

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412 and 413

[CMS-1529-P]

RIN 0938-AO30

Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008: Proposed Annual Payment Rate Updates, and Policy Changes; and Proposed Hospital Direct and Indirect Graduate Medical Education Policy Changes

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would update the annual payment rates for the Medicare prospective payment system (PPS) for inpatient hospital services provided by long-term care hospitals (LTCHs). The proposed payment amounts and factors used to determine the updated Federal rates that are described in this proposed rule were determined based on the LTCH PPS rate year July 1, 2007 through June 30, 2008. 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, 2007, through June 30, 2008, would also be derived from the LTCH PPS rate year calculations. We are also proposing to make policy changes which include proposed revisions to the GME and IME policies. In addition, we are adding a technical amendment correcting the regulations text at § 412.22.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on April 2, 2007.

ADDRESSES: In commenting, please refer to file code CMS-1529-P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

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

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

2. *By regular mail.* You may mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, *Attention:* CMS-1529-P, P.O. Box 8015, Baltimore, MD 21244-8015.

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

3. *By express or overnight mail.* You may send written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, *Attention:* CMS-1529-P, Mail Stop C4-26-5, 7500 Security Boulevard, Baltimore, MD 21244-1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786-7197 in advance to schedule your arrival with one of our staff members. Room 445-G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201; or 7500 Security Boulevard, Baltimore, MD 21244-1850.

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

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

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

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

FOR FURTHER INFORMATION CONTACT: Tzvi Hefter, (410) 786-4487 (General information).

Judy Richter, (410) 786-2590 (General information, payment adjustments for special cases, and onsite discharges and readmissions, interrupted stays, co-

located providers, and short-stay outliers).

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

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

Miechal Lefkowitz, (410) 786-5316 (Graduate Medical Education payments).

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

Renate Rockwell, (410) 786-4645 (Graduate Medical Education payments).

Elizabeth Truong, (410) 786-6005 (Federal rate update, budget neutrality, other adjustments, and calculation of the payment rates).

Michael Treitel, (410) 786-4552 (High cost outliers and cost-to-charge ratios).

SUPPLEMENTARY INFORMATION:

Submission of Public Comments: We welcome comments from the public on all issues set forth in this rule to assist us in fully considering issues and developing policies. You can assist us by referencing the file code [CMS-1529-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. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: <http://www.cms.hhs.gov/eRulemaking>. Click on the link "Electronic Comments on CMS Regulations" on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1-800-743-3951.

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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:
- AAMC Association of American Medical Colleges
- AFMAA Academic Family Medicine Advocacy Alliance
- AHA American Hospital Association
- AHIMA American Health Information Management Association
- ALOS Average length of stay
- ALTHA Acute Long Term Hospital Association
- AMGA American Medical Group Association
- AMPRA American Medical Peer Review Association
- AOA American Osteopathic Association
- APR All patient refined
- ASCA Administrative Simplification Compliance Act of 2002 (Pub. L. 107-105)
- BBA Balanced Budget Act of 1997 (Pub. L. 105-33)
- BBRA Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999 (Pub. L. 106-113)
- BIPA Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Benefits Improvement and Protection Act of 2000 (Pub. L. 106-554)
- BN Budget neutrality
- CBSA Core-based statistical area
- CCR Cost-to-charge ratio
- C&M Coordination and maintenance
- CMI Case-mix index
- CMS Centers for Medicare & Medicaid Services
- COLA Cost of living adjustment
- CS Consolidated severity-adjusted
- CY Calendar year
- DSH Disproportionate share of low-income patients
- DRGs Diagnosis-related groups
- FI Fiscal intermediary
- FMC Family Medicine Center
- FTE Full-time equivalent
- FY Federal fiscal year
- GME Graduate medical education
- HCO High-cost outlier
- HCRIS Hospital cost report information system
- HHA Home health agency
- HHS (Department of) Health and Human Services
- HIPAA Health Insurance Portability and Accountability Act (Pub. L. 104-191)
- HIPC Health Information Policy Council
- HwHs Hospitals within hospitals
- ICD-9-CM International Classification of Diseases, Ninth Revision, Clinical Modification (codes)
- IME Indirect medical education
- I-O Input-Output
- IPF Inpatient psychiatric facility
- IPPS [Acute Care Hospital] Inpatient Prospective Payment System
- IRF Inpatient rehabilitation facility
- LOS Length of stay
- LTC-DRG Long-term care diagnosis-related group
- LTCH Long-term care hospital
- MCE Medicare code editor
- MDC Major diagnostic categories
- MedPAC Medicare Payment Advisory Commission
- MedPAR Medicare provider analysis and review
- MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108-173)
- MSA Metropolitan statistical area
- NAICS North American Industrial Classification System
- NALTH National Association of Long Term Hospitals
- NCHS National Center for Health Statistics
- OACT [CMS'] Office of the Actuary
- OBRA 86 Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99-509)
- OMB Office of Management and Budget
- OPM U.S. Office of Personnel Management
- O.R. Operating room
- OSCAR Online Survey Certification and Reporting (System)
- OTN One-Time Notification
- PIP Periodic interim payment

PLI Professional liability insurance
 PMSA Primary metropolitan statistical area
 PPI Producer Price Indexes
 PPS Prospective payment system
 PRA Per resident amount
 PSF Provider specific file
 QIO Quality Improvement Organization
 (formerly Peer Review organization (PRO))
 RIA Regulatory impact analysis
 RPL Rehabilitation psychiatric long-term
 care (hospital)
 RTI Research Triangle Institute,
 International
 RY Rate year (begins July 1 and ends June
 30)
 SIC Standard industrial code
 SNF Skilled nursing facility
 SSO Short-stay outlier
 TEFRA Tax Equity and Fiscal
 Responsibility Act of 1982 (Pub. L. 97–248)
 TEP Technical expert panel
 UHDDS Uniform hospital discharge data set

I. Background

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

A. Legislative and Regulatory Authority

Section 123 of the Medicare, Medicaid, and SCHIP [State Children’s Health Insurance Program] Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113) as amended by section 307(b) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106–554) provides for payment for both the operating and capital-related costs of hospital inpatient stays in long-term care hospitals (LTCHs) under Medicare Part A based on prospectively set rates. The Medicare prospective payment system (PPS) for LTCHs applies to hospitals described in section 1886(d)(1)(B)(iv) of the Social Security Act (the Act), effective for cost reporting periods beginning on or after October 1, 2002.

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

Section 123 of the BBRA requires the PPS for LTCHs to be a “per discharge”

system with a diagnosis-related group (DRG) based patient classification system that reflects the differences in patient resources and costs in LTCHs. It also requires that the “per discharge” system maintain budget neutrality (BN). We believe the statutory mandate for BN applies only to the first year of the implementation of the LTCH PPS such that estimated payments in the first year of the PPS were projected to equal payments that would have been paid for operating and capital-related costs of LTCHs had this new payment system not been enacted.

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

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

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

is to describe Medicare discharges.) The August 30, 2002 final rule further details the payment policy under the TEFRA system (67 FR 55954).

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

In the June 6, 2003 **Federal Register**, we published a final rule that set forth the FY 2004 annual update of the payment rates for the Medicare PPS for inpatient hospital services furnished by LTCHs (68 FR 34122). 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 RY). In addition, we changed the publication schedule for the annual update to allow for an effective date of July 1. The payment amounts and factors used to determine the annual update of the LTCH PPS Federal rate is based on a LTCH PPS rate year. While the LTCH payment rate update is effective July 1, the annual update of the LTC-DRG classifications and relative weights are linked to the annual adjustments of the acute care hospital inpatient DRGs and are effective each October 1.

In the Prospective Payment System for Long-Term Care Hospitals RY 2007: Annual Payment Rate Updates, Policy Changes, and Clarifications final rule (71 FR 27798) (hereinafter referred to as the RY 2007 LTCH PPS final rule), we set forth the 2007 LTCH PPS rate year annual update of the payment rates for the Medicare PPS for inpatient hospital services provided by LTCHs. We also adopted the “Rehabilitation, Psychiatric, Long-Term Care (RPL)” market basket under the LTCH PPS in place of the excluded hospital with capital market basket. In addition, we implemented a zero percent update to

the LTCH PPS Federal rate for RY 2007. We also revised the existing payment adjustment for short stay outlier (SSO) cases by reducing part of the current payment formula and adding a fourth component to that payment formula. Also, we sunsetted the surgical DRG exception to the payment policy established under the 3-day or less interruption of stay policy. Finally, we clarified the policy at § 412.534(c) for adjusting the LTCH PPS payment so that the LTCH PPS payment is equivalent to what would otherwise be payable under § 412.1(a).

B. Criteria for Classification as a LTCH

1. Classification as a LTCH

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

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

In the RY 2005 LTCH PPS final rule (69 FR 25674), we specified the procedure for calculating a hospital's inpatient average length of stay (ALOS) for purposes of classification as a LTCH.

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

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

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

As we stated in the FY 2004 Inpatient Prospective Payment System (IPPS) final rule, published in the August 1, 2003 *Federal Register*, prior to the implementation of the LTCH PPS, we did rely on data from the most recently submitted cost report for purposes of calculating the ALOS (68 FR 45464). The calculation to determine whether an acute care hospital qualifies for LTCH status was based on total days

and discharges for LTCH inpatients. However, with the implementation of the LTCH PPS, for the ALOS specified under § 412.23(e)(2)(i), we revised § 412.23(e)(3)(i) to only count total days and discharges for Medicare inpatients (67 FR 55970 through 55974). In addition, the ALOS specified under § 412.23(e)(2)(ii) is calculated by dividing the total number of days for all patients, including both Medicare and non-Medicare inpatients (less leave or pass days) by the number of total discharges for the hospital's most recent complete cost reporting period. As we discussed in the FY 2004 IPPS final rule, we are unable to capture the necessary data from our present cost reporting forms (68 FR 45464). Therefore, we have notified FIs and LTCHs that until the cost reporting forms are revised, for purposes of calculating the ALOS, we will be relying upon census data extracted from Medicare Provider Analysis and Review (MedPAR) files that reflect each LTCH's cost reporting period (68 FR 45464). Requirements for hospitals seeking classification as LTCHs that have undergone a change in ownership, as described in § 489.18, are set forth in § 412.23(e)(3)(iv).

2. Hospitals Excluded From the LTCH PPS

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

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

C. Transition Period for Implementation of the LTCH PPS

In the August 30, 2002 final rule (67 FR 55954), we provided for a 5-year transition period. During this 5-year transition period, a LTCH's total payment under the PPS was based on an increasing percentage of the Federal rate with a corresponding decrease in the percentage of the LTCH PPS payment that is based on reasonable cost

concepts. However, effective for cost reporting periods beginning on or after October 1, 2006, total LTCH PPS payments are based on 100 percent of the Federal rate.

D. Limitation on Charges to Beneficiaries

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

E. Administrative Simplification Compliance Act (ASCA) and Health Insurance Portability and Accountability Act (HIPAA) Compliance

Claims submitted to Medicare must comply with both the Administrative Simplification Compliance Act (ASCA) (Pub. L. 107-105), and Health Insurance Portability and Accountability Act (HIPAA) (Pub. L. 104-191). Section 3 of the ASCA requires that the Medicare Program deny payment under Part A or Part B for any expenses incurred for items or services “for which a claim is submitted other than in an electronic form specified by the Secretary.” Section 1862(h) of the Act (as added by section 3(a) of the ASCA) provides that the Secretary shall waive such denial in two specific types of cases and may also waive such denial “in such unusual cases as the Secretary finds appropriate” (68 FR 48805). Section 3 of the ASCA operates in the context of the ASCA provisions of HIPAA, which include, among other provisions, the transactions and code sets standards requirements

codified as 45 CFR parts 160 and 162, subparts A and I through R (generally known as the Transactions Rule). The Transactions Rule requires covered entities, including covered health care providers, to conduct the covered electronic transactions according to the applicable transactions and code sets standards.

II. Summary of the Major Contents of This Proposed Rule

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

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

Also, in section III. of this preamble, we are proposing to establish a BN requirement for when the LTC-DRG classifications and relative weights are updated annually to reflect changes in relative LTCH resource use. This requirement would ensure that estimated aggregate LTCH PPS payments would not decrease or increase as a result of the annual update to the LTC-DRG classifications and relative weights.

As discussed in section IV.C. of this preamble, we are proposing a 0.71 percent update to the LTCH PPS Federal rate for the 2008 LTCH PPS rate year based on an adjustment to the most recent estimate of the LTCH PPS market basket to account for changes in coding practices. Also in section IV. of this preamble, we discuss the proposed prospective payment rate for RY 2008, and in section VI. we discuss the applicable adjustments to the proposed payment rates, including the proposed revisions to the wage index, proposed labor-related share, the proposed cost-of-living adjustment (COLA) factors, and the proposed outlier threshold, for the 2008 LTCH PPS rate year.

In section V.A.1.b. of this preamble, we discuss an approach being considered to make a change to our present payment methodology for certain SSO cases. Under this approach, payment for SSO cases would be subject to a further adjustment where the patient's LOS at the LTCH is less than or equal to an IPPS LOS threshold for the DRG.

In section V.B. of this preamble, we discuss the proposed expansion of the present 25 percent admission policy at existing § 412.534(c) to those certain situations not already affected by that existing policy. We are proposing to specify that for cost reporting periods beginning on or after July 1, 2007, that “grandfathered” LTCH HwHs and LTCH satellites, at § 412.22(f) and § 412.22(h)(3)(i) respectively, would also be included in the policy set forth at existing § 412.534. We are also proposing that if the percentage of LTCH's or LTCH satellite facility's discharges that were admitted from any non-co-located referring hospital exceeds 25 percent (or the applicable percentage) for a particular cost reporting period, an adjusted amount would be made for those Medicare discharges that were admitted from that referring hospital beyond the 25 percent (or the applicable percentage) threshold.

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

In section XI. of this preamble, we will discuss the recommendations made by the Research Triangle Institute, International's (RTI) evaluation of the feasibility of adopting recommendations made in the June 2004 Medicare Payment Advisory Commission (MedPAC) Report. (Addendum B will include the executive summary of the RTI report.)

In section XII. of this preamble, we discuss our proposal to redefine the statutory term “all or substantially all of the costs for the training program in the nonhospital setting.” The statute requires that hospitals must pay all of substantially all of the costs for training in a nonhospital site in order to count FTE residents training in the nonhospital setting for Medicare graduate medical education (GME) payment purposes. We are proposing to revise § 413.75(b) to introduce a new definition of “all or substantially all of the costs for the training program in the nonhospital setting” to mean, at least 90 percent of the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries attributable to direct GME. In addition, we are proposing to revise § 412.105(f)(1)(ii)(C) for IME and § 413.78 to reflect this new definition of “all or substantially all” of the GME costs in a nonhospital setting, effective for cost reporting periods beginning on or after July 1, 2007.

In section XVI. of this preamble, we analyze the impact of the proposed changes presented in this proposed rule on Medicare expenditures, Medicare-

participating LTCHs, and Medicare beneficiaries.

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

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

A. Background

Section 123 of the BBRA requires that the Secretary implement a PPS for LTCHs (that is, a per discharge system with a DRG-based patient classification system reflecting the differences in patient resources and costs. Section 307(b)(1) of the BIPA modified the requirements of section 123 of the BBRA by requiring that the Secretary examine "the feasibility and the impact of basing payment under such a system [the LTCH PPS] on the use of existing (or refined) hospital DRGs that have been modified to account for different resource use of LTCH patients, as well as the use of the most recently available hospital discharge data."

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

In a departure from the IPPS, we use low volume LTC-DRGs (less than 25 LTCH cases) in determining the LTC-DRG weights, since LTCHs do not typically treat the full range of diagnoses as do acute care hospitals. To manage the large number of low volume DRGs (all DRGs with fewer than 25 cases), we group low volume DRGs into 5 quintiles based on average charge per discharge. (A listing of the current composition of low volume quintiles used in determining the FY 2007 LTC-DRG relative weights appears in the FY 2007 IPPS final rule (71 FR 47974 through 47978).) We also account for adjustments to payments for cases in which the stay at the LTCH is less than or equal to five-sixths of the geometric ALOS and classify these cases as SSO cases. (A detailed discussion of the application of the Lewin Group model

that was used to develop the LTC-DRGs appears in the August 30, 2002 LTCH PPS final rule (67 FR 55978).)

B. Patient Classifications Into DRGs

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

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

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

Medicare FIs enter the clinical and demographic information into their claims processing systems and subject this information to a series of automated screening processes called the Medicare Code Editor (MCE). These screens are designed to identify cases that require further review before assignment into a DRG can be made. During this process, the following types of cases are selected for further development:

- Cases that are improperly coded. (For example, diagnoses are shown that are inappropriate, given the sex of the patient. Code 68.6, Radical abdominal hysterectomy, would be an inappropriate code for a male.)
- Cases including surgical procedures not covered under Medicare. (For example, organ transplant in a non-approved transplant center.)
- Cases requiring more information. (For example, ICD-9-CM codes are required to be entered at their highest level of specificity. There are valid 3-

digit, 4-digit, and 5-digit codes. That is, code 262, Other severe protein-calorie malnutrition, contains all appropriate digits, but if it is reported with either fewer or more than 3 digits, the claim will be rejected by the MCE as invalid.)

- Cases with principal diagnoses that do not usually justify admission to the hospital. (For example, code 437.9, unspecified cerebrovascular disease. While this code is valid according to the ICD-9-CM coding scheme, a more precise code should be used for the principal diagnosis.)

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

The GROUPER software is used both to classify past cases to measure relative hospital resource consumption to establish the DRG weights and to classify current cases for purposes of determining payment. The records for all Medicare hospital inpatient discharges are maintained in the MedPAR file. The data in this file are used to evaluate possible DRG classification changes and to recalibrate the DRG weights during our annual update under both the IPPS (§ 412.60(e)) and the LTCH PPS (§ 412.517). As discussed in greater detail in sections III.D. and E. of this preamble, with the implementation of section 503(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173), there is the possibility that one feature of the GROUPER software program may be updated twice during a Federal FY (October 1 and April 1) as required by the statute for the IPPS (69 FR 48954 through 48957). Specifically, as we discussed in the FY 2007 IPPS final rule, diagnosis and procedure codes for new medical technology may be created

and added to existing DRGs in the middle of the Federal FY on April 1 (71 FR 47959 and 47971). However, this policy change will have no effect on the LTC-DRG relative weights (during the FY), 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 during the FY as result of this policy. The use of the ICD-9-CM code set is also compliant with the current requirements of the Transactions and Code Sets Standards regulations at 45 CFR parts 160 and 162, published in accordance with HIPAA.

C. Organization of DRGs

The DRGs are organized into 25 major diagnostic categories (MDCs), most of which are based on a particular organ system of the body; the remainder involve multiple organ systems (such as MDC 22, Burns). Accordingly, the principal diagnosis determines MDC assignment. Within most MDCs, cases are then divided into surgical DRGs and medical DRGs. Surgical DRGs are assigned based on a surgical hierarchy that orders operating room (O.R.) procedures or groups of O.R. procedures by resource intensity. The GROUPER software program does not recognize all ICD-9-CM procedure codes as procedures that affect DRG assignment, that is, procedures which are not surgical (for example, EKG), or minor surgical procedures (for example, 86.11, Biopsy of skin and subcutaneous tissue).

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

As discussed in greater detail in the FY 2007 IPPS final rule (71 FR 47898 through 47912 and 47973), in its March 2005 Report to Congress, "Physician-Owned Specialty Hospitals," MedPAC recommended that the Secretary improve payment accuracy in the hospital IPPS by, among other things, "refining the current DRGs to more fully capture differences in severity of illness among patients." (Recommendation 1, p. 93.) As we discussed in that same final rule (71 FR 47973), although we did not adopt a new severity-adjusted patient classification system under the IPPS, for FY 2007, we refined the current CMS-DRG patient classification system by creating 20 new CMS-DRGs and modifying 32 others across 13 different clinical areas for Version 24.0 of the GROUPER software that we expect will improve the CMS-DRG system's recognition of severity of illness for FY 2007. As noted previously in this section, the LTCH PPS patient classification system (that is, LTC-DRGs) is the same patient classification system used under the IPPS (that is, CMS DRGs). As such, the updates to the CMS DRG patient classification system used under the IPPS for FY 2007 (GROUPER Version 24.0), are the updates that apply to the LTC-DRGs used under the LTCH PPS for FY 2007.

In the FY 2007 IPPS final rule, we present the changes to the DRG patient classification system for FY 2007 (71 FR 47939 through 47962). In that rule, we adopted the IPPS GROUPER Version 24.0 for FY 2007 to process LTCH PPS claims for LTCH discharges occurring from October 1, 2006 through September 30, 2007 (71 FR 47973). As noted above in this section and as we also discussed in the FY 2007 IPPS final rule, in its March 1, 2005 Report to Congress on Medicare Payment Policy (page 64) and Recommendation 1 in the 2005 Report to Congress on Physician-Owned Specialty Hospitals, MedPAC recommended that CMS, among other things, refine the current DRGs under the IPPS to more fully capture differences in severity of illness among patients. In evaluating this MedPAC recommendation for the IPPS, we evaluated the APR-DRG Grouper used by MedPAC in its analysis. Based on that analysis, we concur with MedPAC that the modified version of the APR DRGs would account more completely for differences in severity of illness and associated costs among hospitals. However, as we clarified in the FY 2007 IPPS proposed rule and reiterated in section II.C.6. of the FY 2007 IPPS final rule, there are still further changes that are important to make to the

consolidated severity-adjusted (CS) DRG system before it is ready for adoption. Therefore, in the FY 2007 IPPS final rule, we did not adopt a new CS DRG system, such as the APR DRGs or a modified version of the APR DRGs, under the IPPS. However, we refined the current CMS-DRG patient classification system by creating 20 new CMS-DRGs and modifying 32 others across 13 different clinical areas for Version 24.0 of the GROUPER software that we expect will improve the CMS DRG system's recognition of severity of illness for FY 2007. As noted previously in this section, the LTCH PPS patient classification system (that is, LTC-DRGs) is the same patient classification system used under the IPPS (that is, CMS DRGs). As such, the updates to the CMS DRG patient classification system used under the IPPS for FY 2007 (GROUPER Version 24.0), are the updates that apply under the LTCH PPS for FY 2007.

As discussed in the FY 2007 IPPS final rule (71 FR 47906), we have engaged a contractor to assist us with completing an evaluation of alternative DRG systems for use under the IPPS that may better recognize severity than the current CMS DRGs and meet other criteria that would make them suitable to adopt for purposes of payment under the IPPS. We expect to complete this evaluation of alternative DRG systems quickly as part of moving forward on adopting a revised DRG system that better recognizes severity in the IPPS rulemaking for FY 2008.

As we also stated in that same FY 2007 IPPS final rule (71 FR 47990), if and when a severity adjusted patient classification system is adopted under the IPPS, we would need to consider whether to propose revisions to the current patient classification system used under the LTCH PPS. Any proposed changes to the patient classification system would be done through notice and comment rulemaking. We believe that it is advantageous to the LTCH community to wait for CMS to first finalize its policies regarding any refinements to the DRG patient classification system used under the IPPS so that we can fully analyze what the effects of such changes would be on LTCH PPS payments. To the extent any changes to the patient classification system used under the IPPS are proposed and subsequently finalized, an analysis could then be performed to determine whether it is appropriate to propose the same patient classification for LTCHs. As noted above in this section, at that time, we would need to consider whether to propose revisions to the patient classification system

under the LTCH PPS, which, if proposed would be done through notice and comment rulemaking.

D. Proposed Update of LTC-DRGs

1. Background

As discussed in greater detail in the FY 2007 IPPS final rule (71 FR 47974), under the LTCH PPS, relative weights for each LTC-DRG are a primary element used to account for the variations in cost per discharge and resource utilization among the payment groups (that is, LTC-DRGs). To ensure that Medicare patients classified to each LTC-DRG have access to an appropriate level of services and to encourage efficiency, each year based on the best available data, 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 relative weight of 1. Under § 412.517, the LTC-DRG classifications and weighting factors (that is, relative weights) are adjusted annually to reflect changes in factors affecting the relative use of LTCH resources, including treatment patterns, technology and number of discharges. For FY 2007, the LTC-DRG classifications and relative weights were updated based on LTCH data from the FY 2005 MedPAR file, which contained hospital bills data from the March 2006 update. The LTC-DRG patient classification system consists of 538 DRGs that formed the basis of the FY 2007 LTCH PPS GROUPE program. The 538 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). The other 536 LTC-DRGs are the same DRGs used in the IPPS GROUPE program for FY 2007 (Version 24.0).

In the past, the annual update to the CMS-DRGs was based on the annual revisions to the ICD-9-CM codes and was effective each October 1. The ICD-9-CM coding update process was revised as discussed in greater detail in the FY 2005 IPPS final rule (69 FR 48953 through 48957). Specifically, section 503(a) of the MMA includes a requirement for updating diagnosis and procedure codes for twice a year instead of the current process of annual updates on October 1 of each year. This requirement is included as part of the amendments to the Act relating to

recognition of new medical technology under the IPPS. (For additional information on this provision, including its implementation and its impact on the LTCH PPS, refer to the FY 2005 IPPS final rule (69 FR 48953 through 48957) and the RY 2006 LTCH PPS final rule (70 FR 24172 through 24177).)

As noted above in this section, with the implementation of section 503(a) of the MMA, there is the possibility that one feature of the GROUPE software program may be updated twice during a Federal FY (October 1 and April 1) as required by the statute for the IPPS. Specifically, diagnosis and procedure codes for new medical technology may be created and added to existing DRGs in the middle of the Federal FY on April 1. No new LTC-DRGs will be created or deleted. Consistent with our current practice, any changes to the DRGs or relative weights will be made at the beginning of the next Federal FY (October 1). Therefore, there will not be any impact on LTC-DRG payments under the LTCH PPS until the following October 1 (although the new ICD-9-CM diagnosis and procedure codes would be recognized April 1). The use of the ICD-9-CM code set is also compliant with the current requirements of the Transactions and Code Sets Standards regulations at 45 CFR parts 160 and 162, issued under HIPAA.

As we explained in the FY 2007 IPPS final rule, annual changes to the ICD-9-CM codes historically were effective for discharges occurring on or after October 1 each year (71 FR 47971). Thus, the manual and electronic versions of the GROUPE software, which are based on the ICD-9-CM codes, were also revised annually and effective for discharges occurring on or after October 1 each year. The patient classification system used under the LTCH PPS (LTC-DRGs) is the same DRG patient classification system used under the IPPS, which historically had been updated annually and was effective for discharges occurring on or after October 1 through September 30 each year. As we mentioned previously in this section, the ICD-9-CM coding update process was revised as a result of the implementation of section 503(a) of the MMA, which includes a requirement for updating diagnosis and procedure codes as often as twice a year instead of the current process of annual updates on October 1 of each year (as discussed in greater detail in section II.D.10. of the FY 2007 IPPS final rule (71 FR 47957 through 47960)). We currently use the ICD-9-CM codes as the code set for diagnoses and procedures. Therefore, the ICD-9-CM codes currently used under both the IPPS and LTCH PPS may

be updated as often as twice a year. As described above in this section, this requirement is included as part of the amendments to the Act relating to recognition of new medical technology under the IPPS.

Despite the fact that aspects of the GROUPE software may be updated to recognize any new technology ICD-9-CM codes, there will be no impact on either LTC-DRG assignments or payments under the LTCH PPS at that time. That is, changes to the LTC-DRGs (such as the creation or deletion of LTC-DRGs) and the relative weights will continue to be updated in the manner and timing (October 1) as they are now. Updates to the GROUPE software for both the IPPS and the LTCH PPS (for relative weights and the creation or deletion of DRGs) are made in the annual IPPS proposed and final rules and are effective each October 1. We have also explained that since we do not publish a mid-year IPPS rule, we will assign any new diagnosis or procedure codes implemented on April 1 to the same DRG in which its predecessor code was assigned, so that there will be no impact on the DRG assignments until the following October 1. Any coding updates will be available through the Web sites provided in section III.E. of this preamble and through the *Coding Clinic for ICD-9-CM*. Publishers and software vendors currently obtain code changes through these sources to update their code books and software system. If new codes are implemented on April 1, revised code books and software systems, including the GROUPE software program, will be necessary because we must use current ICD-9-CM codes. Therefore, for purposes of the LTCH PPS, because each ICD-9-CM code must be included in the GROUPE algorithm to classify each case into a LTC-DRG, the GROUPE software program used under the LTCH PPS would need to be revised to accommodate any new codes.

In implementing section 503(a) of the MMA, there will only be an April 1 update if diagnosis and procedure codes are requested and approved. We note that any new codes created for April 1 implementation will be limited to those diagnosis and procedure code revisions primarily needed to describe new technologies and medical services. However, we reiterate that the process of discussing updates to the ICD-9-CM has been an open process through the ICD-9-CM Coordination and Maintenance (C&M) Committee since 1995. Requestors will be given the opportunity to present the merits for a new code and make a clear and convincing case for the need to update

ICD-9-CM codes through an April 1 update.

At the September 2006 ICD-9-CM C&M Committee meeting, there were no requests for an April 1, 2007 implementation of ICD-9-CM codes, and therefore, the next update to the ICD-9-CM coding system will not occur until October 1, 2007 (FY 2008). Presently, as there were no coding changes suggested for an April 1, 2007 update, the ICD-9-CM coding set implemented on October 1, 2006, will continue through September 30, 2007 (FY 2007). The next update to the LTC-DRGs and relative weights for FY 2008 will be presented in the FY 2008 IPPS proposed and final rules. Furthermore, we would notify LTCHs of any revisions to the GROUPER software used under the IPPS and LTCH PPS that would be implemented April 1, 2008. As noted previously in this section, in the FY 2007 IPPS final rule (71 FR 47973), we used Version 24.0 of the CMS GROUPER, which was used under the IPPS for FY 2007, to classify cases for LTCH PPS discharges that would occur on or after October 1, 2006 and on or before September 30, 2007.

2. Proposed Budget Neutrality (BN) Requirement for the Annual LTC-DRG Update

As noted above in this section, currently under § 412.517, the LTC-DRG classifications and relative weights are adjusted annually to reflect changes in factors affecting the relative use of LTCH resources, such as treatment patterns, technology and number of discharges. Currently, there are no statutory or regulatory requirements that the annual update to the LTC-DRG classifications and relative weights be done in a budget neutral manner. Historically, since the initial implementation of the LTCH PPS in FY 2003, we have updated the LTC-DRG relative weights each year without a BN adjustment based on the most recent available LTCH claims data, which reflect current LTCH patient mix and coding practices, and appropriately reflected more or less resource use than the previous year's LTC-DRG relative weights (71 FR 47991). When we proposed changes to the LTC-DRGs for FY 2007 in the FY 2007 IPPS proposed rule, we estimated that those proposed changes to the LTC-DRG classifications and relative weights would result in about an estimated 1.4 percent decrease in estimated aggregate LTCH PPS payments (71 FR 24413). As we discussed in the FY 2007 IPPS final rule (71 FR 47991), several commenters, including MedPAC, urged us to establish a BN requirement for the

annual reclassification and recalibration of the LTC-DRGs so that, in future years, the LTCH PPS could avoid an estimated decrease in estimated aggregate payments, such as the estimated 1.4 percent decrease that resulted from the proposed update to the LTC-DRGs and relative weights for FY 2007. In response to previous proposed annual updates to the LTC-DRG relative weights, we also received comments recommending that a BN adjustment be applied in determining the LTC-DRG relative weights to mitigate LTCH PPS payment fluctuations. (See the FY 2005 IPPS final rule (69 FR 48999 through 49000), and the FY 2006 IPPS final rule (70 FR 47333 through 47334).)

In response to those comments, we explained that we understood the commenters' concern with the estimated decrease in payments under LTCH PPS based upon the changes in the LTC-DRGs and relative weights proposed for FY 2007. However, as we discussed in the FY 2007 IPPS final rule, we did not postpone the proposed FY 2007 reclassification and recalibration of the LTC-DRGs, nor did we implement those changes in a budget neutral manner. We noted several reasons for the annual fluctuations in LTC-DRG relative weights that have resulted in both estimated increases and decreases in estimated aggregate LTCH PPS payments in the 4 years since the implementation of the LTCH PPS in FY 2003. Specifically, we reiterated our belief that several factors have affected the changes to the LTC-DRG relative weights over the past 4 years, including actual improvements in coding so that cases are appropriately assigned to LTC-DRGs. We also explained that, as noted above in this section, historically we recalibrated the LTC-DRG relative weights each year based on the most recent available LTCH claims data, which reflect current LTCH patient mix and coding practices, and appropriately reflects more or less resource use than the previous year's LTC-DRG relative weights. The intended purpose of the annual recalibration of the LTC-DRG relative weights is to reflect any variation in coding practices and charges from the previous year and to help ensure that the LTC-DRG relative weights in the upcoming fiscal year will result in appropriate and accurate payments to LTCHs for the resources they expend to treat their Medicare patients. (71 FR 47984 through 47989)

We also reminded the commenters that under the IPPS, there is a statutory requirement that the annual DRG reclassification and recalibration changes be made in a manner that

assures that the estimated aggregate payments are neither greater than nor less than the estimated aggregate payments that would have been made without the changes, but there is no corresponding statutory requirement under the LTCH PPS. However, we noted that, given the considerable discretion granted to the Secretary under section 123 of the BBRA and section 307(b) of the BIPA of 2000 to develop the LTCH PPS, it is possible that, at some point, the Secretary would consider using this broad authority to establish a BN policy for the annual update of the LTC-DRG classifications and relative weights. We further stated that if we find that it would be appropriate to propose making the updates to the LTC-DRGs and relative weights in a budget neutral manner, the public would have the opportunity to submit comments on any proposed change during the rulemaking process.

As we explained in the FY 2007 IPPS final rule (71 FR 47985 through 47986), a LTCH's case-mix index (CMI) is defined as its case weighted average LTC-DRG relative weight for all its discharges in a given period. Changes in CMI consist of two components: "real" CMI changes and "apparent" CMI changes. Real CMI increase is defined as the increase in the average LTC-DRG relative weights resulting from the hospital's treatment of more resource intensive patients. Apparent CMI increase is defined as the increase in CMI due to changes in coding practices. The computed (or observed) CMI increase is defined as real CMI increase (due to an increase in patient severity) plus the increase due to changes in coding practices (including better documentation of the medical record by physicians and more complete coding of the medical record by coders). If LTCH patients have more costly impairments, lower functional status, or increased comorbidities, and thus require more resources in the LTCH, we consider this a real change in case-mix. Conversely, if LTCH patients have the same impairments, functional status, and comorbidities but are coded differently resulting in higher payment, we consider this an apparent change in case-mix. We believe that changes in payment rates, including the LTC-DRG relative weights, should accurately reflect changes in LTCHs' true cost of treating patients (real CMI increase), and should not be influenced by changes in coding practices (apparent CMI increase).

As stated above in this section, apparent CMI increase results from cases being grouped to a LTC-DRG with a higher weight than it would be

without such changes in coding practices. As we discussed in the FY 2007 IPPS final rule (71 FR 48343 through 48344), in discussing the impact of the changes to the LTC-DRG classifications and relative weights established for FY 2007 that were estimated to result in an aggregate decrease in LTCH PPS payments of approximately 1.3 percent, we explained that changes in coding practices (rather than patient severity) primarily resulted in fluctuations in the LTC-DRG relative weights in the past. Specifically, based on an analysis of FY 2005 LTCH claims data, we continued to observe that the average LTC-DRG relative weight decreases due to an increase of relatively lower charge cases being assigned to LTC-DRGs with higher relative weights in the prior year. Contributing to this increase in these relatively lower charge cases being assigned to LTC-DRGs with higher relative weights in the prior year are improvements in coding practices, which are typical when moving from a reasonable cost-based payment system to a PPS. The impact of including cases with relatively lower charges into LTC-DRGs that had a relatively higher relative weight in the previous version of the GROUPER software is a decrease in the average relative weight for those LTC-DRGs in the updated version of the GROUPER software.

We note that this same phenomenon of relatively lower charge cases being assigned to LTC-DRGs with higher relative weights in the prior year was also observed when we analyzed the LTCH claims data from FY 2003 and FY 2004 to update the LTC-DRG relative weights for FY 2005 and FY 2006, respectively (see the FY 2005 IPPS final rule (69 FR 48999) and the FY 2006 IPPS final rule (70 FR 47701 through 47702).) However, this phenomenon was more notable based on the FY 2004 LTCH claims data that were used to update the LTC-DRG relative weights for FY 2006, where the changes to the LTC-DRG weights established were estimated to result in a decrease in aggregate LTCH PPS payments of 4.2 percent (as compared to the estimated 1.3 percent decrease in aggregate LTCH PPS payments based on the FY 2005 LTCH claims data used to determine the FY 2007 LTC-DRG relative weights). Because the estimated decrease in aggregate LTCH PPS payments due to the update to the LTC-DRG relative weights based on more recent (FY 2005) LTCH claims data was significantly lower (1.3 percent estimated based on the LTC-DRG changes for FY 2007) than it was based on FY 2004 LTCH claims

data (4.2 percent estimated based on the LTC-DRG changes for FY 2006), we believe that, as LTCHs have become more familiar with the ICD-9-CM coding principles and guidelines used under a DRG-based system, annual changes in LTCH CMI are approaching the point where the observed CMI increase is primarily due to changes in real CMI (that is, increased patient severity) rather than apparent CMI (that is, changes in coding practices). In other words, because we have observed that, over time as LTCHs have gained more experience with ICD-9-CM coding, estimated changes in LTCH PPS payments due to recalibration of the LTC-DRG relative weights based on more recent claims data (for example, the FY 2007 LTC-DRG relative weights calculated from FY 2005 LTCH claims data as compared to the FY 2006 LTC-DRG relative weights calculated from FY 2004 LTCH claims data) have diminished over time. That is, we have estimated smaller fluctuations in aggregate LTCH PPS payments as a result of the annual recalibration of the LTC-DRG relative weights based on more recent LTCH claims data generated after the implementation of the LTCH PPS (for example, the 1.3 percent estimated decrease in aggregate LTCH PPS payments for FY 2007 based on FY 2005 LTCH claims data). For these reasons, we believe that LTCH coding practices have stabilized such that the most recent available LTCH claims data now primarily reflect changes in the resources used by the average LTCH patient in a particular LTC-DRG (and not changes in coding practices). Thus, we believe that the most recent available data (as described below in this section) mainly reflect the true costs of treating LTCH patients, and as discussed above, we believe changes in payment rates, including the LTC-DRGs, should reflect such costs.

Furthermore, a LTCH CMI analysis based on the most recent available LTCH claims data, which is discussed in section IV.C. of this preamble, also supports our belief that observed CMI increase is primarily due to changes in real CMI (that is, increased patient severity) rather than apparent CMI (that is, changes in coding practices). Specifically, this CMI analysis indicates that changes in LTCH coding practices, which resulted in fluctuations in the LTC-DRG relative weights in the past, appear to be stabilizing as LTCHs have become more familiar with a DRG-based system. As discussed in section IV.C.2.

of this preamble, the overall observed change in LTCH CMI from FY 2003 compared to FY 2004 was an increase of approximately 6.75 percent while the overall observed change in LTCH CMI from FY 2004 compared to FY 2005 was an increase of approximately 3.49 percent, which is only about half of the LTCH CMI growth measured from the prior period (that is, the 6.75 percent from FY 2003 to FY 2004). Furthermore, preliminary analysis of FY 2006 LTCH claims data, which reflects over 3 full years of experience under the LTCH PPS for most LTCHs, shows an even smaller overall observed CMI increase of about 1.9 percent from FY 2005 compared to FY 2006. Again, the observed CMI increase from FY 2005 to FY 2006 is only about half of the LTCH CMI growth measured from the prior period (that is, the 3.49 percent from FY 2004 to FY 2005). Because this LTCH CMI analysis shows that observed CMI is declining, we believe that LTCH coding practices have stabilized such that changes in LTCH CMI are now primarily due to changes in real CMI (that is, increased patient severity) rather than apparent CMI (that is, changes in coding practices). In other words, because we believe that the observed annual CMI increase is primarily "real" and not "apparent," it is no longer necessary to update the LTC-DRGs in a non-budget neutral manner (as discussed in greater detail below in this section). As stated above in this section, we believe that changes in payment rates, including the LTC-DRG relative weights, should accurately reflect changes in LTCHs' true cost of treating patients (real CMI increase) and should not be influenced by changes in coding practices (apparent CMI increase).

In light of these facts, in order to mitigate estimated fluctuations in estimated aggregate LTCH PPS payments, as urged by past commenters, we have given further consideration to the issue of establishing a BN requirement for annual LTC-DRG reclassification and recalibration. Therefore, in this proposed rule, under the broad authority conferred upon the Secretary under section 123 of the BBRA as amended by section 307(b) of the BIPA to develop the LTCH PPS, we are proposing that, beginning with the LTC-DRG update for FY 2008, the annual update to the LTC-DRG classifications and relative weights would be done in a budget neutral manner such that estimated aggregate LTCH PPS payments would be unaffected, that is, would be neither greater than nor less than the estimated aggregate LTCH PPS payments that

would have been made without the proposed LTC-DRG classification and relative weight changes. Accordingly, we are proposing to revise § 412.517 to specify that annual changes to the LTC-DRG classifications and the recalibration of the LTC-DRG relative weights are made in a budget neutral manner such that estimated aggregate LTCH PPS payments are not affected. We believe that it would be appropriate to update the LTC-DRG classifications and relative weights in a budget neutral manner at this time for the reasons discussed below.

As noted above in this section, the relative weight for each LTC-DRG represents the resources needed by an average inpatient LTCH case in that LTC-DRG, such that LTCH 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 relative weight of 1. As also noted above in this section, in the past when we recalibrated the LTC-DRG relative weights each year without a BN adjustment based on the most recent available LTCH claims data, we believe that the resulting LTC-DRG relative weights appropriately reflected more or less resource use than the previous year's LTC-DRG relative weights, and that the estimated aggregate payment changes were appropriate given that the LTCH claims data used to determine those LTC-DRG relative weights reflected changes in coding practices, as well as changes in actual resource use. Historically, we have not updated the LTC-DRGs in a budget neutral manner because, as discussed above in this section, we believed that past fluctuations in the LTC-DRG relative weights were primarily due to changes in LTCH coding practices, which included both "real" and "apparent" changes in LTCHs' case-mix. We believe that changes in the LTCH PPS payment rates, including the LTC-DRG relative weights, should accurately reflect changes in LTCHs' true cost of treating patients (real CMI increase), and should not be influenced by changes in coding practices (apparent CMI increase). Therefore, in the past we did not update the LTC-DRGs in a budget neutral manner so that "apparent" CMI changes were not permanently built into the LTCH PPS payment rates. Because LTCH 2006 claims data does not appear to significantly reflect changes in LTCH coding practices in response to the implementation of the LTCH PPS (as explained above in this section), we believe that it may be appropriate to update the LTC-DRGs so that estimated aggregate LTCH PPS payments would

neither increase or decrease since we believe that changes in the LTC-DRG classifications and relative weights should accurately reflect changes in LTCHs' resource use (that is, true cost of treating patients) and should not be influenced by changes in coding practices, and that the most recent such LTCH claims data primarily reflects changes in the resources needed by an average LTCH case in a particular LTC-DRG (and not changes in coding practices). Thus, we now believe it would be reasonable and appropriate to update the LTC-DRGs in a budget neutral manner, beginning in FY 2008, so that estimated aggregate payments under the LTCH PPS would be unaffected (that is, estimated aggregate LTCH PPS payments would not be greater than or less than they would have been without the proposed LTC-DRG classification and relative weight changes) by any changes resulting from the annual reclassification and recalibration of the LTC-DRGs. Updating the LTC-DRGs in a budget neutral manner would result in an annual update to the individual LTC-DRG classifications and relative weights based on the most recent available data to reflect changes in relative LTCH resource use; however, the LTC-DRG relative weights would be uniformly adjusted to ensure that estimated aggregate payments under the LTCH PPS would not be affected (that is, decreased or increased).

Under this proposal, we intend to update the LTC-DRG classifications and relative weights for FY 2008 based on the best available data at the time to allow for changes in factors affecting hospital resource use, including but not limited to, practice patterns and new technology. This would be done in a budget neutral manner, such that estimated aggregate payments under the LTCH PPS would neither decrease or increase as a result of the changes due to the annual reclassification and recalibration of the LTC-DRGs. Because, under this proposal, we would continue to use the most recent available LTCH data, the updated LTC-DRG relative weights would continue to reflect changes in LTCH resource use (as is the case under the current (non-budget neutral) LTC-DRG update methodology). Thus, for example, if the most recent LTCH claims data showed that the resource use for hypothetical LTC-DRG "ABC" is double the resource use for hypothetical LTC-DRG "XYZ," then the value of the relative weight for LTC-DRG "ABC" would be about twice the value of relative weight for LTC-DRG "XYZ."

In addition to accounting for changes in relative resource use, to include a BN requirement for the annual update to the LTC-DRGs under this proposal, the updated LTC-DRG relative weights would need to be uniformly adjusted to ensure that estimated aggregate LTCH PPS payments would not be affected. That is, a BN factor would need to be computed to ensure that the LTC-DRG reclassification and recalibration process, by itself, neither increases nor decreases estimated aggregate LTCH PPS payments. To accomplish BN when annually updating the LTC-DRG classifications and relative weights under the proposed change to § 412.517, we are proposing to use a method that is similar to the methodology used under the IPPS. Specifically, we are proposing that after recalibrating the LTC-DRG relative weights, as we do under our existing methodology (as described in detail in the FY 2007 IPPS final rule (71 FR 47978 through 47981)), we would apply a single BN adjustment factor (which would be published annually in the IPPS proposed and final rules when we update the LTC-DRGs and relative weights) to each of those relative weights. The LTC-DRG BN adjustment factor would ensure that estimated aggregate LTCH PPS payments (based on the most recent available LTCH claims data) after recalibration (the "new" relative weights) would be equal to estimated aggregate LTCH PPS payments (for the same most recent available LTCH claims data) before recalibration (the current or "old" relative weights). (Information on the IPPS DRG BN adjustment can be found in the FY 2007 IPPS final rule (71 FR 47970).) As noted above in this section, the annual update to the LTC-DRG classifications and relative weights provided for under the current § 412.517 is presented in the IPPS proposed and final rules, and under the proposed changes to § 412.517 presented in this proposed rule, the proposed BN update to the LTC-DRGs for FY 2008 would be presented in the FY 2008 IPPS proposed rule in the spring of 2007.

E. ICD-9-CM Coding System

1. Uniform Hospital Discharge Data Set (UHDDS) Definitions

Because the assignment of a case to a particular LTC-DRG will help determine the amount that will be paid for the case, it is important that the coding is accurate. Classifications and terminology used in the LTCH PPS are consistent with the ICD-9-CM and the UHDDS, as recommended to the Secretary by the National Committee on Vital and Health Statistics ("Uniform

Hospital Discharge Data: Minimum Data Set, National Center for Health Statistics (NCHS), April 1980”) and as revised in 1984 by the Health Information Policy Council (HIPC) of the Department of Health and Human Services (HHS).

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

- Diagnoses are defined to include all diagnoses that affect the current hospital stay.

- Principal diagnosis is defined as the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.

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

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

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

The ICD-9-CM C&M Committee is a Federal interdepartmental committee, co-chaired by the National Center for Health Statistics (NCHS) and CMS, that is charged with maintaining and updating the ICD-9-CM system. The C&M Committee is jointly responsible for approving coding changes, and developing errata, addenda, and other modifications to the ICD-9-CM to reflect newly developed procedures and

technologies and newly identified diseases. The C&M Committee is also responsible for promoting the use of Federal and non-Federal educational programs and other communication techniques with a view toward standardizing coding applications and upgrading the quality of the classification system.

The NCHS has lead responsibility for the ICD-9-CM diagnosis codes included in the Tabular List and Alphabetic Index for Diseases, while we have the lead responsibility for the ICD-9-CM procedure codes included in the Tabular List and Alphabetic Index for Procedures. The C&M Committee encourages participation by health-related organizations in this process and holds public meetings for discussion of educational issues and proposed coding changes twice a year at the CMS Central Office located in Baltimore, Maryland. The agenda and dates of the meetings can be accessed on our Web site at <http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes>.

As discussed previously in this section, for the IPPS, section 503(a) of the MMA includes a requirement for updating diagnosis and procedure codes twice a year instead 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 statutory requirement could have a significant impact on health care providers, coding staff, publishers, system maintainers, and software systems, among others, we solicited comments on our proposed provisions to implement this requirement as part of the FY 2005 IPPS proposed rule (69 FR 28220 through 28221). We responded to comments and published our new policy regarding the updating of diagnosis and procedure codes (currently the ICD-9-CM) in the FY 2005 IPPS final rule (69 FR 48953 through 48957). In addition, we established a policy for the possibility of an April 1 ICD-9-CM diagnosis and procedure code update in the RY 2006 LTCH PPS final rule (70 FR 24176) since LTCH systems would be expected to recognize and report those new codes through the channels described in this section even though no DRG additions or deletions or changes to relative weights will occur prior to the usual October 1 update. (For more detailed information on the affect of the statutory mandates directed at the IPPS as amended by section 503(a) of the MMA, refer to the FY 2005 IPPS final rule (69 FR 48954 through 48957) and the RY

2007 LTCH PPS final rule (71 FR 27806 through 27808)).

Current addendum and code title information is published on the CMS Web site at: http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/04_addendum.asp. Summary tables showing new, revised, and deleted code titles are also posted on the CMS Web site at http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp. Information on ICD-9-CM diagnosis codes can be found at <http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/>. Information on new, revised, and deleted ICD-9-CM codes is also available in the American Hospital Association (AHA) publication, *the Coding Clinic for ICD-9-CM*. AHA also distributes information to publishers and software vendors. We also send copies of all ICD-9-CM coding changes to our contractors for use in updating their systems and providing education to providers. In addition, 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 continue to urge LTCHs to focus on improved coding practices. Inappropriate coding of cases can adversely affect the uniformity of cases in each LTC-DRG and produce inappropriate weighting factors at recalibration. Because of concerns raised by LTCHs concerning correct coding, we have asked the AHA to provide additional clarification and instruction on proper coding in the LTCH setting. The AHA will provide this instruction via their established process of addressing questions through their publication, the *Coding Clinic for ICD-9-CM*. Written questions or requests for clarification may be addressed to the Central Office on ICD-9-CM, American Hospital Association, One North Franklin, Chicago, IL 60606. A form for question(s) is available for download and can be mailed on AHA's Web site at: www.ahacentraloffice.org. In addition, current coding guidelines are available at the NCHS Web site: <http://www.cdc.gov/nchs/datawh/ftperv/ftpicd9/ftpicd9.htm#conv>.

In conjunction with the cooperating parties (AHA, the American Health Information Management Association (AHIMA), and NCHS), we reviewed actual medical records and continue to emphasize the importance of the quality

of the documentation under the LTCH PPS. Based on the LTCH claims data analysis described above in section III.D.2. of this preamble, we fully believe that with some experience under a PPS, the quality of the documentation and coding of LTCHs has improved, as it did for the IPPS. However, because of the need for proper coding by LTCHs, the cooperating parties have plans to assist their members with continued improvement in documentation and coding issues for the LTCHs through specific questions and coding guidelines. The importance of consistent and complete documentation is emphasized in the revised ICD-9-CM Official Guidelines for Coding and Reporting: "A joint effort between the attending physician and coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without this documentation, the application of all coding guidelines is a difficult, if not impossible task" (Coding Clinic for ICD-9-CM, Fourth Quarter 2002, page 115).

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

Since implementation of the LTCH PPS, our Medicare FIs have conducted training and provided assistance to LTCHs in correct coding. We have also issued manuals containing procedures, as well as coding instructions to LTCHs and FIs. We will continue to conduct training and provide guidance on an "as needed" basis. We also refer readers to

the detailed discussion on correct coding practices in the August 30, 2002 LTCH PPS final rule (67 FR 55981 through 55983). Additional coding instructions and examples will be published in the *Coding Clinic for ICD-9-CM*.

F. Method for Updating the LTC-DRG Relative Weights

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

Under this payment system, relative weights for each LTC-DRG are a primary element used to account for the variations in cost per discharge and resource utilization among the payment groups as described in § 412.515. To ensure that Medicare patients who are classified to each LTC-DRG have access to 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 2007 IPPS final rule, the LTC-DRG relative weights effective under the LTCH PPS for Federal FY 2007 were calculated using the March 2006 update of FY 2005 MedPAR data and Version 24.0 of the GROUPER software (71 FR 47973). We use total days and total charges in the calculation of the LTC-DRG relative weights.

LTCHs often specialize in certain areas, such as ventilator-dependent patients and rehabilitation or 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 2007 IPPS final rule for further information on the application of the hospital-specific relative value methodology under the LTCH PPS (71 FR 47974 through 47975).)

To account for LTC-DRGs with low volume (that is, with fewer than 25 LTCH cases), we grouped those low volume LTC-DRGs into 1 of 5 categories (quintiles) based on average charges, for the purposes of determining relative weights. For FY 2007 based on the FY 2005 MedPAR data, we identified 180 LTC-DRGs that contained between 1 and 24 cases. This list of low volume LTC-DRGs was then divided into 1 of the 5 low volume quintiles, each containing 36 LTC-DRGs (180 / 5 = 36). Each of the low volume LTC-DRGs grouped to a specific quintile received the same relative weight and ALOS using the formula applied to the regular LTC-DRGs (25 or more cases). (See the FY 2007 IPPS final rule for further explanation of the development and composition of each of the 5 low volume quintiles for FY 2007 (71 FR 47975 through 47978).)

After grouping the cases in the appropriate LTC-DRG, we calculated the relative weights by first removing statistical outliers and cases with a LOS of 7 days or less. Next, we adjusted the number of cases remaining in each LTC-DRG for the effect of SSO cases under § 412.529. The short-stay adjusted discharges and corresponding charges were used to calculate "relative adjusted weights" in each LTC-DRG using the hospital-specific relative value method. We also adjusted the LTC-DRG relative weights to account for nonmonotonically increasing relative weights. That is, we made an adjustment if cases classified to the LTC-DRG "with CCs" of a "with CC"/"without CC" pair had a lower average charge than the corresponding LTC-DRG "without CCs" by assigning the same weight to both LTC-DRGs in the "with CC"/"without CC" pair. (See the FY 2007 IPPS final rule for further details on the steps for calculating the LTC-DRG relative weights (71 FR 47978 through 47984).)

In addition, of the 538 LTC-DRGs in the LTCH PPS for FY 2007, based on LTCH cases in the FY 2005 MedPAR files, we identified 183 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 2005 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 183 LTC-DRGs using the method described in this section of the preamble. However, since patients with a number of the diagnoses under these LTC-DRGs may be treated at LTCHs beginning in FY 2007, we assigned relative weights to each of the 183 "no volume" LTC-DRGs based on clinical similarity and relative costliness to one of the remaining 355 (538 - 183 = 355) LTC-DRGs for which we were able to determine relative weights, based on the FY 2005 claims data. (A list of the current no-volume LTC-DRGs and further explanation of their FY 2007 relative weight assignment can be found in the FY 2007 IPPS final rule (71 FR 47980 through 47984).)

Furthermore, for FY 2007, we established LTC-DRG relative weights of 0.0000 for heart, kidney, liver/intestinal, lung, simultaneous pancreas/kidney, and pancreas transplants (LTC-DRGs 103, 302, 480, 495, 512 and 513, respectively) because presently no LTCH meets the applicable requirements to perform Medicare covered transplant procedures. However, if in the future, a LTCH seeks to meet such requirements as a Medicare-approved transplant center to perform Medicare-covered transplant procedures, we believe that the application and approval procedure would allow sufficient time for us to propose appropriate weights for the LTC-DRGs affected. At the present time, we included these 6 transplant LTC-DRGs in the GROUPER software program for administrative purposes. As the LTCH PPS uses the same GROUPER software program for LTCHs as is used under the IPPS, removing these DRGs would be administratively burdensome.

As we noted previously in this proposed rule, there were no new ICD-9-CM code requests for an April 1, 2007 update. Therefore, Version 24.0 of the DRG GROUPER software established in the FY 2007 IPPS final rule will continue to be effective until October 1, 2007. Moreover, the LTC-DRGs and relative weights for FY 2007 established in Table 11 of that same IPPS final rule (71 FR 48321 through 48331) will continue to be effective until October 1, 2007, (just as they would have been even if there had been any new ICD-9-CM code requests for an April 1, 2007 update). Accordingly, Table 3 in Addendum A to this proposed rule lists

the LTC-DRGs and their respective relative weights, geometric ALOS, and five-sixths of the geometric ALOS that we will continue to use for the period of July 1, 2007 through September 30, 2007. (This table is the same as Table 11 of the Addendum to the FY 2007 IPPS final rule.) The next update to the ICD-9-CM coding system will be presented in the FY 2008 IPPS proposed rule (since there will be no April 1, 2007 updates to the ICD-9-CM coding system). In addition, the proposed DRGs and GROUPER for FY 2008 that would be used for the IPPS and the LTCH PPS, effective October 1, 2007, will be presented in the IPPS FY 2008 proposed rule that will be published in the **Federal Register**.

IV. Proposed Changes to the LTCH PPS Payment Rates for the 2008 LTCH PPS Rate Year

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

A. Overview of the Development of the Payment Rates

The LTCH PPS was effective for a LTCH's first cost reporting period beginning on or after October 1, 2002. Effective with that cost reporting period, LTCHs are paid, during a 5-year transition period, a total LTCH prospective payment that is comprised of an increasing proportion of the LTCH PPS Federal rate and a decreasing proportion based on reasonable cost-based principles, unless the hospital makes a one-time election to receive payment based on 100 percent of the Federal rate as specified in § 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 at § 412.515 through § 412.532. In this section, we discuss the proposed factors that would be used to update the LTCH PPS standard Federal rate for the 2008 LTCH PPS rate year that would be effective for LTCH discharges occurring on or after July 1, 2007 through June 30, 2008. When we implemented the LTCH PPS in the August 30, 2002 LTCH PPS final rule (67 FR 56029 through 56031), we computed the LTCH PPS standard Federal payment rate for FY 2003 by updating the best latest available (FY 1998 or FY 1999) Medicare inpatient operating and capital cost data, using the excluded hospital market basket.

Section 123(a)(1) of the BBRA requires that the PPS developed for LTCHs be budget neutral for the initial year of implementation. Therefore, in calculating the standard Federal rate under § 412.523(d)(2), we set total estimated LTCH PPS payments equal to estimated payments that would have been made under the reasonable cost-based payment methodology had the PPS for LTCHs not been implemented. Section 307(a) of the BIPA specified that the increases to the hospital-specific target amounts and the cap on the target amounts for LTCHs for FY 2002 provided for by section 307(a)(1) of the BIPA shall not be considered in the development and implementation of the LTCH PPS.

Furthermore, as specified at § 412.523(d)(1), the standard Federal rate is reduced by an adjustment factor to account for the estimated proportion of outlier payments under the LTCH PPS to total estimated LTCH PPS payments (8 percent). For further details on the development of the FY 2003 standard Federal rate, see the August 30, 2002 LTCH PPS final rule (67 FR 56027 through 56037), and for subsequent updates to the LTCH PPS Federal rate, refer to the following final rules: RY 2004 LTCH PPS final rule (68 FR 34134 through 34140), RY 2005 LTCH PPS final rule (69 FR 25682 through 25684), RY 2006 LTCH PPS final rule (70 FR 24179 through 24180), and RY 2007 LTCH PPS final rule (71 FR 27819 through 27827).

B. LTCH PPS Market Basket

1. Overview of the RPL Market Basket

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

In the August 30, 2002 final rule (67 FR 56016 through 56017 and 56030), which implemented the LTCH PPS, we established the use of the excluded hospital with capital market basket as the LTCH PPS market basket. The excluded hospital with capital market basket was also used to update the limits on LTCHs' operating costs for inflation under the TEFRA reasonable cost-based payment system. We

explained that we believe the use of the excluded hospital with capital market basket to update LTCHs' costs for inflation was appropriate because the excluded hospital market basket (with a capital component) measures price increases of the services furnished by excluded hospitals, including LTCHs. For further details on the development of the excluded hospital with capital market basket, see the RY 2004 LTCH PPS final rule (68 FR 34134 through 34137).

In the RY 2007 LTCH PPS final rule (71 FR 27810), we noted that based on our research, we did not develop a market basket specific to LTCH services. We are still unable to create a separate market basket specifically for LTCHs due to the small number of facilities and the limited amount of data that is reported (for instance, only approximately 15 percent of LTCHs reported contract labor cost data for 2002). In that same final rule, under the broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of the BIPA, we adopted the "Rehabilitation, Psychiatric and Long-Term Care (RPL) market basket" as the appropriate market basket of goods and services under the LTCH PPS for discharges occurring on or after July 1, 2006. Specifically, beginning with the 2007 LTCH PPS rate year, for the LTCH PPS, we adopted the use of the RPL market basket based on FY 2002 cost report data as it was the best available data. We choose to use the FY 2002 Medicare cost reports because these are the most recent, relatively complete cost data for inpatient rehabilitation facilities (IRFs), inpatient psychiatric facilities (IPF), and LTCHs.

The RPL market basket is determined based on the operating and capital costs of IRFs, IPFs and LTCHs. Since all IRFs are now paid under the IRF PPS Federal payment rate, nearly all LTCHs are paid 100 percent of the Federal rate under the LTCH PPS, and most IPFs are transitioning to payment based on 100 percent of the Federal per diem payment amount under the IPF PPS (payments to IPFs will be based exclusively on 100 percent of the Federal rate for cost reporting periods beginning on or after January 1, 2008), the RPL market basket reflects changes in the operating and capital costs for these hospitals. As we explained in that same final rule, we believe a market basket based on the data of IRFs, IPFs and LTCHs is appropriate to use under the LTCH PPS since it is the best available data that reflects the cost structures of LTCHs.

For further details on the development of the RPL market basket, including the methodology for determining the operating and capital portions of the RPL market basket, see the RY 2007 LTCH PPS final rule (71 FR 27810 through 27817).

2. Proposed Market Basket Estimate for the 2008 LTCH PPS Rate Year

Consistent with our historical practice, we estimate market basket increase based on Global Insight's forecast using the most recent available data. The most recent estimate of the RPL market basket for July 1, 2007 through June 30, 2008 (the 2008 LTCH PPS rate year), based on Global Insight's 3rd quarter 2006 forecast with history through the 2nd quarter of 2006, is 3.2 percent. Global Insight, Inc. is a nationally recognized economic and financial forecasting firm that contracts with CMS to forecast changes in the components of the market baskets. Consistent with our historical practice of using market basket estimates based on the most recent available data, we propose that if more recent data is available when we develop the final rule, we would use such data, if appropriate.

As discussed in greater detail in this section, for the 2008 LTCH PPS rate year, we are proposing to update the standard Federal rate by 0.71 percent. The proposed update reflects an adjustment based on the most recent market basket estimate (currently 3.2 percent) and an adjustment to account for the increase in case-mix in the prior period (FY 2005) that resulted from changes in coding practices rather than an increase in patient severity. We are also proposing that if more recent data are available (for example, a more recent estimate of the market basket), we would use such data, if appropriate, to determine the RY 2008 update in the final rule and thus, the rate update noted in regulation text could change.

