*
387	No	No	15	MED *	PREMATURITY W MAJOR PROBLEMS	3.1771	*	*
388	No	No	15	MED *	PREMATURITY W/O MAJOR PROBLEMS	1.9170	*	*
389	No	No	15	MED *	FULL TERM NEONATE W MAJOR PROBLEMS	3.2636	3.4	6.8
390	No	No	15	MED *	NEONATE W OTHER SIGNIFICANT PROBLEMS	1.1551	*	*
391	No	No	15	MED *	NORMAL NEWBORN	0.1564	*	*
392	No	No	16	SURG	SPLENECTOMY AGE >17	3.0233	6.3	8.9
393	No	No	16	SURG *	SPLENECTOMY AGE 0-17	1.3819	*	*
394	No	No	16	SURG	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS	1.9302	4.5	7.3
395	Yes	No	16	MED	RED BLOOD CELL DISORDERS AGE >17	0.7988	3.1	4.1
396	No	No	16	MED	RED BLOOD CELL DISORDERS AGE 0-17	0.6647	2.6	3.1
397	No	No	16	MED	COAGULATION DISORDERS	1.3280	3.7	5.1
398	Yes	No	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	1.1253	4.1	5.5
399	Yes	No	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC	0.6720	2.6	3.2
400	No	No	17	SURG	NO LONGER VALID	0.0000	0.0	0.0
401	Yes	No	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	2.9657	8.1	11.3
402	Yes	No	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC	1.1614	2.8	3.9
403	Yes	No	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	1.8609	5.7	8.0
404	Yes	No	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	0.9229	3.0	4.1
405	No	No	17	MED *	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0-17	1.9592	*	*
406	No	No	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC	2.7165	6.7	9.4
407	No	No	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC	1.1529	2.8	3.5

DRG	FY 07 Final Rule Post-Acute Care DRG	FY 07 Final Rule Special Pay DRG	MDC	TYPE	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
408	No	No	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC	2.1595	5.1	8.2
409	No	No	17	MED	RADIOTHERAPY	1.2841	4.5	6.0
410	No	No	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	1.0901	2.9	3.8
411	No	No	17	MED *	HISTORY OF MALIGNANCY W/O ENDOSCOPY	0.3681	1.6	2.0
412	No	No	17	MED *	HISTORY OF MALIGNANCY W ENDOSCOPY	0.8559	1.5	1.6
413	No	No	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	1.3352	5.0	6.8
414	No	No	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC	0.7666	3.0	4.1
415	No	No	18	SURG	NO LONGER VALID	0.0000	0.0	0.0
416	No	No	18	MED	NO LONGER VALID	0.0000	0.0	0.0
417	No	No	18	MED	SEPTICEMIA AGE 0-17	1.8734	5.2	6.5
418	Yes	No	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	1.0997	4.7	6.1
419	No	No	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W CC	0.8616	3.4	4.4
420	No	No	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	0.5963	2.6	3.2
421	No	No	18	MED	VIRAL ILLNESS AGE >17	0.7748	3.1	4.0
422	No	No	18	MED	VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0-17	0.6150	2.6	3.7
423	Yes	No	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	1.8370	5.9	8.2
424	No	No	19	SURG	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	2.2452	7.4	11.5
425	No	No	19	MED	ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION	0.6304	2.6	3.5
426	No	No	19	MED	DEPRESSIVE NEUROSES	0.5125	3.1	4.3
427	No	No	19	MED	NEUROSES EXCEPT DEPRESSIVE	0.5578	3.2	4.7
428	No	No	19	MED	DISORDERS OF PERSONALITY & IMPULSE CONTROL	0.7791	4.5	7.3
429	Yes	No	19	MED	ORGANIC DISTURBANCES & MENTAL RETARDATION	0.8390	4.3	5.7
430	Yes	No	19	MED	PSYCHOSES	0.7266	5.8	8.0
431	No	No	19	MED	CHILDHOOD MENTAL DISORDERS	0.6736	4.2	6.8
432	No	No	19	MED	OTHER MENTAL DISORDER DIAGNOSES	0.6601	2.7	4.0
433	No	No	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	0.3277	2.1	2.9
434	No	No	20	MED	NO LONGER VALID	0.0000	0.0	0.0
435	No	No	20	MED	NO LONGER VALID	0.0000	0.0	0.0
436	No	No	20	MED	NO LONGER VALID	0.0000	0.0	0.0

DRG	FY 07 Final Rule Post-Acute Care DRG	FY 07 Final Rule Special Pay DRG	MDC	TYPE	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
437	No	No	20	MED	NO LONGER VALID	0.0000	0.0	0.0
438	No	No	20	MED	NO LONGER VALID	0.0000	0.0	0.0
439	No	No	21	SURG	SKIN GRAFTS FOR INJURIES	1.9078	5.4	8.5
440	Yes	No	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES	1.9293	5.6	8.5
441	No	No	21	SURG	HAND PROCEDURES FOR INJURIES	0.9954	2.3	3.5
442	Yes	No	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W CC	2.5515	6.0	8.9
443	Yes	No	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W/O CC	1.0498	2.7	3.5
444	Yes	No	21	MED	TRAUMATIC INJURY AGE >17 W CC	0.7776	3.2	4.1
445	Yes	No	21	MED	TRAUMATIC INJURY AGE >17 W/O CC	0.5296	2.3	2.8
446	No	No	21	MED *	TRAUMATIC INJURY AGE 0-17	0.3037	*	*
447	No	No	21	MED	ALLERGIC REACTIONS AGE >17	0.5730	1.9	2.6
448	No	No	21	MED *	ALLERGIC REACTIONS AGE 0-17	0.1000	*	*
449	No	No	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC	0.8730	2.7	3.7
450	No	No	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC	0.4419	1.6	2.0
451	No	No	21	MED *	POISONING & TOXIC EFFECTS OF DRUGS AGE 0-17	0.2697	10.2	10.5
452	No	No	21	MED	COMPLICATIONS OF TREATMENT W CC	1.0680	3.5	5.0
453	No	No	21	MED	COMPLICATIONS OF TREATMENT W/O CC	0.5300	2.2	2.8
454	No	No	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC	0.8615	3.0	4.1
455	No	No	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC	0.4840	1.8	2.3
456	No	No	22	MED	NO LONGER VALID	0.0000	0.0	0.0
457	No	No	22	MED	NO LONGER VALID	0.0000	0.0	0.0
458	No	No	22	SURG	NO LONGER VALID	0.0000	0.0	0.0
459	No	No	22	SURG	NO LONGER VALID	0.0000	0.0	0.0
460	No	No	22	MED	NO LONGER VALID	0.0000	0.0	0.0
461	No	No	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES	1.5643	3.3	5.6
462	Yes	No	23	MED	REHABILITATION	0.9442	8.3	9.8
463	Yes	No	23	MED	SIGNS & SYMPTOMS W CC	0.7158	3.1	3.9
464	Yes	No	23	MED	SIGNS & SYMPTOMS W/O CC	0.5269	2.4	2.9
465	No	No	23	MED	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	0.5944	2.5	3.7
466	No	No	23	MED	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	0.7636	2.8	5.3

DRG	FY 07 Final Rule Post-Acute Care DRG	FY 07 Final Rule Special Pay DRG	MDC	TYPE	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
467	No	No	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	0.4754	1.9	2.7
468	Yes	No		SURG	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	3.9880	9.6	13.0
469	No	No		**	PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	0.0000	0.0	0.0
470	No	No		**	UNGROUPABLE	0.0000	0.0	0.0
471	Yes	Yes	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY	3.0376	4.1	4.6
472	No	No	22	SURG	NO LONGER VALID	0.0000	0.0	0.0
473	No	No	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	3.3599	7.3	12.7
474	No	No	04	SURG	NO LONGER VALID	0.0000	0.0	0.0
475	No	No	04	MED	NO LONGER VALID	0.0000	0.0	0.0
476	No	No		SURG	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	2.1586	6.9	9.9
477	Yes	No		SURG	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	2.0895	5.9	8.7
478	No	No	05	SURG	NO LONGER VALID	0.0000	0.0	0.0
479	No	No	05	SURG	OTHER VASCULAR PROCEDURES W/O CC	1.4403	1.9	2.6
480	No	No	PRE	SURG	LIVER TRANSPLANT AND/OR INTESTINAL TRANSPLANT	9.3990	14.0	19.1
481	No	No	PRE	SURG	BONE MARROW TRANSPLANT	6.3832	18.7	22.0
482	Yes	No	PRE	SURG	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES	3.3413	9.4	11.8
483	No	No	PRE	SURG	NO LONGER VALID	0.0000	0.0	0.0
484	No	No	24	SURG	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	5.0950	8.5	12.8
485	Yes	No	24	SURG	LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TRAUMA	3.5053	8.2	10.1
486	No	No	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA	4.8313	8.5	12.3
487	Yes	No	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA	1.8927	5.2	7.1
488	No	No	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE	5.1250	12.2	17.7
489	No	No	25	MED	HIV W MAJOR RELATED CONDITION	1.7871	5.8	8.2
490	No	No	25	MED	HIV W OR W/O OTHER RELATED CONDITION	1.0389	3.8	5.3

DRG	FY 07 Final Rule Post-Acute Care DRG	FY 07 Final Rule Special Pay DRG	MDC	TYPE	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
491	No	No	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY	1.7205	2.5	3.0
492	No	No	17	MED	CHEMOTHERAPY W ACUTE LEUKEMIA OR W USE OF HI DOSE CHEMOAGENT	3.4869	8.9	13.8
493	No	No	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.8291	4.6	6.0
494	No	No	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	1.0328	2.1	2.7
495	No	No	PRE	SURG	LUNG TRANSPLANT	8.4190	14.2	17.3
496	No	No	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION	6.3677	6.4	8.8
497	Yes	Yes	08	SURG	SPINAL FUSION EXCEPT CERVICAL W CC	3.8171	4.8	5.7
498	Yes	Yes	08	SURG	SPINAL FUSION EXCEPT CERVICAL W/O CC	2.9880	3.3	3.7
499	No	No	08	SURG	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC	1.3863	3.0	4.2
500	No	No	08	SURG	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC	0.9210	1.8	2.2
501	Yes	No	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W CC	2.6398	8.4	10.4
502	Yes	No	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W/O CC	1.4281	5.0	5.8
503	No	No	08	SURG	KNEE PROCEDURES W/O PDX OF INFECTION	1.2440	3.0	3.9
504	No	No	22	SURG	EXTEN. BURNS OR FULL THICKNESS BURN W/MV 96+HRS W/SKIN GFT	11.2212	20.8	28.0
505	No	No	22	MED	EXTEN. BURNS OR FULL THICKNESS BURN W/MV 96+HRS W/O SKIN GFT	2.6339	2.8	6.9
506	No	No	22	SURG	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA	3.7919	10.8	15.2
507	No	No	22	SURG	FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA	1.9318	5.4	7.8
508	No	No	22	MED	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ W CC OR SIG TRAUMA	1.4169	5.3	7.5
509	No	No	22	MED	FULL THICKNESS BURN W/O SKIN GRFT OR INH INJ W/O CC OR SIG TRAUMA	0.8347	3.7	5.3

DRG	FY 07 Final Rule Post-Acute Care DRG	FY 07 Final Rule Special Pay DRG	MDC	TYPE	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
510	No	No	22	MED	NON-EXTENSIVE BURNS W CC OR SIGNIFICANT TRAUMA	1.2468	4.2	6.1
511	No	No	22	MED	NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA	0.6833	2.6	3.7
512	No	No	PRE	SURG	SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT	6.2610	11.1	13.6
513	No	No	PRE	SURG	PANCREAS TRANSPLANT	3.9658	8.9	10.6
514	No	No	05	SURG	NO LONGER VALID	0.0000	0.0	0.0
515	No	No	05	SURG	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH	5.2306	2.2	3.8
516	No	No	05	SURG	NO LONGER VALID	0.0000	0.0	0.0
517	No	No	05	SURG	NO LONGER VALID	0.0000	0.0	0.0
518	No	No	05	SURG	PERC CARDIO PROC W/O CORONARY ARTERY STENT OR AMI	1.6367	1.8	2.5
519	No	No	08	SURG	CERVICAL SPINAL FUSION W CC	2.5421	2.9	4.7
520	No	No	08	SURG	CERVICAL SPINAL FUSION W/O CC	1.7568	1.6	1.9
521	Yes	No	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	0.7339	4.2	5.5
522	Yes	No	20	MED	ALC/DRUG ABUSE OR DEPEND W REHABILITATION THERAPY W/O CC	0.6008	7.5	9.4
523	No	No	20	MED	ALC/DRUG ABUSE OR DEPEND W/O REHABILITATION THERAPY W/O CC	0.4182	3.2	3.9
524	No	No	01	MED	TRANSIENT ISCHEMIA	0.7371	2.6	3.1
525	No	No	05	SURG	OTHER HEART ASSIST SYSTEM IMPLANT	12.1909	7.7	14.3
526	No	No	05	SURG	NO LONGER VALID	0.0000	0.0	0.0
527	No	No	05	SURG	NO LONGER VALID	0.0000	0.0	0.0
528	No	No	01	SURG	INTRACRANIAL VASCULAR PROC W PDX HEMORRHAGE	7.0543	13.3	16.4
529	Yes	No	01	SURG	VENTRICULAR SHUNT PROCEDURES W CC	2.1665	4.7	7.4
530	Yes	No	01	SURG	VENTRICULAR SHUNT PROCEDURES W/O CC	1.2175	2.3	2.9
531	Yes	No	01	SURG	SPINAL PROCEDURES W CC	3.1057	6.4	9.3
532	Yes	No	01	SURG	SPINAL PROCEDURES W/O CC	1.4551	2.8	3.7
533	No	No	01	SURG	EXTRACRANIAL PROCEDURES W CC	1.5468	2.4	3.7
534	No	No	01	SURG	EXTRACRANIAL PROCEDURES W/O CC	0.9932	1.4	1.7
535	No	No	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK	7.3768	6.9	9.3
536	No	No	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK	6.6073	5.5	7.3
537	Yes	No	08	SURG	LOCAL EXCIS & REMOV OF INT FIX DEV EXCEPT HIP & FEMUR W CC	1.8351	4.7	6.6
538	Yes	No	08	SURG	LOCAL EXCIS & REMOV OF INT FIX DEV EXCEPT HIP & FEMUR W/O CC	1.0284	2.2	2.9

DRG	FY 07 Final Rule Post-Acute Care DRG	FY 07 Final Rule Special Pay DRG	MDC	TYPE	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
539	No	No	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR OR PROCEDURE W CC	3.1863	6.8	10.6
540	No	No	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR OR PROCEDURE W/O CC	1.1759	2.6	3.5
541	Yes	No	PRE	SURG	ECMO OR TRACH W MV 96+HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	19.2267	37.1	44.5
542	Yes	No	PRE	SURG	TRACH W MV 96+HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	11.6047	27.3	32.7
543	Yes	No	01	SURG	CRANIOTOMY W MOJOR DEVICE IMPLANT OR ACUTE COMPLEX CNS PRINCIPAL DIAGNOSIS	4.3496	7.9	11.6
544	Yes	No	08	SURG	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY	1.9873	4.0	4.4
545	Yes	Yes	08	SURG	REVISION OF HIP OR KNEE REPLACEMENT	2.5306	4.4	5.2
546	No	No	08	SURG	SPINAL FUSION EXC CERV WITH CURVATURE OF THE SPINE OR MALIG	5.3820	7.0	8.8
547	Yes	No	05	SURG	CORONARY BYPASS W CARDIAC CATH W MAJOR CV DX	6.1357	10.9	12.4
548	Yes	No	05	SURG	CORONARY BYPASS W CARDIAC CATH W/O MAJOR CV DX	4.6440	8.1	8.9
549	Yes	Yes	05	SURG	CORONARY BYPASS W/O CARDIAC CATH W MAJOR CV DX	5.0241	8.6	10.2
550	Yes	Yes	05	SURG	CORONARY BYPASS W/O CARDIAC CATH W/O MAJOR CV DX	3.5928	6.2	6.8
551	No	No	05	SURG	PERMANENT CARDIAC PACEMAKER IMPL W MAJ CV DX OR AICD LEAD OR GNRTR	3.0368	4.2	6.1
552	No	No	05	SURG	OTHER PERMANENT CARDIAC PACEMAKER IMPLANT W/O MAJOR CV DX	2.0871	2.5	3.5
553	Yes	No	05	SURG	OTHER VASCULAR PROCEDURES W CC W MAJOR CV DX	3.0091	6.3	9.3
554	Yes	No	05	SURG	OTHER VASCULAR PROCEDURES W CC W/O MAJOR CV DX	2.0771	3.7	5.6
555	No	No	05	SURG	PERCUTANEOUS CARDIOVASCULAR PROC W MAJOR CV DX	2.3062	3.4	4.8
556	No	No	05	SURG	PERCUTANEOUS CARDIOVASC PROC W NON-DRUG-ELUTING STENT W/O MAJ CV DX	1.7782	1.6	2.0
557	No	No	05	SURG	PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W MAJOR CV DX	2.7610	3.0	4.1

DRG	FY 07 Final Rule Post-Acute Care DRG	FY 07 Final Rule Special Pay DRG	MDC	TYPE	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
558	No	No	05	SURG	PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W/O MAJ CV DX	2.0814	1.5	1.8
559	No	No	01	MED	ACUTE ISCHEMIC STROKE WITH USE OF THROMBOLYTIC AGENT	2.2513	5.4	6.9
560	No	No	01	MED	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM	2.9031	8.2	10.6
561	No	No	01	MED	NON-BACTERIAL INFECTIONS OF NERVOUS SYSTEM EXCEPT VIRAL MENINGITIS	2.2176	7.4	9.6
562	Yes	No	01	MED	SEIZURE AGE > 17 W CC	1.0582	3.7	4.9
563	Yes	No	01	MED	SEIZURE AGE > 17 W/O CC	0.6432	2.6	3.2
564	No	No	01	MED	HEADACHES AGE >17	0.6933	2.6	3.4
565	Yes	No	04	MED	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT 96+ HOURS	5.2294	13.4	15.8
566	Yes	No	06	MED	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT < 96 HOURS	2.3335	5.6	7.8
567	Yes	No	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROC AGE > 17 W CC W MAJOR GI DX	5.2173	12.7	16.0
568	Yes	No	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES PROC AGE > 17 W CC W/O MAJOR GI DX	3.3635	8.3	11.5
569	Yes	No	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC W MAJOR GI DX	4.3425	11.9	14.6
570	Yes	No	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC W/O MAJOR GI DX	2.6978	8.4	10.1
571	No	No	06	MED	MAJOR ESOPHAGEAL DISORDERS	1.1126	3.8	4.8
572	Yes	No	08	MED	MAJOR GASTROINTESTINAL DISORDERS AND PERITONEAL INFECTIONS	1.3378	5.6	7.1
573	Yes	No	11	SURG	MAJOR BLADDER PROCEDURES	3.3457	9.1	11.1
574	No	No	16	MED	MAJOR HEMATOLOGIC/IMMUNOLOGIC DIAG EXC SICKLE CELL CRISIS & COAGUL	1.2698	4.3	5.7

DRG	FY 07 Final Rule Post-Acute Care DRG	FY 07 Final Rule Special Pay DRG	MDC	TYPE	DRG Title	Weights	Geometric Mean LOS	Arithmetic Mean LOS
575	Yes	No	18	MED	SEPTICEMIA W MV96+ HOURS AGE >17	5.9388	13.2	16.1
576	Yes	No	18	MED	SEPTICEMIA W/O MV96+ HOURS AGE >17	1.5953	5.5	7.3
577	No	No	01	SURG	CAROTID ARTERY STENT PROCEDURE	1.7844	1.6	2.3
578	Yes	No	18	SURG	INFECTIOUS & PARASITIC DISEASES W OR PROCEDURE	4.8492	12.8	16.7
579	Yes	No	18	SURG	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W OR PROCEDURE	2.8386	8.4	11.5

DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.
NOTE: AN ASTERISK IN THE GMLOS OR AMLOS COLUMN INDICATES THERE IS NO DATA TO COMPUTE.
NOTE: ARITHMETIC MEAN IS PRESENTED FOR INFORMATIONAL PURPOSES ONLY.
NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR TRANSFER CASES.
NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.

TABLE 6A.--NEW DIAGNOSIS CODES

Diagnosis Code	Description	CC	MDC	DRG
052.2	Postvaricella myelitis	Y	1	543, 561
053.14	Herpes zoster myelitis	Y	1	543, 561
054.74	Herpes simplex myelitis	Y	1	543, 561
238.71	Essential thrombocythemia	N	16	398, 399
238.72	Low grade myelodysplastic syndrome lesions	N	16	395, 396
238.73	High grade myelodysplastic syndrome lesions	N	16	395, 396
238.74	Myelodysplastic syndrome with 5q deletion	N	16	395, 396
238.75	Myelodysplastic syndrome, unspecified	N	16	395, 396
238.76	Myelofibrosis with myeloid metaplasia	N	17	401, 402, 403, 404, 539, 540
238.79	Other lymphatic and hematopoietic tissues	N	17	401, 402, 403, 404, 539, 540
277.30	Amyloidosis, unspecified	N	8	240, 241
277.31	Familial Mediterranean fever	N	8	240, 241
277.39	Other amyloidosis	N	8	240, 241
284.01	Constitutional red blood cell aplasia	N	16	574
284.09	Other constitutional aplastic anemia	N	16	574
284.1	Pancytopenia	N	16	395, 396
284.2	Myelophthisis	N	17	401, 402, 403, 404, 539, 540
288.00	Neutropenia, unspecified	N	16 25	574 490
288.01	Congenital neutropenia	N	16 25	574 490
288.02	Cyclic neutropenia	N	16 25	574 490
288.03	Drug induced neutropenia	N	16 25	574 490
288.04	Neutropenia due to infection	N	16 25	574 490
288.09	Other neutropenia	N	16 25	574 490

Diagnosis Code	Description	CC	MDC	DRG
288.4	Hemophagocytic syndromes	N	16	398, 399
288.50	Leukocytopenia, unspecified	N	16	398, 399
288.51	Lymphocytopenia	N	16	398, 399
288.59	Other decreased white blood cell count	N	16	398, 399
288.60	Leukocytosis, unspecified	N	16	398, 399
288.61	Lymphocytosis (symptomatic)	N	16	398, 399
288.62	Leukemoid reaction	N	16	398, 399
288.63	Monocytosis (symptomatic)	N	16	398, 399
288.64	Plasmacytosis	N	16	398, 399
288.65	Basophilia	N	16	398, 399
288.69	Other elevated white blood cell count	N	16	398, 399
289.53	Neutropenic splenomegaly	N	16	398, 399
289.83	Myelofibrosis	N	17	401, 402, 403, 404, 539, 540
323.01	Encephalitis and encephalomyelitis in viral diseases classified elsewhere	N	1	543, 561
323.02	Myelitis in viral diseases classified elsewhere	N	1	543, 561
323.41	Other encephalitis and encephalomyelitis due to infection classified elsewhere	N	1	543, 561
323.42	Other myelitis due to infection classified elsewhere	N	1	543, 561
323.51	Encephalitis and encephalomyelitis following immunization procedures	N	1	543, 561
323.52	Myelitis following immunization procedures	N	1	543, 561
323.61	Infectious acute disseminated encephalomyelitis (ADEM)	N	1	543, 561
323.62	Other postinfectious encephalitis and encephalomyelitis	N	1	543, 561
323.63	Postinfectious myelitis	N	1	543, 561
323.71	Toxic encephalitis and encephalomyelitis	N	1	34, 35, 543
323.72	Toxic myelitis	N	1	34, 35, 543
323.81	Other causes of encephalitis and encephalomyelitis	N	1 25	543, 561 489
323.82	Other causes of myelitis	N	1 25	543, 561 489
331.83	Mild cognitive impairment, so stated	N	1	12

Diagnosis Code	Description	CC	MDC	DRG
333.71	Athetoid cerebral palsy	N	1	12
333.72	Acute dystonia due to drugs	N	1	34, 35
333.79	Other acquired torsion dystonia	N	1	34, 35
333.85	Subacute dyskinesia due to drugs	N	1	34, 35
333.94*	Restless Legs Syndrome	N	1	12
338.0	Central pain syndrome	N	23	463, 464
338.11	Acute pain due to trauma	N	23	463, 464
338.12	Acute post-thoracotomy pain	N	23	463, 464
338.18	Other acute postoperative pain	N	23	463, 464
338.19	Other acute pain	N	23	463, 464
338.21	Chronic pain due to trauma	N	23	463, 464
338.22	Chronic post-thoracotomy pain	N	23	463, 464
338.28	Other chronic postoperative pain	N	23	463, 464
338.29	Other chronic pain	N	23	463, 464
338.3	Neoplasm related pain (acute) (chronic)	N	23	463, 464
338.4	Chronic pain syndrome	N	23	463, 464
341.20	Acute (transverse) myelitis NOS	N	1	543, 561
341.21	Acute (transverse) myelitis in conditions classified elsewhere	N	1	543, 561
341.22	Idiopathic transverse myelitis	N	1	543, 561
377.43	Optic nerve hypoplasia	N	2	45
379.60	Inflammation (infection) of postprocedural bleb, unspecified	N	2	46, 47, 48
379.61	Inflammation (infection) of postprocedural bleb, stage 1	N	2	46, 47, 48
379.62	Inflammation (infection) of postprocedural bleb, stage 2	N	2	46, 47, 48
379.63	Inflammation (infection) of postprocedural bleb, stage 3	N	2	46, 47, 48
389.15	Sensorineural hearing loss, unilateral	N	3	73, 74
389.16	Sensorineural hearing loss, asymmetrical	N	3	73, 74
429.83	Takotsubo syndrome	N	5	144, 145
478.11	Nasal mucositis (ulcerative)	N	3 15	73, 74 391[1]

Diagnosis Code	Description	CC	MDC	DRG
478.19	Other disease of nasal cavity and sinuses	N	3 15	73, 74 391[1]
518.7	Transfusion related acute lung injury (TRALI)	Y	4	101, 102
519.11	Acute bronchospasm	N	PRE 4	482 96, 97, 98
519.19	Other diseases of trachea and bronchus	N	PRE 4	482 96, 97, 98
521.81	Cracked tooth	N	PRE 3	482 185, 186, 187
521.89	Other specific diseases of hard tissues of teeth	N	PRE 3	482 185, 186, 187
523.00	Acute gingivitis, plaque induced	N	PRE 3	482 185, 186, 187
523.01	Acute gingivitis, non-plaque induced	N	PRE 3	482 185, 186, 187
523.10	Chronic gingivitis, plaque induced	N	PRE 3	482 185, 186, 187
523.11	Chronic gingivitis, non-plaque induced	N	PRE 3	482 185, 186, 187
523.30	Aggressive periodontitis, unspecified	N	PRE 3	482 185, 186, 187
523.31	Aggressive periodontitis, localized	N	PRE 3	482 185, 186, 187
523.32	Aggressive periodontitis, generalized	N	PRE 3	482 185, 186, 187
523.33	Acute periodontitis	N	PRE 3	482 185, 186, 187
523.40	Chronic periodontitis, unspecified	N	PRE 3	482 185, 186, 187
523.41	Chronic periodontitis, localized	N	PRE 3	482 185, 186, 187
523.42	Chronic periodontitis,generalized	N	PRE 3	482 185, 186, 187

Diagnosis Code	Description	CC	MDC	DRG
525.60	Unspecified unsatisfactory restoration of tooth	N	PRE 3	482 185, 186, 187
525.61	Open restoration margins	N	PRE 3	482 185, 186, 187
525.62	Unrepairable overhanging of dental restorative materials	N	PRE 3	482 185, 186, 187
525.63	Fractured dental restorative material without loss of material	N	PRE 3	482 185, 186, 187
525.64	Fractured dental restorative material with loss of material	N	PRE 3	482 185, 186, 187
525.65	Contour of existing restoration of tooth biologically incompatible with oral health	N	PRE 3	482 185, 186, 187
525.66	Allergy to existing dental restorative material	N	PRE 3	482 185, 186, 187
525.67	Poor aesthetics of existing restoration	N	PRE 3	482 185, 186, 187
525.69	Other unsatisfactory restoration of existing tooth	N	PRE 3	482 185, 186, 187
526.61	Perforation of root canal space	N	PRE 3	482 185, 186, 187
526.62	Endodontic overfill	N	PRE 3	482 185, 186, 187
526.63	Endodontic underfill	N	PRE 3	482 185, 186, 187
526.69	Other periradicular pathology associated with previous endodontic treatment	N	PRE 3	482 185, 186, 187
528.00	Stomatitis and mucositis, unspecified	N	PRE 3	482 185, 186, 187
528.01	Mucositis (ulcerative) due to antineoplastic therapy	N	PRE 3	482 185, 186, 187
528.02	Mucositis (ulcerative) due to other drugs	N	PRE 3	482 185, 186, 187
528.09	Other stomatitis and mucositis (ulcerative)	N	PRE 3	482 185, 186, 187

Diagnosis Code	Description	CC	MDC	DRG
538	Gastrointestinal mucositis (ulcerative)	N	6	182, 183, 184
608.20	Torsion of testis, unspecified	N	12	352
608.21	Extravaginal torsion of spermatic cord	N	12	352
608.22	Intravaginal torsion of spermatic cord	N	12	352
608.23	Torsion of appendix testis	N	12	352
608.24	Torsion of appendix epididymis	N	12	352
616.81	Mucositis (ulcerative) of cervix, vagina, and vulva	N	13	358, 359, 368
616.89	Other inflammatory disease of cervix, vagina and vulva	N	13	358, 359, 368
618.84	Cervical stump prolapse	N	13	358, 359, 369
629.29	Other female genital mutilation status	N	13	358, 359, 369
629.81	Habitual aborter without current pregnancy	N	13	358, 359, 369
629.89	Other specified disorders of female genital organs	N	13	358, 359, 369
649.00	Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable	N	14	469
649.01	Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition	N	14	370, 371, 372, 373, 374, 375
649.02	Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication	N	14	370, 371, 372, 373, 374, 375
649.03	Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication	N	14	383, 384
649.04	Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication	N	14	376, 377
649.10	Obesity complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable	N	14	469
649.11	Obesity complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition	N	14	370, 371, 372, 373, 374, 375

Diagnosis Code	Description	CC	MDC	DRG
649.12	Obesity complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication	N	14	370, 371, 372, 373, 374, 375
649.13	Obesity complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication	N	14	383, 384
649.14	Obesity complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication	N	14	376, 377
649.20	Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable	N	14	469
649.21	Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition	N	14	370, 371, 372, 373, 374, 375
649.22	Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication	N	14	370, 371, 372, 373, 374, 375
649.23	Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication	N	14	383, 384
649.24	Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication	N	14	376, 377
649.30	Coagulation defects complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable	N	14	469
649.31	Coagulation defects complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition	N	14	370, 371, 372, 373, 374, 375
649.32	Coagulation defects complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication	N	14	370, 371, 372, 373, 374, 375
649.33	Coagulation defects complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication	N	14	383, 384

Diagnosis Code	Description	CC	MDC	DRG
649.34	Coagulation defects complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication	N	14	376, 377
649.40	Epilepsy complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable	N	14	469
649.41	Epilepsy complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition	N	14	370, 371, 372, 373, 374, 375
649.42	Epilepsy complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication	N	14	370, 371, 372, 373, 374, 375
649.43	Epilepsy complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication	N	14	383, 384
649.44	Epilepsy complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication	N	14	376, 377
649.50	Spotting complicating pregnancy, unspecified as to episode of care or not applicable	N	14	469
649.51	Spotting complicating pregnancy, delivered, with or without mention of antepartum condition	N	14	370, 371, 372, 373, 374, 375
649.53	Spotting complicating pregnancy, antepartum condition or complication	N	14	383, 384
649.60	Uterine size date discrepancy, unspecified as to episode of care or not applicable	N	14	469
649.61	Uterine size date discrepancy, delivered, with or without mention of antepartum condition	N	14	370, 371, 372, 373, 374, 375
649.62	Uterine size date discrepancy, delivered, with mention of postpartum complication	N	14	370, 371, 372, 373, 374, 375
649.63	Uterine size date discrepancy, antepartum condition or complication	N	14	383, 384
649.64	Uterine size date discrepancy, postpartum condition or complication	N	14	376, 377
729.71	Nontraumatic compartment syndrome of upper extremity	N	8	248
729.72	Nontraumatic compartment syndrome of lower extremity	N	8	248
729.73	Nontraumatic compartment syndrome of abdomen	N	8	248

Diagnosis Code	Description	CC	MDC	DRG
729.79	Nontraumatic compartment syndrome of other sites	N	8	248
731.3	Major osseous defects	N	8	244, 245
768.7*	Hypoxic-ischemic encephalopathy (HIE)	N	15	390
770.87*	Respiratory arrest of newborn	N	15	390
770.88*	Hypoxemia of newborn	N	15	390
775.81*	Other acidosis of newborn	N	15	390
775.89*	Other neonatal endocrine and metabolic disturbances	N	15	390
779.85*	Cardiac arrest of newborn	Y	15	387[2], 389[2]
780.32	Complex febrile convulsions	Y	1	26, 562, 563
780.96	Generalized pain	N	23	463, 464
780.97	Altered mental status	N	23	463, 464
784.91	Postnasal drip	N	3	73, 74
784.99	Other symptoms involving head and neck	N	3	73, 74
788.64	Urinary hesitancy	N	11	325, 326, 327
788.65	Straining on urination	N	11	325, 326, 327
793.91	Image test inconclusive due to excess body fat	N	23	463, 464
793.99	Other nonspecific abnormal findings on radiological and other examinations of body structure	N	23	463, 464
795.06	Papanicolaou smear of cervix with cytologic evidence of malignancy	N	13	358, 359, 369
795.81	Elevated carcinoembryonic antigen [CEA]	N	23	463, 464
795.82	Elevated cancer antigen 125 [CA 125]	N	23	463, 464
795.89	Other abnormal tumor markers	N	23	463, 464
958.90	Compartment syndrome, unspecified	N	21	454, 455
958.91	Traumatic compartment syndrome of upper extremity	N	21	454, 455
958.92	Traumatic compartment syndrome of lower extremity	N	21	454, 455
958.93	Traumatic compartment syndrome of abdomen	N	21	454, 455
958.99	Traumatic compartment syndrome of other sites	N	21	454, 455

Diagnosis Code	Description	CC	MDC	DRG
995.20	Unspecified adverse effect of unspecified drug, medicinal and biological substance	N	15 21	387[3], 389[3] 449, 450, 451
995.21	Arthus phenomenon	N	15 21	387[3], 389[3] 449, 450, 451
995.22	Unspecified adverse effect of anesthesia	N	15 21	387[3], 389[3] 449, 450, 451
995.23	Unspecified adverse effect of insulin	N	15 21	387[3], 389[3] 449, 450, 451
995.27	Other drug allergy	N	15 21	387[3], 389[3] 449, 450, 451
995.29	Unspecified adverse effect of other drug, medicinal and biological substance	N	15 21	387[3], 389[3] 449, 450, 451
V18.51	Family history, Colonic polyps	N	23	467
V18.59	Family history, Other digestive disorders	N	23	467
V26.34	Testing of male for genetic disease carrier status	N	23	467
V26.35	Encounter for testing of male partner of habitual aborter	N	23	467
V26.39	Other genetic testing of male	N	23	467
V45.86	Bariatric surgery status	N	23	467
V58.30	Encounter for change or removal of nonsurgical wound dressing	N	23	467
V58.31	Encounter for change or removal of surgical wound dressing	N	23	467
V58.32	Encounter for removal of sutures	N	23	467
V72.11	Encounter for hearing examination following failed hearing screening	N	23 15	467 391[1]
V72.19	Other examination of ears and hearing	N	23 15	467 391[1]
V82.71	Screening for genetic disease carrier status	N	23	467
V82.79	Other genetic screening	N	23	467
V85.51	Body Mass Index, pediatric, less than 5th percentile for age	N	23	467
V85.52	Body Mass Index, pediatric, 5th percentile to less than 85th percentile for age	N	23	467

Diagnosis Code	Description	CC	MDC	DRG
V85.53	Body Mass Index, pediatric, 85th percentile to less than 95th percentile for age	N	23	467
V85.54	Body Mass Index, pediatric, greater than or equal to 95th percentile for age	N	23	467
V86.0	Estrogen receptor positive status [ER+]	N	23	467
V86.1	Estrogen receptor negative status [ER-]	N	23	467

[1]On "Only secondary diagnosis" list.
[2]Principal or secondary diagnosis of major problem.
[3]Secondary diagnosis of major problem
*These diagnosis codes were discussed at the March 23-24, 2006 ICD-9-CM Coordination and Maintenance Committee meeting and were not finalized in time to include in the proposed rule. They will be implemented on October 1, 2006.

TABLE 6B.--NEW PROCEDURE CODES

Procedure Code	Description	OR	MDC	DRG
00.44	Procedure on vessel bifurcation	N	--	--
00.56	Insertion or replacement of implantable pressure sensor (lead) for intracardiac hemodynamic monitoring	Y	5	117, 120[1]
00.57	Implantation or replacement of subcutaneous device for intracardiac hemodynamic monitoring	Y	5	118, 120[1]
00.77*	Hip replacement bearing surface, ceramic-on-polyethylene	N	--	--
00.85*	Resurfacing hip, total, acetabulum and femoral head	Y	8 21 24	471, 544 442, 443 485
00.86*	Resurfacing hip, partial, femoral head	Y	8 10 21 24	471, 544 292, 293 442, 443 485
00.87*	Resurfacing hip, partial, acetabulum	Y	8 10 21 24	471, 544 292, 293 442, 443 485
01.28*	Placement of intracerebral catheter(s) via burr hole(s)	Y	1 17 21 24	1, 2, 3, 543 406, 407, 539, 540 442, 443 484
13.90*	Operation on lens, Not Elsewhere Classified	Y	2 21 24 --	39 442, 443 486 476, 477
13.91*	Implantation of intraocular telescope prosthesis	Y	2 21 24 --	39 442, 443 486 476, 477
32.23*	Open ablation of lung lesion or tissue	Y	4 17	75 406, 407, 539, 540
32.24*	Percutaneous ablation of lung lesion or tis	Y	4	76, 77

Procedure Code	Description	OR	MDC	DRG
32.25*	Thoracoscopic ablation of lung lesion or tissue	Y	4 17	75 406, 407, 539, 540
32.26*	Other and unspecified ablation of lung lesion or tissue	Y	4	75
33.71*	Endoscopic insertion or replacement of bronchial valve(s)	N[2]	17	412
33.78*	Endoscopic removal of bronchial device(s) or substances	N[2]	17	412
33.79*	Endoscopic insertion of other bronchial device or substances	N[2]	17	412
35.55*	Repair of ventricular septal defect with prosthesis, closed technique	Y	5	108
36.33*	Endoscopic transmyocardial revascularization	Y	5	108
36.34*	Percutaneous transmyocardial revascularization	Y	5	108
37.20	Noninvasive programmed electrical stimulation [NIPS]	N		
39.74	Endovascular removal of obstruction from head and neck vessel(s)	Y	1 21 24	1, 2, 3, 543 442, 443 486
50.23*	Open ablation of liver lesion or tissue	Y	6 7	170, 171 191, 192
50.24*	Percutaneous ablation of liver lesion or tissue	Y	6 7	170, 171 191, 192
50.25*	Laparoscopic ablation of liver lesion or tissue	Y	6 7	170, 171 191, 192
50.26*	Other and unspecified ablation of liver lesion or tissue	Y	6 7	170, 171 191, 192
55.32*	Open ablation of renal lesion or tissue	Y	11	303, 304, 305
55.33*	Percutaneous ablation of renal lesion or tissue	Y	11	303, 304, 305
55.34*	Laparoscopic ablation of renal lesion or tissue	Y	11	303, 304, 305
55.35*	Other and unspecified ablation of renal lesion or tissue	Y	11	303, 304, 305
68.41	Laparoscopic total abdominal hysterectomy	Y	13 14	354, 355, 357, 358, 359 375

Procedure Code	Description	OR	MDC	DRG
68.49	Other and unspecified total abdominal hysterectomy	Y	13 14	354, 355, 357, 358, 359 375
68.61	Laparoscopic radical abdominal hysterectomy	Y	13 14	353 375
68.69	Other and unspecified radical abdominal hysterectomy	Y	13 14	353 375
68.71	Laparoscopic radical vaginal hysterectomy [LRVH]	Y	13 14	353 375
68.79	Other and unspecified radical vaginal hysterectomy	Y	13 14	353 375

[1] Assigned to DRG 120 when both 00.56 and 00.57 are reported.
[2]Non-operating room procedure that affects DRG assignment.
*These procedure codes were discussed at the March 23-24, 2006 ICD-9-CM Coordination and Maintenance Committee meeting and were not finalized in time to include in the proposed rule. They will be implemented on October 1, 2006.

TABLE 6C.--INVALID DIAGNOSIS CODES

Diagnosis Code	Description	CC	MDC	DRG
238.7	Other lymphatic and hematopoietic tissues	N	17	401, 402, 403, 404, 539, 540
277.3	Amyloidosis	N	8	240, 241
284.0	Constitutional aplastic anemia	Y	16	395, 396
288.0	Agranulocytosis	Y	16 25	398, 399 490
323.0	Encephalitis in viral diseases classified elsewhere	N	1	20, 543
323.4	Other encephalitis due to infection classified elsewhere	N	1	20, 543
323.5	Encephalitis following immunization procedures	N	1	20, 543
323.6	Postinfectious encephalitis	N	1	20, 543
323.7	Toxic encephalitis	N	1	34, 35, 543
323.8	Other causes of encephalitis	N	1 25	20, 543 489
333.7	Symptomatic torsion dystonia	N	1	1 2 3 12
478.1	Other diseases of nasal cavity and sinuses	N	3 15	73, 74 391[1]
519.1	Other diseases of trachea and bronchus, not elsewhere classified	N	PRE 4	482 96, 97, 98
521.8	Other specific diseases of hard tissues of teeth	N	PRE 3	482 185, 186, 187
523.0	Acute gingivitis	N	PRE 3	482 185, 186, 187
523.1	Chronic gingivitis	N	PRE 3	482 185, 186, 187
523.3	Acute periodontitis	N	PRE 3	482 185, 186, 187
523.4	Chronic periodontitis	N	PRE 3	482 185, 186, 187

Diagnosis Code	Description	CC	MDC	DRG
528.0	Stomatitis	N	PRE 3	482 185, 186, 187
608.2	Torsion of testis	N	12	352
616.8	Other specified inflammatory diseases of cervix, vagina, and vulva	N	13	358, 359, 368
629.8	Other specified disorders of female genital organs	N	13	358, 359, 369
775.8*	Other transitory neonatal endocrine and metabolic disturbances	N	15	390
784.9	Other symptoms involving head and neck	N	3	73, 74
793.9	Other nonspecific abnormal findings on radiological and other examinations of body structure	N	23	463, 464
995.2	Unspecified adverse effect of drug, medicinal and biological substance	N	15 21	387[2], 389[2] 449, 450, 451
V18.5	Family history, Digestive disorders	N	23	467
V58.3	Attention to surgical dressings and sutures	N	23	467
V72.1	Examination of ears and hearing	N	15 23	391[1] 467

[1]On "Only secondary diagnosis" list.
[2]Principal or secondary diagnosis of major problem.
*This diagnosis code was discussed at the March 23-24, 2006 ICD-9-CM Coordination and Maintenance Committee meeting and was not finalized in time to include in the proposed rule. It will be deleted on October 1, 2006.

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TABLE 6D.--INVALID PROCEDURE CODES

Procedure Code	Description	OR	MDC	DRG
13.9*	Other operations on lens	Y	2	39
			21	442-443
			24	486
68.4	Total abdominal hysterectomy	Y	13	354, 355, 357, 358, 359
			14	375
68.6	Radical abdominal hysterectomy	Y	13	353
			14	375
68.7	Radical vaginal hysterectomy	Y	13	353
			14	375

*This procedure code was discussed at the March 23-24, 2006 ICD-9-CM Coordination and Maintenance Committee meeting and was not finalized in time to include in the proposed rule. The change will be implemented on October 1, 2006.

TABLE 6E.--REVISED DIAGNOSIS CODE TITLES

Diagnosis Code	Description	CC	MDC	DRG
255.10	Hyperaldosteronism, unspecified	N	10	300, 301
285.29	Anemia of other chronic disease	N	16	395, 396
323.1	Encephalitis, myelitis, and encephalomyelitis in rickettsial diseases classified elsewhere	N	1	543, 561
323.2	Encephalitis, myelitis, and encephalomyelitis in protozoal diseases classified elsewhere	N	1	543, 561
323.9	Unspecified causes of encephalitis, myelitis, and encephalomyelitis	N	1 25	543, 561 489
333.6	Genetic torsion dystonia	N	1	12
345.40	Localization-related (focal) (partial) epilepsy and epileptic syndromes with complex partial seizures, without mention of intractable epilepsy	N	1	26, 562, 563
345.41	Localization-related (focal) (partial) epilepsy and epileptic syndromes with complex partial seizures, with intractable epilepsy	Y	1	26, 562, 563
345.50	Localization-related (focal) (partial) epilepsy and epileptic syndromes with simple partial seizures, without mention of intractable epilepsy	N	1	26, 562, 563
345.51	Localization-related (focal) (partial) epilepsy and epileptic syndromes with simple partial seizures, with intractable epilepsy	Y	1	26, 562, 563
345.80	Other forms of epilepsy and recurrent seizures, without mention of intractable epilepsy	N	1	26, 562, 563
345.81	Other forms of epilepsy and recurrent seizures, with intractable epilepsy	Y	1	26, 562, 563
389.11	Sensory hearing loss, bilateral	N	3	73, 74

Diagnosis Code	Description	CC	MDC	DRG
389.12	Neural hearing loss, bilateral	N	3	73, 74
389.14	Central hearing loss, bilateral	N	3	73, 74
389.18	Sensorineural hearing loss of combined types, bilateral	N	3	73, 74
403.00	Hypertensive chronic kidney disease, malignant, with chronic kidney disease stage I through stage IV, or unspecified	Y	11	315, 316
403.01	Hypertensive chronic kidney disease, malignant, with chronic kidney disease stage V or end stage renal disease	Y	PRE 11	512[1] 315, 316
403.10	Hypertensive chronic kidney disease, benign, with chronic kidney disease stage I through stage IV, or unspecified	N	11	315, 316
403.11	Hypertensive chronic kidney disease, benign, with chronic kidney disease stage V or end stage renal disease	Y	PRE 11	512[1] 315, 316
403.90	Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage I through stage IV, or unspecified	N	11	315, 316
403.91	Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage V or end stage renal disease	Y	PRE 11	512[1] 315, 316
404.00	Hypertensive heart and chronic kidney disease, malignant, without heart failure and with chronic kidney disease stage I through stage IV, or unspecified	Y	5	134
404.01	Hypertensive heart and chronic kidney disease, malignant, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified	Y	5 15	121[2], 124[3], 127, 535, 547[4], 549[4], 551[4], 553[4], 555[4], 557[4] 387[5], 389[5]

Diagnosis Code	Description	CC	MDC	DRG
404.02	Hypertensive heart and chronic kidney disease, malignant, without heart failure and with chronic kidney disease stage V or end stage renal disease	Y	PRE 11	512[1] 315, 316
404.03	Hypertensive heart and chronic kidney disease, malignant, with heart failure and with chronic kidney disease stage V or end stage renal disease	Y	PRE 5 15	512[1] 121[2], 124[3], 127, 535, 547[4], 549[4], 551[4], 553[4], 555[4], 557[4] 387[5], 389[5]
404.10	Hypertensive heart and chronic kidney disease, benign, without heart failure and with chronic kidney disease stage I through stage IV, or unspecified	N	5	134
404.11	Hypertensive heart and chronic kidney disease, benign, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified	Y	5 15	121[2], 124[3], 127, 535, 547[4], 549[4], 551[4], 553[4], 555[4], 557[4] 387[5], 389[5]
404.12	Hypertensive heart and chronic kidney disease, benign, without heart failure and with chronic kidney disease stage V or end stage renal disease	Y	PRE 11	512[1] 315, 316
404.13	Hypertensive heart and chronic kidney disease, benign, with heart failure and chronic kidney disease stage V or end stage renal disease	Y	PRE 5 15	512[1] 121[2], 124[3], 127, 535, 547[4], 549[4], 551[4], 553[4], 555[4], 557[4] 387[5], 389[5]
404.90	Hypertensive heart and chronic kidney disease, unspecified, without heart failure and with chronic kidney disease stage I through stage IV, or unspecified	N	5	134

Diagnosis Code	Description	CC	MDC	DRG
404.91	Hypertensive heart and chronic kidney disease, unspecified, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified	Y	5 15	121[2], 124[3], 127, 535, 547[4], 549[4], 551[4], 553[4], 555[4], 557[4] 387[5], 389[5]
404.92	Hypertensive heart and chronic kidney disease, unspecified, without heart failure and with chronic kidney disease stage V or end stage renal disease	Y	PRE 11	512[1] 315, 316
404.93	Hypertensive heart and chronic kidney disease, unspecified, with heart failure and chronic kidney disease stage V or end stage renal disease	Y	PRE 5 15	512[1] 121[2], 124[3], 127, 535, 547[4], 549[4], 551[4], 553[4], 555[4], 557[4] 387[5], 389[5]
524.21	Malocclusion, Angle's class I	N	PRE 3	482 185, 186, 187
524.22	Malocclusion, Angle's class II	N	PRE 3	482 185, 186, 187
524.23	Malocclusion, Angle's class III	N	PRE 3	482 185, 186, 187
524.35	Rotation of tooth/teeth	N	PRE 3	482 185, 186, 187
600.00	Hypertrophy (benign) of prostate without urinary obstruction and other lower urinary tract symptom(LUTS)	N	12	348, 349
600.01	Hypertrophy (benign) of prostate with urinary obstruction and other lower urinary tract symptoms (LUTS)	N	12	348, 349
600.20	Benign localized hyperplasia of prostate without urinary obstruction and other lower urinary tract symptoms (LUTS)	N	12	348, 349

Diagnosis Code	Description	CC	MDC	DRG
600.21	Benign localized hyperplasia of prostate with urinary obstruction and other lower urinary tract symptoms (LUTS)	N	12	348, 349
600.90	Hyperplasia of prostate, unspecified, without urinary obstruction and other lower urinary symptoms (LUTS)	N	12	348, 349
600.91	Hyperplasia of prostate, unspecified, with urinary obstruction and other lower urinary symptoms (LUTS)	N	12	348, 349
768.3	Fetal distress first noted during labor and delivery, in liveborn infant	N	15	390
780.31	Febrile convulsions (simple), unspecified	Y	1 15	26, 562, 563 387[5], 389[5]
780.95	Excessive crying of child, adolescent, or adult	N	23	463, 464
790.93	Elevated prostate specific antigen [PSA]	N	23	463, 464
873.63	Tooth (broken) (fractured) (due to trauma), without mention of complication	N	3 24	185, 186, 187 487
873.73	Tooth (broken) (fractured) (due to trauma), complicated	N	3 24	185, 186, 187 487
995.91	Sepsis	Y	18	417, 575, 576
995.92	Severe sepsis	Y	18	417, 575, 576
995.93	Systemic inflammatory response syndrome due to noninfectious process without acute organ dysfunction	Y	18	417, 575, 576
995.94	Systemic inflammatory response syndrome due to noninfectious process with acute organ dysfunction	Y	18	417, 575, 576
V26.31	Testing of female for genetic disease carrier status	N	23	467
V26.32	Other genetic testing of female	N	23	467

[1]Principal or secondary diagnosis
[2] Principal or secondary diagnosis of major complication
[3] Principal or secondary diagnosis of complex diagnosis
[4] Principal or secondary diagnosis of major cardiovascular condition
[5]Principal or secondary diagnosis of major problem

TABLE 6F.--REVISED PROCEDURE CODE TITLES

Procedure Code	Description	OR	MDC	DRG
01.26*	Insertion of catheter(s) into cranial cavity or tissue	N		
01.27*	Removal of catheter(s) from cranial cavity or tissue	N		
35.53*	Repair of ventricular septal defect with prosthesis, open technique	Y	5	108
37.26	Catheter based invasive electrophysiologic testing	N[1]	5	104, 518, 555, 556, 557, 558
68.39*	Other and unspecified subtotal abdominal hysterectomy	Y	13	354, 355, 357, 358, 359
			14	375
68.59*	Other and unspecified vaginal hysterectomy	Y	13	354, 355, 357, 358, 359
			14	375

[1]Non- OR code that affects DRG assignment.

*These procedure codes were discussed at the March 23-24, 2006 ICD-9-CM Coordination and Maintenance Committee meeting and were not finalized in time to include in the proposed rule. They will be implemented on October 1, 2006.

BILLING CODE 4120-01-C

[CCs that are added to the list are in this Table 6G—Additions to the CC Exclusions List. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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TABLE 6H.—DELETIONS FROM THE CC EXCLUSIONS LIST

[CCs that are deleted from the list are in this Table 6H—Deletions to the CC Exclusions List. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6H.—DELETIONS FROM THE CC EXCLUSIONS LIST—Continued

[CCs that are deleted from the list are in this Table 6H—Deletions to the CC Exclusions List. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6H.—DELETIONS FROM THE CC EXCLUSIONS LIST—Continued

[CCs that are deleted from the list are in this Table 6H—Deletions to the CC Exclusions List. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6H.—DELETIONS FROM THE CC EXCLUSIONS LIST—Continued

[CCs that are deleted from the list are in this Table 6H—Deletions to the CC Exclusions List. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6H.—DELETIONS FROM THE CC EXCLUSIONS LIST—Continued

[CCs that are deleted from the list are in this Table 6H—Deletions to the CC Exclusions List. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 6H.—DELETIONS FROM THE CC EXCLUSIONS LIST—Continued

[CCs that are deleted from the list are in this Table 6H—Deletions to the CC Exclusions List. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

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TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2005 MEDPAR UPDATE MARCH 2006 GROUPER V23.0

DRG	Number discharge	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
1	24,464	9.6076	2	4	7	12	19
2	10,338	4.3927	1	2	3	6	8
3	3	11.0000	4	4	8	21	21
6	288	3.0833	1	1	2	3	7
7	15,034	9.2559	2	4	7	12	19
8	3,441	2.7629	1	1	2	3	6
9	1,775	6.0248	1	3	4	7	11
10	19,639	5.9172	2	3	4	7	11
11	3,074	3.5501	1	2	3	5	7
12	56,196	5.3631	2	3	4	6	10
13	7,529	4.8515	2	3	4	6	8
14	278,864	5.3705	2	3	4	7	10
15	20,004	4.0156	1	2	3	5	7
16	17,310	6.3008	2	3	5	8	12
17	2,967	3.0334	1	1	2	4	6
18	33,512	5.1525	2	3	4	6	9
19	8,422	3.3749	1	2	3	4	6
20	6,409	9.8313	3	5	8	12	18
21	2,220	6.1752	2	3	5	8	12
22	3,169	5.0104	2	2	4	6	10
23	10,671	3.8995	1	2	3	5	7
24	63,246	4.6433	1	2	3	6	9
25	27,218	3.1280	1	2	2	4	6
26	25	3.8000	1	1	2	5	9
27	5,974	4.7370	1	1	3	6	10
28	19,919	5.5701	1	2	4	7	11
29	6,517	3.2118	1	1	3	4	6
31	5,043	3.9038	1	2	3	5	7
32	1,900	2.2716	1	1	2	3	4
34	27,478	4.7063	1	2	4	6	9
35	7,843	3.0360	1	1	3	4	5
36	1,045	1.7962	1	1	1	1	1
37	1,219	4.1132	1	1	3	5	8
38	50	2.8000	1	1	2	3	6
39	328	2.1220	1	1	1	2	3
40	1,188	4.2315	1	1	3	4	6
42	901	3.0844	1	1	2	3	5
43	125	2.9600	1	1	2	4	5
44	1,291	4.7506	2	3	4	6	8
45	2,771	3.0278	1	2	2	4	6
46	3,930	4.1913	1	2	3	5	8
47	1,308	3.0145	1	1	2	4	6
49	2,416	4.5219	1	2	3	5	9
50	2,026	1.8638	1	1	1	2	3
51	193	2.6684	1	1	1	3	5
52	316	1.6962	1	1	1	2	3
53	2,147	4.0051	1	1	2	5	9
55	1,370	2.8832	1	1	1	3	6
56	451	2.6785	1	1	2	3	5
57	888	3.1543	1	1	2	3	7
59	126	2.3730	1	1	2	3	5
60	3	1.6667	1	1	1	3	3
61	222	6.0541	1	1	4	8	13
62	4	1.5000	1	1	1	1	3
63	2,827	4.5313	1	1	3	6	10
64	3,234	6.2004	1	2	4	8	13

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2005 MEDPAR UPDATE MARCH 2006 GROUPER V23.0—Continued

DRG	Number discharge	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
65	40,495	2.7634	1	1	2	3	5
66	8,197	3.1080	1	1	2	4	6
67	379	3.6834	1	2	3	5	8
68	18,963	3.8500	1	2	3	5	7
69	5,104	2.9414	1	2	2	4	5
70	25	2.4000	1	1	2	3	4
71	70	4.3429	1	2	3	5	7
72	1,326	3.3205	1	2	3	4	6
73	9,961	4.2979	1	2	3	5	8
74	3	3.3333	3	3	3	4	4
75	46,867	9.5747	3	5	7	12	19
76	48,182	10.4832	3	5	8	13	20
77	2,096	4.4938	1	2	4	6	9
78	49,708	6.0925	2	4	5	7	10
79	160,452	8.0513	3	4	7	10	15
80	7,128	5.2173	2	3	4	6	9
81	6	6.1667	2	3	5	8	8
82	63,222	6.6658	2	3	5	9	13
83	7,154	5.1918	2	3	4	6	10
84	1,402	3.1284	1	2	3	4	5
85	22,231	6.1082	2	3	5	8	12
86	1,714	3.4568	1	2	3	4	7
87	96,725	6.3706	2	3	5	8	12
88	427,153	4.8563	2	3	4	6	9
89	554,440	5.5245	2	3	5	7	10
90	43,208	3.7030	1	2	3	5	6
91	53	3.4151	1	1	2	4	6
92	16,523	5.9402	2	3	5	7	11
93	1,436	3.7632	1	2	3	5	7
94	13,657	5.9022	2	3	5	8	12
95	1,576	3.3839	1	2	3	4	6
96	59,742	4.2995	2	2	4	5	7
97	26,592	3.3652	1	2	3	4	6
98	13	3.0769	2	2	2	4	6
99	21,402	3.0982	1	1	2	4	6
100	6,406	2.1071	1	1	2	3	4
101	23,399	4.1820	1	2	3	5	8
102	4,907	2.5345	1	1	2	3	5
103	884	35.1640	8	11	22	46	78
104	20,125	14.6458	6	8	12	18	26
105	32,635	9.9310	4	6	8	11	18
106	3,440	10.9392	5	7	9	13	18
108	8,759	10.7132	4	6	9	13	19
110	57,721	8.0026	1	3	6	10	16
111	10,783	3.1055	1	1	2	4	6
113	34,750	12.5640	4	6	10	15	24
114	7,960	8.3485	2	4	7	11	16
117	5,350	4.2781	1	1	2	5	9
118	7,634	3.0183	1	1	2	4	7
119	963	5.3998	1	1	3	7	13
120	33,561	8.9647	1	3	6	12	19
121	150,085	6.1981	2	3	5	8	11
122	54,555	3.2992	1	1	3	4	6
123	29,576	4.7318	1	1	3	6	11
124	120,562	4.3876	1	2	3	6	9
125	92,475	2.7008	1	1	2	3	5
126	5,424	10.6875	3	6	9	13	19
127	667,522	5.0851	2	3	4	6	9
128	4,213	5.1899	2	3	5	6	9
129	3,527	2.5373	1	1	1	2	5
130	87,554	5.3511	1	3	4	7	10
131	22,885	3.6965	1	2	3	5	6
132	101,433	2.8006	1	1	2	3	5
133	5,845	2.1384	1	1	2	3	4
134	39,838	3.1001	1	2	2	4	6
135	7,171	4.2924	1	2	3	5	8
136	939	2.6944	1	1	2	3	5
138	206,296	3.8764	1	2	3	5	7
139	73,965	2.4267	1	1	2	3	4
140	31,123	2.4049	1	1	2	3	4

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2005 MEDPAR UPDATE MARCH 2006 GROUPER V23.0—Continued

DRG	Number discharge	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
141	123,214	3.4307	1	2	3	4	6
142	49,069	2.4897	1	1	2	3	4
143	237,871	2.0978	1	1	2	3	4
144	104,970	5.8254	1	2	4	7	11
145	5,698	2.5470	1	1	2	3	5
146	10,278	9.7685	4	6	8	11	17
147	2,613	5.5427	2	4	5	7	8
148	133,146	11.9344	5	6	9	15	22
149	19,525	5.6364	3	4	5	7	8
150	22,987	10.7225	4	6	9	13	19
151	5,401	5.0224	1	2	4	7	9
152	5,016	7.9314	3	5	7	9	14
153	1,953	4.8669	2	3	5	6	7
154	27,071	12.9678	3	6	10	16	25
155	6,015	3.9583	1	2	3	6	8
156	4	9.2500	7	7	8	8	14
157	8,329	5.6899	1	2	4	7	11
158	3,716	2.6453	1	1	2	3	5
159	19,241	5.0838	1	2	4	6	10
160	11,945	2.6548	1	1	2	3	5
161	10,158	4.5026	1	2	3	6	9
162	4,952	2.0889	1	1	1	3	4
163	5	2.4000	1	1	2	3	5
164	6,003	7.6838	3	4	7	9	13
165	2,457	3.9935	2	2	4	5	7
166	5,157	4.3198	1	2	3	5	8
167	4,922	2.1260	1	1	2	3	4
168	1,538	4.8563	1	2	3	6	10
169	774	2.7661	1	1	2	3	5
170	17,939	10.6904	2	5	8	13	21
171	1,404	4.1660	1	2	3	5	8
172	33,099	6.7836	2	3	5	8	13
173	2,192	3.4995	1	1	3	4	7
174	261,557	4.6848	2	3	4	6	8
175	29,879	2.8529	1	2	2	4	5
176	14,653	5.0912	2	3	4	6	9
177	7,659	4.4332	2	2	4	5	8
178	2,559	3.0770	1	2	3	4	5
179	14,734	5.7800	2	3	4	7	11
180	91,464	5.2570	2	3	4	6	10
181	25,262	3.3086	1	2	3	4	6
182	297,116	4.4864	1	2	3	5	8
183	81,577	2.8984	1	1	2	4	5
184	79	4.2911	1	2	3	4	8
185	6,254	4.4915	1	2	3	6	9
186	7	3.1429	1	2	2	3	5
187	647	4.1468	1	2	3	6	8
188	93,711	5.4548	1	2	4	7	10
189	13,047	3.0530	1	1	2	4	6
190	65	4.8000	1	2	3	6	8
191	10,595	12.3655	3	6	9	15	25
192	1,380	5.5087	1	3	5	7	9
193	4,044	12.5321	5	7	10	15	23
194	461	6.2603	2	4	6	8	11
195	2,846	10.5569	4	6	9	13	19
196	595	5.3345	2	3	5	7	9
197	16,435	9.0254	3	5	7	11	16
198	4,114	4.2859	2	3	4	5	7
199	1,484	8.9892	2	4	7	12	19
200	1,017	10.3520	1	3	7	13	21
201	2,717	13.5628	3	6	10	17	27
202	27,516	6.1264	2	3	5	7	12
203	32,434	6.4368	2	3	5	8	12
204	69,460	5.3914	2	3	4	6	10
205	32,822	5.8530	2	3	4	7	11
206	2,051	3.8035	1	2	3	5	7
207	38,329	5.2350	1	2	4	7	10
208	9,427	2.9434	1	1	2	4	5
210	126,884	6.6228	3	4	5	8	11
211	25,813	4.5833	3	3	4	5	7

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2005 MEDPAR UPDATE MARCH 2006 GROUPER V23.0—Continued

DRG	Number discharge	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
212	10	2.5000	1	2	2	4	4
213	9,511	8.9931	2	4	7	11	18
216	19,925	5.3298	1	1	3	7	12
217	15,693	12.1157	3	5	8	15	24
218	30,213	5.3787	2	3	4	7	10
219	21,194	3.1641	1	2	3	4	5
220	2	4.0000	1	1	7	7	7
223	12,689	3.2720	1	1	2	4	6
224	9,927	1.9411	1	1	1	2	3
225	6,275	5.2709	1	2	4	7	11
226	6,776	6.3719	1	3	4	8	13
227	4,855	2.6360	1	1	2	3	5
228	2,683	4.2046	1	1	3	5	9
229	1,117	2.5004	1	1	2	3	5
230	2,474	5.4321	1	2	4	7	11
232	572	2.7395	1	1	2	3	6
233	18,500	6.3363	1	2	5	8	13
234	9,052	2.6740	1	1	1	3	6
235	4,763	4.6431	1	2	4	6	8
236	41,789	4.4010	1	3	4	5	8
237	1,925	3.7844	1	2	3	5	7
238	9,693	7.9706	2	4	6	9	14
239	40,343	6.0356	2	3	5	7	11
240	12,933	6.4411	2	3	5	8	12
241	2,818	3.6427	1	2	3	4	6
242	2,725	6.4499	2	3	5	8	12
243	100,998	4.4968	1	2	4	6	8
244	16,946	4.4343	1	2	4	5	8
245	5,798	3.0942	1	1	3	4	5
246	1,393	3.5635	1	2	3	4	6
247	21,356	3.2905	1	2	3	4	6
248	16,406	4.8154	2	3	4	6	8
249	13,490	3.9493	1	1	3	5	8
250	4,165	3.8363	1	2	3	5	7
251	2,059	2.7936	1	1	3	3	5
252	1	1.0000	1	1	1	1	1
253	24,816	4.5259	2	3	4	5	8
254	10,019	3.0639	1	2	3	4	5
255	1	1.0000	1	1	1	1	1
256	7,606	4.9471	1	2	4	6	9
257	13,128	2.5517	1	1	2	3	5
258	11,400	1.6964	1	1	1	2	3
259	2,660	2.8173	1	1	1	3	7
260	2,431	1.4048	1	1	1	1	2
261	1,571	2.2037	1	1	1	2	4
262	602	4.6561	1	2	3	6	9
263	22,544	10.4724	3	5	7	13	20
264	3,912	6.2150	2	3	5	7	11
265	4,036	6.5347	1	2	4	8	14
266	2,230	3.0296	1	1	2	4	6
267	276	4.2428	1	1	3	5	8
268	1,007	3.6495	1	1	2	4	7
269	11,070	7.9865	2	3	6	10	15
270	2,573	3.5876	1	1	3	5	7
271	21,579	6.7917	2	3	5	8	12
272	6,079	5.8195	2	3	4	7	11
273	1,256	3.7070	1	2	3	5	7
274	2,222	6.1787	1	3	5	7	11
275	173	3.2081	1	1	2	4	6
276	1,611	4.6096	1	2	4	6	8
277	119,184	5.4238	2	3	4	7	9
278	33,737	3.9926	2	2	3	5	7
279	6	4.1667	1	2	3	5	5
280	19,335	3.9854	1	2	3	5	7
281	6,583	2.7961	1	1	2	3	5
283	6,770	4.5786	1	2	3	6	8
284	1,845	2.9176	1	1	2	4	5
285	8,079	9.8267	3	5	8	12	18
286	2,869	5.1921	2	2	4	6	10
287	5,462	9.5002	3	5	7	11	18

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2005 MEDPAR UPDATE MARCH 2006 GROUPER V23.0—Continued

DRG	Number discharge	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
288	11,463	3.7000	1	2	3	4	6
289	6,352	2.3909	1	1	1	2	5
290	11,894	2.0268	1	1	1	2	3
291	60	1.4833	1	1	1	1	2
292	7,592	9.9870	2	4	8	12	19
293	317	4.7192	1	2	3	6	8
294	96,836	4.2502	1	2	3	5	8
295	4,384	3.7003	1	2	3	4	7
296	247,467	4.6444	1	2	4	6	9
297	42,523	3.0312	1	2	3	4	5
298	111	3.5405	1	1	2	4	6
299	1,529	5.0680	1	2	4	6	9
300	21,700	5.8032	2	3	5	7	11
301	3,909	3.3592	1	2	3	4	6
302	10,499	7.9355	4	5	6	9	13
303	24,646	7.2778	3	4	6	8	14
304	14,090	8.3271	2	3	6	10	17
305	3,012	3.1016	1	2	3	4	6
306	5,818	5.5734	1	2	3	8	13
307	1,950	2.0292	1	1	2	2	3
308	6,684	6.1339	1	2	4	8	14
309	3,266	1.9801	1	1	1	2	4
310	25,386	4.4935	1	2	3	6	10
311	5,890	1.8514	1	1	1	2	3
312	1,328	4.9315	1	2	3	6	10
313	505	2.3921	1	1	2	3	5
314	2	89.0000	5	5	173	173	173
315	34,911	6.7495	1	1	4	9	16
316	204,550	6.1591	2	3	5	8	12
317	2,716	3.5044	1	1	2	4	7
318	5,914	5.9731	1	3	4	7	12
319	384	2.5651	1	1	2	3	5
320	225,069	4.9879	2	3	4	6	9
321	31,860	3.5371	1	2	3	4	6
322	67	3.5821	2	2	3	4	6
323	20,427	3.1029	1	1	2	4	6
324	4,637	1.8462	1	1	1	2	3
325	9,930	3.7407	1	2	3	5	7
326	2,586	2.5607	1	1	2	3	5
327	11	2.0000	1	1	2	2	3
328	574	3.4146	1	1	3	4	6
329	54	1.6852	1	1	1	2	3
331	57,039	5.4034	1	2	4	7	10
332	4,145	3.0625	1	1	2	4	6
333	247	5.3320	1	2	4	6	9
334	9,532	4.0415	1	2	3	5	7
335	12,203	2.4946	1	2	2	3	4
336	28,202	3.2201	1	1	2	4	7
337	21,501	1.8442	1	1	2	2	3
338	674	5.7953	1	2	4	8	13
339	1,237	5.1924	1	2	3	7	12
340	1	2.0000	2	2	2	2	2
341	3,131	3.2031	1	1	1	3	7
342	457	3.0394	1	1	2	3	6
344	2,343	2.7222	1	1	1	3	7
345	1,390	5.4324	1	2	3	7	12
346	3,963	5.9066	2	3	4	7	11
347	234	2.7094	1	1	2	3	5
348	4,262	4.0082	1	2	3	5	7
349	554	2.6408	1	1	2	3	5
350	7,281	4.5187	2	2	4	5	8
352	1,177	4.1623	1	2	3	5	9
353	3,092	6.0155	2	3	4	7	11
354	7,572	5.5539	2	3	4	6	10
355	5,006	3.0224	2	2	3	3	4
356	22,278	1.8696	1	1	2	2	3
357	5,543	8.0319	3	4	6	10	15
358	20,961	3.8545	2	2	3	4	7
359	28,665	2.3497	1	2	2	3	3
360	14,282	2.5518	1	1	2	3	4

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2005 MEDPAR UPDATE MARCH 2006 GROUPER V23.0—Continued

DRG	Number discharge	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
361	287	2.9303	1	1	2	3	6
362	2	1.0000	1	1	1	1	1
363	1,981	4.0848	1	2	2	4	9
364	1,380	4.1754	1	2	3	5	8
365	1,617	7.8411	2	3	5	10	16
366	4,654	6.2426	1	3	5	8	12
367	438	2.9612	1	1	2	3	5
368	4,145	6.4068	2	3	5	8	12
369	3,727	3.2659	1	1	2	4	6
370	2,251	4.9964	2	3	4	5	7
371	2,715	3.3908	2	3	3	4	4
372	1,377	3.4415	2	2	2	3	5
373	5,284	2.2470	1	2	2	3	3
374	153	2.9739	2	2	2	3	4
375	12	6.5000	1	2	3	6	8
376	476	3.2815	1	2	2	4	7
377	109	4.4954	1	2	3	6	8
378	202	2.1782	1	1	2	3	4
379	500	3.2960	1	1	2	3	6
380	111	2.0180	1	1	1	2	4
381	170	2.4647	1	1	1	2	4
382	48	1.4792	1	1	1	1	2
383	2,806	3.6433	1	1	2	4	7
384	151	2.5960	1	1	1	3	4
387	1	9.0000	9	9	9	9	9
389	3	8.6667	1	1	2	3	3
392	2,140	8.8757	2	4	6	11	19
394	2,761	7.3032	1	2	5	9	16
395	115,607	4.2768	1	2	3	5	8
396	20	2.9500	1	2	3	3	4
397	16,443	5.1098	1	2	4	6	10
398	18,696	5.7191	2	3	4	7	11
399	1,643	3.3603	1	2	3	4	6
401	6,462	11.0371	2	5	8	14	22
402	1,348	3.8858	1	1	3	5	9
403	31,551	7.8595	2	3	6	10	16
404	3,624	3.9914	1	2	3	5	8
406	2,304	9.3859	2	4	7	12	20
407	616	3.4935	1	2	3	5	7
408	1,949	8.2104	1	2	5	10	19
409	1,750	6.0383	2	3	4	6	12
410	29,067	3.7654	1	2	3	4	6
411	5	2.0000	1	1	1	3	4
412	9	1.5556	1	1	2	2	2
413	5,748	6.7189	2	3	5	9	13
414	481	4.0146	1	2	3	5	7
415	55,992	14.0950	4	6	11	17	27
416	288,502	7.4508	2	3	6	9	14
417	33	6.5455	2	3	5	8	12
418	29,991	6.0675	2	3	5	7	11
419	17,719	4.3438	1	2	3	5	8
420	3,023	3.1667	1	2	3	4	5
421	13,262	4.0156	1	2	3	5	7
422	79	3.6456	1	2	2	4	7
423	8,970	8.0750	2	3	6	10	15
424	1,041	11.5053	2	4	8	14	23
425	13,101	3.4571	1	1	3	4	6
426	4,237	4.3099	1	2	3	5	8
427	1,579	4.6390	1	2	3	5	9
428	845	7.2769	1	2	4	8	14
429	23,941	5.4509	2	3	4	6	10
430	75,545	7.7573	2	3	6	9	15
431	333	6.6667	1	2	4	7	11
432	402	4.0199	1	1	3	4	8
433	4,472	2.8233	1	1	2	3	4
439	1,759	8.3337	1	3	5	9	17
440	5,216	8.1532	2	3	5	9	16
441	686	3.4125	1	1	2	4	6
442	18,608	8.6730	2	3	6	10	17
443	3,590	3.5279	1	1	3	5	7

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2005 MEDPAR UPDATE MARCH 2006 GROUPER V23.0—Continued

DRG	Number discharge	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
444	6,014	4.0328	1	2	3	5	7
445	2,243	2.8270	1	1	2	3	5
447	6,324	2.5745	1	1	2	3	5
449	40,869	3.6910	1	1	3	4	7
450	7,453	1.9804	1	1	1	2	4
451	2	10.5000	8	8	13	13	13
452	28,831	4.9369	1	2	3	6	10
453	5,388	2.7572	1	1	2	3	5
454	4,741	4.1080	1	2	3	5	8
455	885	2.2802	1	1	2	3	4
461	2,290	5.5782	1	1	3	7	12
462	7,891	9.5516	4	5	7	10	13
463	32,925	3.8763	1	2	3	5	7
464	7,635	2.8998	1	1	2	4	5
465	163	3.4724	1	1	2	4	6
466	1,204	4.9086	1	1	2	4	7
467	1,028	2.6722	1	1	2	3	5
468	52,062	12.5395	3	6	10	16	24
471	16,780	4.8545	3	3	4	5	8
473	8,582	12.4204	2	3	7	17	32
475	119,965	10.6382	2	5	9	14	20
476	2,851	9.9056	1	4	8	14	20
477	28,211	8.5081	1	3	7	11	17
479	27.660	2.5490	1	1	2	3	5
480	908	19.1013	6	8	13	23	39
481	1,199	22.0025	12	16	20	24	33
482	5,084	11.1810	4	6	9	13	20
484	472	12.7564	2	5	10	17	26
485	3,714	9.4715	4	5	7	11	18
486	2,712	12.1962	2	5	10	16	24
487	5,017	6.8405	1	3	5	9	14
488	828	17.6437	4	7	12	21	33
489	13,555	8.1669	2	3	6	10	15
490	5,255	5.3115	1	2	4	6	9
491	22,688	3.0224	1	2	2	3	5
492	3,924	13.8081	3	5	6	23	32
493	61,129	6.0304	2	3	5	8	11
494	24,558	2.6900	1	1	2	4	5
495	342	17.3421	8	10	13	20	33
496	3,727	8.7631	3	4	6	10	17
497	31,236	5.6849	3	3	5	6	9
498	21,296	3.6794	2	3	3	4	5
499	35,261	4.1633	1	2	3	5	8
500	46,497	2.1981	1	1	2	3	4
501	3,203	9.8392	4	5	8	12	18
502	762	5.6995	2	3	5	7	10
503	5,916	3.9238	1	2	3	5	7
504	192	28.0260	8	13	24	36	51
505	180	6.8889	1	1	2	6	13
506	964	15.1432	3	7	12	20	30
507	322	7.7112	1	3	6	10	14
508	655	7.3542	1	3	5	9	14
509	155	5.2323	1	2	3	6	11
510	1,783	6.0432	1	2	4	7	12
511	627	3.6364	1	1	2	4	7
512	550	13.6200	6	8	10	14	25
513	216	10.7407	5	7	8	11	17
515	58,668	3.8406	1	1	1	5	9
518	23,803	2.4598	1	1	1	3	5
519	12,597	4.6702	1	1	3	6	11
520	16,544	1.9403	1	1	1	2	3
521	29,404	5.2599	1	2	4	6	8
522	3,423	10.2875	3	4	5	7	8
523	14,428	3.7573	1	2	3	4	5
524	109,116	3.1429	1	2	3	4	6
525	206	14.2718	1	3	7	17	35
528	1,845	16.3252	6	9	14	21	29
529	5,115	7.2502	1	2	4	9	16
530	3,391	2.9451	1	1	2	3	6
531	4,910	8.9709	2	4	7	11	18

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2005 MEDPAR UPDATE MARCH 2006 GROUPER V23.0—Continued

DRG	Number discharge	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
532	2,849	3.6413	1	1	3	5	7
533	46,773	3.6548	1	1	2	4	8
534	42,812	1.7223	1	1	1	2	3
535	8,822	9.2409	2	4	8	12	18
536	8,260	7.2738	2	3	6	9	14
537	8,986	6.5032	1	3	5	8	13
538	5,461	2.9145	1	1	2	4	6
539	4,978	10.5552	2	4	7	14	23
540	1,501	3.5097	1	1	3	4	7
541	25,114	41.6431	16	23	34	50	72
542	23,126	30.3529	11	17	25	37	52
543	5,507	11.7066	2	5	9	16	23
544	446,467	4.3995	3	3	4	5	7
545	43,772	5.0362	3	3	4	6	8
546	2,364	8.7657	3	4	7	10	16
547	32,723	12.1254	6	8	10	14	20
548	32,268	8.7755	5	6	8	10	13
549	13,145	10.0860	5	6	8	12	18
550	34,583	6.7752	4	5	6	8	10
551	53,960	6.0685	1	2	5	8	12
552	82,137	3.4766	1	1	2	5	7
553	39,301	9.0530	1	3	7	12	19
554	77,365	5.5722	1	2	4	7	12
555	37,404	4.8144	1	2	3	6	10
556	19,008	2.0085	1	1	1	2	4
557	124,278	4.1023	1	2	3	5	8
558	193,170	1.8108	1	1	1	2	4
559	2,895	6.8370	2	3	5	8	13
	12,150,46						

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2005 MEDPAR UPDATE MARCH 2006 GROUPER V24.0

DRG	Number discharge	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
1	24,403	9.6172	2	4	7	12	19
2	10,188	4.4271	1	2	4	6	8
3	3	11.0000	4	4	8	21	21
6	288	3.0833	1	1	2	3	7
7	15,033	9.2561	2	4	7	12	19
8	3,442	2.7638	1	1	2	3	6
9	1,775	6.0248	1	3	4	7	11
10	19,628	5.9178	2	3	4	7	11
11	3,085	3.5546	1	2	3	5	7
12	55,972	5.3686	2	3	4	6	10
13	7,529	4.8515	2	3	4	6	8
14	278,864	5.3705	2	3	4	7	10
15	20,004	4.0156	1	2	3	5	7
16	17,302	6.3015	2	3	5	8	12
17	2,975	3.0376	1	1	2	4	6
18	33,467	5.1537	2	3	4	6	9
19	8,467	3.3795	1	2	3	4	6
21	2,220	6.1752	2	3	5	8	12
22	3,169	5.0104	2	2	4	6	10
23	10,671	3.8995	1	2	3	5	7
26	25	3.8000	1	1	2	5	9
27	5,974	4.7370	1	1	3	6	10
28	19,912	5.5699	1	2	4	7	11
29	6,524	3.2149	1	1	3	4	6
31	5,039	3.9036	1	2	3	5	7
32	1,904	2.2757	1	1	2	3	4
34	27,632	4.7034	1	2	4	6	9
35	7,913	3.0404	1	1	3	4	5
36	308	1.9156	1	1	1	1	2
37	1,219	4.1132	1	1	3	5	8
38	50	2.8000	1	1	2	3	6
39	328	2.1220	1	1	1	2	3

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2005 MEDPAR UPDATE MARCH 2006 GROUPER V24.0—Continued

DRG	Number discharge	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
40	1,188	4.2315	1	1	3	4	6
42	1,638	2.4823	1	1	1	2	3
43	125	2.9600	1	1	2	4	5
44	1,291	4.7506	2	3	4	6	8
45	2,771	3.0278	1	2	2	4	6
46	3,929	4.1917	1	2	3	5	8
47	1,309	3.0145	1	1	2	4	6
49	2,416	4.5219	1	2	3	5	9
50	2,026	1.8638	1	1	1	2	3
51	193	2.6684	1	1	1	3	5
52	235	1.5149	1	1	1	2	2
53	2,147	4.0051	1	1	2	5	9
55	1,370	2.8832	1	1	1	3	6
56	451	2.6785	1	1	2	3	5
57	742	3.2520	1	1	2	3	7
59	126	2.3730	1	1	2	3	5
60	3	1.6667	1	1	1	3	3
61	222	6.0541	1	1	4	8	13
62	4	1.5000	1	1	1	1	3
63	2,827	4.5313	1	1	3	6	10
64	3,234	6.2004	1	2	4	8	13
65	40,495	2.7634	1	1	2	3	5
66	8,197	3.1080	1	1	2	4	6
67	379	3.6834	1	2	3	5	8
68	18,918	3.8500	1	2	3	5	7
69	5,149	2.9493	1	2	2	4	5
70	25	2.4000	1	1	2	3	4
71	70	4.3429	1	2	3	5	7
72	1,326	3.3205	1	2	3	4	6
73	9,961	4.2979	1	2	3	5	8
74	3	3.3333	3	3	3	4	4
75	46,867	9.5747	3	5	7	12	19
76	48,166	10.4844	3	5	8	13	20
77	2,112	4.5123	1	2	4	6	9
78	49,708	6.0925	2	4	5	7	10
79	160,420	8.0517	3	4	7	10	15
80	7,160	5.2197	2	3	4	6	9
81	6	6.1667	2	3	5	8	8
82	63,222	6.6658	2	3	5	9	13
83	7,153	5.1922	2	3	4	6	10
84	1,403	3.1276	1	2	3	4	5
85	22,228	6.1087	2	3	5	8	12
86	1,717	3.4549	1	2	3	4	6
87	96,725	6.3706	2	3	5	8	12
88	427,153	4.8563	2	3	4	6	9
89	554,136	5.5251	2	3	5	7	10
90	43,512	3.7080	2	2	3	5	6
91	53	3.4151	1	1	2	4	6
92	16,519	5.9408	2	3	5	7	11
93	1,440	3.7625	1	2	3	5	7
94	13,656	5.9023	2	3	5	8	12
95	1,577	3.3843	1	2	3	4	6
96	59,631	4.3002	2	2	4	5	7
97	26,703	3.3674	1	2	3	4	6
98	13	3.0769	2	2	2	4	6
99	21,392	3.0989	1	1	2	4	6
100	6,416	2.1061	1	1	2	3	4
101	23,370	4.1822	1	2	3	5	8
102	4,936	2.5432	1	1	2	3	5
103	886	35.2641	8	11	22	46	78
104	20,125	14.6458	6	8	12	18	26
105	32,635	9.9310	4	6	8	11	18
106	3,440	10.9392	5	7	9	13	18
108	8,758	10.7099	4	6	9	13	19
110	57,710	8.0024	1	3	6	10	16
111	10,785	3.1058	1	1	2	4	6
113	34,750	12.5640	4	6	10	15	24
114	7,959	8.3465	2	4	7	11	16
117	5,350	4.2781	1	1	2	5	9
118	7,634	3.0183	1	1	2	4	7

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2005 MEDPAR UPDATE MARCH 2006 GROUPER V24.0—Continued

DRG	Number discharge	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
119	963	5.3998	1	1	3	7	13
120	33,561	8.9647	1	3	6	12	19
121	150,085	6.1981	2	3	5	8	11
122	54,555	3.2992	1	1	3	4	6
123	29,576	4.7318	1	1	3	6	11
124	120,562	4.3876	1	2	3	6	9
125	92,475	2.7008	1	1	2	3	5
126	5,424	10.6875	3	6	9	13	19
127	667,522	5.0851	2	3	4	6	9
128	4,213	5.1899	2	3	5	6	9
129	3,527	2.5373	1	1	1	2	5
130	87,480	5.3514	1	3	4	7	10
131	22,959	3.7009	1	2	3	5	6
132	101,418	2.8006	1	1	2	3	5
133	5,860	2.1410	1	1	2	3	4
134	39,838	3.1001	1	2	2	4	6
135	7,167	4.2931	1	2	3	5	8
136	943	2.6957	1	1	2	3	5
138	206,188	3.8769	1	2	3	5	7
139	74,073	2.4274	1	1	2	3	4
140	31,123	2.4049	1	1	2	3	4
141	123,116	3.4312	1	2	3	4	6
142	49,167	2.4904	1	1	2	3	4
143	237,871	2.0978	1	1	2	3	4
144	104,925	5.8262	1	2	4	7	11
145	5,743	2.5581	1	1	2	3	5
146	10,276	9.7688	4	6	8	11	17
147	2,615	5.5449	2	4	5	7	8
149	19,545	5.6387	3	4	5	7	8
150	22,981	10.7232	4	6	9	13	19
151	5,407	5.0255	1	2	4	7	9
152	5,016	7.9314	3	5	7	9	14
153	1,953	4.8669	2	3	5	6	7
155	6,019	3.9621	1	2	3	6	8
156	4	9.2500	7	7	8	8	14
157	8,321	5.6913	1	2	4	7	11
158	3,724	2.6488	1	1	2	3	5
159	19,233	5.0843	1	2	4	6	10
160	11,953	2.6555	1	1	2	3	5
161	10,152	4.5036	1	2	3	6	9
162	4,958	2.0896	1	1	1	3	4
163	5	2.4000	1	1	2	3	5
164	5,999	7.6861	3	4	7	9	13
165	2,461	3.9939	2	2	4	5	7
166	5,156	4.3200	1	2	3	5	8
167	4,923	2.1261	1	1	2	3	4
168	1,640	4.7726	1	2	3	6	10
169	899	2.6151	1	1	2	3	4
170	17,935	10.6919	2	5	8	13	21
171	1,408	4.1648	1	2	3	5	8
172	33,065	6.7846	2	3	5	8	13
173	2,226	3.5341	1	1	3	4	7
174	253,265	4.6853	2	3	4	6	8
175	29,252	2.8605	1	2	2	4	5
176	14,653	5.0912	2	3	4	6	9
177	7,656	4.4327	2	2	4	5	8
178	2,562	3.0800	1	2	3	4	5
179	14,734	5.7800	2	3	4	7	11
180	91,370	5.2580	2	3	4	6	10
181	25,356	3.3125	1	2	3	4	6
182	255,772	4.0692	1	2	3	5	7
183	79,046	2.8475	1	1	2	4	5
184	72	3.7361	1	1	2	4	7
185	6,254	4.4915	1	2	3	6	9
186	7	3.1429	1	2	2	3	5
187	647	4.1468	1	2	3	6	8
188	87,040	5.3291	1	2	4	6	10
189	12,406	2.9703	1	1	2	4	5
190	10	3.0000	1	1	2	6	6
191	10,592	12.3671	3	6	9	15	25

