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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412

[CMS–1485–F]

RIN 0938–AO06

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

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

ACTION: Final Rule.

SUMMARY: This final rule updates the annual payment rates for the Medicare prospective payment system (PPS) for inpatient hospital services provided by long-term care hospitals (LTCHs). The payment amounts and factors used to determine the updated Federal rates that are described in this final rule have been determined for 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 will continue to be effective each October 1. The outlier threshold for July 1, 2006, through June 30, 2007, is also derived from the LTCH PPS rate year calculations. We are also finalizing policy changes and making clarifications.

DATES: This final rule is effective July 1, 2006.

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Acronyms

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

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
HCO High-cost outlier
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
NAICS North American Industrial Classification System
NCHS National Center for Health Statistics
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))
RIA Regulatory impact analysis
RPL Rehabilitation psychiatric long-term care (hospital)
RTI Research Triangle Institute, International
RY Rate year (begins July 1 and ends June 30)
SIC Standard industrial code
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

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) provides 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 the 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. Generally, 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 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 FY 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 co-located 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 a 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 FY 2004 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 (68 FR 45464). 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 FY 2004 IPPS final rule, we are unable to capture the necessary data from our present cost reporting forms (68 FR 45464). 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 (ASCA) and Health Insurance Portability and Accountability Act (HIPAA) 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 the ASCA requires that the Medicare Program 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 the 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 the ASCA.) Section 3 of the 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. Publication of Proposed Rulemaking

On January 27, 2006, we published the RY 2007 LTCH PPS proposed rule in the Federal Register (71 FR 4648 through 4779) that set forth the proposed annual update to the payments for the Medicare prospective payment system (PPS) for inpatient hospital services provided by long-term care hospitals (LTCHs) for the 2007 LTCH PPS rate year. (The annual update of the LTC–DRG classifications and relative weights for FY 2007 remains linked to the annual adjustments of the acute care hospital inpatient DRG system, which will be published by August 1, 2006 and will be effective October 1, 2006.

In the RY 2007 LTCH PPS proposed rule (71 FR 4648 through 4779), we discussed the proposed annual update to the payment rates for the Medicare LTCH PPS, as well as other proposed policy changes. The following is a summary of the major areas that we addressed in the proposed rule.

In the proposed rule, we discussed 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. (See section IV. of this preamble.)

In addition, we proposed 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. (See section V.B. of this preamble.)

We also proposed 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. (See section V.C. of this preamble.)

In that same proposed rule, we discussed the proposed prospective payment rate for RY 2007, and 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 also proposed revisions to the cost-to-charge ratio and reconciliation provisions as they apply to LTCH outlier payment policies. (See section V.C. and V.D. of this preamble.)

In addition, we discussed our proposal to revise the LTCH PPS labor-related share based on RPL market basket and our proposal to revise the labor-related and non-labor related shares of the Federal rate based on the RPL market basket. We also proposed to postpone the deadline for making the one-time prospective adjustment for the Federal rate at § 412.523(d)(3). (See section V.D. of this preamble.)

Also, we proposed 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. We also proposed 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). (See section VI.A. of this preamble.)

For LTCH hospitals within hospitals (HwHs) and LTCH satellites, we proposed 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 will calculate the LTCH PPS payment amount that is equivalent to what would otherwise be paid under the IPPS. We also proposed 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). (See section VI.B. of this preamble.)

In the same proposed rule, we discussed our on-going monitoring protocols under the LTCH PPS. (See section XI. of this preamble.)

In addition, we discussed 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. (See section XII. of this preamble.)

We also analyzed the impact of the proposed changes presented in the proposed rule on Medicare expenditures, Medicare-participating LTCHs, and Medicare beneficiaries. (See section XIV. of this preamble.)

In Appendix A of the proposed rule, we presented 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.

We received a total of 860 timely comments on the proposed rule. The major issues addressed by the commenters included: The proposed update framework; the proposed RPL framework; the proposed update to the Federal rate for RY 2007; the proposed high cost outlier (HCO) threshold for RY 2007; the proposed revision to the cost-to-charge ratios and reconciliation provisions as they apply to LTCH outlier payment policies; the proposed sunsetting of the surgical-DRG exception to the 3-day or less interruption of stay policy; the proposed SSO policy; the proposed postponement of the one-time prospective adjustment to the standard Federal rate; the proposed clarification of the present policy for adjusting the LTCH PPS payment for LTCH HwHs and LTCH satellites; and discussion of the recommendations made by RTI.

Summaries of the public comments received and our responses to those comments are described below under the appropriate heading.

III. Summary of the Major Contents of This Final Rule

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

A. Update Changes

In section IV 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, which 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 V. through XII. of this preamble, we specify the factors and adjustments used to determine the LTCH PPS rates that are applicable to the 2007 LTCH PPS rate year, including revisions to the wage index, the applicable adjustments to payments, cost-of-living adjustment factors, the outlier threshold, the budget neutrality factor, MedPAC recommendations and monitoring.

In section V.B. of this preamble, we are adopting the ''Rehabilitation, Psychiatric, Long-Term Care (RPL)'' market basket under the LTCH PPS in place of the excluded hospital with capital market basket. We are also revising the labor-related share (and non-labor related share) of the Federal rate based on the RPL market basket. (See section V.D.1.c. of this preamble).

As discussed in section V.C. of this preamble, we are implementing a zero percent update to the LTCH PPS Federal rate for the 2007 LTCH PPS rate year based on an adjustment to the most recent estimate of the LTCH PPS market basket to account for apparent case-mix increase.

While we proposed to revise the cost-to-charge ratio and reconciliation provisions as they apply to LTCH outlier payment policies, we are not making these changes in this final rule; rather, in response to comments, we are again proposing these policies in the FY 2007 IPPS proposed rule, and we are including additional data requested by commenters.

B. Policy Changes

In section V.D.6. of this preamble, we are postponing the deadline for making the one-time prospective adjustment for the Federal rate at § 412.523(d)(3).

In section VI.A. of this preamble, we are revising the existing payment adjustment for SSO cases. Also in section VI.A. of this preamble, we are sunsetting 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 VI.B. of this preamble, for LTCH hospitals within hospitals (HwHs) and LTCH satellites, we are clarifying at § 412.534(c) the policy for adjusting the LTCH PPS payment based on the amount that would be determined under the IPPS methodology. We state the methodology used for calculating the LTCH PPS payment amount that is equivalent to what would otherwise be paid under the IPPS. We are also codifying 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).

C. MedPAC Recommendations

In section XII.A. of this preamble, we discuss the recommendation made in

the March 2006 *Report to Congress: Medicare Payment Policy* to eliminate an update to payment rates for long-term care services for RY 2007.

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

In Appendix A of this final 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.

D. Impact

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

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

A. Background

Section 123 of the BBRA specifically requires that the Secretary implement a PPS for LTCHs (that is, a per discharge system with a DRG-based patient classification system reflecting the differences in patient resources and costs in LTCHs while maintaining budget neutrality). Section 307(b)(1) of the 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 the 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). A listing of the composition of proposed low volume quintiles used in determining the proposed FY 2007 LTC–DRG relative weights appears in the FY 2007 IPPS proposed rule (71 FR 24054 through 24058). 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, a 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 an 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 to use the ASC X12N 837 Health Care Claim: Institutional, Volumes 1 and 2, version 4010, and the applicable standard medical data code sets for the institutional health care claim or equivalent encounter information transaction. (See 45 CFR 162.1002 and 45 CFR 162.1102).

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 the 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 IV.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–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 (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 could 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 planned 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).

In the FY 2007 IPPS proposed rule, we present the proposed changes to the DRG system for FY 2007 (71 FR 24049). In that rule, we proposed to use the IPPS GROUPER Version 24.0 for FY 2007 to process LTCH PPS claims for LTCH discharges occurring from October 1, 2006 through September 30, 2007 (71 FR 24049). As we also noted in that proposed rule, in its March 1, 2005 Report to Congress on Medicare Payment Policy (page 64) and Recommendation 1 in the 2005 Report to Congress on Physician-Owned Specialty Hospitals, MedPAC recommended that CMS, among other things, refine the current DRGs under the IPPS to more fully capture differences in severity of illness among patients. In evaluating this MedPAC recommendation for the IPPS, we are evaluating the APR–DRG Grouper used by MedPAC in its analysis. Based on this analysis, we developed a consolidated severity adjusted DRG system that we believe could be a better alternative for recognizing severity of illness among the Medicare population that we are considering to propose for future use under the IPPS. As discussed above in this section, the LTCH PPS uses the same patient classification system (that is, DRGs). In response to MedPAC recommendations that severity adjusted DRGs be adopted under the IPPS, we are examining the possibility of adopting a consolidated version of the APR–DRGs. In the event that severity adjusted DRGs, such as the consolidated severity adjusted DRGs, are adopted under the IPPS, we would need to consider whether to revise the patient classification system under the LTCH PPS. Any proposed changes to the patient classification system would be done through notice and comment rulemaking.

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. 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, historically in the health care industry 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 on April 1 [sic] of each year, but the addition of such codes shall not require the Secretary to adjust the payment (or diagnosis-related group classification) * * * until the fiscal year that begins after such date.'' This requirement 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 until the following October 1. Any coding updates will be available through the websites provided in section IV.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 an 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 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. As noted previously in this section, in the FY 2007 IPPS proposed rule (71 FR 24050), we proposed to use Version 24.0 of the CMS GROUPER, which would be used under the IPPS for FY 2007, to classify cases for LTCH PPS discharges that would occur on or after October 1, 2006 and on or before September 30, 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 the Department of Health and Human Services (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 on 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, the *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 have been 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 IV.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, the *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: *http://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 for the 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 effects 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 the *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).)

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 final rule lists the LTC–DRGs and their respective relative weights, geometric ALOS, and five-sixths of the geometric ALOS 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 was presented in the FY 2007 IPPS proposed rule (since there will be no April 1, 2006 updates to the ICD–9–CM coding system). In addition, the proposed DRGs and GROUPER for FY 2007 that would be used for the IPPS and the LTCH PPS, effective October 1, 2006, were presented in the IPPS FY 2007 proposed rule in the **Federal Register** (71 FR 24049 through 24068). As discussed in that proposed rule, we proposed to calculate the proposed LTC–DRG relative weights for FY 2007 using total Medicare allowable charges from FY 2005 Medicare LTCH bill data from the December 2005 update of the MedPAR file, which were the best available data at that time, and we used the proposed Version 24.0 of the CMS GROUPER, which would be the same GROUPER that we proposed to use under the IPPS in FY 2007 to classify cases. Furthermore, to calculate the final LTC–DRG relative weights for FY 2007, we proposed that if more recent data are available (for example, data from the March 2006 update of the MedPAR file), we would use that data and use the finalized Version 24.0 of the CMS GROUPER. Table 11 of the Addendum to the FY 2007 IPPS proposed rule lists the proposed LTC–DRGs and their respective proposed relative weights, proposed geometric ALOS, and proposed five-sixths of the geometric ALOS that would be effective for LTCH PPS discharges occurring on or after October 1, 2006 through September 30, 2007 (71 FR 24394 through 24403).

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

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 factors that will be used to update the LTCH PPS standard Federal rate for the 2007 LTCH PPS rate year that will be effective for LTCH 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 for the initial year of implementation. 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 the BIPA specified that the increases to the hospital-specific target amounts and the cap on the target amounts for LTCHs for FY 2002 provided for by section 307(a)(1) of the BIPA shall not be considered 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. 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 excluded hospital with capital market basket used under the LTCH PPS, 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 inpatient rehabilitation facility (IRF) PPS. The RPL market basket is based on the operating and capital costs of 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 the broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of the BIPA to develop the LTCH PPS, in the RY 2007 LTCH PPS proposed rule (71 FR 4659), we proposed 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. In that proposed rule, we proposed that we would adopt the RPL market basket based on FY 2002 cost report data beginning in the 2007 LTCH PPS rate year, under the LTCH PPS. We chose 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.

As also discussed in that proposed rule, the RPL market basket reflects the operating and capital cost structures for IRFs, IPFs, and LTCHs. We proposed to exclude children's hospitals, 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. Children's hospitals, cancer hospitals, and RNHCIs are not reimbursed under a PPS. Also, based on FY 2002 data, the cost structures for these 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 hospitals, children's hospitals, and RNHCIs. Therefore, the compensation cost weights for IRFs, IPFs, and LTCHs are larger than those in cancer hospitals, children's hospitals, and RNHCIs. In addition, the depreciation cost weights for IRFs, IPFs, and LTCHs are noticeably smaller than those for children's hospitals, cancer hospitals, and RNCHIs. Therefore, including the fact that IRFs, IPFs, and LTCHs are subject to a PPS while children's hospitals, cancer hospitals 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.

Comment: We received several comments supporting our proposal to adopt the RPL market basket based on FY 2002 cost report data under the LTCH PPS, beginning in the 2007 LTCH PPS rate year. Along with their endorsement of this proposal, a few commenters stated that the proposed capital weight methodology may be skewed. As previously stated in this rule, we stated in the proposed rule that the depreciation cost weights for IRFs, IPFs, and LTCHs are smaller than those for children's and cancer hospitals. The commenter noted that since most LTCHs are ''units within hospitals'' (that is, hospitals-within-hospitals), the proposed methodology may be more heavily aligned with a ''unit'' perspective as proposed to a ''freestanding hospital'' perspective. The commenters claim that freestanding LTCHs will have higher depreciation costs, which are probably closer to those associated with children's and cancer hospitals.

Response: The RPL market basket is based on data from freestanding IRFs, IPFs, and LTCHs. As a general rule, we do not include hospital-based facilities in our market baskets because expense data for a hospital-based facility are influenced by the allocation of overhead over the entire institution. Due to this method of allocation, total expenses will be correct, but the expenses of the individual components may be skewed. The cost structures of freestanding LTCHs should reflect purchasing patterns of the average LTCH.

Our analysis of depreciation cost weights is based on freestanding facilities. This depreciation cost weight (depreciation costs as a percent of total capital costs) for freestanding LTCHs is approximately 57 percent compared to 85 percent for children's and cancer hospitals. Therefore, we do not believe that the proposed capital weight methodology is skewed (that is, more heavily aligned with a hospital-based perspective since they are not included in our market basket). Rather, we believe the RPL market basket accurately reflects the capital cost structure of freestanding LTCHs serving Medicare beneficiaries.

In the following discussion, we provide a background on market baskets and describe the methodologies we used to develop the operating and capital portions of the FY 2002-based RPL market basket that we are adopting for use under the LTCH PPS beginning in RY 2007 under broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of the BIPA.

1. Overview of the RPL Market Basket

The 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 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 answers the question of how much it would 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 final rule, we are rebasing and revising the market basket used to update the LTCH PPS. Specifically, as noted above in this section and as we proposed in the RY 2007 LTCH PPS proposed rule (71 FR 4659 through 4666), beginning in the 2007 LTCH PPS rate year, we are using the FY 2002-based RPL market basket, which is described in greater detail below in this section.

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

The 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: Wages, drugs, professional liability insurance (PLI), and a residual ''all other'' category. 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 IPPS hospital 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 (I–O) 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, PLI, and a residual ''all other'' category. As stated above in this section, we are using 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 will 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 IRFs, IPFs, and LTCHs reported benefit cost data in FY 2002. We noticed an increase in the cost data for these expense categories over the last 4 years. (We note that in the future, there may be sufficient IRF, IPF, and LTCH cost report data to develop the weights for these expenditure categories.)

Since the cost weights for the RPL market basket are based on facility costs, we are limiting our sample to hospitals with a Medicare average length of stay (ALOS) 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 are using 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 will use 15 percent because it includes those LTCHs and IRFs whose Medicare ALOS is within approximately 5 days of the facility ALOS. We believe this edit provides us with a representative sample of LTCHs and IRFs serving Medicare beneficiaries.

We are using a less stringent measure of Medicare ALOS 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 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 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 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 RPL market basket is accounted for by wages, drugs, and PLI data from FY 2002 Medicare cost report data for IRFs, IPFs, and LTCHs.

Comment: Several commenters propose that we regularly re-analyze the RPL cost report data, which are the basis of the RPL market basket. They note that the methodology used for the RPL market basket includes data from the IPPS hospital market basket. These commenters encouraged us to work with providers to improve the cost reports from IRFs, IPFs, and LTCHs to ensure that the data used for the RPL market basket represent only the types of excluded hospitals for which the RPL market basket was developed. Furthermore, they believe that improving the data reported on the cost reports of IRFs, IPFs, and LTCHs would not only refine the RPL market basket but also would improve the accuracy of the labor-related share to which the wage index is applied.

Response: As noted above in this section, we rely on the IPPS hospital cost report data to supplement the IRF, IPF, and LTCH Medicare cost report

data for benefits, contract labor, and blood and blood products. For example, the ratio of the benefit cost weight to the wages and salaries cost weight in the FY 2002-based IPPS market basket is applied to the RPL wages and salaries cost weight to derive a benefit cost weight for the RPL market basket. We did not directly use the IPPS Medicare cost report data, rather we used these data to determine the relationships between benefits, contract labor, and blood and blood products with wages and salaries. The wages and salaries cost weight in the RPL market basket is derived using the IRF, IPF and LTCH Medicare cost reports and accounts for 50 percent of the RPL market basket. As noted above in this section and as discussed in the RY 2007 LTCH PPS proposed rule (71 FR 4660), due to data limitations, this was the best methodology for developing the latter cost weights.

We agree with the commenters that improving the data reported on the cost reports of IRFs, IPFs, and LTCHs could improve the RPL market basket and labor-related share. We have noticed this data improvement on other provider-type cost reports. Therefore, we encourage IRFs, IPFs, and LTCHs to fully complete their cost reports; this would help us in developing the most complete and accurate market basket possible. We will continue to analyze RPL cost report data on a regular basis.

The following is a summary outlining the choice of the proxies we used for the operating portion of the market basket. The price proxies for the capital portion are described in more detail in section V.B.3. of this preamble. With the exception of the Professional Liability proxy, all the price proxies for the operating portion of the 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 will 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 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 for this final rule 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 RY 2004 LTCH PPS 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 2002-based RPL market basket including cost categories, weights, and price proxies for the operating portion of the market basket. The price proxies for the capital portion are described in more detail in the capital methodology section. 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 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 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 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 3 percentage points are due to the new base year (FY 2002 instead of FY 1997), 3 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 ALOS in within 30 or 50 percent of the total facility ALOS), and the remaining 2 percentage points are due to the exclusion of other types of IPPS-excluded hospitals (that is, only including IPFs, IRFs, and LTCHs in the market basket and excluding childrens hospitals, cancer hospitals, and RNCHIs).

TABLE 2.—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	FY 2002-based RPL market basket	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.
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 expense categories from Table 2.

a. Wages and Salaries

For measuring the price growth of wages in the FY 2002-based RPL market basket, consistent with our proposal, we will use the ECI for wages and salaries for civilian hospital workers as the proxy for wages in the RPL market basket. The RPL market basket uses the BLS' Employment Cost Indexes (ECIs) as proxies for wages and salaries, and benefits for civilian industry workers classified in the Standard Industrial Code (SIC) 806, Hospitals. However, beginning April 28, 2006, with the publication of March 2006 data, the ECIs will be converted from the SIC system to the North American Industrial Classification System (NAICS). The NAICS-based ECI for hospitals (NAICS 622) is similar (at least 90 percent identical) to the SIC-based ECI for hospitals. Therefore, when they are available, we will use the NAICS-based ECIs for hospitals as proxies to reflect the rate-of-price change for the wages and salaries and employee benefits cost categories in the 2002-based RPL market basket. The RPL market basket and labor-related share in this final rule will use the most recent data available from BLS. We do not expect the RPL market basket and labor-related share to change significantly when the conversion from the SIC system to the NAICS system takes place.

b. Employee Benefits

The 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 will 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) will 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) will be applied to this component.

f. Water and Sewage

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

g. Professional Liability Insurance (PLI)

The FY 2002-based RPL market basket will 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 will 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 there is no change in the proxy in this final rule.

h. Pharmaceuticals

The percentage change in the price of prescription drugs as measured by the PPI (PPI Code #PPI32541DRX) will 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) will 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) will 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) will 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) will 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) will 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) will 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) will be used.

p. Apparel

The percentage change in the price of apparel as measured by the PPI (Commodity Code #381) will 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) will 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) will be applied to this component. Using this index will 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 products 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 the RY 2007 LTCH PPS proposed rule (71 FR 4663), 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 using 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 will continue to evaluate this proxy for its appropriateness and will 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) will 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) will 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 will 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) will be applied to this component.

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

Unlike for the operating costs of the FY 2002-based RPL market basket, we do 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, as we proposed, in this final rule we used 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. As explained in the RY 2007 LTCH PPS proposed rule (71 FR 4663), we believe this is the best approach since these data are the most similar to the capital cost structures of those IRFs, IPFs, and LTCHs serving Medicare beneficiaries that require inpatient hospital services.

As we proposed, in this final rule we calculated weights for the 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 weights for both operating and capital costs. The resulting 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 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. As explained in the RY 2007 LTCH PPS proposed rule (71 FR 4664), we assume 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 are 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 split between building and fixed equipment and movable equipment was determined using the FY 2001 Medicare cost reports for IRFs, IPFs, and LTCHs. As explained in the RY 2007 LTCH PPS proposed rule (71 FR 4664), 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. In the FY 2003 IPPS final rule, we also used this methodology to compute the 1997-based index (August 1, 2002; 67 FR 50044).

The 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.

As we proposed, for this final rule we 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 used 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. As explained in the RY 2007 LTCH PPS proposed rule (71 FR 4664), 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 use a 75–25 split to allocate interest expenses to government/nonprofit and for-profit hospitals' interest as stated in the FY 2006 IPPS final rule (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 using the vintage weights to compute vintage-weighted price changes associated with depreciation and interest expense.

Vintage weights are an integral part of the 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 FY 2002-based RPL market basket reflects the annual price changes associated with capital costs, and is a useful simplification of the actual capital investment process. As explained in the RY 2007 LTCH PPS proposed rule (71 FR 4664), 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 FY 2002-based RPL market basket will 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 need 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. As explained in the RY 2007 LTCH PPS proposed rule (71 FR 4664), the early Medicare Cost Reports are not sufficiently completed to have capital data to meet this need. While the AHA Panel Survey provides a consistent database back to 1963, it does not provide annual capital purchases. However, the AHA Panel Survey provides 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 use FY 2001 Medicare Cost Reports for IPPS hospitals to determine the expected life of building and fixed equipment and movable equipment. As explained in the RY 2007 LTCH PPS proposed rule (71 FR 4664), 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.

As we proposed, for this final rule we also used 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 are determined. Then, we calculate 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.

As we proposed, for this final rule for building and fixed equipment vintage weights, the real annual capital purchase amounts for building and fixed equipment derived from the AHA Panel Survey are 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. As explained in the RY 2007 LTCH PPS proposed rule (71 FR 4664), we believe this proxy continues to meet our criteria of reliability, timeliness, availability, and relevance (discussed previously in this final rule). 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 movable equipment vintage weights, as we proposed, for this final rule the real annual capital purchase amounts for movable equipment derived from the AHA Panel Survey are 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 FY 2002 average movable equipment vintage weights.

As we proposed, for this final rule for 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 are used. Nominal annual purchase amounts are 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 FY 2002 average interest vintage weights. The vintage weights for the index are presented in Table 3.

In addition to the price proxies for depreciation and interest costs described above in the vintage weighted capital section, as we proposed, for this final rule we used 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 will be reflected in the price changes of residential rent because rent is assumed to move with taxes and insurance in order to maintain profit margins. The price proxies for each of the capital cost categories are the same as those used for the FY 2003 IPPS final rule (67 FR 50044) capital input price index.

TABLE 3.—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	0.021	0.065	0.010
2	0.022	0.071	0.012
3	0.025	0.077	0.014
4	0.027	0.082	0.016
5	0.029	0.086	0.019
6	0.031	0.091	0.023
7	0.033	0.095	0.026
8	0.035	0.100	0.029
9	0.038	0.106	0.033
10	0.040	0.112	0.036
11	0.042	0.117	0.039
12	0.045	.....	0.043
13	0.047	.....	0.048
14	0.049	.....	0.053
15	0.051	.....	0.056
16	0.053	.....	0.059
17	0.056	.....	0.062
18	0.057	.....	0.064
19	0.058	.....	0.066
20	0.060	.....	0.070
21	0.060	.....	0.071
22	0.061	.....	0.074
23	0.061	.....	0.076
Total	1.000	1.000	1.000

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

As discussed previously in this final rule, beginning in the 2007 LTCH PPS rate year, we are adopting the FY 2002-based RPL market basket as the appropriate market basket of goods and services under the LTCH PPS. As discussed in greater detail below, we are implementing the proposed zero percent reduction to the LTCH PPS Federal rate for the 2007 LTCH PPS rate year as discussed in the RY 2007 LTCH PPS proposed rule (71 FR 4667 through 4670), rather than using an update based solely on the most recent estimate of the LTCH PPS market basket as we have done in the past. In addition, as we discuss in section V.D.1.c. of this preamble, as we proposed, for this final rule we are revising the LTCH PPS labor-related share based on the 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 FY 2002-based RPL market basket.

In the RY 2007 LTCH PPS proposed rule (71 FR 4666), the most recent estimate of the RPL market basket at that time for July 1, 2006 through June 30, 2007 (the 2007 LTCH PPS rate year) was 3.6 percent, which was based on Global Insight's 3rd quarter 2005 forecast with history through the 2nd quarter of 2005. In this final rule, consistent with our historical practice of using the most recent available data, based on Global Insight's 1st quarter 2006 forecast with history through the 4th 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 3.4 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 1st quarter 2006 forecast, with history through the 4th quarter of 2005, for the 2007 LTCH PPS rate year is also 3.4 percent. Table 4 compares the 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 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 FY 2002-based RPL having a larger compensation (that 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 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.—FY 2002-BASED RPL MARKET BASKET AND FY 1997-BASED EXCLUDED HOSPITAL WITH CAPITAL MARKET BASKET, PERCENT CHANGES: 2000–2008

Fiscal year (FY)	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	4.0
Average RY 2001–2005	3.8	3.8
Forecast:		
RY 2006	3.6	3.8
RY 2007	3.4	3.4
RY 2008	3.2	3.1
RY 2009	2.9	2.8
Average RY 2006–2009	3.3	3.3

Source: Global Insight, Inc. 1st Qtr 2006, @USMACRO/CNTL0306 @CISSIM/CNTL08R3.SIM

C. 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 PPS would be equal to the 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.

In the RY 2007 LTCH PPS proposed rule (71 FR 4667 through 4670), we explain how we developed the proposed standard Federal rate for the 2007 LTCH PPS rate year. Specifically, we explained our rationale, which was based on our ongoing monitoring activities, for proposing a zero percent update to the standard Federal rate for the 2007 LTCH PPS rate year, which was based on the most recent estimate in the RPL market basket offset by an adjustment for changes in coding practices, 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. Therefore, in that proposed rule, we proposed a standard Federal rate for the 2007 LTCH PPS rate year of $38,086.04. In the discussion that follows, we explain how we developed the final standard Federal rate for the 2007 LTCH PPS rate year. Specifically, we explain our rationale, which is based on our ongoing monitoring activities, for the zero percent update to the standard Federal rate for the 2007 LTCH PPS rate year, which is based on the most recent estimate in the RPL market basket offset by an adjustment for changes in coding practices as discussed in greater detail below, rather than solely using the most recent estimate of the RPL market basket as the update factor for the Federal rate for the upcoming rate year. Thus, the standard Federal rate for the 2007 LTCH PPS rate year will 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 56086), 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 update to the standard Federal rate for the 2007 LTCH PPS rate year.

As we discussed in the RY 2007 LTCH PPS proposed rule (71 FR 4667), although we do not have enough complete data at this time to 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 did not propose to employ an analytical update framework in that proposed rule to determine the 2007 LTCH PPS rate year update to the standard Federal rate,

we presented a preliminary model of an update framework, using the best available data and concepts, in Appendix A of that proposed rule, which we may propose to adopt at some time in the future under the LTCH PPS. Furthermore, in the RY 2007 LTCH PPS proposed rule, we solicited comments on that preliminary update framework methodology and its application, which we may propose to adopt at some time in the future under the LTCH PPS. Also, we stated that we would appreciate comments regarding recommendations to improve it.

We received a few comments on the preliminary model of an update framework that was presented in Appendix A of the RY 2007 LTCH PPS proposed rule (71 FR 4742 through 4747). In this final rule, we are again 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 under the LTCH PPS, in Appendix A of this final rule. We have responded to the comments that we received on the preliminary update framework model presented in the RY 2007 LTCH PPS proposed rule in Appendix A of this final rule. We continue to solicit comments on this preliminary update framework methodology and its application, which we may propose to adopt at some time in the future under the LTCH PPS. 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. 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) and in the RY 2007 LTCH PPS proposed rule (71 FR 4667), 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 discussed in the RY 2007 LTCH PPS proposed rule (71 FR 4667 through 4670), 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 the BIPA to include appropriate adjustments, including updates, in the establishment of the LTCH PPS, we proposed 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 RY 2007 rate year would remain the same as the standard Federal rate in effect during the 2006 rate year ($38,086.04).

In this final rule, as we discuss in greater detail below, because we continue to 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 the BIPA to include appropriate adjustments, including updates, in the establishment of the LTCH PPS, we are revising § 412.523(c)(3)(ii), to specify that, for discharges occurring on or after July 1, 2006 and on or before June 30, 2007, there will be a zero percent update to the standard Federal rate from the previous year. That is, the standard Federal rate for the July 1, 2006 through June 30, 2007 rate year will be $38,086.04.

As we discussed in the RY 2007 LTCH PPS proposed rule (71 FR 4667), and 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. As discussed in greater detail in the RY 2007 LTCH PPS proposed rule (71 FR 4667 through 4670), we believe the proposed zero percent update factor for RY 2007, which was based on the most recent estimate of the proposed RPL market basket at that time, adjusted to account for coding improvements, is supported by our findings regarding CMI, Medicare margins, and patient census based on the most recent complete LTCH data.

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 will 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 will be without such changes in coding practices, which results in a higher LTCH PPS payment that does necessarily reflect the true cost of treating the patient. Therefore, in the RY 2007 LTCH PPS proposed rule (71 FR 4668), under the broad discretionary authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of the BIPA to include appropriate adjustments, including updates, in the establishment of the LTCH PPS, we proposed 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. We explained that it is important to eliminate the effect of coding or classification changes because they do not reflect the true cost of treating patients.

As we discussed in the RY 2007 LTCH PPS proposed rule (71 FR 4668), we asked 3M Health Information Systems (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 indicated, among other things, that 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 due to treatment of more resource intensive patients rather than to improvements in documentation or more complete coding of the medical record during this period). Using the average annual 2.75 percent observed CMI increase as a baseline, we separated the CMI increase between FY 2003 and FY 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.

As we also stated in the RY 2007 LTCH PPS proposed rule (71 FR 4668), the calculated observed CMI increase between FY 2003 and FY 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). Therefore, we stated our belief that 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 addition, in the RY 2007 LTCH PPS proposed rule (71 FR 4669), we discussed an internal CMS analysis, which shows high Medicare margins among LTCHs since the implementation of the LTCH PPS in FY 2003. We calculated ''revenue-weighted'' Medicare margins, which are the sum of LTCH inpatient Medicare revenue (payments) minus the sum of LTCH inpatient Medicare expenses (costs) divided by the sum of LTCH inpatient Medicare revenue (payments). This margin calculation, also utilized by MedPAC in its analyses, is used to evaluate the overall financial status of LTCHs. Specifically, our analysis found that LTCH Medicare margins for FY 2003 (the first year of the LTCH PPS) were 7.8 percent and preliminary cost report data for FY 2004 reveal an even higher Medicare margin of 12.7 percent.

We also noted 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. In the RY 2007 LTCH PPS proposed rule (71 FR 4668), we discussed the Commission's preliminary findings that were presented at the October 7, 2005 public meeting. In MedPAC's March 2006 Report to Congress on Medicare Payment Policy, the Commission recommended that the update to the LTCH PPS Federal rate be eliminated for RY 2007 (Section 4C; page 219). We also discussed the review by a Medicare program safeguard contractor and other investigations of LTCHs treating patients that do not require hospital-level care.

Additionally, in the RY 2007 LTCH PPS proposed rule (71 FR 4670), we noted that the proposed zero percent update for the 2007 LTCH PPS rate year may make the one-time prospective adjustment to the LTCH PPS Federal rate, provided for under § 412.523(d)(3), 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 change. We solicited 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. Specifically, as explained in greater detail below, to the extent of our review of FY 2003 LTCH data (which will include but, is not limited to changes in case-mix) show that, if by coincidence after updating the Federal rate by zero percent for RY 2007, the standard Federal rate is appropriate, it is possible that any further adjustment to the Federal rate may be unnecessary.

Comment: A few commenters stated that CMS, in proposing a zero percent update to the Federal rate for RY 2007, failed to consider the recent revisions to the guidelines for utilizing DRG 475 (''Respiratory System Diagnosis with Ventilator Support'') that have resulted in reduced payments to LTCHs, despite that the same resources are being expended.

Response: As discussed in section III. of the preamble of this final rule, the LTC–DRG assignments are based on GROUPER logic. The GROUPER is a software product that analyzes coding information submitted by hospitals, and subsequently makes a DRG assignment. CMS is responsible for GROUPER maintenance, including the assignment of DRGs. The DRG information is used to make payment to hospitals on behalf of Medicare beneficiaries treated by these hospitals. In contrast, the role of the AHA is to publish, in their document *Coding Clinic for ICD–9–CM*, coding guidelines and advice as designated by the four cooperating parties. The cooperating parties that have final approval of the published coding advice are the AHA, the American Health Information Management Association (AHIMA), CMS, and the National Centers for Health Statistics.

While the commenters have noted ''revisions to the guidelines for utilizing DRG 475'', it is not clear what guidelines are being cited. To address this comment in a responsible manner,

we would need more information than has been provided by the commenters. Furthermore, as discussed below in this preamble, the zero percent update finalized in this final rule is an adjustment that we have made to account for the case mix ''creep'' that was observed during FY 2004. Accordingly, any subsequent ''revisions to guidelines'' would have no impact on our need to make this adjustment in determining the RY 2007 Federal rate.

Comment: As an alternative to the proposed zero percent update, one commenter encouraged CMS to work with the AHA in developing more stringent coding practices as currently considered by the ''Coding Clinic'' if it believes additional coding practices are needed.

Response: In section III.E.3. of this final rule, we emphasize the need for proper coding by LTCHs. We also explain that 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. As we noted earlier, the coding guidelines currently published by the AHA are the result of the joint collaboration of CMS, AHA, AHIMA, and the National Centers for Health Statistics.

Comment: Many commenters expressed concern that the proposed changes to the SSO policy in conjunction with the proposed zero percent update would reduce hospital payments by nearly 15 percent, forcing LTCHs to operate at a loss when treating Medicare patients. They urged CMS to provide the full market basket update to the Federal rate for RY 2007.

Response: We disagree that the proposed zero percent update to the Federal rate would have resulted in ''reduced'' hospital payments. In the RY 2007 LTCH PPS proposed rule, we proposed to offset the market basket by an amount equal to the increase in case mix that was due solely to improved documentation and coding rather than changes in real case mix. At the time of the proposed rule, that increase was within rounding error of the market basket, and therefore resulted in a proposed Federal rate for RY 2007 that was equal to the RY 2006 Federal rate, and not a reduction to the RY 2006 Federal rate. We have provided throughout this section of this final rule, as we did in the proposed rule, our rationale for including an adjustment to account for changes in coding practices in the determination of the RY 2007 Federal rate. As discussed in the RY 2007 LTCH PPS proposed rule, and as discussed in greater detail below, we analyzed changes in the LTCHs' CMI in conjunction with a detailed analysis of LTCH margins since the implementation of the LTCH PPS, and our zero percent update policy is also based on these analyses.

In response to the commenters concern that the proposed changes to the SSO policy could also force LTCHs to operate at a loss, in section VI.A.1. of the preamble of this final rule below, we discuss the changes to the SSO policy that we are establishing in this final rule, and in section XV. of this final rule we discuss the projected impact of those changes (as well as the other changes established in this final rule) on estimated aggregate LTCH PPS payments for RY 2007. Specifically, in our discussion of the estimated decrease in aggregate LTCH PPS payments for RY 2007, we explain that we do not believe that this change will result in an adverse impact on LTCHs because, as a result of the change to the SSO payment formula, we believe that LTCHs will significantly reduce the number of short-stay cases that they admit. We believe that by paying appropriately for these SSO cases by removing the financial incentive for LTCHs to admit those very short stay cases that could otherwise receive appropriate treatment at an acute-care hospital (and paid under the IPPS), LTCHs will change their admission patterns for these patients. The estimated 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), and we believe that the estimated decrease in LTCH payments per discharge for RY 2007 discussed in section XV. of this final rule will only occur if LTCHs were to continue to admit the same number of SSO patients with very short lengths of stay. Furthermore, as also discussed in section XV. of this final rule, we do not believe that this change will force LTCHs to operate at a loss because, based on our recent margins analysis (discussed in greater detail below in this section). LTCH margins for FY 2003 are in excess of 7 percent, and preliminary FY 2004 data shows margins in excess of 12 percent. Therefore, we believe that even with an estimated decrease in LTCHs' payments per discharge for the 2007 LTCH PPS rate year, LTCH PPS payments will be sufficient to compensate LTCHs for the costs of the efficient delivery of LTCH services to LTCH patients.

Comment: Several commenters believed that CMS should allow a full market basket update to the LTCH PPS Federal rate for RY 2007. Other commenters stated that the LTCH PPS Federal rate should be updated annually by the most recent estimate of the market basket.

Response: As we have discussed throughout this section of the preamble of this final rule, while we continue to believe that an update to the 2007 LTCH PPS rate year should be based on the most recent estimate of the LTCH PPS market basket, we believe it appropriate that the market basket be offset by an adjustment to account for changes in coding practices. Such an adjustment will 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. We wish to emphasize that the RY 2007 Federal rate update of zero percent established in this final rule (as discussed in greater detail below) is based on the estimate of the LTCH PPS market basket for RY 2007. As we discussed in the RY 2007 LTCH PPS proposed rule and as we have discussed in greater detail above in this section, we believe that in determining the Federal rate update for RY 2007 it is appropriate to apply an adjustment to the most recent estimate of the LTCH PPS market basket to eliminate the effect of coding or classification changes that do not reflect real changes in LTCHs' case-mix. This adjustment is necessary in order to serve to account for payments that were made based on improved coding (rather than increased patient severity) in prior years.

As we noted in the RY 2007 LTCH PPS proposed rule (71 FR 4670) and as we reiterate below, the revision to § 412.525(c)(3) established in this final rule will address an update to the LTCH PPS Federal rate for the 2007 LTCH PPS rate year. We will 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 LTCH data available that would be presented in upcoming LTCH proposed rules. Furthermore, as discussed above in section IV.C.2. of this preamble, we are also examining the potential for developing and implementing an update framework under the LTCH PPS. We believe an update framework, which would incorporate the market basket as one component, will enhance the methodology for updating payments by addressing factors such as case-mix, intensity, and productivity, beyond

changes in pure input prices (measured by the market basket). (As noted in section V.C.2 of this final 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 final rule.) However, at this time, we are not proposing a specific annual update framework. As noted above, we will wait until we have collected sufficient and complete LTCH PPS data to evaluate payments and costs under the LTCH PPS before proposing to establish such a framework for determining the annual update to the LTCH PPS Federal rate in the future.

Comment: Many commenters stated that 3M's analysis of LTCH claims data was flawed. They stated that because a number of LTCHs did not transition to the LTCH PPS until FY 2004, using FY 2003 as a comparison to FY 2001 was wrong. The commenters also suggested that CMS would need to compare the CMI increases for LTCHs that elected reimbursement at the full Federal rate at the beginning or some time during the transition period to CMI increases for LTCHs that chose to go through the full 5-year transition. They emphasized that since LTCHs were transitioning to the LTCH PPS, it is unlikely that LTCHs were aggressively coding the stays of their Medicare patients.

Response: We appreciate the commenters' concern that errors were made in analyzing LTCHs' CMI data; however, we disagree with the commenters that 3M's analysis of LTCH claims data was flawed. We believe commenters erroneously presumed that coding improvement begins on the date the LTCH elected to be reimbursed at the full Federal rate under the LTCH PPS and not before. Because providers paid under the transition blend have at least a portion of their payments based on the Federal rate, which is based on ICD–9–CM diagnosis and the accurate coding of procedure codes, we believe LTCHs still had an incentive to improve coding while they were transitioning to the full Federal rate. In addition, the commenters provide no evidence that the large increase from the 2.75 percent average annual increase in CMI in the years prior to the implementation of the LTCH PPS to the 6.75 percent increase in LTCH CMI found between FY 2003 and FY 2004 resulted from a sudden increase in patient acuity in one year, especially when analyzed in the context of the relatively small increase in costs observed during this same period.

Comment: A few commenters asserted that the average intensity of Medicare inpatients has increased significantly from pre-PPS levels. Therefore, they believe the assumption that ''real'' case-mix is 2.75 percent is faulty.

Response: As explained in the RY 2007 LTCH PPS proposed rule (71 FR 4668), we made the assumption that real case-mix was 2.75 percent based on the average annual CMI increase in the three years prior to the full implementation of the LTCH PPS (that is, between FY 2001 and FY 2003). As we acknowledged in that same proposed rule, while it may be true that the average intensity has increased from pre-PPS levels, it is not supported by our analysis of the change in LTCHs' costs. As we stated in the RY 2007 LTCH PPS proposed rule, we did not observe a large increase in cost per discharge between FY 2003 and FY 2004, which we would have expected if the observed CMI increase was due to real CMI change (treating sicker patients). We would have expected to see a large increase in costs per discharge to pay for the resources needed to treat sicker patients if the CMI increase was due to ''real'' CMI change.

We do not believe the assumption that the increase in ''real'' case-mix is 2.75 percent is faulty. 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. As stated in the RY 2007 LTCH PPS proposed rule, 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 had applied the information from past studies on case-mix change to the analysis of the LTCHs CMI increase. 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)), in updating IPPS rates we have consistently assumed that real case-mix change for IPPS hospitals was a fairly steady 1.0 to 1.4 percent per year. If we had applied this same assumption to LTCHs, we would have concluded that nearly 5.35 percent (6.75 percent minus 1.4 percent) of the change in case-mix during the first year of the LTCH PPS is apparent CMI and not real CMI. Consequently, if we had applied this more conservative estimate of real case-mix increase, the proposed update to the Federal rate for RY 2007 would have been a reduction to the current Federal rate rather than leaving the Federal rate unchanged.

Comment: Several commenters stated that CMS was unfairly penalizing LTCHs twice for ''case mix creep'' (that is, the ''apparent'' CMI increase between FYs 2003 and 2004). They stated that CMS had already corrected any coding issues from FY 2004 by reweighting the LTC–DRGs for FY 2006 based on that data, which resulted in an estimated 4.2 percent reduction in payments to LTCHs.

Response: Under the LTCH PPS, we determine LTC–DRG relative weights as discussed in section III. of this preamble, to account for the difference in resource use by patients exhibiting the case complexity and multiple medical problems characteristic of LTCH patients. As we discussed in the FY 2006 IPPS final rule (70 FR 47701 through 47702), we recalibrated FY 2006 LTC–DRG relative weights based on an analysis of LTCH claims data from the FY 2004 MedPAR file. Thus, FY 2004 LTCH claims data, which reflected improved coding, were used to determine the LTC–DRG relative weights used to pay LTCH PPS discharges occurring during FY 2006.

While it is true that the reweighting of the LTC–DRGs using FY 2004 LTCH claims served to update the relative weights based on actual claims data in each LTC–DRG, which also reflects coding improvements that occurred in FY 2004, the recalibration of LTC–DRG weights only corrects for any coding improvement for the purpose of making accurate LTCH PPS payments in FY 2006. However, annual recalibration does not serve to account for payments that were made based on improved coding (rather than patient severity) in prior years. The case mix adjustment to the market basket in determining the RY 2007 Federal rate is meant to reduce current payments to account for the increase payments that occurred in FY 2004 that resulted from the CMI increase that is attributable to ''case-mix'' creep in that year. Therefore, we disagree that providers are being penalized twice for the LTCH coding improvements that occurred in FY 2004 (that is, ''case-mix creep'').

Comment: Several commenters contend that our margins analysis is flawed. The commenters state that although we reported that preliminary data showed LTCH margins of 12.7 percent for FY 2004, an examination of MedPAC LTCH margin data shows that almost a quarter of LTCHs (23 percent) had negative Medicare margins in 2004. One of the commenters also stated that MedPAC did not take into consideration the effect of the ''25 percent rule'' on reimbursement to LTCH hospitals-within-hospitals (HWHs) for admissions from the host hospital when modeling LTCH Medicare margins. The

commenter also believes that in stating that the reported increases in costs were not found to be commensurate with the reported increases in CMI (and Medicare payments), CMS did not allow for any increase in efficiency by LTCHs. However, in the update framework section (Appendix A of the RY 2007 LTCH PPS proposed rule), the commenter points out that CMS suggests that it may begin measuring efficiency, and may also account for such a factor in a possible proposed future update framework methodology. The commenter believes CMS is inconsistent with regards to efficiency.

Response: As we explained in the RY 2007 LTCH PPS proposed rule, the margins analysis was revenue-weighted (that is, calculated by adding the total Medicare payments and expenses for all LTCHs). CMS and MedPAC use this type of margin calculation to assess whether Medicare payment rates to LTCHs (as a provider class) are adequate. The commenter states that nearly one-quarter of LTCHs had negative margins in FY 2004, we note that based on the preliminary data for FY 2004, one-quarter of LTCHs had margins greater than 18 percent. Therefore, it is reasonable and expected that we estimate aggregate positive LTCH margins in excess of 12 percent for FY 2004, as stated below in this section.

Based on data from the LTCHs' cost reports received as of December 31, 2005, updated LTCH margins analysis for this final rule continues to show high Medicare margins among LTCHs since the implementation of the LTCH PPS in FY 2003. As we did for the RY 2007 LTCH PPS proposed rule, 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 general. In an analysis of the latest available LTCH cost reports, we found that LTCH Medicare margins for FY 2003 (the first year of the LTCH PPS) were 7.8 percent and preliminary cost report data for FY 2004 based on the most recent update to the cost report data in HCRIS reveal an even higher Medicare margin of 12.7 percent. For periods prior to the implementation of the LTCH PPS (that is, FY 1999 through FY 2002), we found that aggregate Medicare margins ranged between a minimum of −2.3 percent in FY 2000, and a maximum of 1.5 percent in FY 2002. MedPAC also noted that LTCH HwHs were found to have higher margins than freestanding LTCHs in RY 2004.

As mentioned by the commenter, when discussing MedPAC's modeling of the 2006 LTCH PPS margins, MedPAC's 2006 LTCH PPS margins analysis did not include the effect of the HwH ''25 percent rule,'' which is the special payment provisions for LTCH HwHs and satellites that we established at § 412.534 in the FY 2005 IPPS final rule. Under this policy we provide a payment adjustment for those patients discharged from co-located LTCHs (that is, HwHs and satellites) admitted from host hospitals that exceeded a specified percentage (in most cases, 25 percent). Medicare patients who reach HCO status in the host hospital are excluded from the count of the percentage of patients admitted directly from the host. We additionally provided a 4-year transition to this policy for existing LTCH HwHs and satellites and those LTCH HwHs paid under the LTCH PPS on October 1, 2005 and whose qualifying period began on or before October 1, 2004; however, all other LTCHs are immediately governed by the percentage thresholds established under § 412.534.

In the transcript of MedPAC's December 8, 2005 public meeting (p. 164), the MedPAC analyst noted that despite the desire to model the effect of the HwH ''25 percent rule'' established at § 412.534 when modeling 2006 LTCH margins, they were unable to do so at that time since the first year of the 5-year phase-in (FY 2005) was ''hold-harmless'' and any fiscal impact (that is, percentage threshold requirements specified at § 412.534) are effective for cost reporting periods beginning during the current fiscal year (FY 2006). As we discussed in the FY 2005 IPPS final rule when we implemented the ''25 percent rule'' at § 412.534 (69 FR 49771), we were unable to estimate the impact of this policy because we anticipated behavioral changes by both the host and the co-located LTCHs resulting from the provision that exempts HCOs from the percentage threshold calculation. We are unable to estimate the impact on new LTCHs that will be immediately subject to the full threshold requirements established following the implementation of those regulations.

As MedPAC noted at their public meeting, FY 2006 is the first year of the 4-year phase-in of the threshold requirements established under § 412.534, and due to the lag time in the availability of data, we currently do not have sufficient FY 2006 data to determine the effect of the implementation of those requirements on LTCHs' behavior. Therefore, we are still unable to estimate the impact of this policy. However, since the policy at § 412.534 exempts IPPS HCOs at the acute-care host hospital from the LTCHs' percentage threshold calculation (as noted above), and since, as noted earlier, the margins for HwHs are higher than those of freestanding LTCHs, we believe that even with some adjustments resulting in a decrease in some co-located LTCHs' RY 2007 LTCH PPS payments due to the threshold requirements under § 412.534, Medicare payments to co-located LTCHs will exceed the Medicare costs of the inpatient hospital services provided to its patients even with a zero percent update to the Federal rate for RY 2007.

As discussed in the RY 2007 LTCH PPS proposed rule, the large observed increase in LTCH case-mix was not accompanied by a corresponding increase in Medicare costs. This is consistent with our belief expressed earlier that a significant part of this observed increase in case-mix is ''apparent'' and not ''real.'' In conjunction with an increase in real case-mix we would have expected to see a significant increase in costs per discharge, even taking into account LTCH operating efficiencies, to pay for the resources needed to treat sicker patients. Consistent with MedPAC's most recent research discussed in its March 2006 Report to Congress (section 4C), our margins analysis 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.

As we also discussed in the RY 2007 LTCH PPS proposed rule, although supported by our LTCHs' margins analysis, the zero percent update to the Federal rate for RY 2007 is primarily based on our analysis of case-mix. This analysis indicates that a significant portion of the observed increase in case-mix from FY 2003 to FY 2004 is due to changes in coding practices rather than an increase in the severity of LTCHs' patients. Specifically, based on the latest available LTCH cost report data, our analysis supports our adjustment to account for changes in coding practices. Specifically, the most recent available LTCH cost report data shows that, while payments (revenue) per discharge increased in excess of the market basket estimate for the period, costs (expenses) per discharge either increased at a significantly lower rate or decreased

slightly for the same period (as discussed in greater detail below).

As noted by the commenter, the conceptual discussion of a preliminary model of an update framework under the LTCH PPS presented in the RY 2007 LTCH PPS proposed rule (71 FR 4742 through 4747), accounts for efficiency as a component of the adjustments for productivity and intensity. However, we have not assumed that the reason costs have not increased commensurate with case-mix (and payments) is due to increased efficiency by LTCHs. As stated previously, the update framework was presented at this point as under development and was not used to determine the proposed update to the standard Federal rate for RY 2007. Furthermore, even the conceptual model of the illustrative LTCH PPS update framework for RY 2007 presented in Appendix A for discussion purposes we had recommended a −0.9 percent adjustment for productivity (an efficiency measure) based on the productivity target used by MedPAC. This factor is based on BLS' estimate of the 10-year moving national average rate of productivity growth (71 FR 4746). This productivity adjustment in the illustrative update framework assumes that an efficient LTCH can produce more output (that is, inpatient hospital services) with the same inputs (that is, labor and capital) such that the full increase in input costs does not have to be passed on by the provider (71 FR 4744). Therefore, the recommended efficiency measure of −0.9 percent adjustment included in the illustrative update framework reduces the adjustment for input prices (that is, market basket estimate) based on the expectation that an efficient LTCH can produce the same output with slightly less than 1 percent less of the same inputs. In absence of accounting for a factor that accounts for efficiency, we would expect that costs per discharge would increase at about the same rate as the estimate of market basket, which has previously been used to update the LTCH PPS Federal rate annually, plus any increase that is based on an increase in patient severity (that is, real case-mix). However, our analysis of LTCHs payments and costs per discharge based on the latest available cost report data supports our adjustment to account for changes in coding practices because it shows that while payments (revenue) per discharge increased approximately 15 percent from FY 2002 to FY 2003 (the first year of the LTCH PPS), costs (expenses) per discharge increased by only about 8 percent for the same period. Thus payments to LTCHs from FY 2002 to FY 2003 increased almost twice as much as the increase of costs during the same period. Furthermore, based on the most recent available LTCH cost report data for FY 2004, we found that while payments (revenue) per discharge increased by approximately 5 percent from FY 2003 to FY 2004, costs (expenses) per discharge actually decreased slightly (about 0.7 percent) for the same period.

As discussed in the RY 2007 LTCH PPS proposed rule, the illustrative update framework shown in Appendix A is only a preliminary model, and we solicited comments regarding improvements or refinements to it that we will consider if we propose to adopt an update framework in the future under the LTCH PPS. By nature, a PPS is a system based on averages, and therefore we expect that LTCHs, like any provider type that is under a PPS system, already have and will continue to become more efficient with the implementation of the LTCH PPS. While increasing efficiency in the services delivered in the treatment of Medicare beneficiaries could result in some reduction in LTCHs' Medicare costs by providing the same output (that is, inpatient hospital services) with a minimum of waste, expense and effort, it is unlikely that the significant difference between the increase in case-mix (and payments per discharge) and change in costs per case (discussed above in this section) is solely the result of increased efficiency of LTCHs. As noted above, our illustrative update framework only included a –0.9 percent adjustment for productivity, while our margins analysis shows a substantially larger difference between the change between payments per discharge and costs per discharge since the implementation of the LTCH PPS, which we believe are due to factors (that is, changes in coding practices) other than increased efficiencies by LTCHs. As we stated in the proposed rule and as noted above, we did not observe a significant increase in cost per discharge. In fact, for FY 2004, the latest cost report data shows a decrease in costs per discharge, which we would have expected to see if the observed CMI increase was due to ''real'' CMI change (treating sicker patients). In addition, as stated in the RY 2007 LTCH PPS proposed rule and as discussed in greater detail in this section of this final rule, a review by a Medicare program safeguard contractor and other anecdotal findings of LTCHs treating patients that do not require hospital-level care further supports the data analysis which show that the increase in LTCHs' CMI is primarily due to factors other than real CMI.

Therefore, we disagree with the commenter that we failed to account for efficiency in determining the update to the Federal rate for RY 2007. We believe that while there may be some reduction in LTCH costs per discharge as a result of efficiency, the difference between LTCHs' cost per discharge and payments per discharge is so profound that it cannot be reasonably assumed that efficiency is the sole basis for that difference. Rather, we believe it is the changes in coding practices, discussed previously, that have led to the substantial difference between LTCHs' cost per discharge and payments per discharge, which has had a significant impact on LTCHs' margins.

Comment: One commenter noted that while the proposed zero percent update appears in MedPAC's recommendations, the Congress has not agreed to take action on MedPAC's recommendation to eliminate an update to the RY 2007 payment rate.

Response: The proposal to provide a zero percent update to the LTCH PPS Federal rate for RY 2007 was consistent with MedPAC's recommendation. Although it is correct that the Congress has not taken specific action to legislate MedPAC's recommendation as stated in the RY 2007 LTCH PPS proposed rule, the Secretary has been given the broad discretionary authority, under section 123 of the BBRA as amended by section 307(b) of the BIPA, to include appropriate adjustments, including updates, in the establishment of the LTCH PPS. We continue to believe that our proposal to establish a zero percent update to the Federal rate to account for ''apparent'' case-mix is appropriate for the reasons discussed in the RY 2007 LTCH PPS proposed rule that were also stated above and is within the broad discretionary authority conferred upon the Secretary in section 123 of the BBRA as amended by section 307(b) of the BIPA. In addition, as discussed above, our margins analysis indicates 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.

Comment: One commenter urged CMS to enact the proposed zero percent update for RY 2007 only if no modifications are made to the SSO payment formulas. The commenter stated that this would be consistent with MedPAC's recommendations based on no change in LTCH payment policies.

Response: As the fiduciary of the Medicare Trust Fund, we are responsible for reexamining our payment systems and revising those

payment systems, if necessary, to ensure that appropriate payments are made for the efficient delivery of care to Medicare patients. This requires that we periodically reexamine the policy components of our payment systems and propose changes accordingly. As we discussed in greater detail in the RY 2007 LTCH PPS proposed rule (71 FR 4667 through 4670), we believe our findings regarding LTCHs' CMI increase, Medicare margins, and patient census supported our proposal of a zero percent update for RY 2007. As discussed in that same proposed rule, we believe that an adjustment to the most recent estimate of the LTCH PPS market basket to account for the effects of changes in coding practices is important to eliminate the effect of coding or classification changes because, as discussed in greater detail in this section, they do not reflect the true cost of treating patients.

Also in the RY 2007 LTCH PPS proposed rule, we proposed changes to the SSO policy based on our review of that policy along with many other LTCH PPS policies and LTCH behavior. As we discussed in that same proposed rule (71 FR 4685 through 4690), the proposed revision to the SSO policy would, among other things, reduce the unintended financial incentive for LTCHs to admit short-stay patients that may exist under the current SSO policy, and therefore, based on the most recent complete data available, we believe revisions to the current SSO policies are necessary and in no way should they be tied to the change made regarding the update for RY 2007. (In section VI.A.1. of the preamble below, we discuss the changes to the SSO policy that we are establishing in this final rule.)

