

DEPARTMENT OF HEALTH AND HUMAN SERVICES**Centers for Medicare & Medicaid Services****42 CFR Part 412****[CMS-1483-F]****RIN 0938-AN28****Medicare Program; Prospective Payment System for Long-Term Care Hospitals: Annual Payment Rate Updates, Policy Changes, and Clarification****AGENCY:** Centers for Medicare & Medicaid Services (CMS), HHS.**ACTION:** Final rule.

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

DATES: This final rule is effective July 1, 2005.

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4537 (Payment adjustments, interrupted stay, and transition period).

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Acronyms

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

- BBA Balanced Budget Act of 1997, (Pub. L. 105-33).
- BBRA Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999, (Pub. L. 106-113).
- BIPA Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Benefits Improvement and Protection Act of 2000, (Pub. L. 106-554).
- CBSA Core-Based Statistical Area.
- CMS Centers for Medicare & Medicaid Services.
- COPS Medicare conditions of participation.
- DRGs Diagnosis-related groups.
- FY Federal fiscal year.
- HCRIS Hospital Cost Report Information System.
- HHA Home health agency.
- HIPAA Health Insurance Portability and Accountability Act, Pub. L. 104-191.
- IPF Inpatient Psychiatric Facility.
- IPPS Acute Care Hospital Inpatient Prospective Payment System.
- IRF Inpatient rehabilitation facility.
- LTC-DRG Long-term care diagnosis-related group.
- LTCH Long-term care hospital.
- MedPAC Medicare Payment Advisory Commission.
- MedPAR Medicare provider analysis and review file.
- OSCAR Online Survey Certification and Reporting (System).
- PPS Prospective Payment System.
- QIO Quality Improvement Organization (formerly Peer Review Organization (PRO)).

RY Rate Year (July 1 through June 30).
 SNF Skilled nursing facility.
 TEFRA Tax Equity and Fiscal
 Responsibility Act of 1982, (Pub. L.
 97–248).

I. Background

A. Legislative and Regulatory Authority

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

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

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

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

In a **Federal Register** document issued on August 30, 2002 (67 FR 55954), we implemented the LTCH PPS authorized under BBRA and BIPA. This system uses information from LTCH patient records to classify patients into distinct long-term care diagnosis-related

groups (LTC–DRGs) based on clinical characteristics and expected resource needs. Payments are calculated for each LTC–DRG and provisions are made for appropriate payment adjustments. Payment rates under the LTCH PPS are updated annually and published in the **Federal Register**.

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

In the August 30, 2002 final rule, we presented an in-depth discussion of the LTCH PPS, including the patient classification system, relative weights, payment rates, additional payments, and the budget neutrality requirements mandated by section 123 of 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 (67 FR 55954) rule for a comprehensive discussion of the research and data that supported the establishment of the LTCH PPS.

On June 6, 2003, we published a final rule in the **Federal Register** (68 FR 34122) that set forth the 2004 annual update of the payment rates for the Medicare PPS for inpatient hospital services furnished by LTCHs. It also changed the annual period for which the payment rates are effective. The annual updated rates are now effective

from July 1 through June 30 instead of from October 1 through September 30. We refer to the July through June time period as a “long-term care hospital rate year” (LTCH PPS rate year). In addition, we changed the publication schedule for the annual update to allow for an effective date of July 1. The payment amounts and factors used to determine the annual update of the LTCH PPS Federal rate is based on a LTCH PPS rate year. While the LTCH payment rate update is effective July 1, the annual update of the LTC–DRG classifications and relative weights are linked to the annual adjustments of the acute care hospital inpatient diagnosis-related groups and are effective each October 1.

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

B. Criteria for Classification as a LTCH

1. Classification as a LTCH

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

Regulations at § 412.23(e)(3) provide that, subject to the provisions of paragraphs (e)(3)(ii) through (e)(3)(iv) of this section, the average Medicare inpatient length of stay, specified under § 412.23(e)(2)(i) is calculated by dividing the total number of covered

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

In the LTCH PPS final rule published on May 7, 2004, we specified the procedure for calculating a hospital's inpatient average length of stay for purposes of classification as a LTCH. That is, if a patient's stay includes days of care furnished during two or more separate consecutive cost reporting periods, the total days of a patient's stay would be reported in the cost reporting period during which the patient is discharged. (69 FR 25705). Therefore, we have revised the regulations at § 412.23(e)(3)(ii) to specify that, effective for cost reporting periods beginning on or after July 1, 2004, in calculating a hospital's average length of stay, if the days of a stay of an inpatient involves days of care furnished during two or more separate consecutive cost reporting periods, the total number of days of the stay are considered to have occurred in the cost reporting period during which the inpatient was discharged.

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

FIs verify that LTCHs meet the average length of stay requirements. We note that the inpatient days of a patient who is admitted to a LTCH without any remaining Medicare days of coverage, regardless of the fact that the patient is a Medicare beneficiary, will not be included in the above calculation. Because Medicare would not be paying for any of the patient's treatment, data on the patient's stay would not be included in the Medicare claims processing systems. In order for both covered and noncovered days of a LTCH hospitalization to be included, a patient admitted to the LTCH must have at least

one remaining benefit day as described in § 409.61 (68 FR 34123).

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

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

In the May 7, 2004 final rule (69 FR 25709), we revised the regulations at § 412.23(e) to clarify our longstanding policy by stating that a satellite facility

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

2. Hospitals Excluded From the LTCH PPS

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

- Veterans Administration hospitals.

• Hospitals that are reimbursed under State cost control systems approved under 42 CFR part 403.

• Hospitals that are reimbursed in accordance with demonstration projects authorized under section 402(a) of Public Law 90–248 (42 U.S.C. 1395b–1) or section 222(a) of Public Law 92–603 (42 U.S.C. 1395b–1 (note)) (statewide all-payer systems, subject to the rate-of-

increase test at section 1814(b) of the Act).

• Nonparticipating hospitals furnishing emergency services to Medicare beneficiaries.

C. Transition Period for Implementation of the LTCH PPS

In the August 30, 2002 final rule, we provided for a 5-year transition period from reasonable cost-based

reimbursement to fully Federal prospective payment for LTCHs (67 FR 56038). However, LTCHs have the option to elect to be paid based on 100 percent of the Federal prospective payment. During the 5-year period, two payment percentages are to be used to determine a LTCH's total payment under the PPS. The blend percentages are as follows:

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

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

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

II. Publication of Proposed Rulemaking

On February 3, 2005, we published a proposed rule in the **Federal Register** (70 FR 5724–5805) that set forth the proposed annual update to the payment rates for the Medicare prospective payment system (PPS) for inpatient hospital services provided by long-term care hospitals (LTCHs) for the 2006

LTCH PPS rate year. (The annual update of the LTC–DRG classifications and relative weights for FY 2006 remains linked to the annual adjustments of the acute care hospital inpatient DRG system, which will be published by August 1, and will be effective October 1, 2004.)

In the February 3, 2005 LTCH PPS proposed rule, we discussed the annual update of LTC–DRG classifications and relative weights and specified that they remain linked to the annual adjustments of the acute care hospital inpatient DRG system, which are based on the annual revisions to the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD–9–CM) codes, effective each October 1. (See section V. of this preamble.)

In that same proposed rule, we proposed to adopt new labor market area definitions for LTCHs which are based on the new Core-Based Statistical Areas (CBSAs), announced by the OMB late in 2000, which are effective for acute care inpatient hospitals October 1, 2004 in the FY 2005 IPPS final rule. The CBSAs were adopted for acute care hospitals under the IPPS (See section V.C.1. of this preamble.)

We also proposed revisions to the wage index, the proposed excluded hospital with capital market basket that would be applied to the current standard Federal rate to determine the prospective payment rates, the applicable adjustments to payment rates, the proposed outlier threshold, the transition period, and the proposed budget neutrality factor. (See sections VII. through X. of this preamble.)

We proposed to clarify our notification policy in § 412.22(e)(3) and (h) to require that when a LTCH or satellite of a LTCH informs its FI of its

co-located status, it also is required to include the name, address and provider numbers of the other co-located hospitals (that is, acute care hospitals, IRFs, and IPFs). Additionally, we proposed to clarify and modify the notification requirement under § 412.532. (Special payment provisions for patients who are transferred to onsite providers and readmitted to a long-term care hospital.)

We also proposed to extend the surgical DRG exception to the “under arrangements” requirement of the 3-day or less interruption of stay policy at § 412.531(b)(1)(ii)(A)(1) through the 2006 rate year, from July 1, 2005 through June 30, 2006. We also propose to extend the surgical DRG exception to the “under arrangements” requirement for the 3-day or less interruption of stay policy at § 412.531(b)(1)(i)(C) from July 1, 2005 through June 30, 2006.

We discussed the recommendations made in the June 2004 Medicare Payment Advisory Commission (MedPAC) Report concerning the definition of LTCHs and our continuing monitoring efforts to evaluate the LTCH PPS, including a review of the QIO's role. (See section X. of this preamble.)

Lastly, we analyzed the impact of the proposed changes in the proposed rule on Medicare expenditures and on Medicare-participating LTCHs and Medicare beneficiaries. (See section XII. of this preamble.)

We received a total of 13 timely items of correspondence containing multiple comments on the proposed rule. The major issues addressed by the commenters included: the reduction of the fixed loss amount pertaining to high-cost outliers, notification in writing to fiscal intermediaries regarding co-located status, adoption of

the CBSA designations, extension of the surgical DRGs and MedPAC/monitoring issues.

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

III. Summary of the Major Contents of This Final Rule

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

A. Update Changes

- In section IV. of this preamble, we discuss the annual update of the LTC-DRG classifications and relative weights and specify that they remain linked to the annual adjustments of the acute care hospital inpatient DRG system, which are based on the annual revisions to the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes effective each October 1.

- In sections V. through X. of this preamble, we specify the factors and adjustments used to determine the LTCH PPS rates that are applicable to the 2006 LTCH PPS rate year, including revisions to the wage index, the excluded hospital with capital market basket that will be applied to the current standard Federal rate to determine the prospective payment rates, the applicable adjustments to payments, the outlier threshold, the short-stay outlier policy for certain LTCHs, the budget neutrality factor, Core-Based Statistical Areas (CBSAs), and MedPAC recommendations/monitoring.

B. Policy Changes

In section IV.8. of this preamble, we are extending the surgical DRG exception in the 3-day or less interruption of stay policy at § 412.531(b)(1)(ii)(A)(1) and § 412.531(b)(1)(i)(C) through the 2006 rate year.

In section V.C.5. of this preamble, we clarify our notification policy for co-located LTCHs and satellites of LTCHs in § 412.22(e)(3) and (h)(5). We require LTCH HwHs and LTCH satellites to inform their FI of their co-located status and also provide relevant identifying information concerning other co-located hospitals.

In section V.C.9. of this preamble, we clarify and modify existing notification requirements for the purpose of implementing § 412.532.

C. MedPAC Report

In section X. of this preamble, we discuss the recommendations made in the June 2004 MedPAC Report concerning the definition of LTCHs and our continuing monitoring efforts to evaluate the LTCH PPS, including a review of the QIO's role.

D. Impact

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

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

A. Background

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

In accordance with section 307(b)(1) of BIPA and § 412.515 of our existing regulations, the LTCH PPS uses information from LTCH patient records to classify patient cases into distinct LTC-DRGs based on clinical characteristics and expected resource needs. The LTC-DRGs used as the patient classification component of the LTCH PPS correspond to the hospital inpatient DRGs in the IPPS. We apply weights to the existing hospital inpatient DRGs to account for the difference in resource use by patients exhibiting the case complexity and multiple medical problems characteristic of LTCHs.

In a departure from the IPPS, we use low volume LTC-DRGs (less than 25 LTCH cases) in determining the LTC-DRG weights, since LTCHs do not typically treat the full range of diagnoses as do acute care hospitals. In order to deal with the large number of low volume DRGs (all DRGs with fewer than 25 cases), we group low volume DRGs into 5 quintiles based on average charge per discharge. (A listing of the current composition of low volume quintiles used in determining the FY

2005 LTC-DRG relative weights appears in the FY 2005 IPPS final rule (August 11, 2004; 69 FR 48986-48989).) We also take into account adjustments to payments for cases in which the stay at the LTCH is five-sixths of the geometric average length of stay and classify these cases as short-stay outlier cases. (A detailed discussion of the application of the Lewin Group model that was used to develop the LTC-DRGs appears in the August 30, 2002 LTCH PPS final rule at 67 FR 55978.)

B. Patient Classifications Into DRGs

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

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

As indicated in the August 30, 2002 LTCH PPS final rule, upon the discharge of the patient from a LTCH, the LTCH must assign appropriate diagnosis and procedure codes from the most current version of the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM). HIPAA, Pub. L. 104-191, transactions and code sets standards regulations (45 CFR parts 160 and 162) require that no later than October 16, 2003, all covered entities must comply with the applicable requirements of subparts A and I through R of part 162. Among other requirements, those provisions direct covered entities that electronically transmit institutional health care claim or equivalent encounter information, for instance, to use the ASC X12N 837 Health Care Claims: Institutional, Volumes 1 and 2, version 4010, and the applicable standard medical data code sets. (See 45 CFR 162.1002 and 45 CFR 162.1102.)

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

- Cases that are improperly coded. (For example, diagnoses are shown that are inappropriate, given the sex of the

patient. Code 68.6, Radical abdominal hysterectomy, would be an inappropriate code for a male.)

- Cases including surgical procedures not covered under Medicare. (For example, organ transplant in a 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 136.3, Pneumocystosis, contains all appropriate digits, but if it is reported with either fewer or more than 4 digits, the claim will be rejected by the MCE as invalid.)

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

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

The GROUPER is used both to classify past cases in order to measure relative hospital resource consumption to establish the DRG weights and to classify current cases for purposes of determining payment. The records for all Medicare hospital inpatient discharges are maintained in the MedPAR file. The data in this file are used to evaluate possible DRG classification changes and to recalibrate the DRG weights during our annual update under both the IPPS (§ 412.60(e)) and the LTCH PPS (§ 412.517). As discussed in greater detail below in sections III.D. and E. of this preamble, with the implementation of section

503(a) of the MMA, there is the possibility that one feature of the GROUPER software program may be updated twice during a Federal fiscal year (October 1 and April 1) as required by the statute for the IPPS (69 FR 48954-48957), August 11, 2004). Specifically, ICD-9 diagnosis and procedure codes for new medical technology may be created and added to existing DRGs in the middle of the Federal fiscal year on April 1. This policy change will have no effect, however, on the LTC-DRG relative weights which will continue to be updated only once a year (October 1), nor will there be any impact on Medicare payments under the LTCH PPS.

C. Organization of DRGs

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

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

consideration of additional diagnoses for DRG determination.)

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

D. Update of LTC-DRGs

For FY 2005, the LTC-DRG patient classification system is based on LTCH data from the FY 2003 MedPAR file, which contained hospital bills data from the March 2004 update. The patient classification system consists of 520 DRGs that formed the basis of the FY 2005 LTCH PPS GROUPER. The 520 LTC-DRGs included two “error DRGs.” As in the IPPS, we include two error DRGs in which cases that cannot be assigned to valid DRGs will be grouped. These two error DRGs are DRG 469 (Principal Diagnosis Invalid as a Discharge Diagnosis) and DRG 470 (Ungroupable). (See the FY 2005 IPPS FY 2005 final rule (69 FR 48982-49000).) The other 518 LTC-DRGs are the same DRGs used in the IPPS GROUPER for FY 2005 (Version 22.0).

In the past, in the health care industry, annual changes to the ICD-9-CM codes were effective for discharges occurring on or after October 1 each year. Thus, the manual and electronic versions of the GROUPER software, which are based on the ICD-9-CM codes, were also revised annually and effective for discharges occurring on or after October 1 each year. As discussed earlier, the patient classification system for the LTCH PPS (LTC-DRGs) is based on the IPPS patient classification system

(CMS-DRGs), which had historically been updated annually and was effective for discharges occurring on or after October 1 through September 30 each year.

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

When we implemented the LTCH PPS, we established that the DRG-based patient classification system for the LTCH PPS would use the same GROUPEr software as the IPPS (August 30, 2002, 67 FR 55954). IPPS updates occur each October 1, as set forth in § 412.8(b). In the June 6, 2003 LTCH PPS final rule (68 FR 34125), when we revised the annual rate update for the LTCH PPS to a July 1 through June 30 schedule, we specified that updates of the LTC-DRGs and re-weighting of LTC-DRG weights would remain linked to the IPPS GROUPEr update which functions on an October 1 through September 30 schedule. Therefore, under this existing policy, during a LTCH PPS rate year, two versions of the GROUPEr software are utilized for purposes of LTC-DRG creation or deletion and relative weight assignment during the LTCH PPS rate year that is established each July 1. The updated LTC-DRG classifications and relative weights in the GROUPEr that were finalized on October 1, preceding the beginning of a LTCH rate year on July 1, are in effect with the new Federal rate

from July 1 through September 30. On October 1, the updated version of the GROUPEr with respect to the LTC-DRG classifications and relative weights will be used from that October 1 through June 30.

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

As noted above, updates to the GROUPEr for both the IPPS and the LTCH PPS (with respect to relative weights and the creation or deletion of DRGs) are made in the annual IPPS proposed and final rules and are effective each October 1. We explained in the FY 2005 IPPS final rule (69 FR 48956), that since we do not publish a

mid-year IPPS rule, April 1 code updates discussed above will not be published in a mid-year IPPS rule. Rather, we will assign any new diagnostic or procedure codes to the same DRG in which its predecessor code was assigned, so that there will be no impact on the DRG assignment. Any proposed coding updates will be available through the websites indicated in the FY 2005 IPPS final rule (69 FR 48956) and provided below in section III.E.2. of this preamble and through the Coding Clinic for ICD-9-CM. Publishers and software vendors currently obtain code changes through these sources in order to update their code books and software systems. If new codes are implemented on April 1, revised code books and software systems, including the GROUPEr software program, will be necessary because we must use current ICD-9-CM codes. Therefore, for purposes of the LTCH PPS, since each ICD-9-CM code must be included in the GROUPEr algorithm to classify each case into a LTC-DRG, the GROUPEr software program used under the LTCH PPS would need be revised to accommodate any new codes.

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

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

GROUPEr programs under the LTCH PPS.

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

As we discussed in the FY 2005 IPPS final rule (69 FR 48956), in implementing section 503(a) of the MMA, there will only be an April 1 update if new technology codes are requested and approved. In that same IPPS final rule, we specified that there are no new codes for April 1, 2005 implementation. However, if new codes had been approved for April 1, 2005 implementation, the subsequent changes to the DRG structure (that is,

the mapping of the new codes to existing DRGs), but not to FY 2005 LTC-DRG relative weights and, consequently, LTCH PPS payment rates, would have resulted in the use of a third GROUPEr during the 2005 LTCH PPS rate year. However, as noted above, since there are no new codes for April 1, 2005 implementation, and the next update to the ICD-9-CM coding system will not occur until October 1, 2005, only two GROUPEr software programs will be used during the 2005 LTCH PPS rate year (July 1, 2004 through June 30, 2005): one GROUPEr from July 1, 2004 through September 30, 2004, and a second GROUPEr from October 1, 2004 through June 30, 2005.

Discharges beginning on or after October 1, 2004 and before October 1, 2005 (Federal FY 2005) are using Version 22.0 of the GROUPEr software for both the IPPS and the LTCH PPS. Consistent with our current practice, any changes to the DRGs or relative weights will be made at the beginning of the Federal fiscal year (October 1). We will notify LTCHs of any revised LTC-DRG relative weights based on the final DRGs and the applicable GROUPEr version for the IPPS that will be effective October 1, 2005. The proposed changes to the LTC-DRGs and relative weights based on the proposed Version 23.0 GROUPEr, which would be effective beginning with discharges occurring on or after October 1, 2005, are discussed in the May 4, 2005 IPPS proposed rule. Furthermore, as discussed above, we would notify LTCHs of any revisions to the CMS GROUPEr that would be implemented April 1, 2006.

E. ICD-9-CM Coding System

1. Uniform Hospital Discharge Data Set (UHDDS) Definitions

Because the assignment of a case to a particular LTC-DRG will help determine the amount that will be paid for the case, it is important that the coding is accurate. Classifications and terminology used in the LTCH PPS are consistent with the ICD-9-CM and the UHDDS, as recommended to the Secretary by the National Committee on Vital and Health Statistics ("Uniform Hospital Discharge Data: Minimum Data Set, National Center for Health Statistics, April 1980") and as revised in 1984 by the Health Information Policy Council (HIPC) of the U.S. Department of Health and Human Services.

We point out that the ICD-9-CM coding terminology and the definitions of principal and other diagnoses of the UHDDS are consistent with the requirements of the HIPAA

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

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

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

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

The ICD-9-CM Coordination and Maintenance (C&M) Committee is a Federal interdepartmental committee, co-chaired by the National Center for Health Statistics (NCHS) and CMS, that is, charged with maintaining and updating the ICD-9-CM system. The C&M Committee is jointly responsible for approving coding changes, and developing errata, addenda, and other modifications to the ICD-9-CM to reflect newly developed procedures and technologies and newly identified diseases. The C&M Committee is also responsible for promoting the use of Federal and non-Federal educational programs and other communication techniques with a view toward standardizing coding applications and

upgrading the quality of the classification system.

The NCHS has lead responsibility for the ICD-9-CM diagnosis codes included in the Tabular List and Alphabetic Index for Diseases, while CMS has lead responsibility for the ICD-9-CM procedure codes included in the Tabular List and Alphabetic Index for Procedures.

The C&M Committee encourages participation by health-related organizations in the above process and holds public meetings for discussion of educational issues and proposed coding changes twice a year at the CMS Central Office located in Baltimore, Maryland. The agenda and dates of the meetings can be accessed on our Web site at: <http://www.cms.gov/paymentsystems/icd9>.

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

While this new requirement states that the Secretary shall not adjust the payment of the DRG classification for any codes created for use on April 1, DRG software and other systems will have to be updated in order to recognize and accept the new codes. Because, as discussed above, the LTC-DRGs are the same DRGs used under the IPPS, this means that the Medicare GROUPER software program used under both the IPPS and the LTCH PPS would need to be revised to reflect ICD-9-CM codes, if any coding changes were implemented on April 1. Furthermore, although the CMS GROUPER software used under both the IPPS and the LTCH PPS would need to be revised to accommodate the new codes effective April 1, there would be no additions or deletions of DRGs nor would the relative weights used under the IPPS and the LTCH PPS, respectively, be changed until the annual update October 1 (to the extent that those changes are warranted), just as they have been historically updated.

As the LTCH PPS is based on the IPPS, we will adopt the same approach used under the IPPS for potential April 1 ICD-9-CM coding changes. That is, we will assign any new diagnosis codes or procedure codes to the same DRG in which its predecessor code was assigned, so there will be no DRG impact in terms of potential DRG assignment until the following October 1. We will maintain the current method of publicizing any new code changes, as noted below. Current addendum and code title information is published on the CMS Web page at: <http://www.cms.hhs.gov/paymentsystem/icd9>. Summary tables showing new, revised, and deleted code titles are also posted on the following CMS Web page: <http://www.cms.hhs.gov/medlearn/icd9code.asp>. Information on ICD-9-CM diagnosis codes can be found at <http://www.cdc.gov/nchs/icd9.htm>. Information on new, revised, and deleted ICD-9-CM codes is also available in the AHA publication Coding Clinic for ICD-9-CM. AHA also distributes information to publishers and software vendors. We also send copies of all ICD-9-CM coding changes to our contractors for use in updating their systems and providing education to providers.

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

It should be noted that any new codes created for April 1 implementation will be limited to those diagnosis and procedure code revisions primarily needed to describe new technologies and medical services. However, we reiterate that the process for discussing updates to the ICD-9-CM has been an open process through the ICD-9-CM C&M Committee since 1995. Any requestor who makes a clear and convincing case for the need to update ICD-9-CM codes for purposes of the IPPS new technology add-on payment process through an April 1 update will be given the opportunity to present the merits of their proposed new code.

To reiterate, at the October 2004 C&M Committee meeting, no new codes were proposed for update on April 1, 2005. While no DRG additions or deletions or changes to relative weights will occur prior to the usual October 1 update, in the event any new codes had been created to describe new technologies and medical services through an April

1, 2005 update, under our policy, LTCH systems would have been expected to recognize and report those new codes through the channels as described above in this section.

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

Therefore, because the LTCH PPS and the IPPS uses the identical GROUPER software, the LTCH PPS will be directly affected by the statutory mandates directed at the IPPS, published in section 503(a) of the MMA. (We note that there is no statutory requirement in the LTCH PPS to make additional payments for new technology.) The practical effect of this provision is that the GROUPER software must accept new ICD-9 codes reflecting the incorporation of new technologies into inpatient treatment at an acute care hospital prior to the scheduled annual update of the GROUPER software. While DRG assignments would not change from October 1 through September 30, it is possible that there could be additional new ICD-9-CM diagnosis and procedure codes during that time, which would be assigned to predecessor DRGs (as described above). For both the IPPS and LTCH coders, it is possible that there will be ICD-9-CM codes in effect from October 1 through March 31, with additional ICD-9-CM codes in effect from April 1 through September 30. Presently, as there were no coding changes suggested for an April 1, 2005 update, the ICD-9-CM coding set implemented on October 1, 2004 will continue through September 30, 2005 (FY 2005).

Of particular note to LTCHs are the invalid diagnosis codes (Table 6C) and the invalid procedure codes (Table 6D) located in the annual proposed and final rules for the IPPS. Claims with invalid

codes are not processed by the Medicare claims processing system.

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

We emphasize the need for proper coding by LTCHs. Inappropriate coding of cases can adversely affect the uniformity of cases in each LTC-DRG and produce inappropriate weighting factors at recalibration. We continue to urge LTCHs to focus on improved coding practices. Because of concerns raised by LTCHs concerning correct coding, we have asked the American Hospital Association (AHA) to provide additional clarification or instruction on proper coding in the LTCH setting. The AHA will provide this instruction via their established process of addressing questions through their publication "Coding Clinic for ICD-9-CM." Written questions or requests for clarification may be addressed to the Central Office on ICD-9-CM, American Hospital Association, One North Franklin, Chicago, IL 60606. A form for the question(s) is available to be downloaded and mailed on AHA's Web site at: <http://www.ahacentraloffice.org>. In addition, current coding guidelines are available at the National Center for Health Statistics (NCHS) Web site: <http://www.cdc.gov/nchs.icd9.htm>.

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

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

Since implementation of the LTCH PPS, our Medicare fiscal intermediaries have been conducting training and providing assistance to LTCHs in correct coding. We have also issued manuals containing procedures as well as coding instructions to LTCHs and fiscal intermediaries. We will continue to conduct such training and provide guidance on an as-needed basis. We also refer readers to the detailed discussion on correct coding practices in the August 30, 2002 LTCH PPS final rule (67 FR 55979). Additional coding instructions and examples will be published in Coding Clinic for ICD-9-CM.

F. Method for Updating the LTC-DRG Relative Weights

As discussed in the May 7, 2004 LTCH PPS final rule (68 FR 25681), under the LTCH PPS, each LTCH will receive a payment that represents an appropriate amount for the efficient delivery of care to Medicare patients. The system must be able to account adequately for each LTCH's case-mix in order to ensure both fair distribution of Medicare payments and access to adequate care for those Medicare patients whose care is more costly. Therefore, in accordance with § 412.523(c), we adjust the standard Federal PPS rate by the LTC-DRG relative weights in determining payment to LTCHs for each case.

Under this payment system, relative weights for each LTC-DRG are a primary element used to account for the

variations in cost per discharge and resource utilization among the payment groups (§ 412.515). To ensure that Medicare patients who are classified to each LTC-DRG have access to an appropriate level of services and to encourage efficiency, we calculate a relative weight for each LTC-DRG that represents the resources needed by an average inpatient LTCH case in that LTC-DRG. For example, cases in a LTC-DRG with a relative weight of 2 will, on average, cost twice as much as cases in a LTC-DRG with a weight of 1.

As we discussed in the FY 2005 IPPS final rule (69 FR 48982), the LTC-DRG relative weights effective under the LTCH PPS for Federal FY 2005 were calculated using the March 2004 update of FY 2003 MedPAR data and Version 22.0 of the CMS GROOPER software. We use total days and total charges in the calculation of the LTC-DRG relative weights.

By nature, LTCHs often specialize in certain areas, such as ventilator-dependent patients and rehabilitation and wound care. Some case types (DRGs) may be treated, to a large extent, in hospitals that have, from a perspective of charges, relatively high (or low) charges. Distribution of cases with relatively high (or low) charges in specific LTC-DRGs has the potential to inappropriately distort the measure of average charges. To account for the fact that cases may not be randomly distributed across LTCHs, we use a hospital-specific relative value method to calculate relative weights. We believe this method removes this hospital-specific source of bias in measuring average charges. Specifically, we reduce the impact of the variation in charges across providers on any particular LTC-DRG relative weight by converting each LTCH's charge for a case to a relative value based on that LTCH's average charge. (See the FY 2005 IPPS final rule (69 FR 48984) for further information on the hospital-specific relative value methodology.)

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

weight and average length of stay using the formula applied to the regular LTC-DRGs (25 or more cases), as described below. (See the FY 2005 IPPS final rule (69 FR 48988–48989) for further explanation of the development and composition of each of the five low volume quintiles for FY 2005.)

After grouping the cases in the appropriate LTC-DRG, we calculated the relative weights by first removing statistical outliers and cases with a length of stay of 7 days or less. Next, we adjusted the number of cases in each LTC-DRG for the effect of short-stay outlier cases under § 412.529. The short-stay adjusted discharges and corresponding charges were used to calculate “relative adjusted weights” in each LTC-DRG using the hospital-specific relative value method described above. (See the FY 2005 IPPS final rule (69 FR 48989) for further details on the steps for calculating the LTC-DRG relative weights.)

We also adjusted the LTC-DRG relative weights to account for nonmonotonically increasing relative weights. That is, we made an adjustment if cases classified to the LTC-DRG “with comorbidities (CCs)” of a “with CC”/“without CC” pair had a lower average charge than the corresponding LTC-DRG “without CCs” by assigning the same weight to both LTC-DRGs in the “with CC”/“without CC” pair. (See FY 2005 IPPS final rule, 69 FR 48991–48992.) In addition, of the 520 LTC-DRGs in the LTCH PPS for FY 2005, based on the FY 2003 MedPAR data, we identified 171 LTC-DRGs for which there were no LTCH cases in the database. That is, no patients who would have been classified to those DRGs were treated in LTCHs during FY 2003 and, therefore, no charge data were reported for those DRGs. Thus, in the process of determining the relative weights of LTC-DRGs, we were unable to determine weights for these 171 LTC-DRGs using the method described above. However, since patients with a number of the diagnoses under these LTC-DRGs may be treated at LTCHs beginning in FY 2005, we assigned relative weights to each of the 171 “no volume” LTC-DRGs based on clinical similarity and relative costliness to one of the remaining 349 (520 – 171 = 349) LTC-DRGs for which we were able to determine relative weights, based on the FY 2003 claims data. (A list of the current no-volume LTC-DRGs and further explanation of their FY 2005 relative weight assignment can be found in the FY 2005 IPPS final rule (69 FR 48992–48999).)

Furthermore, for FY 2005, we established LTC-DRG relative weights

of 0.0000 for heart, kidney, liver, lung, and simultaneous pancreas/kidney transplants (LTC-DRGs 103, 302, 480, 495, 512 and 513, respectively) because Medicare will only cover these procedures if they are performed at a hospital that has been certified for the specific procedures by Medicare and presently no LTCH has been so certified. If in the future, however, a LTCH applies for certification as a Medicare-approved transplant center, we believe that the application and approval procedure would allow sufficient time for us to propose appropriate weights for the LTC-DRGs affected. At the present time, though, we included these six transplant LTC-DRGs in the GROUPER program for administrative purposes. As the LTCH PPS uses the same GROUPER program for LTCHs as is used under the IPPS, removing these DRGs would be administratively burdensome.

As we stated in the FY 2005 IPPS final rule, we will continue to use the same LTC-DRGs and relative weights for FY 2005 until October 1, 2005. Accordingly, Table 3 in the Addendum to this final rule lists the LTC-DRGs and their respective relative weights and arithmetic mean length of stay that we will continue to use for the period of July 1, 2005 through September 30, 2005. (This table is the same as Table 11 of the Addendum to the FY 2005 IPPS final rule (69 FR 49738–49754), including the revisions to Table 11 published in the October 7, 2004 correction notice (69 FR 60267–60271)). As we noted above, the next proposed update to the ICD-9-CM coding system is presented in the May 4, 2005 FY 2006 IPPS proposed rule (since there were no April 1 updates to the ICD-9-CM coding system). The final update to the ICD-9-CM coding system that will be effective beginning October 1, 2005, and the final DRGs and GROUPER for FY 2006 that will be used for the IPPS and the LTCH PPS, effective October 1, 2005, will be presented in the IPPS FY 2006 proposed and final rule in the **Federal Register**. The final LTC-DRG relative weights that will be established in the FY 2006 IPPS final rule will be used in determining payments for discharges occurring between October 1, 2005 and September 30, 2006 (We note that if there is an April 1, 2006 update to the ICD-9-CM coding system, there will be a change in the GROUPER software effective April 1, 2006; however, there would be no change to the LTC-DRG relative weights, as discussed above).

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

A. Overview of the Development of the Payment Rates

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

The basic methodology for determining LTCH PPS Federal prospective payment rates is set forth in the regulations at § 412.515 through § 412.532. Below we discuss the factors that will be used to update the LTCH PPS standard Federal rate for the 2006 LTCH PPS rate year that will be effective for LTCHs discharges occurring on or after July 1, 2005 through June 30, 2006. When we implemented the LTCH PPS in the August 30, 2002 LTCH PPS final rule (67 FR 56029), we computed the LTCH PPS standard Federal payment rate for FY 2003 by updating the best available (FY 1998 or FY 1999) Medicare inpatient operating and capital costs per case data, using the excluded hospital market basket.

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

Furthermore, as specified at § 412.523(d)(1), the standard Federal rate is reduced by an adjustment factor to account for the estimated proportion of outlier payments under the LTCH PPS to total estimated LTCH PPS payments (8 percent). For further details on the development of the FY 2003 standard Federal rate, see the August 30,

2002 LTCH PPS final rule (67 FR 56027), for the 2004 LTCH PPS rate year, see the June 6, 2003 final rule (68 FR 34122–34190), and for the 2005 LTCH PPS rate year, see the May 7, 2004 LTCH PPS final rule (69 FR 25674–25748). Under the existing regulations at § 412.523(c)(3)(ii), we update the standard Federal rate annually to adjust for the most recent estimate of the projected increases in prices for LTCH inpatient hospital services.

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

As established in the May 7, 2004 LTCH PPS final rule (69 FR 25683), based on the most recent estimate of the excluded hospital with capital market basket, adjusted to account for the change in the LTCH PPS rate year update cycle, the current LTCH PPS standard Federal rate which is effective from July 1, 2004 through June 30, 2005 (the 2005 LTCH PPS rate year), is \$36,833.69.

In the discussion that follows, we explain how we developed the standard Federal rate for the 2006 LTCH PPS rate year. The standard Federal rate for the 2006 LTCH PPS rate year will be calculated based on the update factor of 1.034. Thus, the standard Federal rate for the 2006 LTCH PPS rate year will increase 3.4 percent compared to the 2005 LTCH PPS rate year standard Federal rate due to the final update to the LTCH PPS Federal rate established in this final rule.

1. Standard Federal Rate Update

Under § 412.523, the annual update to the LTCH PPS standard Federal rate must be equal to the percentage change in the excluded hospital with capital market basket. As we discussed in the August 30, 2002 LTCH PPS final rule (67 FR 56087), in the future we may propose to develop a framework to update payments to LTCHs that would account for other appropriate factors that affect the efficient delivery of services and care provided to Medicare patients. As we discussed in the February 3, 2005 proposed rule (70 FR 5735), we have not yet collected sufficient data to allow for the analysis and development of an update framework under the LTCH PPS because the LTCH PPS has only been implemented for slightly more than 2 years (that is, for cost reporting periods beginning on or after October 1, 2002). Therefore, we did not address an update framework for the 2006 LTCH PPS rate year in that same proposed rule or in this final rule. However, we note that a conceptual basis for the proposal of

developing an update framework in the future can be found in Appendix B of the August 30, 2002 LTCH PPS final rule (67 FR 56086).

a. Description of the Market Basket for LTCHs for the 2006 LTCH PPS Rate Year

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

Under the reasonable cost-based payment system, the excluded hospital market basket was used to update the hospital-specific limits on payment for operating costs of LTCHs. Currently, the excluded hospital market basket is based on operating costs from cost report data from FY 1997 and includes data from Medicare-participating long-term care, rehabilitation, psychiatric, cancer, and children's hospitals. Since the costs of LTCH are included in the excluded hospital market basket, this market basket index, in part, also reflects the costs of LTCHs. However, in order to capture the total costs (operating and capital-related) of LTCHs, we added a capital component to the excluded hospital market basket for use under the LTCH PPS. We refer to this index as the excluded hospital with capital market basket.

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

In the August 30, 2002 LTCH PPS final rule (67 FR 56016 and 56085–56086), we discussed why we believe the excluded hospital with capital market basket provides a reasonable measure of the price changes facing LTCHs. In the May 7, 2004 LTCH PPS final rule (69 FR 25682–25683), we

discussed our research into the feasibility of developing a market basket specific to LTCH services. However, based on this research, we did not develop a market basket specific to LTCH services. In that same final rule, we explained why we continue to believe that the excluded hospital with capital market basket is the appropriate market basket for the LTCH PPS.

As we explained in the February 3, 2005 proposed rule (70 FR 5737), for the reasons discussed in those final rules (August 30, 2002 and May 7, 2004), we continue to believe that an excluded hospital with capital market basket adequately reflects the price changes facing LTCHs. We considered whether we would propose the use of a new “Rehabilitation, Psychiatric and Long-Term Care (RPL) market basket” instead of the existing excluded hospital with capital market basket for IRFs, IPFs, and LTCHs. The RPL market basket would have been based on the operating and capital costs of IRFs, IPFs, and LTCHs, which are almost all paid under a prospective payment systems. (We note that not all IPFs have begun to be paid under the IPF PPS yet because it was implemented for cost reporting periods beginning on or after January 1, 2005.) Because the development of the RPL market basket was not completed in time for us to consider proposing its use for the proposed 2006 LTCH PPS rate year update, we were unable to discuss it in the February 3, 2005 LTCH PPS proposed rule, and, therefore, we proposed to continue to use the excluded hospital with capital market basket. Thus, in that same proposed rule (70 FR 5737), we did not propose to revise the market basket used under the LTCH PPS because, as we explain above, we believe that the excluded hospital with capital market basket was the most appropriate market basket available at that time to use in determining the proposed update to the Federal rate for the 2006 LTCH PPS rate year.

Therefore, although we are considering the development of the RPL market basket because we did not propose to use the RPL market basket under the LTCH PPS for the 2006 LTCH PPS rate year, we are not discussing its use under the LTCH PPS for the 2006 rate year in this final rule. We will consider proposing the use of the RPL market basket under the LTCH PPS in the future and will analyze its applicability for the LTCH PPS. We intend to present our analyses in the 2007 LTCH PPS rate year proposed rule. Any future revisions to the LTCH PPS market basket will be proposed and subject to public comment.

We received no comments on our continued use of the FY 1997-based excluded hospital with capital market basket under the LTCH PPS. Accordingly, in this final rule, we will continue to use the FY 1997-based excluded hospital with capital market basket as the LTCH PPS market basket for determining the update to the LTCH PPS standard Federal rate for the 2006 LTCH PPS rate year. Even though we did not receive any comments on our continued use of the FY 1997-based excluded hospital with capital market basket under the LTCH PPS, in future proposed rules, we will continue to solicit comments about issues particular to LTCHs that should be considered in relation to the appropriate market basket to use under the LTCH PPS and to encourage suggestions for additional data sources that may be available.

b. LTCH Market Basket Increase for the 2006 LTCH Rate Year

As we discussed in the May 7, 2004 LTCH PPS final rule (69 FR 25683), for the update to the 2005 LTCH PPS rate year, we calculated the estimated increase between the 2004 LTCH PPS rate year (July 1, 2003 through June 30, 2004) and the 2005 LTCH PPS rate year (July 1, 2004 through June 30, 2005) based on Global Insight's forecast of the revised and rebased FY 1997-based excluded hospital with capital market basket using data available through the fourth quarter of 2003. The market basket for the 2005 LTCH PPS rate year was 3.1 percent (69 FR 25683).

Consistent with our historical practice of estimating market basket increases based on Global Insight's forecast of the FY 1997-based excluded hospital with capital market basket, in the February 3, 2005 proposed rule (70 FR 5735), we proposed a 3.1 percent update to the Federal rate based on the most recent

available data at that time (that is, data through the third quarter of 2004). Global Insights, Inc. is a nationally recognized economic and financial forecasting firm that contracts with CMS to forecast components of the market basket. In this final rule, consistent with our historical practice of estimating market basket increases based on Global Insight's forecast of the FY 1997-based excluded hospital with capital market basket, using more recent data through the first quarter of 2005, we are using a 3.4 percent update to the Federal rate for the 2006 LTCH PPS rate year. In accordance with § 412.523, this update will represent the most recent estimate of the increase in the excluded hospital with capital market basket for the 2006 LTCH PPS rate year.

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

In the May 7, 2004 LTCH PPS final rule (69 FR 25683), we established a standard Federal rate of \$36,833.69 for the 2005 LTCH PPS rate year that was based on the best available data and policies established in that final rule. In the February 3, 2005 proposed rule (70 FR 5736), we proposed a standard Federal rate of \$37,975.53 for the 2006 LTCH PPS rate year based on a proposed market basket update of 3.1 percent. Since the proposed standard Federal rate for the 2006 LTCH PPS rate year had already been adjusted for differences in case-mix, wages, cost-of-living, and high-cost outlier payments, we did not propose to make any additional adjustments in the standard Federal rate for those factors.

In this final rule, in accordance with § 412.523, we are establishing a standard Federal rate of \$38,086.04 based on the most recent estimate of the LTCH PPS market basket of 3.4 percent. Since the standard Federal rate for the

2006 LTCH PPS rate year has already been adjusted for differences in case-mix, wages, cost-of-living, and high-cost outlier payments, we did not make any additional adjustments in the standard Federal rate for these factors.

