Federal Register

Friday,
January 27, 2006

Part II

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Part 412

Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412

[CMS–1485–P]

RIN 0938–AO06

Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would update the annual payment rates for the Medicare prospective payment system (PPS) for inpatient hospital services provided by long-term care hospitals (LTCHs). The proposed payment amounts and factors used to determine the updated Federal rates that are described in this proposed rule were determined based on the LTCH PPS rate year July 1, 2006 through June 30, 2007. The annual update of the long-term care diagnosis-related group (LTC–DRG) classifications and relative weights remains linked to the annual adjustments of the acute care hospital inpatient diagnosis-related group system, and would continue to be effective each October 1. The proposed outlier threshold for July 1, 2006, through June 30, 2007, would also be derived from the LTCH PPS rate year calculations. We are also proposing to make policy changes and clarifications.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on March 20, 2006.

ADDRESSES: In commenting, please refer to file code CMS–1485–P. 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/*. (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–1485–P, P.O. Box 8012, Baltimore, MD 21244–8012.

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–1485–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–7197 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.

Submission of comments on paperwork requirements. You may submit comments on this document's paperwork requirements by mailing your comments to the addresses provided at the end of the ''Collection of Information Requirements'' section in this document.

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

FOR FURTHER INFORMATION CONTACT:

Tzvi Hefter, (410) 786–4487 (General information).

Judy Richter, (410) 786–2590 (General information, payment adjustments for special cases, and onsite discharges and readmissions, interrupted stays, co-located providers, and short-stay outliers).

Michele Hudson, (410) 786–5490 (Calculation of the payment rates, LTC–DRGs, relative weights and case-mix index, market basket, wage index, budget neutrality, and other payment adjustments).

Ann Fagan, (410) 786–5662 (Patient classification system).

Miechal Lefkowitz, (410) 786–5316 (High-cost outliers and cost-to-charge ratios).

Linda McKenna, (410) 786–4537 (Payment adjustments, interrupted stay, and transition period).

Nancy Kenly, (410) 786–7792 (Federal rate update and case-mix index).

SUPPLEMENTARY INFORMATION:

Submission of Public 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–1485-P] 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. CMS posts all comments received before the close of the comment period on its public website as soon as possible after they are received. Comments received timely will 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.

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Acronyms

Because of the many terms to which we refer by acronym in this proposed rule, we are listing the acronyms used and their corresponding terms in alphabetical order below:

3M 3M Health Information Systems
AHA American Hospital Association
AHIMA American Health Information Management Association
ALOS Average length of stay
APR All patient refined
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)
BLS Bureau of Labor Statistics
CBSA Core-based statistical area
CC Complications and comorbidities
CCR Cost-to-charge ratio
C&M Coordination and maintenance
CMI Case-mix index
CMS Centers for Medicare & Medicaid Services
CMSA Consolidated metropolitan statistical area
COLA Cost of living adjustment
COPS Medicare conditions of participation
CPI Consumer Price Indexes
DSH Disproportionate share of low-income patients
DRGs Diagnosis-related groups
ECI Employment Cost Indexes
FI Fiscal intermediary
FY Federal fiscal year
HCRIS Hospital cost report information system
HHA Home health agency
HHS (Department of) Health and Human Services
HIPAA Health Insurance Portability and Accountability Act (Pub. L. 104–191)
HIPC Health Information Policy Council
HwHs Hospitals Within Hospitals
ICD–9–CM International Classification of Diseases, Ninth Revision, Clinical Modification (codes)
IME Indirect medical education
I–O Input-Output
IPF Inpatient psychiatric facility
IPPS Acute Care Hospital Inpatient Prospective Payment System
IRF Inpatient rehabilitation facility
LOS Length of stay
LTC–DRG Long-term care diagnosis-related group
LTCH Long-term care hospital
MCE Medicare code editor
MDC Major diagnostic categories
MedPAC Medicare Payment Advisory Commission
MedPAR Medicare provider analysis and review file
MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108–173)
MSA Metropolitan statistical area
NCHS National Center for Health Statistics
NECMA New England County metropolitan area
OPM U.S. Office of Personnel Management
O.R. Operating room
OSCAR Online Survey Certification and Reporting (System)
PIP Periodic interim payment
PLI Professional liability insurance
PMSA Primary metropolitan statistical area
PPI Producer Price Indexes
PPS Prospective payment system
QIO Quality Improvement Organization (formerly Peer Review organization (PRO))
RPL Rehabilitation psychiatric long-term care (hospital)
RTI Research Triangle Institute, International
RY Rate year (July 1 through June 30)
SNF Skilled nursing facility
SSO Short-stay outlier
TEFRA Tax Equity and Fiscal Responsibility Act of 1982 (Pub. L. 97–248)
UHDDS Uniform hospital discharge data set

I. Background

[If you choose to comment on issues in this section, please include the caption ''BACKGROUND'' at the beginning of your comments.]

A. Legislative and Regulatory Authority

Section 123 of the Medicare, Medicaid, and SCHIP (State Children's

Health Insurance Program] Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113) as amended by section 307(b) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106–554) provide for payment for both the operating and capital-related costs of hospital inpatient stays in long-term care hospitals (LTCHs) under Medicare Part A based on prospectively set rates. The Medicare prospective payment system (PPS) for LTCHs applies to hospitals described in section 1886(d)(1)(B)(iv) of the Social Security Act (the Act), effective for cost reporting periods beginning on or after October 1, 2002.

Section 1886(d)(1)(B)(iv)(I) of the Act defines a LTCH as ''a hospital which has an average inpatient length of stay (as determined by the Secretary) of greater than 25 days.'' Section 1886(d)(1)(B)(iv)(II) of the Act also provides an alternative definition of LTCHs: specifically, a hospital that first received payment under section 1886(d) of the Act in 1986 and has an average inpatient length of stay (LOS) (as determined by the Secretary of Health and Human Services (the Secretary)) of greater than 20 days and has 80 percent or more of its annual Medicare inpatient discharges with a principal diagnosis that reflects a finding of neoplastic disease in the 12-month cost reporting period ending in FY 1997.

Section 123 of the BBRA requires the PPS for LTCHs to be a per discharge system with a diagnosis-related group (DRG) based patient classification system that reflects the differences in patient resources and costs in LTCHs while maintaining budget neutrality.

Section 307(b)(1) of BIPA, among other things, mandates that the Secretary shall examine, and may provide for, adjustments to payments under the LTCH PPS, including adjustments to DRG weights, area wage adjustments, geographic reclassification, outliers, updates, and a disproportionate share adjustment.

In a **Federal Register** document issued on August 30, 2002, we implemented the LTCH PPS authorized under BBRA and BIPA (67 FR 55954). This system uses information from LTCH patient records to classify patients into distinct long-term care diagnosis-related groups (LTC-DRGs) based on clinical characteristics and expected resource needs. Payments are calculated for each LTC-DRG and provisions are made for appropriate payment adjustments. Payment rates under the LTCH PPS are updated annually and published in the **Federal Register**.

The LTCH PPS replaced the reasonable cost-based payment system under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (Pub. L. 97–248) for payments for inpatient services provided by a LTCH with a cost reporting period beginning on or after October 1, 2002. (The regulations implementing the TEFRA reasonable cost-based payment provisions are located at 42 CFR Part 413.) With the implementation of the PPS for acute care hospitals authorized by the Social Security Amendments of 1983 (Pub. L. 98–21), which added section 1886(d) to the Act, certain hospitals, including LTCHs, were excluded from the PPS for acute care hospitals and were paid their reasonable costs for inpatient services subject to a per discharge limitation or target amount under the TEFRA system. For each cost reporting period, a hospital-specific ceiling on payments was determined by multiplying the hospital's updated target amount by the number of total current year Medicare discharges. The August 30, 2002 final rule further details the payment policy under the TEFRA system (67 FR 55954).

In the August 30, 2002 final rule, we also presented an in-depth discussion of the LTCH PPS, including the patient classification system, relative weights, payment rates, additional payments, and the budget neutrality requirements mandated by section 123 of the BBRA. The same final rule that established regulations for the LTCH PPS under 42 CFR part 412, subpart O, also contained LTCH provisions related to covered inpatient services, limitation on charges to beneficiaries, medical review requirements, furnishing of inpatient hospital services directly or under arrangement, and reporting and recordkeeping requirements. We refer readers to the August 30, 2002 final rule for a comprehensive discussion of the research and data that supported the establishment of the LTCH PPS (67 FR 55954).

On June 6, 2003, we published a final rule in the **Federal Register** (68 FR 34122) that set forth the 2004 annual update of the payment rates for the Medicare PPS for inpatient hospital services furnished by LTCHs. It also changed the annual period for which the payment rates are effective. The annual updated rates are now effective from July 1 through June 30 instead of from October 1 through September 30. We refer to the July through June time period as a ''long-term care hospital rate year'' (LTCH PPS rate year). In addition, we changed the publication schedule for the annual update to allow for an effective date of July 1. The payment amounts and factors used to determine the annual update of the LTCH PPS Federal rate is based on a LTCH PPS rate year. While the LTCH payment rate update is effective July 1, the annual update of the LTC–DRG classifications and relative weights are linked to the annual adjustments of the acute care hospital inpatient DRGs and are effective each October 1.

On May 6, 2005, we published the Prospective Payment System for Long-Term Care Hospitals: Annual Payment Rate Updates, Policy Changes, and Clarifications final rule (70 FR 24168) (hereinafter referred to as the RY 2006 LTCH PPS final rule). In this rule, we set forth the 2006 LTCH PPS rate year annual update of the payment rates for the Medicare PPS for inpatient hospital services provided by LTCHs. We also discussed clarification of the notification policy for colocated LTCHs and satellite facilities. The RY 2006 LTCH PPS final rule also included a provision to extend the surgical DRG exception in the 3-day or less interruption of stay policy at § 412.531 as well as a provision that clarified and modified existing notification requirements for the purpose of implementing § 412.532.

B. Criteria for Classification as a LTCH

1. Classification as a LTCH

Under the existing regulations at § 412.23(e)(1) and (e)(2)(i), which implement section 1886(d)(1)(B)(iv)(I) of the Act, to qualify to be paid under the LTCH PPS, a hospital must have a provider agreement with Medicare and must have an average Medicare inpatient LOS of greater than 25 days. Alternatively, § 412.23(e)(2)(ii) states that for cost reporting periods beginning on or after August 5, 1997, a hospital that was first excluded from the PPS in 1986 and can demonstrate that at least 80 percent of its annual Medicare inpatient discharges in the 12-month cost reporting period ending in FY 1997 have a principal diagnosis that reflects a finding of neoplastic disease must have an average inpatient LOS for all patients, including both Medicare and non-Medicare inpatients, of greater than 20 days.

Section 412.23(e)(3) provides that, subject to the provisions of paragraphs (e)(3)(ii) through (e)(3)(iv) of this section, the average Medicare inpatient LOS, specified under § 412.23(e)(2)(i) is calculated by dividing the total number of covered and noncovered days of stay of Medicare inpatients (less leave or pass days) by the number of total Medicare discharges for the hospital's most recent complete cost reporting

period. Section 412.23 also provides that subject to the provisions of paragraphs (e)(3)(ii) through (e)(3)(iv) of this section, the average inpatient LOS specified under § 412.23(e)(2)(ii) is calculated by dividing the total number of days for all patients, including both Medicare and non-Medicare inpatients (less leave or pass days) by the number of total discharges for the hospital's most recent complete cost reporting period.

In the RY 2005 LTCH PPS final rule (69 FR 25674), we specified the procedure for calculating a hospital's inpatient average length of stay (ALOS) for purposes of classification as a LTCH. That is, if a patient's stay includes days of care furnished during two or more separate consecutive cost reporting periods, the total days of a patient's stay would be reported in the cost reporting period during which the patient is discharged (69 FR 25705). Therefore, we revised the regulations at § 412.23(e)(3)(ii) to specify that, effective for cost reporting periods beginning on or after July 1, 2004, in calculating a hospital's ALOS, if the days of an inpatient stay involve days of care furnished during two or more separate consecutive cost reporting periods, the total number of days of the stay are considered to have occurred in the cost reporting period during which the inpatient was discharged.

Fiscal intermediaries (FIs) verify that LTCHs meet the ALOS requirements. We note that the inpatient days of a patient who is admitted to a LTCH without any remaining Medicare days of coverage, regardless of the fact that the patient is a Medicare beneficiary, will not be included in the above calculation. Because Medicare would not be paying for any of the patient's treatment, data on the patient's stay would not be included in the Medicare claims processing systems. As described in § 409.61, in order for both covered and noncovered days of a LTCH hospitalization to be included, a patient admitted to the LTCH must have at least one remaining benefit day (68 FR 34123).

The FI's determination of whether or not a hospital qualified as an LTCH is based on the hospital's discharge data from the hospital's most recent complete cost reporting period (§ 412.23(e)(3)) and is effective at the start of the hospital's next cost reporting period (§ 412.22(d)). However, if the hospital does not meet the ALOS requirement as specified in § 412.23(e)(2)(i) and (ii), the hospital may provide the intermediary with data indicating a change in the ALOS by the same method for the period of at least 5 months of the immediately preceding 6-month period (69 FR 25676). Our interpretation of the current regulations at § 412.23(e)(3) was to allow hospitals to submit data using a period of at least 5 months of the most recent data from the immediately preceding 6-month period.

As we stated in the Inpatient Prospective Payment System (IPPS) final rule, published August 1, 2003, prior to the implementation of the LTCH PPS, we did rely on data from the most recently submitted cost report for purposes of calculating the ALOS. The calculation to determine whether an acute care hospital qualifies for LTCH status was based on total days and discharges for LTCH inpatients. However, with the implementation of the LTCH PPS, for the ALOS specified under § 412.23(e)(2)(i), we revised § 412.23(e)(3)(i) to only count total days and discharges for Medicare inpatients (67 FR 55970 through 55974). In addition, the ALOS specified under § 412.23(e)(2)(ii) is calculated by dividing the total number of days for all patients, including both Medicare and non-Medicare inpatients (less leave or pass days) by the number of total discharges for the hospital's most recent complete cost reporting period. As we discussed in the August 1, 2003 IPPS final rule, we are unable to capture the necessary data from our present cost reporting forms. Therefore, we have notified FIs and LTCHs that until the cost reporting forms are revised, for purposes of calculating the ALOS, we will be relying upon census data extracted from Medicare Provider Analysis and Review (MedPAR) files that reflect each LTCH's cost reporting period (68 FR 45464). Requirements for hospitals seeking classification as LTCHs that have undergone a change in ownership, as described in § 489.18, are set forth in § 412.23(e)(3)(iv).

2. Hospitals Excluded From the LTCH PPS

The following hospitals are paid under special payment provisions, as described in § 412.22(c) and, therefore, are not subject to the LTCH PPS rules:

- Veterans Administration hospitals.
- Hospitals that are reimbursed under State cost control systems approved under 42 CFR part 403.
- Hospitals that are reimbursed in accordance with demonstration projects authorized under section 402(a) of the Social Security Amendments of 1967 (Pub. L. 90–248) (42 U.S.C. 1395b–1) or section 222(a) of the Social Security Amendments of 1972 (Pub. L. 92–603) (42 U.S.C. 1395b–1 (note)) (Statewide all-payer systems, subject to the rate-of-increase test at section 1814(b) of the Act).
- Nonparticipating hospitals furnishing emergency services to Medicare beneficiaries.

C. Transition Period for Implementation of the LTCH PPS

In the August 30, 2002 final rule, we provided for a 5-year transition period from reasonable cost-based reimbursement to a full Federal prospective payment based on 100 percent of the Federal rate for LTCHs (67 FR 56038). However, existing LTCHs and LTCHs that are not defined as new in § 412.533(d) have the option to elect to be paid based on 100 percent of the Federal prospective payment. During the 5-year period, two payment percentages are to be used to determine a LTCH's total payment under the PPS. The blend percentages are as shown in Table 1.

TABLE 1

Cost reporting periods beginning on or after	Prospective payment federal rate percentage	Reasonable cost-based reimbursement rate percentage
October 1, 2002	20	80
October 1, 2003	40	60
October 1, 2004	60	40
October 1, 2005	80	20
October 1, 2006	100	0

D. Limitation on Charges to Beneficiaries

In the August 30, 2002 final rule, we presented an in-depth discussion of beneficiary liability under the LTCH PPS (67 FR 55974 through 55975). In the RY 2005 LTCH PPS final rule (69 FR 25676), we clarified that the discussion of beneficiary liability in the August 30, 2002 final rule was not meant to establish rates or payments for, or define Medicare-eligible expenses. Under § 412.507, as consistent with other established hospital prospective payment systems, a LTCH may not bill a Medicare beneficiary for more than the deductible and coinsurance amounts as specified under § 409.82, § 409.83, and § 409.87 and for items and services as specified under § 489.30(a), if the Medicare payment to the LTCH is the full LTC–DRG payment amount. However, under the LTCH PPS, Medicare will only pay for days for which the beneficiary has coverage until the short-stay outlier (SSO) threshold is exceeded. (See section V.A.1.a. of this preamble.) Therefore, if the Medicare payment was for a SSO case (§ 412.529) that was less than the full LTC–DRG payment amount because the beneficiary had insufficient remaining Medicare days, the LTCH could also charge the beneficiary for services delivered on those uncovered days (§ 412.507).

E. Administrative Simplification Compliance Act and Health Insurance Portability and Accountability Act Compliance

Claims submitted to Medicare must comply with both the Administrative Simplification Compliance Act (ASCA) (Pub. L. 107–105), and Health Insurance Portability and Accountability Act (HIPAA) (Pub. L. 104–191). Section 3 of ASCA requires the Medicare Program, to deny payment under Part A or Part B for any expenses for items or services ''for which a claim is submitted other than in an electronic form specified by the Secretary.'' Section 1862(h) of the Act (as added by section 3(a) of ASCA) provides that the Secretary shall waive such denial in two types of cases and may also waive such denial ''in such unusual cases as the Secretary finds appropriate.'' (Also, see 68 FR 48805, August 15, 2003, implementing section 3 of ASCA.) Section 3 of ASCA operates in the context of the Administrative Simplification provisions of HIPAA, which include, among other provisions, the transactions and code sets standards requirements codified as 45 CFR parts 160 and 162, subparts A and I through R (generally known as the Transactions Rule). The Transactions Rule requires covered entities, including covered providers, to conduct covered electronic transactions according to the applicable transactions and code sets standards.

II. Summary of the Major Contents of This Proposed Rule

In this proposed rule, we are setting forth the proposed annual update to the payment rates for the Medicare LTCH PPS, as well as, proposing other policy changes. The following is a summary of the major areas that we are addressing in this proposed rule:

In section III of this preamble, we discuss the LTCH PPS patient classification and the relative weights which remain linked to the annual adjustments of the acute care hospital inpatient DRG system, and are based on the annual revisions to the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD–9-CM) codes effective each October 1.

In section IV.B. of this preamble, we propose to adopt the ''Rehabilitation, Psychiatric, Long Term Care (RPL)'' market basket under the LTCH PPS in place of the excluded hospital with capital market basket.

As discussed in section IV.C. of this preamble, we are proposing a zero percent update to the LTCH PPS Federal rate for the 2007 LTCH PPS rate year instead of the most recent estimate of the LTCH PPS market basket.

Also in section IV.C. of this preamble, we discuss the proposed prospective payment rate for RY 2007, and in section IV.D. we discuss the applicable adjustments to the proposed payment rates, including the proposed revisions to the wage index, the proposed cost-of-living adjustment factors, the proposed outlier threshold, and the proposed transition period budget neutrality factor for the 2007 LTCH PPS rate year. We are also proposing revisions to the cost-to-charge ratio and reconciliation provisions as they apply to LTCH outlier payment policies.

In section IV.D.1.c. of this preamble, we also discuss our proposal to revise the LTCH PPS labor-related share based on RPL market basket. Also in section IV.D. of this preamble, we are proposing to postpone the deadline for making the one-time prospective adjustment for the Federal rate at § 412.523(d)(3).

In section V.A. of this preamble, we are proposing to revise the existing payment adjustment for SSO cases by reducing the part of the current payment formula that is based on costs and adding a fourth component to the current payment formula. Also in section V.A. of this preamble, we are proposing to sunset the surgical DRG exception to the payment policy established under the 3-day or less interruption of stay regulations at § 412.531(a)(1).

In section V.B. of this preamble, for LTCH hospitals within hospitals (HwHs) and LTCH satellites, we are proposing to clarify at § 412.534(c) that under the policy for adjusting the LTCH PPS payment based on the amount that would be determined under the IPPS payment methodology, we calculate the LTCH PPS payment amount that is equivalent to what would otherwise be paid under the IPPS. We are also proposing to codify in regulations the general formula we currently use to give affect to the regulations as they pertain to calculating an amount under subpart O that is equivalent to an amount that would be determined under § 412.1(a).

In section X. of this preamble, we will discuss our on-going monitoring protocols under the LTCH PPS.

In section XI of this preamble, we will discuss the recommendations made by the Research Triangle Institute, International's (RTI) evaluation of the feasibility of adopting recommendations made in the June 2004 MedPAC Report.

In section XIII of this preamble, we analyze the impact of the proposed changes presented in this proposed rule on Medicare expenditures, Medicare-participating LTCHs, and Medicare beneficiaries.

In Appendix A of this proposed rule, we present a description of a preliminary model of an update framework under the LTCH PPS that we may propose to use in the future for purposes of the annual updating of the LTCH PPS Federal rate in future years.

III. Long-Term Care Diagnosis-Related Group (LTC-DRG) Classifications and Relative Weights

[If you choose to comment on issues in this section, please include the caption ''LTC–DRG CLASSIFICATIONS AND RELATIVE WEIGHTS'' at the beginning of your comments.]

A. Background

Section 123 of the BBRA specifically requires that the PPS for LTCHs be a per discharge system with a DRG-based patient classification system reflecting the differences in patient resources and costs in LTCHs while maintaining budget neutrality. Section 307(b)(1) of BIPA modified the requirements of section 123 of the BBRA 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 DRGs that have been modified to account for different

resource use of LTCH patients as well as the use of the most recently available hospital discharge data.''

In accordance with section 123 of the BBRA as amended by section 307(b)(1) of BIPA and § 412.515, we use information derived from LTCH PPS patient records to classify these cases into distinct LTC–DRGs based on clinical characteristics and estimated resource needs. The LTC–DRGs used as the patient classification component of the LTCH PPS correspond to the hospital inpatient DRGs in the IPPS. We assign an appropriate weight to the LTC–DRGs to account for the difference in resource use by patients exhibiting the case complexity and multiple medical problems characteristic of LTCHs.

In a departure from the IPPS, we use low volume LTC–DRGs (less than 25 LTCH cases) in determining the LTC–DRG weights, since LTCHs do not typically treat the full range of diagnoses as do acute care hospitals. In order to manage the large number of low volume DRGs (all DRGs with fewer than 25 cases), we group low volume DRGs into 5 quintiles based on average charge per discharge. (A listing of the current composition of low volume quintiles used in determining the FY 2006 LTC–DRG relative weights appears in the FY 2006 IPPS final rule (70 FR 47329 through 47332).) We also account for adjustments to payments for cases in which the stay at the LTCH is less than or equal to five-sixths of the geometric ALOS and classify these cases as SSO cases. (A detailed discussion of the application of the Lewin Group model that was used to develop the LTC–DRGs appears in the August 30, 2002 LTCH PPS final rule (67 FR 55978).)

B. Patient Classifications Into DRGs

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

(1) Principal diagnosis.
(2) Up to eight additional diagnoses.
(3) Up to six procedures performed.
(4) Age.
(5) Sex.
(6) Discharge status of the patient.

As indicated in the August 30, 2002 LTCH PPS final rule, upon the discharge of the patient from a LTCH, the LTCH must assign appropriate diagnosis and procedure codes from the most current version of the ICD–9–CM. HIPAA transactions and code sets standards regulations (45 CFR parts 160 and 162) require that no later than October 16, 2003, all covered entities must comply with the applicable requirements of subparts A and I through R of part 162. Among other requirements, those provisions direct covered entities that electronically transmit institutional health care claim or equivalent encounter information, for instance, to use the ASC X12N 837 Health Care Claim: Institutional, Volumes 1 and 2, version 4010, and the applicable standard medical data code sets. (See 45 CFR 162.1002 and 45 CFR 162.1102).

Medicare FIs 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 DRG can be made. During this process, the following types of cases are selected for further development:

- Cases that are improperly coded. (For example, diagnoses are shown that are inappropriate, given the sex of the patient. Code 68.6, Radical abdominal hysterectomy, would be an inappropriate code for a male.)
- Cases including surgical procedures not covered under Medicare. (For example, organ transplant in a non-approved transplant center.)
- Cases requiring more information. (For example, ICD–9–CM codes are required to be entered at their highest level of specificity. There are valid 3-digit, 4-digit, and 5-digit codes. That is, code 262, Other severe protein-calorie malnutrition, contains all appropriate digits, but if it is reported with either fewer or more than 3 digits, the claim will be rejected by the MCE as invalid.)
- Cases with principal diagnoses that do not usually justify admission to the hospital. (For example, code 437.9, unspecified cerebrovascular disease. While this code is valid according to the ICD–9–CM coding scheme, a more precise code should be used for the principal diagnosis.)

After screening through the MCE, each claim will be classified into the appropriate LTC–DRG by the Medicare LTCH GROUPER software. As indicated in August 30, 2002 LTCH PPS final rule, the Medicare GROUPER software, which is used under the LTCH PPS, is specialized computer software, and is the same GROUPER software program used under the IPPS. The GROUPER software was developed as a means of classifying each case into a DRG on the basis of diagnosis and procedure codes and other demographic information (age, sex, and discharge status). Following the LTC–DRG assignment, the Medicare FI determines the prospective payment by using the Medicare PRICER program, which accounts for hospital-specific adjustments. Under the LTCH PPS, we provide an opportunity for the LTCH to review the LTC–DRG assignments made by the FI and to submit additional information within a specified timeframe as specified in § 412.513(c).

The GROUPER software is used both to classify past cases in order to measure relative hospital resource consumption to establish the DRG weights and to classify current cases for purposes of determining payment. The records for all Medicare hospital inpatient discharges are maintained in the MedPAR file. The data in this file are used to evaluate possible DRG classification changes and to recalibrate the DRG weights during our annual update under both the IPPS (§ 412.60(e)) and the LTCH PPS (§ 412.517). As discussed in greater detail in sections III.D. and E. of this preamble, with the implementation of section 503(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (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 (FY) (October 1 and April 1) as required by the statute for the IPPS (69 FR 48954 through 48957). Specifically, as we discussed in the FY 2006 IPPS final rule, ICD–9 diagnosis and procedure codes for new medical technology may be created and added to existing DRGs in the middle of the Federal FY on April 1 (70 FR 47323). 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, published in accordance with HIPAA.

C. Organization of DRGs

The 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. Surgical DRGs are assigned based on a surgical hierarchy that orders operating room (O.R.) procedures or groups of O.R. procedures

by resource intensity. The GROUPER software program does not recognize all ICD–9–CM procedure codes as procedures that affect DRG assignment, that is, procedures which are not surgical (for example, EKG), or minor surgical procedures (for example, 86.11, Biopsy of skin and subcutaneous tissue).

The medical DRGs are generally differentiated on the basis of diagnosis. Both medical and surgical DRGs may be further differentiated based on age, sex, discharge status, and presence or absence of complications or comorbidities (CC). We note that CCs are defined by certain secondary diagnoses not related to, or not inherently a part of, the disease process identified by the principal diagnosis. (For example, the GROUPER software would not recognize a code from the 800.0x series, Skull fracture, as a CC when combined with principal diagnosis 850.4, Concussion with prolonged loss of consciousness, without return to preexisting conscious level.) In addition, we note that the presence of additional diagnoses does not automatically generate a CC, as not all DRGs recognize a comorbid or complicating condition in their definition. (For example, DRG 466, Aftercare without History of Malignancy as Secondary Diagnosis, is based solely on the principal diagnosis, without consideration of additional diagnoses for DRG determination.)

In its June 2000, Report to Congress, MedPAC recommended that the Secretary ''* * * improve the hospital inpatient prospective payment system by adopting, as soon as practicable, diagnosis-related group refinements that more fully capture differences in severity of illness among patients,'' (Recommendation 3A, p. 63). In response to that recommendation, we determined at that time that it was not practical to develop a refinement to inpatient hospital DRGs based on severity due to time and resource requirements. However, this does not preclude us from development of a severity-adjusted DRG refinement in the future. That is, a refinement to the list of CCs could be incorporated into the existing DRG structure. It is also possible that a more comprehensive severity adjusted structure may be created if a new code set is adopted. That is, if ICD–9–CM is replaced by ICD–10–CM (for diagnostic coding) and ICD–10–PCS (for procedure coding) or by other code sets, a severity concept may be built into the resulting DRG assignments. Of course, any change to the code set would be adopted through the process established in the HIPAA Administrative Simplification Standards provisions.

In its March 2005 Report to Congress, ''Physician-Owned Specialty Hospitals,'' MedPAC recommended that the Secretary improve payment accuracy in the hospital IPPS by, among other things, ''refining the current DRGs to more fully capture differences in severity of illness among patients.'' (Recommendation 1, p. 93.) In the FY 2006 IPPS final rule (70 FR 47474 through 47479), we stated that we expected to make changes to the DRGs to better reflect severity of illness and we indicated that we plan to conduct a comprehensive review of the CCs list for FY 2007. We also indicated that we are considering the possibility of proposing to use the All Patient Refined (APR) DRGs under the IPPS for FY 2007. We explained that we did not propose to adopt the APR–DRGS under the IPPS for FY 2006 because it would represent a significant undertaking that could have a substantial effect on all hospitals and there was insufficient time to fully analyze a change of that magnitude. However, as an interim step to better recognize severity in the DRG system for FY 2006, until we can complete a more comprehensive analysis of the APR–DRG system and CC list as part of a complete analysis of the MedPAC recommendations that we plan to perform over the next year, we established cardiovascular DRGs 547 through 558 as described in the FY 2006 IPPS final rule (70 FR 47474 through 47478).

D. Update of LTC–DRGs

For FY 2006, the LTC–DRG patient classification system was based on LTCH data from the FY 2004 MedPAR file, which contained hospital bills data from the March 2005 update. The patient classification system consists of 526 DRGs that formed the basis of the FY 2006 LTCH PPS GROUPER program. The 526 LTC–DRGs included two ''error DRGs.'' As in the IPPS, we included two error DRGs in which cases that cannot be assigned to valid DRGs will be grouped. These two error DRGs are DRG 469 (Principal Diagnosis Invalid as a Discharge Diagnosis) and DRG 470 (Ungroupable). (See the FY 2006 IPPS final rule (70 FR 47323 through 47341)). The other 524 LTC–DRGs are the same DRGs used in the IPPS GROUPER program for FY 2006 (Version 23.0).

In the past, the annual update to the CMS DRGs was based on the annual revisions to the ICD–9–CM codes and was effective each October 1. Recently, the ICD–9–CM coding update process was revised as discussed in greater detail in the FY 2005 IPPS final rule (69 FR 48954 through 48957). Specifically, section 503(a) of the MMA includes a requirement for updating ICD–9–CM codes twice a year instead of the current process of annual updates on October 1 of each year. This requirement is included as part of the amendments to the Act relating to recognition of new medical technology under the IPPS. (For additional information on this provision, including its implementation and its impact on the LTCH PPS, refer to the FY 2005 IPPS final rule (69 FR 48952 through 48957) and the RY 2006 LTCH PPS final rule (70 FR 24172 through 24177).)

As discussed in the RY 2006 LTCH PPS final rule, with the implementation of section 503(a) of the MMA, there is the possibility that one feature of the GROUPER software program may be updated twice during a Federal FY (October 1 and April 1) as required by the statute for the IPPS (70 FR 24173 through 24175). Specifically, 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 FY on April 1. No new LTC–DRGs will be created or deleted. Consistent with our current practice, any changes to the DRGs or relative weights will be made at the beginning of the next Federal FY (October 1). Therefore, there will not 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, issued under HIPAA.

As we explained in the FY 2006 IPPS final rule, 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 (70 FR 47323). 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. The patient classification system used under the LTCH PPS (LTC–DRGs) is based on the DRG patient classification system used under the IPPS, which historically had been updated annually and effective for discharges occurring on or after October 1 through September 30 each year. As we also mentioned, the ICD–9–CM coding update process was revised as a result of the implementation of section 503(a) of the MMA, which includes a requirement for updating ICD–9–CM codes as often as twice a year instead of the current process of annual updates on October 1 of each year. As discussed

in the FY 2005 IPPS final rule, this requirement is included as part of the amendments to the Act relating to recognition of new medical technology under the IPPS (69 FR 48954 through 48957). Section 503(a) of the MMA amended section 1886(d)(5)(K) of the Act by adding a new paragraph (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 FY that begins after such date.'' This requirement will improve 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.

Despite the fact that aspects of the GROUPER software may be updated to recognize any new technology ICD–9–CM codes, 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.

Updates to the GROUPER software for both the IPPS and the LTCH PPS (for 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 since we do not publish a midyear IPPS rule, 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. Any coding updates will be available through the Web sites provided in section III.E. 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 the MMA, 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.

Discharges between October 1, 2005, and September 30, 2006, (Federal FY 2006) are using Version 23.0 of the GROUPER software for both the IPPS and the LTCH PPS. Consistent with our current practice, any changes to the DRGs or relative weights will be made at the beginning of the Federal FY (October 1). We will notify LTCHs of any revised LTC–DRG relative weights based on the final DRGs and the applicable version of the GROUPER software program that will be effective October 1, 2006, in the annual IPPS proposed and final rules. At the September 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 will 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 next update to the LTC–DRGs and relative weights for FY 2007 will be presented in the FY 2007 IPPS proposed and final rules. Furthermore, we would notify LTCHs of any revisions to the GROUPER software used under the IPPS and LTCH PPS that would be implemented April 1, 2007.

E. ICD–9–CM Coding System

1. Uniform Hospital Discharge Data Set (UHDDS) Definitions

Because the assignment of a case to a particular LTC–DRG will help determine the amount that will be paid for the case, it is important that the coding is accurate. Classifications and terminology used in the LTCH PPS are consistent with the ICD–9–CM and the 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 HHS.

We note 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 HIPAA Administrative Simplification Act of 1996 (45 CFR part 162). Furthermore, the UHDDS was used as a standard for the development of policies and programs related to hospital discharge statistics by both governmental and nongovernmental sectors for over 30 years. In addition, the following definitions (as described in the 1984 Revision of the UHDDS, approved by the Secretary for use starting January 1986) are requirements of the ICD–9–CM coding system, and have been used as a standard for the development of the CMS DRGs:

- Diagnoses are defined to include all diagnoses that affect the current hospital stay.
- Principal diagnosis is defined as the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.
- Other diagnoses (also called secondary diagnoses or additional diagnoses) are defined as all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received or the LOS or both. Diagnoses that relate to an earlier episode of care that have no bearing on the current hospital stay are excluded.
- All procedures performed will be reported. This includes those that are surgical in nature, carry a procedural risk, carry an anesthetic risk, or require specialized training.

We provide LTCHs with a 60-day window after the date of the notice of the initial LTC–DRG assignment to request review of that assignment. Additional information may be provided by the LTCH to the FI as part of that review.

2. Maintenance of the ICD–9–CM Coding System

The ICD–9–CM Coordination and Maintenance (C&M) Committee is a Federal interdepartmental committee, co-chaired by the National Center for Health Statistics (NCHS) and CMS, that is charged with maintaining and updating the ICD–9–CM system. The C&M 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 C&M 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 NCHS has lead responsibility for the ICD–9–CM diagnosis codes included in the Tabular List and Alphabetic Index for Diseases, while we have the lead responsibility for the ICD–9–CM procedure codes included in the Tabular List and Alphabetic Index for Procedures. The C&M Committee encourages participation by health-related organizations in this process and holds public meetings for discussion of educational issues and proposed coding changes twice a year at the CMS Central Office located in Baltimore, Maryland. The agenda and dates of the meetings can be accessed on our Web site at: *http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes.*

As discussed previously in this section of the preamble, section 503(a) of the MMA includes a requirement for updating ICD–9–CM codes twice a year instead of the current process of annual updates on October 1 of each year. This requirement will improve the recognition of new technologies under the IPPS by accounting for them in the GROUPER software at an earlier date. Because this new statutory requirement could have a significant impact on health care providers, coding staff, publishers, system maintainers, and software systems, among others, we solicited comments on our proposed provisions to implement this requirement as part of the FY 2005 IPPS proposed rule (69 FR 28220 through 28221). We responded to comments and published our new policy regarding the updating of ICD–9–CM codes in the FY 2005 IPPS final rule (69 FR 48954 through 48957).

While this new requirement states that the Secretary shall not adjust the payment of the DRG classification for any codes created for use on April 1, DRG software and other systems will have to be updated in order to recognize and accept the new codes. If any coding changes were implemented on April 1, the Medicare GROUPER software program used under both the IPPS and the LTCH PPS would need to be revised to reflect the new ICD–9–CM codes because the LTC–DRGs are the same DRGs used under the IPPS. Furthermore, although the GROUPER software used under both the IPPS and the LTCH PPS would need to be revised to accommodate the new codes effective April 1, there would be no additions or deletions of DRGs nor would the relative weights used under the IPPS and the LTCH PPS, respectively, be changed until the annual update October 1 (to the extent that those changes are warranted), just as they are historically updated. As the LTCH PPS is based on the IPPS, we adopted the same approach used under the IPPS for potential April 1 ICD–9–CM coding changes. That is, we will assign any new diagnosis codes or procedure codes to the same DRG in which its predecessor code was assigned, so there will be no DRG impact in terms of potential DRG assignment until the following October 1. We will maintain the current method of publicizing any new code changes, as noted below. Current addendum and code title information is published on the CMS Web page at: *http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/04_addendum.asp.* Summary tables showing new, revised, and deleted code titles are also posted on the following CMS Web page: *http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp.* Information on ICD–9–CM diagnosis codes can be found at *http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/.* Information on new, revised, and deleted ICD–9–CM codes is also available in the American Hospital Association (AHA) publication Coding Clinic for ICD–9–CM. AHA also distributes information to publishers and software vendors. We also send copies of all ICD–9–CM coding changes to our contractors for use in updating their systems and providing education to providers.

If the April 1 changes are made to ICD–9–CM diagnosis or procedure codes, LTCHs will be required to obtain the new codes, coding books, or encoder updates, and make other system changes in order to capture and report the new codes. When we implemented section 503(a) of the MMA in the FY 2005 IPPS final rule, we indicated that we were aware of the additional burden this will have on health care providers.

It should be noted 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 for discussing updates to the ICD–9–CM has been an open process through the ICD–9–CM C&M Committee since 1995. Any requestor who makes 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 will be given the opportunity to present the merits of their proposed new code.

At the September 2005 C&M Committee meeting, no new codes were proposed for update on April 1, 2006. While no DRG additions or deletions or changes to relative weights will occur prior to the usual October 1 update, in the event any new codes were created to describe new technologies and medical services through an April 1, 2006 update, under our policy established in the RY 2006 final rule (70 FR 24176), LTCH systems would be expected to recognize and report those new codes through the channels as described in this section.

The ICD–9–CM coding changes that have been adopted by the C&M Committee would become effective either at the beginning of each Federal FY (October 1) or, in the case of codes created to capture new technology, April 1 of each year. Coders will be expected to use the most current ICD–9–CM codes, as updated. Because we do not publish a mid-year IPPS rule, the currently accepted avenues of information dissemination will be used to inform all ICD–9–CM code users of any changes to the coding system. These avenues were described in section III.D. of this preamble and were discussed at length in the FY 2005 IPPS final rule (69 FR 48956). Coders in LTCHs using the updated ICD–9–CM coding system will be on the same schedule as the rest of the health care industry. In the past, the updated ICD–9–CM was not available for use until October 1 of each year.

Therefore, because the LTCH PPS and the IPPS use the same GROUPER software, the LTCH PPS will be directly affected by the statutory mandates directed at the IPPS as amended by section 503(a) of the MMA. (We note that there is no statutory requirement in the LTCH PPS to make additional payments for new technology.) The practical effect of this provision is that the GROUPER software must accept new ICD–9–CM codes reflecting the incorporation of new technologies into inpatient treatment at an acute care hospital prior to the scheduled annual update of the GROUPER software. Despite the fact that there are no provisions for additional payments for new technology under the LTCH PPS as there are under the IPPS, statutory compliance requires an alteration of the GROUPER software used under the IPPS, and since the LTCH PPS uses the same GROUPER software that is used under the IPPS, this consequently means that the GROUPER software used under the LTCH PPS would change.''

While DRG assignments would not change from October 1 through September 30, it is possible that there could be additional new ICD–9–CM diagnosis and procedure codes during that time, which would be assigned to predecessor DRGs. For both the IPPS and LTCH coders, it is possible that there will be ICD–9–CM codes in effect from October 1 through March 31, with additional ICD–9–CM codes in effect from April 1 through September 30. 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).

Of particular note to LTCHs are the invalid diagnosis codes (Table 6C) and the invalid procedure codes (Table 6D) located in the annual proposed and final rules for the IPPS. Claims with invalid codes are not processed by the Medicare claims processing system.

3. Coding Rules and Use of ICD–9–CM Codes in LTCHs

We emphasize the need for proper coding by LTCHs. Inappropriate coding of cases can adversely affect the uniformity of cases in each LTC–DRG and produce inappropriate weighting factors at recalibration. We continue to urge LTCHs to focus on improved coding practices. Because of concerns raised by LTCHs concerning correct coding, we have asked the AHA to provide additional clarification or instruction on proper coding in the LTCH setting. The AHA will provide this instruction via their established process of addressing questions through their publication ''Coding Clinic for ICD–9–CM.'' Written questions or requests for clarification may be addressed to the Central Office on ICD–9–CM, American Hospital Association, One North Franklin, Chicago, IL 60606. A form for question(s) is available for download and can be mailed on AHA's Web site at: *www.ahacentraloffice.org.* In addition, current coding guidelines are available at the NCHS Web site: *http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/ftpicd9.htm#conv.*

In conjunction with the cooperating parties (AHA, the American Health Information Management Association (AHIMA), and NCHS), we reviewed actual medical records and are concerned about the quality of the documentation under the LTCH PPS, as was the case at the beginning of the IPPS. We fully believe that, with experience, the quality of the documentation and coding will improve, as it did for the IPPS. The cooperating parties have plans to assist their members with improvement in documentation and coding issues for the LTCHs through specific questions and coding guidelines. The importance of good documentation is emphasized in the revised ICD–9–CM Official Guidelines for Coding and Reporting: ''A joint effort between the attending physician and coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without this documentation, the application of all coding guidelines is a difficult, if not impossible, task.'' (Coding Clinic for ICD–9–CM, Fourth Quarter 2002, page 115)

To improve medical record documentation, LTCHs should be aware that if the patient is being admitted for continuation of treatment of an acute or chronic condition, guidelines at Section I.B.10 of the Coding Clinic for ICD–9–CM, Fourth Quarter 2002 (page 129) are applicable concerning selection of principal diagnosis. To clarify coding advice issued in the August 30, 2002 final rule (67 FR 55979), at Guideline I.B.12, Late Effects, we state that a late effect is considered to be the residual effect (condition produced) after the acute phase of an illness or injury has terminated (Coding Clinic for ICD–9–CM, Fourth Quarter 2002, page 129). Regarding whether a LTCH should report the ICD–9–CM code(s) for an unresolved acute condition instead of the code(s) for late effect of rehabilitation, we emphasize that each case must be evaluated on its unique circumstances and coded appropriately. Depending on the documentation in the medical record, either a code reflecting the acute condition or rehabilitation could be appropriate in a LTCH.

Since implementation of the LTCH PPS, our Medicare FIs have conducted training and provided assistance to LTCHs in correct coding. We have also issued manuals containing procedures as well as coding instructions to LTCHs and FIs. We will continue to conduct training and provide guidance on an as-needed basis. We also refer readers to the detailed discussion on correct coding practices in the August 30, 2002 LTCH PPS final rule (67 FR 55981 through 55983). Additional coding instructions and examples will be published in Coding Clinic for ICD–9–CM.

F. Method for Updating the LTC–DRG Relative Weights

As discussed in the August 30, 2002 LTCH PPS final rule that implemented the LTCH PPS, under the LTCH PPS, each LTCH will receive a payment that represents an appropriate amount for the efficient delivery of care to Medicare patients (67 FR 55984). The system must be able to account adequately for each LTCH's case-mix in order to ensure both a fair distribution of Medicare payments and access to adequate care for those Medicare patients whose care is more costly. Therefore, in § 412.523(c), we adjust the standard Federal PPS rate by the LTC–DRG relative weights in determining payment to LTCHs for each case.

Under this payment system, 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 as described in § 412.515. To ensure that Medicare patients who are 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.

As we discussed in the FY 2006 IPPS final rule, the LTC–DRG relative weights effective under the LTCH PPS for Federal FY 2006 were calculated using the March 2005 update of FY 2004 MedPAR data and Version 23.0 of the GROUPER software (70 FR 47325). We use total days and total charges in the calculation of the LTC–DRG relative weights.

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. 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 method to calculate relative weights. We believe this method removes this hospital-specific source of bias in measuring 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. (See the FY 2006 IPPS final rule for further information on the hospital-

specific relative value methodology (70 FR 47328 through 47329).)

In order to account for LTC–DRGs with low volume (that is, with fewer than 25 LTCH cases), we grouped those low volume LTC–DRGs into 1 of 5 categories (quintiles) based on average charges, for the purposes of determining relative weights. For FY 2006 based on the FY 2004 MedPAR data, we identified 171 LTC–DRGs that contained between 1 and 24 cases. This list of low volume LTC–DRGs was then divided into 1 of the 5 low volume quintiles, each containing a minimum of 34 LTC–DRGs (171/5 = 34 with 1 LTC–DRG as a remainder). Each of the low volume LTC–DRGs grouped to a specific quintile received the same relative weight and ALOS using the formula applied to the regular LTC–DRGs (25 or more cases). (See the FY 2006 IPPS final rule for further explanation of the development and composition of each of the 5 low volume quintiles for FY 2006 (70 FR 47329 through 47332).)

After grouping the cases in the appropriate LTC–DRG, we calculated the relative weights by first removing statistical outliers and cases with a LOS of 7 days or less. Next, we adjusted the number of cases remaining in each LTC–DRG for the effect of short-stay outlier cases under § 412.529. The short-stay adjusted discharges and corresponding charges were used to calculate ''relative adjusted weights'' in each LTC–DRG using the hospital-specific relative value method. We also adjusted the LTC–DRG relative weights to account for nonmonotonically increasing relative weights. That is, we made an adjustment if cases classified to the LTC–DRG ''with complications or comorbidities (CCs)'' of a ''with CC''/''without CC'' pair had a lower average charge than the corresponding LTC–DRG ''without CCs'' by assigning the same weight to both LTC–DRGs in the ''with CC''/''without CC'' pair. (See the FY 2006 IPPS final rule for further details on the steps for calculating the LTC–DRG relative weights (70 FR 47336 through 47341).)

In addition, of the 526 LTC–DRGs in the LTCH PPS for FY 2006, based on LTCH cases in the FY 2004 MedPAR files, we identified 196 LTC–DRGs for which there were no LTCH cases in the database. That is, no patients who would have been classified to those DRGs were treated in LTCHs during FY 2004 and, therefore, no charge data were reported for those DRGs. Thus, in the process of determining the relative weights of LTC–DRGs, we were unable to determine weights for these 196 LTC–DRGs using the method described in this section of the preamble. However, since patients with a number of the diagnoses under these LTC–DRGs may be treated at LTCHs beginning in FY 2006, we assigned relative weights to each of the 196 ''no volume'' LTC–DRGs based on clinical similarity and relative costliness to one of the remaining 330 (526 − 196 = 330) LTC–DRGs for which we were able to determine relative weights, based on the FY 2004 claims data. (A list of the current no-volume LTC–DRGs and further explanation of their FY 2006 relative weight assignment can be found in the FY 2006 IPPS final rule (70 FR 47337 through 47341).)

Furthermore, for FY 2006, we established LTC–DRG relative weights of 0.0000 for heart, kidney, liver, lung, and simultaneous pancreas/kidney transplants (LTC–DRGs 103, 302, 480, 495, 512 and 513, respectively) 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. If in the future, however, 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 propose appropriate weights for the LTC–DRGs affected. At the present time, we included these 6 transplant LTC–DRGs in the GROUPER software program for administrative purposes. As the LTCH PPS uses the same GROUPER software program for LTCHs as is used under the IPPS, removing these DRGs would be administratively burdensome.

As we noted previously, there were no new ICD–9–CM code requests for an April 1, 2006 update. Therefore, Version 23.0 of the DRG GROUPER software established in the FY 2006 IPPS final rule (70 FR 47284 through 47322) will continue to be effective until October 1, 2006. Moreover, the LTC–DRGs and relative weights for FY 2006 established in that same IPPS final rule (70 FR 47681 through 47689) will continue to be effective until October 1, 2006, (just as they would have been even if there had been any new ICD–9–CM code requests for an April 1, 2006 update). Accordingly, Table 3 in the Addendum to this proposed rule lists the LTC–DRGs and their respective relative weights, geometric mean LOS, and five-sixths of the geometric mean LOS that we will continue to use for the period of July 1, 2006 through September 30, 2006. (This table is the same as table 11 of the Addendum to the FY 2006 IPPS final rule (70 FR 47681 through 47689). The next update to the ICD–9–CM coding system will be presented in the FY 2007 IPPS proposed rule (since there will be no April 1, 2006 updates to the ICD–9–CM coding system). The final update to the ICD–9–CM coding system that would become effective October 1, 2006, and the final DRGs and GROUPER for FY 2007 that would be used for the IPPS and the LTCH PPS, effective October 1, 2006, will be presented in the IPPS FY 2007 proposed and final rule in the **Federal Register**. At that time, we will also present the next annual update to the LTC–DRG relative weights based on the final DRGs and GROUPER software version that will be established for FY 2007.

IV. Proposed Changes to the LTCH PPS Payment Rates for the 2007 LTCH PPS Rate Year

[If you choose to comment on issues in this section, please include the caption ''PROPOSED CHANGES TO LTCH PPS PAYMENT RATES FOR THE 2007 LTCH PPS RATE YEAR'' at the beginning of your comments.]

A. Overview of the Development of the Payment Rates

The LTCH PPS was effective for a LTCH's first cost reporting period beginning on or after October 1, 2002. Effective with that cost reporting period, LTCHs are paid, during a 5-year transition period, on the basis of an increasing proportion of the LTCH PPS Federal rate and a decreasing proportion of a hospital's payment under the reasonable cost-based payment system, unless the hospital makes a one-time election to receive payment based on 100 percent of the Federal rate (see § 412.533). New LTCHs (as defined at § 412.23(e)(4)) are paid based on 100 percent of the Federal rate, with no phase-in transition payments.

The basic methodology for determining LTCH PPS Federal prospective payment rates is set forth in the regulations at § 412.515 through § 412.532. Below we discuss the proposed factors that will be used to update the LTCH PPS standard Federal rate for the 2007 LTCH PPS rate year that would be effective for LTCHs discharges occurring on or after July 1, 2006 through June 30, 2007. When we implemented the LTCH PPS in the August 30, 2002 final rule (67 FR 56029 through 56031), we computed the LTCH PPS standard Federal payment rate for FY 2003 by updating the best available (FY 1998 or FY 1999) Medicare inpatient operating and capital costs per case data, using the excluded hospital market basket.

Section 123(a)(1) of the BBRA requires that the PPS developed for LTCHs be budget neutral. Therefore, in

calculating the standard Federal rate under § 412.523(d)(2), we set total estimated LTCH PPS payments equal to estimated payments that would have been made under the reasonable cost-based payment methodology had the PPS for LTCHs not been implemented. Section 307(a) of BIPA specified that the increases to the hospital-specific target amounts and cap on the target amounts for LTCHs for FY 2002 provided for by section 307(a)(1) of BIPA shall not be taken into account in the development and implementation of the LTCH PPS.

Furthermore, as specified at § 412.523(d)(1), the standard Federal rate is reduced by an adjustment factor to account for the estimated proportion of outlier payments under the LTCH PPS to total estimated LTCH PPS payments (8 percent). For further details on the development of the FY 2003 standard Federal rate, see the August 30, 2002 LTCH PPS final rule (67 FR 56027 through 56037), and for subsequent updates to the LTCH PPS Federal rate, refer to the following final rules: RY 2004 LTCH PPS final rule (68 FR 34134 through 34140), RY 2005 LTCH PPS final rule (69 FR 25682 through 25684), and RY 2006 LTCH PPS final rule (70 FR 24179 through 24180).

B. Proposed LTCH PPS Market Basket

Historically, the Medicare program used a market basket to account for price increases of the services furnished by providers. The market basket used for the LTCH PPS includes both operating and capital-related costs of LTCHs because the LTCH PPS uses a single payment rate for both operating and capital-related costs. The development of the LTCH PPS standard Federal rate is discussed in further detail in the August 30, 2002 LTCH PPS final rule (67 FR 56027 through 56033).

In the August 30, 2002 final rule (67 FR 56016 through 56017 and 56030), which implemented the LTCH PPS, we established the use of the excluded hospital with capital market basket as the LTCH PPS market basket. The excluded hospital market basket was used to update the limits on LTCHs' operating costs for inflation under the former reasonable cost-based (TEFRA) payment system. We explained in that same final rule that we believe that the use of the excluded hospital market basket to update LTCHs' costs for inflation was appropriate because the excluded hospital market basket (with a capital component) measures price increases of the services furnished by excluded hospitals, including LTCHs. Since the costs of LTCHs are included in the excluded hospital market basket, this market basket index, in part, also reflects the costs of LTCHs. However, in order to capture the total costs (operating and capital-related) of LTCHs, we added a capital component to the excluded hospital market basket for use under the LTCH PPS. We refer to this index as the ''Excluded Hospital with Capital'' market basket. Currently, the excluded hospital with capital market basket used to update LTCH PPS payments is based on 1997 Medicare cost report data and includes Medicare participating psychiatric, rehabilitation, long term care, cancer, and childrens hospitals (68 FR 34137). (For further details on the development of the FY 1997-based LTCH PPS market basket, see the RY 2004 LTCH PPS final rule (68 FR 34134 through 34137)).

In the RY 2006 LTCH PPS final rule (70 FR 24179), we noted that based on our research, we did not develop a market basket specific to LTCH services. Presently, we are still unable to create a separate market basket specifically for LTCHs due to the small number of facilities and the limited data that are provided (for instance, approximately 15 percent of LTCHs reported contract labor cost data for 2002). We noted in that same final rule that we would discuss the use of the ''Rehabilitation, Psychiatric and Long-Term Care (RPL) market basket'' under the LTCH PPS, which is currently used under the IRF PPS. The RPL market basket is based on the operating and capital costs of inpatient rehabilitation facilities (IRFs), inpatient psychiatric facilities (IPFs) and LTCHs. Since all IRFs are now paid under the IRF PPS Federal payment rate, nearly all LTCHs are paid 100 percent of the Federal rate under the LTCH PPS, and most IPFs are transitioning to payment based on 100 percent of the Federal per diem payment amount under the IPF PPS (payments will be based on 100 percent of the Federal rate for cost reporting periods beginning on or after January 1, 2008), under broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of BIPA to develop the LTCH PPS, we are proposing to adopt the RPL market basket as the appropriate market basket of goods and services under the LTCH PPS for discharges occurring on or after July 1, 2006. The RPL market basket would reflect the operating and capital cost structures for these hospitals. Specifically, beginning in the 2007 LTCH PPS rate year, we are proposing to adopt under the LTCH PPS the RPL market basket based on FY 2002 cost report data as it is the best available data. We choose to use the FY 2002 Medicare cost reports because these are the most recent, relatively complete cost data for IRFs, IPF, and LTCHs serving Medicare beneficiaries.

We propose to exclude childrens, cancer hospitals, and religious nonmedical healthcare institutions (RNHCIs) from the RPL market basket because their payments are based entirely on reasonable costs subject to rate-of-increase limits established under the authority of section 1886(b) of the Act, and implemented in § 413.40. Childrens and cancer hospitals are not reimbursed under a PPS. Also, based on FY 2002 data, the cost structures for childrens and cancer hospitals are noticeably different than the cost structures of the IRFs, IPFs, and LTCHs. The services offered in IRFs, IPFs, and LTCHs are typically more labor-intensive than those offered in cancer and childrens hospitals. Therefore, the compensation cost weights for IRFs, IPFs, and LTCHs are larger than those in cancer and childrens hospitals. In addition, the depreciation cost weights for IRFs, IPFs, and LTCHs are noticeably smaller than those for childrens and cancer hospitals.

Therefore, including the fact that IRFs, IPFs and LTCHs are subject to a PPS while childrens, cancer and RNCHIs continue to receive payment based on reasonable costs, we believe a market basket based on the data of IRFs, IPFs and LTCHs is appropriate to use under the LTCH PPS since it is the best available data that would reflect the cost structures of LTCHs. In the following discussion we provide a background on market baskets and describe the methodologies we propose to use under broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of BIPA to develop the LTCH PPS for purposes of determining the operating and capital portions of the FY 2002-based RPL market basket.

1. Overview of the RPL Market Basket

The proposed RPL market basket is a fixed weight, Laspeyres-type price index that is constructed in three steps. First, a base period is selected (in this case, FY 2002) and total base period expenditures are estimated for a set of mutually exclusive and exhaustive spending categories based upon type of expenditure. Then the proportion of total operating costs that each category represents is determined. These proportions are called cost or expenditure weights. Second, each expenditure category is matched to an appropriate price or wage variable, referred to as a price proxy. In nearly every instance, these price proxies are price levels derived from publicly

available statistical series that are published on a consistent schedule, preferably at least on a quarterly basis. Finally, the expenditure weight for each cost category is multiplied by the level of its respective price proxy for a given period. The sum of these products (that is, the expenditure weights multiplied by their price levels) for all cost categories yields the composite index level of the market basket in a given period. Repeating this step for other periods produces a series of market basket levels over time. Dividing an index level for a given period by an index level for an earlier period produces a rate of growth in the input price index over that time period.

A market basket is described as a fixed-weight index because it quantifies the cost, at another time, to purchase the same mix of goods and services purchased to provide hospital services in a base period. The effects on total expenditures resulting from changes in the quantity or mix of goods and services (intensity) purchased subsequent to the base period are not measured. In this manner, the market basket measures only pure price change. Only when the index is rebased would the quantity and intensity effects be captured in the cost weights. Therefore, we rebase the market basket periodically so that cost weights reflect changes in the mix of goods and services that hospitals purchase (hospital inputs) to furnish patient care between base periods.

The terms rebasing and revising, while often used interchangeably, actually denote different activities. Rebasing means moving the base year for the structure of costs of an input price index (for example, shifting the base year cost structure from FY 1997 to FY 2002). Revising means changing data sources, methodology, or price proxies used in the input price index. In this proposed rule, we are proposing to rebase and revise the market basket used to update the LTCH PPS. Specifically, as noted above in this section, for the 2007 LTCH PPS rate year, we are proposing to use the FY 2002-based RPL market basket, which is described in greater detail below in this section.

2. Proposed Methodology for Operating Portion of the RPL Market Basket

The proposed operating portion of the FY 2002-based RPL market basket consists of several major cost categories derived from the FY 2002 Medicare cost reports for IRFs, IPFs, and LTCHs. We choose to use the FY 2002 Medicare cost reports because these are the most recent, relatively complete cost data for IRFs, IPFs, and LTCHs serving Medicare beneficiaries. Generally, if detailed cost data are not available for these Medicare cost reports, we prefer to use the PPS hospital (IPPS) Medicare cost reports to supplement IPF, IRF, and LTCH data because this is a comprehensive source of cost data for hospitals serving Medicare beneficiaries. When the IPPS Medicare cost report data are not available, we choose the best publicly available data source, such as the Bureau of Economic Analysis Input-Output Tables.

We use the IRF, IPF, and LTCH Medicare cost reports to derive these major cost categories for the RPL market basket which include wages, drugs, professional liability insurance (PLI), and a residual ''all other.'' As stated above in this section, we propose to use FY 2002 as the base year because we believe this is the most recent, relatively complete year of Medicare cost report data. Due to insufficient Medicare cost report data for IRFs, IPFs, and LTCHs, we propose to develop cost weights for benefits, contract labor, and blood and blood products using the FY 2002-based IPPS market basket (70 FR 23384), which we explain in more detail later in this section. For example, less than 30 percent of IRF, IPF, and LTCH reported benefit cost data in FY 2002. We noticed an increase in the cost data for these expense categories over the last four years. (we note that in the future, there may be sufficient IRFs, IPFs, and LTCHs cost report data to develop the weights for these expenditure categories.

Since the cost weights for the proposed RPL market basket are based on facility costs, we are proposing to limit our sample to hospitals with a Medicare average LOS within a comparable range of the total facility ALOS. We believe this provides a more accurate reflection of the structure of costs for Medicare treatments. Our goal is to measure cost shares that are reflective of case-mix and practice patterns associated with providing services to Medicare beneficiaries.

We propose to use those cost reports for IRFs and LTCHs whose Medicare ALOS is within 15 percent (that is, 15 percent higher or lower) of the total facility ALOS for the hospital. This is the same edit applied to the FY 1992-based and FY 1997-based excluded hospital with capital market basket. Consistent with the development of the RPL market basket adopted under the IRF PPS in the FY 2006 IRF PPS final rule (70 FR 47909), we propose 15 percent because it includes those LTCHs and IRFs whose Medicare LOS is within approximately 5 days of the facility LOS. We believe this edit provides us with a representative sample of LTCHs and IRFs serving Medicare beneficiaries.

We propose to use a less stringent measure of Medicare LOS for IPFs whose ALOS is within 30 or 50 percent (depending on the total facility ALOS) of the total facility ALOS. This less stringent edit allows us to increase our sample size by over 150 reports and produce a cost weight more consistent with the overall facility. When developing the FY 1997-based excluded hospital with capital market basket, the edit we applied to IPFs was based on the best available data at the time.

The detailed cost categories under the residual (that is, the remaining portion of the market basket after excluding wages and salaries, drugs, and professional liability cost weights) are derived from the FY 2002-based IPPS market basket and the 1997 Benchmark Input-Output (I–O) Tables published by the Bureau of Economic Analysis, U.S. Department of Commerce. The FY 2002-based IPPS market basket was developed using FY 2002 Medicare hospital cost reports with the most recent and detailed cost data (70 FR 47388). The 1997 Benchmark I–O is the most recent, comprehensive source of cost data for all hospitals. The proposed RPL cost weights for benefits, contract labor, and blood and blood products were derived using the FY 2002-based IPPS market basket. For example, the ratio of the benefit cost weight to the wages and salaries cost weight in the FY 2002-based IPPS market basket was applied to the RPL wages and salaries cost weight to derive a benefit cost weight for the RPL market basket. The remaining proposed RPL operating cost categories were derived using the 1997 Benchmark I–O Tables, aged to 2002 using relative price changes. (The methodology we used to age the data involves applying the annual price changes from the price proxies to the appropriate cost categories. We repeat this practice for each year.) Therefore, using this methodology, roughly 59 percent of the proposed RPL market basket is accounted for by wages, drugs, and PLI data from FY 2002 Medicare cost report data for IRFs, LTCHs, and IPFs.

The following is a summary outlining the choice of the proxies we propose to use for the operating portion of the market basket. The price proxies for the capital portion are described in more detail in section IV.B.3. of this preamble. With the exception of the Professional Liability proxy, all the proposed price proxies for the operating portion of the proposed RPL market basket are based on Bureau of Labor

Statistics (BLS) data and are grouped into one of the following BLS categories:

• Producer Price Indexes (PPIs) measure price changes for goods sold in other than retail markets. PPIs are preferable price proxies for goods that hospitals purchase as inputs in producing their outputs because the PPIs would better reflect the prices faced by hospitals. For example, we propose to use a special PPI for prescription drugs, rather than the Consumer Price Index (CPI) for prescription drugs because hospitals generally purchase drugs directly from the wholesaler. The PPIs that we propose to use measure price change at the final stage of production.

• Consumer Price Indexes (CPIs) measure changes in the prices of final goods and services bought by the typical consumer. Because they may not represent the price faced by a producer, we use CPIs only if an appropriate PPI were not available, or if the expenditures were more similar to those of retail consumers in general rather than purchases at the wholesale level. For example, the CPI for food purchases away from home is used as a proxy for contracted food services.

• Employment Cost Indexes (ECIs) measure the rate of change in employee wage rates and employer costs for employee benefits per hour worked. These indexes are fixed-weight indexes and strictly measure the change in wage rates and employee benefits per hour. Appropriately, they are not affected by shifts in employment mix.

We evaluated the price proxies using the criteria of reliability, timeliness, availability, and relevance. Reliability indicates that the index is based on valid statistical methods and has low sampling variability. Widely accepted statistical methods ensure that the data were collected and aggregated in a way that can be replicated. Low sampling variability is desirable because it indicates that the sample reflects the typical members of the population. (Sampling variability is variation that occurs by chance because a sample was surveyed rather than the entire population.) Timeliness implies that the proxy is published regularly, preferably at least once a quarter.

The market baskets are updated quarterly, and therefore, it is important that the underlying price proxies be up-to-date, reflecting the most recent data available. We believe that using proxies that are published regularly (at least quarterly, when possible) helps to ensure that we are using the most recent data available to update the market basket. We strive to use publications that are disseminated frequently because we believe that this is an optimal way to stay abreast of the most current data available. Availability means that the proxy is publicly available. We prefer that our proxies are publicly available because this will help ensure that our market basket updates are as transparent to the public as possible. In addition, this enables the public to be able to obtain the price proxy data on a regular basis.

Finally, relevance means that the proxy is applicable and representative of the cost category weight to which it is applied. The CPIs, PPIs, and ECIs selected by us to be proposed in this regulation meet these criteria. Therefore, we believe that they continue to be the best measure of price changes for the cost categories to which they would be applied.

We note that the proxies are the same as those used for the FY 1997-based excluded hospital with capital market basket, which is currently used under the LTCH PPS, and are the same proxies as those used for the FY 2002-based excluded hospital market basket that is used to update the reasonable cost-based portion of LTCHs' blended transition payments (70 FR 47399 through 47403). Because these proxies meet our criteria of reliability, timeliness, availability, and relevance, we believe they continue to be the best measure of price changes for the cost categories. For further discussion on the FY 1997-based excluded hospital with capital market basket, see the 2004 LTCH PPS rate year final rule (68 FR 34134 through 34136). For further discussion on the FY 2002-based excluded hospital market basket, see the FY 2006 IPPS final rule (70 FR 47400 through 47403).

Table 2 sets forth the complete proposed 2002-based RPL market basket including cost categories, weights, and price proxies. For comparison purposes, the corresponding FY 1997-based excluded hospital with capital market basket, which is currently used under the LTCH PPS, is also listed.

Wages and salaries are 52.895 percent of total costs for the proposed FY 2002-based RPL market basket compared to 47.335 percent for the FY 1997-based excluded hospital with capital market basket. Employee benefits are 12.982 percent for the proposed FY 2002-based RPL market basket compared to 10.244 percent for the FY 1997-based excluded hospital with capital market basket. As a result, compensation costs (wages and salaries plus employee benefits) for the proposed FY 2002-based RPL market basket are 65.877 percent of costs compared to 57.579 percent for the FY 1997-based excluded hospital with capital market basket. Of the 8 percentage-point difference between the compensation shares, approximately three percentage points are due to the proposed new base year (FY 2002 instead of FY 1997), three percentage points are due to revised LOS edit (that is, including only IRFs and LTCHs whose Medicare ALOS is within 15 percent of the total facility ALOS for the hospital and including only IPFs whose Medicare average LOS in within 30 or 50 percent of the total facility ALOS), and the remaining two percentage points are due to the proposed exclusion of other types of IPPS-excluded hospitals (that is, only including IPFs, IRFs, and LTCHs in the market basket and excluding childrens, cancer hospitals and RNCHIs.).

TABLE 2.—PROPOSED FY 2002-BASED RPL MARKET BASKET COST CATEGORIES, WEIGHTS, AND PROXIES WITH FY 1997-BASED EXCLUDED HOSPITAL WITH CAPITAL MARKET BASKET USED FOR COMPARISON

Expense categories	FY 1997-based excluded hospital with capital market basket	Proposed FY 2002-based RPL market basket	Proposed FY 2002 RPL market basket price proxies
Total	100.000	100.000	
Compensation	57.579	65.877	
Wages and Salaries *	47.335	52.895	ECI–Wages and Salaries, Civilian Hospital Workers.
Employee Benefits *	10.244	12.982	ECI–Benefits, Civilian Hospital Workers.
Professional Fees, Non-Medical	4.423	2.892	ECI–Compensation for Professional, Specialty & Technical Workers.

TABLE 2.—PROPOSED FY 2002-BASED RPL MARKET BASKET COST CATEGORIES, WEIGHTS, AND PROXIES WITH FY 1997-BASED EXCLUDED HOSPITAL WITH CAPITAL MARKET BASKET USED FOR COMPARISON—Continued

Expense categories	FY 1997-based excluded hospital with capital market basket	Proposed FY 2002-based RPL market basket	Proposed FY 2002 RPL market basket price proxies
Utilities	1.180	0.656	
Electricity	0.726	0.351	PPI–Commercial Electric Power.
Fuel Oil, Coal, etc.	0.248	0.108	PPI–Refined Petroleum Products.
Water and Sewage	0.206	0.197	CPI–U—Water & Sewage Maintenance
Professional Liability Insurance	0.733	1.161	CMS Professional Liability Premium Index.
All Other Products and Services	27.117	19.265	
All Other Products	17.914	13.323	
Pharmaceuticals	6.318	5.103	PPI Prescription Drugs.
Food: Direct Purchase	1.122	0.873	PPI Processed Foods & Feeds.
Food: Contract Service	1.043	0.620	CPI–U Food Away From Home.
Chemicals	2.133	1.100	PPI Industrial Chemicals.
Blood and Blood Products**	0.748		
Medical Instruments	1.795	1.014	PPI Medical Instruments & Equipment.
Photographic Supplies	0.167	0.096	PPI Photographic Supplies.
Rubber and Plastics	1.366	1.052	PPI Rubber & Plastic Products.
Paper Products	1.110	1.000	PPI Converted Paper & Paperboard Products.
Apparel	0.478	0.207	PPI Apparel.
Machinery and Equipment	0.852	0.297	PPI Machinery & Equipment.
Miscellaneous Products	0.783	1.963	PPI Finished Goods less Food & Energy.
All Other Services	9.203	5.942	
Telephone	0.348	0.240	CPI–U Telephone Services.
Postage	0.702	0.682	CPI–U Postage.
All Other: Labor Intensive	4.453	2.219	ECI–Compensation for Private Service Occupations.
All Other: Non-labor Intensive	3.700	2.800	CPI–U All Items.
Capital-Related Costs	8.968	10.149	
Depreciation	5.586	6.186	
Fixed Assets	3.503	4.250	Boeckh Institutional Construction 23-year useful life.
Movable Equipment	2.083	1.937	WPI Machinery & Equipment 11-year useful life.
Interest Costs	2.682	2.775	
Nonprofit	2.280	2.081	Average yield on domestic municipal bonds (source: Moody's Aaa bonds vintage).
For Profit	0.402	0.694	Average yield on Moody's AAA bonds vintage weighted (23 years).
Other Capital-Related Costs	0.699	1.187	CPI–U Residential Rent.

