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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412

[CMS–1483–P]

RIN 0938–AN28

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

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would update the annual payment rates for the Medicare prospective payment system (PPS) for inpatient hospital services provided by long-term care hospitals (LTCHs). The payment amounts and factors used to determine the updated Federal rates that are described in this proposed rule have been determined based on the LTCH PPS rate year July 1, 2005 through June 30, 2006. The annual update of the long-term care diagnosis-related group (LTC–DRG) classifications and relative weights remains linked to the annual adjustments of the acute care hospital inpatient diagnosis-related group system, and would continue to be effective each October 1. The proposed outlier threshold for July 1, 2005 through June 30, 2006 is also derived from the LTCH PPS rate year calculations. We are proposing to adopt new labor market area definitions for the purpose of geographic classification and the wage index. We are also proposing policy changes and clarifications.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on March 29, 2005.

ADDRESSES: In commenting, please refer to file code CMS–1483–P. Because of staff and resource limitations, we cannot accept comments by facsimile (fax) transmission.

You may submit comments in one of three ways (no duplicates, please):

1. *Electronically.* You may submit electronic comments on specific issues in this regulation to *http://www.cms.hhs.gov/regulations/ecomments.* (Attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word.)

2. *By mail.* You may mail written comments (one original and two copies) to the following address ONLY:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1483–P, P.O. Box 8011, Baltimore, MD 21244–8011.

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

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

Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201; or 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

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

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

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

FOR FURTHER INFORMATION CONTACT: Tzvi Hefter, (410) 786–4487 (General information); Judy Richter, (410) 786–2590 (General information, transition payments, payment adjustments for special cases, and onsite discharges and readmissions, interrupted stays, co-located providers, and short-stay outliers); Michele Hudson, (410) 786–5490 (Calculation of the payment rates, relative weights and case-mix index, market basket update, and payment adjustments); Mark Zezza, (410) 786–7937 (Calculation of the payment rates wage index, wage index, and payment adjustments); Ann Fagan, (410) 786–5662 (Patient classification system); Miechal Lefkowitz, (410) 786–5316 (High-cost outliers and budget neutrality); Linda McKenna, (410) 786–4537 (Payment adjustments, interrupted stay, and transition period).

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on all issues set forth in this rule to assist us in fully considering issues and developing policies. You can assist us by referencing the file code (CMS–1483–P) and the specific ''issue identifier'' that precedes the section on which you choose to comment.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. After the close of the comment period, CMS posts all electronic comments received before the close of the comment period on its public Web site. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone (410) 786–7197.

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Acronyms

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

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
CPSA Core-Based Statistical Area
CMS Centers for Medicare & Medicaid Services
COPS Medicare conditions of participation
DRGs Diagnosis-related groups
FY Federal fiscal year
HCRIS Hospital Cost Report Information System
HHA Home health agency
HIPAA Health Insurance Portability and Accountability Act, Pub. L. 104–191
IPF Inpatient Psychiatric Facility
IPPS Acute Care Hospital Inpatient Prospective Payment System
IRF Inpatient rehabilitation facility
LTC–DRG Long-term care diagnosis-related group
LTCH Long-term care hospital
MedPAC Medicare Payment Advisory Commission
MedPAR Medicare provider analysis and review file
OSCAR Online Survey Certification and Reporting (System)
PPS Prospective Payment System
QIO Quality Improvement Organization (formerly Peer Review organization (PRO))
RY Rate Year (July 1 through June 30)
SNF Skilled nursing facility
TEFRA Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248

I. Background

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

A. Legislative and Regulatory Authority

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

Section 1886(d)(1)(B)(iv)(I) of the Act defines a LTCH as ''a hospital which has an average inpatient length of stay (as determined by the Secretary) of greater than 25 days.'' Section 1886(d)(1)(B)(iv)(II) of the Act also provides an alternative definition of LTCHs: Specifically, a hospital that first received payment under section 1886(d) of the Act in 1986 and has an average inpatient length of stay (as determined by 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 Pub. L. 106–113 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 Pub. L. 106–554, 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 (67 FR 55954), we implemented the LTCH PPS authorized under Pub. L. 106–113 and Pub. L. 106–554. 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 prospective payment system for acute care hospitals authorized by the Social Security Amendments of 1983 (Pub. L. 98–21), which added section 1886(d) to the Act, certain hospitals, including LTCHs, were excluded from the PPS for acute care hospitals and were paid their reasonable costs for inpatient services subject to a per discharge limitation or target amount under the TEFRA system. For each cost reporting period, a hospital-specific ceiling on payments was determined by multiplying the hospital's updated target amount by the number of total current year Medicare discharges. The August 30, 2002 final rule further details payment policy under the TEFRA system (67 FR 55954).

In the August 30, 2002 final rule, we 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 Pub. L. 106–113. The same final rule that established regulations for the LTCH PPS under 42 CFR part 412, subpart O, also contained LTCH provisions related to covered inpatient services, limitation on charges to beneficiaries, medical review requirements, furnishing of inpatient hospital services directly or under arrangement, and reporting and recordkeeping requirements.

We refer readers to the August 30, 2002 final (67 FR 55954) rule for a comprehensive discussion of the research and data that supported the establishment of the LTCH PPS.

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

On May 7, 2004 we published a final rule in the **Federal Register** (69 FR 25674) that set forth the 2005 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 procedures under which a satellite facility or remote location of a LTCH may be designated as a separately certified LTCH. In addition, the final rule included a provision to expand the existing interrupted stay policy at § 412.531, and a revision to the procedure for computing the day count in the average length of stay calculation for Medicare patients for hospitals qualifying as LTCHs at § 412.23(e)(3)(ii).

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 length of stay of greater than 25 days. Alternatively, 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 length of stay for all patients, including both Medicare and non-Medicare inpatients, of greater than 20 days (§ 412.23(e)(2)(ii)).

Regulations at § 412.23(e)(3) provide that, subject to the provisions of paragraphs (e)(3)(ii) through (e)(3)(iv) of this section, the average Medicare inpatient length of stay, 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 length of stay 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 LTCH PPS final rule published on May 7, 2004, we specified the procedure for calculating a hospital's inpatient average length of stay 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 have 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 average length of stay, if the days of a stay of an inpatient involves 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.

Effective for cost reporting periods beginning on or after July 1, 2004, but before July 1, 2005, a one-year exception is provided in the event some providers failed to meet the 25-day ALOS criteria due to this change in policy. In these cases, the fiscal intermediary will do an additional calculation to determine if these providers meet the average length of stay methodology found in § 412.23(e)(3)(i).

Fiscal intermediaries verify that LTCHs meet the average length of stay 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. 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 as described in § 409.61 (68 FR 34123).

The fiscal intermediary's determination of whether or not a

hospital qualified as an LTCH is based on the hospital's discharge data from the hospital's most recent complete cost reporting period (§ 412.23(e)(3)) and is effective at the start of the hospital's next cost reporting period (§ 412.22(d)). However, if the hospital does not meet the average length of stay requirement as specified in § 412.23(e)(2)(i) and (ii), the hospital may provide the intermediary with data indicating a change in the average length of stay 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 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 average length of stay. 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, with respect to the average length of stay specified under § 412.23(e)(2)(i), we revised § 412.23(e)(3)(i) to only count total days and discharges for Medicare inpatients (68 FR 45464). In addition, the average length of stay 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 pointed out in the IPPS final rule, we are unable to capture the necessary data from our present cost reporting forms. We have, therefore, notified fiscal intermediaries and LTCHs that until the cost reporting forms are revised, for purposes of calculating the average length of stay, we will be relying upon census data extracted from 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).

In the May 7, 2004 final rule (69 FR 25709), we revised the regulations at § 412.23(e) to clarify our longstanding policy by stating that a satellite facility or remote location that voluntarily separates from its parent LTCH in order to become an independent LTCH it must first be considered a State-licensed and Medicare-certified hospital before seeking classification as a LTCH. In this regard, a satellite facility or remote location that voluntarily wishes to become an independent LTCH is required to demonstrate that it meets the average length of stay requirements, as specified under §412.23(e)(2)(i) and (ii), based on discharges that occur on or after the effective date of its participation under Medicare as a separate hospital. Once the satellite facility or remote location is Medicare certified, then the hospital may consider using the length of stay data accumulated as a hospital to satisfy the classification requirements for becoming a ''specialty'' hospital (in this case, a LTCH). That is, the hospital must demonstrate that it has a Medicare inpatient length of stay of greater than 25 days. The data used to calculate the Medicare average length of stay is based on discharges that occur after the satellite facility or remote location has established itself as a separate participating hospital. However, there is an exception to this policy for satellite facilities and remote locations of LTCHs that are affected by § 413.65(e)(3) and that were in existence prior to the effective date of the provider-based location requirements; that is, cost reporting periods beginning on or after July 1, 2003. We will assign new Medicare provider numbers to former satellite facilities or remote locations that have become certified as Medicare participating hospitals. However, if these newly certified hospitals should fail the provider-based locations requirements under § 413.65(e)(3), they may be classified as LTCHs if they meet specific conditions. Under this exception, calculation of the ALOS for purposes of qualifying as a LTCH are based on discharge data during the 5 months of the immediate 6 months preceding the facility's separation from the main hospital. This provision only applies to those facilities or locations that became subject to the revised provider-based location rules on July 1, 2003, and that seek classification as LTCHs for Medicare payment purposes.

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 Public Law 90–248 (42 U.S.C. 1395b–1) or section 222(a) of Public Law 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 fully Federal prospective payment for LTCHs (67 FR 56038). However, LTCHs 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 follows:

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. Health Insurance Portability and Accountability Act Compliance

We note that as of October 16, 2002, a LTCH that was required to comply with the Administrative Simplification Standards under the Health Insurance Portability and Accountability Act (HIPAA) (Pub. L. 104–191) and that had not obtained an extension in compliance with the Administrative Compliance Act (Pub. L. 107–105) is obligated to comply with the standards for submitting claim forms to the LTCH's Medicare fiscal intermediary (45 CFR 162.1002 and 45 CFR 162.1102). Beginning October 16, 2003, LTCHs that obtained an extension and that are required to comply with the HIPAA Administrative Simplification Standards must start submitting electronic claims in compliance with the HIPAA regulations cited above, among others.

II. Summary of the Major Contents of This Proposed Rule

In this proposed rule, we propose to set forth the annual update to the payment rates for the Medicare 2006 LTCH PPS rate year. The following is a summary of the proposed update changes that we are addressing in this final rule:

- In section IV. of this preamble, we discuss the annual update of LTC–DRG classifications and relative weights and specify that they 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.
- As discussed in section IV.C.1. of this preamble, we are proposing to adopt new labor market area definitions for LTCHs which are based on the new Core-Based Statistical Areas (CBSAs), announced by the OMB late in 2000. The CBSAs were adopted for acute care hospitals under the IPPS effective October 1, 2004 in the FY 2005 IPPS final rule.
- In sections VI. through IX. of this preamble, we are including proposed revisions to the wage index, the proposed excluded hospital with capital market basket that would be applied to the current standard Federal rate to determine the prospective payment rates, the applicable adjustments to payment rates, the proposed outlier threshold, the transition period, and the proposed budget neutrality factor.
- In section IX. of this preamble, we discuss the recommendations made in the June 2004 MedPAC Report concerning the definition of LTCHs. In this section, we also discuss our continuing monitoring efforts to evaluate the LTCH PPS, including a review of the QIO's role.
- In section XII. of this preamble, we analyze the impact of the proposed changes in this proposed rule on Medicare expenditures and on Medicare-participating LTCHs and Medicare beneficiaries.

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

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

A. Background

Section 123 of Pub. L. 106–113 specifically requires that the PPS for LTCHs be a per discharge system with a DRG-based patient classification system reflecting the differences in patient resources and costs in LTCHs while maintaining budget neutrality. Section 307(b)(1) of Pub. L. 106–554 modified the requirements of section 123 of Pub. L. 106–113 by specifically requiring that the Secretary examine ''the feasibility and the impact of basing payment under such a system [the LTCH PPS] on the use of existing (or refined) hospital 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 307(b)(1) of Pub. L. 106–554 and § 412.515 of our existing regulations, the LTCH PPS uses information from LTCH patient records to classify patient cases into distinct LTC–DRGs based on clinical characteristics and expected resource needs. The LTC–DRGs used as the patient classification component of the LTCH PPS correspond to the hospital inpatient DRGs in the IPPS. We apply weights to the existing hospital inpatient 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 deal with 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 composition of low volume quintiles appears in the August 30, 2002 LTCH PPS final rule at 67 FR 55986.) We also take into account adjustments to payments for cases in which the stay at the LTCH is five-sixths of the geometric average length of stay and classify these cases as short-stay outlier 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 at 67 FR 55978.)

B. Patient Classifications Into DRGs

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

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

As indicated in the August 30, 2002 LTCH PPS final rule, upon the discharge of the patient from a LTCH, the LTCH must assign appropriate diagnosis and procedure codes from the most current version of the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD–9–CM). As of October 16, 2002, a LTCH that was required to comply with the HIPAA Administrative Simplification Standards and that had not obtained an extension in compliance with the Administrative Compliance Act (Pub. L. 107–105) is obligated to comply with the standards at 45 CFR 162.1002 and 45 CFR 162.1102. Completed claim forms are to be submitted to the LTCH's Medicare fiscal intermediary.

Medicare fiscal intermediaries enter the clinical and demographic information into their claims processing systems and subject this information to a series of automated screening processes called the Medicare Code Editor (MCE). These screens are designed to identify cases that require further review before assignment into a 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 nonapproved transplant center.)

• Cases requiring more information. (For example, ICD–9–CM codes are required to be entered at their highest level of specificity. There are valid 3-digit, 4-digit, and 5-digit codes. That is, code 136.3, Pneumocystosis, contains all appropriate digits, but if it is reported with either fewer or more than 4 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. As indicated in August 30, 2002 LTCH PPS final, the Medicare GROUPER, 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 fiscal intermediary determines the prospective payment by using the Medicare PRICER program, which accounts for hospital-specific adjustments. As provided for under the IPPS, we provide an opportunity for the LTCH to review the LTC–DRG assignments made by the fiscal intermediary and to submit additional information within a specified timeframe (§ 412.513(c)).

The GROUPER 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 below in sections III.D. and E. of this preamble, with the implementation of section 503(a) of Pub. L. 108–173, there is the possibility that one feature of the GROUPER software program may be updated twice during a Federal fiscal year (October 1 and April 1) as required by the statute for the IPPS (69 FR 48954–48957), August 11, 2004). Specifically, ICD–9 diagnosis and procedure codes for new medical technology may be created and added to existing DRGs in the middle of the Federal fiscal year on April 1. This policy change will have no effect, however, 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.

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 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 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). We have determined it is not practical at this time 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 comorbidities and complications 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.

D. Update of LTC–DRGs

For FY 2005, the LTC–DRG patient classification system was based on LTCH data from the FY 2003 MedPAR file, which contained hospital bills data from the March 2004 update. The patient classification system consisted of 520 DRGs that formed the basis of the FY 2004 LTCH PPS GROUPER. The 520 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 2005 IPPS FY 2005 final rule (69 FR 408982–49000).) The other 518 LTC–DRGs are the same DRGs used in the IPPS GROUPER for FY 2005 (Version 22.0).

In the past, 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. Thus, the manual and electronic versions of the GROUPER software, which are based on the ICD–9–CM codes, were also revised annually and effective for discharges occurring on or after October 1 each year. As discussed earlier, the patient classification system for the LTCH PPS (LTC–DRGs) is based on the IPPS patient classification system (CMS–DRGs), which had historically been updated annually and was effective for discharges occurring on or after October 1 through September 30 each year.

Recently, the ICD–9–CM coding update process has been revised as discussed in greater detail in the FY 2005 IPPS final rule (69 FR 48954–48957). Specifically, section 503(a) of Pub. L. 108–173 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. Section 503(a) of Pub. L. 108–173 amended section 1886(d)(5)(K) of the Act by adding a new clause (vii) which states that ''the Secretary shall provide for the addition of new diagnosis and procedure codes by April 1 of each year, but the addition of such codes shall not require the Secretary to adjust the payment (or diagnosis-related group classification) * * * until the fiscal year that begins after such date.'' This requirement will improve the recognition of new technologies under the IPPS by accounting for the GROUPER software at an earlier date. Despite the fact that aspects of the GROUPER software may be updated to recognize any new technology codes, there will be no impact on either LTC–DRG assignments or payments under the LTCH PPS. That is, no new LTC–DRGs will be created or deleted and the relative weights will remain the same.

In the August 30, 2002 final rule (67 FR 55984), when we established the LTCH PPS, we determined that the DRG-based patient classification system for the LTCH PPS would use the same GROUPER software as the IPPS, and therefore would be updated each October 1, as set forth in § 412.8(b). In the June 6, 2003 LTCH PPS final rule (68 FR 34125–34128), when we revised the annual rate update for the LTCH PPS to a July 1 through June 30 schedule, we specified that updates of the LTC–DRGs and re-weighting of LTC–DRG weights would remain linked to the IPPS GROUPER update which functions on an October 1 through September 30 schedule. Therefore, under this existing policy, during a LTCH PPS rate year, two versions of the GROUPER software are utilized for purposes of DRG creation or deletion and relative weight assignment during the LTCH PPS rate year that is established each July 1. The updated LTC–DRG classifications and relative weights in the GROUPER that were finalized on October 1, preceding the beginning of a LTCH rate year on July 1, would be in effect with the new Federal rate from July 1 through September 30. On October 1, the updated version of the GROUPER would be used from that October 1 through June 30.

The updated DRGs and GROUPER software, used by both the IPPS and the LTCH PPS, are based on the ICD–9–CM codes updated. (The use of the ICD–9–CM codes in this manner is consistent with current usage and the HIPAA regulations.) As noted above, historically, these codes have been published annually in the IPPS proposed rule and final rule. Consistent with historical approaches taken in the IPPS and LTCH PPS, October 1 will continue to be the effective date of revisions to the CMS DRGs and the LTC–DRGs. However, because of the statutory changes under Section 503(a) of Pub. L. 108–173, new ICD–9–CM codes may become effective on both October 1 and April 1. In the past, the new or revised ICD–9–CM codes were not used by the industry for either the IPPS or the LTCH PPS until the beginning of the Federal fiscal year (effective for discharges occurring on or after October 1). Beginning with FY 2005, as we explained above, under the authority of Section 503(a) of Pub. L. 108–173 which amends section 1886(d)(5)(K) of the Act, there is the potential for new ICD–9–CM codes to become effective both at the beginning of the Federal fiscal year, October 1, and also on April 1. As we have already noted, a full discussion along with a description of the implementation of this provision, was published in the **Federal Register** in the FY 2005 IPPS final rule (69 FR 48954–48957). We want to emphasize, however, that although it was established that the IPPS GROUPER, which is also used by the LTCH PPS, could be calibrated with respect to ICD–9–CM codes, two times each year, October and April, as necessary, to allow the inclusion of new codes reflecting new medical technologies and procedures for patients in acute care hospitals and that, therefore, the GROUPER could be updated to recognize any new codes in April, the inclusion of these new codes would not result in the creation or deletion of LTC–DRGs or changes in the relative weights and, therefore, would not affect the DRG assigned by the GROUPER for LTC–DRGs, nor payments under the LTCH PPS.

As noted above, updates to the GROUPER for both the IPPS and the LTCH PPS (with respect to relative weights and the creation or deletion of DRGs) are made in the annual IPPS proposed and final rules and are effective each October 1. We explained in the FY 2005 IPPS final rule (69 FR 48956), that since we do not publish a mid-year IPPS rule, April 1 code updates discussed above will not be published in a mid-year IPPS rule. Rather, we will assign any new diagnostic or procedure codes to the same DRG in which its predecessor code was assigned, so that there will be no impact on the DRG assignment. Any proposed coding updates will be available through the Web sites indicated in the FY 2005 IPPS final rule (69 FR 48956) and provided below in section III.E.2. 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 systems. 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, since each ICD–9–CM code must be included in the GROUPER algorithm to classify each case into a LTC–DRG, the GROUPER software program used under the LTCH PPS would need to be revised to accommodate any new codes.

As mentioned above, however, an April 1 update of the ICD–9–CM codes would only result in a change to the CMS DRG GROUPER software program effective April 1, so that it will recognize the new technology code and assign it to the appropriate DRG, but will not result in a change to the relative weights used under either the IPPS or the LTCH PPS, respectively. Consistent with our current practice, any changes to the DRGs or relative weights will be made at the beginning of the next Federal fiscal year (October 1).

As specified in the May 7, 2004 LTCH PPS final rule (69 FR 25674) and the FY 2005 IPPS final rule (69 FR 48982), and discussed above, we annually update to the LTCH PPS payment rates effective from July 1 through June 30 each year. As a result, the LTCH PPS currently uses two GROUPER software programs during a LTCH PPS rate year (July 1 through June 30): one GROUPER for 3 months (from July 1 through September 30); and an updated GROUPER for 9 months (from October 1 through June 30). The need to use two GROUPERs was based upon the October 1 effective date of the updated ICD–9–CM coding system. As previously discussed, new ICD–9–CM codes may result in changes to the structure of the DRGs caused by mapping the new codes to existing DRGs. In order for the industry to be on the same schedule (for both the IPPS and the LTCH PPS) for the use of the most current ICD–9–CM codes, it had

been necessary for us to apply two GROUPER programs under the LTCH PPS.

With the potential addition of new codes effective on April 1, the LTCH PPS may now use three GROUPER programs during the LTCH PPS rate year (July 1 through June 30), if new diagnosis and procedure codes are added on April 1. Specifically, one GROUPER (GROUPER 1) would be used for the first 3 months (from July 1 through September 30); a second GROUPER (GROUPER 2) would be used for the next 6 months (from October 1 through March 31); and the third GROUPER (GROUPER 3) would be used for the last 3 months (from April 1 through June 30). The need to use three GROUPER software programs during a single LTCH PPS rate year in the event of an April 1 ICD–9–CM code update is because it is necessary to use the updated ICD–9–CM codes (as explained above) in order to classify each case into a LTC–DRG for payment purposes. The change from GROUPER 1 to GROUPER 2 (on October 1) would coincide with the annual update to the LTC–DRGs and relative weights under § 412.517, which would be effective for that entire Federal fiscal year, just as it has been since we implemented the LTCH PPS. The change from GROUPER 2 to GROUPER 3 (on April 1) would only update the CMS DRG structure by mapping the new code to an existing DRG, and would not result in the addition or deletion of any DRGs nor would it result in a change to the LTC–DRG relative weights. If no new diagnoses or procedure codes are added on April 1, however, there would be no need to update the GROUPER and we would continue to use 2 GROUPERs during the course of a LTCH PPS rate year as is currently done. But even with an April 1 update to the ICD–9–CM codes (and consequently the GROUPER software), only two sets of LTC–DRG relative weights will be used during a LTCH PPS rate year (July 1 through June 30), one set from July 1 though September 30 and a second set from October 1 through June 30, just as we have done since we moved the annual LTCH PPS update to July 1 (effective beginning July 1, 2003).

As we discussed in the FY 2005 IPPS final rule (69 FR 48956), in implementing section 503(a) of Pub. L. 108–173, there will only be an April 1 update if new technology codes are requested and approved. In that same IPPS final rule, we specified that there are no new codes for April 1, 2005 implementation. However, if new codes had been approved for April 1, 2005 implementation, the subsequent changes to the DRG structure (that is, the mapping of the new codes to existing DRGs), but not to FY 2005 LTC–DRG relative weights and, consequently, LTCH PPS payment rates, would have resulted in the use of a third GROUPER during the 2005 LTCH PPS rate year. However, as noted above, since there are no new codes for April 1, 2005 implementation, and the next update to the ICD–9–CM coding system will not occur until October 1, 2005, only two GROUPER software programs will be used during the 2005 LTCH PPS rate year (July 1, 2004 through June 30, 2005): one GROUPER from July 1, 2004 through September 30, 2004, and a second GROUPER from October 1, 2004 through June 30, 2005.

Discharges beginning on October 1, 2004 and before October 1, 2005 (Federal FY 2005) are using Version 22.0 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 fiscal year (October 1). We will notify LTCHs of any revised LTC–DRG relative weights based on the final DRGs and the applicable GROUPER version for the IPPS that will be effective October 1, 2005. Furthermore, as discussed above, we would notify LTCHs of any revisions to the CMS GROUPER that would be implemented April 1, 2006.

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 U.S. Department of Health and Human Services.

We point out 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 has been 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 of Health and Human Services 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 length of stay 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 fiscal intermediary 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 CMS has 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 the above 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.gov/paymentsystems/icd9*.

As discussed above, section 503(a) of Pub. L. 108–173 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 28220–28221). 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 48954–48957).

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. Because, as discussed above, the LTC–DRGs are the same DRGs used under the IPPS, this means that the Medicare GROUPER software program used under both the IPPS and the LTCH PPS would need to be revised to reflect ICD–9–CM codes, if any coding changes were implemented on April 1. Furthermore, although the CMS GROUPER software used under both the IPPS and the LTCH PPS would need to be revised to accommodate the new codes effective April 1, there would be no additions or deletions of DRGs nor would the relative weights used under the IPPS and the LTCH PPS, respectively, be changed until the annual update October 1 (to the extent that those changes are warranted), just as they have been historically updated. As the LTCH PPS is based on the IPPS, we will adopt 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/paymentsystem/icd9*. Summary tables showing new, revised, and deleted code titles are also posted on the following CMS Web page: *http://www.cms.hhs.gov/medlearn/icd9code.asp*. Information on ICD–9–CM diagnosis codes can be found at *http://www.cdc.gov/nchs/icd9.htm*. Information on new, revised, and deleted ICD–9–CM codes is also available in the AHA publication Coding Clinic for ICD–9–CM. AHA also distributes information to publishers and software vendors. We also send copies of all ICD–9–CM coding changes to our contractors for use in updating their systems and providing education to providers.

If the April 1 changes are made to ICD–9–CM diagnosis or procedure codes, LTCHs will be required to obtain the new codes, coding books, or encoder updates, and make other system changes in order to capture and report the new codes. We indicated in the IPPS final rule 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.

To reiterate, at the October 2004 C&M Committee meeting, no new codes were proposed for update on April 1, 2005. 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 had been created to describe new technologies and medical services through an April 1, 2005 update, under our proposed policy, LTCH systems would have been expected to recognize and report those new codes through the channels as described above in this section.

As discussed above, the ICD–9–CM coding changes that have been adopted by the C&M Committee could become effective either at the beginning of each Federal fiscal year, 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 updated 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 above in section III.D. of this preamble and have been 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, which is 5 months after the date that we publish the LTCH annual payment rate update final rule.

Therefore, because the LTCH PPS and the IPPS uses the identical GROUPER software, the LTCH PPS will be directly affected by the statutory mandates directed at the IPPS, promulgated in section 503(a) of Pub. L. 108–173. The practical effect of this provision is that the GROUPER software must accept new ICD–9 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 by both the IPPS and the LTCH PPS. 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 (as described above). 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, 2005 update, the ICD–9–CM coding set implemented on October 1, 2004 will continue through September 30, 2005 (FY 2005).

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 American Hospital Association (AHA) to provide additional clarification or instruction on proper coding in the LTCH setting. The AHA will provide this instruction via their established process of addressing questions through their publication ''Coding Clinic for ICD–9–CM.'' Written questions or requests for clarification may be addressed to the Central Office on ICD–9–CM, American Hospital Association, One North Franklin, Chicago, IL 60606. A form for the question(s) is available to be downloaded and mailed on AHA's Web site at: *www.ahacentraloffice.org*. In addition, current coding guidelines are available at the National Center for Health Statistics (NCHS) Web site: *www.cdc.gov/nchs.icd9.htm*.

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, just as it did for the IPPS. As noted above, 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 such documentation, the application of all coding guidelines is a difficult, if not impossible, task.'' (Coding Clinic for ICD–9–CM, Fourth Quarter 2002, page 115)

To improve medical record documentation, LTCHs should be aware that if the patient is being admitted for continuation of treatment of an acute or chronic condition, guidelines at Section I.B.10 of the Coding Clinic for ICD–9–CM, Fourth Quarter 2002 (page 129) are applicable concerning selection of principal diagnosis. To clarify coding advice issued in the August 30, 2002 final rule (67 FR 55979–55981), we would like to point out that at Guideline I.B.12, Late Effects, a late effect is considered to be the residual effect (condition produced) after the acute phase of an illness or injury has terminated (Coding Clinic for ICD–9–CM, Fourth Quarter 2002, page 129). Regarding whether a LTCH should report the ICD–9–CM code(s) for an unresolved acute condition instead of the code(s) for late effect of rehabilitation, we emphasize that each case must be evaluated on its unique circumstances and coded appropriately. Depending on the documentation in the medical record, either a code reflecting the acute condition or rehabilitation could be appropriate in a LTCH.

Since implementation of the LTCH PPS, our Medicare fiscal intermediaries have been conducting training and providing assistance to LTCHs in correct coding. We have also issued manuals containing procedures as well as coding instructions to LTCHs and fiscal intermediaries. We will continue to conduct such 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 55979–55981). Additional coding instructions and examples will be published in Coding Clinic for ICD–9–CM.

F. Method for Updating the LTC–DRG Relative Weights

As discussed in the May 7, 2004 LTCH PPS final rule (68 FR 25681), under the LTCH PPS, each LTCH will receive a payment that represents an appropriate amount for the efficient delivery of care to Medicare patients. The system must be able to account adequately for each LTCH's case-mix in order to ensure both fair distribution of Medicare payments and access to adequate care for those Medicare patients whose care is more costly. Therefore, in accordance with § 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 (§ 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 2005 IPPS final rule (69 FR 48982–49000), the LTC–DRG relative weights effective under the LTCH PPS for Federal FY 2005 were calculated using the March 2004 update of FY 2003 MedPAR data and Version 22.0 of the CMS GROUPER software. 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 2005 IPPS final rule (69 FR 48984) for further information on the hospital-specific relative value methodology.)

In order to account for LTC–DRGs with low volume (that is, with fewer than 25 LTCH cases), we grouped those low volume LTC–DRGs into one of five categories (quintiles) based on average charges, for the purposes of determining relative weights. For FY 2005 based on the FY 2003 MedPAR data, we identified 172 LTC–DRGs that contained between 1 and 24 cases. This list of low volume LTC–DRGs was then divided into one of the five low volume quintiles, each containing a minimum of 34 LTC–DRGs (172/5 = 34 with 2 LTC–DRG as a remainder). Each of the low volume LTC–DRGs grouped to a specific quintile received the same relative weight and average length of stay using the formula applied to the regular LTC–DRGs (25 or more cases), as described below. (See the FY 2005 IPPS final rule

(69 FR 48988–48989) for further explanation of the development and composition of each of the five low volume quintiles for FY 2005.)

After grouping the cases in the appropriate LTC–DRG, we calculated the relative weights by first removing statistical outliers and cases with a length of stay of 7 days or less. Next, we adjusted the number of cases 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 described above. (*See* the FY 2005 IPPS final rule (69 FR 48989–48992) for further details on the steps for calculating the LTC–DRG relative weights.)

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 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 August 11, 2003 IPPS final rule, 69 FR 48991–48992.) In addition, of the 520 LTC–DRGs in the LTCH PPS for FY 2005, based on the FY 2003 MedPAR data, we identified 171 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 2003 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 171 LTC–DRGs using the method described above. However, since patients with a number of the diagnoses under these LTC–DRGs may be treated at LTCHs beginning in FY 2005, we assigned relative weights to each of the 171 ''no volume'' LTC–DRGs based on clinical similarity and relative costliness to one of the remaining 349 (520 − 171=349) LTC–DRGs for which we were able to determine relative weights, based on the FY 2003 claims data. (A list of the no-volume LTC–DRGs and further explanation of their relative weight assignment can be found in the FY 2005 IPPS final rule (69 FR 48992–48999).)

Furthermore, for FY 2005, we established LTC–DRG relative weights of 0.0000 for heart, kidney, liver, lung, pancreas, and simultaneous pancreas/kidney transplants (LTC–DRGs 103, 302, 480, 495, 512 and 513, respectively) 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, though, we included these six transplant LTC–DRGs in the GROUPER program for administrative purposes. As the LTCH PPS uses the same GROUPER program for LTCHs as is used under the IPPS, removing these DRGs would be administratively burdensome.

As we stated in the FY 2005 IPPS final rule, we will continue to use the same LTC–DRGs and relative weights for FY 2005 until October 1, 2005. Accordingly, Table 3 in the Addendum to this proposed rule lists the LTC–DRGs and their respective relative weights and arithmetic mean length of stay that we will continue to use for the period of July 1, 2005 through September 30, 2005. (This table is the same as Table 11 of the Addendum to the FY 2005 IPPS final rule (69 FR 49738–49754), including the revisions to Table 11 published in the October 7, 2004 correction notice (69 FR 60267–60271)). As we noted above, the next update to the ICD–9–CM coding system will be presented in the FY 2006 IPPS proposed rule (since there were no April 1 updates to the ICD–9–CM coding system) and the final DRGs and GROUPER for FY 2006 that will be used for the IPPS and the LTCH PPS, effective October 1, 2005, will be presented in the IPPS FY 2006 proposed and final rule in the **Federal Register**.

Accordingly, we will notify LTCHs of the revised LTC–DRG relative weights for use in determining payments for discharges occurring between October 1, 2005 and September 30, 2006 (unless there is an April 1, 2006 update to the ICD–9–CM coding system, as discussed above), based on the final DRGs and the applicable GROUPER version that will be established in FY 2006 IPPS final rule.

IV. Proposed Changes to the LTCH PPS Rates and Proposed Changes in Policy for the 2006 LTCH PPS Rate Year

[If you choose to comment on issues in this section, please include the caption ''PROPOSED CHANGES TO LTCH PPS RATES AND POLICY FOR THE 2006 LTCH PPS RATE YEAR'' at the beginning of your comments.]

A. Overview of the Development of the Payment Rates

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

The basic methodology for determining LTCH PPS Federal prospective payment rates is set forth in the regulations at §§ 412.515 through 412.532. Below we discuss the proposed factors that would be used to update the LTCH PPS standard Federal rate for the 2006 LTCH PPS rate year that would be effective for LTCHs discharges occurring on or after July 1, 2005 through June 30, 2006. When we implemented the LTCH PPS in the August 30, 2002 LTCH PPS final rule (67 FR 56029–56031), 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 Pub. L. 106–113 requires that the PPS developed for LTCHs be budget neutral. Therefore, in calculating the standard Federal rate under § 412.523(d)(2), we set total estimated LTCH PPS payments equal to estimated payments that would have been made under the reasonable cost-based payment methodology had the PPS for LTCHs not been implemented. Section 307(a) of Pub. L. 106–554 specified that the increases to the hospital-specific target amounts and cap on the target amounts for LTCHs for FY 2002 provided for by section 307(a)(1) of Pub. L. 106–554 shall not be taken into account in the development and implementation of the LTCH PPS. Furthermore, as specified at § 412.523(d)(1), the standard Federal rate is reduced by an adjustment factor to account for the estimated proportion of outlier payments under the LTCH PPS to total 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 56027–56037), for the 2004 LTCH PPS rate year rate, see the June 6, 2003 final rule (68

FR 34122–34190), and for the 2005 LTCH PPS rate year rate, see the May 7, 2004 LTCH PPS final rule (69 FR 25674–25748). 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. The proposed update to the standard Federal rate for the 2006 LTCH PPS rate year is discussed below.

B. Proposed Update to the Standard Federal Rate for the 2006 LTCH PPS Rate Year

As established in the May 7, 2004 LTCH PPS final rule (69 FR 25683), 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, 2004 through June 30, 2005 (the 2005 LTCH PPS rate year), is $36,833.69.

In the discussion that follows, we explain how we developed the proposed standard Federal rate for the 2006 LTCH PPS rate year. The proposed standard Federal rate for the 2006 LTCH PPS rate year would be calculated based on the update factor of 1.031. Thus, the proposed standard Federal rate for the 2006 LTCH PPS rate year would increase 3.1 percent compared to the 2005 LTCH PPS rate year standard Federal rate due to the proposed update to the LTCH PPS Federal rate.

1. Proposed Standard Federal Rate Update

Under § 412.523, the annual update to the LTCH PPS standard Federal rate must be equal to the percentage change in the excluded hospital with capital market basket (described in further detail below). As we discussed in the August 30, 2002 LTCH PPS final rule (67 FR 56087), 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. As we discussed in the May 7, 2004 final rule (69 FR 25674), because the LTCH PPS has only been implemented for slightly more than 2 years (that is, for cost reporting periods beginning on or after October 1, 2002), we have not yet collected sufficient data to allow for the analysis and development of an update framework under the LTCH PPS. Therefore, we are not addressing an update framework for the 2006 LTCH PPS rate year in this proposed rule. However, we note that a conceptual basis for the proposal of developing an update framework in the future can be found in Appendix B of the August 30, 2002 LTCH PPS final rule (67 FR 56086–56090).

a. *Description of the Proposed Market Basket for LTCHs for the 2006 LTCH PPS Rate Year.* A market basket has historically been used in the Medicare program 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 56027–56037).

Under the reasonable cost-based payment system, the excluded hospital market basket was used to update the hospital-specific limits on payment for operating costs of LTCHs. Currently, the excluded hospital market basket is based on operating costs from cost report data from FY 1997 and includes data from Medicare-participating long-term care, rehabilitation, psychiatric, cancer, and children's hospitals. Since LTCHs' costs 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.

As we discussed in the August 30, 2002 LTCH PPS final rule (67 FR 56016 and 56086), beginning with the implementation of the LTCH PPS in FY 2003, the excluded hospital with capital market basket, based on FY 1992 Medicare cost report data, has been used for updating payments to LTCHs. In the May 7, 2004 LTCH PPS final rule (69 FR 25683), we revised and rebased the excluded hospital with capital market basket, using more recent data, that is, using FY 1997 base year data beginning with the 2004 LTCH PPS rate year. (For further details on the development of the FY 1997-based LTCH PPS market basket, *see* the May 7, 2004 LTCH PPS final rule (69 FR 25683)).

In the August 30, 2002 LTCH PPS final rule (67 FR 56016 and 56085–56086), we discussed why we believe the excluded hospital with capital market basket provides a reasonable measure of the price changes facing LTCHs. In the May 7, 2004 LTCH PPS final rule (69 FR 25682–25683), we discussed our research into the feasibility of developing a market basket specific to LTCH services. However, based on this research, we did not develop a market basket specific to LTCH services. In that same final rule, we explained why we continue to believe that the excluded hospital with capital market basket is the appropriate market basket for the LTCH PPS.

For the reasons discussed in those final rules (August 30, 2002 and May 7, 2004), we continue to believe that an excluded hospital with capital market basket adequately reflects the price changes facing LTCHs. Therefore, in this proposed rule, we are proposing to continue to use the FY 1997-based excluded hospital with capital market basket as the LTCH PPS market basket for determining the proposed update to the LTCH PPS standard Federal rate for the 2006 LTCH PPS rate year. We continue to solicit comments about issues particular to LTCHs that should be considered in relation to the FY 1997-based excluded hospital with capital market basket and to encourage suggestions for additional data sources that may be available.

b. *Proposed LTCH Market Basket Increase for the 2006 LTCH Rate Year.* As we discussed in the May 7, 2004 LTCH PPS final rule (69 FR 25683), for the update to the 2005 LTCH PPS rate year, we calculated the estimated increase between the 2004 LTCH PPS rate year (July 1, 2003 through June 30, 2004) and the 2005 LTCH PPS rate year (July 1, 2004 through June 30, 2005) based on Global Insight's forecast of the revised and rebased FY 1997-based excluded hospital with capital market basket using data available through the fourth quarter of 2003. The market basket for the 2005 LTCH PPS rate year was 3.1 percent (69 FR 25683). Consistent with our historical practice of estimating market basket increases based on Global Insight's forecast of the FY 1997-based excluded hospital with capital market basket using more recent data through the third quarter of 2004, we are proposing a 3.1 percent update to the Federal rate for the 2006 LTCH PPS rate year. In accordance with § 412.523, this proposed update would represent the most recent estimate of the increase in the excluded hospital with capital market basket for the 2006 LTCH PPS rate year.

2. Proposed Standard Federal Rate for the 2006 LTCH PPS Rate Year

In the May 7, 2004 LTCH PPS final rule (69 FR 25683), we established a standard Federal rate of $36,833.69 for the 2005 LTCH PPS rate year that was

based on the best available data and policies established in that final rule.

In this proposed rule, in accordance with § 412.523, we are proposing to establish a standard Federal rate of $37,975.53 based on the most recent estimate of the LTCH PPS market basket of 3.1 percent. Since the proposed standard Federal rate for the 2006 LTCH PPS rate year has already been adjusted for differences in case-mix, wages, cost-of-living, and high-cost outlier payments, we are not proposing to make any additional adjustments in the proposed standard Federal rate for these factors.

C. Proposed Calculation of Proposed LTCH Prospective Payments for the 2006 LTCH PPS Rate Year

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

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 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 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.

1. Proposed Adjustment for Area Wage Levels

a. *Background.* Under the authority of section 307(b) of Pub. L. 106–554, 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, 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 section 1886(d)(8) or section 1886(d)(10) of the Act. Furthermore, as we discussed in the August 30, 2002 LTCH PPS final rule (67 FR 56015–56019), 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 the following table:

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

For example, for cost reporting periods beginning on or after October 1, 2004 and 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 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. 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 May 7, 2004 LTCH PPS final rule (69 FR 25674), because the LTCH PPS has only been recently implemented (slightly over 2 years) and because of the lag time in availability of cost report data, sufficient new data have not been generated that would enable us to conduct a comprehensive reevaluation of the appropriateness of adjusting the phase-in. However, we have reviewed the most recent data (FY 2001–FY 2003) available and did not find any evidence to support a change in the 5-year phase-in of the wage index. Specifically, our statistical analysis still does not show a significant relationship between LTCHs' costs and their geographic location. Therefore, in this proposed rule, we are not proposing a change in the phase-in of the adjustment for area wage levels under § 412.525(c).

b. *Proposed Labor-Related Share.* In the August 30, 2002 LTCH PPS final rule (67 FR 56016), we established a labor-related share of 72.885 percent based on the relative importance of the labor-related share of operating costs (wages and salaries, employee benefits, professional fees, postal services, and all

other labor-intensive services) and capital costs of the excluded hospital with capital market basket based on FY 1992 data. In the March 7, 2003 proposed rule (68 FR 11249–11250), 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 the August 1, 2002 IPPS final rule, we did not update the IPPS or excluded hospital labor-related shares for FY 2003 (67 FR 50041–50042), and we discussed our research into the appropriateness of this policy. Specifically, we discussed the methods that we were reviewing for establishing the labor-related share and our intention to continue to explore all options for alternative data and a methodology 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.