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2005 MEDPAR UPDATE MARCH 2006 GROUPER V24.0—Continued

DRG	Number discharge	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
192	1,380	5.5087	1	3	5	7	9
193	4,042	12.5339	5	7	10	15	23
194	463	6.2721	2	4	6	8	11
195	2,846	10.5569	4	6	9	13	19
196	595	5.3345	2	3	5	7	9
197	16,432	9.0256	3	5	7	11	16
198	4,117	4.2888	2	3	4	5	7
199	1,484	8.9892	2	4	7	12	19
200	1,017	10.3520	1	3	7	13	21
201	2,717	13.5628	3	6	10	17	27
202	27,516	6.1264	2	3	5	7	12
203	32,434	6.4368	2	3	5	8	12
204	69,460	5.3914	2	3	4	6	10
205	32,803	5.8542	2	3	4	7	11
206	2,070	3.8024	1	2	3	5	7
207	38,305	5.2356	1	2	4	7	10
208	9,451	2.9471	1	1	2	4	5
210	126,867	6.6230	3	4	5	8	11
211	25,830	4.5839	3	3	4	5	7
212	10	2.5000	1	2	2	4	4
213	9,553	9.0206	2	4	7	11	18
216	19,883	5.3088	1	1	3	7	12
217	15,724	12.1410	3	5	8	15	24
218	30,210	5.3789	2	3	4	7	10
219	21,197	3.1642	1	2	3	4	5
220	2	4.0000	1	1	7	7	7
223	12,688	3.2719	1	1	2	4	6
224	9,928	1.9413	1	1	1	2	3
225	6,275	5.2709	1	2	4	7	11
226	6,771	6.3738	1	3	4	8	13
227	4,860	2.6372	1	1	2	3	5
228	2,679	4.2027	1	1	3	5	9
229	1,121	2.5112	1	1	2	3	5
230	2,474	5.4321	1	2	4	7	11
232	572	2.7395	1	1	2	3	6
233	18,493	6.3374	1	2	5	8	13
234	9,059	2.6746	1	1	1	3	6
235	4,763	4.6431	1	2	4	6	8
236	41,789	4.4010	1	3	4	5	8
237	1,925	3.7844	1	2	3	5	7
238	9,693	7.9706	2	4	6	9	14
239	40,343	6.0356	2	3	5	7	11
240	12,896	6.4472	2	3	5	8	12
241	2,855	3.6515	1	2	3	4	6
242	2,725	6.4499	2	3	5	8	12
243	100,998	4.4968	1	2	4	6	8
244	16,933	4.4351	1	2	4	5	8
245	5,811	3.0950	1	1	3	4	5
246	1,393	3.5635	1	2	3	4	6
247	21,356	3.2905	1	2	3	4	6
248	16,406	4.8154	2	3	4	6	8
249	13,490	3.9493	1	1	3	5	8
250	4,164	3.8365	1	2	3	5	7
251	2,060	2.7937	1	1	3	3	5
252	1	1.0000	1	1	1	1	1
253	24,805	4.5258	2	3	4	5	8
254	10,030	3.0656	1	2	3	4	5
255	1	1.0000	1	1	1	1	1
256	7,606	4.9471	1	2	4	6	9
257	13,126	2.5519	1	1	2	3	5
258	11,402	1.6964	1	1	1	2	3
259	2,660	2.8173	1	1	1	3	7
260	2,431	1.4048	1	1	1	1	2
261	1,571	2.2037	1	1	1	2	4
262	602	4.6561	1	2	3	6	9
263	22,532	10.4725	3	5	7	13	20
264	3,924	6.2273	2	3	5	7	11
265	4,036	6.5347	1	2	4	8	14
266	2,230	3.0296	1	1	2	4	6
267	276	4.2428	1	1	3	5	8

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2005 MEDPAR UPDATE MARCH 2006 GROUPER V24.0—Continued

DRG	Number discharge	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
268	1,007	3.6495	1	1	2	4	7
269	11,061	7.9889	2	3	6	10	15
270	2,582	3.5930	1	1	3	5	7
271	21,579	6.7917	2	3	5	8	12
272	6,067	5.8218	2	3	4	7	11
273	1,268	3.7161	1	2	3	5	7
274	2,214	6.1847	1	3	5	7	11
275	181	3.2652	1	1	2	4	6
276	1,611	4.6096	1	2	4	6	8
277	119,041	5.4248	2	3	4	7	9
278	33,880	3.9954	2	2	3	5	7
279	6	4.1667	1	2	3	5	5
280	19,329	3.9844	1	2	3	5	7
281	6,589	2.8001	1	1	2	3	5
283	6,755	4.5760	1	2	3	6	8
284	1,860	2.9403	1	1	2	4	5
285	8,082	9.8285	3	5	8	12	18
286	2,869	5.1921	2	2	4	6	10
287	5,462	9.5002	3	5	7	11	18
288	11,460	3.6971	1	2	3	4	6
289	6,352	2.3909	1	1	1	2	5
290	11,894	2.0268	1	1	1	2	3
291	60	1.4833	1	1	1	1	2
292	7,590	9.9858	2	4	8	12	19
293	318	4.7673	1	2	3	6	8
294	96,836	4.2502	1	2	3	5	8
295	4,384	3.7003	1	2	3	4	7
296	247,119	4.6457	1	2	4	6	9
297	42,871	3.0365	1	2	3	4	5
298	111	3.5405	1	1	2	4	6
299	1,529	5.0680	1	2	4	6	9
300	21,678	5.8044	2	3	5	7	11
301	3,931	3.3666	1	2	3	4	6
302	10,496	7.9354	4	5	6	9	13
303	19,984	6.3149	2	3	5	7	12
304	13,649	8.1660	2	3	6	10	17
305	2,690	3.0331	1	2	2	4	5
306	5,818	5.5734	1	2	3	8	13
307	1,950	2.0292	1	1	2	2	3
308	5,454	5.2913	1	2	3	7	12
309	2,964	1.7190	1	1	1	2	3
310	25,380	4.4933	1	2	3	6	10
311	5,896	1.8552	1	1	1	2	3
312	1,328	4.9315	1	2	3	6	10
313	505	2.3921	1	1	2	3	5
314	2	89.0000	5	5	173	173	173
315	34,913	6.7494	1	1	4	9	16
316	205,633	6.1505	2	3	5	8	12
317	2,716	3.5044	1	1	2	4	7
318	5,912	5.9738	1	3	4	7	12
319	386	2.5725	1	1	2	3	5
320	224,944	4.9886	2	3	4	6	9
321	31,985	3.5383	1	2	3	4	6
322	67	3.5821	2	2	3	4	6
323	20,425	3.1030	1	1	2	4	6
324	4,639	1.8463	1	1	1	2	3
325	9,924	3.7401	1	2	3	5	7
326	2,592	2.5656	1	1	2	3	5
327	11	2.0000	1	1	2	2	3
328	574	3.4146	1	1	3	4	6
329	54	1.6852	1	1	1	2	3
331	56,139	5.4124	1	2	4	7	10
332	3,963	3.0636	1	1	2	4	6
333	244	5.3648	1	2	4	6	10
334	9,529	4.0421	1	2	3	5	7
335	12,206	2.4946	1	2	2	3	4
336	28,193	3.2206	1	1	2	4	7
337	21,510	1.8441	1	1	2	2	3
338	674	5.7953	1	2	4	8	13
339	1,237	5.1924	1	2	3	7	12

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2005 MEDPAR UPDATE MARCH 2006 GROUPER V24.0—Continued

DRG	Number discharge	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
340	1	2.0000	2	2	2	2	2
341	3,131	3.2031	1	1	1	3	7
342	457	3.0394	1	1	2	3	6
344	2,343	2.7222	1	1	1	3	7
345	1,390	5.4324	1	2	3	7	12
346	3,962	5.9079	2	3	4	7	11
347	235	2.7021	1	1	2	3	5
348	4,262	4.0082	1	2	3	5	7
349	554	2.6408	1	1	2	3	5
350	7,281	4.5187	2	2	4	5	8
352	1,177	4.1623	1	2	3	5	9
353	3,092	6.0155	2	3	4	7	11
354	7,572	5.5539	2	3	4	6	10
355	5,006	3.0224	2	2	3	3	4
356	22,085	1.8693	1	1	2	2	3
357	5,543	8.0319	3	4	6	10	15
358	20,947	3.8543	2	2	3	4	7
359	28,679	2.3506	1	2	2	3	3
360	13,879	2.5012	1	1	2	3	4
361	287	2.9303	1	1	2	3	6
362	2	1.0000	1	1	1	1	1
363	2,157	4.2165	1	2	3	5	9
364	1,800	3.8100	1	1	3	5	8
365	1,617	7.8411	2	3	5	10	16
366	4,645	6.2474	1	3	5	8	12
367	447	2.9776	1	1	2	4	5
368	4,145	6.4068	2	3	5	8	12
369	3,727	3.2659	1	1	2	4	6
370	2,251	4.9964	2	3	4	5	7
371	2,715	3.3908	2	3	3	4	4
372	1,377	3.4415	2	2	2	3	5
373	5,284	2.2470	1	2	2	3	3
374	153	2.9739	2	2	2	3	4
375	12	6.5000	1	2	3	6	8
376	476	3.2815	1	2	2	4	7
377	109	4.4954	1	2	3	6	8
378	202	2.1782	1	1	2	3	4
379	500	3.2960	1	1	2	3	6
380	111	2.0180	1	1	1	2	4
381	170	2.4647	1	1	1	2	4
382	48	1.4792	1	1	1	1	2
383	2,806	3.6433	1	1	2	4	7
384	151	2.5960	1	1	1	3	4
387	1	9.0000	9	9	9	9	9
389	3	8.6667	1	1	2	3	3
392	2,140	8.8757	2	4	6	11	19
394	2,761	7.3032	1	2	5	9	16
395	101,519	4.0933	1	2	3	5	8
396	18	3.0556	1	2	3	3	4
397	16,443	5.1098	1	2	4	6	10
398	6,708	5.4499	1	2	4	7	10
399	1,084	3.2260	1	1	3	4	6
401	6,451	11.0460	2	5	8	14	22
402	1,359	3.9014	1	1	3	5	9
403	31,351	7.8732	2	3	6	10	16
404	3,824	4.0811	1	2	3	5	8
406	2,304	9.3859	2	4	7	12	20
407	616	3.4935	1	2	3	5	7
408	1,949	8.2104	1	2	5	10	19
409	1,750	6.0383	2	3	4	6	12
410	29,067	3.7654	1	2	3	4	6
411	5	2.0000	1	1	1	3	4
412	9	1.5556	1	1	2	2	2
413	5,742	6.7180	2	3	5	9	13
414	487	4.0575	1	2	3	5	7
417	33	6.5455	2	3	5	8	12
418	29,991	6.0675	2	3	5	7	11
419	17,640	4.3459	1	2	3	5	8
420	3,102	3.1847	1	2	3	4	6
421	13,262	4.0156	1	2	3	5	7

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2005 MEDPAR UPDATE MARCH 2006 GROUPER V24.0—Continued

DRG	Number discharge	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
422	79	3.6456	1	2	2	4	7
423	8,970	8.0750	2	3	6	10	15
424	1,041	11.5053	2	4	8	14	23
425	13,101	3.4571	1	1	3	4	6
426	4,237	4.3099	1	2	3	5	8
427	1,579	4.6390	1	2	3	5	9
428	845	7.2769	1	2	4	8	14
429	23,941	5.4509	2	3	4	6	10
430	75,545	7.7573	2	3	6	9	15
431	333	6.6667	1	2	4	7	11
432	402	4.0199	1	1	3	4	8
433	4,472	2.8233	1	1	2	3	4
439	1,759	8.3337	1	3	5	9	17
440	5,216	8.1532	2	3	5	9	16
441	686	3.4125	1	1	2	4	6
442	18,606	8.6736	2	3	6	10	17
443	3,592	3.5276	1	1	3	5	7
444	6,013	4.0331	1	2	3	5	7
445	2,244	2.8266	1	1	2	3	5
447	6,324	2.5745	1	1	2	3	5
449	40,859	3.6912	1	1	3	4	7
450	7,463	1.9812	1	1	1	2	4
451	2	10.5000	8	8	13	13	13
452	28,822	4.9372	1	2	3	6	10
453	5,397	2.7589	1	1	2	3	5
454	4,739	4.1087	1	2	3	5	8
455	887	2.2807	1	1	2	3	4
461	2,290	5.5782	1	1	3	7	12
462	7,891	9.5516	4	5	7	10	13
463	32,894	3.8764	1	2	3	5	7
464	7,666	2.9032	1	1	2	4	5
465	163	3.4724	1	1	2	4	6
466	1,204	4.9086	1	1	2	4	7
467	1,028	2.6722	1	1	2	3	5
468	52,050	12.5411	3	6	10	16	24
471	15,677	4.5470	3	3	4	5	7
473	8,582	12.4204	2	3	7	17	32
476	2,851	9.9056	1	4	8	14	20
477	28,205	8.5083	1	3	7	11	17
479	27,673	2.5493	1	1	2	3	5
480	908	19.1013	6	8	13	23	39
481	1,199	22.0025	12	16	20	24	33
482	5,084	11.1810	4	6	9	13	20
484	472	12.7564	2	5	10	17	26
485	3,714	9.4715	4	5	7	11	18
486	2,712	12.1962	2	5	10	16	24
487	5,017	6.8405	1	3	5	9	14
488	828	17.6437	4	7	12	21	33
489	13,555	8.1669	2	3	6	10	15
490	5,255	5.3115	1	2	4	6	9
491	22,688	3.0224	1	2	2	3	5
492	3,924	13.8081	3	5	6	23	32
493	61,105	6.0306	2	3	5	8	11
494	24,582	2.6927	1	1	2	4	5
495	342	17.3421	8	10	13	20	33
496	3,727	8.7631	3	4	6	10	17
497	31,227	5.6855	3	3	5	6	9
498	21,305	3.6795	2	3	3	4	5
499	35,251	4.1635	1	2	3	5	8
500	46,507	2.1984	1	1	2	3	4
501	3,201	9.8416	4	5	8	12	18
502	764	5.7003	2	3	5	7	10
503	5,916	3.9238	1	2	3	5	7
504	192	28.0260	8	13	24	36	51
505	180	6.8889	1	1	2	6	13
506	963	15.1547	3	7	12	20	30
507	323	7.6997	1	3	6	10	14
508	655	7.3542	1	3	5	9	14
509	155	5.2323	1	2	3	6	11
510	1,783	6.0432	1	2	4	7	12

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY FY 2005 MEDPAR UPDATE MARCH 2006 GROUPER V24.0—Continued

DRG	Number discharge	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
511	627	3.6364	1	1	2	4	7
512	550	13.6200	6	8	10	14	25
513	226	10.6327	5	7	8	11	17
515	58,749	3.8459	1	1	2	5	9
518	23,803	2.4598	1	1	1	3	5
519	12,589	4.6711	1	1	3	6	11
520	16,552	1.9409	1	1	1	2	3
521	29,368	5.2609	1	2	4	6	8
522	3,425	10.2908	3	4	5	7	8
523	14,462	3.7574	1	2	3	4	5
524	109,116	3.1429	1	2	3	4	6
525	205	13.7366	1	3	7	17	35
528	1,845	16.3252	6	9	14	21	29
529	5,027	7.1317	1	2	4	9	16
530	3,362	2.9140	1	1	2	3	5
531	4,994	9.0631	2	4	7	12	18
532	2,882	3.6724	1	1	3	5	7
533	43,722	3.6996	1	1	2	4	9
534	40,255	1.7365	1	1	1	2	3
535	8,831	9.2481	2	4	8	12	18
536	8,262	7.2781	2	3	6	9	14
537	8,985	6.5037	1	3	5	8	13
538	5,462	2.9143	1	1	2	4	6
539	4,974	10.5589	2	4	7	14	23
540	1,505	3.5163	1	1	3	4	7
541	25,113	41.6433	16	23	34	50	72
542	23,126	30.3529	11	17	25	37	52
543	5,718	11.3902	2	4	9	16	23
544	446,467	4.3995	3	3	4	5	7
545	44,844	5.1255	3	3	4	6	9
546	2,364	8.7657	3	4	7	10	16
547	32,721	12.1244	6	8	10	14	20
548	32,268	8.7755	5	6	8	10	13
549	13,144	10.0859	5	6	8	12	18
550	34,583	6.7752	4	5	6	8	10
551	53,881	6.0660	1	2	5	8	12
552	82,137	3.4766	1	1	2	5	7
553	39,303	9.0525	1	3	7	12	19
554	77,366	5.5730	1	2	4	7	12
555	37,404	4.8144	1	2	3	6	10
556	19,008	2.0085	1	1	1	2	4
557	124,278	4.1023	1	2	3	5	8
558	193,170	1.8108	1	1	1	2	4
559	2,895	6.8370	2	3	5	8	13
560	3,457	10.2242	3	5	8	13	19
561	2,952	9.3713	2	5	8	12	18
562	52,973	4.8176	1	2	4	6	9
563	21,161	3.1806	1	2	3	4	6
564	16,330	3.4475	1	2	3	4	6
565	46,864	15.3640	6	9	13	19	26
566	73,101	7.6086	1	3	6	10	15
567	10,369	15.6256	6	8	12	19	29
568	16,698	11.3181	2	5	9	14	22
569	60,835	14.2697	6	8	12	17	26
570	72,291	9.9702	4	6	8	12	18
571	11,162	4.7775	2	2	4	6	9
572	49,006	6.9624	2	3	5	8	13
573	6,687	10.9047	5	6	8	12	19
574	26,637	5.6791	2	3	4	7	11
575	10,982	15.6028	6	8	13	19	27
576	277,520	7.1282	2	3	6	9	14
577	5,608	2.3229	1	1	1	2	5
578	35,320	15.9644	5	8	13	20	30
579	20,672	10.9008	3	5	8	13	22
	12,150,466						

TABLE 8A.— STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS—JULY 2006

State	Urban	Rural
Alabama	0.263	0.336
Alaska	0.407	0.7
Arizona	0.284	0.36
Arkansas	0.336	0.356
California	0.238	0.342
Colorado	0.308	0.508
Connecticut	0.427	0.501
Delaware	0.496	0.462
District of Columbia	0.357	.....
Florida	0.251	0.295
Georgia	0.351	0.403
Hawaii	0.366	0.447
Idaho	0.474	0.541
Illinois	0.327	0.417
Indiana	0.417	0.453
Iowa	0.376	0.458
Kansas	0.299	0.443
Kentucky	0.381	0.386
Louisiana	0.301	0.361
Maine	0.496	0.457
Maryland	0.763	0.882
Massachusetts	0.476	.....
Michigan	0.373	0.47
Minnesota	0.39	0.523
Mississippi	0.327	0.376
Missouri	0.329	0.381
Montana	0.427	0.497
Nebraska	0.365	0.477
Nevada	0.229	0.455
New Hampshire	0.455	0.448
New Jersey	0.181	.....
New Mexico	0.382	0.384
New York	0.362	0.526
North Carolina	0.441	0.43
North Dakota	0.438	0.456
Ohio	0.372	0.543
Oklahoma	0.317	0.402
Oregon	0.472	0.43
Pennsylvania	0.277	0.436
Puerto Rico	0.457	.....
Rhode Island	0.409	.....
South Carolina	0.291	0.298
South Dakota	0.354	0.447
Tennessee	0.317	0.383
Texas	0.278	0.353
Utah	0.423	0.588
Vermont	0.556	0.627
Virginia	0.363	0.377
Washington	0.424	0.469
West Virginia	0.484	0.466
Wisconsin	0.431	0.48
Wyoming	0.4	0.562

TABLE 8B.— STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS— JULY 2006

State	Ratio
Alabama	0.025
Alaska	0.04
Arizona	0.025
Arkansas	0.026
California	0.016
Colorado	0.029
Connecticut	0.031
Delaware	0.037
District of Columbia	0.024

TABLE 8B.— STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS— JULY 2006—Continued

State	Ratio
Florida	0.023
Georgia	0.03
Hawaii	0.032
Idaho	0.036
Illinois	0.026
Indiana	0.037
Iowa	0.028
Kansas	0.032
Kentucky	0.03
Louisiana	0.029
Maine	0.035
Maryland	0.013
Massachusetts	0.034
Michigan	0.031
Minnesota	0.029
Mississippi	0.029
Missouri	0.028
Montana	0.036
Nebraska	0.039
Nevada	0.022
New Hampshire	0.036
New Jersey	0.013
New Mexico	0.033
New York	0.03
North Carolina	0.037
North Dakota	0.041
Ohio	0.03
Oklahoma	0.03
Oregon	0.032
Pennsylvania	0.023
Puerto Rico	0.034
Rhode Island	0.023
South Carolina	0.026
South Dakota	0.033
Tennessee	0.032
Texas	0.027
Utah	0.038
Vermont	0.043
Virginia	0.037
Washington	0.034
West Virginia	0.034
Wisconsin	0.039
Wyoming	0.047

TABLE 8C.—STATEWIDE AVERAGE TOTAL COST-TO-CHARGE RATIOS FOR LTCHS—JULY 2006

State	Urban	Rural
Alabama	0.287	0.366
Alaska	0.441	0.764
Arizona	0.308	0.394
Arkansas	0.367	0.389
California	0.252	0.363
Colorado	0.332	0.573
Connecticut	0.458	0.540
Delaware	0.532	0.505
District of Columbia*	0.388	.....
Florida	0.272	0.336
Georgia	0.380	0.437
Hawaii	0.397	0.484
Idaho	0.510	0.582
Illinois	0.351	0.456
Indiana	0.454	0.499
Iowa	0.397	0.497
Kansas	0.326	0.486
Kentucky	0.411	0.418
Louisiana	0.331	0.392
Maine	0.533	0.473
Maryland**	0.450	0.360
Massachusetts*	0.505	.....
Michigan	0.406	0.506
Minnesota	0.418	0.552
Mississippi	0.356	0.400
Missouri	0.355	0.415
Montana	0.459	0.543
Nebraska	0.400	0.526
Nevada	0.250	0.525
New Hampshire	0.492	0.481
New Jersey*	0.194	.....
New Mexico	0.415	0.417
New York	0.390	0.561
North Carolina	0.482	0.471
North Dakota	0.476	0.503
Ohio	0.398	0.587
Oklahoma	0.345	0.439
Oregon	0.504	0.454
Pennsylvania	0.296	0.469
Puerto Rico*	0.489	.....
Rhode Island*	0.432	.....
South Carolina	0.315	0.326
South Dakota	0.384	0.487
Tennessee	0.348	0.417
Texas	0.303	0.384
Utah	0.459	0.650
Vermont	0.601	0.667
Virginia	0.398	0.415
Washington	0.459	0.516
West Virginia	0.517	0.499
Wisconsin	0.473	0.519
Wyoming	0.440	0.615

*All counties in the State or Territory are classified as urban, with the exception of Massachusetts, which has areas designated as rural. However, no short-term acute care IPPS hospitals or LTCHs are located in those areas as of July 2006.

**National average IPPS total cost-to-charge ratios, as discussed in section II.E. of this final rule.

Note: The following Table 9A is a tentative table and does not reflect decisions that are yet to be made by CMS pending the final calculation of the occupationa l mix adjusted wage index. The information about reclassifie d CBSAs reflects the latest information available to CMS regarding MGCRB and Administrat or reclassific ation decisions for FY 2007. A revised Table 9A reflecting CMS' decisions on behalf of hospitals using occupationa l mix adjusted wage indices will be published in a subsequent Federal Register notice between August 1 and October 1, 2006, as well as on CMS' Web site. Hospitals will then have 30 days from the date the data appears on the CMS Web site to revise a decision made by CMS on their behalf. (See section III.H. of the preamble (Revisions to the Wage Index Based on Hospital Redesignations).)

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITALS AND CBSA—FY 2007

Provider No.	Geographic CBSA	Reclassified CBSA 10/1/2006–3/31/2007	Reclassified CBSA 4/1/2007–9/30/2007	LUGAR
010005	01	13820	13820	
010008	01	33860	33860	
010009	19460	26620	26620	
010012	01	16860	16860	
010022	01	40660	40660	LUGAR
010025	01	17980	17980	
010029	12220	17980	17980	
010035	01	13820	13820	
010044	01	13820	13820	
010045	01	13820	13820	
010054	19460	26620	26620	
010059	19460	26620	26620	
010065	01	33860	33860	
010072	01	11500	11500	LUGAR
010083	01	37860	37860	
010085	19460	26620	26620	
010100	01	37860	37860	
010101	01	11500	11500	LUGAR
010118	01	46220	46220	
010126	01	33860	33860	
010143	01	13820	13820	
010150	01	33860	33860	
010158	01	19460	19460	
010164	01	11500	11500	LUGAR
020008	02	11260	11260	
030007	03	22380	22380	
030033	03	22380	22380	
040014	04	30780	30780	
040017	04	22220	22220	
040019	04	32820	32820	
040020	27860	32820	32820	
040027	04	44180	44180	
040039	04	26	26	
040041	04	30780	30780	
040047	04	26	26	
040069	04	32820	32820	
040071	38220	30780	30780	
040076	04	30780	30780	
040078	26300	30780	30780	
040080	04	27860	27860	
040088	04	43340	43340	
040091	04	45500	45500	
040100	04	30780	30780	
040119	04	30780	30780	
050006	05	39820	39820	
050009	34900	46700	46700	
050013	34900	46700	46700	
050014	05	40900	40900	
050022	40140	42044	42044	
050042	05	39820	39820	
050046	37100	.....	31084	
050054	40140	42044	42044	
050065	42044	31084	31084	
050069	42044	31084	31084	
050071	41940	36084	36084	
050073	46700	36084	36084	
050076	41884	36084	36084	
050082	37100	.....	31084	
050089	40140	31084	31084	
050090	42220	41884	41884	
050099	40140	31084	31084	
050101	46700	36084	36084	
050102	40140	42044	42044	
050118	44700	33700	33700	
050129	40140	31084	31084	
050136	42220	41884	41884	
050140	40140	31084	31084	
050150	05	40900	40900	
050159	37100	.....	31084	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITALS AND CBSA—FY 2007—Continued

Provider No.	Geographic CBSA	Reclassified CBSA 10/1/2006–3/31/2007	Reclassified CBSA 4/1/2007–9/30/2007	LUGAR
050168	42044	31084	31084	
050173	42044	31084	31084	
050174	42220	41884	41884	
050193	42044	31084	31084	
050197	41884	36084	36084	
050224	42044	31084	31084	
050226	42044	31084	31084	
050228	41884	36084	36084	
050230	42044	31084	31084	
050236	37100	.....	31084	
050243	40140	42044	42044	
050245	40140	31084	31084	
050251	05	39900	39900	
050272	40140	31084	31084	
050279	40140	31084	31084	
050291	42220	41884	41884	
050292	40140	42044	42044	
050298	40140	31084	31084	
050300	40140	31084	31084	
050327	40140	31084	31084	
050329	40140	42044	42044	
050348	42044	31084	31084	
050367	46700	36084	36084	
050385	42220	41884	41884	
050390	40140	42044	42044	
050394	37100	.....	31084	
050423	40140	42044	42044	
050426	42044	31084	31084	
050430	05	39900	39900	
050510	41884	36084	36084	
050517	40140	31084	31084	
050526	42044	31084	31084	
050534	40140	42044	42044	
050535	42044	31084	31084	
050541	41884	36084	36084	
050543	42044	31084	31084	
050547	42220	41884	41884	
050548	42044	31084	31084	
050549	37100	.....	31084	
050550	42044	31084	31084	
050551	42044	31084	31084	
050567	42044	31084	31084	
050569	05	42220	42220	
050570	42044	31084	31084	
050573	40140	42044	42044	
050580	42044	31084	31084	
050584	40140	31084	31084	
050585	42044	31084	31084	
050586	40140	31084	31084	
050589	42044	31084	31084	
050592	42044	31084	31084	
050594	42044	31084	31084	
050603	42044	31084	31084	
050609	42044	31084	31084	
050616	37100	.....	31084	
050667	34900	46700	46700	
050678	42044	31084	31084	
050680	46700	36084	36084	
050684	40140	42044	42044	
050686	40140	42044	42044	
050690	42220	41884	41884	
050693	42044	31084	31084	
050694	40140	42044	42044	
050701	40140	42044	42044	
050709	40140	31084	31084	
050718	40140	42044	42044	
050720	42044	31084	31084	
050728	42220	41884	41884	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITALS AND CBSA—FY 2007—Continued

Provider No.	Geographic CBSA	Reclassified CBSA 10/1/2006–3/31/2007	Reclassified CBSA 4/1/2007–9/30/2007	LUGAR
050749	37100	.....	31084	
060001	24540	19740	19740	
060003	14500	19740	19740	
060023	24300	19740	19740	
060027	14500	19740	19740	
060044	06	19740	19740	
060049	06	22660	22660	
060075	06	24300	24300	
060096	06	19740	19740	
060103	14500	19740	19740	
070001	35300	.....	35004	
070003	07	25540	25540	LUGAR
070005	35300	.....	35004	
070006	14860	.....	35644	
070010	14860	.....	35644	
070016	35300	.....	35004	
070017	35300	.....	35004	
070018	14860	.....	35644	
070019	35300	.....	35004	
070021	07	25540	25540	LUGAR
070022	35300	.....	35004	
070028	14860	.....	35644	
070031	35300	.....	35004	
070033	14860	35644	35644	
070034	14860	.....	35644	
070036	25540	35300	35300	
070038	35300	.....	35004	
070039	35300	.....	35004	
080004	20100	48864	48864	
080006	08	20100	20100	
080007	08	36140	36140	
090001	47894	13644	13644	
100022	33124	22744	22744	
100023	10	36740	36740	
100024	10	33124	33124	
100045	19660	36740	36740	
100049	10	29460	29460	
100081	10	23020	23020	LUGAR
100109	10	36740	36740	
100118	10	27260	27260	
100139	10	23540	23540	LUGAR
100150	10	33124	33124	
100157	29460	45300	45300	
100176	48424	38940	38940	
100217	42680	38940	38940	
100232	10	27260	27260	
100239	45300	42260	42260	
100249	10	45300	45300	
100252	10	38940	38940	
100258	48424	22744	22744	
100292	10	23020	23020	LUGAR
110001	19140	12060	12060	
110002	11	12060	12060	
110003	11	27260	27260	
110023	11	12060	12060	
110025	15260	27260	27260	
110029	23580	12060	12060	
110038	11	46660	46660	
110040	11	12060	12060	LUGAR
110041	11	12020	12020	
110052	11	16860	16860	LUGAR
110054	40660	12060	12060	
110069	47580	31420	31420	
110075	11	42340	42340	
110088	11	12060	12060	LUGAR
110095	11	46660	46660	
110117	11	12060	12060	LUGAR
110122	46660	45220	45220	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITALS AND CBSA—FY 2007—Continued

Provider No.	Geographic CBSA	Reclassified CBSA 10/1/2006–3/31/2007	Reclassified CBSA 4/1/2007–9/30/2007	LUGAR
110125	11	31420	31420	
110128	11	42340	42340	
110150	11	12060	12060	
110153	47580	31420	31420	
110168	40660	12060	12060	
110187	11	12060	12060	LUGAR
110189	11	12060	12060	
110205	11	12060	12060	
120028	12	26180	26180	
130002	13	29	29	
130003	30300	28420	28420	
130018	13	38540	38540	
130049	17660	44060	44060	
130067	13	26820	26820	LUGAR
140012	14	16974	16974	
140015	14	41180	41180	
140032	14	41180	41180	
140033	29404	16974	16974	
140034	14	41180	41180	
140040	14	37900	37900	
140043	14	40420	40420	
140046	14	41180	41180	
140058	14	41180	41180	
140064	14	37900	37900	
140084	29404	16974	16974	
140093	19180	16580	16580	
140100	29404	16974	16974	
140110	14	16974	16974	
140130	29404	16974	16974	
140143	14	37900	37900	
140160	14	40420	40420	
140161	14	16974	16974	
140164	14	41180	41180	
140189	14	16580	16580	
140202	29404	16974	16974	
140233	40420	16974	16974	
140234	14	37900	37900	
140236	14	28100	28100	LUGAR
140291	29404	16974	16974	
150002	23844	16974	16974	
150004	23844	16974	16974	
150006	33140	43780	43780	
150008	23844	16974	16974	
150011	15	26900	26900	
150015	33140	16974	16974	
150030	15	26900	26900	LUGAR
150034	23844	16974	16974	
150048	15	17140	17140	
150051	14020	26900	26900	
150065	15	26900	26900	
150069	15	17140	17140	
150076	15	43780	43780	
150088	11300	26900	26900	
150090	23844	16974	16974	
150102	15	23844	23844	LUGAR
150112	18020	26900	26900	
150113	11300	26900	26900	
150122	15	26900	26900	
150125	23844	16974	16974	
150126	23844	16974	16974	
150133	15	23060	23060	
150146	15	23060	23060	
150147	23844	16974	16974	
160001	16	19780	19780	
160016	16	19780	19780	
160057	16	26980	26980	
160064	16	24	24	
160080	16	19340	19340	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITALS AND CBSA—FY 2007—Continued

Provider No.	Geographic CBSA	Reclassified CBSA 10/1/2006–3/31/2007	Reclassified CBSA 4/1/2007–9/30/2007	LUGAR
160089	16	19780	19780	
160147	16	19780	19780	
170006	17	27900	27900	
170010	17	46140	46140	
170012	17	48620	48620	
170013	17	48620	48620	
170020	17	48620	48620	
170023	17	48620	48620	
170033	17	48620	48620	
170058	17	28140	28140	
170068	17	11100	11100	
170120	17	27900	27900	
170142	17	45820	45820	
170175	17	48620	48620	
170190	17	45820	45820	
170193	17	48620	48620	
180005	18	26580	26580	
180011	18	30460	30460	
180012	21060	31140	31140	
180013	14540	34980	34980	
180017	18	21060	21060	
180018	18	30460	30460	
180019	18	17140	17140	
180024	18	31140	31140	
180027	18	17300	17300	
180029	18	28700	28700	
180044	18	26580	26580	
180048	18	31140	31140	
180066	18	34980	34980	
180069	18	26580	26580	
180075	18	14540	14540	LUGAR
180078	18	26580	26580	
180080	18	28940	28940	
180093	18	21780	21780	
180102	18	17300	17300	
180104	18	17300	17300	
180116	18	14	14	
180124	14540	34980	34980	
180127	18	31140	31140	
180132	18	30460	30460	
180139	18	30460	30460	
190001	19	35380	35380	
190003	19	29180	29180	
190015	19	35380	35380	
190086	19	33740	33740	
190099	19	12940	12940	
190106	19	10780	10780	
190131	12940	35380	35380	
190155	19	12940	12940	LUGAR
190164	19	10780	10780	
190191	19	12940	12940	
190208	19	4	4	
190218	19	43340	43340	
190223	19	12940	12940	LUGAR
200020	38860	40484	40484	
200024	30340	38860	38860	
200034	30340	38860	38860	
200039	20	38860	38860	
200050	20	12620	12620	
200063	20	38860	38860	
220001	49340	14484	14484	
220002	15764	14484	14484	
220008	39300	14484	14484	
220010	21604	14484	14484	
220011	15764	14484	14484	
220019	49340	14484	14484	
220020	38860	40484	40484	
220025	49340	14484	14484	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITALS AND CBSA—FY 2007—Continued

Provider No.	Geographic CBSA	Reclassified CBSA 10/1/2006–3/31/2007	Reclassified CBSA 4/1/2007–9/30/2007	LUGAR
220028	49340	14484	14484	
220029	21604	14484	14484	
220033	21604	14484	14484	
220035	21604	14484	14484	
220049	15764	14484	14484	
220058	49340	14484	14484	
220060	14484	12700	12700	
220062	49340	14484	14484	
220063	15764	14484	14484	
220070	15764	14484	14484	
220073	39300	14484	14484	
220077	44140	25540	25540	
220080	21604	14484	14484	
220082	15764	14484	14484	
220084	15764	14484	14484	
220090	49340	14484	14484	
220095	49340	14484	14484	
220098	15764	14484	14484	
220101	15764	14484	14484	
220105	15764	14484	14484	
220133	15764	14484	14484	
220163	49340	14484	14484	
220171	15764	14484	14484	
220174	21604	14484	14484	
230002	19804	.....	11460	
230003	26100	.....	34740	
230013	47644	.....	19804	
230019	47644	.....	19804	
230020	19804	.....	11460	
230022	23	29620	29620	
230024	19804	.....	11460	
230029	47644	.....	19804	
230030	23	40980	40980	
230035	23	24340	24340	LUGAR
230036	23	13020	13020	
230037	23	11460	11460	
230047	47644	19804	19804	
230053	19804	.....	11460	
230054	23	24580	24580	
230065	19804	.....	11460	
230069	47644	11460	11460	
230071	47644	.....	19804	
230072	26100	.....	34740	
230077	40980	22420	22420	
230080	23	40980	40980	
230089	19804	.....	11460	
230092	27100	29620	29620	
230093	23	24340	24340	
230096	23	28020	28020	
230097	23	24340	24340	
230099	33780	11460	11460	
230104	19804	.....	11460	
230105	23	13020	13020	
230119	19804	.....	11460	
230121	23	29620	29620	LUGAR
230130	47644	.....	19804	
230134	23	26100	26100	LUGAR
230135	19804	.....	11460	
230142	19804	.....	11460	
230146	19804	.....	11460	
230151	47644	.....	19804	
230165	19804	.....	11460	
230174	26100	.....	34740	
230176	19804	.....	11460	
230195	47644	19804	19804	
230204	47644	19804	19804	
230207	47644	.....	19804	
230208	23	24340	24340	LUGAR

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITALS AND CBSA—FY 2007—Continued

Provider No.	Geographic CBSA	Reclassified CBSA 10/1/2006–3/31/2007	Reclassified CBSA 4/1/2007–9/30/2007	LUGAR
230217	12980	29620	29620	
230223	47644	.....	19804	
230227	47644	19804	19804	
230244	19804	.....	11460	
230254	47644	.....	19804	
230257	47644	19804	19804	
230264	47644	19804	19804	
230269	47644	.....	19804	
230270	19804	.....	11460	
230273	19804	.....	11460	
230277	47644	.....	19804	
230279	47644	11460	11460	
230293	19804	.....	11460	
230295	23	26100	26100	LUGAR
240018	24	33460	33460	
240030	24	41060	41060	
240036	41060	33460	33460	
240064	24	20260	20260	
240069	24	40340	40340	
240071	24	40340	40340	
240075	24	41060	41060	
240088	24	41060	41060	
240093	24	33460	33460	
240105	24	40340	40340	LUGAR
240150	24	40340	40340	LUGAR
240187	24	33460	33460	
240211	24	33460	33460	
250002	25	22520	22520	
250004	25	32820	32820	
250006	25	32820	32820	
250009	25	27180	27180	
250023	25	25060	25060	LUGAR
250031	25	27140	27140	
250034	25	32820	32820	
250040	37700	25060	25060	
250042	25	32820	32820	
250044	25	22520	22520	
250069	25	46220	46220	
250079	25	27140	27140	
250081	25	46220	46220	
250082	25	38220	38220	
250094	25620	25060	25060	
250097	25	12940	12940	
250099	25	27140	27140	
250100	25	46220	46220	
250104	25	27140	27140	
250117	25	25060	25060	LUGAR
260009	26	28140	28140	
260011	27620	17860	17860	
260015	26	27860	27860	
260017	26	41180	41180	
260022	26	16	16	
260025	26	41180	41180	
260049	26	44180	44180	LUGAR
260050	26	41140	41140	
260064	26	17860	17860	
260074	26	17860	17860	
260094	26	44180	44180	
260110	26	41180	41180	
260113	26	14	14	
260116	26	14	14	
260119	26	27860	27860	
260175	26	28140	28140	
260183	26	41180	41180	
260186	26	17860	17860	
270003	27	24500	24500	
270011	27	24500	24500	
270017	27	33540	33540	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITALS AND CBSA—FY 2007—Continued

Provider No.	Geographic CBSA	Reclassified CBSA 10/1/2006–3/31/2007	Reclassified CBSA 4/1/2007–9/30/2007	LUGAR
270051	27	33540	33540	
280009	28	30700	30700	
280023	28	30700	30700	
280032	28	30700	30700	
280061	28	53	53	
280065	28	24540	24540	
280077	28	36540	36540	
280125	28	43580	43580	
290002	29	16180	16180	LUGAR
290006	29	39900	39900	
290008	29	41620	41620	
290019	16180	39900	39900	
300005	30	31700	31700	
300011	31700	15764	15764	
300012	31700	15764	15764	
300014	40484	31700	31700	
300017	40484	21604	21604	
300018	40484	31700	31700	
300019	30	49340	49340	
300020	31700	15764	15764	
300023	40484	21604	21604	
300029	40484	21604	21604	
300034	31700	15764	15764	
310002	35084	35644	35644	
310009	35084	35644	35644	
310013	35084	35644	35644	
310014	15804	37964	37964	
310015	35084	35644	35644	
310017	35084	35644	35644	
310018	35084	35644	35644	
310021	45940	35084	35084	
310031	15804	20764	20764	
310038	20764	35644	35644	
310039	20764	35644	35644	
310048	20764	35084	35084	
310050	35084	35644	35644	
310054	35084	35644	35644	
310070	20764	35644	35644	
310076	35084	35644	35644	
310078	35084	35644	35644	
310081	15804	37964	37964	
310083	35084	35644	35644	
310093	35084	35644	35644	
310096	35084	35644	35644	
310108	20764	35644	35644	
310119	35084	35644	35644	
320005	22140	10740	10740	
320006	32	42140	42140	
320013	32	42140	42140	
320014	32	29740	29740	
320033	32	42140	42140	LUGAR
320063	32	36220	36220	
320065	32	36220	36220	
330004	28740	39100	39100	
330008	33	15380	15380	LUGAR
330027	35004	35644	35644	
330038	33	40380	40380	LUGAR
330073	33	40380	40380	LUGAR
330079	33	47	47	
330085	33	45060	45060	
330094	33	28740	28740	
330103	33	39	39	
330106	35004	.....	35644	
330136	33	45060	45060	
330157	33	45060	45060	
330167	35004	.....	35644	
330181	35004	.....	35644	
330182	35004	35644	35644	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITALS AND CBSA—FY 2007—Continued

Provider No.	Geographic CBSA	Reclassified CBSA 10/1/2006–3/31/2007	Reclassified CBSA 4/1/2007–9/30/2007	LUGAR
330191	24020	10580	10580	
330198	35004	.....	35644	
330224	28740	39100	39100	
330225	35004	.....	35644	
330229	27460	21500	21500	
330235	33	45060	45060	LUGAR
330239	27460	21500	21500	
330250	33	15540	15540	
330259	35004	35644		
330277	33	27060	27060	
330331	35004	.....	35644	
330332	35004	.....	35644	
330359	33	39100	39100	LUGAR
330372	35004	.....	35644	
330386	33	39100	39100	
340004	24660	49180	49180	
340008	34	16740	16740	
340010	24140	39580	39580	
340013	34	24860	24860	
340014	49180	24660	24660	
340021	34	16740	16740	
340023	11700	24860	24860	
340027	34	24780	24780	
340039	34	16740	16740	
340047	49180	24660	24660	
340050	34	22180	22180	
340051	34	25860	25860	
340068	34	48900	48900	
340069	39580	20500	20500	
340070	15500	24660	24660	
340071	34	39580	39580	LUGAR
340073	39580	20500	20500	
340091	24660	49180	49180	
340109	34	47260	47260	
340114	39580	20500	20500	
340115	34	20500	20500	
340124	34	39580	39580	LUGAR
340126	34	39580	39580	
340127	34	20500	20500	
340129	34	16740	16740	
340131	34	24780	24780	
340136	34	20500	20500	LUGAR
340138	39580	20500	20500	
340144	34	16740	16740	
340145	34	16740	16740	LUGAR
340147	40580	39580	39580	
340148	49180	24660	24660	
340173	39580	20500	20500	
350003	35	13900	13900	
350006	35	13900	13900	
350009	35	22020	22020	
360008	36	26580	26580	
360010	36	10420	10420	
360011	36	18140	18140	
360013	36	30620	30620	
360014	36	18140	18140	
360019	10420	17460	17460	
360020	10420	17460	17460	
360025	41780	17460	17460	
360027	10420	17460	17460	
360036	36	17460	17460	
360039	36	18140	18140	
360054	36	26580	26580	
360065	36	17460	17460	
360078	10420	17460	17460	
360079	19380	17140	17140	
360084	15940	10420	10420	
360086	44220	19380	19380	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITALS AND CBSA—FY 2007—Continued

Provider No.	Geographic CBSA	Reclassified CBSA 10/1/2006–3/31/2007	Reclassified CBSA 4/1/2007–9/30/2007	LUGAR
360095	36	45780	45780	
360096	36	49660	49660	LUGAR
360107	36	45780	45780	
360121	36	11460	11460	
360150	10420	17460	17460	
360159	36	18140	18140	
360175	36	18140	18140	
360185	36	49660	49660	LUGAR
360187	44220	19380	19380	
360197	36	18140	18140	
360211	48260	38300	38300	
360238	36	49660	49660	LUGAR
360241	10420	17460	17460	
360245	36	17460	17460	LUGAR
360253	19380	17140	17140	
370004	37	27900	27900	
370006	37	17	17	
370014	37	43300	43300	
370015	37	46140	46140	
370016	37	36420	36420	
370018	37	46140	46140	
370022	37	30020	30020	
370025	37	46140	46140	
370026	37	36420	36420	
370034	37	22900	22900	
370047	37	43300	43300	
370049	37	36420	36420	
370099	37	46140	46140	
370103	37	45	45	
370113	37	22220	22220	
380001	38	38900	38900	
380022	38	18700	18700	LUGAR
380027	38	21660	21660	
380050	38	32780	32780	
380090	38	21660	21660	
390006	39	25420	25420	
390013	39	25420	25420	
390030	39	10900	10900	
390031	39	39740	39740	LUGAR
390046	49620	29540	29540	
390048	39	25420	25420	
390052	39	11020	11020	
390065	39	47894	47894	
390066	30140	25420	25420	
390071	39	48700	48700	LUGAR
390079	39	13780	13780	
390081	37964	48864	48864	
390086	39	44300	44300	
390091	39	38300	38300	
390093	39	38300	38300	
390110	27780	38300	38300	
390113	39	36	36	
390133	10900	37964	37964	
390138	39	47894	47894	
390150	39	38300	38300	LUGAR
390151	39	13644	13644	
390156	37964	48864	48864	
390180	37964	48864	48864	
390222	37964	48864	48864	
390246	39	48700	48700	
400048	25020	41980	41980	
410010	39300	14484	14484	
410012	39300	14484	14484	
410013	39300	35980	35980	
420007	43900	24860	24860	
420009	42	24860	24860	LUGAR
420020	42	16700	16700	
420027	11340	24860	24860	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITALS AND CBSA—FY 2007—Continued

Provider No.	Geographic CBSA	Reclassified CBSA 10/1/2006–3/31/2007	Reclassified CBSA 4/1/2007–9/30/2007	LUGAR
420028	42	44940	44940	LUGAR
420030	42	16700	16700	
420036	42	16740	16740	
420039	42	43900	43900	LUGAR
420067	42	42340	42340	
420068	42	12260	12260	
420069	42	44940	44940	LUGAR
420070	44940	17900	17900	
420071	42	24860	24860	
420080	42	42340	42340	
420083	43900	24860	24860	
420085	34820	48900	48900	
430012	43	43620	43620	
430014	43	22020	22020	
430094	43	53	53	
440002	27180	32820	32820	
440008	44	27180	27180	
440020	44	26620	26620	
440024	17420	16860	16860	
440025	44	34	34	
440035	17300	34980	34980	
440050	44	11700	11700	
440056	34100	28940	28940	
440058	44	16860	16860	
440059	44	34980	34980	
440060	44	27180	27180	
440067	34100	28940	28940	
440068	44	16860	16860	
440072	44	32820	32820	
440073	44	34980	34980	
440148	44	34980	34980	
440151	44	34980	34980	
440175	44	34980	34980	
440180	44	28940	28940	
440185	17420	16860	16860	
440192	44	34980	34980	
450007	45	41700	41700	
450032	45	43340	43340	
450039	23104	19124	19124	
450059	41700	12420	12420	
450064	23104	19124	19124	
450073	45	10180	10180	
450080	45	30980	30980	
450087	23104	19124	19124	
450099	45	11100	11100	
450121	23104	19124	19124	
450135	23104	19124	19124	
450137	23104	19124	19124	
450144	45	36220	36220	
450148	23104	19124	19124	
450187	45	26420	26420	
450192	45	19124	19124	
450194	45	19124	19124	
450196	45	19124	19124	
450211	45	26420	26420	
450214	45	26420	26420	
450224	45	46340	46340	
450283	45	19124	19124	LUGAR
450286	45	17780	17780	LUGAR
450324	43300	19124	19124	
450347	45	26420	26420	
450351	45	23104	23104	
450389	45	19124	19124	LUGAR
450393	43300	19124	19124	
450395	45	26420	26420	
450400	45	47380	47380	
450419	23104	19124	19124	
450438	45	26420	26420	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITALS AND CBSA—FY 2007—Continued

Provider No.	Geographic CBSA	Reclassified CBSA 10/1/2006–3/31/2007	Reclassified CBSA 4/1/2007–9/30/2007	LUGAR
450447	45	19124	19124	
450451	45	23104	23104	
450469	43300	19124	19124	
450484	45	30980	30980	
450508	45	46340	46340	
450547	45	19124	19124	
450563	23104	19124	19124	
450639	23104	19124	19124	
450653	45	33260	33260	
450656	45	46340	46340	
450672	23104	19124	19124	
450675	23104	19124	19124	
450677	23104	19124	19124	
450694	45	26420	26420	
450747	45	19124	19124	
450755	45	31180	31180	
450770	45	12420	12420	LUGAR
450779	23104	19124	19124	
450813	45	41700	41700	
450830	45	36220	36220	
450839	45	43340	43340	
450858	23104	19124	19124	
450872	23104	19124	19124	
450880	23104	19124	19124	
460004	36260	41620	41620	
460005	36260	41620	41620	
460007	46	41100	41100	
460011	46	39340	39340	
460021	41100	29820	29820	
460039	46	36260	36260	
460041	36260	41620	41620	
460042	36260	41620	41620	
470001	47	30	30	
470011	47	15764	15764	
470012	47	38340	38340	
490004	25500	16820	16820	
490005	49020	47894	47894	
490013	49	31340	31340	
490018	49	16820	16820	
490042	13980	40220	40220	
490048	40220	31340	31340	
490079	49	24660	24660	
490092	49	40060	40060	
490105	49	28700	28700	
490106	49	16820	16820	
490109	47260	40060	40060	
500002	50	28420	28420	
500003	34580	42644	42644	
500016	48300	42644	42644	
500021	45104	42644	42644	
500024	36500	45104	45104	
500039	14740	42644	42644	
500041	31020	38900	38900	
500072	50	42644	42644	
500079	45104	42644	42644	
500108	45104	42644	42644	
500129	45104	42644	42644	
500139	36500	45104	45104	
500143	36500	45104	45104	
510001	34060	38300	38300	
510002	51	40220	40220	
510006	51	38300	38300	
510018	51	16620	16620	LUGAR
510024	34060	38300	38300	
510030	51	34060	34060	
510046	51	16620	16620	
510047	51	38300	38300	
510062	51	16620	16620	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITALS AND CBSA—FY 2007—Continued

Provider No.	Geographic CBSA	Reclassified CBSA 10/1/2006–3/31/2007	Reclassified CBSA 4/1/2007–9/30/2007	LUGAR
510070	51	16620	16620	
510071	51	16620	16620	
510077	51	26580	26580	
520002	52	48140	48140	
520021	29404	16974	16974	
520028	52	31540	31540	
520037	52	48140	48140	
520059	39540	29404	29404	
520060	52	22540	22540	LUGAR
520066	27500	31540	31540	
520071	52	33340	33340	LUGAR
520076	52	31540	31540	
520088	22540	33340	33340	
520094	39540	33340	33340	
520095	52	31540	31540	
520096	39540	33340	33340	
520102	52	33340	33340	LUGAR
520107	52	24580	24580	
520113	52	24580	24580	
520116	52	33340	33340	LUGAR
520173	52	20260	20260	
520189	29404	16974	16974	
530015	53	26820	26820	
530025	53	22660	22660	

Note: The following Table 9B is a tentative table and does not reflect decisions that are yet to be made by CMS pending the final calculation of the occupational mix adjusted wage index. The information about reclassified CBSAs reflects the latest information available to CMS regarding MGCRB and Administrator reclassification decisions for FY 2007. A revised Table 9B reflecting CMS' decisions on behalf of hospitals using occupational mix adjusted wage indices will be published in a subsequent Federal Register notice between August 1 and October 1, 2006, as well as on CMS' Web site. Hospitals will then have 30 days from the date the data appears on the CMS Web site to revise a decision made by CMS on their behalf. (See section III.H. of the preamble (Revisions to the Wage Index Based on Hospital Redesignations)).

TABLE 9B.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL UNDER SECTION 508 OF PUB. L. 108–173—FY 2007

Provider No.	Note	Geograraphic CBSA	Wage index CBSA—10/1/06–3/31/07	Wage Index CBSA—4/1/07–9/30/07*	Own wage index—10/1/06–3/31/07
050494		05	42220		
050549		37100	42220		
070001		35300	35004		
070005		35300	35004		
070006	*	14860	35644		
070010		14860	35644		
070016		35300	35004		
070017		35300	35004		
070018	*	14860	35644		
070019		35300	35004		
070022		35300	35004		
070028		14860	35644		
070031		35300	35004		
070034	*	14860	35644		
070039		35300	35004		
140155	*	28100	16974	16974	
140186	*	28100	16974	16974	
160040		47940	16300		
160067		47940	16300		
160110		47940	16300		
220046		38340	14484		
230003		26100	28020		
230004		34740	28020		

TABLE 9B.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL UNDER SECTION 508 OF PUB. L. 108–173—FY 2007—Continued

Provider No.	Note	Geograraphic CBSA	Wage index CBSA— 10/1/06–3/31/07	Wage Index CBSA— 4/1/07–9/30/07*	Own wage index— 10/1/06–3/31/07
230013		47644	22420		
230019		47644	22420		
230020		19804	11460		
230024		19804	11460		
230029		47644	22420		
230038		24340	28020		
230053		19804	11460		
230059		24340	28020		
230066		34740	28020		
230071		47644	22420		
230072		26100	28020		
230089		19804	11460		
230104		19804	11460		
230106		24340	28020		
230119		19804	11460		
230130		47644	22420		
230135		19804	11460		
230146		19804	11460		
230151		47644	22420		
230165		19804	11460		
230174		26100	28020		
230176		19804	11460		
230207		47644	22420		
230223		47644	22420		
230236		24340	28020		
230254		47644	22420		
230269		47644	22420		
230270		19804	11460		
230273		19804	11460		
230277		47644	22420		
250078	*	25620	25060	25060	
250122		25	25060		
270002	*	27	33540	33540	
270012	*	24500	33540	33540	
270023		33540	13740		
270032		27	13740		
270057		27	13740		
310028		35084	35644		
310051		35084	35644		
310060		10900	35644		
310115		10900	35644		
310120		35084	35644		
330023	*	39100	35644	35644	
330049		39100	35644		
330067	*	39100	35644	35644	
330106		35004			To be determined
330126		39100	35644		
330135		39100	35644		
330205		39100	35644		
330209		39100	35004		
330264		39100	35004		
340002		11700	16740		
350002		13900	22020		
350010		35	22020		
350014		35	22020		
350015		13900	22020		
350017		35	22020		
350019	*	24220	22020	22020	
350030		35	22020		
390001		42540	10900		
390003		39	10900		
390044	***	39	37964	37964	
390045	**	39	10900		
390096	***	39	37964	37964	
390054		42540	29540		
390072		39	10900		
390095		42540	10900		
390119		42540	10900		

TABLE 9B.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL UNDER SECTION 508 OF PUB. L. 108–173—FY 2007—Continued

Provider No.	Note	Geograraphic CBSA	Wage index CBSA— 10/1/06– 3/31/07	Wage Index CBSA— 4/1/07– 9/30/07*	Own wage index— 10/1/06–3/31/07
390137		42540	10900		
390169		42540	10900		
390185		42540	29540		
390192		42540	10900		
390237		42540	10900		
390270		42540	29540		
430005		43	39660		
430008	*	43	43620	43620	
430013	*	43	43620	43620	
430015		43	43620		
430048		43	43620		
430060		43	43620		
430064		43	43620		
430077		39660	43620		
430091		39660	43620		
450010		48660	32580		
450072		26420	26420		
450591		26420	26420		
470003		15540	14484		
490001		49	31340		
490024		40220	19260		
530008	*	53	16220	16220	
530010	*	53	16220	16220	

*These hospitals are assigned a wage index value under a special exceptions policy (see the FY 2005 IPPS final rule, 69 FR 49105).

**This hospital has been assigned a wage index for the 1st half of FY 2007 under a special exceptions policy. (See section IV.G.6. of the preamble).

***These hospitals are receiving the same wage index for FY 2007 as hospitals reclassified to the wage index CBSA under a special exceptions policy. (See section IV.G.7. of the preamble). NOTE: The following Table 9C is a tentative table. The final Table 9C will be published in a subsequent Federal Register notice.

TABLE 9C.—HOSPITALS REDESIGNATED AS RURAL UNDER SECTION 1886(D)(8)(E) OF THE ACT—FY 2007

Provider No.	Geographic CBSA	Redesignated rural area
050192	23420	05
050469	40140	05
050528	32900	05
050618	40140	05
070004	25540	07
100048	37860	10
100134	27260	10
140167	14	14
170137	29940	17
230078	35660	23
250126	32820	25
260006	41140	26
260047	27620	26
260195	44180	26
330044	46540	33
330245	46540	33
330268	10580	33
360125	36	36
370054	36420	37
380040	13460	38
390181	39	39
390183	39	39
390201	39	39
440135	34980	44
440144	44	44
450052	45	45
450078	10180	45
450243	10180	45
450348	45	45

TABLE 9C.—HOSPITALS REDESIGNATED AS RURAL UNDER SECTION 1886(D)(8)(E) OF THE ACT—FY 2007—Continued

Provider No.	Geographic CBSA	Redesignated rural area
500148	48300	50
520060	52	52

TABLE 10.—*TENTATIVE GEOMETRIC MEAN PLUS THE LESSER OF .75 OF THE NATIONAL ADJUSTED OPERATING STANDARDIZED PAYMENT AMOUNT (INCREASED TO REFLECT THE DIFFERENCE BETWEEN COSTS AND CHARGES) OR .75 OF ONE STANDARD DEVIATION OF MEAN CHARGES BY DIAGNOSIS-RELATED GROUP (DRG) JULY 2006[1]

DRG	Number of cases	Threshold
1	24,393	$53,859
2	10,183	$37,071
3	3	$58,210
6	288	$16,764
7	15,032	$41,272
8	3,441	$31,202
9	1,775	$25,427
10	19,625	$25,060
11	3,083	$18,954

TABLE 10.—*TENTATIVE GEOMETRIC MEAN PLUS THE LESSER OF .75 OF THE NATIONAL ADJUSTED OPERATING STANDARDIZED PAYMENT AMOUNT (INCREASED TO REFLECT THE DIFFERENCE BETWEEN COSTS AND CHARGES) OR .75 OF ONE STANDARD DEVIATION OF MEAN CHARGES BY DIAGNOSIS-RELATED GROUP (DRG) JULY 2006[1]—Continued

DRG	Number of cases	Threshold
12	55,941	$18,864
13	7,525	$17,686
14	278,664	$24,952
15	19,988	$20,852
16	17,297	$26,470
17	2,973	$15,671
18	33,442	$21,265
19	8,461	$15,788
21	2,220	$26,884
22	3,168	$23,889
23	10,670	$17,034
26	25	$20,742
27	5,971	$25,126
28	19,909	$25,472
29	6,522	$15,804
31	5,039	$21,114
32	1,903	$14,176
34	27,626	$21,155
35	7,908	$14,353
36	307	$17,756

TABLE 10.—*TENTATIVE GEOMETRIC MEAN PLUS THE LESSER OF .75 OF THE NATIONAL ADJUSTED OPERATING STANDARDIZED PAYMENT AMOUNT (INCREASED TO REFLECT THE DIFFERENCE BETWEEN COSTS AND CHARGES) OR .75 OF ONE STANDARD DEVIATION OF MEAN CHARGES BY DIAGNOSIS-RELATED GROUP (DRG) JULY 2006[1]—Continued

DRG	Number of cases	Threshold
37	1,219	$24,755
38	50	$12,318
39	328	$14,729
40	1,187	$22,468
42	1,636	$17,058
43	125	$12,886
44	1,290	$14,781
45	2,770	$16,499
46	3,929	$16,766
47	1,309	$12,103
49	2,415	$31,272
50	2,024	$19,196
51	193	$19,075
52	234	$14,080
53	2,145	$26,675
55	1,368	$20,084
56	451	$19,390
57	742	$20,308
59	126	$14,929
60	3	$18,786
61	222	$28,823
62	4	$7,163
63	2,827	$26,792
64	3,234	$23,219
65	40,485	$13,493
66	8,195	$12,916
67	379	$17,186
68	18,914	$14,138
69	5,147	$10,697
70	25	$7,437
71	70	$15,616
72	1,326	$16,659
73	9,957	$18,043
74	3	$8,024
75	46,851	$48,022
76	48,157	$43,553
77	2,111	$25,956
78	49,690	$26,233
79	160,369	$29,354
80	7,158	$18,880
81	6	$25,916
82	63,189	$26,608
83	7,153	$21,595
84	1,403	$12,778
85	22,221	$25,180
86	1,717	$15,470
87	96,689	$26,951
88	427,043	$19,077
89	553,984	$21,998
90	43,488	$13,140
91	53	$11,541
92	16,513	$24,878
93	1,440	$16,320
94	13,655	$23,750
95	1,577	$12,584
96	59,616	$15,882
97	26,688	$11,788
98	13	$12,310
99	21,386	$15,711
100	6,410	$12,191
101	23,368	$18,513
102	4,930	$12,459
103	886	$234,602
104	20,120	$123,729
105	32,625	$93,408
106	3,440	$110,994
108	8,757	$89,200
110	57,708	$59,122
111	10,783	$45,058
113	34,727	$45,309
114	7,959	$30,170
117	5,349	$25,612
118	7,618	$33,293
119	963	$25,956
120	33,555	$36,437
121	150,046	$29,682
122	54,522	$20,932
123	29,562	$25,715
124	120,510	$29,669
125	92,404	$23,736
126	5,422	$40,901
127	667,290	$21,942
128	4,210	$15,608
129	3,521	$21,829
130	87,465	$20,048
131	22,952	$12,056
132	101,372	$13,633
133	5,853	$12,293
134	39,815	$13,564
135	7,164	$19,603
136	943	$14,059
138	206,126	$17,760
139	74,038	$11,503
140	31,103	$11,146
141	123,082	$16,534
142	49,143	$13,230
143	237,807	$12,604
144	104,877	$24,605
145	5,742	$12,881
146	10,269	$45,041
147	2,614	$31,225
149	19,523	$30,188
150	22,971	$44,974
151	5,403	$27,702
152	5,011	$33,350
153	1,951	$23,250
155	6,015	$27,694
156	4	$42,508
157	8,316	$25,981
158	3,718	$14,389
159	19,221	$28,296
160	11,939	$18,822
161	10,145	$25,544
162	4,950	$15,299
163	5	$14,048
164	5,996	$38,818
165	2,457	$25,554
166	5,154	$29,280
167	4,909	$19,591
168	1,640	$25,296
169	895	$16,736
170	17,929	$44,476
171	1,408	$26,705
172	33,047	$26,380
173	2,225	$17,045
174	253,126	$21,911
175	29,235	$12,602
176	14,648	$23,944
177	7,654	$20,572
178	2,557	$15,461
179	14,727	$22,980
180	91,335	$20,871
181	25,350	$12,528
182	255,693	$17,100
183	79,005	$13,059
184	72	$12,775
185	6,251	$18,862
186	7	$5,729
187	646	$18,324
188	87,004	$22,789
189	12,389	$12,993
190	10	$13,793
191	10,586	$54,694
192	1,379	$32,567
193	4,040	$51,607
194	461	$32,138
195	2,846	$50,174
196	594	$32,425
197	16,420	$41,918
198	4,109	$26,021
199	1,481	$37,144
200	1,017	$39,787
201	2,717	$52,741
202	27,495	$25,140
203	32,423	$26,174
204	69,425	$23,010
205	32,781	$23,351
206	2,069	$16,166
207	38,288	$24,720
208	9,444	$15,527
210	126,728	$36,053
211	25,766	$26,659
212	10	$18,683
213	9,549	$33,765
216	19,882	$35,362
217	15,719	$41,753
218	30,181	$32,729
219	21,168	$23,440
220	2	$23,903
223	12,681	$25,312
224	9,900	$18,601
225	6,275	$26,110
226	6,770	$29,333
227	4,857	$18,593
228	2,678	$24,524
229	1,121	$15,634
230	2,473	$26,447

TABLE 10.—*TENTATIVE GEOMETRIC MEAN PLUS THE LESSER OF .75 OF THE NATIONAL ADJUSTED OPERATING STANDARDIZED PAYMENT AMOUNT (INCREASED TO REFLECT THE DIFFERENCE BETWEEN COSTS AND CHARGES) OR .75 OF ONE STANDARD DEVIATION OF MEAN CHARGES BY DIAGNOSIS-RELATED GROUP (DRG) JULY 2006[1]—Continued

DRG	Number of cases	Threshold
232	570	$20,883
233	18,488	$34,629
234	9,054	$27,553
235	4,763	$16,190
236	41,769	$15,355
237	1,924	$13,823
238	9,693	$26,230
239	40,335	$23,007
240	12,890	$24,447
241	2,848	$14,324
242	2,722	$22,524
243	100,967	$16,980
244	16,921	$15,376
245	5,808	$10,439
246	1,393	$13,417
247	21,347	$12,715
248	16,397	$18,868
249	13,487	$15,452
250	4,164	$15,019
251	2,060	$10,708
253	24,800	$16,458
254	10,027	$10,209
256	7,605	$17,958
257	13,112	$19,571
258	11,381	$15,394
259	2,660	$21,525
260	2,419	$15,097
261	1,569	$20,644
262	602	$20,936
263	22,523	$32,381
264	3,924	$22,357
265	4,035	$28,309
266	2,229	$19,597
267	276	$20,106
268	1,007	$25,612
269	11,061	$30,462
270	2,581	$17,761
271	21,573	$21,481
272	6,062	$20,880
273	1,268	$12,695
274	2,214	$22,743
275	181	$13,374
276	1,611	$15,518
277	118,989	$18,380
278	33,858	$11,743
279	6	$9,028
280	19,325	$16,053
281	6,587	$11,088
283	6,751	$15,599
284	1,860	$9,705
285	8,075	$35,308
286	2,868	$34,849
287	5,460	$31,315
288	11,449	$36,434
289	6,342	$19,683
290	11,870	$18,835
291	60	$12,847
292	7,589	$41,562
293	318	$27,393
294	96,811	$16,300
295	4,383	$16,230
296	247,069	$17,299
297	42,864	$10,800
298	111	$11,190
299	1,529	$21,390
300	21,669	$23,232
301	3,928	$13,530
302	10,492	$53,266
303	19,976	$35,819
304	13,647	$37,422
305	2,957	$25,305
306	5,818	$25,921
307	1,947	$13,760
308	5,453	$27,129
309	2,964	$19,731
310	25,376	$25,322
311	5,889	$14,252
312	1,328	$24,325
313	505	$16,679
314	2	$63,693
315	34,913	$34,732
316	205,567	$24,393
317	2,713	$17,231
318	5,910	$24,031
319	386	$13,806
320	224,861	$18,200
321	31,967	$12,268
322	67	$13,265
323	20,412	$18,194
324	4,635	$11,389
325	9,919	$14,495
326	2,592	$9,794
327	11	$4,294
328	574	$15,404
329	54	$11,795
331	56,121	$22,457
332	3,962	$13,793
333	244	$18,788
334	9,525	$29,865
335	12,194	$23,947
336	28,187	$18,026
337	21,481	$12,476
338	674	$26,938
339	1,237	$24,409
341	3,131	$26,307
342	457	$16,760
344	2,341	$26,248
345	1,390	$24,261
346	3,961	$22,447
347	235	$12,285
348	4,262	$15,649
349	554	$10,003
350	7,277	$16,400
352	1,177	$16,558
353	3,089	$31,178
354	7,566	$29,684
355	4,987	$19,221
356	22,033	$16,309
357	5,537	$37,740
358	20,928	$24,238
359	28,580	$17,269
360	13,854	$18,919
361	287	$23,680
362	2	$6,876
363	2,155	$23,016
364	1,799	$19,187
365	1,617	$32,690
366	4,645	$23,871
367	446	$12,997
368	4,145	$23,493
369	3,723	$14,329
370	2,249	$17,536
371	2,705	$12,708
372	1,376	$10,820
373	5,273	$7,551
374	153	$13,095
375	12	$22,605
376	476	$12,906
377	109	$24,239
378	201	$16,324
379	499	$8,220
380	111	$9,315
381	169	$15,169
382	48	$3,953
383	2,806	$10,556
384	151	$7,391
389	3	$46,615
392	2,139	$45,751
394	2,759	$31,094
395	101,471	$16,872
396	18	$13,668
397	16,393	$23,048
398	6,706	$23,192
399	1,080	$14,880
401	6,450	$43,894
402	1,356	$25,221
403	31,326	$29,940
404	3,820	$20,305
406	2,303	$42,371
407	615	$24,760
408	1,948	$33,871
409	1,748	$25,028
410	29,054	$23,858
411	5	$9,758
412	9	$9,301
413	5,741	$25,510
414	487	$16,429
417	33	$28,208
418	29,977	$22,175
419	17,634	$18,485
420	3,099	$12,971
421	13,255	$16,146
422	79	$11,674
423	8,963	$28,718
424	1,041	$36,310
425	13,096	$13,576
426	4,235	$10,358

TABLE 10.—*TENTATIVE GEOMETRIC MEAN PLUS THE LESSER OF .75 OF THE NATIONAL ADJUSTED OPERATING STANDARDIZED PAYMENT AMOUNT (INCREASED TO REFLECT THE DIFFERENCE BETWEEN COSTS AND CHARGES) OR .75 OF ONE STANDARD DEVIATION OF MEAN CHARGES BY DIAGNOSIS-RELATED GROUP (DRG) JULY 2006[1]—Continued

DRG	Number of cases	Threshold
427	1,579	$11,150
428	845	$13,754
429	23,937	$16,826
430	75,524	$13,556
431	333	$12,627
432	402	$13,998
433	4,471	$6,847
439	1,759	$29,659
440	5,216	$29,541
441	686	$20,435
442	18,596	$37,577
443	3,589	$22,629
444	6,012	$16,302
445	2,242	$11,469
447	6,323	$11,513
449	40,846	$18,238
450	7,446	$9,442
451	2	$19,193
452	28,815	$21,741
453	5,394	$11,421
454	4,738	$17,849
455	887	$10,666
461	2,290	$27,945
462	7,872	$17,133
463	32,884	$15,084
464	7,661	$11,312
465	163	$12,726
466	1,204	$14,603
467	1,026	$10,034
468	52,034	$57,083
470	128	$25,336
471	15,629	$55,462
473	8,578	$38,317
476	2,850	$35,279
477	28,196	$34,210
479	27,646	$30,664
480	908	$128,168
481	1,198	$88,802
482	5,081	$49,179
484	472	$75,098
485	3,713	$51,983
486	2,712	$69,277
487	5,016	$32,011
488	828	$63,276
489	13,547	$28,578
490	5,252	$21,783
491	22,663	$35,757
492	3,924	$44,444
493	61,082	$34,552
494	24,547	$22,715
495	342	$121,068
496	3,726	$96,376
497	31,199	$62,663
498	21,280	$52,014
499	35,237	$28,340
500	46,422	$19,794
501	3,200	$42,436
502	764	$29,393
503	5,910	$26,641
504	192	$146,326
505	180	$28,322
506	963	$50,293
507	323	$31,953
508	654	$23,720
509	155	$16,128
510	1,782	$21,239
511	627	$13,459
512	550	$90,167
513	226	$67,279
515	58,660	$86,655
518	23,763	$34,494
519	12,586	$44,219
520	16,525	$35,867
521	29,364	$15,459
522	3,423	$12,513
523	14,462	$8,492
524	109,013	$16,146
525	205	$156,053
528	1,845	$107,773
529	5,026	$36,123
530	3,360	$25,556
531	4,993	$45,570
532	2,882	$28,122
533	43,711	$29,882
534	40,198	$21,414
535	8,826	$119,398
536	8,259	$108,963
537	8,983	$32,586
538	5,459	$22,310
539	4,973	$44,568
540	1,504	$25,469
541	25,104	$250,678
542	23,115	$151,096
543	5,718	$64,315
544	445,785	$39,430
545	44,802	$44,809
546	2,360	$83,370
547	32,709	$97,710
548	32,245	$79,387
549	13,141	$80,448
550	34,565	$63,344
551	53,869	$51,334
552	82,060	$40,475
553	39,292	$46,776
554	77,351	$36,869
555	37,378	$42,650
556	18,974	$37,645
557	124,154	$51,129
558	192,632	$42,278
559	2,894	$40,715
560	3,457	$44,371
561	2,952	$35,689
562	52,955	$22,123
563	21,145	$13,990
564	16,327	$15,294
565	46,822	$78,211
566	73,082	$39,116
567	10,363	$72,688
568	16,695	$48,792
569	60,815	$63,221
570	72,246	$44,142
571	11,153	$23,679
572	48,982	$25,169
573	6,682	$51,652
574	26,619	$24,475
575	10,977	$85,769
576	277,472	$28,296
577	5,596	$35,303
578	35,311	$64,885
579	20,665	$39,571

*As noted in section II.G.5 of the preamble to this final rule, the final national adjusted operating standardized amounts as well as the final version of this table will be published in a subsequent FEDERAL REGISTER notice between August 1 and October 1, 2006.

[1] Cases taken from the FY 2005 MedPAR file; DRGs are from GROUPER Version 24.0.