* Labor-related
** Blood and blood-related products are included in miscellaneous products
Note: Due to rounding, weights may not sum to total.

The following is an explanation of the proposed expense categories from Table 2.

a. Wages and Salaries

For measuring the price growth of wages in the proposed FY 2002-based RPL market basket, we propose to use the ECI for wages and salaries for civilian hospital workers as the proxy for wages in the RPL market basket.

b. Employee Benefits

The proposed FY 2002-based RPL market basket uses the ECI for employee benefits for civilian hospital workers.

c. Nonmedical Professional Fees

The ECI for compensation for professional and technical workers in private industry would be applied to this category since it includes occupations such as management and consulting, legal, accounting, and engineering services.

d. Fuel, Oil, Coal, and Gasoline.

The percentage change in the price of gas fuels as measured by the PPI (Commodity Code #0552) would be applied to this component.

e. Electricity

The percentage change in the price of commercial electric power as measured by the PPI (Commodity Code #0542) would be applied to this component.

f. Water and Sewerage

The percentage change in the price of water and sewage maintenance as measured by the CPI for all urban consumers (CPI Code #CUUR0000SEHG01) would be applied to this component.

g. Professional Liability Insurance (PLI)

The proposed FY 2002-based RPL market basket would use the percentage change in hospital PLI premiums as estimated by the CMS Hospital Professional Liability Index for the proxy of this category. In the FY 1997-based excluded hospital with capital market basket, the same proxy was used. We continue to research options for improving our proxy for PLI. This research includes exploring various options for expanding our current survey, including the identification of another entity that would be willing to work with us to collect more complete and comprehensive data. We are also exploring other options such as third party or industry data that might assist us in creating a more precise measure of PLI premiums. At this time we have not identified a preferred option, therefore no change is proposed for the proxy in this proposed rule.

h. Pharmaceuticals

The percentage change in the price of prescription drugs as measured by the PPI (PPI Code #PPI32541DRX) would be used as a proxy for this cost category.

This is a special index produced by BLS as a proxy in the 1997-based excluded hospital with capital market basket.

i. Food: Direct Purchases

The percentage change in the price of processed foods and feeds as measured by the PPI (Commodity Code #02) would be applied to this component.

j. Food: Contract Service

The percentage change in the price of food purchased away from home as measured by the CPI for all urban consumers (CPI Code #CUUR0000SEFV) would be applied to this component.

k. Chemicals

The percentage change in the price of industrial chemical products as measured by the PPI (Commodity Code #061) would be applied to this component. While the chemicals hospitals purchase include industrial as well as other types of chemicals, the industrial chemicals component constitutes the largest proportion by far. Thus we believe that Commodity Code #061 is the appropriate proxy.

l. Medical Instruments

The percentage change in the price of medical and surgical instruments as measured by the PPI (Commodity Code #1562) would be applied to this component.

m. Photographic Supplies

The percentage change in the price of photographic supplies as measured by the PPI (Commodity Code #1542) would be applied to this component.

n. Rubber and Plastics

The percentage change in the price of rubber and plastic products as measured by the PPI (Commodity Code #07) would be applied to this component.

o. Paper Products

The percentage change in the price of converted paper and paperboard products as measured by the PPI (Commodity Code #0915) would be used.

p. Apparel

The percentage change in the price of apparel as measured by the PPI (Commodity Code #381) would be applied to this component.

q. Machinery and Equipment

The percentage change in the price of machinery and equipment as measured by the PPI (Commodity Code #11) would be applied to this component.

r. Miscellaneous Products

The percentage change in the price of all finished goods less food and energy as measured by the PPI (Commodity Code #SOP3500) would be applied to this component. Using this index would remove the double-counting of food and energy prices, which are captured elsewhere in the market basket. The weight for this cost category is higher, in part, than in the 1997-based index because the weight for blood and blood products (1.188) is added to it. In the 1997-based excluded hospital with capital market basket we included a separate cost category for blood and blood products, using the BLS PPI for blood and derivatives as a price proxy. A review of recent trends in the PPI for blood and derivatives suggests that its movements may not be consistent with the trends in blood costs faced by hospitals. While this proxy did not match exactly with the product hospitals are buying, its trend over time appears to be reflective of the historical price changes of blood purchased by hospitals. However, an apparent divergence between the BLS PPI for blood and derivatives and trends in blood costs faced by hospitals over recent years led us to reevaluate whether the PPI for blood and derivatives was an appropriate measure of the changing price of blood. As discussed in both the FY 2006 IPPS and IRF PPS proposed rules, we ran test market baskets classifying blood into three separate cost categories: Blood and blood products; contained within chemicals as was done for the 1992-based excluded hospital with capital market basket; and, within miscellaneous products. These categories use as proxies the following PPIs: the PPI for blood and blood products, the PPI for chemicals, and the PPI for finished goods less food and energy, respectively. Of these three proxies, the PPI for finished goods less food and energy moved most like the recent blood cost and price trends. In addition, the impact on the overall market basket by using different proxies for blood was negligible, mostly due to the relatively small weight for blood in the market basket.

Therefore, we are proposing to use the PPI for finished goods less food and energy for the blood proxy because we believe it more appropriately proxies price changes (not quantities or required tests) associated with blood purchased by hospitals because it moved most like the recent blood cost and price trends. (We note that we would continue to evaluate this proxy for its appropriateness and, if adopted, would explore the development of alternative price indexes to proxy the price changes associated with this cost for presentation in a future proposed rule.)

s. Telephone

The percentage change in the price of telephone services as measured by the CPI for all urban consumers (CPI Code #CUUR0000SEED) would be applied to this component.

t. Postage

The percentage change in the price of postage as measured by the CPI for all urban consumers (CPI Code #CUUR0000SEEC01) would be applied to this component.

u. All Other Services, Labor Intensive

The percentage change in the ECI for compensation paid to service workers employed in private industry would be applied to this component.

v. All Other Services, Nonlabor Intensive

The percentage change in the all items component of the CPI for all urban consumers (CPI Code # CUUR0000SA0) would be applied to this component.

3. Proposed Methodology for Capital Portion of the RPL Market Basket

Unlike for the operating costs of the proposed FY 2002-based RPL market basket, we did not have IRF, IPF, and LTCH FY 2002 Medicare cost report data for the capital cost weights, due to a change in the FY 2002 reporting requirements. Rather, we propose to use these hospitals' expenditure data for the capital cost categories of depreciation, interest, and other capital expenses for FY 2001, and age the data to a FY 2002 base year using relevant price proxies. We believe this is the best approach since these data are the capital cost structures of those IRFs, IPFs and LTCHs serving Medicare beneficiaries that require inpatient hospital services.

We calculated weights for the proposed RPL market basket capital costs using the same set of Medicare cost reports used to develop the operating share for IRFs, IPFS, and LTCHs in order to use consistent expense data in developing the proposed weights for both operating and capital costs. The resulting proposed capital weight for the FY 2002 base year is 10.149 percent. This is based on FY 2001 Medicare cost report data for IRFs, IPFs, and LTCHs, aged to FY 2002 using relevant price proxies.

Lease expenses are not a separate cost category in the proposed market basket, but are distributed among the cost categories of depreciation, interest, and

other, reflecting the assumption that the underlying cost structure of leases is similar to capital costs in general. We assumed 10 percent of lease expenses are overhead and assigned them to the other capital expenses cost category as overhead. We base this assignment of 10 percent of lease expenses to overhead on the common assumption that overhead is 10 percent of costs. The remaining lease expenses were distributed to the three cost categories based on the weights of depreciation, interest, and other capital expenses not including lease expenses.

Depreciation contains two subcategories: building and fixed equipment, and movable equipment. The proposed split between building and fixed equipment and movable equipment was determined using the FY 2001 Medicare cost reports for IRFs, IPFs, and LTCHs. We believe this is the best available data source because it reflects the capital cost structures of those IRFs, IPFs and LTCHs serving Medicare beneficiaries. This methodology was also used to compute the 1997-based index (67 FR 50044).

The proposed total interest expense cost category is split between the government/nonprofit and for-profit hospitals. The 1997-based excluded hospital with capital market basket allocated 85 percent of the total interest cost weight to the government nonprofit interest, proxied by average yield on domestic municipal bonds, and 15 percent to for-profit interest, proxied by average yield on Moody's Aaa bonds.

We propose to derive the split using the relative FY 2001 Medicare cost report data for PPS hospitals on interest expenses for the government/nonprofit and for-profit hospitals. Due to insufficient Medicare cost report data for IPFs, IRFs, and LTCHs, we propose to use the same split used in the IPPS capital input price index, which is 75 percent of the total interest cost weight of the government/non-profit interest and 25 percent of for-profit interest. We believe that this split reflects the latest relative cost structure of interest expenses for hospitals because it is based on the most recent complete hospital cost report data and, therefore, we propose to use a 75–25 split to allocate interest expenses to government/nonprofit and for-profit hospitals' interest (70 FR 47408).

Since capital is acquired and paid for over time, capital expenses in any given year are determined by both past and present purchases of physical and financial capital. The vintage-weighted capital index is intended to capture the long-term consumption of capital, using vintage weights for depreciation (physical capital) and interest (financial capital). These vintage weights reflect the purchase patterns of building and fixed equipment and movable equipment over time. Depreciation and interest expenses are determined by the amount of past and current capital purchases. Therefore we are proposing to use the vintage weights to compute vintage-weighted price changes associated with depreciation and interest expense.

Vintage weights are an integral part of the proposed FY 2002-based RPL market basket. Capital costs are inherently complicated and are determined by complex capital purchasing decisions, over time, based on factors such as interest rates and debt financing. In addition, capital is depreciated over time instead of being consumed in the same period it is purchased. The capital portion of the proposed FY 2002-based RPL market basket would reflect the annual price changes associated with capital costs, and would be a useful simplification of the actual capital investment process. By accounting for the vintage nature of capital, we are able to provide an accurate, stable annual measure of price changes. Annual nonvintage price changes for capital are unstable due to the volatility of interest rate changes. Therefore, they do not reflect the actual annual price changes for Medicare capital-related costs. The capital component of the proposed FY 2002-based RPL market basket would reflect the underlying stability of the capital acquisition process and provide hospitals with the ability to plan for changes in capital payments.

To calculate the vintage weights for depreciation and interest expenses, we needed a time series of capital purchases for building and fixed equipment and movable equipment. We found no single source that provides the best time series of capital purchases by hospitals for all of the above components of capital purchases. The early Medicare Cost Reports were not sufficiently completed to have capital data to meet this need. While the AHA Panel Survey provided a consistent database back to 1963, it did not provide annual capital purchases. However, the AHA Panel Survey provided a time series of depreciation expenses through 1997 which could be used to infer capital purchases over time. From 1998 to 2001, hospital depreciation expenses were calculated by multiplying the AHA Annual Survey total hospital expenses by the ratio of depreciation to total hospital expenses from the Medicare cost reports. Beginning in 2001, the AHA Annual Survey began collecting depreciation expenses. We note that we hope to be able to propose to use these data in proposed rebasings that would be presented in future proposed rules.

In order to estimate capital purchases from AHA data on depreciation and interest expenses, the expected life for each cost category (building and fixed equipment, movable equipment, and debt instruments) is needed. Due to insufficient Medicare cost report data for IPFs, IRFs, and LTCHs, we propose to use FY 2001 Medicare Cost Reports for IPPS hospitals to determine the expected life of building and fixed equipment and movable equipment. We believe this data source reflects the latest relative cost structure of depreciation expenses for all hospital types, including IPFs, IRFs, and LTCHs, and is the best available data at this time. The expected life of any piece of equipment can be determined by dividing the value of the asset (excluding fully depreciated assets) by its current year depreciation amount. This calculation yields the estimated useful life of an asset if depreciation were to continue at current year levels, assuming straight-line depreciation. From the FY 2001 Medicare cost reports for IPPS hospitals the expected life of building and fixed equipment was determined to be 23 years, and the expected life of movable equipment was determined to be 11 years.

We also propose to use the fixed and movable weights derived from FY 2001 Medicare cost reports for IPFs, IRFs, and LTCHs to separate the depreciation expenses into annual amounts of building and fixed equipment depreciation and movable equipment depreciation because this is the best available data source. By multiplying the annual depreciation amounts by the expected life calculations from the FY 2001 Medicare cost reports, year-end asset costs for building and fixed equipment and movable equipment were determined. Then, we calculated a time series back to 1963 of annual capital purchases by subtracting the previous year asset costs from the current year asset costs. From this capital purchase time series we are able to calculate the vintage weights for building and fixed equipment, movable equipment, and debt instruments. An explanation of each of these sets of vintage weights follows.

For proposed building and fixed equipment vintage weights, the real annual capital purchase amounts for building and fixed equipment derived from the AHA Panel Survey were used. The real annual purchase amount was used to capture the actual amount of the physical acquisition, net of the effect of price inflation. This real annual

purchase amount for building and fixed equipment was produced by deflating the nominal annual purchase amount by the building and fixed equipment price proxy, the Boeckh Institutional Construction Index. This is the same proxy used for the FY 1997-based excluded hospital with capital market basket. We believe this proxy continues to meet our criteria of reliability, timeliness, availability, and relevance. Since building and fixed equipment has an expected life of 23 years, the vintage weights for building and fixed equipment are deemed to represent the average purchase pattern of building and fixed equipment over 23-year periods. With real building and fixed equipment purchase estimates back to 1963, 16 23-year periods could be averaged to determine the average vintage weights for building and fixed equipment that are representative of average building and fixed equipment purchase patterns over time. Vintage weights for each 23-year period are calculated by dividing the real building and fixed capital purchase amount in any given year by the total amount of purchases in the 23-year period. This calculation is done for each year in the 23-year period, and for each of the 16 23-year periods. The average of each year across the 16 23-year periods is used to determine the 2002 average building and fixed equipment vintage weights.

For proposed movable equipment vintage weights, the real annual capital purchase amounts for movable equipment derived from the AHA Panel Survey were used to capture the actual amount of the physical acquisition, net of price inflation. This real annual purchase amount for movable equipment is calculated by deflating the nominal annual purchase amount by the movable equipment price proxy, the PPI for Machinery and Equipment. This is the same proxy used for the FY 1997-based excluded hospital with capital market basket. We believe this proxy, which meets our criteria, is the best measure of price changes for this cost category. Since movable equipment has an expected life of 11 years, the vintage weights for movable equipment are deemed to represent the average purchase pattern of movable equipment over an 11-year period. With real movable equipment purchase estimates available back to 1963, 28 11-year periods could be averaged to determine the average vintage weights for movable equipment that are representative of average movable equipment purchase patterns over time. Vintage weights for each 11-year period are calculated by dividing the real movable capital purchase amount for any given year by the total amount of purchases in the 11-year period. This calculation is done for each year in the 11-year period, and for each of the 28 11-year periods. The average of the 28 11-year periods is used to determine the proposed FY 2002 average movable equipment vintage weights.

For proposed interest vintage weights, the nominal annual capital purchase amounts for total equipment (building and fixed and movable) derived from the AHA Panel and Annual Surveys were used. Nominal annual purchase amounts were used to capture the value of the debt instrument. Since hospital debt instruments have an expected life of 23 years, the vintage weights for interest are deemed to represent the average purchase pattern of total equipment over 23-year periods. With nominal total equipment purchase estimates available back to 1963, 16 23-year periods could be averaged to determine the average vintage weights for interest that are representative of average capital purchase patterns over time. Vintage weights for each 23-year period are calculated by dividing the nominal total capital purchase amount for any given year by the total amount of purchases in the 23-year period. This calculation is done for each year in the 23-year period and for each of the 16 23-year periods. The average of the 16 23-year periods is used to determine the proposed FY 2002 average interest vintage weights. The proposed vintage weights for the index are presented in Table 3.

In addition to the proposed price proxies for depreciation and interest costs described above in the vintage weighted capital section, we propose to use the CPI–U for Residential Rent as a price proxy for other capital-related costs. Other capital-related costs are mainly composed of taxes and insurance. There is no price proxy for these specific costs; however, we believe the price changes associated with these costs would be reflected in the price changes of residential rent because rent is assumed to move with taxes and insurance on order to maintain profit margins. The price proxies for each of the capital cost categories are the same as those used for the IPPS final rule (67 FR 50044) capital input price index.

TABLE 3.—PROPOSED CMS FY 2002-BASED RPL MARKET BASKET CAPITAL VINTAGE WEIGHTS

Year	Fixed assets (23 year weights)	Movable assets (11 year weights)	Interest: capital-related (23 year weights)
1	.021	.065	.010
2	.022	.071	.012
3	.025	.077	.014
4	.027	.082	.016
5	.029	.086	.019
6	.031	.091	.023
7	.033	.095	.026
8	.035	.100	.029
9	.038	.106	.033
10	.040	.112	.036
11	.042	.117	.039
12	.045		.043
13	.047		.048
14	.049		.053
15	.051		.056
16	.053		.059
17	.056		.062
18	.057		.064
19	.058		.066
20	.060		.070
21	.060		.071

TABLE 3.—PROPOSED CMS FY 2002-BASED RPL MARKET BASKET CAPITAL VINTAGE WEIGHTS—Continued

Year	Fixed assets (23 year weights)	Movable assets (11 year weights)	Interest: capital-related (23 year weights)
22	.061		.074
23	.061		.076
Total	1.000	1.000	1.000

4. Proposed Market Basket Estimate for the 2007 LTCH PPS Rate Year

As discussed previously in this proposed rule, beginning in the 2007 LTCH PPS rate year, we are proposing to adopt the FY 2002-based RPL market basket as the appropriate market basket of goods and services under the LTCH PPS. We are proposing a zero percent update to the LTCH PPS Federal rate for the 2007 LTCH PPS rate year rather than proposing an update based solely on the most recent estimate of the proposed LTCH PPS market basket as we have done in the past. However, as we discuss in section IV.D.1.c. of this preamble, we are proposing to revise the LTCH PPS labor-related share based on the proposed RPL market basket. In Table 4, we are presenting a comparison of the most recent estimates of the increase to the current LTCH PPS market basket (that is, the FY 1997-based excluded hospital with capital market basket) and the proposed FY 2002-based RPL market basket.

Based on Global Insight's 3rd quarter 2005 forecast with history through the 2nd quarter of 2005, the most recent estimate of the RPL market basket for July 1, 2006 through June 30, 2007 (the 2007 LTCH PPS rate year) is 3.6 percent. Global Insight, Inc. is a nationally recognized economic and financial forecasting firm that contracts with CMS to forecast the components of the market baskets. Using the current FY 1997-based excluded hospital with capital market basket, Global Insight's 3rd quarter 2005 forecast, with history through the 2nd quarter of 2005, for the 2007 LTCH PPS rate year would also be 3.6 percent. Table 4 compares the proposed FY 2002-based RPL market basket and the FY 1997-based excluded hospital with capital market basket percent changes. For both the historical and forecasted periods between FY 2000 and FY 2008, the difference between the two market baskets is minor with the exception of FY 2002, where the proposed FY 2002-based RPL market basket increased 3/10 of a percentage point higher than the FY 1997-based excluded hospital with capital market basket. This is primarily due to the proposed FY 2002-based RPL having a larger compensation (this is, the sum of wages and salaries and benefits) cost weight than the FY 1997-based index and the price changes associated with compensation costs increasing much faster than the prices of other market basket components. Also contributing is the ''all other nonlabor intensive'' cost weight, which is smaller in the proposed FY 2002-based RPL market basket than in the FY 1997-based index, as well as the slower price changes associated with these costs.

TABLE 4.—PROPOSED FY 2002-BASED RPL MARKET BASKET AND FY 1997-BASED EXCLUDED HOSPITAL WITH CAPITAL MARKET BASKET, PERCENT CHANGES: 2000–2008

Fiscal year (FY)	Proposed rebased FY 2002-based RPL market basket	FY 1997-based excluded hospital market basket with capital
Historical data:		
RY 2001	3.8	3.9
RY 2002	4.1	3.8
RY 2003	3.8	3.7
RY 2004	3.6	3.6
RY 2005	3.8	3.9
Average RY 2001–2005	3.8	3.8
Forecast:		
RY 2006	3.7	3.8
RY 2007	3.6	3.6
RY 2008	3.5	3.5
RY 2009	3.3	3.1
Average RY 2006–2009	3.5	3.5

Source: Global Insight, Inc. 3rd Qtr 2005, @USMACRO/CNTL0905 @CISSIM/TL0805.SIM.

C. Proposed Standard Federal Rate for the 2007 LTCH PPS Rate Year

1. Background

Under the existing regulations at § 412.523(c)(3)(ii), we update the standard Federal rate annually to adjust for the most recent estimate of the projected increases in prices for LTCH inpatient hospital services. We established this regulation in the August 30, 2002 final rule (67 FR 56030), which implemented the LTCH PPS, because at that time we believed that was the most appropriate method for updating the LTCH PPS Standard Federal rate annually for years after FY 2003. When we moved the date of the annual update of the LTCH PPS from October 1 to July 1 in the RY 2004 LTCH PPS final rule (68 FR 34138), we revised § 412.523(c)(3) to specify that for LTCH PPS rate years beginning on or after July 1, 2003, the annual update to the standard Federal rate for the LTCH prospective payment system would be equal previous rate year's Federal rate updated by the most recent estimate of increases in the appropriate market basket of goods and services included in

covered inpatient LTCH services because, at that time, we continued to believe that was the most appropriate method for updating the LTCH PPS Standard Federal rate annually for years after RY 2004. As established in the RY 2006 LTCH PPS final rule (70 FR 24179), based on the most recent estimate of the excluded hospital with capital market basket, adjusted to account for the change in the LTCH PPS rate year update cycle, the current LTCH PPS standard Federal rate which is effective from July 1, 2005 through June 30, 2006 (the 2006 LTCH PPS rate year) is $38,086.04 (70 FR 24179). In the discussion that follows, we explain how we developed the proposed standard Federal rate for the 2007 LTCH PPS rate year. Specifically, we explain our rationale, which is based on our ongoing monitoring activities, for proposing a zero percent update to the standard Federal rate for the 2007 LTCH PPS rate year rather than proposing to solely use the most recent estimate of the proposed RPL market basket as the update factor for the Federal rate for the upcoming rate year. Thus, the proposed standard Federal rate for the 2007 LTCH PPS rate year would be $38,086.04.

2. Description of a Preliminary Model of an Update Framework Under the LTCH PPS

In the August 30, 2002 final rule (67 FR 56087), which implemented the LTCH PPS, we stated that in the future we may propose to develop a framework to update payments to LTCHs that would account for other appropriate factors that affect the efficient delivery of services and care provided to Medicare patients. A conceptual basis for the proposal of developing an update framework in the future was presented in Appendix B of that same final rule (67 FR 56086). In subsequent final rules that updated the LTCH PPS standard Federal rate for years after FY 2003, we explained that we did not propose an update framework because we had not yet collected sufficient data to allow for the analysis and development of a framework under the LTCH PPS (see 68 FR 34134, 69 FR 25682, and 70 FR 24179). Since the LTCH PPS was implemented just slightly over 3 years ago (for cost reporting periods beginning on or after October 1, 2002) and due to the time lag in the availability of Medicare data, we continue to believe that we still do not yet have sufficient data to develop an update framework upon which to base the proposed update to the standard Federal rate for the 2007 LTCH PPS rate year.

Although we do not have enough complete data at this time to propose an update for RY 2007 based on an update framework, we believe that the almost 2 full years of data generated under the LTCH PPS is sufficient data to begin the discussion of the development of a potential update framework that we may propose to use in the future under the LTCH PPS for the annual update to the LTCH standard Federal rate. Therefore, although we are not proposing to employ an analytical update framework in this proposed rule to determine the proposed 2007 LTCH PPS rate year update to the standard Federal rate, in Appendix A of this proposed rule, we are presenting a preliminary model of an update framework, using the best available data and concepts, which we may propose to adopt at some time in the future.

We are soliciting comments on this preliminary update framework methodology and its application that may be proposed in the future. Also, we would appreciate comments regarding recommendations to improve it. We note that this preliminary model of an update framework for the LTCH PPS is based on the conceptual discussion of a LTCH PPS update framework that was presented in the August 30, 2002 final rule (67 FR 56086), and is similar to the update framework formerly used to develop the operating IPPS annual update recommendation (69 FR 28816 through 28817) and that which is currently used under the capital IPPS for inpatient short-term acute-care hospitals set forth at § 412.308(c)(1)(ii).

3. Proposed Update to the Standard Federal Rate for the 2007 LTCH PPS Rate Year

Currently, under § 412.523, the annual update to the LTCH PPS standard Federal rate is equal to the most recent estimate of increases in the prices of an appropriate market basket of goods and services included in covered inpatient LTCH services (that is, presently, the excluded hospital with capital market basket). As we indicated in previous LTCH PPS final rules (67 FR 56014, 68 FR 34157, 69 FR 25712, and 70 FR 24209 through 24213), we have developed a monitoring system to assist us in evaluating the LTCH PPS. We have used the results of these monitoring efforts, along with the most recently available LTCH PPS data to assess current payment adequacy under the LTCH PPS. As we discuss in greater detail, because we believe that current payments are more than adequate to account for price increases in the services furnished by LTCHs during the 2007 LTCH PPS rate year, under the broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of BIPA to include appropriate adjustments in the establishment of the LTCH PPS, we are proposing to revise § 412.523(c)(3)(ii), to specify that, for discharges occurring on or after July 1, 2006 and on or before June 30, 2007, the standard Federal rate from the previous year would be updated by a factor of zero percent. That is, the standard Federal rate for the July 1, 2006 through June 30, 2007 rate year would remain the same as the standard Federal rate in effect during the 2006 rate year (July 1, 2005 through June 30, 2006), that is, $38,086.04.

In the August 30, 2002 final rule (67 FR 56014), we describe an on-going monitoring component of the new LTCH PPS that would enable us to evaluate the impact of the new payment policies. We stated that if our data indicate that changes to the system might be warranted, we may consider proposing revisions to these policies in the future. Since the implementation of the LTCH PPS (for cost reporting periods beginning on or after October 1, 2002), there has been tremendous growth in the number of LTCHs reimbursed by Medicare. Specifically, the number of LTCHs has almost doubled over the past 3 years 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 (CMI) and margins under the LTCH PPS. Margins are defined as payment-to-cost ratios of LTCH inpatient Medicare payments to LTCH inpatient Medicare costs. We believe the proposed zero percent update factor for RY 2007 is supported by our findings regarding CMI, Medicare margins, and patient census based on the most recent complete LTCH data. The following is a discussion of our analysis of each of these factors.

A LTCH's CMI is defined as its case weighted average LTC–DRG relative weight for all its discharges in a given period. Changes in CMI consist of two components: ''real'' CMI changes and ''apparent'' CMI changes. Real CMI 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 CMI increase is defined as the increase in CMI due to changes in coding practices. Observed CMI increase is defined as real CMI increase plus the increase in computed CMI 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). If LTCH patients have more costly impairments, lower functional status, or increased comorbidities, and thus require more resources in the LTCH, we would 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 CMI increase), and should not be influenced by changes in coding practices (apparent CMI increase). Apparent CMI 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 LTCH PPS payment that does not necessarily reflect the true cost of treating the patient. Therefore, under the broad discretionary authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of BIPA to include appropriate adjustments in the establishment of the LTCH PPS, we are proposing to revise 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. It is important to eliminate the effect of coding or classification changes because, as discussed above in this section, they do not reflect the true cost of treating patients. We believe that the adjustment we are proposing to eliminate the effect of coding or classification changes that do not reflect real changes in LTCHs' case-mix would reduce the amount that RY 2007 LTCH PPS payments would have been absent this adjustment so that payments would become more aligned with the true costs of treating LTCH patients.

As described in our August 30, 2002 final rule, we contracted with 3M Health Information Systems (3M) to analyze LTCH data to support our efforts in developing the original LTCH PPS in 2002. We have continued our contract with 3M to assist CMS in developing potential refinements to the LTCH PPS, including some of the proposed changes presented in this proposed rule. As part of this research, we asked 3M to examine changes in case-mix and coding since the implementation of the LTCH PPS based on the most recently available data. As part of their analysis, 3M compared FY 2003 LTCH claims data from the first year of implementation of the PPS with the FY 2001 claims data (generated prior to the implementation of the LTCH PPS), which is the same LTCH claims data used to develop the LTCH PPS.

The analysis performed by 3M indicates that the observed case-mix in LTCHs increased by 5.6 percent between FY 2001 and FY 2003. The average annual CMI 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 is 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 CMI increase (that is, we assume that the increase in case-mix is not due to improvements in documentation or more complete coding of the medical record during this period). Using the average annual 2.75 percent observed CMI increase as a baseline, we can separate the CMI increase between FYs 2003 and 2004 into the real CMI increase, which is based on the treatment of more resource intensive patients, and the apparent CMI increase, which is due to improvements in documentation and coding practices.

The calculated observed CMI increase between FYs 2003 and 2004 was 6.75 percent. Assuming that the real CMI increase observed (on average) from FY 2001 to FY 2003 remained relatively constant into FY 2005, then the difference of 4.0 percent (6.75 percent minus 2.75 percent) represents the apparent CMI increase due to improvements in documentation and coding. This is considerably higher than the 0.34 percent behavioral offset originally estimated by CMS actuaries, which was used in the development of the FY 2003 LTCH PPS standard Federal rate (67 FR 56033). We note that the 4.0 percent apparent CMI increase is a conservative estimate when compared to the 5.35 percent apparent CMI increase that would result if we applied the information from past studies on case-mix change. Based on past studies of IPPS 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)), we have assumed that real case-mix change for IPPS hospitals was a fairly steady 1.0 to 1.4 percent per year. If we apply this same assumption to LTCHs, nearly 5.35 percent (6.75 percent − 1.4 percent) of the change in case-mix during the first year of the LTCH PPS is apparent CMI and not real CMI.

We recognize that the LTCH PPS may have increased incentives for LTCHs to take patients with greater impairment, lower function, or increased comorbidities because the more complicated the patient's principle diagnosis and accompanying comorbidities, the higher the relative weight for the LTC–DRG, and the higher the resulting LTCH PPS payment. Under TEFRA, LTCHs were paid on the basis of Medicare reasonable costs limited by a hospital-specific target amount per discharge, which were based on base-year cost per case. Thus, LTCHs may have greater incentives to admit more costly patients and therefore, we expected to see an increase in the observed CMI due to the implementation of the LTCH PPS. However, we believe a significant portion of the 6.75 percent increase in CMI between FY 2003 and FY 2004 is due to changes in coding practices rather than the treatment of more resource intensive patients. In our analysis of cost per discharge, we found that while payments (revenue) per discharge increased approximately 17 percent from FY 2002 to FY 2003 (the first year of LTCH PPS), costs (expenses) per discharge increased by only 8 percent for the same period. Thus payments to LTCHs from FY 2002 to FY 2003 increased more than 2 times as much as the increase of costs during the same period. We didn't observe a large increase in cost per discharge, which we would have expected to see if the observed CMI was due to ''real'' CMI change (treating sicker patients). We would have expected to see a large increase in costs per discharge if the CMI was due to real CMI change because we expected LTCHs to admit more severely ill patients as described previously which we thought would have required more resources to treat these patients. Furthermore, review by a Medicare program safeguard contractor working with the FI sampled LTCH claims with specific diagnoses in one LTCH and determined that the majority of those patients were not ''hospital-

level'' patients. Rather, the level of care needed by these patients was more suitable for a Skilled Nursing Facility (SNF) than a LTCH. The QIO reviewed a sample of the claims that had been determined not to be hospital-level patients by the Medicare program safeguard contractor and concurred with its assessment of most of those cases. Anecdotally, we have heard of other investigations of LTCHs treating patients that do not require hospital-level care. This finding further supports the data showing that cost per discharge did not increase as rapidly as LTCHs' CMI and that the increase in LTCHs' CMI is primarily due to factors other than real CMI.

In addition, an internal CMS analysis shows high Medicare margins among LTCHs since the implementation of the LTCH PPS in FY 2003. Specifically, 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 calculation, also utilized by MedPAC in its analyses, is used to evaluate the overall financial status of LTCHs. In an analysis of the latest available LTCH cost reports, we found that LTCH Medicare payments for FY 2003 (the first year of the LTCH PPS) were 8.8 percent higher than LTCHs' Medicare costs. Preliminary cost report data for FY 2004 reveal an even higher Medicare margin of 11.7 percent. For the period prior to the implementation of the LTCH PPS (that is, FY 1996 through FY 2002), we found that Medicare margins ranged between a minimum of −2.2 percent in FY 2002, and a maximum of 2.9 percent in FY 1997.

We note that MedPAC is presently engaged in an evaluation of payment adequacy for LTCHs, which upon completion, will be published in the Commission's 2006 Reports to the Congress. At the Commission's October 7, 2005 public meeting, the preliminary findings were presented. The report included the following:

- The number of LTCHs increased rapidly since the implementation of the LTCH PPS; the increase in the volume of cases was even greater; and beneficiaries' access to care has also increased;
- Medicare spending has increased more rapidly than volume.
- LTCHs have access to capital and are rapidly expanding into market areas that had no LTCHs prior to the establishment of the LTCH PPS for FY 2003, as well as in areas that already had LTCHs.
- Medicare payments under the LTCH PPS are ''attractive'' since despite the fact that LTCHs could opt to be phased-in to the fully Federal payments over 5 years, with a decreasing percentage of payments based on their former TEFRA payments, since 2004, 93 percent of LTCHs have opted to be paid 100 percent under the Federal rate.
- In evaluating adequacy of payments, it can generally be assumed that if the payments are adequate, the volume of patients will increase. This was true under the LTCH PPS, where cases increased 12 percent per year between 2001 and 2004, while Medicare spending increased 25 percent per year for the same period.
- Medicare LTCH spending increased 28 percent from 2003 to 2004.

(The transcript of the discussion of LTCH payment adequacy from the October 7, 2005 MedPAC public meeting can be found at the following web address: *http://www.medpac.gov/public_meetings/transcripts/1005_allcombined_transc.pdf* (pages 256 through 298).)

Consistent with MedPAC's most recent research, our margins analysis indicates 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. We believe this is because the large observed increase in LTCH case-mix was not accompanied by a corresponding increase in Medicare costs. This is consistent with our belief expressed earlier that a significant part of this observed increase in case-mix is ''apparent'' and not ''real.'' Therefore, under the broad discretionary authority conferred upon the Secretary in section 123(a) of the BBRA as amended by section 307(b)(1) of the BIPA to make appropriate adjustments, as explained previously, we believe that it is fiscally prudent and appropriate to propose to revise § 412.523(c)(3)(iii) to specify that the standard Federal rate for the LTCH PPS rate year July 1, 2006 through June 30, 2007, would be the standard Federal rate from the previous year be updated by a factor of zero percent. A zero percent update factor would reflect an adjustment to the market basket update to account for the increase in the apparent case-mix in the prior period. Based on our analysis of the observed LTCH case-mix increase, we estimate that 4 percent of the 6.75 percent calculated observed LTCH CMI increase is due to improvements in documentation and coding and not due to an increase in the severity of the patients being treated at LTCHs. As previously noted, the Federal payment rate was offset by 0.34 percent to reflect expected behavioral changes, including changes in coding. The recent estimate of apparent CMI increase (4 percent) indicates that an additional 3.66 percent adjustment (4 percent apparent CMI increase minus 0.34 percent behavioral offset) should be made to the Federal payment rate to account for improvements in coding. Accounting for the most recent estimate of the RPL market basket increase (3.6 percent) and the additional adjustment for improvements in coding (3.66 percent), the resulting update is within rounding error of zero percent. We are proposing a zero percent update for the 2007 LTCH PPS rate year, which would result in a proposed LTCH PPS standard Federal rate of $38,086.04 for the 2007 LTCH PPS rate year. We believe that a zero percent update for the 2007 LTCH PPS rate year is appropriate to protect the integrity of the Medicare Trust Funds by ensuring that the LTCH PPS payment rates better reflect the true costs of treating LTCH patients. Furthermore, based on the sizeable Medicare margins among LTCHs, we believe that the proposed standard Federal rate for the 2007 LTCH PPS rate year would not affect beneficiary access to LTCH services since LTCHs would continue to be paid adequately to reflect the cost of resources needed to treat Medicare beneficiaries.

As discussed in section IV.B.4. of this preamble, the most recent estimate of the proposed LTCH PPS market basket is 3.6 percent for the 2007 LTCH PPS rate year. If we were not proposing to revise § 412.523(c)(3) to provide a zero percent update to the standard Federal rate for the 2007 LTCH PPS rate year to account for changes in coding that do not reflect real changes in the severity and cost of LTCH patients presented in this proposed rule, under existing § 412.523(c)(3)(ii) the proposed update would have been 3.6 percent.

We note that the proposed revision to § 412.525(c)(3) would only address an update to the LTCH PPS Federal rate through the 2007 LTCH PPS rate year. We intend to propose future revisions to § 412.525(c)(3) to address future proposed updates to the LTCH PPS Federal rates in future rate years based on an analysis of the most recent available LTCH data that would be presented in upcoming LTCH proposed rules. As noted previously in this proposed rule and in the August 30, 2002 final rule (67 FR 56097), we are examining the potential for developing and implementing an update framework

under the LTCH PPS. We believe an update framework, used in combination with the market basket, would enhance the methodology for updating payments by addressing factors beyond changes in pure input prices (measured by the market basket) such as case-mix, intensity, and productivity. (As noted in section IV.C.2 of this proposed rule, a preliminary model of an update framework that may be proposed at some later date for future use under the LTCH PPS is presented in Appendix A of this proposed rule.) However, we are not proposing a specific annual update framework until we have collected sufficient complete LTCH PPS data to evaluate payments and costs under the LTCH PPS.

In addition, currently as implemented in § 412.523(d)(3), we have provided for the possibility of making a one-time prospective adjustment to the LTCH PPS rates so that any significant difference from actual payments and the estimated payments for the first year of the LTCH PPS is not perpetuated in the prospective payment rates for future years. As discussed in section IV.D.5. of this proposed rule, we are not proposing an adjustment to the LTCH PPS rates under § 412.523(d)(3) in this proposed rule; however, we intend to continue to collect and interpret new data to determine if an adjustment should be proposed in the future. In addition, as also discussed in section IV.D.5. of this proposed rule, we are proposing to postpone the deadline of the possible one-time prospective adjustment to the LTCH PPS rates provided for in § 412.523(d)(3) to July 1, 2008 in order to maximize the availability of data used to conduct a comprehensive evaluation of the LTCH PPS. However, we note that the proposed zero percent update for the 2007 LTCH PPS rate year may make this one-time prospective adjustment to the LTCH PPS Federal rate unnecessary if our comprehensive analysis of the LTCH PPS determines that LTCH PPS payments and the costs for LTCH services become aligned as a result of this proposed change. We solicit comments on whether the proposed zero percent for the 2007 LTCH PPS rate year is appropriate or if an alternative percentage reduction should be applied to the standard Federal rate for the 2007 LTCH PPS rate year.

4. Proposed Standard Federal Rate for the 2007 LTCH PPS Rate Year

In the RY 2006 LTCH PPS final rule (70 FR 24180), we established a standard Federal rate of $38,086.04 for the 2006 LTCH PPS rate year that was based on the best available data and policies established in that final rule. In this proposed rule, we would revise § 412.523(c)(3) to establish a standard Federal rate based on a zero percent update as discussed in section IV. B. of this proposed rule. Therefore, based on the proposed zero percent update, the proposed standard Federal rate for RY 2007 would be $38,086.04. As we stated in the RY 2006 LTCH PPS final rule, the standard Federal rate of $38,086.04 was already adjusted for differences in case-mix, wages, cost-of-living, and high cost outlier payments. Therefore, we made additional adjustments in the RY 2006 LTCH PPS standard Federal rate for those factors (70 FR 24180). Similarly, since the proposed standard Federal rate for the 2007 LTCH PPS rate year has already been adjusted for differences in case-mix, wages, cost-of-living, and high-cost outlier payments, we would not propose to make any additional adjustments in the proposed standard Federal rate for these factors.

D. Calculation of Proposed LTCH Prospective Payments for the 2007 LTCH PPS Rate Year

The basic methodology for determining prospective payment rates for LTCH inpatient operating and capital-related costs is set forth in § 412.515 through § 412.532. In accordance with § 412.515, we assign appropriate weighting factors to each LTC–DRG to reflect the estimated relative cost of hospital resources used for discharges within that group as compared to discharges classified within other groups. The amount of the prospective payment is based on the standard Federal rate, established under § 412.523, and adjusted for the LTC–DRG relative weights, differences in area wage levels, cost-of-living in Alaska and Hawaii, high-cost outliers, and other special payment provisions (short-stay outliers (SSO) under § 412.529 and interrupted stays under § 412.531).

In accordance with § 412.533, during the 5-year transition period, payment is based on the applicable transition blend percentage of the adjusted Federal rate and the reasonable cost-based payment rate unless the LTCH makes a one-time election to receive payment based on 100 percent of the Federal rate. A LTCH defined as ''new'' under § 412.23(e)(4) is paid based on 100 percent of the Federal rate with no blended transition payments (§ 412.533(d)). As discussed in the August 30, 2002 final rule (67 FR 56038), and in accordance with § 412.533(a), the applicable transition blends are as shown in Table 5.

TABLE 5

Cost reporting periods beginning on or after	Federal rate percentage	Reasonable cost-based payment rate percentage
October 1, 2002	20	80
October 1, 2003	40	60
October 1, 2004	60	40
October 1, 2005	80	20
October 1, 2006	100	0

Accordingly, for cost reporting periods beginning during FY 2005 (that is, on or after October 1, 2004, and on or before September 30, 2005), blended payments under the transition methodology are based on 40 percent of the LTCH's reasonable cost-based payment rate and 60 percent of the adjusted LTCH PPS Federal rate. For cost reporting periods that begin during FY 2006 (that is, on or after October 1, 2005 and on or before September 30, 2006), blended payments under the transition methodology will be based on 20 percent of the LTCH's reasonable cost-based payment rate and 80 percent of the adjusted LTCH PPS Federal rate. For cost reporting periods beginning on or after October 1, 2006 (FY 2007), Medicare payment to LTCHs will be determined entirely (100 percent) under the LTCH PPS Federal rate.

1. Proposed Adjustment for Area Wage Levels

a. Background

Under the authority of section 123 of the BBRA as amended by section 307(b) of the BIPA, we established an adjustment to the LTCH PPS Federal rate to account for differences in LTCH area wage levels at § 412.525(c). The labor-related share of the LTCH PPS Federal rate, currently estimated by the excluded hospital with capital market basket, is adjusted to account for geographic differences in area wage levels by applying the applicable LTCH PPS wage index. The applicable LTCH PPS wage index is computed using wage data from inpatient acute care hospitals without regard to reclassification under sections 1886(d)(8) or 1886(d)(10) of the Act. Furthermore, as we discussed in the August 30, 2002 LTCH PPS final rule (67 FR 56015), we established a 5-year transition to the full wage adjustment. The applicable wage index phase-in percentages are based on the start of a LTCH's cost reporting period as shown in Table 6.

TABLE 6

Cost reporting periods beginning on or after	Phase-in percentage of the full wage index
October 1, 2002	1/5th (20 percent).
October 1, 2003	2/5ths (40 percent).
October 1, 2004	3/5ths (60 percent).
October 1, 2005	4/5ths (80 percent).
October 1, 2006	5/5ths (100 percent).

For example, for cost reporting periods beginning on or after October 1, 2004 and on or before September 30, 2005 (FY 2005), the applicable LTCH wage index value is three-fifths of the applicable full LTCH PPS wage index value. Similarly, for cost reporting periods beginning on or after October 1, 2005 and on or before September 30, 2006 (FY 2006), the applicable LTCH wage index value will be four-fifths of the applicable full LTCH PPS wage index value. The wage index adjustment will be completely phased-in beginning with cost reporting periods beginning in FY 2007, that is, for cost reporting periods beginning on or after October 1, 2006, the applicable LTCH wage index value will be the full (five-fifths) LTCH PPS wage index value. As we established in the August 30, 2002 LTCH PPS final rule (67 FR 56018), the applicable full LTCH PPS wage index value is calculated from acute-care hospital inpatient wage index data without taking into account geographic reclassification under sections 1886(d)(8) and (d)(10) of the Act.

In that same final rule (67 FR 56018), we stated that we would continue to reevaluate LTCH data as they become available and would propose to adjust the phase-in if subsequent data support a change. As we discussed in the RY 2006 LTCH PPS final rule (70 FR 24181), because the LTCH PPS was only recently implemented (slightly over 2 years) and because of the time lag in availability of cost report data, sufficient new data have not been generated that would enable us to conduct a comprehensive reevaluation of the appropriateness of adjusting the phase-in. However, for this proposed rule, we have reviewed the most recent data (FY 2002–FY 2004) available and did not find any evidence to support a change in the 5-year phase-in of the wage index. Specifically, our statistical analysis still does not show a significant relationship between LTCHs' costs and their geographic location. Therefore, in this proposed rule, we are not proposing a change in the phase-in of the adjustment for area wage levels under § 412.525(c).

b. Geographic Classifications/Labor Market Area Definitions

As discussed in the August 30, 2002 LTCH PPS final rule, which implemented the LTCH PPS (67 FR 56015 through 56019), in establishing an adjustment for area wage levels under § 412.525(c), the labor-related portion of a LTCH's Federal prospective payment is adjusted by using an appropriate wage index based on the labor market area in which the LTCH is located. In the 2006 LTCH PPS rate year final rule (70 FR 24184 through 24185), in § 412.525(c), we revised the labor market area definitions used under the LTCH PPS effective for discharges occurring on or after July 1, 2005 based on the Office of Management and Budget's (OMB's) Core Based Statistical Area (CBSA) designations based on 2000 Census data because we believe that those new labor market area definitions will ensure that the LTCH PPS wage index adjustment most appropriately accounts for and reflects the relative hospital wage levels in the geographic area of the hospital as compared to the national average hospital wage level. As set forth in § 412.525(c)(2), a LTCH's wage index is determined based on the location of the LTCH in an urban or rural area as defined in § 412.64(b)(1)(ii)(A) through (C). An urban area under the LTCH PPS is defined as is defined at § 412.64(b)(1)(ii)(A) and (B). In general, an urban area is defined as a Metropolitan Statistical Area (MSA) as defined by the OMB. (In addition, a few counties located outside of MSAs are considered urban as specified at § 412.64(b)(1)(ii)(B).) Under § 412.64(b)(1)(ii)(C), a rural area is defined as any area outside of an urban area. We note that these are the same CBSA-based designations implemented for acute care inpatient hospitals under the IPPS at § 412.64(b) effective October 1, 2004 (69 FR 49026 through 49034). For further discussion of the labor market area (geographic classification) definitions used under the LTCH PPS, see the 2006 LTCH PPS rate year final rule (70 FR 24182 through 24191).

c. Proposed Labor-Related Share

In the August 30, 2002 LTCH PPS final rule (67 FR 56016), we established a labor-related share of 72.885 percent based on the relative importance of the labor-related share of operating costs (wages and salaries, employee benefits, professional fees, postal services, and all other labor-intensive services) and capital costs of the excluded hospital with capital market basket based on FY 1992 data. In the June 6, 2003 final rule (68 FR 34142), in conjunction with our revision and rebasing of the excluded hospital with capital market basket from a FY 1992 to a FY 1997 base year, we discussed revising the labor-related share based on the relative importance of the labor-related share of operating and capital costs of the excluded hospital with capital market basket based on FY 1997 data. However, in the June 6, 2003 final rule (68 FR 34142), while we adopted the revised and rebased FY 1997-based LTCH PPS market basket as the LTCH PPS update factor for the 2004 LTCH PPS rate year, we decided not to update the labor-related share under the LTCH PPS pending further analysis of the current labor share methodology.

In LTCH PPS final rules subsequent to the FY 2003 LTCH PPS final rule in which we established the current labor-related share (68 FR 34142, 69 FR 25685 through 25686 and 70 FR 24182), we explained that the primary reason that we did not update the LTCH PPS labor-related share for the 2004, 2005 and 2006 LTCH PPS rate years was because of data and methodological concerns, which was the same reason for not updating the labor-related share under the IPPS for FY 2004 (68 FR 45467 through 45468) and FY 2005 (69 FR 49069), which are equally applicable to the LTCH PPS. We indicated that we would conduct further analysis to determine the most appropriate methodology and data for determining the labor-related share. We also stated that we would propose to update the IPPS and excluded hospital labor-related shares, if necessary, once our research is complete.

In the FY 2006 IPPS final rule, the labor-related share under the IPPS that is ''estimated by the Secretary from time to time'' as specified in section 1886(d)(3)(E) of the Act was revised and rebased based on the FY 2002-based IPPS hospital market basket for discharges occurring on or after October 1, 2005 using our established methodology of defining the labor-related share as 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, the IPPS labor-related share ''estimated by the Secretary from time to time'' was calculated by adding the relative weights for these operating cost categories. In that same final rule we stated that we continue to believe, as we stated in the past, that these operating cost categories likely are related to, are influenced by, or vary with the local markets (70 FR 47392 through 47393). (We note that section 403 of the MMA

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 under the IPPS unless this employment ''would result in lower payments than would otherwise be made.'') In that same final rule, we also revised and rebased the excluded hospital market basket, which is used to update the reasonable cost-based portion of LTCHs' blended transition payments (70 FR 47399 through 47403).

As we stated previously, once our research into the labor-related share methodology was complete, we would update the IPPS and excluded hospital labor-related shares based on that research and the best available data if necessary. In this proposed rule, we are proposing to update the LTCH PPS labor-related share based on the proposed RPL market basket as discussed in section IV.D.1.c. of this preamble. We are proposing to adopt the RPL market basket under the LTCH PPS because we believe that this market basket is developed based on the best available data that reflect the cost structures of LTCHs. Specifically, we are proposing to revise the LTCH PPS labor-related share from 72.885 percent (as established in the August 30, 2002 final rule (67 FR 56016) based on the FY 1997-based excluded hospital with capital market basket) to 75.923 percent based on the relative importance of the labor-related share of operating costs (wages and salaries, employee benefits, professional fees, and all other labor-intensive services) and capital costs of the proposed RPL market basket based on FY 2002 data, as discussed in greater detail below.

Consistent with our historical practice, the labor-related share is determined by identifying the national average proportion of operating costs that are related to, influenced by, or varies with the local labor market. Using our current definition of labor-related, the labor-related share is the sum of the relative importance of wages and salaries, fringe benefits, professional fees, labor-intensive services, and a portion of the capital share from an appropriate market basket. We are proposing to use the proposed FY 2002-based RPL market basket costs to determine the proposed labor-related share for the LTCH PPS effective for discharges occurring on or after July 1, 2006 as it is based on the most recent available data. The proposed labor-related share for the 2007 LTCH PPS rate year would be the sum of the relative importance of each labor-related cost category, and would reflect the different rates of price change for these cost categories between the base year (FY 2002) and the 2007 LTCH PPS rate year. Based on the most recent available data, the sum of the proposed relative importance for 2007 LTCH PPS rate year for operating costs (wages and salaries, employee benefits, professional fees, and labor-intensive services) would be 71.845, as shown in Table 7. The portion of capital that is influenced by the local labor market is estimated to be 46 percent, which is the same percentage used in the 1997-based excluded hospital with capital market basket currently used under the LTCH PPS. Since the relative importance for capital would be 8.866 percent of the proposed FY 2002-based RPL market basket for the 2007 LTCH PPS rate year based on the latest available data, we are proposing to multiply the estimated portion of capital influenced by the local labor market (46 percent) by the relative importance for capital of the proposed FY 2002-based RPL market basket (8.866 percent) to determine the proposed labor-related share of capital for the 2007 LTCH PPS rate year. The result would be 4.078 percent (0.46 × 8.866 percent), which we propose to add to 71.845 percent for the operating cost amount to determine the total proposed labor-related share for the 2007 LTCH PPS rate year. Thus, based on the latest available data, we are proposing to use a labor-related share of 75.923 percent under the LTCH PPS for the 2007 LTCH PPS rate year. This proposed labor-related share is determined using the same methodology as employed in calculating the current LTCH labor-related share (67 FR 56016). If more recent data become available before the publication of the final rule and if we revise the LTCH PPS labor-related share based on the proposed FY 2002-based RPL market basket, we propose that we would use that data to determine the labor-related share for the 2007 LTCH PPS rate year in the final rule.

Table 7 shows the proposed 2007 LTCH PPS rate year relative importance labor-related share using the proposed 2002-based RPL market basket and the current relative importance labor-related share using the FY 1997-based excluded hospital with capital market basket.

TABLE 7.—TOTAL LABOR-RELATED SHARE-RELATIVE IMPORTANCE FOR THE 2007 FOR THE PROPOSED RPL MARKET BASKET AND THE EXCLUDED HOSPITAL WITH CAPITAL MARKET BASKET

Cost category	Proposed FY 2002-based RPL market basket relative importance (percent) for the 2007 LTCH PPS rate year	FY 1997-based excluded hospital with capital market basket relative importance (percent currently used under the LTCH PPS)
Wages and salaries	52.761	50.381
Employee benefits	14.008	11.525
Professional fees	2.903	2.059
Postal Services*	.....	0.244
All other labor-intensive services**	2.173	5.219
Subtotal	71.845	69.428
Labor-related share of capital costs	4.078	3.457
Total	75.923	72.885

* No longer considered labor related.

** Other labor intensive services includes landscaping services, services to buildings, detective and protective services, repair services, laundry services, advertising, auto parking and repairs, physical fitness facilities, and other government enterprises.

d. Proposed Wage Index Data

In the RY 2006 LTCH PPS final rule (70 FR 24190 through 24191), we established LTCH PPS wage index values for the 2006 LTCH PPS rate year calculated from the same data (generated in cost reporting periods beginning during FY 2000) used to compute the FY 2005 acute care hospital inpatient wage index data without taking into account geographic reclassification under sections 1886(d)(8) and (d)(10) of the Act because that was the best available data at that time. The LTCH wage index values applicable for discharges occurring on or after July 1, 2005 through June 30, 2006 are shown in Table 1 (for urban areas) and Table 2 (for rural areas) in the Addendum to the RY 2006 LTCH PPS final rule. Acute care hospital inpatient wage index data are also used to establish the wage index adjustment used in the IRF PPS, HHA PPS, and SNF PPS. As we discussed in the August 30, 2002 LTCH PPS final rule (67 FR 56019), since hospitals that are excluded from the IPPS are not required to provide wage-related information on the Medicare cost report and because we would need to establish instructions for the collection of this LTCH data in order to establish a geographic reclassification adjustment under the LTCH PPS, the wage adjustment established under the LTCH PPS is based on a LTCH's actual location without regard to the urban or rural designation of any related or affiliated provider.

In this proposed rule, under the broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of BIPA to determine appropriate adjustments under the LTCH PPS, we are proposing that, for the 2007 LTCH PPS rate year, the same data (generated in cost reporting periods beginning during FY 2002) used to compute the FY 2006 acute care hospital inpatient wage index data without taking into account geographic reclassification under sections 1886(d)(8) and (d)(10) of the Act would be used to determine the applicable wage index values under the LTCH PPS because these data (FY 2002) are the most recent complete data. We are proposing to continue to use IPPS wage data as a proxy to determine the proposed LTCH wage index values for the 2007 LTCH PPS rate year because both LTCHs and acute-care hospitals are required to meet the same certification criteria set forth in section 1861(e) of the Act to participate as a hospital in the Medicare program and they both compete in the same labor markets, and therefore experience similar wage-related costs. These data are the same FY 2002 acute care hospital inpatient wage data that were used to compute the FY 2006 wage indices currently used under the IPPS, SNF PPS and HHA PPS.

The proposed LTCH wage index values that would be applicable for discharges occurring on or after July 1, 2006 through June 30, 2007, are shown in Table 1 (for urban areas) and Table 2 (for rural areas) in the Addendum to this proposed rule.

As discussed above in section IV.D.1.a. of this preamble, the applicable wage index phase-in percentages are based on the start of a LTCH's cost reporting period beginning on or after October 1st of each year during the 5-year transition period. Thus, for cost reporting periods beginning on or after October 1, 2004 and before October 1, 2005 (FY 2005), the labor portion of the standard Federal rate is adjusted by three-fifths of the applicable LTCH wage index value. For cost reporting periods beginning on or after October 1, 2005 and before October 1, 2006 (FY 2006), the labor portion of the standard Federal rate is adjusted by four-fifths of the applicable LTCH wage index value. Specifically, for a LTCH's cost reporting period beginning during FY 2006, for discharges occurring on or after July 1, 2006 through June 30, 2007, the applicable wage index value would be four-fifths of the full FY 2006 acute care hospital inpatient wage index data, without taking into account geographic reclassification under sections 1886(d)(8) and (d)(10) of the Act (shown in Tables 1 and 2 in the Addendum to this proposed rule).

Because the phase-in of the wage index does not coincide with the LTCH PPS rate year (July 1st through June 30th), most LTCHs will experience a change in the wage index phase-in percentages during the LTCH PPS rate year. For example, during the 2007 LTCH PPS rate year, for a LTCH with a January 1st FY, the four-fifths wage index will be applicable for the first 6 months of the 2007 LTCH PPS rate year (July 1, 2006 through December 31, 2006) and the full (five-fifths) wage index will be applicable for the second 6 months of the 2007 LTCH PPS rate year (January 1, 2007 through June 30, 2007). We also note that some providers will still be in the third year of the 5-year phase-in of the LTCH wage index (that is, those LTCHs who entered the 5-year phase-in during their cost reporting periods that began between July 1, 2003 and September 30, 2003). For the remainder of those LTCHs' FY 2005 cost reporting periods that will coincide with the first 3 months of RY 2007, the applicable wage index value would be three-fifths of the full FY 2006 acute care hospital inpatient wage index data, without taking into account geographic reclassification under sections 1886(d)(8) and (d)(10) of the Act (as shown in Tables 1 and 2 in the Addendum to this proposed rule). Since there are no longer any LTCHs in their cost reporting period that began during FYs 2003 and 2004 (the first and second years of the 5-year wage index phase-in), we are no longer showing the 1/5th and 2/5ths wage index values in Tables 1 and 2 in the Addendum to this proposed rule.

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

In the August 30, 2002 final rule (67 FR 56022), we established, under § 412.525(b), a cost-of-living adjustment (COLA) for LTCHs located in Alaska and Hawaii to account for the higher costs incurred in those States. In the RY 2006 LTCH PPS final rule (70 FR 24191), for the 2006 LTCH PPS rate year, we established that we make a COLA to payments for LTCHs located in Alaska and Hawaii by multiplying the standard Federal payment rate by the appropriate factor listed in Table I. of that same final rule.

Similarly, in this proposed rule, under broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of BIPA to determine appropriate adjustments under the LTCH PPS, for the 2007 LTCH PPS rate year we are proposing to make a COLA to payments to LTCHs located in Alaska and Hawaii by multiplying the proposed standard Federal payment rate by the proposed factors listed in Table 8 because these are currently the most recent available data. These proposed factors are obtained from the U.S. Office of Personnel Management (OPM) and are currently used under the IPPS. In addition, we propose that if OPM releases revised COLA factors before March 1, 2006, we would use them for the development of the payments for the 2007 LTCH rate year and publish them in the LTCH PPS final rule.

TABLE 8.—PROPOSED COST-OF-LIVING ADJUSTMENT FACTORS FOR ALASKA AND HAWAII HOSPITALS FOR THE 2007 LTCH PPS RATE YEAR

Alaska:	
All areas	1.25
Hawaii:	
Honolulu County	1.25
Hawaii County	1.165
Kauai County	1.2325

TABLE 8.—PROPOSED COST-OF-LIVING ADJUSTMENT FACTORS FOR ALASKA AND HAWAII HOSPITALS FOR THE 2007 LTCH PPS RATE YEAR—Continued

Maui County	1.2375
Kalawao County	1.2375

3. Proposed Adjustment for High-Cost Outliers

a. Background

Under the broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of BIPA, in the regulations at § 412.525(a), we established an adjustment for additional payments for outlier cases that have extraordinarily high costs relative to the costs of most discharges. Providing additional payments for outliers strongly improves the accuracy of the LTCH PPS in determining resource costs at the patient and hospital level. These additional payments reduce the financial losses that would otherwise be caused by treating patients who require more costly care and, therefore, reduce the incentives to underserve these patients. We set the outlier threshold before the beginning of the applicable rate year so that total estimated outlier payments are projected to equal 8 percent of total estimated payments under the LTCH PPS. Outlier payments under the LTCH PPS are determined consistent with the IPPS outlier policy.

Under § 412.525(a), we make outlier payments for any discharges if the estimated cost of a case exceeds the adjusted LTCH PPS payment for the LTC–DRG plus a fixed-loss amount. The fixed-loss amount is the amount used to limit the loss that a hospital will incur under the outlier policy for a case with unusually high costs. This results in Medicare and the LTCH sharing financial risk in the treatment of extraordinarily costly cases. 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 cost-to-charge ratio (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).

Under the LTCH PPS, we determine a fixed-loss amount, that is, the maximum loss that a LTCH can incur under the LTCH PPS for a case with unusually high costs before the LTCH will receive any additional payments. We calculate the fixed-loss amount by estimating aggregate payments with and without an outlier policy. The fixed-loss amount will result in estimated total outlier payments being projected to be equal to 8 percent of projected total LTCH PPS payments. Currently, MedPAR claims data and CCRs based on data from the most recent provider specific file (PSF) (or to the applicable Statewide average CCR if a LTCH's CCR data are faulty or unavailable) are used to establish a fixed-loss threshold amount under the LTCH PPS.

b. Cost-to-Charge Ratios (CCRs)

In determining outlier payments, we calculate the estimated cost of the case by multiplying the LTCH's overall CCR by the Medicare allowable charges for the case.

As we discussed in greater detail in the June 9, 2003 IPPS high cost outlier final rule (68 FR 34506 through 34516), because the LTCH PPS high-cost outlier policy (§ 412.525) is modeled after the IPPS outlier policy, we believed that it and the short-stay outlier (SSO) policy (§ 412.529) are susceptible to the same payment vulnerabilities that became evident under the IPPS and therefore, merited revision. Thus, we revised the high-cost outlier policy at § 412.525(a) and short-stay policy at § 412.529 in that same final rule for the determination of LTCHs' CCRs and the reconciliation of outlier payments.

Under the LTCH PPS, a single prospective payment per discharge is made for both inpatient operating and capital-related costs, and therefore, we compute a single ''overall'' or ''total'' CCR for LTCHs based on the sum of their operating and capital costs (as described in Chapter 3, section 150.24, of the Medicare Claims Processing Manual (CMS Pub. 100–4) as compared to total charges. Specifically, a LTCH's CCR is calculated by dividing a LTCH's total Medicare costs (that is, the sum of its operating and capital inpatient routine and ancillary costs) divided 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 Transmittal A–03–058 (Change Request 2785; July 3, 2003).)

As a result of the changes established in the June 9, 2003 IPPS high cost outlier final rule, as we discussed in previous LTCH PPS final rules ((RY 2004, 68 FR 34144 through 34146); (RY 2005, 69 FR 25687 through 25690); and (RY 2006, 70 FR 24192 through 24194)), under our current policy a LTCH is assigned the applicable Statewide average CCR if, among other things, a LTCH's CCR is found to be in excess of the applicable maximum CCR threshold (that is, the combined IPPS operating and capital CCR ceiling). As we explained in that same final rule (68 FR 34507), CCRs above this threshold are most likely due to faulty data reporting or entry, and therefore, these CCRs should not be used to identify and make payments for outlier cases. Such data are clearly errors and should not be relied upon. Thus, under our established policy, if a LTCH's CCR is above the applicable ceiling, the applicable combined IPPS Statewide average CCR is assigned to the LTCH instead of the CCR computed from its most recent (settled or tentatively settled) cost report data.

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 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 ALOS is greater than 25 days (see § 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 ALOS of greater than 25 days. In addition, since there are less than 400 LTCHs, which 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.

As noted previously in this proposed rule, under the LTCH PPS, there is a single prospective payment per discharge for both inpatient operating and capital-related costs, and therefore, we compute a single ''overall'' or ''total'' CCR for LTCHs based on the sum of their Medicare operating and capital costs and charges. However, under the IPPS, Medicare per discharge payments to acute-care hospitals for the costs of inpatient operating services are made under the ''Operating IPPS'' and per discharge payments to acute-care hospitals for inpatient capital-related

costs are made under the ''Capital IPPS.'' Because separate payments are made to acute-care hospitals under the IPPS for operating and capital costs, separate operating and capital CCRs are calculated and used in determining IPPS high cost outlier payments. Accordingly, under the IPPS a separate ''operating'' CCR ceiling and a ''capital'' CCR ceiling are determined annually. As we explained previously in this proposed rule and as stated in annual instructions (see Transmittal A–02–093 (Change Request 2288; September 27, 2002); Transmittal A–03–073 (Change Request 2891; August 22, 2003); Transmittal 309 (Change Request 3459; October 1, 2004); and Transmittal 692 (Change Request 4046; September 30, 2005)), under our current policy, if a LTCH's CCR is above the applicable ''combined'' IPPS operating and capital ceiling (that is, adding the separate IPPS operating and capital CCR ceiling together), the applicable Statewide average CCR is assigned to the LTCH. 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, we are proposing to revise § 412.525(a)(4) to specify that, for discharges occurring on or after October 1, 2006, if, among other things, 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 CCR), established and published annually by CMS), the FI may use a Statewide average CCR (also established annually by CMS).

This proposed change is similar to our existing policy (established in the June 9, 2003 IPPS high cost outlier final rule as previously discussed in this proposed rule). Under proposed revised § 412.525(a)(4)(iv)(C)(*2*), for discharges occurring on or after October 1, 2006, we are proposing that we would determine the single ''total'' CCR ceiling, based on IPPS CCR data, by first calculating the total (that is, operating and capital) CCR for each hospital and then determining the average total CCR for all hospitals. The ceiling would then be established at 3 standard deviations from the mean total CCR rather than determining the LTCH total CCR ceiling by adding the separate IPPS operating CCR and capital CCR ceilings as we do under our current policy. Specifically, 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) 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 costs.

As explained previously in this proposed rule, there is a single LTCH PPS Federal rate rather than a separate operating standardized amount and a capital Federal rate, as there is under the IPPS. (We note, as discussed in greater detail below in this section, in conjunction with this proposed change in the calculation of the LTCH CCR ceiling, we are also proposing a change in our methodology for calculating the applicable Statewide average CCRs under the LTCH PPS to be based on hospital-specific ''total'' CCRs.) Our rationale for proposing to continue to use IPPS data to determine the LTCH CCR ceiling annually continues to be the same as the one stated above. We note that we are proposing that the proposed refinement to our methodology for determining the annual CCR ceiling under the LTCH PPS at proposed revised § 412.525(a)(4)(iv)(C)(*2*) would be effective for discharges occurring on or after October 1, 2006 rather than July 1, 2006 because, we are proposing 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. Since both the separate IPPS operating and capital CCRs ceilings and the 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 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, 2006 (since, 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).

Also in the June 9, 2003 IPPS high cost outlier final rule, we established our existing policy that, for discharges occurring on or after August 8, 2003, that in addition to assigning the applicable Statewide average CCR to a LTCH whose CCR is above the ceiling, the FI may use the applicable Statewide average CCR for LTCHs for whom data with which to calculate a CCR is not available (for example, missing or faulty data) or 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 of this chapter). (We note that consistent with our current policy, either CMS or the hospital may request the use of a different (higher or lower) CCR based on substantial evidence that such a CCR more accurately reflects the hospital's actual costs and charges. This applies to new (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 a new LTCH provider number). Rather, the cost and charge data from the IPPS hospital's cost report (even if it is more or less than a 12-month cost reporting period) would be used to determine the LTCH's CCR.)

Thus, 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, we are also proposing to revise § 412.525(a)(4), for discharges occurring on or after October 1, 2006, to codify in subpart O of part 42 of the CFR the remaining LTCH PPS high cost 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 are proposing these additional revisions to § 412.525(a)(4), as discussed in greater detail below in this section, because we believe that a position such as this would more precisely describe the application of those policies as they relate to the determination of LTCH CCRs 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, similar to our current policy, we are proposing in § 412.525(a)(4)(iv)(C) to specify that the FI 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 of this chapter); (2) LTCHs whose CCR is in excess of the LTCH CCR ceiling (that is, 3 standard deviations above the corresponding national geometric mean total CCR, as discussed in greater previously in this proposed rule); and (3) other LTCHs for whom data with which to calculate a CCR is not available (for example, missing or faulty data). Also similar to our current practice, under proposed § 412.525(a)(4)(iv)(C), for discharges occurring on or after October 1, 2006, we are proposing that we would annually establish Statewide average ''total'' CCRs (as explained below in this section) for use under the LTCH PPS based on IPPS data rather than assigning the combined (operating and capital) Statewide average CCRs (see Transmittal 692 (Change Request 4046; September 30, 2005)). 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 (that we add together under our current policy to determine the applicable ''combined'' Statewide average CCR for LTCHs) to compute Statewide average total CCRs by first calculating the total (that is, operating and capital) CCR for each hospital and then determining the average total CCR for all hospitals in each State rather than adding together the separate applicable IPPS operating and capital Statewide average CCRs as we do under our current policy. We are also proposing 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 should continue to consult the annual IPPS proposed and final rules for changes to the applicable Statewide average total CCRs that would be effective for discharges occurring on or after October 1, 2006 (since, 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 proposed § 412.525(a)(4)(iv)(C) is the same as the one stated above for proposing to use IPPS data to determine a ''total'' LTCH CCR ceiling.

Similar to our current policy, we are also proposing to specify under proposed § 412.525(a)(4)(iv)(B), 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 recent settled cost report or the most recent tentative settled cost report, whichever is from the latest cost reporting period. Furthermore, we are proposing under proposed § 412.525(a)(4)(iv)(A) to state that CMS may specify an alternative to the CCR computed under proposed § 412.525(a)(4)(iv)(B), that is the CCR computed from the most recent settled cost report or the most recent tentative settled cost report, whichever is later, or a hospital may also request that its FI 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 proposed revised § 412.525(a)(4)(iv)(A) and (B) are similar to our existing policy established in the June 9, 2003 IPPS high cost outlier final rule (68 FR 34506 through 34513).

In conjunction with the proposed revisions to § 412.525(a)(4) concerning the determination of LTCHs' CCRs discussed above in this section, we are also proposing to revise § 412.525(a)(4) to codify in subpart O of part 42 of the CFR the existing outlier reconciliation provisions, including the proposed editorial clarifications to those existing policies, which are discussed in greater detail below in section IV.D.3.d. of this preamble. Furthermore, because CCRs are also used in determining payments under the existing SSO policy (§ 412.529), as discussed in greater detail in section VI.A.1. of this preamble, we are also proposing to revise § 412.529(c), for discharges occurring on or after October 1, 2006, to make the same changes to the SSO policy. In addition, we are also proposing a technical correction to existing § 412.525(a)(3) to change the plural reference from cost-to-charge ''ratios'' to the singular reference cost-to-charge ''ratio'' because under the LTCH PPS a single (total) CCR is computed for LTCHs.

c. Establishment of the Proposed Fixed-Loss Amount

When we implemented the LTCH PPS, as discussed in the August 30, 2002 final rule (67 FR 56022 through 56026), under the broad authority of section 123 of the BBRA as amended by section 307(b) of BIPA, we established a fixed-loss amount so that total estimated outlier payments are projected to equal 8 percent of total estimated payments under the LTCH PPS. To determine the fixed-loss amount, we estimate outlier payments and total LTCH PPS payments for each case using claims data from the MedPAR files. Specifically, to determine the outlier payment for each case, we estimate the cost of the case by multiplying the Medicare covered charges from the claim by the LTCH's hospital specific CCR. Under § 412.525(a)(3), if the estimated cost of the case exceeds the outlier threshold (the sum of the adjusted Federal prospective payment for the LTC–DRG and the fixed-loss amount), we pay an outlier payment equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted Federal prospective payment for the LTC–DRG and the fixed-loss amount).