As we discussed in greater detail in the May 7, 2004 LTCH PPS final rule (69 FR 25685–25686), the LTCH PPS was modeled after the IPPS for short-term, acute care hospitals. Specifically, the LTCH PPS uses the same patient classification system (CMS–DRGs) as the IPPS, and many of the case-level and facility-level adjustments explored or adopted for the LTCH PPS are payment adjustments under the IPPS (69 FR 25686). In fact, LTCHs are certified as acute care hospitals to participate as a hospital in the Medicare program, and in general, qualify for payment under the LTCH PPS instead of the IPPS solely because their Medicare inpatient average length of stay is greater than 25 days (69 FR 25686). In addition, prior to qualifying as a LTCH, hospitals generally are paid under the IPPS during the period in which they demonstrate that they have an average Medicare inpatient length of stay of greater than 25 days (69 FR 25686).

The primary reason that we did not update the LTCH PPS labor-related share for the 2004 and 2005 LTCH PPS rate years was the same reason that we explained for not updating the labor-related share under the IPPS for FY 2004 (see August 1, 2003; 68 FR 27226) and FY 2005 (see FY 2005 IPPS final rule (69 FR 49069)), which are equally applicable to the LTCH PPS. As we noted above, and as we explained in the May 7, 2004 LTCH PPS final rule (69 FR 5686), we did not revise the labor-related share under the IPPS based on the revised and rebased FY 1997 hospital market basket and the excluded hospital market basket because of data and methodological concerns. We indicated that we would conduct further analysis to determine the most appropriate methodology and data for determining the labor-related share.

The IPPS labor-related share of 71.066 percent was established in the August 29, 1997 IPPS final rule (62 FR 45995), effective for IPPS discharges occurring on or after October 1, 1997 (FY 1998). This (71.066 percent) is the most recent estimate of ''the proportion (as estimated by CMS from time to time) of Federal rates'' under the IPPS adjusted to account for different area wage levels and labor-related costs (§ 412.62(k)). As also explained in the August 29, 1997 IPPS final rule (62 FR 45995), the labor-related portion of the IPPS operating standardized amounts is determined by summing the labor-related items of the revised 1992-based operating prospective payment hospital market basket (that is, wages and salaries, employee benefits, professional fees, business services, computer and data processing services, postage, and all other labor intensive services). This is the same methodology used to determine the operating portion of the current LTCH PPS labor-related share established in the August 30, 2002 LTCH PPS final rule (67 FR 56016), which is effective for LTCH PPS discharges occurring in cost reporting periods beginning on or after October 1, 2002 (FY 2003). (Note, as discussed in the August 30, 2002 LTCH PPS final rule (67 FR 56016), because the LTCH PPS standard Federal rate includes both operating and capital costs, the LTCH PPS labor-related share includes the labor-related share of capital costs as well as the labor-related share of operating costs.)

As noted above, the IPPS labor-related share of 71.066 percent became effective for IPPS discharges occurring on after October 1, 1997. As we also discussed in the May 7, 2004 LTCH PPS final rule (69 FR 25686), for purposes of payment under the IPPS, section 403 of Pub. L. 108–173 amended section 1886(d) of the Act to provide that for discharges occurring on or after October 1, 2004, the Secretary must employ 62 percent as the labor-related share under the IPPS, unless this ''would result in lower payments to a hospital than would otherwise be made.'' That is, beginning in FY 2005 under the IPPS, the labor-related share remains 71.066 percent for acute-care hospitals with a wage index greater than 1.0, while the labor-related share is equal to 62 percent for acute-care hospitals under the IPPS with a wage index less than or equal to 1.0 (69 FR 49070). This alternative labor-related share is only applicable to acute care hospitals paid under the IPPS and does not apply to LTCHs.

The current LTCH PPS labor share (72.885 percent) was developed using the same methodology used to develop the existing IPPS labor share (71.066). The statutory alternative (62 percent) is limited to acute care hospitals paid under the IPPS and does not apply to hospitals paid under the LTCH PPS. Since we had not yet completed the research of the labor-share methodology used to establish the current IPPS labor-related share estimated by CMS from time (71.066 percent) and the current LTCH PPS labor-related share (72.885 percent), we did not change the LTCH PPS labor-share for the 2005 LTCH PPS rate year.

Since we are continuing our research into updating the hospital labor-related share and because we have not implemented a change in the methodology for determining both the existing IPPS labor-related share estimated by CMS from time to time (as discussed in the FY 2005 IPPS final rule (69 FR 49069–49070)) and the current LTCH PPS labor-related share, we are not proposing to change the LTCH PPS labor-related share at this time. Accordingly, we are proposing that the labor-related share for the 2006 LTCH PPS rate year remain at 72.885 percent. As is the case under the IPPS, once our research on the labor-related share is complete, any future revisions to the LTCH PPS labor-related share will be proposed and subject to public comment in a future rule.

c. *Proposed Revision of LTCH PPS Geographic Classifications.* As discussed in the August 30, 2002 LTCH PPS final rule, which implemented the LTCH PPS (67 FR 56015), 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. As set forth in § 412.525(c), a LTCH's wage index is determined based on the location of the LTCH in an urban or rural area as defined in § 412.62(f)(1)(ii) and (f)(1)(iii), respectively. An urban area, under the LTCH PPS, is defined at § 412.62(f)(1)(ii)(A) and (B). In general,

an urban area is defined as a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA) as defined by the Office of Management and Budget (OMB). (In addition, a few counties located outside of MSAs are considered urban as specified at § 412.62(f)(1)(ii)(B).) Under § 412.62(f)(1)(iii), a rural area is defined as any area outside of an urban area. The geographic classifications defined in § 412.62(f)(1)(ii) and (f)(1)(iii), respectively, were used under the IPPS from FYs 1984 through 2004 (§§ 412.62(f) and 412.63(b)), and have been used under the LTCH PPS since it was implemented for cost reporting periods beginning on or after October 1, 2002 (FY 2003).

Under the IPPS, the wage index is calculated and assigned to hospitals on the basis of the labor market area in which the hospital is located or geographically reclassified to in accordance with sections 1886(d)(8) and (d)(10) of the Act. Under the LTCH PPS, the wage index is calculated using IPPS wage index data (as discussed below in section IV.C.1.d of this preamble) on the basis of the labor market area in which the hospital is located, but without taking into account geographic reclassification under sections 1886(d)(8) and (d)(10) of the Act. The applicable LTCH wage index value is assigned to a LTCH on the basis of the labor market area in which the LTCH is geographically located.

The current LTCH PPS labor market areas are defined based on the definitions of MSAs, Primary MSAs (PMSAs), and NECMAs issued by the OMB (commonly referred to collectively as ''MSAs''). These MSA definitions, which are discussed in greater detail below, are currently used under the LTCH PPS and other non-IPPS prospective payment systems (that is, the inpatient rehabilitation facility PPS (IRF PPS), the inpatient psychiatric facility PPS (IPF PPS), the home health agency PPS (HHA PPS), and the skilled nursing facility PPS (SNF PPS)). In the FY 2005 IPPS final rule (67 FR 49026–49034), revised labor market area definitions were adopted under the IPPS (§ 412.64(b)), which were effective October 1, 2004. These new standards, called Core-Based Statistical Areas (CBSAs), were announced by the OMB late in 2000 and are discussed in greater detail below.

1. *Current LTCH PPS Labor Market Areas Based on MSAs.* Below, we will provide a description of the current labor markets that have been used for area wage adjustments under the LTCH PPS since its implementation for cost reporting periods beginning on or after October 1, 2002. Previously, we have not described the labor market areas used under the LTCH PPS in detail, although we have published each area's wage index in tables, in the LTCH PPS final rules, each year and noted the use of the geographic area (MSA) in applying the wage index adjustment in LTCH PPS payment examples in the final regulation implementing the LTCH PPS (August 30, 2002 67 FR 56037–56038). The LTCH industry has also understood that the same labor market areas in use under the IPPS (from the time LTCH PPS was implemented, for cost reporting periods beginning on or after October 1, 2002) would be used under the LTCH PPS. Because OMB has adopted new statistical area definitions (as discussed in greater detail below) and we are proposing to adopt new labor market area definitions based on these areas under the LTCH PPS (as discussed in greater detail below), we believe it is helpful to provide a more detailed description of the current LTCH PPS labor market areas, in order to better understand the proposed change to the LTCH PPS labor market areas presented below in this proposed rule.

As mentioned earlier, since the implementation of the LTCH PPS in the August 30, 2002 LTCH PPS final rule, we have used labor market areas to further characterize urban and rural areas as determined under § 412.62(f)(1)(ii) and (iii). To this end, we have defined labor market areas under the LTCH PPS based on the definitions of MSAs, PMSAs, and NECMAs issued by the OMB, which is consistent with the IPPS approach. The OMB also designates Consolidated MSAs (CMSAs). A CMSA is a metropolitan area with a population of one million or more, comprising two or more PMSAs (identified by their separate economic and social character). For purposes of the wage index, we use the PMSAs rather than CMSAs because they allow a more precise breakdown of labor costs. If a metropolitan area is not designated as part of a PMSA, we use the applicable MSA.

These different designations use counties as the building blocks upon which they are based. Therefore, under the LTCH PPS, hospitals are assigned to either an MSA, PMSA, or NECMA based on whether the county in which the LTCH is located is part of that area. All of the counties in a State outside a designated MSA, PMSA, or NECMA are designated as rural. Specifically, for purposes of calculating the wage index, we currently combine all of the counties in a State outside a designated MSA, PMSA, or NECMA together to calculate the statewide rural wage index for each State. The labor market area definitions currently used under the LTCH PPS are the same as those used for acute care inpatient hospitals under the IPPS prior to FY 2005 (69 FR 49026).

2. *Core-Based Statistical Areas.* The OMB reviews its Metropolitan Area (MA) definitions preceding each decennial census. As discussed in the FY 2005 IPPS final rule (69 FR 49027), in the fall of 1998, the OMB chartered the Metropolitan Area Standards Review Committee to examine the MA standards and develop recommendations for possible changes to those standards. Three notices related to the review of the standards, providing an opportunity for public comment on the recommendations of the Committee, were published in the **Federal Register** on the following dates: December 21, 1998 (63 FR 70526); October 20, 1999 (64 FR 56628); and August 22, 2000 (65 FR 51060).

In the December 27, 2000 **Federal Register** (65 FR 82228–82238), the OMB announced its new standards. In that notice, the OMB defines a Core-Based Statistical Area (CBSA), beginning in 2003, as ''a geographic entity associated with at least one core of 10,000 or more population, plus adjacent territory that has a high degree of social and economic integration with the core as measured by commuting ties. The standards designate and define two categories of CBSAs: MSAs and Micropolitan Statistical Areas.'' (65 FR 82236)

According to the OMB, MSAs are based on urbanized areas of 50,000 or more population, and Micropolitan Statistical Areas (referred to in this discussion as Micropolitan Areas) are based on urban clusters of at least 10,000 population, but less than 50,000 population. Counties that do not fall within CBSAs (either MSAs or Micropolitan Areas) are deemed ''Outside CBSAs.'' In the past, the OMB defined MSAs around areas with a minimum core population of 50,000, and smaller areas were ''Outside MSAs.'' On June 6, 2003, the OMB announced the new CBSAs, comprised of MSAs and the new Micropolitan Areas based on Census 2000 data. (A copy of the announcement may be obtained at the following Internet address: *http://www.whitehouse.gov/omb/bulletins/fy04/b04–03.html.*) The new CBSA designations recognize 49 new MSAs and 565 new Micropolitan Areas, and extensively revise the composition of many of the existing MSAs. There are 1,090 counties in MSAs under the new CBSA designations (previously, there were 848

counties in MSAs). Of these 1,090 counties, 737 are in the same MSA as they were prior to the change in designations, 65 are in a different MSA, and 288 were not previously designated to any MSA. There are 674 counties in Micropolitan Areas. Of these, 41 were previously in an MSA, while 633 were not previously designated to an MSA. There are five counties that previously were designated to an MSA but are no longer designated to either an MSA or a new Micropolitan Area: Carter County, KY; St. James Parish, LA; Kane County, UT; Culpepper County, VA; and King George County, VA. For a more detailed discussion of the conceptual basis of the new CBSAs, refer to the FY 2005 IPPS final rule (67 FR 49026–49034).

3. *Proposed Revision of the LTCH PPS Labor Market Areas.* In its June 6, 2003 announcement, the OMB cautioned that these new definitions ''should not be used to develop and implement Federal, State, and local nonstatistical programs and policies without full consideration of the effects of using these definitions for such purposes. These areas should not serve as a general-purpose geographic framework for nonstatistical activities, and they may or may not be suitable for use in program funding formulas.''

As discussed in the FY 2005 IPPS final rule (69 FR 49027), we have previously examined alternatives to the use of MSAs for the purpose of establishing labor market areas for Medicare wage indices in general. For purposes of the proposed changes to the LTCH PPS labor market areas, we examined the same alternatives to the use of MSAs as examined under the IPPS. In the May 27, 1994, IPPS proposed rule (59 FR 27724), we presented our latest research concerning possible future refinements to the labor market areas. Specifically, we discussed and solicited comment on the proposal by the Prospective Payment Assessment Commission (ProPAC), a predecessor organization to the Medicare Payment Advisory Commission (MedPAC), for hospital-specific labor market areas based on each hospital's nearest neighbors, and our research and analysis on alternative labor market areas. Even though we found that none of the alternative labor market areas that we studied provided a distinct improvement over the use of MSAs, we presented an option using the MSA-based wage index, but generally giving a hospital's own wages a higher weight than under the current system. We also described for comment a State labor market option, under which hospitals would be allowed to design labor market areas within their own State boundaries.

We described the comments we received in the June 2, 1995 IPPS proposed rule (60 FR 29219). Specifically, as we discussed in that same proposed rule, there was no consensus among the commenters on the choice for new labor market areas. Many individual hospitals that commented on that proposed rule expressed dissatisfaction with all of the proposals. However, several State hospital associations that commented on that proposed rule stated that the options merited further study. Therefore, at that time we contacted the association representatives that participated in our November 1993 meeting on labor market issues in which we solicited ideas for additional types of labor market research to conduct. None of the individuals we contacted suggested any ideas for further research. After considering these same options for the LTCH PPS, we conclude that there is no basis for believing that either the nearest neighbor option or the State labor market option would result in a wage index adjustment that would be more appropriate for LTCHs than the MSA-based wage index adjustment. As discussed in the June 2, 1995 IPPS proposed rule (60 FR 29219), these options could inappropriately reward the highest cost hospitals with higher wage indexes and there would likely be less than full consent by hospitals to participate in the alternative options, particularly if hospitals face lower reimbursement due to the change.

Consequently, consistent with the approach taken under the IPPS, we have used MSAs to define labor market areas for purposes of Medicare wage indices in the LTCH PPS since its implementation for cost reporting periods beginning on or after October 1, 2002. In fact, MSAs are also used to define labor market areas for purposes of the wage index for many of the other Medicare payment systems (for example, IRF PPS, SNF PPS, HHA PPS, Outpatient PPS, and IPF PPS). While we recognize MSAs are not designed specifically to define labor market areas, we believe they do represent a useful proxy for this purpose, and our analysis and discussion here are focused on issues related to adopting the new CBSA-based designations to define labor market areas for purposes of the IPPS and for purposes of proposing them for LTCH PPS.

Historically, Medicare prospective payment systems have utilized MA definitions developed by the OMB. The labor market areas currently used under the LTCH PPS (described above in section IV.C.1.c.1. of this preamble) are based on the MA definitions issued by the OMB. As noted above, the OMB reviews its MA definitions preceding each decennial census to reflect more recent population changes. As discussed in greater detail above in section IV.C.1.c.2., the CBSAs are the OMB's latest MA definitions based on the Census 2000 data. Because we believe that the OMB's latest MA designations more accurately reflect the local economies and wage levels of the areas in which hospitals are currently located, we adopted revised labor market area designations based on the OMB's CBSA designations under the IPPS effective October 1, 2004.

When we implemented the wage index adjustment at § 412.525(c) under the LTCH PPS in the August 30, 2002 LTCH PPS final rule (67 FR 56016), we explained that the LTCH PPS wage index adjustment was intended to reflect the relative hospital wage levels in the geographic area of the hospital as compared to the national average hospital wage level. Because we believe that the OMB's CBSA designations based on Census 2000 data reflect the most recent available geographic classifications (MA definitions), we are proposing to revise the labor market area definitions used under the LTCH PPS based on the OMB's CBSA designations to 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. Specifically, we are proposing to revise the LTCH PPS labor market definitions based on the OMB's new CBSA designations (as discussed in greater detail below) effective for LTCH PPS discharges occurring on or after July 1, 2005. Accordingly, we are proposing to revise § 412.525(c) to specify that for discharges occurring on or after July 1, 2005, the application of the wage index under the LTCH PPS would be made on the basis of the location of the facility in an urban or rural area as defined in § 412.64(b)(1)(ii)(A)–(C). (As a conforming change, we are also proposing to revise § 412.525(c) to state that the current labor area definitions in the existing § 412.525(c) would be effective for discharges occurring in cost reporting periods beginning on or after October 1, 2002 and before July 1, 2005.)

We also note that these are the same labor market area definitions (based on the OMB's new CBSA designations) implemented for acute care inpatient hospitals under the IPPS at § 412.64(b), which were effective for those hospitals

beginning October 1, 2004 as discussed in the FY 2005 IPPS final rule (69 FR 49026–49034). As discussed above in section IV.C.1.b. of this preamble, the LTCH PPS was modeled after the IPPS for short-term acute care inpatient hospitals. The similarity between the IPPS and the LTCH PPS includes the adoption in the initial implementation of the LTCH PPS of the same labor market area definitions under the LTCH PPS that existed under the IPPS at that time, as well as the use of acute care inpatient hospitals' wage data in calculating the LTCH PPS wage index. Therefore, besides reflecting the most recent available geographic classifications and, consequently, more accurately reflecting the current labor markets (which is the primary reason for proposing to adopt OMB's new CBSA-based designations), we believe that proposing to revise the LTCH PPS labor marker area definitions based on OMB's new CBSA-based designations is also consistent with our historical practice of modeling LTCH PPS policy after IPPS policy.

Below, we discuss the composition of the proposed LTCH PPS labor market areas based on the OMB's new CBSA designations. It should be noted that OMB's new CBSA designations are comprised of several county-based area definitions as explained above, which include Metropolitan Areas, Micropolitan Areas, and areas ''outside CBSAs.'' Under the LTCH PPS, since the implementation of the LTCH PPS, we have used two types of labor market areas, urban and rural. As discussed in greater detail below, in this proposed rule, in proposing to adopt revised labor market areas under the LTCH PPS based on OMB's new CBSA-based designations, we are proposing to continue to have 2 types of labor market areas (urban and rural). In the discussion that follows, we explain our proposal to recognize Metropolitan Areas, which include New England MSAs and Metropolitan Divisions, as urban. We also explain our proposal to recognize Micropolitan Areas and areas ''outside CBSAs'' as rural. The following discussion will describe the proposed methodology for mapping OMB's CBSA-based designations into the LTCH PPS (urban area or rural area) format.

a. *New England MSAs.* As stated above, under the LTCH PPS, we currently use NECMAs to define labor market areas in New England, because these are county-based designations rather than the 1990 MSA definitions for New England, which used minor civil divisions such as cities and towns. Under the current MSA definitions, NECMAs provided more consistency in labor market definitions for New England compared with the rest of the country, where MSAs are county-based. Under the new CBSAs, the OMB has now defined the MSAs and Micropolitan Areas in New England on the basis of counties. The OMB also established New England City and Town Areas, which are similar to the previous New England MSAs.

In order to create consistency across all LTCH labor market areas, under the LTCH PPS, we are proposing to use the county-based areas for all MSAs in the nation, including those in New England. The OMB has now defined the New England area based on counties, creating a city- and town-based system as an alternative. We believe that adopting county-based labor market areas for the entire country except those in New England would lead to inconsistencies in our designations. Adopting county-based labor market areas for the entire country provides consistency and stability in Medicare program payment because all of the labor market areas throughout the country, including New England, would be defined using the same system (that is, counties) rather than different systems in different areas of the county, and minimizes programmatic complexity.

In addition, we have consistently employed a county-based system for New England for precisely that reason: to maintain consistency with the labor market definitions used throughout the country. Because we have never used cities and towns for defining LTCH labor market areas, employing a county-based system in New England maintains that consistent practice. We note that this is consistent with the implementation of the CBSA-based designations under the IPPS for New England (69 FR 49028). Accordingly, under the LTCH PPS we are proposing to use the New England MSAs as determined under the proposed new CBSA-based labor market area definitions in defining the proposed revised LTCH PPS labor market areas.

b. *Metropolitan Divisions.* Under the OMB's new CBSA designations, a Metropolitan Division is a county or group of counties within a CBSA that contains a core population of at least 2.5 million, representing an employment center, plus adjacent counties associated with the main county or counties through commuting ties. A county qualifies as a main county if 65 percent or more of its employed residents work within the county and the ratio of the number of jobs located in the county to the number of employed residents is at least 0.75. A county qualifies as a secondary county if 50 percent or more, but less than 65 percent, of its employed residents work within the county and the ratio of the number of jobs located in the county to the number of employed residents is at least .75. After all the main and secondary counties are identified and grouped, each additional county that already has qualified for inclusion in the MSA falls within the Metropolitan Division associated with the main/secondary county or counties with which the county at issue has the highest employment interchange measure. Counties in a Metropolitan Division must be contiguous. (65 FR 82236)

The construct of relatively large MSAs being comprised of Metropolitan Divisions is similar to the current construct of CMSAs comprised of PMSAs. As noted above, in the past, the OMB designated CMSAs as Metropolitan Areas with a population of one million or more and comprised of two or more PMSAs. Under the LTCH PPS, we currently use the PMSAs rather than CMSAs to define labor market areas because they comprise a smaller geographic area with potentially varying labor costs due to different local economies. We believe that CMSAs may be too large of an area with a relatively large number of hospitals, to accurately reflect the local labor costs of all of the individual hospitals included in that relatively ''large'' area. A large market area designation increases the likelihood of including many hospitals located in areas with very different labor market conditions within the same market area designation. This variation could increase the difficulty in calculating a single wage index that would be relevant for all hospitals within the market area designation. Similarly, we believe that MSAs with a population of 2.5 million or greater may be too large of an area to accurately reflect the local labor costs of all of the individual hospitals included in that relatively ''large'' area. Furthermore, as indicated above, Metropolitan Divisions represent the closest approximation to PMSAs, the building block of the current LTCH PPS labor market area definitions, and therefore, would most accurately maintain our current structuring of the LTCH PPS labor market areas. Therefore, as implemented under the IPPS (69 FR 49029), we are proposing to use the Metropolitan Divisions where applicable (as described below) under the proposed new CBSA-based labor market area definitions.

In addition to being comparable to the organization of the labor market areas under current MSA designations (that is, the use of PMSAs rather than

CMSAs), we believe that proposing to use Metropolitan Divisions where applicable (as described below) under the LTCH PPS would result in a more accurate adjustment for the variation in local labor market areas for LTCHs. Specifically, if we would recognize the relatively ''larger'' CBSA that comprises two or more Metropolitan Divisions as an independent labor market area for purposes of the wage index, it would be too large and would include the data from too many hospitals to compute a wage index that would accurately reflect the various local labor costs of all of the individual hospitals included in that relatively ''large'' CBSA. As mentioned earlier, a large market area designation increases the likelihood of including many hospitals located in areas with very different labor market conditions within the same market area designation. This variation could increase the difficulty in calculating a single wage index that would be relevant for all hospitals within the market area designation. Rather, by proposing to recognize Metropolitan Divisions where applicable (as described below) under the proposed new CBSA-based labor market area definitions under the LTCH PPS, we believe that in addition to more accurately maintaining the current structuring of the LTCH PPS labor market areas, the local labor costs would be more accurately reflected, thereby resulting in a wage index adjustment that better reflects the variation in the local labor costs of the local economies of the LTCHs located in these relatively ''smaller'' areas.

Below we describe where Metropolitan Divisions would be applicable under the proposed new CBSA-based labor market area definitions under the LTCH PPS.

Under OMB's new CBSA-based designations, there are 11 MSAs containing Metropolitan Divisions: Boston; Chicago; Dallas; Detroit; Los Angeles; Miami; New York; Philadelphia; San Francisco; Seattle; and Washington, D.C. Although these MSAs were also CMSAs under the prior definitions, in some cases these areas have been significantly altered. Under the current LTCH PPS MSA designations, Boston is a single NECMA. Under the proposed CBSA-based labor market area designations, it would be comprised of 4 Metropolitan Divisions. Los Angeles would go from 4 PMSAs under the current LTCH PPS MSA designations to 2 Metropolitan Divisions under the proposed CBSA-based labor market area designations because 2 MSAs became separate MSAs. The New York CMSA would go from 15 PMSAs under the current LTCH PPS MSA designations down to only 4 Metropolitan Divisions under the proposed CBSA-based labor market area designations. Five PMSAs in Connecticut under the current LTCH PPS MSA designations would become separate MSAs under the proposed CBSA-based labor market area designations, and the number of PMSAs in New Jersey under the current LTCH PPS MSA designations would go from 5 to 2, with the consolidation of 2 New Jersey PMSAs (Bergen-Passaic and Jersey City) into the New York-Wayne-White Plains, NY-NJ Division, under the proposed CBSA-based labor market area designations. In San Francisco, under the proposed CBSA-based labor market area designations, only 2 Divisions would remain where there were once 6 PMSAs some of which are now separate MSAs under the current LTCH PPS labor market area designations.

Under the current LTCH PPS labor market area designations, Cincinnati, Cleveland, Denver, Houston, Milwaukee, Portland, Sacramento, and San Juan are all designated as CMSAs, but would no longer be designated as CMSAs under the proposed CBSA-based labor market area designations. As noted previously, the population threshold to be designated a CMSA under the current LTCH PPS labor market area designations is one million. In most of these cases, counties currently in a PMSA under the current LTCH PPS labor market area designations would become separate, independent MSAs under the proposed CBSA-based labor market area designations.

c. *Micropolitan Areas.* Under the OMB's new CBSA-based designations, Micropolitan Areas are essentially a third area definition made up mostly of currently rural areas, but also include some or all of areas that are currently designated as an urban MSA. As discussed in greater detail in the FY 2005 IPPS final rule (69 FR 49029–49032), how these areas are treated would have significant impacts on the calculation and application of the wage index. Specifically, whether or not Micropolitan Areas are included as part of the respective statewide rural wage indices would impact the value of statewide rural wage index of any State that contains a Micropolitan Area because a hospital's classification as urban or rural affects which hospitals' wage data are included in the statewide rural wage index. As discussed above in section IV.C.1.c.1., we combine all of the counties in a State outside a designated urban area together to calculate the statewide rural wage index for each State.

In general, including Micropolitan Areas as part of the statewide rural labor market area would result in an increase to the statewide rural wage index because hospitals located in those Micropolitan Areas typically have higher labor costs than other rural hospitals in the State. Alternatively, as discussed in greater detail below, if Micropolitan Areas would be recognized as independent labor market areas, because there would be so few hospitals in each labor market area, the wage indices for LTCHs in those areas could become relatively unstable as they would change considerably from year to year.

Because we currently use MSAs to define urban labor market areas and we group all the hospitals in counties within each State that are not assigned to an MSA together into a statewide rural labor market area, we have used the terms ''urban'' and ''rural'' wage indexes in the past for ease of reference. However, the introduction of Micropolitan Areas by the OMB potentially complicates this terminology because these areas include many hospitals that are currently included in the statewide rural labor market areas.

We are proposing to treat Micropolitan Areas as rural labor market areas under the LTCH PPS for the reasons outlined below. That is, counties that are assigned to a Micropolitan area under the CBSA-based designations would be treated the same as other ''rural'' counties that are not assigned to either an MSA (Metropolitan Statistical Area) or a Micropolitan Area. Therefore, in determining a LTCH's applicable wage index (based on IPPS hospital wage index data, as discussed in greater detail below in section IV.C.d. of this preamble), we propose that a LTCH in a Micropolitan Area under the OMB's CBSA-based designations would be classified as ''rural'' and would be assigned the statewide rural wage index for the State in which it resides.

In the FY 2005 IPPS final rule (69 FR 49029–49032), we discuss our evaluation of the impact of treating Micropolitan Areas as part of the statewide rural labor market area instead of treating Micropolitan Areas as independent labor market areas for hospitals paid under the IPPS. As an alternative to treating Micropolitan Areas as part of the statewide rural labor market area for purposes of the LTCH PPS, we examined treating Micropolitan Areas as separate (urban) labor market areas, just as we did when implementing the revised labor market areas under the IPPS. As discussed in that same final rule, one of the reasons

Micropolitan Areas have such a dramatic impact on the wage index is, because Micropolitan Areas encompass smaller populations than MSAs, they tend to include fewer hospitals per Micropolitan Area. Currently, there are only 25 MSAs with one hospital in the MSA. However, under the new proposed CBSA-based definitions, there are 373 Micropolitan Areas with one hospital, and 49 MSAs with only one hospital.

This large number of labor market areas with only one hospital and the increased potential for dramatic shifts in the wage indexes from 1 year to the next is a problem for several reasons. First, it creates instability in the wage index from year to year for a large number of hospitals. Second, it reduces the averaging effect (This averaging effect allows for more data points to be used to calculate a representative standard of measured labor costs within a market area.) lessening some of the incentive for hospitals to operate efficiently. This incentive is inherent in a system based on the average hourly wages for a large number of hospitals, as hospitals could profit more by operating below that average. In labor market areas with a single hospital, high wage costs are passed directly into the wage index with no counterbalancing averaging with lower wages paid at nearby competing hospitals. Third, it creates an arguably inequitable system when so many hospitals have wage indexes based solely on their own wages, while other hospitals' wage indexes are based on an average hourly wage across many hospitals.

For the reasons noted above, and consistent with the treatment of these areas under the IPPS, we are proposing not to adopt Micropolitan Areas as independent labor market areas under the LTCH PPS, but instead, we propose that Micropolitan Areas, under the CBSA-based labor market area definitions, would be considered part of the statewide rural labor market area. Accordingly, we are proposing that the LTCH PPS statewide rural wage index would be determined using acute-care IPPS hospital wage data (the rational for using IPPS hospital wage data is discussed in greater detail below in section IV.C.1.d. of this preamble) from hospitals located in non-MSA areas (for example, rural areas, including Micropolitan Areas) and that statewide rural wage index would be assigned to LTCHs located in those non-MSA areas.

4. Implementation of the Proposed Revised Labor Market Areas Under the LTCH PPS

We note that, consistent with our policy under the IPPS, we are not proposing to adopt the proposed new labor market area definitions themselves in a budget neutral manner. As we discussed in the August 30, 2002 LTCH PPS final rule, under section 123 of Pub. L. 106–113, and section 307 of Pub. L. 106–554, the Secretary generally has broad authority in developing the LTCH PPS, including whether and how to make adjustments to the LTCH PPS. In that same final rule we state that we will consider whether it is appropriate for us to propose a budget neutrality adjustment in the annual update of some aspects of the LTCH PPS under our broad discretionary authority under the statute to provide ''appropriate adjustments'' to the LTCH PPS. Until the 5-year transition from cost-based reimbursement to prospective payment is complete, including the end of the phase-in of the wage index adjustment under § 412.525(c), we believe that it would not be appropriate to update any aspects of the LTCH PPS in a budget neutral manner. A primary reason for waiting until after the transition is complete before evaluating aspects of the LTCH PPS, including the budget neutrality issue, is that the data available to analyze such issues is very limited, because the LTCH PPS is still relatively new and there is a lag time in data availability. Also, the fact that a number of LTCHs were and some still are operating under the transition period from TEFRA to LTCH PPS may make the available data even less appropriate for an analysis, since hospitals may still be modifying their behavior based on their transition to prospective payment and our data may not yet replace any operational changes LTCHs may have made in response to prospective payment. Once the transition is complete, we will have a better opportunity to evaluate the impacts of the implementation of this new payment system based on a number of years of LTCH PPS data.

To facilitate an understanding of the proposed policies related to the proposed change to the LTCH PPS labor market areas discussed above, in Table 4 of the Addendum of this proposed rule, we are providing a listing of each LTCH's State and county location; existing labor market area designation; and its proposed new CBSA-based labor market area designation based on the best available cost report data from HCRIS (FYs 1999–2003) and county information from our OSCAR database. We encourage LTCHs to review the county location and both the current and proposed labor market area assignments for accuracy. Any questions or corrections (including additions or deletions) to the information provided in Table 4 should be emailed to the following CMS Web address: *ltchpps@cms.hhs.gov.* A link to this address can be found on the following CMS Web page *http://www.cms.hhs.gov/providers/longterm/default.asp.*

When the revised labor market areas based on the OMB's new CBSA-based designations were adopted under the acute care hospital IPPS beginning on October 1, 2004, a transition to the new labor market area designations was established due to the scope and significant implications of these new boundaries and to buffer the subsequent significant impacts it may have on payments to numerous hospitals. As discussed in the FY 2005 IPPS final rule (69 FR 49032), during FY 2005, a blend of wage indexes is calculated for those acute care IPPS hospitals experiencing a drop in their wage indexes because of the adoption of the new labor market areas. Also, as described in that same final rule (69 FR 49032), under the IPPS, hospitals that previously were located in an urban MSA, but then became rural under the new CBSA-based definitions are assigned the wage index value of the urban area to which they previously belonged, for 3 years (FYs 2005–2007).

Because the former MSA-based labor market areas used under the IPPS had been used for payment for over 10 years, we believe it was necessary to provide additional protection given the scope and potentially significant implications of these new labor market areas on numerous acute-care hospitals. Therefore, we implemented a transition under the IPPS from the former MSA-based labor market area designation to the new CBSA-based labor market area designation for acute-care hospitals that would receive a lower wage index as a result of the change in the labor market area designations.

We recognize that, just like IPPS hospitals, many LTCHs would experience decreases in their wage index as a result of the proposed labor market area changes. At the same time, a significant number of LTCHs would benefit from these proposed changes. However, because we are in the midst of a transition to a full wage-index adjustment under the LTCH PPS, we believe that the effects on the LTCH PPS wage index from the proposed changes to the LTCH PPS labor market areas definitions would be mitigated. Specifically, as noted above, most

LTCHs are presently still in their FY 2004 cost reporting period (the vast majority of LTCHs start their cost reporting periods on July 1 or September 1), and are, therefore, in the 2nd year of the 5-year phase-in of the LTCH PPS wage index adjustment, and the applicable wage index value is ⅖ths (40 percent) of the applicable full LTCH PPS wage index adjustment. Since most LTCHs are only in the 2nd year of the 5-year phase-in of the wage index adjustment, for most LTCHs, the labor-related portion of the standard Federal rate is only adjusted by 40 percent of the applicable full wage index (that is, ⅖ths wage index value). As also noted above, the LTCH PPS wage index adjustment is made by multiplying the LTCH PPS standard Federal rate by the applicable wage index value, and the current LTCH PPS labor related-share is 72.885 percent. Consequently, for most LTCHs, only 29 percent of the standard Federal rate is affected by the wage index adjustment (72.885 percent × 0.4 = 29.154 percent), and the proposed revision to the labor market area definitions based on OMB's new CBSA-based designations would only have a minimal impact on LTCH PPS payments. Therefore, we do not believe it is necessary to propose a transition policy for the proposed revision to the LTCH PPS labor market area definitions because the impact of the proposed revision to the labor market area definitions would only have a minimal impact on LTCH PPS payments (as explained above).

For the reasons discussed in greater detail below, we are not proposing a transition under the LTCH PPS from the current MSA-based labor market area designations to the new CBSA-based labor market area designations. Rather, we are proposing under the LTCH PPS to adopt the new CBSA-based labor market area definitions beginning with the 2006 LTCH PPS rate year without a transition period. As also discussed in greater detail below, we believe that this proposed policy is appropriate because despite significant similarities between the LTCH PPS and the IPPS, there are clear distinctions between the payment systems, particularly regarding wage index issues.

The most significant distinction upon which we have based this proposed policy determination is that where acute care hospitals under the IPPS have been paid using full wage index adjusted payments since 1983 and had used the previous IPPS MSA-based labor market area designations for over 10 years, under the LTCH PPS, a wage index adjustment is being phased-in over a 5-year period, and as noted above, most LTCHs are only in the 2nd year of the 5-year phase-in of the wage index adjustment (that is, LTCH cost reporting periods beginning during FY 2004 as established in the August 30, 2002 LTCH PPS final rule (67 FR 56016–56019)). As explained in greater detail above, the impact that the wage index can have on LTCH PPS payments is limited at this point, since only a small percentage of the LTCH PPS standard Federal rate is affected by the wage index (approximately 29 percent in most cases, as explained above) because of the 5-year phase-in of the wage index adjustment.

Our initial analysis of the appropriateness of including a wage index adjustment in the March 22, 2004 proposed rule for the LTCH PPS (67 FR 13465–13466) indicated that a wage adjustment did not lead to an increase in the accuracy of LTCH PPS payments because a statistical analysis did not show a significant relationship between LTCHs costs and their geographic location. However, based upon comments, we revisited this proposed determination after additional data analysis and a more general policy evaluation, and we stated that we ''believe that the conceptual reasons for having an area wage adjustment support transitioning into a wage adjustment, notwithstanding the data problems and issues with the regression analysis'' (*see* August 30, 2002 LTCH PPS final rule (67 FR 56018)). However, given the lack of strong empirical evidence to support a wage index adjustment under the LTCH PPS, we provided for a 5-year transition to the full implementation of the wage index adjustment. We also noted 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.'' In each subsequent LTCH PPS proposed and final rule since FY 2003, we have evaluated the most recent LTCH data available and still have found no empirical evidence to support a change in the 5-year phase-in of the wage index adjustment under the LTCH PPS.

Therefore, where a wage index adjustment has been a stable feature of the acute care hospital IPPS since its 1983 implementation and had utilized the prior MSA-based labor market area designation for over 10 years, this is not the case for the LTCH PPS which has only been implemented since October 1, 2002. Furthermore, as explained above, most LTCHs are presently still in their FY 2004 cost reporting period (the vast majority of LTCHs start their cost reporting periods on July 1 or September 1), and are, therefore, in the 2nd year of the 5-year phase-in of the LTCH PPS wage index adjustment, and the applicable wage index value is ⅖ths (40 percent) of the full LTCH PPS wage index adjustment. As also noted above, the LTCH PPS wage index adjustment is made by multiplying the LTCH PPS standard Federal rate by the applicable wage index value, and the current LTCH PPS labor related-share is 72.885 percent. Consequently, for most LTCHs, only 29 percent of the standard Federal rate is affected by the wage index adjustment (72.885 percent × 0.4 = 29.154 percent). Therefore, the proposed revision to the labor market area definitions based on OMB's new CBSA-based designations would only have a minimal impact on LTCH PPS payments.

Because the impact of the proposed revision to the labor market area definitions would only have a minimal impact on LTCH PPS payments (as explained above), we do not believe it is necessary to propose a transition policy for the proposed revision to the LTCH PPS labor market area definitions. In contrast, a transition policy to the revised IPPS labor market area definitions under the IPPS was appropriate because, as there is no phase-in of a wage index adjustment under the IPPS as there currently is under the LTCH PPS, the full labor-related share of either 71.066 percent or 62 percent (as discussed above in section IV.C.1.b. of this preamble) of the IPPS standardized amount (that is, Federal rate) is affected by the IPPS wage index adjustment, which resulted in a more significant projected impact for acute care hospitals under the IPPS. Furthermore, we do believe that it is necessary to further transition any proposed changes to the LTCH PPS wage index adjustment, including the proposed revision of the labor market area definitions, because, in fact, the LTCH PPS wage index adjustment is still being phased-in over 5 years as established in the August 30, 2002 final rule (67 FR 56018). Accordingly, to the extent the new CBSA-based labor market area definitions are implemented, we would not expect them to have as significant of an impact on LTCHs, as they do for IPPS hospitals since the full wage index adjustment had been a stable factor of IPPS payment for over 20 years.

An additional distinction between the IPPS and the LTCH PPS regarding the wage index adjustment is that the IPPS policies that provide for blended and hold-harmless payments during the transition from MSA-based labor market areas to CBSA-based labor market areas described above were implemented in a

budget neutral manner under the IPPS (69 FR 49034–49035 and 49275). (We note the new labor market area definitions themselves, not the transition policies that provide for blended and hold-harmless payments, under the IPPS were not adopted in a budget neutral manner (69 FR 49034). However, as noted above, wage index changes are not budget neutral under the LTCH PPS. Under the IPPS, hospitals located in areas with a lower wage index being calculated under their new CBSA designation in comparison to what they would have been assigned under the old MSA designation were given a blend consisting of 50 percent of the new CBSA wage index and 50 percent of the old MSA wage index. This essentially increases the wage index for those hospitals, which results in an increase in their payment since the blended MSA/CBSA wage index is higher than the full CBSA wage index. However, because the IPPS wage index transition payments were implemented in a budget neutral manner, it did not result in increased spending by Medicare, but rather a redistribution of dollars across IPPS acute-care hospitals. If we were to propose a similar transition under the LTCH PPS to the one implemented under the IPPS, it would result in additional LTCH spending by the Medicare program if we did so without a budget neutrality adjustment.

Therefore, given the fact that the LTCH PPS has only been implemented for hospital cost reporting periods beginning on or after October 1, 2002, (which means that payments to many LTCHs have only been governed by the LTCH PPS for slightly more than 2 years), and that even for LTCHs that are negatively affected by the new CBSA-based designations, the LTCH PPS wage index adjustment, at this point, has not been fully implemented and we do not believe that it is appropriate or necessary to propose a transition to the proposed new CBSA-based labor market areas for purposes of the LTCH PPS wage index adjustment under § 412.525(c).

In addition, we are proposing to revise § 412.525(c) to clarify the application of the current adjustment for area wage levels under the LTCH PPS, which was originally established in the August 30, 2002 final rule (67 FR 56015–56019). Specifically, we are proposing to revise § 412.525(c) to state that the labor portion of a LTCH's Federal prospective payment is adjusted to account for geographical differences in the area wage levels using an appropriate wage index (established by CMS). The wage index reflects the relative level of hospital wages and wage-related costs in the geographic area of the hospital compared to the national average level of hospital wages and wage-related costs. Currently, urban or rural area is determined in accordance with the definitions at § 412.62(f)(1)(ii) and (iii). As we discussed above, because we are proposing to revise those definitions in this proposed rule, urban or rural area would be determined in accordance with the proposed revisions to § 412.525(c)(1) or the proposed revisions to § 412.525(c)(2), respectively. In addition, § 412.525(c) would be revised to specify that the appropriate wage index (established by CMS) is updated annually. We note that this proposed revision to the language in § 412.525(c), which codifies our existing policy into regulations, is similar to the wage index adjustment codified in regulations under the IPPS at § 412.64(h). As stated above, this proposed clarification to § 412.525(c) clearly outlines in regulations our established methodology for the application of the area wage adjustment under the LTCH PPS. As noted above, this methodology was established when we implemented the LTCH PPS (that is, cost reporting periods beginning on or after October 1, 2002) in the August 30, 2002 final rule (67 FR 56015–56019).

d. *Wage Index Data.* In the May 7, 2004 final rule (69 FR 25684–25686), we established LTCH PPS wage index values for the 2005 LTCH PPS rate year calculated from the same data (generated in cost reporting periods beginning during FY 2000) used to compute the FY 2004 acute care hospital inpatient wage index data without taking into account geographic reclassification under sections 1886(d)(8) and (d)(10) of the Act. The LTCH wage index values applicable for discharges occurring on or after July 1, 2004 through June 30, 2005 are shown in Table 1 (for urban areas) and Table 2 (for rural areas) in the Addendum to that final rule. Acute care hospital inpatient wage index data is also used to establish the wage index adjustment used in the IRF PPS, IPF PPS, HHA PPS, SNF PPS, and inpatient psychiatric facility PPS (IPF). 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. Thus, because complete LTCH wage-related data are not currently available on the cost report, we do not have complete LTCH wage related data to use for the purposes of creating a LTCH wage index based on LTCH wage data, and since the labor market areas of acute care hospitals under the IPPS are similar to those of LTCHs, we believe wage data of acute care IPPS hospitals accurately capture the relationship between the wage related costs for LTCHs in an area as compared to the national average. Therefore, we believe IPPS acute care hospitals' wage data are the best available data to use for the wage index under the LTCH PPS.