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

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

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

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

Accordingly, for cost reporting periods beginning during FY 2005 (that is, on or after October 1, 2004, and before September 30, 2005), blended payments under the transition methodology are based on 40 percent of the LTCH's reasonable cost-based payment rate and 60 percent of the adjusted LTCH PPS Federal rate. For

cost reporting periods that begin during FY 2006 (that is, on or after October 1, 2005 and before September 30, 2006), blended payments under the transition methodology will be based on 20 percent of the LTCH's reasonable cost-based payment rate and 80 percent of the adjusted LTCH PPS Federal rate.

1. Adjustment for Area Wage Levels

a. Background

Under the authority of section 307(b) of the BBA, we established an adjustment to the LTCH PPS Federal rate to account for differences in LTCH area wage levels at § 412.525(c). The labor-related share of the LTCH PPS Federal rate, estimated by the excluded

hospital with capital market basket, is adjusted to account for geographic differences in area wage levels by applying the applicable LTCH PPS wage index. The applicable LTCH PPS wage index is computed using wage data from inpatient acute care hospitals without regard to reclassification under section 1886(d)(8) or section 1886(d)(10) of the Act. Furthermore, as we discussed in the August 30, 2002 LTCH PPS final rule (67 FR 56015), we established a 5-year transition to the full wage adjustment. The applicable wage index phase-in percentages are based on the start of a LTCH's cost reporting period as shown in the following table:

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

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

In that same final rule (67 FR 56018), we stated that we would continue to reevaluate LTCH data as they become available and would propose to adjust the phase-in if subsequent data support a change. As we discussed in the February 3, 2005 proposed rule (70 FR 5736), because the LTCH PPS has only been recently implemented (slightly over 2 years) and because of the lag time in availability of cost report data, sufficient new data have not been generated that would enable us to conduct a comprehensive reevaluation of the appropriateness of adjusting the phase-in. However, as we discussed in that same proposed rule, we have reviewed the most recent cost report and claims data (FY 2001–FY 2003) available and did not find any evidence to support a change in the 5-year phase-in of the wage index. Specifically, our

statistical analysis still does not show a significant relationship between LTCHs' costs and their geographic location. Accordingly, in the February 3, 2005 proposed rule, we did not propose a change in the phase-in of the adjustment for area wage levels under § 412.525(c).

Comment: One commenter urges us to immediately implement 100 percent area wage index adjustment instead of the existing five-year phase-in of the wage index adjustment.

Response: As noted above, we have reevaluated our wage-index phase-in policy and for the 2006 LTCH PPS rate year, we will not be implementing a full wage index adjustment for LTCHs. In the August 30, 2002 LTCH PPS final rule in which we described our determinations regarding the inclusion of various payment adjustments in the new LTCH PPS, we included a highly detailed description of the full range of data analyses and reasoning upon which we based our decision to include a 5-year phase-in to a full wage-index adjustment for the LTCH PPS (67 FR 55954 and 56015–56019). As we discussed in greater detail in that same final rule (67 FR 56018), “the limitations in the current data from LTCHs and we noted that although “* * * the statistical analysis did not show a significant relationship between LTCHs' costs and their geographic location, we believe that it is appropriate to include some adjustment for area wages.” We also explained that the conceptual reasons for having a wage index adjustment support transitioning to a wage adjustment despite the data problems and issues with the regression analysis.

Accordingly, we adopted the suggestion of one of our commenters and established a 5-year phase-in for the area-wage adjustment with an assurance to revisit relevant data as it became available and that we would propose to adjust the phase-in if subsequent data support a change. As we discussed in the May 7, 2004 LTCH PPS final rule (69 FR 25684), because the LTCH PPS has only been recently implemented (slightly over 2 years) and because of the lag time in availability of cost report data, sufficient new data have not been generated that would enable us to conduct a comprehensive reevaluation of the appropriateness of adjusting the phase-in. In the August 30, 2002 LTCH PPS final rule (67 FR 56018), we stated that we would continue to reevaluate LTCH data as they become available and would propose to adjust the phase-in if subsequent data support a change. As we noted above and as we discussed in the February 3, proposed rule, upon review of the most recent data (FY

2001–FY 2003), we did not find any evidence to support a change in the 5-year phase-in of the wage index. Specifically, our statistical analysis still does not show a significant relationship between LTCHs' costs and their geographic location that would justify a full 100 percent implementation of an area wage index adjustment for LTCHs. Therefore, at this time, we are not adjusting the phase-in of the wage index adjustment in this final rule. The 5-year phase-in of the wage index adjustment will continue as shown in the table above (as we established in the August 30, 2002 final rule (67 FR 56015)).

Finally, we note that section 505 of the MMA established new section 1886(d)(13) of the Act, which requires that the Secretary establish a process to make adjustments to the hospital wage index based on commuting patterns of hospital employees. We believe that this requirement for an “out-commuting” or “out-migration” adjustment applies specifically to the acute care hospitals paid under the IPPS. Therefore, we did not propose such an adjustment under the LTCH PPS in the February 3, 2005 proposed rule, nor are we establishing such an adjustment under the LTCH PPS in this final rule.

b. Labor-Related Share

In the August 30, 2002 LTCH PPS final rule (67 FR 56016), we established a labor-related share of 72.885 percent based on the relative importance of the labor-related share of operating costs (wages and salaries, employee benefits, professional fees, postal services, and all other labor-intensive services) and capital costs of the excluded hospital with capital market basket based on FY 1992 data. In the March 7, 2003 proposed rule (68 FR 11249), in conjunction with our revision and rebasing of the excluded hospital with capital market basket from a FY 1992 to a FY 1997 base year, we discussed revising the labor-related share based on the relative importance of the labor-related share of operating and capital costs of the excluded hospital with capital market basket based on FY 1997 data. However, in the June 6, 2003 final rule (68 FR 34142), while we adopted the revised and rebased FY 1997-based LTCH PPS market basket as the LTCH PPS update factor for the 2004 LTCH PPS rate year, we decided not to update the labor-related share under the LTCH PPS pending further analysis of the current labor share methodology.

In the August 1, 2002 IPPS final rule, we did not update the IPPS or excluded hospital labor-related shares for FY 2003 (67 FR 50041), and we discussed our research into the appropriateness of this

policy. Specifically, we discussed the methods that we were reviewing for establishing the labor-related share and our intention to continue to explore all options for alternative data and a methodology for determining the labor-related share. We also stated that we would propose to update the IPPS and excluded hospital labor-related shares, if necessary, once our research is complete.

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

The primary reason that we did not update the LTCH PPS labor-related share for the 2004 and 2005 LTCH PPS rate years was the same reason that we explained for not updating the labor-related share under the IPPS for FY 2004 (see August 1, 2003; 68 FR 27226) and FY 2005 (see FY 2005 IPPS final rule (69 FR 49069)), which are equally applicable to the LTCH PPS. As we noted above, and as we explained in the May 7, 2004 LTCH PPS final rule (69 FR 25686), we did not revise the labor-related share under the IPPS based on the revised and rebased FY 1997 hospital market basket and the excluded hospital market basket because of data and methodological concerns. We indicated that we would conduct further analysis to determine the most appropriate methodology and data for determining the labor-related share.

The IPPS labor-related share of 71.066 percent was established in the August 29, 1997 IPPS final rule (62 FR 45995), effective for IPPS discharges occurring on or after October 1, 1997 (FY 1998). This (71.066 percent) is the most recent estimate of “the proportion (as estimated by CMS from time to time) of Federal rates” under the IPPS adjusted to account for different area wage levels and labor-related costs (§ 412.62(k)). As

also explained in the August 29, 1997 IPPS final rule (62 FR 45995), the labor-related portion of the IPPS operating standardized amounts is determined by summing the labor-related items of the revised 1992-based operating prospective payment hospital market basket (that is, wages and salaries, employee benefits, professional fees, business services, computer and data processing services, postage, and all other labor intensive services). This is the same methodology used to determine the operating portion of the current LTCH PPS labor-related share established in the August 30, 2002 LTCH PPS final rule (67 FR 56016), which is effective for LTCH PPS discharges occurring in cost reporting periods beginning on or after October 1, 2002 (FY 2003). (Note, as discussed in the August 30, 2002 LTCH PPS final rule (67 FR 56016), because the LTCH PPS standard Federal rate includes both operating and capital costs, the LTCH PPS labor-related share includes the labor-related share of capital costs as well as the labor-related share of operating costs.)

As noted above, the IPPS labor-related share of 71.066 percent became effective for IPPS discharges occurring on or after October 1, 1997. As we also discussed in the February 3, 2005 proposed rule (70 FR 5737), for purposes of payment under the IPPS, section 403 of MMA amended section 1886(d) of the Act to provide that for discharges occurring on or after October 1, 2004, the Secretary must employ 62 percent as the labor-related share under the IPPS, unless this “would result in lower payments to a hospital than would otherwise be made.” That is, beginning in FY 2005 under the IPPS, the labor-related share remains 71.066 percent for acute-care hospitals with a wage index greater than 1.0, while the labor-related share is equal to 62 percent for acute-care hospitals under the IPPS with a wage index less than or equal to 1.0 (69 FR 49070). This alternative labor-related share is only applicable to acute care hospitals paid under the IPPS and does not apply to LTCHs.

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

percent), we did not change the LTCH PPS labor-share for the 2005 LTCH PPS rate year.

Since we are continuing our research into updating the hospital labor-related share and because we have not implemented a change in the methodology for determining both the existing IPPS labor-related share estimated by CMS from time to time (as discussed in the FY 2005 IPPS final rule (69 FR 49069)) and the current LTCH PPS labor-related share, in the February 3, 2005 proposed rule, we did not propose to change the LTCH PPS labor-related share at this time. We received no comments on our proposal not to revise the labor-related share for the 2006 LTCH PPS rate year. Accordingly, under the broad authority in section 123 of the BBRA and section 307(b)(1) of BIPA, the labor-related share for the 2006 LTCH PPS rate year will remain at 72.885 percent. As is the case under the IPPS, once our research on the labor-related share is complete, any future revisions to the LTCH PPS labor-related share will be proposed and subject to public comment in a future rule.

c. Revision of LTCH PPS Geographic Classifications

As discussed in the August 30, 2002 LTCH PPS final rule, which implemented the LTCH PPS (67 FR 56015), in establishing an adjustment for area wage levels under § 412.525(c), the labor-related portion of a LTCH's Federal prospective payment is adjusted by using an appropriate wage index. As set forth in § 412.525(c), a LTCH's wage index is determined based on the location of the LTCH in an urban or rural area as defined in § 412.62(f)(1)(ii) and (f)(1)(iii), respectively. An urban area, under the LTCH PPS, is defined at § 412.62(f)(1)(ii)(A) and (B). In general, an urban area is defined as a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA) as defined by the Office of Management and Budget (OMB). (In addition, a few counties located outside of MSAs are considered urban as specified at § 412.62(f)(1)(ii)(B).) Under § 412.62(f)(1)(iii), a rural area is defined as any area outside of an urban area. The geographic classifications defined in § 412.62(f)(1)(ii) and (f)(1)(iii), respectively, were used under the IPPS from FYs 1984 through 2004 (§ 412.62(f) and § 412.63(b)), and have been used under the LTCH PPS since it was implemented for cost reporting periods beginning on or after October 1, 2002 (FY 2003).

Under the IPPS, the wage index is calculated and assigned to hospitals on the basis of the labor market area in

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

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

1. Current LTCH PPS Labor Market Areas Based on MSAs

Below, we will provide a description of the current labor markets that have been used for area wage adjustments under the LTCH PPS since its implementation for cost reporting periods beginning on or after October 1, 2002. As we discussed in the February 3, 2005 proposed rule, previously, we have not described the labor market areas used under the LTCH PPS in detail, although we have published each area's wage index in tables, in the LTCH PPS final rules, each year and noted the use of the geographic area (MSA) in applying the wage index adjustment in LTCH PPS payment examples in the final regulation implementing the LTCH PPS (August 30, 2002, 67 FR 56037). The LTCH industry has also understood that the same labor market areas in use under the IPPS (from the time LTCH PPS was implemented, for cost reporting periods beginning on or after October 1, 2002) would be used under the LTCH PPS. As we also explained in the February 3, 2005 proposed rule,

because OMB has adopted new statistical area definitions (as discussed in greater detail below) and we proposed to adopt new labor market area definitions based on these areas under the LTCH PPS (as discussed in greater detail below), we believe it is helpful to provide a more detailed description of the current LTCH PPS labor market areas, in order to better understand the change to the LTCH PPS labor market areas presented below in this final rule.

As mentioned earlier, since the implementation of the LTCH PPS in the August 30, 2002 LTCH PPS final rule, we have used labor market areas to further characterize urban and rural areas as determined under § 412.62(f)(1)(ii) and (iii). To this end, we have defined labor market areas under the LTCH PPS based on the definitions of MSAs, PMSAs, and NECMAs issued by the OMB, which is consistent with the IPPS approach (prior to the adoption of the new CBSA-based labor market areas under the IPPS rule beginning in FY 2005). Prior to modifying its statistical area definitions. The OMB also designates Consolidated MSAs (CMSAs). A CMSA is a metropolitan area with a population of one million or more, comprising two or more PMSAs (identified by their separate economic and social character). For purposes of the LTCH PPS wage index, we use the PMSAs rather than CMSAs because they allow a more precise breakdown of labor costs. If a metropolitan area is not designated as part of a PMSA, we use the applicable MSA.

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

2. Core-Based Statistical Areas

The OMB reviews its Metropolitan Area definitions preceding each decennial census. As discussed in the FY 2005 IPPS final rule (69 FR 49027), in the fall of 1998, the OMB chartered

the Metropolitan Area Standards Review Committee to examine the Metropolitan Area standards and develop recommendations for possible changes to those standards. Three notices related to the review of the standards, providing an opportunity for public comment on the recommendations of the Committee, were published in the **Federal Register** on the following dates: December 21, 1998 (63 FR 70526); October 20, 1999 (64 FR 56628); and August 22, 2000 (65 FR 51060).

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

According to OMB, MSAs are based on urbanized areas of 50,000 or more population, and Micropolitan Statistical Areas (referred to in this discussion as Micropolitan Areas) are based on urban clusters of at least 10,000 population, but less than 50,000 population. Counties that do not fall within CBSAs (either MSAs or Micropolitan Areas) are deemed “Outside CBSAs.” In the past, the OMB defined MSAs around areas with a minimum core population of 50,000, and smaller areas were “Outside MSAs.” On June 6, 2003, OMB announced the new CBSAs, comprised of MSAs and the new Micropolitan Areas based on Census 2000 data. (A copy of the announcement may be obtained at the following Internet address: <http://www.whitehouse.gov/omb/bulletins/fy04/b04-03.html>.) The new CBSA designations recognize 49 new MSAs and 565 new Micropolitan Areas, and extensively revise the composition of many of the existing MSAs. There are 1,090 counties in MSAs under the new CBSA designations (previously, there were 848 counties in MSAs). Of these 1,090 counties, 737 are in the same MSA as they were prior to the change in designations, 65 are in a different MSA, and 288 were not previously designated to any MSA. There are 674 counties in Micropolitan Areas. Of these, 41 were previously in an MSA, while 633 were not previously designated to an MSA. There are five counties that previously were designated to an MSA but are no longer designated to either an MSA or a new Micropolitan Area: Carter County,

KY; St. James Parish, LA; Kane County, UT; Culpepper County, VA; and King George County, VA. For a more detailed discussion of the conceptual basis of the new CBSAs, refer to the FY 2005 IPPS final rule (67 FR 49026–49034).

3. Revision of the LTCH PPS Labor Market Areas

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

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

We described the comments we received in the June 2, 1995 IPPS proposed rule (60 FR 29219). Specifically, as we discussed in that same proposed rule, there was no consensus among the commenters on the choice for new labor market areas. Many individual hospitals that commented on that proposed rule expressed dissatisfaction with all of the proposals. However, several State hospital associations that commented

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

Consequently, consistent with the approach taken under the IPPS, we have used MSAs to define labor market areas for purposes of Medicare wage indices in the LTCH PPS since its implementation for cost reporting periods beginning on or after October 1, 2002. In fact, MSAs are also used to define labor market areas for purposes of the wage index for many of the other Medicare payment systems (for example, IRF PPS, SNF PPS, HHA PPS, Outpatient PPS, and IPF PPS). While we recognize MSAs are not designed specifically to define labor market areas, we believe they do represent a reasonable and appropriate proxy for this purpose, because they are based upon characteristics we believe also generally reflect the characteristics of unified labor market areas. For example, CBSAs reflect a core population plus an adjacent territory that reflects a high degree of social and economic integration. This integration is measured by commuting ties, thus, demonstrating that these areas may draw workers from the same general areas. In addition, the most recent CBSAs reflect the most up to date information. The OMB reviews its Metropolitan Area definitions preceding each decennial census to reflect recent population changes and the CBSAs are based on the Census 2000 data. Our analysis and discussion here are focused on issues related to adopting the new CBSA-based designations to define labor market areas for purposes of the IPPS and for purposes of proposing them for LTCH PPS.

Historically, Medicare PPSs have utilized Metropolitan Area definitions

developed by OMB. The labor market areas currently used under the LTCH PPS (described above in section V.C.1.c.1. of this preamble) are based on the Metropolitan Area definitions issued by OMB. As noted above, OMB reviews its definitions preceding each decennial census to reflect more Metropolitan Area recent population changes. As discussed in greater detail above in section V.C.1.c.2., the CBSAs are the OMB’s latest Metropolitan Area definitions based on the Census 2000 data. As we discussed in the February 3, 2005 proposed rule (70 FR 5739), because we believe that OMB’s latest Metropolitan Area designations more accurately reflect the local economies and wage levels of the areas in which hospitals are currently located, under the LTCH PPS we proposed to adopt revised labor market area designations based on the OMB’s CBSA designations which were adopted under the IPPS.

Comment: Five commenters supported our proposed adoption of revised labor market area designations under the LTCH PPS based on the OMB’s CBSA designations, stating that they believe that as the CBSA designations more precisely defines distinct labor market areas for LTCHs. We received no comments opposing the proposed revisions to the LTCH PPS labor market area definitions.

Response: We appreciate the commenters’ support for the adoption of the proposed changes to the LTCH PPS labor market area definitions based on OMB’s new CBSA designations for, as noted above, and we agree with the commenters that the proposed changes to the LTCH PPS labor market area definitions would more precisely define distinct labor market areas for LTCHs. Accordingly, in this final rule, under the broad authority of section 123 of Pub. L. 106–113 and section 307(b)(1) of Pub. L. 106–554, we are adopting revised labor market area definitions under the LTCH PPS based on OMB’s new CBSA designations, as discussed in greater detail below. When we implemented the wage index adjustment at § 412.525(c) under the LTCH PPS in the August 30, 2002 LTCH PPS final rule (67 FR 56016), we explained that the LTCH PPS wage index adjustment was intended to reflect the relative hospital wage levels in the geographic area of the hospital as compared to the national average hospital wage level. Because we believe that OMB’s CBSA designations based on Census 2000 data reflect the most recent available geographic classifications (Metropolitan Area definitions), we are revising the labor market area definitions used under the LTCH PPS based on OMB’s CBSA

designations to ensure that the LTCH PPS wage index adjustment most appropriately accounts for and reflects the relative hospital wage levels in the geographic area of the hospital as compared to the national average hospital wage level. Specifically, we are revising the LTCH PPS labor market definitions based on OMB's new CBSA designations (as discussed in greater detail below) effective for LTCH PPS discharges occurring on or after July 1, 2005. Accordingly, as we proposed in the February 3, 2005 proposed rule (70 FR 5739), we are revising § 412.525(c) to specify that for discharges occurring on or after July 1, 2005, the application of the wage index under the LTCH PPS will be made on the basis of the location of the facility in an urban or rural area as defined in § 412.64(b)(1)(ii)(A)-(C). (As a conforming change, as we proposed in the February 3, 2005 LTCH PPS proposed rule, we are also revising § 412.525(c) to specify when the current labor area definitions in the existing § 412.525(c) are applicable. We note that in this final rule, we are revising the final regulations text at § 412.525(c)(1) to explicitly state that the current MSA-based labor area definitions are effective "for cost reporting periods beginning on or after October 1, 2002, with respect to discharges occurring during the period covered by such cost reports but before July 1, 2005." We are clarifying the regulations text because we do not want the public to misinterpret the "July 1, 2005" date as referring to "cost reporting periods" when in fact it applies to "discharges." In addition, we want to make it clear that the urban and rural definitions in § 412.62(f)(1)(iii), respectively, apply to a LTCH's discharges occurring no earlier than the date upon which the LTCH became subject to the LTCH PPS. Although we did our best to convey this in the proposed regulations text presented in the February 3, 2005 proposed rule, we believe that the regulations text could be improved to better reflect this clarification. While this revision is not a change in the policy presented in the February 3, 2005 LTCH PPS proposed rule (70 FR 5739), we believe that this language change more clearly articulates that the current MSA-based labor market definitions are effective for LTCH discharges occurring before July 1, 2005 that are subject to the LTCH PPS (that is, occurring in cost reporting periods beginning on or after October 1, 2002). We also note that these are the same labor market area definitions (based on the OMB's new CBSA designations) implemented for acute care inpatient hospitals under the IPPS

at § 412.64(b), which were effective for those hospitals beginning October 1, 2004 as discussed in the FY 2005 IPPS final rule (69 FR 49026).

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

Below, we discuss the composition of the LTCH PPS labor market areas based on the OMB's new CBSA designations, as we proposed in the February 3, 2005 proposed rule. It should be noted that OMB's new CBSA designations are comprised of several county-based area definitions as explained above, which include Metropolitan Areas, Micropolitan Areas, and areas "outside CBSAs." Under the LTCH PPS, since the implementation of the LTCH PPS, we have used two types of labor market areas, urban and rural. As discussed in greater detail below, in this final rule, in adopting revised labor market areas under the LTCH PPS based on OMB's new CBSA-based designations, we will continue to have 2 types of labor market areas (urban and rural). In the discussion that follows, we explain our recognition of Metropolitan Areas, which include New England MSAs and Metropolitan Divisions, as urban. We also explain our recognition of Micropolitan Areas and areas "outside CBSAs" as rural. The following discussion, which was presented in the February 3, 2005 proposed rule (70 FR 5739–5742), describes the methodology for mapping OMB's CBSA-based designations into the LTCH PPS (urban area or rural area) format.

a. New England MSAs

As stated above, under the LTCH PPS, we currently use NECMAs to define labor market areas in New England, because these are county-based designations rather than the 1990 MSA

definitions for New England, which used minor civil divisions such as cities and towns. Under the current MSA definitions, NECMAs provided more consistency in labor market definitions for New England compared with the rest of the country, where MSAs are county-based. Under the new CBSAs, OMB has now defined the MSAs and Micropolitan Areas in New England on the basis of counties. OMB also established New England City and Town Areas, which are similar to the previous New England MSAs.

In order to create consistency across all LTCH labor market areas, in the February 3, 2005 proposed rule (70 FR 5740), under the LTCH PPS, we proposed to use the county-based areas for all MSAs in the nation, including those in New England. The OMB has now defined the New England area based on counties, creating a city and town-based system as an alternative. As we explained in that same proposed rule, we believe that adopting county-based labor market areas for the entire country except those in New England would lead to inconsistencies in our designations. Adopting county-based labor market areas for the entire country provides consistency and stability in Medicare program payment because all of the labor market areas throughout the country, including New England, would be defined using the same system (that is, counties) rather than different systems in different areas of the country, and minimizes programmatic complexity.

In addition, we have consistently employed a county-based system for New England for precisely that reason: To maintain consistency with the labor market definitions used throughout the country. Because we have never used cities and towns for defining LTCH labor market areas, employing a county-based system in New England maintains that consistent practice. We note that this is consistent with the implementation of the CBSA-based designations under the IPPS for New England (69 FR 49028). Accordingly, under the LTCH PPS we will use the New England MSAs as determined under the new CBSA-based labor market area definitions in defining the revised LTCH PPS labor market areas. We did not receive any comments regarding the proposed use of county-based areas for all MSAs in the nation, including those in New England, in our proposal to make revisions to the LTCH PPS labor market area definitions based on OMB's CBSA designations. Therefore, under the broad authority of section 123 of Pub. L. 106–113 and section 307(b)(1) of Pub. L. 106–554, we are adopting this

policy as final as part of the changes to the LTCH PPS labor market area definitions we are establishing in this final rule for the reasons explained above.

b. Metropolitan Divisions

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

The construct of relatively large MSAs being comprised of Metropolitan Divisions is similar to the current construct of CMSAs comprised of PMSAs. As noted above, in the past, the OMB designated CMSAs as Metropolitan Areas with a population of one million or more and comprised of two or more PMSAs. Under the LTCH PPS, we currently use the PMSAs rather than CMSAs to define labor market areas because they comprise a smaller geographic area with potentially varying labor costs due to different local economies. As we discussed in the February 3, 2005 proposed rule (70 FR 5740), we believe that CMSAs may be too large of an area with a relatively large number of hospitals, to accurately reflect the local labor costs of all of the individual hospitals included in that relatively "large" area. A large market area designation increases the likelihood of including many hospitals located in areas with very different labor market conditions within the same market area designation. This variation could increase the difficulty in calculating a single wage index that would be relevant for all hospitals

within the market area designation. Similarly, we believe that MSAs with a population of 2.5 million or greater may be too large of an area to accurately reflect the local labor costs of all of the individual hospitals included in that relatively "large" area. Furthermore, as indicated above, Metropolitan Divisions represent the closest approximation to PMSAs, the building block of the current LTCH PPS labor market area definitions, and, therefore, would most accurately maintain our current structuring of the LTCH PPS labor market areas. Therefore, as implemented under the IPPS (69 FR 49029), under the LTCH PPS we proposed to use the Metropolitan Divisions where applicable (as described below) under the new CBSA-based labor market area definitions. We did not receive any comments regarding our proposed use of Metropolitan Divisions under our proposed revisions to the LTCH PPS labor market area definitions based on OMB's new CBSA designations. Therefore, under the broad authority of section 123 of Pub. L. 106-113 and section 307(b)(1) of Pub. L. 106-554, we are adopting this policy as final as part of the changes we are making to the LTCH PPS labor market area definitions in this final rule for the reasons explained above.

In addition to being comparable to the organization of the labor market areas under current MSA designations (that is, the use of PMSAs rather than CMSAs), we believe that using Metropolitan Divisions where applicable (as described below) under the LTCH PPS will result in a more accurate adjustment for the variation in local labor market areas for LTCHs. Specifically, if we recognize the relatively "larger" CBSA that comprises two or more Metropolitan Divisions as an independent labor market area for purposes of the wage index, it will be too large and will include the data from too many hospitals to compute a wage index that would accurately reflect the various local labor costs of all of the individual hospitals included in that relatively "large" CBSA. As mentioned earlier, a large market area designation increases the likelihood of including many hospitals located in areas with very different labor market conditions within the same market area designation. This variation could increase the difficulty in calculating a single wage index that would be relevant for all hospitals within the market area designation. Rather, by recognizing Metropolitan Divisions where applicable (as described below) under the new CBSA-based labor market

area definitions under the LTCH PPS, we believe that in addition to more accurately maintaining the current structuring of the LTCH PPS labor market areas, the local labor costs will be more accurately reflected, thereby resulting in a wage index adjustment that better reflects the variation in the local labor costs of the local economies of the LTCHs located in these relatively "smaller" areas.

As discussed below, and in the February 3, 2005 proposed rule (70 FR 5741), we describe where Metropolitan Divisions will be applicable under the new CBSA-based labor market area definitions under the LTCH PPS.

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

Under the current LTCH PPS labor market area designations, Cincinnati, Cleveland, Denver, Houston, Milwaukee, Portland, Sacramento, and San Juan are all designated as CMSAs, but will no longer be designated as CMSAs under the CBSA-based labor

market area designations. As noted previously, the population threshold to be designated a CMSA under the current LTCH PPS labor market area designations is one million. In most of these cases, counties currently in a PMSA under the current LTCH PPS labor market area designations will become separate, independent MSAs under the CBSA-based labor market area designations.

c. Micropolitan Areas

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

In general, as discussed in the February 3, 2005 proposed rule (70 FR 5741), including Micropolitan Areas as part of the statewide rural labor market area would result in an increase to the statewide rural wage index because hospitals located in those Micropolitan Areas typically have higher labor costs than other rural hospitals in the State. Alternatively, as discussed in greater detail below, if Micropolitan Areas would be recognized as independent labor market areas, because there would be so few hospitals in each labor market area, the wage indices for LTCHs in those areas could become relatively unstable as they would change considerably from year to year.

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

hospitals that are currently included in the statewide rural labor market areas.

In the February 3, 2005 proposed rule (70 FR 5741), we proposed to treat Micropolitan Areas as rural labor market areas under the LTCH PPS for the reasons outlined below. That is, counties that are assigned to a Micropolitan area under the CBSA-based designations would be treated the same as other "rural" counties that are not assigned to either an MSA (Metropolitan Statistical Area) or a Micropolitan Area. We received no comments on our proposal to treat Micropolitan Areas as rural labor market areas under the LTCH PPS. Therefore, for the reasons discussed above and under the broad authority of section 123 of Pub. L. 106-113 and section 307(b)(1) of Pub. L. 106-554, we are adopting this policy as final as part of the changes we are making to the LTCH PPS labor market area definitions in this final rule. Accordingly, in determining a LTCH's applicable wage index (based on IPPS hospital wage index data, as discussed in greater detail below in section V.C.d. of this preamble), a LTCH in a Micropolitan Area under the OMB's CBSA-based designations will be classified as "rural" and will be assigned the statewide rural wage index for the State in which it resides.

In the FY 2005 IPPS final rule (69 FR 49029-49032), we discuss our evaluation of the impact of treating Micropolitan Areas as part of the statewide rural labor market area instead of treating Micropolitan Areas as independent labor market areas for hospitals paid under the IPPS. As an alternative to treating Micropolitan Areas as part of the statewide rural labor market area for purposes of the LTCH PPS, we examined treating Micropolitan Areas as separate (urban) labor market areas, just as we did when implementing the revised labor market areas under the IPPS. As discussed in that same final rule, one of the reasons Micropolitan Areas have such a dramatic impact on the wage index is, because Micropolitan Areas encompass smaller populations than MSAs, they tend to include fewer hospitals per Micropolitan Area. There were only 25 MSAs with one hospital in the MSA. However, under the new CBSA-based definitions, there are 373 Micropolitan Areas with one hospital, and 49 MSAs with only one hospital.

This large number of labor market areas with only one hospital and the increased potential for dramatic shifts in the wage indexes from 1 year to the next is a problem for several reasons. First, it creates instability in the wage index

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

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

Comment: One commenter brought to our attention the fact that that we included two Micropolitan Areas, Enid, OK (CBSA 21240) and Jamestown, NY (CBSA 27640), in our Table of proposed urban area wage indexes (as shown in Table 1 of the addendum to the February 3, 2005 proposed rule (70 FR 5772)).

Response: We thank the commenter for bringing this inadvertent error to our attention. We have removed those two Micropolitan areas (which we proposed to treat as rural) from Table 1 (urban area wage indexes) of the Addendum to this final rule. We also want to note that, despite this error, the statewide average rural wage indexes in Table 2 for rural OK and NY, respectively, correctly included the wage data for these Micropolitan areas.

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

As we discussed in the February 3, 2005 proposed rule (70 FR 5742), consistent with our policy under the IPPS, we did not propose to adopt the new labor market area definitions themselves in a budget neutral manner. We did not receive any comments and, therefore, under the generally broad authority conferred upon the Secretary to develop the LTCH PPS under section 123 of Pub. L. 106–113 and section 307 of Pub. L. 106–554, are not adopting the new labor market area definitions under the LTCH PPS in a budget neutral manner, just as implemented under the IPPS.

Furthermore, as we also discussed in that same proposed rule and as we discussed in the August 30, 2002 LTCH PPS final rule, under section 123 of the BBRA, and section 307 of the BIPA, the Secretary generally has broad authority in developing the LTCH PPS, including whether and how to make adjustments to the LTCH PPS. In that same final rule we state that we will consider whether it is appropriate for us to propose a budget neutrality adjustment in the annual update of some aspects of the LTCH PPS under our broad discretionary authority under the statute to provide “appropriate adjustments” to the LTCH PPS. Until the 5-year transition from cost-based reimbursement to prospective payment is complete, including the end of the phase-in of the wage index adjustment under § 412.525(c), as we explained in the February 3, 2005 proposed rule, we believe that it would not be appropriate to update any aspects of the LTCH PPS in a budget neutral manner. A primary reason for waiting until after the transition is complete before evaluating aspects of the LTCH PPS, including the budget neutrality issue, is that the data available to analyze such issues is very limited because the LTCH PPS is still relatively new and there is a lag time in data availability. Also, the fact that a number of LTCHs were and some still are transitioning to 100 percent of the Federal prospective payment rate may make the available data even less appropriate for an analysis, since hospitals may still be modifying their behavior based on their transition to prospective payment and our data may not yet replace any operational changes LTCHs may have made in response to prospective payment. Once the transition is complete, we will have a better opportunity to evaluate the impacts of the implementation of this new payment system based on a number of years of LTCH PPS data.

To facilitate an understanding of the policies related to the change to the LTCH PPS labor market areas discussed above, in Table 4 of the Addendum of this final rule, we are providing a listing of each LTCH’s State and county location; existing labor market area designation; and its new CBSA-based labor market area designation based on the best available cost report data from HCRIS (FYs 1999–2003) and county information from our OSCAR database. Any questions or corrections (including additions or deletions) to the information provided in Table 4 should be e-mailed to the following CMS Web address: cmsltchpps@cms.hhs.gov. A link to this address can be found on the following CMS Web page <http://www.cms.hhs.gov/providers/longterm/default.asp>. We also note that a crosswalk file is available on the CMS Web page <http://www.cms.hhs.gov/providers/longterm/frnotices.asp>, which shows, by county, a crosswalk of the MSA-based labor market areas to the new CBSA-based labor-market areas adopted in this final rule.

As we discussed in the February 3, 2005 proposed rule (70 FR 5743), when the revised labor market areas based on the OMB’s new CBSA-based designations were adopted under the acute care hospital IPPS beginning on October 1, 2004, a transition to the new labor market area designations was established due to the scope and significant implications of these new boundaries and to buffer the subsequent significant impacts it may have on payments to numerous hospitals. As discussed in the FY 2005 IPPS final rule (69 FR 49032), during FY 2005, a blend of wage indexes is calculated for those acute care IPPS hospitals experiencing a drop in their wage indexes because of the adoption of the new labor market areas. Also, as described in that same final rule (69 FR 49032), under the IPPS, hospitals that previously were located in an urban MSA, but then became rural under the new CBSA-based definitions are assigned the wage index value of the urban area to which they previously belonged, for 3 years (FYs 2005–2007).

Also, in the February 3, 2005 proposed rule, we explained that we did not believe it was necessary to propose a transition policy for the revision to the LTCH PPS labor market area definitions because the impact of the revision to the labor market area definitions would only have a minimal impact on LTCH PPS payments (as explained below). Instead, under the LTCH PPS, we proposed to adopt the new CBSA-based labor market area definitions beginning with the 2006 LTCH PPS rate year without a transition period. As also

discussed in greater detail below, we believe that this policy is appropriate because despite significant similarities between the LTCH PPS and the IPPS, there are clear distinctions between the payment systems, particularly regarding wage index issues.

The most significant distinction upon which we have based this policy determination, as we discussed in the February 3, 2005 proposed rule, is that where acute care hospitals under the IPPS have been paid using full wage index adjusted payments since 1983 and had used the previous IPPS MSA-based labor market area designations for over 10 years, under the LTCH PPS, a wage index adjustment is being phased-in over a 5-year period, and as noted above, most LTCHs are still in their FY 2004 cost reporting period (the vast majority of LTCHs start their cost reporting periods on July 1 or September 1), and are, therefore, in the 2nd year of the 5-year phase-in of the LTCH PPS wage index adjustment, and the applicable wage index value is $\frac{2}{5}$ ths (40 percent) of the applicable full LTCH PPS wage index adjustment. Since most LTCHs are only in the 2nd year of the 5-year phase-in of the wage index adjustment, for most LTCHs, the labor-related portion of the standard Federal rate is only adjusted by 40 percent of the applicable full wage index (that is, $\frac{2}{5}$ th wage index value). The LTCH PPS wage index adjustment is made by multiplying the LTCH PPS standard Federal rate by the applicable wage index value, and the current LTCH PPS labor related-share is 72.885 percent. Consequently, for most LTCHs, only 29 percent of the standard Federal rate is affected by the wage index adjustment ($72.885 \text{ percent} \times 0.4 = 29.154 \text{ percent}$), and the revision to the labor market area definitions based on OMB’s new CBSA-based designations will only have a minimal impact on LTCH PPS payments. Thus, the impact that the wage index can have on LTCH PPS payments is limited at this point, since only a small percentage of the LTCH PPS standard Federal rate is affected by the wage index (approximately 29 percent in most cases, as explained above) because of the 5-year phase-in of the wage index adjustment.

Our initial analysis of the appropriateness of including a wage index adjustment in the March 22, 2002 proposed rule for the LTCH PPS (67 FR 13465) indicated that a wage adjustment did not lead to an increase in the accuracy of LTCH PPS payments because a statistical analysis did not show a significant relationship between LTCHs costs and their geographic location. However, based upon

comments, we revisited this proposed determination after additional data analysis and a more general policy evaluation, and we stated that we “believe that the conceptual reasons for having an area wage adjustment support transitioning into a wage adjustment, notwithstanding the data problems and issues with the regression analysis” (see August 30, 2002 LTCH PPS final rule (67 FR 56018)). However, given the lack of strong empirical evidence to support a wage index adjustment under the LTCH PPS, we provided for a 5-year transition to the full implementation of the wage index adjustment. We also noted that we would “* * * continue to reevaluate LTCH data as they become available and would propose to adjust the phase-in if subsequent data support a change.” In each subsequent LTCH PPS proposed and final rule since FY 2003, we have evaluated the most recent LTCH data available and still have found no empirical evidence to support a change in the 5-year phase-in of the wage index adjustment under the LTCH PPS.

A wage index adjustment has been a stable feature of the acute care hospital IPPS since its 1983 implementation and, furthermore, the IPPS had utilized the prior MSA-based labor market area designation for over 10 years. As explained in detail above, the proposed revisions to the labor market area definitions based on OMB's new CBSA designations would not have the same impact on the LTCH PPS, which has only been implemented since October 1, 2002, as it did on the IPPS. Given the clear distinction between the impact of the revisions to the labor market area definitions on the IPPS as compared to those same proposed revisions to the LTCH PPS, therefore, we believe that, although it is appropriate to adopt transition policies for acute care hospitals under the IPPS, it is also equally appropriate not to treat the impact of the proposed revisions to the LTCH PPS labor market area definitions in the same way under the LTCH PPS. We believe that the revision to the labor market area definitions based on OMB's new CBSA-based designations would only have a minimal impact on LTCH PPS payments.

As we discussed in the February 3, 2005 proposed rule, because the impact of the revision to the labor market area definitions would only have a minimal impact on LTCH PPS payments (as explained above), we do not believe it is necessary to have a transition policy for the revision to the LTCH PPS labor market area definitions. In contrast, a transition policy to the revised IPPS labor market area definitions under the

IPPS was appropriate because individual hospitals could experience a significant impact as a result of the new labor market definitions, especially because the full labor-related share of either 71.066 percent or 62 percent (as discussed above in section V.C.1.b. of this preamble) of the IPPS standardized amount (that is, Federal rate) is affected by the IPPS wage index adjustment, which resulted in a more significant projected impact for acute care hospitals under the IPPS. Furthermore, as we explained in that same proposed rule, we do not believe that it is necessary to further transition any changes to the LTCH PPS wage index adjustment, including the revision of the labor market area definitions, because, in fact, the LTCH PPS wage index adjustment is still being phased-in over 5 years as established in the August 30, 2002 LTCH PPS final rule (67 FR 56018). Accordingly, in the February 3, 2005 proposed rule, we explained that, to the extent the new CBSA-based labor market area definitions are implemented, we would not expect them to have as significant of an impact on LTCHs, as they do for IPPS hospitals since the full wage index adjustment had been a stable factor of IPPS payment for over 20 years.

Comment: One commenter believes that we should implement our proposed revisions to the LTCH PPS labor market area based on OMB's CBSA designations with the same transition as was implemented under the IPPS.

Response: As discussed in the February 3, 2005 proposed rule, we did not provide for a transition policy under the LTCH PPS for changes to the labor market area definitions even though a transition policy was implemented under the IPPS. We believe it was necessary to provide additional protection to acute care hospitals that due to the new CBSA designations experienced reductions in their wage indices, given the scope and potentially significant implications of these new labor market areas. Moreover, as noted above, a wage index adjustment has been a stable feature of the acute care hospital IPPS almost since its implementation in 1983. The prior MSA-based labor market area designations were utilized in IPPS for over 10 years, thus, reinforcing our belief that a transition policy was appropriate.

We recognize that, just like IPPS hospitals, many LTCHs would experience decreases in their wage index as a result of the labor market area changes. At the same time, a significant number of LTCHs may benefit from these changes. However, we believe that

because we are in the midst of a 5-year transition to a full wage-index adjustment under the LTCH PPS, the effects of these newest CBSA-based changes to the LTCH PPS labor market areas definitions will be mitigated. Specifically, as noted above, many LTCHs are still in the early stages of the 5-year phase-in of the LTCH PPS wage index adjustment. In fact, many LTCHs are only in the 2nd year of the 5-year phase-in of the LTCH PPS wage index adjustment. Therefore, for most LTCHs, the labor-related portion of the standard Federal rate is only adjusted by 40 percent of the applicable full wage index (that is, $\frac{2}{5}$ th wage index value). Also, as noted above, the LTCH PPS wage index adjustment is made by multiplying the LTCH PPS standard Federal rate by the applicable wage index value, and the current LTCH PPS labor related-share is 72.885 percent. Consequently, for most LTCHs, only 29 percent of the standard Federal rate is affected by the wage index adjustment ($72.885 \text{ percent} \times 0.4 = 29.154 \text{ percent}$), and the proposed revision to the labor market area definitions based on OMB's new CBSA-based designations will only have a minimal impact on LTCH PPS payments.