In the RY 2006 LTCH PPS final rule (70 FR 24194), in calculating the fixed-loss amount that would result in outlier payments projected to be equal to 8 percent of total estimated payments for the 2006 LTCH PPS rate year, we used claims data from the December 2004 update of the FY 2004 MedPAR files and CCRs from the December 2004 update of the PSF, as that was the best available data at that time. As we discussed in that same final rule (70 FR 24193 through 24194), we believe that CCRs from the PSF were the best available CCR data for determining LTCHs' LTCH PPS payments during the 2006 LTCH PPS rate year because they were the most recently available CCRs (at that time) actually used to make LTCH PPS payments.

As we also discussed in the RY 2006 LTCH PPS rate year final rule (70 FR 24192 through 24193), we calculated a single fixed-loss amount for the 2006 LTCH PPS rate year based on the version 22.0 of the GROUPER, which was the version in effect as of the beginning of the LTCH PPS rate year (that is, July 1, 2005 for the 2006 LTCH PPS rate year). In addition, we applied the current outlier policy under § 412.525(a) in determining the fixed-loss amount for the 2006 LTCH PPS rate

year; that is, we assigned the applicable Statewide average CCR only to LTCHs whose CCRs exceeded the ceiling (and not when they fell below the floor). Accordingly, we used the FY 2005 IPPS combined operating and capital CCR ceiling of 1.409 (70 FR 24192). (Our rationale for using the FY 2005 combined IPPS operating and capital CCR ceiling for LTCHs stated in section IV.D.3.b. of this preamble.) As noted in that same final rule, in determining the fixed-loss amount for the 2006 LTCH PPS rate year using the CCRs from the PSF, there were no LTCHs with missing CCRs or with CCRs in excess of the current ceiling and, therefore, there was no need for us to independently assign the applicable Statewide average CCR to any LTCHs in determining the fixed-loss amount for the 2006 LTCH PPS rate year (as this may have already been done by the FI in the PSF in accordance with the established policy).

Accordingly, in 2006 LTCH PPS rate year final rule (70 FR 24194), we established a fixed-loss amount of $10,501 for the 2006 LTCH PPS rate year. Thus, we pay an outlier case 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted Federal LTCH PPS payment for the LTC–DRG and the fixed-loss amount of $10,501).

In this proposed rule, for the 2007 LTCH PPS rate year, we used the June 2005 update of the FY 2004 MedPAR claims data to determine a proposed fixed-loss amount that would result in outlier payments projected to be equal to 8 percent of total estimated payments, based on the policies described in this proposed rule, because these data are the most recent complete LTCH data available. Furthermore, as noted previously, we determined the proposed fixed-loss amount based on the version of the GROUPER that would be in effect as of the beginning of the 2007 LTCH PPS rate year (July 1, 2006), that is, Version 23.0 of the GROUPER (70 FR 47324).

We also used CCRs from the June 2005 update of the Provider Specific File for determining the proposed fixed-loss amount for the 2007 LTCH PPS rate year as they are currently the most recent complete available data. If more recent CCR data are available, we propose to use it for determining the fixed-loss amount for the 2007 LTCH PPS rate year in the final rule. As we discussed previously in this proposed rule, we are proposing a change to our methodology for our annual determination of the applicable LTCH CCR ceiling and applicable Statewide average CCRs that would be assigned in determining a LTCH's CCR effective for discharges occurring on or after October 1, 2006. As noted above in this section, under this proposal, the current LTCH CCR ceiling and applicable Statewide average CCRs, established for discharges occurring on or after October 1, 2005, would remain in effect for discharges occurring on or before September 30, 2006. In determining the proposed fixed-loss amount for the 2007 LTCH PPS rate year, we are proposing to use the current FY 2006 applicable IPPS combined operating and capital CCR ceiling of 1.423 and Statewide average CCRs (as discussed in the FY 2006 IPPS final rule (70 FR 47496) and established in Transmittal 692 (September 30, 2005)) such that the current applicable Statewide average CCR would be assigned if, among other things, a LTCH's CCR exceeded the current ceiling (1.423). Our reason for proposing to use the existing LTCH CCR ceiling and Statewide average CCRs to determine the proposed RY 2007 fixed-loss amount even though we are proposing to change our methodology for determining the CCR ceiling and Statewide average CCRs effective for discharges occurring on or after October 1, 2006, is because, based on our analysis of the data used to determine the FY 2006 LTCH CCR ceiling, we believe that this methodology change would result in a minor change in the numerical value of the LTCH CCR ceiling, and therefore, would have a negligible effect on the LTCHs' CCRs used to determine the proposed fixed-loss amount for the 2007 LTCH PPS rate year. Moreover, we note that in determining the proposed fixed-loss amount for the 2007 LTCH PPS rate year using the CCRs from the PSF, there was no need for us to independently assign the applicable Statewide average CCR to any LTCHs in determining the proposed fixed-loss amount for the 2007 LTCH PPS rate year (as this may have already been done by the FI in the PSF in accordance with our established policy). (Currently, the applicable FY 2006 IPPS Statewide averages can be found in Tables 8A and 8B of the FY 2006 IPPS final rule (70 FR 47672).)

Accordingly, based on the data and policies described in this proposed rule, we are proposing a fixed-loss amount of $18,489 for the 2007 LTCH PPS rate year. Thus, we would pay an outlier case 80 percent of the difference between the estimated cost of the case and the proposed outlier threshold (the sum of the adjusted proposed Federal LTCH payment for the LTC–DRG and the proposed fixed-loss amount of $18,489). We note that the proposed fixed-loss amount for the 2007 LTCH PPS rate year is significantly higher than the current fixed-loss amount of $10,501. This proposed change in the fixed-loss amount would primarily be due to the projected decrease in LTCH PPS payments resulting from the proposed change in the SSO policy under § 412.529 (discussed in greater detail in section V.A.1. of this preamble) and the changes to the LTC–DRG relative weights for FY 2006 (as discussed in the FY 2006 IPPS final rule (70 FR 47355)). Because we are projecting approximately an 11 percent decrease in aggregate LTCH PPS payments in the 2007 LTCH PPS rate year (as discussed in section XIII. of this proposed rule), we believe that an increase in the proposed fixed-loss amount is appropriate and necessary to maintain the requirement that estimated outlier payments would equal 8 percent of estimated total LTCH PPS payments, as required under § 412.525(a). Maintaining the fixed-loss amount at the current level would result in high cost outlier payments that significantly exceed the current regulatory requirement that estimated outlier payments would be projected to equal 8 percent of estimated total LTCH PPS payments. We note that in the August 30, 2002 final rule (67 FR 56022 through 56024), based on our regression analysis, we established the outlier target at 8 percent of estimated total LTCH PPS payments to allow us to achieve a balance between the ''conflicting considerations of the need to protect hospitals with costly cases, while maintaining incentives to improve overall efficiency.'' In that same final rule (67 FR 56023), we also explained that our regression analysis showed that additional increments of outlier payments over 8 percent (that is, raising the outlier target to a larger percentage than 8 percent) would reduce financial risk, but by successively smaller amounts. Since outlier payments are included in budget neutrality calculations, outlier payments would be funded by prospectively reducing the non-outlier PPS payment rates by the proportion of projected outlier payments to projected total PPS payments in the absence of outlier payments; the higher the outlier target, the greater the (prospective) reduction to the base payment rate in order to maintain budget neutrality. As another alternative to the proposed reduction to the fixed-loss amount for RY 2007, we are soliciting comments on whether we should revisit the regression analysis discussed above in this section that was used to establish the existing 8 percent

outlier target, using the most recent available data to evaluate whether the current outlier target of 8 percent should be adjusted, and therefore may result in less of an increase in the fixed-loss amount for RY 2007. After revisiting this issue and an analysis of the most recent complete available data, due to the lag time in the availability of data, we now believe the most appropriate time to revisit a budget neutral policy change in the outlier policy (among other things), which would affect future LTCH PPS payment rates, would be after the conclusion of the 5-year transition period when we expect to have several years of data generated after the implementation of the LTCH PPS.

As an alternative to proposing to raise the fixed-loss amount for FY 2007, we also examined adjusting the marginal cost factor (that is, the percentage that Medicare will pay of the estimated cost of a case that exceeds the sum of the adjusted Federal prospective payment for the LTC–DRG and the fixed-loss amount for LTCH PPS outlier cases as specified in § 412.525(a)(3)), as a means of ensuring that estimated outlier payments would be projected to equal 8 percent of estimated total LTCH PPS payments. As we established in the August 30, 2002 final rule (67 FR 56022 through 56026), under the LTCH PPS high-cost outlier policy at § 412.525(a)(3), the marginal cost factor is currently equal to 80 percent. A marginal cost factor equal to 80 percent means that for an outlier case we pay the LTCH 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted Federal rate for the LTC–DRG PPS payment and the fixed-loss amount).

In addition, as we discussed in the August 30, 2002 final rule (67 FR 56023) that implemented the LTCH PPS, the marginal cost factor is designed to ensure ''a balance between the need to protect LTCHs financially, while encouraging them to treat expensive patients and maintaining the incentives of a prospective payment system to improve the efficient delivery of care.'' Decreasing the marginal cost factor from the established 80 percent, while maintaining the current fixed-loss amount ($10,501), would decrease total estimated outlier payments because we would pay a smaller percentage of the estimated costs that exceed the outlier threshold (the sum of the adjusted Federal rate for the LTC–DRG and the fixed-loss amount). For example, if we were to decrease the marginal cost factor to 65 percent without raising the fixed-loss amount, we would pay outlier cases 15 percent less (80 percent minus 65 percent) of the estimated costs that exceed the outlier threshold (the sum of the adjusted Federal rate for the LTC–DRG and the fixed-loss amount).

While this alternative could ensure that outlier payments are projected to equal 8 percent of estimated total LTCH PPS payments by reducing estimated aggregate outlier payments, it may not maintain the existing balance between providing an incentive for LTCHs to treat expensive patients and improving the efficient delivery of care because a policy such as this would reduce the financial protection currently afforded to LTCHs under the current high cost outlier policy (with an 80 percent marginal cost factor), which could result in LTCHs' inability to treat seriously ill and costly patients. This is because we believe it may be more financially difficult for LTCHs to absorb a greater share of the costs of a true high cost outlier case (that is, a case with an unusually high cost) than it would be to have a higher fixed-loss amount. Keeping the marginal cost factor at 80 percent while proposing to raise the fixed-loss amount would afford more financial protection to LTCHs than proposing to lower the fixed-loss amount and retain the current fixed loss amount. Because a relatively higher fixed-loss amount identifies fewer cases as high cost outlier cases (since the amount that the estimated cost of the case must exceed before the case qualifies as a high cost outlier case is higher), such a proposed policy better identifies LTCH patients that are truly unusually costly cases, which is consistent with our intent of the LTCH high cost outlier policy as stated when we implemented the LTCH PPS in the August 30, 2002 final rule (67 FR 56025). As we discussed in that same final rule (67 FR 56023 through 56024), our analysis of payment-to-cost ratios for outlier cases showed that a marginal cost factor of 80 percent appropriately addresses outlier cases that are significantly more expensive than nonoutlier cases, while simultaneously maintaining the integrity of the LTCH PPS.

Although proposing to raise the fixed-loss amount from $10,501 to $18,489 (based on the policies presented in this proposed rule) would increase the amount of the loss that a LTCH must incur under the LTCH PPS for a case with unusually high costs before the LTCH would receive any additional Medicare payments, as we explained previously in this proposed rule, we believe the 80 percent marginal cost factor continues to adequately maintain the LTCHs' share of the financial risk in treating the most costly patients and ensure the efficient delivery of services. As we discussed in the August 30, 2002 final rule when we established the high cost outlier policy, our analysis showed that a marginal cost factor of 80 percent appropriately addresses outlier cases that are significantly more expensive than nonoutlier cases. Accordingly, we are not proposing to adjust the marginal cost factor under the LTCH PPS high-cost outlier policy; however, we are soliciting comments on whether we should revisit the regression analysis that was used to establish the existing 80 percent marginal cost factor, using the most recent available data to evaluate whether the current marginal cost factor of 8 percent in the current high cost outlier policy should be adjusted, and therefore may result in less of an increase in the fixed-loss amount for RY 2007.

Furthermore, we note that the proposed fixed-loss amount of $18,489 is lower than the FY 2003 fixed-loss amount of $24,450 (67 FR 56023) and the 2004 LTCH PPS rate year fixed-loss amount of $19,590 (68 FR 34144), and only slightly higher than the 2005 LTCH PPS rate year fixed-loss amount of $17,864 (69 FR 25688), all of which were in effect during the time period that we are currently estimating positive Medicare margins (as discussed in greater detail in section IV.C.3 of this preamble). Therefore, we believe the proposed fixed-loss amount of $18,489 would appropriately identify unusually costly LTCH cases while maintaining the integrity of the LTCH PPS. Thus, under the broad authority of section 123(a)(1) of the BBRA and section 307(b)(1) of BIPA, we are proposing to establish a fixed-loss amount of $18,489 based on the best available LTCH data and the policies presented in this proposed rule because, we believe a proposed increase in the fixed-loss amount is appropriate and necessary to maintain estimated outlier payments equal to 8 percent of estimated total LTCH PPS payments, as required under § 412.525(a).

d. Reconciliation of Outlier Payments Upon Cost Report Settlement

In the June 9, 2003 high-cost outlier final rule (68 FR 34508 through 34512), we established a policy for LTCHs that provided that effective for 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 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. (We note that, in that same final rule (68 FR 34513), we also established similar changes to the SSO policy under the LTCH PPS at § 412.529(c)(5)(ii).) These changes regarding the reconciliation of outlier payments under the LTCH PPS were made in conjunction with the changes regarding the determination of LTCHs' CCRs that we established under § 412.525(a)(4) in the June 9, 2003 IPPS high cost outlier final rule, as discussed in greater detail in section IV.D.3.b. of this preamble. (We note that the instructions for implementing these regulations under both the IPPS and the LTCH PPS are discussed in further detail in Program Memorandum Transmittal A–03–058. Additional information on the administration of the reconciliation process under the IPPS is provided in CMS Program Transmittal 707 (October 12, 2005; Change Request 3966). We note that irrespective of the proposed changes to the high cost outlier and SSO policies presented in this proposed 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.)

As discussed in section V.C.3.b. of this preamble, we are proposing, for discharges occurring on or after October 1, 2006, to codify into the LTCH PPS section of the regulations (subpart O of part 42 of the CFR) 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. (We are also proposing to make those same changes under the SSO policy at § 412.529 as discussed in section V.A.1. of this preamble).

In this proposed rule, under the broad authority of section 123 of the BBRA and section 307(b)(1) of BIPA, we are also proposing to revise § 412.525(a)(4), for discharges occurring on or after October 1, 2006, to codify in subpart O of part 42 of the CFR 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 note that we are also proposing to make the same changes concerning the reconciliation of outlier payments under (and the SSO provisions at § 412.529(c)), as discussed below in section V.A.1.a. of this preamble.) We are proposing the additional revisions to § 412.525(a)(4) 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, at § 412.525(a)(4)(iv)(D), similar to our current policy, we are proposing 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, at § 412.525(a)(4)(iv)(E), similar to our current policy, we are proposing 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. Also consistent with our current policy, we are proposing 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. We are proposing to make these additional revisions to § 412.525(a)(4) because we believe that such proposed changes would be more consistent with the LTCH PPS single payment rate (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 outlier payments applicable under the LTCH PPS regulations in subpart O of part 42 of the CFR.

e. Application of Outlier Policy to Short-Stay Outlier (SSO) Cases

As we discussed in the August 30, 2002 final rule (67 FR 56026), under some rare circumstances, a LTCH discharge could qualify as a SSO case (as defined under § 412.529 and discussed in section V.B.4. of this preamble) and also as a high-cost outlier case. In this scenario, a patient could be hospitalized for less than five-sixths of the geometric ALOS for the specific LTC–DRG, and yet incur extraordinarily high treatment costs. If the costs exceeded the outlier threshold (that is, the SSO payment plus the fixed-loss amount), the discharge would be eligible for payment as a high-cost outlier. Thus, for a SSO case in the 2007 LTCH PPS rate year, the high-cost outlier payment would be 80 percent of the difference between the estimated cost of the case and the proposed outlier threshold (the sum of the proposed fixed-loss amount of $18,489 and the amount paid under the SSO policy). (We note that in section V.A.1. of this preamble, we are also proposing changes to the SSO policy at § 412.529, which are consistent with the proposed revisions to § 412.525(a)(4) regarding our policies on the determination of LTCH CCRs and, the reconciliation of outlier payments.)

4. Other Payment Adjustments

As indicated earlier, we have broad authority under section 123(a)(1) of the BBRA as amended by section 307(b) of BIPA to determine appropriate adjustments under the LTCH PPS, including whether (and how) to provide for adjustments to reflect variations in the necessary costs of treatment among LTCHs. Thus, in the August 30, 2002 final rule (67 FR 56014 through 56027), we discussed our extensive data analysis and rationale for not implementing an adjustment for geographic reclassification, rural location, treating a disproportionate share of low-income patients (DSH), or indirect medical education (IME) costs. In that same final rule, we stated that we would collect data and reevaluate the appropriateness of these adjustments in the future once more LTCH data become available after the LTCH PPS is implemented.

Because the LTCH PPS has only been implemented for slightly over 3 years and there is a time lag in data availability, sufficient new data has not been generated that would enable us to conduct a comprehensive reevaluation of these payment adjustments. We now believe that after the completion of the 5-year transition, sufficient new data that will be generated while LTCHs are subject to the LTCH PPS may be available for a comprehensive reevaluation of payment adjustments such as geographic reclassification, rural location, DSH, and IME. Nonetheless, we are reviewing the limited data that are available and find no evidence to support additional proposed policy changes. Therefore, in this proposed rule, we are not proposing to make any adjustments for geographic reclassification, rural location, DSH, or

IME. However, we will continue to collect and interpret new data as they become available in the future to determine if these data support proposing any additional payment adjustments. Specifically, as we discuss in greater detail in section IV.D.6. of this preamble, we have revisited the possible one-time prospective adjustment to the LTCH prospective payment system rates at § 412.523(d)(3), and after further analysis and evaluation we now believe that it is appropriate to wait for the conclusion of the 5-year transition to 100 percent fully Federal payments under the LTCH PPS, to maximize the availability of data that are reflective of LTCH behavior in response to the implementation of the LTCH PPS to be used to conduct a comprehensive evaluation of the potential payment adjustment policies (such as rural location, DSH and IME) in conjunction with our evaluation of the possibility of making a one-time prospective adjustment to the LTCH prospective payment system rates provided for at § 412.523(d)(3).

5. Proposed Budget Neutrality Offset To Account for the Transition Methodology

Under § 412.533, we implemented a 5-year transition, during which a LTCH is paid an increasing percentage of the LTCH PPS Federal prospective payment and a decreasing percentage of its payments based on the reasonable cost-based payment methodology for each discharge. Furthermore, we allow a LTCH (other than those defined as ''new'' under § 412.23(e)(4) to elect to be paid based on 100 percent of the standard Federal rate in lieu of the blended methodology.

The standard Federal rate was determined as if all LTCHs will be paid based on 100 percent of the standard Federal rate. As stated earlier, we provide for a 5-year transition period that allows LTCHs to receive payments based partially on the reasonable cost-based methodology. In order to maintain budget neutrality for FY 2003 as required by section 123(a)(1) of the BBRA during the 5-year transition period, we reduce all LTCH Medicare payments (whether a LTCH elects payment based on 100 percent of the Federal rate or whether a LTCH is being paid under the transition blend methodology) to account for the cost of the applicable transition period methodology in a given LTCH PPS rate year.

Specifically, we reduce all LTCH Medicare payments during the 5-year transition by a factor that is equal to 1 minus the ratio of the estimated TEFRA reasonable cost-based payments that would be made if the LTCH PPS was not implemented, to the projected total Medicare program PPS payments (that is, payments made under the transition methodology and the option to elect payment based on 100 percent of the Federal rate).

In the RY 2006 LTCH PPS final rule (70 FR 24202), based on the best available data at that time, we projected that approximately 98 percent of LTCHs will be paid based on 100 percent of the standard Federal rate rather than receive payment under the transition blend methodology for the 2006 LTCH PPS rate year. Using the same methodology described in the August 30, 2002 final rule (67 FR 56034), this projection, which used updated data and inflation factors, was based on our estimate that either: (1) A LTCH has already elected payment based on 100 percent of the Federal rate prior to the start of the 2006 LTCH PPS rate year (July 1, 2005); or (2) a LTCH would receive higher payments based on 100 percent of the 2006 LTCH PPS rate year standard Federal rate compared to the payments it would receive under the transition blend methodology. Similarly, we projected that the remaining 2 percent of LTCHs will choose to be paid based on the applicable transition blend methodology (as set forth under § 412.533(a)) because they would receive higher payments than if they were paid based on 100 percent of the 2006 LTCH PPS rate year standard Federal rate.

Also in the RY 2006 LTCH PPS final rule (70 FR 24202), based on the best available data at that time and policy revisions described in that same rule, we projected that the full effect of the remaining 2 years of the transition period (including the election option) would result in a cost to the Medicare program of approximately $1.675 million. Specifically, for the RY 2006 LTCH PPS, we estimated that the cost of the transition would be approximately $1 million. Because this amount is only a small percentage of total LTCH PPS payments for the 2006 LTCH PPS rate year (estimated at over $3 billion), the formula that we use to establish the budget neutrality offset to account for the additional costs of the transition period resulted in a factor of zero percent. Therefore, in that same final rule, we established a 0.0 percent reduction (a budget neutrality offset of 1.000) to all LTCH payments in the 2006 LTCH PPS rate year to account for the $1 million estimated cost of the transition period methodology (including the option to elect payment based on 100 percent of the Federal rate). We also indicated that we would use a budget neutrality offset for each of the remaining years of the transition period to account for the estimated costs for the respective LTCH PPS rate years. In that same final rule, we estimated that there would be a 0.0 percent budget neutrality offset to LTCH PPS payments during the remaining years of the transition period since, we estimated at that time that the additional cost to the Medicare program resulting from the transition period methodology would be so small that the budget neutrality factor determined under our established methodology would round to zero.

In this proposed rule, based on the updated data using the same methodology established in the August 30, 2002 final rule (67 FR 56034), we are projecting that approximately 97 percent of LTCHs would be paid based on 100 percent of the proposed standard Federal rate rather than receive payment under the transition blend methodology during the 2007 LTCH PPS rate year. This projection, which used updated data, is based on our estimate that either: (1) A LTCH has already elected payment based on 100 percent of the Federal rate prior to the beginning of the 2007 LTCH PPS rate year (July 1, 2006); or (2) a LTCH would receive higher payments based on 100 percent of the proposed standard Federal rate compared to the payments they would receive under the transition blend methodology. Similarly, we project that the remaining 3 percent of LTCHs would choose to be paid based on the transition blend methodology at § 412.533 because those payments are estimated to be higher than if they were paid based on 100 percent of the proposed standard Federal rate. The applicable transition blend percentage is applicable for a LTCH's entire cost reporting period beginning on or after October 1 (unless the LTCH elects payment based on 100 percent of the Federal rate). We note that this projection is slightly lower than the projection that 98 percent of LTCHs would be paid based on 100 percent of the proposed standard Federal rate rather than receive payment under the transition blend methodology during the 2006 LTCH PPS rate year discussed in the RY 2006 LTCH PPS final rule (70 FR 24202). The reason for this slight decrease is due to how our established methodology (described in this section) determines which LTCHs would be projected to receive payments based on 100 percent of the Federal rate in a given rate year. Specifically, under our established methodology, if a LTCH has not already elected payment based on 100 percent of the Federal rate then we evaluate whether a LTCH would receive

higher payments based on 100 percent of the proposed standard Federal rate or under the applicable transition blend methodology based on the most recent available data. Based on the best available data at that time, we projected that a few LTCHs that had not already elected payment based on 100 percent of the Federal rate would make such an election for RY 2006 because we projected that their payments based on 100 percent of the Federal rate would exceed their payments under the applicable transition blend. Therefore, those LTCHs were counted in the number of LTCHS that would be paid based on 100 percent of the Federal rate in RY 2006. However, based on the most recent available data used for this proposed rule, those LTCHs have not elected to receive payments based on 100 percent of the Federal rate and are being paid under the applicable transition blend methodology. Under our methodology for determining the percentage of LTCHs paid based on 100 percent of the federal rate, based on the most recent available data, we are projecting that for the RY 2007 LTCH PPS rate year, the applicable transition blend methodology payments to those LTCHs would be greater than payment based 100 percent of the Federal rate, and therefore, those LTCHs would not be included in the number of LTCHS that we estimate would be paid based on 100 percent of the Federal rate in RY 2007. Based on the policies presented in this proposed rule, we are projecting a decrease in their estimated payments based on 100 percent of the Federal rate in RY 2007 payment as compared to their estimated payments based on 100 percent of the Federal rate in RY 2006 primarily as a result of the proposed changes to the SSO policy (see section V.A.1. of this preamble) and the proposed increase in the outlier fixed-loss amount (see section IV.D.3.c. of this preamble). Because we are projecting a decrease in payments based on 100 percent of the Federal rate for these LTCHs, the estimated RY 2007 payments based on the applicable transition blend methodology are now higher than their estimated RY 2007 payments based on 100 percent of the Federal rate, we do not project that these LTCH would elect payment based on 100 percent of the Federal rate for RY 2007. Thus, the slight decrease in the our projection in the number of LTCHs that would be paid based on 100 percent of the Federal rate for the 2007 LTCH PPS rate year is appropriate.

Based on the best available data and the proposed policies described in this proposed rule, we are projecting that in absence of a transition budget neutrality offset, the full effect of the final full year of the transition period (including the election option) as compared to payments as if all LTCHs would be paid based on 100 percent of the Federal rate would result in a cost to the Medicare program of approximately 2.8 million. (As discussed in the RY 2006 final rule (70 FR 24201), we are no longer projecting a small cost for the 2008 LTCH PPS rate year (July 1, 2007 through June 30, 2008) even though some LTCH's will have a cost reporting period for the 5th year of the transition period which will be concluding in the first 3 months of the 2008 LTCH PPS rate year because based on the most available data, we are projecting that the vast majority of LTCHs would have made the election to be paid based on 100 percent of the Federal rate rather than the transition blend which would result in a negligible cost to the Medicare program.)

Accordingly, using the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 56034), based on updated data and the policies and rates presented in this proposed rule, we are proposing a 0.1 percent reduction (a budget neutrality offset of 0.999) to all LTCHs' payments for discharges occurring on or after July 1, 2006 and through June 30, 2007, to account for the estimated cost of the transition period methodology (including the option to elect payment based on 100 percent of the Federal rate) of approximately $2.8 million for the 2007 LTCH PPS rate year. We note that this proposed offset for the 2007 LTCH PPS rate year is slightly larger than the 0.0 percent reduction (a budget neutrality offset of 1.000) established for the 2006 LTCH PPS rate year (70 FR 24202). This is because we are now projecting that a few less LTCHs would elect payment based on 100 percent of the Federal rate than we were projecting when we determined the transition period budget neutrality offset for the 2006 LTCH PPS rate year based on the most recent available data.

6. One-Time Prospective Adjustment to the Standard Federal Rate

As we discussed in the August 30, 2002 final rule (67 FR 56036), consistent with the statutory requirement for budget neutrality in section 123(a)(1) of the BBRA, we intended that estimated aggregate payments under the LTCH PPS for FY 2003 equal the estimated aggregate payments that would be made if the LTCH PPS were not implemented. Our methodology for estimating payments for purposes of the budget neutrality calculations uses the best available data at the time and necessarily reflects assumptions. As the LTCH PPS progresses, we are monitoring payment data and will evaluate the ultimate accuracy of the assumptions used in the budget neutrality calculations (for example, inflation factors, intensity of services provided, or behavioral response to the implementation of the LTCH PPS) described in the August 30, 2002 LTCH PPS final rule (67 FR 56027 through 56037). To the extent these assumptions significantly differ from actual experience, the aggregate amount of actual payments may turn out to be significantly higher or lower than the estimates on which the budget neutrality calculations were based.

Section 123(a)(1) of the BBRA as amended by section 307(b) of BIPA provides broad authority to the Secretary in developing the LTCH PPS, including the authority for appropriate adjustments. Under this broad authority, as implemented in the existing regulations at § 412.523(d)(3), we have provided for the possibility of making a one-time prospective adjustment to the LTCH PPS rates by October 1, 2006, so that the effect of any significant difference between actual payments and estimated payments for the first year of the LTCH PPS would not be perpetuated in the LTCH PPS rates for future years. (As discussed in greater detail below, we are proposing to extend the deadline for making this adjustment to July 1, 2008 to this proposed rule.

In the RY 2006 LTCH PPS final (70 FR 24203), based on the best available data at that time, we estimated that total Medicare program payments for LTCH services over the next 5 LTCH PPS rate years would be $3.32 billion for the 2006 LTCH PPS rate year; $3.38 billion for the 2007 LTCH PPS rate year; $3.48 billion for the 2008 LTCH PPS rate year; $3.63 billion for the 2009 LTCH PPS rate year; and $3.79 billion for the 2010 LTCH PPS rate year.

In this proposed rule, consistent with the methodology established in the August 30, 2002 final rule (67 FR 56036), based on the most recent available data, we estimate that total Medicare program payments for LTCH services for the next 5 LTCH PPS rate years would be as shown in Table 9.

TABLE 9

LTCH PPS rate year	Estimated payments ($ in billions)
2007	$5.27
2008	5.44
2009	5.64
2010	5.88

TABLE 9—Continued

LTCH PPS rate year	Estimated payments ($ in billions)
2011	6.15

In accordance with the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 56037), these estimates are based on the most recent available date, including the projection that 97 percent of LTCHs would elect to be paid based on 100 percent of the 2007 LTCH PPS rate year proposed standard Federal rate rather than the applicable transition blend and an estimated increase in the number of discharges from LTCHs. (We note that the 5-year spending estimates shown in Table 9 are significantly higher than the 5-year spending estimates presented in the RY 2006 LTCH PPS final rule (70 FR 24203). This is primarily due to an adjustment by our Office of the Actuary (OACT) to account for the significant increase in the expected number of LTCH discharges based on the most recent complete available LTCH discharge data.) These estimates are also based on our estimate of LTCH PPS rate year payments to LTCHs using OACT's most recent estimate of the excluded hospital with capital (currently used under the LTCH PPS) market basket of 3.6 percent for the 2007 LTCH PPS rate year, 3.5 percent for the 2008 LTCH PPS rate year, 3.1 percent for the 2009 LTCH PPS rate year, 2.6 percent for the 2010 LTCH PPS rate year, and 3.0 percent for the 2011 LTCH PPS rate year. (We note that, although we are proposing a zero percent update to the LTCH PPS Federal rate for RY 2007 (as discussed in section IV.C.3. of this proposed rule) OACT develops its spending projections based on existing policy and therefore, changes that have not yet been implemented are not reflected in the spending projections shown in this section.) We also considered OACT's most recent projections of changes in Medicare beneficiary enrollment that there would be a change in Medicare fee-for-service beneficiary enrollment of −2.3 percent in the 2007 LTCH PPS rate year, −1.0 percent in the 2008 LTCH PPS rate year, 0.3 percent in the 2008 and 2009 LTCH PPS rate years and, 0.6 percent in the 2010 LTCH PPS rate year. (We note that, based on the most recent available data, OACT is projecting a slight decrease in Medicare fee-for-service Part A enrollment for the 2007 and 2008 LTCH PPS rate years, in part, because they are projecting an increase in Medicare managed care enrollment as a result of the implementation of several provisions of the MMA of 2003.)

As we discussed in the RY 2006 LTCH PPS final rule (70 FR 24204), because the LTCH PPS was only recently implemented, sufficient new data has not been generated that would enable us to conduct a comprehensive reevaluation of our budget neutrality calculations. Accordingly, we did not make a one-time adjustment under § 412.523(d)(3). At this time, we still do not have sufficient new data to enable us to conduct a comprehensive reevaluation of our budget neutrality calculations. Therefore, in this proposed rule, we are not proposing to make a one-time adjustment under § 412.523(d)(3) so that the effect of any significant difference between actual payments and estimated payments for the first year of the LTCH PPS is not perpetuated in the PPS rates for future years. However, as discussed in greater detail below, we will continue to collect and interpret new data as the data become available in the future to determine if this adjustment should be proposed. Additionally, as discussed in greater detail below, we believe that it is appropriate to propose postponement of the requirement established in § 412.523(d)(3) due to the time lag in the availability of Medicare data upon which this adjustment would be based. Therefore, we propose to revise § 412.523(d)(3) by postponing the October 1, 2006 deadline to July 1, 2008.

In the August 30, 2002 final rule implementing the LTCH PPS (67 FR 55954), we set forth the implementing regulations, based upon the broad authority granted to the Secretary, under section 123 of the BBRA as amended by section 307(b) of the BIPA. Section 123(a)(1) of the BBRA, required that the system ''maintain budget neutrality'' for FY 2003, that is, that estimated aggregate payments under the LTCH prospective payment system would equal the estimated aggregate payments that would be made if the LTCH prospective payment system would not be implemented for FY 2003. The methodology for determining the LTCH PPS standard Federal rate for FY 2003 that would ''maintain budget neutrality'' is described in considerable detail in the August 30, 2002 final rule (67 FR 56027 through 56037). As we discussed in that same final rule, our methodology for estimating payments for the purposes of budget neutrality calculations used the best available data and necessarily reflects assumptions in estimating aggregate payments that would be made if the LTCH PPS was not implemented. We also stated our intentions to monitor LTCH PPS payment data to evaluate the ultimate accuracy of the assumptions used in the budget neutrality calculations (for example, inflation factors, intensity of services provided, or behavioral response to the implementation of the LTCH PPS). To the extent that those assumptions significantly differ from actual experience, the aggregate amount of actual payments during FY 2003 may turn out to be significantly higher or lower than the estimates upon which the budget neutrality calculations were based. (67 FR 56036) In that same final rule, the Secretary exercised his broad authority in establishing the LTCH PPS and provided for the possibility of a one-time prospective adjustment to the LTCH prospective payment system rates by October 1, 2006 at § 412.523(d)(3). The purpose of that provision was to prevent any significant difference between actual payments and estimated payments for the first year of the LTCH prospective payment system, when we established the budget neutral Federal rate, as required by the statute (discussed previously), from being perpetuated in the prospective payment system rates for future years.

When we implemented the LTCH PPS, we established at § 412.533 a 5-year transition to full payments based on the LTCH PPS standard Federal rate. In addition, during that 5-year period, existing LTCHs (those that had their first cost reporting period as an LTCH prior to October 1, 2002), could elect for either full payment under the adjusted Federal rate payment determined under § 412.523, or be phased-in to the full Federal rate payment over 5 years in annual increments of 20 percent, with the remainder of the payment amount being determined under the former cost-based reimbursement rules set forth in the TEFRA system, (under part 413 of the same subchapter). Thus, for LTCH cost reporting periods beginning on or after October 1, 2006, the fifth year of the transition, payments to all LTCHs will be based fully (100 percent) on the LTCH PPS standard Federal rate.

In addition to developing a LTCH PPS standard Federal rate that would ''maintain budget neutrality'' for FY 2003, under the LTCH PPS, Federal prospective payments are adjusted to account for various factors (as discussed below). As noted previously in this proposed rule, the Secretary was granted considerable discretion in the design of the payment system. Specifically, under section 307(b) of the BIPA, the Secretary shall ''examine and * * * may provide for appropriate adjustments to the long-term hospital payment system, including adjustments to DRG weights, area wage adjustments,

geographic reclassification, outliers, updates, and a disproportionate share adjustment.'' Thus, the Secretary was also given tremendous discretionary authority to determine which adjustments to include in the LTCH PPS. In developing the LTCH PPS, to evaluate whether the accuracy of the payment system would be enhanced by the inclusion of particular payment adjustments, and hence the appropriateness of those payment adjustments for the LTCH PPS, we contracted with 3M Health Information Systems to assist us with the analyses. These analyses include, among other techniques, the use of regression models and payment simulations to determine whether there was a correlation between an LTCH's cost per case and the inclusion of particular payment adjustments. We examined payment variables applicable to the inpatient acute-care hospital and IRF prospective payment systems, including the local wage variation (wage index), disproportionate share patient percentage (DSH), indirect medical education (IME), variables that account for location in a rural or large urban area, and a cost of living adjustment (COLA) for Alaska and Hawaii (67 FR 56015 through 56027). We concluded, in that August 30, 2002 final rule, that based on the best available LTCH data and consistent with the broad legal authority afforded to the Secretary, the LTCH PPS would include payment adjustments featured in other prospective payment systems: payments for high cost outliers (§ 412.525(a)); an area wage adjustment which would be phased-in over 5-years (§ 412.525(c)); and a COLA (§ 412.525(b)). Additionally, we established several adjustments specific to the LTCH PPS, such as adjusted payments for short'stay outliers (§ 412.529), interrupted stays (§ 412.531), and on-site discharges and readmittances (§ 412.532).

In each final rule for the LTCH PPS subsequent to the implementation of the LTCH PPS for FY 2003, as new data from LTCHs generated under the LTCH PPS has become available, we have revisited our determinations regarding the inclusion of specific payment adjustments (68 FR 34140 through 34150, 69 FR 25684 through 25701, and 70 FR 24190 through 24198). Although no additional payment adjustments were added since the initial implementation of the LTCH PPS in FY 2003, we stated that we would collect data and reevaluate the appropriateness of these adjustments in the future when more LTCH PPS data becomes available after the implementation of the LTCH PPS. After revisiting this issue and conducting extensive data analysis, we now believe that the current deadline of October 1, 2006, for making the one time adjustment to eliminate any significant difference between the actual payments and estimated payments for the first year of the PPS is too short. After the conclusion of the 5-year transition period (that is, after RY 2007), we now believe that sufficient new data will be generated by the LTCH PPS for a comprehensive reevaluation of these payment adjustments, including geographic reclassification, rural location, DSH, and IME.

The final year of the 5-year transition to full payments for all LTCHs based on the adjusted Federal rate will begin for cost reporting periods beginning on or after October 1, 2006 (FY 2007) and end with cost reporting periods beginning before October 1, 2007 (FY 2008). After the conclusion of the 5-year transition period (October 1, 2007), we expect to have between 3 and 4 years (FYs 2003 through 2006) of LTCH data generated since the implementation of the LTCH PPS. We note that there is a lag time between the submission of claims data and cost report data, and the availability of that data in the MedPAR files and HCRIS, respectively. Based on a comprehensive analysis of that data, we may then propose to revise some LTCH PPS payment adjustments for future years for the LTCH PPS.

Consistent with our intent to wait for the conclusion of the 5-year transition to 100 percent fully Federal payments under the LTCH PPS, to maximize the availability of data used to conduct a comprehensive evaluation of the payment adjustment policies issued at the inception of the LTCH PPS for FY 2003, we believe that it is appropriate to propose postponement of the requirement established by existing § 412.523(d)(3), described previously, which allowed for the possibility of making a one-time prospective adjustment to the LTCH prospective payment system rates from the current date of October 1, 2006 to an adjustment that would be effective on or before July 1, 2008. Currently, due to the time lag in the availability of Medicare data, the best available full year of LTCH claims data are from FY 2004 and the most complete full year of LTCH cost report data are from FY 2003. We believe that postponing the deadline of the possible one-time prospective adjustment to the LTCH PPS rates provided for in § 412.523(d)(3) to July 1, 2008 would result in the availability of additional data generated under the LTCH PPS and therefore our decisions regarding a possible adjustment would be based on more complete and up-to-date data. This data would be reflective of LTCH behavior in response to the implementation of the LTCH PPS. In addition, after further analysis, we believe that after the end of the transition may be the appropriate time to implement this one-time prospective adjustment, which was written to ensure that the effect of any significant difference between actual payments and estimated payments for the first year of the LTCH PPS would not be perpetuated in the prospective payment rates for future years. We note that we are proposing a July 1, 2008 rather than an October 1, 2007 date in keeping with the established rate year cycle. Although the LTCH PPS Federal rate was initially established with an October 1 through September 30th rate cycle, currently the LTCH PPS Federal rate is updated on a July 1 through June 30 rate year cycle (68 FR 34125 through 34128).

The final year of the 5-year phase-in of the LTCH PPS will begin for cost reporting periods beginning on or after October 1, 2006, during which payments will be 100 percent of the adjusted Federal rate for all LTCHs. Since the inception of the LTCH PPS, we have noted that we fully intend to review our payment adjustments when more LTCH PPS data become available after the implementation of the LTCH PPS because at that point we would have a sufficient amount of data with which to evaluate the impact of existing policy and to make informed decisions for the future of the payment system. After further consideration explained previously, we believe that after the end of the 5-year transition period it would be the appropriate time for both our planned reevaluation of the LTCH PPS payment adjustments as well as the possible ''one-time adjustment of the payment rates'' at § 412.525(d)(3). Therefore, we are proposing to revise § 412.523(d)(3) to change the deadline for the establishment of the possible one-time prospective adjustment from October 1, 2006 to July 1, 2008 and to synchronize these interrelated data analyses for purposes of determining future proposed payment policies under the LTCH PPS.

In section IV.C.3. of this proposed rule, where we discuss the proposed zero percent update factor to the standard Federal rate for the 2007 LTCH PPS rate year, we describe two aspects of our data monitoring activities, both of which impact continuing annual policy updates and determinations for the LTCH PPS which are the basis of our annual rule-making activities and **Federal Register** publications.

For the on-going implementation of the payment system, which entails determining annual system updates for the LTCH PPS, we engage in data monitoring and analysis of patient and facility level data. The most recent claims and cost data are used for this rate-setting purpose. From the outset of the LTCH PPS, we established a monitoring component to the system directed by our Office of Research, Development, and Information (ORDI) with additional data analysis provided by 3M Health Information Systems. The purposes of this protocol, as described in section X. of this proposed rule was to evaluate the impact of the LTCH PPS on the LTCH universe and to provide on-going data analysis that would enable CMS to determine the effectiveness of various policies and to alert CMS to issues which could require further regulation. Frequently, reviews and analyses of the data utilized for the annual updates have suggested directions for future research, which have resulted in policy proposals. We have revised and formulated several significant policies since the outset of the LTCH PPS based on the data analyses, including the 3-day or fewer interruption of stay policy at § 412.531 (69 FR 25690 through 25700), the LTCH HwH and LTCH satellite payment adjustment at § 412.534 (69 FR 49191 through 49214), the proposed revisions to the SSO policy at § 412.529 in section V.A.1. of this proposed rule, and the proposed zero percent update to the standard Federal rate, as described in section IV.C.3. of this proposed rule.

In the previous discussion, we have noted that we intend to reevaluate the LTCH PPS at the end of the 5-year transition to full Federal payments, based upon a comprehensive analysis of data generated since the start of the payment system for cost reporting periods beginning during FY 2003, in order to determine whether further payment adjustments are warranted. We have also proposed to revise § 412.523(d)(3) to postpone the establishment of the possible one-time prospective adjustment from October 1, 2006 to July 1, 2008.

Evaluating the appropriateness of this adjustment will entail a thorough review of the actual Medicare costs incurred by LTCHs during the first year of the LTCH PPS, that is, for LTCH cost reporting periods beginning on or after October 1, 2002 during which we were statutorily required to maintain budget neutrality as specified in section 123 of the BBRA. When we established the FY 2003 standard Federal rate, in order to meet this requirement, we used the most recent LTCH cost data available at that time, and trended that data forward to estimate what Medicare would have paid to LTCHS under the TEFRA payment system if the PPS were not implemented (67 FR 56033). (The methodology for determining the LTCH PPS standard Federal rate for FY 2003 that would ''maintain budget neutrality'' is described in considerable detail in the August 30, 2002 final rule (67 FR 56027 through 56037).)

As we discussed in that same final rule, our methodology for estimating payments for the purposes of budget neutrality calculations, utilized the best available data and necessarily reflected assumptions in estimating aggregate payments that would have been made had the LTCH PPS not been implemented. We also stated our intentions to monitor LTCH PPS data to evaluate the ultimate accuracy of the assumptions used in the budget neutrality calculations (for example, inflation factors, intensity of services provided, or behavioral response to the implementation of the LTCH PPS). To the extent that those assumptions significantly differed from actual experience, the aggregate amount of actual payments during FY 2003 could result as significantly higher or lower than the estimates upon which the budget neutrality calculations were based (67 FR 56036).

At the outset of the LTCH PPS, we provided for the possibility of a one-time prospective adjustment at § 412.523(d)(3). Among other things, we wanted the opportunity to adjust the standard Federal payment rate once accurate data was available that reflected the actual cost-based payments that would have been made under the Medicare program during FY 2003 if the LTCH PPS had not been implemented, rather than perpetuate any error in the Federal rate in future years.

We are proposing to postpone the adjustment until July 1, 2008 because by that time, given the lag time typically involved in the entire cost report settlement procedure, we will be able to utilize the most accurate data reflecting the actual costs incurred by LTCHs for cost reporting periods beginning during FY 2003. It is important to note that there are many LTCHs with cost reporting periods from September 1 through August 30 which first became subject to the LTCH PPS on September 1, 2003. Given the lag time required for typical cost report settlement involving submission, desk review, and in some cases an audit, which can take approximately 2 additional years to complete (and we expect to audit a number of LTCH cost reports for the purpose of this analysis), we do not believe that the October 1, 2006 deadline established § 412.523(d)(3) is reasonable or realistic. In fact, we believe that for cost reports for providers on August 2004 fiscal year ending date, we would be in possession of the most reliable cost report data indicating the actual costs of the Medicare program of the LTCH PPS during the year in which we established the Federal payment rate by July 2007 and any proposed correction, if finalized could then be implemented on July 1, 2008.

Therefore, we believe that postponing the deadline for this possible one-time prospective adjustment until July 1, 2008 would allow us to have the best available data from the first year of the LTCH PPS upon which to base an adjustment such as this.

Specifically, we wish to emphasize the distinction between the sufficiency of the data utilized for the annual data analysis that resulted in our proposed zero percent update for RY 2007 and the proposed postponement of the possible one-time prospective adjustment to the standard Federal rate, at proposed § 412.523(d)(3). We believe that the proposed annual adjustment of zero percent is based on the best data from FY 2004, including case-mix data which is derived from the MedPAR files, and data analysis coordinated by ORDI, assisted by 3M Health Information Services. The case-mix data used to make this adjustment is current and accurate and is not dependent upon the procedures of the cost report settlement. However, the data review that we believe necessary for the comprehensive analysis of the accuracy of the Federal payment rate under § 412.523(d)(3), which would be applied prospectively (and therefore has the potential to affect all future LTCH PPS Federal rates), is dependent on Medicare data that will only be available by July, 2007. We believe that only through a thorough analysis of the most comprehensive and accurate data from the first year of the implementation of the LTCH PPS for FY 2003 (including settled and fully audited cost reports) will we be able to reliably determine whether the one-time prospective adjustment to the standard Federal rate, which if issued will have an impact on all future payments under the LTCH PPS, should be proposed.

V. Other Proposed Policy Changes for the 2007 LTCH PPS Rate Year

A. Proposed Adjustments for Special Cases

1. Adjustment for SSO Cases

a. Proposed Changes to the Method for Determining the Payment Amount for SSO Cases

In the August 30, 2002 rule for the LTCH PPS, under § 412.529, we established a special payment policy for SSO cases, that is LTCH PPS cases with a LOS of less than or equal to five-sixths of the geometric ALOS for each LTC–DRG. When we established the SSO policy, we explained that ''[a] short-stay outlier case may occur when a beneficiary receives less than the full course of treatment at the LTCH before being discharged. These patients may be discharged to another site of care or they may be discharged and not readmitted because they no longer require treatment. Furthermore, patients may expire early in their LTCH stay'' (67 FR 55995). Also in the August 30, 2002 final rule, we stated that when we first described the policy, in the March 27, 2002 proposed rule, ''* * * we based the proposed policy on the belief that many of these patients could have been treated more appropriately in an acute hospital subject to the acute care hospital inpatient prospective payment system'' (67 FR 55995). Therefore, under the LTCH PPS, we implemented a special payment adjustment for SSO cases. Under the existing SSO policy at § 412.529, for LTCH PPS discharges with a LOS of up to and including five-sixths the geometric ALOS for the LTC–DRG, in general, we adjust the per discharge payment under the LTCH PPS by the lesser of 120 percent of the estimated cost of the case, 120 percent of the LTC–DRG specific per diem amount multiplied by the LOS of that discharge, or the full LTC–DRG payment.

As noted previously, generally LTCHs are defined by statute as having an ALOS of greater than 25 days. We stated that we believe that the SSO payment adjustment results in more appropriate payments, since 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. Payment-to-cost ratios simulated for LTCHs, for the cases described above, indicated that if LTCHs received a full LTC–DRG payment for those cases, they were significantly ''overpaid'' for the resources they have actually expended.

In establishing the SSO policy we also believe that providing a reduced payment for SSO cases would discourage hospitals from admitting patients for whom they were unable to provide complete treatment in order to maximize payment. We also believed that the policy did not severely penalize providers that, in good faith, had admitted a patient and provided some services before realizing that the beneficiary could receive more appropriate treatment at another site of care. As we explained in the FY 2003 LTCH PPS final rule, establishing a SSO payment for these types of cases addressed the incentives inherent in a discharge-based prospective payment system for LTCHs for treating patients with a short LOS (67 FR 55995 through 56000).

When we established the SSO adjustment at the outset of the LTCH PPS, we noted in the August 30, 2002 final rule that the regression analyses and simulations based on prior years' LTCH claims data generated under the former reasonable cost-based (TEFRA) based system, upon which we based many of our policy determinations regarding the design of the LTCH PPS for FY 2003, indicated that nearly half of LTCH cases would be paid on an adjusted per discharge amount based on the SSO payment policy established at existing § 412.529 once the LTCH PPS was implemented. However, we did believe that ''* * * this data analysis does not necessarily predict the future behavior of LTCHs operating under a prospective payment system. The data used in the analysis are a product or reflection of the practice patterns of hospitals that operate under the mechanisms of the TEFRA payment system, which are different from the principles of a prospective payment system. However, these are the best data available upon which we can simulate LTCH behavior under the new LTCH prospective payment system. We believe that once the LTCH prospective payment system is implemented, the practice patterns of LTCHs will change. We anticipate that hospitals will alter their admission, treatment, and discharge patterns. Thus, we fully expect that an increasing majority of cases will be reimbursed on an unadjusted per discharge basis during the transition from reasonable cost-based reimbursement to prospective payments.'' (67 FR 55999)

As we noted in the August 30, 2003 final rule, ''* * * [B]ased on our experience in implementing other Medicare prospective payment systems, we fully expect that as new data are received, we may revisit policy decisions described in this final rule. Furthermore, our Office of Research, Development, and Information [ORDI] will be tracking the impact of the prospective payments on LTCHs, other hospitals that treat long-term care patients, and other post-acute care providers, which will enable us to determine whether additional policy changes are warranted'' (67 FR 55999).

A change in the SSO policy was published in the RY 2004 LTCH PPS final rule (68 FR 34148), following a thorough reexamination of the impact of the SSO policy on subclause (II) LTCHs, authorized by section 1886(d)(1)(B)(iv)(II) of the Act which we implemented at § 412.23(e)(2)(ii). At that time, we revised certain aspects of the SSO policy in order to meet the specific needs of this type of LTCH. This provision provided an exception to the general definition of an LTCH set forth in section 1886(d)(1)(B)(iv)(I) of the Act, implemented at § 412.23(e)(2)(i), specifying that to qualify as a LTCH, a hospital must have first been excluded as a LTCH in calendar year (CY) 1986, have an average inpatient LOS of greater than 20 days, and demonstrate that 80 percent or more of its annual Medicare inpatient discharges in the 12-month cost reporting period ending in FY 1997 have a principal diagnosis that reflects a finding of neoplastic disease (62 FR 46016 and 46026). In the RY 2004 final rule, we particularly noted that the Congress recognized the existence and importance of a distinct category of LTCHs that might not otherwise warrant exclusion from the acute care inpatient PPS under subclause (I) but which nonetheless fulfilled a unique and vital role in serving a particular subset of Medicare patients. Consistent with existing policies that differentiated subclause (II) LTCHs from other LTCHs, we determined that it was reasonable for us to consider whether or not a policy that was designed for LTCHs designated under subclause (I) could reasonably and equitably be applied to a subclause (II) LTCH without some measure of adjustment. Therefore, in the RY 2004 LTCH PPS final rule, we provided an additional adjustment to the SSO policy for subclause (II) LTCHs. Specifically, in the RY 2004 LTCH PPS final rule (68 FR 34147 through 34148), we made a temporary adjustment to the applicable percentages used in the SSO payment formula at § 412.529(c) (applied to the cost of the SSO or the per diem LTCH DRG payment) used to calculate Medicare payments under the SSO policy. Specifically, at existing § 412.529(c)(4) for LTCHs designated under section 1886(d)(1)(B)(iv)(II) of the Act and § 412.23(e)(2)(ii), we

established a temporary adjustment that will sunset upon their first cost reporting period beginning on or after October 1, 2006. Under existing policy, for SSOs from a subclause (I) LTCH, Medicare payment is the least of the following: 120 percent of the LTC–DRG per diem amount multiplied by the LOS of the discharge; 120 percent of the cost of the case; or the full LTC–DRG. Under this temporary § 412.529(c)(4) adjustment, we substitute the following percentages for the 120 percent figure used in the SSO payment formula at § 412.529(c) for subclause (I) hospitals. Therefore, for discharges from a subclause (II) LTCHs, occurring on or after July 1, 2003, for cost reporting periods beginning during the first year of the 5-year LTCH PPS transition period, the SSO percentage is 195 percent. For discharges occurring in the cost reporting periods beginning during the second year of the transition period, the applicable SSO percentage is 193 percent; for discharges occurring in cost reporting periods beginning during the third year of the transition period, the applicable percentage is 165 percent; for discharges occurring in the cost reporting period beginning during the fourth year of the transition, the percentage is 136 percent; and for discharges occurring in cost reporting periods beginning during the fifth year of the 5-year transition, (and for discharges occurring in all future cost reporting periods), the SSO percentage for ''subclause (II)'' LTCHs, would be 120 percent, that is, the same as it currently is for all other LTCHs under the LTCH PPS.

As we continue to monitor the SSO policy, an analysis of LTCH claims data from the FY 2004 MedPAR files (using version 23 of the GROUPER), reveals that approximately 37 percent of LTCH discharges continue to be paid under the provisions of the existing SSO policy at § 412.529. As noted previously, at the outset of the LTCH PPS, the data upon which we based our system indicated that 48.4 percent of patients admitted to LTCHs fell into the category of SSOs, a percentage that we believed to be inappropriately high, given that the category of LTCH was established to care for Medicare beneficiaries requiring long-term hospital-level care. We believe our existing policy accounts for the fact that an LTCH in good faith could admit a patient and provide some services before realizing that the beneficiary would receive more appropriate treatment at another site of care. But in establishing the SSO policy, which provided a reduced payment for cases with a LOS that is up to and including five-sixths of the geometric ALOS for the LTC–DRG, it was our intent to not encourage hospitals to admit patients for whom a long-term hospital stay was not medically necessary and therefore, for whom the LTCH would not be providing complete treatment. We were concerned that these inappropriate admissions could be made in order to maximize payment (67 FR 55995). As noted previously, when this policy was established, at the start of the LTCH PPS for cost reporting periods beginning on or after October 1, 2002, nearly one-half (48.4 percent) of all LTCH cases would have been paid as SSOs. However, we believed that the percentage of short-stay outliers would drop significantly from 48.4 percent once the LTCH PPS was implemented. We believe that the 37 percent of LTCH discharges (that is, more than one-third of all LTCH patients) that the FY 2004 MedPAR identified as SSO cases continues to be an inappropriate number of patients being treated in LTCHs who most likely do not require the full measure of resources available in a hospital that has been established to treat patients requiring long-stay hospital-level care. Generally, if these patients required the type of care associated with LTCHs, the patients would most likely be in the LTCH for the duration of the LOS associated with the particular LTC–DRG to which the case is assigned. Therefore, we are concerned that the existing SSO payment adjustment at § 412.529, which generally will pay a per discharge amount based upon the least of 120 percent of the specific LTC–DRG per diem amount (multiplied by the LOS); 120 percent of the estimated costs of the case; or the full LTC–DRG payment as specified in existing § 412.529(c)(1), may unintentionally provide a financial incentive for LTCHs to admit patients not requiring the level of care available in that setting.

In the August 30, 2002 final rule, when first we presented our rationale for establishing the SSO policy, we noted that since LTCHs are defined by statute as generally having an ALOS greater than 25 days, we had proposed payment adjustments to make appropriate payment for cases that may not necessarily require the type of services intended to be provided at a LTCH or may have been transferred from an acute hospital prematurely'' (67 FR 55999). We continue to have these concerns, and we believe that our data indicate that after more than 3 years of the LTCH PPS, a policy reexamination is both necessary and appropriate, when more than one-third of LTCH PPS patients are paid under the SSO provision. In order to address these concerns, we are proposing two specific changes to the existing SSO payment methodology under § 412.529. Under existing policy, in general, Medicare will pay for a SSO case at the least of the following: 120 percent of the estimated costs of the case, 120 percent of the per diem LTCH PPS payment amount for the specific LTC–DRG multiplied by the LOS of the discharge, or the full LTCH PPS payment for the LTC–DRG. We believe that the current payment adjustment for SSO cases appears to be providing a financial incentive to inappropriately admit short-stay patients to LTCHs as evidenced by the high percentage of SSO cases. Consistent with the Secretary's broad authority ''to provide for appropriate adjustments to the long-term hospital payment system * * *'' established under section 123 of the BBRA as amended by section 307(b)(1) of BIPA, we are proposing to reduce the current adjustment at existing § 412.529(c)(1)(ii) which is based on 120 percent of the costs of the case to 100 percent of the costs of the case for discharges occurring on or after July 1, 2006 at proposed § 412.529(c)(2)(ii). We believe that by reducing the Medicare payment to the LTCH for a specific SSO case so that it would be equal to but not exceed the estimated costs incurred for that case, we may be removing what we believe could be a financial incentive that the current policy has established to treat short stay cases in LTCHs. We are not proposing to change the payment option of 120 percent of the per diem for a specific LTC–DRG multiplied by the LOS for that case because of the specific calculations upon which we based this aspect of the SSO policy adjustment. As described in detail in the FY 2003 final rule LTCH PPS, when we first established the SSO policy, we found that five-sixths of the geometric ALOS would be the SSO threshold where the full LTC–DRG payment would be made at 120 percent. That is, by adjusting the per discharge payment by paying at 120 percent of the per diem DRG payment, once a stay reaches five-sixths of the geometric ALOS for the LTC–DRG, the full DRG payment will have been made. We continue to believe that this specific methodology, described above in this section, which results in a gradual increase in payment as the LOS increases without producing a payment ''cliff'' at any one point, provides a reasonable payment option under the SSO policy. (67 FR 55997, August 30, 2002)

We believe it is inappropriate that more than one-third of Medicare patients treated in the special category of hospitals that was established by the Congress, under section 1886(d)(1)(B)(iv) of the Act to address the treatment of patients requiring extended hospital-level care are actually short-stay patients, as defined in § 412.529(a), and do not receive such extended hospital-level care. Therefore, we are proposing reduce the current adjustment at existing § 412.529(c)(1)(ii) from 120 percent of the costs of the case to 100 percent of the costs of the case for discharges occurring on or after July 1, 2006, for LTCHs described in § 412.23(e)(2)(i) resulting in a LTCH PPS Medicare payment equivalent to but not exceeding the estimated costs of the case. We believe that the proposed revision to the SSO payment methodology further discourages inappropriate admissions of these patients to LTCHs because we would be removing the financial incentive to admit cases that do not typically belong in LTCHs but would be more appropriately treated in another setting (for example, an inpatient acute care hospital).

Further, since the vast majority of LTCH patients are admitted directly from IPPS acute care hospitals, a fact verified by our patient data files (National Claims History Files), a recent MedPAC Report (June 2003, p. 79), and by research done by the Urban Institute at the outset of the LTCH PPS and RTI, we believe that the admission of short-stay patients at LTCHs may indicate premature and even inappropriate discharges from the referring acute care hospitals. For example, if an acute care hospital patient required additional inpatient services, it would usually be most appropriate for the acute care hospital to continue to treat the patient rather than discharging and admitting the patient to an LTCH for a short-stay episode.

We believe that in order to remove what may be an inappropriate financial incentive for a LTCH to admit a short-stay case, as well as, to discourage LTCHs from behaving like acute care hospitals by having a significant number of cases with lengths of stay commensurate with acute care hospitals and also to discourage LTCHs from admitting patients that could be premature discharges from acute care hospitals, we are proposing in § 412.529(c)(2)(iv) to add a fourth payment method to the three alternatives under § 412.529(c) for SSO cases. Specifically, we are proposing to revise § 412.529 to provide that for discharges from LTCHs described in § 412.23(e)(2)(i) occurring on or after July 1, 2006, payment for a SSO case would be the least of the following: 120 percent of the per diem amount for a specific LTC–DRG multiplied by the LOS of the discharge; 100 percent of the estimated costs of the case (which we are proposing in this proposed rule as a change from the existing 120 percent of estimated costs); the full LTCH PPS payment for the LTC–DRG; or a LTCH PPS payment comparable to the payment that would otherwise be paid under the IPPS.

We believe that this proposed additional component to the SSO payment formula is particularly appropriate because it reflects our concern that generally, LTCHs that admit SSO patients with lengths of stay more typical of an acute care hospital may be, in fact, behaving like acute care hospitals. Therefore, we are proposing to include an alternative payment method under the LTCH PPS SSO adjustment that could result in an LTCH PPS payment to the LTCH for a SSO stay that would be comparable to what Medicare would pay to an acute care hospital for the same case. Furthermore, since over 80 percent of all LTCH patients (FY 2003 MedPAR) are admitted from acute care hospitals to an LTCH, of which many become a SSO, an acute care hospital's discharge of a patient who is still in need of acute-level care may indicate a premature and inappropriate discharge from the acute care hospital, an inappropriate admission to the LTCH, and result in a second, unnecessary Medicare payment to the LTCH. We originally established a similar payment adjustment under the LTCH PPS at § 412.534 for LTCH HwHs and LTCH satellites for which greater than 25 percent of its patients were admitted from a host hospital (69 FR 49191 through 49214). Under that policy, unless the patient reached high cost outlier status at the acute care hospital prior to discharge, Medicare payments to the LTCH HwH or satellite for those cases in excess of the threshold were based upon the lesser of a payment under the LTCH PPS or an LTCH PPS amount equivalent to what would otherwise have been paid under the IPPS. This payment adjustment reflected our belief that if patient-shifting between a host hospital and its co-located LTCH exceeded a specific threshold, the onsite LTCH was functioning like a de facto unit of the acute care hospital, a configuration not permitted by section 1886(d)(1)(B) of the Act, which authorizes rehabilitation and psychiatric units but not LTCH units. We reasoned that if the patient was in effect, being treated in a ''unit'' of the acute care hospital, it was reasonable to issue a payment methodology that took this into account. For LTCH HwH or satellite discharges in excess of the 25 percent (or appropriate percentage) threshold, therefore, as specified in § 412.534, Medicare will make a payment based upon the lesser of the LTCH PPS payment otherwise payable under subpart O and an amount under this subpart that is equivalent to an amount that would be paid under the IPPS.

We believe that adapting the underlying premise of the payment adjustment at § 412.534 to a new payment adjustment method under the SSO policy is particularly appropriate, since we are concerned (and our data seems to confirm) that LTCHs may be admitting patients that should otherwise be treated in acute care hospitals, as evidenced by lengths of stay more in keeping with an acute care hospital stay than the considerably longer stays characteristic of LTCHs. We believe this additional proposed payment method, under the LTCH PPS for SSO patients under which, following the procedure set forth under § 412.529, the LTCH could receive a Medicare payment comparable to that which would otherwise be paid under the IPPS, is an appropriate response to the fact that an LTCH treating such patients may, in fact, be functioning like an acute care hospital.

We are also very concerned that acute care hospitals may be shifting their patients to LTCHs, resulting in a high incidence of SSOs. This pattern may indicate a premature discharge from the acute care hospital (where less than a full course of treatment was delivered) and an unnecessary admission to the LTCH. Despite the fact that the payment adjustment at § 412.534, based on the 25 percent (or applicable percentage) threshold, focused on inappropriate patient movement between co-located providers (69 FR 49191 through 49214), we do not believe that co-location is a prerequisite to inappropriate patient-shifting between an acute care hospital and an LTCH. As we discuss in section V.B. of this proposed rule, with the explosive growth in the numbers of free-standing LTCHs since 2004, many of which receive patients from a single acute care hospital, we are monitoring patient shifting that is occurring with growing regularity. (This issue is discussed in depth in section X. of this proposed rule.)

We believe that it is essential to guard the Medicare Trust Fund against admission and discharge practices that could result in more than one payment

for what was essentially one episode of patient care and, as we noted above in this section, we are concerned that there may be a correlation between the fact that one-third of LTCH discharges are SSO cases and what, in some cases, may be inappropriate admissions of patients who are prematurely discharged from acute care hospitals. We would also note that from the outset of the LTCH PPS, in our FY 2003 final rule for the LTCH PPS, we stated that ''many of these [SSO] patients could have been treated more appropriately in an acute care hospital subject to the acute care hospital inpatient prospective payment system'' (67 FR 55995). Therefore, we are proposing a fourth alternative in the SSO payment formula at § 412.529 that is similar to the existing payment adjustment at § 412.534, discussed in section V.B. of this proposed rule.

In the discussion that follows, for the sake of clarity, we use phrases such as ''IPPS DRG relative weights,'' and the ''IPPS labor-related share,'' in describing features of the IPPS that we would use in calculating LTCH PPS payments under this proposed new alternative adjustment. We want to emphasize, however, that such a payment is not an IPPS payment but rather, a payment under the LTCH PPS that is generally derived from the IPPS payment methodology. Therefore, for Medicare payments for SSO cases under the LTCH PPS as specified in proposed § 412.529(c)(2)(iv), we are proposing that ''an amount under subpart O that is comparable to an amount that otherwise would be paid under the IPPS'' would be calculated based on the sum of the applicable operating and capital IPPS rates in effect at the time of the discharge from the LTCH as established in the applicable IPPS final rule published annually in the **Federal Register**. This is necessary since, under the IPPS, there are separate Medicare rates for operating (subpart D of part 412) and capital (subpart M of part 412) costs to acute care hospitals; while, under the LTCH PPS, there is a single payment for the operating and capital costs of the inpatient hospital services provided to LTCH Medicare patients. We are also proposing that ''an amount under subpart O that is comparable to an amount that otherwise would be paid under the IPPS'' would be calculated including the applicable differences in resource use (that is, IPPS DRG relative weights), differences in area wage levels (that is, wage index), a cost-of-living adjustment for hospitals located in Alaska and Hawaii, the treatment of a disproportionate share of low income patients (DSH), if applicable, and an adjustment for indirect medical education (IME), if applicable. (We would emphasize that under this proposed policy, Medicare payments, payable under subpart O, would be ''comparable'' to what would otherwise be paid under the IPPS, rather than ''equal'' to an IPPS payment because, as we explain, there are specific features of the IPPS that do not directly translate into the LTCH PPS, so would be no way to establish or evaluate whether the LTCH payments are ''equal'' to an amount that would be paid under the IPPS. In proposing to use the word ''comparable,'' to describe this payment alternative to the existing SSO policy, we intend to make clear that such payments would be calculated by applying IPPS principles to achieve a close approximation of payments that would be made under the IPPS, recognizing the fact that not all components of the IPPS can be carried out precisely in the LTCH PPS context.

Specifically, under this proposed policy, for payments under the LTCH PPS, we would calculate an amount payable under subpart O comparable to what would otherwise be paid under the IPPS for the costs of inpatient operating services which would be based on the standardized amount determined under § 412.64(c), adjusted by the applicable DRG weighting factors at § 412.60 as set forth at § 412.64(g). This amount would be further adjusted for different area wage levels using the applicable IPPS labor-related share based on the CBSA where the LTCH is physically located set forth at § 412.525(c) and the IPPS wage index for non-reclassified hospitals as shown in Tables 4A and 4B in the annual IPPS final rule. (In the RY 2006 LTCH PPS final rule (70 FR 24200), we discuss the inapplicability of geographic reclassification procedures for LTCHs.) For LTCHs located in Alaska and Hawaii, we propose that this amount would also be adjusted by the applicable proposed COLA factor used under the IPPS published annually in the IPPS final rule. (We note currently that the same COLA factors are used under both the IPPS and the LTCH PPS.)

We are additionally proposing that this proposed revised payment adjustment alternative (an amount comparable to what would otherwise be paid under the IPPS for the costs of inpatient operating services) would also include a DSH adjustment (see § 412.106), if applicable, for discharges governed by § 412.529.

Under this proposed revision to the LTCH PPS SSO payment adjustment at proposed § 412.529(c)(2)(iv), we are proposing that in the case of a LTCH that is a teaching hospital, we would determine the IME payment for the LTCH by imputing a limit on the number of full-time equivalent (FTE) residents that may be counted for IME (IME cap) based on the LTCH's direct GME cap (which would already have been established for an LTCH which had residency programs as set forth at § 413.79(c)(2)), thus calculating an IME payment for this LTCH that is in accord with the IPPS payment formula set forth at § 412.105. We are adapting this methodology from the payment adjustment established for LTCH HwHs and LTCH satellites under § 412.534 where the applicable payment alternative is described as an amount ''equivalent'' to what would otherwise be paid under the IPPS. The use of a proxy for the IME cap is necessary because it would not be appropriate to apply the IPPS IME rules literally in the context of this LTCH PPS payment adjustment. Under the IPPS, IME payment regulations at § 412.105, limits were established on the number of FTE residents a hospital is permitted to count for IME payments based on the hospital's 1996 cost report. This IME FTE resident cap under the IPPS would not translate appropriately to an LTCH since an LTCH would not have reported any FTE residents for IME on its 1996 cost report. Therefore, we believe the use of the LTCH's direct GME cap for the purpose of calculating the payment adjustment alternative under proposed § 412.529(c)(2)(iv) is reasonable since it is based on the best available data on residency programs at LTCHs (which could be computed from direct GME data for LTCHs that had residency programs). Using an imputed GME cap would enable us to factor an adjustment for residency programs into a Medicare payment under the LTCH PPS for those SSO cases where the least of the payment alternatives results in an amount under the LTCH PPS comparable to what would otherwise be paid under the IPPS. Both a DSH adjustment and an IME adjustment, as necessary, could be computed from data already collected on the LTCH's cost report.