Therefore, because the intended purposes of the proposed adjustment to the SSO policy and the proposed Federal rate update for RY 2007 are different, as explained above, we believe changes to these policies should be evaluated independently. Although, as discussed in greater detail below in section V.A.1. of this preamble, we are modifying the proposed SSO policy for the RY 2007 LTCH PPS final rule. As we discussed in this section, we continue to believe that an adjustment to the most recent estimate of the LTCH PPS market basket to account for the effects of changes in coding practices in determining the update to the Federal rate for RY 2007 is also necessary and appropriate.

Comment: Many commenters noted that the Medicare Program Safeguard Contractor Review of one LTCH is not representative data upon which to base the proposed zero percent adjustment.

Response: As stated in the RY 2007 LTCH PPS proposed rule, the information obtained from the Medicare Program Safeguard Contractor Review and the other anecdotal investigations of LTCHs treating patients that do not require hospital-level care was only one factor of our analysis. As discussed in that same proposed rule and as reiterated above, the primary factors upon which our proposal to determine an update to the Federal rate for RY 2007 was our CMI analysis and our Medicare margins analysis. We agree with the commenters that we are not aware of any determination made to indicate that LTCHs consistently admit non-hospital level patients.

Comment: One commenter stated that while it may be true that some LTCHs posted significant positive margins and saw significant increases in their case-mix, not all LTCHs had that experience. The commenter questioned how hospitals with negative margins would survive with a zero percent update in RY 2007. Another commenter stated that ''older'' LTCHs should be ''grandfathered'' from implementation of the proposed zero percent update for RY 2007. The commenter states that grandfathering ''older'' LTCHs would ensure that these hospitals are not affected by the perceived abuses of other newer hospitals.

Response: Prior to the implementation of the LTCH PPS, LTCHs were reimbursed under reasonable cost principles (TEFRA), which established payments to LTCHs based on hospital-specific limits for inpatient operating costs. However, in response to the industry's advocacy for a PPS for LTCHs, in section 123 of the BBRA as amended by section 307(b) of the BIPA, the Congress directed the Secretary of HHS to develop a per-discharge PPS for payment for LTCHs. The LTCH PPS was implemented in FY 2003.

By definition, payments under a PPS are predicated on averages. Therefore, while it may be true that some ''older'' LTCHs may not have experienced as large of an increase in case mix between FY 2003 and FY 2004, the same could be true of some LTCHs in other categories. In addition, our findings reveal that while some LTCHs endured negative margins, one-quarter of all LTCHs posted margins greater than 18 percent. Because, in general, PPS policies are based on averages, we do not believe it would be appropriate to exclude or ''grandfather'' hospital groups based on their Medicare participation date from implementation of the Federal rate update for RY 2007. Therefore, the RY 2007 Federal rate established in this final rule, as discussed below, will be applicable to an LTCH regardless of the age of the facility.

Comment: A few commenters questioned how CMS could justify proposing a zero update to the Federal rate for RY 2007, while at the same time proposing to postpone the implementation of the one-time adjustment to account for differences between actual and estimated payments for the first year of the LTCH PPS due to coding and other factors until July 1, 2008. One commenter asserted that this approach is contrary to PPS design and undermines the integrity and predictability of the payment system. The commenter also stated that CMS should pursue a one-time adjustment independent of a market basket update for RY 2007. Another commenter stated that CMS should use the zero update as the one-time adjustment and not extend the deadline.

Response: The commenters are referring to the one-time prospective adjustment at § 412.523(d)(3), which states that the Secretary may make 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 the RY 2007 LTCH PPS proposed rule (71 FR 4681 through 4684), the purpose of this one-time adjustment is to ensure that ultimately, total payments under the LTCH PPS are ''budget neutral'' to what total payments would have been if the LTCH PPS were not implemented in FY 2003, by correcting for possible significant errors in the calculation of the FY 2003 LTCH PPS standard Federal rate. The one-time adjustment would ensure that any errors in past estimates would not be perpetuated in the LTCH PPS rates for future years, while the proposed adjustment to account for coding practices in the proposed update to the Federal rate for RY 2007 is intended to adjust payments made in FY 2004 to account for the increase in CMI due to improved documentation and coding rather than an increase in patient severity. Therefore, because the intended purposes of the adjustments are different, as explained above, we disagree with the commenter that the zero percent update to the Federal rate for RY 2007 is ''contrary to the PPS design and undermines the integrity and predictability of the payment system.'' Furthermore, we do not believe that the proposed zero percent update to the Federal rate for RY 2007 should replace the possible one-time budget neutrality

adjustment or vice versa since the intended purposes of the adjustments are different (as explained above in this section). However, as we noted in the RY 2007 LTCH PPS proposed rule and as we reiterated above, it is possible that the proposed zero percent update for the 2007 LTCH PPS rate year may make the one-time prospective adjustment to the LTCH PPS Federal rate, provided for under § 412.523(d)(3), unnecessary if our comprehensive analysis of the LTCH PPS determines that LTCH PPS payments and the costs for LTCH services have become aligned as a result of this change. Specifically, the purpose of the one-time budget neutrality adjustment under § 412.523(d)(3) is intended to account for possible significant errors in the various factors and assumptions (not just case-mix increase) used in calculating the FY 2003 standard Federal rate. To the extent our review of FY 2003 LTCH data show, if by coincidence after updating the Federal rate by zero percent for RY 2007, that the standard Federal rate is appropriate, any further adjustment to the Federal rate may be unnecessary. Similarly, if our comprehensive analysis of the LTCH PPS determines that the current Federal rate, which is based on the FY 2003 standard Federal rate, is inappropriate (that is, either too high or too low), then an adjustment under § 412.523(d)(3) would be necessary.

As discussed in greater detail in the RY 2007 LTCH PPS proposed rule (71 FR 4680 through 4682), we proposed to extend the deadline for making the possible one-time adjustment until July 1, 2008 because we do not now believe that we will have sufficient data to make the determination by the current deadline of October 1, 2006. Specifically, as discussed in greater detail below in section V.D.6. of this preamble, 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) would we be able to reliably determine whether the one-time prospective adjustment to the standard Federal rate, which if issued would have an impact on all future payments under the LTCH PPS, should be proposed. 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 in § 412.523(d)(3) is now reasonable or realistic. In fact, we believe that for providers whose FY 2003 cost reporting periods began at the end of FY 2003 (that is, September 2003) and ended in August 2004, 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.

To summarize, despite the concerns expressed by the commenters, as discussed above, we continue to believe that our CMI analysis and Medicare margins analysis are sound. We continue to believe that an update to the 2007 LTCH PPS rate year based on the LTCH PPS market basket, offset by an adjustment to account for changes in coding practices, is appropriate to protect the integrity of the Medicare Trust Fund by ensuring that the LTCH PPS payment rates better reflect the true costs of treating LTCH patients.

Therefore, in this final rule, under the broad discretionary authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of the BIPA to include appropriate adjustments, including updates, in the establishment of the LTCH PPS, as proposed, we are revising 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. As discussed in the RY 2007 LTCH PPS proposed rule and as reiterated above, it is important to eliminate the effect of coding or classification changes because, they do not reflect the true cost of treating patients.

Specifically, in this final rule, we are revising § 412.523(c)(3)(iii) to specify that the standard Federal rate for the LTCH PPS rate year beginning July 1, 2006 and ending June 30, 2007, will be the standard Federal rate from the previous year, as explained below. A zero percent update factor will reflect an adjustment to the market basket update to account for the increase in the apparent case-mix in the prior period. As explained in the RY 2007 LTCH PPS proposed rule (71 FR 4669), 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.

Therefore, in the RY 2007 LTCH PPS proposed rule (71 FR 4669), we proposed a zero percent update by offsetting the most recent estimate of the proposed RPL market basket for RY 2007 of 3.6 percent by an adjustment for changes in coding practices of 3.66 (that is, $4.0 - 0.34 = 3.66$), which is within rounding of zero percent. As discussed above in section V.B.4. of this final rule, the most recent estimate of the RPL market basket for RY 2007 is 3.4 percent, which is 0.2 percent lower than the estimate of the RPL market basket for RY 2007 at the time of the development of the proposed rule. Although we note the most recent update of the market basket discussed in this final rule is 0.2 percent lower than the estimate of the market basket discussed in the RY 2007 LTCH PPS proposed rule, we continue to believe that a zero percent update to the Federal rate for RY 2007 is appropriate and will account for changes in coding practices that do not reflect increased severity of LTCH patients for the reasons discussed below. As discussed in greater detail above, changes in CMI consist of ''real'' CMI changes and ''apparent'' CMI changes. In determining the proposed zero percent update to the Federal rate for RY 2007, we measured LTCHs' observed case-mix increase between FY 2003 and FY 2004, and we used the average case-mix increase from the 3 years prior to the implementation of the LTCH PPS as a proxy for the portion of that observed case-mix increase that we consider to be ''real.'' We do not believe that there is a significant difference between the most recent estimate of the market basket for RY 2007 (3.4 percent) and the estimate used in the RY 2007 LTCH PPS proposed rule (3.6 percent). Furthermore, there could be some minimal variation in how much of the observed case-mix increase represents real case-mix changes. In addition, because the proposed update for RY 2007 at proposed § 412.523(c)(3)(iii) explicitly specified that the RY 2007 standard Federal rate would be the previous LTCH PPS rate year updated by an update factor of zero percent, we believe some commenters may not have

been aware that the final update for RY 2007 could have been different than (that is, greater than or less than) zero percent. Thus, we believe that the best approach in this final rule is to adopt an update factor of zero percent. For these reasons, we believe that a zero percent update to the Federal rate for RY 2007 will appropriately account for changes in coding practices that do not reflect increased severity of LTCH patients. We note that, as discussed above, a zero percent update is consistent with MedPAC's LTCH PPS update recommendation for RY 2007. Therefore, in this final rule, under the broad discretionary authority conferred upon the Secretary by section 123(a) of the BBRA as amended by section 307(b) of the BIPA to include appropriate adjustments, including updates, in the establishment of the LTCH PPS, for the reasons discussed previously in this final rule, we are establishing a zero percent update to the standard Federal rate for RY 2007. Accordingly, we are specifying under § 412.525(c)(3)(iii) that the standard Federal rate for the LTCH PPS rate year July 1, 2006 through June 30, 2007, will be the standard Federal rate from the previous LTCH PPS rate year. Based on the zero percent update to the Federal rate for RY 2007 LTCH PPS rate year, the LTCH PPS standard Federal rate for the 2007 LTCH PPS rate year will be $38,086.04, as discussed in section V.C.4. of this final rule.

As discussed in section V.B.4. of this preamble, the most recent estimate of the LTCH PPS market basket is 3.4 percent for the 2007 LTCH PPS rate year. If we were not revising § 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 final rule, under existing § 412.523(c)(3)(ii) the update would be 3.4 percent. We also note that although we are establishing a zero percent update to the Federal rate for RY 2007 in this final rule, we continue to believe that, based on the sizeable Medicare margins among LTCHs, the standard Federal rate for the 2007 LTCH PPS rate year established in this final rule will 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 we noted in the RY 2007 LTCH PPS proposed rule (71 FR 4670), the revision to § 412.525(c)(3) established in this final rule will only address an update to the LTCH PPS Federal rate through the 2007 LTCH PPS rate year. We will 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 final 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, will 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 V.C.2 of this final 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 final 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.

As discussed in the RY 2007 LTCH PPS proposed rule (71 FR 4670), currently as implemented in § 412.523(d)(3), we are providing 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 V.D.5. of this final rule, we are not making an adjustment to the LTCH PPS rates under § 412.523(d)(3) in this final rule; however, we will 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 final rule, we are 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 in order to maximize the availability of data used to conduct a comprehensive evaluation of the LTCH PPS. However, as explained above in this section, the zero percent update to the Federal rate 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 change.

4. 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 the RY 2007 LTCH PPS proposed rule (71 FR 4670), we proposed a standard Federal rate of $38,086.04 for the 2007 LTCH PPS rate year based on the best available data and policies presented in that proposed rule. As we stated in that proposed 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 (HCO) payments. Therefore, we did not propose to make additional adjustments in the RY 2006 LTCH PPS standard Federal rate for those factors (70 FR 24180). In this final rule, we are revising § 412.523(c)(3) to establish a standard Federal rate based on a zero percent update as discussed above in section V. B. of this final rule. Therefore, based on the zero percent update, the standard Federal rate for RY 2007 will be $38,086.04. Since the standard Federal rate for the 2007 LTCH PPS rate year has already been adjusted for differences in case-mix, wages, cost-of-living, and HCO payments, we are not making any additional adjustments in the standard Federal rate for these factors.

D. Calculation of 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, HCOs, and other special payment provisions (SSOs 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. 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.—LTCH PPS WAGE INDEX PHASE-IN PERCENTAGES

Cost reporting periods beginning on or after	Phase-In percentage of the full wage index
October 1, 2002	1/5 (20 percent).
October 1, 2003	2/5 (40 percent).
October 1, 2004	3/5 (60 percent).
October 1, 2005	4/5 (80 percent).
October 1, 2006	5/5 (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. As we discussed in the RY 2007 LTCH PPS proposed rule (71 FR 4670), we have reviewed the most recent data (FY 2002 through 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 that proposed rule, we did not propose a change to the phase-in of the adjustment for area wage levels under § 412.525(c). We received no comments on the phase-in of the wage index. Therefore, as we proposed, we are making no change in the 5-year phase-in of the wage index in this final rule.

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) 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 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. 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 the RY 2007 LTCH PPS proposed rule (71 FR 4671 through 4672), we proposed to update the LTCH PPS labor-related share based on the proposed RPL market basket (which is described in section V.B. of this preamble). As explained in that proposed rule, we proposed to adopt the RPL market basket under the LTCH PPS because we believe that this market basket would be developed based on the best available data that reflect the cost structures of LTCHs. Therefore, we proposed 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 RPL market basket based on FY 2002 data. We also proposed that if more recent data become available before the publication of the final rule and if we ultimately revise the LTCH PPS labor-related share based on the proposed FY 2002-based RPL market basket, we would use that data to determine the labor-related share for the 2007 LTCH PPS rate year in the final rule.

We received no comments on our proposal to update the LTCH PPS labor-related share based on the RPL market basket beginning in RY 2007. (As discussed above, we received a few comments on our proposal to adopt the RPL market basket under the LTCH PPS. Those comments and responses are presented in section V.B. of this preamble.) Therefore, in this final rule, we are updating the LTCH PPS labor-related share based on the RPL market basket (which is described in section V.B. of this preamble). We are adopting the RPL market basket under the LTCH PPS because we believe that this market

basket was developed based on the best available data that reflect the cost structures of LTCHs. As discussed in section V.B. of this preamble, we now have data from the first quarter of 2006 in determining the FY 2002-based RPL market basket. Based on this more recent data, in this final rule, we are revising 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 75.665 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 RPL market basket based on FY 2002 data, as discussed in greater detail below in this final rule. As discussed in the RY 2007 LTCH PPS proposed rule (71 FR 4672), 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 using the FY 2002-based RPL market basket costs to determine the 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 labor-related share for the 2007 LTCH PPS rate year will be the sum of the relative importance of each labor-related cost category, and will 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 relative importance for 2007 LTCH PPS rate year for operating costs (wages and salaries, employee benefits, professional fees, and labor-intensive services) will be 71.586, 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 FY 1997-based excluded hospital with capital market basket currently used under the LTCH PPS. Since the relative importance for capital will be 8.867 percent of the FY 2002-based RPL market basket for the 2007 LTCH PPS rate year based on the latest available data, we are multiplying the estimated portion of capital influenced by the local labor market (46 percent) by the relative importance for capital of the FY 2002-based RPL market basket (8.867 percent) to determine the labor-related share of capital for the 2007 LTCH PPS rate year. The result will be 4.079 percent (0.46×8.867 percent), which we add to 71.586 percent for the operating cost amount to determine the total labor-related share for the 2007 LTCH PPS rate year. Thus, based on the latest available data, we are using a labor-related share of 75.665 percent under the LTCH PPS for the 2007 LTCH PPS rate year. This labor-related share is determined using the same methodology as employed in calculating the current LTCH labor-related share (67 FR 56016).

Table 7 shows the 2007 LTCH PPS rate year relative importance labor-related share using the FY 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 RPL MARKET BASKET AND THE EXCLUDED HOSPITAL WITH CAPITAL MARKET BASKET

Cost category	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 importance (percent currently used under relative the LTCH PPS)
Wages and salaries	52.506	48.021
Employee benefits	14.042	11.534
Professional fees	2.886	4.495
Postal Services*	.....	0.635
All other labor-intensive services**	2.152	4.411
Subtotal	71.586	69.096
Labor-related share of capital costs	4.079	3.222
Total	75.665	72.318

* 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. 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 the RY 2007 LTCH PPS proposed rule (71 FR 4673), under the broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of the BIPA to determine appropriate adjustments under the LTCH PPS, for the 2007 LTCH PPS rate year, we proposed to use the same data (generated in cost reporting periods beginning during FY 2002) that was 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 to determine the applicable wage index values under the LTCH PPS because these data (FY 2002) are the most recent complete data. In that same proposed rule, we explained that we are continuing to propose to use IPPS wage data as a proxy to determine the 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. We also noted that 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 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 the RY 2007 LTCH PPS proposed rule (71 FR 4747 through 4771).

We received no comments on the proposed wage index values that would be applicable for discharges occurring on or after July 1, 2006 through June 30, 2007. Therefore, in this final rule, under the broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of the BIPA to determine appropriate adjustments under the LTCH PPS, for the 2007 LTCH PPS rate year, we are using the same data (generated in cost reporting periods beginning during FY 2002) that was 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 to determine the applicable wage index values under the LTCH PPS because these data (FY 2002) are the most recent complete data. We are continuing to use IPPS wage data as a proxy to determine the 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 LTCH wage index values that will be applicable for discharges occurring on or after July 1, 2006 through June 30, 2007, are shown in Tables 1 (for urban areas) and Tables 2 (for rural areas) in the Addendum to this final rule.

As discussed in section V.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 will 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 final 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 1 fiscal year, 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 will 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 final rule). Since there are no longer any LTCHs in their cost reporting period that began during FY 2003 and FY 2004 (the first and second years of the 5-year wage index phase-in), we are no longer showing the 1/5 and 2/5 wage index values in Tables 1 and 2 in the Addendum to this final rule.

2. 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 the RY 2007 LTCH PPS proposed rule (71 FR 4673 through 4674), under broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of the BIPA to determine appropriate adjustments under the LTCH PPS, for the 2007 LTCH PPS rate year we proposed to make a COLA to payments to LTCHs located in Alaska and Hawaii by multiplying the standard Federal payment rate by the factors listed in Table 8 of that proposed rule because those were currently the most recent available data. Those factors were obtained from the U.S. Office of

Personnel Management (OPM) and are currently used under the IPPS. In addition, we also proposed 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.

We received no comments on the proposed COLA factors for LTCHs located in Alaska and Hawaii for RY 2007. We also note that OPM has not released revised COLA factors since the publication of the RY 2007 LTCH PPS proposed rule. Therefore, in this final rule, under broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of the BIPA to determine appropriate adjustments under the LTCH PPS, for the 2007 LTCH PPS rate year we are making a COLA to payments to LTCHs located in Alaska and Hawaii by multiplying the standard Federal payment rate by the factors listed in Table 8 because these are currently the most recent available data. These factors are obtained from OPM and are currently used under the IPPS.

TABLE 8.—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
Maui County	1.2375
Kalawao County	1.2375

3. Adjustment for High-Cost Outliers (HCOs)

a. Background

Under the broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of the 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 HCO 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 HCO final rule (68 FR 34506 through 34516), because the LTCH PPS HCO policy (§ 412.525) is modeled after the IPPS outlier policy, we believed that it and the 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 HCO 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.

As discussed in the RY 2007 LTCH PPS proposed rule (71 FR 4674), 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).

In the RY 2007 LTCH PPS proposed rule (71 FR 4674 through 4676, and 4690 through 4692), we discussed our current methodology for determining hospitals' CCRs under the LTCH PPS HCO and SSO policies, and we presented a proposal to refine our methodology for determining the annual CCR ceiling and statewide average CCRs. In that same proposed rule, we also discussed our existing policy for the reconciliation of LTCH PPS high-cost and SSO payments along with our proposal to codify in subpart O of part 412 those policies, including proposed modifications and editorial clarifications to the existing policies.

Historically, annual updates to the LTCH CCR ceiling and statewide average CCRs have been effective October 1. In the RY 2007 LTCH PPS proposed rule, we proposed revisions to the policies governing the determination of LTCHs' CCRs and the reconciliation of HCO and SSO payments which would be effective October 1, 2006. In addition, we stated that the specific LTCH CCR ceiling and statewide average CCRs reflecting these proposed policy changes, which would be effective October 1, 2006, and would be presented in the annual IPPS proposed and final rules.

We received a few specific comments concerning the proposed changes to the policies governing the determination of LTCHs' CCRs. Several other commenters referenced one of the specific comments of another commenter on the proposed changes to the methodology for determining LTCH CCRs in their own comments on the RY 2007 LTCH PPS proposed rule. Based on a commenter's synopsis of our proposed changes

concerning the determination of LTCH's CCRs, we believe that the commenters clearly understood the nature and purpose of the proposed changes. However, the commenters stated that in the RY 2007 LTCH PPS proposed rule, we did not provide an analysis of the effect of the proposed change, nor did we provide an example of the new CCR values under this proposed methodology. Another commenter did not ''object in concept to the proposed combination of [IPPS] operating and capital cost-to-charge ratios' to compute a ''total'' CCR for each IPPS hospital by adding together each hospital's operating CCR and its capital CCR from which to compute the LTCH CCR ceiling and applicable statewide average CCRs. However, the commenter also pointed out that we did not provide any impact data and requested that we defer adoption of the proposed change until such data are provided for comment. Therefore, in the FY 2007 IPPS proposed rule (71 FR 24126 through 24135), we again proposed these same changes to the policies governing the determination of LTCHs' CCRs and the reconciliation of HCO and SSO payments that we proposed in the RY 2007 LTCH PPS proposed rule. Along with that proposal, we also included in that IPPS proposed rule the values of the proposed LTCH CCR ceiling (1.131) and the proposed statewide average LTCH CCRs (as shown in Table 8C of the FY 2007 IPPS proposed rule; 71 FR 24377) that would be effective October 1, 2006, based on our proposed policy changes (along with the proposed values of the LTCH CCR ceiling and statewide average CCRs that would be determined under our current methodology). Therefore, in this final rule, we are not finalizing any changes to the policies governing the determination of LTCHs' CCRs or the reconciliation of LTCH PPS HCO and SSO payments. We will further respond to any comments received on the proposal concerning changes to the policies governing the determination of LTCHs' CCRs and the reconciliation of LTCH PPS HCO and SSO payments presented again in the FY 2007 IPPS proposed rule (71 FR 24126 through 24132) in the FY 2007 IPPS final rule that will be published this summer.

c. Establishment of the 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 the 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' 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 is stated in section V.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 the RY 2006 LTCH PPS 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 the RY 2007 LTCH PPS proposed rule (71 FR 4676 through 4678), we used the June 2005 update of the FY 2004 MedPAR claims data to determine a 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 that proposed rule, because those data were the most recent complete LTCH data available at that time. Furthermore, we proposed to determined the 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).

As also discussed in the RY 2007 LTCH PPS proposed rule (71 FR 4676), we used CCRs from the June 2005 update of the PSF for determining the fixed-loss amount for the 2007 LTCH PPS rate year as they were the most recent complete available data at that time. We further proposed that 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. In determining the proposed fixed-loss amount for the 2007 LTCH PPS rate year, we also used 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 will be assigned if, among other things, a LTCH's CCR exceeded the current ceiling (1.423). As explained in the RY 2007 LTCH PPS proposed rule (71 FR 4677), our rationale for using the existing LTCH CCR ceiling and

Statewide average CCRs to determine the proposed RY 2007 fixed-loss amount even though we proposed to change our methodology for determining the CCR ceiling and Statewide average CCRs effective for discharges occurring on or after October 1, 2006, was because, based on our analysis of the data used to determine the FY 2006 LTCH CCR ceiling, we believe that the proposed 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, as we noted in that same proposed rule, 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 (as this may have already been done by the FI in the PSF in accordance with our established policy).

In the RY 2007 LTCH PPS proposed rule (71 FR 4677), based on the data and policies described in that proposed rule, the proposed fixed-loss amount would be $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 outlier threshold (the sum of the adjusted Federal LTCH payment for the LTC–DRG and the fixed-loss amount of $18,489). We also noted that the proposed fixed-loss amount for the 2007 LTCH PPS rate year was significantly higher than the current fixed-loss amount of $10,501. In that proposed rule, we explained that the change in the proposed fixed-loss amount was primarily due to the projected decrease in LTCH PPS payments resulting from the proposed change in the SSO policy under § 412.529 and the changes to the LTC–DRG relative weights for FY 2006. Specifically, because we projected approximately an 11 percent decrease in aggregate LTCH PPS payments in the 2007 LTCH PPS rate year based on the proposed policies presented in the proposed rule, we believed that a proposed increase in the fixed-loss amount would be 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 proposed fixed-loss amount at the current level would result in HCO payments that significantly exceed the current regulatory requirement that estimated outlier payments will be projected to equal 8 percent of estimated total LTCH PPS payments.

We also noted 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. Therefore, as another alternative to the proposed increase to the fixed-loss amount for RY 2007, in the RY 2007 LTCH PPS proposed rule (71 FR 4677 through 4678), we solicited 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.

As an alternative to proposing to raise the fixed-loss amount for FY 2007, in the RY 2007 LTCH PPS proposed rule (71 FR 4677), 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 HCO 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).

Comment: Several commenters opposed any option that would allow CMS to revisit the regression analysis that was used to establish the existing 80 percent marginal cost factor and existing outlier target of 8 percent. The commenters explained that the LTCH PPS is still in its early stages and further changes to the marginal cost factor or 8 percent outlier target would result in instability to the system. The commenters cautioned against making any premature changes to the factors affecting HCO payments to LTCHS, particularly the marginal cost factor and outlier target established by regulation. Also, the commenters agreed that keeping the marginal cost factor at 80 percent and the outlier pool at 8 percent better identifies LTCH patients that are truly unusually costly cases, and that the policy appropriately addresses outlier cases that are significantly more expensive than non-outlier cases.

One commenter expressed concern about the proposed significant increase to the fixed-loss amount for RY 2007 and urged CMS to exempt LTCHs that have high case mix levels (that is, over 1.5) from this policy since they are more likely to have high cost cases. As an alternative, the commenter suggested that we increase the marginal cost factor to 90 percent or 100 percent instead of 80 percent.

Response: We agree with the commenters that based on the regression analysis done for the implementation of the LTCH PPS (August 30, 2002; 68 FR 56022 through 56026), keeping the marginal cost factor at 80 percent and the outlier pool at 8 percent best identifies LTCH patients that are truly unusually costly cases, and that such a policy appropriately addresses LTCH HCO cases that are significantly more expensive than non-outlier cases. Furthermore, as we stated in the August 30, 2002 final rule (67 FR 56023 through 56027) 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 PPS to improve the efficient delivery of care.'' Therefore, as supported by many commenters, we did not revisit the regression analysis that was used to establish the existing 80 percent marginal cost factor and existing outlier target of 8 percent for this final rule. Accordingly, we are not making

any changes to the marginal cost factor or outlier target for RY 2007 in this final rule.

We do not believe that it is necessary or appropriate to exempt LTCHs that have a high CMI from any changes to the HCO policy that would be established for RY 2007. We disagree with the commenter that a high case mix necessarily correlates to a higher likelihood of having unusually HCO cases. A LTCH's case-mix is defined as its case weighted average LTC–DRG relative weight for all its discharges in a given period. The relative weight for each LTC–DRG represents the resources needed by an average inpatient LTCH case in that LTC–DRG. For example, cases in an LTC–DRG with a relative weight of 2.0 will, on average, cost twice as much as cases in an LTC–DRG with a weight of 1.0, and therefore, on average, are paid twice as much as well. Thus, a ''high'' case-mix level is an indication of the level of intensity of the types of patients treated at a LTCH and not necessarily an indication of treating a large number of unusually high cost cases. In fact, LTCHs could have a relatively ''high'' CMI but have few or no HCO cases. Therefore, we are not adopting the commenters' suggestion to exempt LTCHs that have high case mix levels from any changes to the HCO policy that would be established for RY 2007.

Furthermore, increasing the marginal cost factor to 90 percent or 100 percent instead of 80 percent for hospitals with high case-mix would result in an increase in total estimated outlier payments because, as we explained in the RY 2006 LTCH PPS final rule (70 FR 24195), we would pay a larger 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 increase the marginal cost factor to 90 percent without raising the fixed-loss amount or 8 percent outlier target, we would pay outlier cases an additional 10 percent (90 percent minus 80 percent) of the estimated costs that exceed the outlier threshold. This alternative would result in estimated outlier payments which would exceed the existing 8 percent outlier target required by the regulations.

As we discussed in the RY 2007 LTCH PPS proposed rule (71 FR 4677), keeping the marginal cost factor at the current level of 80 percent while proposing to raise the fixed-loss amount to a level that will generate an estimated aggregate 8 percent outlier payments would afford more financial protection to LTCHs than proposing to lower the marginal cost factor and retain the current fixed loss amount. A relatively higher fixed-loss amount identifies fewer cases as HCO cases since the amount that the estimated cost of the case must exceed before the case qualifies as a HCO case is higher. However, this policy better identifies LTCH patients that are truly unusually costly cases, which is consistent with our intent of the LTCH HCO 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. Therefore, as supported by several commenters, we are not revising the existing 80 percent marginal cost factor, and are not adopting the commenter's recommendation to increase the marginal cost factor.

To summarize, consistent with the regression analysis that was used to establish the existing marginal cost factor and existing outlier target for RY 2007, the marginal cost factor will remain at 80 percent and estimated outlier payments will remain at 8 percent. As we stated in the RY 2007 LTCH PPS proposed rule (71 FR 4678), after revisiting the 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 any changes 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.

Comment: One commenter believes that the estimated proposed reduction to aggregate LTCH PPS payments that would result from the proposed changes to the SSO policy causes a ''perverse'' consequence of an increase to the fixed-loss amount, thus lowering reimbursement for long-term, high cost cases. The commenter believes that LTCHs would suffer a double penalty of lower payments due to the proposed SSO policy and the proposed increase to the HCO fixed-loss amount. The commenter added that CMS has not provided an explanation how LTCHs would finance the added cost of these long stay, high cost cases (as a result of the proposed increase to the outlier threshold).

One commenter noted that the proposed increase to the fixed-loss amount would cause hospitals that do not have many SSO cases to be inadequately reimbursed for their high cost cases. The commenter also added that the proposed increase to the fixed-loss amount coupled with the proposed zero percent increase to the Federal Rate would serve as a disincentive for LTCHs to accept patients with high costs and who also exceed the ALOS, thereby affecting patient access for these cases.

Another commenter stated that the proposed increase to the outlier threshold failed to consider the acuity of patients and is based only on mathematics. The commenter added that the proposed adjustment to the fixed-loss amount would increase LTCHs' loss on these cases before they qualify for an additional payment as HCOs. The commenter recommended that if CMS believes an increase to the fixed-loss amount is warranted, CMS should increase the fixed-loss amount the same amount as the annual update factor.

Several other commenters also expressed concern about the significant proposed increase to the fixed-loss amount and along with other commenters requested that CMS review and reconsider the proposed increase to the fixed-loss amount and consider establishing a lower fixed loss amount (than the proposed fixed-loss amount) for RY 2007 in the LTCH PPS final rule so that HCO cases receive appropriate payments.

Response: While we understand the commenters concerns about the proposed increase to the fixed-loss amount, as we discussed in the RY 2007 LTCH PPS proposed rule (71 FR 4677), the proposed increase to the fixed-loss amount had a direct correlation to our estimated decrease in aggregate LTCH PPS payments for RY 2007 that we projected would result primarily due to the proposed changes to the SSO policy.

Although some of the commenters did suggest different alternatives to updating the fixed-loss amount, those suggestions are either not consistent with maintaining estimated outlier payments at the projected 8 percent of total estimated payments or would require us to lower the marginal cost factor in order to maintain estimated outlier payments at 8 percent of total estimated payments, which several commenters opposed. As we discussed above and consistent with the recommendation of several commenters, we did not revisit the regression analysis that was used as a basis to

establish the existing marginal cost factor and existing 8 percent outlier target, the marginal cost factor will remain at 80 percent and the outlier target will remain at 8 percent for RY 2007. Maintaining the fixed-loss amount at the current level, as we discussed in the RY 2007 LTCH PPS proposed rule (71 FR 4677) would result in HCO payments that significantly exceed the current regulatory requirement that estimated outlier payments are projected to equal 8 percent of estimated total LTCH PPS payments. 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.'' That regression analysis also 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. Outlier payments are budget neutral, and therefore, outlier payments are funded by prospectively reducing the non-outlier PPS payment rates by projected total outlier payments. The higher the outlier target, the greater the (prospective) reduction to the base payment that would need to be applied to the Federal rate in order to maintain budget neutrality (August 30, 2002; 67 FR 56022 through 56024).

As we also discussed in the RY 2007 LTCH PPS proposed rule (71 FR 4678), under the LTCH PPS HCO policy at § 412.525(a)(3), at a marginal cost factor equal to 80 percent, Medicare pays 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). 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.'' Our regression analysis showed that a marginal cost factor of 80 percent appropriately addresses outlier cases that are significantly more expensive than nonoutlier cases. Specifically, 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. Thus, the existing outlier policy (that is, the 8 percent outlier target in conjunction with the 80 percent marginal cost factor) derived from our regression analysis is designed to maintain the balance between providing an incentive for LTCHs to treat expensive patients and improving the efficient delivery of care. (August 30, 2002; (67 FR 56022 through 56026)

As discussed in greater detail below, we continue to believe that an increase to the fixed-loss amount is appropriate. The intent of the HCO policy, as stated when we implemented the LTCH PPS, is to make an additional payment to LTCHs for cases that truly have unusually high costs. We disagree with the commenter who believes that LTCHs would be penalized twice by lowering payments as a result of the changes to the SSO policy and the increase to the HCO fixed-loss amount. Although the changes to the SSO policy result in an estimated decrease in aggregate LTCH PPS payments, which necessitates an increase to the HCO fixed-loss amount, as discussed above, we are maintaining the existing 8 percent outlier target. Therefore, although we are lowering aggregate estimated outlier payments; they will continue to be projected to be equal to 8 percent of total estimate LTCH PPS payments. However, we acknowledge that an increase to the fixed-loss amount will increase a LTCH's loss on a specific case before it qualifies for an additional payment as HCOs, as pointed out a few commenters; however, as we explained in the RY 2007 LTCH PPS proposed rule (71 FR 4678), because a relatively higher fixed-loss amount identifies fewer cases as HCO cases (since the amount that the estimated cost of the case must exceed before the case qualifies as a HCO case is higher), such a policy better identifies LTCH patients that are truly unusually costly cases.

As discussed above, the intent of the HCO policy is to provide an additional payment to LTCH cases that truly have unusually high costs. We would remind the commenter who pointed out that we did not provide an explanation of how LTCHs would finance HCO cases with an increase to the fixed-loss amount that, if we would not increase the fixed-loss amount, HCO payments would represent significantly more than 8 percent of estimated total LTCH PPS payments. Thus, the cases that would receive an additional HCO payment would no longer represent the cases that truly have unusually high costs as compared to the universe of ''typical'' LTCH cases, and warrant an additional HCO payment. Furthermore, as discussed above, HCO payments are budget neutral and are funded by prospectively reducing the non-outlier PPS payment rates by projected total outlier payments. The higher the outlier target, the greater the (prospective) reduction to the base payment that would need to be applied to the Federal rate in order to maintain budget neutrality. Therefore, we continue to believe that it is appropriate to increase the fixed-loss amount in order to maintain outlier payments at the projected 8 percent of total estimated payments. Such a policy continues to appropriately identify cases that are truly HCO cases (that is, cases with an unusually high cost). Because maintaining an 8 percent outlier target necessitates an increase to the fixed-loss amount and will appropriately identify unusually costly cases, we do not believe that increasing the fixed-loss amount will result in a disincentive for LTCHs to accept patients with high costs or exceed the ALOS. In fact, for LTCHs, in general, a case that should receive a high cost outlier payment is typically high cost because the patient has a longer than ALOS. Moreover, the industry has stated in many of its comments submitted on the RY 2007 LTCH PPS proposed rule that it has no way of determining a LTCH's LOS upon admission. Therefore, we do not believe that the increase to the fixed-loss amount established in this final rule, which is significantly lower than the proposed RY 2007 fixed-loss amount (as discussed below), will result in these patients not being treated at LTCHs. Furthermore, as we discuss in the impact analysis presented in section XV. of this final rule, since based on our margins analysis 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 do not expect that an increase to the fixed-loss amount will result in an adverse financial impact on affected LTCHs nor will there be an effect on beneficiaries' access to care. Also, for the reasons discussed above, we are not adopting the commenter's suggestion to update the fixed-loss by the most recent estimate of the LTCH PPS market basket since that would result in estimated outlier payments in excess of 8 percent of estimated total LTCH PPS payments. Because an increase in HCO payments would result in an offset to the Federal rate, thereby lowering the payment rate to all LTCH cases, such a result could underpay inlier LTCH cases that typically consume the average resource of the particular LTC–DRG.

In response to the commenter that believes that the estimated proposed changes to the SSO policy causes a ''perverse'' consequence of an increase to the fixed-loss amount, we believe that it is inappropriate to maintain the current (that is, lower) fixed-loss amount, which would increase aggregate estimated outlier payments beyond 8 percent. The HCO policy was intended to identify only a limited percentage of aggregate LTCH PPS payments for an additional payment for unusually costly cases. As noted above, the LTCH PPS HCO policy is budget neutral and, therefore, reduces payments to LTCHs for SSO cases, many of which 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 (as discussed in greater detail below in section V.A.1.a. of this preamble). As explained in the RY 2007 LTCH PPS proposed rule (71 FR 4677), the proposed increase to the fixed-loss amount was primarily due to the projected decrease in aggregate LTCH PPS payments resulting from the change in the SSO policy in order to maintain the requirement that estimated outlier payments would equal only 8 percent of estimated total LTCH PPS payments, as required under § 412.525(a). If we would not increase the fixed-loss amount, HCO payments would represent significantly more than 8 percent of estimated total LTCH PPS payments. Thus, the cases that would receive an additional HCO payment would no longer represent the cases that truly have unusually high costs as compared to the universe of ''typical'' LTCH cases, and warrant an additional HCO payment. This is because, as we discussed in the August 30, 2002 final rule (67 FR 56022) when we implemented the LTCH PPS, our regression analysis showed that an 8 percent outlier target would achieve the balance of reducing financial risk for the treatment of unusually costly cases, reducing incentives to underserve costly beneficiaries, and improving overall fairness of the PPS. Furthermore, we note that the 8 percent outlier target under the LTCH PPS is significantly higher than the outlier target under the IPPS. The outlier thresholds under the IPPS are set so that operating IPPS outlier payments are projected to be only 5.1 percent of total operating IPPS DRG payments (70 FR 47501).

Several commenters based their comments on the assumption that long lengths of stay or high patient acuity (for example, case-mix) are directly related to whether a case should receive a HCO payment. As we explained above in section IV.C.3. of this preamble, we do not agree that a case with a high case-mix necessarily correlates to a higher likelihood of the case having an unusually high cost. A case with a ''high case-mix'' is a case that is grouped to a LTC–DRG with a ''high'' relative weight. The relative weight of the LTC–DRG represents the resources needed by an average inpatient LTCH case in that LTC–DRG. For example, cases in an LTC–DRG with a relative weight of 2.0 will, on average, cost twice as much as cases in a LTC–DRG with a weight of 1.0, and therefore, on average, are paid twice as much as well. Thus, a ''high'' case-mix for a particular case is an indication of the relatively ''high'' level of intensity of that patient relative to LTCH patients in other LTC–DRGs but not necessarily an indication of unusually high cost for patients within that LTC–DRG. In fact, a case could have a relatively ''high'' case-mix (that is, in a LTC–DRG with a ''high'' relative weight and therefore higher LTC–DRG payment) but have the same costs or cost less than other cases in that same LTC–DRG, which receive an appropriate payment based on the relative weight of that LTC–DRG. Therefore, as discussed in greater detail above, we believe that an increase to the fixed-loss amount is appropriate in order to maintain the requirement that estimated outlier payments equal 8 percent of estimated total LTCH PPS payments, a level, which based on our regression analysis, we believe most appropriately identifies unusually high cost cases.

The policy change for SSO cases established in this final rule (as discussed in section IV.A.1.a. of this preamble) is intended to revise payments for SSO cases to an appropriate level. The fact that a particular LTCH does not treat many SSO cases does not have any impact on the effect of the change to the SSO policy on the HCO fixed-loss amount. This is because, under our existing HCO policy, estimated aggregate outlier payments are projected to equal 8 percent of estimated aggregate LTCH PPS payments. As discussed in greater detail above, the intent of the HCO policy is to provide an additional payment to LTCH cases that truly have unusually high costs. We would remind commenters who stated that an increase to the fixed-loss amount would cause LTCHs that do not have many SSO cases to be inadequately reimbursed for their HCO cases, that if we would not increase the fixed-loss amount, cases that do not necessarily represent cases that truly have unusually high costs as compared to the universe of ''typical'' LTCH cases would receive a HCO payment. Furthermore, if we were to raise aggregate HCO payments in excess of the current 8 percent outlier target, we would have to lower the Federal rate by the amount that projected total outlier payments would exceed the current 8 percent outlier target. Such a prospective adjustment to the Federal rate would reduce payments to ''typical'' LTCH cases, which based on our regression analysis, could result in inadequate reimbursement to those inlier cases. Therefore, we disagree with the commenters that an increase to the fixed-loss amount would cause LTCHs that do not have many SSO cases to be inadequately reimbursed for their HCO cases.

In conclusion, in 2003, when we became aware that IPPS and LTCH PPS HCO (and SSO) policies were susceptible to payment vulnerabilities, we proposed and ultimately finalized changes to the HCO (and SSO) policies that were in the regulations at that time. Historically, it is our practice that when upon review of an existing policy and we find that a change in that policy is necessary, we establish appropriate changes through the notice and comment rulemaking process. Consistent with this historical practice, we reviewed the current HCO policy at § 412.525(a), as discussed in greater detail above. As recommended by many commenters, we have reviewed our methodology for determining the fixed-loss amount for RY 2007 in this final rule to ensure that both LTCH HCO cases and LTCH inlier cases receive appropriate payments (since, as discussed above, outlier payments under the LTCH PPS are budget neutral). Accordingly, based on this review, as we discussed in the RY 2007 LTCH PPS proposed rule and as we discuss in greater detail above in this section, we believe that an increase to the fixed-loss amount for RY 2007 is appropriate. We are using the same methodology that we proposed to use in the RY 2007 proposed rule to calculate the fixed-loss amount for RY 2007 in this final rule (using updated data and the policies established in this final rule, as described below) in order to maintain estimated outlier payments at the projected 8 percent of total estimated payments. However, as we discuss in greater detail below in section V.A.1.a of this preamble, based on the comments we received concerning the proposed changes to the SSO policy, we are revising our proposed changes to the SSO policy that will be established in this final rule. We

estimate that the final SSO policy established in this final rule will result in a significantly smaller decrease in aggregate LTCH PPS payments for RY 2007. Accordingly, although the fixed-loss amount for RY 2007 is higher than current fixed-loss amount ($10,501), since under the final SSO policy aggregate payments will no longer be reduced by over 11 percent, but rather we estimate aggregate payments will only be reduced by about 4 percent. Therefore, to maintain estimated outlier payments at the projected 8 percent of total estimated payments, it is not necessary for us to raise the fixed-loss amount as much as in the RY 2007 LTCH PPS proposed rule. Consequently, the final fixed-loss amount for RY 2007 (discussed in greater detail below) is $14,887, which is considerably less than the proposed RY 2007 fixed-loss amount of $18,489.

As stated above, we annually determine the fixed-loss amount so that estimated outlier payments are projected to equal 8 percent of total estimated LTCH PPS payments. In this final rule for the 2007 LTCH PPS rate year, we used the December 2005 update of the FY 2005 MedPAR claims data to determine a 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 final rule, because these data are the most recent complete LTCH data available. Furthermore, as noted previously, we determined the 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 December 2005 update of the PSF for determining the fixed-loss amount for the 2007 LTCH PPS rate year as they are currently the most recent complete available data. In determining the fixed-loss amount for the 2007 LTCH PPS rate year, we are using 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 using the existing LTCH CCR ceiling and Statewide average CCRs to determine the RY 2007 fixed-loss amount even though we have proposed to change our methodology for determining the CCR ceiling and Statewide average CCRs effective for discharges occurring on or after October 1, 2006 in the FY 2007 IPPS proposed rule (71 FR 23996), is because we believe that this methodology change would result in a minor change in the numerical value of the LTCH CCR ceiling based on our analysis of the data used to determine the proposed FY 2007 LTCH CCR ceiling, and therefore, would have a negligible effect on the LTCHs' CCRs used to determine the fixed-loss amount for the 2007 LTCH PPS rate year. Moreover, we note that in determining the 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 (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 final rule, the fixed-loss amount will be $14,887 for the 2007 LTCH PPS rate year. Thus, we will 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 payment for the LTC–DRG and the fixed-loss amount of $14,887). We note that the fixed-loss amount for the 2007 LTCH PPS rate year is higher than the current fixed-loss amount of $10,501. This change in the fixed-loss amount will primarily be due to the projected decrease in LTCH PPS payments resulting from the change in the SSO policy under § 412.529 (discussed in greater detail in section VI.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 a 4 percent decrease in estimated aggregate LTCH PPS payments in the 2007 LTCH PPS rate year (as discussed in section XV. of this final rule), we believe that an increase in the 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). As discussed in greater detail above, an outlier target of 8 percent of estimated total LTCH PPS payments allows 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'' (67 FR 56022 through 56024).

We note that the fixed-loss amount of $14,887 is substantially lower than the proposed RY 2007 fixed-loss amount of $18,489 (71 FR 4676 through 4678). Furthermore, we note that the fixed-loss amount of $14,887 is significantly lower than the FY 2003 fixed-loss amount of $24,450 (67 FR 56023), the 2004 LTCH PPS rate year fixed-loss amount of $19,590 (68 FR 34144), and 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 V.C.3 of this preamble). Thus, during the years when the fixed-loss amount was greater than the $14,887 established for RY 2007 in this final rule, the majority of LTCHs operated with positive Medicare margins, and therefore, we do not expect that a fixed-loss amount of $14,887 will result in an adverse impact of LTCHs in RY 2007. Moreover, we believe the fixed-loss amount of $14,887 will 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 the BIPA, we are establishing a fixed-loss amount of $14,887 based on the best available LTCH data and the policies presented in this final rule because, we believe an 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 HCO 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 LTCH's CCRs that we established under § 412.525(a)(4) in the June 9, 2003 IPPS HCO final rule, as discussed in greater detail in section V.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 changes to the HCO and SSO policies presented in this final rule, we are currently developing additional instructions on the administration of the existing reconciliation process under the LTCH PPS that will be similar to the IPPS reconciliation process.)

In the RY 2007 LTCH PPS proposed rule (71 FR 4678 through 4679), for discharges occurring on or after October 1, 2006, we proposed to codify into the LTCH PPS section of the regulations (subpart O of part 42 of the CFR) the provisions concerning the reconciliation of LTCH PPS outlier payments, including editorial clarifications, that would more precisely describe the application of those policies along with the proposed changes to our methodology for determining the annual LTCH CCR ceiling and applicable Statewide average CCRs under the LTCH PPS (discussed previously in this final rule).

As discussed above in section VI.D.3.b. of this preamble, we received a few specific comments concerning the proposed changes to the policies governing the determination of LTCHs' CCRs. In light of those comments, in the FY 2007 IPPS proposed rule (71 FR 24126 through 24132), we proposed the same changes to the policies governing the determination of LTCHs' CCRs and the reconciliation of HCO and SSO payments that we proposed in the RY 2007 LTCH PPS proposed rule. Therefore, in this final rule, we are not finalizing any changes to the policies governing the determination of LTCHs' CCRs or the reconciliation of LTCH PPS HCO and SSO payments. We will respond further to any comments received on the proposal concerning changes to the policies governing the determination of LTCHs' CCRs and the reconciliation of LTCH PPS HCO and SSO payments presented again in the FY 2007 IPPS proposed rule (71 FR 24126 through 24135) in the FY 2007 IPPS final rule that will be published this summer.

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 the 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.

As we discussed in the RY 2007 LTCH PPS proposed rule (71 FR 4679 through 4680), 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 reviewed the limited data that was available and find no evidence to support additional policy changes. Therefore, in that proposed rule, we did not propose to make any adjustments for geographic reclassification, rural location, DSH, or IME. We also stated that 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 the RY 2007 LTCH PPS proposed rule (71 FR 4679 through 4680), we proposed to revisit the possible one-time prospective adjustment to the LTCH PPS rates at § 412.523(d)(3), and after further analysis and evaluation we now believe that it would be 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 PPS rates provided for at § 412.523(d)(3).

We received no comments on any potential adjustments for geographic reclassification, rural location, DSH, or IME. In addition, we received no comments on our proposal to conduct a comprehensive reevaluation of payment adjustments such as geographic reclassification, rural location, DSH, and IME after the completion of the 5-year transition once sufficient new data is generated while LTCHs are subject to the LTCH PPS may be available. Therefore, in this final rule, we are not making any adjustments for geographic reclassification, rural location, DSH, or IME. Furthermore, we will conduct a comprehensive reevaluation of payment adjustments such as geographic reclassification, rural location, DSH, and IME after the completion of the 5-year transition once we believe that sufficient new data that has been generated while LTCHs are subject to the LTCH PPS is available.

5. 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 the RY 2007 LTCH PPS proposed rule (71 FR 4680 through 4681), based on the updated data using the same methodology established in the August 30, 2002 final rule (67 FR 56034), we projected 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. Similarly, we projected 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 also noted that this projection was 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 the RY 2007 LTCH PPS proposed rule, the data showed that 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, in the RY 2007 LTCH PPS proposed rule, we projected that for the RY 2007 LTCH PPS rate year, the applicable transition blend methodology payments to those LTCHs would be greater than payment based on 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 that proposed rule, we projected 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 and the proposed increase in the outlier fixed-loss amount. Because we projected 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, and therefore, we did not project that these LTCHs 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 the RY 2007 LTCH PPS proposed rule, we

projected that, in the 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. Accordingly, using the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 56034), in the RY 2007 LTCH PPS proposed rule (71 FR 4681), we proposed 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 received no comments on our proposed 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). In this final 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 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 during the 2007 LTCH PPS rate year. This projection, which used updated data, as described above, 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 standard Federal rate compared to the payments they would receive under the transition blend methodology. Similarly, we project that the remaining 2 percent of LTCHs will 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 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 will be paid based on 100 percent of the 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). As discussed in the RY 2007 LTCH PPS proposed rule (71 FR 4681) and as reiterated above, we believe that the slight decrease in 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 policies described in this final 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 will be paid based on 100 percent of the Federal rate would result in a negligible cost to the Medicare program. Specifically, based on the most recent available data, we estimate that the cost of the transition period methodology (including the option to elect payment based on 100 percent of the Federal rate) will be less than $1 million in RY 2007. As discussed above, to account for the cost of the transition methodology in a given LTCH PPS rate year during the 5-year transition, we reduce all LTCH Medicare payments by a factor that is equal to 1 minus the ratio of the estimated reasonable cost-based payments that would have been made if the LTCH PPS had not been 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). Because we estimate that the additional cost of the transition period methodology (including the option to elect payment based on 100 percent of the Federal rate) will be less than $1 million for the 2007 LTCH PPS rate year and because this amount is a small percentage of total LTCH PPS payments (estimated at over $5 billion, as shown in Table 9), the formula that we have used to establish the budget neutrality offset in prior years results in a factor (as described above) that we reduce all LTCH Medicare payments by to account for those additional costs of zero (as a function of rounding). In addition, as discussed in the RY 2007 LTCH PPS proposed rule (71 FR 4681), 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 will have made the election to be paid based on 100 percent of the Federal rate rather than the transition blend which will 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 final rule, we are implementing a zero percent reduction (a budget neutrality offset of 1.000) 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 less than $1 million for the 2007 LTCH PPS rate year.

We note that this offset for the 2007 LTCH PPS rate year is the same as the current zero percent transition period budget neutrality offset established in the RY 2006 LTCH PPS final rule (70 FR 24202). We also note that the transition period budget neutrality offset for the 2007 LTCH PPS rate year established in this final rule is slightly lower than the proposed 0.999 percent budget neutrality offset proposed in for the RY 2007 LTCH PPS proposed rule (71 FR 4681). This is because we are now projecting that a few more LTCHs will elect payment based on 100 percent of the Federal rate than we projected when we determined the transition period budget neutrality offset for the 2007 LTCH PPS rate year based on the most recent available data in the RY 2007 LTCH PPS proposed rule because we are no longer projecting as large of a decrease in aggregate LTCH PPS payments for RY 2007 as a result of the policies established in this final rule.

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 the 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, as we proposed, we are extending the deadline for making this adjustment to July 1, 2008, in this final rule.)

In the RY 2006 LTCH PPS final rule (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 the RY 2007 LTCH PPS proposed rule (71 FR 4681), consistent with the methodology established in the August 30, 2002 final rule (67 FR 56036), based on the most recent available data at that time, we estimate that total Medicare program payments for LTCH services for the next 5 LTCH PPS rate years would be $5.27 billion for the 2007 LTCH PPS rate year; $5.44 billion for the 2008 LTCH PPS rate year; $5.64 billion for the 2009 LTCH PPS rate year; $5.88 billion for the 2010 LTCH PPS rate year; and $6.15 billion for the 2011 LTCH PPS rate year. We also noted that those 5-year spending estimates were significantly higher that the 5-year spending estimates presented in the RY 2006 LTCH PPS final rule (70 FR 24203). We explained that 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 available LTCH discharge data.

In this final 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.—RATE YEAR ESTIMATE TOTAL MEDICARE PROGRAM PAYMENTS FOR LTCH SERVICES

LTCH PPS rate year	Estimated payments ($ in billions)
2007	$5.27
2008	5.43
2009	5.63
2010	5.86
2011	6.13

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 data, including the projection that 98 percent of LTCHs would elect to be paid based on 100 percent of the 2007 LTCH PPS rate year standard Federal rate rather than the applicable transition blend and an estimated increase in the number of discharges from LTCHs. 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 market basket (currently used under the LTCH PPS) of 3.4 percent for the 2007 LTCH PPS rate year, 3.1 percent for the 2008 LTCH PPS rate year, 2.8 percent for the 2009 LTCH PPS rate year, 2.3 percent for the 2010 LTCH PPS rate year, and 2.7 percent for the 2011 LTCH PPS rate year. (We note that, although we are establishing a zero percent update to the LTCH PPS Federal rate for RY 2007 (as discussed in section V.C.3. of this final 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 −0.3 percent in the 2007 LTCH PPS rate year, 0.1 percent in the 2008 LTCH PPS rate year, 0.2 percent in the 2009 LTCH PPS rate year, −0.3 percent in the 2010 LTCH PPS rate year, and −0.2 percent in the 2011 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, 2009 and 2010 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). As discussed in the RY 2007 LTCH PPS proposed rule (71 FR 4682), 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 that proposed rule, we did not propose 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, in that same proposed rule, we stated that 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 also discussed in the RY 2007 LTCH PPS proposed rule (71 FR 4682 through 4684), we believe that it would be appropriate to postpone 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. We explained that 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) would we be able to reliably determine whether the one-time prospective adjustment to the standard Federal rate, which if issued would have an impact on all future payments under the LTCH PPS, should be proposed. Therefore, we proposed to revise § 412.523(d)(3) by postponing the October 1, 2006 deadline to July 1, 2008.

Comment: One commenter believes that CMS should be consistent and conduct the one-time adjustment in the same manner and for the same reasons as it has done for all PPSs. Specifically, the commenter states that both the LTCH PPS and the IRF PPS are affected

by changes in coding practices resulting from the implementation of a PPS; however, under the IRF PPS, CMS made a ''one-time'' adjustment when it reduced the standard payment conversion factor (that is, the IRF PPS base rate) by 1.9 percent in FY 2006 to account for changes in coding practices that did not reflect actual changes in patient severity based on an analysis performed by the Rand corporation. The commenter also believes it is inequitable to treat LTCHs differently than IRFs when accounting for payment increases due to changes in coding by potentially penalizing LTCHs twice for changes, once by providing no update and a second time, by extending the regulatory timeframe to establish the one-time adjustment to the Federal rate, since the proposed adjustment to account for case-mix increase that is not real in determining the update for RY 2007 would be a permanent adjustment that *de facto* reduces the rate of the increase of the Federal rate. Therefore, the commenter stated that CMS should eliminate the possible one-time adjustment as it would have already accomplished the purposes of that adjustment by proposing a zero percent update to the RY 2007 Federal rate.

In referring to the transition period budget neutrality adjustment, one commenter states that CMS already employs a means to ensure budget neutrality, and therefore, the extension of the deadline for the one-time budget neutrality adjustment is unnecessary. Another commenter stated that CMS should use the proposed zero percent update as the one-time adjustment and not extend the deadline, while another commenter stated that CMS should pursue a one-time adjustment independent of the Federal rate update for RY 2007.