In this proposed rule, we are proposing that for the for the 2006 LTCH PPS rate year, acute care hospital inpatient wage index data generated from cost reporting periods beginning during FY 2001 without taking into account geographic reclassification under sections 1886(d)(8) and (d)(10) of the Act would be used to determine the applicable wage index values under the LTCH PPS because these data (FY 2001) are the most recent complete data. These data are the same FY 2001 acute care hospital inpatient wage data that were used to compute the FY 2005 wage indices currently used under the IPPS, SNF PPS, and HHA PPS. The proposed full wage index values that would be applicable for LTCH PPS discharges occurring on or after July 1, 2005 through June 30, 2006 are shown in Tables 1 and 2 in the Addendum of this proposed rule.

The proposed LTCH wage index values that would be 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 of this proposed rule. (We note a labeling error published in prior years wage index tables used in the LTCH PPS. That labeling error was the listing of Stanly County, NC as one of the areas under MSA 1520 when, in fact, we consider Stanly County, NC to be a rural area in North Carolina. Stanly County wage data have always been correctly treated as rural in the actual creation of the LTCH wage index values, and it has only been the listing of Stanly County under MSA 1520 in prior years LTCH PPS index tables that was in error. Consequently, Table 1a in the Addendum of this proposed rule correctly removes Stanly County from the list of areas that fall under the MSA

1520 wage index. As this is strictly a labeling correction that does not affect the actual computation of the wage index values, any LTCHs located in Stanly County, NC, will continue to fall under, and use, the wage index for rural North Carolina.)

As noted above, a listing of each LTCH's State and county location; existing MSA-based labor market area designation; and its proposed new CBSA-based labor market area designation based on the best available cost report data (FYs 1999–2003) from HCRIS and county information from our OSCAR database, are shown in Table 4 of the Addendum of this proposed rule. As we also noted earlier in this section, we encourage LTCHs to review the county location and both the current and proposed labor market area assignments for accuracy. Any questions or corrections (including additions or deletions) to the information provided in Table 4 should be e-mailed to the following CMS web address: *ltchpps@cms.hhs.gov.* A link to this address can be found on the following CMS Web page *http://www.cms.hhs.gov/providers/longterm/default.asp.*

As discussed earlier in this section (IV.C.1.a.), the applicable wage index phase-in percentages are based on the start of a LTCH's cost reporting period beginning on or after October 1 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 would be adjusted by three-fifths of the applicable LTCH wage index value. For example, for a LTCH's discharges occurring during the 2006 LTCH PPS rate year (that is, July 1, 2005 through June 30, 2006) and occurring in the LTCH's cost reporting period beginning during FY 2005, the applicable wage index value would be three-fifths of the full 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 (shown in Tables 1 and 2 of the Addendum to this proposed rule). Similarly, for a LTCH's discharges occurring during the 2006 LTCH PPS rate year (that is, July 1, 2005 through June 30, 2006) and occurring in the LTCH's cost reporting period beginning during FY 2006, the applicable wage index value would be four-fifths of the full 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 (shown in Tables 1 and 2 in the Addendum to this proposed rule).

Because the phase-in of the wage index does not coincide with the LTCH PPS rate year (July 1 through June 30), most LTCHs will experience a change in the wage index phase-in percentages during the LTCH PPS rate year. For example, during the 2006 LTCH PPS rate year, for a LTCH with a January 1 fiscal year, the three-fifths wage index would be applicable for the first 6 months of the 2006 LTCH PPS rate year (July 1, 2005 through December 31, 2005) and the four-fifths wage index would be applicable for the second 6 months of the 2006 LTCH PPS rate year (January 1, 2006 through June 30, 2006). We also note that some providers will still be in the second year of the 5-year phase-in of the LTCH wage index (that is, those LTCHs who began the second year of the 5-year phase-in during their cost reporting periods that began between July 1, 2004 and September 30, 2004). For the remainder of those LTCHs' FY 2004 cost reporting periods which will conclude during the first 3 months of the 2006 LTCH PPS rate year, the applicable wage index value would be two-fifths of the full 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 as shown in Tables 1 and 2 in the Addendum to this proposed rule. Since there are no longer any LTCHs in their cost reporting period that began during FY 2003 (the first year of the 5-year wage index phase-in), we are no longer showing the ⅕th wage index value in Tables 1 and 2 in the Addendum to this proposed rule.

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

In the August 30, 2002 LTCH PPS 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. (The inadvertent omission of § 412.525(b) by the OFR noted in the May 7, 2004 LTCH PPS final rule (69 FR 25686) has been corrected in 42 CFR Parts 400 to 429 revised as of October 1, 2004) In the May 7, 2004 final rule (69 FR 25686), for the 2005 LTCH PPS rate year, we established that we make a COLA to payments for LTCHs located in Alaska and Hawaii by multiplying the standard Federal payment rate by the appropriate factor listed in Table I of that same final rule.

Similarly, in this proposed rule, for the 2006 LTCH PPS rate year we are proposing to make a COLA to payments to LTCHs located in Alaska and Hawaii by multiplying the proposed standard Federal payment rate by the proposed factors listed in Table I below. These proposed factors are obtained from the U.S. Office of Personnel Management (OPM) and are currently used under the IPPS. In addition, we propose that if the OPM releases revised COLA factors before March 1, 2005, we would use them for the development of the payments for the 2006 LTCH rate year and publish them in the LTCH PPS final rule.

TABLE I.—PROPOSED COST-OF-LIVING ADJUSTMENT FACTORS FOR ALASKA AND HAWAII HOSPITALS FOR THE 2006 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. Proposed Adjustment for High-Cost Outliers

a. *Background.* Under § 412.525(a), we make 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 under serve these patients. We set the outlier threshold before the beginning of the applicable rate year so that total outlier payments are projected to equal 8 percent of total payments under the LTCH PPS.

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 an outlier policy. This results in Medicare and the LTCH sharing financial risk in the treatment of extraordinarily costly cases. 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 by the Medicare allowable covered charge. In accordance with

§ 412.525(a), 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 simulating aggregate payments with and without an outlier policy. The fixed-loss amount would 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 cost-to-charge ratios based on data from the latest available cost report data from Hospital Cost Report Information System (HCRIS) and corresponding MedPAR claims data are used to establish a fixed-loss threshold amount under the LTCH PPS.

b. *Cost-to-charge ratios (CCRs).* As we noted above, we calculate the estimate of the cost of the case used in determining LTCH PPS outlier payments by multiplying the Medicare allowable charges for the case by the LTCH's overall CCR. As we established in the June 9, 2003 IPPS high-cost outlier final rule (68 FR 34494–34515), currently (for discharges occurring on or after October 1, 2003) fiscal intermediaries (FIs) use either the most recent settled cost report or the most recent tentative settled cost report, whichever is from the later period, to determine a LTCH's CCR. As we specified in Program Memorandum Transmittal A–02–093 when we implemented the LTCH PPS and as codified in regulation at § 412.525(a)(4)(ii), for discharges occurring on or after August 8, 2003, for LTCHs that we are unable to compute a CCR (for example, due to faulty or unavailable data), we assign the applicable statewide average CCR to the LTCH. (Currently, the applicable statewide average CCRs can be found in Tables 8A and 8B of the FY 2005 IPPS final rule (69 FR 49687–49688).)

As set forth in § 412.525(a)(4)(ii), by cross-referencing § 412.84(i)(3), currently, we apply the applicable statewide average CCR when a LTCH's CCR exceeds the maximum CCR threshold (ceiling) set forth specifically at § 412.84(i)(3)(ii). As we explained in the June 9, 2003 high cost outlier final rule (68 FR 34506–34507), CCRs above this range are probably due to faulty data reporting or entry. Therefore, these CCRs should not be used to identify and make payments for outlier cases because the data are clearly errors and should not be relied upon. We also made a similar change to the short-stay outlier policy at § 412.529. Since CCRs are also used in determining short-stay outlier payments, the rationale for that change mirrors that for high-cost outliers. (The current LTCH PPS CCR ceiling is 1.409, which is equal to the combined operating and capital CCR ceilings (as established in the FY 2005 IPPS final rule (69 FR 49287)).)

Currently, (for discharges occurring on or after August 8, 2003, only a maximum CCR threshold (ceiling) is applied to a LTCH's CCR ratio. For discharges occurring on or after August 8, 2003), a minimum CCR threshold (floor) is no longer applicable (See June 8, 2003, 68 FR 34506–34507). As discussed above, if a LTCH's cost-to-charge ratio is above the ceiling, the applicable statewide average CCR is assigned to the LTCH. However, a LTCH's CCR is no longer raised to the applicable statewide average CCR if it falls below a minimum CCR threshold (floor) for discharges occurring on or after August 8, 2003, as we discussed in the June 9, 2003 high cost outlier final rule (68 FR 34507), in order to prevent hospitals from receiving inappropriately high outlier payments. (Refer to the June 9, 2003 high-cost outlier final rule (68 FR 34507) for further explanation of the establishment of the current CCR policy.)

c. *Establishment of the Proposed Fixed-Loss Amount.* When we implemented the LTCH PPS, as discussed in the August 30, 2002 final rule (67 FR 56022–56026), we establish 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. 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. In accordance with § 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 proposed fixed-loss amount).

In the May 7, 2004 final rule, in calculating the fixed-loss amount that would result in outlier payments projected to be equal to 8 percent of total payments for the 2005 LTCH PPS rate year, we used claims data from the December 2003 update of the FY 2003 MedPAR files, as that was the best available data at that time. We calculated LTCHs' CCRs for determining the fixed-loss amount based on the latest available cost report data in HCRIS from FYs 1999 through 2002. Also, as we explained in that same final rule (68 FR 25687), we calculated a single fixed-loss amount for the 2005 LTCH PPS rate year based on Version 21.0 of the GROUPER, which was the version in effect as of the beginning of the LTCH PPS rate year (that is, July 1, 2004 for the 2005 LTCH PPS rate year).

We also applied the current outlier policy under § 412.525(a) in determining the fixed-loss amount for the 2005 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 2004 IPPS combined operating and capital CCR ceiling of 1.366 (as explained in the IPPS final rule, published August 1, 2003 (68 FR 45346)). As we explained in that same final rule, we believe that using the FY 2004 combined IPPS operating and capital CCR ceiling for LTCHs is appropriate for the same reasons we stated above regarding the use of the FY 2004 combined operating and capital CCR ceiling under the IPPS.

For the 2005 LTCH PPS rate year, in the May 7, 2004 final rule (69 FR 25689), we established a fixed-loss amount of $17,864. Thus, in the 2005 LTCH PPS rate year 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 $17,864).

In this proposed rule, we are not proposing a change in our established methodology for determining the fixed-loss amount. However, we are proposing to use more recently available data to determine the proposed fixed-loss amount for the 2006 LTCH PPS rate year, including the most recent available claims data and data from the Provider Specific File (PSF). Specifically, for the 2006 LTCH PPS rate year, we are proposing to use the September 2004 update of the FY 2003 MedPAR claims data to determine a proposed fixed-loss amount that would result in projected outlier payments being equal to 8 percent of total projected LTCH PPS

payments, based on the policies described in this proposed rule, because these data are the best LTCH data available. As noted above, we determined the proposed fixed-loss amount based on the version of the GROUPER that would be in effect as of the beginning of the 2006 LTCH PPS rate year (July 1, 2005), that is, Version 22.0 of the LTCH PPS GROUPER (69 FR 48982).

As we explained above, in determining the LTCH PPS fixed-loss amount, CCRs are used to estimate the cost of each case by multiplying the Medicare covered charges from the claim by the LTCH's CCR. Rather than using CCRs calculated from the latest available cost report data in HCRIS and corresponding claims data from the MedPAR data as we did when we determined the 2005 LTCH PPS rate year fixed-loss amount (as noted above), in this proposed rule, for purposes of determining the proposed fixed-loss amount for the 2006 LTCH PPS rate year, we are proposing to use CCRs from the PSF as they are the best available data for the LTCH PPS because, as we discuss in greater detail below, they are more recent data and were actually used to make LTCH PPS payment.

The PSF contains CCRs computed by FIs in accordance with Program Memorandum Transmittal A–02–093 and Program Memorandum Transmittal A–03–058, which reflects the changes made in the June 9, 2003 high-cost outlier final rule (68 FR 34494), including the use of either the most recently settled or tentatively settled cost report, whichever is later, to determine a LTCH's CCR. This also includes the assignment of the applicable statewide average CCR by the FI in cases where the FI was unable to compute a CCR (for example, due to faulty or unavailable data), or the CCR computed by the FI exceeded the applicable CCR ceiling. While FIs have been determining a CCR for each LTCH and entering them on the PSF (as instructed in Program Transmittal A–02–093) in order to determine the LTCH PPS payment for each discharge using the LTCH PPS PRICER software, we have only recently had access to the complete PSF data for all LTCHs due to the lag time in data availability (the LTCH PPS has only been implemented for slightly over 2 years, that is cost reporting periods beginning on or after October 1, 2002). Thus, this is the first opportunity that we have had to use CCRs from the PSF in determining the fixed-loss amount.

We are proposing to use CCRs from the PSF rather than computing CCRs from the latest MedPAR claims data and corresponding cost report data for purposes of determining the proposed fixed-loss amount under the LTCH PPS because we believe that using these CCRs to estimate the cost of the case used determining outlier payments would be more accurate than they would be using our current source for obtaining CCRs to estimate the fixed-loss amount (that is, calculating CCRs from the latest cost report data in HCRIS and corresponding claims data in the MedPAR files, as explained above). Specifically, as we discuss in greater detail below, CCRs in the PSF are based on the most recently settled or tentatively settled cost report, whichever is later, where as the CCRs computed from HCRIS and corresponding MedPAR data are several years old due to the lag time in data availability. Increasing the accuracy of estimated outlier payments in determining the fixed-loss amount by using CCRs from the PSF rather than CCRs computed from HCRIS and corresponding MedPAR data would help ensure that outlier payments are projected to equal 8 percent of total LTCH PPS payments as we established in the August 30, 2002 final rule (67 FR 56026). Using CCRs from the PSF should result in a more precise fixed-loss amount because these CCRs are based on more recent available data and, as explained above, these are the CCRs actually used by FIs to make LTCH PPS payments using the LTCH PPS PRICER software.

Specifically, for purposes of determining the proposed 2006 LTCH PPS rate year fixed-loss amount, we are proposing to use CCRs from the June 2004 update of the PSF, which are the CCRs that were used by FIs to make LTCH PPS payments to LTCHs as of June 30, 2004. As noted above, the CCRs in this file also reflect the changes to the CCR and outlier policy made in the June 9, 2003 high cost outlier final rule (68 FR 34494), which includes the use of either the most recently settled or tentatively settled cost reports, whichever is later, by FIs to determine a LTCHs CCR.

In addition, because all LTCHs paid under the LTCH PPS have an entry in the PSF, for all of the LTCHs with claims in the September 2004 update of the Fy 2003 MedPAR files (which we used to determine the proposed fixed-loss amount), there were no LTCHs with missing CCRs, and, therefore, there was no need to assign the applicable statewide average CCR to any LTCHs in determining the proposed fixed-loss amount (unless this was already done by the FI when entering the CCR in the PSF). This results in a more accurate CCR for each LTCH, and therefore a more accurate estimate of the cost of each case for LTCHs that, in the past, were assigned the applicable statewide average CCR in determining the fixed-loss amount because the data needed to compute a CCR were unavailable. (We note that consistent with our established methodology for determining CCRs for the purposes of determining the fixed-loss amount, if, in the future, a LTCH were missing a CCR in the PSF, we would assign the applicable statewide average CCR.)

We believe that CCRs from the PSF are a better approximation of the CCRs that would be used to determine LTCHs' LTCH PPS payments during the 2006 LTCH PPS rate year because these are the most recent available CCRs actually used to make LTCH PPS payments. The CCRs that we have previously used to estimate the fixed-loss amount, computed from cost report data in HCRIS and corresponding claims data in the MedPAR files, were not used by FIs to make LTCH payments. Data from the PSF have only recently become available for all LTCHs because the LTCH PPS has only been implemented for slightly over 2 years (that is, cost reporting periods beginning on or after October 1, 2002). Prior to the availability of PSF data, for purposes of determining the fixed-loss amount, CCRs were computed based on the best available data (that is, from cost report data in HCRIS and corresponding MedPAR claims data). However, because there is lag time in the submission of cost report data in HCRIS, CCRs may have been computed from cost reports that were several years old. In addition, often the applicable statewide average CCR was assigned to LTCHs when cost report and corresponding claims data to compute a CCR were unavailable. This proposed change in the source of obtaining CCRs for computing the fixed-loss amount results in more up-to-date and generally lower CCRs. This is the same data source used for obtaining CCRs under the IPPS for determining the IPPS fixed-loss amount annually (FY 2005 IPPS final rule, 69 FR 49276).

As stated above, in this proposed rule, we are only proposing to change the data source for obtaining the CCRs used in determining the fixed-loss amount and not our established methodology for determining the fixed-loss amount or our established rules for determining CCRs for LTCH PPS payment purposes. Accordingly, based on the data and policies described above, we are proposing a fixed-loss amount of $11,544 for the 2006 LTCH PPS rate year. Thus, we would pay an outlier

case 80 percent of the difference between the estimated cost of the case and the proposed outlier threshold (the sum of the adjusted proposed Federal LTCH payment for the LTC–DRG and the proposed fixed-loss amount of $11,544).

We note that the proposed fixed-loss amount of $11,544 for the 2006 LTCH PPS rate year is significantly lower than the current fixed-loss amount of $17,864 for the 2005 LTCH PPS rate year. This notable change in the proposed fixed-loss amount is primarily due to the proposed change in the source of LTCHs' CCRs used to estimate costs when estimating LTCH PPS payments (specifically, using CCRs from the PSF rather than computing them from HCRIS and corresponding MedPAR data). As described above, in the past we have used CCRs calculated using costs from the most recent available cost report data in HCRIS and corresponding charges from MedPAR claims data. As also noted above, often the statewide average CCR was assigned to LTCHs when data to compute a CCR was unavailable. However, for the 2006 LTCH PPS rate year, in determining the proposed fixed-loss amount, we are proposing to use CCRs from the PSF because, as we discussed above, we believe that these CCRs would more closely approximate the CCRs that will be used to make payments to LTCHs during the 2006 LTCH PPS rate and would result in a more accurate estimate of the cost of each case used in determining outlier payments.

As we noted above, CCRs from the PSF are based on more recent data and are generally lower than the CCRs computed from cost report data in HCRIS and corresponding claims data in the MedPAR files. Specifically, in comparing the best available data for 301 LTCHs, we found that almost 40 percent of LTCHs would experience a decrease in the CCR we used for computing the proposed fixed-loss amount. The decrease in the CCRs was in excess of 75 percent for some LTCHs in which the applicable statewide average CCR was assigned in determining the 2005 LTCH PPS rate year fixed-loss amount where data to compute a CCR was unavailable.

In determining estimated outlier payments (80 percent of costs beyond the fixed-loss amount), as discussed above, costs are estimated by multiplying the Medicare covered charges for the case by the LTCH's CCR. When relatively lower CCRs are used to estimate costs from charges, the resulting estimated cost of each case is lower, thereby reducing outlier payments since outlier payments are 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). Lowering the fixed-loss amount results in more cases qualifying as outlier cases as well as increases the amount of the outlier payment for outlier cases because the maximum loss that a LTCH must incur before receiving an outlier payment (that is, the fixed-loss amount) would be smaller. Thus, in order to maintain that outlier payments would be equal to 8 percent of total LTCH PPS payments, the outlier fixed-loss should be lowered.

As stated above, we have established that under the LTCH PPS, outlier payments are estimated to be equal to 8 percent of total LTCH PPS payments. An analysis of recent LTCH PPS claims indicates that the 2004 and 2005 LTCH PPS rate year outlier fixed-loss amounts may have resulted in LTCH PPS outlier payments that fell below the estimated 8 percent. Specifically, based on claims discharged during the 2004 LTCH PPS rate year (July 1, 2003 through June 30, 2004), we estimate that outlier payments equal about 6 percent of total LTCH PPS payments.

As an alternative to lowering the fixed-loss amount, we 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 (§ 412.525(a)(3)), as a means of assuring that estimated outlier payments would be projected to equal 8 percent of total LTCH PPS payments. Under the LTCH PPS high-cost outlier policy at § 412.525(a)(3), the marginal cost factor is currently equal to 80 percent, as we established in the August 30, 2002 final rule (67 FR 56022–56026). As we discuss in that same final rule, a marginal cost factor equal to 80 percent means that we pay the LTCH for 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 rate for the LTC–DRG PPS payment and the fixed-loss amount).

As we discussed in the August 30, 2002 final rule (67 FR 56023), the marginal cost factor is designed to share the financial risk of treating extremely costly LTCH cases between LTCHs and the Medicare program by providing ''a balance between the need to protect LTCHs financially, while encouraging them to treat expensive patients and maintain the incentives of a prospective payment system to improve the efficient delivery of care.'' Increasing the marginal cost factor from the established 80 percent, while maintaining the existing fixed-loss amount would increase total outlier payments because 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 propose to increase the marginal cost factor to 90 percent without lowering the fixed-loss amount, we would pay outlier cases an additional 10 percent (90 percent minus 80 percent) of the estimated costs that exceed the outlier threshold (the sum of the adjusted Federal rate for the LTC–DRG and the fixed-loss amount).

While this alternative would also ensure that outlier payments are projected to equal 8 percent of total LTCH PPS payments, it would not maintain the incentive for LTCHs to treat expensive patients and improve the efficient delivery of care. It would significantly reduce the LTCHs' share of the financial risk in treating those costly patients. As we discussed in the August 30, 2002 final rule (67 FR 56023–56024), 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 non-outlier cases, while simultaneously maintaining the integrity of the LTCH PPS.

Our proposal to lower the fixed-loss amount from the current fixed-loss amount of $17,864 to the proposed fixed-loss amount of $11,544 would reduce the amount of the loss that a LTCH must incur under the LTCH PPS for a case with unusually high costs before the LTCH will receive any additional Medicare payments. However, as we explain above, we believe the 80 percent marginal cost factor would continue to adequately maintain the LTCHs' share of the financial risk in treating those costly patients and ensure the efficient delivery of services. Under our proposed fixed-loss amount, LTCHs would still have to first lose $11,544 before receiving any additional payment for treating an unusually costly case. We believe the proposed fixed-loss amount of $11,544 in conjunction with the requirement that the LTCH is responsible for 20 percent of all estimated cost incurred beyond the outlier threshold (the sum of the adjusted Federal rate for the LTC–DRG PPS payment and the fixed-loss amount) would be significant enough to avoid the ''incentive'' to reach the outlier threshold in order to receive an

additional payment. Therefore, we believe the proposed fixed-loss amount of $11,544 would sufficiently identify unusually costly LTCH cases while maintaining the integrity of the LTCH PPS.

Accordingly, we are not proposing to adjust the marginal cost factor under the LTCH PPS high-cost outlier policy. Rather, as discussed in detail above, we believe that employing actual CCR data from the PSF for purposes of determining the proposed fixed-loss amount, which were actually used to make LTCH PPS payments, would result in a more accurate estimate of LTCH PPS outlier payments. Therefore, a decrease in the fixed-loss amount is appropriate and necessary to maintain that outlier payments would equal 8 percent of total LTCH PPS payments, as required under § 412.525(a).

d. *Reconciliation of Outlier Payments Upon Cost Report Settlement.* In the June 9, 2003 high-cost outlier final rule (68 FR 34508–34512), consistent with the change made for acute care hospitals under the IPPS at § 412.84(m), we established under § 412.525(a)(4)(ii), by cross-referencing § 412.84(m), that effective for LTCH PPS discharges occurring on or after August 8, 2003, reconciliation of outlier payments may be made upon cost report settlement to account for differences between the actual CCR and the estimated CCR ratio for the period during which the discharge occurs. As is the case with the changes made to the outlier policy for acute care hospitals under the IPPS, the instructions for implementing these regulations are discussed in further detail in Program Memorandum Transmittal A–03–058. In addition, in that same final rule (68 FR 34513), we established a similar change to the short-stay outlier policy at § 412.529(c)(5)(ii).

We also discussed in the June 9, 2003 IPPS high-cost outlier final rule (68 FR 34494–34515), consistent with the policy change for acute care hospitals under the IPPS at § 412.84(i)(2), that, for LTCH PPS discharges occurring on or after October 1, 2003, FIs will use either the most recent settled cost report or the most recent tentative settled cost report, whichever is from the later period, to determine a LTCH's CCR. In addition, in that same final rule, we established a similar change to the short-stay outlier policy at § 412.529(c)(5)(iii).

e. *Application of Outlier Policy to Short-Stay Outlier Cases.* As we discussed in the August 30, 2002 LTCH PPS final rule (67 FR 56026), under some rare circumstances, a LTCH discharge could qualify as a short-stay outlier case (as defined under § 412.529 and discussed in section V.B.4. of this preamble) and also as a high-cost outlier case. In such a scenario, a patient could be hospitalized for less than five-sixths of the geometric average length of stay for the specific LTC–DRG, and yet incur extraordinarily high treatment costs. If the costs exceeded the outlier threshold (that is, the short-stay outlier payment plus the fixed-loss amount), the discharge would be eligible for payment as a high-cost outlier. Thus, for a short-stay outlier case in the 2006 LTCH PPS rate year, the high-cost outlier payment will be 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the proposed fixed-loss amount of $11,544 and the amount paid under the short-stay outlier policy).

4. Proposed Adjustments for Special Cases

a. *General.* As discussed in the August 30, 2002 LTCH PPS final rule (67 FR 55995), under section 123 of Pub. L. 106–113, the Secretary generally has broad authority in developing the PPS for LTCHs, including whether (and how) to provide for adjustments to reflect variations in the necessary costs of treatment among LTCHs.

Generally, LTCHs, as described in section 1886(d)(1)(B)(iv) of the Act, are distinguished from other inpatient hospital settings by maintaining an average inpatient length of stay of greater than 25 days. However, LTCHs may have cases that have stays of considerably less than the average length of stay and that receive significantly less than the full course of treatment for a specific LTC–DRG. As we explained in the August 30, 2002 LTCH PPS final rule (67 FR 55954), these cases would be paid inappropriately if the hospital were to receive the full LTC–DRG payment. Below we discuss the payment methodology for these special cases.

b. *Adjustment for Short-Stay Outlier Cases.* 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.

Generally, LTCHs are defined by statute as having an average inpatient length of stay of greater than 25 days. We believe that a payment adjustment for short-stay outlier cases results in more appropriate payments because these cases most likely would not receive a full course of treatment in this short period of time and a full LTC–DRG payment may not always be appropriate. Payment-to-cost ratios simulated for LTCHs, for the cases described above, show that if LTCHs receive a full LTC–DRG payment for those cases, they would be significantly ''overpaid'' for the resources they have actually expended.

Under § 412.529, in general, we adjust the per discharge payment to the least of 120 percent of the cost of the case, 120 percent of the LTC–DRG specific per diem amount multiplied by the length of stay of that discharge, or the full LTC–DRG payment, for all cases with a length of stay up to and including five-sixths of the geometric average length of stay of the LTC–DRG.

As we noted in section V.C.3. of this preamble, in the June 9, 2003 high-cost outlier final rule (68 FR 34494–34515), we revised the methodology for determining CCRs for acute care hospitals under the IPPS because we became aware that payment vulnerabilities existed in the previous IPPS outlier policy. Consistent with the policy established for acute care hospitals under the IPPS at § 412.84(i) and (m) in the June 9, 2003 high-cost outlier final rule (68 FR 34515), and similar to the policy change described above for LTCH PPS high-cost outlier payments at § 412.525(a)(4)(ii), we established under § 412.529(c)(5)(ii) that for discharges on or after August 8, 2003, short-stay outlier payments are subject to the provisions in the regulations at § 412.84(i)(1), (i)(3) and (i)(4), and (m).

In addition, we also discussed in the June 9, 2003 high-cost outlier final rule (68 FR 34508–34513) that short-stay outlier payments are subject to the provisions in the regulations at § 412.84(i)(2) for discharges on or after October 1, 2003 in accordance with § 412.529(c)(5)(iii). In addition, in that same final rule, we established that the applicable statewide average CCR is applied when a LTCH's CCR exceeds the ceiling. Thus, the applicable statewide average CCR is no longer applied when a LTCH's CCR falls below the floor. Furthermore, we also established that any reconciliation of payments for short-stay outliers may be made upon cost report settlement to account for differences between the estimated CCR and the actual CCR for the period during which the discharge occurs. In the June 6, 2003 final rule (68 FR 34146–34148), for certain hospitals that qualify as LTCHs under section 1886(d)(1)(B)(iv)(II) of the Act (''subclause (II)'' LTCHs) as added by section 4417(b) of Pub. L. 105–33, and implemented in § 412.23(e)(2)(ii), we

established a temporary adjustment to the short-stay outlier policy during the 5-year transition period. Under § 412.529(c)(4), effective for discharges from a ''subclause (II)'' LTCH occurring on or after July 1, 2003, the short-stay outlier percentage is 195 percent during the first year of the hospital's 5-year transition. For the second cost reporting period, the short-stay outlier percentage is 193 percent; for the third cost reporting period, the percentage is 165 percent; for the fourth cost reporting period, the percentage is 136 percent; and for the final cost reporting period of the 5-year transition (and future cost reporting periods), the short-stay outlier percentage is 120 percent, that is, the same as it is for all other LTCHs under the LTCH PPS.

As we discussed in the June 6, 2003 final rule (68 FR 34147), we established this formula with the expectation that an adjustment to short-stay outlier payments during the transition will result in reducing the difference between payments and costs for a ''subclause (II)'' LTCH for the period of July 1, 2003 through the end of the transition period, when the LTCH PPS will be fully phased-in.

As we stated in that same final rule, we also expect that during this 5-year period, ''subclause (II)'' LTCHs will make every attempt to adopt the type of efficiency enhancing policies that generally result from the implementation of prospective payment systems in other health care settings. We are not proposing any changes to the short-stay outlier policy in this proposed rule.

5. Hospital-within-Hospitals and Satellites of LTCHs Notification Requirements

In the August 30, 2002 LTCH PPS final rule, we established a notification requirement for LTCHS that were HwHs as defined in § 412.22(e) and satellites of LTCHs, defined at § 412.22(h)(5) and for LTCHs and satellites of LTCHs that were subject to onsite provider payment adjustment under § 412.532. At § 412.22(e)(3) and (h)(5) and § 412.532(i), respectively, we require LTCHs to notify their FIs and CMS of their co-located status within 60 days of the start of the hospital's first cost reporting period under the LTCH PPS. We also established an additional notification requirement at § 412.532(i), for LTCHs subject to the onsite provider payment adjustment at § 412.532, to notify their FIs and CMS within 60 days of a change in co-located status. We intended that these regulations also require the LTCHs to identify the Medicare providers, that is, acute care hospitals, as well as other excluded hospitals and units (IRFs and IPFs), and SNFs with which they were co-located.

It appears, however, that this expectation is unclear in our present regulations because we have been informed by our Regional offices and FIs that LTCHs, for which they are responsible, have in many cases neglected to specify the names, addresses, and provider identification numbers of their co-located providers. We are proposing to clarify our policy that when a LTCH informs its fiscal intermediary of its co-located status, it also would be required to include the name, address, and the provider numbers of the other co-located providers (that is, acute care hospitals, as well as other excluded hospitals and units (IRFs and IPFs) and SNFs) with which they were co-located. Furthermore, since the existing regulation text at § 412.22(e)(3) and (h)(5) required that the notification take place within 60 days of the LTCH's first cost reporting period beginning on or after October 1, 2002 and § 412.532(i) required that the notification occur within 60 days of the effective date of the original regulation (October 1, 2002), and this timeframe for many providers has long since passed, we are proposing to eliminate that specific timing requirement in favor of the on-going, prospective notification requirement described above, which is also clearer and more comprehensive. We are also proposing to delete the phrase ''and within 60 days of a change in co-located status'' from § 412.532(i) because we believe that this proposed continuing notification requirement in the proposed revised regulation text at § 412.22(e)(3) and (h)(5), as well as at § 412.532(i) would include the obligation to notify CMS and the fiscal intermediary in writing of any changes in co-located status and the obligation to provide the requisite information detailed above. We are proposing revisions to each of the three notification provisions, therefore, to establish consistency and to clearly state the on-going requirement that LTCH HwHs and satellites of LTCHs inform their fiscal intermediary and CMS in writing of the names, addresses, and provider numbers of other applicable co-located Medicare providers.

6. Other Payment Adjustments

As indicated earlier, we have broad authority under section 123 of Pub. L. 106–113, 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 LTCH PPS final rule (67 FR 56014–56027), we discussed our extensive data analysis and rationale for not implementing an adjustment for geographic reclassification, rural location, treating a disproportionate share of low-income patients (DSH), or indirect medical education (IME) costs. In that same final rule, we stated that we would collect data and reevaluate the appropriateness of these adjustments in the future once more LTCH data become available after the LTCH PPS is implemented.

Because the LTCH PPS has only been implemented for a few years and there is a lag-time in data availability, sufficient new data have still not yet been generated that would enable us to conduct a comprehensive reevaluation of these payment adjustments. Nonetheless, we have reviewed the limited data that are available and have found no evidence to support additional proposed policy changes. Therefore, in this proposed rule, we are not proposing to make any adjustments for geographic reclassification, rural location, DSH, or IME. However, we will continue to collect and interpret new data as they become available in the future to determine if these data support proposing any additional payment adjustments.

7. Proposed Budget Neutrality Offset to Account for the Transition Methodology

Under § 412.533, we implemented a 5-year transition period from reasonable cost-based payment to prospective payment, during which a LTCH is paid an increasing percentage of the LTCH PPS rate and a decreasing percentage of its payments under the reasonable cost-based payment methodology for each discharge. Furthermore, we allow a LTCH 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. Section 123(a)(1) of the Pub. L. 106–113 requires that the Secretary shall develop a per discharge prospective payment system for LTCHs and such system shall ''maintain budget neutrality.'' Accordingly, as we established in the August 30, 2002 final rule (67 FR 56033–56036), 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).

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 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).

In the May 7, 2004 final rule (69 FR 25702), based on the best available data at that time, we projected that approximately 93 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 2005 LTCH PPS rate year. Using the same methodology described in the August 30, 2002 LTCH PPS 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 2005 LTCH PPS rate year (July 1, 2004); or (2) a LTCH would receive higher payments based on 100 percent of the 2005 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 7 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 2005 LTCH PPS rate year standard Federal rate.

In that same final rule, 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 4 years of the transition period (including the election option) would result in a cost to the Medicare program of $29 million. Specifically, for the 2005 LTCH PPS rate year, we estimated that the cost of the transition would be $15 million. In order to maintain budget neutrality, 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 discussed in the May 7, 2004 LTCH PPS final rule, we established a 0.5 percent reduction (0.995) to all LTCH payments in the 2005 LTCH PPS rate year to account for the $15 million estimate cost of the transition period methodology (including the option to elect payment based on 100 percent of the Federal rate) for the 2005 LTCH PPS rate year. Furthermore, we indicated that we would propose 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 this proposed rule, based on the most recent available data, using the same methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 56034), we are projecting that approximately 94 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. This projection, which used updated data is based on our estimate that either: (1) A LTCH has already elected payment based on 100 percent of the Federal rate prior to the beginning of the 2006 LTCH PPS rate year (July 1, 2005); or (2) a LTCH would receive higher payments based on 100 percent of the proposed standard Federal rate compared to the payments they would receive under the transition blend methodology. Similarly, we project that the remaining 6 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).

Based on the best available data and the proposed policies described in this proposed rule, we are projecting that in the absence of a transition period budget neutrality offset, the full effect of the remaining 3 years 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 $10 million as follows:

LTCH PPS rate year	Estimated cost (in millions)
2006	7
2007	3
2008	0

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 as we discussed above, based on the most recent 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.

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 discussed in this proposed rule, we are proposing to implement a 0.2 percent reduction (0.998) to all LTCHs' payments for discharges occurring on or after July 1, 2005 and through June 30, 2006, 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 the $7 million for the 2006 LTCH PPS rate year.

As noted above, in order to maintain budget neutrality, we indicated that we would propose 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 this proposed rule, based on the best available data, we estimate the following proposed budget neutrality offsets to LTCH PPS payments during the remaining years of the transition period: 0.1 percent (0.999) for the 2007 LTCH PPS rate year, and 0 percent (no adjustment) for the 2008 LTCH PPS rate year. As noted above, we believe there is no longer a need for a small offset in the 2008 LTCH PPS rate year because we project that the vast majority of those LTCHs whose 5th year of the transition period will be concluding in the first 3 months of the 2008 LTCH PPS rate year will be paid based on 100 percent of the Federal rate rather than the transition blend.

As we discussed in the August 30, 2002 LTCH PPS final rule (67 FR 56036), consistent with the statutory requirement for budget neutrality in section 123(a)(1) of Public Law 106–113, 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 reflect 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 56027–56037). 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 of Pub. L. 106–113 and section 307 of Pub. L. 106–554 provide broad authority to the Secretary in developing the LTCH PPS, including the authority for appropriate adjustments. Under this broad authority, as implemented in the 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.

In the May 7, 2004 LTCH PPS final (69 FR 25703–25704), 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 $2.96 billion for the 2005 LTCH PPS rate year; $2.98 billion for the 2006 LTCH PPS rate year; $2.95 billion for the 2007 LTCH PPS rate year; $3.01 billion for the 2008 LTCH PPS rate year; and $3.12 billion for the 2009 LTCH PPS rate year.

In this proposed rule, consistent with the methodology established in the August 30, 2002 LTCH PPS 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 follows:

LTCH PPS rate year	Estimated payments ($ in billions)
2006	2.94
2007	2.90
2008	2.96
2009	3.08
2010	3.24

In accordance with the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 56037), these estimates are based on the projection that 94 percent of LTCHs would elect to be paid based on 100 percent of the 2006 LTCH PPS rate year proposed standard Federal rate rather than the applicable transition blend, and our estimate of 2006 LTCH PPS rate year payments to LTCHs using our Office of the Actuary's most recent estimate of the excluded hospital with capital market basket of 3.1 percent for the 2006 LTCH PPS rate year, 2.9 percent for the 2007 LTCH PPS rate year, 2.7 for the 2008 LTCH PPS rate year, and 2.9 percent for the 2009 and 2010 LTCH PPS rate years. We also took into account our Office of the Actuary's projection that there would be a change in Medicare beneficiary enrollment of −4.9 percent in the 2006 LTCH PPS rate year, −6.5 percent in the 2007 LTCH PPS rate year, −1.1 percent in the 2008 LTCH PPS rate year, 0.2 percent in the 2009 LTCH PPS rate year, and 0.8 percent in the 2010 LTCH PPS rate year. (We note that, based on the most recent available data, our Office of the Actuary 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 Medicare Prescription Drug, Improvement, and Modernization Act of 2003.)

As we discussed in the May 7, 2004 LTCH PPS final rule (69 FR 25704), because the LTCH PPS has only been recently implemented, sufficient new data have not been generated that would enable us to conduct a comprehensive reevaluation of our budget neutrality calculations. Accordingly, we did not make a one-time adjustment under § 412.523(d)(3). At this time, we still do not have sufficient new data to enable us to conduct a comprehensive reevaluation of our budget neutrality calculations. Therefore, in this proposed rule, we are not proposing to make a one-time adjustment under § 412.523(d)(3) so that the effect of any significant difference between actual payments and estimated payments for the first year of the LTCH PPS is not perpetuated in the PPS rates for future years. However, we will continue to collect and interpret new data as the data become available in the future to determine if such an adjustment should be proposed.

8. Extension of the Interrupted Stay Policy

In the May 7, 2004 LTCH PPS final rule, we revised the definition of an ''interruption of a stay'' at § 412.531 by establishing two distinct categories, ''[a] 3-day or less interruption of stay'' at (a)(1) and ''[a] greater than 3-day interruption of stay'' at (a)(2). The ''greater than 3-day interruption of stay'' which was directly based on the original ''interruption of stay'' policy that had been implemented at the start of the LTCH prospective payment system (August 30, 2002 LTCH PPS final rule, 67 FR 56002) is defined as a stay at a LTCH during which a Medicare inpatient is discharged from the LTCH to an acute care hospital, an IRF, or a SNF (or swing bed) for a period of greater than 3 days, but is readmitted to the LTCH within the applicable fixed day period, that is, between 4 and 9 consecutive days for an acute care hospital, between 4 and 27 consecutive days for an IRF, and between 4 and 45 consecutive days for a SNF. In each of these cases, the day count begins on the day of discharge from the LTCH, (which is also the day of admission to the other site of care), even though the payment features of the greater than 3-day policy itself govern the stay only after day 4 once the 3-day policy, described below, no longer applies.

As defined in the previous paragraph, for purposes of Medicare payment to the LTCH, a greater than 3-day interruption of stay is treated as only one discharge from the LTCH and generates only one LTC–DRG payment. However, under this policy, Medicare makes a separate payment to the intervening provider (that is, acute care hospital, IRF, or SNF) for the treatment or care given to the beneficiary during the interruption.

In implementing this policy, we provided that, in the event a Medicare inpatient is discharged from a LTCH and is readmitted and the stay qualifies as an interrupted stay, the provider must cancel the claim generated by the original stay in the LTCH and submit one claim for the entire stay. (For further details, see Medicare Program Memorandum Transmittal A–02–093, September 2002.)

On the other hand, if the patient stay exceeds the total fixed-day threshold outside of the LTCH at the other facility before being readmitted, two separate LTCH PPS payments would be made. One would be based on the principal diagnosis and length of stay for the first discharge from the LTCH and the other based on the principal diagnosis and length of stay for the second discharge from the LTCH. Depending upon their lengths of stay, both stays could result in payments as a short-stay outlier (§ 412.529), a full LTC–DRG, or even a high-cost outlier. Further, if the principal diagnosis is the same for both admissions, the hospital could receive two similar payments. It is also important to note that under the existing greater than 3-day interrupted stay policy, a separate Medicare payment is made to the intervening provider under that provider's payment system.