Under this proposed LTCH PPS payment adjustment, an amount payable under subpart O comparable to what would otherwise be paid under the IPPS would also include payment for the costs of inpatient capital-related costs based on the capital Federal rate at § 412.308(c), which would be adjusted by the applicable IPPS DRG weighting factors at § 412.60 as set forth at § 412.312(b). This amount would be further adjusted by the applicable geographic adjustment factors set forth

at § 412.316, including wage index, (based on the CBSA where a LTCH is physically located and derived from the IPPS wage index for non-reclassified hospitals as shown in tables 4A and 4B of the annual IPPS final rule) large urban location, if applicable, and the IPPS COLA factor used under the IPPS for LTCHs located in Alaska and Hawaii. (The same COLA factors are used under both the IPPS and the LTCH PPS.).

For LTCH discharges governed by the proposed revision of the SSO policy under the LTCH PPS, an amount comparable to what would be paid under the IPPS for the inpatient capital-related costs would also include a DSH adjustment (§ 412.320), if applicable and an IME adjustment (§ 412.322), if applicable. (As with IPPS payment for operating costs, a DSH or an IME adjustment for the purposes of this proposed policy could be computed from data already collected on the LTCH's cost report, as necessary.)

Under this proposed policy, an amount payable under subpart O comparable to what would otherwise be paid under the IPPS would equal the sum of the amount comparable to what would otherwise be paid under the IPPS for the costs of inpatient operating services and the amount comparable to what would be paid under the IPPS for inpatient capital-related costs (as described previously). We note that we are proposing that ''a LTCH PPS payment amount comparable to what would be paid under the IPPS'' would not include additional payments for extraordinarily high cost cases under the IPPS outlier policy (§ 412.80(a)) since, under existing LTCH PPS policy, a SSO case that meets the criteria for a LTCH PPS high cost outlier payment at § 412.525(a)(1) (that is, if the estimated costs of the case exceed the adjusted LTC–DRG payment plus a fixed loss amount) would be receive an additional payment under the LTCH PPS high cost outlier policy at § 412.525(a) (67 FR 56026, August 30, 2002). For purposes of high cost outliers under the SSO policy, we use a fixed loss amount calculated under § 412.252(a) and not a fixed loss amount based on § 412.80(a). We propose to use the term ''comparable'' in the fourth payment alternative so that the public would realize that this payment alternative is not exactly the same as the one that is similarly worded in § 412.534(c)(2), (d)(1), and (e)(1), discussed in section V.B. of this proposed rule.

Therefore, as noted previously in this proposed rule, we are proposing to add an additional method to the existing payment alternatives (that is, the least of 120 percent of the per diem LTC–DRG multiplied by the number of inpatient days as specified in § 412.529(c)(2)(i), 120 percent of the costs of the case as specified in § 412.529(c)(2)(ii), or the full LTC–DRG payment as specified in § 412.529(c)(2)(iii)). Specifically, we are proposing in § 412.529(c)(2)(iv) that Medicare would pay an amount comparable to the amount that would have been paid under the IPPS for a particular case if that amount is lower than the existing 3 payment alternatives. Medicare would pay the LTCH 80 percent of the costs of the case that exceed the sum of the applicable option and the fixed loss amount determined under § 412.525(a). In addition, we are proposing a change to § 412.529(c)(2)(ii) that decreases the 120 percent of the costs to 100 percent of costs.

Under existing LTCH PPS SSO policy at § 412.529(c), the payment is ultimately based on the least of: 120 percent of the LTC–DRG specific per diem amount multiplied by the LOS of the discharge; 120 percent of the cost of the case; or the full LTC–DRG. A high cost outlier payment could be made for a SSO stay if the total costs of the case exceed the least of these three options, plus the appropriate fixed-loss amount under § 412.525. In this proposed rule, for reasons described previously, we have proposed to lower the 120 percent of costs to 100 percent, and we have also proposed a fourth alternative method for this formula: An LTCH PPS payment comparable to what would otherwise have been paid under the IPPS. We would emphasize that under this proposed policy we are not proposing to change the basic payment determinations in the existing SSO payment policy for high cost outliers. Therefore, as noted previously in this proposed rule, if the costs of the case exceeded the payment resulting from this formula plus the LTCH PPS fixed loss amount, Medicare payment to the LTCH for this case, would include high cost outlier payment set forth at § 412.525.

Accordingly, even with the proposed additional alternative to the SSO payment policy at proposed § 412.529(c)(2)(iv), high cost outlier payments for a SSO discharge would continue to be paid under the existing SSO policy established at the start of the LTCH PPS (for cost reporting periods beginning during FY 2003) where high cost outlier payments, based upon the use of the LTCH PPS fixed loss amount, were governed by § 412.525.

We note that the approach taken under § 412.534 for high cost outliers is different than the approach that has been taken for more than the last 3 years with short-stay outliers that are also high cost outliers (67 FR 56026, 68 FR 34145, 69 FR 25689, 70 FR 24197). Specifically, since the beginning of the LTCH PPS, a SSO that is also a high cost outlier has utilized the fixed loss amount calculated under § 412.525. Accordingly, we are not aware of any reason at this time to change this policy, regardless of the fact that we are now proposing to add a fourth alternative payment method under the SSO policy (that is, a payment under subpart O that is comparable to an amount otherwise payable under § 412.1(a)). Furthermore, we believe that it is beneficial from an administrative efficiency perspective to maintain our current policy for a SSO that also hits high cost outlier status.

We have provided that under the LTCH HwH and satellite payment adjustment at § 412.534, payment for discharges will be ''the lesser of the amount otherwise payable under this subpart [subpart O] or the amount that is otherwise payable under this subpart that is equivalent to the amount that would be otherwise payable under § 412.1(a) [the IPPS].'' We acknowledge that under this policy, if payment is based on the latter and the case is a high cost outlier, § 412.80 will govern the LTCH PPS payment. Therefore, if the estimated coast of the case exceeds the DRG payment plus the fixed loss amount under § 412.80(a), the LTCH would receive an additional payment based on the high cost outlier policy under the IPPS. If payment is based on an amount otherwise payable under Subpart O, and the case is a high cost outlier, § 412.525 will govern. If the estimated cost of the case exceeds the adjusted LTCH–DRG payment plus a fixed loss amount under § 412.525(a), the LTCH would receive an additional payment based on the LTCH PPS high cost outlier policy. We believe that proposing the additional alternative in § 412.529(c)(2)(iv) to the payment options under the SSO policy, which, if applicable, could result in a high cost outlier payment determined under § 412.525, is consistent with our existing SSO high cost outlier policy and the proposed policy would maintain that consistency. However, we are specifically asking for comments on whether we should use a fixed loss amount derived from the IPPS high cost outlier policy at § 412.80(a), where the least of the four options in the rate is comparable to the IPPS rate in the event that a SSO case also qualifies for a high cost outlier payment under the LTCH PPS.

We established special provisions for the SSO policy for subclause (II) LTCHs in the RY 2004 LTCH PPS final rule (68

FR 34147). We are proposing to exempt subclause (II) LTCHs from the proposed additional revisions to the SSO policy discussed previously until the 5th year of the phase-in for such an LTCH of the LTCH PPS (that is, for discharges occurring during cost reporting periods beginning on or after October 1, 2006). This proposed approach is consistent with our existing policy as it applies to subclause (II) LTCHs in that these LTCHs do not become subject to the specific SSO percentages established for subclause (I) LTCHs until cost reporting periods beginning on or after October 1, 2006. Therefore, since the percentages applied under the SSO policy for subclause II LTCHs do not go to 120 percent until the fifth year of the transition, the proposed reduction from 120 percent of the estimated costs of the case to 100 percent of the estimated costs would not apply to a subclause (II) LTCH until that time, nor would the proposed additional alternative, of an amount payable under Subpart O comparable to the amount that would otherwise be paid under the IPPS, apply to discharges from a subclause (II) LTCH until such an LTCH's cost reporting period beginning on or after October 1, 2006. Therefore, under our proposed policy, we are proposing that SSO discharges at a subclause (II) LTCH that had a cost reporting period beginning on January 1, for example, would be subject to all of the four payment alternatives (including the proposed reduction to 100 percent of costs and the proposed addition of option of ''a payment comparable to what would otherwise have been paid under the IPPS'') for discharges occurring on or after the start of its 5th year of the transition on January 1, 2007.

Our proposal to exempt subclause (II) LTCHs from the proposed revisions to the SSO policy at § 412.529(c)(2) until cost reporting periods beginning on or after October 1, 2006 is consistent with our understanding of Congressional intent in establishing this special category of LTCHs in section 4417(b) of the BBA, which states that 80 percent of the annual Medicare inpatient discharges, in such a subclause (II) LTCH, in the 12-month reporting period ending in Federal FY 1997 would have had principal diagnosis that reflects a finding of neoplastic disease. The Congress, in enacting subclause II, provided an exception to the general definition of LTCHs under subclause I. In the RY 2004 LTCH PPS final rule (68 FR 34148), we evaluated the SSO policy for subclause II LTCHs, and we noted that the unique Congressional mandate set forth in section 1886(d)(1)(B)(iv)(II) of the Act circumscribes such a LTCHs' admission policies to the extent that it is being identified as a LTCH in order to provide a particular type of service (for which the ALOS is greater than 20 days) to a particular population (at least 80 percent have a principal diagnosis of neoplastic disease). We stated that we believed that a LTCH in this category might not be able to readily address the type of patients and the costs it incurs for those patients as would LTCHs described under subclause I. We believed that it is necessary to adjust the short stay policy for subclause (II) LTCHs during the 5-year transition period, so that a LTCH of this type could continue to serve its community, as intended by the Congress (68 FR 34148).

We continue to believe that hospitals fitting this description fulfill a unique and vital service for certain Medicare beneficiaries. We further believe, as we discussed in significant detail in the RY 2004 final rule, that it was necessary to temporarily adjust the short stay policy for subclause (II) LTCHs during the 5-year transition period, so that an LTCH of this type could continue to serve its community as they adjust their behavior. We also stated in the FY 2004 final rule that we expected that during this 5-year period, the subclause (II) LTCHs will make every attempt to adopt the type of efficiency enhancing policies that generally result from the implementation of prospective payment systems in other health care settings (69 FR 34148). Therefore, we are proposing that hospitals that qualify as subclause (II) LTCHs would become subject to the new proposed payment options for SSO discharges, when a subclause (II) LTCH would also become fully subject to the general SSO policy at § 412.529, which would be for discharges occurring in the cost reporting period beginning on or after October 1, 2006.

b. Proposed Changes to the Determination of Cost-to-Charge Ratios (CCRs) and Reconciliation of SSO Cases

In the June 9, 2003 IPPS outlier final rule (68 FR 34507), we revised the short-stay policy at § 412.529 (and the high-cost outlier policy at § 412.525(a)) because, as we discussed above in this section, we believed that the SSO (and high cost outlier) policy are susceptible to the same payment vulnerabilities that became evident under the IPPS, and therefore, merited revision. Therefore, in the regulations under existing § 412.529(c)(5)(ii) and (iii), we established a policy for the determination of LTCH CCRs and the reconciliation of SSO payments, for discharges occurring on or after August 8, 2003 (§ 412.529(c)(5)(ii)) and October 1, 2003 (§ 412.529(c)(5)(iii)), respectively. (As noted above in this section, in that same final rule, we established the same changes to the high-cost outlier policy at existing § 412.525(a)(4)(ii) and (iii).)

As we discuss in section IV.D.3.b. of this preamble, we are proposing to revise the existing regulations at § 412.525(a)(4) to codify in subpart O of part 42 of the CFR 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, and the provisions governing the reconciliation of high cost outlier payments. We are proposing these changes, as we discuss in greater detail below in this section, because we believe that such proposed changes would be more consistent with the LTCH PPS single payment rate, and because we believe it would be more appropriate and administratively simpler to include the regulatory provisions that pertain only to LTCHs for the determination of LTCH PPS outlier payments applicable under the LTCH PPS regulations in subpart O of part 42 of the CFR (as opposed to subpart A). Since CCRs are also used in determining SSO payments under § 412.529, we are proposing, under the broad authority of section 123 of the BBRA and section 307(b)(1) of BIPA, to revise § 412.529(c) consistent with the proposed changes to § 412.525(a)(4) discussed in section IV.D.3. of this preamble.

Specifically, we are proposing that in § 412.529(c)(4)(iv)(C)(*2*) would specify, that for discharges occurring on or after October 1, 2006, if, among other things, 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 CCR (established and published annually by CMS)), the FI may use a Statewide average CCR (also established annually by CMS). (We note that, similar to our current policy, we are also proposing under proposed § 412.529(c)(4)(iv)(C) that the FI may use a Statewide average CCR in two other circumstances, which are discussed in greater detail below in this section.) This proposed change is similar to our existing policy (established in the June 9, 2003 IPPS high cost outlier final rule (68 FR 34494)) and the proposed change to the LTCH PPS high cost outlier policy discussed previously in this proposed rule. Under proposed § 412.529(c)(4)(iv)(C)(*2*), for discharges

occurring on or after October 1, 2006, we are proposing that we would determine the single ''total'' CCR ceiling (as we proposed under the high cost outlier policy at proposed § 412.525(a)(4)(iv)(C)(*2*), as explained in section IV.D.3.b. of this preamble) by first calculating the total (that is, operating and capital) CCR for each hospital and then determining the average total CCR for all hospitals. The total LTCH CCR ceiling would then be established at 3 standard deviations from that average total CCR rather than determining the LTCH CCR ceiling by adding together the separate IPPS operating CCR ceiling and IPPS capital CCR ceiling as we do under our current policy. (We note, as discussed in greater detail below in this section, in conjunction with this proposed change in the calculation of the LTCH CCR ceiling, we are also proposing a change in our methodology for calculating the applicable Statewide average CCRs under the LTCH PPS to be based on ''total'' hospital-specific CCRs.) Specifically, we are proposing under the SSO policy at § 412.529(c)(4)(iv)(C), to 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 the single LTCH ''total'' CCR ceiling based on IPPS hospital-specific total (operating and capital) Medicare costs and charges, as explained above in this section. In addition, under this proposal, the total CCR ceiling would continue to be published annually in the IPPS proposed and final rules, and therefore, the public should continue to consult the annual IPPS proposed and final rules for changes to the applicable LTCH PPS Statewide average total CCRs that would be effective for discharges occurring on or after October 1, 2006 (since, under this proposal the current applicable combined Statewide average CCRs, 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.) The rationale for this proposed change to the SSO policy at proposed § 412.529(c)(4)(iv)(C) mirrors the rationale provided for the proposed changes to the high cost outlier policy at proposed § 412.525(a)(4)(iv)(C) discussed in section IV.D.3.b. of this preamble.

Also consistent with the proposed changes to § 412.525(a)(4)(iv), under the broad authority of section 123 of the BBRA and section 307(b)(1) of BIPA, we are also proposing at § 412.529(c)(4)(iv)(A) through (C), for discharges occurring on or after October 1, 2006, to codify in subpart O of part 42 of the CFR the remaining LTCH PPS SSO policy changes concerning the determination of LTCHs' CCRs 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 in order to more precisely describe the application of those policies as they relate LTCHs. Specifically, similar to our current policy and consistent with the proposed changes to the high cost outlier policy at § 412.525(a)(4) discussed previously in this proposed rule, we are proposing in § 412.529(c)(4)(iv)(C) to specify that the FI 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 of this chapter); (2) LTCHs whose CCR is in excess of the LTCH CCR ceiling (that is, 3 standard deviations above the corresponding national geometric mean total CCR); and (3) other LTCHs for whom data with which to calculate a CCR is not available (for example, missing or faulty data). (As we noted in section IV.D.3.b. of this preamble and consistent with our current regulations, either CMS or the hospital may request the use of a different (higher or lower) CCR based on substantial evidence that such a CCR more accurately reflects the hospital's actual costs and charges. This applies to new (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 a new LTCH provider number). Rather, the cost and charge data from the IPPS hospital's cost report (even if it is more or less than a 12-month cost reporting period) would be used to determine the LTCH's CCR.)

Also similar to our current practice and consistent with the proposed change to the high cost outlier policy discussed previously in this proposed rule, under § 412.525(c)(4)(iv)(C), for discharges occurring on or after October 1, 2006, we are proposing that we would annually establish Statewide average ''total'' CCRs for use under the LTCH PPS based on IPPS data by first calculating the total (that is, operating and capital) CCR for each hospital and then determining the average total CCR for all hospitals in each State rather than assigning the combined (operating and capital) Statewide average CCRs, as we do under our current policy. Specifically, in proposing to compute Statewide average total CCRs, we would use the same IPPS CCR data that we currently use to annually establish the separate IPPS operating Statewide average CCRs and capital Statewide CCRs (that we add together under our current policy to determine the applicable ''combined'' Statewide average CCR for LTCHs) to compute Statewide average total CCRs as explained above in this section. In addition, under this proposal, the Statewide average total CCRs would continue to be published annually in the IPPS proposed and final rules and therefore, the public should continue to consult the annual IPPS proposed and final rules for changes to the applicable LTCH PPS Statewide average total CCRs that would be effective for discharges occurring on or after October 1, 2006 (since, under this proposal, the current applicable combined Statewide average CCRs, 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).

Our rationale for this proposed change to the SSO policy at proposed § 412.529(c)(4)(iv)(C) mirrors the rationale provided for the proposed changes to the high cost outlier policy at proposed § 412.525(a)(4)(iv)(C) discussed in greater detail in section IV.D.3.b. of this preamble.

In addition, we are proposing under § 412.529(c)(4)(iv)(B), similar to our current policy and consistent with the proposed change to the high cost outlier policy discussed above, for discharges occurring on or after October 1, 2006, that the CCR applied at the time a claim is processed would be based on either the most recent settled cost report or the most recent tentative settled cost report, whichever is from the latest cost reporting period. Furthermore, we are proposing under § 412.529(c)(4)(iv)(A) that CMS may specify an alternative to the CCR computed from the most recent settled cost report or the most recent tentative settled cost report, whichever is later, or a hospital may also request that its FI use a different (higher or lower) CCR based on substantial evidence presented by the hospital. As noted previously in this proposed rule, these proposed revisions to our policy

for determining a LTCH's CCR for discharges occurring on or after October 1, 2006 under proposed revised § 412.529(c)(4)(iv)(A) and (B) are similar to our existing policy established in the June 9, 2003 IPPS high cost outlier final rule (68 FR 34506 through 34513) and consistent with the proposed changes to the high cost outlier policy previously discussed in this proposed rule.

Furthermore, similar to our current policy and consistent with the proposed change to the high cost outlier policy discussed previously in this proposed rule , under the broad authority under section 123 of the BBRA as amended by section 307(b) of BIPA, we are also proposing in under § 412.529(c)(4)(iv), for discharges occurring on or after October 1, 2006, to codify in the LTCH PPS regulations (subpart O of part 42 of the CFR) the outlier reconciliation provisions that were established in the June 9, 2003 IPPS high cost outlier final rule (68 FR 34506 through 34513) including proposed editorial clarifications to those provisions (which are the same as the proposed changes to the high cost outlier policy discussed above in section IV.D.3.d. of the preamble of this proposed rule). Specifically, under § 412.529(c)(4)(iv)(D), similar to our current policy and consistent with the proposed change to the high cost outlier policy, we are proposing 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, at proposed § 412.529(c)(4)(iv)(E), similar to our current policy and consistent with the proposed change to the high cost outlier policy, we are proposing 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. This adjustment would be based upon a widely available index that would be established in advance by the Secretary and would be applied from the midpoint of the cost reporting period to the date of reconciliation. Our rationale for these proposed changes to the SSO policy at proposed § 412.529(c)(4)(iv)(D) and (E) mirrors the rationale provided for the proposed changes to the high cost outlier policy at proposed § 412.525(a)(4)(iv)(D) and (E), discussed in greater detail in section IV.D.3.d. of this preamble.

2. The 3-Day or Less Interruption of Stay

In the RY 2005 LTCH PPS final rule, we revised the definition of an ''interruption of a stay'' at § 412.531(a) by establishing two distinct categories, ''[a] 3-day or less interruption of stay'' and ''[a] greater than 3-day interruption of stay'' at § 412.531(a)(2). The payment features of the ''greater than 3-day'' policy itself apply beginning with day 4 once the ''3-day or less'' policy no longer applies.

The 3-day or less interruption of stay policy is defined at § 412.531(a)(1) as ''a stay at a LTCH during which a Medicare inpatient is discharged from the LTCH to an acute care hospital, IRF, SNF, or the patient's home and readmitted to the same LTCH within 3 days of the discharge from the LTCH. The 3-day or less period begins with the date of discharge from the LTCH and ends not later than midnight of the third day.'' As discussed in detail in the RY 2005 LTCH PPS final rule (69 FR 25691 through 25700), there are several components to the payment for the 3-day or less interruption of stay.

First, subject to § 412.531(b)(1)(ii)(A)(*1*) and (b)(1)(ii)(A)(*2*), only one LTC–DRG payment will be made to the LTCH for the patient who is discharged from the LTCH to an acute care hospital, IRF, SNF, or patient's home and readmitted to the same LTCH within 3 days. Secondly, under § 412.531(b)(1)(ii)(A)(*2*), any off-site tests or medical treatment, either inpatient or outpatient, provided at an acute care hospital or an IRF, or care at a SNF and that are not otherwise excluded under § 412.509(a), must be provided by the LTCH ''under arrangements'' if the patient is readmitted to the LTCH within 3 days. We established a time-limited specific exception to the ''under arrangements'' requirement during the RY 2005 LTCH PPS, at § 412.531(b)(1)(ii)(A)(*1*), in the event that the treatment was grouped to a surgical DRG under the IPPS at an acute care hospital (69 FR 25696 through 25700).

We also stated that in addition to having sufficient data to decide upon continuing the exception, we will evaluate whether additional refinements to the overall 3-day or less interruption of stay policy were warranted (69 FR 25697). In the RY 2006 LTCH PPS final rule, we extended the surgical-DRG exception to the 3-day or less interruption of stay policy because, as we stated, ''[t]he 3-day interruption of stay policy was first implemented on July 1, 2004, and, therefore, we do not yet have sufficient data to accomplish the above evaluations * * *'' We continued, ''we will be analyzing claims data over the next year to determine whether the surgical DRG exception to the 'under arrangements' feature of the 3-day or less interrupted stay policy is actively accomplishing our goal of reducing unnecessary Medicare payments and to deter inappropriate Medicare payments while not compromising beneficiary access to medically necessary services. We believe that we will have sufficient data to evaluate continuation of the exception and also whether additional refinements to the overall 3-day or less interruption of stay policy are warranted'' (70 FR 24206).

We also specified that we were particularly interested in analyzing data from LTCHs to determine whether there was a significant increase in interruptions of 4 days since the establishment of the policy. To the extent interruption of stay had increased to at least 4 days (one day past the 3-day threshold that would prevent the 3-day or less policy from being triggered), we believed that this behavior could indicate inappropriate efforts to side-step the provisions of our 3-day or less interruption of stay policy.

As part of our on-going monitoring program (as discussed in Section X. of this proposed rule), ORDI analyzed claims from the MedPAR files for LTCH discharges from July 1, 2004 through June 30, 2005 and performed the data analysis necessary for evaluating the impact of the surgical DRG exception to the 3-day or less interruption of stay policy. As shown in Table 10, the data revealed the following for RY 2005 LTCH PPS.

TABLE 10

Total LTCH discharges	120,895
Total covered charges	$8,694,137,026.00
Average covered charge	$71,855.00
Total cases assigned an IPPS Surgical DRG	459

TABLE 10—Continued

Average covered charge for:	
Non-surgical DRGs	$18,103.00
Surgical DRGs	$22,429
Total covered charges for surgical stays were	$10,294,925

The 459 cases that were governed by the surgical DRG exception represented 0.003 percent of total LTCH discharges and the total covered charges for those surgical DRGs, $10,294,925, represented 0.1 percent of covered charges to LTCHs for RY 2005. Furthermore, the data revealed that the median value of the covered charges for the surgical DRGs at the acute care hospitals were $14,900. In addition, for FY 2004, 57 percent of the covered charges were below $21,720 and 90 percent were below $33,679.

These data do not convince us that a continuation of the surgical DRG exception to the 3 day or less interruption of stay policy is warranted. We believe that the numbers cited above support the following conclusions:

• The surgical cases that fell within this exception are present in only a small fraction of LTCH hospitalizations and that therefore, they were neither numerous nor would they be significantly costly for LTCHs to cover under arrangements;

• The surgical DRGs for which Medicare claims were submitted by the acute care hospital appear to support, in large part, our original hypothesis (that if a LTCH patient was discharged to an acute care hospital for only 1, 2, or 3 days, followed by a readmission to the LTCH, there could be reason to believe that the treatment delivered, even if it was grouped to a surgical DRG, was not a major procedure because of the relatively short LOS, and, therefore, should have been provided ''under arrangements.'') A reasonable and systematic examination of a subset of the above noted 459 surgical DRGs additionally revealed the following:

• Of 47 cases governed by the exception and for which Medicare made an additional surgical DRG payment to the acute care hospital, in over half of these cases, the entire stay in the LTCH was also grouped to a surgical LTC–DRG. In 10 of these cases, the IPPS DRG and the LTC–DRG were the same. This indicates that *at least* in these 10 cases, the LTCH claim included the procedure that was delivered at the acute care hospital (for which Medicare issued an additional payment to the IPPS) and is strongly suggestive of poor documentation in the medical record, poor coding, or gaming. Since LTCHs typically do not perform significant surgical procedures, three examples of additional irregularities are as follows:

—LTC–DRG 468, ''extensive OR procedures unrelated to principal diagnosis,'' with DRG 478, ''other vascular procedures w/cc'' at the acute care hospital;

—LTC–DRG 148, small and large bowel procedures w/cc at the LTCH and DRG 442 ''other OR procedures with injuries w/cc'' at the acute care hospital.

—LTC–DRG 76, other respiratory system OR procedures with CC at the LTCH and DRG 415, O.R. procedure for infectious and parasitic diseases at the acute care hospital.

• The specific surgical DRGs into which the acute care treatments were grouped appear to arise directly from the principle diagnoses at the LTCH, a concern that we originally stated in the January 30, 2004 proposed rule for the LTCH PPS when we described the ''under arrangements'' feature of the proposed 3-day or less interruption of stay policy (69 FR 4771).

Table 11 shows examples drawn from the above cited subset of claims for July 1, 2004 through June 30, 2005.

TABLE 11

LTC–DRG	DRGs
182 (Esophagitis gastroenteritis, and miscellaneous other digestive disorders >17 w/cc.	17 Other digestive system operating room procedures.
271 Skin ulcers	270 Other skin, subcutaneous tissue and breast procedures w/cc.
348 Prostatitis	336 Trans-urethral prostatectomy.
87 Pulmonary edema and respiratory failure	55 Miscellaneous ENT, mouth, or throat procedures.
418 Post-operative and post traumatic infections	415 Operating room procedure for infectious or parasitic diseases.
144 Other circulatory system diagnosis w/cc	120 Other circulatory system operating room procedures.

The basic premise of a PPS recognizes that Medicare pays hospitals an amount per discharge based on the average costs of delivering care for that diagnosis (which is assigned a DRG), and some cases require more hospital resources to be expended, where others, require less. Therefore, in some cases, Medicare payments will be lower than the hospital's costs but in other cases, the payments will exceed the costs. In the January 30, 2004 LTCH PPS proposed rule, we stated that surgical treatment that is directly related to the principle diagnosis at the LTCH and which only required 3 days or less of care at the acute care hospital, should be provided by the LTCH either directly or ''under arrangements'' since Medicare payment to the LTCH for this particular case was ''payment in full'' as specified in § 412.509(b) (69 FR 4771). It has been standard Medicare PPS policy for over two decades that the LTCH hospitalization, the surgical treatment arising from this hospitalization, and the post-operative stay at the LTCH are to be viewed as one episode of care and therefore, the LTC–DRG payment would be adequate compensation for the entire episode. (In fact, when LTCHs were paid under the reasonable-cost based TEFRA payment policy—subject to hospital-specific ceilings or 'target amounts'—prior to the FY 2003 implementation of the LTCH PPS, the ''under arrangements'' policy, enabled LTCHs to include the costs of these off-site treatments on Medicare claims, thereby resulting in higher TEFRA target amounts.) However, when we restated the ''under arrangements'' policy for the 3-day or less interruption of stay, and proposed its codification in the RY 2005 proposed rule for the LTCH PPS, in response to comments received on the January 30, 2004 proposed rule, we did agree to establish a 1-year exception to the ''under arrangements'' feature of the 3-day or less interruption of stay policy for cases that grouped to a surgical DRG

during an intervening acute care hospitalization. We subsequently extended this exception for an additional year in order to gather sufficient data with which to determine the value of retaining this exception to the general policy.

Therefore, based on the above data analysis and under the broad discretionary authority granted by section 123 of the BBRA as amended by section 307(b) of the BIPA for the Secretary for the development and implementation of the LTCH PPS, (including the ability to make appropriate adjustments), we are proposing not to renew the surgical-DRG exception to interrupted stay of 3 days or less policy for LTCH PPS RY 2007. Under § 412.531, with the proposed sunsetting of this exception for LTCH PPS RY 2007, treatment at an acute care hospital that was grouped to a surgical DRG would be considered part of the LTCH stay and paid for by the LTCH ''under arrangements.'' (see § 412.509(c)). Our analytic sample of LTCH cases that included a 3 day or less interruption of stay that was governed by the surgical DRG-exception, indicates that at least one-half of the LTCH claims themselves included surgical care, despite the patient's discharge to the acute care hospital for treatment that was grouped to a surgical DRG and for which a separate claim was submitted to Medicare by the acute care hospital. Since typically, LTCHs do not perform significant surgical procedures, upon analyzing the data, CMS coders have suggested that some of the LTCH claims may inappropriately be including the surgical procedure performed during the prior acute care stay, complications from which led to the LTCH admission. Alternatively, if LTCHs are presently coding for the surgical procedures that are being delivered in the acute care hospital during a 3-day or less interruption of stay, in many of these cases they should be paying for this treatment ''under arrangements.'' Furthermore, in the cases where both the same DRG is reported by both the LTCH and the acute care hospital treating the patient during the 3 day or less interruption, Medicare may be paying twice for the same treatment. In any event, the above scenarios are indicative of poor documentation in the medical record, poor coding, or gaming of the Medicare system.

Therefore, we are proposing to discontinue this policy because we do not believe that the surgical exception to the 3-day or less interruption of stay policy is ''* * * actively accomplishing our goal of reducing unnecessary Medicare payments and * * * deter[ing] unnecessary inappropriate Medicare payments while not compromising beneficiary access to medically necessary services'' (70 FR 24206).

However, there were cases among those that we reviewed, that may have been accurately coded, and that actually represented a LTCH patient whose LTCH treatment was interrupted by a surgery which entailed a 3-day or less inpatient stay at an acute care hospital for a problem unrelated to the on-going treatment at the LTCH. Once the proposed sunsetting of the surgical DRG exception goes into effect, an LTCH will be responsible for paying for surgical cases performed at an acute care hospital ''under arrangements'' but at that point, will also be able to include that surgical procedure on the claim that will be submitted to Medicare for the entire stay. Our coders tell us that the presence of a significant surgical procedure on the claim may impact the LTC–DRG to which a case is assigned by the GROUPER software used by the FI in determining the amount that Medicare will pay for that case. However, there may be situations where this does not occur and inclusion of the surgical procedure does not result in grouping the case to a higher-weighted LTC–DRG (and thus increase the Medicare payment). In these cases, we would emphasize, that, since, as noted previously, the ''under arrangements'' policy was a feature of the previous TEFRA payment policy, prior to the FY 2003 implementation of the LTCH PPS, and costs of off-site surgeries were typically included in LTCH claims, so that to the extent providers included those costs on their claims, that these costs were included in the establishment of the LTCH PPS base rate, which section 123(a)(1) of the BBRA required to be budget neutral for FY 2003, to what Medicare would pay had the PPS not been implemented.

We would further note that we do not believe that the numbers of cases nationwide that would fall within the surgical DRG exception would represent a significant financial burden for LTCHs to absorb over a cost-reporting period, given the nature of the LTCH PPS.

We also believe, that the LTCH PPS high cost outlier policy at § 412.525(a) will provide somewhat of a financial cushion for the LTCH in those very few cases where a LTCH patient whose hospitalization at the LTCH was interrupted for 3 days or less for a very costly surgical treatment at an acute care hospital, in the same way that it presently does if costs for a costly non-surgical inpatient or outpatient treatment during a 3 day or less interrupted stay at an acute care hospital, an IRF, or for care at a SNF, result in high cost outlier status for that case at the LTCH. Accordingly, we are not proposing to extend this exception because we believe that our analysis of the data from the MedPAR files from LTCH discharges occurring from July 1, 2004 through June 30, 2005 indicates that the exception does not appear to have an overall beneficial effect on the program nor would its absence have a strong negative impact on LTCHs.

Our further examination of the subset of the data indicates that the exception may be fostering confusion, perpetuating poor coding, and even encouraging gaming by creating a distinction within the well-established Medicare ''under arrangements'' policy between surgical and non-surgical procedures and treatments delivered during an episode of hospital-level care. Moreover, we have discovered many LTCHs are including the surgical procedures performed at the acute care hospital during the interruption, in their claims and therefore the LTCH hospitalizations are being grouped to surgical DRGs while claims for what appear to be the same surgeries are also being submitted by acute care hospitals. Use of the same surgical DRG in both the LTCH's claim for the case and the acute care hospital's claims for the surgery in some of these cases indicates that Medicare may be paying twice for the exact same operation, a situation directly contravened by sections 1862(a)(14) and 1861(w)(1) of the Act, § 411.15, § 412.509 and one that may involve fraud and abuse issues.

In the RY 2006 LTCH PPS final rule (70 FR 24206), we also expressed concerns about the whether our data would reveal an increase in the numbers of interruptions of 4 days indicating an effort by certain LTCHs to side-step the ''under arrangements'' provisions of our 3-day or less interruption of stay policy. Our data revealed that there were 1,076 4-day stays at acute care hospitals following a LTCH hospitalization during the 2005 rate year, of which 528 (just under half) returned for further treatment to the LTCH following the 4-day interruption. If the interruption in an LTCH patient's stay exceeds 3 days, under existing policy at § 412.531(b)(1)(ii)(B)and § 412.531(c), payment would be governed by the greater than 3-day or interruption of stay policy at § 412.531(b) and Medicare would generate a separate payment to an intervening provider where the patient received treatment or care, thus discharging the LTCH from responsibility to pay for the acute care services ''under arrangements.''

Furthermore, an interruption in a LTCH stay in excess of 3 days, where the patient returns home but still receives outpatient treatment prior to returning to the LTCH, would result not only in separate Medicare payments for the outpatient care but would also in an additional discharge payment to the LTCH since the greater than 3-day interruption of stay policy only applies to intervening acute care hospital, IRF, or SNF stays. We will be evaluating data from RY 2004 and RY 2005 on Medicare payments for services or care delivered during LTCH interruptions of stay of 4 days that would otherwise have been governed by the ''under arrangements'' feature of the 3-day or less interruption of stay policy at § 412.531(b)(1)(ii)(A)(2) to determine whether an additional day is being arbitrarily added to the interruption prior to readmittance to the LTCH for purposes of thwarting the goal of the policy. We believe it may be appropriate in the future to propose a revision to the 3-day interruption provision and to establish a 4-day threshold.

B. Special Payment Provisions for LTCH Hospitals Within Hospitals and LTCH Satellites

In the IPPS final rule for FY 2005, when we established the special payment provisions at § 412.534 for LTCHs that were HwHs or were satellites of LTCHs, we were seeking, in part, to address the on-going proliferation of LTCHs that were HwHs or satellites. (OSCAR files report that there were 105 LTCHs in 1993, of which 10 were HwHs. In October 2005, there are 373 LTCHs, many of which are HwHs.) We were particularly concerned with patient shifting between the host hospitals and the LTCH HwH or satellite for financial rather than for medical reasons (69 FR 49191) and with the resulting inappropriate increased cost to the Medicare system.

In that PPS final rule, we quoted the FY 1995 IPPS final rule where we first discussed the concern that LTCH HwHs were, in effect, operating as step-down units of acute care hospitals. We explained that this was inconsistent with the statutory framework and that such a configuration could lead to two Medicare bills being submitted and paid (one from the acute care hospital and the other from the LTCH) for what was essentially one episode of care. (69 FR 49191, 59 FR 45389) When we established the separateness and control criteria for LTCH HwHs at § 412.22(e) in the FY 1995 IPPS final rule, our main objective was to protect the integrity of the IPPS by ensuring that those costly, long-stay patients who could reasonably continue treatment in that setting would not be unnecessarily discharged to an onsite LTCH, a behavior that would skew and undermine the Medicare IPPS DRG system. We explained that the Federal standardized payment amount for the IPPS was based on the average cost of an acute care patient across all acute care hospitals. This assumes that, on average, both high-cost and low-cost patients are treated at a hospital. Although Medicare might pay a hospital less than was expended for a particular case, over a period of time, the hospital would also receive more than was expended for other cases. However, an acute care hospital that consistently discharges higher cost patients to a post-acute care setting for the purpose of lowering its costs undercuts the foundation of the IPPS DRG system, which is based on averages. In this circumstance, the hospital inappropriately would have incurred lower costs under the IPPS because the course of acute treatment was not completed and the hospital did not incur those additional costs for the remainder of the patient's stay at the IPPS acute care hospital. Once that patient is discharged from the IPPS acute care hospital to the LTCH, the patient, still under active treatment for an acute illness, will be admitted to a LTCH, thereby generating a second admission and Medicare payment that would not have taken place but for the fact of co-location (59 FR 45389).

As explained previously, there was and continues to be concern that the LTCH HwH/host configuration could result in patient admission, treatment, and discharge patterns that are guided more by attempts to maximize Medicare payments than by patient welfare. In order to establish clear division between a host hospital and an on-site LTCH where the linking of an IPPS hospital and a LTCH could lead to two Medicare payments for what was essentially one episode of patient care, we issued ''separateness and control'' regulations in that FY 1995 IPPS Final Rule at (former) § 412.23(e), for LTCHs that were seeking to co-locate with acute care hospitals as HwHs (59 FR 45390). In the ensuing decade, we revisited the issue of HwHs several times (for example, 60 FR 45836, 62 FR 46012, 67 FR 56010, 68 FR 45462), during which we clarified and amplified the separateness and control requirements. In the FY 1998 IPPS final rule, we extended the application of these rules beyond LTCHs to include other classes of facilities that might seek exclusion from the IPPS as HwHs, such as IRFs (although the vast majority of HwHs have continued to be LTCHs) (62 FR 46014). Additionally, although our original regulations for HwHs focused solely on the relationship between a LTCH HwH and an acute care host, and this is still, by far, the most common configuration, nothing in the regulations precludes other types of hospitals, for example, an IRFs from establishing HwHs (69 FR 49198).

In addition, in the FY 1998 final rule, we established a ''grandfathering'' provision for HwHs in existence prior to September 30, 1995 at § 412.22(f), and in the FY 2004 IPPS final rule, we clarified and codified the requirements for ''grandfathered'' HwHs (68 FR 45463). We believed at that time that these rules were sufficient solutions to our concerns about LTCH HwHs functioning as long-stay units of acute care hosts.

Therefore, prior to FY 2005, a HwH was required to meet the separateness and control criteria set forth at § 412.22(e). In order to be excluded from the IPPS, the HwH had to have a separate governing body, a separate chief medical officer, a separate medical staff, and a separate chief executive officer. Regarding the performance of basic hospital functions (former § 412.22(e)(5)), the hospital had to meet at least one of the following criteria: (1) The hospital performs the basic functions through the use of employees or under contracts or other agreements with entities other than the hospital occupying space in the same building or on the same campus, or a third entity that controls both hospitals; (2) for the same period of at least 6 months immediately preceding the first cost reporting period for which exclusion is sought, the cost of the services that the hospital obtained under contracts or other agreements with the hospital occupying space in the same building or on the same campus, or with a third entity that controls both hospitals, is no more than 15 percent of the hospital's total inpatient operating costs, as defined in § 412.2(c) (that is, inpatient operating costs include operating costs for routine services, such as costs of room, board, and routine nursing services; operating costs for ancillary services such as laboratory or radiology; special care unit operating costs; malpractice insurance costs related to serving inpatients; and preadmission services); or (3) for the same period of at least 6 months immediately preceding the first cost reporting period for which exclusion is sought, the hospital had an inpatient population of whom at least 75 percent were referred to the hospital from a source other than another hospital occupying space in the same

building or on the same campus or with a third entity that controls both hospitals.

It was our experience that the vast majority of HwHs elected to meet the second of the three criteria at § 412.22(e)(5), that is, the cost of the services that the hospital obtained from the co-located hospital or with a third entity that controls both hospitals could be no more than 15 percent of its total inpatient operating costs.

As detailed in the FY 2005 proposed rule and final rule for the IPPS (69 FR 28323 through 28327, 69 FR 49191 through 49214), with the noted explosive growth in the number of LTCHs, (and with LTCH HwHs, in particular) and concomitant costs to the Medicare program, we reevaluated the effectiveness of existing policies regarding HwHs insofar as whether they sufficiently protected the Medicare program from the problems that we envisioned in the FY 1995 IPPS final rule and subsequent rules. We also questioned the effectiveness of the ''separateness and control'' requirements alone because entities have used complex arrangements among corporate affiliates, and obtained services from those affiliates, thereby impairing or diluting the separateness of the corporate entity. While technically remaining within the parameters of the rule, these arrangements were intermingling corporate interests so that the corporate distinctness has been lost.

In accordance with notice and comment rule-making and following serious consideration of the public comments that we received on our proposed policy revisions for LTCH HwHs, regulatory changes were finalized for HwH separateness and control policies at § 412.22(e) and a new payment adjustment at § 412.534 was established for LTCH HwHs and satellites of LTCHs in our FY 2005 IPPS final rule (69 FR 49191 through 49214).

Specifically, for cost reporting periods beginning on or after October 1, 2004, for LTCHs we eliminated the 15 percent test under then existing § 412.22(e)(5)(ii), the performance of basic hospital functions test under former § 412.22(e)(5)(i) and the 75 percent of admissions from other than the host criteria at former § 412.22(e)(5)(iii) for LTCH HwHs. If a LTCH demonstrated compliance with the medical and administrative separateness, and control policies at § 412.22(e)(1)(i) through (e)(1)(iv) under our finalized policy, it satisfied the LTCH HwH requirements. We additionally established a payment adjustment for LTCH HwHs (and also for satellites of LTCHs) at § 412.534, which we believed addressed our on-going concerns regarding the relationship between LTCH discharges who were admitted from the host hospital. We included LTCH satellites in this payment adjustment because we believe that that the co-location of a host hospital and a LTCH satellite may result in the same incentives for inappropriate patient movement as exist for hosts and LTCH HwHs.

The payment adjustment at § 412.534, Special payment provisions for long-term care hospitals within hospitals and satellites of LTCHs, mandated that if a LTCH HwH or LTCH satellite's discharges that were admitted from its host hospital exceed 25 percent (or the applicable percentage) of its total Medicare discharges for the LTCH HwH or LTCH satellite's cost reporting period, an adjusted payment would be made. The adjustment would be the lesser of the otherwise payable amount under the LTCH PPS or the LTCH PPS amount that was equivalent to what Medicare would otherwise pay under the IPPS. In determining whether a hospital exceeded the 25 percent criterion, patients transferred from the host hospital that have already qualified for outlier payments at the host would not count as part of the host's 25 percent (or the applicable percentage) and therefore, the payment would not be subject to the adjustment. Those patients would be eligible for otherwise unadjusted payment under the LTCH PPS. Discharged Medicare patients that were admitted from the host before the LTCH HwH or LTCH satellite crosses the 25 percent threshold would be paid an otherwise unadjusted payment under the LTCH PPS.

We also finalized additional adjustments to the 25 percent policy for specific circumstances. For LTCH HwHs or LTCH satellites located in a rural area, instead of the 25 percent criterion, the payment adjustment would be imposed if the majority (that is, more than 50 percent) of the Medicare patients discharged from the LTCH HwH or LTCH satellite were admitted from the host. That is, for those LTCH HwH or satellite Medicare discharges in excess of the 50 percent threshold, the payment adjustment would be applied unless those cases had reached high cost outlier status at the host hospital prior to discharge, in which case, they would not be counted towards the 50 percent threshold. In addition, in determining the percentage of Medicare patients discharged from the LTCH HwH or LTCH satellite that were admitted from the rural host, any patients that had been Medicare outliers at the host and then discharged to the LTCH HwH or LTCH satellite would be considered as if they were admitted to the LTCH from a non-host hospital. For urban single or MSA dominant hospitals, we would allow the LTCH HwH or LTCH satellite to discharge Medicare patients that were admitted from the host up to the host's percentage of total Medicare discharges for like hospitals in the MSA. We would apply a floor of 25 percent and a ceiling of 50 percent to this variation. In addition, in determining the percentage of discharged Medicare patients that were admitted to the LTCH HwH or LTCH satellite from the urban single or MSA dominant host hospital, any patients that had been Medicare outliers at the host and then transferred to the LTCH HwH or LTCH satellite would be considered as if they were admitted to the LTCH from a non-host hospital.

We also provided a 4-year transition for existing LTCH HwHs or LTCH satellites for the purpose of providing a reasonable period during which the host and the LTCH HwH or LTCH satellite would be able to adapt to the requirements of the new policy. Also included in this transition policy were LTCHs-under-formation that satisfied the following two-prong requirement: (1) The hospital was paid under the provisions of subpart O of part 412 on October 1, 2005, and (2) whose qualifying period under § 412.23(e) began on or before October 1, 2004. For cost reporting periods beginning on or after October 1, 2004 through September 30, 2005, these hospitals were to be grandfathered, with the first year as a ''hold harmless'.

However, we required that even for grandfathered facilities, in the first cost reporting period, the hold harmless year, the percentage of Medicare discharges admitted from the host hospital to the LTCH HwH or LTCH satellite could not exceed the percentage of discharges admitted from the host hospital to the LTCH in its FY 2004 cost reporting period. Therefore, while we grandfathered existing LTCH HwHs and allowing for a 4-year transition, beginning on or after October 1, 2004 and before October 1, 2005 (FY 2005), those hospitals could not increase the percentage of discharges admitted from the host in excess of the percentage that they had admitted in FY 2004.

After the first grandfathered cost reporting period, these LTCH HwHs and LTCH satellites were required to meet a percentage transition over the 3 years beginning in FY 2006. For the second year (cost reporting periods beginning on or after October 1, 2005 but before October 1, 2006), the applicable percentage of discharges admitted from the host with no payment adjustment

would be the lesser of the percentage of their discharges admitted from their host for their FY 2004 cost reporting period or 75 percent. For the third year (cost reporting periods beginning on or after October 1, 2006 but before October 1, 2007), the applicable percentage of discharges admitted from the host with no payment adjustment would be the lesser of the percentage of their discharges admitted from their host for their FY 2004 cost reporting period or 50 percent, and finally 25 percent (or other applicable percentage) beginning with the third year (cost reporting periods beginning on or after October 1, 2008).

These finalized payment policies and the concerns that they address echo concerns first expressed in the FY 1995 final rule for the IPPS, when we began to regulate new entities that we named ''hospitals within hospitals.'' As noted elsewhere in this preamble, the reason that we proposed the changes in the criteria for LTCH HwH qualification at § 412.22(e) in the FY 2005 IPPS proposed rule (69 FR 28323 through 28327) was the nexus between these concerns and the recent explosive growth in the numbers of LTCH HwHs. Furthermore, as detailed in the FY 2005 IPPS final rule, (69 FR 49201), these regulations were grounded in a thorough review of the available data as well as exhaustive policy evaluations.

The present 25 percent policy is being implemented in a location-specific manner, which means that the computation of the percentage of LTCH HwH or LTCH satellite discharges admitted from a host is based solely on the admissions from the physically co-located host and not from other campuses or remote locations which may share a common Medicare Provider number with the host.

However as a result of our monitoring efforts to date (see section X. of the preamble to this proposed rule), we have become increasingly aware that the intent of our existing policy is being thwarted by creative patient-shifting in some communities where there is more than one LTCH HwH or LTCH satellite. We have come to understand, based upon specific inquiries from LTCHs and their attorneys or agents, and also from questions posed by our fiscal intermediaries (FIs), that some host hospitals within the same community are arranging to cross-refer to another's co-located LTCH (HwH or satellite). This behavior circumvents the intent of the payment adjustment which was to hinder the *de facto* establishment of a LTCH unit of a host hospital, which is precluded by law, and to discourage inappropriate patient-shifting between a host and a LTCH HwH or satellite. This practice undermines the basic premise of the IPPS DRG classification system and generates inappropriate Medicare payments. Another attempt to circumvent the present regulation at § 412.534 is a situation wherein a patient at a LTCH (that is co-located with a host as a HwH or satellite) admits a patient from the host, provides treatment, then transports the patient to another location of that LTCH (a free-standing hospital or another HwH or satellite not co-located with the host hospital) for special treatment after which the patient is discharged from that other location. Since the payment adjustment is being implemented in a location-specific basis, we believe that this ''transporting'' of the patient to another site is an attempt to side-step the location-specific feature of the existing payment adjustment. We have considerable concern about attempts to game Medicare by circumventing the intent of the 25 percent (or applicable percentage) patient threshold payment adjustment at § 412.534.

In addition, as a result of implementing the payment adjustment at § 412.534 for patients exceeding the 25 percent (or applicable percentage) threshold for LTCH HwHs and satellites of LTCHs, the most recent growth in the LTCH universe is occurring with the development of free-standing LTCHs. Many of these facilities receive patients from one referring hospital and as is the case with host/HwH or satellite configurations, we are concerned about these non-co-located LTCHs may, in fact, be functioning like a long-stay unit of those referring hospitals.

As we first stated in the FY 1995 IPPS final rule, ''we agree that the extent to which a facility accepts patients from outside sources can be an important indicator of its function as a separate facility, not merely a unit of another hospital. In general, a facility's functional separateness should be reflected in its ability to attract patients from sources other than the hospital that it serves. For example, if a facility receives all (or nearly all) of its admissions independently (that is, from outside sources), it can reasonably be assumed to be functioning separately from the host hospital (59 FR 45391).'' In establishing the concept of ''functional separateness'' in the above quote from the FY 1995 IPPS final rule, we were identifying a broader phenomenon than just the relationship between a host acute care hospital and a LTCH HwH or satellite of a LTCH. As noted below, this concern has been communicated to us from a variety of sources.

MedPAC's comments on the proposed payment adjustment for LTCH HwHs in the FY 2005 IPPS proposed rule focused directly on this issue and expressed concern that the 25 percent patient threshold policy would have a significant impact and could possibly lead to an inequitable situation for co-located LTCHs as compared to freestanding LTCHs. Among its concerns were the following: that freestanding LTCHs also have strong relationships with acute care hospitals, and that where on average LTCH HwHs receive 61 percent of their patients from their hosts, freestanding LTCHs receive 42 percent from their primary referring hospital; that a 25 percent rule that only applies to LTCH HwHs and not to freestanding LTCHs and may therefore be inequitable; and furthermore, this approach may be circumvented by an increase in the number of freestanding LTCHs instead of a LTCH HwH (69 FR 49211).

We received comments on the FY 2005 IPPS proposed rule (69 FR 28196) challenging a proposed policy to preclude common ownership of a host and a HwH (which we did not finalize). Two other commenters noted that the financial incentive to accept inappropriate patients from an acute care hospital can exist when the acute care hospital and the LTCH are commonly owned or when there is common governance, a situation that can exist even without co-location, that is, a freestanding LTCH, exempt from the requirements of § 412.22(e) could be owned and governed by the hospital from which it receives the majority of its referrals (69 FR 49202).

In discussion with a LTCH trade association, we were informed of a study that it commissioned from the Lewin Group that included a percentage breakdown of patients referred to free-standing (for example, non-co-located) LTCHs (and other post-acute providers) from ''single-source acute hospitals.'' According to the association, the data indicated ''* * * that it is common practice for LTCHs * * * to admit patients from a single-source acute care hospital'' and that 71.2 percent of free-standing LTCHs admit more than 25 percent of their patients from a single source acute-care hospital.

We are also anecdotally aware of the existence of frequent ''arrangements'' in many communities between Medicare acute and post-acute hospital-level providers that may not have any ties of ownership or governance relating to patient shifting that are based on mutual financial advantage rather than on significant medical benefits for a patient.

In our response to the MedPAC comment, we stated that ''[w]hile we also understand the reservations expressed in the comments, we want to emphasize that * * * we are establishing these revised payment policies in this final notice for LTCH HwHs or satellites and not freestanding LTCHs because of the considerable growth in the number of LTCH HwH and because, ever since we first became aware of the existence of LTCH HwHs in 1994, we have been mindful of the strong resemblance that they bore to LTCH units of acute care hospitals, a configuration precluded by statute (69 FR 49211).''

Notwithstanding this response and the finalized payment adjustment at § 412.534 which focused solely on LTCH HwHs and satellites of LTCHs, we took considerable note of these comments and the specific information that they included. Since the October 1, 2004 implementation of the payment adjustment for LTCH HwHs and satellites of LTCHs at § 412.534, through our LTCH PPS monitoring initiative (see Section X.), we have become aware that the growth in the LTCH universe is now occurring through the development of free-standing LTCHs. As of October 2005, there were 376 LTCHs in our OSCAR database, of which 201 are reported as freestanding (for example, not co-located with another Medicare hospital-level provider) and 175 of which are HwHs. But since October 1, 2004, of the 25 new LTCHs established, 22 are free-standing. We have been informed directly that at least one particular LTCH chain that formerly specialized in the establishment of HwHs and satellites is now concentrating on the development of free-standing LTCHs. Reviews of public documents posted at the corporate Web site and analysis of the expected consequences of the policy at other investor-oriented sites describe a focus on building free-standing LTCHs which we believe may imply a response to the payment adjustment for co-located LTCHs established under § 412.534.

We believe that this information indicates that the concerns that we expressed about the explosive growth in the number of LTCHs has shifted because of the implementation of the payment adjustment at § 412.534 from the development of co-located LTCHs as HwHs or satellites of LTCHs to the establishment of free-standing LTCHs.

We further conducted our own data analysis of sole-source (for example, one hospital referring to one LTCH) relationships between acute care hospitals and non-co-located LTCHs. The FY 2004 and FY 2005 MedPAR files indicate 63.7 percent of the 201 free-standing LTCHs have at least 25 percent of their Medicare discharges admitted from a sole acute care hospital; for 23.9 percent of the freestanding LTCHs, the percentage is 50 percent or more; and for 6.5 percent, 75 percent or more of their Medicare discharges are admitted from a sole acute care hospital.

We therefore believe that the danger of LTCHs functioning as ''units'' appears to be occurring not only in LTCH HwHs and LTCH satellites but also with free-standing LTCHs and that in many cases, these non-co-located LTCHs and their sole referral source may be functioning in ways that appear to have erased the line of ''functional separateness'' between these LTCHs and their referring acute care hospitals. We are concerned about these situations and in this context, we continue to believe that ''* * * the extent to which a facility accepts patients from outside sources can be an important indicator of its function as a separate facility, not merely a unit of another hospital (59 FR 45391).''

We believe that our analysis of the available data and our awareness of growth patterns and behavioral changes in the LTCH industry corroborate the concerns expressed in correspondence and comments, but particularly in MedPAC's comments on our proposed payment adjustment for co-located LTCHs in the FY 2004 IPPS final rule (69 FR 49211). In addition, the spiked increase in the number of free-standing LTCHs and their admission patterns appear to confirm MedPAC's concerns that the industry may be circumventing the intent of the payment adjustment policy at § 412.534 aimed at combating LTCHs functioning as ''units'' by creating free-standing LTCHs instead of LTCHs co-located as HwHs or satellites.

As we note previously in this proposed rule, we are keenly aware of the explosive growth in the number of free-standing LTCHs. Specifically, we are continuing to analyze patient claims data for acute care patients who are admitted to free-standing LTCHs for discharge and LOS information in order to evaluate whether Medicare is paying twice for what would essentially be one episode of care. We are considering appropriate adjustments to address this issue.

Furthermore, we want to emphasize that we are closely monitoring patient shifting activities between host hospitals and LTCH HwHs or LTCH satellites, paying particular attention to evidence of inappropriate cross-referrals. We believe that a pattern of this behavior by hospitals would indicate an attempt to side-step the requirements of § 412.534 and could warrant an investigation by HHS's Office of the Investigator General.

Under § 412.534 for LTCH cost reporting periods beginning on or after October 1, 2004, we published the existing payment adjustment detailed above, for LTCH HwHs and LTCH satellites that focused on the percentage of Medicare patients being shifted from host hospitals to co-located LTCHs. Under this provision, we specified that if greater than 25 percent (or the appropriate percentage) of a LTCH HwH's or LTCH satellite's discharges during any cost reporting year were admitted from a host hospital, a payment adjustment would be applied to those discharges that exceeded the applicable threshold percentage (unless those patients had reached high-cost outlier status at the host hospital as specified in § 412.534(c)). (For LTCHs that qualified under § 412.534(f), we established a 4-year transition to the full payment adjustment.) Specifically, this payment adjustment provides that Medicare will pay the lesser of the amount otherwise payable under the LTCH PPS or an LTCH PPS payment amount equivalent to what would be paid under the IPPS for discharges in excess of the threshold amount.

It has come to our attention that the phrase ''an amount equivalent to the amount that would otherwise be determined under the rules at subpart A, § 412.1(a)'', that is, the IPPS, in existing § 412.534(c)(2), (d)(1), and (e)(1) and our specific interpretation of its implementation may not be entirely apparent. Therefore, we are clarifying that, as explained below in this section, the use of the term ''equivalent'' does not necessarily mean precisely equal. We are also proposing to codify the formula that we currently use to give effect to this phrase in existing § 412.534, described in this proposed rule, for purposes of administrative clarity.

To clarify the meaning of the term ''equivalent,'' we want to emphasize that we chose that word rather than ''equal'' when referring to the amount payable under this subpart (the amount that is equivalent to the ''* * * amount that would be otherwise determined under the rules at subpart A, § 412.1(a)). The term ''equivalent'' was used in this regulation because, although it was and continues to be our intent to include a payment adjustment under the LTCH PPS that closely replicates what an IPPS payment would have been for the same episode of care, several features of the IPPS cannot be translated directly into the LTCH PPS. Therefore, we believed that the term ''equivalent'' would

support the ultimate goals of the policy adjustment, while also allowing for a reasonable and equitable implementation. For example, under the IPPS, payments for IME are limited based on the hospital's IME cap. The hospital's IME cap is determined based on the number of IME FTE residents counted by the hospital for purposes of IME on its 1996 cost report. In the case of a LTCH, since it necessarily would not have reported any FTE residents for IME on its 1996 cost report, it would not be appropriate to apply the IPPS IME rules literally in the context of this LTCH PPS payment adjustment.

We are clarifying that we chose to use the term ''equivalent'' in § 412.534(c)(2), (d)(1), and (e)(1) because we believe this language accurately reflects our intent to apply IPPS payment principles to develop a payment that approximates for LTCHs the payment for a particular case that would have been made under the IPPS. For example, in the case of a LTCH that is a teaching hospital, if a particular LTCH discharge is governed by the 25 percent payment policy adjustment set forth at § 412.534, we would determine the IME payment under the LTCH PPS by imputing an IME cap based on the LTCH's direct GME cap (which would have been determined for an LTCH that has residency programs as set forth at § 413.79(c)(2)) and using that imputed IME cap to calculate an IME payment for this LTCH. We believe this methodology is reasonable since it is based on the best available data on residency programs at LTCHs. Using an imputed IME cap could enable us to factor an adjustment for indirect costs of residency programs into a Medicare payment under the payment adjustment at § 412.534 for those cases in excess of the 25 percent (or applicable percentage) threshold where the Medicare payment would be based on an amount under the LTCH PPS equivalent to what would otherwise be paid under the IPPS.

As explained previously, we are proposing to codify the formula we use to give affect to the phrase ''an amount under subpart O that is equivalent to what otherwise would be paid under the IPPS.'' The existing regulations at § 412.534(c)(2), (d)(1), and (e)(1) establish the applicable payment adjustment for LTCH HwHs and satellites not subject to the transition established under § 412.534(f) for cost reporting periods beginning on or after October 1, 2004 and for cost reporting periods beginning on or after October 1, 2007 for those LTCH HwHs and LTCH satellites that will be transitioning to the full adjustment. Under those provisions, Medicare will pay for discharges from a LTCH HwH or LTCH satellite that were admitted from their host hospital in excess of the 25 percent (or applicable percentage) threshold based upon the lesser of the amount otherwise payable under [the LTCH PPS] or the amount payable under this subpart that is equivalent to the amount that would otherwise be payable under [the IPPS]. The paragraphs below detail the specific payment features of the IPPS that we use and are proposing to codify in regulation for administrative efficiency in order to allow Medicare to generate a fair and equitable ''equivalent'' IPPS payment under the LTCH PPS for those LTCH discharges governed by the payment adjustment at § 412.534.

In the discussion that follows, we use phrases such as ''IPPS DRG relative weights,'' the ''IPPS high cost outlier'' and the ''IPPS fixed loss amount'' in describing features of the IPPS that we use in calculating LTCH payments for LTCH HwHs and LTCH satellites. However, we want to emphasize that such a payment is not an IPPS payment but rather, a payment under the LTCH PPS that is generally derived from the IPPS payment methodology.

Specifically, under § 412.534, we are proposing to codify the formula that we use to give affect to the phrase, an amount payable under this subpart that is equivalent to what would be paid under the [IPPS]. This formula provides that an amount under subpart O that is equivalent to what would otherwise have been paid under the IPPS, would be calculated based on the sum of the applicable operating and capital IPPS rates in effect at the time of the discharge from the LTCH as established in the applicable IPPS final rule published annually in the **Federal Register** (since there is a single rate under the LTCH PPS to pay for the operating and capital costs of the inpatient hospitals services provided to LTCH Medicare patients) and applicable IPPS payment system adjustments for differences in resource use (that is, IPPS DRG relative weights); differences in area wage levels (that is, the IPPS wage index); cost-of-living adjustment, if applicable; the treatment of a disproportionate share of low income patients (DSH), if applicable; and indirect medical education (IME), if applicable. If the amount payable by Medicare for a specific discharge was the amount under subpart O that is equivalent to what would be otherwise payable under the IPPS and the case also qualified as an IPPS high cost outlier under this payment adjustment formula, payment would be based on the IPPS high cost outlier policy at § 412.80(a) because the resulting payment would then be more equivalent to what would have been payable under the IPPS. (Similarly, if under this payment adjustment, the lesser amount resulted in an ''otherwise payable amount under the LTCH PPS,'' and the stay qualified as a high-cost outlier, Medicare would generate a high cost outlier payment governed by the LTCH PPS high cost outlier policy at § 412.525(a).)

Under this formula, we are proposing to codify in regulations, an amount payable under this subpart that is equivalent to what would otherwise be paid under the IPPS for the costs of inpatient operating services would be based on the standardized amount determined under § 412.64(c), adjusted by the applicable IPPS DRG weighting factors as specified in § 412.64(g). This amount would be further adjusted for area wage levels using the applicable IPPS labor-related share based on the CBSA where the LTCH is physically located set forth at § 412.525(c) and the IPPS wage index for non-reclassified hospitals as shown in Tables 4A and 4B in the annual IPPS final rule. (In the RY 2005 LTCH PPS final rule (70 FR 24200) we discuss the inapplicability of geographic reclassification procedures for LTCHs.) For LTCHs located in Alaska and Hawaii, this amount would also be adjusted by the applicable COLA factors used under the IPPS. Furthermore, for LTCH discharges governed by this payment adjustment, an amount payable under subpart O that is equivalent to what would otherwise be paid under the IPPS for the costs of inpatient operating services would also include, where applicable, a DSH adjustment (§ 412.106) and where applicable, an IME adjustment (as discussed at § 413.79(c)(2)).

Additionally, to arrive at an LTCH PPS payment amount equivalent to what would otherwise be payable under the IPPS, a LTCH would also be paid under the LTCH PPS for the costs of inpatient capital-related costs, using the capital Federal rate determined under § 412.308(c), adjusted by the applicable IPPS DRG weighting factors at § 412.60. This amount would be further adjusted by the applicable geographic adjustment factors set forth at § 412.316, including local cost variation (based on the IPPS wage index for non-reclassified hospitals in Tables 4A and 4B of the annual IPPS final rule), large urban location and COLA, if applicable, based on the IPPS geographic classifications published annually in the IPPS final rule.

For discharges governed by this payment adjustment under the LTCH

PPS, an amount payable under subpart O that is equivalent to an amount that would otherwise be paid under the IPPS for the inpatient capital-related costs would also include a DSH adjustment (§ 412.320), if applicable and an equivalent IME adjustment, (§ 412.322) if applicable.

A LTCH PPS payment amount equivalent to what would be paid under the IPPS would be determined based on the sum of the amount equivalent to what would be paid under the IPPS inpatient operating services and the amount equivalent to what would be paid under the IPPS for inpatient capital-related costs. This is necessary since under the IPPS, there are separate Medicare rates for operating (subpart D of part 412) and capital (subpart M of part 412) costs to acute care hospitals while under the LTCH PPS, there is a single payment rate for the operating and capital costs of the inpatient hospitals services provided to LTCH Medicare patients.

We note that in section V.A.1. of this proposed rule, we have proposed an additional component to the SSO payment adjustment at proposed § 412.529(c)(2)(iv) that is based on an amount ''comparable'' to what would otherwise be paid under the IPPS rather than an amount ''equivalent'' under the existing payment adjustment at § 412.534. Although the proposed new payment adjustment option under the SSO policy was adapted from the existing LTCH HwH and LTCH satellite payment adjustment at § 412.534, it also preserves a distinction in the existing SSO policy established at the start of the LTCH PPS for FY 2003: The use of the LTCH PPS fixed loss amount should a SSO case also qualify for high cost outlier payments after the SSO payment amount is determined. In contrast, as noted previously, under the payment adjustment for LTCH HwHs and LTCH satellites at § 412.534, if the amount payable by Medicare for a specific discharge was the amount under subpart O that is *equivalent* to what would be otherwise payable under the IPPS and the case also qualified as a high cost outlier, the outlier payment for this case under the LTCH PPS would be based on the IPPS high cost outlier policy at § 412.80(a) because the resulting payment would then be more equivalent to what would have been payable under the IPPS. Similarly, if under this payment adjustment, the lesser amount resulted in an ''otherwise payable amount under the LTCH PPS,'' and the stay qualified as a high-cost outlier, Medicare would generate a high cost outlier payment governed by the LTCH PPS fixed loss amount calculated under § 412.525(a). If the estimated cost of the case exceeds the adjusted LTC–DRG plus a fixed loss amount under § 412.525(a), the LTCH would receive an additional payment based on the LTCH PPS high cost outlier policy.

Therefore, although there are significant similarities between the two payment adjustments, as detailed in section V.A.1 of this proposed rule, there is a distinction between them regarding the computation of any applicable high cost outlier payments. Under the LTCH HwH and satellite payment adjustment at § 412.534, payment for discharges governed by the policy, will be ''the lesser of the amount otherwise payable under this subpart [subpart O] or the amount that is otherwise payable under this subpart that is equivalent to the amount that would be otherwise payable under § 412.1(a) [the IPPS].'' From an implementation standpoint, Medicare would generate an applicable payment to the LTCH for this discharge (which could include a high cost outlier payment) but this payment would be subject to reconciliation at the end of the LTCH's cost reporting period when it would be determined whether or not the particular discharge was subject to the payment adjustment at § 412.534, that is, whether the discharge exceeded the 25 percent (or applicable percentage) threshold. If this is the case, and the calculation of the lesser of the amounts for a specific discharge resulted in Medicare paying an amount under the LTCH PPS that was equivalent to what would otherwise have been paid under the IPPS, and that payment included a high cost outlier payment, this LTCH PPS payment would be governed by the regulations at § 412.80(a), based on the IPPS high cost outlier policy. If the lesser of the two amounts is the otherwise payable amount under the LTCH PPS (which could be the case if the stay was a SSO, under § 412.529) the original LTCH PPS Medicare payment which included the high cost outlier payment under § 412.525 will be finalized by the FI.

In contrast, under the existing LTCH PPS SSO policy at § 412.529(c), high cost outlier payments could be made for a SSO stay, regardless of whether the payment is ultimately based on: 120 percent of the LTC–DRG specific per diem amount multiplied by the LOS of the discharge; 120 percent of the cost of the case; or the full LTC–DRG, if the total costs of the case exceed the least of these three options, plus the appropriate fixed-loss amount under § 412.525. In this proposed rule, for reasons described in section V.A.1, we have proposed to lower the 120 percent of costs to 100 percent, and we have also proposed the above noted additional alternative to this formula: An LTCH PPS payment comparable to what would otherwise have been paid under the IPPS. We have not proposed to change the existing SSO payment policy for high cost outliers, even though we are proposing this new alternative, and therefore, if the costs of the case exceeded the payment resulting from this formula by the fixed loss amount under the LTCH PPS, Medicare payment to the LTCH for this case, would include high cost outlier payment set forth at § 412.525.

Therefore, although there are significant similarities between the payment adjustment at existing § 412.534, under which Medicare pays an amount *equivalent* to what would otherwise have been paid under the IPPS (which we are proposing to clarify and codify at § 412.534(f)(1)), and the proposed additional payment alternative under the SSO adjustment at proposed § 412.529(c)(2)(iv), under which Medicare would pay an amount *comparable* to what would otherwise have been paid under the IPPS, we wish to emphasize the distinctions in applicable high cost outlier payments under these two payment adjustments.

Consequently, we are clarifying the term ''equivalent'' at § 412.534(c)(2), (d)(1), and (e)(1) in our payment adjustment and proposing to codify the formula we use to give affect to these existing regulations.

In § 412.534, we established special payment provisions for long-term care hospitals within hospitals and satellites of LTCHs. (69 FR 49206) At subparagraph (d), we set forth a further payment adjustment for LTCHs that were co-located as HwHs or as satellites of LTCHs with rural hospitals and we cited the definition of rural at § 412.62(f). This cite was incorrect since beginning in FY 2005, we adopted OMB's revised standards for defining MSAs (69 FR 49026) and therefore, the definition of rural that we intended to cite in § 412.534(d) was § 412.64(b)(1)(ii)(C). We are therefore proposing to correct § 412.534(d) to correctly cite the revised definition of rural at § 412.64(b)(1)(ii)(C).