An additional distinction between the IPPS and the LTCH PPS regarding the wage index adjustment is that the IPPS policies that provide for a transition policy from MSA-based labor market areas to CBSA-based labor market areas were implemented in a budget neutral manner under the IPPS (69 FR 49034–49035 and 49275). However, as noted above, wage index changes are not budget neutral under the LTCH PPS; therefore, a transition policy similar to what was implemented for the IPPS would result in additional LTCH spending by the Medicare program. Therefore, as explained in more detail above, despite the fact that we have established a transition policy for the implementation of CBSA-based labor market areas under the IPPS, we do not believe that it is either appropriate or necessary to establish a similar transition policy under the LTCH PPS. This is the case, in large part, because there are clear differences in the impact of the wage index adjustment between the IPPS and the LTCH PPS. Primarily, we would note that the full 100 percent wage index adjustment has been a feature of the IPPS since its beginning in 1983 where under the LTCH PPS, which has been in effect for cost reporting periods beginning on or after October 1, 2002, many LTCHs are only in the 2nd year of a 5-year phase-in of a full wage index adjustment. Therefore,

even though there are many LTCHs that will experience decreases in their wage index as a result of the labor market changes, and there are a significant number of LTCHs that may benefit from the changes, we believe that the effects of the changes to the LTCH PPS labor market area definition resulting from the new CBSA-based designations will be mitigated because, presently, payments to LTCHs do not include a full wage index adjustment. Therefore, under the broad authority of section 123 of Pub. L. 106–113 and section 307(b)(1) of Pub. L. 106–554, we are not providing for a transition period for purposes of implementing the new CBSA-based labor market area definitions.

In addition, in the February 3, 2005 proposed rule (70 FR 5744), we proposed to revise § 412.525(c) to clarify the application of the current adjustment for area wage levels under the LTCH PPS, which was originally established in the August 30, 2002 final rule (67 FR 56015–56019). Specifically, we proposed to revise § 412.525(c) to state that the labor portion of a LTCH's Federal prospective payment is adjusted to account for geographical differences in the area wage levels using an appropriate wage index (established by CMS). The wage index reflects the relative level of hospital wages and wage-related costs in the geographic area of the hospital compared to the national average level of hospital wages and wage-related costs. Currently, urban or rural area is determined in accordance with the definitions at § 412.62(f)(1)(ii) and (iii). We received no comments on our proposed revisions to § 412.525(c), and, therefore, are adopting those changes in this final rule. As we discussed above, because we are revising those definitions in this final rule, urban or rural area will be determined in accordance with the revisions to § 412.525(c)(1) or the revisions to § 412.525(c)(2), respectively. In addition, § 412.525(c) will be revised to specify that the appropriate wage index (established by CMS) is updated annually. We note that this revision to the language in § 412.525(c), which codifies our existing policy into regulations, is similar to the wage index adjustment codified in regulations under the IPPS at § 412.64(h). As stated above, this clarification to § 412.525(c) clearly outlines in regulations our established methodology for the application of the area wage adjustment under the LTCH PPS. As noted above, this methodology was established when we implemented the LTCH PPS (that is, cost reporting periods beginning on or after October 1,

2002) in the August 30, 2002 final rule (67 FR 56015).

d. Wage Index Data

In the May 7, 2004 final rule (69 FR 25684), we established LTCH PPS wage index values for the 2005 LTCH PPS rate year calculated from the same data (generated in cost reporting periods beginning during FY 2000) used to compute the FY 2004 acute care hospital inpatient wage index data without taking into account geographic reclassification under sections 1886(d)(8) and (d)(10) of the Act. The LTCH wage index values applicable for discharges occurring on or after July 1, 2004 through June 30, 2005 are shown in Table 1 (for urban areas) and Table 2 (for rural areas) in the Addendum to that final rule. Acute care hospital inpatient wage index data is also used to establish the wage index adjustment used in the IRF PPS, IPF PPS, HHA PPS, SNF PPS, and inpatient psychiatric facility PPS (IPF). As we discussed in the August 30, 2002 LTCH PPS final rule (67 FR 56019), since hospitals that are excluded from the IPPS are not required to provide wage-related information on the Medicare cost report and because we would need to establish instructions for the collection of this LTCH data in order to establish a geographic reclassification adjustment under the LTCH PPS, the wage adjustment established under the LTCH PPS is based on a LTCH's actual location without regard to the urban or rural designation of any related or affiliated provider. Therefore, because complete LTCH wage-related data are not currently available on the cost report, we do not have complete LTCH wage related data to use for the purposes of creating a LTCH wage index based on LTCH wage data, and since the labor market areas of acute care hospitals under the IPPS are similar to those of LTCHs, we believe wage data of acute care IPPS hospitals accurately capture the relationship between the wage related costs for LTCHs in an area as compared to the national average. Therefore, we believe IPPS acute care hospitals' wage data are the best available data to use for the wage index under the LTCH PPS.

In the February 3, 2005 proposed rule, for the 2006 LTCH PPS rate year, we proposed to use acute care hospital inpatient wage index data generated from cost reporting periods beginning during FY 2001 without taking into account geographic reclassification under sections 1886(d)(8) and (d)(10) of the Act to determine the applicable wage index values under the LTCH PPS because these data (FY 2001) are the

most recent complete data. These data are the same FY 2001 acute care hospital inpatient wage data that were used to compute the FY 2005 wage indices currently used under the IPPS, SNF PPS, and HHA PPS. The proposed full wage index values applicable for LTCH PPS discharges occurring on or after July 1, 2005 through June 30, 2006 are shown in Tables 1 and 2 in the Addendum to that same proposed rule (70 FR 5772–5806). As we noted in earlier in this section, we inadvertently included two Micropolitan Areas, Enid, OK (CBSA 21240) and Jamestown, NY (CBSA 27640) (which we proposed to treat as rural), in Table 1 (proposed urban area wage indexes) of the Addendum to the February 3, 2005 proposed rule. Despite this error, the proposed statewide average rural wage indexes in Table 2 of the Addendum to that same proposed rule for rural OK and NY, respectively, correctly included the wage data for these Micropolitan areas. We have removed these two geographic areas from Table 1 (urban area wage indexes) of the Addendum to this final rule. We received no comments on the proposed wage index values for 2006 LTCH PPS rate year. Accordingly, in this final rule, we are establishing wage index values for the 2006 LTCH PPS rate year calculated from the same data used to calculate the FY 2005 acute care hospital wage index used under the IPPS (generated in FY 2001) without taking into account geographic reclassification under sections 1886(d)(8) and (d)(10) of the Act. The LTCH wage index values that will be applicable for discharges occurring on or after July 1, 2005 through June 30, 2006, are shown in Table 1 (for urban areas) and Table 2 (for rural areas) in the Addendum to this final rule. We note a labeling error published in prior years wage index tables used in the LTCH PPS. That labeling error was the listing of Stanly County, NC as one of the areas under MSA 1520 when, in fact, we consider Stanly County, NC to be a rural area in North Carolina. Stanly County wage data have always been correctly treated as rural in the actual creation of the LTCH wage index values, and it has only been the listing of Stanly County under MSA 1520 in prior years LTCH PPS index tables that was in error. Consequently, Table 1a in the Addendum to this final rule correctly removes Stanly County from the list of areas that fall under the MSA 1520 wage index. As this is strictly a labeling correction that does not affect the actual computation of the wage index values, any LTCHs located in Stanly County,

NC, will continue to fall under, and use, the wage index for rural North Carolina. As we also noted above, we have removed the inadvertent inclusion of two Micropolitan Areas (which we are treating as rural), Enid, OK (CBSA 21240) and Jamestown, NY (CBSA 27640), from Table 1 (urban area wage indexes) of the addendum to this final rule).

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

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

the LTCH's cost reporting period beginning during FY 2006, the applicable wage index value will be four-fifths of the full FY 2005 acute care hospital inpatient wage index data, without taking into account geographic reclassification under sections 1886(d)(8) and (d)(10) of the Act (shown in Tables 1 and 2 in the Addendum to this final rule).

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

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

In the August 30, 2002 LTCH PPS final rule (67 FR 56022), we established, under § 412.525(b), a cost-of-living adjustment (COLA) for LTCHs located in Alaska and Hawaii to account for the higher costs incurred in those States. (The inadvertent omission of § 412.525(b) by the OFR noted in the May 7, 2004 LTCH PPS final rule (69 FR 25686) has been corrected in 42 CFR parts 400 to 429 revised as of October 1, 2004). In the May 7, 2004 final rule (69 FR 25686), for the 2005 LTCH PPS rate year, we established that we make

a COLA to payments for LTCHs located in Alaska and Hawaii by multiplying the standard Federal payment rate by the appropriate factor listed in Table I of that same final rule.

In the February 3, 2005 proposed rule, for the 2006 LTCH PPS rate year, we proposed to make a COLA to payments to LTCHs located in Alaska and Hawaii by multiplying the standard Federal payment rate by the factors listed in Table I below. These factors are obtained from the U.S. Office of Personnel Management (OPM) and are currently used under the IPPS. In addition, in that same proposed rule, we proposed that if the OPM releases revised COLA factors before March 1, 2005, we would use them for the development of the payments for the 2006 LTCH rate year and publish them in the LTCH PPS final rule. The OPM has not revised the COLA factors for Alaska and Hawaii since the publication of the proposed rule. Therefore, we are using the proposed COLA factors published in the February 3, 2005 proposed rule for this final rule.

We received no comments on the proposed COLA factors for LTCHs located in Alaska and Hawaii for the 2006 LTCH PPS rate year. Therefore, under § 412.525(b) and the broad authority of section 123 of Pub. L. 106–113 and section 307(b)(1) of Pub. L. 106–554, we are establishing the COLA factors for LTCHs located in Alaska and Hawaii, as shown below in Table I, for the 2006 LTCH PPS rate year.

TABLE I.—COST-OF-LIVING ADJUSTMENT FACTORS FOR ALASKA AND HAWAII HOSPITALS FOR THE 2006 LTCH PPS RATE YEAR

Alaska:	
All areas	1.25
Hawaii:	
Honolulu County	1.25
Hawaii County	1.165
Kauai County	1.2325
Maui County	1.2375
Kalawao County	1.2375

3. Adjustment for High-Cost Outliers

a. Background

Under § 412.525(a), we make an adjustment for additional payments for outlier cases that have extraordinarily high costs relative to the costs of most discharges. Providing additional payments for outliers strongly improves the accuracy of the LTCH PPS in determining resource costs at the patient and hospital level. These additional payments reduce the financial losses that would otherwise be caused by treating patients who require more

costly care and, therefore, reduce the incentives to underserve these patients. We set the outlier threshold before the beginning of the applicable rate year so that total outlier payments are projected to equal 8 percent of estimated total payments under the LTCH PPS.

Under § 412.525(a), we make outlier payments for any discharges if the estimated cost of a case exceeds the adjusted LTCH PPS payment for the LTC-DRG plus a fixed-loss amount. The fixed-loss amount is the amount used to limit the loss that a hospital will incur under 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. The LTCH's loss is limited to the fixed-loss amount and a fixed percentage of costs above the marginal cost factor. We calculate the estimated cost of a case by multiplying the overall hospital cost-to-charge ratio by the Medicare allowable covered charge. In accordance with § 412.525(a)(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 simulating estimated aggregate payments with and without an outlier policy. We set the fixed-loss amount at a level that would result in estimated total outlier payments being projected to be equal to 8 percent of projected total LTCH PPS payments. Currently, MedPAR claims data and cost-to-charge ratios based on data from the latest available cost report data from the Hospital Cost Report Information System (HCRIS) and corresponding MedPAR claims data are used to establish a fixed-loss threshold amount under the LTCH PPS.

b. Cost-to-Charge Ratios (CCRs)

As we noted above, we calculate the estimate of the cost of the case used in determining LTCH PPS outlier payments by multiplying the Medicare allowable charges for the case by the LTCH's overall CCR. As we established in the June 9, 2003 IPPS high-cost outlier final rule (68 FR 34494–34515), for discharges occurring on or after October 1, 2003, FIs use either the most recent settled cost report or the most recent tentative settled cost report, whichever is from the later period, to

determine a LTCH's CCR. As we specified in Program Memorandum Transmittal A-02-093 when we implemented the LTCH PPS and as codified in regulation at § 412.525(a)(4)(ii) which incorporates § 412.84(i)(3), for discharges occurring on or after August 8, 2003, for LTCHs for which we are unable to compute an accurate CCR (for example, due to faulty or unavailable data), we assign the applicable statewide average CCR to the LTCH. (Currently, the applicable statewide average CCRs can be found in Tables 8A and 8B of the FY 2005 IPPS final rule (69 FR 49687–49688).)

As set forth in § 412.525(a)(4)(ii), by cross-referencing § 412.84(i)(3), currently, we apply the applicable statewide average CCR when a LTCH's CCR exceeds the maximum CCR threshold (ceiling) set forth at § 412.84(i)(3)(ii). As we explained in the June 9, 2003 high-cost outlier final rule (68 FR 34506–34507), CCRs above this range are probably due to faulty data reporting or entry. Therefore, these CCRs should not be used to identify and make payments for outlier cases because the data are clearly errors and should not be relied upon. We also have a similar policy regarding use of the statewide average CCR under the short-stay outlier policy at § 412.529. Since CCRs are also used in determining short-stay outlier payments, the rationale for that policy mirrors that for high-cost outliers. (As specified in Transmittal 309 (October 1, 2004), the current LTCH PPS CCR ceiling is 1.409, which is equal to the combined operating and capital CCR ceilings (69 FR 49278).)

Currently, for discharges occurring on or after August 8, 2003, only a maximum CCR threshold (ceiling) is applied to a LTCH's CCR ratio. For discharges occurring on or after August 8, 2003, a minimum CCR threshold (floor) is no longer applicable (See June 8, 2003, 68 FR 34506–34507). As discussed above, if a LTCH's CCR is above the ceiling, the applicable statewide average CCR is assigned to the LTCH. However, a LTCH's CCR is no longer raised to the applicable statewide average CCR if it falls below a minimum CCR threshold (floor) for discharges occurring on or after August 8, 2003, in order to prevent hospitals from receiving inappropriately high outlier payments. As we explained in the June 6, 2003 final rule, (68 FR 34143–34144), we believe that using the current combined IPPS operating and capital CCR ceiling for LTCHs is appropriate since LTCHs are certified as acute care hospitals that meet the criteria set forth in section 1861(e) of the Act to

participate as a hospital in the Medicare program, and, in general, hospitals are paid as LTCHs only because their Medicare average length of stay is greater than 25 days in accordance with § 412.23(e). Furthermore, as explained in that same final rule, prior to qualifying as a LTCH under § 412.23(e)(2)(i), a hospital generally is paid as an acute care hospital under the IPPS during the period in which it demonstrates that it has an average length of stay of greater than 25 days. (Refer to the June 9, 2003 high-cost outlier final rule (68 FR 34506–34507) for further explanation of the establishment of the current CCR policy.)

c. Establishment of the Fixed-Loss Amount

When we implemented the LTCH PPS, as discussed in the August 30, 2002 final rule (67 FR 56022–56026), 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. Specifically, to determine the outlier payment for each case, we estimate the cost of the case by multiplying the Medicare covered charges from the claim by the LTCH's hospital specific CCR. In accordance with § 412.525(a)(3), if the estimated cost of the case exceeds the outlier threshold (the sum of the adjusted Federal prospective payment for the LTC-DRG and the fixed-loss amount), we pay an outlier payment equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted Federal prospective payment for the LTC-DRG and the fixed-loss amount).

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

the LTCH PPS rate year (that is, July 1, 2004, for the 2005 LTCH PPS rate year).

We also applied the current outlier policy under § 412.525(a) in determining the fixed-loss amount for the 2005 LTCH PPS rate year. Accordingly, we used the FY 2004 IPPS combined operating and capital CCR ceiling of 1.366 (as explained in the IPPS final rule, published August 1, 2003 (68 FR 45478)) to evaluate whether each LTCH's CCR exceeded the ceiling. (Our rationale for using the FY 2004 combined IPPS operating and capital CCR ceiling for LTCHs is stated above in section V.C.3.b. of this preamble.) As we discuss in greater detail below, in determining the fixed-loss amount for the 2005 LTCH PPS rate year, there were no LTCHs with missing CCRs or with CCRs in excess of the current ceiling and, therefore, there was no need to assign the applicable statewide average CCR to any LTCHs in determining the fixed-loss amount (unless this was already done by the FI).

For the 2005 LTCH PPS rate year, in the May 7, 2004 final rule (69 FR 25689), we established a fixed-loss amount of \$17,864. Thus, in the 2005 LTCH PPS rate year, we pay an outlier case 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted Federal LTCH PPS payment for the LTC-DRG and the fixed-loss amount of \$17,864).

In the February 3, 2005 proposed rule (70 FR 5746–5749), we did not propose to change our established methodology for determining the fixed-loss amount. However, we proposed to use more recently available data to determine the fixed-loss amount for the 2006 LTCH PPS rate year, including the most recent available claims data and data from the Provider Specific File (PSF). Specifically, in that same proposed rule, for the 2006 LTCH PPS rate year, we used the September 2004 update of the FY 2003 MedPAR claims data to determine a proposed fixed-loss amount that would result in projected outlier payments being equal to 8 percent of total projected LTCH PPS payments, based on the policies described in that proposed rule, because those data were the best LTCH data available at that time. As noted above, we determined the proposed fixed-loss amount based on the version of the GROUPER that will be in effect as of the beginning of the 2006 LTCH PPS rate year (July 1, 2005), that is, Version 22.0 of the LTCH PPS GROUPER (69 FR 48982).

As we explained in the February 3, 2005 proposed rule, in determining the LTCH PPS fixed-loss amount, CCRs are used to estimate the cost of each case by

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

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

We proposed to use the CCRs from the PSF rather than computing CCRs from the latest MedPAR claims data and corresponding cost report data for purposes of determining the fixed-loss amount under the LTCH PPS because, as we discussed in the February 3, 2005 proposed rule, we believe that using these CCRs to estimate the cost of the case used in determining outlier payments would be more accurate than using our current source for obtaining CCRs to estimate the fixed-loss amount (that is, calculating CCRs from the latest cost report data in HCRIS and

corresponding claims data in the MedPAR files, as explained above). Specifically, as we discuss in greater detail below, CCRs in the PSF are based on the most recently settled or tentatively settled cost report, whichever is later, whereas the CCRs computed from HCRIS and corresponding MedPAR data are several years old due to the lag time in data availability. Increasing the accuracy of the estimate of outlier payments that is used in determining the fixed-loss amount by using CCRs from the PSF rather than CCRs computed from HCRIS and corresponding MedPAR data would help ensure that outlier payments are projected to equal 8 percent of total estimated LTCH PPS payments as we established in the August 30, 2002 final rule (67 FR 56026). Using CCRs from the PSF should result in a more precise fixed-loss amount because these CCRs are based on more recent available data and, as explained above, these are the CCRs actually used by FIs to make LTCH PPS payments using the LTCH PPS PRICER software. As discussed in the February 3, 2005 proposed rule, the CCRs in the PSF also reflect the changes to the CCR and outlier policy made in the June 9, 2003 high-cost outlier final rule (68 FR 34494), which includes the use of either the most recently settled or tentatively settled cost reports, whichever is later, by FIs to determine a LTCH's CCR. In addition, because all of the LTCHs with claims in the September 2004 update of the FY 2003 MedPAR files (which we used to determine the proposed fixed-loss amount) have an entry in the PSF, there were no LTCHs with missing CCRs, and, therefore, there was no need to assign the applicable statewide average CCR to any LTCHs in determining the fixed-loss amount for the 2006 LTCH PPS rate year (unless this was already done by the FI when entering the CCR in the PSF). This results in a more accurate CCR for each LTCH, and therefore a more accurate estimate of the cost of each case for LTCHs that, in the past, were assigned the applicable statewide average CCR in determining the fixed-loss amount because the data needed to compute a CCR were unavailable. (We note that consistent with our established methodology for determining CCRs for the purposes of determining the fixed-loss amount, if, in the future, a LTCH were missing a CCR in the PSF, we would assign the applicable statewide average CCR.)

We believe that CCRs from the PSF are a better approximation of the CCRs that would be used to determine LTCHs' LTCH PPS payments during the 2006

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

As stated above, in the February 3, 2005 proposed rule, we only proposed to change the data source for obtaining the CCRs used in determining the fixed-loss amount and not our established methodology for determining the fixed-loss amount or our established rules for determining CCRs for LTCH PPS payment purposes. In that same proposed rule, for purposes of determining the proposed 2006 LTCH PPS rate year fixed-loss amount that would result in projected outlier payments being equal to 8 percent of total projected LTCH PPS payments, we used CCRs from the June 2004 update of the PSF, and LTCH claims from the September 2004 update of the FY 2003 MedPAR files. Accordingly, based on the data and policies described in that proposed rule, we proposed a fixed-loss amount of \$11,544 for the 2006 LTCH PPS rate year. Thus, we proposed to pay an outlier case 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted Federal LTCH payment for the LTC-DRG and the fixed-loss amount of \$11,544).

As we discussed in the February 3, 2005 proposed rule, the proposed fixed-loss amount of \$11,544 for the 2006 LTCH PPS rate year is significantly lower than the current fixed-loss amount of \$17,864 for the 2005 LTCH PPS rate year. This notable change in the fixed-loss amount is primarily due to the change in the source of LTCHs' CCRs that are used to estimate costs when estimating LTCH PPS payments (specifically, using CCRs from the PSF rather than computing them from HCRIS and corresponding MedPAR data). As we discussed in that same proposed rule and as we discuss in greater detail below, we believe that a decrease in the fixed-loss amount is appropriate and necessary to maintain that estimated outlier payments would equal 8 percent of estimated total LTCH PPS payments, as required under § 412.525(a).

Comment: Seven commenters supported our decision to use hospital-specific CCRs, which resulted in a significant reduction in the proposed fixed-loss amount. One provider particularly endorsed the resulting reduction in the fixed-loss amount which, in the future, should help ensure that estimated outlier payments would equal 8 percent of estimated total Medicare payments to LTCHs. Several of the hospitals that commented noted that since this change would effectively reduce the financial loss suffered by LTCHs in treating high-cost cases, it would be highly effective in encouraging LTCHs to provide treatment for the some of the sickest Medicare beneficiaries.

Response: We appreciate the commenters' endorsement of our use of hospital-specific CCRs for purposes of determining the 2006 LTCH PPS rate year fixed-loss amount. As stated above, in proposing the revised outlier threshold, we have not proposed a change to our established methodology for determining the fixed-loss amount, we only proposed changing the data source.

At the outset of the LTCH PPS, we used the best available data in calculating the CCRs, which were the latest available cost data in HCRIS and corresponding claims data from MedPAR. The most recently available claims data from the PSF that we proposed to use to update the CCRs have only recently become available for all LTCHs. The LTCH PPS has only been in effect for slightly over 2 years (that is, for cost reporting periods beginning on or after October 1, 2002) and because many LTCHs did not transition to the LTCH PPS until FY 2003, the PSF was not created until relatively recently. For the 2006 LTCH PPS rate year, in

calculating the proposed fixed-loss amount under § 412.525(a), we used the September 2004 update of the FY 2003 MedPAR claims data because those data were the best available LTCH data.

Therefore, in this final rule we are establishing that in determining a fixed-loss amount that would result in estimated outlier payments equal to 8 percent of estimated total LTCH PPS payments, we will use the CCRs from the latest available PSF. Consistent with our established policy, we will continue to assign the applicable statewide average CCRs if a LTCH's CCR is unavailable or exceeds the maximum CCR threshold (as discussed above). In this final rule, for purposes of determining the final 2006 LTCH PPS rate year fixed-loss amount, we are using CCRs from the December 2004 update of the PSF, which are the CCRs that were used by FIs to make LTCH PPS payments to LTCHs as of December 31, 2004, and LTCH claims data from the December 2004 update of the FY 2004 MedPAR files, as these are the best available data. As discussed above, the CCRs in the PSF also reflect the changes to the CCR and outlier policy made in the June 9, 2003 high-cost outlier final rule (68 FR 34494), which include the use of either the most recently settled or tentatively settled cost reports, whichever is later, by FIs to determine a LTCH's CCR. In addition, because all of the LTCHs with claims in the December 2004 update of the FY 2004 MedPAR files (which we used to determine the fixed-loss amount for the final 2006 LTCH PPS rate year) have an entry in the PSF, there were no LTCHs with missing CCRs, and, therefore, there was no need to assign the applicable statewide average CCR to any LTCHs in determining the fixed-loss amount (unless this was already done by the FI when entering the CCR in the PSF). (We note that consistent with our established methodology for determining CCRs for the purposes of determining the fixed-loss amount, if, in the future, a LTCH were missing a CCR in the PSF, we would assign the applicable statewide average CCR.)

Based on the data and policies described in this final rule, we are establishing a fixed-loss amount of \$10,501 for the 2006 LTCH PPS rate year. Thus, we will pay an outlier case 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted Federal LTCH payment for the LTC-DRG and the fixed-loss amount of \$10,501). We note that the fixed-loss amount of \$10,501 for the 2006 LTCH PPS rate year is lower than the proposed fixed-loss amount for the 2006 LTCH

PPS rate year of \$11,544 and significantly lower than the current fixed-loss amount of \$17,864 for the 2005 LTCH PPS rate year. As we discussed in the February 3, 2005 proposed rule, this notable change in the fixed-loss amount for the 2006 LTCH PPS rate year as compared to the 2005 LTCH PPS rate year is primarily due to the change in the source of LTCHs' CCRs used to estimate costs when estimating LTCH PPS payments (specifically, using CCRs from the PSF rather than computing them from HCRIS and corresponding MedPAR data). As described above, in the past we have used CCRs that were calculated using costs from the most recent available cost report data in HCRIS and corresponding charges from MedPAR claims data. As also noted above, often the statewide average CCR was assigned to LTCHs when data to compute a CCR was unavailable. However, for the 2006 LTCH PPS rate year, in determining the fixed-loss amount, we are using CCRs from the PSF because, as we discussed above, we believe that these CCRs will more closely approximate the CCRs that will be used to make payments to LTCHs during the 2006 LTCH PPS rate and will result in a more accurate estimate of the cost of each case used in determining outlier payments.

As we noted above, CCRs from the PSF are based on more recent data and are generally lower than the CCRs computed from cost report data in HCRIS and corresponding claims data in the MedPAR files. Specifically, in comparing the best available data for 335 LTCHs, we found that almost 40 percent of LTCHs would experience a decrease in the CCR we used for computing the fixed-loss amount. Furthermore, for those LTCHs with a CCR in the PSF that is lower than CCRs used to determine the 2005 LTCH PPS rate year fixed-loss amount, we found that the difference in the CCRs was more than a 75 percent decrease for some LTCHs for which the applicable statewide average CCR previously been assigned because we were unable to compute a CCR (for example, due to faulty or unavailable data).

In determining estimated outlier payments (80 percent of costs beyond the fixed-loss amount), as discussed above, costs are estimated by multiplying the Medicare-covered charges for the case by the LTCH's CCR. When relatively lower CCRs are used to estimate costs from charges, the resulting estimated cost of each case is lower, thereby reducing estimated outlier payments since outlier payments are projected to equal 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). As we discussed in the February 3, 2005 proposed rule, lowering the fixed-loss amount results in more cases qualifying as outlier cases as well as an increase in the amount of the outlier payment for an outlier case because the maximum loss that a LTCH must incur before receiving an outlier payment (that is, the fixed-loss amount) will be smaller. Thus, in order to ensure that estimated outlier payments will be equal to 8 percent of estimated total LTCH PPS payments, the outlier fixed-loss amount should be lowered.

As stated above, we have established that under the LTCH PPS, outlier payments are estimated to be equal to 8 percent of estimated total LTCH PPS payments. As we discussed in the February 3, 2005 proposed rule, an analysis of recent LTCH PPS claims indicates that the 2004 and 2005 LTCH PPS rate year outlier fixed-loss amounts may have resulted in LTCH PPS outlier payments that fell below the estimated 8 percent. Specifically, based on claims discharged during the 2004 LTCH PPS rate year (July 1, 2003 through June 30, 2004), we estimate that outlier payments equal about 6 percent of estimated total LTCH PPS payments.

As an alternative to lowering the fixed-loss amount, as we discussed in the February 3, 2005 proposed rule, we examined adjusting the marginal cost factor (that is, the percentage that Medicare will pay of the estimated cost of a case that exceeds the sum of the adjusted Federal prospective payment for the LTC-DRG and the fixed-loss amount for LTCH PPS outlier cases (§ 412.525(a)(3)), as a means of ensuring that estimated outlier payments would be projected to equal 8 percent of estimated total LTCH PPS payments. Under the LTCH PPS high-cost outlier policy at § 412.525(a)(3), the marginal cost factor is currently equal to 80 percent, as we established in the August 30, 2002 final rule (67 FR 56022–56026). As we discuss in that same final rule, a marginal cost factor equal to 80 percent means that we pay the LTCH for an outlier case, 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted Federal rate for the LTC-DRG PPS payment and the fixed-loss amount).

As we discussed in the August 30, 2002 final rule (67 FR 56023), the marginal cost factor is designed to share the financial risk of treating extremely costly LTCH cases between LTCHs and the Medicare program by providing “a balance between the need to protect

LTCHs financially, while encouraging them to treat expensive patients and maintain the incentives of a prospective payment system to improve the efficient delivery of care.” Increasing the marginal cost factor from the established 80 percent, while maintaining the existing fixed-loss amount would increase total outlier payments because we would pay a larger percentage of the estimated costs that exceed the outlier threshold (the sum of the adjusted Federal rate for the LTC-DRG and the fixed-loss amount). For example, if we were to increase the marginal cost factor to 90 percent without lowering the fixed-loss amount, we would pay outlier cases an additional 10 percent (90 percent minus 80 percent) of the estimated costs that exceed the outlier threshold (the sum of the adjusted Federal rate for the LTC-DRG and the fixed-loss amount).

While this alternative would also help to ensure that outlier payments are projected to equal 8 percent of estimated total LTCH PPS payments, it would not maintain the existing balance between providing an incentive for LTCHs to treat expensive patients and improving the efficient delivery of care. It would significantly reduce the LTCHs' share of the financial risk in treating those costly patients. As we discussed in the August 30, 2002 final rule (67 FR 56023–56024), our analysis of payment-to-cost ratios for outlier cases showed that a marginal cost factor of 80 percent appropriately addresses outlier cases that are significantly more expensive than non-outlier cases, while simultaneously maintaining the integrity of the LTCH PPS.

Lowering the fixed-loss amount from \$17,864 to \$10,501 will reduce the amount of the loss that a LTCH must incur under the LTCH PPS for a case with unusually high costs before the LTCH will receive any additional Medicare payments. However, as we explain above, we believe the 80 percent marginal cost factor continues to adequately maintain the LTCHs' share of the financial risk in treating those costly patients and ensure the efficient delivery of services. LTCHs will still have to first lose \$10,501 before receiving any additional payment for treating an unusually costly case. We believe the fixed-loss amount of \$10,501 in conjunction with the requirement that the LTCH is responsible for 20 percent of all estimated costs incurred beyond the outlier threshold (the sum of the adjusted Federal rate for the LTC-DRG PPS payment and the fixed-loss amount) will be significant enough to avoid the “incentive” for LTCHs to allow cases to reach the outlier

threshold in order to receive an additional payment. Therefore, we believe the fixed-loss amount of \$10,501 will sufficiently identify unusually costly LTCH cases while maintaining the integrity of the LTCH PPS. Consequently, under the broad authority of section 123 of Pub. L. 106–113 and section 307(b)(1) of Pub. L. 106–554, we are adopting a fixed-loss amount of \$10,501 that is calculated from CCRs derived from the best available claims data and CCRs from the PSF.

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

We note that the fixed-loss amount for the 2006 LTCH PPS rate year established in this final rule (\$10,501) is less than the fixed-loss amount (\$11,544) proposed in the February 3, 2005 proposed rule. This is primarily due to the fact that the average case-mix of the LTCH claims in the FY 2004 MedPAR files, which are being used to compute the final fixed-loss amount is higher than the average case-mix of the LTCH claims in the FY 2003 MedPAR files, which were used to compute the proposed fixed-loss amount. Specifically, based on the claims in the December 2004 update of the MedPAR files and version 22.0 of the GROUPE, we found that the average case-mix increased over 6 percent from FY 2003 to FY 2004. In addition, the final standard Federal rate of \$38,086.04, which is based on the most recent estimate of the market basket update of 3.4 percent, is 0.3 percent higher than the proposed Federal rate of \$37,975.53, which was based on the proposed market basket update of 3.1 percent, as discussed above in section V.B.1.b of this preamble. Both the increase in case-mix and the increase in the Federal rate result in slightly higher overall payments to LTCHs. Therefore, it is necessary for the fixed-loss amount to decrease slightly in order to ensure that estimated outlier payments remain equal to 8 percent of estimated total LTCH PPS payments.

As we stated above, based on an analysis of recent LTCH claims data, we now estimate that actual outlier payments in the 2004 LTCH PPS rate

year equal about 6 percent of actual total LTCH PPS payments. In this final rule, as discussed above, using the best data available at this time we are establishing a revised fixed-loss amount (outlier threshold) so that estimated outlier payments are projected to be 8 percent of estimated total LTCH PPS payments in the 2006 LTCH PPS rate year; the revised outlier threshold is significantly lower than the current outlier threshold. We will continue to monitor outlier payments, including actual outlier payments in the 2006 LTCH PPS rate year. Although we do not adjust the outlier threshold for a given year to account for differences between projected payments and actual payments, we do examine actual payments for purposes of determining whether it might be necessary to refine our estimation methodology. In setting the outlier threshold for the 2007 LTCH PPS rate year, we will use the best data available at the time and also propose refinements to the estimation methodology if necessary and appropriate so that our projections for the 2007 LTCH PPS rate year are as accurate as possible.

Comment: One commenter noted that the fixed-loss amount and, therefore, the outlier threshold has been decreasing since the start of the LTCH PPS. The commenter also noted that we indicated in the proposed rule that based on claims discharged during the 2004 LTCH PPS rate year, we estimated that outlier payments that were made during the 2004 LTCH PPS rate year were approximately equal to 6 percent of estimated total LTCH PPS payments. The commenter suggests that this 6 percent figure means that the “process utilized by CMS to project [o]utlier payments has resulted in roughly 2 percent of the [o]utlier budget funding to not be paid to providers.” The commenter suggests that CMS implement a one-time adjustment to account for the portion of outlier funds that have not been paid to LTCHs since the inception of the LTCH PPS and further that CMS implement a threshold that ensures that the entire 8 percent of estimated total LTCH PPS payments set aside for outlier payments for future years is paid to providers.

Response: As discussed above, the progressive decrease in the fixed-loss amount has resulted from the fact that the CCRs that we have previously used to estimate the fixed-loss amount were determined based on cost report data in HCRIS and corresponding claims data in the MedPAR files, but that data were not used by FIs to make actual LTCH PPS payments. Data from the PSF, which are used to make outlier payments under

the LTCH PPS, have only recently become available for all LTCHs. Also, as noted above, because there is lag time between the submission of cost report data in HCRIS and the availability of that data, CCRs may have been computed from cost reports that were several years old. Furthermore, for many LTCHs the applicable statewide average CCR was assigned to the LTCH when cost report and corresponding claims data to compute a CCR were unavailable. Accordingly, as our data sources have more accurately reflected actual LTCH PPS payments, the fixed-loss amount has been determined based on more recent CCR data and it has progressively decreased each year since the start of the LTCH PPS. As discussed above, the change in the fixed-loss amount for the 2006 LTCH PPS rate year is primarily a result of using CCRs from the PSF to estimate costs under the LTCH PPS rather than computing CCRs from HCRIS and corresponding MedPAR data. (This is the same data source used for obtaining CCRs under the IPPS for determining the IPPS outlier fixed-loss amount (69 FR 49276, August 11, 2004).)

As we noted in the February 3, 2005 proposed rule and reiterate in the discussion above, an analysis of recent LTCH PPS claims indicates that the outlier fixed-loss amounts established for the 2004 and 2005 LTCH PPS rate years may have resulted in LTCH PPS outlier payments that fell below the estimated 8 percent in those rate years. We would remind the commenter that the decision to make estimated outlier payments equal to 8 percent of the estimated total payments under the LTCH PPS was based on data analyses by our contractors when we first designed the LTCH PPS effective for LTCH cost reporting periods beginning during FY 2003. The August 30, 2002 final rule (67 FR 56022–56027) details our determinations based on the results of the evaluations presented by 3M Health Information Systems and also an industry study commissioned by NALTH, as well as the original study by the RAND Corporation for the IPPS (57 FR 23640, June 4, 1992). As noted in that final rule, “In order to determine the most appropriate outlier policy, we analyzed the extent to which the various options would reduce financial risk, reduce incentives to underserve costly beneficiaries, and improve the overall fairness of the system. We believed an outlier target of 8 percent would allow us to achieve a balance of the above stated goals.” (57 FR 56023).

The regulations at § 412.523(d)(1) specify that “CMS adjusts the standard Federal rate by a reduction factor of 8

percent, the estimated proportion of outlier payments" under the LTCH PPS as described in § 412.525(a). This policy is similar to the policy for outliers under the IPPS. Under the IPPS there have been some years when outlier payments exceed the projected target percentage (5.1 percent) and other years when they fall below. In the August 11, 2004 final rule for the IPPS, we stated that "[n]evertheless, consistent with the policy and statutory interpretations that we have maintained since the inception of the IPPS, we do not plan to make payments to ensure that the percentage of total outlier payments actually reflect the percentage target of total IPPS payments." (69 FR 49278)

Each year we estimate, based on the best data available at the time, the amount Medicare will pay LTCHs under the LTCH PPS. Based on that estimate, and an estimate of the proposed outlier payments that would be paid, we establish a fixed-loss amount that will generate estimated outlier payments that would equal 8 percent of the estimated total payments under the LTCH PPS. Thus, we estimate the fixed-loss amount based on the best available data to us at the time. If ultimately it is determined that some of the estimated factors used to determine the fixed-loss amount were not accurate and, therefore, we ultimately pay either more or less than 8 percent as outlier payments, no adjustment to future LTCH PPS payments is appropriate. Therefore, a payment adjustment to providers that would represent the difference between estimated outlier payments and those that Medicare actually made since the start of the LTCH PPS would not be appropriate. We believe, however, that the use of the PSF for determining CCRs for purposes of calculating the fixed-loss amount, will most likely result in actual outlier payments that more closely equal the requirement for estimated outlier payments to equal 8 percent of estimated total LTCH PPS payments.

Based on the data and policies described in this final rule, we are establishing a fixed-loss amount of \$10,501 for the 2006 LTCH PPS rate year. Thus, we will pay an outlier case 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted Federal LTCH payment for the LTC-DRG and the fixed-loss amount of \$10,501). As also discussed above, consistent with our longstanding policy under both the IPPS and the LTCH PPS, we are not making any additional adjustments to the outlier policy at § 412.525(a) or to the standard Federal rate to account for any amount that actual outlier payments may have been

more or less than 8 percent of estimated total LTCH PPS payments.

d. Reconciliation of Outlier Payments Upon Cost Report Settlement

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

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

e. Application of Outlier Policy to Short-Stay Outlier Cases

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

loss amount of \$10,501 and the amount paid under the short-stay outlier policy).

4. Adjustments for Special Cases

a. General

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

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

b. Adjustment for Short-Stay Outlier Cases

A short-stay outlier case may occur when a beneficiary receives less than the full course of treatment at the LTCH before being discharged. These patients may be discharged to another site of care or they may be discharged and not readmitted because they no longer require treatment. Furthermore, patients may expire early in their LTCH stay.

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

Under § 412.529, in general, we adjust the per discharge payment to the least of 120 percent of the cost of the case, 120 percent of the LTC-DRG specific per diem amount multiplied by the length of stay of that discharge, or the full LTC-DRG payment, for all cases

with a length of stay up to and including five-sixths of the geometric average length of stay of the LTC-DRG.

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

In addition, we also discussed in the June 9, 2003 high-cost outlier final rule (68 FR 34508–34513) that short-stay outlier payments are subject to the provisions in the regulations at § 412.84(i)(2) for discharges on or after October 1, 2003 in accordance with § 412.529(c)(5)(iii). In addition, in that same final rule, we established that the applicable statewide average CCR is applied when a LTCH's CCR exceeds the ceiling or in certain other instances as specified in § 412.84(i)(3). Thus, the applicable statewide average CCR is no longer applied when a LTCH's CCR falls below the floor. Furthermore, we also established that any reconciliation of payments for short-stay outliers may be made upon cost report settlement to account for differences between the estimated CCR and the actual CCR for the period during which the discharge occurs. In the June 6, 2003 final rule for the 2004 LTCH PPS rate year (68 FR 34146–34148), for certain hospitals that qualify as LTCHs under section 1886(d)(1)(B)(iv)(II) of the Act ("subclause (II)" LTCHs) as added by section 4417(b) of Pub. L. 105–33, and implemented in § 412.23(e)(2)(ii), we established a temporary adjustment to the short-stay outlier policy during the 5-year transition period. Under § 412.529(c)(4), effective for discharges from a "subclause (II)" LTCH occurring on or after July 1, 2003, the short-stay outlier percentage is 195 percent during the first year of the hospital's 5-year transition. For the second cost reporting period, the short-stay outlier percentage is 193 percent; for the third cost reporting period, the percentage is 165 percent; for the fourth cost reporting period, the percentage is 136 percent;

and for the final cost reporting period of the 5-year transition (and future cost reporting periods), the short-stay outlier percentage is 120 percent, that is, the same as it is for all other LTCHs under the LTCH PPS.

As we discussed in the June 6, 2003 final rule for the 2004 LTCH PPS rate year (68 FR 34147), we established this formula with the expectation that an adjustment to short-stay outlier payments during the transition will result in reducing the difference between payments and costs for a "subclause (II)" LTCH for the period of July 1, 2003 through the end of the transition period, when the LTCH PPS will be fully phased-in.

As we stated in that same final rule, we also expect that during this 5-year period, "subclause (II)" LTCHs will make every attempt to adopt the type of efficiency enhancing policies that generally result from the implementation of prospective payment systems in other health care settings. We did not propose any changes to the short-stay outlier policy in the February 3, 2005 proposed rule and did not receive any comments regarding the short-stay outlier policy at § 412.529.