TABLE 11.—FY 2007 LTC–DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY

LTC–DRG	Description	Relative weight	Geometric average length of stay	5/6ths of the geometric average length of stay
1	[5] CRANIOTOMY AGE >17 W CC	1.6835	37.1	30.9
2	[6] CRANIOTOMY AGE >17 W/O CC	1.6835	37.1	30.9
3	[6] CRANIOTOMY AGE 0–17	1.6835	37.1	30.9

TABLE 11.—FY 2007 LTC–DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY—Continued

LTC–DRG	Description	Relative weight	Geometric average length of stay	5/6ths of the geometric average length of stay
6	[6]CARPAL TUNNEL RELEASE	0.4175	17.0	14.2
7	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC	1.2052	36.1	30.1
8	[2]PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC	0.5594	21.0	17.5
9	SPINAL DISORDERS & INJURIES	1.0424	34.0	28.3
10	NERVOUS SYSTEM NEOPLASMS W CC	0.6971	22.1	18.4
11	[2]NERVOUS SYSTEM NEOPLASMS W/O CC	0.5594	21.0	17.5
12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	0.6788	25.1	20.9
13	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	0.6003	23.1	19.3
14	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION	0.6772	24.9	20.8
15	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT	0.7705	26.1	21.8
16	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	0.6978	23.1	19.3
17	[2]NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	0.5594	21.0	17.5
18	CRANIAL & PERIPHERAL NERVEDISORDERS W CC	0.7503	25.4	21.2
19	CRANIAL & PERIPHERAL NERVEDISORDERS W/O CC	0.4512	19.5	16.3
21	[3]VIRAL MENINGITIS	0.7819	23.9	19.9
22	[3]HYPERTENSIVE ENCEPHALOPATHY	0.7819	23.9	19.9
23	NONTRAUMATIC STUPOR & COMA	1.0118	29.4	24.5
26	[6]SEIZURE & HEADACHE AGE 0–17	0.5594	21.0	17.5
27	TRAUMATIC STUPOR & COMA, COMA >1 HR	0.9978	30.6	25.5
28	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W CC	0.7983	25.8	21.5
29	[1]TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC	0.4175	17.0	14.2
30	[6]TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0–17	0.4175	17.0	14.2
31	[1]CONCUSSION AGE >17 W CC	0.4175	17.0	14.2
32	[6]CONCUSSION AGE >17 W/O CC	0.4175	17.0	14.2
33	[6]CONCUSSION AGE 0–17	0.4175	17.0	14.2
34	OTHER DISORDERS OF NERVOUS SYSTEM W CC	0.7029	23.4	19.5
35	OTHER DISORDERS OF NERVOUS SYSTEMW/O CC	0.5080	21.1	17.6
36	[6]RETINAL PROCEDURES	0.5594	21.0	17.5
37	[6]ORBITAL PROCEDURES	0.5594	21.0	17.5
38	[6]PRIMARY IRIS PROCEDURES	0.5594	21.0	17.5
39	[6]LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	0.5594	21.0	17.5
40	[6]EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	0.5594	21.0	17.5
41	[6]EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0–17	0.5594	21.0	17.5
42	[6]INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	0.5594	21.0	17.5
43	[6]HYPHEMA	0.4175	17.0	14.2
44	[3]ACUTE MAJOR EYE INFECTIONS	0.7819	23.9	19.9
45	[1]NEUROLOGICAL EYE DISORDERS	0.4175	17.0	14.2
46	[2]OTHER DISORDERS OF THE EYE AGE >17 W CC	0.5594	21.0	17.5
47	[6]OTHER DISORDERS OF THE EYE AGE >17 W/O CC	0.4175	17.0	14.2
48	[6]OTHER DISORDERS OF THE EYE AGE 0–17	0.4175	17.0	14.2
49	[6]MAJOR HEAD & NECK PROCEDURES	1.1625	29.5	24.6
50	[6]SIALOADENECTOMY	1.1625	29.5	24.6
51	[6]SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	1.1625	29.5	24.6
52	[6]CLEFT LIP & PALATE REPAIR	1.1625	29.5	24.6
53	[6]SINUS & MASTOID PROCEDURES AGE >17	1.1625	29.5	24.6
54	[6]SINUS & MASTOID PROCEDURES AGE 0–17	1.1625	29.5	24.6
55	[4]MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES	1.1625	29.5	24.6
56	[6]RHINOPLASTY	1.1625	29.5	24.6
57	[6]T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17.	0.4175	17.0	14.2
58	[6]T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17.	0.4175	17.0	14.2
59	[6]TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	0.4175	17.0	14.2
60	[6]TONSILLECTOMY &/OR ADENOIDECTOMYONLY, AGE 0–17	0.4175	17.0	14.2
61	[6]MYRINGOTOMY W TUBE INSERTION AGE >17	0.4175	17.0	14.2
62	[6]MYRINGOTOMY W TUBE INSERTION AGE 0–17	0.4175	17.0	14.2
63	[4]OTHER EAR, NOSE, MOUTH & THROATO.R. PROCEDURES	1.1625	29.5	24.6
64	EAR, NOSE, MOUTH & THROAT MALIGNANCY	1.1797	26.2	21.8
65	[1]DYSEQUILIBRIUM	0.4175	17.0	14.2
66	[6]EPISTAXIS	0.4175	17.0	14.2
67	[3]EPIGLOTTITIS	0.7819	23.9	19.9
68	OTITIS MEDIA & URI AGE >17 W CC	0.6211	20.3	16.9
69	[1]OTITIS MEDIA & URI AGE >17 W/O CC	0.4175	17.0	14.2
70	[6]OTITIS MEDIA & URI AGE 0–17	0.4175	17.0	14.2
71	[6]LARYNGOTRACHEITIS	0.5594	21.0	17.5
72	[3]NASAL TRAUMA & DEFORMITY	0.7819	23.9	19.9
73	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17	0.7745	22.9	19.1
74	[6]OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0–17	0.4175	17.0	14.2

TABLE 11.—FY 2007 LTC–DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY—Continued

LTC–DRG	Description	Relative weight	Geometric average length of stay	5/6ths of the geometric average length of stay
75	MAJOR CHEST PROCEDURES	1.9944	33.5	27.9
76	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.3982	42.5	35.4
77	[2] OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	0.5594	21.0	17.5
78	PULMONARY EMBOLISM	0.6746	22.6	18.8
79	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	0.8182	22.8	19.0
80	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC	0.6485	20.9	17.4
81	[6] RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0–17	0.4175	17.0	14.2
82	RESPIRATORY NEOPLASMS	0.8242	21.4	17.8
83	[1] MAJOR CHEST TRAUMA W CC	0.4175	17.0	14.2
84	[6] MAJOR CHEST TRAUMA W/O CC	0.4175	17.0	14.2
85	PLEURAL EFFUSION W CC	0.6956	21.4	17.8
86	[6] PLEURAL EFFUSION W/O CC	0.4175	17.0	14.2
87	PULMONARY EDEMA & RESPIRATORY FAILURE	1.0295	24.8	20.7
88	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	0.6411	19.3	16.1
89	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	0.6802	20.6	17.2
90	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	0.4958	17.8	14.8
91	[6] SIMPLE PNEUMONIA & PLEURISY AGE 0–17	0.5594	21.0	17.5
92	INTERSTITIAL LUNG DISEASE W CC	0.6638	19.6	16.3
93	[1] INTERSTITIAL LUNG DISEASE W/O CC	0.4175	17.0	14.2
94	PNEUMOTHORAX W CC	0.6785	21.3	17.8
95	[8] PNEUMOTHORAX W/O CC	0.6785	21.3	17.8
96	BRONCHITIS & ASTHMA AGE >17 W CC	0.6230	18.9	15.8
97	[8] BRONCHITIS & ASTHMA AGE >17 W/O CC	0.6230	18.9	15.8
98	[6] BRONCHITIS & ASTHMA AGE 0–17	0.5594	21.0	17.5
99	RESPIRATORY SIGNS & SYMPTOMS W CC	0.9381	24.6	20.5
100	[3] RESPIRATORY SIGNS & SYMPTOMS W/O CC	0.7819	23.9	19.9
101	OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	0.8147	22.2	18.5
102	[1] OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	0.4175	17.0	14.2
103	[7] HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM	0.0000	0.0	0.0
104	[6] CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W CARDIAC CATH.	1.1625	29.5	24.6
105	[6] CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W/O CARDIAC CATH.	1.1625	29.5	24.6
106	[6] CORONARY BYPASS W PTCA	1.1625	29.5	24.6
108	[6] OTHER CARDIOTHORACIC PROCEDURES	1.1625	29.5	24.6
110	[4] MAJOR CARDIOVASCULAR PROCEDURES W CC	1.1625	29.5	24.6
111	[6] MAJOR CARDIOVASCULAR PROCEDURES W/O CC	1.1625	29.5	24.6
113	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE.	1.3942	36.1	30.1
114	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	1.2425	33.0	27.5
117	[2] CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT	0.5594	21.0	17.5
118	[3] CARDIAC PACEMAKER DEVICE REPLACEMENT	0.7819	23.9	19.9
119	[3] VEIN LIGATION & STRIPPING	0.7819	23.9	19.9
120	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	1.0893	31.4	26.2
121	CIRCULATORY DISORDERS W AMI & MAJOR COMP, DISCHARGED ALIVE	0.7451	22.4	18.7
122	[2] CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE.	0.5594	21.0	17.5
123	CIRCULATORY DISORDERS W AMI, EXPIRED	0.7858	17.0	14.2
124	[4] CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG.	1.1625	29.5	24.6
125	[1] CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG.	0.4175	17.0	14.2
126	ACUTE & SUBACUTE ENDOCARDITIS	0.8867	26.3	21.9
127	HEART FAILURE & SHOCK	0.6832	21.2	17.7
128	[2] DEEP VEIN THROMBOPHLEBITIS	0.5594	21.0	17.5
129	[1] CARDIAC ARREST, UNEXPLAINED	0.4175	17.0	14.2
130	PERIPHERAL VASCULAR DISORDERS W CC	0.6484	22.8	19.0
131	PERIPHERAL VASCULAR DISORDERS W/O CC	0.5267	21.0	17.5
132	ATHEROSCLEROSIS W CC	0.6621	20.7	17.3
133	[2] ATHEROSCLEROSIS W/O CC	0.5594	21.0	17.5
134	HYPERTENSION	0.4909	21.7	18.1
135	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC	0.8014	23.8	19.8
136	[1] CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC	0.4175	17.0	14.2
137	[6] CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0–17	0.4175	17.0	14.2
138	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	0.6618	21.9	18.3
139	[2] CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	0.5594	21.0	17.5
140	[1] ANGINA PECTORIS	0.4175	17.0	14.2
141	SYNCOPE & COLLAPSE W CC	0.5891	22.1	18.4

TABLE 11.—FY 2007 LTC–DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY—Continued

LTC–DRG	Description	Relative weight	Geometric average length of stay	5/6ths of the geometric average length of stay
142	[8] SYNCOPE & COLLAPSE W/O CC	0.5891	22.1	18.4
143	[1] CHEST PAIN	0.4175	17.0	14.2
144	OTHER CIRCULATORY SYSTEM DIAGNOSESW CC	0.7715	22.1	18.4
145	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	0.4292	17.0	14.2
146	[5] RECTAL RESECTION W CC	1.6835	37.1	30.9
147	[6] RECTAL RESECTION W/O CC	0.7819	23.9	19.9
149	[6] MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	0.7819	23.9	19.9
150	[5] PERITONEAL ADHESIOLYSIS W CC	1.6835	37.1	30.9
151	[6] PERITONEAL ADHESIOLYSIS W/O CC	0.4175	17.0	14.2
152	[5] MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.6835	37.1	30.9
153	[6] MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.6835	37.1	30.9
155	[6] STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC.	1.6835	37.1	30.9
156	[6] STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0–17	1.6835	37.1	30.9
157	[3] ANAL & STOMAL PROCEDURES W CC	0.7819	23.9	19.9
158	[6] ANAL & STOMAL PROCEDURES W/O CC	0.7819	23.9	19.9
159	[5] HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC	1.6835	37.1	30.9
160	[1] HERNIA PROCEDURES EXCEPT INGUINAL& FEMORAL AGE >17 W/O CC	0.4175	17.0	14.2
161	[6] INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC	0.4175	17.0	14.2
162	[6] INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC	0.4175	17.0	14.2
163	[6] HERNIA PROCEDURES AGE 0–17	0.4175	17.0	14.2
164	[6] APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	0.7819	23.9	19.9
165	[6] APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	0.7819	23.9	19.9
166	[6] APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	0.7819	23.9	19.9
167	[6] APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	0.7819	23.9	19.9
168	[5] MOUTH PROCEDURES W CC	1.6835	37.1	30.9
169	[6] MOUTH PROCEDURES W/O CC	0.5594	21.0	17.5
170	OTHER DIGESTIVE SYSTEM O.R.PROCEDURES W CC	1.6163	35.8	29.8
171	[3] OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC	0.7819	23.9	19.9
172	DIGESTIVE MALIGNANCY W CC	0.8497	21.8	18.2
173	[2] DIGESTIVE MALIGNANCY W/O CC	0.5594	21.0	17.5
174	G.I. HEMORRHAGE W CC	0.7149	22.9	19.1
175	[2] G.I. HEMORRHAGE W/O CC	0.5594	21.0	17.5
176	COMPLICATED PEPTIC ULCER	0.9514	24.8	20.7
177	[2] UNCOMPLICATED PEPTIC ULCER W CC	0.5594	21.0	17.5
178	[6] UNCOMPLICATED PEPTIC ULCER W/O CC	0.4175	17.0	14.2
179	INFLAMMATORY BOWEL DISEASE	0.8157	23.3	19.4
180	G.I. OBSTRUCTION W CC	0.9126	22.8	19.0
181	[1] G.I. OBSTRUCTION W/O CC	0.4175	17.0	14.2
182	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC	0.7866	21.8	18.2
183	[1] ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC.	0.4175	17.0	14.2
184	[6] ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0–17	0.4175	17.0	14.2
185	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17.	0.6634	23.2	19.3
186	[6] DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0–17.	0.5594	21.0	17.5
187	[6] DENTAL EXTRACTIONS & RESTORATIONS	0.5594	21.0	17.5
188	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	0.9596	24.4	20.3
189	[2] OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	0.5594	21.0	17.5
190	[6] OTHER DIGESTIVE SYSTEM DIAGNOSESAGE 0–17	0.5594	21.0	17.5
191	[5] PANCREAS, LIVER & SHUNT PROCEDURES W CC	1.6835	37.1	30.9
192	[6] PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	1.6835	37.1	30.9
193	[4] BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC.	1.1625	29.5	24.6
194	[6] BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC.	1.1625	29.5	24.6
195	[5] CHOLECYSTECTOMY W C.D.E. W CC	1.6835	37.1	30.9
196	[6] CHOLECYSTECTOMY W C.D.E. W/O CC	1.1625	29.5	24.6
197	[4] CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	1.1625	29.5	24.6
198	[6] CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC	1.1625	29.5	24.6
199	[3] HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	0.7819	23.9	19.9
200	[5] HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY	1.6835	37.1	30.9
201	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES	1.5802	28.8	24.0
202	CIRRHOSIS & ALCOHOLIC HEPATITIS	0.6011	20.2	16.8
203	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	0.7466	19.6	16.3
204	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	0.8853	22.1	18.4
205	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC	0.6933	23.1	19.3

TABLE 11.—FY 2007 LTC–DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY—Continued

LTC–DRG	Description	Relative weight	Geometric average length of stay	5/6ths of the geometric average length of stay
206	[8] DISORDERS OF LIVER EXCEPT MALIG, CIRR, ALC HEPA W/O CC	0.6933	23.1	19.3
207	DISORDERS OF THE BILIARY TRACT W CC	0.7295	21.5	17.9
208	[1] DISORDERS OF THE BILIARY TRACT W/O CC	0.4175	17.0	14.2
210	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC	1.4826	41.9	34.9
211	[6] HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC	1.6835	37.1	30.9
212	[6] HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0–17	1.6835	37.1	30.9
213	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS.	1.1871	33.5	27.9
216	BIOPSIES OF MUSCULOSKELETAL SYSTEM& CONNECTIVE TISSUE	1.2147	37.6	31.3
217	WND DEBRID & SKN GRFT EXCEPT HAND, FOR MUSCSKELET & CONN TISS DIS.	1.2414	36.5	30.4
218	[5] LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W CC.	1.6835	37.1	30.9
219	[6] LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W/O CC.	1.6835	37.1	30.9
220	[6] LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE 0–17.	1.6835	37.1	30.9
223	[4] MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC.	1.1625	29.5	24.6
224	[1] SHOULDER, ELBOW OR FOREARM PROC, EXC MAJOR JOINT PROC, W/O CC.	0.4175	17.0	14.2
225	FOOT PROCEDURES	0.9550	30.6	25.5
226	SOFT TISSUE PROCEDURES W CC	1.0626	34.3	28.6
227	[3] SOFT TISSUE PROCEDURES W/O CC	0.7819	23.9	19.9
228	[3] MAJOR THUMB OR JOINT PROC, OR OTH HAND OR WRIST PROC W CC	0.7819	23.9	19.9
229	[6] HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	0.4175	17.0	14.2
230	[5] LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR	1.6835	37.1	30.9
232	[5] ARTHROSCOPY	1.6835	37.1	30.9
233	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	1.1724	32.4	27.0
234	[6] OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC	0.4175	17.0	14.2
235	[3] FRACTURES OF FEMUR	0.7819	23.9	19.9
236	FRACTURES OF HIP & PELVIS	0.6802	28.9	24.1
237	[1] SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH	0.4175	17.0	14.2
238	OSTEOMYELITIS	0.8589	28.4	23.7
239	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY.	0.6031	20.6	17.2
240	CONNECTIVE TISSUE DISORDERS W CC	0.7134	22.4	18.7
241	[1] CONNECTIVE TISSUE DISORDERS W/O CC	0.4175	17.0	14.2
242	SEPTIC ARTHRITIS	0.7700	26.2	21.8
243	MEDICAL BACK PROBLEMS	0.6028	22.3	18.6
244	BONE DISEASES & SPECIFICARTHROPATHIES W CC	0.5516	22.0	18.3
245	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	0.4463	19.4	16.2
246	[2] NON-SPECIFIC ARTHROPATHIES	0.5594	21.0	17.5
247	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE	0.4582	17.6	14.7
248	TENDONITIS, MYOSITIS & BURSITIS	0.7328	23.2	19.3
249	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	0.6370	24.0	20.0
250	[1] FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC	0.4175	17.0	14.2
251	[6] FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC	0.4175	17.0	14.2
252	[6] FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0–17	0.5594	21.0	17.5
253	FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE >17 W CC	0.5609	24.0	20.0
254	[1] FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE >17 W/O CC.	0.4175	17.0	14.2
255	[6] FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE 0–17	0.5594	21.0	17.5
256	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES.	0.7132	23.6	19.7
257	[5] TOTAL MASTECTOMY FOR MALIGNANCY W CC	1.6835	37.1	30.9
258	[6] TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.7819	23.9	19.9
259	[3] SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC	0.7819	23.9	19.9
260	[6] SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.7819	23.9	19.9
261	[2] BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION.	0.5594	21.0	17.5
262	[4] BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY	1.1625	29.5	24.6
263	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	1.2748	38.0	31.7
264	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC	0.8507	29.9	24.9
265	SKIN GRAFT &/OR DEBRID EXCEPT FORSKIN ULCER OR CELLULITIS W CC.	1.1019	30.2	25.2
266	[3] SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC.	0.7819	23.9	19.9

TABLE 11.—FY 2007 LTC–DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY—Continued

LTC–DRG	Description	Relative weight	Geometric average length of stay	5/6ths of the geometric average length of stay
267	[6] PERIANAL & PILONIDAL PROCEDURES	0.7819	23.9	19.9
268	[4] SKIN, SUBCUTANEOUS TISSUE &BREAST PLASTIC PROCEDURES	1.1625	29.5	24.6
269	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.2075	34.7	28.9
270	[3] OTHER SKIN, SUBCUT TISS & BREASTPROC W/O CC	0.7819	23.9	19.9
271	SKIN ULCERS	0.8269	26.9	22.4
272	MAJOR SKIN DISORDERS W CC	0.6584	23.0	19.2
273	[1] MAJOR SKIN DISORDERS W/O CC	0.4175	17.0	14.2
274	MALIGNANT BREAST DISORDERS W CC	0.7231	21.8	18.2
275	[6] MALIGNANT BREAST DISORDERS W/O CC	0.7819	23.9	19.9
276	[2] NON-MALIGNANT BREAST DISORDERS	0.5594	21.0	17.5
277	CELLULITIS AGE >17 W CC	0.6089	20.9	17.4
278	CELLULITIS AGE >17 W/O CC	0.4254	18.0	15.0
279	[6] CELLULITIS AGE 0–17	0.4175	17.0	14.2
280	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC	0.7148	24.1	20.1
281	[2] TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC	0.5594	21.0	17.5
282	[6] TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0–17	0.5594	21.0	17.5
283	MINOR SKIN DISORDERS W CC	0.6876	23.1	19.3
284	[2] MINOR SKIN DISORDERS W/O CC	0.5594	21.0	17.5
285	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DISORDERS.	1.2418	31.6	26.3
286	[6] ADRENAL & PITUITARY PROCEDURES	1.1625	29.5	24.6
287	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS.	1.0402	33.0	27.5
288	[4] O.R. PROCEDURES FOR OBESITY	1.1625	29.5	24.6
289	[6] PARATHYROID PROCEDURES	1.1625	29.5	24.6
290	[6] THYROID PROCEDURES	1.1625	29.5	24.6
291	[6] THYROGLOSSAL PROCEDURES	1.1625	29.5	24.6
292	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	1.1549	32.0	26.7
293	[8] OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	1.1549	32.0	26.7
294	DIABETES AGE >35	0.6958	23.9	19.9
295	[2] DIABETES AGE 0–35	0.5594	21.0	17.5
296	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	0.7092	22.3	18.6
297	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC	0.4596	19.3	16.1
298	[6] NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0–17	0.4175	17.0	14.2
299	[3] INBORN ERRORS OF METABOLISM	0.7819	23.9	19.9
300	ENDOCRINE DISORDERS W CC	0.7004	23.7	19.8
301	[2] ENDOCRINE DISORDERS W/O CC	0.5594	21.0	17.5
302	[7] KIDNEY TRANSPLANT	0.0000	0.0	0.0
303	[6] KIDNEY AND URETER PROCEDURES FOR NEOPLASM	0.7819	23.9	19.9
304	[4] KIDNEY AND URETER PROCEDURES FOR NON-NEOPLASM W CC	1.1625	29.5	24.6
305	[6] KIDNEY AND URETER PROCEDURES FOR NON-NEOPLASM W/O CC	0.7819	23.9	19.9
306	[4] PROSTATECTOMY W CC	1.1625	29.5	24.6
307	[6] PROSTATECTOMY W/O CC	1.1625	29.5	24.6
308	[4] MINOR BLADDER PROCEDURES W CC	1.1625	29.5	24.6
309	[6] MINOR BLADDER PROCEDURES W/O CC	1.1625	29.5	24.6
310	[4] TRANSURETHRAL PROCEDURES W CC	1.1625	29.5	24.6
311	[6] TRANSURETHRAL PROCEDURES W/O CC	1.1625	29.5	24.6
312	[3] URETHRAL PROCEDURES, AGE >17 W CC	0.7819	23.9	19.9
313	[6] URETHRAL PROCEDURES, AGE >17 W/O CC	0.7819	23.9	19.9
314	[6] URETHRAL PROCEDURES, AGE 0–17	0.7819	23.9	19.9
315	OTHER KIDNEY & URINARY TRACT PROCEDURES	1.4016	33.9	28.3
316	RENAL FAILURE	0.8321	22.9	19.1
317	ADMIT FOR RENAL DIALYSIS	0.9102	24.4	20.3
318	KIDNEY & URINARY TRACT NEOPLASMS WCC	0.7565	21.0	17.5
319	[6] KIDNEY & URINARY TRACT NEOPLASMSW/O CC	0.7819	23.9	19.9
320	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	0.6200	21.7	18.1
321	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	0.4450	18.5	15.4
322	[6] KIDNEY & URINARY TRACT INFECTIONS AGE 0–17	0.4175	17.0	14.2
323	[1] URINARY STONES W CC, &/OR ESW LITHOTRIPSY	0.4175	17.0	14.2
324	[1] URINARY STONES W/O CC	0.4175	17.0	14.2
325	[2] KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC	0.5594	21.0	17.5
326	[6] KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC	0.4175	17.0	14.2
327	[6] KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0–17	0.4175	17.0	14.2
328	[6] URETHRAL STRICTURE AGE >17 W CC	0.5594	21.0	17.5
329	[6] URETHRAL STRICTURE AGE >17 W/O CC	0.5594	21.0	17.5
330	[6] URETHRAL STRICTURE AGE 0–17	0.5594	21.0	17.5
331	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC	0.7773	22.5	18.8
332	[1] OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC	0.4175	17.0	14.2

TABLE 11.—FY 2007 LTC–DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY—Continued

LTC–DRG	Description	Relative weight	Geometric average length of stay	5/6ths of the geometric average length of stay
333	[6] OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0–17	0.4175	17.0	14.2
334	[6] MAJOR MALE PELVIC PROCEDURES W CC	0.4175	17.0	14.2
335	[1] MAJOR MALE PELVIC PROCEDURES W/OCC	0.4175	17.0	14.2
336	[4] TRANSURETHRAL PROSTATECTOMY W CC	1.1625	29.5	24.6
337	[6] TRANSURETHRAL PROSTATECTOMY W/O CC	1.1625	29.5	24.6
338	[3] TESTES PROCEDURES, FOR MALIGNANCY	0.7819	23.9	19.9
339	[3] TESTES PROCEDURES, NON-MALIGNANCY AGE >17	0.7819	23.9	19.9
340	[6] TESTES PROCEDURES, NON-MALIGNANCY AGE 0–17	0.7819	23.9	19.9
341	[5] PENIS PROCEDURES	1.6835	37.1	30.9
342	[6] CIRCUMCISION AGE >17	0.7819	23.9	19.9
343	[6] CIRCUMCISION AGE 0–17	0.7819	23.9	19.9
344	[3] OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY.	0.7819	23.9	19.9
345	[4] OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY.	1.1625	29.5	24.6
346	[3] MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC	0.7819	23.9	19.9
347	[1] MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC	0.4175	17.0	14.2
348	[2] BENIGN PROSTATIC HYPERTROPHY W CC	0.5594	21.0	17.5
349	[6] BENIGN PROSTATIC HYPERTROPHY W/O CC	0.7819	23.9	19.9
350	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	0.5606	21.0	17.5
351	[6] STERILIZATION, MALE	0.7819	23.9	19.9
352	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	0.8209	27.5	22.9
353	[6] PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY.	1.1625	29.5	24.6
354	[6] UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	1.1625	29.5	24.6
355	[6] UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC	1.1625	29.5	24.6
356	[6] FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	1.1625	29.5	24.6
357	[6] UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY	1.1625	29.5	24.6
358	[6] UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	1.1625	29.5	24.6
359	[6] UTERINE & ADNEXA PROC FOR NONMALIGNANCY W/O CC-	1.1625	29.5	24.6
360	[6] VAGINA, CERVIX & VULVA PROCEDURES	1.1625	29.5	24.6
361	[6] LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	0.4175	17.0	14.2
362	[6] ENDOSCOPIC TUBAL INTERRUPTION	0.4175	17.0	14.2
363	[6] D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	0.4175	17.0	14.2
364	[6] D&C, CONIZATION EXCEPT FOR MALIGNANCY	0.4175	17.0	14.2
365	[4] OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	1.1625	29.5	24.6
366	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	0.9106	21.6	18.0
367	[1] MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	0.4175	17.0	14.2
368	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	0.7846	21.3	17.8
369	[3] MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	0.7819	23.9	19.9
370	[6] CESAREAN SECTION W CC	0.4175	17.0	14.2
371	[6] CESAREAN SECTION W/O CC	0.4175	17.0	14.2
372	[6] VAGINAL DELIVERY W COMPLICATING DIAGNOSES	0.4175	17.0	14.2
373	[6] VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	0.4175	17.0	14.2
374	[6] VAGINAL DELIVERY W STERILIZATION &/OR D&C	0.4175	17.0	14.2
375	[6] VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	0.4175	17.0	14.2
376	[4] POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	1.1625	29.5	24.6
377	[6] POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	0.4175	17.0	14.2
378	[6] ECTOPIC PREGNANCY	0.4175	17.0	14.2
379	[6] THREATENED ABORTION	0.4175	17.0	14.2
380	[6] ABORTION W/O D&C	0.4175	17.0	14.2
381	[6] ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	0.4175	17.0	14.2
382	[6] FALSE LABOR	0.4175	17.0	14.2
383	[1] OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	0.4175	17.0	14.2
384	[6] OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	0.4175	17.0	14.2
385	[6] NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY.	0.4175	17.0	14.2
386	[6] EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE.	0.4175	17.0	14.2
387	[6] PREMATURITY W MAJOR PROBLEMS	0.4175	17.0	14.2
388	[6] PREMATURITY W/O MAJOR PROBLEMS	0.4175	17.0	14.2
389	[6] FULL TERM NEONATE W MAJOR PROBLEMS	0.4175	17.0	14.2
390	[6] NEONATE W OTHER SIGNIFICANT PROBLEMS	0.4175	17.0	14.2
391	[6] NORMAL NEWBORN	0.4175	17.0	14.2
392	[6] SPLENECTOMY AGE >17	1.1625	29.5	24.6
393	[6] SPLENECTOMY AGE 0–17	1.1625	29.5	24.6
394	[4] OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS.	1.1625	29.5	24.6

TABLE 11.—FY 2007 LTC–DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY—Continued

LTC–DRG	Description	Relative weight	Geometric average length of stay	5/6ths of the geometric average length of stay
395	RED BLOOD CELL DISORDERS AGE >17	0.6651	21.9	18.3
396	[6] RED BLOOD CELL DISORDERS AGE 0–17	0.4175	17.0	14.2
397	COAGULATION DISORDERS	0.8276	20.4	17.0
398	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	0.6278	20.8	17.3
399	[1] RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC	0.4175	17.0	14.2
401	[4] LYMPHOMA & NON-ACUTE LEUKEMIA WOTHER O.R. PROC W CC	1.1625	29.5	24.6
402	[6] LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC	0.5594	21.0	17.5
403	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	0.8846	23.9	19.9
404	[3] LYMPHOMA & NON-ACUTE LEUKEMIA W/OCC	0.7819	23.9	19.9
405	[6] ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0–17	0.7819	23.9	19.9
406	[5] MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC.	1.6835	37.1	30.9
407	[6] MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC.	1.1625	29.5	24.6
408	[4] MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC	1.1625	29.5	24.6
409	RADIOTHERAPY	0.8416	23.2	19.3
410	CHEMOTHERAPY W/O ACUTE LEUKEMIA ASSECONDARY DIAGNOSIS	1.2527	28.7	23.9
411	[6] HISTORY OF MALIGNANCY W/O ENDOSCOPY	0.5594	21.0	17.5
412	[6] HISTORY OF MALIGNANCY W ENDOSCOPY	0.5594	21.0	17.5
413	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	0.8429	21.4	17.8
414	[3] OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC	0.7819	23.9	19.9
417	[6] SEPTICEMIA AGE 0–17	0.7819	23.9	19.9
418	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	0.7961	24.1	20.1
419	[2] FEVER OF UNKNOWN ORIGIN AGE >17 W CC	0.5594	21.0	17.5
420	[2] FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	0.5594	21.0	17.5
421	VIRAL ILLNESS AGE >17	0.7065	20.4	17.0
422	[6] VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0–17	0.4175	17.0	14.2
423	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	1.0426	23.2	19.3
424	[5] O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	1.6835	37.1	30.9
425	[1] ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION	0.4175	17.0	14.2
426	DEPRESSIVE NEUROSES	0.4038	22.5	18.8
427	[2] NEUROSES EXCEPT DEPRESSIVE	0.5594	21.0	17.5
428	DISORDERS OF PERSONALITY & IMPULSE CONTROL	0.5183	24.5	20.4
429	ORGANIC DISTURBANCES & MENTAL RETARDATION	0.5326	24.0	20.0
430	PSYCHOSES	0.4024	23.1	19.3
431	[2] CHILDHOOD MENTAL DISORDERS	0.5594	21.0	17.5
432	[1] OTHER MENTAL DISORDER DIAGNOSES	0.4175	17.0	14.2
433	[6] ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	0.4175	17.0	14.2
439	SKIN GRAFTS FOR INJURIES	1.2203	36.0	30.0
440	WOUND DEBRIDEMENTS FOR INJURIES	1.2248	34.4	28.7
441	[2] HAND PROCEDURES FOR INJURIES	0.5594	21.0	17.5
442	OTHER O.R. PROCEDURES FOR INJURIES W CC	1.3670	34.9	29.1
443	[6] OTHER O.R. PROCEDURES FOR INJURIES W/O CC	0.5594	21.0	17.5
444	TRAUMATIC INJURY AGE >17 W CC	0.6598	23.2	19.3
445	[2] TRAUMATIC INJURY AGE >17 W/O CC	0.5594	21.0	17.5
446	[6] TRAUMATIC INJURY AGE 0–17	0.5594	21.0	17.5
447	[2] ALLERGIC REACTIONS AGE >17	0.5594	21.0	17.5
448	[6] ALLERGIC REACTIONS AGE 0–17	0.5594	21.0	17.5
449	[3] POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC	0.7819	23.9	19.9
450	[2] POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC	0.5594	21.0	17.5
451	[6] POISONING & TOXIC EFFECTS OF DRUGS AGE 0–17	0.7819	23.9	19.9
452	COMPLICATIONS OF TREATMENT W CC	0.9275	25.7	21.4
453	COMPLICATIONS OF TREATMENT W/O CC	0.5790	21.6	18.0
454	[3] OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC	0.7819	23.9	19.9
455	[6] OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC	0.7819	23.9	19.9
461	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES	1.1466	32.7	27.3
462	REHABILITATION	0.5823	22.1	18.4
463	SIGNS & SYMPTOMS W CC	0.6082	22.9	19.1
464	SIGNS & SYMPTOMS W/O CC	0.5831	24.3	20.3
465	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	0.6877	21.2	17.7
466	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS.	0.6700	21.7	18.1
467	[3] OTHER FACTORS INFLUENCING HEALTHSTATUS	0.7819	23.9	19.9
468	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	2.1478	40.5	33.8
469	[7] PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	0.0000	0.0	0.0
470	[7] UNGROUPABLE	0.0000	0.0	0.0
471	[5] BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY.	1.6835	37.1	30.9

TABLE 11.—FY 2007 LTC–DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY—Continued

LTC–DRG	Description	Relative weight	Geometric average length of stay	5/6ths of the geometric average length of stay
473	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	0.9917	25.3	21.1
476	[5]PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	1.6835	37.1	30.9
477	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	1.5119	35.9	29.9
479	[2]OTHER VASCULAR PROCEDURES W/O CC	0.5594	21.0	17.5
480	[7]LIVER TRANSPLANT AND/ORINTESTINAL TRANSPLANT	0.0000	0.0	0.0
481	[6]BONE MARROW TRANSPLANT	1.1625	29.5	24.6
482	[5]TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES;	1.6835	37.1	30.9
484	[6]CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	1.6835	37.1	30.9
485	[6]LIMB REATTACHMENT, HIP & FEMUR PROC FOR MULTIPLE SIGNIFICANTTRAUMA.	1.1625	29.5	24.6
486	[3]OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA	0.7819	23.9	19.9
487	[4]OTHER MULTIPLE SIGNIFICANT TRAUMA	1.1625	29.5	24.6
488	[4]HIV W EXTENSIVE O.R. PROCEDURE	1.1625	29.5	24.6
489	HIV W MAJOR RELATED CONDITION	0.9436	22.1	18.4
490	HIV W OR W/O OTHER RELATED CONDITION	0.6456	20.3	16.9
491	[5]MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY.	1.6835	37.1	30.9
492	[2]CHEMO W ACUTE LEUKEMIA AS SDX OR W USE OF HIGH DOSE CHEMO AGENT.	0.5594	21.0	17.5
493	[4]LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.1625	29.5	24.6
494	[6]LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	1.1625	29.5	24.6
495	[7]LUNG TRANSPLANT	0.0000	0.0	0.0
496	[4]COMBINED ANTERIOR/POSTERIOR SPINAL FUSION	1.1625	29.5	24.6
497	[5]SPINAL FUSION EXCEPT CERVICAL WCC	1.6835	37.1	30.9
498	[6]SPINAL FUSION EXCEPT CERVICAL W/O CC	1.6835	37.1	30.9
499	[5]BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC	1.6835	37.1	30.9
500	[4]BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC	1.1625	29.5	24.6
501	KNEE PROCEDURES W PDX OF INFECTION W CC	1.2164	33.3	27.8
502	[3]KNEE PROCEDURES W PDX OF INFECTION W/O CC	0.7819	23.9	19.9
503	[4]KNEE PROCEDURES W/O PDX OFINFECTION	1.1625	29.5	24.6
504	[5]EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV 96+ HRS W SKIN GRAFT.	1.6835	37.1	30.9
505	[5]EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV 96+ HRS W/O SKIN GRAFT.	1.6835	37.1	30.9
506	[4]FULL THICKNESS BURN W SKIN GRAFTOR INHAL INJ W CC OR SIG TRAUMA.	1.1625	29.5	24.6
507	[6]FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA.	0.4175	17.0	14.2
508	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ W CC OR SIG TRAUMA.	0.7588	25.6	21.3
509	[1]FULL THICKNESS BURN W/O SKIN GRFTOR INH INJ W/O CC OR SIG TRAUMA.	0.4175	17.0	14.2
510	NON-EXTENSIVE BURNS W CC OR SIGNIFICANT TRAUMA	0.6720	22.6	18.8
511	[1]NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA	0.4175	17.0	14.2
512	[7]SIMULTANEOUS PANCREAS/KIDNEYTRANSPLANT	0.0000	0.0	0.0
513	[7]PANCREAS TRANSPLANT	0.0000	0.0	0.0
515	[4]CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH	1.1625	29.5	24.6
518	[6]PERCUTANEOUS CARDIOVASC PROC W/O CORONARY ARTERY STENT OR AMI.	0.4175	17.0	14.2
519	[4]CERVICAL SPINAL FUSION W CC	1.1625	29.5	24.6
520	[6]CERVICAL SPINAL FUSION W/O CC	1.6835	37.1	30.9
521	[2]ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	0.5594	21.0	17.5
522	[6]ALCOHOL/DRUG ABUSE OR DEPENDENCE W REHABILITATION THERAPY W/O CC.	0.5594	21.0	17.5
523	[1]ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W/O CC.	0.4175	17.0	14.2
524	[2]TRANSIENT ISCHEMIA	0.5594	21.0	17.5
525	[6]OTHER HEART ASSIST SYSTEM IMPLANT	1.6835	37.1	30.9
528	[6]INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE	1.6835	37.1	30.9
529	[5]VENTRICULAR SHUNT PROCEDURES W CC	1.6835	37.1	30.9
530	[6]VENTRICULAR SHUNT PROCEDURES W/O CC	1.6835	37.1	30.9
531	[5]SPINAL PROCEDURES W CC	1.6835	37.1	30.9
532	[3]SPINAL PROCEDURES W/O CC	0.7819	23.9	19.9
533	[4]EXTRACRANIAL PROCEDURES W CC	1.1625	29.5	24.6
534	[6]EXTRACRANIAL PROCEDURES W/O CC	1.1625	29.5	24.6
535	[5]CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK	1.6835	37.1	30.9
536	[6]CARDIAC DEFIB IMPLANT W CARDIACCATH W/O AMI/HF/SHOCK	1.1625	29.5	24.6

TABLE 11.—FY 2007 LTC–DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY—Continued

LTC–DRG	Description	Relative weight	Geometric average length of stay	5/6ths of the geometric average length of stay
537	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXCEPT HIP & FEMUR W CC.	1.4672	39.9	33.3
538	[4]LOCAL EXCISION & REMOVAL INT FIX DEVICES EXCEPT HIP & FEMUR W/O CC.	1.1625	29.5	24.6
539	[4]LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W CC	1.1625	29.5	24.6
540	[6]LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W/O CC	0.4175	17.0	14.2
541	ECMO OR TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R..	3.8893	58.1	48.4
542	TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R..	2.8689	45.1	37.6
543	[5]CRANIOTOMY W MAJOR DEVICE IMPLANT OR ACUTE COMPLEX CNS PDX.	1.6835	37.1	30.9
544	[5]MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY.	1.6835	37.1	30.9
545	[5]REVISION OF HIP OR KNEE REPLACEMENT	1.6835	37.1	30.9
546	[6]SPINAL FUSION EXC CERV WITH CURVATURE OF THE SPINE OR MALIG.	1.6835	37.1	30.9
547	[6]CORONARY BYPASS W CARDIAC CATH W MAJOR CV DX	1.1625	29.5	24.6
548	[6]CORONARY BYPASS W CARDIAC CATHW/O MAJOR CV DX	1.1625	29.5	24.6
549	[6]CORONARY BYPASS W/O CARDIAC CATH W MAJOR CV DX	1.1625	29.5	24.6
550	[6]CORONARY BYPASS W/O CARDIAC CATH W/O MAJOR CV DX	1.1625	29.5	24.6
551	PERMANENT CARDIAC PACEMAKER IMPL W MAJ CV DX OR AICD LEAD OR GNRTR.	1.6035	29.5	24.6
552	[4]OTHER PERMANENT CARDIAC PACEMAKER IMPLANT W/O MAJOR CV DX.	1.1625	29.5	24.6
553	OTHER VASCULAR PROCEDURES W CC W MAJOR CV DX	1.5837	32.5	27.1
554	OTHER VASCULAR PROCEDURES W CC W/O MAJOR CV DX	1.2817	31.6	26.3
555	[3]PERCUTANEOUS CARDIOVASCULAR PROC W MAJOR CV DX	0.7819	23.9	19.9
556	[6]PERCUTANEOUS CARDIOVASC PROC W NON-DRUG-ELUTING STENT W/O MAJ CV DX.	0.4175	17.0	14.2
557	[4]PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W MAJOR CV DX.	1.1625	29.5	24.6
558	[6]PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W/O MAJ CV DX.	0.4175	17.0	14.2
559	[6]ACUTE ISCHEMIC STROKE WITH USE OTHROMBOLYTIC AGENT F	0.7819	23.9	19.9
560	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM	0.9308	25.5	21.3
561	NON-BACTERIAL INFECTIONS OF NERVOUS SYSTEM EXCEPT VIRAL MENINGITIS.	0.8145	22.3	18.6
562	SEIZURE AGE >17 W CC	0.6844	23.2	19.3
563	[2]SEIZURE AGE >17 W/O CC	0.5594	21.0	17.5
564	HEADACHES AGE >17	0.7565	24.1	20.1
565	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT 96+ HOURS.	2.0557	34.7	28.9
566	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT < 96 HOURS.	1.5445	27.4	22.8
567	[5]STOMACH, ESOPHAGEAL & DUODENAL PROC AGE >17 W CC W MAJOR GI DX.	1.6835	37.1	30.9
568	[5]STOMACH, ESOPHAGEAL & DUODENAL PROC AGE >17 W CC W/O MAJOR GI DX.	1.6835	37.1	30.9
569	[5]MAJOR SMALL & LARGE BOWEL PROCEDURES W CC W MAJOR GI DX	1.6835	37.1	30.9
570	[5]MAJOR SMALL & LARGE BOWEL PROCEDURES W CC W/O MAJOR GI DX.	1.6835	37.1	30.9
571	MAJOR ESOPHAGEAL DISORDERS	0.8214	21.9	18.3
572	MAJOR GASTROINTESTINAL DISORDERS AND PERITONEAL INFECTIONS	0.8505	23.3	19.4
573	[5]MAJOR BLADDER PROCEDURES	1.6835	37.1	30.9
574	MAJOR HEMATOLOGIC/IMMUNOLOGIC DIAG EXC SICKLE CELL CRISIS & COAGUL.	0.8106	19.7	16.4
575	SEPTICEMIA W MV 96+ HOURS AGE >17	1.6583	27.8	23.2
576	SEPTICEMIA W/O MV 96+ HOURS AGE >17	0.7925	23.0	19.2
577	[6]CAROTID ARTERY STENT PROCEDURE	1.1625	29.5	24.6
578	O. R. PROCEDURE W PDX EXC POSTOPERATIVE OR POST-TRAUMATIC INFECTION.	1.4849	35.7	29.8
579	O. R. PROCEDURE W PDX OF POSTOPERATIVE OR POST-TRAUMATIC INFECTION.	1.2978	35.2	29.3

[1] Relative weights for these LTC–DRGs were determined by assigning these cases to low-volume quintile 1.
[2] Relative weights for these LTC–DRGs were determined by assigning these cases to low-volume quintile 2.
[3] Relative weights for these LTC–DRGs were determined by assigning these cases to low-volume quintile 3.
[4] Relative weights for these LTC–DRGs were determined by assigning these cases to low-volume quintile 4.

[5] Relative weights for these LTC–DRGs were determined by assigning these cases to low-volume quintile 5.
[6] Relative weights for these LTC–DRGs were determined by assigning these cases to the appropriate low volume quintile because they had no LTCH cases in the FY 2005 MedPAR file.
[7] Relative weights for these LTC–DRGs were assigned a value of 0.0000.
[8] Relative weights for these LTC–DRGs were determined after adjusting to account for nonmonotonicity (see step 5 above).

Appendix A—Regulatory Impact Analysis

I. Overall Impact

We have examined the impacts of this final rule, this interim final rule with comment period, and this notice with comment period as required by Executive Order 12866 (September 1993, Regulatory Planning and Review) and the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year).

We have determined that these rules are a major rule as defined in 5 U.S.C. 804(2). We estimate that the changes for FY 2007 operating and capital payments will redistribute in excess of $100 million among different types of inpatient cases. The market basket update to the IPPS rates required by the statute, in conjunction with other payment changes finalized in this rule, will result in an approximate $3.4 billion increase in FY 2007 operating and capital payments. This amount does not reflect changes in hospital admissions or case-mix intensity in operating PPS payments, which would also affect overall payment changes. The $142 million in funds for the loan program for cancer center costs under the Health Care Infrastructure Improvement Program is appropriated specifically for the loan program and not more than $2 million may be used for the administration costs of the program.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are considered to be small entities, either by nonprofit status or by having revenues of $6 million to $29 million in any 1 year. (For details, see the Small Business Administration's final rule that sets forth size standards for health care industries at 65 FR 69432, November 17, 2000.) For purposes of the RFA, all hospitals and other providers and suppliers are considered to be small entities. Individuals and States are not included in the definition of a small entity. We believe that this proposed rule will have a significant impact on small entities as explained in this Appendix. Because we acknowledge that many of the affected entities are small entities, the analysis discussed throughout the preamble of this proposed rule constitutes our initial regulatory flexibility analysis. Therefore, in the proposed rule, we solicited comments on our estimates and analysis of the impact of the proposed rule on those small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any proposed rule that may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we previously defined a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA). However, under the new labor market definitions, we no longer employ NECMAs to define urban areas in New England. Therefore, we now define a small rural hospital as a hospital that is located outside of an MSA and has fewer than 100 beds. Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the IPPS, we continue to classify these hospitals as urban hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately $120 million. This proposed rule will not mandate any requirements for State, local, or tribal governments, nor will it affect private sector costs.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. As stated above, this rule will not have a substantial effect on State and local governments.

The following analysis, in conjunction with the remainder of this document, demonstrates that this rule is consistent with the regulatory philosophy and principles identified in Executive Order 12866, the RFA, and section 1102(b) of the Act. The rule will affect payments to a substantial number of small rural hospitals, as well as other classes of hospitals, and the effects on some hospitals may be significant.

II. Objectives

The primary objective of the IPPS is to create incentives for hospitals to operate efficiently and minimize unnecessary costs while at the same time ensuring that payments are sufficient to adequately compensate hospitals for their legitimate costs. In addition, we share national goals of preserving the Medicare Hospital Insurance Trust Fund.

We believe the changes in this final rule will further each of these goals while maintaining the financial viability of the hospital industry and ensuring access to high quality health care for Medicare beneficiaries. We expect that these changes will ensure that the outcomes of this payment system are reasonable and equitable while avoiding or minimizing unintended adverse consequences.

III. Limitations of Our Analysis

The following quantitative analysis presents the projected effects of our policy changes, as well as statutory changes effective for FY 2007, on various hospital groups. We estimate the effects of individual policy changes by estimating payments per case while holding all other payment policies constant. We use the best data available, but, generally, we do not attempt to predict behavioral responses to our policy changes, and we do not make adjustments for future changes in such variables as admissions, lengths of stay, or case-mix. As we have done in the previous rules, we solicited comments and information about the anticipated effects of these changes on hospitals and our methodology for estimating them. Any timely comments we have received in response to the FY 2007 IPPS proposed rule are addressed below under the appropriate subject heading in this final rule.

IV. Hospitals Included In and Excluded From the IPPS

The prospective payment systems for hospital inpatient operating and capital-related costs encompass nearly all general short-term, acute care hospitals that participate in the Medicare program. There were 36 Indian Health Service hospitals in our database, which we excluded from the analysis due to the special characteristics of the prospective payment methodology for these hospitals. Among other short-term, acute care hospitals, only the 46 such hospitals in Maryland remain excluded from the IPPS under the waiver at section 1814(b)(3) of the Act.

As of July 2006, there are 3,595 IPPS hospitals to be included in our analysis. This represents about 60 percent of all Medicare-participating hospitals. The majority of this impact analysis focuses on this set of hospitals. There are also approximately 1,282 critical access hospitals (CAHs). These small, limited service hospitals are paid on the basis of reasonable costs rather than under the IPPS. There are also 1,254 excluded hospitals

and 2,305 excluded units that are excluded from the IPPS. These excluded hospitals include psychiatric hospitals and units (now referred to as IPFs), rehabilitation hospitals and units (now referred to as IRFs), long-term care hospitals (now referred to as LTCHs), children's hospitals, and cancer hospitals. Religious Non-Medical Health Care Institutions (RNHCIs) are also included. The impacts of our policy changes on these hospitals and institutions are discussed below.

V. Effects on Excluded Hospitals and Hospital Units

As of July 2006, there were 1,254 hospitals excluded from the IPPS. Of these 1,254 hospitals, 482 IPFs, 81 children's hospitals, 11 cancer hospitals, and 17 RNHCIs are being paid, in whole or in part, on a reasonable cost basis subject to the rate-of-increase ceiling under § 413.40. The remaining providers, 271 IRFs and 392 LTCHs, are paid 100 percent of the Federal prospective rate under the IRF PPS and the LTCH PPS, respectively. We note that, currently, there are 16 LTCHs that are being paid under the LTCH PPS transition blend methodology, which is based in part on a reasonable cost that is subject to a rate-of-increase ceiling under § 413.40. Effective for cost reporting periods beginning on or after October 1, 2006 (FY 2007), these LTCHs will no longer receive a portion of their payment that is based, in part, on a reasonable cost subject to a rate-of-increase ceiling. Rather, in accordance with § 412.533, for FY 2007, all LTCHs are to be paid 100 percent of the adjusted Federal prospective payment amount. In addition, there are 1,293 IPFs (paid on a blend of the IPF PPS per diem payment and the TEFRA reasonable cost-based payment) and 1,012 IRFs (paid under the IRF PPS) co-located in hospitals otherwise subject to the IPPS. Under § 413.40(a)(2)(i)(A), the rate-of-increase ceiling is not applicable to the 93 IPPS excluded hospitals and units in Maryland that are paid in accordance with the waiver at section 1814(b)(3) of the Act.

In the past, hospitals and units excluded from the IPPS have been paid based on their reasonable costs subject to limits as established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Hospitals that continue to be paid fully on a reasonable cost basis are subject to TEFRA limits for FY 2007. For these hospitals (cancer and children's hospitals), consistent with section 1886(b)(3)(B)(ii) of the Act, as was proposed the final update will be the percentage increase in the FY 2007 IPPS operating market basket, currently estimated to be 3.4 percent. In addition, in accordance with § 403.752(a) of the regulations, RNHCIs are paid under § 413.40, which also uses section 1886(b)(3)(B)(ii) of the Act to update the percentage increase in the rate-of-increase limits. For RNHCIs, the update will be the percentage increase in the FY 2007 IPPS operating market basket increase, currently estimated to be 3.4 percent.

IRFs are paid under a prospective payment system (IRF PPS) for cost reporting periods beginning on or after January 1, 2002. For cost reporting periods beginning during FY 2007, the IRF PPS is based on 100 percent of the adjusted Federal IRF prospective payment amount, updated annually. Therefore, these hospitals are not affected by this final rule.

Effective for cost reporting periods beginning on or after October 1, 2002, LTCHs are paid under a LTCH PPS, based on a Federal prospective payment amount that is updated annually. Existing LTCHs receive a blended payment that consists of the Federal prospective payment rate and a reasonable cost-based payment rate over a 5-year transition period, unless the LTCH elects to be paid at 100 percent of the Federal prospective rate at the beginning of any of its cost reporting periods during the 5-year transition period. Under § 412.533, the 5-year transition period for all existing LTCHs subject to the LTCH PPS began with the LTCH's first cost reporting period beginning on or after October 1, 2002, and is extended through the LTCH's cost reporting period beginning on or after October 1, 2006. In accordance with § 412.533, for cost reporting periods beginning on or after October 1, 2006, the LTCH PPS transition blend percentages are 100 percent of the Federal prospective payment amount and zero percent of the amount calculated under reasonable cost principles. Therefore, even though FY 2007 is the fifth year of the 5-year transition period established under § 412.533, because the reasonable cost principles amount is zero percent for cost reporting periods beginning during FY 2007, LTCHs will no longer receive a portion of their payment that is based in part on a reasonable cost subject to the rate-of-increase ceiling. Thus, there is no longer a need for an update factor for LTCH's TEFRA target amount for FY 2007 and beyond.

Section 124 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA) required the development of a per diem prospective payment system (PPS) for payment of inpatient hospital services furnished in IPFs. The final rule implementing the IPF PPS (69 FR 66922) established a 3-year transition to the IPF PPS during which some providers will receive a blend of the IPF PPS per diem payment and the TEFRA reasonable cost-based payment. For purposes of determining what the TEFRA payment to the IPF will be, we updated the IPF's TEFRA target amount by the excluded hospital market basket percentage increase of 3.4 percent.

The impact on excluded hospitals and hospital units of the update in the rate-of-increase limit depends on the cumulative cost increases experienced by each excluded hospital or unit since its applicable base period. For excluded hospitals and units that have maintained their cost increases at a level below the rate-of-increase limits since their base period, the major effect is on the level of incentive payments these hospitals and hospital units receive. Conversely, for excluded hospitals and hospital units with per-case cost increases above the cumulative update in their rate-of-increase limits, the major effect is the amount of excess costs that will not be reimbursed.

We note that, under § 413.40(d)(3), an excluded hospital or unit whose costs exceed 110 percent of its rate-of-increase limit receives its rate-of-increase limit plus 50 percent of the difference between its reasonable costs and 110 percent of the limit, not to exceed 110 percent of its limit. In addition, under the various provisions set forth in § 413.40, certain excluded hospitals and hospital units can obtain payment adjustments for justifiable increases in operating costs that exceed the limit. However, at the same time, by generally limiting payment increases, we continue to provide an incentive for excluded hospitals and hospital units to restrain the inappropriate spending for patient services.

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

A. Basis and Methodology of Estimates

In this final rule, we are announcing policy changes and payment rate updates for the IPPS for operating costs. Changes to the capital payments are discussed in section VIII. of this Appendix. We note that due to the decision in *Bellevue Hosp. Center* v. *Leavitt*, in which the Court of Appeals for the Second Circuit (the Court) ordered CMS to apply the occupational mix adjustment to 100 percent of the wage index effective for FY 2007 (see section III.C. of this final rule for more details of this Court decision), we are unable to finalize the FY 2007 wage index data at this time. Therefore, we are also unable to finalize the relative weights, budget neutrality calculations, the outlier threshold, the outlier offsets and the standardized payment amounts. We have calculated tentative amounts for all of these factors and have based the impacts shown in the following pages on these tentative amounts. When the final 100 percent occupational mix adjusted wage data is available, we will recalculate impacts and publish them in a separate **Federal Register** notice prior to October 1, 2006.

Based on the overall percentage change in payments per case estimated using our payment simulation model, we estimate that total FY 2007 operating payments will increase 3.5 percent compared to FY 2006 largely due to the statutorily mandated update to the IPPS rates. This amount does not reflect changes in hospital admissions or case-mix intensity, which would also affect overall payment changes.

We have prepared separate impact analyses of the changes to each system. This section deals with changes to the operating prospective payment system. Our payment simulation model relies on the most recent available data to enable us to estimate the impacts on payments per case of certain changes in this rule. However, there are other changes for which we do not have data available that would allow us to estimate the payment impacts using this model. For those changes, we have attempted to predict the payment impacts based upon our experience and other more limited data.

The data used in developing the quantitative analyses of changes in payments per case presented below are taken from the FY 2005 MedPAR file and the most current Provider-Specific File that is used for payment purposes. Although the analyses of the changes to the operating PPS do not incorporate cost data, data from the most

recently available hospital cost report were used to categorize hospitals. Our analysis has several qualifications. First, in this analysis, we do not make adjustments for behavioral changes that hospitals may adopt in response to the policy changes, and we do not adjust for future changes in such variables as admissions, lengths of stay, or case-mix. Second, due to the interdependent nature of the IPPS payment components, it is very difficult to precisely quantify the impact associated with each change. Third, we use various sources for the data used to categorize hospitals in the tables. In some cases, particularly the number of beds, there is a fair degree of variation in the data from different sources. We have attempted to construct these variables with the best available source overall. However, for individual hospitals, some miscategorizations are possible.

Using cases from the FY 2005 MedPAR file, we simulated payments under the operating IPPS given various combinations of payment parameters. Any short-term, acute care hospitals not paid under the IPPS (Indian Health Service hospitals and hospitals in Maryland) were excluded from the simulations. The impact of payments under the capital IPPS, or the impact of payments for costs other than inpatient operating costs, are not analyzed in this section. Estimated payment impacts of FY 2007 changes to the capital IPPS are discussed in section VIII. of this Appendix.

The changes discussed separately below are the following:

- The effect of a reduced update to the standardized amount for hospitals that do not comply with section 1886(b)(3)(B)(viii) of the Act by submitting quality data in accordance with our requirements.
- The effects of the MDH payment changes set forth in section 5003 of Pub. L. 109–171.
- The effects of the revisions we are adopting to our methodology for calculating DRG relative weights.
- The effects of the annual reclassification of diagnoses and procedures and the recalibration of the DRG relative weights required by section 1886(d)(4)(C) of the Act. The relative weights used in estimating this impact are not yet final as the wage data used in the relative weight computation is not available at this time.
- The effects of the changes in hospitals' wage index values reflecting wage data from hospitals' cost reporting periods beginning during FY 2003, compared to the FY 2002 wage data are shown in this impact but are not yet final because the occupational mix wage data that will be used to calculate the FY 2007 wage indices are not available at this time.
- The effects of the wage and recalibration budget neutrality factors are shown in this impact but are not yet final because occupational mix adjusted wage indices are yet to be calculated.
- The effects of the remaining labor market area transition for those hospitals that were urban under the old labor market area designations and are now considered rural hospitals are shown in this impact but are not yet final pending calculation of the final occupational mix adjusted wage indices.
- The effects of geographic reclassifications by the MGCRB that will be effective in FY 2007 are shown in this impact but are not yet final because we will be making reclassification decisions for hospitals subsequent to this final rule prior to October 1, 2006, based on the final occupational mix adjusted wage indices.
- The effects of section 505 of Pub. L. 108–173, which provides for an increase in a hospital's wage index if the hospital qualifies by meeting a threshold percentage of residents of the county where the hospital is located who commute to work at hospitals in counties with higher wage indexes, are shown in this impact but are not yet final because the final occupational mix adjusted wage data are not available at this time.
- The total estimated change in payments based on FY 2007 policies and MMA and DRA-imposed changes relative to payments based on FY 2006 policies.

To illustrate the impacts of the FY 2007 changes, our analysis begins with a FY 2006 baseline simulation model using: the FY 2007 market basket update of 3.4 percent; the FY 2006 DRG GROUPER (version 23.0); the CBSA designations for hospitals based on OMB's June 2003 MSA definitions; the FY 2006 wage index; and no MGCRB reclassifications. Outlier payments are set at 5.1 percent of total operating DRG and outlier payments.

Section 1886(b)(3)(B)(vii) of the Act, as added by section 501(b) of Pub. L. 108–173, and amended by section 5001(a) of Pub. L. 109–171, provides that, for FYs 2005 through 2006, the update factors will be reduced by 0.4 percentage points for any hospital that does not submit quality data. Section 5001(a) of Pub. L. 109–171 provides that for FY 2007 and subsequent years, the update factor will be reduced by 2.0 percentage points for any hospital that does not submit quality data or that fails the quality data validation process. At the time this impact was prepared, 117 providers did not receive the full market basket rate-of-increate for FY 2006 because they failed the quality data submission process. For purposes of the simulations shown below, we modeled the payment changes for FY 2007 using a reduced update for these 117 hospitals. However, we do not have enough information to determine which hospitals will not receive the full market basket rate-of-increase for FY 2007 at this time.

Each final and statutory policy change is then added incrementally to this baseline, finally arriving at an FY 2007 model incorporating all of the changes. This simulation allows us to isolate the effects of each change.

Our final comparison illustrates the percent change in payments per case from FY 2006 to FY 2007. Three factors not discussed separately have significant impacts here. The first is the update to the standardized amount. In accordance with section 1886(b)(3)(B)(i) of the Act, we have updated standardized amounts for FY 2007 using the most recently forecasted hospital market basket increase for FY 2007 of 3.4 percent. (Hospitals that fail to comply with the quality data submission requirement to receive the full update will receive an update reduced by 2.0 percentage points to 1.4 percent.) Under section 1886(b)(3)(B)(iv) of the Act, the updates to the hospital-specific amounts for sole community hospitals (SCHs) and for Medicare-dependent small rural hospitals (MDHs) are also equal to the market basket increase, or 3.4 percent.

A second significant factor that affects changes in hospitals' payments per case from FY 2006 to FY 2007 is the change in MGCRB status from one year to the next. That is, payments may be reduced for hospitals reclassified in FY 2006 that are no longer reclassified in FY 2007. Conversely, payments may increase for hospitals not reclassified in FY 2006 that are reclassified in FY 2007. In some cases, these impacts can be quite substantial, so if a relatively small number of hospitals in a particular category lose their reclassification status, the percentage change in payments for the category may be below the national mean. However, this effect is alleviated by section 1886(d)(10)(D)(v) of the Act, which provides that reclassifications for purposes of the wage index are for a 3-year period.

A third significant factor is that we currently estimate that actual outlier payments during FY 2006 will be 4.6 percent of total DRG payments. When the FY 2006 final rule was published, we projected FY 2006 outlier payments would be 5.1 percent of total DRG plus outlier payments; the average standardized amounts were offset correspondingly. The effects of the lower than expected outlier payments during FY 2006 (as discussed in the Addendum to this final rule) are reflected in the analyses below comparing our current estimates of FY 2006 payments per case to estimated FY 2007 payments per case (with outlier payments projected to equal 5.1 percent of total DRG payments).

B. Analysis of Table I

Table I displays the results of our analysis of changes for FY 2007. The table categorizes hospitals by various geographic and special payment consideration groups to illustrate the varying impacts on different types of hospitals. The top row of the table shows the overall impact on the 3,595 hospitals included in the analysis. There are 149 fewer hospitals than were included in the impact analysis in the FY 2006 final rule (70 FR 47690).

The next four rows of Table I contain hospitals categorized according to their geographic location: All urban, which is further divided into large urban and other urban; and rural. There are 2,590 hospitals located in urban areas included in our analysis. Among these, there are 1,441 hospitals located in large urban areas (populations over 1 million), and 1,149 hospitals in other urban areas (populations of 1 million or fewer). In addition, there are 1,005 hospitals in rural areas. The next two groupings are by bed-size categories, shown separately for urban and rural hospitals. The final groupings by geographic location are by census divisions, also shown separately for urban and rural hospitals.

The second part of Table I shows hospital groups based on hospitals' FY 2007 payment classifications, including any

reclassifications under section 1886(d)(10) of the Act. For example, the rows labeled urban, large urban, other urban, and rural show that the number of hospitals paid based on these categorizations after consideration of geographic reclassifications (including reclassifications under 1886(d)(8)(B) and 1886(d)(8)(E) which have implications for capital payments) are 2,608, 1,450, 1,158, and 987, respectively.

The next three groupings examine the impacts of the changes on hospitals grouped by whether or not they have GME residency programs (teaching hospitals that receive an IME adjustment) or receive DSH payments, or some combination of these two adjustments. There are 2,511 nonteaching hospitals in our analysis, 843 teaching hospitals with fewer than 100 residents, and 241 teaching hospitals with 100 or more residents.

In the DSH categories, hospitals are grouped according to their DSH payment status, and whether they are considered urban or rural for DSH purposes. The next category groups together hospitals considered urban after geographic reclassification, in terms of whether they receive the IME adjustment, the DSH adjustment, both, or neither.

The next five rows examine the impacts of the changes on rural hospitals by special payment groups (sole community hospitals (SCHs), rural referral centers (RRCs), and Medicare dependent hospitals (MDHs)), as well as rural hospitals not receiving a special payment designation. There were 187 RRCs, 376 SCHs, 146 MDHs, 98 hospitals that are both SCHs and RRCs, and 8 hospitals that are both MDHs and RRCs.

The next two groupings are based on type of ownership and the hospital's Medicare utilization expressed as a percent of total patient days. These data are taken primarily from the FY 2004 Medicare cost reports, if available (otherwise FY 2003 data are used).

The next series of groupings concern the geographic reclassification status of hospitals. The first grouping displays all urban hospitals that were reclassified by the MGCRB for FY 2007. The next grouping shows the MGCRB rural reclassifications. The final three rows in Table I contain hospitals located in urban counties, but deemed to be rural under section 1886(d)(8)(E) of the Act, hospitals located in rural counties but deemed to be urban under section 1886(d)(8)(B) of the Act, and hospitals currently reclassified under section 508 of Pub. L. 108–173, which expires on March 31, 2007.

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TABLE I.--IMPACT ANALYSIS OF CHANGES FOR FY 2007

	No. of Hospitals[1] (1)	Quality Data Rate Difference[2] (2)	DRA MDH Provisions[3] (3)	FY 2007 Transition al 1/3 Cost 2/3 Charge Weights & DRG Changes[4] (4)	FY 2007 Wage Data[5] (5)	FY 2007 DRG, Rel. Wts. and Wage index Changes[6] (6)	FY 2007 Wage index Transition for Hospitals Moving from Urban to Rural[7] (7)	FY 2007 MGCRB Reclass-ifications[8] (8)	FY 2007 Out-Migration Adjustment[9] (9)	All FY 2007 Changes[10] (10)
All Hospitals	3,595	0.0	0.1	0.2	0.1	0.0	0.0	0.0	0.1	3.5
By Geographic Location:										
Urban hospitals	2,590	0.0	0.0	0.2	0.1	0.0	0.0	-0.3	0.1	3.4
Large urban areas (populations over 1 million)	1,441	0.0	0.0	0.3	0.1	0.1	0.0	-0.4	0.0	3.5
Other urban areas (populations of 1 million or fewer)	1,149	0.0	0.0	0.0	0.2	-0.1	0.0	-0.1	0.1	3.3
Rural hospitals	1,005	0.0	0.4	0.3	-0.1	0.0	0.3	2.4	0.1	3.7
Bed Size (Urban):										
0-99 beds	651	-0.1	0.1	0.3	0.2	0.2	0.0	-0.5	0.0	3.6
100-199 beds	867	0.0	0.0	0.5	0.2	0.5	0.0	-0.1	0.0	3.8
200-299 beds	492	0.0	0.0	0.3	0.1	0.1	0.0	-0.3	0.1	3.6
300-499 beds	413	0.0	0.0	0.1	0.2	-0.1	0.0	-0.4	0.1	3.3
500 or more beds	167	0.0	0.0	0.0	0.0	-0.4	0.0	-0.4	0.0	3.0
Bed Size (Rural):										
0-49 beds	348	-0.1	0.7	0.5	-0.3	0.0	0.1	1.0	0.2	4.2
50-99 beds	370	-0.1	1.1	0.4	-0.2	0.1	0.3	1.3	0.2	4.6
100-149 beds	174	0.0	0.1	0.4	-0.1	0.0	0.6	2.7	0.1	3.4
150-199 beds	68	0.0	0.0	0.2	-0.1	-0.1	0.5	3.9	0.1	3.3
200 or more beds	45	0.0	0.0	-0.1	-0.1	-0.3	0.0	3.4	0.0	2.9
Urban by Region:										
New England	128	0.0	0.0	0.3	0.6	0.6	0.0	0.3	0.0	2.9
Middle Atlantic	357	0.0	0.0	0.4	0.1	0.2	0.0	-0.1	0.1	3.2
South Atlantic	388	0.0	0.0	0.1	-0.3	-0.5	0.0	-0.4	0.0	3.2
East North Central	395	0.0	0.0	0.2	0.3	0.2	0.0	-0.3	0.0	3.6
East South Central	165	0.0	0.0	-0.1	-0.4	-0.8	0.0	-0.4	0.1	2.9
West North Central	157	0.0	0.0	0.0	-0.1	-0.4	0.0	-0.6	0.0	3.2

	No. of Hospitals[1] (1)	Quality Data Rate Difference[2] (2)	DRA MDH Provisions[3] (3)	FY 2007 Transitional 1/3 Cost 2/3 Charge Weights & DRG Changes[4] (4)	FY 2007 Wage Data[5] (5)	FY 2007 DRG, Rel. Wts. and Wage Index Changes[6] (6)	FY 2007 Wage Index Transition for Hospitals Moving from Urban to Rural[7] (7)	FY 2007 MGCRB Reclass-ifications[8] (8)	FY 2007 Out-Migration Adjustment[9] (9)	All FY 2007 Changes[10] (10)
West South Central	374	0.0	0.0	0.1	-0.5	-0.7	0.0	-0.5	0.0	3.0
Mountain	149	0.0	0.0	0.1	0.6	0.5	0.0	-0.2	0.0	4.3
Pacific	424	0.0	0.0	0.4	0.9	1.0	0.0	-0.4	0.1	4.5
Puerto Rico	53	0.0	0.0	0.2	-1.2	-1.3	0.0	-0.6	0.0	2.2
Rural by Region:										
New England	19	0.0	2.3	0.5	-0.4	0.0	0.0	2.0	0.1	5.6
Middle Atlantic	72	0.0	1.1	0.5	0.1	0.5	0.1	2.3	0.0	5.0
South Atlantic	176	-0.1	0.1	0.4	-0.3	-0.1	0.2	2.5	0.2	3.5
East North Central	125	0.0	0.5	0.2	-0.2	-0.2	0.1	1.8	0.0	3.8
East South Central	180	0.0	0.2	0.3	0.1	0.0	0.2	2.9	0.1	3.4
West North Central	116	0.0	0.7	0.2	0.0	0.0	0.0	2.2	0.1	4.0
West South Central	193	0.0	0.3	0.3	-0.4	-0.3	0.6	3.2	0.2	3.2
Mountain	81	-0.1	0.0	0.3	-0.4	-0.2	2.5	0.9	0.1	3.0
Pacific	43	0.0	0.2	0.3	0.1	0.3	0.0	2.2	0.1	3.7
By Payment Classification:										
Urban hospitals	2,608	0.0	0.0	0.2	0.1	0.0	0.0	-0.3	0.1	3.4
Large urban areas (populations over 1 million)	1,450	0.0	0.0	0.3	0.0	0.1	0.0	-0.4	0.0	3.5
Other urban areas (populations of 1 million or fewer)	1,158	0.0	0.0	0.0	0.2	-0.1	0.0	-0.1	0.1	3.3
Rural areas	987	0.0	0.5	0.3	-0.1	0.0	0.3	2.3	0.1	3.8
Teaching Status:										
Nonteaching	2,511	0.0	0.1	0.4	0.1	0.2	0.0	0.3	0.1	3.8
Fewer than 100 residents	843	0.0	0.0	0.1	0.0	-0.1	0.0	-0.1	0.0	3.3
100 or more residents	241	0.0	0.0	0.0	0.1	-0.1	0.0	-0.3	0.0	3.0
Urban DSH:										
Non-DSH	906	0.0	0.1	0.2	0.1	0.0	0.0	-0.1	0.0	3.6
100 or more beds	1,520	0.0	0.0	0.2	0.1	0.0	0.0	-0.3	0.1	3.4
Less than 100 beds	347	-0.1	0.1	0.6	0.2	0.5	0.0	-0.3	0.0	3.9

	No. of Hospitals[1] (1)	Quality Data Rate Difference[2] (2)	DRA MDH Provisions[3] (3)	FY 2007 Transitional 1/3 Cost 2/3 Charge Weights & DRG Changes[4] (4)	FY 2007 Wage Data[5] (5)	FY 2007 DRG, Rel. Wts. and Wage Index Changes[6] (6)	FY 2007 Wage Index Transition for Hospitals Moving from Urban to Rural[7] (7)	FY 2007 MGCRB Reclassifications[8] (8)	FY 2007 Out-Migration Adjustment[9] (9)	All FY 2007 Changes[10] (10)
Rural DSH:										
SCH	385	-0.1	0.9	0.3	-0.2	0.0	0.3	0.8	0.1	4.2
RRC	199	0.0	0.1	0.2	-0.1	-0.1	0.2	3.8	0.0	3.3
Other Rural:										
100 or more beds	55	0.0	0.0	0.6	-0.1	0.2	1.1	1.0	0.2	3.2
Less than 100 beds	183	-0.1	0.0	0.6	-0.2	0.0	0.5	1.1	0.3	3.4
Urban teaching and DSH:										
Both teaching and DSH	815	0.0	0.0	0.1	0.0	-0.1	0.0	-0.4	0.0	3.2
Teaching and no DSH	201	0.0	0.0	0.1	0.2	0.0	0.0	-0.1	0.1	3.3
No teaching and DSH	1,052	0.0	0.0	0.4	0.2	0.3	0.0	-0.2	0.1	3.8
No teaching and no DSH	540	0.0	0.0	0.2	0.1	0.0	0.0	-0.3	0.0	3.6
Special Hospital Types:										
RRC	187	0.0	0.0	0.1	0.1	-0.1	0.2	3.4	0.1	3.4
SCH	376	0.0	0.0	0.2	-0.2	0.0	0.3	0.5	0.1	3.4
MDH	146	-0.1	4.7	0.5	-0.2	0.2	0.0	0.8	0.1	8.2
SCH and RRC	98	0.0	0.0	0.1	-0.2	-0.3	0.0	2.3	0.0	3.2
MDH and RRC	8	0.0	11.5	0.3	-0.2	0.2	0.0	1.1	0.0	13.1
Type of Ownership:										
Voluntary	2,102	0.0	0.0	0.2	0.1	0.0	0.0	0.0	0.1	3.4
Proprietary	880	0.0	0.0	0.3	-0.1	-0.1	0.1	0.0	0.0	3.6
Government	603	0.0	0.1	0.2	0.0	0.0	0.0	0.1	0.1	3.5
Unknown	10	0.0	0.0	2.2	0.1	1.9	0.0	-0.2	0.2	7.7
Medicare Utilization as a Percent of Inpatient Days:										
0-25	243	0.0	0.0	0.5	0.2	0.5	0.0	-0.3	0.0	4.0
25-50	1,328	0.0	0.0	0.2	0.1	-0.1	0.0	-0.4	0.0	3.3
50-65	1,478	0.0	0.1	0.2	0.1	0.0	0.0	0.4	0.1	3.5
Over 65	462	0.0	0.3	0.1	-0.1	-0.2	0.0	0.6	0.1	3.6
Unknown	84	0.0	0.0	0.9	-0.2	0.4	0.0	-0.5	0.1	4.6

	No. of Hospitals[1] (1)	Quality Data Rate Difference[2] (2)	DRA MDH Provisions[3] (3)	FY 2007 Transitional 1/3 Cost 2/3 Charge Weights & DRG Changes[4] (4)	FY 2007 Wage Data[5] (5)	FY 2007 DRG, Rel. Wts. and Wage Index Changes[6] (6)	FY 2007 Wage Index Transition for Hospitals Moving from Urban to Rural[7] (7)	FY 2007 MGCRB Reclassifications[8] (8)	FY 2007 Out-Migration Adjustment[9] (9)	All FY 2007 Changes[10] (10)
Urban Hospitals Reclassified by the Medicare Geographic Classification Review Board: First Half FY 2007 Reclassifications:	325	0.0	0.0	0.2	0.3	0.2	0.0	2.1	0.0	3.6
Urban Nonreclassified, First Half FY 2007:	2,240	0.0	0.0	0.2	0.1	0.0	0.0	-0.6	0.1	3.4
All Urban Hospitals Reclassified Second Half FY 2007:	385	0.0	0.0	0.2	0.2	0.2	0.0	1.6	0.0	3.4
Urban Nonreclassified Hospitals Second Half FY 2007:	2,180	0.0	0.0	0.2	0.1	0.0	0.0	-0.7	0.1	3.4
All Rural Hospitals Reclassified Full Year FY 2007:	375	0.0	0.4	0.2	-0.1	-0.1	0.1	4.0	0.0	3.5
Rural Nonreclassified Hospitals Full Year FY 2007:	569	-0.1	0.5	0.5	-0.2	0.1	0.7	-0.4	0.3	4.0
All Section 401 Reclassified Hospitals:	33	0.0	1.2	0.2	0.1	0.3	0.0	0.2	0.0	5.3
Other Reclassified Hospitals (Section 1886(d)(8)(B))	60	-0.1	0.6	0.6	-0.1	0.3	0.0	3.5	0.0	4.4
Section 508 Hospitals	95	0.0	0.0	0.2	0.1	0.0	0.0	-0.3	0.1	1.7
Specialty Hospitals										
Cardiac specialty Hospitals	21	-0.1	0.0	-2.0	-0.1	-2.4	0.0	-0.6	0.0	1.2

[1] Because data necessary to classify some hospitals by category were missing, the total number of hospitals in each category may not equal the national total. Discharge data are from FY 2005, and hospital cost report data are from reporting periods beginning in FY 2004 and FY 2003.

[2] This column displays the payment impact for hospitals that either did not submit quality update information or failed the validation requirements in FY 2006. At this time, information is not available to us about whether hospitals will meet the requirements for the full hospital market basket increase for FY 2007. In the absence of these data, we are simulating rates for FY 2007 using the same list of hospitals that did not meet the requirements for the full hospital market basket increase in FY 2006.

[3] This column displays the impact of the Deficit Reduction Act section 5003 that apply to Medicare Dependent Hospitals.

[4] This column displays the **tentative** payment impact of the changes to the V24 GROUPER and the recalibration of the DRG HSRVcc weights based on FY 2005 MedPAR data in accordance with section 1886(d)(4)(C)(iii) of the Act.

[5] This column displays the tentative payment impact of updating the wage index data with no occupational mix adjustment applied to the FY 2003 cost report data.

[6] This column displays the tentative payment impact of the budget neutrality factor for DRG and wage index changes (no occupational mix adjustment applied to the wage index) data in accordance with section 1886(d)(4)(C)(iii) of the Act and section 1886(d)(3)(E) of the Act.

[7] Shown here are the tentative effects of providing rural hospitals formerly located in urban areas with urban wage index values in FY 2007. The effects reflected here are budget neutral: this column therefore includes the effect of the 0.999605 adjustment that we have applied to the rates to ensure budget neutrality.

[8] Shown here are the tentative effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB). The effects demonstrate the FY 2007 payment impact of going from no reclassifications to the reclassifications scheduled to be in effect for FY 2007. Reclassification for prior years has no bearing on the payment impacts shown here. This column reflects the geographic budget neutrality factor of 0.991850.

[9] This column displays the tentative impact of the FY 2007 implementation of section 505 of Pub. L. 108-173, which provides for an increase in a hospital's wage index if the hospital qualifies by meeting a threshold percentage of residents of the county where the hospital is located who commute to work at hospitals in counties with higher wage indexes.

[10] This column shows tentative changes in payments from FY 2006 to FY 2007. It incorporates all of the changes displayed in Columns 3, 4, 7, 8, and 9 (the changes displayed in Columns 5 and 6 are included in Column 7). It also reflects the impact of the FY 2007 update, changes in hospitals' reclassification status in FY 2007 compared to FY 2006, and the changes in payments as a result of continuing the reclassifications under section 508 of Pub. L. 108-173. The sum of these impacts may be different from the percentage changes shown here due to rounding and interactive effect.

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

Column 2 of Table I shows the effect of assigning a reduced update to the standardized amount to hospitals that either fail to submit quality data or fail the data validation requirements. This column shows the effect of paying these providers based on an update of market basket, less 2.0 percentage points (1.4 percent) relative to a full market basket update (3.4 percent), for FY 2007. There are 117 hospitals in this analysis that did not receive the full market basket update for FY 2006. Most of these hospitals are either small rural or small urban hospitals. For purposes of simulation only, we used these same hospitals to simulate the effects on IPPS payments receiving a reduced FY 2007 update. However, at this time, information is not available to determine the hospitals that do not meet the requirements for the full hospital market increase for FY 2007. If the same hospitals were to fail to meet the requirements for the full market basket rate-of-increase for FY 2007 as in FY 2006, we project that hospitals in the small urban and rural hospital categories (0–99 beds) will receive an overall decrease in payments of 0.1 percent.

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

In Column 3 of Table I, we show the effects of implementing section 5003 of Pub. L. 109–171 for MDHs. Section 5003(b) requires MDHs to rebase their hospital-specific rate to the FY 2002 cost reporting period, if doing so increases their target amount. Section 5003(c) increases the hospital-specific payment amount from the Federal rate plus 50 percent of the difference between the Federal rate and the hospital-specific amount (presuming the hospital-specific amount exceeds the Federal amount) to the Federal rate plus 75 percent of the difference. In addition, MDHs are no longer subject to the 12-percent cap on their DSH payments, effective FY 2007.

This column compares the FY 2007 payment rates under the section 5003 provisions to payments under the FY 2006 MDH provisions. (The MDH provisions were set to expire at the end of FY 2006 but were extended by section 5003(a)(1).) Overall, hospitals experience a 0.1 percent increase. This is primarily due to the substantial increase in payments to MDH providers; MDH providers experience a 4.7 percent increase, while MDH/RRC combination providers experience an 11.5 percent increase.

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

In Column 4 of Table I, we present the combined effects of the DRG reclassifications and recalibration, as discussed in section II. of the preamble to this final rule. Section 1886(d)(4)(C)(i) of the Act requires us annually to make appropriate classification changes in order to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources.

As discussed in the preamble of this final rule, we are changing the relative weight calculation methodology from a charge-based method to a cost-based method. Further, we are implementing the new methodology under a 3-year transition such that weights in FY 2007 are ⅓ cost-based and ⅔ charge-based. In this column, we compare aggregate payments using the FY 2007 blended relative weights(GROUPER Version 24) to the FY 2006 DRG relative charge weights (GROUPER Version 23.0) so the percentages shown here illustrate the effect of changes to the DRGs and relative weights. The method of calculating the relative weights and the reclassification changes to the GROUPER are described in more detail in section II. of the preamble to this final rule. We note that, consistent with section 1886(d)(4)(C)(iii) of the Act, we have applied a budget neutrality factor to ensure that the overall payment impact of the DRG changes (combined with the wage index changes) is budget neutral. This tentative budget neutrality factor of 0.997968 is applied to payments in Column 6 and not Column 4 because it is a combined DRG reclassification and recalibration and wage index budget neutrality factor.

In general, surgical DRGs tend to have charges concentrated in ancillary cost center groups while medical DRGs tend to have charges concentrated in routine or intensive care unit (ICU) cost center groups. As discussed in the preamble of this final rule, the CCRs for ancillary cost center groups are lower than the cost to charge ratios for routine and ICU cost center groups, indicating that the charge markups for ancillary services are higher. Because the standardized cost-based relative weight methodology adjusts the weights to remove differential mark-ups in charges, the FY 2007 cost-based weights are redistributed among medical and surgical DRGs, which will result in a redistribution of payments among hospitals according to the types of cases they provide. For instance, hospitals that perform more surgical procedures are likely to experience decreases in payments while hospitals with heavy concentrations of medical DRGs are expected to experience increases in payments. Hospitals with a case-mix that is equal to average will see little or no change in payment.

Due to the fact that we significantly modified our proposal and are adopting cost weights without the hospital-specific portion of the methodology, the impacts for the final rule are much smaller than those we proposed. The payment impacts are further moderated because we are implementing the change to the relative weights over a 3-year transition period. Therefore, the impacts shown in this column are generally smaller than those for the proposed rule. Rural DSH hospitals with less than 100 beds and small rural hospitals (0–49 beds) have payment increases of 0.6 percent and 0.7 percent, respectively. Cardiac specialty hospitals experience the greatest decline in payments of 2.2 percent and rural hospitals with more than 200 beds and urban hospitals in the East South Central Region have the next largest decreases of 0.1 percent.

F. Effects of Wage Index Changes (Column 5)

Section 1886(d)(3)(E) of the Act requires that, beginning October 1, 1993, we annually update the wage data used to calculate the wage index. In accordance with this requirement, the wage index for FY 2007 is based on data submitted for hospital cost reporting periods beginning on or after October 1, 2002 and before October 1, 2003. However, we note that this impact is calculated on wage data with no occupational mix adjustment due to the decision in *Bellevue Hosp. Center* v. *Leavitt*, in which the Court of Appeals for the Second Circuit ordered CMS to apply the occupational mix adjustment to 100 percent of the wage index effective for FY 2007 (see section III.C. of this final rule for more details of this Court decision). Because the effects of the wage index data are dependent, in part, upon the occupational mix adjusted wage index, and due to the short timeframe for implementing the Court's order, we are not able to provide the final occupational mix adjusted wage data impacts with this FY 2007 IPPS final rule. We will include the FY 2007 occupational mix adjusted wage index and related impacts in a separate **Federal Register** notice to be published prior to October 1, 2006. We believe these procedures comply with section 1886(d)(6) of the Act because, by August 1, we will have described our data and methods for calculating the wage index and IPPS rates in this FY 2007 IPPS final rule, but the actual impacts concerning the wage index will not be issued until a later date.

The estimated impact of the new wage data (with no occupational mix applied) on hospital payments is isolated in Column 5 by holding the other payment parameters constant in this simulation. That is, Column 5 shows the percentage changes in payments when going from a model using the FY 2006 wage index, based on FY 2002 wage data and having a 10-percent occupational mix adjustment applied, to a model using the FY 2007 pre-reclassification wage index, based on FY 2003 wage data with no occupational mix applied. The wage data collected on the FY 2003 cost report are the same as the FY 2002 wage data that were used to calculate the FY 2006 wage index. The impacts shown in Column 5 are likely to change with the application of the occupational mix adjustment to 100 percent of the wage index. The final impacts will be shown and discussed in a subsequent **Federal Register** notice to be published prior to October 1, 2006.

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

Section 1886(d)(4)(C)(iii) of the Act requires that changes to DRG reclassifications and the relative weights cannot increase or decrease aggregate payments. In addition, section 1886(d)(3)(E) of the Act specifies that any updates or adjustments to the wage index are to be budget neutral. As noted in the Addendum to this final rule, in determining the budget neutrality factor, we equated simulated aggregate payments for FY 2006 and FY 2007 using the FY 2005 Medicare utilization data after applying the changes to

the DRG relative weights and the wage index. However, we note that the payment impact and budget neutrality factors are calculated by applying an occupational mix adjustment to 10 percent of the FY 2006 wage index and zero percent of the FY 2007 wage index due to the decision in *Bellevue Hosp. Center* v. *Leavitt*, as stated previously.

We computed a tentative wage and DRG recalibration budget neutrality factor of 0.997030. The 0.0 percent impact for all hospitals demonstrates that these changes, in combination with the budget neutrality factor, are budget neutral. In Table I, the combined overall impacts of the effects of both the DRG reclassifications and the updated wage index are shown in Column 6. The changes in this column are the sum of the changes in Columns 4 and 5, combined with the budget neutrality factor for the wage index, including the wage index floor for urban areas required by section 4410 of Pub. L. 105–33. There also may be some variation of plus or minus 0.1 percentage point due to rounding.

Currently, we project that large urban hospitals will show a 0.1 percent increase, other urban hospitals will experience a 0.1 percent decrease, and rural hospitals will not be affected. We are not able to provide the final DRG and wage index budget neutrality impacts with this FY 2007 IPPS final rule due to the short timeframes for implementing the Court's order for implementation of the occupational mix adjustment. However, we will recalculate the budget neutrality factor to include the effects of the 100 percent occupational mix adjustment when the data become available, and we will publish updated payment impacts in a subsequent **Federal Register** notice document prior to October 1, 2006.

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

To help alleviate the decreased payments for urban hospitals that became rural under the new labor market area definitions, for purposes of the wage index, we adopted a policy in FY 2005 to allow them to maintain the wage index assignment of the MSA where they were located for the 3-year period FY 2005, FY 2006, and FY 2007. Column 7 shows the impact of the remaining labor market area transition, for those hospitals that were urban under the old labor market area designations and are now considered rural hospitals. Section 1886(d)(3)(E) of the Act specifies that any updates or adjustments to the wage index are to be budget neutral. Therefore, we applied a tentative adjustment of 0.999605 to ensure that the effects of reclassification are budget neutral as indicated by the zero effect on payments to hospitals overall. However, we note that this budget neutrality factor and this impact are both calculated using FY 2007 wage data with no occupational mix adjustment due to the decision in *Bellevue Hosp. Center* v. *Leavitt*. We are not able to provide the final urban to rural hold harmless budget neutrality impacts with this FY 2007 IPPS final rule. This information will also be include in a separate **Federal Register** notice to be published prior to October 1, 2006. Currently, the rural hospital row shows a 0.3 percent benefit from this provision as these hold harmless hospitals are now considered geographically rural.

I. Effects of MGCRB Reclassifications (Column 8)

Our impact analysis to this point has assumed hospitals are paid on the basis of their actual geographic location (with the exception of ongoing policies that provide that certain hospitals receive payments on other bases than where they are geographically located, such as hospitals in rural counties that are deemed urban under section 1886(d)(8)(B) of the Act). The changes in Column 8 reflect the per case payment impact of moving from this baseline to a simulation incorporating the MGCRB decisions for FY 2007 which affect hospitals' wage index area assignments.

By February 28 of each year, the MGCRB makes reclassification determinations that will be effective for the next fiscal year, which begins on October 1. The MGCRB may approve a hospital's reclassification request for the purpose of using another area's wage index value. The FY 2007 wage index values incorporate all of the MGCRB's reclassification decisions for FY 2007. The wage index values also reflect any decisions made by the CMS Administrator through the appeals and review process through February 28, 2006.

For FY 2007, as stated in the FY 2006 IPPS final rule (70 FR 47382, August 12, 2005), we established procedural rules under section 1886(d)(10)(D)(v) of the Act to address specific circumstances where individual and group reclassifications involve a section 508 hospital. The rules were designed to recognize the special circumstances of section 508 hospital reclassifications ending mid-year during FY 2007 and were intended to allow previously approved reclassifications to continue through March 31, 2007, and new section 1886(d)(10) reclassifications to begin April 1, 2007, upon the conclusion of the section 508 reclassifications. Under these procedural rules, some section 1886(d)(10) hospital reclassifications are only in effect for the second half of the fiscal year.

The first and second half fiscal year section 1886(d)(10) reclassifications permitted under these procedural rules have implications for the calculation of the reclassified wage indices and the reclassification budget neutrality factor. Section 1886(d)(8)(c) of the Act provides requirements for determining the wage index values for hospitals that were reclassified as a result of the MGCRB decisions under 1886(d)(10) of the Act. As provided in the statute, we are required to calculate a separate wage index for hospitals reclassified to an area if including the wage data for the reclassified hospitals would reduce the area wage index by more than 1 percent.

Because of the half-year reclassifications permitted under the procedural rules, in this final rule, we are issuing two separate wage indexes for affected areas (one effective from October 1, 2006, through March 31, 2007 and a second reclassified wage index effective April 1, 2007, through September 30, 2007). The FY 2007 wage index values are calculated based on the wage data for hospitals reclassified to the area in the respective half of the fiscal year. The impact of this policy is modeled in Column 8 of Table I above.

The overall effect of geographic reclassification is required by section 1886(d)(8)(D) of the Act to be budget neutral. In this final rule, we are calculating one budget neutrality adjustment that reflects the average of the adjustments required for first and second half fiscal year reclassifications, respectively. Therefore, we applied a tentative adjustment of 0.991850 to ensure that the effects of the section 1886(d)(10) reclassifications are budget neutral. (See section II.A. of the Addendum to this final rule.) However, we note that this budget neutrality factor and this impact are both calculated using wage adjustment applied due to the decision in *Bellevue Hosp. Center* v. *Leavitt*. As noted earlier, CMS will apply a reclassification decision for FY 2007 on behalf of hospitals to give them the highest wage index. Hospitals will then have 30 days from the date of public display of the separate notice to be published prior to October 1, 2006 at the Office of the Federal Register to revise the decision that CMS made on their behalf. We are unable to state with certainty that all of the reclassified providers shown in Table 9A in the Addendum to this final rule will retain their approved reclassifications for FY 2007 once the final occupational mix adjusted wage indices are known. We will include the FY 2007 occupational mix adjusted wage index related impacts and our reclassification decisions made on behalf of hospitals in a separate **Federal Register** notice document to be published prior to October 1, 2006.

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

Section 1886(d)(13) of the Act, as added by section 505 of Pub. L. 108–173, provides for an increase in the wage index for hospitals located in certain counties that have a relatively high percentage of hospital employees who reside in the county, but work in a different area with a higher wage index. Hospitals located in counties that qualify for the payment adjustment are to receive an increase in the wage index that is equal to a weighted average of the difference between the wage index of the resident county and the higher wage index work area(s), weighted by the overall percentage of workers who are employed in an area with a higher wage index. We note that this impact is based on the section 505 wage index adjustments in place as of FY 2006. As the FY 2007 adjustments must be calculated using wage data with an occupational mix adjustment and because we do not yet have these data due to the decision in *Bellevue Hosp. Center* v. *Leavitt*, we were unable to assess whether any new counties would qualify for section 505 adjustments for FY 2007 prior to the publication of this final rule. In the notice that we publish in the

Federal Register notice prior to October 1, 2006, we will show any new counties that qualify for the section 505 adjustment for FY 2007 and any related impacts that result from application of the out-migration adjustment to the revised occupational mix adjusted wage indices.

K. Effects of All Changes (Column 10)

Column 10 compares our estimate of payments per case between FY 2006 and FY 2007, incorporating all changes reflected in this final rule for FY 2007 (including statutory changes). This column includes all of the policy changes. We note that this impact is calculated using standardized amounts, outlier estimates, and budget neutrality factors based on wage data with no occupational mix adjustment applied due to the decision in *Bellevue Hosp. Center* v. *Leavitt*.

Currently, Column 10 reflects the impact of all FY 2007 changes (other than the final occupational mix adjusted wage indices) relative to FY 2006, including those shown in Columns 2 through 9 as well as other factors that are not applied until the final rates are calculated. The average increase for all hospitals is approximately 3.5 percent. This increase includes the effects of the 3.4 percent market basket update. It also reflects the 0.5 percentage point difference between the projected outlier payments in FY 2006 (5.1 percent of total DRG payments) and the current estimate of the percentage of actual outlier payments in FY 2006 (4.6 percent), as described in the introduction to this Appendix and the Addendum to this final rule. As a result, payments are projected to be 0.5 percentage points lower in FY 2006 than originally estimated, resulting in a 0.5 percentage point greater increase for FY 2007 than would otherwise occur. In addition, the impact of section 505 adjustments accounted for a 0.1 percent increase. Indirect medical education formula changes for teaching hospitals under section 502 of Pub. L. 108–173, changes in payments due to the difference between the FY 2006 and FY 2007 wage index values assigned to providers reclassified under section 508 of Pub. L. 108–173, and changes in the incremental increase in payments from section 505 of Pub. L. 108–173 out-migration adjustments account for the remaining −0.6 percent.

There might also be interactive effects among the various factors comprising the payment system that we are not able to isolate. For these reasons, the values in Column 10 may not equal the product of the percentage changes described above.

The overall change in payments per case for hospitals in FY 2007 would increase by 3.5 percent. Hospitals in urban areas would experience a 3.4 percent increase in payments per case compared to FY 2006. Hospitals in large urban areas would experience a 3.5 percent increase in payments and hospitals in other urban areas would experience a 3.3 percent increase in payments. Hospitals in rural areas, meanwhile, would experience a 3.7 percent payment increase.

Among urban census divisions, the largest payment increases would be 4.5 percent in the Pacific region and 4.3 percent in the Mountain region. The smallest urban increase is 2.2 percent in Puerto Rico.

Among rural regions in Column 10, no hospital category would experience overall payment decreases. The New England and Middle Atlantic regions would benefit the most, with 5.6 and 5 percent increases, respectively. The smallest increase would occur in the Mountain region, with a 3.0 percent increases in payments.

Among special categories of rural hospitals in Column 10, MDH/RRC providers receive an increase in payments of 11.5 percent and MDH providers receive an increase of 4.7 percent, primarily due to the changes to MDH payments set forth in section 5003 of Pub. L. 109–171.

Urban hospitals reclassified for the first half of FY 2007 are anticipated to receive an increase of 3.6 percent, while urban hospitals that reclassified for the second half of FY 2007 are expected to receive an increase of 3.4 percent. The same set of rural hospitals is reclassified for the first and second half of FY 2007. Rural hospitals reclassifying for the entire year of FY 2007 are anticipated to receive a 3.5 percent payment increase. Those hospitals located in rural counties, but deemed to be urban under section 1886(d)(8)(B) of the Act are expected to receive an increase in payments of 4.4 percent. Hospitals that were reclassified under section 508 of Pub. L. 108–173, which is only effective through March 31, 2007, are expected to receive an increase of 1.7 percent. This lower estimated increase in payment is due to the expiration of the higher section 508 wage indices in effect for 6 months of FY 2007. We caution that all of these impacts will be revised prior to October 1, 2006 when the occupational mix wage indices are calculated for FY 2007.