VI. Computing the Proposed Adjusted Federal Prospective Payments for the 2007 LTCH PPS Rate Year

In accordance with § 412.525 and as discussed in section IV.C. of this proposed rule, the standard Federal rate is adjusted to account for differences in area wages by multiplying the labor-related share of the standard Federal rate by the appropriate LTCH PPS wage

index (as shown in Tables 1 and 2 of the Addendum to this proposed rule). The standard Federal rate is also adjusted to account for the higher costs of hospitals in Alaska and Hawaii by multiplying the nonlabor-related share of the standard Federal rate by the appropriate cost-of-living factor (shown in Table 7 in section IV.D.1.c. of this preamble). In the RY 2006 LTCH PPS final rule (70 FR 24180), we established a standard Federal rate of $38,086.04 for the 2006 LTCH PPS rate year. In this proposed rule, based on the best available data and the proposed policies described in this proposed rule, we are proposing that the standard Federal rate for the 2007 LTCH PPS rate year remain $38,086.04 as discussed in section IV.B. of this preamble. We illustrate the methodology used to adjust the proposed Federal prospective payments for the 2007 LTCH PPS rate year in the following examples:

Example: During the 2007 LTCH PPS rate year, a Medicare patient is in a LTCH located in Chicago, Illinois (CBSA 16974). This LTCH is in the fourth year of the wage index phase-in, thus, the proposed four-fifths wage index values are applicable. The proposed four-fifths wage index value for CBSA 16974 is 1.0632 (see Table 1 in the Addendum to this proposed rule). The Medicare patient is classified into LTC–DRG 9 (Spinal Disorders and Injuries), which has a relative weight of 0.9720 (see Table 3 of the Addendum to this proposed rule).

To calculate the LTCH's total proposed adjusted Federal prospective payment for this Medicare patient, we compute the proposed wage-adjusted Federal prospective payment amount by multiplying the proposed unadjusted standard Federal rate ($38,086.04) by the proposed labor-related share (75.923 percent) and the proposed wage index value (1.0632). This proposed wage-adjusted amount is then added to the nonlabor-related portion of the proposed unadjusted standard Federal rate (24.077 percent; adjusted for cost of living, if applicable) to determine the adjusted Federal rate, which is then multiplied by the LTC–DRG relative weight (0.9720) to calculate the total proposed adjusted Federal prospective payment for the 2007 LTCH PPS rate year ($38,795.95). Finally, as discussed in section IV.C.5. of this preamble, for the 2007 LTCH PPS rate year, we proposed a 0.0 percent reduction (a budget neutrality offset of 1.000) to the total proposed adjusted Federal prospective payment to account for the costs of the transition methodology.

The following illustrates the components of the calculations in the example in Table 12.

TABLE 12

Unadjusted Proposed Standard Federal Prospective Payment Rate	$38,086.04
Proposed Labor-Related Share	× 0.75923
Proposed Labor-Related Portion of the Federal Rate	= $28,916.06
Proposed 4/5ths Wage Index (CBSA 16974)	× 1.0632
Proposed Wage-Adjusted Labor Share of Federal Rate	= $30,743.55
Proposed Nonlabor-Related Portion of the Federal Rate ($38,086.04 × 0.24077)	+ $9,169.98
Proposed Adjusted Federal Rate Amount	= $39,913.53
LTC–DRG 9 Relative Weight	× 0.9720
Total Proposed Adjusted Federal Prospective Payment (Before the Budget Neutrality Offset)	= $38,795.95
Proposed Budget Neutrality Offset	× 0.999
Total Proposed Federal Prospective Payment (Including the Budget Neutrality Offset)	= $38,757.15

VII. Transition Period

To provide a stable fiscal base for LTCHs, under § 412.533, we implemented a 5-year transition period whereby a LTCH (except those defined as ''new'' under § 412.23(e)(4)) receives payment consisting of a portion based on reasonable cost-based reimbursement under the TEFRA system and a portion based on the Federal prospective payment rate (unless the LTCH elects payment based on 100 percent of the Federal rate). Under the average pricing system, payment is not based on the experience of an individual hospital. As discussed in the August 30, 2002 final rule (67 FR 56038), we believe that a 5-year phase-in provides LTCHs time to adjust their operations and capital financing to the LTCH PPS, which is based on prospectively determined Federal payment rates. Furthermore, we believe that the 5-year phase-in of the LTCH PPS also allows LTCH personnel to develop proficiency with the LTC–DRG coding system, which will result in improvement in the quality of the data used for generating our annual determination of relative weights and payment rates.

Under § 412.533, the 5-year transition period for all hospitals subject to the LTCH PPS begins with the hospital's first cost reporting period beginning on or after October 1, 2002 and extends through the hospital's last cost reporting period beginning before October 1, 2007. During the 5-year transition period, a LTCH's total payment under the LTCH PPS is based on two payment percentages—one based on reasonable cost-based (TEFRA) payments and the other based on the standard Federal prospective payment rate. The percentage of payment based on the LTCH PPS Federal rate increases by 20 percentage points each year, while the reasonable cost-based payment rate percentage decreases by 20 percentage points each year, for the next 4 fiscal years. For cost reporting periods beginning on or after October 1, 2006, Medicare payment to LTCHs will be determined entirely under the Federal rate. The blend percentages as set forth in § 412.533(a) are shown in Table 13.

TABLE 13

Cost reporting periods beginning on or after	Federal rate percentage	Reasonable cost principles rate percentage
October 1, 2002	20	80
October 1, 2003	40	60
October 1, 2004	60	40
October 1, 2005	80	20
October 1, 2006	100	0

For cost reporting periods that begin on or after October 1, 2005, and before October 1, 2006 (FY 2006), the total payment for an existing LTCH that has not elected payment under 100 percent of the Federal prospective payment rate

is 20 percent of the amount calculated under reasonable cost principles for that specific LTCH and 80 percent of the Federal prospective payment amount. For cost reporting periods that begin on or after October 1, 2006 (FY 2007), the total payment for a LTCH will be zero percent of the amount calculated under reasonable cost principles for that specific LTCH and 100 percent of the Federal prospective payment amount. As we noted in the June 6, 2003 final rule (68 FR 34155), the change in the effective date of the annual LTCH PPS rate update from October 1 to July 1 has no effect on the LTCH PPS transition period as set forth in § 412.533(a). That is, LTCHs paid under the transition blend under § 412.533(a) will receive those blend percentages for the entire 5-year transition period (unless they elect payments based on 100 percent of the Federal rate). Furthermore, LTCHs paid under the transition blend will receive the appropriate blend percentages of the Federal and reasonable cost-based rate for their entire cost reporting period as prescribed in § 412.533(a)(1) through (a)(5).

The reasonable cost-based rate percentage is a LTCH specific amount that is based on the amount that the LTCH would have been paid (under TEFRA) if the PPS were not implemented. Medicare FIs will continue to compute the LTCH reasonable cost-based payment amount according to § 412.22(b) of the regulations and sections 1886(d) and (g) of the Act.

In implementing the LTCH PPS, one of our goals is to transition hospitals to prospective payments based on 100 percent of the adjusted Federal prospective payment rate as soon as appropriate. Therefore, under § 412.533(c), we allow an LTCH (other than new LTCHs defined at § 412.23(e)(4)), which is subject to a blended rate, to elect payment based on 100 percent of the Federal rate at the start of any of its cost reporting periods during the 5-year transition period rather than incrementally shifting from reasonable cost-based payments to prospective payments. Once a LTCH elects to be paid based on 100 percent of the Federal rate, it will not be able to revert to the transition blend. For cost reporting periods that began on or after December 1, 2002 through September 30, 2006, a LTCH must notify its FI in writing of its election on or before the 30th day prior to the start of the LTCH's next cost reporting period regardless of any postmarks or anticipated delivery dates. For example, a LTCH with a cost reporting period that begins on May 1, 2006, must notify its FI in writing of an election on or before April 1, 2006.

Under § 412.533(c)(2)(i), the notification by the LTCH to make the election must be made in writing to the Medicare FI. Under § 412.533 (c)(2)(iii), the FI must receive the request on or before the specified date (that is, on or before the 30th day before the applicable cost reporting period begins for cost reporting periods beginning on or after December 1, 2002 through September 30, 2006), regardless of any postmarks or anticipated delivery dates.

Requests received, postmarked, or delivered by other means after the specified date in § 412.533(c)(2)(iii) will not be accepted. If the specified date falls on a day that the postal service or other delivery sources are not open for business, the LTCH will be responsible for allowing sufficient time for the delivery of the request before the deadline. If a LTCH's request is not received timely, payment will be based on the transition period blend percentages.

VIII. Payments to New LTCHs

Under § 412.23(e)(4), for purposes of Medicare payment under the LTCH PPS, we define a new LTCH as a provider of inpatient hospital services that meets the qualifying criteria for LTCHs, set forth in § 412.23(e)(1) and (e)(2), and under present or previous ownership (or both), has its first cost reporting period as a LTCH begins on or after October 1, 2002. We also specify in § 412.500 that the LTCH PPS is applicable to LTCHs for cost reporting periods beginning on or after October 1, 2002. As we discussed in the August 30, 2002 final rule (67 FR 56040), this definition of new LTCHs should not be confused with those LTCHs first paid under the TEFRA payment system for discharges occurring on or after October 1, 1997, described in section 1886(b)(7)(A) of the Act, as added by section 4416 of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33). As stated in § 413.40(f)(2)(ii), for cost reporting periods beginning on or after October 1, 1997, the payment amount for a ''new'' (post-FY 1998) LTCH is the lower of the hospital's net inpatient operating cost per case or 110 percent of the national median target amount payment limit for hospitals in the same class for cost reporting periods ending during FY 1996, updated to the applicable cost reporting period (see 62 FR 46019, August 29, 1997). Under the LTCH PPS, those ''new'' LTCHs that meet the definition of ''new'' under § 413.40(f)(2)(ii) and that have their first cost reporting period as a LTCH beginning prior to October 1, 2002, will be paid under the transition methodology described in § 412.533.

Under § 412.533(d), new LTCHs will not participate in the 5-year transition from reasonable cost-based reimbursement to prospective payment. As we discussed in the August 30, 2002 final rule (67 FR 56040), the transition period is intended to provide existing LTCHs time to adjust to payment under the new system. Since these new LTCHs with their first cost reporting periods as LTCHs beginning on or after October 1, 2002, would not have received payment under reasonable cost-based reimbursement for the delivery of LTCH services prior to the effective date of the LTCH PPS, we do not believe that those new LTCHs require a transition period in order to make adjustments to their operations and capital financing, as will LTCHs that have been paid under the reasonable cost-based methodology.

IX. Method of Payment

Under § 412.513, a Medicare LTCH patient is classified into a LTC-DRG based on the principal diagnosis, up to eight additional (secondary) diagnoses, and up to six procedures performed during the stay, as well as, age, sex, and discharge status of the patient. The LTC–DRG is used to determine the Federal prospective payment that the LTCH will receive for the Medicare-covered Part A services the LTCH furnished during the Medicare patient's stay. Under § 412.541(a), the payment is based on the submission of the discharge bill. The discharge bill also provides data to allow for reclassifying the stay from payment at the full LTC–DRG rate to payment for a case as a SSO (under § 412.529) or as an interrupted stay (under § 412.531), or to determine if the case will qualify for a high-cost outlier payment (under § 412.525(a)).

Accordingly, the ICD–9–CM codes and other information used to determine if an adjustment to the full LTC–DRG payment is necessary (for example, LOS or interrupted stay status) are recorded by the LTCH on the Medicare patient's discharge bill and submitted to the Medicare FI for processing. The payment represents payment in full, under § 412.521(b), for inpatient operating and capital-related costs, but not for the costs of an approved medical education program, bad debts, blood clotting factors, anesthesia services by hospital-employed nonphysician anesthetists or obtained under arrangement, or the costs of photocopying and mailing medical records requested by a Quality Improvement Organization (QIO), which are costs paid outside the LTCH PPS.

As under the previous reasonable cost-based payment system, under § 412.541(b), a LTCH may elect to be paid using the periodic interim payment (PIP) method described in § 413.64(h) and may be eligible to receive accelerated payments as described in § 413.64(g).

For those LTCHs that are paid during the 5-year transition based on the blended transition methodology in § 412.533(a) for cost reporting periods that began on or after October 1, 2002, and before October 1, 2006, the PIP amount is based on the transition blend. For those LTCHs that are paid based on 100 percent of the standard Federal rate, the PIP amount is based on the estimated prospective payment for the year rather than on the estimated reasonable cost-based reimbursement. We exclude high-cost outlier payments that are paid upon submission of a discharge bill from the PIP amounts. In addition, Part A costs that are not paid for under the LTCH PPS, including Medicare costs of an approved medical education program, bad debts, blood clotting factors, anesthesia services by hospital-employed nonphysician anesthetists or obtained under arrangement, and the costs of photocopying and mailing medical records requested by a QIO, are subject to the interim payment provisions (§ 412.541(c)).

Under § 412.541(d), LTCHs with unusually long lengths of stay that are not receiving payment under the PIP method may bill on an interim basis (60 days after an admission and at intervals of at least 60 days after the date of the first interim bill) and ''should include any high cost outlier payment determined as of the last day for which the services have been billed.''

X. Monitoring

In the August 30, 2002 final rule (67 FR 56014), we described an on-going monitoring component to the new LTCH PPS. Specifically, we discussed on-going analysis of the various policies that we believe would provide equitable payment for stays that reflect less than the full course of treatment and reduce the incentives for inappropriate admissions, transfers, or premature discharges of patients that are present in a discharge-based PPS. To this end, we have designed system features utilizing MedPAR data that will enable CMS and the FI to track beneficiary movement to and from a LTCH and to and from another Medicare provider. We also stated our intent to collect and interpret data on changes in average lengths of stay under the LTCH PPS for specific LTC–DRGs and the impact of these changes on the Medicare program. As a result of our data analysis, we have revisited a number of our original and even pre-LTCH PPS policies in order to address what we believe are behaviors by certain LTCHs that lead to inappropriate Medicare payments. In recent **Federal Register** publications, we have proposed and subsequently finalized revisions to the interruption of stay policy in the RY 2005 LTCH PPS final rule (69 FR 25690 through 25700), and we established a payment adjustment for LTCH HwHs and satellites in the FY 2005 IPPS final rule (69 FR 49191 through 49214).

On-going data analysis is also the basis for four of the policies that we are proposing in this notice. As noted in section V.A.2, we are proposing to ''sunset'' the surgical DRG exception to the 3 day or less interruption of stay policy at § 412.531(b)(1)(ii)(A)(*1*). As we discuss in detail in section V.A.1., we have determined that eliminating this exception will not result in significant hardship for LTCHs. In section V.A.2., we have also revisited the payment adjustment established for short-stay outliers (§ 412.529) as a consequence of recent data analysis and have proposed additional options under that policy. In addition to these three proposed policies, as a result of our analysis and on-going monitoring protocols, we are also proposing a zero percent update to the Federal payment rate for RY 2007, which is explained in detail in section IV.B.4. of this proposed rule.

As we discuss in section V.B.1., our monitoring of discharges between acute care hospitals and LTCHs reveals that a significant number of LTCHs that are ''free-standing'', that is, not colocated with other hospital-level providers (as defined in § 412.22(e) and § 412.22(h)), also admit their patients from one specific acute care hospital. When we established the payment adjustment for LTCH HwHs and satellites of LTCHs at § 412.534, we reiterated our concern that these on-site LTCHs could be functioning as units of their host (generally, an acute care hospital), a configuration that is not permitted in section 1886(d)(1)(B) of the Act. (The statute specifically allows only for IRF and IPF units in acute care hospitals but not for LTCH units.) Therefore, we note that in addition to monitoring compliance with the payment adjustment established under § 412.534 for LTCH HwHs and satellites of LTCHs, we will also be monitoring admissions of patients to freestanding LTCHs from referring acute hospitals. We believe that on-going data analysis of this patient movement may enable us to determine whether these ''free-standing'' LTCHs are functioning, in a similar way as some LTCH HwHs and LTCH satellites, as step-down units of their referring hospitals and are considering additional payment adjustments to address this issue.

As we discussed in the RY 2004 LTCH PPS final rule (68 FR 34157), the Medicare Payment Advisory Commission (MedPAC) endorsed our monitoring activity as a primary aspect of the design and on-going functioning of the LTCH PPS. Furthermore, the Commission pursued an independent research initiative that led to a section in the MedPAC Report entitled ''Defining long-term care hospitals'' published in the June, 2004 Report to Congress. This study included recommendations that we develop facility and patient criteria for LTCH admission and treatment and that we require a review by Quality Improvement Organizations (QIO) to evaluate whether LTCH admissions meet criteria for medical necessity once the recommended facility and patient criteria are established.

Therefore, in addition to pursuing our on-going monitoring program under the direction of ORDI, existing QIO monitoring and studies described in the RY 2006 LTCH PPS final rule (70 FR 24211), and our considerations of expanding the QIO role in the LTCH PPS, we awarded a contract to Research Triangle Institute, International (RTI) in September 2004 for a thorough examination of the feasibility of implementing MedPAC's recommendations in the June 2004 Report to Congress (which we detail in section XI. of this proposed rule). In the RY 2005 LTCH PPS final rule, we noted that this research contract, which was funded for FY 2005 was presently being executed and therefore, we anticipated that we would be able to include some preliminary findings in the RY 2007 LTCH PPS final rule. In this proposed rule, as noted previously, we have included a section that describes RTI's analyses for the purpose of providing an opportunity for public comment prior to the finalizing of RTI's final report.

XI. RTI Report on MedPAC June 2004 LTCH Recommendations

In the RY 2006 LTCH PPS final rule (70 FR 24209), we discussed Chapter 5 of MedPAC's June 2004 Report to Congress (RTC), ''Defining Long-Term Care Hospitals'' (LTCHs). In that Report, the Commission recommended that the Congress and the Secretary define LTCHs by facility and patient criteria to ensure that patients admitted to LTCH facilities are medically complex and have a good chance of improvement. In

addition, the Commission recommended expanding the statement of work for the Quality Improvement Organizations (QIOs) to enable them to monitor LTCH compliance with any newly-established hospital and patient criteria.

As detailed in that same final rule, in response to the recommendation in MedPAC's June 2004 Report, on September 27, 2004, we awarded a contract to Research Triangle Institute, International (RTI) for a thorough examination of the feasibility of implementing the Commission's recommendations based on the performance of a wide variety of analytic tasks using CMS data files, and information RTI would collect from physicians, providers, and LTCH trade associations. This contract, ''Long Term Care Hospital (LTCH) Payment System Refinement/Evaluation,'' will result in a report that will assist CMS in the development of criteria for assuring appropriate and cost-effective use of LTCHs in the Medicare program. With the recommendations of MedPAC's June 2004 Report to Congress as a point of departure, RTI began to evaluate the feasibility of developing patient and facility level characteristics for LTCHs in order to identify and distinguish the role of these hospitals as a Medicare provider.

In that same final rule, we also described RTI's project plan which will be completed in two phases. Phase I focuses on an analysis of LTCHs within the current Medicare system: their history as participating providers; their case mix; the criteria currently used by QIOs to determine the appropriateness of treatment in LTCHs; and the site of care for patients treated in areas that lack LTCHs. RTI is reviewing prior analyses of these issues by MedPAC and other contractors (such as the Urban Institute, 3M Health Information Systems, and The Lewin Group) and is also having additional discussions with MedPAC, other researchers, and the QIOs. Building on the work of Phase I, Phase II addresses the feasibility of MedPAC's proposed criteria based on a three-pronged approach: Medicare claims analysis to examine patient differences across settings; interviews with QIOs and providers to examine level of care definitions currently being used or tested; and finally site visits to interview providers with the objective of distinguishing LTCHs from other inpatient settings for payment purposes. During October through December 2005, RTI scheduled and conducted site visits to LTCHs throughout the country that are representative of the various types of LTCHs. A team of RTI researchers and CMS analysts, including a physician, participated in these visits.

A. Overview of the Issues

RTI's research is guided by a conceptual framework based upon several fundamental premises:

- The goal of the Medicare program is the cost-effective delivery of the highest quality of medical services to beneficiaries.
- LTCHs are the highest paid hospitals in the Medicare program. Despite the fact that their availability varies widely across the nation, they have increased in numbers exponentially over the last 10 years. The research is to determine whether this increase is due to growing patient demand or industry response to generous payment policies.
- In parts of the country that lack LTCHs, LTCH-type patients may receive hospital-level treatment at acute hospitals as outlier patients, at IRFs, or in some cases, IPFs with significantly lower payments per beneficiary discharge than at LTCHs. The research attempts to determine whether patient outcomes are equivalent across these sites.

In order to evaluate the feasibility of developing patient and facility-level criteria specific to LTCHs, it must be determined whether there are identifiable differences in the care delivered at LTCHs as compared with other hospital-level providers for the same type of Medicare patient and if so, what distinguishes the services delivered by LTCHs from services at other settings. One clear and easily measurable difference is Medicare payments for services since payments for LTCH-type patients may differ dramatically depending on site of care due to the different base payment rates for each provider category. Determining whether there is a correlation between the higher payments at LTCHs and improved patient outcomes for the same types of patients in different treatment settings is the central question RTI will answer. Since there is a wide variation in the range of post-acute care available throughout the country, if payments are equivalent per case and patient outcomes are generally equal in different areas of the country, the variations may be explained as a reflection of variations in regional practices. However, if outcomes differ substantially for certain types of patients, indicating that LTCH patients have better outcomes, the recent growth of the LTCH industry could result in the availability of a better level of care for Medicare beneficiaries nationwide. Alternatively, if payments differ between provider types but patient outcomes are equivalent, one could question whether higher cost LTCH services are needed for all types of cases currently treated, or more specifically, which types of patients benefit from the higher cost LTCH services. Building on MedPAC's earlier work (May 2004, June 2004), RTI researchers are examining differences in payments and outcomes for patients treated in these various settings.

B. Describing the LTCH Universe since FY 2003

RTI is examining changes in the availability of LTCHs over time. The number of LTCHs has more than tripled from 105 in 1993 to 363 as of March 2005. Although the two States with the largest number of LTCHs are Texas and Louisiana, substantial growth is also occurring in States with large numbers of elderly populations including Pennsylvania, Ohio, Michigan, Georgia, Indiana, and Oklahoma.

Using Geographic Information Services (GIS) software to spatially present the different types of inpatient post-acute services in acute care hospital referral regions (as defined by Dartmouth Atlas 2005), RTI is highlighting the regional variation in the availability of LTCHs and other substitute providers. The resulting maps indicate that while LTCHs are widely available in the northeast and southern States, in the western part of the nation they are localized in several small areas (for example, Nevada and Utah) and relatively few LTCHs exist on the west coast. IPFs and IRFs, in contrast, are more common in the west and north central parts of the U.S. where there are few, if any, LTCHs. Also, RTI is identifying significant changes in the LTCH universe in terms of their ownership. The draft report submitted to CMS notes the following facts:

- For-profit hospitals entered the market during the 1990s and grew continuously until 2005 when they accounted for 58 percent of all LTCHs.
- While the number of non-profit hospitals also grew rapidly, they continued to account for only one-third of all LTCHs through 2005.
- The number of government-owned hospitals declined dramatically from 25 percent to only 8 percent of the LTCHs in 2005.

There are generally three distinct types of LTCHs with the following basic characteristics and patients:

- The majority of LTCHs specialize in what they consider to be medically complex patients (including many respiratory and ventilator-dependent

patients), and some of these have ICU-type units;

- In some regions, LTCHs may focus on rehabilitation patients; and
- In other areas, LTCHs may be primarily treating patients who could otherwise be in IPFs.

LTCHs in these last two categories differ significantly from the first, because generally the patients are less medically complex.

C. Patient, Facility, and Alternative Treatment Site Analysis

RTI is analyzing claims from the 100 percent MedPAR files for CY 2003, including acute care, LTCH, IRF, IPF, and SNF records. Episodes are constructed to include 180 days of potential use beginning with admission to the index hospital and including payments and use of associated home health services. The fundamental goals of the analytic work are to identify differences between patient populations, utilization patterns, outcomes, Medicare program payments by site of care, and most significantly, to develop a profile of the LTCH admission in 2003. This profile is based on primary diagnoses and examines the use of other services prior and subsequent to the LTCH admission.

RTI is also analyzing the data for the acute care hospital patients with multiple comorbidities who have reached outlier status at the acute care hospital with data for LTCH patients with similar profiles. Data on acute care patients who have reached outlier status prior to admission to an LTCH are evaluated to determine if there are: (1) Clear factors that predicted LTCH use, (2) differences in hospital readmission rates between those who use LTCHs and those who do not; and (3) program cost differences between the two types of patients.

D. Specific Findings From Claims Analysis

The following is a summary of the specific issues that the RTI draft report will examine followed by a brief description of their draft findings from their review of 100 percent of CY 2003 MedPAR data.

1. LTCHs Population

Table 14 lists the 50 most common DRGs admitted to LTCHs in 2003 as a result of the draft report findings and their relative ranking in various settings. The top five types of admissions illustrate the heterogeneity of the population treated in these facilities and their relative importance as admissions to other facilities. While the relative ranking in each facility may differ, the absolute number of cases admitted to LTCHs may be similar to other settings (Table 15). For example, DRG 012: Nervous System Disorders are almost as likely to go to an IRF facility for a non-outlier stay as to be admitted to an LTCH according to the draft report findings. While this DRG is ranked 3rd among LTCH and 8th among IRF admissions, the number of cases admitted to LTCHs and non-outlier IRFs is fairly comparable (5,846 compared to 5,508, respectively). Further, nearly five times as many cases are admitted to IPFs (28,911).

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TABLE 14: Top 50 LTCH DRGs ranked across providers (based on RTI Draft Report)

DRG Code		DRG Name		LTCH Rank	Acute Outlier Rank	IRF Rank[1]	PSYCH Rank[2]
475		Respiratory System Diagnosis With Ventilator Support		1	3		
462		Rehabilitation		2		1	
012		Degenerative Nervous System Disorders		3		8	3
271		Skin Ulcers		4			
249		Aftercare, Musculoskeletal System & Connective Tissue		5		12	
087		Pulmonary Edema & Respiratory Failure		6			
088		Chronic Obstructive Pulmonary Disease		7	40	11	
466		Aftercare w/o History of Malignancy As Secondary Diagnosis		8			
089		Simple Pneumonia & Pleurisy Age >17 w CC		9	24		
079		Respiratory Infections & Inflammations Age >17 w CC		10	21		
127		Heart Failure & Shock		11	6	16	
416		Septicemia Age >17		12	5		
263		Skin Graft &/or Debrid for Skin Ulcer or Cellulitis w CC		13			
430		Psychoses		14			1
316		Renal Failure		15	22		
238		Osteomyelitis		16			
277		Cellulitis Age >17 w CC		17			
418		Postoperative & Post-Traumatic Infections		18			
130		Peripheral Vascular Disorders w CC		19		13	
320		Kidney & Urinary Tract Infections Age >17 w CC		20			
144		Other Circulatory System Diagnoses w CC		21	30		
463		Signs & Symptoms w CC		22		9	
076		Other Resp System O.R. Procedures w CC		23	18		
452		Complications of Treatment w CC		24			
188		Other Digestive System Diagnoses Age >17 w CC		25			
296		Nutritional & Misc Metabolic Disorders Age >17 w CC		26	36		
182		Esophagitis, Gastroent & Misc Digest Disorders Age >17 w CC		27	39		
468		Extensive O.R. Procedure Unrelated To Principal Diagnosis		28	9		
465		Aftercare w History of Malignancy As Secondary Diagnosis		29			
082		Respiratory Neoplasms		30			

DRG Code		DRG Name		LTCH Rank	Acute Outlier Rank	IRF Rank[1]	PSYCH Rank[2]
217		Wnd Debrid & Skn Grft except Hand, for Muscskelet & Conn Tiss Dis		31	33		
415		O.R. Procedure for Infectious & Parasitic Diseases		32	7		
243		Medical Back Problems		33		6	
294		Diabetes Age >35		34			
483		Tracheostomy except for Face, Mouth & Neck Diagnoses		35	1		
461		O.R. Proc w Diagnoses of Other Contact w Health Services		36		10	
034		Other Disorders of Nervous System w CC		37		18	
429		Organic Disturbances & Mental Retardation		38			2
014		Specific Cerebrovascular Disorders except TIA		39	23	5	
126		Acute & Subacute Endocarditis		40			
120		Other Circulatory System O.R. Procedures		41	26		
172		Digestive Malignancy w CC		42			
331		Other Kidney & Urinary Tract Diagnoses Age >17 w CC		43			
256		Other Musculoskeletal System & Connective Tissue Diagnoses		44			
132		Atherosclerosis w CC		45		14	
204		Disorders of Pancreas except Malignancy		46	47		
403		Lymphoma & Non-Acute Leukemia w CC		47	43		
020		Nervous System Infection except Viral Meningitis		47			
099		Respiratory Signs & Symptoms w CC		48			
242		Septic Arthritis		49			
101		Other Respiratory System Diagnoses w CC		50			
248		Tendonitis, Myositis & Bursitis		50			

RTI analyses of Medicare Administrative files, 2003.
[1]IRF Rank includes rankings for only the top 20 IRF DRGs.
[2]PSYCH Rank includes rankings for only the top 10 IPF DRGs.

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Table 15 shows the variation in these admission rates to different sites of care. While LTCHs treat a wide range of DRGs, the majority of these cases are also treated in alternative settings. For example, LTCHs treat only 16 percent of the total DRG 012 cases while the IPFs treated 71 percent of these cases. It is interesting to note, in general, that LTCHs treat a relatively small proportion of all types of cases compared to other settings.

2. Similarities Between the Acute Outlier and LTCH Samples

The most common admission to both the LTCHs and the subset of acute admissions with high-cost outlier payments are the respiratory patients. DRG 475 is the most common LTCH admission and the third most common in the acute outlier group, both admitting over 8,000 cases a year. Infection cases, such as DRG 416: Septicemia, are also quite common in the LTCH and acute outlier populations as are renal failure patients (DRG 316). These types of cases are frequently admitted as either a primary or secondary diagnosis in this population. While patients with skin conditions are common to both LTCHs and other hospitals, LTCHs appear to specialize in different subsets of the patients. LTCHs have a large number of DRG 271: Skin Ulcer patients (5,348 cases) while acute care hospitals are more likely to be treating DRG 217: Wound debridement cases. DRG 127: (Heart failure and shock) cases also are common across settings although the severity of illness may differ.

The population treated in LTCHs is diverse and frequently found in alternative settings. As indicated in Table 15, the top 50 DRGs for LTCHs constitute 86 percent of all LTCH discharges. These same DRGs account for 40 percent of acute outlier discharges, 93 percent of IRF outliers and 81 percent of IRF non-outliers (majority due to rehabilitation), 87 percent of psychiatric discharges (with 72 percent due to psychoses) and 56 percent of SNFs/swing beds discharges.

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TABLE 15: Top 50 LTCH DRGS, Discharges by Provider Type, 2003 (based on the RTI Draft Report)

Rank	DRG	DRG Description	LTCH		Acute Outliers		IRF Outliers		IRF Non-Outliers		Psych. Hospital/Units		SNFs/Swing Beds	
			Percent of all Discharges	N	Percent of all Discharges	N	Percent of all Discharges	N	Percent of all Discharges	N	Percent of all Discharges	N	Percent of all Discharges	N
1	475	Respiratory System Diagnosis With Ventilator Support	8.76	10,140	4.67	8,221	0.02	5	0.00	2	0.00	11	0.01	53
2	462	Rehabilitation	6.16	7,131	0.01	25	79.74	20,094	67.19	317,899	0.01	36	8.15	30,970
3	012	Degenerative Nervous System Disorders	5.05	5,846	0.20	360	0.75	188	1.16	5,508	6.09	28,911	4.98	18,936
4	271	Skin Ulcers	4.62	5,348	0.10	179	0.06	15	0.07	313	0.00	1	1.39	5,293
5	249	Aftercare, Musculoskeletal System & Connective Tissue	4.53	5,238	0.03	58	0.29	74	0.81	3,832	0.00	0	1.56	5,927
6	087	Pulmonary Edema & Respiratory Failure	4.20	4,863	0.37	659	0.27	69	0.16	749	0.00	11	1.53	5,823
7	088	Chronic Obstructive Pulmonary Disease	4.20	4,856	0.66	1,157	0.71	180	0.85	4,017	0.02	74	2.72	10,324
8	466	Aftercare w/o History of Malignancy As Secondary Diagnosis	3.81	4,413	0.01	12	0.02	4	0.35	1,657	0.00	5	1.35	5,136
9	089	Simple Pneumonia & Pleurisy Age >17 w CC	3.76	4,352	1.18	2,070	0.18	46	0.33	1,571	0.02	86	2.47	9,405
10	079	Respiratory Infections & Inflammations Age >17 w CC	3.55	4,113	1.35	2,374	0.11	27	0.07	335	0.00	20	0.71	2,715
11	127	Heart Failure & Shock	3.21	3,717	2.65	4,662	0.36	90	0.57	2,687	0.01	48	4.05	15,414
12	416	Septicemia Age >17	2.99	3,459	2.70	4,755	0.02	6	0.07	341	0.00	22	1.26	4,798
13	263	Skin Graft &/or Debrid for Skn Ulcer or Cellulitis w CC	2.59	2,996	0.52	911	0.02	6	0.00	17	0.00	3	0.02	76
14	430	Psychoses	2.14	2,479	0.09	163	0.00	0	0.01	29	72.26	343,219	2.27	8,627
15	316	Renal Failure	2.07	2,391	1.24	2,188	0.11	28	0.10	489	0.01	29	2.03	7,711
16	238	Osteomyelitis	1.62	1,874	0.09	158	0.06	16	0.08	358	0.00	4	0.45	1,729
17	277	Cellulitis Age >17 w CC	1.57	1,822	0.25	447	0.07	18	0.10	491	0.00	16	0.75	2,834
18	418	Postoperative & Post-Traumatic Infections	1.48	1,713	0.16	286	0.06	15	0.04	203	0.00	2	0.36	1,359
19	130	Peripheral Vascular Disorders w CC	1.25	1,451	0.29	505	0.36	90	0.70	3,314	0.00	11	1.23	4,684
20	320	Kidney & Urinary Tract Infections Age >17 w CC	1.20	1,388	0.40	701	0.05	12	0.08	383	0.02	116	1.19	4,534
21	144	Other Circulatory System Diagnoses w CC	1.16	1,338	0.79	1,389	0.09	22	0.21	989	0.01	25	0.76	2,892
22	463	Signs & Symptoms w CC	1.14	1,316	0.05	89	0.60	152	0.89	4,204	0.01	30	1.77	6,741
23	076	Other Resp System O.R. Procedures w CC	0.99	1,141	1.37	2,408	0.01	2	0.00	4	0.00	5	0.00	19
24	452	Complications of Treatment w CC	0.96	1,116	0.17	307	0.04	9	0.05	222	0.00	3	0.13	476
25	188	Other Digestive System Diagnoses Age >17 w CC	0.96	1,108	0.52	917	0.08	20	0.12	574	0.00	6	0.56	2,142
26	296	Nutritional & Misc Metabolic Disorders Age >17 w CC	0.88	1,019	0.68	1,199	0.07	17	0.10	459	0.02	100	0.84	3,196

Rank	DRG	DRG Description	LTCH		Acute Outliers		IRF Outliers		IRF Non-Outliers		Psych. Hospital/Units		SNFs/Swing Beds	
			Percent of all Discharges	N	Percent of all Discharges	N	Percent of all Discharges	N	Percent of all Discharges	N	Percent of all Discharges	N	Percent of all Discharges	N
27	182	Esophagitis, Gastroent & Misc Digest Disorders Age >17 w CC	0.68	785	0.66	1,166	0.06	15	0.12	553	0.01	25	1.05	4,005
28	468	Extensive O.R. Procedure Unrelated To Principal Diagnosis	0.67	776	2.38	4,190	0.05	12	0.00	19	0.01	33	0.01	20
29	465	Aftercare w History of Malignancy As Secondary Diagnosis	0.66	760	0.00	1	0.00	1	0.03	128	0.00	0	0.09	330
30	082	Respiratory Neoplasms	0.64	736	0.39	680	0.02	6	0.10	462	0.00	10	0.37	1,415
31	217	Wnd Debrid & Skn Grft except Hand, for Muscskelet & Conn Tiss Dis	0.63	728	0.73	1,292	0.01	3	0.01	33	0.00	5	0.01	39
32	415	O.R. Procedure for Infectious & Parasitic Diseases	0.60	695	2.42	4,261	0.02	4	0.00	5	0.00	1	0.01	39
33	243	Medical Back Problems	0.58	672	0.16	283	0.58	147	2.20	10,398	0.00	21	1.73	6,584
34	483	Tracheostomy except for Face, Mouth & Neck Diagnoses	0.55	638	7.38	13,000	0.03	8	0.00	1	0.00	8	0.00	0
35	461	O.R. Proc w Diagnoses of Other Contact w Health Services	0.55	631	0.03	60	5.51	1,389	0.59	2,812	0.00	1	0.08	312
36	294	Diabetes Age >35	0.54	630	0.27	484	0.05	12	0.09	417	0.01	41	2.04	7,775
37	034	Other Disorders of Nervous System w CC	0.49	570	0.13	227	0.46	117	0.52	2,442	0.02	108	0.96	3,663
38	014	Specific Cerebrovascular Disorders except TIA	0.46	531	1.24	2,177	1.20	302	2.27	10,731	0.01	61	0.98	3,722
39	429	Organic Disturbances & Mental Retardation	0.46	528	0.05	83	0.01	3	0.03	129	8.78	41,720	3.14	11,946
40	126	Acute & Subacute Endocarditis	0.42	482	0.11	202	0.01	3	0.01	30	0.00	0	0.06	228
41	120	Other Circulatory System O.R. Procedures	0.41	474	0.95	1,676	0.02	5	0.00	13	0.00	2	0.01	55
42	172	Digestive Malignancy w CC	0.41	469	0.29	509	0.04	10	0.12	569	0.00	4	0.34	1,286
43	331	Other Kidney & Urinary Tract Diagnoses Age >17 w CC	0.40	458	0.31	546	0.01	2	0.04	171	0.00	13	0.31	1,191
44	256	Other Musculoskeletal System & Connective Tissue Diagnoses	0.39	451	0.02	36	0.07	17	0.19	879	0.00	4	0.69	2,611
45	132	Atherosclerosis w CC	0.37	425	0.08	140	0.33	83	0.70	3,333	0.00	16	0.99	3,759
46	204	Disorders of Pancreas except Malignancy	0.35	400	0.56	986	0.01	3	0.03	135	0.00	5	0.23	871
47	403	Lymphoma & Non-Acute Leukemia w CC	0.34	394	0.60	1,062	0.04	11	0.04	169	0.00	2	0.18	677
48	020	Nervous System Infection except Viral Meningitis	0.34	392	0.21	362	0.13	33	0.09	449	0.00	10	0.17	629
49	099	Respiratory Signs & Symptoms w CC	0.30	352	0.02	42	0.02	4	0.02	106	0.00	3	0.23	890
50	242	Septic Arthritis	0.29	334	0.01	20	0.04	11	0.03	123	0.00	1	0.11	428

RTI analyses of Medicare Administrative files, 2003.
SOURCE: BBAR037

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3. Differences in DRG-Specific Diagnoses Across Treatment Settings

While certain DRGs may be common to multiple settings, the underlying diagnoses (ICD9–CM) may differ. Table 16 addresses whether facilities are specializing in certain subsets of patients within DRGs. As mentioned previously, the largest group of LTCH discharges are patients with respiratory system diagnosis with ventilator support (DRG 475) but within this DRG the majority of discharges from LTCHs come from ''other lung diseases'' (89.2 percent). Pulmonary collapse, some emphysema, acute edema of lung and acute respiratory failure fall under this category. Only 41 percent of acute outlier patients within DRG 475 were discharged with this ICD–9–CM code. Instead, the DRG 475 patients in the acute outlier setting had higher proportions admitted with pneumonia-related or chronic bronchitis diagnoses.

The underlying diagnoses in DRG 012: Degenerative nervous system disorders varied extensively across settings. More than 80 percent of the LTCH admissions had late effects of cerebrovascular disease, as did 74.5 percent of the IRF outliers; however, this dropped to 54.2 percent of the IRF non-outliers and 52.5 percent of those in SNF/swing beds. Psychiatric patients in this DRG were more likely to have cerebral degeneration (95.7 percent), which includes Alzheimer's disease. Parkinson's Disease is the third most common diagnoses in this group, accounting for 4.2 percent of the LTCH cases and over 26 percent of the non-outlier IRF cases.

The primary diagnoses for DRG 249: Aftercare of musculoskeletal system and connective tissue (DRG 249) also differed across settings. Four-fifths of patients in LTCHs and SNF/swing beds (82.4 percent, 78.6 percent, respectively) were there for ''other orthopedic aftercare,'' (which included, for example, the removal of fracture plate, pins, rods, screws) and the aftercare for healing traumatic or pathologic fractures. In contrast, in the acute outlier, IRF outlier, and IRF non-outlier populations these patients were more likely to be treated for a replacement and graft-related complications.

Among the 50 most frequent types of LTCH admissions, the most expensive case is DRG 076 (Other Respiratory System OR Procedures w/CC) which has an average Medicare episode payment of $120,806 (Table 17). While this case is ranked the 23rd most common type of LTCH admission, it is the most expensive type of episode due to its high acute and LTCH hospital payments. These cases have the second highest acute payments prior to LTCH admission ($60,612) and the second highest LTCH payment ($58,357). The combined acute and LTCH LOS is 81 days, of which two-thirds is LTCH days (55 days).

The most common LTCH case, DRG 475: Respiratory System Diagnosis with Ventilator Support is the second most expensive LTCH episode. Medicare payments for these cases are $118,635 on average and the average length stay from hospital admission to LTCH discharge is 70 days. These cases have the most expensive acute hospital stay and the fourth most expensive LTCH stay.

DRG 462: Rehabilitation is the second most common type of LTCH admission, although it accounts for only one-third as many admissions as go to IRFs with outlier payments. These cases are ranked 35th in terms of episode payments with almost half of the payments ($20,311) related to the LTCH admission. The average length stay in the LTCH is 27 days following 11 days in the acute hospital. This DRG is also the most common IRF admission and accounts for two-thirds of all IRF cases. In contrast to the LTCH, IRF payments range from $11,741 for the majority of cases to $23,104 for the small percent that receive IRF outlier adjustments. Little is known about the differences in severity across the different settings since Functional Independence Measures (FIM scores) are only collected in the IRF.

The majority of LTCH cases are admitted from an acute hospital (79.2 percent), and has higher LTCH payments than acute care hospital payments. This is particularly true among the 20 most expensive LTCH cases, the exceptions being DRG 76, DRG 475, DRG 87, DRG 99, and DRG 452 which have higher acute payments. The more common skin ailments, including DRG 263, DRG 217, and DRG 271, have LTCH payments two to three times greater than the preceding acute stay payment.

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TABLE 16: Top LTCH Primary Diagnoses Among Select DRGs by Provider Type, 2003 (based on the RTI Draft Report)

			LTCH %	Acute Outliers %	IRF Outliers %	IRF Non-Outliers %	Psych Hospital/Units %	SNF/ Swing Beds %
DRG475: Respiratory System Diagnosis With Ventilator Support								
			N=10140	N=8221	N=5	N=2	N=11	N=53
1	518	Other Lung Diseases*	89.16	41.31	100.00	100.00	72.73	67.92
2	482	Oth Bacterial Pneumonia*	2.22	11.87	0.00	0.00	0.00	3.77
3	486	Pneumonia, Organism Nos	1.99	15.48	0.00	0.00	0.00	7.55
4	491	Chronic Bronchitis*	1.70	6.45	0.00	0.00	0.00	3.77
5	507	Solid/Liq Pneumonitis*	1.60	11.29	0.00	0.00	18.18	3.77
6	496	Chr Airway Obstruct Nec	1.17	0.00	0.00	0.00	0.00	9.43
DRG462: Rehabilitation								
			N=7131	N=25	N=20094	N=317899	N=36	N=30979
1	V57	Rehabilitation Procedure*	100.00	100.00	100.00	100.00	100.00	99.99
2	V52	Fitting Of Prosthesis*	0.00	0.00	0.00	0.00	0.00	0.01
DRG012: Degenerative Nervous System Disorders								
			N=5846	N=360	N=188	N=5508	N=28911	N=18936
1	438	Late Eff Cerebrovasc Dis*	82.19	14.17	74.47	54.27	0.60	52.53
2	331	Cerebral Degeneration*	10.93	24.44	3.72	7.15	95.66	26.52
3	332	Parkinson's Disease*	4.16	10.00	13.30	26.16	2.84	13.81
4	342	Hemiplegia*	0.82	0.28	6.38	8.22	0.00	4.72
6	333	Extrapyramidal Dis Nec*	0.50	2.22	0.53	1.22	0.81	1.12
7	358	Myoneural Disorders*	0.48	42.50	0.00	1.16	0.00	0.47
8	335	Ant Horn Cell Disease*	0.31	3.89	1.60	1.34	0.00	0.40

			LTCH %	Acute Outliers %	IRF Outliers %	IRF Non-Outliers %	Psych Hospital/Units %	SNF/ Swing Beds %
DRG249: Aftercare, Musculoskeletal System & Connective Tissue								
			N=5238	N=58	N=74	N=3832	N=0	N=5297
1	V54	Oth Orthopedic Aftercare*	82.36	3.45	25.68	11.40	0.00	78.57
2	996	Replace & Graft Complic*	16.00	96.55	68.92	86.80	0.00	16.15
3	905	Late Eff Musculoskel Inj*	1.60	0.00	4.05	1.59	0.00	5.25
4	V52	Fitting Of Prosthesis*	0.04	0.00	1.35	0.21	0.00	0.00
5	V53	Adjustment Of Oth Device*	0.00	0.00	0.00	0.00	0.00	0.03
DRG296: Nutritional & Misc Metabolic Disorders Age >17 w CC								
			N=1019	N=1199	N=17	N=459	N=100	N=3196
1	263	Prot-Cal Malnutr Nec/Nos*	46.61	5.34	11.76	3.05	1.00	12.83
2	276	Fluid/Electrolyte Dis*	24.83	82.40	29.41	58.17	77.00	56.88
3	783	Nutrit/Metab/Devel Symp*	9.32	4.09	0.00	18.52	14.00	16.96
4	261	Nutritional Marasmus	8.24	1.58	0.00	1.09	0.00	0.59
5	275	Dis Mineral Metabolism*	2.94	3.00	0.00	5.23	2.00	2.03
6	262	Oth Severe Malnutrition	2.85	0.83	0.00	0.44	0.00	0.84
7	278	Obesity/Hyperaliment*	2.36	0.83	29.41	6.97	3.00	3.35
8	269	Oth Nutrition Deficiency*	1.28	0.00	5.88	0.44	0.00	0.78
9	260	Kwashiorkor	0.79	0.17	5.88	0.65	0.00	0.09
10	251	Oth Pancreatic Disorder*	0.39	1.08	5.88	2.83	0.00	4.97
11	266	B-Complex Deficiencies*	0.10	0.08	11.76	1.96	3.00	0.31

RTI analyses of Medicare Administrative files, 2003.

TABLE 17: Average Episode Payments and Length of Stay For Top 50 LTCH Admissions by Type of Hospitalization, 2003 (based on the RTI Draft Report)

LTCH Rank	DRG	DRG LABEL	Episode Payment	Prior Acute Payment	LTCH Payment	Other PAC Payments	Prior Acute LOS	LTCH LOS
3	12	Degenerative Nervous System Disorders	42,549	9,762	23,270	9,516	9	32
38	14	Specific Cerebrovascular Disorders except TIA	48,352	14,728	22,947	10,677	11	28
48	20	Nervous System Infection except Viral Meningitis	63,706	22,976	29,698	11,032	17	33
37	34	Other Disorders of Nervous System w CC	54,841	22,844	23,876	8,120	14	42
23	76	Other Resp System O.R. Procedures w CC	120,806	60,612	58,357	1,837	26	55
10	79	Respiratory Infections & Inflammations Age >17 w CC	49,480	16,190	24,650	8,639	14	29
30	82	Respiratory Neoplasms	30,205	13,689	16,909	0	13	23
6	87	Pulmonary Edema & Respiratory Failure	87,291	50,483	32,942	3,866	23	40
7	88	Chronic Obstructive Pulmonary Disease	38,975	9,498	20,920	8,558	10	25
9	89	Simple Pneumonia & Pleurisy Age >17 w CC	40,607	10,343	21,892	8,371	10	26
49	99	Respiratory Signs & Symptoms w CC	67,997	33,871	26,088	8,037	20	32
41	120	Other Circulatory System O.R. Procedures	60,084	14,706	36,685	8,694	13	43
40	126	Acute & Subacute Endocarditis	53,298	18,483	24,243	10,571	15	30
11	127	Heart Failure & Shock	40,564	11,488	20,767	8,309	12	25
19	130	Peripheral Vascular Disorders w CC	44,460	11,413	23,500	9,546	12	30
45	132	Atherosclerosis w CC	55,687	24,480	21,432	9,774	15	27
21	144	Other Circulatory System Diagnoses w CC	49,022	17,555	21,514	9,953	14	26
42	172	Digestive Malignancy w CC	37,456	16,515	19,089	1,852	16	25
27	182	Esophagitis, Gastroent & Misc Digest Disorders Age >17 w CC	41,396	9,789	22,587	9,020	13	28
25	188	Other Digestive System Diagnoses Age >17 w CC	56,087	19,886	26,507	9,693	18	29

LTCH Rank	DRG	DRG LABEL	Episode Payment	Prior Acute Payment	LTCH Payment	Other PAC Payments	Prior Acute LOS	LTCH LOS
46	204	Disorders of Pancreas except Malignancy	57,538	20,930	24,461	12,147	19	26
31	217	Wnd Debrid & Skn Grft except Hand,for Muscskelet & Conn Tiss Dis	60,879	14,126	37,949	8,804	13	46
16	238	Osteomyelitis	48,406	11,659	26,802	9,946	12	36
50	242	Septic Arthritis	45,547	11,068	24,964	9,514	12	32
33	243	Medical Back Problems	35,958	8,628	20,813	6,517	9	28
5	249	Aftercare, Musculoskeletal System & Connective Tissue	40,735	10,084	22,178	8,474	8	28
44	256	Other Musculoskeletal System & Connective Tissue Diagnoses	48,821	13,929	24,096	10,797	14	30
13	263	Skin Graft &/or Debrid for Skn Ulcer or Cellulitis w CC	57,663	12,035	39,725	5,904	12	50
4	271	Skin Ulcers	47,911	12,257	28,404	7,250	12	38
17	277	Cellulitis Age >17 w CC	39,912	8,075	22,050	9,788	9	28
36	294	Diabetes Age >35	41,474	9,019	23,395	9,060	10	33
26	296	Nutritional & Misc Metabolic Disorders Age >17 w CC	40,132	11,730	21,838	6,563	13	28
15	316	Renal Failure	53,639	18,062	24,578	10,999	16	29
20	320	Kidney & Urinary Tract Infections Age >17 w CC	38,522	7,606	22,035	8,882	9	28
43	331	Other Kidney & Urinary Tract Diagnoses Age >17 w CC	47,973	13,177	23,961	10,835	14	29
47	403	Lymphoma & Non-Acute Leukemia w CC	44,708	15,062	21,955	7,691	15	27
32	415	O.R. Procedure for Infectious & Parasitic Diseases	69,419	21,932	39,754	7,733	17	46
12	416	Septicemia Age >17	49,721	15,873	24,481	9,366	14	29
18	418	Postoperative & Post-Traumatic Infections	54,669	20,527	24,488	9,654	16	30
39	429	Organic Disturbances & Mental Retardation	31,124	7,235	18,210	5,679	8	44
14	430	Psychoses	26,347	5,058	19,514	1,775	7	35

LTCH Rank	DRG	DRG LABEL	Episode Payment	Prior Acute Payment	LTCH Payment	Other PAC Payments	Prior Acute LOS	LTCH LOS
24	452	Complications of Treatment w CC	59,745	26,090	25,553	8,102	20	31
35	461	O.R. Proc w Diagnoses of Other Contact w Health Services	67,114	21,370	35,722	10,022	17	44
2	462	Rehabilitation	41,838	13,060	20,311	8,466	11	27
22	463	Signs & Symptoms w CC	40,146	12,860	20,955	6,331	12	27
29	465	Aftercare w History of Malignancy As Secondary Diagnosis	53,551	24,024	20,700	8,827	16	25
8	466	Aftercare w/o History of Malignancy As Secondary Diagnosis	54,988	23,781	21,764	9,444	15	26
28	468	Extensive O.R. Procedure Unrelated To Principal Diagnosis	89,096	37,946	47,320	3,831	19	53
1	475	Respiratory System Diagnosis With Ventilator Support	118,635	71,947	44,239	2,449	27	43
34	483	Tracheostomy except for Face,Mouth & Neck Diagnoses	87,990	23,157	59,719	5,113	16	59

RTI analyses of Medicare Administrative files, 2003.
NOTE: Other PAC Payments include average Medicare payments for SNF, HH, IRF, and general acute readmissions.
SOURCE: LTCH sample, Gage124

TABLE 18: Top 7 LTCH Hospital Discharges by DRG and Census Region, 2003 (based on the RTI Draft Report)

DRG		New England	Mid-Atlantic	E. North Central	W. North Central	South Atlantic	E. South Central	W. South Central	Western Mountain	Pacific
1.	475	428	800	2,676	605	1,595	664	1,980	590	802
2.	462	185	786	733	160	704	863	3,307	206	187
3.	012	869	334	455	600	411	248	2,568	164	197
4.	271	99	271	751	302	584	249	2,523	288	281
5.	249	917	316	415	71	490	190	2,450	168	221
6.	087	253	370	832	374	809	227	1,214	346	438
7.	088	850	229	524	175	434	164	2,043	195	242
Total Discharges		3,601	3,106	6,386	2,287	5,027	2,605	16,085	1,957	2,368

RTI analyses of Medicare Administrative files, 2003.

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4. Variation of Payment and Use Patterns by Regional Location

Table 18 presents LTCH discharges by DRG and by census region to examine differences in the types of cases admitted to LTCHs across the regions. Use of these hospitals may vary because of the availability of alternative providers in certain parts of the country.

The West South Central region by far has the largest number of discharges from LTCHs. Excluding this region, the number of discharges was lowest in the Western Mountain region and highest in the East North Central region.

DRG 475 (respiratory with ventilator support) accounted for the highest number of discharges in most regions. These discharges were by far the most common among the 7 DRGs listed in the East North Central region and the South Atlantic. However, there were three regions where this DRG was not the most frequent type of discharge among those listed: New England, East South Central and West South Central. In the New England region, DRG 249 (Aftercare, Musculoskeletal System and Connective Tissues), DRG 012 (Degenerative Nervous System Disorders) and DRG 088 (COPD) were more common than DRG 475. In the East South Central and West South Central regions, DRG 462 (Rehabilitation) was the most common DRG.

5. Payment Variation Across Regions

Despite the fact that the LTCH PPS, like all prospective payment systems is designed to provide a uniform Medicare payment for each LTC–DRG, there are facility and patient level adjustments that may impact the payments for any specific case. Under the LTCH PPS, for example, there is an area wage adjustment (which is being phased-in over 5 years) which would impact payments regionally. There may also be variations among LTCHs and across regions in the admission of short stay outliers, the number of interrupted stay cases, and on-site discharges and readmittances, all of which could affect Medicare per discharge payments.

RTI examined Medicare payments and levels of use across different regions. Among the 20 most frequently admitted LTCH conditions, DRG 475 was the highest cost DRG across all regions. In the West South Central, with its high volume of LTCH admissions, the second most expensive type of case is the DRG 263: Skin Graft and Debridement for Skin Ulcer which ranked 13th in volume across all LTCH admissions.

Use levels also varied regionally. As with the payments, LOS for DRG 475 was highest in New England as compared to the shortest stays for these cases being in the West South Central region which had the highest number of these admissions. In general, New England lengths of stay were longer than in other parts of the nation for respiratory and infection cases as well as nervous system disorders. Skin ulcers, pulmonary edema, respiratory infections, skin graft and debridements, psychoses, and renal failure cases also tended to stay longer in the northeast.

6. Identifying LTCH Patients Relative to Other PAC Patients

While the proportion of post acute patients entering LTCHs is relatively small compared to other post acute settings (only 1.8 percent in 2002), the number of beneficiaries discharged from IPPS hospitals in 2002 into LTCHs more than doubled between 1996 and 2002. Thirty-six percent of the LTCH admissions were subsequently admitted to a SNF, IRF, or readmitted to an acute care hospital.

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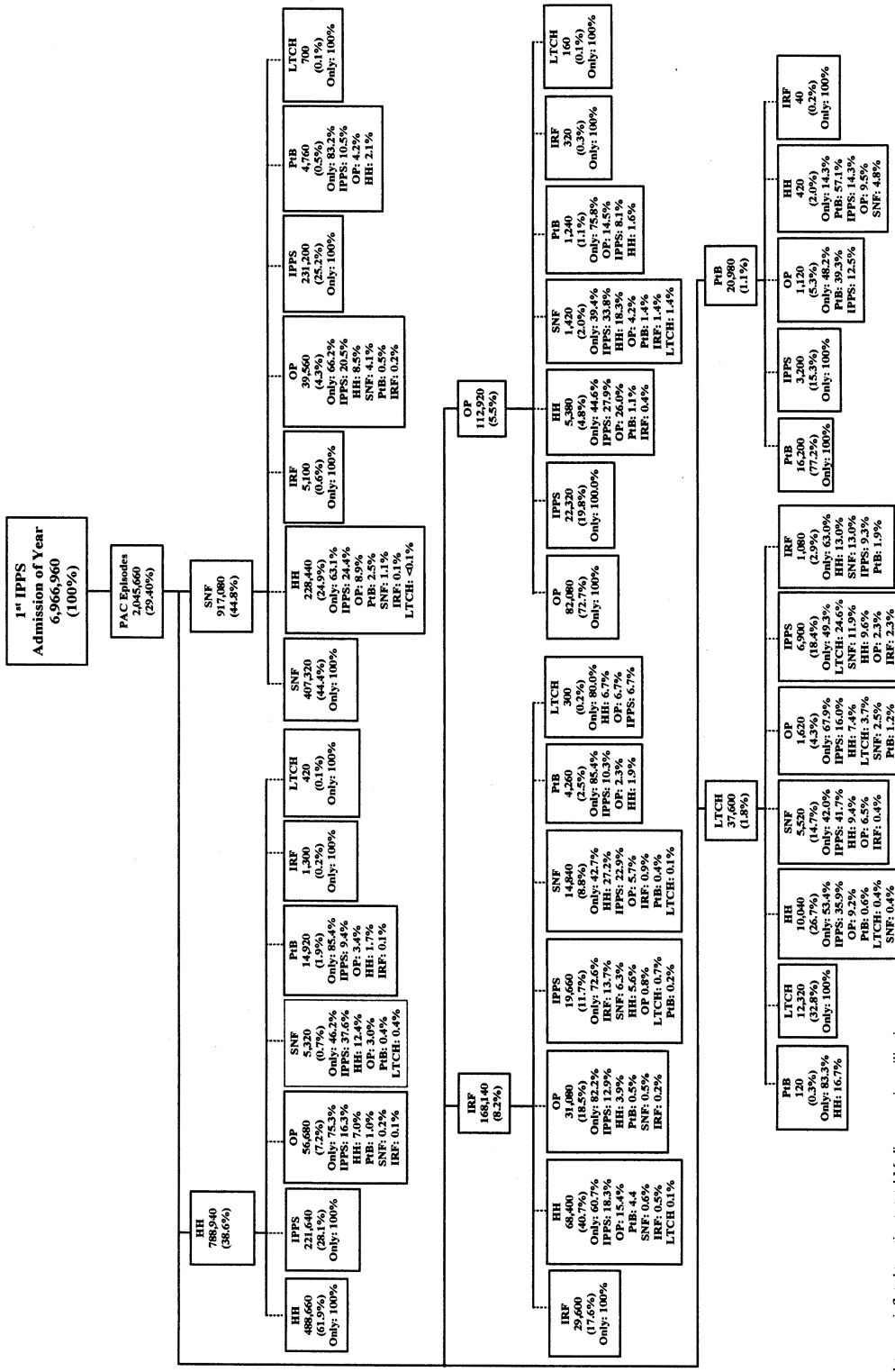
FIGURE 1: Post acute care transitions for IPPS hospital discharges, 2002



NOTE: Sample data were inflated to estimate total Medicare service utilization.

SOURCE: RTI Analysis of 1996 Medpar and SAF files, 5 percent sample (BBAR 028).

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LTCH users tend to have a higher number of comorbidities relative to other types of post acute episodes. RTI also evaluated medical complexity by using Hierarchical Coexisting Condition (HCC) scores which are based on a patient's Medicare expenditures from the year preceding the index IPPS admission. ''LTCH only'' users had the highest average HCC score of any episode type.

7. Average Medicare Payments

Several studies have shown that LTCH stays are more costly to the Medicare program on average than stays within other post acute settings (MedPAC 2003).

a. LTCH and Acute Outlier Episodes of Care

RTI compared the resources, payments, and outcomes of LTCH patients with one of 50 common LTCH DRGs to those admitted to an acute care hospital and for whom the acute care hospital received an outlier payment ('Acute Outlier') (Table 19). These two samples are separate, yet somewhat overlapping. The LTCH sample provides a profile of all LTCH admissions and it includes the 80 percent of admissions who had a prior hospital stay, of which 12.4 percent had an outlier adjustment as well as the remaining 20 percent who may have been admitted from home, a SNF, IRF, or physician's office. The acute outlier sample includes all acute care cases that received an outlier payment for one of the top 50 LTCH DRGs. This sample contains both cases that did and did not use LTCHs and provides an overview of high cost, longer stay patients in the acute hospital who could have potentially been admitted to an LTCH. Episodes are defined as 180 day periods beginning with an index stay at either the LTCH or the acute setting.

Using 2003 claims, the two sets of episodes were created based on the index, or qualifying, acute care hospital stay. An episode is defined as all Medicare services provided in an acute hospital, LTCH, IRF, SNF, IPF, or home health agency within 180 days of the index admission. Within the 100 percent of 2003 MedPAR files, 102,749 LTCH episodes were identified.

The acute outlier episode sample has 54,023 cases that had a qualifying admission at an acute hospital with an outlier payment and an LTCH-like DRG. Only about 11 percent of these cases were discharged to an LTCH despite the sample being based on the top 50 DRGs commonly treated in an LTCH.

Demographic Characteristics. The two samples differed in terms of their demographic characteristics. Compared to acute outlier episodes, LTCH admissions were older (73.1 years vs. 71.4 years), more likely to be female (55 percent vs. 50 percent) and living in a State with a higher concentration of LTCHs (57 percent vs. 23 percent). Acute outlier episodes had a higher proportion of deaths compared to LTCH cases (61 percent vs. 42 percent).

Severity of Illness. Several measures of severity of illness were included and they are useful for understanding differences in the types of resources used in these two types of hospitals. The results show that both Acute Outlier (AO) and LTCH episodes had comparably high numbers of comorbid diagnosis on the index claim (8.8 vs. 8.1, respectively). The Charlson Comorbidity Index, a widely used severity and mortality measure in health services research, scores were also comparable but relatively low (1.6 vs. 1.5, respectively). However, there were substantially more procedures performed during the index AO stay (4.6 vs. 1.7 procedures). Both types of admissions had intensive care unit (ICU) stays and coronary care unit (CCU) stays, although these were longer in the acute outlier episodes compared to LTCH cases (21 days vs. 1 day, on average across all cases). Almost 22 percent of the acute outlier sample with ICU/CCU days had surgery during the outlier stay. These differences reflect differences in the types of procedures completed in an acute hospital compared to an LTCH.

Regarding the most common conditions (that is, DRG) in both settings, LTCH episodes were more likely to have a DRG for respiratory conditions (DRG 079, 087, 088, 089), and ''Degenerative Nervous System Disorders.'' AO populations were more likely than LTCH admissions to be treated for ''Heart Failure & Shock.''. The following LTCH DRGs also accounted for a larger share of the LTCH sample than the acute outlier group: Aftercare, Musculoskeletal System & Connective Tissue; Aftercare w/o History of Malignancy As Secondary Diagnosis; Skin Ulcers; and a DRG for Rehabilitation. Interestingly, despite DRG 475 being the most common LTCH admission, they represent a higher share of the acute outlier episodes than the LTCH admissions (14 percent vs. 9 percent among LTCH episodes).

Acute hospital readmission rates (Table 20) were somewhat higher in LTCH episodes (40 percent) than acute outlier episodes (36 percent). Of those readmitted from an LTCH episode, 2.3 percent received outlier adjustments for the subsequent acute stay. Subsequent service use also differed between the two populations. The LTCH sample was more likely to use home health care (33.2 percent v. 24.3 percent). However, they were less likely to use an IRF or SNF (5 percent vs. 7 percent and 26 percent vs. 31 percent, respectively).

Almost 80 percent of the LTCH admissions were admitted from an acute hospitalization within 5 days prior to the index LTCH admission. Among these episodes, 63 percent had surgery during this prior hospitalization and 12 percent of the acute stays included an outlier payment, with an average hospital payment of $24,790 per stay. Among these outlier episodes, almost all cases had surgery (99 percent) and required intensive or coronary care (93 percent) with lengthy stays in the acute hospital prior to the LTCH admission.

TABLE 19: Episode Characteristics (based on the RTI Draft Report)

Characteristics	Acute outlier episodes	LTCH Episodes
Sample Size	54,023	102,749
Demographics		
Age (years)	71.4	73.1
Female (%)	50.1	55.4
White race (%)	77.6	75.4
Died during year (%)	60.6	41.5
% living in high LTCH States *	22.9	57.2
Severity		
Diagnosis count at index admission	8.8	8.1
Procedure count at index admission	4.6	1.7
Average number of days in ICU and CCU	21.2	1.1
Surgery/ICU/CCU	21.9	-
Charlson Comorbidity Index	1.6	1.5
Selected DRGs or conditions at index admission as % of admissions		
Respiratory (DRG=079,087,088,089)	10.8	15.6
Ventilator (DRG=475)	14.4	8.9
CHF (DRG=127)	8.1	3.2
Nervous (DRG=012)	0.6	5.3
Aftercare, musculoskeletal and connective tissue (DRG=249)	0.0	4.6
Aftercare, no history of malignancy (DRG=466)	0.0	3.8
Skin Ulcer (DRG=271)	0.0	4.4
Rehabilitation (DRG=462)	0.0	6.4

RTI analyses of Medicare Administrative files, 2003.

* High LTCH States include Indiana, Louisiana, Massachusetts, Michigan, Pennsylvania, Ohio, and Texas.

TABLE 20: Episode Utilization (based on the RTI Draft Report)

	Acute Outlier	LTCH
Total number of cases	54,023	102,749
Post-index admission to...		
Acute hospitals (Readmissions)	36.2%	40.0%
with acute outlier payment	-	2.3
LTCH	10.5	9.7
Home health agency	24.3	33.2
IRF	7.4	4.6
IPF	0.6	1.5
SNF	30.9	26.2
Prior acute hospitalization...	-	79.2
Percent of episodes with surgery at prior acute admission	-	62.7
Percent with an acute outlier payment...	-	12.4
Of acute outliers...		
Average outlier payment	-	$24,790.49
Percent with surgery	-	99.2%
Average number of procedures	-	5.4
Percent with ICU/CCU stay	-	93.1%
Average number of ICU days	-	19.5
Average number of CCU days	-	4.0

RTI analyses of Medicare Administrative files, 2003.

b. Acute Outlier Episodes Compared to LTCH Episodes

RTI has noted the differences between the LTCH population and the subset of acute admissions with a DRG commonly found in the LTCH admissions and for whom an outlier payment is made. The acute outlier sample is further broken out by whether the case resulted in an LTCH admission. Table 21 shows that only 10.5 percent of the acute outlier cases with these DRGs were discharged to an LTCH. As expected, the average episode payments for LTCH users were 87 percent greater than payments for outlier episodes that did not include LTCH admissions. About half the difference is due to the LTCH payment but the other half is largely due to substantially higher payments for the acute outlier stay ($80,380 for those discharged to an LTCH compared to $54,390 for outlier cases who did not use LTCHs). The average LTCH payment in the outlier sample is also higher than the average LTCH admission payment ($34,990 compared to $26,786).

The average hospitalization in the acute care hospital for an outlier stay is significantly longer than the average stay preceding an LTCH admission (25 to 28 days versus 14.5 days). While 79.2 percent of all LTCH admissions have an acute care stay in the 5 days preceding LTCH admission, only 12 percent of them are outlier cases. The majority of LTCH admissions are not acute outliers. Also, once in the LTCH, about 40 percent of all cases are discharged with a SSO adjustment. Despite this, the average length stay in the all LTCHs is 32.8 days.

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TABLE 21: Comparison of Utilization and Expenditures Between Acute Outlier and LTCH Episodes (based on the RTI Draft Report)

Analysis of Use	Acute Outlier episode				LTCH episodes	
	No LTCH Admission		LTCH Admission			
	Average Pmt/Use	% of total AO episodes	Average Pmt/Use	% of total AO episodes	Average Pmt/Use	% of total LTCH episodes
Number of episodes	48348	----	5675	—	102,749	—
Total episode payments per user	69557	100%	$130532	100.0%	$55,314	100.0%
LTCH payments	----	---	34990	10.5	26,786	100.0
Acute hospital payments	54390	100%	80380	100.0	22,100	79.2%
IRF payments	19353	7%	17237	9%	16,261	4.6%
IPF	8587	1%	5951	0%	9,565	1.5%
SNF payments	10352	31%	11694	29%	11,352	26.2%
Home health payments	3591	24%	3888	24%	4,115	33.3%
Readmit acute hospitalization payments	21664	35%	21231	44%	14,512	40.0%
Total episode LOS (days) per user						
LTCH	------	-----	38	10.5%	32.8	100.0%
Acute	25.6		28.2		14.5	79.2%
IRF	19.7	7%	20.4	9%	19.6	4.6%
Psych	17.3	01%	12.5	0%	19.3	1.5%
SNF	77.7	31%	69.5	29%	88.5	26.2%
Home Health	55	24%	57	24%	64.2	33.3%
Readmit acute hospitalization	18.4	35%	16.8	44%	14.2	40.0%
Ancillary service use, among users only						
Index intensive care day count	22.3	72%	28.0	85%	14.0	8.0%
Index coronary care day count	15.7	27%	17.1	27%	20.1	0.1%
% with surgical procedure codes at index	90%		11%		—	59.8%
Index inhalation therapy charge amount	26935	91%	40209	96%	12,825	70.9%
Index lab charge amount	26730	99%	34935	100%	3984	95.7%

Analysis of Use	Acute Outlier episode				LTCH episodes	
	No LTCH Admission		LTCH Admission			
	Average Pmt/Use	% of total AO episodes	Average Pmt/Use	% of total AO episodes	Average Pmt/Use	% of total LTCH episodes
Index MRI charge amount	4157	15%	4272	16%	2,827	2.7%
Index OT charge amount	1232	41%	1133	52%	2,116	79.1%
Index operating room charge	10013	71%	14785	88%	4,009	17.3%
Index PT charge amount	2175	77%	1996	84%	2,564	86.7%
Index radiology charge	10341	99%	13223	100%	1,663	76.2%
Index med/surg supply charge	20671	98%	29029	100%	5,925	92.1%

RTI analyses of Medicare Administrative files, 2003.

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The subsequent use of IRFs and SNFs is slightly lower in the LTCH universe than in the acute outlier sample. However, within the acute outliers, those who were first discharged to LTCHs were less likely to use IRFs and SNFs, although their payments were generally higher when they did use these services.