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

In the August 30, 2002 LTCH PPS final rule, we established a notification requirement for LTCHs that were HwHs, as defined in § 412.22(e) and satellites of LTCHs, as defined in § 412.22(h)(5), and for LTCHs and satellites of LTCHs that were subject to onsite provider payment adjustment under § 412.532. At existing § 412.22(e)(3) and (h)(5), we require a LTCH HwH or a satellite of a LTCH, respectively, to notify its FI and CMS of its co-located status within 60 days of the start of its first cost reporting period under the LTCH PPS. At existing § 412.532(i), we require the LTCH or satellite of a LTCH that is co-located with another hospital or a SNF to provide notification of its co-location within 60 days following the effective date of the regulations. We also established an additional notification requirement at § 412.532(i) for a LTCH or a satellite of a LTCH subject to the onsite provider payment adjustment at § 412.532, to notify its FI and CMS within 60-days of a change in co-located status. We intended that these regulations also require LTCHs and satellites of LTCHs to identify particular co-located Medicare providers.

As we discussed in the February 3, 2005 proposed rule (70 FR 5750), it appears that this expectation is unclear

in our present regulations. We have been informed by some of our regional offices and FIs that LTCHs and satellites of LTCHs, for which they are responsible, have in many cases neglected to specify the name(s), address(es), and Medicare provider number(s) of the co-located providers covered by § 412.22(e)(3), (h)(5), and § 412.532, as applicable. Therefore, in that same proposed rule, with respect to § 412.22(e)(3), we proposed to clarify our policy that a LTCH that occupies space in a building used by another hospital or in one or more entire buildings located on the same campus as buildings used by another hospital and that meets the criteria of paragraph (e)(1) or (e)(2) of § 412.22 must inform its FI and CMS in writing of its co-located status, as well as, provide the name(s), address(es), and the Medicare provider number(s) of the other co-located hospitals (that is, acute care hospitals, IRFs, and psychiatric facilities and units).

We also proposed to clarify that with respect to § 412.22(h)(5), a satellite of a LTCH that occupies space in a building used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital, and that meets the criteria of paragraphs (h)(1) through (h)(4) of § 412.22 must notify its FI and CMS in writing of its co-location and identify by name(s), address(es), and Medicare provider number(s) those hospital(s) with which it is co-located. In addition, we proposed to clarify the notification requirements in § 412.532 that apply to a LTCH or satellite of a LTCH. For example, we clarified that the notification requirements apply to a LTCH or a satellite of a LTCH that is co-located with a SNF. Furthermore, since the existing regulation text at § 412.22(e)(3) and (h)(5) required that the notification take place within 60 days of the LTCH's first cost reporting period beginning on or after October 1, 2002 and § 412.532(i) required that the notification occur within 60 days of the effective date of the original regulation (cost reporting periods beginning on or after October 1, 2002), and this timeframe for many providers has long since passed, we proposed to eliminate the specific timing requirement in favor of the on-going, prospective notification requirement described above, which is also clearer and more comprehensive. Therefore, we proposed to delete the phrase "within 60 days of its first cost reporting period that begins on or after October 1, 2002" at § 412.22(e)(3) and (h)(5). We also proposed to delete the phrase "within 60 days following the

effective date of these regulations” from § 412.532(i). We also proposed to delete the phrase “and within 60 days of a change in co-located status” from § 412.532(i) because, as we explained in that same proposed rule, we believe that the proposed continuing notification requirement in the revised regulation text at § 412.22(e)(3) and (h)(5), as well as at § 412.532(i), would include the obligation to notify CMS and the FI in writing of any changes in co-located status and the obligation to provide the requisite information detailed above. Accordingly, we proposed to revise each of the three notification provisions, to establish consistency and to clearly state the on-going requirement that a LTCH or satellite of a LTCH that is co-located with another hospital or a SNF inform their FIs and CMS in writing of the name(s), address(es), and Medicare provider number(s) of particular co-located Medicare providers.

Comment: While three commenters agreed with the proposed clarification of the notification requirement, one of the commenters requested that there be no penalty for a provider who fails to meet the notification requirement.

Response: While we thank these commenters for their support, we would point out that our notification requirements have existed since the implementation of the LTCH PPS. What we proposed in the February 3, 2005 LTCH PPS proposed rule were clarifications of these requirements.

In the August 30, 2002 LTCH PPS final rule, we stated that we would be monitoring HwHs and satellite facilities of LTCHs for compliance with existing regulations, growth in numbers and transfer patterns. To that end, we included a requirement in the regulations at § 412.22(e)(3) and (h)(5), respectively, that HwHs and satellites of LTCHs notify their FIs and CMS regional offices about their co-location with any other hospital, within 60 days following the initial effective date of the LTCH PPS. In addition, we provided for an additional requirement at § 412.532(i), to have a LTCH (including a satellite of a LTCH) that is subject to the onsite provider payment adjustment notify its FI and CMS within 60 days of a change in its co-located status and within 60 days following the effective date of those regulations. We believed that § 412.532(i) of the regulations also requires that a LTCH that is co-located with another hospital or a SNF identify particular Medicare co-located providers that are covered within the scope of § 412.532(a), as applicable. Also, in the February 3, 2005 proposed rule (70 FR 5755), we proposed a revision to § 412.532(i) to clarify that the

notification requirement applies to situations where a LTCH, or a satellite of a LTCH, occupies space in a building used by a SNF or in one or more entire buildings located on the same campus as buildings used by a SNF. However, in the course of revising language in § 412.532(i), while we clearly intended to apply the notification requirement to a LTCH or a satellite of a LTCH that is co-located with a SNF, we are concerned that the public may misinterpret the proposed regulation text to mean that a LTCH or a satellite of a LTCH which is co-located with a SNF need only provide notification if it meets the requirements in § 412.22(e)(1) or (e)(2) or § 412.22(h)(1) through (h)(4). However, since those regulations do not currently apply to a LTCH or a satellite of a LTCH which is co-located with a SNF, we believe the intent of this change, that is, to apply the notification requirement to a LTCH or a satellite of a LTCH that occupies space in a building used by a SNF or in one or more entire buildings located on the same campus as buildings used by a SNF, would not be met. This is clearly contrary to our intent as expressed in the February 3, 2005 proposed rule (70 FR 5755). Accordingly, we have restructured the paragraph to clarify that only a LTCH or a satellite of a LTCH that is co-located with another hospital (that is, onsite acute care hospital, an onsite IRF, or an onsite psychiatric facility or unit) is required to meet the specific criteria at § 412.22(e)(1) or (e)(2) or § 412.22(h)(1) through (h)(4). The regulation text as revised does not require these criteria to be met in the case of a SNF that is co-located with a LTCH or satellite of a LTCH for the notification requirement to apply.

In addition, we had indicated in the February 3, 2005 proposed rule that a LTCH or a satellite of a LTCH would have to provide specific information about those providers specified at § 412.532(a). In this final rule, we are making an editorial change to § 412.532(i) by deleting the general reference to providers “specified at paragraph (a)” and in its place inserting the specific providers listed in paragraph (a) to which the particular provision applies.

For the reasons explained previously, we are finalizing our proposed regulation text concerning the notification requirements (with some minor editorial clarifications) and our proposal to eliminate the specific timing requirements.

We believe that these clarifications to the notification requirements establish consistency and clearly state the ongoing requirement that a LTCH HwHs

and a satellite of a LTCH that is co-located with another hospital or SNF notify their CMS regional office and FI in writing, supplying the requisite information. Since we did not receive any comments in opposition to our proposed clarifications, we are finalizing those clarifications with the editorial modifications discussed above. Therefore, in this final rule, we are revising each of the three notification provisions to establish consistency and to clearly state the on-going requirement that a LTCH or a satellite of a LTCH that is co-located with another hospital or a SNF inform their FI and CMS in writing of the name(s), address(es), and Medicare provider number(s) of particular co-located Medicare providers. While we did not propose a penalty for nonconformance with the notification requirements, we trust that, being aware of our monitoring activities with regard to this regulation, LTCHs would make every effort to comply with the notification requirements. As stated in the August 30, 2002 LTCH PPS final rule, if we believe that LTCHs are not complying with this requirement, it may become necessary for us to revisit the existing regulations dealing with ownership and control of HwHs through notice and comment rulemaking.

6. Other Payment Adjustments

As indicated earlier, we have broad authority under section 123 of Pub. L. 106–113, including whether (and how) to provide for adjustments to reflect variations in the necessary costs of treatment among LTCHs. Thus, in the August 30, 2002 LTCH PPS final rule (67 FR 56014–56027), we discussed our extensive data analysis and rationale for not implementing an adjustment for geographic reclassification, rural location, treating a disproportionate share of low-income patients (DSH), or indirect medical education (IME) costs. In that same final rule, we stated that we would collect data and reevaluate the appropriateness of these adjustments in the future once more LTCH data become available after the LTCH PPS is implemented.

Because the LTCH PPS has only been implemented for a few years and there is a lag-time in data availability, sufficient new data have still not yet been generated that would enable us to conduct a comprehensive reevaluation of these payment adjustments. Nonetheless, we have reviewed the limited data that are available and have found no evidence to support additional proposed policy changes. Therefore, in the February 3, 2005 proposed rule, we did not propose 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.

Comment: Three of the commenters who supported our proposed adoption of the revised labor market areas based on OMB's new CBSA designations urged us to allow LTCHs the same opportunity that exists for acute care hospitals of applying for geographic reclassification to neighboring counties for wage index purposes. To limit this option to acute care hospitals in the same labor market, they argue, puts LTCHs at a competitive disadvantage. In stating the value of consistency in the Medicare program, one commenter notes the automatic "out-migration adjustment" in section 505 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 for acute care hospitals in qualifying counties where hospital employees commute to higher wage index areas. The commenter urges us to, therefore, consider geographic reclassification for LTCHs, particularly one that could meet qualifications for reclassification to a neighboring urban CBSA under the criteria and conditions for geographic reclassification set forth in 42 CFR 412.230 through 234 through the Medicare Geographic Classification Review Board (MGCRB).

Response: We appreciate the commenters' support for the adoption of OMB's new CBSA-based designations for the LTCH PPS and, as noted above, we will be finalizing that provision. However, we are not adopting the suggestion to establish a geographic reclassification procedure for LTCHs that parallels either the MGCRB set forth in section 1886(d)(10) of the Act and implemented at 42 CFR 412.230, or the recent "out-migration adjustment" in section 505 of the MMA of 2003, which adds section 1886(d)(13) to the Act and is implemented at 42 CFR 412.64(h)(5)(i). The Congress clearly targeted both of these provisions, as well as the reclassification provision set forth in section 1886(d)(8) of the Act, specifically for "subsection (d)" hospitals, that is, inpatient acute care hospitals. As we discuss below, we believe that the considerable administrative burdens inherent in establishing a reclassification process for a hospital system as authorized by the Congress for the approximately 4,500 "subsection (d)" hospitals nationwide, is neither reasonable nor appropriate for the LTCH system with only approximately 350 hospitals that

are unevenly dispersed throughout the country.

In the August 1, 2002 final rule for the LTCH PPS, in which we presented features of the new payment system and detailed explanation of the analytical foundations of our determinations, we stated that we were not implementing an adjustment for geographic reclassification in the LTCH PPS because our data supported "neither an adjustment to account for differences in area wage levels nor an adjustment for LTCHs located in rural areas or large urban areas * * *" In that final rule, we noted that " * * * regression analysis indicated that wage adjustment for LTCHs would not increase the accuracy of payments" (67 FR 56019). Although we did provide for a 5-year phase-in of the wage adjustment for LTCHs in the August 1, 2002 final rule, we determined that we would not establish a geographic reclassification process for the initial years of the LTCH PPS. We cited the fact that excluded hospitals (that is, hospitals paid under the TEFRA payment system) were not required to provide wage-related information on the Medicare cost report (Worksheet S-3). At that point, we were not prepared to create instructions for data collection on LTCH wage-related costs or to develop the full range of application and determination procedures required in order to establish a new geographic reclassification system. Furthermore, in the August 1, 2002 final rule, where we established a 5-year phase-in to a full wage index for the new LTCH PPS, we sought consistency with area wage adjustments made to all other postacute providers (that is, the existing HHA, SNF, and IRF PPSs) in using "pre-reclassification" inpatient acute care hospital wage data without regard to any approved geographic reclassifications under section 1886(d)(8) or 1886(d)(10) of the Act. The resulting phased-in area wage adjustment for LTCHs is based on the provider's actual location, without regard to the urban or rural designation of any affiliated or related providers. In further discussing geographic reclassification, we noted that the administrative burden resulting from an attempt to develop an adjustment for geographic reclassification far outweighed any potential resulting benefits. The administrative burden of developing a geographic reclassification process would likely entail creating a provider application with an appropriate deadline (and engaging in Paperwork Reduction Act analysis), creating an entity to process, evaluate and determine provider applications,

and establishing an appeals process for those who disagreed with the reclassification decision. Also, we would need to develop criteria for geographic reclassification as well as evaluate the effect of a reclassification provision in terms of budget neutrality. We would need to publish reclassification data in each payment notice and reclassification determinations would need to be completed by the effective date of each year's payment notice. We believe this administrative burden outweighs the benefit that would be received by the few LTCH hospitals that would receive reclassification under such a system. Thus, we reiterate our belief that it is neither reasonable nor cost-effective to establish a reclassification system under the LTCH PPS.

In section XII. (Regulatory Impact Analysis) of the February 3, 2005 proposed rule, we provided data in Table II of that section that indicated that the impact of the change from the 2005 LTCH PPS rate year to the 2006 LTCH PPS rate year for wage index changes for the LTCH PPS, which include the progression of the phase-in of the wage index and the proposed update in the wage index data, as well as the proposed change in the labor market area definitions, is, on average, a positive increase in payments of 0.1 percent. (The same table also indicates that the average percent change in payments per discharge from the 2005 LTCH PPS rate year to the 2006 LTCH PPS rate year, as a result of all changes being proposed, is estimated to be an increase of 5.5 percent.) (70 FR 5764)

Therefore, while we do understand that there are a few individual LTCHs and also one particular county near Boston that will experience more than a negligible negative impact because of the adoption of CBSAs, and, therefore, believe themselves to be at a competitive disadvantage with regard to hiring hospital personnel as compared to acute care hospitals in the same market, we continue to believe that, as described above, it is not administratively feasible to establish a geographic reclassification procedure for so few LTCHs. (Table II indicates that for LTCHs in New England, the average percent change in Medicare payments per discharge from the 2005 LTCH PPS rate year to the 2006 LTCH PPS rate year is estimated to be an increase of 7.5 percent.) We believe that it is revealing of Congressional intent that existing reclassification provisions in the statute continue to be limited to short-term acute care or "section (d)" hospitals. Furthermore, the Congress has not deemed it appropriate to

mandate a geographical reclassification policy for any of the IPPS-excluded hospital prospective payment systems. We do not believe that the small universe of LTCHs that are slightly negatively affected by the CBSA-based labor market area definitions as they apply to their wage index adjustment would justify the serious and considerable administrative burden entailed in establishing a geographic reclassification adjustment under the LTCH PPS.

7. Budget Neutrality Offset To Account for the Transition Methodology

Under § 412.533, we implemented a 5-year transition period for moving to 100 percent of the Federal prospective payment rate, during which a LTCH is paid an increasing percentage of the LTCH PPS Federal payment rate and a decreasing percentage of reasonable cost-based payment for each discharge. Furthermore, we allow a LTCH to elect to be paid based on 100 percent of the standard Federal rate in lieu of the blended methodology.

The standard Federal rate was determined as if all LTCHs will be paid based on 100 percent of the standard Federal rate. As stated earlier, we provide for a 5-year transition period that allows LTCHs to receive payments based partially on the reasonable cost-based methodology. Section 123(a)(1) of the Pub. L. 106–113 requires that the Secretary shall develop a per discharge prospective payment system for LTCHs and such system shall “maintain budget neutrality.” Accordingly, as we established in the August 30, 2002 final rule (67 FR 56033–56036), during the 5-year transition period, we reduce all LTCH Medicare payments (whether a LTCH elects payment based on 100 percent of the Federal rate or whether a LTCH is being paid under the transition blend methodology) to account for the cost of the transition methodology in the given LTCH PPS rate year. Specifically, we reduce all LTCH Medicare payments during the 5-year transition by a factor that is equal to 1 minus the ratio of the estimated reasonable cost-based payments that would have been made if the LTCH PPS had not been implemented to the projected total Medicare program PPS payments (that is, payments made under the transition methodology and the option to elect payment based on 100 percent of the Federal rate).

In the May 7, 2004 final rule (69 FR 25702), based on the best available data at that time, we projected that approximately 93 percent of LTCHs will be paid based on 100 percent of the standard Federal rate rather than receive

payment under the transition blend methodology for the 2005 LTCH PPS rate year. Using the same methodology described in the August 30, 2002 LTCH PPS final rule (67 FR 56034), this projection, which used updated data and inflation factors, was based on our estimate that either—(1) A LTCH has already elected payment based on 100 percent of the Federal rate prior to the start of the 2005 LTCH PPS rate year (July 1, 2004); or (2) a LTCH would receive higher payments based on 100 percent of the 2005 LTCH PPS rate year standard Federal rate compared to the payments it would receive under the transition blend methodology. Similarly, we projected that the remaining 7 percent of LTCHs will choose to be paid based on the applicable transition blend methodology (as set forth under § 412.533(a)) because they would receive higher payments than if they were paid based on 100 percent of the 2005 LTCH PPS rate year standard Federal rate.

In that same final rule, based on the best available data at that time and policy revisions described in that same rule, we projected that the full effect of the remaining 4 years of the transition period (including the election option) would result in a cost to the Medicare program of \$29 million. Specifically, for the 2005 LTCH PPS rate year, we estimated that the cost of the transition would be \$15 million. In order to maintain budget neutrality, using the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 56034) based on updated data and the policies and rates discussed in the May 7, 2004 LTCH PPS final rule, we established a 0.5 percent reduction (0.995) to all LTCH payments in the 2005 LTCH PPS rate year to account for the \$15 million estimated cost of the transition period methodology (including the option to elect payment based on 100 percent of the Federal rate) for the 2005 LTCH PPS rate year. Furthermore, we indicated that we would propose a budget neutrality offset for each of the remaining years of the transition period to account for the estimated costs for the respective LTCH PPS rate years.

In the February 3, 2005 proposed rule (70 FR 5754), based on the best available data at that time, using the same methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 56034), we projected that approximately 94 percent of LTCHs would be paid based on 100 percent of the standard Federal rate rather than receive payment under the transition blend methodology during the 2006 LTCH PPS rate year. This projection 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 beginning of the 2006 LTCH PPS rate year (July 1, 2005); or (2) a LTCH would receive higher payments based on 100 percent of the standard Federal rate compared to the payments they would receive under the transition blend methodology. Similarly, we projected that the remaining 6 percent of LTCHs would choose to be paid based on the transition blend methodology at \$412.533 because those payments are estimated to be higher than if they were paid based on 100 percent of the standard Federal rate.

Based on the best available data and the policies described in the February 3, 2005 proposed rule, we projected that in the absence of a transition period budget neutrality offset, the full effect of the remaining 3 years of the transition period (including the election option) as compared to payments as if all LTCHs would be paid based on 100 percent of the Federal rate would result in a cost to the Medicare program of \$10 million as follows: \$7 million in the 2006 LTCH PPS rate year; \$3 million in the 2007 LTCH PPS rate year; and no cost in the 2008 LTCH PPS rate year. As we explained in that same 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 because as we discussed above, 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.

Accordingly, using the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 56034) based on updated data and the policies and rates discussed in the February 3, 2005 proposed rule, we proposed a 0.2 percent reduction (0.998) to all LTCHs' payments for discharges occurring on or after July 1, 2005 and through June 30, 2006, to account for the estimated cost of the transition period methodology (including the option to elect payment based on 100 percent of the Federal rate) of the \$7 million for the 2006 LTCH PPS rate year. We note that we did not receive any comments regarding our proposed budget neutrality factor to account for the cost of the transition period.

Therefore, in this final rule, based on the most recent available data, using the same methodology established in the

August 30, 2002 LTCH PPS final rule (67 FR 56034), we are projecting that approximately 98 percent of LTCHs will be paid based on 100 percent of the standard Federal rate rather than receive payment under the transition blend methodology during the 2006 LTCH PPS rate year. This projection, which uses updated data, is based on our estimate that either: (1) A LTCH has already elected payment based on 100 percent of the Federal rate prior to the beginning of the 2006 LTCH PPS rate year (July 1, 2005); or (2) a LTCH will receive higher payments based on 100 percent of the standard Federal rate compared to the payments they would receive under the transition blend methodology. Similarly, we project that the remaining 2 percent of LTCHs will choose to be paid based on the transition blend methodology at \$412.533 because those payments are estimated to be higher than if they were paid based on 100 percent of the standard Federal rate. The applicable transition blend percentage applies to the LTCH's entire cost reporting period beginning on or after October 1 (unless the LTCH elects payment based on 100 percent of the Federal rate).

Based on the best available data and the policies described in this final rule, we are projecting that the full effect of the remaining years of the transition period (including the election option) as compared to payments as if all LTCHs would be paid based on 100 percent of the Federal rate will result in a negligible cost to the Medicare program. Specifically, based on the most recent available data, we estimate that the cost of the transition period methodology (including the option to elect payment based on 100 percent of the Federal rate) would be approximately \$1 million in the 2006 LTCH PPS rate year and approximately \$675 thousand in the 2007 LTCH PPS rate year. As stated above, to account for the cost of the transition methodology in a given LTCH PPS rate year during the 5-year transition, we reduce all LTCH Medicare payments by a factor that is equal to 1 minus the ratio of the estimated reasonable cost-based payments that would have been made if the LTCH PPS had not been implemented to the projected total Medicare program PPS payments (that is, payments made under the transition methodology and the option to elect payment based on 100 percent of the Federal rate). Because we estimate that the additional cost of the transition period methodology (including the option to elect payment based on 100 percent of the Federal rate) will be

approximately \$1 million for the 2006 LTCH PPS rate year (and will be less than \$1 million for the 2007 LTCH PPS rate year) and because this amount is a small percentage of total LTCH PPS payments (estimated at over \$3 billion, as shown in the table below), the formula that we have used to establish the budget neutrality offset in prior years results in a factor (as described above) that we reduce all LTCH Medicare payments by to account for those additional costs of zero (as a function of rounding). In addition, as explained above, we are no longer projecting an additional cost to the Medicare program resulting from the transition period methodology (including the option to elect payment based on 100 percent of the Federal rate) for the 2008 LTCH PPS rate year.

Accordingly, using the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 56034), based on updated data and the policies and rates discussed in this final rule, we are establishing a 0.0 percent reduction (a budget neutrality offset of 1.000) to all LTCHs' payments for discharges occurring on or after July 1, 2005 and through June 30, 2006, to account for the estimated cost of the transition period methodology (including the option to elect payment based on 100 percent of the Federal rate). As stated above, in order to maintain budget neutrality, we indicated that we will use a budget neutrality offset for each of the remaining years of the transition period to account for the estimated costs for the respective LTCH PPS rate years. In this final rule, based on the best available data, we estimate there would be a 0.0 percent budget neutrality offset to LTCH PPS payments during the remaining years of the transition period since, as explained above, we currently estimate that the additional cost to the Medicare program resulting from the transition period methodology is so small that the budget neutrality factor determined under our established methodology would round to zero.

As we discussed in the August 30, 2002 LTCH PPS final rule (67 FR 56036), consistent with the statutory requirement for budget neutrality in section 123(a)(1) of Pub. L. 106-113, we intended that estimated aggregate payments under the LTCH PPS for FY 2003 equal the estimated aggregate payments that would be made if the LTCH PPS were not implemented. Our methodology for estimating payments for purposes of the budget neutrality calculations uses the best available data at the time and necessarily reflect assumptions. As the LTCH PPS progresses, we are monitoring payment

data and will evaluate the ultimate accuracy of the assumptions used in the budget neutrality calculations (for example, inflation factors, intensity of services provided, or behavioral response to the implementation of the LTCH PPS) described in the August 30, 2002 LTCH PPS final rule (67 FR 56027-56037). To the extent these assumptions significantly differ from actual experience, the aggregate amount of actual payments may turn out to be significantly higher or lower than the estimates on which the budget neutrality calculations were based.

Section 123 of Pub. L. 106-113 and section 307 of Pub. L. 106-554 provide broad authority to the Secretary in developing the LTCH PPS, including the authority for appropriate adjustments. Under this broad authority, as implemented in the regulations at §412.523(d)(3), we have provided for the possibility of making a one-time prospective adjustment to the LTCH PPS rates by October 1, 2006, so that the effect of any significant difference between actual payments and estimated payments for the first year of the LTCH PPS would not be perpetuated in the LTCH PPS rates for future years.

In the May 7, 2004 LTCH PPS final (69 FR 25703-25704), based on the best available data at that time, we estimated that total Medicare program payments for LTCH services over the next 5 LTCH PPS rate years would be \$2.96 billion for the 2005 LTCH PPS rate year; \$2.98 billion for the 2006 LTCH PPS rate year; \$2.95 billion for the 2007 LTCH PPS rate year; \$3.01 billion for the 2008 LTCH PPS rate year; and \$3.12 billion for the 2009 LTCH PPS rate year.

In the February 3, 2005 proposed rule, consistent with the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 56036), based on the best available data at that time, we estimated that total Medicare program payments for LTCH services for the next 5 LTCH PPS rate years would be \$2.94 billion in the 2006 LTCH PPS rate year; \$2.90 billion in the 2007 LTCH PPS rate year; \$2.96 billion in the 2008 LTCH PPS rate year; \$3.08 billion in the 2009 LTCH PPS rate year; and \$3.24 billion in the 2010 LTCH PPS rate year. These estimates were based on the projection that 94 percent of LTCHs would elect to be paid based on 100 percent of the 2006 LTCH PPS rate year proposed standard Federal rate rather than the applicable transition blend, and our estimate of 2006 LTCH PPS rate year payments to LTCHs. These estimates were also based on our Office of the Actuary's most recent estimate of the excluded hospital with capital market basket for the 2006 through 2010

LTCH PPS rate years and our Office of the Actuary's projection of the change in Medicare beneficiary fee-for-service enrollment for the 2006 through 2010 LTCH PPS rate years (70 FR 5752).

Comment: Two commenters requested that we include estimates of the impact of our recent payment adjustment for LTCH HwHs and satellites of LTCHs in our projections of future LTCH PPS payments.

Response: The tables in section V.C.7. of this preamble and the impact analysis in section XII.B.5. have not factored in the estimated impact of the recent payment adjustment for LTCH HwHs and satellites of LTCHs that were established in the August 11, 2004 IPPS final rule and codified at § 412.534. In that same final rule, we noted that quantifying the effect of the payment adjustment for LTCH HwHs and satellites under § 412.534 on Medicare expenditures for the LTCH PPS was problematic because “[w]e cannot estimate the numbers of existing entities that will be affected by these revisions, nor can we estimate the specific DRGs that will be affected at those hospitals” (69 FR 49771). We expected some degree of behavioral changes in discharge and admission policies between host hospitals and their LTCH HwHs or LTCH satellites, but “* * * we [also] do not know the number of new applications for either LTCH hospital-within-a-hospital or LTCH satellite status that would [be] subject to review under these new circumstances.” (69 FR 49771) Additionally, we note that we adopted a “hold harmless” policy the first year following the implementation of this policy (cost reporting periods beginning on or after October 1, 2004). That is, LTCH HwHs and LTCH satellites are not subject to the payment adjustment if the percentage of discharges admitted by the LTCH HwH or satellite of the LTCH from the host hospital do not exceed the percentage of discharges admitted from the host in its FY 2004 cost reporting period (§ 412.534(f)(1)). Furthermore, under § 412.534(f), we have also provided for a transition to the full payment adjustment for a hospital that is 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 know from comments that we received on the May 18, 2004 IPPS proposed rule (69 FR 28196) that there could be a considerable number of these LTCHs in formation and yet since they are presently acute care hospitals, they are receiving Medicare payments under the IPPS. No claims or cost reporting data have been submitted by these hospitals

under the LTCH PPS because they are not LTCHs at this time and, therefore, our projections would be unable to capture data on this not-inconsiderable group of providers that would be affected by the payment adjustment.

Since the publication of the August 11, 2004 final rule, however, we have compiled a more comprehensive list of HwHs and asked our Office of the Actuary to utilize the best available Medicare data in order to evaluate whether it could be used to create a preliminary estimate of the impact of the LTCH HwH and satellite payment adjustment on Medicare payments during the three years of the transition to the full payment adjustment (FYs 2006–2008). Presently, based on our best data available to us, we believe that there are approximately 170 HwHs, but, because of the lag time in the availability of discharge data, we do not have complete data on the percentage of each LTCH's discharges that were admitted from its host during FY 2004. However, we do have specific discharge pattern data from 48 HwHs and their hosts (for CY 2003) provided by a LTCH HwH chain.

Our Office of the Actuary evaluated the available data on those LTCH HwHs to develop projections based on the specified yearly ceilings of admissions from the host during the transition (that is, 75 percent in FY 2006, 50 percent in 2007 and 25 percent in FY 2008) and extrapolated the results from these calculations to the remaining LTCH HwHs for which we lacked specific patient discharge pattern data. Because of the limited availability of hospital-specific admission and discharge data, those estimates were based on several assumptions, including behavioral changes by hosts that would result in fewer patients being discharged to the LTCH HwH and no additional increase in the number of LTCH patients.

Although the actual result of these analyses, projections, and extrapolations initially indicated an estimated reduction in Medicare payments under the LTCH PPS, these estimates do not account for the possibility that there could be an increase in the number of non-outlier patients discharged from host hospitals who were admitted to and receive Medicare covered services at another LTCH that was not co-located with the host. Since these LTCHs that are not co-located with the host would also submit claims under the LTCH PPS for treating the Medicare beneficiaries admitted, at this point, we believe it would be inappropriate to project a significant reduction in payments to LTCHs under the LTCH PPS. Therefore, based on the data available at this time,

we continue to believe that it is difficult to accurately quantify the impact on Medicare payments under the LTCH PPS resulting from the recent payment adjustment at § 412.534. We believe that any attempt to include the impact of this particular policy in our projections of future LTCH PPS spending could undermine the credibility of these projections. For these reasons, while the effect of the change to the LTCH HwH and LTCH satellite policy has been considered, we do not believe that it is appropriate at this point to reduce our projection of LTCH PPS payments in this final rule.

As we explained in detail in our August 11, 2004 final rule for the IPPS (69 FR 49196) we implemented the payment adjustment for LTCH HwHs and satellites at § 412.534 because we believe that the co-location of LTCHs or LTCH satellites with other Medicare providers, particularly acute care hospitals, bore a “strong resemblance * * * to LTCH units of acute care hospitals, a configuration precluded by statute.” (69 FR 49201, August 11, 2004) Although we are not presently capable of publishing reliable data projections that reflect the impact of this policy on the LTCH PPS, we continue to believe, as stated in the August 11, 2004 final rule, “* * * [t]o the extent that these policy revisions will eliminate hospital-within-hospital arrangements that circumvented our existing requirements, the Medicare program will avoid making unnecessary payments under the more costly” LTCH prospective payment system (69 FR 49771).

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

LTCH PPS rate year	Estimated payments (\$ in billions)
2006	3.32
2007	3.38
2008	3.48
2009	3.63
2010	3.79

In accordance with the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 56037), these estimates are based on the projection that 98 percent of LTCHs will elect to be paid based on 100 percent of the 2006 LTCH PPS rate year proposed standard Federal rate rather than the applicable transition blend, and our estimate of 2006 LTCH PPS rate year

payments to LTCHs using our Office of the Actuary's most recent estimate of the excluded hospital with capital market basket of 3.4 percent for the 2006 LTCH PPS rate year, 3.0 percent for the 2007 LTCH PPS rate year, 2.8 for the 2008 LTCH PPS rate year, and 2.9 percent for the 2009 and 2010 LTCH PPS rate years. We also took into account our Office of the Actuary's projection that there will be a change in Medicare fee-for-service beneficiary enrollment of -1.0 percent in the 2006 LTCH PPS rate year, -2.1 percent in the 2007 LTCH PPS rate year, -1.0 percent in the 2008 LTCH PPS rate year, 0.3 percent in the 2009 and 2010 LTCH PPS rate years. (We note that, based on the most recent available data, our Office of the Actuary is projecting a slight decrease in Medicare fee-for-service Part A enrollment, in part, because they are projecting an increase in Medicare managed care enrollment as a result of the implementation of several provisions of the MMA of 2003.)

As we discussed in the May 7, 2004 LTCH PPS final rule (69 FR 25704), because the LTCH PPS has only been recently implemented, sufficient new data have not been generated that would enable us to conduct a comprehensive reevaluation of our budget neutrality calculations. Accordingly, we did not make a one-time adjustment under § 412.523(d)(3). In the February 3, 2005 proposed rule (70 FR 5752), we explained that at this time, we still do not have sufficient new data to enable us to conduct a comprehensive reevaluation of our budget neutrality calculations. Therefore, we did not propose to make a one-time adjustment under § 412.523(d)(3) so that the effect of any significant difference between actual payments and estimated payments for the first year of the LTCH PPS is not perpetuated in the PPS rates for future years.

We note that we did not receive any comments on our proposal not to make a one-time adjustment under § 412.523(d)(3) in the LTCH PPS rate year 2006. Accordingly, at this time, we are not making a one-time adjustment under § 412.523(d)(3) so that the effect of any significant difference between actual payments and estimated payments for the first year of the LTCH PPS is not perpetuated into the LTCH PPS rates for future years. However, we will continue to collect and interpret new data as the data become available in the future to determine if such an adjustment should be proposed.

8. Extension of the Interrupted Stay Policy

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

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

In implementing this policy, we provided that, in the event a Medicare inpatient is discharged from a LTCH and is readmitted and the stay qualifies as an interrupted stay, the provider must cancel the claim generated by the original stay in the LTCH and submit one claim for the entire stay. (For further details, see Medicare Program Memorandum Transmittal A-02-093, September 2002.) On the other hand, if the patient stay exceeds the total fixed-day threshold at the other facility before being readmitted to the LTCH, two separate LTCH PPS payments would be made. One would be based on the principal diagnosis and length of stay for the first discharge from the LTCH and the other based on the principal diagnosis and length of stay for the second discharge from the LTCH.

Depending upon their lengths of stay, both stays could result in payments as a short-stay outlier (§ 412.529), a full LTC-DRG, or even a high-cost outlier. Further, if the principal diagnosis is the same for both admissions, the hospital could receive two similar payments. It is also important to note that under the existing greater than 3-day interruption of stay policy, a separate Medicare payment is made to the intervening provider under that provider's payment system.

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

Existing regulations at § 412.509(c) require a LTCH to furnish all necessary covered services for a Medicare beneficiary who is an inpatient of the hospital either directly or "under arrangements" (as defined in § 409.3). The "under arrangements" policy set forth in § 412.509 derives from the regulations at § 411.15(m), which implement section 1862(a)(14) of the Act. Section 1862(a) of the Act specifies the services for which no payment may be made under Medicare Part A and Part B and also specifies the exception for certain services to be furnished "under arrangements" by providers. Under section 1862(a)(14) of the Act, notwithstanding any other provision of

this title, “no payment may be made under part A or part B for any expenses incurred for items or services which are other than physicians’ services (as defined in regulations promulgated specifically for purposes of this paragraph), services described by section 1861(s)(2)(K) of the Act (certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist, and which are furnished to an individual who is a patient of a hospital or critical access hospital by an entity other than the hospital or critical access hospital, unless the services are furnished under arrangements (as defined in section 1861(w)(1) of the Act)) with the entity made by the hospital or critical access hospital.” Section 1861(w)(1) of the Act states that “[t]he term ‘arrangements’ is limited to arrangements under which receipt of payment by the hospital, critical access hospital, skilled nursing facility, home health agency, or hospice program (whether in its own right or as agent), with respect to services for which an individual is entitled to have payment made under this title, discharges the liability of such individual or any other person to pay for the services.” We believed the objective of these statutory provisions, which were implemented for inpatient acute care hospitals in regulations at § 411.15(m) and subsequently at § 412.509 for LTCHs, was to discharge financial liability for inpatients who may have received additional care off-premises and to assign payment responsibility for the care to the hospital that is being paid for that beneficiary’s total care for that spell of illness.

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

the interrupted stay policy under the LTCH PPS.

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

If a LTCH obtains, from another facility “under arrangements,” a specific test or procedure that is not available on the LTCH’s premises for one of its inpatients, as contemplated by § 412.509, a discharge and a subsequent readmission would therefore be unnecessary and inappropriate. This is true even if it is necessary to transport the patient to another facility to receive the arranged-for service. In this situation, generally, the LTCH would include the medically necessary test or procedure on its patient claim to Medicare which could have an effect on the assignment of the LTC-DRG and, thus, the Medicare payment to the LTCH, and the LTCH would be responsible for paying the provider directly for the test or procedure. Under the 3-day or less interruption of stay policy, if a LTCH patient is discharged to an acute care hospital, IRF, SNF, or patient’s home and returns to the LTCH for further hospital-level care within 3 days, any Medicare-covered services delivered during that interruption will be deemed to have been delivered “under arrangements” and included in the one episode of care for which Medicare will pay the LTCH. Furthermore, under § 409.3, when services are furnished “under arrangements,” Medicare payments made to the provider that arranged for the services discharges the liability of the beneficiary or any other person to pay for those services.

Our policy was premised on the belief that 3 days, in most instances, represented an appropriate interval for establishing whether or not the reason

for the patient’s readmission was directly connected to the original episode of care at the LTCH. Therefore, no additional claim can be submitted to Medicare by the other provider that actually furnished the test or procedure if the patient is readmitted to the LTCH within 3 days since the initial LTCH admission triggered a Medicare payment under the LTCH prospective payment system that has been calibrated to cover payment for all necessary Medicare covered services delivered to a beneficiary during that episode of care.

Moreover, under this established policy, where the LTCH is required to pay for outpatient or inpatient medical treatment or care provided at an acute care hospital, an IRF or SNF during any days of the 3-day or less interruption, all days of the 3-day or less interruption that the patient is away from the LTCH will be included in that patient’s day count at the LTCH. If the LTCH patient goes home during the interruption and receives no additional medical care prior to being readmitted to the LTCH, the intervening days will not be included in the day count because the LTCH did not deliver any services to the patient during those days either directly or “under arrangement.”

In the policy, as established in the May 7, 2004 LTCH PPS final rule, for LTCH rate year 2005, we did provide a limited exception to the prohibition against additional Medicare payments to an intervening provider under the less than 3-day interruption of stay policy at § 412.531(b)(1)(ii)(A)(1). Under this exception, during the 2005 LTCH PPS rate year, if a patient was discharged from a LTCH, admitted as an inpatient to an acute care hospital and readmitted to the same LTCH within 3 days, and if the treatment that was delivered at the acute care hospital was grouped to a surgical DRG, Medicare will pay the acute care hospital separately for that surgical treatment. We also provided in § 412.531(b)(1)(i)(c) that the number of days that a beneficiary spends away from a LTCH during a 3-day or less interruption of stay during which a beneficiary receives a procedure that is grouped to a surgical DRG under the IPPS in an acute care hospital during the 2005 LTCH PPS rate year is not included in determining the length of stay of the patient at the LTCH. We established this exception in response to comments on the original policy that we proposed in the January 30, 2004 proposed rule (69 FR 4768–4772) requesting that we take into consideration the following scenario: the occurrence of an emergency “totally unrelated” to a LTCH patient’s admitting diagnoses that occurred and

requiring surgery at an acute inpatient hospital, followed by the readmission of the patient within 3-days to the LTCH for a continuation of treatment of the patient's initial medical problems.

In our response to these concerns, we noted that the 3-day or less interruption of stay policy at 412.531 resulted from our concern that if a LTCH patient was discharged to an acute care hospital for only 1, 2, or 3 days, followed by a readmission to the LTCH, there could be reason to believe that the treatment delivered, even if it was grouped to a surgical DRG, was not a major procedure because of the relatively short length of stay, and, therefore, should have been provided "under arrangements."

In the May 7, 2004 LTCH PPS final rule, we stated that over the course of the first year of implementation of the revised 3-day or less interrupted stay policy, we would study relevant claims data in order to evaluate whether further proposed refinements to this policy would be warranted in this year's rule. Specifically, we stated that we would analyze new data to determine whether problems associated with LTCH interrupted stays equally affected all settings to which LTCH patients may have been discharged and subsequently readmitted and we would closely monitor patterns of discharges and readmissions under the first year of this policy. In order to pursue these analyses, we stated that we would be using relevant claims data as soon as they were available to determine whether our policy was producing its desired effect of reducing unnecessary and inappropriate Medicare payments while not compromising beneficiary access to medically necessary services. The 3-day interruption of stay policy was first implemented on July 1, 2004, and, therefore, we do not yet have sufficient data to accomplish the above evaluations. Therefore, in the February 3, 2005 proposed rule (70 FR 5754), we proposed to extend the surgical DRG exception in § 412.531(b)(1)(i)(C) and (b)(ii)(A)(1) through the 2006 LTCH rate year, from July 1, 2005 through June 30, 2006. As we explained in that same proposed rule, at that point, the policy will have been in effect for 12 months, and we believe that we will be better able to evaluate whether this exception should be extended further as well as whether the overall policy requires modification in order to serve the overall goals of the Medicare program.

Comment: Three commenters expressed strong support for our proposed one-year extension of the surgical DRG exception to our 3-days or less interrupted stay policy, noting that

it prevents LTCHs from having to pay for costly surgical procedures "under arrangements" for patients who are otherwise being treated at LTCHs. One of the commenters urged us to make it a permanent feature of the policy.

Response: We appreciate the commenters' support for our proposed policy. As noted above, we will be analyzing claims data over the next year to determine whether the surgical DRG exception to the "under arrangements" feature of the 3-day or less interrupted stay policy is actively accomplishing our goal of reducing unnecessary Medicare payments and to deter inappropriate Medicare payments while not compromising beneficiary access to medically necessary services. We believe that we will have sufficient data to evaluate continuation of the exception and also whether additional refinements to the overall 3-day or less interruption of stay policy are warranted. We are particularly interested in analyzing data from LTCHs to determine whether there has been a significant increase in interruptions of 4-days since the establishment of the policy. To the extent interruption of stay has increased to at least 4 days, this behavior may indicate inappropriate efforts to side-step the provisions of our 3-day or less interruption of stay policy. Therefore, as proposed, we are extending the surgical DRG exception through the 2006 LTCH PPS rate year, from July 1, 2005–June 30, 2006 in § 412.531(b)(1)(i)(C) and (b)(ii)(A)(1).