The 3-day or less interruption of stay policy is defined at § 412.531(a)(1) as ''a stay at a long-term care hospital during which a Medicare inpatient is discharged from the long-term care hospital to an acute care hospital, IRF, SNF, or the patient's home and readmitted to the same long-term care hospital within 3-days of the discharge

from the long-term care hospital. The 3-day or less period begins with the date of discharge from the long-term care hospital and ends not later than midnight of the third day.'' As discussed in detail in the May 7, 2004 LTCH PPS final rule (69 FR 25691–25700), there are several components to this policy. First, 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, any off-site tests or medical treatment, either inpatient or outpatient, delivered at an acute care hospital or an IRF, or care at a SNF, will be covered by the LTCH ''under arrangements'' if the patient is readmitted to the LTCH within 3 days. (We established a specific exception to the ''under arrangements'' requirement during the 2005 LTCH PPS rate year, which we will review below, at § 412.531(b)(1)(ii)(A)(1), in the event that the treatment was grouped to a surgical DRG under the IPPS at an acute care hospital.)

Existing regulations at § 412.509(c) require a LTCH to furnish all necessary covered services for a Medicare beneficiary who is an inpatient of the hospital either directly or ''under arrangements'' (as defined in § 409.3). The ''under arrangements'' policy set forth in § 412.509 derives from the regulations at § 411.15(m), which implement section 1862(a)(14) of the Act. Section 1862(a) of the Act specifies the services for which no payment may be made under Medicare Part A and Part B and also specifies the exception for certain services to be furnished ''under arrangements'' by providers. Under section 1862(a)(14) of the Act, notwithstanding any other provision of this title, ''no payment may be made under part A or part B for any expenses incurred for items or services which are other than physicians' services (as defined in regulations promulgated specifically for purposes of this paragraph), services described by section 1861(s)(2)(K) of the Act (certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist, and which are furnished to an individual who is a patient of a hospital or critical access hospital by an entity other than the hospital or critical access hospital, unless the services are furnished under arrangements (as defined in section 1861(w)(1) of the Act)) with the entity made by the hospital or critical access hospital.'' Section 1861(w)(1) of the Act states that ''[t]he term 'arrangements' is limited to arrangements under which receipt of payment by the hospital, critical access hospital, skilled nursing facility, home health agency, or hospice program (whether in its own right or as agent), with respect to services for which an individual is entitled to have payment made under this title, discharges the liability of such individual or any other person to pay for the services.'' We believed the objective of these statutory provisions, which were implemented for inpatient acute care hospitals in regulations at § 411.15(m) and subsequently at § 412.509 for LTCHs, was to discharge financial liability for inpatients who may have received additional care off-premises and to assign payment responsibility for the care to the hospital that is being paid for that beneficiary's total care for that spell of illness.

Over the years, we have often referred to this as the ''prohibition against unbundling'' for purposes of emphasizing that if a Medicare provider ''unbundles'' specific components of a beneficiary's total inpatient care (provided either ''directly'' or ''under arrangements'') and sends separate claims to Medicare for those tests or treatments, the provider would be acting in violation of the statute and applicable regulations. Since LTCHs treat patients with multicomorbidities who are often in need of a wide range of diagnostic and treatment modalities and lengthy hospitalizations, we believe that in this particular setting, this statutory requirement was particularly vulnerable to gaming. For that reason, in formulating the ''3-days or less interruption of stay policy'' at § 412.531(a), we clarified the existing general unbundling prohibition and the unbundling prohibition as it applied to the interrupted stay policy under the LTCH PPS.

As noted above, we were concerned that LTCH patients, under active treatment, were being inappropriately discharged to other treatment sites, receiving tests or procedures related to one of the diagnoses for which the patient was being hospitalized and which otherwise should have been provided at the LTCH either directly or ''under arrangements'' (§ 412.509) prior to being readmitted to the LTCH. Such behavior resulted in another claim being submitted to Medicare by the other treatment site for those tests or procedures. Since it is a fundamental principle of all prospective payment systems that payments associated with specific diagnostic group include all costs associated with rendering care to the type of patients treated, the behavior described above on the part of the LTCH, would result in an additional and inappropriate Medicare payments for services delivered by an intervening provider.

If a LTCH obtains, from another facility ''under arrangements,'' a specific test or procedure that is not available on the LTCH's premises for one of its inpatients, as contemplated by § 412.509, a discharge and a subsequent readmission would therefore be unnecessary and inappropriate. This is true even if it is necessary to transport the patient to another facility to receive the arranged-for service. In this situation, generally, the LTCH would include the medically necessary test or procedure on its patient claim to Medicare which could have an effect on the assignment of the LTC–DRG and, thus, the Medicare payment to the LTCH, and the LTCH would be responsible for paying the provider directly for the test or procedure. Under the 3-day or less interruption of stay policy, if a LTCH patient is discharged to an acute care hospital, IRF, SNF, or patient's home and returns to the LTCH for further hospital-level care within 3 days, any Medicare-covered services delivered during that interruption will be deemed to have been delivered ''under arrangements and included in the one episode of care for which Medicare will pay the LTCH. Furthermore, under § 409.3, when services are furnished ''under arrangements,'' Medicare payments made to the provider that arranged for the services discharges the liability of the beneficiary or any other person to pay for those services. Our policy was premised on the belief that 3 days, in most instances, represented an appropriate interval for establishing whether or not the reason for the patient's readmission was directly connected to the original episode of care at the LTCH. Therefore, no additional claim can be submitted to Medicare by the other provider that actually furnished the test or procedure if the patient is readmitted to the LTCH within 3 days since the initial LTCH admission triggered a Medicare payment under the LTCH prospective payment system that has been calibrated to cover payment for all necessary Medicare covered services delivered to a beneficiary during that episode of care.

Moreover, under this finalized policy, where the LTCH is required to pay for outpatient or inpatient medical treatment or care provided at an acute care hospital, an IRF or SNF during any days of the 3-day or less interruption, all days of the 3-day or less interruption that the patient is away from the LTCH

will be included in that patient's day count at the LTCH. If the LTCH patient goes home during the interruption and receives no additional medical care prior to being readmitted to the LTCH, the intervening days will not be included in the day count because the LTCH did not deliver any services to the patient during those days either directly or ''under arrangement''.

In the final policy, as established in the May 7, 2004 LTCH PPS final rule, for LTCH rate year 2005, we did provide a limited exception to the prohibition against additional Medicare payments to an intervening provider under the less than 3-day interruption of stay policy at § 412.531(b)(1)(ii)(A)(1). Under this exception, if a patient was discharged from a LTCH, admitted as an inpatient to an acute care hospital and readmitted to the same LTCH within 3 days, and if the treatment that was delivered at the acute care hospital was grouped to a surgical DRG Medicare will pay the acute care hospital separately for that surgical treatment. We established this exception in response to comments on the original policy that we proposed in the January 30, 2004 proposed rule (69 FR 4768–4772) requesting that we take into consideration the following scenario: The occurrence of an emergency ''totally unrelated'' to a LTCH patient's admitting diagnoses that occurred and requiring surgery at an acute inpatient hospital, followed by the readmission of the patient within 3 days to the LTCH for a continuation of treatment of the patient's initial medical problems.

In our response to these concerns, we noted that the 3-day or less interruption of stay policy at 412.531 resulted from our concern 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 length of stay, and, therefore, should have been provided ''under arrangements.''

In the May 7, 2004 LTCH PPS final rule, we stated that over the course of the first year of implementation of the revised 3-day or less interrupted stay policy, we would study relevant claims data in order to evaluate whether further proposed refinements to this policy would be warranted in this year's rule. Specifically, we stated that we would analyze new data to determine whether problems associated with LTCH interrupted stays equally affected all settings to which LTCH patients may have been discharged and subsequently readmitted; and we would closely monitor patterns of discharges and readmissions under the first year of this policy. In order to pursue these analyses, we stated that we would be using relevant claims data as soon as they were available to determine whether our policy was producing its desired effect of reducing unnecessary and inappropriate Medicare payments while not compromising beneficiary access to medically necessary services. The 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. Therefore, we are proposing to extend the surgical DRG exception through the 2006 LTCH rate year, from July 1, 2005 through June 30, 2006. At that point, the policy will have been in effect for 12 months and we believe that we will be able to better evaluate whether this exception should be extended further as well as whether the overall policy requires modification in order to serve the overall goals of the Medicare program.

9. Onsite Discharges and Readmittances

Under § 412.532, generally, if more than 5 percent of all Medicare discharges during a cost reporting period are patients who are discharged to an onsite SNF, IRF, or psychiatric facility, or to an onsite acute care hospital and who are then directly readmitted to the LTCH (including a satellite facility), only one LTC–DRG payment will be made to the LTCH for these type of discharges and readmittances during the LTCH's cost reporting period. Therefore, payment for the entire stay will be paid either as one full LTC–DRG payment or a short-stay outlier, depending on the duration of the entire LTCH stay.

In applying the 5-percent threshold, we apply one threshold for discharges and readmittances with the co-located acute care hospital. There is also a separate 5-percent threshold for the aggregate of all discharges and readmittances to the LTCH from its co-located SNFs, IRFs, and psychiatric facilities. In the case of a LTCH that is co-located with an acute care hospital, an IRF, or a SNF, the interrupted stay policy at § 412.531 applies until the 5-percent threshold is reached. Once the applicable 5-percent threshold is reached, all LTCH discharges and readmittances from the co-located acute care hospital for that cost reporting period are paid as one discharge pursuant to § 412.532. This means that once the 5-percent threshold has been reached, even if a discharged LTCH Medicare patient was readmitted to the LTCH following a stay in an acute care hospital of greater than 9 days, if the facilities share a common location, the subsequent discharge from the LTCH will not represent a separate hospitalization for payment purposes. Under this policy, the total stay for a patient will include LTCH days prior to the interruption and, also, the days after the readmission to the LTCH that followed the interruption and Medicare will make one LTC–DRG payment when the patient is discharged during a cost reporting period. One LTC–DRG will be assigned based upon all patient diagnoses and care delivered to the patient during the entire LTCH stay and included on the discharge claim regardless of the length of stay at the acute care hospital during the interruption.

Similarly, if the LTCH has exceeded its 5-percent threshold for all discharges to an onsite IRF, SNF, or psychiatric hospital or unit, which were readmitted to the LTCH from those providers, the subsequent LTCH discharge for those patients will not be treated as a separate discharge for Medicare payment purposes. (Unless the up to 3-day interrupted stay policy is applicable, payment to an acute care hospital under the IPPS, to the IRF under the IRF PPS, or to a SNF under the SNF PPS, will not be affected. Payments to the psychiatric facility also will not be affected.)

In the August 30, 2002 LTCH PPS final rule, we established a notification requirement for LTCHs that were HwHs as defined in § 412.22(e) and satellites of LTCHs, defined at § 412.22(h)(5) and for LTCHs and for satellites of LTCHs that were subject to the onsite provider payment adjustment under § 412.532(i) because they were co-located with other Medicare providers, as specified in § 412.532(a). At § 412.22(e)(3) and (h)(5), as well as at § 412.532(i), respectively, we require LTCHs to notify us and their FIs of their co-located status within 60 days of the start of the hospital's first cost reporting period under the LTCH PPS. At § 412.532(i), we also established an additional notification requirement for LTCHs subject to the onsite provider payment adjustment at § 412.532, to notify their FIs and CMS within 60 days of a change in co-located status. We intended that these regulations also require the LTCHs to identify the Medicare providers, that is, acute care hospitals, as well as other excluded hospitals and units (IRFs and IPFs), and SNFs with which they were co-located and their addresses and Medicare provider numbers for purposes of implementing the payment adjustment for co-located providers described above.

It appears, however, that this expectation is unclear in our existing regulations because we have been informed by our Regional offices and FIs that LTCHs, for which they are responsible, have in many cases neglected to specify the names, addresses, and provider identification numbers of their co-located providers. We are proposing to clarify our policy that when a LTCH informs its fiscal intermediary of its co-located status, it also would be required to include the name, address, and the provider numbers of the other co-located providers (that is, acute care hospitals, as well as other excluded hospitals and units (IRFs and IPFs) and SNFs) with which they were co-located. Furthermore, since the existing regulation text at § 412.22(e)(3) and (h)(5) required that the notification take place within 60 days of the LTCH's first cost reporting period beginning on or after October 1, 2002 and § 412.532(i) required that the notification occur within 60 days of the effective date of the original regulation (October 1, 2002), and this timeframe for many LTCHs has long since passed, we are eliminating that specific timing requirement in favor of the on-going prospective notification requirement described above, which is also clearer and more comprehensive. We are proposing to delete the phrase ''and within 60 days of a change in co-located status'' from § 412.532(i) because we believe that this continuing notification requirement in the proposed revised regulation text at § 412.532(i) as well as at § 412.22(e)(3) and (h)(5) would include the obligation to notify CMS and the fiscal intermediary in writing of any change in co-located status and the obligation to provide the requisite information detailed above. We are proposing revisions to each of the notification provisions at § 412.531(i), and at § 412.22(e)(3) and (h)(5) to establish consistency and to clearly state the on-going requirement that LTCH HwHs and satellites of LTCHs inform their fiscal intermediaries and CMS of the names, addresses, and provider numbers of other co-located Medicare providers. Although § 412.532(i) previously mentioned LTCHs and satellites of LTCHs that occupy space in a building used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital and that meet the criteria of § 412.22(h)(1) through (h)(4), the scope of § 412.532 is clearly broader than this. Specifically, § 412.532(a) also includes SNFs among the providers subject to this policy. We are, therefore, proposing to revise the regulation text at § 412.532(i) to include all providers at § 412.532(a).

V. Computing the Proposed Adjusted Federal Prospective Payments for the 2006 LTCH PPS Rate Year

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

In accordance with § 412.525 and as discussed in section IV.C. of this proposed rule, the standard Federal rate is adjusted to account for differences in area wages by multiplying the labor-related share of the standard Federal rate by the appropriate LTCH PPS wage index (as shown in Tables 1 and 2 of the Addendum to this proposed rule). The standard Federal rate is also adjusted to account for the higher costs of hospitals in Alaska and Hawaii by multiplying the nonlabor-related share of the standard Federal rate by the appropriate cost-of-living factor (shown in Table I in section IV.C.2. of this preamble). In the May 7, 2004 final rule (69 FR 25674), we established a standard Federal rate of $36,833.69 for the 2005 LTCH PPS rate year. In this proposed rule, based on the best available data, previously established policies, and the proposed policies described in this rule, we are proposing to establish a standard Federal rate of $37,975.53 for the 2006 LTCH PPS rate year as discussed in section IV.B. of this preamble. We illustrate the methodology used to adjust the proposed Federal prospective payments for the 2006 LTCH PPS rate year in the following example: During the 2006 LTCH PPS rate year, a Medicare patient is in a LTCH located in Chicago-Naperville-Joliet, Illinois (CBSA 16974). This LTCH is in the third year of the wage index phase-in, thus, the proposed three-fifths wage index values are applicable. The proposed three-fifths wage index value for CBSA 16974 is 1.0521 (see Table 1 in the Addendum to this proposed rule). The Medicare patient is classified into LTC–DRG 9 (Spinal Disorders and Injuries), which has a relative weight of 1.0950 (see Table 3 of the Addendum to this proposed rule). To calculate the LTCH's total proposed adjusted Federal prospective payment for this Medicare patient, we compute the proposed wage-adjusted Federal prospective payment amount by multiplying the proposed unadjusted standard Federal rate ($37,975.53) by the proposed labor-related share (72.885 percent) and the proposed wage index value (1.0521). This proposed wage-adjusted amount is then added to the nonlabor-related portion of the proposed unadjusted standard Federal rate (27.115 percent; adjusted for cost of living, if applicable) to determine the adjusted Federal rate, which is then multiplied by the LTC–DRG relative weight (1.0950) to calculate the total proposed adjusted Federal prospective payment for the 2006 LTCH PPS rate year ($43,162.25). Finally, as discussed in section IV.C.6. of this preamble, for the 2006 LTCH PPS rate year, the total proposed adjusted Federal prospective payment is reduced by the proposed 0.2 percent budget neutrality offset to account for the costs of the transition methodology.

The following illustrates the components of the calculations in this example:

Unadjusted Standard Federal Prospective Payment Rate:	$37,975.53
Labor-Related Share	0.72885
Labor-Related Portion of the Federal Rate	= $27,678.47
3/5ths Wage Index (CBSA 16974)	1.0521
Wage-Adjusted Labor Share of Federal Rate	= $29,120.52
Nonlabor-Related Portion of the Federal Rate ($37,975.53 × 0.27115)	+ $ 10,297.06
Adjusted Federal Rate Amount	= $39,417.58
LTC–DRG 9 Relative Weight	× 1.0950
Total Adjusted Federal Prospective Payment (Before the Budget Neutrality Offset)	= $43,162.25
Budget Neutrality Offset	× 0.998
Total Federal Prospective Payment (Including the Budget Neutrality Offset)	= $42,816.95

VI. Transition Period

To provide a stable fiscal base for LTCHs, under § 412.533, we implemented a 5-year transition period from reasonable cost-based reimbursement under the TEFRA system to a prospective payment based on industry-wide average operating and capital-related costs. 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.

In accordance with § 412.533, the 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, 2006. 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 2 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 as follows:

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, 2004, and before October 1, 2005 (FY 2005), the total payment for a LTCH is 40 percent of the amount calculated under reasonable cost principles for that specific LTCH and 60 percent of the Federal prospective payment amount. For cost reporting periods that begin on or after October 1, 2005 and before October 1, 2006 (FY 2006), the total payment for a LTCH will be 20 percent of the amount calculated under reasonable cost principles for that specific LTCH and 80 percent of the Federal prospective payment amount. As we noted in the May 7, 2004 final rule (69 FR 25674), 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 fiscal intermediaries 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 PPS for LTCHs, one of our goals is to transition hospitals to full prospective payments as soon as appropriate. Therefore, under § 412.533(c), we allow a LTCH, which is subject to a blended rate, to elect payment based on 100 percent of the Federal rate at the start of any of its cost reporting periods during the 5-year transition period rather than incrementally shifting from reasonable cost-based payments to prospective payments. Once a LTCH elects to be paid based on 100 percent of the Federal rate, it will not be able to revert to the transition blend. For cost reporting periods that began on or after December 1, 2002, and for the remainder of the 5-year transition period, a LTCH must notify its fiscal intermediary in writing of its election on or before the 30th day prior to the start of the LTCH's next cost reporting period. For example, a LTCH with a cost reporting period that begins on May 1, 2005, must notify its fiscal intermediary in writing of an election before April 1, 2005.

Under § 412.533(c)(2)(i), the notification by the LTCH to make the election must be made in writing to the Medicare fiscal intermediary. Under §§ 412.533(c)(2)(ii) and (c)(2)(iii), the intermediary 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.

Notifications received, postmarked, or delivered by other means after the specified date 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 notification is not received timely, payment will be based on the transition period blend percentages.

VII. 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 otherwise meets the qualifying criteria for LTCHs, set forth in § 412.23(e)(1) and (e)(2), under present or previous ownership (or both), and its first cost reporting period as a LTCH begins on or after October 1, 2002. We also specify in § 412.500 that the LTCH PPS is applicable to hospitals with a cost

reporting period that began 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 Public Law 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.

As noted above and in accordance with § 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.

VIII. 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 short-stay outlier (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, length of stay or interrupted stay status) are recorded by the LTCH on the Medicare patient's discharge bill and submitted to the Medicare fiscal intermediary for processing. The payment represents payment in full, under § 412.521(b), for inpatient operating and capital-related costs, but not for the costs of an approved medical education program, bad debts, blood clotting factors, anesthesia services by hospital-employed nonphysician anesthetists or obtained under arrangement, or the costs of photocopying and mailing medical records requested by a Quality Improvement Organization (QIO), which are costs paid outside the LTCH PPS.

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

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

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

IX. MedPAC Recommendations/ Monitoring

The Medicare Payment Advisory Commission's (MedPAC's) June 2004 Report to the Congress: Variation and Innovation in Medicare, contained a chapter on ''Defining Long-Term Care Hospitals.'' In this chapter, the Commission focused on a broad range of issues central to understanding LTCHs which, although rapidly increasing in number, is still the smallest of all provider categories, but the most costly to the Medicare program per beneficiary episode of care.

The Commission identified particular problems such as growth of the LTCH industry, and high payment rates that appear to result from current payment incentives. Specifically the report states, ''[F]irst, the financial incentive of the acute and long-term care hospital PPSs are likely to encourage facilities to selectively retain and admit certain types of patients to minimize their costs. Acute hospitals have a financial incentive to transfer patients as quickly as possible if they are likely to become high-cost outliers (to avoid losses on those patients). LTCHs have an incentive to admit patients with a given diagnosis who are likely to require fewer resources. Second, as the number of LTCHs grows, facilities may find it increasingly difficult to find patients who truly require LTCH-level care; this would lead to an increase in lower severity patients being cared for in LTCHs and higher Medicare spending. Finally, LTCH care is costly. The per case base rate in $37,000 and payments can be as high as $115,000 per case for the most complex patients.'' (pp. 127–8)

The Commission also examined LTCHs in the June 2003 Report to the Congress, entitled, ''Monitoring post-acute care.'' Citing that Report, the Commission compared beneficiaries treated in LTCHs and other settings and determined that based on ''the 11 most common diagnoses in LTCHs, using descriptive analysis and controlling for diagnosis related group (DRG) and severity of illness * * * that patients in market areas with LTCHs had similar acute hospital lengths of stay [preceding the LTCH stay] whether they used these facilities or not.'' Further, ''[p]atients who used LTCHs were three to five times less likely to use skilled nursing facility (SNF) care, suggesting that SNFs

and long-term care hospitals may be substitutes.'' The June 2004 Report had also noted that ''* * * Medicare pays more for patients treated in LTCHs, compared with patients not treated in them'', but also concluded that this study, as well as the rapid and continuing growth in the number of LTCHs, the corresponding increases in Medicare spending, combined with the markedly uneven distribution of LTCHs throughout the country, raised additional issues for further research. (p. 122)

In its June 2004 Report to the Congress, the Commission reported the results of this subsequent research, both qualitative and quantitative, which focused on the following questions: What role do long-term care hospitals play in providing care?; Where are clinically similar patients treated in areas without long-term care hospitals?; and How do Medicare payments and outcomes compare for LTCH patients versus those in other settings? (p. 122). The Commission's research utilized structured interviews with health care providers and hospital administrators; site visits and clinical presentations; and quantitative analyses of markets with and without LTCHs and patient-level analyses to examine outcomes and per-episode impact on Medicare costs. Responses to these questions included the following assertions:

- LTCHs provide post-acute care to a small number of medically complex patients who are more stable than patients in an intensive care unit (ICU) but may still have unresolved underlying complex medical conditions.
- The use of LTCHs is associated with certain diagnoses, severity levels and the proximity of the facility.
- In areas without LTCHs, acute hospitals and SNFs are the principal substitutes of LTCHs.
- When LTCH care is not targeted to patients most likely to need this level of care, care for patients at a LTCH is more costly to Medicare than for similar patients in alternative settings. Conversely, when LTCH care is targeted to patients most likely to need this level of care, costs for those patients appear to be comparable to costs for those who use other settings (and costs for LTCH patients with tracheostomies save Medicare money) in large part because of fewer acute hospital readmissions for those patients. (pp 121–134)

The Commission's interpretations of its qualitative and quantitative research findings led to two specific recommendations:

''5A—The Congress and the Secretary should define long-term care hospitals by facility and patient criteria that ensure that patients admitted to these facilities are medically complex and have a good chance at improvement.

- Facility-level criteria should characterize this level of care by features such as staffing, patient evaluation and review processes, and mix of patients.
- Patient-level criteria should identify specific clinical characteristics and treatment modalities.

5B—The Secretary should require the Quality Improvement Organizations to review long-term care hospital admissions for medical necessity and monitor that these facilities are in compliance with defining criteria.'' (p. 120).

Since the publication of MedPAC's recommendations, we have discussed the implications of the Report with several trade associations that represent different facets of the LTCH industry (for example, older non-profit LTCHs; a for-profit chain that specializes in a particular case-mix; another for-profit chain which functions mainly in the HwH model).

In response to the recommendation in MedPAC's June 2004 Report that the Secretary examine defining LTCHs by facility and patient criteria, we have awarded a contract to Research Triangle Institute (RTI), International for a thorough examination of the Commission's recommendations based on the performance of a wide variety of analytic tasks using CMS data files, and also utilizing information collected from physicians, providers, and LTCH trade associations. This contract, ''Long Term Care Hospital (LTCH) Payment System Refinement/Evaluation,'' will assist (CMS) in researching MedPAC's recommendations regarding the 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, International will evaluate patient or facility level characteristics for LTCHs in order to identify and distinguish the role of these hospitals as a Medicare provider. This effort will be multi-faceted. Claims analysis of patients treated by LTCHs, as well as outlier patients treated at acute care hospitals will provide information to help direct this work, and several additional types of data sources will be used to evaluate these two issues, including administrative data such as Medicare claims as well as primary data collected through interviews, and a secondary analysis of existing regulatory requirements. As they gather information for the purposes of determining the feasibility of establishing LTCH patient and facility-level criteria, our contractor has been directed to include information from representatives, along with other stake-holders in the LTCH industry. Additionally, the contractor will examine the present role of QIOs in the Medicare program, focusing on their responsibilities regarding the LTCH PPS, as well as the potential for an expanded QIO role as suggested by MedPAC's recommendations. The goals of this research will be to document current practices related to the MedPAC recommendations, both in terms of provider certification, quality reviews, and hospital practice patterns.

Specifically, the project itself will be completed in two phases. Phase I, which is presently being undertaken by the contractor, focuses on an analysis of LTCHs within the current Medicare system, their history as participating providers, their case-mix, the criteria used by QIOs to determine the appropriateness of treatment in LTCHs, and where similar patients are treated in areas that lack LTCHs. Prior analyses of these issues by other contractors will be utilized as well as preliminary discussions with MedPAC, other researchers, and the QIOs. Building on the work of Phase I, Phase II will continue to address the feasibility of MedPAC's proposed criteria by first investigating the appropriateness of patient level criteria to determine whether there are distinctions between patients treated in LTCHs and other types of potential substitute providers (with particular attention to varying outcomes). Medicare claims data will be utilized for comparisons of LTCH patients and long-stay patients who are treated in acute care hospitals that have attained high cost outlier status. A separate analysis will be made for a subset of LTCH patients with diagnoses that are typically treated in IRFs. The contractor is then planning interviews with QIOs for the purpose of gathering information on assessment measures for each setting. Comparisons of these instruments will be made across regions for their usefulness as standardized patient screening or assessment tools. The contractors then plan to evaluate the outcomes of their research in the context of MedPAC's recommendation for the development of facility-level criteria, using claims, interviews, and document reviews. To the extent the analyses suggest that changes should be made that may affect LTCH payments, LTCH discharges, or the definition of LTCH, such proposed changes could necessitate some statutory or regulatory changes.

In the August 30, 2002 final rule (67 FR 56014), we described an on-going monitoring component of the new LTCH

PPS that would enable us to evaluate the impact of the new payment policies. 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 us and the fiscal intermediary to track beneficiary movement to and from a LTCH and track LTCH patients 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 part of our data analysis, we have revisited a number of our original and even pre-LTCH PPS policies in order to address what we believed were behaviors by certain LTCHs that have led to inappropriate Medicare payments. In recent **Federal Register** publications, for example, we have proposed and subsequently finalized revisions to the interruption of stay policy (69 FR 25692, May, 2004), and we established a payment adjustment for LTCH HwHs and satellites (69 FR 49191, August 11, 2004).

Also, in the June 6, 2003 final rule (68 FR 34157), we explained that, given that the only requirement that distinguishes a LTCH from other acute care hospitals is an average inpatient length of stay of greater than 25 days, we continue to be concerned about the extent to which LTCH services and patients differ from those services and patients treated in other Medicare covered settings (for example, SNFs and IRFs) and how the LTCH PPS will affect the access, quality, and costs across the health care continuum. Thus, we will be monitoring trends in the supply and utilization of LTCHs and Medicare's costs in LTCHs relative to other Medicare providers. For example, we intend to conduct medical record reviews of Medicare patients to monitor changes in service use (ventilator use, for example) over a LTCH episode of care and to assess patterns in the average length of stay at the facility level.

We also are collecting data on patients staying for periods of 6 months or longer in LTCHs and believe that QIOs will be evaluating whether or not such extensive stays may be indicative of LTCH patients who could be more appropriately served at a SNF.

As we discussed in the June 6, 2003 final rule (68 FR 34157), the MedPAC endorsed this monitoring activity as a primary aspect of the design and on-going functioning of the LTCH PPS. Furthermore, as discussed earlier, the Commission, in its June, 2004 Report to the Congress, recommended that we develop facility and patient criteria for LTCH admission and treatment and require a review by QIOs to evaluate whether LTCH admissions meet criteria for medical necessity once the recommended facility and patient criteria are established.

The involvement of QIOs in the LTCH PPS was established at the outset of the system at § 412.508, and was described in the August 30, 2002 final rule (67 FR 55975). Specific activities for QIOs regarding LTCHs are included in contracts awarded by our Office of Clinical Standards and Quality (OCSQ) detailing their scope(s) of work among which are reviewing random samples of LTCH records for medical necessity and coding for generating national payment error estimates; proposing projects to reduce improper payments utilizing the national payment error cause analysis or their own data collection. One direction that is being explored by OCSQ for this type of project is the identification of LTCHs that have specific diagnoses codes related to medically unnecessary admissions, or perhaps high levels of short-stay outliers.

In January 2004, QIOs began reviewing medical records for LTCH claims for the specific purpose of estimating a national payment error rate. Presently, QIOs review 116 LTCH cases each month for admission necessity, for acute care admission, and coding. A cause analysis will be done after the first year's sampling to discern patterns of improper payments for admission necessity and coding. The payment error estimates and some of these analyses will be included in the annual fee-for-service error report.

We continue to be concerned that our policies must assure that LTCHs only treat patients for whom the LTCH level of care is appropriate in order to ensure that Medicare is a prudent purchaser of these very costly services. In addressing one aspect of the issue of whether patients in LTCHs truly need hospital-level of care, beginning in October 2004 and slated to end in July 2005 OCSQ has undertaken a study of LTCH short-stay outliers. Under the short-stay outlier policy at § 412.529, when a LTCH patient stay is considered a short-stay outlier for Medicare payment purposes, the LTCH receives an adjusted (generally lower) payment when the covered days of care do not exceed 5/6 of the (geometric) average length of stay for the particular LTC–DRG assigned to the case. The study evaluates the extent of short-stay outliers and the possibility of retention of patients by the LTCH when the LTCH patient no longer requires hospital-level of care and could be effectively served in a SNF. Due to possible reductions in payment combined with a need to maintain an average length of stay of greater than 25 days to remain an LTCH, we believe that LTCHs may be retaining these patients beyond the short-stay outlier threshold in order to increase Medicare payments. The three QIOs located in States which house the majority of LTCHs are conducting reviews on six months of records from the monthly random sample for this study in order to assess this situation and to determine whether and to what extent patients are being retained at the LTCH beyond their need for hospital-level care and whether retention can be linked to the increased payment for patients exceeding the short-stay outlier threshold. If it is determined that retaining LTCH patients unnecessarily beyond the short-stay outlier threshold is a significant payment issue, OCSQ plans to add this review type to the standard QIO LTCH review.

In addition to existing tasks and the above research study on short-stay outliers, in accordance with the goals of our on-going monitoring program as well as MedPAC's June 2003 recommendations, we believe the QIO's findings will be invaluable in both identifying the most appropriate type of patients for treatment at a LTCH as well as to begin to explore measures of cost-effectiveness for LTCH services.

Currently, we do not require LTCHs to submit any clinical or other quality data, thus, any measurement activity must be based solely on claims. General concerns that we have raised since the establishment of the LTCH PPS, however, and the analysis and very specific recommendations in the MedPAC's June 2004 Report have led us to question what level of additional data beyond current claims would be required for the creation of clinical quality measures for LTCHs. Furthermore, we are presently evaluating whether CMS's Quality Measurement and Health Assessment Group (QMHAG) will need to build a quality measurement program for the LTCH setting. (A quality measurement program would generally establish processes or a group of tasks or processes which, if completed satisfactorily, would indicate a level of compliance with program goals. Clinical quality measures for acute care hospitals based on voluntary data submission and for nursing homes and home health

agencies based on a mandatory standardized data submission are currently being generated.)

As in the acute care hospital, in order to establish a robust set of clinical quality measures for LTCHs, the domains would have to reach a broad population, be based on medical evidence, be scientifically valid, and be actionable. We are also considering measures that cut across other care delivery sites and are broadly focused around areas such as medication management or patient safety. We anticipate a mix of process and outcomes measures that would reflect expected care for each setting, but we also believe that the measures should not ultimately be limited to clinical measures, but should include measures of institutional procedures related to delivery of care systems and patients' actual experience of care. Moreover, if these measures are to be used to relate payment to outcome or performance, it is essential that the measures be adequately risk adjusted.

Therefore, in addition to pursuing our on-going monitoring program under the direction of our Office of Research, Development, and Information (ORDI), existing QIO monitoring and studies, and our considerations of expanding the QIO role in the LTCH PPS, as noted above, we have awarded a contract to RTI International for a thorough examination of the feasibility of implementing MedPAC's recommendations that are contained in the June 2004 Report to the Congress. The research contract was funded for FY 2005 and we anticipate that we will be able to include some preliminary findings in the FY 2006 final rule.

X. Collection of Information Requirements

The collection requirements associated with this proposed rule are exempt from the PRA as stipulated under P.L. 100–203, Section 4201.

XI. Regulatory Impact Analysis

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

A. Introduction

We have examined the impact of this proposed rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 16, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act (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). In this proposed rule, we are using the most recent estimate of the LTCH PPS market basket, updated claims data, and updated wage index values to estimate proposed payments for the 2006 LTCH PPS rate year. Based on the best available data for 261 LTCHs, we estimate that the proposed 3.1 percent increase to the standard Federal rate for the 2006 LTCH PPS rate year, in conjunction with the proposed decrease in fixed-loss amount (discussed in section IV.C.3. of this proposed rule) and the proposed slight decrease in the transition period budget neutrality offset (discussed in section IV.C.7. of this proposed rule), would result in an increase in payments from the 2005 LTCH PPS rate year of $159 million for the 261 LTCHs. (Section IV.C.7. of this proposed rule includes an estimate of Medicare program payments for LTCH services.) Because the combined distributional effects and costs to the Medicare program are estimated to be greater than $100 million, this proposed rule is considered a major economic rule, as defined above.

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

Currently, our database of 261 LTCHs includes the data for 62 non-profit (voluntary ownership control) LTCHs and 191 proprietary LTCHs. The remaining 8 LTCHs are Government owned and operated. (See Table II.) The impact of the proposed changes for the 2006 LTCH PPS rate year are discussed below in section XII.B.4.c of this proposed rule. The provisions of this proposed rule represent a 5.5 percent increase in estimated proposed payments in the 2006 LTCH PPS rate year for all LTCHs (as shown in Table II below). We do not expect the proposed incremental increase of 5.5 percent to the LTCH PPS Medicare payment rates, including the 0.1 percent incremental increase due to the proposed wage index changes (discussed in section IV.C.1. of this proposed rule), to have a significant adverse effect on the overall revenues of most LTCHs. In addition, LTCHs also provide services to (and generate revenue from) patients other than Medicare beneficiaries. Accordingly, we certify that this proposed rule would not have a significant impact on a substantial number of small entities, in accordance with RFA.

3. Impact on Rural Hospitals

Section 1102(b) of the Social Security Act requires us to prepare a regulatory impact analysis if a proposed or final rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. As discussed in detail below, the rates and policies set forth in this proposed rule would not have a adverse impact on rural hospitals based on the data of the 16 rural hospitals in our database of the 261 LTCHs for which data were available.

4. Unfunded Mandates

Section 202 of the UMRA requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million or more.

This proposed rule would not mandate any requirements for State, local, or tribal governments, nor would it result in expenditures by the private sector of $110 million or more in any one year.

5. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications.

We have examined this proposed rule under the criteria set forth in Executive Order 13132 and have determined that this proposed rule would not have any significant impact on the rights, roles, and responsibilities of State, local, or tribal governments or preempt State law, based on the 8 State and local LTCHs in our database of 261 LTCHs for which data were available.

B. Anticipated Effects of Proposed Payment Rate Changes

We discuss the impact of the proposed payment rate changes in this proposed rule below in terms of their fiscal impact on the Medicare budget and on LTCHs.

1. Budgetary Impact

Section 123(a)(1) of Medicare, Medicaid and State Child Health Insurance Program (SCHIP) Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113) requires that the PPS developed for LTCHs ''maintain budget neutrality.'' Therefore, in calculating the standard Federal rate under § 412.523(d)(2), we set total payments for FY 2003 under the LTCH PPS so that aggregate payments under the LTCH PPS are estimated to equal to the amount that would have been paid if this PPS had not been implemented. However, as discussed in greater detail in the August 30, 2002 final rule (67 FR 56033–56036), the FY 2003 LTCH PPS standard Federal rate ($34,956.15) was calculated as though all LTCHs would be paid based on 100 percent of the standard Federal rate in FY 2003. As discussed in section IV.C.7. of this proposed rule, we apply a proposed budget neutrality offset to payments to account for the monetary effect of the 5-year transition to full prospective payment under the LTCH PPS and the policy to permit LTCHs to elect, during the transition, to be paid based on 100 percent of the proposed standard Federal rate rather than a blend of proposed Federal prospective payments and reasonable cost-based payments. The amount of the proposed offset is equal to 1 minus the ratio of the estimated payments based on 100 percent of the LTCH PPS Federal rate to the projected total Medicare program payments that would be made under the transition methodology and the option to elect payment based on 100 percent of the Federal prospective payment rate.

2. Impact on Providers

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

In order to understand the impact of the proposed changes to the LTCH PPS discussed in this proposed rule on different categories of LTCHs for the 2006 LTCH PPS rate year, it is necessary to estimate payments per discharge under the LTCH PPS rates and factors for the 2005 LTCH PPS rate year (*see* the May 7, 2005 final rule; 68 FR 25674) and to estimate payments per discharge that would be made under the proposed LTCH PPS rates and factors for the 2006 LTCH PPS rate year, as discussed in the preamble of this proposed rule. To this end, we determined the percent change in payments per discharge of estimated 2005 LTCH PPS rate year payments to estimated 2006 LTCH PPS rate year payments for each category of LTCHs. In addition, for each category of LTCHs, we have included the estimated percent change in payments per discharge resulting from the proposed LTCH PPS wage index changes (described in section IV.C.1. of this proposed rule). The proposed wage index changes for the 2006 LTCH PPS rate year include the proposed changes to the LTCH PPS wage index for the 2006 LTCH PPS rate year include the proposed change in the labor market area definitions, the proposed update in the wage index data, and the established phase-in of the LTCH PPS wage index adjustment, from 2005 LTCH PPS rate year (LTCHs' FYs 2004 and 2005 cost reporting periods) to the 2006 LTCH PPS rate year (LTCHs' FYs 2005 and 2006 LTCH cost reporting periods).

Hospital groups were based on characteristics provided in the Online Survey Certification and Reporting (System) (OSCAR) data, FYs 2000 through 2003 cost report data, and Provider Specific File data. Hospitals with incomplete characteristics were grouped into the ''unknown'' category. Hospital groups include:

—Location: Large Urban/Other Urban/Rural
—Participation Date
—Ownership Control
—Census Region
—Bed Size

To estimate the impacts among the various categories of providers during the LTCH PPS transition period, it is imperative 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 (Table III below), we estimated payments only for those providers for whom we are able to calculate payments based on reasonable cost-based methodology. For example, if we did not have at least 2 years of historical cost data for a LTCH, we were unable to determine an update to the LTCH's target amount to estimate payment under reasonable cost-based methodology.

Using LTCH cases from the FY 2003 MedPAR file and cost data from FYs 1999 through 2002 to estimate payments under the current reasonable cost-based principles, we have obtained both case-mix and cost data for 261 LTCHs. Thus, for the impact analyses reflecting the applicable transition blend percentages and the option to elect payment based on 100 percent of the Federal rate (see Table II below), we used data from 261 LTCHs. While currently there are more than 300 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 2003 MedPAR data for the 261 LTCHs in our database provide sufficient representation in the LTC-DRGs containing discharges for patients who received respiratory and ventilator-

dependent care based on the relatively large number of LTCH cases in LTC–DRGs for these diagnoses. However, using cases from the FY 2003 MedPAR file we had case-mix data for 301 LTCHs. Cost data to determine current payments under reasonable cost-based methodology payments are not needed to simulate payments based on 100 percent of the proposed Federal rate. Therefore, for the impact analyses reflecting fully phased-in prospective payments (see Table III below), we used data from 301 LTCHs.

These impacts reflect the estimated ''losses'' or ''gains'' among the various classifications of LTCHs for the 2005 LTCH PPS rate year (July 1, 2004 through June 30, 2005) compared to the 2006 LTCH PPS rate year (July 1, 2005 through June 30, 2006). Prospective payments for the 2005 LTCH rate year were based on the standard Federal rate of $36,833.69 and the hospitals' estimated case-mix based on FY 2003 claims data. Estimated prospective payments for the 2006 LTCH PPS rate year are based on the proposed standard Federal rate of $37,975.53 and the same FY 2003 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 short-stay outliers (as described in section IV.C.4.b. of this proposed rule) and the proposed adjustments for area wage differences (as described in section IV.C.1. of this proposed rule) and for the cost-of-living for Alaska and Hawaii (as described in section IV.C.2. of this proposed rule). Additional payments would also be made for high-cost outlier cases (as described in section IV.C.3. of this proposed rule). As noted in section IV.C.6. of this proposed rule, we are not proposing to make adjustments for rural location, geographic reclassification, indirect medical education costs, or a disproportionate share of low-income patients because sufficient new data have not been generated that would enable us to conduct a comprehensive reevaluation of these payment adjustments.

For estimated 2006 LTCH PPS rate year payments, we used the applicable proposed LTCH wage index values effective for discharges occurring on or after July 1, 2005 through June 30, 2006 (as shown in Tables 1 and 2 of the Addendum to this proposed rule) based on the proposed CBSA-based labor market area designations (described in section IV.C.1.c.1. of this proposed rule).

For estimated 2005 LTCH PPS rate year payments, we used the applicable LTCH wage index values effective for discharges occurring on or after July 1, 2004 through June 30, 2005 based on the existing MSA-based labor market area designations (see May 7, 2004 (69 FR 25685)). We adjusted for area wage differences for estimated 2005 LTCH PPS rate year payments by computing a weighted average of a LTCH's applicable wage index during the period from July 1, 2004, through June 30, 2005, 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, 2003 and before September 30, 2004 (FY 2004), the labor portion of the Federal rate was adjusted by two-fifths of the applicable ''LTCH PPS wage index'' (that is, the FY 2004 IPPS wage index data without taking into account geographic reclassification, under sections 1886(d)(8) and (d)(10)) of the Act). 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. Therefore, during the 2005 LTCH PPS rate year (July 1, 2004 through June 30, 2005), a provider with a cost reporting period that began October 1, 2003, had 3 months of payments under the two-fifths wage index value and 9 months of payment under the three-fifths wage index value. For this provider, for the purposes of estimating payments for the impact analyses, we computed a blended wage index of 25 percent (3 months/12 months) of the two-fifths wage index value and 75 percent (9 months/12 months) of the three-fifths wage index value. The applicable LTCH PPS wage index values for the 2005 LTCH PPS rate year are shown in Tables 1 and 2 of the Addendum to the May 7, 2004 final rule (69 FR 25722–25741).