Some commenters contend that for CMS to propose to extend the deadline for the possible one-time budget neutrality adjustment would constitute ''an abuse of its statutory authority.'' These commenters assert that by our own admission (citing the RY 2007 LTCH PPS proposed rule (71 FR 4682)), we are already in possession of the data that is needed to determine if the possible one-time budget neutrality adjustment under § 412.523(d)(3) is necessary. The commenters question why if FY 2003 cost report data which is needed to determine if the possible one-time budget neutrality adjustment is currently available, we believe it is necessary to obtain more ''reliable'' cost data for FY 2004 before deciding to impose the one-time (budget neutrality) adjustment. These commenters believe that postponing the deadline would allow CMS to ''wait until 'any significant difference' arises in the aggregate to trigger the [possibly] one-time [budget neutrality] adjustment.'' Consequently, they recommended that CMS withdraw its proposal to extend the deadline for exercising a one-time prospective adjustment. CMS would therefore only have until October 1, 2006 to exercise the one-time adjustment, as originally contemplated.

Response: The commenter believes that we are being inconsistent with our application of ''one-time'' adjustments under the IRF PPS and the LTCH PPS since, in the FY 2006 IRF PPS final rule (70 FR 47880), we applied a ''one-time'' adjustment of 1.9 percent to the standard payment amount for FY 2006 to account for changes in provider coding practices that did not reflect real changes in case mix, and in determining the update to the LTCH PPS Federal rate for RY 2007, we proposed to make an adjustment to account for changes in coding practices that do not reflect real changes in case mix in addition to the existing ''one-time'' budget neutrality adjustment at § 412.523(d)(3). However, we believe that the commenter has mistakenly assumed that the adjustment to the most recent estimate of the market basket to account for changes in coding practices in determining the proposed Federal rate for RY 2007 is the same as the possible one-time prospective adjustment provided for under § 412.523(d)(3). As we stated above in this section, when we established the regulations at § 412.523(d)(3), we provided for the possibility of making a one-time prospective adjustment to the LTCH PPS rates 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 (August 30, 2002; 67 FR 56027 through 56037). The purpose of this one-time adjustment is to ensure that total estimated payments under the LTCH PPS in FY 2003 were ''budget neutral'' to what total estimated payments would have been if the LTCH PPS were not implemented in FY 2003 by correcting for possible significant errors in the calculation of the LTCH PPS FY 2003 standard Federal rate. However, as we discuss in greater detail above in section IV.C.3. of this preamble, the proposed adjustment to the LTCH PPS market basket to account for changes in coding practices for the determination of the Federal rate for RY 2007 update is a separate adjustment to the Federal rate. While the one-time adjustment would ensure that any errors in past estimates would not be perpetuated in the LTCH PPS rates for future years, the proposed adjustment to account for coding practices in the proposed update to the Federal rate for RY 2007 is intended to adjust the Federal rate for increased payments made in FY 2004 that resulted from an increase in CMI due to improved documentation and coding rather than an increase in patient severity. Therefore, because the intended purposes of the adjustments are different, as explained above, we do not believe that we are acting in an inconsistent manner by making two separate adjustments under the LTCH PPS (one adjustment to account for changes in coding practices in determining the RY 2007 Federal rate and the other under § 412.523(d)(3) to ensure budget neutrality in the first year of the LTCH PPS (FY 2003)). We also note that, although we made a ''one-time'' adjustment under the IRF PPS to account for the effect of coding or classification changes that do not reflect real changes in case mix that resulted in increased Medicare payments to IRFs for the time period between 1999 and 2002, the statute does not preclude CMS from making additional adjustments under the IRF PPS in the future based on evidence of coding or classification changes that do not reflect real changes in case mix, to the extent that such changes affect aggregate IRF PPS payments.

In addition, we do not believe that the adjustment to the market basket estimate to account for changes in coding practices in determining the update to the LTCH PPS Federal rate for RY 2007 necessarily replaces the need for a possible one-time budget neutrality adjustment. However, as we noted in the RY 2007 LTCH PPS proposed rule and as we reiterated above, the zero percent update to the Federal rate for the 2007 LTCH PPS rate year may make the one-time prospective adjustment to the LTCH PPS Federal rate provided for under § 412.523(d)(3) unnecessary. Specifically, to the extent our review of FY 2003 data (which will include, but is not limited to changes in case-mix) shows that, if by coincidence after updating the Federal rate by zero percent in RY 2007, the Federal rate is appropriate, it is possible that any further adjustment to the Federal rate may be unnecessary. Furthermore, as discussed in greater detail below, since the intended purpose of the one-time adjustment at § 412.523(d)(3) is to ensure that total estimated payments under the LTCH PPS in FY 2003 were ''budget neutral'' to what total estimated payments would have been if the LTCH

PPS were not implemented in FY 2003, we believe it is incumbent upon us to extend the deadline for this adjustment to ensure that we are in possession of the most reliable cost report data indicating the actual LTCH costs during FY 2003. Therefore, as discussed above, because the intended purposes of the adjustment to the market basket to account for changes in coding practices in determining the RY 2007 Federal rate and the possible ''one-time'' adjustment under § 421.523(d)(3) are different, we disagree with the commenter that LTCHs will be penalized twice by establishing a zero percent update for RY 2007 and extending the deadline for determining the possible ''one-time'' adjustment under § 412.523(d)(3).

We also disagree with the commenters' contention that our proposal to extend the deadline for the possible one-time budget neutrality adjustment would constitute ''an abuse of its statutory authority.'' Rather, as we stated in the RY 2007 LTCH PPS proposed rule (71 FR 4681)), section 123(a)(1) of the BBRA, required that the system ''maintain budget neutrality'' for FY 2003. Moreover, section 123(a)(1) of the BBRA as amended by section 307(b)(1) of the BIPA confers broad authority on the Secretary to make appropriate adjustments under the LTCH PPS. Consequently, we believe we would be fulfilling our statutory mandate to ensure that FY 2003 payments under the LTCH PPS are in fact budget neutral. Under budget neutrality, estimated aggregate payments under the LTCH prospective payment system would equal the estimated aggregate payments that would be made if the LTCH PPS 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 actually be significantly higher or lower than the estimates upon which the budget neutrality calculations were based. Therefore, in implementing the LTCH PPS, 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 PPS rates 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 PPS, when we established the budget neutral Federal rate, as required by the statute (discussed previously), from being perpetuated in the PPS rates for future years.

It is accurate that currently the most recent complete year of LTCH cost report data is FY 2003 (the data which is needed to determine if the possible one-time budget neutrality adjustment is necessary). However, the vast majority of the FY 2003 LTCH cost report data is currently only ''as submitted'' by the LTCH and has not yet been reviewed before being settled (or audited) by the FI. LTCH cost report data from FY 2004 is also currently available; however, it is only partially complete (that is, not all LTCHs' FY 2004 cost reports are available). As we explained in the RY 2007 LTCH PPS proposed rule (71 FR 4684), because of the lag time typically involved in the entire cost report settlement process, currently we are not able to utilize the most accurate and complete data reflecting the actual costs incurred by LTCHs for cost reporting periods beginning during FY 2003 because the majority of LTCHs' FY 2003 cost reports are not as yet settled. Specifically, as noted in the RY 2007 LTCH PPS proposed rule, 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 at § 412.523(d)(3) is any longer reasonable or realistic. In fact, we believe that it would be inappropriate to develop and propose such an adjustment that would be effective by October 1, 2006, as required by the current regulations, to the Federal rate under § 412.523(d)(3) when we do not believe that we are in possession of the most reliable cost report data indicating the actual costs of LTCHs during the year in which we established the LTCH PPS (FY 2003). As we explained in the RY 2007 LTCH PPS proposed rule (71 FR 4684), we believe that we will be in possession of the most reliable FY 2003 cost report data reflecting the actual costs of LTCHs during the year in which we established the standard Federal payment rate for LTCHs with an August 2004 fiscal year ending date by July 2007. Therefore, any proposed adjustment could then be proposed, and if ultimately finalized, implemented on July 1, 2008. Furthermore, we believe that having additional years of data that were generated under the LTCH PPS (such as FY 2004 LTCH cost report data, and possibly partially complete FY 2005 LTCH cost report data) may be useful in assisting us in evaluating the settled and audited FY 2003 LTCH cost report data. Subsequent years data may be helpful in determining if the possible one-time budget neutrality adjustment under § 412.523(d)(3) is necessary, as it may help us to identify aberrant or erroneous FY 2003 data.

In the RY 2007 LTCH PPS proposed rule (71 FR 4685), we emphasized the distinction between the sufficiency of the data utilized for the analysis that supported the proposed update to the Federal rate for RY 2007 and the proposal to postpone the possible one-time prospective adjustment to the Federal rate at § 412.523(d)(3). Specifically, the RY 2007 update to the Federal rate 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 OACT, ORDI, and assisted by 3M. The LTCH claims data used to make this case-mix adjustment are current and accurate and are not dependent upon the cost report settlement process. 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 settled Medicare cost report data that we expect will 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 a one-time prospective adjustment to the Federal

rate should be proposed. Therefore, we believe that postponing the deadline for this possible one-time prospective adjustment until July 1, 2008 will allow us to have the best available data from the first year of the LTCH PPS (FY 2003) upon which to base such an adjustment.

We disagree with the commenters that suggest that the transition period budget neutrality adjustment should make it unnecessary to postpone the deadline for making the possible one-time budget neutrality adjustment under § 412.523(d)(3). As discussed above in section V.D.5. of this preamble, during each year of the 5-year transition period, we reduce all LTCH Medicare payments (whether an LTCH elects payment based on 100 percent of the Federal rate or whether an 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. We established this adjustment because the standard Federal rate was determined as if all LTCHs would be paid based on 100 percent of the standard Federal rate. However, since we provided for a 5-year transition period that allows LTCHs to choose to receive blended payments based partially on the reasonable cost-based methodology, it was necessary to make a budget neutrality adjustment that accounts for the additional costs to the Medicare program that result from the increased payments to LTCHs that choose to receive blended payments. As reiterated above, we separately provided for the possibility of making a one-time prospective adjustment to the LTCH PPS rates at § 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 would not be perpetuated in the LTCH PPS rates for future years. Therefore, as explained above, because the intended purposes of the adjustments are vastly different, we do not believe that the transition period budget neutrality adjustment can replace the need for a possible one-time budget neutrality adjustment.

To summarize, we believe that postponing the deadline for this possible one-time prospective adjustment until July 1, 2008 will allow us to have the best available data from the first year of the LTCH PPS (FY 2003) upon which to base an adjustment. Therefore, in this final rule, we are postponing the deadline for the possible one-time budget neutrality adjustment under § 412.523(d)(3). Accordingly, in this final rule, under broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of the BIPA to include appropriate adjustments in the development of the LTCH PPS, we are revising § 412.523(d)(3) to specify that the Secretary will review payments under the LTCH PPS and may make a one-time prospective adjustment to the LTCH PPS rate 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 LTCH PPS is not perpetuated in the LTCH PPS rates for future years. Finally, as we discussed in the RY 2007 LTCH PPS proposed rule and as stated above in section IV.D.4. of this preamble, we note that we intend to revisit our earlier determinations as to the appropriateness of other payment adjustments (for example, DSH, or IME) at the same time that we would establish the possible one-time prospective adjustment by July 1, 2008.

VI. Other Policy Changes for the 2007 LTCH PPS Rate Year

A. Adjustments for Special Cases

1. Adjustment for Short-Stay Outlier (SSO) Cases

a. 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 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 (5/6) of 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 an LTCH-level of treatment in such a short period of time and the 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 would be significantly ''overpaid'' for the resources they have actually expended in treating those patients.

In establishing the SSO policy, we also believed that providing a reduced payment for SSO cases would discourage hospitals from admitting patients for whom they would not provide complete treatment to maximize Medicare payments. 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 an 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) 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 § 412.529 once the LTCH PPS was implemented. However, as we stated in that rule, we 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 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 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 an LTCH, a hospital must have first been excluded as an LTCH in calendar year (CY) 1986, have an inpatient ALOS 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 case or the per diem LTC–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 such hospitals' first cost reporting period beginning on or after October 1, 2006. Under existing policy, Medicare payment to a subclause (I) LTCH for SSOs 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 estimated cost of the case; or the full LTC–DRG. Under this temporary adjustment at § 412.529(c)(4) for a subclause (II) LTCH, we substitute the following percentages for the 120 percent figure used for subclause (I) hospitals in the SSO payment formula at § 412.529(c). For discharges, occurring on or after July 1, 2003, for cost reporting periods beginning during the first year of the 5-year LTCH PPS transition period for subclause (II) LTCHs, 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 also be 120 percent, that is, the same as it is currently for all other LTCHs under the LTCH PPS.

As we continue to monitor the SSO policy, as we discussed in the RY 2007 LTCH PPS proposed rule (71 FR 4636), an analysis of LTCH claims data from the FY 2004 MedPAR files (using version 23.0 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 LTCHs are excluded by statute from the IPPS since it is understood that LTCHs are established to care for patients requiring long-term hospital-level care. We believed our existing policy accounted 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 appropriate. We were concerned that these inappropriate admissions could be made 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 SSOs would drop significantly from 48.4 percent once the LTCH PPS was implemented. As we stated in the RY 2007 LTCH PPS proposed rule, we expressed our concern that the existing SSO payment adjustment at § 412.529, which generally will pay a per discharge amount based upon the lesser 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 have provided a financial incentive for LTCHs to admit patients more appropriately treated in other settings.

In the August 30, 2002 final rule, when we first 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 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 so many SSO cases have short lengths of stay. In fact, a large percentage of SSOs have a LOS of 14 days or less. To address these concerns, in the RY 2007 LTCH PPS proposed rule, 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 proposed to reduce the current adjustment at existing § 412.529(c)(1)(ii), which is based on 120 percent of the estimated costs of the case, to 100 percent of the estimated costs of the case for discharges occurring on or after July 1, 2006. We believe that by reducing the Medicare payment to the LTCH for a specific SSO case so that it would not exceed the estimated costs incurred for that case, we would 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 changing 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 LTC–DRG payment, once a stay reaches five-sixths of the geometric ALOS for the LTC–DRG, the full LTC–DRG payment will have been made. We continue to believe that this specific methodology, 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)

As discussed in the RY 2007 LTCH PPS proposed rule, we believe that this proposed revision to the SSO payment methodology reducing the 120 percent of cost option to 100 percent of costs would further discourage inappropriate admissions of these patients to LTCHs because we will 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 by RTI, as we discussed in the RY 2007 LTCH PPS proposed rule, 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 a LTCH for a short-stay episode.

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 more typical of acute care hospitals and also to discourage LTCHs from admitting patients that could be premature discharges from acute care hospitals, in the RY 2007 LTCH PPS proposed rule, we also proposed to add a fourth payment method to the three alternatives under § 412.529(c) for SSO cases. Specifically, we proposed 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 proposed to change from the existing 120 percent of estimated costs); the full LTCH PPS payment for the LTC–DRG; or a payment amount under the LTCH PPS that is comparable to the payment that would otherwise be paid under the IPPS.

We explained that this additional component to the SSO payment formula would be 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 proposed to include an alternative payment method under the LTCH PPS SSO adjustment that could result in a 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 DRG. Furthermore, since over 80 percent of all LTCH patients (FY 2003 MedPAR) are admitted from acute care hospitals to LTCHs, of which many become SSOs, 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 and an inappropriate admission to the LTCH, which would result in a second, Medicare payment for the case of the patient to the LTCH for what is actually one episode of care. We established a similar payment adjustment under the LTCH PPS at § 412.534 for a LTCH HwH or LTCH satellite for which greater than 25 percent (or the appropriate specified percentage) of its patients were admitted from a host hospital in the FY 2005 IPPS final rule (69 FR 49191 through 49214). Under that policy, unless the patient reached high cost outlier (HCO) status at the acute care hospital prior to discharge, Medicare payments to the LTCH HwH or satellite for those cases in excess of the applicable threshold are based upon the lesser of a payment otherwise payable under the LTCH PPS or a LTCH PPS amount equivalent to what would have been paid for such a discharge 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 as 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 of acute care hospitals. We reasoned that if the patient was in effect, being treated in a ''unit'' of the acute care hospital, it was reasonable to revise the payment methodology and take 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.

As we discussed in the RY 2007 LTCH PPS proposed rule, we believe that adapting the underlying premise of the payment adjustment at § 412.534 to a new payment adjustment method under the SSO policy would be particularly appropriate, since we were concerned (and our data seemed to confirm) that LTCHs may be admitting patients that would otherwise be treated in acute care hospitals, as evidenced by lengths of stay at LTCHs more in

keeping with an acute care hospital stay, than the considerably longer lengths of stay characteristic of LTCHs. We believed that under this proposed additional payment method under the LTCH PPS for SSO patients, the LTCH could receive a Medicare LTCH PPS payment comparable to that which would be paid under the IPPS.

As we also discussed in the RY 2007 LTCH PPS proposed rule, we are very concerned that acute care hospitals may be shifting some of their potentially longer stay patients to LTCHs, resulting in a high incidence of SSOs at LTCHs. 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. The payment adjustment at § 412.534, based on the 25 percent (or applicable percentage) threshold, focused on inappropriate patient movement between co-located providers. However, we do not believe that co-location is a prerequisite to inappropriate patient-shifting between an acute care hospital and a LTCH.

As indicated previously, section 123 of the BBRA, as amended by section 307(b)(1) of the BIPA confers broad discretionary authority on the Secretary to implement a prospective payment system for LTCHs, including providing for appropriate adjustments to the payment system. This broad authority gives the Secretary great flexibility to fashion a LTCH PPS based on both original policies as well as concepts borrowed from other payments systems that are adapted, where appropriate, to the LTCH context. In the instant case, our finalized SSO policy utilizes, in large part, principles from the IPPS payment methodology and builds upon those concepts to create a LTCH PPS payment adjustment that results in an appropriate payment for those inpatient stays that we believe are not characteristic of LTCHs but could be more appropriately treated in another setting.

Consequently, in the discussion that follows, as we explained in the RY 2007 LTCH PPS proposed rule, 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 new alternative adjustment. We want to emphasize, however, that such a payment would not be an IPPS payment but rather, a payment under the LTCH PPS that is generally comparable to a payment under the IPPS payment methodology. Therefore, for Medicare payments for SSO cases under the LTCH PPS we proposed to add a fourth option that would be ''an amount under subpart O that is comparable to an amount that otherwise would be paid under the IPPS'' that 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 would be 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 also proposed to add 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 COLA 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 explained, there are specific features of the IPPS that do not directly translate into the LTCH PPS, so there would be no way to assure that LTCH payments are ''equal'' to an amount that would be paid under the IPPS. In using the word ''comparable,'' to describe this payment alternative to the existing SSO policy, we intended 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, in the RY 2007 LTCH PPS proposed rule, we proposed that 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 determined under § 412.60. This amount would be further adjusted to account for different area wage levels by geographic area using the applicable IPPS labor-related share, based on the CBSA where the LTCH is physically located as set forth at § 412.525(c) and using the IPPS wage index for non-reclassified hospitals published 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, this amount would also be adjusted by the applicable proposed COLA factor used under the IPPS published annually in the IPPS final rule. (Currently these same COLA factors are used under both the IPPS and the LTCH PPS.)

Additionally, this SSO proposed revised payment adjustment alternative (that is, an amount comparable to what would be paid under the IPPS for the case) could also include a DSH adjustment (see § 412.106), if applicable. Under the proposed revision to the LTCH PPS SSO payment adjustment in the case of a LTCH that is a teaching hospital, we explained that we would determine the IME payment adjustment 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 as set forth at § 413.79(c)(2) (which would already have been established for a LTCH which had residency programs). Thus, we proposed calculating an IME payment for the LTCH that is comparable to the IPPS payment formula set forth at § 412.105. 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 number of residents reported by the hospital 1996 cost report. The use of a proxy for the IME cap would be necessary because it would not be appropriate to apply the IPPS IME rules literally in the context of this LTCH PPS payment adjustment.

Thus, we proposed calculating an IME payment for a LTCH that is a teaching hospital that is comparable to the IPPS payment formula set forth at § 412.105. The use of a proxy for the IME cap would be necessary because it would not be appropriate to apply the IPPS IME rules literally in the context of this LTCH PPS payment adjustment. This IME FTE resident cap under the IPPS would not translate appropriately to a LTCH. Since a LTCH was not paid IME in 1996 it would not have reported any FTE residents for IME purposes on its 1996 cost report. Therefore, we proposed using the LTCH's direct GME

resident cap for the purpose of calculating the proposed payment adjustment alternative for SSOs. We believed this proposal was reasonable since it would cap the number of FTE residents that could be counted for IME payment purposes of calculating a comparable IME payment 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 IME FTE resident cap based on GME data would enable us to factor an adjustment for indirect costs of residency programs into a Medicare payment under the LTCH PPS for those SSO cases where the least of the payment alternatives is an amount under the LTCH PPS comparable to what would 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.

Therefore, we proposed to refer to the LTCH's direct GME resident cap for the purpose of calculating the proposed payment adjustment alternative for SSOs. We believed this proposal was reasonable since it would cap the number of FTE residents that could be counted for purposes of calculating a comparable IME payment 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).

As we discussed in the RY 2007 LTCH PPS proposed rule, under this proposed LTCH PPS payment adjustment, an amount payable under subpart O comparable to what would be paid under the IPPS would also include payment for inpatient capital-related costs, based on the proposed revision to the LTCH PPS SSO payment adjustment. In the case of a LTCH that is a teaching hospital, we explained that we would determine the comparable IME payment adjustment 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 as set forth at § 413.79(c)(2) (which would already have been established for a LTCH which had residency programs) and 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). We proposed that 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 published in the annual IPPS final rule), and large urban location, if applicable.

We note that we proposed 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)(3)). Under existing LTCH PPS policy, a SSO case that meets the criteria for a LTCH PPS HCO payment at § 412.525(a)(1) (that is, if the estimated costs of the case exceed the adjusted LTC–DRG SSO payment plus the fixed loss amount) would receive an additional payment under the LTCH PPS HCO policy at § 412.525(a) (67 FR 56026, August 30, 2002). For purposes of HCOs under the proposed SSO policy, we would continue to use a fixed-loss amount calculated under § 412.525(a), and not a fixed-loss amount based on § 412.80(a). Medicare would pay the LTCH 80 percent of the costs of the case that exceed the sum of the applicable option of the least of the four proposed payment options, described above, and the fixed-loss amount determined under § 412.525(a). As we discussed in the RY 2007 LTCH PPS proposed rule, we used the term ''comparable'' in the proposed fourth payment alternative so that the public will 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 VI.B. of the RY 2007 proposed rule.

Therefore, in the RY 2007 proposed rule, we proposed two changes to the existing SSO payment provision. First, we proposed to decrease the percentage of costs in the current SSO payment formula (that is, 120 percent of the costs) to 100 percent of costs. Secondly, we proposed to add a fourth option that Medicare would pay an LTCH PPS payment amount comparable to the amount that would have otherwise been paid under the IPPS for such a case, if that amount is lower than the other three payment alternatives.

As we discussed in the RY 2007 LTCH PPS proposed rule, we established special provisions for the SSO policy for subclause (II) LTCHs in the RY 2004 LTCH PPS final rule (68 FR 34147). We proposed to exempt subclause (II) LTCHs from the proposed additional revisions to the SSO policy discussed above until the 5th year of the phase-in of the LTCH PPS for such a LTCH (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 proposed SSO policy for subclause (II) LTCHs would not be reduced 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 additional proposed 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 a LTCH's cost reporting period beginning on or after October 1, 2006. Therefore, under the proposed policy discussed in the RY 2007 LTCH PPS proposed rule, SSO discharges at a subclause (II) LTCH that had a January 1 through December 31 cost reporting period, for example, would be subject to the proposed changes to the SSO provision (including the proposed reduction to 100 percent of costs and the proposed addition of the fourth 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.

The proposal to exempt subclause (II) LTCHs from the proposed revisions to the SSO policy that would be effective beginning in RY 2007 until cost reporting periods beginning on or after October 1, 2006 was consistent with our understanding of Congressional intent in establishing this special category of LTCHs in section 4417(b) of the BBA. The Congress provided an exception to the general definition of LTCHs under subclause (I) and subclause (II). 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 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 was necessary to adjust the original 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).

As we discussed in the RY 2007 LTCH PPS proposed rule, we proposed that hospitals that qualify as subclause (II) LTCHs would become subject to the proposed changes to the SSO provision, when a subclause (II) LTCH would become fully subject to the general SSO policy at § 412.529, which will be for discharges occurring in the first cost reporting period beginning on or after October 1, 2006.

We received many comments on our proposed revisions to the SSO policy representing the views of trade associations representing LTCHs, both for-profit and not-for-profit LTCH groups, medical corporations that include LTCHs, state medical societies, a Chamber of Commerce, legislators, physicians and other hospital staff, and several interested citizens. In general, commenters did not support our proposed policy and the payment reductions to LTCHS that would result if it was finalized.

Comment: Several commenters supported CMS's goal of analyzing the role of LTCHs as one of several treatment settings among post-acute providers for Medicare beneficiaries. However, they urged us not to finalize the portion of the proposed SSO policy that would include the alternative payment option for payment comparable to the IPPS payment amount. These commenters believe that finalizing this policy would result in drastic payment reductions and consequential losses to the LTCHs. One commenter noted that our proposed policies had made it necessary to answer the following question: ''Where is the proper place for LTCHs along the continuum of care for Medicare beneficiaries and how is this place substituted for in areas where there are no or few LTCHs.'' The commenter further stated that this was ''a proper question to ask for a prudent purchaser of care'' but urged us to arrive at a ''clinically-based'' answer to this question.

Response: We appreciate the commenters' recognition of the very serious issues regarding LTCHs underlying our proposed policy revisions. The commenter is also correct in questioning the role of LTCHs in the continuum of beneficiary care. As a provider category, LTCHs were created by section 1886(d)(1)(B)(iv)(I) of the Act and defined by the statute: a LTCH is ''a hospital which has an average inpatient LOS (as determined by the Secretary) of greater than 25 days.'' (Subclause (II) LTCHs, discussed below in these responses, which were established under the BBA of 1997, function under highly specific requirements.) As a ''prudent purchaser of care,'' we believe that we have the mandate to appropriately pay for the hospital-level services provided to Medicare beneficiaries. The RTI study, that is discussed in section XII.B. of the preamble to this final rule, represents a highly significant step in the direction of evaluating the clinical role for LTCHs. In addition to the RTI study, there is considerable attention being focused by CMS on issues of substitution of services among provider types, and the potential for the development of a uniform assessment tool across post-acute providers. As RTI evaluates the feasibility of identifying clinically-based criteria for LTCH patients, it continues to concern us that patients with the same general medical profile as these LTCH patients are also being treated nationally at acute care hospitals, generally as HCOs. Although, as described in detail in our responses below, we are not finalizing this specific revision to the SSO policy, as proposed, we continue to be concerned about the significant number of extremely short-stay patients currently receiving treatment at LTCHs, a provider type that is distinguished solely by its focus on long-stay hospital-level care.

Comment: While many commenters urged us not to finalize the proposed formula for SSO payments that included the option of an IPPS-comparable payment amount, they did express considerable understanding of our concerns about the payment incentives inherent in the existing SSO policy, particularly with regards to the very short stays. We received numerous suggestions on an approach more targeted with the goals of avoiding excessive payment for such very short stays, avoiding underpayment of appropriate admissions, and also avoiding any payment incentives that would allow LTCHs to retain patients unnecessarily to exceed the SSO thresholds. Although opposing these proposed revisions, one commenter encouraged us to modify the proposed policy to strike a balance between payment adequacy and financial incentives.

A number of commenters urged us to establish a category of very short stay discharges (VSSDs) mirroring the payment policy for stays of 1 through 7 days that we proposed when we designed the LTCH PPS (67 FR 13453, March 22, 2002) suggesting that we continue to pay the remainder of SSO cases under the existing SSO policy. The commenters presented several other variations in the definition of a VSSD and also suggestions for a SSO policy payment methodology, which include:

- VSSD cases would be defined as cases with a LOS of less than 1/6 of the geometric ALOS. These VSSDs would be paid under our proposed policy.
- VSSD cases should be defined from 1 through 5 or 7 days, and be reimbursed at 100 percent of cost.
- VSSD cases should be reimbursed at a percentage of cost (for example, 95 percent) with the 5 percent reallocated to other SSO payment levels.
- Define VSSD cases as 10 to 20 percent of the geometric ALOS: (1) Reduce costs from 120 percent to 100 percent for VSSD cases; (2) For other cases up to 5/6 of the geometric mean LOS, 110 percent costs.
- Create three categories of SSO cases—VSSD cases, intermediate short stay cases, and all other short stay cases up to 5/6 (existing definition of SSO): (1) A VSS case is a case that has a LOS equal to or less than 2/6 of the geometric ALOS for a LTC–DRG and paid the lesser of the three existing options with 100 percent of cost (instead of 120 percent); (2) Intermediate short stay cases would be between 5/6 of the geometric ALOS and 4/6 of the geometric ALOS, and paid the lesser of the three existing options with 110 to 115 percent of cost (instead of 120 percent); (3) All others would be those cases that exceed 4/6 of the geometric ALOS but are less than or equal to 5/6 of the geometric ALOS and paid the least of three existing options with 115 to 120 percent of cost.
- For cases with lengths of stay less than or equal to 20 percent of the geometric ALOS, use IPPS-comparable payment rates.
- For VSSD cases, the SSO payment should be 100 percent of costs for 8–20 day stays and the full LTC–DRG for stays of 20 or more days. LTCH cases with a LOS greater than 20 days should be removed from the SSO definition.
- For cases where the ALOS is equal to or less than 20 percent of the geometric mean LOS, Medicare should pay less than cost (that is, at 80 percent or 90 percent of cost) and reallocate the remainder to other LTCH PPS payments.
- Pay all SSO patients at 110 percent of cost.
- For VSSD cases, payments should be 100 percent costs or 22 percent per diem; for stays of 8 days through the up to 5/6 the geometric ALOS, use the same method as presently used.
- Convert the IPPS comparable payment to per diem (similar to transfer DRG methodology) and pay based on

the actual number of days that a patient is in the LTCH without capping the payment at the full IPPS DRG to recognize the amount of resources and effort expended by the LTCH.

• Pay SSOs under an additional LTC–DRG similar to CMG 5000 under the IRF PPS if the LOS is below a certain number of days. It would receive a low fixed payment.

Response: We have carefully evaluated the comments that we received on the proposed modifications to the SSO payment policy. Specifically, we understand the commenters' concerns that applying the option of an IPPS-comparable payment to all SSO cases at LTCHs would result not only in paying for very short stay cases under this policy, but also could result in making such a payment under the same LTCH PPS SSO policy option for a patient who is treated for a relatively long stay. Accordingly, under our finalized policy, we believe that it is appropriate to provide that as the length of a SSO stay increases, the case begins to resemble a more ''typical'' LTCH stay and consequentially, it is appropriate that payment should be based increasingly more on what would otherwise be payable under the LTCH PPS. Therefore, under the SSO policy at § 412.529, effective for discharges occurring on or after July 1, 2006, we will pay the lesser of 100 percent of the estimated costs for the discharge, 120 percent of the per diem of the LTC–DRG multiplied by the LOS, the full LTC–DRG payment, or a blend of the comparable IPPS per diem payment amount (capped at the full IPPS comparable payment amount) and the 120 percent of the LTC–DRG per diem payment amount (as described in greater detail below). The IPPS comparable payment amount portion of the blend at § 412.529 is determined in the same manner as we proposed in the RY 2007 LTCH PPS proposed rule (71 FR 4688 through 4690), and as described above in this section. (As noted elsewhere, the SSO policy has been a feature of the LTCH PPS since its inception for FY 2003 based on data analysis of FY 1998 and 1999 MedPAR files. The data simulations and projections upon which the existing policy was based, as well as alternatives that we evaluated, are detailed in the FY 2003 final rule for the LTCH PPS (67 FR 55954, 55995–56006).)

We are not establishing a category of VSSDs or VSSOs, suggested by a significant number of commenters for the same reason that we originally decided not to distinguish such cases at the inception of the LTCH PPS for FY 2003 (67 FR 55954, 56000 through 56002). At that time, we determined that such a policy produced a payment ''cliff,'' by which a significantly higher payment would result from an 8 day stay than from a 7 day stay. Although we agree that generally, LTCH stays of 7 days or less are the most obvious example of a stay that should not be treated at an LTCH (and some of the commenters suggested a VSSD threshold of as few as 5 days), we believe that the policy that we are finalizing, described in detail below, addresses this concern without providing an inappropriate payment incentive for extending a patient stay at an LTCH. The payment alternative that we are finalizing is based on recognizing the distinction between the shortest stays and those stays that, although still technically are SSOs, more typically represent the type of cases for which the LTCH provider category was established.

In this final rule, therefore, under the SSO policy at revised § 412.529, beginning with discharges occurring during RY 2007, we will pay the lesser of 100 percent of the estimated costs of the discharge (as we proposed in the RY 2007 LTCH PPS proposed rule), 120 percent of the LTC–DRG per diem payment amount multiplied by the LOS, the full LTC–DRG payment, or an LTCH PPS payment based on a blend of the IPPS-comparable per diem payment amount (capped at the full IPPS comparable payment amount), and the 120 percent of the LTC–DRG per diem payment amount (as derived from a feature of the existing SSO policy) (as described in greater detail below).

We are providing for this fourth option based on the above described blend of payments because, as noted above, we believe that as the length of a SSO stay increases, the case begins to resemble a more ''typical'' LTCH stay as defined under section 1886(d)(1)(B)(IV)(I) of the Act and envisioned by the statutes authorizing the establishment of the LTCH PPS. Consequentially, under the blend alternative to the SSO policy at § 412.529(c)(2)(iv) that we are establishing in this final rule, as the LOS of the SSO case increases, the percentage of the IPPS comparable per diem amount will decrease and the percentage of the 120 percent of the LTC–DRG specific per diem amount will increase. We are further ''capping'' the IPPS-comparable per diem portion of the blend option at an amount comparable to the full IPPS payment amount, described below, for a specific DRG. We believe that capping the IPPS comparable per diem amount portion of the blend option of the SSO payment formula at the full IPPS comparable payment amount is consistent with the overall premise of the blend alternative, stated above. In capping the IPPS-comparable portion of the blend payment at an amount that would be comparable to the full IPPS comparable payment amount, we affirm the underpinnings of the revised SSO policy that we are finalizing, which are, that as the LOS of a LTCH hospitalization increases, the treatment resources and costs associated with the stay are more in keeping with typical payments under the LTCH PPS and less comparable to an IPPS stay. The IPPS-comparable amount under this finalized SSO payment option, will be determined by the methodology that we proposed in the RY 2007 proposed rule for the fourth option to the SSO payment adjustment. Although we are not finalizing that policy, we are adopting the definition of ''IPPS comparable'' established in the RY 2007 LTCH PPS proposed rule.

We would also note that the patient classification system for both the IPPS and the LTCH PPS is the DRG system. The only distinction between the DRG systems used by the IPPS and the LTCH PPS is the weights assigned to each DRG that we derive from the data emerging from acute care hospitals and LTCHs, respectively. Under the blend payment option for SSOs described below, as the LOS of a SSO increases, the percentage of the payments based on the LTC–DRGs will increase and the percentage of the payment based on the IPPS-comparable payment derived from the IPPS DRGs will decrease.

Specifically, in the RY 2007 LTCH PPS proposed rule, we proposed that 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 determined under § 412.60 as specified at § 412.64(g). This amount would be further adjusted to account for different area wage levels by geographic area using the applicable IPPS labor-related share, based on the CBSA where the LTCH is physically located as set forth at § 412.525(c) and using the IPPS wage index for non-reclassified hospitals published 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, this amount would also be adjusted by the applicable proposed

COLA factor used under the IPPS published annually in the IPPS final rule. (Currently these same COLA factors are used under both the IPPS and the LTCH PPS.)

Additionally, this SSO proposed revised payment adjustment alternative (that is, an amount comparable to what would be paid under the IPPS for the case) could also include a DSH adjustment (see § 412.106), if applicable.

Under the proposed revision to the LTCH PPS SSO payment adjustment in the case of a LTCH that is a teaching hospital, we explained that we would determine the IME payment adjustment 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 as set forth at § 413.79(c)(2) (which would already have been established for a LTCH which had residency programs). Thus, we proposed calculating an IME payment for this LTCH that is comparable to the IPPS payment formula set forth at § 412.105. The use of a proxy for the IME cap would be 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 the number of residents reported by the hospital 1996 cost report. This IME FTE resident cap under the IPPS would not translate appropriately to a LTCH. Since a LTCH was not paid IME in 1996 it would not have reported any FTE residents for IME purposes on its 1996 cost report. Therefore, we proposed using the LTCH's direct GME cap for the purpose of calculating the proposed payment adjustment alternative for SSOs. We believed this proposal was reasonable since it would cap residents for IME payment purposes 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 is an amount under the LTCH PPS comparable to what would 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.

As we discussed in the RY 2007 LTCH PPS proposed rule, an IPPS comparable amount under the LTCH PPS for the purposes of the SSO payment adjustment, would also include payment for 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. 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 published in the annual IPPS final rule), and large urban location, if applicable.

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)). Under existing LTCH PPS policy, a SSO case that meets the criteria for a LTCH PPS HCO payment at § 412.525(a)(1) (that is, if the estimated costs of the case exceed the adjusted LTC–DRG SSO payment plus the fixed-loss amount) would receive an additional payment under the LTCH PPS HCO policy at § 412.525(a) (67 FR 56026; August 30, 2002). For purposes of HCOs under the proposed SSO policy, we would continue to use a fixed-loss amount calculated under § 412.525(a), and not a fixed-loss amount based on § 412.80(a). 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). As we discussed in the RY 2007 LTCH PPS proposed rule, we used the term ''comparable'' in the proposed fourth payment alternative so that the public will 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 VI.B. of the RY 2007 LTCH PPS proposed rule.

Therefore, under the SSO policy that we are finalizing in this final rule, we are providing for a blend alternative under the LTCH PPS at § 412.529(c)(2)(iv), that is based on a percentage of the payment calculated using the standard Federal payment rate and LTC–DRG weights utilized under the LTCH PPS and, as described above, a percentage of the paymentscomparable to the standard Federal rates, DRG weights, and applicable payment policies established under the IPPS.

Specifically, for the ''LTCH'' component of this SSO payment option, the percentage based of the 120 percent of the LTC–DRG per diem amount will be based on the ratio of the (covered) LOS of the case to the lesser of the SSO threshold for the LTC–DRG (that is, 5/6 of the geometric ALOS of the LTC–DRG) or 25 days (as discussed below). In addition, the LOS in the numerator may not exceed the number of days in the denominator (that is, the percentage may not exceed 100 percent). The remaining percent of the blend alternative at § 412.529(c)(2)(iv) (that is, 100 percent minus the percentage that is based on the 120 percent of the LTC–DRG per diem amount explained above) will be applied to the IPPS comparable per diem amount, detailed above. For purposes of the blend payment option, we have also specified that the IPPS comparable per diem amount will be capped at the full IPPS comparable amount, as explained below.

In explaining this blend payment option, we want to emphasize, there has been no change in our existing policy at § 412.503 regarding Medicare payment for covered days under the LTCH PPS. Therefore, under the SSO policy at revised § 412.529, including the above described blend option, until the SSO threshold (5/6 the ALOS for each LTC–DRG) is exceeded at which point a full LTC–DRG payment is generated, Medicare payment for a specific case is based on the number of days of coverage remaining to each beneficiary. We also want to note that in determining the percentage of the LTC–DRG-based portion of the blend option, we utilize the lesser of 25 days or the SSO threshold (5/6 ALOS of each LTC–DRG) as the number divided into the covered days of the stay. In keeping with the underlying premise of the blend option under the SSO policy, we believe that as the length of a SSO stay increases, the stay more closely resembles a characteristic LTCH stay. Consequently, for specific purposes of the blend, we believe that utilizing the ''greater than 25 day'' statutory definition as a benchmark for identifying an appropriate LTCH hospitalization recognizes Congressional intent in establishing LTCHs as a distinct provider category. In computing the blend option, therefore, as described below, we believe that it is both fair and reasonable that for each patient stay, we utilize the lesser of the LTC–DRG's specific SSO threshold or 25 days as the denominator.

The following example illustrates how the blend alternative at § 412.529(c)(2)(iv) would be determined where the LTCH patient has a covered LOS of 11 days, has an estimated cost of $11,775, and is grouped to hypothetical DRG XYZ. For purposes of this example, for DRG XYZ, the full LTC–DRG payment is $38,597.41, the LTCH PPS geometric ALOS is 33.6 days,

the LTCH PPS SSO threshold (that is, 5/6 of the geometric ALOS) is 28.0 days, the full IPPS comparable amount is $8,019.82, and the IPPS geometric ALOS is 4.5 days. For this example, the blend alternative at § 412.529(c)(2)(iv) would be calculated as follows:

• Step (1): Determine the LTC–DRG per diem portion of the blend alternative at § 412.529(c)(2)(iv).

(a) The 120 percent of the LTC–DRG per diem amount for the 11 days stay is equal to the full LTC–DRG payment divided by the geometric ALOS of LTC–DRG XYZ multiplied by the covered LOS and multiplied by 1.2.

$$\$15,163.28 = \left(\frac{\$38,597.41}{33.6 \text{ days}} \times 11 \text{ days} \times 1.2 \right)$$

(b) The percentage of the 120 percent of the LTC–DRG per diem amount for 11 days is calculated by dividing the covered LOS by the lesser of the 5/6 ALOS of LTC–DRG XYZ or 25 days (that is, 11 days ÷ 25 days = 0.44). (In this example, 25 days was used in the denominator since the 5/6 ALOS of LTC–DRG XYZ (28.0 days) is greater than 25 days. If the 5/6 ALOS of LTC–DRG XYZ was less than 25 days, that value would have been used in the denominator of this calculation. In addition, the LOS in the numerator may not exceed the number of days in the denominator (that is, the percentage may not exceed 100 percent).

(c) Determine the LTC–DRG per diem portion of the blend alternative at § 412.529(c)(2)(iv) by multiplying the percentage determined in Step 1b by the 120 percent of the LTC–DRG per diem amount for the 11 days (from Step 1a) (that is, 0.44 × $15,163.28 = $6,671.84).

• Step (2): Determine the IPPS comparable per diem portion of the blend alternative at § 412.529(c)(2)(iv).

(a) The IPPS comparable per diem amount is equal to the full IPPS comparable amount divided by the geometric ALOS of IPPS DRG XYZ multiplied by the covered LOS (that is, $8,019.82 ÷ 4.5 days × 11 days = $19,604.00. However, since this amount exceeds the full IPPS comparable amount ($8,019.82), only the full IPPS comparable amount ($8,019.82) will be used in the blend alternative calculation.

(b) The percentage of the IPPS comparable per diem amount is calculated by subtracting the percentage determined in Step 1b from 100 percent (that is, 1 minus the covered LOS divided by the lesser of the 5/6 ALOS of DRG XYZ or 25 days) or 1 minus 0.44 (as shown in Step 1b = 0.56).

(c) Determine the payment amount of the IPPS comparable per diem portion of the blend alternative at § 412.529(c)(2)(iv) for the 11-day stay by multiplying the percentage determined in Step 2b by the IPPS comparable per diem amount (from Step 2a), (that is, 0.56 × $8,019.82 = $4,491.10).

• Step (3): Compute the total payment amount of the blend alternative at § 412.529(c)(2)(iv) by adding the LTC–DRG per diem portion (Step 1c) and the IPPS comparable per diem portion (Step 2c), (that is, 6,671.84 + $4,491.10 = $11,162.94).

Table 10 provides detailed instructions for calculating payments using the blend alternative.

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TABLE 10: Example of Blend Alternative under §412.529(c)(2)(iv) for DRG XYZ

Step Number	Description of Step	Description of Calculation	Example of Calculation	Result
1a	Determine 120 percent of the LTC-DRG per diem amount	Divide the full LTC-DRG payment by the geometric ALOS of LTC-DRG XYZ and multiply that per diem amount by both the covered LOS and 1.2.	$\frac{\$38,597.41}{33.6\ days} \times 11\ days \times 1.2$	$15,163.28
1b	Calculate the percentage of the 120 percent of the LTC-DRG per diem amount	Divide the covered LOS by the lesser of the 5/6th ALOS of LTC-DRG XYZ or 25 days.	11 days ÷ 25 days	0.44
1c	Determine the LTC-DRG per diem portion of the blend alternative at §412.529(c)(2)(iv)	Multiply the percentage determined in step (1-b) by the LTC-DRG per diem amount in step (1-a).	0.44 x $15,163.28	$6,652.04
2a	Calculate the IPPS comparable per diem amount	Divide the full IPPS comparable amount by the geometric ALOS of DRG XYZ and multiply by the covered LOS.	$\frac{\$8,019.82}{4.5\ days} \times 11\ days$	$19,604.00
2b	Determine the IPPS comparable amount to be used in the blend alternative at §412.529(c)(2)(iv)	Compare the full IPPS comparable amount to the IPPS comparable per diem amount to determine which is the least amount.	The full IPPS comparable amount ($8,019.82) is lower than the IPPS comparable per diem amount ($19,604.00)	$8,019.82
2c	Calculate the percentage of the per diem comparable IPPS amount	Subtract the percentage determined in step (1-b) from 1 (that is, 1 minus the covered LOS divided by the lesser of the 5/6th ALOS of LTC-DRG XYZ or 25 days).	1 – 0.44	0.56
2d	Determine the IPPS comparable per diem portion of the blend alternative at §412.529(c)(2)(iv)	Multiply the percentage determined in step (2-c) by the IPPS comparable per diem amount determined in step (2-b).	0.56 x $8,019.82	$4,491.10
3	Compute the blend alternative at §412.529(c)(2)(iv)	Add the LTC-DRG per diem portion determined in step (1-c) and the IPPS comparable per diem portion determined in step (2-d).	$6,671.84 + $4,491.10	$11,162.94

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In this example, the SSO payment would equal $11,162.94 (using the blend alternative at § 412.529(c)(2)(iv)) since it is lower than 100 percent of cost ($11,775), 120 percent of the LTC–DRG per diem ($15,163.28), and the full LTC–DRG payment ($38,597.41).

If, in the above example, the covered LOS of the patient would have been 24 days, the blend alternative percentage of the 120 percent of the LTC–DRG per diem amount in step 1b would be 0.96 (instead of 0.44) and the blend percentage of the IPPS comparable per diem amount in step 2c would be 0.04 (instead of 0.56). For a covered LOS of 24 days, the 120 percent of the LTC–DRG per diem amount would be $33,083.97. The comparable IPPS per diem amount would be $42,772.37, which is greater than the full IPPS comparable amount ($8,019.82). Thus, for a covered LOS of 24 days, the amount determined under the blend alternative at § 412.529(c)(2)(iv) would be as follows:

$32,080.97=[(0.96 × $33,083.52) + (0.04 × $8,019.82)].

As the LOS of an SSO case approaches the SSO threshold (that is, 5/6 of the geometric ALOS of the LTC–DRG), the amount determined under the blend alternative at § 412.529(c)(2)(iv) more closely approximates a full LTC–DRG payment. For instance, in the example with a covered LOS of 24 days discussed above, the amount determined under the blend alternative at § 412.529(c)(2)(iv) ($32,080.97) is approximately 83 percent of the full LTC–DRG payment ($38,597.41).

For cases with very short lengths of stay (that is, even less than the IPPS ALOS), the IPPS comparable per diem amount portion of the blended payment amount would be less than the full IPPS comparable payment amount based on the per diem calculation described above, which would be a percentage of the full IPPS comparable payment. Furthermore, as described below, as the LOS reaches the lower of the five-sixths SSO threshold or 25 days, the payment could be equal to the full LTC–DRG (based on existing SSO policy). Because we are limiting the denominator of the blend percentage to the lesser of the 5/6 ALOS or 25 days, for SSO cases in LTC–DRGs that have an SSO threshold of greater than or equal to 25 days and that have a covered LOS of 25 days or more, the blend alternative at § 412.529(c)(2)(iv) will equal 120 percent of the LTC–DRG per diem amount determined under § 412.529(d)(1). For instance, in the example presented above in this section, where the SSO threshold for DRG XYZ is equal to 28.0 days, for an LTCH patient with a covered LOS of either 25, 26, 27 or 28 days, the blend alternative at § 412.529(c)(2)(iv) will equal 120 percent of the LTC–DRG per diem amount based on the covered LOS of the stay (that is, $33,083.52 for a 25-day LOS). Under this revised SSO policy, once the covered LOS equals 25 days, Medicare payment for an SSO case would be based on the lesser of 100 percent of the estimated cost of the case, 120 percent of the per diem LTC–DRG multiplied by the LOS or the full LTC–DRG since the blend option as described above, at that 25-day point, will be based on 100 percent of the LTC–DRG per diem payment amount and 0 percent of the IPPS comparable per diem payment amount. Therefore, once the LOS is 25 days or more, the blend method ceases to apply for purposes of calculating the payment amount and instead, the payment amount for the fourth option is equal to one of the other options: 120 percent of the LTC–DRG per diem amount. In this example, calculation of SSO payment for days 26, 27, or 28 would be based on the lesser of those alternatives and if the patient remained at the LTCH on or after day 29, the SSO threshold would be exceeded and a full LTC–DRG would be generated.

Although we did not adopt many of the commenters' suggestions that we distinguish VSSO or VSSD cases and pay them either at or below cost, we do believe that this finalized payment policy for SSO cases endorses their premise that such cases do not fit the typical profile of LTCH cases and it can be reasonably argued that such cases should not be paid similarly to those that are more characteristic of LTCH cases. In general, we believe that our finalized policy, which transitions from a larger percentage of the LTCH PPS payment that is based on the IPPS comparable per diem amount to a higher proportion of payment based on the 120 percent of the LTC–DRG per diem amount as the LOS increases, realistically addresses our significant concerns that the shortest LOS cases could have continued to be treated at an acute care hospital and not require an LTCH stay and therefore payments to LTCHs under the LTCH PPS should be adjusted accordingly.

Comment: We received numerous comments that praised the quality care given to Medicare beneficiaries by the LTCHs in their areas and urged us not to make significant cuts in Medicare payments which they fear would result in reduced services. The commenters asserted that, coupled with CMS' decision to maintain LTCH standard Federal rates from RY 2006, revision of the payment adjustment for SSO patients will be detrimental to the industry as costs of providing care will exceed payment. The commenters further stated that underpayment to LTCHs will cause patients with complex medical conditions to lose access to appropriate care and increase costs to acute care hospitals which will be forced to continue caring for these sicker patients. The commenters believed that the revised SSO payment policy, as proposed, would have a profound impact on the entire health care system of their communities since their LTCHs are a critical component of the state health care delivery system. They state that since LTCHs offer specialized services not available elsewhere, severe cutbacks for LTCHs could resonate throughout the entire health care system. One commenter noted that CMS made a statement that it does not expect any changes in quality of care or access to services for Medicare beneficiaries under the LTCH PPS based on proposed rule policies. However, one of the commenters believes, to the contrary, a decrease in payments will have pervasive effects on LTCHs. Moreover, the commenter pointed out that the impact of changes in our payments to LTCHs because of the proposed SSO policy revisions will not only affect services offered to ''the most vulnerable patients,'' but also will have an impact on the staff of the LTCHs. Several of the commenters specify that they envision that acute care hospitals will be overtaxed and incur additional costs without being able to free up ICU beds for patients who need short-term acute care services. They also state that the acute care hospitals in their communities may not be able to meet patient needs for those needing LTCH services.

Response: We understand the serious concerns expressed by the commenters and, although we are not finalizing the particular SSO policy revisions as it was proposed, we want to assure the commenters that we are aware of their concerns. We also agree that if a Medicare beneficiary is appropriately referred, and admitted, to one of the approximately 400 LTCHs in the United States for a complex medical condition, the beneficiary could receive excellent medical care from a highly trained and committed professional staff. As discussed above in this section, we revisited the specific proposed payment revisions to the SSO policy based on the many clear and well-crafted comments that we received, and the policy that we are finalizing will not have the more

extensive financial consequences on longer SSO cases expected by the commenters from the proposed policy changes. As explained in more detail in the impact section of this notice, we estimate that the financial impact on LTCHs from this final policy will be significantly less than the original proposed policy.

Therefore, we do not believe that the revisions to the SSO policy that we are finalizing will result in LTCHs going out of business nor that significant services would have to be curtailed with dire consequences for beneficiaries, staff or the local medical care system. As noted elsewhere, our data indicates that for FY 2003, the aggregate margins for LTCHs were 7.8 percent and for 2004, they were 12.7 percent. Therefore, we believe that even with decreased Medicare payments for SSO patients, such as we are envisioning based on this finalized payment policy and detailed in the Impact (see section XV. to this final rule), we believe that LTCHs will generally be able to continue delivering high quality medical care to their patients. We continue to believe, however, that acute-care hospitals should not be discharging patients to LTCHs without having provided a full episode of care and we also continue to have concerns about LTCHs admitting those short stay patients who could otherwise continue to be treated in acute care hospitals. We have revised our policy under the SSO adjustment and in finalizing the blend option for paying SSO patients, we do not believe that we are requiring any additional determinations nor are we creating any circumstance that should not already be incorporated in the determination to admit a patient to an LTCH following treatment at an acute care hospital.

Comment: Numerous commenters argued that our proposed IPPS-comparable payment option under the SSO policy, if finalized, could be expected to discourage physicians from discharging patients from acute care hospitals and admitting them to LTCHs. Thus, they charged that we were establishing a system wherein clinical judgment is being trumped by determinations based solely on payment. The commenters further stated that since physicians discharge patients to LTCHs because it is in the patients' best interests, we would be substituting our judgment for a physician, setting a very dangerous precedent. Furthermore, physicians cannot be expected to guess the LOS or the death of a severely ill patient upon admittance to the LTCH. The commenters also note that there is available data supporting the medical determination that physicians are discharging patients to the LTCH setting because the patient's needs are better served in the LTC setting than in an acute care hospital setting.

Response: As stated above in this section, we have revised our proposed IPPS-comparable payment option in light of the comments that we have received and after further data and policy analysis. Contrary to what the commenter states, however, the policy objective underlying the proposed SSO rule was to preclude LTCHs and physicians from taking advantage of a system that significantly overpays for patients that do not require the extensive resources that such high payments are intended to support. As discussed later, we recognize that some SSO cases are unavoidable due to death or an unexpected clinical improvement and early discharge. However, we have noted that in a community where both acute care and LTCH beds are available, patients are routinely transferred from the acute care hospital to the LTCH for the remainder of care just because the LTCH resource is available. We are concerned that this trend has increased exponentially because it provides an acceptable disposition of the patient for the physician, and because it is an expeditious means of lowering the acute hospital LOS and costs. There is no question that the multidisciplinary approach for certain complex patients (for example, ventilator weaning) is appropriate. However, we are very concerned that the LTCH is assuming the role of the acute care hospital for many other patients, at a far higher cost, which it is possible to do as long as the LTCH continues to maintain an ALOS of 25 days for purposes of qualifying for payments under the LTCH. We do not believe, moreover, that the payment policy option that we are finalizing for SSO discharges will deter physicians from delivering appropriate care to beneficiaries or from making appropriate referrals to LTCHs. We are seeking, in finalizing this payment policy, to remove any financial incentive that could encourage an LTCH to admit a patient from an acute-care hospitals prior to that patient having received a full episode of care at the acute care hospital.

Comment: Several commenters cited a study centered at Barlow Respiratory Hospital that charted the course of ventilator weaning treatment for 1419 medically unstable patients at 23 LTCHs from March 2002 through February 2003. The study reports that more than 50 percent of this group of patients were weaned from the ventilators and evidenced improvement both neurologically and functionally. The commenters assert that this study exemplifies the excellent level of care for such patients at LTCHs.

Response: We agree with the commenters that the results of the ''Barlow'' study indicate a significant rate of very positive outcomes for the very sick LTCH patients who were included in the study. In the late 1990s, we sponsored a ventilator demonstration study which included, among other acute care settings, the Mayo Clinic and Temple University Hospital, that also reported impressive results. We further understand that the results of the Barlow study were used for the establishment of national ventilator-weaning protocols issued by the National Institutes of Health and that input from the Temple University program continues to be critical in formulating national standards. We believe that these programs established a level of excellence that should be emulated by all hospital-level facilities that treat ventilator-dependent patients, including acute care hospitals, LTCHs, and IRFs. Accordingly, we believe it is not simply the fact that the patient is treated at a LTCH that is critical to predicting positive results. Rather, it is the type of clinical intervention that is furnished to the patient at the hospital. In many cases that intervention is currently exemplified at acute care IPPS hospitals, as well as at LTCHs.

Comment: Several commenters claim that even for what we would term ''appropriate'' admissions, our proposed payment option under the SSO policy that could generate an IPPS-comparable payment will erect barriers to the use of LTCHs. One commenter described the typical LTCH patient: An elderly patient with persistent multiple-system failures who is de-conditioned and protocol-resistant. The commenter asserted that these patients respond impressively to the aggressive blending of therapeutic interventions, interdisciplinary teams, and medical intervention that is not otherwise available in the community or tertiary hospital setting. The commenter states that from ''a case rate reimbursement perspective,'' grouping such a ''treatment-resistant'' population with the rest of the general acute care population is highly inappropriate. Two commenters asserted that even when adjusted for HCOs, acute care hospitals are not designed or intended to provide service to long-term care-type patients. The commenters emphasized that acute care hospitals are not designed to provide extended care services, unlike LTCHs, with their specially trained expert staff and clinicians and multi-disciplinary approaches. LTCHs, noted one commenter, are like acute care

hospitals but must sustain a high level of care for longer periods.