9. Onsite Discharges and Readmittances

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

In applying the 5-percent threshold, we apply one threshold for discharges and readmittances with the co-located acute care hospital. There is also a separate 5-percent threshold for the aggregate of all discharges and readmittances to the LTCH from its co-located SNFs, IRFs, and psychiatric facilities. In the case of a LTCH that is co-located with an acute care hospital, an IRF, or a SNF, the interrupted stay

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

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

In the August 30, 2002 LTCH PPS final rule, we established a notification requirement for LTCHs that were HwHs, as defined in § 412.22(e), and satellites of LTCHs, as defined at § 412.22(h)(5), and for LTCHs and satellites of LTCHs that were subject to the onsite provider payment adjustment under § 412.532 because they were co-located with other Medicare providers, as specified in § 412.532(a). At existing § 412.22(e)(3) and (h)(5), we require a LTCH HwH and a satellite of a LTCH, respectively, to notify its FI and CMS of its co-located status within 60 days of the start of its first cost reporting period under the LTCH PPS. At existing § 412.532(i), we require the LTCH or satellite of a LTCH that is co-located with another hospital or a SNF to provide notification of its co-location within 60-days following the effective date of the regulations. We also

established an additional notification requirement at § 412.532(i), for a LTCH or satellite of a LTCH, subject to the onsite provider payment adjustment at § 412.532 to notify its FI and CMS within 60 days of a change in co-located status. We intended that these regulations also require LTCHs and satellites of LTCH that are co-located with other hospitals or SNFs to identify particular co-located Medicare providers.

As we discussed in the February 3, 2005 proposed rule (70 FR 5750), it appears that this expectation is unclear in our present regulations. We have been informed by some of our regional offices and FIs that LTCHs and satellites of LTCHs, for which they are responsible, have in many cases neglected to specify the name(s), address(es), and Medicare provider number(s) of the co-located providers covered by § 412.22(e)(3), (h)(5), and § 412.532, as applicable. Therefore, in that same proposed rule, with respect to § 412.22(e)(3), we proposed to clarify our policy that a LTCH that occupies space in a building used by another hospital, or in one or more entire buildings located on the same campus as buildings used by a hospital and that meets the criteria of paragraph (e)(1) or (e)(2) of § 412.22, must inform its FI and CMS in writing of its co-located status, as well as, provide the name(s), address(es), and the Medicare provider number(s) of the other co-located providers (that is, acute care hospitals, IRFs, and psychiatric facilities and units). We also proposed to clarify that, with respect to § 412.22(h)(5), a satellite of a LTCH that occupies space in a building used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital, and that meets the criteria of paragraphs (h)(1) through (h)(4) of § 412.22, must notify its FI and CMS in writing of its co-located status and identify by name(s), address(es), and Medicare provider number(s), those hospital(s) with which it is co-located.

In addition, we proposed to clarify the notification requirements in § 412.532 that apply to a LTCH or satellite of a LTCH to which § 412.532 applies. For example, we clarified that the notification requirements apply to a LTCH or a satellite of a LTCH that is co-located with a SNF. Furthermore, since the existing regulation text at § 412.22(e)(3) and (h)(5) required that the notification take place within 60 days of the LTCH's first cost reporting period beginning on or after October 1, 2002 and § 412.532(i) required that the notification occur within 60 days of the effective date of the original regulation

(cost reporting periods beginning on or after October 1, 2002), and this timeframe for many providers has long since passed, we proposed to eliminate the specific timing requirement in favor of the on-going, prospective notification requirement described above, which is also clearer and more comprehensive. Therefore, we proposed to delete the phrase "within 60 days of its first cost reporting period that begins on or after October 1, 2002" at § 412.22(e)(3) and (h)(5). We also proposed to delete the phrase "within 60 days following the effective date of these regulations" from § 412.532(i). We also proposed to delete the phrase "and within 60 days of a change in co-located status" from § 412.532(i) because, as we explained in that same proposed rule, we believe that the proposed continuing notification requirement in the revised regulation text at § 412.22(e)(3) and (h)(5), as well as at § 412.532(i), would include the obligation to notify CMS and the FI in writing of any changes in co-located status and the obligation to provide the requisite information detailed above. We also proposed to clarify that the notification requirement in § 412.532(i) applied to a LTCH or a satellite of a LTCH that is co-located with a SNF. Accordingly, we proposed to revise each of the three notification provisions, to establish consistency and to clearly state the on-going requirement that a LTCH and a satellite of a LTCH that is co-located with another hospital or a SNF inform their FIs and CMS in writing of the name(s), address(es), and Medicare provider number(s) of particular co-located Medicare providers.

As discussed earlier in the comment and response in section V.C.8. of this preamble, several commenters agreed with our proposed clarification of the notification requirement. There were no comments on the proposed elimination of the specific timing requirement, that is, notification occurs within 60 days of the LTCH's first cost reporting period beginning on or after October 1, 2002 and the notification occurs within 60 days of the effective date of the original regulation (October 1, 2002) and that notification occurs within 60 days of a change in co-located status, nor were there comments regarding our clarification that the notification requirements apply to a LTCH or a satellite of a LTCH that is co-located with a SNF. As explained in detail earlier in this section of the preamble, we are finalizing our proposed notification requirements with some minor editorial modifications.

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

In accordance with § 412.525 and as discussed in section V.C. of this final rule, the standard Federal rate is adjusted to account for differences in area wages by multiplying the labor-related share of the standard Federal rate by the appropriate LTCH PPS wage index (as shown in Tables 1 and 2 of the Addendum to this final rule). The standard Federal rate is also adjusted to account for the higher costs of hospitals in Alaska and Hawaii by multiplying the nonlabor-related share of the standard Federal rate by the appropriate cost-of-living factor (shown in Table I in section V.C.2. of this preamble). In the May 7, 2004 final rule (69 FR 25674), we established a standard Federal rate of \$36,833.69 for the 2005 LTCH PPS rate year. In February 3, 2005 proposed rule, based on the best available data, previously established policies, and the proposed policies described in that rule, we proposed a standard Federal rate of \$37,975.53 for the 2006 LTCH PPS rate year as discussed in section V.B. of this preamble. In this final rule, based on the best available data and the finalized policies described in this final rule, we are establishing a standard Federal rate of \$38,086.04 for the 2006 LTCH PPS rate year as discussed in section IV.B. of this preamble. We illustrate the methodology used to adjust the Federal prospective payments for the 2006 LTCH PPS rate year in the following example: During the 2006 LTCH PPS rate year, a Medicare patient is in a LTCH located in Chicago-Naperville-Joliet, Illinois (CBSA 16974). This LTCH is in the third year of the wage index phase-in, thus, the three-fifths wage index values are applicable. The three-fifths wage index value for CBSA 16974 is 1.0521 (see Table 1 in the Addendum to this final rule). The Medicare patient is classified into LTC-DRG 9 (Spinal Disorders and Injuries), which has a relative weight of 1.0950 (see Table 3 in the Addendum to this final rule). To calculate the LTCH's total adjusted Federal prospective payment for this Medicare patient, we compute the wage-adjusted Federal prospective payment amount by multiplying the unadjusted standard Federal rate (\$38,086.04) by the labor-related share (72.885 percent) and the wage index value (1.0521). This wage-adjusted amount is then added to the nonlabor-related portion of the unadjusted standard Federal rate (27.115 percent; adjusted for cost of living, if applicable) to determine the adjusted Federal rate, which is then multiplied by the LTC-DRG relative

weight (1.0950) to calculate the total adjusted Federal prospective payment for the 2006 LTCH PPS rate year (\$43,287.85). Finally, as discussed in section V.C.6. of this preamble, for the

2006 LTCH PPS rate year, there will be a 0.0 percent reduction (a budget neutrality offset of 1.000) to the total adjusted Federal prospective payment to

account for the costs of the transition methodology.

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

Unadjusted Standard Federal Prospective Payment Rate	\$38,086.04
Labor-Related Share	0.72885
Labor-Related Portion of the Federal Rate	= \$27,759.01
3/5ths Wage Index (CBSA 16974)	1.0521
Wage-Adjusted Labor Share of Federal Rate	= \$29,205.25
Nonlabor-Related Portion of the Federal Rate (\$38,086.04 × 0.27115)	+ \$10,327.03
Adjusted Federal Rate Amount	= \$39,532.28
LTC-DRG 9 Relative Weight	× 1.0950
Total Adjusted Federal Prospective Payment (Before the Budget Neutrality Offset)	= \$43,287.85
Budget Neutrality Offset	× 1.000
Total Federal Prospective Payment (Including the Budget Neutrality Offset)	= \$43,287.85

VII. Transition Period

To provide a stable fiscal base for LTCHs, under § 412.533, we implemented a 5-year transition period whereby a LTCH receives payment consisting of a portion based on reasonable cost principles and a portion based on the Federal prospective payment rate (unless the LTCH elects payments based on 100 percent of the Federal rate). As discussed in the August 30, 2002 final rule (67 FR 56038), we believe that a 5-year phase-in provides LTCHs time to adjust their operations and capital financing to the LTCH PPS, which is based on prospectively determined Federal payment rates. Furthermore, we believe that the 5-year phase-in of the LTCH PPS also allows LTCH personnel to develop proficiency with the LTC-DRG coding system, which will result in improvement in the quality of the data used for generating our annual determination of relative weights and payment rates.

In accordance with § 412.533, the transition period for all hospitals subject to the LTCH PPS begins with the hospital's first cost reporting period beginning on or after October 1, 2002 and extends through the hospital's last cost reporting period beginning before October 1, 2006. During the 5-year transition period, a LTCH's total payment under the LTCH PPS is based on two payment percentages—one based on reasonable cost-based (TEFRA) payments and the other based on the standard Federal prospective payment rate. The percentage of payment based on the LTCH PPS Federal rate increases by 20 percentage points each year, while the reasonable cost-based payment rate percentage decreases by 20 percentage points each year, for the next 2 fiscal

years. For cost reporting periods beginning on or after October 1, 2006, Medicare payment to LTCHs will be determined entirely under the Federal rate. The blend percentages as set forth in § 412.533(a) are as follows:

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

For cost reporting periods that begin on or after October 1, 2004, and before October 1, 2005 (FY 2005), the total payment for a LTCH is 40 percent of the amount calculated under reasonable cost principles for that specific LTCH and 60 percent of the Federal prospective payment amount. For cost reporting periods that begin on or after October 1, 2005 and before October 1, 2006 (FY 2006), the total payment for a LTCH will be 20 percent of the amount calculated under reasonable cost principles for that specific LTCH and 80 percent of the Federal prospective payment amount. As we noted in the May 7, 2004 final rule (69 FR 25674), the change in the effective date of the annual LTCH PPS rate update from October 1 to July 1 has no effect on the LTCH PPS transition period as set forth in § 412.533(a). That is, LTCHs paid under the transition blend under § 412.533(a) will receive those blend percentages for the entire 5-year transition period (unless they elect payments based on 100 percent of the Federal rate). Furthermore, LTCHs paid under the transition blend will receive the appropriate blend percentages of the

Federal and reasonable cost-based rate for their entire cost reporting period as prescribed in § 412.533(a)(1) through (a)(5).

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

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

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

intermediary must receive the request on or before the specified date (that is, on or before the 30th day before the applicable cost reporting period begins for cost reporting periods beginning on or after December 1, 2002 through September 30, 2006), regardless of any postmarks or anticipated delivery dates.

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

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

As we discussed in the August 30, 2002 final rule (67 FR 56040), this definition of new LTCHs should not be confused with those LTCHs first paid under the TEFRA payment system for discharges occurring on or after October 1, 1997, described in section 1886(b)(7)(A) of the Act, as added by section 4416 of the Balanced Budget Act of 1997 (BBA'97) (Pub. L. 105-33). As stated in § 413.40(f)(2)(ii), for cost reporting periods beginning on or after October 1, 1997, the payment amount for a "new" (post-FY 1998) LTCH is the lower of the hospital's net inpatient operating cost per case or 110 percent of the national median target amount payment limit for hospitals in the same class for cost reporting periods ending during FY 1996, updated to the applicable cost reporting period (see 62 FR 46019, August 29, 1997). Under the LTCH PPS, those "new" LTCHs that meet the definition of "new" under § 413.40(f)(2)(ii) and that have their first cost reporting period as a LTCH beginning prior to October 1, 2002, will be paid under the transition methodology described in § 412.533.

As noted above and in accordance with § 412.533(d), new LTCHs will not participate in the 5-year transition from reasonable cost-based reimbursement to

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

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 short-stay outlier (under § 412.529) or as an interrupted stay (under § 412.531), or to determine if the case will qualify for a high-cost outlier payment (under § 412.525(a)).

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

As under the previous reasonable cost-based payment system, under § 412.541(b), a LTCH may elect to be paid using the periodic interim payment

(PIP) method described in § 413.64(h) and may be eligible to receive accelerated payments as described in § 413.64(g).

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

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

X. MedPAC Recommendations/Monitoring

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

The Commission identified particular problems such as growth of the LTCH industry, and high payment rates that appear to result from current payment incentives. Specifically the report states, "[F]irst, the financial incentive of the acute and long-term care hospital PPSs are likely to encourage facilities to selectively retain and admit certain types of patients to minimize their costs. Acute hospitals have a financial incentive to transfer patients as quickly as possible if they are likely to become

high-cost outliers (to avoid losses on those patients). LTCHs have an incentive to admit patients with a given diagnosis who are likely to require fewer resources. Second, as the number of LTCHs grows, facilities may find it increasingly difficult to find patients who truly require LTCH-level care; this would lead to an increase in lower severity patients being cared for in LTCHs and higher Medicare spending. Finally, LTCH care is costly. The per case base rate in \$37,000 and payments can be as high as \$115,000 per case for the most complex patients.” (pp. 127–8)

The Commission also examined LTCHs in the June 2003 Report to the Congress, entitled, “Monitoring post-acute care.” Citing that Report, the Commission compared beneficiaries treated in LTCHs and other settings and determined that based on “the 11 most common diagnoses in LTCHs, using descriptive analysis and controlling for diagnosis related group (DRG) and severity of illness * * * that patients in market areas with LTCHs had similar acute hospital lengths of stay [preceding the LTCH stay] whether they used these facilities or not.” Further, “[p]atients who used LTCHs were three to five times less likely to use skilled nursing facility (SNF) care, suggesting that SNFs and long-term care hospitals may be substitutes.” The June 2004 Report had also noted that “* * * Medicare pays more for patients treated in LTCHs, compared with patients not treated in them”, but also concluded that this study, as well as the rapid and continuing growth in the number of LTCHs, the corresponding increases in Medicare spending, combined with the markedly uneven distribution of LTCHs throughout the country, raised additional issues for further research. (p. 122)

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

- LTCHs provide post-acute care to a small number of medically complex patients who are more stable than patients in an intensive care unit (ICU) but may still have unresolved underlying complex medical conditions.

- The use of LTCHs is associated with certain diagnoses, severity levels and the proximity of the facility.

- In areas without LTCHs, acute hospitals and SNFs are the principal substitutes of LTCHs.

- When LTCH care is not targeted to patients most likely to need this level of care, care for patients at a LTCH is more costly to Medicare than for similar patients in alternative settings. Conversely, when LTCH care is targeted to patients most likely to need this level of care, costs for those patients appear to be comparable to costs for those who use other settings (and costs for LTCH patients with tracheostomies save Medicare money) in large part because of fewer acute hospital readmissions for those patients. (pp. 121–134)

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

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

- Facility-level criteria should characterize this level of care by features such as staffing, patient evaluation and review processes, and mix of patients.

- Patient-level criteria should identify specific clinical characteristics and treatment modalities.

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

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

In response to the recommendation in MedPAC’s June 2004 Report that the Secretary examine defining LTCHs by facility and patient criteria, we have awarded a contract to Research Triangle Institute (RTI), International for a thorough examination of the Commission’s recommendations based on the performance of a wide variety of

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

Specifically, the project itself will be completed in two phases. Phase I, which is presently being undertaken by the contractor, focuses on an analysis of LTCHs within the current Medicare system, their history as participating providers, their case-mix, the criteria used by QIOs to determine the appropriateness of treatment in LTCHs, and where similar patients are treated in areas that lack LTCHs. Prior analyses of these issues by other contractors will be utilized as well as preliminary discussions with MedPAC, other researchers, and the QIOs. Building on the work of Phase I, Phase II will continue to address the feasibility of MedPAC’s proposed criteria by first investigating the appropriateness of patient level criteria to determine

whether there are distinctions between patients treated in LTCHs and other types of potential substitute providers (with particular attention to varying outcomes). Medicare claims data will be utilized for comparisons of LTCH patients and long-stay patients who are treated in acute care hospitals that have attained high cost outlier status. A separate analysis will be made for a subset of LTCH patients with diagnoses that are typically treated in IRFs. The contractor is then planning interviews with QIOs for the purpose of gathering information on assessment measures for each setting. Comparisons of these instruments will be made across regions for their usefulness as standardized patient screening or assessment tools. The contractors then plan to evaluate the outcomes of their research in the context of MedPAC's recommendation for the development of facility-level criteria, using claims, interviews, and document reviews. To the extent the analyses suggest that changes should be made that may affect LTCH payments, LTCH discharges, or the definition of LTCH, such proposed changes could necessitate some statutory or regulatory changes.

In the August 30, 2002 final rule (67 FR 56014), we described an on-going monitoring component of the new LTCH PPS that would enable us to evaluate the impact of the new payment policies. Specifically, we discussed on-going analysis of the various policies that we believe would provide equitable payment for stays that reflect less than the full course of treatment and reduce the incentives for inappropriate admissions, transfers, or premature discharges of patients that are present in a discharge-based PPS. To this end, we have designed system features utilizing MedPAR data that will enable us and the fiscal intermediary to track beneficiary movement to and from a LTCH and track LTCH patients to and from another Medicare provider. We also stated our intent to collect and interpret data on changes in average lengths of stay under the LTCH PPS for specific LTC-DRGs and the impact of these changes on the Medicare program. As part of our data analysis, we have revisited a number of our original and even pre-LTCH PPS policies in order to address what we believed were behaviors by certain LTCHs that have led to inappropriate Medicare payments. In recent **Federal Register** publications, for example, we have proposed and subsequently finalized revisions to the interruption of stay policy (69 FR 25692, May, 2004), and we established a payment adjustment

for LTCH HwHs and satellites (69 FR 49191, August 11, 2004).

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

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

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

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

admissions, or perhaps high levels of short-stay outliers.

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

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

In addition to existing tasks and the above research study on short-stay

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

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

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

Therefore, in addition to pursuing our on-going monitoring program under the direction of our Office of Research, Development, and Information (ORDI), existing QIO monitoring and studies, and our considerations of expanding the

QIO role in the LTCH PPS, as noted above, we have awarded a contract to RTI International for a thorough examination of the feasibility of implementing MedPAC's recommendations that are contained in the June 2004 Report to the Congress. The research contract was funded for FY 2005 and we anticipate that we will be able to make available RTI's findings in the FY 2007 LTCH PPS proposed rule.

Comment: Several commenters agreed with the MedPAC recommendations that were published in the February 3, 2005 proposed rule, and support CMS' decision to engage RTI in a research study to examine the feasibility of implementing the MedPAC recommendations. In addition, the majority commented that CMS and RTI should work in a collaborative effort with the LTCH community which is also compiling critical data. One commenter stated his belief that there is a geographic diversity among LTCHs due to the continuum of care resources available in a given area of the country. In this respect, the commenter opposes any attempt to narrowly define LTCHs based upon a so-called "LTCH Prototype." Furthermore, the commenter believes that in order to comprehend the variations in lengths of stay among LTCHs, we must look to external contributory factors as well as LTCH specific internal data. Two other commenters, while supporting CMS' proposal to develop a quality measurement program for LTCHs, suggest that CMS establish some type of expert panel comprised of, among others, LTCH professionals, physicians and respiratory therapists. Several commenters are concerned that MedPAC did not recommend examining the role of nursing facilities, many of which attempt to provide a level of service far above their intended role and capabilities in the continuum of care. They question whether these facilities provide the same level of care and quality provided by LTCHs.

Response: We appreciate the commenters' support of our decision to have RTI assist us in examining potential criteria for assuring appropriate and cost effective use of LTCHs in the Medicare program. As you are aware, MedPAC identified particular problems, such as growth of the LTCH industry and high payment rates that appear to result from current payment incentives. Moreover, the Commission's interpretation of its qualitative and quantitative research findings led to two specific recommendations: "5A—The Congress and the Secretary should define long-term care hospitals by facility and patient criteria that ensure

that patients admitted to these facilities are medically complex and have a good chance at improvement * * *. 5B—The Secretary should require the Quality Improvement Organizations to review long-term care hospital admissions for medical necessity and monitor that these facilities are in compliance with defining criteria." As a result of MedPAC's recommendations, we awarded a contract to RTI International for a thorough examination of MedPAC's recommendations based on the performance of a wide variety of analytic tasks using our data files, and also utilizing information collected from physicians, providers, and LTCH trade associations. The information collected, both internally and externally, in this project is intended to provide information that will allow the Congress or the Secretary to develop criteria for distinguishing LTCHs from other acute care hospitals. We believe our role here is not to narrowly define the role of an LTCH, but rather to evaluate all information available to us in order to identify and distinguish the role of these hospitals as Medicare providers. Central to determining criteria for defining LTCHs is understanding differences between LTCHs and other types of post-acute providers and their patients. The contractor will use Medicare claims and payment data to examine the feasibility of patient level criteria and facility level criteria by studying differences between patients treated in LTCHs and other hospitals. As stated in the February 3, 2005 proposed rule, the contractor will examine the present role of QIOs in the Medicare program, focusing on their responsibilities regarding the LTCH PPS. The goals of this research is to document current practices related to the MedPAC recommendations, both in terms of provider certification, quality reviews, and hospital practice patterns.

The project itself will be completed in two phases. Phase I, which is near completion, focuses on an analysis of LTCHs within the current Medicare system, their history as participating providers, their case-mix, the criteria used by QIOs to determine the appropriateness of treatment in LTCHs, and determining where similar patients are being treated in areas that lack LTCHs. Prior analyses of these issues by other contractors will be utilized as well as preliminary discussions with MedPAC, other researchers, and the QIOs.

Building on the work of Phase I, Phase II will continue to carry out the analysis of the feasibility of MedPAC's criteria and making recommendations for revising the policies affecting LTCHs. Medicare claims data will be

utilized for comparisons of LTCH patients and long-stay patients who are treated in acute care hospitals that have attained high-cost outlier status. A separate analysis will be made for a subset of LTCH patients with diagnoses that are typically treated in IRFs. The contractor is then planning site visits, discussions with LTCH professionals, physicians, and therapists, and interviews with QIOs. These visits and interviews will be useful for understanding the differences between the types of admissions treated at LTCHs as compared to other providers and whether they vary clinically or are a function of varying availability of substitute providers in a geographic area. The contractor then plans to evaluate the outcomes of its research in the context of MedPAC's recommendation for the development of facility-level criteria, using claims, interviews, and document reviews. To the extent the analyses suggest that changes should be made that may affect LTCH payments, LTCH discharges, or the definition of LTCH, such proposed changes may necessitate either statutory or regulatory changes, or both.

In response to the commenters who expressed concern that MedPAC did not address the role of nursing facilities in the continuum of post-acute care, the level of service that these facilities deliver, and whether they deliver the same level of care and quality delivered by LTCHs, we are not in a position to comment on the subjects which MedPAC chooses to evaluate. We would note, however, that the June 2003 MedPAC report did include a discussion of the use of SNFs following a beneficiary's acute care hospital stay as an alternative to hospitalization at a LTCH. (p. 81–84) MedPAC's June 2004 report also compared Medicare payments to SNFs, IRFs, and LTCHs for specific principal diagnoses and noted, among other findings, that "The sharp decrease in probability of use of skilled nursing facilities by long-term care hospital users suggests that SNFs and LTCHs are substitutes." The report also stated that "Long term care hospital clinicians, however, are adamant that treatment provided in SNFs is not as intensive as care provided in LTCHs." (p. 126.) We would additionally assert that despite the fact that we have tasked RTI to focus on evaluating the development of facility and patient-level criteria for LTCHs and QIO review, we expect that the final report will also include some discussion of the distinctions between hospital-level care provided at LTCHs and the SNF-level care.

XI. Collection of Information Requirements

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

XII. Regulatory Impact Analysis

A. Introduction

We have examined the impact of this final rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 16, 1980, Pub. L. 96–354), section 1102(b) of the Act, the Unfunded Mandates Reform Act of 1995 (UMRA) (Pub. L. 104–4), and Executive Order 13132.

1. Executive Order 12866

Executive Order 12866 (as amended by Executive Order 13258, which merely assigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any one year). In this final rule, we are using the most recent estimate of the LTCH PPS market basket, updated claims data, and updated wage index values to estimate payments for the 2006 LTCH PPS rate year. Based on the best available data for 259 LTCHs, we estimate that the 3.4 percent increase to the standard Federal rate for the 2006 LTCH PPS rate year, in conjunction with the decrease in fixed-loss amount (discussed in section V.C.3. of this final rule) and the decrease in the transition period budget neutrality offset (discussed in section V.C.7. of this final rule), will result in an increase in payments from the 2005 LTCH PPS rate year of \$169 million. (Section V.C.7. of this final rule includes an estimate of Medicare program payments for LTCH services.) Because the combined distributional effects and costs to the Medicare program are estimated to be greater than \$100 million, this final rule is considered a major economic rule, as defined above.

2. Regulatory Flexibility Act (RFA)

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

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

Currently, our database of 259 LTCHs includes the data for 62 non-profit (voluntary ownership control) LTCHs and 189 proprietary LTCHs. The remaining 8 LTCHs are Government owned and operated. (See Table II.) The impact of the changes for the 2006 LTCH PPS rate year are discussed below in section XII.B.4.c of this final rule. The provisions of this final rule represent a 5.7 percent increase in estimated payments in the 2006 LTCH PPS rate year for all LTCHs (as shown in Table II below). We do not expect the incremental increase of 5.7 percent to the LTCH PPS Medicare payment rates, including the 0.1 percent incremental decrease due to the wage index changes (discussed in section V.C.1. of this final rule), to have a significant adverse effect on the overall revenues of most LTCHs. In addition, LTCHs also provide services to (and generate revenue from) patients other than Medicare beneficiaries. Accordingly, we certify that this final rule will not have a significant impact on a substantial number of small entities, in accordance with RFA.

3. Impact on Rural Hospitals

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

rural hospitals based on the data of the 16 rural hospitals in our database of the 259 LTCHs for which data were available.

4. Unfunded Mandates

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

5. Federalism

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

We have examined this final rule under the criteria set forth in Executive Order 13132 and have determined that this final rule will not have any significant impact on the rights, roles, and responsibilities of State, local, or tribal governments or preempt State law, based on the 8 State and local LTCHs in our database of 259 LTCHs for which data were available.

B. Anticipated Effects of Payment Rate Changes

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

1. Budgetary Impact

Section 123(a)(1) of Medicare, Medicaid and State Child Health Insurance Program (SCHIP) Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113) requires that the PPS developed for LTCHs “maintain budget neutrality.” Therefore, in calculating the standard Federal rate under § 412.523(d)(2), we set total payments for FY 2003 under the LTCH PPS so that aggregate payments under the LTCH PPS are estimated to equal to the amount that would have been paid if this PPS had not been implemented. However, as discussed in greater detail in the August 30, 2002 final rule (67 FR 56033–56036), the FY 2003 LTCH PPS standard Federal rate (\$34,956.15) was calculated as though all LTCHs would be paid based on 100 percent of the standard Federal rate in FY 2003. As discussed in section V.C.7. of this final

rule, we apply a budget neutrality offset to payments to account for the monetary effect of the 5-year transition to full prospective payment under the LTCH PPS and the policy to permit LTCHs to elect, during the transition, to be paid based on 100 percent of the standard Federal rate rather than a blend of Federal prospective payments and reasonable cost-based payments. The amount of the offset is equal to 1 minus the ratio of the estimated payments based on 100 percent of the LTCH PPS Federal rate to the projected total Medicare program payments that will be made under the transition methodology and the option to elect payment based on 100 percent of the Federal prospective payment rate.

2. Impact on Providers

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

In order to understand the impact of the changes to the LTCH PPS discussed in this final rule on different categories of LTCHs for the 2006 LTCH PPS rate year, it is necessary to estimate payments per discharge under the LTCH PPS rates and factors for the 2005 LTCH PPS rate year (see the May 7, 2005 final rule; 68 FR 25674) and to estimate payments per discharge that will be made under the LTCH PPS rates and factors for the 2006 LTCH PPS rate year, as discussed in the preamble of this final rule. To this end, we determined the percent change in payments per discharge of estimated 2005 LTCH PPS rate year payments to estimated 2006 LTCH PPS rate year payments for each category of LTCHs. In addition, for each category of LTCHs, we have included the estimated percent change in payments per discharge resulting from

the LTCH PPS wage index changes (described in section V.C.1. of this final rule). The wage index changes for the 2006 LTCH PPS rate year include the change in the labor market area definitions, the update in the wage index data, and the established phase-in of the LTCH PPS wage index adjustment from the 2005 LTCH PPS rate year (LTCHs’ FYs 2004 and 2005 cost reporting periods) to the 2006 LTCH PPS rate year (LTCHs’ FYs 2005 and 2006 LTCH cost reporting periods).

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

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

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

Using LTCH cases from the FY 2004 MedPAR file and cost data from FYs 1999 through 2002 to estimate payments under the current reasonable cost-based principles, we have obtained both case-mix and cost data for 259 LTCHs. Thus, for the impact analyses reflecting the applicable transition blend percentages and the option to elect payment based on 100 percent of the Federal rate (see Table II below), we used data from 259 LTCHs. While currently there are more than 300 LTCHs, the most recent growth is predominantly in for-profit LTCHs that provide respiratory and ventilator-dependent patient care. We believe that the discharges from the FY 2004

MedPAR data for the 259 LTCHs in our database provide sufficient representation in the LTC-DRGs containing discharges for patients who received respiratory and ventilator-dependent care based on the relatively large number of LTCH cases in LTC-DRGs for these diagnoses. However, using cases from the FY 2004 MedPAR file we had case-mix data for 335 LTCHs. Cost data to determine current payments under reasonable cost-based methodology payments are not needed to simulate payments based on 100 percent of the Federal rate. Therefore, for the impact analyses reflecting fully phased-in prospective payments (see Table III below), we used data from 335 LTCHs.

These impacts reflect the estimated “losses” or “gains” among the various classifications of LTCHs for the 2005 LTCH PPS rate year (July 1, 2004 through June 30, 2005) compared to the 2006 LTCH PPS rate year (July 1, 2005 through June 30, 2006). Prospective payments for the 2005 LTCH rate year were based on the standard Federal rate of \$36,833.69 and the hospitals’ estimated case-mix based on FY 2004 LTCH claims data. Estimated prospective payments for the 2006 LTCH PPS rate year are based on the standard Federal rate of \$38,086.04 and the same FY 2004 LTCH claims data.

3. Calculation of Prospective Payments

To estimate payments under the LTCH PPS, we simulated payments on a case-by-case basis by applying the payment policy for short-stay outliers (as described in section V.C.4.b. of this final rule) and the adjustments for area wage differences (as described in section V.C.1. of this final rule) and for the cost-of-living for Alaska and Hawaii (as described in section V.C.2. of this final rule). Additional payments would also be made for high-cost outlier cases (as described in section V.C.3. of this final rule). As noted in section V.C.6. of this final rule, we are not making adjustments for rural location, geographic reclassification, indirect medical education costs, or a disproportionate share of low-income patients because sufficient new data have not been generated that would enable us to conduct a comprehensive reevaluation of these payment adjustments.

For estimated 2005 LTCH PPS rate year payments, we used the applicable LTCH wage index values effective for discharges occurring on or after July 1, 2004 through June 30, 2005 based on the existing MSA-based labor market area designations (see May 7, 2004 (69 FR 25685)). We adjusted for area wage

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

For estimated 2006 LTCH PPS rate year payments, we used the applicable LTCH wage index values effective for discharges occurring on or after July 1, 2005 through June 30, 2006 (as shown in Tables 1 and 2 of the Addendum to this final rule) based on the CBSA-based labor market area designations (described in section V.C.1.c.1. of this final rule). Because some providers may experience a change in the wage index phase-in percentage during that period, we adjusted for area wage differences for estimated 2006 LTCH PPS rate year payments by computing a weighted average of a LTCH’s applicable wage index during the period from July 1, 2005, through June 30, 2006. For cost reporting periods that began on or after October 1, 2004 and before September 30, 2005, the labor portion of the Federal rate is adjusted by three-fifths of the applicable LTCH PPS wage index (that is, as discussed in section V.C.1. of this final rule, the FY 2005 IPPS acute care hospital wage index data without

taking into account geographic reclassification under sections 1886(d)(8) and (d)(10) of the Act). For cost reporting periods beginning on or after October 1, 2005 and before September 30, 2006, the labor portion of the Federal rate will be adjusted by four-fifths of the applicable LTCH PPS wage index. The applicable LTCH PPS wage index values for the 2006 LTCH PPS rate year are shown in Tables 1 and 2 of the Addendum to this final rule.

For estimated 2005 LTCH PPS rate year payments, for those LTCHs projected to receive payment under the transition blend methodology, we also calculated payments using the applicable transition blend percentages. During the 2005 LTCH PPS rate year, based on the transition blend percentages set forth in § 412.533(a), some providers may experience a change in the transition blend percentage during the period from July 1, 2004 through June 30, 2005. For example, during the period from July 1, 2004 through June 30, 2005, a provider with a cost reporting period beginning on October 1, 2003 (which is paid under the 60/40 transition blend (60 percent of payments based on reasonable cost-based methodology and 40 percent of payments under the LTCH PPS) beginning October 1, 2003) has 3 months (July 1, 2004 through September 30, 2004) under the 60/40 blend and 9 months (October 1, 2004 through June 30, 2005) of payment under the 40/60-transition blend (40 percent of payments based on reasonable cost-based methodology and 60 percent of payments under the LTCH PPS for cost reporting periods beginning during FY 2005). (The 40 percent/60 percent blend will continue until the provider’s cost reporting period beginning on October 1, 2005 (FY 2006).)

Similarly, during the 2006 LTCH PPS rate year, based on the transition blend percentages set forth in § 412.533(a), some of the providers paid under the transition blend methodology may experience a change in the transition blend percentage during the period from July 1, 2005 through June 30, 2006. For example, during the period from July 1, 2005 through June 30, 2006, a provider with a cost reporting period beginning on October 1, 2004 (which is paid under the 40/60 transition blend would have 3 months (July 1, 2005 through September 30, 2005) under the 40/60 blend and 9 months (October 1, 2005 through June 30, 2006) of payment under the 20/80-transition blend (20 percent of payments based on reasonable cost-based methodology and 80 percent of payments under the LTCH PPS for cost reporting periods beginning

during FY 2006). (The 20 percent/80 percent blend will continue until the provider's cost reporting period beginning on October 1, 2006 (FY 2007).)

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

Then we applied the budget neutrality offset to payments to account for the effect of the 5-year transition methodology and election of payment based on 100 percent of the Federal rate on Medicare program payments (established in the August 30, 2002 final rule (67 FR 56034)). In estimating 2005 LTCH PPS rate year payments, we applied the 0.5 percent (0.995) budget neutrality offset to payments to account for the effect of the 5-year transition

methodology and election of payment based on 100 percent of the Federal rate on Medicare program payments (See the May 7, 2004 final rule (68 FR 25674)) to each LTCH's estimated payments under the LTCH PPS for the 2005 LTCH PPS rate year. Similarly, in estimating 2006 LTCH PPS rate year payments, we applied the 0.0 percent (1.000) budget neutrality offset to payments to account for the effect of the 5-year transition methodology and election of payment based on 100 percent of the Federal rate on Medicare program payments (see section V.C.7 of this final rule) to each LTCH's estimated payments under the LTCH PPS for the 2006 LTCH PPS rate year. The impact shown below in Table II is based on our projection of using the best available data for 259 LTCHs that approximately 2 percent of LTCHs will be paid based on the transition blend methodology and 98 percent of LTCHs will elect payment based on 100 percent of the Federal rate.

In Table III below, we also show the impact if the LTCH PPS were fully implemented; that is, as if there were an immediate transition to fully Federal prospective payments under the LTCH PPS for the 2005 LTCH PPS rate year and the 2006 LTCH PPS rate year. Accordingly, in the impact analysis shown in Table III., the respective budget neutrality adjustments to account for the 5-year transition

methodology on LTCHs' Medicare program payments for the 2005 and 2006 LTCH PPS rate years (0.5 percent and the 0.0 percent, respectively) were not applied to LTCHs' estimated payments under the LTCH PPS.

Tables II and III below illustrate the aggregate impact of the payment system among various classifications of LTCHs.

- The first column, LTCH Classification, identifies the type of LTCH.
- The second column lists the number of LTCHs of each classification type.
- The third column identifies the number of long-term care cases.
- The fourth column shows the estimated payment per discharge for the 2005 LTCH PPS rate year.
- The fifth column shows the estimated payment per discharge for the 2006 LTCH PPS rate year.
- The sixth column shows the percent change in estimated LTCH PPS payments based on the wage index changes from the 2005 LTCH PPS rate year to the 2006 LTCH PPS rate year (as discussed in section V.C.1. of this final rule).
- The seventh column shows the percent change of 2005 LTCH PPS rate year estimated payments compared to the 2006 LTCH PPS rate year estimated payments for all changes (as discussed in the preamble of this final rule).

**Table II.--Projected Impact Reflecting Applicable
Transition Blend Percentages of Prospective Payments and
Reasonable Cost-Based (TEFRA) Payments and Option to Elect
Payment Based on 100 Percent of the Federal Rate¹
(Estimated 2005 LTCH PPS Rate Year Payments Compared
to Estimated 2006 LTCH PPS Rate Year Payments)**

LTCH Classification	Number of LTCHs	Number of LTCH Cases	Average 2005 LTCH PPS Rate Year Payment Per Case ²	Average 2006 LTCH PPS Rate Year Payment Per Case ³	Percent Change from RY 2005 to RY 2006 for Wage Index Changes ⁴	Percent Change from RY 2005 to RY 2006 for All Changes ⁵
All Providers	259	101,189	\$32,020	\$33,855	-0.1	5.7
BY LOCATION:						
Rural	16	4,496	\$28,438	\$29,474	-2.3	3.6
Urban	243	96,693	\$32,187	\$34,059	0.0	5.8
Large	105	33,362	\$30,551	\$32,010	-0.7	4.8
Other	138	63,331	\$33,048	\$35,138	0.3	6.3
BY PARTICIPATION DATE:						
Before October 1983	15	7,674	\$25,441	\$27,211	1.1	7.0
October 1983 - September 1993	45	21,996	\$34,025	\$36,176	0.2	6.3
October 1993 - September 2002	199	71,519	\$32,109	\$33,854	-0.3	5.4
BY OWNERSHIP CONTROL:						
Voluntary	62	22,987	\$30,321	\$32,172	0.1	6.1
Proprietary	189	76,018	\$32,706	\$34,540	-0.2	5.6
Government	8	2,184	\$26,032	\$27,732	-0.5	6.5
BY CENSUS REGION:						
New England	13	9,236	\$25,719	\$27,645	1.4	7.5
Middle Atlantic	18	6,050	\$32,266	\$33,728	-1.0	4.5
South Atlantic	25	9,201	\$34,927	\$36,929	-0.3	5.7
East North Central	50	15,069	\$35,079	\$36,977	0.0	5.4
East South Central	15	4,675	\$33,635	\$35,483	-0.7	5.5
West North Central	17	4,732	\$35,621	\$37,572	-0.4	5.5
West South Central	88	40,114	\$29,604	\$31,153	-0.5	5.2
Mountain	20	5,611	\$33,391	\$35,490	0.4	6.3
Pacific	13	6,501	\$39,484	\$42,592	1.5	7.9
BY BED SIZE:						
Beds: 0 - 24	23	3,816	\$32,826	\$34,737	-0.9	5.8
Beds: 25 - 49	127	34,131	\$31,983	\$33,585	-0.6	5.0
Beds: 50 - 74	37	13,489	\$34,190	\$36,190	0.0	5.8
Beds: 75 - 124	36	16,787	\$32,919	\$34,922	0.1	6.1
Beds: 125 - 199	24	20,998	\$30,255	\$32,022	0.0	5.8
Beds: 200 +	12	11,968	\$31,258	\$33,431	1.0	7.0

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

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

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

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

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

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

LTCH Classification	Number of LTCHs	Number of LTCH Cases	Average 2005 LTCH PPS Rate Year Payment Per Case ²	Average 2006 LTCH PPS Rate Year Payment Per Case ³	Percent Change from RY 2005 to RY 2006 for Wage Index Changes ⁴	Percent Change from RY 2005 to RY 2006 for All Changes ⁵
All Providers	335	117,651	\$32,183	\$33,874	-0.2	5.3
BY LOCATION:						
Rural	27	6,245	\$29,976	\$31,178	-2.4	4.0
Urban	308	111,406	\$32,306	\$34,025	-0.1	5.3
Large	140	40,209	\$31,092	\$32,497	-0.9	4.5
Other	168	71,197	\$32,992	\$34,888	0.3	5.7
BY PARTICIPATION DATE:						
Before October 1983	17	7,727	\$25,473	\$27,108	1.1	6.4
October 1983 – September 1993	45	21,996	\$34,173	\$36,169	0.2	5.8
October 1993 – September 2002	207	74,050	\$32,173	\$33,769	-0.4	5.0
After October 2002	66	13,878	\$32,818	\$34,563	-0.6	5.3
BY OWNERSHIP CONTROL:						
Voluntary	69	25,140	\$30,500	\$32,297	-0.1	5.9
Proprietary	219	85,425	\$33,016	\$34,705	-0.2	5.1
Government	9	2,212	\$25,951	\$27,510	-0.5	6.0
Unknown	38	4,874	\$29,089	\$30,331	-1.0	4.3
BY CENSUS REGION:						
New England	15	9,289	\$25,766	\$27,557	1.4	7.0
Middle Atlantic	22	6,989	\$32,079	\$33,307	-1.1	3.8
South Atlantic	41	12,042	\$35,732	\$37,684	-0.3	5.5
East North Central	61	17,235	\$35,108	\$36,877	-0.1	5.0
East South Central	21	5,751	\$34,653	\$36,486	-0.9	5.3
West North Central	17	4,732	\$35,800	\$37,590	-0.3	5.0
West South Central	121	49,128	\$29,635	\$31,044	-0.6	4.8
Mountain	22	5,960	\$34,278	\$36,375	0.3	6.1
Pacific	15	6,525	\$39,621	\$42,533	1.5	7.4
BY BED SIZE:						
Beds: 0 – 24	35	5,938	\$32,542	\$34,243	-1.4	5.2
BY BED SIZE:						
Beds: 25 – 49	172	41,705	\$32,592	\$34,100	-0.6	4.6
Beds: 50 – 74	42	14,712	\$33,736	\$35,612	-0.2	5.6
Beds: 75 – 124	42	20,340	\$32,904	\$34,738	0.1	5.6
Beds: 125 – 199	25	22,131	\$30,339	\$31,978	0.0	5.4
Beds: 200+	14	12,021	\$31,328	\$33,338	1.0	6.4
Unknown	5	804	\$25,148	\$25,970	-1.1	3.3

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

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

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

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

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

4. Results

Based on the most recent available data (as described above for 259 LTCHs), we have prepared the following summary of the impact (as shown in Table II) of the LTCH PPS set forth in this final rule.

a. Location

We evaluated each LTCH's location (urban or rural) based on the CBSA-based labor market area definitions described in section V.C.1.c.1. of this final rule. Based on the most recent available data, the vast majority of LTCHs are in urban areas.