Determining and Evaluating Levels of Care

A key issue in defining the distinct role of LTCHs in the Medicare provider continuum is the need to objectively define the service intensity level an LTCH should provide relative to other providers in the continuum. As part of this effort, RTI is examining the definitions currently used by the Medicare program, LTCH providers, potential substitute providers, and insurers regarding the relative role of acute hospitals, LTCHs, IRFs, and SNFs. Included are reviews of the Medicare conditions of participation governing each of these providers, the QIOs and insurance industry's guidelines for determining appropriate levels of care, and the post acute industry's definitions of their own and others levels of care as developed for Congressional testimony or internal discussions. In addition, RTI has conducted site visits to speak with the physicians and discharge planning staff at LTCHs regarding the types of cases they typically do or do not admit.

First, because of the rising interest in better defining post acute care in all settings, several groups developed definitions of intensity for the post acute continuum either for Congressional testimony or as internal working documents of provider associations or in managed care organizations. These definitions were made available to RTI and compared across industries to understand the role each expects LTCHs and the alternative providers to serve in treating Medicare beneficiaries. These comparisons can be summarized in terms of the frequency of physician visits and nursing hours, as shown in Table 22. The LTCHs and IRFs also tend to differ by the primary diagnosis, with the LTCHs focusing on medical intensity and IRFs focusing on rehabilitation intensity.

TABLE 22.—CLINICAL INTENSITY ASSOCIATED WITH DIFFERENT LEVELS OF CARE

[Based on the RTI Draft Report]

	LTCH	IRF	SNF
Physician visits	Daily 2–3/week	2–3/week Close med Supervision	General supervision at least every 14–30 days.
Consulting physician	2–3/week	Frequent	As needed.
Nursing hours	6–12 hr/day	6.5 Rehab RN	2.5–4 hours/day.

RTI analyses of Medicare Administrative files, 2003.
Source: RTI analysis of PAC comparisons developed by the PAC industries.

Second, RTI reviewed the Medicare certification and conditions of participation regulations for LTCHs and potential substitute providers. These certification regulations define: What constitutes a type of provider; their certification requirements; and the coverage criteria associated with each. Many of the requirements are common across the IPPS, IRF, IPF, and LTCHs. Each is providing inpatient acute care. In addition, the IRFs and IPFs have staffing requirements that include team-related management of their patients, professional specializations that reflect the respective services, and special provisions governing their units and satellite facilities. LTCHs lack most of these requirements. Instead, they must meet the same requirements as IPPS acute hospitals and then demonstrate that they meet the LOS requirement, that is, they treat Medicare patients for an average of greater than 25 days on an annual basis. They have additional requirements governing their ability to open HwHs. However, they lack many of the staffing and treatment requirements that Medicare requires for IRFs and IPFs to qualify as specialized inpatient hospitals.

Third, RTI reviewed insurance and industry-based definitions of the level of care distinctions that are commonly applied to different Medicare providers. These standards are generally used by the Medicare QIOs and private insurance review entities to make coverage decisions. QIOs have statutory authority under section 1154(a) of the Act to: Review the necessity and reasonability of services delivered under Medicare; whether these services meet professionally recognized standards of health care; and whether these services, consistent with the provision of appropriate medical care, could be ''effectively provided more economically * * * in an inpatient health care facility of a different type.''

Although QIOs are not required to utilize uniform criteria nationwide for these determinations, most of them rely on Interqual as a baseline screening tool with physician-level decision-making for cases that appear to fall outside the acceptable level of care guidelines. QIOs were interviewed regarding the specific strengths and weaknesses of the screening criteria they presently use and their applicability for CMS purposes.

Phone interviews with QIOs in Connecticut, Louisiana Maryland/DC, Massachusetts, Michigan, Nevada/Utah, New York, Pennsylvania and Texas (nine QIOs that represent 11 States/districts) were conducted. In general, States were selected that had a high number or growing number of LTCHs and also those that had possible substitute providers, such as IRFs, IPFs or SNFs. RTI also selected States that had high numbers of LTCHs and at least one other type of provider to examine how the QIOs view similar cases and make determinations regarding appropriate use of LTCHs compared to potential substitutions.

In general, most of the QIOs and many of the hospital chains used a variation of the Interqual definitions of level of care to determine appropriateness of admissions. These criteria measure a potential patient's severity of illness based on combinations of conditions and intensity of service based on expected resources needed to treat the patient if admitted. In addition, hospitals may use other criteria to determine if a patient is appropriate for treatment at their facility. Parts of the LTCH industry have proposed guidelines for their hospitals to use in determining appropriate admissions. These criteria are less specific than those used by the QIOs although all are used as guidelines with the final determinations made by physicians.

Fourth, patient assessment tools, screening criteria, and intensity measures were collected from LTCHs through their associations and corporate entities. These tools are used by LTCHs to determine appropriateness of admissions, intensity of patients served,

and outcomes expected from the treatment. They provide information on items commonly used by LTCHs to track patient conditions, treatment needs, and determine staffing levels. In addition to information on patient demographics, insurance, and medical history, the forms contain items on patient acuity, including measures of their blood gas, glucose levels, oxygen saturation levels, respiratory rates, and functional levels, as well as, treatment needs (such as tube feeding, central lines, and IV medications, GI suctioning, dialysis (hemodialysis or peritoneal), ventilator weaning, pain management, wound measures, or telemetry monitoring.) These measures cover the range of special services provided by LTCHs and can be useful for measuring patient acuity differences. While they provide objective measures of patient intensity, much work remains to be done in setting the levels for determining whether a patient belongs in an LTCH or an alternative site of care. Proposed levels were already developed by Interqual and other private sector entities, as well as, parts of the industry. More discussion is needed to set specific levels of care determinations that include the range of specialists treating these patients. RTI is reviewing these proposed criteria along with existing criteria and patient assessment models used by QIOs, LTCHs, and incorporating input from clinicians with the objective of developing recommendations to CMS regarding a patient assessment instrument for LTCHs.

Site Visits

RTI researchers, accompanied by CMS analysts (including a physician with clinical experience in LTCHs) visited LTCHs around the country. Sites were selected based on a breakdown of hospital referral regions (as defined by Dartmouth Atlas 2005) to select areas that vary in the availability of LTCHs, IRFs, IPFs, and SNFs across the U.S. and with the input and cooperation of LTCH industry groups.

Facilities were selected to provide an overview of the range of populations typically treated in LTCHs and varying in geographic distribution, facility age, and medical specializations. Hospitals were selected to include free standing, HwHs, and satellites as well as LTCHs representing several different types of facilities such as: Older non-profit LTCHs specializing in specific types of cases; newer for-profit chains, co-located LTCHs that are part of a medical system; and other providers that treat LTCH-type patients.

These site visits are essential in providing an in-depth examination of LTCHs' populations and services relative to other types of facilities and under different models of care. Personnel at LTCHs were asked to contrast their level of care with that provided in other treatment settings, including acute care hospitals, IRFs, and SNFs.

Interview materials were developed to ensure that the same questions were asked regarding the difference in intensity or level of care for patients treated in an LTCH versus other inpatient hospital-level settings or SNFs. The following groups were interviewed from host hospitals: Discharge planners, medical directors, admissions directors, nursing/quality assurance directors, therapy directors, and in some cases, the finance directors. The focus was on the types of patients admitted, differences in expectations regarding outcomes and, relative payment to cost differences across differently certified beds.

Although we expect the final RTI report on this project to have a substantial impact on future Medicare policy for LTCHs, we still believe that even with the development of defined patient and perhaps facility-level criteria, that the retention of many of the specific payment adjustment features of the LTCH PPS presently in place may still be both necessary and appropriate for purposes of protecting the integrity of the Medicare Trust Fund. We expect that the RTI's final report will be submitted to us in late Spring 2006.

XII. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements:

Section 412.525 Adjustments to the Federal Prospective Payment Provision for Short-Stay Outliers

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 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 FI to substantiate its request for the use of a different CCR by their FI. For example, necessary documentation, as stipulated by CMS and the FI, 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 × 10 facilities), to comply with this requirement.

Section 412.529 Special Payment Provision for Short-Stay Outliers

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 FI to substantiate its request for the use of a different CCR by their FI. For example, necessary documentation, as stipulated by CMS and the FI, 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 × 10 facilities), to comply with this requirement.

We will be submitting a copy of this proposed rule to OMB for its review of the information collection requirements described above. These requirements are not effective until they have been approved by OMB.

If you comment on these information collection and recordkeeping requirements, please mail copies directly to the following:

Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Regulations Development Group, Attn: William N. Parham, III, [CMS–1485–P], Room C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850; and

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Carolyn Lovett, CMS Desk Officer, [CMS–1485–P], *carolyn_lovett@omb.eop.gov.* Fax (202) 395–6974.

XIII. Regulatory Impact Analysis

A. Introduction

We have examined the impact of this proposed 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 Act, the Unfunded Mandates Reform Act of 1995 (UMRA) (Pub. L. 104–4), and Executive Order 13132.

1. Executive Order 12866

Executive Order 12866 (as amended by Executive Order 13258, which merely assigns 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 one year). We are using the proposed rates, factors and policies presented in this proposed rule, including updated proposed wage index values, and the best available claims data to estimate proposed payments for the 2007 LTCH PPS rate year. Based on the best available data for 259 LTCHs, we estimate that the proposed change to the SSO policy (as discussed in section V.A.1. of this preamble) for the 2007 LTCH PPS rate year, in conjunction with the proposed changes to the area wage adjustment (discussed in section IV.D.1. of the preamble of this proposed rule) the proposed increase in the outlier fixed-loss amount (discussed in section IV.D.3.c. of this preamble) and the proposed slight increase in the budget neutrality offset to account for the transition methodology (as discussed in section IV.D.5. of this preamble), would result in a decrease in estimated payments from the 2006 LTCH PPS rate year of approximately $362 million for the 259 LTCHs. (An estimate of Medicare program payments for LTCH services for the next 5 years is shown in section XIII.B.5. of this proposed rule.) Because the combined distributional effects and costs to the Medicare program are greater than $100 million, this proposed rule is considered a major economic rule, as defined in this section.

2. Regulatory Flexibility Act (RFA)

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $26 million or less in any 1 year. For purposes of the RFA, all hospitals (and most other providers and suppliers) are considered small entities according to the Small Business Administration's latest size standards (for further information, see the Small Business Administration's regulation at 65 FR 69432, November 17, 2000). Because we lack data on individual hospital receipts, we cannot determine the number of small proprietary LTCHs. Therefore, we assume that all LTCHs are considered small entities for the purpose of the analysis that follows. Medicare fiscal intermediaries are not considered to be small entities. Individuals and States are not included in the definition of a small entity.

Currently, our database of 259 LTCHs includes the data for 61 non-profit (voluntary ownership control) LTCHs and 189 proprietary LTCHs. The remaining 9 LTCHs are Government-owned and operated (see Table 23). The impact of the proposed changes for the 2007 LTCH PPS rate year is discussed below in section XIII.B.4.c. of this proposed rule. The provisions of this proposed rule are estimated to result in approximately an 11 percent decrease in estimated payments per discharge in the 2007 LTCH PPS rate year on average to LTCHs (as shown in Table 23). As discussed in greater detail below in this section (and as shown in Table 23), the majority of the approximately 11 percent decrease in estimated payments in the 2007 LTCH PPS rate year as compared to the 2006 LTCH PPS rate year is due to the proposed change in the payment formula for SSO cases (discussed in section V.A.1.a. of the preamble of this proposed rule). We do not believe that this proposed change would result in an adverse impact on affected LTCHs for the reasons discussed below in this section. We believe that, if implemented, the proposed changes to the SSO policy would accomplish our stated goal of removing the incentive for LTCHs to admit patients for whom a long-term hospital stay is not necessary and therefore, for whom the LTCH would not be providing complete treatment.

As we discuss in greater detail in section V.A.1.a. of the preamble of this proposed rule, currently about 37 percent of all LTCH cases are short-stay outliers, most of which were admitted to the LTCH directly from an acute-care hospital. Thus, many short-stay cases may be still in need of acute-level care at the time of admission to the LTCH, which may indicate a premature and inappropriate discharge from the acute care hospital. As we also discussed in the preamble above, we believe that the proposed changes to the SSO policy would result in a more appropriate payment for short-stay cases treated at LTCHs. We believe that by removing the financial incentive for LTCHs to admit such a larger percentage of short-stay cases by paying appropriately for these cases, LTCHs would change their admission patterns for these patients. Specifically, we believe that if the proposed changes to the SSO are implemented, most LTCHs would substantially reduce the number of short-stay cases that they admit (and most of those patients would continue to receive treatment at the acute-care hospital from which they are typically discharged from immediately prior to their LTCH (short-stay) admission).

The estimated 11.1 percent decrease in LTCH PPS payments for RY 2007 was determined based on the current LTCH admission pattern of SSO cases (that is, currently about 37 percent of all LTCH cases). Thus, we believe that the estimated 11.1 percent decrease in LTCH payments per discharge for RY 2007 would only occur if LTCHs were to continue to admit the same number of SSO patients. Since the majority of the approximately 11 percent decrease in estimated payments is due to the proposed change in the SSO policy and since we anticipate that LTCHs would no longer admit such a large percentage of SSO patients if such proposed changes are implemented, we believe that the actual decrease in LTCHs' payments for RY 2007 would be considerably less than 11 percent. (Although we expect LTCHs to admit fewer cases under this proposed change,

we believe that most LTCHs, which are HwHs, would not experience an increase in cost per discharge as a result of unoccupied beds. Rather, we expect that LTCHs would make a commensurate reduction in available beds. LTCHs would lease fewer beds, and therefore, the LTCHs' cost per discharge would not increase dramatically.)

Furthermore, our Medicare margins analysis of the most recent LTCH cost report data, show that LTCH PPS payments for FY 2003 were 8.8 percent higher than LTCHs' Medicare costs, and preliminary cost report data for FY 2004 reveal an even higher Medicare margin of 11.7 percent (as discussed in greater detail in section IV.C.3. of the preamble to this proposed rule). Since LTCH PPS payments appear to be more than adequate to cover the costs of the efficient delivery of care to patients at LTCHs, based on this margins analysis, we believe that even with an estimated decrease in LTCHs' payments per discharge for the 2007 LTCH PPS rate year, which may result from, among other things, the continued treatment of some short-stay cases and the estimated slight decrease in payments due to the proposed changes to the area wage adjustment (see Table 23 below in this section) LTCH PPS payments in RY 2007 would still be sufficient to compensate LTCHs for the costs of the efficient delivery of LTCH services to LTCH patients. Thus, we do not expect that the provisions of this proposed rule would result in an adverse financial impact on affected LTCHs nor would there be an effect on beneficiaries' access to care.

For the reasons discussed above, we do not expect an estimated decrease of 11.1 percent to the LTCH PPS Medicare payment rates to have a significant adverse effect on the ability of most LTCHs to provide cost efficient services to Medicare patients. In addition, LTCHs provide some services to (and generate revenue from) patients other than Medicare beneficiaries. The revenue to LTCHs from treating those patients is not affected by this proposed rule. Accordingly, we certify that this proposed rule would not have a significant impact on a substantial number of small entities, in accordance with RFA.

3. Impact on Rural Hospitals

Section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a proposed or final 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 shown in Table 23, we are estimating an 11.3 percent decrease in payment per discharge for the 2007 LTCH PPS rate year as compared to the 2006 LTCH PPS rate year based on the data of the 9 rural hospitals in our database of 259 LTCHs for which complete data were available.

As discussed above in this section, the majority of the approximately 11 percent decrease in estimated payments in the 2007 LTCH PPS rate year as compared to the 2006 LTCH PPS rate year for rural LTCHs is due to the proposed change in the payment formula for SSO cases (discussed in section V.A.1.a of the preamble of this proposed rule). We do not believe that this proposed change would result in an adverse impact on rural LTCHs because, under this proposed change, we believe that LTCHs (including rural LTCHs) would significantly reduce the number of short-stay cases that they admit since such a policy would remove the financial incentive for LTCHs to treat short-stay cases by paying appropriately for them (as we discussed in greater detail above in section XIII.A.2. of this proposed rule). Furthermore, we believe that if the proposed changes to the SSO policy are implemented, although most LTCHs (including rural LTCHs) would admit fewer short-stay cases, most of those patients would continue to receive treatment at the acute-care hospital from which they are typically discharged from immediately prior to their LTCH (short-stay) admission, and most LTCHs (which are HwHs) would not experience an increase in cost per discharge as a result of unoccupied beds.

The estimated 11.3 percent decrease in LTCH PPS payments for RY 2007 for rural LTCHs was determined based on the current LTCH admission pattern of SSO cases (that is, currently about 37 percent of all LTCH cases). Thus, we believe that the estimated 11.3 percent decrease in LTCH payments per discharge for RY 2007 for rural LTCHs would only occur if rural LTCHs were to continue to admit the same percentage of SSO patients. Since the majority of the approximately 11 percent decrease in estimated payments for rural LTCHs is due to the proposed change in the SSO policy and since we anticipate that LTCHs (including rural LTCHs) would no longer admit such a large percentage of SSO patients if such proposed changes are implemented, we believe that the actual decrease in rural LTCHs' payments for RY 2007 would be considerably less than 11 percent. Therefore, we believe that the estimated 11.3 percent decrease in payments per discharge for the 2007 LTCH PPS rate year for rural LTCHs would only occur if LTCHs maintain the same level of SSO patients.

Moreover, as also discussed in greater detail above in section XIII.A.2. of this proposed rule, based on our Medicare margins analysis for LTCHs which shows payments in excess of costs for FYs 2003 and 2004, we believe that even with an estimated decrease in LTCHs' payments per discharge for the 2007 LTCH PPS rate year, LTCH PPS payments to rural LTCHs would still be sufficient to compensate LTCHs for the costs of the efficient delivery of LTCH services to LTCH patients. (For additional information on the impact of the proposed changes on rural LTCHs presented in this proposed rule, refer to the discussion of the impact analysis in section XIII.B.4 of this proposed rule.)

For the reasons discussed in this section, we do not expect that the provisions of this proposed rule would result in an adverse financial impact on rural LTCHs nor would there be an effect on beneficiaries' access to care. Therefore, we do not expect an estimated decrease of 11.3 percent to the LTCH PPS Medicare payment rates for rural LTCHs to have a significant adverse effect on the ability of most LTCHs to provide cost efficient services to Medicare patients. Accordingly, we substantiate that the rates and policies set forth in this proposed rule would not have an adverse impact on rural hospitals based on the data of the 9 rural hospitals in our database of 259 LTCHs for which data were available.

4. Unfunded Mandates

Section 202 of the UMRA requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditures in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of $120 million or more. This proposed rule would not mandate any requirements for State, local, or tribal governments, nor would it result in expenditures by the private sector of $110 million or more in any one year.

5. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it publishes 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 examined this proposed rule under the criteria set forth in Executive

Order 13132 and have determined that this proposed rule would not have any significant impact on the rights, roles, and responsibilities of State, local, or tribal governments or preempt State law, based on the 9 State and local LTCHs in our database of 259 LTCHs for which data were available.

B. Anticipated Effects of Proposed Payment Rate Changes

We discuss the impact of the proposed changes to the payment rates, factors, and policies presented in this proposed rule in terms of their fiscal impact on the Medicare budget and on LTCHs.

1. Budgetary Impact

Section 123(a)(1) of BBRA requires that the PPS developed for LTCHs ''maintain budget neutrality.'' Therefore, in calculating the FY 2003 standard Federal rate under § 412.523(d)(2), we set total estimated payments for FY 2003 under the LTCH PPS so that aggregate payments under the LTCH PPS are estimated to equal the amount that would have been paid if the LTCH PPS had not been implemented. However, as discussed in greater detail in the August 30, 2002 final rule (67 FR 56033 through 56036), the FY 2003 LTCH PPS standard Federal rate ($34,956.15) was calculated based on all LTCHs being paid 100 percent of the standard Federal rate in FY 2003. As discussed in section IV.D.5. of this proposed rule, we would apply a proposed budget neutrality offset to payments to account for the monetary effect of the 5-year transition period and the policy to permit LTCHs to elect to be paid based on 100 percent of the proposed standard Federal rate rather than a blend of proposed Federal prospective payments and reasonable cost-based payments during the transition. The amount of the proposed offset is equal to 1 minus the ratio of the estimated payments based on 100 percent of the LTCH PPS Federal rate to the projected total Medicare program payments that would be made under the transition methodology and the option to elect payment based on 100 percent of the Federal prospective payment rate.

2. Impact on Providers

The basic methodology for determining a LTCH PPS payment is set forth in § 412.515 through § 412.525. In addition to the basic LTC–DRG payment (standard Federal rate x LTC–DRG relative weight), we make adjustments for differences in area wage levels, cost-of-living adjustment for Alaska and Hawaii, and short-stay outliers. Furthermore, LTCHs may also receive high-cost outlier payments for those cases that qualify based on the threshold established each rate year. Section 412.533 provides for a 5-year transition to payments based on 100 percent of the Federal prospective payment rate. During the 5-year transition period, payments to LTCHs are based on an increasing percentage of the LTCH PPS Federal rate and a decreasing percentage of payment based on reasonable cost-based methodology. Section 412.533(c) provides for a one-time opportunity for LTCHs to elect payments based on 100 percent of the LTCH PPS Federal rate.

In order to understand the impact of the proposed changes to the LTCH PPS discussed in this proposed rule on different categories of LTCHs for the 2007 LTCH PPS rate year, it is necessary to estimate payments per discharge under the LTCH PPS rates, factors and policies established for the RY 2006 LTCH PPS final rule and to estimate proposed payments per discharge that would be made under the proposed LTCH PPS rates, factors and policies for the 2007 LTCH PPS rate year (as discussed in the preamble of this proposed rule). We also evaluated the percent change in payments per discharge of estimated 2006 LTCH PPS rate year payments to estimated proposed 2007 LTCH PPS rate year payments for each category of LTCHs.

Hospital groups were based on characteristics provided in the Online Survey Certification and Reporting (System) (OSCAR) data, FYs 2001 through 2003 cost report data, and Provider Specific File data. Hospitals with incomplete characteristics were grouped into the ''unknown'' category. Hospital groups include:

- Location: Large Urban/Other Urban/Rural
- Participation date
- Ownership control
- Census region
- Bed size

To estimate the impacts among the various categories of providers during the LTCH PPS transition period, it is necessary that reasonable cost-based methodology payments and prospective payments contain similar inputs. More specifically, in the impact analysis showing the impact reflecting the applicable transition blend percentages of prospective payments and reasonable cost-based methodology payments and the option to elect payment based on 100 percent of the proposed Federal rate (see Table 24), we estimated payments only for those providers for whom we are able to calculate payments based on reasonable cost-based methodology. For example, if we did not have at least 2 years of historical cost data for a LTCH, we were unable to determine an update to the LTCH's target amount to estimate payment under reasonable cost-based methodology.

Using LTCH cases from the FY 2004 MedPAR file and cost data from FYs 1999 through 2003 to estimate payments under the current reasonable cost-based principles, we have obtained both case-mix and cost data for 259 LTCHs. Thus, for the impact analyses reflecting the applicable transition blend percentages of proposed prospective payments and reasonable cost-based methodology payments and the option to elect payment based on 100 percent of the Federal rate (see Table 23), we used data from 259 LTCHs. While currently there are more than 375 LTCHs, the most recent growth is predominantly in for-profit LTCHs that provide respiratory and ventilator-dependent patient care. We believe that the discharges from the FY 2004 MedPAR data for the 259 LTCHs in our database provide sufficient representation in the LTC–DRGs containing discharges for patients who received respiratory and ventilator-dependent care based on the relatively large number of LTCH cases in LTC–DRGs for these diagnoses. However, using cases from the FY 2004 MedPAR file we had case-mix data for 337 LTCHs. Cost data to determine current payments under reasonable cost-based methodology payments are not needed to simulate payments based on 100 percent of the proposed Federal rate. Therefore, for the impact analyses reflecting fully phased-in prospective payments (see Table 24), we used data from 337 LTCHs.

These impacts reflect the estimated ''losses'' or ''gains'' among the various classifications of LTCHs for the 2006 LTCH PPS rate year (July 1, 2005 through June 30, 2006) compared to the 2007 LTCH PPS rate year (July 1, 2006 through June 30, 2007). Prospective payments for the 2006 LTCH rate year were based on the standard Federal rate of $38,086.04, the outlier fixed-loss amount of $10,501, and the hospitals' estimated case-mix based on FY 2004 LTCH claims data. Estimated proposed prospective payments for the 2007 LTCH PPS rate year would be based on the proposed standard Federal rate of $38,086.04 (based on the proposed zero percent update discussed in section IV.C.3. of this proposed rule), the proposed outlier fixed-loss amount of $18,489, and the same FY 2004 LTCH claims data.

3. Calculation of Prospective Payments

To estimate payments under the LTCH PPS, we simulated payments on a case-by-case basis by applying the

proposed payment policy for short-stay outliers (as described in section V.A.1. of this proposed rule), the proposed adjustments for area wage differences (as described in section IV.D.1. of this proposed rule), and for the cost-of-living for Alaska and Hawaii (as described in section IV.D.2. of this proposed rule). Additional payments would also be made for high-cost outlier cases (as described in section IV.D.3. of this proposed rule). As noted in section IV.D.4. of this proposed rule, we are not proposing to make adjustments for rural location, geographic reclassification, indirect medical education costs, or a disproportionate share of low-income patients because sufficient new data have not been generated that would enable us to conduct a comprehensive reevaluation of these payment adjustments. We adjusted for area wage differences for estimated 2006 LTCH PPS rate year payments by computing a weighted average of a LTCH's applicable wage index during the period from July 1, 2005 through June 30, 2006 because some providers may experience a change in the wage index phase-in percentage during that period. For cost reporting periods beginning on or after October 1, 2004 and before September 30, 2005 (FY 2005), the labor portion of the Federal rate was adjusted by three-fifths of the applicable LTCH PPS wage index. For cost reporting periods beginning on or after October 1, 2005 and before September 30, 2006 (FY 2006), the labor portion of the Federal rate is adjusted by four-fifths of the applicable LTCH PPS wage index. Therefore, during RY 2006, a provider with a cost reporting period that began October 1, 2005 would have 3 months of payments under the three-fifths wage index value and 9 months of payment under the four-fifths wage index value. For this provider, we computed a blended wage index of 25 percent (3 months/12 months) of the three-fifths wage index value and 75 percent (9 months/12 months) of the four-fifths wage index value. The applicable LTCH PPS wage index values for the 2006 LTCH PPS rate year are shown in Tables 1 and 2 of the Addendum to the RY 2006 LTCH PPS final rule (70 FR 24224 through 24247). We adjusted for area wage differences for estimated 2006 LTCH PPS rate year payments using the current LTCH PPS labor-related share of 72.885 percent (70 FR 241852).

Similarly, we adjusted for area wage differences for estimated proposed 2007 LTCH PPS rate year payments by computing a weighted average of a LTCH's applicable wage index during the period from July 1, 2006 through June 30, 2007 because some providers may experience a change in the wage index phase-in percentage during that period. For cost reporting periods that began on or after October 1, 2005 and on or before September 30, 2006 (FY 2006), the labor portion of the Federal rate is adjusted by four-fifths of the applicable LTCH PPS wage index. For cost reporting periods beginning on or after October 1, 2006, the labor portion of the Federal rate is adjusted by the full (five-fifths) applicable LTCH PPS wage index. The applicable proposed LTCH PPS wage index values for the 2007 LTCH PPS rate year are shown in Tables 1 and 2 of the Addendum to this proposed rule. We adjusted for area wage differences for estimated proposed 2007 LTCH PPS rate year payments using the proposed LTCH PPS labor-related share of 75.923 percent (see section IV.D.1.c. of this proposed rule).

For those providers projected to receive payment under the transition blend methodology, we also calculated payments using the applicable transition blend percentages. During the 2006 LTCH PPS rate year, based on the transition blend percentages set forth in § 412.533(a), some providers may experience a change in the transition blend percentage during the period from July 1, 2005 through June 30, 2006. For example, during the period from July 1, 2005 through June 30, 2006, a provider with a cost reporting period beginning on October 1, 2004 (which is paid under the 40/60 transition blend (40 percent of payments based on reasonable cost-based methodology and 60 percent of payments under the LTCH PPS)) had 3 months (July 1, 2005 through September 30, 2005) under the 40/60 blend and 9 months (October 1, 2005 through June 30, 2006) of payment under the 20/80-transition blend (20 percent of payments based on reasonable cost-based methodology and 80 percent of payments under the LTCH PPS). The 20/80 transition blend will continue until the provider's cost reporting period beginning on October 1, 2006 (FY 2007).

Similarly, during the 2007 LTCH PPS rate year, based on the transition blend percentages set forth in § 412.533(a), some of the providers that would be paid under the transition blend methodology may experience a change in the transition blend percentage during the period from July 1, 2006 through June 30, 2007. For example, during the period from July 1, 2006 through June 30, 2007, a provider with a cost reporting period beginning on October 1, 2005 (which is paid under the 20/80 transition blend) would have 3 months (July 1, 2006 through September 30, 2006) under the 20/80 blend and 9 months (October 1, 2006 through June 30, 2007) of payment based on 100 percent of Federal rate payments under the LTCH PPS (and zero percent based on reasonable cost-based methodology). The provider will continue to receive payments based on 100 percent of the LTCH PPS Federal rate for its cost reporting period beginning on October 1, 2006 (FY 2007).

In estimating blended transition payments, we estimated payments based on the reasonable cost-based methodology, in accordance with the requirements at section 1886(b) of the Act. For those providers who have not already made the election (as determined from PSF data) to be paid based on 100 percent of the Federal rate, we compared the estimated blended transition payment to the LTCH's estimated payment if it would elect payment based on 100 percent of the Federal rate. If we estimated that the LTCH would be paid more based on 100 percent of the Federal rate, we assumed that it would elect to bypass the transition methodology and would receive payments based on 100 percent of prospective payment.

We applied the applicable budget neutrality offset to payments to account for the effect of the 5-year transition methodology and election of payment based on 100 percent of the Federal rate on Medicare program payments (established in the August 30, 2002 final rule (67 FR 56034)). In estimating 2006 LTCH PPS rate year payments, we applied the 0.0 percent (a budget neutrality factor of 1.0) budget neutrality offset to payments to account for the effect of the 5-year transition methodology and election of payment based on 100 percent of the Federal rate on Medicare program payments (see the RY 2006 LTCH PPS final rule (70 FR 24202)) to each LTCH's estimated payments under the LTCH PPS for the 2006 LTCH PPS rate year. Similarly, in estimating proposed 2007 LTCH PPS rate year payments, we applied the proposed 0.1 percent (a budget neutrality factor of 0.999) budget neutrality offset to payments to account for the effect of the 5-year transition methodology and election of payment based on 100 percent of the Federal rate on Medicare program payments (see section IV.D.5. of this proposed rule) to each LTCH's estimated payments under the LTCH PPS for the 2007 LTCH PPS rate year. The impact, based on our projection using the best available data for 259 LTCHs that approximately 3 percent of LTCHs would be paid based on the transition blend methodology and 97 percent of LTCHs would elect

payment based on 100 percent of the Federal rate is shown in Table 23.

In Table 24, we also show the impact if all LTCHs would be paid 100 percent of the Federal rate; that is, as if there were a mandatory immediate transition to fully Federal prospective payments under the LTCH PPS for the 2006 LTCH PPS rate year and the 2007 LTCH PPS rate year. In the impact analysis shown in Table 24, the respective budget neutrality adjustments to account for the 5-year transition methodology on LTCHs' Medicare program payments for the 2006 and 2007 LTCH PPS rate years (0.0 percent and the proposed 0.1 percent, respectively) were not applied to LTCHs' estimated payments under the LTCH PPS.

Tables 23 and 24 illustrate the estimated aggregate impact of the payment system among various classifications of LTCHs.

- The first column, LTCH Classification, identifies the type of LTCH.
- The second column lists the number of LTCHs of each classification type.
- The third column identifies the number of long-term care cases.
- The fourth column shows the estimated payment per discharge for the 2006 LTCH PPS rate year.
- The fifth column shows the estimated proposed payment per discharge for the 2007 LTCH PPS rate year.
- The sixth column shows the estimated percent decrease in estimated payments per discharge from the 2006 LTCH PPS rate year to the 2007 LTCH PPS rate year for proposed changes to the area wage adjustment at § 412.525(c) (as discussed in section IV.D.1. of the preamble of this proposed rule).
- The seventh column shows the estimated percent change in estimated payments per discharge from the 2006 LTCH PPS rate year to the 2007 LTCH PPS rate year for proposed changes to the SSO policy at § 412.529 (as discussed in section V.A.1.a. of the preamble of this proposed rule).
- The eighth column shows the percent decrease in estimated payments per discharge from the 2006 LTCH PPS rate year to the 2007 LTCH PPS rate year for all proposed changes (as discussed in the preamble of this proposed rule.)

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TABLE 23: Projected Impact Reflecting Applicable Transition Blend Percentages of Prospective Payments and Reasonable Cost-Based (TEFRA) Payments and Option to Elect Payment Based on 100 Percent of the Federal Rate[1]

(Estimated 2006 LTCH PPS Rate Year Payments Compared to Estimated Proposed 2007 LTCH PPS Rate Year Payments)

LTCH Classification	Number of LTCHs	Number of LTCH Cases	Average RY 2006 LTCH PPS Payment Per Case[2]	Average Proposed RY 2007 LTCH PPS Payment Per Case[3]	Percent Change in Payments Per Discharge from RY 2006 to RY 2007 for Proposed Area Wage Adjustment Changes[4]	Percent Decrease in Proposed Payments Per Discharge from RY 2006 to RY 2007 for Proposed Changes to the SSO Policy[5]	Percent Decrease in Proposed Payments Per Discharge from RY 2006 to RY 2007 for All Proposed Changes[6]
ALL PROVIDERS	259	101,628	$32,133	$28,574	-0.5	11.4	11.1
BY LOCATION:							
RURAL	9	2,337	$26,576	$23,577	-3.0	8.7	11.3
URBAN	250	99,291	$32,264	$28,692	-0.4	11.4	11.1
LARGE	107	34,592	$30,104	$26,257	0.1	11.1	10.2
OTHER	143	64,699	$33,419	$29,994	-1.5	12.0	11.8
BY PARTICIPATION DATE:							
BEFORE OCT. 1983	15	7,816	$26,414	$23,247	0.4	13.3	12.0
OCT. 1983 - SEPT. 1993	45	22,126	$34,415	$30,889	0.1	11.2	10.2
OCT. 1993 - SEPT. 2002	199	71,686	$32,052	$28,441	-0.8	11.3	11.3
BY OWNERSHIP CONTROL:							
VOLUNTARY	61	23,016	$30,721	$26,658	-0.6	13.5	13.2
PROPRIETARY	189	76,363	$32,741	$29,339	-0.4	10.7	10.4
GOVERNMENT	9	2,249	$25,953	$22,239	-1.9	13.1	14.3

BY CENSUS REGION:							
NEW ENGLAND	13	9,370	$26,545	$23,177	0.8	14.4	12.7
MIDDLE ATLANTIC	18	6,080	$32,583	$29,138	-0.8	10.5	10.6
SOUTH ATLANTIC	24	9,063	$35,918	$31,970	-0.6	11.2	11.0
EAST NORTH CENTRAL	50	15,165	$35,307	$31,577	-0.5	10.8	10.6
EAST SOUTH CENTRAL	15	4,718	$33,288	$29,271	-1.4	11.5	12.1
WEST NORTH CENTRAL	17	4,755	$36,017	$31,884	-1.0	11.3	11.5
WEST SOUTH CENTRAL	89	40,288	$29,252	$25,754	-1.1	11.5	12.0
MOUNTAIN	20	5,670	$33,277	$29,608	0.4	12.3	11.0
PACIFIC	13	6,519	$40,243	$37,711	2.0	9.2	6.3
BY BED SIZE:							
BEDS: 0-24	22	3,658	$32,365	$27,996	-1.6	12.7	13.5
BEDS: 25-49	127	34,341	$31,862	$28,097	-1.1	11.5	11.8
BEDS: 50-74	37	13,560	$34,462	$30,630	-0.4	11.5	11.1
BEDS: 75-124	37	16,861	$33,267	$29,853	0.0	11.1	10.3
BEDS: 125-199	24	21,106	$30,353	$27,022	-0.4	11.3	11.0
BEDS: 200 +	12	12,102	$31,748	$28,727	0.7	11.0	9.5

[1] These calculations take into account that some providers may experience a change in the LTCH PPS blend percentage changes during the 2006 and 2007 LTCH PPS rate years. For example, during the period of July 1, 2006 through June 30, 2007, a provider with a cost reporting period beginning October 1, 2005 would have 3 months (July 1, 2006 through September 30, 2006) of payments under the 20/80 blend (4/5ths wage index) and 9 months (October 1, 2006 through June 30, 2007) of payment under the full (5/5ths) wage index).

[2] Estimated average payment per case for the 12-month period of July 1, 2005 through June 30, 2006.

[3] Estimated average payment per case for the 12-month period of July 1, 2006 through June 30, 2007.

[4] Percent change in estimated payments per discharge from the 2006 LTCH PPS rate year to the 2007 LTCH PPS rate year for the proposed changes to the area wage adjustment policy at §412.525(c) (as discussed in section IV.D.1. of the preamble of this proposed rule).

[5] Percent decrease in estimated payments per discharge from the 2006 LTCH PPS rate year to the 2007 LTCH PPS rate year for the proposed changes to the short-stay outlier policy at §412.529 (as discussed in section V.A.1.a. of the preamble of this proposed rule).

[6] Percent decrease in estimated payments per discharge from the 2006 LTCH PPS rate year (as established in the RY 2006 LTCH PPS final rule (70 FR 24168 through 24261)) to those proposed for the 2007 LTCH PPS rate year (as discussed in the preamble of this proposed rule).

Table 24: Projected Impact Reflecting the Fully Phased-In LTCH PPS Prospective Payments[1]

(Estimated 2006 LTCH PPS Rate Year Payments Compared to Estimated Proposed 2007 LTCH PPS Rate Year Payments)

LTCH Classification	Number of LTCHs	Number of LTCH Cases	Average RY 2006 LTCH PPS Payment Per Case[2]	Average Proposed RY 2007 LTCH PPS Payment Per Case[3]	Percent Change in Payments Per Discharge from RY 2006 to RY 2007 for Proposed Area Wage Adjustment Changes[4]	Percent Decrease in Proposed Payments Per Discharge from RY 2006 to RY 2007 for Proposed Changes to the SSO Policy[5]	Percent Decrease in Proposed Payments Per Discharge from RY 2006 to RY 2007 for All Proposed Changes[6]
ALL PROVIDERS	337	118,525	$31,939	$28,340	-0.6	11.6	11.3
BY LOCATION:							
RURAL	19	3,761	$26,612	$23,357	-3.0	10.0	12.2
URBAN	318	114,764	$32,113	$28,504	-0.5	11.6	11.2
LARGE	173	72,680	$33,116	$29,673	0.0	11.3	10.4
OTHER	145	42,084	$30,382	$26,485	-1.5	12.2	12.8
BY PARTICIPATION DATE:							
BEFORE OCT. 1983	16	7,848	$26,374	$23,245	0.4	13.2	11.9
OCT. 1983 - SEPT. 1993	45	22,126	$34,391	$30,830	0.1	11.4	10.4
OCT. 1993 - SEPT. 2002	208	74,435	$31,962	$28,364	-0.8	11.3	11.3
AFTER OCT. 2002	68	14,116	$31,064	$27,150	-1.0	12.4	12.6
BY OWNERSHIP CONTROL:							
VOLUNTARY	69	25,396	$30,715	$26,604	-0.6	13.8	13.4
PROPRIETARY	221	85,879	$32,640	$29,208	-0.5	10.9	10.5
GOVERNMENT	9	2,249	$25,905	$22,235	-1.9	13.1	14.2
UNKNOWN	38	5,001	$28,830	$25,010	-1.4	12.7	13.2
BY CENSUS REGION:							

NEW ENGLAND	14	9,402	$26,511	$23,178	0.8	14.3	12.6
MIDDLE ATLANTIC	23	7,035	$31,983	$28,642	-0.9	10.4	10.4
SOUTH ATLANTIC	41	12,150	$35,668	$31,603	-0.7	11.7	11.4
EAST NORTH CENTRAL	61	17,353	$34,923	$31,107	-0.6	11.2	10.9
EAST SOUTH CENTRAL	22	5,861	$33,334	$29,184	-1.6	11.9	12.4
WEST NORTH CENTRAL	17	4,755	$36,017	$31,650	-1.0	12.0	12.1
WEST SOUTH CENTRAL	122	49,392	$29,191	$25,702	-1.1	11.6	12.0
MOUNTAIN	22	6,032	$33,228	$29,589	0.4	12.2	11.0
PACIFIC	15	6,545	$40,182	$37,637	2.0	9.3	6.3
BY BED SIZE:							
BEDS: 0-24	35	5,997	$30,310	$26,328	-1.8	-12.2	-13.1
BEDS: 25-49	172	42,034	$32,112	$28,262	-1.1	-11.7	-12.0
BEDS: 50-74	42	14,789	$33,862	$30,040	-0.5	-11.8	-11.3
BEDS: 75-124	43	20,430	$32,907	$29,496	0.0	-11.2	-10.4
BEDS: 125-199	25	22,243	$30,329	$26,918	-0.4	-11.7	-11.2
BEDS: 200 +	13	12,134	$31,708	$28,724	0.7	-11.0	-9.4
UNKNOWN	7	898	$23,983	$21,237	-2.2	-9.8	-11.5

[1] These calculations take into account that some providers may experience a change in the LTCH PPS blend percentage changes during the 2006 and 2007 LTCH PPS rate years. For example, during the period of July 1, 2006 through June 30, 2007, a provider with a cost reporting period beginning October 1, 2005 would have 3 months (July 1, 2006 through September 30, 2006) of payments under the 20/80 blend (4/5ths wage index) and 9 months (October 1, 2006 through June 30, 2007) of payment under the full (5/5ths) wage index.

[2] Estimated average payment per case for the 12-month period of July 1, 2005 through June 30, 2006.

[3] Estimated average payment per case for the 12-month period of July 1, 2006 through June 30, 2007.

[4] Percent change in estimated payments per discharge from the 2006 LTCH PPS rate year to the 2007 LTCH PPS rate year for the proposed changes to the area wage adjustment policy at §412.525(c) (as discussed in section IV.D.1. of the preamble of this proposed rule).

[5] Percent decrease in estimated payments per discharge from the 2006 LTCH PPS rate year to the 2007 LTCH PPS rate year for the proposed changes to the short-stay outlier policy at §412.529 (as discussed in section V.A.1.a. of the preamble of this proposed rule).

[6] Percent decrease in estimated payments per discharge from the 2006 LTCH PPS rate year (as established in the RY 2006 LTCH PPS final rule (70 FR 24168 through 24261)) to those proposed for the 2007 LTCH PPS rate year (as discussed in the preamble of this proposed rule).

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4. Results

Based on the most recent available data (as described previously for 259 LTCHs), we have prepared the following summary of the impact (as shown above in Table 23) of the LTCH PPS set forth in this proposed rule. The impact analysis in Table 23 shows that estimated payments per discharge are expected to decrease approximately 11 percent on average for all LTCHs from the 2006 LTCH PPS rate year as compared to the 2007 LTCH PPS rate year as a result of the proposed changes presented in this proposed rule. As noted previously, the estimated percent decrease in payments per discharge from the 2006 LTCH PPS rate year to the 2007 LTCH PPS rate year is largely attributable to the proposed change in the payment formula for SSO cases (discussed in section V.A.1.a. of this proposed rule). Specifically, under the proposed changes to the SSO policy for RY 2007, approximately 96 percent of LTCH SSO cases (which is approximately 36 percent of all LTCH cases) would receive a lower payment than under the current SSO policy. We believe this proposed policy is appropriate given that many of these short-stay cases most likely do not belong in a LTCH, which in general are intended to treat patients with an ALOS of greater than 25 days. As we discussed in greater detail in section IV.D.3.c. of the preamble of this proposed rule), given the regulatory requirement at § 412.525(a) that estimated outlier payments equal to 8 percent of estimated total LTCH PPS payments, this estimated decrease in LTCH PPS payments for RY 2007 resulting from the proposed changes to the SSO policy would require a proposed increase in the high-cost outlier fixed-loss amount in order to maintain that estimated outlier payments at 8 percent of the reduced estimated total LTCH PPS payments (resulting from the proposed changes to the SSO policy). The proposed increase in the outlier fixed-loss amount and the proposed slight increase in the budget neutrality offset to account for the transition methodology (discussed in section IV.D.5. of this proposed rule) are also factors contributing to the proposed decrease in payments per discharge from the 2006 LTCH PPS rate year to the 2007 LTCH PPS rate year. For example, many LTCHs are expected to receive a decrease in high-cost outlier payments. A result of the proposed increase to the fixed-loss amount from the 2006 LTCH PPS rate year ($10,501) to the 2007 LTCH PPS rate year ($18,489), fewer cases would qualify as outlier cases (that is, the estimated cost of the case exceeds the outlier threshold). Since, many LTCHs would receive fewer outlier payments, total estimated payments per discharge would discharge (as discussed in section IV.D.3. of this proposed rule).

a. Location

Based on the most recent available data, the majority of LTCHs are in urban areas. Approximately 3.5 percent of the LTCHs are identified as being located in a rural area, and approximately 2.3 percent of all LTCH cases are treated in these rural hospitals. Impact analysis in Table 23 shows that the percent decrease in estimated payments per discharge for the 2006 LTCH PPS rate year compared to the 2007 LTCH PPS rate year for rural LTCHs would be −11.3 percent, and would be −11.1 percent for urban LTCHs (see Table 23). While rural LTCHS are expected to experience a lower decrease in payments due to the proposed changes in the SSO policy because they treat a smaller percentage of SSO cases, they are projected to experience a higher decrease in payments per discharge as a result of the proposed changes to the area wage adjustment (discussed in section IV.D.1. of the preamble of this proposed rule). Specifically, rural LTCHs are expected to experience a higher decrease in payments per discharge as a result of the proposed changes to the area wage adjustment because the wage index for all rural LTCHs is less than 1.0, and therefore, they would experience a decrease in payments per discharge as a result of the proposed increase in the labor-related share and the progression of the 5-year phase-in of the wage index adjustment.

Large urban LTCHs are projected to experience a 12.8 percent decrease in payments per discharge from the 2006 LTCH PPS rate year compared to the 2007 LTCH PPS rate year, while other urban LTCHs are projected to experience a 11.8 percent decrease in payments per discharge from the 2006 LTCH PPS rate year compared to the 2007 LTCH PPS rate year (see Table 23). Other urban LTCHs are projected to experience a higher than average decrease in payments per discharge primarily because of the proposed changes to the area wage adjustment (discussed in section IV.D.1. of the preamble of this proposed rule). Specifically, the majority of other urban LTCHs (over 80 percent) are located in urban areas that have a proposed wage index value of less than 1.0, and therefore, would experience a higher than average decrease in payments per discharge as a result of the proposed increase in the labor-related share and the progression of the 5-year phase-in of the wage index adjustment. In addition, other urban LTCHs have a slightly higher percentage of SSO cases and therefore are projected to experience a slightly higher than average decrease in payments per discharge as a result of the proposed changes to the SSO policy (as discussed in greater detail above in this section).

b. Participation Date

LTCHs are grouped by participation date into three categories: (1) Before October 1983; (2) between October 1983 and September 1993; and (3) between October 1993 and September 2002. At this time, we do not have sufficient cost report data for any of the LTCHs that began participating in the Medicare program after October 2002 (the implementation of the LTCH PPS), and, therefore, they are not included in the impact analysis shown in Table 23.

Based on the most recent available data, the majority, approximately 71 percent, of the LTCH cases are in hospitals that began participating between October 1993 and September 2002, and are projected to experience an 11.3 percent decrease in payments per discharge from the 2006 LTCH PPS rate year compared to the 2007 LTCH PPS rate year. Approximately 22 percent of the cases are in LTCHs that began participating in Medicare between October 1983 and September 1993, and those LTCHs are projected to experience a 10.2 percent decrease in payments per discharge from the 2006 LTCH PPS rate year compared to the 2007 LTCH PPS rate year (see Table 23). We are projecting that LTCHs that began participating in Medicare between October 1983 and September 1993 would experience a lower than average decrease in payments for RY 2007 primarily because we are projecting that these LTCH would experience a slight increase (0.1 percent) in payments per discharge due to the proposed changes to the area wage adjustment. Specifically, many of the LTCHs that began participating in Medicare between October 1983 and September 1993 are located in areas where the proposed RY 2007 wage index value would be greater than the RY 2006 wage index value. In addition, several of these LTCH are located in areas that have a proposed wage index value of greater than 1.0, and therefore, would experience a slight increase in payments per discharge as a result of the proposed increase in the labor-related share and the progression of the 5-year phase-in of the wage index adjustment.

LTCHs that began participating before October 1983 are projected to experience a 12.0 percent decrease in payments per discharge from the 2006 LTCH PPS rate year compared to the 2007 LTCH PPS rate year (see Table 23).

We are projecting that LTCHs that began participating in Medicare before October 1983 would experience a higher than average decrease in payments for RY 2007 as compared to RY 2006 primarily because many of these LTCHs have a higher than average percentage of SSO cases, and therefore, we are projecting that they would experience a higher than average decrease in payments per discharge due to the proposed changes to the SSO policy.

c. Ownership Control

LTCHs are grouped into three categories based on ownership control type: voluntary; proprietary; and government.

Based on the most recent available data, approximately 3.5 percent of LTCHs are government owned and operated. We expect that for these government-owned and operated LTCHs, 2007 LTCH PPS rate year payments per discharge would decrease 14.3 percent in comparison to the 2006 LTCH PPS rate year (see Table 23). We are projecting that government-run LTCHs would experience a higher than average decrease in payment in RY 2007 as compared to RY 2006 primarily due to the proposed changes to the SSO policy, since many of these LTCHs have a higher than average percentage of SSO cases. Also contributing to the projected higher than average decrease in payments in RY 2007 as compared to RY 2006 for government-run LTCHs is the effect of the proposed changes to the area wage adjustment. Specifically, all but 1 of the 9 government-run LTCHs in our database are located in areas where the proposed wage index value for RY 2007 is less than 1.0, and therefore, would experience a higher than average decrease in payments per discharge as a result of the proposed increase in the labor-related share and the progression of the 5-year phase-in of the wage index adjustment.

Similarly, we project that 2006 LTCH PPS rate year payments per discharge for voluntary LTCHs would decrease 13.2 percent in comparison to the 2006 LTCH PPS rate year (see Table 23). We are projecting that voluntary LTCHs would experience a higher than average decrease in payments in RY 2007 as compared to RY 2006 primarily due to the proposed changes to the SSO policy, since approximately two-thirds (40 LTCHs) of the voluntary LTCHs have a higher than average percentage of SSO cases.

The majority (approximately 73 percent) of LTCHs are proprietary. We project that 2007 LTCH PPS rate year payments per discharge for these proprietary LTCHs would decrease 10.4 percent in comparison to the 2006 LTCH PPS rate year (see Table 23). We are projecting that proprietary LTCHs would experience a lower than average decrease in payments in RY 2007 as compared to RY 2006 primarily due to our estimate that these LTCHs would experience a lower than average decrease in payments due to the proposed changes to the SSO policy, since many proprietary LTCHs have a lower than average percentage of SSO cases.

d. Census Region

Payments per discharge for the 2007 LTCH PPS rate year are estimated to decrease for LTCHs located in all regions in comparison to the 2006 LTCH PPS rate year. As explained in greater detail above in this section, the estimated percent decrease in payments per discharge from the 2006 LTCH PPS rate year to the 2007 LTCH PPS rate year is largely attributable to the proposed change in the payment formula for SSO cases, the proposed changes in the area wage adjustment, the proposed increase in outlier fixed-loss amount, and the proposed slight decrease in the transition period budget neutrality offset.

Of the 9 census regions, we project that the estimated decrease in proposed 2007 LTCH PPS rate year payments per discharge in comparison to the 2006 LTCH PPS rate year would have the largest impact on LTCHs in the New England region (12.7 percent; see Table 23). LTCHs located in New England are expected to experience an increase (0.8 percent) in payments due to the proposed changes in the area wage adjustment, since all New England LTCHs are located in areas where the proposed wage index value for RY 2007 is greater than 1.0, and therefore, would experience an increase in payments per discharge as a result of the proposed increase in the labor-related share and the progression of the 5-year phase-in of the wage index adjustment. However, even with this projected increase in payments from the proposed changes in the area wage adjustment, because the vast majority of New England LTCH treat a higher than average percentage of SSO cases, we are projecting that these LTCHs would experience a higher than average decrease in payments in RY 2007 as a result of the proposed changes to the SSO policy.

We project that proposed 2007 LTCH PPS rate year payments per discharge would decrease the least for LTCHs in the Pacific region in comparison to the 2006 LTCH PPS rate year (6.3 percent; see Table 23). We estimate that for LTCHs located in the Pacific region, the projected decrease in payments per discharge for the 2007 LTCH PPS rate year compared to the 2006 LTCH PPS rate year is less than the decreases projected for other regions, because all LTCHs in this region are located in areas where the proposed RY 2007 wage index value is greater than the RY 2006 wage index value. Furthermore, all of the LTCHs located in the Pacific region are located in areas where the proposed wage index value for RY 2007 is greater than 1.0, and therefore, would experience an increase in payments per discharge as a result of the proposed increase in the labor-related share and the progression of the 5-year phase-in of the wage index adjustment. In addition, many of the Pacific LTCHs treat a lower than average percentage of SSO cases, and therefore, we are projecting that these LTCHs would experience a lower than average decrease in average payments as a result of the proposed changes to the SSO policy.

e. Bed Size

LTCHs were grouped into six categories based on bed size: 0–24 beds; 25–49 beds; 50–74 beds; 75–124 beds; 125–199 beds; and 200+ beds.

We are projecting a decrease in 2007 LTCH PPS rate year payments per discharge in comparison to the 2006 LTCH PPS rate year for all bed size categories. Most LTCHs are in bed size categories where 2007 LTCH PPS rate year payments per discharge are projected to decrease by at least 10 percent in comparison to the 2006 LTCH PPS rate year. As discussed in greater detail above in this section, the estimated percent decrease in payments per discharge from the 2006 LTCH PPS rate year to the 2007 LTCH PPS rate year is largely attributable to the proposed change in the payment formula for SSO cases, the proposed changes in the area wage adjustment, the proposed increase in outlier fixed-loss amount, and the proposed slight increase in the transition period budget neutrality offset.

We project that LTCHs with greater than 200 beds would have the smallest decrease in estimated 2007 LTCH PPS rate year payments per discharge in comparison to the 2006 LTCH PPS rate year (9.5 percent), followed by LTCHs with 75–124 beds (10.3 percent). This lower than average decrease in projected payments per discharge for LTCHs with

greater than 200 beds and for LTCHs with 75–124 beds is largely due to the proposed changes to the area wage adjustment. Specifically, for LTCHs with 75–124 beds, the majority of these LTCHs are located in areas where the proposed change in the wage index value from RY 2006 to RY 2007 would be very small, and therefore we are projecting that the proposed changes to the area wage adjustment would have a negligible impact on these LTCHs' RY 2007 payments (0.0 percent) rather than decreasing their RY 2007 payments (as we estimate would be the impact of such proposed changes for ''All Providers'' as shown in Table 23). For LTCHs with greater than 200 beds, the majority of these LTCHs are located in areas where the proposed RY 2007 wage index value is greater than the RY 2006 wage index value. In addition, the majority of LTCHs with greater than 200 beds are located in areas where the proposed RY 2007 wage index value is greater than 1.0, and therefore, would experience an increase in payments per discharge as a result of the proposed increase in the labor-related share and the progression of the 5-year phase-in of the wage index adjustment.

Payments per discharge for the 2007 LTCH PPS rate year for LTCHs with 0–24 beds are projected to decrease the most in comparison to the 2006 LTCH PPS rate year (13.5 percent; see Table 23), followed by LTCHs with 25–49 beds (11.8 percent; see Table 23). This higher than average decrease in projected payments per discharge for LTCHs with less than 49 beds (that is, LTCHs in the 0–24 bed size category and LTCHs in the 25–49 bed size category) is largely due to the proposed changes to the area wage adjustment. Specifically, the majority of LTCHs with 49 beds or less are located in areas where the proposed RY 2007 wage index value is less than the RY 2006 wage index value. In addition, the majority of LTCHs with 49 beds or less are located in areas where the proposed RY 2007 wage index is less than 1.0, and therefore, would experience a higher than average decrease in payments per discharge as a result of the proposed increase in the labor-related share and the progression of the 5-year phase-in of the wage index adjustment. Furthermore, many of LTCHs with 0–24 beds have a higher than average percent of SSO cases, and therefore, would experience a higher than average decrease in payments per discharge as a result of the proposed changes to the SSO policy.

5. Effect on the Medicare Program

Based on actuarial projections, we estimate that Medicare spending (total estimated Medicare program payments) for LTCH services over the next 5 years would be as shown in Table 25:

TABLE 25

LTCH PPS rate year	Estimated payments ($ in billions)
2007	$5.27
2008	5.44
2009	5.64
2010	5.88
2011	6.15

These estimates are based on the most recent and complete LTCH data available, including the projection that 97 percent of LTCHs would elect to be paid based on 100 percent of the 2007 LTCH PPS rate year proposed standard Federal rate rather than the applicable transition blend, and an estimated increase in the number of discharges from LTCHs. (We note that the 5-year spending estimates shown in above Table 25 are significantly higher than the 5-year spending estimates presented in the 2006 LTCH PPS final rule (70 FR 24203). This is primarily due to an adjustment by our Office of the Actuary (OACT) to account for the significant increase in the expected number of LTCH discharges based on the most recent complete available LTCH discharge data.) These estimates are also based on the current estimate of the increase in the excluded hospital with capital market basket (currently used under the LTCH PPS) of 3.6 percent for the 2007 LTCH PPS rate year, 3.5 percent for the 2008 LTCH PPS rate year, 3.1 for the 2009 LTCH PPS rate year, 2.6 percent for the 2010 LTCH PPS rate year and 3.0 percent for the 2011 LTCH PPS rate year. (We note that, although we are proposing a zero percent update to the LTCH PPS Federal rate for RY 2007 (as discussed in section IV.C.3. of this proposed rule), OACT develops its spending projections based on existing policy and therefore, changes that have not yet been implemented are not reflected in the spending projections shown in Table 25.) We estimate that there would be a change in Medicare fee-for service beneficiary enrollment of −2.3 percent in the 2007 LTCH PPS rate year, −1.0 percent in the 2008 LTCH PPS rate year, 0.3 percent in 2009 and 2010 LTCH PPS rate years, and 0.6 percent in the 2011 LTCH PPS rate year, and an estimated increase in the total number of LTCHs. (We note that, based on the most recent available data, OACT is projecting a decrease in Medicare fee-for-service Part A enrollment, in part, because they are projecting an increase in Medicare managed care enrollment as a result of the implementation of several provisions of the MMA.)

Consistent with the statutory requirement for budget neutrality, as we discussed in the August 30, 2002 final rule that implemented the LTCH PPS, in developing the LTCH PPS, we intended for estimated aggregate payments under the LTCH PPS in FY 2003 would equal the estimated aggregate payments that would have been made if the LTCH PPS were not implemented. Our methodology for estimating payments for purposes of the budget neutrality calculations uses the best available data and necessarily reflects assumptions. As we collect data from LTCHs, we will monitor payments and evaluate the ultimate accuracy of the assumptions used to calculate the budget neutrality calculations (that is, inflation factors, intensity of services provided, or behavioral response to the implementation of the LTCH PPS). As discussed in section IV.D.6. of this proposed rule, we still do not have sufficient new cost report and claims data generated under the LTCH PPS to enable us to conduct a comprehensive reevaluation of our FY 2003 budget neutrality calculation at this time.

Section 123 of BBRA and section 307 of BIPA provide the Secretary with extremely broad authority in developing the LTCH PPS, including the authority for appropriate adjustments. In accordance with this broad authority, we may discuss in a future proposed rule a possible one-time prospective adjustment to the LTCH PPS rates under § 412.523(d)(3) to maintain budget neutrality so that the effect of the difference between actual payments and estimated payments for the first year of LTCH PPS is not perpetuated in the PPS rates for future years. As discussed in section IV.D.6. of this proposed rule, due to the lag time in the availability of Medicare data upon which this adjustment would be based, we believe that it is appropriate to propose a postponement of the requirement established in § 412.523(d)(3) from the existing October 1, 2006 deadline to July 1, 2008.

6. Effect on Medicare Beneficiaries

Under the LTCH PPS, hospitals receive payment based on the average resources consumed by patients for each diagnosis. We do not expect any changes in the quality of care or access to services for Medicare beneficiaries under the LTCH PPS, but we expect that

paying prospectively for LTCH services would enhance the efficiency of the Medicare program.

C. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf),* in Table 26, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this proposed rule. Table 26 provides our best estimate of the proposed decrease in Medicare payments under the LTCH PPS as a result of the proposed changes presented in this proposed rule based on the data for 259 LTCHs in our database. All expenditures are classified as transfers to Medicare providers (that is, LTCHs).

TABLE 26.—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES, FROM THE 2006 LTCH PPS RATE YEAR TO THE 2007

[LTCH PPS rate year (in millions)]

Category	Transfers
Annualized Monetized Transfers.	Negative transfer—Estimated decrease in expenditures: $362.
From Whom To Whom?	Federal Government To LTCH Medicare Providers.

In accordance with the provisions of Executive Order 12866, this proposed rule was reviewed by the Office of Management and Budget.

List of Subjects in 42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services would amend 42 CFR chapter IV as set forth below:

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 O—Prospective Payment System for Long-Term Care Hospitals

2. Section 412.523 is amended by—

A. Revising paragraph (c)(3)(ii).

B. Adding new paragraph (c)(3)(iii).

C. Revising paragraph (d)(3).

The revisions and addition read as follows:

§ 412.523 Methodology for calculating the Federal prospective payment rates.

* * * * *

(c) * * *

(3) * * *

(ii) *For long-term care hospital prospective payment system rate years beginning on or after July 1, 2003 and ending on or before June 30, 2006.* The standard Federal rate for long-term care hospital prospective payment system rate years beginning on or after July 1, 2003 and ending on or before June 30, 2006 is the standard Federal rate for the previous long-term care hospital prospective payment system rate year, updated by the increase factor described in paragraph (a)(2) of this section, and adjusted, as appropriate, as described in paragraph (d) of this section. For the rate year from July 1, 2003 through June 30, 2004, the updated and adjusted standard Federal rate is offset by a budget neutrality factor to account for updating the FY 2003 standard Federal rate on July 1 rather than October 1.

(iii) *For long-term care hospital prospective payment system rate year July 1, 2006 through June 30, 2007.* The standard Federal rate for long-term care hospital prospective payment system rate year July 1, 2006 through June 30, 2007 is the standard Federal rate for the previous long-term care hospital prospective payment system rate year, updated by an update factor of zero percent. The standard Federal rate is adjusted, as appropriate, as described in paragraph (d) of this section.

* * * * *

(d) * * *

(3) *One-time prospective adjustment.* The Secretary reviews payments under this prospective payment system and may make a one-time prospective adjustment to the long-term care hospital prospective payment system rates on or before July 1, 2008, so that the effect of any significant difference between actual payments and estimated payments for the first year of the long-term care hospital prospective payment system is not perpetuated in the prospective payment rates for future years.

* * * * *

3. 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 new paragraph (a)(4)(iv).

The revisions and addition 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 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 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 (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 tentative 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*) New hospitals that have not yet submitted their 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*) Hospitals 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*) Other hospitals for whom data with which to calculate a cost-to-charge ratio is 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.

* * * * *

4. Section 412.529 is amended by—

A. Revising paragraph (c).

B. Adding new paragraph (d).

The revision and addition read as follows:

§ 412.529 Special payment provision for short-stay outliers.

* * * * *

(c) *Method for determining the payment amount.* (1) For discharges from long-term care hospitals described under § 412.23(e)(2)(i), occurring before July 1, 2006, the LTCH prospective payment system adjusted payment amount for a short-stay outlier case is the least of the following amounts:

(i) 120 percent of the LTC–DRG specific per diem amount determined under paragraph (d)(1) of this section multiplied by the length of stay of the discharge;

(ii) 120 percent of the cost of the case determined under paragraph (d)(2) of this section; or

(iii) The Federal prospective payment for the LTC–DRG.

(2) For discharges occurring on or after July 1, 2006, from long-term care hospitals described under § 412.23(e)(2)(i), and for discharges occurring in cost reporting periods beginning on or after October 1, 2006, from the long-term care hospitals described under § 412.23(e)(2)(ii), the LTCH prospective payment system adjusted payment amount for a short-stay outlier case is the least of the following amounts:

(i) 120 percent of the LTC–DRG specific per diem amount determined under paragraph (d)(1) of this section multiplied by the length of stay of the discharge;

(ii) 100 percent of the cost of the case determined under paragraph (d)(2) of this section;

(iii) The Federal prospective payment for the LTC–DRG; or

(iv) An amount payable under subpart O that is comparable to an amount that is otherwise paid under the hospital inpatient prospective payment system determined under paragraph (d)(3) of this section.

(3) The adjusted payment amount for discharges from long-term care hospitals described under § 412.23(e)(2)(ii) that occur on or after October 1, 2002, through June 30, 2003, is determined under paragraph (c)(1) of this section. Effective for discharges occurring on or after July 1, 2003, subject to provisions of paragraph (c)(3)(v) of this section, for long-term care hospitals described under § 412.23(e)(2)(ii), the adjusted payment amount for a short-stay outlier is determined under the formulas set forth in paragraphs (c)(3)(i) through (iv) of this section.

(i) For the first year of the transition period, as specified at § 412.533(a)(1), under the formula set forth in paragraph (c)(1) of this section, the percentages specified for the LTC–DRG specific per diem amount and the cost of the case under paragraphs (c)(1)(i) and (c)(1)(ii) of this section are substituted with 195 percent.

(ii) For the second year of the transition period, as specified at § 412.533(a)(2), under the formula set forth in paragraph (c)(1) of this section, the percentages specified for the LTC–DRG specific per diem amount and the cost of the case under paragraphs (c)(1)(i) and (c)(1)(ii) of this section are substituted with 193 percent.

(iii) For the third year of the transition period, as specified at § 412.533(a)(3), under the formula set forth in paragraph (c)(1) of this section, the percentages specified for the LTC–DRG specific per diem amount and the cost of the case under paragraphs (c)(1)(i) and (c)(1)(ii) of this section are substituted with 165 percent.

(iv) For the fourth year of the transition period, as specified at § 412.533(a)(4), under the formula set forth in paragraph (c)(1) of this section, the percentages specified for the LTC–DRG specific per diem amount and cost of the case under paragraphs (c)(1)(i) and (c)(1)(ii) of this section are substituted with 136 percent.

(v) For discharges occurring in cost reporting periods beginning on or after October 1, 2006 (beginning with the fifth year of the transition period), as specified at § 412.533(a)(5)), short-stay outlier payments to long-term care hospitals described under § 412.23(e)(2)(ii) are made in accordance with the formula set forth in paragraph (c)(2) of this section.

(4) *Short-stay outlier payments.* (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)(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. 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 tentative 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*) New hospitals that have not yet submitted their 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*) Hospitals 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*) Other hospitals for whom data with which to calculate a cost-to-charge ratio is 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)(4)(iv)(C)(*4*) 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) *Calculation of costs.* (1) CMS calculates a per diem amount for short-stay outliers for each LTC–DRG by dividing the product of the standard Federal payment rate and the LTC–DRG weight by the geometric mean length of stay of the specific LTC–DRG.

(2) To determine the cost of a case, CMS uses the hospital-specific cost-to-charge ratio and the Medicare allowable charges for the case.

(3) CMS calculates, under Subpart O, an amount comparable to what would otherwise be paid under the hospital Inpatient prospective payment system based on the sum of the applicable operating inpatient prospective payment system standardized amount and capital inpatient prospective payment system Federal rate in effect at the time of the LTCH discharge.

(i) *Operating inpatient prospective payment system standardized amount.* The operating inpatient prospective payment system standardized amount—

(A) Is adjusted for the applicable inpatient prospective payment system DRG weighting factors.

(B) Is adjusted for different area wage levels based on the geographic classifications set forth at § 412.64(b)(1)(ii)(A) through (C) and the applicable inpatient prospective payment system labor-related share, using the applicable inpatient prospective payment system wage index value for non-reclassified inpatient prospective payment system hospitals. For LTCHs located in Alaska and Hawaii, this amount is also adjusted by the applicable inpatient prospective payment system cost of living adjustment factors.

(C) Includes, where applicable, adjustments for indirect medical education costs and the costs of serving a disproportionate share of low-income patients.

(ii) *Capital inpatient prospective payment system Federal rate.* The capital inpatient prospective payment system Federal rate—

(A) Is adjusted for the applicable inpatient prospective payment system DRG weighting factors.

(B) Is adjusted for the applicable geographic adjustment factors, including local cost variation based on the geographic classifications set forth at § 412.64(b)(1)(ii)(A) through (C) and the applicable full inpatient prospective payment system wage index value for non-reclassified inpatient prospective payment system hospitals and, applicable large urban location cost of living adjustment factors for LTCHs in Alaska and Hawaii, if applicable.

(C) Includes, where applicable, adjustments for indirect medical education costs and the costs of serving a disproportionate share of low-income patients.

5. Section 412.531 is amended by—

A. Revising paragraph (b)(1)(i)(C).

B. Redesignating paragraph (b)(1)(ii)(A)(*2*) as (b)(1)(ii)(A)(*3*).

C. Adding new paragraph (b)(1)(ii)(A)(*2*).

The revisions and additions read as follows:

§ 412.531 Special payment provisions when an interruption of a stay occurs in a long-term care hospital.

* * * * *

(b) * * *

(1) * * *

(i) * * *

(C) Surgical DRG exception to the 3-day or less interruption of stay policy.

(*1*) The number of days that a beneficiary spends away from a long-term care hospital during a 3-day or less interruption of stay under paragraph (a)(1) of this section during which the beneficiary receives a procedure grouped to a surgical DRG under the inpatient prospective payment system in an acute care hospital during the 2005 and 2006 LTCH prospective payment system rate years are not included in determining the length of stay of the patient at the long-term care hospital.

(*2*) For discharges occurring on or after July 1 2006, the number of days that a beneficiary spends away from a long-term care hospital during a 3-day or less interruption of stay under paragraph (a)(1) of this section during which the beneficiary receives a procedure grouped to a surgical DRG under the inpatient prospective payment system in an acute care hospital are included in determining the length of stay of the patient at the long-term care hospital.

* * * * *

(ii) * * *

(A) * * *

(*2*) For discharges occurring on or after July 1, 2006, for a 3-day or less interruption of stay under paragraph (a)(1) of this section in which a long-term care hospital discharges a patient to an acute care hospital and the patient's treatment during the interruption is grouped into a surgical DRG under the acute care inpatient hospital prospective payment system, the services must be provided under arrangements in accordance with § 412.509(c). CMS does not make a separate payment to the acute care hospital for the surgical treatment. The LTC–DRG payment made to the long-term care hospital is considered payment in full as specified in § 412.521(b).

* * * * *

6. Section 412.534 is amended by—

A. Revising paragraph (c)(1).

B. Revising paragraph (c)(2).

C. Revising paragraph (d)(1).

D. Revising paragraph (e)(1).

E. Redesignating paragraph (f) as paragraph (g).

F. Adding new paragraph (f).

The revisions and addition read as follows:

§ 412.534 Special payment provisions for long-term care hospitals within hospitals and satellites of long-term care hospitals.