Response: Under this fourth payment option, as the LOS increases, the payment for such cases under the LTCH PPS will be based on a decreasing percentage of an IPPS-comparable per diem amount and an increasing percentage of the LTC–DRG per diem payment amount. We believe that this payment adjustment recognizes the particular expertise of LTCHs treating a population who require long-term care because the payment percentage based on the 120 percent of the LTC–DRG per diem amount increases (and the payment percentage based on the IPPS-comparable per diem amount decrease) as the patient LOS increases. However, we do not agree with the statement that ''acute care hospitals are not designed to provide extended care services'' such as is the care provided in LTCHs. Although there may be communities with LTCHs where the acute care hospitals may have functionally ''restricted'' their services because of the presence of these LTCHs, as well as the financial advantages and clinical niche that they have sought to fill, acute care hospitals are equipped to provide services to the same population, and the IPPS under which they are paid, is calibrated based on the resources needed to treat those patients. Moreover, because there are over 3,500 acute care hospitals and approximately only 400 LTCHs, which are not distributed uniformly throughout the U.S. (for example, few are located in California), many acute care hospitals are providing care for the vast majority of Medicare beneficiaries requiring the type of care described by the above commenters. Our FY 2005 MedPAR files indicate that 20 percent of cases treated at acute care hospitals nationwide have lengths of stay between 7 and 14 days (that is, 2,386,057 out of a total of 11,855,205 cases). Additionally, 5.2 percent of acute care hospital cases (617,219) or have LOS greater than 14 days. We believe, that in those acute care hospitals, to paraphrase the final commenter, those patients are receiving in an acute care hospital paid under the IPPS, the ''high level of care for longer periods,'' they would also receive as patients at an LTCH.

Comment: Several commenters claimed that we based our proposed revision of the SSO policy that could have resulted in an IPPS-comparable payment for a particular SSO case, on the incorrect assumption that ''short stay'' LTCH patients are clinically similar to short term acute care hospital patients. They assert that the SSO thresholds (5/6 of the geometric ALOS for each LTC–DRG) were never meant to be a measure of the appropriateness of an LTCH admission, but rather, were mathematically derived from the per diem payment amounts, which were based on a methodology that would produce a payment-to-cost ratio for SSO cases close to one. Furthermore, one commenter states the presence of a SSO patient does not indicate a premature discharge from an acute care hospital, citing that at this commenter's LTCHs, 11 percent of the patients had previously qualified as HCOs at the referring acute care hospital. Additionally, the commenters asserted that we are mistaken in its claim that LTCHs can foresee the LOS for patients admitted to LTCHs or predict likely deaths, where in actuality, upon admission, there is generally no substantial clinical difference between long stay and ''short stay'' patients. Commenters found it to be incongruous that a patient in LTC–DRG 475 (Respiratory System Diagnosis with Ventilator Support) would still be an SSO patient (for example, 28 days for LTC–DRG 475) and could be hospitalized in an LTCH for greater than 25 days (the definition of an LTCH). A case such as this could be appropriately treated in a LTCH. The commenters noted that physicians cannot and should not be asked to predict the LOS or the likely death of severely ill patients. Commenters further asserted that we have made an erroneous assumption that LOS equates to ''severity of illness'' (SOI) and is a proxy for the appropriateness of an admission. However, the commenters assert that this is not the case. They point to another incorrect belief in the proposed rule that LTCHs function like acute care hospitals when they have patients for the same LOS. On the contrary, the commenters assert that SSO patients are being admitted because they look just like ''inliers,'' and we have proposed that LTCHs absorb payment rates that bear no relationship to the costs of furnishing patient care at the LTCH level.

Furthermore, based on claims analysis, using the APR–DRGs, the medical complexity and mortality rates of SSO patients, as measured by the SOI and ''risk of mortality'' (ROM) standards are very similar to that of the LTCH ''inlier'' patient population. The commenters further presented comparisons between these measures for SSO patients and for patients with the same DRGs in acute care hospitals, indicating that 52 percent of all patients admitted to LTCHs were in the highest APR–DRG ROM categories, whereas only 24 percent of acute care patients are in those same categories, resulting in a total percentage of APR–DRGs 3 and 4 at LTCHs among the SSO population that is approximately double that of acute care hospitals. The commenters noted that higher patient acuity correlates to higher utilization of facility resources, and hence, higher costs, which argues against our proposed policy that would significantly lower reimbursements for SSO cases. Several commenters also provided a comparison of case mix indices (CMI) for LTCH SSO cases and cases at acute care hospitals. The commenters assert that SSOs at LTCHs have a relative CMI that parallels the CMI of LTCH ''inlier'' cases at LTCHs and which is 72 percent higher than the comparable CMI at acute care hospitals.

Response: We are well aware that not every SSO patient can be so identified at the time of admission to an LTCH. We further recognize that many patients who will eventually be defined as SSO patients because their LTCH stay is equal to or less than 5/6 of the GMLOS for their particular LTC–DRG, may, upon admission, present the same severity of illness and risk of mortality as ''inlier'' LTCH patients. In this respect, the assertions and data presented by the commenters comparing the SOI and ROM based on the APR–DRGs of SSO patients to those of ''inliers'' were persuasive, and coupled with additional considerations, we revisited our proposed payment policy for SSO cases. We agree that SSO thresholds described by the commenters were never meant to be a measure of the appropriateness of an LTCH admission, but rather, were mathematically derived from the per diem payment amounts. We believe this enabled us to arrive at a reasonable payment policy at the outset of the LTCH PPS for cases that had lengths of stay significantly shorter than those patients fitting the typical profile of those who should be treated at LTCHs. We recognize that an LTCH admission could be a medically complex one (an appropriate LTCH admission) with a relatively long LOS and still be considered an SSO case. We also acknowledge that, in some cases, LTCH admissions could also have qualified as HCOs at the referring acute care hospital. We still have concerns, however, that patients in LTC–DRGs with significantly shorter stays than the ALOS for that particular DRG might have been unnecessarily admitted to the LTCH rather than receiving all of their care in the acute care hospital. In addition, we are adjusting the LTCH PPS to appropriately pay for those stays that consume far less than a full array

of services in the LTCH for the particular LTC–DRG.

We believe this to be the case since our data indicates a correlation between the LOS at an acute care hospital for a patient following treatment at the highest level of intensity (ICU or CCU), that is, the number of ''recuperative'' days, and whether or not the patient was admitted to an LTCH upon discharge from the acute care hospital. As Table 11 indicates, an analysis of the CY 2004 MedPAR files revealed that for the specified DRGs for acute care cases following ICU/CCU days, there were significantly fewer ''recuperative'' days for acute care HCO patients that were discharged and admitted to an LTCH than for those patients that were discharged directly from the acute care hospital. For acute care cases in DRGs 475 (Respiratory system diagnosis with ventilator support) and DRG 483 (Trach with mechanical vent 96+ hours or PDX except face, mouth and neck diagnosis), the number of ''recuperative'' days were considerably shorter at the acute care hospital if there was a discharge followed by an admission to an LTCH. We believe that this data confirms MedPAC's assertion in the June 2004 Report to the Congress that ''patients who use LTCHs have shorter acute hospital lengths of stay than similar patients'' (p. 125).

TABLE 11.—LOS, ICU/CCU LOS, AND POST-ICU/CCU LOS FOR SELECTED INPATIENT DRGS BY POST-DISCHARGE STATUS

[Live discharges only]

	Acute				High Cost Outlier			
DRG	Cases	LOS	Inlier ICU/CCU days	Post ICU/CCU days	Cases	LOS	Outlier ICU/CCU days	Post ICU/CCU days
475—no LTCH	65,937	10.5	6.4	4.1	3,887	32.5	20.5	12
475—LTCH	3,286	12.5	9.5	3	515	29.6	22.6	7
483—no LTCH	11,726	31.5	21.8	9.7	3,257	73.6	53.6	20
483—LTCH	8,920	26.6	23.3	3.3	2,353	45.7	41	4.7
001—no LTCH	22,174	9	4.2	4.8	1,271	29.2	16.9	12.3
001—LTCH	477	13.4	8.2	5.2	125	29	21.8	7.2
014—no LTCH	216,972	5.5	1.7	3.8	1,257	28.1	13.5	14.6
014—LTCH	3,145	7.9	3.5	4.4	108	24.2	16.9	7.3
148—no LTCH	117,537	10.5	2.4	8.1	6,552	33.5	14.5	19
148—LTCH	1,623	16	6.3	9.7	763	31.7	17.9	13.8
012—no LTCH	53,838	5.2	0.7	4.5	294	27.7	9.6	18.1
012—LTCH	329	6.8	1.4	5.4	11	20.8	11.5	9.3
087—no LTCH	68,976	6.5	2.1	4.4	476	29.9	14	15.9
087—LTCH	1,192	9.3	4.4	4.9	37	24.7	15.1	9.6
079—no LTCH	139,412	8	1.3	6.7	1,429	34	9.3	24.7
079—LTCH	2,543	10	2.7	7.3	73	30.5	10.5	20
088—no LTCH	387,285	4.8	0.8	4	501	30	9.3	20.7
088—LTCH	2,474	7.3	2.1	5.2	32	30.4	13	17.4
089—no LTCH	488,931	5.6	0.9	4.7	1,067	27.9	8.8	19.1
089—LTCH	2,999	8	2.2	5.8	53	29.2	13.5	15.7
416—no LTCH	194,850	7.4	1.6	5.8	3,660	28.7	13.3	15.4
416—LTCH	3,749	9.7	3.8	5.9	390	25.6	18.1	7.5
482—no LTCH	4,841	9.8	3.3	6.5	241	35.2	14.9	20.3
482—LTCH	145	13	6.5	6.5	31	33.3	21.8	11.5

We further agree that some SSO patients become so by virtue of death or a faster than expected recovery and early discharge, and that in certain LTC–DRGs, the SSO threshold still requires a relatively long hospital stay (for example, DRG 475, Respiratory System Diagnosis with Ventilator Support). However, in the absence of better admission criteria, we still are concerned that LTCHs are admitting some SSO patients that could have received their full care at the acute care hospital and/or SNF level facility.

However, we do not agree with two comparisons made by a considerable number of the commenters concerning the SOI and ROM of LTCH SSO patients to those of acute care patients based on similar lengths of stay and case-mix indices. Although we will not be finalizing the specific proposed SSO payment policy option that the commenters were opposing, we believe that it is essential to evaluate the basis of these last comparisons.

These commenters submitted data indicating that even though they may be inpatients grouped to the same DRG, for the same number of days, a SSO patient at a LTCH is much sicker and has a greater chance of dying than does the acute care patient. Although we will not be finalizing the specific proposed SSO payment policy option that the commenters were opposing, we believe that it is essential to evaluate the basis of these last comparisons.

Generally, even a patient in an appropriate LTCH admission that has been previously hospitalized in an acute care hospital received the diagnostic work up and major interventional treatment during that initial stay. Assuming that the patient continued to need hospital-level care after being somewhat stabilized and was discharged to a LTCH, the discharge to a LTCH could have been determined as clinically appropriate. The clinical status of this patient at this point cannot be reasonably compared to a typical patient who is treated in the acute care hospital and who is grouped to the same DRG. This is the case because the original patient has already been treated at that initial level and has required additional hospital-level care either by remaining at the acute care hospital, which would be paid for under the IPPS (perhaps as a HCO), or by being admitted to a LTCH where the stay could either be a SSO or an ''inlier.'' The only valid comparison of the SOIs and ROMs of two such patients in the context of the commenter's concerns,

would be to contrast the SOI and ROMs of the patient at the LTCH with the patient who, following the same initial intervention at the acute care hospital, continued treatment at the acute care hospital.

We understand that the proposed option that could have resulted in paying for a SSO stay based on the IPPS-comparable amount would have resulted in significant payment reductions to LTCHs for all SSO cases, even those that by all clinical measures could be considered appropriate LTCH patients. However, we still believe that modifications to the SSO policy are necessary to ensure that payments for those cases appropriately reflect the resources necessary to treat those patients, which we believe are not the same as the resources necessary to treat a patient requiring the full level of care available at a LTCH, with lengths of stay over the SSO threshold for the LTC–DRG. At the outset of the LTCH PPS, we established the SSO payment adjustment to address this distinction which we continue to believe is a valid and reasonable consideration for Medicare payments to LTCHs (67 FR 55995, August 30, 2002).

We believe that the finalized payment policy for SSO cases, described above, responds to the concerns stated by these commenters. That is, since LTCHs are certified as acute care hospitals that are distinguished, by virtue of their greater than 25-day ALOS, for Medicare payments under the LTCH PPS, per discharge payments are based upon the high utilization of resources and long stays generally associated with a specific type of patient. Therefore, we will be paying SSO patients based on the least of 100 percent of the estimated costs, 120 percent of the LTC–DRG per diem multiplied by the LOS, the full LTC–DRG payment, or a blend of the IPPS comparable per diem payment amount capped at the full IPPS comparable payment amount and the 120 percent of the LTC–DRG per diem payment amount. (The specifics of this option are detailed in responses above.) We believe that this option is both fair and reasonable because as the length of a SSO stay increases, the case begins to resemble a LTCH stay that requires the full resources of a LTCH, as we believe was envisioned by the Congress when they crafted the statutory definition of a ''subclause (I)'' LTCH, ''a hospital which has an inpatient LOS (as determined by the Secretary) of greater than 25 days'' in section 1886(d)(1)(B)(iv)(I) of the Act, and thus, is more appropriate for payment under the LTCH PPS. As noted above, LTC–DRG weights and payment rates under the LTCH PPS have been calculated to reflect services delivered to Medicare beneficiaries with complex medical conditions that result in a greater use of hospital resources, long inpatient stays, and significantly higher Medicare payments.

It remains a significant concern, however, that in some cases LTCH admissions are encouraged and facilitated by the referring acute care hospital to reduce the acute hospital LOS, rather than on the basis of objective LTCH admission criteria leading to higher numbers of SSO patients inappropriately admitted to LTCHs. (For this reason, we have awarded a contract to RTI, discussed in section XII of this final rule, for the purpose of evaluating the feasibility of establishing such objective criteria.) We are also concerned that in areas where LTCH beds are plentiful, the ALOS data indicates that physicians may be less likely to adhere to objective LTCH admission criteria to reduce acute care hospital LOS and also to achieve a satisfactory patient disposition, neither of which are the intended functions of LTCHs.

Comment: Many commenters asked that we not finalize the proposed SSO policy revisions, stating that the SSO payment option that could pay the LTCH based on an amount comparable to what would otherwise have been paid under the IPPS was not based on solid data analysis and supportable conclusions. In fact, a number of commenters asserted that the proposed policy was not based on data but rather on ''erroneous and unsubstantiated assumptions'' that all SSO patients are inappropriately admitted to LTCHs and inappropriately discharged from acute care hospitals. The commenters noted that, because of the way in which the policy was formulated, the percentage of LTCH cases that are paid under the SSO payment policy was a function of the SSO threshold and the dispersion of cases above and below the ALOS for the LTC–DRGs, that is, statistically, the SSO definition at 5/6 of the geometric ALOS would necessarily produce approximately 37 percent of cases as SSOs. Therefore, under the commenters belief that given the regulatory 5/6 definition of SSOs, which we had not proposed to change, the percentage of SSO cases was not amenable to change just based upon LTCHs admission policies. One commenter noted that for a significant number of patients to fall below 5/6 ALOS for a LTC–DRG is expected in a LTCH. Additionally, commenters noted that a case may qualify as a SSO because the patient has run out of covered days, regardless of the actual LOS in the LTCH and that in establishing our policy for qualifying as a LTCH (that is, meeting the average greater than 25 day LOS for a particular cost reporting period), we have recognized the ''appropriateness'' of including ''total'' rather than just ''covered'' days of a stay, since regardless of the payer, if the patient is still receiving hospital-level care, the facility is functioning like a LTCH. For this reason, these commenters urged us to remove such cases from the calculations we used to develop a SSO payment policy. Some commenters expressed concerns about the reliability of the data that underlay our policy proposals and asserted that our proposals are based on faulty assumptions, insufficient data, and a fundamental lack of understanding of the valuable care LTCHs provide. Moreover, the commenters assert that LTCH patients are just not the same type of patients as acute patients; they believe that our proposed policies indicate that we are unaware of the distinction between acute care patients and patients at LTCHs. They further claim that they did not believe that the public was able to submit meaningful comments to our proposed policies because of our data flaws, our biases, and the resulting policies that we proposed.

Response: As stated in the previous response, we believe that we do have a thorough understanding of the types of cases in which LTCHs specialize but we are also aware that the vast majority of LTCH patients are admitted following treatment at acute care hospitals. The patient's stay at the acute care hospital generated a Medicare payment under the IPPS, and the subsequent admission to a LTCH, an acute care hospital with an ALOS of greater than 25 days, will generate an additional Medicare payment. To protect the Medicare Trust Fund from what may be inappropriate and/or unnecessary payments, and to ensure that the program is not paying twice for the same episode of care, we feel that it is essential that we evaluate those cases that are admitted for an unusually short stay following an initial treatment at another acute care hospital to acute care hospitals that specialize in long-stay care, since that second stay will trigger another Medicare payment. In MedPAC's June 2004 Report to the Congress, the Commission stated that, ''* * * Living near a LTCH increases a beneficiary's probability of using such a facility. For example, living in a market area with a LTCH quadruples the probability of LTCH use. Being hospitalized in an acute hospital with a LTCH located within the hospital also

quadruples the probability that a beneficiary will use a long-term care hospital'' (page 125).

Although we acknowledge that our establishment of the 5/6 of the geometric ALOS threshold, from a statistical standpoint, will result in approximately 37 percent of LTCH cases being defined as SSOs, we are still extremely concerned with the number of cases that are being treated in LTCHs that fall considerably below the geometric ALOS for any given LTC–DRG. In fact, as stated previously, in the commenters various and specific suggestions for how to reasonably and fairly pay SSOs, the commenters themselves drew a distinction between those cases that fall within the definition of a SSO but are more in keeping with the LOS generally associated with a LTCH (for example, a case assigned to LTC–DRG 482 with SSO threshold of 32.1 days, would still be paid as a SSO if the patient was treated in the LTCH for 25 days) and those cases that many commenters referred to as ''Very Short Stay Outliers (VSSO)'' or ''Very Short Stay Discharges (VSSD).'' In the finalized SSO policy, described elsewhere in these responses, the payment formula particularly takes into account our very strong belief that LTCHs are acute care hospitals that specialize in treating patients requiring ''long-stay'' hospital-level care. The LTCH PPS has been designed and calibrated to pay specifically for that type of care. Since the inception of the LTCH PPS, when we established the SSO adjustment (67 FR 5594 through 55995, August 30, 2002) under our payment regulations at § 412.529, we have provided that if a LTCH treats patients not requiring a long stay, Medicare pays the LTCH based on the applicable payment adjustment option, described above. Furthermore, as we revise the payment options in this final rule for the SSO policy, we continue to believe that such a payment adjustment is reasonable for all short stay patients, including those that die shortly after their admission to the LTCH. The FY 2004 MedPAR data indicates that 43 percent of all patients that die in LTCHs are deaths that occur within the first 14 days of the stay, with 35 percent of SSO deaths occurring within the first 7 days following admission. As we have since the inception of the LTCH PPS, we continue to believe that Medicare payments for those death cases occurring within the SSO threshold should be determined under the SSO policy since the length of the patient's treatment in the LTCH did not utilize the full measure of hospital resources for which the full LTC–DRG payment was calibrated.

Conversely, our data indicates that of all SSO cases, approximately 60 percent of the discharges are 14 days or less and also that acute care hospitals treat a significant percentage of patients for longer than the 5 day ALOS. (In acute care hospitals, paid under the IPPS, over 20 percent, in the aggregate, of patients that are treated have a LOS of between 14 and 7 days.) Therefore, as described below, we believe that the SSO policy that we are finalizing under the LTCH PPS provides a fair and reasonable payment, in light of the above stated concerns that the short-term hospital-level care that LTCHs provide for many SSO cases may be substituting for care that could otherwise be delivered at acute care hospitals and for which at best, Medicare would otherwise pay under the IPPS.

Under the new option of our finalized policy, we recognize that, as the length of a SSO stay increases, the case begins to more resemble a more ''typical'' LTCH stay and therefore, it is more appropriate for payment to reflect the amount otherwise payable under the LTCH PPS. Therefore, we will pay the lesser of 100 percent of the estimated costs for the discharge, 120 percent of the per diem of the LTC–DRG multiplied by the LOS, the full LTC–DRG payment, or a blend of the IPPS comparable per diem payment amount capped at the full IPPS comparable payment amount, and 120 percent of the LTC–DRG per diem payment amount. For each day, as the LOS increases, the percentage of the IPPS-comparable per diem amount will decrease and the percentage based on the 120 percent of the LTC–DRG specific per diem amount will increase. Because the formula uses the IPPS-comparable per diem amount, capped by the full IPPS-comparable amount, for cases with very short lengths of stay (that is, less than the IPPS ALOS), the IPPS-comparable amount portion of the blended payment amount would be less than the full IPPS comparable payment amount. Mathematically, as the LOS reaches the lower of the 5/6 SSO threshold or 25 days, the payment under the fourth option, the blend (that is, zero percent of the IPPS comparable per diem amount added to 100 percent of the 120 percent LTC–DRG per diem amount) will be equal to the 120 percent of the LTC–DRG per diem amount.

Under the LTCH PPS at § 412.507 Medicare will pay for inpatient care delivered only on those days that the beneficiary has coverage until the LOS exceeds the SSO threshold and becomes an inlier stay. Therefore, since the inception of the LTCH PPS for FY 2003, we established the distinction between ''covered days'' and ''total days'' of a LTCH stay. At the point when a patient's benefits exhaust, the patient is ''discharged for payment purposes'' and even though the patient may continue to be hospitalized at the LTCH, Medicare will pay only for the covered days, with the patient (or the patient's secondary insurance) being responsible for the remaining days' LTCH costs. For example, even though a patient could have been treated in an LTCH for 40 days, if upon admission, the patient only had 20 covered days remaining, for Medicare payment purposes, the stay could qualify as a SSO, unless the 20 covered days exceeded the 5/6 threshold for the LTC–DRG to which the case was grouped, at which point, the stay would become an inlier stay and a full LTC–DRG payment would be generated. Several commenters urged us to remove SSO cases occurring as a result of such lapses of Medicare coverage from our revised SSO policy but based on our data analysis, we will not be excluding benefit exhausted cases from the policy. According to FY 2005 MedPAR data, these cases constitute only 3.31 percent of SSO cases. It has been our policy since the beginning of the LTCH PPS to count those stays during which benefits are exhausted as SSOs if the covered portion of the stay is less than 5/6 of the geometric ALOS for the DRG. In this way, we appropriately determine payment based on the part A-covered stay. At the same time, we continue counting the total days of the stay for purposes of qualification as a LTCH, because that calculation is intended to reflect the length of care provided to Medicare beneficiaries. Our policy, however, of including total days for Medicare patients to identify hospitals qualifying (or continuing to qualify) as LTCHs indicates our recognition that conceivably, a beneficiary may be appropriately treated in a LTCH for example, for 40 days, and yet because the beneficiary had only 5 remaining benefit days, would be reported in our claims data as a 5-day SSO case. We would be interested in revisiting this issue and would solicit comments to that end. For the present, however, since, as noted above, a very small percentage of SSO cases are caused by beneficiaries exhausting benefits, the above discussed benefits exhaust cases will continue to be governed by the finalized SSO policy.

As stated above previously in this section, although we are not finalizing the proposed SSO payment policy, we will address the commenters concerns

questioning the integrity of the data upon which we based our proposed policy for the IPPS-comparable option to payments under the SSO policy and who also took great issue with our explanations for the proposed policy. We believe that the commenters' concerns actually arose from the anticipated impact of the proposed policy on their LTCHs, since the issue of the major impact, an estimated 11 percent decrease in, an aggregate payment, was the underlying concern raised by most commenters, rather than actual doubts about the accuracy of our data. We disagree that the public was denied the opportunity for meaningful comment on our proposed policies, as we will discuss below. Further, we believe this RY 2007 regulation cycle for the LTCH PPS actually presents an excellent example of a rule-making experience as envisioned by the Administrative Procedures Act, and the Secretary's general rule-making authority as established under section 1871(b)(2) of the Act, as well as demonstrating our responsiveness to public comment on proposed policies. Reacting to several of the proposed provisions in the RY 2007 LTCH PPS proposed rule (71 FR 4648), industry stakeholders engaged consultants, including the Lewin Group and Avalere Health LLC, that re-analyzed our data used in the development of our proposed policy, as well as our specific policy proposal for revision to SSO policy. Their reports and findings were submitted to us along with the industry's comments on the proposed rule and the reports were frequently quoted by other commenters. As noted throughout these responses, based upon the comments and serious proposals that we received (which are listed above), as well as other information that was provided by stakeholders, we revisited the proposed policy and in response to those concerns, have, in fact, not finalized those aspects that the commenters found the most troubling.

Therefore, rather than stakeholders being prevented from submitting meaningful comments on the policies in the RY 2007 LTCH PPS proposed rule, the actual sequence leading up to the finalized payment option under the SSO policy, exemplifies the objectives of notice and comment rule-making. As noted above, the resulting comments, have had a significant impact on our revisiting and revising the proposed policy.

Comment: Two commenters suggested that rather than challenging the cases that are admitted from acute care hospitals, we should be more concerned about inappropriate admittances from non-hospital settings such as SNFs or elsewhere.

Response: In response to the commenters' suggestion that we review inappropriate admittances from non-hospital settings, after analyzing recent data, we note that approximately 80 percent of the patients admitted to the LTCHs come from the short term acute-care hospitals and only 20 percent are admitted from other non-hospital settings. Since SNFs do not offer hospital-level care but are still dealing with patients with compromised health, we believe that generally, a decision to transport a SNF patient to a hospital, would generally be made because the patient appears to the medical professionals at the SNF to be in need of a higher level of medical treatment or care than is available at the SNF. (In fact, such patients would typically be admitted to the acute care hospital rather than to a LTCH.) However, both an acute-care hospital and a LTCH offer acute hospital-level care. As discussed above, we are very concerned about the treatment of a short-stay patient who could reasonably and effectively continue to be treated in an acute-care hospital and paid for under the IPPS, being admitted unnecessarily to a LTCH, which specializes in treating patients requiring long-term hospital-level care and paid for under a PPS which has been calibrated based upon the high resource use associated with long patient stays. Furthermore, admission of such a patient could also result in an unnecessary and inappropriate LTCH hospitalization, which would also result in a second Medicare payment for what was essentially, one episode of care.

Comment: Several commenters stated that although CMS claimed it had insufficient data for a one-time adjustment to the standard Federal rate, and proposed a postponement of this evaluation and potential policy implementation, we asserted that we had sufficient data when we proposed the payment revision to the SSO policy. The commenters believe that if we have insufficient data for the purposes of determining the former policy, we have insufficient data for the major policy change signified by the proposed SSO payment policy revision. The commenters stated that when comparing data from FY 2003 to FY 2004 for SSO cases, there was a decrease of SSO cases from 48 percent in FY 2003 to 37 percent in FY 2004. Since FY 2004 was the second year of the transition to full payments under the LTCH PPS and LTCHs were paid using a blend (that is, 60 percent of payments were based on what would have been paid under the reasonable cost-based (TEFRA) methodology), commenters stated that the payment policy incentives we built into the PPS, which were designed to discourage short stay patients, would not have been reflected in FY 2004 data. Therefore, several commenters urged that we reexamine the number of SSOs at the end of the transition or not before reviewing FY 2005 data which is the first year that more than 50 percent of each LTCH PPS will be based on the Federal rate and impacted by the SSO payment criteria. The commenters maintained that we will only be able to determine whether the current SSO payment methodology is fair after we compare more than one year of cost reporting data post transition, a valid analysis of facility characteristics and resources of LTCHs to acute care hospitals for the same DRGs.

Response: We do not believe that the position we have taken in these two policy areas, establishing a revised payment option for SSO cases and postponing the one-time adjustment to the standard Federal rate is inconsistent. Rather, these proposals are based on two different data sources that have different collection procedures and different analytic potentials. We believe, for reasons explained below, that the changes that we have made to the payment options for SSO discharges are based on credible and sufficient data even though the transition period to full payments under the Federal rate specified in § 412.533 is not yet complete. The data, which we utilized when we designed the SSO policy at the outset of the LTCH PPS for FY 2003 (which is the basis for the 48 percent figure of the ''base year'' SSO cases) was based on LTCH data generated during FY 2001 when LTCHs were still being paid under the TEFRA system. Notwithstanding providing for a 5-year transition and our earlier projections that in FY 2003 payments would be more generous under the blend (that is, we believed that 49 percent would opt for the blend, whereas 51 percent would opt for full Federal payments), the DRG-based per discharge payments under the LTCH PPS provided an incentive so that, based on the data used in the RY 2005 LTCH PPS final rule from the Provider Specific File at the close of CY 2003, in fact, we estimated that 93 percent of LTCHs would be paid fully under the LTCH PPS for RY 2005 (69 FR 25701, May 7, 2004). We believe that this indicates LTCH behavior at that point, which was in the middle of the second year of the 5-year transition, was being shaped by the incentives associated with all aspects of the LTCH

PPS, from more accurate coding of LTC–DRGs, to the graduated payments under the SSOs, as well as to the financial advantages inherent in 100 percent payment under the Federal rate. Furthermore, for purposes of evaluating patient-level data, we use the MedPAR claims files which are updated quarterly. Therefore, for FY 2004, using the best available data for the RY 2007 LTCH PPS proposed rule, we were able to determine that based on 118,525 cases from 337 LTCHs, 10,530 discharges have lengths of stay of 7 days or less; 16,411 of 8 to 14 days; 36,989 of 15 to 25 days; and 54,595 of greater than 25 days. When we evaluated SSO data, therefore, we did not base either the proposed revision of the SSO policy or the finalized policy on isolated data. Rather, we compared the data from FY 2001, which was used to formulate the LTCH PPS, and the most recent available LTCH PPS discharge data available at that time (that is, FY 2004).

At the outset of the LTCH PPS, we established a monitoring component (discussed in section XI. in this preamble of this final rule) which operates continually under the direction of our Office of Research, Development, and Information (ORDI) and provides us with data analysis and policy input. We will continue to monitor all aspects of the LTCH PPS, including the SSO policy, particularly in light of the finalized changes that we are making for RY 2007, focusing on the impact of our revisions on LTCH behavior. As we noted in the RY 2007 LTCH PPS proposed rule, we would use the conclusion of the 5-year transition (FY 2007) as a benchmark and for any adjustment under the one-time adjustment in RY 2008. We plan to conduct a comprehensive analysis of all of the payment adjustment policies, including our SSO policy, issued at the inception of the LTCH PPS for FY 2003. This payment analysis would be conducted to evaluate whether significant revisions would be appropriate. Moreover, the analysis of cost reports, and patient and facility characteristics mentioned by some of the commenters were evaluated as part of the RTI study (which we expect to be submitted in final form later this year) discussed in section XII of this preamble.

The proposal to postpone the one-time potential adjustment to the standard Federal rate is addressed in greater detail elsewhere in these responses. However, we note that the data source for such an evaluation would be LTCH cost reports (CMS HCRIS files) and, given that a LTCH is permitted to submit its cost report within 6 months of the end of the cost report period, plus the lag time required for typical cost report settlement involving submission, desk review, and in some cases, auditing, we did not believe that the October 1, 2006 deadline was reasonable particularly in light of the potential significance of any adjustment. Accordingly, we believe that in the context of the need to make adjustments that will be based on cost report data, it is accurate to state that the necessary data are not yet available. However, in the context of the SSO change which is based, in part, on the LOS data which are derived from claims information from the MedPAR files, those data are currently available, and therefore, it is appropriate to finalize that change based on existing data.

Comment: Several commenters suggested that prior to finalizing the changes to the SSO policy specified in the RY 2007 LTCH PPS proposed rule, we should first evaluate the impact of the 25 percent rule which was based on many of the concerns that we expressed regarding movement of patients prematurely from acute care hospitals to LTCHs.

Response: The regulation that the commenters refer to is ''Special payment provisions for long-term care hospitals within hospitals and satellites of long-term care hospitals'' which was implemented for October 1, 2004, and which focused on high percentages of patients being admitted to LTCH HwHs and satellites of LTCHs from host acute care hospitals and which specified payment adjustments, in general, for discharges in excess of 25 percent. We believe the SSO policy is not related to the special payment provisions for long-term care HwHs and satellites of LTCHs which was implemented for October 1, 2004, and which focused on high percentages of patients being admitted to LTCH HwHs and satellites of LTCHs from host acute-care hospitals and which specified payment adjustments, in general, for discharges in excess of LTCH 25 percent. The SSO policy addresses the appropriate payment formula for patients with lengths of stay significantly below the average for LTCHs patients in that LTC–DRG. Therefore, we see no connection between the two policies and we believe that it is unnecessary to postpone modifications to the SSO policy.

Comment: A few commenters questioned whether we had considered the impact of the expanded post-acute transfer rule in formulating the proposed changes in the SSO policy.

Response: The expanded post-acute care transfer policy, which was finalized in the FY 2006 IPPS final rule (70 FR 47411), affects DRGs that have a high volume of discharges to post-acute care facilities and a disproportionate use of post-acute care services. The purpose of the policy is to avoid providing an incentive for a hospital to transfer a patient to another hospital early in the patient's stay to minimize costs while still receiving the full DRG payment. Although we expect that policy to have some impact on the discharge behavior of acute care hospitals because the expanded policy will reduce payments to acute care hospitals, under the IPPS, for discharges prior to reaching the geometric ALOS for one of the included DRGs, it does not necessarily affect the issues being addressed by the SSO policy change. Both of these policies are ensuring that Medicare payments are appropriate given the types of treatment provided in each setting. We believe that the revised payment formula for SSO patients that we are finalizing will appropriately pay LTCHs for delivering services to patients who do not otherwise require the lengths of stay that are characteristic of LTCHs. The SSO policy will address payments to LTCHs for patients discharged from the acute care hospital even after the geometric ALOS.

Comment: Several commenters believe that we are incorrect that LTCHs could be admitting patients not requiring long stays, noting that LTCHs actually have a disincentive to admit short stay patients because LTCH certification status can be at risk if the hospital does not maintain an ALOS of more than 25 days.

Response: Under the TEFRA system, all inpatient days (whether covered by Medicare or not) were included in the LOS computation, and the mathematical determination was based upon the number of patient days—during the cost reporting period when they occurred—divided by discharges occurring during that same period of time (67 FR 55954, 55971). With the establishment of the per discharge LTCH PPS, we restricted the patient count for purposes of qualifying as a LTCH solely to Medicare patients (67 FR 55971), and we implemented the policy of ''days following the discharges,'' under which, if a patient's stay crosses two cost reporting periods, the total days of that stay (both covered and non-covered days) would be included in the computation during the cost-reporting period that the discharge occurred (69 FR 257405, May 7, 2004).

Our data reveals that the general ALOS of most LTCHs varies only slightly. Generally, LTCHs maintain an ALOS that is just over 25 days, meeting the statutory definition of a LTCH, that

is, having an ALOS of greater than 25 days. Furthermore, we understand that LTCHs closely monitor their yearly ALOS and that one extremely long-stay case can mathematically offset for a number of short-stay cases. From studying the hospital-specific data, we believe that this is indeed the case for many LTCHs. We also believe that the payment policy that has been utilized since the start of the LTCH PPS for FY 2003 has not operated as a financial disincentive for the admission of patients who will not ultimately require long-stay hospital-level care. In fact, we note that our data shows approximately 27,000 SSO cases with a LOS of 14 days or less. This indicates that even with over 20 percent of their discharges having such a short ALOS, LTCHs have maintained their greater than 25-day statutory ALOS. Therefore, we believe that it is both possible for a LTCH to maintain its designation and also admit many very short stay cases.

Comment: We received comments requesting that we exempt subclause (II) LTCHs from the proposed changes to payments for SSO cases, which under our proposed regulation would be subject for cost reporting periods beginning on or after October 1, 2006. Because of the unique mandate established by the Congress for these LTCHs, the commenters believe that our proposed policy directly threatens the financial integrity of subclause (II) LTCHs. The commenter noted that for FY 2004, we established a specific exception to the existing SSO policy because they presented data that indicated that over 50 percent of their patients would qualify as SSOs because of the Congress' delineation of their unique census and mission. Therefore, the commenter states, subclause (II) LTCHs cannot control either case mix or LOS and most of our concerns about SSOs would be inapplicable to such LTCHs because of this category of facility's unique services and programs.

Response: By enacting section 4417(b) of the BBA, and providing an exception to the general definition of a LTCH as set forth in section 1886(d)(1)(B)(iv)(I) of the Act, 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). Under this provision, which we implemented at § 412.23(e)(2)(ii), to qualify as a subclause (II) LTCH, a hospital must have first been excluded as a LTCH in CY 1986, have an inpatient ALOS of greater than 20 days, and demonstrate that 80 percent or more of its annual Medicare inpatient discharges in the 12-month reporting period ending in Federal FY 1997 have a principal diagnosis that reflects a finding of neoplastic disease. (62 FR 46016 and 46026, August 29, 1997.) Acknowledging the distinction between hospitals qualifying as LTCHs under section 1886(d)(1)(B)(iv)(I) of the Act (subclause (I) LTCHs), when we developed the PPS for LTCHs, we revised the greater than 25 day ALOS criteria to include only Medicare patients for these subclause (I) LTCHs. However, for LTCHs under section 1886(d)(1)(B)(iv)(II) of the Act (subclause (II) LTCHs), no change was made to the methodology for calculating the LTCH's ALOS, since ''* * * we have no reason to believe that the change in methodology for determining the average inpatient LOS would better identify the hospitals that Congress intended to exclude under subclause (II)'' (67 FR 55974, August 30, 2002). Consistent with existing policies that differentiate between subclause (II) LTCHs and subclause (I) LTCHs, we agree with the commenters that it is reasonable for CMS to consider whether or not a policy that has been designed for LTCHs designated under subclause (I) can reasonably and equitably be applied to a subclause (II) LTCH without some measure of adjustment. Moreover, in establishing this category of LTCHs, in effect, the Congress limited its potential case-mix, therein distinguishing it even further from the larger group of LTCHs. Since the theoretical foundations of a DRG-based PPS are that where the costs of one case may exceed its payment, the opposite is also likely to happen, and that where some types of cases are always very expensive for a hospital to treat, others are, in general, less costly, it is assumed that hospitals under a DRG-based system, therefore, can typically exercise some influence over their case-mix and their services to achieve fiscal stability. This option is generally not open to subclause (II) LTCHs. According to CMS claims data for CY 2001, at one subclause (II) LTCH, more than 93 percent of Medicare patients expired. Over half of the patients at this hospital would qualify as SSOs (97 percent of those SSOs expired), where others had extremely long lengths of stay.

By establishing subclause (II) LTCHs, the Congress provided an exception to the general definition of a LTCH under subclause (I), and therein endorsed the unique mission of a particular type of hospital. We do not believe that the Congress intended for policies put in place for LTCHs described under subclause (I) to undermine the viability of a LTCH described under subclause (II).

As we evaluated the SSO policy for subclause (II) LTCHs, we believe that a LTCH in this category may 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).

Accordingly, we are not finalizing the specific options to the SSO policy published in the RY 2007 LTCH PPS proposed rule for a subclause (II) LTCH. We have revisited the relevant data for subclause (II) LTCHs attendant upon receiving the comments, and we now believe that retaining the existing SSO policy with the three current options to govern Medicare SSO payments at the beginning of their first cost reporting period beginning on or after October 1, 2006, continues to be both reasonable and equitable for subclause (II) LTCHs as well as for the Medicare program. Payments to subclause (II) LTCHs under the SSO policy, therefore, will be governed by the specific percentages and schedule at new § 412.529(e)(2)(v). We consider the current adjustment under the SSO policy for LTCHs designated under section 1886(d)(1)(B)(iv)(II) of the Act and § 412.23(e)(2)(ii) to be a reasonable and equitable response to the particular situation of a subclause (II) LTCH under the LTCH PPS.

Comment: Several commenters noted that SSO policy has been a feature of the LTCH PPS since the start of FY 2003, and, therefore, payments for care to this population based upon SSO methodology were anticipated in setting the standard Federal rate. The commenters stated that to cut SSO payments so radically at this time raises issues relating to the PPS's budget neutrality and to finalize the SSO policy without a ''material increase in payment rates for inlier cases,'' casts doubts on the ongoing fairness of the overall payment system.

Response: We believe that commenters' when referring to the budget neutrality requirement mean a system-wide budget neutrality requirement. A system-wide budget neutrality requirement means, specifically, payments under the LTCH PPS are always estimated to equal estimated system-wide (that is, aggregate) payments that would have been made under the reasonable cost-based (TEFRA) payment methodology if the LTCH PPS were not implemented. We disagree with the commenter's claim that the SSO policy violates the statutory requirement that the LTCH PPS be budget neutral. We note that under section 123(a) of the BBRA,

Congress required that the Secretary develop ''* * * a per discharge prospective payment system for payment for inpatient hospital services of long-term care hospitals described in section 1886(d)(1)(B)(iv) of the Act (42 U.S.C. 1395ww(d)(1)(B)(iv)) under the Medicare program. Such system shall include an adequate patient classification system that is based on diagnosis-related groups (DRGs) and that reflects the differences in patient resource use and costs, and shall maintain budget neutrality.'' We have interpreted the requirement to ''maintain budget neutrality'' to require that the Secretary set total estimated prospective payments for FY 2003 equal to estimated payments that would have been made under the TEFRA methodology if the PPS for LTCHs was not implemented. It has been our consistent interpretation that the statutory requirement for budget neutrality applies exclusively to FY 2003. In FY 2003, we set total estimated LTCH PPS payments for FY 2003 equal to estimated payments that would have been made under the TEFRA methodology if the PPS for LTCHs was not implemented. Consequently, we believe that we have satisfied the budget neutrality requirement under the statute. Moreover, we have broad discretionary authority under section 123(a)(1) of the BBRA as amended by section 307(b)(1) of the BIPA to provide appropriate adjustments, including updates. Thus, we are acting within that broad authority in establishing changes to the SSO policy beginning in RY 2007.

There are several reasons that we do not believe that the Congress intended perpetual system-wide budget neutrality. We note below, a partial list of those reasons. For example, a system-wide budget neutrality requirement that applies perpetually would affect the Secretary's ability to operate the prospective payment system for LTCHs efficiently. To illustrate, if the Secretary were to propose to adjust payments upward in a particular instance because he finds that payments are ''too low'', under a perpetual budget neutral system the Secretary would be forced to reduce estimated payments for other cases to fund the additional costs associated with the proposed adjustment. However, this shifting of resources may then cause payments to LTCHs for those cases that were being reduced to offset the proposed adjustment to then be inappropriately ''too low.'' We do not believe the Congress intended such a result for every adjustment that will be made to the LTCH PPS in perpetuity. Rather, as with all dynamic and evolving systems, we believe that based upon monitoring and the analysis of data, the Secretary has the discretion and obligation to formulate polices and establish payment adjustments that will ensure that the Secretary continues to pay LTCHs appropriately for beneficiary care.

Also, we note that none of the statutory charges for the other prospective payment systems (for example, IPPS, SNF PPS, IRF PPS) require system-wide budget neutrality for perpetuity. We are not aware of anything unique about LTCHs or the need to establish a LTCH PPS that would have compelled the Congress to legislate a system that mandates budget neutrality in perpetuity. Consequently, we do not believe that in the instant case, the Congress departed from its consistent approach for budget neutrality and intended to create a statute which applies a completely different standard to the LTCH PPS.

As noted above, we will not be finalizing the specific IPPS-comparable payment option that we proposed for SSO cases, but rather have significantly modified the formula, in large part, because of our responsiveness to our commenters' concerns. Despite this, we have no reason to believe that ''inlier'' cases are being ''underpaid'' at LTCHs. MedPAR data from FY 2003 and part of FY 2004 indicate an aggregate 16.1 percent margin on LTCH inlier cases. We believe that the SSO policy that we are finalizing, as described in detail above, is reasonable and fair, and we see no additional need to increase payments to LTCH inlier cases as a consequence of this policy.

Comment: We received one comment asking if we considered what would be the impact on the calibration of the LTC–DRG weights under the proposed changes in payments for SSOs.

Response: As discussed in the FY 2006 IPPS final rule when we updated the LTC–DRGs and relative weights (70 FR 47336), the LTC–DRG relative weights were adjusted for SSOs by using the ratio of the LOS of the case to the geometric ALOS of the LTC–DRG and does not use the actual payment amount (or cost) to adjust for SSO cases in the annual recalibration of the LTC–DRG relative weights. Therefore, the changes to the SSO policy would have no impact on the LTC–DRG relative weights. Under the current LTC–DRG relative weight recalibration methodology, there is no reason for changing how the LTC–DRG relative weights are computed under the final SSO policy.

Comment: A number of commenters stated that the proposed IPPS-comparable option for payment under the SSO policy is a violation of the express will of the Congress in establishing the category of hospitals that were excluded from the IPPS under section 1886(d)(1)(B) of the Act. The commenters stated that under that provision the Congress acknowledged that these excluded hospitals (that is, LTCHs, IRFs, IPFs, childrens hospitals and cancer hospitals) could not reasonably be paid under a DRG system that had been designed to pay for treatment in acute care hospitals under the IPPS. Further, these commenters stated that we had thwarted the intentions of the Congress to establish a unique PPS that is specific to LTCHs in subsequent legislation (that is, the BBRA of 1999 and the BIPA of 2000). The commenters claimed that the proposed IPPS-comparable option to the SSO payment policy would be forbidden under these enabling statutes because such a payment option would ignore the ''differences in patient resource use and cost'' at LTCHs. One commenter criticized our use of the phrase ''a payment otherwise comparable to what would have been paid under the IPPS'' as a disingenuous attempt to side-step the Congressional mandate that the LTCHs not be paid based on the acute care IPPS. Therefore, the commenter believes that we violated the statutory intent that LTCHs be excluded from the IPPS in issuing the proposed IPPS-comparable payment adjustment under the revised SSO policy.

A number of commenters cite our proposed policy as a violation of the Court's two-prong test for validity of a regulation established under *Chevron U.S.A., Inc.* v. *Natural Resources Defense Counsel, Inc.* 467 U.S. 837, 842–843 (1984). Under the ruling, the Court asks whether the Congress addressed, in clear language, the issue in question and, if the answer is affirmative, the effect is given to the ''unambiguously expressed intent of the Congress.'' If the ''statute is silent or ambiguous with respect to the specific issue,'' the Agency's interpretation is allowed to stand as long as it is based on a permissible construction of the statute.'' Id at 843. Deference to the Agency's interpretation is ''only appropriate when the agency has exercised its own judgment'' and is not based upon an erroneous view of the law.

Response: In responding to the commenters' claims, we would first reiterate that we are not finalizing the specifics of the proposed IPPS-comparable option for payments under the SSO policy. In response to commenters' concerns and following

further data and policy analysis we believe that the policy that we are finalizing in this rule, and described in detail above, fairly addresses a circumstance that we presume was not envisioned when the Congress authorized the LTCH designation at section 1886(d)(1)(B)(I) of the Act (that is, paying for a substantial number of short stay patients—particularly those with extremely short stays—under a payment system designed to treat long-stay patients). Moreover, we believe that the quote used to establish Congressional intent actually addresses the situation that we faced in determining how to pay for short stay patients at a LTCH: ''[T]he DRG system was developed for short-term acute care general hospitals and as currently constructed, does not adequately take into account *special circumstances of diagnoses requiring long stays*'' (Report of the Committee on Ways & Means, U.S. House of Representatives to Accompany HR 1900, HR Report No. 98–25, at 141 (1983) Legislative history of the 1983 SS Amendments). We do not believe that we violated Congressional intent in either the BBRA of 1999 or the BIPA of 2000 in establishing a payment adjustment under the LTCH PPS that addresses our concerns about a significant number of short stay patients being treated at LTCHs. As indicated previously, section 123 of the BBRA, as amended by section 307(b)(1) of the BIPA confers broad discretionary authority on the Secretary to implement a prospective payment system for LTCHs, including providing for appropriate adjustments to the payment system. This broad authority gives the Secretary great flexibility to fashion a LTCH PPS based on both original policies as well as concepts borrowed from other payments systems that are adapted, where appropriate, to the LTCH context. In the instant case, our finalized SSO policy utilizes, in large part, principles from the IPPS payment methodology and builds upon those concepts to create a LTCH PPS payment adjustment that results in an appropriate payment for those inpatient stays that we believe could be more appropriately treated in another setting. The PPS system authorized under both the BBRA and the BIPA emphasized the specific needs, resource use, costs, and payments for the patients who required hospital-level care for extended stays. Moreover, the authority extended to the Secretary by the BIPA included the discretion to ''provide for appropriate adjustments to the long-term hospital payment system,'' which, from the inception of the LTCH PPS for FY 2003, we have interpreted to include the establishment of a payment adjustment for discharges that have lengths of stay considerably less than the ALOS and that receive significantly less than the full course of treatment for a specific LTC–DRG'' (67 FR 55995; August 30, 2002). Rather than our special payments for SSO violating the Congressional mandate for a distinction between the payment systems for acute care hospitals and, as according to the committee report cited above, ''diagnoses requiring long stays,'' we believe that our payment policies are directly in accord with Congressional intent. We further believe that the new option of the blended payment actually captures Congressional intent since as the LOS appears to be more typical of the type of stay for which the LTCH PPS was established, the payment is based on a decreasing percentage of IPPS-comparable per diem payment amount while the percentage of payment based on the 120 percent of the LTC–DRG per diem payment amount increases. Therefore, we believe that our finalized payment adjustment for SSOs under which one payment option could be a blend of a percentage of an IPPS-comparable per diem payment amount that will decrease in direct proportion to an increase in the LOS and a percentage payment of the 120 percent LTC–DRG per diem payment amount, which will increase based on the LOS at the LTCH, is grounded in several existing Medicare payment adjustments. We also believe that the gradually shifting percentage of the payment blend recognizes the increasing use of resources and costs as the stay lengthens, and it is consistent with the Ways and Means Committee's above-cited definition of ''special circumstances of diagnoses requiring long stays.''

We disagree with commenters that our LTCH PPS SSO policy that is based on an IPPS comparable payment amount is a payment under the IPPS. As indicated in various places throughout the preamble, section 123 of the BBRA, as amended by section 307(b)(1) of the BIPA, confers broad discretionary authority on the Secretary to implement a PPS for LTCHs, including providing for appropriate adjustments to the system. This broad authority gives the Secretary great flexibility to fashion a LTCH PPS based on both original policies as well as concepts borrowed from other payment systems that are adapted, where appropriate, to the LTCH context. In the instant case, our finalized SSO policy utilizes principles from the IPPS payment methodology and builds upon those concepts to create a LTCH PPS payment adjustment that results in an appropriate payment for those inpatient stays that we believe do not typically belong in LTCHs but would be more appropriately treated in another setting. In this final rule, we are further refining our existing SSO policy. Therefore, we disagree with commenters that the Secretary is acting in contradiction of the statute and inconsistently with the Chevron doctrine.

Comment: Several commenters stated that when the Congress established LTCHs, they were described as hospitals with ''an average in patient LOS of greater than 25 days'' and that the statute did not say that cases must stay a ''minimum of 25 days.'' The commenters stated that the word ''average'' implies half of the lengths of stay would be below 25 days. The commenters maintained that statements made by CMS indicate that short stays at LTCHs are inappropriate. However, the commenter claims that it was clearly the Congress's intent that in establishing the definition of LTCHs, half of the patients would stay for fewer than 25 days.

Response: We agree with the commenter that the statutory definition of a LTCH as a hospital with an ALOS of greater than 25 days allows a hospital to include short stay patients in meeting the average of greater than 25 days threshold. However, in both the BBRA and the BIPA, which authorized the development of the LTCH PPS, the Secretary was granted considerable authority to examine and to provide appropriate adjustments to the system. We believe that both in establishing LTCHs as hospitals excluded from the IPPS and also in mandating the development of the LTCH PPS, the Congress intended LTCHs to treat long-stay patients with lengths of stay of approximately 25 days or more. The specific policies that we have established under the LTCH PPS are based on our interpretation of what the Congress intended for payment to LTCHs in the treatment of patients requiring an extended stay that could result in higher costs to the Medicare program. The SSO policy at § 412.529 is an example of the premises upon which we developed the LTCH PPS since it provides for fractional payment of the LTC–DRG to a LTCH for stays that do not require the full resources typical of LTCHs. Similarly, the charge data generated from SSOs are given a fractional weight in setting LTC–DRG weights as opposed to those cases that generate a full LTC–DRG payment. Given the broad discretionary authority conferred by the statute to develop the

LTCH PPS, we do not believe the Congress intended to limit the Secretary's ability to make adjustment under the LTCH PPS for those cases that do not receive the full resources of a case in the respective LTC–DRG.

Comment: One commenter urged us to review how Medicare Advantage views the use of LTCHs. If a patient covered by Medicare Advantage (MA) is at risk of deconditioning, according to the commenter, the patient is sent to a specific LTCH. This is because the prospects for restoration are increased and, additionally, such a policy also opens the plan's ICU and overall bed-day utilization rates.

Response: MA plans are required to furnish enrollees with all medically necessary Medicare A and B services. Accordingly, MA coordinated care plans must contract with Medicare certified hospitals to ensure hospital access for its enrollees in the plan's service area. In some areas where there are cooperating LTCHs, MA organizations may elect to contract with LTCHs to provide care for their plan members. However, the terms of these contracts, including payment rates, are unique for each MA organization, its contracted providers (for example, LTCHs), and hospitals. Therefore, we are not able to comment on the particular situation to which the commenter is referring.

Comment: Several commenters stated that the proposed IPPS-comparable payment adjustment option under the SSO policy created a strong incentive to ''slow down provision of care'' because by extending the stay of a SSO LTCH patient by a few days (depending upon the particular LTC–DRG), a LTCH would receive the full LTC–DRG payment rather than the least of the proposed SSO formula, which could result in an IPPS-comparable payment to the LTCH. The commenters believe that it is in the LTCHs' best interests not to discharge the patient because the payment difference between the IPPS-comparable payment adjustment and the full LTC–DRG payment is so significant, particularly for stays approaching the 5/6 geometric ALOS threshold. A number of commenters stated that the proposed payment policy for SSOs actually inverted the logic of the PPS and rather reinforced the former incentive of cost-based reimbursement because more profit would be derived from longer stays. The commenters urged us to reconsider the proposed policy because they believe it contradicts the fundamental principle of a PPS, which is to reward efficiency. Several commenters asserted that under the proposed policy, successfully discharging the patient earlier because of efficiency and expertise to alternative care settings results in a financial penalty. Moreover, the commenters claimed this rewards providers who keep patients through the threshold. Furthermore, several commenters stated that our proposed revision to the SSO policy (that is, the IPPS-comparable payment option), which commenters said would significantly underpay SSO patients, countered the principles of prospective payment. Other commenters asserted that all PPSs operated in terms of an ''averaging principle'' which we were violating with the proposed IPPS-comparable payment option under the SSO policy. One commenter specified that ''SSO reimbursements are currently providing the margins that keep overall PPS payments in balance by offsetting losses on HCOs in particular.'' One aspect of this principle that they claim we are violating, is that by eliminating the opportunity for LTCHs to care for patients with costs that are less than Medicare payments, we are eliminating chances for those LTCHs to overcome losses by caring for patients whose costs of treatment exceed reimbursement levels.

Response: We understand the commenters' concerns that our proposed IPPS-comparable payment option under the SSO policy could extend patient stays (that is, ''slowing down the provision of care'') to exceed the threshold and thus be paid a full LTC–DRG payment. In response to this comment and also to the claim that finalizing such a policy could have the unintended effect of ''inverting'' the logic of prospective payments so that an LTCH would reap financial benefits from longer (perhaps less efficient) stays, we would reiterate that we are not finalizing the specific proposed policy to which the commenters refer. We believe that the policy that we are establishing in this final rule more directly addresses our concerns that the current payment formula under the LTCH PPS overpays for those very short-stay SSO cases that could otherwise have been treated in a short-term acute-care setting, while the final policy provides a higher payment amount than the proposed policy for SSOs with longer lengths of stay. The graduated payment scale, which increases the proportion of a LTC–DRG-based payment while decreasing the proportion of an IPPS-comparable-based payment, pays appropriately for long-stay cases while not overpaying for very short SSO stays. Under this finalized policy, Medicare will be paying more appropriately for the shorter stays that we believe could otherwise be treated in an acute care hospital while paying significantly more for those longer-stay cases that more closely resemble typical LTCH cases. Moreover, we believe that the graduated per diem increase of payments based on LTC–DRG weights in our final SSO policy does not penalize LTCHs for effective care that could result in an earlier discharge. Rather we believe that the policy provides for a fair payment for the efficiency and expertise that, in the case of an appropriate LTCH admission, could lead to a discharge that would be somewhat below the five-sixths SSO threshold and thus be paid as a SSO. Although we will be monitoring LTCH behavior, it is also our expectation that this revised policy will provide minimal rewards for unnecessarily lengthening a stay.