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

For FY 2007, we are continuing to apply the volume adjustment criteria we specified in the FY 2005 IPPS final rule (69 FR 49099). We expect that two providers would receive the low-volume adjustment for FY 2007. We included these additional payments to providers in the impact table shown above and we estimate the impact of these providers receiving the additional 25-percent payment increase to be approximately $89,000.

M. Impact Analysis of Table II

Table II presents the projected impact of the changes for FY 2007 for urban and rural hospitals and for the different categories of hospitals shown in Table I. It compares the estimated payments per case for FY 2006 with the average estimated per case payments for FY 2007, as calculated under our models. Thus, this table presents, in terms of the average dollar amounts paid per discharge, the combined effects of the changes presented in Table I. The percentage changes shown in the last column of Table II equal the percentage changes in average payments from Column 10 of Table I.

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TABLE II.--IMPACT ANALYSIS OF CHANGES FOR FY 2007
OPERATING PROSPECTIVE PAYMENT SYSTEM
(PAYMENTS PER CASE)

	Number of Hospitals (1)	Average FY 2006 Payment Per Case[1] (2)	Average FY 2007 Payment Per Case[1] (3)	All FY 2007 Changes (4)
All hospitals	3,595	8,535	8,830	3.5
By Geographic Location:				
Urban hospitals	2,590	8,950	9,256	3.4
Large urban areas (populations over 1 million)	1,441	9,367	9,699	3.5
Other urban areas (populations of 1 million or fewer)	1,149	8,443	8,719	3.3
Rural hospitals	1,005	6,206	6,437	3.7
Bed Size (Urban):				
0-99 beds	651	6,727	6,968	3.6
100-199 beds	867	7,489	7,774	3.8
200-299 beds	492	8,400	8,700	3.6
300-499 beds	413	9,405	9,720	3.3
500 or more beds	167	11,388	11,736	3.0
Bed Size (Rural):				
0-49 beds	348	5,196	5,413	4.2
50-99 beds	370	5,601	5,858	4.6
100-149 beds	174	6,182	6,391	3.4
150-199 beds	68	6,915	7,140	3.3
200 or more beds	45	7,870	8,102	2.9
Urban by Region:				
New England	128	9,388	9,660	2.9
Middle Atlantic	357	9,833	10,151	3.2
South Atlantic	388	8,476	8,746	3.2
East North Central	395	8,561	8,868	3.6
East South Central	165	8,209	8,449	2.9
West North Central	157	8,683	8,959	3.2
West South Central	374	8,447	8,703	3.0
Mountain	149	8,799	9,174	4.3
Pacific	424	10,741	11,228	4.5
Puerto Rico	53	4,190	4,281	2.2
Rural by Region:				
New England	19	8,092	8,548	5.6
Middle Atlantic	72	6,254	6,567	5.0
South Atlantic	176	6,023	6,233	3.5
East North Central	125	6,415	6,658	3.8
East South Central	180	5,969	6,172	3.4
West North Central	116	6,392	6,648	4.0
West South Central	193	5,660	5,839	3.2
Mountain	81	6,554	6,749	3.0
Pacific	43	7,567	7,850	3.7
By Payment Classification:				
Urban hospitals	2,608	8,938	9,243	3.4
Large urban areas (populations over 1 million)	1,450	9,355	9,686	3.5
Other urban areas (populations of 1 million or fewer)	1,158	8,429	8,703	3.3
Rural areas	987	6,255	6,492	3.8
Teaching Status:				
Non-teaching	2,511	7,118	7,388	3.8
Fewer than 100 Residents	843	8,636	8,924	3.3
100 or more Residents	241	12,605	12,988	3.0
Urban DSH:				
Non-DSH	906	7,719	7,994	3.6
100 or more beds	1,520	9,423	9,743	3.4
Less than 100 beds	347	6,154	6,395	3.9
Rural DSH:				
SCH	385	5,779	6,021	4.2
RRC	199	6,935	7,164	3.3
Other Rural:				
100 or more beds	55	5,737	5,920	3.2
Less than 100 beds	183	5,104	5,279	3.4
Urban teaching and DSH:				
Both teaching and DSH	815	10,366	10,699	3.2
Teaching and no DSH	201	8,599	8,881	3.3
No teaching and DSH	1,052	7,614	7,904	3.8
No teaching and no DSH	540	7,282	7,545	3.6
Rural Hospital Types:				
RRC	187	7,277	7,523	3.4
SCH	376	6,161	6,370	3.4

	Number of Hospitals (1)	Average FY 2006 Payment Per Case[1] (2)	Average FY 2007 Payment Per Case[1] (3)	All FY 2007 Changes (4)
MDH	146	5,171	5,594	8.2
SCH and RRC	98	7,350	7,584	3.2
MDH and RRC	8	6,397	7,234	13.1
Unknown				
Type of Ownership:				
Voluntary	2,102	8,676	8,972	3.4
Proprietary	880	7,711	7,987	3.6
Government	603	8,772	9,081	3.5
Unknown	10	13,196	14,214	7.7
Medicare Utilization as a Percent of Inpatient Days:				
0-25	243	12,181	12,663	4.0
25-50	1,328	9,737	10,061	3.3
50-65	1,478	7,432	7,696	3.5
Over 65	462	6,650	6,887	3.6
Unknown	84	9,920	10,374	4.6
Hospitals Reclassified by the Medicare Geographic Classification Review Board: FY 2005 Reclassifications:				
Urban Hospitals Reclassified by the Medicare Geographic Classification Review Board: First Half FY 2007 Reclassifications:	325	8,736	9,051	3.6
Urban Nonreclassified, First Half FY 2007:	2,240	8,993	9,298	3.4
All Urban Hospitals Reclassified Second Half FY 2007:	385	8,954	9,259	3.4
Urban Nonreclassified Hospitals Second Half FY 2007:	2,180	8,961	9,267	3.4
All Rural Hospitals Reclassified Second Half FY 2007:	375	6,730	6,967	3.5
Rural Nonreclassified Hospitals Second Half FY 2007:	569	5,519	5,739	4.0
All Section 401 Reclassified Hospitals:	33	6,968	7,336	5.3
Other Reclassified Hospitals (Section 1886(d)(8)(B))	60	5,909	6,168	4.4
Section 508 Hospitals	95	9,309	9,471	1.7
Specialty Hospitals				
Cardiac Specialty Hospitals	21	11,363	11,502	1.2

[1] These payment amounts per case do not reflect any estimates of annual case-mix increase.

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VII. Effects of Other Policy Changes

In addition to those policy changes discussed above that we are able to model using our IPPS payment simulation model, we are making various other changes in this final rule. Generally, we have limited or no specific data available with which to estimate the impacts of these changes. Our estimates of the likely impacts associated with these other changes are discussed below.

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

In section II.F. of the preamble to this final rule, we discuss the changes in the LTC–DRG relative weights for FY 2007, which are based on the Version 24.0 of the CMS GROUPER (including the changes in the classifications, relative weights and geometric mean length of stay for each LTC–DRG). As also discussed in that same section of this final rule, currently, there is no statutory or regulatory requirement that the annual update to the LTC–DRG classifications and relative weights be done in a budget neutral manner. As discussed above in section II.F. of the preamble of this final rule, the LTCH PPS is still in the midst of a transition from a reasonable cost-based payment system to fully Federal PPS payments, during which time LTCH treatment patterns and coding practices, which are reflected in the LTCH claims data, appear to continue to change as LTCHs adapt to this new payment system.

The LTCH PPS was implemented for cost reporting periods beginning on or after October 1, 2002 (FY 2003). Therefore, the FY 2005 MedPAR data used to compute the FY 2007 LTC–DRG relative weights in this final rule are based on LTCH claims data taken from only the second full year of the LTCH PPS. Based on LTCH cases in the March 2006 update of the FY 2005 MedPAR files, we estimate that the changes to the LTC–DRG classifications and relative weights for FY 2007 would result in an aggregate decrease in LTCH PPS payments of approximately 1.3 percent based on the data from the 369 LTCHs in our database. (We note that this estimated aggregate decrease in LTCH PPS payments of approximately 1.3 percent was determined based on the current payment

rates and policies established in the RY 2007 LTCH PPS final rule (71 FR 27798 through 27939) and the revised LTC–DRG classifications, relative weights and average lengths of stay established for FY 2007 in this final rule).

When we compared the GROUPER Version 23.0 (FY 2006) LTC–DRG relative weights to the GROUPER Version 24.0 (FY 2007) LTC–DRG relative weights, we found that approximately 68 percent of the LTC–DRGs would have a higher relative weight under Version 23.0, while the remaining approximately 32 percent of the LTC–DRGs would have a higher relative weight under Version 24.0. We also found that, based on FY 2005 LTCH cases, the GROUPER Version 23.0 LTC–DRG relative weights were, on average, approximately 3.3 percent higher than the GROUPER Version 24.0 LTC–DRG relative weights. In addition, based on an analysis of the most recent available LTCH claims data from the FY 2005 MedPAR file, we continue to observe that the average LTC–DRG relative weight decreases due to an increase of relatively lower charge cases being assigned to LTC–DRGs with higher relative weights in the prior year.

Contributing to this increase in these relatively lower charge cases being assigned to LTC–DRGs with higher relative weights in the prior year are improvements in coding practices, which are typical when moving from a reasonable cost-based payment system to a PPS. The impact of including additional cases with relatively lower charges into LTC–DRGs that had a relatively higher relative weight in the GROUPER Version 23.0 (FY 2006) is a decrease in the average relative weight for those LTC–DRGs in the GROUPER Version 24.0. As noted above in section II.F. of the preamble to this final rule, LTCHs are a specialized provider type that typically do not treat a broad spectrum of patients in their facilities with many different diagnoses. While there are 538 valid GROUPER Version 24.0 LTC–DRGs, 183 LTC–DRGs have no LTCH cases. In addition, another 180 LTC–DRGs are categorized as "low volume" (that is, have less than 25 cases annually). Consequently, only about 175 LTC–DRGs are used by most LTCHs on a "regular basis" (that is, nationally LTCHs discharge, in total, an average of 25 or more of these cases annually).

Of these 175 LTC–DRGs that are used on a "regular basis," we found that approximately 65 percent of the LTC–DRGs would have higher relative weights under GROUPER Version 23.0 in comparison to GROUPER Version 24.0, and the remaining 35 percent of the 175 LTC–DRGs that are used on a "regular basis" would have higher relative weights under GROUPER Version 24.0 in comparison to GROUPER Version 23.0. In addition, about 30 percent of the 175 LTC–DRGs that are used on a "regular basis" would experience a decrease in the average charge per case as compared to the average charge per case in that DRG based on FY 2004 data, which generally results in a lower relative weight. Moreover, of the 175 LTC–DRGs that are used on a "regular basis," approximately 62 percent of those LTC–DRGs would experience a change in the average charge per case from FY 2004 LTCH data as compared to FY 2005 LTCH data that is less than the increase in overall average LTCH charges across all LTC–DRGs from FY 2004 to FY 2005 of about 8.3 percent. Accordingly, those LTC–DRGs would also have a reduction in their relative weight as compared to the relative weight in FY 2006. For those LTC–DRGs in which the average charge within the LTC–DRG increase is less than 8.3 percent, the relative weights for those LTC–DRGs would decrease because the average charge for each of those LTC–DRGs is being divided by a larger number (that is, the average charge across all LTC–DRGs). For the reasons discussed above, we believe that the changes in the LTC–DRG relative weights for FY 2007, which include a significant number of LTC–DRGs with lower relative weights, would result in approximately a 1.3 percent decrease in estimated aggregate LTCH PPS payments.

B. Effects of New Technology Add-On Payments

In section II.G. of the preamble to this final rule, we discuss add-on payments for new medical services and technologies. As explained in that section, we are no longer required to ensure that any add-on payments for new technology under section 1886(d)(5)(K) of the Act are budget neutral. However, we are still providing an estimate of the payment increases here, as they will have an impact on total payments made in FY 2007. New technology add-on payments are limited to the lesser of 50 percent of the costs of the technology, or 50 percent of the costs in excess of the DRG payment for the case. Because it is difficult to predict the actual new technology add-on payment for each case, we are estimating the increase in payment for FY 2007 as if every claim with these add-on payments will receive the maximum add-on payment. As discussed in section II.G. of the preamble to this final rule, we are approving the X STOP Interspinous Process Decompression System for new technology add-on payments. As stated in the proposed rule, the applicant estimated that there would be a total of 2,124 patients (424 in DRG 499 and 1,700 in DRG 500) eligible to receive the device in FY 2007. Therefore, we estimate that payments for this technology will increase overall FY 2007 payments by $9.35 million.

In addition, we are continuing to make add-on payments in FY 2007 for two technologies that were approved for FY 2006 new technology add-on payments: Restore® Rechargeable Implantable Neurostimulator and GORE TAG. We estimate these payments for these technologies will increase overall FY 2007 payments by $6.01 million and $16.61 million, respectively.

The total increase in payments for these three new technologies, approximately $31.97 million, is not reflected in the tables.

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

In section IV.A. of the preamble to this final rule, we discuss new requirements for hospital reporting of quality data based on our continuing experience with this program and recent legislation. Section 5001(a) of Pub. L. 109–171 (DRA) sets out extensive new requirements for the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program. The RHQDAPU program was established to implement section 501(b) of Pub. L. 108–173 (MMA). Section 5001(a) of Pub. L. 109–171 revised the mechanism used to update the standardized amount for payment for hospital inpatient operating costs. New sections 1886(b)(3)(B)(viii)(I) and (II) of the Act provide that the payment update for FY 2007 and each subsequent fiscal year will be reduced by 2.0 percentage points for any "subsection (d) hospital" that does not submit certain quality data in a form and manner, and at a time, specified by the Secretary.

We have modeled the payment impact of this change in Table 1 of this Appendix, and discussed it in section VI. of this Appendix. We discuss other policy changes we are making to the RHQDAPU program in section IV.A. of the preamble to this final rule.

We also note that, for the FY 2007 payment update, hospitals must pass our validation requirement of a minimum of 80 percent reliability, based upon our chart-audit validation process, for the first three quarters of data from CY 2005. These data were due to the QIO Clinical Warehouse by July 15, 2005 (first quarter CY 2005 discharges), November 15, 2005 (second quarter CY 2005 discharges), and February 15, 2005 (third quarter CY 2005 discharges). We have continued our efforts to ensure that QIOs provide assistance to all hospitals that wish to submit data. In the preamble of this final rule, we are providing additional validation criteria to ensure that the quality data being sent to CMS are accurate. The requirement of 5 charts per hospital will result in approximately 19,000 charts per quarter total submitted to the agency. We reimburse hospitals for the cost of sending charts to the Clinical Data Abstraction Center (CDAC) at the rate of 12 cents per page for copying and approximately $4.00 per chart for postage. Our experience shows that the average chart received at the CDAC is approximately 140 pages. Thus, the agency will have expenditures of approximately $380,000 per quarter to collect the charts. Given that we reimburse for the data collection effort, we believe that a requirement for five charts per hospital per quarter represents a minimal burden to the participating hospital.

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

In section IV.C. of the preamble to this final rule, we discuss the payment changes for MDHs made by section 5003 of Pub. L. 109–171. We modeled the payment impact of these changes in Table 1 of this Appendix and discussed them in section VI. of this Appendix.

In addition, in section IV.C.2. of the preamble to this final rule, we discussed changes to the data source and methodology that we will use to compute the volume decrease adjustment for MDHs and SCHs. If certain requirements are met, this adjustment may be made if the hospital's total discharges

decrease by more than 5 percent from one cost reporting period to the next. We do not believe that these changes will have any significant impact on Medicare payment to these hospitals.

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

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

In section IV.H.2. of the preamble to this final rule, we discuss our changes related to determining the weighted average GME PRA for a merged teaching hospital. Our current policy is that when two or more teaching hospitals merge, we determine a weighted PRA for the surviving merged hospital using GME costs and resident data from the *base year cost report* for each teaching hospital in the merger. We are revising our policy to determine a merged teaching hospital's PRA by using PRA data and FTE resident data from *the most recent settled cost reports* of the merging hospitals, rather than using the direct GME cost data from the hospitals' base year cost report. This policy revision is administrative in nature, and we do not foresee that the revision will result in payment increases to merged teaching hospitals.

2. Determination of PRAs for New Teaching Hospitals

In section IV.H.3. of the preamble to this final rule, we discuss the methodology for determining the hospital-specific PRA for new teaching hospitals and we make a change to the existing regulations at § 413.77(e) in order to specify a base period for certain situations, that is, for new teaching hospitals that did not have residents on duty during the first month of the cost reporting period in which the hospital became a new teaching hospital. The base period for these hospitals would be the next cost reporting period following the cost reporting period where any residents were on duty at the new teaching hospital. Because this change is administrative in nature, we do not foresee that it will result in a financial impact for FY 2007.

3. Requirements for Counting and Appropriate Documentation of FTE Residents

In section IV.H.4. of the preamble to this final rule, we are clarifying the policies that apply in determining hospitals' FTE resident counts for Medicare GME payment purposes. Because this is a clarification of existing policy, there is no financial impact for FY 2007.

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

In section IV.H.5. of the preamble to this final rule, we are clarifying our policy that, with respect to residency training in nonhospital settings, only the time residents spend in patient care activities may be counted for purposes of direct GME and IME payments; and with respect to training in the hospital, residents training in all areas of the hospital complex may be counted for direct GME purposes, but may only be counted for IME purposes if the residents are furnishing patient care. Because we are clarifying existing policy, there is no financial impact of this clarification for FY 2007.

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

In section IV.J. of the preamble to this final rule, we discuss several policy changes under the EMTALA requirements. We are clarifying that any participating hospital with specialized capabilities or facilities, even if it does not have a dedicated emergency department, may not refuse to accept an appropriate transfer if the hospital has the capacity to treat the individual. We note that this proposed revision does not reflect any change in current CMS policy. We further note that the revision will not require hospitals without dedicated emergency departments to open dedicated emergency departments nor will it impose any EMTALA obligation on these hospitals with respect to individuals who come to the hospital as their initial point of entry into the medical system seeking a medical screening examination or treatment for a medical condition. Thus, there will be no impact on Medicare payment policies or practices.

In addition, we are modifying the definition of "labor" to state that a woman experiencing contractions is in true labor unless a physician, certified nurse-midwife, or other qualified medical person acting within his or her scope of practice as defined in hospital medical staff bylaws and State law, certifies that, after a reasonable time of observation, the woman is in false labor. The effect of this change will be to have a single, uniform policy on the personnel who are authorized to make a determination as to whether an individual has an emergency medical condition. This change will have a Medicare payment effect, if any, only on payments to physicians and nonphysician practitioners under the physician fee schedule. The amount of any impact will be negligible because only a very small number of Medicare beneficiaries are women of childbearing age.

G. Effects of Policy on Rural Community Hospital Demonstration Program

In section IV.L. of the preamble to this final rule, we discuss our implementation of section 410A of Pub. L. 108–173 that required the Secretary to establish a demonstration that will modify reimbursement for inpatient services for up to 15 small rural hospitals. Section 410A(c)(2) requires that "in conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented." As discussed in section IV.L. of the preamble to this final rule, we are satisfying this requirement by adjusting national IPPS rates by a factor that is sufficient to account for the added costs of this demonstration. We estimate that the average additional annual payment for FY 2007 that will be made to each participating hospital under the demonstration will be approximately $1,021,985. We based this estimate on the recent historical experience of the difference between inpatient cost and payment for hospitals that are participating in the demonstration. For the 9 participating hospitals, the total annual impact of the demonstration program is estimated to be $9,197,870. The adjustment factor to the Federal rate used in calculating Medicare inpatient prospective payments as a result of the demonstration is 0.999905.

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

In section VI.A.5. of the preamble to this final rule, we discuss our revision of the regulations for grandfathered HwHs, grandfathered hospital satellites and grandfathered satellite units at §§ 412.22(f), 412.22(h), and 412.25(e), respectively, to allow these facilities to increase or decrease their square footage or decrease the number of beds without jeopardizing their grandfathered status.

We estimate that there will be no net effect on the treatment of such hospitals as a result of this final rule. Payments to most HwHs and satellites are made on a prospective rate basis. For these facilities, our policy of allowing either increases or decreases in square footage would have no cost impact, since the prospective rates are not affected by a facility's changes in square footage. However, if grandfathered HwHs and satellites facilities were to decrease their number of beds, as provided by the policy revision that we are finalizing, the effect of this change will likely be a reduction in Medicare payments to such hospitals and satellite facilities because they will probably have fewer discharges.

A small number of grandfathered HwHs and satellite facilities, specifically children's and cancer hospitals and satellites of these facilities, are paid on a cost-related basis under the TEFRA system. Under that system, increases or decreases in square footage may cause corresponding increases or decreases in the costs on which payments to the facilities are based. However, any increases in costs caused by increased square footage may be offset by other factors. For example, under our policy a grandfathered HwH or satellite facility could reduce its number of beds and the decreased utilization flowing from this change may offset any added costs resulting from an increase in the square footage of a grandfathered hospital or satellite facility paid under the TEFRA system. Moreover, an increase in facility square footage to modernize a physical facility or to accommodate new equipment or technology may also result in improved efficiency, leading to reduced operating costs. The cost savings resulting from these increases in efficiency could also partially or entirely offset any cost increases. Because we cannot predict which grandfathered HwHs or satellite facilities will opt to increase or decrease their size or to decrease their bed numbers, we are unable to quantify the impact of these changes. (We are only aware of one cancer hospital and three children's hospitals that are HwHs.) However, overall we expect that there will be offsetting cost increases and reductions, with no net change in costs.

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

In section VI.A.6. of the preamble to this final rule, we discuss our revision and clarification of the existing policies governing the determination of LTCHs' CCRs and the reconciliation of high-cost and short-stay outlier payments under the LTCH PPS. Under the LTCH PPS high-cost outlier and short-stay outlier policies, CCRs are used to determine the estimated cost of the case by multiplying the LTCH's overall CCR by the Medicare allowable charges for the case.

In that section, specifically, we present a revision of our methodology for determining the annual LTCH CCR ceiling. Based on the most recent complete IPPS total CCR data, we are establishing a total CCR ceiling of 1.321 under the LTCH PPS effective October 1, 2006. This ceiling was determined based on the same data used to determine the separate IPPS operating CCR ceiling (1.26) and IPPS capital CCR ceiling (0.154). The LTCH CCR ceiling determined under our current "combined" methodology will result in a slightly higher LTCH CCR ceiling (that is, 1.26 + 0.154 = 1.414) for FY 2007 compared to the "total" CCR ceiling of 1.321 for FY 2007. However, we note that, based on the most recent complete IPPS and LTCH CCR data, there are no LTCHs that currently have a CCR that is greater than the ceiling of 1.321 (the highest LTCH CCR in the database of 392 LTCHs is 1.1277). Therefore, based on these data, because no LTCHs currently have a CCR that is in excess of the LTCH CCR ceiling we are establishing for FY 2007 in this final rule, we believe that there will be no significant impact on LTCH PPS payments based on this policy.

Also in section VI.A.6. of the preamble to this final rule, we discuss our revision of our methodology for determining the applicable statewide average LTCH CCRs. Based on the most recent complete IPPS total CCR data, the LTCH PPS statewide average CCRs that would be effective October 1, 2006, are presented in Table 8C of the Addendum to this final rule. A comparison of the statewide average total CCRs in Table 8C of the Addendum to this final rule to the "combined" statewide average CCRs that would be calculated under our existing methodology from the operating PPS statewide average CCRs in Table 8A of the Addendum to this final rule and the capital PPS statewide average CCRs in Table 8B of the Addendum to this final rule shows that the changes to our methodology for determining LTCH statewide average CCRs will result in minor changes in the average CCR for each state. In particular, the largest decrease in a statewide average CCR (with the exception of Maryland, which will be assigned the national average total CCR as discussed in section VI.A.6 of the preamble of this final rule) will be in urban Wyoming (-0.7 percent), and there is currently only one LTCH located in Wyoming. The largest increase in a statewide average CCR will be in urban District of Columbia (0.7 percent), and there are currently only two LTCHs located in the District of Columbia. Thus, we believe that the change in the methodology for determining the applicable statewide average LTCH CCRs established in this final rule will result in no significant impact on LTCH PPS payments.

In addition, in section VI.A.6 of the preamble of this final rule we discussed our codification in Subpart O of 42 CFR Part 412 the provisions governing the determination of LTCHs' CCRs and the reconciliation of high cost and short-stay outlier payments under the LTCH PPS, including modifications and editorial clarifications to our existing methodology. These changes are similar or almost identical (except for the minor clarifications and modifications) to our current policy governing the determination of LTCHs' CCRs and the reconciliation of high cost and short-stay outlier payments under the LTCH PPS, and therefore, there will be no expected impact if such policies were codified.

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

In section VII. of the preamble to this final rule, we discuss our clarification of our regulations regarding payment for Medicare services furnished outside the United States. The clarification revises references in our regulations that could be read to limit Medicare payment for certain services furnished outside the United States to services furnished in Canada or Mexico, contrary to the provisions of the Act. Only a small fraction of Medicare claims are paid as a result of services furnished outside of the United States. Moreover, we are unaware of any claims for payment that would otherwise satisfy the requirements under the Act that have not been paid due to the language in our current regulations. Therefore, because we are clarifying existing policy, this clarification has little or no financial impact for FY 2007.

K. Effects of Policy on Limitation on Payments to SNFs

In section IX. of the preamble to this final rule, we discuss the implementation of section 5004 of Pub. L. 109–171, which mandated that, for cost reporting periods beginning on or after October 1, 2005, Medicare payments to SNFs for certain otherwise allowable debt amounts attributable to the coinsurance amounts for patients who are not certain specified dual eligible individuals be reduced by 30 percent. We anticipate that the provisions of section 5004 of Pub. L. 109–171 will result in a savings to the Medicare program of $490 million over the 5-year period from FY 2006 to FY 2010.

L. Effects of Policy on CAP for Outpatient Drugs and Biologicals Under Part B for the Purpose of Calculating the Average Sales Price

We have reviewed the effects of the provisions of XII. of this final rule as required by Executive Order 12866, the RFA, section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995, and Executive Order 13132. We believe the change to the definition of "unit" will be beneficial to CAP drug vendors, as they will be able to exclude from the ASP calculation, for the initial 3-year contract period under the CAP, units of CAP drugs sold to an approved CAP vendor for use under the CAP drug program.

VIII. Impact of Changes in the Capital PPS

A. General Considerations

Fiscal year (FY) 2001 was the last year of the 10-year transition period established to phase in the PPS for hospital capital-related costs. During the transition period, hospitals were paid under one of two payment methodologies: fully prospective or hold harmless. Under the fully prospective methodology, hospitals were paid a blend of the capital Federal rate and their hospital-specific rate (see § 412.340). Under the hold-harmless methodology, unless a hospital elected payment based on 100 percent of the capital Federal rate, hospitals were paid 85 percent of reasonable costs for old capital costs (100 percent for SCHs) plus an amount for new capital costs based on a proportion of the capital Federal rate (see § 412.344). As we state in section V. of the preamble of this final rule, with the 10-year transition period ending with hospital cost reporting periods beginning on or after October 1, 2001 (FY 2002), beginning in FY 2002 capital prospective payment system payments for most hospitals are based solely on the capital Federal rate. Therefore, we no longer include information on obligated capital costs or projections of old capital costs and new capital costs, which were factors needed to calculate payments during the transition period, for our impact analysis.

In accordance with § 412.312, the basic methodology for determining a capital PPS payment is:

(Standard Federal Rate) × (DRG weight) × (Geographic Adjustment Factor (GAF)) × (Large Urban Add-on, if applicable) × (COLA for hospitals located in Alaska and Hawaii) × (1 + Disproportionate Share (DSH) Adjustment Factor + Indirect Medical Education (IME) Adjustment Factor, if applicable).

In addition, hospitals may also receive outlier payments for those cases that qualify under the threshold established for each fiscal year.

The data used in developing the impact analysis presented below are taken from the March 2006 update of the FY 2005 MedPAR file and the March 2006 update of the Provider-Specific File that is used for payment purposes. Although the analyses of the changes to the capital prospective payment system do not incorporate cost data, we used the March 2006 update of the most recently available hospital cost report data (FYs 2003 and 2004) to categorize hospitals. Our analysis has several qualifications. First, we do not make adjustments for behavioral changes that hospitals may adopt in response to policy changes. Second, due to the interdependent nature of the IPPS, it is very difficult to precisely quantify the impact associated with each change. Third, we draw upon various sources for the data used to categorize hospitals in the tables. In some cases (for instance, the number of beds), there is a fair degree of variation in the data from different sources. We have attempted to construct these variables with the best available sources overall. However, for

individual hospitals, some miscategorizations are possible.

Using cases from the March 2006 update of the FY 2005 MedPAR file, we simulated payments under the capital PPS for FY 2006 and FY 2007 for a comparison of total payments per case. Any short-term, acute care hospitals not paid under the general IPPS (Indian Health Service hospitals and hospitals in Maryland) are excluded from the simulations.

As we explain in section III.A. of the Addendum to this final rule, payments are no longer made under the regular exceptions provision under §§ 412.348(b) through (e). Therefore, we no longer use the actuarial capital cost model (described in Appendix B of the August 1, 2001 proposed rule (66 FR 40099)). We modeled payments for each hospital by multiplying the capital Federal rate by the GAF and the hospital's case-mix. We then added estimated payments for indirect medical education, disproportionate share, large urban add-on, and outliers, if applicable. For purposes of this impact analysis, the model includes the following assumptions:

- We estimate that the Medicare case-mix index will increase by 1.0 percent in both FYs 2006 and 2007.
- We estimate that the Medicare discharges will be 13.5 million in FY 2006 and 13.1 million in FY 2007 for a 3.0 percent decrease from FY 2006 to FY 2007.
- The capital Federal rate was updated beginning in FY 1996 by an analytical framework that considers changes in the prices associated with capital-related costs and adjustments to account for forecast error, changes in the case-mix index, allowable changes in intensity, and other factors. The FY 2007 update is 1.1 percent (see section III.A.1.of the Addendum to this final rule).
- In addition to the FY 2007 update factor, the tentative FY 2007 capital Federal rate was calculated based on a tentative GAF/DRG budget neutrality factor of 0.9994, a tentative outlier adjustment factor of 0.9568, and an exceptions adjustment factor of 0.9997.

B. Results

We used the actuarial model described above to estimate the potential impact of our changes for FY 2007 on total capital payments per case, using a universe of 3,595 hospitals. As described above, the individual hospital payment parameters are taken from the best available data, including the March 2006 update of the FY 2005 MedPAR file, the March 2006 update to the Provider-Specific File, and the most recent cost report data from the March 2006 update of HCRIS. In Table III, we present a comparison of total payments per case for FY 2006 compared to FY 2007 based on the FY 2007 payment policies. Column 2 shows estimates of payments per case under our model for FY 2006. Column 3 shows estimates of payments per case under our model for FY 2007. Column 4 shows the total percentage change in payments from FY 2006 to FY 2007. The change represented in Column 4 includes the 1.1 percent update to the capital Federal rate, a 0.0 percent increase in case-mix, changes in the adjustments to the capital Federal rate (for example, the effect of the hospital wage index on the GAF), and reclassifications by the MGCRB. The comparisons are provided by: (1) Geographic location; (2) region; and (3) payment classification.

The simulation results show that, on average, capital payments per case can be expected to increase 2.3 percent in FY 2007. In addition to the 1.1 percent increase due to the capital market basket update, this projected increase in capital payments per case is largely attributable to the change in the DRG recalibration process methodology for FY 2007 as discussed in section II.C. of the preamble. The tentative GAF and tentative outlier factor impose equal but opposite effects on capital payments (−0.2 percent and 0.2 percent, respectively), and therefore have a zero net effect on capital payments per case.

The results of our comparisons by geographic location and by region are consistent with the results we expected after applying the changes to the DRG recalibration methodology. The geographic comparison shows that urban hospitals are expected to experience a 2.3 percent increase in IPPS capital payments per case, while rural hospitals are expected to experience a 2.1 percent increase in capital payments per case. This difference is mostly due to the changes to the methodology used to recalibrate DRGs discussed in section II.C. of the preamble of this final rule. As discussed in greater detail in that section of this final rule, analysis of our current methodology for setting DRG weights (using gross charges) indicates that bias is introduced into the weighting process. Specifically, we have also observed that ancillary service cost centers, in general, have higher charge markups than routine and ICU service cost centers, and therefore, higher weights for DRGs that use more ancillary services as opposed to DRGs that use more routine services. Surgical DRGs tend to have charges concentrated in ancillary cost center groups while medical DRGs tend to have charges concentrated in routine or ICU cost center groups. The bias in our current methodology results in artificially higher DRG relative weights for hospitals that are generally more expensive, such as teaching hospitals and specialty hospitals. Hospitals with these characteristics are generally found in urban locations.

The redistributive impact of our proposals to reform the current DRG system was evident in the capital impact analysis as discussed in the proposed rule. Consequently, the proposed rule impact analysis showed greater capital increases per case for rural hospitals, as expected, than for hospitals in urban locations. In response to comments on the proposed rule, significant modifications were made to our DRG proposals. The modifications made in this final rule to our proposed changes to the DRG system are intended to moderate the payment redistribution, and the capital impact analysis reflects those modifications accordingly. Further mitigating the effects of the changes is moving to a 3-year transition period to apply the new methodology. The capital impact was also somewhat affected by the wage-index changes from the proposed rule to the final rule because the GAF values are derived from the wage index. The wage index used in the proposed rule included an occupational mix component. Due to circumstances as described in section III.C. of the preamble to this final rule, the wage index used in these calculations is tentative, and will be updated in a future **Federal Register** document, as well as on the CMS Web site.

All regions are estimated to receive an increase in total capital payments per case from FY 2006 to FY 2007. Changes vary by region from a minimum increase of 0.4 percent (Puerto Rico) urban to a maximum increase of 3.2 percent (Pacific) urban. The change in payments per case for all hospitals is 2.3 percent and is similar to the change indicated in the proposed rule. However, the differences between urban and rural hospitals in this final rule are noticeably less than the differences observed in the proposed rule. As previously discussed, the increases in payments are largely attributable to changes in the DRG recalibration methodology, and the lesser degree of difference between rural and urban hospitals" capital payment increases from the proposed rule and this final rule is due to the modifications made to the proposed DRG reforms. By type of ownership, the increases in payment are similar among all three types. Government hospitals and proprietary hospitals are both projected to have a 2.4 percent increase in total payments, while payments to voluntary hospitals are expected to increase 2.3 percent.

Section 1886(d)(10) of the Act established the MGCRB. Before FY 2005, hospitals could apply to the MGCRB for reclassification for purposes of the standardized amount, wage index, or both. Section 401(c) of Pub. L. 108–173 equalized the standardized amounts under the operating IPPS. Therefore, beginning in FY 2005, there is no longer reclassification for the purposes of the standardized amounts; however, hospitals still may apply for reclassification for purposes of the wage index for FY 2007. Reclassification for wage index purposes also affects the GAF because that factor is constructed from the hospital wage index.

As discussed in section III.H.5. of the preamble of this final rule, procedural rules were established in the FY 2006 final rule (70 FR 47382) to recognize the special circumstances of section 508 hospital reclassifications ending mid-year during FY 2007. Under these procedural rules, some section 1886(d)(10) hospital reclassifications are only in effect for the second half of the fiscal year. These half fiscal year reclassifications have implications for the calculation of reclassified wage indices and therefore, affect capital payments because GAF values are calculated from the hospital wage index.

To present the effects of the hospitals being reclassified for FY 2007, we show the average payments per case for reclassified hospitals for each half of FY 2007 compared to the average payments per case for the same time period in FY 2006. The reclassified groups are compared to all other nonreclassified hospitals for the same time period. These categories are further identified by urban and rural designation. In general, the average payments per case in the first half of FY 2007

is the same as the average payments per case in the second half of FY 2007 with the exception of urban reclassifications, which decreases by 0.1 percent (2.5 percent to 2.4 percent) for the second half of FY 2007. Rural nonreclassified hospitals are expected to have the largest increases in payments (2.5 percent in both halves), as compared to the 2.0 percent increase for rural reclassified hospitals (for both halves of FY 2007). Falling between the percentage increase for rural non-reclassified hospitals and the increase for rural reclassified hospitals are the urban hospitals. Reclassified (urban) hospitals are projected to have increases of 2.5 percent and 2.4 percent in the first and second halves of FY 2007, respectively, while nonreclassified (urban) hospitals are projected to have a slightly lesser increase of 2.3 percent.

As discussed in section VI.B. of the preamble of this final rule, we are making a technical revision to § 412.316(b) and § 412.320 to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on or for capital DSH to reflect our historic policy that hospitals reclassified as rural under § 412.103 also are considered rural under capital PPS regulations. Currently, there are 38 hospitals that reclassified under this regulation and only 12 of these hospitals (about 0.3 percent of all IPPS hospitals) will be affected by the technical revisions to sections § 412.316(b) and § 412.320 concerning the treatment of hospitals reclassified as rural under section § 412.103. Based on the most recent available data, we estimate that the impact of these changes will be a less than 0.00001 percent decrease in aggregate IPPS payments.

TABLE III.—COMPARISON OF TOTAL PAYMENTS PER CASE

[FY 2006 payments compared to FY 2007 payments]

	Number of hospitals	Average FY 2006 payments/ case	Average FY 2007 payments/ case	Change
By Geographic Location:				
All hospitals	3,595	753	771	2.3
Large urban areas (populations over 1 million)	1,441	849	870	2.5
Other urban areas (populations of 1 million of fewer)	1,149	731	746	2.1
Rural areas	1,005	513	524	2.1
Urban hospitals	2,590	796	814	2.3
0–99 beds	651	617	632	2.4
100–199 beds	867	673	691	2.7
200–299 beds	492	751	769	2.4
300–499 beds	413	827	845	2.2
500 or more beds	167	1,005	1,027	2.1
Rural hospitals	1,005	513	524	2.1
0–49 beds	348	422	433	2.5
50–99 beds	370	469	481	2.5
100–149 beds	174	516	526	2.0
150–199 beds	68	564	574	1.8
200 or more beds	45	642	652	1.6
By Region:				
Urban by Region	2,590	796	814	2.3
New England	128	853	870	2.0
Middle Atlantic	357	873	893	2.3
South Atlantic	388	755	770	2.0
East North Central	395	782	802	2.6
East South Central	165	720	733	1.8
West North Central	157	783	799	2.1
West South Central	374	740	755	2.0
Mountain	149	787	811	3.1
Pacific	424	920	949	3.2
Puerto Rico	53	347	349	0.4
Rural by Region	1,005	513	524	2.1
New England	19	686	699	1.9
Middle Atlantic	72	518	532	2.6
South Atlantic	176	497	509	2.2
East North Central	125	547	558	2.0
East South Central	180	476	486	2.2
West North Central	116	540	550	2.0
West South Central	193	464	473	1.9
Mountain	81	535	544	1.6
Pacific	43	616	631	2.4
By Payment Classification:				
All hospitals	3,595	753	771	2.3
Large urban areas (populations over 1 million)	1,450	848	869	2.5
Other urban areas (populations of 1 million of fewer)	1,158	730	746	2.1
Rural areas	987	515	526	2.1
Teaching Status:				
Non-teaching	2,511	630	645	2.5
Fewer than 100 Residents	843	765	782	2.2
100 or more Residents	241	1,100	1,125	2.2
Urban DSH:				
100 or more beds	1,520	821	840	2.3
Less than 100 beds	347	543	558	2.7
Rural DSH:				
Sole Community (SCH/EACH)	385	464	475	2.2
Referral Center (RRC/EACH)	199	569	580	1.9

TABLE III.—COMPARISON OF TOTAL PAYMENTS PER CASE—Continued

[FY 2006 payments compared to FY 2007 payments]

	Number of hospitals	Average FY 2006 payments/ case	Average FY 2007 payments/ case	Change
Other Rural:				
100 or more beds	55	475	485	2.0
Less than 100 beds	183	423	433	2.5
Urban teaching and DSH:				
Both teaching and DSH	815	902	922	2.2
Teaching and no DSH	201	816	834	2.3
No teaching and DSH	1,052	667	684	2.6
No teaching and no DSH	540	700	717	2.4
Rural Hospital Types:				
Non special status hospitals	288	451	461	2.4
RRC/EACH	142	577	590	2.2
SCH/EACH	339	477	487	2.2
Medicare-dependent hospitals (MDH)	127	433	445	2.7
SCH, RRC and EACH	83	580	588	1.3
Hospitals Reclassified by the Medicare Geographic Classification Review Board:				
FY2007 Reclassifications:				
All Urban Reclassified 1st Half	325	775	795	2.5
All Urban Non-Reclassified 1st Half	2,240	800	819	2.3
All Rural Reclassified 1st Half	375	558	569	2.0
All Rural Non-Reclassified 1st Half	569	450	462	2.5
All Urban Reclassified 2nd Half	385	800	819	2.4
All Urban Non-Reclassified 2nd Half	2,180	796	815	2.3
All Rural Reclassified 2nd Half	375	558	569	2.0
All Rural Non-Reclassified 2nd Half	569	450	462	2.5
All Section 401 Reclassified Hospitals	33	548	554	1.1
Other Reclassified Hospitals (Section 1886(d)(8)(B))	53	516	527	2.2
Type of Ownership:				
Voluntary	2,102	771	789	2.3
Proprietary	880	679	696	2.4
Government	603	740	757	2.4
Medicare Utilization as a Percent of Inpatient Days:				
0–25	243	999	1,030	3.0
25–50	1,328	855	875	2.3
50–65	1,478	663	679	2.3
Over 65	462	597	609	2.1

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

In section XI. of the preamble to this final rule, we finalize the provisions of a September 30, 2005 interim final rule with comment period and the proposed changes in a September 30, 2005 proposed rule relating to the selection criteria and the forgiveness of indebtedness for loans made to certain hospitals engaged in research in the causes, prevention, and treatment of cancer under the Health Care Infrastructure Improvement Program. This section of this final rule affects qualifying hospitals as defined in section 1897 of the Act that have been selected to receive funds under the loan program.

This provision will have little impact on the Medicare Trust Fund. The Congress provided $142 million for the loan program effective July 1, 2004, through September 30, 2008, and of the $142 million, not more than $2 million may be used for the administration of the loan program for each of the fiscal years (that is, 2004 through 2008).

X. Alternatives Considered

This final rule contains a range of policies, including some changes related to specific DRA and MMA provisions. The preamble of this final rule provides descriptions of the statutory provisions that are addressed, identifies those policies when discretion has been exercised, presents rationale for our decisions and, where relevant, alternatives that were considered.

In addition, we did not consider any alternatives to the policies we are implementing in this final rule relating to the implementation of the loan program under the Health Care Infrastructure Improvement Program because the statute specifically authorized the conditions under which the Secretary may forgive a loan provided under the program.

XI. Overall Conclusion

The changes in this final rule will affect all classes of hospitals. Some hospitals are expected to experience significant gains and others less significant gains, but overall hospitals are projected to experience positive updates in IPPS payments in FY 2007. Table I of section VI of this Appendix demonstrates the estimated distributional impact of the IPPS budget neutrality requirements for DRG and wage index changes, for the hold harmless transition for rural hospitals formerly classified as urban, and for the wage index reclassifications under the MGCRB. Table I also shows an overall increase of 3.4 percent in operating payments, which, in conjunction with the estimated 2.0 percent increase in capital payments to IPPS providers shown in Table III of section VIII of this Appendix, should result in a net increase of $3.33 billion to IPPS providers. The discussions presented in the previous pages, in combination with the rest of this final rule, constitute a regulatory impact analysis.

XII. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehousegov/omb/circulars/a004/a-4.pdf*), in Table IV below, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this final rule. This table provides our best estimate of the increase in Medicare payments on providers as a result of the changes to the IPPS, the LTCH case-mix, and the limitation on payments to SNFs for bad debt presented in this rule. All expenditures are classified as transfers to Medicare providers.

The Congress provided $142 million for the loan program, effective July 1, 2004,

through September 30, 2008. Of the $142 million, not more than $2 million may be used for the administration of the loan program for each of the fiscal years (that is FY 2004 through FY 2008).

TABLE IV.—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES FROM FY 2006 TO FY 2007

Category annualized monetized transfers from whom to whom	Transfers $3.889 billion federal government to IPPS medicare providers, LTCHs, and SNFs
Total	$3.889 Billion.

XIII. Executive Order 12866

In accordance with the provisions of Executive Order 12866, the Office of Management and Budget reviewed this final rule.

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

I. Background

Section 1886(e)(4)(A) of the Act requires that the Secretary, taking into consideration the recommendations of the Medicare Payment Advisory Commission (MedPAC), recommend update factors for inpatient hospital services for each fiscal year that take into account the amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. Under section 1886(e)(5)(B) of the Act, we are required to publish factors recommended by the Secretary in the final IPPS rule. Accordingly, we are publishing our final recommendations for the appropriate update factors for the IPPS standardized amount, the hospital-specific rates for SCHs and MDHs, and the rate-of-increase limits for hospitals and hospital units excluded from the IPPS.

Section 1886(b)(3)(B)(i)(XX) of the Act, as amended by section 5001(a) of Pub. L. 109–171, sets the FY 2007 percentage increase in the operating cost standardized amount equal to the rate-of-increase in the hospital market basket for IPPS hospitals in all areas, subject to the hospital submitting quality information under rules established by the Secretary under section 1886(b)(3)(B)(viii) of the Act. For hospitals that do not provide these data, the update is equal to the market basket percentage increase less 2.0 percentage points.

Consistent with current law, based on the Office of the Actuary's second quarter 2006 forecast of the FY 2007 market basket increase of 3.4 percent, the FY 2007 update to the standardized amount for hospitals subject to the acute inpatient prospective payment system is 3.4 percent (that is, the market basket rate-of-increase) for hospitals in all areas, provided the hospital submits quality data in accordance with our rules. For hospitals that do not submit quality data, the update to the standardized amount is 1.4 percent (that is, the market basket rate-of-increase minus 2.0 percentage points). (In the proposed rule, the most recent estimate of the market basket increase was also 3.4 percent.)

Section 1886(b)(3)(B)(iv) of the Act sets the FY 2007 percentage increase in the hospital-specific rates applicable to SCHs and MDHs equal to the rate set forth in section 1886(b)(3)(B)(i) of the Act (that is, the same update factor as for all other hospitals subject to the IPPS, or the rate-of-increase in the market basket). Therefore, the update to the hospital-specific rates applicable to SCHs and MDHs is also 3.4 percent.

Section 1886(b)(3)(B)(ii) of the Act is used for purposes of determining the percentage increase in the rate-of-increase limits for children's and cancer hospitals. Section 1886(b)(3)(B)(ii) of the Act sets the percentage increase in the rate-of-increase limits equal to the market basket percentage increase for years after FY 2002. In accordance with § 403.752(a) of the regulations, RNHCIs are paid under § 413.40, which also uses section 1886(b)(3)(B)(ii) of the Act to update the percentage increase in the rate-of-increase limits. Section 1886(j)(3)(C) of the Act addresses the increase factor for the Federal prospective payment rate of IRFs. Section 123 of Pub. L. 106–113, as amended by section 307(b) of Pub. L. 106–554, provides the statutory authority for updating payment rates under the LTCH PPS.

Some LTCHs and IPFs are transitioning to 100 percent of the Federal rate and currently receive a blend of reasonable cost-based payments computed under the TEFRA methodology and their respective Federal payment rates. As discussed below, the transition ends for LTCHs (not defined as new and that have not elected to be paid under 100 percent of the Federal rate) for cost reporting periods beginning on or after October 1, 2006. Therefore, because no portion of LTCHs' prospective payments will be based on reasonable costs for cost reporting periods beginning on or after October 1, 2006, we are not providing an FY 2007 rate-of-increase adjustment under section 1886(b)(3)(B)(ii) of the Act for LTCHs.

Currently, children's hospitals, cancer hospitals and RNHCIs are the remaining three types of hospitals still reimbursed fully under reasonable costs. As we discuss in section IV. of the Addendum to this final rule, we are providing the FY 2007 IPPS operating market basket percentage increase (3.4 percent) that is being used to update the target limits for children's hospitals, cancer hospitals, and RNHCIs. (In the proposed rule, the most recent estimate of the market basket increase was also 3.4 percent for children's hospitals, cancer hospitals, and RNHCIs.)

Effective since cost reporting periods beginning FY 2003, LTCHs have been paid under the LTCH PPS, which was implemented with a 5-year transition period for LTCHs not defined as new under § 412.23(e)(4) (hereafter referred to as "existing"). (Refer to 67 FR 55954, August 30, 2002.) An existing LTCH could have elected to be paid on 100 percent of the Federal prospective rate at the start of any of its cost reporting periods during the 5-year transition period. During this transition period, if an existing LTCH did not elect to be paid 100 percent of the Federal prospective payment rate, it received a payment which consisted of a blend of its reasonable cost-based payment (subject to the TEFRA rate-of-increase limits) and the Federal prospective payment rate. Because the transition period ends with LTCH cost reporting periods beginning on or after October 1, 2006, those LTCHs who now receive blended payments will be paid based on 100 percent of the Federal prospective rate.

Effective for cost reporting periods beginning on or after January 1, 2005, IPFs are paid under the IPF PPS. IPF PPS payments are based on a Federal per diem rate that is based on the sum of the average routine operating, ancillary, and capital costs for each patient day of psychiatric care in an IPF, adjusted for budget neutrality. During a transition period between January 1, 2005 and January 1, 2008, existing IPFs are paid based on a blend of the reasonable cost-based payments, subject to the TEFRA limit, and the Federal per diem base rate. For cost reporting periods beginning on or after January 1, 2008, IPFs will be paid based on 100 percent of the Federal per diem rate. For purposes of the update factor for FY 2007, the portion of the IPF PPS transitional blend payment based on reasonable costs would be determined by updating the IPF's TEFRA limit by the current estimate of the excluded hospital market basket, which is estimated to be 3.4 percent. The update factor of 4.3 percent to the Federal per diem rate for July 1, 2006, through June 30, 2007, was provided in the RY 2007 IPF final rule (71 FR 27046).

IRFs are paid under the IRF PPS for cost reporting periods beginning on or after January 1, 2002. For cost reporting periods beginning on or after October 1, 2002 (FY 2003), and thereafter, the Federal prospective payments to IRFs are based on 100 percent of the adjusted Federal IRF prospective payment amount, updated annually. (Refer to the IRF final rule (69 FR 45721).) In the FY 2007 IRF PPS proposed rule (71 FR 28106 and 28125), we proposed an update factor of 3.4 percent to the IRF PPS for FY 2007. The final update factor for the FY 2007 IRF PPS will be published in the FY 2007 IRF PPS final rule.

Comment: One commenter believed the market basket update of 3.4 percent is inadequate. The commenter claimed that data for 1998 through 2006 indicate that hospital costs increased 37.9 percent, while Medicare payments increased 19.7 percent, resulting in a shortfall of $4.4 billion. The commenter noted that continual underfunding by CMS will further threaten the financial viability of not-for-profit hospitals in Michigan, thus limiting their ability to provide service to Medicare beneficiaries and others.

Response: The current market basket forecast update of 3.4 percent is based on Global Insight, Inc.'s (GII) 2006 second quarter forecast with historical data through the first quarter of 2006. GII is a nationally recognized economic and financial forecasting firm that contracts with CMS to forecast the components of the market baskets. In the FY 2006 IPPS rule, we noted that over the last several years, dramatic fluctuations in the price of certain costs

(mainly energy costs) have made it difficult to forecast the IPPS market basket. With our input and consultation, GII recently evaluated and modified its forecasting models to help enhance their accuracy. GII's latest forecast is based on these improved models and takes into account national and global economic trends.

We will continue to monitor both the accuracy of our market basket updates and the profitability of IPPS hospitals, as well as work with GII to ensure the most accurate updates possible.

Comment: One commenter was concerned that GII's methodology has a built-in bias of under projecting during the period when the overall economy is transitioning from a high growth and low inflation era to a low growth and high inflation period. The commenter explained that, during a transition period, the extrapolation of historical data tends to have larger projection variances and therefore adjustments should be made to correct these systematic projection biases during the time of major business cycle reversals. As a result, the commenter recommended that CMS include an adjustment in its projection methodology to correct for this systematic bias or adjust the projection error in its subsequent years' payments.

Response: CMS and GII recognize the complexities associated with projecting prices during times of major business cycle reversals. GII includes adjustments in their forecasts to account for these systematic biases. GII employs a simultaneous equation approach to solve both macro and micro simulation models for the underlying components of the hospital market basket. Using this simultaneous approach facilitates the accurate inclusion of broader economic conditions, such as economy-wide growth and inflationary pressures, to be more accurately reflected in the micro level components that comprise the market basket. In addition, as part of these micro models, underlying businesses cycles, seasonal changes, and market fluctuations are incorporated to ensure forecasts accurately control for these market conditions during forecast cycles.

Comment: One commenter was concerned that it is consistently disproportionately negatively affected by Medicare rate policies. The commenter recommended that no hospital receive less payments in the current year than the previous year or optimally CMS should provide a minimum payment increase of 2 percent.

Response: We thank the commenter for its comments. However, as noted above, section 1886(b)(3)(B)(i)(XX) of the Act, as amended by section 5001(a) of Pub. L. 109–171, ties the FY 2007 percentage increase in the operating cost standardized amount equal to the rate-of-increase in the hospital market basket for IPPS hospitals in all areas. Therefore, we do not have the statutory authority to implement the changes to the update factors that the commenter is requesting.

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

In recommending an update, the Secretary takes into account the factors such as the recommendations of MedPAC, the long-term solvency of the Medicare Trust Funds, and the capacity of the hospital industry to continually provide access to high quality care to Medicare beneficiaries through adequate payment to health care providers. In years prior to FY 2006, in making a recommendation, we included an update framework that analyzed hospital productivity, scientific and technological advances, practice pattern changes, changes in case-mix, the effects of reclassification on recalibration and forecast error correction. As we stated in the FY 2007 proposed rule, we are no longer including this analysis in our recommendation for the update (71 FR 24420).

In the FY 2007 IPPS proposed rule, we proposed to recommend an update of 2.95 percent, which reflected the CMS Office of the Actuary's most recent forecast of the FY 2007 market basket increase minus an adjustment factor of 0.45 percentage points based on the FY 2007 President's budget. We did not receive any public comments regarding this issue. In this final rule, we are also recommending an update for IPPS hospitals based on the forecasted market basket increase of 3.4 percent from the Office of the Actuary's most recent (second quarter) 2006 forecast of the FY 2007 market basket increase minus an adjustment factor of 0.45 percentage points based on the FY 2007 President's budget. Thus, the Secretary's final recommendation for the update to the IPPS standardized amount for all hospitals is 2.95 percentage points for hospitals that provide the required quality data.

In addition to making a recommendation for IPPS hospitals, in accordance with section 1886(e)(4)(A) of the Act, we are also recommending update factors for all other types of hospitals. Using the 2006 second quarter forecast from the Office of the Actuary of the FY 2007 market basket increase and an adjustment factor based on the FY 2007 President's budget, for FY 2007, for SCHs and MDHs, we are also recommending an update of 2.95 percent.

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

We did not receive any public comments concerning our proposed recommendations for updating the rate-of-increase for FY 2007 for cancer hospitals, RNHCIs, and children's hospitals. Our final recommendation does not differ from the proposed recommendation. The second quarter forecast from the Office of the Actuary of the FY 2007 market basket increase is also 3.4 percent for these excluded hospitals and hospital units. Thus, using an adjustment factor based on the FY 2007 President's budget, the Secretary's final recommendation is for a 2.95 percent increase to the target limits for cancer hospitals, RNHCIs, and children's hospitals.

Further, we did not receive any public comments concerning our proposed recommendations for the update factors for IPFs. For IPFs that are currently paid a blend of reasonable cost-based (subject to the TEFRA limits) and Federal prospective payment amounts, based on the estimate from the Office of the Actuary and an adjustment factor from the FY 2007 President's budget, in the proposed rule, we recommended an update factor of 3.15 percent for the portion of the payment that is based on reasonable costs, subject to the TEFRA limits. Based on second quarter data from the Office of the Actuary and an adjustment factor from the FY 2007 President's budget, we are recommending a final update of 2.95 percent for the portion of the payment that is based on reasonable costs, subject to the TEFRA limits.

Consistent with the RY 2007 LTCH PPS proposed rule (71 FR 4648), in the FY 2007 IPPS proposed rule, we recommended that the Federal rate remain unchanged for FY 2007. In this final rule, consistent with the RY 2007 LTCH final rule (71 FR 27826), we are recommending that the Federal rate to the LTCH PPS remain unchanged for FY 2007.

In the RY 2007 IPF PPS proposed rule (71 FR 3620) and in the FY 2006 IPPS proposed rule, we proposed an update factor of 4.5 percent to the IPF PPS for RY 2007. The proposed update reflected an increase from the 18-month period beginning January 1, 2005, when the IPF PPS was first adopted. However, in the RY 2007 IPF final rule (71 FR 27040), we recommended an update factor of 4.3 percent. Consistent with the RY 2007 IPF final rule, in this IPPS final rule, we are recommending an update factor of 4.3 percent for IPFs.

In the FY 2007 IPPS proposed rule, consistent with the President's FY 2007 budget, we recommended the Federal rate to the IRF PPS remain unchanged for FY 2007. We note, as mentioned above, in the FY 2007 IRF PPS proposed rule (71 FR 281206 and 28125), we proposed an update factor of 3.4 percent to the IRF PPS for FY 2007. The final update factor for the FY 2007 IRF PPS will be published in the FY 2007 IRF PPS final rule. Therefore, in this final rule, consistent with FY 2007 IRF PPS final rule, we are recommending the update factor that will be published in the FY 2007 IRF PPS final rule. We refer readers to the FY 2007 IRF PPS final rule to view the update factor.

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

Because the operating and capital prospective payment systems remain separate, we are continuing to use separate updates for operating and capital payments. The final update to the capital payment rates is discussed in section III. of the Addendum to this final rule.

[FR Doc. 06–6692 Filed 8–1–06; 4:00 pm]

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August 18, 2006

Part III

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 412, 414, and 424
Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal FY 2007; Provisions Concerning Competitive Acquisition for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); Accreditation of DMEPOS Suppliers; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 412, 414, and 424

[CMS–1540–F]

RIN 0938–AO16

Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2007; Certain Provisions Concerning Competitive Acquisition for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); Accreditation of DMEPOS Suppliers

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

ACTION: Final rule.

SUMMARY: This final rule will update the prospective payment rates for inpatient rehabilitation facilities (IRFs) for Federal fiscal year (FY) 2007 (for discharges occurring on or after October 1, 2006 and on or before September 30, 2007) as required under section 1886(j)(3)(C) of the Social Security Act (the Act).

We are revising existing policies regarding the prospective payment system within the authority granted under section 1886(j) of the Act. In addition, we are revising the current regulation text to reflect the changes enacted under section 5005 of the Deficit Reduction Act of 2005.

This final rule will also establish certain requirements related to competitive acquisition for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) and establish accreditation of DMEPOS suppliers as required under section 302 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

EFFECTIVE DATES: The regulatory changes to part 412 of 42 CFR are effective October 1, 2006. The regulatory changes to part 414 of 42 CFR, other than § 414.406(e), are effective August 31, 2006. The regulatory changes to part 424 of 42 CFR are effective October 2, 2006. The updated IRF prospective payment rates are effective October 1, 2006, for discharges occurring on or after October 1, 2006 and on or before September 30, 2007 (that is, during FY 2007).

FOR FURTHER INFORMATION CONTACT:

Pete Diaz, (410) 786–1235, for information regarding the IRF PPS 75 percent rule.

Susanne Seagrave, (410) 786–0044, for information regarding the new IRF PPS payment policies.

Zinnia Ng, (410) 786–4587, for information regarding the wage index and the IRF prospective payment rate calculation.

Sandra Bastinelli, (410) 786–3630, for information regarding accreditation of DMEPOS suppliers.

LT Camille Soondar, (410) 786–9370, for information regarding accreditation of DMEPOS suppliers.

CDR Marie Casey, (410) 786–7861, for information regarding accreditation of DMEPOS suppliers.

Linda Smith, (410) 786–5650, for information regarding the DMEPOS quality standards.

Michael Keane, (410) 786–4495, for information on DMEPOS competitive bidding implementation contractors.

Alexis Meholic, (410) 786–2300, for issues related to education and outreach under the DMEPOS competitive bidding program.

SUPPLEMENTARY INFORMATION:

Table of Contents

Acronyms

Because of the many terms to which we refer by acronym in this final rule, we are listing the acronyms used and their corresponding terms in alphabetical order below.

ADC Average Daily Census
ASCA Administrative Simplification Compliance Act of 2002, Pub. L. 107–105
BBA Balanced Budget Act of 1997, Pub. L. 105–33
BBRA Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999, Pub. L. 106–113
BIPA Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Benefits Improvement and Protection Act of 2000, Pub. L. 106–554
CBA Competitive Bidding Area
CBIC Competitive Bidding Implementation Contractor
CBSA Core-Based Statistical Area
CCMO CMS Consortium Contractor Management Officer
CCR Cost-to-Charge Ratio
CFR Code of Federal Regulations
CMG Case-Mix Group
CY Calendar Year
DMERC Durable Medical Equipment Regional Carrier
DMEPOS Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
DRA Deficit Reduction Act of 2005, Pub. L. 109–171
DRG Diagnosis-Related Group
DSH Disproportionate Share Hospital
ECI Employment Cost Indexes
FI Fiscal Intermediary
FR **Federal Register**
FTE Full-Time Equivalent
FY Federal Fiscal Year
GDP Gross Domestic Product
HCPCS Healthcare Common Procedure Coding System
HHH Hubert H. Humphrey Building
HIPAA Health Insurance Portability and Accountability Act, Pub. L. 104–191
HIT Health Information Technology
ICD–9–CM International Classification of Diseases, Ninth Revision, Clinical Modification
IFMC Iowa Foundation for Medical Care
IIC Inflation Indexed Charge
IPPS Inpatient Prospective Payment System
IRF Inpatient Rehabilitation Facility
IRF–PAI Inpatient Rehabilitation Facility-Patient Assessment Instrument
IRF PPS Inpatient Rehabilitation Facility Prospective Payment System
IRVEN Inpatient Rehabilitation Validation and Entry
LCD Local Coverage Determination
LIP Low-Income Percentage
MEDPAR Medicare Provider Analysis and Review
MLN Medicare Learning Network
MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108–173)
MSA Metropolitan Statistical Area
NAICS North American Industrial Classification System
NCMRR National Center for Medical Rehabilitation Research
NIH National Institutes of Health
NSC National Supplier Clearinghouse
OCI Organizational and Consultant Conflicts of Interest
OIG Office of Inspector General
OMB Office of Management and Budget
PAC Post Acute Care
PAI Patient Assessment Instrument
PAOC Program Advisory and Oversight Committee
PPS Prospective Payment System
RAND RAND Corporation
RFB Request for Bids
RFA Regulatory Flexibility Act, Pub. L. 96–354
RIA Regulation Impact Analysis
RIC Rehabilitation Impairment Category
RO Regional Office
RPL Rehabilitation, Psychiatric, and Long-Term Care Hospital Market Basket
SCHIP State Children's Health Insurance Program
SIC Standard Industrial Code
TEFRA Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248

I. Background

A. Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS)

We received approximately 58 timely items of correspondence on the FY 2007 Inpatient Rehabilitation Facility Prospective Payment System proposed rule (71 FR 28106, May 15, 2006). Summaries of the public comments and our responses to those comments are set forth below under the appropriate section heading of this final rule.

1. Historical Overview of the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) for Fiscal Years (FYs) 2002 Through 2006

Section 4421 of the Balanced Budget Act of 1997 (BBA, Pub. L. 105–33), as amended by section 125 of the Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999 (BBRA, Pub. L. 106–113), and by section 305 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA, Pub. L. 106–554), provides for the implementation of a per discharge prospective payment system (PPS), through section 1886(j) of the Social Security Act (the Act), for inpatient rehabilitation hospitals and inpatient rehabilitation units of a hospital (hereinafter referred to as IRFs).

Payments under the IRF PPS encompass inpatient operating and capital costs of furnishing covered rehabilitation services (that is, routine, ancillary, and capital costs) but not costs of approved educational activities, bad debts, and other services or items outside the scope of the IRF PPS. Although a complete discussion of the IRF PPS provisions appears in the August 7, 2001 final rule (66 FR 41316) as revised in the FY 2006 IRF PPS final rule (70 FR 47880), we are providing below a general description of the IRF PPS for fiscal years (FYs) 2002 through 2006.

Under the IRF PPS from FY 2002 through FY 2005, as described in the August 7, 2001 final rule, the Federal prospective payment rates were computed across 100 distinct case-mix groups (CMGs). We constructed 95 CMGs using rehabilitation impairment categories (RICs), functional status (both motor and cognitive), and age (in some cases, cognitive status and age may not be a factor in defining a CMG). In addition, we constructed five special CMGs to account for very short stays and for patients who expire in the IRF.

For each of the CMGs, we developed relative weighting factors to account for a patient's clinical characteristics and expected resource needs. Thus, the weighting factors accounted for the relative difference in resource use across all CMGs. Within each CMG, we created tiers based on the estimated effects that certain comorbidities would have on resource use.

We established the Federal PPS rates using a standardized payment conversion factor (formerly referred to as the budget neutral conversion factor). For a detailed discussion of the budget neutral conversion factor, please refer to our August 1, 2003 final rule (68 FR 45674, 45684 through 45685). In the FY 2006 IRF PPS final rule (70 FR 47880), we discussed in detail the methodology for determining the standard payment conversion factor.

We applied the relative weighting factors to the standard payment conversion factor to compute the unadjusted Federal prospective payment rates. Under the IRF PPS from FYs 2002 through 2005, we then applied adjustments for geographic variations in wages (wage index), the percentage of low-income patients, and location in a rural area (if applicable) to the IRF's unadjusted Federal prospective payment rates. In addition, we made adjustments to account for short-stay transfer cases, interrupted stays, and high cost outliers.

For cost reporting periods that began on or after January 1, 2002 and before October 1, 2002, we determined the final prospective payment amounts using the transition methodology prescribed in section 1886(j)(1) of the Act. Under this provision, IRFs transitioning into the PPS were paid a blend of the Federal IRF PPS rate and the payment that the IRF would have received had the IRF PPS not been

implemented. This provision also allowed IRFs to elect to bypass this blended payment and immediately be paid 100 percent of the Federal IRF PPS rate. The transition methodology expired as of cost reporting periods beginning on or after October 1, 2002 (FY 2003), and payments for all IRFs now consist of 100 percent of the Federal IRF PPS rate.

In the FY 2006 IRF PPS final rule (70 FR 47880), we implemented refinements that became effective for discharges beginning on or after October 1, 2005. We published correcting amendments to the FY 2006 IRF PPS final rule in the **Federal Register** on September 30, 2005 (70 FR 57166). Any reference to the FY 2006 IRF PPS final rule in this rule also includes the provisions effective in the correcting amendments.

In the FY 2006 final rule (70 FR 47880 and 70 FR 57166), we finalized a number of refinements to the IRF PPS case-mix classification system (the CMGs and the corresponding relative weights) and the case-level and facility-level adjustments. These refinements were based on analyses by the RAND Corporation (RAND), a non-partisan economic and social policy research group, using calendar year 2002 and FY 2003 data. These were the first significant refinements to the IRF PPS since its implementation. In conducting the analysis, RAND used claims and clinical data for services furnished after the implementation of the IRF PPS. These newer data sets were more complete, and reflected improved coding of comorbidities and patient severity by IRFs. The researchers were able to use new data sources for imputing missing values and more advanced statistical approaches to complete their analyses. The RAND reports supporting the refinements made to the IRF PPS are available on the CMS Web site at: *http://www.cms.hhs.gov/InpatientRehabFacPPS/09_Research.asp.*

The final key policy changes, effective for discharges occurring on or after October 1, 2005, are discussed in detail in the FY 2006 IRF PPS final rule (70 FR 47880 and 70 FR 57166). The following is a brief summary of the key policy changes:

- We adopted the Office of Management and Budget's (OMB's) Core-Based Statistical Area (CBSA) market area definitions in a budget neutral manner. We made this geographic adjustment using the most recent final wage data available (that is, pre-reclassification and pre-floor hospital wage index based on FY 2001 hospital wage data). In addition, we implemented a budget-neutral 3-year hold harmless policy for IRFs that were considered rural in FY 2005, but became urban in FY 2006 under the CBSA definitions, as described in the FY 2006 IRF PPS final rule (70 FR 47880, 47923 through 47925).
- We also implemented a payment adjustment to account for changes in coding that did not reflect real changes in case mix. Thus, we reduced the standard payment amount by 1.9 percent to account for these changes in coding following implementation of the IRF PPS. Our contractors conducted a series of analyses to identify real case mix change over time and the effect of this change on aggregate IRF PPS payments. A detailed discussion of the analysis and research appears in the FY 2006 IRF PPS final rule (70 FR 47880).
- In addition, we made modifications to the CMGs, tier comorbidities, and relative weights in a budget-neutral manner. The final rule included a number of adjustments to the IRF classification system that are designed to improve the system's ability to predict IRF costs. The data indicated that moving or eliminating some comorbidity codes from the tiers, redefining the CMGs, and other minor changes to the system would improve the ability of the classification system to ensure that Medicare payments to IRFs continue to be aligned with the costs of care. These refinements resulted in 87 CMGs using Rehabilitation Impairment Categories (RICs), functional status (motor and cognitive scores), and age (in some cases, cognitive status and age may not be factors in defining CMGs). The five special CMGs remained the same as they had been before FY 2006 and continue to account for very short stays and for patients who expired in the IRF.
- In addition, we implemented a new teaching status adjustment for IRFs, similar to the one adopted for inpatient psychiatric facilities. We implemented the teaching status adjustment in a budget neutral manner.
- We also revised and rebased the market basket. We finalized the use of a new market basket reflecting the operating and capital cost structures for rehabilitation, psychiatric, and long term care (RPL) hospitals to update IRF payment rates. The RPL market basket excludes data from cancer hospitals, children's hospitals, and religious non-medical institutions. In addition, we rebased the market basket to account for 2002-based cost structures for RPL hospitals. Further, we calculated the labor-related share using the RPL market basket.
- In addition, we updated the rural adjustment (from 19.14 percent to 21.3 percent), the low-income percentage (LIP) adjustment (from an exponent of 0.484 to an exponent of 0.6229), and the outlier threshold amount (from $11,211 to $5,129, as further revised in the FY 2006 IRF PPS correction notice (70 FR 57166, 57168)). We implemented the changes to the rural and LIP adjustments in a budget neutral manner. Since the implementation of the IRF PPS, we have maintained a CMS Web site as a primary information resource for the IRF PPS. The Web siteURL is *http://www.cms.hhs.gov/InpatientRehabFacPPS/* and may be accessed to download or view publications, software, data specifications, educational materials, and other information pertinent to the IRF PPS.

2. Requirements for Updating the IRF PPS Rates

On August 7, 2001, we published a final rule titled "Medicare Program; Prospective Payment System for Inpatient Rehabilitation Facilities" in the **Federal Register** (66 FR 41316) that established a PPS for IRFs as authorized under section 1886(j) of the Act and codified at subpart P of part 412 of the Medicare regulations. In the August 7, 2001 final rule, we set forth the per discharge Federal prospective payment rates for FY 2002, which provided payment for inpatient operating and capital costs of furnishing covered rehabilitation services (that is, routine, ancillary, and capital costs) but not costs of approved educational activities, bad debts, and other services or items that are outside the scope of the IRF PPS. The provisions of the August 7, 2001 final rule were effective for cost reporting periods beginning on or after January 1, 2002. On July 1, 2002, we published a correcting amendment to the August 7, 2001 final rule in the **Federal Register** (67 FR 44073). Any references to the August 7, 2001 final rule in this final rule include the provisions effective in the correcting amendment.

Section 1886(j)(5) of the Act and 42 CFR 412.628 of the regulations require the Secretary to publish in the **Federal Register**, on or before the August 1 that precedes the start of each new FY, the classifications and weighting factors for the IRF CMGs and a description of the methodology and data used in computing the prospective payment rates for the upcoming FY. On August 1, 2002, we published a notice in the **Federal Register** (67 FR 49928) to update the IRF Federal prospective payment rates from FY 2002 to FY 2003

using the methodology as described in § 412.624. As stated in the August 1, 2002 notice, we used the same classifications and weighting factors for the IRF CMGs that were set forth in the August 7, 2001 final rule to update the IRF Federal prospective payment rates from FY 2002 to FY 2003. We continued to update the prospective payment rates in accordance with the methodology set forth in the August 7, 2001 final rule for each succeeding FY up to and including FY 2005. For FY 2006, however, we published a final rule that revised several IRF PPS policies (70 FR 47880), as summarized in section I.A.1 of this final rule. The provisions of the FY 2006 IRF PPS final rule became effective for discharges occurring on or after October 1, 2005.

On May 15, 2006, we published a proposed rule in the **Federal Register** (71 FR 28106) to update the IRF Federal prospective payment rates from FY 2006 to FY 2007. In this final rule for FY 2007, we update the IRF Federal prospective payment rates. In addition, we update the outlier threshold amount and the cost-to-charge ratio ceilings from FY 2006 to FY 2007. We are also implementing a 2.6 percent reduction to the FY 2007 standard payment amount to account for changes in coding practices that do not reflect real changes in case mix. (See section V.A of this final rule for further discussion of the reduction of the standard payment amount to account for coding changes.)

We are also implementing revisions to the tier comorbidities and the relative weights to ensure that IRF PPS payments reflect, as closely as possible, the costs of caring for patients in IRFs. (See section IV for a detailed discussion of these changes.) The FY 2007 Federal prospective payment rates are effective for discharges occurring on or after October 1, 2006 and on or before September 30, 2007.

In addition, we are revising the regulation text in § 412.23(b)(2)(i) and § 412.23(b)(2)(ii) pursuant to our authority in section 5005 of the Deficit Reduction Act of 2005 (DRA, Pub. L. 109–171) and section 1886(d)(1)(B) of the Act. Section 5005 of the DRA required that we revise the applicable percentages stipulated in the May 7, 2004 final rule (69 FR 25752). The effect of this change prolongs by an additional year the duration of the phased transition to the full 75 percent threshold established in current regulation text. In addition, under the authority in section 1886(d)(1)(B) of the Act, we are similarly extending by an additional year the use of comorbid conditions that meet the criteria outlined in the regulations to count for purposes of determining compliance with the classification criteria in § 412.23(b)(2)(i).

3. Operational Overview of the Current IRF PPS

As described in the August 7, 2001 final rule and subsequent rules, upon the admission and discharge of a Medicare Part A fee-for-service patient, the IRF is required to complete the appropriate sections of the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF–PAI). Generally, the encoded IRF–PAI software product includes patient grouping programming called the GROUPER software. The GROUPER software uses specific Patient Assessment Instrument (PAI) data elements to classify (or group) patients into distinct CMGs and account for the existence of any relevant comorbidities.

The GROUPER software produces a five-digit CMG number. The first digit is an alpha-character that indicates the comorbidity tier. The last four digits represent the distinct CMG number. (Free downloads of the Inpatient Rehabilitation Validation and Entry (IRVEN) software product, including the GROUPER software, are available on the CMS Web site at *http://www.cms.hhs.gov/InpatientRehabFacPPS/06_Software.Asp.*)

Once a patient is discharged, the IRF completes the Medicare claim (UB–92 or its equivalent) using the five-digit CMG number and sends it to the appropriate Medicare fiscal intermediary (FI). Claims submitted to Medicare must comply with both the Administrative Simplification Compliance Act (ASCA, Pub. L. 107–105), and the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Pub. L. 104–191). For a detailed discussion on this issue and additional legal citations, please visit the electronic billing & electronic data interchange (EDI) transactions Web site at: *http://www.cms.hhs.gov/ElectronicBillingEDITrans/.*

The Medicare FI processes the claim through its software system. This software system includes pricing programming called the PRICER software. The PRICER software uses the CMG number, along with other specific claim data elements and provider-specific data, to adjust the IRF's prospective payment for interrupted stays, transfers, short stays, and deaths, and then applies the applicable adjustments to account for the IRF's wage index, percentage of low-income patients, rural location, and outlier payments. For discharges occurring on or after October 1, 2005, the IRF PPS payment also reflects the new teaching status adjustment that became effective as of FY 2006, as discussed in the FY 2006 IRF PPS final rule (70 FR 47880).

4. Summary of Revisions to the IRF PPS for FY 2007

In this final rule, we make the following revisions and updates:

- Update the relative weight and average length of stay tables based on re-analysis of the data by CMS and our contractor, the RAND Corporation, as discussed in section IV of this final rule. This update will be reflected in the IRF GROUPER software and other applicable CMS publications.
- Reduce the standard payment amount by 2.6 percent to account for coding changes that do not reflect real changes in case mix, as discussed in section V.A of this final rule.
- Update the FY 2007 IRF PPS payment rates by the market basket, as discussed in section V.B of this final rule.
- Update the FY 2007 IRF PPS payment rates by the labor related share, the wage indexes, and the second year of the hold harmless policy in a budget neutral manner, as discussed in section V.C of this final rule.
- Update the outlier threshold for FY 2007 to $5,534, as discussed in section VI.A of this final rule.
- Update the urban and rural national cost-to-charge ratio ceilings for purposes of determining outlier payments under the IRF PPS and clarify the methodology described in the regulation text, as discussed in section VI.B of this final rule.
- Revise the regulation text at § 412.23(b)(2)(i) and § 412.23(b)(2)(ii) in the following manner so that the compliance thresholds reflect section 5005 of the DRA: (1) For cost reporting periods starting on or after July 1, 2006, and before July 1, 2007, the compliance threshold is 60 percent. (2) For cost reporting periods starting on or after July 1, 2007 and before July 1, 2008, the compliance threshold is 65 percent. (3) For cost reporting periods starting on or after July 1, 2008, the compliance threshold is 75 percent. In addition, comorbidities may not be used to determine if the 75 percent compliance threshold is met. However, comorbidities meeting the criteria outlined in the regulations may be used to determine if the applicable compliance threshold is met for cost reporting periods beginning on or after July 1, 2004 and before July 1, 2008.

B. Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

On May 1, 2006, we issued a proposed rule to implement the Medicare DMEPOS Competitive Bidding Program and other issues (71 FR 25654). To ensure timely implementation of the Medicare DMEPOS Competitive Bidding Program, we are choosing to respond in this final rule to comments submitted on certain provisions of the May 1, 2006 proposed rule. These provisions include DMEPOS competitive bidding implementation contractors, DMEPOS competitive bidding education and outreach, quality standards for DMEPOS suppliers, and accreditation of DMEPOS suppliers. We received approximately 600 timely comments on these provisions of the May 1, 2006 proposed rule. Summaries of the public comments and our responses to those comments are set forth below under the appropriate section headings of this final rule.

1. The Medicare DMEPOS Competitive Bidding Program

Section 302(b)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, Pub. L. 108–173) amended section 1847 of the Act to require the Secretary to establish and implement programs under which competitive bidding areas are established throughout the United States for contract award purposes for the furnishing of certain competitively priced items for which payment is made under Part B (the "Medicare DMEPOS Competitive Bidding Program"). Section 1847(a)(2) of the Act provides that the items and services that may be furnished under the competitive bidding programs include certain DME and associated supplies, enteral nutrition and associated supplies, and off-the-shelf orthotics. In addition, section 1847 of the Act specifies the requirements and conditions for implementation of the Medicare DMEPOS Competitive Bidding Program. Competitive bidding provides a way to harness marketplace dynamics to create incentives for suppliers to provide quality items in an efficient manner and at a reasonable cost.

2. Implementation Contractors

Section 1847(b)(9) of the Act provides that the Secretary may contract with appropriate entities to implement the Medicare DMEPOS Competitive Bidding Program. Section 1847(a)(1)(C) of the Act also authorizes the Secretary to waive provisions of the Federal Acquisition Regulation (FAR) as necessary for the efficient implementation of this section, other than provisions relating to confidentiality of information and other provisions as the Secretary determines appropriate.

In the May 1, 2006 proposed rule (71 FR 25661), we proposed to designate one or more competitive bidding implementation contractors (CBICs) for the purpose of implementing the Medicare DMEPOS Competitive Bidding Program (proposed § 414.406(a)). We also discussed the six primary functions of the program (see 71 FR 25661), which include overall oversight and decision-making, operation design functions (including the design of both bidding and outreach material templates, as well as program processes), bidding and evaluation, access and quality monitoring, outreach and education, and claims processing. We respond to comments on our proposal in section X.A of this preamble.

3. Quality Standards for Suppliers of DMEPOS

Section 302(a)(1) of the MMA added section 1834(a)(20) to the Act, which requires the Secretary to establish and implement quality standards for suppliers of certain items, including consumer service standards, to be applied by recognized independent accreditation organizations. Suppliers of DMEPOS must comply with the DMEPOS quality standards in order to furnish any item for which Part B makes payment, and also in order to receive or retain a supplier billing number used to submit claims for reimbursement for any such item for which payment can be made by Medicare. Section 1834(a)(20)(D) of the Act requires us to apply these DMEPOS quality standards to suppliers of the following items for which we deem the standards to be appropriate:

- Covered items, as defined in section 1834(a)(13), for which payment may be made under section 1834(a);
- Prosthetic devices and orthotics and prosthetics described in section 1834(h)(4); and
- Items described in section 1842(s)(2) of the Act, which include medical supplies, home dialysis supplies and equipment, therapeutic shoes, parenteral and enteral nutrients, equipment, and supplies, electromyogram devices, salivation devices, blood products, and transfusion medicine.

Section 1834(a)(20)(E) of the Act explicitly authorizes the Secretary to establish the DMEPOS quality standards by program instructions or otherwise after consultation with representatives of relevant parties. After consulting with such representatives, including the Program Advisory and Oversight Committee (PAOC) (please see 71 FR 25658 for a discussion of this committee) and a wide range of other stakeholders, we published the draft quality standards on the CMS Web sitein September 2005 (see *http://www.cms.hhs.gov/competitiveAcqforDMEPOS/*) and provided for a 60-day public comment period. We received more than 5,600 public comments on the draft DMEPOS quality standards. After careful consideration of all comments, these quality standards will be published shortly on the CMS Web site. They will appear on the CMS Web site at *http://www.cms.hhs.gov/competitiveAcqforDMEPOS/*. The quality standards will become effective for use as part of the accreditation selection process when posted on the Web site. All suppliers of DMEPOS and other items to which section 1834(a)(20) of the Act applies will be required to meet the DMEPOS quality standards established under that section. Finally, section 1847(b)(2)(A)(i) of the Act requires an entity (a DMEPOS supplier) to meet the DMEPOS quality standards specified by the Secretary under section 1834(a)(20) of the Act before being awarded a contract under the Medicare DMEPOS Competitive Bidding Program.

4. Accreditation for Suppliers of DMEPOS and Other Items

Section 1834(a)(20)(B) of the Act requires the Secretary, notwithstanding section 1865(b) of the Act, to designate and approve one or more independent accreditation organizations to apply the DMEPOS quality standards established under section 1834(a)(20) of the Act to suppliers of DMEPOS and other items. The Medicare program currently contracts with State agencies to perform survey and review functions for providers and suppliers to approve their participation in or coverage under the Medicare program. Additionally, section 1865(b) of the Act sets forth the general procedures for CMS to designate national accreditation organizations to deem providers or suppliers to meet Medicare conditions of participation or coverage if they are accredited by a national accreditation organization approved by CMS. Many types of providers and suppliers have a choice between having the State agency or the CMS-approved accreditation organization survey them. If the supplier selects the CMS-approved accreditation organization and is in compliance with the accreditation organization standards, it is generally

deemed to meet the Medicare conditions of participation or coverage. We are responsible for the oversight and monitoring of the State agencies and the approved accreditation organizations. The procedures, implemented by the Secretary, for designating private and national accreditation organizations and the Federal review process for accreditation organizations appear in regulations at 42 CFR parts 422 (for Medicare Advantage organizations) and 488 (for most providers and suppliers). To accommodate suppliers that want to participate in the Medicare DMEPOS Competitive Bidding Program, we will phase-in the accreditation process and give preference to accreditation organizations that prioritize their surveys to accredit suppliers in the selected MSAs and competitive bidding areas. We will provide further guidance in a **Federal Register** notice on the submission procedures for accreditation.

5. Summary of DMEPOS Provisions

This final rule responds to public comments on the following provisions of the May 1, 2006 proposed rule (71 FR 25654):

- Requirements for competitive bidding implementation contractors, as discussed in section X.A of this final rule.
- Our plans for DMEPOS competitive bidding education and outreach, as discussed in section X.B of this final rule.
- Issues related to the DMEPOS quality standards for DMEPOS suppliers, as discussed in section X.C of this final rule.
- Accreditation requirements for DMEPOS suppliers as discussed in section X.D of this final rule.

II. Provisions of the Proposed Rule

A. IRF PPS

In the FY 2007 IRF PPS proposed rule (71 FR 28106), we proposed to make revisions to the regulation text in order to implement the proposed policy changes for IRFs for FY 2007 and subsequent fiscal years. Specifically, we proposed to make conforming changes in 42 CFR part 412. These proposed revisions and other proposed changes are discussed in detail below.

1. Section 412.23 Excluded Hospitals: Classifications

As discussed in section VI of the FY 2007 IRF PPS proposed rule (71 FR 28106), we proposed to revise the regulation text in paragraphs (b)(2)(i) and (b)(2)(ii) to reflect the applicable percentages specified in this section as amended by the DRA. To summarize, for cost reporting periods—

(a) Beginning on or after July 1, 2005 and before July 1, 2007, the hospital has served an inpatient population of whom at least 60 percent;

(b) Beginning on or after July 1, 2007 and before July 1, 2008, the hospital has served an inpatient population of whom at least 65 percent; and

(c) Beginning on or after July 1, 2008, the hospital has served an inpatient population of whom at least 75 percent require intensive rehabilitative services for treatment of one or more of the conditions specified at paragraph (b)(2)(iii) of this section.

Under the proposal to revise the transition timeframes in order to implement the DRA provision, a facility would not have to meet the 75 percent compliance threshold until its first cost reporting period beginning on or after July 1, 2008. In addition to the above DRA requirements pertaining to the applicable compliance percentage requirements under § 412.23(b)(2), we proposed to permit a comorbidity that meets the criteria as specified in § 412.23(b)(2)(i) to continue to be used to determine the compliance threshold for cost reporting periods that begin before July 1, 2008. However, for cost reporting periods beginning on or after July 1, 2008, a comorbidity specified in § 412.23(b)(2)(i) cannot be used to determine compliance at the 75 percent threshold.