C. Proposed Standard Federal Rate for the 2008 LTCH PPS Rate Year

1. Background

At § 412.523(c)(3)(ii), for LTCH PPS rate years beginning RY 2004 through RY 2006, we updated the standard Federal rate to adjust for the most recent estimate of the projected increases in prices for LTCH inpatient hospital services. We established the policy of annually updating the standard Federal rate by the increase factor described in the RY 2004 LTCH PPS final rule (68 FR 34138) because at that time we believed that was the most appropriate method for updating the LTCH PPS standard

Federal rate annually for years after FY 2003. When we moved the date of the annual update of the LTCH PPS from October 1 to July 1 in the RY 2004 LTCH PPS final rule (68 FR 34138), we revised § 412.523(c)(3) to specify that for LTCH PPS rate years beginning on or after July 1, 2003, the annual update to the standard Federal rate for the LTCH PPS would be equal to the previous rate year's Federal rate updated by the most recent estimate of increases in the appropriate market basket of goods and services included in covered inpatient LTCH services. We believed that was the most appropriate method for updating the LTCH PPS standard Federal rate annually for years after RY 2004. In the RY 2007 LTCH PPS final rule (71 FR 27818), we established at § 412.523(c)(3)(iii) that the update to the standard Federal rate for the 2007 LTCH PPS rate year is zero percent. As discussed in that same final rule, we explained that rather than solely using the most recent estimate of the LTCH PPS market basket as the basis of the update factor for the Federal rate for RY 2007, we believed it was appropriate to adjust the rate to account for the changes in coding practices (rather than patient severity) as indicated by our ongoing monitoring activities.

Accordingly, we established the LTCH PPS standard Federal rate, effective from July 1, 2006 through June 30, 2007 (the 2007 LTCH PPS rate year), at \$38,086.04 (71 FR 27818). Additionally, in the RY 2007 LTCH PPS proposed rule (71 FR 4742 through 4747), we provided a description of a preliminary model of an update framework under the LTCH PPS. We received few comments on that update framework preliminary model. As discussed in the RY 2007 LTCH PPS final rule (71 FR 27818 through 27819 and 27902 through 27906), although we did not propose to adopt an analytical update framework, we continued to solicit comments on the framework based on the preliminary model, using the best available data and concepts, and we may propose to adopt a framework at some time in the future. We continue to be interested in comments and suggestions on the preliminary model of an update framework under the LTCH PPS that was present in Appendix A of the RY 2007 LTCH PPS final rule (71 FR 27902 through 27906).

In the discussion that follows, we explain how we developed the proposed standard Federal rate for the 2008 LTCH PPS rate year. Specifically, we explain our rationale, which is based on our ongoing monitoring activities, for proposing an annual update to the

standard Federal rate for RY 2008 that reflects an adjustment for the most recent market basket estimate and an adjustment to account for the increase in case-mix in a prior period (FY 2005) that resulted from changes in coding practices rather than an increase in patient severity.

2. Proposed Update to the Standard Federal Rate for the 2008 LTCH PPS Rate Year

Under § 412.523(c)(3)(ii), for RY 2004 through RY 2006, the annual update to the LTCH PPS standard Federal rate was equal to the most recent estimate of increases in the prices of an appropriate market basket of goods and services included in covered inpatient LTCH services. As noted above in this section, in the RY 2007 LTCH PPS final rule, under the broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of BIPA to include appropriate adjustments in the establishment of the LTCH PPS, for discharges occurring on or after July 1, 2006 and on or before June 30, 2007 (RY 2007), we specified at § 412.523(c)(3)(iii) that the standard Federal rate from the previous year would be updated by a factor of zero percent. That is, the standard Federal rate for the 2007 LTCH PPS rate year remained the same as the standard Federal rate in effect during the 2006 LTCH PPS rate year (July 1, 2005 through June 30, 2006) (that is, \$38,086.04).

As discussed in greater detail in the RY 2007 LTCH PPS final rule (71 FR 27819 through 27827), the update to the standard Federal rate for RY 2007 was determined based on the estimate of the LTCH PPS market basket and an analysis of LTCH case-mix, in conjunction with a review of LTCHs' margins and our ongoing LTCH monitoring activities. Specifically, from our CMI analysis, we calculated the observed CMI increase between FY 2003 and FY 2004 (6.75 percent) and determined that a significant portion of the 6.75 percent increase in CMI between FY 2003 and FY 2004 is due to changes in coding practices, which we define as "apparent" increase in case-mix, rather than the treatment of more resource intensive patients. We also noted that the large observed increase in LTCH case-mix was not accompanied by a corresponding increase in Medicare costs. Finally, we noted in the RY 2007 LTCH PPS final rule (71 FR 27826 through 27827) that although the most recent update of the market basket discussed in that final rule is 0.2 percent lower than the estimate of the market basket discussed in the RY 2007

LTCH PPS proposed rule, we believed that finalizing a zero percent update to the Federal rate for RY 2007 was appropriate for several reasons. First, we did not believe that there was a significant difference between the most recent estimates of the market basket for RY 2007 (3.4 percent) and the estimate used in the RY 2007 LTCH PPS proposed rule (3.6 percent). Furthermore, there could be some minimal variation in how much of the observed case-mix increase represents real case-mix changes. Finally, because the proposed update for RY 2007 at § 412.523(c)(3)(iii) explicitly specified that the RY 2007 standard Federal rate would be the previous LTCH PPS rate year updated by an update factor of zero percent, we believe some commenters may not have been aware that the final update for RY 2007 could have been different than (that is, greater than or less than) zero percent. Thus, we believed that the best approach was to adopt an update factor of zero percent in the final rule for RY 2007, which reflected both the market basket estimate and an adjustment to account for the increase in case-mix in a prior period (FY 2004) that resulted from changes in coding practices rather than an increase in patient severity. In that same final rule (71 FR 27821), we stated that the revision to § 412.523(c)(3) only addressed an update to the LTCH PPS Federal rate for the 2007 LTCH PPS rate year (§ 412.523(c)(3)(iii)), and that we would propose future revisions to § 412.523(c)(3) to address future proposed updates to the LTCH PPS Federal rates in future rate years based on an analysis of the most recent available LTCH data.

In determining the proposed update to the standard Federal rate for the 2008 LTCH PPS rate year, we again performed a CMI analysis using the most recent available LTCH claims data and found the observed CMI increase between FY 2004 and FY 2005 to be 3.49 percent. We believe that there is still some component of apparent CMI increase within the observed CMI increase of 3.49 percent that is due to coding practices rather than the treatment of more resource intensive patients (real CMI increase). Therefore, we believe it is appropriate to propose an adjustment to the market basket update for RY 2008 to account for the apparent CMI increase for a subsequent prior period (that is, CMI increase due to changes in coding practices during FY 2005). As discussed in detail in the RY 2007 LTCH PPS final rule (71 FR 27819 through 27827), in determining the update to the LTCH PPS Federal rate

for RY 2007, we used 2.75 percent as the proxy for "real" CMI change during RY 2004. We noted in that same final rule (71 FR 27822) that we were aware of a well-established RAND Corporation (RAND) study ["Has DRG Creep Crept Up? Decomposing the Case-Mix Index Change Between 1987 and 1988" by G. M. Carter, J. P. Newhouse, and D. A. Relles, R-4098-HCFA/ProPAC (1991)]. Based upon such study, we determined that real case-mix change for IPPS hospitals was a fairly steady 1.0 and 1.4 percent per year. We also noted that in updating IPPS rates, we have consistently assumed that real case-mix change was between 1.0 to 1.4 percent per year, which is a more conservative estimate of real case-mix increase than the 2.75 percent used in determining the update to the Federal rate for RY 2007 (71 FR 27822). However, we explained that we believed at the time it was appropriate to utilize the estimate of 2.75 percent as a proxy for real CMI increase in determining the update for RY 2007 rather than the estimates based on the RAND study (71 FR 27819 through 27827). We believe it is appropriate to factor the impact of moving from a reasonable cost-based (TEFRA) payment system to a PPS into our CMI analysis for RY 2007. In determining the update for RY 2007, we measured the observed CMI increase from FY 2003 (the year LTCHs began transitioning to PPS payments from reasonable cost-based payments) to FY 2004 (the first full year after implementation of the LTCH PPS). Under the reasonable cost-based payment system, there was little incentive for LTCHs to attempt to influence payments through changes in coding practices. Under the former reasonable cost-based payment system, a LTCH's payments were limited on the costs per discharge of its patients in a base year updated. Since payment was based on the resource use of a particular mix of patients in the base year, there may have been reluctance on the part of LTCHs, in subsequent years, to accept more resource-intensive patients than those patients they treat in their base year. In contrast, under the LTCH PPS, payment is DRG-based. Payments are dependent on the DRG to which a patient is assigned as determined by the patient's diagnosis. Therefore, a LTCH could treat higher severity patients with the expectation that payment will be determined based on the hospital case mix in the current year and without the concern, under the former payment system, that its costs for those more resource intensive patients would be limited by the cost per discharge limits

that were established by its patient mix in its base year. Immediately following the transition to the LTCH PPS, a LTCH could receive payment for treating patients with higher severity that require more intensive resources, which would have caused the LTCH to exceed its set limit under the TEFRA system. Therefore, we expected that in the first full year following implementation of the LTCH PPS, LTCHs would take advantage of this change and treat more severe patients. Accordingly, we believe that it is reasonable to assume that the real CMI increase in that first full year after implementation of the LTCH PPS would be somewhat higher than the 1.0 to 1.4 percent annual increase.

Thus, in the CMI analysis conducted for RY 2007 based on case mix data from FY 2003 to FY 2004, we used 2.75 percent as the proxy for the real CMI increase component of the total 6.75 percent observed CMI increase. (For a more detailed discussion on the 2.75 percent proxy for real CMI increase, refer to the RY 2007 LTCH PPS final rule (71 FR 27819 through 27827).)

Consequently for RY 2007, by removing the real CMI increase component (2.75 percent) from the observed CMI increase (6.75 percent), the apparent CMI increase from FY 2003 to FY 2004 was estimated to be 4.0 percent ($6.75 - 2.75 = 4.0$). The rate for RY 2007 was offset by 3.4 percent to account for the changes in coding practices that do not reflect increased severity of LTCH patients (which accounts for the fact that we have already included a 0.34 percent behavioral offset in establishing the initial LTCH PPS Federal rate). For further information on the update to the Federal rate for RY 2007, see the RY 2007 final rule (71 FR 27819 through 27827).

For this proposed rule, the CMI analysis performed in determining the proposed Federal rate update for RY 2008 is based on the observed CMI increase from FY 2004 to FY 2005 (the first and second full years of the LTCH PPS, respectively). We believe that as the LTCH PPS matured and LTCHs have become more familiar with the DRG-based payment system, it is more appropriate to utilize the estimate of real case-mix increase (1.0 percent to 1.4 percent) based on the RAND study that is typically found in acute care hospitals under the IPPS. Furthermore, an analysis of the most recent available LTCH claims data shows a steady decrease in the observed CMI from year to year since FY 2003 (the observed CMI change between FY 2003 and FY 2004 is 6.75 percent, between FY 2004 and FY 2005 is 3.49 percent, and between

FY 2005 and FY 2006 is estimated to be 1.9 percent), which suggests that both apparent and real components of CMI are decreasing as the LTCH PPS matures. Given the estimated 1.9 percent observed CMI increase for FY 2006, it appears that it is inappropriate to assume a constant annual real case mix of 2.75 percent.

Therefore, for periods beyond the first full year of the LTCH PPS, we believe it is no longer appropriate to use such a generous estimate of real CMI. (Many LTCHs have cost reporting periods beginning in August and thus were not paid under the LTCH PPS until August 2003. For those hospitals, the first full year of the LTCH PPS was during FY 2004.) While the well-established "real" case-mix parameters based on the RAND study are based on IPPS data, we believe they are appropriate to apply under the LTCH PPS for the reasons explained below in this section. However, we are soliciting comments on other data sources that could be used to determine a proxy for real LTCH PPS case-mix change other than the 1.0 to 1.4 percent per year case-mix parameters based on the RAND study. As we have discussed numerous times in previous LTCH PPS proposed and final rules, acute care hospitals paid under the IPPS and LTCHs paid under the LTCH PPS have much in common. Hospitals paid under both systems are required to meet the same certification criteria set forth in section 1861(e) of the Act to participate as a hospital in the Medicare program. LTCHs are certified as acute care hospitals but are classified as LTCHs for payment purposes solely because such hospitals generally have an inpatient ALOS of greater than 25 days (as set forth in section 1886(d)(1)(B)(iv)(I) of the Act). Furthermore, the LTCH PPS uses the same patient classification system that is used under the IPPS, and several LTCH PPS payment policies, such as the area wage adjustment (§ 412.525(c)), COLA for Alaska and Hawaii (§ 412.525(b)), and high cost outlier (HCO) policy (§ 412.525(a)) are modeled after the similar IPPS policies.

Therefore, we believe it is appropriate to propose utilizing the estimate of real CMI increase based on the RAND study of 1.0 percent as the proxy for the portion of the observed 3.49 percent CMI increase from FY 2004 to FY 2005 that represents real CMI changes for use in determining the proposed RY 2008 Federal rate update. We propose to use the more conservative 1.0 percent (rather than the 1.4 percent) as a proxy for real CMI increase because it is consistent with what is used under the IPPS and we believe the similarities between LTCHs and acute care hospitals

are significant as we explained previously. (For a more detailed discussion on the 1.0 percent for real CMI increase utilized in the IPPS, see the FY 2007 IPPS final rule (71 FR 48156 through 48158), and the FY 1994 IPPS proposed rule (58 FR 30444).) Accordingly, since the observed CMI change for FY 2005 is estimated at 3.49 percent (based on the most recent available LTCH case-mix data from FY 2004 compared to FY 2005), accounting for the real CMI change of 1.0 percent, we believe that 2.49 percent ($3.49 - 1.0 = 2.49$) of that increase reflects CMI increase that is due to changes in coding practices (rather than patient severity).

As we discussed in greater detail in the RY 2007 LTCH PPS final rule (71 FR 27819 through 27827), while we continue to believe that an update to the LTCH PPS Federal rate year should be based on the most recent estimate of the LTCH PPS market basket, we believe it appropriate that the rate be offset by an adjustment to account for changes in coding practices that do not reflect increased patient severity. Such an adjustment protects the integrity of the Medicare Trust Funds by ensuring that the LTCH PPS payment rates better reflect the true costs of treating LTCH patients (71 FR 27798 through 27820). Therefore, in determining the proposed RY 2008 update to the LTCH PPS Federal rate, we believe it is appropriate to apply an adjustment to eliminate the effect of coding or classification changes in a prior period (FY 2005) that do not reflect real changes in LTCHs' case-mix. Specifically, the proposed case-mix adjustment in determining the proposed RY 2008 Federal rate is meant to reduce current payments to account for the increase in payments in FY 2005 that resulted from the CMI increase that was attributable to the apparent case-mix increase in that year. As was the case when we determined the RY 2007 update factor, this adjustment would be necessary to account for payments that were made based on improved coding (rather than increased patient severity) in prior years. Therefore, in this proposed rule, under the broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of the BIPA to include appropriate adjustments, including updates, in the establishment of the LTCH PPS, we are proposing to revise § 412.523(c)(3), to specify that, for discharges occurring on or after July 1, 2007 and on or before June 30, 2008, the standard Federal rate from the previous year would be updated by 0.71 percent, which is based on the most recent market basket estimate (3.2 percent)

adjusted by the apparent CMI (2.49 percent) due to changes in coding practice rather than an increase in patient severity. As explained above in this section, the proposed update factor for RY 2008 is based on the most recent estimate of the LTCH PPS market basket offset by an adjustment to account for changes in case-mix in prior periods due to changes in coding practices rather than increased patient severity. We note that the proposed update factor of 0.71 percent is higher than the zero percent update recommended by the MedPAC for RY 2008 (MedPAC Public Meeting, January 9, 2007, Meeting Transcript pp. 225–226). We are soliciting comments on a possible zero percent update to the standard Federal rate for RY 2008.

Furthermore, since we are proposing to use the most recent estimates of the market basket and CMI increase in the prior period (FY 2005) for calculating the update factor to the LTCH PPS Federal rate, we note that at the time the analysis must be performed for the final rule, we will consider comments received on this proposed rule and would also use the most recent estimates available at that time, if appropriate, which may be different from the data we are using in this proposed rule. Therefore, the proposed update factor applied to the standard Federal rate may change in the final rule. Consequently, the update factor in the regulation text would change accordingly.

At this time, the most recent estimate of the LTCH PPS market basket is 3.2 percent, and the most recent estimate of apparent CMI increase in the prior period (FY 2005), that is, case-mix increase due to changes in coding practices, is 2.49 percent. Therefore, we are proposing that the RY 2008 update factor to the LTCH PPS Federal rate would be an estimated 0.71 percent ($3.2 - 2.49 = 0.71$), which reflects the proposed adjustment to the most recent market basket estimate and accounts for the increase in case-mix in the prior period that resulted from changes in coding practices rather than an increase in patient severity. Accordingly, under the same broad authority conferred upon the Secretary under the BBRA and the BIPA referenced above in this section, we are proposing to specify under § 412.523(c)(3)(iv), that, for discharges occurring on or after July 1, 2007 and on or before June 30, 2008, the standard Federal rate from the previous year would be updated by 0.71 percent, determined based on an adjustment to the most recent estimate of the market basket to account for case-mix increase in the prior period (FY 2005) that is due

to changes in coding practices rather than patient severity.

3. Proposed Standard Federal Rate for the 2008 LTCH PPS Rate Year

In the RY 2007 LTCH PPS final rule (71 FR 27827), we established a standard Federal rate of \$38,086.04 for the 2007 LTCH PPS rate year that was based on the best available data and policies established in that final rule. In this proposed rule, under the broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of the BIPA, we are proposing an annual update to the standard Federal rate for RY 2008 that reflects an adjustment for the most recent market basket estimate and an adjustment to account for the increase in case-mix in a prior period (FY 2005) that resulted from changes in coding practices rather than an increase in patient severity. Therefore, based on the proposed update factor for RY 2008 of 0.71 percent, the proposed standard Federal rate for RY 2008 would be \$38,356.45. Since the proposed standard Federal rate for the 2008 LTCH PPS rate year has already been adjusted for differences in case-mix, wages, COLAs, and HCO payments, we are not proposing to make any additional adjustments in the proposed standard Federal rate for these factors. Finally, we propose that if more recent data becomes available, we would use that data, if appropriate, to determine the update to the standard Federal rate for the RY 2008 final rule.

D. Calculation of Proposed LTCH Prospective Payments for the 2008 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, COLA in Alaska and Hawaii, HCOs, and other special payment provisions (SSOs under § 412.529 and interrupted stays under § 412.531).

In accordance with § 412.533, during the 5-year transition period, which is currently in its final year for LTCH cost reporting periods beginning on or after

October 1, 2006 (FY 2007), a total LTCH PPS payment was based on the applicable transition blend percentage of the adjusted Federal rate and a percentage based on reasonable cost principles unless the LTCH made a one-time election to receive payment based on 100 percent of the Federal rate. In the final year of the 5-year transition period, which begins with LTCH cost reporting periods beginning on or after October 1, 2006, as specified at § 412.533, a total LTCH PPS payment is 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 as specified in § 412.533(d). As discussed in the August 30, 2002 LTCH PPS final rule (67 FR 56038), the applicable transition blends are set forth in § 412.533(a).

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

1. Proposed Adjustment for Area Wage Levels

a. Background

Under the authority of section 123 of the BBRA as amended by section 307(b) of the BIPA, we established an adjustment to the LTCH PPS Federal rate to account for differences in LTCH area wage levels at § 412.525(c). The labor-related share of the LTCH PPS Federal rate, currently estimated by the FY 2002-based RPL market basket (as discussed in greater detail in section IV.D.1.c. of this preamble), is adjusted to account for geographic differences in area wage levels by applying the applicable LTCH PPS wage index. The applicable LTCH PPS wage index is computed using wage data from inpatient acute care hospitals without regard to reclassification under sections 1886(d)(8) or 1886(d)(10) of the Act. Furthermore, as we discussed in the August 30, 2002 LTCH PPS final rule (67 FR 56015), we established a 5-year transition to the full wage adjustment. The applicable wage index phase-in percentages are based on the start of a LTCH’s cost reporting period as shown in Table 1.

TABLE 1

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

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

b. Geographic Classifications/Labor Market Area Definitions

As discussed in the August 30, 2002 LTCH PPS final rule, which implemented the LTCH PPS (67 FR 56015 through 56019), in establishing an adjustment for area wage levels under § 412.525(c), the labor-related portion of a LTCH's Federal prospective payment is adjusted by using an appropriate wage index based on the labor market area in which the LTCH is located. In the 2006 LTCH PPS rate year final rule (70 FR 24184 through 24185), in § 412.525(c), we revised the labor market area definitions used under the LTCH PPS effective for discharges occurring on or after July 1, 2005 based on the Office of Management and Budget's (OMB's) Core Based Statistical Area (CBSA) designations based on 2000 Census data because we believe that those new labor market area definitions will ensure that the LTCH PPS wage index adjustment most appropriately accounts for and reflects the relative hospital wage levels in the geographic area of the hospital as compared to the national average hospital wage level. As set forth in § 412.525(c)(2), a LTCH's wage index is determined based on the location of the

LTCH in an urban or rural area as defined in § 412.64(b)(1)(ii)(A) through (C). An urban area under the LTCH PPS is defined at § 412.64(b)(1)(ii)(A) and (B). In general, an urban area is defined as a Metropolitan Statistical Area (MSA) as defined by the OMB. (In addition, a few counties located outside of MSAs are considered urban as specified at § 412.64(b)(1)(ii)(B).) Under § 412.64(b)(1)(ii)(C), a rural area is defined as any area outside of an urban area.

We note that these are the same CBSA-based designations implemented for acute care inpatient hospitals under the IPPS at § 412.64(b) effective October 1, 2004 (69 FR 49026 through 49034). For further discussion of the labor market area (geographic classification) definitions used under the LTCH PPS, see the 2006 LTCH PPS rate year final rule (70 FR 24182 through 24191).

c. Proposed Labor-Related Share

In the August 30, 2002 LTCH PPS final rule (67 FR 56016), we established a labor-related share of 72.885 percent based on the relative importance of the labor-related share of operating costs (wages and salaries, employee benefits, professional fees, postal services, and all other labor-intensive services) and capital costs of the excluded hospital with capital market basket based on FY 1992 data.

As we discussed in LTCH PPS final rules subsequent to the FY 2003 LTCH PPS final rule in which we established the original LTCH PPS labor-related share (68 FR 34142, 69 FR 25685 through 25686, and 70 FR 24182), once our research into the labor-related share methodology was complete, we would update the IPPS and excluded hospital labor-related shares based on that research and the best available data if necessary. Accordingly, we conducted analysis of our labor share methodology, which was completed prior to the development of the RY 2007 LTCH PPS proposed and final rules. In the RY 2007 LTCH PPS final rule (71 FR 27829), we updated the LTCH PPS labor-related share based on the FY 2002-based RPL market basket (discussed in section IV.B. of this preamble) because we believe that this market basket was developed based on the best available data that reflect the cost structures of LTCHs.

Consistent with our historical practice, the labor-related share currently used under the LTCH PPS is determined by identifying the national average proportion of operating costs and capital costs that are related to, influenced by, or vary with the local labor market. Specifically, in the RY

2007 LTCH PPS final rule (71 FR 27829 through 27832), we revised the LTCH PPS labor-related share from 72.885 percent (as established in the August 30, 2002 final rule (67 FR 56016) based on the FY 1997-based excluded hospital with capital market basket) to 75.665 percent based on the relative importance of the labor-related share of operating costs (wages and salaries, employee benefits, professional fees, and all other labor-intensive services) and capital costs of the proposed RPL market basket based on FY 2002 data from the first quarter of 2006.

As discussed in section IV.B.2. of this preamble, we now have data from the 3rd quarter of 2006 (with history through the 2nd quarter of 2006) available for determining the labor-related share of the FY 2002-based RPL market basket. Based on this more recent data, in this proposed rule, under the broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of the BIPA, consistent with our historical practice of determining the labor-related share by identifying the national average proportion of operating costs and capital costs that are related to, influenced by, or varies with the local labor market, we are proposing to revise the LTCH PPS labor-related share from 75.665 percent to 75.511 percent based on the relative importance of the labor-related share of operating costs (wages and salaries, employee benefits, professional fees, and all other labor-intensive services) and capital costs of the FY 2002-based RPL market basket from the third quarter of 2006, as shown in Table 2. The labor-related share is the sum of the relative importance of wages and salaries, fringe benefits, professional fees, labor-intensive services, and a portion of the capital share from an appropriate market basket. In this proposed rule, for RY 2008, we are proposing to use the FY 2002-based RPL market basket costs based on data from the 3rd quarter of 2006 to determine the labor-related share for the LTCH PPS effective for discharges occurring on or after July 1, 2007, as this is the most recent available data. The labor-related share for the 2008 LTCH PPS rate year would continue to be the sum of the relative importance of each labor-related cost category, and would reflect the different rates of price change for these cost categories between the base year (FY 2002) and the 2008 LTCH PPS rate year. Consistent with our historical practice of using the best data available, if more recent data are available to determine the labor-related share of the RPL market basket (used under the

LTCH PPS), we propose to use it for determining the labor-related share for the 2008 LTCH PPS rate year in the final rule.

Based on the most recent available data, we are proposing that the sum of the relative importance for 2008 LTCH PPS rate year for operating costs (wages and salaries, employee benefits, professional fees, and labor-intensive services) would be 71.484, as shown in Table 2. The portion of capital that is influenced by the local labor market is still estimated to be 46 percent, which is the same percentage used when we established the current labor-related share in the RY 2007 LTCH PPS final rule. Since, based on the most recent available data, the relative importance

for capital would be 8.754 percent of the FY 2002-based RPL market basket for the 2008 LTCH PPS rate year, we are proposing to multiply the estimated portion of capital influenced by the local labor market (46 percent) by the relative importance for capital (8.754 percent) to determine the proposed labor-related share of capital for the 2008 LTCH PPS rate year. The result would be 4.027 percent (0.46×8.754 percent), which we would add to the proposed 71.484 percent for the operating cost amount to determine the proposed total labor-related share for the 2008 LTCH PPS rate year. Thus, based on the latest available data, we are proposing to use a labor-related share of 75.511 percent (71.484 percent + 4.027

percent) under the LTCH PPS for the 2008 LTCH PPS rate year. As noted above in this section, this proposed labor-related share is determined using the same methodology as employed in calculating the current LTCH labor-related share (71 FR 27830) and the labor-related shares used under the IRF PPS and IPF PPS, which also use the RPL market basket.

Table 2 shows the 2007 LTCH PPS rate year relative importance labor-related share of the FY 2002-based RPL market basket (established in the RY 2007 LTCH PPS final rule) and the proposed 2008 LTCH PPS rate year relative importance labor-related share of the FY 2002-based RPL market basket.

TABLE 2.—RY 2007 LABOR-RELATED SHARE RELATIVE IMPORTANCE AND PROPOSED RY 2008 LABOR-RELATED SHARE RELATIVE IMPORTANCE OF THE FY 2002-BASED RPL MARKET BASKET

Cost category	RY 2007 relative importance *	Proposed RY 2008 relative importance
Wages and Salaries	52.506	52.359
Employee Benefits	14.042	14.095
Professional fees	2.886	2.899
All other labor intensive services	2.152	2.131
Subtotal	71.586	71.484
Labor share of capital costs	4.079	4.027
Total Labor-related share	75.665	75.511

* As established in the RY 2007 LTCH PPS final rule (71 FR 27830).

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

d. Proposed Wage Index Data

In the RY 2007 LTCH PPS final rule (71 FR 27830 through 27831), we established LTCH PPS wage index values for the 2007 LTCH PPS rate year calculated from the same data (generated in cost reporting periods beginning during FY 2002) used to compute the FY 2006 acute care hospital inpatient wage index data without taking into account geographic reclassification under sections 1886(d)(8) and (d)(10) of the Act because that was the best available data at that time. The LTCH wage index values applicable for discharges occurring on or after July 1, 2006 through June 30, 2007 are shown in Table 1 (for urban areas) and Table 2 (for rural areas) in the Addendum to the RY 2007 LTCH PPS final rule (71 FR 27906 through 27930). Acute care hospital inpatient wage index data are also used to establish the wage index adjustment used in the IRF PPS, HHA PPS, and SNF PPS. As we discussed in the August 30, 2002 LTCH PPS final rule (67 FR 56019), since hospitals that are excluded from the IPPS are not

required to provide wage-related information on the Medicare cost report and because we would need to establish instructions for the collection of this LTCH data to establish a geographic reclassification adjustment under the LTCH PPS, the wage adjustment established under the LTCH PPS is based on a LTCH's actual location without regard to the urban or rural designation of any related or affiliated provider.

In this proposed rule, under the broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of BIPA to determine appropriate adjustments under the LTCH PPS, we are proposing that, for the 2008 LTCH PPS rate year, the same data (generated in cost reporting periods beginning during FY 2003) used to compute the FY 2007 acute care hospital inpatient wage index data without taking into account geographic reclassification under sections 1886(d)(8) and (d)(10) of the Act would be used to determine the applicable wage index values under the LTCH PPS because these data (FY 2003) are the

most recent complete data. We are proposing to continue to use IPPS wage data as a proxy to determine the proposed LTCH wage index values for the 2008 LTCH PPS rate year because both LTCHs and acute-care hospitals are required to meet the same certification criteria set forth in section 1861(e) of the Act to participate as a hospital in the Medicare program and they both compete in the same labor markets, and, therefore, experience similar wage-related costs. These data are the same FY 2003 acute care hospital inpatient wage data that were used to compute the FY 2007 wage indices currently used under the IPPS, skilled nursing facility (SNF) PPS and home health agency (HHA) PPS. The proposed LTCH wage index values that would be applicable for discharges occurring on or after July 1, 2007 through June 30, 2008, are shown in Table 1 (for urban areas) and Table 2 (for rural areas) in Addendum A to this proposed rule.

As discussed in section IV.D.1.a. of this preamble, the applicable wage index phase-in percentages are based on the start of a LTCH's cost reporting

period beginning on or after October 1st of each year during the 5-year transition period. Thus, cost reporting periods beginning on or after October 1, 2005 and before October 1, 2006 (FY 2006), the labor-related portion of the standard Federal rate is adjusted by four-fifths of the applicable LTCH wage index value. The wage index adjustment will be completely phased-in beginning with cost reporting periods beginning in FY 2007. That is, for cost reporting periods beginning on or after October 1, 2006, the labor-related portion of the standard Federal rate is adjusted by the full (five-fifths) applicable LTCH wage index value.

Because the phase-in of the wage index does not coincide with the LTCH PPS rate year (July 1st through June 30th), most LTCHs will experience a change in the wage index phase-in percentages during the LTCH PPS rate year. For example, during the 2008 LTCH PPS rate year, for a LTCH with a September 1st fiscal year, the four-fifths wage index will be applicable for the first 2 months of the 2007 LTCH PPS rate year (July 1, 2007 through August 31, 2007) and the full (five-fifths) wage index will be applicable for the next 10 months of the 2008 LTCH PPS rate year (September 1, 2007 through June 30, 2008). For the remainder of such a LTCH's FY 2006 cost reporting periods, which coincides with the first 2 months of RY 2008, the applicable wage index value would be four-fifths of the full FY 2007 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 Addendum A to this proposed rule). Beginning with this LTCH's FY 2007 cost reporting period that will begin during RY 2008, the applicable wage index value would be the full (five-fifths) FY 2007 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 Addendum A to this proposed rule). We note that since there are no longer any LTCHs in their cost reporting periods that began during FY 2003 through FY 2005 (the first three years of the 5-year wage index phase-in), we are no longer showing the 1/5th, 2/5ths and 3/5ths wage index values in Tables 1 and 2 in Addendum A to this proposed rule.

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

In the August 30, 2002 final rule (67 FR 56022), we established, under § 412.525(b), a COLA for LTCHs located

in Alaska and Hawaii to account for the higher costs incurred in those States. In the RY 2007 LTCH PPS final rule (71 FR 27832), for the 2007 LTCH PPS rate year, we established 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 8 of that same final rule.

Similarly, in this proposed rule, under the broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of BIPA to determine appropriate adjustments under the LTCH PPS, for the 2008 LTCH PPS rate year we are proposing 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 3 because these are currently the most recent available data. These proposed factors are obtained from the U.S. Office of Personnel Management (OPM) and are currently used under the IPPS. In addition, we propose that if OPM releases revised COLA factors before March 1, 2007, we would use them for the development of the payments for the 2008 LTCH rate year and publish them in the LTCH PPS final rule.

TABLE 3.—PROPOSED COST-OF-LIVING ADJUSTMENT FACTORS FOR ALASKA AND HAWAII HOSPITALS FOR THE 2008 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 (HCOs)

a. Background

Under the broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of BIPA, in the regulations at § 412.525(a), we established an adjustment for additional payments for outlier cases that have extraordinarily high costs relative to the costs of most discharges. Providing additional payments for outliers strongly improves the accuracy of the LTCH PPS in determining resource costs at the patient and hospital level. These additional payments reduce the financial losses that would otherwise be incurred when treating patients who require more costly care and, therefore, reduce the

incentives to underserve these patients. We set the outlier threshold before the beginning of the applicable rate year so that total estimated outlier payments are projected to equal 8 percent of total estimated payments under the LTCH PPS. Outlier payments under the LTCH PPS are determined consistent with the IPPS outlier policy.

Under § 412.525(a), we make outlier payments for any discharges if the estimated cost of a case exceeds the adjusted LTCH PPS payment for the LTC-DRG plus a fixed-loss amount. The fixed-loss amount is the amount used to limit the loss that a hospital will incur under the outlier policy for a case with unusually high costs. This results in Medicare and the LTCH sharing financial risk in the treatment of extraordinarily costly cases. Under the LTCH PPS HCO policy, the LTCH's loss is limited to the fixed-loss amount and a fixed percentage of costs above the outlier threshold (LTCH DRG payment plus the fixed loss amount) determined by the marginal cost factor. We calculate the estimated cost of a case by multiplying the overall hospital cost-to-charge ratio (CCR) by the Medicare allowable covered charge. In accordance with § 412.525(a)(3), we pay outlier cases 80 percent of the difference between the estimated cost of the patient case and the outlier threshold (the sum of the adjusted Federal prospective payment for the LTC-DRG and the fixed-loss amount).

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

b. Cost-to-Charge Ratios (CCRs)

In determining outlier payments, we calculate the estimated cost of the case by multiplying the LTCH's overall CCR by the Medicare allowable charges for the case. As we discussed in greater detail in the June 9, 2003 IPPS HCO final rule (68 FR 34506 through 34516), because the LTCH PPS HCO policy at § 412.525 is modeled after the IPPS

outlier policy, we believed that it and the SSO policy at § 412.529 are susceptible to the same payment vulnerabilities that became evident under the IPPS and, therefore, merited revision. Thus, we revised the HCO policy at § 412.525(a) and the SSO policy at § 412.529 in that same final rule for the determination of LTCHs' CCRs and the reconciliation of outlier payments.

Under the LTCH PPS, a single prospective payment per discharge is made for both inpatient operating and capital-related costs, and, therefore, we compute a single "overall" or "total" CCR for LTCHs based on the sum of their operating and capital costs (as described in Chapter 3, section 150.24, of the Medicare Claims Processing Manual (CMS Pub. 100-4)) as compared to total charges. Specifically, a LTCH's CCR is calculated by dividing a LTCH's total Medicare costs (that is, the sum of its operating and capital inpatient routine and ancillary costs) by its total Medicare charges (that is, the sum of its operating and capital inpatient routine and ancillary charges). (Instructions regarding the changes established in the June 9, 2003 IPPS HCO final rule for both LTCHs and IPPS hospitals can be found in Transmittal A-03-058 (Change Request 2785; July 3, 2003).)

As a result of the changes established in the June 9, 2003 IPPS HCO final rule, as we discussed in the RY 2007 LTCH PPS final rule (71 FR 27832 through 27833) and the FY 2007 IPPS final rule (71 FR 48119 through 48121), a LTCH is assigned the applicable Statewide average CCR if, among other things, a LTCH's CCR is found to be in excess of the applicable maximum CCR threshold (that is, the LTCH CCR ceiling). As we explained in the FY 2007 IPPS final rule (71 FR 48117), CCRs above this threshold are most likely due to faulty data reporting or entry, and, therefore, these CCRs should not be used to identify and make payments for outlier cases. Such data are clearly errors and should not be relied upon. Thus, under our established policy, if a LTCH's CCR is above the applicable ceiling, the applicable LTCH PPS Statewide average CCR is assigned to the LTCH instead of the CCR computed from its most recent (settled or tentatively settled) cost report data.

Under § 412.525(a)(4)(ii), for discharges occurring on or after August 8, 2003, and before October 1, 2006, we determined the applicable LTCH PPS Statewide average CCRs using the "combined" IPPS operating and capital Statewide average CCRs (that is, adding the separate IPPS operating and capital

CCRs together to determine the LTCH PPS Statewide average CCRs).

Also, under § 412.525(a)(4)(ii), for discharges occurring on or after August 8, 2003, and before October 1, 2006, if a LTCH's CCR is above the applicable "combined" IPPS operating and capital ceiling (that is, adding the separate IPPS operating and capital CCR ceiling together), the applicable Statewide average CCR may be assigned to the LTCH.

As we explained in the FY 2007 IPPS final rule (71 FR 48117 through 48121), we revised our methodology for determining the annual CCR ceiling and Statewide average CCRs under the LTCH PPS because we believe that those changes are consistent with the LTCH PPS single payment rate for inpatient operating and capital costs. Therefore, under the broad authority of section 123 of the BBRA and section 307(b)(1) of BIPA, in that same final rule, we revised our methodology used to determine the LTCH CCR ceiling. For discharges occurring on or after October 1, 2006, we established that the LTCH CCR ceiling specified under § 412.525(a)(4)(iv)(C)(2) is calculated as three standard deviations above the corresponding national geometric mean total CCR (established and published annually by CMS). (The FI may use a Statewide average CCR if, among other things, a LTCH's CCR is in excess of the LTCH CCR ceiling.) The LTCH total CCR ceiling is determined based on IPPS CCR data, by first calculating the "total" (that is, operating and capital) IPPS CCR for each hospital and then determining the average "total" IPPS CCR for all IPPS hospitals. (Our rationale for using IPPS hospital data is discussed in the FY 2007 IPPS final rule (71 FR 48117) and reiterated below in this section.) The LTCH CCR ceiling is then established at 3 standard deviations from the corresponding national geometric mean total CCR. (For further detail on our methodology for annually determining the LTCH CCR ceiling, refer to the FY 2007 IPPS final rule (71 FR 48117 through 48119).) We also established that the LTCH "total" CCR ceiling used under the LTCH PPS will continue to be published annually in the IPPS proposed and final rules, and the public should continue to consult the annual IPPS proposed and final rules for changes to the LTCH total CCR ceiling that would be effective for discharges occurring on or after October 1 each year. Accordingly, in the FY 2007 IPPS final rule (71 FR 48119), we established a FY 2007 LTCH PPS total CCR ceiling of 1.321, effective for discharges occurring on or after October 1, 2006.

In addition, under the broad authority of section 123 of the BBRA and section 307(b)(1) of BIPA, we revised our methodology to determine the Statewide average CCRs under § 412.525(a)(4)(iv)(C) for use under the LTCH PPS in a manner similar to the way we compute the "total" CCR ceiling using IPPS CCR data (71 FR 48120). Specifically, under this revised methodology we first calculate the total (that is, operating and capital) CCR for each IPPS hospital. We then calculate the weighted average "total" CCR for all IPPS hospitals in the rural areas of the State and the weighted average "total" CCR for all IPPS hospitals in the urban areas of the State. (For further detail on our methodology for annually determining the LTCH urban and rural Statewide average CCRs, refer to the FY 2007 IPPS final rule (71 FR 48119 through 48121).) We also established that the applicable Statewide average "total" (operating and capital) CCRs used under the LTCH PPS will continue to be published annually in the IPPS proposed and final rules, and the public should continue to consult the annual IPPS proposed and final rules for changes to the applicable Statewide average total CCRs that would be effective for discharges occurring on or after October 1 each year. Accordingly, in the FY 2007 IPPS final rule (71 FR 48122), the FY 2007 LTCH PPS Statewide average total CCRs for urban and rural hospitals, effective for discharges occurring on or after October 1, 2006, were presented in Table 8C of the Addendum of that final rule (71 FR 48303).

As we explained in the FY 2007 IPPS final rule (71 FR 48117), we continue to believe it is appropriate to use IPPS operating and capital CCRs to compute the LTCH total CCR ceiling and the Statewide average CCRs because LTCHs' cost and charge structures are similar to that of IPPS acute-care hospitals. For instance, LTCHs are certified as acute care hospitals, as set forth in section 1861(e) of the Act to participate as a hospital in the Medicare program, and these hospitals, in general, are paid as LTCHs only because their Medicare ALOS is greater than 25 days as specified in § 412.23(e). Furthermore, prior to qualifying as a LTCH under § 412.23(e)(2)(i), a hospital generally is paid as an acute-care hospital under the IPPS during the period in which it demonstrates that it has an ALOS of greater than 25 days. In addition, since there are less than 400 LTCHs, which are unevenly geographically distributed throughout the United States, there may not be sufficient LTCH CCR data to

determine an appropriate LTCH PPS CCR ceiling using LTCH data.

In the FY 2007 IPPS final rule, in addition to revising our methodology for determining the annual CCR ceiling and Statewide average CCRs under the LTCH PPS for discharges occurring on or after October 1, 2006, under the broad authority of section 123 of the BBRA and section 307(b)(1) of BIPA, we revised § 412.525(a)(4)(iv) for discharges occurring on or after October 1, 2006, to codify in 42 CFR part 412, subpart O the remaining LTCH PPS outlier policy changes that were established in the June 9, 2003 IPPS HCO final rule (68 FR 34506 through 34513), including modifications and editorial clarifications to those existing policies established in that final rule. We made these revisions because we believe that they more precisely describe the application of those policies as they relate to the determination of LTCH CCRs because these changes are consistent with the changes to the calculation of the LTCH CCR ceiling.

Specifically, in the FY 2007 IPPS final rule (71 FR 48119), under the broad authority of section 123 of the BBRA and section 307(b)(1) of BIPA, we established under the LTCH PPS HCO policy at § 412.525(a)(4)(iv)(C) that the FI may use a Statewide average CCR, which is established annually by CMS, if it is unable to determine an accurate CCR for a LTCH in one of the following three circumstances: (1) New LTCHs that have not yet submitted their first Medicare cost report (for this purpose, consistent with current policy, a new LTCH would be defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with § 489.18); (2) LTCHs whose CCR is in excess of the LTCH CCR ceiling; and (3) other LTCHs for whom data with which to calculate a CCR are not available (for example, missing or faulty data). (Other sources of data that the FI may consider in determining a LTCH's CCR included data from a different cost reporting period for the LTCH, data from the cost reporting period preceding the period in which the hospital began to be paid as a LTCH (that is, the period of at least 6 months that it was paid as a short-term acute care hospital), or data from other comparable LTCHs, such as LTCHs in the same chain or in the same region.)

Additionally, in the FY 2007 IPPS final rule (71 FR 48121), we established under § 412.525(a)(4)(iv)(B) and § 412.529(c)(3)(iv)(B) that, for discharges occurring on or after October 1, 2006, the CCR applied at the time a claim is processed will be based on either the most recently settled cost report or the

most recent tentatively settled cost report, whichever is from the latest cost reporting period. Under the broad authority of section 123 of the BBRA and section 307(b)(1) of BIPA, in that same final rule, we also established at § 412.525(a)(4)(iv)(A) that, for discharges occurring on or after October 1, 2006, we may specify an alternative to the CCR computed under § 412.525(a)(4)(iv)(B) (that is, computed from the most recently settled cost report or the most recent tentatively settled cost report, whichever is later), or a hospital may also request that the FI use a different (higher or lower) CCR based on substantial evidence presented by the hospital. In addition, under the broad authority of section 123 of the BBRA and section 307(b)(1) of BIPA, we revised § 412.525(a)(3) to change the plural reference from cost-to-charge "ratios" to the singular reference to a cost-to-charge "ratio" in that final rule. For a complete discussion on all these revisions to our methodology for determining a LTCH's CCR, refer to the FY 2007 IPPS final rule (71 FR 48119 through 48121). We note that in that same FY 2007 IPPS final rule, we made similar revisions to the SSO policy at § 412.529(c)(3), as discussed in V.A.1.b. of the preamble of this proposed rule.

c. Establishment of the Proposed Fixed-Loss Amount

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

In the RY 2007 LTCH PPS final rule (71 FR 27838), in calculating the fixed-

loss amount that would result in estimated outlier payments projected to be equal to 8 percent of total estimated payments for the 2007 LTCH PPS rate year, we used claims data from the December 2005 update of the FY 2005 MedPAR files and CCRs from the December 2005 update of the PSF, as that was the best available data at that time. We believe that CCRs from the PSF are the best available CCR data for determining estimated LTCH PPS payments for a given LTCH PPS rate year because they are the most recently available CCRs actually used to make LTCH PPS payments.

As we also discussed in the RY 2007 LTCH PPS rate year final rule (71 FR 27838), we calculated a single fixed-loss amount for the 2007 LTCH PPS rate year based on the version 23.0 of the GROUPER, which was the version in effect as of the beginning of the LTCH PPS rate year (that is, July 1, 2006 for the 2007 LTCH PPS rate year). In addition, we applied the outlier policy under § 412.525(a) in determining the fixed-loss amount for the 2007 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 2006 LTCH PPS CCR ceiling of 1.423 (71 FR 27838). As noted in that same final rule, in determining the fixed-loss amount for the 2007 LTCH PPS rate year using the CCRs from the PSF, there were no LTCHs with missing CCRs or with CCRs in excess of the current ceiling and, therefore, there was no need for us to independently assign the applicable Statewide average CCR to any LTCHs in determining the fixed-loss amount for the 2007 LTCH PPS rate year (as this may have already been done by the FI in the PSF in accordance with the established policy).

Accordingly, in 2007 LTCH PPS rate year final rule (71 FR 27838), we established a fixed-loss amount of \$14,887 for the 2007 LTCH PPS rate year. Thus, we pay an outlier case 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted Federal LTCH PPS payment for the LTC-DRG and the fixed-loss amount of \$14,887).

In this proposed rule, for the 2008 LTCH PPS rate year, we used the March 2006 update of the FY 2005 MedPAR claims data to determine a proposed fixed-loss amount that would result in estimated outlier payments projected to be equal to 8 percent of total estimated payments, based on the policies described in this proposed rule, because these data are the most recent complete

LTCH data available. Consistent with our historical practice of using the best data available, if more recent LTCH claims data become available, we propose to use it for determining the fixed-loss amount for the 2008 LTCH PPS rate year in the final rule. Furthermore, as noted previously, we determined the proposed fixed-loss amount based on the version of the GROUPER that would be in effect as of the beginning of the 2008 LTCH PPS rate year (July 1, 2007), that is, Version 24.0 of the GROUPER (as established in the FY 2007 IPPS final rule (71 FR 47973)).

We also used CCRs from the June 2006 update of the PSF for determining the proposed fixed-loss amount for the 2008 LTCH PPS rate year as they are currently the most recent complete available data. Consistent with our historical practice of using the best data available, if more recent CCR data are available, we propose to use it for determining the fixed-loss amount for the 2008 LTCH PPS rate year in the final rule. As we discussed in this proposed rule, we revised our methodology for our annual determination of the applicable LTCH CCR ceiling and applicable Statewide average CCRs in determining a LTCH's CCR effective for discharges occurring on or after October 1, 2006 in the FY 2007 IPPS final rule (71 FR 48117 through 48122). Accordingly, in determining the proposed fixed-loss amount for the 2008 LTCH PPS rate year, we used the current FY 2007 applicable LTCH "total" CCR ceiling of 1.321 and LTCH Statewide average "total" CCRs established under our revised methodology in the FY 2007 IPPS final rule (71 FR 48118 and 48121) such that the current applicable Statewide average CCR would be assigned if, among other things, a LTCH's CCR exceeded the current ceiling (1.321). We note that in determining the proposed fixed-loss amount for the 2008 LTCH PPS rate year using the CCRs from the PSF, there was no need for us to independently assign the applicable Statewide average CCR to any LTCHs (as this may have already been done by the FI in the PSF in accordance with our established policy). (Currently, the applicable FY 2007 LTCH Statewide average CCRs can be found in Table 8C of the FY 2007 IPPS final rule (71 FR 48303).)

Accordingly, based on the data and policies described in this proposed rule, we are proposing a fixed-loss amount of \$18,774 for the 2008 LTCH PPS rate year. Thus, we would pay an outlier case 80 percent of the difference between the estimated cost of the case and the proposed outlier threshold (the

sum of the adjusted proposed Federal LTCH payment for the LTC-DRG and the proposed fixed-loss amount of \$18,774). We note that the proposed fixed-loss amount for the 2008 LTCH PPS rate year is higher than the current fixed-loss amount of \$14,887. In addition to being based on the most recent available LTCH data to estimate the cost of each LTCH case, this proposed change in the fixed-loss amount is primarily due to the projected decrease in estimated aggregate LTCH PPS payments that is expected to result from the approach discussed for the SSO policy under § 412.529 (discussed in greater detail in section V.A.2. of this preamble), in conjunction with the proposed changes to the area wage adjustment (discussed in greater detail in section IV.D.1. of this preamble) and the changes to the LTC-DRG relative weights for FY 2007 (as discussed in the FY 2007 IPPS final rule (71 FR 47971 through 47994)). We note that if the approach discussed for the SSO policy was not considered, then the proposed fixed-loss amount would be \$18,207.

As discussed in greater detail in the impact analysis presented in section XVI.B.4. of this proposed rule, we are projecting that the proposed changes, including the approach discussed for the SSO policy presented in section V.A.2. of this proposed rule, would result in a 0.7 percent decrease in estimated payments per discharge in RY 2008 as compared to RY 2007, on average, for all LTCHs. While we are projecting that the proposed 0.71 percent update to the Federal rate (discussed in section IV.C. of this preamble) would result in an increase in estimated payments per discharge in RY 2008 as compared to RY 2007, this increase would be offset by the projected decrease in estimated payments per discharge from RY 2007 to RY 2008 of 0.9 percent due to the approach being considered for the SSO policy and a projected decrease in estimated payments per discharge from RY 2007 to RY 2008 of 0.5 percent due to the proposed changes to the area wage adjustment (including the progression of the established phase-in of that adjustment). Without taking the approach being considered for the SSO policy into account, the proposed changes to the payment rate and policies noted above would result in a 0.3 percent increase in estimated payments per discharge in RY 2008 as compared to RY 2007. Furthermore, as we discussed in the FY 2007 IPPS final rule (71 FR 48343 through 47994), the changes to the LTC-DRG relative weights for FY 2007, which we used to

determine the proposed RY 2008 fixed-loss amount, were projected to result in a 1.3 percent decrease in estimated aggregate LTCH PPS payments in FY 2007.

Because of the estimated decrease in aggregate LTCH PPS payments proposed for the 2008 LTCH PPS rate year (as discussed above in this section), we believe that an increase in the proposed fixed-loss amount is appropriate and necessary to maintain the requirement that estimated outlier payments would be projected to be equal to 8 percent of estimated total LTCH PPS payments, as required under § 412.525(a). As we discussed in the RY 2007 final rule (71 FR 27836), maintaining the fixed-loss amount at the current level would result in HCO payments that significantly exceed the current regulatory requirement that estimated outlier payments would be projected to equal 8 percent of estimated total LTCH PPS payments. Based on the regression analysis that was performed when we implemented the LTCH PPS (August 30, 2002 final rule (67 FR 56022 through 56027)), we established the outlier target at 8 percent of estimated total LTCH PPS payments to allow us to achieve a balance between the "conflicting considerations of the need to protect hospitals with costly cases, while maintaining incentives to improve overall efficiency" (67 FR 56024). That regression analysis also showed that additional increments of outlier payments over 8 percent (that is, raising the outlier target to a larger percentage than 8 percent) would reduce financial risk, but by successively smaller amounts. Outlier payments are budget neutral, and therefore, outlier payments are funded by prospectively reducing the non-outlier PPS payment rates by projected total outlier payments. The higher the outlier target, the greater the (prospective) reduction to the base payment would need to be applied to the Federal rate to maintain BN.

As we discussed in the RY 2007 LTCH PPS final rule (71 FR 27834 through 27835) when we proposed to increase the fixed-loss amount for RY 2007 (over the RY 2006 fixed-loss amount), as an alternative to the proposal to raise the RY 2007 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 as specified in § 412.525(a)(3)), which is currently equal to 80 percent, as a means of ensuring that estimated outlier payments would be projected to

equal 8 percent of estimated total LTCH PPS payments. When we initially established the 80 percent marginal cost factor in the August 30, 2002 final rule (67 FR 56022 through 56027), we explained that our analysis of payment-to-cost ratios for HCO cases showed that a marginal cost factor of 80 percent appropriately addresses outlier cases that are significantly more expensive than nonoutlier cases, while simultaneously maintaining the integrity of the LTCH PPS.

In proposing an increase to the fixed-loss amount for RY 2007 (71 FR 27834), we also solicited comments on whether we should revisit the regression analysis discussed above in this section that was used to establish the existing 8 percent outlier target and 80 percent marginal cost factor, using the most recent available data to evaluate whether the current outlier target of 8 percent or the 80 percent marginal cost factor should be adjusted, and therefore, could have resulted in less of an increase in the fixed-loss amount for RY 2007. In response to this solicitation (as summarized in the RY 2007 LTCH PPS final rule (71 FR 27834 through 24835)), several commenters opposed any option that would allow us to revisit the regression analysis that was used to establish the existing 80 percent marginal cost factor and existing outlier target of 8 percent. The commenters stated their belief that the LTCH PPS is still in its early stages and further changes to the 80 percent marginal cost factor or 8 percent outlier target would result in instability to the system. The commenters cautioned against making any premature changes to the factors affecting HCO payments to LTCHs, particularly the marginal cost factor and outlier target established by regulation when the LTCH PPS was implemented. Also, the commenters agreed that keeping the marginal cost factor at 80 percent and the outlier pool at 8 percent better identifies LTCH patients that are truly unusually costly cases, and that this policy appropriately addresses outlier cases that are significantly more expensive than non-outlier cases.

In response to these comments, we agreed with the commenters that, based on the regression analysis done for the implementation of the LTCH PPS (August 30, 2002; 67 FR 56022 through 56026), a marginal cost factor of 80 percent and an outlier target of 8 percent best identifies LTCH patients that are truly unusually costly cases, and that such a policy appropriately addresses LTCH HCO cases that are significantly more expensive than non-outlier cases, which is consistent with our intent of the LTCH HCO policy as stated when

we implemented the LTCH PPS in the August 30, 2002 final rule (67 FR 56025). Therefore, as supported by many commenters, in the RY 2007 LTCH PPS final rule (71 FR 27835), we did not revisit the regression analysis that was used to establish the existing 80 percent marginal cost factor and existing outlier target of 8 percent, and therefore, did not make any changes to the marginal cost factor or outlier target in that final rule. Furthermore, we stated that after revisiting this issue and an analysis of the most recent complete available data, due to the lag time in the availability of data, we now believe the most appropriate time to revisit a budget neutral policy change in the outlier policy (among other things), which would affect future LTCH PPS payment rates, would be after the conclusion of the 5-year transition period when we expect to have several years of data generated after the implementation of the LTCH PPS.

Although proposing to raise the fixed-loss amount from \$14,887 to \$18,774 (based on the policies presented in this proposed rule) would increase the amount of the "loss" that a LTCH must incur under the LTCH PPS for a case with unusually high costs before the LTCH would receive any additional Medicare payments, as we discussed above and as we explained in greater detail in the RY 2007 LTCH PPS final rule, based on the best available data, we continue to believe that the existing 8 percent outlier target and 80 percent marginal cost factor continue to adequately maintain the LTCHs' share of the financial risk in treating the most costly patients and ensure the efficient delivery of services. Accordingly, we are not proposing to adjust the existing 8 percent outlier target or 80 percent marginal cost factor under the LTCH PPS HCO policy at this time. However, we continue to be interested in any comments that would support revisiting the analysis that was used to establish the existing 8 percent outlier target and the existing 80 percent marginal cost factor, using the most recent available data to evaluate whether any changes to the current HCO policy should be made, and therefore, may result in less of an increase in the fixed-loss amount for RY 2008.

Furthermore, we note that the proposed fixed-loss amount of \$18,774 is lower than the FY 2003 fixed-loss amount of \$24,450 (67 FR 56023) and the 2004 LTCH PPS rate year fixed-loss amount of \$19,590 (68 FR 34144), and only slightly higher than the 2005 LTCH PPS rate year fixed-loss amount of \$17,864 (69 FR 25688), all of which were in effect during the time period

that we estimate positive Medicare margins (as discussed in the RY 2007 LTCH PPS final rule (71 FR 27820 through 27825)). Therefore, we believe the proposed fixed-loss amount of \$18,774 would appropriately identify unusually costly LTCH cases while maintaining the integrity of the LTCH PPS. Thus, under the broad authority of section 123(a)(1) of the BBRA and section 307(b)(1) of BIPA, we are proposing to establish a fixed-loss amount of \$18,774 based on the best available LTCH data and the policies presented in this proposed rule because we believe a proposed increase in the fixed-loss amount is appropriate and necessary to maintain estimated outlier payments are projected to be equal to 8 percent of estimated total LTCH PPS payments, as required under § 412.525(a).

d. Reconciliation of Outlier Payments Upon Cost Report Settlement

In the June 9, 2003 HCO final rule (68 FR 34508 through 34512), we established our policy for LTCHs that provided that effective for LTCH PPS discharges occurring on or after August 8, 2003, any reconciliation of outlier payments will be based upon the actual CCR computed from the costs and charges incurred in the period during which the discharge occurs. In that same final rule, we also established that, for discharges occurring on or after August 8, 2003, at the time of any reconciliation, outlier payments may be adjusted to account for the time value of any underpayments or overpayments based upon a widely available index to be established in advance by the Secretary and will be applied from the midpoint of the cost reporting period to the date of reconciliation. (Additional information on the administration of the reconciliation process under the IPPS is provided in CMS Program Transmittal 707 (October 12, 2005; Change Request 3966). We note that we are currently developing additional instructions on the administration of the reconciliation process under the LTCH PPS that would be similar to the IPPS reconciliation process.)

In the FY 2007 IPPS final rule (71 FR 48121 through 48122), for discharges occurring on or after October 1, 2006, we codified into the LTCH PPS section of the regulations (42 CFR part 412, subpart O) the provisions governing the determination of LTCHs' CCRs, including modifications and editorial clarifications to our existing methodology for determining the annual LTCH CCR ceiling and applicable Statewide average CCRs under the LTCH PPS. (We note that we also made

the same changes under the SSO policy at § 412.529(c)(3), as discussed in section V.A.1.c. of this preamble.

In the FY 2007 IPPS final rule (71 FR 48122), under the broad authority of section 123 of the BBRA and section 307(b)(1) of BIPA, we revised § 412.525(a)(4)(iv)(D) through (E), for discharges occurring on or after October 1, 2006, to codify in subpart O of 42 CFR part 412 the provisions discussed concerning the reconciliation of LTCH PPS outlier payments, including editorial clarifications discussed in greater detail in this section, that would more precisely describe the application of those policies. Specifically, at § 412.525(a)(4)(iv)(D), we specified that for discharges occurring on or after October 1, 2006, any reconciliation of outlier payments will be based on the CCR calculated based on a ratio of costs-to-charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled. In addition, at § 412.525(a)(4)(iv)(E), we specified that for discharges occurring on or after October 1, 2006, at the time of any reconciliation, outlier payments may be adjusted to account for the time value of any underpayments or overpayments. We also specified that such an adjustment will be based upon a widely available index to be established in advance by the Secretary and will be applied from the midpoint of the cost reporting period to the date of reconciliation. We made these additional revisions to § 412.525(a)(4) because we believe that these changes are more consistent with the LTCH PPS single payment rate for inpatient operating and capital costs (as discussed in greater detail previously), and because we believe it is more appropriate and administratively simpler to include all of the regulatory provisions concerning the determination of LTCH PPS outlier payments applicable under the LTCH PPS regulations in subpart O of 42 CFR part 412 of the CFR.

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

As we discussed in the August 30, 2002 final rule (67 FR 56026), under some rare circumstances, a LTCH discharge could qualify as a SSO case (as defined under § 412.529 and discussed in section V.A.1.a. of this preamble) and also as a HCO case. In this scenario, a patient could be hospitalized for less than five-sixths of the geometric ALOS for the specific LTC-DRG, and yet incur extraordinarily high treatment costs. If the costs exceeded the outlier threshold (that is,

the SSO payment plus the fixed-loss amount), the discharge would be eligible for payment as a HCO. Thus, for a SSO case in the 2008 LTCH PPS rate year, the HCO payment would be 80 percent of the difference between the estimated cost of the case and the proposed outlier threshold (the sum of the proposed fixed-loss amount of \$18,774 and the amount paid under the SSO policy).

4. Other Payment Adjustments

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

As we discussed in the RY 2007 LTCH PPS final rule (71 FR 27839), we now believe that after the completion of the 5-year transition, sufficient new data that will have been generated while LTCHs are subject to the LTCH PPS may be available for a comprehensive reevaluation of payment adjustments such as geographic reclassification, rural location, DSH, and IME. The end of the 5-year transition occurs with cost reporting periods beginning on or after October 1, 2007. 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. As we also discussed in the RY 2007 LTCH PPS final rule (71 FR 27839), we now believe that it is appropriate to wait for the conclusion of the 5-year transition to 100 percent of the Federal rate under the LTCH PPS, to maximize the availability of data that are reflective of LTCH behavior in response to the implementation of the LTCH PPS to be used to conduct a comprehensive evaluation of the potential payment adjustment policies

(such as rural location, DSH and IME) in conjunction with our evaluation of the possibility of making a one-time prospective adjustment to the LTCH PPS rates provided for at § 412.523(d)(3).

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

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

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

Specifically, during the LTCH PPS rate years governed under the 5-year transition policy at § 412.533(a), we reduce all LTCH Medicare payments during the 5-year transition by a factor that is equal to 1 minus the ratio of the estimated TEFRA reasonable cost-based payments that would be made if the LTCH PPS was not implemented, to the projected total Medicare program PPS payments (that is, payments made under the transition methodology and the option to elect payment based on 100 percent of the Federal rate).

In the RY 2007 LTCH PPS final rule (71 FR 27841), based on the best available data at that time, we projected that approximately 98 percent of LTCHs will be paid based on 100 percent of the standard Federal rate rather than receive payment under the transition blend methodology for the 2006 LTCH PPS rate year. Using the same methodology described in the August 30, 2002 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 2007 LTCH PPS rate year (July 1, 2006); or (2) a LTCH would receive higher payments based on 100 percent of the 2007 LTCH PPS rate year standard Federal rate compared to the payments it would receive under the transition blend methodology. Similarly, we projected that the remaining 2 percent of LTCHs would 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 2007 LTCH PPS rate year standard Federal rate.

Also in the RY 2007 LTCH PPS final rule (71 FR 24202), based on the best available data at that time and policy revisions described in that same rule, we projected that in absence of a transition BN offset, the full effect of the final full year of the transition period (including the election option) as compared to payments as if all LTCHs would be paid based on 100 percent of the Federal rate would result in a negligible cost to the Medicare program (that is, less than \$1 million in RY 2007). Because the \$1 million in estimated costs to the Medicare program was such a small percentage of the estimated total LTCH payments for RY 2007 (over \$5 billion), the formula that we use to establish the BN offset resulted in a factor, which we reduce all Medicare payments by to account for the additional costs of the transition methodology of zero (due to rounding). Therefore, we established a zero percent transition period BN offset to all LTCH PPS payments for discharge occurring on or after July 1, 2006 through June 30, 2007, to account for the estimated cost of the transition period methodology (including the option to elect payment based on 100 percent of the Federal rate) in RY 2007. Furthermore, in that same final rule (71 FR 27841), we explained that 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. This is because, based on the most available data, we are projecting that the vast majority of LTCHs would have made the election to be paid based on 100 percent of the Federal rate rather than the transition blend which would result in a negligible cost to the Medicare

program. In fact, based on the most recent available data from the July 2006 update of the PSF, we continue to estimate that nearly all (over 98 percent) LTCHs are currently being paid based on 100 percent of the Federal rate (rather than the transition blend methodology). Even for those few remaining LTCHs paid under the transition blend methodology set forth at § 412.533(a), the majority of their LTCH PPS payments are now based on at least 80 percent of the Federal rate and 20 percent of the reasonable cost amount (for cost reporting periods beginning during FY 2006) since there are no longer any LTCHs in their cost reporting periods that began during FY 2003 through FY 2005 (the first three years of the 5-year transition period). Therefore, we continue to believe that there would be no measurable estimated cost to the Medicare program due to the transition period methodology (including the option to elect payment based on 100 percent of the Federal rate) in RY 2008. Accordingly, in this proposed rule, based on updated data and using the same methodology established in the August 30, 2002 final rule (67 FR 56034), we are not proposing a transition BN offset to all LTCH PPS payments for discharges occurring on or after July 1, 2007 through June 30, 2008, 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, since some LTCHs may still be paid under the 4th year of the transition blend methodology, specified at § 412.533, for the first 3 months of RY 2008) in RY 2008.