For estimated 2006 LTCH PPS rate year payments, we used the applicable proposed LTCH wage index values effective for discharges occurring on or after July 1, 2005 through June 30, 2006 (as shown in Tables 1 and 2 of the Addendum to this proposed rule) based on the proposed CBSA-based labor market area designations (described in section IV.C.1.c.1. of this proposed rule). Because some providers may experience a change in the wage index phase-in percentage during that period, 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. For cost reporting periods that began on or after October 1, 2004 and before September 30, 2005, the labor portion of the Federal rate is adjusted by three-fifths of the applicable LTCH PPS wage index (that is, as discussed in section IV.C.1. of this proposed rule, the FY 2005 IPPS acute care hospital wage index data without taking into account geographic reclassification under sections 1886(d)(8) and (d)(10) of the Act). For cost reporting periods beginning on or after October 1, 2005 and before September 30, 2006, the labor portion of the Federal rate will be adjusted by four-fifths of the applicable LTCH PPS wage index. The proposed applicable LTCH PPS wage index values for the 2006 LTCH PPS rate year are shown in Tables 1 and 2 of the Addendum to this proposed rule.

For estimated 2005 LTCH PPS rate year payments, for those LTCHs projected to receive payment under the transition blend methodology, we also calculated payments using the applicable transition blend percentages. During the 2005 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, 2004 through June 30, 2005. For example, during the period from July 1, 2004 through June 30, 2005, a provider with a cost reporting period beginning on October 1, 2003 (which is paid under the 60/40 transition blend (60 percent of payments based on reasonable cost-based methodology and 40 percent of payments under the LTCH PPS) beginning October 1, 2003) has 3 months (July 1, 2004 through September 30, 2004) under the 60/40 blend and 9 months (October 1, 2004 through June 30, 2005) of payment under the 40/60-transition blend (40 percent of payments based on reasonable cost-based methodology and 60 percent of payments under the LTCH PPS for cost reporting periods beginning during FY 2005). (The 40 percent/60 percent blend will continue until the provider's cost reporting period beginning on October 1, 2005 (FY 2006).)

Similarly, during the 2006 LTCH PPS rate year, based on the transition blend percentages set forth in § 412.533(a), some of the providers paid under the transition blend methodology 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 would have 3 months (July 1, 2005 through September 30, 2005) under the 40/60 blend and 9 months (October 1, 2005 through June 30, 2006) of payment under the 20/80-transition blend (20 percent of payments based on reasonable cost-based methodology and 80 percent of payments under the LTCH PPS for cost reporting periods beginning during FY 2006). (The 20 percent/80 percent blend will continue until the provider's cost reporting period beginning on October 1, 2006 (FY 2007).)

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

Then we applied the 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 2005 LTCH PPS rate year payments, we applied the 0.5 percent budget neutrality offset to payments to account for the effect of the 5-year transition methodology and election of payment based on 100 percent of the Federal rate on Medicare program payments (*See* the May 7, 2004 final rule (68 FR 25674)) to each LTCH's estimated payments under the LTCH PPS for the 2005 LTCH PPS rate year. Similarly, in estimating 2006 LTCH PPS rate year payments, we applied the proposed 0.2 percent budget neutrality offset to payments to account for the effect of the 5-year transition methodology and election of payment based on 100 percent of the Federal rate on Medicare program payments (*see* section IV.C.7 of this proposed rule) to each LTCH's estimated payments under the LTCH PPS for the 2006 LTCH PPS rate year. The impact shown below in Table II is based on our projection of using the best available data that approximately 6 percent of LTCHs would be paid based on the transition blend methodology or would elect payment based on 100 percent of the Federal rate.

In Table III below, we also show the impact if the LTCH PPS were fully implemented; that is, as if there were an immediate transition to fully Federal prospective payments under the LTCH PPS for the 2005 LTCH PPS rate year and the 2006 LTCH PPS rate year. Accordingly, in the impact analysis shown in Table III., the respective budget neutrality adjustments to account for the 5-year transition methodology on LTCHs' Medicare program payments for the 2005 and 2006 LTCH PPS rate years (0.5 percent and the proposed 0.2 percent, respectively) were not applied to LTCHs' estimated payments under the LTCH PPS.

Tables II and III below illustrate the 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 2005 LTCH PPS rate year.
- The fifth column shows the estimated payment per discharge for the proposed 2006 LTCH PPS rate year.
- The sixth column shows the percent change in estimated LTCH PPS payments based on the proposed wage index changes from the 2005 LTCH PPS rate year to the proposed 2006 LTCH PPS rate year (as discussed in section IV.C.1. of this proposed rule).
- The seventh column shows the percent change of 2005 LTCH PPS rate year estimated payments compared to the proposed 2006 LTCH PPS rate year estimated payments for all proposed changes (as discussed in the preamble of this proposed rule).

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Table II.--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 2005 LTCH PPS Rate Year Payments Compared to Estimated Proposed 2006 LTCH PPS Rate Year Payments)

LTCH Classification	Number of LTCHs	Number of LTCH Cases	Average 2005 LTCH PPS Rate Year Payment Per Case[2]	Average 2006 LTCH PPS Rate Year Payment Per Case[3]	Percent Change from RY 2005 to RY 2006 for Wage Index Changes[4]	Percent Change from RY 2005 to RY 2006 for All Changes[5]
All Providers	261	102,304	$28,437	$29,989	0.1	5.5
BY LOCATION:						
Rural	16	4,685	$26,423	$27,123	-2.5	2.6
Urban	245	97,619	$28,533	$30,127	0.2	5.6
Large	105	33,065	$27,588	$28,856	-0.6	4.6
Other	140	64,554	$29,018	$30,777	0.6	6.1
BY PARTICIPATION DATE:						
Before October 1983	15	7,730	$23,759	$25,357	1.3	6.7
October 1983 - September 1993	44	22,565	$28,435	$30,053	0.5	5.7
October 1993 - September 2002	202	72,009	$28,939	$30,466	-0.1	5.3
BY OWNERSHIP CONTROL:						
Voluntary	62	23,629	$27,846	$29,426	0.3	5.7
Proprietary	191	76,316	$28,716	$30,285	0.1	5.5
Government	8	2,359	$25,326	$26,047	-1.5	2.8
BY CENSUS REGION:						
New England	13	9,556	$24,100	$25,840	1.7	7.2
Middle Atlantic	18	6,409	$28,046	$29,281	-0.5	4.4
South Atlantic	25	8,873	$31,065	$32,464	-0.3	4.5
East North Central	50	14,871	$31,599	$33,345	0.3	5.5
East South Central	15	4,516	$29,506	$30,973	-0.5	5.0
West North Central	17	4,860	$31,167	$32,709	0.0	4.9
West South Central	90	41,406	$26,557	$27,922	-0.4	5.1
Mountain	20	5,391	$28,856	$30,585	0.6	6.0
Pacific	13	6,422	$33,274	$35,757	1.7	7.5
BY BED SIZE:						
Beds: 0 - 24	23	3,507	$29,826	$31,420	-0.5	5.3
Beds: 25 - 49	128	34,207	$28,710	$30,155	-0.3	5.0
Beds: 50 - 74	37	13,696	$29,959	$31,488	0.0	5.1
Beds: 75 - 124	37	17,318	$28,127	$29,562	0.0	5.1
Beds: 125 - 199	24	20,221	$27,281	$28,824	0.4	5.7
Beds: 200+	12	13,355	$27,962	$29,969	1.2	7.2

[1] These calculations take into account that some providers may experience a change in the LTCH PPS blend percentage changes during the 2005 and 2006 LTCH PPS rate years. For example, during the period of July 1, 2005 through June 30, 2006, a provider with a cost reporting period beginning October 1, 2006 would have 3 months (July 1, 2005 through September 30, 2005) of payments under the 40/60 blend (3/5ths wage index) and 9 months (October 1, 2005 through June 30, 2006) of payment under the 20/80 blend (4/5ths wage index).

[2] Estimated average payment per case for the 12-month period of July 1, 2004 through June 30, 2005.

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

[4] Percent change in estimated payments per discharge based on the 2005 LTCH PPS rate year wage index (as established in the May 7, 2004 final rule) compared to the proposed 2006 LTCH PPS rate year wage index (as proposed in section IV.C.1. this proposed rule), including the proposed change in the labor market area definitions, the proposed update in the wage index data and the progression of the phase-in of the LTCH PPS wage index adjustment from 2005 LTCH PPS rate year (FYs 2004 and 2005 LTCHs' cost reporting periods) to the 2006 LTCH PPS rate year (as described in section IV.C.1.a. of this proposed rule).

[5] Percent change in estimated payments per discharge from the 2005 LTCH PPS rate year (as established in the May 7, 2004 final rule) to the 2006 LTCH PPS rate year (as discussed in this proposed rule).

Table III.--Projected Impact Reflecting the Fully Phased-In LTCH PPS Prospective Payments (Estimated 2005 LTCH PPS Rate Year Payments Compared to Estimated Proposed 2006 LTCH PPS Rate Year Payments)

LTCH Classification	Number of LTCHs	Number of LTCH Cases	Average 2005 LTCH PPS Rate Year Payment Per Case[2]	Average 2006 LTCH PPS Rate Year Payment Per Case[3]	Percent Change from RY 2005 to RY 2006 for Wage Index Changes[4]	Percent Change from RY 2005 to RY 2006 for All Changes[5]
All Providers	301	108,136	$28,436	$29,975	-0.2	5.4
BY LOCATION:						
Rural	22	5,257	$25,959	$26,956	-2.3	3.8
Urban	279	102,879	$28,563	$30,129	-0.1	5.5
Large	125	35,035	$27,753	$28,999	-0.9	4.5
Other	154	67,844	$28,981	$30,713	0.3	6.0
BY PARTICIPATION DATE:						
Before October 1983	17	7,766	$23,827	$25,410	1.2	6.6
October 1983 - September 1993	45	22,611	$28,308	$29,928	0.1	5.7
October 1993 - September 2002	209	74,262	$28,961	$30,472	-0.4	5.2
After October 2002	30	3,497	$28,361	$29,854	-0.5	5.3
BY OWNERSHIP CONTROL:						
Voluntary	69	25,093	$27,839	$29,467	0.0	5.8
Proprietary	219	80,098	$28,827	$30,352	-0.2	5.3
Government	10	2,431	$23,500	$24,831	-0.5	5.7
Unknown	3	514	$20,019	$20,317	-2.4	1.5
BY CENSUS REGION:						
New England	15	9,592	$24,179	$25,875	1.5	7.0
Middle Atlantic	21	6,962	$27,636	$28,802	-0.9	4.2
South Atlantic	31	9,471	$30,933	$32,551	-0.2	5.2
East North Central	56	15,361	$31,829	$33,491	-0.1	5.2
East South Central	18	4,735	$29,596	$31,011	-1.0	4.8
West North Central	17	4,860	$31,075	$32,680	-0.3	5.2
West South Central	108	45,079	$26,593	$27,947	-0.6	5.1
Mountain	22	5,654	$29,105	$30,835	0.3	5.9
Pacific	13	6,422	$33,368	$35,826	1.4	7.4
BY BED SIZE:						
Beds: 0 - 24	30	4,279	$29,073	$30,541	-1.0	5.0
Beds: 25 - 49	149	36,229	$28,936	$30,318	-0.6	4.8
Beds: 50 - 74	38	13,729	$29,690	$31,318	-0.2	5.5
Beds: 75 - 124	42	18,665	$28,074	$29,617	0.0	5.5
Beds: 125 - 199	25	21,329	$27,407	$28,939	0.0	5.6
Beds: 200+	14	13,391	$28,062	$30,007	1.0	6.9
Unknown	3	514	$20,019	$20,317	-2.4	1.5

[1] Estimated average payment per case for the 12-month period of July 1, 2004 through June 30, 2005.

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

[3] Percent change in estimated payments per discharge based on the 2005 LTCH PPS rate year wage index (as established in the May 7, 2004 final rule) compared to the proposed 2006 LTCH PPS rate year wage index (as proposed in section IV.C.1. this proposed rule), including the proposed change in the labor market area definitions, the proposed update in the wage index data and the progression of the phase-in of the LTCH PPS wage index adjustment from 2005 LTCH PPS rate year to the 2006 LTCH PPS rate year (as described in section IV.C.1.a. of the preamble of this proposed rule).

[4] Percent change in estimated payments per discharge from the 2005 LTCH PPS rate year (as established in the May 7, 2004 final rule) to the 2006 LTCH PPS rate year (as proposed in this proposed rule).

[5] Percent change in estimated payments per discharge from the 2005 LTCH PPS rate year (as established in the May 7, 2004 final rule) to the 2006 LTCH PPS rate year (as discussed in this proposed rule).

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4. Results

Based on the most recent available data (as described above for 261 LTCHs), we have prepared the following summary of the impact (as shown in Table II) of the LTCH PPS set forth in this proposed rule.

a. *Location.* We evaluated each LTCH's location (urban or rural) based on the proposed CBSA-based labor market area definitions described in section IV.C.1.c.1. of this proposed rule. Based on the most recent available data, the vast majority of LTCHs are in urban areas. Approximately 6 percent of the LTCHs are identified as being located in a rural area, and approximately 4.5 percent of all LTCH cases are treated in these rural hospitals. Impact analysis in Table II shows that for rural LTCHs the percent change in estimated payments per discharge for the 2006 LTCH PPS rate year would increase 2.6 percent in comparison to the 2005 LTCH PPS rate year from all of the proposed changes, which reflects the estimated 2.5 percent decrease in payments per discharge from the proposed wage index changes. The primary reason for the projected increase in payments per discharge for all proposed changes for rural LTCHs is a combination of the proposed 3.1 percent increase in the standard Federal rate and a projected increase in outlier payments as a result of the proposed decrease in outlier fixed-loss amount (discussed in section IV.C.3. of this proposed rule), which results in more cases qualifying as outlier cases and receiving additional outlier payments. This projected increase in estimated payments per discharge for rural LTCHs is partially offset by a projected decrease in payments per discharge as a result of the proposed changes in the wage index.

Rural LTCHs are projected to experience a relatively large decrease in payments due to the proposed wage index changes primarily because of the progression of the 5-year phase-in of the wage index adjustment. That is, because the wage index of most rural areas is less than 1.0, as rural LTCHs progress through the 5-year phase-in of the wage index adjustment (for example, the two-fifths wage index for cost reporting periods beginning during FY 2004 to the three-fifths wage index for cost reporting periods beginning during FY 2005), their wage index decreases, which results in a decrease in their payments. This would occur even if we had not proposed to revise the labor market area definitions based on OMB's CBSA designations. For example (as shown in Table 2 of the Addendum to this proposed rule), the proposed three-fifths wage index for rural Arizona of 0.9362 is less than the proposed two-fifths wage index for rural Arizona of 0.9574. In addition, we identified three LTCHs that are currently urban under the existing MSA-based labor market area designations that would become rural under the proposed new CBSA-based labor market designations, and as a result, are projected to experience a relatively larger decrease in payments per discharge due to the proposed changes in the wage index. (*See* Table II.)

For urban LTCHs, the percent change in estimated payments per discharge for the 2006 LTCH PPS rate year are projected to increase 5.6 percent in comparison to the 2005 LTCH PPS rate year from all proposed changes, which reflects a 0.2 percent increase from the proposed wage index changes. Payments per discharge for the 2006 LTCH PPS rate year are projected to increase 4.6 percent for large urban LTCHs in comparison to the 2005 LTCH PPS rate year from all of the proposed changes, including a projected 0.6 percent decrease from the proposed wage index changes. We project that 2006 LTCH PPS rate year payments per discharge would increase 6.1 percent in comparison to the 2005 LTCH PPS rate year for urban LTCHs, including a projected 0.6 percent increase for the proposed wage index changes.

As noted above and discussed in greater detail below, the projected increase in payments per discharge for all proposed changes for both large and other urban LTCHs is largely due to the proposed 3.1 percent increase to the standard Federal rate and a projected increase in outlier payments as a result of the proposed decrease in the outlier fixed amount. These projected increases in payments per discharge reflecting all proposed changes for LTCHs that are located in large urban areas are partially offset by a projected decrease in

payments per discharge for the proposed wage index changes. The projected decrease in payments per discharge based solely on the proposed wage index changes are largely due to the progression of the 5-year phase-in of the wage index adjustment, as explained above, since the majority of LTCHs are in large urban areas with wage index values that are slightly less than 1.0. Large urban LTCHs are projected to experience a decrease in payments per discharge for the proposed wage index changes because, in addition to the effect of the progression of the 5-year phase-in of the wage index adjustment, as explained above, the proposed wage index for a few large urban areas, such as Houston, Texas, would be slightly lower under the proposed CBSA-based labor market area designations than they would be under the existing MSA-based labor market area designations. (*See* Table II.)

As noted above, in addition to the proposed update to the standard Federal rate, the estimated percent increase in payments per discharge for all proposed changes from the 2005 LTCH PPS rate year to the 2006 LTCH PPS rate year is largely attributable to the decrease in the outlier fixed-loss amount (discussed in section IV.C.3. of this proposed rule). For the 2005 LTCH PPS rate year, the outlier fixed loss amount is $17,864 (as established in the May 7, 2004 final rule). Therefore, currently a case qualifies for an additional LTCH PPS outlier payment if the estimated cost of the case exceeds the outlier threshold (the sum of the adjusted Federal LTCH payment for the LTC–DRG and the fixed-loss amount of $17,864). For the 2006 LTCH PPS rate year, we are proposing an outlier fixed loss amount of $11,544. Therefore, a case would qualify for an additional LTCH PPS outlier payment if the estimated cost of the case exceeds the proposed outlier threshold (the sum of the adjusted proposed Federal LTCH payment for the LTC–DRG and the proposed fixed-loss amount of $11,544). Therefore, we estimate that more cases would qualify as outlier cases (the estimated cost of the case exceeds the proposed outlier threshold) and would receive outlier payments, thereby increasing total estimated payments per discharge. In the aggregate, LTCHs are not expected to experience a significant impact as a result of the proposed changes to the wage index. As discussed throughout this impact section, certain groups of hospitals are projected to benefit from the proposed changes to the wage index while other groups of LTCHs are projected to be negatively impacted by the proposed changes to the wage index. However, as a result of the aggregate effect of the proposed update to the standard Federal rate combined with the proposed decrease in the outlier fixed-loss amount, we estimate that all LTCH categories would experience an increase in payments.

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

Based on the most recent available data, the majority, approximately 77 percent, of the LTCH discharges are in LTCHs hospitals that began participating between October 1993 and September 2002, and we estimated that 2006 LTCH PPS rate year payments per discharge would increase 5.3 percent in comparison to the 2005 LTCH PPS rate year due to all proposed changes, which includes the estimated 0.1 percent decrease in payments per discharge due to the proposed wage index changes.

Approximately 22 percent of the discharges are in LTCHs that began participating in Medicare between October 1983 and September 1993, and 2006 LTCH PPS rate year payments per discharge are projected to increase 5.7 percent in comparison to the 2005 LTCH PPS rate year from all proposed changes, which includes the estimated 0.5 percent increase in payments per discharge from the proposed wage index changes. Payments per discharge for the 2006 LTCH PPS rate year are estimated to increase 6.7 percent in comparison to the 2005 LTCH PPS rate year for LTCHs that began participating before October 1983 from all proposed changes, including the estimated 1.3 percent increase in payments per discharge from the proposed wage index changes. This increase in projected payments per discharge from the proposed changes in the wage index for LTCHs that began participating before October 1983 is largely due to a combination of the proposed change to the CBSA-based labor market area definitions and the increase in the percentage of the wage index adjustment as required by the 5-year phase-in of the wage index adjustment (for example, two-fifths of the wage index adjustment for cost reporting periods beginning during FY 2004 increasing to three-fifths of the wage index adjustment for cost reporting periods beginning during FY 2005). (See Table II.)

In addition, as discussed above, these increases in payments for the 2006 LTCH PPS rate year are also due to the proposed decrease in the outlier fixed-loss amount (as discussed in section IV.C.3. of this proposed rule). As a result, more cases would qualify as outlier cases (the estimated cost of the case exceeds the proposed outlier threshold) and, therefore, would receive outlier payments, thereby increasing total estimated payments per discharge. As also noted above, in the aggregate LTCHs are not expected to experience a significant impact as a result of the proposed changes to the wage index. While certain groups of LTCHs are projected to benefit from the proposed changes to the wage index, other groups of LTCHs are projected to be negatively impacted by the proposed changes to the wage index.

c. *Ownership Control.* LTCHs are grouped into three categories based on ownership control type—(1) voluntary; (2) proprietary; and (3) government.

Based on the most recent available data, approximately 3 percent of LTCHs are government owned and operated. We project that for these government owned and operated LTCHs, 2006 LTCH PPS rate year payments per discharge would increase 2.8 percent in comparison to the 2005 LTCH PPS rate year from all proposed changes, including the estimated 1.5 percent decrease in payments per discharge from the proposed wage index changes. This estimated decrease in estimated payments per discharge for the proposed wage index changes is largely due to the current applicable percentage of the 5-year phase-in of the wage index adjustment, as explained above, since the majority of government run LTCHs are located in areas with wage index values that are less than 1.0. Because government owned and operated LTCHs are expected to experience a slight decrease in payments per discharge from the proposed changes to the wage index, we project that they would experience a slightly smaller increase in payments per discharge from all proposed changes as compared to other LTCHs.

We project that 2006 LTCH PPS rate year payments per discharge for voluntary and proprietary LTCHs would increase 5.7 percent and 5.5 percent, respectively, in comparison to the 2005 LTCH PPS rate year for all proposed changes, including the estimated 0.3 percent and 0.1 percent increase, respectively, in payments per discharge from the proposed wage index changes. As noted above, in addition to the

proposed update to the standard Federal rate, the estimated percent increase in payments per discharge for all proposed changes from the 2005 LTCH PPS rate year to the 2006 LTCH PPS rate year is largely attributable to the proposed decrease in outlier fixed loss amount (discussed in section IV.C.3. of this proposed rule), which would result in more cases qualifying as outlier cases (the estimated cost of the case exceeds the proposed outlier threshold) and, therefore, would receive additional outlier payments, thereby increasing total estimated payments per discharge. (See Table II.)

d. *Census Region.* Payments per discharge for the 2006 LTCH PPS rate year are estimated to increase for LTCHs located in all regions in comparison to the 2005 LTCH PPS rate year from all proposed changes. Of the nine census regions, we project that the increase in 2006 LTCH PPS rate year payments per discharge in comparison to the 2005 LTCH PPS rate year would be the largest for LTCHs in the Pacific and New England regions. Specifically, 2006 LTCH rate year payments per discharge for LTCHs in the Pacific and New England regions are projected to increase 7.5 percent and 7.2 percent, respectively, in comparison to the 2005 LTCH PPS rate year, which includes the estimated 1.7 percent increase from the proposed wage index changes for both areas. As explained above, these relatively large increases in payments from all proposed changes for the 2006 LTCH PPS rate year for LTCHs in the New England and Pacific regions are mostly attributable to the proposed decrease in the outlier fixed-loss amount (discussed in section IV.C.3. of this proposed rule), which results in more cases qualifying as outlier cases (the estimated cost of the case exceeds the proposed outlier threshold) and, therefore, would receive additional outlier payments, thereby increasing total estimated payments per discharge. Furthermore, in addition to the proposed update to the standard Federal rate, we believe that many LTCHs in the New England and Pacific regions would experience an increase in payments because of an the annual percentage increase of the phase-in of the wage index adjustment, (two-fifths of the applicable LTCH PPS wage index for cost reporting periods beginning on or after October 1, 2003; three-fifths of the applicable wage index for cost reporting periods beginning on or after October 1, 2004; and four-fifths of the applicable wage index for cost reporting periods beginning on or after October 1, 2005) since most of the LTCHs in these regions are located in areas that have a wage index value of greater than 1.0. (*See* Table II.).

We project that 2006 LTCH PPS rate year payments per discharge would increase the least for LTCHs in the MidAtlantic and South Atlantic regions in comparison to the 2005 LTCH PPS rate year for all changes (4.4 percent and 4.5 percent, respectively). We project that for LTCHs located in the Middle Atlantic and South Atlantic regions, 2006 LTCH PPS payments per discharge would decrease slightly in comparison to the 2005 LTCH PPS rate year from the proposed wage index changes (0.5 percent and 0.3 percent, respectively). We are projecting a slight decrease in payments per discharge from the proposed wage index changes, which results in a slightly lower percent increase in payments per discharge from all proposed changes, for LTCHs located in these regions because of the progression of the 5-year phase-in of the wage index adjustment. Specifically, many LTCHs located in these areas would have a wage index value of less than 1.0. (See Table II.)

e. *Bed Size.* LTCHs were grouped into six categories based on bed size—0–24 beds, 25–49 beds, 50–74 beds, 75–124 beds, 125–199 beds, and 200+ beds.

For all bed size categories, we are projecting an increase in 2006 LTCH PPS rate year payments per discharge in comparison to the 2005 LTCH PPS rate year from all proposed changes. Most LTCHs are in bed size categories where 2006 LTCH PPS rate year payments per discharge are projected to increase approximately 5 percent in comparison to the 2005 LTCH PPS rate year from all proposed changes.

We project that LTCHs with greater than 200 beds would have the largest increase in estimated 2006 LTCH PPS rate year payments per discharge in comparison to the 2005 LTCH PPS rate year from all proposed changes (7.2 percent), including the estimated increase from the proposed wage index changes of 1.2 percent. This increase in projected payments per discharge for all proposed changes for LTCHs with greater than 200 beds is largely due to a combination of the proposed 3.1 percent increase in the standard Federal rate, a projected increase in outlier payments resulting from the proposed decrease in outlier fixed amount, as explained above, and the increase in projected payment per discharge from the proposed wage index changes. This increase in projected payments per discharge from the proposed changes in the wage index for LTCHs with greater than 200 beds is largely due to a combination of the proposed change to the CBSA-based labor market area definitions and the increase in the percentage of the wage index adjustment as required by the 5-year phase-in of the wage index adjustment because most LTCHs with greater than 200 beds are located in an area with a wage index value of greater than 1.0. (See Table II.)

Payments per discharge for the 2006 LTCH PPS rate year for LTCHs with 0–24 beds and 25–49 beds are projected to increase in comparison to the 2005 LTCH PPS rate year from all proposed changes (5.3 percent and 5.0 percent, respectively), which includes the estimated decrease in payments per discharge from the proposed wage indexes changes (−0.5 percent and −0.3 percent, respectively). This slight decrease in estimated payments per discharge from the proposed wage index changes is largely due to the progression of the 5-year phase-in of the wage index adjustment (as explained above) since the majority of LTCHs with fewer than 50 beds are located in areas with a wage index value of less than 1.0. (See Table II.)

5. Effect on the Medicare Program

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

LTCH PPS rate year	Estimated payments ($ in billions)
2006	$2.94
2007	2.90
2008	2.96
2009	3.08
2010	3.24

These estimates are based on the current estimate of the increase in the excluded hospital with capital market basket of 3.1 percent for the 2006 LTCH PPS rate year, 2.9 percent for the 2007, 2.7 for the 2008 LTCH PPS rate year, 2.9 percent for the 2009 LTCH PPS rate year and 2010 LTCH PPS rate years. We estimate that there would be a change in Medicare beneficiary enrollment of −4.9 percent in the 2006 LTCH PPS rate year, −6.5 percent in the 2007 LTCH PPS rate year, −1.1 percent in 2008 LTCH PPS rate year, 0.2 percent in the 2009 LTCH PPS rate year, 0.8 percent in the 2010 LTCH PPS rate year, and an estimated increase in the total number of LTCHs. (We note that, based on the most recent available data, our Office of the Actuary is projecting a decrease in Medicare fee-for-service Part A enrollment, in part, because of a projected increase in Medicare managed

care enrollment as a result of the implementation of several provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.)

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 used the best available data and necessarily reflected assumptions. As we collect data from LTCHs, we continue to 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 above in section IV.C.7. of the preamble of this proposed rule, because the LTCH PPS has only been implemented for about 2.5 years, due to the lag time in the availability of data, at this time, 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 calculations.

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 to maintain budget neutrality so that the effect of the difference between actual payments and estimated payments for the first year of LTCH PPS is not perpetuated in the PPS rates for future years. As discussed above in section IV.C.7. of this proposed rule, because the LTCH PPS was only recently implemented, we do not yet have sufficient complete data to determine whether such an adjustment is warranted.

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 IV below, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this proposed rule. This table provides our best estimate of the increase in Medicare payments under the LTCH PPS as a result of the proposals presented in this proposed rule based on the data for 261 LTCHs in our database. All expenditures are classified as transfers to Medicare providers (that is, LTCHs).

TABLE IV.—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES, FROM THE 2005 LTCH PPS RATE YEAR TO THE 2006 LTCH PPS RATE YEAR

[In millions]

Category	TRANSFERS.
Annualized Monetized Transfers.	$158.
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.

In accordance with the discussion in this preamble, the Centers for Medicare & Medicaid Services amends 42 CFR Chapter IV, part 412 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).

2. Section 412.22 is amended by revising paragraphs (e)(3) and (h)(5) to read as follows:

§ 412.22 Excluded hospitals and hospital units: General rules.

* * * * *

(e) * * *

* * * * *

(3) *Notification of co-located status.* A long-term care hospital that occupies space in a building used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital and that meets the criteria of paragraphs (e)(1) or (e)(2) of this section must notify its fiscal intermediary and CMS in writing of its co-location and identify by name, address, and Medicare provider number those hospital(s) with which it is co-located.

* * * * *

(h) * * *

* * * * *

(5) *Notification of co-located status.* A satellite of a long-term care hospital that occupies space in a building used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital and that meets the criteria of paragraphs (h)(1) through (h)(4) of this section must notify its fiscal intermediary and CMS in writing of its co-location and identify by name, address, and Medicare provider number, those hospital(s) with which it is co-located.

3. Section 412.525 is amended by revising paragraph (c) to read as follows:

§ 412.525 Adjustments to the Federal prospective Payments

* * * * *

(c) *Adjustments for area levels.* The labor portion of a long-term care hospital's Federal prospective payment is adjusted to account for geographical differences in the area wage levels using an appropriate wage index (established by CMS), which reflects the relative level of hospital wages and wage-related costs in the geographic area (that is, urban or rural area as determined in accordance with paragraph (c)(1) or (c)(2) of this section) of the hospital compared to the national average level of hospital wages and wage-related costs. The appropriate wage index (established by CMS) is updated annually.

(1) For discharges occurring in cost reporting periods beginning on or after October 1, 2002 and occurring before July 1, 2005, the application of the wage index under the long-term care hospital prospective payment system is made on the basis of the location of the facility in an urban or rural area as defined in § 412.62(f)(1)(ii) and (f)(1)(iii), respectively.

(2) For discharges occurring on or after July 1, 2005, the application of the wage index under the long-term care hospital prospective payment system made on the basis of the location of the facility in an urban or rural area as

defined in § 412.64(b)(1)(ii)(A) through (C).

* * * * *

4. Section 412.531 is amended by revising paragraphs (b)(1)(i)(C) and (b)(1)(ii)(A)(*1*) to 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) 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 that is grouped to a surgical DRG under the inpatient prospective payment system in an acute care hospital during the 2005 and 2006 long-term care hospital prospective payment system rate year is not included in determining the length of stay of the patient at the long-term care hospital.

* * * * *

(ii) * * *

(A) * * *

(*1*) For a 3-day or less interruption of stay under paragraph (a)(1) of this section in which a long-term care hospital discharges a patient to an acute care hospital and the patient's treatment during the interruption is grouped into a surgical DRG under the acute care inpatient hospital prospective payment system, for the LTCH 2005 and 2006 rate years, CMS also makes a separate payment to the acute care hospital for the surgical DRG discharge in accordance with paragraph (b)(1)(i)(C) of this section.

* * * * *

5. Section 412.532 is amended by revising paragraph (i) to read as follows:

§ 412.532 Special payment provisions for patients who are transferred to onsite providers and readmitted to a long-term care hospital.

* * * * *

(i) A long-term care hospital or a satellite of a long-term care hospital that occupies space in a building used by another hospital, or SNF, or in one or more entire buildings located on the same campus as buildings used by another hospital or SNF and that meets the criteria of § 412.22(e)(1) or (e)(2) or 412.22(h)(1) through (h)(4) must notify its fiscal intermediary and CMS in writing of its co-location and identify by name, address, and Medicare provider number, those providers specified at paragraph (a) of this section with which it is co-located.

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

Dated: January 14, 2005.

Mark McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Dated: January 28, 2005.

Michael O. Leavitt,

Secretary.

The following addendum will not appear in the Code of Federal Regulations.

Addendum

This addendum contains the tables referred to throughout the preamble to this proposed rule. The tables presented below are as follows:

Table 1.—Proposed Long-Term Care Hospital Proposed Wage Index for Urban Areas (based on Proposed CBSA-based Labor Market Area Designations) for Discharges Occurring from July 1, 2005 through June 30, 2006

Table 2.—Proposed Long-Term Care Hospital Proposed Wage Index for Rural Areas (based on Proposed CBSA-based Labor Market Area Designations) for Discharges Occurring from July 1, 2005 through June 30, 2006

Table 3.—FY 2005 LTC–DRG Relative Weights, Geometric Mean Length of Stay, and Short-Stay Five-Sixths Average Length of Stay for Discharges Occurring from July 1, 2005 through September 30, 2006. (Note: This is the same information provided in Table 11 of the August 11, 2004 IPPS final rule (69 FR 49738–49754, as revised in the October 7, 2004 IPPS correction notice, 69 FR 60266–60271), which has been reprinted here for convenience.)

Table 4.—A Listing of Long-Term Care Hospitals' State and County Location; Current Labor Market Area Designation; and Proposed New CBSA-based Labor Market Area Designation

BILLING CODE 4120–01–P

Table 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS BASED ON PROPOSED CBSA LABOR MARKET AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2005 THROUGH JUNE 30, 2006[1]

CBSA Code	Urban Area (Constituent Counties)	Full Wage Index[2]	2/5[THS] Wage Index[3]	3/5[THS] Wage Index[4]	4/5[THS] Wage Index[5]
10180	Abilene, TX Callahan County, TX Jones County, TX Taylor County, TX	0.7850	0.9140	0.8710	0.8280
10380	Aguadilla-Isabela-San Sebastián, PR Aguada Municipio, PR Aguadilla Municipio, PR Añasco Municipio, PR Isabela Municipio, PR Lares Municipio, PR Moca Municipio, PR Rincón Municipio, PR San Sebastián Municipio, PR	0.4280	0.7712	0.6568	0.5424
10420	Akron, OH Portage County, OH Summit County, OH	0.9055	0.9622	0.9433	0.9244
10500	Albany, GA Baker County, GA Dougherty County, GA Lee County, GA Terrell County, GA Worth County, GA	1.1266	1.0506	1.0760	1.1013
10580	Albany-Schenectady-Troy, NY Albany County, NY Rensselaer County, NY Saratoga County, NY Schenectady County, NY Schoharie County, NY	0.8650	0.9460	0.9190	0.8920
10740	Albuquerque, NM Bernalillo County, NM Sandoval County, NM Torrance County, NM Valencia County, NM	1.0485	1.0194	1.0291	1.0388
10780	Alexandria, LA Grant Parish, LA Rapides Parish, LA	0.8171	0.9268	0.8903	0.8537

CBSA Code	Urban Area (Constituent Counties)	Full Wage Index[2]	2/5[THS] Wage Index[3]	3/5[THS] Wage Index[4]	4/5[THS] Wage Index[5]
10900	Allentown-Bethlehem-Easton, PA-NJ Warren County, NJ Carbon County, PA Lehigh County, PA Northampton County, PA	0.9501	0.9800	0.9701	0.9601
11020	Altoona, PA Blair County, PA	0.8462	0.9385	0.9077	0.8770
11100	Amarillo, TX Armstrong County, TX Carson County, TX Potter County, TX Randall County, TX	0.9178	0.9671	0.9507	0.9342
11180	Ames, IA Story County, IA	0.9479	0.9792	0.9687	0.9583
11260	Anchorage, AK Anchorage Municipality, AK Matanuska-Susitna Borough, AK	1.2165	1.0866	1.1299	1.1732
11300	Anderson, IN Madison County, IN	0.8713	0.9485	0.9228	0.8970
11340	Anderson, SC Anderson County, SC	0.8670	0.9468	0.9202	0.8936
11460	Ann Arbor, MI Washtenaw County, MI	1.1022	1.0409	1.0613	1.0818
11500	Anniston-Oxford, AL Calhoun County, AL	0.7881	0.9152	0.8729	0.8305
11540	Appleton, WI Calumet County, WI Outagamie County, WI	0.9131	0.9652	0.9479	0.9305
11700	Asheville, NC Buncombe County, NC Haywood County, NC Henderson County, NC Madison County, NC	0.9191	0.9676	0.9515	0.9353
12020	Athens-Clarke County, GA Clarke County, GA Madison County, GA Oconee County, GA Oglethorpe County, GA	1.0202	1.0081	1.0121	1.0162

CBSA Code	Urban Area (Constituent Counties)	Full Wage Index[2]	2/5[THS] Wage Index[3]	3/5[THS] Wage Index[4]	4/5[THS] Wage Index[5]
12060	Atlanta-Sandy Springs-Marietta, GA				
	Barrow County, GA				
	Bartow County, GA				
	Butts County, GA				
	Carroll County, GA				
	Cherokee County, GA				
	Clayton County, GA				
	Cobb County, GA				
	Coweta County, GA				
	Dawson County, GA				
	DeKalb County, GA				
	Douglas County, GA				
	Fayette County, GA				
	Forsyth County, GA				
	Fulton County, GA				
	Gwinnett County, GA				
	Haralson County, GA				
	Heard County, GA				
	Henry County, GA				
	Jasper County, GA				
	Lamar County, GA				
	Meriwether County, GA				
	Newton County, GA				
	Paulding County, GA				
	Pickens County, GA				
	Pike County, GA				
	Rockdale County, GA				
	Spalding County, GA				
	Walton County, GA	0.9971	0.9988	0.9983	0.9977
12100	Atlantic City, NJ				
	Atlantic County, NJ	1.0931	1.0372	1.0559	1.0745
12220	Auburn-Opelika, AL				
	Lee County, AL	0.8215	0.9286	0.8929	0.8572
12260	Augusta-Richmond County, GA-SC				
	Burke County, GA				
	Columbia County, GA				
	McDuffie County, GA				
	Richmond County, GA				
	Aiken County, SC				
	Edgefield County, SC	0.9154	0.9662	0.9492	0.9323

CBSA Code	Urban Area (Constituent Counties)	Full Wage Index[2]	2/5[THS] Wage Index[3]	3/5[THS] Wage Index[4]	4/5[THS] Wage Index[5]
12420	Austin-Round Rock, TX Bastrop County, TX Caldwell County, TX Hays County, TX Travis County, TX Williamson County, TX	0.9595	0.9838	0.9757	0.9676
12540	Bakersfield, CA Kern County, CA	1.0036	1.0014	1.0022	1.0029
12580	Baltimore-Towson, MD Anne Arundel County, MD Baltimore County, MD Carroll County, MD Harford County, MD Howard County, MD Queen Anne's County, MD Baltimore City, MD	0.9907	0.9963	0.9944	0.9926
12620	Bangor, ME Penobscot County, ME	0.9955	0.9982	0.9973	0.9964
12700	Barnstable Town, MA Barnstable County, MA	1.2335	1.0934	1.1401	1.1868
12940	Baton Rouge, LA Ascension Parish, LA East Baton Rouge Parish, LA East Feliciana Parish, LA Iberville Parish, LA Livingston Parish, LA Pointe Coupee Parish, LA St. Helena Parish, LA West Baton Rouge Parish, LA West Feliciana Parish, LA	0.8319	0.9328	0.8991	0.8655
12980	Battle Creek, MI Calhoun County, MI	0.9366	0.9746	0.9620	0.9493
13020	Bay City, MI Bay County, MI	0.9574	0.9830	0.9744	0.9659
13140	Beaumont-Port Arthur, TX Hardin County, TX Jefferson County, TX Orange County, TX	0.8616	0.9446	0.9170	0.8893
13380	Bellingham, WA Whatcom County, WA	1.1642	1.0657	1.0985	1.1314
13460	Bend, OR Deschutes County, OR	1.0603	1.0241	1.0362	1.0482

CBSA Code	Urban Area (Constituent Counties)	Full Wage Index[2]	2/5[THS] Wage Index[3]	3/5[THS] Wage Index[4]	4/5[THS] Wage Index[5]
13644	Bethesda-Frederick-Gaithersburg, MD Frederick County, MD Montgomery County, MD	1.0956	1.0382	1.0574	1.0765
13740	Billings, MT Carbon County, MT Yellowstone County, MT	0.8961	0.9584	0.9377	0.9169
13780	Binghamton, NY Broome County, NY Tioga County, NY	0.8447	0.9379	0.9068	0.8758
13820	Birmingham-Hoover, AL Bibb County, AL Blount County, AL Chilton County, AL Jefferson County, AL St. Clair County, AL Shelby County, AL Walker County, AL	0.9157	0.9663	0.9494	0.9326
13900	Bismarck, ND Burleigh County, ND Morton County, ND	0.7505	0.9002	0.8503	0.8004
13980	Blacksburg-Christiansburg-Radford, VA Giles County, VA Montgomery County, VA Pulaski County, VA Radford City, VA	0.7951	0.9180	0.8771	0.8361
14020	Bloomington, IN Greene County, IN Monroe County, IN Owen County, IN	0.8587	0.9435	0.9152	0.8870
14060	Bloomington-Normal, IL McLean County, IL	0.9111	0.9644	0.9467	0.9289
14260	Boise City-Nampa, ID Ada County, ID Boise County, ID Canyon County, ID Gem County, ID Owyhee County, ID	0.9352	0.9741	0.9611	0.9482
14484	Boston-Quincy, MA Norfolk County, MA Plymouth County, MA Suffolk County, MA	1.1771	1.0708	1.1063	1.1417