2. Section 412.624 Methodology for Calculating the Federal Prospective Payment Rates

In section IV of the FY 2007 IRF PPS proposed rule, we proposed to revise the current regulation text in paragraph (e)(5) to clarify that the cost-to-charge ratio for IRFs is a single overall (combined operating and capital) cost-to-charge ratio. We wish to emphasize that we follow the methodology described in § 412.84(i) and § 412.84(m) except that the IRF PPS uses a single overall (combined operating and capital) cost-to-charge ratio, and uses national averages instead of statewide averages.

3. Additional Proposed Changes

- Update the tier comorbidities, the relative weights, and the average length of stay tables based on a reconsideration of the data used in the FY 2006 IRF classification refinements, as discussed in section II of the FY 2007 IRF PPS proposed rule (71 FR 28106). This update will be reflected in the IRF GROUPER software and the FY 2007 payment rates.
- Reduce the FY 2007 standard payment amount by 2.9 percent to account for coding changes when the IRF PPS was implemented that do not reflect real changes in case mix, as discussed in detail in section III.A of the FY 2007 IRF PPS proposed rule (71 FR 28106).
- Update payment rates for rehabilitation facilities using the IRF market basket, IRF labor-related share, and CBSA urban and rural wage indexes, as discussed in sections III.B and C of the FY 2007 IRF PPS proposed rule (71 FR 28106).
- Update the outlier threshold amount for FY 2007 to $5,609, as discussed in section IV.A of the FY 2007 IRF PPS proposed rule (71 FR 28106).
- Update the national average urban and rural cost-to-charge ratios (CCR) used for new IRFs, IRFs whose overall CCR is in excess of 3 standard deviations above the national geometric mean, and IRFs for whom accurate data are not available to calculate a CCR, as discussed in detail in section IV.B of the FY 2007 IRF PPS proposed rule (71 FR 28106).

B. DMEPOS

On May 1, 2006, we published in the **Federal Register** (71 FR 23654) a proposed rule that would, in part, implement the Medicare DMEPOS Competitive Bidding Program for certain DMEPOS items, as required by sections 1847(a) and (b) of the Social Security Act (the Act). As indicated in section I.B of this final rule, to ensure timely implementation of the Medicare DMEPOS Competitive Bidding Program, we are choosing to respond to comments on the following proposals in the May 1, 2006 proposed rule. In summary, we proposed to—

- Designate one or more competitive bidding implementation contractors (CBICs) for the purpose of implementing the Medicare DMEPOS Competitive Bidding Program (proposed § 414.406(a)).
- Implement an outreach and education plan to ensure the effective implementation of the Medicare DMEPOS Competitive Bidding Program.
- Establish requirements for accreditation of DMEPOS suppliers.

In addition, we are clarifying in this final rule certain issues related to the establishment of quality standards for suppliers of certain DMEPOS items, which will be applied by recognized independent accreditation organizations under section 1834(a)(20) of the Act.

These provisions are described in detail in sections X.A. through I of this preamble.

III. Analysis of and Response to Public Comments

A. IRF PPS

In response to the publication of the FY 2007 IRF PPS proposed rule, we received approximately 58 timely items of correspondence from the public. We received numerous comments from various trade associations and major organizations. Comments also originated from inpatient rehabilitation facilities, members of Congress, health care industry organizations, State health departments, and health care consulting firms. The following discussion, arranged by subject area, includes a summary of the public comments that we received, and our responses to the comments appear under the appropriate heading.

B. DMEPOS

We received approximately 600 pieces of correspondence on a timely basis that contained comments on the provisions of the May 1, 2006 proposed rule (71 FR 25654) that are included in this final rule. The remainder of this preamble sets forth a detailed discussion of the proposed provisions concerning implementation contractors, education and outreach, and accreditation; a summary of the public comments received on each subject area; our responses to those comments; and a presentation of the final policies. This preamble also contains a discussion of certain issues relating to the quality standards that will be applied by the independent accrediting organizations.

IV. Refinements to the IRF Patient Classification System

A. Changes to the Existing List of Tier Comorbidities

The IRF PPS uses a patient's principal diagnosis or impairment to classify the patient into a rehabilitation impairment category (RIC), and then uses the patient's comorbidities (secondary diagnoses) to determine whether to classify the patient into a higher-paying tier. In the FY 2007 proposed rule (71 FR 28106), we proposed revisions to the tier comorbidities in the IRF GROUPER for FY 2007 to ensure that IRF PPS payments continue to reflect as accurately as possible the costs of care. In addition, we proposed to indicate ongoing changes to the IRF GROUPER software to reflect the most current national coding guidelines, by posting a complete ICD–9 table (including new, discontinued, and modified codes) on the IRF PPS Web site, because we realized that we did not have a mechanism for ensuring that the IRF GROUPER would reflect the latest guidelines. We also proposed to continue to report the complete list of ICD–9 codes associated with the tiers in the IRF GROUPER documentation, which is also posted on the IRF PPS Web site.

We received several comments on the proposed changes to the existing list of tier comorbidities, which are summarized below.

Comment: Comments were generally favorable regarding our proposed revisions to the existing list of tier comorbidities. In particular, several commenters expressed support for our proposed deletion of certain category codes, which they indicated would increase clarity and accuracy in coding. Further, several commenters supported our proposal to continue to update the IRF GROUPER to reflect ICD–9–CM national coding guidelines, and to make any substantive changes to the tier comorbidities (that is, changes other than those that merely ensure that the list of tier comorbidities continues to reflect the annual updates to the ICD–9 national coding guidelines) through notice and comment procedures. These commenters also supported our proposal to update Appendix C to reflect current policies.

Response: We agree that our proposal to delete certain category codes should help to eliminate any confusion that providers might have experienced regarding the appropriate codes to use in recording patient comorbidities.

We also agree with the commenters that updating Appendix C each year, and making it a Web-based document rather than including it in the IRF regulations, will provide a more comprehensive solution that will allow providers to stay informed of any changes to the IRF GROUPER as soon as they occur. Any document, such as Appendix C, that contains such an extensive list of ICD–9 codes runs the risk of becoming out-of-date quickly when it is published in regulations. We believe that making the document available on the IRF PPS Web site (*http://www.cms.hhs.gov/InpatientRehabFacPPS/*) will make it easier for CMS to give providers the most current information and, more importantly, will allow providers easier access to the latest information.

Comment: Several commenters expressed reservations about particular revisions that we had proposed. In particular, several commenters asked that CMS retain ICD–9 codes 453.40, 453.41, and 453.42 (various types of venous thrombosis) on the list of tier comorbidities for which providers receive additional payments because of the increased costs associated with these comorbidities, and one commenter asked that we retain ICD–9 codes 799.01 and 799.02 for similar reasons. One commenter also noted recent increases in the rate at which providers are using ICD–9 code 453.41 and asked that CMS delay deleting this code from the IRF grouper until the underlying clinical reasons for its recent increased use could be determined. One commenter requested that the original ICD–9 code (453.8) associated with codes 453.40, 453.41, and 453.42 be added to the list of tier comorbidities in the IRF GROUPER.

Response: In Appendix C of the August 7, 2001 final rule (66 FR 41316, 41414 through 41427), we provided the list of comorbidity codes to be used in the original IRF GROUPER, based on the statistical analysis conducted by RAND for CMS in developing the IRF PPS. On October 1, 2004, the ICD–9–CM Coordination and Maintenance Committee created ICD–9 codes 453.40, 453.41, and 453.42 to represent more specific clinical conditions related to the clinical condition associated with ICD–9 code 453.8 (Venous Thrombosis). Effective October 2004, we inadvertently added codes 453.40 (Ven Embol Thrmbs unspec DP vsls lower extremity), 453.41 (Ven Embol Thrmbs DP vsls prox lower extremity), and 453.42 (Ven Embol Thrmbs DP vsls distal lower extremity) to the IRF GROUPER, even though code 453.8 was never included in the IRF payment algorithm, and therefore was not listed in Appendix C of the August 7, 2001 final rule. The addition of these codes to the IRF GROUPER was not based on any evidence that these codes should have been included on the list, but resulted instead from a simple miscommunication.

Similarly, ICD–9 codes 799.01 (Asphyxia) and 799.02 (Hypoxemia) were created in October 2005 in association with code 799.0. However, code 799.0 (Asphyxia) was never included in the IRF payment algorithm, and therefore was not listed in Appendix C of the August 7, 2001 final rule. Thus, codes 799.01 and 799.02 were also inadvertently added through a simple miscommunication, and the addition of these codes to the IRF GROUPER was not based on any evidence that these codes should have been included on the list.

RAND's regression analysis of the tier comorbidities for both the FY 2002 and FY 2006 final rules focused on the additional costs that an IRF would be expected to incur in caring for a patient with a particular comorbidity (using FY 2003 data). Neither RAND's statistical

analysis for the FY 2002 final rule, nor the subsequent statistical analysis for the FY 2006 final rule, showed that the additional costs of the comorbidities associated with ICD–9 codes 453.8, 453.40, 453.41, 453.42, 799.0, 799.01, or 799.02 are sufficient to warrant inclusion in a tier. In addition, RAND sought advice from a technical expert panel that it convened. The technical expert panel reviewed all of RAND's findings regarding the tier comorbidities and generally agreed with RAND's findings and recommendations. RAND did not recommend that we add these codes to the IRF GROUPER.

Further, since code 453.41 was first approved in October 2004, we do not believe it is surprising that use of this code increased in 2005, especially because providers were made more aware of the code due to its inadvertent inclusion in the IRF GROUPER.

Thus, we are finalizing our decision to delete ICD–9 codes 453.40, 453.41, 453.42, 799.01, and 799.02 from the IRF GROUPER, and we are not adding code 453.8. However, we will continue monitoring the costs associated with various patient comorbidities. If future analyses indicate that any of these ICD–9 codes should be included in one of the tiers in the IRF GROUPER, we will consider adding them through notice and comment procedures.

Comment: One commenter suggested that we consider adding ICD–9 code 282.69 (other sickle cell disease with crisis) to the IRF GROUPER because the commenter believes that this code should be treated as a pair with code 282.68 (other sickle cell disease w/o crisis), which we proposed to add to the IRF GROUPER for FY 2007.

Response: We agree with the commenter, and we note that code 282.69 is already included as one of the comorbidities that generates an additional tier 3 payment in the IRF GROUPER. In fact, this code has always been included in the IRF payment algorithm, and is therefore listed in Appendix C of the August 7, 2001 final rule (66 FR 41423). We are not proposing any changes regarding code 282.69. For FY 2007, we will add code 282.68.

Comment: Several commenters recommended that CMS publish the final changes to the tier comorbidities in the IRF–PAI training manual and in Appendix C.

Response: We agree with the commenters' recommendation and will update both the IRF–PAI training manual and Appendix C with the most current list of tier comorbidities for FY 2007.

In reviewing the refinements that we made to the tier comorbidities for FY 2006, we realized that we did not have an explicit mechanism for updating the IRF GROUPER to account for annual changes to the ICD–9–CM national coding guidelines or to alert providers to these changes. Thus, we believe that the best way to accomplish both of these goals, and to ensure that providers have access to the most up-to-date IRF GROUPER information possible is to make the documents containing the final list of ICD–9 codes used in the IRF GROUPER Web-based, rather than publishing each technical update in regulation. The ICD–9 code updates might occur more frequently than CMS publishes an IRF rule in the **Federal Register**, so it would be impractical to keep Appendix C updated based on annual ICD–9 national coding guideline changes if we were to try to publish Appendix C in the **Federal Register** each time Appendix C is updated to reflect new codes. We believe a Web-based product will allow providers to have the most convenient and timely possible access to the latest available information. Therefore, both updated documents will be available on the IRF PPS Web site(located at *http://www.cms.hhs.gov/InpatientRehabFacPPS/*) before October 1, 2006.

To clarify, as discussed in the FY 2007 IRF PPS proposed rule (71 FR 28106, 28111), we will update these Web-based documents regularly to reflect changes in the ICD–9 national coding guidelines that are technical in nature. For example, the ICD–9 national coding guidelines added ICD–9 codes 341.20 through 341.22 for October 2006 to correspond to codes 323.8 and 323.9 that are currently in the IRF Grouper. Thus, we will add codes 341.20 through 341.22 to the IRF Grouper and to Appendix C on the IRF PPS Web site as soon as the changes become effective. However, any substantive changes to the comorbid conditions on the list of tier comorbidities in the IRF GROUPER will be proposed through notice and comment procedures. Thus, hypothetically speaking, if we were to discover later through our ongoing analysis of the IRF classification and payment systems that one (or possibly more than one) of these ICD–9 codes does not belong on the list of tier comorbidities—either because it does not substantially increase the IRFs' costs of caring for patients with that comorbidity, or because it is not clinically relevant as discussed in the August 7, 2001 final rule—then we would later propose to delete this code (or codes) through notice and comment procedures. To reiterate, this is only a hypothetical example. We have no intent to delete codes 341.20 through 341.22 at this time.

The finalized list of tier comorbidities for FY 2007 that we are posting on the IRF PPS Web site and in the IRF GROUPER documentation as of October 1, 2006 will generally reflect the August 7, 2001 final rule (66 FR 41316, 41414 through 41427) as modified by the tier comorbidity changes adopted in this final rule, as well as changes adopted due to ICD–9 national coding guideline updates. This version will constitute the baseline for any future updates to the tier comorbidities.

Comment: One commenter expressed confusion over the listing of ICD–9 code 250.01 in the FY 2006 IRF GROUPER, while the FY 2006 IRF PPS final rule indicated that CMS was adding code 250.1, which was not listed in the FY 2006 IRF GROUPER.

Response: On September 30, 2005, we published a correction notice (70 FR 57166) that implemented some technical corrections to the FY 2006 IRF PPS final rule. One of these technical corrections was to change code 250.1 to 250.01.

Comment: One commenter requested that CMS add an ICD–9 code that represents the condition HYPOALBUMINEMIA to the list of tier comorbidities to account for the added costs of patients with this condition.

Response: We would need to conduct further statistical analysis to determine whether this condition should be included in the list of tier comorbidities. We will take the commenter's recommendation into consideration for the future.

Final Decision: After carefully considering all of the comments that we received on the proposed changes to the existing list of tier comorbidities, we are finalizing our decision to implement all of the changes as proposed, including the additions listed in Table 1, the deletions listed in Table 2, and the movement of the codes listed in Table 3 from tier 2 to tier 3.

TABLE 1.—ICD–9 CODES THAT WE WILL ADD TO THE IRF PPS GROUPER

ICD–9–CM	ICD–9–CM Label	Tier	RIC Exclusion
466.11	ACU BRONCHOLITIS D/T RSV	3	15
466.19	ACU BRNCHLTS D/T OTH ORG	3	15
282.68	OTH SICKLE–CELL DISEASE W/O CRISIS	3	None.
567.29	OTH SUPPURATIVE PERITONITIS	3	None.

TABLE 2.—ICD–9 CODES THAT WE WILL DELETE FROM THE IRF PPS GROUPER

ICD–9–CM	ICD–9–CM Label	Tier
453.40	VEN EMBOL THRMBS UNSPEC DP VSLS LWR EXTREM	3
453.41	VEN EMBOL THRMBS DP VSLS PROX LWR EXTREM	3
453.42	VEN EMBOL THRMBS DP VSLS DIST LWR EXTREM	3
799.01	ASPHYXIA	3
799.02	HYPOXEMIA	3

TABLE 3.—ICD–9 CODES THAT WE WILL MOVE FROM TIER 2 TO TIER 3 IN THE IRF PPS GROUPER

ICD–9–CM	ICD–9–CM Label	Tier	RIC Exclusion
112.4	CANDIDIASIS OF LUNG	3	15
112.5	DISSEMINATED CANDIDIASIS	3	None.
112.81	CANDIDAL ENDOCARDITIS	3	14
112.83	CANDIDAL MENINGITIS	3	03, 05
112.84	CANDIDAL ESOPHAGITIS	3	None.
785.4	GANGRENE	3	10, 11
995.90	SIRS NOS	3	None.
995.91	SIRS INF W/O ORG DYS	3	None.
995.92	SIRS INF W ORG DYS	3	None.
995.93	SIRS NON–INF W/O ORG DYS	3	None.
995.94	SIRS NON–INF W ORG DYS	3	None.

B. Changes to the Case-Mix Group (CMG) Relative Weights

As specified in § 412.620(b)(1), we calculate a relative weight for each CMG that is proportional to the resources needed by an average inpatient rehabilitation case in that CMG. (For example, cases in a CMG with a relative weight of 2, on average, will cost twice as much as cases in a CMG with a relative weight of 1.) Relative weights account for the variance in cost per discharge and resource utilization among the payment groups, and their use helps to ensure that IRF PPS payments support beneficiary access to care as well as provider efficiency. In the FY 2007 IRF PPS proposed rule (71 FR 28106), we proposed to update the relative weights for FY 2007 based on a revised analysis of the data used to construct the relative weights for FY 2006, which had revealed certain minor discrepancies.

We received numerous comments on the proposed changes to the CMG relative weights, which are summarized below.

Comment: Numerous commenters expressed concern that the proposed CMG relative weights for FY 2007 were based on the same FY 2003 data used to compute the FY 2006 CMG relative weights. These commenters asked that CMS recalculate the CMG relative weights for FY 2007 using the latest available data.

Response: We asked RAND to recalculate the CMG relative weights for FY 2007 to correct some minor discrepancies found in the tier comorbidities used in the analysis of the FY 2006 relative weights. After we published the FY 2006 IRF PPS final rule (70 FR 47880), we conducted a post-implementation review to ensure that the FY 2006 revisions were implemented correctly. Because the revisions for FY 2007 are merely designed to resolve some of the minor discrepancies identified in this post-implementation review and not to implement additional refinements, we believe it is appropriate to continue to use the same data that we used for the FY 2006 IRF PPS final rule. We agree that, in the future, any rebasing or recalibration of the system should be done using the most current available data.

Comment: Several commenters requested copies of the updated RAND analysis that produced the revised CMG relative weights for FY 2007.

Response: The updated analysis that RAND performed in recalculating the CMG relative weights for this final rule was identical to its analysis for the FY 2002 and FY 2006 IRF PPS final rules, with the exception of correcting some of the minor discrepancies in the data used in the FY 2006 analysis. For a detailed description of the methodology that RAND used to calculate the CMG relative weights for the FY 2002, FY 2006, and current final rules, please refer to pages 41351 through 41353 of the August 7, 2001 final rule (66 FR 41316). The data that RAND used for the FY 2006 and FY 2007 CMG relative weight calculations are the FY 2003 IRF MEDPAR data merged with the FY 2003 IRF–PAI and cost report data. The analysis that RAND conducted for us for FY 2007 produced the updated CMG relative weight and average length of stay figures displayed in Table 4 of this final rule.

Comment: We received some comments expressing concerns about the accuracy of the average length of stay values. One commenter suggested that the average length of stay values for the different tiers should be

proportional to payment and that, for example, the average length of stay values for tier 1 (the highest paying tier) should always be higher than the average lengths of stay for tiers 2 and 3 and the "no comorbidity" tier. Another commenter asked that we re-examine the average length of stay value for the traumatic spinal cord injury patients in tier 1 to ensure that it is consistent with medical practice, stating that these patients require relatively long rehabilitation periods.

Response: We have reviewed the average length of stay values, in general and for the traumatic spinal cord injury CMGs in particular, and we believe they are correct. The average length of stay values shown in Table 4 are entirely driven by the data. Whereas we impose a constraint on the CMG relative weights under which the relative weight for a higher-paying tier can never be lower than the relative weight for a lower-paying tier, we do not constrain the average length of stay values. They represent the average number of days that patients in a given CMG and tier were in an IRF.

As we indicated in the FY 2006 IRF PPS final rule (70 FR 47901), the relative weights for each of the CMGs and tiers represent the relative costliness of patients in those CMGs and tiers compared with patients in other CMGs and tiers. The average length of stay for each CMG and tier, however, represents the average number of days that patients in that CMG and tier were treated in IRFs, based on the FY 2003 data. We determine IRF PPS payments on a per-discharge basis, meaning that providers receive a pre-determined payment amount according to an individual patient's CMG and tier classification, regardless of the number of days that patient is treated in the IRF. The only exceptions to this general policy are for very short-stay cases and for certain transfer cases. Because payments are made on a per-discharge basis, there is not necessarily a correlation between the number of days a patient is treated in an IRF and the payment amount for that patient. If, for example, the relative weight for a particular CMG in tier 1 is higher than the relative weight for that same CMG in the "no comorbidity" tier, this means that cases in that CMG in tier 1 are expected to be more costly for the IRF to treat than cases in that CMG in the "no comorbidity" tier. However, the average length of stay of patients in that CMG in tier 1 might sometimes actually be lower than the average length of stay of patients in that CMG in the "no comorbidity" tier; for example, the "tier 1" patients could require significantly more intensive treatment for a shorter period of time, while the "no comorbidity" patients could require less intensive treatment over a longer period of time. Thus, the relative weights may not bear a proportional relationship to the average length of stay values.

We do not require IRFs to treat the average length of stay values as goals or targets for particular cases. IRFs are generally free to treat particular patients for as few or as many days as is medically appropriate. We encourage IRFs to admit patients for the length of time that results in the best quality of care for the patient.

Final Decision: After carefully reviewing all of the comments that we received on the proposed changes to the CMG relative weights, we are finalizing our decision to update the CMG relative weights and the average length of stay values for FY 2007, as shown in Table 4.

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Table 4: FY 2007 IRF PPS Relative Weights and Average Lengths of Stay for Case-Mix Groups

CMG	CMG Description (M=motor, C=cognitive, A=age)	Relative Weights				Average Length of Stay			
		Tier1	Tier2	Tier3	None	Tier1	Tier2	Tier3	None
0101	Stroke M>51.05	0.7707	0.7303	0.6572	0.6347	8	11	9	9
0102	Stroke M>44.45 and M<51.05 and C>18.5	0.9493	0.8995	0.8095	0.7818	11	15	11	10
0103	Stroke M>44.45 and M<51.05 and C<18.5	1.1192	1.0605	0.9544	0.9218	14	13	12	12
0104	Stroke M>38.85 and M<44.45	1.1885	1.1260	1.0134	0.9787	13	14	13	13
0105	Stroke M>34.25 and M<38.85	1.4261	1.3512	1.2161	1.1745	16	17	16	15
0106	Stroke M>30.05 and M<34.25	1.6594	1.5722	1.4150	1.3666	18	20	18	18
0107	Stroke M>26.15 and M<30.05	1.9150	1.8145	1.6330	1.5771	21	23	21	20
0108	Stroke M<26.15 and A>84.5	2.2160	2.0997	1.8897	1.8250	28	29	25	24
0109	Stroke M>22.35 and M<26.15 and A<84.5	2.1998	2.0843	1.8758	1.8116	23	26	24	23
0110	Stroke M<22.35 and A<84.5	2.6287	2.4907	2.2416	2.1649	30	33	28	27
0201	Traumatic brain injury M>53.35 and C>23.5	0.8143	0.6806	0.6080	0.5647	10	9	9	8

CMG	CMG Description (M=motor, C=cognitive, A=age)	Relative Weights				Average Length of Stay			
		Tier1	Tier2	Tier3	None	Tier1	Tier2	Tier3	None
0202	Traumatic brain injury M>44.25 and M<53.35 and C>23.5	1.0460	0.8743	0.7810	0.7254	12	10	11	9
0203	Traumatic brain injury M>44.25 and C<23.5	1.2503	1.0450	0.9335	0.8671	15	15	12	12
0204	Traumatic brain injury M>40.65 and M<44.25	1.3390	1.1192	0.9998	0.9287	15	16	13	13
0205	Traumatic brain injury M>28.75 and M<40.65	1.6412	1.3718	1.2254	1.1382	17	18	16	15
0206	Traumatic brain injury M>22.05 and M<28.75	2.1445	1.7924	1.6011	1.4873	23	22	21	20
0207	Traumatic brain injury M<22.05	2.7664	2.3122	2.0655	1.9185	35	29	26	25
0301	Non-traumatic brain injury M>41.05	1.1394	0.9533	0.8552	0.7772	12	12	11	10
0302	Non-traumatic brain injury M>35.05 and M<41.05	1.4875	1.2446	1.1164	1.0147	14	16	14	13
0303	Non-traumatic brain injury M>26.15 and M<35.05	1.7701	1.4810	1.3285	1.2074	20	19	17	16
0304	Non-traumatic brain injury M<26.15	2.4395	2.0410	1.8309	1.6640	32	25	23	21
0401	Traumatic spinal cord injury M>48.45	0.9587	0.8456	0.7722	0.6858	12	12	11	10
0402	Traumatic spinal cord injury M>30.35 and M<48.45	1.3256	1.1691	1.0676	0.9482	18	16	14	13
0403	Traumatic spinal cord injury M>16.05 and M<30.35	2.3069	2.0347	1.8580	1.6502	22	24	24	22
0404	Traumatic spinal cord injury M<16.05 and A>63.5	4.1542	3.6639	3.3458	2.9717	51	46	41	37
0405	Traumatic spinal cord injury M<16.05 and A<63.5	3.1371	2.7668	2.5266	2.2441	33	37	33	28

CMG	CMG Description (M=motor, C=cognitive, A=age)	Relative Weights				Average Length of Stay			
		Tier1	Tier2	Tier3	None	Tier1	Tier2	Tier3	None
0501	Non-traumatic spinal cord injury M>51.35	0.7648	0.6455	0.5687	0.5071	9	8	8	7
0502	Non-traumatic spinal cord injury M>40.15 and M<51.35	1.0262	0.8661	0.7630	0.6804	13	12	11	9
0503	Non-traumatic spinal cord injury M>31.25 and M<40.15	1.3596	1.1476	1.0109	0.9014	15	15	13	12
0504	Non-traumatic spinal cord injury M>29.25 and M<31.25	1.6984	1.4335	1.2628	1.1260	21	19	16	15
0505	Non-traumatic spinal cord injury M>23.75 and M<29.25	2.0171	1.7025	1.4997	1.3373	23	22	19	18
0506	Non-traumatic spinal cord injury M<23.75	2.7402	2.3128	2.0374	1.8167	29	28	26	23
0601	Neurological M>47.75	0.8991	0.7330	0.7019	0.6522	11	10	9	9
0602	Neurological M>37.35 and M<47.75	1.1968	0.9757	0.9342	0.8682	13	13	13	12
0603	Neurological M>25.85 and M<37.35	1.5326	1.2495	1.1965	1.1118	17	17	15	15
0604	Neurological M<25.85	1.9592	1.5973	1.5295	1.4213	22	20	21	19
0701	Fracture of lower extremity M>42.15	0.9028	0.7717	0.7338	0.6617	12	11	10	9
0702	Fracture of lower extremity M>34.15 and M<42.15	1.1736	1.0033	0.9539	0.8602	13	14	13	12
0703	Fracture of lower extremity M>28.15 and M<34.15	1.4629	1.2506	1.1890	1.0722	16	17	16	14
0704	Fracture of lower extremity M<28.15	1.7969	1.5361	1.4605	1.3170	20	20	19	18
0801	Replacement of lower extremity joint M>49.55	0.6537	0.5504	0.5131	0.4607	7	7	7	6

CMG	CMG Description (M=motor, C=cognitive, A=age)	Relative Weights				Average Length of Stay			
		Tier1	Tier2	Tier3	None	Tier1	Tier2	Tier3	None
0802	Replacement of lower extremity joint M>37.05 and M<49.55	0.8542	0.7193	0.6704	0.6020	10	10	9	8
0803	Replacement of lower extremity joint M>28.65 and M<37.05 and A>83.5	1.2707	1.0700	0.9974	0.8956	15	15	13	12
0804	Replacement of lower extremity joint M>28.65 and M<37.05 and A<83.5	1.1040	0.9296	0.8665	0.7781	13	12	12	10
0805	Replacement of lower extremity joint M>22.05 and M<28.65	1.3927	1.1727	1.0931	0.9816	17	16	14	13
0806	Replacement of lower extremity joint M<22.05	1.6723	1.4082	1.3126	1.1787	18	19	17	15
0901	Other orthopedic M>44.75	0.8425	0.7641	0.6868	0.6120	10	11	10	9
0902	Other orthopedic M>34.35 and M<44.75	1.1088	1.0057	0.9039	0.8056	13	13	12	11
0903	Other orthopedic M>24.15 and M<34.35	1.4638	1.3277	1.1934	1.0635	18	19	16	15
0904	Other orthopedic M<24.15	1.8341	1.6636	1.4952	1.3325	25	23	21	19
1001	Amputation, lower extremity M>47.65	0.9625	0.8879	0.7957	0.7361	11	11	11	10
1002	Amputation, lower extremity M>36.25 and M<47.65	1.2709	1.1724	1.0507	0.9719	14	15	14	13
1003	Amputation, lower extremity M<36.25	1.7876	1.6491	1.4779	1.3671	19	22	19	18

CMG	CMG Description (M=motor, C=cognitive, A=age)	Relative Weights				Average Length of Stay			
		Tier1	Tier2	Tier3	None	Tier1	Tier2	Tier3	None
1101	Amputation, non-lower extremity M>36.35	1.2554	1.0482	0.9225	0.8496	14	15	12	11
1102	Amputation, non-lower extremity M<36.35	1.8824	1.5717	1.3832	1.2739	19	19	18	17
1201	Osteoarthritis M>37.65	1.0177	0.8785	0.8182	0.7405	11	12	11	10
1202	Osteoarthritis M>30.75 and M<37.65	1.3168	1.1367	1.0586	0.9581	15	16	14	13
1203	Osteoarthritis M<30.75	1.6241	1.4020	1.3057	1.1817	21	19	17	16
1301	Rheumatoid, other arthritis M>36.35	1.0354	0.9636	0.8511	0.7429	12	13	11	10
1302	Rheumatoid, other arthritis M>26.15 and M<36.35	1.4321	1.3327	1.1772	1.0275	15	18	15	14
1303	Rheumatoid, other arthritis M<26.15	1.8250	1.6984	1.5002	1.3094	22	21	20	18
1401	Cardiac M>48.85	0.8160	0.7351	0.6534	0.5861	10	9	9	8
1402	Cardiac M>38.55 and M<48.85	1.1038	0.9944	0.8839	0.7928	12	13	12	11
1403	Cardiac M>31.15 and M<38.55	1.3705	1.2347	1.0975	0.9844	16	16	14	13
1404	Cardiac M<31.15	1.7370	1.5649	1.3910	1.2477	21	20	18	16
1501	Pulmonary M>49.25	0.9986	0.8870	0.7793	0.7399	11	13	10	10
1502	Pulmonary M>39.05 and M<49.25	1.2661	1.1246	0.9880	0.9381	13	15	12	12
1503	Pulmonary M>29.15 and M<39.05	1.5457	1.3730	1.2062	1.1453	16	16	15	15
1504	Pulmonary M<29.15	2.0216	1.7957	1.5775	1.4979	26	21	20	18
1601	Pain syndrome M>37.15	1.0070	0.8550	0.7774	0.6957	12	11	10	10
1602	Pain syndrome M>26.75 and M<37.15	1.3826	1.1739	1.0673	0.9552	15	17	14	13

CMG	CMG Description (M=motor, C=cognitive, A=age)	Relative Weights				Average Length of Stay			
		Tier1	Tier2	Tier3	None	Tier1	Tier2	Tier3	None
1603	Pain syndrome M<26.75	1.7025	1.4455	1.3143	1.1762	19	19	18	16
1701	Major multiple trauma without brain or spinal cord injury M>39.25	0.9818	0.9641	0.8479	0.7368	12	12	11	10
1702	Major multiple trauma without brain or spinal cord injury M>31.05 and M<39.25	1.2921	1.2688	1.1158	0.9696	14	16	15	13
1703	Major multiple trauma without brain or spinal cord injury M>25.55 and M<31.05	1.5356	1.5080	1.3262	1.1524	17	20	18	16
1704	Major multiple trauma without brain or spinal cord injury M<25.55	1.9246	1.8899	1.6620	1.4443	26	26	22	19
1801	Major multiple trauma with brain or spinal cord injury M>40.85	1.1920	0.9866	0.8243	0.7342	15	13	13	10
1802	Major multiple trauma with brain or spinal cord injury M>23.05 and M<40.85	1.9058	1.5774	1.3179	1.1738	19	21	18	16
1803	Major multiple trauma with brain or spinal cord injury M<23.05	3.4302	2.8391	2.3721	2.1127	43	33	30	27
1901	Guillian Barre M>35.95	1.2399	1.0986	1.0965	0.9350	14	13	14	12
1902	Guillian Barre M>18.05 and M<35.95	2.3194	2.0552	2.0512	1.7491	27	25	25	23
1903	Guillian Barre M<18.05	3.3464	2.9651	2.9593	2.5235	37	39	31	33
2001	Miscellaneous M>49.15	0.8734	0.7381	0.6735	0.6084	10	10	9	8
2002	Miscellaneous M>38.75 and M<49.15	1.1447	0.9674	0.8827	0.7975	12	13	12	11

CMG	CMG Description (M=motor, C=cognitive, A=age)	Relative Weights				Average Length of Stay			
		Tier1	Tier2	Tier3	None	Tier1	Tier2	Tier3	None
2003	Miscellaneous M>27.85 and M<38.75	1.4777	1.2488	1.1395	1.0294	16	16	15	14
2004	Miscellaneous M<27.85	1.9716	1.6662	1.5204	1.3735	25	22	20	18
2101	Burns M>0	2.1842	2.1842	1.6606	1.4587	27	24	20	17
5001	Short-stay cases, length of stay is 3 days or fewer				0.2201				2
5101	Expired, orthopedic, length of stay is 13 days or fewer				0.6351				8
5102	Expired, orthopedic, length of stay is 14 days or more				1.5985				22
5103	Expired, not orthopedic, length of stay is 15 days or fewer				0.7203				8
5104	Expired, not orthopedic, length of stay is 16 days or more				1.8784				24

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V. FY 2007 IRF Federal Prospective Payment Rates

A. Reduction of the Standard Payment Amount to Account for Coding Changes

According to research conducted by the RAND Corporation under contract with CMS, changes in provider coding practices increased Medicare payments to IRFs between 1999 and 2002 by at least 1.9 percent and as much as 5.8 percent. (We note that RAND revised its report in late 2005 to reflect an upper bound (high-end estimate) of 5.9 percent, instead of the 5.8 percent that we reported in the FY 2006 IRF PPS proposed and final rules. However, because our FY 2006 proposed rule refers to a 5.8 percent upper bound, we will continue to use the 5.8 percent figure for this final rule.) In the FY 2007 proposed rule (71 FR 28106), we proposed to apply a 2.9 percent reduction to the standard payment amount for FY 2007 to adjust for changes in coding that, according to RAND's research, did not reflect real changes in IRF case mix. This proposed reduction would be in addition to the 1.9 percent adjustment implemented for FY 2006 and would result in a total adjustment of 4.8 percent (1.9 + 2.9 = 4.8), which still falls well within the range that RAND estimated.

However, we stated in the proposed rule that we were continuing to analyze the data and, therefore, the specific amount of the final payment adjustment was subject to change for this final rule based on the results of the ongoing analysis. As noted below, we also received a significant number of comments that uniformly recommended no reduction for FY 2007. Accordingly, we have revised the amount of the proposed reduction for this final rule, as discussed below, and will implement a reduction of 2.6 percent.

Public comments and our responses on the proposed reduction of the standard payment amount to account for coding changes are summarized below.

Comment: The majority of commenters expressed significant concerns about the proposed 2.9 percent reduction to the standard payment amount for FY 2007, and all who commented on this proposal indicated that CMS should not implement any reduction to the standard payment amount for FY 2007. Although they expressed a number of specific concerns (which we address separately below), the commenters generally indicated that IRFs are currently experiencing a significant amount of volatility and, for this reason, CMS should not implement an additional reduction to the standard payment amount for FY 2007. Further, many commenters asserted that RAND expressed more confidence in the findings at the low end of its estimated range (1.9 percent), and that CMS had already used RAND's analysis to justify the 1.9 percent coding adjustment for FY 2006. Several commenters also questioned CMS' conclusion that real case mix in IRFs had not increased substantially.

Response: In light of recent changes to the IRF PPS that affect utilization trends, including the phase-in of the IRF 75 percent rule compliance percentage, we have chosen to take an incremental approach to adjusting for changes in coding that do not reflect real changes in case mix. In the FY 2006 final rule (70 FR 47880), we implemented a 1.9 percent reduction to the standard payment amount, and noted that it was the "lowest possible amount of change attributable to coding changes," as determined by RAND's analysis. In that final rule, we decided to implement the lowest possible amount to account for the possibility that some of the observed changes may have been attributable to factors other than coding changes or could be temporary changes associated with the transition to a new payment system. However, we indicated that we would continue to review the need for any further reduction in the standard payment amount in subsequent years as part of our overall monitoring and evaluation of the IRF PPS.

Based on our continued review, we believe a further reduction is warranted. Since publication of the FY 2006 final rule, we have continued our fiscal oversight of the IRF PPS and have conducted detailed analyses of IRF payment and utilization practices. We re-examined RAND's analysis of the 1999 and 2002 data (contained in RAND's report entitled "Preliminary Analyses of Changes in Coding and Case Mix Under the Inpatient Rehabilitation Facility Prospective Payment System"). We believe it is appropriate to base our decision to implement a further reduction on RAND's analysis because the additional adjustment is intended to reflect more fully the impact of coding changes (that do not reflect real changes in case mix) from the same period for which we implemented the 1.9 percent reduction in FY 2006 (that is, 2002).

We disagree with the commenters who believe that the lower end of RAND's estimate is more valid than the higher end. We further believe that our decision for FY 2006 to make an adjustment of 1.9 percent is indicative only of our intent to adjust incrementally for coding changes, and is not an indication that the higher end of the estimate is less valid than the lower. Indeed, in contrast to some of the commenters, we find it compelling that RAND found that coding changes accounted for at least 1.9 percent of the increases in payment in 2002. In our view, this means that the actual amount was likely somewhat higher than 1.9 percent. As we discussed in the FY 2006 final rule, a separate analysis by RAND found that if all IRFs had been paid based on 100 percent of the IRF PPS payment rates throughout all of 2002, PPS payments during 2002 would have been 17 percent higher than IRFs' costs. We stated that we believed this suggested that we could have proposed a reduction greater than 1.9 percent. We continue to believe this is the case. Further, if RAND's analysis did not support a conclusion that coding change likely accounted for more than 1.9 percent of the increase in payments, RAND would not have provided a range of estimates. However, RAND reported that IRF payments were at least 1.9 percent and as much as 5.8 percent higher than expected as a result of changes in coding that did not reflect real changes in case mix.

As the commenters noted, several portions of RAND's report discuss the difficulty of estimating with precision the amount of change in case mix that is real and the amount that is a result of changes in coding that do not reflect real changes in case mix. However, we believe this discussion was merely an acknowledgement of the complexity of the analysis, and did not represent a lack of confidence in the upper end of RAND's estimated range (1.9 to 5.8 percent).

Further, the technical expert panel (consisting of representatives from industry groups, other government entities, academia, and other researchers) that RAND assembled to advise it on its methodology and review its findings expressed general agreement with RAND's analytical approaches. We have also carefully reviewed RAND's report, and we continue to believe that the analyses that support both the upper- and lower-bounds of RAND's range of estimates are analytically sound. In particular, we believe the approach that RAND used in examining IRF patients' acute care hospital records before admission to the IRF provides a good indication of IRF patients' acuity because the vast majority of IRF patients are referred to the IRF from the acute care hospital setting. As detailed in RAND's report, most of the changes in case mix that RAND documented from the acute care hospital records indicated that IRF patients should have been less costly to treat in 2002 than in 1999. This analysis produced RAND's upper-bound estimate that as much as 5.8 percent of the changes in aggregate payments were a result of changes in coding that did not reflect real changes in case mix. For the reasons discussed in its report, RAND acknowledged that the 5.8 percent estimate was an upper-bound estimate and that, therefore, the actual change in aggregate payments as a result of coding change was likely lower than this. However, we believe it is an incorrect interpretation of RAND's results to suggest that RAND only expressed confidence in its 1.9 percent estimate. If RAND had believed that 1.9 percent was the final result of its analysis, RAND would have recommended that CMS implement a coding adjustment of exactly 1.9 percent, not at least 1.9 percent, and would not have given a range of up to 5.8 percent. We interpret the 1.9 percent figure to be a floor for our adjustment for coding changes that do not reflect real changes in case mix, rather than an upper limit for such an adjustment.

As noted previously, we initially chose to adopt a conservative approach by implementing only a 1.9 percent adjustment for FY 2006, even though we believe that RAND's analysis suggested that the actual effects of coding changes that do not reflect a real change in case mix were likely larger than 1.9 percent. We chose this more conservative approach for FY 2006 because we believed that an incremental approach to implementing the payment reduction was appropriate in view of all of the other recent Medicare policy changes, such as the phase in of the 75 percent rule compliance percentage. We continue to favor an incremental approach, for this same reason. However, as described in the FY 2007 proposed rule and for the reasons described below, we are convinced that an additional coding adjustment is needed to adjust the impact of coding changes not related to real changes in case mix. As part of our ongoing assessment, we examined a recent MedPAC analysis of trends in IRF costs that we believe indicates that case mix changes had a lower impact on payment than we initially thought, and therefore that coding changes had a larger impact on payments than we initially thought. In its March 2006 report, MedPAC reported that IRFs' cost increases in 2003 and 2004 (2.4 percent and 3.6 percent respectively) lagged far behind payment increases. During 2002 and 2003, MedPAC reported that IRF PPS payments were increasing at a rate of "more than 10 percent per year." From this, MedPAC concluded that "payments have far outpaced cost growth" during the first years of the IRF PPS. We believe that the relatively low cost increases that MedPAC found suggest that case mix was not increasing as rapidly as IRF PPS payments, because if case mix had been increasing substantially, this would have led to rapidly rising costs.

As we discussed in the proposed rule, we also analyzed changes in the distribution of patients across the four

IRF payment tiers from calendar year 2002 through calendar year 2005. The purpose of this analysis was to evaluate whether an additional adjustment was needed to eliminate the effects of coding changes that do not represent real changes in case mix from payments in the initial implementation year of the IRF PPS, and we analyzed the calendar year 2002 through calendar year 2005 data because it was the most complete post-PPS data available. For determining IRF PPS payments, we classify patients into one of four tiers within a CMG, based on the presence of any relevant comorbidities. One of the tiers contains patients with no relevant comorbidities. The other three tiers contain patients with increasingly costly comorbidities. For this reason, an IRF will receive higher payments for patients in one of the three more-costly tiers than for patients in the "no comorbidity" tier.

As indicated in Table 6 of the proposed rule, we found that the proportion of IRF patients in the lowest-paying tier (the tier for patients with "no comorbidities") decreased by 6 percentage points between calendar years 2002 and 2005. Conversely, the proportion of patients in each of the three higher-paying tiers increased each year. As we indicated previously, we do not believe real case mix was increasing substantially, because MedPAC's findings indicate that costs were not rising as rapidly as we would have expected if case mix had been increasing significantly during this period. Thus, we believe this potential disparity lends further support to the conclusion that a substantial portion of the unexpected increase in IRF payments when we first implemented the IRF PPS was a result of changes in provider coding practices that do not reflect real changes in case mix. We believe the MedPAC and CMS analyses, taken together, combined with our interpretation of the RAND report suggesting that the amount of coding change likely represented more than 1.9 percent of the aggregate payment increases, suggest that our FY 2006 decision to reduce the standard payment by only 1.9 percent, the lowest possible amount, was a very conservative approach. As we indicated previously, we intended to take a conservative approach for FY 2006 because we believed, and continue to believe, that an incremental approach to the coding adjustment is best given the other recent Medicare policy changes that we have implemented for IRFs. As part of that incremental approach, we believe making the additional adjustment for FY 2007 is warranted based on the mandate of Section 1886(j)(2)(C)(ii) of the Act.

Comment: Many commenters expressed specific concerns about the effects of the recent phase-in of the 75 percent rule compliance percentage, including concerns that the enforcement of the 75 percent rule was having a larger effect on the population of patients being admitted to IRFs than CMS's 75 percent rule impact analysis would have predicted. These commenters indicated that it would be inappropriate to implement any reduction to the standard payment amount to account for coding changes, not only for FY 2007 but also until the 75 percent rule is fully phased in and CMS has had an opportunity to analyze the data that reflect the full phase-in of the compliance percentage.

Response: We do not agree with the commenters that CMS should delay the implementation of a reduction to the standard payment amount to account for coding changes that do not reflect real changes in case mix that occurred when we first began implementing the IRF PPS, as required by statute and for the reasons outlined immediately above. For FY 2006, we implemented a very conservative adjustment of 1.9 percent in recognition that IRFs' current cost structures may be changing as they strive to comply with other recent Medicare policy changes, such as the 75 percent rule. As described in further detail below, in further recognition of these changes and in response to comments, we are lowering our proposed reduction from 2.9 percent to 2.6 percent. However, the 75 percent rule and the reduction to the standard payment amount to account for coding change involve separate statutory mandates. The purpose of the 75 percent rule is to adhere to the statutory requirement to differentiate IRF facilities from IPPS hospitals and other types of inpatient hospital facilities. The purpose of the reduction to the standard payment amount is to adhere to the statutory requirement to adjust the standard payment amount to account for changes in coding that affect aggregate payments and do not reflect real changes in case mix. We believe that the statute requires us to establish policies for both purposes.

The impact analysis contained in the May 7, 2004 IRF classification criteria final rule used the best available data to estimate the effects of the revised regulations. However, although we strive to be as accurate as possible in our estimation of the effects of the policies we implement, an impact analysis is always a projection of what we believe will happen in the future based on historical data, and therefore uncertain. Because we understand the commenters' concerns regarding the effects of the 75 percent rule on beneficiaries and on providers, we are continuing our close monitoring of the impact of the multi-year phase in of the 75 percent rule compliance percentage on beneficiaries' access to IRF services and on IRFs' costs of treating various types of patients. As detailed in CMS' November 30, 2005 memorandum entitled "Inpatient Rehabilitation Facility PPS and the 75 Percent Rule," (available on the IRF PPS Web site at *http://www.cms.hhs.gov/InpatientRehabFacPPS/*), our analysis indicates that the effects of the 75 percent rule have been focused on a few specific conditions, but have resulted in improved access to care for certain types of patients, such as those being treated for a stroke, for which IRF services can be particularly beneficial.

As discussed in detail in the IRF classification criteria final rule (69 FR 25752), published May 7, 2004, we implemented a phase-in schedule for the 75 percent compliance threshold to give providers ample time to adjust their admission practices to comply with the full threshold. Further, as discussed in section VII of this final rule, in accordance with section 5005 of the DRA, we are revising the compliance thresholds that must be met for certain cost reporting periods, which effectively allows providers an additional cost reporting period to meet the 60 percent compliance threshold and delays the full phase-in of the 75 percent compliance threshold. In addition, patient comorbidities will continue to be used to determine compliance for an additional cost reporting period, until the full 75 percent compliance threshold becomes effective. Thus, we believe that both of these measures, along with our decision to implement a 2.6 percent reduction instead of a 2.9 percent reduction, will ease the transition for providers by allowing them more time to adjust their practices to comply with the regulations.

Comment: Some commenters expressed concerns about the local coverage determinations (LCDs) being used by some of the fiscal intermediaries in denying some IRF claims. They said that these policies were creating instability in the system that would be intensified by the imposition of the additional reduction to the standard payment amount for FY 2007.

Response: Because LCDs were not discussed in the proposed rule, a substantive discussion of LCD policies

is outside the scope of this final rule. However, to the extent that the commenters believe CMS should delay implementation of the reduction to the standard payment amount for FY 2007 because of the LCD issues, we disagree with the commenters. We continue to believe that we have an obligation to implement a reduction to the standard payment amount to account for coding changes that do not reflect real changes in case mix that occurred when we first began implementing the IRF PPS, as required by statute and for the reasons outlined above. We will continue to monitor the effects of the LCDs closely and will take these effects into account in our ongoing analyses of IRF payment policies. We note that the FIs have discretion in formulating and implementing the most appropriate LCDs for their areas, as long as they are not inconsistent with the national policies defined by CMS, and we fully support their efforts in this regard.

Comment: Numerous commenters questioned why CMS was using older data to support the proposed reduction to the standard payment amount for FY 2007. They asked CMS to collect and analyze FY 2005 and FY 2006 data (which would be representative of the changes under the 75 percent rule) before implementing any reductions in payments.

Response: We agree with the commenters that it will be important to continue to analyze the most current available data over the coming years, especially when complete data from the full phase-in of the 75 percent rule become available, to ensure that IRF payments continue to reflect as closely as possible the costs of care in IRFs. If our analysis of this data shows that additional refinements need to be made to the system, we will propose them in the future. However, we do not believe that this precludes us from making current refinements to the system that adjust payments for the effects of coding changes (that do not reflect real changes in case mix) that occurred when the IRF PPS was first implemented, for the reasons described in detail above.

Comment: Several commenters incorrectly cited a 16 percent behavioral offset that was implemented at the start of the IRF PPS, which they believed had already accounted for the expected changes in IRF payments due to changes in coding. These commenters suggested that this behavioral offset eliminated the need for the FY 2006 and FY 2007 coding adjustments.

Response: As described in the August 7, 2001 final rule (66 FR 41316, 41366 through 41367), we applied a 1.16 percent (not 16 percent) behavioral offset to IRF PPS payments to account for the inherent incentives of a discharge-based prospective payment system to discharge patients earlier than under the previous cost-based IRF payment system. In that final rule, we expressed our expectation that reductions in IRF lengths of stay under the IRF PPS would lead to lower costs for the facilities and that, in the absence of a behavioral offset, payments would be too high because they would continue to reflect IRFs' higher costs with the longer lengths of stay under the previous payment system. We have, in fact, observed rapid decreases in lengths of stay for IRF patients since we implemented the IRF PPS.

In addition, as explained in detail in RAND's report titled "Preliminary Analyses of Changes in Coding and Case Mix Under the Inpatient Rehabilitation Facility Prospective Payment System" (available on RAND's Web site at *http://www.rand.org/publications/TR/TR213/*), RAND accounted for the 1.16 percent behavioral offset adjustment when estimating the amount of observed case mix change that was a result of real case mix change and the amount that was a result of coding changes that do not reflect real changes in case mix. The range of estimates for the amount of case mix and coding change that RAND developed (1.9 percent to 5.8 percent) contains an adjustment to account for this behavioral offset.

Comment: Several commenters stated that one effect of the FY 2006 refinements to the IRF classification system was to lower IRF payments by 2.2 percent, and recommended that CMS restore 2.2 percent to the IRF PPS payments for FY 2007.

Response: As described in detail in the FY 2006 IRF PPS final rule (70 FR 47880, 47886 through 47904), we implemented several refinements to the IRF classification system for FY 2006, based on analysis conducted by RAND, to ensure that payments are aligned as closely as possible with the costs of care in IRFs. The FY 2006 refinements included a redefinition of the IRF case mix groups (CMGs), so that the new CMGs were based on the most current and complete post-PPS data available. We implemented these revisions in a budget-neutral manner, so that aggregate payments to providers were not estimated to increase or decrease as a result of these refinements. However, in the impact section of the FY 2006 IRF PPS final rule, we discussed the redistribution of payments that we estimated would occur in FY 2006 as a result of the implementation of these refinements. We estimated that some providers would experience increases in payments and that some providers would experience decreases in payments as a result of these refinements.

Many of the commenters cited a report titled "Evaluation of the Proposed Coding Adjustment to the Standardized Payment Amount for FY 2007," prepared by the Lewin Group for the HealthSouth Corporation in July 2006, as the source of the 2.2 percent estimate of the decrease in payments resulting from the FY 2006 IRF classification refinements. The report contained two separate analyses of changes in IRFs' case mix indexes (CMIs) between 2002 and 2006 that the authors of the report believe are due to the changes to the classification system that we implemented for FY 2006. The first analysis did not use the same methodology for computing the CMI that RAND and CMS use, and the authors of the report indicated that they had less confidence in this analysis for that reason. The second analysis, from which Lewin's 2.2 percent estimate is derived, used the same methodology that RAND and CMS use to calculate the CMI, but the analysis used IRF–PAI data from only 592 facilities (out of a total of about 1,240 IRFs nationwide). Lewin obtained data on these 592 facilities from the database maintained by the Uniform Data System for Medical Rehabilitation (UDS_{mr}).

In contrast, our estimates of the effects of the FY 2006 refinements to the classification system are based on analysis of 1,188 IRFs nationwide, for which we had complete data at the time that we were conducting the impact analysis for the FY 2006 IRF PPS final rule. We believe that our estimates of the effects of the FY 2006 refinements are more representative of the effects on the industry than Lewin's analysis because our database includes all IRFs for which we were able to match claims and IRF–PAI data. As illustrated in the first row of column 7 in Table 13 of the IRF PPS final rule, we estimated that aggregate payments to all IRFs would neither increase nor decrease as a result of the FY 2006 refinements to the IRF classification system, because we implemented these changes in a budget neutral manner, as described in detail in that final rule. However, in that final rule, we also indicated that we estimated that the refinements to the classification system would result in some redistribution of payments among different types of providers, with some groups estimated to experience payment increases and some groups estimated to experience payment decreases. For example, we estimated that these refinements could result in an estimated

2.7 percent decrease in payments to rural providers in the Pacific region and an estimated 2.6 percent increase in payments to rural providers in the Mountain region. In Table 13 of the FY 2006 IRF PPS final rule, we provide additional information on the estimated effects on IRF PPS payments of the policy changes implemented in that final rule.

In contrast to our analysis, the report by the Lewin Group suggested that the refinements to the classification system resulted in an across-the-board decrease to aggregate IRF payments of about 2.2 percent because, they contend, the refinements caused a decrease in IRFs' CMIs. To assist CMS in analyzing the differences between CMS's impact analysis and the findings contained in Lewin's report, UDS_{mr} gave CMS the provider numbers for 589 of the facilities that Lewin used in the analysis on which Lewin's 2.2 percent estimate is based. Out of these 589 facilities, we were able to match 551 to our IRF database. Some of the 38 provider numbers that did not match appeared to be Medicare provider numbers for skilled nursing facilities, acute care hospital facilities, or other types of providers. We repeated the same analysis that we had conducted for the FY 2006 IRF PPS final rule, as detailed on pages 47944 through 47952 of that final rule, with the 551 provider numbers that we could match. From this analysis, we determined that these 551 IRFs were more likely to experience expected decreases in payment as a result of the FY 2006 refinements to the classification system than the other IRFs in our database. However, we found that other IRFs experienced corresponding increases in payments as a result of the FY 2006 classification refinements. Thus, we disagree with the Lewin report's finding that the FY 2006 classification refinements reduced IRF payments across the board by 2.2 percent and believe that the impact analysis we published in the FY 2006 IRF PPS final rule continues to represent our best estimate of the effects of these changes. However, when we have complete data from FY 2006 to analyze, we will revisit our analysis and determine whether additional refinements to the system are necessary in the future.

Comment: Several commenters expressed concerns that the revised average length of stay values in the FY 2006 IRF PPS final rule may have affected payments for short-stay transfer cases and thereby contributed to a reduction in IRF payments. These commenters urged CMS to take this into account when considering whether an additional reduction to the standard payment amount is necessary for FY 2007.

Response: The average length of stay values published in the FY 2006 IRF PPS final rule (70 FR 47880, 47902 through 47904) and in section IV.B of this final rule are not used to determine payments to IRFs other than to determine payments for short-stay transfer cases. These values are entirely driven by the data that providers submit and have been falling consistently in recent years as the average number of days that patients spend in IRFs continues to decline. The overall decline in the average length of stay values likely has resulted in fewer cases qualifying for the per diem short-stay transfer payments, meaning that more cases have likely received the full CMG payments rather than the per diem payments.

Because the average length of stay values that we estimate are entirely data-driven, then, we believe that any changes in payments that result from updated average length of stay values are appropriately reflecting changes in the costs of care in IRFs.

Comment: Several commenters suggested that the FY 2006 refinements should serve as a new baseline for evaluating payments in the system, and that CMS should wait until the data are available to assess how providers respond to the FY 2006 changes before implementing an additional coding adjustment.

Response: As the commenters suggested, the FY 2006 refinements were intended to establish a new baseline for payments in the system, and we will be analyzing this new data for FY 2006 and beyond as part of our ongoing monitoring of the system to ensure that payments reflect as closely as possible the costs of caring for patients in IRFs. However, because, as noted above, the statute requires us to adjust payment rates for IRF services if we determine that changes in coding (that do not reflect real changes in case mix) have resulted in or will result in changes in aggregate payments under the IRF classification system, we do not believe that we should defer implementing the additional adjustment for FY 2007.

Comment: Several commenters expressed concerns that the calendar year 2002 data that RAND used to analyze changes in coding and case mix may have been based on HealthSouth cost report data that, for reasons detailed in the FY 2006 IRF PPS final rule, were not complete.

Response: As we discussed in detail in the FY 2006 IRF PPS final rule (70 FR 47880, 47884), RAND's analysis included 98 IRF providers affiliated with HealthSouth that omitted home office cost data from the 2002 and 2003 cost reports filed with CMS. However, we detailed in the FY 2006 final rule how RAND and CMS accounted for this data in the analyses for that final rule. In that final rule, we also stated that the omission of the home office cost data would have no effect on the 1.9 percent coding adjustment for FY 2006, because the only data affected by the omission of the home office costs were the cost report data and these data were not used in the analysis that supported the 1.9 percent coding adjustment. The same RAND analysis is used to support the additional coding adjustment for FY 2007, so the home office cost omission similarly has no effect on the FY 2007 coding adjustment.

Comment: Several commenters questioned CMS's legal authority to make the FY 2007 coding adjustment, claiming that the statute does not include review of Medicare margins as a reason for a coding adjustment.

Response: We disagree with the commenters' interpretation of our authority under the statute. We interpret section 1886(j)(2)(C)(ii) of the Act as requiring the Secretary to apply a coding adjustment to the payment rate when the evidence shows that such an adjustment is necessary to ensure that changes in aggregate payments are the result of real changes in case mix and do not reflect changes in coding that are unrelated to real changes in case mix. As noted previously, we have based our assessment of the amount that changes in aggregate payments in the first year of the implementation of the IRF PPS were a result of real case mix changes and the amount that they were a result of coding changes that do not reflect real changes in case mix on RAND's analysis, not on an analysis of IRF margins. However, we have used MedPAC's analysis of IRF margins to inform our understanding of growth in IRF costs over time, which we believe has direct bearing on our understanding of trends in IRFs' real case mix. We believe that actual increases in IRF case mix in the early years of the IRF PPS would have been accompanied by larger increases in the costs associated with treating higher acuity patients.

Comment: Some commenters questioned the CMS analyses of changes in coding practices, believing that providers were being penalized for reacting to changes in the IRF PPS coding structure.

Response: The coding adjustments for FY 2006 and FY 2007 are not intended to penalize providers for reacting to

changes in the IRF PPS coding structure. We encourage providers to improve the accuracy with which they are recording patient's clinical information. However, we are required by statute to adjust payments if we determine that changes in payments are a result of changes in coding that do not reflect real changes in case mix. Further, we believe it is appropriate to consider provider responses to changes in IRF coding as part of our efforts to evaluate the need for payment adjustments because a rapid change in provider coding practices could reflect changes in IRF payment policies rather than a change in patient severity.

Comment: One commenter asked whether the data presented in Table 6 on page 28124 of the proposed rule was based on calendar year or fiscal year data.

Response: We used calendar year IRF–PAI data in the analysis for Table 6 on page 28124 of the proposed rule.

Comment: One commenter noted that the ICD–9 code 278.02 (overweight) was not recommended by the ICD–9–CM Committee and approved by the National Center for Health Care Statistics for use until October 2005, and therefore it was not surprising that this code was used fewer than 10 times before that date.

Response: We do not find the fact that the code was new as of October 2005 to have any bearing on our conclusion that the dramatic increase in its use likely reflected changes in the IRF payment structure rather than in patient severity levels. Indeed, the fact that the code was new in October 2005 and its level of use rose immediately upon its introduction, indicates to us that providers are able to adapt their coding practices quickly to reflect coding changes. Thus, the increase in the code's use, in our view, continues to suggest that providers respond more rapidly to coding changes than we initially believed.

Final Decision: After carefully considering all of the comments that we received on the proposed reduction to the standard payment amount to account for coding changes that do not reflect real changes in case mix, we have decided to decrease the amount of the reduction to 2.6 percent, rather than the 2.9 percent that we had proposed. As we indicated in the proposed rule, we considered both 2.9 percent and 2.3 percent as possible reductions to the standard payment amount for FY 2007. However, in view of the industry's rapid adaptation to coding changes, we chose to propose a 2.9 percent reduction to the standard payment amount instead of the 2.3 percent reduction we had considered. The additional analyses the commenters offered in response to the proposed rule did not express a preference for either 2.9 percent or 2.3 percent, but were designed to show that we should not implement any additional reduction to the standard payment amount for FY 2007. In fact, some commenters presented analyses to show that CMS should provide a net increase to the standard payment amount for FY 2007 to compensate for the 2.2 percent reduction they contend occurred because of the FY 2006 refinements to the classification system (as discussed above). Further, commenters said that they did not believe that either the lower 2.3 percent reduction or the proposed 2.9 percent reduction were appropriate. Instead, commenters generally rejected any reduction to the standard payment amount. As explained previously, no reduction to the standard payment amount was not a reasonable option in light of RAND's analysis and the additional data we evaluated (as described above). Consequently, because we continue to believe a 2.3 percent reduction is too low, and in view of the significant concerns raised by commenters about the proposed 2.9 percent reduction, we have decided to implement a 2.6 percent reduction. The 2.6 percent reduction represents the midpoint between the 2.9 percent we had proposed and the 2.3 percent reduction we also had considered proposing, which would have fallen at approximately the middle of RAND's range of estimates.

In view of the significant concerns that commenters raised, and in continuing recognition of the significant changes in IRFs' patient populations that may be occurring as a result of the current phase in of the 75 percent rule compliance percentage, we have decided that the best approach at this time is to continue to exercise caution by adopting a slightly more conservative approach to further reducing the standard payment amount. In this way, we provide IRFs more flexibility in adapting their admission practices and cost structures to the recent regulatory changes.

However, as the commenters suggested, we intend to continue analyzing changes in coding and case mix closely using the most current available data, as part of our ongoing monitoring of the IRF PPS. If, based on updated analysis, we determine that additional adjustments are needed to ensure that changes in aggregate payments are the result of real changes in case mix and not merely the result of changes in coding that do not reflect real changes in case mix, we intend to propose additional payment refinements.

For FY 2007, therefore, we are continuing our incremental approach to adjusting payments for coding changes that occurred when we first began implementing the IRF PPS in 2002. Together with the 1.9 percent reduction that we implemented for FY 2006, the 2.6 percent reduction for FY 2007 will result in a total adjustment of 4.5 percent (1.9 + 2.6 = 4.5). Because 4.5 percent is still well within the range of RAND's estimates of the effects of coding changes that do not reflect real changes in case mix on IRF PPS payments that occurred between 1999 and 2002, we continue to believe that we are still providing flexibility to account for the possibility that some of the observed changes may be attributable to factors other than coding changes.

We will use the same methodology that we used in the FY 2006 IRF PPS final rule (70 FR 47880, 47908) to reduce the standard payment amount to adjust for coding changes that affect payment. To reduce the standard payment amount by 2.6 percent for FY 2007, we will multiply the standard payment amount by 0.974 (obtained by subtracting 0.026 from 1.000).

In section V.D of this final rule, we further describe how we will adjust the standard payment amount by the budget neutrality factors for the wage index, the second year of the hold harmless policy, and the revisions to the CMG relative weights and tier comorbidities to produce the final FY 2007 standard payment conversion factor. In Table 6 of this final rule, we provide a step-by-step calculation that results in the FY 2007 standard payment conversion factor.

B. FY 2007 IRF Market Basket Increase Factor and Labor-Related Share

Section 1886(j)(3)(C) of the Act requires the Secretary to establish an increase factor that reflects changes over time in the prices of an appropriate mix of goods and services included in the covered IRF services, which is referred to as a market basket index. Accordingly, in updating the FY 2007 payment rates set forth in this final rule, we apply an appropriate increase factor to the FY 2006 IRF PPS payment rates that is based on the rehabilitation, psychiatric, and long-term care hospital (RPL) market basket. In constructing the RPL market basket, we used the methodology set forth in the FY 2006 IRF PPS final rule (70 FR 47880, 47908 through 47915) and described in the FY 2007 proposed rule.

Most of the comments that we received on the market basket and labor-

related share support the update to the market basket increase and labor-related share based on more recent data as discussed in the FY 2007 proposed rule. We did not receive any comments on the continued use of the Bureau of Labor Statistics (BLS) Employment Cost Indexes (ECI) data in light of the BLS change in system usage to the North American Industrial Classification Systems based ECI.

Final Decision: For this final rule, the FY 2007 IRF market basket increase factor is 3.3 percent. This is based on the Global Insight, Inc. (GII) forecast for the second quarter of 2006 (2006q2) with historical data through the first quarter of 2006 (2006q1). The 3.3 percent market basket increase factor is 0.1 percentage point lower than the increase that we published in the proposed rule, which was based on GII's forecast for the first quarter of 2006 (2006q1).

In addition, we used the methodology described in the FY 2006 IRF PPS final rule to update the labor-related share for FY 2007. As shown in Table 5, the final FY 2007 IRF labor-related share (which is based on GII's forecast for the second quarter of 2006) is 75.612 percent in this final rule. This is approximately 0.1 percentage point lower than the labor-related share that we published in the proposed rule, which reflected GII's forecast for the first quarter of 2006 (2006q1).

Comment: One commenter believes that Global Insight, Inc.'s (GII's) market basket projection for FY 2007 underestimates the inflation pressure that hospitals face in serving Medicare beneficiaries. The commenter indicates that GII's latest forecast of the RPL market basket for FY 2006 is 3.8 percent compared to the final IRF PPS FY 2006 update of 3.6 percent.

Response: The FY 2007 IRF update of 3.3 percent is based on GII's most recent forecast, which includes the latest available historical data through 2006q1. This forecast reflects the expected inflation pressures that hospitals will face in FY 2007. The GII figure will not be final until the release of GII's 2006q4 forecast, which will include historical data through 2006q3. We continue to work closely with GII to ensure the most accurate projections possible.

TABLE 5.—FY 2007 IRF LABOR-RELATED SHARE RELATIVE IMPORTANCE

Cost category	FY 2007 IRF Labor-related relative importance
Wages and salaries	52.406
Employee benefits	14.084
Professional fees	2.898
All other labor intensive services	2.142
Subtotal	71.530
Labor-related share of capital costs	4.082
Total	75.612

Source: Global Insight, Inc. 2nd Qtr 2006, @USMACRO/CONTROL0606 @CISSIM/TL0506.SIM.

C. Area Wage Adjustment

Section 1886(j)(6) of the Act requires the Secretary to adjust the proportion (as estimated by the Secretary from time to time) of rehabilitation facilities' costs attributable to wages and wage-related costs by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the rehabilitation facility compared to the national average wage level for those facilities. The Secretary is required to update the wage index on the basis of information available to the Secretary on the wages and wage-related costs to furnish rehabilitation services. Any adjustments or updates made under section 1886(j)(6) of the Act for a FY are made in a budget neutral manner.

In the FY 2007 proposed rule, we proposed to maintain the methodology and policies described in the FY 2006 IRF PPS final rule to determine the wage index, labor market area definitions, areas with missing hospital data, and hold harmless policy consistent with the rationales outlined in that final rule (70 FR 47880, 47917 through 47933).

In our review of Table 1 in the Addendum of the proposed rule, we found that the wage index published for Hinesville, Georgia (CBSA 25980) is incorrect. The corrected wage index for this area can be found in Table 1 of the Addendum in this final rule.

We received only a few comments on maintaining the methodology described in the FY 2006 final rule (70 FR 47880) for FY 2007. The comments and our responses are summarized below.

Comment: We received comments supporting our transition to the full CBSA-based labor market area definitions. However, we received several comments that recommended extending the blended wage index for another year to protect certain IRFs that would otherwise experience wage index reductions of 8 percent or more.

Response: In the FY 2006 proposed rule, we had not proposed a transition to the CBSA-based labor market area designations. However, after a review of the comments, we provided a budget neutral transition to the CBSAs, which will expire for discharges occurring on or after October 1, 2006. We agreed with commenters that it is appropriate to assist providers in adapting to the changes from MSA to CBSA in a manner that provides the most benefit to the largest number of providers. Therefore, our FY 2006 final rule adopted a transition policy that provided measurable relief to the greatest number of adversely affected IRFs with the least impact to the rest of the facilities. In the FY 2006 final rule, we discuss other transition policies recommended by the public in order to transition from the MSA to CBSA-based designations. A full discussion of the alternative transition policies that we considered and our decision to adopt the 1-year blended wage index appears in the FY 2006 final rule (70 FR 47880, 47922 through 47923).

We also adopted a hold harmless policy specifically for rural IRFs whose labor market designations changed from rural to urban under the CBSA-based labor market area designations. This policy specifically applied to IRFs that had previously been designated rural and which, effective October 1, 2005, would otherwise have become ineligible for the 19.14 percent rural adjustment. For FY 2007, the second year of the 3-year phase out of the budget-neutral hold harmless policy, the adjustment will be up to 6.38 percent for IRFs that meet the criteria described in the FY 2006 final rule (70 FR 47880, 47923 through 47926).

As stated in our FY 2006 final rule, we did not extend the hold harmless policy to encompass facilities that remain in an urban area, because we believe that the transition wage index mitigated the impact of the change from MSAs to CBSAs. We note that periodic updating of the wage data routinely produces a certain degree of fluctuation in wage index values, which would occur even in the absence of a conversion to the CBSA-based structure.

In reviewing the data, we found that updating the wage data by itself produced similar levels of fluctuation in wage index values under either the MSA or CBSA designations. In general, we found that approximately 1 percent of IRFs would experience a decrease of 8 percent or more in the wage index under either the MSA or CBSA

designations. However, under the CBSA designations, 57 percent either remained the same or had an increase in the wage index. We also examined the impact of the wage index if we had remained under the MSA-based designations. Under this scenario, we find that only 48 percent of IRFs would have remained the same or would have had an increase in the wage index. Thus, we find that more providers would expect to have no change or an increase in the wage index under the CBSA designations. We also note that the decrease or increase in the wage index fluctuates from year to year based on the updated wage data. Therefore, we are not revising our current wage index policy at this time.

Comment: A few commenters requested that we adopt wage index policies like those under the acute inpatient prospective payment systems (IPPS). The IPPS wage index policies would allow IRFs to benefit from the IPPS reclassification and/or rural floor policies. (A discussion of the IPPS reclassification and rural floor policies may be found on our Web site at *http://www.cms.hhs.gov/AcuteInpatientPPS/01_overview.asp.*)

In addition, we were also urged to use the most recent hospital cost report wage data available for FY 2007 instead of the most recent final hospital cost report wage data available. Several commenters recommended that we engage in wage index discussions with the industry, but recognized that legislative action may be necessary to accomplish some or all of the changes that they recommended.

Response: For FY 2007, we did not propose changes in the IRF PPS methodology relating to the wage index, either to use more recent hospital wage data or to adopt the reclassification or rural floor provisions used in IPPS. Therefore, we are not revising the IRF methodology described in the FY 2006 IRF PPS final rule. The rationale for our current wage index policies may be found in the FY 2006 final rule (70 FR 47880, 47927 through 47928). However, we agree that we should engage in further discussions with the industry to evaluate possible wage index alternatives.

Final Decision: The FY 2007 wage index will be based solely on the CBSA-based labor market area definitions and the corresponding wage index (rather than on a blended wage index). We will use the most recent final pre-reclassified and pre-floor hospital wage data available (FY 2002 hospital wage data) based on the CBSA labor market area definitions consistent with the rationale outlined in the FY 2006 IRF PPS final rule.

D. Description of the Standard Payment Conversion Factor and the Payment Rates for FY 2007

In the FY 2006 final rule (70 FR 47880, 47937 through 47398), we revised the IRF regulations text by adding § 412.624(d)(4) to indicate that we apply a factor when revisions are made to the tier comorbidities and the IRF classification system, the rural adjustment, the LIP adjustment, the teaching status adjustment, the hold harmless adjustment, or other budget-neutral policies. To clarify, we did not propose changes to the rural adjustment of 21.3 percent, the LIP exponential factor of 0.6229, or the teaching status adjustment exponential factor of 0.9012. They remain as described in the FY 2006 IRF PPS final rule. As discussed in greater detail in the FY 2007 proposed rule, because we are not changing these policies, we do not need to calculate budget neutrality factors for these policies because they are assumed in the FY 2006 standard payment conversion factor.

As described in the FY 2007 proposed rule, we will apply factors to the standard payment amount for the changes that we proposed for FY 2007, to ensure that estimated aggregate payments in FY 2007 are not greater or less than those that would have been made in the year without the updates to the wage index and labor-related share, the second year of the hold harmless policy, and the revisions to the tier comorbidities and relative weights. A description of the methodology used to derive the budget neutrality factors for these changes is included in our FY 2007 proposed rule. These same steps are used to determine the budget neutrality factors that reflect the final policies for FY 2007, as discussed in this section below.

Final Decision: We did not receive any comments regarding the methodology used to derive the budget neutrality factors. Therefore, we will apply the wage index and labor-related share budget neutrality factor of 1.0016 and the budget neutrality factor for the combined hold harmless, tier comorbidity, and relative weight changes of 1.0093. Please see Table 9 in this final rule to see how these changes are estimated to affect payments among different types of facilities. These budget neutrality factors are slightly different from the FY 2007 proposed rule because the market basket and labor-related share are based on updated data as described in section V.B of this final rule.

The standard payment conversion factor of $12,981 and the payment rates in Table 6 and Table 7 (respectively) will be used for FY 2007. The standard payment conversion factor in this final rule is greater than the standard payment conversion factor in the proposed rule because we used updated data for the market basket and labor-related share and will implement a 2.6 percent reduction instead of a 2.9 percent reduction to the standard payment amount (as discussed in sections V.A and B of this final rule).

Thus, consistent with § 412.624(d)(4), we apply these factors to the standard payment amount in order to make the changes described in this final rule in a budget neutral manner for FY 2007. We used the methodology described in sections V.A and B of this final rule. We use the FY 2006 standard payment conversion factor ($12,762) and apply the market basket (3.3 percent), which equals $13,183. Then, we apply a reduction to the standard payment amount of 2.6 percent as discussed in section V.A of this final rule, which equals $12,840. We then apply the budget-neutral wage adjustment of 1.0016 to $12,840, which results in a standard payment amount of $12,861.

Next, we combine the factors for the tier comorbidity and CMG relative weight changes (1.0080) and for the second year of the hold harmless policy (1.0013) by multiplying the two factors to establish a single budget neutrality factor for the two changes (1.0013 * 1.0080 = 1.0093). We apply this overall budget neutrality factor to the standard payment amount of $12,861, resulting in the standard payment conversion factor of $12,981 for FY 2007 (Table 6).

TABLE 6.—CALCULATIONS TO DETERMINE THE FY 2007 STANDARD PAYMENT CONVERSION FACTOR

Explanation for adjustment	Calculations
FY 2006 Standard Payment Conversion Factor	$12,762
FY 2007 Market Basket Increase Factor	× 1.033

TABLE 6.—CALCULATIONS TO DETERMINE THE FY 2007 STANDARD PAYMENT CONVERSION FACTOR—Continued

Explanation for adjustment	Calculations
Subtotal	= $13,183
One-Time 2.6% Reduction for Coding Changes	× 0.974
Subtotal	= $12,840
Budget Neutrality Factor for the Wage Index and Labor-Related Share	× 1.0016
Subtotal	= $12,861
Budget Neutrality Factor for the Hold Harmless Provision and Revisions to the Tier Comorbidities and the CMG Relative Weights	× 1.0093
FY 2007 Standard Payment Conversion Factor	= $12,981

The FY 2007 standard payment conversion factor is applied to each of the CMG relative weights shown in Table 4, "FY 2007 IRF PPS Relative Weights and Average Lengths of Stay for Case-Mix Groups," to compute the unadjusted IRF prospective payment rates for FY 2007 shown in Table 7. To clarify further, the budget neutrality factors described above would be applied only for FY 2007. However, if necessary, we will apply budget neutrality factors in applicable years hereafter to the extent that further adjustments are made to the IRF PPS consistent with § 412.624(d)(4). Otherwise, the general methodology to determine the Federal prospective payment rate is described in § 412.624(c)(3)(ii).

The resulting unadjusted IRF prospective payment rates for FY 2007 are shown below in Table 7, "FY 2007 Payment Rates."

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Table 7: FY 2007 Payment Rates

CMG	Payment Rate Tier 1	Payment Rate Tier 2	Payment Rate Tier 3	Payment Rate No Comorbidity
0101	$10,004.46	$9,480.02	$8,531.11	$8,239.04
0102	$12,322.86	$11,676.41	$10,508.12	$10,148.55
0103	$14,528.34	$13,766.35	$12,389.07	$11,965.89
0104	$15,427.92	$14,616.61	$13,154.95	$12,704.50
0105	$18,512.20	$17,539.93	$15,786.19	$15,246.18
0106	$21,540.67	$20,408.73	$18,368.12	$17,739.83
0107	$24,858.62	$23,554.02	$21,197.97	$20,472.34
0108	$28,765.90	$27,256.21	$24,530.20	$23,690.33
0109	$28,555.60	$27,056.30	$24,349.76	$23,516.38
0110	$34,123.15	$32,331.78	$29,098.21	$28,102.57
0201	$10,570.43	$8,834.87	$7,892.45	$7,330.37
0202	$13,578.13	$11,349.29	$10,138.16	$9,416.42
0203	$16,230.14	$13,565.15	$12,117.76	$11,255.83
0204	$17,381.56	$14,528.34	$12,978.40	$12,055.45
0205	$21,304.42	$17,807.34	$15,906.92	$14,774.97
0206	$27,837.75	$23,267.14	$20,783.88	$19,306.64
0207	$35,910.64	$30,014.67	$26,812.26	$24,904.05
0301	$14,790.55	$12,374.79	$11,101.35	$10,088.83
0302	$19,309.24	$16,156.15	$14,491.99	$13,171.82
0303	$22,977.67	$19,224.86	$17,245.26	$15,673.26
0304	$31,667.15	$26,494.22	$23,766.91	$21,600.38
0401	$12,444.88	$10,976.73	$10,023.93	$8,902.37
0402	$17,207.61	$15,176.09	$13,858.52	$12,308.58
0403	$29,945.87	$26,412.44	$24,118.70	$21,421.25
0404	$53,925.67	$47,561.09	$43,431.83	$38,575.64
0405	$40,722.70	$35,915.83	$32,797.79	$29,130.66
0501	$9,927.87	$8,379.24	$7,382.29	$6,582.67
0502	$13,321.10	$11,242.84	$9,904.50	$8,832.27
0503	$17,648.97	$14,897.00	$13,122.49	$11,701.07
0504	$22,046.93	$18,608.26	$16,392.41	$14,616.61
0505	$26,183.98	$22,100.15	$19,467.61	$17,359.49
0506	$35,570.54	$30,022.46	$26,447.49	$23,582.58
0601	$11,671.22	$9,515.07	$9,111.36	$8,466.21
0602	$15,535.66	$12,665.56	$12,126.85	$11,270.10
0603	$19,894.68	$16,219.76	$15,531.77	$14,432.28
0604	$25,432.38	$20,734.55	$19,854.44	$18,449.90
0701	$11,719.25	$10,017.44	$9,525.46	$8,589.53
0702	$15,234.50	$13,023.84	$12,382.58	$11,166.26
0703	$18,989.90	$16,234.04	$15,434.41	$13,918.23
0704	$23,325.56	$19,940.11	$18,958.75	$17,095.98
0801	$8,485.68	$7,144.74	$6,660.55	$5,980.35
0802	$11,088.37	$9,337.23	$8,702.46	$7,814.56
0803	$16,494.96	$13,889.67	$12,947.25	$11,625.78
0804	$14,331.02	$12,067.14	$11,248.04	$10,100.52
0805	$18,078.64	$15,222.82	$14,189.53	$12,742.15
0806	$21,708.13	$18,279.84	$17,038.86	$15,300.70
0901	$10,936.49	$9,918.78	$8,915.35	$7,944.37
0902	$14,393.33	$13,054.99	$11,733.53	$10,457.49
0903	$19,001.59	$17,234.87	$15,491.53	$13,805.29
0904	$23,808.45	$21,595.19	$19,409.19	$17,297.18
1001	$12,494.21	$11,525.83	$10,328.98	$9,555.31

Table 7: FY 2007 Payment Rates

CMG	Payment Rate Tier 1	Payment Rate Tier 2	Payment Rate Tier 3	Payment Rate No Comorbidity
1002	$16,497.55	$15,218.92	$13,639.14	$12,616.23
1003	$23,204.84	$21,406.97	$19,184.62	$17,746.33
1101	$16,296.35	$13,606.68	$11,974.97	$11,028.66
1102	$24,435.43	$20,402.24	$17,955.32	$16,536.50
1201	$13,210.76	$11,403.81	$10,621.05	$9,612.43
1202	$17,093.38	$14,755.50	$13,741.69	$12,437.10
1203	$21,082.44	$18,199.36	$16,949.29	$15,339.65
1301	$13,440.53	$12,508.49	$11,048.13	$9,643.58
1302	$18,590.09	$17,299.78	$15,281.23	$13,337.98
1303	$23,690.33	$22,046.93	$19,474.10	$16,997.32
1401	$10,592.50	$9,542.33	$8,481.79	$7,608.16
1402	$14,328.43	$12,908.31	$11,473.91	$10,291.34
1403	$17,790.46	$16,027.64	$14,246.65	$12,778.50
1404	$22,548.00	$20,313.97	$18,056.57	$16,196.39
1501	$12,962.83	$11,514.15	$10,116.09	$9,604.64
1502	$16,435.24	$14,598.43	$12,825.23	$12,177.48
1503	$20,064.73	$17,822.91	$15,657.68	$14,867.14
1504	$26,242.39	$23,309.98	$20,477.53	$19,444.24
1601	$13,071.87	$11,098.76	$10,091.43	$9,030.88
1602	$17,947.53	$15,238.40	$13,854.62	$12,399.45
1603	$22,100.15	$18,764.04	$17,060.93	$15,268.25
1701	$12,744.75	$12,514.98	$11,006.59	$9,564.40
1702	$16,772.75	$16,470.29	$14,484.20	$12,586.38
1703	$19,933.62	$19,575.35	$17,215.40	$14,959.30
1704	$24,983.23	$24,532.79	$21,574.42	$18,748.46
1801	$15,473.35	$12,807.05	$10,700.24	$9,530.65
1802	$24,739.19	$20,476.23	$17,107.66	$15,237.10
1803	$44,527.43	$36,854.36	$30,792.23	$27,424.96
1901	$16,095.14	$14,260.93	$14,233.67	$12,137.24
1902	$30,108.13	$26,678.55	$26,626.63	$22,705.07
1903	$43,439.62	$38,489.96	$38,414.67	$32,757.55
2001	$11,337.61	$9,581.28	$8,742.70	$7,897.64
2002	$14,859.35	$12,557.82	$11,458.33	$10,352.35
2003	$19,182.02	$16,210.67	$14,791.85	$13,362.64

Table 7: FY 2007 Payment Rates

CMG	Payment Rate Tier 1	Payment Rate Tier 2	Payment Rate Tier 3	Payment Rate No Comorbidity
2004	$25,593.34	$21,628.94	$19,736.31	$17,829.40
2101	$28,353.10	$28,353.10	$21,556.25	$18,935.38
5001	$0.00	$0.00	$0.00	$2,857.12
5101	$0.00	$0.00	$0.00	$8,244.23
5102	$0.00	$0.00	$0.00	$20,750.13
5103	$0.00	$0.00	$0.00	$9,350.21
5104	$0.00	$0.00	$0.00	$24,383.51

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E. Example of the Methodology for Adjusting the Federal Prospective Payment Rates

As described in the FY 2007 proposed rule and in this final rule, Table 8 illustrates the methodology for adjusting the Federal prospective payments. The examples below are based on two hypothetical Medicare beneficiaries, both classified into CMG 0110 (without comorbidities). The unadjusted Federal prospective payment rate for CMG 0110 (without comorbidities) can be found in Table 7 above.

One beneficiary is in Facility A, a hypothetical IRF located in rural Spencer County, Indiana, and another beneficiary is in Facility B, a hypothetical IRF located in urban Harrison County, Indiana. Facility A, a non-teaching hospital, has a disproportionate share hospital (DSH) percentage of 5 percent (which results in a LIP adjustment of 1.0309), a wage index of 0.8624, and an applicable rural adjustment of 21.3 percent. Facility B, a teaching hospital, has a DSH percentage of 15 percent (which results in a LIP adjustment of 1.0910), a wage index of 0.9251, and an applicable teaching status adjustment of 0.109.

To calculate each IRF's labor and non-labor portion of the Federal prospective payment, we begin by taking the unadjusted Federal prospective payment rate for CMG 0110 (without comorbidities) from Table 7 above. Then, we multiply the estimated labor-related share (75.612) described in section V.B by the unadjusted Federal prospective payment rate. To determine the non-labor portion of the Federal prospective payment rate, we subtract the labor portion of the Federal payment from the unadjusted Federal prospective payment.

To compute the wage-adjusted Federal prospective payment, we multiply the result of the labor portion of the Federal payment by the appropriate wage index found in the Addendum in Tables 1 and 2, which will result in the wage-adjusted amount. Next, we compute the wage-adjusted Federal payment by adding the wage-adjusted amount to the non-labor portion.

To adjust the Federal prospective payment by the facility-level adjustments, there are several steps. First, we take the wage-adjusted Federal prospective payment and multiply it by the appropriate rural and LIP adjustments (if applicable). Then, to determine the appropriate amount of additional payment for the teaching status adjustment (if applicable), we multiply the teaching status adjustment (0.109, in this example) by the wage-adjusted and rural-adjusted amount (if applicable). Finally, we add the additional teaching status payments (if applicable) to the wage, rural, and LIP-adjusted Federal prospective payment rate. Table 8 illustrates the components of the adjusted payment calculation.

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Table 8: Example of Computing an IRF's FY 2007 Federal Prospective Payment

Steps		Rural Facility A (Spencer Co., IN)		Urban Facility B (Harrison Co., IN)	
1	Unadjusted Federal Prospective Payment		$28,102.57		$28,102.57
2	Labor Share	X	0.75612	X	0.75612
3	Labor Portion of Federal Payment	=	$21,248.92	=	$21,248.92
4	CBSA Based Wage Index (shown in the Addendum , Tables 1 and 2)	X	0.8624	X	0.9251
5	Wage-Adjusted Amount	=	$18,325.06	=	$19,657.37
6	Nonlabor Amount	+	$6,853.65	+	$6,853.65
7	Wage-Adjusted Federal Payment	=	$25,178.72	=	$26,511.03
8	Rural Adjustment	X	1.213	X	1.000
9	Wage- and Rural- Adjusted Federal Payment	=	$30,541.79	=	$26,511.03
10	LIP Adjustment	X	1.0309	X	1.0910
11	FY2007 Wage-, Rural- and LIP-Adjusted Federal Prospective Payment Rate	=	$31,485.53	=	$28,923.53
12	FY 2007 Wage- and Rural-Adjusted Federal Prospective Payment		$30,541.79		$26,511.03
13	Teaching Status Adjustment	X	0.000	X	0.109
14	Teaching Status Adjustment Amount	=	$0.00	=	$2,889.70
15	FY2007 Wage-, Rural-, and LIP-Adjusted Federal Prospective Payment Rate	+	$31,485.53	+	$28,923.53
16	Total FY 2007 Adjusted Federal Prospective Payment	=	$31,485.53	=	$31,813.23

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Thus, the adjusted payment for Facility A would be $31,485.53, and the adjusted payment for Facility B would be $31,813.23.