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

As we discussed in the August 30, 2002 LTCH PPS final rule (67 FR 56036), consistent with the statutory requirement for BN in section 123(a)(1) of the BBRA, we estimated aggregate payments under the LTCH PPS for FY 2003 to be equal to the estimated aggregate payments that would be made if the LTCH PPS were not implemented. Our methodology for estimating payments for purposes of the BN calculations used the best available data at the time and necessarily reflected assumptions. As the LTCH PPS progresses, we are monitoring payment data and will evaluate the ultimate accuracy of the assumptions used in the BN calculations (for example, inflation factors, intensity of services provided, or behavioral response to the implementation of the LTCH PPS) described in the August 30, 2002 LTCH

PPS final rule (67 FR 56027 through 56037). To the extent these assumptions significantly differ from actual experience, the aggregate amount of actual payments may turn out to be significantly higher or lower than the estimates on which the BN calculations were based.

Section 123(a)(1) of the BBRA as amended by section 307(b) of BIPA provides broad authority to the Secretary in developing the LTCH PPS, including the authority for establishing appropriate adjustments. Under this broad authority to make appropriate adjustments, as implemented in the existing § 412.523(d)(3) (as revised in the RY 2007 LTCH PPS final rule), we have provided for the possibility of making a one-time prospective adjustment to the LTCH PPS rates by July 1, 2008, so that the effect of any significant difference between actual payments and estimated payments for the first year of the LTCH PPS would not be perpetuated in the LTCH PPS rates for future years. In the RY 2007 LTCH PPS final rule (71 FR 27842), 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 \$5.27 billion for the 2007 LTCH PPS rate year; \$5.43 billion for the 2008 LTCH PPS rate year; \$5.63 billion for the 2009 LTCH PPS rate year; \$5.86 billion for the 2010 LTCH PPS rate year; and \$6.13 billion for the 2011 LTCH PPS rate year.

In this proposed rule, consistent with the methodology established in the August 30, 2002 final rule (67 FR 56036), based on the most recent available data, we estimate that total Medicare program payments for LTCH services for the next 5 LTCH PPS rate years would be as shown in Table 4.

TABLE 4

LTCH PPS rate year	Estimated payments (\$ in billions)
2008	\$4.65
2009	4.84
2010	5.02
2011	5.24
2012	5.48

In accordance with the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 56037), these estimates are based on the most recent available data, including the projection that nearly all LTCHs will be paid based on 100 percent of the LTCH PPS standard Federal rate during the majority of RY 2008 (in accordance with the transition blend percentages set

forth at § 412.533(a)). These estimates are also based on our estimate of LTCH PPS rate year payments to LTCHs using CMS' Office of the Actuary's (OACT) most recent estimate of the RPL market basket of 3.2 percent for the 2008 LTCH PPS rate year, 2.9 percent for the 2009 LTCH PPS rate year, 2.5 percent for the 2010 LTCH PPS rate year, and 2.9 percent for the 2011 and 2012 LTCH PPS rate years. (We note that OACT develops its spending projections based on existing policy. Therefore, changes that have not yet been implemented are not reflected in the spending projections shown in this section.) We also considered OACT's most recent projections of changes in Medicare beneficiary enrollment that estimate a change in Medicare fee-for-service beneficiary enrollment of 0.2 percent in the 2008 LTCH PPS rate year, 0.5 percent in the 2009 LTCH PPS rate year, 0.1 percent in the 2010 LTCH PPS rate year, 0.2 percent in the 2011 LTCH PPS rate year and, 0.4 percent in the 2012 LTCH PPS rate year.

In the August 30, 2002 LTCH PPS final rule implementing the LTCH PPS (67 FR 55954), we set forth the implementing regulations, based upon the broad authority granted to the Secretary, under section 123 of the BBRA as amended by section 307(b) of the BIPA. Section 123(a)(1) of the BBRA required that the system "maintain budget neutrality" for FY 2003, that is, that estimated aggregate payments under the LTCH PPS would be projected to be equal to the estimated aggregate payments that would be made if the LTCH PPS would not be implemented for FY 2003. The methodology for determining the LTCH PPS standard Federal rate for FY 2003 that would "maintain budget neutrality" is described in considerable detail in the August 30, 2002 final rule (67 FR 56027 through 56037). As we discussed in that same final rule, our methodology for estimating payments for the purposes of BN calculations used the best available data and necessarily reflects assumptions in estimating aggregate payments that would be made if the LTCH PPS was not implemented. We also stated our intentions to monitor LTCH PPS payment data to evaluate the ultimate accuracy of the assumptions used in the BN calculations (for example, inflation factors, intensity of services provided, or behavioral response to the implementation of the LTCH PPS). To the extent that those assumptions significantly differ from actual experience, the estimated aggregate amount of actual payments during FY 2003 may result in

significantly higher or lower estimated payments than the estimates upon which the BN calculations were based. In that same final rule, the Secretary exercised his broad authority in establishing the LTCH PPS and provided for the possibility of a one-time prospective adjustment to the LTCH PPS rates by October 1, 2006, in § 412.523(d)(3) (this deadline was revised to July 1, 2008, in the RY 2007 LTCH PPS final rule). The purpose of that provision was to prevent any significant difference between actual payments and estimated payments for the 1st year of the LTCH PPS, when we established the budget neutral Federal rate as required by the statute (discussed previously), from being perpetuated in the PPS rates for future years.

As we discussed in the RY 2007 LTCH PPS final rule (71 FR 27842 through 27844), because the LTCH PPS was only recently implemented, sufficient new data had not been generated that would enable us to conduct a comprehensive reevaluation of our BN calculations. Therefore, in that same final rule, we did not implement 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 1st year of the LTCH PPS would not be perpetuated in the PPS rates for future years. However, we stated that we will continue to collect and interpret new data as it becomes available in the future to determine if this adjustment should be proposed. Therefore, in the RY 2007 LTCH PPS final rule (71 FR 27842), we revised § 412.523(d)(3) by changing the original October 1, 2006 deadline (established in the August 30, 2002 final rule that implemented the LTCH PPS) to July 1, 2008, to postpone the requirement due to the time lag in the availability of Medicare data upon which this adjustment would be based.

As we discussed in the RY 2007 LTCH PPS final rule (71 FR 27843 through 27844), we now believe that after the conclusion of the 5-year transition period sufficient new data will be generated by the LTCH PPS for a comprehensive reevaluation of our FY 2003 BN calculations. Specifically, we explained that the final year of the 5-year transition to LTCH PPS payments based on 100 percent of the Federal rate for all LTCHs will begin for cost reporting periods beginning on or after October 1, 2006 (FY 2007), and end with cost reporting periods beginning before October 1, 2007 (FY 2008). After the conclusion of the 5-year transition period (October 1, 2007), we expect to have between 3 and 4 years (FY 2003 through FY 2006) of LTCH data

generated since the implementation of the LTCH PPS. We note that there is a lag time between the submission of claims data and cost report data, and the availability of that data in the MedPAR files and HCRIS, respectively. Based on a comprehensive analysis of that data, we may then propose to make a one-time prospective adjustment to the LTCH PPS rates as provided for in § 412.523(d)(3). As also explained in that same final rule, we believe that postponing the deadline of the possible one-time prospective adjustment to the LTCH PPS rates provided for in § 412.523(d)(3) to July 1, 2008, would result in the availability of additional data generated under the LTCH PPS and, therefore, our decisions regarding a possible adjustment would be based on more complete and up-to-date data. This data would be reflective of LTCH behavior in response to the implementation of the LTCH PPS.

Evaluating the appropriateness of the possible one-time prospective adjustment will entail a thorough review of the actual Medicare costs incurred by LTCHs during the 1st year of the LTCH PPS, that is, for LTCH cost reporting periods beginning on or after October 1, 2002 through September 30, 2003. When we established the FY 2003 standard Federal rate to be budget neutral, we used the most recent LTCH cost data available at that time, and trended that data forward to estimate what Medicare would have paid to LTCHs under the TEFRA payment system if the PPS were not implemented (67 FR 56033). Our methodology for estimating payments for the purposes of BN calculations, utilized the best available data and necessarily reflected assumptions in estimating aggregate payments that would have been made had the LTCH PPS not been implemented. (The methodology for determining the LTCH PPS standard Federal rate for FY 2003 that would "maintain budget neutrality" is described in considerable detail in the August 30, 2002 LTCH PPS final rule (67 FR 56027 through 56037).) In that same final rule (67 FR 56036), we also stated our intentions to monitor LTCH PPS data to evaluate the ultimate accuracy of the assumptions used in the BN calculations (for example, inflation factors, intensity of services provided, or behavioral response to the implementation of the LTCH PPS). To the extent that those assumptions significantly differed from actual experience, the aggregate amount of actual payments during FY 2003 could be significantly higher or lower than the

estimates upon which the BN calculations were based.

At the outset of the LTCH PPS, we provided for the possibility of a one-time prospective adjustment at § 412.523(d)(3). Among other things, we wanted the opportunity to adjust the LTCH PPS Federal payment rate once data were available that reflected the actual cost-based payments that would have been made under the Medicare program during FY 2003 if the LTCH PPS had not been implemented, rather than perpetuate any significant difference between actual payments and estimated payments in the 1st year of the LTCH PPS used in determining the Federal rate into future years. Therefore, in the RY 2007 LTCH PPS final rule, we revised § 412.523(d)(3) to postpone the adjustment until July 1, 2008, because by that time, given the lag time typically involved in the entire cost report settlement procedure, we believe we will be able to utilize the most accurate data reflecting the actual costs incurred by LTCHs for cost reporting periods beginning during FY 2003.

We continue to believe that collecting and evaluating new data as it becomes available will allow us to have the best data from the 1st year of the LTCH PPS upon which to base an adjustment such as this. As we explained in the RY 2007 LTCH PPS final rule (71 FR 27844), there are many LTCHs with cost reporting periods from September 1 through August 30 which first became subject to the LTCH PPS on September 1, 2003. Given the lag time required for typical cost report settlement involving submission, desk review, and in some cases an audit, which can take approximately 2 additional years to complete (and we expect to audit a number of LTCH cost reports for the purpose of this analysis), we believe that the October 1, 2006 deadline established § 412.523(d)(3) is no longer reasonable or realistic. In fact, we believe that for cost reports for providers on August 2004 fiscal year ending date, we would be in possession of the most reliable cost report data, indicating the actual costs of the Medicare program of the LTCH PPS during the year in which we established the Federal payment rate by July 2007. Any proposed adjustment under § 412.523(d)(3), if finalized could then be implemented on July 1, 2008. Therefore, at this time, for the reasons discussed in this section, we believe that we still do not have sufficient new data to enable us to conduct a comprehensive reevaluation of our FY 2003 BN calculations. Accordingly, in this proposed rule, we are not proposing

to make a one-time adjustment under § 412.523(d)(3) at this time.

V. Other Proposed Policy Changes for the 2008 LTCH PPS Rate Year

[If you choose to comment on issues in this section, please include the caption "OTHER PROPOSED POLICY CHANGES FOR THE 2008 LTCH PPS RATE YEAR" at the beginning of your comments.]

A. Short Stay Outlier (SSO) Cases

1. Background

In the August 30, 2002 rule for the LTCH PPS, under § 412.529, we established a special payment policy for SSO cases, that is, cases with a covered LOS that is less than or equal to five-sixths of the geometric average LOS for each LTC-DRG. When we established the SSO policy, we explained that "[a] short-stay outlier case may occur when a beneficiary receives less than the full course of treatment at the LTCH before being discharged (67 FR 55995). Also in the August 30, 2002 LTCH PPS final rule, we stated that when we first described the policy, in the March 27, 2002 proposed rule, " * * * we based the proposed policy on the belief that many of these patients could have been treated more appropriately in an acute hospital subject to the acute care hospital inpatient prospective payment system" (67 FR 55995). Therefore, under the LTCH PPS, we implemented a special payment adjustment for SSO cases. Under the original SSO policy, for LTCH PPS discharges with a covered LOS of up to and including five-sixths the geometric average LOS for the LTC-DRG, we adjusted the per discharge payment under the LTCH PPS by the least of 120 percent of the estimated cost of the case, 120 percent of the LTC-DRG specific per diem amount multiplied by the covered LOS of that discharge, or the full LTC-DRG payment 67 FR 55995 through 56000).

As noted previously, generally LTCHs are defined by statute as having an ALOS of greater than 25 days. We stated that we believed that the SSO payment adjustment results in more appropriate payments, since these cases most likely did not receive a full course of a LTCH-level of treatment in such a short period of time and the full LTC-DRG payment would generally not be appropriate. Payment-to-cost ratio analyses indicated that if LTCHs received a full LTC-DRG payment for those cases, they would have been significantly "overpaid" for the resources they have actually expended in treating those patients (67 FR 55995 through 56000).

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

2. Additional Discussion of the SSO Payment Formula

In the August 30, 2002 LTCH PPS final rule, when we first presented our rationale for establishing the SSO policy, we had proposed an adjustment to ensure appropriate payment for cases that we believed may have been transferred from an acute hospital prematurely. Even if a patient was an appropriate admission to the LTCH, we also believed that a short stay case at a LTCH most likely did not receive a full course of medical treatment during the short stay and that a full LTC-DRG payment would therefore, be inappropriate (67 FR 55995 through 56000).

In keeping with these concerns, and based on an evaluation of data from more than 3 years of the LTCH PPS, which revealed that a large percentage of SSOs had a covered LOS of 14 days or less, we revised our payment policy for SSO cases in the RY 2007 LTCH PPS final rule for subclause (I) LTCHs (71 FR 27845 through 27870).

Consistent with the Secretary's broad authority "to provide for appropriate adjustments to the long-term hospital payment system * * *" established under section 123 of the BBRA as amended by section 307(b)(1) of BIPA, for RY 2007, we reduced the cost-based option of the SSO policy adjustment to 100 percent of the estimated costs of the case for discharges occurring on or after July 1, 2006. We believed that by reducing the Medicare payment to a LTCH for a specific SSO case so that it would not exceed the estimated costs incurred for that case, we would be removing what we believed could be a financial incentive to admit and treat SSO cases that the then existing policy had established for LTCHs. We did not change the payment option of 120 percent of the per diem for a specific LTC-DRG multiplied by the covered LOS for that case because as described

in detail in the FY 2003 final rule LTCH PPS, when we first established the SSO policy, we found that by adjusting the per discharge payment by paying at 120 percent of the per diem LTC-DRG payment, once a stay reaches five-sixths of the geometric average LOS for the LTC-DRG, the full LTC-DRG payment will have been made (67 FR 55999). We continue to believe that this specific methodology, which results in a gradual increase in payment as the LOS increases without producing a significant payment "cliff" at any one point, provides a reasonable payment option under the SSO policy.

However, an analysis of the FY 2004 MedPAR data indicated that even under the existing SSO policy, LTCHs were admitting short stay patients that we believe could have continued treatment at the acute care hospitals (paid for under the IPPS) but could have been actually being prematurely discharged to LTCHs. Therefore, in the RY 2007 LTCH PPS final rule, we added a fourth payment option. This fourth payment alternative, a blend of an LTCH PPS amount that is comparable to the IPPS per diem payment amount, and 120 percent of the LTC-DRG per diem payment amount, as described below in this section, reflects our belief that as the length of a SSO stay increases, the case begins to resemble a more "typical" LTCH stay and, therefore, it is appropriate that incrementally, payment should be based more on what would otherwise be payable under the LTCH PPS and less on the IPPS-comparable amount. (Specifics of calculating the IPPS-comparable amount are set forth in considerable detail in the RY 2007 LTCH PPS final rule (71 FR 27852 through 27853).

We noted at the outset of the LTCH PPS for FY 2003, that the LTCH standard rate was calibrated based on LTCH resources expended in treating a patient population requiring long stays. Therefore, in establishing the SSO policy at the beginning of the LTCH PPS, we determined that it was appropriate that we not pay a full LTC-DRG payment for a patient stay not requiring those resources (67 FR 55995 through 56000). Our revision of the payment formula for SSOs for RY 2007 reflected our belief that where a case met our definition of a SSO at § 412.529(a), as the covered LOS increased, the case began to more closely resemble a characteristic LTCH case (and less like a short term acute care hospital case). Therefore, it was appropriate to base an increasing percentage of payment for SSOs on the LTC-DRG payment amount and a decreasing percentage of the LTCH PPS

payment amount based upon the IPPS-comparable amount.

We continue to believe that in defining a LTCH as a hospital with an inpatient ALOS of greater than 25 days in section 1886(d)(1)(B)(iv)(I) of the Act, that the Congress was focusing on LOS as the essential characteristic of this provider category. Furthermore, we believe that the statutory change requiring the establishment of the LTCH PPS emphasized that the payment system should reflect the different resource use related to inpatient hospital services provided by hospitals specified by section 1886(d)(1)(B)(iv) of the Act, that is, by LTCHs (71 FR 27865). Specifically, we believe that the language of the statute indicates that the Congress believed that LTCHs *treat* or should be treating patients with different medical needs which results in those patients having a significantly longer LOS than those acute care hospital patients that we pay for under the IPPS.

In section 4422 of the BBA of 1997, which required that the Secretary develop a legislative proposal for the establishment of a PPS for LTCHs, the Congress specified that the system "shall include an adequate patient classification system that reflects the differences in patient resource use and costs among such hospitals." Section 123 of the BBRA of 1999, which required implementation of a PPS for LTCHs for cost reporting periods beginning on or after October 1, 2002, specified, among other things, that the system be a per discharge payment system, based on diagnosis-related groups (DRGs), and "reflects the differences in patient resource use and costs" of long-term care hospital patients. Section 307(b) of the BIPA of 2000 required the Secretary "to examine the feasibility and the impact of basing payment under such a system on the use of existing (or refined) hospital DRGs that have been modified to account for different resource use of LTCH patients."

When we developed the LTCH PPS for FY 2003, the most recently available MedPAR data (generally, for FYs 1998 and 1999) revealed that 52 percent of the Medicare patients at LTCHs nationwide had a LOS of less than two-thirds of the ALOS for the LTC-DRG to which they were grouped. Of these cases, 20 percent had stays of less than 8 days. Since payments under the LTCH PPS were based on the resources necessary for treatment requiring long term hospital-level stays, beginning with the start of the LTCH PPS, we established the SSO policy, to provide appropriate payment for stays that were

significantly shorter than the ALOS for each specific LTC-DRG.

The original SSO policy focused on our concerns that a SSO patient would generally receive less than the full course of treatment at the LTCH before being discharged and a full LTC-DRG payment would not be appropriate (67 FR 55943, 55995 through 55996). As we noted in the RY 2007 LTCH PPS final rule, when we revised the SSO policy based on our analysis of the nearly 3 years of data since we designed the LTCH PPS, we believed that our SSO policy should reflect our conviction that many SSO patients could otherwise have continued to receive appropriate care in the acute care hospital from which they were admitted. Had these patients not been discharged from the acute care hospital, the additional days of treatment would have continued to have been paid for under the IPPS (71 FR 27845 through 27865).

Section 123 of the BBRA, as amended by section 307(b) of the BIPA, confers broad authority on the Secretary to implement a PPS for LTCHs, including provisions for appropriate adjustments to the payment system. This broad authority gives the Secretary flexibility to fashion a LTCH PPS based on both original policies, as well as concepts borrowed from other payment systems that are adapted, where appropriate to the LTCH context. In the RY 2007 LTCH PPS final rule, we formulated a payment adjustment under the LTCH PPS that we believed would result in an appropriate payment adjustment for those inpatient stays that we believe are not characteristic of LTCHs but could be more appropriately treated in another setting.

Subsequent to the RY 2007 LTCH PPS final rule, we have performed additional analysis of more recent data FY 2005 MedPAR data, and have determined that 42 percent of LTCH SSO discharges, or approximately 19,750 cases, had lengths of stay that were less than or equal to the average LOS plus one standard deviation of an IPPS discharge that is the same DRG as the LTC-DRG to which the case was assigned. (One standard deviation is a statistical test which measures the certainty of the average of a set of measurements for the purpose of data analysis. The standard deviation is the quantity commonly used by statisticians to measure the variation in a data set.) We believe that it is appropriate to compare the covered LOS of a LTCH case grouped to a particular LTC-DRG to the ALOS plus one standard deviation for the corresponding DRG under the IPPS. At one standard deviation, we have identified approximately 68 percent of

the IPPS cases within that DRG that were discharged from acute care hospitals and paid for under the IPPS. Using the statistical test of one standard deviation of the ALOS for each DRG under the IPPS, identifies the majority of IPPS discharges in any DRG.

We believe that the 42 percent of LTCH SSO cases in the RY 2005 MedPAR files with lengths of stay that are equal to or less than the IPPS ALOS plus one standard deviation for the same DRGs under the IPPS appear to be comparable to typical stays at acute care hospitals.

Although LTCHs are certified by Medicare as acute care hospitals, we believe that the Congress intended for the higher LTCH PPS payments to be made to LTCHs that treat patients requiring prolonged hospital-level care. Payments under the LTCH PPS, in compliance with the statutory mandates, have been calibrated based on “the different resource use” of LTCHs as compared to acute care hospitals paid under the IPPS. We believe that we are “overpaying,” under the LTCH PPS, for those SSO cases in LTCHs with covered lengths of stay that are equal to or less than the typical IPPS ALOS (that is, a LOS that is less than or equal to the average IPPS LOS plus one standard deviation for the same DRG under the IPPS).

We further believe that in excluding LTCHs from being paid under the IPPS, the Congress also recognized several types of hospital-level providers that offered a different type of treatment than could reasonably be paid for under the IPPS. Specifically, in the FY 2002 LTCH PPS final rule, we reviewed the history of LTCHs as hospitals excluded from the IPPS. At that time we quoted the legislative history of the 1983 Social Security Amendments which stated, with regard to LTCHs, that the “DRG system was developed for short-term acute care general hospitals and as currently constructed does not adequately account for special circumstances of diagnoses requiring

long stays” (Report of the Committee on Ways and Means, U.S. House of Representatives, to Accompany HR 1900, H.R. Rept. No. 98025, at 141 (1983) (67 FR 55957)). Therefore, from the very outset of the IPPS, the Congress distinguished LTCHs from short term acute care hospitals by patients’ lengths of stay. The PPS for LTCHs that we implemented in FY 2003, complied with the statutory mandate, cited above in this section, that payments under the LTCH PPS be calibrated based on “the different resource use” of these long-stay LTCH patients as distinct from the resources used to treat short stay patients at acute care hospitals and paid under the IPPS. Consequently, as we stated in the RY 2007 LTCH PPS final rule, we believe that “LTCHs that admit SSO patients with lengths of stay more typical of an acute care hospital may be, in fact, behaving like acute care hospitals” (71 FR 27847), and we also believe that it is reasonable for payments under the LTCH PPS for such cases to reflect this behavior.

Our data indicates that for the approximately 350 LTCHs in existence during FY 2005 that discharged approximately 130,000 cases, 46,600 discharges were SSO patients. During that same period, the approximately 3,600 acute care hospitals throughout the United States discharged approximately 12.7 million Medicare beneficiaries. At the approximately 3,600 acute care hospitals, treatment for Medicare patients is paid for under the IPPS, including those cases with a LOS that is the same as the LOS for SSO treated at a LTCH. However at a LTCH, even under the blend payment option of the SSO policy that we established for RY 2007, a percentage of the payment for those short stay patients at LTCHs may be based on a payment rate that was calculated to reflect the “different resource use” at LTCHs as compared to payment based on DRGs at acute care hospitals paid for under the IPPS. We believe that based on this analysis under

the existing SSO policy for short stay patients where the patient’s LOS is less than or equal to the average LOS plus one standard deviation for the same DRG at an acute care hospital, paid for under the IPPS, our blended payment methodology could result in an excessive payment.

Our data further indicates that typically LTCHs admit approximately 80 percent of their patients from acute care hospitals where their urgent conditions have been diagnosed, treated, and stabilized. We believe that when these patients are admitted to a LTCH for an extremely short stay, the LTCH appears to be serving as a step-down unit of the acute care hospital (71 FR 27857 through 27858). (Section 1886(d)(1)(B) of the Act, provides for the establishment of rehabilitation and psychiatric units of section 1886(d) hospitals (that is, acute care hospitals paid for under the IPPS) but not LTCH units.)

As we stated in the RY 2007 LTCH PPS final rule, “* * * an analysis of the CY 2004 MedPAR files revealed that for specified DRGs for acute care cases following ICU/CCU days, there were significantly fewer ‘recuperative’ days (nearly 50 percent) for acute care outlier patients that were discharged from the acute care hospital and then admitted to a LTCH than for those patients that were discharged from the acute care hospital and not subsequently admitted to a LTCH. For example, under the IPPS for DRG 475 (Respiratory system diagnosis with ventilator support) and DRG 483 (Trach with mechanical vent 96+ hours or PDX except face, mouth and neck diagnosis), the number of “recuperative” days were considerably shorter at the acute care hospital if there was a discharge at the acute care hospital followed by an admission to a LTCH. The data in Table 5 is consistent with our belief that many LTCHs appear to be admitting some SSO patients that could have received the care at the acute care hospital. (71 FR 27857)

TABLE 5.—HCO LOS, ICU/CCU LOS, AND POST-ICU/CCU LOS FOR SELECTED INPATIENT DRGs BY POST-DISCHARGE STATUS
[Live discharges only]

DRG	Cases	LOS	Outlier ICU/CCU days	Post ICU/CCU days
475 (no LTCH)	3,887	32.5	20.5	12
475 (with LTCH)	515	29.6	22.6	7
483 (no LTCH)	3,257	73.6	53.6	20
483 (with LTCH)	2,353	45.7	41	4.7

In our analysis of what we believe are excessive payments under the existing

LTCH PPS for the shortest SSOs, we are focusing on those SSO cases where a

LTCH patient’s covered LOS at the LTCH is less than or equal to the ALOS

plus one standard deviation for the same DRG at acute care hospitals (the "IPPS comparable threshold") and distinguishing between those SSO cases with lengths of stay that are less than or equal to the "IPPS comparable threshold" from those that exceed that threshold.

For the purposes of this discussion, whether the LTCH SSO case is within the "IPPS comparable threshold" is determined by comparing the covered LOS of that SSO case which has been assigned to a particular LTC-DRG to the ALOS for the same DRG under the IPPS. For example, if the covered LOS of the LTCH SSO case is equal to or less than the average LOS plus one standard deviation for the same DRG under the IPPS, the LTCH SSO case would be within the "IPPS comparable threshold". We believe an alternative payment option would be appropriate for such a case. We are considering an approach where if the covered LOS was equal to or less than the "IPPS comparable threshold" (defined above in this section) of the same DRG under the IPPS, the SSO payment methodology could be revised so that payment would be based upon the least of 100 percent of estimated costs of the case as determined under § 412.529(d)(2); 120 percent of the LTC-DRG per diem multiplied by the covered LOS of the case as determined under § 412.529(d)(1); the Federal prospective payment for the LTC-DRG as determined under § 412.529(d)(3); or an LTCH PPS amount comparable to the IPPS per diem amount as defined at § 412.529(d)(4), not to exceed the full IPPS comparable amount.

We would note that the RTI Report, discussed in Section XI. of this proposed rule, includes an RTI recommendation that "* * * for LTCH cases whose LOS is within 1 standard deviation of the IPPS average LOS, LTCHs should be paid the IPPS rate. When this occurs, it suggests that LTCH is providing general acute care for these patients. This will allow LTCHs to treat these cases but be paid on an equitable basis with other acute hospitals since the shorter length stay would suggest general acute treatment is being provided." (Recommendation 11, p. 139) (We discuss the RTI report in Section XI. and have included the Executive Summary of the RTI Report as Addendum B of this proposed rule.)

Under this approach, SSO cases with covered lengths of stay that exceed the "IPPS comparable threshold" would continue to be paid under the existing SSO payment policy at § 412.529(c)(2) which is the least of: 100 percent of the estimate cost of the case as determined

under § 412.529(d)(2); 120 percent of the per diem of the LTC-DRG multiplied by the covered LOS of the case as determined under § 412.529(d)(1); the Federal prospective payment for the LTC-DRG as determined under § 412.529(d)(3); or a blend of the 120 percent of the LTC-DRG specific per diem amount and an amount comparable to the IPPS per diem amount as set forth in § 412.529(c)(2)(iv). (The methodology for the calculation of these amounts is specified at § 412.529(d).)

We believe this approach is appropriate because we believe that we should continue to ensure that the LTCH PPS payments are appropriate for all cases; including those with a LOS that resemble cases typically treated at acute care hospitals. Therefore, as noted in the above discussion in this section, for the shortest SSO cases (that is, if the LTCH patient's covered LOS is less than or equal to the "IPPS-comparable threshold"), the IPPS comparable per diem amount, capped at the full IPPS comparable amount that is used under the blend option of the current SSO policy, under this approach could be the fourth payment option in the SSO payment formula, replacing the blend option in the adjusted LTCH PPS payment formula at existing § 412.529(c)(2)(iv). We are considering this policy because we believe that based on our analysis for this particular type of case, it is inappropriate for Medicare to pay a LTCH a LTCH PPS payment that results in a per discharge payment amount that is greater than a hospital paid under the IPPS. Consistent with this approach, those SSO cases where the covered LOS exceeded the "IPPS-comparable threshold," payment (that is, cases that more closely resemble a characteristic LTCH case and less a short term acute care hospital case) would continue to be made under the existing SSO policy at § 412.529(c)(2).

In considering this policy direction, at the present time, we do not believe that this approach for SSOs would be appropriate for the specific situation of a subsection (II) LTCH (that is, a LTCH meeting the definition specified in section 1886(d)(1)(B)(iv)(II) of the Act). We have addressed the uniqueness of this type of LTCH in several notices ((62 FR 45966, 46016, and 46026), (67 FR 55954 and 55974), (68 FR 34147 through 34148) (71 FR 27863)). We believe that subsection (II) LTCHs operate under a unique Congressional mandate which, as set forth in section 1886(d)(1)(B)(iv)(II) of the Act, circumscribes such a LTCHs' admission policies to the extent that it is being identified as a LTCH in order to provide

a particular type of service (for which the ALOS is greater than 20 days) to a particular population (at least 80 percent have a principal diagnosis of neoplastic disease) (68 FR 34147). Exempting subsection (II) LTCHs under this approach is consistent with positions regarding the application of SSO policies to subclause (II) LTCHs. For example, in RY 2004, we provided a distinctive phase-in formula for subclause (II) LTCHs (§ 412.529(e)), and in the RY 2007 LTCH PPS final rule, we did not apply SSO policy revisions for subclause (I) LTCHs (§ 412.529(c)(2)) to subclause (II) LTCHs ((68 FR 34122, 34147 through 34148) (71 FR 27798,27863)).

To encourage a thorough and accurate evaluation of this approach, we have included a column in Table 3 of Addendum A of this proposed rule, which sets forth what would be the IPPS-comparable threshold for each LTC-DRG. We note that to determine the "IPPS Comparable Threshold" for some DRGs it may be necessary to supplement IPPS hospital statistical data due to a low volume of IPPS cases grouped to those DRGs. In addition, although IPPS hospital statistical data for the six transplant DRGs (103, 302, 480, 495, 512 and 513) and two error DRGs (469 and 470) may be available, we could assign a value of zero for the "IPPS Comparable Threshold" for these LTC-DRGs. This is consistent with our on-going policy under the LTCH PPS to assign a value of 0.0000 to the relative weights for these LTC-DRGs, as discussed in section III.D.

As we have stated in this section, we continue to be concerned about appropriate payment for SSO cases under the LTCH PPS, and therefore, we are considering a policy change for the purpose of differentiating between those SSO cases that we believe are more appropriately admitted and treated at LTCHs as distinguished from those with a LOS that resemble cases typically treated at acute care hospitals. As described in this section, for the shortest SSO cases (that is, if the LTCH patient's covered LOS is less than or equal to the "IPPS-comparable threshold"), the IPPS comparable per diem amount, capped at the full IPPS-comparable amount that is used under the blend option of the current SSO policy, could be the fourth payment option in the SSO payment formula, replacing the blend option in the adjusted LTCH PPS SSO payment formula at existing § 412.529(c)(2)(iv). Consistent with this approach, those SSO cases where the covered LOS exceeded the "IPPS-comparable threshold," payment (that is, cases that more closely resemble a characteristic

LTCH case and less a short term acute care hospital case) would continue to be made under the existing SSO policy at § 412.529(c)(2).

As we detailed in this discussion, we are concerned as to whether it is appropriate to pay cases that have a covered LOS in the LTCH that is less than or equal to the IPPS ALOS plus one standard deviation for the same DRG more than would be paid under the IPPS for a similar case. We are interested in soliciting comments on this approach as well as suggestions as to alternative ways in which to address our concerns.

Technical Correction.

We are proposing a technical correction to existing § 412.529(a) which would add the term “covered” immediately before the phrase “length of stay” in the initial definition of a SSO case. This technical correction is not a substantive policy change but rather corrects the regulatory definition of a SSO case so that it is consistent with policy determinations that we have made since the FY 2003 implementation of the LTCH PPS. We would note that utilizing only Medicare covered days for payment purposes has been our policy from the outset of the LTCH PPS, as is specified at § 412.503 where we defined “discharge” for purposes of payment, as “* * * when the patient stops receiving Medicare-covered long-term care services * * *”. Furthermore, in subsequent revisions of our SSO policy, we included the term “covered” in new regulation text, that is, § 412.529(c)(2)(iv)(A) and proposed § 412.529(c)(3)(i)(B) and (c)(3)(ii)(B). We are proposing this technical correction to conform all references in the regulation text at § 412.529 to our existing policy regarding a SSO discharge which is determined based on the number of “covered” days in the patient stay.

3. Determination of Cost-to-Charge Ratios (CCRs)

In the FY 2007 IPPS final rule (71 FR 48117 through 48121), similar to the revisions to the HCO policy as discussed in IV.D.3.d. of the preamble of this proposed rule, we revised our methodology for determining the annual CCR ceiling and Statewide average CCRs under the LTCH PPS because we believe that those changes are more consistent with the LTCH PPS single payment rate for inpatient operating and capital costs. Under the broad authority of section 123 of the BBRA and section 307(b)(1) of BIPA, for discharges occurring on or after October 1, 2006, the LTCH CCR ceiling specified under § 412.529(c)(3)(iv)(C)(2) is calculated as

three standard deviations above the corresponding national geometric mean total CCR (established and published annually by CMS). (As discussed in greater detail in this section, the FI may use a Statewide average CCR if, among other things, a LTCH’s CCR is in excess of the LTCH CCR ceiling.) The LTCH total CCR ceiling is determined based on IPPS CCR data, by first calculating the “total” (that is, operating and capital) IPPS CCR for each IPPS hospital and then determining the average “total” IPPS CCR for all hospitals. The LTCH CCR ceiling is then established at 3 standard deviations from the corresponding national geometric mean total CCR. (For further detail on our methodology for annually determining the LTCH CCR ceiling, refer to the FY 2007 IPPS final rule (71 FR 48117 through 48119).) We also established that the LTCH “total” CCR ceiling used under the LTCH PPS will continue to be published annually in the IPPS proposed and final rules, and the public should continue to consult the annual IPPS proposed and final rules for changes to the LTCH total CCR ceiling that would be effective for discharges occurring on or after October 1 each year. Accordingly, in the FY 2007 IPPS final rule (71 FR 48119), we established a FY 2007 LTCH total CCR ceiling of 1.321, effective for discharges occurring on or after October 1, 2006.

In addition, under the broad authority of section 123 of the BBRA and section 307(b)(1) of BIPA, for discharges on or after October 1, 2006, we revised our methodology to determine the Statewide average CCRs under § 412.529(c)(3)(iv)(C) for use under the LTCH PPS in a manner similar to the way we compute the “total” LTCH CCR ceiling using IPPS CCR data (71 FR 48120). Specifically, under this revised methodology, we first calculate the total (that is, operating and capital) CCR for each IPPS hospital. We would then calculate a weighted average “total” CCR for all IPPS hospitals in the rural areas of the State and weighted average “total” CCR for all IPPS hospitals in the urban areas of the State. (For further detail on our methodology for annually determining the LTCH urban and rural Statewide average CCRs, refer to the FY 2007 IPPS final rule (71 FR 48119 through 48121).) We also established that the applicable Statewide average “total” (operating and capital) CCRs used under the LTCH PPS will continue to be published annually in the IPPS proposed and final rules, and the public should continue to consult the annual IPPS proposed and final rules for changes to the applicable Statewide

average total CCRs that would be effective for discharges occurring on or after October 1 each year. Accordingly, in the FY 2007 IPPS final rule (71 FR 48122), the FY 2007 LTCH PPS Statewide average total CCRs for urban and rural hospitals, effective for discharges occurring on or after October 1, 2006, were presented in Table 8C of the Addendum of that final rule (71 FR 48303).

Additionally, in the FY 2007 IPPS final rule (71 FR 48119), under the broad authority of section 123 of the BBRA and section 307(b)(1) of BIPA, we established under the LTCH PPS SSO policy at § 412.529(c)(3)(iv)(C) that the FI may use a Statewide average CCR, which is established annually by CMS, if it is unable to determine an accurate CCR for a LTCH in one of the following three circumstances: (1) New LTCHs that have not yet submitted their first Medicare cost report (for this purpose, a new LTCH would be defined as an entity that has not accepted assignment of an existing hospital’s provider agreement in accordance with § 489.18); (2) LTCHs whose CCR is in excess of the LTCH CCR ceiling; and (3) other LTCHs for whom data with which to calculate a CCR are not available (for example, missing or faulty data). Other sources of data that the FI may consider in determining a LTCH’s CCR included data from a different cost reporting period for the LTCH, data from the cost reporting period preceding the period in which the hospital began to be paid as a LTCH (that is, the period of at least 6 months that it was paid as a short-term acute care hospital), or data from other comparable LTCHs, such as LTCHs in the same chain or in the same region.

Furthermore, in the FY 2007 IPPS final rule (71 FR 48121), we established under § 412.529(c)(3)(iv)(B) that, for discharges occurring on or after October 1, 2006, the CCR applied at the time a claim is processed will be based on either the most recently settled cost report or the most recent tentatively settled cost report, whichever is from the latest cost reporting period. Under the broad authority of section 123 of the BBRA and section 307(b)(1) of BIPA, in that same final rule, we also established at § 412.529(c)(3)(iv)(A) that, for discharges occurring on or after October 1, 2006, we may specify an alternative to the CCR computed under § 412.529(c)(3)(iv)(B) (that is, computed from the most recently settled cost report or the most recent tentatively settled cost report, whichever is later), or a hospital may also request that the FI use a different (higher or lower) CCR based on substantial evidence presented by the hospital. A complete discussion

of these revisions to our methodology for determining a LTCH's CCR is discussed in the FY 2007 IPPS final rule (71 FR 48119 through 48121).

4. Reconciliation of SSO Cases

In the FY 2007 IPPS final rule (71 FR 48121 through 48122), under the broad authority of section 123 of the BBRA and section 307(b)(1) of BIPA, we revised § 412.529(c)(3)(iv)(D) through (E), for discharges occurring on or after October 1, 2006, to codify in subpart O of 42 CFR part 412 the provisions concerning the reconciliation of LTCH PPS outlier payments, including editorial clarifications discussed in greater detail below in this section, that would more precisely describe the application of those policies.

Specifically, at § 412.529(c)(3)(iv)(D), similar to our current policy, we specified that for discharges occurring on or after October 1, 2006, any reconciliation of outlier payments will be based on the CCR calculated based on a ratio of costs to charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled. In addition, at § 412.529(c)(3)(iv)(E), we specified that for discharges occurring on or after October 1, 2006, at the time of any reconciliation, outlier payments may be adjusted to account for the time value of any underpayments or overpayments. Such an adjustment will be based upon a widely available index to be established in advance by the Secretary and will be applied from the midpoint of the cost reporting period to the date of reconciliation. We made these additional revisions to § 412.529(c)(3) because we believe that these changes would be more consistent with the LTCH PPS single payment rate, and because we believe it would be more appropriate and administratively simpler to include all of the regulatory provisions concerning the determination of LTCH PPS outlier payments applicable under the LTCH PPS regulations at subpart O of 42 CFR part 412. (For a complete discussion on the revisions made to the SSO reconciliation policy, refer to the FY 2007 IPPS final rule (71 FR 48121 through 48122).)

B. Proposed Expansion of Special Payment Provisions for LTCH Hospitals Within Hospitals (HwHs) and LTCH Satellites: Proposed Expansion of the 25 Percent Rule to Certain Situations Not Currently Covered Under Existing § 412.534

In the FY 2005 IPPS final rule we established the special payment

provisions at § 412.534 for LTCHs that are HwHs and for satellites of LTCHs that are co-located with host hospitals. In developing that policy, we were particularly concerned with patient shifting between the host acute care hospitals and the co-located LTCH HwH or satellite for financial rather than for medical reasons, a scenario that we believed was encouraged by physical proximity, and that resulted in inappropriate increased cost to the Medicare program (69 FR 49191). We specified in the FY 2005 IPPS final rule that the payment adjustment for co-located LTCHs at § 412.534 was also applicable to hospitals other than acute care hospitals that served as hosts to both LTCH HwHs and satellites of LTCHs and that we had similar concerns to those stated above regarding patient shifting between such hosts and their co-located LTCHs. However, the vast majority of host hospitals continue to be acute care hospitals (69 FR 49198).

In the FY 2005 IPPS final rule, we quoted the FY 1995 IPPS final rule where we first discussed the concern that LTCH HwHs were, in effect, operating as step-down units of acute care hospitals. We explained that this was inconsistent with the statutory framework and that such a configuration could lead to two Medicare bills being submitted (one from the acute care hospital and the other from the LTCH) for what was essentially one episode of care (69 FR 49191 through 49192, 59 FR 45389).

When we first established the separateness and control criteria for LTCH HwHs at § 412.22(e) in the FY 1995 IPPS final rule, our main objective was to address the shifting of costly, long-stay patients from the host to the on-site LTCH, resulting in two hospital stays which would result in a financial windfall for both providers. We sought to protect the integrity of the IPPS by ensuring that those costly, long-stay patients who could reasonably continue treatment in an acute care hospital would not be unnecessarily discharged to an onsite LTCH, a behavior that would undermine the Medicare IPPS DRG payment system for acute care hospitals. We explained that the Federal standardized payment amount for the IPPS was based on the average cost of an acute care patient across all acute care hospitals. This is premised on the assumption that, on average, both high-cost and low-cost patients are treated at hospitals. Although we might pay a hospital less than was expended for a particular costly case, the hospital would also receive more than was expended for other less costly cases. However, an acute care hospital that

consistently discharges higher cost patients to a post-acute care setting for the purpose of lowering its costs, undercuts the foundation of the IPPS DRG payment system which is based on averages, as noted above. In this circumstance, the hospital inappropriately would have incurred lower costs under the IPPS because the course of acute treatment had not been completed and the hospital did not incur those additional costs for what would have been the remainder of the patient's stay at the IPPS acute care hospital. We were concerned that once that patient was discharged from the IPPS acute care hospital, the patient, still under active treatment for the same condition, would be admitted to a LTCH, thereby generating a second admission and Medicare payment that would not have taken place but for the availability of the LTCH (59 FR 45389 through 45393).

With the growth of satellite entities, another category of co-located facility, we established "separateness and control" policies applicable to satellites of excluded hospitals, which we defined at § 412.22(h) as "a part of a hospital that provides inpatient services in a building also used by another hospital or in one or more entire buildings located on the same campus as buildings used by another hospital." In the FY 2003 IPPS final rule at § 412.22(h), we finalized additional regulations governing the satellites of hospitals (64 FR 41532 through 41535 and 67 FR 50105 through 50106).

As detailed in the FY 2005 proposed rule and final rule for the IPPS (69 FR 28323 through 28327, 69 FR 49191 through 49214), with the explosive growth in the number of LTCH HwHs and concomitant cost to the Medicare program, we reevaluated the effectiveness of existing policies regarding HwHs. (OSCAR data showed that there were 105 LTCHs in 1993 of which 10 were HwHs. By October 2005, there were 373 LTCHs of which most were HwHs.) We reconsidered whether our regulations sufficiently protected the Medicare program from the problems that we envisioned in the FY 1995 IPPS final rule, as discussed in this section. We also questioned the effectiveness of the "performance of basic hospital functions" aspect of the "separateness and control" requirements alone because we were aware that some co-located providers had been establishing complex arrangements among corporate affiliates, and had obtained services from those affiliates, masking true corporate identities and therein diluting or impairing the effectiveness of the

separateness criteria in determining whether both hospitals were interrelated. While technically remaining within the parameters of the rule, these arrangements intermingled corporate interests so that the corporate distinctness was lost, thus side-stepping the intent of our regulations. (Although we have had similar concerns regarding patient movement between host hospitals and their satellites, there had never been any “performance of basic hospital functions” criteria established in § 412.22(h) because satellites are part of another hospital, and therefore, share a Medicare provider number with “the hospital of which they are a part” thus making it administratively burdensome to distinguish between the inpatient operating costs of the main hospital and its satellite(s).)

In the FY 2005 IPPS final rule, following serious consideration of the public comments that we received on our proposed policy revisions for LTCH HwHs and satellites (69 FR 28323 through 28327) and further evaluation of the issues, regulatory changes were finalized for HwH separateness and control policies at § 412.22(e) and a new payment adjustment was established for LTCH HwHs and for satellites of LTCHs at § 412.534. (We wish to note that the term “satellite facility” in this section refers to satellites of excluded hospitals, in particular, LTCHs, and does not include satellites of excluded units at § 412.25.)

Specifically, in the FY 2005 IPPS final rule (69 FR 49091 through 49214), effective for cost reporting periods beginning on or after October 1, 2004, for LTCHs we eliminated the performance of basic hospital functions test under § 412.22(e)(5)(i), the 15 percent test under existing § 412.22(e)(5)(ii), and the 75 percent of admissions from other than the host criteria at § 412.22(e)(5)(iii). A LTCH that met administrative separateness and control requirements at § 412.22(e)(1)(i) through (e)(1)(iv), under our finalized policy, satisfied the LTCH HwH requirements. (As noted above in this section, the performance of basic hospital functions test does not exist for satellites. Therefore, we did not similarly revise § 412.22(h).) However, we established a payment adjustment based upon an annual threshold criteria for LTCH HwHs or LTCH satellites at § 412.534 of 25 percent (or an applicable percentage) for LTCH discharges who were admitted from their host hospitals.

Section 412.534, Special payment provisions for long-term care hospitals within hospitals and satellites of long-term care hospitals, provides that if a LTCH HwH or LTCH satellite’s

discharges that were admitted from its host hospital exceed 25 percent (or the applicable percentage) of its total Medicare discharges for the LTCH HwH or LTCH satellite’s cost reporting period, an adjusted payment would be made at the lesser of the otherwise payable amount under the LTCH PPS or the amount payable under the LTCH PPS that would be equivalent to what Medicare would otherwise pay under the IPPS. In determining whether a hospital met the 25 percent (or applicable percentage) criterion, patients transferred from the host hospital that had already qualified for outlier payments at the host would not count as a discharge that had been admitted from the host. (We commonly refer to this throughout the preamble and regulations text as the discharge not being counted towards the applicable threshold.)

It is important to note that if the hospital exceeds its threshold, LTCH discharges admitted from the host before the LTCH exceeds the 25 percent threshold, would be paid an otherwise unadjusted payment under the LTCH PPS. That is, not adjusted by § 412.534.

We also finalized additional adjustments to the 25 percent policy for specific circumstances. For LTCH HwHs or LTCH satellites located in a rural area, there is no payment adjustment applied under § 412.534 if no more than 50 percent rather than 25 percent of the Medicare patients discharged were admitted from the host. In addition, in determining the percentage of patients admitted from the host, any patients that had been Medicare outliers at the host and then discharged to the rural LTCH HwH or LTCH satellite would be considered as if they were admitted to the LTCH or satellite from a non-host hospital. In addition, in the case of a LTCH or LTCH satellite facility that was co-located with the only other hospital in the MSA or with an MSA-dominant hospital, as defined at § 412.534(e)(4), we provided a payment threshold that we believed responded to “the unique needs of these communities” (69 FR 49207). Under § 412.534(e)(2), we do not adjust payments to those LTCH HwHs or LTCH satellite facilities as long as the percentage of Medicare patients discharged from the LTCH HwH or LTCH satellite that were admitted from the urban single or MSA dominant host hospital, did not exceed the percentage of the *total* Medicare discharges in the MSA in which the hospital is located that were discharged from the host hospital, for the cost reporting period for which the adjustment would be made, but in no case is the percentage less than 25 percent or more than 50

percent. In addition, in determining the percentage of patients admitted to the LTCH from the urban single or MSA dominant host hospital, any patients that had been Medicare outliers at the host and then transferred to the LTCH HwH or LTCH satellite would be considered as if they were admitted to the LTCH from a non-host hospital. (When we refer to “the 25 percent (or applicable percentage)” patient threshold throughout this proposed rule, the “applicable percentage” refers to these special adjustments that we have provided for the special circumstances of rural, urban single, or MSA-dominant hospital or to the percentage associated with the transition policy, discussed below in this section.)

When implementing this policy, we also provided for a 4-year transition for existing LTCH HwHs or LTCH satellites that met the applicable criteria outlined in the regulations to allow a reasonable period during which hosts and co-located LTCH HwH or LTCH satellites and specific “LTCHs under formation” would be able to adapt to the requirements of the new policy. For cost reporting periods beginning on or after October 1, 2004 through September 30, 2005, these transitioned hospitals were to be grandfathered, with the 1st year as a “hold harmless” year. However, we required that even for these facilities that were being phased-in to the full payment adjustment, in the first cost reporting period, the hold harmless year, the percentage of discharges admitted from the host hospital to the LTCH could not exceed the percentage of discharges admitted from the host hospital to the LTCH HwH or LTCH satellite in its FY 2004 cost reporting period. (For the purposes of § 412.534, we established the hospital’s cost reporting period during FY 2004, the last cost reporting period prior to the implementation of § 412.534, as a “base period” for purposes of establishing the gradual phase-in of the full payment threshold adjustment (69 FR 49196).)

Therefore, while we allowed for a 4-year transition for those above specified LTCH HwHs and satellites for cost reporting periods beginning on or after October 1, 2004 and before October 1, 2005 (FY 2005), payments to the LTCH hospital or LTCH satellite facility would be limited based on the percentage that it had admitted during its FY 2004 cost reporting period. After the first grandfathered cost reporting period, these LTCH HwHs and LTCH satellite facilities were required to meet a percentage transition over the 3-year period beginning in FY 2006. For the second year (cost reporting periods

beginning on or after October 1, 2005 but before October 1, 2006), the percentage of Medicare discharges that may be admitted from the host with no adjustment may not exceed the lesser of the percentage of their discharges admitted from their host during its FY 2004 cost reporting period or 75 percent. For the third year (cost reporting periods beginning on or after October 1, 2006 but before October 1, 2007), the percentage of Medicare discharges that may be admitted from the host with no adjustment may not exceed the lesser of the percentage of its Medicare discharges admitted from its host during its FY 2004 cost reporting period beginning or 50 percent, and finally, 25 percent (or other applicable percentage) beginning with the fourth year (cost reporting periods beginning on or after October 1, 2007). Additionally, the 25 percent policy for co-located LTCHs is currently implemented in a location-specific manner, which means that the computation of the percentage of LTCH HwH or LTCH satellite discharges admitted from a host is based solely on the admissions from the physically co-located host and not from other campuses or remote locations which may share a common Medicare provider number with the host.

Although the payment adjustment at § 412.534 focused on LTCH HwHs and satellites of LTCHs and its host hospitals, the relationship between a receiving provider and any referring hospital has been an issue of concern for the Medicare program, even in the absence of co-location. Under section 1886(d)(5)(J) of the Act, added by section 4407 of the BBA of 1997, the Congress provided for a post-acute transfer policy which addressed certain patient discharges from acute care hospitals that subsequently received additional treatment delivered by a second Medicare provider. We believe that the Congress enacted this legislation to discourage acute care hospitals from prematurely discharging patients to another treatment setting in order to increase Medicare payment.

The Congress' enactment of the legislation authorizing the post-acute transfer policy is indicative of its serious concerns about patient shifting between acute and post-acute providers. In the case of the post-acute transfer policy, described above in this section, we focused on overpayment, under the IPPS, to the transferring hospital when a patient is prematurely discharged to another provider during the same episode of illness.

The payment adjustment for co-located LTCHs at § 412.534 was based

on concerns similar to those underlying the post-acute transfer policy at § 412.4, that is, an inappropriately truncated hospitalization at a host facility and an admission to another provider, specifically a LTCH, for which an additional Medicare payment would be generated. However, the payment adjustment at § 412.534 is not applied to the transferring hospital but rather, to discharges from the co-located LTCH to which the presumably prematurely discharged patient has been admitted. Moreover, although the referring hospital under the post-acute transfer policy must be an acute care hospital, for the purposes of the payment adjustment at § 412.534, any hospital is a potential host if it is co-located with a LTCH HwH or LTCH satellite.

The payment adjustment under § 412.534 applies only to determining payments under the LTCH PPS for patients discharged from the LTCH or LTCH satellite which had been admitted to the LTCH or LTCH satellite from the onsite host hospital. For example, if an IRF was co-located with an LTCH HwH and upon discharge from the IRF, the patient was admitted to the onsite LTCH, upon discharge from the LTCH, Medicare payment for that LTCH discharge, would be governed by § 412.534 (69 FR 49198). This would also be the case for a patient shifted to a LTCH from a co-located host acute care hospital following complications from a surgical procedure; a patient requiring rehabilitation who has been discharged from a host IRF to a LTCH; or a patient who had been an inpatient at an IPF and was discharged to an onsite LTCH for care that could otherwise have been continued at the host hospital (that a significant number of LTCHs specialize in rehabilitation and psychiatric cases further supports this point (71 FR 4704 through 4719)). We believe that it is appropriate to pay the LTCH HwH or LTCH satellite that is co-located with an IRF or IPF and exceeds the applicable threshold at the IPPS equivalent rate and not a LTCH PPS rate that would be equivalent to the amount otherwise paid under the IRF or IPF PPS rate, since the HwH and the satellite LTCH are, as we explained earlier in this section, facilities that in many ways are comparable to an acute care hospital.

When we proposed the 25 percent (or applicable percentage) payment adjustment for co-located LTCHs in the FY 2005 IPPS proposed rule, MedPAC expressed concern that the 25 percent patient threshold policy would have a significant impact and could possibly lead to an inequitable situation for co-located LTCHs, as compared to

freestanding LTCHs. Among their concerns were the following: freestanding LTCHs also have strong relationships with acute care hospitals, and that where on average LTCH HwHs receive 61 percent of their patients from their hosts, on average freestanding LTCHs receive 42 percent of their patients from their primary referring hospital; a 25 percent rule that only applied to LTCH HwHs and not to freestanding LTCHs could therefore be inequitable; and this approach could be circumvented by an increase in the number of freestanding LTCHs instead of LTCH HwHs (69 FR 49211).

In the RY 2007 LTCH PPS final rule, we also stated that according to a commenter, the data indicated “* * * that it is common practice for LTCHs * * * to admit patients from a single-source acute care hospitals” and that 71.2 percent of free-standing LTCHs admit more than 25 percent of their patients from a single source acute-care hospital (71 FR 27878).

Additionally, in comments received on a proposed policy to preclude common ownership of a host and a HwH (which was not finalized), two commenters asserted that the financial incentive to accept inappropriate patients from an acute care hospital could exist only when the acute care hospital and the LTCH were commonly owned and when there was common governance, a situation that “can exist even without co-location, that is, a freestanding LTCH, exempt from the requirements of § 412.22(e) could be owned and governed by the hospital from which it receives the majority of its referrals” (69 FR 49202). Despite the commenters' assertions, we do not believe that either common ownership or co-location are the only circumstances under which financial incentives exist for acute care hospitals to prematurely discharge Medicare patients to LTCHs for additional treatment during the same episode of patient care. In fact, we are aware anecdotally of the existence of “arrangements” between Medicare acute and post-acute hospital-level providers that may not have any ties of ownership or governance relating to patient shifting that appear to be based on mutual financial gain rather than on significant medical benefits for the patient. This could be the case if an acute care hospital discharges a Medicare beneficiary who continues to require hospital-level care, to preclude that patient's case from reaching outlier status at the acute care hospital, to an LTCH for additional treatment. Under this scenario, Medicare would pay the acute care hospital under the IPPS for

the beneficiary's care but the hospital would be able to avoid both the "fixed loss" amount and absorbing 20 percent of the remaining costs of patient care, as established under the IPPS outlier policy at subpart F of part 412.

However, Medicare would be responsible for an additional payment, to the LTCH, under the LTCH PPS upon the patient's discharge from the LTCH. Accordingly, we believe that additional regulation in this area is both necessary and appropriate in order to protect the Medicare Trust Fund when generating two payments under two different payment systems for what was essentially one episode of beneficiary care.

When we finalized the payment adjustment at § 412.534 which focused solely on co-located LTCHs, that is, LTCH HwHs and satellites of LTCHs, and as we subsequently noted in the RY 2007 final rule for the LTCH PPS, we took considerable note of these comments and we have continued since that time to monitor the relationships between referring hospitals and LTCHs (71 FR 27878). Specifically, we have analyzed patient claims data from the 2004 MedPAR files for acute care patients who are admitted to free-standing LTCHs. We have analyzed the discharge and LOS information from this data to evaluate whether there is a significant difference in patient shifting behavior between co-located LTCHs and their host acute care hospitals and those free-standing LTCHs that admit a majority of their patients from particular referring acute care hospitals. (As stated previously, in fact for the purposes of the payment adjustment at existing § 412.534, any inpatient hospital-level provider is a potential host if it is co-located with a LTCH HwH or LTCH satellite (69 FR 49198). Similarly, free-standing LTCHs also admit patients from sources other than acute care hospitals. However, our data reveals that approximately 80 percent of all LTCH admissions are from acute care hospitals. Therefore, our data analysis discussed below in this section, focuses on the relationship between a referring acute care hospital and a LTCH.)

We also analyzed data on relationships between LTCHs and acute care hospitals from which they received a significant percentage of referrals. The RY 2005 MedPAR files indicate that only 12.0 percent of the then 174 free-standing LTCHs admitted 25 percent or less of their Medicare discharges from an individual acute care hospital; for 36.8 percent of those freestanding LTCHs, the percentage was between 25 and 50 percent; for 34.5 percent it is between 50 and 75 percent, and for

16.66 percent of those free-standing LTCHs it was between 75 and 100 percent of their Medicare discharges that were admitted from one acute care hospital. Thus, the data indicates that for over 50 percent of all freestanding LTCHs, at least 50 percent of their discharges were for patients admitted from an individual acute care hospital.

Generally, the data reveals minimal differences for cases grouped to the same DRG between the ALOS at the acute care hospital prior to an admission to a co-located LTCH and the ALOS at a referring acute hospital prior to admission to a free-standing LTCH. For example, we evaluated data from CY 2004 MedPAR files regarding LTC-DRG 475, Respiratory System Diagnosis with Ventilator Support, for both LTCH HwHs with more than 25 percent of their discharges admitted from their host hospital and free-standing LTCHs with more than 25 percent of their discharges admitted from an individual referring hospital. The ALOS for patients stays that have not reached outlier status at the host prior to being discharged to the co-located LTCH was 12.7 days and for free-standing LTCHs, the average LOS at their individual referring hospital was 12.9 days. Similarly, for LTC-DRG 416, Septicemia, the ALOS at the host acute care hospital was 9.8 days prior to admission to the co-located LTCH and the prior ALOS at the individual referring acute care hospital was 9.6 days prior to admission to the free-standing LTCH. We believe that this data indicates considerable similarity between the patient shifting behavior at acute care hospitals and co-located LTCHs and acute care hospitals and LTCHs that are not co-located. We would have expected the LOS at the acute care hospital that discharged patients to non-co-located LTCHs to be longer.

Furthermore, as noted above in this section, we have concentrated on the relationships between acute care hospitals and non-co-located LTCHs in this discussion, because approximately 80 percent of Medicare patients in LTCHs are admitted from acute care hospitals. However, we believe that the same concerns, articulated above, would also exist when the patient source is not an acute care hospital. There could still be a financial incentive on the part of the referring hospital (for example, an IRF, to prematurely discharge a beneficiary to a LTCH for additional post-acute treatment in order to avoid absorbing high treatment costs under the IRF outlier policy at § 412.624(e)(5)) that would result in two Medicare payments, one to the initial provider

and the other to the LTCH for a single episode of beneficiary care. (We recognize that a patient could experience a medical crisis while an inpatient at an IRF, but typically, the most appropriate setting for such urgent care would be a general acute care hospital, rather than a LTCH.)

We believe that this data gives further credence to concerns articulated by MedPAC and the assertions made by the Lewin Group in its comments on our FY 2005 IPPS proposed rule regarding the "strong relationships" for referral purposes that exist between many acute care hospitals and free-standing LTCHs. Although our decade-old concerns, about LTCHs functioning as long-stay or step-down "units" of acute care hospitals, focused on co-located LTCHs (HwHs and LTCH satellites), we believe that this data indicates that many free-standing LTCHs may also be serving the same purpose as those that are co-located, that is, as functional step-down units of their primary referring acute care hospital.

We are also concerned about other attempts to evade our regulations at § 412.534. In implementing the HwH regulations at § 412.22(e) and the satellite regulations at § 412.22(h), we have consistently utilized the definition of "campus" that was established in the provider-based regulations at § 413.65(a)(2) which specifies that a campus is "the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual basis, by the CMS regional office, to be part of the provider's campus." We have become aware of certain LTCH companies that have both established new LTCHs and/or are considering relocating existing HwHs or LTCH satellites so that they are at least 300 yards from the acute care hospital, thus side-stepping the intent of existing § 412.534. We believe that our proposals to extend the existing payment policy will address the type of "gaming," described above in this section, as well as dealing with our concern that LTCHs appear to be admitting patients from referring hospitals prior to the delivery of a full episode of care so that we are making two payments, one to the referring hospital and another much higher payment under the LTCH PPS to the LTCH for what is essentially one episode of care. While reviewing the following proposals, we would also be interested in receiving suggestions as to other ways in which we could

effectively address attempts to evade the intent of our regulations governing patient-shifting between referring hospitals and LTCHs.

We first noted in the RY 2006 LTCH PPS final rule (71 FR 27878), our concern that in many cases the line of “functional separateness” between free-standing LTCHs and their major referral sources appears to have been erased. We believe that our analysis of patient movement between these facilities supports these concerns.