For the commenters that indicated that the SSO policy is inconsistent with the averaging principle inherent in a PPS, we believe it is very important to evaluate the adjustment in light of the following. In a PPS there are numerous principles (for example, appropriate payment, predictability, averaging, beneficiary access to appropriate care, equity) that we try to balance simultaneously when making policy decisions. The averaging principle, while an important principle in the LTCH PPS, is not the only principle by which we make our policy decisions. For example, in the case of SSOs and HCOs, we must determine how to appropriately pay for aberrant cases that are much shorter (in the case of short stays) and much costlier (in the case of HCOs) when compared to typical cases in the relevant LTC–DRG.

In the case of short stays, if we failed to adjust the payment to reflect that the case did not receive the full resources of a typical LTCH stay for the particular DRG, the PPS payment would be greatly ''overpaying'' for the stay, may serve as an incentive to game the system, and would waste valuable Trust Fund dollars. Similarly, in the case of HCOs, if we did not adjust the payment to reflect the extraordinary high costs that a LTCH was incurring for treating a particular patient when compared to a typical case in the respective LTC–DRG, we would be ''underpaying'' significantly for the case. We have stated that providing additional money for HCOs strongly improves the accuracy of the payment system as well as reduces the incentive to under serve these patients (69 FR 55954 and 56022). Since we do not pay short stays outliers or HCOs an amount paid to ''inliers''/ cases that have lengths of stay or costs commensurate with other cases in the respective LTC–DRG, but instead make

payment adjustments to reflect the unique circumstances of these cases, the averaging principle is less heavily emphasized under these circumstances to achieve equity, appropriate payments that accurately reflect resource costs at the patient and hospital level, and beneficiary access to medical care.

We believe that, given that LTCHs are defined as acute care hospitals that have an average inpatient LOS of greater than 25 days, the payment policies under the LTCH PPS appropriately reflect the averaging principle. That is, where some cases within the inlier range will have generated relatively lower costs, other cases will generate higher costs and Medicare will pay a LTCH the same for both less and more costly cases. The SSO policy, along with the HCO policy, addresses payments for cases that fall outside the normal types of averaging in the inlier range in the PPS and ensures that payment for SSO cases is not greatly in excess of the resources required to treat those cases. The payment system modeling and data projections that we generated in developing the revised payment options for SSOs that we are finalizing in this final rule at § 412.529(c)(4), indicates that our payments will be consistent with the particular way in which the ''averaging principle'' is applied to the LTCH PPS, described above. Therefore, this policy that we are finalizing does not represent a change from the underlying premise of either the prospective payment or the particular approach that we used in determining how to pay for short stays at LTCHs since the outset of the LTCH PPS for FY 2003. We also believe that this finalized policy should reduce any payment incentive under the present SSO policy to admit short-stay patients who could otherwise be treated at short term acute care hospitals paid for under the IPPS.

With regards to the commenters who noted that, ''SSO reimbursements are currently providing the margins that keep overall PPS payments in balance by offsetting losses on HCOs in particular,'' we would note that MedPAR data from FY 2003 and part of FY 2004 also reveal that payments to LTCHs for SSOs and inliers more than offset losses for HCOs and, in fact, produces an aggregate average margin of 10.5 percent. Furthermore, since the HCO threshold decreased from RY 2004 to RY 2005 from $19,590 to $17,864, it is probable that the aggregate margin for the later period is even higher. Therefore, the policy that we are finalizing will decrease the margins that our data indicates have generally been realized by LTCHs for their SSO patients under the existing SSO payment policy. In large part, these margins have resulted from excessive payment for those very short-stay SSO cases. However, we are not finalizing the proposed policy which would have significantly reduced Medicare payments for all SSO discharges. We believe that the revised SSO payment policy that we are finalizing addresses our concerns with excessive payments for very short stay SSO cases while providing a higher payment amount than the proposed policy for SSOs with longer lengths of stay.

Comment: One commenter noted that payments under the SSO policy that we have proposed under the IPPS-comparable option did not account for cases that are SSOs at LTCHs but would be HCOs at a short term acute-care hospital. In addition, the commenters state that it is possible that these cases could qualify as a HCO at a short term acute-care hospital and still be an SSO at the LTCH.

Response: The commenter's statement is accurate. Although we are not finalizing the specific proposed IPPS-comparable payment option, we remain concerned about making appropriate payments to LTCHs and ensuring that appropriate patient care is what determines admission to a LTCH. In our reevaluation of our SSO policy, we have expressed concern that our policy either at the short term acute-hospital or the LTCH-level may provide an incentive for LTCHs to admit patients from short term acute-care hospitals once their costs exceed what the hospital expected Medicare to pay—a circumstance that we did not want our payment policy to encourage either at the acute care hospital or at the LTCH. Rather, a patient treated at a short term acute-care hospital who becomes a HCO patient, upon being stabilized and still continues to need hospital care, could appropriately be discharged to a LTCH for post-acute care. In this situation, the patient would have received the full measure of treatment at the short term acute-care hospital since the high costs associated with outlier payments are included in the computations leading to both the establishment of the DRG relative weights, as well as setting the fixed-loss amount associated with the HCO threshold. Therefore, the goal of our payment policy is for Medicare to pay appropriately for the care given to the patient and for the patient's required level of care to be the determining factor in hospital admissions.

Comment: Many commenters submitted suggestions for us to consider as we move to establish both facility and patient-level criteria for LTCHs as recommended in MedPAC's June 2004 Report to Congress. One commenter asserted that: Adjustments should not compromise quality of care to beneficiaries or limit access to services; the payment system should reward providers that provide high quality, cost efficient care to Medicare beneficiaries; adjustments should not undermine the predictive power of the PPS or its efficiency in tying payments to actual service costs; the payment system should remain as uncomplicated and transparent as possible to providers; with the exception of very HCOs, payment policy should never result in payment below cost; and the payment system should permit providers to achieve reasonable margins as a basis for implementing technologies and replacing or renovating existing physical plant or equipment. Another commenter specified that we should adopt requirements for pre-admission, concurrent and post-hoc review of the appropriateness of LTCH admissions, as well as require physician certification (a practice that is required for other providers) of medical necessity for LTCH services based on guidelines established by CMS through the notice and comment rulemaking process.

Another commenter urged us to adopt uniform admission and continuing stay screening criteria to ensure that only appropriate patients are admitted to LTCHs, noting that some LTCHs use InterQual (a product of McKesson Provider Technologies) which is the screening instrument used by the majority of QIOs and that we should require the use of this or some other instrument. We were also urged to adopt MedPAC's recommendation and expand the sample of LTCH cases reviewed by QIOs for admission and continuing stay appropriateness. Several commenters informed us that an association of LTCHs and a QIO are developing screening criteria that ensure the severity of illness and the intensity of treatment is appropriate and valid. One commenter specifically requested that we change the criteria for LTCH classification. The recommended changes included measuring and monitoring LTCH patient characteristics by using a 25-day ALOS and requiring that at least 50 percent of every LTCH's discharges would be classified into an APR-DRG severity of illness (SOI) level 3 or 4. Several commenters addressed the issue of patient outcomes, specifically whether there is any relationship between higher payments at LTCHs and improved patient outcomes when the similar patients are treated in different treatment centers. Many commenters acknowledged our

concern about the appropriateness of the ''shortest'' of the short stays at LTCHs and the payment consequences for the Medicare system but stated that the focus on clinical and facility level criteria was a viable alternative, that is, ''* * * provide needed cost savings while assuring that the clinical determination of proper level of care continues to be based on medical necessity determination.'' Several commenters offered to work with Medicare to develop sound and reasonable criteria that would allow us to tighten clinical criteria appropriately. It was suggested that we work with industry to develop a consensus on patient assessment and placement criteria. Several commenters asserted that the proposed policies do not address the real problems cited by CMS regarding the growth of the LTCH industry and the behavior of some operators. The commenters warned that these problems will continue until we have established facility and patient level standards. One commenter noted, ''[U]ntil this occurs, too many operators will continue to find ways to admit low acuity patients and capture a payment mechanism that was carefully developed to serve complex, high acuity patients. This will continue to offer the high profit margins that drive the rapid growth of LTCHs.''

Response: We thank the commenters for sharing their thoughts on the future of the LTCH PPS, the direction we should follow to assure the highest level of patient care, admission and treatment of appropriate patients at LTCHs, and fair payment policies. We note that LTCHs are certified as acute care hospitals but are classified as LTCHs for payment purposes. We believe the commenter means to address the issue of classification. In response to the commenters that specifically requested that we change certification criteria for LTCH classification, we note that such action may require legislative action. Recommendations that we focus on the relationship between patient outcomes and payments and appropriate placement and assessment criteria echo some of the major issues that we have asked RTI to study. We are aware of McKesson Provider Technologies' screening instrument, InterQual, and its use by many QIOs as well as LTCHs, and we have been informed of the work being done by individual hospital groups and hospital associations to develop other instruments. (Suggestions regarding the roles of QIOs in evaluating LTCH admissions are addressed elsewhere in these responses.) We appreciate the statements made by many commenters in support of concerns underlying many of our policies and for the overall goals of our regulations. We believe that we have been accessible to providers and we thank them for their offers to participate in further discussions on the development of criteria. Moreover, we also support the strengthening of pre-admission provider certification criteria for LTCH admissions and any other criteria that better define medically complex patients for the purpose of distinguishing them in terms of appropriate level of care. We believe that many of the issues raised by commenters will be addressed in RTI's final recommendations, which we expect to be submitted in the late Spring of 2006. We further believe that under the revised SSO policy blend option that we are finalizing in this final rule, the Medicare program will pay for short stay cases under a fair, equitable, and reasonable methodology which will not undermine patient access to LTCHs, should not result in any compromise in the quality of care offered by LTCHs, and will not undermine either the principles nor the predictive power of the LTCH PPS.

Comment: MedPAC commented that they share our concerns about short stay patients in LTCHs. However, MedPAC found that our proposed revisions to the SSO policy ''too severe'' because they believe that over time the policy would continue to affect a large percentage of admissions regardless of the admission policies of LTCHs. Furthermore, MedPAC does not believe that our proposed policy addresses the underlying problem of LTCHs which is the lack of patient and facility criteria, including national admission standards (such as specific clinical characteristics and treatments), as well as discharge criteria. MedPAC notes facility characteristics could include requirements for multidisciplinary teams, and a requirement that a percentage of cases meet established SOI criteria. MedPAC urged us to move forward with their recommendations for the development of this criteria, outlined in the June 2004 Report to Congress (which they understand is the goal of RTI's work). MedPAC believes moving in this direction would better provide appropriate care to beneficiaries who need the level of care provided by LTCHs.

Response: We thank MedPAC for supporting our goals regarding short stays at LTCHs. As noted above, we are not finalizing the proposed policy. Rather, we have developed a policy which we believe will eliminate many of the incentives to admit inappropriate patients whose very short stays do not require the full resources of a LTCH. We agree with MedPAC's assertions that evaluating the development of patient and facility criteria, and the establishment of national admission standards including clinical characteristics and treatments, as well as discharge criteria, are of central importance. Our contract with RTI, discussed in section XII of this final rule, focuses on the feasibility of implementing MedPAC's June 2004 Recommendations and, as noted above, we expect the final report to be submitted in the late Spring of 2006.

Comment: One commenter, acknowledging CMS's and MedPAC's concerns about the continued growth in the numbers of LTCHs and significant increases in costs to the Medicare system, suggested a moratorium on the establishment of new LTCHs. The commenter noted that most likely this may require legislative action.

Response: We thank the commenter for supporting our general concerns. A moratorium on the development of new LTCHs may require action by the Congress.

Comment: One commenter stated that the proposed SSO policy dictated that all SSO cases were inappropriate admissions to LTCHs, and that our position is antagonistic to QIO procedures and standards, defeats important patient rights, and directly interferes with professional judgment of clinicians. The commenter believes that the proposed rule dictates that all SSO cases should remain in an acute care hospital setting which gives rise to notice of non-coverage issues and that in such instances, we may be required to send a notice of non-coverage under existing regulations and manuals.

Response: We would point out that the proposed IPPS-comparable option of the SSO policy to which the commenter is objecting is not being finalized. Rather, after the consideration of comments, we are finalizing a policy that we believe pays fairly for longer stays that still qualify as SSOs but yet does not provide a financial incentive for inappropriately admitting of the shortest of stays. We continue to believe that LTCHs were established by the Congress to provide hospital-level care for long stay patients, that is, patients requiring hospital-level care for an average Medicare inpatient LOS of greater than 25 days. There has been no intent by CMS to establish a rule restricting LTCH admissions to ''defeat important patient rights'' or to otherwise interfere with the judgment of physicians. Rather we seek to encourage the admissions of patients generally

requiring the type of care associated with LTCHs and to pay appropriately for care and treatment provided to these patients. While we had previously discussed the role of QIOs regarding the LTCH PPS, we would also emphasize that, presently, there is no review of hospital-level care that distinguishes whether care should be delivered at a short-term acute-care hospital or at a LTCH, as long as the care is appropriate. Both are certified under Medicare to provide acute care inpatient hospital services.

Under our QIO program, QIOs compare services to standards of care to determine whether services are reasonable and medically necessary, whether the quality of services meets professionally recognized standards, and whether services in an inpatient hospital or other inpatient health care facility could, consistent with the provision of appropriate medical care, be effectively provided more economically on an outpatient basis or in an inpatient facility of a different type. We have not historically interpreted any of these areas of review to involve determinations of which kind of acute care facility would be appropriate, and we do not regard short term acute-care hospitals and LTCHs as facilities ''of a different type.''

We disagree with the commenters' statements regarding notices of non-coverage. We are not determining that treatment of a short-stay patient at a LTCH is a non-covered service. We are also not requiring possible SSO patients to remain in short term acute care hospitals. Rather, we are ensuring appropriate payments for the care of SSO patients under the LTCH PPS. A notice of non-coverage is generally issued when a patient disagrees with being discharged from an acute care hospital to a SNF, despite a medical determination that hospital-level care is no longer appropriate. The patient, at that time, may exercise the right to have the QIO review the proposed discharge to determine whether the discharge from the hospital is appropriate. However, if a Medicare beneficiary disagrees with being discharged from a short term acute-care hospital to a LTCH, no notice of non-coverage would be issued because there is no change in the level of care (both are certified as acute care hospital providers). There is no need for the QIO to review the appropriateness of the discharge.

Comment: Several commenters believe most LTCH admissions are based on InterQual criteria, also used by most QIOs, and that the use of these criteria has led to a significant drop in SSO cases. (InterQual is a product of McKesson Provider Technologies which is the screening instrument used by the majority of QIOs.) These commenters stated that, in our proposed rule, we discussed a QIO sampling of 116 LTCH records (selected on a monthly basis) and noted the resulting determination that 29 percent of the LTCHs' admissions were not medically necessary, that is, did not require hospital-level care, but also noted as well that this finding was not characteristic of most LTCHs. In contrast, individual commenters noted that QIO reviews of a sample of LTCH cases at specific LTCHs or of LTCHs that are part of a LTCH corporation reveal that in three separate evaluations, 1.1, 1.6, and 1.0 percent, respectively, of the samples were denied for lack of medical necessity or for inappropriate admission. The commenters further asserted that we have no basis to say that the number of SSOs should be reduced further since their admissions were evaluated under ''widely-accepted, objective criteria.'' In fact, the commenters stated there was a drop in SSOs of 30 percent, indicating that LTCH PPS incentives are working and CMS should target cases, following a meaningful analysis of data that reveal inappropriate admissions to LTCHs. Focusing on an expanded role for QIOs, as recommended by the MedPAC June 2004 Report to Congress, two commenters suggested that since there will be no update in the standard Federal payment rate under the LTCH PPS, that we assign available funds for increased QIO reviews.

Response: We appreciate that several commenters noted that there had been a decrease in the number of SSO cases since the start of the LTCH PPS for FY 2003. Some of the commenters pointed out that the change can be attributed to our present policy that endorses our general goal of reducing the number of cases admitted to LTCHs since some could be effectively treated at short-term acute care hospitals.

While we are aware of the use of admission criteria, including InterQual, by a large percentage of LTCHs and believe that although these instruments may provide a significant service regarding base-line admission determinations at LTCHs, we also understand that such instruments focus on the distinction between acute care and sub-acute care, that is, SNF-level of care, and determinations of ''medical necessity'' or ''inappropriate admission'' are based only on whether the patient should be hospitalized, rather than on whether the hospitalization should occur at a LTCH or at a general acute care hospital. Although we know there are products in the marketplace that are targeted to the LTCH population, our review of the criteria used by those products did not assure us that the criteria clarifies any specifics other than whether the patient needs acute hospital-level care. As explained earlier, we have revised the proposed IPPS-comparable option of the SSO policy and we believe that the finalized policy, described in detail above, provides a fair and reasonable payment for LTCHs treating SSO patients. Moreover, we believe that the policy reflects our belief that as the LOS of a particular patient increases, the stay begins to resemble the type of stay envisioned by the Congress when the LTCH payment classification was established in 1983.

In response to commenter's assertions about the QIO's present responsibility regarding LTCHs, we believe that it is appropriate to clarify the work that QIOs currently perform in the Medicare program. Under § 412.508, the QIOs function in LTCHs parallel their functions with short-term acute care hospitals. Prior to the implementation of the LTCH PPS for FY 2003, there was no QIO role regarding medical necessity and coding of LTCH claims (FIs were tasked with that activity and until January of 2004, when appropriate procedures were in place, QIOs only performed retrospective reviews in LTCHs for quality of care). QIOs are empowered by statute to determine if Medicare-covered services are medically necessary and provided in the appropriate setting, specifically, a hospital as opposed to a SNF.

Since January 2004, we have selected and QIOs have reviewed an annual national random sample of 116 LTCH records per month (approximately 1400 cases total per year), quoted by a number of commenters. Recent analysis of the 2004 sample revealed that 17.4 percent of LTCH claims were determined to be payment errors and 5.9 percent of the claims were determined to be admission denials. This sampling represents the QIO's role of retrospective review (for example, ''At the time of admission, did the patient require an acute level of care and was Diagnosis Related Group (DRG) coding correct?'') If a LTCH admission was determined not to be medically necessary or not in the appropriate setting, the result of the review could be a recovery of funds by the Medicare program. In addition, if ICD–9–CM coding was determined to be incorrect, the claim would be adjusted to reflect the correct coding, whether that meant an increase or a decrease in payment.

A QIO uses criteria, based on typical patterns of practice in the QIO's review

area for the review setting. For example, if a patient in a particular state requires acute psychiatric care, then the screening criteria should be acute inpatient psychiatric criteria. The QIOs also consult with a physician(s) and practitioner(s) actively engaged in practice in that state and to the extent possible, a specialty match, when making the determination that care was or was not medically necessary. Although a QIO review can detect whether or not the patient requires an acute level of care or whether care in a SNF would be appropriate, since both acute care hospitals and LTCHs are certified as acute care hospitals, QIOs do not make the distinction between whether a patient should be hospitalized at an acute care hospital or at a LTCH, so long as the patient requires an acute level of care.

QIOs are authorized by statute to determine whether, in case such services and items are proposed to be provided in a hospital or other health care facility on an inpatient basis, such services and items could, consistent with the provision of appropriate medical care, be effectively provided more economically on an outpatient basis or in an inpatient health care facility of a different type as specified in section 1154(a)(1)(C) of the Act. Therefore, QIOs have authority to determine the appropriate hospital-level setting in the face of objective criteria. But there is no objective criteria distinguishing between settings where acute care is delivered. Since the statute states ''a facility of a different type,'' because short term acute care hospitals and LTCHs are very similar and provide the same level of care, CMS has at no time interpreted ''a facility of a different type'' in section 1154(a)(1)(C) of the Act to mean that QIOs must distinguish between them.

In a memorandum issued to the Regional Offices, Chief Executive Officers, and all QIOs, from the Director of the Quality Improvement Group of the CMS Office of Clinical Standards on October 28, 2004, among other matters, the following policy was further clarified:

''**Note:** there are different provider types that may offer the same level of intensity of inpatient care. QIOs do not specify which provider type should be used when the level of intensity is the same. For example, a patient requires an acute level of care that could be delivered in a short-term acute care PPS hospital, a long-term care hospital or an acute rehabilitation hospital. The QIO determines what intensity of care is appropriate (that is, the patient requires an acute level of care) but would not specify as a matter of admission necessity which provider type the patient should be admitted to. If the QIO determines that there is a quality of care concern implicated, that issue should be addressed through the quality review process.''

Under current contracts, QIOs review LTCH cases under the following circumstances: When a claim is selected for purposes of determining or lowering the payment error rate; if there is a QIO-identified need to perform additional review based on their contractual responsibilities; if there is an immediate appeal of certain beneficiary notices; as a result of the referral of a case or cases; or when there is a beneficiary complaint or other quality of care concern.

Since one of the recommendations made by MedPAC in their June 2004 Report to Congress was for an increased role for the QIOs in monitoring criteria to assure that LTCHs are treating appropriate patients, researchers from RTI have been in contact with several QIOs nationwide in order to evaluate their role. Any attempt, however, to involve QIOs in the on-going determination of the appropriateness of admissions, continuing stay or discharge for a significant proportion of LTCH patients was never envisioned when the QIO program was established. There will not be a reassignment of Medicare funds to QIOs from the LTCH PPS.

Comment: One commenter expressed concern that if our proposed policy revision for SSOs is finalized, FIs will not have sufficient time to make necessary system changes to process payment and substantial payment delays to providers will result.

Response: As noted above, we are not finalizing the specific proposed IPPS-comparable payment revision to the SSO policy, and in the previous responses, we have described the policy that we are finalizing for RY 2007. In response to the commenters' concerns, we have been assured by our systems analysts that there should be no delay in the processing of claims under the final policy.

Comment: One commenter asserted that the high cost of Medicare payments is directly related to high physicians' billing. Therefore, the commenter suggested that rather than reducing payments to LTCHs through our proposed SSO payment policy, Medicare should consider a limit on physician inpatient billing.

Response: This comment is beyond the scope of this regulation.

Comment: Several commenters noted that payment issues for post acute care hospital-level providers cut across provider types and urged us not to ''operate in a silo,'' by allowing competition among such providers for patients without clear clinical guidelines as to what would be the most appropriate setting for the patient. Another commenter asserted that the RTI study could serve as the basis for an in-depth discussion between CMS, physicians, LTCHs, and patients regarding how to address our broader concerns in a fair, fiscally sound manner.

Response: We understand and share the concerns expressed by these commenters. Although the central focus of the RTI study is to determine the feasibility of establishing LTCH-specific patient and facility-level criteria, a comprehensive evaluation required our researchers to analyze claims from alternative providers such as acute care hospitals, IRFs, IPFs, and also SNFs since many patients who could otherwise be treated at LTCHs receive treatment or care in one of those alternative settings. In the RY 2007 LTCH PPS proposed rule, we included a substantial portion of RTI's work in this area (71 FR 4704 through 4726). The RTI report (discussed in section XII of this final rule) should be finalized by late Spring 2006 and we are expecting the final report to provide us with further information and recommendations on the particular issues raised by the commenters. In general, we believe that we have been very responsive to the LTCH industry while conducting this analysis, responding to specific concerns as well as meeting with physicians, representatives, and LTCHs, and their representatives throughout the year. Once we have evaluated the results of RTI's final report, we will make the findings available to the public. These findings will serve as the basis for future conversations between CMS and the public.

Comment: Some commenters submitted very specific comments describing the essential role that LTCHs play in their continuum of health care, and warning of negative consequences should LTCHs be forced to close as a result of our proposed SSO payment adjustment.

Response: As previously stated in this final rule, we have decided not to finalize the proposed IPPS-comparable payment option to the SSO policy. Rather, we believe that the finalized policy will provide appropriate payment for SSO patients at LTCHs. We understand the important care that is rendered at LTCHs and the significance of these facilities in their individual communities, as well as the impact that a successful LTCH stay can have on the life of patients and families. We believe

that in our finalized SSO policy we have addressed the basic goals of refining our payment policies under the LTCH PPS to ensure that Medicare beneficiaries receive high quality medical care in an appropriate provider setting, and that Medicare renders payment that reflects fair and reasonable payment for that care.

Comment: One commenter noted the important role that LTCHs may have to play in the event of an avian influenza pandemic because of their significant ventilator capacity and urged us to not hamper the ability of LTCHs to serve as important components in our national public health response system by finalizing the proposed SSO policy.

Response: We believe that the policies established in this RY 2007 final rule, including the SSO payment policy revision, will result in LTCHs being unable to continue to provide hospital-level care, particularly in the areas of their expertise, such as treating patients requiring ventilator care. In the event of a national public health response, we would expect that LTCHs will continue to function in an appropriate manner providing necessary and appropriate health care to their communities.

b. 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 HCO policy at § 412.525(a)) because, as we discussed above in this section, we believed that the SSO (and HCO) 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 HCO policy at existing § 412.525(a)(4)(ii) and (iii).)

In the RY 2007 LTCH PPS proposed rule (71 FR 4674 through 4676, and 4690 through 4692), we discussed our current methodology for determining hospitals' CCRs under the LTCH PPS HCO and SSO policies, and we presented a proposal to refine our methodology for determining the annual CCR ceiling and statewide average CCRs. In that same proposed rule, we also discussed our existing policy for the reconciliation of LTCH PPS HCO and SSO payments along with our proposal to codify in subpart O of part 412 those policies, including proposed modifications and editorial clarifications to those existing policies.

Historically, annual updates to LTCH CCR ceiling and statewide average CCRs have been effective October 1, and in the RY 2007 LTCH PPS proposed rule, we proposed revisions to the policies governing the determination of LTCHs' CCRs and the reconciliation of HCO and SSO payments which would be effective October 1, 2006. In addition, we stated that the LTCH CCR ceiling and statewide average CCRs reflecting the proposed policy changes, which would be effective October 1, 2006, would be presented in the annual IPPS proposed and final rules.

As noted above in section V.D.3.b. of this preamble, we received a few specific comments concerning the proposed changes to the policies governing the determination of LTCHs' CCRs. Several other commenters referenced one of the specific comments on the proposed changes to the methodology for determining LTCH CCRs in their own comments on the RY 2007 LTCH PPS proposed rule. Based on a commenter's synopsis of our proposed changes concerning the determination of LTCH's CCRs, we believe that the commenters clearly understood the nature and purpose of the proposed changes. However, the commenters pointed out that, in the RY 2007 LTCH PPS proposed rule, we did not provide an analysis of the effect of the proposed change, nor did we provide an example of the new CCR values under this proposed methodology. Another commenter did not ''object in concept to the proposed combination of [IPPS] operating and capital cost-to-charge ratios'' to compute a ''total'' CCR for each IPPS hospital by adding together each hospital's operating and capital CCR from which to compute the LTCH CCR ceiling and applicable statewide average CCRs. However, the commenter also pointed out that we did not provide any impact data and requested that we defer adoption of the proposed change until such data are provided for comment. Therefore, in the FY 2007 IPPS proposed rule (71 FR 24132 through 24136), we again proposed these same changes to the policies governing the determination of LTCHs' CCRs and the reconciliation of HCO and SSO payments that we proposed in the RY 2007 LTCH PPS proposed rule. We note that in the FY 2007 IPPS proposed rule, we also tried to further clarify our explanations of our proposed method for calculating the CCR ceiling and statewide average CCRs under the LTCH PPS. Consequently, although the policy proposal presented in that proposed rule is the same as the proposal presented in the RY 2007 LTCH PPS proposed rule, the explanations have been further simplified where possible. Along with that proposal, we also included in that IPPS proposed rule the values of the proposed LTCH CCR ceiling (1.131) and the proposed statewide average LTCH CCRs (as shown in Table 8C of the FY 2007 IPPS proposed rule; 71 FR 24377) that would be effective October 1, 2006, based on our proposed policy changes (along with the proposed values of the LTCH CCR ceiling and statewide average CCRs that would be determined under our current methodology). Therefore, in this final rule, we are not finalizing any changes to the policies governing the determination of LTCHs' CCRs or the reconciliation of LTCH PPS HCO and SSO payments. We will respond further to any comments received on the proposal concerning changes to the policies governing the determination of LTCHs' CCRs and the reconciliation of LTCH PPS HCO and SSO payments presented in the FY 2007 IPPS proposed rule (71 FR 24125 through 24136) in the FY 2007 IPPS final rule that will be published this summer.

As we discuss above, we are revising § 412.529 of the existing regulations based on the changes we are establishing to the SSO payment formula in this final rule. Since we are not finalizing any changes to the policies governing the determination of LTCHs' CCRs or the reconciliation of SSO payments, the changes we are making to § 412.529 in this final rule reflect our existing policy regarding the determination of LTCHs' CCRs and the reconciliation of SSO payments. Also as discussed above, in the FY 2007 IPPS proposed rule, we again proposed changes regarding the determination of LTCHs' CCRs and the reconciliation of LTCH PPS SSO payments under § 412.529(c) based on the existing regulatory language in § 412.529. We note that, to the extent the policy changes we proposed in the FY 2007 IPPS proposed rule regarding the determination of LTCHs' CCRs and the reconciliation of SSO payments are implemented, we may need to make conforming changes to the regulatory language in § 412.529 in the FY 2007 IPPS final rule to ensure that any such changes are consistent with (and do not contradict) the changes we are making to § 412.529 in this final rule.

2. The 3-day or Less Interruption of Stay Policy

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'' at § 412.531(a)(1) 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 tests or medical treatment, either inpatient or outpatient, provided at an acute care hospital or an IRF, or at a SNF and 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 at the acute care hospital was grouped to a surgical DRG under the IPPS (69 FR 25696 through 25700).

We also stated that, in addition to having sufficient data to decide upon continuing the exception, we would 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 for RY 2006, 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 XI. of this final 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 to evaluate the impact of the surgical DRG exception to the 3-day or less interruption of stay policy. As shown in Table 12, the data revealed the following for the RY 2005 LTCH PPS.

TABLE 12

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 at an acute care hospital	459
Average covered charge for:	
DRGs Non-surgical	$18,103.00
DRGs Surgical	$22,429
Total covered charges for surgical stays	$10,294,925

The data does 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 data 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 at the acute care hospital, and, therefore, should have been provided ''under arrangements.''

We note that after a reasonable and systematic examination of the data mentioned above, there are 459 surgical DRGs (less than 0.4 percent of all cases). Additionally, the data revealed that the specific surgical DRGs into which the acute care treatments were grouped appear to arise directly from the principal 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 13 shows examples drawn from the above cited subset of claims for July 1, 2004 through June 30, 2005.

TABLE 13

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 that 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 principal 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 incurred by the LTCH for these 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 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); sections 1861(w)(1), 1862(a)(14), and 1871 of the Act; and § 411.15 and § 412.509 of the regulations, we are not renewing the surgical-DRG exception to the 3-day or less interruption of stay policy for LTCH PPS RY 2007. Under § 412.531, with the 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 believe 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. 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 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.

Because we believe LTCH's discharges are grouped to DRGs that are often reflective of the surgery, 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). We are therefore discontinuing the policy for the surgical exception.

However, there were cases among those that we reviewed that appear to 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 sunsetting of the surgical DRG exception goes into effect, a LTCH will be responsible for paying the costs of surgical services performed at an acute care hospital ''under arrangements.'' However, at that point, the LTCH will be able to include that surgical procedure on its claim that will be submitted to Medicare even though the procedure was not provided to the patient directly by the LTCH. 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 the 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, to the extent providers included those costs on their claims, these additional costs were included in the establishment of the LTCH PPS base rate.

We would further note that we do not believe that the numbers of cases nationwide that would fall within the surgical DRG exception 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 HCO 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. This is consistent with the HCO policy applicable 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.

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 some 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 and § 412.509. Accordingly, we believe that based on our analysis of the data from the MedPAR files from all LTCH discharges occurring from July 1, 2004 through June 30, 2005, 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.

In the RY 2006 LTCH PPS final rule (70 FR 24206), we also expressed concerns about 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. If the interruption in a 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 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 result 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 further revision to the 3-day or less interruption of stay provision and to establish another threshold.

Comment: Commenters questioned whether the cost of these surgical cases were correctly reported under the TEFRA payment system, thus, making it questionable whether such costs were included in the LTCH PPS base period costs. Two commenters stated that the surgical procedures are not included in the current relative weights as coding for this care was never historically included by most LTCHs; thus, the proposal to discontinue the exception would inappropriately require LTCHs to care for vulnerable populations without adequate reimbursement. They recommend that we postpone our elimination of the surgical exception until such time as the costs can be accounted for in the DRG weights. Commenters also noted that one year of data is not adequate to eliminate this exception.

Response: We note that under the TEFRA payment system, if a LTCH patient required tests and procedures that were unavailable at a LTCH, under section 1862(a)(14) of the Act, implemented in regulations at § 411.15(m), the statute requires that they be provided ''under arrangements.'' Thus, if a LTCH patient required tests and procedures that were unavailable at the LTCH, we assume that the LTCH had provided those services ''under arrangements'' (and did not discharge the patient to another site of care and directly admit the patient following the off-site treatment) because that was the process required by the statute and regulations. Consequently, we believe that hospitals included the costs of medical services procured elsewhere ''under arrangements'' in a patient's Medicare claim. Under the TEFRA system, these additional costs would then have been included in the hospital target amount and would be paid for by Medicare. We expect that as responsible corporate entities, LTCHs take necessary steps to comply with Medicare regulations which they are required to follow through their provider agreements under Part 489. We presume that LTCHs, to the extent that they were following our regulations, would have included the costs of services furnished ''under arrangements'' in their cost reports.

Data from FY 2000 and CY 2002 MedPAR files were analyzed to track patients discharged from a LTCH, admitted to other inpatient sites, which were followed by readmission to the LTCH. (We believe that the data we accumulated for these two years was more than adequate to base a decision for the surgical exception.) If tests and procedures were being provided for ''under arrangements,'' in compliance with our regulations, significant patient movement, that is, discharge from the LTCH followed by a subsequent readmission to the LTCH, would have been uncommon. Our data indicated that in FY 2000, only 1.1 percent of all Medicare LTCH patients were readmitted to a LTCH within 3 days of a discharge (912 cases out of 80,893 total cases) of which less than 700 were treated in acute-care hospitals during the 3-day interruption. We believe that this data indicates that prior to the implementation of the LTCH PPS, the vast majority of LTCHs complied with the ''under arrangements'' regulations. Therefore, since the patient was not discharged to procure the service, but rather remained a LTCH patient, even though the LTCH moved the patient to another site for needed tests or care, those tests or care were provided ''under arrangements''. Accordingly, the costs of these services should be included in the patients' Medicare claims during those years and, thus, should have been

factored in when we were calculating our base rates for the LTCH PPS. Moreover, the charges included charges associated with these services, thus, allowing us to use this charge data when determining the LTC–DRG weights for the LTCH PPS.

Comment: One commenter stated that any ''suggestion'' by CMS coders that the LTCH claims may be incorrect because some LTCH claims included surgical care and are grouped to surgical DRGs is a concern that can be dealt with on a case-by-case basis, without eliminating the surgical exception. Another commenter suggested that this concern regarding incorrect coding may be resolved by requiring greater participation in the coding clinics that are available, as well as working with both the QIO and the FIs to develop better coding skills. Another commenter stated that if we believe some of the problems are due to LTCH claims, including surgical procedures performed during the prior acute stay, then we should correct the problem through focused audits and not by eliminating this surgical exception.

Response: As we have stated elsewhere in this document, our decision to discontinue the surgical DRG exception for the 3-day or less interruption of stay policy is based on the results of our analyses of claims data. Although we had agreed to provide for a temporary exception to the 3-day or less interrupted stay provision, we have now determined that it is no longer appropriate. On further examination of the data, we believe that this surgical exception caused some confusion, thus, perpetuating other problems (for example, coding). We disagree with the commenter's suggestion that we should address this issue by conducting coding clinics to improve coding skills. Based on the data described below, we believe the exception is not necessary even if LTCHs were to be ''educated'' as to proper coding techniques. As we stated previously in the RY 2006 LTCH PPS final rule, and as we reiterated in the RY 2007 LTCH PPS proposed rule (71 FR 4692), ''* * * we will be analyzing claims data over the next year to determine whether the surgical DRG exception to the 'under arrangement' 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.'' Based on the analysis of this claims data, as well as our belief that this exception is not actively accomplishing our goals as stated above, we believe it is appropriate to discontinue the surgical exception to the 3-day or less interrupted stay policy. Furthermore, we do not agree with the commenters that addressing the problem of including the surgical procedure for those LTCHs that did not provide the service ''under arrangements'' is an appropriate use of the limited QIO budget.

Comment: Several commenters opposed the elimination of the surgical DRG exception because they strongly believe that the cost of these surgical DRG cases should not be left to the LTCHs. Moreover, one commenter stated that eliminating the surgical exception along with other reductions throughout this final rule will certainly have a strong negative impact on LTCHs and their ability to be able to continue to provide services. Another commenter stated that it was unfair for CMS to apply some significant financial changes and expect LTCHs to continue to shoulder higher unreimbursed costs. One commenter suggested that a one-time adjustment be made to include the additional cost to pay for these services ''under arrangement'' in the standard Federal rate. Commenters also noted that a statement was made that the number of cases involved with the surgical exception represents only a small number of LTCH hospitalizations and therefore these cases ''* * * would not represent a significant financial burden for LTCHs to absorb over a cost-reporting period, given the nature of the LTCH PPS.'' They believe that this statement is not a valid reason for CMS to eliminate the surgical exception.

Response: With regard to the commenters' concerns that our elimination of the surgical exception would place undue financial burden on LTCHs, we note that, previously, under the TEFRA payment system, LTCHs were required to provide all necessary patient care, either directly or ''under arrangements.'' 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. Therefore, the LTC–DRG payment would be adequate compensation for the entire episode of patient care.

As we have discussed previously in this final regulation, we stated that we would ''be analyzing claims data over the next year to determine whether the surgical DRG exception to the 'under arrangement' feature was accomplishing the goal of reducing unnecessary Medicare payments and to deter inappropriate Medicare payments while not compromising beneficiary access to medically necessary services'' (71 FR 4692). CMS analyzed claims from MedPAR files for LTCH discharges from July 1, 2004 through June 30, 2005 and performed the analysis necessary for evaluating the impact of the surgical DRG exception to the 3-day or less interruption of stay policy. As a result of the above data analyses, we are discontinuing the surgical exception to the 3-day or less interruption of stay 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 days'' (70 FR 24206).

B. Special Payment Provisions for LTCH Hospitals Within Hospitals (HwHs) 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 were 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. To establish a 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, and 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 hospital, and this is still, by far, the most common configuration, nothing in the regulations precludes other types of hospitals, for example, IRFs, from establishing HwHs (69 FR 49198).

In addition, in the FY 1998 IPPS 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 host hospitals.

Therefore, prior to FY 2005, a HwH was required to meet the separateness and control criteria set forth at § 412.22(e). 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) (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 §A412.22(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 had 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

believed 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 HwHs and satellites of LTCHs, mandates that if a LTCH HwH's 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's 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 HCO 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. 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 were discharged to the LTCH HwH or LTCH satellite would be considered as if they were admitted to the LTCH from a non-host hospital. Furthermore, 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) the hospital's 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 allowed 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, the grandfathered LTCH HwHs and LTCH satellites were required to meet an increasing percentage threshold over the next 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, 2007).

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 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.

As we stated in the RY 2007 LTCH PPS proposed rule (71 FR 4648), as a result of our monitoring efforts to date (see section XI. of the preamble to this final 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 also 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 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 on 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 expressed 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 that 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 may therefore be inequitable; and furthermore, that this approach may be circumvented by an increase in the number of freestanding LTCHs instead of LTCH HwHs (69 FR 49211).

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 single-source acute care hospitals'' 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 HwHs 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 XI.), 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 website 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.

Therefore, we 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 final 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 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 Inspector 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 HCO 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 a 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 the existing § 412.534(c)(2), (d)(1), and (e)(1) and our specific interpretation of its implementation may not be entirely apparent. Therefore, we clarified in the proposed rule that, as explained below in this section, the use of the term ''equivalent'' does not necessarily mean precisely equal. We are also codifying the formula that we currently use to give effect to this phrase in existing § 412.534, described in this final rule, for purposes of administrative clarity.

To clarify the meaning of the term ''equivalent,'' we 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 resembles 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'' supports 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 FTE resident cap. The hospital's IME FTE resident cap is determined based on the number of FTE residents counted by the hospital for purposes of IME on its base year (usually 1996) cost report. In the case of a LTCH, since it would not have reported any FTE residents for IME on the base year cost report, it would not be appropriate to apply the IPPS IME rules literally in the context of this LTCH PPS payment adjustment.

We use the term ''equivalent'' in § 412.534(c)(2), (d)(1), and (e)(1) because we believe this language accurately reflects our intent to utilize and build upon IPPS payment principles to develop a payment adjustment under the LTCH PPS 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 IPPS-equivalent IME payment adjustment under the LTCH PPS by imputing an IME FTE resident cap based on the LTCH's direct GME cap (which would have been determined for a LTCH that has residency programs as set forth at § 413.79(c)(2)) and using that imputed IME FTE resident cap to calculate an IME payment adjustment 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 FTE resident 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 codifying the formula we use to give effect 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 patients discharged 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 codifying in regulation for administrative efficiency 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 HCO'' and the ''IPPS fixed loss amount'' in describing features of the IPPS that we use and build upon in the LTCH PPS to make appropriate adjustments when 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, is a payment under the LTCH PPS that is equivalent to a payment that would be derived from the IPPS payment methodology.

As was proposed in the RY 2007 LTCH PPS proposed rule (71 FR 4648), we are codifying in regulations that 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 published in the annual IPPS final rule. (In the FY 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 a 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 under § 412.312(b). 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 published in the annual IPPS final rule), large urban location, and COLA, if applicable.

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 hospital's services provided to LTCH Medicare patients.

We note that in section VI.A.1. of this final rule, we have added an additional component to the SSO payment adjustment at § 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 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 HCO 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 HCO, the outlier payment for this case under the LTCH PPS would be based on the IPPS HCO 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 HCO, Medicare would generate a HCO 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 HCO policy.

Therefore, although there are significant similarities between the two payment adjustments, as detailed in section VI.A.1 of this final rule, there is a distinction between them regarding the computation of any applicable HCO 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 HCO 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 HCO payment, this LTCH PPS payment would be governed by the regulations at § 412.80(a)(3), based on the IPPS HCO 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 HCO payment under § 412.525 will be finalized by the FI.

In contrast, under the existing LTCH PPS SSO policy at § 412.529(c), HCO 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 the RY 2007 LTCH PPS proposed rule (71 FR 4648), we had proposed a fourth component to the SSO payment formula; however, in response to public comments, we have made substantial revisions to this fourth component of the SSO payment formula. Therefore, for the reasons described in section VI.A.1, we are lowering the 120 percent of costs to 100 percent, and we are also adding a revised fourth component to the current SSO payment formula, (that is, a blend of an amount comparable to what would otherwise be paid under the IPPS computed as a per diem, capped at the full IPPS DRG payment amount and 120 percent of the LTC–DRG per diem amount. For each day, as the LOS increases, the percentage of the IPPS comparable amount will decrease and the percentage based on 120 percent of the per diem LTC–DRG specific amount will increase. As the LOS reaches the lower of the five-sixths SSO threshold

or 25 days, the payment will no longer be limited by the fourth option. We are not, however, changing the existing SSO payment policy for HCOs, 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 HCO payment set forth at § 412.525.

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

In § 412.534, we established special payment provisions for long-term care HwHs 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 correcting § 412.534(d) to cite the revised definition of rural at § 412.64(b)(1)(ii)(C).

We received the following comments on our discussion regarding the 25 percent rule for HwHs in LTCHs that we discussed in the RY 2007 LTCH PPS proposed rule.

Comment: Several commenters submitted views on our discussion in the RY 2007 LTCH PPS proposed rule regarding the 25 percent rule for HwHs in LTCHs. Some commenters suggested that instead of expanding the 25 percent admission threshold, we should work with the LTCH industry to develop the types of clinically-based certification criteria recommended by MedPAC, which focus on patient characteristics and the level of patient care services that should be available at every LTCH. Other commenters stated that expansion of the 25 percent rule to free-standing LTCHs is an arbitrary policy that puts patient care in jeopardy while making no progress towards MedPAC's goal of ensuring that patients are treated in the appropriate settings. Commenters stated their belief that compliance with the 25 percent rule would be almost impossible in communities where there may be only one or two short-term acute care hospitals, so expansion of the rule could effectively eliminate the ability of any LTCH (freestanding or HwH) to exist in these communities. As a result, residents in need of long-term care services would either need to travel outside the community or receive inappropriate care in their community. Several commenters stated that our allegation that LTCHs are operating as acute care hospital ''units'' was misdirected and that neither freestanding nor HwH LTCHs demonstrate the type of operational and financial integration with a referring hospital that are the hallmark of ''unit'' status (that is, each LTCH operates under its own provider agreement; files cost reports independently from others; and independently meets the hospital's conditions of participation).

Response: We did not propose to make a change to expand the 25 percent rule to freestanding LTCHs in the RY 2007 LTCH PPS proposed rule. However, we do appreciate the commenters' response to the concerns we raised in the proposed rule, and will take the comments into account as we further consider this issue for possible future rulemaking.

We did not receive any comments regarding our clarification of ''equivalent'' and ''comparable'' for IPPS payments. Therefore, we will be finalizing this proposed clarification.

We received a significant number of comments that expressed specific concerns about several features of the LTCH PPS that were beyond the scope of this regulation and we will not be addressing them at this time.

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

In accordance with § 412.525 and as discussed in section V.C. of this final 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 final 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 8 in section V.D.2. 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 the RY 2007 proposed rule (71 FR 4667 through 4670) we proposed that the standard Federal rate for the 2007 LTCH PPS rate year would remain $38,086.04. In this final rule, based on the best available data and the policies described in this final rule, the standard Federal rate for the 2007 LTCH PPS rate year will be $38,086.04 as discussed in section V.C. of this preamble. We illustrate the methodology used to adjust the 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 four-fifths wage index values are applicable. The four-fifths wage index value for CBSA 16974 is 1.0632 (see Table 1 in the Addendum to this final 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 final rule).

To calculate the LTCH's total adjusted Federal prospective payment for this Medicare patient, we compute the wage-adjusted Federal prospective payment amount by multiplying the unadjusted standard Federal rate ($38,086.04) by the labor-related share (75.655 percent) and the wage index value (1.0632). This wage-adjusted amount is then added to the nonlabor-related portion of the unadjusted standard Federal rate (24.335 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 adjusted Federal prospective payment for the 2007 LTCH PPS rate year ($38,789.92). Finally, as discussed in section V.D.5. of this preamble, for the 2007 LTCH PPS rate year, we are establishing a budget neutrality offset of 1.0 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 14.

TABLE 14

Unadjusted Standard Federal Prospective Payment Rate	$38,086.04
Labor-Related Share	× 0.75665
Labor-Related Portion of the Federal Rate	= $28,817.80
4/5 Wage Index (CBSA 16974)	× 1.0632
Wage-Adjusted Labor Share of Federal Rate	= $30,639.09
Nonlabor-Related Portion of the Federal Rate ($38,086.04 x 0.24335)	+ $ 9,268.24
Adjusted Federal Rate Amount	= $39,907.33

TABLE 14—Continued

LTC–DRG 9 Relative Weight	× 0.9720
Total Adjusted Federal Prospective Payment (Before the Budget Neutrality Offset)	= $38,789.92
Budget Neutrality Offset	× 1.0
Total Federal Prospective Payment (Including the Budget Neutrality Offset)	= $38,789.92

VIII. 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 15.

TABLE 15

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 a 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 based on 100 percent of the Federal rate. 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 have notified 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.

IX. 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 begin 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.

X. 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 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 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.''

XI. 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 (69 FR 25692), and we established a payment adjustment for LTCH HwHs and satellites (69 FR 49191).

On-going data analysis was also the basis for three of the issues that we had addressed in the proposed rule. As noted in section V., we are ''sunsetting'' the surgical DRG exception to the 3 day or less interruption of stay policy at § 412.531(b)(2)(A)(*1*). We determined that eliminating this exception will not result in significant hardship for LTCHs. Our analyses of discharges between acute care hospitals and LTCHs revealed that a significant number of LTCHs that are not co-located 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 envisioned 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. In section V. of the proposed rule, we had suggested that we would be looking into the possibility of extending the payment adjustment established under § 412.534 for LTCH HwHs and satellites of LTCHs to all LTCHs including freestanding LTCHs that we believe are LTCHs functioning as step-down units of a hospital. In making any such decision in the future, we will take into account comments that we received on this issue. In addition, as a result of our analysis and on-going monitoring protocols, we are establishing a zero percent update to the Federal payment rate for RY 2007, which is explained in detail in section IV.

As we discussed in the June 6, 2003 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 MedPAC's June 2004 Report to Congress entitled ''Defining long-term care hospitals''. 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 XII. of this final 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 presented specifics of the RTI project in the RY 2007 LTCH PPS proposed rule. In this final rule, as noted previously, we have included a section that describes RTI's analyses.

Comment: One commenter asked why CMS continues to issue changes to the LTCH PPS rather than letting market forces determine its direction. Another commenter also invoked the marketplace in asserting that the large increase in the number of LTCHs is market-driven, that is, if the operators were not sensing a need and patients were not coming, the number of LTCHs would not be growing. The commenter suggested that CMS should not be concerned about the rapid growth in this provider type and allow the market to regulate growth.

Response: We disagree with the commenters' suggestions that CMS should not continue to issue changes to the LTCH PPS, but rather let market forces determine its direction. In establishing the Medicare system, the Congress imposed the responsibility to provide health insurance for Medicare beneficiaries. The mandate for implementing the Medicare program tasks CMS with fiduciary responsibilities that require us to develop an effective and efficient payment system to finance the delivery of medical services to beneficiaries who have financed Medicare as taxpayers and who depend upon the program as their primary health insurance when they retire. In order to meet these responsibilities, CMS established a regulatory framework governing the payment for those health care services covered by Medicare for program beneficiaries in a manner that protects both the trust fund and the program recipient against those forces in the market place that may be driven primarily by a desire to maximize Medicare payments. Therefore, our objective in issuing LTCH regulations for all aspects of the health care delivery system as it impacts Medicare beneficiaries, is to be a prudent purchaser of medical services. Our awareness of market forces, our monitoring programs and data analyses, and information garnered from our regional offices and FIs indicate to us that the remarkable growth in the number of LTCHs during the last several years may be for the most part, driven by the opportunity to earn large profits on the treatment of Medicare patients. Therefore, we proposed and ultimately are finalizing regulations that we believe further our mandated role as a prudent purchaser of medical services and also as guardian of the Medicare Trust Fund. Accordingly, we believe that in an industry where Medicare is by far the primary payer for services provided, we cannot rely solely on market forces to determine how much the program should pay for beneficiary care.

XII. MedPAC Recommendations

A. Discussion of MedPAC's March 2006 Report to Congress: Medicare Payment Policy

On March 1, 2006, MedPAC released its Report to Congress: Medicare Payment Policy fulfilling its legislative mandate to evaluate Medicare policy issues and make specific recommendations to Congress. In the March 2006 Report, MedPAC included a discussion of LTCH payments and the resultant recommendation by the Commission in Chapter 4C, Long-term care hospital services. MedPAC found that Medicare payments for LTCH services are more than adequate, basing this conclusion on various measures including, but not limited to, access to care, volume services, and supply of facilities. MedPAC recommended to the Congress that the update to payment rates for LTCH services should be eliminated for FY 2007.

As discussed in the final rule, 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 Balanced Budget Refinement Act (BBRA) as amended by section 307(a) of the Budget Improvement and

Protection Act (BIPA) to include appropriate adjustments in the establishment of the LTCH PPS, we are revising our regulations to specify that for discharges occurring on or after July 1, 2006 and on or before July 31, 2007, the standard Federal rate from the previous year would be updated by a factor of zero percent. We note that our decision to apply a zero update is consistent with the recommendation the Commission made to the Congress. Further discussion of this issue can be found in section XX of the final rule.

B. RTI Report on MedPAC's June 2004 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''. 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 Payment System Refinement/Evaluation,'' will result in a report that will assist CMS in the evaluating 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 evaluated 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.

RTI's project plan was completed in two phases. Phase I focused 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 reviewed prior analyses of these issues by MedPAC and other contractors (such as the Urban Institute, 3M Health Information Systems, and The Lewin Group) and conducted additional discussions with MedPAC, other researchers, and the QIOs. Building on the work of Phase I, Phase II addressed 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.

We anticipate that RTI will submit their final report to us in late Spring of 2006. We note that while this report may 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.

XIII. Health Care Information Transparency Initiative

In the FY 2007 Hospital Inpatient Prospective Payment System proposed rule (71 FR 23996), we discussed in detail the Health Care Information Transparency Initiative and our efforts to promote effective use of health information technology (HIT) as a means to help improve health care quality and improve efficiency. Specifically, for the transparency initiative, we discussed several potential options for making pricing and quality information available to the public (71 FR 24120 through 24121). We solicited comments on the ways HHS can encourage transparency in health care quality and pricing whether through its leadership on voluntary initiatives or through regulatory requirements. We also are seeking comment on the HHS's statutory authority to impose such requirements.

In addition, we discussed the potential for HIT to facilitate improvements in the quality and efficiency of health care services (71 FR 24100 through 24101). We solicited comments on our statutory authority to encourage the adoption and use of HIT. The 2007 Budget states that ''the Administration supports the adoption of health information technology (IT) as a normal cost of doing business to ensure patients receive high quality care.'' We also are seeking comments on the appropriate role of HIT in a potential value-based purchasing program, beyond the intrinsic incentives of a prospective payment system to provide efficient care, encourage the avoidance of unnecessary costs, and increase quality of care. In addition, we are seeking comments on the promotion of the use of effective HIT through Medicare conditions of participation.

We intend to consider both the health care information transparency initiative and the use of HIT as we refine and update all Medicare payment systems. Therefore, while these initiatives are not included in this final rule, we are in the process of seeking input on these initiatives in various proposed Medicare payment rules being issued this year and may pursue these policies in future rulemaking for the LTCH PPS.

XIV. Collection of Information Requirements

In the RY 2007 LTCH PPS proposed rule (71 FR 4648), we outlined the collection of information requirements associated with the provisions presented in that rule.

In summary, section 412.525(a)(4)(iv)(A) proposed 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.

Section 412.529(c)(4)(iv)(A) proposed 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 aforementioned information collection requirements were proposed again in the FY 2007 IPPS proposed rule, and to the extent they are implemented, will be presented in the FY 2007 IPPS final rule published this summer in the **Federal Register**. Prior to the publication of the IPPS final rule, we will submit a formal information collection request to the Office of Management and Budget (OMB) for its review and approval of the information collection requirements described above. These requirements are not effective until they have been approved by OMB.

XV. Regulatory Impact Analysis

A. Introduction

We have examined the impacts of this final rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 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 rates, factors and policies presented in this final rule, including updated wage index values, and the best available claims data to estimate payments for the 2007 LTCH PPS rate year. Based on the best available data for 347 LTCHs, we estimate that the change to the SSO policy (as discussed in section VI.A.1. of the preamble of this final rule) for the 2007 LTCH PPS rate year, in conjunction with the changes to the area wage adjustment (discussed in section V.D.1. of the preamble of this final rule), and the increase in the outlier fixed-loss amount (discussed in section V.D.3.c. of the preamble of this final rule), will result in a decrease in estimated payments from the 2006 LTCH PPS rate year of approximately $156 million for the 347 LTCHs. (An estimate of Medicare program payments for LTCH services for the next 5 years is shown in section XV.B.5. of the preamble of this final rule.) Because the combined distributional effects and costs to the Medicare program are greater than $100 million, this final 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 $6 million to $29 million 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 FIs are not considered to be small entities. Individuals and States are not included in the definition of a small entity.

Currently, our database of 347 LTCHs includes the data for 69 non-profit (voluntary ownership control) LTCHs and 232 proprietary LTCHs. Of the remaining 46 LTCHs, 10 LTCHs are Government-owned and operated and the ownership type of the other 36 LTCHs are unknown (*see* Table 16). The impact of the changes for the 2007 LTCH PPS rate year is discussed below in section XV.B.4.c. of the preamble of this final rule. The provisions of this final rule are estimated to result in approximately a 3.7 percent decrease in estimated payments per discharge in the 2007 LTCH PPS rate year on average to LTCHs (as shown in Table 16). As discussed in greater detail below in this section (and as shown in Table 16), the majority of the approximately 3.7 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 change in the payment formula for SSO cases (discussed in section VI.A.1.a. of the preamble of this final rule). We do not believe that this change will result in an adverse impact on affected LTCHs for the reasons discussed below in this section. We believe that the revisions to the SSO policy established in this final rule will 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. Furthermore, we believe the revisions to the SSO policy will result in appropriate payments for those relatively shorter LOS cases.

As we discuss in greater detail in section VI.A.1.a. of the preamble of this final rule, currently about 37 percent of all LTCH cases are SSOs, most of which were admitted to the LTCH directly from an acute-care hospital. Of these almost 48,000 LTCH SSO cases from FY 2005, about 60 percent have a LOS of less than or equal to 14 days, of which almost 24 percent have a LOS of less than or equal to 7 days. 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 and an inappropriate admission to a LCTH. Moreover, many of these very short-stay cases most likely do not receive a full course of a LTCH-level of treatment in such a short period of time since LTCHs generally are intended to treat patients with an ALOS of greater than 25 days, and therefore, we believe that the changes to the SSO policy will result in more appropriate payments for short-stay cases treated at LTCHs. We believe that by paying appropriately for these SSO cases and removing the financial incentive for LTCHs to admit those very short stay cases that could otherwise receive appropriate treatment at an acute-care hospital (and be paid under the IPPS), LTCHs will change their admission patterns for these patients. Specifically, we believe that in response to the implementation of the revision to the SSO payment formula, most LTCHs will significantly reduce the number of very short-stay cases that they admit (and most of those patients will continue to receive treatment at the acute-care hospital from which they are typically discharged immediately prior to their LTCH (short-stay) admission).