CBSA Code	Urban Area (Constituent Counties)	Full Wage Index[2]	2/5[THS] Wage Index[3]	3/5[THS] Wage Index[4]	4/5[THS] Wage Index[5]
14500	Boulder, CO Boulder County, CO	1.0046	1.0018	1.0028	1.0037
14540	Bowling Green, KY Edmonson County, KY Warren County, KY	0.8140	0.9256	0.8884	0.8512
14740	Bremerton-Silverdale, WA Kitsap County, WA	1.0614	1.0246	1.0368	1.0491
14860	Bridgeport-Stamford-Norwalk, CT Fairfield County, CT	1.2835	1.1134	1.1701	1.2268
15180	Brownsville-Harlingen, TX Cameron County, TX	1.0125	1.0050	1.0075	1.0100
15260	Brunswick, GA Brantley County, GA Glynn County, GA McIntosh County, GA	1.1933	1.0773	1.1160	1.1546
15380	Buffalo-Niagara Falls, NY Erie County, NY Niagara County, NY	0.9339	0.9736	0.9603	0.9471
15500	Burlington, NC Alamance County, NC	0.8967	0.9587	0.9380	0.9174
15540	Burlington-South Burlington, VT Chittenden County, VT Franklin County, VT Grand Isle County, VT	0.9322	0.9729	0.9593	0.9458
15764	Cambridge-Newton-Framingham, MA Middlesex County, MA	1.1189	1.0476	1.0713	1.0951
15804	Camden, NJ Burlington County, NJ Camden County, NJ Gloucester County, NJ	1.0675	1.0270	1.0405	1.0540
15940	Canton-Massillon, OH Carroll County, OH Stark County, OH	0.8895	0.9558	0.9337	0.9116
15980	Cape Coral-Fort Myers, FL Lee County, FL	0.9371	0.9748	0.9623	0.9497
16180	Carson City, NV Carson City, NV	1.0352	1.0141	1.0211	1.0282
16220	Casper, WY Natrona County, WY	0.9243	0.9697	0.9546	0.9394
16300	Cedar Rapids, IA Benton County, IA Jones County, IA Linn County, IA	0.8975	0.9590	0.9385	0.9180

CBSA Code	Urban Area (Constituent Counties)	Full Wage Index[2]	2/5[THS] Wage Index[3]	3/5[THS] Wage Index[4]	4/5[THS] Wage Index[5]
16580	Champaign-Urbana, IL Champaign County, IL Ford County, IL Piatt County, IL	0.9527	0.9811	0.9716	0.9622
16620	Charleston, WV Boone County, WV Clay County, WV Kanawha County, WV Lincoln County, WV Putnam County, WV	0.8876	0.9550	0.9326	0.9101
16700	Charleston-North Charleston, SC Berkeley County, SC Charleston County, SC Dorchester County, SC	0.9420	0.9768	0.9652	0.9536
16740	Charlotte-Gastonia-Concord, NC-SC Anson County, NC Cabarrus County, NC Gaston County, NC Mecklenburg County, NC Union County, NC York County, SC	0.9743	0.9897	0.9846	0.9794
16820	Charlottesville, VA Albemarle County, VA Fluvanna County, VA Greene County, VA Nelson County, VA Charlottesville City, VA	1.0294	1.0118	1.0176	1.0235
16860	Chattanooga, TN-GA Catoosa County, GA Dade County, GA Walker County, GA Hamilton County, TN Marion County, TN Sequatchie County, TN	0.9207	0.9683	0.9524	0.9366
16940	Cheyenne, WY Laramie County, WY	0.8980	0.9592	0.9388	0.9184

CBSA Code	Urban Area (Constituent Counties)	Full Wage Index[2]	2/5[THS] Wage Index[3]	3/5[THS] Wage Index[4]	4/5[THS] Wage Index[5]
16974	Chicago-Naperville-Joliet, IL				
	Cook County, IL				
	DeKalb County, IL				
	DuPage County, IL				
	Grundy County, IL				
	Kane County, IL				
	Kendall County, IL				
	McHenry County, IL				
	Will County, IL	1.0868	1.0347	1.0521	1.0694
17020	Chico, CA				
	Butte County, CA	1.0542	1.0217	1.0325	1.0434
17140	Cincinnati-Middletown, OH-KY-IN				
	Dearborn County, IN				
	Franklin County, IN				
	Ohio County, IN				
	Boone County, KY				
	Bracken County, KY				
	Campbell County, KY				
	Gallatin County, KY				
	Grant County, KY				
	Kenton County, KY				
	Pendleton County, KY				
	Brown County, OH				
	Butler County, OH				
	Clermont County, OH				
	Hamilton County, OH				
	Warren County, OH	0.9516	0.9806	0.9710	0.9613
17300	Clarksville, TN-KY				
	Christian County, KY				
	Trigg County, KY				
	Montgomery County, TN				
	Stewart County, TN	0.8022	0.9209	0.8813	0.8418
17420	Cleveland, TN				
	Bradley County, TN				
	Polk County, TN	0.7844	0.9138	0.8706	0.8275
17460	Cleveland-Elyria-Mentor, OH				
	Cuyahoga County, OH				
	Geauga County, OH				
	Lake County, OH				
	Lorain County, OH				
	Medina County, OH	0.9650	0.9860	0.9790	0.9720
17660	Coeur d'Alene, ID				
	Kootenai County, ID	0.9339	0.9736	0.9603	0.9471

CBSA Code	Urban Area (Constituent Counties)	Full Wage Index[2]	2/5[THS] Wage Index[3]	3/5[THS] Wage Index[4]	4/5[THS] Wage Index[5]
17780	College Station-Bryan, TX Brazos County, TX Burleson County, TX Robertson County, TX	0.9243	0.9697	0.9546	0.9394
17820	Colorado Springs, CO El Paso County, CO Teller County, CO	0.9792	0.9917	0.9875	0.9834
17860	Columbia, MO Boone County, MO Howard County, MO	0.8396	0.9358	0.9038	0.8717
17900	Columbia, SC Calhoun County, SC Fairfield County, SC Kershaw County, SC Lexington County, SC Richland County, SC Saluda County, SC	0.9392	0.9757	0.9635	0.9514
17980	Columbus, GA-AL Russell County, AL Chattahoochee County, GA Harris County, GA Marion County, GA Muscogee County, GA	0.8690	0.9476	0.9214	0.8952
18020	Columbus, IN Bartholomew County, IN	0.9388	0.9755	0.9633	0.9510
18140	Columbus, OH Delaware County, OH Fairfield County, OH Franklin County, OH Licking County, OH Madison County, OH Morrow County, OH Pickaway County, OH Union County, OH	0.9737	0.9895	0.9842	0.9790
18580	Corpus Christi, TX Aransas County, TX Nueces County, TX San Patricio County, TX	0.8647	0.9459	0.9188	0.8918
18700	Corvallis, OR Benton County, OR	1.0545	1.0218	1.0327	1.0436
19060	Cumberland, MD-WV Allegany County, MD Mineral County, WV	0.8662	0.9465	0.9197	0.8930

CBSA Code	Urban Area (Constituent Counties)	Full Wage Index[2]	2/5THS Wage Index[3]	3/5THS Wage Index[4]	4/5THS Wage Index[5]
19124	Dallas-Plano-Irving, TX Collin County, TX Dallas County, TX Delta County, TX Denton County, TX Ellis County, TX Hunt County, TX Kaufman County, TX Rockwall County, TX	1.0074	1.0030	1.0044	1.0059
19140	Dalton, GA Murray County, GA Whitfield County, GA	0.9558	0.9823	0.9735	0.9646
19180	Danville, IL Vermilion County, IL	0.8392	0.9357	0.9035	0.8714
19260	Danville, VA Pittsylvania County, VA Danville City, VA	0.8643	0.9457	0.9186	0.8914
19340	Davenport-Moline-Rock Island, IA-IL Henry County, IL Mercer County, IL Rock Island County, IL Scott County, IA	0.8773	0.9509	0.9264	0.9018
19380	Dayton, OH Greene County, OH Miami County, OH Montgomery County, OH Preble County, OH	0.9303	0.9721	0.9582	0.9442
19460	Decatur, AL Lawrence County, AL Morgan County, AL	0.8894	0.9558	0.9336	0.9115
19500	Decatur, IL Macon County, IL	0.8122	0.9249	0.8873	0.8498
19660	Deltona-Daytona Beach-Ormond Beach, FL Volusia County, FL	0.8898	0.9559	0.9339	0.9118

CBSA Code	Urban Area (Constituent Counties)	Full Wage Index[2]	2/5[THS] Wage Index[3]	3/5[THS] Wage Index[4]	4/5[THS] Wage Index[5]
19740	Denver-Aurora, CO Adams County, CO Arapahoe County, CO Broomfield County, CO Clear Creek County, CO Denver County, CO Douglas County, CO Elbert County, CO Gilpin County, CO Jefferson County, CO Park County, CO	1.0904	1.0362	1.0542	1.0723
19780	Des Moines, IA Dallas County, IA Guthrie County, IA Madison County, IA Polk County, IA Warren County, IA	0.9266	0.9706	0.9560	0.9413
19804	Detroit-Livonia-Dearborn, MI Wayne County, MI	1.0349	1.0140	1.0209	1.0279
20020	Dothan, AL Geneva County, AL Henry County, AL Houston County, AL	0.7537	0.9015	0.8522	0.8030
20100	Dover, DE Kent County, DE	0.9825	0.9930	0.9895	0.9860
20220	Dubuque, IA Dubuque County, IA	0.8748	0.9499	0.9249	0.8998
20260	Duluth, MN-WI Carlton County, MN St. Louis County, MN Douglas County, WI	1.0340	1.0136	1.0204	1.0272
20500	Durham, NC Chatham County, NC Durham County, NC Orange County, NC Person County, NC	1.0363	1.0145	1.0218	1.0290
20740	Eau Claire, WI Chippewa County, WI Eau Claire County, WI	0.9139	0.9656	0.9483	0.9311
20764	Edison, NJ Middlesex County, NJ Monmouth County, NJ Ocean County, NJ Somerset County, NJ	1.1136	1.0454	1.0682	1.0909

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20940	El Centro, CA Imperial County, CA	0.8856	0.9542	0.9314	0.9085
21060	Elizabethtown, KY Hardin County, KY Larue County, KY	0.8684	0.9474	0.9210	0.8947
21140	Elkhart-Goshen, IN Elkhart County, IN	0.9278	0.9711	0.9567	0.9422
21300	Elmira, NY Chemung County, NY	0.8445	0.9378	0.9067	0.8756
21340	El Paso, TX El Paso County, TX	0.9181	0.9672	0.9509	0.9345
21420	Enid, OK Garfield County, OK	0.9001	0.9600	0.9401	0.9201
21500	Erie, PA Erie County, PA	0.8699	0.9480	0.9219	0.8959
21604	Essex County, MA Essex County, MA	1.0662	1.0265	1.0397	1.0530
21660	Eugene-Springfield, OR Lane County, OR	1.0940	1.0376	1.0564	1.0752
21780	Evansville, IN-KY Gibson County, IN Posey County, IN Vanderburgh County, IN Warrick County, IN Henderson County, KY Webster County, KY	0.8372	0.9349	0.9023	0.8698
21820	Fairbanks, AK Fairbanks North Star Borough, AK	1.1146	1.0458	1.0688	1.0917
21940	Fajardo, PR Ceiba Municipio, PR Fajardo Municipio, PR Luquillo Municipio, PR	0.3939	0.7576	0.6363	0.5151
22020	Fargo, ND-MN Cass County, ND Clay County, MN	0.9114	0.9646	0.9468	0.9291
22140	Farmington, NM San Juan County, NM	0.8049	0.9220	0.8829	0.8439
22180	Fayetteville, NC Cumberland County, NC Hoke County, NC	0.9363	0.9745	0.9618	0.9490

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22220	Fayetteville-Springdale-Rogers, AR-MO Benton County, AR Madison County, AR Washington County, AR McDonald County, MO	0.8636	0.9454	0.9182	0.8909
22380	Flagstaff, AZ Coconino County, AZ	1.0787	1.0315	1.0472	1.0630
22420	Flint, MI Genesee County, MI	1.1178	1.0471	1.0707	1.0942
22500	Florence, SC Darlington County, SC Florence County, SC	0.8833	0.9533	0.9300	0.9066
22520	Florence-Muscle Shoals, AL Colbert County, AL Lauderdale County, AL	0.7883	0.9153	0.8730	0.8306
22540	Fond du Lac, WI Fond du Lac County, WI	0.9897	0.9959	0.9938	0.9918
22660	Fort Collins-Loveland, CO Larimer County, CO	1.0218	1.0087	1.0131	1.0174
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL Broward County, FL	1.0165	1.0066	1.0099	1.0132
22900	Fort Smith, AR-OK Crawford County, AR Franklin County, AR Sebastian County, AR Le Flore County, OK Sequoyah County, OK	0.8283	0.9313	0.8970	0.8626
23020	Fort Walton Beach-Crestview-Destin, FL Okaloosa County, FL	0.8786	0.9514	0.9272	0.9029
23060	Fort Wayne, IN Allen County, IN Wells County, IN Whitley County, IN	0.9807	0.9923	0.9884	0.9846
23104	Fort Worth-Arlington, TX Johnson County, TX Parker County, TX Tarrant County, TX Wise County, TX	0.9472	0.9789	0.9683	0.9578
23420	Fresno, CA Fresno County, CA	1.0536	1.0214	1.0322	1.0429

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23460	Gadsden, AL Etowah County, AL	0.8049	0.9220	0.8829	0.8439
23540	Gainesville, FL Alachua County, FL Gilchrist County, FL	0.9459	0.9784	0.9675	0.9567
23580	Gainesville, GA Hall County, GA	0.9557	0.9823	0.9734	0.9646
23844	Gary, IN Jasper County, IN Lake County, IN Newton County, IN Porter County, IN	0.9310	0.9724	0.9586	0.9448
24020	Glens Falls, NY Warren County, NY Washington County, NY	0.8467	0.9387	0.9080	0.8774
24140	Goldsboro, NC Wayne County, NC	0.8778	0.9511	0.9267	0.9022
24220	Grand Forks, ND-MN Polk County, MN Grand Forks County, ND	0.9091	0.9636	0.9455	0.9273
24300	Grand Junction, CO Mesa County, CO	0.9900	0.9960	0.9940	0.9920
24340	Grand Rapids-Wyoming, MI Barry County, MI Ionia County, MI Kent County, MI Newaygo County, MI	0.9420	0.9768	0.9652	0.9536
24500	Great Falls, MT Cascade County, MT	0.8810	0.9524	0.9286	0.9048
24540	Greeley, CO Weld County, CO	0.9444	0.9778	0.9666	0.9555
24580	Green Bay, WI Brown County, WI Kewaunee County, WI Oconto County, WI	0.9590	0.9836	0.9754	0.9672
24660	Greensboro-High Point, NC Guilford County, NC Randolph County, NC Rockingham County, NC	0.9190	0.9676	0.9514	0.9352
24780	Greenville, NC Greene County, NC Pitt County, NC	0.9183	0.9673	0.9510	0.9346

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24860	Greenville, SC Greenville County, SC Laurens County, SC Pickens County, SC	0.9557	0.9823	0.9734	0.9646
25020	Guayama, PR Arroyo Municipio, PR Guayama Municipio, PR Patillas Municipio, PR	0.4005	0.7602	0.6403	0.5204
25060	Gulfport-Biloxi, MS Hancock County, MS Harrison County, MS Stone County, MS	0.8950	0.9580	0.9370	0.9160
25180	Hagerstown-Martinsburg, MD-WV Washington County, MD Berkeley County, WV Morgan County, WV	0.9715	0.9886	0.9829	0.9772
25260	Hanford-Corcoran, CA Kings County, CA	0.9296	0.9718	0.9578	0.9437
25420	Harrisburg-Carlisle, PA Cumberland County, PA Dauphin County, PA Perry County, PA	0.9359	0.9744	0.9615	0.9487
25500	Harrisonburg, VA Rockingham County, VA Harrisonburg City, VA	0.9275	0.9710	0.9565	0.9420
25540	Hartford-West Hartford-East Hartford, CT Hartford County, CT Litchfield County, CT Middlesex County, CT Tolland County, CT	1.1054	1.0422	1.0632	1.0843
25620	Hattiesburg, MS Forrest County, MS Lamar County, MS Perry County, MS	0.7362	0.8945	0.8417	0.7890
25860	Hickory-Lenoir-Morganton, NC Alexander County, NC Burke County, NC Caldwell County, NC Catawba County, NC	0.9502	0.9801	0.9701	0.9602
25980	Hinesville-Fort Stewart, GA Liberty County, GA Long County, GA	0.7715	0.9086	0.8629	0.8172

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26100	Holland-Grand Haven, MI				
	Ottawa County, MI	0.9388	0.9755	0.9633	0.9510
26180	Honolulu, HI				
	Honolulu County, HI	1.1013	1.0405	1.0608	1.0810
26300	Hot Springs, AR				
	Garland County, AR	0.9249	0.9700	0.9549	0.9399
26380	Houma-Bayou Cane-Thibodaux, LA				
	Lafourche Parish, LA				
	Terrebonne Parish, LA	0.7721	0.9088	0.8633	0.8177
26420	Houston-Baytown-Sugar Land, TX				
	Austin County, TX				
	Brazoria County, TX				
	Chambers County, TX				
	Fort Bend County, TX				
	Galveston County, TX				
	Harris County, TX				
	Liberty County, TX				
	Montgomery County, TX				
	San Jacinto County, TX				
	Waller County, TX	0.9973	0.9989	0.9984	0.9978
26580	Huntington-Ashland, WV-KY-OH				
	Boyd County, KY				
	Greenup County, KY				
	Lawrence County, OH				
	Cabell County, WV				
	Wayne County, WV	0.9564	0.9826	0.9738	0.9651
26620	Huntsville, AL				
	Limestone County, AL				
	Madison County, AL	0.8851	0.9540	0.9311	0.9081
26820	Idaho Falls, ID				
	Bonneville County, ID				
	Jefferson County, ID	0.9059	0.9624	0.9435	0.9247
26900	Indianapolis, IN				
	Boone County, IN				
	Brown County, IN				
	Hamilton County, IN				
	Hancock County, IN				
	Hendricks County, IN				
	Johnson County, IN				
	Marion County, IN				
	Morgan County, IN				
	Putnam County, IN				
	Shelby County, IN	1.0113	1.0045	1.0068	1.0090

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26980	Iowa City, IA Johnson County, IA Washington County, IA	0.9654	0.9862	0.9792	0.9723
27060	Ithaca, NY Tompkins County, NY	0.9589	0.9836	0.9753	0.9671
27100	Jackson, MI Jackson County, MI	0.9146	0.9658	0.9488	0.9317
27140	Jackson, MS Copiah County, MS Hinds County, MS Madison County, MS Rankin County, MS Simpson County, MS	0.8291	0.9316	0.8975	0.8633
27180	Jackson, TN Chester County, TN Madison County, TN	0.8900	0.9560	0.9340	0.9120
27260	Jacksonville, FL Baker County, FL Clay County, FL Duval County, FL Nassau County, FL St. Johns County, FL	0.9537	0.9815	0.9722	0.9630
27340	Jacksonville, NC Onslow County, NC	0.8401	0.9360	0.9041	0.8721
27460	Jamestown, NY Chautauqua County, NY	0.7589	0.9036	0.8553	0.8071
27500	Janesville, WI Rock County, WI	0.9583	0.9833	0.9750	0.9666
27620	Jefferson City, MO Callaway County, MO Cole County, MO Moniteau County, MO Osage County, MO	0.8338	0.9335	0.9003	0.8670
27740	Johnson City, TN Carter County, TN Unicoi County, TN Washington County, TN	0.8146	0.9258	0.8888	0.8517
27780	Johnstown, PA Cambria County, PA	0.8380	0.9352	0.9028	0.8704
27860	Jonesboro, AR Craighead County, AR Poinsett County, AR	0.8144	0.9258	0.8886	0.8515

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27900	Joplin, MO Jasper County, MO Newton County, MO	0.8721	0.9488	0.9233	0.8977
28020	Kalamazoo-Portage, MI Kalamazoo County, MI Van Buren County, MI	1.0676	1.0270	1.0406	1.0541
28100	Kankakee-Bradley, IL Kankakee County, IL	1.0603	1.0241	1.0362	1.0482
28140	Kansas City, MO-KS Franklin County, KS Johnson County, KS Leavenworth County, KS Linn County, KS Miami County, KS Wyandotte County, KS Bates County, MO Caldwell County, MO Cass County, MO Clay County, MO Clinton County, MO Jackson County, MO Lafayette County, MO Platte County, MO Ray County, MO	0.9629	0.9852	0.9777	0.9703
28420	Kennewick-Richland-Pasco, WA Benton County, WA Franklin County, WA	1.0520	1.0208	1.0312	1.0416
28660	Killeen-Temple-Fort Hood, TX Bell County, TX Coryell County, TX Lampasas County, TX	0.9242	0.9697	0.9545	0.9394
28700	Kingsport-Bristol-Bristol, TN-VA Hawkins County, TN Sullivan County, TN Bristol City, VA Scott County, VA Washington County, VA	0.8240	0.9296	0.8944	0.8592
28740	Kingston, NY Ulster County, NY	0.9000	0.9600	0.9400	0.9200

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28940	Knoxville, TN Anderson County, TN Blount County, TN Knox County, TN Loudon County, TN Union County, TN	0.8548	0.9419	0.9129	0.8838
29020	Kokomo, IN Howard County, IN Tipton County, IN	0.8986	0.9594	0.9392	0.9189
29100	La Crosse, WI-MN Houston County, MN La Crosse County, WI	0.9289	0.9716	0.9573	0.9431
29140	Lafayette, IN Benton County, IN Carroll County, IN Tippecanoe County, IN	0.9067	0.9627	0.9440	0.9254
29180	Lafayette, LA Lafayette Parish, LA St. Martin Parish, LA	0.8306	0.9322	0.8984	0.8645
29340	Lake Charles, LA Calcasieu Parish, LA Cameron Parish, LA	0.7935	0.9174	0.8761	0.8348
29404	Lake County-Kenosha County, IL-WI Lake County, IL Kenosha County, WI	1.0342	1.0137	1.0205	1.0274
29460	Lakeland, FL Polk County, FL	0.8930	0.9572	0.9358	0.9144
29540	Lancaster, PA Lancaster County, PA	0.9883	0.9953	0.9930	0.9906
29620	Lansing-East Lansing, MI Clinton County, MI Eaton County, MI Ingham County, MI	0.9658	0.9863	0.9795	0.9726
29700	Laredo, TX Webb County, TX	0.8747	0.9499	0.9248	0.8998
29740	Las Cruces, NM Dona Ana County, NM	0.8784	0.9514	0.9270	0.9027
29820	Las Vegas-Paradise, NV Clark County, NV	1.1378	1.0551	1.0827	1.1102
29940	Lawrence, KS Douglas County, KS	0.8644	0.9458	0.9186	0.8915
30020	Lawton, OK Comanche County, OK	0.8212	0.9285	0.8927	0.8570

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30140	Lebanon, PA Lebanon County, PA	0.8570	0.9428	0.9142	0.8856
30300	Lewiston, ID-WA Nez Perce County, ID Asotin County, WA	0.9314	0.9726	0.9588	0.9451
30340	Lewiston-Auburn, ME Androscoggin County, ME	0.9562	0.9825	0.9737	0.9650
30460	Lexington-Fayette, KY Bourbon County, KY Clark County, KY Fayette County, KY Jessamine County, KY Scott County, KY Woodford County, KY	0.9359	0.9744	0.9615	0.9487
30620	Lima, OH Allen County, OH	0.9330	0.9732	0.9598	0.9464
30700	Lincoln, NE Lancaster County, NE Seward County, NE	1.0208	1.0083	1.0125	1.0166
30780	Little Rock-North Little Rock, AR Faulkner County, AR Grant County, AR Lonoke County, AR Perry County, AR Pulaski County, AR Saline County, AR	0.8826	0.9530	0.9296	0.9061
30860	Logan, UT-ID Franklin County, ID Cache County, UT	0.9094	0.9638	0.9456	0.9275
30980	Longview, TX Gregg County, TX Rusk County, TX Upshur County, TX	0.8801	0.9520	0.9281	0.9041
31020	Longview, WA Cowlitz County, WA	1.0224	1.0090	1.0134	1.0179
31084	Los Angeles-Long Beach-Glendale, CA Los Angeles County, CA	1.1732	1.0693	1.1039	1.1386

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31140	Louisville, KY-IN Clark County, IN Floyd County, IN Harrison County, IN Washington County, IN Bullitt County, KY Henry County, KY Jefferson County, KY Meade County, KY Nelson County, KY Oldham County, KY Shelby County, KY Spencer County, KY Trimble County, KY	0.9122	0.9649	0.9473	0.9298
31180	Lubbock, TX Crosby County, TX Lubbock County, TX	0.8777	0.9511	0.9266	0.9022
31340	Lynchburg, VA Amherst County, VA Appomattox County, VA Bedford County, VA Campbell County, VA Bedford City, VA Lynchburg City, VA	0.9017	0.9607	0.9410	0.9214
31420	Macon, GA Bibb County, GA Crawford County, GA Jones County, GA Monroe County, GA Twiggs County, GA	0.9887	0.9955	0.9932	0.9910
31460	Madera, CA Madera County, CA	0.8521	0.9408	0.9113	0.8817
31540	Madison, WI Columbia County, WI Dane County, WI Iowa County, WI	1.0306	1.0122	1.0184	1.0245
31700	Manchester-Nashua, NH Hillsborough County, NH Merrimack County, NH	1.0642	1.0257	1.0385	1.0514
31900	Mansfield, OH Richland County, OH	0.9189	0.9676	0.9513	0.9351
32420	Mayagüez, PR Hormigueros Municipio, PR Mayagüez Municipio, PR	0.4493	0.7797	0.6696	0.5594

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32580	McAllen-Edinburg-Pharr, TX				
	Hidalgo County, TX	0.8602	0.9441	0.9161	0.8882
32780	Medford, OR				
	Jackson County, OR	1.0534	1.0214	1.0320	1.0427
32820	Memphis, TN-MS-AR				
	Crittenden County, AR				
	DeSoto County, MS				
	Marshall County, MS				
	Tate County, MS				
	Tunica County, MS				
	Fayette County, TN				
	Shelby County, TN				
	Tipton County, TN	0.9217	0.9687	0.9530	0.9374
32900	Merced, CA				
	Merced County, CA	1.0575	1.0230	1.0345	1.0460
33124	Miami-Miami Beach-Kendall, FL				
	Miami-Dade County, FL	0.9870	0.9948	0.9922	0.9896
33140	Michigan City-La Porte, IN				
	LaPorte County, IN	0.9332	0.9733	0.9599	0.9466
33260	Midland, TX				
	Midland County, TX	0.9384	0.9754	0.9630	0.9507
33340	Milwaukee-Waukesha-West Allis, WI				
	Milwaukee County, WI				
	Ozaukee County, WI				
	Washington County, WI				
	Waukesha County, WI	1.0076	1.0030	1.0046	1.0061
33460	Minneapolis-St. Paul-Bloomington, MN-WI				
	Anoka County, MN				
	Carver County, MN				
	Chisago County, MN				
	Dakota County, MN				
	Hennepin County, MN				
	Isanti County, MN				
	Ramsey County, MN				
	Scott County, MN				
	Sherburne County, MN				
	Washington County, MN				
	Wright County, MN				
	Pierce County, WI				
	St. Croix County, WI	1.1066	1.0426	1.0640	1.0853
33540	Missoula, MT				
	Missoula County, MT	0.9618	0.9847	0.9771	0.9694

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33660	Mobile, AL Mobile County, AL	0.7995	0.9198	0.8797	0.8396
33700	Modesto, CA Stanislaus County, CA	1.1966	1.0786	1.1180	1.1573
33740	Monroe, LA Ouachita Parish, LA Union Parish, LA	0.7903	0.9161	0.8742	0.8322
33780	Monroe, MI Monroe County, MI	0.9506	0.9802	0.9704	0.9605
33860	Montgomery, AL Autauga County, AL Elmore County, AL Lowndes County, AL Montgomery County, AL	0.8300	0.9320	0.8980	0.8640
34060	Morgantown, WV Monongalia County, WV Preston County, WV	0.8730	0.9492	0.9238	0.8984
34100	Morristown, TN Grainger County, TN Hamblen County, TN Jefferson County, TN	0.7790	0.9116	0.8674	0.8232
34580	Mount Vernon-Anacortes, WA Skagit County, WA	1.0576	1.0230	1.0346	1.0461
34620	Muncie, IN Delaware County, IN	0.8580	0.9432	0.9148	0.8864
34740	Muskegon-Norton Shores, MI Muskegon County, MI	0.9741	0.9896	0.9845	0.9793
34820	Myrtle Beach-Conway-North Myrtle Beach, SC Horry County, SC	0.9022	0.9609	0.9413	0.9218
34900	Napa, CA Napa County, CA	1.2531	1.1012	1.1519	1.2025
34940	Naples-Marco Island, FL Collier County, FL	1.0558	1.0223	1.0335	1.0446

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34980	Nashville-Davidson--Murfreesboro, TN				
	Cannon County, TN				
	Cheatham County, TN				
	Davidson County, TN				
	Dickson County, TN				
	Hickman County, TN				
	Macon County, TN				
	Robertson County, TN				
	Rutherford County, TN				
	Smith County, TN				
	Sumner County, TN				
	Trousdale County, TN				
	Williamson County, TN				
	Wilson County, TN	1.0086	1.0034	1.0052	1.0069
35004	Nassau-Suffolk, NY				
	Nassau County, NY				
	Suffolk County, NY	1.2907	1.1163	1.1744	1.2326
35084	Newark-Union, NJ-PA				
	Essex County, NJ				
	Hunterdon County, NJ				
	Morris County, NJ				
	Sussex County, NJ				
	Union County, NJ				
	Pike County, PA	1.1687	1.0675	1.1012	1.1350
35300	New Haven-Milford, CT				
	New Haven County, CT	1.1807	1.0723	1.1084	1.1446
35380	New Orleans-Metairie-Kenner, LA				
	Jefferson Parish, LA				
	Orleans Parish, LA				
	Plaquemines Parish, LA				
	St. Bernard Parish, LA				
	St. Charles Parish, LA				
	St. John the Baptist Parish, LA				
	St. Tammany Parish, LA	0.9103	0.9641	0.9462	0.9282

CBSA Code	Urban Area (Constituent Counties)	Full Wage Index[2]	2/5[THS] Wage Index[3]	3/5[THS] Wage Index[4]	4/5[THS] Wage Index[5]
35644	New York-Wayne-White Plains, NY-NJ Bergen County, NJ Hudson County, NJ Passaic County, NJ Bronx County, NY Kings County, NY New York County, NY Putnam County, NY Queens County, NY Richmond County, NY Rockland County, NY Westchester County, NY	1.3311	1.1324	1.1987	1.2649
35660	Niles-Benton Harbor, MI Berrien County, MI	0.8847	0.9539	0.9308	0.9078
35980	Norwich-New London, CT New London County, CT	1.1596	1.0638	1.0958	1.1277
36084	Oakland-Fremont-Hayward, CA Alameda County, CA Contra Costa County, CA	1.5220	1.2088	1.3132	1.4176
36100	Ocala, FL Marion County, FL	0.9153	0.9661	0.9492	0.9322
36140	Ocean City, NJ Cape May County, NJ	1.0810	1.0324	1.0486	1.0648
36220	Odessa, TX Ector County, TX	0.9798	0.9919	0.9879	0.9838
36260	Ogden-Clearfield, UT Davis County, UT Morgan County, UT Weber County, UT	0.9216	0.9686	0.9530	0.9373
36420	Oklahoma City, OK Canadian County, OK Cleveland County, OK Grady County, OK Lincoln County, OK Logan County, OK McClain County, OK Oklahoma County, OK	0.8982	0.9593	0.9389	0.9186
36500	Olympia, WA Thurston County, WA	1.1006	1.0402	1.0604	1.0805

CBSA Code	Urban Area (Constituent Counties)	Full Wage Index[2]	2/5THS Wage Index[3]	3/5THS Wage Index[4]	4/5THS Wage Index[5]
36540	Omaha-Council Bluffs, NE-IA Harrison County, IA Mills County, IA Pottawattamie County, IA Cass County, NE Douglas County, NE Sarpy County, NE Saunders County, NE Washington County, NE	0.9754	0.9902	0.9852	0.9803
36740	Orlando, FL Lake County, FL Orange County, FL Osceola County, FL Seminole County, FL	0.9742	0.9897	0.9845	0.9794
36780	Oshkosh-Neenah, WI Winnebago County, WI	0.9099	0.9640	0.9459	0.9279
36980	Owensboro, KY Daviess County, KY Hancock County, KY McLean County, KY	0.8434	0.9374	0.9060	0.8747
37100	Oxnard-Thousand Oaks-Ventura, CA Ventura County, CA	1.1105	1.0442	1.0663	1.0884
37340	Palm Bay-Melbourne-Titusville, FL Brevard County, FL	0.9633	0.9853	0.9780	0.9706
37460	Panama City-Lynn Haven, FL Bay County, FL	0.8124	0.9250	0.8874	0.8499
37620	Parkersburg-Marietta, WV-OH Washington County, OH Pleasants County, WV Wirt County, WV Wood County, WV	0.8288	0.9315	0.8973	0.8630
37700	Pascagoula, MS George County, MS Jackson County, MS	0.7974	0.9190	0.8784	0.8379
37860	Pensacola-Ferry Pass-Brent, FL Escambia County, FL Santa Rosa County, FL	0.8306	0.9322	0.8984	0.8645
37900	Peoria, IL Marshall County, IL Peoria County, IL Stark County, IL Tazewell County, IL Woodford County, IL	0.8886	0.9554	0.9332	0.9109

CBSA Code	Urban Area (Constituent Counties)	Full Wage Index[2]	2/5THS Wage Index[3]	3/5THS Wage Index[4]	4/5THS Wage Index[5]
37964	Philadelphia, PA Bucks County, PA Chester County, PA Delaware County, PA Montgomery County, PA Philadelphia County, PA	1.0865	1.0346	1.0519	1.0692
38060	Phoenix-Mesa-Scottsdale, AZ Maricopa County, AZ Pinal County, AZ	0.9982	0.9993	0.9989	0.9986
38220	Pine Bluff, AR Cleveland County, AR Jefferson County, AR Lincoln County, AR	0.8673	0.9469	0.9204	0.8938
38300	Pittsburgh, PA Allegheny County, PA Armstrong County, PA Beaver County, PA Butler County, PA Fayette County, PA Washington County, PA Westmoreland County, PA	0.8736	0.9494	0.9242	0.8989
38340	Pittsfield, MA Berkshire County, MA	1.0439	1.0176	1.0263	1.0351
38540	Pocatello, ID Bannock County, ID Power County, ID	0.9601	0.9840	0.9761	0.9681
38660	Ponce, PR Juana Díaz Municipio, PR Ponce Municipio, PR Villalba Municipio, PR	0.5006	0.8002	0.7004	0.6005
38860	Portland-South Portland-Biddeford, ME Cumberland County, ME Sagadahoc County, ME York County, ME	1.0112	1.0045	1.0067	1.0090
38900	Portland-Vancouver-Beaverton, OR-WA Clackamas County, OR Columbia County, OR Multnomah County, OR Washington County, OR Yamhill County, OR Clark County, WA Skamania County, WA	1.1403	1.0561	1.0842	1.1122

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38940	Port St. Lucie-Fort Pierce, FL Martin County, FL St. Lucie County, FL	1.0046	1.0018	1.0028	1.0037
39100	Poughkeepsie-Newburgh-Middletown, NY Dutchess County, NY Orange County, NY	1.1363	1.0545	1.0818	1.1090
39140	Prescott, AZ Yavapai County, AZ	0.9892	0.9957	0.9935	0.9914
39300	Providence-New Bedford-Fall River, RI-MA Bristol County, MA Bristol County, RI Kent County, RI Newport County, RI Providence County, RI Washington County, RI	1.0929	1.0372	1.0557	1.0743
39340	Provo-Orem, UT Juab County, UT Utah County, UT	0.9588	0.9835	0.9753	0.9670
39380	Pueblo, CO Pueblo County, CO	0.8752	0.9501	0.9251	0.9002
39460	Punta Gorda, FL Charlotte County, FL	0.9441	0.9776	0.9665	0.9553
39540	Racine, WI Racine County, WI	0.9045	0.9618	0.9427	0.9236
39580	Raleigh-Cary, NC Franklin County, NC Johnston County, NC Wake County, NC	1.0057	1.0023	1.0034	1.0046
39660	Rapid City, SD Meade County, SD Pennington County, SD	0.8912	0.9565	0.9347	0.9130
39740	Reading, PA Berks County, PA	0.9215	0.9686	0.9529	0.9372
39820	Redding, CA Shasta County, CA	1.1835	1.0734	1.1101	1.1468
39900	Reno-Sparks, NV Storey County, NV Washoe County, NV	1.0456	1.0182	1.0274	1.0365

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40060	Richmond, VA Amelia County, VA Caroline County, VA Charles City County, VA Chesterfield County, VA Cumberland County, VA Dinwiddie County, VA Goochland County, VA Hanover County, VA Henrico County, VA King and Queen County, VA King William County, VA Louisa County, VA New Kent County, VA Powhatan County, VA Prince George County, VA Sussex County, VA Colonial Heights City, VA Hopewell City, VA Petersburg City, VA Richmond City, VA	0.9397	0.9759	0.9638	0.9518
40140	Riverside-San Bernardino-Ontario, CA Riverside County, CA San Bernardino County, CA	1.0970	1.0388	1.0582	1.0776
40220	Roanoke, VA Botetourt County, VA Craig County, VA Franklin County, VA Roanoke County, VA Roanoke City, VA Salem City, VA	0.8415	0.9366	0.9049	0.8732
40340	Rochester, MN Dodge County, MN Olmsted County, MN Wabasha County, MN	1.1504	1.0602	1.0902	1.1203
40380	Rochester, NY Livingston County, NY Monroe County, NY Ontario County, NY Orleans County, NY Wayne County, NY	0.9281	0.9712	0.9569	0.9425

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40420	Rockford, IL Boone County, IL Winnebago County, IL	0.9626	0.9850	0.9776	0.9701
40484	Rockingham County-Strafford County, NH Rockingham County, NH Strafford County, NH	1.0221	1.0088	1.0133	1.0177
40580	Rocky Mount, NC Edgecombe County, NC Nash County, NC	0.8998	0.9599	0.9399	0.9198
40660	Rome, GA Floyd County, GA	0.8878	0.9551	0.9327	0.9102
40900	Sacramento--Arden-Arcade--Roseville, CA El Dorado County, CA Placer County, CA Sacramento County, CA Yolo County, CA	1.1700	1.0680	1.1020	1.1360
40980	Saginaw-Saginaw Township North, MI Saginaw County, MI	0.9814	0.9926	0.9888	0.9851
41060	St. Cloud, MN Benton County, MN Stearns County, MN	1.0215	1.0086	1.0129	1.0172
41100	St. George, UT Washington County, UT	0.9458	0.9783	0.9675	0.9566
41140	St. Joseph, MO-KS Doniphan County, KS Andrew County, MO Buchanan County, MO DeKalb County, MO	1.0013	1.0005	1.0008	1.0010

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41180	St. Louis, MO-IL Bond County, IL Calhoun County, IL Clinton County, IL Jersey County, IL Macoupin County, IL Madison County, IL Monroe County, IL St. Clair County, IL Crawford County, MO Franklin County, MO Jefferson County, MO Lincoln County, MO St. Charles County, MO St. Louis County, MO Warren County, MO Washington County, MO St. Louis City, MO	0.9076	0.9630	0.9446	0.9261
41420	Salem, OR Marion County, OR Polk County, OR	1.0556	1.0222	1.0334	1.0445
41500	Salinas, CA Monterey County, CA	1.3823	1.1529	1.2294	1.3058
41540	Salisbury, MD Somerset County, MD Wicomico County, MD	0.9123	0.9649	0.9474	0.9298
41620	Salt Lake City, UT Salt Lake County, UT Summit County, UT Tooele County, UT	0.9561	0.9824	0.9737	0.9649
41660	San Angelo, TX Irion County, TX Tom Green County, TX	0.8167	0.9267	0.8900	0.8534
41700	San Antonio, TX Atascosa County, TX Bandera County, TX Bexar County, TX Comal County, TX Guadalupe County, TX Kendall County, TX Medina County, TX Wilson County, TX	0.9003	0.9601	0.9402	0.9202
41740	San Diego-Carlsbad-San Marcos, CA San Diego County, CA	1.1267	1.0507	1.0760	1.1014

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41780	Sandusky, OH Erie County, OH	0.9017	0.9607	0.9410	0.9214
41884	San Francisco-San Mateo-Redwood City, CA Marin County, CA San Francisco County, CA San Mateo County, CA	1.4712	1.1885	1.2827	1.3770
41900	San Germán-Cabo Rojo, PR Cabo Rojo Municipio, PR Lajas Municipio, PR Sabana Grande Municipio, PR San Germán Municipio, PR	0.5240	0.8096	0.7144	0.6192
41940	San Jose-Sunnyvale-Santa Clara, CA San Benito County, CA Santa Clara County, CA	1.4722	1.1889	1.2833	1.3778

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41980					
	San Juan-Caguas-Guaynabo, PR				
	Aguas Buenas Municipio, PR				
	Aibonito Municipio, PR				
	Arecibo Municipio, PR				
	Barceloneta Municipio, PR				
	Barranquitas Municipio, PR				
	Bayamón Municipio, PR				
	Caguas Municipio, PR				
	Camuy Municipio, PR				
	Canóvanas Municipio, PR				
	Carolina Municipio, PR				
	Cataño Municipio, PR				
	Cayey Municipio, PR				
	Ciales Municipio, PR				
	Cidra Municipio, PR				
	Comerío Municipio, PR				
	Corozal Municipio, PR				
	Dorado Municipio, PR				
	Florida Municipio, PR				
	Guaynabo Municipio, PR				
	Gurabo Municipio, PR				
	Hatillo Municipio, PR				
	Humacao Municipio, PR				
	Juncos Municipio, PR				
	Las Piedras Municipio, PR				
	Loíza Municipio, PR				
	Manatí Municipio, PR				
	Maunabo Municipio, PR				
	Morovis Municipio, PR				
	Naguabo Municipio, PR				
	Naranjito Municipio, PR				
	Orocovis Municipio, PR				
	Quebradillas Municipio, PR				
	Río Grande Municipio, PR				
	San Juan Municipio, PR				
	San Lorenzo Municipio, PR				
	Toa Alta Municipio, PR				
	Toa Baja Municipio, PR				
	Trujillo Alto Municipio, PR				
	Vega Alta Municipio, PR				
	Vega Baja Municipio, PR				
	Yabucoa Municipio, PR	0.4645	0.7858	0.6787	0.5716

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42020	San Luis Obispo-Paso Robles, CA San Luis Obispo County, CA	1.1118	1.0447	1.0671	1.0894
42044	Santa Ana-Anaheim-Irvine, CA Orange County, CA	1.1611	1.0644	1.0967	1.1289
42060	Santa Barbara-Santa Maria-Goleta, CA Santa Barbara County, CA	1.0771	1.0308	1.0463	1.0617
42100	Santa Cruz-Watsonville, CA Santa Cruz County, CA	1.4779	1.1912	1.2867	1.3823
42140	Santa Fe, NM Santa Fe County, NM	1.0909	1.0364	1.0545	1.0727
42220	Santa Rosa-Petaluma, CA Sonoma County, CA	1.2961	1.1184	1.1777	1.2369
42260	Sarasota-Bradenton-Venice, FL Manatee County, FL Sarasota County, FL	0.9629	0.9852	0.9777	0.9703
42340	Savannah, GA Bryan County, GA Chatham County, GA Effingham County, GA	0.9460	0.9784	0.9676	0.9568
42540	Scranton--Wilkes-Barre, PA Lackawanna County, PA Luzerne County, PA Wyoming County, PA	0.8543	0.9417	0.9126	0.8834
42644	Seattle-Bellevue-Everett, WA King County, WA Snohomish County, WA	1.1492	1.0597	1.0895	1.1194
43100	Sheboygan, WI Sheboygan County, WI	0.8948	0.9579	0.9369	0.9158
43300	Sherman-Denison, TX Grayson County, TX	0.9617	0.9847	0.9770	0.9694
43340	Shreveport-Bossier City, LA Bossier Parish, LA Caddo Parish, LA De Soto Parish, LA	0.9132	0.9653	0.9479	0.9306
43580	Sioux City, IA-NE-SD Woodbury County, IA Dakota County, NE Dixon County, NE Union County, SD	0.9070	0.9628	0.9442	0.9256