Therefore, under the broad authority conferred on the Secretary by section 123 of the BBRA, as amended by section 307(b) of the BIPA to implement a prospective payment system for LTCHs, including authority to provide for appropriate adjustments to the payment system, we are proposing to extend the payment adjustment at § 412.534, presently applicable to co-located subclause (I) LTCHs, to *all* subclause (I) LTCHs (section 1886(d)(1)(B)(iv)(I) of the Act), as explained below in this section. (For the purposes of the discussion of this proposed policy, “subclause (I) LTCH” is also intended to include satellites of these LTCHs. Our proposal regarding subclause (II) LTCHs, that is those LTCHs that meet the definition at section 1886(d)(1)(B)(iv)(II) of the Act, is discussed below in this section.) Specifically, at proposed § 412.536, we are setting forth proposed regulations that govern payments under the LTCH PPS for LTCH and LTCH satellite Medicare discharges admitted from non-co-located hospitals. We are proposing that the policy provisions of the existing 25 percent (or applicable percentage) payment adjustment would apply to any subclause (I) LTCH or LTCH satellite regardless of the physical proximity to the hospital from which it is accepting admissions. In order to apply this policy at all subclause (I) LTCHs and LTCH satellites, we are additionally proposing to revise existing § 412.534 to include a new provision at proposed § 412.534(h) that would extend the 25 percent (or applicable percentage) payment threshold to those grandfathered co-located subclause (I) LTCH HwHs and LTCH satellites at § 412.22(f) and § 412.22(h)(3)(i), respectively, for Medicare discharges that had been admitted from the grandfathered LTCH of LTCH satellite facility’s host for cost reporting periods beginning on or after July 1, 2007. (We address the issue of satellites of subclause (II) LTCHs below in this section.)

We are proposing to add new § 412.536 that will specify a comparable payment adjustment governing Medicare discharges from subclause (I)

LTCHs and LTCH satellites that were admitted from non-co-located hospitals. We note that under this proposal, the payment adjustment at § 412.536 would also apply to those Medicare discharges from co-located subclause (I) LTCHs (HwHs and LTCH satellite facilities) that have been admitted from hospitals other than those with which they are co-located. We believe that this proposed policy will address our concerns with LTCHs and LTCH satellites that in many cases appear to be functioning like step-down units of acute care hospitals.

Furthermore, we believe it is appropriate that the same analytical standards and payment policies be applied by Medicare to all subclause (I) LTCHs. Therefore, we are proposing to amend existing § 412.534 to include subclause (I) grandfathered LTCH HwHs and LTCH satellite facilities, as well as proposing to use the same thresholds applicable to co-located LTCH HwHs and LTCH satellite facilities for subclause (I) LTCHs and LTCH satellite facilities that admit Medicare patients from non-co-located hospitals under § 412.536. Specifically, we are proposing that for cost reporting periods beginning on or after July 1, 2007, as we specify in proposed revised § 412.534(h), this payment adjustment would include those subclause (I) LTCH HwHs and satellites that have been “grandfathered” under § 412.22(f) and § 412.22(h)(3)(i) respectively and that are presently exempted from the existing payment adjustment for co-located LTCHs. As noted previously, both grandfathered HwHs at § 412.22(f) and satellite facilities at § 412.22(h)(3)(i) are permitted to retain their exclusions from the IPPS despite not meeting “separateness and control” policies with regard to their relationships with their host hospitals, as long as they continue to comply with applicable Medicare requirements. This proposed inclusion of grandfathered LTCH HwHs and LTCH satellites in the 25 percent (or applicable percentage) threshold policy would not affect their ability to continue to be “grandfathered” and excluded from the IPPS. Moreover, as noted above, the proposed 25 percent (or the applicable percentage) threshold policy governing discharges from subclause (I) LTCHs that had been admitted from any individual non-co-located hospital, at new proposed § 412.536, would also apply in determining payments under the LTCH PPS for Medicare discharges from LTCH HwHs and LTCH satellites that had been admitted from non-co-located hospitals other than their hosts, including grandfathered HwHs and LTCH satellites. Under the proposed

policies applicable to grandfathered subclause (I) LTCH HwHs and LTCH satellites, we would pay an adjusted amount for those discharged Medicare patients that were admitted from their co-located host, under proposed § 412.534(h) or from any other referring hospital under proposed § 412.536, in excess of the applicable percentage threshold. The grandfathered LTCHs and LTCH satellite facility’s Medicare discharges that reached outlier status at the host, at proposed § 412.534(b), or at the non-co-located referring hospital, as proposed at § 412.536, would not count towards the applicable threshold.

When we implemented the existing 25 percent (or applicable percentage) for cost reporting periods beginning on or after October 1, 2004, we opted to do so on a “location-specific” basis rather than based on Medicare provider numbers. That is, we applied the percentage threshold payment adjustment only to discharges from a specific location of a LTCH HwH or LTCH satellite that were admitted from the host hospital with which they share a building or campus. However, since implementing this policy, we have been contacted by numerous representatives of LTCH chains whose questions appear to indicate that the site-specific implementation of the threshold percentage had resulted in patient-shifting between hospital locations that shared a Medicare provider number and even between separately owned LTCHs (for their mutual advantage) that side-stepped the intent of our policy. Specifically, we offer the following example of a situation that was occurring: a host hospital at Location A was discharging patients to a LTCH HwH or satellite at Location B while the host hospital at Location B discharged patients to the LTCH HwH or satellite at Location A.

We believe that since we are proposing to expand the 25 percent policy to all subclause (I) LTCHs and LTCH satellite facilities it is appropriate to propose inclusion of LTCH HwHs and LTCH satellites, grandfathered respectively under § 412.22(f) and § 412.22(h)(3)(i), in our proposal. The provisions at proposed § 412.534(h) would apply for Medicare discharges from grandfathered LTCH and LTCH satellite facilities admitted from co-located hospitals and the provisions at § 412.536 would apply for discharges admitted from any individual non-co-located referring hospital. As we noted in our RY 2007 final rule regarding grandfathered HwHs, “[W]e do not believe that it is reasonable to assume that by creating a limited exception for these hospitals, the Congress was

immunizing these facilities from any further regulation by the Secretary as to their growth and financial impact on the Medicare program. We do not believe the Congress was establishing a separate class of providers" (71 FR 48109).

Furthermore, for those co-located LTCHs already subject to the 25 percent (or applicable percentage) payment adjustment at existing § 412.534, the proposed policy expansion at proposed § 412.536 would apply to payments under the LTCH PPS for patients discharged from co-located LTCHs (HwHs and satellites) that were admitted from referral sources *other* than their host hospital(s).

Therefore, we are proposing that, for cost reporting periods beginning on or after July 1, 2007, that a subclause (I) LTCH or LTCH satellite that discharges more than 25 percent (or applicable percentage) of Medicare patients admitted from *any* non-co-located individual hospital (that had not already reached outlier status, as discussed above) would be subject to the proposed payment adjustment at proposed § 412.536 for Medicare discharges from that hospital in excess of the applicable threshold. Furthermore, we believe that with the application of our proposed policy at § 412.536 to Medicare discharges from subclause (I) LTCH HwHs and LTCH satellites that were admitted from any individual non-co-located referring hospitals, we are closing the "location-specific loophole" established by the implementation of § 412.534, described above. The proposed change would affect all LTCHs or LTCH satellite Medicare discharges that were admitted from hospitals that are located on a different campus.

The proposed payment adjustment at proposed § 412.534(h) for grandfathered LTCH HwHs and LTCH satellite facilities will track the applicable provisions of the existing payment adjustment at § 412.534. Therefore, we are proposing at § 412.534(h) that for cost reporting periods beginning on or after July 1, 2007, the provisions of § 412.534 would also apply to grandfathered subclause (I) LTCH HwHs and LTCH satellite facilities. Accordingly, under the proposed changes to § 412.534, if the percentage of the grandfathered LTCH or LTCH satellite's discharged Medicare inpatient population that were admitted from its co-located host exceeds 25 percent (or the applicable percentage) of the LTCH's Medicare discharges for that cost reporting period, an adjusted payment would be made for those discharges that were admitted from that hospital beyond the 25 percent threshold (or the applicable percent threshold), at the

lesser of the otherwise payable amount under subpart O of 42 CFR part 412 or the amount payable under subpart O that would be equivalent to what Medicare would otherwise pay under the rules at subpart A, § 412.1(a). (The specifics of this payment formula are explained in considerable detail in the RY 2007 LTCH PPS final rule (71 FR 27879).) In addition, we are proposing that for cost reporting periods beginning on or after July 1 2007, that the existing transition to the full 25 percent (or applicable percentage) threshold, specified at § 412.534(g) would apply, as well to these grandfathered subclause (I) LTCH HwHs and LTCH satellites. We provide at existing § 412.534(g), that in order to qualify for the transition, the LTCH HwH or LTCH satellite facility must have been paid under the provisions of subpart O on October 1, 2004, or was a hospital paid under the provisions of subpart O on October 1, 2005, and whose qualifying period under § 412.23(e) began on or before October 1, 2004. We believe that it is appropriate to apply the same October 1, 2004 base year to all subclause (I) co-located HwHs and satellites, including grandfathered subclause (I) LTCH HwHs and LTCH satellites, applicable to all other co-located LTCHs. Accordingly, the percentage set forth in § 412.534(g)(3), which is the lesser of the percentage of patients admitted from the host during its FY 2004 cost reporting period or the 50 percent threshold would apply to those grandfathered facilities with cost reporting periods beginning on or after July 1, 2007 and before October 1, 2007. Those grandfathered subclause (I) LTCH HwHs and LTCH satellites with cost reporting periods beginning on or after October 1, 2007 have the 25 percent (or applicable percentage) payment adjustment threshold, as specified in § 412.534(g)(4) applied immediately, with no phase-in.

In proposing the expansion of the 25 percent threshold payment adjustment policy for cost reporting periods beginning on or after July 1, 2007, to all subclause (I) LTCH and LTCH satellite facilities (including LTCH HwHs) for Medicare discharges admitted from non-co-located hospitals, we are proposing at the new § 412.536, to generally track the provisions of the payment formula at existing § 412.534. For example, in determining whether a hospital meets the 25 percent criterion, Medicare discharges that have already qualified for outlier payments at the non-co-located referring hospital would not be included in the count of Medicare

discharges admitted from the referring hospital.

That is, even though the case would count as a discharge from the LTCH and be included in the denominator of the percentage calculation, because the patient had been an outlier at the referring hospital the case would not count towards determining whether or not the LTCH had exceeded the applicable threshold (that is, it would not be included in the numerator). An example of this is as follows: If one month prior to the end of a cost reporting period, a LTCH discharged 98 Medicare patients, 24 of which were admitted from an individual referring hospital, and during that last month, two additional patients were discharged from the LTCH that had been admitted from that referring hospital, at the close of the cost reporting period, there would have been a total of 100 discharges from the LTCH and the relevant concern would be to determine whether or not those last two cases would have caused the LTCH to exceed the 25 percent threshold. If the cases had achieved outlier status at the referring hospital, they would be not included in the percentage calculation (which would remain, for that referring hospital, at $24/100$) and not having caused the LTCH to exceed the 25 percent threshold, they would not be included in the numerator of the calculation. If both of those LTCH cases had been discharged from that referring hospital prior to having achieved outlier status, under our proposed policy, the percentage calculation would be 26 percent ($26/100$) and, having exceeded the 25 percent threshold, Medicare would apply the payment adjustment set forth in § 412.536 to the last discharge.

We are also proposing, under proposed § 412.534, that for those patients, the LTCH or LTCH satellite facility would be eligible for payment under the LTCH PPS with no adjustment even after the 25 percent (or applicable percentage) threshold was exceeded. (As under existing § 412.534, proposed § 412.536 will provide that a subclause (I) LTCH or LTCH satellite facility's Medicare discharges (including HwHs) admitted from any individual non-co-located referring hospital before the LTCH exceeds the 25 percent threshold or applicable threshold for that hospital would be paid an otherwise unadjusted payment under the LTCH PPS.)

We are also proposing not to extend the proposed payment adjustment in § 412.534(h) and § 412.536 to those LTCHs and LTCH satellite facilities that we refer to as subclause (II) LTCHs and LTCH satellites, established by section

1886(d)(1)(B)(iv)(II) of the Act. The policy that we are proposing for subclause (I) LTCHs and LTCH satellites is based on a calculation of the percentage of Medicare discharges that a LTCH admits from an individual hospital during a cost reporting period as compared to the LTCH's total Medicare discharges during that cost reporting period. Because of a significant policy distinction that we made at the start of the LTCH PPS for FY 2003, at this time we do not believe that this proposed policy should be applied to subclause (II) LTCHs and LTCH satellite facilities. With the implementation of the LTCH PPS, we revised the § 412.23(e)(2)(i) and (e)(3)(i) to calculate the ALOS based solely on Medicare patients who required long-stay hospitalizations at subclause (I) LTCHs defined by section 1886(d)(1)(B)(iv)(I) of the Act; however, we did not change the formula for calculating the ALOS for a LTCH governed by section 1886(d)(1)(B)(iv)(II) of the Act, implemented at § 412.23(e)(2)(ii), for a "subclause (II)" LTCH. We believed that in establishing a "subclause (II)" LTCH, the Congress provided an exception to the general definition of LTCHs under subclause (I). We had no reason to believe that the change in methodology for determining the average inpatient LOS would better identify the hospitals that the Congress intended to exclude under subclause (II) (67 FR 55974). Similarly, when we established the existing 25 percent or applicable percentage payment adjustment at § 412.534, we determined that its application to subclause (II) LTCHs was inappropriate because the designation of a subclause (II) LTCH was not dependent upon Medicare discharges (69 FR 49205). Therefore, we are not proposing to apply the expansion of the 25 percent policy that we are proposing at new § 412.536 and amended § 412.534 to LTCHs and LTCH satellite facilities defined under section 1886(d)(1)(B)(iv)(II) of the Act. The existing and proposed amended payment threshold adjustments at § 412.534 and at proposed § 412.536 for subclause (I) LTCHs and LTCH satellites are based solely on percentages of LTCH Medicare discharges. As stated above, we continue to believe that since we include both Medicare and non-Medicare discharges in our calculations for defining a subclause (II) LTCH at § 412.23(e)(2)(ii) that applying a payment adjustment that is based solely on Medicare discharges may not be appropriate. Furthermore, consistent with our policy not to include satellites of subclause (II) LTCHs which were

specifically grandfathered at § 412.22(h)(3)(ii) in proposed § 412.536, we have excluded subclause (II) LTCH satellites in the proposed application of the 25 percent payment adjustment for co-located grandfathered LTCHs at proposed § 412.534(h).

In summary, we are proposing a new provision at § 412.534(h) that would apply the policies established under existing § 412.534 to grandfathered subclause (I) LTCH HwHs and LTCH satellites for Medicare discharges that were admitted from co-located host hospitals. We are also proposing to apply those policies at § 412.534 to Medicare discharges admitted from any individual non-co-located referring hospitals to all subclause (I) LTCHs and LTCH satellites at proposed § 412.536, generally tracking the existing regulation at § 412.534, where applicable.

We are also proposing additional adjustments to the 25 percent policy at § 412.536 for specific circumstances in order to be consistent with the policy for co-located LTCHs under § 412.534. At proposed § 412.536(c) for Medicare discharges from subclause (I) LTCHs or LTCH satellites located in rural areas, we are proposing that Medicare discharges in excess of 50 percent, rather than 25 percent of the LTCH's total Medicare discharges for a cost reporting period from an individual non-co-located referring hospital would be subject to the payment adjustment specified at proposed § 412.536(c). In addition, in the case of a rural subclause (I) LTCH or LTCH satellite facility, in determining the percentage of Medicare discharges admitted from a non-co-located referring hospital, any patients that had been Medicare outliers at the referring hospital and then discharged to the LTCH or LTCH satellite are not counted towards the threshold percentage (as described above).

In proposed § 412.536, we are also providing that if the non-co-located referring hospital is the only other hospital in the MSA or an MSA-dominant hospital as defined at proposed § 412.536(e)(4), we proposed to allow the subclause (I) LTCH or LTCH satellite facility a threshold percentage equal to the non-co-located referring hospital's percentage of total Medicare discharges for like hospitals in the MSA for the most recent fiscal year that data is available. Consistent with our policy at existing § 412.534(e), we also propose to apply a floor of 25 percent and a ceiling of 50 percent to this threshold for those hospitals described in proposed § 412.536(d)(4). As with the existing policy for co-located LTCHs, we believe that this

adjusted payment threshold responds to "the unique needs of these communities" (69 FR 49207). Similar to the existing provisions at § 412.534(e)(2), we would not adjust payments to these hospitals as long as the percentage of Medicare patients discharged from the LTCH or LTCH satellite that were admitted from the non-co-located referring urban single or MSA-dominant hospital, did not exceed this threshold. In addition, in determining the percentage of Medicare discharges admitted to the LTCH or LTCH satellite facility from the urban single or MSA dominant hospital, any patients that had been Medicare outliers at the referring hospital before being admitted to the LTCH or LTCH satellite would not count towards the applicable threshold, as discussed above.

The proposed payment adjustment at § 412.536 would be synchronized with the phase-in of the current policy adjustment for LTCH HwHs and LTCH satellites at existing § 412.534(g). Therefore, for cost reporting periods beginning on or after July 1, 2007, and before October 1, 2007, the percentage of Medicare discharges that may be admitted from the non-co-located referring hospital with no payment adjustment is the lesser of the percentage of Medicare discharges admitted from the host during its FY 2005 cost reporting period or the 50 percent threshold. We note that under our proposed provision, at § 412.536, subclause (I) LTCHs and LTCH satellite facilities with cost reporting periods beginning on or after July 1, 2007, and before October 1, 2007, would be limited by the percentage of total Medicare discharges admitted from the referring non-co-located hospital during the FY 2005 cost reporting period, rather than utilizing the FY 2004 "base year" which is applicable under § 412.534. We are also proposing that in determining the percentage of Medicare discharges admitted from any referring hospital, patients who reached HCO status at the referring hospital before being admitted to the LTCH or LTCH satellite would not count towards the applicable threshold, as discussed above.

Subclause (I) LTCHs and LTCH satellite facilities with a cost reporting period beginning on or after October 1, 2007, would have the 25 percent (or applicable percentage) payment threshold applied. The percentage of Medicare discharges that a subclause (I) LTCH or satellite facility may admit from any individual non-co-located referring hospital with no payment adjustment for Medicare discharges admitted from that hospital may not

exceed 25 percent or the applicable percentage (the additional adjustments for rural, urban-single, or MSA-dominant hospitals).

It is important to note that we are also proposing that co-located subclause (I) LTCHs (HwHs and LTCH satellite facilities) would also be subject to the applicable payment adjustment threshold at § 412.536 for those Medicare discharges admitted from any individual hospital with which they are not co-located.

Finally, in proposing this payment adjustment, we believe that we are addressing policy concerns that are consistent with those that we originally expressed when we implemented the payment adjustment for LTCHs discharging patients that were admitted from co-located hospitals.

VI. Computing the Proposed Adjusted Federal Prospective Payments for the 2008 LTCH PPS Rate Year

In accordance with § 412.525 and as discussed in section IV.C. of this proposed rule, the standard Federal rate is adjusted to account for differences in area wages by multiplying the labor-related share of the standard Federal rate by the appropriate LTCH PPS wage index (as shown in Tables 1 and 2 of Addendum A 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 3 in section IV.D.2 of this preamble). In the RY 2007 LTCH PPS final rule (71 FR 27827), we established a standard Federal rate of \$38,086.04 for the 2007 LTCH PPS rate year. In this proposed rule, based on the best available data and the proposed policies described in this proposed rule, we are proposing that the standard Federal rate for the 2008 LTCH PPS rate year would be \$38,356.45 as discussed in section IV.C.3. of this preamble. We illustrate the methodology that would be used to adjust the proposed Federal prospective payments for the 2008 LTCH PPS rate year in the following examples:

Example:

During the 2008 LTCH PPS rate year, a Medicare patient is in a LTCH located in Chicago, Illinois (CBSA 16974). This LTCH is in the final year of the wage index phase-in, thus, the proposed full (that is, five-fifths) wage index values are applicable. The proposed full LTCH PPS wage index value for CBSA 16974 is 1.0751 (see Table 1 in Addendum A to this proposed rule). The Medicare patient is classified into LTC-DRG 9 (Spinal Disorders and Injuries), which

has a current relative weight of 1.0424 (see Table 3 of Addendum A to this proposed rule).

To calculate the LTCH's proposed total adjusted Federal prospective payment for this Medicare patient, we compute the proposed wage-adjusted Federal prospective payment amount by multiplying the proposed unadjusted standard Federal rate (\$38,356.45) by the proposed labor-related share (75.511 percent) and the proposed wage index value (1.0751). This proposed wage-adjusted amount is then added to the nonlabor-related portion of the proposed unadjusted standard Federal rate (24.489 percent; adjusted for cost of living, if applicable) to determine the proposed adjusted Federal rate, which is then multiplied by the LTC-DRG relative weight (1.0424) to calculate the proposed total adjusted Federal prospective payment for the 2008 LTCH PPS rate year (\$42,250.14). (As discussed in section IV.C.5. of this preamble, for the 2008 LTCH PPS rate year, we are no longer proposing to apply a transition period BN offset (to account for the costs of the transition methodology) in determining the proposed total adjusted Federal prospective payment.) Table 6 illustrates the components of the calculations in this example.

TABLE 6

Unadjusted Proposed Standard Federal Prospective Payment Rate	\$38,356.45
Proposed Labor-Related Share	× 0.75511
Proposed Labor-Related Portion of the Federal Rate	= \$28,963.34
Proposed Full Wage Index (CBSA 16974) ...	× 1.0751
Proposed Wage-Adjusted Labor Share of Federal Rate	= \$31,138.49
Proposed Nonlabor-Related Portion of the Federal Rate (\$38,356.45 × 0.24489)	+ \$9,393.11
Proposed Adjusted Federal Rate Amount	= \$40,531.60
LTC-DRG 9 Relative Weight	× 1.0424
Proposed Total Adjusted Federal Prospective Payment*	= \$42,250.14

*We are no longer proposing to apply a transition period BN offset to account for the costs of the transition methodology in determining the proposed total adjusted Federal prospective payment for RY 2008.)

VII. Transition Period

To provide a stable fiscal base for LTCHs, under § 412.533, we implemented a 5-year transition period whereby a LTCH (except those defined as “new” under § 412.23(e)(4)) received a LTCH PPS payment consisting of a portion based on reasonable cost-based reimbursement principles under the TEFRA system and a portion based on the Federal prospective payment rate (unless the LTCH elected payment based on 100 percent of the Federal rate). As discussed in the August 30, 2002 final rule (67 FR 56038), we believed that a 5-year phase-in provided LTCHs time to adjust their operations and capital financing to the LTCH PPS, which is based on prospectively determined Federal payment rates. Furthermore, we believed that the 5-year phase-in under the LTCH PPS also allowed LTCH personnel to develop proficiency with the LTC-DRG coding system, which will result in improvement in the quality of the data used for generating our annual determination of relative weights and payment rates.

Under § 412.533, the 5-year transition period for all hospitals subject to the LTCH PPS began with the hospital's first cost reporting period beginning on or after October 1, 2002 and extends through the hospital's last cost reporting period beginning before October 1, 2007. During the 5-year transition period, a LTCH's total PPS payment under the LTCH PPS was based on two payment percentages—one based on reasonable cost-based principles and the other based on the standard Federal prospective payment rate. The percentage of the LTCH PPS payment based on the LTCH PPS Federal rate increased by 20 percentage points each year, while the reasonable portion of the LTCH PPS payment based on cost-based principles decreased by 20 percentage points each year, for the next 4 fiscal years. For cost reporting periods beginning on or after October 1, 2006, Medicare payment to LTCHs will be determined entirely under the Federal rate.

In implementing the LTCH PPS, one of our goals was to transition hospitals to prospective payments based on 100 percent of the adjusted Federal prospective payment rate as soon as appropriate. Therefore, under § 412.533(c), we allowed a LTCH (other than new LTCHs defined at § 412.23(e)(4)), which was 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.

Once a LTCH elected to be paid based on 100 percent of the Federal rate, it could not revert back to the transition blend.

VIII. Payments to New LTCHs

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

Under § 412.533(d), new LTCHs, as defined in § 412.23(e)(4), will be paid based on 100 percent of the standard Federal rate. As we discussed in the August 30, 2002 final rule (67 FR 56040), the transition period was 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 did not believe that those new LTCHs required a transition period in order to make adjustments to their operations and capital financing, as will LTCHs that have been paid under the reasonable cost-based methodology.

IX. Method of Payment

Under § 412.513, a Medicare LTCH patient is classified into a LTC–DRG based on the principal diagnosis, up to eight additional (secondary) diagnoses, and up to six procedures performed during the stay, as well as age, sex, and discharge status of the patient. The LTC–DRG is used to determine the Federal prospective payment that the

LTCH will receive for the Medicare-covered Part A services the LTCH furnished during the Medicare patient’s stay. Under § 412.541(a), the payment is based on the submission of the discharge bill. The discharge bill also provides data to allow for reclassifying the stay from payment at the full LTC–DRG rate to payment for a case as a SSO (under § 412.529) or as an interrupted stay (under § 412.531), or to determine if the case will qualify for a HCO payment (under § 412.525(a)).

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

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

For those LTCHs that are being paid under the transition methodology set forth at § 412.533, 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 HCO payments that are paid upon submission of a discharge bill from the PIP amounts. In addition, Part A costs that are not paid for under the LTCH PPS, including Medicare costs of an approved medical education program, bad debts, blood clotting factors, anesthesia services by hospital-employed nonphysician anesthetists and the costs of photocopying and mailing medical records requested by a QIO, are subject to the interim payment provisions as specified in § 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 this should include any HCO payment determined as of the last day for which the services have been billed.

X. Monitoring

In the August 30, 2002 final rule (67 FR 56014), we described an on-going monitoring component to the new LTCH PPS. Specifically, we discussed on-going analysis of the various policies that we believe would provide equitable payment for stays that reflect less than the full course of treatment and reduce the incentives for inappropriate admissions, transfers, or premature discharges of patients that are present in a discharge-based PPS. As a result of our data analysis, we have revisited a number of our original and even pre-LTCH PPS policies in order to address what we believe are behaviors by certain LTCHs that lead to inappropriate Medicare payments. In recent **Federal Register** publications, we have proposed and subsequently finalized revisions to the interruption of stay policy in the RY 2005 LTCH PPS final rule (69 FR 25692), and we established a payment adjustment for LTCH HwHs and satellites in the FY 2005 IPPS final rule (69 FR 49191 through 49214).

In section V.A.2., we are revisiting the payment adjustment methodology established for SSOs (71 FR 27845) as a consequence of recent data analysis and discuss an approach being considered that would revise one of the existing four alternatives under the existing SSO payment methodology for certain SSO cases to an amount that would otherwise be paid under the IPPS.

As we discuss in section X., our monitoring of discharges between acute care hospitals and LTCHs reveals that a significant number of LTCHs that are “free-standing”, that is, not co-located with other hospital-level providers (as defined in § 412.22(e) and § 412.22(h)), admit their patients from one specific acute care hospital. When we established the payment adjustment for LTCH HwHs and satellites of LTCHs at § 412.534, we stated our concern that these on-site LTCHs could be functioning as units of their host (generally, an acute care hospital), a configuration that is not permitted in section 1886(d)(1)(B) of the Act. (The statute specifically allows only for IRF and IPF units in acute care hospitals, but not for LTCH units.) As a result of our data monitoring and analysis, which is detailed in section V.B. of this proposed rule, we propose to expand the existing payment adjustment at

§ 412.534 to apply to certain situations not currently covered by the existing policy for LTCHs co-located with other hospitals.

As we discussed in the RY 2004 LTCH PPS final rule (68 FR 34157), the Medicare Payment Advisory Commission (MedPAC) endorsed our monitoring activity as a primary aspect of the design of the LTCH PPS. Furthermore, the Commission pursued an independent research initiative that led to a section in MedPAC's June 2004 Report to Congress entitled "Defining long-term care hospitals". This study included recommendations that we develop facility and patient criteria for LTCH admission and treatment and that we require a review by QIOs to evaluate whether LTCH admissions meet criteria for medical necessity once the recommended facility and patient criteria are established (70 FR 24209). In response to the recommendation in MedPAC's June 2004 Report, we awarded a contract to Research Triangle Institute, International (RTI), on September 27, 2004, to conduct a thorough examination of the feasibility of implementing MedPAC's recommendations.

We are continuing to pursue our on-going program, existing QIO monitoring and studies described in the RY 2006 LTCH PPS final rule (70 FR 24211), and our considerations of expanding the QIO role in the LTCH PPS. Furthermore, RTI has completed its examination of the feasibility of implementing MedPAC's recommendations in the June 2004 Report to Congress. However, we note that we do not anticipate expanding QIO activities during the current scope of work.

The Executive Summary of RTI's final report is included in Addendum B of this proposed rule and is available on our Web site at http://www.cms.hhs.gov/LongTermCareHospitalPPS/02a_RTIReports.asp#TopOfPage.

XI. MedPAC Recommendations: The RTI Contract

With the recommendations of MedPAC's June 2004 Report to Congress as a point of departure, RTI evaluated the feasibility of developing patient and facility level characteristics for LTCHs to identify and distinguish the role of these hospitals as a Medicare provider.

RTI completed this project in two phases. In Phase I, RTI prepared a background report summarizing existing information regarding LTCHs' current role in the Medicare system: Their history as Medicare participating providers; the types of patients they treat; the criteria QIOs currently use to

review appropriateness of care in these settings; and the types of regulations they face as Medicare participating providers. This work reviewed prior analyses of these issues and included discussions with MedPAC, other researchers, CMS, the QIOs, and the hospital associations.

In Phase II, RTI collected additional information on tools currently used by the QIOs and the industry to assess patient appropriateness for admission; analyzed claims to understand differences between hospital patients with outlier stays in non-LTCHs and those treated in LTCHs; and visited different types of hospitals to observe first-hand how LTCH patients differ from those in other settings and how this pattern varies in different parts of the country. RTI worked with different associations, including the National Association of Long Term Hospitals (NALTH), the Acute Long Term Hospital Association (ALTHA), the AHA, and the American Medical Peer Review Association (AMPRA), as well as several of the larger LTCH chains. The final report submitted by RTI summarizes these efforts and makes numerous recommendations to CMS regarding LTCHs.

The reports on both Phase I and Phase II of RTI's research have been posted on our Web site at http://www.cms.hhs.gov/LongTermCareHospitalPPS/02a_RTIReports.asp#TopOfPage. Please note that this report does not represent our position or policy. We are currently evaluating RTI's recommendations regarding the feasibility of developing patient and facility level criteria from several standpoints. Most significantly, we are concerned that several of RTI's recommendations may require statutory changes. Furthermore, even among those recommendations for action that would be accomplished on a regulatory level, there are many significant issues that require further analysis. We have consistently encouraged meaningful contact between RTI and industry stakeholders throughout this research phase of the contract. Furthermore, RTI has solicited on-going involvement and will continue to seek such input from physicians who treat LTCH type patients both in LTCHs and as inpatients in other provider settings in forming a technical expert panel (TEP) to further develop some of its recommendations. RTI is currently determining the appropriate composition of this group, preparing a time table, and preparing an agenda for the TEP.

While the reports from both Phase I and Phase II of RTI's research are posted

in their entirety on the CMS Web site at http://www.cms.hhs.gov/LongTermCareHospitalPPS/02a_RTIReports.asp#TopOfPage, we are including The Executive Summary of RTI's Phase II report in Addendum B to this proposed rule. This material is being reproduced as received from the contractors and does not represent our position or policy.

XII. Payment for Direct Graduate Medical Education (GME) (§ 413.79)

[If you choose to comment on issues in this section, please include the caption "PAYMENT FOR DIRECT GRADUATE MEDICAL EDUCATION" at the beginning of your comments.]

A. GME Background

Section 1886(h) of the Act, as added by section 9202 of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (Pub. L. 99-272) and implemented in regulations at existing § 413.75 through § 413.83, establishes a methodology for determining payments to hospitals for the direct costs of approved graduate medical education (GME) programs. Section 1886(h)(2) of the Act, as added by COBRA, sets forth a payment methodology for direct GME costs involving the determination of a hospital-specific, base-period per resident amount (PRA) that is calculated by dividing a hospital's allowable costs of GME for a base period by its number of residents in the base period. The base period is, for most hospitals, the hospital's cost reporting period beginning in FY 1984 (that is, the period beginning between October 1, 1983, through September 30, 1984). Generally, for cost reporting periods beginning on or after July 1, 1985, Medicare direct GME payments are calculated by multiplying the hospital's PRA by the weighted number of full-time equivalent (FTE) residents working in all areas of the hospital (and nonhospital sites, when applicable), and by the hospital's Medicare percentage of total inpatient days. In addition, as specified in section 1886(h)(2)(D)(ii) of the Act, for cost reporting periods beginning between October 1, 1993, through September 30, 1995, each hospital-specific PRA for the previous cost reporting period is not updated for inflation for any FTE residents who are not either a primary care or an obstetrics and gynecology resident. As a result, hospitals that trained primary care, and obstetrics and gynecology residents, as well as nonprimary care residents in FY 1994 or FY 1995, have two separate PRAs: One for primary care, and obstetrics and gynecology residents; and one for nonprimary care residents.

The Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999 (Pub. L. 106-113) (BBRA) amended section 1886(h)(2) of the Act to establish a methodology for the use of a national average PRA in computing direct GME payments for cost reporting periods beginning on or after October 1, 2000, and on or before September 30, 2005. The BBRA established a "floor" for hospital-specific PRAs that is equal to 70 percent of the locality-adjusted national average PRA. In addition, the BBRA established a "ceiling" that limited the annual inflation update to a hospital-specific PRA if the hospital's PRA exceeded 140 percent of the locality-adjusted national average PRA. Section 511 of the Benefits Improvement and Protection Act of 2000 (Pub. L. 106-554) (BIPA) increased the floor established by the BBRA to equal 85 percent of the locality-adjusted national average PRA. For purposes of calculating direct GME payments, each hospital-specific PRA is compared to the floor and the ceiling to determine whether a hospital-specific PRA should be revised.

Section 1886(h)(4)(F) of the Act established limits on the number of allopathic and osteopathic residents that a hospital may count for purposes of calculating direct GME payments. For most hospitals, the limits are the number of allopathic and osteopathic FTE residents training in the hospital's most recent cost reporting period ending on or before December 31, 1996.

B. Residents Training in Nonhospital Settings

1. Background

For purposes of direct GME payments, since July 1, 1987, the statute allows hospitals to count the time residents spend training in sites that are not part of the hospital (referred to as "nonprovider" or "nonhospital sites") under certain conditions. Section 1886(h)(4)(E) of the Act requires that the Secretary's rules concerning computation of FTE residents for purposes of direct GME payments "provide that only time spent in activities relating to patient care shall be counted and that all the time so spent by a resident under an approved medical residency training program shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs all, or substantially all, of the costs for the training program in that setting." (Section 1886(h)(4)(E) of the Act, as added by section of 9314 of

the Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99-509) (OBRA 86).) Regulations regarding the treatment of time spent by residents training in nonhospital sites for purposes of direct GME payments were first implemented in the September 29, 1989 final rule (54 FR 40286). In regulations adopted in that same rule at § 413.86(f)(3) (now § 413.78(c)), we stated that a hospital may count the time residents spend in nonprovider settings for purposes of direct GME payment if the residents spend their time in patient care activities and there is a written agreement between the hospital and the nonprovider entity stating that the hospital will incur all or substantially all of the costs of the program. The regulations at that time defined "all or substantially all" of the costs to include the residents' compensation for the time spent at the nonprovider setting. Before October 1, 1997, for IME payment purposes, hospitals were not permitted to count the time residents spent training in nonhospital settings. Section 4621(b)(2) of the BBA revised section 1886(d)(5)(B) of the Act to allow providers to count time residents spend training in nonprovider sites for IME purposes, effective for discharges occurring on or after October 1, 1997. Specifically, section 1886(d)(5)(B)(iv) of the Act was amended to provide that "all the time spent by an intern or resident in patient care activities under an approved medical residency program at an entity in a nonhospital setting shall be counted towards the determination of full-time equivalency if the hospital incurs all, or substantially all, of the costs for the training program in that setting." In the July 31, 1998 final rule (63 FR 41004 through 41005) at § 412.105(f)(1)(ii)(C) and § 413.78(d) (formerly designated § 413.86(f)(4)), we specified the requirements a hospital must meet to include the time spent by residents training in a nonhospital site in its FTE count for portions of cost reporting periods occurring on or after January 1, 1999 for purposes of both direct GME and IME payments. Section 413.75(b) redefined "all or substantially all of the costs for the training program in the nonhospital setting" as the residents' salaries and fringe benefits (including travel and lodging where applicable), and the portion of the cost of teaching physicians' salaries and fringe benefits attributable to direct GME. Section 413.78(e) provides that, in order for a hospital to be permitted to count FTE residents training in a nonhospital setting, a written agreement must be in place between the hospital and the nonhospital site providing that

the hospital will incur the costs of the resident's salary and fringe benefits while the resident is training in the nonhospital site. The hospital must also provide reasonable compensation to the nonhospital site for supervisory teaching activities, and the written agreement must specify that compensation amount.

2. Moratorium on Disallowances of Allopathic or Osteopathic Family Practice Residents Training Time in Nonhospital Settings, and Questions and Answers (Qs&As) on CMS Web Site (Section 713 of the MMA and § 413.78)

In order for the hospital to incur "all or substantially all" of the costs in accordance with the regulations, the actual cost of the time spent by teaching physicians in supervising residents in the nonhospital setting must be compensated by the hospital. The amount of supervisory GME costs is dependent upon the teaching physician's salary and the percentage of time that he or she devotes to activities related to the residency program at the nonhospital site. (We note that the teaching physician's involvement in the provision of patient care is not considered attributable to direct GME.) As long as there are supervisory GME costs associated with the nonhospital training, the hospital must reimburse the nonhospital setting for those costs in order to count FTE resident time spent in the nonhospital site for purposes of IME and direct GME payments.

Many hospitals have entered into written agreements with nonhospital sites that state that the teaching physician is "volunteering" his or her time in the nonhospital site, and, therefore, the hospital is not providing any compensation to the teaching physician. Other hospitals have paid only a nominal amount of compensation for the supervisory teaching physicians' time in the nonhospital setting. Because § 413.78(d) requires that the hospital must incur "all or substantially all" of the direct GME costs, including those costs associated with the teaching physician, regardless of whether the written agreement states that the teaching physician is "volunteering," we have required that the hospital pay these costs in order to count FTE residents training in the nonhospital site, as long as these teaching physician costs exist.

Section 713 of the MMA imposed a 1-year moratorium relating to certain nonhospital site teaching physician costs for the period from January 1, 2004, through December 31, 2004. During this 1-year period, we were required to allow hospitals to count FTE

allopathic or osteopathic family practice residents training in nonhospital settings for IME and direct GME payment purposes without regard to the financial arrangement between the hospital and the teaching physician practicing in the nonhospital setting to which the resident was assigned.

We instructed our contractors (formerly called “fiscal intermediaries” or “FIs”) regarding the effect of section 713 of the MMA in the One-Time Notification (OTN), “Changes to the FY 2004 Graduate Medical Education (GME) Payments as Required by the Medicare Modernization Act of 2003 (MMA)” (CR 3071, Transmittal 61, issued on March 12, 2004). Generally, we stated in the OTN that, when settling prior year cost reports during this 1-year period, or for family practice residents actually training in nonhospital settings during this 1-year period, contractors should allow hospitals to count allopathic and osteopathic family practice residents training in a nonhospital setting for direct GME and IME payment purposes without regard to the financial arrangement between the hospital and the nonhospital site pertaining to the teaching physicians’ costs associated with the residency program. For further information on this provision and for a summary of comments and responses related to this provision, please refer to the FY 2005 IPPS final rule (69 FR 49176).

Furthermore, in response to questions and concerns raised by the industry and Medicare contractors as to how to determine the costs associated with residency training at the nonhospital setting, as well as how and when to pay the nonhospital setting for these costs, we posted Qs&As on the CMS Web site on April 8, 2005 at <http://www.cms.hhs.gov/AcuteInpatientPPS/Downloads/nonhospQA.pdf>. In the Qs&As, in response to the question of whether there are situations where it is acceptable for the teaching physician to “volunteer” his or her time supervising residents at the nonhospital site, we stated that “* * * the relevant question is not whether volunteerism is permissible, but whether there is a cost to the nonhospital site for supervising the resident training. If there is a cost, the hospital must reimburse the nonhospital site for those costs.” We further stated that we believe in situations where the teaching physician receives a predetermined compensation amount for his or her time at the nonhospital site that does not vary with the number of patients he or she treats, there is a cost for the teaching physician time spent in GME activities. In contrast, if the physician’s

compensation at the nonhospital site is based solely on his or her billings, there is no cost for teaching physician time spent in GME activities. Accordingly, the statute continues to require that a hospital must pay “all or substantially all” the costs of training residents at the nonhospital site in order to count FTE residents training at that site, including teaching physician costs, as long as those costs exist.

3. Requirements for Written Agreements for Residency Training in Nonhospital Settings (§ 413.78(e))

In implementing section 1886(h)(4)(E) of the Act, in order to assist contractors in determining whether a hospital incurred “all or substantially all” of the costs of the program in the nonhospital setting, we required in § 413.78(c) and (d) (formerly § 413.86(f)(3) and (4)) that there must be a written agreement between the hospital and the nonhospital site stating that the hospital will incur “all or substantially all” of the costs of training in the nonhospital setting. We later specified at § 413.78(d)(2) that the written agreement must indicate the amount of compensation provided by the hospital to the nonhospital site for supervisory teaching activities.

In an effort to respond to concerns expressed by hospitals about the administrative burden associated with meeting the written agreement requirements, in the FY 2005 IPPS final rule (69 FR 49179), at § 413.78(e), we revised our regulations to allow hospitals to choose to either enter into a written agreement with the nonhospital site before the hospital may begin to count residents training at the nonhospital site, or to pay concurrently for the cost of training at the nonhospital setting. That is, in the absence of a written agreement, hospitals are required to pay “all or substantially all” of the costs of the training program in the nonhospital setting by the end of the third month following the month in which the training occurs.

4. Modification of the Definition of “All or Substantially All of the Costs for the Training Program in the Nonhospital Setting”

We have met numerous times with industry representatives with the goal of developing a proposal which would respond to the concerns expressed by the teaching hospital community about the administrative burden associated with determining and documenting that hospitals are paying for “all or substantially all” of the costs for the training in the nonhospital setting.

Some industry representatives recently suggested that we could ease administrative burdens by modifying the requirements hospitals must satisfy to meet the statutory requirement to incur “all or substantially all” of the costs by allowing a teaching physician to attest that at least 90 percent of the teaching physician’s GME time is spent in patient care activities. However, we explained in response that the statutory test is tied to whether the hospital has incurred “all or substantially all” of the costs of the training at that site, not to how the teaching physician’s GME time is spent. Therefore, we do not believe the attestation proposed by the industry adequately addresses the statutory requirement that the hospital incur “all or substantially all” of the costs of the training program at that site. We continue to believe that any Medicare policy approach to allowing hospitals to count FTE residents training in nonhospital settings for IME and direct GME payment purposes must be consistent with the statutory requirement that hospitals incur “all, or substantially all” of the costs of a training program in a nonhospital setting. The statute is clearly concerned about the cost to the nonhospital site, and we believe the statute has set a priority to move resources, in terms of both residents and funding, out into community settings. Therefore, where there is a cost to the nonhospital setting for training residents, we believe that the Medicare program is obligated to ensure that the nonhospital settings receive the funding they are entitled to receive from hospitals under the statute.

Accordingly, we continue to believe that our current definition of “all or substantially all” of the costs, which is based on the costs of the training program at the nonhospital site, is true to the intent of the statute. However, to address the industry’s concerns related to burdensome documentation requirements, we propose to establish an alternative methodology that hospitals may choose to use in determining and paying for the teaching physician costs attributable to direct GME in the nonhospital sites. As we explain below in this section, we are proposing to revise the current definition of “all or substantially all” of the costs to require hospitals to incur a percentage of the costs of the training program at the nonhospital site. Our proposal also generally incorporates the industry representatives’ concept of a 90 percent threshold, but does not specifically relate it to the percentage of time spent by the teaching physician on GME activities, as suggested by industry

representatives. Furthermore, as explained in more detail below in this section, in determining whether a hospital has met the 90 percent cost threshold, we are proposing to allow hospitals to use certain shortcuts or proxies in the place of actual cost data specific to each teaching physician at each nonhospital site. However, hospitals would always still have the option of calculating the actual teaching physician costs and the 90 percent threshold using actual cost data specific to all, or some of their applicable teaching physicians. That is, even if a hospital chooses to calculate the direct GME costs of a program using actual teaching physician time and cost data (as under existing regulations) rather than using the proxies, under this proposal, a hospital would only be required to pay *at least* 90 percent of the total of the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the teaching physicians' costs attributable to direct GME for a program at the nonhospital site. That is, we are proposing that a hospital would no longer be required to pay 100 percent of the residents' salaries and fringe benefits (including travel and lodging where applicable), plus the portion of the teaching physicians' costs attributable to direct GME at the nonhospital site. Instead, we are proposing that a hospital would be required to pay for 90 percent of the GME costs of a training program in a nonhospital site, and would have a choice between two approaches for calculating teaching physician's costs.

Currently, "all or substantially all of the costs for the training program in the nonhospital setting" is defined at § 413.75(b) as the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries and fringe benefits attributable to direct GME. We are proposing to define "all or substantially all of the costs for the training program in the nonhospital setting" under § 413.75(b) (prospectively for cost reporting periods beginning on or after July 1, 2007) to mean at least 90 percent of the total of the costs of the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries attributable to direct GME. We believe this standard is consistent with the statute, in that hospitals would still be required to incur substantially all of the costs of training programs in nonhospital settings, and we would expect this

standard to further encourage hospitals to shift training to nonhospital settings as intended by the statute. Under this revised definition of "all or substantially all" of the costs for the training program in the nonhospital setting, we would create a 90 percent threshold that hospitals must meet in order to count FTE resident time spent training at the nonhospital setting for IME and direct GME payment purposes. Additionally, under the new definition, hospitals would only have to incur a minimum of 90 percent of the costs of the program at a nonhospital site to count FTE resident time spent training at the site. Furthermore, as is the case with the current definition of "all or substantially all," the new definition would not include overhead costs.

We are also soliciting comments on our proposed effective date for purposes of both direct GME and IME as to whether this proposal should be effective immediately for portions of cost reporting periods occurring on or after July 1, 2007, or alternatively, for cost reporting periods beginning on or after July 1, 2007. Although an effective date of "portions of cost reporting periods occurring on or after July 1, 2007," would provide a more immediate response to concerns raised by teaching hospitals, we are concerned that establishing new policies in the middle of hospitals' cost reporting periods presents some logistical challenges, both from an implementation and an audit perspective. Therefore, we are proposing that the new definition of "all or substantially all" of the costs would be effective for both direct GME and IME for cost reporting periods beginning on or after July 1, 2007, although, as stated above in this section, we are specifically soliciting comments on this effective date.

As we explained, rather than adopt the industry's suggested standard of 90 percent of the teaching physicians' time spent in patient care activities, which we do not believe would be sufficiently true to the requirements of the statute, as a compromise, we propose to accept that hospitals have incurred "all or substantially all" of the costs of the program at the nonhospital site (and are therefore permitted to count the FTE residents training at the nonhospital site for IME and direct GME Medicare payment purposes) if the hospital incurs at least *90 percent of the costs* of training at that site. Under this proposal, a hospital would not have to demonstrate that it has incurred the costs of the teaching physician's time if it has otherwise incurred at least 90 percent of the nonhospital site training costs by paying the residents' salaries

and fringe benefits (including travel and lodging where applicable) during the time spent training at the site. However, if the residents' salaries and fringe benefits (including travel and lodging where applicable) account for less than 90 percent of the costs of training at the nonhospital site, we propose the hospital would have to compensate the nonhospital site for its teaching physician costs so that the hospital is incurring at least 90 percent of the training program costs at the nonhospital site. If the hospital does not meet the 90 percent threshold by only paying for the cost of the residents' salaries and fringe benefits (including travel and lodging where applicable), we propose the hospital would have to meet the threshold by incurring some portion of the teaching physicians' salaries that is attributable to direct GME.

As previously stated in the Qs&As on the CMS Web site on April 8, 2005 at <http://www.cms.hhs.gov/AcuteInpatientPPS/Downloads/nonhospQA.pdf> (Answer #4), we believe there are typically no costs for teaching physician time if the physician's compensation at the nonhospital site is based solely and directly on the number of patients treated and for which he or she bills, which is the case with a solo practitioner. When the solo practitioner is not treating patients, he or she is not receiving payment for any other duties at the nonhospital site. Therefore, in this instance, there is no cost to the nonhospital site for the teaching physician's time. However, in the case of a group practice or clinic setting, the physician often receives a predetermined payment amount, such as a salary, for his or her work at the nonhospital site. This predetermined payment amount reflects all of his or her responsibilities at the nonhospital site, including treating patients, training residents, and other administrative activities (as applicable), and he or she may receive that predetermined payment from the nonhospital site regardless of how many patients he or she actually treats. The predetermined amount implicitly also compensates the physician for supervising residents. A portion of this implicit compensation is the cost attributable to teaching activities, and, in order to count the residents training at that site, the hospital must pay the nonhospital site this amount. However, there may be instances in a group practice, where a teaching physician is not receiving a form of predetermined compensation for his or her work at the nonhospital site.

For example, three physicians may work in the same office and share overhead expenses such as electricity and rent, but otherwise, there is no sharing of revenues from patient care activities, and the physicians operate as solo practitioners and are not compensated according to some predetermined arrangement. In cases such as these, we assume that the teaching physician is functioning as a solo practitioner and that teaching physician costs for GME training at the nonhospital site are zero. Accordingly, this proposal affects members of group practices where the teaching physician receives a salary or other form of predetermined compensation for his or her work at the nonhospital site. However, we note that under our proposal, in the case of solo practitioners, hospitals must continue to pay for at least 90 percent of the total cost of the residents' salaries and fringe benefits, including travel and lodging where applicable.

5. Implementation of a 90 Percent Cost Threshold

In proposing a new revised definition of "all or substantially all" of the costs of the program at a nonhospital site, and in establishing a 90 percent threshold, there are several variables that are important in the methodology for determining the minimum amount that a hospital must pay in order to count FTE residents training in a nonhospital site. These variables are: teaching physicians' salaries, residents' salaries and fringe benefits (including travel and lodging where applicable), the number of hours per week that the teaching physician spends in direct GME (not billable patient care) activities in the nonhospital site, and the number of hours that a nonhospital site is open each week. To provide the reader with a context for the new methodology that we are proposing, we will first explain the methodology briefly, provide two examples, and then proceed to an in-depth discussion of each variable (see section XII.B.5.b. of the preamble of this proposed rule).

a. Methodology

One of the primary complaints voiced by the hospital industry over the past several years is that our policy requiring hospitals to determine the portion of the teaching physician cost attributable to direct GME in the nonhospital site results in an untenable documentation burden since many physicians are reluctant to disclose their salary information to the hospitals. One solution to this problem suggested by the hospital industry is to use national average physician salary information as

a proxy for teaching physician-specific salaries in the determination of the total cost of the program at a nonhospital site. In addition, since the cost of the teaching physician time that the hospital must incur is based on the amount of time the teaching physician spends in nonpatient care GME activities, the hospital industry has been concerned that determining this GME time could require burdensome time studies. Therefore, we are proposing to adopt an alternative methodology that hospitals may choose to use, instead of actual costs, to calculate teaching physician costs in nonhospital sites. Using this alternative methodology, to facilitate a less burdensome way for a hospital to calculate the teaching physician costs associated with GME training at the nonhospital site, we propose to allow hospitals to use 3 hours per week as a presumptive standard number of hours that a teaching physician spends in nonpatient care GME activities at a particular nonhospital site. To determine the percentage of the average salary associated with the 3 hours the teaching physician is presumed to spend in nonpatient care GME activities, we propose that a hospital would divide 3 hours by the number of hours the nonhospital site is open each week. Next, we propose that the hospital would multiply this percentage of time spent in nonpatient care GME activities by the national average salary of that teaching physician's specialty to calculate the cost of the teaching physician's direct GME time. The cost of the teaching physician's direct GME time would then be added to the costs of the salaries and fringe benefits (including travel and lodging expenses, where applicable) of the FTE resident(s) rotating in that program to that nonhospital site to determine the GME costs for that program at that site. (If FTE resident(s) are not rotating to a particular nonhospital site throughout a whole year, then the national average salary of the teaching physician would be prorated accordingly. The cost of the residents' salaries and fringe benefits (including travel and lodging where applicable) would already be reflective of an FTE count). We propose that the hospital must pay at least 90 percent of these total GME costs for the program at that nonhospital site in order to count the resident(s) training there for direct GME and IME purposes. If the hospital is already paying all, or even a portion of the residents' salaries and fringe benefits (including travel and lodging where applicable), and if the amount that the hospital is paying for the

residents' salaries and fringe benefits (including travel and lodging where applicable) is equal to at least 90 percent of the GME costs at the nonhospital site (that is, the 90 percent threshold), then the hospital would be considered to be incurring "all or substantially all" of the costs, and need not incur an additional amount for teaching physician compensation to be permitted to include the FTE residents training in the nonhospital site in its FTE count for purposes of direct GME and IME payments. However, if the costs of the residents' salaries and fringe benefits (including travel and lodging where applicable) does not equal at least 90 percent of the GME costs of the training program at the nonhospital site, then the hospital must incur an additional amount for teaching physician costs based on the national average salary information until it is incurring at least 90 percent of the GME costs for that nonhospital site program. That is, under the proposed alternative definition of "all or substantially all" of the costs, a hospital is required to incur at least 90 percent of the total GME costs for a particular program at a particular nonhospital site. The GME costs of a particular program at a particular nonhospital site consist of FTE residents' salaries and fringe benefits (including travel and lodging costs where applicable), and the portion of teaching physician compensation (which may be based on national average survey data) attributable to direct GME. As will be explained in more detail below in this section, the hospital always has the option of documenting the actual teaching physician's cost using actual time or salary information to pay at least 90 percent of the total costs of the program at the nonhospital site. In summary, the formula for determining the 90 percent threshold, or the minimum amount that a hospital must pay for the GME costs of a particular program at a particular nonhospital site is:

$$0.90 \times [(sum\ of\ each\ FTE\ resident's\ salary + fringe\ benefits\ (including\ travel\ and\ lodging\ where\ applicable))\ plus\ the\ portion\ of\ the\ teaching\ physician's\ compensation\ attributable\ to\ direct\ GME\ activities.]$$

The portion of the teaching physician's compensation attributable to direct GME activities may be calculated as follows:

$$(3/number\ of\ hours\ nonhospital\ site\ is\ open\ per\ week) \times (national\ average\ salary\ for\ each\ teaching\ physician^*)$$

* The number of teaching physicians included in this formula is subject to a 1:1

resident to teaching physician limit, as explained below in this section.

The following are two examples of the proposed alternative methodology:

Example 1: Assume one teaching physician is supervising one FTE resident in a nonhospital site for 1 residency year. The national average published salary amount for that teaching physician's specialty is \$120,000, and he works in a clinic that is open 60 hours per week. Using the standard of 3 hours spent in GME activities per week, the teaching physician spends 5 percent of his time in GME activities (that is, $3/60 = 0.05$ or 5 percent). To determine the cost of the teaching physician's time, the hospital may make the following calculation: $\$120,000 \times 0.05 = \$6,000$. This teaching physician's cost is added to the resident's salary and fringe benefits to calculate the cost of the training at the nonhospital site in the following manner: $\$6,000$ [cost of one teaching physician] + $\$60,000$ [actual cost of the FTE residents' salary & fringe benefits] = $\$66,000$. To meet the proposed new definition of "all or substantially all," the hospital would be required to pay at least 90 percent of the costs of the training program at the nonhospital site, which in this example equals \$59,400 (that is, $0.90 \times \$66,000$). Since in this case the cost of one FTE resident's salary and fringe benefits is \$60,000, the hospital could reach the 90 percent cost threshold by simply incurring the resident's salary and fringe benefits during training at the nonhospital site.

Example 2: Assume one teaching physician is supervising one FTE resident in a nonhospital site for an entire residency year. The national average published salary amount for that teaching physician's specialty is \$200,000, and she works in a clinic that is open 40 hours per week. Using the standard of 3 hours spent in GME activities per week, the teaching physician spends 7.5 percent of her time in GME activities (that is, $3/40 = 0.075$ or 7.5 percent). To determine the cost of the teaching physician's time, the hospital may make the following calculation: $\$200,000 \times 0.075 = \$15,000$. This teaching physician's cost is added to the resident's salary and fringe benefits to calculate the cost of the training at the nonhospital site in the following manner: $\$15,000$ [cost of one teaching physician] + $\$60,000$ [actual cost of the FTE residents' salary and fringe benefits] = $\$75,000$. To meet the proposed new definition of "all or substantially all," the hospital would be required to incur at least 90 percent of the costs of the training at the nonhospital site, which in this example equals \$67,500 (that is, $0.90 \times \$75,000$). Since in this case the cost of one FTE resident's

salary and fringe benefits is \$60,000, the hospital has not met the 90 percent threshold by only incurring the resident's salary and fringe benefits. The hospital would have to incur at least an additional \$7,500 of the cost (that is, $\$67,500 - \$60,000$) to reach the 90 percent threshold to be permitted to count the FTE resident for IME and direct GME purposes. Alternatively, the hospital could document the actual teaching physician cost using time or salary information specific to that teaching physician at that site, and use that amount to calculate 90 percent of the actual training program costs.

b. Explanation of Variables

In the following section, we discuss each variable in the proposed methodology for determining the cost that a hospital must incur in order to count FTE residents training in nonhospital sites, and explain our rationale for proposing to employ each of these variables. As stated previously, the proposed variables are: teaching physicians' salaries; residents' salaries and fringe benefits (including travel and lodging where applicable); the number of hours per week that the teaching physician spends in nonpatient care GME activities in a nonhospital site; and the number of hours that a nonhospital site is open each week.

(1) National Average Physician Salary Data by Specialty

One of the foremost objections voiced by the hospital industry to our current policy is the documentation burden associated with requesting salary information from individual teaching physicians in nonhospital sites. Hospitals believe that many teaching physicians in nonhospital sites are reluctant to disclose their personal salary information, yet this disclosure is necessary to enable the hospital to determine and pay the nonhospital site for the actual costs of the GME program in accordance with our current regulations. One suggestion mentioned by the hospital industry as an alternative to obtaining individual teaching physician-specific salary information is to allow hospitals to use national average salary survey data by specialty. We understand that there are a number of organizations that conduct annual national surveys on physician compensation. We are proposing to

allow hospitals to use physician compensation survey data as a proxy to determine the teaching physician costs associated with GME in a program at a particular nonhospital site. For example, one such national organization that collects data on physician compensation that we are considering using is the American Medical Group Association (AMGA). AMGA's 2006 *Medical Group Compensation and Financial Survey* was performed under contract by RSM McGladrey. Founded in 1950, AMGA (formerly the American Association of Medical Clinics) is a trade association which dedicates itself to making the " * * * multi-specialty medical group model the preferred delivery system for patient-centered, affordable, quality medical care in America," and represents 283 medical groups that include an average of 272 physicians. AMGA's use of the term "medical group" is based on the American Medical Association's definition of "group practice," which is defined as a group that "includes the provision of health care services by three or more physicians who are formally organized as a legal entity governed by physicians in which business, clinical, and administrative facilities, records and personnel are shared and the practice goals, objectives, and values are commonly defined. Income from medical services provided by the group is treated as receipts of the group and is distributed according to some prearranged plan." AMGA has been performing surveys like the 2006 *Medical Group Compensation and Financial Survey* since 1986. The 2006 survey was sent to over 2,600 medical groups, including medical groups that are not members of AMGA. To give readers an idea of the average compensation amounts in the survey, we have randomly selected 10 specialties included in the 2006 survey and listed their compensation information in Table 7. If we adopt the AMGA survey for use to determine the cost of teaching physicians' time attributable to GME, we would make the salary information for all specialties accessible to hospitals on our Web site and would provide it in a manner similar to Table 7.

TABLE 7.—PHYSICIAN SALARY INFORMATION

*Specialty	Mean salary (in dollars)	Median salary (in dollars)
Cardiology	\$411,916	\$363,081
Dermatology	336,531	306,935
Family Medicine	187,891	178,366
Gynecology and Obstetrics	286,418	271,273
Internal Medicine	192,264	183,840

TABLE 7.—PHYSICIAN SALARY INFORMATION—Continued

*Specialty	Mean salary (in dollars)	Median salary (in dollars)
Ophthalmology	307,044	281,112
Pediatrics & Adolescent: General	191,122	182,186
Physical Medicine and Rehabilitation	208,442	207,004
Diagnostic Radiology: Non-Interventional	415,521	400,000
General Surgery	331,970	310,736

*This information was obtained from the 2006 Medical Group Compensation and Financial Survey published by the American Medical Group Association® (AMGA). For further information, visit AMGA's Web site at <http://www.amga.org/>.

We are soliciting comments as to whether we should use the mean or median compensation amounts for purposes of determining the teaching physicians' cost. In addition, although we recognize that there are generally geographic variations in salary amounts within each specialty (and, although not included in Table 7, AMGA does provide some detail of salaries by geographic area), we are proposing to use the single national average or median salary amount for each specialty, rather than consider geographic variations, because we would like to simplify and streamline the proposed methodology for determining the GME costs in nonhospital sites as much as possible. We are specifically soliciting comments about whether AMGA's salary information should be used, and if not, which other physician compensation survey (or possible mix of surveys) would be more appropriate for this purpose, and whether we should consider additional factors such as geographic variation in physician salaries within each specialty. We note that we believe it is important for the organization providing specialty-specific physician compensation information for this purpose to be one that is nationally recognized as an authoritative source. Additionally, we believe the data should contain compensation amounts for the fullest range possible of specialties and subspecialties, and should be issued annually so that hospitals will always have the most current data to use in determining the teaching physician costs in nonhospital sites. In addition, we would prefer a survey that is available to the public at no cost. (We understand that a number of these surveys are proprietary.) We are also soliciting comments as to how to make the survey data available in the most efficient possible manner.

Regardless of the survey source that we ultimately use, we are proposing that hospitals would use the most recent survey data available as of the beginning

of the hospital's particular cost reporting year. For example—

- If residents are rotating to a particular nonhospital site to receive training in family practice in a hospital's cost reporting year beginning January 1, 2008, then the hospital would use the family practice average salary from the most recently issued survey (in the case of AMGA, 2007) as the salary cost of that teaching physician, even though that teaching physician may in fact earn more or less than that national average salary amount.
- If the teaching physician is a neurologist providing residents with neurology training in a nonhospital site in a hospital's cost reporting year beginning July 1, 2007, then the hospital would use the neurology average salary from most recently issued survey (in the case of AMGA, 2006, since AMGA's surveys are typically released in August) as the salary cost of that teaching physician.

Determining Teaching Physicians' Cost

In determining the teaching physicians' cost, the specialty of the teaching physician is the relevant criterion, not the specialty of the residents that the teaching physician is training in the nonhospital site. Generally, we believe the specialty of the teaching physician will be self-evident, and the hospital can easily locate the national average salary information for that teaching physician's specialty on the survey (for example, if family practice residents are rotating to a dermatology practice to receive training in dermatology, then the national average salary for dermatologists would be used from the survey). However, it is possible that the teaching physician is highly specialized and the average compensation for his or her subspecialty is not listed in the survey we decide to use. In such a case, we are proposing that the hospital should use the immediately less-specialized form of that specialty applicable to that teaching physician (or the hospital may use the physician's actual salary information). For example,

if residents are receiving training from a forensic pathologist, and the national average salary for the subspecialty of forensic pathology is not included in the physician compensation survey, then we are proposing that the hospital should instead use the national average salary for the specialty of pathology to determine the cost of that teaching physician. We believe this is the simplest method of assigning a national average physician compensation amount in the instance where the teaching physician's actual subspecialty is not included in the survey. However, we are soliciting comments as to whether it is possible or appropriate to use survey data from other sources in the event that data is not available from the particular survey source.