The estimated 3.7 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, of which about 60 percent have a LOS of less than or equal to 14 days). Thus, we believe that the estimated 3.7 percent decrease in LTCH payments per discharge for RY 2007 will only occur if LTCHs were to continue to admit the same number and type of SSO patients. Since the majority of the decrease in estimated payments is due to the change in the SSO policy and since we anticipate that LTCHs will no longer admit such a large number of VSSO patients when these changes are implemented, we believe that the actual decrease in LTCHs' payments for RY 2007 will be less than estimated 3.7 percent. (Although we expect LTCHs to admit fewer cases under this change, we believe that most LTCHs, which are HwHs, will not experience an increase in cost per discharge as a result of unoccupied beds. Rather, we expect that LTCHs will make a commensurate reduction in available beds. LTCHs will lease fewer beds, and therefore, the LTCHs' cost per discharge will not increase dramatically.)

Furthermore, our Medicare margins analysis of the most recent LTCH cost report data, show that LTCH PPS Medicare margins for FY 2003 were 7.8 percent, and preliminary cost report data for FY 2004 reveal an even higher Medicare margin of 12.7 percent (as discussed in greater detail in section IV.C.3. of the preamble to this final 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 3.7 percent 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 aggregate payments due to the changes to the area wage adjustment (*see* Table 16), LTCH PPS payments in RY 2007 will still be sufficient to compensate LTCHs for the costs of the efficient delivery of LTCH services to LTCH patients. (As noted above, LTCH PPS Medicare margins (7.8 percent for FY 2003 and 12.7 percent for FY 2004) appear to be at least twice the estimated percent decrease in Medicare payments for RY 2007 (3.7 percent).) Thus, we do not expect that the provisions of this final rule will result in an adverse financial impact on affected LTCHs nor will there be an effect on beneficiaries' access to care.

For the reasons discussed above, we do not expect an estimated decrease of 3.7 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, and therefore, the revenue to LTCHs from treating those patients is not affected by this final rule. Accordingly, we certify that this final rule will not have a significant impact on a substantial number of small entities, in accordance with the RFA.

3. Impact on Rural Hospitals

Section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. As shown in Table 16, we are estimating a 5.8 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 22 rural hospitals in our database of 347 LTCHs for which complete data were available.

As shown below in Table 16, the majority of the estimated decrease in payments in the 2007 LTCH PPS rate year as compared to the 2006 LTCH PPS rate year for rural LTCHs is due to the change in the area wage adjustment (as discussed in greater detail in section V.D.1. of the preamble of this final rule). Specifically, because all rural LTCHs are located in areas with a wage index value that is less than 1.0, the increase in the labor-related share for RY 2007 that we are establishing in this final rule (discussed in section IV.d.1.c. of the preamble) is expected to result in an estimated decrease in payments to rural LTCHs. We also note that, although we are not making any changes to the 5-year phase-in of the wage index adjustment that was established when the LTCH PPS was implemented (August 30, 2002; 67 FR 56018), the continued progression of this phase-in also contributes to the estimated decrease in payments to rural LTCHs for RY 2007. Specifically, since under the established phase-in of the wage-index adjustment, LTCHs receive an increasing amount of the applicable full wage index value (which is less than 1.0 for all rural LTCHs), we expect that rural LTCHs payments per discharge will decrease from RY 2006 to RY 2007 as a result of the progression of the 5-year phase-in of the wage index adjustment. Thus, a portion of the estimated 2.9 percent decrease in payments per discharge for rural LTCHs due to changes in the wage index adjustment (see Table 16) is due to the established 5-year phase-in of the wage index adjustment and is not due to policy changes established in this final rule.

Furthermore, we continue to believe that payments to rural LTCHs in RY 2007 will be adequate to cover the cost of the efficient delivery of LTCH services to Medicare Patients. Based on our recent margins analysis (discussed in section IV.C.3. of this final rule), LTCH margins for FY 2003 are in excess of 7 percent, and preliminary FY 2004 data show margins in excess of 12 percent. Moreover, margins for rural LTCHs for FY 2003 are in excess of 9 percent, and preliminary FY 2004 data shows margins in excess of 11 percent for rural LTCHs. Therefore, based on the positive margins for rural LTCHs, 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 will be sufficient to compensate LTCHs for the costs of the efficient delivery of LTCH services to LTCH patients.

The payment formula for SSO cases (discussed in section VI.A.1.a of the preamble of this final rule) also contributes to the estimated decrease in payments to rural LTCHs for RY 2007. However, we do not believe that this change will result in an adverse impact on rural LTCHs because, as a result of this change, we believe that LTCHs (including rural LTCHs) will significantly reduce the number of short-stay cases that they admit since this policy is expected to remove the financial incentive for LTCHs to treat very short-stay cases by paying appropriately for them. Furthermore, although most LTCHs (including rural LTCHs) are expected to admit fewer short-stay cases upon implementation of the changes to the SSO policy, 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 5.8 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) of which about 60 percent have a LOS of less than

or equal to 14 days. Thus, we believe that the estimated 5.8 percent decrease in LTCH payments per discharge for RY 2007 for rural LTCHs will only occur if rural LTCHs continue to admit the same number and type of SSO patients. Since half of the approximately 5.8 percent decrease in estimated payments for rural LTCHs is due to the change in the SSO policy and since we anticipate that LTCHs (including rural LTCHs) will no longer admit such a large number of SSO patients for whom payments will be affected by this change to the SSO payment formula (in particular, those with a very short LOS) when these changes are implemented, we believe that the actual decrease in rural LTCHs' payments for RY 2007 will be considerably less than 5.8 percent. Therefore, we believe that the estimated 5.8 percent decrease in payments per discharge for the 2007 LTCH PPS rate year for rural LTCHs will only occur if LTCHs maintain the same level and type of SSO patients.

Since, for the reasons discussed in this section, we believe that any decrease in rural LTCH's payments per discharge from RY 2006 to RY 2007 will be less than the estimated decrease of 5.8 percent shown in Table 16, we are unable to determine whether the changes established in this final rule would have a significant adverse effect on rural LTCHs. However, as explained above, do not expect that the provisions of this final rule will affect the ability of the vast majority of rural LTCHs to provide cost efficient services to Medicare patients nor do we expect there will be an effect on beneficiaries' access to care. (For additional information on the impact of the changes on rural LTCHs presented in this final rule, refer to the discussion of the impact analysis in section XV.B.4 of this final rule.)

4. Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any one year of $100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately $120 million. This final rule will not mandate any requirements for State, local, or tribal governments, nor will it result in expenditures by the private sector of $120 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 final rule under the criteria set forth in Executive Order 13132 and have determined that this final rule will not have any significant impact on the rights, roles, and responsibilities of State, local, or tribal governments or preempt State law, based on the 10 State and local LTCHs in our database of 347 LTCHs for which data are available.

6. Summary of Comments and Responses on the RY 2007 Proposed Rule Regulatory Impact Analysis

In section XIII of the RY 2007 LTCH PPS proposed rule (71 FR 4727 through 4747), in accordance with Executive Order 12866 (September 1993, Regulatory Planning and Review), the RFA (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Act, the UMRA (Pub. L. 104–4), and Executive Order 13132, we examined the impact of the provisions presented in that proposed rule. Specifically, we discussed the impact of the proposed changes to the payment rates, factors, and policies presented in that proposed rule in terms of their fiscal impact on the Medicare budget and on LTCHs under the provisions referenced above.

Comment: Some commenters suggested that CMS should reconsider the regulatory impact of the proposed rule and issue a revised RIA, as well as allow for comment on the revised RIA. Specifically, the commenters state that ''the proposed 11.1 percent decrease in LTCH PPS payments is based upon unreliable data and analyses by CMS and, as a result, the projections set forth in the RIA are conjecture at best.'' Therefore, the commenters believe that the LTCH industry is unable to ''* * * evaluate, meaningfully comment, and rely * * *'' on CMS' conclusions set forth in the RIA. The commenters believe the RIA does not provide discussion on how ''the statutorily-mandated budget neutrality of the LTCH PPS * * *'' will be maintained and disagrees with CMS' statement that it does not anticipate any changes in Medicare beneficiary access to services or in quality of patient care while there is currently a 11.1 percent reduction in LTCH payments due to reductions in SSO payments, a 4.2 percent decrease due to the LTC DRGs being reweighted, as well as a proposed zero market basket update, and revisions to the guidelines for using DRG 475. Another commenter stated that CMS failed to do any analysis to demonstrate that the proposed estimated 11.1 percent payment decrease and proposed zero percent update maintains a budget neutral LTCH PPS, as required by statute.

Response: CMS strongly disagrees with the commenters' assertion that ''projections set forth in the RIA are conjecture at best.'' Projections in the RIA of the RY 2007 LTCH PPS proposed rule modeled proposed policy changes that included proposed changes to SSO payments, expected case-mix index changes, the proposed changes to the area wage adjustment, and the proposed changes to HCO payments. The results of the payment models shown in the RIA used LTCH Medicare cost report data from the most recent update of the HCRIS files and Medicare claims data from the most recent update of the MedPAR files. We also relied upon provider information from the Online Survey Certification and Reporting (OSCAR) database and from the provider specific file (PSF), which is a file that is maintained by the FIs and is used in paying Medicare provider claims. These are the best and most reliable data sources available to CMS for modeling the impacts of policy changes. We note that these same databases are used in modeling payment impacts under the IPPS, the outpatient PPS, the IRF PPS and the IPF PPS, as well as other Medicare payment systems.

As we stated in the RY 2007 LTCH PPS proposed rule, 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, 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. Thus, for that impact analysis (shown in Table 23 of the RY 2007 LTCH PPS proposed rule (71 FR 4732 through 4733)), we used data from 259 LTCHs. Since cost data to determine payments under the reasonable cost-based methodology were not needed to simulate payments based on 100 percent

of the proposed Federal rate, we were able to project the impact analyses reflecting fully phased-in prospective payments using data from 337 LTCHs (as shown in Table 24 of the RY 2007 LTCH PPS proposed rule (71 FR 4734 through 4735)).

The RIA in the RY 2007 LTCH PPS proposed rule, showing both the impact on providers in the transition period and the impact of the fully phased-in LTCH PPS, which was made available to the public, provided commenters with an opportunity to provide CMS with comments. In response to the commenters' belief that the RIA is based on unsound data, we remind the commenters that, as in every year since the inception of the LTCH PPS, the public has had occasion to access the data files used by CMS in determining changes to the LTCH PPS payment policy through communication with our Office of Information Services (OIS). (Information about obtaining MedPAR files and other Medicare data files is posted on the CMS Web page at: *http://www.cms.hhs.gov/FilesForOrderGenInfo/*.) Additionally, the impact data used in the development of the RIA were posted on the CMS Web site for public review. We note that reports based on evaluation of these data sources by two different entities were quoted liberally in many of the comments that we received on the RY 2007 proposed rule. Therefore, we do not agree with the assertion by this commenter that commenters in general were unable to meaningfully evaluate the data.

We believe that commenters when referring to the budget neutrality requirement mean a system-wide budget neutrality requirement. A system-wide budget neutrality requirement means, specifically, payments under the LTCH PPS are always estimated to equal estimated system-wide (that is, aggregate) payments that would have been made under the reasonable cost-based (TEFRA) payment methodology if the LTCH PPS were not implemented. We disagree with the commenters that the RIA presented in the RY 2007 LTCH PPS proposed rule should have discussed ''the statutorily-mandated budget neutrality of the LTCH PPS'' or that proposed estimated 11.1 percent payment decrease and proposed zero percent update violates the statutory requirement that the LTCH PPS be budget neutral. We note that under section 123(a) of the BBRA, the Congress required that the Secretary develop ''* * * a per discharge prospective payment system for payment for inpatient hospital services of long-term care hospitals described in section 1886(d)(1)(B)(iv) of Act (42 U.S.C. 1395ww(d)(1)(B)(iv)) under the Medicare program. Such system shall include an adequate patient classification system that is based on diagnosis-related groups (DRGs) and that reflects the differences in patient resource use and costs, and shall maintain budget neutrality.'' We have interpreted the requirement to ''maintain budget neutrality'' to require that the Secretary set total estimated prospective payments for FY 2003 equal to estimated payments that would have been made under the TEFRA methodology if the prospective payment system for LTCHs was not implemented. It has been our consistent interpretation that the statutory requirement for budget neutrality applies exclusively to FY 2003. In FY 2003, we set total estimated LTCH PPS payments for FY 2003 equal to estimated payments that would have been made under the TEFRA methodology if the prospective payment system for LTCHs was not implemented. Consequently, we believe that we have satisfied the budget neutrality requirement under the statute. Moreover, we have broad discretionary authority under section 123(a)(1) of the BBRA as amended by section 307(b)(1) of the BIPA to provide appropriate adjustments, including updates. Thus, we are acting within that broad authority in establishing policy changes in this final rule, including a zero percent update to the Federal rate for RY 2007 (discussed in section V.C.3. of the preamble of this final rule)and changes to the SSO payment formula (discussed in section IV.A.1.a. of the preamble of this final rule).

There are several reasons that we do not believe that the Congress intended perpetual system-wide budget neutrality. We note below a partial list of these reasons. For example, a system-wide budget neutrality requirement that applies perpetually would affect the Secretary's ability to operate the prospective payment system for LTCHs efficiently. To illustrate, if the Secretary were to propose to adjust payments upward in a particular instance because he finds that payments are ''too low,'' under a perpetual budget neutral system the Secretary would be forced to reduce estimated payments for other cases in order to fund the additional costs associated with the proposed adjustment. However, this shifting of resources may then cause payments to LTCHs for those cases that were being reduced to offset the proposed adjustment to then be inappropriately ''too low.'' We do not believe the Congress intended such a result for every adjustment that will be made to the LTCH PPS in perpetuity. Rather, as with all dynamic and evolving systems, we believe that based upon monitoring and the analysis of data, the Secretary has the discretion and obligation to formulate polices and establish payment adjustments that will pay LTCHs appropriately for beneficiary care.

Also, we note that none of the statutory charges for the other prospective payment systems (that is, IPPS, SNF PPS, IRF PPS) require system-wide budget neutrality for perpetuity. We are not aware of anything unique about LTCHs or the need to establish a LTCH PPS that would have compelled the Congress to legislate a system that mandates budget neutrality in perpetuity. Consequently, we do not believe that in the instant case, the Congress departed from its consistent approach with respect to budget neutrality and intended to create a statute which applies a completely different standard to the LTCH PPS.

As we discussed in the RY 2007 LTCH PPS proposed rule (71 FR 4728) and as we reiterated in this RIA, although most LTCHs are expected to admit fewer short-stay cases upon implementation of the changes to the SSO policy, the majority 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. Furthermore, as we discuss in section IV.C.3. of the preamble of this final rule, our Medicare margins analysis of the most recent LTCH cost report data shows a 7.8 percent Medicare margin for FY 2003, and preliminary cost report data for FY 2004 reveal an even higher Medicare margin of 12.7 percent. 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 3.7 percent decrease in LTCHs' payments per discharge for the 2007 LTCH PPS rate year, those payments will still be sufficient to compensate LTCHs for the costs of the efficient delivery of LTCH services to LTCH patients. (As noted above, LTCH PPS Medicare margins (7.8 percent for FY 2003 and 12.7 percent for FY 2004) appear to be at least twice the estimated percent decrease in Medicare payments for RY 2007 (3.7 percent).) Therefore, we do not believe that the estimated decrease in LTCH PPS payments for RY 2007 will result in an adverse financial

impact on affected LTCHs nor will there be an effect on beneficiaries' access to care or in quality of patient care.

Comment: Several commenters believe that those policies that we proposed for RY 2007 which would, if implemented, result in reductions to the amounts paid by Medicare to LTCHs for RY 2007, were based on materially flawed data that do not support the payment changes presented in the proposed rule. They believe that we failed to comply with the Federal Data Quality Act, and OMB, HHS and CMS Guidelines which address the quality of the data used for policy development, in particular, meeting standards of utility, objectivity, integrity, and transparency and reproducibility. Because the commenters believe that we have violated these data quality standards, they were deprived of the opportunity to submit meaningful comments, as required by the Administrative Procedures Act (APA), and they urge CMS to take the appropriate steps that would result in the withdrawal of the FY 2007 LTCH PPS proposed rule and the publication of a new proposed rule. The commenters also stated that a Freedom of Information Act (FOIA) request for data included in the proposed rule was submitted but to date they have not received a written response to their FOIA request.

Response: We disagree with the commenter's claims that the data utilized in the development of the RY 2007 LTCH PPS proposed rule were materially flawed, did not comply with the Federal Data Quality Act, and did not meet established OMB, Department, and Agency guidelines for data quality. As previously stated, the data sources used in estimating the payment impacts from policy changes proposed in the RY 2007 LTCH PPS proposed rule were the HCRIS files that contain Medicare cost report data, the MedPAR files that contain Medicare claims data, the OSCAR database and the PSF (which is maintained by the FIs and used in paying Medicare claims). These are the best and most reliable data sources available to CMS for modeling the impacts of policy changes. We note that these same databases are used in modeling payment impacts under the IPPS, the outpatient PPS, the IRF PPS and the IPF PPS, as well as other Medicare payment systems. In addition to our posting the impact files from the LTCH PPS proposed rule on the CMS website, as always, commenters had access to the same CMS data files that we utilized through communication with our Office of Information Services (OIS).

The fact that the data we used in the development of the RY 2007 LTCH PPS proposed rule were available and transparent to the public was attested to by the detailed data analyses included with a significant number of the public comments we received on the RY 2007 LTCH PPS proposed rule. Therefore, for the reasons stated above, we disagree with the commenters' assertions that the data used by CMS in the RY 2007 LTCH PPS proposed rule does not meet transparency and reproducibility standards. As is the case with any change in policy, modifications to current policy are not based on erroneous assumptions, but rather analyses of applicable data and comments submitted in response to the proposed rule. Staffing constraints precluded our Freedom of Information Group from expeditiously processing the FOIA request. However, we again note that the data requested via the FOIA process was available to the public through our OIS department. The fact that the data were readily available to the public is evidenced by the inclusion of the results of the publics' analysis of our data in many of the comments we received on the RY 2007 LTCH PPS proposed rule.

Comment: A number of commenters noted that Medicare spending on LTCHs is about 1.4 percent of total Medicare spending, and stated that the CMS policies for RY 2007, that would result in over an 11 percent cut in Medicare spending on LTCHs, would have a disproportionate impact on LTCHs.

Response: It is widely understood that since there are over 3,500 acute care hospitals nationwide and just under 400 LTCHs, that a significant majority of Medicare patients requiring long-stay hospital-level care are being treated in short-term acute-care hospitals throughout the country. Furthermore, notice has been taken that where for FY 2006, the standard Federal payment under the IPPS (for operating and capital costs) is about $5,200, while for RY 2006, it is about $38,086 under the LTCH PPS. Therefore, in response to the comment about the particular financial impact on LTCHs among Medicare providers of our proposed policies, we would note that although presently LTCHs serve only a relatively small percentage of Medicare beneficiaries, the costs per beneficiary are the highest among Medicare provider types.

Furthermore, as noted in MedPAC's March 2006 Report to the Congress, the growth in Medicare spending for LTCHs in 2004 alone was close to 38 percent. From 2001 through 2004, the number of Medicare beneficiaries using LTCHs rose 13 percent per year, the supply of LTCHs increased 9 percent per year, the volume of services increased 12 percent annually, while Medicare spending on LTCHs rose 25 percent per year. As discussed in section VI.C.3. of the preamble to this final rule, based on our case-mix and margins analyses, we believe that a zero percent update to the Federal rate is appropriate to account for changes in coding practices that are not attributable to an increase in LTCH patient severity. In addition, the zero percent update to the Federal rate for RY 2007 is consistent with MedPAC's recommendation.

Additionally, while we are modifying the proposed SSO policy changes presented in the proposed rule (as discussed in section VI.A.1.a. of the preamble of this final rule), it is still incumbent upon us, in light of the unintended financial incentive that may exist under the current SSO policy for LTCHs to admit very short stay cases that could otherwise receive appropriate treatment at an acute-care hospital and be paid under the IPPS, to revisit and refine payments for short-stay patients at LTCHs. We also wish to emphasize that our policies are not dictated by budgetary limitations; rather they are based on making appropriate payments to services provided to Medicare patients.

B. Anticipated Effects of Payment Rate Changes

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

1. Budgetary Impact

Section 123(a)(1) of the BBRA requires that the PPS developed for LTCHs ''maintain budget neutrality.'' As discussed above in this section, we believe that the statute's mandate for budget neutrality applies only to the first year of the implementation of the LTCH PPS (that is, FY 2003). 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 V.D.5. of the preamble to this final rule, we will

apply a 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 standard Federal rate rather than a blend of Federal prospective payments and reasonable cost-based payments during the transition. The amount of the 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 will 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 multiplied by the LTC–DRG relative weight), we make adjustments for differences in area wage levels, COLA for Alaska and Hawaii, and SSOs. Furthermore, LTCHs may also receive HCO 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.

To understand the impact of these changes to the LTCH PPS discussed in this final 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 payments per discharge that will be made under the LTCH PPS rates, factors and policies for the 2007 LTCH PPS rate year (as discussed in the preamble of this final rule). We also evaluated the percent change in payments per discharge of estimated 2006 LTCH PPS rate year payments to estimated 2007 LTCH PPS rate year payments for each category of LTCHs.

Hospital groups were based on characteristics provided in the OSCAR data, FY 2001 through FY 2003 cost report data in HCRIS, and PSF 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 existing providers (that is, those that are not defined as ''new'' as under § 412.23(e)(4)) during the LTCH PPS transition period, it is necessary that reasonable cost-based methodology payments and prospective payments contain similar inputs. As discussed in section IX of the preamble of this final rule, under § 412.533(d), ''new'' LTCHs will not participate in the 5-year transition from reasonable cost-based reimbursement to prospective payment, and therefore, no portion of their LTCH PPS payments are based on reasonable cost-based principles. 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 Federal rate (see Table 17), for existing LTCHs, 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. However, we were able to estimate payments for all new LTCHs since no portion of their estimated LTCH PPS payments are based on the reasonable cost methodology. As a result, only case-mix data is necessary to calculate their LTCH PPS payments.

Using LTCH cases from the FY 2005 MedPAR file and cost data from FY 1999 through FY 2003 to estimate payments under the current reasonable cost-based principles, we have obtained both case-mix and cost data (if required) for 347 LTCHs. Thus, for the impact analyses 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 Federal rate (see Table 16), we used data from 347 LTCHs. While currently there are just under 400 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 2005 MedPAR data for the 347 LTCHs in our database, which includes 232 proprietary LTCHs, 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 2005 MedPAR file we had case-mix data for 363 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 Federal rate. Therefore, for the impact analyses reflecting fully phased-in prospective payments (see Table 17) we used data from 363 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 2005 LTCH claims data. Estimated prospective payments for the 2007 LTCH PPS rate year will be based on the standard Federal rate of $38,086.04 (based on the zero percent update discussed in section V.C.3. of the preamble to this final rule), the outlier fixed-loss amount of $14,887, and the same FY 2005 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 payment policy for SSOs (as described in section VI.A.1. of the preamble of this final rule), the adjustments for area wage differences (as described in section V.D.1. of the preamble of this final rule), and for the cost-of-living for Alaska and Hawaii (as described in section V.D.2. of the preamble of this final rule). Additional payments will also be made for HCOs (as described in section V.D.3. of this final rule). As noted in section V.D.4. of this final rule, we are not making adjustments for rural location, geographic reclassification, indirect medical education costs, or a DSH payment for the treatment 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 payments 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 24182).

Similarly, we adjusted for area wage differences for estimated 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 LTCH PPS wage index values for the 2007 LTCH PPS rate year are shown in Tables 1 and 2 of the Addendum to this final rule. We adjusted for area wage differences for estimated 2007 LTCH PPS rate year payments using the LTCH PPS labor-related share of 75.665 percent (see section V.D.1.c. of this final 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 Federal rate)) 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 Federal rate). 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 will 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) will 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) and for its subsequent cost reporting periods.

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 the Federal rate.

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 both RY 2006 and RY 2007 LTCH PPS 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 to each LTCH's estimated payments under the LTCH PPS for the 2006 and 2007 LTCH PPS rate years. (See the RY 2006 LTCH PPS final rule (70 FR 24202) and section IV.D.5. of this final rule.) The impact, based on our projection using the best available data for 347 LTCHs that approximately 2 percent of LTCHs will be paid based on the transition blend methodology and 98 percent of LTCHs will elect payment based on 100 percent of the Federal rate is shown in Table 16.

In Table 17, 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 17, 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 in both RY 2006 and RY 2007) were not applied to LTCHs' estimated payments under the LTCH PPS.

Tables 16 and 17 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 payment per discharge for the 2007 LTCH PPS rate year.
- The sixth 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 changes to the area wage adjustment at § 412.525(c) (as discussed in section V.D.1. of the preamble of this final rule).

• The seventh 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 changes to the SSO policy at § 412.529 (as discussed in section VI.A.1.a. of the preamble of this final 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 changes (as discussed in the preamble of this rule).

TABLE 16.—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 2007 LTCH PPS rate year payments] [2]

LTCH classification	Number of LTCHs	Number of LTCH cases	Average RY 2006 LTCH PPS payment per case [3]	Average RY 2007 LTCH PPS payment per case [4]	Percent decrease [5] in payments per discharge from RY 2006 to RY 2007 for area wage adjustment changes [6]	Percent decrease [5] in payments per discharge from RY 2006 to RY 2007 for changes to the SSO policy [7]	Percent decrease [5] in payments per discharge from RY 2006 to RY 2007 for all changes [8]
All Providers	347	125,095	$33,208	$31,963	0.6	3.6	3.7
By Location:							
Rural	22	4,549	27,014	25,445	2.9	3.1	5.8
Urban	325	120,546	33,442	32,209	0.5	3.6	3.7
Large	173	74,841	34,281	33,225	−0.1	3.5	3.1
Other	152	45,705	32,068	30,544	1.5	3.6	4.8
By Participation Date:							
Before Oct. 1983	14	7,733	28,212	27,402	−0.5	3.8	2.9
Oct. 1983–Sept. 1993	44	22,598	34,793	33,698	−0.1	3.6	3.1
Oct. 1993–Sept. 2002	200	72,061	33,036	31,756	0.7	3.5	3.9
After Oct. 2002	89	22,703	33,879	32,447	1.0	3.6	4.2
By Ownership Control:							
Voluntary	69	24,463	32,377	30,974	0.6	4.1	4.3
Proprietary	232	91,066	33,308	32,119	0.5	3.4	3.6
Government	10	2,368	30,055	28,664	1.3	3.5	4.6
Unknown	36	7,198	35,814	34,431	0.9	3.4	3.9
By Census Region:							
New England	13	9,641	28,013	27,218	−0.8	4.1	2.8
Middle Atlantic	17	5,644	33,731	32,491	0.7	3.3	3.7
South Atlantic	24	8,766	37,107	35,776	0.6	3.5	3.6
East North Central	50	15,550	37,175	35,848	0.5	3.5	3.6
East South Central	15	4,934	33,723	32,127	1.5	3.6	4.7
West North Central	17	5,046	36,558	35,084	1.0	3.5	4.0
West South Central	90	40,177	29,601	28,278	1.2	3.6	4.5
Mountain	19	5,796	34,771	33,762	−0.5	3.8	2.9
Pacific	13	6,838	40,880	40,592	−1.9	3.1	0.7
By Bed Size:							
Beds: 0–24	26	4,219	33,049	31,389	1.7	3.6	5.0
Beds: 25–49	164	41,796	33,546	32,081	1.1	3.6	4.4
Beds: 50–74	56	21,825	33,307	32,056	0.6	3.6	3.8
Beds: 75–124	40	20,064	34,428	33,399	0.0	3.4	3.0
Beds: 125–199	24	22,264	31,069	29,949	0.4	3.6	3.6
Beds: 200+	11	10,551	33,043	32,265	−0.8	3.6	2.4
Unknown	26	4,376	35,336	33,861	1.2	3.4	4.2

[1] As discussed above, this impact analysis reflects the applicable transition methodology (i.e., the applicable blend percentages of the Federal rate and reasonable cost-based methodology payments or the option to elect payment based on 100 percent of the Federal rate) for existing LTCHs, and therefore, only includes those existing LTCHs (347) that have cases in the FY 2005 MedPAR files for whom we are able to calculate payments based on the reasonable cost-based methodology.

[2] 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 will have 3 months (July 1, 2006 through September 30, 2006) of payments under the 20/80 blend (4/5 wage index) and 9 months (October 1, 2006 through June 30, 2007) of payment under the full 5/5 wage index).

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

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

[5] As the percent change shown in this column represents an estimated percent decrease in payments per discharge, a negative (i.e., minus) sign indicates an estimated percent increase in payments per discharge and the absence of a sign (i.e., a positive sign) indicates an estimated percent decrease in payments per discharge.

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

[7] Percent decrease in estimated payments per discharge from the 2006 LTCH PPS rate year to the 2007 LTCH PPS rate year for the changes to the SSO policy at § 412.529 (as discussed in section VI.A.1.a. of the preamble of this final rule).

[8] 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 for the 2007 LTCH PPS rate year (as discussed in the preamble of this final rule). Note, this column, which shows the estimated percent decrease in payments per discharge for all changes, may not exactly equal the sum of the estimated percent decrease in payments per discharge for area wage adjustment changes (column 6) and for SSO policy changes (column 7) due to the effect of estimated changes in aggregate high cost outlier payments as well as other interactive effects that cannot be isolated.

TABLE 17.—PROJECTED IMPACT REFLECTING THE FULLY PHASED-IN LTCH PPS PROSPECTIVE PAYMENTS [1]

[Estimated 2006 LTCH PPS rate year payments compared to estimated 2007 LTCH PPS rate year payments] [2]

LTCH classification	Number of LTCHs	Number of LTCH cases	Average RY 2006 LTCH PPS payment per case [3]	Average RY 2007 LTCH PPS payment per case [4]	Percent decrease [5] in payments per discharge from RY 2006 to RY 2007 for area wage adjustment changes [6]	Percent decrease [5] in payments per discharge from RY 2006 to RY 2007 for changes to the SSO policy [7]	Percent decrease [5] in payments per discharge from RY 2006 to RY 2007 for all changes [8]
All Providers	363	128,989	$33,212	$31,983	−0.6	3.6	3.7
By Location:							
Rural	24	5,009	26,832	25,281	−3.1	3.0	5.8
Urban	339	123,980	33,470	32,253	−0.5	3.6	3.6
Large	180	77,385	34,355	33,314	0.1	3.5	3.0
Other	159	46,595	32,000	30,493	−1.5	3.6	4.7
By Participation Date:							
Before Oct. 1983	15	7,925	28,051	27,274	0.5	3.7	2.8
Oct. 1983–Sept. 1993	44	22,598	34,771	33,692	0.1	3.7	3.1
Oct. 1993–Sept. 2002	208	75,331	33,106	31,844	−0.7	3.5	3.8
After Oct. 2002	89	22,703	33,879	32,447	−1.0	3.6	4.2
Unknown	7	432	29,681	28,836	0.1	3.4	2.8
By Ownership Control:							
Voluntary	71	25,789	32,398	31,025	−0.6	4.1	4.2
Proprietary	238	92,562	33,262	32,083	−0.5	3.4	3.5
Government	10	2,368	30,032	28,667	−1.3	3.5	4.5
Unknown	44	8,270	36,104	34,797	−0.7	3.3	3.6
By Census Region:							
New England	14	9,83	27,888	27,122	0.8	4.0	2.7
Middle Atlantic	28	7,667	34,813	33,626	−0.5	3.3	3.4
South Atlantic	42	13,594	37,084	35,72	−0.6	3.5	3.7
East North Central	65	18,514	37,421	36,030	−0.6	3.6	3.7
East South Central	28	7,490	33,442	31,784	−1.7	3.7	5.0
West North Central	18	5,125	36,543	35,057	−1.0	3.6	4.1
West South Central	130	52,411	29,679	28,372	−1.2	3.5	4.4
Mountain	22	6,341	35,121	34,060	0.4	3.9	3.0
Pacific	16	8,014	41,173	40,871	1.8	3.1	0.7
By Bed Size:							
Beds: 0–24	29	4,751	32,650	31,0102	−1.6	3.5	4.7
Beds: 25–49	168	43,400	33,628	2,181	−1.1	3.6	4.3
Beds: 50–74	56	21,825	33,307	32,069	−0.6	3.6	3.7
Beds: 75–124	40	20,064	34,425	33,412	0.0	3.4	2.9
Beds: 125–199	25	23,398	31,266	30,14	−0.3	3.6	3.6
Beds: 200 +	12	10,743	32,838	32,086	0.8	3.6	2.3
Unknown	33	4,808	34,828	33,409	−1.1	3.4	4.1

[1] As discussed above, this impact analyses reflects fully phased-in prospective payments, and therefore, cost data to determine current payments under reasonable cost-based methodology payments are not needed. Therefore, we are able to use all of the LTCHs (363) that have cases in the FY 2005 MedPAR files.

[2] 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 will have 3 months (July 1, 2006 through September 30, 2006) of payments under the 20/80 blend (4/5 wage index) and 9 months (October 1, 2006 through June 30, 2007) of payment under the full (5/5) wage index.

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

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

[5] As the percent change shown in this column represents an estimated percent decrease in payments per discharge, a negative (*i.e.*, minus) sign indicates an estimated percent increase in payments per discharge and the absence of a sign (*i.e.*, a positive sign) indicates an estimated percent decrease in payments per discharge.

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

[7] Percent decrease in estimated payments per discharge from the 2006 LTCH PPS rate year to the 2007 LTCH PPS rate year for the changes to the SSO policy at § 412.529 (as discussed in section VI.A.1.a. of the preamble of this final rule).

[8] 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 for the 2007 LTCH PPS rate year (as discussed in the preamble of this final rule). Note, this column, which shows the estimated percent decrease in payments per discharge for all changes, may not exactly equal the sum of the estimated percent decrease in payments per discharge for area wage adjustment changes (column 6) and for SSO policy changes (column 7) due to the effect of estimated changes in aggregate high cost outlier payments as well as other interactive effects that cannot be isolated.

4. Results

Based on the most recent available data (as described previously for 347 LTCHs), we have prepared the following summary of the impact (as shown above in Table 16) of the LTCH PPS set forth in this final rule. The impact analysis in Table 16 shows that estimated payments per discharge are expected to decrease approximately 3.7 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 changes presented in this final 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 change in the payment formula for SSO cases (discussed in section VI.A.1.a. of this final rule). Specifically, under the changes to the SSO policy for RY 2007, the vast majority of LTCH SSO cases (which is approximately 37 percent of all LTCH cases) will receive a lower payment than under the current SSO policy. We believe the revisions we are establishing to the SSO policy in this final rule are appropriate, as discussed in greater detail in section VI.A.1.a. of the preamble of this final rule, given that many of these very short-stay cases most likely do not receive a full course of a LTCH-level of treatment in such a short period of time since, in general, LTCHs are intended to treat patients with an ALOS of greater than 25 days. Furthermore, since most SSO cases which were admitted to the LTCH directly from an acute-care hospital, they may still be 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 and inappropriate admissions to the LTCH. Therefore, we believe that the changes to the SSO policy will result in more appropriate payments for short-stay cases treated at LTCHs.

As we discussed in greater detail in section V.D.3.c. of the preamble of this final rule, given the regulatory requirement at § 412.525(a) 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 changes to the SSO policy requires an increase in the HCO fixed-loss amount in order to maintain estimated outlier payments at 8 percent of the reduced estimated total LTCH PPS payments (resulting from the changes to the SSO policy and other policy changes presented in this final rule). Thus, the increase in the outlier fixed-loss amount also contributes to the 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 HCO payments. As a result of the increase to the fixed-loss amount from the 2006 LTCH PPS rate year ($10,501) to the 2007 LTCH PPS rate year ($14,887), fewer cases will qualify as outlier cases (that is, the estimated cost of the case exceeds the outlier threshold). Since many LTCHs are expected to receive fewer outlier payments, total estimated payments per discharge are expected to decrease (as discussed in section V.D.3. of this final rule).

As we discussed in greater detail in section V.D.1. of the preamble of this final rule, we are updating the wage index values for RY 2007 and continuing with the progression of the 5-year phase-in of the wage index adjustment. In addition, we are increasing the labor-related share from 72.885 percent to 75.665 percent under the LTCH PPS beginning in RY 2007. LTCHs located in areas with a RY 2007 wage index value that is greater than 1.0 will experience an increase in payments per discharge as a result of the increase in the labor-related share and the progression of the 5-year phase-in of the wage index adjustment. Thus, the changes to the wage index adjustment established in this final rule for LTCHs located in areas with a RY 2007 wage index value that is greater than 1.0 are expected to mitigate some of the projected decrease in payments per discharge that will result from the changes to the SSO policy and the outlier threshold. Similarly, LTCHs located in areas with a RY 2007 wage index value that is less than 1.0 are expected to experience a decrease in payments per discharge as a result of the increase in the labor-related share and the progression of the 5-year phase-in of the wage index adjustment. Consequently, the changes to the wage index adjustment established in this final rule for LTCHs located in areas with a RY 2007 wage index value that is less than 1.0 are expected to also contribute to the projected decrease in payments per discharge from RY 2006 as compared to RY 2007.

a. Location

Based on the most recent available data, the majority of LTCHs are in urban areas. Approximately 6 percent of the LTCHs are identified as being located in a rural area, and approximately 3.6 percent of all LTCH cases are treated in these rural hospitals. The impact analysis in Table 16 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 will be 5.8 percent, and will be 3.7 percent for urban LTCHs. While rural LTCHs are expected to experience a smaller decrease in payments due to the 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 changes to the area wage adjustment (discussed in section V.D.1. of the preamble of this final rule). Specifically, rural LTCHs are expected to experience a higher decrease in payments per discharge as a result of the changes to the area wage adjustment. The wage index for all rural LTCHs is less than 1.0, and therefore, they are expected to experience a decrease in payments per discharge as a result of the 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 3.1 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 4.8 percent decrease in payments per discharge from the 2006 LTCH PPS rate year compared to the 2007 LTCH PPS rate year (see Table 16). Other urban LTCHs are projected to experience a higher than average decrease in payments per discharge primarily because of the changes to the area wage adjustment (discussed in section V.D.1. of the preamble of this final rule). Specifically, the majority of other urban LTCHs (over 80 percent) are located in urban areas that have a wage index value of less than 1.0, and therefore, are expected to experience a higher than average decrease in payments per discharge as a result of the 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 changes to the SSO policy (as discussed in greater detail above in this section).

b. Participation Date

LTCHs are grouped by participation date into four categories: (1) Before October 1983; (2) between October 1983 and September 1993; (3) between October 1993 and September 2002; and (4) after October 2002. Based on the most recent available data, the majority (approximately 58 percent) of the LTCH

cases are in hospitals that began participating between October 1993 and September 2002, and are projected to experience a 3.9 percent decrease in payments per discharge from the 2006 LTCH PPS rate year compared to the 2007 LTCH PPS rate year. Approximately 18 percent of LTCH PPS cases are in LTCHs that began participating in Medicare between October 1983 and September 1993, and those LTCHs are projected to experience a 3.1 percent decrease in payments per discharge from the 2006 LTCH PPS rate year compared to the 2007 LTCH PPS rate year (see Table 16). We are projecting that LTCHs that began participating in Medicare between October 1983 and September 1993 will experience a lower than average decrease in payments for RY 2007 primarily because we are projecting that these LTCHs are expected to experience a slight increase (0.1 percent) in payments per discharge due to the 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 RY 2007 wage index value will be greater than the RY 2006 wage index value. In addition, several of these LTCHs are located in areas that have a wage index value of greater than 1.0, and therefore, are expected to experience a slight increase in payments per discharge as a result of the 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 2.9 percent decrease in payments per discharge from the 2006 LTCH PPS rate year compared to the 2007 LTCH PPS rate year (see Table 16). We are projecting that LTCHs that began participating in Medicare before October 1983 will experience a smaller than average decrease in payments for RY 2007 as compared to RY 2006 primarily because we are projecting that LTCHs in this participation date category will experience a slight increase in payments in RY 2007 as compared to RY 2006 due to the changes to the area wage adjustment (discussed in section V.D.1. of the preamble of this final rule). Specifically, the majority of LTCHs that began participating in Medicare before October 1983 are located in areas where the RY 2007 wage index value will be greater than the RY 2006 wage index value. In addition, many of these LTCHs are located in areas that will have a wage index value of greater than 1.0, and therefore, will experience a slight increase in payments per discharge as a result of the increase in the labor-related share and the progression of the 5-year phase-in of the wage index adjustment. Approximately 18 percent of LTCH PPS cases are in LTCHs that began participating in Medicare after October 2002 (that is, the implementation of the LTCH PPS), and those LTCHs are projected to experience a 4.2 percent decrease in payments per discharge from the 2006 LTCH PPS rate year compared to the 2007 LTCH PPS rate year (see Table 16). We are projecting that LTCHs that began participating in Medicare after October 2002 will experience a higher than average decrease in payments for RY 2007 primarily because we are projecting that these LTCHs will experience a larger decrease (−1.0 percent) in payments per discharge due to the changes to the area wage adjustment. Specifically, the majority of the LTCHs that began participating in Medicare after October 2002 are located in areas where the RY 2007 wage index value will be less than the RY 2006 wage index value. In addition, several of these LTCHs are located in areas that will have a wage index value of less than 1.0, and therefore, are expected to experience a decrease in payments per discharge as a result of the increase in the labor-related share and the progression of the 5-year phase-in of the wage index adjustment.

c. Ownership Control

Other than LTCHs whose ownership control type is unknown, LTCHs are grouped into three categories based on ownership control type: voluntary; proprietary; and government.

Based on the most recent available data, approximately 2.9 percent of LTCHs are identified as government-owned and operated. We expect that for these government-owned and operated LTCHs, 2007 LTCH PPS rate year payments per discharge will decrease 4.6 percent in comparison to the 2006 LTCH PPS rate year (see Table 16). We are projecting that government-run LTCHs will experience a higher than average decrease in payment in RY 2007 as compared to RY 2006 primarily due to the effect of the changes to the area wage adjustment (discussed in section V.D.1. of the preamble of this proposed rule). Specifically, all but 2 of the 10 government-run LTCHs in our database are located in areas where the wage index value for RY 2007 is less than 1.0, and therefore, are expected to experience a higher than average decrease in payments per discharge as a result of the increase in the labor-related share and the progression of the 5-year phase-in of the wage index adjustment.

Similarly, we project that 2007 LTCH PPS rate year payments per discharge for voluntary LTCHs will decrease 4.3 percent in comparison to the 2006 LTCH PPS rate year payments (see Table 16). We are projecting that voluntary LTCHs will experience a higher than average decrease in payments in RY 2007 as compared to RY 2006 primarily due to the changes to the SSO policy, since approximately two-thirds of the voluntary LTCHs have a higher than average percentage of SSO cases.

The majority (approximately 67 percent) of LTCHs are identified as proprietary. We project that 2007 LTCH PPS rate year payments per discharge for these proprietary LTCHs will decrease 3.6 percent in comparison to the 2006 LTCH PPS rate year (see Table 16). We are projecting that proprietary LTCHs will experience a slightly lower than average decrease in payments in RY 2007 as compared to RY 2006 primarily due to our estimate that these LTCHs will experience a slightly lower than average decrease in payments due to the changes to the SSO policy, since many proprietary LTCHs have a lower than average percentage of SSO cases. Proprietary LTCHs are also expected to experience a slightly lower than average decrease in payments from RY 2006 to RY 2007 due to the changes to the area wage adjustment since several proprietary LTCHs are expected to experience an increase to their wage index value from RY 2006 to RY 2007.

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 change in the payment formula for SSO cases, the changes in the area wage adjustment, and the increase in the outlier fixed-loss amount.

Of the 9 census regions, we project that the estimated decrease in 2007 LTCH PPS rate year payments per discharge in comparison to the 2006 LTCH PPS rate year will have the largest impact on LTCHs in the East South Central and West South Central regions (4.7 percent and 4.5 percent, respectively; see Table 16). LTCHs located in both the East and West South Central regions are expected to experience a higher than average decrease in payments due to the changes in the area wage adjustment (1.5 percent for the East South Central

region and 1.2 percent for the West South Central region). Since nearly all LTCHs located in the East South Central region and the West South Central region are located in areas with a wage index value that is less than 1.0, they are expected to experience a decrease in payments per discharge as a result of the increase in the labor-related share and the progression of the 5-year phase-in of the wage index adjustment.

We project that 2007 LTCH PPS rate year payments per discharge will decrease the least for LTCHs in the Pacific region in comparison to the 2006 LTCH PPS rate year (0.7 percent; see Table 16). 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 we are projecting an increase in estimated LTCH PPS payments from RY 2006 to RY 2007 as a result of the changes to the area wage adjustment. Specifically, we are projecting an increase in estimated LTCH PPS payments due to the changes to the area wage adjustment because all LTCHs in this region are located in areas where the 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 wage index value for RY 2007 is greater than 1.0, and therefore, are expected to experience an increase in payments per discharge as a result of the 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 project that these LTCHs will experience a lower than average decrease in average payments as a result of the changes to the SSO policy.

e. Bed Size

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

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 3.5 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 change in the payment formula for SSO cases, the changes in the area wage adjustment, and the increase in the outlier fixed-loss amount.

We project that LTCHs with greater than 200 beds will have the smallest decrease in estimated 2007 LTCH PPS rate year payments per discharge in comparison to the 2006 LTCH PPS rate year (2.4 percent), followed by LTCHs with 75–124 beds (3.0 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 changes to the area wage adjustment. Specifically, for LTCHs with 75–124 beds, the majority of these LTCHs are located in areas where the change in the wage index value from RY 2006 to RY 2007 will be very small, and therefore, we project that the changes to the area wage adjustment will have a negligible impact on these LTCHs' RY 2007 payments (0.0 percent) rather than decreasing their RY 2007 payments (as we estimate will be the impact of these changes for ''All Providers'' as shown in Table 16). For LTCHs with greater than 200 beds, the majority of these LTCHs are located in areas where the 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 RY 2007 wage index value is greater than 1.0, and therefore, are expected to experience an increase in payments per discharge as a result of the 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 (5.0 percent; see Table 16), followed by LTCHs with 25–49 beds (4.4 percent; see Table 16). 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 changes to the area wage adjustment. Specifically, the majority of LTCHs with 49 beds or less are located in areas where the 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 RY 2007 wage index is less than 1.0, and therefore, are expected to experience a higher than average decrease in payments per discharge as a result of the increase in the labor-related share and the progression of the 5-year phase-in of the wage index adjustment.

5. Effect on the Medicare Program

Based on actuarial projections, an estimate of Medicare spending (total estimated Medicare program payments) for LTCH services over the next 5 years based on current LTCH PPS policy and based on policy changes established in this final rule is shown in Table 18:

TABLE 18.—FIVE-YEAR ESTIMATED MEDICARE PROGRAM PAYMENTS FOR LTCH SERVICES

LTCH PPS rate year	Estimated payments based on current policy ($ in billons)	Estimated payments based on policy changes established in this final rule ($ in billions)	Difference reflecting policy changes established in this final rule ($ in millions)
2007	5.267	4.917	350
2008	5.427	5.017	410
2009	5.626	5.186	440
2010	5.858	5.398	460
2011	6.131	5.641	490

These estimates are based on the most recent LTCH data available, including the projection that 98 percent of LTCHs will elect to be paid based on 100 percent of the 2007 LTCH PPS rate year 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 18 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 available LTCH discharge data.) The estimate of payments based on current policy (shown in column 2 of Table 18) is based on the current estimate of the increase in the excluded hospital with capital market basket (currently used under the LTCH PPS) of 3.4 percent for the 2007 LTCH PPS rate year, 3.1 percent for the 2008 LTCH PPS rate year, 2.8 for the 2009 LTCH PPS rate year, 2.3 percent for the 2010 LTCH PPS rate year and 2.7 percent for the 2011 LTCH PPS rate year. (We note that, although we have established a zero percent update to the LTCH PPS Federal rate for RY 2007 (as discussed in section V.C.3. of this final rule) and are adopting the RPL market basket beginning in RY 2007 (as discussed in section V.B. of this final rule), OACT develops its spending projections based on existing policy and therefore, changes that have not as yet been implemented are not reflected in the spending projections shown in Table 18.) We estimate that there will be a change in Medicare fee-for-service beneficiary enrollment of −0.3 percent in the 2007 LTCH PPS rate year, 0.1 percent in the 2008 LTCH PPS rate year, 0.2 percent in the 2009 LTCH PPS rate year, −0.3 percent in the 2010 LTCH PPS rate year, and −0.2 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 for determining the FY 2003 standard Federal rate 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 V.D.6. of this final 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 the LTCH PPS is not perpetuated in the PPS rates for future years. As discussed in section V.D.6. of this final rule, due to the lag time in the availability of Medicare data upon which this adjustment would be based, we have postponed the requirement established in existing § 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 will 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 19, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this final rule. Table 19 provides our best estimate of the decrease in Medicare payments under the LTCH PPS as a result of the changes presented in this final rule based on the data for 347 LTCHs in our database. All expenditures are classified as transfers to Medicare providers (that is, LTCHs).

TABLE 19.—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: $156.
From Whom to Whom?	Federal Government to LTCH Medicare Providers.

In accordance with the provisions of Executive Order 12866, this final 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 amends 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) * * *

(i) * * *

(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 beginning July 1, 2006 and ending June 30, 2007.* The standard Federal rate for long-term care hospital prospective payment system rate year beginning July 1, 2006 and ending June 30, 2007 is the standard Federal rate for the previous long-term care hospital prospective payment system rate year updated by 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 412.529 is amended by—
■ A. Revising paragraph (c).
■ B. Adding new paragraph (d).
■ C. Adding new paragraph (e).

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;

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

(iii) The Federal prospective payment for the LTC–DRG determined under paragraph (d)(3) of this section.

(2) For discharges occurring on or after July 1, 2006, from long-term care hospitals described under § 412.23(e)(2)(i), 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;

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

(iii) The Federal prospective payment for the LTC–DRG as determined under paragraph (d)(3) of this section; or

(iv) An amount payable under subpart O computed as a blend of an amount comparable to the hospital inpatient prospective payment system per diem amount determined under paragraph (d)(4)(i) of this section and the 120 percent of the LTC–DRG specific per diem payment amount determined under paragraph (d)(1) of this section.

(A) The blend percentage applicable to the 120 percent of the LTC–DRG specific per diem payment amount determined under paragraph (d)(1) of this section is determined by dividing the covered length-of-stay of the case by the lesser of five-sixths of the geometric average length of stay of the LTC–DRG or 25 days, not to exceed 100 percent.

(B) The blend percentage of the amount determined under paragraph (d)(4)(i) of this section is determined by subtracting the percentage determined in paragraph (A) from 100 percent.

(3) *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 the estimated cost-to-charge ratio and the actual cost-to-charge ratio of the case.

(ii) For discharges occurring on or after August 8, 2003, 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, short-stay outlier payments are subject to the provisions of § 412.84(i)(2) for adjustments to cost-to-charge ratios.

(d) *Calculation of alternative payment amounts.* (1) *Determining the LTC–DRG per diem amount.* CMS calculates the LTC–DRG 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 relative weight by the geometric average length of stay of the specific LTC–DRG multiplied by the covered days of the stay.

(2) *Determining the estimated cost of a case.* To determine the estimated cost of a case, CMS multiplies the hospital-specific cost-to-charge ratio by the Medicare allowable charges for the case.

(3) *Determining the Federal prospective payment for the LTC–DRG.* CMS calculates the Federal prospective payment for the LTC–DRG by multiplying the adjusted standard Federal payment rate by the LTC–DRG relative weight.

(4) *Determining the amount comparable to the hospital inpatient prospective payment system per diem amount.* (i) *General.* Under Subpart O, CMS calculates—

(A) 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 the capital inpatient prospective payment system Federal rate in effect at the time of the LTCH discharge.

(B) An amount comparable to the hospital inpatient prospective payment system per diem amount for each DRG that is determined by dividing the amount that would otherwise be paid under the hospital inpatient prospective payment system computed under paragraph (A) of this section by the hospital inpatient prospective payment system geometric average length of stay of the specific DRG multiplied by the covered days of the stay.

(C) For purposes of the blend amount described in paragraph (c)(2)(iv) of this section, the payment amount specified under subparagraph (B) of this section

may not exceed the full amount comparable to what would otherwise be paid under the hospital inpatient prospective payment system determined under subparagraph (A) of this section.

(ii) *Hospital inpatient prospective payment system operating standardized amount.* The hospital inpatient prospective payment system operating standardized amount—

(A) Is adjusted for the applicable hospital 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 hospital inpatient prospective payment system labor-related share, using the applicable hospital inpatient prospective payment system wage index value for non-reclassified hospitals. For LTCHs located in Alaska and Hawaii, this amount is also adjusted by the applicable hospital 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.

(iii) *Hospital inpatient prospective payment system capital Federal rate.* The hospital inpatient prospective payment system capital 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 hospital inpatient prospective payment system wage index value for non-reclassified 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.

(e) Short-stay outlier payments to long-term care hospitals described under § 412.23(e)(2)(ii).

(1) For discharges occurring on or after October 1, 2002, through June 30, 2003, 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;

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

(iii) The Federal prospective payment for the LTC–DRG determined under paragraph (d)(3) of this section.

(2) For discharges occurring on or after July 1, 2003, subject to the provisions of paragraph (e)(2)(v) of this section, the adjusted payment amount for a short-stay outlier is determined under the formulas set forth in paragraphs (e)(1)(i) through (iv) of this section with the following substitutions:

(i) For the first year of the transition period, as specified at § 412.533(a)(1), the 120 percent specified for the LTC–DRG specific per diem amount and the 120 percent of the cost of the case in the formula under paragraphs (e)(1)(i) and (e)(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), the 120 percent specified for the LTC–DRG specific per diem amount and the 120 percent of the cost of the case in the formula under paragraphs (e)(1)(i) and (e)(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), the 120 percent specified for the LTC–DRG specific per diem amount and the 120 percent of the cost of the case in the formula under paragraphs (e)(1)(i) and (e)(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), the 120 percent specified for the LTC–DRG specific per diem amount and 120 percent of the cost of the case in the formula under paragraphs (e)(1)(i) and (e)(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 are made based on the least of the following amounts:

(A) 120 percent of the LTC–DRG specific per diem amount determined under paragraph (d)(1) of this section;

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

(C) The Federal prospective payment for the LTC–DRG determined under paragraph (d)(3) of this section.

■ 4. 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 hospital 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 hospital 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 hospital inpatient 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).

* * * * *

■ 5. 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 hospital inpatient prospective payment system operating standardized amount and capital Federal rate in effect at the time of the LTCH discharge.

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

(i) Is adjusted for the applicable hospital 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 hospital inpatient prospective payment system labor-related share, using the applicable hospital inpatient prospective payment system wage index value for non-reclassified hospitals. For LTCHs located in Alaska and Hawaii, this amount is also adjusted by the applicable hospital 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) *Hospital inpatient prospective payment system capital Federal rate.* The hospital inpatient prospective payment system capital Federal rate—

(i) Is adjusted for the applicable hospital 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 hospital inpatient prospective payment system wage index value for non-reclassified 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 established for the hospital inpatient prospective payment system.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: April 19, 2006.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Approved: May 1, 2006.

Michael O. Leavitt,

Secretary.

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 the 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, as discussed in section IV.B. of this final rule, we are adopting the FY 2002-based RPL market basket under the LTCH PPS beginning in RY 2007.) As we discuss in section IV.C.3. of this final rule, based on our analysis of the best available LTCH case-mix and margins data, we are revising § 412.523(c) to specify that for the 2007 LTCH PPS rate year, the standard Federal rate from the previous year will 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 final rule, we are repeating below the conceptual basis for developing such an update framework that was outlined in the RY 2007 LTCH PPS proposed rule (71 FR 4742 through 4747) using the latest available data.

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 IPPS Federal rate. 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 the RY 2007 LTCH PPS proposed rule, we solicited comments concerning the use and feasibility of the conceptual approach outlined in section B of this Appendix. Specifically, we requested 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 the capital IPPS, the features of a LTCH-specific update framework would need to be based on sound policy and methodology. In this final rule we are again presenting a conceptual basis for the framework along with an illustrative LTCH PPS framework for RY 2007 based on the latest available data (shown in section E of this Appendix). We received two comments on the conceptual basis for the framework, which included an illustrative LTCH PPS framework for RY 2007 that was presented in the RY 2007 LTCH PPS proposed rule. These comments are addressed below in section G of this Appendix.