VI. Update to Payments for High-Cost Outliers Under the IRF PPS

A. Update to the Outlier Threshold Amount for FY 2007

A case qualifies for an outlier payment if the estimated cost of the case exceeds the adjusted outlier threshold, in which case we make an outlier payment equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold. In the August 7, 2001 final rule, we discussed our decision to set the outlier threshold amount so that estimated outlier payments would equal 3 percent of total estimated payments. In the FY 2007 proposed rule (71 FR 28106), we proposed to update the outlier threshold amount to $5,609 in accordance with this policy. However, the appropriate outlier threshold amount for FY 2007 depends on the other policies, especially the coding adjustment, contained in this final rule.

We received several comments on the proposed update to the outlier threshold amount for FY 2007, which are summarized below.

Comment: Two commenters expressed concerns about the accuracy of the FY 2007 estimated outlier payments that we reported in the IRF rate setting file posted in conjunction with the FY 2007 proposed rule. They stated that in some cases, the information was not consistent with the actual outlier payments that they received in FYs 2004 and 2005. The commenters asked CMS to re-examine and verify our outlier payment calculations and to delay implementing an adjustment to the outlier threshold amount for FY 2007 until we can be sure the information is correct.

Response: We have re-examined our estimated outlier payment calculations, and we cannot find any inconsistencies in these calculations or with the IRF rate setting data file that we posted on the IRF PPS Web site. We did obtain some specific examples from the industry, but we did not find that the differences between their calculations and ours indicated any inaccuracies in our database. We believe two factors might contribute to a particular facility's receiving different outlier payments for FYs 2004 and 2005 than the outlier payments that we estimate for FY 2007. First, the actual outlier payments that providers received in FYs 2004 and 2005 were calculated based on the outlier threshold amount at that time, which was $11,211. The estimated outlier payments for FY 2007 in the proposed rule rate setting file are based on the proposed FY 2007 outlier threshold amount of $5,609. Second, we used the most current available data on IRFs' cost-to-charge ratios (CCRs) to calculate the estimated FY 2007 outlier payments. The CCRs for a particular provider can vary widely over time, in part because of the ceiling that we impose on them. Thus, a provider's current CCR used in the analysis for the FY 2007 proposed and final rules could have changed substantially from the CCR used to compute the actual outlier payments for FYs 2004 and 2005.

We note that the information in the IRF rate setting file posted on the IRF PPS Web siteis not used to determine payments to providers. The fiscal intermediaries determine IRF payments using their own data files, including the appropriate CCRs.

We welcome any specific provider concerns regarding the information contained in the IRF rate setting files, and we will work with providers to investigate any potential discrepancies in the information that we use in our analysis. However, we have not been able to find any discrepancies, and we believe that our analysis continues to demonstrate the need to update the outlier threshold amount for FY 2007 to ensure that estimated outlier payments continue to equal 3 percent of total estimated payments.

Comment: A few commenters expressed concerns about the methodology that CMS uses to estimate cost and charge growth for the purposes of calculating the outlier threshold amount. Two commenters referred to alternative methodologies developed by MedPAC and others that had been recommended for the IPPS to estimate declining CCRs. The commenters encouraged CMS to review our calculations of the outlier threshold amount carefully, use more recent data, and consider applying the suggested methodological changes to the IRF PPS to ensure that the full 3 percent of outlier funds is used.

Response: We have reviewed the comments submitted for consideration in the IPPS, and we appreciate the alternative methodologies suggested and have considered them carefully. The CCR applied to charges provides Medicare with the most accurate measure of a provider's per-case cost for the purpose of paying for high-cost outlier cases at the point that we process the initial claim. The CCR is based on the providers' own cost and charge information as reported by the providers. For the purposes of this final rule, we have used the same methodology for projecting cost and charge growth that is used in the IPPS and in other Medicare payment systems, and we believe that this methodology is appropriate for IRFs for the same reasons that it is appropriate for IPPS hospitals. This methodology ensures that we pay the appropriate amounts over and above the standard PPS payment amount for unusually high-cost cases. We intend to consult with IPPS and MedPAC staff on a regular basis regarding outlier issues, and will investigate options for using more current data to update the outlier threshold amount in future years.

Final Decision: Based on a careful review of the comments that we received on the proposed update to the outlier threshold amount for FY 2007, we are finalizing our decision to update the outlier threshold amount for FY 2007 to $5,534. This outlier threshold amount is slightly lower than the $5,609 that we proposed, due to the reduction of the coding adjustment from the 2.9 percent adjustment that we had proposed to the 2.6 percent coding adjustment that we are finalizing in this final rule. Because the coding adjustment affects the estimated amount of aggregate payments for FY 2007, it also affects our estimate of the outlier threshold amount that we estimate will maintain estimated outlier payments at 3 percent of total estimated payments.

B. Update to the IRF Cost-to-Charge Ratio Ceilings and Clarification to the Regulation Text for FY 2007

As specified in § 412.624(e)(5), we apply a ceiling to IRFs' cost-to-charge ratios (CCRs). In the FY 2007 IRF PPS proposed rule, we proposed to update the national average urban and rural CCRs and to revise § 412.624(e)(5) to emphasize that we calculate a single overall cost-to-charge ratio (combined operating and capital) for IRFs because IRF PPS payments are based on a prospective payment per discharge for both inpatient operating and capital-related costs. We proposed to update the national urban and rural CCRs for IRFs to 0.488 and 0.613, respectively. However, we noted that these estimates were subject to change in this final rule based on updated analysis and data.

We did not receive any comments on the proposed update to the IRF cost-to-charge ratio ceilings or clarification to the regulation text for FY 2007. However, we updated our analysis using the most recent available data. For the proposed rule, we used the FY 2004 cost report data compiled by CMS as of December 2005, at which point the FY 2004 cost reports were about 85 percent complete. For this final rule, we have used the FY 2004 cost report data compiled as of March 2006, at which point we had about 97 percent of the FY 2004 cost report information. Thus, based on the more recent cost report data, we are finalizing the national average urban CCR at 0.484 and the national average rural CCR at 0.600, as well as our estimate of 3 standard deviations above the corresponding national geometric mean, which we are finalizing at 1.56 for FY 2007.

VII. Revisions to the Classification Criteria Percentage for IRFs

In order to be excluded from the acute care inpatient hospital PPS specified in § 412.1(a)(1) and instead be paid under the IRF PPS, a hospital or rehabilitation unit of an acute care hospital must meet the requirements for classification as an IRF contained in subpart B of part 412. Section 412.23(b)(2) specifies that an IRF's cost reporting period will determine the percentage of the IRF's total inpatient population that required intensive rehabilitation services for treatment of at least one of the 13 medical conditions listed in the regulation. The compliance percentage requirement is commonly known as the "75 percent rule," and is one of the criteria that Medicare uses for classifying a hospital or a rehabilitation unit of an acute care hospital as an IRF.

On May 7, 2004, we published a final rule (69 FR 25752) that specified the compliance percentage requirements that a hospital or rehabilitation unit of an acute care hospital must meet during a particular cost reporting period in order to be classified as an IRF. However, section 5005 of the DRA of 2005 revised the compliance percentage requirements in § 412.23(b)(2) that must be met for certain cost reporting periods in order for a hospital or rehabilitation unit of an acute care hospital to be classified as an IRF. Therefore, in order

to conform the regulations to the DRA, we proposed modifying the compliance percentages in § 412.23(b)(2)(i) and (ii) as follows:

- Reducing the compliance threshold that must be met from 65 to 60 percent for cost reporting periods beginning on or after July 1, 2006, and before July 1, 2007.
- Reducing the compliance threshold that must be met from 75 to 65 percent for cost reporting periods beginning on or after July 1, 2007, and before July 1, 2008.
- Stipulating that an IRF with a cost reporting period beginning on or after July 1, 2008, must meet a compliance threshold of 75 percent.

In addition to specifying a compliance threshold, § 412.23(b)(2)(i) currently permits a patient's comorbidity that meets certain qualifying criteria as outlined in the regulations to count toward satisfying the classification criteria percentage. However, § 412.23(b)(2)(ii) currently provides that a patient's comorbidities will not be used to determine compliance once the transition to the 75 percent compliance level has been completed. Since the transition to the 75 percent compliance threshold has been extended one year, we also proposed a 1-year extension of the current policy of using a patient's comorbidities to the extent they met the conditions outlined in our regulations to determine compliance with the classification criteria in § 412.23(b)(2)(i). Thus, under our proposal, an IRF with a cost reporting period beginning before July 1, 2008 would be able to use comorbidities to count toward the required applicable percentage requirements outlined in the regulations. This proposed approach maintains consistency with our current approach with respect to the counting of comorbidities before the 75 percent threshold applies. We received many comments as summarized below on the proposed revisions to the classification criteria.

Comment: Commenters supported the proposed revisions to the compliance thresholds that IRFs must meet for certain cost reporting periods. However, most of the commenters requested that we not terminate the use of comorbidities to determine the compliance percentage once the extended transition period has expired.

Response: In the May 7, 2004 final rule (69 FR 25752, 25762), we stated that we planned to use the phase-in period to the 75 percent compliance threshold to evaluate the use of comorbidities for determining compliance with the classification percentage criteria. We believed that many IRFs probably would have to make adjustments not only to their case-mix but to their operating procedures in order to respond to changes in the regulations, the methodology for determining compliance, and the local coverage policies FIs had or were planning to implement. We believed that such adjustments might take some IRFs a considerable amount of time. Therefore, we wanted to use the phase-in period to the 75 percent compliance threshold to provide administrative flexibility so that a case with a comorbidity that met the qualifying conditions specified above would be included as part of the IRF population used to calculate the compliance percentage.

As we stated in the May 7, 2004 final rule (69 FR 25752, 25762), we will use the phase-in period to the 75 percent compliance threshold to evaluate whether the regulations should be revised. As part of that evaluation process, we will consider if we should propose to extend the time period that comorbidities meeting the qualifying conditions outlined in the regulations are included as part of the process that determines the compliance percentage. We have not completed our analysis on this issue and, thus, because our review is incomplete we believe that it is premature to extend beyond the transition period the use of a patient's comorbidities in determining if an IRF met the compliance threshold.

Final Decision: Consistent with the proposed rule and the rationale discussed above, we are finalizing our proposed policy as set forth in this paragraph. In accordance with section 5005 of the DRA, we are extending the transition period to the 75 percent compliance threshold, as follows: For cost reporting periods starting on or after July 1, 2006, and before July 1, 2007, the compliance threshold is 60 percent. For cost reporting periods starting on or after July 1, 2007, and before July 1, 2008, the compliance threshold is 65 percent. For cost reporting periods starting on or after July 1, 2008, the compliance threshold is 75 percent. Under the authority of section 1886(d)(1)(B) of the Act, we are continuing until the end of the extended transition period to permit the use of comorbidities that meet the qualifying criteria in § 412.23(b)(2)(i)(A) through § 412.23(b)(2)(i)(C) to count toward satisfying the required applicable percentages in § 412.23(b)(2)(i). However, for cost reporting periods starting on or after July 1, 2008, comorbidities may not be used when calculating the compliance percentage attained by an IRF.

VIII. IRF PPS: Other Issues

A. Integrated Post Acute Care Payment

In the FY 2007 IRF proposed rule, we described our plans to explore refinements to the existing provider-oriented "silos" to create a more seamless system for payment and delivery of post-acute care (PAC) under Medicare. This new model will be characterized by more consistent payments for the same type of care across different sites of service, quality driven pay-for-performance incentives, and collection of uniform clinical assessment information to support quality and discharge planning functions. We also noted that section 5008 of the DRA provides for a demonstration on uniform assessment and data collection across different sites of service. We are in the early stages of developing a standard, comprehensive assessment instrument to be completed at hospital discharge and ultimately integrated with PAC assessments, and the demonstration will enable us to test the usefulness of this instrument, and to analyze cost and outcomes across different PAC sites.

Comment: We received several comments from providers and their representatives or associations on the post-acute care reform demonstration discussion of the May 15, 2006 proposed rule. Most of the commenters expressed support for the objective of aligning Medicare payment more closely with the clinical characteristics of post-acute patients. A number of commenters recommended that developing a common patient assessment instrument should be developed collaboratively with post acute care providers. Many offered to provide insight on the demonstration design and the development of the instrument. The commenters noted that the instrument must be capable of taking into account the medical and resource needs of individual patients, such as functional ability and medical status. One commenter recommended use of the IRF–PAI.

Response: Currently, we are in the early stages of designing the instrument and the demonstration. Although it is too early in the process to communicate specific details about either the instrument or the demonstration design, CMS is committed to including industry representatives in various stages of both efforts. We intend to convene technical advisory panels with industry representatives at several points in the project, including a panel to review the proposed assessment instrument once developed, and a panel to assist in recruiting providers for the

demonstration. We will provide status information on the progress of the instrument design as well as demonstration progress via CMS public Web sites, open door forums, and stakeholder meetings. Further, in accordance with section 5008(c) of the DRA, We plan to publish a Report to the Congress upon completion of the demonstration and the associated analysis.

Comment: One commenter requested that CMS provide the rehabilitation industry with access to the University of Colorado study on uniform patient assessment.

Response: We have made this report publicly available via our quality initiatives general information Web site, at *http://www.cms.hhs.gov/QualityInitiativesGenInfo/.*

B. Transparency and Health Information Technology Initiatives

The FY 2007 Inpatient Prospective Payment Systems (IPPS) proposed rule (71 FR 23996, April 25, 2006) discussed in detail the Health Care Information Transparency Initiative and our efforts to promote effective use of health information technology (HIT) as a means of promoting health care quality and greater efficiency. The IPPS proposed rule also discussed several potential options for making pricing and quality information more readily available to the public (71 FR 24120 through 24121). It solicited comments on ways to encourage transparency in health care quality and pricing, whether through voluntary incentives or through regulatory requirements, and sought comments on the Department's statutory authority to impose these requirements. In addition, it discussed the potential for HIT to facilitate improvements in the quality and efficiency of health care services (71 FR 24100 through 24101), and the appropriate role of HIT in potential value-based purchasing programs. The IPPS proposed rule also invited comments on the promotion of the use of HIT through Medicare conditions of participation.

Subsequently, in the FY 2007 IRF PPS proposed rule (71 FR 28134 through 28135, May 15, 2006), we invited comments on the specific implications of these initiatives for the IRF PPS. We received a small number of comments in response to the FY 2007 IRF PPS proposed rule's transparency and HIT discussions. However, as they are all generalized comments that are not specific to the IRF setting, we are inviting the commenters to refer to the FY 2007 IPPS final rule for full responses to comments received on the FY 2007 IPPS proposed rule's comprehensive discussions of transparency and HIT.

IX. Miscellaneous IRF PPS Public Comments

Comment: We received numerous comments requesting that CMS make additional IRF data files and software available to the public. The commenters specifically requested wage index data, cost report data, IRF–PAI data, MEDPAR data, data on facility adjustments, data files such as those produced for IPPS hospitals, other data files that CMS uses in the analyses that support the proposed and final rules, and the software program or software algorithm used by the fiscal intermediaries to determine the 75 percent rule presumptive compliance percentage.

Response: The data files mentioned by the commenters are generally available (and were generally available during the comment period for this final rule) to the public through CMS' standard data distribution systems. More information on CMS's data distribution policies is available on CMS's Web site at *http://www.cms.hhs.gov/researchers/statsdata.asp.*

Regarding the specific files that the commenters mentioned, we post the wage index files for the proposed and final rules each year on the IRF PPS Web site, along with the rate setting file. The cost report data are publicly available on the CMS Web site. The IRF–PAI and the MEDPAR data are generally available through CMS' standard data distribution systems for patient-level data. We include the data that we use in our analysis regarding other facility-level adjustments in the IRF rate setting file that is posted on the IRF PPS Web sitein conjunction with each proposed and final rule. Data on IRF facility-level adjustments are also available for download from the CMS Web sitein a file called the provider-specific file. We also encourage IRFs to contact their fiscal intermediaries regarding the data used to compute payments for their particular facilities.

We are in the process of developing user-friendly specifications for the software program used to determine presumptive compliance with the 75 percent rule. In the near future, we will post the data specifications for the software program on the IRF PPS Web site.

In addition, we will consult with the IPPS staff and examine the data files that are publicly distributed in conjunction with the IPPS proposed and final rules. Where feasible, we will make every effort to provide additional IRF data files that would be helpful to industry representatives and researchers.

Comment: A few commenters requested that we provide clarification on the teaching status and full-time equivalent (FTE) resident cap of a facility that converts from a long-term care hospital (LTCH), or another type of inpatient facility, to an IRF.

Response: We did not propose any changes to the IRF teaching status adjustment in the FY 2007 proposed rule. Thus, this comment is outside the scope of this final rule. However, we intend to issue future guidance on the teaching status of facilities that convert to IRFs in our standard contractor communication documents. We also intend to publish a provider education article on the CMS Medicare Learning Network (MLN), and post a clarification of this issue on the IRF PPS Web site.

Comment: We also received other comments that are outside the scope of this final rule, such as support for the revisions to the rural and LIP adjustments that we implemented in the FY 2006 IRF PPS final rule. We also received a comment reiterating a number of concerns with the IRF classification revisions that were implemented in the FY 2006 IRF PPS final rule, particularly the weighted motor score methodology and the revised CMG definitions.

Response: Although we did not propose any changes to the rural and LIP adjustments for FY 2007, we appreciate the commenters' support for the changes that we implemented for FY 2006. Regarding the commenter's concerns about the weighted motor score methodology and the revisions to the CMG definitions implemented for FY 2006, we will carefully consider the issues raised by the commenter in our future analyses of the IRF classification system.

Comment: We received a number of general comments on the 75 percent rule that are outside the scope of this final rule. For example, commenters urged CMS to conduct research to revise the conditions contained in the 75 percent rule that are currently considered appropriate for treatment in an IRF, saying that these conditions are out of date and do not reflect current treatment practices. Commenters also urged CMS to conduct research to develop a new method for classifying a facility as an IRF. Until such research is completed and the 75 percent rule is updated, they requested that CMS stop enforcement of the current compliance criteria. The commenters generally stated that patients are denied access to care because of the 75 percent rule, and that patients receive better rehabilitation

care in an IRF due to better medical management. The commenters urged CMS to develop or fund research studies in conjunction with NIH, independent researcher, or industry consortiums. In addition to direct funding assistance, they recommended ways in which we could support these research efforts by either waiving enforcement of the 75 percent rule or of local coverage determinations (LCDs) for facilities participating in research projects.

Response: Because the 75 percent rule provisions in the proposed rule were limited to the compliance thresholds that IRFs must meet for certain cost reporting periods and the extension of the use of comorbidities in determining compliance for an additional cost reporting period (until the full 75 percent compliance percentage becomes effective), these general comments on the 75 percent rule are outside of the scope of this final rule. We note that we responded to these and other similar comments in the May 7, 2004 (69 FR 25752) final rule. However, we continue to be concerned with ensuring that patients have access to treatment in the most appropriate settings. Therefore, we will continue to monitor patients' access to care carefully and will, as warranted, propose additional refinements to our policies in the future to ensure that patients continue to have appropriate access to care.

In addition, we are committed to supporting the research effort through the development of a series of collaborative relationships. For example, we have collaborated with the National Center for Medical Rehabilitation Research (NCMRR) of the National Institute of Child Health and Human Development at the National Institutes of Health (NIH) in convening a panel of rehabilitation experts that reviewed the medical literature in order to provide guidance regarding the optimal approaches to research. This review found a paucity of relevant studies and confirmed the need for additional work to identify the benefits of IRF care for different types of patients and to collect comparative outcome data across care settings. Since that time, both CMS and NIH staff have worked with researchers in an informal advisory capacity to support industry efforts to design and run clinical studies. In fact, we recently met with the director of the NCMRR to discuss how NCMRR and CMS could collaborate in encouraging and sponsoring research, and are in the process of developing a set of appropriate research questions that can be used to establish a common focus for discussion and design of new studies. We were also pleased to learn that industry representatives are themselves providing financial support to new research efforts. We believe that by working together, we can foster clinical studies that meet NIH criteria, and that the results of these studies can be used to support a comprehensive review of CMS's methods for classifying facilities as IRFs.

Further, as discussed in section VIII of this final rule, CMS is exploring refinements to the existing provider-oriented "silos" to create a more seamless delivery system for payment and delivery of post-acute care (PAC) under Medicare. The new model will be characterized by more consistent payments for the same type of care across different sites of service. We expect that the knowledge gained through this initiative will also help us to understand the similarities and differences among post-acute care settings.

X. DMEPOS Competitive Bidding Implementation Provisions and Accreditation for DMEPOS Suppliers

A. Implementation Contractor

1. Legislative Provisions

Section 1847(b)(9) of the Act provides that the Secretary may contract with appropriate entities to implement the Medicare DMEPOS Competitive Bidding Program. Section 1847(a)(1)(C) of the Act also authorizes the Secretary to waive such provisions of the Federal Acquisition Regulation (FAR) as are necessary for the efficient implementation of this section, other than provisions relating to confidentiality of information and such other provisions as the Secretary determines appropriate.

2. Provisions of the May 1, 2006 Proposed Rule

In the May 1, 2006 proposed rule (71 FR 25661), we proposed to designate one or more competitive bidding implementation contractors (CBICs) for the purpose of implementing the Medicare DMEPOS Competitive Bidding Program (proposed § 414.406(a)). In addition, we specified that the Secretary is exercising his authority under section 1847(a)(1)(C) of the Act to waive all requirements of the FAR, other than provisions dealing with confidentiality, because of the need for expeditious implementation of a program of this significance and magnitude. However, we stated that the Secretary's exercise of discretion on this issue would not preclude us from voluntarily using or adapting certain provisions of the FAR for purposes of the Medicare DMEPOS Competitive Bidding Program.

We stated in the proposed rule that we envision that the Medicare DMEPOS Competitive Bidding Program will have six primary functions, including overall oversight, operation design functions (including the design of both bidding and outreach material templates, as well as program processes), bidding and evaluation, access and quality monitoring, outreach and education, and claims processing. We also stated that we considered the organizational structure and requirements necessary to conduct these functions, and chose to exercise our contracting authority under section 1847(b)(9) of the Act and contract with one or more CBICs to assist us with many of these functions.

In the proposed rule, we described several options that we considered in designing the most appropriate framework for implementing the Medicare DMEPOS Competitive Bidding Program. As the implementation of competitive bidding involves many functions that are time limited and require specialized skills (for example, setting up bidding areas, reviewing bids, and setting single payment amounts), we believe that it would be prudent initially to implement most aspects of the Medicare DMEPOS Competitive Bidding Program through one or more CBICs. Processing of Medicare claims for most DMEPOS is currently done by two DME regional carriers (DMERCS) and two DME Medicare Administrative Contractors (DME MACs). We note that we are currently in the process of transitioning from DMERCs to DME MACs. For purposes of consistency, from this point forward, we will be referencing the DME regional carriers as DME MACs. Under our proposal, the DME MACs would process claims for DMEPOS items subject to competitive bidding. We also stated that we had evaluated the anticipated feasibility and cost of using one or more implementation contractors to assist us with implementing the Medicare DMEPOS Competitive Bidding Program, concentrating on the potential for capturing economies of scale and scope, program consistency, existing resources and infrastructure, and the viability of implementation under the timeframe mandated by section 1847(a)(1)(B) of the Act.

We proposed to contract with one or more CBICs to conduct some program functions at a national level and interact with the DME MAC contractors. Specifically, we envisioned that the CBIC(s) would conduct certain functions related to competitive bidding, such as preparing the request for bids (RFB), performing bid evaluations, selecting qualified

suppliers, and setting single payment amounts for all competitive bidding areas. In addition, the CBIC(s) would be charged with educating the DME MACs on the bidding process and procedures. The CBIC(s) would also assist CMS and the DME MACs in monitoring program effectiveness, access, and quality. The DME MACs would continue to provide outreach and education to beneficiaries and suppliers in their regions, process claims, apply the single payment amounts set by the CBIC(s) for each competitive bidding area, and continue to be responsible for complaints related to claims processing. We would continue to be responsible for overall oversight as well as policy-related outreach and education to the CBIC(s), DME MACs, suppliers, and beneficiaries.

We stated that in our view, this approach would achieve economies of scale, since the responsibility for producing program materials and evaluating bids would rest with the CBIC(s). As a result, we believed that this approach would both lower costs and ensure regional consistency in that the responsibility would not be divided between various entities.

We also discussed two other alternatives that we had considered for implementation of the Medicare DMEPOS Competitive Bidding Program. The first was to have each DME MAC conduct competitive bidding in its respective area and be responsible for all activities related to competitive bidding. The second alternative was to have the CMS Consortium Contractor Management Officer (CCMO)/Regional Offices (RO) and DME MACs implement the program. However, we stated that we believed that by using one or more specialized CBICs, we could successfully implement and effectively manage this program.

3. Public Comments Received and Our Responses

Comment: Two commenters support our decision to use competitive bidding implementation contractor(s) to implement the program. Another commenter stated that selecting and announcing implementation contractors are essential tasks for starting the Medicare DMEPOS Competitive Bidding Program.

Response: We agree. We expect to award one or more contracts to appropriate entities in order to assist us in implementing this program.

Comment: Several commenters expressed concern that we proposed to use our authority under section 1847(a)(1)(C) of the Act to waive all of the provisions of the Federal Acquisition Act (FAR), except those dealing with confidentiality of information. The commenters suggested that this waiver would lead to bidders using dishonest tactics and would result in inferior DMEPOS items and services being furnished to beneficiaries.

Response: After considering these comments and the best interest of the program, we have decided to apply the FAR to the CBIC for this instance. In this final rule, we are only responding to comments as they relate to the procurement of CBIC services. Section 1847(a)(1)(C) of the Act allows the Secretary to waive such provisions of the FAR as are necessary for the efficient implementation of the Medicare DMEPOS Competitive Bidding Program. We have determined that it is currently unnecessary for the efficient implementation of this program to waive the FAR to procure the CBIC(s) services.

Comment: One commenter asserted that we should strictly limit the use of CBICs to ensure responsiveness to small businesses. The commenter expressed concern that there could be situations in which neither we nor the CBICs would be clearly responsible for making important decisions. Such situations could be particularly problematic for small businesses with limited resources. This commenter further stated that there must be appropriate oversight and accountability if we choose to proceed with the use of one or more CBICs.

Response: We continue to believe that it is necessary and appropriate for us to use one or more CBIC(s) to assist in implementing the Medicare DMEPOS Competitive Bidding Program. We agree that it is important to establish clear lines of responsibility and accountability for the CBIC(s). As we indicated in the proposed rule, we will be responsible for overall oversight of the CBIC(s). We expect that the CBIC(s) will conduct certain functions, such as developing and implementing an ombudsman program to provide education and assistance to stakeholders involved in the program, and developing and implementing a monitoring process to ensure that complaints will be addressed and resolved in a timely manner. The CBIC duties will be fully detailed in the final CBIC contract(s).

Comment: One commenter was unclear as to how the CBIC(s) and DMERCs will interact in terms of development of policy. The commenter noted that the contractors must work together, and with us, to ensure that beneficiaries have access to all of the recertification/retesting requirements that may be implemented as a result of competitive bidding.

Response: We will require the CBIC(s) to develop and maintain strong relationships with all appropriate Medicare contractors to ensure that all interested parties have the necessary education and access to the requirements and guidelines set forth for the Medicare DMEPOS Competitive Bidding Program. We also intend to work closely with the CBIC(s) and to engage in our own efforts to educate suppliers on the specifics of this program. In terms of the interaction between the CBIC(s) and the DME MACS, we have previously stated that the CBIC(s) will be responsible for certain functions related to competitive bidding, such as preparing the request for bids, performing bid evaluations, and setting single payment amounts for items furnished under the program, and the DME MACs will be responsible for claims processing. Although the CBIC(s) and the DME MACs will be interacting on a number of functions, such as educating the public about the program and conducting monitoring activities, we would be responsible for overall oversight and policy development under the program. To the extent that the commenter referenced recertification/retesting requirements, we believe that the commenter is referring to the need for physicians and treating practitioners to, on some occasions, provide new documentation and certification to a supplier that a DMEPOS item furnished to a beneficiary remains medically necessary. We would like to clarify that we are not developing recertification or retesting requirements for the Medicare DMEPOS Competitive Bidding Program, and that the implementation of the program would not change or alter any existing certification requirements.

Comment: One commenter noted that the CBIC is a vital part of the entire process and that suppliers need to know more about the credentialing process for the CBIC and what type of authoritative power it will possess.

Response: As noted above, we will follow FAR requirements and engage in a full and open competition to procure the CBIC services in this instance. We will also provide the CBIC(s) with guidelines and roles for implementing the competitive bidding program. Also, as we noted above, we will monitor and review all CBIC functions on a consistent basis to ensure that the CBIC(s) is performing its intended functions. In addition, we will be providing an intensive education program for suppliers to inform them about the Medicare DMEPOS Competitive Bidding Program. This

educational program will inform suppliers in the competitive bidding areas about the Medicare DMEPOS Competitive Bidding Program as well as functions of the CBIC(s).

Comment: One commenter noted that we should utilize multiple CBICs to ensure that correct and effective implementation of the competitive bidding program is guaranteed and that cost savings to the Medicare program is a priority.

Response: We appreciate the comment and will take it into consideration as we evaluate the most cost-efficient and productive way to procure CBIC services.

Comment: One commenter requested that we define the quantitative, objective measures and evaluation tools that the CBIC(s) will use in evaluating the bids submitted by suppliers.

Response: Bid evaluation methodology will be addressed in a future rulemaking. We will ensure that the CBIC uses appropriate methodologies and tools to evaluate bids.

Comment: One commenter recommended that we eliminate regional inconsistencies and that the CBIC should be established, structured, and managed to ensure national consistency.

Response: We agree. When we implement the competitive bidding program, it is our goal to implement it consistently in each competitive bidding area. We will accomplish this by requiring the CBIC(s) to apply the same methodologies and policies that are adopted for the Medicare DMEPOS Competitive Bidding Program in each competitive bidding area.

Comment: Several commenters recommended that we ensure that any CBIC entity avoids any potential conflict of interest. Several commenters gave the same example of a conflict of interest as the CBIC also being a private payor that negotiates directly with DME suppliers in a managed care context.

Response: We agree that we should take steps in procuring CBIC services to ensure that the CBIC(s) do not have any potential conflicts of interest that could interfere with their ability to fulfill their contract obligations. For example, we plan to specify in the CBIC contract that the CBIC contractor shall not, throughout the duration of the contract, use information received as a result of the Medicare DMEPOS Competitive Bidding Program for any purpose other than for purposes of fulfilling its contract obligations, unless that information is otherwise publicly available. We believe it is in the best interest of the public as well as the Federal government that there are no conflicts of interest between the CBIC(s) and other entities.

Additionally, we note that the FAR, in Subpart 9.5, Organizational and Consultant Conflicts of Interest (OCI) requires the contracting officer to identify, evaluate, neutralize, or mitigate any potential OCIs prior to award. The FAR Subpart seeks to avoid any conflict of interest that, among other considerations, will bias a contractor's judgment.

Comment: Several commenters asked a variety of questions related to the CBIC selection process and performance evaluation. Specifically, one commenter asked what criteria will be used to select the CBIC. Another commenter asked how CMS would audit the CBIC's performance. Another commenter asked what the service expectations were of the CBIC relative to educating the DMERCs and suppliers.

Response: As noted in our response to a previous comment, we are currently following the requirements of the FAR in procuring and monitoring the CBIC(s). Some examples of the CBIC functions and service expectations were discussed above and will be addressed in the final CBIC contract(s). We will evaluate the CBIC performance in accordance with the FAR and agency procedures annually and at the time the work under the contract(s) is completed.

Final Decision: After consideration of the public comments received, we are finalizing at this time two paragraphs of proposed § 414.406. First, we are finalizing proposed § 414.406(a), which allows us to designate one or more CBICs for the purpose of implementing the Medicare DMEPOS Competitive Bidding Program. Second, we are finalizing proposed § 414.406(e), which codifies our proposal to have the regional carrier (now referred to as a DME MAC) that would otherwise be processing claims for a particular geographic region also process claims for items furnished under a competitive bidding program in the same geographic region. We will respond to any comments that we receive on our proposals related to proposed §§ 414.406(b)–(d), as well as comments that relate to other issues related to implementing the Medicare DMEPOS Competitive Bidding Program in a future rulemaking.

B. Education and Outreach

1. Supplier Education

In the May 1, 2006 proposed rule (71 FR 25683 through 25684), we provided a discussion of our plans to undertake a proactive education campaign to provide all suppliers with information about the Medicare DMEPOS Competitive Bidding Program, bidding timelines, and bidding and program requirements. We stated that the goal of this campaign is to make it as easy as possible for suppliers to submit bids.

To ensure that suppliers have timely access to accurate information on competitive bidding, we stated that we planned to instruct the CBIC and the DME MACs to provide early education and resources to suppliers, referral agents, beneficiaries, and other providers who service a competitive bidding area. Customer service support, ombudsman networks, and the claims processing system would all be used to notify and educate all parties regarding competitive bidding. The CBIC(s) would be instructed to utilize data analysis in tailoring outreach to those that will be directly affected by competitive bidding.

We also indicated that, after the release of bidding instructions, we would hold bidders conferences that would provide an open forum to educate suppliers and allow us to disseminate additional information. We stated that more information on the bidders conferences and other competitive bidding activities would be available on our Web site at *http://www.cms.hhs.gov/center/dme.asp*. We note that this is an updated Web site address that is different from the one that was listed in the proposed rule.

We additionally indicated that each DME MAC would include discussions and updates on competitive bidding as part of its existing outreach mechanisms. We stated that the fundamental goal of our supplier educational outreach is to ensure that those who supply DMEPOS products to Medicare beneficiaries receive the information they need in a timely manner so that they have an understanding of the program and our expectations.

Comment: One commenter agreed with our overall plan to use the CBIC, regional carriers, customer service support, and the claims processing system to notify and educate all parties regarding competitive bidding.

Response: We appreciate this comment. We continue to expect to use these resources as part of our education and outreach efforts.

Comment: One commenter suggested that we conduct extensive outreach to the supplier community so that suppliers can understand what is required of them in submitting bids. Other commenters expressed concern about our ability to communicate with suppliers within the initial ten MSAs and with suppliers that may have small

operations within an MSA but may be part of a larger organization located outside of that MSA.

Response: We plan to conduct an extensive education and outreach campaign to educate suppliers about the Medicare DMEPOS Competitive Bidding Program and to facilitate understanding of competitive bidding implementation efforts. We are committed to educating suppliers about this program as part of our ongoing educational efforts. Bidders conferences will be part of the educational process for those suppliers that are interested in bidding. At these conferences, we expect to provide information about the Medicare DMEPOS Competitive Bidding Program, such as technical details about the bidding forms and the process for submitting bids. These conferences will be open to all suppliers interested in learning the bid submission process, regardless of whether they are located in one of the ten initial areas that we designate as competitive bidding areas. In addition, we plan to utilize other educational tools, which may include a Medicare Learning Network Webpage dedicated to DMEPOS competitive bidding, contractor bulletins, etc., to disseminate information about the program as widely as possible. Further, we plan to work closely with the CIBC(s) that we designate, as well as the DME MACs, so that they are properly equipped to both educate suppliers about the program and to respond to questions.

Comment: One commenter urged us to include specific educational requirements that address each of the components that will be included in the composite bid that will create the single payment amount for each item. The commenter noted that such components would include, for example, the cost of equipment, training, supplies, transportation of the device, and beneficiary education on safe use of the equipment, etc. The commenter was concerned that if suppliers are not educated regarding what to include in their bids, then they might not submit bids that actually reflect all of the components that make up the safe operation of a piece of durable medical equipment in a beneficiary's home.

Response: We agree that all suppliers must be educated on what is to be included in their bid prices for competitively bid products. As part of our education and outreach campaign, we will inform suppliers of the items and services that they should include in their bids, such as training, supplies, transportation of the device, beneficiary education on safe use of the equipment, etc.

Comment: One commenter agreed that bidders conferences should be held to provide an open forum for suppliers to exchange information with us. One commenter requested information on the logistics for the bidders conferences. A commenter suggested that it might be helpful to allow suppliers who will be introduced to competitive bidding in 2009 to speak with those suppliers who were introduced in 2007.

Response: We will provide logistical information about bidders conferences as soon as it becomes available. We expect to make this information available on the CMS Web site and elsewhere, as appropriate. The purpose of the bidders conferences is to provide information about the Medicare DMEPOS Competitive Bidding Program, such as technical details about the bidding forms and the process for submitting bids. However, we encourage suppliers that participate in competitive bidding in 2007 to share their experiences with suppliers that plan to participate in future competitive bidding rounds.

Comment: One commenter suggested that the CMS Web sitebe revamped to make it more user-friendly, in order for beneficiaries to easily access publications.

Response: We recognize the importance of having a high-quality, helpful Web site. We plan to make our Web site as user-friendly as possible.

Comment: A commenter recommended that the PAOC review any educational materials that relate to the DMEPOS Competitive Bidding Program to ensure that appropriate communications are sent to suppliers.

Response: The Program Advisory and Oversight Committee (PAOC) meets periodically to review policy considerations and issues that we are considering with respect to the Medicare DMEPOS Competitive Bidding Program. The PAOC will continue to be available to provide us with advice until the end of 2009. We are using the PAOC for advice on implementation of the program and intend to take PAOC advice we have received into consideration when developing educational materials. Additional information about the PAOC can be found at 71 FR 25658.

Comment: Several commenters suggested that competitive bidding education must be provided to suppliers' referral sources, such as home health agencies, health insurance companies, HMOs, hospitals, physical and occupational therapists, and others. The commenters also believed that we should hold educational sessions for suppliers to ensure consistency in the way beneficiaries are educated and in the information they are provided. They suggested that we provide materials that can be used by suppliers to educate beneficiaries effectively about the Medicare DMEPOS Competitive Bidding Program. Additionally, they indicated that we should not depend solely on either suppliers or our Web siteto educate beneficiaries and that we should hold town hall meetings in each competitive bidding area (CBA) to ensure that beneficiaries and referral sources are knowledgeable about the competitive bidding program. One commenter requested that we collaborate with industry groups to develop appropriate communications to be sent to suppliers to minimize confusion in the supplier community. One commenter suggested that we make a concerted effort to educate non-contract suppliers in an MSA and suppliers in non-competitively bid areas.

Response: We plan to conduct an extensive education and outreach campaign to educate beneficiaries, suppliers, and referral agents about the Medicare DMEPOS Competitive Bidding Program. Our outreach strategy will be designed to ensure that information is consistent, readily available, and disseminated through a variety of information sources. We discuss our plans for beneficiary education in section X.B.2 of this final rule.

2. Beneficiary Education

As we stated in the May 1, 2006 proposed rule (71 FR 25684), the Medicare DMEPOS Competitive Bidding Program will have an impact on the beneficiaries who receive DMEPOS items in a competitive bidding area (CBA). Competitive bidding represents a new way for Medicare beneficiaries to receive their DMEPOS products and for setting payment for DMEPOS items; therefore, we believe that education is important to the success of the program.

We outlined our plans to educate beneficiaries utilizing numerous approaches. For example, we stated that our press office might consider creating press releases and fact sheets for each CBA. In addition, notices could provide summaries of competitive bidding, background information, and objectives of the competitive bidding program. Publications might also be available on the CMS Web sites, and from local contractors and the DME MACs.

We stated that we believe it is important for beneficiaries to learn about the benefits of the Medicare DMEPOS Competitive Bidding Program, such as lower out-of-pocket expenses and increased quality of products, from

suppliers that have completed the detailed selection process that CMS will require under the program. We also expect that the implementation of quality standards and accreditation requirements for DMEPOS suppliers will result in higher quality items and services being furnished to beneficiaries.

Comment: A few commenters stated that they appreciate our commitment in providing a proactive education approach. One commenter indicated that beneficiary education will be critical to the success of the program.

Response: We agree with the commenters and recognize the importance of an extensive education and outreach campaign to educate beneficiaries, suppliers, and referral agents about the DMEPOS Medicare Competitive Bidding Program.

Comment: One commenter encouraged us to provide beneficiary education and outreach for beneficiaries with diabetes. The commenter noted that ensuring that beneficiaries have access to their diabetic supplies and remain compliant with their diabetes self-management programs, as well as ensuring that beneficiaries understand the proper procedures for obtaining supplies while away from home, are two areas where aggressive education and outreach efforts are needed.

Response: We agree that a comprehensive education program is necessary to ensure the success of the Medicare DMEPOS Competitive Bidding Program. We plan to conduct an aggressive education and outreach campaign for all beneficiaries, including those who have diabetes, to ensure that they understand competitive bidding and have sufficient access to contract suppliers that can furnish the items they need.

Comment: A commenter indicated that many Medicare beneficiaries temporarily change their residences during the course of a year, and thus may find themselves outside of a specified competitive bidding area for several months at a time. The commenter urged us to establish a system to ensure that all beneficiaries will continue to have access to their suppliers even while residing outside of their permanent domiciles.

The commenter suggested that this plan should require that suppliers aggressively educate beneficiaries on the proper procedures for obtaining their supplies while away from home, and should allow beneficiaries to purchase extra supplies for extended vacations or temporary changes of residence. Further, the commenter noted that this plan should allow beneficiaries to purchase their supplies from non-contract suppliers in the event of an emergency.

Response: We expect that our educational program will address the issue of beneficiaries who temporarily change their residence during the course of the year. We will address in a future final rule the portions of this comment pertaining to emergency situations and the proposed policy for ensuring that beneficiaries who maintain a permanent residence in a competitive bidding area but travel outside the area have sufficient access to items while traveling.

Comment: One commenter stated that CMS should clearly specify in the final rule, or require CBICs to identify, the necessary telephone and internet resources that beneficiaries may use to raise questions and concerns related to the competitive bidding program.

Response: We agree that beneficiaries need to have access to appropriate resources on the Medicare DMEPOS Competitive Bidding Program. We note that we are in the process of developing our education and outreach campaign. We expect to identify appropriate telephone and internet resources for beneficiaries to use, which may include 1–800–MEDICARE and *www.medicare.gov*. Future guidance on this will be forthcoming as we move into the education and outreach phase of competitive bidding.

Comment: Some commenters recommended that a comprehensive education process be organized and put in place before implementation of the Medicare DMEPOS Competitive Bidding Program. A commenter stated that competitive bidding will drastically alter the way beneficiaries receive needed medical products and supplies.

Response: We plan to conduct an educational campaign for suppliers, beneficiaries, and referral agents before we begin the Medicare DMEPOS Competitive Bidding Program. We agree that this program may change the way beneficiaries receive needed DMEPOS items and the payment amount for these items, but note that beneficiaries will continue to have sufficient access to needed DMEPOS items and services under the program.

Comment: A few commenters stated concerns about the enormity of communicating to all referral sources and our ability to communicate effectively with beneficiaries, particularly when they are traveling. A commenter believed that beneficiaries will not understand the DMEPOS Competitive Bidding Program. The commenter requested that we define and publish plans for communicating information about implementing the program.

Response: Our outreach strategy will have a consistent message that is readily available and disseminated using a variety of tools, techniques, and informational sources. We also expect to use appropriate educational resources to educate beneficiaries on the specifics of the program. These resources might include 1–800–MEDICARE and *www.medicare.gov*. In addition, we are exploring the possibility of working with beneficiary organizations and local groups to conduct beneficiary outreach and develop beneficiary-focused communications. We also plan on coordinating a proactive outreach campaign at the national, regional and state levels in which we expect to provide accurate, reliable, relevant, and understandable information about the Medicare DMEPOS Competitive Bidding Program. Through these activities, we anticipate being able to sufficiently educate beneficiaries on what they need to know in order to obtain DMEPOS items and services under the program.

Comment: One commenter indicated that special attention should be given to inner city, minority, and low income populations who may be more difficult to contact than the population at large.

Response: We understand that Medicare beneficiaries are an extremely diverse population with different educational needs. We will consider this diversity in developing and implementing our education and outreach program.

Comment: One commenter recommended that we publish supplier customer satisfaction survey results and/or statistics on quality measures to assist beneficiaries in making informed decisions regarding contract supplier selection. The commenter also stated that we should not mislead beneficiaries by stating that one focus of our education efforts toward beneficiaries will be the increased quality of products that beneficiaries will be receiving as a result of competitive bidding.

Response: We will be monitoring beneficiary satisfaction under the Medicare DMEPOS Competitive Bidding Program and are in the process of determining how best to measure it. We expect that implementing DMEPOS quality standards and accreditation will lead to increased quality of items and services throughout the DMEPOS industry. Therefore, we believe it is accurate to indicate in our education campaign that beneficiaries will receive improved quality DMEPOS items and services under the Medicare DMEPOS Competitive Bidding Program. We also note that we expect to see this improved

quality not just in the DMEPOS items and services that are furnished by contract suppliers under the Medicare DMEPOS Competitive Bidding Program, but in the items and services furnished by all accredited DMEPOS suppliers.

Comment: A commenter suggested that we should target direct mail or disseminate information through high-Medicare-volume physician offices rather than through expensive direct-to-consumer television or media advertising. A commenter suggested that we rely on the homecare supplier community to educate beneficiaries.

Response: We are in the process of finalizing our education and outreach plan. We will consider the suggestion to engage physicians and the homecare supplier community in our efforts to disseminate information through physicians as we move forward with this plan. However, we note that the education and outreach strategy will have a consistent message that is readily available and disseminated through a variety of tools, techniques, and information sources.

Comment: One commenter suggested that we use webinars (interactive Web-based seminars) and teleconferences to provide education on the competitive bidding program. The commenter suggested that the education and outreach program start sooner rather than later.

Response: We are in the process of finalizing our education and outreach campaign and will consider using webinars and teleconferences as part of our overall approach to disseminate information as widely as possible. We expect to disseminate our message timely through a variety of tools, techniques, and informational sources.

Comment: A commenter expressed concern that beneficiaries would not know about the implications of the DMEPOS Competitive Bidding Program until such time as they attempt to obtain a particular item. Since many beneficiaries are not able to go to a pharmacy, the commenter observed that we have a significant challenge in educating beneficiaries and their caregivers about the program. The commenter also asserted that beneficiaries should know that the type and quality of DMEPOS items and services they receive under the program might be different from the ones they are currently using. The commenter added that beneficiary education materials should provide information on these important facts, and not just on the benefits of competitive bidding.

Response: Our objective will be to inform beneficiaries timely about all of the changes that will affect them as a result of the Medicare DMEPOS Competitive Bidding Program. We are aware of the challenges we face in ensuring that beneficiaries understand the program prior to attempting to obtain items. As we have noted above, our outreach strategy is to create a consistent message that is disseminated through a variety of tools, techniques and information sources. We also expect that as a result of implementing quality standards and accreditation requirements for all DMEPOS suppliers, including suppliers that participate in competitive bidding, beneficiaries will be able to obtain high quality DMEPOS items and services under the program.

C. Quality Standards for Suppliers of DMEPOS

Section 302(a)(1) of the MMA added section 1834(a)(20) to the Act, which requires the Secretary to establish and implement DMEPOS quality standards for suppliers of certain items, including consumer service standards, to be applied by recognized independent accreditation organizations. Suppliers of DMEPOS must comply with the quality standards in order to furnish any item, for which payment is made under Part B, and to receive and retain a supplier billing number used to submit claims for reimbursement for any such item for which payment may be made under Medicare. Section 1834(a)(20)(D) of the Act requires us to apply these DMEPOS quality standards to suppliers of the following items for which we deem the DMEPOS quality standards to be appropriate:

- Covered items, as defined in section 1834(a)(13) of the Act, for which payment may be made under section 1834(a);
- Prosthetic devices and orthotics and prosthetics described in section 1834(h)(4)of the Act; and
- Items described in section 1842(s)(2) of the Act, which include medical supplies; home dialysis supplies and equipment; therapeutic shoes; parenteral and enteral nutrients, equipment, and supplies; electromyogram devices; salivation devices; blood products; and transfusion medicine.

Section 1834(a)(20)(E) of the Act explicitly authorizes the Secretary to establish the DMEPOS quality standards by program instruction or otherwise after consultation with representatives of relevant parties. After consulting with a wide range of stakeholders, we determined that it was in the best interest of the industry and beneficiaries to publish the DMEPOS quality standards through program instructions and select the accreditation organizations in order to ensure that suppliers that want to participate in competitive bidding will know what DMEPOS quality standards they must meet in order to be awarded a contract.

After consultation with a wide range of stakeholders, we published the draft DMEPOS quality standards on the CMS Web site at *http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/* and provided for a 60-day public comment period. We received more than 5,600 public comments on the draft quality standards. After careful consideration of all comments, these quality standards will be published shortly on the CMS Web site. They will be available at *http://www.cms.hhs.gov/competitiveAcqforDMEPOS/*. The DMEPOS quality standards will become effective for use as part of the accreditation selection process when posted on the Web site. The quality standards will be applied by the accreditation organizations, and all suppliers of DMEPOS and other items to which section 1834(a)(20) of the Act applies will be required to meet them as part of the accreditation process.

As is authorized under section 1834(a)(20)(E)of the Act, we will be establishing the DMEPOS quality standards through program instruction and will publish them on our Web site. Although we previously stated that we would propose to address DMEPOS supplier requirements for enrollment and enforcement procedures in a future rule, we do not plan on issuing another rule concerning these issues at this time.

Comment: Several commenters expressed concern that the quality standards had not yet been issued in final form. One commenter stated that issuing final quality standards and selecting accreditation organizations are essential tasks for starting the competitive bidding program. A commenter requested that we extend the comment period on the May 1, 2006 proposed rule for 120 days so that the commenter could develop detailed responses to a number of issues raised in the proposed rule, including the finalization of quality standards and the impact of the proposed rule on coordination of care. Other commenters suggested that we should provide additional time for suppliers to analyze the quality standards in conjunction with our proposed rule on competitive bidding and to identify criteria we will use to identify accrediting bodies.

Response: We agree that the quality standards are a key factor in ensuring the success of the Medicare DMEPOS Competitive Bidding Program. We have provided for extensive opportunity for public input on the quality standards. In

addition to seeking the advice of the Program Advisory and Oversight Committee (PAOC), discussed in more detail in the May 1, 2006 proposed rule at 71 FR 25658, we posted the draft quality standards on our Web site on September 26, 2005 for a public comment period that ended November 28, 2005. After careful consideration of all comments, these quality standards will be published on the CMS Web site at *http://www.cms.hhs.gov/competitiveAcqforDMEPOS/*. The DMEPOS quality standards will become effective for use as part of the accreditation selection process when posted on the Web site. We believe that this public process provided sufficient opportunity for stakeholders to comment on the draft quality standards and do not believe that granting an extension of the comment period on the May 1, 2006 proposed rule or additional time to comment on the draft quality standards themselves is necessary.

Comment: Several commenters suggested that we not implement competitive bidding until we issue quality standards and select accreditation organizations. Commenters also specifically suggested that we should not select the 10 MSAs for the first phase of competitive bidding until we issue quality standards and select accreditation organizations.

Response: As noted earlier, we expect to issue the quality standards in the near future. We expect to identify the 10 competitive bidding areas in which competitive bidding will take place after we publish a future final rule on the Medicare DMEPOS Competitive Bidding Program. Our proposals for selecting accreditation organizations are discussed in section X.D of this final rule.

Comment: A commenter recommended that we base our quality standards on the existing standards used by the Accreditation Commission for Health Care (ACHC), Community Health Accreditation Program (CHAPS), and Joint Commission on Accreditation of Healthcare Organizations (JCAHO). One commenter encouraged us to include diabetes management experts in the development of the DMEPOS quality standards.

Response: These comments appear to concern the substantive nature of the draft quality standards that were developed and published on our Web site on September 26, 2005. We expect to respond to all the comments that we received on the draft DMEPOS quality standards in an accompanying document that will be published shortly on the CMS Web site at *http://www.cms.hhs.gov/competitiveAcqforDMEPOS/*. The DMEPOS quality standards will become effective for use as part of the accreditation selection process when posted on the Web site.

Comment: Seven commenters supported the implementation of quality standards, while others opposed the implementation of additional quality standards and accreditation requirements. Another commenter suggested that quality standards should be appropriate, realistic, and clearly defined.

Response: We appreciate the comments that expressed support for the establishment and implementation of DMEPOS quality standards, which is mandated by section 1834(a)(20) of the Act. We have worked collaboratively with a wide range of stakeholders to ensure that the quality standards are reflective of best industry practices for business and beneficiary services.

Comment: One commenter recommended that CMS provide its proposed revisions to the draft quality standards to the Program Advisory and Oversight Committee (PAOC) for review and comment before adopting these standards in final form. The commenter also recommended that CMS use these final standards to identify appropriate accreditation organizations for DMEPOS suppliers.

Response: These comments appear to concern the substantive nature of the draft quality standards that were developed and published on our Web site on September 26, 2005. We expect to respond to all the comments that we received on the draft DMEPOS quality standards in an accompanying document that will be published shortly on the CMS Web site at *http://www.cms.hhs.gov/competitiveAcqforDMEPOS/*.

D. Accreditation for Suppliers of DMEPOS and Other Items

Section 1834(a)(20)(B) of the Act requires the Secretary, notwithstanding section 1865(b) of the Act, to designate and approve one or more independent accreditation organizations to apply the DMEPOS quality standards to suppliers of DMEPOS and other items. Section 1865(b) of the Act sets forth the general procedures for CMS to designate national accreditation organizations that can deem suppliers to meet Medicare conditions of participation or coverage if they are accredited by a national accreditation organization approved by CMS. Certain limited types of suppliers have a choice between having the State agency or the CMS-approved accreditation organization survey them pursuant to our regulation at § 488.6. If such suppliers select the CMS-approved accreditation organization and meet the accreditation organization's standards, we deem them to have met the Medicare conditions of participation or coverage. We are responsible for the oversight and monitoring of the State agencies and the approved accreditation organizations. The procedures, implemented by the Secretary, for designating non-DMEPOS accreditation organizations and the Federal review process for accreditation organizations are located at parts 422 (for Medicare Advantage organizations) and 488 (for most providers and certain suppliers).

To accommodate DMEPOS suppliers that wish to participate in the Medicare DMEPOS Competitive Bidding Program, we will phase-in the accreditation process and give preference to accreditation organizations to prioritize their surveys to accredit suppliers in the selected competitive bidding areas. We will specify the approval submission procedures for accreditation organizations to accredit DMEPOS suppliers after this rule is finalized.

Section 1847(b)(2)(A)(i) of the Act specifies that a contract may not be awarded to any entity unless the entity meets applicable DMEPOS quality standards specified by the Secretary under section 1834(a)(20) of the Act. Any DMEPOS supplier seeking to participate in the Medicare DMEPOS Competitive Bidding Program will need to satisfy the DMEPOS quality standards issued under section 1834(a)(20) of the Act. In addition, section 1834(a)(20) of the Act gives us the authority to establish through program instructions or otherwise DMEPOS quality standards for all suppliers of DMEPOS and other items, including those who do not participate in competitive bidding, and to designate one or more independent accreditation organizations to implement the DMEPOS quality standards.

In the May 1, 2006 proposed rule (71 FR 25684), to ensure the integrity of suppliers' businesses and products, we proposed to revise § 424.57 of our existing regulations and add a new § 424.58.

E. Special Payment Rules for Items Furnished by DMEPOS Suppliers and Issuance of DMEPOS Supplier Billing Privileges (§ 424.57)

In accordance with sections 1834(a)(20) and 1834(j)(1)(B)(ii)(IV) of the Act, in the May 1, 2006 proposed rule (71 FR 25685), we proposed to revise § 424.57 to specify in a proposed new paragraph (c)(22) that all suppliers of DMEPOS and other items be accredited by a CMS-approved

accreditation organization to receive and retain a supplier billing number. We proposed the following definitions under § 424.57(a): "CMS-approved accreditation organization" would mean a recognized independent accreditation organization approved by CMS under § 424.58; an "Accredited DMEPOS supplier" would mean a supplier that has been accredited by a recognized independent accreditation organization meeting the requirements of and approved by CMS in accordance with § 424.58; and an "Independent accreditation organization" would mean an accreditation organization that accredits a supplier of DMEPOS and other items and services for a specific DMEPOS product category or a full line of DMEPOS product categories.

Comment: Four commenters supported our proposed requirement at § 424.57(c)(22) that all DMEPOS suppliers be accredited by a CMS-approved accreditation organization in order to receive a supplier number. One commenter expressed concern that some accreditation organizations might be unsuitable to accredit DMEPOS suppliers because these organizations have a hospital and home health nursing orientation and lack an understanding of how suppliers function, while another commenter noted that currently, the standards of accreditation organizations vary greatly. Another commenter stated that they were uncertain as to how CMS planned to proceed with its accreditation process for the retail pharmacy industry and to conform to standards not yet developed for a retail pharmacy or mail order pharmacy. Another commenter asked whether we had selected accreditation organizations.

Response: We will take into consideration the uniqueness of the DMEPOS environment by considering proposals from those accreditation organizations that can demonstrate their skills, knowledge, and ability, to survey the DMEPOS supplier industry. We hope to receive proposals from those accreditation organizations that have experience with specialized supplies (such as orthotics and prosthetics) or supplier types (such as pharmacies and physicians' offices).

Comment: Several commenters noted that the costs of meeting quality standards and accreditation requirements will cause suppliers to furnish inexpensive equipment and that some suppliers of purchased equipment will not provide service that beneficiaries are not trained to perform.

Response: We believe that the DMEPOS quality standards represent basic good business practices and that meeting the DMEPOS quality standards will result in improved quality of items and services furnished to Medicare beneficiaries. Approving accreditation organizations that only accredit one supplier type gives a small business owner the opportunity to reduce its accreditation cost. In the impact analysis, we have assumed costs to be on the average of $3,000 over a 3-year period.

Comment: One commenter recommended that we require all suppliers to receive accreditation. Another commenter stated that currently an accrediting body would consider a new location of an accredited supplier to be accredited without conducting an on-site visit. The commenter recommended that CMS make an allowance for this situation and consider any new location associated with an already-accredited supplier to qualify for the immediate issuance of a Medicare supplier number, followed up by a subsequent accreditation survey.

Response: We agree and will require enrolled, accredited DMEPOS suppliers to notify their accreditation organizations when a new location is opened. The accrediting organization of the enrolled DMEPOS supplier may accredit the new supplier location for three months after it is operational without a site visit.

Comment: Commenters suggested that a supplier should not be required to be reaccredited each time that it elects to add a new product line.

Response: We disagree and are requiring that a DMEPOS supplier disclose upon enrollment all products and services for which they are seeking accreditation. Thus, if a new product line is added after enrollment, the supplier must notify the accrediting body of the new product or service so that the supplier can be re-surveyed and accredited for these new products or services.

After consideration of the public comments received, we are finalizing our proposal with modifications. We have modified § 424.57(c)(22), to clarify that all suppliers of DMEPOS and other items and services must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services for which the supplier is accredited in order for the supplier to receive payment for those specific products and services.

We added a new provision at § 424.57(c)(23), requiring that DMEPOS suppliers must notify their accreditation organizations when a new DMEPOS location is opened. The accreditation organization may accredit the new supplier location for three months after it is operational without visiting the new site visit.

We added a new provision at § 424.57(c)(24), which requires that all DMEPOS supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare. An accredited supplier can be denied enrollment or their enrollment could be revoked, if we determined that they were not in compliance with the DMEPOS quality standards.

We have added a new provision at § 424.57(c)(25), requiring that all DMEPOS suppliers must disclose upon enrollment all products and services, for which they are seeking accreditation. If a new product line or service is added after enrollment, the supplier will be responsible for notifying the accrediting body of the new product so that the supplier can be re-surveyed and accredited for these new products.

F. Accreditation (§ 424.58)

In accordance with section 1834(a)(20) of the Act, in the May 1, 2006 proposed rule (71 FR 25685 and 25702), we proposed to add a new § 424.58(a) and (b) to set requirements for CMS-approved accreditation organizations in the application of the quality standards to suppliers of DMEPOS and other items.

To promote consistency in accrediting suppliers throughout the Medicare program, we proposed to use existing criteria (with modifications) for the application, reapplication, selection, and oversight of accreditation organizations detailed at 42 CFR Part 488 and apply them to organizations accrediting suppliers of DMEPOS and other items. We proposed to require an independent accreditation organization applying for approval or reapproval of deeming authority to—

- Identify the types of DMEPOS supplies and services for which the organization is requesting approval.
- Provide CMS with a detailed comparison of the organization's accreditation requirements and standards with the applicable Medicare DMEPOS quality standards (for example, a crosswalk);
- Provide a detailed description of the organization's survey processes, including procedures for performing unannounced surveys, frequency of the surveys performed, copies of the organization's survey forms, guidelines and instructions to surveyors, and quality review processes for deficiencies identified with accreditation requirements;

- Describe the decision-making processes and describe procedures used to notify suppliers of compliance or noncompliance with the accreditation requirements;
- Describe procedures used to monitor the correction of deficiencies found during the survey; and
- Describe procedures for coordinating surveys with another accrediting organization if the organization does not accredit all products that the supplier provides.

In the proposed rule, we indicated that we would request detailed information about the professional background of the individuals who perform surveys for the accreditation organization, including: The size and composition of accreditation survey teams for each type of supplier accredited; the education and experience requirements that surveyors must meet; the content and frequency of the continuing education training provided to survey personnel; the evaluation systems used to monitor the performance of individual surveyors and survey teams; and policies and procedures for a surveyor or institutional affiliate of an accrediting organization that participates in a survey or accreditation decision regarding a DMEPOS supplier with which this individual or institution is professionally or financially affiliated.

We also indicated that we would request a description of the organization's data management, analysis, and reporting system for its surveys and accreditation decisions, including the kinds of reports, tables, and other displays generated by that system. We would require a description of the organization's procedures for responding to and investigating complaints against accredited facilities including policies and procedures regarding coordination of these activities with appropriate licensing bodies, ombudsman programs, National Supplier Clearinghouse, and with CMS; a description of the organization's policies and procedures for notifying CMS of facilities that fail to meet the requirements of the accrediting organization; a description of all types, categories, and duration of accreditation decisions offered by the organization; a list of all currently accredited suppliers; a list of the types and categories of accreditation currently held by each supplier; a list of the expiration date of each supplier's current accreditation; and a list of the next survey cycles for all DMEPOS suppliers' accreditation surveys scheduled to be performed by the organization.

We proposed that we would require the accreditation organization to submit the following supporting documentation:

- A written presentation that would demonstrate the organization's ability to furnish CMS with electronic data in ASCII-comparable code.
- A resource analysis that would demonstrate that the organization's staffing, funding, and other resources are sufficient to perform the required surveys and related activities.
- An acknowledgement that the organization would permit its surveyors to serve as witnesses if CMS took an adverse action against the DMEPOS supplier based on the accreditation organization's findings.

We proposed to survey accredited suppliers from time to time to validate the survey process of a DMEPOS accreditation organization (validation survey). These surveys would be conducted on a representative sample basis or in response to allegations of supplier noncompliance with DMEPOS quality standards. When conducted on a representative sample basis, we proposed that the survey would be comprehensive and address all Medicare DMEPOS quality standards or would focus on a specific standard. When conducted in response to an allegation, we proposed that the CMS survey team would survey for any standard that we determined was related to the allegations. If the CMS survey team substantiated a deficiency and determined that the supplier was out of compliance with the DMEPOS quality standards, we proposed to revoke the supplier billing number and reevaluate the accreditation organization's approved status. We proposed to require a supplier selected for a validation survey to authorize the validation survey to occur and to authorize the CMS survey team to monitor the correction of any deficiencies found through the validation survey. We proposed that if a supplier selected for a validation survey failed to comply with the requirements at § 424.58(b)(4), it would no longer be deemed to meet the DMEPOS quality standards and its supplier billing number would be revoked.

Comment: Commenters stated that it would be difficult for accreditation organizations to survey timely the large number of suppliers, with commenters noting that the accreditation process can take six to 12 months. A commenter noted that it was unclear whether any of the accrediting bodies would be willing or able to meet our requirements to be a CMS-approved accreditation organization. A commenter stated that it would be difficult for suppliers to become accredited before the bidding process began. Commenters requested that CMS provide sufficient time after it identifies accreditation organizations for suppliers to become accredited.

Response: Our DMEPOS quality standards for use by accreditation organizations are streamlined and require less resources to implement than are currently used by some accreditation organizations. We believe that the quality standards that have been developed are appropriate, realistic, and clearly defined.

Comment: Several commenters suggested that we "grandfather" suppliers already accredited by organizations that we select as accreditation organizations, while another commenter opposed such "grandfathering," stating that only suppliers that receive accreditations which address our revised quality standards should be allowed to contract under the bidding program. Some commenters suggested that CMS should grandfather any organization that meets minimal accreditation standards, even if that organization is not ultimately selected as an accrediting organization or if the standards used are not totally consistent with the standards required by CMS.

Response: We recognize the need to provide an alternative mechanism to accommodate currently accredited suppliers. As stated in the proposed rule we will provide further guidance on a process to accredit DMEPOS suppliers that currently maintain an accreditation with an accreditation organization.

Comment: One commenter argued that the role of the Medicare National Supplier Clearinghouse (NSC) should be limited to reviewing complaints regarding non-compliance, conducting spot checks for compliance with the accreditation standards, and issuing supplier numbers based on accreditation verification.

Response: We appreciate this comment; however, this rule does not address the role of the NSC.

Comment: One commenter observed that most enteral patients are in long-term care facilities. Most of these patients receive enteral nutrition from suppliers that focus only on the long-term care market. The commenter believed that the proposed rule would require enteral nutrition suppliers to be accredited for compliance with the Part B standards, even though those standards do not apply to the patients they serve. The commenter stated that the provision of enteral nutrition to patients who qualify for the home

health benefit would not be subject to the new Part B standards. Another commenter stated that manufacturers of customized ocular prosthetics are excluded from the accreditation requirements that we proposed at § 424.58 because these items are not included in proposed § 414.402. Several commenters stated that CMS should deem pharmacies, occupational therapists, physical therapists and ophthalmologists as accredited because of the licensure and education requirements that they already fulfill and because their role as a supplier is inextricably linked to their professional service. Another commenter stated that skilled nursing homes should be excluded from the implementation of this rule.

Response: The Secretary may implement standards for such items and services listed at 1834(a)(20)(D) as he deems appropriate. The Secretary has decided to implement quality standards for all such items and services.

Comment: Several commenters noted that the accreditation process is costly, with estimates ranging from two thousand to 20 thousand dollars. They noted that accreditation was expensive and burdensome to many DMEPOS suppliers, including small suppliers, rural suppliers, pharmacies, non-mail order suppliers with small numbers of employees, suppliers that furnish supplies to a high percentage of beneficiaries that live nearby, suppliers with a small volume of Medicare business, or a limited line of supplies (such as diabetic supplies). Several of these commenters suggested exempting suppliers with these characteristics from the accreditation requirement or creating a two-tier system with less expensive and burdensome alternatives to current accreditation fees. One commenter suggested that hospitals and other health care suppliers with certified DME programs should not be required to acquire new certification until the current certification expires. One commenter suggested making accreditation mandatory to keep the quality standards consistent.

Response: We do not have the statutory authority to exempt any categories of suppliers under section 1834(a)(20) of the Act except insofar as the Secretary exempts specific DMEPOS items and services under (20)(D). Suppliers must meet our DMEPOS quality standards as applied by approved accreditation organizations pursuant to section 1834(a)(20)(B) of the Act. We hope that approving many DMEPOS accreditation organizations will induce competition and decrease cost.

Comment: One commenter questioned why CMS could not deem between one and three already-existing accrediting organizations to meet its expectations and then require any supplier that wishes to participate in competitive acquisition to become accredited by one of those three organizations. One commenter suggested modifying § 424.58(b) by adding special categories for orthotics and prosthetics and pedorthics accrediting organizations.

Response: We do want to receive applications from existing organizations. However, in order to accommodate the large number of DMEPOS suppliers that need to be accredited in order to bid, we must allow a variety of organizations to become accreditation organizations. We believe § 424.58(b) does include categories such as orthotics and prosthetics and pedorthics. Therefore in order to accommodate small and specialty suppliers, we hope to receive applications from small or specialty accrediting firms that will be able to accredit these specialty suppliers at a reduced cost.

Comment: One commenter indicated that CMS should require accrediting bodies to submit their conflict of interest disclosure policies, since some surveyors also have consulting businesses that may conflict with certain clients.

Response: We agree and have added this requirement.

Comment: Two commenters stated that the process for the validation survey of suppliers should be outlined in greater detail in the regulation's preamble to include the survey frequency, who will perform the surveys, and the methodology used to determine the validation sample.

Response: We plan to issue further guidance regarding the validation survey process through program instructions.

Comment: One commenter stated that proposed 42 CFR 424.58(b)(3) is redundant and confusing to specify "If CMS discovers a deficiency and determines that the DMEPOS supplier is out of compliance with Medicare quality standards, * * *.".

Response: We agree and we have revised the language appropriately.

Comment: One commenter stated that it is unclear what is meant by the use of the term "subsequent full accreditation survey" and that there is no statutory authority that would permit CMS to specify that the accreditation organization perform a survey at its own expense.

Response: "Subsequent full accreditation survey" is a type of survey that may be performed by the accreditation organization if CMS determines that the DMEPOS supplier is out of compliance with the Medicare DMEPOS quality standards. The statutory authority for this requirement is found in Section 1834(a)(20)(B), which permits the Secretary to utilize his discretion in deciding the terms under which accreditation organizations will be approved to accredit DMEPOS suppliers.

Comment: One commenter suggested that the CMS oversight provision should be clarified to describe: Who is eligible to be "a designated survey team;" the methodology for selecting suppliers for the CMS survey; and detailed information on how the disparity rate will be calculated. The commenter also suggested that we clarify what is meant by "disparity between findings that constitute immediate jeopardy to patient health and safety" and "widespread or systemic problems in an organization's process."

Response: In order to accommodate the dynamics of the survey process and the ever-changing needs of the DMEPOS suppliers, we plan to issue the specifics of our oversight strategies in program instructions.

Comment: Two commenters stated that accrediting bodies do not currently notify ombudsman programs or NSC of unfavorable accreditation decisions. The commenter stated that any such notice process should be preceded by or include an appropriate appeal and cure process for suppliers to access prior to any punitive action being taken (Although the commenter didn't specify the exact organization that he believed would take such punitive action). A mediation process must be included in the overall plan so that an accreditation organization would have a channel for appealing CMS's validation survey findings.

Response: We agree and we have added the requirement that the accreditation organizations provide a copy of their dispute resolution policies and or appeals policies/procedures to CMS. Additionally, we plan to provide a venue for accreditation organizations and suppliers to resolve conflicts about deficiency findings. We will issue further guidance on this process through program instructions.

Comment: One commenter submitted detailed information on the nature of the commenter's organization and the specific accreditation costs that it incurs, and argued that unless a supplier has already undergone an accreditation process, it cannot properly estimate its costs associated with seeking and maintaining accreditation

and, therefore, it cannot submit an accurate bid to CMS.

Response: We appreciate this information. We have utilized this information in our analysis of the rule's financial impact on DMEPOS suppliers.

Comment: One commenter suggested that CMS should have a supplier's accrediting organizations conduct follow-up visits with the supplier on any allegation of supplier noncompliance with quality standards. The commenter asserted that the Program Integrity Unit's (PIU's) current plan of auditing only high-volume, claims-generating DMEPOS suppliers creates a situation where those suppliers are audited over and over again, with largely successful outcomes, while smaller suppliers that may not be following Medicare guidelines go unaudited for many years. They noted that audits represent a large administrative burden for suppliers, and those that pass successfully should be moved on to some kind of representative sampling methodology to ensure ongoing compliance. The commenter suggested that if the PIU continues its current sampling methodology, it will continue to overlook those suppliers that are more likely to be violating rules and regulations than the ones that have high volume and pass audits successfully time after time.

Response: We appreciate the comment regarding activities of the Program Integrity Units (PIUs). (Although the commenter didn't specify the exact organization to which he was referring, we assume the commenter means CMS's Program Integrity Unit, which is a branch of CMS's Office of Financial Management). However, the PIU's role is to ensure that claims submitted for Medicare reimbursement are covered, correctly coded and are reasonable and necessary based on the clinical condition of the patient. PIUs are not responsible for ensuring compliance with DMEPOS quality standards.

Comment: One commenter asked whether CMS would set ethical conduct standards for an accreditation organization's dispute-resolution process when suppliers challenged such organization's adverse findings. This commenter suggested that the hearing process for the accreditation organizations needs to be formal and involve a more independent, objective mediator than one that is appointed by the CMS Administrator. The commenter indicated that the hearing process should allow for testimony and other evidence to be accepted and admissible under the usual rules of court procedures.

Response: We understand the commenter's concerns about the fair and objective process when there is a dispute over the accreditation findings. We will be asking accreditation organizations to address their practices for dispute resolution in their CMS approval application.

Comment: A commenter indicated that the accreditation process should include reasonable mechanisms that the accrediting organization must use to identify those suppliers which are not in compliance with minimum competency requirements. The commenter recommended adding a description of the organization's method for determining the process that surveyors would utilize to assess compliance with each accreditation standard, including a description of how the organization would translate surveyor observations into a score for each accreditation standard; how that score would aggregate into an overall score; and how that score would identify competent suppliers.

Response: We agree with the commenter's suggestion but believe it is best implemented through guidance. We plan to utilize many of these processes as well as those that are consistent with existing accreditation procedures identified in Part 488.

Comment: Commenters recommended that each accrediting organization should be compelled to demonstrate that it has the knowledge and experience necessary to properly classify suppliers and measure their organizational performance in the specific product and service types.

Response: We agree and we will address eligibility criteria through future program instructions.

Comment: Commenters argued that the two-calendar day requirement for reporting non-compliance to CMS under § 424.58(c)(4) is an unreasonable standard because it failed to recognize holidays and weekends as periods when complying with this requirement would be problematic. They suggested that it is more reasonable for CMS to require this critical notification via any format within five business days. They further requested CMS to identify those specific standards with which noncompliance would rise to the level of posing immediate jeopardy to a beneficiary or to the general public.

Response: We disagree with the first part of the comment as we believe that two calendar days is a reasonable standard and is consistent with our current survey requirements. "Immediate jeopardy to a beneficiary or to the public" is determined by criteria set by the accreditation organization. We will review these criteria at the time of the application process.

Comment: Some commenters noted that it takes 6 months to prepare for an initial survey and 4 months for an ongoing survey. They added that a supplier going through accreditation for the first time will need 10 to 12 months to complete that process. The commenters observed that CMS should expect it to take a minimum of one year for some suppliers to complete the accreditation process and become officially accredited.

Response: Our DMEPOS quality standards for use by accreditation organizations are streamlined and require less resources to implement than are currently used by some accreditation organizations. We believe that the quality standards that have been developed are appropriate, realistic, and clearly defined. We are requiring that accreditation organizations perform unannounced surveys. This will assist in reducing the survey process timeframe and cost.

Comment: Commenters requested us to clarify the relationship between accreditation organizations and CMS complaint investigation more broadly. In particular, when a supplier organization is deemed to be in full compliance with the quality standards and the 21 supplier standards by an approved accreditation organization, the commenters asked whether CMS will be permitted to separately revoke or suspend a supplier's participation status if CMS determines that the supplier was not in compliance with these requirements.

Response: We will be providing further guidance on the relationship between accreditation organizations and CMS complaint investigations in program instructions. However, if a complaint or validation survey discovered serious deficiencies CMS could revoke the supplier's billing number in accordance with § 424.58(b)(3).

Comment: Commenters observed that the regulation requiring applicants to submit a lengthy history of companies that it has accredited would not allow new companies to enter the market in a timely manner.

Response: We understand the commenter's concern. This history will not give an existing organization an advantage over a new organization. We will be considering all new and established accrediting organizations equally during the review process.

Comment: Some commenters asserted that requiring full disclosure of an

accreditation report for each accredited supplier constitutes an invasion of privacy regarding the supplier and would be a breach of proprietary information. They asked under what authority CMS could require full disclosure about customers of a private business.

Response: We disagree with this comment. We are not requiring accreditation organizations to provide information about suppliers not participating in Medicare, and enrollment for a supplier number is strictly voluntary. However, in order to ensure that accreditation organizations are correctly implementing CMS quality standards, we believe that having access to supplier-specific information will be necessary.

After consideration of the public comments received, we are adopting as final with modifications the provisions under the proposed new § 424.58(a) and (b), containing the application and reapplication procedures for CMS-approved accreditation organizations in the application of the DMEPOS quality standards to suppliers of DMEPOS and other items.

As part of their application process, accreditation organizations must provide CMS with a detailed description of their dispute resolution process to allow DMEPOS suppliers the opportunity to appeal negative survey findings or decisions. We have added a new provision at § 424.58(b)(1)(iii) to require accreditation organizations to have a policy and procedure in place to allow DMEPOS suppliers to dispute a negative accreditation survey or survey findings. This process is consistent with existing processes under part 422.

In response to public comments, we have revised the provision at § 424.58(b)(3) to state that if CMS discovers a supplier was not in compliance with the DMEPOS supplier quality standards, CMS may revoke the supplier's billing number or require the accreditation organization to perform a subsequent full accreditation survey at the accreditation organization's expense.

We have also revised § 424.58(b)(6) to indicate that if a validation survey results in a finding that the supplier was not in compliance with one or more DMEPOS quality standards, the supplier no longer meets the DMEPOS quality standards and may have its supplier billing number revoked.

G. Ongoing Responsibilities of CMS-Approved Accreditation Organizations

In this final rule, we require that DMEPOS independent accreditation organizations approved by CMS undertake the following activities on an ongoing basis:

- Provide to CMS in written form and on a monthly basis all of the following:

++ Copies of all accreditation surveys along with any survey-related information that CMS may require (including corrective action plans and summaries of CMS requirements that are not met).

++ Notice of all accreditation decisions.

++ Notice of all complaints related to suppliers of DMEPOS and other items.

++ Information about any supplier of DMEPOS and other items for which the accreditation organization has denied the supplier's accreditation request.

++ Notice of any proposed changes in its accreditation standard, requirements, or survey processes. If the accreditation organization implemented the changes before or without CMS approval, CMS has the authority to withdraw its approval of the accreditation organization.

- Submit to CMS (within 30 days of a change in CMS quality standard requirements):

++ An acknowledgment of CMS's notification of the change;

++ A revised crosswalk reflecting the new DMEPOS quality standard requirements; and

++ An explanation of how the accreditation organization would alter its standards to conform to CMS's new requirements, within the timeframes specified by CMS in the notification.

- Permit its surveyors to serve as witnesses if CMS takes an adverse action against a supplier based on accreditation findings.
- Provide CMS with written notice of any deficiencies and adverse actions implemented by the independent accreditation organization against an accredited DMEPOS supplier within 2 calendar days of identifying these deficiencies, if these deficiencies pose immediate jeopardy to a beneficiary and/or the general public.
- Provide CMS with written policies and procedures to ensure that DMEPOS suppliers are accredited every 3 years.
- Provide written notice of CMS's withdrawal of the accreditation organization's approval to all accredited suppliers within 10 calendar days of receipt of CMS's withdrawal notice.
- Provide, on an annual basis, summary data specified by CMS that related to the past year's accreditation activities and trends.

Comment: One commenter suggested that the guidelines proposed in § 424.58(c) were unreasonable.

Response: We disagree. Section 424.58(c) addresses the ongoing responsibilities of a CMS-approved accreditation organization. This section provides requirements with which the accreditation organization must comply on an ongoing basis in the application of the DMEPOS quality standards to suppliers of DMEPOS and other items.

Comment: Three commenters indicated that requiring notice of all complaints related to suppliers of DMEPOS and other items and services is overly broad and burdensome, and that section 424.58(c)(1)(iii) is redundant with § 424.58(c)(1)(iv) and should be eliminated.

Response: These provisions are not redundant. Section 424.58(c)(1)(iii) requires that accreditation organizations provide a notice or listing of all complaints received. Section 424.58(c)(1)(iv) requires that an accreditation organization provides information on the outcomes of the remedial and adverse actions that it takes against the suppliers that it accredits.

Comment: One commenter indicated that requiring approved accreditation organizations to provide copies of all written surveys, corrective action plans, and summaries represent a significant paperwork burden to the accrediting organization and CMS.

Response: We disagree, and note that in order for us to ensure the integrity of the DMEPOS accreditation program these requirements are necessary and are consistent with existing accreditation requirements for providers and suppliers under part 488.

Comment: One commenter indicated that scoring methodologies differ amongst the three accrediting organizations and slightly different standards and requirements may be assessed. Without an executive summary written by either the accrediting organization or the supplier itself, CMS might find itself unable to interpret the results of the survey accurately.

Response: We agree and we are requiring the accreditation organizations to describe their decisionmaking process to reduce misinterpretation of survey findings. We also note that the accreditation organizations must submit a crosswalk to their own standards as part of the application process.

Comment: One commenter requested that CMS provide a reasonable timeframe for itself in which to review an accreditation organization's request for change under § 424.58(c)(1)(v). The commenter recommended that CMS commit to respond to any proposed change within 60 days of submission by the approved accrediting organization.

Response: We plan to provide a reasonable timeframe in which we will review an accrediting organization's request for change and will outline this timeframe through program instructions.

Comment: Two commenters indicated that though they thought it was reasonable for CMS to expect the accrediting organizations to inform the agency of changes in standards, it was unreasonable to penalize the organization by withdrawing its approval if it implemented the changes before or without CMS' approval.

Response: We disagree and believe that this requirement is essential to ensure that appropriate DMEPOS standards are being utilized by accreditation organizations.

Comment: A commenter requested clarification on what constitutes "written format" in § 424.58(c)(1).

Response: We will clarify in the regulation text that written format means either hard copy or electronic format.

Comment: One commenter suggested amending § 424.58(c)(5) by inserting the word "business" between "10" and "days" and that notice should be required only after CMS has issued a final determination that approval is to be withdrawn.

Response: We agree that this requirement should be clarified but that notice should be more prompt than 10 business days. Therefore, we will revise the regulation to add the word "calendar" between the words "10" and "days".

After consideration of the public comments received, we are adopting as final with modifications the following:

We have modified § 424.58(c)(1) to clarify that written format means either hard copy or electronic format.

We have revised § 424.58(c)(2) and (5) to add the word "calendar" before the word "days".

H. Continuing Federal Oversight of Approved Accreditation Organizations

Section 424.58(d) establishes specific criteria and procedures for continuing oversight and for withdrawing approval of an accreditation organization.

1. Equivalency Review

We will compare the accreditation organization's standards and its application and enforcement of those standards to the comparable CMS quality standard requirements and processes when: CMS imposes new requirements or changes its survey process; an accreditation organization proposes to adopt new quality standards or changes in its survey process; or the term of an accreditation organization's approval expires.

2. Validation Survey

A CMS survey team will conduct a survey of the accreditation organization, examine the results of the accreditation organization's own survey procedure onsite, or observe the accreditation organization's survey, in order to validate the organization's accreditation process. At the conclusion of the review, we will identify any accreditation programs for which validation survey results indicate:

- A 10 percent rate of disparity between findings by the accreditation organization and findings by CMS on standards that do not constitute immediate jeopardy to patient health and safety if not met;
- Any disparity between findings by the accreditation organization and findings by CMS on standards that constitute immediate jeopardy to patient health and safety if not met; or
- Widespread or systemic problems in the organization's accreditation processes such that the accreditation of the DMEPOS supplier no longer provides assurance that the supplier meets or exceeds the Medicare requirements, irrespective of the rate of disparity.

3. Notice of Intent To Withdraw Approval for Deeming Authority

If an equivalency review, validation review, onsite observation, or our concerns with the ethical conduct of the accreditation organization suggest that the accreditation organization is not meeting the requirements of § 424.58, we will provide the accreditation organization with written notice of our intent to withdraw approval of the accreditation organization's deeming authority. We will collaborate with the DMEPOS accreditation organization in order to transition those DMEPOS suppliers to a new accreditation organization.

4. Withdrawal of Approval for Deeming Authority

We will withdraw approval of an accreditation organization at any time if we determine that: accreditation by the organization no longer guarantees that the suppliers of DMEPOS and other items met the DMEPOS quality standards and that the failure to meet those standards poses or may potentially pose an immediate jeopardy to the health or safety of Medicare beneficiaries or constitutes a significant hazard to public health; or the accreditation organization fails to meet its obligations for application and reapplication procedures.

Comment: One commenter suggested that the term "guarantees" should be replaced by "adequate assurance" since the latter term more appropriately represents the process of accreditation in that accreditation can provide such assurance that the quality standards are met but cannot "guarantee" such an assertion.

Response: We will clarify this in the regulation text. After consideration of public comments received, we are adopting as final with modifications the following:

We have modified § 424.58(d)(4)(i) to utilize the term "adequately assures" that, rather than "guarantees". The modified provision now states "Accreditation by the organization no longer adequately assures that the suppliers of DMEPOS and other items and services are meeting the DMEPOS quality standards, and that failure to meet those standards could jeopardize the health or safety of Medicare beneficiaries and could constitute a significant hazard to the public health."

I. Reconsideration

If an accreditation organization is dissatisfied with a CMS determination that its accreditation requirements do not provide or no longer provide reasonable assurance that the entities accredited by such organization meet the applicable DMEPOS supplier quality standards, such organization would be entitled to reconsideration of that determination. We will reconsider any determination to deny, remove, or not renew the approval of deeming authority to accreditation organizations if the accreditation organization files a written request for reconsideration through its authorized officials or through its legal representative.

The request must be filed within 30 days of the receipt of CMS notice of an adverse determination or non-renewal. The request for reconsideration must specify the findings or issues with which the accreditation organization disagrees and the reasons for the disagreement. A requestor may withdraw its request for reconsideration at any time before the issuance of a reconsideration determination. In response to a request for reconsideration, we will provide the accreditation organization the opportunity for an informal hearing that will be conducted by a hearing officer appointed by the Administrator of CMS. The hearing will provide the accreditation organization the opportunity to present, in writing and in person, evidence or documentation to

refute the determination to deny approval, or to withdraw (or not renew) deeming authority.

We will provide written notice of the time and place of the informal hearing at least 10 calendar days before the scheduled date. The informal reconsideration hearing will be open to CMS and the organization requesting the reconsideration, including authorized representatives, technical advisors (individuals with knowledge of the facts of the case or presenting interpretation of the facts), and legal counsel. The hearing will be conducted by the hearing officer, who will receive testimony and documents related to the proposed action. The hearing officer may accept testimony and other evidence that would be inadmissible under the usual rules of court procedures. The hearing officer will not have the authority to compel by subpoena the production of witnesses, papers, or other evidence. Within 45 calendar days of the close of the hearing, the hearing officer will present the findings and recommendations to the accrediting organization that requested the reconsideration. The written report of the hearing officer will include separate numbered findings of fact and the legal conclusions of the hearing officer. The hearing officer's decision will be final.