* * * * *

(c) * * *

(1) Except as provided in paragraph (g) of this section, for any cost reporting period beginning on or after October 1, 2004 in which the long-term care hospital or its satellite facility has a discharged Medicare inpatient population of whom no more than 25 percent were admitted to the hospital or its satellite facility from the co-located hospital, payments are made under the rules at § 412.500 through § 412.541 in this subpart with no adjustment under this section.

(2) Except as provided in paragraph (d), (e), or (g) of this section, for any cost reporting period beginning on or after October 1, 2004 in which the long-term care hospital or satellite facility has a discharged Medicare inpatient population of whom more than 25 percent were admitted to the hospital or satellite facility from the co-located hospital, payments for the patients who are admitted from the co-located hospital and who cause the long-term care hospital or satellite facility to exceed the 25 percent threshold for discharged patients who have been admitted from the co-located hospital are the lesser of the amount otherwise payable under this subpart or the amount payable under this subpart that is equivalent, as set forth in paragraph (f) of this section, to the amount that would be determined under the rules at Subpart A, § 412.1(a). Payments for the remainder of the long-term care hospital's or satellite facility's patients are made under the rules in this subpart at § 412.500 through § 412.541 with no adjustment under this section.

* * * * *

(d) * * *

(1) Subject to paragraph (g) of this section, in the case of a long-term care hospital or satellite facility that is located in a rural area as defined in

§ 412.64(b)(1)(ii)(C) and is co-located with another hospital for any cost reporting period beginning on or after October 1, 2004 in which the long-term care hospital or satellite facility has a discharged Medicare inpatient population of whom more than 50 percent were admitted to the long-term care hospital or satellite facility from the co-located hospital, payments for the patients who are admitted from the co-located hospital and who cause the long-term care hospital or satellite facility to exceed the 50 percent threshold for discharged patients who were admitted from the co-located hospital are the lesser of the amount otherwise payable under this subpart or the amount payable under this subpart that is equivalent, as set forth in paragraph (f) of this section, to the amount that were otherwise payable under subpart A, § 412.1(a). Payments for the remainder of the long-term care hospital's or satellite facility's patients are made under the rules in this subpart at § 412.500 through § 412.541 with no adjustment under this section.

* * * * *

(e) * * *

(1) Subject to paragraph (g) of this section, In the case of a long-term care hospital or satellite facility that is co-located with the only other hospital in the MSA or with a MSA dominant hospital as defined in paragraph (e)(4) of this section, for any cost reporting period beginning on or after October 1, 2004 in which the long-term care hospital or satellite facility has a discharged Medicare inpatient population of whom more than the percentage calculated under paragraph (e)(2) of this section were admitted to the hospital from the co-located hospital, payments for the patients who are admitted from the co-located hospital and who cause the long-term care hospital to exceed the applicable threshold for discharged patients who have been admitted from the co-located hospital are the lesser of the amount otherwise payable under this subpart or the amount under this subpart that is equivalent, as set forth in paragraph (f) of this section, to the amount that otherwise would be determined under Subpart A, § 412.1(a). Payments for the remainder of the long-term care hospital's or satellite facility's patients are made under the rules in this subpart with no adjustment under this section.

* * * * *

(f) *Calculation of rates.* (1) *Calculation of LTCH prospective payment system amount.* CMS calculates an amount payable under subpart O equivalent to an amount that would otherwise be paid under the hospital inpatient prospective payment system based on the sum of the applicable operating inpatient prospective payment system standardized amount and capital inpatient prospective payment system Federal rate in effect at the time of the LTCH discharge.

(2) *Operating inpatient prospective payment system standardized amount.* The operating inpatient prospective payment system standardized amount—

(i) Is adjusted for the applicable inpatient prospective payment system DRG weighting factors;

(ii) Is adjusted for different area wage levels based on the geographic classifications set forth at § 412.64(b)(1)(ii)(A) through (C) and the applicable inpatient prospective payment system labor-related share, using the applicable inpatient prospective payment system wage index value for non-reclassified inpatient prospective payment system hospitals. For LTCHs located in Alaska and Hawaii, this amount is also adjusted by the applicable inpatient prospective payment system cost of living adjustment factors;

(iii) Includes, where applicable, adjustments for indirect medical education costs and the costs of serving a disproportionate share of low-income patients.

(3) *Capital inpatient prospective payment system Federal rate.* The capital inpatient prospective payment system Federal rate —

(i) Is adjusted for the applicable inpatient prospective payment system DRG weighting factors;

(ii) Is adjusted by the applicable geographic adjustment factors, including local cost variation based on the applicable geographic classifications set forth at § 412.64(b)(1)(ii)(A) through (C) and the applicable full inpatient prospective payment system wage index value for non-reclassified inpatient prospective payment system hospitals, applicable large urban location and cost of living adjustment factors for LTCHs for Alaska and Hawaii, if applicable;

(iii) Includes, where applicable, capital inpatient prospective payment system adjustments for indirect medical education costs and the costs of serving a disproportionate share of low-income patients.

(4) *High cost outlier.* An additional payment for high cost outlier cases is based on the fixed loss amount paid under the inpatient prospective payment system if the estimated operating and capital costs exceed the applicable inpatient prospective payment system outlier threshold.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance)

Dated: December 8, 2005.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Approved: January 19, 2006.

Michael O. Leavitt,

Secretary.

Editorial Note: The following appendix will not appear in the Code of Federal Regulations.

Appendix A—Description of a Preliminary Model of an Update Framework under the LTCH PPS

Section 307(b) of BIPA requires that the Secretary shall examine and may provide for appropriate adjustments to the LTCH PPS, including updates. Updates are necessary to appropriately account for changes in the prices of goods and services used by a provider in furnishing care to patients. A market basket has historically been used under the Medicare program in setting update factors for services furnished by providers. When we established the LTCH PPS for FY 2003 in the August 30, 2002 final rule (67 FR 56030), we established under § 412.523(c)(3)(ii) that for FYs after FY 2003, the LTCH PPS Federal rate was to be the previous year's Federal rate updated by the most recent estimate of the LTCH PPS market basket. When we moved the date of the annual update of the LTCH PPS from October 1 to July 1, beginning with the RY 2004 LTCH PPS final rule (68 FR 34138), we revised § 412.523(c)(3)(ii) to specify that for LTCH PPS rate years beginning on or after July 1, 2003, the annual update to the standard Federal rate for the LTCH prospective payment system will be equal to the previous rate year's Federal rate updated by the most recent estimate of the LTCH PPS market basket. (Currently, the LTCH PPS market basket is the FY 1997-based excluded hospital with capital market basket index (68 FR 34134 through 34137); however, we are proposing to adopt the FY 2002-based RPL market basket, as discussed in section IV.B. of this proposed rule.) As we discuss in section IV.C.3. of this proposed rule, based on our analysis of the best available LTCH case-mix and margins data, we are proposing to revise § 412.523(c) to specify that for the 2007 LTCH PPS rate year, the standard Federal rate from the previous year would be updated by a factor of zero percent. However, in the future we may propose to develop an update framework to update payments to LTCHs that would account for other appropriate factors that affect the efficient delivery of services and care provided to Medicare patients. The update framework would be proposed in accordance with the notice and comment rulemaking process. While we are not implementing a specific update framework for the LTCH prospective payment system at this time in this proposed rule, we are providing a conceptual basis for developing such an update framework.

A. Need for an Update Framework

Under the LTCH prospective payment system, Medicare payments to LTCHs are based on a predetermined national payment amount per discharge. Under section 123 of the BBRA and section 307(b) of the BIPA, the Secretary has broad discretionary authority to make appropriate adjustments to the LTCH payment system, including updates to the payment rates. Our goal is to develop a method for analyzing and comparing expected trends in the underlying cost per discharge to use in establishing these updates. However, as stated earlier, until an appropriate update framework is developed, future updates may be based on the increase in the applicable LTCH PPS market basket.

The market basket for the LTCH PPS, developed by OACT, represents only one component in the measure of growth in LTCHs' costs per discharge. It captures only the pure price change of inputs (labor, materials, and capital) used by the hospital to produce a constant quantity and quality of care. However, other factors also contribute to the change in costs per discharge, including changes in case-mix, intensity, and productivity.

Previously, under the acute care hospital IPPS for operating costs (the operating IPPS), we utilized an update framework to account for these other factors and to make annual recommendations to the Congress concerning the magnitude of the update. We continue to use a similar framework under the acute care hospital IPPS for capital costs (the capital IPPS) to determine the annual update to the capital PPS Federal rate. We also use a similar framework under the SNF PPS. Based on our experience in developing other update frameworks, we are currently examining these factors and exploring ways that they could be measured and incorporated into an update framework for the LTCH PPS. We are also examining additional conceptual and data issues that must be considered when the framework is constructed and applied.

In the August 30, 2002 final rule (67 FR 56087), we pointed out that it is important to develop successively more refined models of an update framework based on our evaluation of public comments and recommendations submitted to us on this issue. We would then further study the potential adjustments using the best available data. To actively pursue the development of an analytical framework that would support the continued appropriateness and relevance of the payment rates for services provided to beneficiaries in LTCHs, in this proposed rule, we are soliciting comments concerning the use and feasibility of the conceptual approach outlined in section B of this Appendix. Specifically, we are requesting comments concerning which factors are appropriate and should be accounted for in the framework, and suggestions concerning potential data sources and analysis to support the model. As with the existing methodology used under both the capital IPPS and SNF PPS, the features of a LTCH-specific update framework would need to be based on sound policy and methodology. Although we received no comments on the conceptual basis for a LTCH PPS update framework presented in the August 30, 2002 final rule, we continue to be interested in comments concerning the potential development of an update framework for the LTCH prospective payment system. Therefore, in this proposed rule we are again presenting a conceptual basis for the framework along with an illustrative LTCH PPS framework for RY 2007 (shown in section E of this Appendix).

B. Factors Inherent in LTCH Payments Per Discharge

In order to understand the factors that determine LTCH costs per discharge, it is first necessary to understand the factors that determine LTCH payments per discharge. Payments per discharge under the LTCH PPS are based on the cost and an implicit normal profit margin to the LTCH in providing an efficient level of care. We have developed a methodology to identify a mutually exclusive and exhaustive set of factors included in LTCH payments per discharge. The discussion here details a set of equations to identify these factors.

In its simplest form, the average payment per discharge to a LTCH can be separated into a cost term and a profit term as shown in Equation 1.

$$\text{EQUATION 1:}\quad \frac{\text{Payments}}{\text{Discharge}} = \frac{\text{Costs}}{\text{Discharge}} + \frac{\text{Profits}}{\text{Discharge}}$$

This equation can be made multiplicative by converting profit per discharge into a profit rate as shown in Equation 2.

$$\text{EQUATION 2:}\quad \frac{\text{Payments}}{\text{Discharge}} = \frac{\text{Costs}}{\text{Discharge}} * \frac{\text{Payments}}{\text{Costs}}$$

An output price term can be introduced into the equation by multiplying and dividing through by input prices and productivity. As shown in Equation 3, the term inside the brackets represents the output price, since an output price reflects the input price and profit margin adjusted for productivity.

$$\text{EQUATION 3:}\quad \frac{\text{Payments}}{\text{Discharge}} = \frac{\text{Costs}}{\text{Discharge}} * \left(\frac{\text{Payments}}{\text{Costs}} * \frac{\text{Input Prices}}{\text{Productivity}} \right) * \frac{\text{Productivity}}{\text{Input Prices}}$$

The cost per discharge term can be further separated by accounting for real case-mix. Under the LTCH PPS, LTC–DRGs are used to classify patients. Based on accurate DRG classification data, average real case-mix per discharge can be incorporated, as shown in Equation 4.

EQUATION 4:

$$\frac{\text{Payments}}{\text{Discharge}} = \frac{\text{Costs / Discharge}}{\text{Real Case Mix/Discharge}} * \frac{\text{Real Case Mix}}{\text{Discharge}} * \left(\frac{\text{Payments}}{\text{Costs}} * \frac{\text{Input Prices}}{\text{Productivity}} \right) * \frac{\text{Productivity}}{\text{Input Prices}}$$

The term ''real'' is imperative here because only true case-mix should be measured, not case-mix caused by improper coding behavior. We believe payment should be based on changes in ''real'' case mix (that is, the treatment of more resource intensive and costly patients) rather than case mix caused by improper coding behavior or changes in coding practice (that is, ''apparent'' case mix change) because ''apparent'' case mix increase does not result in an increase in a hospital's cost of treating those patients. By rearranging the terms in Equation 4, a set of mutually exclusive and exhaustive factors such as those shown in Equation 5 can be identified.

EQUATION 5:

$$\frac{\text{Payments}}{\text{Discharge}} = \left(\frac{\dfrac{\text{Costs}}{\text{Discharge}}}{\text{Input Prices} * \dfrac{\text{Real Case Mix}}{\text{Discharge}}} * \text{Productivity} \right) * \frac{\text{Real Case Mix}}{\text{Discharge}} * \frac{1}{\text{Productivity}} * \text{Input Prices} * \frac{\text{Payments}}{\text{Costs}}$$

The term in brackets can be analyzed in two steps. First, excluding the productivity term results in case-mix adjusted real cost per discharge, which is input intensity per discharge. Second, multiplying input intensity by productivity results in case-mix adjusted real payment per discharge, or output intensity per discharge. The rationale behind this step is explained in detail in section C.

The result of this exercise is that LTCH payment per discharge can be determined from the following factors as shown in Equation 6.

EQUATION 6:

$$\text{Payment Per Discharge} = \frac{\left(\begin{array}{c} \text{Case-Mix-Constant} \\ \text{Real Output Intensity} \\ \text{Per Discharge} \end{array} \right) * \left(\begin{array}{c} \text{Real Case Mix} \\ \text{per Discharge} \end{array} \right) * (\text{Input Prices}) * (\text{Profit Margins})}{\text{Productivity}}$$

Thus, it holds that the change in LTCH payment per discharge is a function of the change in these factors as shown in Equation 6. In order to determine an annual update that most accurately reflects the underlying cost to the LTCH of efficiently providing care, the four factors related to cost must be accounted for when an update framework is developed. A brief discussion of each factor, including specific conceptual and data issues, is provided in section C.

C. Defining Each Factor Inherent in LTCH Costs Per Discharge

Each cost factor from Equation 6 in section B is discussed here in detail. Because this is a basic conceptual discussion, it is likely that more detailed issues may be relevant that are not explored here.

1. Input Prices

Input prices are the pure prices of inputs used by the LTCH in providing services. When we refer to inputs, we are referring to costs, which have both a price and a quantity component. The price is an input price, and the quantity component reflects real inputs or real costs. Similarly, when we refer to outputs, we are referring to payments, which also have both a price and a quantity component. The price component is the transaction output price, and the quantity component is the real output or real payment. The real inputs include labor, capital, and other materials, such as drugs. By definition, an input price reflects prices that LTCHs encounter in purchasing these inputs, whereas an output price reflects the prices that buyers encounter in purchasing LTCH services. We currently measure input prices using the excluded hospital with capital market basket; however, as discussed section IV.B. of this proposed rule, we are proposing to adopt the RPL market basket, which is based on the operating and capital costs of IRFs, IPFs and LTCHs. While not specific to LTCHs, we believe this index would adequately reflect the input prices faced by LTCHs.

2. Productivity

Productivity measures the efficiency of the LTCH in producing outputs. It is the amount of real outputs, or real payments that can be produced from a given amount of real inputs or real costs. For LTCHs, these inputs are in the form of both labor and capital; thus, they represent multifactor productivity, as not just labor productivity is reflected. Equation 7 shows how multifactor productivity can be measured in terms of available data, such as payments, costs, and input prices:

$$\text{EQUATION 7: Productivity} = \frac{\text{Real Payments}}{\text{Real Costs}} = \frac{(\text{Payments/Output Price})}{(\text{Costs/Input Price})} = \frac{\text{Payments}}{\text{Costs}} * \frac{\text{Input Price}}{\text{Output Price}}$$

Rearranging the terms, this multifactor productivity equation (Equation 7) was used as the basis for incorporating an output price term in Equation 3. This equation is the basis for understanding the relationship between input prices, output prices, profit margins, and productivity.

Equation 6 shows that productivity is divided through the equation, offsetting other factors. The theory behind this offset is that if an efficient LTCH in a competitive market can produce more output with the same amount of inputs, the full increase in input costs does not have to be passed on by the provider to maintain a normal profit margin.

3. Real Case Mix Per Discharge

Real case mix per discharge is the average overall mix of care provided by the LTCH, as measured using the LTC–DRG classification

system. Over time, a measure of real case mix will change as care is given in more or less complex LTC–DRGs. Changes in the level of care within a LTC–DRG classification group would not be reflected in a case-mix measure based on LTC–DRGs, but instead should be captured in the intensity factor of Equation 6. The important distinction here is the difference between real and nominal case-mix. Under the LTCH prospective payment system, LTCHs will submit claims using the LTC–DRG classification system. The case-mix reflected by the claims is considered ''nominal''. However, the reported classification can reflect the true level of care provided or improper coding behavior. An example of improper coding behavior would be the upcoding, or case-mix ''creep,'' that took place when the acute care hospital IPPS was implemented. (For further details, see ProPAC's March 1, 1994 Report and Recommendations to Congress (pp. 73–74).) Any change in case-mix that is not associated with the actual level of care or a true change in the level of care provided must be excluded in order to determine real case-mix.

4. Case-Mix Constant Real Output Intensity Per Discharge

Intensity is the true underlying nature of the product or service and can take the form of output or input intensity, or both. In the case of LTCHs, output intensity per discharge is associated with real payment per discharge, while input intensity per discharge is associated with real cost per discharge. For example, input intensity would be associated with a nurse's hours when providing treatment, whereas output intensity would be associated with the type and number of treatments a nurse provides. The underlying nature of LTCH services is determined by factors such as technological capabilities, increased utilization of inputs (such as labor or drugs), site of care, and practice patterns. Because these factors can be difficult to measure, intensity per discharge is usually calculated as a residual after the other factors from Equation 6 were accounted for.

Accounting for output intensity associated with an efficient LTCH can be more accurately analyzed using a LTCH's costs rather than its payments. This analysis would also provide an alternative to developing or using a transaction output price index. Equation 8 shows how to use the definition of an output price as defined earlier to convert the equation for output intensity per discharge to reflect costs instead of payments, as used in Equation 6.

EQUATION 8: Case-Mix-Constant Real Output Intensity per Discharge

$$= \frac{[\text{Payments} / \text{Discharge}]}{\text{Output Prices}*\text{Real Case Mix/Discharge}}$$

$$= \frac{[\text{Payments/Discharge}]}{\left(\frac{\text{Payments}}{\text{Costs}} * \frac{\text{Input Prices}}{\text{Productivity}}\right)*\text{Real Case Mix/Discharge}}$$

$$= \frac{[\text{Payments/Discharge}]*\text{Costs}}{\text{Payments}*\frac{\text{Input Prices}}{\text{Productivity}}*\text{Real Case Mix/Discharge}}$$

$$= \frac{\text{Payments}*[\text{Costs/Discharge}]}{\text{Payments}*\frac{\text{Input Prices}}{\text{Productivity}}*\text{Real Case Mix/Discharge}}$$

$$= \frac{[\text{Costs/Discharge}]}{\frac{\text{Input Prices}}{\text{Productivity}}*\text{Real Case Mix/Discharge}}$$

$$= \frac{[\text{Costs/Discharge}]}{\text{Input Prices}*\text{Real Case Mix/Discharge}}*\text{Productivity}$$

The last equation in Equation 8 is identical to the term in brackets in Equation 5, case-mix constant real input intensity per discharge multiplied by productivity. Thus, output intensity per discharge can be defined in such a way that cost data from the LTCH are utilized. This equation can be broken down even further to account for different types of input intensity per discharge. We discuss this matter more fully in section D.

D. Applying the Factors That Affect LTCH Costs Per Discharge in an Update Framework

As discussed earlier, payments per discharge under the LTCH PPS have been updated annually since the LTCH PPS was implemented for cost-reporting periods beginning on or after October 1, 2002. Under this proposed rule, the standard Federal rate from the previous year would be updated by a factor of zero percent based on our analysis of LTCH margins and case-mix using the best available data. The development of an update framework with a sound conceptual basis provides the capability to understand the underlying trends in LTCH costs per discharge for an efficient provider.

Previously we identified factors inherent in LTCH costs per discharge. Changes in these factors determine the change in LTCH costs per discharge and fitting these factors into an appropriate framework would allow us to accurately reflect changes in the underlying costs for efficient LTCHs. The following explanation accounts for each of these factors from Equation 6 under the LTCH PPS:

- Change in case-mix constant real output intensity per discharge would be accounted for in the update framework, reflecting the factors that affect not only case-mix constant real input intensity per discharge, but also productivity, which is determined separately. Factors that can cause changes in case-mix constant real input intensity per discharge include, but are not limited to, changes in site of service, changes in within-LTC–DRG case-mix, changes in practice patterns, changes in the use of inputs, and changes in technology available.
- Changes in nominal case-mix are automatically included in the payment to the LTCH. Therefore, the update framework should include an adjustment to convert changes in nominal case-mix per discharge to changes in real case-mix per discharge, if they are different.
- Change in multifactor productivity would be accounted for in the update framework. The availability of historical data

on input prices, payments, and costs are useful in the analysis of this factor.

• Changes in input prices for labor, material, and capital would be accounted for in the update framework using an input price index, or market basket. To assist in updating payments for LTCH services, OACT currently has developed an input price index; this is currently the excluded hospital with capital market basket, and we are proposing to use the RPL market basket as discussed in section IV.B. of the preamble of this proposed rule.

• In an update framework, a forecast error adjustment would be included to reflect that the updates are set prospectively and a forecast error for a given year should not be perpetuated in payments for future years. In the case of the acute care hospital IPPS, this prospective adjustment is made on a 2-year lag and only if the error exceeds a defined threshold (0.25 percentage points).

E. Illustrative LTCH Prospective Payment System Update Framework for the 2007 LTCH PPS Rate Year

Table 27 shows an illustrative update framework for the LTCH PPS for RY 2007. Some of the factors in the LTCH framework are computed using Medicare cost report data, while others are determined based on policy considerations. This is consistent with the factors in the capital IPPS and SNF PPS update frameworks. This design for a LTCH update framework is for illustrative purposes only, as much more work needs to be done to determine the appropriate level of detail for each factor.

MedPAC supported this for updating payments and applied a similar framework when it proposed updates to hospital payments in its annual Report to Congress (MedPAC, 2000). The appropriateness of this framework for updating hospital payments was also discussed in the article, ''Are PPS Payments Adequate? Issues for Updating and Assessing Rates'' (*Health Care Financing Review*, Winter 1992). We believe a similar framework would be useful for analyzing updates to LTCH payments.

If we applied this update framework to determine the LTCH PPS standard Federal rate for RY 2007, the update factor for RY 2007 would be −0.5 percent. This estimate is based on the best available data at this time. The estimated update factor is based on a projected 3.6 percent increase in the proposed RPL market basket, a 0.0 adjustment for intensity, a −0.9 percent adjustment for productivity, a −4.0 percent adjustment for case-mix, and a forecast error correction of 0.8 percent. The following is a description of the policy adjustments that have been applied under the illustrative LTCH PPS update framework for RY 2007.

The case-mix index is the measure of the average DRG weight for cases paid under the LTCH PPS. 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 (''apparent'' case-mix index).

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.

As discussed in section IV.C.3. of the preamble of this proposed rule, for RY 2007, we are estimating a 6.75 percent nominal increase in the case-mix index. We estimate that the real case-mix increase would equal 2.75 percent in RY 2007. The net adjustment for change in case-mix is the difference between the projected increase in real case-mix and the projected nominal increase in real case-mix. Therefore, the estimated adjustment for case-mix change would be −4.0 percentage points (2.75 percent minus 6.75 percent).

The framework also contains an adjustment for forecast error. The market basket 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 increases in prices and the forecast used in calculating the update factors. There is a 2-year lag between the forecast and the measurement of the forecast error. A forecast error of 0.8 percentage points was calculated for the RY 2005 update. That is, current historical data indicate that the forecasted RY 2005 market basket (3.1 percent) understated the actual realized price increases (3.9 percent) by 0.8 percentage points. Therefore, a 0.8 percent adjustment would be appropriate to account for the forecast error under the illustrative LTCH PPS update framework for RY 2007.

Under this framework, we also make an adjustment for productivity, an efficiency measure. Productivity measures the ability of hospitals to reduce the quantity of inputs required to produce a unit of service while maintaining quality. MedPAC has recommended a productivity target based on the Bureau of Labor Statistics' estimate of the 10-year moving national average rate of productivity growth. The productivity target currently equals 0.9 percent. This target is lower than the productivity estimate calculated using the latest available LTCH cost report data. Therefore, under the illustrative LTCH PPS update framework for RY 2007, we would recommend a 0.9 percent adjustment for productivity.

We also make an adjustment for changes in intensity. The intensity factor reflects how hospital services are utilized to produce the final product, that is, the discharge. This component accounts for changes in these types of factors, such as the use of quality-enhancing services, for changes in within-DRG severity, and for expected modification of practice patterns to remove non-cost effective services. Based on the latest available LTCH data, we calculated a negative intensity factor. As we have done in the past under the IPPS, when we have found that case-mix consistent intensity is declining, we believe that it would be appropriate to apply a zero intensity adjustment under the illustrative LTCH PPS update framework for RY 2007 (August 1, 2000, 65 FR 47119).

Table 27 illustrates what a possible LTCH PPS update framework would be if we proposed to determine the annual update to the LTCH PPS Federal rate based on a framework model such as this for RY 2007. This conceptual model of a LTCH PPS update framework is for illustrative purposes only. As we discuss in greater detail in section IV.C.3. of the preamble of this proposed rule, we are proposing a 0 percent update to the LTCH PPS standard Federal rate for RY 2007.

TABLE 27.—ILLUSTRATIVE LTCH PPS UPDATE FRAMEWORK FOR RY 2007

Factors	Percent change
Price (+):	
Proposed RPL Market Basket	3.6
Forecast Error	0.8
Productivity (−)	0.9
Output Intensity (+)	0.0
Input Intensity Productivity	0.9
Case-mix Creep Adjustment (+)	−4.0
Nominal Case-Mix	−6.75
Real Case-Mix	2.75
Other factors (+)	0.0
Total	−0.5

F. Additional Conceptual and Data Issues

Additional conceptual issues specific to the LTCH PPS include the relevance of a site-of-service substitution adjustment, the necessity of an adjustment for LTC–DRG reclassification, the handling of one-time factors, and consistency with other types of hospital updates since LTCHs are similar in structure to these other types of hospitals.

Under the acute care hospital IPPS, a site-of-service substitution factor (captured as part of intensity) was necessary because of the incentive to shift care from inpatient hospital to other settings such as hospital outpatient departments, SNFs, or HHAs. For the LTCH PPS, it is not clear without additional research whether there is an incentive to shift care either into or out of the LTCH because of the changes in behavior created by the different Medicare payment systems.

A reclassification and recalibration adjustment under the acute care hospital IPPS is necessary to account for changes in the case-mix or the types of patients treated by hospitals resulting from the annual reclassification and recalibration of the DRGs. This adjustment for case-mix is applied to the current FY update, but reflects the effect of revisions in the FY that is 2 years before that fiscal year. Whether a LTC–DRG reclassification adjustment would be necessary in the update framework would depend on the data availability and the likelihood of revisions to LTC–DRG classifications on a periodic basis.

There is also a question about how to handle one-time factors (an example of these could be the increased costs of converting computer systems to Year 2000 compliance). An update framework might be an appropriate mechanism to account for these items, but because of uncertainty surrounding their impact on costs, determining an appropriate adjustment amount may be difficult.

LTCHs are heterogeneous and are designated as a separate payment category only because their patients have longer average lengths of stay. This raises the question of whether certain factors in an update framework for LTCHs should be consistent with the factors in an update framework for other types of hospitals since they face similar cost pressures. Additional research in this area would need to be conducted to determine the reasonableness of having consistent updates.

The purpose of this conceptual discussion is not to determine how the identified factors of the update framework would be measured. We recognize that there are significant measurement issues in accurately determining the factors that would account for growth in costs per discharge for efficiently providing care. This is driven, in part, by the shift from a cost-based payment system with an upper payment limit to a PPS. Significant research and data collection would be necessary to accurately measure these factors over the historical period. One example of this would be to measure the distinction between real and nominal case-mix change. However, many of these same concerns were also encountered and successfully addressed in the hospital IPPS update framework.

The discussion here provides the conceptual basis for developing an update framework for the LTCH PPS that reflects changes in the underlying costs of efficiently providing services. It is important to note that the framework would not handle distribution issues such as geographic wage variations. Due to some variations in technical methodologies for measuring the factors of an update framework, and because of some of the data concerns mentioned earlier, implementing an update framework for the LTCH PPS would involve making significant policy decisions on issues similar to those made for the hospital IPPS update framework. We invite comments on the type of data sources to use, what other factors (if any) we should consider in an update framework, and any additional comments concerning the issues discussed in this proposed rule regarding the update framework.

The following addendum will not appear in the Code of Federal Regulations.

Addendum

This addendum contains the tables referred to throughout the preamble to this proposed rule. The tables presented below are as follows:

Table 1: Proposed Long-Term Care Hospital Wage Index for Urban Areas for Discharges Occurring from July 1, 2006 through June 30, 2007.

Table 2: Proposed Long-Term Care Hospital Wage Index for Rural Areas for Discharges Occurring from July 1, 2006 through June 30, 2007.

Table 3: FY 2006 LTC-DRG Relative Weights and Geometric Mean Length of Stay for Discharges Occurring from October 1, 2005 through September 30, 2006. (Note: This is the same information provided in Table 11 of the FY 2006 IPPS final rule (August 12, 2005; 70 FR 47681 through 47690), which has been reprinted here for convenience.)

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2006 THROUGH JUNE 30, 2007 [1]

CBSA Code	Urban Area (Constituent Counties)	3/5 Wage Index [2]	4/5 Wage Index [3]	Full Wage Index [4]
10180	Abilene, TX.			
	Callahan County, TX.			
	Jones County, TX.			
	Taylor County, TX	0.8738	0.8317	0.7896
10380	Aguadilla-Isabela-San Sebastián, PR.			
	Aguada Municipio, PR.			
	Aguadilla Municipio, PR.			
	A±asco Municipio, PR.			
	Isabela Municipio, PR.			
	Lares Municipio, PR.			
	Moca Municipio, PR.			
	Rinón Municipio, PR.			
	San Sebastián Municipio, PR	0.6843	0.5790	0.4738
10420	Akron, OH.			
	Portage County, OH.			
	Summit County, OH	0.9389	0.9186	0.8982
10500	Albany, GA.			
	Baker County, GA.			
	Dougherty County, GA.			
	Lee County, GA.			
	Terrell County, GA.			
	Worth County, GA	0.9177	0.8902	0.8628
10580	Albany-Schenectady-Troy, NY.			
	Albany County, NY.			
	Rensselaer County, NY.			
	Saratoga County, NY.			
	Schenectady County, NY.			
	Schoharie County, NY	0.9153	0.8871	0.8589
10740	Albuquerque, NM.			
	Bernalillo County, NM.			
	Sandoval County, NM.			
	Torrance County, NM.			
	Valencia County, NM	0.9810	0.9747	0.9684
10780	Alexandria, LA.			
	Grant Parish, LA.			
	Rapides Parish, LA	0.8820	0.8426	0.8033
10900	Allentown-Bethlehem-Easton, PA-NJ.			
	Warren County, NJ.			
	Carbon County, PA.			

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2006 THROUGH JUNE 30, 2007 [1]—Continued

CBSA Code	Urban Area (Constituent Counties)	3/5 Wage Index [2]	4/5 Wage Index [3]	Full Wage Index [4]
	Lehigh County, PA.			
	Northampton County, PA	0.9891	0.9854	0.9818
11020	Altoona, PA.			
	Blair County, PA	0.9366	0.9155	0.8944
11100	Amarillo, TX.			
	Armstrong County, TX.			
	Carson County, TX.			
	Potter County, TX.			
	Randall County, TX	0.9494	0.9325	0.9156
11180	Ames, IA.			
	Story County, IA	0.9722	0.9629	0.9536
11260	Anchorage, AK.			
	Anchorage Municipality, AK.			
	Matanuska-Susitna Borough, AK	1.1137	1.1516	1.1895
11300	Anderson, IN.			
	Madison County, IN	0.9152	0.8869	0.8586
11340	Anderson, SC.			
	Anderson County, SC	0.9398	0.9198	0.8997
11460	Ann Arbor, MI.			
	Washtenaw County, MI	1.0515	1.0687	1.0859
11500	Anniston-Oxford, AL.			
	Calhoun County, AL	0.8609	0.8146	0.7682
11540	Appleton, WI.			
	Calumet County, WI.			
	Outagamie County, WI	0.9573	0.9430	0.9288
11700	Asheville, NC.			
	Buncombe County, NC.			
	Haywood County, NC.			
	Henderson County, NC.			
	Madison County, NC	0.9571	0.9428	0.9285
12020	Athens-Clarke County, GA.			
	Clarke County, GA.			
	Madison County, GA.			
	Oconee County, GA.			
	Oglethorpe County, GA	0.9913	0.9884	0.9855
12060	Atlanta-Sandy Springs-Marietta, GA.			
	Barrow County, GA.			
	Bartow County, GA.			
	Butts County, GA.			
	Carroll County, GA.			
	Cherokee County, GA.			
	Clayton County, GA.			
	Cobb County, GA.			
	Coweta County, GA.			
	Dawson County, GA.			
	DeKalb County, GA.			
	Douglas County, GA.			
	Fayette County, GA.			
	Forsyth County, GA.			
	Fulton County, GA.			
	Gwinnett County, GA.			
	Haralson County, GA.			
	Heard County, GA.			
	Henry County, GA.			
	Jasper County, GA.			
	Lamar County, GA.			
	Meriwether County, GA.			
	Newton County, GA.			
	Paulding County, GA.			
	Pickens County, GA.			
	Pike County, GA.			
	Rockdale County, GA.			
	Spalding County, GA.			
	Walton County, GA	0.9876	0.9834	0.9793
12100	Atlantic City, NJ.			
	Atlantic County, NJ	1.0969	1.1292	1.1615
12220	Auburn-Opelika, AL.			
	Lee County, AL	0.8860	0.8480	0.8100
12260	Augusta-Richmond County, GA-SC.			

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2006 THROUGH JUNE 30, 2007 [1]—Continued

CBSA Code	Urban Area (Constituent Counties)	3/5 Wage Index [2]	4/5 Wage Index [3]	Full Wage Index [4]
	Burke County, GA.			
	Columbia County, GA.			
	McDuffie County, GA.			
	Richmond County, GA.			
	Aiken County, SC.			
	Edgefield County, SC	0.9849	0.9798	0.9748
12420	Austin-Round Rock, TX.			
	Bastrop County, TX.			
	Caldwell County, TX.			
	Hays County, TX.			
	Travis County, TX.			
	Williamson County, TX	0.9662	0.9550	0.9437
12540	Bakersfield, CA.			
	Kern County, CA	1.0282	1.0376	1.0470
12580	Baltimore-Towson, MD.			
	Anne Arundel County, MD.			
	Baltimore County, MD.			
	Carroll County, MD.			
	Harford County, MD.			
	Howard County, MD.			
	Queen Anne's County, MD.			
	Baltimore City, MD	0.9938	0.9918	0.9897
12620	Bangor, ME.			
	Penobscot County, ME	0.9996	0.9994	0.9993
12700	Barnstable Town, MA.			
	Barnstable County, MA	1.1560	1.2080	1.2600
12940	Baton Rouge, LA.			
	Ascension Parish, LA.			
	East Baton Rouge Parish, LA.			
	East Feliciana Parish, LA.			
	Iberville Parish, LA.			
	Livingston Parish, LA.			
	Pointe Coupee Parish, LA.			
	St. Helena Parish, LA.			
	West Baton Rouge Parish, LA.			
	West Feliciana Parish, LA	0.9156	0.8874	0.8593
12980	Battle Creek, MI.			
	Calhoun County, MI	0.9705	0.9606	0.9508
13020	Bay City, MI.			
	Bay County, MI	0.9606	0.9474	0.9343
13140	Beaumont-Port Arthur, TX.			
	Hardin County, TX.			
	Jefferson County, TX.			
	Orange County, TX	0.9047	0.8730	0.8412
13380	Bellingham, WA.			
	Whatcom County, WA	1.1039	1.1385	1.1731
13460	Bend, OR.			
	Deschutes County, OR	1.0472	1.0629	1.0786
13644	Bethesda-Gaithersburg-Frederick, MD.			
	Frederick County, MD.			
	Montgomery County, MD	1.0890	1.1186	1.1483
13740	Billings, MT.			
	Carbon County, MT.			
	Yellowstone County, MT	0.9300	0.9067	0.8834
13780	Binghamton, NY.			
	Broome County, NY.			
	Tioga County, NY	0.9137	0.8850	0.8562
13820	Birmingham-Hoover, AL.			
	Bibb County, AL.			
	Blount County, AL.			
	Chilton County, AL.			
	Jefferson County, AL.			
	St. Clair County, AL.			
	Shelby County, AL.			
	Walker County, AL	0.9375	0.9167	0.8959
13900	Bismarck, ND.			
	Burleigh County, ND.			
	Morton County, ND	0.8544	0.8059	0.7574
13980	Blacksburg-Christiansburg-Radford, VA.			

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2006 THROUGH JUNE 30, 2007 [1]—Continued

CBSA Code	Urban Area (Constituent Counties)	3/5 Wage Index [2]	4/5 Wage Index [3]	Full Wage Index [4]
	Giles County, VA.			
	Montgomery County, VA.			
	Pulaski County, VA.			
	Radford City, VA	0.8772	0.8363	0.7954
14020	Bloomington, IN.			
	Greene County, IN.			
	Monroe County, IN.			
	Owen County, IN	0.9068	0.8758	0.8447
14060	Bloomington-Normal, IL.			
	McLean County, IL	0.9445	0.9260	0.9075
14260	Boise City-Nampa, ID.			
	Ada County, ID.			
	Boise County, ID.			
	Canyon County, ID.			
	Gem County, ID.			
	Owyhee County, ID	0.9431	0.9242	0.9052
14484	Boston-Quincy, MA.			
	Norfolk County, MA.			
	Plymouth County, MA.			
	Suffolk County, MA	1.0935	1.1246	1.1558
14500	Boulder, CO.			
	Boulder County, CO	0.9840	0.9787	0.9734
14540	Bowling Green, KY.			
	Edmonson County, KY.			
	Warren County, KY	0.8927	0.8569	0.8211
14740	Bremerton-Silverdale, WA.			
	Kitsap County, WA	1.0405	1.0540	1.0675
14860	Bridgeport-Stamford-Norwalk, CT.			
	Fairfield County, CT	1.1555	1.2074	1.2592
15180	Brownsville-Harlingen, TX.			
	Cameron County, TX	0.9882	0.9843	0.9804
15260	Brunswick, GA.			
	Brantley County, GA.			
	Glynn County, GA.			
	McIntosh County, GA	0.9587	0.9449	0.9311
15380	Buffalo-Niagara Falls, NY.			
	Erie County, NY.			
	Niagara County, NY	0.9707	0.9609	0.9511
15500	Burlington, NC.			
	Alamance County, NC	0.9343	0.9124	0.8905
15540	Burlington-South Burlington, VT.			
	Chittenden County, VT.			
	Franklin County, VT.			
	Grand Isle County, VT	0.9646	0.9528	0.9410
15764	Cambridge-Newton-Framingham, MA.			
	Middlesex County, MA	1.0703	1.0938	1.1172
15804	Camden, NJ.			
	Burlington County, NJ.			
	Camden County, NJ.			
	Gloucester County, NJ	1.0310	1.0414	1.0517
15940	Canton-Massillon, OH.			
	Carroll County, OH.			
	Stark County, OH	0.9361	0.9148	0.8935
15980	Cape Coral-Fort Myers, FL.			
	Lee County, FL	0.9614	0.9485	0.9356
16180	Carson City, NV.			
	Carson City, NV	1.0140	1.0187	1.0234
16220	Casper, WY.			
	Natrona County, WY	0.9416	0.9221	0.9026
16300	Cedar Rapids, IA.			
	Benton County, IA.			
	Jones County, IA.			
	Linn County, IA	0.9295	0.9060	0.8825
16580	Champaign-Urbana, IL.			
	Champaign County, IL.			
	Ford County, IL.			
	Piatt County, IL	0.9756	0.9675	0.9594
16620	Charleston, WV.			
	Boone County, WV.			

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2006 THROUGH JUNE 30, 2007 [1]—Continued

CBSA Code	Urban Area (Constituent Counties)	3/5 Wage Index [2]	4/5 Wage Index [3]	Full Wage Index [4]
	Clay County, WV.			
	Kanawha County, WV.			
	Lincoln County, WV.			
	Putnam County, WV	0.9067	0.8756	0.8445
16700	Charleston-North Charleston, SC.			
	Berkeley County, SC.			
	Charleston County, SC.			
	Dorchester County, SC	0.9547	0.9396	0.9245
16740	Charlotte-Gastonia-Concord, NC-SC.			
	Anson County, NC.			
	Cabarrus County, NC.			
	Gaston County, NC.			
	Mecklenburg County, NC.			
	Union County, NC.			
	York County, SC	0.9850	0.9800	0.9750
16820	Charlottesville, VA.			
	Albemarle County, VA.			
	Fluvanna County, VA.			
	Greene County, VA.			
	Nelson County, VA.			
	Charlottesville City, VA	1.0112	1.0150	1.0187
16860	Chattanooga, TN-GA.			
	Catoosa County, GA.			
	Dade County, GA.			
	Walker County, GA.			
	Hamilton County, TN.			
	Marion County, TN.			
	Sequatchie County, TN	0.9453	0.9270	0.9088
16940	Cheyenne, WY.			
	Laramie County, WY	0.9265	0.9020	0.8775
16974	Chicago-Naperville-Joliet, IL.			
	Cook County, IL.			
	DeKalb County, IL.			
	DuPage County, IL.			
	Grundy County, IL.			
	Kane County, IL.			
	Kendall County, IL.			
	McHenry County, IL.			
	Will County, IL	1.0474	1.0632	1.0790
17020	Chico, CA.			
	Butte County, CA	1.0307	1.0409	1.0511
17140	Cincinnati-Middletown, OH-KY-IN.			
	Dearborn County, IN.			
	Franklin County, IN.			
	Ohio County, IN.			
	Boone County, KY.			
	Bracken County, KY.			
	Campbell County, KY.			
	Gallatin County, KY.			
	Grant County, KY.			
	Kenton County, KY.			
	Pendleton County, KY.			
	Brown County, OH.			
	Butler County, OH.			
	Clermont County, OH.			
	Hamilton County, OH.			
	Warren County, OH	0.9769	0.9692	0.9615
17300	Clarksville, TN-KY.			
	Christian County, KY.			
	Trigg County, KY.			
	Montgomery County, TN.			
	Stewart County, TN	0.8970	0.8627	0.8284
17420	Cleveland, TN.			
	Bradley County, TN.			
	Polk County, TN	0.8883	0.8511	0.8139
17460	Cleveland-Elyria-Mentor, OH.			
	Cuyahoga County, OH.			
	Geauga County, OH.			
	Lake County, OH.			

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2006 THROUGH JUNE 30, 2007 [1]—Continued

CBSA Code	Urban Area (Constituent Counties)	3/5 Wage Index [2]	4/5 Wage Index [3]	Full Wage Index [4]
	Lorain County, OH.			
	Medina County, OH	0.9528	0.9370	0.9213
17660	Coeur d'Alene, ID.			
	Kootenai County, ID	0.9788	0.9718	0.9647
17780	College Station-Bryan, TX.			
	Brazos County, TX.			
	Burleson County, TX.			
	Robertson County, TX	0.9340	0.9120	0.8900
17820	Colorado Springs, CO.			
	El Paso County, CO.			
	Teller County, CO	0.9681	0.9574	0.9468
17860	Columbia, MO.			
	Boone County, MO.			
	Howard County, MO	0.9007	0.8676	0.8345
17900	Columbia, SC.			
	Calhoun County, SC.			
	Fairfield County, SC.			
	Kershaw County, SC.			
	Lexington County, SC.			
	Richland County, SC.			
	Saluda County, SC	0.9434	0.9246	0.9057
17980	Columbus, GA-AL.			
	Russell County, AL.			
	Chattahoochee County, GA.			
	Harris County, GA.			
	Marion County, GA.			
	Muscogee County, GA	0.9136	0.8848	0.8560
18020	Columbus, IN.			
	Bartholomew County, IN	0.9753	0.9670	0.9588
18140	Columbus, OH.			
	Delaware County, OH.			
	Fairfield County, OH.			
	Franklin County, OH.			
	Licking County, OH.			
	Madison County, OH.			
	Morrow County, OH.			
	Pickaway County, OH.			
	Union County, OH	0.9916	0.9888	0.9860
18580	Corpus Christi, TX.			
	Aransas County, TX.			
	Nueces County, TX.			
	San Patricio County, TX	0.9130	0.8840	0.8550
18700	Corvallis, OR.			
	Benton County, OR	1.0437	1.0583	1.0729
19060	Cumberland, MD-WV.			
	Allegany County, MD.			
	Mineral County, WV	0.9590	0.9454	0.9317
19124	Dallas-Plano-Irving, TX.			
	Collin County, TX.			
	Dallas County, TX.			
	Delta County, TX.			
	Denton County, TX.			
	Ellis County, TX.			
	Hunt County, TX.			
	Kaufman County, TX.			
	Rockwall County, TX	1.0137	1.0182	1.0228
19140	Dalton, GA.			
	Murray County, GA.			
	Whitfield County, GA	0.9447	0.9263	0.9079
19180	Danville, IL.			
	Vermilion County, IL	0.9417	0.9222	0.9028
19260	Danville, VA.			
	Pittsylvania County, VA.			
	Danville City, VA	0.9093	0.8791	0.8489
19340	Davenport-Moline-Rock Island, IA-IL.			
	Henry County, IL.			
	Mercer County, IL.			
	Rock Island County, IL.			
	Scott County, IA	0.9234	0.8979	0.8724

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2006 THROUGH JUNE 30, 2007 [1]—Continued

CBSA Code	Urban Area (Constituent Counties)	3/5 Wage Index [2]	4/5 Wage Index [3]	Full Wage Index [4]
19380	Dayton, OH.			
	Greene County, OH.			
	Miami County, OH.			
	Montgomery County, OH.			
	Preble County, OH	0.9438	0.9251	0.9064
19460	Decatur, AL.			
	Lawrence County, AL.			
	Morgan County, AL	0.9081	0.8775	0.8469
19500	Decatur, IL.			
	Macon County, IL	0.8840	0.8454	0.8067
19660	Deltona-Daytona Beach-Ormond Beach, FL.			
	Volusia County, FL	0.9579	0.9439	0.9299
19740	Denver-Aurora, CO.			
	Adams County, CO.			
	Arapahoe County, CO.			
	Broomfield County, CO.			
	Clear Creek County, CO.			
	Denver County, CO.			
	Douglas County, CO.			
	Elbert County, CO.			
	Gilpin County, CO.			
	Jefferson County, CO.			
	Park County, CO	1.0434	1.0578	1.0723
19780	Des Moines-West Des Moines, IA.			
	Dallas County, IA.			
	Guthrie County, IA.			
	Madison County, IA.			
	Polk County, IA.			
	Warren County, IA	0.9801	0.9735	0.9669
19804	Detroit-Livonia-Dearborn, MI.			
	Wayne County, MI	1.0254	1.0339	1.0424
20020	Dothan, AL.			
	Geneva County, AL.			
	Henry County, AL.			
	Houston County, AL	0.8633	0.8177	0.7721
20100	Dover, DE.			
	Kent County, DE	0.9866	0.9821	0.9776
20220	Dubuque, IA.			
	Dubuque County, IA	0.9414	0.9219	0.9024
20260	Duluth, MN-WI.			
	Carlton County, MN.			
	St. Louis County, MN.			
	Douglas County, WI	1.0128	1.0170	1.0213
20500	Durham, NC.			
	Chatham County, NC.			
	Durham County, NC.			
	Orange County, NC.			
	Person County, NC	1.0146	1.0195	1.0244
20740	Eau Claire, WI.			
	Chippewa County, WI.			
	Eau Claire County, WI	0.9521	0.9361	0.9201
20764	Edison, NJ.			
	Middlesex County, NJ.			
	Monmouth County, NJ.			
	Ocean County, NJ.			
	Somerset County, NJ	1.0749	1.0999	1.1249
20940	El Centro, CA.			
	Imperial County, CA	0.9344	0.9125	0.8906
21060	Elizabethtown, KY.			
	Hardin County, KY.			
	Larue County, KY	0.9281	0.9042	0.8802
21140	Elkhart-Goshen, IN.			
	Elkhart County, IN	0.9776	0.9702	0.9627
21300	Elmira, NY.			
	Chemung County, NY	0.8950	0.8600	0.8250
21340	El Paso, TX.			
	El Paso County, TX	0.9386	0.9182	0.8977
21500	Erie, PA.			
	Erie County, PA	0.9242	0.8990	0.8737

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2006 THROUGH JUNE 30, 2007 [1]—Continued

CBSA Code	Urban Area (Constituent Counties)	3/5 Wage Index [2]	4/5 Wage Index [3]	Full Wage Index [4]
21604	Essex County, MA.			
	Essex County, MA	1.0323	1.0430	1.0538
21660	Eugene-Springfield, OR.			
	Lane County, OR	1.0491	1.0654	1.0818
21780	Evansville, IN-KY.			
	Gibson County, IN.			
	Posey County, IN.			
	Vanderburgh County, IN.			
	Warrick County, IN.			
	Henderson County, KY.			
	Webster County, KY	0.9228	0.8970	0.8713
21820	Fairbanks, AK.			
	Fairbanks North Star Borough, AK	1.0845	1.1126	1.1408
21940	Fajardo, PR.			
	Ceiba Municipio, PR.			
	Fajardo Municipio, PR.			
	Luquillo Municipio, PR	0.6492	0.5322	0.4153
22020	Fargo, ND-MN.			
	Cass County, ND.			
	Clay County, MN	0.9092	0.8789	0.8486
22140	Farmington, NM.			
	San Juan County, NM	0.9105	0.8807	0.8509
22180	Fayetteville, NC.			
	Cumberland County, NC.			
	Hoke County, NC	0.9650	0.9533	0.9416
22220	Fayetteville-Springdale-Rogers, AR-MO.			
	Benton County, AR.			
	Madison County, AR.			
	Washington County, AR.			
	McDonald County, MO	0.9197	0.8929	0.8661
22380	Flagstaff, AZ.			
	Coconino County, AZ	1.1255	1.1674	1.2092
22420	Flint, MI.			
	Genesee County, MI	1.0393	1.0524	1.0655
22500	Florence, SC.			
	Darlington County, SC.			
	Florence County, SC	0.9368	0.9158	0.8947
22520	Florence-Muscle Shoals, AL.			
	Colbert County, AL.			
	Lauderdale County, AL	0.8963	0.8618	0.8272
22540	Fond du Lac, WI.			
	Fond du Lac County, WI	0.9784	0.9712	0.9640
22660	Fort Collins-Loveland, CO.			
	Larimer County, CO	1.0073	1.0098	1.0122
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL.			
	Broward County, FL	1.0259	1.0346	1.0432
22900	Fort Smith, AR-OK.			
	Crawford County, AR.			
	Franklin County, AR.			
	Sebastian County, AR.			
	Le Flore County, OK.			
	Sequoyah County, OK	0.8938	0.8584	0.8230
23020	Fort Walton Beach-Crestview-Destin, FL.			
	Okaloosa County, FL	0.9323	0.9098	0.8872
23060	Fort Wayne, IN.			
	Allen County, IN.			
	Wells County, IN.			
	Whitley County, IN	0.9876	0.9834	0.9793
23104	Fort Worth-Arlington, TX.			
	Johnson County, TX.			
	Parker County, TX.			
	Tarrant County, TX.			
	Wise County, TX	0.9692	0.9589	0.9486
23420	Fresno, CA.			
	Fresno County, CA	1.0323	1.0430	1.0538
23460	Gadsden, AL.			
	Etowah County, AL	0.8763	0.8350	0.7938
23540	Gainesville, FL.			
	Alachua County, FL.			

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2006 THROUGH JUNE 30, 2007 [1]—Continued

CBSA Code	Urban Area (Constituent Counties)	3/5 Wage Index [2]	4/5 Wage Index [3]	Full Wage Index [4]
	Gilchrist County, FL	0.9633	0.9510	0.9388
23580	Gainesville, GA.			
	Hall County, GA	0.9324	0.9099	0.8874
23844	Gary, IN.			
	Jasper County, IN.			
	Lake County, IN.			
	Newton County, IN.			
	Porter County, IN	0.9637	0.9516	0.9395
24020	Glens Falls, NY.			
	Warren County, NY.			
	Washington County, NY	0.9135	0.8847	0.8559
24140	Goldsboro, NC.			
	Wayne County, NC	0.9265	0.9020	0.8775
24220	Grand Forks, ND-MN.			
	Polk County, MN.			
	Grand Forks County, ND	0.8741	0.8321	0.7901
24300	Grand Junction, CO.			
	Mesa County, CO	0.9730	0.9640	0.9550
24340	Grand Rapids-Wyoming, MI.			
	Barry County, MI.			
	Ionia County, MI.			
	Kent County, MI.			
	Newaygo County, MI	0.9634	0.9512	0.9390
24500	Great Falls, MT.			
	Cascade County, MT	0.9431	0.9242	0.9052
24540	Greeley, CO.			
	Weld County, CO	0.9742	0.9656	0.9570
24580	Green Bay, WI.			
	Brown County, WI.			
	Kewaunee County, WI.			
	Oconto County, WI	0.9690	0.9586	0.9483
24660	Greensboro-High Point, NC.			
	Guilford County, NC.			
	Randolph County, NC.			
	Rockingham County, NC	0.9462	0.9283	0.9104
24780	Greenville, NC.			
	Greene County, NC.			
	Pitt County, NC	0.9655	0.9540	0.9425
24860	Greenville, SC.			
	Greenville County, SC.			
	Laurens County, SC.			
	Pickens County, SC	1.0016	1.0022	1.0027
25020	Guayama, PR.			
	Arroyo Municipio, PR.			
	Guayama Municipio, PR.			
	Patillas Municipio, PR	0.5909	0.4545	0.3181
25060	Gulfport-Biloxi, MS.			
	Hancock County, MS.			
	Harrison County, MS.			
	Stone County, MS	0.9357	0.9143	0.8929
25180	Hagerstown-Martinsburg, MD-WV.			
	Washington County, MD.			
	Berkeley County, WV.			
	Morgan County, WV	0.9693	0.9591	0.9489
25260	Hanford-Corcoran, CA.			
	Kings County, CA	1.0022	1.0029	1.0036
25420	Harrisburg-Carlisle, PA.			
	Cumberland County, PA.			
	Dauphin County, PA.			
	Perry County, PA	0.9588	0.9450	0.9313
25500	Harrisonburg, VA.			
	Rockingham County, VA.			
	Harrisonburg City, VA	0.9453	0.9270	0.9088
25540	Hartford-West Hartford-East Hartford, CT.			
	Hartford County, CT.			
	Litchfield County, CT.			
	Middlesex County, CT.			
	Tolland County, CT	1.0644	1.0858	1.1073
25620	Hattiesburg, MS.			

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2006 THROUGH JUNE 30, 2007 [1]—Continued

CBSA Code	Urban Area (Constituent Counties)	3/5 Wage Index [2]	4/5 Wage Index [3]	Full Wage Index [4]
	Forrest County, MS.			
	Lamar County, MS.			
	Perry County, MS	0.8561	0.8081	0.7601
25860	Hickory-Lenoir-Morganton, NC.			
	Alexander County, NC.			
	Burke County, NC.			
	Caldwell County, NC.			
	Catawba County, NC	0.9353	0.9137	0.8921
25980	Hinesville-Fort Stewart, GA.			
	Liberty County, GA.			
	Long County, GA	0.8597	0.8130	0.7662
26100	Holland-Grand Haven, MI.			
	Ottawa County, MI	0.9433	0.9244	0.9055
26180	Honolulu, HI.			
	Honolulu County, HI	1.0728	1.0971	1.1214
26300	Hot Springs, AR.			
	Garland County, AR	0.9403	0.9204	0.9005
26380	Houma-Bayou Cane-Thibodaux, LA.			
	Lafourche Parish, LA.			
	Terrebonne Parish, LA	0.8736	0.8315	0.7894
26420	Houston-Sugar Land-Baytown, TX.			
	Austin County, TX.			
	Brazoria County, TX.			
	Chambers County, TX.			
	Fort Bend County, TX.			
	Galveston County, TX.			
	Harris County, TX.			
	Liberty County, TX.			
	Montgomery County, TX.			
	San Jacinto County, TX.			
	Waller County, TX	0.9998	0.9997	0.9996
26580	Huntington-Ashland, WV-KY-OH.			
	Boyd County, KY.			
	Greenup County, KY.			
	Lawrence County, OH.			
	Cabell County, WV.			
	Wayne County, WV	0.9686	0.9582	0.9477
26620	Huntsville, AL.			
	Limestone County, AL.			
	Madison County, AL	0.9488	0.9317	0.9146
26820	Idaho Falls, ID.			
	Bonneville County, ID.			
	Jefferson County, ID	0.9652	0.9536	0.9420
26900	Indianapolis-Carmel, IN.			
	Boone County, IN.			
	Brown County, IN.			
	Hamilton County, IN.			
	Hancock County, IN.			
	Hendricks County, IN.			
	Johnson County, IN.			
	Marion County, IN.			
	Morgan County, IN.			
	Putnam County, IN.			
	Shelby County, IN	0.9952	0.9936	0.9920
26980	Iowa City, IA.			
	Johnson County, IA.			
	Washington County, IA	0.9848	0.9798	0.9747
27060	Ithaca, NY.			
	Tompkins County, NY	0.9876	0.9834	0.9793
27100	Jackson, MI.			
	Jackson County, MI	0.9582	0.9443	0.9304
27140	Jackson, MS.			
	Copiah County, MS.			
	Hinds County, MS.			
	Madison County, MS.			
	Rankin County, MS.			
	Simpson County, MS	0.8987	0.8649	0.8311
27180	Jackson, TN.			
	Chester County, TN.			

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2006 THROUGH JUNE 30, 2007 [1]—Continued

CBSA Code	Urban Area (Constituent Counties)	3/5 Wage Index [2]	4/5 Wage Index [3]	Full Wage Index [4]
	Madison County, TN	0.9378	0.9171	0.8964
27260	Jacksonville, FL.			
	Baker County, FL.			
	Clay County, FL.			
	Duval County, FL.			
	Nassau County, FL.			
	St. Johns County, FL	0.9574	0.9432	0.9290
27340	Jacksonville, NC.			
	Onslow County, NC	0.8942	0.8589	0.8236
27500	Janesville, WI.			
	Rock County, WI	0.9723	0.9630	0.9538
27620	Jefferson City, MO.			
	Callaway County, MO.			
	Cole County, MO.			
	Moniteau County, MO.			
	Osage County, MO	0.9032	0.8710	0.8387
27740	Johnson City, TN.			
	Carter County, TN.			
	Unicoi County, TN.			
	Washington County, TN	0.8762	0.8350	0.7937
27780	Johnstown, PA.			
	Cambria County, PA	0.9012	0.8683	0.8354
27860	Jonesboro, AR.			
	Craighead County, AR.			
	Poinsett County, AR	0.8747	0.8329	0.7911
27900	Joplin, MO.			
	Jasper County, MO.			
	Newton County, MO	0.9149	0.8866	0.8582
28020	Kalamazoo-Portage, MI.			
	Kalamazoo County, MI.			
	Van Buren County, MI	1.0229	1.0305	1.0381
28100	Kankakee-Bradley, IL.			
	Kankakee County, IL	1.0433	1.0577	1.0721
28140	Kansas City, MO-KS.			
	Franklin County, KS.			
	Johnson County, KS.			
	Leavenworth County, KS.			
	Linn County, KS.			
	Miami County, KS.			
	Wyandotte County, KS.			
	Bates County, MO.			
	Caldwell County, MO.			
	Cass County, MO.			
	Clay County, MO.			
	Clinton County, MO.			
	Jackson County, MO.			
	Lafayette County, MO.			
	Platte County, MO.			
	Ray County, MO	0.9686	0.9581	0.9476
28420	Kennewick-Richland-Pasco, WA.			
	Benton County, WA.			
	Franklin County, WA	1.0371	1.0495	1.0619
28660	Killeen-Temple-Fort Hood, TX.			
	Bell County, TX.			
	Coryell County, TX.			
	Lampasas County, TX	0.9116	0.8821	0.8526
28700	Kingsport-Bristol-Bristol, TN-VA.			
	Hawkins County, TN.			
	Sullivan County, TN.			
	Bristol City, VA.			
	Scott County, VA.			
	Washington County, VA	0.8832	0.8443	0.8054
28740	Kingston, NY.			
	Ulster County, NY	0.9553	0.9404	0.9255
28940	Knoxville, TN.			
	Anderson County, TN.			
	Blount County, TN.			
	Knox County, TN.			
	Loudon County, TN.			

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2006 THROUGH JUNE 30, 2007 [1]—Continued

CBSA Code	Urban Area (Constituent Counties)	3/5 Wage Index [2]	4/5 Wage Index [3]	Full Wage Index [4]
	Union County, TN	0.9065	0.8753	0.8441
29020	Kokomo, IN.			
	Howard County, IN.			
	Tipton County, IN	0.9705	0.9606	0.9508
29100	La Crosse, WI-MN.			
	Houston County, MN.			
	La Crosse County, WI	0.9738	0.9651	0.9564
29140	Lafayette, IN.			
	Benton County, IN.			
	Carroll County, IN.			
	Tippecanoe County, IN	0.9242	0.8989	0.8736
29180	Lafayette, LA.			
	Lafayette Parish, LA.			
	St. Martin Parish, LA	0.9057	0.8742	0.8428
29340	Lake Charles, LA.			
	Calcasieu Parish, LA.			
	Cameron Parish, LA	0.8700	0.8266	0.7833
29404	Lake County-Kenosha County, IL-WI.			
	Lake County, IL.			
	Kenosha County, WI	1.0257	1.0343	1.0429
29460	Lakeland, FL.			
	Polk County, FL	0.9347	0.9130	0.8912
29540	Lancaster, PA.			
	Lancaster County, PA	0.9816	0.9755	0.9694
29620	Lansing-East Lansing, MI.			
	Clinton County, MI.			
	Eaton County, MI.			
	Ingham County, MI	0.9876	0.9835	0.9794
29700	Laredo, TX.			
	Webb County, TX	0.8841	0.8454	0.8068
29740	Las Cruces, NM.			
	Dona Ana County, NM	0.9080	0.8774	0.8467
29820	Las Vegas-Paradise, NV.			
	Clark County, NV	1.0862	1.1150	1.1437
29940	Lawrence, KS.			
	Douglas County, KS	0.9122	0.8830	0.8537
30020	Lawton, OK.			
	Comanche County, OK	0.8723	0.8298	0.7872
30140	Lebanon, PA.			
	Lebanon County, PA	0.9075	0.8767	0.8459
30300	Lewiston, ID-WA.			
	Nez Perce County, ID.			
	Asotin County, WA	0.9932	0.9909	0.9886
30340	Lewiston-Auburn, ME.			
	Androscoggin County, ME	0.9599	0.9465	0.9331
30460	Lexington-Fayette, KY.			
	Bourbon County, KY.			
	Clark County, KY.			
	Fayette County, KY.			
	Jessamine County, KY.			
	Scott County, KY.			
	Woodford County, KY	0.9445	0.9260	0.9075
30620	Lima, OH.			
	Allen County, OH	0.9535	0.9380	0.9225
30700	Lincoln, NE.			
	Lancaster County, NE.			
	Seward County, NE	1.0128	1.0171	1.0214
30780	Little Rock-North Little Rock, AR.			
	Faulkner County, AR.			
	Grant County, AR.			
	Lonoke County, AR.			
	Perry County, AR.			
	Pulaski County, AR.			
	Saline County, AR	0.9248	0.8998	0.8747
30860	Logan, UT-ID.			
	Franklin County, ID.			
	Cache County, UT	0.9498	0.9331	0.9164
30980	Longview, TX.			
	Gregg County, TX.			

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2006 THROUGH JUNE 30, 2007 [1]—Continued

CBSA Code	Urban Area (Constituent Counties)	3/5 Wage Index [2]	4/5 Wage Index [3]	Full Wage Index [4]
	Rusk County, TX.			
	Upshur County, TX	0.9238	0.8984	0.8730
31020	Longview, WA.			
	Cowlitz County, WA	0.9747	0.9663	0.9579
31084	Los Angeles-Long Beach-Glendale, CA.			
	Los Angeles County, CA	1.1070	1.1426	1.1783
31140	Louisville-Jefferson County, KY-IN.			
	Clark County, IN.			
	Floyd County, IN.			
	Harrison County, IN.			
	Washington County, IN.			
	Bullitt County, KY.			
	Henry County, KY.			
	Jefferson County, KY.			
	Meade County, KY.			
	Nelson County, KY.			
	Oldham County, KY.			
	Shelby County, KY.			
	Spencer County, KY.			
	Trimble County, KY	0.9551	0.9401	0.9251
31180	Lubbock, TX.			
	Crosby County, TX.			
	Lubbock County, TX	0.9270	0.9026	0.8783
31340	Lynchburg, VA.			
	Amherst County, VA.			
	Appomattox County, VA.			
	Bedford County, VA.			
	Campbell County, VA.			
	Bedford City, VA.			
	Lynchburg City, VA	0.9215	0.8953	0.8691
31420	Macon, GA.			
	Bibb County, GA.			
	Crawford County, GA.			
	Jones County, GA.			
	Monroe County, GA.			
	Twiggs County, GA	0.9666	0.9554	0.9443
31460	Madera, CA.			
	Madera County, CA	0.9228	0.8970	0.8713
31540	Madison, WI.			
	Columbia County, WI.			
	Dane County, WI.			
	Iowa County, WI	1.0395	1.0527	1.0659
31700	Manchester-Nashua, NH.			
	Hillsborough County, NH.			
	Merrimack County, NH	1.0212	1.0283	1.0354
31900	Mansfield, OH.			
	Richland County, OH	0.9935	0.9913	0.9891
32420	Mayagüez, PR.			
	Hormigueros Municipio, PR.			
	Mayagüez Municipio, PR	0.6412	0.5216	0.4020
32580	McAllen-Edinburg-Mission, TX.			
	Hidalgo County, TX	0.9360	0.9147	0.8934
32780	Medford, OR.			
	Jackson County, OR	1.0135	1.0180	1.0225
32820	Memphis, TN-MS-AR.			
	Crittenden County, AR.			
	DeSoto County, MS.			
	Marshall County, MS.			
	Tate County, MS.			
	Tunica County, MS.			
	Fayette County, TN.			
	Shelby County, TN.			
	Tipton County, TN	0.9638	0.9518	0.9397
32900	Merced, CA.			
	Merced County, CA	1.0665	1.0887	1.1109
33124	Miami-Miami Beach-Kendall, FL.			
	Miami-Dade County, FL	0.9850	0.9800	0.9750
33140	Michigan City-La Porte, IN.			
	LaPorte County, IN	0.9639	0.9519	0.9399

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2006 THROUGH JUNE 30, 2007 [1]—Continued

CBSA Code	Urban Area (Constituent Counties)	3/5 Wage Index [2]	4/5 Wage Index [3]	Full Wage Index [4]
33260	Midland, TX.			
	Midland County, TX	0.9708	0.9611	0.9514
33340	Milwaukee-Waukesha-West Allis, WI.			
	Milwaukee County, WI.			
	Ozaukee County, WI.			
	Washington County, WI.			
	Waukesha County, WI	1.0088	1.0117	1.0146
33460	Minneapolis-St. Paul-Bloomington, MN-WI.			
	Anoka County, MN.			
	Carver County, MN.			
	Chisago County, MN.			
	Dakota County, MN.			
	Hennepin County, MN.			
	Isanti County, MN.			
	Ramsey County, MN.			
	Scott County, MN.			
	Sherburne County, MN.			
	Washington County, MN.			
	Wright County, MN.			
	Pierce County, WI.			
	St. Croix County, WI	1.0645	1.0860	1.1075
33540	Missoula, MT.			
	Missoula County, MT	0.9684	0.9578	0.9473
33660	Mobile, AL.			
	Mobile County, AL	0.8735	0.8313	0.7891
33700	Modesto, CA.			
	Stanislaus County, CA	1.1131	1.1508	1.1885
33740	Monroe, LA.			
	Ouachita Parish, LA.			
	Union Parish, LA	0.8819	0.8425	0.8031
33780	Monroe, MI.			
	Monroe County, MI	0.9681	0.9574	0.9468
33860	Montgomery, AL.			
	Autauga County, AL.			
	Elmore County, AL.			
	Lowndes County, AL.			
	Montgomery County, AL	0.9171	0.8894	0.8618
34060	Morgantown, WV.			
	Monongalia County, WV.			
	Preston County, WV	0.9052	0.8736	0.8420
34100	Morristown, TN.			
	Grainger County, TN.			
	Hamblen County, TN.			
	Jefferson County, TN	0.8777	0.8369	0.7961
34580	Mount Vernon-Anacortes, WA.			
	Skagit County, WA	1.0272	1.0363	1.0454
34620	Muncie, IN.			
	Delaware County, IN	0.9358	0.9144	0.8930
34740	Muskegon-Norton Shores, MI.			
	Muskegon County, MI	0.9798	0.9731	0.9664
34820	Myrtle Beach-Conway-North Myrtle Beach, SC.			
	Horry County, SC	0.9360	0.9147	0.8934
34900	Napa, CA.			
	Napa County, CA	1.1586	1.2114	1.2643
34940	Naples-Marco Island, FL.			
	Collier County, FL	1.0083	1.0111	1.0139
34980	Nashville-Davidson—Murfreesboro, TN.			
	Cannon County, TN.			
	Cheatham County, TN.			
	Davidson County, TN.			
	Dickson County, TN.			
	Hickman County, TN.			
	Macon County, TN.			
	Robertson County, TN.			
	Rutherford County, TN.			
	Smith County, TN.			
	Sumner County, TN.			
	Trousdale County, TN.			
	Williamson County, TN.			