In addition, although it may not be a common occurrence, it is possible that residents could be receiving training in a nonhospital site from a teaching physician that is board certified in more than one specialty, but the residents are only receiving training in one of the specialties in which the physician is board certified. In this case, we are proposing that the national average salary that should be used to determine the teaching physician's cost should be the one for the specialty in which the teaching physician is training the residents. For example, if residents are being supervised by a cardiologist who is board certified in internal medicine and cardiology, but the residents are training with him or her specifically to learn internal medicine, then we are proposing that the hospital should use the national average salary for internal medicine, and not cardiology, to determine the teaching cost of that physician. That is, in instances where the residents are receiving training at a nonhospital site from a teaching physician that is board certified in more than one specialty, and it is unclear which specialty to use for purposes of assigning a national average salary to that physician, we are proposing that the question for the hospital to ask is, why are the residents training with that physician? If the answer is, "to receive

training in Specialty X," then the national average salary amount for Specialty X should be used to determine the teaching physician's cost. If the answer is, "to receive training in Specialty Y," then the national average salary amount for Specialty Y should be used to determine the teaching physician's cost, regardless of the specific board certification that the teaching physician has actually received. In general, the hospital, with assistance from the GME Program Director as necessary, should be able to document for the Medicare contractor the specialty in which the residents are receiving training at the nonhospital site, and the national average physician compensation amount for that specialty used in paying "all or substantially all" of the costs, as defined in this proposed rule.

Multiple Teaching Physicians and Residents: 1:1 Resident to Teaching Physician Ratio

We understand that it is not unusual for several residents in the same program to rotate to a particular nonhospital site at the same time, and be supervised by one teaching physician, or for residents to be supervised by several teaching physicians during their time at that nonhospital site. In determining the total costs of the training program at the nonhospital site, it is necessary to consider all of the residents' salaries and fringe benefits (including travel and lodging where applicable), and the teaching physicians' national average salaries. However, to maintain administrative simplicity, we are proposing to allow hospitals to apply a maximum of a 1:1 resident-to-teaching physician ratio "limit" in determining the total GME costs applicable to a program at a nonhospital site. For example, if at the nonhospital site there are two teaching physicians and one FTE resident, the hospital may determine 90 percent of the total costs of the program using a 1:1 resident-to-teaching physician ratio, not a 1:2 resident-to-teaching physician ratio. The 90 percent threshold would be based on the total cost of the one FTE resident (salary and fringe benefits, and travel and lodging where applicable) and one teaching physician (national average salary for the specialty multiplied by the percentage of time spent in nonpatient care GME activities). Similarly, if a hospital rotated 3 FTE residents in the same program to a particular nonhospital site with 7 physicians, unless the hospital documents otherwise, we would assume that all 7 physicians supervise the residents at some point during the training, but, for

purposes of determining the 90 percent threshold, we propose to assume that there are only 3 FTE residents being supervised by 3 teaching physicians. Accordingly, the 90 percent threshold would be based on the total cost of the 3 FTE residents' salaries and fringe benefits (including travel and lodging where applicable) and 3 teaching physicians (national average salaries for the specialties multiplied by the percentage of time spent in nonpatient care GME activities). (In addition, we note that the 1:1 limit may be applied to FTE fractions, as well. That is, if in the preceding example, 3.5 FTE residents were being supervised by 7 physicians, the 90 percent threshold would be determined based on the costs associated with a resident-to-teaching physician ratio of 3.5:3.5.)

In the case of multiple teaching physicians, we must also consider that a particular nonhospital site may be staffed by physicians in different specialties. For example, an orthopedics practice may include orthopedists and radiologists. In this case, we would still maintain the 1:1 resident-to-teaching physician limit, even if the teaching physicians are in different specialties, unless the hospital can document that the number of physicians actually teaching the residents is less than the number of FTE residents training at that nonhospital site. Once the number of teaching physicians is established, we are proposing that the hospital would determine the national average salary for each of those teaching physicians from the national survey data, and then calculate the average national salary of the mix of physician specialties in the practice to be used in computing the 90 percent threshold. For example, assume that 3 FTE residents are rotating to an orthopedic surgery practice staffed by a total of 7 physicians; 4 are orthopedic surgeons, and 3 are diagnostic radiologists. Again, unless the hospital documents otherwise, we would assume that all 7 physicians supervise the residents at some point during their rotation to this practice. First, the hospital would access the national average salary for orthopedic surgeons (assume \$400,000), and the national average salaries for diagnostic radiologists (assume \$412,000). Then, the hospital would calculate the average salary for these physicians as follows: $[(\$400,000 \times 4) + (\$412,000 \times 3)] / 7 = \$405,143$. Next, the 1:1 resident-to-teaching physician ratio would be applied, such that for purposes of determining the 90 percent threshold, there would be 3 FTE residents and 3 teaching physicians. Since the 3

teaching physicians are not in the same specialty, the hospital would multiply the average salary cost of \$405,143 by 3 to get the total teaching physician salaries for the training program at that site ($\$405,143 \times 3 = \$1,215,429$). The hospital would then multiply \$1,215,429 by the percentage of time spent by the teaching physicians in nonpatient care GME activities (that percentage is 3 hours divided by the number of hours the practice is open during a week) to determine the teaching physician GME cost for the training program at that site. This teaching physician cost is then added to the salaries and fringe benefits (including travel and lodging where applicable) of the 3 FTE residents to determine the GME cost of the program at that practice, and the hospital must ensure that it incurs at least 90 percent of that GME cost to count the 3 FTE residents training at the nonhospital site.

We note that, as we indicated above in this section, if there are several physicians in a nonhospital site, we would assume that they all supervise the residents at some point during the residents' training. However, it may be that in fact only some of the physicians actually supervise the residents, while other physicians are not involved in the training program at all. The hospital may wish to document that only certain physicians are involved in the training program (in order to more accurately represent the structure and costs of the training program in a particular nonhospital site). Such documentation would increase the number of residents relative to teaching physicians that is used to calculate the teaching physician costs. That is, using the example above where the resident-to-teaching physician limit was presumed to be 3:3, since there were actually 3 FTE residents and 7 physicians, if the hospital can document that only 2 physicians supervised the residents (and the other 5 physicians were not involved in the GME program at all), then the resident-to-teaching physician ratio would be 3:2. As a result, the hospital might be required to incur less teaching physician costs, if any, to meet the 90 percent threshold.

(2) Residents' Salaries and Fringe Benefits

The second variable in our proposed methodology for determining the costs of a program at a nonhospital site is the salaries and fringe benefits (including travel and lodging where applicable) of the FTE residents that are rotating to a particular nonhospital site. We understand that since the salaries and

fringe benefits (including travel and lodging where applicable) of most residents are already paid by hospitals (either directly, or by reimbursing another entity such as a medical school), the portion of the actual cost of the residents attributable to training in the nonhospital setting can be easily identified and documented by a hospital. Therefore, as under existing regulations, in determining the 90 percent threshold for a particular program at a specific nonhospital site, the hospital must use the actual cost of each FTE resident's salary and fringe benefits (including travel and lodging where applicable). In addition, the cost of the residents will vary by specialty and by program year. Furthermore, as with current policy, the total residents' costs will be based on the FTE number rotating to a particular nonhospital site in a cost reporting period, not the number of individuals actually training in a nonhospital site.

(3) The Number of Hours Spent in Nonpatient Care GME Activities in a Week and the Number of Hours That the Nonhospital Site Is Open in a Week

The third variable used in the determination of the costs of a training program at a nonhospital site is the amount of time that the teaching physician(s) spends on direct GME (nonpatient care) activities in a week. As we first explained in the July 31, 1998 **Federal Register** (63 FR 40987), and more recently in the August 8, 2005 Qs&As posted on the CMS Web site at <http://www.cms.hhs.gov/AcuteInpatientPPS/Downloads/nonhospQA.pdf>, determination of the teaching physician costs to the nonhospital site is dependent upon the teaching physician's salary and the percentage of time he or she devotes to activities related to non-billable GME activities at the nonhospital site (such as conferences, practice management, lectures, and administrative activities like resident evaluations). Hospitals and teaching physicians have protested that documenting the percentage of time that teaching physicians spend on activities relating to nonpatient care GME activities at the nonhospital site is an onerous and impractical task. In an effort to eliminate the documentation burden on physicians of keeping track of the amount of time they spend in nonpatient care GME activities in the nonhospital site, rather than require teaching physicians to estimate the number of hours per week that they spend in such activities with or on behalf of the residents, we are proposing an alternative option that hospitals may choose to use to determine the

percentage of the teaching physician's time that is spent in nonpatient care GME activities. This option is an administrative shortcut or a proxy that we are proposing, rather than continuing to require in all cases that the hospital must document and pay for the actual costs of a training program at a nonhospital site. However, a hospital always has the option of documenting and paying for at least 90 percent of the costs of a program at a nonhospital site using the teaching physician's actual salary and information on the time spent in nonpatient care GME activities.

Under the proposed proxy methodology, we would apply a presumed standard number of hours spent by teaching physicians in nonpatient care GME activities in every nonhospital site. Specifically, we are proposing to use a standard of 3 hours per week spent in nonpatient care GME activities by teaching physicians. We propose that the 3 hour standard would be used in all cases in the formula for determining the teaching physician costs at *all* nonhospital sites, regardless of the specialty of the residents or the number of teaching physicians or residents training at that nonhospital site. Although some hospital industry representatives have stated that the amount of time spent by teaching physicians in nonpatient care GME activities in nonhospital sites is "de minimus," and, therefore, there is typically little if any teaching cost to the nonhospital site, we believe there is also evidence indicating that in many cases the teaching physician is spending a significant amount of time with or on behalf of the residents in nonpatient care GME activities. We believe the standard of 3 hours of nonpatient care GME activities per week is a reasonable proxy based on data collected from surveys conducted by the Association of American Medical Colleges (AAMC), the American Osteopathic Association (AOA), and the Academic Family Medicine Advocacy Alliance (AFMAA), in addition to information compiled from our own informal surveys of teaching physicians.

In September 2005, in response to a request by CMS, the AFMAA, AOA, and AAMC conducted informal surveys to determine the amount of time spent in nonpatient care activities by teaching physicians in nonhospital sites. In the survey results shared with CMS by these associations, we received a range of hours for the amount of teaching physician time spent per week in nonpatient care GME activities at the nonhospital site. Such nonpatient care GME time included time spent by the teaching physician in training activities

when the patient was not present and time spent in administrative activities related to the GME program. The surveys showed means ranging from 1.1 to 4.0 hours per week and medians of 1.5 to 4.0 hours per week for time spent on residency training when patients were not present. The surveys also showed means ranging from 1.6 to 4.7 hours per week and medians of 0 to 2 hours per week for time spent on administrative activities related to residency training at the nonhospital site. Given the range of survey results, we believe that 3 hours per week serves as a reasonable number to use as a shortcut or a proxy for determining teaching physician time spent in nonpatient care GME activities at the nonhospital site. As previously stated, hospitals always still have the option of calculating teaching physician costs and the 90 percent cost threshold using actual data (as under current regulations) specific to the number of hours the teaching physician spends per week on GME activities at the nonhospital site. For example, if a hospital can document that a teaching physician actually spends 1.5 hours per week on GME activities at the nonhospital site, then the hospital may use 1.5 hours per week in calculating the teaching physician cost and the 90 percent cost threshold.

We are proposing to use the standard of 3 hours of nonpatient care activities per week as the proxy regardless of the number of FTE residents the teaching physician is supervising because we believe that when the number of FTE residents at a nonhospital site increases, the teaching physician time associated with those FTE residents in many instances will increase by only a small multiple. For example, a teaching physician would provide a lecture to the residents together, rather than separately lecturing each FTE resident training at the nonhospital site. Accordingly, the time spent by the teaching physician in nonpatient care activities may increase only slightly with each additional FTE resident being supervised.

While we are proposing to use the standard number of hours spent by teaching physician(s) in nonpatient care direct GME activities across all training occurring at all nonhospital sites (that is, 3 hours per week), we are proposing to introduce a fourth variable in the determination of the cost of a training program in a nonhospital site that will vary depending on the specific nonhospital site. This fourth variable is the number of hours that a nonhospital site is open each week. Since only a percentage of the teaching physician's

salary is attributable to direct GME activities, and that percentage is based on time he or she devotes to activities related to non-billable GME activities at the nonhospital site, we are proposing to determine this percentage by dividing the standard number of hours spent in nonpatient care GME activities by the number of hours the *specific* nonhospital site is open each week. We are proposing that the numerator will always be 3 hours, and the denominator will vary depending on the nonhospital site. For example, if FTE residents rotate throughout the year to a nonhospital site that is open 40 hours per week, then the percentage of time spent by the teaching physician(s) in nonpatient care GME activities throughout the year at that site is $3/40 = 0.075$ or 7.5 percent. (If FTE residents rotate to that nonhospital site for only a portion of a year, then the ratio of $3/40$ would be further multiplied by the percentage of the year that the FTE residents train there. For example, if the FTE residents only rotate to this nonhospital site for 3 months of the year, then the percentage of time that the teaching physician(s) spends on nonpatient care GME activities at that site equals $(3/40 \times 0.25 = 0.019$ or 1.9 percent). Similarly, if FTE residents rotate throughout the year to a nonhospital site that is open 50 hours per week, then the percentage of time spent by the teaching physician(s) in nonpatient care direct GME activities throughout the year is $3/50 = 0.06$ or 6 percent. We recognize that the teaching physician(s) may not spend 100 percent of his or her time in that nonhospital site. In fact, many teaching physicians spend some of their week working in a hospital or other facilities. However, we believe that deriving the true amount of time spent by each teaching physician in each nonhospital site in nonpatient care GME activities would involve the imposition of another form of the documentation burden that the hospital industry and teaching physicians have found onerous up to this point. This proposed methodology eliminates the need for any time studies and it is easy to gather the information needed.

We also acknowledge that this proposal to use the number of hours that a particular nonhospital site is open as a proxy in the denominator for determining the percentage of time spent by the teaching physician(s) in nonpatient care GME activities could, in some extreme instances, result in an unusually high percentage of teaching time, which, in turn, would result in a determination of unusually high teaching costs. This is so because, since 3 hours is a constant in the numerator,

the fewer the number of hours the clinic is open (the denominator), the greater the calculated percentage of time spent by the teaching physician in nonpatient care GME activities. To use an extreme example, if a clinic is only open 10 hours a week, then $3/10$, or 30 percent of the national average salary for the teaching physician's specialty would represent the teaching physician's cost that would be used to determine 90 percent of the costs of the program at the clinic. However, we believe that, for most nonhospital training situations, this proposal to use the 3 hour standard and the number of hours the nonhospital site is open per week is a reasonable alternative to the current procedures for determining the actual teaching physician's cost because these proxies are easily obtainable, discrete numbers that do not necessitate any time studies. Nevertheless, we are soliciting comments on alternative proxies that might be appropriate to use in the place of the ratio of 3 hours to the number of hours a nonhospital site is open per week. We also note that in the event that this proposed methodology for calculating teaching physician costs in a particular nonhospital site results in an unrealistic amount, we reiterate that a hospital always has the option of determining and paying at least 90 percent of the GME costs using actual physician salary and teaching time information, for all, or some of its training programs occurring in nonhospital settings. In fact, we are proposing that a hospital may choose to use a combination of actual information and proxy information for determining the teaching physician cost. For example, a hospital may choose to use actual physician salary information instead of the national average survey data, but use the 3 hour standard and the number of hours the nonhospital site is open per week to determine the percentage of time spent on teaching activities, or vice versa. Furthermore, we reiterate that under the proposed new definition of "all or substantially all," even if a hospital chooses to document the teaching physician cost using actual teaching physician-specific information, the hospital need only incur 90 percent of the residents' salaries and fringe benefits (including travel and lodging where applicable), and the portion of the teaching physicians' salaries attributable to direct GME, and *not* 100 percent of those costs.

Under our proposal, 90 percent of the GME costs for a particular program at a particular nonhospital site would be the minimum amount that a hospital must

pay to count the FTE resident(s) training at that site for direct GME and IME purposes. If the hospital is already paying the resident's salaries and fringe benefits (including travel and lodging where applicable), and if the costs of the resident's salaries and fringe benefits are equal to at least 90 percent of the total GME costs at the nonhospital site (that is, the 90 percent threshold), then the hospital is paying "all or substantially all" of the costs in accordance with our proposed definition, and need not pay an additional amount for teaching physician compensation in order to count the FTE residents. However, if the hospital is paying less than 90 percent of the costs of the training program at the nonhospital site, then the hospital must pay an additional amount toward the teaching physician costs until it is paying at least 90 percent of the GME costs for that program. We believe our proposal is relatively simple, easy to administer, and eliminates the documentation burdens cited by the industry as being associated with the current policy. However, we note again that even under our proposal, a hospital is not precluded from choosing to calculate and pay 90 percent of the teaching costs of a program in a nonhospital site in accordance with the existing policy requirements. That is, the hospital may still choose to document the actual teaching physician cost using actual time and salary information from the teaching physician(s) to determine what the true direct GME costs are at that nonhospital site. Once the hospital calculates the actual direct GME costs, we propose that it would only be required to pay at least 90 percent of the actual direct GME costs, consistent with our proposed definition of "all or substantially all of the costs for the training program in the nonhospital setting."

The following is an additional example of the application of the proposed methodology:

Example: For the July 2008 through June 2009 academic year, a hospital with a family practice program sends 3 FTE residents (in different program years) to train at the Family Medicine Center (FMC), a nonhospital site. The hospital's cost reporting period began on January 1, 2008. The FMC is staffed by 5 physicians, all of whom supervise the residents at some point during the year. Four of the physicians are family practitioners, and 1 physician is a psychiatrist. The FMC is open for 50 hours per week. To determine the cost of the teaching physicians, the hospital refers to the most recent national average salary amounts on the national survey published prior to January 1, 2008, which is the 2007 survey. Assume that the national average published salary amount for family practice is \$180,000, and the national

average published salary amount for psychiatry is \$187,000. Since there are multiple physicians in different specialties (absent specific documentation provided by the hospital), the average salary of one FMC physician is calculated as follows: $[(\$180,000 \times 4 \text{ family practice physicians}) + (\$187,000 \times 1 \text{ psychiatrist})] / 5 = \$181,400$. Since the residents are on the payroll of the hospital, the hospital knows that the total actual cost of the 3 FTE residents' salaries and fringe benefits (including travel and lodging, if applicable) is \$182,000. After applying the 1:1 resident-to-teaching physician limit, there are 3 FTE residents to 3 teaching physicians (again, absent specific documentation provided by the hospital). Thus, the GME cost of the 3 teaching physicians is calculated as follows: $(\$181,400 \times 3) \times (3 \text{ hours} / 50 \text{ hours}) = \$32,652$. This teaching physicians' cost of \$32,652 is added to the residents' cost of \$182,000 to arrive at the total cost of the training program at the nonhospital site of \$214,652. To meet the proposed definition of "all or substantially all," the hospital would be required to pay at least 90 percent of the costs of the training program at the nonhospital site, which in this example equals \$193,187 (that is, $0.90 \times \$214,652$). Since in this case the cost of the 3 FTE residents' salaries and fringe benefits is \$182,000, the hospital would not reach the 90 percent cost threshold by simply incurring the costs associated with the residents. The hospital must pay at least an additional \$11,187 (that is, $\$193,187 - \$182,000$) to meet the 90 percent threshold and satisfy the requirement to pay "all or substantially all" of the costs of the family practice program at the FMC.

C. Other Issues To Be Considered

Although we are proposing a revised standard for a hospital to incur "all or substantially all of the costs for the training program in the nonhospital setting" in order to count FTE residents training in nonhospital sites, the other existing regulations regarding nonhospital sites would still generally apply, but would require some modification. Under the existing regulations at § 413.78(e), a hospital is permitted to count residents training in nonhospital sites only if the residents spend their time in patient care activities, and the hospital must comply with either of the following: (a) It must pay all or substantially all of the costs of the training program in the nonhospital site by the end of the third month following the month in which the training in the nonhospital site occurred; or (b) it must have a written agreement with the nonhospital site that states that the hospital will incur the cost of the resident's salary and fringe benefits while the resident is training in the nonhospital site and the hospital is providing reasonable compensation to the nonhospital site for supervisory teaching activities. The written agreement must indicate the

compensation the hospital is providing to the nonhospital site for supervisory teaching activities. We are proposing to add a new § 413.78(f) for cost reporting periods beginning on or after July 1, 2007, to reflect the revised definition of "all or substantially all of the costs for the training program in the nonhospital setting." First, if a hospital chooses to make concurrent payments; that is, pay the training costs by the end of the third month following the month in which the training occurred, then we propose that the hospital must be able to document for audit purposes that the concurrent payments it makes reflects "all or substantially all" of the costs, in accordance with the new proposed definition at § 413.75(b).

Alternatively, if the hospital chooses to maintain a written agreement with the nonhospital site (which, we note, must be in place before the hospital may begin to count residents training at a nonhospital site), we are proposing that the new § 413.78(f) would state that the written agreement must indicate that the hospital will incur at least 90 percent of the total of the costs of the resident's salary and fringe benefits (including travel and lodging where applicable) while the resident is training in the nonhospital site and the portion of the cost of the teaching physician's salary attributable to direct GME. We are proposing that the written agreement should specify the total compensation amount the hospital will incur to the nonhospital site to meet the 90 percent "all or substantially all" threshold, and whether this amount reflects only residents' salaries and fringe benefits (including travel and lodging where applicable), or reflects an amount for teaching physician compensation as well. We believe the written agreement should specify the total amount of nonhospital site training costs the hospital will incur and specify what costs are included in that amount because the hospital would need to determine up front the amount it must pay to the nonhospital site in order to meet the 90 percent threshold and incur "all or substantially all" of the cost in accordance with our proposed definition. In addition, the provision of this information in the written agreement will simplify the audit process when the Medicare contractor determines whether the amount paid by the hospital to the nonhospital site reflects "all or substantially all" of the costs of the program in the nonhospital site in accordance with the new proposed definition at § 413.75(b). We note that regardless of whether a hospital chooses to make concurrent

payments to the nonhospital site, or to have a written agreement, the hospital must demonstrate that it is paying for at least 90 percent of the costs of each program at each nonhospital site according to the following formula (although actual data may be used in place of the proxies):

$$0.90 \times [(sum \text{ of each FTE resident's salary} + \text{ fringe benefits (including travel and lodging where applicable)}) \text{ plus the portion of the teaching physician's compensation attributable to direct GME activities}].$$

The portion of the teaching physician's compensation attributable to direct GME activities may be calculated as follows:

$$(3 / \text{number of hours nonhospital site is open per week}) \times (\text{national average salary for each teaching physician}).$$

If there are no teaching costs (because, for example, the residents are rotating to a nonhospital site where the teaching physician is a solo practitioner), then the written agreement should indicate that the specified compensation amount reflects only residents' salaries and fringe benefits (including travel and lodging where applicable) because there are no teaching physician costs (since the teaching physician is a solo practitioner). Finally, we note that, as under existing regulations, if the hospital does choose to have a written agreement with the nonhospital site, the hospital must, at a minimum, liquidate the costs identified in the written agreement in accordance with the regulations at § 413.100(c)(2)(i).

In addition, we note that under current policy, a hospital may choose to provide non-monetary, in-kind compensation rather than provide direct financial compensation to the nonhospital site for supervisory teaching activities. Under the new proposed definition of "all or substantially all," a hospital would still be permitted to provide in-kind compensation to the nonhospital site, but, as under current policy, the hospital must be able to document that the value of the in-kind compensation is at least equivalent monetarily to the portion of the actual or proxy-based costs for that physician attributable to nonpatient care GME activities. That is, the hospital must show that the value of in-kind compensation is sufficient to meet the 90 percent threshold using the formula stated above in this section.

We also believe it is important to review how the written agreement requirements apply when a hospital's residents rotate to nonhospital sites such as clinics owned by a medical

school. As we stated in response to Question 9 on the Qs&As on our Web site at <http://www.cms.hhs.gov/AcuteInpatientPPS/Downloads/nonhospQA.pdf>, “rather than having a written agreement with each clinic, it would be appropriate for the hospital to have a written agreement with the medical school, since the medical school owns the clinics. If the residents are training in various medical school clinics, *the hospital must have written agreement(s) reflecting the compensation arrangements for each clinic*” (emphasis added). Unfortunately, we have learned of numerous situations where a hospital has a single agreement with the medical school in which the hospital specifies a lump sum dollar amount that it is paying the medical school for GME-related services that the medical school is providing, but there is no breakout at all as to the specific training costs attributable to individual clinics, or to the specific programs at those clinics. Without a breakout of the residents’ salaries and fringe benefits (including travel and lodging where applicable), and the portion of the teaching physicians’ salaries attributable to nonpatient care GME activities at each nonhospital site, the Medicare contractor is unable to determine whether the hospital has properly paid the costs of each specialty program at each nonhospital site in accordance with the statutory and regulatory requirements. Likewise, under the new proposed definition of “all or substantially all,” whether hospitals pay for the costs of a program at a nonhospital site on a concurrent basis, or if they have a written agreement, they must be able to document how they are paying for “all or substantially all” of the costs of a particular program at each nonhospital site. Global agreements with lump sum payment amounts, either for teaching physician costs or for nonhospital training in general, have not been sufficient under existing policy and would not be sufficient under the proposed policy. Similarly, as under current policy, if two (or more) hospitals both train residents in the same accredited program, and the residents rotate to the same nonhospital site(s), the hospitals cannot share the costs of that program at that nonhospital site (for example, by dividing the FTE residents they wish to count according to some pre-determined methodology), as this violates the statutory requirement at section 1886(h)(4)(E) of the Act that the hospital incur “*all, or substantially all, of the costs for the training program in that setting*” (emphasis added). Finally,

as under current policy, we note that in the instance where a hospital is sending residents in several different specialty programs to train in the same nonhospital site, and it wishes to count all of those FTE residents for purposes of IME and direct GME payment, the hospital must be able to document that it is separately meeting the “all or substantially all” threshold for each specialty program at that site. (That is, the hospital would determine the 90 percent threshold in accordance with the proposed methodology described above separately for multiple teaching physicians and residents, and would apply the resident-to-teaching physician ratio limit if applicable).

In summary, we are proposing to revise § 413.75(b) to modify the definition of “all or substantially all of the costs for the training program in the nonhospital setting” to reflect the policies in place between January 1, 1999 and July 1, 2007, and our proposed policy on or after July 1, 2007. We are revising the definition of “all or substantially all of the costs for the training program in the nonhospital setting” to mean: (a) Effective on or after January 1, 1999 and for cost reporting periods beginning before July 1, 2007, the residents’ salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians’ salaries and fringe benefits attributable to direct graduate medical education (GME); and (b) effective for cost reporting periods beginning on or after July 1, 2007, at least 90 percent of the total of the costs of the residents’ salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians’ salaries attributable to direct GME.

In addition, we are proposing to revise § 412.105(f)(1)(ii)(C) for IME and add a new § 413.78(f) to reflect the revised requirement to pay “all or substantially all” of the GME costs in a nonhospital site, effective for cost reporting periods beginning on or after July 1, 2007.

XIII. Technical Amendment

In the Revisions to Hospital Inpatient Prospective Payment Systems—FY 2007 final rule (71 FR 47870 through 48136), in an amendatory instruction to § 412.22(h)(3), we inadvertently omitted the words “introductory text.” Therefore, paragraphs § 412.22(h)(3)(i) and (ii) were removed. We are proposing to replace § 412.22(h)(3)(i) and (ii) in this proposed rule.

XIV. Waiver of Proposed Rulemaking and Delay in the Effective Date

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on the proposed rule in accordance with 5 U.S.C. section 553(b) of the Administrative Procedure Act (APA). The notice of proposed rulemaking includes a reference to the legal authority under which the rule is proposed, and the terms and substances of the proposed rule or a description of the subjects and issues involved. This procedure can be waived, however, if an agency finds good cause that a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued.

In addition, we ordinarily provide a 30-day delay in the effective date of the provisions of a proposed rule. Section 553(d) of the APA (5 U.S.C. section 553(d)) ordinarily requires a 30-day delay in the effective date of final rules after the date of their publication in the **Federal Register**. This 30-day delay in effective date can be waived, however, if an agency finds for good cause that the delay is impracticable, unnecessary, or contrary to the public interest, and the agency incorporates a statement of the finding and its reasons in the rule issued.

In the Revisions to Hospital Inpatient Prospective Payment Systems—FY 2007 Occupational Mix Adjustment to Wage Index; Implementation; Final rule (71 FR 47870 through 48136), in an amendatory instruction to § 412.22(h)(3), we inadvertently omitted the words “introductory text.” Therefore, paragraphs § 412.22(h)(3)(i) and (ii) were removed from the CFR. We believe that since we are merely making a technical correction by correcting an amendatory instruction and since these paragraphs were subject to notice and comment when originally added to the CFR, we have just cause to waive additional notice and comment rulemaking at this time. Also, it is in the public interest to have these paragraphs reinstated immediately because the entities to which these provisions apply may believe they will no longer be excluded from the IPPS and may be in the process of closing their facilities including transferring patients to other facilities. In addition, it is in the public interest to have these paragraphs reinstated immediately because they are part of current policy. The paragraphs are being added without any changes to the language or its intent. For these same reasons, we believe that we have

just cause to waive the 30-day delay in effective date since we are correcting an error from the previously published rule and not implementing new policy.

For the reasons stated above in this section, we find that both notice and comment and the 30-day delay in effective date for this correction are unnecessary and impracticable, and that it is in the public interest to make this notice effective in conjunction with the final rule to which the corrections apply (and could be contrary to the public interest to do otherwise). The technical correction is effective as if it had been included in the Revisions to Hospital Inpatient Prospective Payment Systems—FY 2007 Occupational Mix Adjustment to Wage Index; Implementation; Final rule.

XV. Collection of Information Requirements

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

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

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

Section 413.78 Direct GME Payments: Determination of the Total Number of FTE Residents

Section 413.78(f) outlines the requirements that must be met for the time residents spend in non-provider settings to be included in determining the number of FTE residents used in the computation of a hospital's resident count. A resident must spend his or her time in patient care activities; the hospital must incur substantially all of the costs of the training program in a nonhospital setting.

In addition, § 413.78(f)(3) requires that a hospital comply with one of the

two requirements listed in § 413.78(f)(3)(i) and § 413.78(f)(3)(ii).

Section 413.78(f)(3)(i) states that a hospital must document that it is paying for all or substantially all of the costs associated with the training program in nonhospital settings. The costs must be incurred between the training date and the end of the third month after the training date. The burden associated with this requirement is the time and effort associated with documenting and maintaining records of the incurred costs and subsequent payments made by a hospital.

Section 413.78(f)(3)(ii) states that a hospital must have a written agreement with the nonhospital site. The agreement must state that the hospital will incur at least 90 percent of the cost of the resident's salary and fringe benefits (and travel and lodging where applicable) while the resident is training in the nonhospital site and the portion of the cost of the teaching physician's salary is attributable to GME. The written agreement must also specify the compensation amount the hospital is paying the nonhospital site, and whether this amount reflects only residents' salaries and fringe benefits (and travel and lodging is applicable), or includes an amount for teaching physician compensation. The burden associated with this requirement is the time and effort associated with drafting, signing, and maintaining the written agreement.

The requirements listed in § 413.78(f)(3)(i) and § 413.78(f)(3)(ii) are exempt from the Paperwork Reduction Act of 1995 in accordance with Pub. L. 99-272.

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

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

Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Regulations Development Group, Attn: William N. Parham, III, [CMS-1529-P], Room C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850; and
Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Carolyn Lovett, CMS Desk Officer, [CMS-1529-P],

carolyn_lovett@omb.eop.gov. Fax (202) 395-6974.

XVI. Regulatory Impact Analysis

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

A. Introduction

We have examined the impacts of this proposed rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354), section 1102(b) of the Act, the Unfunded Mandates Reform Act of 1995 (UMRA) (Pub. L. 104-4), and Executive Order 13132.

1. Executive Order 12866

Executive Order 12866 (as amended by Executive Order 13258, which merely assigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any one year). We are using the proposed rates, factors and policies presented in this proposed rule, including updated proposed wage index values, and the best available claims and CCR data to estimate the change in proposed payments for the 2008 LTCH PPS rate year. Based on the best available data for 369 LTCHs, we estimate that the proposed expansion of the existing payment provision for co-located LTCHs (HwHs and satellites of LTCHs) at existing § 412.534 to certain situations not presently covered by existing § 412.534 for subclause (I) LTCHs (as discussed in section V.B. of the preamble of this proposed rule), in conjunction with the proposed update to the Federal rate for RY 2008 (discussed in section IV.C. of the preamble of this proposed rule), the proposed changes to the area wage adjustment (discussed in section IV.D.1. of the preamble of this proposed rule), and the proposed increase in the outlier fixed-loss amount (discussed in section IV.D.3.c. of the preamble of this proposed rule) for the 2008 LTCH PPS rate year, would result in a decrease in estimated payments from the 2007 LTCH PPS rate year of approximately \$80 million (or about 2.0 percent) for the 369 LTCHs in our database.

Regarding the approach discussed for addressing our concerns with the existing SSO policy presented in section V.A.2. of the preamble of this proposed rule, we estimate that such an approach would result in a decrease in estimated payments in the 2008 LTCH PPS rate year of about an additional \$37 million (for a total decrease in estimated

aggregate payments of \$117 million (\$80 million plus \$37 million) or about 2.9 percent) for the 369 LTCHs in our database. (An estimate of Medicare program payments for LTCH services for the next 5 years is shown in section IV.D.5. of the preamble of this proposed rule. The impact of the proposed policy change relating to payment for Hospital

Direct and Indirect Graduate Medical Education Payments (GME) is discussed in section XVI.C.2. of this regulatory impact analysis.) The estimated impact of the provisions presented in this proposed rule (as detailed above) for the 369 LTCHs in our database are in Table 8.

TABLE 8.—ESTIMATED IMPACT OF THE PROVISIONS OF THIS PROPOSED RULE ¹

Proposed policy	Estimated percent change in estimated aggregate LTCH PPS payments
Proposed Payment Rate and Policy Changes:	
Proposed Changes to the Federal Rate ²	0.61
Proposed Changes to the Area Wage Adjustment	-0.49
Approach Discussed for SSO Policy	-0.91
Subtotal ³	-0.7
Expansion of the "25 Percent" Policy ⁴	-2.2
Total ⁵ (-0.7% + -2.2%)	-2.9

¹ Percent change in estimated aggregate LTCH PPS payments from the 2007 LTCH PPS rate year to the 2008 LTCH PPS rate year based on the best available data for 369 LTCHs.

² As discussed in greater detail in section XV.B.4. of this regulatory impact analysis, because about 35 percent of all LTCH cases are projected to receive a payment under the existing SSO policy that is based either on the estimated cost of the case or the "IPPS comparable amount" (rather than the proposed Federal rate). Therefore, the percent change in estimated aggregate LTCH PPS payments due to the proposed changes to the Federal rate, 0.61 percent, is slightly less than the proposed update to the Federal rate of 0.71 percent.

³ In absence of including the approach considered for the SSO policy (discussed in section V.A.2. of this proposed rule), we estimate that in place of the 0.7 percent decrease in estimated aggregate LTCH PPS payments, on average, for all LTCHs, there would be 0.25 percent increase in estimated aggregate LTCH PPS payments, on average, for all LTCHs for all proposed payment rate and policy changes. We also note that the estimated percent change for all proposed payment rate and policy changes may not exactly equal the sum of the estimated percent change for the proposed changes to the Federal rate, the proposed changes to the area wage adjustment and the approach discussed for the SSO policy due to the effect of estimated changes in aggregate HCO payments as well as other interactive effects that cannot be isolated.

⁴ Proposed expansion of the existing special payment provision for co-located LTCHs (HwHs and satellites of LTCHs) at existing § 412.534 to certain situations not presently covered by existing § 412.534 for subclause (I) LTCHs (as discussed in section V.B. of the preamble of this proposed rule).

⁵ Total estimated impact of the provisions of this proposed rule (that is, sum of the estimated impact of the proposed payment rate and policy change, including the approach discussed for the SSO policy, and the estimated impact of the expansion of the "25 percent" policy). We note that in absence of including the approach discussed for the SSO policy, we project that the total estimated impact of the provisions of this proposed rule are projected to result in a 2.0 percent decrease in estimated aggregate LTCH PPS payments.

Because the combined distributional effects and estimated changes to the Medicare program payments would be greater than \$100 million if we take into consideration the approach discussed for the SSO policy (in section V.A.2. of the preamble of this proposed rule), this proposed rule would be considered a major economic rule, as defined in this section. We note the \$117 million (or 2.9 percent) decrease in estimated aggregate LTCH PPS payments resulting from the provisions presented in this proposed rule does not reflect changes in LTCH admissions or case-mix intensity in estimated LTCH PPS payments, which would also affect overall payment changes.

2. Regulatory Flexibility Act (RFA)

The RFA requires agencies to analyze options for regulatory relief of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most

hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of \$6 million to \$29 million in any 1 year. For purposes of the RFA, proprietary hospitals are small entities if they meet the small business size standard described above (for further information, see the Small Business Administration's regulation at 65 FR 69432, November 17, 2000). Because we lack data on individual hospital receipts, we cannot determine the number of small proprietary LTCHs. Therefore, we assume that all LTCHs are considered small entities for the purpose of the analysis that follows. Medicare FIs are not considered to be small entities. Individuals and States are not included in the definition of a small entity.

Currently, our database of 369 LTCHs includes the data for 78 non-profit (voluntary ownership control) LTCHs and 246 proprietary LTCHs. Of the

remaining 45 LTCHs, 13 LTCHs are Government-owned and operated and the ownership type of the other 32 LTCHs is unknown (as shown in Table 9). The impact of the proposed payment rate and policy changes for the 2008 LTCH PPS rate year (including the proposed update to the Federal rate, proposed changes to the area wage adjustment, and the approach discussed for the SSO policy) is discussed in section XVI.B.4.c. of this regulatory impact analysis. The impact of other proposed policy changes, such as the effects of the proposed expansion of the special payment provisions for LTCHs HwHs and LTCH satellites to certain situations not presently covered by § 412.534 for subclause (I) LTCHs, is discussed in section XVI.C. of this regulatory impact analysis.

As we discuss in detail throughout the preamble of this proposed rule, based on the most recent available LTCH data, we believe that although the

provisions of this proposed rule would result in a decrease in estimated aggregate LTCH PPS payments, we believe the resulting LTCH PPS payment amounts result in appropriate Medicare payments. However, we believe that although appropriate, the provisions of this proposed rule could have a significant impact on some small entities (as defined above in this section). As also discussed in greater detail below in this section, we are unable to determine how significant the impact of some of the provisions of this proposed rule may be on small entities since we expect many LTCHs to adjust their admission practices if some of these provisions are implemented. We note that LTCHs have been adapting their behavior in response to the policy changes we have implemented over the past few years (for example, the annual update to the LTC-DRG relative weights, the "25 percent policy" at existing § 412.534, the revision to the SSO payment formula at existing § 412.529(c)(2), and the zero percent update to the RY 2007 Federal rate). Although those policy changes were projected to result in decreases in estimated aggregate LTCH PPS payments, the growth in the number of LTCHs has continued (although at a reduced rate). Based on the most recent available OSCAR data, the number of LTCHs has increased over 10 percent in the past 2 years (from October 1, 2004 and October 1, 2006). Because we acknowledge that many of the affected entities are small entities, the analysis discussed throughout the preamble of this proposed rule, in conjunction with the discussion presented in greater detail below in this section and throughout the remainder of this regulatory impact analysis, constitutes our initial RFA. Therefore, in this proposed rule, we are soliciting comments on our estimates and analysis of the impact of the provisions of this proposed rule on small entities.

The proposed changes presented in this proposed rule, which include the proposed payment rate and policy changes and the proposed expansion of the "25 percent" policy (described above in this section), are estimated to result in approximately a 2.0 percent (\$80 million) decrease in estimated payments per discharge in the 2008 LTCH PPS rate year, on average, to all LTCHs. As shown Table 8, taking into consideration the approach discussed for the SSO policy in section V.A.2. of the preamble of this proposed rule in addition to the proposed payment rate and policy changes and the proposed expansion of the "25 percent" policy

(described above in this section), we estimate that the provisions of this proposed rule could result in approximately a 2.9 percent (or \$117 million) decrease in estimated payments per discharge in the 2008 LTCH PPS rate year, on average, to all LTCHs. Table 8 shows that the proposed payment rate and policy changes (including the approach discussed for the SSO policy) is projected to result in a 0.7 percent decrease in estimated aggregate LTCH PPS payments, and the proposed expansion of the "25 percent" policy is projected to result in a 2.2 percent decrease in estimated aggregate LTCH PPS payments. Thus, the majority of the approximately 2.9 percent decrease in estimated aggregate payments in the 2008 LTCH PPS rate year as compared to the 2007 LTCH PPS rate year would be due to the proposed expansion of the special payment provisions for co-located LTCHs to certain situations not presently covered by existing § 412.534 for subclause (I) LTCHs (as discussed in section V.B. of this proposed rule).

As discussed in greater detail in section XVI.C.1. of this regulatory impact analysis, because we believe that this proposed policy would discourage inappropriate patient shifting to LTCHs and would encourage all subclause (I) LTCHs to engage in more appropriate admission policies since, under this proposal no payment adjustment would be made if the patient has reached HCO status at the co-located host (under the proposed revision to § 412.534) or at the referring hospital (under proposed § 412.536) prior to being admitted for additional post-acute care at the LTCH (as discussed in greater detail in section V.B. of this proposed rule). Because we expect that such a proposed policy would reduce the financial incentives that may be present currently for certain situations not presently covered by existing § 412.534 to admit patients prematurely discharged from other hospitals, we believe this proposed policy would result in fewer admissions to LTCHs before a complete course of patient care is provided at the non-co-located referring hospital (under proposed § 412.536) or co-located referring hospital (under the proposed revision to § 412.534). Thus, any change in admission practices as a result of this proposed policy would result in less of a decrease in estimated aggregate LTCH PPS payments than the 2.2 percent (90 million) estimated based on current admission practices. Thus, the projected 2.2 percent (decrease in estimated aggregate LTCH PPS payments resulting from this proposed policy change would

only occur if there were no changes in LTCH admission practices. Furthermore, we believe that this proposed policy would result in appropriate Medicare payments since, as noted above, we expect that such a policy would reduce the financial incentives to admit patients prematurely discharged from other hospitals and would encourage all LTCHs to engage in more appropriate admission policies. For these reasons, although we estimate that, if implemented, this proposed policy would result in a decrease in estimated aggregate LTCH PPS payments, we do not believe that such a projected decrease in estimated aggregate LTCH PPS payments, although possibly significant, would adversely affect LTCHs' ability to deliver efficient care to Medicare beneficiaries nor would there be an adverse affect on Medicare beneficiaries' access to care.

The impact analysis of proposed payment rate and policy changes in Table 9 (including the approach discussed for the SSO policy in section V.A.2. of the preamble of this proposed rule) shows that estimated payments per discharge are expected to decrease approximately 0.7 percent, on average, for all LTCHs from the 2007 LTCH PPS rate year as compared to the 2008 LTCH PPS rate year. Although we are proposing a 0.71 percent increase to the Federal rate for RY 2008 (as discussed in section IV.C. of this proposed rule), the projected percent decrease in estimated payments per discharge from the 2007 LTCH PPS rate year to the 2008 LTCH PPS rate year is attributable to the proposed changes to the area wage adjustment (discussed in section IV.D.1. of this proposed rule), in conjunction with the approach discussed for SSO cases in section V.A.2. of this proposed rule, as well as the proposed increase to the HCO fixed-loss amount (as discussed in section IV.D.3.c. of this proposed rule). (As discussed in greater detail in section XVI.B.4., the 2.2 percent decrease in estimated aggregate LTCH PPS payments due to the proposed expansion of the "25 percent policy" to certain situations not presently covered by existing § 412.534 for subclause (I) LTCHs is not reflected in Table 9. However, as noted above, the impact of that proposed policy is discussed in greater detail in section XVI.C.1. of this regulatory impact analysis.)

As the impact analysis in Table 9 shows, estimated changes to the area wage adjustment from RY 2007 to RY 2008 (resulting from both established policy and proposed changes presented in section IV.D.1. of this proposed rule, as discussed in greater detail below in

this section) contribute to the decrease in estimated aggregate LTCH PPS payments from the 2007 LTCH PPS rate year to the 2008 LTCH PPS rate year. As discussed in section IV.D.1. of this proposed rule, we are proposing to update the wage index values for RY 2008, in accordance with the progression of the existing 5-year phase-in of the area wage adjustment, based on the most recent available wage data. We believe that proposing to update the LTCH PPS wage index based on the most recent available wage data would ensure that the LTCH PPS wage index adjustment 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. In addition, we are proposing to decrease the labor-related share from 75.665 percent to 75.511 percent under the LTCH PPS for RY 2008 based on the most recent available data on the relative importance of the labor-related share of operating and capital costs of the LTCH PPS market basket (also discussed in section IV.D.1. of this proposed rule). We believe that proposing to revise the labor-related share based on the most recent available data would appropriately identify the portion of the proposed LTCH PPS Federal rate that is adjusted to account for geographic differences in area wage levels by applying the applicable proposed LTCH PPS wage index value. As discussed in greater detail in section IV.D.1. of this proposed rule, we believe that these proposed changes to the LTCH PPS area wage adjustment based on the most recent available wage data and data on the relative importance of the labor-related share of the LTCH PPS market basket, respectively, would result in appropriate and accurate LTCH PPS payments for the resources used by LTCHs in a given area. Such updated data appropriately reflects national differences in area wage levels and identifies the portion of the proposed Federal rate that should be adjusted to account for such differences in area wages.

We also note that, even though we have not proposed to make any changes to the existing 5-year phase-in of the wage index adjustment that was established when the LTCH PPS was implemented (August 30, 2002; 67 FR 56018), the continued progression of this phase-in also contributes to the decrease in estimated aggregate LTCH PPS payments for RY 2008. That is, since under the established phase-in of the wage-index adjustment, LTCHs receive an increasing percentage of the

applicable full wage index value (which is less than 1.0 for the majority of LTCHs), we expect that estimated aggregate LTCH PPS payments would decrease from RY 2007 to RY 2008 as a result of the progression of the existing 5-year phase-in of the area wage adjustment. Thus, the majority of the 0.5 percent decrease in estimated payments per discharge, on average, for all LTCHs (see Table 9) is due to the existing 5-year phase-in of the wage index adjustment, and is not due to proposed policy changes presented in this proposed rule. Because the existing 5-year phase-in of the area wage adjustment has been a feature of the LTCH PPS since it was implemented beginning October 1, 2002, and since a large majority (over 70 percent) of LTCHs are located in areas where historically the wage index value is less than 1.0, the decrease in estimated aggregate LTCH PPS payments resulting from this policy should be anticipated by LTCHs, and therefore, already accounted for in their fiscal planning. In addition, we note that, although the portion of the decrease in estimated aggregate LTCH PPS payments that is due to the existing 5-year phase-in of the wage index adjustment is expected, we believe that any change in LTCHs' wage index values under this policy is appropriate since LTCHs will be receiving an increasing percentage of the applicable full wage index value, which, by definition, reflects the relative hospital wage levels for the area in which the LTCH is located as compared to the national average hospital wage level.

Because we cannot determine to what extent LTCHs may have planned for the decrease in estimated aggregate LTCH PPS payments that is due to the existing 5-year phase-in of the area wage adjustment, even though the impact may be significant for some LTCHs, we believe that most LTCHs would not be adversely affected since, as explained above, we believe that the proposed changes to the area wage adjustment (that is, the proposed use of update wage data and the proposed change in the labor-related share), in conjunction with the continued progression of the 5-year phase-in of the area wage adjustment, would result in appropriate LTCH PPS payments in RY 2008. For these reasons, we believe that the decrease in estimated aggregate LTCH PPS payments resulting from proposed changes to the area wage adjustment, although possibly significant for some LTCHs, is appropriate and would not adversely affect LTCHs' ability to deliver efficient care to Medicare

beneficiaries nor would there be an adverse affect on Medicare beneficiaries' access to care.

In addition, as also shown in Table 9, the approach for the SSO policy discussed in section V.A.2. of this proposed rule would also contribute to the estimated 0.7 percent decrease in estimated aggregate LTCH PPS payments in RY 2008, on average, for all LTCHs. Under that approach, we believe that the LTCH cases that appear to be "similar to" the same type of cases treated in an acute care hospital and paid for under the IPPS, as discussed in greater detail in section V.A.2. of this proposed rule, would receive an appropriately adjusted LTCH PPS payment to treat such cases. We believe that those SSO cases that are "similar to IPPS cases" most likely do not receive a full course of an LTCH-level of treatment in such a short period of time since, in general, LTCHs are intended to treat longer stay patients. Although we project a decrease in estimated aggregate LTCH PPS with the approach discussed for the SSO policy in section V.A.2. of this proposed rule, we believe that such an approach would result in appropriate and adequate Medicare payments for the treatment of Medicare beneficiaries with a LOS is "similar to" typical IPPS cases.

Furthermore, we believe that, if adopted, the approach to the SSO policy discussed in section V.A.2. of the preamble of this proposed rule would accomplish our stated goal of removing the incentive for LTCHs to admit patients for whom a long-term hospital stay is not necessary, and therefore, for whom the LTCH would not be providing complete treatment. As noted previously, the vast majority of LTCH cases, including SSO cases, are admitted to the LTCH directly from an acute-care hospital, and therefore, many SSO cases may still be in need of acute-level care (as we discuss in greater detail in section V.A.2. of the preamble of this proposed rule). Therefore, we believe that in response to the approach discussed for the SSO policy in section V.A.2. of this proposed rule LTCHs may reduce the number of SSO cases that are "similar to IPPS cases" that they admit (and most of those patients would continue to receive treatment at the acute-care hospital). To the extent that LTCHs continue to admit SSO cases that are "similar to IPPS cases," we believe that this approach to the SSO policy would result in an adjusted LTCH PPS payment that is appropriate, as discussed above. For these reasons, although we estimate that the approach to the SSO policy discussed in section V.A.2. of this proposed rule would result in a decrease in estimated

aggregate LTCH PPS payments, we do not believe that such an impact on estimated aggregate LTCH PPS payments, although possibly significant, would adversely affect LTCHs' ability to deliver efficient care to Medicare beneficiaries nor would there be an adverse affect on Medicare beneficiaries' access to care.

For all of the reasons discussed above in this section, although we do not expect an estimated incremental decrease of 2.9 percent (approximately \$117 million) in estimated aggregate LTCH PPS payments to have a significant adverse financial impact on LTCHs, nor do we expect there would be an effect on beneficiaries' access to care, we acknowledge that the provisions of this proposed rule could have a significant impact on some small entities. However, we believe that the provisions of this proposed rule would result in appropriate LTCH PPS payments in RY 2008. We also note that LTCHs provide some services to (and generate revenue from) patients other than Medicare beneficiaries, and the revenue to LTCHs from treating those patients is not affected by this proposed rule. The analysis presented above, in conjunction with the remainder of this section, demonstrates that this proposed rule is consistent with the regulatory philosophy and principles identified in the RFA. We believe the provisions presented in this proposed rule would affect payments to LTCHs, and the effects on some LTCHs, although they may be significant, are appropriate (as discussed above).

3. Impact on Rural Hospitals

Section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. As shown in Table 9, we are projecting a 2.6 percent decrease in estimated payments per discharge for the 2008 LTCH PPS rate year as compared to the 2007 LTCH PPS rate year for rural LTCHs as a result of the proposed payment rate changes, including the approach discussed for addressing our concerns with the existing SSO policy presented in section V.A.2. of the preamble of this proposed rule, based on the data of the 25 rural LTCHs in our database of 369 LTCHs for which complete data were available.

As shown in Table 9, the majority of the estimated decrease in estimated LTCH PPS payments in the 2008 LTCH PPS rate year as compared to the 2007 LTCH PPS rate year for proposed payment rate and policy changes for rural LTCHs is due to the proposed change in the area wage adjustment (as discussed in greater detail in section V.D.1. of the preamble of this proposed rule). Specifically, as discussed above, although we are not making any changes to the existing 5-year phase-in of the wage index adjustment that was established when the LTCH PPS was implemented (August 30, 2002; 67 FR 56018), the continued progression of this phase-in contributes to the decrease in estimated payments to rural LTCHs for RY 2008. This is because, under the established phase-in of the wage-index adjustment, LTCHs receive an increasing percentage of the applicable full wage index value (which is less than 1.0 for *all* of the 25 rural LTCHs in our database), we expect that estimated payments per discharge for rural LTCHs would decrease from RY 2007 to RY 2008 as a result of the progression of the 5-year phase-in of the wage index adjustment. Thus, the majority of the projected 2.6 percent decrease in estimated payments per discharge shown in Table 9 for rural LTCHs is due to the existing 5-year phase-in of the wage index adjustment, and is not due to proposed policy changes presented in this proposed rule. As discussed above, we believe that the decrease in estimated aggregate LTCH PPS payments resulting from this existing policy should be anticipated by LTCHs, and therefore, already accounted for in their fiscal planning. In addition, we note that, although the portion of the decrease in estimated aggregate LTCH PPS payments that is due to this existing policy is expected, we believe that any change in LTCHs' wage index values due to the continued progression of the phase-in of the area wage adjustment is appropriate since LTCHs will be receiving an increasing percentage of the applicable full wage index value, which, by definition, reflects the relative hospital wage levels for the area in which the LTCH is located as compared to the national average hospital wage level.

Furthermore, as also explained in greater detail above, we believe that the proposed changes to the area wage adjustment presented in this proposed rule (that is, the proposed use of update wage data and the proposed change in the labor-related share) would result in accurate and appropriate LTCH PPS payments in RY 2008 since they are

based on the most recent available data. Such updated data appropriately reflect national differences in area wage levels and identifies the portion of the proposed Federal rate that should be adjusted to account for such differences in area wages, thereby, resulting in accurate and appropriate LTCH PPS payments. Because we cannot determine to what extent LTCHs may have planned for the decrease in estimated aggregate RY 2008 LTCH PPS payments that results from the existing 5-year phase-in of the area wage adjustment, we believe that although the effects of the proposed changes to the area wage adjustment on some rural LTCH may be significant, most rural LTCHs should be not adversely affected because those proposed changes are expected to result in appropriate LTCH PPS payments in RY 2008.

We also believe that the proposed expansion of the payment adjustment at existing § 412.534 to certain situations not presently covered by that policy for subclause (I) LTCHs may have a significant adverse impact on some rural LTCHs, although we cannot determine how significant for the reasons explained below in this section. Even though this proposed policy is estimated to reduce estimated aggregate LTCH PPS payments in RY 2008 and may result in a significant impact on some rural LTCHs, we also believe, that such changes would result in appropriately adjusted LTCH PPS payments (as explained below in this section). As discussed in greater detail in section V.B. of this proposed rule, in designing features of the original "25 percent policy" for co-located LTCHs (HwHs and LTCH satellites), which we are proposing to extend to certain situations not presently covered by existing § 412.534 for subclause (I) LTCHs, we provided special treatment for rural hospitals which would increase the threshold from 25 percent to 50 percent. When we established the 25 percent (or applicable percentage) payment adjustment for co-located LTCHs at existing § 412.534, after which this proposed payment adjustment for situations not presently covered by that policy has been modeled, we noted in response to comments that "the Congress has authorized special treatment for rural areas under the Medicare program because of the particular geographic and demographic challenges in those locations, as well as the difference between the provision and availability of medical services as compared to urban areas" (69 FR 49206). Therefore, under our proposed policy, we would apply the same

rationale to certain situations not presently covered by existing § 412.534 that would occur in subclause (I) LTCHs that are located in rural areas. Accordingly, rather than a 25 percent threshold (as is being proposed for most urban LTCHs), for rural LTCHs, the payment adjustment would be applied only to those LTCH's or LTCH satellite facility's Medicare discharges that were admitted from a non-co-located referring hospital under proposed § 412.536 or co-located host under the proposed revision to § 412.534 that are in excess of 50 percent of the LTCH's total Medicare discharges for that hospital for any cost reporting period. Under this proposal, consistent with the existing policy at § 412.534, no payment adjustment would be made if the patient has reached HCO status at the referring hospital (under proposed § 412.536) or at the co-located host (under the proposed revision to § 412.534) prior to being admitted for additional post-acute care at the LTCH. That is, in calculating the proposed 50 percent threshold (for rural LTCHs), patients who achieved HCO status prior to admission to the LTCH would not be counted toward the applicable threshold under proposed § 412.536 or under the proposed revision to § 412.534 (although the admission would still be counted toward the LTCH's total Medicare discharges).

Furthermore, because such a policy would reduce the financial incentives for all LTCHs, including rural LTCHs, to admit patients prematurely discharged from other hospitals, we believe this proposed policy would result in fewer admissions to LTCHs before a complete course of patient care is provided at the referring hospital. As noted above, any changes in admission practices as a result of this proposed policy would result in less of a decrease in estimated aggregate LTCH PPS payments than the \$90 million estimated based on current admission practices. Thus, the decrease in estimated aggregate LTCH PPS payments to rural LTCHs resulting from this proposed policy change would only occur if there were no change in rural LTCH admission practices. It is our intention, under this proposed policy, to discourage LTCHs from serving as "step-down" units after a patient has been diagnosed and received initial treatment at another hospital, a scenario that results in two Medicare payments (one to the referring hospital and one to the LTCH) for what was essentially one episode of patient care. Rather, it is our intent to encourage LTCHs to admit patients who required additional long-stay hospital-level treatment following

the provision of a full episode of care at the referring hospital. For those patients, under this proposed policy, Medicare would pay an unadjusted amount under the LTCH PPS. We believe that this proposed policy would result in more appropriate admission policies by rural LTCHs. Therefore, we believe that although the effects on some rural LTCHs of the proposed expansion of the payment adjustment at existing § 412.534 to certain situations not presently covered by that policy for subclause (I) LTCHs may be significant, most rural LTCHs should be not adversely affected because this proposed policy change is expected to result in changes in admission practices and appropriate payments for such cases, as explained above in this section.

In addition, the approach for SSO policy discussed in section V.A.2. of this proposed rule would also contribute to the projected decrease in estimated payments to rural LTCHs for RY 2008. As discussed below in section XVI.B.4.a. of this regulatory impact analysis, we project a slightly larger than average decrease in estimated payments per discharge (as compared to urban LTCHs; see column 9 of Table 9) if this approach were adopted. About 40 percent of rural LTCHs treat a larger than average percentage of SSO cases (in fact, based on FY 2005 data for a few rural LTCHs, SSO cases represent over half of their total cases). However, we are not able to determine whether this approach, if adopted, would result in an adverse financial impact on rural LTCHs because we believe that most LTCHs (including rural LTCHs) would reduce the number of SSO cases that they admit that are "similar to IPPS cases" (as discussed in greater detail above). (We note that although we expect most LTCHs (including rural LTCHs) to admit fewer SSO cases under this approach to the SSO policy, most of those patients would continue to receive treatment at the acute-care hospital from which they are typically discharged immediately prior to their LTCH (short-stay) admission.) Thus, the projected 2.6 percent decrease in estimated payments per discharge shown in Table 9 for rural LTCHs represent an average maximum reduction in estimated aggregate LTCH PPS payments in RY 2008, and since we anticipate that LTCHs (including rural LTCHs) would admit fewer SSO patients for whom payments would be affected by this approach to the SSO policy, if adopted, we believe that the actual decrease in rural LTCHs' payments for RY 2008 would be less than the 2.6 percent decrease in

estimated payments for RY 2008 shown in Table 9.

Furthermore, to the extent that rural LTCHs would continue to admit SSO cases with a LOS that is "similar to IPPS cases," we believe the approach discussed for the SSO policy would result in an appropriate adjusted LTCH PPS payment because we believe that many of those SSO cases most likely do not receive a full course of a LTCH-level of treatment in such a short period of time since, in general, LTCHs are intended to treat longer stay patients. Therefore, although we estimate the approach discussed for the SSO policy in section V.A.2. of this proposed rule could result in a decrease in estimated aggregate LTCH PPS payment to rural LTCHs, we do not believe that such an estimated impact on rural LTCHs' LTCH PPS payments, even though possibly significant, would adversely affect most rural LTCHs because this approach would be expected to result in changes in admission practices and in appropriate payments for such cases.

For these reasons, we believe that there may be a significant impact on some rural LTCHs resulting from the proposed changes present in this proposed rule. However, a portion of the decrease in rural LTCHs' estimated payments per discharge from RY 2007 to RY 2008 would be less than what we estimate based on current admission practices (as explained above in this section). We also believe (as discussed previously) a significant portion of the projected decrease in estimated payments per discharge for RY 2008, which is due to the established phase-in of the wage index adjustment, is not a result of a proposed policy change, and may already be accounted for in LTCHs' fiscal plans. Therefore, although we believe this proposed rule would affect payments to rural LTCHs, and the effects on some rural LTCHs, although appropriate, may be significant, we are unable to determine how significantly the proposed changes presented in this proposed rule, if adopted, would adversely affect rural LTCHs. However, because we expect changes in admission practice and appropriate payments, if the changes present in this proposed rule are adopted (as discussed above), we do not anticipate that the provisions of this proposed rule would affect the ability of the vast majority of rural LTCHs to provide cost efficient services to Medicare patients nor do we expect there would be an adverse effect on beneficiaries' access to care. The analysis presented above, in conjunction with the remainder of this regulatory impact analysis, demonstrates that this proposed rule is

consistent with the regulatory philosophy and principles identified in section 1102(b) of the Act. (For additional information on the estimated impact of the changes on rural LTCHs presented in this proposed rule, refer to section XVI.B.4.a. of this regulatory impact analysis.) However, in this proposed rule, we are soliciting comments on our estimates and analysis of the impact of the provisions of this proposed rule on rural LTCHs.

4. Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any one year of \$100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately \$120 million. This proposed rule would not mandate any requirements for State, local, or tribal governments, nor would it result in expenditures by the private sector of \$120 million or more in any 1 year.

5. Federalism

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

We have examined this proposed rule under the criteria set forth in Executive Order 13132 and have determined that this proposed rule would not have any significant impact on the rights, roles, and responsibilities of State, local, or tribal governments or preempt State law, based on the 13 State and local LTCHs in our database of 369 LTCHs for which data were available.

6. Alternatives Considered

In preamble of this proposed rule, we are setting forth the proposed annual update to the payment rates for the LTCH PPS, as well as proposing other policy changes and discussing approaches for other areas of concern. In this preamble, we specify the statutory authority for the provisions that are presented, identify those proposed policies (and approaches discussed) when discretion has been exercised, and present rationale for our decisions, alternatives that were considered and solicit comments on suggested alternatives from commenters (where relevant).

B. Anticipated Effects of Proposed Payment Rate Changes

We discuss the impact of the proposed changes to the payment rates, factors, and other payment rate policies presented in the preamble of this proposed rule (including the approach discussed for the SSO policy in section IV.A.2. of this proposed rule) in terms of their estimated fiscal impact on the Medicare budget and on LTCHs. (We note that the impact of other policy changes presented in this proposed rule, which do not directly affect the LTCH PPS per discharge payment rates (for example, the proposed expansion of the existing payment provision for co-located LTCHs to certain situations not presently covered by existing § 412.534 for subclause (I) LTCHs discussed in section V.B. of this proposed rule and the proposed policy change relating to GME payments discussed in section XII. of this proposed rule), are not included as part of the impact analysis shown in Table 9. However, the impact of certain other proposed policies are discussed separately in section XVI.C. of this regulatory impact analysis.