B. Factors Inherent in LTCH Payments Per Discharge

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.

$$\frac{\text{Payments}}{\text{Discharge}} = \frac{\text{Costs}}{\text{Discharge}} + \frac{\text{Profits}}{\text{Discharge}} \qquad \text{(Eq. 1)}$$

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

$$\frac{\text{Payments}}{\text{Discharge}} = \frac{\text{Costs}}{\text{Discharge}} * \frac{\text{Payments}}{\text{Costs}} \qquad \text{(Eq. 2)}$$

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.

$$\frac{\text{Payments}}{\text{Discharge}} = \frac{\text{Costs}}{\text{Discharge}} * \left(\frac{\text{Payments}}{\text{Costs}} * \frac{\text{Input Prices}}{\text{Productivity}} \right) * \frac{\text{Productivity}}{\text{Input Prices}} \qquad \text{(Eq. 3)}$$

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.

$$\frac{\text{Payments}}{\text{Discharge}} = \frac{\text{Costs/Discharge}}{\text{Real Case Mix/Discharge}} * \frac{\text{Real Case Mix}}{\text{Discharge}} * \left(\frac{\text{Payments}}{\text{Costs}} * \frac{\text{Input Prices}}{\text{Productivity}} \right) * \frac{\text{Productivity}}{\text{Input Prices}} \qquad \text{(Eq. 4)}$$

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.

$$\frac{\text{Payments}}{\text{Discharge}} = \left(\frac{\dfrac{\text{Costs}}{\text{Discharge}}}{\text{Input Prices} * \dfrac{\text{Real Case Mix}}{\text{Discharge}}} * \text{Productivity} \right) * \frac{\text{Real Case Mix}}{\text{Discharge}} * \frac{1}{\text{Productivity}} * \text{Input Prices} * \frac{\text{Payments}}{\text{Costs}} \qquad \text{(Eq. 5)}$$

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.

$$\text{Payments Per Discharge} = \frac{\left(\begin{array}{c} \text{Case-Mix-Constant} \\ \text{Real Output Intensity} \\ \text{Per Discharge} \end{array} \right) * \left(\begin{array}{c} \text{Real Case Mix} \\ \text{per Discharge} \end{array} \right) * (\text{Input Prices}) * (\text{Profit Margins})}{\text{Productivity}} \qquad \text{(Eq. 6)}$$

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 in section IV.B. of this final rule, we are implementing our proposal 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:

$$\text{Productivity} = \frac{\text{Real Payments}}{\text{Real Costs}} = \frac{(\text{Payments/Output Price}}{(\text{Costs/Input Price})} = \frac{\text{Payments}}{\text{Costs}} * \frac{\text{Input Price}}{\text{Output Price}} \qquad \text{(Eq. 7)}$$

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.

$$\text{Case-Mix-Constant Real Output Intensity per Discharge}$$

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

$$= \frac{[\text{Paymenta/Discharge}] * \text{Costs}}{\text{Payments} * \frac{\text{Input Prices}}{\text{Productivity}} * \text{Real Case Mix/Discharge}} = \frac{\text{Payments} * [\text{Costs/Discharge}]}{\text{Payments} * \frac{\text{Input Prices}}{\text{Productivity}} * \text{Real Case Mix/Discharge}} \qquad \text{(Eq. 8)}$$

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

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 final rule, the standard Federal rate from the previous year will 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 finalizing our proposal to adopt the RPL market basket under the LTCH PPS as discussed in section IV.B. of the preamble of this final 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 20 shows an illustrative update framework for the LTCH PPS for RY 2007 based on the latest available data. 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 update framework. 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 -0.6 percent. This estimate is based on the best available data at this time. The estimated update factor is based on a projected 3.4 percent increase in the 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 0.9 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 CMI 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 CMI corresponds to an equal percentage increase in hospital payments.

The CMI can change for any of several reasons:

• Changes in the average resource use of Medicare patients (real case-mix change);

• Changes in hospital coding of patient records resulting in higher weight DRG assignments (''apparent'' CMI).

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 final rule, for RY 2007, we are estimating a 6.75 percent nominal increase in the CMI. 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 0.9 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 (4.0 percent) by 0.9 percentage points. Therefore, a 0.9 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 20 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 final rule, we are establishing a zero percent update to the LTCH PPS standard Federal rate for RY 2007.

TABLE A–1.—ILLUSTRATIVE LTCH PPS UPDATE FRAMEWORK FOR RY 2007

Factors	Percent change
Price (+):	4.3
Proposed RPL Market Basket	3.4
Forecast Error	0.9
Productivity(−)	0.9
Output Intensity (+):	0.0
Input Intensity	−0.9
Productivity	0.9
Case-mix Creep Adjustment (+):	−4.0
Nominal Case-Mix	−6.75
Real Case-Mix	2.75
Other factors (+)	0.0
Total	−0.6

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 the 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.

G. Summary of Public Comments and CMS Responses

Comment: One commenter stated that given the complexity of the conceptual ideas put forth for updating the LTCH payments and the limited time afforded to comment on the entire proposed rule, CMS should extend the time frame to which it will accept comments regarding the update framework. Commenters also recommended that CMS further refine the update framework with input from the industry.

Response: We note that in accordance with section 1871 of the Act, we provided for a 60-day comment period, which closed at 5 p.m. on March 20, 2006, for the public to provide comments on the proposed policy changes and clarifications presented in the RY 2007 LTCH PPS proposed rule (71 FR 4648). Moreover, we reiterate that we are not implementing a specific update framework for determining the RY 2007 Federal rate under the LTCH PPS at this time. As we stated in the RY 2007 LTCH PPS proposed rule, we intend for the development of such an update framework to be a process that evolves after evaluating input from the industry. Therefore, we are open to working with the public to refine the data sources and formulas used to determine the values of the individual components of such a framework that would be proposed, in the future, to update the standard Federal rate. Therefore, as noted previously in the Appendix, we continue to solicit comments to assist us in refining the data sources and methods that would be used to implement such a framework under the LTCH PPS. Any future proposal to develop an update framework would be proposed in accordance with the notice and comment rulemaking process.

Comment: One commenter was concerned that some inputs into this ''new market basket methodology'' (that is, the conceptual model of an update framework) appear to be subjective and at the discretion of CMS. The commenter believes that the market basket update should be calculated using objective, reliable, and verifiable mathematical concepts and publicly available data, rather than using ''policy considerations'' and other subjective variables.

Response: We would like to clarify that this is not a ''new market basket methodology,'' but instead a way to determine an appropriate payment update. The market basket is only one factor of a complex update framework. We support the public's involvement in helping us refine the data sources and methods that could be used to implement an update framework. While it is our preference to use ''verifiable mathematical concepts and publicly available data,'' there may be instances in which such data is unavailable. Therefore, there will be a need to utilize policy considerations and other subjective information in determining a proposed update framework. We believe it would be inappropriate to implement the framework without having all of the factors reflected.

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 final rule. The tables presented below are as follows:

Table 1: Long-Term Care Hospital Wage Index for Urban Areas for Discharges Occurring from July 1, 2006 through June 30, 2007

Table 2: 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, Geometric Average Length of Stay and five-sixths of the Geometric Average Length of Stay (for Short-Stay Outlier Cases) for Discharges Occurring on or after October 1, 2005 through September 30, 2006. (Note: This is the same information provided in Table 11 of the FY 2006 IPPS final rule (70 FR 47681 through 47690), which has been reprinted here for convenience.)

TABLE 1.—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	0.8738	0.8317	0.7896
	Callahan County, TX.			
	Jones County, TX.			
	Taylor County, TX.			
10380	Aguadilla-Isabela-San Sebastiá, PR	0.6843	0.5790	0.4738
	Aguada Municipio, PR.			
	Aguadilla Municipio, PR.			

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2006 THROUGH JUNE 30, 2007[1]—Continued

BSA code CBSA code	Urban area (constituent counties)	3/5 wage index[2]	4/5 wage index[3]	Full wage index[4]
	Añasco Municipio, PR.			
	Isabela Municipio, PR.			
	Lares Municipio, PR.			
	Moca Municipio, PR.			
	Rincón Municipio, PR.			
	San Sebastiá Municipio, PR.			
10420	Akron, OH	0.9389	0.9186	0.8982
	Portage County, OH.			
	Summit County, OH.			
10500	Albany, GA	0.9177	0.8902	0.8628
	Baker County, GA.			
	Dougherty County, GA.			
	Lee County, GA.			
	Terrell County, GA.			
	Worth County, GA.			
10580	Albany-Schenectady-Troy, NY	0.9153	0.8871	0.8589
	Albany County, NY.			
	Rensselaer County, NY.			
	Saratoga County, NY.			
	Schenectady County, NY.			
	Schoharie County, NY.			
10740	Albuquerque, NM	0.9810	0.9747	0.9684
	Bernalillo County, NM.			
	Sandoval County, NM.			
	Torrance County, NM.			
	Valencia County, NM.			
10780	Alexandria, LA	0.8820	0.8426	0.8033
	Grant Parish, LA.			
	Rapides Parish, LA.			
10900	Allentown-Bethlehem-Easton, PA-NJ	0.9891	0.9854	0.9818
	Warren County, NJ.			
	Carbon County, PA.			
	Lehigh County, PA.			
	Northampton County, PA.			
11020	Altoona, PA	0.9366	0.9155	0.8944
	Blair County, PA.			
11100	Amarillo, TX	0.9494	0.9325	0.9156
	Armstrong County, TX.			
	Carson County, TX.			
	Potter County, TX.			
	Randall County, TX.			
11180	Ames, IA	0.9722	0.9629	0.9536
	Story County, IA.			
11260	Anchorage, AK	1.1137	1.1516	1.1895
	Anchorage Municipality, AK.			
	Matanuska-Susitna Borough, AK.			
11300	Anderson, IN	0.9152	0.8869	0.8586
	Madison County, IN.			
11340	Anderson, SC	0.9398	0.9198	0.8997
	Anderson County, SC.			
11460	Ann Arbor, MI	1.0515	1.0687	1.0859
	Washtenaw County, MI.			
11500	Anniston-Oxford, AL	0.8609	0.8146	0.7682
	Calhoun County, AL.			
11540	Appleton, WI	0.9573	0.9430	0.9288
	Calumet County, WI.			
	Outagamie County, WI.			
11700	Asheville, NC	0.9571	0.9428	0.9285
	Buncombe County, NC.			
	Haywood County, NC.			
	Henderson County, NC.			
	Madison County, NC.			
12020	Athens-Clarke County, GA	0.9913	0.9884	0.9855
	Clarke County, GA.			
	Madison County, GA.			
	Oconee County, GA.			
	Oglethorpe County, GA.			
12060	Atlanta-Sandy Springs-Marietta, GA	0.9876	0.9834	0.9793

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2006 THROUGH JUNE 30, 2007[1]—Continued

BSA code				
CBSA code	Urban area (constituent counties)	3/5 wage index[2]	4/5 wage index[3]	Full wage index[4]
	Barrow County, GA.			
	Bartow County, GA.			
	Butts County, GA.			
	Carroll County, GA.			
	Cherokee County, GA.			
	Clayton County, GA.			
	Cobb County, GA.			
	Coweta County, GA.			
	Dawson County, GA.			
	DeKalb County, GA.			
	Douglas County, GA.			
	Fayette County, GA.			
	Forsyth County, GA.			
	Fulton County, GA.			
	Gwinnett County, GA.			
	Haralson County, GA.			
	Heard County, GA.			
	Henry County, GA.			
	Jasper County, GA.			
	Lamar County, GA.			
	Meriwether County, GA.			
	Newton County, GA.			
	Paulding County, GA.			
	Pickens County, GA.			
	Pike County, GA.			
	Rockdale County, GA.			
	Spalding County, GA.			
	Walton County, GA.			
12100	Atlantic City, NJ	1.0969	1.1292	1.1615
	Atlantic County, NJ.			
12220	Auburn-Opelika, AL	0.8860	0.8480	0.8100
	Lee County, AL.			
12260	Augusta-Richmond County, GA-SC	0.9849	0.9798	0.9748
	Burke County, GA.			
	Columbia County, GA.			
	McDuffie County, GA.			
	Richmond County, GA.			
	Aiken County, SC.			
	Edgefield County, SC.			
12420	Austin-Round Rock, TX	0.9662	0.9550	0.9437
	Bastrop County, TX.			
	Caldwell County, TX.			
	Hays County, TX.			
	Travis County, TX.			
	Williamson County, TX.			
12540	Bakersfield, CA	1.0282	1.0376	1.0470
	Kern County, CA.			
12580	Baltimore-Towson, MD	0.9938	0.9918	0.9897
	Anne Arundel County, MD.			
	Baltimore County, MD.			
	Carroll County, MD.			
	Harford County, MD.			
	Howard County, MD.			
	Queen Anne's County, MD.			
	Baltimore City, MD.			
12620	Bangor, ME	0.9996	0.9994	0.9993
	Penobscot County, ME.			
12700	Barnstable Town, MA	1.1560	1.2080	1.2600
	Barnstable County, MA.			
12940	Baton Rouge, LA	0.9156	0.8874	0.8593
	Ascension Parish, LA.			
	East Baton Rouge Parish, LA.			
	East Feliciana Parish, LA.			
	Iberville Parish, LA.			
	Livingston Parish, LA.			
	Pointe Coupee Parish, LA.			
	St. Helena Parish, LA.			
	West Baton Rouge Parish, LA.			

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2006 THROUGH JUNE 30, 2007[1]—Continued

BSA code CBSA code	Urban area (constituent counties)	3/5 wage index[2]	4/5 wage index[3]	Full wage index[4]
	West Feliciana Parish, LA.			
12980	Battle Creek, MI	0.9705	0.9606	0.9508
	Calhoun County, MI.			
13020	Bay City, MI	0.9606	0.9474	0.9343
	Bay County, MI.			
13140	Beaumont-Port Arthur, TX	0.9047	0.8730	0.8412
	Hardin County, TX.			
	Jefferson County, TX.			
	Orange County, TX.			
13380	Bellingham, WA	1.1039	1.1385	1.1731
	Whatcom County, WA.			
13460	Bend, OR	1.0472	1.0629	1.0786
	Deschutes County, OR.			
13644	Bethesda-Gaithersburg-Frederick, MD	1.0890	1.1186	1.1483
	Frederick County, MD.			
	Montgomery County, MD.			
13740	Billings, MT	0.9300	0.9067	0.8834
	Carbon County, MT.			
	Yellowstone County, MT.			
13780	Binghamton, NY	0.9137	0.8850	0.8562
	Broome County, NY.			
	Tioga County, NY.			
13820	Birmingham-Hoover, AL	0.9375	0.9167	0.8959
	Bibb County, AL.			
	Blount County, AL.			
	Chilton County, AL.			
	Jefferson County, AL.			
	St. Clair County, AL.			
	Shelby County, AL.			
	Walker County, AL.			
13900	Bismarck, ND	0.8544	0.8059	0.7574
	Burleigh County, ND.			
	Morton County, ND.			
13980	Blacksburg-Christiansburg-Radford, VA	0.8772	0.8363	0.7954
	Giles County, VA.			
	Montgomery County, VA.			
	Pulaski County, VA.			
	Radford City, VA.			
14020	Bloomington, IN	0.9068	0.8758	0.8447
	Greene County, IN.			
	Monroe County, IN.			
	Owen County, IN.			
14060	Bloomington-Normal, IL	0.9445	0.9260	0.9075
	McLean County, IL.			
14260	Boise City-Nampa, ID	0.9431	0.9242	0.9052
	Ada County, ID.			
	Boise County, ID.			
	Canyon County, ID.			
	Gem County, ID.			
	Owyhee County, ID.			
14484	Boston-Quincy, MA	1.0935	1.1246	1.1558
	Norfolk County, MA.			
	Plymouth County, MA.			
	Suffolk County, MA.			
14500	Boulder, CO	0.9840	0.9787	0.9734
	Boulder County, CO.			
14540	Bowling Green, KY	0.8927	0.8569	0.8211
	Edmonson County, KY.			
	Warren County, KY.			
14740	Bremerton-Silverdale, WA	1.0405	1.0540	1.0675
	Kitsap County, WA.			
14860	Bridgeport-Stamford-Norwalk, CT	1.1555	1.2074	1.2592
	Fairfield County, CT.			
15180	Brownsville-Harlingen, TX	0.9882	0.9843	0.9804
	Cameron County, TX.			
15260	Brunswick, GA	0.9587	0.9449	0.9311
	Brantley County, GA.			
	Glynn County, GA.			

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2006 THROUGH JUNE 30, 2007[1]—Continued

BSA code				
CBSA code	Urban area (constituent counties)	3/5 wage index[2]	4/5 wage index[3]	Full wage index[4]
	McIntosh County, GA.			
15380	Buffalo-Niagara Falls, NY	0.9707	0.9609	0.9511
	Erie County, NY.			
	Niagara County, NY.			
15500	Burlington, NC	0.9343	0.9124	0.8905
	Alamance County, NC.			
15540	Burlington-South Burlington, VT	0.9646	0.9528	0.9410
	Chittenden County, VT.			
	Franklin County, VT.			
	Grand Isle County, VT.			
15764	Cambridge-Newton-Framingham, MA	1.0703	1.0938	1.1172
	Middlesex County, MA.			
15804	Camden, NJ	1.0310	1.0414	1.0517
	Burlington County, NJ.			
	Camden County, NJ.			
	Gloucester County, NJ.			
15940	Canton-Massillon, OH	0.9361	0.9148	0.8935
	Carroll County, OH.			
	Stark County, OH.			
15980	Cape Coral-Fort Myers, FL	0.9614	0.9485	0.9356
	Lee County, FL.			
16180	Carson City, NV	1.0140	1.0187	1.0234
	Carson City, NV.			
16220	Casper, WY	0.9416	0.9221	0.9026
	Natrona County, WY.			
16300	Cedar Rapids, IA	0.9295	0.9060	0.8825
	Benton County, IA.			
	Jones County, IA.			
	Linn County, IA.			
16580	Champaign-Urbana, IL	0.9756	0.9675	0.9594
	Champaign County, IL.			
	Ford County, IL.			
	Piatt County, IL.			
16620	Charleston, WV	0.9067	0.8756	0.8445
	Boone County, WV.			
	Clay County, WV.			
	Kanawha County, WV.			
	Lincoln County, WV.			
	Putnam County, WV.			
16700	Charleston-North Charleston, SC	0.9547	0.9396	0.9245
	Berkeley County, SC.			
	Charleston County, SC.			
	Dorchester County, SC.			
16740	Charlotte-Gastonia-Concord, NC-SC	0.9850	0.9800	0.9750
	Anson County, NC.			
	Cabarrus County, NC.			
	Gaston County, NC.			
	Mecklenburg County, NC.			
	Union County, NC.			
	York County, SC.			
16820	Charlottesville, VA	1.0112	1.0150	1.0187
	Albemarle County, VA.			
	Fluvanna County, VA.			
	Greene County, VA.			
	Nelson County, VA.			
	Charlottesville City, VA.			
16860	Chattanooga, TN-GA	0.9453	0.9270	0.9088
	Catoosa County, GA.			
	Dade County, GA.			
	Walker County, GA.			
	Hamilton County, TN.			
	Marion County, TN.			
	Sequatchie County, TN.			
16940	Cheyenne, WY	0.9265	0.9020	0.8775
	Laramie County, WY.			
16974	Chicago-Naperville-Joliet, IL	1.0474	1.0632	1.0790
	Cook County, IL.			
	DeKalb County, IL.			

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2006 THROUGH JUNE 30, 2007[1]—Continued

BSA code

CBSA code	Urban area (constituent counties)	3/5 wage index[2]	4/5 wage index[3]	Full wage index[4]
	DuPage County, IL.			
	Grundy County, IL.			
	Kane County, IL.			
	Kendall County, IL.			
	McHenry County, IL.			
	Will County, IL.			
17020	Chico, CA	1.0307	1.0409	1.0511
	Butte County, CA.			
17140	Cincinnati-Middletown, OH-KY-IN	0.9769	0.9692	0.9615
	Dearborn County, IN.			
	Franklin County, IN.			
	Ohio County, IN.			
	Boone County, KY.			
	Bracken County, KY.			
	Campbell County, KY.			
	Gallatin County, KY.			
	Grant County, KY.			
	Kenton County, KY.			
	Pendleton County, KY.			
	Brown County, OH.			
	Butler County, OH.			
	Clermont County, OH.			
	Hamilton County, OH.			
	Warren County, OH.			
17300	Clarksville, TN-KY	0.8970	0.8627	0.8284
	Christian County, KY.			
	Trigg County, KY.			
	Montgomery County, TN.			
	Stewart County, TN.			
17420	Cleveland, TN	0.8883	0.8511	0.8139
	Bradley County, TN.			
	Polk County, TN.			
17460	Cleveland-Elyria-Mentor, OH	0.9528	0.9370	0.9213
	Cuyahoga County, OH.			
	Geauga County, OH.			
	Lake County, OH.			
	Lorain County, OH.			
	Medina County, OH.			
17660	Coeur d'Alene, ID	0.9788	0.9718	0.9647
	Kootenai County, ID.			
17780	College Station-Bryan, TX	0.9340	0.9120	0.8900
	Brazos County, TX.			
	Burleson County, TX.			
	Robertson County, TX.			
17820	Colorado Springs, CO	0.9681	0.9574	0.9468
	El Paso County, CO.			
	Teller County, CO.			
17860	Columbia, MO	0.9007	0.8676	0.8345
	Boone County, MO.			
	Howard County, MO.			
17900	Columbia, SC	0.9434	0.9246	0.9057
	Calhoun County, SC.			
	Fairfield County, SC.			
	Kershaw County, SC.			
	Lexington County, SC.			
	Richland County, SC.			
	Saluda County, SC.			
17980	Columbus, GA-AL	0.9136	0.8848	0.8560
	Russell County, AL.			
	Chattahoochee County, GA.			
	Harris County, GA.			
	Marion County, GA.			
	Muscogee County, GA.			
18020	Columbus, IN	0.9753	0.9670	0.9588
	Bartholomew County, IN.			
18140	Columbus, OH	0.9916	0.9888	0.9860
	Delaware County, OH.			
	Fairfield County, OH.			

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2006 THROUGH JUNE 30, 2007[1]—Continued

BSA code CBSA code	Urban area (constituent counties)	3/5 wage index[2]	4/5 wage index[3]	Full wage index[4]
	Franklin County, OH.			
	Licking County, OH.			
	Madison County, OH.			
	Morrow County, OH.			
	Pickaway County, OH.			
	Union County, OH.			
18580	Corpus Christi, TX	0.9130	0.8840	0.8550
	Aransas County, TX.			
	Nueces County, TX.			
	San Patricio County, TX.			
18700	Corvallis, OR	1.0437	1.0583	1.0729
	Benton County, OR.			
19060	Cumberland, MD-WV	0.9590	0.9454	0.9317
	Allegany County, MD.			
	Mineral County, WV.			
19124	Dallas-Plano-Irving, TX	1.0137	1.0182	1.0228
	Collin County, TX.			
	Dallas County, TX.			
	Delta County, TX.			
	Denton County, TX.			
	Ellis County, TX.			
	Hunt County, TX.			
	Kaufman County, TX.			
	Rockwall County, TX.			
19140	Dalton, GA	0.9447	0.9263	0.9079
	Murray County, GA.			
	Whitfield County, GA.			
19180	Danville, IL	0.9417	0.9222	0.9028
	Vermilion County, IL.			
19260	Danville, VA	0.9093	0.8791	0.8489
	Pittsylvania County, VA.			
	Danville City, VA.			
19340	Davenport-Moline-Rock Island, IA-IL	0.9234	0.8979	0.8724
	Henry County, IL.			
	Mercer County, IL.			
	Rock Island County, IL.			
	Scott County, IA.			
19380	Dayton, OH	0.9438	0.9251	0.9064
	Greene County, OH.			
	Miami County, OH.			
	Montgomery County, OH.			
	Preble County, OH.			
19460	Decatur, AL	0.9081	0.8775	0.8469
	Lawrence County, AL.			
	Morgan County, AL.			
19500	Decatur, IL	0.8840	0.8454	0.8067
	Macon County, IL.			
19660	Deltona-Daytona Beach-Ormond Beach, FL	0.9579	0.9439	0.9299
	Volusia County, FL.			
19740	Denver-Aurora, CO	1.0434	1.0578	1.0723
	Adams County, CO.			
	Arapahoe County, CO.			
	Broomfield County, CO.			
	Clear Creek County, CO.			
	Denver County, CO.			
	Douglas County, CO.			
	Elbert County, CO.			
	Gilpin County, CO.			
	Jefferson County, CO.			
	Park County, CO.			
19780	Des Moines,-West Des Moines, IA	0.9801	0.9735	0.9669
	Dallas County, IA.			
	Guthrie County, IA.			
	Madison County, IA.			
	Polk County, IA.			
	Warren County, IA.			
19804	Detroit-Livonia-Dearborn, MI	1.0254	1.0339	1.0424
	Wayne County, MI.			

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2006 THROUGH JUNE 30, 2007[1]—Continued

BSA code			
CBSA code	Urban area (constituent counties)	3/5 wage index[2]	4/5 wage index[3]	Full wage index[4]
20020	Dothan, AL	0.8633	0.8177	0.7721
	Geneva County, AL.			
	Henry County, AL.			
	Houston County, AL.			
20100	Dover, DE	0.9866	0.9821	0.9776
	Kent County, DE.			
20220	Dubuque, IA	0.9414	0.9219	0.9024
	Dubuque County, IA.			
20260	Duluth, MN-WI	1.0128	1.0170	1.0213
	Carlton County, MN.			
	St. Louis County, MN.			
	Douglas County, WI.			
20500	Durham, NC	1.0146	1.0195	1.0244
	Chatham County, NC.			
	Durham County, NC.			
	Orange County, NC.			
	Person County, NC.			
20740	Eau Claire, WI	0.9521	0.9361	0.9201
	Chippewa County, WI.			
	Eau Claire County, WI.			
20764	Edison, NJ	1.0749	1.0999	1.1249
	Middlesex County, NJ.			
	Monmouth County, NJ.			
	Ocean County, NJ.			
	Somerset County, NJ.			
20940	El Centro, CA	0.9344	0.9125	0.8906
	Imperial County, CA.			
21060	Elizabethtown, KY	0.9281	0.9042	0.8802
	Hardin County, KY.			
	Larue County, KY.			
21140	Elkhart-Goshen, IN	0.9776	0.9702	0.9627
	Elkhart County, IN.			
21300	Elmira, NY	0.8950	0.8600	0.8250
	Chemung County, NY.			
21340	El Paso, TX	0.9386	0.9182	0.8977
	El Paso County, TX.			
21500	Erie, PA	0.9242	0.8990	0.8737
	Erie County, PA.			
21604	Essex County, MA	1.0323	1.0430	1.0538
	Essex County, MA.			
21660	Eugene-Springfield, OR	1.0491	1.0654	1.0818
	Lane County, OR.			
21780	Evansville, IN-KY	0.9228	0.8970	0.8713
	Gibson County, IN.			
	Posey County, IN.			
	Vanderburgh County, IN.			
	Warrick County, IN.			
	Henderson County, KY.			
	Webster County, KY.			
21820	Fairbanks, AK	1.0845	1.1126	1.1408
	Fairbanks North Star Borough, AK.			
21940	Fajardo, PR	0.6492	0.5322	0.4153
	Ceiba Municipio, PR.			
	Fajardo Municipio, PR.			
	Luquillo Municipio, PR.			
22020	Fargo, ND-MN	0.9092	0.8789	0.8486
	Cass County, ND.			
	Clay County, MN.			
22140	Farmington, NM	0.9105	0.8807	0.8509
	San Juan County, NM.			
22180	Fayetteville, NC	0.9650	0.9533	0.9416
	Cumberland County, NC.			
	Hoke County, NC.			
22220	Fayetteville-Springdale-Rogers, AR-MO	0.9197	0.8929	0.8661
	Benton County, AR.			
	Madison County, AR.			
	Washington County, AR.			
	McDonald County, MO.			

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2006 THROUGH JUNE 30, 2007[1]—Continued

BSA code

CBSA code	Urban area (constituent counties)	3/5 wage index[2]	4/5 wage index[3]	Full wage index[4]
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. 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.	0.9690	0.9586	0.9483

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2006 THROUGH JUNE 30, 2007[1]—Continued

BSA code				
CBSA code	Urban area (constituent counties)	3/5 wage index[2]	4/5 wage index[3]	Full wage index[4]
	Kewaunee County, WI.			
	Oconto County, WI.			
24660	Greensboro-High Point, NC	0.9462	0.9283	0.9104
	Guilford County, NC.			
	Randolph County, NC.			
	Rockingham County, NC.			
24780	Greenville, NC	0.9655	0.9540	0.9425
	Greene County, NC.			
	Pitt County, NC.			
24860	Greenville, SC	1.0016	1.0022	1.0027
	Greenville County, SC.			
	Laurens County, SC.			
	Pickens County, SC.			
25020	Guayama, PR	0.5909	0.4545	0.3181
	Arroyo Municipio, PR.			
	Guayama Municipio, PR.			
	Patillas Municipio, PR.			
25060	Gulfport-Biloxi, MS	0.9357	0.9143	0.8929
	Hancock County, MS.			
	Harrison County, MS.			
	Stone County, MS.			
25180	Hagerstown-Martinsburg, MD-WV	0.9693	0.9591	0.9489
	Washington County, MD.			
	Berkeley County, WV.			
	Morgan County, WV.			
25260	Hanford-Corcoran, CA	1.0022	1.0029	1.0036
	Kings County, CA.			
25420	Harrisburg-Carlisle, PA	0.9588	0.9450	0.9313
	Cumberland County, PA.			
	Dauphin County, PA.			
	Perry County, PA.			
25500	Harrisonburg, VA	0.9453	0.9270	0.9088
	Rockingham County, VA.			
	Harrisonburg City, VA.			
25540	Hartford-West Hartford-East Hartford, CT	1.0644	1.0858	1.1073
	Hartford County, CT.			
	Litchfield County, CT.			
	Middlesex County, CT.			
	Tolland County, CT.			
25620	Hattiesburg, MS	0.8561	0.8081	0.7601
	Forrest County, MS.			
	Lamar County, MS.			
	Perry County, MS.			
25860	Hickory-Lenoir-Morganton, NC	0.9353	0.9137	0.8921
	Alexander County, NC.			
	Burke County, NC.			
	Caldwell County, NC.			
	Catawba County, NC.			
25980	Hinesville-Fort Stewart, GA	0.8597	0.8130	0.7662
	Liberty County, GA.			
	Long County, GA.			
26100	Holland-Grand Haven, MI	0.9433	0.9244	0.9055
	Ottawa County, MI.			
26180	Honolulu, HI	1.0728	1.0971	1.1214
	Honolulu County, HI.			
26300	Hot Springs, AR	0.9403	0.9204	0.9005
	Garland County, AR.			
26380	Houma-Bayou Cane-Thibodaux, LA	0.8736	0.8315	0.7894
	Lafourche Parish, LA.			
	Terrebonne Parish, LA.			
26420	Houston-Sugar Land-Baytown, TX	0.9998	0.9997	0.9996
	Austin County, TX.			
	Brazoria County, TX.			
	Chambers County, TX.			
	Fort Bend County, TX.			
	Galveston County, TX.			
	Harris County, TX.			
	Liberty County, TX.			

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2006 THROUGH JUNE 30, 2007[1]—Continued

BSA code				
CBSA code	Urban area (constituent counties)	3/5 wage index[2]	4/5 wage index[3]	Full wage index[4]
	Montgomery County, TX.			
	San Jacinto County, TX.			
	Waller County, TX.			
26580	Huntington-Ashland, WV-KY-OH	0.9686	0.9582	0.9477
	Boyd County, KY.			
	Greenup County, KY.			
	Lawrence County, OH.			
	Cabell County, WV.			
	Wayne County, WV.			
26620	Huntsville, AL	0.9488	0.9317	0.9146
	Limestone County, AL.			
	Madison County, AL.			
26820	Idaho Falls, ID	0.9652	0.9536	0.9420
	Bonneville County, ID.			
	Jefferson County, ID.			
26900	Indianapolis-Carmel, IN	0.9952	0.9936	0.9920
	Boone County, IN.			
	Brown County, IN.			
	Hamilton County, IN.			
	Hancock County, IN.			
	Hendricks County, IN.			
	Johnson County, IN.			
	Marion County, IN.			
	Morgan County, IN.			
	Putnam County, IN.			
	Shelby County, IN.			
26980	Iowa City, IA	0.9848	0.9798	0.9747
	Johnson County, IA.			
	Washington County, IA.			
27060	Ithaca, NY	0.9876	0.9834	0.9793
	Tompkins County, NY.			
27100	Jackson, MI	0.9582	0.9443	0.9304
	Jackson County, MI.			
27140	Jackson, MS	0.8987	0.8649	0.8311
	Copiah County, MS.			
	Hinds County, MS.			
	Madison County, MS.			
	Rankin County, MS.			
	Simpson County, MS.			
27180	Jackson, TN	0.9378	0.9171	0.8964
	Chester County, TN.			
	Madison County, TN.			
27260	Jacksonville, FL	0.9574	0.9432	0.9290
	Baker County, FL.			
	Clay County, FL.			
	Duval County, FL.			
	Nassau County, FL.			
	St. Johns County, FL.			
27340	Jacksonville, NC	0.8942	0.8589	0.8236
	Onslow County, NC.			
27500	Janesville, WI	0.9723	0.9630	0.9538
	Rock County, WI.			
27620	Jefferson City, MO	0.9032	0.8710	0.8387
	Callaway County, MO.			
	Cole County, MO.			
	Moniteau County, MO.			
	Osage County, MO.			
27740	Johnson City, TN	0.8762	0.8350	0.7937
	Carter County, TN.			
	Unicoi County, TN.			
	Washington County, TN.			
27780	Johnstown, PA	0.9012	0.8683	0.8354
	Cambria County, PA.			
27860	Jonesboro, AR	0.8747	0.8329	0.7911
	Craighead County, AR.			
	Poinsett County, AR.			
27900	Joplin, MO	0.9149	0.8866	0.8582
	Jasper County, MO.			

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2006 THROUGH JUNE 30, 2007[1]—Continued

BSA code

CBSA code	Urban area (constituent counties)	3/5 wage index[2]	4/5 wage index[3]	Full wage index[4]
	Newton County, MO.			
28020	Kalamazoo-Portage, MI	1.0229	1.0305	1.0381
	Kalamazoo County, MI.			
	Van Buren County, MI.			
28100	Kankakee-Bradley, IL	1.0433	1.0577	1.0721
	Kankakee County, IL.			
28140	Kansas City, MO-KS	0.9686	0.9581	0.9476
	Franklin County, KS.			
	Johnson County, KS.			
	Leavenworth County, KS.			
	Linn County, KS.			
	Miami County, KS.			
	Wyandotte County, KS.			
	Bates County, MO.			
	Caldwell County, MO.			
	Cass County, MO.			
	Clay County, MO.			
	Clinton County, MO.			
	Jackson County, MO.			
	Lafayette County, MO.			
	Platte County, MO.			
	Ray County, MO.			
28420	Kennewick-Richland-Pasco, WA	1.0371	1.0495	1.0619
	Benton County, WA.			
	Franklin County, WA.			
28660	Killeen-Temple-Fort Hood, TX	0.9116	0.8821	0.8526
	Bell County, TX.			
	Coryell County, TX.			
	Lampasas County, TX.			
28700	Kingsport-Bristol-Bristol, TN-VA	0.8832	0.8443	0.8054
	Hawkins County, TN.			
	Sullivan County, TN.			
	Bristol City, VA.			
	Scott County, VA.			
	Washington County, VA.			
28740	Kingston, NY	0.9553	0.9404	0.9255
	Ulster County, NY.			
28940	Knoxville, TN	0.9065	0.8753	0.8441
	Anderson County, TN.			
	Blount County, TN.			
	Knox County, TN.			
	Loudon County, TN.			
	Union County, TN.			
29020	Kokomo, IN	0.9705	0.9606	0.9508
	Howard County, IN.			
	Tipton County, IN.			
29100	La Crosse, WI-MN	0.9738	0.9651	0.9564
	Houston County, MN.			
	La Crosse County, WI.			
29140	Lafayette, IN	0.9242	0.8989	0.8736
	Benton County, IN.			
	Carroll County, IN.			
	Tippecanoe County, IN.			
29180	Lafayette, LA	0.9057	0.8742	0.8428
	Lafayette Parish, LA.			
	St. Martin Parish, LA.			
29340	Lake Charles, LA	0.8700	0.8266	0.7833
	Calcasieu Parish, LA.			
	Cameron Parish, LA.			
29404	Lake County-Kenosha County, IL-WI	1.0257	1.0343	1.0429
	Lake County, IL.			
	Kenosha County, WI.			
29460	Lakeland, FL	0.9347	0.9130	0.8912
	Polk County, FL.			
29540	Lancaster, PA	0.9816	0.9755	0.9694
	Lancaster County, PA.			
29620	Lansing-East Lansing, MI	0.9876	0.9835	0.9794
	Clinton County, MI.			

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2006 THROUGH JUNE 30, 2007[1]—Continued

BSA code

CBSA code	Urban area (constituent counties)	3/5 wage index[2]	4/5 wage index[3]	Full wage index[4]
	Eaton County, MI.			
	Ingham County, MI.			
29700	Laredo, TX	0.8841	0.8454	0.8068
	Webb County, TX.			
29740	Las Cruces, NM	0.9080	0.8774	0.8467
	Dona Ana County, NM.			
29820	Las Vegas-Paradise, NV	1.0862	1.1150	1.1437
	Clark County, NV.			
29940	Lawrence, KS	0.9122	0.8830	0.8537
	Douglas County, KS.			
30020	Lawton, OK	0.8723	0.8298	0.7872
	Comanche County, OK.			
30140	Lebanon, PA	0.9075	0.8767	0.8459
	Lebanon County, PA.			
30300	Lewiston, ID-WA	0.9932	0.9909	0.9886
	Nez Perce County, ID.			
	Asotin County, WA.			
30340	Lewiston-Auburn, ME	0.9599	0.9465	0.9331
	Androscoggin County, ME.			
30460	Lexington-Fayette, KY	0.9445	0.9260	0.9075
	Bourbon County, KY.			
	Clark County, KY.			
	Fayette County, KY.			
	Jessamine County, KY.			
	Scott County, KY.			
	Woodford County, KY.			
30620	Lima, OH	0.9535	0.9380	0.9225
	Allen County, OH.			
30700	Lincoln, NE1.0128	1.0171	1.0214	
	Lancaster County, NE.			
	Seward County, NE.			
30780	Little Rock-North Little Rock, AR	0.9248	0.8998	0.8747
	Faulkner County, AR.			
	Grant County, AR.			
	Lonoke County, AR.			
	Perry County, AR.			
	Pulaski County, AR.			
	Saline County, AR.			
30860	Logan, UT-ID	0.9498	0.9331	0.9164
	Franklin County, ID.			
	Cache County, UT.			
30980	Longview, TX	0.9238	0.8984	0.8730
	Gregg County, TX.			
	Rusk County, TX.			
	Upshur County, TX.			
31020	Longview, WA	0.9747	0.9663	0.9579
	Cowlitz County, WA.			
31084	Los Angeles-Long Beach-Glendale, CA	1.1070	1.1426	1.1783
	Los Angeles County, CA.			
31140	Louisville-Jefferson County, KY-IN	0.9551	0.9401	0.9251
	Clark County, IN.			
	Floyd County, IN.			
	Harrison County, IN.			
	Washington County, IN.			
	Bullitt County, KY.			
	Henry County, KY.			
	Jefferson County, KY.			
	Meade County, KY.			
	Nelson County, KY.			
	Oldham County, KY.			
	Shelby County, KY.			
	Spencer County, KY.			
	Trimble County, KY.			
31180	Lubbock, TX	0.9270	0.9026	0.8783
	Crosby County, TX.			
	Lubbock County, TX.			
31340	Lynchburg, VA	0.9215	0.8953	0.8691
	Amherst County, VA.			

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2006 THROUGH JUNE 30, 2007[1]—Continued

BSA code

CBSA code	Urban area (constituent counties)	3/5 wage index[2]	4/5 wage index[3]	Full wage index[4]
	Appomattox County, VA.			
	Bedford County, VA.			
	Campbell County, VA.			
	Bedford City, VA.			
	Lynchburg City, VA.			
31420	Macon, GA	0.9666	0.9554	0.9443
	Bibb County, GA.			
	Crawford County, GA.			
	Jones County, GA.			
	Monroe County, GA.			
	Twiggs County, GA.			
31460	Madera, CA	0.9228	0.8970	0.8713
	Madera County, CA.			
31540	Madison, WI	1.0395	1.0527	1.0659
	Columbia County, WI.			
	Dane County, WI.			
	Iowa County, WI.			
31700	Manchester-Nashua, NH	1.0212	1.0283	1.0354
	Hillsborough County, NH.			
	Merrimack County, NH.			
31900	Mansfield, OH	0.9935	0.9913	0.9891
	Richland County, OH.			
32420	Mayagüez, PR	0.6412	0.5216	0.4020
	Hormigueros Municipio, PR.			
	Mayagüez Municipio, PR.			
32580	McAllen-Edinburg-Mission, TX	0.9360	0.9147	0.8934
	Hidalgo County, TX.			
32780	Medford, OR	1.0135	1.0180	1.0225
	Jackson County, OR.			
32820	Memphis, TN-MS-AR	0.9638	0.9518	0.9397
	Crittenden County, AR.			
	DeSoto County, MS.			
	Marshall County, MS.			
	Tate County, MS.			
	Tunica County, MS.			
	Fayette County, TN.			
	Shelby County, TN.			
	Tipton County, TN.			
32900	Merced, CA	1.0665	1.0887	1.1109
	Merced County, CA.			
33124	Miami-Miami Beach-Kendall, FL	0.9850	0.9800	0.9750
	Miami-Dade County, FL.			
33140	Michigan City-La Porte, IN	0.9639	0.9519	0.9399
	LaPorte County, IN.			
33260	Midland, TX	0.9708	0.9611	0.9514
	Midland County, TX.			
33340	Milwaukee-Waukesha-West Allis, WI	1.0088	1.0117	1.0146
	Milwaukee County, WI.			
	Ozaukee County, WI.			
	Washington County, WI.			
	Waukesha County, WI.			
33460	Minneapolis-St. Paul-Bloomington, MN-WI	1.0645	1.0860	1.1075
	Anoka County, MN.			
	Carver County, MN.			
	Chisago County, MN.			
	Dakota County, MN.			
	Hennepin County, MN.			
	Isanti County, MN.			
	Ramsey County, MN.			
	Scott County, MN.			
	Sherburne County, MN.			
	Washington County, MN.			
	Wright County, MN.			
	Pierce County, WI.			
	St. Croix County, WI.			
33540	Missoula, MT	0.9684	0.9578	0.9473
	Missoula County, MT.			
33660	Mobile, AL	0.8735	0.8313	0.7891

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2006 THROUGH JUNE 30, 2007[1]—Continued

BSA code

CBSA code	Urban area (constituent counties)	3/5 wage index[2]	4/5 wage index[3]	Full wage index[4]
	Mobile County, AL.			
33700	Modesto, CA	1.1131	1.1508	1.1885
	Stanislaus County, CA.			
33740	Monroe, LA	0.8819	0.8425	0.8031
	Ouachita Parish, LA.			
	Union Parish, LA.			
33780	Monroe, MI	0.9681	0.9574	0.9468
	Monroe County, MI.			
33860	Montgomery, AL	0.9171	0.8894	0.8618
	Autauga County, AL.			
	Elmore County, AL.			
	Lowndes County, AL.			
	Montgomery County, AL.			
34060	Morgantown, WV	0.9052	0.8736	0.8420
	Monongalia County, WV.			
	Preston County, WV.			
34100	Morristown, TN	0.8777	0.8369	0.7961
	Grainger County, TN.			
	Hamblen County, TN.			
	Jefferson County, TN.			
34580	Mount Vernon-Anacortes, WA	1.0272	1.0363	1.0454
	Skagit County, WA.			
34620	Muncie, IN	0.9358	0.9144	0.8930
	Delaware County, IN.			
34740	Muskegon-Norton Shores, MI	0.9798	0.9731	0.9664
	Muskegon County, MI.			
34820	Myrtle Beach-Conway-North Myrtle Beach, SC	0.9360	0.9147	0.8934
	Horry County, SC 34900 Napa, CA	1.1586	1.2114	1.2643
	Napa County, CA.			
34940	Naples-Marco Island, FL	1.0083	1.0111	1.0139
	Collier County, FL.			
34980	Nashville-Davidson--Murfreesboro, TN	0.9874	0.9832	0.9790
	Cannon County, TN.			
	Cheatham County, TN.			
	Davidson County, TN.			
	Dickson County, TN.			
	Hickman County, TN.			
	Macon County, TN.			
	Robertson County, TN.			
	Rutherford County, TN.			
	Smith County, TN.			
	Sumner County, TN.			
	Trousdale County, TN.			
	Williamson County, TN.			
	Wilson County, TN.			
35004	Nassau-Suffolk, NY	1.1631	1.2175	1.2719
	Nassau County, NY.			
	Suffolk County, NY.			
35084	Newark-Union, NJ-PA	1.1130	1.1506	1.1883
	Essex County, NJ.			
	Hunterdon County, NJ.			
	Morris County, NJ.			
	Sussex County, NJ.			
	Union County, NJ.			
	Pike County, PA.			
35300	New Haven-Milford, CT	1.1132	1.1510	1.1887
	New Haven County, CT.			
35380	New Orleans-Metairie-Kenner, LA	0.9397	0.9196	0.8995
	Jefferson Parish, LA.			
	Orleans Parish, LA.			
	Plaquemines Parish, LA.			
	St. Bernard Parish, LA.			
	St. Charles Parish, LA.			
	St. John the Baptist Parish, LA.			
	St. Tammany Parish, LA.			
35644	New York-White Plains-Wayne, NY-NJ	1.1913	1.2550	1.3188
	Bergen County, NJ.			
	Hudson County, NJ.			

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2006 THROUGH JUNE 30, 2007[1]—Continued

BSA code CBSA code	Urban area (constituent counties)	3/5 wage index[2]	4/5 wage index[3]	Full wage index[4]
	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.			
35660	Niles-Benton Harbor, MI	0.9327	0.9103	0.8879
	Berrien County, MI.			
35980	Norwich-New London, CT	1.0807	1.1076	1.1345
	New London County, CT.			
36084	Oakland-Fremont-Hayward, CA	1.3208	1.4277	1.5346
	Alameda County, CA.			
	Contra Costa County, CA.			
36100	Ocala, FL	0.9355	0.9140	0.8925
	Marion County, FL.			
36140	Ocean City, NJ	1.0607	1.0809	1.1011
	Cape May County, NJ.			
36220	Odessa, TX	0.9930	0.9907	0.9884
	Ector County, TX.			
36260	Ogden-Clearfield, UT	0.9417	0.9223	0.9029
	Davis County, UT.			
	Morgan County, UT.			
	Weber County, UT.			
36420	Oklahoma City, OK	0.9419	0.9225	0.9031
	Canadian County, OK.			
	Cleveland County, OK.			
	Grady County, OK.			
	Lincoln County, OK.			
	Logan County, OK.			
	McClain County, OK.			
	Oklahoma County, OK.			
36500	Olympia, WA	1.0556	1.0742	1.0927
	Thurston County, WA.			
36540	Omaha-Council Bluffs, NE-IA	0.9736	0.9648	0.9560
	Harrison County, IA.			
	Mills County, IA.			
	Pottawattamie County, IA.			
	Cass County, NE.			
	Douglas County, NE.			
	Sarpy County, NE.			
	Saunders County, NE.			
	Washington County, NE.			
36740	Orlando-Kissimmee, FL	0.9678	0.9571	0.9464
	Lake County, FL.			
	Orange County, FL.			
	Osceola County, FL.			
	Seminole County, FL.			
36780	Oshkosh-Neenah, WI	0.9510	0.9346	0.9183
	Winnebago County, WI.			
36980	Owensboro, KY	0.9268	0.9024	0.8780
	Daviess County, KY.			
	Hancock County, KY.			
	McLean County, KY.			
37100	Oxnard-Thousand Oaks-Ventura, CA	1.0973	1.1298	1.1622
	Ventura County, CA.			
37340	Palm Bay-Melbourne-Titusville, FL	0.9903	0.9871	0.9839
	Brevard County, FL.			
37460	Panama City-Lynn Haven, FL	0.8803	0.8404	0.8005
	Bay County, FL.			
37620	Parkersburg-Marietta-Vienna, WV-OH	0.8962	0.8616	0.8270
	Washington County, OH.			
	Pleasants County, WV.			
	Wirt County, WV.			
	Wood County, WV.			
37700	Pascagoula, MS	0.8894	0.8525	0.8156

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2006 THROUGH JUNE 30, 2007[1]—Continued

BSA code

CBSA code	Urban area (constituent counties)	3/5 wage index[2]	4/5 wage index[3]	Full wage index[4]
	George County, MS.			
	Jackson County, MS.			
37860	Pensacola-Ferry Pass-Brent, FL	0.8858	0.8477	0.8096
	Escambia County, FL.			
	Santa Rosa County, FL.			
37900	Peoria, IL	0.9322	0.9096	0.8870
	Marshall County, IL.			
	Peoria County, IL.			
	Stark County, IL.			
	Tazewell County, IL.			
	Woodford County, IL.			
37964	Philadelphia, PA	1.0623	1.0830	1.1038
	Bucks County, PA.			
	Chester County, PA.			
	Delaware County, PA.			
	Montgomery County, PA.			
	Philadelphia County, PA.			
38060	Phoenix-Mesa-Scottsdale, AZ	1.0076	1.0102	1.0127
	Maricopa County, AZ.			
	Pinal County, AZ.			
38220	Pine Bluff, AR	0.9208	0.8944	0.8680
	Cleveland County, AR.			
	Jefferson County, AR.			
	Lincoln County, AR.			
38300	Pittsburgh, PA	0.9307	0.9076	0.8845
	Allegheny County, PA.			
	Armstrong County, PA.			
	Beaver County, PA.			
	Butler County, PA.			
	Fayette County, PA.			
	Washington County, PA.			
	Westmoreland County, PA.			
38340	Pittsfield, MA	1.0109	1.0145	1.0181
	Berkshire County, MA.			
38540	Pocatello, ID	0.9611	0.9481	0.9351
	Bannock County, ID.			
	Power County, ID.			
38660	Ponce, PR	0.6963	0.5951	0.4939
	Juana Díaz Municipio, PR.			
	Ponce Municipio, PR.			
	Villalba Municipio, PR.			
38860	Portland-South Portland-Biddeford, ME	1.0229	1.0306	1.0382
	Cumberland County, ME.			
	Sagadahoc County, ME.			
	York County, ME.			
38900	Portland-Vancouver-Beaverton, OR-WA	1.0760	1.1013	1.1266
	Clackamas County, OR.			
	Columbia County, OR.			
	Multnomah County, OR.			
	Washington County, OR.			
	Yamhill County, OR.			
	Clark County, WA.			
	Skamania County, WA.			
38940	Port St. Lucie-Fort Pierce, FL	1.0074	1.0098	1.0123
	Martin County, FL.			
	St. Lucie County, FL.			
39100	Poughkeepsie-Newburgh-Middletown,	1.0535	1.0713	1.0891
				NY
	Dutchess County, NY.			
	Orange County, NY.			
39140	Prescott, AZ	0.9921	0.9895	0.9869
	Yavapai County, AZ.			
39300	Providence-New Bedford-Fall River, RI-MA	1.0580	1.0773	1.0966
	Bristol County, MA.			
	Bristol County, RI.			
	Kent County, RI.			
	Newport County, RI.			
	Providence County, RI.			

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2006 THROUGH JUNE 30, 2007[1]—Continued

BSA code

CBSA code	Urban area (constituent counties)	3/5 wage index[2]	4/5 wage index[3]	Full wage index[4]
	Washington County, RI.			
39340	Provo-Orem, UT	0.9700	0.9600	0.9500
	Juab County, UT.			
	Utah County, UT.			
39380	Pueblo, CO	0.9174	0.8898	0.8623
	Pueblo County, CO.			
39460	Punta Gorda, FL	0.9553	0.9404	0.9255
	Charlotte County, FL.			
39540	Racine, WI	0.9398	0.9198	0.8997
	Racine County, WI.			
39580	Raleigh-Cary, NC	0.9815	0.9753	0.9691
	Franklin County, NC.			
	Johnston County, NC.			
	Wake County, NC.			
39660	Rapid City, SD	0.9392	0.9190	0.8987
	Meade County, SD.			
	Pennington County, SD.			
39740	Reading, PA	0.9812	0.9749	0.9686
	Berks County, PA.			
39820	Redding, CA	1.1322	1.1762	1.2203
	Shasta County, CA.			
39900	Reno-Sparks, NV	1.0589	1.0786	1.0982
	Storey County, NV.			
	Washoe County, NV.			
40060	Richmond, VA	0.9597	0.9462	0.9328
	Amelia County, VA.			
	Caroline County, VA.			
	Charles City County, VA.			
	Chesterfield County, VA.			
	Cumberland County, VA.			
	Dinwiddie County, VA.			
	Goochland County, VA.			
	Hanover County, VA.			
	Henrico County, VA.			
	King and Queen County, VA.			
	King William County, VA.			
	Louisa County, VA.			
	New Kent County, VA.			
	Powhatan County, VA.			
	Prince George County, VA.			
	Sussex County, VA.			
	Colonial Heights City, VA.			
	Hopewell City, VA.			
	Petersburg City, VA.			
	Richmond City, VA.			
40140	Riverside-San Bernardino-Ontario, CA	1.0616	1.0822	1.1027
	Riverside County, CA.			
	San Bernardino County, CA.			
40220	Roanoke, VA	0.9024	0.8699	0.8374
	Botetourt County, VA.			
	Craig County, VA.			
	Franklin County, VA.			
	Roanoke County, VA.			
	Roanoke City, VA.			
	Salem City, VA.			
40340	Rochester, MN	1.0679	1.0905	1.1131
	Dodge County, MN.			
	Olmsted County, MN.			
	Wabasha County, MN.			
40380	Rochester, NY	0.9473	0.9297	0.9121
	Livingston County, NY.			
	Monroe County, NY.			
	Ontario County, NY.			
	Orleans County, NY.			
	Wayne County, NY.			
40420	Rockford, IL	0.9990	0.9987	0.9984
	Boone County, IL.			
	Winnebago County, IL.			