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43620	Sioux Falls, SD Lincoln County, SD McCook County, SD Minnehaha County, SD Turner County, SD	0.9441	0.9776	0.9665	0.9553
43780	South Bend-Mishawaka, IN-MI St. Joseph County, IN Cass County, MI	0.9447	0.9779	0.9668	0.9558
43900	Spartanburg, SC Spartanburg County, SC	0.9519	0.9808	0.9711	0.9615
44060	Spokane, WA Spokane County, WA	1.0660	1.0264	1.0396	1.0528
44100	Springfield, IL Menard County, IL Sangamon County, IL	0.8738	0.9495	0.9243	0.8990
44140	Springfield, MA Franklin County, MA Hampden County, MA Hampshire County, MA	1.0176	1.0070	1.0106	1.0141
44180	Springfield, MO Christian County, MO Dallas County, MO Greene County, MO Polk County, MO Webster County, MO	0.8557	0.9423	0.9134	0.8846
44220	Springfield, OH Clark County, OH	0.8748	0.9499	0.9249	0.8998
44300	State College, PA Centre County, PA	0.8461	0.9384	0.9077	0.8769
44700	Stockton, CA San Joaquin County, CA	1.0564	1.0226	1.0338	1.0451
44940	Sumter, SC Sumter County, SC	0.8520	0.9408	0.9112	0.8816
45060	Syracuse, NY Madison County, NY Onondaga County, NY Oswego County, NY	0.9468	0.9787	0.9681	0.9574
45104	Tacoma, WA Pierce County, WA	1.1078	1.0431	1.0647	1.0862
45220	Tallahassee, FL Gadsden County, FL Jefferson County, FL Leon County, FL Wakulla County, FL	0.8655	0.9462	0.9193	0.8924

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45300	Tampa-St. Petersburg-Clearwater, FL Hernando County, FL Hillsborough County, FL Pasco County, FL Pinellas County, FL	0.9024	0.9610	0.9414	0.9219
45460	Terre Haute, IN Clay County, IN Sullivan County, IN Vermillion County, IN Vigo County, IN	0.8517	0.9407	0.9110	0.8814
45500	Texarkana, TX-Texarkana, AR Miller County, AR Bowie County, TX	0.8413	0.9365	0.9048	0.8730
45780	Toledo, OH Fulton County, OH Lucas County, OH Ottawa County, OH Wood County, OH	0.9524	0.9810	0.9714	0.9619
45820	Topeka, KS Jackson County, KS Jefferson County, KS Osage County, KS Shawnee County, KS Wabaunsee County, KS	0.8904	0.9562	0.9342	0.9123
45940	Trenton-Ewing, NJ Mercer County, NJ	1.0276	1.0110	1.0166	1.0221
46060	Tucson, AZ Pima County, AZ	0.8926	0.9570	0.9356	0.9141
46140	Tulsa, OK Creek County, OK Okmulgee County, OK Osage County, OK Pawnee County, OK Rogers County, OK Tulsa County, OK Wagoner County, OK	0.8690	0.9476	0.9214	0.8952
46220	Tuscaloosa, AL Greene County, AL Hale County, AL Tuscaloosa County, AL	0.8336	0.9334	0.9002	0.8669
46340	Tyler, TX Smith County, TX	0.9502	0.9801	0.9701	0.9602

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46540	Utica-Rome, NY				
	Herkimer County, NY				
	Oneida County, NY	0.8295	0.9318	0.8977	0.8636
46660	Valdosta, GA				
	Brooks County, GA				
	Echols County, GA				
	Lanier County, GA				
	Lowndes County, GA	0.8341	0.9336	0.9005	0.8673
46700	Vallejo-Fairfield, CA				
	Solano County, CA	1.4279	1.1712	1.2567	1.3423
46940	Vero Beach, FL				
	Indian River County, FL	0.9477	0.9791	0.9686	0.9582
47020	Victoria, TX				
	Calhoun County, TX				
	Goliad County, TX				
	Victoria County, TX	0.8470	0.9388	0.9082	0.8776
47220	Vineland-Millville-Bridgeton, NJ				
	Cumberland County, NJ	1.0573	1.0229	1.0344	1.0458
47260	Virginia Beach-Norfolk-Newport News, VA-NC				
	Currituck County, NC				
	Gloucester County, VA				
	Isle of Wight County, VA				
	James City County, VA				
	Mathews County, VA				
	Surry County, VA				
	York County, VA				
	Chesapeake City, VA				
	Hampton City, VA				
	Newport News City, VA				
	Norfolk City, VA				
	Poquoson City, VA				
	Portsmouth City, VA				
	Suffolk City, VA				
	Virginia Beach City, VA				
	Williamsburg City, VA	0.8894	0.9558	0.9336	0.9115
47300	Visalia-Porterville, CA				
	Tulare County, CA	0.9975	0.9990	0.9985	0.9980
47380	Waco, TX				
	McLennan County, TX	0.8146	0.9258	0.8888	0.8517
47580	Warner Robins, GA				
	Houston County, GA	0.8489	0.9396	0.9093	0.8791

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47644	Warren-Farmington Hills-Troy, MI Lapeer County, MI Livingston County, MI Macomb County, MI Oakland County, MI St. Clair County, MI	1.0112	1.0045	1.0067	1.0090
47894	Washington-Arlington-Alexandria, DC-VA-MD-WV District of Columbia, DC Calvert County, MD Charles County, MD Prince George's County, MD Arlington County, VA Clarke County, VA Fairfax County, VA Fauquier County, VA Loudoun County, VA Prince William County, VA Spotsylvania County, VA Stafford County, VA Warren County, VA Alexandria City, VA Fairfax City, VA Falls Church City, VA Fredericksburg City, VA Manassas City, VA Manassas Park City, VA Jefferson County, WV	1.1023	1.0409	1.0614	1.0818
47940	Waterloo-Cedar Falls, IA Black Hawk County, IA Bremer County, IA Grundy County, IA	0.8633	0.9453	0.9180	0.8906
48140	Wausau, WI Marathon County, WI	0.9570	0.9828	0.9742	0.9656
48260	Weirton-Steubenville, WV-OH Jefferson County, OH Brooke County, WV Hancock County, WV	0.8280	0.9312	0.8968	0.8624
48300	Wenatchee, WA Chelan County, WA Douglas County, WA	0.9427	0.9771	0.9656	0.9542
48424	West Palm Beach-Boca Raton-Boynton Beach, FL Palm Beach County, FL	1.0362	1.0145	1.0217	1.0290

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48540	Wheeling, WV-OH Belmont County, OH Marshall County, WV Ohio County, WV	0.7449	0.8980	0.8469	0.7959
48620	Wichita, KS Butler County, KS Harvey County, KS Sedgwick County, KS Sumner County, KS	0.9457	0.9783	0.9674	0.9566
48660	Wichita Falls, TX Archer County, TX Clay County, TX Wichita County, TX	0.8332	0.9333	0.8999	0.8666
48700	Williamsport, PA Lycoming County, PA	0.8485	0.9394	0.9091	0.8788
48864	Wilmington, DE-MD-NJ New Castle County, DE Cecil County, MD Salem County, NJ	1.1049	1.0420	1.0629	1.0839
48900	Wilmington, NC Brunswick County, NC New Hanover County, NC Pender County, NC	0.9237	0.9695	0.9542	0.9390
49020	Winchester, VA-WV Frederick County, VA Winchester City, VA Hampshire County, WV	1.0496	1.0198	1.0298	1.0397
49180	Winston-Salem, NC Davie County, NC Forsyth County, NC Stokes County, NC Yadkin County, NC	0.9401	0.9760	0.9641	0.9521
49340	Worcester, MA Worcester County, MA	1.0996	1.0398	1.0598	1.0797
49420	Yakima, WA Yakima County, WA	1.0322	1.0129	1.0193	1.0258
49500	Yauco, PR Guánica Municipio, PR Guayanilla Municipio, PR Peñuelas Municipio, PR Yauco Municipio, PR	0.4493	0.7797	0.6696	0.5594
49620	York-Hanover, PA York County, PA	0.9150	0.9660	0.9490	0.9320

CBSA Code	Urban Area (Constituent Counties)	Full Wage Index[2]	2/5[THS] Wage Index[3]	3/5[THS] Wage Index[4]	4/5[THS] Wage Index[5]
49660	Youngstown-Warren-Boardman, OH-PA Mahoning County, OH Trumbull County, OH Mercer County, PA	0.9237	0.9695	0.9542	0.9390
49700	Yuba City, CA Sutter County, CA Yuba County, CA	1.0363	1.0145	1.0218	1.0290
49740	Yuma, AZ Yuma County, AZ	0.8871	0.9548	0.9323	0.9097

1 As discussed in section IV.C.1.d. of the preamble of this proposed rule, because there are no longer any LTCHs in their cost reporting period that began during FY 2003 (the first year of the 5-year wage index phase-in), we are no longer showing the 1/5th wage index value. For further details on the 5-year phase-in of the wage index, see section IV.C.1.of this proposed rule.

2 Wage index calculated using the same wage data used to compute the wage index used by acute care hospitals under the IPPS for Federal FY 2005 (that is, fiscal year 2001 audited acute care hospital inpatient wage data) without regard to reclassification under section 1886(d)(8) or section 1886(d)(10) of the Act.

3 Two-fifths of the proposed full wage index value, applicable for a LTCH's cost reporting period beginning on or after October 1, 2003 through September 30, 2004 (Federal FY 2004). That is, for a LTCH's cost reporting period that begins during Federal FY 2004 and located in Chicago, Illinois (CBSA 16974), the proposed 2/5ths wage index value is computed as ((2*1.0868) + 3))/5 = 1.0347. For further details on the 5-year phase-in of the wage index, see section IV.C.1. of this proposed rule.

4 Three-fifths of the proposed full wage index value, applicable for a LTCH's cost reporting period beginning on or after October 1, 2005 through September 30, 2006 (Federal FY 2005). That is, for a LTCH's cost reporting period that begins during Federal FY 2005 and located in Chicago, Illinois (CBSA 16974), the proposed 3/5ths wage index value is computed as ((3*1.0868) + 2))/5 = 1.0521. For further details on the 5-year phase-in of the wage index, see section IV.C.1. of this proposed rule.

5 Four-fifths of the proposed full wage index value, applicable for a LTCH's cost reporting period beginning on or after October 1, 2006 through September 30, 2007 (Federal FY 2006). That is, for a LTCH's cost reporting period that begins during Federal FY 2006 and located in Chicago, Illinois (CBSA 16974), the proposed 4/5ths wage index value is computed as ((4*1.0868) + 1))/5 = 1.0694. For further details on the 5-year phase-in of the wage index, see section IV.C.1. of this proposed rule.

Table 2.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX (BASED ON PROPOSED CBSA LABOR MARKET AREAS) FOR RURAL AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2005 THROUGH JUNE 30, 2006[1]

CBSA Code	Nonurban Area	Full Wage Index[2]	2/5ths Wage Index[3]	3/5ths Wage Index[4]	4/5ths Wage Index[5]
01	Alabama	0.7628	0.9051	0.8577	0.8102
02	Alaska	1.1746	1.0698	1.1048	1.1397
03	Arizona	0.8936	0.9574	0.9362	0.9149
04	Arkansas	0.7406	0.8962	0.8444	0.7925
05	California	1.0524	1.0210	1.0314	1.0419
06	Colorado	0.9368	0.9747	0.9621	0.9494
07	Connecticut	1.1917	1.0767	1.1150	1.1534
08	Delaware	0.9503	0.9801	0.9702	0.9602
10	Florida	0.8574	0.9430	0.9144	0.8859
11	Georgia	0.7733	0.9093	0.8640	0.8186
12	Hawaii	1.0522	1.0209	1.0313	1.0418
13	Idaho	0.8227	0.9291	0.8936	0.8582
14	Illinois	0.8339	0.9336	0.9003	0.8671
15	Indiana	0.8653	0.9461	0.9192	0.8922
16	Iowa	0.8475	0.9390	0.9085	0.8780
17	Kansas	0.8079	0.9232	0.8847	0.8463
18	Kentucky	0.7755	0.9102	0.8653	0.8204
19	Louisiana	0.7345	0.8938	0.8407	0.7876
20	Maine	0.9039	0.9616	0.9423	0.9231
21	Maryland	0.9220	0.9688	0.9532	0.9376
22	Massachusetts[6]	------	------	------	------
23	Michigan	0.8786	0.9514	0.9272	0.9029
24	Minnesota	0.9330	0.9732	0.9598	0.9464
25	Mississippi	0.7635	0.9054	0.8581	0.8108
26	Missouri	0.7762	0.9105	0.8657	0.8210
27	Montana	0.8701	0.9480	0.9221	0.8961

CBSA Code	Nonurban Area	Full Wage Index[2]	2/5ths Wage Index[3]	3/5ths Wage Index[4]	4/5ths Wage Index[5]
28	Nebraska	0.9035	0.9614	0.9421	0.9228
29	Nevada	0.9280	0.9712	0.9568	0.9424
30	New Hampshire	0.9940	0.9976	0.9964	0.9952
31	New Jersey[6]	------	------	------	------
32	New Mexico	0.8680	0.9472	0.9208	0.8944
33	New York	0.8151	0.9260	0.8891	0.8521
34	North Carolina	0.8563	0.9425	0.9138	0.8850
35	North Dakota	0.7743	0.9097	0.8646	0.8194
36	Ohio	0.8693	0.9477	0.9216	0.8954
37	Oklahoma	0.7686	0.9074	0.8612	0.8149
38	Oregon	0.9914	0.9966	0.9948	0.9931
39	Pennsylvania	0.8310	0.9324	0.8986	0.8648
40	Puerto Rico[6]	------	------	------	------
41	Rhode Island[6]	------	------	------	------
42	South Carolina	0.8683	0.9473	0.9210	0.8946
43	South Dakota	0.8398	0.9359	0.9039	0.8718
44	Tennessee	0.7869	0.9148	0.8721	0.8295
45	Texas	0.7966	0.9186	0.8780	0.8373
46	Utah	0.8287	0.9315	0.8972	0.8630
47	Vermont	0.9375	0.9750	0.9625	0.9500
49	Virginia	0.8049	0.9220	0.8829	0.8439
50	Washington	1.0312	1.0125	1.0187	1.0250
51	West Virginia	0.7865	0.9146	0.8719	0.8292
52	Wisconsin	0.9492	0.9797	0.9695	0.9594
53	Wyoming	0.9182	0.9673	0.9509	0.9346

1 As discussed in section IV.C.1.d. of the preamble of this proposed rule, because there are no longer any LTCHs in their cost reporting period that began during FY 2003 (the first year of the 5-year wage index phase-in), we are no longer showing the 1/5th wage index value. For further details on the 5-year phase-in of the wage index, see section IV.C.1.of this proposed rule.

2 Wage index calculated using the same wage data used to compute the wage index used by acute care hospitals under the IPPS for Federal FY 2005 (that is, fiscal year 2001 audited acute care hospital inpatient wage data) without regard to reclassification under section 1886(d)(8) or section 1886(d)(10) of the Act.

3 Two-fifths of the proposed full wage index value, applicable for a LTCH's cost reporting period beginning on or after October 1, 2003 through September 30, 2004 (Federal FY 2004). That is, for a LTCH's cost reporting period that begins during Federal FY 2004 and located in rural Illinois, the proposed 2/5^{ths} wage index value is computed as ((2*0.8339) + 3))/5 = 0.9336. For further details on the 5-year phase-in of the wage index, see section IV.C.1. of this proposed rule.

4 Three-fifths of the proposed full wage index value, applicable for a LTCH's cost reporting period beginning on or after October 1, 2005 through September 30, 2006 (Federal FY 2005). That is, for a LTCH's cost reporting period that begins during Federal FY 2005 and located in rural Illinois, the proposed 3/5^{ths} wage index value is computed as ((3*0.8339) + 2))/5 = 0.9003. For further details on the 5-year phase-in of the wage index, see section IV.C.1. of this proposed rule.

5 Four-fifths of the proposed full wage index value, applicable for a LTCH's cost reporting period beginning on or after October 1, 2006 through September 30, 2007 (Federal FY 2006). That is, for a LTCH's cost reporting period that begins during Federal FY 2006 and located in rural Illinois, the proposed 4/5^{ths} wage index value is computed as ((3*0.8339) + 2))/5 = 0.8671. For further details on the 5-year phase-in of the wage index, see section IV.C.1. of this proposed rule.

6 All counties within the State are classified as urban.

TABLE 3.-- FY 2005 LTC-DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY

LTC-DRG	Description	Relative Weight	Geo-metric Average Length of Stay	5/6ths of the Geo-metric Average Length of Stay
1	4 CRANIOTOMY AGE >17 W CC	1.1899	28.5	23.8
2	8 CRANIOTOMY AGE >17 W/O CC	1.1899	28.5	23.8
3	8 CRANIOTOMY AGE 0-17	1.1899	28.5	23.8
6	8 CARPAL TUNNEL RELEASE	0.6064	21.1	17.6
7	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC	1.4458	36.7	30.6
8	2 PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC	0.6064	21.1	17.6
9	SPINAL DISORDERS & INJURIES	1.0950	31.3	26.1
10	NERVOUS SYSTEM NEOPLASMS W CC	0.9022	25.0	20.8
11	1 NERVOUS SYSTEM NEOPLASMS W/O CC	0.4586	16.9	14.1
12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	0.7416	25.6	21.3
13	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	0.7820	24.6	20.5
14	INTRACRANIAL HEMORRHAGE OR STROKE W INFARCT	0.8189	25.9	21.6
15	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT	0.7868	27.2	22.7
16	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	0.8358	24.7	20.6
17	2 NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	0.6064	21.1	17.6
18	CRANIAL & PERIPHERAL NERVE DISORDERS W CC	0.7755	24.8	20.7
19	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	0.6583	21.1	17.6
20	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	1.0558	27.0	22.5
21	4 VIRAL MENINGITIS	1.1899	28.5	23.8
22	2 HYPERTENSIVE ENCEPHALOPATHY	0.6064	21.1	17.6
23	NONTRAUMATIC STUPOR & COMA	1.1225	26.6	22.2
24	SEIZURE & HEADACHE AGE >17 W CC	0.6740	22.4	18.7
25	2 SEIZURE & HEADACHE AGE >17 W/O CC	0.6064	21.1	17.6
26	8 SEIZURE & HEADACHE AGE 0-17	0.6064	21.1	17.6
27	TRAUMATIC STUPOR & COMA, COMA >1 HR	1.1418	28.3	23.6
28	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W CC	0.9250	29.8	24.8
29	3 TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC	0.8508	24.3	20.3
30	8 TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0-17	0.8508	24.3	20.3
31	2 CONCUSSION AGE >17 W CC	0.6064	21.1	17.6

LTC-DRG	Description	Relative Weight	Geo-metric Average Length of Stay	5/6ths of the Geo-metric Average Length of Stay
32	8 CONCUSSION AGE >17 W/O CC	0.6064	21.1	17.6
33	8 CONCUSSION AGE 0-17	0.6064	21.1	17.6
34	OTHER DISORDERS OF NERVOUS SYSTEM W CC	0.8418	24.2	20.2
35	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	0.6976	22.6	18.8
36	8 RETINAL PROCEDURES	0.4586	16.9	14.1
37	8 ORBITAL PROCEDURES	0.4586	16.9	14.1
38	8 PRIMARY IRIS PROCEDURES	0.4586	16.9	14.1
39	8 LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	0.4586	16.9	14.1
40	8 EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	0.4586	16.9	14.1
41	8 EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17	0.4586	16.9	14.1
42	8 INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	0.4586	16.9	14.1
43	1 HYPHEMA	0.4586	16.9	14.1
44	3 ACUTE MAJOR EYE INFECTIONS	0.8508	24.3	20.3
45	1 NEUROLOGICAL EYE DISORDERS	0.4586	16.9	14.1
46	2 OTHER DISORDERS OF THE EYE AGE >17 W CC	0.6064	21.1	17.6
47	1 OTHER DISORDERS OF THE EYE AGE >17 W/O CC	0.4586	16.9	14.1
48	8 OTHER DISORDERS OF THE EYE AGE 0-17	0.4586	16.9	14.1
49	8 MAJOR HEAD & NECK PROCEDURES	1.1899	28.5	23.8
50	8 SIALOADENECTOMY	1.1899	28.5	23.8
51	8 SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	1.1899	28.5	23.8
52	8 CLEFT LIP & PALATE REPAIR	1.1899	28.5	23.8
53	8 SINUS & MASTOID PROCEDURES AGE >17	1.1899	28.5	23.8

LTC-DRG	Description	Relative Weight	Geo-metric Average Length of Stay	5/6ths of the Geo-metric Average Length of Stay
54	8 SINUS & MASTOID PROCEDURES AGE 0-17	1.1899	28.5	23.8
55	5 MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES	1.8658	38.6	32.2
56	8 RHINOPLASTY	1.1899	28.5	23.8
57	8 T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	0.6064	21.1	17.6
58	8 T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	0.6064	21.1	17.6
59	8 TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	0.6064	21.1	17.6
60	8 TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	0.6064	21.1	17.6
61	8 MYRINGOTOMY W TUBE INSERTION AGE >17	0.6064	21.1	17.6
62	8 MYRINGOTOMY W TUBE INSERTION AGE 0-17	0.6064	21.1	17.6
63	4 OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES	1.1899	28.5	23.8
64	EAR, NOSE, MOUTH & THROAT MALIGNANCY	1.2588	27.4	22.8
65	DYSEQUILIBRIUM	0.3858	16.2	13.5
66	8 EPISTAXIS	0.6064	21.1	17.6
67	8 EPIGLOTTITIS	1.1899	28.5	23.8
68	OTITIS MEDIA & URI AGE >17 W CC	0.6115	21.3	17.8
69	2 OTITIS MEDIA & URI AGE >17 W/O CC	0.6064	21.1	17.6
70	8 OTITIS MEDIA & URI AGE 0-17	0.6064	21.1	17.6
71	8 LARYNGOTRACHEITIS	0.4586	16.9	14.1
72	8 NASAL TRAUMA & DEFORMITY	0.8508	24.3	20.3
73	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17	0.9341	23.5	19.6
74	8 OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0-17	0.6064	21.1	17.6
75	MAJOR CHEST PROCEDURES	2.0661	31.9	26.6

LTC-DRG	Description	Relative Weight	Geo-metric Average Length of Stay	5/6ths of the Geo-metric Average Length of Stay
76	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.3823	41.6	34.7
77	5 OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	1.8658	38.6	32.2
78	PULMONARY EMBOLISM	0.7424	22.0	18.3
79	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	0.9350	23.7	19.8
80	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC	0.9215	26.7	22.3
81	8 RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0-17	0.6064	21.1	17.6
82	RESPIRATORY NEOPLASMS	0.7591	19.9	16.6
83	2 MAJOR CHEST TRAUMA W CC	0.6064	21.1	17.6
84	1 MAJOR CHEST TRAUMA W/O CC	0.4586	16.9	14.1
85	7 PLEURAL EFFUSION W CC	0.7852	22.0	18.3
86	7 PLEURAL EFFUSION W/O CC	0.7852	22.0	18.3
87	PULMONARY EDEMA & RESPIRATORY FAILURE	1.6797	30.4	25.3
88	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	0.7334	20.1	16.8
89	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	0.7762	21.2	17.7
90	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	0.7494	21.9	18.3
91	8 SIMPLE PNEUMONIA & PLEURISY AGE 0-17	0.8508	24.3	20.3
92	INTERSTITIAL LUNG DISEASE W CC	0.7318	20.4	17.0
93	1 INTERSTITIAL LUNG DISEASE W/O CC	0.4586	16.9	14.1
94	PNEUMOTHORAX W CC	0.8348	21.3	17.8
95	1 PNEUMOTHORAX W/O CC	0.4586	16.9	14.1
96	BRONCHITIS & ASTHMA AGE >17 W CC	0.7575	20.2	16.8
97	BRONCHITIS & ASTHMA AGE >17 W/O CC	0.5305	16.6	13.8
98	8 BRONCHITIS & ASTHMA AGE 0-17	0.4586	16.9	14.1
99	RESPIRATORY SIGNS & SYMPTOMS W CC	1.0648	25.8	21.5
100	RESPIRATORY SIGNS & SYMPTOMS W/O CC	0.9048	22.9	19.1

LTC-DRG	Description	Relative Weight	Geo-metric Average Length of Stay	5/6ths of the Geo-metric Average Length of Stay
101	7 OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	0.8737	21.9	18.3
102	7 OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	0.8737	21.9	18.3
103	6 HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM	0.0000	0.0	0.0
104	8 CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W CARD CATH	0.4586	16.9	14.1
105	8 CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W/O CARD CATH	0.4586	16.9	14.1
106	8 CORONARY BYPASS W PTCA	0.4586	16.9	14.1
107	8 CORONARY BYPASS W CARDIAC CATH	0.4586	16.9	14.1
108	4 OTHER CARDIOTHORACIC PROCEDURES	1.1899	28.5	23.8
109	2 CORONARY BYPASS W/O PTCA OR CARDIAC CATH	0.6064	21.1	17.6
110	1 MAJOR CARDIOVASCULAR PROCEDURES W CC	0.4586	16.9	14.1
111	8 MAJOR CARDIOVASCULAR PROCEDURES W/O CC	0.4586	16.9	14.1
113	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE	1.3298	36.2	30.2
114	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	1.1780	33.3	27.8
115	4 PRM CARD PACEM IMPL W AMI/HR/SHOCK OR AICD LEAD OR GNRTR	1.1899	28.5	23.8
116	5 OTHER PERMANENT CARDIAC PACEMAKER IMPLANT	1.8658	38.6	32.2
117	2 CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT	0.6064	21.1	17.6
118	5 CARDIAC PACEMAKER DEVICE REPLACEMENT	1.8658	38.6	32.2
119	1 VEIN LIGATION & STRIPPING	0.4586	16.9	14.1
120	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	1.2014	32.6	27.2
121	CIRCULATORY DISORDERS W AMI & MAJOR COMP, DISCHARGED ALIVE	0.8293	21.8	18.2

LTC-DRG	Description	Relative Weight	Geo-metric Average Length of Stay	5/6ths of the Geo-metric Average Length of Stay
122	3 CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE	0.8508	24.3	20.3
123	CIRCULATORY DISORDERS W AMI, EXPIRED	0.9890	18.6	15.5
124	3 CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG	0.8508	24.3	20.3
125	5 CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG	1.8658	38.6	32.2
126	ACUTE & SUBACUTE ENDOCARDITIS	0.8439	24.6	20.5
127	HEART FAILURE & SHOCK	0.7597	21.6	18.0
128	3 DEEP VEIN THROMBOPHLEBITIS	0.8508	24.3	20.3
129	2 CARDIAC ARREST, UNEXPLAINED	0.6064	21.1	17.6
130	PERIPHERAL VASCULAR DISORDERS W CC	0.7072	22.7	18.9
131	PERIPHERAL VASCULAR DISORDERS W/O CC	0.5718	20.6	17.2
132	ATHEROSCLEROSIS W CC	0.7086	22.6	18.8
133	ATHEROSCLEROSIS W/O CC	0.5629	19.4	16.2
134	HYPERTENSION	0.6674	21.5	17.9
135	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC	0.8908	24.6	20.5
136	3 CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC	0.8508	24.3	20.3
137	8 CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0-17	0.8508	24.3	20.3
138	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	0.7451	22.0	18.3
139	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	0.5488	19.3	16.1
140	2 ANGINA PECTORIS	0.6064	21.1	17.6
141	7 SYNCOPE & COLLAPSE W CC	0.5304	22.5	18.8
142	7 SYNCOPE & COLLAPSE W/O CC	0.5304	22.5	18.8
143	1 CHEST PAIN	0.4586	16.9	14.1
144	7 OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	0.7913	21.8	18.2

LTC-DRG	Description	Relative Weight	Geo-metric Average Length of Stay	5/6ths of the Geo-metric Average Length of Stay
145	7 OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	0.7913	21.8	18.2
146	8 RECTAL RESECTION W CC	1.8658	38.6	32.2
147	8 RECTAL RESECTION W/O CC	1.8658	38.6	32.2
148	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	2.0460	35.1	29.3
149	1 MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	0.4586	16.9	14.1
150	5 PERITONEAL ADHESIOLYSIS W CC	1.8658	38.6	32.2
151	8 PERITONEAL ADHESIOLYSIS W/O CC	1.8658	38.6	32.2
152	5 MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.8658	38.6	32.2
153	8 MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.8658	38.6	32.2
154	5 STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC	1.8658	38.6	32.2
155	8 STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC	1.8658	38.6	32.2
156	8 STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0-17	1.8658	38.6	32.2
157	4 ANAL & STOMAL PROCEDURES W CC	1.1899	28.5	23.8
158	8 ANAL & STOMAL PROCEDURES W/O CC	1.1899	28.5	23.8
159	3 HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC	0.8508	24.3	20.3
160	8 HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC	0.8508	24.3	20.3
161	5 INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC	1.8658	38.6	32.2
162	8 INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC	0.4586	16.9	14.1
163	8 HERNIA PROCEDURES AGE 0-17	0.4586	16.9	14.1
164	8 APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	1.8658	38.6	32.2
165	8 APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	1.8658	38.6	32.2

LTC-DRG	Description	Relative Weight	Geo-metric Average Length of Stay	5/6ths of the Geo-metric Average Length of Stay
166	8 APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	1.8658	38.6	32.2
167	8 APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	1.8658	38.6	32.2
168	4 MOUTH PROCEDURES W CC	1.1899	28.5	23.8
169	8 MOUTH PROCEDURES W/O CC	0.8508	24.3	20.3
170	7 OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	1.7448	33.3	27.8
171	7 OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC	1.7448	33.3	27.8
172	7 DIGESTIVE MALIGNANCY W CC	0.8822	22.8	19.0
173	7 DIGESTIVE MALIGNANCY W/O CC	0.8822	22.8	19.0
174	7 G.I. HEMORRHAGE W CC	0.7067	21.9	18.3
175	7 G.I. HEMORRHAGE W/O CC	0.7067	21.9	18.3
176	COMPLICATED PEPTIC ULCER	1.0124	23.3	19.4
177	3 UNCOMPLICATED PEPTIC ULCER W CC	0.8508	24.3	20.3
178	1 UNCOMPLICATED PEPTIC ULCER W/O CC	0.4586	16.9	14.1
179	INFLAMMATORY BOWEL DISEASE	0.8728	23.4	19.5
180	G.I. OBSTRUCTION W CC	0.9438	22.2	18.5
181	2 G.I. OBSTRUCTION W/O CC	0.6064	21.1	17.6
182	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC	0.8373	23.1	19.3
183	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC	0.6992	20.7	17.3
184	8 ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0-17	0.6064	21.1	17.6
185	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17	0.8447	24.2	20.2
186	8 DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0-17	0.8508	24.3	20.3
187	8 DENTAL EXTRACTIONS & RESTORATIONS	0.8508	24.3	20.3

LTC-DRG	Description	Relative Weight	Geo-metric Average Length of Stay	5/6ths of the Geo-metric Average Length of Stay
188	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	0.9751	24.0	20.0
189	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	0.8839	22.9	19.1
190	8 OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17	0.8508	24.3	20.3
191	5 PANCREAS, LIVER & SHUNT PROCEDURES W CC	1.8658	38.6	32.2
192	8 PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	1.8658	38.6	32.2
193	1 BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC	0.4586	16.9	14.1
194	8 BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC	0.4586	16.9	14.1
195	8 CHOLECYSTECTOMY W C.D.E. W CC	1.8658	38.6	32.2
196	8 CHOLECYSTECTOMY W C.D.E. W/O CC	1.8658	38.6	32.2
197	5 CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	1.8658	38.6	32.2
198	8 CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC	1.8658	38.6	32.2
199	8 HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	0.8508	24.3	20.3
200	3 HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY	0.8508	24.3	20.3
201	4 OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES	1.1899	28.5	23.8
202	CIRRHOSIS & ALCOHOLIC HEPATITIS	0.7217	23.3	19.4
203	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	0.7867	20.9	17.4
204	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	0.8626	21.5	17.9
205	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC	0.7596	23.0	19.2
206	2 DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC	0.6064	21.1	17.6

LTC-DRG	Description	Relative Weight	Geo-metric Average Length of Stay	5/6ths of the Geo-metric Average Length of Stay
207	DISORDERS OF THE BILIARY TRACT W CC	0.6492	19.3	16.1
208	1 DISORDERS OF THE BILIARY TRACT W/O CC	0.4586	16.9	14.1
209	5 MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF LOWER EXTREMITY	1.8658	38.6	32.2
210	5 HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC	1.8658	38.6	32.2
211	8 HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC	1.8658	38.6	32.2
212	8 HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17	1.8658	38.6	32.2
213	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS	1.1696	33.9	28.3
216	5 BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	1.8658	38.6	32.2
217	WND DEBRID & SKN GRFT EXCEPT HAND, FOR MUSCSKELET & CONN TISS DIS	1.3123	37.2	31.0
218	4 LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W CC	1.1899	28.5	23.8
219	8 LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W/O CC	1.1899	28.5	23.8
220	8 LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE 0-17	1.1899	28.5	23.8
223	8 MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC	1.1899	28.5	23.8
224	8 SHOULDER, ELBOW OR FOREARM PROC, EXC MAJOR JOINT PROC, W/O CC	0.6064	21.1	17.6
225	FOOT PROCEDURES	1.0601	30.4	25.3
226	5 SOFT TISSUE PROCEDURES W CC	1.8658	38.6	32.2
227	2 SOFT TISSUE PROCEDURES W/O CC	0.6064	21.1	17.6
228	3 MAJOR THUMB OR JOINT PROC, OR OTH HAND OR WRIST PROC W CC	0.8508	24.3	20.3
229	1 HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	0.4586	16.9	14.1

LTC-DRG	Description	Relative Weight	Geo-metric Average Length of Stay	5/6ths of the Geo-metric Average Length of Stay
230	5 LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR	1.8658	38.6	32.2
232	8 ARTHROSCOPY	0.8508	24.3	20.3
233	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	1.5135	34.5	28.8
234	3 OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC	0.8508	24.3	20.3
235	FRACTURES OF FEMUR	0.7920	30.3	25.3
236	FRACTURES OF HIP & PELVIS	0.7348	26.9	22.4
237	1 SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH	0.4586	16.9	14.1
238	OSTEOMYELITIS	0.9329	28.9	24.1
239	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY	0.6619	21.4	17.8
240	CONNECTIVE TISSUE DISORDERS W CC	0.7160	23.1	19.3
241	1 CONNECTIVE TISSUE DISORDERS W/O CC	0.4586	16.9	14.1
242	SEPTIC ARTHRITIS	0.7943	26.2	21.8
243	MEDICAL BACK PROBLEMS	0.6072	22.3	18.6
244	BONE DISEASES & SPECIFIC ARTHROPATHIES W CC	0.5705	22.3	18.6
245	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	0.5109	19.3	16.1
246	NON-SPECIFIC ARTHROPATHIES	0.5884	21.4	17.8
247	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE	0.5445	21.4	17.8
248	TENDONITIS, MYOSITIS & BURSITIS	0.7830	24.3	20.3
249	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	0.6907	23.9	19.9
250	2 FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC	0.6064	21.1	17.6
251	2 FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC	0.6064	21.1	17.6
252	8 FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0-17	0.8508	24.3	20.3

LTC-DRG	Description	Relative Weight	Geo-metric Average Length of Stay	5/6ths of the Geo-metric Average Length of Stay
253	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W CC	0.8368	28.5	23.8
254	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W/O CC	0.6956	27.1	22.6
255	8 FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE 0-17	0.8508	24.3	20.3
256	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	0.7491	23.3	19.4
257	8 TOTAL MASTECTOMY FOR MALIGNANCY W CC	0.4586	16.9	14.1
258	8 TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.4586	16.9	14.1
259	8 SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC	0.4586	16.9	14.1
260	1 SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.4586	16.9	14.1
261	5 BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION	1.8658	38.6	32.2
262	3 BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY	0.8508	24.3	20.3
263	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	1.3568	39.1	32.6
264	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC	1.0622	33.0	27.5
265	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC	1.4363	35.7	29.8
266	3 SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC	0.8508	24.3	20.3
267	5 PERIANAL & PILONIDAL PROCEDURES	1.8658	38.6	32.2
268	5 SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES	1.8658	38.6	32.2
269	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.3904	38.4	32.0
270	3 OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC	0.8508	24.3	20.3

LTC-DRG	Description	Relative Weight	Geo-metric Average Length of Stay	5/6ths of the Geo-metric Average Length of Stay
271	SKIN ULCERS	0.9572	28.4	23.7
272	MAJOR SKIN DISORDERS W CC	0.7956	25.0	20.8
273	1 MAJOR SKIN DISORDERS W/O CC	0.4586	16.9	14.1
274	MALIGNANT BREAST DISORDERS W CC	0.9535	27.7	23.1
275	1 MALIGNANT BREAST DISORDERS W/O CC	0.4586	16.9	14.1
276	2 NON-MALIGANT BREAST DISORDERS	0.6064	21.1	17.6
277	CELLULITIS AGE >17 W CC	0.6711	21.6	18.0
278	CELLULITIS AGE >17 W/O CC	0.5277	19.0	15.8
279	8 CELLULITIS AGE 0-17	0.4586	16.9	14.1
280	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC	0.8840	27.1	22.6
281	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC	0.8190	28.3	23.6
282	8 TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0-17	0.8508	24.3	20.3
283	MINOR SKIN DISORDERS W CC	0.7712	22.9	19.1
284	1 MINOR SKIN DISORDERS W/O CC	0.4586	16.9	14.1
285	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DISORDERS	1.2799	35.9	29.9
286	8 ADRENAL & PITUITARY PROCEDURES	1.1899	28.5	23.8
287	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS	1.1090	32.4	27.0
288	3 O.R. PROCEDURES FOR OBESITY	0.8508	24.3	20.3
289	8 PARATHYROID PROCEDURES	1.1899	28.5	23.8
290	8 THYROID PROCEDURES	1.1899	28.5	23.8
291	8 THYROGLOSSAL PROCEDURES	1.1899	28.5	23.8
292	4 OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	1.1899	28.5	23.8
293	8 OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	1.1899	28.5	23.8
294	DIABETES AGE >35	0.7472	23.8	19.8
295	2 DIABETES AGE 0-35	0.6064	21.1	17.6
296	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	0.7973	23.7	19.8

LTC-DRG	Description	Relative Weight	Geo-metric Average Length of Stay	5/6ths of the Geo-metric Average Length of Stay
297	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC	0.6225	21.6	18.0
298	8 NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0-17	0.6064	21.1	17.6
299	4 INBORN ERRORS OF METABOLISM	1.1899	28.5	23.8
300	7 ENDOCRINE DISORDERS W CC	0.7948	24.6	20.5
301	7 ENDOCRINE DISORDERS W/O CC	0.7948	24.6	20.5
302	6 KIDNEY TRANSPLANT	0.0000	0.0	0.0
303	4 KIDNEY,URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM	1.1899	28.5	23.8
304	4 KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC	1.1899	28.5	23.8
305	2 KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC	0.6064	21.1	17.6
306	4 PROSTATECTOMY W CC	1.1899	28.5	23.8
307	3 PROSTATECTOMY W/O CC	0.8508	24.3	20.3
308	4 MINOR BLADDER PROCEDURES W CC	1.1899	28.5	23.8
309	8 MINOR BLADDER PROCEDURES W/O CC	1.1899	28.5	23.8
310	3 TRANSURETHRAL PROCEDURES W CC	0.8508	24.3	20.3
311	8 TRANSURETHRAL PROCEDURES W/O CC	0.8508	24.3	20.3
312	4 URETHRAL PROCEDURES, AGE >17 W CC	1.1899	28.5	23.8
313	8 URETHRAL PROCEDURES, AGE >17 W/O CC	1.1899	28.5	23.8
314	8 URETHRAL PROCEDURES, AGE 0-17	0.6064	21.1	17.6
315	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	1.4618	34.2	28.5
316	RENAL FAILURE	0.9175	23.6	19.7
317	ADMIT FOR RENAL DIALYSIS	0.9238	22.1	18.4
318	7 KIDNEY & URINARY TRACT NEOPLASMS W CC	0.7798	22.5	18.8
319	7 KIDNEY & URINARY TRACT NEOPLASMS W/O CC	0.7798	22.5	18.8
320	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	0.7798	22.5	18.8

LTC-DRG	Description	Relative Weight	Geo-metric Average Length of Stay	5/6ths of the Geo-metric Average Length of Stay
321	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	0.5721	21.9	18.3
322	8 KIDNEY & URINARY TRACT INFECTIONS AGE 0-17	0.4586	16.9	14.1
323	2 URINARY STONES W CC, &/OR ESW LITHOTRIPSY	0.6064	21.1	17.6
324	1 URINARY STONES W/O CC	0.4586	16.9	14.1
325	3 KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC	0.8508	24.3	20.3
326	1 KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC	0.4586	16.9	14.1
327	8 KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0-17	0.4586	16.9	14.1
328	2 URETHRAL STRICTURE AGE >17 W CC	0.6064	21.1	17.6
329	8 URETHRAL STRICTURE AGE >17 W/O CC	0.6064	21.1	17.6
330	8 URETHRAL STRICTURE AGE 0-17	0.6064	21.1	17.6
331	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC	0.8240	22.9	19.1
332	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC	0.6263	22.3	18.6
333	8 OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0-17	0.6064	21.1	17.6
334	8 MAJOR MALE PELVIC PROCEDURES W CC	1.8658	38.6	32.2
335	8 MAJOR MALE PELVIC PROCEDURES W/O CC	1.8658	38.6	32.2
336	4 TRANSURETHRAL PROSTATECTOMY W CC	1.1899	28.5	23.8
337	8 TRANSURETHRAL PROSTATECTOMY W/O CC	1.1899	28.5	23.8
338	5 TESTES PROCEDURES, FOR MALIGNANCY	1.8658	38.6	32.2
339	1 TESTES PROCEDURES, NON-MALIGNANCY AGE >17	0.4586	16.9	14.1