1. Budgetary Impact

Section 123(a)(1) of the BBRA requires that the PPS developed for LTCHs “maintain budget neutrality.” We believe that the statute’s mandate for budget neutrality (BN) applies only to the first year of the implementation of the LTCH PPS (that is, FY 2003). Therefore, in calculating the FY 2003 standard Federal rate under § 412.523(d)(2), we set total estimated payments for FY 2003 under the LTCH PPS so that estimated aggregate payments under the LTCH PPS are estimated to equal the amount that would have been paid if the LTCH PPS had not been implemented. However, as discussed in greater detail in the August 30, 2002 final rule (67 FR 56033 through 56036), the FY 2003 LTCH PPS standard Federal rate (\$34,956.15) was calculated based on all LTCHs being paid 100 percent of the standard Federal rate in FY 2003. As discussed in section IV.D.5. of this proposed rule, during LTCH rate years governed by the 5-year transition period policy set forth at § 412.533(a), we applied a BN offset to payments to account for the monetary effect of the applicable transition period methodology (including the option to elect payments based on 100 percent of the Federal rate in lieu of the transition blend methodology) in a given LTCH PPS rate year. Specifically, for FY 2003 and RYs 2004 through 2007, the amount of the transition period BN offset was 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. However, as we discuss in greater detail in section IV.D.5. of this proposed rule, 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. Based on the most recent available data, we are projecting that the vast majority of LTCHs would have made the election to be paid based on 100 percent of the Federal rate rather than the transition blend, which would result in a negligible cost to the Medicare program. Therefore, in this proposed rule, we did not propose a transition BN offset to all LTCH PPS payments for RY 2008 to account for the estimated cost of the transition period methodology (including the option to elect payment based on 100 percent of the Federal rate) in RY 2008.

2. Impact on Providers

The basic methodology for determining a per discharge LTCH PPS payment is set forth in § 412.515 through § 412.525. In addition to the basic LTC–DRG payment (standard Federal rate multiplied by the LTC–DRG relative weight), we make adjustments for differences in area wage levels, COLA for Alaska and Hawaii, and SSOs. Furthermore, LTCHs may also receive HCO payments for those cases that qualify based on the threshold established each rate year.

To understand the impact of the proposed changes to the LTCH PPS payment rates and payment rate policy changes discussed in sections IV. and V.A. of this proposed rule on different categories of LTCHs for the 2008 LTCH PPS rate year, it is necessary to estimate payments per discharge under the LTCH PPS rates, factors and policies established for RY 2007 (established in the RY 2007 LTCH PPS final rule (71 FR 27798 through 27939)) and to estimate proposed payments per discharge that would be made under the proposed LTCH PPS rates, factors and policies for the 2008 LTCH PPS rate year (as discussed in the preamble of this proposed rule). We also evaluated the change in estimated 2007 LTCH PPS rate year payments to estimated proposed 2008 LTCH PPS rate year

payments (on a per discharge basis) for each category of LTCHs.

Hospital groups were based on characteristics provided in the OSCAR data, FY 2002 through FY 2004 cost report data in HCRIS, and PSF data. Hospitals with incomplete characteristics were grouped into the "unknown" category. Hospital groups include:

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

To estimate the impacts of the proposed payment rates and payment rate policy changes among the various categories of existing providers, we used LTCH cases from the FY 2005 MedPAR file to estimate payments for RY 2007 and to estimate proposed payments for RY 2008 for 369 LTCHs. While currently there are just under 400 LTCHs, the most recent growth is predominantly in for-profit LTCHs that provide respiratory and ventilator-dependent patient care. We believe that the discharges from the FY 2005 MedPAR data for the 369 LTCHs in our database, which includes 246 proprietary LTCHs, provide sufficient representation in the LTC-DRGs containing discharges for patients who received LTCH care for the most commonly treated LTCH patients' diagnoses.

As discussed in greater detail in section VII. of this proposed rule, under the 5-year transition set forth at § 412.533(a), a LTCH's total payment under the LTCH PPS was based on an increasing percentage of the Federal rate with a corresponding decrease in the percentage of its LTCH PPS payment based on reasonable cost principles. However, effective for cost reporting periods beginning on or after October 1, 2006, total LTCH PPS payments are based entirely on the Federal rate. Therefore, even though some LTCH's will have a cost reporting period for the 4th year of the transition period that will be concluding in the first 3 months of the 2008 LTCH PPS rate year, the portion of those LTCHs' LTCH PPS payments that will be based on reasonable cost principles during RY 2008 is negligible relative to LTCH PPS payments based on the Federal rate. This is because, as discussed in greater detail in section IV.D.5. of this proposed rule, based on the most recent available data, we are projecting that the vast majority of LTCHs have already made the election to be paid based on 100 percent of the Federal rate rather than the transition blend prior to the start of their FY 2006 cost reporting period (that

is, the 4th year of the transition period as set forth at § 412.533(a)), and even for those few remaining LTCHs paid under the transition blend methodology set forth at § 412.533(a), their total LTCH PPS payments are now based mostly on the Federal rate (since the transition blend percentages for cost reporting periods beginning during FY 2006 are 80 percent of the Federal rate and 20 percent of the LTCH PPS payment based on reasonable cost principles). Therefore, in this proposed rule, we are no longer providing a separate impact table reflecting the applicable transition blend percentages, which required cost data to determine estimated LTCH PPS payments based on reasonable cost principles. Accordingly, the impact analyses of the proposed payment rates and payment rate policy changes presented below reflects estimated LTCH PPS payments to all LTCHs based solely on the Federal rate.

These impacts reflect the estimated "losses" or "gains" among the various classifications of LTCHs for the 2007 LTCH PPS rate year (July 1, 2006 through June 30, 2007) compared to the 2008 LTCH PPS rate year (July 1, 2007 through June 30, 2008) based on the proposed payment rates and payment rate policy changes presented in this proposed rule. Prospective payments for the 2007 LTCH rate year were based on the standard Federal rate of \$38,086.04, the outlier fixed-loss amount of \$14,887, and the LTCHs' estimated case-mix based on FY 2005 LTCH claims data. Estimated proposed prospective payments for the 2008 LTCH PPS rate year would be based on the proposed standard Federal rate of \$38,356.45 (based on the proposed 0.71 percent update discussed in section IV.C.3. of the preamble to this proposed rule), the proposed outlier fixed-loss amount of \$18,774, and the same FY 2005 LTCH claims data.

3. Calculation of Prospective Payments

To estimate per discharge payments under the LTCH PPS, we simulated payments on a case-by-case basis by applying the established (for RY 2007) and proposed (for RY 2008) adjustments for area wage differences (as described in section IV.D.1. of the preamble of this proposed rule), and the COLA for Alaska and Hawaii (as described in section IV.D.2. of the preamble of this proposed rule). As discussed above, we also accounted for the existing payment policy for SSOs in RY 2007 and the approach for the SSO policy in RY 2008 discussed in section V.A.2. of this proposed rule). Additional payments would also be made for HCOs (as described in section IV.D.3. of this

proposed rule). As noted in section IV.D.4. of this proposed rule, we are not proposing to make adjustments for rural location, geographic reclassification, indirect medical education costs, or a DSH payment for the treatment of low-income patients because sufficient new data have not been generated that would enable us to conduct a comprehensive reevaluation of these payment adjustments.

We adjusted for area wage differences for estimated 2007 LTCH PPS rate year payments by computing a weighted average of a LTCH's applicable wage index during the period from July 1, 2006 through June 30, 2007 because some providers may experience a change in the wage index phase-in percentage during that period. For cost reporting periods beginning on or after October 1, 2005, and before September 30, 2006 (FY 2006), the labor portion of the Federal rate is adjusted by four-fifths of the applicable LTCH PPS wage index. For cost reporting periods beginning on or after October 1, 2006, and before September 30, 2007 (FY 2007), the labor portion of the Federal rate is adjusted by five-fifths (that is, the full amount) of the applicable LTCH PPS wage index. Therefore, during RY 2007, a provider with a cost reporting period that began October 1, 2006, would have 3 months (July 2006 through September 2006) of payments under the four-fifths wage index value and 9 months (October 2006 through June 2007) of payment under the (full) five-fifths wage index value. For this provider, we computed a blended wage index of 25 percent (3 months/12 months) of the four-fifths wage index value and 75 percent (9 months/12 months) of the (full) five-fifths wage index value. The applicable LTCH PPS wage index values for the 2007 LTCH PPS rate year are shown in Tables 1 and 2 of the Addendum to the RY 2007 LTCH PPS final rule (71 FR 27906 through 27930). We adjusted for area wage differences for estimated 2007 LTCH PPS rate year payments using the current LTCH PPS labor-related share of 75.665 percent (71 FR 27830).

Similarly, we adjusted for area wage differences for estimated proposed 2008 LTCH PPS rate year payments by computing a weighted average of a LTCH's applicable wage index during the period from July 1, 2007, through June 30, 2008, because, although under the established phase-in of the wage index adjustment for cost reporting periods beginning on or after October 1, 2006, the applicable LTCH wage index value is the full (five-fifths) LTCH PPS wage index value, during RY 2008 some providers will still experience a change in the wage index phase-in percentage

during that period. For example, during RY 2008, a provider with a FY 2006 cost reporting period that began September 1, 2006, (and will end on August 31, 2007,) would have 2 months (July 2007 and August 2007) of payments under the proposed four-fifths wage index value and 10 months (September 2007 through June 2007) of payment under the proposed (full) five-fifths wage index value. For this provider, we computed a blended wage index of 16.7 percent (2 months/12 months) of the proposed four-fifths wage index value and 83.3 percent (10 months/12 months) of the proposed (full) five-fifths wage index value. The proposed applicable LTCH PPS wage index values for the 2008 LTCH PPS rate year are shown in Tables 1 and 2 of Addendum A to this proposed rule. We adjusted for area wage differences for estimated 2008 LTCH PPS rate year payments using the proposed LTCH PPS labor-related share of 75.511 percent (see section IV.D.1.c. of this proposed rule).

As noted previously in this proposed rule, under the 5-year transition set forth at § 412.533(a), a LTCH's total payment under the LTCH PPS was based on an increasing percentage of the Federal rate with a corresponding decrease in the percentage of the LTCH PPS payment that is based on reasonable cost principles. However, effective for cost reporting periods beginning on or after October 1, 2006, total LTCH PPS payments are based solely on the Federal rate. Therefore, even though some LTCH's will have a cost reporting period for the 4th year of the transition period that will be concluding in the first 3 months of the 2008 LTCH PPS rate year, the portion of those LTCH PPS payments that will be based on reasonable cost principles during RY 2008 is negligible relative to

LTCH PPS payments based on the Federal rate, and therefore, we are no longer estimating transition payments as we have done in past impact analyses (for example, 71 FR 27892).

Furthermore, in estimating both RY 2007 and proposed RY 2008 LTCH PPS payments, we did not apply a transition period BN 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)). This is because, for RY 2007, we established a 0.0 percent BN offset (a BN factor of 1.0) 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 in RY 2007 (71 FR 27841). As noted above and discussed in greater detail in section IV.D.5. of this proposed rule, we are not proposing a transition period BN offset to all LTCH PPS payments in RY 2008 to account for the estimated cost of the transition period methodology (including the option to elect payment based on 100 percent of the Federal rate) in RY 2008 since we are projecting that such costs would be negligible.

As noted in Table 9, we show the impact as if all LTCHs would be paid 100 percent of the Federal rate since, based on the most recent available data and the transition blend percentages set forth at § 412.533(a), nearly all LTCH PPS payments would be based on 100 percent of the applicable LTCH PPS standard Federal rate during the majority of RYs 2007 and 2008. Table 9 illustrates the estimated aggregate impact of the LTCH PPS 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 LTCH cases.
- The fourth column shows the estimated payment per discharge for the 2007 LTCH PPS rate year.
- The fifth column shows the estimated proposed payment per discharge for the 2008 LTCH PPS rate year.
- The sixth column shows the estimated percentage change in estimated payments per discharge from the 2007 LTCH PPS rate year to the 2008 LTCH PPS rate year for proposed changes to the Federal rate.
- The seventh column shows the percentage change in estimated payments per discharge from the 2007 LTCH PPS rate year to the 2008 LTCH PPS rate year for proposed changes to the area wage adjustment at § 412.525(c) (as discussed in section IV.D.1. of the preamble of this proposed rule).
- The eighth column shows the percent change in estimated payments per discharge from the 2007 LTCH PPS rate year to the 2008 LTCH PPS rate year for the approach discussed for addressing our concerns with the existing SSO policy at § 412.529 (as discussed in section V.A.2. of the preamble of this proposed rule).
- The ninth column shows the estimated percentage change in estimated payments per discharge from the 2007 LTCH PPS rate year to the 2008 LTCH PPS rate year for all proposed changes (and includes the estimated impact of the approach for the SSO policy discussed in section V.A.2. of the preamble of this proposed rule).

TABLE 9.—PROJECTED IMPACT OF PROPOSED PAYMENT RATE AND PAYMENT RATE POLICY CHANGES TO LTCH PPS PAYMENTS FOR RY 2008*

[Estimated 2007 LTCH PPS rate year payments compared to estimated proposed 2008 LTCH PPS rate year payments*]

LTCH Classification	Number of LTCHs	Number of LTCH PPS cases	Average estimated RY 2007 LTCH PPS rate year payment per case ¹	Average estimated proposed RY 2008 LTCH PPS rate year payment per case ²	Percent increase in estimated payments per discharge from RY 2007 to (proposed) RY 2008 for proposed changes to the Federal rate ⁴	Percent decrease ³ in estimated payments per discharge from RY 2007 to RY 2008 for proposed changes to the area wage adjustment ⁵	Percent decrease ³ in estimated payments per discharge from RY 2007 to RY 2008 for approach discussed for the SSO policy ^{6*}	Percent decrease ³ in estimated payments per discharge from RY 2007 to RY 2008 for all proposed changes ^{7*}
ALL PROVIDERS	369	129,584	\$31,486	\$31,278	0.6	0.5	0.9	0.7
BY LOCATION:								
RURAL	25	5,044	25,100	24,447	0.7	2.2	1.0	2.6
URBAN	344	124,540	31,744	31,555	0.6	0.5	0.9	0.6
LARGE	181	77,511	32,819	32,768	0.6	0.1	0.9	0.2
OTHER	163	47,029	29,974	29,555	0.6	1.1	1.0	1.4

TABLE 9.—PROJECTED IMPACT OF PROPOSED PAYMENT RATE AND PAYMENT RATE POLICY CHANGES TO LTCH PPS PAYMENTS FOR RY 2008*—Continued

[Estimated 2007 LTCH PPS rate year payments compared to estimated proposed 2008 LTCH PPS rate year payments*]

LTCH Classification	Number of LTCHs	Number of LTCH PPS cases	Average estimated RY 2007 LTCH PPS rate year payment per case ¹	Average estimated proposed RY 2008 LTCH PPS rate year payment per case ²	Percent increase in estimated payments per discharge from RY 2007 to (proposed) RY 2008 for proposed changes to the Federal rate ⁴	Percent decrease ³ in estimated payments per discharge from RY 2007 to RY 2008 for proposed changes to the area wage adjustment ⁵	Percent decrease ³ in estimated payments per discharge from RY 2007 to RY 2008 for approach discussed for the SSO policy ^{6*}	Percent decrease ³ in estimated payments per discharge from RY 2007 to RY 2008 for all proposed changes ^{7*}
BY PARTICIPATION DATE:								
BEFORE OCT. 1983	15	7,966	26,999	27,157	0.6	-0.1	0.4	-0.6
OCT. 1983-SEPT. 1993	44	22,661	33,171	33,050	0.6	0.3	1.0	0.4
OCT. 1993-SEPT. 2002	207	75,380	31,382	31,169	0.6	0.6	0.9	0.7
AFTER OCT. 2002	101	23,163	31,709	31,303	0.6	1.0	1.0	1.3
UNKNOWN	2	414	31,888	32,068	0.6	-0.4	0.8	-0.6
BY OWNERSHIP CONTROL:								
VOLUNTARY	78	26,725	30,329	30,069	0.6	0.6	1.0	0.9
PROPRIETARY	246	96,236	31,715	31,532	0.6	0.5	0.9	0.6
GOVERNMENT	13	3,087	32,116	31,763	0.6	0.9	0.9	1.1
UNKNOWN	32	3,536	33,437	33,072	0.6	0.8	1.0	1.1
BY CENSUS REGION:								
NEW ENGLAND	14	9,858	26,775	26,984	0.6	-0.4	0.5	-0.8
MIDDLE ATLANTIC	28	7,697	32,405	32,063	0.6	1.0	0.9	1.1
SOUTH ATLANTIC	43	13,684	35,178	34,834	0.6	0.9	1.0	1.0
EAST NORTH CENTRAL	66	18,555	35,545	35,508	0.6	0.1	0.9	0.1
EAST SOUTH CENTRAL	28	7,525	31,242	30,611	0.6	1.6	1.2	2.0
WEST NORTH CENTRAL	18	5,173	34,383	34,057	0.6	0.7	1.0	0.9
WEST SOUTH CENTRAL	134	52,681	27,848	27,454	0.6	1.2	0.9	1.4
MOUNTAIN	22	6,378	33,642	33,894	0.6	-1.0	1.1	-0.7
PACIFIC	16	8,033	41,224	41,801	0.6	-1.3	0.8	-1.4
BY BED SIZE:								
BEDS: 0-24	25	4,120	29,754	29,266	0.6	1.1	1.1	1.6
BEDS: 25-49	174	43,374	31,469	31,133	0.6	0.9	0.9	1.1
BEDS: 50-74	57	22,539	31,860	31,664	0.6	0.4	1.0	0.6
BEDS: 75-124	45	21,862	32,641	32,473	0.6	0.5	0.9	0.5
BEDS: 125-199	23	21,724	30,395	30,286	0.6	0.3	0.9	0.4
BEDS: 200 +	13	12,429	30,756	30,869	0.6	-0.2	0.7	-0.4
UNKNOWN	32	3,536	33,437	33,072	0.6	0.8	1.0	1.1

* As discussed above in section XVI.A.1. of this regulatory impact analysis, we estimate that the approach discussed for addressing our concerns with the existing SSO policy presented in section V.A.2. of the preamble of this proposed rule would result in the decrease in estimated payments in the 2008 LTCH PPS rate year (approximately an additional \$37 million, on average, for all LTCHs as shown in column 8). However, we note that in absence of including such an approach, we estimate that in place of the 0.7 percent decrease in estimated payments per discharge, on average, for all LTCHs (shown in column 9), there would be 0.3 percent increase in estimated payments per discharge, on average, for all LTCHs from the 2007 LTCH PPS rate year to the 2008 LTCH PPS rate year for all proposed payment rate and policy changes presented in the preamble of this proposed rule. We also note that, as discussed above in section XVI.B.4. of this regulatory impact analysis, the 2.2 percent decrease in estimated aggregate LTCH PPS payments due to the proposed expansion of the special payment provision for co-located LTCHs to certain situations not presently covered by existing § 412.534 for subclause (l) LTCHs (as discussed in section V.B. of this proposed rule) is not reflected in this impact table. However, the impact of the proposed expansion of the "25 percent" policy is discussed in greater detail below in section XVI.C.1. of this regulatory impact analysis.

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

² Estimated proposed average estimated payment per case for the 12-month period of July 1, 2007 through June 30, 2008.

³ As the percent change shown in this column represents a percent decrease in estimated payments per discharge, a negative (that is, minus) sign indicates a percent increase in estimated payments per discharge and the absence of a sign (that is, a positive sign) indicates a percent decrease in estimated payments per discharge.

⁴ Percent change in estimated payments per discharge from the 2007 LTCH PPS rate year to the 2008 LTCH PPS rate year for the proposed changes to the Federal rate. (Note, as discussed in section XVI.B.4. of this regulatory impact analysis, because about 35 percent of all LTCH cases are projected to receive a payment under the existing SSO policy that is based either on the estimated cost of the case or the "IPPS comparable amount" (rather than the proposed Federal rate), the percent change in estimated payments per discharge due to the proposed changes to the Federal rate for most of the categories of LTCHs, 0.6 percent, is slightly less than the proposed update to the Federal rate of 0.71 percent.)

⁵ Percent change in estimated payments per discharge from the 2007 LTCH PPS rate year to the 2008 LTCH PPS rate year for proposed changes to the area wage adjustment policy at § 412.525(c) (as discussed in section V.D.1. of the preamble of this proposed rule).

⁶ Percent change in estimated payments per discharge from the 2007 LTCH PPS rate year to the 2008 LTCH PPS rate year for the approach discussed to address our concerns with the existing SSO policy at § 412.529 (presented in section V.A.1.a. of the preamble of this proposed rule).

⁷ Percent change in estimated payments per discharge from the 2007 LTCH PPS rate year (as established in the RY 2007 LTCH PPS final rule (71 FR 27798 through 27939)) to the 2008 LTCH PPS rate year (as discussed in the preamble of this proposed rule, including the approach to the SSO policy discussed in section V.A.2. of this proposed rule) for all of the payment rate and policy provisions presented in the preamble of this proposed rule. Note, this column, which shows the percent change in estimated payments per discharge for all proposed changes, may not exactly equal the sum of the percent changes in estimated payments per discharge for proposed changes to the Federal rate (column 7), for proposed area wage adjustment changes (column 8) and the approach discussed for the SSO policy (column 9) due to the effect of estimated changes in aggregate HCO payments, as well as other interactive effects that cannot be isolated.

4. Results

Based on the most recent available data (as described previously for 369 LTCHs), we have prepared the following summary of the impact (as shown in

Table 9) of the proposed LTCH PPS payment rate and payment rate policy changes presented in this proposed rule (including the approach to the SSO policy discussed in section V.A.2. of this proposed rule). (As noted above, the

impact of other policy changes presented in this proposed rule, which do not directly affect the LTCH PPS per discharge payment rate, such as the proposed expansion of the existing payment provision for co-located LTCHs

to certain situations not presently covered by existing § 412.534 for subclause (I) LTCHs, are not included as part of the impact analysis shown in Table 9. However, the impact of those other proposed policies are discussed separately in section XVI.C. of this regulatory impact analysis.)

The impact analysis in Table 9 shows that estimated payments per discharge are expected to decrease approximately 0.7 percent, on average, for all LTCHs from the 2007 LTCH PPS rate year as compared to the 2008 LTCH PPS rate year as a result of the proposed payment rate and policy changes presented in this proposed rule. We note that although we are proposing a 0.71 percent increase to the Federal rate for RY 2008, the impact analysis shown in Table 9 (column 6), only shows a 0.6 percent increase in estimated payments per discharge from RY 2007 to RY 2008, for most categories of LTCHs, as a result of the proposed changes to the Federal rate. The reason that this column shows an estimated 0.6 percent increase rather than an estimated 0.7 percent increase (based on the proposed 0.71 percent update to the Federal rate) is because about 35 percent of all LTCH cases are projected to receive a payment under the existing SSO policy. Under either the existing SSO policy or the approach for the SSO policy discussed in section V.A.2. of this proposed rule, the majority of SSO cases would receive an adjusted LTCH PPS payment in RY 2008 that would be based either on the estimated cost of the case or the "IPPS comparable amount" (that is, either under the "blend amount" at existing § 412.529(c)(2)(iv) or the amount discussed in our approach to address our concerns with the existing SSO policy) rather than a LTCH PPS payment based on the proposed Federal rate. Therefore, because over 30 percent of all LTCH PPS cases would receive a payment that is not based on the proposed Federal rate, the percent change in estimated payments per discharge due to the proposed changes to the Federal rate for most categories of LTCHs shown in Table 9 is projected to be slightly less (0.6 percent) than the proposed 0.71 percent update to the Federal rate. Although, we are proposing a 0.71 percent increase to the Federal rate for RY 2008, the projected percent decrease in estimated payments per discharge from the 2007 LTCH PPS rate year to the 2008 LTCH PPS rate year shown in Table 9 is due the proposed changes to the area wage adjustment (discussed in section IV.D.1. of this proposed rule), in conjunction with the approach to the SSO policy (discussed

in section V.A.2. of this proposed rule) and the proposed increase to the HCO fixed-loss amount (as discussed in section IV.D.3.c. of this proposed rule).

Specifically, as we discussed in greater detail in section IV.D.1. of the preamble of this proposed rule, we are proposing to update the wage index values for RY 2008 in accordance with the progression of the 5-year phase-in of the wage index adjustment. We are also proposing to decrease the labor-related share from 75.665 percent to 75.511 percent under the LTCH PPS beginning in RY 2008. Because this proposed change to the labor-related share would lower the portion of the Federal rate that is adjusted by the wage index to account for differences in local cost variation (in accordance with § 412.525(c)), LTCHs located in areas with a proposed RY 2008 wage index value that is greater than 1.0 would experience a slight decrease in estimated payments per discharge as a result of the proposed decrease in the labor-related share. Conversely, LTCHs located in areas with a proposed RY 2008 wage index value that is less than 1.0 are expected to experience an increase in estimated payments per discharge as a result of the proposed decrease in the labor-related share since a smaller portion of the Federal rate would be adjusted by the proposed wage index to account for differences in local cost variation (in accordance with § 412.525(c)). However, the effect of the progression of the 5-year phase-in of the wage index adjustment, which results in a relatively more significant decrease in estimated payments for LTCHs located in areas with a proposed RY 2008 wage index value that is less than 1.0, would likely offset the effect on payments due to the decrease in the labor-related share. Consequently, the proposed changes to the wage index adjustment presented in this proposed rule for LTCHs located in areas with a proposed RY 2008 wage index value that is less than 1.0 are expected to also contribute to the projected decrease in estimated payments per discharge from RY 2007 as compared to RY 2008.

In addition, under the approach discussed to address our concerns with the existing SSO policy (discussed in section V.A.2. of this proposed rule), those LTCH SSO cases with a covered LOS that is less than or equal to the IPPS ALOS plus one standard deviation for the same DRG would receive a lower adjusted LTCH PPS payment than under the current SSO policy. We believe that the LTCH cases meeting the criteria stated above appear to be similar to the same type of cases treated in an acute care hospital and paid for under the

IPPS since one standard deviation is a statistical test which measures the certainty of the average of a set of measurements for the purpose of this data analysis. Accordingly, we believe the approach discussed for the SSO policy could be appropriate, given that many of these SSO cases that are "similar to IPPS cases" most likely do not receive a full course of a LTCH-level of treatment in such a short period of time since, in general, LTCHs are intended to treat longer stay patients. Furthermore, since by far the majority of SSO cases were admitted to the LTCH directly from an acute-care hospital, they are likely to still be in need of acute-level care at the time of admission to the LTCH. We believe that this may indicate that the LTCH admission is a premature and inappropriate discharge from the acute-care hospital and an inappropriate admission to the LTCH. We believe that the approach for the SSO policy could result in appropriate payments for short-stay cases treated at LTCHs as discussed in greater detail in section V.A.2. of this proposed rule.

Furthermore, as we discussed in greater detail in section IV.D.3.c. of the preamble of this proposed rule, given the regulatory requirement at § 412.525(a) that estimated outlier payments equal 8 percent of estimated total LTCH PPS payments, this decrease in estimated LTCH PPS payments for RY 2008 resulting primarily from the proposed changes to the SSO policy and the proposed changes to the area wage adjustment would require a proposed increase in the HCO fixed-loss amount to maintain estimated outlier payments at 8 percent of the estimated total LTCH PPS payments (resulting from the proposed payment rate and policy changes presented in this proposed rule). Thus, the proposed increase in the outlier fixed-loss amount also contributes to the projected decrease in estimated payments per discharge from the 2007 LTCH PPS rate year to the 2008 LTCH PPS rate year. For example, many LTCHs are expected to receive a decrease in HCO payments. As a result of the proposed increase to the fixed-loss amount from the 2007 LTCH PPS rate year (\$14,887) to the 2008 LTCH PPS rate year (\$18,774), fewer cases would qualify as outlier cases (that is, the estimated cost of the case exceeds the outlier threshold). Since many LTCHs are expected to receive fewer outlier payments, total estimated payments per discharge are expected to decrease slightly from RY 2007 to RY 2008.

a. Location

Based on the most recent available data, the majority of LTCHs are in urban areas. Approximately 7 percent of the LTCHs are identified as being located in a rural area, and approximately 4 percent of all LTCH cases are treated in these rural hospitals. The impact analysis presented in Table 9 shows that the percent decrease in estimated payments per discharge for the 2007 LTCH PPS rate year compared to the 2008 LTCH PPS rate year for rural LTCHs would be 2.6 percent for all proposed changes, and would be 0.6 percent for urban LTCHs for all proposed changes.

The primary reasons that the projected percent decrease in estimated payments to rural LTCHs is greater than that for urban LTCHs is that rural LTCHs are expected to experience a larger decrease in estimated payments due to the approach discussed for the SSO policy because, based on the most recent available data, many rural LTCHs treat a larger than average percentage of SSO cases (in fact, for a few rural LTCHs, SSO cases represent over half of their total cases based on FY 2005 data). Furthermore, rural LTCHs are projected to experience a higher than average decrease in estimated payments per discharge as a result of the proposed changes to the area wage adjustment because the proposed wage index for all rural LTCHs is less than 1.0, as explained above in this section.

Large urban LTCHs are projected to experience a 0.2 percent decrease in estimated payments per discharge from the 2007 LTCH PPS rate year compared to the 2008 LTCH PPS rate year, while other urban LTCHs are projected to experience a 1.4 percent decrease in estimated payments per discharge from the 2007 LTCH PPS rate year compared to the 2008 LTCH PPS rate year, as shown in Table 9. Other urban LTCHs are projected to experience a higher than average decrease in estimated payments per discharge primarily because of the proposed changes to the area wage adjustment. This is because the majority of other urban LTCHs (over 80 percent) are located in urban areas that have a proposed wage index value of less than 1.0, and therefore, would experience a higher than average decrease in estimated payments per discharge as a result of the proposed changes to the wage index adjustment, as explained above. In addition, other urban LTCHs have a slightly higher percentage of SSO cases and therefore, are projected to experience a slightly higher than average decrease in estimated payments per discharge as a

result of the approach discussed for the SSO policy (as also discussed in greater detail above in this section).

Large urban LTCHs are projected to experience a lower than average decrease in estimated payments per discharge for all changes primarily because of the proposed changes to the area wage adjustment because the majority of large urban LTCHs are located in urban areas that have a proposed wage index value of greater than 1.0, as explained above in this section.

b. Participation Date

LTCHs are grouped by participation date into four categories: (1) Before October 1983; (2) between October 1983 and September 1993; (3) between October 1993 and September 2002; and (4) after October 2002. Based on the most recent available data, the majority (approximately 56 percent) of the LTCH cases are in hospitals that began participating between October 1993 and September 2002, and are projected to experience a 0.7 percent decrease in estimated payments per discharge from the 2007 LTCH PPS rate year compared to the 2008 LTCH PPS rate year, as shown in Table 9.

Approximately 12 percent of LTCH PPS cases are in LTCHs that began participating in Medicare between October 1983 and September 1993, and those LTCHs are projected to experience a 0.4 percent decrease in estimated payments per discharge from the 2007 LTCH PPS rate year compared to the 2008 LTCH PPS rate year, as shown in Table 9. We are projecting that LTCHs that began participating in Medicare between October 1983 and September 1993 would experience a lower than average decrease in estimated payments for RY 2008 primarily because we are projecting that these LTCHs are expected to experience a lower than average decrease (0.3 percent) in estimated payments per discharge due to the proposed changes to the area wage adjustment. This is because many of the LTCHs that began participating in Medicare between October 1983 and September 1993 are located in areas where the proposed RY 2008 wage index value would be greater than the RY 2007 wage index value, and because several of these LTCHs are located in areas that have a proposed wage index value of greater than 1.0, (as explained above).

LTCHs that began participating before October 1983 are projected to experience a 0.6 percent increase in estimated payments per discharge from the 2007 LTCH PPS rate year compared to the 2008 LTCH PPS rate year (see

Table 9). We are projecting that LTCHs that began participating in Medicare before October 1983 would experience an increase in estimated payments for RY 2008 as compared to RY 2007 primarily because we are projecting that LTCHs in this participation date category would experience a slight increase in estimated payments in RY 2008 as compared to RY 2007 due to the proposed changes to the area wage adjustment. This is because many of the LTCHs that began participating in Medicare before October 1983 are located in areas where the proposed RY 2008 wage index value would be greater than the proposed RY 2007 wage index value, and because several of these LTCHs are located in areas that would have a proposed RY 2008 wage index value of greater than 1.0, (as discussed in section XVI.B.4. of this regulatory impact analysis). In addition, LTCHs that began participating in Medicare before October 1983 are expected to experience a lower than average decrease in estimated payments due to the approach discussed for the SSO policy (discussed in section V.A.2. of this proposed rule). Specifically, based on the FY 2005 LTCH claims data, the majority of LTCHs in this participation date category treat a smaller than average percentage of SSO cases.

Approximately 27 percent of LTCHs began participating in Medicare after October 2002 (that is, the beginning of the LTCH PPS, which was implemented for cost reporting periods beginning on or after October 1, 2002), and those LTCHs are projected to experience a 1.3 percent decrease in estimated payments per discharge from the 2007 LTCH PPS rate year compared to the 2008 LTCH PPS rate year (see Table 9). We are projecting that LTCHs that began participating in Medicare after October 2002 will experience a higher than average decrease in estimated payments for RY 2008 primarily because we are projecting that these LTCHs would experience a larger than average decrease (1.0 percent) in estimated payments per discharge due to the proposed changes to the area wage adjustment. This is because the majority of the LTCHs that began participating in Medicare after October 2002 are located in areas where the proposed RY 2008 wage index value would be less than the RY 2007 wage index value, and because the majority (over 80 percent) of these LTCHs are located in areas that would have a proposed RY 2008 wage index value of less than 1.0, (as discussed above in this section).

c. Ownership Control

Other than LTCHs whose ownership control type is unknown, LTCHs are grouped into three categories based on ownership control type: Voluntary; proprietary; and government. Based on the most recent available data, approximately 4 percent of LTCHs are identified as government-owned and operated. We expect that for these government-owned and operated LTCHs, estimated 2008 LTCH PPS rate year payments per discharge would decrease 1.1 percent in comparison to the 2007 LTCH PPS rate year, as shown in Table 9. We are projecting that government-run LTCHs would experience a higher than average decrease in estimated payments in RY 2008 as compared to RY 2007 primarily due to the effect of the proposed changes to the area wage adjustment. This is because all but 3 of the 13 government-run LTCHs in our database are located in areas where the proposed wage index value for RY 2008 is less than 1.0, as explained above.

Similarly, we project that estimated 2008 LTCH PPS rate year payments per discharge for voluntary LTCHs, which account for approximately 21 percent of LTCHs, would decrease 0.9 percent in comparison to estimated 2007 LTCH PPS rate year payments (see Table 9). We are projecting that voluntary LTCHs would experience a slightly higher than average decrease in estimated payments in RY 2008 as compared to RY 2007 due to the proposed changes to the wage index adjustment, as well as the approach discussed for the SSO policy. Specifically, we expect voluntary LTCHs would experience a slightly higher than average decrease in estimated payments in RY 2008 as compared to RY 2007 due to the approach discussed for the SSO policy since over half (48 LTCHs) of the voluntary LTCHs have a higher than average percentage of SSO cases. We expect voluntary LTCHs would experience a slightly higher than average decrease in estimated payments in RY 2008 as compared to RY 2007 due to the proposed changes to the wage index adjustment since over three-quarters (61 LTCHs) of the voluntary LTCHs are located in areas where the proposed wage index value is less than 1.0 (as discussed above).

The majority (approximately 67 percent) of LTCHs are identified as proprietary. We project that 2008 LTCH PPS rate year estimated payments per discharge for these proprietary LTCHs would decrease 0.6 percent in comparison to the 2007 LTCH PPS rate year (see Table 9).

d. Census Region

Estimated payments per discharge for the 2008 LTCH PPS rate year are projected to decrease for LTCHs located in most regions (with the exception of New England, Mountain, and Pacific regions) in comparison to the 2007 LTCH PPS rate year. The percent decrease in estimated payments per discharge from the 2007 LTCH PPS rate year to the 2008 LTCH PPS rate year for most regions is largely attributable to the approach discussed for the SSO policy, the proposed changes in the area wage adjustment, and the increase in the HCO fixed-loss amount (as explained above).

Of the 9 census regions, we project that the decrease in proposed 2008 LTCH PPS rate year estimated payments per discharge in comparison to the 2007 LTCH PPS rate year would have the largest impact on LTCHs in the East South Central and West South Central regions (2.0 percent and 0.5 percent, respectively; see Table 9). LTCHs located in both the East South Central and West South Central regions are expected to experience a higher than average decrease in estimated payments due to the proposed changes in the area wage adjustment (1.6 percent for the East South Central region, and 1.2 percent for the West South Central region, as shown in Table 9). This is because nearly all LTCHs located in the East South Central region and the West South Central regions are located in areas with a wage index value that is less than 1.0 (as described above). In addition, LTCHs are also expected to experience a higher than average decrease in estimated payments per discharge due to the approach discussed for the SSO policy since many of the LTCHs in these two regions have a larger than average percentage of SSO cases (based on FY 2005 LTCH claims data).

We project that proposed 2008 LTCH PPS rate year estimated payments per discharge would increase for LTCHs in the New England, Mountain and Pacific region in comparison to the 2007 LTCH PPS rate year (0.8 percent, 0.7 percent and 1.4 percent, respectively; see Table 9). We estimate that for LTCHs located in these three regions, the projected increases in estimated payments per discharge for the 2008 LTCH PPS rate year compared to the 2007 LTCH PPS rate year are largely a result of the proposed changes to the area wage adjustment. Specifically, we are projecting an increase in estimated LTCH PPS payments due to the changes to the area wage adjustment because all LTCHs in the New England and Pacific

regions and the majority (over 68 percent) of LTCHs in the Mountain region are located in areas where the proposed wage index value for RY 2008 is greater than 1.0, and because many of the LTCHs in these three regions are located in areas where the proposed RY 2008 wage index value is greater than the RY 2007 wage index value (as described above).

e. Bed Size

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

We are projecting a decrease in estimated 2008 LTCH PPS rate year payments per discharge in comparison to the 2007 LTCH PPS rate year for all bed size categories except for the category with greater than 200 beds. Most LTCHs are in bed size categories where estimated 2008 LTCH PPS rate year payments per discharge are projected to decrease between 1.1 percent and 1.6 percent in comparison to the 2007 LTCH PPS rate year (that is, LTCHs with less than 49 beds). As noted above, the projected percent increase in estimated payments per discharge from the 2007 LTCH PPS rate year to the 2008 LTCH PPS rate year is largely attributable to the approach discussed for the SSO policy, the proposed changes in the area wage adjustment, and the proposed increase in the outlier fixed-loss amount (as explained above).

Estimated payments per discharge for the 2008 LTCH PPS rate year for LTCHs with 0–24 beds are projected to decrease the most in comparison to the 2007 LTCH PPS rate year (1.6 percent; see Table 9), followed by LTCHs with 25–49 beds (1.1 percent; see Table 9). This higher than average decrease in estimated payments per discharge for LTCHs with less than 49 beds (that is, LTCHs in the 0–24 bed size category and LTCHs in the 25–49 bed size category) is largely due to the proposed changes to the area wage adjustment and the approach discussed for the SSO policy. Specifically, the majority of LTCHs with 49 beds or less are located in areas where the proposed RY 2008 wage index value is less than the RY 2007 wage index value. In addition, the majority (over 80 percent) of LTCHs with 49 beds or less are located in areas where the proposed RY 2008 wage index is less than 1.0. Furthermore, many of the LTCHs with less than 25 beds have a larger than average percentage of SSO cases, and therefore, are expected to experience a larger than average decrease in estimated payments

per discharge due to the approach discussed for the SSO policy.

We project that LTCHs with greater than 200 beds would have a slight increase in estimated 2008 LTCH PPS rate year payments per discharge in comparison to the 2007 LTCH PPS rate year (0.4 percent; see Table 9). This slight increase in estimated payments per discharge for LTCHs with greater than 200 beds is primarily due to the proposed changes to the area wage adjustment. This is because the majority of these LTCHs are located in areas where the proposed RY 2008 wage index value is greater than the RY 2007 wage index value, and because 12 of the 13 LTCHs with greater than 200 beds are located in an area where the proposed RY 2008 wage index value is greater than 1.0 (as described above).

5. Effect on the Medicare Program

Based on actuarial projections, an estimate of Medicare spending (total estimated Medicare program payments) for LTCH services over the next 5 years based on current LTCH PPS policy (as established in previous LTCH PPS final rules) is shown in Table 4 in section IV.D.5. of the preamble of this proposed rule. As noted we project that the provisions of this proposed rule (including the approach discussed for the SSO policy), would result in a decrease in estimated aggregate LTCH PPS payments in RY 2008 of about \$117 million (or about 2.9 percent) for the 369 LTCHs in our database, as explained in greater detail above in section XVI.A. of this regulatory impact analysis.

Consistent with the statutory requirement for BN, as we discussed in the August 30, 2002 final rule that implemented the LTCH PPS, in developing the LTCH PPS, we intended estimated aggregate payments under the LTCH PPS in FY 2003 be projected to 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 BN calculations for determining the FY 2003 standard Federal rate uses the best available data and necessarily reflects assumptions. As we collect data from LTCHs, we will monitor payments and evaluate the ultimate accuracy of the assumptions used in the BN calculations (that is, inflation factors, intensity of services provided, or behavioral response to the implementation of the LTCH PPS). As discussed in section IV.D.6. of this proposed rule, we still do not have sufficient new cost report and claims data generated under the LTCH PPS to enable us to conduct a comprehensive

reevaluation of our FY 2003 BN calculation at this time.

Section 123 of the BBRA and section 307 of the BIPA provide the Secretary with extremely broad authority in developing the LTCH PPS, including the authority for appropriate adjustments. In accordance with this broad authority, we may discuss in a future proposed rule a possible one-time prospective adjustment to the LTCH PPS rates under § 412.523(d)(3) on or before July 1, 2008, so that the effect of any significant differences between actual payments and estimated payments for the first year of the LTCH PPS is not perpetuated in the LTCH PPS payment rates for future years.

6. Effect on Medicare Beneficiaries

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

C. Impact of Other Proposed Policy Changes

1. Effects of Proposed Policy Expansion of the Special Payment Provisions for LTCH HwHs and LTCH Satellites to Certain Situations Not Presently Covered by Existing § 412.534 for Subclause (I) LTCHs

In section V.B. of the preamble to this proposed rule, we are proposing to revise § 412.534 and add a § 412.536 to expand the existing payment provision for co-located LTCHs (HwHs and satellites of LTCHs) to certain situations not presently covered by existing § 412.534 for subclause (I) LTCHs. Under the existing policy, which was finalized for FY 2004, a payment adjustment is applied to those discharges from co-located LTCHs that were admitted from host hospitals that are in excess of a specified threshold unless those patients had reached HCO status at the referring hospital. Following a 4-year phase-in of this payment adjustment, for cost reporting periods beginning during FY 2008, the threshold is 25 percent or an applicable percentage established under the regulation that takes into account the particular circumstances of rural, urban single, or MSA dominant hospitals. Specifically, at existing § 412.534, we have provided that under the LTCH PPS, Medicare will pay the lesser of an amount otherwise payable under subpart O of 42 CFR part 412 or a LTCH

PPS payment amount equivalent to what would have been paid under the IPPS for those discharges that were not HCOs from the referring hospital and that exceed 25 percent (or the applicable percentage) of the LTCH or LTCH satellite's Medicare discharges for any cost reporting period (69 FR 49191 through 49213). We originally established this payment adjustment because our data suggested that in many cases, hospitals were prematurely shifting patients to co-located LTCHs, and therefore, that we were generating a Medicare payment to the first hospital (generally an acute care hospital paid under the IPPS) and also an additional Medicare payment under the LTCH PPS to an LTCH for what was, in essence, one episode of care. Consequently, we believed that in such circumstances co-located LTCHs were functioning as step-down units of their host hospitals, a configuration which is not permitted under section 1886(d)(1)(B) of the Act, which provides for the establishment of rehabilitation and psychiatric units of acute care hospitals but does not allow LTCH units.

As detailed in section V.B. of the preamble of this proposed rule, our data suggests that many of our concerns regarding patient shifting between co-located providers also pertain to those LTCHs that are not co-located with other hospitals. The RY 2005 LTCH discharges from the MedPAR files indicate that only about 12 percent of the then 174 free-standing LTCHs admitted 25 percent or less of their Medicare discharges from an individual acute care hospital; for about 37 percent of those freestanding LTCHs, the percentage was between 25 and 50 percent; for about 34 percent, it was between 50 and 75 percent; and for about 17 percent of those free-standing LTCHs, it was between 75 and 100 percent of their Medicare discharges were admitted from one acute care hospital. In addition, the RY 2005 LTCH discharges from the MedPAR files indicate that for over 50 percent of all LTCHs, at least 50 percent of their discharges are for patients admitted from an individual acute care hospital. Based on this data, as discussed in section V.B. of this proposed rule, we have proposed to expand this described payment adjustment at existing § 412.534 to apply equally to certain situations not presently covered by existing § 412.534 for subclause (I) LTCHs beginning with cost reporting periods starting in RY 2008. Under this proposed policy, if any subclause (I) LTCH's or satellite facility's discharges that had been admitted from any non-

co-located referring hospital (under proposed § 412.536) or from a co-located host (under the proposed revision to § 412.534) exceed 25 percent (or the applicable percentage) for the LTCH's cost reporting period, an adjusted payment would be made at the lesser of the otherwise payable amount under the LTCH PPS or the LTCH PPS payment amount that would be equivalent to what Medicare would otherwise pay under the IPPS.

It is our intent that the proposed revisions would discourage inappropriate patient shifting to LTCHs before the referring hospital delivers a full episode of patient care. To the extent that LTCHs change their behaviors because this proposed policy reduces the financial incentives for certain situations not presently covered by existing § 412.534 to admit patients prematurely discharged from other hospitals, we believe that there would be savings to the Medicare program. Specifically, as under the existing policy for co-located LTCHs at existing § 412.534, the proposed payment adjustment would not apply to either those subclause (I) LTCH discharges admitted from non-co-located referring hospitals (under proposed § 412.536) or those subclause (I) LTCH HwH or satellite discharges admitted from co-located host hospitals (under the proposed revision to § 412.534) that have already reached HCO status.

At this time, based on the most recent LTCH claims data available and assuming no change in LTCH behavior if this proposed policy were implemented, we estimate that the proposed extension of the 25 percent (or applicable percentage) threshold at existing § 412.534 to certain situations not presently covered by existing § 412.534 subclause (I) LTCHs would result in savings of \$90 million to the Medicare program (or 2.2 percent decrease in estimated aggregate LTCH PPS payments) in RY 2008. (As noted above, this estimated \$90 million impact is in addition to the estimated impact of the proposed payment rate and policy changes discussed in section XVI.B.4. of this regulatory impact analysis. Thus, the projected 2.2 percent decrease in estimated aggregate LTCH PPS payments due to this proposed policy is included in the 2.9 percent decrease in estimated aggregate LTCH PPS payments projected for all of the provisions of this proposed rule, as

explained in greater detail above in section XVI.A. of this regulatory impact analysis.) As discussed above in this section, because we believe that this proposed policy would discourage inappropriate patient shifting to LTCHs before the non-co-located referring hospital or co-located host delivered a full episode of patient care and because we believe that this proposed policy would result in appropriate Medicare payments under the LTCH PPS, we do not believe that there would be an adverse financial impact on LTCHs, nor would there be an adverse impact on Medicare beneficiaries' access to care.

2. Effects of Proposed Policy Change Relating to Payment for Direct Graduate Medical Education (GME)

In section XII. of the preamble of this proposed rule, with respect to the rules that hospitals must meet to count residents training in nonhospital settings for indirect medical education (IME) and direct GME payment purposes, we are proposing to revise § 413.75(b) to revise the definition of "all or substantially all of the costs for the training program in the nonhospital setting." The revised definition would be at least 90 percent of the total cost of the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries attributable to direct GME. This differs from the current definition of "all or substantially all of the costs for the training program in the nonhospital setting" which requires that, to count FTE residents training in nonhospital setting, hospitals must pay for 100 percent of the residents' salaries and fringe benefits, as well as the portion of the actual cost of the teaching physicians' salary and fringe benefits attributable to GME activities during the time the residents are training in the nonhospital site. In addition, under the proposed definition of "all or substantially all" of the costs, in response to hospitals' concerns regarding the difficulty of acquiring actual salary data from teaching physicians to document the actual cost of the teaching physicians' time spent on GME activities, we are proposing to allow hospitals to use certain proxy information, such as national average physician compensation amounts, to calculate the cost of the teaching

physicians' time spent in GME activities in nonhospital sites.

We believe that the administrative burden on hospitals related to calculating and documenting that they are paying for all or substantially all of the costs of residency training in nonhospital sites would be significantly reduced, if not eliminated, under our proposal. If the proposed changes are *not* made, and we continue to require that hospitals provide extensive documentation that they are paying for "all" of the costs of the training program in the nonhospital setting, we understand that there is industry concern that hospitals may significantly reduce the amount of training occurring in nonhospital settings, and may transfer that residency training back to hospitals. We further note that the Congress intended to encourage the shift of training to nonhospital settings and we believe this proposed policy change could facilitate further shifts to nonhospital settings. Since we are *not* proposing a change that would impact the aggregate amount of residency training that will occur, and Medicare would continue to pay for residency training occurring in hospitals, overall Medicare payments for residency training as a result of this proposal will remain constant.

D. Accounting Statement

As discussed in section XVI.A.1. of this regulatory impact analysis, including the approach discussed for addressing our concerns with the existing SSO policy (presented in section V.A.2. of the preamble of this proposed rule) in the impact analysis of this proposed rule results in a decrease in estimated aggregate payments of \$117 million (or about 2.9 percent) for the 369 LTCHs in our database. Therefore, as required by OMB Circular A-4 (available at <http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf>), in Table 10, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this proposed rule. Table 10 provides our best estimate of the proposed decrease in Medicare payments under the LTCH PPS as a result of the provisions presented in this proposed rule based on the data for the 369 LTCHs in our database. All expenditures are classified as transfers to Medicare providers (that is, LTCHs).

TABLE 10.—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES, FROM THE 2007 LTCH PPS RATE YEAR TO THE 2008 LTCH PPS RATE YEAR

[In millions]

Category	Transfers
Annualized Monetized Transfers	Negative transfer—Estimated decrease in expenditures: \$117.*
From Whom To Whom?	Federal Government To LTCH Medicare Providers.

* As noted above and as discussed in greater detail above in section XVI.A.1. of this regulatory impact analysis, we have included the approach discussed for addressing our concerns with the existing SSO policy in the impact analysis of this proposed rule, which is projected to result in a \$117 million decrease in estimated aggregate LTCH PPS payments from RY 2007 to RY 2008. However, we note that in absence of including such an approach, we estimate that the estimated impact of the provisions of this proposed rule are projected to result in an \$80 million decrease in estimated aggregate LTCH PPS payments from RY 2007 to RY 2008.

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

List of Subjects

42 CFR Part 412

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

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Reporting and recordkeeping requirements.

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

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

1. The authority citation for part 412 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh) and section 124 of Pub. L. 106–113 (113 Stat. 1501A–332).

Subpart B—Hospital Services Subject to and Excluded From the Prospective Payment Systems for Inpatient Operating Costs and Inpatient Capital-Related Costs

2. Section 412.22 is amended by adding paragraphs (h)(3)(i) and (ii) to read as follows:

§ 412.22 Excluded hospitals and hospital units: General rules.

* * * * *

(h) * * *

(3) * * *

(i) Any hospital structured as a satellite facility on September 30, 1999, and excluded from the prospective payment systems on that date, to the extent the hospital continues operating under the same terms and conditions, including the number of beds and square footage considered, for the

purposes of Medicare participation and payment, to be part of the hospital, in effect on September 30, 1999; or

(ii) Any hospital excluded from the prospective payment systems under § 412.23(e)(2)(ii).

* * * * *

Subpart G—Special Treatment of Certain Facilities Under the Prospective Payment System for Inpatient Operating Costs

3. Section 412.105 is amended by revising paragraph (f)(1)(ii)(C) to read as follows:

§ 412.105 Special treatment: Hospitals that incur indirect costs for graduate medical education programs.

* * * * *

(f) * * *

(1) * * *

(ii) * * *

(C) Effective for discharges occurring on or after October 1, 1997, the time spent by a resident in a nonhospital setting in patient care activities, as defined in § 413.75(b) of this subchapter, under an approved medical residency training program is counted towards the determination of full-time equivalency if the criteria set forth in § 413.78(c), (d), (e), or (f) of this subchapter, as applicable, are met.

* * * * *

Subpart O—Prospective Payment System for Long-Term Care Hospitals

4. Section 412.517 is amended by —
A. Redesignating the introductory text and paragraphs (a), (b), (c), and (d) as paragraphs (a) introductory text, (a)(1), (a)(2), (a)(3), and (a)(4), respectively.

B. Adding new paragraph (b).

The addition reads as follows:

§ 412.517 Revision of LTC–DRG group classifications and weighting factors.

* * * * *

(b) Beginning in FY 2008, the annual changes to the LTC–DRG classifications and recalibration of the weighting factors described in paragraph (a) are made in a budget neutral manner such

that estimated aggregate LTCH PPS payments are not affected.

5. Section 412.523 is amended by adding new paragraph (c)(3)(iv) to read as follows:

§ 412.523 Methodology for calculating the Federal prospective payment rates.

* * * * *

(c) * * *

(3) * * *

(iv) For long-term care hospital prospective payment system rate year beginning July 1, 2007 and ending June 30, 2008. The standard Federal rate for long-term care hospital prospective payment system rate year beginning July 1, 2007 and ending June 30, 2008 is the standard Federal rate for the previous long-term care hospital prospective payment system rate year updated by 0.71 percent. The standard Federal rate is adjusted, as appropriate, as described in paragraph (d) of this section.

* * * * *

6. Section 412.534 is amended by—

A. Revising paragraph (b).

B. Adding paragraph (h).

The revision and addition read as follows:

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

* * * * *

(b) Patients admitted from hospitals not located in the same building or on the same campus as the long-term care hospital or long-term care hospital satellite. Payments to the long-term care hospital for patients admitted to the long-term care hospital to a satellite of the long-term care hospital from another hospital that is not the co-located hospital are made under the rules in this subpart with no adjustment under this section. For cost reporting periods beginning on or after July 1, 2007, payments to the long-term care hospital or long-term care hospital satellite facility for patients admitted to the LTCH hospital or LTCH satellite facility of the long-term care hospital from another hospital that is not the co-

located hospital are subject to the provisions in § 412.536.

* * * * *

(h) *Effective date of policies in this section.* The policies set forth in this section apply to discharges occurring in cost reporting periods beginning on or after July 1, 2007 from long-term care hospitals as described in § 412.23(e)(2)(i) that meet criteria in § 412.22(f) and satellite facilities of long-term care hospitals as described at § 412.22(h)(3)(i).

7. Section 412.536 is added to read as follows:

§ 412.536 Special payment provisions for long-term care hospitals and satellites not co-located with other hospitals.

(a) *Scope.* For cost reporting periods beginning on or after July 1, 2007, the policies set forth in this section apply to discharges from long-term care hospitals as described in § 412.23(e)(2)(i) and satellite facilities of long-term care hospitals described in § 412.22(h), including satellite facilities of long-term care hospitals described in (h)(3)(i) but excluding satellite facilities described in (h)(3)(ii).

(b) For cost reporting periods beginning on or after July 1, 2007, payments for discharged patients admitted from a hospital not located in the same building or on the same campus as the long-term care hospital or long-term care hospital satellite facility will be made under either paragraph (b)(1) or paragraph (b)(2) of this section.

(1) Except as provided in paragraphs (c), (d) or (f) of this section, for any cost reporting period beginning on or after July 1, 2007 in which a long-term care hospital or a long-term care hospital satellite facility has a discharged Medicare inpatient population of whom no more than 25 percent were admitted to the hospital or the satellite facility from any individual hospital, payments for the Medicare discharges admitted from that hospital are made under the rules at § 412.500 through § 412.541 in this subpart with no adjustment under this section.

(2) Except as provided in paragraph (c), (d), or (f) of this section, for any cost reporting period beginning on or after July 1, 2007 in which a long-term care hospital or long-term care hospital satellite facility has a discharged Medicare inpatient population of whom more than 25 percent were admitted to the hospital or satellite facility from any individual hospital, payment for the Medicare discharges who are admitted from that hospital and who cause the long-term care hospital or satellite facility to exceed the 25 percent threshold for discharged patients who

have been admitted from that referring hospital, are determined at the lesser of the amount otherwise payable under this subpart or the amount payable under this subpart that is equivalent, as set forth in paragraph (e) of this section, to the amount that would be determined under the rules at Subpart A, § 412.1(a). Payments for the remainder of the long-term care hospital's or satellite facility's patients admitted from that referring hospital are made under the rules in this subpart at § 412.500 through § 412.541 with no adjustment under this section.

(3) In determining the percentage of Medicare discharges admitted to the long-term care hospital or long-term care hospital satellite facility from any referring hospital under paragraphs (b)(1) and (b)(2) of this section, patients on whose behalf a Medicare outlier payment was made to the referring hospital are not counted towards the 25 percent threshold from that referring hospital.

(c) *Special treatment of rural hospitals.* (1) Subject to paragraph (f) of this section, in the case of a long-term care hospital or long-term care hospital satellite facility that is located in a rural area as defined in § 412.64(b)(1)(ii)(C) that has a discharged Medicare inpatient population of whom more than 50 percent were admitted to the long-term care hospital or long-term care hospital satellite facility from a hospital, payment for the Medicare discharges who are admitted from that hospital and who cause the long-term care hospital or satellite facility to exceed the 50 percent threshold for Medicare discharges is determined at the lesser of the amount otherwise payable under this subpart or the amount payable under this subpart that is equivalent, as set forth in paragraph (e) of this section, to the amount that is otherwise payable under subpart A, § 412.1(a). Payments for the remainder of the long-term care hospital's or long-term care hospital satellite facility's Medicare discharges admitted from the referring hospital are made under the rules in this subpart at § 412.500 through § 412.541 with no adjustment under this section.

(2) In determining the percentage of Medicare discharges admitted from the referring hospital under paragraph (c)(1) of this section, patients on whose behalf a Medicare outlier payment was made at the referring hospital are not counted toward the 50 percent threshold.

(d) *Special treatment of urban single or MSA dominant hospitals.* (1) Subject to paragraph (f) of this section, in the case of a long-term care hospital or long-term care hospital satellite facility that admits Medicare patients from the only other hospital in the MSA or from a

MSA dominant hospital as defined in paragraph (d)(4) of this section, for any cost reporting period beginning on or after July 1, 2007, in which the long-term care hospital or satellite facility has a discharged Medicare inpatient population of whom more than the percentage calculated under paragraph (d)(2) of this section were admitted to the hospital from the urban single or MSA-dominant referring hospital, payment for the Medicare discharges who are admitted from the referring hospital and who cause the long-term care hospital or long-term care hospital satellite facility to exceed the applicable threshold for Medicare discharges who have been admitted from the referring hospital is the lesser of the amount otherwise payable under this subpart or the amount under this subpart that is equivalent, as set forth in paragraph (e) of this section, to the amount that otherwise would be determined under Subpart A, § 412.1(a). Payments for the remainder of the long-term care hospital's or satellite facility's Medicare discharges admitted from that referring hospital are made under the rules in this subpart at § 412.500 through § 412.541 with no adjustment under this section.

(2) For purposes of paragraph (d)(1) of this section, the percentage used is the percentage of total Medicare discharges in the Metropolitan Statistical Area (MSA) in which the hospital is located that are from the referring hospital for the cost reporting period for which the adjustment was made, but in no case is less than 25 percent or more than 50 percent.

(3) In determining the percentage of patients admitted from the referring hospital under paragraph (d)(1) of this section, patients on whose behalf a Medicare outlier payment was made at the referring hospital are not counted toward the applicable threshold.

(4) For purposes of this paragraph, an "MSA-dominant hospital" is a hospital that has discharged more than 25 percent of the total hospital Medicare discharges in the MSA in which the hospital is located.

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

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

The hospital inpatient prospective payment system operating standardized amount—

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

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

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

(3) *Hospital inpatient prospective payment system capital Federal rate.*

The hospital inpatient prospective payment system capital Federal rate—

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

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

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

(4) *High cost outlier.* An additional payment for high cost outlier cases is based on the fixed loss amount established for the hospital inpatient prospective payment system.

(f) *Transition period for long-term care hospitals and long-term care hospital satellite facilities paid under this subpart.* (1) In the case of a long-term care hospital or a long-term care hospital satellite facility that is paid under the provisions of this subpart, for cost reporting periods beginning on or after July 1, 2007, the amount paid is based on the following:

(2) For long term care hospitals or long term care hospital satellite facilities with cost reporting period beginning on

or after July 1, 2007, and before October 1, 2007, the percentage of Medicare discharges admitted from the referring hospital with no payment adjustment, may not exceed the lesser of the percentage of the long term care hospital or long-term care hospital satellite's Medicare discharges that were admitted from the referring hospital during the FY 2005 cost reporting period or 50 percent. In determining the percentage of Medicare discharges admitted from the referring hospital under this paragraph, patients on whose behalf a Medicare outlier payment was made at the referring hospital are not counted toward this threshold.

(3) For long term care hospitals or long term care hospital satellites with cost reporting periods beginning on or after October 1, 2007, the percentage of Medicare discharges admitted from any referring hospital with no payment adjustment, may not exceed 25 percent or the applicable percentage determined under paragraph (c) or (d) of this section.

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

8. The authority citation for part 413 continues to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1861(v), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395d(d), 1395f(b), 1395g, 1395l(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww); and sec. 124 of Pub. L. 106–133 (113 Stat. 1501A–332).

Subpart F—Specific Categories of Costs

9. Section 413.75(b) is amended by revising the definition “all or substantially all of the costs for the training program in the nonhospital setting” to read as follows:

§ 413.75 Direct GME payments: General requirements.

* * * * *
(b) * * *
* * * * *

All or substantially all of the costs for the training program in the nonhospital setting means—(1) Effective on or after January 1, 1999 and for cost reporting periods beginning before July 1, 2007, the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries and

fringe benefits attributable to direct graduate medical education (GME); and

(2) Effective for cost reporting periods beginning on or after July 1, 2007, at least 90 percent of the total of the costs of the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries attributable to direct GME.

* * * * *

10. Section 413.78 is amended by adding new paragraph (f) to read as follows:

§ 413.78 Direct GME payments: Determination of the total number of FTE residents

* * * * *

(f) For cost reporting periods beginning on or after July 1, 2007, the time residents spend in non-provider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs may be included in determining the number of FTE residents the calculation of a hospital's resident count if the following conditions are met—

(1) The resident spends his or her time in patient care activities.

(2) The hospital must incur all or substantially all of the costs for the training program in the nonhospital setting(s) (in accordance with the definition under § 413.75(b)).

(3) The hospital must comply with one of the following:

(i) The hospital must document that it is paying for all or substantially all of the costs for the training program in a nonhospital setting(s) attributable to training that occurs during a month by the end of the third month following the month in which the training in the nonhospital site occurred; or

(ii) There is a written agreement between the hospital and the nonhospital site that states that the hospital will incur at least 90 percent of the total of the costs of the resident's salary and fringe benefits (and travel and lodging where applicable) while the resident is training in the nonhospital site and the portion of the cost of the teaching physician's salary attributable to direct GME. The written agreement must specify the total amount the hospital will incur, and must indicate the portion of this amount that reflects residents' salaries and fringe benefits (and travel and lodging where applicable), and the portion of this amount that reflects teaching physician compensation.

(4) The hospital is subject to the principles of community support and redistribution of costs as specified in § 413.81.

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

Dated: December 14, 2006.

Leslie V. Norwalk,

*Acting Administrator, Centers for Medicare
& Medicaid Services.*

Approved: January 24, 2007.

Michael O. Leavitt,

Secretary.

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

Addendum A

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

Table 1: Proposed Long-Term Care Hospital Wage Index for Urban Areas for Discharges Occurring from July 1, 2007 through June 30, 2008.

Table 2: Proposed Long-Term Care Hospital Wage Index for Rural Areas for Discharges Occurring from July 1, 2007 through June 30, 2008.