After consideration of the public comments received, we are adopting as final without substantive modification the provisions of the new proposed § 424.58(d) governing continuing Federal oversight of approved accreditation organizations relating to equivalency reviews, validation reviews, notice of intent to withdraw approval for deeming authority, withdrawal of approval for deeming authority, and reconsiderations. We have revised § 424.58(e)(6) and (8) to add the word "calendar" before the word "days".

XI. Provisions of the Final Regulations

A. IRF PPS

The provisions of this final rule restate the provisions of the FY 2007 IRF PPS proposed rule (71 FR 28106) except as noted elsewhere in the preamble. Following is a highlight of the policies that we are finalizing in this final rule:

- We are revising the relative weight and average length of stay tables based on re-analysis of the data by CMS and our contractor, the RAND Corporation, as discussed in section IV of this final rule.
- We are reducing the standard payment amount by 2.6 percent to account for coding changes that do not reflect real changes in case mix, as discussed in section V.A of this final rule.
- We are updating the FY 2007 IRF PPS payment rates by the market basket (3.3 percent), as discussed in section V.B of this final rule.
- We are updating the FY 2007 IRF PPS payment rates by the labor related share (75.612 percent), the wage indexes, and the second year of the hold harmless policy in a budget neutral manner, as discussed in sections V.C and D of this final rule.
- We are updating the outlier threshold amount for FY 2007 to $5,534, as discussed in section VI.A of this final rule.
- We are updating the urban and rural national cost-to-charge ratio ceilings for purposes of determining outlier payments under the IRF PPS and are clarifying the methodology described in the regulation text, as discussed in section VI.B of this final rule.
- We are revising the regulation text at § 412.23(b)(2)(i) and § 412.23(b)(2)(ii) to reflect the compliance percentages specified in section 5005 of the DRA, as discussed in section VII of this final rule. In addition, we are revising § 412.23(b)(2)(i) to permit comorbidities meeting the qualifying criteria outlined in § 412.23(b)(2)(i)(A) and (B) and (C) to count toward satisfying the compliance percentages specified in § 412.23(b)(2)(i).
- We are making a technical correction to amend the cross-reference to several portions of § 412.624(e) that currently appear in the regulation text in § 412.624(f)(2)(v), by re-inserting a cross-reference to paragraph (e)(1). We inadvertently deleted this reference in the FY 2006 final rule.

B. Quality Standards and Accreditation for DMEPOS Suppliers

The provisions of this final rule restate the provisions of the May 1, 2006 proposed rule, except as follows:

- We have modified § 404.406(e) to make a technical change to clarify that the Durable Medical Equipment Medicare Administrative Contractors will be taking over for the DMERCs/ regional carriers for processing DMEPOS claims.
- We have modified § 424.57(c)(22), to clarify that all suppliers of DMEPOS and other items and services must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services for which the supplier is accredited in order for the supplier to receive payment for those specific products and services.
- We have added a new provision at § 424.57(c)(23), requiring that all DMEPOS suppliers must notify their accreditation organizations when a new location is opened. The accrediting organization of the enrolled DMEPOS supplier may accredit the new supplier location for three months after it is operational without a new site visit.
- We have added a new provision at § 424.57(c)(24), which requires that each supplier location, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare. An accredited supplier may be denied enrollment or its enrollment may be revoked, if CMS determines that it was not in compliance with the DMEPOS quality standards.
- We have added a new provision at § 424.57(c)(25), which requires that all DMEPOS suppliers must disclose upon enrollment all products and services for which they are seeking accreditation. If a new product line is added after enrollment, the supplier will be responsible for notifying the accrediting body of the new product or service so that the supplier can be re-surveyed and accredited for these new products or services.
- We are adding a provision at § 424.58(b)(l)(iii) that accreditation organizations must provide CMS with a detailed description of their dispute resolution process and policies which would allow DMEPOS suppliers the opportunity to appeal negative survey findings or decisions.
- We are revising the provision at § 424.58(b)(3) to state that if CMS discovers a supplier was not in compliance with the DMEPOS supplier quality standards, CMS may revoke the supplier's billing number or require the accreditation organization to perform a subsequent full accreditation survey at the accreditation organization's expense.
- We are revising the provision at § 424.58(b)(6) to indicate that if a validation survey results in a finding that the supplier was not in compliance with one or more DMEPOS supplier quality standards, the supplier no longer meets the DMEPOS quality standards and may have its supplier billing number revoked.
- We have modified § 424.58(c)(1) to clarify that written format means either hard copy or electronic format.
- We have revised § 424.58(c)(2) and (5) and § 424.58(e)(6) and (8) to add the word "calendar" before the word "days."

• We have modified § 424.58(d)(4)(i) to utilize the term "adequately assures" that rather than "guarantees." The modified provision now states "Accreditation by the organization no longer adequately assures that the suppliers of DMEPOS and other items and services are meeting the supplier quality standards, and that failure to meet those requirements could jeopardize the health or safety of Medicare beneficiaries and could constitute a significant hazard to the public health."

XII. Waiver of Delayed Effective Date

We ordinarily provide a 60-day delay in the effective date of the provisions of a rule in accordance with the Administrative Procedure Act (APA) (5 U.S.C. 553(d), which requires a 30-day delayed effective date, and the Congressional Review Act (5 U.S.C. 801(a)(3)), which requires a 60-day delayed effective date for major rules. However, we can waive the delay in effective date if the Secretary finds, for good cause, that such delay is impracticable, unnecessary, or contrary to the public interest, and incorporates a statement of the finding and the reasons in the rule issued. 5 U.S.C. 553(d)(3); 5 U.S.C. 808(2).

The Secretary finds that good cause exists to implement the regulatory changes to part 414 of 42 CFR, other than § 414.406(e), related to Competitive Bidding Implementation Contractors (CBICs) for the Medicare DMEPOS Competitive Bidding Program on August 31, 2006. We note that we are not waiving the APA requirements since we are giving 30 days notice. We are, however, waiving the 60-day delayed effective date for major rules. Section 1847(b)(9) of the Act explicitly allows the Secretary to contract with appropriate entities to implement the Medicare DMEPOS Competitive Bidding Program. The Secretary has determined that it is administratively necessary to use one or more CBICs to assist in implementing the Medicare DMEPOS Competitive Bidding Program. This final rule codifies this statutory provision in regulations.

Under section 1847(a)(1)(B) of the Act, the Medicare DMEPOS Competitive Bidding Program must be phased in so that the competition under the programs occurs in 10 of the largest metropolitan statistical areas (MSAs) in 2007. To comply with that statutory mandate, it will be necessary for us to designate one or more CBICs, as well as finalize contracts with those entities, prior to October 1, 2006 (the beginning of Federal Fiscal Year (FY) 2007)) so that the CBIC(s) have sufficient time to prepare for the bidding process and to educate thousands of DMEPOS suppliers and referral agents, as well as millions of Medicare beneficiaries prior to the beginning of the bidding process. If one or more CBIC(s) are not designated before October 1, 2006, there will be insufficient time for those entities to conduct the large-scale preparations necessary to ensure the success of the program consistent with our statutory mandate. Additionally, if we are unable to designate one or more CBIC(s) prior to the end of FY 2006 then our ability to meet the implementation timetable set forth in section 1847(a)(1)(B) of the Act would be further jeopardized. Therefore, the Secretary has determined that it would be impracticable and contrary to the public interest to delay the effective date of the regulatory changes to part 414 of 42 CFR, other than § 414.406(e). An effective date of August 31, 2006, for the regulatory changes to part 414 of 42 CFR, other than § 414.406(e), will ensure that the procurement of CBIC services can proceed and will afford the selected CBIC(s) needed time to prepare for the bidding process and education of beneficiaries, suppliers, and referral agents on the Medicare DMEPOS Competitive Bidding Program.

For all these reasons, we believe that a 60-day delay in the effective date of the provisions that apply to the CBIC(s) would be impracticable and contrary to the public interest. We therefore find good cause for waiving the 60-day delay in the effective date for the regulatory changes to part 414 of 42 CFR, other than § 414.406(e).

XIII. Collection of Information Requirements

The sections of this document pertaining to the IRF PPS and to the DMEPOS do not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

XIV. Regulatory Impact Analysis for the IRF PPS

A. Overall IRF PPS Impact

We have examined the impacts of this final rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA, September 16, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). This final rule is a major rule, as defined in Title 5, United States Code, section 804(2), because we estimate the impact to the Medicare program, and the annual effects to the overall economy, will be more than $100 million. We estimate that the total impact of these changes for estimated FY 2007 payments compared to estimated FY 2006 payments will be an increase of approximately $50 million (this reflects a $220 million increase from the update to the payment rates and a $10 million increase due to updating the outlier threshold amount to increase estimated outlier payments from 2.9 percent in FY 2006 to 3.0 percent in FY 2007, offset by a $180 million estimated decrease from the reduction to the standard payment amount to account for changes in coding that do not reflect real changes in case mix).

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most IRFs and most other providers and suppliers are considered small entities, either by nonprofit status or by having revenues of $6 million to $29 million in any 1 year. (For details, see the Small Business Administration's final rule that set forth size standards for health care industries, at 65 FR 69432, November 17, 2000.) Because we lack data on individual hospital receipts, we cannot determine the number of small proprietary IRFs. Therefore, we assume that all IRFs (an approximate total of 1,200 IRFs, of which approximately 60 percent are nonprofit facilities) are considered small entities. The Department of Health and Human Services generally uses a revenue impact of 3 to 5 percent as a significance threshold under the RFA. Because the net effect of this final rule on almost all facilities will only be about 1 percent or less of revenues, and will be positive, we have concluded that this final rule will not have a significant effect on a

substantial number of small entities. Medicare fiscal intermediaries and carriers are not considered to be small entities. Individuals and States are not included in the definition of a small entity.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. As discussed in detail below, the rates and policies set forth in this final rule will not have an adverse impact on rural hospitals based on the data of the 181 rural units and 20 rural hospitals in our database of 1,202 IRFs for which data were available.

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately $120 million. The IRF PPS portions of this final rule will not mandate any requirements for State, local, or tribal governments, nor will they affect private sector costs.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a final rule that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. As stated above, this final rule will not have a substantial effect on State and local governments.

B. Anticipated Effects of the IRF PPS Final Rule

We discuss below the impacts of this final rule on the budget and on IRFs.

1. Basis and Methodology of Estimates

This final rule sets forth updates of the IRF PPS rates contained in the FY 2006 final rule and establishes a 2.6 percent decrease to the standard payment amount to account for the increase in estimated aggregate payments as a result of changes in coding that do not reflect real changes in case mix. In addition, we are updating the comorbidity tiers and the CMG relative weights, and the outlier threshold amount.

Based on the above, we estimate that the FY 2007 impact will be a net increase of $50 million in payments to IRF providers (this reflects a $220 million estimated increase from the update to the payment rates and a $10 million estimated increase due to updating the outlier threshold amount to increase estimated outlier payments from 2.9 percent in FY 2006 to 3.0 percent in FY 2007, offset by a $180 million estimated decrease from the reduction to the standard payment amount to account for the increase in estimated aggregate payments as a result of changes in coding that do not reflect real changes in case mix). The impact analysis in Table 9 of this final rule represents the projected effects of the policy changes in the IRF PPS for FY 2007 compared with estimated IRF PPS payments in FY 2006 without the policy changes. We estimate the effects by estimating payments while holding all other payment variables constant. We use the best data available, but we do not attempt to predict behavioral responses to these changes, and we do not make adjustments for future changes in such variables as number of discharges or case-mix.

We note that certain events may combine to limit the scope or accuracy of our impact analysis, because such an analysis is future-oriented and, thus, susceptible to forecasting errors because of other changes in the forecasted impact time period. Some examples could be legislative changes made by the Congress to the Medicare program that would impact program funding, or changes specifically related to IRFs. In addition, changes to the Medicare program may continue to be made as a result of the BBA, the BBRA, the BIPA, the MMA, the DRA, or new statutory provisions. Although these changes may not be specific to the IRF PPS, the nature of the Medicare program is such that the changes may interact, and the complexity of the interaction of these changes could make it difficult to predict accurately the full scope of the impact upon IRFs.

In updating the rates for FY 2007, we made a number of standard annual revisions and clarifications mentioned elsewhere in this final rule (for example, the update to the wage and market basket indexes used to adjust the Federal rates). These revisions will increase payments to IRFs by approximately $220 million.

The aggregate change in payments associated with this final rule is estimated to be an increase in payments to IRFs of $50 million for FY 2007. The market basket increase of $220 million and the $10 million increase due to updating the outlier threshold amount to increase estimated outlier payments from 2.9 percent in FY 2006 to 3.0 percent in FY 2007, combined with the estimated decrease of $180 million due to the reduction to the standard payment amount to account for coding changes (not related to real changes in case mix), results in a net change in estimated payments from FY 2006 to FY 2007 of $50 million.

The impacts are shown in Table 9. The following changes are discussed separately below:

- The effects of applying the budget-neutral labor-related share and wage index adjustment, as required under section 1886(j)(6) of the Act.
- The effects of the expiration of the one-year budget-neutral transition policy for adopting the new CBSA-based geographic area definitions announced by OMB in June 2003.
- The effects of the update to the outlier threshold amount to increase total estimated outlier payments from 2.9 to 3 percent of total estimated payments for FY 2007, consistent with section 1886(j)(4) of the Act.
- The effects of the annual market basket update (using the RPL market basket) to IRF PPS payment rates, as required by sections 1886(j)(3)(A)(i) and 1886(j)(3)(C) of the Act.
- The effects of the decrease to the standard payment amount to account for the increase in estimated aggregate payments as a result of changes in coding that do not reflect real changes in case mix, as required under section 1886(j)(2)(C)(ii) of the Act.
- The effects of the second year of the 3-year budget-neutral hold-harmless policy for IRFs that were rural under § 412.602 during FY 2005, but are urban under § 412.602 during FY 2006 and FY 2007 and lose the rural adjustment, resulting in a loss of estimated IRF PPS payments if not for the hold harmless policy.
- The effect of the budget-neutral revisions to the comorbidity tiers and the CMG relative weights, under the authority of section 1886(j)(2)(C)(i) of the Act.
- The total change in estimated payments based on the FY 2007 policies relative to estimated FY 2006 payments without the policies.

2. Description of Table 9

The table below categorizes IRFs by geographic location, including urban or rural location and location with respect to CMS's nine census divisions (as defined on the cost report) of the country. In addition, the table divides IRFs into those that are separate rehabilitation hospitals (otherwise

called freestanding hospitals in this section), those that are rehabilitation units of a hospital (otherwise called hospital units in this section), rural or urban facilities by ownership (otherwise called for-profit, non-profit, and government), and by teaching status. The top row of the table shows the overall impact on the 1,202 IRFs included in the analysis.

The next 12 rows of Table 9 contain IRFs categorized according to their geographic location, designation as either a freestanding hospital or a unit of a hospital, and by type of ownership: all urban, which is further divided into urban units of a hospital, urban freestanding hospitals, and by type of ownership; and rural, which is further divided into rural units of a hospital, rural freestanding hospitals, and by type of ownership. There are 1,001 IRFs located in urban areas included in our analysis. Among these, there are 807 IRF units of hospitals located in urban areas and 194 freestanding IRF hospitals located in urban areas. There are 201 IRFs located in rural areas included in our analysis. Among these, there are 181 IRF units of hospitals located in rural areas and 20 freestanding IRF hospitals located in rural areas. There are 398 for-profit IRFs. Among these, there are 326 IRFs in urban areas and 72 IRFs in rural areas. There are 743 non-profit IRFs. Among these, there are 630 urban IRFs and 113 rural IRFs. There are 61 government-owned IRFs. Among these, there are 45 urban IRFs and 16 rural IRFs.

The remaining three parts of Table 9 show IRFs grouped by their geographic location within a region, and the last part groups IRFs by teaching status. First, IRFs located in urban areas are categorized with respect to their location within a particular one of the nine CMS geographic regions. Second, IRFs located in rural areas are categorized with respect to their location within a particular one of the nine CMS geographic regions. In some cases, especially for rural IRFs located in the New England, Mountain, and Pacific regions, the number of IRFs represented is small. Finally, IRFs are grouped by teaching status, including non-teaching IRFs, IRFs with an intern and resident to average daily census (ADC) ratio less than 10 percent, IRFs with an intern and resident to ADC ratio greater than or equal to 10 percent and less than or equal to 19 percent, and IRFs with an intern and resident to ADC ratio greater than 19 percent.

The estimated impact of each change to the facility categories listed above is shown in the columns of Table 9. The description of each column is as follows:

Column (1) shows the facility classification categories described above.

Column (2) shows the number of IRFs in each category.

Column (3) shows the number of cases in each category.

Column (4) shows the estimated effect of adjusting the outlier threshold amount so that estimated outlier payments increase from 2.9 percent in FY 2006 to 3 percent of total estimated payments for FY 2007.

Column (5) shows the estimated effect of the market basket update to the IRF PPS payment rates.

Column (6) shows the estimated effect of the update to the IRF labor-related share, wage index, and hold harmless policy.

Column (7) shows the estimated effects of the budget-neutral revisions to the comorbidity tiers and the CMG relative weights.

Column (8) shows the estimated effects of the decrease in the standard payment amount to account for the increase in aggregate payments as a result of changes in coding that do not reflect real changes in case mix, as discussed in section V.A of this final rule. Section 1886(j)(2)(C)(ii) of the Act requires us to adjust the per discharge PPS payment rate to eliminate the effect of coding or classification changes that do not reflect real changes in case mix if we determine that these changes result in a change in aggregate payments under the classification system.

Column (9) compares our estimates of the payments per discharge, incorporating all changes reflected in this final rule for FY 2007, to our estimates of payments per discharge in FY 2006 (without these changes). The average estimated increase for all IRFs is approximately 0.8 percent. This estimated increase includes the effects of the 3.3 percent market basket update. It also includes the 0.1 percent overall estimated increase to IRF payments from the update to the outlier threshold amount, and the estimated impact of the 2.6 percent reduction to the standard payment amount to account for changes in coding that increased payments to IRFs. Because we will make the remainder of the changes outlined in this final rule in a budget-neutral manner, they will not affect total estimated IRF payments in the aggregate. However, as described in more detail in each section, they will affect the estimated distribution of payments among providers.

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Table 9: Projected Impact on the IRF PPS for FY 2007

Facility Classification (1)	No. of IRFs (2)	No. of cases (3)	Outlier (4)	Market Basket (5)	FY07 Wage Index, Labor-share, and Hold Harmless (6)	Comorbid. Tier and relative weight Revisions (7)	2.6% reduct (8)	Est. Total Change (9)
Total	1,202	487,281	0.1%	3.3%	0.0%	0.0%	-2.6%	0.8%
Urban unit	807	272,017	0.2%	3.3%	-0.1%	0.0%	-2.6%	0.7%
Rural unit	181	38,880	0.1%	3.3%	0.0%	0.1%	-2.6%	0.8%
Urban hospital	194	168,880	0.1%	3.3%	0.2%	0.0%	-2.6%	0.9%
Rural hospital	20	7,504	0.1%	3.3%	0.3%	0.0%	-2.6%	1.0%
Urban For-Profit	326	167,631	0.1%	3.3%	0.1%	0.1%	-2.6%	0.9%
Rural For-Profit	72	16,106	0.1%	3.3%	-0.2%	0.1%	-2.6%	0.6%
Urban Non-Profit	630	258,037	0.1%	3.3%	0.0%	0.0%	-2.6%	0.7%
Rural Non-Profit	113	26,950	0.1%	3.3%	0.2%	0.1%	-2.6%	1.1%
Urban Government	45	15,229	0.2%	3.3%	0.1%	0.1%	-2.6%	1.1%
Rural Government	16	3,328	0.2%	3.3%	-0.4%	0.2%	-2.6%	0.5%
Urban	1,001	440,897	0.1%	3.3%	0.0%	0.0%	-2.6%	0.8%
Rural	201	46,384	0.1%	3.3%	0.0%	0.1%	-2.6%	0.9%
Urban by region								
New England	36	21,739	0.1%	3.3%	-0.2%	0.0%	-2.6%	0.6%
Middle Atlantic	159	80,502	0.1%	3.3%	0.6%	0.1%	-2.6%	1.4%
South Atlantic	127	78,495	0.1%	3.3%	-0.3%	0.1%	-2.6%	0.5%
East North Central	192	70,435	0.1%	3.3%	-0.3%	-0.3%	-2.6%	0.1%
East South Central	50	29,203	0.1%	3.3%	0.2%	0.0%	-2.6%	0.9%
West North Central	70	23,874	0.2%	3.3%	-0.6%	-0.1%	-2.6%	0.0%
West South Central	183	81,394	0.1%	3.3%	0.0%	0.1%	-2.6%	0.9%
Mountain	74	27,231	0.1%	3.3%	0.0%	0.1%	-2.6%	0.9%
Pacific	110	28,024	0.2%	3.3%	0.8%	-0.2%	-2.6%	1.5%
Rural by region								
New England	4	1,010	0.2%	3.3%	2.1%	-0.1%	-2.6%	2.9%
Middle Atlantic	19	6,074	0.1%	3.3%	0.5%	0.3%	-2.6%	1.4%
South Atlantic	25	6,692	0.1%	3.3%	-0.8%	0.2%	-2.6%	0.1%
East North Central	29	6,255	0.1%	3.3%	0.4%	0.0%	-2.6%	1.2%
East South Central	22	5,629	0.1%	3.3%	0.3%	0.1%	-2.6%	1.1%
West North Central	34	6,471	0.2%	3.3%	0.0%	0.0%	-2.6%	0.8%
West South Central	55	12,650	0.2%	3.3%	-0.3%	0.1%	-2.6%	0.6%
Mountain	9	1,041	0.3%	3.3%	-1.9%	0.1%	-2.6%	-1.0%
Pacific	4	562	0.2%	3.3%	2.8%	0.1%	-2.6%	3.7%
Teaching Status								
Non-teaching	1,090	433,028	0.1%	3.3%	0.0%	0.1%	-2.6%	0.8%
Resident to ADC less than 10%	61	35,227	0.1%	3.3%	0.3%	-0.3%	-2.6%	0.8%
Resident to ADC 10%-19%	32	15,011	0.1%	3.3%	-0.3%	-0.4%	-2.6%	0.1%
Resident to ADC greater than 19%	19	4,015	0.1%	3.3%	-0.1%	-0.1%	-2.6%	0.6%

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3. Impact of the Update to the Outlier Threshold Amount (Column 4, Table 9)

In the FY 2006 IRF PPS final rule (70 FR 30188), we used FY 2003 patient-level claims data (the best, most complete data available at that time) to set the outlier threshold amount for FY 2006 so that estimated outlier payments will equal 3 percent of total estimated payments for FY 2006. For this final rule, we have updated our analysis using FY 2004 data. Between FYs 2003 and 2004, we observed that IRFs' cost-to-charge ratios continued to fall, a trend that has occurred each year since we first implemented the IRF PPS. We are still investigating the reasons for this. However, this decrease in cost-to-charge ratios affected our estimate of outlier payments as a percentage of total estimated payments for FY 2006, which declined from 3 percent using the FY 2003 data to 2.9 percent using the updated FY 2004 data. Thus, we will adjust the outlier threshold amount for FY 2007 to $5,534 in order to set total estimated outlier payments equal to 3 percent of total estimated payments in

FY 2007 (see section VI.A of this final rule for a detailed discussion of the factors that influence how we arrive at the outlier threshold amount). The estimated change in total payments between FY 2006 and FY 2007, therefore, includes a 0.1 percent overall estimated increase in payments because the outlier portion of total payments is estimated to increase from 2.9 percent to 3 percent.

The impact of this update (as shown in column 4 of Table 9) is to increase estimated overall payments to IRFs by 0.1 percent. We estimate the largest increase in payments to be a 0.3 percent increase in payments to rural IRFs in the Mountain region. We do not estimate that any group of IRFs will experience a decrease in payments from this update.

4. Impact of the Market Basket Update to the IRF PPS Payment Rates (Column 5, Table 9)

In column 5 of Table 9, we present the estimated effects of the market basket update to the IRF PPS payment rates. In the aggregate, and across all hospital groups, the update will result in a 3.3 percent increase in overall payments to IRFs.

5. Impact of the Full CBSA Wage Index, Labor-Related Share, and the Hold Harmless Policy for FY 2007 (Column 6, Table 9)

In column 6 of Table 9, we present the effects of the budget neutral wage index, labor-related share, and the hold harmless policy. In FY 2006, we provided a 1-year blended wage index and a 3–year phase out of the rural adjustment for IRFs that changed designation because of the change from MSAs to CBSAs (referenced as the hold harmless policy). We applied the blended wage index to all IRFs and the hold harmless policy to those IRFs that qualify, as described in § 412.624(e)(7), in order to mitigate the impact of the change from the MSA-based labor area definitions to the CBSA-based labor area definitions for IRFs.

As discussed in this final rule, the blended wage index expires in FY 2007 and will not be applied for discharges occurring on or after October 1, 2006. Because we are in the second year of the hold harmless policy, we are not changing this policy and will continue to apply it as described in the FY 2006 final rule in a budget neutral manner.

As discussed in this final rule, we are updating the wage index based on the CBSA-based labor market area definitions in a budget neutral manner. We will also apply the second year of the hold harmless policy in a budget neutral manner. Thus, in the aggregate, the estimated impact of the wage index and the labor-related share is zero percent.

In the aggregate for all urban and all rural IRFs, we do not estimate that these changes will affect overall estimated payments to IRFs. However, we estimate these changes to have small distributional effects. We estimate the largest increase in payments to be a 2.8 percent increase for rural IRFs in the Pacific region and the largest decrease in payments to be a 1.9 percent decrease among rural IRFs in the Mountain region.

6. Impact of the Changes to the Comorbidity Tiers and the CMG Relative Weights (Column 7, Table 9)

In column 7 of Table 9, we present the effects of the changes to the comorbidity tiers and the CMG relative weights. Since we are implementing these changes in a budget neutral manner, we estimate that they will have no overall effect on payments to IRFs. Similarly, we estimate no overall effect of these changes on payments to urban IRFs. However, we estimate a 0.1 percent increase in payments to rural IRFs. We estimate the largest increase in payments to be a 0.3 percent increase among rural IRFs located in the Middle Atlantic region. We estimate the largest decrease to be a 0.4 percent decrease among teaching IRFs with intern and resident to average daily census ratios in the 10 percent to 19 percent category.

7. Impact of the 2.6 Percent Decrease to the Standard Payment Amount to Account for Coding Changes (Column 8, Table 9)

In column 8 of Table 9, we present the effects of the decrease in the standard payment amount to account for the increase in estimated aggregate payments as a result of changes in coding that do not reflect real changes in case mix.

In the aggregate, and across all hospital groups, we estimate that the policy will result in a 2.6 percent decrease in overall payments to IRFs. Thus, we estimate that the 2.6 percent reduction in the standard payment amount will result in a cost savings to the Medicare program of approximately $180 million.

C. IRF PPS Accounting Statement

As required by OMB Circular A–4 (available at) *http://www.whitehouse.gov/omb/circulars/a004/a–4.pdf*, in Table 10 below, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this final rule. This table provides our best estimate of the increase in Medicare payments under the IRF PPS as a result of the changes presented in this final rule based on the data for 1,202 IRFs in our database. All estimated expenditures are classified as transfers to Medicare providers (that is, IRFs).

TABLE 10.— ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES, FROM THE 2006 IRF PPS RATE YEAR TO THE 2007 IRF PPS RATE YEAR (IN MILLIONS)

Category	Transfers
Annualized Monetized Transfers	$50 million.
From Whom To Whom?	Federal Government to IRF Medicare Providers.

D. IRF PPS Alternatives Considered

Because we have determined that this final rule will have a significant economic impact on IRFs, we will discuss the alternative changes to the IRF PPS that we considered.

We considered a reduction to the standard payment amount by an amount of up to 3.9 percent (5.8 percent minus the 1.9 percent adjustment to the standard payment amount for FY 2006), because one of RAND's methodologies for determining the amount of real change in case mix and the amount of coding change that occurred between 1999 and 2002 suggested that coding change could have been responsible for up to 5.8 percent of the observed increase in IRFs' case mix. This suggests that we could have implemented a reduction greater than 2.6 percent and as high as 3.9 percent. We also considered the possibility of making a somewhat lower adjustment of 2.3 percent, which would fall at approximately the middle of RAND's range of estimates. However, for the

reasons discussed in section V.A of this final rule, we have instead decided to implement a 2.6 percent reduction to the standard payment amount. Further, in light of recent changes to the IRF PPS that affect IRF utilization trends, including the revised phase-in schedule of the IRF 75 percent rule compliance percentage, we believe it is appropriate to take an incremental approach in adjusting for coding changes. In this way, we maintain the flexibility to assess the impact of these changes and propose additional changes, if appropriate, in the future.

We considered not updating the comorbidity tiers and the CMG relative weights for FY 2007. However, as described in section IV of this final rule, re-analysis of the data indicates that some minor technical revisions are appropriate to align the distribution of payments as closely as possible with the costs of IRF care.

We also considered not updating the outlier threshold amount for FY 2007. However, analysis of updated FY 2004 data indicates that estimated outlier payments would not equal 3 percent of estimated total payment for FY 2007 unless we update the outlier threshold amount.

E. IRF PPS Conclusion (Column 9, Table 9)

Overall, estimated payments per discharge for IRFs in FY 2007 are projected to increase by 0.8 percent, compared with those in FY 2006, as reflected in column 9 of Table 9. We estimate that IRFs in rural areas will experience a 0.9 percent increase in estimated payments per discharge compared with FY 2006. We estimate that IRFs in urban areas will experience a 0.8 percent increase in estimated payments per discharge compared with FY 2006. We estimate that rehabilitation units in urban areas will experience a 0.7 percent increase in estimated payments per discharge, while freestanding rehabilitation hospitals in urban areas will experience a 0.9 percent increase in estimated payments per discharge. We estimate that rehabilitation units in rural areas will experience a 0.8 percent increase in estimated payments per discharge, while freestanding rehabilitation hospitals in rural areas will experience a 1.0 percent increase in estimated payments per discharge.

Overall, we estimate that the largest payment increase will be 3.7 percent among rural IRFs in the Pacific region. We estimate that the only overall decrease in estimated payments will be a 1.0 percent decrease for rural IRFs in the Mountain region.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

XV. Regulatory Impact Analysis for DMEPOS Suppliers

A. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). We estimate that accreditation expenses for DMEPOS suppliers may exceed this threshold.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, section 604, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Approximately 90 percent of DMEPOS suppliers are considered small businesses according to the Small Business Administration's size standards, with total revenues of $6 million or less in any 1 year. Individuals and States are not included in the definition of a small entity. This final rule will have a significant impact on small businesses.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. We have determined that this rule will not have a significant effect on small rural hospitals. We expect that small rural hospitals primarily furnish inpatient and outpatient hospital services, rather than services that would require compliance with the DMEPOS quality standards and accreditation.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately $120 million. We estimate the total undiscounted annualized accreditation costs for DMEPOS suppliers between CY 2007 and CY 2011 to be approximately $93.1 million.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. We have determined that this final rule will not have substantial direct effects on the rights, roles, and responsibilities of States.

B. Anticipated Effects for DMEPOS Suppliers

Under the proposed rule, DMEPOS suppliers will have to be accredited by an approved accreditation organization in order to obtain a supplier number and to receive Medicare reimbursement for DMEPOS items and services furnished to beneficiaries. This section of the rule will have an impact on DMEPOS suppliers and organizations that accredit DMEPOS suppliers. DMEPOS suppliers will incur costs for becoming accredited. Accreditation organizations will incur costs to accredit suppliers; we assume that these costs are approximately equal to the accreditation fees paid by suppliers.

To estimate the impact on suppliers, we calculate the total cost of accreditation as the sum of accreditation fees and other accreditation costs, and we multiply this cost by the number of suppliers requiring accreditation. Our calculation incorporates other relevant factors, including the number of suppliers that are already accredited, the number of suppliers that probably will not seek accreditation because they currently are not receiving Medicare reimbursement, and the possible phase-in timing for accreditation. These factors are described in more detail below. Costs are calculated over a period of 5 years, beginning in 2007.

Factors Affecting the Cost Impact

The National Supplier Clearinghouse (NSC) issues 10-digit NSC supplier numbers to suppliers that bill Medicare

for DMEPOS items and services. Some DMEPOS suppliers operate multiple locations while others operate at a single location. Suppliers that are part of a single firm share the first 6 digits of the 10-digit NSC supplier number, with the last 4 digits set equal to 0001, 0002, and so on to denote individual locations. In the following discussion, we will refer to the first 6 digits as the "6-digit NSC supplier number" to represent individual suppliers, while the 10-digit number represents individual supplier locations.

The distinction is important for the impact analysis because accreditation organizations generally charge one fee for a supplier's first location, and a lower fee for subsequent locations. Some of the accreditation organizations also offer lower accreditation fees to small suppliers, which typically have few locations.

There are currently 118,406 unique 10-digit NSC numbers and 65,549 unique 6-digit NSC numbers. This total includes suppliers as well as providers and physicians that furnish items under Medicare Part B as suppliers. The distribution of locations by supplier is very uneven across the industry. Over 90 percent of suppliers operate a single location, while some drug chains, grocery stores, optometry companies, and a few medical equipment companies have over a hundred locations.

Suppliers with NSC numbers are diverse. Physicians and other professionals who bill Medicare Part B carriers account for 14 percent of 10-digit NSC numbers; durable medical equipment companies account for 17 percent; drug stores, grocery stores, and optician/optometry companies account for 53 percent; and orthotic/prosthetic makers account for 11 percent.

Number of Suppliers Currently Accredited

Currently, there is no single registry that tracks the number of DMEPOS suppliers and locations that are accredited. Media reports and data from DMEPOS accreditation organizations suggest that about 2,500 suppliers and 7,500 locations are currently accredited.

Suppliers That Probably Will Not Seek Accreditation

Many suppliers that currently have NSC supplier numbers are small, receive relatively little in Medicare payments, and/or do not specialize in DMEPOS. In 2004, about 7,154 suppliers received $0 in allowed charges, and 29,155 received between $1 and $10,000; the corresponding numbers in 2005 were 6,679 and 30,121 suppliers. These suppliers will have to make a business decision on whether to seek accreditation. In our base impact analysis, we assume that the approximately 6,900 suppliers that currently receive $0 in allowed charges will not seek accreditation. This accounts for about 11.7 percent of single-location suppliers that are not currently accredited.

Accreditation Fees

Fees vary between accreditation organizations and, in general, currently cover all or some of the following items: application fee, manuals, initial accreditation fee (which can cover 1 to 3 years), annual renewal fees (when the accreditation fee only covers the first year), onsite surveys (generally once every 3 years), and travel for survey personnel. At least one accreditation organization includes consultations within its base fee. Accreditation costs also vary by the size of the supplier seeking accreditation, its number of locations, and the number of services that it provides. Because of these factors, it is sometimes difficult to compare fees across accreditation organizations. We obtained information on total accreditation fees from four accreditation organizations that currently accredit DME suppliers and a fifth organization that recently formed to perform accreditations. In addition, we obtained information on total accreditation fees for two organizations that accredit orthotic and prosthetic suppliers; these costs were generally lower than accreditation fees for other DME suppliers. Although the information obtained from the accrediting organizations is helpful in determining the overall impact, we believe that the fees under the DMEPOS accreditation process will be close to or below the lower fee estimates because we will be requiring a more streamlined accreditation process. Because the details of the accreditation process are not currently known to potential DMEPOS accrediting organizations, it is difficult to make definitive projections for fees under the DMEPOS accreditation program with certainty.

In addition to information that we received from accrediting organizations on fees under the current process, we received public comments on accreditation fees. We also have data, which were presented to the PAOC, which estimate lower fees. Based on all information that we obtained, we estimate accreditation fees will be approximately $3,000 for a DME supplier. Because accreditation is for a 3-year period, the estimated average cost per year would be approximately $1,000. We expect that accreditation fees for an orthotics and prosthetics supplier would be approximately $2,000; the average cost per year would then be approximately $670.

We recognize that becoming accredited imposes a burden on DMEPOS suppliers, especially small suppliers. We have attempted to minimize that burden. In compliance with section 604 of the RFA, we have responded to public comments in section X.D of this final rule, and we have implemented the following options to minimize the burden of accreditation on suppliers, including small businesses:

- Multiple accreditation organizations: We expect that many accrediting organizations will apply to become and be selected as DMEPOS accrediting organizations. We believe that selection of more than one accreditation organization and specialty organizations will introduce competition resulting in reductions in accreditation costs.
- Required plan for small businesses. During the application process, we will ask accreditation organizations to include a plan that details their methodology to reduce accreditation fees and burden for small or specialty DMEPOS suppliers and DMEPOS suppliers that have multiple locations.
- Strict application of quality standards: Currently, accreditation organizations use a survey process in which they expand on published conditions of participation or other standards, which often requires a lengthy onsite evaluation. This results in greater travel expenditures incurred by the accreditation organization and results in higher accreditation survey fees. We believe that the DMEPOS quality standards (developed in collaboration with accreditation, DME, and small business industry experts) will be sufficiently streamlined in order to ensure an effective and efficient survey process. We strongly believe that accreditation organizations will not need to expand on these standards in order to deter fraudulent practices and ensure quality DMEPOS services.
- Streamlined process: Currently, accreditation organizations require activities such as consultation services and purchasing manuals. We have clarified in this final rule that the role of the accreditation organization is to ensure compliance with the quality standards and that accreditation should not be contingent on using consultation services or purchasing manuals. Therefore, we believe that the cost of performing DMEPOS surveys that do not include these additional

accreditation organization activities will be significantly less. Some accrediting organizations may require a 6-month survey preparation process that includes self-assessment. Under accreditation for DMEPOS suppliers, all surveys will be unscheduled; therefore, there may not be a 6-month survey preparation time and additional costs associated with preparation time.

• Reasonable quality standards: We plan to issue quality standards that represent basic good business practices. Many DMEPOS suppliers should already be complying with the standards and have incorporated these practices into their daily operations. Therefore, there would be no "ramp up costs" and DMEPOS suppliers would not need to devote significant time to be compliant with many of these standards. Additionally, it is our belief that compliance with the quality standards will result in more efficient and effective business practices and will assist DMEPOS suppliers in reducing overall costs.

• All Part B suppliers will need to meet these accreditation requirements. We hope to minimize burden and duplication of effort for suppliers that have already been accredited, Medicare-certified, and/or licensed under state law, by taking into consideration any previous accreditation, certification, and/or licensure findings that indicate that DMEPOS quality standards are being met at the time the accreditation organization surveys the supplier.

Other Accreditation Costs

It is difficult to estimate precisely the costs of preparing for accreditation. However, we note that we will be instituting a streamlined process under which the accrediting organization will be using unannounced surveys. Nevertheless, we recognize that there is a cost to the supplier to come into compliance initially, and thus prepare for the accreditation survey, this process should result in minimal preparation and cost.

TABLE 11. TOTAL ACCREDITATION COSTS ($ MILLIONS)

	2007	2008	2009	2010	2011	5-year Total Costs (Undiscounted)	5-year Total Costs (Discounted @ 3%)	5-year Total Costs (Discounted @7%)
Total Accreditation Fees	$37.99	$58.58	$79.17	$67.37	$67.37	$310.48	$290.99	$268.28
Total Other Accreditation Costs	18.99	29.29	39.59	33.68	33.68	155.24	145.50	134.14
Total Costs	56.98	87.87	118.76	101.05	101.05	465.72	436.50	402.41

Uncertainty

There are at least three important sources of uncertainty in estimating the impact of accreditation on DMEPOS suppliers. First, our estimates assume that all current DMEPOS suppliers with positive Medicare payments will seek accreditation. As noted previously, many suppliers that currently have NSC supplier numbers are small, receive relatively little in Medicare payments, and/or do not specialize in DMEPOS. We assume that suppliers that currently receive no Medicare allowed charges will choose not to seek accreditation, and that many of the suppliers with allowed charges between $1 and $10,000 may decide not to incur the costs of accreditation. It is also possible that these suppliers may choose to expand their businesses in anticipation of the DMEPOS Competitive Bidding Program being implemented.

Second, it is unclear how high or low accreditation fees will be in the future. With required accreditation causing more suppliers to seek accreditation, fees may fall if the accreditation organizations can enjoy economies of scale as they expand. This would lessen the impact on DMEPOS suppliers.

Third, the timing of accreditation could differ from our assumption that one-third of suppliers will be accredited during each of the next 3 years. We cannot precisely predict the timing of accreditation surveys and how this might affect costs.

C. Alternatives Considered for DMEPOS Suppliers

Section 302 (a)(1) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) added section 1834(a)(20) of the Social Security Act (the Act) and requires the Secretary to establish and implement quality standards for suppliers of certain items, including consumer service standards, to be applied by recognized independent accreditation organizations.

In compliance with section 604 of the RFA, we have implemented options to minimize the burden of accreditation on suppliers, which include approving multiple accreditation organizations that serve smaller suppliers, and accreditation organizations that will be responsible for only surveying the streamlined quality standards for compliance and not providing any consultative services that may increase the time and cost of the survey process. Also, we believe that unannounced surveys will reduce the time and cost involved in suppliers' receiving and reviewing documents prior to the survey.

D. Accounting Statement for DMEPOS Suppliers

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf*), in the table below we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this final rule. This table provides our best estimate of the costs under section 1834(a)(20) of the Act. All expenditures are classified as costs to the suppliers from the DMEPOS accreditation organizations.

ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES, FROM CY 2007 TO CY 2011

(in millions/year)

Category	Costs	Discount rate	From whom to whom
Costs-Annualized Monetized	$80.48	7%	DMEPOS to Accreditation Organizations
Costs-Annualized Monetized	$87.30	3%	DMEPOS to Accreditation Organizations

E. Conclusion for DMEPOS Suppliers

We estimate that DMEPOS suppliers will incur total accreditation costs from this regulation of $465.7 million over 5 years. Discounted at 7 percent and at 3 percent, the 5-year accreditation costs to DMEPOS suppliers are approximately $402.4 million and $436.5 million, respectively. In CY 2007, we estimate the total accreditation costs to be approximately $56.98 million. In CY 2008 and CY 2009, we estimate the total accreditation costs to be approximately $87.87 million and $118.76 million, respectively. In CY 2010 and CY 2011, we estimate the total accreditation costs to be approximately $101.1 million annually. The DME supplier accreditation requirement has no anticipated fiscal impact on the benefit payments from the Medicare trust funds.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 414

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 424

Emergency medical services, Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

■ For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as follows:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

■ 1. 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).

Subpart P—Prospective Payment for Inpatient Rehabilitation Hospitals and Rehabilitation Units

■ 2. Section 412.23 is amended by—

■ A. Revising paragraph (b)(2)(i) introductory text.

■ B. Revising paragraph (b)(2)(ii).

The revisions read as follows:

§ 412.23 Excluded hospitals: Classifications.

* * * * *

(b) * * *

(2) * * *

(i) For cost reporting periods beginning on or after July 1, 2004 and before July 1, 2005, the hospital has served an inpatient population of whom at least 50 percent, and for cost reporting periods beginning on or after July 1, 2005 and before July 1, 2007, the hospital has served an inpatient population of whom at least 60 percent, and for cost reporting periods beginning on or after July 1, 2007 and before July 1, 2008, the hospital has served an inpatient population of whom at least 65 percent required intensive rehabilitative services for treatment of one or more of the conditions specified at paragraph (b)(2)(iii) of this section. A patient with a comorbidity, as defined at § 412.602, may be included in the inpatient population that counts toward the required applicable percentage if—

* * * * *

(ii) For cost reporting periods beginning on or after July 1, 2008, the hospital has served an inpatient population of whom at least 75 percent required intensive rehabilitative services for treatment of one or more of the conditions specified in paragraph (b)(2)(iii) of this section. A patient with a comorbidity as described in paragraph (b)(2)(i) of this section is not included in the inpatient population that counts toward the required 75 percent.

* * * * *

■ 3. In § 412.624, paragraphs (e)(5) and (f)(2)(v) are revised to read as follows:

§ 412.624 Methodology for calculating the Federal prospective payment rates.

* * * * *

(e) * * *

(5) *Adjustment for high-cost outliers.* CMS provides for an additional payment to an inpatient rehabilitation facility if its estimated costs for a patient exceed a fixed dollar amount (adjusted for area wage levels and factors to account for treating low-income patients, for rural location, and for teaching programs) as specified by CMS. The additional payment equals 80 percent of the difference between the estimated cost of the patient and the sum of the adjusted Federal prospective payment computed under this section and the adjusted fixed dollar amount. Effective for discharges occurring on or after October 1, 2003, additional payments made under this section will be subject to the adjustments at § 412.84(i), except that CMS calculates a single overall (combined operating and capital) cost-to-charge ratio and national averages that will be used instead of statewide averages. Effective for discharges occurring on or after October 1, 2003, additional payments made under this section will also be subject to adjustments at § 412.84(m), except that CMS calculates a single overall (combined operating and capital) cost-to-charge ratio.

* * * * *

(f) * * *

(2) * * *

(v) By applying the adjustments described in paragraphs (e)(1), (e)(2), (e)(3), (e)(4), and (e)(7) of this section to the unadjusted payment amount determined in paragraph (f)(2)(iv) of this section to equal the adjusted transfer payment amount.

* * * * *

PART 414—PAYMENT FOR PART B MEDICAL AND OTHER HEALTH SERVICES

■ 4. The authority citation for part 414 continues to read as follows:

Authority: Secs. 1102, 1871, and 1881(b)(1) of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395rr(b)(1)).

Subpart A—General Provisions

■ 5. Section 414.1 is amended by adding in numerical order the statutory sections to read as follows:

§ 414.1 Basis and scope.

* * * * *

1847(a) and (b)—Competitive bidding for certain durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).

* * * * *

■ 6. A new subpart F is added to read as follows:

Subpart F—Competitive Bidding for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

Secs.
414.400–414.404 [Reserved]
414.406 Implementation of programs.
414.408–414.426 [Reserved]

Subpart F—Competitive Bidding for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

§ 414.400–§ 414.404 [Reserved]

§ 414.406 Implementation of programs.

(a) *Implementation contractor.* CMS designates one or more implementation contractors for the purpose of implementing this subpart.

(b)–(d) [Reserved]

(e) *Claims processing.* The Durable Medical Equipment Medicare Administrative Contractor designated to process DMEPOS claims for a particular geographic region also processes claims for items furnished under a competitive bidding program in the same geographic region.

§ 414.408–§ 414.426 [Reserved]

PART 424—CONDITIONS FOR MEDICARE PAYMENT

■ 7. The authority citation for part 424 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart A—General Provisions

■ 8. Section 424.1 is amended by adding in numerical order the statutory sections to read as follows:

§ 424.1 Basis and scope.

* * * * *

1834(a)—Payment for durable medical equipment.

1834(j)—Requirements for suppliers of medical equipment and supplies.

* * * * *

Subpart D—To Whom Payment Is Ordinarily Made

■ 9. Section 424.57 is amended by—
■ A. Adding the definitions "Accredited DMEPOS suppliers," "CMS approved accreditation organization" and "Independent accreditation organization" in alphabetical order in paragraph (a).
■ B. Adding new paragraphs (c)(22)–(c)(25). The additions and revision read as follows:

§ 424.57 Special payment rules for items furnished by DMEPOS Suppliers and issuance of DMEPOS Supplier billing privileges.

(a) *Definitions.* * * *

Accredited DMEPOS suppliers means suppliers that have been accredited by a recognized independent accreditation organization approved by CMS in accordance with the requirements at § 424.58.

CMS approved accreditation organization means a recognized independent accreditation organization approved by CMS under § 424.58.

* * * * *

Independent accreditation organization means an accreditation organization that accredits a supplier of DMEPOS and other items and services for a specific DMEPOS product category or a full line of DMEPOS product categories.

* * * * *

(c) *Application certification standards.* * * *

(22) All suppliers of DMEPOS and other items and services must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services, for which the supplier is accredited in order for the supplier to receive payment for those specific products and services.

(23) All DMEPOS suppliers must notify their accreditation organization when a new DMEPOS location is opened. The accreditation organization may accredit the new supplier location for three months after it is operational without requiring a new site visit.

(24) All DMEPOS supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare. An accredited supplier may be denied enrollment or their enrollment may be revoked, if CMS determines that they are not in compliance with the DMEPOS quality standards.

(25) All DMEPOS suppliers must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation. If a new product line is added after enrollment, the DMEPOS supplier will be responsible for notifying the accrediting body of the new product so that the DMEPOS supplier can be re-surveyed and accredited for these new products.

* * * * *

■ 10. A new § 424.58 is added to read as follows:

§ 424.58 Accreditation.

(a) *Scope and purpose.* This part implements section 1834(a)(20)(B) of the Act, which requires the Secretary to designate and approve one or more independent accreditation organizations for purposes of enforcing the DMEPOS quality standards for suppliers of DMEPOS and other items or services. Section 1847(b)(2)(A)(i) of the Act requires a DMEPOS supplier to meet the DMEPOS quality standards under section 1834(a)(20) of the Act before being awarded a contract.

(b) *Application and reapplication procedures for accreditation organizations.* (1) An independent accreditation organization applying for approval or re-approval of authority to survey suppliers for compliance with the DMEPOS quality standards is required to furnish the following to CMS:

(i) A list of the types of DMEPOS supplies, and a list of products and services for which the organization is requesting approval.

(ii) A detailed comparison of the organization's accreditation requirements and standards with the applicable DMEPOS quality standards, such as a crosswalk.

(iii) A detailed description of the organization's operational processes, including procedures for performing unannounced surveys, frequency of the surveys performed, copies of the organization's survey forms, guidelines and instructions to surveyors, quality review processes for deficiencies identified with accreditation requirements, and dispute resolution processes and policies when there is a negative survey finding or decision.

(iv) Procedures used to notify DMEPOS suppliers of compliance or noncompliance with the accreditation requirements.

(v) Procedures used to monitor the correction of deficiencies found during an accreditation survey.

(vi) Procedures for coordinating surveys with another accrediting organization if the organization does not accredit all products the supplier provides.

(vii) Detailed professional information about the individuals who perform surveys for the accreditation organization, including the size and composition of accreditation survey teams for each type of DMEPOS supplier accredited, and the education and experience requirements surveyors must meet. The information must include the following:

(A) The content and frequency of the continuing education training provided to survey personnel.

(B) The evaluation systems used to monitor the performance of individual surveyors and survey teams.

(C) Policies and procedures for a surveyor or institutional affiliate of the independent accrediting organization that participates in a survey or accreditation decision regarding a DMEPOS supplier with which that individual or institution is professionally or financially affiliated.

(viii) A description of the organization's data management, analysis and reporting system for its surveys and accreditation decisions, including the kinds of reports, tables, and other displays generated by that system.

(ix) Procedures for responding to, and investigating complaints against, accredited facilities, including policies and procedures regarding coordination of these activities with appropriate licensing bodies, ombudsman programs, the National Supplier Clearinghouse, and CMS.

(x) The organization's policies and procedures for notifying CMS of facilities that fail to meet the accreditation organization's requirements.

(xi) A description of all types, categories, and durations of accreditations offered by the organization.

(xii) A list of the following:

(A) All currently accredited DMEPOS suppliers.

(B) The types and categories of accreditation currently held by each supplier.

(C) The expiration date of each supplier's current accreditation.

(D) The upcoming survey cycles for all DMEPOS suppliers' accreditation surveys scheduled to be performed by the organization.

(xiii) A written presentation that demonstrates the organization's ability to furnish CMS with electronic data in ASCII comparable code.

(xiv) A resource analysis that demonstrates that the organization's staffing, funding, and other resources are adequate to perform fully the required surveys and related activities.

(xv) An agreement that the accreditation organization will permit its surveyors to serve as witnesses if CMS takes an adverse action based on accreditation findings.

(2) *Validation survey.* CMS surveys suppliers of DMEPOS and other items and services accredited under this section on a representative sample basis, or in response to substantial allegations of noncompliance, in order to validate the accreditation organization's survey process. When conducted—

(i) On a representative sample basis, the CMS survey may be comprehensive or focus on a specific standard;

(ii) In response to a substantial allegation, CMS surveys for any standard that CMS determines is related to the allegations.

(3) *Discovery of a deficiency.* If CMS discovers that a DMEPOS supplier was not in compliance with the DMEPOS supplier quality standards, CMS may revoke the supplier's billing number or require the accreditation organization to perform a subsequent full accreditation survey at the accreditation organization's expense.

(4) *Authorization.* A supplier selected for a validation survey must authorize the—

(i) Validation survey to take place; and

(ii) CMS survey team to monitor the correction of any deficiencies found through the validation survey.

(5) *Refusal to cooperate with survey.* If a supplier selected for a validation survey fails to comply with the requirements specified at paragraph (b)(4) of this section, it is deemed to no longer meet the DMEPOS supplier quality standards and may have its supplier billing number revoked.

(6) *Validation survey findings.* If a validation survey results in a finding that the supplier was not in compliance with one or more DMEPOS supplier quality standards, the supplier no longer meets the DMEPOS quality standards and may have its supplier billing number revoked.

(c) *Ongoing responsibilities of a CMS-approved accreditation organization.* An accreditation organization approved by CMS must undertake the following activities on an ongoing basis:

(1) Provide to CMS all of the following in written format (either electronic or hard copy) and on a monthly basis all of the following:

(i) Copies of all accreditation surveys, together with any survey-related information that CMS may require (including corrective action plans and summaries of findings with respect to unmet CMS requirements).

(ii) Notice of all accreditation decisions.

(iii) Notice of all complaints related to suppliers of DMEPOS and other items and services.

(iv) Information about any supplier of DMEPOS and other items and services against which the CMS-approved accreditation organization has taken remedial or adverse action, including revocation, withdrawal, or revision of the supplier's accreditation.

(v) Notice of any proposed changes in its accreditation standards or requirements or survey process. If the organization implements the changes before or without CMS' approval, CMS may withdraw its approval of the accreditation organization.

(2) Within 30 calendar days of a change in CMS requirements, submit to CMS:

(i) An acknowledgment of CMS's notification of the change.

(ii) A revised cross walk reflecting the new requirements.

(iii) An explanation of how the accreditation organization plans to alter its standards to conform to CMS's new requirements, within the timeframes specified in the notification of change it receives from CMS.

(3) Permit its surveyors to serve as witnesses if CMS takes an adverse action based on accreditation findings.

(4) Within 2 calendar days of identifying a deficiency of an accredited DMEPOS supplier that poses immediate jeopardy to a beneficiary or to the general public, provide CMS with written notice of the deficiency and any adverse action implemented by the accreditation organization.

(5) Within 10 calendar days after CMS's notice to a CMS-approved accreditation organization that CMS intends to withdraw approval of the accreditation organization, provide written notice of the withdrawal to all of the CMS-approved accreditation organization's accredited suppliers.

(6) Provide, on an annual basis, summary data specified by CMS that relate to the past year's accreditation activities and trends.

(d) *Continuing Federal oversight of approved accreditation organizations.* This paragraph establishes specific criteria and procedures for continuing oversight and for withdrawing approval of a CMS-approved accreditation organization.

(1) *Equivalency review.* CMS compares the accreditation organization's standards and its application and enforcement of those standards to the comparable CMS requirements and processes when—

(i) CMS imposes new requirements or changes its survey process;

(ii) An accreditation organization proposes to adopt new standards or changes in its survey process; or

(iii) The term of an accreditation organization's approval expires.

(2) *Validation survey.* CMS or its designated survey team may conduct a survey of an accredited DMEPOS supplier, examine the results of a CMS-approved accreditation organization's survey of a supplier, or observe a CMS-approved accreditation organization's onsite survey of a DMEPOS supplier, in order to validate the CMS-approved accreditation organization's accreditation process. At the conclusion of the review, CMS identifies any accreditation programs for which validation survey results indicate—

(i) A 10 percent rate of disparity between findings by the accreditation organization and findings by CMS or its designated survey team on standards that do not constitute immediate jeopardy to patient health and safety if unmet;

(ii) Any disparity between findings by the accreditation organization and findings by CMS on standards that constitute immediate jeopardy to patient health and safety if unmet; or

(iii) That, irrespective of the rate of disparity, there are widespread or systemic problems in an organization's accreditation process such that accreditation by that accreditation organization no longer provides CMS with adequate assurance that suppliers meet or exceed the Medicare requirements.

(3) *Notice of intent to withdraw approval.* CMS provides the organization written notice of its intent to withdraw approval if an equivalency review, validation review, onsite observation, or CMS's daily experience with the accreditation organization suggests that the accreditation organization is not meeting the requirements of this section.

(4) *Withdrawal of approval.* CMS may withdraw its approval of an accreditation organization at any time if CMS determines that—

(i) Accreditation by the organization no longer adequately assures that the suppliers of DMEPOS and other items and services are meeting the DMEPOS quality standards, and that failure to meet those requirements could jeopardize the health or safety of Medicare beneficiaries and could constitute a significant hazard to the public health; or

(ii) The accreditation organization has failed to meet its obligations with respect to application or reapplication procedures.

(e) *Reconsideration.* (1) An accreditation organization dissatisfied with a determination that its accreditation requirements do not provide or do not continue to provide reasonable assurance that the entities accredited by the accreditation organization meet the applicable supplier quality standards is entitled to a reconsideration. CMS reconsiders any determination to deny, remove, or not renew the approval of deeming authority to accreditation organizations if the accreditation organization files a written request for reconsideration by its authorized officials or through its legal representative.

(2) The request must be filed within 30 calendar days of the receipt of CMS notice of an adverse determination or non-renewal.

(3) The request for reconsideration must specify the findings or issues with which the accreditation organization disagrees and the reasons for the disagreement.

(4) A requestor may withdraw its request for reconsideration at any time before the issuance of a reconsideration determination.

(5) In response to a request for reconsideration, CMS provides the accreditation organization the opportunity for an informal hearing to be conducted by a hearing officer appointed by the Administrator of CMS and provide the accreditation organization the opportunity to present, in writing and in person, evidence or documentation to refute the determination to deny approval, or to withdraw or not renew deeming authority.

(6) CMS provides written notice of the time and place of the informal hearing at least 10 calendar days before the scheduled date.

(7) The informal reconsideration hearing is open to CMS and the organization requesting the reconsideration, including authorized representatives; technical advisors (individuals with knowledge of the facts of the case or presenting interpretation of the facts); and legal counsel.

(i) The hearing is conducted by the hearing officer who receives testimony and documents related to the proposed action.

(ii) Testimony and other evidence may be accepted by the hearing officer even though it is inadmissible under the rules of court procedures.

(iii) The hearing officer does not have the authority to compel by subpoena the production of witnesses, papers, or other evidence.

(8) Within 45 calendar days of the close of the hearing, the hearing officer presents the findings and recommendations to the accreditation organization that requested the reconsideration.

(9) The written report of the hearing officer includes separate numbered findings of fact and the legal conclusions of the hearing officer. The hearing officer's decision is final.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplemental Medical Insurance Program).

Dated: July 20, 2006.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Approved: July 28, 2006.

Michael O. Leavitt,

Secretary.

The following addendum will not appear in the Code of Federal Regulations.

Addendum

This addendum contains the tables referred to throughout the preamble of this final rule. The tables presented below are as follows:

Table 1.—Core-Based Statistical Area Urban Wage Index effective for discharges occurring on or after October 1, 2006 and on or before September 30, 2007

Table 2.—Core-Based Statistical Area Rural Wage Index effective for discharges occurring on or after October 1, 2006 and on or before September 30, 2007

The following addendum will not appear in the Code of Federal Regulations.

Addendum

This addendum contains the tables referred to throughout the preamble of this final rule. The tables presented below are as follows:

Table 1.—Inpatient Rehabilitation Facility Wage Index for Urban Areas for Discharges Occurring from October 1, 2006 through September 30, 2007

Table 2.—Inpatient Rehabilitation Facility Wage Index for Rural Areas for Discharges Occurring from October 1, 2006 through September 30, 2007

TABLE 1.—INPATIENT REHABILITATION FACILITY WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007

CBSA code	Urban area (constituent counties)	Wage index
10180	Abilene, TX	0.7896
	Callahan County, TX.	
	Jones County, TX.	
	Taylor County, TX.	
10380	Aguadilla-Isabela-San Sebastián, PR	0.4738
	Aguada Municipio, PR.	
	Aguadilla Municipio, PR.	
	Añasco Municipio, PR.	
	Isabela Municipio, PR.	
	Lares Municipio, PR.	
	Moca Municipio, PR.	
	Rincón Municipio, PR.	
	San Sebastián Municipio, PR.	
10420	Akron, OH	0.8982
	Portage County, OH.	
	Summit County, OH.	
10500	Albany, GA	0.8628
	Baker County, GA.	
	Dougherty County, GA.	
	Lee County, GA.	
	Terrell County, GA.	
	Worth County, GA.	
10580	Albany-Schenectady-Troy, NY	0.8589
	Albany County, NY.	
	Rensselaer County, NY.	
	Saratoga County, NY.	
	Schenectady County, NY.	
	Schoharie County, NY.	
10740	Albuquerque, NM	0.9684
	Bernalillo County, NM.	
	Sandoval County, NM.	
	Torrance County, NM.	
	Valencia County, NM.	
10780	Alexandria, LA	0.8033
	Grant Parish, LA.	
	Rapides Parish, LA.	
10900	Allentown-Bethlehem-Easton, PA–NJ	0.9818
	Warren County, NJ.	
	Carbon County, PA.	
	Lehigh County, PA.	
	Northampton County, PA.	
11020	Altoona, PA	0.8944
	Blair County, PA.	
11100	Amarillo, TX	0.9156
	Armstrong County, TX.	
	Carson County, TX.	
	Potter County, TX.	
	Randall County, TX.	
11180	Ames, IA	0.9536
	Story County, IA.	
11260	Anchorage, AK	1.1895
	Anchorage Municipality, AK.	
	Matanuska-Susitna Borough, AK.	
11300	Anderson, IN	0.8586

TABLE 1.—INPATIENT REHABILITATION FACILITY WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Madison County, IN.	
11340	Anderson, SC	0.8997
	Anderson County, SC.	
11460	Ann Arbor, MI	1.0859
	Washtenaw County, MI.	
11500	Anniston-Oxford, AL	0.7682
	Calhoun County, AL.	
11540	Appleton, WI	0.9288
	Calumet County, WI.	
	Outagamie County, WI.	
11700	Asheville, NC	0.9285
	Buncombe County, NC.	
	Haywood County, NC.	
	Henderson County, NC.	
	Madison County, NC.	
12020	Athens-Clarke County, GA	0.9855
	Clarke County, GA.	
	Madison County, GA.	
	Oconee County, GA.	
	Oglethorpe County, GA.	
12060	Atlanta-Sandy Springs-Marietta, GA	0.9793
	Barrow County, GA.	
	Bartow County, GA.	
	Butts County, GA.	
	Carroll County, GA.	
	Cherokee County, GA.	
	Clayton County, GA.	
	Cobb County, GA.	
	Coweta County, GA.	
	Dawson County, GA.	
	DeKalb County, GA.	
	Douglas County, GA.	
	Fayette County, GA.	
	Forsyth County, GA.	
	Fulton County, GA.	
	Gwinnett County, GA.	
	Haralson County, GA.	
	Heard County, GA.	
	Henry County, GA.	
	Jasper County, GA.	
	Lamar County, GA.	
	Meriwether County, GA.	
	Newton County, GA.	
	Paulding County, GA.	
	Pickens County, GA.	
	Pike County, GA.	
	Rockdale County, GA.	
	Spalding County, GA.	
	Walton County, GA.	
12100	Atlantic City, NJ	1.1615
	Atlantic County, NJ.	
12220	Auburn-Opelika, AL	0.8100
	Lee County, AL.	
12260	Augusta-Richmond County, GA–SC	0.9748
	Burke County, GA.	
	Columbia County, GA.	
	McDuffie County, GA.	
	Richmond County, GA.	
	Aiken County, SC.	
	Edgefield County, SC.	
12420	RAustin-Round Rock, TX	0.9437
	Bastrop County, TX.	
	Caldwell County, TX.	
	Hays County, TX.	
	Travis County, TX.	
	Williamson County, TX.	
12540	Bakersfield, CA	1.0470
	Kern County, CA.	
12580	Baltimore-Towson, MD	0.9897
	Anne Arundel County, MD.	

TABLE 1.—INPATIENT REHABILITATION FACILITY WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Baltimore County, MD.	
	Carroll County, MD.	
	Harford County, MD.	
	Howard County, MD.	
	Queen Anne's County, MD.	
	Baltimore City, MD.	
12620	Bangor, ME	0.9993
	Penobscot County, ME.	
12700	Barnstable Town, MA	1.2600
	Barnstable County, MA,	
12940	Baton Rouge, LA	0.8593
	Ascension Parish, LA.	
	East Baton Rouge Parish, LA.	
	East Feliciana Parish, LA.	
	Iberville Parish, LA.	
	Livingston Parish, LA.	
	Pointe Coupee Parish, LA.	
	St. Helena Parish, LA.	
	West Baton Rouge Parish, LA.	
	West Feliciana Parish, LA.	
12980	Battle Creek, MI	0.9508
	Calhoun County, MI.	
13020	Bay City, MI	0.9343
	Bay County, MI.	
13140	Beaumont-Port Arthur, TX	0.8412
	Hardin County, TX.	
	Jefferson County, TX.	
	Orange County, TX.	
13380	Bellingham, WA	1.1731
	Whatcom County, WA.	
13460	Bend, OR	1.0786
	Deschutes County, OR.	
13644	Bethesda-Gaithersburg-Frederick, MD	1.1483
	Frederick County, MD.	
	Montgomery County, MD.	
13740	Billings, MT	0.8834
	Carbon County, MT.	
	Yellowstone County, M.	
13780	Binghamton, NY	0.8562
	Broome County, NY.	
	Tioga County, NYT.	
13820	Birmingham-Hoover, AL	0.8959
	Bibb County, AL.	
	Blount County, AL.	
	Chilton County, AL.	
	Jefferson County, AL.	
	St. Clair County, AL.	
	Shelby County, AL.	
	Walker County, AL.	
13900	Bismarck, ND	0.7574
	Burleigh County, ND.	
	Morton County, ND.	
13980	Blacksburg-Christiansburg-Radford, VA	0.7954
	Giles County, VA.	
	Montgomery County, VA.	
	Pulaski County, VA.	
	Radford City, VA.	
14020	Bloomington, IN	0.8447
	Greene County, IN.	
	Monroe County, IN.	
	Owen County, IN.	
14060	Bloomington-Normal, IL	0.9075
	McLean County, IL.	
14260	Boise City-Nampa, ID	0.9052
	Ada County, ID.	
	Boise County, ID.	
	Canyon County, ID.	
	Gem County, ID.	
	Owyhee County, ID.	
14484	Boston-Quincy, MA	1.1558

TABLE 1.—INPATIENT REHABILITATION FACILITY WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Norfolk County, MA.	
	Plymouth County, MA.	
	Suffolk County, MA.	
14500	Boulder, CO	0.9734
	Boulder County, CO.	
14540	Bowling Green, KY	0.8211
	Edmonson County, KY.	
	Warren County, KY.	
14740	Bremerton-Silverdale, WA	1.0675
	Kitsap County, WA.	
14860	Bridgeport-Stamford-Norwalk, CT	1.2592
	Fairfield County, CT.	
15180	Brownsville-Harlingen, TX	0.9804
	Cameron County, TX.	
15260	Brunswick, GA	0.9311
	Brantley County, GA.	
	Glynn County, GA.	
	McIntosh County, GA.	
15380	Buffalo-Niagara Falls, NY	0.9511
	Erie County, NY.	
	Niagara County, NY.	
15500	Burlington, NC	0.8905
	Alamance County, NC.	
15540	Burlington-South Burlington, VT	0.9410
	Chittenden County, VT.	
	Franklin County, VT.	
	Grand Isle County, VT.	
15764	Cambridge-Newton-Framingham, MA	1.1172
	Middlesex County, MA.	
15804	Camden, NJ	1.0517
	Burlington County, NJ.	
	Camden County, NJ.	
	Gloucester County, NJ.	
15940	Canton-Massillon, OH	0.8735
	Carroll County, OH.	
	Stark County, OH.	
15980	Cape Coral-Fort Myers, FL	0.9356
	Lee County, FL.	
16180	Carson City, NV	1.0234
	Carson City, NV.	
16220	Casper, WY	0.9026
	Natrona County, WY.	
16300	Cedar Rapids, IA	0.8825
	Benton County, IA.	
	Jones County, IA.	
	Linn County, IA.	
16580	Champaign-Urbana, IL	0.9594
	Champaign County, IL.	
	Ford County, IL.	
	Piatt County, IL.	
16620	Charleston, WV	0.8445
	Boone County, WV.	
	Clay County, WV.	
	Kanawha County, WV.	
	Lincoln County, WV.	
	Putnam County, WV.	
16700	Charleston-North Charleston, SC	0.9245
	Berkeley County, SC.	
	Charleston County, SC.	
	Dorchester County, SC.	
16740	Charlotte-Gastonia-Concord, NC–SC	0.9750
	Anson County, NC.	
	Cabarrus County, NC.	
	Gaston County, NC.	
	Mecklenburg County, NC.	
	Union County, NC.	
	York County, SC.	
16820	Charlottesville, VA	1.0187
	Albemarle County, VA.	
	Fluvanna County, VA.	

TABLE 1.—INPATIENT REHABILITATION FACILITY WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Greene County, VA.	
	Nelson County, VA.	
	Charlottesville City, VA.	
16860	Chattanooga, TN–GA	0.9088
	Catoosa County, GA.	
	Dade County, GA.	
	Walker County, GA.	
	Hamilton County, TN.	
	Marion County, TN.	
	Sequatchie County, TN.	
16940	Cheyenne, WY	0.8775
	Laramie County, WY.	
16974	Chicago-Naperville-Joliet, IL	1.0790
	Cook County, IL.	
	DeKalb County, IL.	
	DuPage County, IL.	
	Grundy County, IL.	
	Kane County, IL.	
	Kendall County, IL.	
	McHenry County, IL.	
	Will County, IL.	
17020	Chico, CA	1.0511
	Butte County, CA.	
17140	Cincinnati-Middletown, OH–KY–IN	0.9615
	Dearborn County, IN.	
	Franklin County, IN.	
	Ohio County, IN.	
	Boone County, KY.	
	Bracken County, KY.	
	Campbell County, KY.	
	Gallatin County, KY.	
	Grant County, KY.	
	Kenton County, KY.	
	Pendleton County, KY.	
	Brown County, OH.	
	Butler County, OH.	
	Clermont County, OH.	
	Hamilton County, OH.	
	Warren County, OH.	
17300	Clarksville, TN-KY	0.8284
	Christian County, KY.	
	Trigg County, KY.	
	Montgomery County, TN.	
	Stewart County, TN.	
17420	Cleveland, TN	0.8139
	Bradley County, TN.	
	Polk County, TN.	
17460	Cleveland-Elyria-Mentor, OH	0.9213
	Cuyahoga County, OH.	
	Geauga County, OH.	
	Lake County, OH.	
	Lorain County, OH.	
	Medina County, OH.	
17660	Coeur d'Alene, ID	0.9647
	Kootenai County, ID.	
17780	College Station-Bryan, TX	0.8900
	Brazos County, TX.	
	Burleson County, TX.	
	Robertson County, TX.	
17820	Colorado Springs, CO	0.9468
	El Paso County, CO.	
	Teller County, CO.	
17860	Columbia, MO	0.8345
	Boone County, MO.	
	Howard County, MO.	
17900	Columbia, SC	0.9057
	Calhoun County, SC.	
	Fairfield County, SC.	
	Kershaw County, SC.	
	Lexington County, SC.	

TABLE 1.—INPATIENT REHABILITATION FACILITY WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Richland County, SC.	
	Saluda County, SC.	
17980	Columbus, GA–AL	0.8560
	Russell County, AL.	
	Chattahoochee County, GA.	
	Harris County, GA.	
	Marion County, GA.	
	Muscogee County, GA.	
18020	Columbus, IN	0.9588
	Bartholomew County, IN.	
18140	Columbus, OH	0.9860
	Delaware County, OH.	
	Fairfield County, OH.	
	Franklin County, OH.	
	Licking County, OH.	
	Madison County, OH.	
	Morrow County, OH.	
	Pickaway County, OH.	
	Union County, OH.	
18580	Corpus Christi, TX	0.8550
	Aransas County, TX.	
	Nueces County, TX.	
	San Patricio County, TX.	
18700	Corvallis, OR	1.0729
	Benton County, OR.	
19060	Cumberland, MD–WV	0.9317
	Allegany County, MD.	
	Mineral County, WV.	
19124	Dallas-Plano-Irving, TX	1.0228
	Collin County, TX.	
	Dallas County, TX.	
	Delta County, TX.	
	Denton County, TX.	
	Ellis County, TX.	
	Hunt County, TX.	
	Kaufman County, TX.	
	Rockwall County, TX.	
19140	Dalton, GA	0.9079
	Murray County, GA.	
	Whitfield County, GA.	
19180	Danville, IL	0.9028
	Vermilion County, IL.	
19260	Danville, VA	0.8489
	Pittsylvania County, VA.	
	Danville City, VA.	
19340	Davenport-Moline-Rock Island, IA–IL	0.8724
	Henry County, IL.	
	Mercer County, IL.	
	Rock Island County, IL.	
	Scott County, IA.	
19380	Dayton, OH	0.9064
	Greene County, OH.	
	Miami County, OH.	
	Montgomery County, OH.	
	Preble County, OH.	
19460	Decatur, AL	0.8469
	Lawrence County, ALVMorgan County, AL.	
19500	Decatur, IL	0.8067
	Macon County, IL.	
19660	Deltona-Daytona Beach-Ormond Beach, FL	0.9299
	Volusia County, FL.	
19740	Denver-Aurora, CO	1.0723
	Adams County, CO.	
	Arapahoe County, CO.	
	Broomfield County, CO.	
	Clear Creek County, CO.	
	Denver County, CO.	
	Douglas County, CO.	
	Elbert County, CO.	
	Gilpin County, CO.	

TABLE 1.—INPATIENT REHABILITATION FACILITY WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007—Continued

CBSA code	Urban area (constituent counties)	Wage-index
	Jefferson County, CO.	
	Park County, CO.	
19780	Des Moines, IA	0.9669
	Dallas County, IA.	
	Guthrie County, IA.	
	Madison County, IA.	
	Polk County, IA.	
	Warren County, IA.	
19804	Detroit-Livonia-Dearborn, MI	1.0424
	Wayne County, MI.	
20020	Dothan, AL	0.7721
	Geneva County, AL.	
	Henry County, AL.	
	Houston County, AL.	
20100	Dover, DE	0.9776
	Kent County, DE.	
20220	Dubuque, IA	0.9024
	Dubuque County, IA.	
20260	Duluth, MN–WI	1.0213
	Carlton County, MN.	
	St. Louis County, MN.	
	Douglas County, WI.	
20500	Durham, NC	1.0244
	Chatham County, NC.	
	Durham County, NC.	
	Orange County, NC.	
	Person County, NC.	
20740	Eau Claire, WI	0.9201
	Chippewa County, WI.	
	Eau Claire County, WI.	
20764	Edison, NJ	1.1249
	Middlesex County, NJ.	
	Monmouth County, NJ.	
	Ocean County, NJ.	
	Somerset County, NJ.	
20940	El Centro, CA	0.8906
	Imperial County, CA.	
21060	Elizabethtown, KY	0.8802
	Hardin County, KY.	
	Larue County, KY.	
21140	Elkhart-Goshen, IN	0.9627
	Elkhart County, IN.	
21300	Elmira, NY	0.8250
	Chemung County, NY.	
21340	El Paso, TX	0.8977
	El Paso County, TX.	
21500	Erie, PA	0.8737
	Erie County, PA.	
21604	Essex County, MA	1.0538
	Essex County, MA.	
21660	Eugene-Springfield, OR	1.0818
	Lane County, OR.	
21780	Evansville, IN–KY	0.8713
	Gibson County, IN.	
	Posey County, IN.	
	Vanderburgh County, IN.	
	Warrick County, IN.	
	Henderson County, KY.	
	Webster County, KY.	
21820	Fairbanks, AK	1.1408
	Fairbanks North Star Borough, AK.	
21940	Fajardo, PR	0.4153
	Ceiba Municipio, PR.	
	Fajardo Municipio, PR.	
	Luquillo Municipio, PR.	
22020	Fargo, ND–MN	0.8486
	Cass County, ND.	
	Clay County, MN.	
22140	Farmington, NM	0.8509
	San Juan County, NM.	

TABLE 1.—INPATIENT REHABILITATION FACILITY WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007—Continued

CBSA code	Urban area (constituent counties)	Wage index
22180	Fayetteville, NC	0.9416
	Cumberland County, NC.	
	Hoke County, NC.	
22220	Fayetteville-Springdale-Rogers, AR–MO	0.8661
	Benton County, AR.	
	Madison County, AR.	
	Washington County, AR.	
	McDonald County, MO.	
22380	Flagstaff, AZ	1.2092
	Coconino County, AZ.	
22420	Flint, MI	1.0655
	Genesee County, MI.	
22500	Florence, SC	0.8947
	Darlington County, SC.	
	Florence County, SC.	
22520	Florence-Muscle Shoals, AL	0.8272
	Colbert County, AL.	
	Lauderdale County, AL.	
22540	Fond du Lac, WI	0.9640
	Fond du Lac County, WI.	
22660	Fort Collins-Loveland, CO	1.0122
	Larimer County, CO.	
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL	1.0432
	Broward County, FL.	
22900	Fort Smith, AR-OK	0.8230
	Crawford County, AR.	
	Franklin County, AR.	
	Sebastian County, AR.	
	Le Flore County, OK.	
	Sequoyah County, OK.	
23020	Fort Walton Beach-Crestview-Destin, FL	0.8872
	Okaloosa County, FL.	
23060	Fort Wayne, IN	0.9793
	Allen County, IN.	
	Wells County, IN.	
	Whitley County, IN.	
23104	Fort Worth-Arlington, TX	0.9486
	Johnson County, TX.	
	Parker County, TX.	
	Tarrant County, TX.	
	Wise County, TX.	
23420	Fresno, CA	1.0538
	Fresno County, CA.	
23460	Gadsden, AL	0.7938
	Etowah County, AL.	
23540	Gainesville, FL	0.9388
	Alachua County, FL.	
	Gilchrist County, FL.	
23580	Gainesville, GA	0.8874
	Hall County, GA.	
23844	Gary, IN	0.9395
	Jasper County, IN.	
	Lake County, IN.	
	Newton County, IN.	
	Porter County, IN.	
24020	Glens Falls, NY	0.8559
	Warren County, NY.	
	Washington County, NY.	
24140	Goldsboro, NC	0.8775
	Wayne County, NC.	
24220	Grand Forks, ND-MN	0.7901
	Polk County, MN.	
	Grand Forks County, ND.	
24300	Grand Junction, CO	0.9550
	Mesa County, CO.	
24340	Grand Rapids-Wyoming, MI	0.9390
	Barry County, MI.	
	Ionia County, MI.	
	Kent County, MI.	
	Newaygo County, MI.	

TABLE 1.—INPATIENT REHABILITATION FACILITY WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007—Continued

CBSA code	Urban area (constituent counties)	Wage index
24500	Great Falls, MT	0.9052
	Cascade County, MT.	
24540	Greeley, CO	0.9570
	Weld County, CO.	
24580	Green Bay, WI	0.9483
	Brown County, WI.	
	Kewaunee County, WI.	
	Oconto County, WI.	
24660	Greensboro-High Point, NC	0.9104
	Guilford County, NC.	
	Randolph County, NC.	
	Rockingham County, NC.	
24780	Greenville, NC	0.9425
	Greene County, NC.	
	Pitt County, NC.	
24860	Greenville, SC	1.0027
	Greenville County, SC.	
	Laurens County, SC.	
	Pickens County, SC.	
25020	Guayama, PR	0.3181
	Arroyo Municipio, PR.	
	Guayama Municipio, PR.	
	Patillas Municipio, PR.	
25060	Gulfport-Biloxi, MS	0.8929
	Hancock County, MS.	
	Harrison County, MS.	
	Stone County, MS.	
25180	Hagerstown-Martinsburg, MD–WV	0.9489
	Washington County, MD.	
	Berkeley County, WV.	
	Morgan County, WV.	
25260	Hanford-Corcoran, CA	1.0036
	Kings County, CA.	
25420	Harrisburg-Carlisle, PA	0.9313
	Cumberland County, PA.	
	Dauphin County, PA.	
	Perry County, PA.	
25500	Harrisonburg, VA	0.9088
	Rockingham County, VA.	
	Harrisonburg City, VA.	
25540	Hartford-West Hartford-East Hartford, CT	1.1073
	Hartford County, CT.	
	Litchfield County, CT.	
	Middlesex County, CT.	
	Tolland County, CT.	
25620	Hattiesburg, MS	0.7601
	Forrest County, MS.	
	Lamar County, MS.	
	Perry County, MS.	
25860	Hickory-Lenoir-Morganton, NC	0.8921
	Alexander County, NC.	
	Burke County, NC.	
	Caldwell County, NC.	
	Catawba County, NC.	
25980	Hinesville-Fort Stewart, GA	[1] 0.9198
	Liberty County, GA.	
	Long County, GA.	
26100	Holland-Grand Haven, MI	0.9055
	Ottawa County, MI.	
26180	Honolulu, HI	1.1214
	Honolulu County, HI.	
26300	Hot Springs, AR	0.9005
	Garland County, AR.	
26380	Houma-Bayou Cane-Thibodaux, LA	0.7894
	Lafourche Parish, LA.	
	Terrebonne Parish, LA.	
26420	Houston-Sugar Land-Baytown, TX	0.9996
	Austin County, TX.	
	Brazoria County, TX.	
	Chambers County, TX.	

TABLE 1.—INPATIENT REHABILITATION FACILITY WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Fort Bend County, TX.	
	Galveston County, TX.	
	Harris County, TX.	
	Liberty County, TX.	
	Montgomery County, TX.	
	San Jacinto County, TX.	
	Waller County, TX.	
26580	Huntington-Ashland, WV–KY–OH	0.9477
	Boyd County, KY.	
	Greenup County, KY.	
	Lawrence County, OH.	
	Cabell County, WV.	
	Wayne County, WV.	
26620	Huntsville, AL	0.9146
	Limestone County, AL.	
	Madison County, AL.	
26820	Idaho Falls, ID	0.9420
	Bonneville County, ID.	
	Jefferson County, ID.	
26900	Indianapolis, IN	0.9920
	Boone County, IN.	
	Brown County, IN.	
	Hamilton County, IN.	
	Hancock County, IN.	
	Hendricks County, IN.	
	Johnson County, IN.	
	Marion County, IN.	
	Morgan County, IN.	
	Putnam County, IN.	
	Shelby County, IN.	
26980	Iowa City, IA	0.9747
	Johnson County, IA.	
	Washington County, IA.	
27060	Ithaca, NY	0.9793
	Tompkins County, NY.	
27100	Jackson, MI	0.9304
	Jackson County, MI.	
27140	Jackson, MS	0.8311
	Copiah County, MS.	
	Hinds County, MS.	
	Madison County, MS.	
	Rankin County, MS.	
	Simpson County, MS.	
27180	Jackson, TN	0.8964
	Chester County, TN.	
	Madison County, TN.	
27260	Jacksonville, FL	0.9290
	Baker County, FL.	
	Clay County, FL.	
	Duval County, FL.	
	Nassau County, FL.	
	St. Johns County, FL.	
27340	Jacksonville, NC	0.8236
	Onslow County, NC.	
27500	Janesville, WI	0.9538
	Rock County, WI.	
27620	Jefferson City, MO	0.8387
	Callaway County, MO.	
	Cole County, MO.	
	Moniteau County, MO.	
	Osage County, MO.	
27740	Johnson City, TN	0.7937
	Carter County, TN.	
	Unicoi County, TN.	
	Washington County, TN.	
27780	Johnstown, PA	0.8354
	Cambria County, PA.	
27860	Jonesboro, AR	0.7911
	Craighead County, AR.	
	Poinsett County, AR.	

TABLE 1.—INPATIENT REHABILITATION FACILITY WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007—Continued

CBSA code	Urban area (constituent counties)	Wage index
27900	Joplin, MO	0.8582
	Jasper County, MO.	
	Newton County, MO.	
28020	Kalamazoo-Portage, MI	1.0381
	Kalamazoo County, MI.	
	Van Buren County, MI.	
28100	Kankakee-Bradley, IL	1.0721
	Kankakee County, IL.	
28140	Kansas City, MO–KS	0.9476
	Franklin County, KS.	
	Johnson County, KS.	
	Leavenworth County, KS.	
	Linn County, KS.	
	Miami County, KS.	
	Wyandotte County, KS.	
	Bates County, MO.	
	Caldwell County, MO.	
	Cass County, MO.	
	Clay County, MO.	
	Clinton County, MO.	
	Jackson County, MO.	
	Lafayette County, MO.	
	Platte County, MO.	
	Ray County, MO.	
28420	Kennewick-Richland-Pasco, WA	1.0619
	Benton County, WA.	
	Franklin County, WA.	
28660	Killeen-Temple-Fort Hood, TX	0.8526
	Bell County, TX.	
	Coryell County, TX.	
	Lampasas County, TX.	
28700	Kingsport-Bristol-Bristol, TN–VA	0.8054
	Hawkins County, TN.	
	Sullivan County, TN.	
	Bristol City, VA.	
	Scott County, VA.	
	Washington County, VA.	
28740	Kingston, NY	0.9255
	Ulster County, NY.	
28940	Knoxville, TN	0.8441
	Anderson County, TN.	
	Blount County, TN.	
	Knox County, TN.	
	Loudon County, TN.	
	Union County, TN.	
29020	Kokomo, IN	0.9508
	Howard County, IN.	
	Tipton County, IN.	
29100	La Crosse, WI-MN	0.9564
	Houston County, MN.	
	La Crosse County, WI.	
29140	Lafayette, IN	0.8736
	Benton County, IN.	
	Carroll County, IN.	
	Tippecanoe County, IN.	
29180	Lafayette, LA	0.8428
	Lafayette Parish, LA.	
	St. Martin Parish, LA.	
29340	Lake Charles, LA	0.7833
	Calcasieu Parish, LA.	
	Cameron Parish, LA.	
29404	Lake County-Kenosha County, IL–WI	1.0429
	Lake County, IL.	
	Kenosha County, WI.	
29460	Lakeland, FL	0.8912
	Polk County, FL.	
29540	Lancaster, PA	0.9694
	Lancaster County, PA.	
29620	Lansing-East Lansing, MI	0.9794
	Clinton County, MI.	