LTC-DRG	Description	Relative Weight	Geo-metric Average Length of Stay	5/6ths of the Geo-metric Average Length of Stay
340	8 TESTES PROCEDURES, NON-MALIGNANCY AGE 0-17	0.4586	16.9	14.1
341	5 PENIS PROCEDURES	1.8658	38.6	32.2
342	8 CIRCUMCISION AGE >17	0.4586	16.9	14.1
343	8 CIRCUMCISION AGE 0-17	0.4586	16.9	14.1
344	5 OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY	1.8658	38.6	32.2
345	5 OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY	1.8658	38.6	32.2
346	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC	0.6556	20.8	17.3
347	1 MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC	0.4586	16.9	14.1
348	2 BENIGN PROSTATIC HYPERTROPHY W CC	0.6064	21.1	17.6
349	2 BENIGN PROSTATIC HYPERTROPHY W/O CC	0.6064	21.1	17.6
350	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	0.7789	22.6	18.8
351	8 STERILIZATION, MALE	0.4586	16.9	14.1
352	4 OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	1.1899	28.5	23.8
353	8 PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY	1.8658	38.6	32.2
354	8 UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	1.8658	38.6	32.2
355	8 UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC	1.8658	38.6	32.2
356	8 FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	1.1899	28.5	23.8
357	8 UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY	1.1899	28.5	23.8
358	8 UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	1.1899	28.5	23.8

LTC-DRG	Description	Relative Weight	Geo-metric Average Length of Stay	5/6ths of the Geo-metric Average Length of Stay
359	8 UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	1.1899	28.5	23.8
360	8 VAGINA, CERVIX & VULVA PROCEDURES	1.1899	28.5	23.8
361	8 LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	0.4586	16.9	14.1
362	8 ENDOSCOPIC TUBAL INTERRUPTION	0.4586	16.9	14.1
363	8 D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	0.4586	16.9	14.1
364	8 D&C, CONIZATION EXCEPT FOR MALIGNANCY	0.4586	16.9	14.1
365	5 OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	1.8658	38.6	32.2
366	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	1.0345	23.9	19.9
367	1 MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	0.4586	16.9	14.1
368	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	0.7168	22.5	18.8
369	3 MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	0.8508	24.3	20.3
370	8 CESAREAN SECTION W CC	0.8508	24.3	20.3
371	8 CESAREAN SECTION W/O CC	0.4586	16.9	14.1
372	8 VAGINAL DELIVERY W COMPLICATING DIAGNOSES	0.4586	16.9	14.1
373	8 VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	0.4586	16.9	14.1
374	8 VAGINAL DELIVERY W STERILIZATION &/OR D&C	0.4586	16.9	14.1
375	8 VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	0.4586	16.9	14.1
376	8 POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	0.4586	16.9	14.1
377	8 POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	0.4586	16.9	14.1

LTC-DRG	Description	Relative Weight	Geo-metric Average Length of Stay	5/6ths of the Geo-metric Average Length of Stay
378	8 ECTOPIC PREGNANCY	0.8508	24.3	20.3
379	8 THREATENED ABORTION	0.4586	16.9	14.1
380	8 ABORTION W/O D&C	0.4586	16.9	14.1
381	8 ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	0.4586	16.9	14.1
382	8 FALSE LABOR	0.4586	16.9	14.1
383	8 OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	0.4586	16.9	14.1
384	8 OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	0.4586	16.9	14.1
385	8 NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	0.4586	16.9	14.1
386	8 EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	0.4586	16.9	14.1
387	8 PREMATURITY W MAJOR PROBLEMS	0.4586	16.9	14.1
388	8 PREMATURITY W/O MAJOR PROBLEMS	0.4586	16.9	14.1
389	8 FULL TERM NEONATE W MAJOR PROBLEMS	0.4586	16.9	14.1
390	8 NEONATE W OTHER SIGNIFICANT PROBLEMS	0.4586	16.9	14.1
391	8 NORMAL NEWBORN	0.4586	16.9	14.1
392	8 SPLENECTOMY AGE >17	1.8658	38.6	32.2
393	8 SPLENECTOMY AGE 0-17	1.8658	38.6	32.2
394	4 OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS	1.1899	28.5	23.8
395	RED BLOOD CELL DISORDERS AGE >17	0.7516	23.7	19.8
396	8 RED BLOOD CELL DISORDERS AGE 0-17	0.6064	21.1	17.6
397	COAGULATION DISORDERS	0.7827	19.2	16.0
398	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	0.7520	21.4	17.8
399	2 RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC	0.6064	21.1	17.6

LTC-DRG	Description	Relative Weight	Geo-metric Average Length of Stay	5/6ths of the Geo-metric Average Length of Stay
401	4 LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	1.1899	28.5	23.8
402	8 LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC	0.8508	24.3	20.3
403	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	0.8996	22.0	18.3
404	1 LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	0.4586	16.9	14.1
405	8 ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0-17	0.4586	16.9	14.1
406	5 MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC	1.8658	38.6	32.2
407	8 MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC	1.1899	28.5	23.8
408	4 MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC	1.1899	28.5	23.8
409	RADIOTHERAPY	0.9104	22.6	18.8
410	4 CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	1.1899	28.5	23.8
411	8 HISTORY OF MALIGNANCY W/O ENDOSCOPY	0.4586	16.9	14.1
412	8 HISTORY OF MALIGNANCY W ENDOSCOPY	0.4586	16.9	14.1
413	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	0.8807	20.7	17.3
414	2 OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC	0.6064	21.1	17.6
415	O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	1.5485	36.5	30.4
416	SEPTICEMIA AGE >17	0.8961	23.9	19.9
417	8 SEPTICEMIA AGE 0-17	0.8508	24.3	20.3
418	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	0.8697	24.7	20.6
419	4 FEVER OF UNKNOWN ORIGIN AGE >17 W CC	1.1899	28.5	23.8

LTC-DRG	Description	Relative Weight	Geo-metric Average Length of Stay	5/6ths of the Geo-metric Average Length of Stay
420	4 FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	1.1899	28.5	23.8
421	VIRAL ILLNESS AGE >17	1.0125	25.1	20.9
422	8 VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0-17	0.6064	21.1	17.6
423	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	0.9425	22.8	19.0
424	5 O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	1.8658	38.6	32.2
425	ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION	0.5649	21.2	17.7
426	DEPRESSIVE NEUROSES	0.5777	26.6	22.2
427	1 NEUROSES EXCEPT DEPRESSIVE	0.4586	16.9	14.1
428	DISORDERS OF PERSONALITY & IMPULSE CONTROL	0.6617	29.1	24.3
429	ORGANIC DISTURBANCES & MENTAL RETARDATION	0.5767	24.4	20.3
430	PSYCHOSES	0.4746	22.7	18.9
431	CHILDHOOD MENTAL DISORDERS	0.4875	22.0	18.3
432	8 OTHER MENTAL DISORDER DIAGNOSES	0.4586	16.9	14.1
433	1 ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	0.4586	16.9	14.1
439	SKIN GRAFTS FOR INJURIES	1.0808	35.0	29.2
440	WOUND DEBRIDEMENTS FOR INJURIES	1.2254	32.2	26.8
441	2 HAND PROCEDURES FOR INJURIES	0.6064	21.1	17.6
442	7 OTHER O.R. PROCEDURES FOR INJURIES W CC	1.4772	37.3	31.1
443	7 OTHER O.R. PROCEDURES FOR INJURIES W/O CC	1.4772	37.3	31.1
444	7 TRAUMATIC INJURY AGE >17 W CC	0.8051	24.4	20.3
445	7 TRAUMATIC INJURY AGE >17 W/O CC	0.8051	24.4	20.3
446	8 TRAUMATIC INJURY AGE 0-17	0.8508	24.3	20.3
447	3 ALLERGIC REACTIONS AGE >17	0.8508	24.3	20.3
448	8 ALLERGIC REACTIONS AGE 0-17	0.8508	24.3	20.3
449	2 POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC	0.6064	21.1	17.6

LTC-DRG	Description	Relative Weight	Geo-metric Average Length of Stay	5/6ths of the Geo-metric Average Length of Stay
450	1 POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC	0.4586	16.9	14.1
451	8 POISONING & TOXIC EFFECTS OF DRUGS AGE 0-17	0.6064	21.1	17.6
452	COMPLICATIONS OF TREATMENT W CC	0.9938	25.4	21.2
453	COMPLICATIONS OF TREATMENT W/O CC	0.7085	22.0	18.3
454	3 OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC	0.8508	24.3	20.3
455	2 OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC	0.6064	21.1	17.6
461	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES	1.2824	35.2	29.3
462	REHABILITATION	0.6569	23.2	19.3
463	SIGNS & SYMPTOMS W CC	0.6631	23.4	19.5
464	SIGNS & SYMPTOMS W/O CC	0.5561	22.7	18.9
465	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	0.6885	20.5	17.1
466	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	0.7286	22.2	18.5
467	2 OTHER FACTORS INFLUENCING HEALTH STATUS	0.6064	21.1	17.6
468	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	2.1286	41.7	34.8
469	6 PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	0.0000	0.0	0.0
470	6 UNGROUPABLE	0.0000	0.0	0.0
471	8 BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY	0.8508	24.3	20.3
473	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	0.8622	20.7	17.3
475	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	2.1015	34.2	28.5
476	3 PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	0.8508	24.3	20.3
477	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	1.5653	35.2	29.3
478	OTHER VASCULAR PROCEDURES W CC	1.4010	33.3	27.8

LTC-DRG	Description	Relative Weight	Geo-metric Average Length of Stay	5/6ths of the Geo-metric Average Length of Stay
479	2 OTHER VASCULAR PROCEDURES W/O CC	0.6064	21.1	17.6
480	6 LIVER TRANSPLANT	0.0000	0.0	0.0
481	8 BONE MARROW TRANSPLANT	1.1899	28.5	23.8
482	8 TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES	1.1899	28.5	23.8
484	8 CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	1.1899	28.5	23.8
485	4 LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TRA	1.1899	28.5	23.8
486	5 OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA	1.8658	38.6	32.2
487	OTHER MULTIPLE SIGNIFICANT TRAUMA	1.1431	24.7	20.6
488	5 HIV W EXTENSIVE O.R. PROCEDURE	1.8658	38.6	32.2
489	HIV W MAJOR RELATED CONDITION	0.9854	23.7	19.8
490	HIV W OR W/O OTHER RELATED CONDITION	1.0495	23.3	19.4
491	8 MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY	1.8658	38.6	32.2
492	8 CHEMOTHERAPY W ACUTE LEUKEMIA OR W USE OF HI DOSE CHEMOAGENT	1.1899	28.5	23.8
493	4 LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.1899	28.5	23.8
494	8 LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	1.1899	28.5	23.8
495	6 LUNG TRANSPLANT	0.0000	0.0	0.0
496	3 COMBINED ANTERIOR/POSTERIOR SPINAL FUSION	0.8508	24.3	20.3
497	3 SPINAL FUSION EXCEPT CERVICAL W CC	0.8508	24.3	20.3
498	8 SPINAL FUSION EXCEPT CERVICAL W/O CC	0.8508	24.3	20.3
499	4 BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC	1.1899	28.5	23.8
500	1 BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC	0.4586	16.9	14.1

LTC-DRG	Description	Relative Weight	Geo-metric Average Length of Stay	5/6ths of the Geo-metric Average Length of Stay
501	4 KNEE PROCEDURES W PDX OF INFECTION W CC	1.1899	28.5	23.8
502	4 KNEE PROCEDURES W PDX OF INFECTION W/O CC	1.1899	28.5	23.8
503	4 KNEE PROCEDURES W/O PDX OF INFECTION	1.1899	28.5	23.8
504	8 EXTENSIVE BURNS OF FULL THICKNESS BURNS WITH MECH VENT 96+HRS WITH SKIN GRAFT	1.8658	38.6	32.2
505	3 EXTENSIVE BURNS OF FULL THICKNESS BURNS WITH MECH VENT 96+HRS WITHOUT SKIN GRAFT	0.8508	24.3	20.3
506	4 FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA	1.1899	28.5	23.8
507	8 FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA	0.8508	24.3	20.3
508	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ W CC OR SIG TRAUMA	0.8303	26.0	21.7
509	1 FULL THICKNESS BURN W/O SKIN GRFT OR INH INJ W/O CC OR SIG TRAUMA	0.4586	16.9	14.1
510	NON-EXTENSIVE BURNS W CC OR SIGNIFICANT TRAUMA	0.9301	26.8	22.3
511	2 NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA	0.6064	21.1	17.6
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 DEFIBRILLATOR IMPLANT W/O CARDIAC CATH	1.8658	38.6	32.2
516	8 PERCUTANEOUS CARDIOVASC PROC W AMI	0.6064	21.1	17.6
517	3 PERC CARDIO PROC W NON-DRUG ELUTING STENT W/O AMI	0.8508	24.3	20.3
518	2 PERC CARDIO PROC W/O CORONARY ARTERY STENT OR AMI	0.6064	21.1	17.6

LTC-DRG	Description	Relative Weight	Geo-metric Average Length of Stay	5/6ths of the Geo-metric Average Length of Stay
519	3 CERVICAL SPINAL FUSION W CC	0.8508	24.3	20.3
520	8 CERVICAL SPINAL FUSION W/O CC	0.8508	24.3	20.3
521	7 ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	0.6011	22.2	18.5
522	7 ALC/DRUG ABUSE OR DEPEND W REHABILITATION THERAPY W/O CC	0.6011	22.2	18.5
523	7 ALC/DRUG ABUSE OR DEPEND W/O REHABILITATION THERAPY W/O CC	0.6011	22.2	18.5
524	TRANSIENT ISCHEMIA	0.6247	22.0	18.3
525	8 OTHER HEART ASSIST SYSTEM IMPLANT	1.8658	38.6	32.2
526	8 PERCUTNEOUS CARDIOVASULAR PROC W DRUG ELUTING STENT W AMI	0.8508	24.3	20.3
527	8 PERCUTNEOUS CARDIOVASULAR PROC W DRUG ELUTING STENT W/O AMI	0.8508	24.3	20.3
528	8 INTRACRANIAL VASCULAR PROC W PDX HEMORRHAGE	1.1899	28.5	23.8
529	4 VENTRICULAR SHUNT PROCEDURES W CC	1.1899	28.5	23.8
530	8 VENTRICULAR SHUNT PROCEDURES W/O CC	1.1899	28.5	23.8
531	4 SPINAL PROCEDURES W CC	1.1899	28.5	23.8
532	1 SPINAL PROCEDURES W/O CC	0.4586	16.9	14.1
533	5 EXTRACRANIAL PROCEDURES W CC	1.8658	38.6	32.2
534	8 EXTRACRANIAL PROCEDURES W/O CC	0.4586	16.9	14.1
535	3 CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK	0.8508	24.3	20.3
536	5 CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK	1.8658	38.6	32.2
537	LOCAL EXCIS & REMOV OF INT FIX DEV EXCEPT HIP & FEMUR W CC	1.2686	35.2	29.3
538	3 LOCAL EXCIS & REMOV OF INT FIX DEV EXCEPT HIP & FEMUR W/O CC	0.8508	24.3	20.3
539	3 LYMPHOMA & LEUKEMIA W MAJOR OR PROCEDURE W CC	0.8508	24.3	20.3

LTC-DRG	Description	Relative Weight	Geo-metric Average Length of Stay	5/6ths of the Geo-metric Average Length of Stay
540	[8] LYMPHOMA & LEUKEMIA W MAJOR OR PROCEDURE W/O CC	0.6064	21.1	17.6
541	TRAC W MECH VENT 96+HRS OR PDX EXCEPT FACE,MOUTH & NECK DX WITH MAJOR OR	3.5184	56.2	46.8
542	TRAC W MECH VENT 96+HRS OR PDX EXCEPT FACE,MOUTH & NECK DX WITHOUT MAJOR OR	2.9337	45.9	38.3
543	[5] CRANIOTOMY W IMPLANT OF CHEMO AGENT OR ACUTE COMPLEX CNS PDX	1.8658	38.6	32.2

[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 after adjusting to account for nonmonotonicity (see step 5 above).

[8] Relative weights for these LTC-DRGs were determined by assigning these cases to the appropriate low volume quintile because they had no LTCH cases in the FY 2003 MedPAR file.

Table 4.—A LISTING OF LONG-TERM CARE HOSPITALS' STATE AND COUNTY LOCATION; CURRENT LABOR MARKET AREA DESIGNATION; AND PROPOSED NEW CBSA-BASED LABOR MARKET AREA DESIGNATION[1].

LTCH Provider Number	Name of LTCH	SSA State and County Code[2]	Proposed CBSA-based Labor Market Area[3]	Current MSA-based Labor Market Area[4]
012006	USA KNOLLWOOD PARK LTC HOSPITAL	01480	33660	5160
012007	LONG TERM CARE HOSP OF JACKSON, THE	01500	33860	5240
012008	SELECT SPECIALTY HOSP-BIRMINGHAM	01360	13820	1000
032000	KINDRED HOSPITAL ARIZONA PHOENIX	03060	38060	6200
032001	SELECT SPECIALTY HOSPITAL ARIZONA INC	03060	38060	6200
032002	KINDRED HOSPITAL - TUCSON	03090	46060	8520
032004	CORNERSTONE HOSPITAL OF SOUTHEAST AZ	03090	46060	8520
032005	SELECT SPECIALTY HOSPITAL ARIZONA INC	03060	38060	6200
042000	SELECT SPECIALTY HOSPITAL	04590	30780	4400
042004	ADVANCE CARE HOSPITAL	04250	26300	04
042005	SEMPERCARE HOSPITAL OF LITTLE ROCK	04590	30780	4400
042006	SELECT SPECIALITY HOSPITAL-FORT SMITH	04650	22900	2720
042007	SEMPERCARE HOSPITAL OF PINE BLUFF	04340	38220	6240
052031	BARLOW HOSPITAL	05200	31084	4480
052032	VENCOR HOSPITAL - LOS ANGELES	05200	31084	4480
052033	VENCOR HOSPITAL - SACRAMENTO	05440	40900	6920
052034	KINDRED HOSPITAL - SF BAY AREA	05000	36084	5775
052035	KINDRED HOSPITAL WESTMINSTER	05400	42044	5945
052036	KINDRED HOSPITAL - SAN DIEGO	05470	41740	7320
052037	VENCOR HOSPITAL - ONTARIO	05460	40140	6780
052038	KINDRED HOSPITAL -- SAN GABRIEL VALLEY	05200	31084	4480
052039	KINDRED HOSPITAL BREA	05400	42044	5945
052043	KENTFIELD REHABILITATION HOSPITAL	05310	41884	7360
052044	CONTINENTAL REHABILITATION HOSPITAL	05470	41740	7320
062008	CMHIP - GENERAL HOSPITAL	06500	39380	6560
062009	KINDRED HOSPITAL DENVER	06150	19740	2080
062011	CRAIG HOSPITAL	06020	19740	2080
062012	LIFECARE HOSPITALS OF DENVER	06150	19740	2080
062013	SCCI HOSPITAL - AURORA	06150	19740	2080
062014	NORTH VALLEY REHAB HOSPITAL - REHAB	06400	06	06

LTCH Provider Number	Name of LTCH	SSA State and County Code[2]	Proposed CBSA-based Labor Market Area[3]	Current MSA-based Labor Market Area[4]
062015	SELECT SPECIALTY HOSPITAL	06150	19740	2080
062016	SEMPERCARE HOSPITAL OF COLO SPRINGS	06200	17820	1720
072003	GAYLORD HOSPITAL INC	07040	35300	5483
072004	HOSPITAL FOR SPECIAL CARE	07010	25540	3283
082000	SELECT SPECIALTY HOSPITAL WILMINGTON	08010	48864	9160
092002	MEDLINK HOSPITAL OF CAPITOL HILL	09000	47894	8840
092003	HADLEY MEMORIAL HOSPITAL	09000	47894	8840
102001	SELECT SPECIALTY HOSPITAL OF MIAMI	10120	33124	5000
102009	KINDRED HOSPITAL BAY AREA TAMPA	10280	45300	8280
102010	KINDRED HOSPITAL SOUTH FLORIDA	10050	22744	2680
102012	SPECIALITY HOSPITAL JACKSONVILLE	10150	27260	3600
102013	KINDRED HOSPITAL CENTRAL TAMPA	10280	45300	8280
102015	KINDRED HOSPITAL NORTH FLORIDA	10090	27260	3600
112000	ROOSEVELT WARM SPRINGS INST FOR REHAB	11740	12060	11
112003	SHEPHERD SPINAL CENTER	11470	12060	0520
112004	KINDRED HOSPITAL - ATLANTA	11470	12060	0520
112005	WESLEY WOODS LTC	11370	12060	0520
112006	DECATUR HOSPITAL	11370	12060	0520
112007	WELLSTAR WINDY HILL HOSPITAL	11290	12060	0520
112008	SPECIALTY HOSPITAL - SELECT AUGUSTA	11840	12260	0600
112009	SELECT SPECIALTY HOSPITAL-ATLANTA	11470	12060	0520
112010	SPECIALTY HOSPITAL AT FLOYD MED CTR	11460	40660	11
112011			42340	7520
142006	THC CHICAGO INC DBA KINDRED HOSP	14170	16974	1600
142008	THC CHICAGO INC DBA KINDRED HOSP CHGO	14141	16974	1600
142009	THC CHICAGO INC DBA KINDRED CHICAGO	14141	16974	1600
142010	RML SPECIALTY HOSPITAL	14250	16974	1600
152007	KINDRED HOSPITAL INDIANAPOLIS	15480	26900	3480
152008	KINDRED HOSPITAL INDIANAPOLIS SOUTH	15400	26900	3480
152010	SELECT SPECIALTY HOSPITAL INDIANAPOLIS	15480	26900	3480
152011	ST ELIZABETH ANN SETON HOSPITAL	15260	15	15

LTCH Provider Number	Name of LTCH	SSA State and County Code[2]	Proposed CBSA-based Labor Market Area[3]	Current MSA-based Labor Market Area[4]
	INC			
152012	SELECT SPECIALTY HOSPITAL-NORTHWEST IN	15440	23844	2960
152013	SELECT SPECIALTY HOSPITAL-BEECH GROVE	15480	26900	3480
152014	SELECT SPECIALTY HOSPITAL-EVANSVILLE	15810	21780	2440
152015	ST ELIZABETH ANN SETON HOSPITAL OF CARMEL	15280	26900	3480
152016	SELECT SPECIALTY HOSPITAL-FT WAYNE	15010	23060	2760
152018	OUR LADY OF PEACE HOSPITAL	15700	43780	7800
152019	SELECT SPECIALTY HOSPITAL-BLOOMINGTON	15020	18020	15
152020	ST ELIZABETH ANN SETON HOSPITAL OF INDIANAPOLIS	15480	26900	3480
152021	ST ELIZABETH ANN SETON HOSPITAL OF KOKOMO	15330	29020	3850
172003	WICHITA SPECIALTY HOSPITAL	17860	48620	9040
172004	SPECIALTY HOSPITAL OF MID-AMERICA	17450	28140	3760
172005	SELECT SPECIALTY HOSPITAL OF KS CITY	17986	28140	3760
172006	SELECT SPECIALTY HOSPITAL OF TOPEKA	17880	45820	8440
172007	SELECT SPECIALTY HOSPITAL WICHITA	17860	48620	9040
182001	KINDRED HOSPITAL LOUISVILLE	18550	31140	4520
182002	CONTINUING CARE HOSP AT ST JOSEPH EAST	18330	30460	4280
182003	SELECT SPECIALTY HOSPITAL LEXINGTON	18330	30460	4280
192004	ASCENSION HOSPITAL	19020	12940	0760
192006	CORNERSTONE HOSPITAL OF BOSSIER CITY	19070	43340	7680
192007	ADVANCE CARE HOSPITAL	19250	35380	5560
192008	DIXON MEDICAL CENTER	19310	12940	0760
192009	KINDRED HOSPITAL NEW ORLEANS	19350	35380	5560
192010	LAGNIAPPE HOSPITAL	19080	43340	7680
192011	LIFECARE HOSPITAL INC	19080	43340	7680
192012	DUBUIS HOSPITAL OF ALEXANDRIA	19390	10780	0220
192013	CORNERSTONE HOSPITAL OF SOUTHWEST LA	19090	29340	3960

LTCH Provider Number	Name of LTCH	SSA State and County Code[2]	Proposed CBSA-based Labor Market Area[3]	Current MSA-based Labor Market Area[4]
192014	GENESIS SPECIALTY HOSPITAL	19060	19	19
192015	LIFE CARE HOSPITAL OF NEW ORLEANS LLC	19430	35380	5560
192016	ST FRANCIS SPECIALTY HOSPITAL	19360	33740	5200
192019	EXTENDED CARE OF SOUTHWEST LOUISIANA	19090	29340	3960
192020	COMMUNITY REHABILITATION OF LAFAYETTE	19270	29180	3880
192022	HEALTHSOUTH NORTH REHAB HOSPITAL	19300	19	19
192023	SPECIALTY HOSPITAL OF NEW ORLEANS	19350	35380	5560
192024	DUBUIS HOSPITAL OF LAKE CHARLES	19090	29340	3960
192025	DUBUIS HOSPITAL OF SHREVEPORT	19080	43340	7680
192026	BERNICE COMMUNITY HOSPITAL	19550	33740	19
192027	OASIS REHABILITATION HOSPITAL	19160	12940	0760
192028	PROFESSIONAL REHABILITATION HOSPITAL	19140	19	19
192029	REHABILITATION HOSP OF ACADIANA	19270	29180	3880
192030	SELECT SPECIALTY HOSPITAL	19250	35380	5560
192031	CORNERSTONE HOSPITAL WEST MONROE	19070	43340	7680
192032	LOUISIANA EXTENDED CARE HOSPITAL LAFAYETTE	19270	29180	3880
192033	MEADOWBROOK REHABILITATION HOSPITAL	19270	29180	3880
192034	ST LANDRY EXTENDED CARE HOSPITAL LLC	19480	19	3880
192035	LOUISISANA EXTENDED CARE HOSP. OF NATCHITOCHES	19340	19	19
192036	HAMMOND REHABILITATION HOSPITAL	19520	19	19
192037	ST ANNE REHABILITATION HOSPITAL	19280	26380	3350
192038	LIFE CARE HOSP. OF NEW ORLEANS KENNER REGIONAL	19350	35380	5560
192039	OASIS LONG TERM ACUTE CARE HOSPITAL	19350	35380	5560
192040	SOUTHEAST REGIONAL MEDICAL CENTER	19520	19	19
192041	CLINTON REHABILITATION HOSPITAL	19180	12940	19
192042	LOUISIANA EXTENDED CARE HOSP	19060	19	19
192043	HEALTHSOUTH OF ALEXANDRIA INC	19390	10780	0220
192044			12940	0760
222000	YOUVILLE REHAB CHRONIC DISEASE HOSP	22090	15764	1123

LTCH Provider Number	Name of LTCH	SSA State and County Code[2]	Proposed CBSA-based Labor Market Area[3]	Current MSA-based Labor Market Area[4]
222002	NORTHEAST SPECIALTY HOSP BRAINTREE	22150	14484	1123
222006	LEMUEL SHATTUCK HOSP	22160	14484	1123
222007	HEBREW REHABILITATION CENTER FOR AGED	22160	14484	1123
222010	JEWISH MEMORIAL HOSPITAL	22160	14484	1123
222026	SHAUGHNESSY-KAPLAN REHAB HOSP HOSP	22040	21604	1123
222027	NEW ENGLAND SINIAI HOSP & REHAB CENTER	22130	14484	1123
222035	SPAULDING REHAB HOSP	22160	14484	1123
222043	SUNHEALTH SPECIALTY HOSPITAL OF SOE MA	22020	39300	1123
222044	VENCOR HOSPITAL NORTH SHORE	22040	21604	1123
222045	KINDRED HOSPITAL - BOSTON	22160	14484	1123
222046	PARK VIEW SPECIALTY HOSPITAL	22070	44140	8003
232012	SELECT SPECIALTY HOSPITAL-FLINT	23240	22420	2640
232019	KINDRED HOSPITAL - DETROIT	23810	19804	2160
232020	BAY SPECIAL CARE CENTER	23080	13020	6960
232021	SELECT SPECIALTY HOSPITAL-WESTERN MICH	23600	34740	3000
232023	SELECT SPECIALTY HOSP-MACOMB CTY INC	23490	47644	2160
232024	SELECT SPECIALTY HOSPITAL-ANN ARBOR	23800	11460	0440
232025	LAKELAND SPECIALTY HOSP AT BERRIEN CTR	23100	35660	0870
232026	LIFECARE HOSPITALS OF WESTERN MICHIGAN	23600	34740	3000
232027			19804	2160
232028	SELECT SPECIALTY HOSPITAL-BATTLE CREEK	23120	12980	3720
232029	SPECTRUM HEALTH-KENT COMMUNITY CAMP	23400	24340	3000
232030			47644	2160
232031	SELECT SPECIALTY HOSPITAL-WYANDOTTE	23810	19804	2160
232032	SELECT SPECIALTY HOSPITAL - NW DETROIT	23810	19804	2160
232033	SELECT SPECIALTY HOSPITAL-SAGINAW	23720	40980	6960
232034	BORGESS-PIPP HEALTH CENTER	23020	23	3000
232035	SEMPERCARE HOSITAL AT BRONSON	23380	28020	3720

LTCH Provider Number	Name of LTCH	SSA State and County Code[2]	Proposed CBSA-based Labor Market Area[3]	Current MSA-based Labor Market Area[4]
242004	HEALTHEAST BETHESDA LUTHERAN HOME	24610	33460	5120
242005	KINDRED HOSPITAL - MINNESOTA	24260	33460	5120
252003	RESTORATIVE CARE HOSPITAL,THE	25240	27140	3560
252005	SELECT SPECIALTY HOSPITAL-BILOXI	25230	25060	0920
252006			25	25
252007	SELECT SPECIALTY HOSPITAL JACKSON	25240	27140	3560
262001	MISSOURI REHABILITATION CTR	26540	26	26
262010	KINDRED HOSPITAL - ST LOUIS	26950	41180	7040
262011	KINDRED HOSPITAL - KANSAS CITY	26470	28140	3760
262012	ALL SAINTS SPECIAL CARE CENTER	26940	41180	7040
262013	SELECT SPECIALTY HOSPITAL	26940	41180	7040
282000	MADONNA REHABILITATION LTC HOSPITAL	28540	30700	4360
282001	SELECT SPECIALTY HOSPITAL - OMAHA	28760	36540	5920
292002	KINDRED HOSPITAL LAS VEGAS	29010	29820	4120
292003	HORIZON SPECIALTY HOSPITAL	29010	29820	4120
292004	TAHOE PACIFIC HOSPITAL- MEADOWS	29150	39900	6720
292005	SELECT SPECIALTY HOSPITAL	29010	29820	4120
292006	HEALTHSOUTH HOSPITAL AT TENAYA	29010	29820	4120
312014	MATHENY SCHOOL & HOSPITAL,THE	31350	20764	5015
322002	KINDRED HOSPITAL ALBUQUERQUE	32000	10740	0200
322003	INTEGRATED SPECIALTY HOSPITAL OF ALBUQ	32000	10740	0200
342012	KINDRED HOSPITAL GREENSBORO	34400	24660	3120
342013	LIFECARE HOSPITALS OF NC	34630	40580	6895
342014	FAYETTEVILLE SPECIALITY HOSPITAL	34250	22180	2560
342015	CAROLINAS SPECIALTY HOSPITAL 7TH FLOOR SOUTH	34590	16740	1520
342016	SEMPERCARE HOSPITAL OF WINSTON-SALEM	34330	49180	3120
352004	SCCI HOSPITAL - FARGO	35080	22020	2520
352005	SCCI HOSPITAL - CENTRAL DAKOTA	35290	13900	1010
362004	DRAKE CENTER INC	36310	17140	1640
362007	ST FRANCIS HEALTH CARE CENTRE	36730	36	36
362014	REHABILITATION HOSPITAL AT HEATHER HIL	36280	17460	1680
362015	GRACE HOSPITAL	36170	17460	1680
362016	SELECT SPECIALTY HOSPITAL-NORTHEAST OHIO, INC	36780	10420	0080
362017	SELECT SPECIALTY HOSP-COLUMBUS	36250	18140	1840

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362018	SELECT SPECIALTY HOSPITAL-COLUMBUS	36250	18140	1840
362019	SELECT SPECIALTY HOSPITAL-CINC	36310	17140	1640
362020	SCCI HOSPITAL LIMA	36010	30620	4320
362021	SCCI HOSPITAL - MANSFIELD	36710	31900	4800
362022	SELECT SPECIALTY HOSPITAL-COL/	36250	18140	1840
362023	MAHONING VALLEY HOSPITAL	36510	49660	9320
362024	SELECT SPECIALTY HOSPITAL - YOUNGSTOWN	36510	49660	9320
362025	SPECIALTY HOSPITAL OF LORAIN	36480	17460	1680
362026	KINDRED HOSPITAL - CLEVELAND	36170	17460	1680
362027	SEMPERCARE HOSPITAL OF AKRON INC	36780	10420	0080
362028	LIFE CARE HOSPITAL OF DAYTON	36580	19380	2000
362029	REGENCY HOSPITAL OF AKRON	36780	10420	0080
372004	KINDRED HOSPITAL OKLAHOMA CITY	37540	36420	5880
372005	EDMOND SPECIALTY HOSPITAL	37540	36420	5880
372006	SELECT SPECIALTY HOSPITAL - TULSA	37710	46140	8560
372007	HILLCREST SPECIALTY HOSPITAL	37710	46140	8560
372008	SELECT SPECIALTY HOSPITAL - OKLA CITY	37540	36420	5880
372009	SELECT SPECIALTY HOSPITAL - OKLA CITY	37540	36420	5880
372011	CONTINUOUS CARE CENTER OF TULSA	37710	46140	8560
372012	SPECIALTY HOSPITAL OF MIDWEST CITY	37540	36420	5880
372015	CENTRIS	37540	36420	5880
372016	INTEGRIS BASS PAVILION	37230	37	2340
372020	ADVANCE CARE HOSPITAL OF OKLAHOMA	37540	36420	5880
392024	LIFECARE HOSPITALS OF PITTSBURGH INC	39010	38300	6280
392025	MERCY SPECIAL CARE HOSPITAL	39480	42540	7560
392026	GIRARD MEDICAL CENTER	39620	37964	6160
392027	KINDRED HOSPITAL PHILADELPHIA	39640	39	39
392028	KINDRED HOSPITAL - PITTSBURGH	39010	38300	6280
392029	SELECT SPECIALTY HOSPITAL O PITTSBURGH	39010	38300	6280
392030	SELECT SPCIALTY HOSPITAL OF PHILA / AEMC	39000	39	39
392031	SELECT SPECIALTY HOSPITAL OF JOHNSTOWN	39160	27780	3680
392032	KINDRED HOSPITAL - DELAWARE COUNTY	39620	37964	6160
392033	GOOD SHEPHERD SPECIALTY HOSPITAL	39470	10900	0240

LTCH Provider Number	Name of LTCH	SSA State and County Code[2]	Proposed CBSA-based Labor Market Area[3]	Current MSA-based Labor Market Area[4]
392034	SCCI HOSPITAL EASTON	39590	10900	0240
392035	SCCI HOSPITAL HARRISBURG	39280	25420	3240
392036	SELECT SPECIALTY HOSPITAL OF GREENSBRG	39770	38300	6280
392037	SELECT SPECIALTY HOSPITAL ERIE	39320	21500	2360
392038	HEALTHSOUTH REHAB HOSP FOR SPECIAL SVS	39270	25420	3240
392039	SELECT SPECIALTY HOSPITAL CTR PA (CP)	39280	25420	3240
392040	SEMPERCARE HOSPITAL OF LANCASTER	39440	29540	4000
392041	HEALTHSOUTH REHAB HOSP OF GREATER PITT	39010	38300	6280
392042	KINDRED HOSPITAL - WYOMING VALLEY	39480	42540	7560
392043	KINDRED HOSPITAL AT HERITAGE VALLEY	39010	38300	6280
412001	ELEANOR SLATER HOSPITAL	41030	39300	6483
422004	SPARTANBURG HOSP FOR RESTORATIVE CARE	42110	42	42
422005	KINDRED HOSPITAL CHARLESTON	42090	16700	1440
422006	INTERMEDICAL HOSPITAL OF SC	42390	17900	1760
422007	REGENCY HOSPITAL OF FLORENCE	42200	22500	2655
432002	SELECT SPECIALTY HOSPITAL	43490	43620	7760
442007	KINDRED HOSPITAL - CHATTANOOGA	44320	16860	1560
442010	BAPTIST MEMORIAL RESTORATIVE CARE HOSP	44780	32820	4920
442011	SELECT SPECIALTY HOSPITAL-NASHVILLE	44180	34980	5360
442012	SELECT SPECIALTY HOSPITAL-KNOXVILLE	44460	28940	3840
442013	METHODIST EXTENDED CARE HOSPITAL	44780	32820	4920
442014	SELECT SPECIALTY HOSPITAL MEMPHIS	44780	32820	4920
442015	SELECT SPECIALTY HOSPITAL-NORTH KNOXVILLE	44460	28940	3840
442016	SELECT SPECIALTY HOSPITAL-TRICITIES	44810	28700	3660
452015	KINDRED HOSPITAL DALLAS	45390	19124	1920
452016	KINDRED HOSPITAL SAN ANTONIO	45130	41700	7240
452017	BAYLOR CENTER FOR RESTORATIVE CARE	45390	19124	1920
452018	HARRIS CONTINUED CARE HOSPITAL	45910	23104	2800
452019	KINDRED HOSPITAL FORT WORTH	45910	23104	2800

LTCH Provider Number	Name of LTCH	SSA State and County Code[2]	Proposed CBSA-based Labor Market Area[3]	Current MSA-based Labor Market Area[4]
452022	SELECT SPECIALTY HOSPITAL-DALLAS	45390	19124	1920
452023	KINDRED HOSPITAL-HOUSTON	45610	26420	3360
452027	SCCI HOSPITAL HOUSTON CENTRAL	45610	26420	3360
452028	KINDRED HOSPITAL-TARRANT COUNTY	45910	23104	2800
452029	HENDRICK CENTER FOR EXTENDED CARE	45911	10180	0040
452031	MEMORIAL SPECIALTY HOSPITAL	45020	45	45
452032	CORNESTONE HOSPITAL OF HOUSTON	45610	26420	3360
452033	TEXAS CENTER FOR INFECTIOUS DISEASE	45130	41700	7240
452034	CORNERSTONE HOSPITAL OF AUSTIN	45940	12420	0640
452035	MESA HILL SPECIALTY HOSPITAL	45480	21340	2320
452036	CORPUS CHRISTI SPECIALTY HOSPITAL	45830	18580	1880
452038	TEXAS NEURO REHABILITATION CENTER	45940	12420	0640
452039	KINDRED HOSPITAL	45610	26420	3360
452040	SPECIALTY HOSPITAL OF SAN ANTONIO	45130	41700	7240
452041	TEXOMA MEDICAL CTR RESTORATIVE CARE	45564	43300	7640
452042	DUBUIS HOSP OF BEAUMONT	45700	13140	0840
452043	GULF POINTE SPECIALITY HOSPITAL	45610	26420	3360
452044	LIFECARE HOSPITAL OF DALLAS	45390	19124	1920
452045	COMPASS HOSP OF SAN ANTONIO,THE	45130	41700	7240
452046	PLAZA SPECIALTY HOSP	45610	26420	3360
452049	SELECT SPECIALTY HOSPITAL-HOUSTON HEIG	45610	26420	3360
452050	SOUTHWEST REGIONAL SPEC HOSPITAL	45770	31180	4600
452051	EAST TEXAS MED CTR SPECIALTY HOSP	45892	46340	8640
452053	CORNERSTONE HOSPITAL OF CENTRAL TEXAS	45940	12420	0640
452054	MEDICAL CITY PLANO	45310	19124	1920
452055	DUBUIS HOSPITAL OF HOUSTON	45610	26420	3360
452056	SCCI HOSPITAL OF VICTORIA	45948	47020	8750
452057	BEACON SPECIALITY HOSPITAL	45610	26420	3360
452059	LIFECARE HOSPITAL OF SAN ANTONIO	45130	41700	7240
452060	SCCI HOSPITAL OF AMARILLO	45860	11100	0320
452061	DUBUIS HOSPITAL OF TEXARKANA	45170	45500	8360
452062	WARM SPRING SPECIALITY HOSPTIAL AT LULING	45562	45	45
452063	LIFECARE HOSPITALS OF SOUTH TX INC	45650	32580	4880
452064	SCCI HOSPITAL - SAN ANGELO	45930	41660	7200
452066	PLUM CREEK SPECIALTY HOSPITAL	45860	11100	0320

LTCH Provider Number	Name of LTCH	SSA State and County Code[2]	Proposed CBSA-based Labor Market Area[3]	Current MSA-based Labor Market Area[4]
452067	IHS HOSPITAL AT DALLAS	45390	19124	1920
452068	IHS HOSPITAL AT WICHITA FALLS	45960	48660	9080
452071	KINDRED HOSPITAL-WHITE ROCK	45390	19124	1920
452072	MEMORIAL HERMANN CONTINUING CARE HOSPI	45610	26420	3360
452073	SELECT SPECIALTY HOSPITAL SAN ANTONIO	45130	41700	7240
452074	TRIUMPH HOSPITAL OF NORTH HOUSTON	45610	26420	3360
452075	TRIUMPH HOSPITAL EAST HOUSTON	45610	26420	3360
452077	HOUSTON REHABILITATION ASSOCIATES	45610	26420	3360
452078	SELECT SPECIALTY HOSPITAL SOUTH DALLAS	45390	19124	1920
452079			21340	2320
452080	TRIUMPH HOSPITAL SOUTHWEST	45610	26420	3360
452081	TRIUMPH HOSPITAL NORTHWEST	45610	26420	3360
452082			45	45
452084	SEMPER CARE HOSPITAL OF MIDLAND	45794	33260	5800
452085	REGENCY HOSPITAL OF ODESSA	45451	36220	5800
462003	SOUTH DAVIS COMMUNITY HOSPITAL	46050	36260	7160
462004	SALT LAKE SPECIALITY MEDICAL CENTER	46180	46	46
492001	LAKE TAYLOR HOSP	49641	47260	5720
492007	HOSPITAL FOR EXTENDED RECOVERY	49641	47260	5720
502001	REG HOSP FOR RESP AND COMPLEX CARE	50160	42644	7600
502002	KINDRED HOSPITAL-SEATTLE	50160	42644	7600
512002	SELECT SPECIALITY HOSPITAL	51190	16620	1480
522004	KINDRED HSPTL MILWAUKEE	52390	33340	5080
522005	LAKEVIEW NEUROREHAB CTR MIDWEST	52500	39540	6600
522006	SELECT SPECIALTY HSPTL MILWAUKEE	52390	33340	5080
522007	LIFECARE HSPTLS OF MILWAUKEE	52390	33340	5080

1 Missing values denote unavailable information.

2 First 2-digits are the SSA State code and the last 3-digits are the SSA county code.

3 Under the proposed CBSA-based labor market area designations, a 5-digit code denotes an urban area and a 2-digit code denotes a rural area.

4 Under the existing MSA-based labor market area designations, a 4-digit code denotes an urban area and a 2-digit code denotes a rural area.

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