Approximately 6 percent of the LTCHs are identified as being located in a rural area, and approximately 4.4 percent of all LTCH cases are treated in these rural hospitals. Impact analysis in Table II shows that for rural LTCHs the percent change in estimated payments per discharge for the 2006 LTCH PPS rate year will increase 3.6 percent in comparison to the 2005 LTCH PPS rate year from all of the established changes, which reflects the estimated 2.3 percent decrease in payments per discharge from the wage index changes. The primary reason for the projected increase in payments per discharge for all changes for rural LTCHs is a combination of the 3.4 percent increase in the standard Federal rate, the decrease in the transition budget neutrality offset (discussed in section V.C.7. of this final rule), and a projected increase in outlier payments as a result of the decrease in outlier fixed-loss amount (discussed in section V.C.3. of this final rule), which results in more cases qualifying as outlier cases and receiving additional outlier payments. This projected increase in estimated payments per discharge for rural LTCHs is partially offset by a projected decrease in payments per discharge as a result of the changes in the wage index.

Rural LTCHs are projected to experience a relatively large decrease in payments due to the wage index changes primarily because of the progression of the 5-year phase-in of the wage index adjustment. That is, because the wage index of most rural areas is less than 1.0, as rural LTCHs progress through the 5-year phase-in of the wage index adjustment (for example, the two-fifths wage index for cost reporting periods beginning during FY 2004 to the three-fifths wage index for cost reporting periods beginning during FY 2005), their wage index decreases, which results in a decrease in their payments. This would occur even if we had not revised the labor market area definitions based on OMB's CBSA

designations. For example (as shown in Table 2 of the Addendum to this final rule), the three-fifths wage index for rural Arizona of 0.9362 is less than the two-fifths wage index for rural Arizona of 0.9574. In addition, we identified three LTCHs that are currently urban under the existing MSA-based labor market area designations that will become rural under the new CBSA-based labor market designations, and as a result, are projected to experience a relatively larger decrease in payments per discharge due to the changes in the wage index. (See Table II.)

For urban LTCHs, the percent change in estimated payments per discharge for the 2006 LTCH PPS rate year are projected to increase 5.0 percent in comparison to the 2005 LTCH PPS rate year from all changes, which reflects an estimated 0.0 percent change resulting from the wage index changes. Payments per discharge for the 2006 LTCH PPS rate year are projected to increase 4.8 percent for large urban LTCHs in comparison to the 2005 LTCH PPS rate year from all of the changes, including a projected 0.7 percent decrease from the wage index changes. We project that 2006 LTCH PPS rate year payments per discharge will increase 6.3 percent in comparison to the 2005 LTCH PPS rate year for other urban LTCHs, including a projected 0.3 percent increase for the wage index changes.

As noted above and discussed in greater detail below, the projected increase in payments per discharge for all changes for both large and other urban LTCHs is largely due to the 3.4 percent increase to the standard Federal rate, the decrease in the transition budget neutrality offset, and a projected increase in outlier payments as a result of the decrease in the outlier fixed amount. These projected increases in payments per discharge reflecting all changes for LTCHs that are located in large urban areas are partially offset by a projected decrease in payments per discharge for the wage index changes. The projected decrease in payments per discharge based solely on the wage index changes are largely due to the progression of the 5-year phase-in of the wage index adjustment, as explained above, since the majority of LTCHs are in large urban areas with wage index values that are slightly less than 1.0. Large urban LTCHs are projected to experience a decrease in payments per discharge for the wage index changes because, in addition to the effect of the progression of the 5-year phase-in of the wage index adjustment, as explained above, the wage index for a few large urban areas, such as Houston, Texas, will be slightly lower under the new

CBSA-based labor market area designations than they would be under the MSA-based labor market area designations. (See Table II.)

As noted above, in addition to the update to the standard Federal rate, the estimated percent increase in payments per discharge for all changes from the 2005 LTCH PPS rate year to the 2006 LTCH PPS rate year is largely attributable to the decrease in the outlier fixed-loss amount (discussed in section V.C.3. of this final rule). For the 2005 LTCH PPS rate year, the outlier fixed-loss amount is \$17,864 (as established in the May 7, 2004 final rule). Therefore, currently a case qualifies for an additional LTCH PPS outlier payment if the estimated cost of the case exceeds the outlier threshold (the sum of the adjusted Federal LTCH payment for the LTC-DRG and the fixed-loss amount of \$17,864). For the 2006 LTCH PPS rate year, the outlier fixed loss-amount is \$10,501. Therefore, a case would qualify for an additional LTCH PPS outlier payment if the estimated cost of the case exceeds the outlier threshold (the sum of the adjusted Federal LTCH payment for the LTC-DRG and the fixed-loss amount of \$10,501). Therefore, we estimate that more cases will qualify as outlier cases (the estimated cost of the case exceeds the proposed outlier threshold) and will receive outlier payments, thereby increasing total estimated payments per discharge. In the aggregate, LTCHs are not expected to experience a significant impact as a result of the changes to the wage index. As discussed throughout this impact section, certain groups of hospitals are projected to benefit from the changes to the wage index while other groups of LTCHs are projected to be negatively impacted by the changes to the wage index. However, as a result of the aggregate effect of the update to the standard Federal rate combined with the decrease in the outlier fixed-loss amount, we estimate that all LTCH categories would experience an increase in payments.

b. Participation Date

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

Based on the most recent available data, the majority, approximately 70 percent, of the LTCH discharges are in LTCHs hospitals that began participating between October 1993 and September 2002, and we estimate that 2006 LTCH PPS rate year payments per discharge will increase 5.4 percent in comparison to the 2005 LTCH PPS rate year due to all changes, which includes the estimated 0.3 percent decrease in payments per discharge due to the wage index changes.

Approximately 22 percent of the discharges are in LTCHs that began participating in Medicare between October 1983 and September 1993, and 2006 LTCH PPS rate year payments per discharge are projected to increase 6.3 percent in comparison to the 2005 LTCH PPS rate year from all changes, which includes the estimated 0.2 percent increase in payments per discharge from the wage index changes. Payments per discharge for the 2006 LTCH PPS rate year are estimated to increase 7.0 percent in comparison to the 2005 LTCH PPS rate year for LTCHs that began participating before October 1983 from all changes, including the estimated 1.1 percent increase in payments per discharge from the wage index changes. This increase in projected payments per discharge from the changes in the wage index for LTCHs that began participating before October 1983 is largely due to a combination of the change to the CBSA-based labor market area definitions and the increase in the percentage of the wage index adjustment as required by the 5-year phase-in of the wage index adjustment (for example, two-fifths of the wage index adjustment for cost reporting periods beginning during FY 2004 increasing to three-fifths of the wage index adjustment for cost reporting periods beginning during FY 2005.). (See Table II.)

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

c. Ownership Control

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

Based on the most recent available data, approximately 3 percent of LTCHs are government owned and operated. We project that for these government owned and operated LTCHs, 2006 LTCH PPS rate year payments per discharge will increase 6.5 percent in comparison to the 2005 LTCH PPS rate year from all changes, including the estimated 0.5 percent decrease in payments per discharge from the wage index changes. This estimated decrease in estimated payments per discharge for the wage index changes is largely due to the current applicable percentage of the 5-year phase-in of the wage index adjustment, as explained above, since the majority of government run LTCHs are located in areas with wage index values that are less than 1.0. The majority (approximately 73 percent) of LTCHs are proprietary. We project that 2006 LTCH PPS rate year payments per discharge for these proprietary LTCHs will increase 5.6 percent in comparison to the 2005 LTCH PPS rate year for all changes, including the estimated 0.2 percent decrease in payments per discharge from the wage index changes. Similarly, we project that 2006 LTCH PPS rate year payments per discharge for voluntary LTCHs will increase 6.1 percent in comparison to the 2005 LTCH PPS rate year for all changes, including the estimated 0.1 percent increase in payments per discharge from the wage index changes. As noted above, in addition to the update to the standard Federal rate and the decrease in the budget neutrality offset, the estimated percent increase in payments per discharge for all changes from the 2005 LTCH PPS rate year to the 2006 LTCH PPS rate year is largely attributable to the decrease in outlier fixed-loss amount (discussed in section IV.C.3. of this final rule), which will result in more cases qualifying as outlier cases (the estimated cost of the case exceeds the outlier threshold) and, therefore, will receive additional outlier payments, thereby increasing total estimated payments per discharge. (See Table II.)

d. Census Region

Payments per discharge for the 2006 LTCH PPS rate year are estimated to increase for LTCHs located in all regions in comparison to the 2005 LTCH PPS rate year from all changes. Of the nine census regions, we project that the increase in 2006 LTCH PPS rate year

payments per discharge in comparison to the 2005 LTCH PPS rate year will be the largest for LTCHs in the Pacific and New England regions. Specifically, 2006 LTCH rate year payments per discharge for LTCHs in the Pacific and New England regions are projected to increase 7.9 percent and 7.5 percent, respectively, in comparison to the 2005 LTCH PPS rate year, which includes the estimated 1.5 percent and 1.4 percent increase, respectively, from the wage index changes for both areas. As explained above, these relatively large increases in payments from all changes for the 2006 LTCH PPS rate year for LTCHs in the New England and Pacific regions are mostly attributable to the decrease in the outlier fixed-loss amount (discussed in section V.C.3. of this final rule), which results in more cases qualifying as outlier cases (the estimated cost of the case exceeds the outlier threshold) and, therefore, will receive additional outlier payments, thereby increasing total estimated payments per discharge. Furthermore, in addition to the update to the standard Federal rate, we believe that many LTCHs in the New England and Pacific regions will experience an increase in payments because of an the annual percentage increase of the phase-in of the wage index adjustment, (two-fifths of the applicable LTCH PPS wage index for cost reporting periods beginning on or after October 1, 2003; three-fifths of the applicable wage index for cost reporting periods beginning on or after October 1, 2004; and four-fifths of the applicable wage index for cost reporting periods beginning on or after October 1, 2005) since most of the LTCHs in these regions are located in areas that have a wage index value of greater than 1.0. (See Table II.).

We project that 2006 LTCH PPS rate year payments per discharge will increase the least for LTCHs in the Middle Atlantic region in comparison to the 2005 LTCH PPS rate year for all changes (4.5 percent). We project that, for LTCHs located in the Middle Atlantic region, 2006 LTCH PPS payments per discharge will decrease slightly in comparison to the 2005 LTCH PPS rate year from the wage index changes (1.0 percent). We are projecting a slight decrease in payments per discharge from the wage index changes, which results in a slightly lower percent increase in payments per discharge from all changes, for LTCHs located in this region because of the progression of the 5-year phase-in of the wage index adjustment. Specifically, many LTCHs located in this area will

have a wage index value of less than 1.0. (See Table II.)

e. Bed Size

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

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

We project that LTCHs with greater than 200 beds will have the largest increase in estimated 2006 LTCH PPS rate year payments per discharge in comparison to the 2005 LTCH PPS rate year from all changes (7.0 percent), including the estimated increase from the wage index changes of 1.0 percent. This increase in projected payments per discharge for all changes for LTCHs with greater than 200 beds is largely due to a combination of the 3.4 percent increase in the standard Federal rate, a decrease in the budget neutrality offset, a projected increase in outlier payments resulting from the decrease in outlier fixed-loss amount, as explained above, and the increase in projected payment per discharge from the wage index changes. This increase in projected payments per discharge from the changes in the wage index for LTCHs with greater than 200 beds is largely due to a combination of the change to the CBSA-based labor market area definitions and the increase in the percentage of the wage index adjustment as required by the 5-year phase-in of the wage index adjustment because most LTCHs with greater than 200 beds are located in an area with a wage index value of greater than 1.0. (See Table II.)

Payments per discharge for the 2006 LTCH PPS rate year for LTCHs with 24–49 beds are projected to increase the least in comparison to the 2005 LTCH PPS rate year from all changes (5.0 percent), which includes the estimated decrease in payments per discharge from the wage indexes changes (–0.6 percent). This slight decrease in estimated payments per discharge from the wage index changes is largely due to the progression of the 5-year phase-in of the wage index adjustment (as explained above) since the majority of LTCHs with 25–49 beds are located in areas with a wage index value of less than 1.0. (See Table II.)

5. Effect on the Medicare Program

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

LTCH PPS rate year	Estimated payments (\$ in billions)
2006	\$3.32
2007	3.38
2008	3.48
2009	3.63
2010	3.79

These estimates are based on the current estimate of the increase in the excluded hospital with capital market basket of 3.4 percent for the 2006 LTCH PPS rate year, 3.0 percent for the 2007, 2.8 for the 2008 LTCH PPS rate year, 2.9 percent for the 2009 and 2010 LTCH PPS rate years. We estimate that there will be a change in Medicare fee-for-service beneficiary enrollment of –1.0 percent in the 2006 LTCH PPS rate year, –2.1 percent in the 2007 LTCH PPS rate year, –1.0 percent in 2008 LTCH PPS rate year, 0.3 percent in the 2009 and 2010 LTCH PPS rate years, and an estimated increase in the total number of LTCHs. (We note that, based on the most recent available data, our Office of the Actuary is projecting a decrease in Medicare fee-for-service Part A enrollment, in part, because of a projected increase in Medicare managed care enrollment as a result of the implementation of several provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.)

Consistent with the statutory requirement for budget neutrality, as we discussed in the August 30, 2002 final rule that implemented the LTCH PPS, in developing the LTCH PPS, we intended for estimated aggregate payments under the LTCH PPS in FY 2003 would equal the estimated aggregate payments that would have been made if the LTCH PPS were not implemented. Our methodology for estimating payments for purposes of the budget neutrality calculations used the best available data and necessarily reflected assumptions. As we collect data from LTCHs, we continue to monitor payments and evaluate the ultimate accuracy of the assumptions used to calculate the budget neutrality calculations (that is, inflation factors, intensity of services provided, or behavioral response to the implementation of the LTCH PPS). As discussed above in section V.C.7. of the preamble of this final rule, because the LTCH PPS has only been implemented

for about 2.5 years, due to the lag time in the availability of data, at this time, we still do not have sufficient new cost report and claims data generated under the LTCH PPS to enable us to conduct a comprehensive reevaluation of our FY 2003 budget neutrality calculations.

Section 123 of BBRA and section 307 of BIPA provide the Secretary with extremely broad authority in developing the LTCH PPS, including the authority for appropriate adjustments. In accordance with this broad authority, we may discuss in a future proposed rule a possible one-time prospective adjustment to the LTCH PPS rates to maintain budget neutrality so that the effect of the difference between actual payments and estimated payments for the first year of LTCH PPS is not perpetuated in the PPS rates for future years. As discussed above in section V.C.7. of this final rule, because the LTCH PPS was only recently implemented, we do not yet have sufficient complete data to determine whether such an adjustment is warranted.

6. Effect on Medicare Beneficiaries

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

C. Accounting Statement

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

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

[In millions]

Category	Transfers
Annualized Monetized Transfers.	\$169.

TABLE IV.—ACCOUNTING STATEMENT:
CLASSIFICATION OF ESTIMATED EX-
PENDITURES, FROM THE 2005 LTCH
PPS RATE YEAR TO THE 2006
LTCH PPS RATE YEAR—Continued
[In millions]

Category	Transfers
From Whom To Whom?	Federal Government To LTCH Medicare Providers.

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

List of Subjects in 42 CFR Part 412

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

■ In accordance with the discussion in this preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV, part 412 as set forth below:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

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

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

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

§ 412.22 Excluded hospitals and hospital units: General rules.

* * * * *

(e) * * *

* * * * *

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

* * * * *

(h) * * *

* * * * *

(5) *Notification of co-located status.* A satellite of a long-term care hospital that occupies space in a building used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another

hospital and that meets the criteria of paragraphs (h)(1) through (h)(4) of this section must notify its fiscal intermediary and CMS in writing of its co-location and identify by name, address, and Medicare provider number, those hospital(s) with which it is co-located.

* * * * *

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

§ 412.525 Adjustments to the Federal prospective payments.

* * * * *

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

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

(2) For discharges occurring on or after July 1, 2005, the application of the wage index under the long-term care hospital prospective payment system is made on the basis of the location of the facility in an urban or rural area as defined in § 412.64(b)(1)(ii)(A) through (C).

* * * * *

■ 4. Section 412.531 is amended by revising paragraphs (b)(1)(i)(C) and (b)(1)(ii)(A)(1) to read as follows:

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

* * * * *

(b) * * *

(1) * * *

(i) * * *

(C) The number of days that a beneficiary spends away from a long-term care hospital during a 3-day or less interruption of stay under paragraph (a)(1) of this section during which the

beneficiary receives a procedure that is grouped to a surgical DRG under the inpatient prospective payment system in an acute care hospital during the 2005 and 2006 long-term care hospital prospective payment system rate year is not included in determining the length of stay of the patient at the long-term care hospital.

* * * * *

(ii) * * *

(A) * * *

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

* * * * *

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

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

* * * * *

(i)(1) A long-term care hospital or a satellite of a long-term care hospital that meets the criteria of § 412.22(e)(1) or (e)(2) or § 412.22(h)(1) through (h)(4) that occupies space in a building used by another hospital or in one or more entire buildings located on the same campus as buildings used by another hospital and must notify its fiscal intermediary and CMS in writing of its co-location and identify by name(s), address(es), and Medicare provider number(s) the onsite acute care hospital, onsite IRF, or onsite psychiatric facility or unit with which it is co-located.

(2) A long term care hospital or satellite of a long term care hospital that occupies space in a building used by a SNF or in one or more entire buildings located on the same campus as buildings used by a SNF must notify its fiscal intermediary and CMS in writing of its co-located status and identify by name, address and Medicare provider number the SNF with which it is co-located.

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

Dated: April 21, 2005.

Mark McClellan,

*Administrator, Centers for Medicare &
Medicaid Services.*

Dated: April 29, 2005.

Michael O. Leavitt,

Secretary.

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

Addendum

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

Table 1.—Long-Term Care Hospital Wage Index for Urban Areas (based on CBSA-based Labor Market Area Designations) for Discharges

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

Table 3.—FY 2005 LTC-DRG Relative Weights, Geometric Mean Length of Stay, and Short-Stay Five-Sixths Average Length of Stay for Discharges
Occurring from July 1, 2005 through

September 30, 2006. (**Note:** This is the same information provided in Table 11 of the August 11, 2004 IPPS final rule (69 FR 49738–49754, as revised in the October 7, 2004 IPPS correction notice, 69 FR 60266–60271), which has been reprinted here for convenience.)

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

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2005 THROUGH JUNE 30, 2006¹

CBSA code	Urban area (constituent counties)	Full wage index ²	2/5ths wage index ³	3/5ths wage index ⁴	4/5ths wage index ⁵
10180	Abilene, TX Callahan County, TX. Jones County, TX. Taylor County, TX.	0.7850	0.9140	0.8710	0.8280
10380	Aguadilla-Isabela-San Sebastián, PR Aguada Municipio, PR. Aguadilla Municipio, PR. Añasco Municipio, PR. Isabela Municipio, PR. Lares Municipio, PR. Moca Municipio, PR. Rincón Municipio, PR. San Sebastián Municipio, PR.	0.4280	0.7712	0.6568	0.5424
10420	Akron, OH Portage County, OH. Summit County, OH.	0.9055	0.9622	0.9433	0.9244
10500	Albany, GA Baker County, GA. Dougherty County, GA. Lee County, GA. Terrell County, GA. Worth County, GA.	1.1266	1.0506	1.0760	1.1013
10580	Albany-Schenectady-Troy, NY Albany County, NY. Rensselaer County, NY. Saratoga County, NY. Schenectady County, NY. Schoharie County, NY.	0.8650	0.9460	0.9190	0.8920
10740	Albuquerque, NM Bernalillo County, NM. Sandoval County, NM. Torrance County, NM. Valencia County, NM.	1.0485	1.0194	1.0291	1.0388
10780	Alexandria, LA Grant Parish, LA. Rapides Parish, LA.	0.8171	0.9268	0.8903	0.8537
10900	Allentown-Bethlehem-Easton, PA-NJ Warren County, NJ. Carbon County, PA. Lehigh County, PA. Northampton County, PA.	0.9501	0.9800	0.9701	0.9601
11020	Altoona, PA Blair County, PA.	0.8462	0.9385	0.9077	0.8770
11100	Amarillo, TX Armstrong County, TX. Carson County, TX. Potter County, TX. Randall County, TX.	0.9178	0.9671	0.9507	0.9342
11180	Ames, IA Story County, IA.	0.9479	0.9792	0.9687	0.9583
11260	Anchorage, AK Anchorage Municipality, AK. Matanuska-Susitna Borough, AK.	1.2165	1.0866	1.1299	1.1732
11300	Anderson, IN	0.8713	0.9485	0.9228	0.8970

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

CBSA code	Urban area (constituent counties)	Full wage index ²	2/5ths wage index ³	3/5ths wage index ⁴	4/5ths wage index ⁵
11340	Madison County, IN. Anderson, SC	0.8670	0.9468	0.9202	0.8936
11460	Anderson County, SC. Ann Arbor, MI	1.1022	1.0409	1.0613	1.0818
11500	Washtenaw County, MI. Anniston-Oxford, AL	0.7881	0.9152	0.8729	0.8305
11540	Calhoun County, AL. Appleton, WI	0.9131	0.9652	0.9479	0.9305
11700	Calumet County, WI. Outagamie County, WI. Asheville, NC	0.9191	0.9676	0.9515	0.9353
12020	Buncombe County, NC. Haywood County, NC. Henderson County, NC. Madison County, NC. Athens-Clarke County, GA	1.0202	1.0081	1.0121	1.0162
12060	Clarke County, GA. Madison County, GA. Oconee County, GA. Oglethorpe County, GA. Atlanta-Sandy Springs-Marietta, GA	0.9971	0.9988	0.9983	0.9977
12100	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.	1.0931	1.0372	1.0559	1.0745
12220	Atlantic City, NJ	0.8215	0.9286	0.8929	0.8572
12260	Atlantic County, NJ. Auburn-Opelika, AL	0.9154	0.9662	0.9492	0.9323
12420	Lee County, AL. Augusta-Richmond County, GA-SC	0.9595	0.9838	0.9757	0.9676
12540	Burke County, GA. Columbia County, GA. McDuffie County, GA. Richmond County, GA. Aiken County, SC. Edgefield County, SC. Austin-Round Rock, TX	1.0036	1.0014	1.0022	1.0029
12580	Bastrop County, TX. Caldwell County, TX. Hays County, TX. Travis County, TX. Williamson County, TX. Bakersfield, CA	0.9907	0.9963	0.9944	0.9926
	Kern County, CA. Baltimore-Towson, MD				

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2005 THROUGH JUNE 30, 2006¹—Continued

CBSA code	Urban area (constituent counties)	Full wage index ²	2/5ths wage index ³	3/5ths wage index ⁴	4/5ths wage index ⁵
	Anne Arundel County, MD. Baltimore County, MD. Carroll County, MD. Harford County, MD. Howard County, MD. Queen Anne's County, MD. Baltimore City, MD.				
12620	Bangor, ME	0.9955	0.9982	0.9973	0.9964
	Penobscot County, ME.				
12700	Barnstable Town, MA	1.2335	1.0934	1.1401	1.1868
	Barnstable County, MA.				
12940	Baton Rouge, LA	0.8319	0.9328	0.8991	0.8655
	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	0.9366	0.9746	0.9620	0.9493
	Calhoun County, MI.				
13020	Bay City, MI	0.9574	0.9830	0.9744	0.9659
	Bay County, MI.				
13140	Beaumont-Port Arthur, TX	0.8616	0.9446	0.9170	0.8893
	Hardin County, TX. Jefferson County, TX. Orange County, TX.				
13380	Bellingham, WA	1.1642	1.0657	1.0985	1.1314
	Whatcom County, WA.				
13460	Bend, OR	1.0603	1.0241	1.0362	1.0482
	Deschutes County, OR.				
13644	Bethesda-Frederick-Gaithersburg, MD	1.0956	1.0382	1.0574	1.0765
	Frederick County, MD. Montgomery County, MD.				
13740	Billings, MT	0.8961	0.9584	0.9377	0.9169
	Carbon County, MT. Yellowstone County, MT.				
13780	Binghamton, NY	0.8447	0.9379	0.9068	0.8758
	Broome County, NY. Tioga County, NY.				
13820	Birmingham-Hoover, AL	0.9157	0.9663	0.9494	0.9326
	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	0.7505	0.9002	0.8503	0.8004
	Burleigh County, ND. Morton County, ND.				
13980	Blacksburg-Christiansburg-Radford, VA	0.7951	0.9180	0.8771	0.8361
	Giles County, VA. Montgomery County, VA. Pulaski County, VA. Radford City, VA.				
14020	Bloomington, IN	0.8587	0.9435	0.9152	0.8870
	Greene County, IN. Monroe County, IN. Owen County, IN.				
14060	Bloomington-Normal, IL	0.9111	0.9644	0.9467	0.9289
	McLean County, IL.				
14260	Boise City-Nampa, ID	0.9352	0.9741	0.9611	0.9482
	Ada County, ID. Boise County, ID. Canyon County, ID. Gem County, ID.				

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2005 THROUGH JUNE 30, 2006¹—Continued

CBSA code	Urban area (constituent counties)	Full wage index ²	2/5ths wage index ³	3/5ths wage index ⁴	4/5ths wage index ⁵
14484	Owyhee County, ID. Boston-Quincy, MA	1.1771	1.0708	1.1063	1.1417
	Norfolk County, MA. Plymouth County, MA. Suffolk County, MA.				
14500	Boulder, CO	1.0046	1.0018	1.0028	1.0037
	Boulder County, CO.				
14540	Bowling Green, KY	0.8140	0.9256	0.8884	0.8512
	Edmonson County, KY. Warren County, KY.				
14740	Bremerton-Silverdale, WA	1.0614	1.0246	1.0368	1.0491
	Kitsap County, WA.				
14860	Bridgeport-Stamford-Norwalk, CT	1.2835	1.1134	1.1701	1.2268
	Fairfield County, CT.				
15180	Brownsville-Harlingen, TX	1.0125	1.0050	1.0075	1.0100
	Cameron County, TX.				
15260	Brunswick, GA	1.1933	1.0773	1.1160	1.1546
	Brantley County, GA. Glynn County, GA. McIntosh County, GA.				
15380	Buffalo-Niagara Falls, NY	0.9339	0.9736	0.9603	0.9471
	Erie County, NY. Niagara County, NY.				
15500	Burlington, NC	0.8967	0.9587	0.9380	0.9174
	Alamance County, NC.				
15540	Burlington-South Burlington, VT	0.9322	0.9729	0.9593	0.9458
	Chittenden County, VT. Franklin County, VT. Grand Isle County, VT.				
15764	Cambridge-Newton-Framingham, MA	1.1189	1.0476	1.0713	1.0951
	Middlesex County, MA.				
15804	Camden, NJ	1.0675	1.0270	1.0405	1.0540
	Burlington County, NJ. Camden County, NJ. Gloucester County, NJ.				
15940	Canton-Massillon, OH	0.8895	0.9558	0.9337	0.9116
	Carroll County, OH. Stark County, OH.				
15980	Cape Coral-Fort Myers, FL	0.9371	0.9748	0.9623	0.9497
	Lee County, FL.				
16180	Carson City, NV	1.0352	1.0141	1.0211	1.0282
	Carson City, NV.				
16220	Casper, WY	0.9243	0.9697	0.9546	0.9394
	Natrona County, WY.				
16300	Cedar Rapids, IA	0.8975	0.9590	0.9385	0.9180
	Benton County, IA. Jones County, IA. Linn County, IA.				
16580	Champaign-Urbana, IL	0.9527	0.9811	0.9716	0.9622
	Champaign County, IL. Ford County, IL. Piatt County, IL.				
16620	Charleston, WV	0.8876	0.9550	0.9326	0.9101
	Boone County, WV. Clay County, WV. Kanawha County, WV. Lincoln County, WV. Putnam County, WV.				
16700	Charleston-North Charleston, SC	0.9420	0.9768	0.9652	0.9536
	Berkeley County, SC. Charleston County, SC. Dorchester County, SC.				
16740	Charlotte-Gastonia-Concord, NC-SC	0.9743	0.9897	0.9846	0.9794
	Anson County, NC. Cabarrus County, NC. Gaston County, NC. Mecklenburg County, NC. Union County, NC. York County, SC.				

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

CBSA code	Urban area (constituent counties)	Full wage index ²	2/5ths wage index ³	3/5ths wage index ⁴	4/5ths wage index ⁵
16820	Charlottesville, VA	1.0294	1.0118	1.0176	1.0235
	Albemarle County, VA.				
	Fluvanna County, VA.				
	Greene County, VA.				
	Nelson County, VA.				
	Charlottesville City, VA.				
16860	Chattanooga, TN-GA	0.9207	0.9683	0.9524	0.9366
	Catoosa County, GA.				
	Dade County, GA.				
	Walker County, GA.				
	Hamilton County, TN.				
	Marion County, TN.				
	Sequatchie County, TN.				
16940	Cheyenne, WY	0.8980	0.9592	0.9388	0.9184
	Laramie County, WY.				
16974	Chicago-Naperville-Joliet, IL	1.0868	1.0347	1.0521	1.0694
	Cook County, IL.				
	DeKalb County, IL.				
	DuPage County, IL.				
	Grundy County, IL.				
	Kane County, IL.				
	Kendall County, IL.				
	McHenry County, IL.				
	Will County, IL.				
17020	Chico, CA	1.0542	1.0217	1.0325	1.0434
	Butte County, CA.				
17140	Cincinnati-Middletown, OH-KY-IN	0.9516	0.9806	0.9710	0.9613
	Dearborn County, IN.				
	Franklin County, IN.				
	Ohio County, IN.				
	Boone County, KY.				
	Bracken County, KY.				
	Campbell County, KY.				
	Gallatin County, KY.				
	Grant County, KY.				
	Kenton County, KY.				
	Pendleton County, KY.				
	Brown County, OH.				
	Butler County, OH.				
	Clermont County, OH.				
	Hamilton County, OH.				
	Warren County, OH.				
17300	Clarksville, TN-KY	0.8022	0.9209	0.8813	0.8418
	Christian County, KY.				
	Trigg County, KY.				
	Montgomery County, TN.				
	Stewart County, TN.				
17420	Cleveland, TN	0.7844	0.9138	0.8706	0.8275
	Bradley County, TN.				
	Polk County, TN.				
17460	Cleveland-Elyria-Mentor, OH	0.9650	0.9860	0.9790	0.9720
	Cuyahoga County, OH.				
	Geauga County, OH.				
	Lake County, OH.				
	Lorain County, OH.				
	Medina County, OH.				
17660	Coeur d'Alene, ID	0.9339	0.9736	0.9603	0.9471
	Kootenai County, ID.				
17780	College Station-Bryan, TX	0.9243	0.9697	0.9546	0.9394
	Brazos County, TX.				
	Burleson County, TX.				
	Robertson County, TX.				
17820	Colorado Springs, CO	0.9792	0.9917	0.9875	0.9834
	El Paso County, CO.				
	Teller County, CO.				
17860	Columbia, MO	0.8396	0.9358	0.9038	0.8717
	Boone County, MO.				
	Howard County, MO.				
17900	Columbia, SC	0.9392	0.9757	0.9635	0.9514

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

CBSA code	Urban area (constituent counties)	Full wage index ²	2/5ths wage index ³	3/5ths wage index ⁴	4/5ths wage index ⁵
17980	Calhoun County, SC. Fairfield County, SC. Kershaw County, SC. Lexington County, SC. Richland County, SC. Saluda County, SC. Columbus, GA-AL	0.8690	0.9476	0.9214	0.8952
18020	Russell County, AL. Chattahoochee County, GA. Harris County, GA. Marion County, GA. Muscogee County, GA. Columbus, IN	0.9388	0.9755	0.9633	0.9510
18140	Bartholomew County, IN. Columbus, OH	0.9737	0.9895	0.9842	0.9790
18580	Delaware County, OH. Fairfield County, OH. Franklin County, OH. Licking County, OH. Madison County, OH. Morrow County, OH. Pickaway County, OH. Union County, OH. Corpus Christi, TX	0.8647	0.9459	0.9188	0.8918
18700	Aransas County, TX. Nueces County, TX. San Patricio County, TX. Corvallis, OR	1.0545	1.0218	1.0327	1.0436
19060	Benton County, OR. Cumberland, MD-WV	0.8662	0.9465	0.9197	0.8930
19124	Allegany County, MD. Mineral County, WV. Dallas-Plano-Irving, TX	1.0074	1.0030	1.0044	1.0059
19140	Collin County, TX. Dallas County, TX. Delta County, TX. Denton County, TX. Ellis County, TX. Hunt County, TX. Kaufman County, TX. Rockwall County, TX. Dalton, GA	0.9558	0.9823	0.9735	0.9646
19180	Murray County, GA. Whitfield County, GA. Danville, IL	0.8392	0.9357	0.9035	0.8714
19260	Vermilion County, IL. Danville, VA	0.8643	0.9457	0.9186	0.8914
19340	Pittsylvania County, VA. Danville City, VA. Davenport-Moline-Rock Island, IA-IL	0.8773	0.9509	0.9264	0.9018
19380	Henry County, IL. Mercer County, IL. Rock Island County, IL. Scott County, IA. Dayton, OH	0.9303	0.9721	0.9582	0.9442
19460	Greene County, OH. Miami County, OH. Montgomery County, OH. Preble County, OH. Decatur, AL	0.8894	0.9558	0.9336	0.9115
19500	Lawrence County, AL. Morgan County, AL. Decatur, IL	0.8122	0.9249	0.8873	0.8498
19660	Macon County, IL. Deltona-Daytona Beach-Ormond Beach, FL	0.8898	0.9559	0.9339	0.9118
19740	Volusia County, FL. Denver-Aurora, CO	1.0904	1.0362	1.0542	1.0723
	Adams County, CO. Arapahoe County, CO.				

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2005 THROUGH JUNE 30, 2006¹—Continued

CBSA code	Urban area (constituent counties)	Full wage index ²	2/5ths wage index ³	3/5ths wage index ⁴	4/5ths wage index ⁵
19780	Broomfield County, CO. Clear Creek County, CO. Denver County, CO. Douglas County, CO. Elbert County, CO. Gilpin County, CO. Jefferson County, CO. Park County, CO. Des Moines, IA	0.9266	0.9706	0.9560	0.9413
19804	Dallas County, IA. Guthrie County, IA. Madison County, IA. Polk County, IA. Warren County, IA. Detroit-Livonia-Dearborn, MI	1.0349	1.0140	1.0209	1.0279
20020	Wayne County, MI. Dothan, AL	0.7537	0.9015	0.8522	0.8030
20100	Geneva County, AL. Henry County, AL. Houston County, AL. Dover, DE	0.9825	0.9930	0.9895	0.9860
20220	Kent County, DE. Dubuque, IA	0.8748	0.9499	0.9249	0.8998
20260	Dubuque County, IA. Duluth, MN-WI	1.0340	1.0136	1.0204	1.0272
20500	Carlton County, MN. St. Louis County, MN. Douglas County, WI. Durham, NC	1.0363	1.0145	1.0218	1.0290
20740	Chatham County, NC. Durham County, NC. Orange County, NC. Person County, NC. Eau Claire, WI	0.9139	0.9656	0.9483	0.9311
20764	Chippewa County, WI. Eau Claire County, WI. Edison, NJ	1.1136	1.0454	1.0682	1.0909
20940	Middlesex County, NJ. Monmouth County, NJ. Ocean County, NJ. Somerset County, NJ. El Centro, CA	0.8856	0.9542	0.9314	0.9085
21060	Imperial County, CA. Elizabethtown, KY	0.8684	0.9474	0.9210	0.8947
21140	Hardin County, KY. Larue County, KY. Elkhart-Goshen, IN	0.9278	0.9711	0.9567	0.9422
21300	Elkhart County, IN. Elmira, NY	0.8445	0.9378	0.9067	0.8756
21340	Chemung County, NY. El Paso, TX	0.9181	0.9672	0.9509	0.9345
21500	El Paso County, TX. Erie, PA	0.8699	0.9480	0.9219	0.8959
21604	Erie County, PA. Essex County, MA	1.0662	1.0265	1.0397	1.0530
21660	Essex County, MA. Eugene-Springfield, OR	1.0940	1.0376	1.0564	1.0752
21780	Lane County, OR. Evansville, IN-KY	0.8372	0.9349	0.9023	0.8698
21820	Gibson County, IN. Posey County, IN. Vanderburgh County, IN. Warrick County, IN. Henderson County, KY. Webster County, KY. Fairbanks, AK	1.1146	1.0458	1.0688	1.0917
21940	Fairbanks North Star Borough, AK. Fajardo, PR	0.3939	0.7576	0.6363	0.5151
	Ceiba Municipio, PR.				

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2005 THROUGH JUNE 30, 2006¹—Continued

CBSA code	Urban area (constituent counties)	Full wage index ²	2/5ths wage index ³	3/5ths wage index ⁴	4/5ths wage index ⁵
22020	Fajardo Municipio, PR. Luquillo Municipio, PR. Fargo, ND-MN	0.9114	0.9646	0.9468	0.9291
22140	Cass County, ND. Clay County, MN. Farmington, NM	0.8049	0.9220	0.8829	0.8439
22180	San Juan County, NM. Fayetteville, NC	0.9363	0.9745	0.9618	0.9490
22220	Cumberland County, NC. Hoke County, NC. Fayetteville-Springdale-Rogers, AR-MO	0.8636	0.9454	0.9182	0.8909
22380	Benton County, AR. Madison County, AR. Washington County, AR. McDonald County, MO.	1.0787	1.0315	1.0472	1.0630
22420	Flagstaff, AZ	1.1178	1.0471	1.0707	1.0942
22500	Coconino County, AZ. Flint, MI	0.8833	0.9533	0.9300	0.9066
22520	Genesee County, MI. Florence, SC	0.7883	0.9153	0.8730	0.8306
22540	Darlington County, SC. Florence County, SC. Florence-Muscle Shoals, AL	0.9897	0.9959	0.9938	0.9918
22660	Colbert County, AL. Lauderdale County, AL. Fond du Lac, WI	1.0218	1.0087	1.0131	1.0174
22744	Fond du Lac County, WI. Fort Collins-Loveland, CO	1.0165	1.0066	1.0099	1.0132
22900	Larimer County, CO. Fort Lauderdale-Pompano Beach-Deerfield Beach, FL	0.8283	0.9313	0.8970	0.8626
23020	Broward County, FL. Fort Smith, AR-OK	0.8786	0.9514	0.9272	0.9029
23060	Crawford County, AR. Franklin County, AR. Sebastian County, AR. Le Flore County, OK. Sequoyah County, OK.	0.9807	0.9923	0.9884	0.9846
23104	Fort Walton Beach-Crestview-Destin, FL	0.9472	0.9789	0.9683	0.9578
23420	Okaloosa County, FL. Fort Wayne, IN	1.0536	1.0214	1.0322	1.0429
23460	Allen County, IN. Wells County, IN. Whitley County, IN.	0.8049	0.9220	0.8829	0.8439
23540	Fort Worth-Arlington, TX	0.9459	0.9784	0.9675	0.9567
23580	Johnson County, TX. Parker County, TX. Tarrant County, TX. Wise County, TX.	0.9557	0.9823	0.9734	0.9646
23844	Fresno, CA	0.9310	0.9724	0.9586	0.9448
24020	Fresno County, CA. Gadsden, AL	0.8467	0.9387	0.9080	0.8774
24140	Etowah County, AL. Gainesville, FL	0.8778	0.9511	0.9267	0.9022
24220	Alachua County, FL. Gilchrist County, FL. Gainesville, GA	0.9091	0.9636	0.9455	0.9273
	Hall County, GA. Gary, IN				
	Jasper County, IN. Lake County, IN. Newton County, IN. Porter County, IN.				
	Glens Falls, NY				
	Warren County, NY. Washington County, NY.				
	Goldsboro, NC				
	Wayne County, NC. Grand Forks, ND-MN				
	Polk County, MN.				