TABLE 1.—INPATIENT REHABILITATION FACILITY WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Eaton County, MI.	
	Ingham County, MI.	
29700	Laredo, TX	0.8068
	Webb County, TX.	
29740	Las Cruces, NM.	
	Dona Ana County, NM	0.8467
29820	Las Vegas-Paradise, NV	1.1437
	Clark County, NV.	
29940	Lawrence, KS	0.8537
	Douglas County, KS.	
30020	Lawton, OK	0.7872
	Comanche County, OK.	
30140	Lebanon, PA	0.8459
	Lebanon County, PA.	
30300	Lewiston, ID–WA	0.9886
	Nez Perce County, ID.	
	Asotin County, WA.	
30340	Lewiston-Auburn, ME	0.9331
	Androscoggin County, ME.	
30460	Lexington-Fayette, KY	0.9075
	VBourbon County, KY.	
	Clark County, KY.	
	Fayette County, KY.	
	Jessamine County, KY.	
	Scott County, KY.	
	Woodford County, KY.	
30620	Lima, OH	0.9225
	Allen County, OH.	
30700	Lincoln, NE	1.0214
	Lancaster County, NE.	
	Seward County, NE.	
30780	Little Rock-North Little Rock, AR	0.8747
	Faulkner County, AR.	
	Grant County, AR.	
	Lonoke County, AR.	
	Perry County, AR.	
	Pulaski County, AR.	
	Saline County, AR.	
30860	Logan, UT–ID	0.9164
	Franklin County, ID.	
	Cache County, UT.	
30980	Longview, TX	0.8730
	Gregg County, TX.	
	Rusk County, TX.	
	Upshur County, TX.	
31020	Longview, WA	0.9579
	Cowlitz County, WA.	
31084	Los Angeles-Long Beach-Glendale, CA	1.1783
	Los Angeles County, CA.	
31140	Louisville, KY–IN	0.9251
	Clark County, IN.	
	Floyd County, IN.	
	Harrison County, IN.	
	Washington County, IN.	
	Bullitt County, KY.	
	Henry County, KY.	
	Jefferson County, KY.	
	Meade County, KY.	
	Nelson County, KY.	
	Oldham County, KY.	
	Shelby County, KY.	
	Spencer County, KY.	
	Trimble County, KY.	
31180	Lubbock, TX	0.8783
	Crosby County, TX.	
	Lubbock County, TX.	
31340	Lynchburg, VA	0.8691
	Amherst County, VA.	
	Appomattox County, VA.	
	Bedford County, VA.	

TABLE 1.—INPATIENT REHABILITATION FACILITY WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Campbell County, VA.	
	Bedford City, VA.	
	Lynchburg City, VA.	
31420	Macon, GA	0.9443
	Bibb County, GA.	
	Crawford County, GA.	
	Jones County, GA.	
	Monroe County, GA.	
	Twiggs County, GA.	
31460	Madera, CA	0.8713
	Madera County, CA.	
31540	Madison, WI	1.0659
	Columbia County, WI.	
	Dane County, WI.	
	Iowa County, WI.	
31700	Manchester-Nashua, NH	1.0354
	Hillsborough County, NH.	
	Merrimack County, NH.	
31900	Mansfield, OH	0.9891
	Richland County, OH.	
32420	Mayagüez, PR	0.4020
	Hormigueros Municipio, PR.	
	Mayagüez Municipio, PR.	
32580	McAllen-Edinburg-Mission, TX	0.8934
	Hidalgo County, TX.	
32780	Medford, OR	1.0225
	Jackson County, OR.	
32820	Memphis, TN–MS–AR	0.9397
	Crittenden County, AR.	
	DeSoto County, MS.	
	Marshall County, MS.	
	Tate County, MS.	
	Tunica County, MS.	
	Fayette County, TN.	
	Shelby County, TN.	
	Tipton County, TN.	
32900	Merced, CA	1.1109
	Merced County, CA.	
33124	Miami-Miami Beach-Kendall, FL	0.9750
	Miami-Dade County, FL.	
33140	Michigan City-La Porte, IN	0.9399
	LaPorte County, IN.	
33260	Midland, TX	0.9514
	Midland County, TX.	
33340	Milwaukee-Waukesha-West Allis, WI	1.0146
	Milwaukee County, WI.	
	Ozaukee County, WI.	
	Washington County, WI.	
	Waukesha County, WI.	
33460	Minneapolis-St. Paul-Bloomington, MN–WI	1.1075
	Anoka County, MN.	
	Carver County, MN.	
	Chisago County, MN.	
	Dakota County, MN.	
	Hennepin County, MN.	
	Isanti County, MN.	
	Ramsey County, MN.	
	Scott County, MN.	
	Sherburne County, MN.	
	Washington County, MN.	
	Wright County, MN.	
	Pierce County, WI.	
	St. Croix County, WI.	
33540	Missoula, MT	0.9473
	Missoula County, MT.	
33660	Mobile, AL	0.7891
	Mobile County, AL.	
33700	Modesto, CA	1.1885
	Stanislaus County, CA.	
33740	Monroe, LA	0.8031

TABLE 1.—INPATIENT REHABILITATION FACILITY WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Ouachita Parish, LA.	
	Union Parish, LA.	
33780	Monroe, MI	0.9468
	Monroe County, MI.	
33860	Montgomery, AL	0.8618
	Autauga County, AL.	
	Elmore County, AL.	
	Lowndes County, AL.	
	Montgomery County, AL.	
34060	Morgantown, WV	0.8420
	Monongalia County, WV.	
	Preston County, WV.	
34100	Morristown, TN	0.7961
	Grainger County, TN.	
	Hamblen County, TN.	
	Jefferson County, TN.	
34580	Mount Vernon-Anacortes, WA	1.0454
	Skagit County, WA.	
34620	Muncie, IN	0.8930
	Delaware County, IN.	
34740	Muskegon-Norton Shores, MI	0.9664
	Muskegon County, MI.	
34820	Myrtle Beach-Conway-North Myrtle Beach, SC	0.8934
	Horry County, SC.	
34900	Napa, CA	1.2643
	Napa County, CA.	
34940	Naples-Marco Island, FL	1.0139
	Collier County, FL.	
34980	Nashville-Davidson—Murfreesboro, TN	0.9790
	Cannon County, TN.	
	Cheatham County, TN.	
	Davidson County, TN.	
	Dickson County, TN.	
	Hickman County, TN.	
	Macon County, TN.	
	Robertson County, TN.	
	Rutherford County, TN.	
	Smith County, TN.	
	Sumner County, TN.	
	Trousdale County, TN.	
	Williamson County, TN.	
	Wilson County, TN.	
35004	Nassau-Suffolk, NY	1.2719
	Nassau County, NY.	
	Suffolk County, NY.	
35084	Newark-Union, NJ–PA	1.1883
	Essex County, NJ.	
	Hunterdon County, NJ.	
	Morris County, NJ.	
	Sussex County, NJ.	
	Union County, NJ.	
	Pike County, PA.	
35300	New Haven-Milford, CT	1.1887
	New Haven County, CT.	
35380	New Orleans-Metairie-Kenner, LA	0.8995
	Jefferson Parish, LA.	
	Orleans Parish, LA.	
	Plaquemines Parish, LA.	
	St. Bernard Parish, LA.	
	St. Charles Parish, LA.	
	St. John the Baptist Parish, LA.	
	St. Tammany Parish, LA.	
35644	New York-White Plains-Wayne, NY–NJ	1.3188
	Bergen County, NJ.	
	Hudson County, NJ.	
	Passaic County, NJ.	
	Bronx County, NY.	
	Kings County, NY.	
	New York County, NY.	
	Putnam County, NY.	

TABLE 1.—INPATIENT REHABILITATION FACILITY WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Queens County, NY.	
	Richmond County, NY.	
	Rockland County, NY.	
	Westchester County, NY.	
35660	Niles-Benton Harbor, MI	0.8879
	Berrien County, MI.	
35980	Norwich-New London, CT	1.1345
	New London County, CT.	
36084	Oakland-Fremont-Hayward, CA	1.5346
	Alameda County, CA.	
	Contra Costa County, CA.	
36100	Ocala, FL	0.8925
	Marion County, FL.	
36140	Ocean City, NJ	1.1011
	Cape May County, NJ.	
36220	Odessa, TX	0.9884
	Ector County, TX.	
36260	Ogden-Clearfield, UT	0.9029
	Davis County, UT.	
	Morgan County, UT.	
	Weber County, UT.	
36420	Oklahoma City, OK	0.9031
	Canadian County, OK.	
	Cleveland County, OK.	
	Grady County, OK.	
	Lincoln County, OK.	
	Logan County, OK.	
	McClain County, OK.	
	Oklahoma County, OK.	
36500	Olympia, WA	1.0927
	Thurston County, WA.	
36540	Omaha-Council Bluffs, NE–IA	0.9560
	Harrison County, IA.	
	Mills County, IA.	
	Pottawattamie County, IA.	
	Cass County, NE.	
	Douglas County, NE.	
	Sarpy County, NE.	
	Saunders County, NE.	
	Washington County, NE.	
36740	Orlando-Kissimmee, FL	0.9464
	Lake County, FL.	
	Orange County, FL.	
	Osceola County, FL.	
	Seminole County, FL.	
36780	Oshkosh-Neenah, WI	0.9183
	Winnebago County, WI.	
36980	Owensboro, KY	0.8780
	Daviess County, KY.	
	Hancock County, KY.	
	McLean County, KY.	
37100	Oxnard-Thousand Oaks-Ventura, CA	1.1622
	Ventura County, CA.	
37340	Palm Bay-Melbourne-Titusville, FL	0.9839
	Brevard County, FL.	
37460	Panama City-Lynn Haven, FL	0.8005
	Bay County, FL.	
37620	Parkersburg-Marietta-Vienna, WV-OH	0.8270
	Washington County, OH.	
	Pleasants County, WV.	
	Wirt County, WV.	
	Wood County, WV.	
37700	Pascagoula, MS	0.8156
	George County, MS.	
	Jackson County, MS.	
37860	Pensacola-Ferry Pass-Brent, FL	0.8096
	Escambia County, FL.	
	Santa Rosa County, FL.	
37900	Peoria, IL	0.8870
	Marshall County, IL.	

TABLE 1.—INPATIENT REHABILITATION FACILITY WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Peoria County, IL.	
	Stark County, IL.	
	Tazewell County, IL.	
	Woodford County, IL.	
37964	Philadelphia, PA	1.1038
	Bucks County, PA.	
	Chester County, PA.	
	Delaware County, PA.	
	Montgomery County, PA.	
	Philadelphia County, PA.	
38060	Phoenix-Mesa-Scottsdale, AZ	1.0127
	Maricopa County, AZ.	
	Pinal County, AZ.	
38220	Pine Bluff, AR	0.8680
	Cleveland County, AR.	
	Jefferson County, AR.	
	Lincoln County, AR.	
38300	Pittsburgh, PA	0.8845
	Allegheny County, PA.	
	Armstrong County, PA.	
	Beaver County, PA.	
	Butler County, PA.	
	Fayette County, PA.	
	Washington County, PA.	
	Westmoreland County, PA.	
38340	Pittsfield, MA	1.0181
	Berkshire County, MA.	
38540	Pocatello, ID	0.9351
	Bannock County, ID.	
	Power County, ID.	
38660	Ponce, PR	0.4939
	Juana Díaz Municipio, PR.	
	Ponce Municipio, PR.	
	Villalba Municipio, PR.	
38860	Portland-South Portland-Biddeford, ME	1.0382
	Cumberland County, ME.	
	Sagadahoc County, ME.	
	York County, ME.	
38900	Portland-Vancouver-Beaverton, OR–WA	1.1266
	Clackamas County, OR.	
	Columbia County, OR.	
	Multnomah County, OR.	
	Washington County, OR.	
	Yamhill County, OR.	
	Clark County, WA.	
	Skamania County, WA.	
38940	Port St. Lucie-Fort Pierce, FL	1.0123
	Martin County, FL.	
	St. Lucie County, FL.	
39100	Poughkeepsie-Newburgh-Middletown, NY	1.0891
	Dutchess County, NY.	
	Orange County, NY.	
39140	Prescott, AZ	0.9869
	Yavapai County, AZ.	
39300	Providence-New Bedford-Fall River, RI–MA	1.0966
	Bristol County, MA.	
	Bristol County, RI.	
	Kent County, RI.	
	Newport County, RI.	
	Providence County, RI.	
	Washington County, RI.	
39340	Provo-Orem, UT	0.9500
	Juab County, UT.	
	Utah County, UT.	
39380	Pueblo, CO	0.8623
	Pueblo County, CO.	
39460	Punta Gorda, FL	0.9255
	Charlotte County, FL.	
39540	Racine, WI	0.8997
	Racine County, WI.	

TABLE 1.—INPATIENT REHABILITATION FACILITY WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007—Continued

CBSA code	Urban area (constituent counties)	Wage index
39580	Raleigh-Cary, NC	0.9691
	Franklin County, NC.	
	Johnston County, NC.	
	Wake County, NC.	
39660	Rapid City, SD	0.8987
	Meade County, SD.	
	Pennington County, SD.	
39740	Reading, PA	0.9686
	Berks County, PA.	
39820	Redding, CA	1.2203
	Shasta County, CA.	
39900	Reno-Sparks, NV.	
	Storey County, NV	1.0982
	Washoe County, NV.	
40060	Richmond, VA	0.9328
	Amelia County, VA.	
	Caroline County, VA.	
	Charles City County, VA.	
	Chesterfield County, VA.	
	Cumberland County, VA.	
	Dinwiddie County, VA.	
	Goochland County, VA.	
	Hanover County, VA.	
	Henrico County, VA.	
	King and Queen County, VA.	
	King William County, VA.	
	Louisa County, VA.	
	New Kent County, VA.	
	Powhatan County, VA.	
	Prince George County, VA.	
	Sussex County, VA.	
	Colonial Heights City, VA.	
	Hopewell City, VA.	
	Petersburg City, VA.	
	Richmond City, VA.	
40140	Riverside-San Bernardino-Ontario, CA	1.1027
	Riverside County, CA.	
	San Bernardino County, CA.	
40220	Roanoke, VA	0.8374
	Botetourt County, VA.	
	Craig County, VA.	
	Franklin County, VA.	
	Roanoke County, VA.	
	Roanoke City, VA.	
	Salem City, VA.	
40340	Rochester, MN	1.1131
	Dodge County, MN.	
	Olmsted County, MN.	
	Wabasha County, MN.	
40380	Rochester, NY	0.9121
	Livingston County, NY.	
	Monroe County, NY.	
	Ontario County, NY.	
	Orleans County, NY.	
	Wayne County, NY.	
40420	Rockford, IL	0.9984
	Boone County, IL.	
	Winnebago County, IL.	
40484	Rockingham County-Strafford County, NH	1.0374
	Rockingham County, NH.	
	Strafford County, NH.	
40580	Rocky Mount, NC	0.8915
	Edgecombe County, NC.	
	Nash County, NC.	
40660	Rome, GA	0.9414
	Floyd County, GA.	
40900	Sacramento—Arden-Arcade—Roseville, CA	1.2969
	El Dorado County, CA.	
	Placer County, CA.	
	Sacramento County, CA.	

TABLE 1.—INPATIENT REHABILITATION FACILITY WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Yolo County, CA.	
40980	Saginaw-Saginaw Township North, MI	0.9088
	Saginaw County, MI.	
41060	St. Cloud, MN	0.9965
	Benton County, MN.	
	Stearns County, MN.	
41100	St. George, UT	0.9392
	Washington County, UT.	
41140	St. Joseph, MO–KS	0.9519
	Doniphan County, KS.	
	Andrew County, MO.	
	Buchanan County, MO.	
	DeKalb County, MO.	
41180	St. Louis, MO–IL	0.8954
	Bond County, IL.	
	Calhoun County, IL.	
	Clinton County, IL.	
	Jersey County, IL.	
	Macoupin County, IL.	
	Madison County, IL.	
	Monroe County, IL.	
	St. Clair County, IL.	
	Crawford County, MO.	
	Franklin County, MO.	
	Jefferson County, MO.	
	Lincoln County, MO.	
	St. Charles County, MO.	
	St. Louis County, MO.	
	Warren County, MO.	
	Washington County, MO.	
	St. Louis City, MO.	
41420	Salem, OR	1.0442
	Marion County, OR.	
	Polk County, OR.	
41500	Salinas, CA	1.4128
	Monterey County, CA.	
41540	Salisbury, MD	0.9064
	Somerset County, MD.	
	Wicomico County, MD.	
41620	Salt Lake City, UT	0.9421
	Salt Lake County, UT.	
	Summit County, UT.	
	Tooele County, UT.	
41660	San Angelo, TX	0.8271
	Irion County, TX.	
	Tom Green County, TX.	
41700	San Antonio, TX	0.8980
	Atascosa County, TX.	
	Bandera County, TX.	
	Bexar County, TX.	
	Comal County, TX.	
	Guadalupe County, TX.	
	Kendall County, TX.	
	Medina County, TX.	
	Wilson County, TX.	
41740	San Diego-Carlsbad-San Marcos, CA	1.1413
	San Diego County, CA.	
41780	Sandusky, OH	0.9019
	Erie County, OH.	
41884	San Francisco-San Mateo-Redwood City, CA	1.4994
	Marin County, CA.	
	San Francisco County, CA.	
	San Mateo County, CA.	
41900	San Germán-Cabo Rojo, PR	0.4650
	Cabo Rojo Municipio, PR.	
	Lajas Municipio, PR.	
	Sabana Grande Municipio, PR.	
	San Germán Municipio, PR.	
41940	San Jose-Sunnyvale-Santa Clara, CA	1.5099
	San Benito County, CA.	

TABLE 1.—INPATIENT REHABILITATION FACILITY WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Santa Clara County, CA.	
41980	San Juan-Caguas-Guaynabo, PR	0.4621
	Aguas Buenas Municipio, PR.	
	Aibonito Municipio, PR.	
	Arecibo Municipio, PR.	
	Barceloneta Municipio, PR.	
	Barranquitas Municipio, PR.	
	Bayamón Municipio, PR.	
	Caguas Municipio, PR.	
	Camuy Municipio, PR.	
	Canóvanas Municipio, PR.	
	Carolina Municipio, PR.	
	Cataño Municipio, PR.	
	Cayey Municipio, PR.	
	Ciales Municipio, PR.	
	Cidra Municipio, PR.	
	Comerío Municipio, PR.	
	Corozal Municipio, PR.	
	Dorado Municipio, PR.	
	Florida Municipio, PR.	
	Guaynabo Municipio, PR.	
	Gurabo Municipio, PR.	
	Hatillo Municipio, PR.	
	Humacao Municipio, PR.	
	Juncos Municipio, PR.	
	Las Piedras Municipio, PR.	
	Loíza Municipio, PR.	
	Manatí Municipio, PR.	
	Maunabo Municipio, PR.	
	Morovis Municipio, PR.	
	Naguabo Municipio, PR.	
	Naranjito Municipio, PR.	
	Orocovis Municipio, PR.	
	Quebradillas Municipio, PR.	
	Río Grande Municipio, PR.	
	San Juan Municipio, PR.	
	San Lorenzo Municipio, PR.	
	Toa Alta Municipio, PR.	
	Toa Baja Municipio, PR.	
	Trujillo Alto Municipio, PR.	
	Vega Alta Municipio, PR.	
	Vega Baja Municipio, PR.	
	Yabucoa Municipio, PR.	
42020	San Luis Obispo-Paso Robles, CA	1.1349
	San Luis Obispo County, CA.	
42044	Santa Ana-Anaheim-Irvine, CA	1.1559
	Orange County, CA.	
42060	Santa Barbara-Santa Maria, CA	1.1694
	Santa Barbara County, CA.	
42100	Santa Cruz-Watsonville, CA	1.5166
	Santa Cruz County, CA.	
42140	Santa Fe, NM	1.0920
	Santa Fe County, NM.	
42220	Santa Rosa-Petaluma, CA	1.3493
	Sonoma County, CA.	
42260	Sarasota-Bradenton-Venice, FL	0.9639
	Manatee County, FL.	
	Sarasota County, FL.	
42340	Savannah, GA	0.9461
	Bryan County, GA.	
	Chatham County, GA.	
	Effingham County, GA.	
42540	Scranton—Wilkes-Barre, PA	0.8540
	Lackawanna County, PA.	
	Luzerne County, PA.	
	Wyoming County, PA.	
42644	Seattle-Bellevue-Everett, WA	1.1577
	King County, WA.	
	Snohomish County, WA.	
43100	Sheboygan, WI	0.8911

TABLE 1.—INPATIENT REHABILITATION FACILITY WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Sheboygan County, WI.	
43300	Sherman-Denison, TX	0.9507
	Grayson County, TX.	
43340	Shreveport-Bossier City, LA	0.8760
	Bossier Parish, LA.	
	Caddo Parish, LA.	
	De Soto Parish, LA.	
43580	Sioux City, IA-NE-SD	0.9381
	Woodbury County, IA.	
	Dakota County, NE.	
	Dixon County, NE.	
	Union County, SD.	
43620	Sioux Falls, SD	0.9635
	Lincoln County, SD.	
	McCook County, SD.	
	Minnehaha County, SD.	
	Turner County, SD.	
43780	South Bend-Mishawaka, IN–MI	0.9788
	St. Joseph County, IN.	
	Cass County, MI.	
43900	Spartanburg, SC	0.9172
	Spartanburg County, SC.	
44060	Spokane, WA	1.0905
	Spokane County, WA.	
44100	Springfield, IL	0.8792
	Menard County, IL.	
	Sangamon County, IL.	
44140	Springfield, MA	1.0248
	Franklin County, MA.	
	Hampden County, MA.	
	Hampshire County, MA.	
44180	Springfield, MO	0.8237
	Christian County, MO.	
	Dallas County, MO.	
	Greene County, MO.	
	Polk County, MO.	
	Webster County, MO.	
44220	Springfield, OH	0.8396
	Clark County, OH.	
44300	State College, PA	0.8356
	Centre County, PA.	
44700	Stockton, CA	1.1307
	San Joaquin County, CA.	
44940	Sumter, SC	0.8377
	Sumter County, SC.	
45060	Syracuse, NY	0.9574
	Madison County, NY.	
	Onondaga County, NY.	
	Oswego County, NY.	
45104	Tacoma, WA	1.0742
	Pierce County, WA.	
45220	Tallahassee, FL	0.8688
	Gadsden County, FL.	
	Jefferson County, FL.	
	Leon County, FL.	
	Wakulla County, FL.	
45300	Tampa-St. Petersburg-Clearwater, FL	0.9233
	Hernando County, FL.	
	Hillsborough County, FL.	
	Pasco County, FL.	
	Pinellas County, FL.	
45460	Terre Haute, IN	0.8304
	Clay County, IN.	
	Sullivan County, IN.	
	Vermillion County, IN.	
	Vigo County, IN.	
45500	Texarkana, TX-Texarkana, AR	0.8283
	Miller County, AR.	
	Bowie County, TX.	
45780	Toledo, OH	0.9574

TABLE 1.—INPATIENT REHABILITATION FACILITY WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Fulton County, OH.	
	Lucas County, OH.	
	Ottawa County, OH.	
	Wood County, OH.	
45820	Topeka, KS	0.8920
	Jackson County, KS.	
	Jefferson County, KS.	
	Osage County, KS.	
	Shawnee County, KS.	
	Wabaunsee County, KS.	
45940	Trenton-Ewing, NJ	1.0834
	Mercer County, NJ.	
46060	Tucson, AZ	0.9007
	Pima County, AZ.	
46140	Tulsa, OK	0.8543
	Creek County, OK.	
	Okmulgee County, OK.	
	Osage County, OK.	
	Pawnee County, OK.	
	Rogers County, OK.	
	Tulsa County, OK.	
	Wagoner County, OK.	
46220	Tuscaloosa, AL	0.8645
	Greene County, AL.	
	Hale County, AL.	
	Tuscaloosa County, AL.	
46340	Tyler, TX	0.9168
	Smith County, TX.	
46540	Utica-Rome, NY	0.8358
	Herkimer County, NY.	
	Oneida County, NY.	
46660	Valdosta, GA	0.8866
	Brooks County, GA.	
	Echols County, GA.	
	Lanier County, GA.	
	Lowndes County, GA.	
46700	Vallejo-Fairfield, CA	1.4936
	Solano County, CA.	
46940	Vero Beach, FL	0.9434
	Indian River County, FL.	
47020	Victoria, TX	0.8160
	Calhoun County, TX.	
	Goliad County, TX.	
	Victoria County, TX.	
47220	Vineland-Millville-Bridgeton, NJ	0.9827
	Cumberland County, NJ.	
47260	Virginia Beach-Norfolk-Newport News, VA–NC	0.8799
	Currituck County, NC.	
	Gloucester County, VA.	
	Isle of Wight County, VA.	
	James City County, VA.	
	Mathews County, VA.	
	Surry County, VA.	
	York County, VA.	
	Chesapeake City, VA.	
	Hampton City, VA.	
	Newport News City, VA.	
	Norfolk City, VA.	
	Poquoson City, VA.	
	Portsmouth City, VA.	
	Suffolk City, VA.	
	Virginia Beach City, VA.	
	Williamsburg City, VA.	
47300	Visalia-Porterville, CA	1.0123
	Tulare County, CA.	
47380	Waco, TX	0.8518
	McLennan County, TX.	
47580	Warner Robins, GA	0.8645
	Houston County, GA.	
47644	Warren-Farmington Hills-Troy, MI	0.9871

TABLE 1.—INPATIENT REHABILITATION FACILITY WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Lapeer County, MI.	
	Livingston County, MI.	
	Macomb County, MI.	
	Oakland County, MI.	
	St. Clair County, MI.	
47894	Washington-Arlington-Alexandria, DC–VA–MD–WV	1.0926
	District of Columbia, DC.	
	Calvert County, MD.	
	Charles County, MD.	
	Prince George's County, MD.	
	Arlington County, VA.	
	Clarke County, VA.	
	Fairfax County, VA.	
	Fauquier County, VA.	
	Loudoun County, VA.	
	Prince William County, VA.	
	Spotsylvania County, VA.	
	Stafford County, VA.	
	Warren County, VA.	
	Alexandria City, VA.	
	Fairfax City, VA.	
	Falls Church City, VA.	
	Fredericksburg City, VA.	
	Manassas City, VA.	
	Manassas Park City, VA.	
	Jefferson County, WV.	
47940	Waterloo-Cedar Falls, IA	0.8557
	Black Hawk County, IA.	
	Bremer County, IA.	
	Grundy County, IA.	
48140	Wausau, WI	0.9590
	Marathon County, WI.	
48260	Weirton-Steubenville, WV–OH	0.7819
	Jefferson County, OH.	
	Brooke County, WV.	
	Hancock County, WV.	
48300	Wenatchee, WA	1.0070
	Chelan County, WA.	
	Douglas County, WA.	
48424	West Palm Beach-Boca Raton-Boynton Beach, FL	1.0067
	Palm Beach County, FL.	
48540	Wheeling, WV-OH	0.7161
	Belmont County, OH.	
	Marshall County, WV.	
	Ohio County, WV.	
48620	Wichita, KS	0.9153
	Butler County, KS.	
	Harvey County, KS.	
	Sedgwick County, KS.	
	Sumner County, KS.	
48660	Wichita Falls, TX	0.8285
	Archer County, TX.	
	Clay County, TX.	
	Wichita County, TX.	
48700	Williamsport, PA	0.8364
	Lycoming County, PA.	
48864	Wilmington, DE–MD–NJ	1.0471
	New Castle County, DE.	
	Cecil County, MD.	
	Salem County, NJ.	
48900	Wilmington, NC	0.9582
	Brunswick County, NC.	
	New Hanover County, NC.	
	Pender County, NC.	
49020	Winchester, VA–WV	1.0214
	Frederick County, VA.	
	Winchester City, VA.	
	Hampshire County, WV.	
49180	Winston-Salem, NC	0.8944
	Davie County, NC.	

TABLE 1.—INPATIENT REHABILITATION FACILITY WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Forsyth County, NC.	
	Stokes County, NC.	
	Yadkin County, NC.	
49340	Worcester, MA	1.1028
	Worcester County, MA.	
49420	Yakima, WA	1.0155
	Yakima County, WA.	
49500	Yauco, PR	0.4408
	Guánica Municipio, PR.	
	Guayanilla Municipio, PR.	
	Peñuelas Municipio, PR.	
	Yauco Municipio, PR.	
49620	York-Hanover, PA	0.9347
	York County, PA.	
49660	Youngstown-Warren-Boardman, OH–PA	0.8603
	Mahoning County, OH.	
	Trumbull County, OH.	
	Mercer County, PA.	
49700	Yuba City, CA	1.0921
	Sutter County, CA.	
	Yuba County, CA.	
49740	Yuma, AZ	0.9126
	Yuma County, AZ.	

[1] At this time, there are no hospitals located in this CBSA-based urban area on which to base a wage index. Therefore, the wage index value is based on the methodology described in the FY 2006 IRF PPS final rule (70 FR 47880). The wage index value for this area is the average wage index for all urban areas within the state.

TABLE 2.—INPATIENT REHABILITATION FACILITY WAGE INDEX FOR RURAL AREAS FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007

CBSA code	Nonurban area	Wage index
01	Alabama	0.7446
02	Alaska	1.1977
03	Arizona	0.8768
04	Arkansas	0.7466
05	California	1.1054
06	Colorado	0.9380
07	Connecticut	1.1730
08	Delaware	0.9579
10	Florida	0.8568
11	Georgia	0.7662
12	Hawaii	1.0551
13	Idaho	0.8037
14	Illinois	0.8271
15	Indiana	0.8624
16	Iowa	0.8509
17	Kansas	0.8035
18	Kentucky	0.7766
19	Louisiana	0.7411
20	Maine	0.8843
21	Maryland	0.9353
22	Massachusetts[2]	1.0216
23	Michigan	0.8895
24	Minnesota	0.9132
25	Mississippi	0.7674
26	Missouri	0.7900
27	Montana	0.8762
28	Nebraska	0.8657
29	Nevada	0.9065
30	New Hampshire	1.0817
31	New Jersey[1]	.....
32	New Mexico	0.8635
33	New York	0.8154
34	North Carolina	0.8540
35	North Dakota	0.7261
36	Ohio	0.8826
37	Oklahoma	0.7581
38	Oregon	0.9826
39	Pennsylvania	0.8291
40	Puerto Rico[2]	0.4047
41	Rhode Island[1]	.....
42	South Carolina	0.8638
43	South Dakota	0.8560
44	Tennessee	0.7895
45	Texas	0.8003
46	Utah	0.8118
47	Vermont	0.9830
48	Virgin Islands	0.7615
49	Virginia	0.8013
50	Washington	1.0510
51	West Virginia	0.7717
52	Wisconsin	0.9509
53	Wyoming	0.9257
65	Guam	0.9611

[1] All counties within the State are classified as urban.

[2] Massachusetts and Puerto Rico have areas designated as rural; however, no shrot-term, acute care hospitals are located in the area(s) for FY 2007. As discussed in the FY 2006 IRF PPS final rule (70 FR 47880), we use the previous year's wage index value until more recent data is available for those areas.

[FR Doc. 06–6694 Filed 8–1–06; 4:00 pm]

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Federal Register

Friday,
August 18, 2006

Part IV

Department of Education

Grants and Cooperative Agreements; Notices

DEPARTMENT OF EDUCATION

Special Demonstration Programs—Model Demonstrations for Assistive Technology Reutilization

AGENCY: Office of Special Education and Rehabilitative Services, Department of Education.

ACTION: Notice of final priorities.

SUMMARY: The Assistant Secretary for the Office of Special Education and Rehabilitative Services (OSERS) announces final priorities under the Special Demonstration Programs administered by the Rehabilitation Services Administration (RSA). The Assistant Secretary may use one or more of these priorities for competitions in fiscal year (FY) 2006 and later years. This notice announces two priorities—a priority for model demonstrations for assistive technology (AT) device reutilization and a priority for a National Assistive Technology Device Reutilization Coordination and Technical Assistance Center (Center). These priorities are intended to increase access to AT devices for individuals with disabilities. The term "AT devices" includes a wide range of AT, such as computers, durable medical equipment, augmentative and alternative communication, and other devices.

EFFECTIVE DATE: These priorities are effective September 18, 2006.

FOR FURTHER INFORMATION CONTACT: Jeremy Buzzell, U.S. Department of Education, 400 Maryland Avenue, SW., room 5025, Potomac Center Plaza, Washington, DC 20202–2800. Telephone: (202) 245–7319 or via Internet: *Jeremy.Buzzell@ed.gov*.

If you use a telecommunications device for the deaf (TDD), you may call the Federal Relay Service (FRS) at 1–800–877–8339.

Individuals with disabilities may obtain this document in an alternative format (e.g., Braille, large print, audiotape, or computer diskette) on request to the contact person listed under **FOR FURTHER INFORMATION CONTACT.**

SUPPLEMENTARY INFORMATION: The purpose of the Special Demonstration Programs is to provide financial assistance to projects that expand and improve the provision of rehabilitation and other services for individuals with disabilities. The projects to be supported under these priorities are intended to improve the provision of AT to individuals with disabilities.

We published a notice of proposed priorities (NPP) for this program in the **Federal Register** on April 26, 2006 (71 FR 24800). The NPP included a background statement that described our rationale for each priority proposed in that notice. This notice of final priorities (NFP) contains several significant changes from the NPP. These changes are explained in the following *Analysis of Comments and Changes*.

Analysis of Comments and Changes

In response to our invitation in the NPP, 17 parties submitted comments on the proposed priorities. An analysis of the comments and of any changes in the priorities since publication of the NPP follows. We discuss substantive issues by topic under the number of the priority to which they pertain. Due to the nature and number of changes made in the priorities, OSERS significantly reorganized the priorities, including renumbering some sections and deleting others.

Generally, we do not address technical and other minor changes and suggested changes the law does not authorize us to make under the applicable statutory authority.

Priority 1—Model Demonstrations for AT Device Reutilization

Priority 1—General

Comments: Four commenters recommended that the amount of funds to cover indirect costs be limited to no more than 10 percent of the grant award in order to ensure that most of the grant funds are used for direct services.

Discussion: It is not necessary to limit indirect costs in the final priority because 34 CFR 373.22 limits indirect costs to 10 percent of the total direct cost base or the grantee's actual indirect costs, whichever is less.

Change: None.

Comment: One commenter requested greater specificity about requiring grantees to provide plans for sustaining their projects beyond the project period of this grant.

Discussion: Programs can be sustained in many ways, so OSERS agrees that a clarification of what is meant by this requirement will be helpful to potential applicants.

Change: OSERS replaced section (c) of Priority 1 with a new section (a)(ii) of Priority 1 to clarify that the project must be designed to sustain itself through its own activities beyond the project period of the grant.

Priority 1—Eligibility Requirements

Comments: Three commenters suggested that interstate collaborations be allowed to apply for grants under Priority 1.

Discussion: Eligible parties already are allowed to apply as a group pursuant to 34 CFR 75.127 through 75.129 and 34 CFR 373.2(a)(6).

Change: OSERS replaced section (b) of Priority 1 with new sections (a)(iii) and (a)(iv) of Priority 1 to clarify that projects may serve a State or group of States.

Comments: Three commenters suggested that grants be limited to one per State. One of these commenters would allow an exception if one project involved a single State and another involved that same State in a multi-State or regional project.

Discussion: Limiting grants to one per State may undermine the competitive grant process and reduce the quality of services to individuals with disabilities, because high quality applications from one State would be passed over for low quality applications from another State. Additionally, as is stated elsewhere in this notice, statewide delivery of services will not be a requirement of applicants. Limiting the grants to one per State may prevent a State from achieving more comprehensive services through multiple grants.

Change: None.

Priority 1—Scope of Services

Comments: Two commenters recommended that rather than requiring projects under Priority 1 to include all types of AT, serve people with all types of disabilities, and be statewide, that grantees be allowed to determine what AT they will reutilize, what types of disabilities will be served, and whether they will serve the entire State.

Discussion: OSERS understands that different capacities and expertise are required to reutilize particular types of devices. Additionally, it is possible that a project can best meet the needs of individuals with disabilities in particular areas of a State rather than on a statewide basis. Therefore, OSERS agrees that projects should have discretion to determine what types of devices they will reutilize and whether they have the capacity to serve statewide. However, individuals with diverse disabilities can benefit from similar devices; therefore, it is not appropriate to give States the discretion to limit the type of disability served.

Change: OSERS has removed language from section (a) of Priority 1 requiring that projects be statewide and recycle all types of AT.

Priority 1—Requirements for Project Operations

Comments: Three commenters recommended that grantees under Priority 1 be required to use

professional technicians to refurbish the recycled devices.

Discussion: Existing device reutilization projects use various models to successfully reutilize AT devices and rely on a wide range of expertise. Given the diversity of programs nationally and the lack of agreed-upon best practices for device reutilization, imposing such a requirement would unfairly restrict applications from viable programs. However, OSERS agrees that it is important to encourage the establishment of best practices in the field of AT device reutilization.

Changes: OSERS deleted sections 1(d) and 2(a) of Priority 2 and added sections (a)(ii), (a)(iv), and (b)(iv) to Priority 2 to require the Center to investigate and nationally disseminate best practices and to explore the need for and feasibility of developing standards of practice.

Priority 1—Collaboration

Comments: Four commenters suggested that every grantee under Priority 1 be required to collaborate with the Statewide Assistive Technology Program (Statewide AT Program) funded under the Assistive Technology Act of 1998, as amended (AT Act), in their State, and two commenters recommended requiring an assurance from the Statewide AT Program in their State that the grantee's application supplements and coordinates with the Statewide AT Program's reutilization activities.

Discussion: Because Statewide AT Programs conduct reutilization activities, OSERS agrees that projects funded under Priority 1 should collaborate with Statewide AT Programs to ensure better services to individuals with disabilities in their States. However, requiring an applicant under Priority 1 to provide an assurance in its application from the Statewide AT Program in its State that the application supplements and coordinates these reutilization activities would unfairly limit applications and undermine the competitive process. Requiring such an assurance from the Statewide AT Program would allow the Statewide AT Program to determine what entities can apply under Priority 1 by agreeing to or refusing to provide an assurance to an entity.

Change: OSERS replaced section (b) of Priority 1, with a new section (a)(iii), which requires that grantees coordinate and collaborate with reutilization activities funded under the AT Act. However, an assurance from the grantee under the AT State Grant program will not be required as part of the application. OSERS also included in section (a)(iii) language from section (h) in the NPP requiring that funds be used to supplement and not supplant the efforts of the Statewide AT Program.

Comments: One commenter recommended including a list of partners with whom grantees funded under Priority 1 should be required to collaborate, including AT Act programs, alternative financing programs, vocational rehabilitation agencies, education agencies, and vendors. An additional two commenters suggested that grantees be required to partner with manufacturers and suppliers of AT to conduct reutilization.

Discussion: OSERS agrees that collaboration is important for projects funded under Priority 1.

Change: OSERS replaced section (b) with a new section (a)(iv), which requires that grantees collaborate with relevant entities as appropriate, including the National Assistive Technology Device Reutilization Coordination and Technical Assistance Center funded under Priority 2, as well as State agencies that fund AT, alternative financing programs, vendors and manufacturers of AT, and other relevant entities and organizations.

Priority 1—Compliance with Regulations and Standards of Practice

Comments: Two commenters want to require grantees under Priority 1 to collaborate with manufacturers to establish standards for useful life by device type, minimum training and expertise for refurbishing and repair staff, and guidelines for training and education of clients and caregivers.

Discussion: OSERS agrees that it may be important to establish standards or best practices in device reutilization. However, if each project funded under Priority 1 works separately with manufacturers to establish standards, the standards will be inconsistent.

Change: OSERS added section (a)(iv) to Priority 2 to require the Center to explore the need for and feasibility of developing standards of practice.

Comments: Two commenters recommended that all grantees under Priority 1 be required to submit an assurance of compliance with all appropriate State and Federal requirements pertinent to the reuse, recycling, and sanitization of devices.

Discussion: While OSERS understands that projects may need assistance in understanding the appropriate State and Federal requirements, Priority 1 projects are subject to State and Federal requirements regardless of an additional assurance. Therefore, such an assurance is unnecessary. We believe it would be appropriate for the Center funded under Priority 2 to provide technical assistance to Priority 1 grantees on State and Federal requirements.

Change: OSERS has added sections (a)(iii) and (b)(iii) to Priority 2 requiring the Center funded under Priority 2 to disseminate information and to provide technical assistance related to relevant State and Federal requirements to projects funded under Priority 1.

Comments: Three commenters requested a requirement that all model demonstrations develop and maintain standards of practice and develop protocols for referrals to AT practitioners to provide evaluations.

Discussion: OSERS agrees that it may be important to develop standards of practice or procedures for referral. However, if each project funded under Priority 1 works separately to develop standards of practice or procedures for referrals, the standards and procedures will be inconsistent.

Change: OSERS added section (a)(iv) to Priority 2 to require the Center to explore the need for and feasibility of developing standards of practice for AT device reutilization nationally.

Priority 1—Data Collection and Reporting

Comments: Three commenters recommended that projects under Priority 1 be required to report to manufacturers when a reuse project has possession of a device and when a device has been involved in an injury or death.

Discussion: We agree that these types of reports may be beneficial. However, if each project funded under Priority 1 works separately with manufacturers to provide that information, reporting will not be standardized or reliable.

Change: OSERS added section (a)(v) to Priority 2 to require the Center to explore the necessity, feasibility, and development of reporting to AT manufacturers by Priority 1 grantees.

Comments: One commenter recommended that one data collection system be formed by RSA, the Center funded under Priority 2, and the grantees, rather than having each grantee form its own system. An additional commenter recommended that grantees under Priority 1 use common measurement standards that are developed by the Center under Priority 2.

Discussion: OSERS agrees that a unified system of measuring and collecting data should be developed, which was intended by the NPP.

Change: OSERS replaced section (d) in Priority 1 and section 1(g) in Priority 2 with a new section (b)(i) of Priority 1

and section (b)(v) of Priority 2 to clarify that RSA, the Center in Priority 2, and projects funded under Priority 1 will work together to develop a unified system of measuring and collecting data and to identify appropriate outcome measures and methods of collecting data.

Comments: Four commenters recommended that the data collection requirements for Priority 1 be the same as the data collection requirements for device reutilization programs under the AT Act. An additional three commenters wanted to require that Priority 1 projects identify and collect data to measure clinical outcomes of individuals served by device reutilization programs.

Discussion: OSERS believes that developing appropriate data collection requirements and identifying outcomes is important. OSERS agrees that data reported by projects funded under Priority 1, at a minimum, should meet the data collection requirements for device reutilization under the AT Act. However, restricting the data collection requirements solely to the requirements under the AT Act would limit the data collection before the full data needs of projects funded under Priority 1 have been explored. Additionally, while OSERS agrees that measuring outcomes, including clinical outcomes, of those served by reutilization programs may be important, outcome measurement will be inconsistent if grantees under Priority 1 separately develop methods of outcome measurement.

Change: OSERS eliminated specific data collection requirements by deleting sections (e) through (g) of Priority 1. Instead, OSERS added sections (b)(i) and (b)(ii) to Priority 1 and sections (b)(v) and (b)(vi) to Priority 2 to require that the Center funded under Priority 2 and projects funded under Priority 1 work together with RSA to develop a data collection system, including identifying appropriate outcomes and outcome measures.

Priority 2— National AT Device Reutilization Coordination and Technical Assistance Center

Priority 2—Eligibility and Collaboration with Stakeholders

Comments: Three commenters wanted to require entities that apply under Priority 2 to have direct experience reutilizing devices in order to be eligible.

Discussion: While OSERS agrees that the expertise from those with direct experience reutilizing devices is important, eligibility requirements are established in section 303(b)(2)(A) of the Rehabilitation Act of 1973, as amended, and 34 CFR 373.2.

Change: None.

Comments: Four commenters recommended that under Priority 2 the grantee be required to create an advisory and oversight committee comprised of stakeholders. An additional three commenters wanted to limit eligibility under Priority 2 to applicants who constitute a collaborative of entities that are stakeholders in reutilization of AT.

Discussion: OSERS agrees that the Center funded under Priority 2 should work with a variety of stakeholders. However, while the eligibility requirements established in 34 CFR 373.2 allow applications by consortia, OSERS does not believe it is appropriate to restrict applications to consortia of stakeholders. In addition, while OSERS believes that the Center should be required to collaborate with stakeholders, effective collaboration with stakeholders can be achieved in many ways. Therefore, OSERS does not believe that it is necessary to require the Center to have an advisory committee. The grantee should have discretion as to the method by which it collaborates and with whom it collaborates.

Changes: OSERS replaced sections 2(c) and 2(e) of Priority 2 with new sections (a) and (c)(v) of Priority 2 to clarify that collaboration with stakeholders is a requirement of the Center funded under Priority 2.

Priority 2—Scope of Work

Comments: Two commenters recommended that the Center be used to identify regulatory issues and ensure compliance.

Discussion: OSERS agrees that the identification and dissemination of State and Federal requirements governing device reutilization is important and that this should be a key responsibility of the Center funded under Priority 2. However, while a Center can disseminate and provide technical assistance about requirements, it cannot enforce these requirements.

Change: OSERS replaced section 1(a) of Priority 2 with a new section (b), which includes (b)(iii) requiring the Center to disseminate information and provide technical assistance on compliance with State and Federal requirements regarding AT device utilization.

Comment: One commenter suggested funding Priority 2 prior to funding Priority 1 to identify regulatory issues and standards of practice prior to the operation of model demonstrations under Priority 1.

Discussion: There are many device reutilization projects already in existence, and there are many instances in which developing or expanding reutilization represents an immediate need for States. Further, OSERS believes that the projects funded under Priority 1 must be able to provide input into the development of any standards of practice. Therefore, it would not be appropriate to delay the funding of projects under Priority 1.

Change: None.

Comment: None.

Discussion: OSERS believes that reutilization of AT devices can be an important part of a national strategy to respond to the needs of individuals with disabilities involved in natural disasters. The Center funded under Priority 2 and the projects funded under Priority 1 present an opportunity to develop a coordinated effort to collect and distribute reutilized AT devices following a natural disaster.

Change: OSERS added section (c)(vi) to Priority 2 requiring the Center to develop a plan for device reutilization to meet the AT needs of individuals with disabilities who are affected by natural disasters.

Note: This notice does not solicit applications. In any year in which we choose to use one or more of these priorities, we invite applications through a notice in the **Federal Register**. When inviting applications we designate each priority as absolute, competitive preference, or invitational. The effect of each type of priority follows:

Absolute priority: Under an absolute priority we consider only applications that meet the priority (34 CFR 75.105(c)(3)).

Competitive preference priority: Under a competitive preference priority we give competitive preference to an application by either (1) awarding additional points, depending on how well or the extent to which the application meets the competitive priority (34 CFR 75.105(c)(2)(i)); or (2) selecting an application that meets the competitive priority over an application of comparable merit that does not meet the priority (34 CFR 75.105(c)(2)(ii)).

Invitational priority: Under an invitational priority we are particularly interested in applications that meet the invitational priority. However, we do not give an application that meets the invitational priority a competitive or absolute preference over other applications (34 CFR 75.105(c)(1)).

Priorities

Priority 1—Model Demonstrations for AT Device Reutilization

This priority supports projects that propose model demonstrations to establish or expand AT device

reutilization to serve consumers in a State or group of States. Projects funded under this priority must—

(a) Establish a new AT device reutilization project, expand an existing AT device reutilization project, or coordinate a partnership of AT device reutilization projects in a State or group of States, that—

(i) Meets the AT needs of individuals with disabilities without regard to type of disability;

(ii) Is designed to sustain itself through its own activities beyond the project period of the grant;

(iii) Coordinates and collaborates directly with, and supplements but does not supplant, reutilization activities in that State or group of States funded under section 4 of the Assistive Technology Act of 1998, as amended; and

(iv) Coordinates and collaborates with providers of AT devices and AT services in the State or group of States and other relevant entities as appropriate, including the National AT Device Reutilization Coordination and Technical Assistance Center (Center) funded by the Department, as well as State agencies that fund AT, alternative financing programs, vendors and manufacturers of AT, and other relevant entities and organizations; and

(b) Participate in data collection by—

(i) Working with RSA and the Center to develop a unified data collection system, including identifying appropriate outcomes and outcome measures; and

(ii) Collecting and reporting data on activities and outcomes as determined by RSA.

Priority 2—National AT Device Reutilization Coordination and Technical Assistance Center

This priority supports a National AT Device Reutilization Coordination and Technical Assistance Center that will address issues of national significance in AT device reutilization; provide technical assistance to AT device reutilization projects funded by the Department under the Model Demonstrations for AT Device Reutilization priority (Model Demonstrations Projects) and from other sources; and coordinate and network AT device reutilization projects funded both under the Model Demonstrations Projects and from other sources.

(a) To address issues of national significance in AT device reutilization, the Center funded under this priority must collaborate with public and private AT stakeholders (including providers of AT devices, AT services, and funding for AT at the State and Federal level; vendors and manufacturers of AT; and other relevant entities and organizations) to—

(i) Identify national issues that affect AT device reutilization;

(ii) Investigate the national scope, trends, best practices, and impact of AT device reutilization;

(iii) Identify Federal and State policies that affect AT device reutilization;

(iv) Explore the need for and feasibility of developing standards of practice for AT device reutilization nationally;

(v) Explore the necessity, feasibility, and development of reporting information to AT manufacturers; and

(vi) Address issues on the national level, such as building relationships among AT device vendors and manufacturers and projects funded under Model Demonstration Projects and working on liability and reimbursement issues.

(b) To provide technical assistance to reutilization projects funded both under Model Demonstrations Projects and from other sources, the Center funded under this priority must—

(i) Assist AT device reutilization projects with establishment, expansion, improvement, and sustainability by disseminating information about best practices and successful models for AT device reutilization;

(ii) Conduct follow-up activities that are designed to enable AT device reutilization programs to continue beyond the three years of Federal funding;

(iii) Disseminate information on Federal and State policies that affect AT device reutilization and how projects should ensure compliance with these policies;

(iv) Disseminate information on standards of practice in AT device reutilization, if applicable;

(v) Work with projects funded under Model Demonstrations Projects, stakeholders, and RSA to identify appropriate outcome measures and methods of collecting data; and

(vi) Work with RSA and grantees under Model Demonstrations Projects to develop a unified data collection system for use by these grantees.

(c) To coordinate and network reutilization projects funded under Model Demonstrations Projects and from other sources, the Center must—

(i) Establish a national network of statewide AT device reutilization systems funded under Model Demonstration Projects and supported by other entities;

(ii) Facilitate information and resource exchange among grantees;

(iii) Encourage interstate activities among grantees;

(iv) Nationally market and promote AT device reutilization to individuals with disabilities and other stakeholders;

(v) Collaborate with relevant national organizations and national networks; and

(vi) Develop a plan for how AT device reutilization projects can meet the AT needs of individuals with disabilities who are affected by natural disasters.

Executive Order 12866

This notice of final priorities has been reviewed in accordance with Executive Order 12866. Under the terms of the order, we have assessed the potential costs and benefits of this regulatory action.

The potential costs associated with the notice of final priorities are those resulting from statutory requirements and those we have determined as necessary for administering this program effectively and efficiently.

In assessing the potential costs and benefits—both quantitative and qualitative—of this notice of final priorities, we have determined that the benefits of the final priorities justify the costs.

We have also determined that this regulatory action does not unduly interfere with State, local, and tribal governments in the exercise of their governmental functions.

Summary of Potential Costs and Benefits

The potential costs associated with these final priorities are minimal, while the benefits are significant. Grantees will increase the number of individuals with disabilities who obtain the AT they need. Grantees may anticipate costs associated with completing the application process in terms of staff time, copying, and mailing or delivery. The use of electronic application technology reduces mailing and copying costs significantly.

Intergovernmental Review

This program is subject to Executive Order 12372 and the regulations in 34 CFR part 79. One of the objectives of the Executive order is to foster an intergovernmental partnership and a strengthened federalism. The Executive order relies on processes developed by State and local governments for coordination and review of proposed Federal financial assistance.

This document provides early notification of our specific plans and actions for this program.

Applicable Program Regulations: 34 CFR part 373.

Electronic Access to This Document

You may view this document, as well as all other Department of Education documents published in the **Federal Register**, in text or Adobe Portable Document Format (PDF) on the Internet at the following site: *www.ed.gov/news/fedregister.*

To use PDF you must have Adobe Acrobat Reader, which is available free at this site. If you have questions about using PDF, call the U.S. Government Printing Office (GPO), toll free, at 1–888–293–6498; or in the Washington, DC, area at (202) 512–1530.

Note: The official version of this document is the document published in the **Federal Register**. Free Internet access to the official edition of the **Federal Register** and the Code of Federal Regulations is available on GPO Access at: *http://www.gpoaccess.gov/nara/index.html.*

Catalog of Federal Domestic Assistance Number 84.235V Special Demonstration Programs)

Program Authority: 29 U.S.C. 773(b).

Dated: August 16, 2006.

John H. Hager,

Assistant Secretary for Special Education and Rehabilitative Services.

[FR Doc. 06–7030 Filed 8–17–06; 8:45 am]

BILLING CODE 4000–01–P

DEPARTMENT OF EDUCATION

Office of Special Education and Rehabilitative Services; Overview Information; Special Demonstration Programs—Model Demonstrations for Assistive Technology (AT) Device Reutilization; Notice Inviting Applications for New Awards for Fiscal Year (FY) 2006

Catalog of Federal Domestic Assistance (CFDA) Number: 84.235V–1.

Dates: Applications Available: August 18, 2006.

Deadline for Transmittal of Applications: September 18, 2006.

Eligible Applicants: The following types of organizations are eligible for assistance under this program:

(1) State vocational rehabilitation agencies.

(2) Community rehabilitation programs.

(3) Indian tribes or tribal organizations.

(4) Other public or nonprofit agencies or organizations, including institutions of higher education.

(5) For-profit organizations.

(6) Consortia that meet the requirements of 34 CFR 75.128 and 75.129.

Estimated Available Funds: $2,000,000.

Estimated Range of Awards: $100,000–$200,000.

Estimated Average Size of Awards: $150,000.

Estimated Number of Awards: 10.

Note: The Department is not bound by any estimates in this notice.

Project Period: Up to 36 months.

Full Text of Announcement

I. Funding Opportunity Description

Purpose of Program: The purpose of the Special Demonstration Programs is to provide financial assistance to eligible entities to expand and improve the provision of rehabilitation and other services for individuals with disabilities.

Priority: This priority is from the notice of final priorities for this program, published elsewhere in this issue of the **Federal Register**.

Absolute Priority: For FY 2006 this priority is an absolute priority. Under 34 CFR 75.105(c)(3) we consider only applications that meet this priority. This priority is:

Model Demonstrations for AT Device Reutilization

Program Authority: 29 U.S.C. 773(b).

Applicable Regulations: (a) The Education Department General Administrative Regulations (EDGAR) in 34 CFR parts 74, 75, 77, 79, 80, 81, 82, 84, 85, 86, 97, 98, and 99. (b) The regulations for this program in 34 CFR part 373. (c) The notice of final priorities, published elsewhere in this issue of the **Federal Register**.

Note: The regulations in 34 CFR part 79 apply to all applicants except federally recognized Indian tribes.

Note: The regulations in 34 CFR part 86 apply to institutions of higher education only.

II. Award Information

Type of Award: Discretionary grants.

Estimated Available Funds: $2,000,000.

Estimated Range of Awards: $100,000–$200,000.

Estimated Average Size of Awards: $150,000.

Estimated Number of Awards: 10.

Note: The Department is not bound by any estimates in this notice.

Project Period: Up to 36 months.

III. Eligibility Information

1. *Eligible Applicants:* The following types of organizations are eligible for assistance under this program:

(1) State vocational rehabilitation agencies.

(2) Community rehabilitation programs.

(3) Indian tribes or tribal organizations.

(4) Other public or nonprofit agencies or organizations, including institutions of higher education.

(5) For-profit organizations.

(6) Consortia that meet the requirements of 34 CFR 75.128 and 75.129.

2. *Cost Sharing or Matching:* This program does not involve cost sharing or matching.

IV. Application and Submission Information

1. *Address To Request Application Package:* Education Publications Center (ED Pubs), P.O. Box 1398, Jessup, MD 20794–1398. Telephone (toll free): 1–877–433–7827. Fax: (301) 470–1244. If you use a telecommunications device for the deaf (TDD), you may call (toll free): 1–877–576–7734.

You may also contact ED Pubs at its Web site: *www.ed.gov/pubs/edpubs.html* or you may contact ED Pubs at its e-mail address: *edpubs@inet.ed.gov.*

If you request an application from ED Pubs, be sure to identify this competition as follows: CFDA number 84.235V–1.

Individuals with disabilities may obtain a copy of the application package in an alternative format (*e.g.*, Braille, large print, audiotape, or computer diskette) by contacting the Grants and Contracts Services Team, U.S. Department of Education, 400 Maryland Avenue, SW., room 5075, Potomac Center Plaza, Washington, DC 20202–2550. Telephone: (202) 245–7363. If you use a telecommunications device for the deaf (TDD), you may call the Federal Relay Service (FRS) at 1–800–877–8339.

2. *Content and Form of Application Submission:* Requirements concerning the content of an application, together with the forms you must submit, are in the application package for this competition. Page Limit: The application narrative (Part III of the application) is where you, the applicant, address the selection criteria that reviewers use to evaluate your application. You must limit Part III to the equivalent of no more than 50 pages, using the following standards:

- A "page" is 8.5″ x 11″, on one side only, with 1″ margins at the top, bottom, and both sides.
- Double space (no more than three lines per vertical inch) all text in the application narrative, including titles, headings, footnotes, quotations, references, and captions, as well as all

text in charts, tables, figures, and graphs.

• Use a font that is either 12 point or larger or no smaller than 10 pitch (characters per inch).

The page limit does not apply to Part I, the cover sheet; Part II, the budget section, including the narrative budget justification; Part IV, the assurances and certifications; or the one-page abstract, the resumes, the bibliography, or the letters of support. However, you must include all of the application narrative in Part III.

Our reviewers will not read any pages of your application that—

• Exceed the page limit if you apply these standards; or

• Exceed the equivalent of the page limit if you apply other standards.

3. *Submission Dates and Times: Applications Available:* August 18, 2006.

Deadline for Transmittal of Applications: September 18, 2006.

Applications for grants under this competition must be submitted electronically using the Grants.gov Apply site (Grants.gov). For information (including dates and times) about how to submit your application electronically or by mail or hand delivery if you qualify for an exception to the electronic submission requirement, please refer to section IV.6. *Other Submission Requirements* in this notice.

We do not consider an application that does not comply with the deadline requirements.

4. *Intergovernmental Review:* This competition is subject to Executive Order 12372 and the regulations in 34 CFR part 79. However, in order to ensure that these FY 2006 grants are made before September 30, 2006, the 60-day intergovernmental review period has been waived.

5. *Funding Restrictions:* We reference regulations outlining funding restrictions in the *Applicable Regulations* section of this notice.

6. *Other Submission Requirements:* Applications for grants under this competition must be submitted electronically unless you qualify for an exception to this requirement in accordance with the instructions in this section.

a. Electronic Submission of Applications. Applications for grants under the Special Demonstration Programs—Model Demonstrations for AT Device Reutilization—CFDA Number 84.235V–1 must be submitted electronically using the Grants.gov Apply site at: *http://www.grants.gov.* Through this site, you will be able to download a copy of the application package, complete it offline, and then upload and submit your application. You may not e-mail an electronic copy of a grant application to us.

We will reject your application if you submit it in paper format unless, as described elsewhere in this section, you qualify for one of the exceptions to the electronic submission requirement *and* submit, no later than two weeks before the application deadline date, a written statement to the Department that you qualify for one of these exceptions. Further information regarding calculation of the date that is two weeks before the application deadline date is provided later in this section under *Exception to Electronic Submission Requirement.*

You may access the electronic grant application for Special Demonstration Programs—Model Demonstrations for AT Device Reutilization at: *http://www.grants.gov.* You must search for the downloadable application package for this program by the CFDA number. Do not include the CFDA number's alpha suffix in your search.

Please note the following:

• When you enter the Grants.gov site, you will find information about submitting an application electronically through the site, as well as the hours of operation.

• Applications received by Grants.gov are time and date stamped. Your application must be fully uploaded and submitted, and must be date/time stamped by the Grants.gov system no later than 4:30 p.m., Washington, DC time, on the application deadline date. Except as otherwise noted in this section, we will not consider your application if it is date/time stamped by the Grants.gov system later than 4:30 p.m., Washington, DC time, on the application deadline date. When we retrieve your application from Grants.gov, we will notify you if we are rejecting your application because it was date/time stamped by the Grants.gov system after 4:30 p.m., Washington, DC time, on the application deadline date.

• The amount of time it can take to upload an application will vary depending on a variety of factors including the size of the application and the speed of your Internet connection. Therefore, we strongly recommend that you do not wait until the application deadline date to begin the submission process through Grants.gov.

• You should review and follow the Education Submission Procedures for submitting an application through Grants.gov that are included in the application package for this competition to ensure that you submit your application in a timely manner to the Grants.gov system. You can also find the Education Submission Procedures pertaining to Grants.gov at *http://e-Grants.ed.gov/help/GrantsgovSubmissionProcedures.pdf.*

• To submit your application via Grants.gov, you must complete all of the steps in the Grants.gov registration process (see *http://www.grants.gov/applicants/get_registered.jsp*). These steps include (1) registering your organization, (2) registering yourself as an Authorized Organization Representative (AOR), and (3) getting authorized as an AOR by your organization. Details on these steps are outlined in the Grants.gov 3-Step Registration Guide (see *http://www.grants.gov/section910/Grants.govRegistrationBrochure.pdf*). You also must provide on your application the same D–U–N–S Number used with this registration. Please note that the registration process may take five or more business days to complete, and you must have completed all registration steps to allow you to submit successfully an application via Grants.gov.

• You will not receive additional point value because you submit your application in electronic format, nor will we penalize you if you qualify for an exception to the electronic submission requirement, as described elsewhere in this section, and submit your application in paper format.

• You must submit all documents electronically, including all information typically included on the following forms: Application for Federal Assistance (SF 424), the Department of Education Supplemental Information for SF 424, Budget Information—Non-Construction Programs (ED 524), and all necessary assurances and certifications. Please note that two of these forms—the SF 424 and the Department of Education Supplemental Information for SF 424—have replaced the ED 424 (Application for Federal Education Assistance). You must attach any narrative sections of your application as files in a .DOC (document), .RTF (rich text), or .PDF (Portable Document) format. If you upload a file type other than the three file types specified above or submit a password protected file, we will not review that material.

• Your electronic application must comply with any page limit requirements described in this notice.

• After you electronically submit your application, you will receive an automatic acknowledgment from Grants.gov that contains a Grants.gov tracking number. The Department will retrieve your application from

Grants.gov and send you a second confirmation by e-mail that will include a PR/Award number (an ED-specified identifying number unique to your application).

- We may request that you provide us original signatures on forms at a later date.

Application Deadline Date Extension in Case of Technical Issues with the Grants.gov System: If you are prevented from electronically submitting your application on the application deadline date because of technical problems with the Grants.gov system, we will grant you an extension until 4:30 p.m., Washington, DC time, the following business day to enable you to transmit your application electronically, or by hand delivery. You also may mail your application by following the mailing instructions as described elsewhere in this notice. If you submit an application after 4:30 p.m., Washington, DC time, on the deadline date, please contact the person listed elsewhere in this notice under **FOR FURTHER INFORMATION CONTACT**, and provide an explanation of the technical problem you experienced with Grants.gov, along with the Grants.gov Support Desk Case Number (if available). We will accept your application if we can confirm that a technical problem occurred with the Grants.gov system and that that problem affected your ability to submit your application by 4:30 p.m., Washington, DC time, on the application deadline date. The Department will contact you after a determination is made on whether your application will be accepted.

Note: Extensions referred to in this section apply only to the unavailability of or technical problems with the Grants.gov system. We will not grant you an extension if you failed to fully register to submit your application to Grants.gov before the deadline date and time or if the technical problem you experienced is unrelated to the Grants.gov system.

Exception to Electronic Submission Requirement: You qualify for an exception to the electronic submission requirement, and may submit your application in paper format, if you are unable to submit an application through the Grants.gov system because—

- You do not have access to the Internet; or
- You do not have the capacity to upload large documents to the Grants.gov system; and
- No later than two weeks before the application deadline date (14 calendar days or, if the fourteenth calendar day before the application deadline date falls on a Federal holiday, the next business day following the Federal holiday), you mail or fax a written statement to the Department, explaining which of the two grounds for an exception prevent you from using the Internet to submit your application. If you mail your written statement to the Department, it must be postmarked no later than two weeks before the application deadline date. If you fax your written statement to the Department, we must receive the faxed statement no later than two weeks before the application deadline date.

Address and mail or fax your statement to: Jeremy Buzzell, U.S. Department of Education, 400 Maryland Avenue, SW., room 5025, Potomac Center Plaza, Washington, DC 20202–2800. FAX: (202) 245–7591.

Your paper application must be submitted in accordance with the mail or hand delivery instructions described in this notice.

b. *Submission of Paper Applications by Mail.* If you qualify for an exception to the electronic submission requirement, you may mail (through the U.S. Postal Service or a commercial carrier) your application to the Department. You must mail the original and two copies of your application, on or before the application deadline date, to the Department at the applicable following address:

By mail through the U.S. Postal Service: U.S. Department of Education, Application Control Center, Attention: (CFDA Number 84.235V–1), 400 Maryland Avenue, SW., Washington, DC 20202–4260; or

By mail through a commercial carrier: U.S. Department of Education, Application Control Center—Stop 4260, Attention: (CFDA Number 84.235V–1), 7100 Old Landover Road, Landover, MD 20785–1506.

Regardless of which address you use, you must show proof of mailing consisting of one of the following:

(1) A legibly dated U.S. Postal Service postmark,

(2) A legible mail receipt with the date of mailing stamped by the U.S. Postal Service,

(3) A dated shipping label, invoice, or receipt from a commercial carrier, or

(4) Any other proof of mailing acceptable to the Secretary of the U.S. Department of Education.

If you mail your application through the U.S. Postal Service, we do not accept either of the following as proof of mailing:

(1) A private metered postmark, or

(2) A mail receipt that is not dated by the U.S. Postal Service.

If your application is postmarked after the application deadline date, we will not consider your application.

Note: The U.S. Postal Service does not uniformly provide a dated postmark. Before relying on this method, you should check with your local post office.

c. *Submission of Paper Applications by Hand Delivery.* If you qualify for an exception to the electronic submission requirement, you (or a courier service) may deliver your paper application to the Department by hand. You must deliver the original and two copies of your application, by hand, on or before the application deadline date, to the Department at the following address: U.S. Department of Education, Application Control Center, Attention: (CFDA Number 84.235V–1), 550 12th Street, SW., Room 7041, Potomac Center Plaza, Washington, DC 20202–4260. The Application Control Center accepts hand deliveries daily between 8:00 a.m. and 4:30 p.m., Washington, DC time, except Saturdays, Sundays, and Federal holidays.

Note for Mail or Hand Delivery of Paper Applications: If you mail or hand deliver your application to the Department:

(1) You must indicate on the envelope and " if not provided by the Department " in the appropriate place on the SF 424 the CFDA number " and suffix letter, if any " of the competition under which you are submitting your application.

(2) The Application Control Center will mail a grant application receipt acknowledgment to you. If you do not receive the grant application receipt acknowledgment within 15 business days from the application deadline date, you should call the U.S. Department of Education Application Control Center at (202) 245–6288.

V. Application Review Information

Selection Criteria: The selection criteria for this competition are from 34 CFR 75.210 and are in the application package.

VI. Award Administration Information

1. *Award Notices:* If your application is successful, we notify your U.S. Representative and U.S. Senators and send you a Grant Award Notification (GAN). We may also notify you informally.

If your application is not evaluated or not selected for funding, we notify you.

2. *Administrative and National Policy Requirements:* We identify administrative and national policy requirements in the application package and reference these and other requirements in the *Applicable Regulations* section of this notice.

We reference the regulations outlining the terms and conditions of an award in the *Applicable Regulations* section of this notice and include these and other specific conditions in the GAN. The GAN also incorporates your approved application as part of your binding commitments under the grant.

3. *Reporting:* At the end of your project period, you must submit a final performance report, including financial information, as directed by the Secretary. If you receive a multi-year award, you must submit an annual performance report that provides the most current performance and financial expenditure information as specified by the Secretary in 34 CFR 75.118.

4. *Performance Measures:* The Government Performance and Results Act of 1993 (GPRA) directs Federal departments and agencies to improve the effectiveness of their programs by engaging in strategic planning, setting outcome-related goals for programs, and measuring program results against those goals. Given that little is known about appropriate outcomes of device reutilization, performance measures will be developed and implemented with the input of grantees and stakeholders during the grant period. Once developed, OSERS will require all grantees to use the same measures.

VII. Agency Contact

For Further Information Contact: Jeremy Buzzell, U.S. Department of Education, 400 Maryland Avenue, SW., room 5025, Potomac Center Plaza, Washington, DC 20202–2800. Telephone: (202) 245–7319 or by e-mail: *jeremy.buzzell@ed.gov*.

If you use a telecommunications device for the deaf (TDD), you may call the Federal Relay Service (FRS) at 1–800–877–8339.

Individuals with disabilities may obtain this document in an alternative format (*e.g.*, Braille, large print, audiotape, or computer diskette) on request to the program contact person listed in this section.

VIII. Other Information

Electronic Access to This Document: You may view this document, as well as all other documents of this Department published in the **Federal Register**, in text or Adobe Portable Document Format (PDF) on the Internet at the following site: *www.ed.gov/news/fedregister*.

To use PDF you must have Adobe Acrobat Reader, which is available free at this site. If you have questions about using PDF, call the U.S. Government Printing Office (GPO), toll free, at 1–888–293–6498; or in the Washington, DC, area at (202) 512–1530.

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Dated: August 16, 2006.

John H. Hager,

Assistant Secretary for Special Education and Rehabilitative Services.

[FR Doc. 06–7031 Filed 8–17–06; 8:45 am]

BILLING CODE 4000–01–P

DEPARTMENT OF EDUCATION

Office of Special Education and Rehabilitative Services; Overview Information; Special Demonstration Programs—National Assistive Technology (AT) Device Reutilization Coordination and Technical Assistance Center; Notice Inviting Applications for New Awards for Fiscal Year (FY) 2006

Catalog of Federal Domestic Assistance (CFDA) Number: 84.235V–2.

Dates: Applications Available: August 18, 2006.

Deadline for Transmittal of Applications: September 18, 2006.

Eligible Applicants: The following types of organizations are eligible for assistance under this program:

(1) State vocational rehabilitation agencies.

(2) Community rehabilitation programs.

(3) Indian tribes or tribal organizations.

(4) Other public or nonprofit agencies or organizations, including institutions of higher education.

(5) For-profit organizations.

(6) Consortia that meet the requirements of 34 CFR 75.128 and 75.129.

Estimated Available Funds: $258,000.

Estimated Number of Awards: 1.

Note: The Department is not bound by any estimates in this notice.

Project Period: Up to 60 months.

Full Text of Announcement

I. Funding Opportunity Description

Purpose of Program: The purpose of the Special Demonstration Programs is to provide financial assistance to eligible entities to expand and improve the provision of rehabilitation and other services for individuals with disabilities.

Priority: This priority is from the notice of final priorities for this program, published elsewhere in this issue of the **Federal Register**.

Absolute Priority: For FY 2006 this priority is an absolute priority. Under 34 CFR 75.105(c)(3) we consider only applications that meet this priority.

This priority is:

National Assistive Technology (AT) Device Reutilization Coordination and Technical Assistance Center

Program Authority: 29 U.S.C. 773(b).

Applicable Regulations: (a) The Education Department General Administrative Regulations (EDGAR) in 34 CFR parts 74, 75, 77, 79, 80, 81, 82, 84, 85, 86, 97, 98, and 99. (b) The regulations for this program in 34 CFR part 373. (c) The notice of final priorities, published elsewhere in this issue of the **Federal Register.**

Note: The regulations in 34 CFR part 79 apply to all applicants except federally recognized Indian tribes.

Note: The regulations in 34 CFR part 86 apply to institutions of higher education only.

II. Award Information

Type of Award: Cooperative agreement.

Estimated Available Funds: $258,000.

Estimated Number of Awards: 1.

Note: The Department is not bound by any estimates in this notice.

Project Period: Up to 60 months.

III. Eligibility Information

1. *Eligible Applicants:* The following types of organizations are eligible for assistance under this program:

(1) State vocational rehabilitation agencies.

(2) Community rehabilitation programs.

(3) Indian tribes or tribal organizations.

(4) Other public or nonprofit agencies or organizations, including institutions of higher education.

(5) For-profit organizations.

(6) Consortia that meet the requirements of 34 CFR 75.128 and 75.129.

2. *Cost Sharing or Matching:* This program does not involve cost sharing or matching.

IV. Application and Submission Information

1. *Address to Request Application Package:* Education Publications Center (ED Pubs), P.O. Box 1398, Jessup, MD 20794–1398. Telephone (toll free): 1–877–433–7827. FAX: (301) 470–1244. If you use a telecommunications device

for the deaf (TDD), you may call (toll free): 1–877–576–7734.

You may also contact ED Pubs at its Web site: www.ed.gov/pubs/edpubs.html or you may contact ED Pubs at its e-mail address: edpubs@inet.ed.gov

If you request an application from ED Pubs, be sure to identify this competition as follows: CFDA number 84.235V–2.

Individuals with disabilities may obtain a copy of the application package in an alternative format (e.g., Braille, large print, audiotape, or computer diskette) by contacting the Grants and Contracts Services Team, U.S. Department of Education, 400 Maryland Avenue, SW., room 5075, Potomac Center Plaza, Washington, DC, 20202–2550. Telephone: (202) 245–7363. If you use a telecommunications device for the deaf (TDD), you may call the Federal Relay Service (FRS) at 1–800–877–8339.

2. *Content and Form of Application Submission:* Requirements concerning the content of an application, together with the forms you must submit, are in the application package for this competition. Page Limit: The application narrative (Part III of the application) is where you, the applicant, address the selection criteria that reviewers use to evaluate your application. You must limit Part III to the equivalent of no more than 60 pages, using the following standards:

- A "page" is 8.5″ x 11″, on one side only, with 1″ margins at the top, bottom, and both sides.
- Double space (no more than three lines per vertical inch) all text in the application narrative, including titles, headings, footnotes, quotations, references, and captions, as well as all text in charts, tables, figures, and graphs.
- Use a font that is either 12 point or larger or no smaller than 10 pitch (characters per inch).

The page limit does not apply to Part I, the cover sheet; Part II, the budget section, including the narrative budget justification; Part IV, the assurances and certifications; or the one-page abstract, the resumes, the bibliography, or the letters of support. However, you must include all of the application narrative in Part III.

Our reviewers will not read any pages of your application that—

- Exceed the page limit if you apply these standards; or
- Exceed the equivalent of the page limit if you apply other standards.

3. *Submission Dates and Times: Applications Available:* August 18, 2006.

Deadline for Transmittal of Applications: September 18, 2006.

Applications for grants under this competition must be submitted electronically using the Grants.gov Apply site (Grants.gov). For information (including dates and times) about how to submit your application electronically or by mail or hand delivery if you qualify for an exception to the electronic submission requirement, please refer to section IV. 6. *Other Submission Requirements* in this notice.

We do not consider an application that does not comply with the deadline requirements.

4. *Intergovernmental Review:* This competition is subject to Executive Order 12372 and the regulations in 34 CFR part 79. However, in order to ensure that these FY 2006 grants are made before September 30, 2006, the 60-day intergovernmental review period has been waived.

5. *Funding Restrictions:* We reference regulations outlining funding restrictions in the *Applicable Regulations* section of this notice.

6. *Other Submission Requirements:* Applications for grants under this competition must be submitted electronically unless you qualify for an exception to this requirement in accordance with the instructions in this section.

a. *Electronic Submission of Applications.* Applications for grants under the Special Demonstration Programs—National AT Device Reutilization Coordination and Technical Assistance Center-CFDA Number 84.235V–2 must be submitted electronically using the Grants.gov Apply site at: *http://www.grants.gov.* Through this site, you will be able to download a copy of the application package, complete it offline, and then upload and submit your application. You may not e-mail an electronic copy of a grant application to us.

We will reject your application if you submit it in paper format unless, as described elsewhere in this section, you qualify for one of the exceptions to the electronic submission requirement and submit, no later than two weeks before the application deadline date, a written statement to the Department that you qualify for one of these exceptions. Further information regarding calculation of the date that is two weeks before the application deadline date is provided later in this section under *Exception to Electronic Submission Requirement.*

You may access the electronic grant application for the Special Demonstration Programs—National AT Device Reutilization Coordination and Technical Assistance Center at: *http://www.grants.gov.* You must search for the downloadable application package for this program by the CFDA number. Do not include the CFDA number's alpha suffix in your search.

Please note the following:

- When you enter the Grants.gov site, you will find information about submitting an application electronically through the site, as well as the hours of operation.
- Applications received by Grants.gov are time and date stamped. Your application must be fully uploaded and submitted, and must be date/time stamped by the Grants.gov system no later than 4:30 p.m., Washington, DC time, on the application deadline date. Except as otherwise noted in this section, we will not consider your application if it is date/time stamped by the Grants.gov system later than 4:30 p.m., Washington, DC time, on the application deadline date. When we retrieve your application from Grants.gov, we will notify you if we are rejecting your application because it was date/time stamped by the Grants.gov system after 4:30 p.m., Washington, DC time, on the application deadline date.
- The amount of time it can take to upload an application will vary depending on a variety of factors including the size of the application and the speed of your Internet connection. Therefore, we strongly recommend that you do not wait until the application deadline date to begin the submission process through Grants.gov.
- You should review and follow the Education Submission Procedures for submitting an application through Grants.gov that are included in the application package for this competition to ensure that you submit your application in a timely manner to the Grants.gov system. You can also find the Education Submission Procedures pertaining to Grants.gov at *http://e-Grants.ed.gov/help/GrantsgovSubmissionProcedures.pdf.*
- To submit your application via Grants.gov, you must complete all of the steps in the Grants.gov registration process (see *http://www.grants.gov/applicants/get_registered.jsp*). These steps include (1) registering your organization, (2) registering yourself as an Authorized Organization Representative (AOR), and (3) getting authorized as an AOR by your organization. Details on these steps are outlined in the Grants.gov 3-Step Registration Guide (see *http://www.grants.gov/section910/*

Grants.govRegistrationBrochure.pdf). You also must provide on your application the same D–U–N–S Number used with this registration. Please note that the registration process may take five or more business days to complete, and you must have completed all registration steps to allow you to submit successfully an application via Grants.gov.

• You will not receive additional point value because you submit your application in electronic format, nor will we penalize you if you qualify for an exception to the electronic submission requirement, as described elsewhere in this section, and submit your application in paper format.

• You must submit all documents electronically, including all information typically included on the following forms: Application for Federal Assistance (SF 424), the Department of Education Supplemental Information for SF 424, Budget Information—Non-Construction Programs (ED 524), and all necessary assurances and certifications. Please note that two of these forms—the SF 424 and the Department of Education Supplemental Information for SF 424—have replaced the ED 424 (Application for Federal Education Assistance). You must attach any narrative sections of your application as files in a .DOC (document), .RTF (rich text), or .PDF (Portable Document) format. If you upload a file type other than the three file types specified above or submit a password protected file, we will not review that material.

• Your electronic application must comply with any page limit requirements described in this notice.

• After you electronically submit your application, you will receive an automatic acknowledgment from Grants.gov that contains a Grants.gov tracking number. The Department will retrieve your application from Grants.gov and send you a second confirmation by e-mail that will include a PR/Award number (an ED-specified identifying number unique to your application).

• We may request that you provide us original signatures on forms at a later date.

Application Deadline Date Extension in Case of Technical Issues with the Grants.gov System: If you are prevented from electronically submitting your application on the application deadline date because of technical problems with the Grants.gov system, we will grant you an extension until 4:30 p.m., Washington, DC time, the following business day to enable you to transmit your application electronically, or by hand delivery. You also may mail your application by following the mailing instructions as described elsewhere in this notice. If you submit an application after 4:30 p.m., Washington, DC time, on the deadline date, please contact the person listed elsewhere in this notice under **FOR FURTHER INFORMATION CONTACT**, and provide an explanation of the technical problem you experienced with Grants.gov, along with the Grants.gov Support Desk Case Number (if available). We will accept your application if we can confirm that a technical problem occurred with the Grants.gov system and that that problem affected your ability to submit your application by 4:30 p.m., Washington, DC time, on the application deadline date. The Department will contact you after a determination is made on whether your application will be accepted.

Note: Extensions referred to in this section apply only to the unavailability of or technical problems with the Grants.gov system. We will not grant you an extension if you failed to fully register to submit your application to Grants.gov before the deadline date and time or if the technical problem you experienced is unrelated to the Grants.gov system.

Exception to Electronic Submission Requirement: You qualify for an exception to the electronic submission requirement, and may submit your application in paper format, if you are unable to submit an application through the Grants.gov system because—

• You do not have access to the Internet; or

• You do not have the capacity to upload large documents to the Grants.gov system; and

• No later than two weeks before the application deadline date (14 calendar days or, if the fourteenth calendar day before the application deadline date falls on a Federal holiday, the next business day following the Federal holiday), you mail or fax a written statement to the Department, explaining which of the two grounds for an exception prevent you from using the Internet to submit your application. If you mail your written statement to the Department, it must be postmarked no later than two weeks before the application deadline date. If you fax your written statement to the Department, we must receive the faxed statement no later than two weeks before the application deadline date.

Address and mail or fax your statement to: Jeremy Buzzell, U.S. Department of Education, 400 Maryland Avenue, SW., room 5025, Potomac Center Plaza, Washington, DC 20202–2800. FAX: (202) 245–7591.

Your paper application must be submitted in accordance with the mail or hand delivery instructions described in this notice.

b. *Submission of Paper Applications by Mail.* If you qualify for an exception to the electronic submission requirement, you may mail (through the U.S. Postal Service or a commercial carrier) your application to the Department. You must mail the original and two copies of your application, on or before the application deadline date, to the Department at the applicable following address:

By mail through the U.S. Postal Service: U.S. Department of Education, Application Control Center, Attention: (CFDA Number 84.235V–2), 400 Maryland Avenue, SW., Washington, DC 20202–4260 or

By mail through a commercial carrier: U.S. Department of Education, Application Control Center—Stop 4260, Attention: (CFDA Number 84.235V–2), 7100 Old Landover Road, Landover, MD 20785–1506.

Regardless of which address you use, you must show proof of mailing consisting of one of the following:

(1) A legibly dated U.S. Postal Service postmark,

(2) A legible mail receipt with the date of mailing stamped by the U.S. Postal Service,

(3) A dated shipping label, invoice, or receipt from a commercial carrier, or

(4) Any other proof of mailing acceptable to the Secretary of the U.S. Department of Education.

If you mail your application through the U.S. Postal Service, we do not accept either of the following as proof of mailing:

(1) A private metered postmark, or

(2) A mail receipt that is not dated by the U.S. Postal Service.

If your application is postmarked after the application deadline date, we will not consider your application.

Note: The U.S. Postal Service does not uniformly provide a dated postmark. Before relying on this method, you should check with your local post office.

c. *Submission of Paper Applications by Hand Delivery.* If you qualify for an exception to the electronic submission requirement, you (or a courier service) may deliver your paper application to the Department by hand. You must deliver the original and two copies of your application, by hand, on or before the application deadline date, to the Department at the following address: U.S. Department of Education, Application Control Center, Attention: (CFDA Number 84.235V–2), 550 12th Street, SW., Room 7041, Potomac Center

Plaza, Washington, DC 20202–4260. The Application Control Center accepts hand deliveries daily between 8 a.m. and 4:30 p.m., Washington, DC time, except Saturdays, Sundays, and Federal holidays.

Note for Mail or Hand Delivery of Paper Applications: If you mail or hand deliver your application to the Department:

(1) You must indicate on the envelope and—if not provided by the Department—in the appropriate place on the SF 424 the CFDA number—and suffix letter, if any—of the competition under which you are submitting your application.

(2) The Application Control Center will mail a grant application receipt acknowledgment to you. If you do not receive the grant application receipt acknowledgment within 15 business days from the application deadline date, you should call the U.S. Department of Education Application Control Center at (202) 245–6288.

V. Application Review Information

Selection Criteria: The selection criteria for this competition are from 34 CFR 75.210 and are in the application package.

VI. Award Administration Information

1. *Award Notices:* If your application is successful, we notify your U.S. Representative and U.S. Senators and send you a Grant Award Notification (GAN). We may also notify you informally.

If your application is not evaluated or not selected for funding, we notify you.

2. *Administrative and National Policy Requirements:* We identify administrative and national policy requirements in the application package and reference these and other requirements in the *Applicable Regulations* section of this notice.

We reference the regulations outlining the terms and conditions of an award in the *Applicable Regulations* section of this notice and include these and other specific conditions in the GAN. The GAN also incorporates your approved application as part of your binding commitments under the grant.

3. *Reporting:* At the end of your project period, you must submit a final performance report, including financial information, as directed by the Secretary. If you receive a multi-year award, you must submit an annual performance report that provides the most current performance and financial expenditure information as specified by the Secretary in 34 CFR 75.118.

4. *Performance Measures:* The Government Performance and Results Act of 1993 (GPRA) directs Federal departments and agencies to improve the effectiveness of their programs by engaging in strategic planning, setting outcome-related goals for programs, and measuring program results against those goals. Given that little is known about appropriate outcomes of device reutilization, performance measures will be developed and implemented with the input of the grantee and stakeholders during the grant period. Once developed, OSERS will require all grantees to use the same measures.

VII. Agency Contact

For Further Information Contact: Jeremy Buzzell, U.S. Department of Education, 400 Maryland Avenue, SW., room 5025, Potomac Center Plaza, Washington, DC 20202–2800. Telephone: (202) 245–7319 or by e-mail: *jeremy.buzzell@ed.gov*.

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VIII. Other Information

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Dated: August 16, 2006.

John H. Hager,

Assistant Secretary for Special Education and Rehabilitative Services.

[FR Doc. 06–7032 Filed 8–17–06; 8:45 am]

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Cherries (sweet) grown in Washington; comments due by 8-18-06; published 6-19-06 [FR E6-09598]

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LIST OF PUBLIC LAWS

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H.R. 3682/P.L. 109–269

To redesignate the Mason Neck National Wildlife Refuge in Virginia as the Elizabeth Hartwell Mason Neck National Wildlife Refuge. (Aug. 12, 2006; 120 Stat. 682)

S. 250/P.L. 109–270

Carl D. Perkins Career and Technical Education Improvement Act of 2006 (Aug. 12, 2006; 120 Stat. 683)

S. 3693/P.L. 109–271

To make technical corrections to the Violence Against Women and Department of Justice Reauthorization Act of 2005. (Aug. 12, 2006; 120 Stat. 750)

H.R. 5683/P.L. 109–272

To preserve the Mt. Soledad Veterans Memorial in San Diego, California, by providing for the immediate acquisition of the memorial by the United States. (Aug. 14, 2006; 120 Stat. 770)

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109th Congress

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