Table 3: FY 2007 LTC-DRG Relative Weights, Geometric Average Length of Stay, and five-sixths of the Geometric Average Length of Stay (for Short-Stay Outlier Cases) (effective for discharges occurring on or after October 1, 2006 through September 30, 2007), and the IPPS Average Length of Stay plus one Standard Deviation (that could be

used under the approach discussed for Short-Stay Outlier policy). (**Note:** The first four columns of this table are the same information provided in Table 11 of the FY 2007 IPPS final rule (71 FR 48321 through 48320), which has been reprinted here for convenience. The fifth column of this table was added to provide information on the approach discussed for the short-stay outlier policy, discussed in section VI.A.2. of the preamble of this proposed rule.)

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2007 THROUGH JUNE 30, 2008 ¹

CBSA code	Urban area (constituent counties)	Full wage index ²	4/5ths wage index ³
10180	Abilene, TX Callahan County, TX. Jones County, TX. Taylor County, TX.	0.8000	0.8400
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.	0.3915	0.5132
10420	Akron, OH Portage County, OH. Summit County, OH.	0.8654	0.8923
10500	Albany, GA Baker County, GA. Dougherty County, GA. Lee County, GA. Terrell County, GA. Worth County, GA.	0.8991	0.9193
10580	Albany-Schenectady-Troy, NY Albany County, NY. Rensselaer County, NY. Saratoga County, NY. Schenectady County, NY. Schoharie County, NY.	0.8720	0.8976
10740	Albuquerque, NM Bernalillo County, NM. Sandoval County, NM. Torrance County, NM. Valencia County, NM.	0.9458	0.9566
10780	Alexandria, LA Grant Parish, LA. Rapides Parish, LA.	0.8006	0.8405
10900	Allentown-Bethlehem-Easton, PA-NJ Warren County, NJ. Carbon County, PA. Lehigh County, PA. Northampton County, PA.	0.9947	0.9958
11020	Altoona, PA Blair County, PA.	0.8812	0.9050
11100	Amarillo, TX Armstrong County, TX. Carson County, TX. Potter County, TX. Randall County, TX.	0.9169	0.9335
11180	Ames, IA Story County, IA.	0.9760	0.9808
11260	Anchorage, AK Anchorage Municipality, AK. Matanuska-Susitna Borough, AK.	1.2023	1.1618
11300	Anderson, IN Madison County, IN.	0.8681	0.8945
11340	Anderson, SC	0.9017	0.9214

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2007 THROUGH JUNE 30, 2008 ¹—Continued

CBSA code	Urban area (constituent counties)	Full wage index ²	4/5ths wage index ³
11460	Anderson County, SC. Ann Arbor, MI	1.0826	1.0661
	Washtenaw County, MI.		
11500	Anniston-Oxford, AL	0.7770	0.8216
	Calhoun County, AL.		
11540	Appleton, WI	0.9455	0.9564
	Calumet County, WI.		
	Outagamie County, WI.		
11700	Asheville, NC	0.9216	0.9373
	Buncombe County, NC.		
	Haywood County, NC.		
	Henderson County, NC.		
	Madison County, NC.		
12020	Athens-Clarke County, GA	0.9856	0.9885
	Clarke County, GA.		
	Madison County, GA.		
	Oconee County, GA.		
	Oglethorpe County, GA.		
12060	Atlanta-Sandy Springs-Marietta, GA	0.9762	0.9810
	Barrow County, GA.		
	Bartow County, GA.		
	Butts County, GA.		
	Carroll County, GA.		
	Cherokee County, GA.		
	Clayton County, GA.		
	Cobb County, GA.		
	Coweta County, GA.		
	Dawson County, GA.		
	DeKalb County, GA.		
	Douglas County, GA.		
	Fayette County, GA.		
	Forsyth County, GA.		
	Fulton County, GA.		
	Gwinnett County, GA.		
	Haralson County, GA.		
	Heard County, GA.		
	Henry County, GA.		
	Jasper County, GA.		
	Lamar County, GA.		
	Meriwether County, GA.		
	Newton County, GA.		
	Paulding County, GA.		
	Pickens County, GA.		
	Pike County, GA.		
	Rockdale County, GA.		
	Spalding County, GA.		
	Walton County, GA.		
12100	Atlantic City, NJ	1.1831	1.1465
	Atlantic County, NJ.		
12220	Auburn-Opelika, AL	0.8096	0.8477
	Lee County, AL.		
12260	Augusta-Richmond County, GA-SC	0.9667	0.9734
	Burke County, GA.		
	Columbia County, GA.		
	McDuffie County, GA.		
	Richmond County, GA.		
	Aiken County, SC.		
	Edgefield County, SC.		
12420	Austin-Round Rock, TX	0.9344	0.9475
	Bastrop County, TX.		
	Caldwell County, TX.		
	Hays County, TX.		
	Travis County, TX.		
	Williamson County, TX.		
12540	Bakersfield, CA	1.0725	1.0580
	Kern County, CA.		
12580	Baltimore-Towson, MD	1.0088	1.0070
	Anne Arundel County, MD.		
	Baltimore County, MD.		

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2007 THROUGH JUNE 30, 2008 ¹—Continued

CBSA code	Urban area (constituent counties)	Full wage index ²	4/5ths wage index ³
	Carroll County, MD. Harford County, MD. Howard County, MD. Queen Anne's County, MD. Baltimore City, MD.		
12620	Bangor, ME	0.9711	0.9769
	Penobscot County, ME.		
12700	Barnstable Town, MA	1.2539	1.2031
	Barnstable County, MA.		
12940	Baton Rouge, LA	0.8084	0.8467
	Ascension Parish, LA. East Baton Rouge Parish, LA. East Feliciana Parish, LA. Iberville Parish, LA. Livingston Parish, LA. Pointe Coupee Parish, LA. St. Helena Parish, LA. West Baton Rouge Parish, LA. West Feliciana Parish, LA.		
12980	Battle Creek, MI	0.9762	0.9810
	Calhoun County, MI.		
13020	Bay City, MI	0.9251	0.9401
	Bay County, MI.		
13140	Beaumont-Port Arthur, TX	0.8595	0.8876
	Hardin County, TX. Jefferson County, TX. Orange County, TX.		
13380	Bellingham, WA	1.1104	1.0883
	Whatcom County, WA.		
13460	Bend, OR	1.0743	1.0594
	Deschutes County, OR.		
13644	Bethesda-Gaithersburg-Frederick, MD	1.0903	1.0722
	Frederick County, MD. Montgomery County, MD.		
13740	Billings, MT	0.8712	0.8970
	Carbon County, MT. Yellowstone County, MT.		
13780	Binghamton, NY	0.8786	0.9029
	Broome County, NY. Tioga County, NY.		
13820	Birmingham-Hoover, AL	0.8894	0.9115
	Bibb County, AL. Blount County, AL. Chilton County, AL. Jefferson County, AL. St. Clair County, AL. Shelby County, AL. Walker County, AL.		
13900	Bismarck, ND	0.7240	0.7792
	Burleigh County, ND. Morton County, ND.		
13980	Blacksburg-Christiansburg-Radford, VA	0.8213	0.8570
	Giles County, VA. Montgomery County, VA. Pulaski County, VA. Radford City, VA.		
14020	Bloomington, IN	0.8533	0.8826
	Greene County, IN. Monroe County, IN. Owen County, IN.		
14060	Bloomington-Normal, IL	0.8944	0.9155
	McLean County, IL.		
14260	Boise City-Nampa, ID	0.9401	0.9521
	Ada County, ID. Boise County, ID. Canyon County, ID. Gem County, ID. Owyhee County, ID.		
14484	Boston-Quincy, MA	1.1679	1.1343

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2007 THROUGH JUNE 30, 2008 ¹—Continued

CBSA code	Urban area (constituent counties)	Full wage index ²	4/5ths wage index ³
14500	Norfolk County, MA. Plymouth County, MA. Suffolk County, MA. Boulder, CO	1.0350	1.0280
14540	Boulder County, CO. Bowling Green, KY	0.8148	0.8518
14740	Edmonson County, KY. Warren County, KY. Bremerton-Silverdale, WA	1.0913	1.0730
14860	Kitsap County, WA. Bridgeport-Stamford-Norwalk, CT	1.2659	1.2127
15180	Fairfield County, CT. Brownsville-Harlingen, TX	0.9430	0.9544
15260	Cameron County, TX. Brunswick, GA	1.0164	1.0131
15380	Brantley County, GA. Glynn County, GA. McIntosh County, GA. Buffalo-Niagara Falls, NY	0.9424	0.9539
15500	Erie County, NY. Niagara County, NY. Burlington, NC	0.8674	0.8939
15540	Alamance County, NC. Burlington-South Burlington, VT	0.9474	0.9579
15764	Chittenden County, VT. Franklin County, VT. Grand Isle County, VT. Cambridge-Newton-Framingham, MA	1.0970	1.0776
15804	Middlesex County, MA. Camden, NJ	1.0392	1.0314
15940	Burlington County, NJ. Camden County, NJ. Gloucester County, NJ. Canton-Massillon, OH	0.9031	0.9225
15980	Carroll County, OH. Stark County, OH. Cape Coral-Fort Myers, FL	0.9342	0.9474
16180	Lee County, FL. Carson City, NV	1.0025	1.0020
16220	Carson City, NV. Casper, WY	0.9145	0.9316
16300	Natrona County, WY. Cedar Rapids, IA	0.8888	0.9110
16580	Benton County, IA. Jones County, IA. Linn County, IA. Champaign-Urbana, IL	0.9644	0.9715
16620	Champaign County, IL. Ford County, IL. Piatt County, IL. Charleston, WV	0.8542	0.8834
16700	Boone County, WV. Clay County, WV. Kanawha County, WV. Lincoln County, WV. Putnam County, WV. Charleston-North Charleston, SC	0.9145	0.9316
16740	Berkeley County, SC. Charleston County, SC. Dorchester County, SC. Charlotte-Gastonia-Concord, NC-SC	0.9554	0.9643
16820	Anson County, NC. Cabarrus County, NC. Gaston County, NC. Mecklenburg County, NC. Union County, NC. York County, SC. Charlottesville, VA	1.0125	1.0100
	Albemarle County, VA.		

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2007 THROUGH JUNE 30, 2008 ¹—Continued

CBSA code	Urban area (constituent counties)	Full wage index ²	4/5ths wage index ³
16860	Fluvanna County, VA. Greene County, VA. Nelson County, VA. Charlottesville City, VA. Chattanooga, TN-GA	0.8948	0.9158
16940	Catoosa County, GA. Dade County, GA. Walker County, GA. Hamilton County, TN. Marion County, TN. Sequatchie County, TN. Cheyenne, WY	0.9060	0.9248
16974	Laramie County, WY. Chicago-Naperville-Joliet, IL	1.0751	1.0601
17020	Cook County, IL. DeKalb County, IL. DuPage County, IL. Grundy County, IL. Kane County, IL. Kendall County, IL. McHenry County, IL. Will County, IL. Chico, CA	1.1053	1.0842
17140	Butte County, CA. Cincinnati-Middletown, OH-KY-IN	0.9601	0.9681
17300	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. Clarksville, TN-KY	0.8436	0.8749
17420	Christian County, KY. Trigg County, KY. Montgomery County, TN. Stewart County, TN. Cleveland, TN	0.8109	0.8487
17460	Bradley County, TN. Polk County, TN. Cleveland-Elyria-Mentor, OH	0.9400	0.9520
17660	Cuyahoga County, OH. Geauga County, OH. Lake County, OH. Lorain County, OH. Medina County, OH. Coeur d'Alene, ID	0.9344	0.9475
17780	Kootenai County, ID. College Station-Bryan, TX	0.9045	0.9236
17820	Brazos County, TX. Burleson County, TX. Robertson County, TX. Colorado Springs, CO	0.9701	0.9761
17860	El Paso County, CO. Teller County, CO. Columbia, MO	0.8542	0.8834
17900	Boone County, MO. Howard County, MO. Columbia, SC	0.8933	0.9146
	Calhoun County, SC. Fairfield County, SC.		

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2007 THROUGH JUNE 30, 2008 ¹—Continued

CBSA code	Urban area (constituent counties)	Full wage index ²	4/5ths wage index ³
17980	Kershaw County, SC. Lexington County, SC. Richland County, SC. Saluda County, SC. Columbus, GA-AL	0.8239	0.8591
	Russell County, AL. Chattahoochee County, GA. Harris County, GA. Marion County, GA. Muscogee County, GA.		
18020	Columbus, IN	0.9318	0.9454
	Bartholomew County, IN.		
18140	Columbus, OH	1.0107	1.0086
	Delaware County, OH. Fairfield County, OH. Franklin County, OH. Licking County, OH. Madison County, OH. Morrow County, OH. Pickaway County, OH. Union County, OH.		
18580	Corpus Christi, TX	0.8564	0.8851
	Aransas County, TX. Nueces County, TX. San Patricio County, TX.		
18700	Corvallis, OR	1.1546	1.1237
	Benton County, OR.		
19060	Cumberland, MD-WV	0.8446	0.8757
	Allegany County, MD. Mineral County, WV.		
19124	Dallas-Plano-Irving, TX	1.0075	1.0060
	Collin County, TX. Dallas County, TX. Delta County, TX. Denton County, TX. Ellis County, TX. Hunt County, TX. Kaufman County, TX. Rockwall County, TX.		
19140	Dalton, GA	0.9093	0.9274
	Murray County, GA. Whitfield County, GA.		
19180	Danville, IL	0.9266	0.9413
	Vermilion County, IL.		
19260	Danville, VA	0.8451	0.8761
	Pittsylvania County, VA. Danville City, VA.		
19340	Davenport-Moline-Rock Island, IA-IL	0.8846	0.9077
	Henry County, IL. Mercer County, IL. Rock Island County, IL. Scott County, IA.		
19380	Dayton, OH	0.9037	0.9230
	Greene County, OH. Miami County, OH. Montgomery County, OH. Preble County, OH.		
19460	Decatur, AL	0.8159	0.8527
	Lawrence County, AL. Morgan County, AL.		
19500	Decatur, IL	0.8172	0.8538
	Macon County, IL.		
19660	Deltona-Daytona Beach-Ormond Beach, FL	0.9263	0.9410
	Volusia County, FL.		
19740	Denver-Aurora, CO	1.0930	1.0744
	Adams County, CO. Arapahoe County, CO. Broomfield County, CO. Clear Creek County, CO.		

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2007 THROUGH JUNE 30, 2008 ¹—Continued

CBSA code	Urban area (constituent counties)	Full wage index ²	4/5ths wage index ³
19780	Denver County, CO. Douglas County, CO. Elbert County, CO. Gilpin County, CO. Jefferson County, CO. Park County, CO. Des Moines,-West Des Moines, IA	0.9214	0.9371
19804	Dallas County, IA. Guthrie County, IA. Madison County, IA. Polk County, IA. Warren County, IA. Detroit-Livonia-Dearborn, MI	1.0281	1.0225
20020	Wayne County, MI. Dothan, AL	0.7381	0.7905
20100	Geneva County, AL. Henry County, AL. Houston County, AL. Dover, DE	0.9847	0.9878
20220	Kent County, DE. Dubuque, IA	0.9133	0.9306
20260	Dubuque County, IA. Duluth, MN-WI	1.0042	1.0034
20500	Carlton County, MN. St. Louis County, MN. Douglas County, WI. Durham, NC	0.9826	0.9861
20740	Chatham County, NC. Durham County, NC. Orange County, NC. Person County, NC. Eau Claire, WI	0.9630	0.9704
20764	Chippewa County, WI. Eau Claire County, WI. Edison, NJ	1.1190	1.0952
20940	Middlesex County, NJ. Monmouth County, NJ. Ocean County, NJ. Somerset County, NJ. El Centro, CA	0.9076	0.9261
21060	Imperial County, CA. Elizabethtown, KY	0.8697	0.8958
21140	Hardin County, KY. Larue County, KY. Elkhart-Goshen, IN	0.9426	0.9541
21300	Elkhart County, IN. Elmira, NY	0.8240	0.8592
21340	Chemung County, NY. El Paso, TX	0.9053	0.9242
21500	El Paso County, TX. Erie, PA	0.8827	0.9062
21604	Erie County, PA. Essex County, MA	1.0418	1.0334
21660	Essex County, MA. Eugene-Springfield, OR	1.0876	1.0701
21780	Lane County, OR. Evansville, IN-KY	0.9071	0.9257
21820	Gibson County, IN. Posey County, IN. Vanderburgh County, IN. Warrick County, IN. Henderson County, KY. Webster County, KY. Fairbanks, AK	1.1059	1.0847
21940	Fairbanks North Star Borough, AK. Fajardo, PR	0.4036	0.5229
	Ceiba Municipio, PR. Fajardo Municipio, PR. Luquillo Municipio, PR.		

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2007 THROUGH JUNE 30, 2008 ¹—Continued

CBSA code	Urban area (constituent counties)	Full wage index ²	4/5ths wage index ³
22020	Fargo, ND-MN Cass County, ND. Clay County, MN.	0.8250	0.8600
22140	Farmington, NM San Juan County, NM.	0.8589	0.8871
22180	Fayetteville, NC Cumberland County, NC. Hoke County, NC.	0.8945	0.9156
22220	Fayetteville-Springdale-Rogers, AR-MO Benton County, AR. Madison County, AR. Washington County, AR. McDonald County, MO.	0.8865	0.9092
22380	Flagstaff, AZ Coconino County, AZ.	1.1601	1.1281
22420	Flint, MI Genesee County, MI.	1.0969	1.0775
22500	Florence, SC Darlington County, SC. Florence County, SC.	0.8388	0.8710
22520	Florence-Muscle Shoals, AL Colbert County, AL. Lauderdale County, AL.	0.7843	0.8274
22540	Fond du Lac, WI Fond du Lac County, WI.	1.0063	1.0050
22660	Fort Collins-Loveland, CO Larimer County, CO.	0.9544	0.9635
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL Broward County, FL.	1.0133	1.0106
22900	Fort Smith, AR-OK Crawford County, AR. Franklin County, AR. Sebastian County, AR. Le Flore County, OK. Sequoyah County, OK.	0.7731	0.8185
23020	Fort Walton Beach-Crestview-Destin, FL Okaloosa County, FL.	0.8643	0.8914
23060	Fort Wayne, IN Allen County, IN. Wells County, IN. Whitley County, IN.	0.9517	0.9614
23104	Fort Worth-Arlington, TX Johnson County, TX. Parker County, TX. Tarrant County, TX. Wise County, TX.	0.9569	0.9655
23420	Fresno, CA Fresno County, CA.	1.0943	1.0754
23460	Gadsden, AL Etowah County, AL.	0.8066	0.8453
23540	Gainesville, FL Alachua County, FL. Gilchrist County, FL.	0.9277	0.9422
23580	Gainesville, GA Hall County, GA.	0.8958	0.9166
23844	Gary, IN Jasper County, IN. Lake County, IN. Newton County, IN. Porter County, IN.	0.9334	0.9467
24020	Glens Falls, NY Warren County, NY. Washington County, NY.	0.8324	0.8659
24140	Goldensboro, NC Wayne County, NC.	0.9171	0.9337
24220	Grand Forks, ND-MN Polk County, MN. Grand Forks County, ND.	0.7949	0.8359
24300	Grand Junction, CO	0.9668	0.9734

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2007 THROUGH JUNE 30, 2008 ¹—Continued

CBSA code	Urban area (constituent counties)	Full wage index ²	4/5ths wage index ³
24340	Mesa County, CO. Grand Rapids-Wyoming, MI	0.9455	0.9564
	Barry County, MI. Ionia County, MI. Kent County, MI. Newaygo County, MI.		
24500	Great Falls, MT	0.8598	0.8878
	Cascade County, MT.		
24540	Greeley, CO	0.9602	0.9682
	Weld County, CO.		
24580	Green Bay, WI	0.9787	0.9830
	Brown County, WI. Kewaunee County, WI. Oconto County, WI.		
24660	Greensboro-High Point, NC	0.8866	0.9093
	Guilford County, NC. Randolph County, NC. Rockingham County, NC.		
24780	Greenville, NC	0.9432	0.9546
	Greene County, NC. Pitt County, NC.		
24860	Greenville, SC	0.9804	0.9843
	Greenville County, SC. Laurens County, SC. Pickens County, SC.		
25020	Guayama, PR	0.3235	0.4588
	Arroyo Municipio, PR. Guayama Municipio, PR. Patillas Municipio, PR.		
25060	Gulfport-Biloxi, MS	0.8915	0.9132
	Hancock County, MS. Harrison County, MS. Stone County, MS.		
25180	Hagerstown-Martinsburg, MD-WV	0.9038	0.9230
	Washington County, MD. Berkeley County, WV. Morgan County, WV.		
25260	Hanford-Corcoran, CA	1.0282	1.0226
	Kings County, CA.		
25420	Harrisburg-Carlisle, PA	0.9402	0.9522
	Cumberland County, PA. Dauphin County, PA. Perry County, PA.		
25500	Harrisonburg, VA	0.9073	0.9258
	Rockingham County, VA. Harrisonburg City, VA.		
25540	Hartford-West Hartford-East	1.0894	1.0715
	Hartford, CT. Hartford County, CT. Litchfield County, CT. Middlesex County, CT. Tolland County, CT.		
25620	Hattiesburg, MS	0.7430	0.7944
	Forrest County, MS. Lamar County, MS. Perry County, MS.		
25860	Hickory-Lenoir-Morganton, NC	0.9010	0.9208
	Alexander County, NC. Burke County, NC. Caldwell County, NC. Catawba County, NC.		
26100	Holland-Grand Haven, MI	0.9163	0.9330
	Ottawa County, MI.		
26180	Honolulu, HI	1.1096	1.0877
	Honolulu County, HI.		
26300	Hot Springs, AR	0.8782	0.9026
	Garland County, AR.		
26380	Houma-Bayou Cane-Thibodaux, LA	0.8082	0.8466
	Lafourche Parish, LA.		

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2007 THROUGH JUNE 30, 2008 ¹—Continued

CBSA code	Urban area (constituent counties)	Full wage index ²	4/5ths wage index ³
26420	Terrebonne Parish, LA. Houston-Sugar Land-Baytown, TX	1.0008	1.0006
	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.		
26580	Huntington-Ashland, WV-KY-OH	0.8997	0.9198
	Boyd County, KY. Greenup County, KY. Lawrence County, OH. Cabell County, WV. Wayne County, WV.		
26620	Huntsville, AL	0.9007	0.9206
	Limestone County, AL. Madison County, AL.		
26820	Idaho Falls, ID	0.9088	0.9270
	Bonneville County, ID. Jefferson County, ID.		
26900	Indianapolis-Carmel, IN	0.9895	0.9916
	Boone County, IN. Brown County, IN. Hamilton County, IN. Hancock County, IN. Hendricks County, IN. Johnson County, IN. Marion County, IN. Morgan County, IN. Putnam County, IN. Shelby County, IN.		
26980	Iowa City, IA	0.9714	0.9771
	Johnson County, IA. Washington County, IA.		
27060	Ithaca, NY	0.9928	0.9942
	Tompkins County, NY.		
27100	Jackson, MI	0.9560	0.9648
	Jackson County, MI.		
27140	Jackson, MS	0.8271	0.8617
	Copiah County, MS. Hinds County, MS. Madison County, MS. Rankin County, MS. Simpson County, MS.		
27180	Jackson, TN	0.8853	0.9082
	Chester County, TN. Madison County, TN.		
27260	Jacksonville, FL	0.9165	0.9332
	Baker County, FL. Clay County, FL. Duval County, FL. Nassau County, FL. St. Johns County, FL.		
27340	Jacksonville, NC	0.8231	0.8585
	Onslow County, NC.		
27500	Janesville, WI	0.9655	0.9724
	Rock County, WI.		
27620	Jefferson City, MO	0.8332	0.8666
	Callaway County, MO. Cole County, MO. Moniteau County, MO. Osage County, MO.		
27740	Johnson City, TN	0.8043	0.8434
	Carter County, TN. Unicoi County, TN.		

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2007 THROUGH JUNE 30, 2008 ¹—Continued

CBSA code	Urban area (constituent counties)	Full wage index ²	4/5ths wage index ³
27780	Washington County, TN. Johnstown, PA	0.8620	0.8896
27860	Cambria County, PA. Jonesboro, AR	0.7662	0.8130
27900	Craighead County, AR. Poinsett County, AR. Joplin, MO	0.8605	0.8884
28020	Jasper County, MO. Newton County, MO. Kalamazoo-Portage, MI	1.0704	1.0563
28100	Kalamazoo County, MI. Van Buren County, MI. Kankakee-Bradley, IL	1.0083	1.0066
28140	Kankakee County, IL. Kansas City, MO-KS	0.9495	0.9596
28420	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.	1.0343	1.0274
28660	Kennewick-Richland-Pasco, WA	0.8901	0.9121
28700	Benton County, WA. Franklin County, WA. Killeen-Temple-Fort Hood, TX	0.7985	0.8388
28740	Bell County, TX. Coryell County, TX. Lampasas County, TX. Kingsport-Bristol-Bristol, TN-VA	0.9367	0.9494
28940	Hawkins County, TN. Sullivan County, TN. Bristol City, VA. Scott County, VA. Washington County, VA. Kingston, NY	0.8249	0.8599
29020	Ulster County, NY. Knoxville, TN	0.9669	0.9735
29100	Anderson County, TN. Blount County, TN. Knox County, TN. Loudon County, TN. Union County, TN. Kokomo, IN	0.9426	0.9541
29140	Howard County, IN. Tipton County, IN. La Crosse, WI-MN	0.8931	0.9145
29180	Houston County, MN. La Crosse County, WI. Lafayette, IN	0.8289	0.8631
29340	Benton County, IN. Carroll County, IN. Tippecanoe County, IN. Lafayette, LA	0.7914	0.8331
29404	Lafayette Parish, LA. St. Martin Parish, LA. Lake Charles, LA	1.0570	1.0456
	Calcasieu Parish, LA. Cameron Parish, LA. Lake County-Kenosha County, IL-WI		
	Lake County, IL.		

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2007 THROUGH JUNE 30, 2008 ¹—Continued

CBSA code	Urban area (constituent counties)	Full wage index ²	4/5ths wage index ³
29460	Kenosha County, WI. Lakeland, FL	0.8879	0.9103
29540	Polk County, FL. Lancaster, PA	0.9589	0.9671
29620	Lancaster County, PA. Lansing-East Lansing, MI	1.0088	1.0070
29700	Clinton County, MI. Eaton County, MI. Ingham County, MI. Laredo, TX	0.7811	0.8249
29740	Webb County, TX. Las Cruces, NM	0.9273	0.9418
29820	Dona Ana County, NM. Las Vegas-Paradise, NV	1.1430	1.1144
29940	Clark County, NV. Lawrence, KS	0.8365	0.8692
30020	Douglas County, KS. Lawton, OK	0.8065	0.8452
30140	Comanche County, OK. Lebanon, PA	0.8679	0.8943
30300	Lebanon County, PA. Lewiston, ID-WA	0.9853	0.9882
30340	Nez Perce County, ID. Asotin County, WA. Lewiston-Auburn, ME	0.9126	0.9301
30460	Androscoggin County, ME. Lexington-Fayette, KY	0.9181	0.9345
30620	Bourbon County, KY. Clark County, KY. Fayette County, KY. Jessamine County, KY. Scott County, KY. Woodford County, KY. Lima, OH	0.9042	0.9234
30700	Allen County, OH. Lincoln, NE	1.0092	1.0074
30780	Lancaster County, NE. Seward County, NE. Little Rock-North Little Rock, AR	0.8890	0.9112
30860	Faulkner County, AR. Grant County, AR. Lonoke County, AR. Perry County, AR. Pulaski County, AR. Saline County, AR. Logan, UT-ID	0.9022	0.9218
30980	Franklin County, ID. Cache County, UT. Longview, TX	0.8788	0.9030
31020	Gregg County, TX. Rusk County, TX. Upshur County, TX. Longview, WA	1.0011	1.0009
31084	Cowlitz County, WA. Los Angeles-Long Beach-Glendale, CA	1.1760	1.1408
31140	Los Angeles County, CA. Louisville-Jefferson County, KY-IN	0.9118	0.9294
	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.		

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2007 THROUGH JUNE 30, 2008 ¹—Continued

CBSA code	Urban area (constituent counties)	Full wage index ²	4/5ths wage index ³
31180	Trimble County, KY. Lubbock, TX	0.8613	0.8890
31340	Crosby County, TX. Lubbock County, TX. Lynchburg, VA	0.8694	0.8955
31420	Amherst County, VA. Appomattox County, VA. Bedford County, VA. Campbell County, VA. Bedford City, VA. Lynchburg City, VA. Macon, GA	0.9519	0.9615
31460	Bibb County, GA. Crawford County, GA. Jones County, GA. Monroe County, GA. Twiggs County, GA. Madera, CA	0.8154	0.8523
31540	Madera County, CA. Madison, WI	1.0840	1.0672
31700	Columbia County, WI. Dane County, WI. Iowa County, WI. Manchester-Nashua, NH	1.0243	1.0194
31900	Hillsborough County, NH. Merrimack County, NH. Mansfield, OH	0.9271	0.9417
32420	Richland County, OH. Mayagüez, PR	0.3848	0.5078
32580	Hormigueros Municipio, PR. Mayagüez Municipio, PR. McAllen-Edinburg-Mission, TX	0.8773	0.9018
32780	Hidalgo County, TX. Medford, OR	1.0818	1.0654
32820	Jackson County, OR. Memphis, TN-MS-AR	0.9373	0.9498
32900	Crittenden County, AR. DeSoto County, MS. Marshall County, MS. Tate County, MS. Tunica County, MS. Fayette County, TN. Shelby County, TN. Tipton County, TN. Merced, CA	1.1471	1.1177
33124	Merced County, CA. Miami-Miami Beach-Kendall, FL	0.9812	0.9850
33140	Miami-Dade County, FL. Michigan City-La Porte, IN	0.9118	0.9294
33260	LaPorte County, IN. Midland, TX	0.9786	0.9829
33340	Midland County, TX. Milwaukee-Waukesha-West Allis, WI	1.0218	1.0174
33460	Milwaukee County, WI. Ozaukee County, WI. Washington County, WI. Waukesha County, WI. Minneapolis-St. Paul-Bloomington, MN-WI	1.0946	1.0757
	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.		

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2007 THROUGH JUNE 30, 2008 ¹—Continued

CBSA code	Urban area (constituent counties)	Full wage index ²	4/5ths wage index ³
33540	Pierce County, WI. St. Croix County, WI. Missoula, MT	0.8928	0.9142
33660	Missoula County, MT. Mobile, AL	0.7913	0.8330
33700	Mobile County, AL. Modesto, CA	1.1729	1.1383
33740	Stanislaus County, CA. Monroe, LA	0.7997	0.8398
33780	Ouachita Parish, LA. Union Parish, LA. Monroe, MI	0.9707	0.9766
33860	Monroe County, MI. Montgomery, AL	0.8009	0.8407
34060	Autauga County, AL. Elmore County, AL. Lowndes County, AL. Montgomery County, AL. Morgantown, WV	0.8423	0.8738
34100	Monongalia County, WV. Preston County, WV. Morristown, TN	0.7933	0.8346
34580	Grainger County, TN. Hamblen County, TN. Jefferson County, TN. Mount Vernon-Anacortes, WA	1.0517	1.0414
34620	Skagit County, WA. Muncie, IN	0.8562	0.8850
34740	Delaware County, IN. Muskegon-Norton Shores, MI	0.9941	0.9953
34820	Muskegon County, MI. Myrtle Beach-Conway-North Myrtle Beach, SC	0.8810	0.9048
34900	Horry County, SC. Napa, CA	1.3374	1.2699
34940	Napa County, CA. Naples-Marco Island, FL	0.9941	0.9953
34980	Collier County, FL. Nashville-Davidson—Murfreesboro, TN	0.9847	0.9878
35004	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.	1.2662	1.2130
35084	Nassau-Suffolk, NY	1.1892	1.1514
35300	Nassau County, NY. Suffolk County, NY. Newark-Union, NJ-PA	1.1953	1.1562
35380	Essex County, NJ. Hunterdon County, NJ. Morris County, NJ. Sussex County, NJ. Union County, NJ. Pike County, PA. New Haven-Milford, CT	0.8831	0.9065
	New Haven County, CT. New Orleans-Metairie-Kenner, LA		
	Jefferson Parish, LA. Orleans Parish, LA. Plaquemines Parish, LA. St. Bernard Parish, LA. St. Charles Parish, LA.		

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2007 THROUGH JUNE 30, 2008 ¹—Continued

CBSA code	Urban area (constituent counties)	Full wage index ²	4/5ths wage index ³
35644	St. John the Baptist Parish, LA. St. Tammany Parish, LA. New York-White Plains-Wayne, NY-NJ	1.3177	1.2542
	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.		
35660	Niles-Benton Harbor, MI	0.8915	0.9132
	Berrien County, MI.		
35980	Norwich-New London, CT	1.1932	1.1546
	New London County, CT.		
36084	Oakland-Fremont-Hayward, CA	1.5819	1.4655
	Alameda County, CA. Contra Costa County, CA.		
36100	Ocala, FL	0.8867	0.9094
	Marion County, FL.		
36140	Ocean City, NJ	1.0472	1.0378
	Cape May County, NJ.		
36220	Odessa, TX	1.0073	1.0058
	Ector County, TX.		
36260	Ogden-Clearfield, UT	0.8995	0.9196
	Davis County, UT. Morgan County, UT. Weber County, UT.		
36420	Oklahoma City, OK	0.8843	0.9074
	Canadian County, OK. Cleveland County, OK. Grady County, OK. Lincoln County, OK. Logan County, OK. McClain County, OK. Oklahoma County, OK.		
36500	Olympia, WA	1.1081	1.0865
	Thurston County, WA.		
36540	Omaha-Council Bluffs, NE-IA	0.9450	0.9560
	Harrison County, IA. Mills County, IA. Pottawattamie County, IA. Cass County, NE. Douglas County, NE. Sarpy County, NE. Saunders County, NE. Washington County, NE.		
36740	Orlando-Kissimmee, FL	0.9452	0.9562
	Lake County, FL. Orange County, FL. Osceola County, FL. Seminole County, FL.		
36780	Oshkosh-Neenah, WI	0.9315	0.9452
	Winnebago County, WI.		
36980	Owensboro, KY	0.8748	0.8998
	Daviess County, KY. Hancock County, KY. McLean County, KY.		
37100	Oxnard-Thousand Oaks-Ventura, CA	1.1546	1.1237
	Ventura County, CA.		
37340	Palm Bay-Melbourne-Titusville, FL	0.9443	0.9554
	Brevard County, FL.		
37460	Panama City-Lynn Haven, FL	0.8027	0.8422
	Bay County, FL.		
37620	Parkersburg-Marietta-Vienna, WV-OH	0.7977	0.8382
	Washington County, OH.		

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2007 THROUGH JUNE 30, 2008 ¹—Continued

CBSA code	Urban area (constituent counties)	Full wage index ²	4/5ths wage index ³
37700	Pleasants County, WV. Wirt County, WV. Wood County, WV. Pascagoula, MS	0.8215	0.8572
37860	George County, MS. Jackson County, MS. Pensacola-Ferry Pass-Brent, FL	0.8000	0.8400
37900	Escambia County, FL. Santa Rosa County, FL. Peoria, IL	0.8982	0.9186
37964	Marshall County, IL. Peoria County, IL. Stark County, IL. Tazewell County, IL. Woodford County, IL. Philadelphia, PA	1.0996	1.0797
38060	Bucks County, PA. Chester County, PA. Delaware County, PA. Montgomery County, PA. Philadelphia County, PA. Phoenix-Mesa-Scottsdale, AZ	1.0287	1.0230
38220	Maricopa County, AZ. Pinal County, AZ. Pine Bluff, AR	0.8383	0.8706
38300	Cleveland County, AR. Jefferson County, AR. Lincoln County, AR. Pittsburgh, PA	0.8674	0.8939
38340	Allegheny County, PA. Armstrong County, PA. Beaver County, PA. Butler County, PA. Fayette County, PA. Washington County, PA. Westmoreland County, PA. Pittsfield, MA	1.0266	1.0213
38540	Berkshire County, MA. Pocatello, ID	0.9400	0.9520
38660	Bannock County, ID. Power County, ID. Ponce, PR	0.4842	0.5874
38860	Juana Díaz Municipio, PR. Ponce Municipio, PR. Villalba Municipio, PR. Portland-South Portland-Biddeford, ME	0.9908	0.9926
38900	Cumberland County, ME. Sagadahoc County, ME. York County, ME. Portland-Vancouver-Beaverton, OR-WA	1.1416	1.1133
38940	Clackamas County, OR. Columbia County, OR. Multnomah County, OR. Washington County, OR. Yamhill County, OR. Clark County, WA. Skamania County, WA. Port St. Lucie-Fort Pierce, FL	0.9833	0.9866
39100	Martin County, FL. St. Lucie County, FL. Poughkeepsie-Newburgh-Middletown, NY	1.0911	1.0729
39140	Dutchess County, NY. Orange County, NY. Prescott, AZ	0.9836	0.9869
39300	Yavapai County, AZ. Providence-New Bedford-Fall River, RI-MA	1.0783	1.0626
	Bristol County, MA. Bristol County, RI. Kent County, RI.		

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2007 THROUGH JUNE 30, 2008 ¹—Continued

CBSA code	Urban area (constituent counties)	Full wage index ²	4/5ths wage index ³
39340	Newport County, RI. Providence County, RI. Washington County, RI. Provo-Orem, UT Juab County, UT. Utah County, UT.	0.9537	0.9630
39380	Pueblo, CO Pueblo County, CO.	0.8753	0.9002
39460	Punta Gorda, FL Charlotte County, FL.	0.9405	0.9524
39540	Racine, WI Racine County, WI.	0.9356	0.9485
39580	Raleigh-Cary, NC Franklin County, NC. Johnston County, NC. Wake County, NC.	0.9864	0.9891
39660	Rapid City, SD Meade County, SD. Pennington County, SD.	0.8833	0.9066
39740	Reading, PA Berks County, PA.	0.9622	0.9698
39820	Redding, CA Shasta County, CA.	1.3198	1.2558
39900	Reno-Sparks, NV Storey County, NV. Washoe County, NV.	1.1963	1.1570
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.	0.9177	0.9342
40140	Riverside-San Bernardino-Ontario, CA Riverside County, CA. San Bernardino County, CA.	1.0904	1.0723
40220	Roanoke, VA Botetourt County, VA. Craig County, VA. Franklin County, VA. Roanoke County, VA. Roanoke City, VA. Salem City, VA.	0.8647	0.8918
40340	Rochester, MN Dodge County, MN. Olmsted County, MN. Wabasha County, MN.	1.1408	1.1126
40380	Rochester, NY Livingston County, NY. Monroe County, NY. Ontario County, NY. Orleans County, NY. Wayne County, NY.	0.8994	0.9195
40420	Rockford, IL Boone County, IL.	0.9989	0.9991

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2007 THROUGH JUNE 30, 2008 ¹—Continued

CBSA code	Urban area (constituent counties)	Full wage index ²	4/5ths wage index ³
40484	Winnebago County, IL. Rockingham County—Strafford County, NH Rockingham County, NH. Strafford County, NH.	1.0159	1.0127
40580	Rocky Mount, NC Edgecombe County, NC. Nash County, NC.	0.8854	0.9083
40660	Rome, GA Floyd County, GA.	0.9193	0.9354
40900	Sacramento—Arden-Arcade—Roseville, CA El Dorado County, CA. Placer County, CA. Sacramento County, CA. Yolo County, CA.	1.3372	1.2698
40980	Saginaw—Saginaw Township North, MI Saginaw County, MI.	0.8874	0.9099
41060	St. Cloud, MN Benton County, MN. Stearns County, MN.	1.0362	1.0290
41100	St. George, UT Washington County, UT.	0.9265	0.9412
41140	St. Joseph, MO-KS Doniphan County, KS. Andrew County, MO. Buchanan County, MO. DeKalb County, MO.	1.0118	1.0094
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.	0.9005	0.9204
41420	Salem, OR Marion County, OR. Polk County, OR.	1.0438	1.0350
41500	Salinas, CA Monterey County, CA.	1.4337	1.3470
41540	Salisbury, MD Somerset County, MD. Wicomico County, MD.	0.8953	0.9162
41620	Salt Lake City, UT Salt Lake County, UT. Summit County, UT. Tooele County, UT.	0.9402	0.9522
41660	San Angelo, TX Irion County, TX. Tom Green County, TX.	0.8362	0.8690
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.	0.8844	0.9075
41740	San Diego—Carlsbad—San Marcos, CA	1.1354	1.1083

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2007 THROUGH JUNE 30, 2008 ¹—Continued

CBSA code	Urban area (constituent counties)	Full wage index ²	4/5ths wage index ³
41780	San Diego County, CA. Sandusky, OH	0.9302	0.9442
41884	Erie County, OH. San Francisco-San Mateo-Redwood City, CA	1.5165	1.4132
41900	Marin County, CA. San Francisco County, CA. San Mateo County, CA. San Germán-Cabo Rojo, PR	0.4885	0.5908
41940	Cabo Rojo Municipio, PR. Lajas Municipio, PR. Sabana Grande Municipio, PR. San Germán Municipio, PR. San Jose-Sunnyvale-Santa Clara, CA	1.5543	1.4434
41980	San Benito County, CA. Santa Clara County, CA. San Juan-Caguas-Guaynabo, PR	0.4452	0.5562
	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. Comerio Municipio, PR. Corozal Municipio, PR. Dorado Municipio, PR. Florida Municipio, PR. Guaynabo Municipio, PR. Gurabo Municipio, PR. Hatillo Municipio, PR. Humacao Municipio, PR. Juncos Municipio, PR. Las Piedras Municipio, PR. Loíza Municipio, PR. Manatí Municipio, PR. Maunabo Municipio, PR. Morovis Municipio, PR. Naguabo Municipio, PR. Naranjito Municipio, PR. Orocovis Municipio, PR. Quebradillas Municipio, PR. Río Grande Municipio, PR. San Juan Municipio, PR. San Lorenzo Municipio, PR. Toa Alta Municipio, PR. Toa Baja Municipio, PR. Trujillo Alto Municipio, PR. Vega Alta Municipio, PR. Vega Baja Municipio, PR. Yabucoa Municipio, PR.		
42020	San Luis Obispo-Paso Robles, CA	1.1598	1.1278
42044	San Luis Obispo County, CA. Santa Ana-Anaheim-Irvine, CA	1.1473	1.1178
42060	Orange County, CA. Santa Barbara-Santa Maria, CA	1.1091	1.0873
42100	Santa Barbara County, CA. Santa Cruz-Watsonville, CA	1.5457	1.4366
42140	Santa Cruz County, CA. Santa Fe, NM	1.0824	1.0659
42220	Santa Fe County, NM. Santa Rosa-Petaluma, CA	1.4464	1.3571
	Sonoma County, CA.		

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2007 THROUGH JUNE 30, 2008 ¹—Continued

CBSA code	Urban area (constituent counties)	Full wage index ²	4/5ths wage index ³
42260	Sarasota-Bradenton-Venice, FL Manatee County, FL. Sarasota County, FL.	0.9868	0.9894
42340	Savannah, GA Bryan County, GA. Chatham County, GA. Effingham County, GA.	0.9351	0.9481
42540	Scranton—Wilkes-Barre, PA Lackawanna County, PA. Luzerne County, PA. Wyoming County, PA.	0.8347	0.8678
42644	Seattle-Bellevue-Everett, WA King County, WA. Snohomish County, WA.	1.1434	1.1147
42680	Sebastian-Vero Beach, FL Indian River County, FL.	0.9573	0.9658
43100	Sheboygan, WI Sheboygan County, WI.	0.9026	0.9221
43300	Sherman-Denison, TX Grayson County, TX.	0.8502	0.8802
43340	Shreveport-Bossier City, LA Bossier Parish, LA. Caddo Parish, LA. De Soto Parish, LA.	0.8865	0.9092
43580	Sioux City, IA-NE-SD Woodbury County, IA. Dakota County, NE. Dixon County, NE. Union County, SD.	0.9200	0.9360
43620	Sioux Falls, SD Lincoln County, SD. McCook County, SD. Minnehaha County, SD. Turner County, SD.	0.9559	0.9647
43780	South Bend-Mishawaka, IN-MI St. Joseph County, IN. Cass County, MI.	0.9842	0.9874
43900	Spartanburg, SC Spartanburg County, SC.	0.9174	0.9339
44060	Spokane, WA Spokane County, WA.	1.0447	1.0358
44100	Springfield, IL Menard County, IL. Sangamon County, IL.	0.8890	0.9112
44140	Springfield, MA Franklin County, MA. Hampden County, MA. Hampshire County, MA.	1.0079	1.0063
44180	Springfield, MO Christian County, MO. Dallas County, MO. Greene County, MO. Polk County, MO. Webster County, MO.	0.8469	0.8775
44220	Springfield, OH Clark County, OH.	0.8593	0.8874
44300	State College, PA Centre County, PA.	0.8784	0.9027
44700	Stockton, CA San Joaquin County, CA.	1.1442	1.1154
44940	Sumter, SC Sumter County, SC.	0.8083	0.8466
45060	Syracuse, NY Madison County, NY. Onondaga County, NY. Oswego County, NY.	0.9691	0.9753
45104	Tacoma, WA Pierce County, WA.	1.0789	1.0631
45220	Tallahassee, FL	0.8942	0.9154

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2007 THROUGH JUNE 30, 2008 ¹—Continued

CBSA code	Urban area (constituent counties)	Full wage index ²	4/5ths wage index ³
45300	Gadsden County, FL. Jefferson County, FL. Leon County, FL. Wakulla County, FL. Tampa-St. Petersburg-Clearwater, FL	0.9144	0.9315
45460	Hernando County, FL. Hillsborough County, FL. Pasco County, FL. Pinellas County, FL. Terre Haute, IN	0.8765	0.9012
45500	Clay County, IN. Sullivan County, IN. Vermillion County, IN. Vigo County, IN. Texarkana, TX-Texarkana, AR	0.8104	0.8483
45780	Miller County, AR. Bowie County, TX. Toledo, OH	0.9586	0.9669
45820	Fulton County, OH. Lucas County, OH. Ottawa County, OH. Wood County, OH. Topeka, KS	0.8730	0.8984
45940	Jackson County, KS. Jefferson County, KS. Osage County, KS. Shawnee County, KS. Wabaunsee County, KS. Trenton-Ewing, NJ	1.0835	1.0668
46060	Mercer County, NJ. Tucson, AZ	0.9202	0.9362
46140	Pima County, AZ. Tulsa, OK	0.8103	0.8482
46220	Creek County, OK. Okmulgee County, OK. Osage County, OK. Pawnee County, OK. Rogers County, OK. Tulsa County, OK. Wagoner County, OK. Tuscaloosa, AL	0.8542	0.8834
46340	Greene County, AL. Hale County, AL. Tuscaloosa County, AL. Tyler, TX	0.8811	0.9049
46540	Smith County, TX. Utica-Rome, NY	0.8396	0.8717
46660	Herkimer County, NY. Oneida County, NY. Valdosta, GA	0.8369	0.8695
46700	Brooks County, GA. Echols County, GA. Lanier County, GA. Lowndes County, GA. Vallejo-Fairfield, CA	1.5137	1.4110
47020	Solano County, CA. Victoria, TX	0.8560	0.8848
47220	Calhoun County, TX. Goliad County, TX. Victoria County, TX. Vineland-Millville-Bridgeton, NJ	0.9832	0.9866
47260	Cumberland County, NJ. Virginia Beach-Norfolk-Newport News, VA-NC	0.8790	0.9032
	Currituck County, NC. Gloucester County, VA. Isle of Wight County, VA. James City County, VA. Mathews County, VA. Surry County, VA.		

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2007 THROUGH JUNE 30, 2008 ¹—Continued

CBSA code	Urban area (constituent counties)	Full wage index ²	4/5ths wage index ³
	York County, VA. Chesapeake City, VA. Hampton City, VA. Newport News City, VA. Norfolk City, VA. Poquoson City, VA. Portsmouth City, VA. Suffolk City, VA. Virginia Beach City, VA. Williamsburg City, VA.		
47300	Visalia-Porterville, CA Tulare County, CA.	0.9968	0.9974
47380	Waco, TX McLennan County, TX.	0.8633	0.8906
47580	Warner Robins, GA Houston County, GA.	0.8380	0.8704
47644	Warren-Troy-Farmington Hills, MI Lapeer County, MI. Livingston County, MI. Macomb County, MI. Oakland County, MI. St. Clair County, MI.	1.0054	1.0043
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.	1.1054	1.0843
47940	Waterloo-Cedar Falls, IA Black Hawk County, IA. Bremer County, IA. Grundy County, IA.	0.8408	0.8726
48140	Wausau, WI Marathon County, WI.	0.9722	0.9778
48260	Weirton-Steubenville, WV-OH Jefferson County, OH. Brooke County, WV. Hancock County, WV.	0.8063	0.8450
48300	Wenatchee, WA Chelan County, WA. Douglas County, WA.	1.0346	1.0277
48424	West Palm Beach-Boca Raton-Boynton Beach, FL Palm Beach County, FL.	0.9649	0.9719
48540	Wheeling, WV-OH Belmont County, OH. Marshall County, WV. Ohio County, WV.	0.7010	0.7608
48620	Wichita, KS Butler County, KS. Harvey County, KS. Sedgwick County, KS. Sumner County, KS.	0.9063	0.9250
48660	Wichita Falls, TX Archer County, TX.	0.8311	0.8649

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2007 THROUGH JUNE 30, 2008¹—Continued

CBSA code	Urban area (constituent counties)	Full wage index ²	4/5ths wage index ³
48700	Clay County, TX. Wichita County, TX. Williamsport, PA	0.8139	0.8511
48864	Lycoming County, PA. Wilmington, DE-MD-NJ	1.0684	1.0547
48900	New Castle County, DE. Cecil County, MD. Salem County, NJ. Wilmington, NC	0.9835	0.9868
49020	Brunswick County, NC. New Hanover County, NC. Pender County, NC. Winchester, VA-WV	1.0091	1.0073
49180	Frederick County, VA. Winchester City, VA. Hampshire County, WV. Winston-Salem, NC	0.9276	0.9421
49340	Davie County, NC. Forsyth County, NC. Stokes County, NC. Yadkin County, NC. Worcester, MA	1.0722	1.0578
49420	Worcester County, MA. Yakima, WA	0.9847	0.9878
49500	Yakima County, WA. Yauco, PR	0.3854	0.5083
49620	Guánica Municipio, PR. Guayanilla Municipio, PR. Peñuelas Municipio, PR. Yauco Municipio, PR. York-Hanover, PA	0.9397	0.9518
49660	York County, PA. Youngstown-Warren-Boardman, OH-PA	0.8802	0.9042
49700	Mahoning County, OH. Trumbull County, OH. Mercer County, PA. Yuba City, CA	1.0730	1.0584
49740	Sutter County, CA. Yuba County, CA. Yuma, AZ	0.9109	0.9287
	Yuma County, AZ.		

¹ As discussed in section IV.D.1.d. of the preamble of this proposed rule, because there will no longer be any LTCHs in their cost reporting periods that began during FYs 2003, 2004 or 2005 (the first 3 years of the 5-year wage index phase-in, respectively), we are no longer showing the 1/5th, 2/5ths and 3/5ths wage index value. For further details on the 5-year phase-in of the wage index, see section IV.D.1. of this proposed rule.

² The wage index values are calculated using the same wage data used to compute the wage index used by acute care hospitals under the IPPS for Federal FY 2007 (that is, fiscal year 2003 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 Four-fifths of the proposed full wage index value, applicable for a LTCH's cost reporting period beginning on or after October 1, 2005 through September 30, 2006 (Federal FY 2006). That is, for a LTCH's cost reporting period that begins during Federal FY 2006 and located in Chicago, Illinois (CBSA 16974), the 4/5ths wage index value is computed as $((4 \times 1.0751) + 1) / 5 = 1.0601$. For further details on the 5-year phase-in of the wage index, see section IV.D.1. of this proposed rule.

TABLE 2.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR RURAL AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2007 THROUGH JUNE 30, 2008¹

CBSA code	Nonurban area	Full wage index ²	4/5ths wage index ³
01	Alabama	0.7591	0.8073
02	Alaska	1.0661	1.0529
03	Arizona	0.8908	0.9126
04	Arkansas	0.7307	0.7846
05	California	1.1454	1.1163
06	Colorado	0.9325	0.9460
07	Connecticut	1.1709	1.1367
08	Delaware	0.9705	0.9764
10	Florida	0.8594	0.8875
11	Georgia	0.7593	0.8074

TABLE 2.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR RURAL AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2007 THROUGH JUNE 30, 2008 ¹—Continued

CBSA code	Nonurban area	Full wage index ²	4/5ths wage index ³
12	Hawaii	1.0448	1.0358
13	Idaho	0.8120	0.8496
14	Illinois	0.8320	0.8656
15	Indiana	0.8538	0.8830
16	Iowa	0.8681	0.8945
17	Kansas	0.7998	0.8398
18	Kentucky	0.7768	0.8214
19	Louisiana	0.7438	0.7950
20	Maine	0.8443	0.8754
21	Maryland	0.8926	0.9141
22	Massachusetts ⁴		
23	Michigan	0.9062	0.9250
24	Minnesota	0.9153	0.9322
25	Mississippi	0.7738	0.8190
26	Missouri	0.7927	0.8342
27	Montana	0.8590	0.8872
28	Nebraska	0.8677	0.8942
29	Nevada	0.8944	0.9155
30	New Hampshire	1.0853	1.0682
31	New Jersey ⁴		
32	New Mexico	0.8332	0.8666
33	New York	0.8232	0.8586
34	North Carolina	0.8588	0.8870
35	North Dakota	0.7215	0.7772
36	Ohio	0.8658	0.8926
37	Oklahoma	0.7629	0.8103
38	Oregon	0.9753	0.9802
39	Pennsylvania	0.8320	0.8656
40	Puerto Rico ⁴		
41	Rhode Island ⁴		
42	South Carolina	0.8566	0.8853
43	South Dakota	0.8480	0.8784
44	Tennessee	0.7827	0.8262
45	Texas	0.7965	0.8372
46	Utah	0.8140	0.8512
47	Vermont	0.9744	0.9795
49	Virginia	0.7940	0.8352
50	Washington	1.0263	1.0210
51	West Virginia	0.7607	0.8086
52	Wisconsin	0.9553	0.9642
53	Wyoming	0.9295	0.9436

¹ As discussed in section IV.D.1.d. of the preamble of this proposed rule, because there are no longer any LTCHs in their cost reporting periods that began during FYs 2003, 2004 or 2005 (the first 3 years of the 5-year wage index phase-in, respectively), we are no longer showing the 1/5th, 2/5ths and 3/5ths wage index value. For further details on the 5-year phase-in of the wage index, see section IV.D.1. of this proposed rule.

² The wage index values are calculated using the same wage data used to compute the wage index used by acute care hospitals under the IPPS for Federal FY 2007 (that is, fiscal year 2003 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 Four-fifths of the proposed full wage index value, applicable for a LTCH's cost reporting period beginning on or after October 1, 2005 through September 30, 2006 (Federal FY 2006). That is, for a LTCH's cost reporting period that begins during Federal FY 2006 and located in rural Illinois, the 4/5ths wage index value is computed as ((4*0.8320) + 1)/5 = 0.8656. For further details on the 5-year phase-in of the wage index, see section IV.D.1. of this proposed rule.

⁴ All counties within the State are classified as urban.