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2006 THROUGH JUNE 30, 2007[1]—Continued

BSA code

CBSA code	Urban area (constituent counties)	3/5 wage index[2]	4/5 wage index[3]	Full wage index[4]
40484	Rockingham County-Strafford County, NH	1.0224	1.0299	1.0374
	Rockingham County, NH.			
	Strafford County, NH.			
40580	Rocky Mount, NC	0.9349	0.9132	0.8915
	Edgecombe County, NC.			
	Nash County, NC.			
40660	Rome, GA	0.9648	0.9531	0.9414
	Floyd County, GA.			
40900	Sacramento--Arden-Arcade--Roseville, CA	1.1781	1.2375	1.2969
	El Dorado County, CA.			
	Placer County, CA.			
	Sacramento County, CA.			
	Yolo County, CA.			
40980	Saginaw-Saginaw Township North, MI	0.9453	0.9270	0.9088
	Saginaw County, MI.			
41060	St. Cloud, MN	0.9979	0.9972	0.9965
	Benton County, MN.			
	Stearns County, MN.			
41100	St. George, UT	0.9635	0.9514	0.9392
	Washington County, UT.			
41140	St. Joseph, MO-KS	0.9711	0.9615	0.9519
	Doniphan County, KS.			
	Andrew County, MO.			
	Buchanan County, MO.			
	DeKalb County, MO.			
41180	St. Louis, MO-IL	0.9372	0.9163	0.8954
	Bond County, IL.			
	Calhoun County, IL.			
	Clinton County, IL.			
	Jersey County, IL.			
	Macoupin County, IL.			
	Madison County, IL.			
	Monroe County, IL.			
	St. Clair County, IL.			
	Crawford County, MO.			
	Franklin County, MO.			
	Jefferson County, MO.			
	Lincoln County, MO.			
	St. Charles County, MO.			
	St. Louis County, MO.			
	Warren County, MO.			
	Washington County, MO.			
	St. Louis City, MO.			
41420	Salem, OR	1.0265	1.0354	1.0442
	Marion County, OR.			
	Polk County, OR.			
41500	Salinas, CA	1.2477	1.3302	1.4128
	Monterey County, CA.			
41540	Salisbury, MD	0.9438	0.9251	0.9064
	Somerset County, MD.			
	Wicomico County, MD.			
41620	Salt Lake City, UT	0.9653	0.9537	0.9421
	Salt Lake County, UT.			
	Summit County, UT.			
	Tooele County, UT.			
41660	San Angelo, TX	0.8963	0.8617	0.8271
	Irion County, TX.			
	Tom Green County, TX.			
41700	San Antonio, TX	0.9388	0.9184	0.8980
	Atascosa County, TX.			
	Bandera County, TX.			
	Bexar County, TX.			
	Comal County, TX.			
	Guadalupe County, TX.			
	Kendall County, TX.			
	Medina County, TX.			
	Wilson County, TX.			
41740	San Diego-Carlsbad-San Marcos, CA	1.0848	1.1130	1.1413

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2006 THROUGH JUNE 30, 2007[1]—Continued

BSA code			
CBSA code	Urban area (constituent counties)	3/5 wage index[2]	4/5 wage index[3]	Full wage index[4]
	San Diego County, CA.			
41780	Sandusky, OH	0.9411	0.9215	0.9019
	Erie County, OH.			
41884	San Francisco-San Mateo-Redwood City, CA	1.2996	1.3995	1.4994
	Marin County, CA.			
	San Francisco County, CA.			
	San Mateo County, CA.			
41900	San Germán-Cabo Rojo, PR	0.6790	0.5720	0.4650
	Cabo Rojo Municipio, PR.			
	Lajas Municipio, PR.			
	Sabana Grande Municipio, PR.			
	San Germán Municipio, PR.			
41940	San Jose-Sunnyvale-Santa Clara, CA	1.3059	1.4079	1.5099
	San Benito County, CA.			
	Santa Clara County, CA.			
41980	San Juan-Caguas-Guaynabo, PR	0.6773	0.5697	0.4621
	Aguas Buenas Municipio, PR.			
	Aibonito Municipio, PR.			
	Arecibo Municipio, PR.			
	Barceloneta Municipio, PR.			
	Barranquitas Municipio, PR.			
	Bayamón Municipio, PR.			
	Caguas Municipio, PR.			
	Camuy Municipio, PR.			
	Canóvanas Municipio, PR.			
	Carolina Municipio, PR.			
	Cataño Municipio, PR.			
	Cayey Municipio, PR.			
	Ciales Municipio, PR.			
	Cidra Municipio, PR.			
	Comerío Municipio, PR.			
	Corozal Municipio, PR.			
	Dorado Municipio, PR.			
	Florida Municipio, PR.			
	Guaynabo Municipio, PR.			
	Gurabo Municipio, PR.			
	Hatillo Municipio, PR.			
	Humacao Municipio, PR.			
	Juncos Municipio, PR.			
	Las Piedras Municipio, PR.			
	Loíza Municipio, PR.			
	Manatí Municipio, PR.			
	Maunabo Municipio, PR.			
	Morovis Municipio, PR.			
	Naguabo Municipio, PR.			
	Naranjito Municipio, PR.			
	Orocovis Municipio, PR.			
	Quebradillas Municipio, PR.			
	Río Grande Municipio, PR.			
	San Juan Municipio, PR.			
	San Lorenzo Municipio, PR.			
	Toa Alta Municipio, PR.			
	Toa Baja Municipio, PR.			
	Trujillo Alto Municipio, PR.			
	Vega Alta Municipio, PR.			
	Vega Baja Municipio, PR.			
	Yabucoa Municipio, PR.			
42020	San Luis Obispo-Paso Robles, CA	1.0809	1.1079	1.1349
	San Luis Obispo County, CA.			
42044	Santa Ana-Anaheim-Irvine, CA	1.0935	1.1247	1.1559
	Orange County, CA.			
42060	Santa Barbara-Santa Maria, CA	1.1016	1.1355	1.1694
	Santa Barbara County, CA.			
42100	Santa Cruz-Watsonville, CA	1.3100	1.4133	1.5166
	Santa Cruz County, CA.			
42140	Santa Fe, NM	1.0552	1.0736	1.0920
	Santa Fe County, NM.			
42220	Santa Rosa-Petaluma, CA	1.2096	1.2794	1.3493

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2006 THROUGH JUNE 30, 2007[1]—Continued

BSA code				
CBSA code	Urban area (constituent counties)	3/5 wage index[2]	4/5 wage index[3]	Full wage index[4]
	Sonoma County, CA.			
42260	Sarasota-Bradenton-Venice, FL	0.9783	0.9711	0.9639
	Manatee County, FL.			
	Sarasota County, FL.			
42340	Savannah, GA	0.9677	0.9569	0.9461
	Bryan County, GA.			
	Chatham County, GA.			
	Effingham County, GA.			
42540	Scranton--Wilkes-Barre, PA	0.9124	0.8832	0.8540
	Lackawanna County, PA.			
	Luzerne County, PA.			
	Wyoming County, PA.			
42644	Seattle-Bellevue-Everett, WA	1.0946	1.1262	1.1577
	King County, WA.			
	Snohomish County, WA.			
42680	Sebastian-Vero Beach, FL	0.9660	0.9547	0.9434
	Indian River County, FL.			
43100	Sheboygan, WI	0.9347	0.9129	0.8911
	Sheboygan County, WI.			
43300	Sherman-Denison, TX	0.9704	0.9606	0.9507
	Grayson County, TX.			
43340	Shreveport-Bossier City, LA	0.9256	0.9008	0.8760
	Bossier Parish, LA.			
	Caddo Parish, LA.			
	De Soto Parish, LA.			
43580	Sioux City, IA-NE-SD	0.9629	0.9505	0.9381
	Woodbury County, IA.			
	Dakota County, NE.			
	Dixon County, NE.			
	Union County, SD.			
43620	Sioux Falls, SD	0.9781	0.9708	0.9635
	Lincoln County, SD.			
	McCook County, SD.			
	Minnehaha County, SD.			
	Turner County, SD.			
43780	South Bend-Mishawaka, IN-MI	0.9873	0.9830	0.9788
	St. Joseph County, IN.			
	Cass County, MI.			
43900	Spartanburg, SC	0.9503	0.9338	0.9172
	Spartanburg County, SC.			
44060	Spokane, WA	1.0543	1.0724	1.0905
	Spokane County, WA.			
44100	Springfield, IL	0.9275	0.9034	0.8792
	Menard County, IL.			
	Sangamon County, IL.			
44140	Springfield, MA	1.0149	1.0198	1.0248
	Franklin County, MA.			
	Hampden County, MA.			
	Hampshire County, MA.			
44180	Springfield, MO	0.8942	0.8590	0.8237
	Christian County, MO.			
	Dallas County, MO.			
	Greene County, MO.			
	Polk County, MO.			
	Webster County, MO.			
44220	Springfield, OH	0.9038	0.8717	0.8396
	Clark County, OH.			
44300	State College, PA	0.9014	0.8685	0.8356
	Centre County, PA.			
44700	Stockton, CA	1.0784	1.1046	1.1307
	San Joaquin County, CA.			
44940	Sumter, SC	0.9026	0.8702	0.8377
	Sumter County, SC.			
45060	Syracuse, NY	0.9744	0.9659	0.9574
	Madison County, NY.			
	Onondaga County, NY.			
	Oswego County, NY.			
45104	Tacoma, WA	1.0445	1.0594	1.0742

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2006 THROUGH JUNE 30, 2007[1]—Continued

BSA code

CBSA code	Urban area (constituent counties)	3/5 wage index[2]	4/5 wage index[3]	Full wage index[4]
	Pierce County, WA.			
45220	Tallahassee, FL	0.9213	0.8950	0.8688
	Gadsden County, FL.			
	Jefferson County, FL.			
	Leon County, FL.			
	Wakulla County, FL.			
45300	Tampa-St. Petersburg-Clearwater, FL	0.9540	0.9386	0.9233
	Hernando County, FL.			
	Hillsborough County, FL.			
	Pasco County, FL.			
	Pinellas County, FL.			
45460	Terre Haute, IN	0.8982	0.8643	0.8304
	Clay County, IN.			
	Sullivan County, IN.			
	Vermillion County, IN.			
	Vigo County, IN.			
45500	Texarkana, TX-Texarkana, AR	0.8970	0.8626	0.8283
	Miller County, AR.			
	Bowie County, TX.			
45780	Toledo, OH	0.9744	0.9659	0.9574
	Fulton County, OH.			
	Lucas County, OH.			
	Ottawa County, OH.			
	Wood County, OH.			
45820	Topeka, KS	0.9352	0.9136	0.8920
	Jackson County, KS.			
	Jefferson County, KS.			
	Osage County, KS.			
	Shawnee County, KS.			
	Wabaunsee County, KS.			
45940	Trenton-Ewing, NJ	1.0500	1.0667	1.0834
	Mercer County, NJ.			
46060	Tucson, AZ	0.9404	0.9206	0.9007
	Pima County, AZ.			
46140	Tulsa, OK	0.9126	0.8834	0.8543
	Creek County, OK.			
	Okmulgee County, OK.			
	Osage County, OK.			
	Pawnee County, OK.			
	Rogers County, OK.			
	Tulsa County, OK.			
	Wagoner County, OK.			
46220	Tuscaloosa, AL	0.9187	0.8916	0.8645
	Greene County, AL.			
	Hale County, AL.			
	Tuscaloosa County, AL.			
46340	Tyler, TX	0.9501	0.9334	0.9168
	Smith County, TX.			
46540	Utica-Rome, NY	0.9015	0.8686	0.8358
	Herkimer County, NY.			
	Oneida County, NY.			
46660	Valdosta, GA	0.9320	0.9093	0.8866
	Brooks County, GA.			
	Echols County, GA.			
	Lanier County, GA.			
	Lowndes County, GA.			
46700	Vallejo-Fairfield, CA	1.2962	1.3949	1.4936
	Solano County, CA.			
47020	Victoria, TX	0.8896	0.8528	0.8160
	Calhoun County, TX.			
	Goliad County, TX.			
	Victoria County, TX.			
47220	Vineland-Millville-Bridgeton, NJ	0.9896	0.9862	0.9827
	Cumberland County, NJ.			
47260	Virginia Beach-Norfolk-Newport News, VA-NC	0.9279	0.9039	0.8799
	Currituck County, NC.			
	Gloucester County, VA.			
	Isle of Wight County, VA.			

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2006 THROUGH JUNE 30, 2007[1]—Continued

BSA code

CBSA code	Urban area (constituent counties)	3/5 wage index[2]	4/5 wage index[3]	Full wage index[4]
	James City County, VA.			
	Mathews County, VA.			
	Surry County, VA.			
	York County, VA.			
	Chesapeake City, VA.			
	Hampton City, VA.			
	Newport News City, VA.			
	Norfolk City, VA.			
	Poquoson City, VA.			
	Portsmouth City, VA.			
	Suffolk City, VA.			
	Virginia Beach City, VA.			
	Williamsburg City, VA.			
47300	Visalia-Porterville, CA	1.0074	1.0098	1.0123
	Tulare County, CA.			
47380	Waco, TX	0.9111	0.8814	0.8518
	McLennan County, TX.			
47580	Warner Robins, GA	0.9187	0.8916	0.8645
	Houston County, GA.			
47644	Warren-Troy-Farmington Hills, MI	0.9923	0.9897	0.9871
	Lapeer County, MI.			
	Livingston County, MI.			
	Macomb County, MI.			
	Oakland County, MI.			
	St. Clair County, MI.			
47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	1.0556	1.0741	1.0926
	District of Columbia, DC.			
	Calvert County, MD.			
	Charles County, MD.			
	Prince George's County, MD.			
	Arlington County, VA.			
	Clarke County, VA.			
	Fairfax County, VA.			
	Fauquier County, VA.			
	Loudoun County, VA.			
	Prince William County, VA.			
	Spotsylvania County, VA.			
	Stafford County, VA.			
	Warren County, VA.			
	Alexandria City, VA.			
	Fairfax City, VA.			
	Falls Church City, VA.			
	Fredericksburg City, VA.			
	Manassas City, VA.			
	Manassas Park City, VA.			
	Jefferson County, WV.			
47940	Waterloo-Cedar Falls, IA	0.9134	0.8846	0.8557
	Black Hawk County, IA.			
	Bremer County, IA.			
	Grundy County, IA.			
48140	Wausau, WI	0.9754	0.9672	0.9590
	Marathon County, WI.			
48260	Weirton-Steubenville, WV-OH	0.8691	0.8255	0.7819
	Jefferson County, OH.			
	Brooke County, WV.			
	Hancock County, WV.			
48300	Wenatchee, WA	1.0042	1.0056	1.0070
	Chelan County, WA.			
	Douglas County, WA.			
48424	West Palm Beach-Boca Raton-Boynton Beach, FL	1.0040	1.0054	1.0067
	Palm Beach County, FL.			
48540	Wheeling, WV-OH	0.8297	0.7729	0.7161
	Belmont County, OH.			
	Marshall County, WV.			
	Ohio County, WV.			
48620	Wichita, KS	0.9492	0.9322	0.9153
	Butler County, KS.			
	Harvey County, KS.			

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2006 THROUGH JUNE 30, 2007[1]—Continued

BSA code

CBSA code	Urban area (constituent counties)	3/5 wage index[2]	4/5 wage index[3]	Full wage index[4]
	Sedgwick County, KS.			
	Sumner County, KS.			
48660	Wichita Falls, TX	0.8971	0.8628	0.8285
	Archer County, TX.			
	Clay County, TX.			
	Wichita County, TX.			
48700	Williamsport, PA	0.9018	0.8691	0.8364
	Lycoming County, PA.			
48864	Wilmington, DE-MD-NJ	1.0283	1.0377	1.0471
	New Castle County, DE.			
	Cecil County, MD.			
	Salem County, NJ.			
48900	Wilmington, NC	0.9749	0.9666	0.9582
	Brunswick County, NC.			
	New Hanover County, NC.			
	Pender County, NC.			
49020	Winchester, VA-WV	1.0128	1.0171	1.0214
	Frederick County, VA.			
	Winchester City, VA.			
	Hampshire County, WV.			
49180	Winston-Salem, NC	0.9366	0.9155	0.8944
	Davie County, NC.			
	Forsyth County, NC.			
	Stokes County, NC.			
	Yadkin County, NC.			
49340	Worcester, MA	1.0617	1.0822	1.1028
	Worcester County, MA.			
49420	Yakima, WA	1.0093	1.0124	1.0155
	Yakima County, WA.			
49500	Yauco, PR	0.6645	0.5526	0.4408
	Guánica Municipio, PR.			
	Guayanilla Municipio, PR.			
	Peñuelas Municipio, PR.			
	Yauco Municipio, PR.			
49620	York-Hanover, PA	0.9608	0.9478	0.9347
	York County, PA.			
49660	Youngstown-Warren-Boardman, OH-PA	0.9162	0.8882	0.8603
	Mahoning County, OH.			
	Trumbull County, OH.			
	Mercer County, PA.			
49700	Yuba City, CA	1.0553	1.0737	1.0921
	Sutter County, CA.			
	Yuba County, CA.			
49740	Yuma, AZ	0.9476	0.9301	0.9126
	Yuma County, AZ.			

[1] As discussed in section IV.D.1.d. of the preamble of this final 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 final rule.

[2] Three-fifths of the 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 3/5ths 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 final rule.

[3] Four-fifths of the 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 4/5ths 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 final rule.

[4] The 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.—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	3/5ths wage index[2]	4/5ths wage index[3]	Full wage index[4]
01	Alabama	0.8468	0.7957	0.7446

TABLE 2.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR RURAL AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2006 THROUGH JUNE 30, 2007 [1]—Continued

CBSA code	Nonurban area	3/5ths wage index [2]	4/5ths wage index [3]	Full wage index [4]
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 insection IV.D.1.d. of the preamble of this final 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), weare no longer showing the 1/5th and 2/5ths wage index value. For further details on the 5-year phase- in of the wage index, see section IV.D.1. of this final rule.

[2] The 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 in patient waged at a without regard to reclassification under section 1886(d)(8) or section 1886(d)(10) of the Act).

[3] Three-fifths of the 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 3/5ths 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 final rule.

[4] Four-fifths of the 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 4/5ths 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 final rule.

[5] All counties with in the State are classified as urban.

TABLE 3.—FY 2006 LTC–DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY AND FIVE-SIXTHS OF THE 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 avenue length of stay	Five-sixths of the geometric length of stay
1	[5] CRANIOTOMY AGE >17 W CC	1.7034	38.5	32.1
2	[7] CRANIOTOMY AGE >17 W/O CC	1.7034	38.5	32.1
3	[7] CRANIOTOMY AGE 0–17	1.7034	38.5	32.1
6	[7] CARPAL TUNNEL RELEASE	0.4499	19.0	15.8
7	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC	1.3984	37.7	31.4
8	[3] PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC	0.7637	24.8	20.7
9	SPINAL DISORDERS & INJURIES	0.9720	33.7	28.1
10	NERVOUS SYSTEM NEOPLASMS W CC	0.7554	24.5	20.4
11	[2] NERVOUS SYSTEM NEOPLASMS W/O CC	0.5837	21.3	17.8
12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	0.6851	25.5	21.3
13	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	0.6531	23.1	19.3
14	INTERCRANIAL HEMORRHAGE OR STROKE WITH INFARCT	0.7783	26.0	21.7
15	NONSPECIFIC CVA & PRECEREBRAL OCCULUSION WITHOUT INFARCT	0.7314	26.8	22.3
16	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	0.7471	23.5	19.6
17	[1] NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	0.4499	19.0	15.8
18	CRANIAL & PERIPHERAL NERVE DISORDERS W CC	0.7197	23.6	19.7
19	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	0.4773	21.2	17.7
20	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	1.0277	27.2	22.7
21	[3] VIRAL MENINGITIS	0.7637	24.8	20.7
22	[4] HYPERTENSIVE ENCEPHALOPATHY	1.1823	29.6	24.7
23	NONTRAUMATIC STUPOR & COMA	0.8054	25.4	21.2
24	SEIZURE & HEADACHE AGE >17 W CC	0.6251	22.6	18.8
25	[1] SEIZURE & HEADACHE AGE >17 W/O CC	0.4499	19.0	15.8
26	[7] SEIZURE & HEADACHE AGE 0–17	0.4499	19.0	15.8
27	TRAUMATIC STUPOR & COMA, COMA >1 HR	0.9444	27.1	22.6
28	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W CC	0.8890	30.2	25.2
29	[2] TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC	0.5837	21.3	17.8
30	[7] TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0–17	0.5837	21.3	17.8
31	[3] CONCUSSION AGE >17 W CC	0.7637	24.8	20.7
32	[7] CONCUSSION AGE >17 W/O CC	0.4499	19.0	15.8
33	[7] CONCUSSION AGE 0–17	0.4499	19.0	15.8
34	OTHER DISORDERS OF NERVOUS SYSTEM W CC	0.8004	25.3	21.1
35	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	0.5698	24.2	20.2
36	[7] RETINAL PROCEDURES	1.1820	29.6	24.7
37	[7] ORBITAL PROCEDURES	1.1820	29.6	24.7
38	[7] PRIMARY IRIS PROCEDURES	1.1820	29.6	24.7
39	[7] LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	1.1820	29.6	24.7
40	[4] EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	1.1820	29.6	24.7
41	[7] EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0–17	1.1820	29.6	24.7
42	[7] INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	1.1820	29.6	24.7
43	[7] HYPHEMA	1.1820	29.6	24.7
44	[2] ACUTE MAJOR EYE INFECTIONS	0.5837	21.3	17.8
45	[7] NEUROLOGICAL EYE DISORDERS	1.1820	29.6	24.7
46	[2] OTHER DISORDERS OF THE EYE AGE >17 W CC	0.5837	21.3	17.8
47	[7] OTHER DISORDERS OF THE EYE AGE >17 W/O CC	1.1820	29.6	24.7
48	[7] OTHER DISORDERS OF THE EYE AGE 0–17	1.1820	29.6	24.7
49	[7] MAJOR HEAD & NECK PROCEDURES	1.1820	29.6	24.7
50	S [7] IALOADENECTOMY	1.1820	29.6	24.7
51	[7] SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	1.1820	29.6	24.7
52	[7] CLEFT LIP & PALATE REPAIR	1.1820	29.6	24.7
53	[7] SINUS & MASTOID PROCEDURES AGE >17	1.1820	29.6	24.7
54	[7] SINUS & MASTOID PROCEDURES AGE 0–17	1.1820	29.6	24.7
55	[7] MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES	1.1820	29.6	24.7
56	[7] RHINOPLASTY	1.1820	29.6	24.7
57	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17.	0.4499	19.0	15.8
58	[7] T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17.	0.4499	19.0	15.8
59	[7] TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17 9	0.4499	19.0	15.8
60	[7] TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17	0.4499	19.0	15.8
61	[3] MYRINGOTOMY W TUBE INSERTION AGE >17	0.7637	24.8	20.7
62	[7] MYRINGOTOMY W TUBE INSERTION AGE 0–17	0.4499	19.0	15.8
63	[4] OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES	1.1820	29.6	24.7
64	EAR, NOSE, MOUTH & THROAT MALIGNANCY	1.1480	26.2	21.8
65	[1] DYSEQUILIBRIUM	0.4499	19.0	15.8
66	[7] EPISTAXIS	0.4499	19.0	15.8

TABLE 3.—FY 2006 LTC–DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY AND FIVE-SIXTHS OF THE 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 avenue length of stay	Five-sixths of the geometric length of stay
67	[3] EPIGLOTTITIS	0.7637	24.8	20.7
68	OTITIS MEDIA & URI AGE >17 W CC1	0.511	18.0	15.0
69	[1] OTITIS MEDIA & URI AGE >17 W/O CC	0.4499	19.0	15.8
70	[7] OTITIS MEDIA & URI AGE 0–17	0.4499	19.0	15.8
71	[7] LARYNGOTRACHEITIS	0.5837	21.3	17.8
72	[7] NASAL TRAUMA & DEFORMITY	0.7637	24.8	20.7
73	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17	0.7535	21.9	18.3
74	[7] OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0–17	0.4499	19.0	15.8
75	[5] MAJOR CHEST PROCEDURES	1.7034	38.5	32.1
76	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.5523	43.9	36.6
77	[5] OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	1.7034	38.5	32.1
78	PULMONARY EMBOLISM	0.6900	21.9	18.3
79	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	0.8280	22.9	19.1
80	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC	0.5986	21.7	18.1
81	[7] RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0–17	0.4499	19.0	15.8
82	RESPIRATORY NEOPLASMS	0.7174	20.1	16.8
83	[2] MAJOR CHEST TRAUMA W CC	0.5837	21.3	17.8
84	[7] MAJOR CHEST TRAUMA W/O CC	0.5837	21.3	17.8
85	PLEURAL EFFUSION W CC	0.7264	21.2	17.7
86	[1] PLEURAL EFFUSION W/O CC	0.4499	19.0	15.8
87	PULMONARY EDEMA & RESPIRATORY FAILURE	1.0812	25.4	21.2
88	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	0.6585	19.6	16.3
89	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	0.6987	20.8	17.3
90	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	0.4970	17.8	14.8
91	[7] SIMPLE PNEUMONIA & PLEURISY AGE 0–17	0.4499	19.0	15.8
92	INTERSTITIAL LUNG DISEASE W CC	0.670	20.2	16.8
93	[2] INTERSTITIAL LUNG DISEASE W/O CC	0.5837	21.3	17.8
94	PNEUMOTHORAX W CC	0.5880	17.0	14.2
95	PNEUMOTHORAX W/O CC	0.4499	19.0	15.8
96	BRONCHITIS & ASTHMA AGE >17 W CC	0.6417	19.4	16.2
97	[2] BRONCHITIS & ASTHMA AGE >17 W/O CC	0.5837	21.3	17.8
98	[7] BRONCHITIS & ASTHMA AGE 0–17	0.5837	21.3	17.8
99	RESPIRATORY SIGNS & SYMPTOMS W CC	0.9219	23.2	19.3
100	[3] RESPIRATORY SIGNS & SYMPTOMS W/O CC	0.7637	24.8	20.7
101	OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	0.8147	21.1	17.6
102	[1] OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	0.4499	19.0	15.8
103	[6] HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM	0.0000	0.0	0.0
104	[7] CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W CARDIAC CATH.	0.7637	24.8	20.7
105	[7] CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W/O CARDIAC CATH.	0.7637	24.8	20.7
106	[7] CORONARY BYPASS W PTCA	0.7637	24.8	20.7
108	[7] OTHER CARDIOTHORACIC PROCEDURES	0.7637	24.8	20.7
110	MAJOR CARDIOVASCULAR PROCEDURES W CC	0.7637	24.8	20.7
111	[7] MAJOR CARDIOVASCULAR PROCEDURES W/O CC	0.763	24.8	20.7
113	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE	1.4887	39.3	32.8
114	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	1.2389	33.2	27.7
117	[4] CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT	1.1820	29.6	24.7
118	[4] CARDIAC PACEMAKER DEVICE REPLACEMENT	1.1820	29.6	24.7
119	[4] VEIN LIGATION & STRIPPING	0.7637	24.8	20.7
120	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	1.0979	31.7	26.4
121	CIRCULATORY DISORDERS W AMI & MAJOR COMP, DISCHARGED ALIVE	0.8429	23.2	19.3
122	[4] CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE	0.5837	21.3	17.8
123	CIRCULATORY DISORDERS W AMI, EXPIRED	1.1811	20.4	17.0
124	[4] CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG	1.1820	29.6	24.7
125	[3] CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG.	0.7637	24.8	20.7
126	ACUTE & SUBACUTE ENDOCARDITIS	0.8386	25.3	21.1
127	HEART FAILURE & SHOCK	0.6857	21.2	17.7
128	[2] DEEP VEIN THROMBOPHLEBITIS	0.5837	21.3	17.8
129	[7] CARDIAC ARREST, UNEXPLAINED	0.7637	24.8	20.7
130	PERIPHERAL VASCULAR DISORDERS W CC	0.6741	23.2	19.3
131	PERIPHERAL VASCULAR DISORDERS W/O CC	0.4675	20.4	17.0
132	ATHEROSCLEROSIS W CC	0.6565	21.8	18.2
133	[1] ATHEROSCLEROSIS W/O CC	0.4499	19.0	15.8
134	HYPERTENSION	0.6354	24.8	20.7

TABLE 3.—FY 2006 LTC–DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY AND FIVE-SIXTHS OF THE 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 avenue length of stay	Five-sixths of the geometric length of stay
135	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC	0.7211	23.7	19.8
136	[2] CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC	0.5837	2.3	17.8
137	[7] CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0–17	0.5837	21.3	17.8
138	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	0.6201	20.5	17.1
139	[2] CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	0.5837	2.3	17.8
140	[1] ANGINA PECTORIS	0.4499	19.0	15.8
141	[8] SYNCOPE & COLLAPSE W CC	0.4271	18.3	15.3
142	[8] SYNCOPE & COLLAPSE W/O CC	0.4271	18.3	15.3
143	[1] CHEST PAIN	0.4499	19.0	15.8
144	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	0.7413	21.7	18.1
145	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	0.4568	18.2	15.2
146	[7] RECTAL RESECTION W CC	1.7034	38.5	32.1
147	[7] RECTAL RESECTION W/O CC	1.7034	38.5	32.1
148	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	1.8616	40.9	34.1
149	[7] MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	0.7637	24.8	20.7
150	[4] PERITONEAL ADHESIOLYSIS W CC	1.1820	29.6	24.7
151	[2] PERITONEAL ADHESIOLYSIS W/O CC	0.5837	21.3	17.8
152	[3] MINOR SMALL & LARGE BOWEL PROCEDURES W CC	0.7637	24.8	20.7
153	[7] MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	0.7637	24.8	20.7
154	[5] STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC	1.7034	38.5	32.1
155	[7] STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC	1.7034	38.5	32.1
156	[7] STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0–17	1.7034	38.5	32.1
157	[4] ANAL & STOMAL PROCEDURES W CC	1.1820	29.6	24.7
158	[7] ANAL & STOMAL PROCEDURES W/O CC	1.1820	29.6	24.7
159	[7] HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC	0.7637	24.8	20.7
160	[7] HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC	0.7637	24.8	20.7
161	[5] INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC	1.7034	38.5	32.1
162	[7] INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC	0.7637	24.8	20.7
163	[7] HERNIA PROCEDURES AGE 0–17	0.7637	24.8	20.7
164	[1] APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	1.7034	38.5	32.1
165	[7] APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	1.7034	38.5	32.1
166	[7] APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W4 CC	1.7034	38.5	32.1
167	[7] APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	1.7034	38.5	32.1
168	[4] MOUTH PROCEDURES W CC	1.1820	29.6	24.7
169	[7] MOUTH PROCEDURES W/O CC	0.7637	24.8	20.7
170	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	1.6271	35.9	29.9
171	[1] OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC	0.4499	19.0	15.8
172	DIGESTIVE MALIGNANCY W CC	0.8553	21.8	18.2
173	[2] DIGESTIVE MALIGNANCY W/O CC	0.5837	21.3	17.8
174	G.I. HEMORRHAGE W CC	0.7119	22.2	18.5
175	[1] G.I. HEMORRHAGE W/O CC	0.4499	19.0	15.8
176	COMPLICATED PEPTIC ULCER	0.8426	21.5	17.9
177	[3] UNCOMPLICATED PEPTIC ULCER W CC	0.7637	24.8	20.7
178	[3] UNCOMPLICATED PEPTIC ULCER W/O CC	0.7637	24.8	20.7
179	INFLAMMATORY BOWEL DISEASE	0.9675	24.0	20.0
180	G.I. OBSTRUCTION W CC	0.9375	23.5	19.6
181	[3] G.I. OBSTRUCTION W/O CC	0.7637	24.8	20.7
182	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC	0.7745	22.6	18.8
183	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC	0.3870	16.8	14.0
184	[7] ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0–17	0.4499	19.0	15.8
185	[3] DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17	0.7637	24.8	20.7
186	[7] DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0–17	0.7637	24.8	20.7
187	[7] DENTAL EXTRACTIONS & RESTORATIONS	0.7637	24.8	20.7
188	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	0.9952	24.0	20.0
189	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	0.4707	18.2	15.2
190	[7] OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0–17	0.4499	19.0	15.8
191	[4] PANCREAS, LIVER & SHUNT PROCEDURES W CC	1.1820	29.6	24.7
192	[7] PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	1.1820	29.6	24.7
193	[3] BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC	0.7637	24.8	20.7
194	[7] BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC.	0.7637	24.8	20.7
195	[3] CHOLECYSTECTOMY W C.D.E. W CC	0.7637	24.8	20.7
196	[7] CHOLECYSTECTOMY W C.D.E. W/O CC	0.7637	24.8	20.7
197	[3] CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	0.7637	24.8	20.7
198	[7] CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC	0.7637	24.8	20.7
199	[7] HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	1.7034	38.5	32.1

TABLE 3.—FY 2006 LTC–DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY AND FIVE-SIXTHS OF THE 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 avenue length of stay	Five-sixths of the geometric length of stay
200	[5] HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY	1.7034	38.5	32.1
201	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES	2.0371	36.1	30.1
202	CIRRHOSIS & ALCOHOLIC HEPATITIS	0.6610	20.6	17.2
203	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	0.7896	19.5	16.3
204	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	0.9441	22.7	18.9
205	DISORDERS OF LIVER EXCEPT MALIG, CIRR, ALC HEPA W CC	0.6642	20.5	17.1
206	[2] DISORDERS OF LIVER EXCEPT MALIG, CIRR, ALC HEPA W/O CC	0.5837	21.3	17.8
207	DISORDERS OF THE BILIARY TRACT W CC	0.7570	21.5	17.9
208	[2] DISORDERS OF THE BILIARY TRACT W/O CC	0.5837	21.3	17.8
210	[5] HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC	1.7034	38.5	32.1
211	[4] HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC	1.1820	29.6	24.7
212	[7] HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0–17	1.7034	38.5	32.1
213	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS.	1.1948	34.0	28.3
216	[4] BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	1.1820	29.6	24.7
217	WND DEBRID & SKN GRFT EXCEPT HAND, FOR MUSCSKELET & CONN TISS DIS.	1.2927	38.0	31.7
218	[5] LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W CC.	1.7034	38.5	32.1
219	[1] LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W/O CC.	0.4499	19.0	15.8
220	[7] LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE 0–17	1.7034	38.5	32.1
223	[3] MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC.	0.7673	24.8	20.7
224	[7] SHOULDER,ELBOW OR FOREARM PROC, EXC MAJOR JOINT PROC, W/O CC	0.7637	24.8	20.7
225	FOOT PROCEDURES	0.9869	28.4	23.7
226	SOFT TISSUE PROCEDURES W CC	0.9443	29.5	24.6
227	[3] SOFT TISSUE PROCEDURES W/O CC	0.7637	24.8	20.7
228	[4] MAJOR THUMB OR JOINT PROC, OR OTH HAND OR WRIST PROC W CC	1.1820	29.6	24.7
229	[7] HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	0.4499	19.0	15.8
230	[5] LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR	1.7034	38.5	32.1
232	[7] ARTHROSCOPY	0.4499	19.0	15.8
233	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	1.3522	34.6	28.8
234	[7] OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC	0.4499	19.0	15.8
235	[3] FRACTURES OF FEMUR	0.7637	24.8	20.7
236	FRACTURES OF HIP & PELVIS	0.6531	25.2	21.0
237	[1] SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH	0.4499	19.0	15.8
238	OSTEOMYELITIS	0.8278	28.3	23.6
239	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY.	0.6935	23.6	19.7
240	CONNECTIVE TISSUE DISORDERS W CC	0.7310	24.8	20.7
241	[1] CONNECTIVE TISSUE DISORDERS W/O CC	0.4499	19.0	15.8
242	SEPTIC ARTHRITIS	0.7864	26.5	22.1
243	MEDICAL BACK PROBLEMS	0.6061	23.4	19.5
244	BONE DISEASES & SPECIFIC ARTHROPATHIES W CC	0.5259	22.2	18.5
245	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	0.4635	20.4	17.0
246	[1] NON-SPECIFIC ARTHROPATHIES	0.4499	19.0	15.8
247	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN 8 TISSUE	0.5548	21.9	18.3
248	TENDONITIS, MYOSITIS & BURSITIS	0.6574	22.6	18.8
249	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	0.6577	24.7	20.6
250	[2] FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC	0.5837	21.3	17.8
251	[1] FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC	0.4499	19.0	15.8
252	[7] 7 FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0–17	0.7637	24.8	20.7
253	FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE >17 W CC	0.6802	26.3	21.9
254	[2] FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE >17 W/O CC	0.5837	21.3	17.8
255	[7] FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE 0–17	0.7637	24.8	20.7
256	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	0.7924	25.3	21.1
257	[7] TOTAL MASTECTOMY FOR MALIGNANCY W CC	0.7637	24.8	20.7
258	[7] TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.7637	24.8	20.7
259	[2] SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC	0.5837	21.3	17.8
260	[7] SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.7637	24.8	20.7
261	[7] BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION.	0.7637	24.8	20.7
262	[1] BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY	0.4499	19.0	15.8
263	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	1.3222	39.5	32.9
264	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC	0.9584	32.0	26.7

TABLE 3.—FY 2006 LTC–DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY AND FIVE-SIXTHS OF THE 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 avenue length of stay	Five-sixths of the geometric length of stay
265	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC	1.0398	33.1	27.6
266	[3] SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC.	0.7637	24.8	20.7
267	[7] PERIANAL & PILONIDAL PROCEDURES	0.7637	24.8	20.7
268	[5] SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES	1.7034	38.5	32.1
269	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.3037	36.1	30.1
270	[3] OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC	0.7637	24.8	20.7
271	SKIN ULCERS	0.8720	27.7	23.1
272	MAJOR SKIN DISORDERS W CC	0.7420	22.6	18.8
273	[1] MAJOR SKIN DISORDERS W/O CC	0.4499	19.0	15.8
274	[3] MALIGNANT BREAST DISORDERS W CC	0.7637	24.8	20.7
275	[7] MALIGNANT BREAST DISORDERS W/O CC	0.7637	24.8	20.7
276	[2] NON-MALIGANT BREAST DISORDERS	0.5837	21.3	17.8
277	CELLULITIS AGE >17 W CC	0.6264	21.0	17.5
278	CELLULITIS AGE >17 W/O CC	0.4420	17.8	14.8
279	[7] CELLULITIS AGE 0–17	0.4499	19.0	15.8
280	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC	0.6698	24.3	20.3
281	[1] TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC	0.4499	19.0	15.8
282	[7] TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0–17	0.4499	19.0	15.8
283	MINOR SKIN DISORDERS W CC	0.6935	23.9	19.9
284	[1] MINOR SKIN DISORDERS W/O CC	0.4499	19.0	15.8
285	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DISORDERS.	1.3501	35.6	29.7
286	[7] ADRENAL & PITUITARY PROCEDURES	1.7034	38.5	32.1
287	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS	1.1387	33.9	28.3
288	[4] O.R. PROCEDURES FOR OBESITY	1.1820	29.6	24.7
289	[7] PARATHYROID PROCEDURES	1.1820	29.6	24.7
290	[5] THYROID PROCEDURES	1.7034	38.5	32.1
291	[7] THYROGLOSSAL PROCEDURES	1.1820	29.6	24.7
292	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	1.3409	31.7	26.4
293	[2] OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	0.5837	21.3	17.8
294	DIABETES AGE >	0.7293	25.0	20.8
295	[3] DIABETES AGE 0–35	0.7637	24.8	20.7
296	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	0.7212	23.1	19.3
297	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC	0.5227	18.4	15.3
298	[7] NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0–17	0.5837	21.3	17.8
299	[4] INBORN ERRORS OF METABOLISM	1.1820	29.6	24.7
300	ENDOCRINE DISORDERS W CC	0.6376	21.2	17.7
301	[1] ENDOCRINE DISORDERS W/O CC	0.4499	19.0	15.8
302	[6] KIDNEY TRANSPLANT	0.0000	0.0	0.0
303	[4] KIDNEY,URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM	1.1820	29.6	24.7
304	[5] KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC	1.7034	38.5	32.1
305	[1] KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC	0.4499	19.0	15.8
306	[2] PROSTATECTOMY W CC	0.5837	21.3	17.8
307	[7] PROSTATECTOMY W/O CC	0.5837	21.3	17.8
308	[3] MINOR BLADDER PROCEDURES W CC	0.7637	24.8	20.7
309	[7] MINOR BLADDER PROCEDURES W/O CC	0.7637	24.8	20.7
310	[4] TRANSURETHRAL PROCEDURES W CC	1.1820	29.6	24.7
311	[7] TRANSURETHRAL PROCEDURES W/O CC	1.1820	29.6	24.7
312	[1] URETHRAL PROCEDURES, AGE >17 W CC	0.4499	19.0	15.8
313	[7] URETHRAL PROCEDURES, AGE >17 W/O CC	0.4499	19.0	15.8
314	[7] URETHRAL PROCEDURES, AGE 0–17	0.4499	19.0	15.8
315	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	1.4055	31.6	26.3
316	RENAL FAILURE	0.8219	22.7	18.9
317	ADMIT FOR RENAL DIALYSIS	0.9852	25.2	21.0
318	KIDNEY & URINARY TRACT NEOPLASMS W CC	0.7586	20.2	16.8
319	[1] KIDNEY & URINARY TRACT NEOPLASMS W/O CC	0.4499	19.0	15.8
320	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	0.6179	22.2	18.5
321	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	0.4792	19.0	15.8
322	[7] KIDNEY & URINARY TRACT INFECTIONS AGE 0–17	0.4499	19.0	15.8
323	[4] URINARY STONES W CC, &/OR ESW LITHOTRIPSY	1.1820	29.6	24.7
324	[7] URINARY STONES W/O CC	0.4499	19.0	15.8
325	[2] KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC	0.5837	21.3	17.8
326	[7] KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC	0.4499	19.0	15.8
327	[7] KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0–17	0.4499	19.0	15.8
328	[1] URETHRAL STRICTURE AGE >17 W CC	0.4499	19.0	15.8

TABLE 3.—FY 2006 LTC–DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY AND FIVE-SIXTHS OF THE 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 avenue length of stay	Five-sixths of the geometric length of stay
329	[7] URETHRAL STRICTURE AGE >17 W/O CC	0.4499	19.0	15.8
330	[7] URETHRAL STRICTURE AGE 0–17	0.4499	19.0	15.8
331	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC	0.8010	23.1	19.3
332	[2] OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC	0.5837	21.3	17.8
333	[7] OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0–17	0.5837	21.3	17.8
334	[2] MAJOR MALE PELVIC PROCEDURES W CC	0.5837	21.3	17.8
335	[7] MAJOR MALE PELVIC PROCEDURES W/O CC	1.7034	38.5	32.1
336	[2] TRANSURETHRAL PROSTATECTOMY W CC	0.5837	21.3	17.8
337	[7] TRANSURETHRAL PROSTATECTOMY W/O CC	0.5837	21.3	17.8
338	[7] TESTES PROCEDURES, FOR MALIGNANCY	0.5837	21.3	17.8
339	[4] TESTES PROCEDURES, NON-MALIGNANCY AGE >17	1.1820	29.6	24.7
340	[7] TESTES PROCEDURES, NON-MALIGNANCY AGE 0–17	1.1820	29.6	24.7
341	[4] PENIS PROCEDURES	1.1820	29.6	24.7
342	[7] CIRCUMCISION AGE >17	1.1820	29.6	24.7
343	[7] CIRCUMCISION AGE 0–17	1.1820	29.6	24.7
344	[1] OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY.	0.4499	19.0	15.8
345	[5] OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY.	1.7034	38.5	32.1
346	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC	0.6060	20.6	17.2
347	[2] MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC	0.5837	21.3	17.8
348	[2] BENIGN PROSTATIC HYPERTROPHY W CC	0.5837	21.3	17.8
349	[7] BENIGN PROSTATIC HYPERTROPHY W/O CC	1.1820	29.6	24.7
350	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	0.6798	21.9	18.3
351	[7] STERILIZATION, MALE	1.1820	29.6	24.7
352	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	0.6375	23.4	19.5
353	[7] PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY.	1.1820	29.6	24.7
354	[7] UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	1.1820	29.6	24.7
355	[7] UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC	1.1820	29.6	24.7
356	[7] FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	1.1820	29.6	24.7
357	[7] UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY	1.1820	29.6	24.7
358	[7] UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	1.1820	29.6	24.7
359	[7] UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	1.1820	29.6	24.7
360	[4] VAGINA, CERVIX & VULVA PROCEDURES	1.1820	29.6	24.7
361	[7] LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	0.7637	24.8	20.7
362	[7] ENDOSCOPIC TUBAL INTERRUPTION	0.7637	24.8	20.7
363	[7] D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	0.7637	24.8	20.7
364	[5] D&C, CONIZATION EXCEPT FOR MALIGNANCY	1.7034	38.5	32.1
365	[5] OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	1.7034	38.5	32.1
366	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	0.7072	20.3	16.9
367	[7] MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	0.7637	24.8	20.7
368	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	0.6416	20.7	17.3
369	[3] MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	0.7637	24.8	20.7
370	[7] CESAREAN SECTION W CC	0.7637	24.8	20.7
371	[7] CESAREAN SECTION W/O CC	0.5837	21.3	17.8
372	[7] VAGINAL DELIVERY W COMPLICATING DIAGNOSES	0.7637	24.8	20.7
373	[7] VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	0.7637	24.8	20.7
374	[7] VAGINAL DELIVERY W STERILIZATION &/OR D&C	0.7637	24.8	20.7
375	[7] VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	0.7637	24.8	20.7
376	[7] POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	0.7637	24.8	20.7
377	[7] POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	0.7637	24.8	20.7
378	[7] ECTOPIC PREGNANCY	0.7637	24.8	20.7
379	[7] THREATENED ABORTION	0.7637	24.8	20.7
380	[7] ABORTION W/O D&C	0.7637	24.8	20.7
381	[7] ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	0.7637	24.8	20.7
382	[7] FALSE LABOR	0.7637	24.8	20.7
383	[7] OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	0.7637	24.8	20.7
384	[7] OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	0.7636	24.8	20.7
385	[7] NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	0.7636	24.8	20.7
386	[7] EXTREME IMMATURITY	1.1820	29.6	24.7
387	[7] PREMATURITY W MAJOR PROBLEMS	1.1820	29.6	24.7
388	[7] PREMATURITY W/O MAJOR PROBLEMS	0.7637	24.8	20.7
389	[7] FULL TERM NEONATE W MAJOR PROBLEMS	1.1820	29.6	24.7
390	[7] NEONATE W OTHER SIGNIFICANT PROBLEMS	1.1820	29.6	24.7
391	[7] NORMAL NEWBORN	0.7637	24.8	20.7

TABLE 3.—FY 2006 LTC–DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY AND FIVE-SIXTHS OF THE 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 avenue length of stay	Five-sixths of the geometric length of stay
392	[7] SPLENECTOMY AGE >17	0.7637	24.8	20.7
393	[7] SPLENECTOMY AGE 0–17	0.7637	24.8	20.7
394	[5] OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS	1.7034	38.5	32.1
395	RED BLOOD CELL DISORDERS AGE >17	0.6581	22.0	18.3
396	[7] RED BLOOD CELL DISORDERS AGE 0–17	0.5837	21.3	17.8
397	COAGULATION DISORDERS	0.8675	22.9	19.1
398	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	0.8240	23.7	19.8
399	[2] RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC	0.5837	21.3	17.8
401	[5] LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	1.7034	38.5	32.1
402	[7] LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC	0.5837	21.3	17.8
403	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	0.8757	21.3	17.8
404	[2] LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	0.5837	21.3	17.8
405	[7] ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0–17	0.5837	21.3	17.8
406	[4] MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC	1.1820	29.6	24.7
407	[7] MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC	1.1820	29.6	24.7
408	[4] MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC	1.1820	29.6	24.7
409	RADIOTHERAPY	0.8642	23.5	19.6
410	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	1.1684	26.4	22.0
411	[7] HISTORY OF MALIGNANCY W/O ENDOSCOPY	0.7637	24.8	20.7
412	[7] HISTORY OF MALIGNANCY W ENDOSCOPY	0.7637	24.8	20.7
413	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	0.8920	20.5	17.1
414	[7] OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC	0.5837	21.3	17.8
415	O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	1.4251	35.6	29.7
416	SEPTICEMIA AGE >17	0.8241	23.5	19.6
417	[7] SEPTICEMIA AGE 0–17	0.7637	24.8	20.7
418	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	0.8252	24.7	20.6
419	[4] FEVER OF UNKNOWN ORIGIN AGE >17 W CC	1.1820	29.6	24.7
420	[7] FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	1.1820	29.6	24.7
421	VIRAL ILLNESS AGE >17	0.9441	27.3	22.8
422	[7] VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0–17	0.4499	19.0	24.7
423	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	0.9505	21.8	18.2
424	[3] O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	0.7637	24.8	20.7
425	[2] ACUTE ADJUSTMENT REACTION & PSYCHOLOGICAL DYSFUNCTION	0.5837	21.3	17.8
426	DEPRESSIVE NEUROSES	0.4113	20.7	17.3
427	NEUROSES EXCEPT DEPRESSIVE	0.4653	23.8	19.8
428	[1] DISORDERS OF PERSONALITY & IMPULSE CONTROL	0.4499	19.0	15.8
429	ORGANIC DISTURBANCES & MENTAL RETARDATION	0.5813	26.8	22.3
430	PSYCHOSES	0.4330	24.2	20.2
431	[1] CHILDHOOD MENTAL DISORDERS	0.4499	19.0	15.8
432	[2] OTHER MENTAL DISORDER DIAGNOSES	0.5837	21.3	17.8
433	[2] ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	0.5837	21.3	17.8
439	SKIN GRAFTS FOR INJURIES	1.3677	35.6	29.7
440	WOUND DEBRIDEMENTS FOR INJURIES	1.3442	36.1	30.1
441	[1] HAND PROCEDURES FOR INJURIES	0.4499	19.0	15.8
442	OTHER O.R. PROCEDURES FOR INJURIES W CC	1.3937	33.4	27.8
443	[3] OTHER O.R. PROCEDURES FOR INJURIES W/O CC	0.7637	24.8	20.7
444	TRAUMATIC INJURY AGE >17 W CC	0.7584	26.3	21.9
445	[1] TRAUMATIC INJURY AGE >17 W/O CC9	0.4499	19.0	15.8
446	[7] TRAUMATIC INJURY AGE 0–17	0.4499	19.0	15.8
447	[2] ALLERGIC REACTIONS AGE >17	0.5837	21.3	17.8
448	[7] ALLERGIC REACTIONS AGE 0–17	0.5837	21.3	17.8
449	[3] POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC	0.7637	24.8	20.7
450	[7] POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC	0.7637	24.8	20.7
451	[7] POISONING & TOXIC EFFECTS OF DRUGS AGE 0–17 7	0.7637	24.8	20.7
452	COMPLICATIONS OF TREATMENT W CC	0.9265	25.3	21.1
453	COMPLICATIONS OF TREATMENT W/O CC	0.5871	23.8	19.8
454	[3] OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC	0.7637	24.8	20.7
455	[7] OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC	0.7637	24.8	20.7
461	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES	1.2245	34.0	28.3
462	REHABILITATION	0.5787	22.4	18.7
463	SIGNS & SYMPTOMS W CC	0.6258	23.8	19.8
464	SIGNS & SYMPTOMS W/O CC	0.5554	24.1	20.1
465	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	0.6958	21.9	18.3
466	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	0.6667	21.9	18.3
467	[3] OTHER FACTORS INFLUENCING HEALTH STATUS	0.7637	24.8	20.7
468	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	2.1478	40.2	33.5

TABLE 3.—FY 2006 LTC–DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY AND FIVE-SIXTHS OF THE 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 avenue length of stay	Five-sixths of the geometric length of stay
469	[6] PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	0.0000	0.0	0.0
470	[6] UNGROUPABLE	0.0000	0.0	0.0
471	[5] BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY	1.7034	38.5	32.1
473	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	0.8537	20.0	16.7
475	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	2.0831	34.6	28.8
476	[4] PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	1.1820	29.6	24.7
477	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	1.5836	35.3	29.4
479	[7] OTHER VASCULAR PROCEDURES W/O CC	0.7637	24.8	20.7
480	[6] LIVER TRANSPLANT	0.0000	0.0	0.0
481	[7] BONE MARROW TRANSPLANT	1.7034	38.5	32.1
482	[5] TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES	1.7034	38.5	32.1
484	[2] CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	0.5837	21.3	17.8
485	[7] LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TR.	1.1820	29.6	24.7
486	[5] OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA	1.7034	38.5	32.1
487	OTHER MULTIPLE SIGNIFICANT TRAUMA	0.8992	26.0	21.7
488	[5] HIV W EXTENSIVE O.R.PROCEDURE	1.7034	38.5	32.1
489	HIV W MAJOR RELATED CONDITION	0.8535	21.4	17.8
490	HIV W OR W/O OTHER RELATED CONDITION	0.4919	16.6	13.8
491	[5] MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY.	1.7034	38.5	32.1
492	[7] CHEMOTHERAPY W ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	1.1820	29.6	24.7
493	[5] LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.7034	38.5	32.1
494	[7] LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	1.7034	38.5	32.1
495	[6] LUNG TRANSPLANT	0.0000	0.0	0.0
496	[7] COMBINED ANTERIOR/POSTERIOR SPINAL FUSION	1.1820	29.6	24.7
497	[4] SPINAL FUSION W CC	1.1820	29.6	24.7
498	[7] SPINAL FUSION W/O CC	1.1820	29.6	24.7
499	[5] BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC	1.7034	38.5	32.1
500	[4] BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC	1.1820	29.6	24.7
501	[5] KNEE PROCEDURES W PDX OF INFECTION W CC	1.7034	38.5	32.1
502	[4] KNEE PROCEDURES W PDX OF INFECTION W/O CC	1.1820	29.6	24.7
503	[2] KNEE PROCEDURES W/O PDX OF INFECTION	0.5837	21.3	17.8
504	[7] EXTENSIVE BURN OR FULL THICKNESS BURNS WITH MECH VENT 96+ HOURS WITH SKIN GRAFT.	1.7034	38.5	32.1
505	[4] EXTENSIVE BURN OR FULL THICKNESS BURNS WITH MECH VENT 96+ HOURS WITHOUT SKIN GRAFT.	1.1820	29.6	24.7
506	[4] FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA.	1.1820	29.6	24.7
507	[3] FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA.	0.7637	24.8	20.7
508	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ W CC OR SIG TRAUMA.	0.8367	29.4	24.5
509	[1] FULL THICKNESS BURN W/O SKIN GRFT OR INH INJ W/O CC OR SIG TRAUMA.	0.4499	19.0	15.8
510	NON-EXTENSIVE BURNS W CC OR SIGNIFICANT TRAUMA	0.7709	24.6	20.5
511	[1] NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA	0.4499	19.0	15.8
512	[6] SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT	0.0000	0.0	0.0
513	[6] PANCREAS TRANSPLANT	0.0000	0.0	0.0
515	[5] CARDIAC DEFIBRILATOR IMPLANT W/O CARDIAC CATH	1.7034	38.5	32.1
518	[7] PERCUTANEOUS CARDIVASCULAR PROC W/O CORONARY ARTERY STENT OR AMI.	0.7637	24.8	20.7
519	[5] CERVICAL SPINAL FUSION W CC	1.7034	38.5	32.1
520	[7] CERVICAL SPINAL FUSION W/O CC	1.1820	29.6	24.7
521	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	0.4457	19.4	16.2
522	[7] ALCOHOL/DRUG ABUSE OR DEPENDENCE W REHABILITATION THERAPY W/O CC.	0.4499	19.0	15.8
523	[7] ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W/O CC.	0.4499	19.0	15.8
524	TRANSIENT ISCHEMIA	0.5043	21.1	17.6
525	[7] OTHER HEART ASSIST SYSTEM IMPLANT	1.7034	38.5	32.1
528	[7] INTRACRANIAL VASCULAR PROC W PDX HEMORRHAGE	1.7034	38.5	32.1
529	[5] VENTRICULAR SHUNT PROCEDURES W CC	1.7034	38.5	32.1
530	[7] VENTRICULAR SHUNT PROCEDURES W/O CC	1.7034	38.5	32.1
531	[3] SPINAL PROCEDURES WITH CC	0.7637	24.8	20.7
532	[3] SPINAL PROCEDURES WITHOUT CC	0.7637	24.8	20.7

TABLE 3.—FY 2006 LTC–DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY AND FIVE-SIXTHS OF THE 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 avenue length of stay	Five-sixths of the geometric length of stay
533	[5] EXTRACRANIAL VASCULAR PROCEDURES WITH CC	1.7034	38.5	32.1
534	[7] EXTRACRANIAL VASCULAR PROCEDURES WITHOUT CC	1.1820	29.6	24.7
535	[7] CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK	1.7034	38.5	32.1
536	[7] CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK	1.7034	38.5	32.1
537	LOCAL EXCISION AND REMOVAL OF INTERNAL FIXATION DEVICES EXCEPT HIP AND FEMUR WITH CC.	1.1615	34.7	28.9
538	[7] LOCAL EXCISION AND REMOVAL OF INTERNAL FIXATION DEVICES EXCEPT HIP AND FEMUR WITHOUT CC.	1.1820	29.6	24.7
539	[4] LYMPHOMA AND LEUKEMIA WITH MAJOR O.R. PROCEDURE WITH CC	1.1820	29.6	24.7
540	[7] LYMPHOMA AND LEUKEMIA WITH MAJOR O.R. PROCEDURE WITHOUT CC	0.5837	21.3	17.8
541	ECMO OR TRACH W MECH VENT 96+ HRS OR PDX EXCEPT FACE,MOUTH & NECK DIAG WITH MAJOR OR.	4.2287	65.6	54.7
542	TRACH W MECH VENT 96+ HRS OR PDX EXCEPT FACE,MOUTH & NECK DIAG WITHOUT MAJOR OR.	3.1869	48.2	40.2
543	CRANIOTOMY W IMPLANT OF CHEMO AGENT OR ACUTE COMPLEX CNS PDX.	1.7034	38.5	32.1
544	[5] MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY	1.7034	38.5	32.1
545	[5] REVISION OF HIP OR KNEE REPLACEMENT	1.7034	38.5	32.1
546	[7] SPINAL FUSION EXCEPT CERVICAL WITH CURVATURE OF SPINE OR MALIGNANCY.	1.7034	38.5	32.1
547	[7] CORONARY BYPASS WITH CARDIAC CATH WITH MAJOR CV DIAGNOSIS	1.7034	38.5	32.1
548	[7] CORONARY BYPASS WITH CARDIAC CATH WITHOUT MAJOR CV DIAGNOSIS.	1.7034	38.5	32.1
549	[7] CORONARY BYPASS WITHOUT CARDIAC CATH WITH MAJOR CV DIAGNOSIS.	1.7034	38.5	32.1
550	[7] CORONARY BYPASS WITHOUT CARDIAC CATH WITHOUT MAJOR CV DIAGNOSIS.	1.7034	38.5	32.1
551	[4] PERMANENT CARDIAC PACEMAKER IMPLANT WITH MAJOR CV DIAGNOSIS OR AICD LEAD OR GNRTR.	1.1820	29.6	24.7
552	[4] OTHER PERMANENT CARDIAC PACEMAKER IMPLANT WITHOUT MAJOR CV DIAGNOSIS.	1.1820	29.6	24.7
553	[8] OTHER VASCULAR PROCEDURES WITH CC WITH MAJOR CV DIAGNOSIS	1.3255	30.6	25.5
554	[8] OTHER VASCULAR PROCEDURES WITH CC WITHOUT MAJOR CV DIAGNOSIS.	1.3255	30.6	25.5
555	[4] PERCUTANEOUS CARDIOVASCULAR PROC WITH MAJOR CV DIAGNOSIS	1.1820	29.6	24.7
556	[8] PERCUTANEOUS CARDIOVASCULAR PROC WITH NON-DRUG-ELUTING STENT WITHOUT MAJOR CV DIAGNOSISPROC WITH NON-DRUG-ELUTING STENT WITHOUT MAJOR CV DIAGNOSIS.	1.1820	29.6	24.7
557	[8] PERCUTANEOUS CARDIOVASCULAR PROC WITH DRUG-ELUTING STENT WITH MAJOR CV DIAGNOSIS.	1.1820	29.6	24.7
558	[7] PERCUTANEOUS CARDIOVASCULAR PROC WITH DRUG-ELUTING STENT WITHOUT MAJOR CV DIAGNOSIS.	1.1820	29.6	24.7
559	[7] ACUTE ISCHEMIC STROKE WITH USE OF THROMBOLYTIC AGENT	0.7637	24.8	20.7

[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.

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