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2005 THROUGH JUNE 30, 2006¹—Continued

CBSA code	Urban area (constituent counties)	Full wage index ²	2/5ths wage index ³	3/5ths wage index ⁴	4/5ths wage index ⁵
24300	Grand Forks County, ND. Grand Junction, CO	0.9900	0.9960	0.9940	0.9920
24340	Mesa County, CO. Grand Rapids-Wyoming, MI	0.9420	0.9768	0.9652	0.9536
24500	Barry County, MI. Ionia County, MI. Kent County, MI. Newaygo County, MI. Great Falls, MT	0.8810	0.9524	0.9286	0.9048
24540	Cascade County, MT. Greeley, CO	0.9444	0.9778	0.9666	0.9555
24580	Weld County, CO. Green Bay, WI	0.9590	0.9836	0.9754	0.9672
24660	Brown County, WI. Kewaunee County, WI. Oconto County, WI. Greensboro-High Point, NC	0.9190	0.9676	0.9514	0.9352
24780	Guilford County, NC. Randolph County, NC. Rockingham County, NC. Greenville, NC	0.9183	0.9673	0.9510	0.9346
24860	Greene County, NC. Pitt County, NC. Greenville, SC	0.9557	0.9823	0.9734	0.9646
25020	Greenville County, SC. Laurens County, SC. Pickens County, SC. Guayama, PR	0.4005	0.7602	0.6403	0.5204
25060	Arroyo Municipio, PR. Guayama Municipio, PR. Patillas Municipio, PR. Gulfport-Biloxi, MS	0.8950	0.9580	0.9370	0.9160
25180	Hancock County, MS. Harrison County, MS. Stone County, MS. Hagerstown-Martinsburg, MD-WV	0.9715	0.9886	0.9829	0.9772
25260	Washington County, MD. Berkeley County, WV. Morgan County, WV. Hanford-Corcoran, CA	0.9296	0.9718	0.9578	0.9437
25420	Kings County, CA. Harrisburg-Carlisle, PA	0.9359	0.9744	0.9615	0.9487
25500	Cumberland County, PA. Dauphin County, PA. Perry County, PA. Harrisonburg, VA	0.9275	0.9710	0.9565	0.9420
25540	Rockingham County, VA. Harrisonburg City, VA. Hartford-West Hartford-East Hartford, CT	1.1054	1.0422	1.0632	1.0843
25620	Hartford County, CT. Litchfield County, CT. Middlesex County, CT. Tolland County, CT. Hattiesburg, MS	0.7362	0.8945	0.8417	0.7890
25860	Forrest County, MS. Lamar County, MS. Perry County, MS. Hickory-Lenoir-Morganton, NC	0.9502	0.9801	0.9701	0.9602
25980	Alexander County, NC. Burke County, NC. Caldwell County, NC. Catawba County, NC. Hinesville-Fort Stewart, GA	0.7715	0.9086	0.8629	0.8172
26100	Liberty County, GA. Long County, GA. Holland-Grand Haven, MI	0.9388	0.9755	0.9633	0.9510
26180	Ottawa County, MI. Honolulu, HI	1.1013	1.0405	1.0608	1.0810
	Honolulu County, HI.				

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

CBSA code	Urban area (constituent counties)	Full wage index ²	2/5ths wage index ³	3/5ths wage index ⁴	4/5ths wage index ⁵
26300	Hot Springs, AR	0.9249	0.9700	0.9549	0.9399
	Garland County, AR.				
26380	Houma-Bayou Cane-Thibodaux, LA	0.7721	0.9088	0.8633	0.8177
	Lafourche Parish, LA.				
	Terrebonne Parish, LA.				
26420	Houston-Baytown-Sugar Land, TX	0.9973	0.9989	0.9984	0.9978
	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	0.9564	0.9826	0.9738	0.9651
	Boyd County, KY.				
	Greenup County, KY.				
	Lawrence County, OH.				
	Cabell County, WV.				
	Wayne County, WV.				
26620	Huntsville, AL	0.8851	0.9540	0.9311	0.9081
	Limestone County, AL.				
	Madison County, AL.				
26820	Idaho Falls, ID	0.9059	0.9624	0.9435	0.9247
	Bonneville County, ID.				
	Jefferson County, ID.				
26900	Indianapolis, IN	1.0113	1.0045	1.0068	1.0090
	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	0.9654	0.9862	0.9792	0.9723
	Johnson County, IA.				
	Washington County, IA.				
27060	Ithaca, NY	0.9589	0.9836	0.9753	0.9671
	Tompkins County, NY.				
27100	Jackson, MI	0.9146	0.9658	0.9488	0.9317
	Jackson County, MI.				
27140	Jackson, MS	0.8291	0.9316	0.8975	0.8633
	Copiah County, MS.				
	Hinds County, MS.				
	Madison County, MS.				
	Rankin County, MS.				
	Simpson County, MS.				
27180	Jackson, TN	0.8900	0.9560	0.9340	0.9120
	Chester County, TN.				
	Madison County, TN.				
27260	Jacksonville, FL	0.9537	0.9815	0.9722	0.9630
	Baker County, FL.				
	Clay County, FL.				
	Duval County, FL.				
	Nassau County, FL.				
	St. Johns County, FL.				
27340	Jacksonville, NC	0.8401	0.9360	0.9041	0.8721
	Onslow County, NC.				
27500	Janesville, WI	0.9583	0.9833	0.9750	0.9666
	Rock County, WI.				
27620	Jefferson City, MO	0.8338	0.9335	0.9003	0.8670
	Callaway County, MO.				
	Cole County, MO.				
	Moniteau County, MO.				

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2005 THROUGH JUNE 30, 2006¹—Continued

CBSA code	Urban area (constituent counties)	Full wage index ²	2/5ths wage index ³	3/5ths wage index ⁴	4/5ths wage index ⁵
27740	Osage County, MO. Johnson City, TN	0.8146	0.9258	0.8888	0.8517
	Carter County, TN. Unicoi County, TN. Washington County, TN.				
27780	Johnstown, PA	0.8380	0.9352	0.9028	0.8704
	Cambria County, PA.				
27860	Jonesboro, AR	0.8144	0.9258	0.8886	0.8515
	Craighead County, AR. Poinsett County, AR.				
27900	Joplin, MO	0.8721	0.9488	0.9233	0.8977
	Jasper County, MO. Newton County, MO.				
28020	Kalamazoo-Portage, MI	1.0676	1.0270	1.0406	1.0541
	Kalamazoo County, MI. Van Buren County, MI.				
28100	Kankakee-Bradley, IL	1.0603	1.0241	1.0362	1.0482
	Kankakee County, IL.				
28140	Kansas City, MO-KS	0.9629	0.9852	0.9777	0.9703
	Franklin County, KS. Johnson County, KS. Leavenworth County, KS. Linn County, KS. Miami County, KS. Wyandotte County, KS. Bates County, MO. Caldwell County, MO. Cass County, MO. Clay County, MO. Clinton County, MO. Jackson County, MO. Lafayette County, MO. Platte County, MO. Ray County, MO.				
28420	Kennewick-Richland-Pasco, WA	1.0520	1.0208	1.0312	1.0416
	Benton County, WA. Franklin County, WA.				
28660	Killeen-Temple-Fort Hood, TX	0.9242	0.9697	0.9545	0.9394
	Bell County, TX. Coryell County, TX. Lampasas County, TX.				
28700	Kingsport-Bristol-Bristol, TN-VA	0.8240	0.9296	0.8944	0.8592
	Hawkins County, TN. Sullivan County, TN. Bristol City, VA. Scott County, VA. Washington County, VA.				
28740	Kingston, NY	0.9000	0.9600	0.9400	0.9200
	Ulster County, NY.				
28940	Knoxville, TN	0.8548	0.9419	0.9129	0.8838
	Anderson County, TN. Blount County, TN. Knox County, TN. Loudon County, TN. Union County, TN.				
29020	Kokomo, IN	0.8986	0.9594	0.9392	0.9189
	Howard County, IN. Tipton County, IN.				
29100	La Crosse, WI-MN	0.9289	0.9716	0.9573	0.9431
	Houston County, MN. La Crosse County, WI.				
29140	Lafayette, IN	0.9067	0.9627	0.9440	0.9254
	Benton County, IN. Carroll County, IN. Tippecanoe County, IN.				
29180	Lafayette, LA	0.8306	0.9322	0.8984	0.8645
	Lafayette Parish, LA. St. Martin Parish, LA.				
29340	Lake Charles, LA	0.7935	0.9174	0.8761	0.8348

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2005 THROUGH JUNE 30, 2006¹—Continued

CBSA code	Urban area (constituent counties)	Full wage index ²	2/5ths wage index ³	3/5ths wage index ⁴	4/5ths wage index ⁵
29404	Calcasieu Parish, LA. Cameron Parish, LA. Lake County-Kenosha County, IL-WI	1.0342	1.0137	1.0205	1.0274
29460	Lake County, IL. Kenosha County, WI. Lakeland, FL	0.8930	0.9572	0.9358	0.9144
29540	Polk County, FL. Lancaster, PA	0.9883	0.9953	0.9930	0.9906
29620	Lancaster County, PA. Lansing-East Lansing, MI	0.9658	0.9863	0.9795	0.9726
29700	Clinton County, MI. Eaton County, MI. Ingham County, MI. Laredo, TX	0.8747	0.9499	0.9248	0.8998
29740	Webb County, TX. Las Cruces, NM	0.8784	0.9514	0.9270	0.9027
29820	Dona Ana County, NM. Las Vegas-Paradise, NV	1.1378	1.0551	1.0827	1.1102
29940	Clark County, NV. Lawrence, KS	0.8644	0.9458	0.9186	0.8915
30020	Douglas County, KS. Lawton, OK	0.8212	0.9285	0.8927	0.8570
30140	Comanche County, OK. Lebanon, PA	0.8570	0.9428	0.9142	0.8856
30300	Lebanon County, PA. Lewiston, ID-WA	0.9314	0.9726	0.9588	0.9451
30340	Nez Perce County, ID. Asotin County, WA. Lewiston-Auburn, ME	0.9562	0.9825	0.9737	0.9650
30460	Androscoggin County, ME. Lexington-Fayette, KY	0.9359	0.9744	0.9615	0.9487
30620	Bourbon County, KY. Clark County, KY. Fayette County, KY. Jessamine County, KY. Scott County, KY. Woodford County, KY. Lima, OH	0.9330	0.9732	0.9598	0.9464
30700	Allen County, OH. Lincoln, NE	1.0208	1.0083	1.0125	1.0166
30780	Lancaster County, NE. Seward County, NE. Little Rock-North Little Rock, AR	0.8826	0.9530	0.9296	0.9061
30860	Faulkner County, AR. Grant County, AR. Lonoke County, AR. Perry County, AR. Pulaski County, AR. Saline County, AR. Logan, UT-ID	0.9094	0.9638	0.9456	0.9275
30980	Franklin County, ID. Cache County, UT. Longview, TX	0.8801	0.9520	0.9281	0.9041
31020	Gregg County, TX. Rusk County, TX. Upshur County, TX. Longview, WA	1.0224	1.0090	1.0134	1.0179
31084	Cowlitz County, WA. Los Angeles-Long Beach-Glendale, CA	1.1732	1.0693	1.1039	1.1386
31140	Los Angeles County, CA. Louisville, KY-IN	0.9122	0.9649	0.9473	0.9298
	Clark County, IN. Floyd County, IN. Harrison County, IN. Washington County, IN. Bullitt County, KY. Henry County, KY. Jefferson County, KY. Meade County, KY.				

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2005 THROUGH JUNE 30, 2006¹—Continued

CBSA code	Urban area (constituent counties)	Full wage index ²	2/5ths wage index ³	3/5ths wage index ⁴	4/5ths wage index ⁵
31180	Nelson County, KY. Oldham County, KY. Shelby County, KY. Spencer County, KY. Trimble County, KY. Lubbock, TX	0.8777	0.9511	0.9266	0.9022
31340	Crosby County, TX. Lubbock County, TX. Lynchburg, VA	0.9017	0.9607	0.9410	0.9214
31420	Amherst County, VA. Appomattox County, VA. Bedford County, VA. Campbell County, VA. Bedford City, VA. Lynchburg City, VA. Macon, GA	0.9887	0.9955	0.9932	0.9910
31460	Bibb County, GA. Crawford County, GA. Jones County, GA. Monroe County, GA. Twiggs County, GA. Madera, CA	0.8521	0.9408	0.9113	0.8817
31540	Madera County, CA. Madison, WI	1.0306	1.0122	1.0184	1.0245
31700	Columbia County, WI. Dane County, WI. Iowa County, WI. Manchester-Nashua, NH	1.0642	1.0257	1.0385	1.0514
31900	Hillsborough County, NH. Merrimack County, NH. Mansfield, OH	0.9189	0.9676	0.9513	0.9351
32420	Richland County, OH. Mayagüez, PR	0.4493	0.7797	0.6696	0.5594
32580	Hormigueros Municipio, PR. Mayagüez Municipio, PR. McAllen-Edinburg-Pharr, TX	0.8602	0.9441	0.9161	0.8882
32780	Hidalgo County, TX. Medford, OR	1.0534	1.0214	1.0320	1.0427
32820	Jackson County, OR. Memphis, TN-MS-AR	0.9217	0.9687	0.9530	0.9374
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	1.0575	1.0230	1.0345	1.0460
33124	Merced County, CA. Miami-Miami Beach-Kendall, FL	0.9870	0.9948	0.9922	0.9896
33140	Miami-Dade County, FL. Michigan City-La Porte, IN	0.9332	0.9733	0.9599	0.9466
33260	LaPorte County, IN. Midland, TX	0.9384	0.9754	0.9630	0.9507
33340	Midland County, TX. Milwaukee-Waukesha-West Allis, WI	1.0076	1.0030	1.0046	1.0061
33460	Milwaukee County, WI. Ozaukee County, WI. Washington County, WI. Waukesha County, WI. Minneapolis-St. Paul-Bloomington, MN-WI	1.1066	1.0426	1.0640	1.0853
	Anoka County, MN. Carver County, MN. Chisago County, MN. Dakota County, MN. Hennepin County, MN. Isanti County, MN. Ramsey County, MN.				

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

CBSA code	Urban area (constituent counties)	Full wage index ²	2/5ths wage index ³	3/5ths wage index ⁴	4/5ths wage index ⁵
	Scott County, MN. Sherburne County, MN. Washington County, MN. Wright County, MN. Pierce County, WI. St. Croix County, WI.				
33540	Missoula, MT	0.9618	0.9847	0.9771	0.9694
	Missoula County, MT.				
33660	Mobile, AL	0.7995	0.9198	0.8797	0.8396
	Mobile County, AL.				
33700	Modesto, CA	1.1966	1.0786	1.1180	1.1573
	Stanislaus County, CA.				
33740	Monroe, LA	0.7903	0.9161	0.8742	0.8322
	Ouachita Parish, LA. Union Parish, LA.				
33780	Monroe, MI	0.9506	0.9802	0.9704	0.9605
	Monroe County, MI.				
33860	Montgomery, AL	0.8300	0.9320	0.8980	0.8640
	Autauga County, AL. Elmore County, AL. Lowndes County, AL. Montgomery County, AL.				
34060	Morgantown, WV	0.8730	0.9492	0.9238	0.8984
	Monongalia County, WV. Preston County, WV.				
34100	Morristown, TN	0.7790	0.9116	0.8674	0.8232
	Grainger County, TN. Hamblen County, TN. Jefferson County, TN.				
34580	Mount Vernon-Anacortes, WA	1.0576	1.0230	1.0346	1.0461
	Skagit County, WA.				
34620	Muncie, IN	0.8580	0.9432	0.9148	0.8864
	Delaware County, IN.				
34740	Muskegon-Norton Shores, MI	0.9741	0.9896	0.9845	0.9793
	Muskegon County, MI.				
34820	Myrtle Beach-Conway-North Myrtle Beach, SC	0.9022	0.9609	0.9413	0.9218
	Horry County, SC.				
34900	Napa, CA	1.2531	1.1012	1.1519	1.2025
	Napa County, CA.				
34940	Naples-Marco Island, FL	1.0558	1.0223	1.0335	1.0446
	Collier County, FL.				
34980	Nashville-Davidson-Murfreesboro, TN	1.0086	1.0034	1.0052	1.0069
	Cannon County, TN. Cheatham County, TN. Davidson County, TN. Dickson County, TN. Hickman County, TN. Macon County, TN. Robertson County, TN. Rutherford County, TN. Smith County, TN. Sumner County, TN. Trousdale County, TN. Williamson County, TN. Wilson County, TN.				
35004	Nassau-Suffolk, NY	1.2907	1.1163	1.1744	1.2326
	Nassau County, NY. Suffolk County, NY.				
35084	Newark-Union, NJ-PA	1.1687	1.0675	1.1012	1.1350
	Essex County, NJ. Hunterdon County, NJ. Morris County, NJ. Sussex County, NJ. Union County, NJ. Pike County, PA.				
35300	New Haven-Milford, CT	1.1807	1.0723	1.1084	1.1446
	New Haven County, CT.				
35380	New Orleans-Metairie-Kenner, LA	0.9103	0.9641	0.9462	0.9282
	Jefferson Parish, LA.				

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

CBSA code	Urban area (constituent counties)	Full wage index ²	2/5ths wage index ³	3/5ths wage index ⁴	4/5ths wage index ⁵
35644	Orleans Parish, LA. Plaquemines Parish, LA. St. Bernard Parish, LA. St. Charles Parish, LA. St. John the Baptist Parish, LA. St. Tammany Parish, LA. New York-Wayne-White Plains, NY-NJ	1.3311	1.1324	1.1987	1.2649
	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	0.8847	0.9539	0.9308	0.9078
	Berrien County, MI.				
35980	Norwich-New London, CT	1.1596	1.0638	1.0958	1.1277
	New London County, CT.				
36084	Oakland-Fremont-Hayward, CA	1.5220	1.2088	1.3132	1.4176
	Alameda County, CA. Contra Costa County, CA.				
36100	Ocala, FL	0.9153	0.9661	0.9492	0.9322
	Marion County, FL.				
36140	Ocean City, NJ	1.0810	1.0324	1.0486	1.0648
	Cape May County, NJ.				
36220	Odessa, TX	0.9798	0.9919	0.9879	0.9838
	Ector County, TX.				
36260	Ogden-Clearfield, UT	0.9216	0.9686	0.9530	0.9373
	Davis County, UT. Morgan County, UT. Weber County, UT.				
36420	Oklahoma City, OK	0.8982	0.9593	0.9389	0.9186
	Canadian County, OK. Cleveland County, OK. Grady County, OK. Lincoln County, OK. Logan County, OK. McClain County, OK. Oklahoma County, OK.				
36500	Olympia, WA	1.1006	1.0402	1.0604	1.0805
	Thurston County, WA.				
36540	Omaha-Council Bluffs, NE-IA	0.9754	0.9902	0.9852	0.9803
	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, FL	0.9742	0.9897	0.9845	0.9794
	Lake County, FL. Orange County, FL. Osceola County, FL. Seminole County, FL.				
36780	Oshkosh-Neenah, WI	0.9099	0.9640	0.9459	0.9279
	Winnebago County, WI.				
36980	Owensboro, KY	0.8434	0.9374	0.9060	0.8747
	Daviess County, KY. Hancock County, KY. McLean County, KY.				
37100	Oxnard-Thousand Oaks-Ventura, CA	1.1105	1.0442	1.0663	1.0884
	Ventura County, CA.				
37340	Palm Bay-Melbourne-Titusville, FL	0.9633	0.9853	0.9780	0.9706
	Brevard County, FL.				

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

CBSA code	Urban area (constituent counties)	Full wage index ²	2/5ths wage index ³	3/5ths wage index ⁴	4/5ths wage index ⁵
37460	Panama City-Lynn Haven, FL	0.8124	0.9250	0.8874	0.8499
	Bay County, FL.				
37620	Parkersburg-Marietta, WV-OH	0.8288	0.9315	0.8973	0.8630
	Washington County, OH.				
	Pleasants County, WV.				
	Wirt County, WV.				
	Wood County, WV.				
37700	Pascagoula, MS	0.7974	0.9190	0.8784	0.8379
	George County, MS.				
	Jackson County, MS.				
37860	Pensacola-Ferry Pass-Brent, FL	0.8306	0.9322	0.8984	0.8645
	Escambia County, FL.				
	Santa Rosa County, FL.				
37900	Peoria, IL	0.8886	0.9554	0.9332	0.9109
	Marshall County, IL.				
	Peoria County, IL.				
	Stark County, IL.				
	Tazewell County, IL.				
	Woodford County, IL.				
37964	Philadelphia, PA	1.0865	1.0346	1.0519	1.0692
	Bucks County, PA.				
	Chester County, PA.				
	Delaware County, PA.				
	Montgomery County, PA.				
	Philadelphia County, PA.				
38060	Phoenix-Mesa-Scottsdale, AZ	0.9982	0.9993	0.9989	0.9986
	Maricopa County, AZ.				
	Pinal County, AZ.				
38220	Pine Bluff, AR	0.8673	0.9469	0.9204	0.8938
	Cleveland County, AR.				
	Jefferson County, AR.				
	Lincoln County, AR.				
38300	Pittsburgh, PA	0.8736	0.9494	0.9242	0.8989
	Allegheny County, PA.				
	Armstrong County, PA.				
	Beaver County, PA.				
	Butler County, PA.				
	Fayette County, PA.				
	Washington County, PA.				
	Westmoreland County, PA.				
38340	Pittsfield, MA	1.0439	1.0176	1.0263	1.0351
	Berkshire County, MA.				
38540	Pocatello, ID	0.9601	0.9840	0.9761	0.9681
	Bannock County, ID.				
	Power County, ID.				
38660	Ponce, PR	0.5006	0.8002	0.7004	0.6005
	Juana Diaz Municipio, PR.				
	Ponce Municipio, PR.				
	Villalba Municipio, PR.				
38860	Portland-South Portland-Biddeford, ME	1.0112	1.0045	1.0067	1.0090
	Cumberland County, ME.				
	Sagadahoc County, ME.				
	York County, ME.				
38900	Portland-Vancouver-Beaverton, OR-WA	1.1403	1.0561	1.0842	1.1122
	Clackamas County, OR.				
	Columbia County, OR.				
	Multnomah County, OR.				
	Washington County, OR.				
	Yamhill County, OR.				
	Clark County, WA.				
	Skamania County, WA.				
38940	Port St. Lucie-Fort Pierce, FL	1.0046	1.0018	1.0028	1.0037
	Martin County, FL.				
	St. Lucie County, FL.				
39100	Poughkeepsie-Newburgh-Middletown, NY	1.1363	1.0545	1.0818	1.1090
	Dutchess County, NY.				
	Orange County, NY.				
39140	Prescott, AZ	0.9892	0.9957	0.9935	0.9914
	Yavapai County, AZ.				

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2005 THROUGH JUNE 30, 2006¹—Continued

CBSA code	Urban area (constituent counties)	Full wage index ²	2/5ths wage index ³	3/5ths wage index ⁴	4/5ths wage index ⁵
39300	Providence-New Bedford-Fall River, RI-MA	1.0929	1.0372	1.0557	1.0743
	Bristol County, MA.				
	Bristol County, RI.				
	Kent County, RI.				
	Newport County, RI.				
	Providence County, RI.				
	Washington County, RI.				
39340	Provo-Orem, UT	0.9588	0.9835	0.9753	0.9670
	Juab County, UT.				
	Utah County, UT.				
39380	Pueblo, CO	0.8752	0.9501	0.9251	0.9002
	Pueblo County, CO.				
39460	Punta Gorda, FL	0.9441	0.9776	0.9665	0.9553
	Charlotte County, FL.				
39540	Racine, WI	0.9045	0.9618	0.9427	0.9236
	Racine County, WI.				
39580	Raleigh-Cary, NC	1.0057	1.0023	1.0034	1.0046
	Franklin County, NC.				
	Johnston County, NC.				
	Wake County, NC.				
39660	Rapid City, SD	0.8912	0.9565	0.9347	0.9130
	Meade County, SD.				
	Pennington County, SD.				
39740	Reading, PA	0.9215	0.9686	0.9529	0.9372
	Berks County, PA.				
39820	Redding, CA	1.1835	1.0734	1.1101	1.1468
	Shasta County, CA.				
39900	Reno-Sparks, NV	1.0456	1.0182	1.0274	1.0365
	Storey County, NV.				
	Washoe County, NV.				
40060	Richmond, VA	0.9397	0.9759	0.9638	0.9518
	Amelia County, VA.				
	Caroline County, VA.				
	Charles City County, VA.				
	Chesterfield County, VA.				
	Cumberland County, VA.				
	Dinwiddie County, VA.				
	Goochland County, VA.				
	Hanover County, VA.				
	Henrico County, VA.				
	King and Queen County, VA.				
	King William County, VA.				
	Louisa County, VA.				
	New Kent County, VA.				
	Powhatan County, VA.				
	Prince George County, VA.				
	Sussex County, VA.				
	Colonial Heights City, VA.				
	Hopewell City, VA.				
	Petersburg City, VA.				
	Richmond City, VA.				
40140	Riverside-San Bernardino-Ontario, CA	1.0970	1.0388	1.0582	1.0776
	Riverside County, CA.				
	San Bernardino County, CA.				
40220	Roanoke, VA	0.8415	0.9366	0.9049	0.8732
	Botetourt County, VA.				
	Craig County, VA.				
	Franklin County, VA.				
	Roanoke County, VA.				
	Roanoke City, VA.				
	Salem City, VA.				
40340	Rochester, MN	1.1504	1.0602	1.0902	1.1203
	Dodge County, MN.				
	Olmsted County, MN.				
	Wabasha County, MN.				
40380	Rochester, NY	0.9281	0.9712	0.9569	0.9425
	Livingston County, NY.				
	Monroe County, NY.				
	Ontario County, NY.				

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

CBSA code	Urban area (constituent counties)	Full wage index ²	2/5ths wage index ³	3/5ths wage index ⁴	4/5ths wage index ⁵
40420	Orleans County, NY. Wayne County, NY. Rockford, IL	0.9626	0.9850	0.9776	0.9701
40484	Boone County, IL. Winnebago County, IL. Rockingham County--Strafford County, NH	1.0221	1.0088	1.0133	1.0177
40580	Rockingham County, NH. Strafford County, NH. Rocky Mount, NC	0.8998	0.9599	0.9399	0.9198
40660	Edgecombe County, NC. Nash County, NC. Rome, GA	0.8878	0.9551	0.9327	0.9102
40900	Floyd County, GA. Sacramento--Arden-Arcade--Roseville, CA	1.1700	1.0680	1.1020	1.1360
40980	El Dorado County, CA. Placer County, CA. Sacramento County, CA. Yolo County, CA.	0.9814	0.9926	0.9888	0.9851
41060	Saginaw-Saginaw Township North, MI	1.0215	1.0086	1.0129	1.0172
41100	Saginaw County, MI. St. Cloud, MN	0.9458	0.9783	0.9675	0.9566
41140	Benton County, MN. Stearns County, MN. St. George, UT	1.0013	1.0005	1.0008	1.0010
41180	Washington County, UT. St. Joseph, MO-KS	0.9076	0.9630	0.9446	0.9261
41420	Doniphan County, KS. Andrew County, MO. Buchanan County, MO. DeKalb County, MO. St. Louis, MO-IL	1.0556	1.0222	1.0334	1.0445
41500	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.	1.3823	1.1529	1.2294	1.3058
41540	Salem, OR	0.9123	0.9649	0.9474	0.9298
41620	Marion County, OR. Polk County, OR. Salinas, CA	0.9561	0.9824	0.9737	0.9649
41660	Monterey County, CA. Salisbury, MD	0.8167	0.9267	0.8900	0.8534
41700	Somerset County, MD. Wicomico County, MD. Salt Lake City, UT	0.9003	0.9601	0.9402	0.9202
	Salt Lake County, UT. Summit County, UT. Tooele County, UT. San Angelo, TX				
	Irion County, TX. Tom Green County, TX. San Antonio, TX				
	Atascosa County, TX. Bandera County, TX. Bexar County, TX. Comal County, TX. Guadalupe County, TX.				

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2005 THROUGH JUNE 30, 2006¹—Continued

CBSA code	Urban area (constituent counties)	Full wage index ²	2/5ths wage index ³	3/5ths wage index ⁴	4/5ths wage index ⁵
41740	Kendall County, TX. Medina County, TX. Wilson County, TX. San Diego-Carlsbad-San Marcos, CA	1.1267	1.0507	1.0760	1.1014
41780	San Diego County, CA. Sandusky, OH	0.9017	0.9607	0.9410	0.9214
41884	Erie County, OH. San Francisco-San Mateo-Redwood City, CA	1.4712	1.1885	1.2827	1.3770
41900	Marin County, CA. San Francisco County, CA. San Mateo County, CA. San Germán-Cabo Rojo, PR	0.5240	0.8096	0.7144	0.6192
41940	Cabo Rojo Municipio, PR. Lajas Municipio, PR. Sabana Grande Municipio, PR. San Germán Municipio, PR. San Jose-Sunnyvale-Santa Clara, CA	1.4722	1.1889	1.2833	1.3778
41980	San Benito County, CA. Santa Clara County, CA. San Juan-Caguas-Guaynabo, PR	0.4645	0.7858	0.6787	0.5716
	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	1.1118	1.0447	1.0671	1.0894
42044	San Luis Obispo County, CA. Santa Ana-Anaheim-Irvine, CA	1.1611	1.0644	1.0967	1.1289
42060	Orange County, CA. Santa Barbara-Santa Maria-Goleta, CA	1.0771	1.0308	1.0463	1.0617
42100	Santa Barbara County, CA. Santa Cruz-Watsonville, CA	1.4779	1.1912	1.2867	1.3823
	Santa Cruz County, CA.				

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2005 THROUGH JUNE 30, 2006¹—Continued

CBSA code	Urban area (constituent counties)	Full wage index ²	2/5ths wage index ³	3/5ths wage index ⁴	4/5ths wage index ⁵
42140	Santa Fe, NM	1.0909	1.0364	1.0545	1.0727
	Santa Fe County, NM.				
42220	Santa Rosa-Petaluma, CA	1.2961	1.1184	1.1777	1.2369
	Sonoma County, CA.				
42260	Sarasota-Bradenton-Venice, FL	0.9629	0.9852	0.9777	0.9703
	Manatee County, FL.				
	Sarasota County, FL.				
42340	Savannah, GA	0.9460	0.9784	0.9676	0.9568
	Bryan County, GA.				
	Chatham County, GA.				
	Effingham County, GA.				
42540	Scranton--Wilkes-Barre, PA	0.8543	0.9417	0.9126	0.8834
	Lackawanna County, PA.				
	Luzerne County, PA.				
	Wyoming County, PA.				
42644	Seattle-Bellevue-Everett, WA	1.1492	1.0597	1.0895	1.1194
	King County, WA.				
	Snohomish County, WA.				
43100	Sheboygan, WI	0.8948	0.9579	0.9369	0.9158
	Sheboygan County, WI.				
43300	Sherman-Denison, TX	0.9617	0.9847	0.9770	0.9694
	Grayson County, TX.				
43340	Shreveport-Bossier City, LA	0.9132	0.9653	0.9479	0.9306
	Bossier Parish, LA.				
	Caddo Parish, LA.				
	De Soto Parish, LA.				
43580	Sioux City, IA-NE-SD	0.9070	0.9628	0.9442	0.9256
	Woodbury County, IA.				
	Dakota County, NE.				
	Dixon County, NE.				
	Union County, SD.				
43620	Sioux Falls, SD	0.9441	0.9776	0.9665	0.9553
	Lincoln County, SD.				
	McCook County, SD.				
	Minnehaha County, SD.				
	Turner County, SD.				
43780	South Bend-Mishawaka, IN-MI	0.9447	0.9779	0.9668	0.9558
	St. Joseph County, IN.				
	Cass County, MI.				
43900	Spartanburg, SC	0.9519	0.9808	0.9711	0.9615
	Spartanburg County, SC.				
44060	Spokane, WA	1.0660	1.0264	1.0396	1.0528
	Spokane County, WA.				
44100	Springfield, IL	0.8738	0.9495	0.9243	0.8990
	Menard County, IL.				
	Sangamon County, IL.				
44140	Springfield, MA	1.0176	1.0070	1.0106	1.0141
	Franklin County, MA.				
	Hampden County, MA.				
	Hampshire County, MA.				
44180	Springfield, MO	0.8557	0.9423	0.9134	0.8846
	Christian County, MO.				
	Dallas County, MO.				
	Greene County, MO.				
	Polk County, MO.				
	Webster County, MO.				
44220	Springfield, OH	0.8748	0.9499	0.9249	0.8998
	Clark County, OH.				
44300	State College, PA	0.8461	0.9384	0.9077	0.8769
	Centre County, PA.				
44700	Stockton, CA	1.0564	1.0226	1.0338	1.0451
	San Joaquin County, CA.				
44940	Sumter, SC	0.8520	0.9408	0.9112	0.8816
	Sumter County, SC.				
45060	Syracuse, NY	0.9468	0.9787	0.9681	0.9574
	Madison County, NY.				
	Onondaga County, NY.				
	Oswego County, NY.				
45104	Tacoma, WA	1.1078	1.0431	1.0647	1.0862

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2005 THROUGH JUNE 30, 2006¹—Continued

CBSA code	Urban area (constituent counties)	Full wage index ²	2/5ths wage index ³	3/5ths wage index ⁴	4/5ths wage index ⁵
45220	Pierce County, WA. Tallahassee, FL	0.8655	0.9462	0.9193	0.8924
	Gadsden County, FL. Jefferson County, FL. Leon County, FL. Wakulla County, FL.				
45300	Tampa-St. Petersburg-Clearwater, FL	0.9024	0.9610	0.9414	0.9219
	Hernando County, FL. Hillsborough County, FL. Pasco County, FL. Pinellas County, FL.				
45460	Terre Haute, IN	0.8517	0.9407	0.9110	0.8814
	Clay County, IN. Sullivan County, IN. Vermillion County, IN. Vigo County, IN.				
45500	Texarkana, TX-Texarkana, AR	0.8413	0.9365	0.9048	0.8730
	Miller County, AR. Bowie County, TX.				
45780	Toledo, OH	0.9524	0.9810	0.9714	0.9619
	Fulton County, OH. Lucas County, OH. Ottawa County, OH. Wood County, OH.				
45820	Topeka, KS	0.8904	0.9562	0.9342	0.9123
	Jackson County, KS. Jefferson County, KS. Osage County, KS. Shawnee County, KS. Wabaunsee County, KS.				
45940	Trenton-Ewing, NJ	1.0276	1.0110	1.0166	1.0221
	Mercer County, NJ.				
46060	Tucson, AZ	0.8926	0.9570	0.9356	0.9141
	Pima County, AZ.				
46140	Tulsa, OK	0.8690	0.9476	0.9214	0.8952
	Creek County, OK. Okmulgee County, OK. Osage County, OK. Pawnee County, OK. Rogers County, OK. Tulsa County, OK. Wagoner County, OK.				
46220	Tuscaloosa, AL	0.8336	0.9334	0.9002	0.8669
	Greene County, AL. Hale County, AL. Tuscaloosa County, AL.				
46340	Tyler, TX	0.9502	0.9801	0.9701	0.9602
	Smith County, TX.				
46540	Utica-Rome, NY	0.8295	0.9318	0.8977	0.8636
	Herkimer County, NY. Oneida County, NY.				
46660	Valdosta, GA	0.8341	0.9336	0.9005	0.8673
	Brooks County, GA. Echols County, GA. Lanier County, GA. Lowndes County, GA.				
46700	Vallejo-Fairfield, CA	1.4279	1.1712	1.2567	1.3423
	Solano County, CA.				
46940	Vero Beach, FL	0.9477	0.9791	0.9686	0.9582
	Indian River County, FL.				
47020	Victoria, TX	0.8470	0.9388	0.9082	0.8776
	Calhoun County, TX. Goliad County, TX. Victoria County, TX.				
47220	Vineland-Millville-Bridgeton, NJ	1.0573	1.0229	1.0344	1.0458
	Cumberland County, NJ.				
47260	Virginia Beach-Norfolk-Newport News, VA-NC	0.8894	0.9558	0.9336	0.9115
	Currituck County, NC. Gloucester County, VA.				

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

CBSA code	Urban area (constituent counties)	Full wage index ²	2/5ths wage index ³	3/5ths wage index ⁴	4/5ths wage index ⁵
	Isle of Wight County, VA. James City County, VA. Mathews County, VA. Surry County, VA. York County, VA. Chesapeake City, VA. Hampton City, VA. Newport News City, VA. Norfolk City, VA. Poquoson City, VA. Portsmouth City, VA. Suffolk City, VA. Virginia Beach City, VA. Williamsburg City, VA.				
47300	Visalia-Porterville, CA	0.9975	0.9990	0.9985	0.9980
	Tulare County, CA.				
47380	Waco, TX	0.8146	0.9258	0.8888	0.8517
	McLennan County, TX.				
47580	Warner Robins, GA	0.8489	0.9396	0.9093	0.8791
	Houston County, GA.				
47644	Warren-Farmington Hills-Troy, MI	1.0112	1.0045	1.0067	1.0090
	Lapeer County, MI. Livingston County, MI. Macomb County, MI. Oakland County, MI. St. Clair County, MI.				
47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	1.1023	1.0409	1.0614	1.0818
	District of Columbia, DC. Calvert County, MD. Charles County, MD. Prince George's County, MD. Arlington County, VA. Clarke County, VA. Fairfax County, VA. Fauquier County, VA. Loudoun County, VA. Prince William County, VA. Spotsylvania County, VA. Stafford County, VA. Warren County, VA. Alexandria City, VA. Fairfax City, VA. Falls Church City, VA. Fredericksburg City, VA. Manassas City, VA. Manassas Park City, VA. Jefferson County, WV.				
47940	Waterloo-Cedar Falls, IA	0.8633	0.9453	0.9180	0.8906
	Black Hawk County, IA. Bremer County, IA. Grundy County, IA.				
48140	Wausau, WI	0.9570	0.9828	0.9742	0.9656
	Marathon County, WI.				
48260	Weirton-Steubenville, WV-OH	0.8280	0.9312	0.8968	0.8624
	Jefferson County, OH. Brooke County, WV. Hancock County, WV.				
48300	Wenatchee, WA	0.9427	0.9771	0.9656	0.9542
	Chelan County, WA. Douglas County, WA.				
48424	West Palm Beach-Boca Raton-Boynton Beach, FL	1.0362	1.0145	1.0217	1.0290
	Palm Beach County, FL.				
48540	Wheeling, WV-OH	0.7449	0.8980	0.8469	0.7959
	Belmont County, OH. Marshall County, WV. Ohio County, WV.				
48620	Wichita, KS	0.9457	0.9783	0.9674	0.9566
	Butler County, KS. Harvey County, KS.				

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2005 THROUGH JUNE 30, 2006¹—Continued

CBSA code	Urban area (constituent counties)	Full wage index ²	2/5ths wage index ³	3/5ths wage index ⁴	4/5ths wage index ⁵
48660	Sedgwick County, KS. Sumner County, KS. Wichita Falls, TX	0.8332	0.9333	0.8999	0.8666
	Archer County, TX. Clay County, TX. Wichita County, TX.				
48700	Williamsport, PA	0.8485	0.9394	0.9091	0.8788
	Lycoming County, PA.				
48864	Wilmington, DE-MD-NJ	1.1049	1.0420	1.0629	1.0839
	New Castle County, DE. Cecil County, MD. Salem County, NJ.				
48900	Wilmington, NC	0.9237	0.9695	0.9542	0.9390
	Brunswick County, NC. New Hanover County, NC. Pender County, NC.				
49020	Winchester, VA-WV	1.0496	1.0198	1.0298	1.0397
	Frederick County, VA. Winchester City, VA. Hampshire County, WV.				
49180	Winston-Salem, NC	0.9401	0.9760	0.9641	0.9521
	Davie County, NC. Forsyth County, NC. Stokes County, NC. Yadkin County, NC.				
49340	Worcester, MA	1.0996	1.0398	1.0598	1.0797
	Worcester County, MA.				
49420	Yakima, WA	1.0322	1.0129	1.0193	1.0258
	Yakima County, WA.				
49500	Yauco, PR	0.4493	0.7797	0.6696	0.5594
	Guánica Municipio, PR. Guayanilla Municipio, PR. Peñuelas Municipio, PR. Yauco Municipio, PR.				
49620	York-Hanover, PA	0.9150	0.9660	0.9490	0.9320
	York County, PA.				
49660	Youngstown-Warren-Boardman, OH-PA	0.9237	0.9695	0.9542	0.9390
	Mahoning County, OH. Trumbull County, OH. Mercer County, PA.				
49700	Yuba City, CA	1.0363	1.0145	1.0218	1.0290
	Sutter County, CA. Yuba County, CA.				
49740	Yuma, AZ	0.8871	0.9548	0.9323	0.9097
	Yuma County, AZ.				

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

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

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

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

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

TABLE 2.—LONG-TERM CARE HOSPITAL WAGE INDEX (BASED ON CBSA LABOR MARKET AREAS) FOR RURAL AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2005 THROUGH JUNE 30, 2006¹

CBSA code	Nonurban area	Full wage index ²	2/5ths wage index ³	3/5ths wage index ⁴	4/5ths wage index ⁵
01	Alabama	0.7628	0.9051	0.8577	0.8102
02	Alaska	1.1746	1.0698	1.1048	1.1397
03	Arizona	0.8936	0.9574	0.9362	0.9149
04	Arkansas	0.7406	0.8962	0.8444	0.7925
05	California	1.0524	1.0210	1.0314	1.0419
06	Colorado	0.9368	0.9747	0.9621	0.9494
07	Connecticut	1.1917	1.0767	1.1150	1.1534
08	Delaware	0.9503	0.9801	0.9702	0.9602
10	Florida	0.8574	0.9430	0.9144	0.8859
11	Georgia	0.7733	0.9093	0.8640	0.8186
12	Hawaii	1.0522	1.0209	1.0313	1.0418
13	Idaho	0.8227	0.9291	0.8936	0.8582
14	Illinois	0.8339	0.9336	0.9003	0.8671
15	Indiana	0.8653	0.9461	0.9192	0.8922
16	Iowa	0.8475	0.9390	0.9085	0.8780
17	Kansas	0.8079	0.9232	0.8847	0.8463
18	Kentucky	0.7755	0.9102	0.8653	0.8204
19	Louisiana	0.7345	0.8938	0.8407	0.7876
20	Maine	0.9039	0.9616	0.9423	0.9231
21	Maryland	0.9220	0.9688	0.9532	0.9376
22	Massachusetts ⁶ .....	.....	.....	.....	.....
23	Michigan	0.8786	0.9514	0.9272	0.9029
24	Minnesota	0.9330	0.9732	0.9598	0.9464
25	Mississippi	0.7635	0.9054	0.8581	0.8108
26	Missouri	0.7762	0.9105	0.8657	0.8210
27	Montana	0.8701	0.9480	0.9221	0.8961
28	Nebraska	0.9035	0.9614	0.9421	0.9228
29	Nevada	0.9280	0.9712	0.9568	0.9424
30	New Hampshire	0.9940	0.9976	0.9964	0.9952
31	New Jersey ⁶ .....	.....	.....	.....	.....
32	New Mexico	0.8680	0.9472	0.9208	0.8944
33	New York	0.8151	0.9260	0.8891	0.8521
34	North Carolina	0.8563	0.9425	0.9138	0.8850
35	North Dakota	0.7743	0.9097	0.8646	0.8194
36	Ohio	0.8693	0.9477	0.9216	0.8954
37	Oklahoma	0.7686	0.9074	0.8612	0.8149
38	Oregon	0.9914	0.9966	0.9948	0.9931
39	Pennsylvania	0.8310	0.9324	0.8986	0.8648
40	Puerto Rico ⁶ .....	.....	.....	.....	.....
41	Rhode Island ⁶ .....	.....	.....	.....	.....
42	South Carolina	0.8683	0.9473	0.9210	0.8946
43	South Dakota	0.8398	0.9359	0.9039	0.8718
44	Tennessee	0.7869	0.9148	0.8721	0.8295
45	Texas	0.7966	0.9186	0.8780	0.8373
46	Utah	0.8287	0.9315	0.8972	0.8630
47	Vermont	0.9375	0.9750	0.9625	0.9500
49	Virginia	0.8049	0.9220	0.8829	0.8439
50	Washington	1.0312	1.0125	1.0187	1.0250
51	West Virginia	0.7865	0.9146	0.8719	0.8292
52	Wisconsin	0.9492	0.9797	0.9695	0.9594
53	Wyoming	0.9182	0.9673	0.9509	0.9346

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

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

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

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

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

⁶ All counties within the State are classified as urban.