TABLE 3.—FY 2007 LTC—DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, FIVE-SIXTHS OF THE GEOMETRIC AVERAGE LENGTH OF STAY AND IPPS AVERAGE LENGTH OF STAY PLUS ONE STANDARD DEVIATION

LTC-DRG	Description	Relative weight	Geometric average length of stay	5/6ths of the geometric average length of stay	IPPS average length of stay plus one standard deviation*
1	⁵ CRANIOTOMY AGE >17 W CC	1.6835	37.1	30.9	16.1
2	⁶ CRANIOTOMY AGE >17 W/O CC	1.6835	37.1	30.9	7.1
3	⁶ CRANIOTOMY AGE 0–17	1.6835	37.1	30.9	20.1
6	⁶ CARPAL TUNNEL RELEASE	0.4175	17.0	14.2	4.8
7	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC.	1.2052	36.1	30.1	15.8
8	² PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC.	0.5594	21.0	17.5	4.2

TABLE 3.—FY 2007 LTC—DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, FIVE-SIXTHS OF THE GEOMETRIC AVERAGE LENGTH OF STAY AND IPPS AVERAGE LENGTH OF STAY PLUS ONE STANDARD DEVIATION—Continued

LTC—DRG	Description	Relative weight	Geometric average length of stay	5/6ths of the geometric average length of stay	IPPS average length of stay plus one standard deviation*
9	SPINAL DISORDERS & INJURIES	1.0424	34.0	28.3	9.7
10	NERVOUS SYSTEM NEOPLASMS W CC	0.6971	22.1	18.4	9.6
11	² NERVOUS SYSTEM NEOPLASMS W/O CC	0.5594	21.0	17.5	5.7
12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	0.6788	25.1	20.9	8.4
13	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	0.6003	23.1	19.3	7.4
14	INTRACRANIAL HEMORRHAGE OR CEREBRALINFARCTION	0.6772	24.9	20.8	8.6
15	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT.	0.7705	26.1	21.8	6.4
16	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	0.6978	23.1	19.3	10.1
17	² NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	0.5594	21.0	17.5	4.7
18	CRANIAL & PERIPHERAL NERVE DISORDERS W CC	0.7503	25.4	21.2	8.2
19	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	0.4512	19.5	16.3	5.3
21	³ VIRAL MENINGITIS	0.7819	23.9	19.9	9.9
22	³ HYPERTENSIVE ENCEPHALOPATHY	0.7819	23.9	19.9	7.9
23	NONTRAUMATIC STUPOR & COMA	1.0118	29.4	24.5	6.1
26	⁶ SEIZURE & HEADACHE AGE 0–17	0.5594	21.0	17.5	6.2
27	TRAUMATIC STUPOR & COMA, COMA >1 HR	0.9978	30.6	25.5	7.6
28	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W CC	0.7983	25.8	21.5	9.1
29	¹ TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC.	0.4175	17.0	14.2	5.0
30**	⁶ TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0–17	0.4175	17.0	14.2	2.0
31	¹ CONCUSSION AGE >17 W CC	0.4175	17.0	14.2	6.2
32	⁶ CONCUSSION AGE >17 W/O CC	0.4175	17.0	14.2	3.4
33**	⁶ CONCUSSION AGE 0–17	0.4175	17.0	14.2	1.6
34	OTHER DISORDERS OF NERVOUS SYSTEM W CC	0.7029	23.4	19.5	7.4
35	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	0.5080	21.1	17.6	4.7
36	⁶ RETINAL PROCEDURES	0.5594	21.0	17.5	2.7
37	⁶ ORBITAL PROCEDURES	0.5594	21.0	17.5	6.6
38	⁶ PRIMARY IRIS PROCEDURES	0.5594	21.0	17.5	4.3
39	⁶ LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	0.5594	21.0	17.5	3.1
40	⁶ EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	0.5594	21.0	17.5	6.7
41**	⁶ EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0–17 ..	0.5594	21.0	17.5	1.6
42	⁶ INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS.	0.5594	21.0	17.5	3.7
43	⁶ HYPHEMA	0.4175	17.0	14.2	4.6
44	³ ACUTE MAJOR EYE INFECTIONS	0.7819	23.9	19.9	7.4
45	¹ NEUROLOGICAL EYE DISORDERS	0.4175	17.0	14.2	4.6
46	² OTHER DISORDERS OF THE EYE AGE >17 W CC	0.5594	21.0	17.5	6.6
47	⁶ OTHER DISORDERS OF THE EYE AGE >17 W/O CC	0.4175	17.0	14.2	4.7
48**	⁶ OTHER DISORDERS OF THE EYE AGE 0–17	0.4175	17.0	14.2	2.9
49	⁶ MAJOR HEAD & NECK PROCEDURES	1.1625	29.5	24.6	7.1
50	⁶ SIALOADENECTOMY	1.1625	29.5	24.6	2.6
51	⁶ SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY.	1.1625	29.5	24.6	4.0
52	⁶ CLEFT LIP & PALATE REPAIR	1.1625	29.5	24.6	2.1
53	⁶ SINUS & MASTOID PROCEDURES AGE >17	1.1625	29.5	24.6	6.2
54**	⁶ SINUS & MASTOID PROCEDURES AGE 0–17	1.1625	29.5	24.6	3.2
55	⁴ MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES.	1.1625	29.5	24.6	4.3
56	⁶ RHINOPLASTY	1.1625	29.5	24.6	4.1
57	⁶ T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17.	0.4175	17.0	14.2	4.9
58**	⁶ T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17.	0.4175	17.0	14.2	1.5
59	⁶ TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	0.4175	17.0	14.2	3.6
60	⁶ TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17.	0.4175	17.0	14.2	2.7
61	⁶ MYRINGOTOMY W TUBE INSERTION AGE >17	0.4175	17.0	14.2	10.2
62	⁶ MYRINGOTOMY W TUBE INSERTION AGE 0–17	0.4175	17.0	14.2	2.3
63	⁴ OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES.	1.1625	29.5	24.6	7.2
64	EAR, NOSE, MOUTH & THROAT MALIGNANCY	1.1797	26.2	21.8	10.2
65	¹ DYSEQUILIBRIUM	0.4175	17.0	14.2	4.2
66	⁶ EPISTAXIS	0.4175	17.0	14.2	4.8
67	³ EPIGLOTTITIS	0.7819	23.9	19.9	5.8
68	OTITIS MEDIA & URI AGE >17 W CC	0.6211	20.3	16.9	5.9

TABLE 3.—FY 2007 LTC—DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, FIVE-SIXTHS OF THE GEOMETRIC AVERAGE LENGTH OF STAY AND IPPS AVERAGE LENGTH OF STAY PLUS ONE STANDARD DEVIATION—Continued

LTC—DRG	Description	Relative weight	Geometric average length of stay	5/6ths of the geometric average length of stay	IPPS average length of stay plus one standard deviation*
69	¹ OTITIS MEDIA & URI AGE >17 W/O CC	0.4175	17.0	14.2	4.5
70	⁶ OTITIS MEDIA & URI AGE 0–17	0.4175	17.0	14.2	3.6
71	⁶ LARYNGOTRACHEITIS	0.5594	21.0	17.5	6.7
72	³ NASAL TRAUMA & DEFORMITY	0.7819	23.9	19.9	5.2
73	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17.	0.7745	22.9	19.1	6.9
74	⁶ OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0–17.	0.4175	17.0	14.2	3.9
75	MAJOR CHEST PROCEDURES	1.9944	33.5	27.9	15.4
76	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.3982	42.5	35.4	17.2
77	² OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	0.5594	21.0	17.5	7.4
78	PULMONARY EMBOLISM	0.6746	22.6	18.8	9.4
79	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC.	0.8182	22.8	19.0	12.9
80	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC.	0.6485	20.9	17.4	8.3
81	⁶ RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0–17	0.4175	17.0	14.2	10.1
82	RESPIRATORY NEOPLASMS	0.8242	21.4	17.8	11.0
83	¹ MAJOR CHEST TRAUMA W CC	0.4175	17.0	14.2	8.2
84	⁶ MAJOR CHEST TRAUMA W/O CC	0.4175	17.0	14.2	4.8
85	PLEURAL EFFUSION W CC	0.6956	21.4	17.8	9.9
86	⁶ PLEURAL EFFUSION W/O CC	0.4175	17.0	14.2	5.5
87	PULMONARY EDEMA & RESPIRATORY FAILURE	1.0295	24.8	20.7	10.3
88	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	0.6411	19.3	16.1	7.5
89	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	0.6802	20.6	17.2	8.6
90	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	0.4958	17.8	14.8	5.6
91	⁶ SIMPLE PNEUMONIA & PLEURISY AGE 0–17	0.5594	21.0	17.5	5.3
92	INTERSTITIAL LUNG DISEASE W CC	0.6638	19.6	16.3	9.4
93	¹ INTERSTITIAL LUNG DISEASE W/O CC	0.4175	17.0	14.2	5.9
94	PNEUMOTHORAX W CC	0.6785	21.3	17.8	9.6
95	⁸ PNEUMOTHORAX W/O CC	0.6785	21.3	17.8	5.3
96	BRONCHITIS & ASTHMA AGE >17 W CC	0.6230	18.9	15.8	6.7
97	⁸ BRONCHITIS & ASTHMA AGE >17 W/O CC	0.6230	18.9	15.8	5.2
98	⁶ BRONCHITIS & ASTHMA AGE 0–17	0.5594	21.0	17.5	4.4
99	RESPIRATORY SIGNS & SYMPTOMS W CC	0.9381	24.6	20.5	4.8
100	³ RESPIRATORY SIGNS & SYMPTOMS W/O CC	0.7819	23.9	19.9	3.1
101	OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	0.8147	22.2	18.5	6.7
102	¹ OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	0.4175	17.0	14.2	3.9
103*** ..	⁷ HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM.	0.0000	0.0	0.0	0.0
104	⁶ CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W CARDIAC CATH.	1.1625	29.5	24.6	22.3
105	⁶ CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W/O CARDIAC CATH.	1.1625	29.5	24.6	15.0
106	⁶ CORONARY BYPASS W PTCA	1.1625	29.5	24.6	16.6
108	⁶ OTHER CARDIOTHORACIC PROCEDURES	1.1625	29.5	24.6	17.1
110	⁴ MAJOR CARDIOVASCULAR PROCEDURES W CC	1.1625	29.5	24.6	13.8
111	⁶ MAJOR CARDIOVASCULAR PROCEDURES W/O CC	1.1625	29.5	24.6	4.9
113	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE.	1.3942	36.1	30.1	20.5
114	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS.	1.2425	33.0	27.5	14.0
117	² CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT.	0.5594	21.0	17.5	6.7
118	³ CARDIAC PACEMAKER DEVICE REPLACEMENT	0.7819	23.9	19.9	4.6
119	³ VEIN LIGATION & STRIPPING	0.7819	23.9	19.9	8.8
120	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	1.0893	31.4	26.2	15.5
121	CIRCULATORY DISORDERS W AMI & MAJOR COMP, DISCHARGED ALIVE.	0.7451	22.4	18.7	10.1
122	² CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE.	0.5594	21.0	17.5	5.3
123	CIRCULATORY DISORDERS W AMI, EXPIRED	0.7858	17.0	14.2	7.6
124	⁴ CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG.	1.1625	29.5	24.6	7.0
125	¹ CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG.	0.4175	17.0	14.2	4.1

TABLE 3.—FY 2007 LTC—DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, FIVE-SIXTHS OF THE GEOMETRIC AVERAGE LENGTH OF STAY AND IPPS AVERAGE LENGTH OF STAY PLUS ONE STANDARD DEVIATION—Continued

LTC—DRG	Description	Relative weight	Geometric average length of stay	5/6ths of the geometric average length of stay	IPPS average length of stay plus one standard deviation*
126	ACUTE & SUBACUTE ENDOCARDITIS	0.8867	26.3	21.9	17.5
127	HEART FAILURE & SHOCK	0.6832	21.2	17.7	8.0
128	² DEEP VEIN THROMBOPHLEBITIS	0.5594	21.0	17.5	8.0
129	¹ CARDIAC ARREST, UNEXPLAINED	0.4175	17.0	14.2	3.5
130	PERIPHERAL VASCULAR DISORDERS W CC	0.6484	22.8	19.0	8.6
131	PERIPHERAL VASCULAR DISORDERS W/O CC	0.5267	21.0	17.5	5.9
132	ATHEROSCLEROSIS W CC	0.6621	20.7	17.3	4.3
133	² ATHEROSCLEROSIS W/O CC	0.5594	21.0	17.5	3.2
134	HYPERTENSION	0.4909	21.7	18.1	4.8
135	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC.	0.8014	23.8	19.8	6.8
136	¹ CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC.	0.4175	17.0	14.2	4.1
137**	⁶ CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0–17.	0.4175	17.0	14.2	3.3
138	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	0.6618	21.9	18.3	6.1
139	² CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC.	0.5594	21.0	17.5	3.7
140	¹ ANGINA PECTORIS	0.4175	17.0	14.2	3.6
141	SYNCOPE & COLLAPSE W CC	0.5891	22.1	18.4	5.3
142	⁸ SYNCOPE & COLLAPSE W/O CC	0.5891	22.1	18.4	3.8
143	¹ CHEST PAIN	0.4175	17.0	14.2	3.1
144	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	0.7715	22.1	18.4	9.6
145	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	0.4292	17.0	14.2	3.9
146	⁵ RECTAL RESECTION W CC	1.6835	37.1	30.9	14.6
147	⁶ RECTAL RESECTION W/O CC	0.7819	23.9	19.9	8.5
149	⁶ MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC ...	0.7819	23.9	19.9	8.1
150	⁵ PERITONEAL ADHESIOLYSIS W CC	1.6835	37.1	30.9	17.3
151	⁶ PERITONEAL ADHESIOLYSIS W/O CC	0.4175	17.0	14.2	8.2
152	⁵ MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.6835	37.1	30.9	12.0
153	⁶ MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC ...	1.6835	37.1	30.9	7.1
155	⁶ STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC.	1.6835	37.1	30.9	6.4
156	⁶ STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0–17.	1.6835	37.1	30.9	12.1
157	³ ANAL & STOMAL PROCEDURES W CC	0.7819	23.9	19.9	9.3
158	⁶ ANAL & STOMAL PROCEDURES W/O CC	0.7819	23.9	19.9	4.1
159	⁵ HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC.	1.6835	37.1	30.9	8.2
160	¹ HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC.	0.4175	17.0	14.2	4.1
161	⁶ INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC.	0.4175	17.0	14.2	7.3
162	⁶ INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC.	0.4175	17.0	14.2	3.1
163	⁶ HERNIA PROCEDURES AGE 0–17	0.4175	17.0	14.2	4.0
164	⁶ APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC.	0.7819	23.9	19.9	11.9
165	⁶ APPENDECTOMY W COMPLICATED PRINCIPALDIAG W/O CC.	0.7819	23.9	19.9	6.1
166	⁶ APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC.	0.7819	23.9	19.9	6.8
167	⁶ APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC.	0.7819	23.9	19.9	3.1
168	⁵ MOUTH PROCEDURES W CC	1.6835	37.1	30.9	7.7
169	⁶ MOUTH PROCEDURES W/O CC	0.5594	21.0	17.5	3.5
170	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	1.6163	35.8	29.8	18.0
171	³ OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC ..	0.7819	23.9	19.9	6.7
172	DIGESTIVE MALIGNANCY W CC	0.8497	21.8	18.2	11.1
173	² DIGESTIVE MALIGNANCY W/O CC	0.5594	21.0	17.5	5.6
174	G.I. HEMORRHAGE W CC	0.7149	22.9	19.1	7.2
175	² G.I. HEMORRHAGE W/O CC	0.5594	21.0	17.5	4.3
176	COMPLICATED PEPTIC ULCER	0.9514	24.8	20.7	8.0
177	² UNCOMPLICATED PEPTIC ULCER W CC	0.5594	21.0	17.5	6.8
178	⁶ UNCOMPLICATED PEPTIC ULCER W/O CC	0.4175	17.0	14.2	4.7
179	INFLAMMATORY BOWEL DISEASE	0.8157	23.3	19.4	9.1

TABLE 3.—FY 2007 LTC—DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, FIVE-SIXTHS OF THE GEOMETRIC AVERAGE LENGTH OF STAY AND IPPS AVERAGE LENGTH OF STAY PLUS ONE STANDARD DEVIATION—Continued

LTC—DRG	Description	Relative weight	Geometric average length of stay	5/6ths of the geometric average length of stay	IPPS average length of stay plus one standard deviation*
180	G.I. OBSTRUCTION W CC	0.9126	22.8	19.0	8.3
181	¹ G.I. OBSTRUCTION W/O CC	0.4175	17.0	14.2	5.1
182	ESOPHAGITIS, GASTROENT & MISC DIGESTDISORDERS AGE >17 W CC.	0.7866	21.8	18.2	6.4
183	¹ ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC.	0.4175	17.0	14.2	4.4
184	⁶ ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0–17.	0.4175	17.0	14.2	5.6
185	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17.	0.6634	23.2	19.3	7.2
186	⁶ DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0–17.	0.5594	21.0	17.5	5.0
187	⁶ DENTAL EXTRACTIONS & RESTORATIONS	0.5594	21.0	17.5	6.8
188	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	0.9596	24.4	20.3	8.5
189	² OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	0.5594	21.0	17.5	4.6
190	⁶ OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0–17	0.5594	21.0	17.5	5.1
191	⁵ PANCREAS, LIVER & SHUNT PROCEDURES W CC	1.6835	37.1	30.9	21.1
192	⁶ PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	1.6835	37.1	30.9	9.3
193	⁴ BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC.	1.1625	29.5	24.6	19.7
194	⁶ BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC.	1.1625	29.5	24.6	9.9
195	⁵ CHOLECYSTECTOMY W C.D.E. W CC	1.6835	37.1	30.9	16.2
196	⁶ CHOLECYSTECTOMY W C.D.E. W/O CC	1.1625	29.5	24.6	8.3
197	⁴ CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC.	1.1625	29.5	24.6	14.0
198	⁶ CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC.	1.1625	29.5	24.6	6.6
199	³ HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY.	0.7819	23.9	19.9	15.2
200	⁵ HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY.	1.6835	37.1	30.9	17.5
201	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES.	1.5802	28.8	24.0	22.6
202	CIRRHOSIS & ALCOHOLIC HEPATITIS	0.6011	20.2	16.8	9.9
203	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	0.7466	19.6	16.3	10.6
204	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	0.8853	22.1	18.4	8.5
205	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC.	0.6933	23.1	19.3	9.4
206	⁸ DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC.	0.6933	23.1	19.3	6.0
207	DISORDERS OF THE BILIARY TRACT W CC	0.7295	21.5	17.9	8.4
208	¹ DISORDERS OF THE BILIARY TRACT W/O CC	0.4175	17.0	14.2	4.6
210	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC.	1.4826	41.9	34.9	9.5
211	⁶ HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC.	1.6835	37.1	30.9	6.3
212	⁶ HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0–17.	1.6835	37.1	30.9	3.8
213	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS.	1.1871	33.5	27.9	15.2
216	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE.	1.2147	37.6	31.3	8.8
217	WND DEBRID & SKN GRFT EXCEPT HAND, FOR MUSCSKELET & CONN TISS DIS.	1.2414	36.5	30.4	20.4
218	⁵ LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W CC.	1.6835	37.1	30.9	8.4
219	⁶ LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W/O CC.	1.6835	37.1	30.9	4.8
220	⁶ LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE 0–17.	1.6835	37.1	30.9	10.5
223	⁴ MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC.	1.1625	29.5	24.6	5.1
224	¹ SHOULDER, ELBOW OR FOREARM PROC, EXC MAJOR JOINT PROC, W/O CC.	0.4175	17.0	14.2	2.8
225	FOOT PROCEDURES	0.9550	30.6	25.5	8.7

TABLE 3.—FY 2007 LTC—DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, FIVE-SIXTHS OF THE GEOMETRIC AVERAGE LENGTH OF STAY AND IPPS AVERAGE LENGTH OF STAY PLUS ONE STANDARD DEVIATION—Continued

LTC—DRG	Description	Relative weight	Geometric average length of stay	5/6ths of the geometric average length of stay	IPPS average length of stay plus one standard deviation*
226	SOFT TISSUE PROCEDURES W CC	1.0626	34.3	28.6	10.6
227	³ SOFT TISSUE PROCEDURES W/O CC	0.7819	23.9	19.9	4.0
228	³ MAJOR THUMB OR JOINT PROC,OR OTH HAND OR WRIST PROC W CC.	0.7819	23.9	19.9	6.7
229	⁶ HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC.	0.4175	17.0	14.2	3.8
230	⁵ LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR.	1.6835	37.1	30.9	8.8
232	⁵ ARTHROSCOPY	1.6835	37.1	30.9	4.1
233	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC.	1.1724	32.4	27.0	10.8
234	⁶ OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC.	0.4175	17.0	14.2	4.1
235	³ FRACTURES OF FEMUR	0.7819	23.9	19.9	7.4
236	FRACTURES OF HIP & PELVIS	0.6802	28.9	24.1	6.8
237	¹ SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH.	0.4175	17.0	14.2	5.9
238	OSTEOMYELITIS	0.8589	28.4	23.7	12.8
239	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY.	0.6031	20.6	17.2	9.6
240	CONNECTIVE TISSUE DISORDERS W CC	0.7134	22.4	18.7	10.3
241	¹ CONNECTIVE TISSUE DISORDERS W/O CC	0.4175	17.0	14.2	5.6
242	SEPTIC ARTHRITIS	0.7700	26.2	21.8	10.2
243	MEDICAL BACK PROBLEMS	0.6028	22.3	18.6	7.1
244	BONE DISEASES & SPECIFIC ARTHROPATHIES W CC	0.5516	22.0	18.3	7.0
245	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	0.4463	19.4	16.2	4.8
246	² NON-SPECIFIC ARTHROPATHIES	0.5594	21.0	17.5	5.6
247	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE.	0.4582	17.6	14.7	5.1
248	TENDONITIS, MYOSITIS & BURSITIS	0.7328	23.2	19.3	7.5
249	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE.	0.6370	24.0	20.0	6.2
250	¹ FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC.	0.4175	17.0	14.2	6.0
251	⁶ FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC.	0.4175	17.0	14.2	4.3
252**	⁶ FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0–17.	0.5594	21.0	17.5	1.8
253	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W CC.	0.5609	24.0	20.0	7.0
254	¹ FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W/O CC.	0.4175	17.0	14.2	4.7
255**	⁶ FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE 0–17.	0.5594	21.0	17.5	2.9
256	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES.	0.7132	23.6	19.7	7.9
257	⁵ TOTAL MASTECTOMY FOR MALIGNANCY W CC	1.6835	37.1	30.9	3.8
258	⁶ TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.7819	23.9	19.9	2.4
259	³ SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC	0.7819	23.9	19.9	4.1
260	⁶ SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.7819	23.9	19.9	1.9
261	² BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION.	0.5594	21.0	17.5	3.2
262	⁴ BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY.	1.1625	29.5	24.6	7.7
263	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC.	1.2748	38.0	31.7	16.9
264	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC.	0.8507	29.9	24.9	9.9
265	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC.	1.1019	30.2	25.2	10.7
266	³ SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC.	0.7819	23.9	19.9	4.7
267	⁶ PERIANAL & PILONIDAL PROCEDURES	0.7819	23.9	19.9	6.8
268	⁴ SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES.	1.1625	29.5	24.6	5.4
269	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.2075	34.7	28.9	13.4

TABLE 3.—FY 2007 LTC—DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, FIVE-SIXTHS OF THE GEOMETRIC AVERAGE LENGTH OF STAY AND IPPS AVERAGE LENGTH OF STAY PLUS ONE STANDARD DEVIATION—Continued

LTC—DRG	Description	Relative weight	Geometric average length of stay	5/6ths of the geometric average length of stay	IPPS average length of stay plus one standard deviation*
270	³ OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC	0.7819	23.9	19.9	5.7
271	SKIN ULCERS	0.8269	26.9	22.4	10.7
272	MAJOR SKIN DISORDERS W CC	0.6584	23.0	19.2	9.3
273	¹ MAJOR SKIN DISORDERS W/O CC	0.4175	17.0	14.2	5.9
274	MALIGNANT BREAST DISORDERS W CC	0.7231	21.8	18.2	10.1
275	⁶ MALIGNANT BREAST DISORDERS W/O CC	0.7819	23.9	19.9	5.2
276	² NON-MALIGNANT BREAST DISORDERS	0.5594	21.0	17.5	7.3
277	CELLULITIS AGE >17 W CC	0.6089	20.9	17.4	8.4
278	CELLULITIS AGE >17 W/O CC	0.4254	18.0	15.0	6.1
279	⁶ CELLULITIS AGE 0–17	0.4175	17.0	14.2	5.8
280	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC.	0.7148	24.1	20.1	6.3
281	² TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC.	0.5594	21.0	17.5	4.3
282**	⁶ TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0–17	0.5594	21.0	17.5	2.2
283	MINOR SKIN DISORDERS W CC	0.6876	23.1	19.3	7.2
284	² MINOR SKIN DISORDERS W/O CC	0.5594	21.0	17.5	4.6
285	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DISORDERS.	1.2418	31.6	26.3	16.0
286	⁶ ADRENAL & PITUITARY PROCEDURES	1.1625	29.5	24.6	8.0
287	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS.	1.0402	33.0	27.5	15.2
288	⁴ O.R. PROCEDURES FOR OBESITY	1.1625	29.5	24.6	5.4
289	⁶ PARATHYROID PROCEDURES	1.1625	29.5	24.6	3.3
290	⁶ THYROID PROCEDURES	1.1625	29.5	24.6	2.8
291	⁶ THYROID GLOSSAL PROCEDURES	1.1625	29.5	24.6	2.1
292	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	1.1549	32.0	26.7	16.9
293	⁸ OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC.	1.1549	32.0	26.7	7.8
294	DIABETES AGE >35	0.6958	23.9	19.9	6.7
295	² DIABETES AGE 0–35	0.5594	21.0	17.5	5.7
296	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC.	0.7092	22.3	18.6	7.3
297	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC.	0.4596	19.3	16.1	4.6
298	⁶ NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0–17	0.4175	17.0	14.2	5.3
299	³ INBORN ERRORS OF METABOLISM	0.7819	23.9	19.9	8.2
300	ENDOCRINE DISORDERS W CC	0.7004	23.7	19.8	9.3
301	² ENDOCRINE DISORDERS W/O CC	0.5594	21.0	17.5	5.2
302***	⁷ KIDNEY TRANSPLANT	0.0000	0.0	0.0	0.0
303	⁶ KIDNEY AND URETER PROCEDURES FOR NEOPLASM	0.7819	23.9	19.9	9.7
304	⁴ KIDNEY AND URETER PROCEDURES FOR NON-NEOPLASM W CC.	1.1625	29.5	24.6	13.4
305	⁶ KIDNEY AND URETER PROCEDURES FOR NON-NEOPLASM W/O CC.	0.7819	23.9	19.9	4.7
306	⁴ PROSTATECTOMY W CC	1.1625	29.5	24.6	9.1
307	⁶ PROSTATECTOMY W/O CC	1.1625	29.5	24.6	2.9
308	⁴ MINOR BLADDER PROCEDURES W CC	1.1625	29.5	24.6	8.6
309	⁶ MINOR BLADDER PROCEDURES W/O CC	1.1625	29.5	24.6	2.4
310	⁴ TRANSURETHRAL PROCEDURES W CC	1.1625	29.5	24.6	7.2
311	⁶ TRANSURETHRAL PROCEDURES W/O CC	1.1625	29.5	24.6	2.7
312	³ URETHRAL PROCEDURES, AGE >17 W CC	0.7819	23.9	19.9	8.0
313	⁶ URETHRAL PROCEDURES, AGE >17 W/O CC	0.7819	23.9	19.9	3.6
314	⁶ URETHRAL PROCEDURES, AGE 0–17	0.7819	23.9	19.9	360.4
315	OTHER KIDNEY & URINARY TRACT PROCEDURES	1.4016	33.9	28.3	11.1
316	RENAL FAILURE	0.8321	22.9	19.1	9.9
317	ADMIT FOR RENAL DIALYSIS	0.9102	24.4	20.3	5.4
318	KIDNEY & URINARY TRACT NEOPLASMS W CC	0.7565	21.0	17.5	9.8
319	⁶ KIDNEY & URINARY TRACT NEOPLASMS W/O CC	0.7819	23.9	19.9	3.9
320	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	0.6200	21.7	18.1	7.7
321	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC ..	0.4450	18.5	15.4	5.4
322	⁶ KIDNEY & URINARY TRACT INFECTIONS AGE 0–17	0.4175	17.0	14.2	5.2
323	¹ URINARY STONES W CC, &/OR ESW LITHOTRIPSY	0.4175	17.0	14.2	4.8
324	¹ URINARY STONES W/O CC	0.4175	17.0	14.2	2.7
325	² KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC.	0.5594	21.0	17.5	5.8

TABLE 3.—FY 2007 LTC—DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, FIVE-SIXTHS OF THE GEOMETRIC AVERAGE LENGTH OF STAY AND IPPS AVERAGE LENGTH OF STAY PLUS ONE STANDARD DEVIATION—Continued

LTC—DRG	Description	Relative weight	Geometric average length of stay	5/6ths of the geometric average length of stay	IPPS average length of stay plus one standard deviation*
326	⁶ KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC.	0.4175	17.0	14.2	3.9
327	⁶ KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0–17.	0.4175	17.0	14.2	2.8
328	⁶ URETHRAL STRICTURE AGE >17 W CC	0.5594	21.0	17.5	5.4
329	⁶ URETHRAL STRICTURE AGE >17 W/O CC	0.5594	21.0	17.5	2.4
330**	⁶ URETHRAL STRICTURE AGE 0–17	0.5594	21.0	17.5	1.6
331	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC.	0.7773	22.5	18.8	8.7
332	¹ OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC.	0.4175	17.0	14.2	4.8
333	⁶ OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0–17	0.4175	17.0	14.2	8.4
334	⁶ MAJOR MALE PELVIC PROCEDURES W CC	0.4175	17.0	14.2	6.1
335	¹ MAJOR MALE PELVIC PROCEDURES W/O CC	0.4175	17.0	14.2	3.7
336	⁴ TRANSURETHRAL PROSTATECTOMY W CC	1.1625	29.5	24.6	4.9
337	⁶ TRANSURETHRAL PROSTATECTOMY W/O CC	1.1625	29.5	24.6	2.6
338	³ TESTES PROCEDURES, FOR MALIGNANCY	0.7819	23.9	19.9	9.7
339	³ TESTES PROCEDURES, NON-MALIGNANCY AGE >17	0.7819	23.9	19.9	8.4
340**	⁶ TESTES PROCEDURES, NON-MALIGNANCY AGE 0–17	0.7819	23.9	19.9	2.4
341	⁵ PENIS PROCEDURES	1.6835	37.1	30.9	4.4
342	⁶ CIRCUMCISION AGE >17	0.7819	23.9	19.9	4.6
343**	⁶ CIRCUMCISION AGE 0–17	0.7819	23.9	19.9	1.7
344	³ OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY.	0.7819	23.9	19.9	3.9
345	⁴ OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY.	1.1625	29.5	24.6	8.6
346	³ MALIGNANCY, MALE REPRODUCTIVE SYSTEM, WCC	0.7819	23.9	19.9	9.6
347	¹ MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC	0.4175	17.0	14.2	4.2
348	² BENIGN PROSTATIC HYPERTROPHY W CC	0.5594	21.0	17.5	6.3
349	⁶ BENIGN PROSTATIC HYPERTROPHY W/O CC	0.7819	23.9	19.9	4.1
350	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	0.5606	21.0	17.5	7.0
351**	⁶ STERILIZATION, MALE	0.7819	23.9	19.9	1.3
352	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	0.8209	27.5	22.9	6.7
353	⁶ PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY.	1.1625	29.5	24.6	9.2
354	⁶ UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC.	1.1625	29.5	24.6	8.2
355	⁶ UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC.	1.1625	29.5	24.6	4.2
356	⁶ FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES.	1.1625	29.5	24.6	2.7
357	⁶ UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY.	1.1625	29.5	24.6	12.3
358	⁶ UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	1.1625	29.5	24.6	5.7
359	⁶ UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC.	1.1625	29.5	24.6	3.3
360	⁶ VAGINA, CERVIX & VULVA PROCEDURES	1.1625	29.5	24.6	3.7
361	⁶ LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	0.4175	17.0	14.2	4.5
362	⁶ ENDOSCOPIC TUBAL INTERRUPTION	0.4175	17.0	14.2	1.0
363	⁶ D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	0.4175	17.0	14.2	6.5
364	⁶ D&C, CONIZATION EXCEPT FOR MALIGNANCY	0.4175	17.0	14.2	6.1
365	⁴ OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES.	1.1625	29.5	24.6	13.0
366	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	0.9106	21.6	18.0	10.2
367	¹ MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	0.4175	17.0	14.2	4.6
368	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	0.7846	21.3	17.8	10.2
369	³ MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS.	0.7819	23.9	19.9	5.1
370	⁶ CESAREAN SECTION W CC	0.4175	17.0	14.2	7.0
371	⁶ CESAREAN SECTION W/O CC	0.4175	17.0	14.2	4.5
372	⁶ VAGINAL DELIVERY W COMPLICATING DIAGNOSES	0.4175	17.0	14.2	4.7
373	⁶ VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	0.4175	17.0	14.2	3.0
374	⁶ VAGINAL DELIVERY W STERILIZATION &/ORD&C	0.4175	17.0	14.2	4.1
375	⁶ VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C.	0.4175	17.0	14.2	11.0

TABLE 3.—FY 2007 LTC—DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, FIVE-SIXTHS OF THE GEOMETRIC AVERAGE LENGTH OF STAY AND IPPS AVERAGE LENGTH OF STAY PLUS ONE STANDARD DEVIATION—Continued

LTC—DRG	Description	Relative weight	Geometric average length of stay	5/6ths of the geometric average length of stay	IPPS average length of stay plus one standard deviation*
376	⁴ POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE.	1.1625	29.5	24.6	5.1
377	⁶ POSTPARTUM & POST ABORTION DIAGNOSES WO.R. PROCEDURE.	0.4175	17.0	14.2	7.2
378	⁶ ECTOPIC PREGNANCY	0.4175	17.0	14.2	3.2
379	⁶ THREATENED ABORTION	0.4175	17.0	14.2	4.8
380	⁶ ABORTION W/O D&C	0.4175	17.0	14.2	2.9
381	⁶ ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY.	0.4175	17.0	14.2	3.6
382	⁶ FALSE LABOR	0.4175	17.0	14.2	2.1
383	¹ OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS.	0.4175	17.0	14.2	5.6
384	⁶ OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS.	0.4175	17.0	14.2	3.6
385**	⁶ NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY.	0.4175	17.0	14.2	1.8
386**	⁶ EXTREME IMMATUREITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE.	0.4175	17.0	14.2	17.9
387**	⁶ PREMATURITY W MAJOR PROBLEMS	0.4175	17.0	14.2	13.3
388**	⁶ PREMATURITY W/O MAJOR PROBLEMS	0.4175	17.0	14.2	8.6
389	⁶ FULL TERM NEONATE W MAJOR PROBLEMS	0.4175	17.0	14.2	17.6
390**	⁶ NEONATE W OTHER SIGNIFICANT PROBLEMS	0.4175	17.0	14.2	3.4
391**	⁶ NORMAL NEWBORN	0.4175	17.0	14.2	3.1
392	⁶ SPLENECTOMY AGE >17	1.1625	29.5	24.6	14.5
393**	⁶ SPLENECTOMY AGE 0–17	1.1625	29.5	24.6	9.1
394	⁴ OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS.	1.1625	29.5	24.6	12.1
395	RED BLOOD CELL DISORDERS AGE >17	0.6651	21.9	18.3	6.5
396	⁶ RED BLOOD CELL DISORDERS AGE 0–17	0.4175	17.0	14.2	4.5
397	COAGULATION DISORDERS	0.8276	20.4	17.0	8.2
398	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	0.6278	20.8	17.3	8.8
399	¹ RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC.	0.4175	17.0	14.2	5.1
401	⁴ LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC.	1.1625	29.5	24.6	18.9
402	⁶ LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC.	0.5594	21.0	17.5	6.3
403	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	0.8846	23.9	19.9	13.2
404	³ LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	0.7819	23.9	19.9	6.6
405**	⁶ ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0–17.	0.7819	23.9	19.9	4.9
406	⁵ MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC.	1.6835	37.1	30.9	15.5
407	⁶ MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC.	1.1625	29.5	24.6	5.5
408	⁴ MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC.	1.1625	29.5	24.6	14.0
409	RADIO THERAPY	0.8416	23.2	19.3	9.5
410	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS.	1.2527	28.7	23.9	5.8
411	⁶ HISTORY OF MALIGNANCY W/O ENDOSCOPY	0.5594	21.0	17.5	3.3
412	⁶ HISTORY OF MALIGNANCY W ENDOSCOPY	0.5594	21.0	17.5	2.1
413	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC.	0.8429	21.4	17.8	11.0
414	³ OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC.	0.7819	23.9	19.9	6.4
417	⁶ SEPTICEMIA AGE 0–17	0.7819	23.9	19.9	10.5
418	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	0.7961	24.1	20.1	9.6
419	² FEVER OF UNKNOWN ORIGIN AGE >17 W CC	0.5594	21.0	17.5	6.8
420	² FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	0.5594	21.0	17.5	4.9
421	VIRAL ILLNESS AGE >17	0.7065	20.4	17.0	6.2
422	⁶ VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0–17	0.4175	17.0	14.2	5.6
423	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES ..	1.0426	23.2	19.3	13.2
424	⁵ O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS.	1.6835	37.1	30.9	19.7

TABLE 3.—FY 2007 LTC—DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, FIVE-SIXTHS OF THE GEOMETRIC AVERAGE LENGTH OF STAY AND IPPS AVERAGE LENGTH OF STAY PLUS ONE STANDARD DEVIATION—Continued

LTC—DRG	Description	Relative weight	Geometric average length of stay	5/6ths of the geometric average length of stay	IPPS average length of stay plus one standard deviation*
425	¹ ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYS-FUNCTION.	0.4175	17.0	14.2	5.3
426	DEPRESSIVE NEUROSES	0.4038	22.5	18.8	6.8
427	² NEUROSES EXCEPT DEPRESSIVE	0.5594	21.0	17.5	7.3
428	DISORDERS OF PERSONALITY & IMPULSE CONTROL	0.5183	24.5	20.4	11.4
429	ORGANIC DISTURBANCES & MENTAL RETARDATION	0.5326	24.0	20.0	8.5
430	PSYCHOSES	0.4024	23.1	19.3	12.6
431	² CHILDHOOD MENTAL DISORDERS	0.5594	21.0	17.5	10.1
432	¹ OTHER MENTAL DISORDER DIAGNOSES	0.4175	17.0	14.2	6.1
433	⁶ ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFTAMA	0.4175	17.0	14.2	4.2
439	SKIN GRAFTS FOR INJURIES	1.2203	36.0	30.0	13.6
440	WOUND DEBRIDEMENTS FOR INJURIES	1.2248	34.4	28.7	13.4
441	² HAND PROCEDURES FOR INJURIES	0.5594	21.0	17.5	5.2
442	OTHER O.R. PROCEDURES FOR INJURIES W CC	1.3670	34.9	29.1	14.5
443	⁶ OTHER O.R. PROCEDURES FOR INJURIES W/O CC	0.5594	21.0	17.5	5.6
444	TRAUMATIC INJURY AGE >17 W CC	0.6598	23.2	19.3	6.4
445	² TRAUMATIC INJURY AGE >17 W/O CC	0.5594	21.0	17.5	4.4
446**	⁶ TRAUMATIC INJURY AGE 0–17	0.5594	21.0	17.5	2.4
447	² ALLERGIC REACTIONS AGE >17	0.5594	21.0	17.5	3.9
448**	⁶ ALLERGIC REACTIONS AGE 0–17	0.5594	21.0	17.5	2.9
449	³ POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC	0.7819	23.9	19.9	5.8
450	² POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC.	0.5594	21.0	17.5	2.9
451	⁶ POISONING & TOXIC EFFECTS OF DRUGS AGE 0–17	0.7819	23.9	19.9	14.4
452	COMPLICATIONS OF TREATMENT W CC	0.9275	25.7	21.4	7.8
453	COMPLICATIONS OF TREATMENT W/O CC	0.5790	21.6	18.0	4.2
454	³ OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC	0.7819	23.9	19.9	6.5
455	⁶ OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC.	0.7819	23.9	19.9	3.4
461	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES.	1.1466	32.7	27.3	8.8
462	REHABILITATION	0.5823	22.1	18.4	14.8
463	SIGNS & SYMPTOMS W CC	0.6082	22.9	19.1	6.1
464	SIGNS & SYMPTOMS W/O CC	0.5831	24.3	20.3	4.5
465	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS.	0.6877	21.2	17.7	5.5
466	AFTERCARE W/O HISTORY OF MALIGNANCY AS SEC-ONDARY DIAGNOSIS.	0.6700	21.7	18.1	7.0
467	³ OTHER FACTORS INFLUENCING HEALTH STATUS	0.7819	23.9	19.9	4.0
468	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	2.1478	40.5	33.8	21.4
469***	⁷ PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAG-NOSIS.	0.0000	0.0	0.0	0.0
470***	⁷ UNGROUPABLE	0.0000	0.0	0.0	0.0
471	⁵ BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY.	1.6835	37.1	30.9	6.2
473	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	0.9917	25.3	21.1	21.4
476	⁵ PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	1.6835	37.1	30.9	17.7
477	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRIN-CIPAL DIAGNOSIS.	1.5119	35.9	29.9	14.8
479	² OTHER VASCULAR PROCEDURES W/O CC	0.5594	21.0	17.5	3.9
480***	⁷ LIVER TRANSPLANT AND/OR INTESTINAL TRANSPLANT	0.0000	0.0	0.0	0.0
481	⁶ BONE MARROW TRANSPLANT	1.1625	29.5	24.6	35.2
482	⁵ TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES	1.6835	37.1	30.9	17.6
484	⁵ CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	1.6835	37.1	30.9	23.1
485	⁶ LIMB REATTACHMENT, HIP & FEMUR PROC FOR MUL-TIPLE SIGNIFICANT TRAUMA.	1.1625	29.5	24.6	14.7
486	³ OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA.	0.7819	23.9	19.9	21.8
487	⁴ OTHER MULTIPLE SIGNIFICANT TRAUMA	1.1625	29.5	24.6	11.5
488	⁴ HIV W EXTENSIVE O.R. PROCEDURE	1.1625	29.5	24.6	29.6
489	HIV W MAJOR RELATED CONDITION	0.9436	22.1	18.4	13.3
490	HIV W OR W/O OTHER RELATED CONDITION	0.6456	20.3	16.9	8.5
491	⁵ MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY.	1.6835	37.1	30.9	4.5

TABLE 3.—FY 2007 LTC—DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, FIVE-SIXTHS OF THE GEOMETRIC AVERAGE LENGTH OF STAY AND IPPS AVERAGE LENGTH OF STAY PLUS ONE STANDARD DEVIATION—Continued

LTC—DRG	Description	Relative weight	Geometric average length of stay	5/6ths of the geometric average length of stay	IPPS average length of stay plus one standard deviation*
492	² CHEMO W ACUTE LEUKEMIA AS SDX OR W USE OF HIGH DOSE CHEMO AGENT.	0.5594	21.0	17.5	23.1
493	⁴ LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC ...	1.1625	29.5	24.6	9.8
494	⁶ LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	1.1625	29.5	24.6	4.2
495*** ..	⁷ LUNG TRANSPLANT	0.0000	0.0	0.0	0.0
496	⁴ COMBINED ANTERIOR/POSTERIOR SPINAL FUSION	1.1625	29.5	24.6	13.8
497	⁵ SPINAL FUSION EXCEPT CERVICAL W CC	1.6835	37.1	30.9	8.3
498	⁶ SPINAL FUSION EXCEPT CERVICAL W/O CC	1.6835	37.1	30.9	5.3
499	⁵ BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC.	1.6835	37.1	30.9	6.6
500	⁴ BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC.	1.1625	29.5	24.6	3.3
501	KNEE PROCEDURES W PDX OF INFECTION W CC	1.2164	33.3	27.8	15.4
502	³ KNEE PROCEDURES W PDX OF INFECTION W/O CC	0.7819	23.9	19.9	8.7
503	⁴ KNEE PROCEDURES W/O PDX OF INFECTION	1.1625	29.5	24.6	6.1
504	⁵ EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV 96+ HRS W SKIN GRAFT.	1.6835	37.1	30.9	48.4
505	⁵ EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV 96+ HRS W/O SKIN GRAFT.	1.6835	37.1	30.9	9.4
506	⁴ FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA.	1.1625	29.5	24.6	26.1
507	⁶ FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA.	0.4175	17.0	14.2	13.2
508	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ W CC OR SIG TRAUMA.	0.7588	25.6	21.3	12.1
509	¹ FULL THICKNESS BURN W/O SKIN GRFT OR INH INJ W/O CC OR SIG TRAUMA.	0.4175	17.0	14.2	8.6
510	NON-EXTENSIVE BURNS W CC OR SIGNIFICANT TRAUMA ..	0.6720	22.6	18.8	9.7
511	¹ NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA.	0.4175	17.0	14.2	5.7
512*** ..	⁷ SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT	0.0000	0.0	0.0	0.0
513*** ..	⁷ PANCREAS TRANSPLANT	0.0000	0.0	0.0	0.0
515	⁴ CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH ..	1.1625	29.5	24.6	5.9
518	⁶ PERCUTANEOUS CARDIOVASC PROC W/O CORONARY ARTERY STENT OR AMI.	0.4175	17.0	14.2	3.7
519	⁴ CERVICAL SPINAL FUSION W CC	1.1625	29.5	24.6	7.4
520	⁶ CERVICAL SPINAL FUSION W/O CC	1.6835	37.1	30.9	2.8
521	² ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	0.5594	21.0	17.5	8.4
522	⁶ ALCOHOL/DRUG ABUSE OR DEPENDENCE W REHABILITATION THERAPY W/O CC.	0.5594	21.0	17.5	16.7
523	¹ ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W/O CC.	0.4175	17.0	14.2	5.8
524	² TRANSIENT ISCHEMIA	0.5594	21.0	17.5	4.8
525	⁶ OTHER HEART ASSIST SYSTEM IMPLANT	1.6835	37.1	30.9	24.1
528	⁶ INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE.	1.6835	37.1	30.9	26.9
529	⁵ VENTRICULAR SHUNT PROCEDURES W CC	1.6835	37.1	30.9	11.7
530	⁶ VENTRICULAR SHUNT PROCEDURES W/O CC	1.6835	37.1	30.9	4.5
531	⁵ SPINAL PROCEDURES W CC	1.6835	37.1	30.9	15.5
532	³ SPINAL PROCEDURES W/O CC	0.7819	23.9	19.9	5.9
533	⁴ EXTRACRANIAL PROCEDURES W CC	1.1625	29.5	24.6	5.7
534	⁶ EXTRACRANIAL PROCEDURES W/O CC	1.1625	29.5	24.6	2.5
535	⁵ CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK.	1.6835	37.1	30.9	15.6
536	⁶ CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK.	1.1625	29.5	24.6	11.7
537	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXCEPT HIP & FEMUR W CC.	1.4672	39.9	33.3	10.8
538	⁴ LOCAL EXCISION & REMOVAL INT FIX DEVICES EXCEPT HIP & FEMUR W/O CC.	1.1625	29.5	24.6	4.5
539	⁴ LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W CC.	1.1625	29.5	24.6	18.1
540	⁶ LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W/O CC.	0.4175	17.0	14.2	5.6
541	ECMO OR TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	3.8893	58.1	48.4	65.8

TABLE 3.—FY 2007 LTC—DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, FIVE-SIXTHS OF THE GEOMETRIC AVERAGE LENGTH OF STAY AND IPPS AVERAGE LENGTH OF STAY PLUS ONE STANDARD DEVIATION—Continued

LTC—DRG	Description	Relative weight	Geometric average length of stay	5/6ths of the geometric average length of stay	IPPS average length of stay plus one standard deviation*
542	TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	2.8689	45.1	37.6	49.1
543	⁵ CRANIOTOMY W MAJOR DEVICE IMPLANT OR ACUTE COMPLEX CNS PDX.	1.6835	37.1	30.9	20.4
544	⁵ MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY.	1.6835	37.1	30.9	6.1
545	⁵ REVISION OF HIP OR KNEE REPLACEMENT	1.6835	37.1	30.9	7.4
546	⁶ SPINAL FUSION EXC CERV WITH CURVATURE OF THE SPINE OR MALIG.	1.6835	37.1	30.9	13.4
547	⁶ CORONARY BYPASS W CARDIAC CATH W MAJOR CV DX	1.1625	29.5	24.6	17.8
548	⁶ CORONARY BYPASS W CARDIAC CATH W/O MAJOR CV DX.	1.1625	29.5	24.6	12.0
549	⁶ CORONARY BYPASS W/O CARDIAC CATH W MAJOR CV DX.	1.1625	29.5	24.6	15.0
550	⁶ CORONARY BYPASS W/O CARDIAC CATH W/O MAJOR CV DX.	1.1625	29.5	24.6	9.3
551	PERMANENT CARDIAC PACEMAKER IMPL W MAJ CV DX OR AICD LEAD OR GNRTR.	1.6035	29.5	24.6	10.3
552	⁴ OTHER PERMANENT CARDIAC PACEMAKER IMPLANT W/O MAJOR CV DX.	1.1625	29.5	24.6	5.5
553	OTHER VASCULAR PROCEDURES W CC W MAJOR CV DX ..	1.5837	32.5	27.1	15.8
554	OTHER VASCULAR PROCEDURES W CC W/O MAJOR CV DX.	1.2817	31.6	26.3	9.3
555	³ PERCUTANEOUS CARDIOVASCULAR PROC W MAJOR CV DX.	0.7819	23.9	19.9	7.8
556	⁶ PERCUTANEOUS CARDIOVASC PROC W NON-DRUG-ELUTING STENT W/O MAJ CV DX.	0.4175	17.0	14.2	2.9
557	⁴ PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W MAJOR CV DX.	1.1625	29.5	24.6	6.5
558	⁶ PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W/O MAJ CV DX.	0.4175	17.0	14.2	2.6
559	⁶ ACUTE ISCHEMIC STROKE WITH USE OF THROMBOLYTIC AGENT.	0.7819	23.9	19.9	10.7
560	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM.	0.9308	25.5	21.3	16.9
561	NON-BACTERIAL INFECTIONS OF NERVOUS SYSTEM EXCEPT VIRAL MENINGITIS.	0.8145	22.3	18.6	15.5
562	SEIZURE AGE >17 W CC	0.6844	23.2	19.3	7.6
563	² SEIZURE AGE >17 W/O CC	0.5594	21.0	17.5	4.9
564	HEADACHES AGE >17	0.7565	24.1	20.1	5.3
565	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT 96+ HOURS.	2.0557	34.7	28.9	23.3
566	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT < 96 HOURS.	1.5445	27.4	22.8	13.2
567	⁵ STOMACH, ESOPHAGEAL & DUODENAL PROC AGE >17 W CC W MAJOR GI DX.	1.6835	37.1	30.9	25.4
568	⁵ STOMACH, ESOPHAGEAL & DUODENAL PROC AGE >17 W CC W/O MAJOR GI DX.	1.6835	37.1	30.9	19.2
569	⁵ MAJOR SMALL & LARGE BOWEL PROCEDURES W CC W MAJOR GI DX.	1.6835	37.1	30.9	22.5
570	⁵ MAJOR SMALL & LARGE BOWEL PROCEDURES W CC W/O MAJOR GI DX.	1.6835	37.1	30.9	14.9
571	MAJOR ESOPHAGEAL DISORDERS	0.8214	21.9	18.3	7.5
572	MAJOR GASTROINTESTINAL DISORDERS AND PERITONEAL INFECTIONS.	0.8505	23.3	19.4	11.0
573	⁵ MAJOR BLADDER PROCEDURES	1.6835	37.1	30.9	16.7
574	MAJOR HEMATOLOGIC/IMMUNOLOGIC DIAG EXC SICKLE CELL CRISIS & COAGUL.	0.8106	19.7	16.4	9.1
575	SEPTICEMIA W MV 96+ HOURS AGE >17	1.6583	27.8	23.2	24.4
576	SEPTICEMIA W/O MV 96+ HOURS AGE >17	0.7925	23.0	19.2	11.8
577	⁶ CAROTID ARTERY STENT PROCEDURE	1.1625	29.5	24.6	3.3
578	O. R. PROCEDURE W PDX EXC POSTOPERATIVE OR POST-TRAUMATIC INFECTION.	1.4849	35.7	29.8	26.5

TABLE 3.—FY 2007 LTC—DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, FIVE-SIXTHS OF THE GEOMETRIC AVERAGE LENGTH OF STAY AND IPPS AVERAGE LENGTH OF STAY PLUS ONE STANDARD DEVIATION—Continued

LTC—DRG	Description	Relative weight	Geometric average length of stay	5/6ths of the geometric average length of stay	IPPS average length of stay plus one standard deviation*
579	O. R. PROCEDURE W PDX OF POSTOPERATIVE OR POST-TRAUMATIC INFECTION.	1.2978	35.2	29.3	18.0

¹ Relative weights for these LTC-DRGs were determined by assigning these cases to low-volume quintile 1.
² Relative weights for these LTC-DRGs were determined by assigning these cases to low-volume quintile 2.
³ Relative weights for these LTC-DRGs were determined by assigning these cases to low-volume quintile 3.
⁴ Relative weights for these LTC-DRGs were determined by assigning these cases to low-volume quintile 4.
⁵ Relative weights for these LTC-DRGs were determined by assigning these cases to low-volume quintile 5.
⁶ Relative weights for these LTC-DRGs were determined by assigning these cases to the appropriate low volume quintile because they had no LTCH cases in the FY 2005 MedPAR file.
⁷ Relative weights for these LTC-DRGs were assigned a value of 0.0000.
⁸ Relative weights for these LTC-DRGs were determined after adjusting to account for nonmonotonicity (see step 5 above).
 * “IPPS Comparable Threshold” that could be used under the approach discussed for the short-stay outlier policy, as discussed in section V.A.2. of the preamble of this proposed rule.
 ** IPPS hospital statistical data for these LTC-DRGs would be supplemented due to a low volume of IPPS cases.
 *** Although IPPS hospital statistical data for these DRGs may be available, a value of zero for the “IPPS Comparable Threshold” would be assigned for these LTC-DRGs since the relative weights for these LTC-DRGs were assigned a value of 0.0000, as discussed in section III. of the preamble of this proposed rule.

Addendum B: Executive Summary of RTI’s Report (See http://www.cms.hhs.gov/LongTermCareHospitalPPS/02a_RTIREports.asp#TopOfPage for a Copy of the Entire Report)

ES.1 Overview of the Project Purpose

This project, “Long-Term Care Hospital (LTCH) Payment System Refinement/Evaluation,” will assist the Centers for Medicare & Medicaid Services (CMS) in developing criteria for assuring appropriate and cost-effective use of LTCHs in the Medicare program. The Medicare Payment Advisory Commission (MedPAC) recommended that CMS examine patient and facility-level criteria to identify and distinguish the role of these hospitals as a Medicare provider. This project evaluated these criteria and scanned the environment to identify feasible options for implementing these types of measures. CMS has been particularly interested in the factors that distinguish LTCHs from other acute care hospitals.

ES.2 The Project Approach

RTI completed this project in two phases. In Phase I, RTI prepared a background report for CMS summarizing existing information regarding LTCHs’ current role in the Medicare system: their history as Medicare participating providers, the types of patients they treat, the criteria Quality Improvement Organizations (QIO) currently use to review appropriateness of care in these settings, and the types of regulations they face as Medicare participating providers. This work reviewed prior analyses of these issues and included discussions with MedPAC, other researchers, CMS, the QIOs, and the hospital associations.

In Phase II, RTI collected additional information, including:

- An examination of tools currently used by the QIOs and the industry to assess patient appropriateness for admission;

- Analysis of claims to understand variations in the LTCH populations and differences between the LTCH populations and those treated in other acute hospitals, particularly those that received outlier payments for the longer stays;

- Administration of site visits at eight LTCHs and 1 acute hospital to interview providers regarding the differences between LTCH patients and those admitted to other hospitals or treated in parts of the country lacking LTCHs.

In recognition of the heterogeneity of LTCHs, RTI worked with each of the different associations, including the National Association of Long Term Hospitals (NALTH), the Acute Long Term Hospital Association (ALTHA), the American Hospital Association (AHA), and the American Medical Rehabilitation Providers Association (AMPRA), as well as several of the larger LTCH chains.

This report summarizes these efforts and makes recommendations to CMS regarding the types of criteria needed to distinguish LTCHs from other types of hospitals. These criteria will help define LTCH patients on the basis of patient care needs or different levels of care. They include both patient and facility-level measures. The report is organized in six sections:

- Section 1 summarizes the importance of, and the issues in, defining criteria for LTCH payments.
- Section 2 provides an overview of the industry growth in recent years and an analysis of whether these changes are occurring throughout all segments of the LTCH industry. Included with these analyses are findings from past work on these issues.
- Section 3 presents analyses of Medicare claims directed at understanding the differences in resources, costs, and outcomes for LTCH patients and similar cases treated in general acute hospitals.
- Section 4 focuses on existing level of care definitions and summarizes the tools currently used to make level of care

determinations by QIOs, hospitals, and healthcare systems, including those criteria applied in areas with and without local LTCHs. Included are interviews with some of the Medicare QIOs as well as analysis of existing tools, such as the InterQual™ level of care determination tools.

- Section 5 presents RTI’s analysis of hospital margins, both LTCH margins and general acute margins for certain types of cases. DRG-specific analysis examines the relationship between Medicare payments and hospital costs for certain types of cases.

- Section 6 presents RTI’s recommendations for identifying cases that should qualify for LTCH payments. Fifteen recommendations are included which focus on patient-level characteristics, facility-level characteristics, issues related to creating consistent standards across acute hospitals for these medically complex patients, and additional administrative changes that would improve CMS’ ability to implement their payment policies.

ES.3 Section Summaries

Section 1: Introduction

This section presents the importance of defining LTCH criteria to distinguish cases that qualify for the higher LTCH PPS payments. Information is presented that compares the LTCH and IPPS rates, case mix weights, and expected length of stay for each DRG. The two hospitals are very similar in that LTCHs must meet acute hospital certification requirements. However, LTCHs must have average Medicare LOS of more than 25 days to qualify for the higher PPS payment rate. The base LTCH payment rate is substantially higher than the IPPS rate (\$38,086 compared to \$5,308 in 2007). While both types of hospitals have payment factors to adjust for higher and lower cost cases, such as short stay and high cost outliers, the average cost episode is substantially higher when LTCHs are used as part of the episode.

This section also compares the certification requirements of LTCHs to other IPPS-

excluded hospitals. The Medicare conditions of participation set staffing and patient management requirements for hospitals to ensure that appropriate care is provided. For the IPPS-excluded hospitals, these standards ensure that the provider can meet the specialized needs of the populations they are treating, such as those required by the acute physical rehabilitation or psychiatric populations.

Differences in expected patient severity, staff expertise, and case mix measurement methods used for LTCHs, IPPS, IRFs, Psychiatric hospitals, and SNFs are also presented. In general, the IPPS covers the most severely ill cases in their ICU, the LTCHs admit cases that are medically complex and equal to an ICU step-down unit in terms of intensity and higher staffing needs, IRFs admit cases that are less medically complex but highly acute in terms of their functional impairments. Psychiatric hospitals and skilled nursing facilities have the least medically complex admissions. The lines between each group are poorly defined.

Section 2: LTCH Availability

This section presents information on the changing supply of LTCHs. The number of LTCHs has grown markedly since the IPPS was established in 1983. Much of the growth has occurred since 1993 when the number of LTCHs exploded from 105 hospitals to the current number of 383 hospitals as of December 2005. The states with the highest number of facilities are also those with the highest number of Medicare beneficiaries, including Texas, Louisiana, Ohio, Pennsylvania, and Michigan to name a few. The number of states with LTCHs has continued growing as well. Many of the new hospitals are for-profit organizations which accounted for 58 percent of all hospitals in December 2005, up from 45 percent in 1996. The greatest growth was in the smaller hospitals with the opening of many hospital in hospitals, although this may be changing in response to Medicare co-location policies.

LTCH hospitals generally specialize in three types of populations. The majority of cases are medically complex, many of whom have respiratory conditions. A second, but smaller group are those admitted for rehabilitation services. And a smaller group are admitted for longer stay psychiatric services. Specialization in different cases is notable by looking at the distributions of cases admitted to each hospital. Respiratory-related, psychoses, and ventilator cases accounted for the highest proportion of admissions at most hospitals (averaging around 15 percent of all admissions/facility). However, the medians were much lower except in the case of ventilator admissions which accounted for 9.3 percent of admissions at half the LTCHs in the US. Also notable are the small proportion of hospitals that have a very high proportion of their cases in certain DRGs. For example, DRG 430: Psychoses accounts for 62 percent of admissions in a few of the LTCHs.

Section 3: LTCH Populations, Potential Substitutes, and Patient Differences Among Hospitals

This work has been useful for answering the questions identified in Section 1,

specifically whether there are differences between LTCH cases and other inpatient cases in terms of the average program payments, beneficiary use levels, and individual outcomes. The first half of this section profiled the typical LTCH admission to examine the types of cases treated in LTCHs, their associated program costs, and this population's use of other services. The results showed that many of the types of patients treated in LTCHs are also treated in other acute care settings. While the most common LTCH admission is DRG 475, the majority of these cases, nationally are treated in IPPS settings, both as inlier and outlier populations. Similarly the second most frequent LTCH admission, DRG 249 is admitted as a non-outlier IRF patient or SNF patient almost as often as an LTCH patient.

LTCH patients also use many services during an episode of care. These cases are frequently readmitted to the general acute hospital (about 40 percent of the time) and may have intervening stays at IRFs or SNFs prior to readmission. Also included were comparisons of the costs and use for patients in the same DRG groups who were treated at other types of inpatient settings. Average costs per case differed by type of setting.

The second part of this section examined the acute care admissions to identify differences between the types of cases likely to be admitted to an LTCH and other acute discharges in the same diagnostic and severity group. The multivariate analysis of this issue suggested that severity is an important predictor of LTCH use. This supports past work suggesting that LTCH cases have a higher severity level, although a large proportion are in APR-DRG group 3, as well as group 4. Being located in a state with a large number of LTCHs was the most important predictor of LTCH use, all else equal.

Examining the acute length of stay differences was also useful for understanding the relative role of general acute and LTCHs in treating these severely ill populations. The multivariate work showed that LTCH users have a shorter acute inpatient length stay. Understanding whether LTCH hospitals are substituting for services already paid to IPPS hospitals or whether LTCHs are providing specialized services is not well understood.

Better measures of acuity are needed to gauge the differences in medical or functional impairments between patients using LTCHs and those using other settings. Additional work in Phase 3 of this project will examine the discharge transitions for acute hospital discharges in areas that lack LTCHs. Using propensity score methods to match patients on diagnosis, severity, and additional factors, as well as control for differences in the availability of services will be important for understanding the potential overlap between acute and LTCH admissions.

Section 4: Determining Levels of Care

This section examines current standards in the Medicare program and private sector for determining appropriate levels of care. We explored three areas: 1) Current Medicare certification rules governing acute, LTCH, IRF, and Psychiatric hospital conditions of participation; 2) QIO and private sector

definitions of populations qualifying for different hospital and PAC sites of care; and 3) QIO's current roles in reviewing appropriateness of hospital admissions. This included interviewing 11 QIOs in states with both LTCHs and other PAC providers.

The Medicare certification rules are important because they set standards of practice to ensure appropriate quality of care is provided to Medicare beneficiaries. While LTCHs must meet the acute inpatient certification requirements, IRF and psychiatric hospitals have additional requirements governing the management of their patients and the types of staff they must employ. Both types of IPPS-excluded hospitals are required to have a physician in charge of an interdisciplinary team that includes professionals of varied backgrounds, specific to the respective types of patients. Nursing and therapy staff are expected to have relevant backgrounds in psychiatric or rehabilitation services, respectively. They are to be lead by a physician with "appropriate training" in the psychiatric hospital or "at least 2 years of rehabilitation training or experience" in the IRF.

They are also limited to admitting certain populations. All psychiatric admissions must be admitted for psychiatric conditions and must be actively treated or discharged. IRFs, on the other hand, can admit a wide range of rehabilitation populations but 50-75 percent must be treated for one of 13 groups of conditions or the IRF can lose its certification.

Patient level criteria were also examined. The Medicare program, in general, does not specify patient level criteria for LTCHs. IRF patients must be well enough to participate in 3 hours therapy/day, in general. Psychiatric patients must be actively treated and not just admitted for monitoring of a chronic condition. Both IRF and psychiatric patients must be improving from treatment or be discharged.

Primary responsibility for monitoring whether Medicare cases are admitted to appropriate facilities rests with the Quality Improvement Organizations (QIO). QIOs were interviewed regarding the tools they use to assess appropriate admissions. Their formal charge is to assess whether the services needed could be provided on a more economical basis in an alternative setting. However, they do not distinguish between types of acute settings.

The QIOS use several tools, although most use one developed by the private sector and used by several other insurers, the InterQual™ tool. This tool is a set of clinical algorithms intended to create mutually exclusive groups of cases for admission to different types of hospitals (acute, LTCH, IRF, psychiatric), as well as SNFs and ambulatory services, such as home health and less intensive psychiatric services. These tools are guidelines for these decisions with final decisions made by physicians or nurses, depending on how complicated a case may be. In general, the InterQual™ tool is a complex set of conditions and treatment needs that identify ICU cases, less intensive hospital cases, and other types of admissions. While this tool is widely used by QIOs, they have not been using it to distinguish between

LTCH and general acute admissions nor do the criteria currently distinguish between those two groups.

Some members of the LTCH industry have proposed criteria for identifying their patients. However, these criteria lacked specificity in several areas and like the InterQual™ tool, failed to distinguish between general acute and LTCH admissions. However, they suggested that all LTCH cases should be medically complex, including any types of rehabilitation or psychiatric cases.

Other parts of the industry suggested that LTCH admissions be restricted to 8 types of cases commonly admitted to LTCHs. However, these proposals failed to distinguish severity within these conditions again, making no distinction between general acute and LTCH severity.

Site visits at eight LTCHs and one acute hospital with a respiratory ventilator unit were conducted to understand the providers' perceptions of appropriate admissions to these settings. Physicians at each site were interviewed regarding the differences between the patients they treated and those treated in an acute hospital ICU, medical/surgical floor, IRF, or SNF. The LTCH physicians perceived themselves as specialists in treating these very complicated patients. Many of the patients are having acute exacerbations of chronic respiratory conditions, multi-system organ failures, and other complications, including wounds and infections. The hospitals provide interdisciplinary treatment teams with nurse staffing levels that were lower than ICU but higher than general units in acute hospitals. Many had ICUs, particularly the free-standing facilities as patients often had emergent care needs, particularly if they were being weaned from a ventilator. The LTCHs consistently distinguished their admissions from ICU cases in that they only admitted medically stable patients. They perceived the acute hospitals' roles to be one of diagnosis and stabilization.

The acute hospital with a ventilator unit was very similar in practice to an LTCH but was paid under the IPPS system. This unit was a special unit where respiratory cases were admitted for higher levels of monitoring than was available on the general floor and interdisciplinary treatment teams cared for the patients. However, anecdotal concerns were also raised about the cost of caring for these difficult patients under the IPPS payment system.

Section 5: Medicare Margins Analysis

This section examined LTCH facility financial performance before and after the introduction of PPS. We found that aggregate facility total margins rose from 4.9% in FY 2002 to 8.9% in FY 2003, and Medicare inpatient PPS margins rose from 1.9% to 8.3% in the same period. In the first year of implementation, the inter-quartile range on LTCH PPS margins was -0.2% to +17.1%. Facilities paid under the phased-in rates and public LTCHs were disproportionately represented at the lower end of the distribution. Many facilities were able to improve their profitability by opting for 100% federal rates in year 2, indicating that the base rate was set at a generous level relative to average standardized cost per case.

Median facility PPS margins were highest among for-profits and highest for those certified in recent years. Margins were lower for those with a higher proportion of high-cost outliers, and—somewhat surprisingly—lower for those with a higher proportion of very short-stay outliers (stays less than one half the geometric mean LOS).

Case-level margin analyses were conducted for claims in FY 2003 and 2004 that were paid under the 100% federal rate. Margins varied substantially across DRGs, even after stratifying to remove the effects of high-cost or short-stay outlier prevalence. Across the 10 most common reasons for admission, average margins were lowest for those in Rehabilitation (-0.1%) and highest for those in Ventilator Support (21.3%). Across all cases the aggregate margin was 12.4%, but it was 17.4% for inlier cases, 13.8% for short-stay outlier cases and -14.3% for high-cost outlier cases. The variation in profitability across DRGs was even greater in multivariate models that were able to control for fixed hospital-specific effects, as well as outlier status.

In fiscal 2004, the median margin for LTCH Ventilator Support cases was 23.1%. We found that in IPPS settings, the median for cases in that same DRG 475 was 13.1%. The mean 1.4%, indicating some cases had very large losses. There is an unusually large amount of within-DRG variation in the IPPS setting; among the roughly half of cases staying 10 days or less, the median margin was 42.6%, compared to negative 27.1% for those staying 10 days or more. IPPS margins were slightly lower for the Ventilator Support cases that transferred to LTCHs than for those with other discharge dispositions. Setting-specific profit differentials require further study using a complete episode-of-care file, to adjust for changes in DRGs across inpatient settings and to control adequately for possible patient selection effects.

We conclude that underlying high LTCH profitability stems from a generous base rate during the first two PPS years. However, substantial variation in profitability across DRGs “including the unusually high margins that we found for Ventilator cases and other respiratory-related DRGs “stems from bias in the DRG weights that causes systematic understatement of costs for cases using relatively more ancillary services. This is a design problem within LTCH PPS that can only be addressed with improved cost-based weights.

Section 6: Recommendations for Identifying Appropriate LTCH Cases

Based on the findings in this report, this Section provides recommendations and discussions for developing patient level criteria, facility level criteria, creating more consistency between general acute and LTCH payment and certification rules, and several administrative issues related to LTCH identification methods. Complete discussions accompany each recommendation in Section 6.

A. Patient-Level Recommendations

Recommendation 1: Restrict LTCH admissions to cases that meet certain medical conditions, including having a primary diagnosis that is medical in nature, not

function or psychiatric, and meeting a certain level of medical complexity that reflects severely ill populations.

Recommendation 2: Require LTCH Admissions to be discharged if not having diagnostic procedures or improving with treatment, such as those receiving long term ventilator management.

Recommendation 3: Develop a list of criteria to measure medical severity for hospital admissions.

Recommendation 4: Establish a Technical Advisory Group.

Recommendation 5: Establish a data collection mechanism to collect this information.

Recommendation 6: Require LTCHs to collect functional measures as well as physiologic measures on all patients receiving physical, occupational, or speech and language pathology services.

B. Facility Level Recommendations

Recommendation 7: Standardize conditions of participation and set staffing requirements to ensure appropriate staff for treating medically complex cases.

Recommendation 8: Keep the 25 day average length stay requirement in place to limit LTCH's incentives to unbundle and clearly delineate between general and long term acute patients.

C. Recommendations To Improve Consistency Between General Acute and Long Term Acute Hospital Payment and Certification Policies

Recommendation 9: Allow LTCHs, like general acute hospitals, to open certified, distinct-part rehabilitation and psychiatric units if CMS finds that restricting LTCH admissions to the medically complex cases results in access problems for IRF or psychiatric patient populations.

Recommendation 10: Require LTCHs to meet the same regulatory restrictions as general acute hospitals by limiting their allowance to only one of each type of distinct-part unit.

Recommendation 11: Establish payment rules that provide a disincentive for LTCHs to transfer cases early to other post acute settings.

Recommendation 12: Conduct additional research to examine costs associated with different segments of an acute episode for medically complex patients. This should also include an examination of the IPPS margins for common types of LTCH cases.

D. Administrative Recommendations

Recommendation 13: Establish a provider identification code for satellite facilities and hospitals in hospitals (HIH).

Recommendation 14: Strengthen the requirement for parent facilities to report satellite locations by requiring them to be identified on the cost report.

Recommendation 15: Clarify QIO roles in overseeing appropriateness of admissions of LTCHs.

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