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2006 THROUGH JUNE 30, 2007 [1]—Continued

CBSA Code	Urban Area (Constituent Counties)	3/5 Wage Index [2]	4/5 Wage Index [3]	Full Wage Index [4]
	Wilson County, TN	0.9874	0.9832	0.9790
35004	Nassau-Suffolk, NY.			
	Nassau County, NY.			
	Suffolk County, NY	1.1631	1.2175	1.2719
35084	Newark-Union, NJ-PA.			
	Essex County, NJ.			
	Hunterdon County, NJ.			
	Morris County, NJ.			
	Sussex County, NJ.			
	Union County, NJ.			
	Pike County, PA	1.1130	1.1506	1.1883
35300	New Haven-Milford, CT.			
	New Haven County, CT	1.1132	1.1510	1.1887
35380	New Orleans-Metairie-Kenner, LA.			
	Jefferson Parish, LA.			
	Orleans Parish, LA.			
	Plaquemines Parish, LA.			
	St. Bernard Parish, LA.			
	St. Charles Parish, LA.			
	St. John the Baptist Parish, LA.			
	St. Tammany Parish, LA	0.9397	0.9196	0.8995
35644	New York-White Plains-Wayne, NY-NJ.			
	Bergen County, NJ.			
	Hudson County, NJ.			
	Passaic County, NJ.			
	Bronx County, NY.			
	Kings County, NY.			
	New York County, NY.			
	Putnam County, NY.			
	Queens County, NY.			
	Richmond County, NY.			
	Rockland County, NY.			
	Westchester County, NY	1.1913	1.2550	1.3188
35660	Niles-Benton Harbor, MI.			
	Berrien County, MI	0.9327	0.9103	0.8879
35980	Norwich-New London, CT.			
	New London County, CT	1.0807	1.1076	1.1345
36084	Oakland-Fremont-Hayward, CA.			
	Alameda County, CA.			
	Contra Costa County, CA	1.3208	1.4277	1.5346
36100	Ocala, FL.			
	Marion County, FL	0.9355	0.9140	0.8925
36140	Ocean City, NJ.			
	Cape May County, NJ	1.0607	1.0809	1.1011
36220	Odessa, TX.			
	Ector County, TX	0.9930	0.9907	0.9884
36260	Ogden-Clearfield, UT.			
	Davis County, UT.			
	Morgan County, UT.			
	Weber County, UT	0.9417	0.9223	0.9029
36420	Oklahoma City, OK.			
	Canadian County, OK.			
	Cleveland County, OK.			
	Grady County, OK.			
	Lincoln County, OK.			
	Logan County, OK.			
	McClain County, OK.			
	Oklahoma County, OK	0.9419	0.9225	0.9031
36500	Olympia, WA.			
	Thurston County, WA	1.0556	1.0742	1.0927
36540	Omaha-Council Bluffs, NE-IA.			
	Harrison County, IA.			
	Mills County, IA.			
	Pottawattamie County, IA.			
	Cass County, NE.			
	Douglas County, NE.			
	Sarpy County, NE.			
	Saunders County, NE.			
	Washington County, NE	0.9736	0.9648	0.9560

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2006 THROUGH JUNE 30, 2007 [1]—Continued

CBSA Code	Urban Area (Constituent Counties)	3/5 Wage Index [2]	4/5 Wage Index [3]	Full Wage Index [4]
36740	Orlando-Kissimmee, FL.			
	Lake County, FL.			
	Orange County, FL.			
	Osceola County, FL.			
	Seminole County, FL	0.9678	0.9571	0.9464
36780	Oshkosh-Neenah, WI.			
	Winnebago County, WI	0.9510	0.9346	0.9183
36980	Owensboro, KY.			
	Daviess County, KY.			
	Hancock County, KY.			
	McLean County, KY	0.9268	0.9024	0.8780
37100	Oxnard-Thousand Oaks-Ventura, CA.			
	Ventura County, CA	1.0973	1.1298	1.1622
37340	Palm Bay-Melbourne-Titusville, FL.			
	Brevard County, FL	0.9903	0.9871	0.9839
37460	Panama City-Lynn Haven, FL.			
	Bay County, FL	0.8803	0.8404	0.8005
37620	Parkersburg-Marietta-Vienna, WV-OH.			
	Washington County, OH.			
	Pleasants County, WV.			
	Wirt County, WV.			
	Wood County, WV	0.8962	0.8616	0.8270
37700	Pascagoula, MS.			
	George County, MS.			
	Jackson County, MS	0.8894	0.8525	0.8156
37860	Pensacola-Ferry Pass-Brent, FL.			
	Escambia County, FL.			
	Santa Rosa County, FL	0.8858	0.8477	0.8096
37900	Peoria, IL.			
	Marshall County, IL.			
	Peoria County, IL.			
	Stark County, IL.			
	Tazewell County, IL.			
	Woodford County, IL	0.9322	0.9096	0.8870
37964	Philadelphia, PA.			
	Bucks County, PA.			
	Chester County, PA.			
	Delaware County, PA.			
	Montgomery County, PA.			
	Philadelphia County, PA	1.0623	1.0830	1.1038
38060	Phoenix-Mesa-Scottsdale, AZ.			
	Maricopa County, AZ.			
	Pinal County, AZ	1.0076	1.0102	1.0127
38220	Pine Bluff, AR.			
	Cleveland County, AR.			
	Jefferson County, AR.			
	Lincoln County, AR	0.9208	0.8944	0.8680
38300	Pittsburgh, PA.			
	Allegheny County, PA.			
	Armstrong County, PA.			
	Beaver County, PA.			
	Butler County, PA.			
	Fayette County, PA.			
	Washington County, PA.			
	Westmoreland County, PA	0.9307	0.9076	0.8845
38340	Pittsfield, MA.			
	Berkshire County, MA	1.0109	1.0145	1.0181
38540	Pocatello, ID.			
	Bannock County, ID.			
	Power County, ID	0.9611	0.9481	0.9351
38660	Ponce, PR.			
	Juana Díaz Municipio, PR.			
	Ponce Municipio, PR.			
	Villalba Municipio, PR	0.6963	0.5951	0.4939
38860	Portland-South Portland-Biddeford, ME.			
	Cumberland County, ME.			
	Sagadahoc County, ME.			
	York County, ME	1.0229	1.0306	1.0382
38900	Portland-Vancouver-Beaverton, OR-WA.			

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2006 THROUGH JUNE 30, 2007 [1]—Continued

CBSA Code	Urban Area (Constituent Counties)	3/5 Wage Index [2]	4/5 Wage Index [3]	Full Wage Index [4]
	Clackamas County, OR.			
	Columbia County, OR.			
	Multnomah County, OR.			
	Washington County, OR.			
	Yamhill County, OR.			
	Clark County, WA.			
	Skamania County, WA	1.0760	1.1013	1.1266
38940	Port St. Lucie-Fort Pierce, FL.			
	Martin County, FL.			
	St. Lucie County, FL	1.0074	1.0098	1.0123
39100	Poughkeepsie-Newburgh-Middletown, NY.			
	Dutchess County, NY.			
	Orange County, NY	1.0535	1.0713	1.0891
39140	Prescott, AZ.			
	Yavapai County, AZ	0.9921	0.9895	0.9869
39300	Providence-New Bedford-Fall River, RI-MA.			
	Bristol County, MA.			
	Bristol County, RI.			
	Kent County, RI.			
	Newport County, RI.			
	Providence County, RI.			
	Washington County, RI	1.0580	1.0773	1.0966
39340	Provo-Orem, UT.			
	Juab County, UT.			
	Utah County, UT	0.9700	0.9600	0.9500
39380	Pueblo, CO.			
	Pueblo County, CO	0.9174	0.8898	0.8623
39460	Punta Gorda, FL.			
	Charlotte County, FL	0.9553	0.9404	0.9255
39540	Racine, WI.			
	Racine County, WI	0.9398	0.9198	0.8997
39580	Raleigh-Cary, NC.			
	Franklin County, NC.			
	Johnston County, NC.			
	Wake County, NC	0.9815	0.9753	0.9691
39660	Rapid City, SD.			
	Meade County, SD.			
	Pennington County, SD	0.9392	0.9190	0.8987
39740	Reading, PA.			
	Berks County, PA	0.9812	0.9749	0.9686
39820	Redding, CA.			
	Shasta County, CA	1.1322	1.1762	1.2203
39900	Reno-Sparks, NV.			
	Storey County, NV.			
	Washoe County, NV	1.0589	1.0786	1.0982
40060	Richmond, VA.			
	Amelia County, VA.			
	Caroline County, VA.			
	Charles City County, VA.			
	Chesterfield County, VA.			
	Cumberland County, VA.			
	Dinwiddie County, VA.			
	Goochland County, VA.			
	Hanover County, VA.			
	Henrico County, VA.			
	King and Queen County, VA.			
	King William County, VA.			
	Louisa County, VA.			
	New Kent County, VA.			
	Powhatan County, VA.			
	Prince George County, VA.			
	Sussex County, VA.			
	Colonial Heights City, VA.			
	Hopewell City, VA.			
	Petersburg City, VA.			
	Richmond City, VA	0.9597	0.9462	0.9328
40140	Riverside-San Bernardino-Ontario, CA.			
	Riverside County, CA.			
	San Bernardino County, CA	1.0616	1.0822	1.1027

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2006 THROUGH JUNE 30, 2007 [1]—Continued

CBSA Code	Urban Area (Constituent Counties)	3/5 Wage Index [2]	4/5 Wage Index [3]	Full Wage Index [4]
40220	Roanoke, VA.			
	Botetourt County, VA.			
	Craig County, VA.			
	Franklin County, VA.			
	Roanoke County, VA.			
	Roanoke City, VA.			
	Salem City, VA	0.9024	0.8699	0.8374
40340	Rochester, MN.			
	Dodge County, MN.			
	Olmsted County, MN.			
	Wabasha County, MN	1.0679	1.0905	1.1131
40380	Rochester, NY.			
	Livingston County, NY.			
	Monroe County, NY.			
	Ontario County, NY.			
	Orleans County, NY.			
	Wayne County, NY	0.9473	0.9297	0.9121
40420	Rockford, IL.			
	Boone County, IL.			
	Winnebago County, IL	0.9990	0.9987	0.9984
40484	Rockingham County-Strafford County, NH.			
	Rockingham County, NH.			
	Strafford County, NH	1.0224	1.0299	1.0374
40580	Rocky Mount, NC.			
	Edgecombe County, NC.			
	Nash County, NC	0.9349	0.9132	0.8915
40660	Rome, GA.			
	Floyd County, GA	0.9648	0.9531	0.9414
40900	Sacramento—Arden-Arcade—Roseville, CA.			
	El Dorado County, CA.			
	Placer County, CA.			
	Sacramento County, CA.			
	Yolo County, CA	1.1781	1.2375	1.2969
40980	Saginaw-Saginaw Township North, MI.			
	Saginaw County, MI	0.9453	0.9270	0.9088
41060	St. Cloud, MN.			
	Benton County, MN.			
	Stearns County, MN	0.9979	0.9972	0.9965
41100	St. George, UT.			
	Washington County, UT	0.9635	0.9514	0.9392
41140	St. Joseph, MO-KS.			
	Doniphan County, KS.			
	Andrew County, MO.			
	Buchanan County, MO.			
	DeKalb County, MO	0.9711	0.9615	0.9519
41180	St. Louis, MO-IL.			
	Bond County, IL.			
	Calhoun County, IL.			
	Clinton County, IL.			
	Jersey County, IL.			
	Macoupin County, IL.			
	Madison County, IL.			
	Monroe County, IL.			
	St. Clair County, IL.			
	Crawford County, MO.			
	Franklin County, MO.			
	Jefferson County, MO.			
	Lincoln County, MO.			
	St. Charles County, MO.			
	St. Louis County, MO.			
	Warren County, MO.			
	Washington County, MO.			
	St. Louis City, MO	0.9372	0.9163	0.8954
41420	Salem, OR.			
	Marion County, OR.			
	Polk County, OR	1.0265	1.0354	1.0442
41500	Salinas, CA.			
	Monterey County, CA	1.2477	1.3302	1.4128
41540	Salisbury, MD.			

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2006 THROUGH JUNE 30, 2007 [1]—Continued

CBSA Code	Urban Area (Constituent Counties)	3/5 Wage Index [2]	4/5 Wage Index [3]	Full Wage Index [4]
	Somerset County, MD.			
	Wicomico County, MD	0.9438	0.9251	0.9064
41620	Salt Lake City, UT.			
	Salt Lake County, UT.			
	Summit County, UT.			
	Tooele County, UT	0.9653	0.9537	0.9421
41660	San Angelo, TX.			
	Irion County, TX.			
	Tom Green County, TX	0.8963	0.8617	0.8271
41700	San Antonio, TX.			
	Atascosa County, TX.			
	Bandera County, TX.			
	Bexar County, TX.			
	Comal County, TX.			
	Guadalupe County, TX.			
	Kendall County, TX.			
	Medina County, TX.			
	Wilson County, TX	0.9388	0.9184	0.8980
41740	San Diego-Carlsbad-San Marcos, CA.			
	San Diego County, CA	1.0848	1.1130	1.1413
41780	Sandusky, OH.			
	Erie County, OH	0.9411	0.9215	0.9019
41884	San Francisco-San Mateo-Redwood City, CA.			
	Marin County, CA.			
	San Francisco County, CA.			
	San Mateo County, CA	1.2996	1.3995	1.4994
41900	San Germán-Cabo Rojo, PR.			
	Cabo Rojo Municipio, PR.			
	Lajas Municipio, PR.			
	Sabana Grande Municipio, PR.			
	San Germán Municipio, PR	0.6790	0.5720	0.4650
41940	San Jose-Sunnyvale-Santa Clara, CA.			
	San Benito County, CA.			
	Santa Clara County, CA	1.3059	1.4079	1.5099
41980	San Juan-Caguas-Guaynabo, PR.			
	Aguas Buenas Municipio, PR.			
	Aibonito Municipio, PR.			
	Arecibo Municipio, PR.			
	Barceloneta Municipio, PR.			
	Barranquitas Municipio, PR.			
	Bayamón Municipio, PR.			
	Caguas Municipio, PR.			
	Camuy Municipio, PR.			
	Canóvanas Municipio, PR.			
	Carolina Municipio, PR.			
	Cataño Municipio, PR.			
	Cayey Municipio, PR.			
	Ciales Municipio, PR.			
	Cidra Municipio, PR.			
	Comerío Municipio, PR.			
	Corozal Municipio, PR.			
	Dorado Municipio, PR.			
	Florida Municipio, PR.			
	Guaynabo Municipio, PR.			
	Gurabo Municipio, PR.			
	Hatillo Municipio, PR.			
	Humacao Municipio, PR.			
	Juncos Municipio, PR.			
	Las Piedras Municipio, PR.			
	Loíza Municipio, PR.			
	Manatí Municipio, PR.			
	Maunabo Municipio, PR.			
	Morovis Municipio, PR.			
	Naguabo Municipio, PR.			
	Naranjito Municipio, PR.			
	Orocovis Municipio, PR.			
	Quebradillas Municipio, PR.			
	Río Grande Municipio, PR.			
	San Juan Municipio, PR.			

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2006 THROUGH JUNE 30, 2007 [1]—Continued

CBSA Code	Urban Area (Constituent Counties)	3/5 Wage Index [2]	4/5 Wage Index [3]	Full Wage Index [4]
	San Lorenzo Municipio, PR.			
	Toa Alta Municipio, PR.			
	Toa Baja Municipio, PR.			
	Trujillo Alto Municipio, PR.			
	Vega Alta Municipio, PR.			
	Vega Baja Municipio, PR.			
	Yabucoa Municipio, PR	0.6773	0.5697	0.4621
42020	San Luis Obispo-Paso Robles, CA.			
	San Luis Obispo County, CA	1.0809	1.1079	1.1349
42044	Santa Ana-Anaheim-Irvine, CA.			
	Orange County, CA	1.0935	1.1247	1.1559
42060	Santa Barbara-Santa Maria, CA.			
	Santa Barbara County, CA	1.1016	1.1355	1.1694
42100	Santa Cruz-Watsonville, CA.			
	Santa Cruz County, CA	1.3100	1.4133	1.5166
42140	Santa Fe, NM.			
	Santa Fe County, NM	1.0552	1.0736	1.0920
42220	Santa Rosa-Petaluma, CA.			
	Sonoma County, CA	1.2096	1.2794	1.3493
42260	Sarasota-Bradenton-Venice, FL.			
	Manatee County, FL.			
	Sarasota County, FL	0.9783	0.9711	0.9639
42340	Savannah, GA.			
	Bryan County, GA.			
	Chatham County, GA.			
	Effingham County, GA	0.9677	0.9569	0.9461
42540	Scranton—Wilkes-Barre, PA.			
	Lackawanna County, PA.			
	Luzerne County, PA.			
	Wyoming County, PA	0.9124	0.8832	0.8540
42644	Seattle-Bellevue-Everett, WA.			
	King County, WA.			
	Snohomish County, WA	1.0946	1.1262	1.1577
42680	Sebastian-Vero Beach, FL.			
	Indian River County, FL	0.9660	0.9547	0.9434
43100	Sheboygan, WI.			
	Sheboygan County, WI	0.9347	0.9129	0.8911
43300	Sherman-Denison, TX.			
	Grayson County, TX	0.9704	0.9606	0.9507
43340	Shreveport-Bossier City, LA.			
	Bossier Parish, LA.			
	Caddo Parish, LA.			
	De Soto Parish, LA	0.9256	0.9008	0.8760
43580	Sioux City, IA-NE-SD.			
	Woodbury County, IA.			
	Dakota County, NE.			
	Dixon County, NE.			
	Union County, SD	0.9629	0.9505	0.9381
43620	Sioux Falls, SD.			
	Lincoln County, SD.			
	McCook County, SD.			
	Minnehaha County, SD.			
	Turner County, SD	0.9781	0.9708	0.9635
43780	South Bend-Mishawaka, IN-MI.			
	St. Joseph County, IN.			
	Cass County, MI	0.9873	0.9830	0.9788
43900	Spartanburg, SC.			
	Spartanburg County, SC	0.9503	0.9338	0.9172
44060	Spokane, WA.			
	Spokane County, WA	1.0543	1.0724	1.0905
44100	Springfield, IL.			
	Menard County, IL.			
	Sangamon County, IL	0.9275	0.9034	0.8792
44140	Springfield, MA.			
	Franklin County, MA.			
	Hampden County, MA.			
	Hampshire County, MA	1.0149	1.0198	1.0248
44180	Springfield, MO.			
	Christian County, MO.			

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2006 THROUGH JUNE 30, 2007 [1]—Continued

CBSA Code	Urban Area (Constituent Counties)	3/5 Wage Index [2]	4/5 Wage Index [3]	Full Wage Index [4]
	Dallas County, MO.			
	Greene County, MO.			
	Polk County, MO.			
	Webster County, MO	0.8942	0.8590	0.8237
44220	Springfield, OH.			
	Clark County, OH	0.9038	0.8717	0.8396
44300	State College, PA.			
	Centre County, PA	0.9014	0.8685	0.8356
44700	Stockton, CA.			
	San Joaquin County, CA	1.0784	1.1046	1.1307
44940	Sumter, SC.			
	Sumter County, SC	0.9026	0.8702	0.8377
45060	Syracuse, NY.			
	Madison County, NY.			
	Onondaga County, NY.			
	Oswego County, NY	0.9744	0.9659	0.9574
45104	Tacoma, WA.			
	Pierce County, WA	1.0445	1.0594	1.0742
45220	Tallahassee, FL.			
	Gadsden County, FL.			
	Jefferson County, FL.			
	Leon County, FL.			
	Wakulla County, FL	0.9213	0.8950	0.8688
45300	Tampa-St. Petersburg-Clearwater, FL.			
	Hernando County, FL.			
	Hillsborough County, FL.			
	Pasco County, FL.			
	Pinellas County, FL	0.9540	0.9386	0.9233
45460	Terre Haute, IN.			
	Clay County, IN.			
	Sullivan County, IN.			
	Vermillion County, IN.			
	Vigo County, IN	0.8982	0.8643	0.8304
45500	Texarkana, TX-Texarkana, AR.			
	Miller County, AR.			
	Bowie County, TX	0.8970	0.8626	0.8283
45780	Toledo, OH.			
	Fulton County, OH.			
	Lucas County, OH.			
	Ottawa County, OH.			
	Wood County, OH	0.9744	0.9659	0.9574
45820	Topeka, KS.			
	Jackson County, KS.			
	Jefferson County, KS.			
	Osage County, KS.			
	Shawnee County, KS.			
	Wabaunsee County, KS	0.9352	0.9136	0.8920
45940	Trenton-Ewing, NJ.			
	Mercer County, NJ	1.0500	1.0667	1.0834
46060	Tucson, AZ.			
	Pima County, AZ	0.9404	0.9206	0.9007
46140	Tulsa, OK.			
	Creek County, OK.			
	Okmulgee County, OK.			
	Osage County, OK.			
	Pawnee County, OK.			
	Rogers County, OK.			
	Tulsa County, OK.			
	Wagoner County, OK	0.9126	0.8834	0.8543
46220	Tuscaloosa, AL.			
	Greene County, AL.			
	Hale County, AL.			
	Tuscaloosa County, AL	0.9187	0.8916	0.8645
46340	Tyler, TX.			
	Smith County, TX	0.9501	0.9334	0.9168
46540	Utica-Rome, NY.			
	Herkimer County, NY.			
	Oneida County, NY	0.9015	0.8686	0.8358
46660	Valdosta, GA.			

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2006 THROUGH JUNE 30, 2007 [1]—Continued

CBSA Code	Urban Area (Constituent Counties)	3/5 Wage Index [2]	4/5 Wage Index [3]	Full Wage Index [4]
	Brooks County, GA.			
	Echols County, GA.			
	Lanier County, GA.			
	Lowndes County, GA	0.9320	0.9093	0.8866
46700	Vallejo-Fairfield, CA.			
	Solano County, CA	1.2962	1.3949	1.4936
47020	Victoria, TX.			
	Calhoun County, TX.			
	Goliad County, TX.			
	Victoria County, TX	0.8896	0.8528	0.8160
47220	Vineland-Millville-Bridgeton, NJ.			
	Cumberland County, NJ	0.9896	0.9862	0.9827
47260	Virginia Beach-Norfolk-Newport News, VA-NC.			
	Currituck County, NC.			
	Gloucester County, VA.			
	Isle of Wight County, VA.			
	James City County, VA.			
	Mathews County, VA.			
	Surry County, VA.			
	York County, VA.			
	Chesapeake City, VA.			
	Hampton City, VA.			
	Newport News City, VA.			
	Norfolk City, VA.			
	Poquoson City, VA.			
	Portsmouth City, VA.			
	Suffolk City, VA.			
	Virginia Beach City, VA.			
	Williamsburg City, VA	0.9279	0.9039	0.8799
47300	Visalia-Porterville, CA.			
	Tulare County, CA	1.0074	1.0098	1.0123
47380	Waco, TX.			
	McLennan County, TX	0.9111	0.8814	0.8518
47580	Warner Robins, GA.			
	Houston County, GA	0.9187	0.8916	0.8645
47644	Warren-Troy-Farmington Hills, MI.			
	Lapeer County, MI.			
	Livingston County, MI.			
	Macomb County, MI.			
	Oakland County, MI.			
	St. Clair County, MI	0.9923	0.9897	0.9871
47894	Washington-Arlington-Alexandria, DC-VA-MD-WV.			
	District of Columbia, DC.			
	Calvert County, MD.			
	Charles County, MD.			
	Prince George's County, MD.			
	Arlington County, VA.			
	Clarke County, VA.			
	Fairfax County, VA.			
	Fauquier County, VA.			
	Loudoun County, VA.			
	Prince William County, VA.			
	Spotsylvania County, VA.			
	Stafford County, VA.			
	Warren County, VA.			
	Alexandria City, VA.			
	Fairfax City, VA.			
	Falls Church City, VA.			
	Fredericksburg City, VA.			
	Manassas City, VA.			
	Manassas Park City, VA.			
	Jefferson County, WV	1.0556	1.0741	1.0926
47940	Waterloo-Cedar Falls, IA.			
	Black Hawk County, IA.			
	Bremer County, IA.			
	Grundy County, IA	0.9134	0.8846	0.8557
48140	Wausau, WI.			
	Marathon County, WI	0.9754	0.9672	0.9590
48260	Weirton-Steubenville, WV-OH.			

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2006 THROUGH JUNE 30, 2007 [1]—Continued

CBSA Code	Urban Area (Constituent Counties)	3/5 Wage Index [2]	4/5 Wage Index [3]	Full Wage Index [4]
	Jefferson County, OH.			
	Brooke County, WV.			
	Hancock County, WV	0.8691	0.8255	0.7819
48300	Wenatchee, WA.			
	Chelan County, WA.			
	Douglas County, WA	1.0042	1.0056	1.0070
48424	West Palm Beach-Boca Raton-Boynton Beach, FL.			
	Palm Beach County, FL	1.0040	1.0054	1.0067
48540	Wheeling, WV-OH.			
	Belmont County, OH.			
	Marshall County, WV.			
	Ohio County, WV	0.8297	0.7729	0.7161
48620	Wichita, KS.			
	Butler County, KS.			
	Harvey County, KS.			
	Sedgwick County, KS.			
	Sumner County, KS	0.9492	0.9322	0.9153
48660	Wichita Falls, TX.			
	Archer County, TX.			
	Clay County, TX.			
	Wichita County, TX	0.8971	0.8628	0.8285
48700	Williamsport, PA.			
	Lycoming County, PA	0.9018	0.8691	0.8364
48864	Wilmington, DE-MD-NJ.			
	New Castle County, DE.			
	Cecil County, MD.			
	Salem County, NJ	1.0283	1.0377	1.0471
48900	Wilmington, NC.			
	Brunswick County, NC.			
	New Hanover County, NC.			
	Pender County, NC	0.9749	0.9666	0.9582
49020	Winchester, VA-WV.			
	Frederick County, VA.			
	Winchester City, VA.			
	Hampshire County, WV	1.0128	1.0171	1.0214
49180	Winston-Salem, NC.			
	Davie County, NC.			
	Forsyth County, NC.			
	Stokes County, NC.			
	Yadkin County, NC	0.9366	0.9155	0.8944
49340	Worcester, MA.			
	Worcester County, MA	1.0617	1.0822	1.1028
49420	Yakima, WA.			
	Yakima County, WA	1.0093	1.0124	1.0155
49500	Yauco, PR.			
	Guánica Municipio, PR.			
	Guayanilla Municipio, PR.			
	Peñuelas Municipio, PR.			
	Yauco Municipio, PR	0.6645	0.5526	0.4408
49620	York-Hanover, PA.			
	York County, PA	0.9608	0.9478	0.9347
49660	Youngstown-Warren-Boardman, OH-PA.			
	Mahoning County, OH.			
	Trumbull County, OH.			
	Mercer County, PA	0.9162	0.8882	0.8603
49700	Yuba City, CA.			
	Sutter County, CA.			
	Yuba County, CA	1.0553	1.0737	1.0921
49740	Yuma, AZ.			
	Yuma County, AZ	0.9476	0.9301	0.9126

[1] As discussed in section IV.D.1.d. of the preamble of this proposed rule, because there will no longer be any LTCHs in their cost reporting periods that began during FYs 2003 or 2004 (the first and second years of the 5-year wage index phase-in, respectively), we are no longer showing the 1/5 and 2/5 wage index value. For further details on the 5-year phase-in of the wage index, see section IV.D.1. of this proposed rule.

[2] Three-fifths of the proposed full wage index value, applicable for a LTCH's cost reporting period beginning on or after October 1, 2004 through September 30, 2005 (Federal FY 2005). That is, for a LTCH's cost reporting period that begins during Federal FY 2005 and located in Chicago, Illinois (CBSA 16974), the proposed 3/5 wage index value is computed as ((3*1.0790) + 2))/5 = 1.0474. For further details on the 5-year phase-in of the wage index, see section IV.D.1. of this proposed rule.

[3] Four-fifths of the proposed full wage index value, applicable for a LTCH's cost reporting period beginning on or after October 1, 2005 through September 30, 2006 (Federal FY 2006). That is, for a LTCH's cost reporting period that begins during Federal FY 2006 and located in Chicago, Illinois (CBSA 16974), the proposed 4/5 wage index value is computed as ((4*1.0790) + 1))/5 = 1.0632. For further details on the 5-year phase-in of the wage index, see section IV.D.1. of this proposed rule.

[4] The proposed wage index values are calculated using the same wage data used to compute the wage index used by acute care hospitals under the IPPS for Federal FY 2006 (that is, fiscal year 2002 audited acute care hospital inpatient wage data without regard to reclassification under section 1886(d)(8) or section 1886(d)(10) of the Act).

TABLE 2.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR RURAL AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2006 THROUGH JUNE 30, 2007 [1]

CBSA Code	Nonurban Area	3/5 Wage Index [2]	4/5 Wage Index [3]	Full Wage Index [4]
01	Alabama	0.8468	0.7957	0.7446
02	Alaska	1.1186	1.1582	1.1977
03	Arizona	0.9261	0.9014	0.8768
04	Arkansas	0.8480	0.7973	0.7466
05	California	1.0632	1.0843	1.1054
06	Colorado	0.9628	0.9504	0.9380
07	Connecticut	1.1038	1.1384	1.1730
08	Delaware	0.9747	0.9663	0.9579
10	Florida	0.9141	0.8854	0.8568
11	Georgia	0.8597	0.8130	0.7662
12	Hawaii	1.0331	1.0441	1.0551
13	Idaho	0.8822	0.8430	0.8037
14	Illinois	0.8963	0.8617	0.8271
15	Indiana	0.9174	0.8899	0.8624
16	Iowa	0.9105	0.8807	0.8509
17	Kansas	0.8821	0.8428	0.8035
18	Kentucky	0.8660	0.8213	0.7766
19	Louisiana	0.8447	0.7929	0.7411
20	Maine	0.9306	0.9074	0.8843
21	Maryland	0.9612	0.9482	0.9353
22	Massachusetts [5]	.....	.....	.....
23	Michigan	0.9337	0.9116	0.8895
24	Minnesota	0.9479	0.9306	0.9132
25	Mississippi	0.8604	0.8139	0.7674
26	Missouri	0.8740	0.8320	0.7900
27	Montana	0.9257	0.9010	0.8762
28	Nebraska	0.9194	0.8926	0.8657
29	Nevada	0.9439	0.9252	0.9065
30	New Hampshire	1.0490	1.0654	1.0817
31	New Jersey [5]	.....	.....	.....
32	New Mexico	0.9181	0.8908	0.8635
33	New York	0.8892	0.8523	0.8154
34	North Carolina	0.9124	0.8832	0.8540
35	North Dakota	0.8357	0.7809	0.7261
36	Ohio	0.9296	0.9061	0.8826
37	Oklahoma	0.8549	0.8065	0.7581
38	Oregon	0.9896	0.9861	0.9826
39	Pennsylvania	0.8975	0.8633	0.8291
40	Puerto Rico [5]	.....	.....	.....
41	Rhode Island [5]	.....	.....	.....
42	South Carolina	0.9183	0.8910	0.8638
43	South Dakota	0.9136	0.8848	0.8560
44	Tennessee	0.8737	0.8316	0.7895
45	Texas	0.8802	0.8402	0.8003
46	Utah	0.8871	0.8494	0.8118
47	Vermont	0.9898	0.9864	0.9830
49	Virginia	0.8808	0.8410	0.8013
50	Washington	1.0306	1.0408	1.0510
51	West Virginia	0.8630	0.8174	0.7717
52	Wisconsin	0.9705	0.9607	0.9509
53	Wyoming	0.9554	0.9406	0.9257

[1] As discussed in section IV.D.1.d. of the preamble of this proposed rule, because there are no longer any LTCHs in their cost reporting periods that began during FYs 2003 and 2004 (the first and second years of the 5-year wage index phase-in, respectively), we are no longer showing the 1/5 and 2/5 wage index value. For further details on the 5-year phase-in of the wage index, see section IV.D.1. of this proposed rule.

[2] The proposed wage index values are calculated using the same wage data used to compute the wage index used by acute care hospitals under the IPPS for Federal FY 2006 (that is, fiscal year 2002 audited acute care hospital inpatient wage data without regard to reclassification under section 1886(d)(8) or section 1886(d)(10) of the Act).

[3] Three-fifths of the proposed full wage index value, applicable for a LTCH's cost reporting period beginning on or after October 1, 2004 through September 30, 2005 (Federal FY 2005). That is, for a LTCH's cost reporting period that begins during Federal FY 2005 and located in rural Illinois, the proposed 3/5 wage index value is computed as ((3*0.8271) + 2))/5 = 0.8963. For further details on the 5-year phase-in of the wage index, see section IV.D.1. of this proposed rule.

[4] Four-fifths of the proposed full wage index value, applicable for a LTCH's cost reporting period beginning on or after October 1, 2005 through September 30, 2006 (Federal FY 2006). That is, for a LTCH's cost reporting period that begins during Federal FY 2006 and located in rural Illinois, the proposed 4/5 wage index value is computed as ((3*0.9271) + 2))/5 = 0.8617. For further details on the 5-year phase-in of the wage index, see section IV.D.1. of this proposed rule.

[5] All counties within the State are classified as urban.

TABLE 3.—FY 2006 LTC–DRGS, RELATIVE WEIGHTS AND GEOMETRIC AVERAGE LENGTH OF STAY

[Effective for discharges occurring on or after October 1, 2005 through September 30, 2006]

LTC–DRG	Description	Relative Weight	Geometric Average Length of Stay
1	[5] CRANIOTOMY AGE >17 W CC	1.7034	38.5
2	[7] CRANIOTOMY AGE > 17 W/O CC	1.7034	38.5
3	[7] CRANIOTOMY AGE 0–17	1.7034	38.5
6	[7] CARPAL TUNNEL RELEASE	0.4499	19.0
7	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC	1.3984	37.7
8	[3] PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC	0.7637	24.8
9	SPINAL DISORDERS & INJURIES	0.9720	33.7
10	NERVOUS SYSTEM NEOPLASMS W CC	0.7554	24.5
11	[2] NERVOUS SYSTEM NEOPLASMS W/O CC	0.5837	21.3
12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	0.6851	25.5
13	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	0.6531	23.1
14	INTERCRANIAL HEMORRHAGE OR STROKE WITH INFARCT	0.7783	26.0
15	NONSPECIFIC CVA & PRECEREBRAL OCCULUSION WITHOUT INFARCT	0.7314	26.8
16	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	0.7471	23.5
17	[1] NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	0.4499	19.0
18	CRANIAL & PERIPHERAL NERVE DISORDERS W CC	0.7197	23.6
19	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	0.4773	21.2
20	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	1.0277	27.2
21	[3] VIRAL MENINGITIS	0.7637	24.8
22	[4] HYPERTENSIVE ENCEPHALOPATHY	1.1820	29.6
23	NONTRAUMATIC STUPOR & COMA	0.8054	25.4
24	SEIZURE & HEADACHE AGE >17 W CC	0.6251	22.6
25	[1] SEIZURE & HEADACHE AGE >17 W/O CC	0.4499	19.0
26	[7] SEIZURE & HEADACHE AGE 0–17	0.4499	19.0
27	TRAUMATIC STUPOR & COMA, COMA >1 HR	0.9444	27.1
28	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W CC	0.8890	30.2
29	[2] TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC	0.5837	21.3
30	[7] TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0–17	0.5837	21.3
31	[3] CONCUSSION AGE >17 W CC	0.7637	24.8
32	[7] CONCUSSION AGE >17 W/O CC	0.4499	19.0
33	[7] CONCUSSION AGE 0–17	0.4499	19.0
34	OTHER DISORDERS OF NERVOUS SYSTEM W CC	0.8004	25.3
35	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	0.5698	24.2
36	[7] RETINAL PROCEDURES	1.1820	29.6
37	[7] ORBITAL PROCEDURES	1.1820	29.6
38	[7] PRIMARY IRIS PROCEDURES	1.1820	29.6
39	[7] LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	1.1820	29.6
40	[4] EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	1.1820	29.6
41	[7] EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0–17	1.1820	29.6
42	[7] INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	1.1820	29.6
43	[7] HYPHEMA	1.1820	29.6
44	[2] ACUTE MAJOR EYE INFECTIONS	0.5837	21.3
45	[7] NEUROLOGICAL EYE DISORDERS	1.1820	29.6
46	[2] OTHER DISORDERS OF THE EYE AGE >17 W CC	0.5837	21.3
47	[7] OTHER DISORDERS OF THE EYE AGE >17 W/O CC	1.1820	29.6
48	[7] OTHER DISORDERS OF THE EYE AGE 0–17	1.1820	29.6
49	[7] MAJOR HEAD & NECK PROCEDURES	1.1820	29.6
50	S7 IALOADENECTOMY	1.1820	29.6
51	[7] SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	1.1820	29.6
52	[7] CLEFT LIP & PALATE REPAIR	1.1820	29.6
53	[7] SINUS & MASTOID PROCEDURES AGE >17	1.1820	29.6
54	[7] SINUS & MASTOID PROCEDURES AGE 0–17	1.1820	29.6
55	[7] MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES	1.1820	29.6
56	[7] RHINOPLASTY	1.1820	29.6
57	[7] T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	0.4499	19.0
58	[7] T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17	0.4499	19.0
59	[7] TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	0.4499	19.0
60	[7] TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17	0.4499	19.0
61	[3] MYRINGOTOMY W TUBE INSERTION AGE >17	0.7637	24.8
62	[7] MYRINGOTOMY W TUBE INSERTION AGE 0–17	0.4499	19.0
63	[4] OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES	1.1820	29.6
64	EAR, NOSE, MOUTH & THROAT MALIGNANCY	1.1480	26.2

TABLE 3.—FY 2006 LTC–DRGS, RELATIVE WEIGHTS AND GEOMETRIC AVERAGE LENGTH OF STAY—Continued

[Effective for discharges occurring on or after October 1, 2005 through September 30, 2006]

LTC–DRG	Description	Relative Weight	Geometric Average Length of Stay
65	[1] DYSEQUILIBRIUM	0.4499	19.0
66	[7] EPISTAXIS	0.4499	19.0
67	[3] EPIGLOTTITIS	0.7637	24.8
68	OTITIS MEDIA & URI AGE >17 W CC	0.5111	18.0
69	[1] OTITIS MEDIA & URI AGE >17 W/O CC	0.4499	19.0
70	[7] OTITIS MEDIA & URI AGE 0–17	0.4499	19.0
71	[7] LARYNGOTRACHEITIS	0.5837	21.3
72	[7] NASAL TRAUMA & DEFORMITY	0.7637	24.8
73	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17	0.7535	21.9
74	[7] OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0–17	0.4499	19.0
75	[5] MAJOR CHEST PROCEDURES	1.7034	38.5
76	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.5523	43.9
77	[5] OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	1.7034	38.5
78	PULMONARY EMBOLISM	0.6900	21.9
79	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	0.8280	22.9
80	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC	0.5986	21.7
81	[7] RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0–17	0.4499	19.0
82	RESPIRATORY NEOPLASMS	0.7174	20.1
83	[2] MAJOR CHEST TRAUMA W CC	0.5837	21.3
84	[7] MAJOR CHEST TRAUMA W/O CC	0.5837	21.3
85	PLEURAL EFFUSION W CC	0.7264	21.2
86	[1] PLEURAL EFFUSION W/O CC	0.4499	19.0
87	PULMONARY EDEMA & RESPIRATORY FAILURE	1.0816	25.4
88	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	0.6585	19.6
89	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	0.6987	20.8
90	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	0.4970	17.8
91	[7] SIMPLE PNEUMONIA & PLEURISY AGE 0–17	0.4499	19.0
92	INTERSTITIAL LUNG DISEASE W CC	0.6704	20.2
93	[2] INTERSTITIAL LUNG DISEASE W/O CC	0.5837	21.3
94	PNEUMOTHORAX W CC	0.5880	17.0
95	[1] PNEUMOTHORAX W/O CC	0.4499	19.0
96	BRONCHITIS & ASTHMA AGE >17 W CC	0.6417	19.4
97	[2] BRONCHITIS & ASTHMA AGE >17 W/O CC	0.5837	21.3
98	[7] BRONCHITIS & ASTHMA AGE 0–17	0.5837	21.3
99	RESPIRATORY SIGNS & SYMPTOMS W CC	0.9219	23.2
100	[3] RESPIRATORY SIGNS & SYMPTOMS W/O CC	0.7637	24.8
101	OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	0.8147	21.1
102	[1] OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	0.4499	19.0
103	[6] HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM	0.0000	0.0
104	[7] CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W CARDIAC CATH	0.7637	24.8
105	[7] CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W/O CARDIAC CATH	0.7637	24.8
106	[7] CORONARY BYPASS W PTCA	0.7637	24.8
108	[7] OTHER CARDIOTHORACIC PROCEDURES	0.7637	24.8
110	[3] MAJOR CARDIOVASCULAR PROCEDURES W CC	0.7637	24.8
111	[7] MAJOR CARDIOVASCULAR PROCEDURES W/O CC	0.7637	24.8
113	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE	1.4887	39.3
114	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	1.2389	33.2
117	[4] CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT	1.1820	29.6
118	[4] CARDIAC PACEMAKER DEVICE REPLACEMENT	1.1820	29.6
119	[3] VEIN LIGATION & STRIPPING	0.7637	24.8
120	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	1.0979	31.7
121	CIRCULATORY DISORDERS W AMI & MAJOR COMP, DISCHARGED ALIVE	0.8429	23.2
122	[2] CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE	0.5837	21.3
123	CIRCULATORY DISORDERS W AMI, EXPIRED	1.1811	20.4
124	[4] CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG	1.1820	29.6
125	[3] CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG	0.7637	24.8
126	ACUTE & SUBACUTE ENDOCARDITIS	0.8386	25.3
127	HEART FAILURE & SHOCK	0.6857	21.2
128	[2] DEEP VEIN THROMBOPHLEBITIS	0.5837	21.3
129	[7] CARDIAC ARREST, UNEXPLAINED	0.7637	24.8
130	PERIPHERAL VASCULAR DISORDERS W CC	0.6741	23.2
131	PERIPHERAL VASCULAR DISORDERS W/O CC	0.4675	20.4
132	ATHEROSCLEROSIS W CC	0.6565	21.8
133	[1] ATHEROSCLEROSIS W/O CC	0.4499	19.0
134	HYPERTENSION	0.6354	24.8
135	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC	0.7211	23.7
136	[2] CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC	0.5837	21.3
137	[7] CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0–17	0.5837	21.3

TABLE 3.—FY 2006 LTC–DRGS, RELATIVE WEIGHTS AND GEOMETRIC AVERAGE LENGTH OF STAY—Continued

[Effective for discharges occurring on or after October 1, 2005 through September 30, 2006]

LTC–DRG	Description	Relative Weight	Geometric Average Length of Stay
138	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	0.6201	20.5
139	[2] CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	0.5837	21.3
140	[1] ANGINA PECTORIS	0.4499	19.0
141	[8] SYNCOPE & COLLAPSE W CC	0.4271	18.3
142	[8] SYNCOPE & COLLAPSE W/O CC	0.4271	18.3
143	[1] CHEST PAIN	0.4499	19.0
144	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	0.7413	21.7
145	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	0.4568	18.2
146	[7] RECTAL RESECTION W CC	1.7034	38.5
147	[7] RECTAL RESECTION W/O CC	1.7034	38.5
148	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	1.8616	40.9
149	[7] MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	0.7637	24.8
150	[4] PERITONEAL ADHESIOLYSIS W CC	1.1820	29.6
151	[2] PERITONEAL ADHESIOLYSIS W/O CC	0.5837	21.3
152	[3] MINOR SMALL & LARGE BOWEL PROCEDURES W CC	0.7637	24.8
153	[7] MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	0.7637	24.8
154	[5] STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC	1.7034	38.5
155	[7] STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC	1.7034	38.5
156	[7] STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0–17	1.7034	38.5
157	[4] ANAL & STOMAL PROCEDURES W CC	1.1820	29.6
158	[7] ANAL & STOMAL PROCEDURES W/O CC	1.1820	29.6
159	[7] HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC	0.7637	24.8
160	[7] HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC	0.7637	24.8
161	[5] INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC	1.7034	38.5
162	[7] INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC	0.7637	24.8
163	[7] HERNIA PROCEDURES AGE 0–17	0.7637	24.8
164	[1] APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	1.7034	38.5
165	[7] APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	1.7034	38.5
166	[7] APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	1.7034	38.5
167	[7] APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	1.7034	38.5
168	[4] MOUTH PROCEDURES W CC	1.1820	29.6
169	[7] MOUTH PROCEDURES W/O CC	0.7637	24.8
170	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	1.6271	35.9
171	[1] OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC	0.4499	19.0
172	DIGESTIVE MALIGNANCY W CC	0.8553	21.8
173	[2] DIGESTIVE MALIGNANCY W/O CC	0.5837	21.3
174	G.I. HEMORRHAGE W CC	0.7119	22.2
175	[1] G.I. HEMORRHAGE W/O CC	0.4499	19.0
176	COMPLICATED PEPTIC ULCER	0.8426	21.5
177	[3] UNCOMPLICATED PEPTIC ULCER W CC	0.7637	24.8
178	[3] UNCOMPLICATED PEPTIC ULCER W/O CC	0.7637	24.8
179	INFLAMMATORY BOWEL DISEASE	0.9675	24.0
180	G.I. OBSTRUCTION W CC	0.9375	23.5
181	[3] G.I. OBSTRUCTION W/O CC	0.7637	24.8
182	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC	0.7745	22.6
183	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC	0.3870	16.8
184	[7] ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0–17	0.4499	19.0
185	[3] DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17	0.7637	24.8
186	[7] DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0–17	0.7637	24.8
187	[7] DENTAL EXTRACTIONS & RESTORATIONS	0.7637	24.8
188	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	0.9952	24.0
189	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	0.4707	18.2
190	[7] OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0–17	0.4499	19.0
191	[4] PANCREAS, LIVER & SHUNT PROCEDURES W CC	1.1820	29.6
192	[7] PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	1.1820	29.6
193	[3] BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC	0.7637	24.8
194	[7] BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC	0.7637	24.8
195	[3] CHOLECYSTECTOMY W C.D.E. W CC	0.7637	24.8
196	[7] CHOLECYSTECTOMY W C.D.E. W/O CC	0.7637	24.8
197	[3] CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	0.7637	24.8
198	[7] CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC	0.7637	24.8
199	[7] HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	1.7034	38.5
200	[5] HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY	1.7034	38.5
201	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES	2.0371	36.1
202	CIRRHOSIS & ALCOHOLIC HEPATITIS	0.6610	20.6
203	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	0.7896	19.5
204	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	0.9441	22.7
205	DISORDERS OF LIVER EXCEPT MALIG, CIRR, ALC HEPA W CC	0.6642	20.5

TABLE 3.—FY 2006 LTC–DRGS, RELATIVE WEIGHTS AND GEOMETRIC AVERAGE LENGTH OF STAY—Continued

[Effective for discharges occurring on or after October 1, 2005 through September 30, 2006]

LTC–DRG	Description	Relative Weight	Geometric Average Length of Stay
206	[2] DISORDERS OF LIVER EXCEPT MALIG, CIRR, ALC HEPA W/O CC	0.5837	21.3
207	DISORDERS OF THE BILIARY TRACT W CC	0.7570	21.5
208	[2] DISORDERS OF THE BILIARY TRACT W/O CC	0.5837	21.3
210	[5] HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC	1.7034	38.5
211	[4] HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC	1.1820	29.6
212	[7] HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0–17	1.7034	38.5
213	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS	1.1948	34.0
216	[4] BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	1.1820	29.6
217	WND DEBRID & SKN GRFT EXCEPT HAND, FOR MUSCSKELET & CONN TISS DIS	1.2927	38.0
218	[5] LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W CC	1.7034	38.5
219	[1] LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W/O CC	0.4499	19.0
220	[7] LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE 0–17	1.7034	38.5
223	[3] MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC	0.7637	24.8
224	[7] SHOULDER, ELBOW OR FOREARM PROC, EXC MAJOR JOINT PROC, W/O CC	0.7637	24.8
225	FOOT PROCEDURES	0.9869	28.4
226	SOFT TISSUE PROCEDURES W CC	0.9443	29.5
227	[3] SOFT TISSUE PROCEDURES W/O CC	0.7637	24.8
228	[4] MAJOR THUMB OR JOINT PROC, OR OTH HAND OR WRIST PROC W CC	1.1820	29.6
229	[7] HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	0.4499	19.0
230	[5] LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR	1.7034	38.5
232	[7] ARTHROSCOPY	0.4499	19.0
233	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	1.3522	34.6
234	[7] OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC	0.4499	19.0
235	[3] FRACTURES OF FEMUR	0.7637	24.8
236	FRACTURES OF HIP & PELVIS	0.6531	25.2
237	[1] SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH	0.4499	19.0
238	OSTEOMYELITIS	0.8278	28.3
239	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY	0.6935	23.6
240	CONNECTIVE TISSUE DISORDERS W CC	0.7310	24.8
241	[1] CONNECTIVE TISSUE DISORDERS W/O CC	0.4499	19.0
242	SEPTIC ARTHRITIS	0.7864	26.5
243	MEDICAL BACK PROBLEMS	0.6061	23.4
244	BONE DISEASES & SPECIFIC ARTHROPATHIES W CC	0.5259	22.2
245	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	0.4635	20.4
246	[1] NON-SPECIFIC ARTHROPATHIES	0.4499	19.0
247	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE	0.5548	21.9
248	TENDONITIS, MYOSITIS & BURSITIS	0.6574	22.6
249	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	0.6577	24.7
250	[2] FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC	0.5837	21.3
251	[1] FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC	0.4499	19.0
252	[7] FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0–17	0.7637	24.8
253	FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE >17 W CC	0.6802	26.3
254	[2] FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE >17 W/O CC	0.5837	21.3
255	[7] FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE 0–17	0.7637	24.8
256	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	0.7924	25.3
257	[7] TOTAL MASTECTOMY FOR MALIGNANCY W CC	0.7637	24.8
258	[7] TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.7637	24.8
259	[2] SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC	0.5837	21.3
260	[7] SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.7637	24.8
261	[7] BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION	0.7637	24.8
262	[1] BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY	0.4499	19.0
263	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	1.3222	39.5
264	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC	0.9584	32.0
265	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC	1.0398	33.1
266	[3] SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC	0.7637	24.8
267	[7] PERIANAL & PILONIDAL PROCEDURES	0.7637	24.8
268	[5] SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES	1.7034	38.5
269	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.3037	36.1
270	[3] OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC	0.7637	24.8
271	SKIN ULCERS	0.8720	27.7
272	MAJOR SKIN DISORDERS W CC	0.7420	22.6
273	[1] MAJOR SKIN DISORDERS W/O CC	0.4499	19.0
274	[3] MALIGNANT BREAST DISORDERS W CC	0.7637	24.8
275	[7] MALIGNANT BREAST DISORDERS W/O CC	0.7637	24.8
276	[2] NON-MALIGANT BREAST DISORDERS	0.5837	21.3
277	CELLULITIS AGE >17 W CC	0.6264	21.0
278	CELLULITIS AGE >17 W/O CC	0.4420	17.8
279	[7] CELLULITIS AGE 0–17	0.4499	19.0

TABLE 3.—FY 2006 LTC–DRGS, RELATIVE WEIGHTS AND GEOMETRIC AVERAGE LENGTH OF STAY—Continued

[Effective for discharges occurring on or after October 1, 2005 through September 30, 2006]

LTC–DRG	Description	Relative Weight	Geometric Average Length of Stay
280	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC	0.6698	24.3
281	[1] TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC	0.4499	19.0
282	[7] TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0–17	0.4499	19.0
283	MINOR SKIN DISORDERS W CC	0.6935	23.9
284	[1] MINOR SKIN DISORDERS W/O CC	0.4499	19.0
285	AMPUTAT OF LOWER LIMB FOR ENDOCRINE, NUTRIT, & METABOL DISORDERS	1.3501	35.6
286	[7] ADRENAL & PITUITARY PROCEDURES	1.7034	38.5
287	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS	1.1387	33.9
288	[4] O.R. PROCEDURES FOR OBESITY	1.1820	29.6
289	[7] PARATHYROID PROCEDURES	1.1820	29.6
290	[5] THYROID PROCEDURES	1.7034	38.5
291	[7] THYROGLOSSAL PROCEDURES	1.1820	29.6
292	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	1.3409	31.7
293	[2] OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	0.5837	21.3
294	DIABETES AGE >35	0.7293	25.0
295	[3] DIABETES AGE 0–35	0.7637	24.8
296	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	0.7212	23.1
297	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC	0.5227	18.4
298	[7] NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0–17	0.5837	21.3
299	[4] INBORN ERRORS OF METABOLISM	1.1820	29.6
300	ENDOCRINE DISORDERS W CC	0.6376	21.2
301	[1] ENDOCRINE DISORDERS W/O CC	0.4499	19.0
302	[6] KIDNEY TRANSPLANT	0.0000	0.0
303	[4] KIDNEY, URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM	1.1820	29.6
304	[5] KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC	1.7034	38.5
305	[1] KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC	0.4499	19.0
306	[2] PROSTATECTOMY W CC	0.5837	21.3
307	[7] PROSTATECTOMY W/O CC	0.5837	21.3
308	[3] MINOR BLADDER PROCEDURES W CC	0.7637	24.8
309	[7] MINOR BLADDER PROCEDURES W/O CC	0.7637	24.8
310	[4] TRANSURETHRAL PROCEDURES W CC	1.1820	29.6
311	[7] TRANSURETHRAL PROCEDURES W/O CC	1.1820	29.6
312	[1] URETHRAL PROCEDURES, AGE >17 W CC	0.4499	19.0
313	[7] URETHRAL PROCEDURES, AGE >17 W/O CC	0.4499	19.0
314	[7] URETHRAL PROCEDURES, AGE 0–17	0.4499	19.0
315	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	1.4055	31.6
316	RENAL FAILURE	0.8219	22.7
317	ADMIT FOR RENAL DIALYSIS	0.9852	25.2
318	KIDNEY & URINARY TRACT NEOPLASMS W CC	0.7586	20.2
319	[1] KIDNEY & URINARY TRACT NEOPLASMS W/O CC	0.4499	19.0
320	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	0.6179	22.2
321	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	0.4792	19.0
322	[7] KIDNEY & URINARY TRACT INFECTIONS AGE 0–17	0.4499	19.0
323	[4] URINARY STONES W CC, &/OR ESW LITHOTRIPSY	1.1820	29.6
324	[7] URINARY STONES W/O CC	0.4499	19.0
325	[2] KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC	0.5837	21.3
326	[7] KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC	0.4499	19.0
327	[7] KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0–17	0.4499	19.0
328	[1] URETHRAL STRICTURE AGE >17 W CC	0.4499	19.0
329	[7] URETHRAL STRICTURE AGE >17 W/O CC	0.4499	19.0
330	[7] URETHRAL STRICTURE AGE 0–17	0.4499	19.0
331	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC	0.8010	23.1
332	[2] OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC	0.5837	21.3
333	[7] OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0–17	0.5837	21.3
334	[2] MAJOR MALE PELVIC PROCEDURES W CC	0.5837	21.3
335	[7] MAJOR MALE PELVIC PROCEDURES W/O CC	1.7034	38.5
336	[2] TRANSURETHRAL PROSTATECTOMY W CC	0.5837	21.3
337	[7] TRANSURETHRAL PROSTATECTOMY W/O CC	0.5837	21.3
338	[7] TESTES PROCEDURES, FOR MALIGNANCY	0.5837	21.3
339	[4] TESTES PROCEDURES, NON-MALIGNANCY AGE >17	1.1820	29.6
340	[7] TESTES PROCEDURES, NON-MALIGNANCY AGE 0–17	1.1820	29.6
341	[4] PENIS PROCEDURES	1.1820	29.6
342	[7] CIRCUMCISION AGE >17	1.1820	29.6
343	[7] CIRCUMCISION AGE 0–17	1.1820	29.6
344	[1] OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY	0.4499	19.0
345	[5] OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY	1.7034	38.5
346	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC	0.6060	20.6
347	[2] MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC	0.5837	21.3

TABLE 3.—FY 2006 LTC–DRGS, RELATIVE WEIGHTS AND GEOMETRIC AVERAGE LENGTH OF STAY—Continued

[Effective for discharges occurring on or after October 1, 2005 through September 30, 2006]

LTC–DRG	Description	Relative Weight	Geometric Average Length of Stay
348	[2] BENIGN PROSTATIC HYPERTROPHY W CC	0.5837	21.3
349	[7] BENIGN PROSTATIC HYPERTROPHY W/O CC	1.1820	29.6
350	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	0.6798	21.9
351	[7] STERILIZATION, MALE	1.1820	29.6
352	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	0.6375	23.4
353	[7] PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY	1.1820	29.6
354	[7] UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	1.1820	29.6
355	[7] UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC	1.1820	29.6
356	[7] FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	1.1820	29.6
357	[7] UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY	1.1820	29.6
358	[7] UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	1.1820	29.6
359	[7] UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	1.1820	29.6
360	[4] VAGINA, CERVIX & VULVA PROCEDURES	1.1820	29.6
361	[7] LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	0.7637	24.8
362	[7] ENDOSCOPIC TUBAL INTERRUPTION	0.7637	24.8
363	[7] D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	0.7637	24.8
364	[5] D&C, CONIZATION EXCEPT FOR MALIGNANCY	1.7034	38.5
365	[5] OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	1.7034	38.5
366	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	0.7072	20.3
367	[7] MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	0.7637	24.8
368	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	0.6416	20.7
369	[3] MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	0.7637	24.8
370	[7] CESAREAN SECTION W CC	0.7637	24.8
371	[7] CESAREAN SECTION W/O CC	0.5837	21.3
372	[7] VAGINAL DELIVERY W COMPLICATING DIAGNOSES	0.7637	24.8
373	[7] VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	0.7637	24.8
374	[7] VAGINAL DELIVERY W STERILIZATION &/OR D&C	0.7637	24.8
375	[7] VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	0.7637	24.8
376	[7] POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	0.7637	24.8
377	[7] POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	0.7637	24.8
378	[7] ECTOPIC PREGNANCY	0.7637	24.8
379	[7] THREATENED ABORTION	0.7637	24.8
380	[7] ABORTION W/O D&C	0.7637	24.8
381	[7] ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	0.7637	24.8
382	[7] FALSE LABOR	0.7637	24.8
383	[7] OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	0.7637	24.8
384	[7] OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	0.7637	24.8
385	[7] NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	0.7637	24.8
386	[7] EXTREME IMMATURITY	1.1820	29.6
387	[7] PREMATURITY W MAJOR PROBLEMS	1.1820	29.6
388	[7] PREMATURITY W/O MAJOR PROBLEMS	0.7637	24.8
389	[7] FULL TERM NEONATE W MAJOR PROBLEMS	1.1820	29.6
390	[7] NEONATE W OTHER SIGNIFICANT PROBLEMS	1.1820	29.6
391	[7] NORMAL NEWBORN	0.7637	24.8
392	[7] SPLENECTOMY AGE >17	0.7637	24.8
393	[7] SPLENECTOMY AGE 0–17	0.7637	24.8
394	[5] OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS	1.7034	38.5
395	RED BLOOD CELL DISORDERS AGE >17	0.6581	22.0
396	[7] RED BLOOD CELL DISORDERS AGE 0–17	0.5837	21.3
397	COAGULATION DISORDERS	0.8675	22.9
398	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	0.8240	23.7
399	[2] RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC	0.5837	21.3
401	[5] LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	1.7034	38.5
402	[7] LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC	0.5837	21.3
403	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	0.8757	21.3
404	[2] LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	0.5837	21.3
405	[7] ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0–17	0.5837	21.3
406	[4] MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W CC	1.1820	29.6
407	[7] MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W/O CC	1.1820	29.6
408	[4] MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R. PROC	1.1820	29.6
409	RADIOTHERAPY	0.8642	23.5
410	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	1.1684	26.4
411	[7] HISTORY OF MALIGNANCY W/O ENDOSCOPY	0.7637	24.8
412	[7] HISTORY OF MALIGNANCY W ENDOSCOPY	0.7637	24.8
413	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	0.8920	20.5
414	[7] OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC	0.5837	21.3
415	O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	1.4251	35.6
416	SEPTICEMIA AGE >17	0.8241	23.5

TABLE 3.—FY 2006 LTC–DRGS, RELATIVE WEIGHTS AND GEOMETRIC AVERAGE LENGTH OF STAY—Continued

[Effective for discharges occurring on or after October 1, 2005 through September 30, 2006]

LTC–DRG	Description	Relative Weight	Geometric Average Length of Stay
417	[7] SEPTICEMIA AGE 0–17	0.7637	24.8
418	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	0.8252	24.7
419	[4] FEVER OF UNKNOWN ORIGIN AGE >17 W CC	1.1820	29.6
420	[7] FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	1.1820	29.6
421	VIRAL ILLNESS AGE >17	0.9441	27.3
422	[7] VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0–17	0.4499	19.0
423	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	0.9505	21.8
424	[3] O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	0.7637	24.8
425	[2] ACUTE ADJUSTMENT REACTION & PSYCHOLOGICAL DYSFUNCTION	0.5837	21.3
426	DEPRESSIVE NEUROSES	0.4113	20.7
427	NEUROSES EXCEPT DEPRESSIVE	0.4653	23.8
428	[1] DISORDERS OF PERSONALITY & IMPULSE CONTROL	0.4499	19.0
429	ORGANIC DISTURBANCES & MENTAL RETARDATION	0.5813	26.8
430	PSYCHOSES	0.4330	24.2
431	[1] CHILDHOOD MENTAL DISORDERS	0.4499	19.0
432	[2] OTHER MENTAL DISORDER DIAGNOSES	0.5837	21.3
433	[2] ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	0.5837	21.3
439	SKIN GRAFTS FOR INJURIES	1.3677	35.6
440	WOUND DEBRIDEMENTS FOR INJURIES	1.3442	36.1
441	[1] HAND PROCEDURES FOR INJURIES	0.4499	19.0
442	OTHER O.R. PROCEDURES FOR INJURIES W CC	1.3937	33.4
443	[3] OTHER O.R. PROCEDURES FOR INJURIES W/O CC	0.7637	24.8
444	TRAUMATIC INJURY AGE >17 W CC	0.7584	26.3
445	[1] TRAUMATIC INJURY AGE >17 W/O CC	0.4499	19.0
446	[7] TRAUMATIC INJURY AGE 0–17	0.4499	19.0
447	[2] ALLERGIC REACTIONS AGE >17	0.5837	21.3
448	[7] ALLERGIC REACTIONS AGE 0–17	0.5837	21.3
449	[3] POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC	0.7637	24.8
450	[7] POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC	0.7637	24.8
451	[7] POISONING & TOXIC EFFECTS OF DRUGS AGE 0–17	0.7637	24.8
452	COMPLICATIONS OF TREATMENT W CC	0.9265	25.3
453	COMPLICATIONS OF TREATMENT W/O CC	0.5871	23.8
454	[3] OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC	0.7637	24.8
455	[7] OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC	0.7637	24.8
461	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES	1.2245	34.0
462	REHABILITATION	0.5787	22.4
463	SIGNS & SYMPTOMS W CC	0.6258	23.8
464	SIGNS & SYMPTOMS W/O CC	0.5554	24.1
465	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	0.6958	21.9
466	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	0.6667	21.9
467	[3] OTHER FACTORS INFLUENCING HEALTH STATUS	0.7637	24.8
468	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	2.1478	40.2
469	[6] PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	0.0000	0.0
470	[6] UNGROUPABLE	0.0000	0.0
471	[5] BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY	1.7034	38.5
473	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	0.8537	20.0
475	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	2.0831	34.6
476	[4] PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	1.1820	29.6
477	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	1.5836	35.3
479	[7] OTHER VASCULAR PROCEDURES W/O CC	0.7637	24.8
480	[6] LIVER TRANSPLANT	0.0000	0.0
481	[7] BONE MARROW TRANSPLANT	1.7034	38.5
482	[5] TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES	1.7034	38.5
484	[2] CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	0.5837	21.3
485	[7] LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TR	1.1820	29.6
486	[5] OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA	1.7034	38.5
487	OTHER MULTIPLE SIGNIFICANT TRAUMA	0.8992	26.0
488	[5] HIV W EXTENSIVE O.R. PROCEDURE	1.7034	38.5
489	HIV W MAJOR RELATED CONDITION	0.8535	21.4
490	HIV W OR W/O OTHER RELATED CONDITION	0.4919	16.6
491	[5] MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY	1.7034	38.5
492	[7] CHEMOTHERAPY W ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	1.1820	29.6
493	[5] LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.7034	38.5
494	[7] LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	1.7034	38.5
495	[6] LUNG TRANSPLANT	0.0000	0.0
496	[7] COMBINED ANTERIOR/POSTERIOR SPINAL FUSION	1.1820	29.6
497	[4] SPINAL FUSION W CC	1.1820	29.6
498	[7] SPINAL FUSION W/O CC	1.1820	29.6

TABLE 3.—FY 2006 LTC–DRGS, RELATIVE WEIGHTS AND GEOMETRIC AVERAGE LENGTH OF STAY—Continued

[Effective for discharges occurring on or after October 1, 2005 through September 30, 2006]

LTC–DRG	Description	Relative Weight	Geometric Average Length of Stay
499	[5] BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC	1.7034	38.5
500	[4] BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC	1.1820	29.6
501	[5] KNEE PROCEDURES W PDX OF INFECTION W CC	1.7034	38.5
502	[4] KNEE PROCEDURES W PDX OF INFECTION W/O CC	1.1820	29.6
503	[2] KNEE PROCEDURES W/O PDX OF INFECTION	0.5837	21.3
504	[7] EXTENSIVE BURN OR FULL THICKNESS BURNS WITH MECH VENT 96+ HOURS WITH SKIN GRAFT.	1.7034	38.5
505	[4] EXTENSIVE BURN OR FULL THICKNESS BURNS WITH MECH VENT 96+ HOURS WITHOUT SKIN GRAFT.	1.1820	29.6
506	[4] FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA	1.1820	29.6
507	[3] FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA	0.7637	24.8
508	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ W CC OR SIG TRAUMA	0.8367	29.4
509	[1] FULL THICKNESS BURN W/O SKIN GRFT OR INH INJ W/O CC OR SIG TRAUMA	0.4499	19.0
510	NON-EXTENSIVE BURNS W CC OR SIGNIFICANT TRAUMA	0.7709	24.6
511	[1] NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA	0.4499	19.0
512	[6] SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT	0.0000	0.0
513	[6] PANCREAS TRANSPLANT	0.0000	0.0
515	[5] CARDIAC DEFIBRILATOR IMPLANT W/O CARDIAC CATH	1.7034	38.5
518	[7] PERCUTANEOUS CARDIVASCULAR PROC W/O CORONARY ARTERY STENT OR AMI	0.7637	24.8
519	[5] CERVICAL SPINAL FUSION W CC	1.7034	38.5
520	[7] CERVICAL SPINAL FUSION W/O CC	1.1820	29.6
521	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	0.4457	19.4
522	[7] ALCOHOL/DRUG ABUSE OR DEPENDENCE W REHABILITATION THERAPY W/O CC	0.4499	19.0
523	[7] ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W/O CC	0.4499	19.0
524	TRANSIENT ISCHEMIA	0.5043	21.1
525	[7] OTHER HEART ASSIST SYSTEM IMPLANT	1.7034	38.5
528	[7] INTRACRANIAL VASCULAR PROC W PDX HEMORRHAGE	1.7034	38.5
529	[5] VENTRICULAR SHUNT PROCEDURES W CC	1.7034	38.5
530	[7] VENTRICULAR SHUNT PROCEDURES W/O CC	1.7034	38.5
531	[3] SPINAL PROCEDURES WITH CC	0.7637	24.8
532	[3] SPINAL PROCEDURES WITHOUT CC	0.7637	24.8
533	[5] EXTRACRANIAL VASCULAR PROCEDURES WITH CC	1.7034	38.5
534	[7] EXTRACRANIAL VASCULAR PROCEDURES WITHOUT CC	1.1820	29.6
535	[7] CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK	1.7034	38.5
536	[7] CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK	1.7034	38.5
537	LOCAL EXCISION AND REMOVAL OF INTERNAL FIXATION DEVICES EXCEPT HIP AND FEMUR WITH CC.	1.1615	34.7
538	[7] LOCAL EXCISION AND REMOVAL OF INTERNAL FIXATION DEVICES EXCEPT HIP AND FEMUR WITHOUT CC.	1.1820	29.6
539	[4] LYMPHOMA AND LEUKEMIA WITH MAJOR O.R. PROCEDURE WITH CC	1.1820	29.6
540	[7] LYMPHOMA AND LEUKEMIA WITH MAJOR O.R. PROCEDURE WITHOUT CC	0.5837	21.3
541	ECMO OR TRACH W MECH VENT 96+ HRS OR PDX EXCEPT FACE, MOUTH & NECK DIAG WITH MAJOR OR.	4.2287	65.6
542	TRACH W MECH VENT 96+ HRS OR PDX EXCEPT FACE, MOUTH & NECK DIAG WITHOUT MAJOR OR.	3.1869	48.2
543	[5] CRANIOTOMY W IMPLANT OF CHEMO AGENT OR ACUTE COMPLEX CNS PDX	1.7034	38.5
544	[5] MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY	1.7034	38.5
545	[5] REVISION OF HIP OR KNEE REPLACEMENT	1.7034	38.5
546	[7] SPINAL FUSION EXCEPT CERVICAL WITH CURVATURE OF SPINE OR MALIGNANCY	1.7034	38.5
547	[7] CORONARY BYPASS WITH CARDIAC CATH WITH MAJOR CV DIAGNOSIS	1.7034	38.5
548	[7] CORONARY BYPASS WITH CARDIAC CATH WITHOUT MAJOR CV DIAGNOSIS	1.7034	38.5
549	[7] CORONARY BYPASS WITHOUT CARDIAC CATH WITH MAJOR CV DIAGNOSIS	1.7034	38.5
550	[7] CORONARY BYPASS WITHOUT CARDIAC CATH WITHOUT MAJOR CV DIAGNOSIS	1.7034	38.5
551	[4] PERMANENT CARDIAC PACEMAKER IMPLANT WITH MAJOR CV DIAGNOSIS OR AICD LEAD OR GNRTR.	1.1820	29.6
552	[4] OTHER PERMANENT CARDIAC PACEMAKER IMPLANT WITHOUT MAJOR CV DIAGNOSIS	1.1820	29.6
553	[8] OTHER VASCULAR PROCEDURES WITH CC WITH MAJOR CV DIAGNOSIS	1.3255	30.6
554	[8] OTHER VASCULAR PROCEDURES WITH CC WITHOUT MAJOR CV DIAGNOSIS	1.3255	30.6
555	[4] PERCUTANEOUS CARDIOVASCULAR PROC WITH MAJOR CV DIAGNOSIS	1.1820	29.6
556	[8] PERCUTANEOUS CARDIOVASCULAR PROC WITH NON-DRUG-ELUTING STENT WITHOUT MAJOR CV DIAGNOSIS.	1.1820	29.6
557	[8] PERCUTANEOUS CARDIOVASCULAR PROC WITH DRUG-ELUTING STENT WITH MAJOR CV DIAGNOSIS.	1.1820	29.6
558	[7] PERCUTANEOUS CARDIOVASCULAR PROC WITH DRUG-ELUTING STENT WITHOUT MAJOR CV DIAGNOSIS.	1.1820	29.6
559	[7] ACUTE ISCHEMIC STROKE WITH USE OF THROMBOLYTIC AGENT	0.7637	24.8

[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 assigned a value of 0.0000.
[7] Relative weights for these LTC-DRGs were determined by assigning these cases to the appropriate low volume quintile because there are no LTCH cases in the FY 2004 MedPAR file.
[8] Relative weights for these LTC-DRGs were determined after adjusting to account for nonmonotonicity.

[FR Doc. 06–665 Filed 1–19–06; 4:05 pm]

BILLING CODE 4120–01–P