TABLE 3.—FY 2005 LTC-DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY (EFFECTIVE FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2004 THROUGH SEPTEMBER 30, 2005)

LTC-DRG	Description	Relative weight	Geometric average length of stay	5/6ths of the geometric average length of stay
1	⁴ CRANIOTOMY AGE >17 W CC	1.1899	28.5	23.8
2	⁸ CRANIOTOMY AGE >17 W/O CC	1.1899	28.5	23.8
3	⁸ CRANIOTOMY AGE 0-17	1.1899	28.5	23.8
6	⁸ CARPAL TUNNEL RELEASE	0.6064	21.1	17.6
7	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC	1.4458	36.7	30.6
8	² PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC	0.6064	21.1	17.6
9	SPINAL DISORDERS & INJURIES	1.0950	31.3	26.1
10	NERVOUS SYSTEM NEOPLASMS W CC	0.9022	25.0	20.8
11	¹ NERVOUS SYSTEM NEOPLASMS W/O CC	0.4586	16.9	14.1
12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	0.7416	25.6	21.3
13	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	0.7820	24.6	20.5
14	INTRACRANIAL HEMORRHAGE OR STROKE W INFARCT	0.8189	25.9	21.6
15	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT	0.7868	27.2	22.7
16	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	0.8358	24.7	20.6
17	² NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	0.6064	21.1	17.6
18	CRANIAL & PERIPHERAL NERVE DISORDERS W CC	0.7755	24.8	20.7
19	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	0.6583	21.1	17.6
20	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	1.0558	27.0	22.5
21	⁴ VIRAL MENINGITIS	1.1899	28.5	23.8
22	² HYPERTENSIVE ENCEPHALOPATHY	0.6064	21.1	17.6
23	NONTRAUMATIC STUPOR & COMA	1.1225	26.6	22.2
24	SEIZURE & HEADACHE AGE >17 W CC	0.6740	22.4	18.7
25	² SEIZURE & HEADACHE AGE >17 W/O CC	0.6064	21.1	17.6
26	⁸ SEIZURE & HEADACHE AGE 0-17	0.6064	21.1	17.6
27	TRAUMATIC STUPOR & COMA, COMA >1 HR	1.1418	28.3	23.6
28	TRAUMATIC STUPOR & COMA, COMA 1 HR AGE 17 W CC	0.9250	29.8	24.8
29	³ TRAUMATIC STUPOR & COMA, COMA 1 HR AGE 17 W/O CC	0.8508	24.3	20.3
30	⁸ TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0-17	0.8508	24.3	20.3
31	² CONCUSSION AGE >17 W CC	0.6064	21.1	17.6
32	⁸ CONCUSSION AGE >17 W/O CC	0.6064	21.1	17.6
33	⁸ CONCUSSION AGE 0-17	0.6064	21.1	17.6
34	OTHER DISORDERS OF NERVOUS SYSTEM W CC	0.8418	24.2	20.2
35	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	0.6976	22.6	18.8
36	⁸ RETINAL PROCEDURES	0.4586	16.9	14.1
37	⁸ ORBITAL PROCEDURES	0.4586	16.9	14.1
38	⁸ PRIMARY IRIS PROCEDURES	0.4586	16.9	14.1
39	⁸ LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	0.4586	16.9	14.1
40	⁸ EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	0.4586	16.9	14.1
41	⁸ EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17	0.4586	16.9	14.1
42	⁸ INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	0.4586	16.9	14.1
43	¹ HYPHEMA	0.4586	16.9	14.1
44	³ ACUTE MAJOR EYE INFECTIONS	0.8508	24.3	20.3
45	¹ NEUROLOGICAL EYE DISORDERS	0.4586	16.9	14.1
46	² OTHER DISORDERS OF THE EYE AGE >17 W CC	0.6064	21.1	17.6
47	¹ OTHER DISORDERS OF THE EYE AGE >17 W/O CC	0.4586	16.9	14.1
48	⁸ OTHER DISORDERS OF THE EYE AGE 0-17	0.4586	16.9	14.1
49	⁸ MAJOR HEAD & NECK PROCEDURES	1.1899	28.5	23.8
50	⁸ SIALOADENECTOMY	1.1899	28.5	23.8
51	⁸ SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	1.1899	28.5	23.8
52	⁸ CLEFT LIP & PALATE REPAIR	1.1899	28.5	23.8
53	⁸ SINUS & MASTOID PROCEDURES AGE >17	1.1899	28.5	23.8
54	⁸ SINUS & MASTOID PROCEDURES AGE 0-17	1.1899	28.5	23.8
55	⁵ MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES	1.8658	38.6	32.2
56	⁸ RHINOPLASTY	1.1899	28.5	23.8
57	⁸ T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	0.6064	21.1	17.6
58	⁸ T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17.	0.6064	21.1	17.6
59	⁸ TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	0.6064	21.1	17.6
60	⁸ TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	0.6064	21.1	17.6
61	⁸ MYRINGOTOMY W TUBE INSERTION AGE >17	0.6064	21.1	17.6
62	⁸ MYRINGOTOMY W TUBE INSERTION AGE 0-17	0.6064	21.1	17.6
63	⁴ OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES	1.1899	28.5	23.8
64	EAR, NOSE, MOUTH & THROAT MALIGNANCY	1.2588	27.4	22.8
65	DYSEQUILIBRIUM	0.3858	16.2	13.5
66	⁸ EPISTAXIS	0.6064	21.1	17.6
67	⁸ EPIGLOTTITIS	1.1899	28.5	23.8

TABLE 3.—FY 2005 LTC-DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY (EFFECTIVE FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2004 THROUGH SEPTEMBER 30, 2005)—Continued

LTC-DRG	Description	Relative weight	Geometric average length of stay	5/6ths of the geometric average length of stay
68	OTITIS MEDIA & URI AGE >17 W CC	0.6115	21.3	17.8
69	² OTITIS MEDIA & URI AGE >17 W/O CC	0.6064	21.1	17.6
70	⁸ OTITIS MEDIA & URI AGE 0-17	0.6064	21.1	17.6
71	⁸ LARYNGOTRACHEITIS	0.4586	16.9	14.1
72	⁸ NASAL TRAUMA & DEFORMITY	0.8508	24.3	20.3
73	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17	0.9341	23.5	19.6
74	⁸ OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0-17	0.6064	21.1	17.6
75	MAJOR CHEST PROCEDURES	2.0661	31.9	26.6
76	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.3823	41.6	34.7
77	⁵ OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	1.8658	38.6	32.2
78	PULMONARY EMBOLISM	0.7424	22.0	18.3
79	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	0.9350	23.7	19.8
80	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC	0.9215	26.7	22.3
81	⁸ RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0-17	0.6064	21.1	17.6
82	RESPIRATORY NEOPLASMS	0.7591	19.9	16.6
83	² MAJOR CHEST TRAUMA W CC	0.6064	21.1	17.6
84	¹ MAJOR CHEST TRAUMA W/O CC	0.4586	16.9	14.1
85	⁷ PLEURAL EFFUSION W CC	0.7852	22.0	18.3
86	⁷ PLEURAL EFFUSION W/O CC	0.7852	22.0	18.3
87	PULMONARY EDEMA & RESPIRATORY FAILURE	1.6797	30.4	25.3
88	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	0.7334	20.1	16.8
89	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	0.7762	21.2	17.7
90	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	0.7494	21.9	18.3
91	⁸ SIMPLE PNEUMONIA & PLEURISY AGE 0-17	0.8508	24.3	20.3
92	INTERSTITIAL LUNG DISEASE W CC	0.7318	20.4	17.0
93	¹ INTERSTITIAL LUNG DISEASE W/O CC	0.4586	16.9	14.1
94	PNEUMOTHORAX W CC	0.8348	21.3	17.8
95	¹ PNEUMOTHORAX W/O CC	0.4586	16.9	14.1
96	BRONCHITIS & ASTHMA AGE >17 W CC	0.7575	20.2	16.8
97	BRONCHITIS & ASTHMA AGE >17 W/O CC	0.5305	16.6	13.8
98	⁸ BRONCHITIS & ASTHMA AGE 0-17	0.4586	16.9	14.1
99	RESPIRATORY SIGNS & SYMPTOMS W CC	1.0648	25.8	21.5
100	RESPIRATORY SIGNS & SYMPTOMS W/O CC	0.9048	22.9	19.1
101	⁷ OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	0.8737	21.9	18.3
102	⁷ OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	0.8737	21.9	18.3
103	⁶ HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM	0.0000	0.0	0.0
104	⁸ CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W CARD CATH	0.4586	16.9	14.1
105	⁸ CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W/O CARD CATH	0.4586	16.9	14.1
106	⁸ CORONARY BYPASS W PTCA	0.4586	16.9	14.1
107	⁸ CORONARY BYPASS W CARDIAC CATH	0.4586	16.9	14.1
108	⁴ OTHER CARDIOTHORACIC PROCEDURES	1.1899	28.5	23.8
109	² CORONARY BYPASS W/O PTCA OR CARDIAC CATH	0.6064	21.1	17.6
110	¹ MAJOR CARDIOVASCULAR PROCEDURES W CC	0.4586	16.9	14.1
111	⁸ MAJOR CARDIOVASCULAR PROCEDURES W/O CC	0.4586	16.9	14.1
113	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE	1.3298	36.2	30.2
114	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	1.1780	33.3	27.8
115	⁴ PRM CARD PACEM IMPL W AMI/HR/SHOCK OR AICD LEAD OR GNRTR	1.1899	28.5	23.8
116	⁵ OTHER PERMANENT CARDIAC PACEMAKER IMPLANT	1.8658	38.6	32.2
117	² CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT	0.6064	21.1	17.6
118	⁵ CARDIAC PACEMAKER DEVICE REPLACEMENT	1.8658	38.6	32.2
119	¹ VEIN LIGATION & STRIPPING	0.4586	16.9	14.1
120	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	1.2014	32.6	27.2
121	CIRCULATORY DISORDERS W AMI & MAJOR COMP, DISCHARGED ALIVE	0.8293	21.8	18.2
122	³ CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE	0.8508	24.3	20.3
123	CIRCULATORY DISORDERS W AMI, EXPIRED	0.9890	18.6	15.5
124	³ CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG	0.8508	24.3	20.3
125	⁵ CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG	1.8658	38.6	32.2
126	ACUTE & SUBACUTE ENDOCARDITIS	0.8439	24.6	20.5
127	HEART FAILURE & SHOCK	0.7597	21.6	18.0
128	³ DEEP VEIN THROMBOPHLEBITIS	0.8508	24.3	20.3
129	² CARDIAC ARREST, UNEXPLAINED	0.6064	21.1	17.6
130	PERIPHERAL VASCULAR DISORDERS W CC	0.7072	22.7	18.9
131	PERIPHERAL VASCULAR DISORDERS W/O CC	0.5718	20.6	17.2
132	ATHEROSCLEROSIS W CC	0.7086	22.6	18.8
133	ATHEROSCLEROSIS W/O CC	0.5629	19.4	16.2
134	HYPERTENSION	0.6674	21.5	17.9

TABLE 3.—FY 2005 LTC-DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY (EFFECTIVE FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2004 THROUGH SEPTEMBER 30, 2005)—Continued

LTC-DRG	Description	Relative weight	Geometric average length of stay	5/6ths of the geometric average length of stay
135	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC	0.8908	24.6	20.5
136	³ CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC	0.8508	24.3	20.3
137	⁸ CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0-17	0.8508	24.3	20.3
138	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	0.7451	22.0	18.3
139	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	0.5488	19.3	16.1
140	² ANGINA PECTORIS	0.6064	21.1	17.6
141	⁷ SYNCOPE & COLLAPSE W CC	0.5304	22.5	18.8
142	⁷ SYNCOPE & COLLAPSE W/O CC	0.5304	22.5	18.8
143	¹ CHEST PAIN	0.4586	16.9	14.1
144	⁷ OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	0.7913	21.8	18.2
145	⁷ OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	0.7913	21.8	18.2
146	⁸ RECTAL RESECTION W CC	1.8658	38.6	32.2
147	⁸ RECTAL RESECTION W/O CC	1.8658	38.6	32.2
148	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	2.0460	35.1	29.3
149	¹ MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	0.4586	16.9	14.1
150	⁵ PERITONEAL ADHESIOLYSIS W CC	1.8658	38.6	32.2
151	⁸ PERITONEAL ADHESIOLYSIS W/O CC	1.8658	38.6	32.2
152	⁵ MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.8658	38.6	32.2
153	⁸ MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.8658	38.6	32.2
154	⁵ STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC	1.8658	38.6	32.2
155	⁸ STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC	1.8658	38.6	32.2
156	⁸ STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0-17	1.8658	38.6	32.2
157	⁴ ANAL & STOMAL PROCEDURES W CC	1.1899	28.5	23.8
158	⁸ ANAL & STOMAL PROCEDURES W/O CC	1.1899	28.5	23.8
159	³ HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC	0.8508	24.3	20.3
160	⁸ HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC	0.8508	24.3	20.3
161	⁵ INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC	1.8658	38.6	32.2
162	⁸ INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC	0.4586	16.9	14.1
163	⁸ HERNIA PROCEDURES AGE 0-17	0.4586	16.9	14.1
164	⁸ APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	1.8658	38.6	32.2
165	⁸ APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	1.8658	38.6	32.2
166	⁸ APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	1.8658	38.6	32.2
167	⁸ APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	1.8658	38.6	32.2
168	⁴ MOUTH PROCEDURES W CC	1.1899	28.5	23.8
169	⁸ MOUTH PROCEDURES W/O CC	0.8508	24.3	20.3
170	⁷ OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	1.7448	33.3	27.8
171	⁷ OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC	1.7448	33.3	27.8
172	⁷ DIGESTIVE MALIGNANCY W CC	0.8822	22.8	19.0
173	⁷ DIGESTIVE MALIGNANCY W/O CC	0.8822	22.8	19.0
174	⁷ G.I. HEMORRHAGE W CC	0.7067	21.9	18.3
175	⁷ G.I. HEMORRHAGE W/O CC	0.7067	21.9	18.3
176	COMPLICATED PEPTIC ULCER	1.0124	23.3	19.4
177	³ UNCOMPLICATED PEPTIC ULCER W CC	0.8508	24.3	20.3
178	¹ UNCOMPLICATED PEPTIC ULCER W/O CC	0.4586	16.9	14.1
179	INFLAMMATORY BOWEL DISEASE	0.8728	23.4	19.5
180	G.I. OBSTRUCTION W CC	0.9438	22.2	18.5
181	² G.I. OBSTRUCTION W/O CC	0.6064	21.1	17.6
182	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC	0.8373	23.1	19.3
183	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC	0.6992	20.7	17.3
184	⁸ ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0-17	0.6064	21.1	17.6
185	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17	0.8447	24.2	20.2
186	⁸ DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0-17	0.8508	24.3	20.3
187	⁸ DENTAL EXTRACTIONS & RESTORATIONS	0.8508	24.3	20.3
188	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	0.9751	24.0	20.0
189	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	0.8839	22.9	19.1
190	⁸ OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17	0.8508	24.3	20.3
191	⁵ PANCREAS, LIVER & SHUNT PROCEDURES W CC	1.8658	38.6	32.2
192	⁸ PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	1.8658	38.6	32.2
193	¹ BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC	0.4586	16.9	14.1
194	⁸ BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC ..	0.4586	16.9	14.1
195	⁸ CHOLECYSTECTOMY W C.D.E. W CC	1.8658	38.6	32.2
196	⁸ CHOLECYSTECTOMY W C.D.E. W/O CC	1.8658	38.6	32.2
197	⁵ CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	1.8658	38.6	32.2
198	⁸ CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC	1.8658	38.6	32.2
199	⁸ HEPATOBIILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	0.8508	24.3	20.3
200	³ HEPATOBIILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY	0.8508	24.3	20.3

TABLE 3.—FY 2005 LTC-DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY (EFFECTIVE FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2004 THROUGH SEPTEMBER 30, 2005)—Continued

LTC-DRG	Description	Relative weight	Geometric average length of stay	5/6ths of the geometric average length of stay
201	⁴ OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES	1.1899	28.5	23.8
202	CIRRHOSIS & ALCOHOLIC HEPATITIS	0.7217	23.3	19.4
203	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	0.7867	20.9	17.4
204	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	0.8626	21.5	17.9
205	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEP A W CC	0.7596	23.0	19.2
206	² DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEP A W/O CC	0.6064	21.1	17.6
207	DISORDERS OF THE BILIARY TRACT W CC	0.6492	19.3	16.1
208	¹ DISORDERS OF THE BILIARY TRACT W/O CC	0.4586	16.9	14.1
209	⁵ MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF LOWER EXTREMITY	1.8658	38.6	32.2
210	⁵ HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC	1.8658	38.6	32.2
211	⁸ HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC	1.8658	38.6	32.2
212	⁸ HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17	1.8658	38.6	32.2
213	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS	1.1696	33.9	28.3
216	⁵ BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	1.8658	38.6	32.2
217	WND DEBRID & SKN GRFT EXCEPT HAND, FOR MUSC SKELET & CONN TISS DIS	1.3123	37.2	31.0
218	⁴ LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W CC	1.1899	28.5	23.8
219	⁸ LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W/O CC	1.1899	28.5	23.8
220	⁸ LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE 0-17	1.1899	28.5	23.8
223	⁸ MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC	1.1899	28.5	23.8
224	⁸ SHOULDER, ELBOW OR FOREARM PROC, EXC MAJOR JOINT PROC, W/O CC	0.6064	21.1	17.6
225	FOOT PROCEDURES	1.0601	30.4	25.3
226	⁵ SOFT TISSUE PROCEDURES W CC	1.8658	38.6	32.2
227	² SOFT TISSUE PROCEDURES W/O CC	0.6064	21.1	17.6
228	³ MAJOR THUMB OR JOINT PROC, OR OTH HAND OR WRIST PROC W CC	0.8508	24.3	20.3
229	¹ HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	0.4586	16.9	14.1
230	⁵ LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR	1.8658	38.6	32.2
232	⁸ ARTHROSCOPY	0.8508	24.3	20.3
233	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	1.5135	34.5	28.8
234	³ OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC	0.8508	24.3	20.3
235	FRACTURES OF FEMUR	0.7920	30.3	25.3
236	FRACTURES OF HIP & PELVIS	0.7348	26.9	22.4
237	¹ SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH	0.4586	16.9	14.1
238	OSTEOMYELITIS	0.9329	28.9	24.1
239	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY	0.6619	21.4	17.8
240	CONNECTIVE TISSUE DISORDERS W CC	0.7160	23.1	19.3
241	¹ CONNECTIVE TISSUE DISORDERS W/O CC	0.4586	16.9	14.1
242	SEPTIC ARTHRITIS	0.7943	26.2	21.8
243	MEDICAL BACK PROBLEMS	0.6072	22.3	18.6
244	BONE DISEASES & SPECIFIC ARTHROPATHIES W CC	0.5705	22.3	18.6
245	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	0.5109	19.3	16.1
246	NON-SPECIFIC ARTHROPATHIES	0.5884	21.4	17.8
247	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE	0.5445	21.4	17.8
248	TENDONITIS, MYOSITIS & BURSITIS	0.7830	24.3	20.3
249	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	0.6907	23.9	19.9
250	² FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC	0.6064	21.1	17.6
251	² FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC	0.6064	21.1	17.6
252	⁸ FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0-17	0.8508	24.3	20.3
253	FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE >17 W CC	0.8368	28.5	23.8
254	FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE >17 W/O CC	0.6956	27.1	22.6
255	⁸ FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE 0-17	0.8508	24.3	20.3
256	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	0.7491	23.3	19.4
257	⁸ TOTAL MASTECTOMY FOR MALIGNANCY W CC	0.4586	16.9	14.1
258	⁸ TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.4586	16.9	14.1
259	⁸ SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC	0.4586	16.9	14.1
260	¹ SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.4586	16.9	14.1
261	⁵ BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION	1.8658	38.6	32.2
262	³ BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY	0.8508	24.3	20.3
263	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	1.3568	39.1	32.6
264	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC	1.0622	33.0	27.5
265	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC	1.4363	35.7	29.8
266	³ SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC	0.8508	24.3	20.3
267	⁵ PERIANAL & PILONIDAL PROCEDURES	1.8658	38.6	32.2
268	⁵ SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES	1.8658	38.6	32.2
269	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.3904	38.4	32.0

TABLE 3.—FY 2005 LTC-DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY (EFFECTIVE FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2004 THROUGH SEPTEMBER 30, 2005)—Continued

LTC-DRG	Description	Relative weight	Geometric average length of stay	5/6ths of the geometric average length of stay
270	³ OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC	0.8508	24.3	20.3
271	SKIN ULCERS	0.9572	28.4	23.7
272	MAJOR SKIN DISORDERS W CC	0.7956	25.0	20.8
273	¹ MAJOR SKIN DISORDERS W/O CC	0.4586	16.9	14.1
274	MALIGNANT BREAST DISORDERS W CC	0.9535	27.7	23.1
275	¹ MALIGNANT BREAST DISORDERS W/O CC	0.4586	16.9	14.1
276	² NON-MALIGANT BREAST DISORDERS	0.6064	21.1	17.6
277	CELLULITIS AGE >17 W CC	0.6711	21.6	18.0
278	CELLULITIS AGE >17 W/O CC	0.5277	19.0	15.8
279	⁸ CELLULITIS AGE 0-17	0.4586	16.9	14.1
280	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC	0.8840	27.1	22.6
281	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC	0.8190	28.3	23.6
282	⁸ TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0-17	0.8508	24.3	20.3
283	MINOR SKIN DISORDERS W CC	0.7712	22.9	19.1
284	¹ MINOR SKIN DISORDERS W/O CC	0.4586	16.9	14.1
285	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DISORDERS	1.2799	35.9	29.9
286	⁸ ADRENAL & PITUITARY PROCEDURES	1.1899	28.5	23.8
287	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS ...	1.1090	32.4	27.0
288	³ O.R. PROCEDURES FOR OBESITY	0.8508	24.3	20.3
289	⁸ PARATHYROID PROCEDURES	1.1899	28.5	23.8
290	⁸ THYROID PROCEDURES	1.1899	28.5	23.8
291	⁸ THYROGLOSSAL PROCEDURES	1.1899	28.5	23.8
292	⁴ OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	1.1899	28.5	23.8
293	⁸ OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	1.1899	28.5	23.8
294	DIABETES AGE >35	0.7472	23.8	19.8
295	² DIABETES AGE 0-35	0.6064	21.1	17.6
296	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	0.7973	23.7	19.8
297	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC	0.6225	21.6	18.0
298	⁸ NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0-17	0.6064	21.1	17.6
299	⁴ INBORN ERRORS OF METABOLISM	1.1899	28.5	23.8
300	⁷ ENDOCRINE DISORDERS W CC	0.7948	24.6	20.5
301	⁷ ENDOCRINE DISORDERS W/O CC	0.7948	24.6	20.5
302	⁶ KIDNEY TRANSPLANT	0.0000	0.0	0.0
303	⁴ KIDNEY,URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM	1.1899	28.5	23.8
304	⁴ KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC	1.1899	28.5	23.8
305	² KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC	0.6064	21.1	17.6
306	⁴ PROSTATECTOMY W CC	1.1899	28.5	23.8
307	³ PROSTATECTOMY W/O CC	0.8508	24.3	20.3
308	⁴ MINOR BLADDER PROCEDURES W CC	1.1899	28.5	23.8
309	⁸ MINOR BLADDER PROCEDURES W/O CC	1.1899	28.5	23.8
310	³ TRANSURETHRAL PROCEDURES W CC	0.8508	24.3	20.3
311	⁸ TRANSURETHRAL PROCEDURES W/O CC	0.8508	24.3	20.3
312	⁴ URETHRAL PROCEDURES, AGE >17 W CC	1.1899	28.5	23.8
313	⁸ URETHRAL PROCEDURES, AGE >17 W/O CC	1.1899	28.5	23.8
314	⁸ URETHRAL PROCEDURES, AGE 0-17	0.6064	21.1	17.6
315	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	1.4618	34.2	28.5
316	RENAL FAILURE	0.9175	23.6	19.7
317	ADMIT FOR RENAL DIALYSIS	0.9238	22.1	18.4
318	⁷ KIDNEY & URINARY TRACT NEOPLASMS W CC	0.7798	22.5	18.8
319	⁷ KIDNEY & URINARY TRACT NEOPLASMS W/O CC	0.7798	22.5	18.8
320	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	0.7798	22.5	18.8
321	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	0.5721	21.9	18.3
322	⁸ KIDNEY & URINARY TRACT INFECTIONS AGE 0-17	0.4586	16.9	14.1
323	² URINARY STONES W CC, &/OR ESW LITHOTRIPSY	0.6064	21.1	17.6
324	¹ URINARY STONES W/O CC	0.4586	16.9	14.1
325	³ KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC	0.8508	24.3	20.3
326	¹ KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC	0.4586	16.9	14.1
327	⁸ KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0-17	0.4586	16.9	14.1
328	² URETHRAL STRICTURE AGE >17 W CC	0.6064	21.1	17.6
329	⁸ URETHRAL STRICTURE AGE >17 W/O CC	0.6064	21.1	17.6
330	⁸ URETHRAL STRICTURE AGE 0-17	0.6064	21.1	17.6
331	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC	0.8240	22.9	19.1
332	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC	0.6263	22.3	18.6
333	⁸ OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0-17	0.6064	21.1	17.6
334	⁸ MAJOR MALE PELVIC PROCEDURES W CC	1.8658	38.6	32.2
335	⁸ MAJOR MALE PELVIC PROCEDURES W/O CC	1.8658	38.6	32.2

TABLE 3.—FY 2005 LTC-DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY (EFFECTIVE FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2004 THROUGH SEPTEMBER 30, 2005)—Continued

LTC-DRG	Description	Relative weight	Geometric average length of stay	5/6ths of the geometric average length of stay
336	⁴ TRANSURETHRAL PROSTATECTOMY W CC	1.1899	28.5	23.8
337	⁸ TRANSURETHRAL PROSTATECTOMY W/O CC	1.1899	28.5	23.8
338	⁵ TESTES PROCEDURES, FOR MALIGNANCY	1.8658	38.6	32.2
339	¹ TESTES PROCEDURES, NON-MALIGNANCY AGE >17	0.4586	16.9	14.1
340	⁸ TESTES PROCEDURES, NON-MALIGNANCY AGE 0-17	0.4586	16.9	14.1
341	⁵ PENIS PROCEDURES	1.8658	38.6	32.2
342	⁸ CIRCUMCISION AGE >17	0.4586	16.9	14.1
343	⁸ CIRCUMCISION AGE 0-17	0.4586	16.9	14.1
344	⁵ OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY	1.8658	38.6	32.2
345	⁵ OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY	1.8658	38.6	32.2
346	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC	0.6556	20.8	17.3
347	¹ MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC	0.4586	16.9	14.1
348	² BENIGN PROSTATIC HYPERTROPHY W CC	0.6064	21.1	17.6
349	² BENIGN PROSTATIC HYPERTROPHY W/O CC	0.6064	21.1	17.6
350	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	0.7789	22.6	18.8
351	⁸ STERILIZATION, MALE	0.4586	16.9	14.1
352	⁴ OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	1.1899	28.5	23.8
353	⁸ PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY	1.8658	38.6	32.2
354	⁸ UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	1.8658	38.6	32.2
355	⁸ UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC	1.8658	38.6	32.2
356	⁸ FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	1.1899	28.5	23.8
357	⁸ UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY	1.1899	28.5	23.8
358	⁸ UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	1.1899	28.5	23.8
359	⁸ UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	1.1899	28.5	23.8
360	⁸ VAGINA, CERVIX & VULVA PROCEDURES	1.1899	28.5	23.8
361	⁸ LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	0.4586	16.9	14.1
362	⁸ ENDOSCOPIC TUBAL INTERRUPTION	0.4586	16.9	14.1
363	⁸ D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	0.4586	16.9	14.1
364	⁸ D&C, CONIZATION EXCEPT FOR MALIGNANCY	0.4586	16.9	14.1
365	⁵ OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	1.8658	38.6	32.2
366	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	1.0345	23.9	19.9
367	¹ MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	0.4586	16.9	14.1
368	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	0.7168	22.5	18.8
369	³ MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	0.8508	24.3	20.3
370	⁸ CESAREAN SECTION W CC	0.8508	24.3	20.3
371	⁸ CESAREAN SECTION W/O CC	0.4586	16.9	14.1
372	⁸ VAGINAL DELIVERY W COMPLICATING DIAGNOSES	0.4586	16.9	14.1
373	⁸ VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	0.4586	16.9	14.1
374	⁸ VAGINAL DELIVERY W STERILIZATION &/OR D&C	0.4586	16.9	14.1
375	⁸ VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	0.4586	16.9	14.1
376	⁸ POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	0.4586	16.9	14.1
377	⁸ POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	0.4586	16.9	14.1
378	⁸ ECTOPIC PREGNANCY	0.8508	24.3	20.3
379	⁸ THREATENED ABORTION	0.4586	16.9	14.1
380	⁸ ABORTION W/O D&C	0.4586	16.9	14.1
381	⁸ ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	0.4586	16.9	14.1
382	⁸ FALSE LABOR	0.4586	16.9	14.1
383	⁸ OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	0.4586	16.9	14.1
384	⁸ OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	0.4586	16.9	14.1
385	⁸ NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	0.4586	16.9	14.1
386	⁸ EXTREME IMMATURETY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	0.4586	16.9	14.1
387	⁸ PREMATURITY W MAJOR PROBLEMS	0.4586	16.9	14.1
388	⁸ PREMATURITY W/O MAJOR PROBLEMS	0.4586	16.9	14.1
389	⁸ FULL TERM NEONATE W MAJOR PROBLEMS	0.4586	16.9	14.1
390	⁸ NEONATE W OTHER SIGNIFICANT PROBLEMS	0.4586	16.9	14.1
391	⁸ NORMAL NEWBORN	0.4586	16.9	14.1
392	⁸ SPLENECTOMY AGE >17	1.8658	38.6	32.2
393	⁸ SPLENECTOMY AGE 0-17	1.8658	38.6	32.2
394	⁴ OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS ...	1.1899	28.5	23.8
395	RED BLOOD CELL DISORDERS AGE >17	0.7516	23.7	19.8
396	⁸ RED BLOOD CELL DISORDERS AGE 0-17	0.6064	21.1	17.6
397	COAGULATION DISORDERS	0.7827	19.2	16.0
398	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	0.7520	21.4	17.8
399	² RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC	0.6064	21.1	17.6
401	⁴ LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	1.1899	28.5	23.8

TABLE 3.—FY 2005 LTC-DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY (EFFECTIVE FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2004 THROUGH SEPTEMBER 30, 2005)—Continued

LTC-DRG	Description	Relative weight	Geometric average length of stay	5/6ths of the geometric average length of stay
402	⁸ LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC	0.8508	24.3	20.3
403	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	0.8996	22.0	18.3
404	¹ LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	0.4586	16.9	14.1
405	⁸ ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0-17	0.4586	16.9	14.1
406	⁵ MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC	1.8658	38.6	32.2
407	⁸ MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC	1.1899	28.5	23.8
408	⁴ MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC	1.1899	28.5	23.8
409	RADIO THERAPY	0.9104	22.6	18.8
410	⁴ CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	1.1899	28.5	23.8
411	⁸ HISTORY OF MALIGNANCY W/O ENDOSCOPY	0.4586	16.9	14.1
412	⁸ HISTORY OF MALIGNANCY W ENDOSCOPY	0.4586	16.9	14.1
413	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	0.8807	20.7	17.3
414	² OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC	0.6064	21.1	17.6
415	O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	1.5485	36.5	30.4
416	SEPTICEMIA AGE >17	0.8961	23.9	19.9
417	⁸ SEPTICEMIA AGE 0-17	0.8508	24.3	20.3
418	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	0.8697	24.7	20.6
419	⁴ FEVER OF UNKNOWN ORIGIN AGE >17 W CC	1.1899	28.5	23.8
420	⁴ FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	1.1899	28.5	23.8
421	VIRAL ILLNESS AGE >17	1.0125	25.1	20.9
422	⁸ VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0-17	0.6064	21.1	17.6
423	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	0.9425	22.8	19.0
424	⁵ O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	1.8658	38.6	32.2
425	ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION	0.5649	21.2	17.7
426	DEPRESSIVE NEUROSES	0.5777	26.6	22.2
427	¹ NEUROSES EXCEPT DEPRESSIVE	0.4586	16.9	14.1
428	DISORDERS OF PERSONALITY & IMPULSE CONTROL	0.6617	29.1	24.3
429	ORGANIC DISTURBANCES & MENTAL RETARDATION	0.5767	24.4	20.3
430	PSYCHOSES	0.4746	22.7	18.9
431	CHILDHOOD MENTAL DISORDERS	0.4875	22.0	18.3
432	⁸ OTHER MENTAL DISORDER DIAGNOSES	0.4586	16.9	14.1
433	¹ ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	0.4586	16.9	14.1
439	SKIN GRAFTS FOR INJURIES	1.0808	35.0	29.2
440	WOUND DEBRIDEMENTS FOR INJURIES	1.2254	32.2	26.8
441	² HAND PROCEDURES FOR INJURIES	0.6064	21.1	17.6
442	⁷ OTHER O.R. PROCEDURES FOR INJURIES W CC	1.4772	37.3	31.1
443	⁷ OTHER O.R. PROCEDURES FOR INJURIES W/O CC	1.4772	37.3	31.1
444	⁷ TRAUMATIC INJURY AGE >17 W CC	0.8051	24.4	20.3
445	⁷ TRAUMATIC INJURY AGE >17 W/O CC	0.8051	24.4	20.3
446	⁸ TRAUMATIC INJURY AGE 0-17	0.8508	24.3	20.3
447	³ ALLERGIC REACTIONS AGE >17	0.8508	24.3	20.3
448	⁸ ALLERGIC REACTIONS AGE 0-17	0.8508	24.3	20.3
449	² POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC	0.6064	21.1	17.6
450	¹ POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC	0.4586	16.9	14.1
451	⁸ POISONING & TOXIC EFFECTS OF DRUGS AGE 0-17	0.6064	21.1	17.6
452	COMPLICATIONS OF TREATMENT W CC	0.9938	25.4	21.2
453	COMPLICATIONS OF TREATMENT W/O CC	0.7085	22.0	18.3
454	³ OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC	0.8508	24.3	20.3
455	² OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC	0.6064	21.1	17.6
461	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES	1.2824	35.2	29.3
462	REHABILITATION	0.6569	23.2	19.3
463	SIGNS & SYMPTOMS W CC	0.6631	23.4	19.5
464	SIGNS & SYMPTOMS W/O CC	0.5561	22.7	18.9
465	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	0.6885	20.5	17.1
466	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	0.7286	22.2	18.5
467	² OTHER FACTORS INFLUENCING HEALTH STATUS	0.6064	21.1	17.6
468	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	2.1286	41.7	34.8
469	⁶ PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	0.0000	0.0	0.0
470	⁶ UNGROUPEABLE	0.0000	0.0	0.0
471	⁸ BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY	0.8508	24.3	20.3
473	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	0.8622	20.7	17.3
475	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	2.1015	34.2	28.5
476	³ PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	0.8508	24.3	20.3
477	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	1.5653	35.2	29.3
478	OTHER VASCULAR PROCEDURES W CC	1.4010	33.3	27.8
479	² OTHER VASCULAR PROCEDURES W/O CC	0.6064	21.1	17.6

TABLE 3.—FY 2005 LTC-DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY (EFFECTIVE FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2004 THROUGH SEPTEMBER 30, 2005)—Continued

LTC-DRG	Description	Relative weight	Geometric average length of stay	5/6ths of the geometric average length of stay
480	⁶ LIVER TRANSPLANT	0.0000	0.0	0.0
481	⁸ BONE MARROW TRANSPLANT	1.1899	28.5	23.8
482	⁸ TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES	1.1899	28.5	23.8
484	⁸ CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	1.1899	28.5	23.8
485	⁴ LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TRA.	1.1899	28.5	23.8
486	⁵ OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA	1.8658	38.6	32.2
487	OTHER MULTIPLE SIGNIFICANT TRAUMA	1.1431	24.7	20.6
488	⁵ HIV W EXTENSIVE O.R. PROCEDURE	1.8658	38.6	32.2
489	HIV W MAJOR RELATED CONDITION	0.9854	23.7	19.8
490	HIV W OR W/O OTHER RELATED CONDITION	1.0495	23.3	19.4
491	⁸ MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY	1.8658	38.6	32.2
492	⁸ CHEMOTHERAPY W ACUTE LEUKEMIA OR W USE OF HI DOSE CHEMOAGENT	1.1899	28.5	23.8
493	⁴ LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.1899	28.5	23.8
494	⁸ LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	1.1899	28.5	23.8
495	⁶ LUNG TRANSPLANT	0.0000	0.0	0.0
496	³ COMBINED ANTERIOR/POSTERIOR SPINAL FUSION	0.8508	24.3	20.3
497	³ SPINAL FUSION EXCEPT CERVICAL W CC	0.8508	24.3	20.3
498	⁸ SPINAL FUSION EXCEPT CERVICAL W/O CC	0.8508	24.3	20.3
499	⁴ BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC	1.1899	28.5	23.8
500	¹ BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC	0.4586	16.9	14.1
501	⁴ KNEE PROCEDURES W PDX OF INFECTION W CC	1.1899	28.5	23.8
502	⁴ KNEE PROCEDURES W PDX OF INFECTION W/O CC	1.1899	28.5	23.8
503	⁴ KNEE PROCEDURES W/O PDX OF INFECTION	1.1899	28.5	23.8
504	⁸ EXTENSIVE BURNS OF FULL THICKNESS BURNS WITH MECH VENT 96+HRS WITH SKIN GRAFT.	1.8658	38.6	32.2
505	³ EXTENSIVE BURNS OF FULL THICKNESS BURNS WITH MECH VENT 96+HRS WITHOUT SKIN GRAFT.	0.8508	24.3	20.3
506	⁴ FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA	1.1899	28.5	23.8
507	⁸ FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA	0.8508	24.3	20.3
508	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ W CC OR SIG TRAUMA ..	0.8303	26.0	21.7
509	¹ FULL THICKNESS BURN W/O SKIN GRFT OR INH INJ W/O CC OR SIG TRAUMA	0.4586	16.9	14.1
510	NON-EXTENSIVE BURNS W CC OR SIGNIFICANT TRAUMA	0.9301	26.8	22.3
511	² NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA	0.6064	21.1	17.6
512	⁶ SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT	0.0000	0.0	0.0
513	⁶ PANCREAS TRANSPLANT	0.0000	0.0	0.0
515	⁵ CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH	1.8658	38.6	32.2
516	⁸ PERCUTANEOUS CARDIOVASC PROC W AMI	0.6064	21.1	17.6
517	³ PERC CARDIO PROC W NON-DRUG ELUTING STENT W/O AMI	0.8508	24.3	20.3
518	² PERC CARDIO PROC W/O CORONARY ARTERY STENT OR AMI	0.6064	21.1	17.6
519	³ CERVICAL SPINAL FUSION W CC	0.8508	24.3	20.3
520	⁸ CERVICAL SPINAL FUSION W/O CC	0.8508	24.3	20.3
521	⁷ ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	0.6011	22.2	18.5
522	⁷ ALC/DRUG ABUSE OR DEPEND W REHABILITATION THERAPY W/O CC	0.6011	22.2	18.5
523	⁷ ALC/DRUG ABUSE OR DEPEND W/O REHABILITATION THERAPY W/O CC	0.6011	22.2	18.5
524	TRANSIENT ISCHEMIA	0.6247	22.0	18.3
525	⁸ OTHER HEART ASSIST SYSTEM IMPLANT	1.8658	38.6	32.2
526	⁸ PERCUTNEOUS CARDIOVASCULAR PROC W DRUG ELUTING STENT W AMI	0.8508	24.3	20.3
527	⁸ PERCUTNEOUS CARDIOVASCULAR PROC W DRUG ELUTING STENT W/O AMI ...	0.8508	24.3	20.3
528	⁸ INTRACRANIAL VASCULAR PROC W PDX HEMORRHAGE	1.1899	28.5	23.8
529	⁴ VENTRICULAR SHUNT PROCEDURES W CC	1.1899	28.5	23.8
530	⁸ VENTRICULAR SHUNT PROCEDURES W/O CC	1.1899	28.5	23.8
531	⁴ SPINAL PROCEDURES W CC	1.1899	28.5	23.8
532	¹ SPINAL PROCEDURES W/O CC	0.4586	16.9	14.1
533	⁵ EXTRACRANIAL PROCEDURES W CC	1.8658	38.6	32.2
534	⁸ EXTRACRANIAL PROCEDURES W/O CC	0.4586	16.9	14.1
535	³ CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK	0.8508	24.3	20.3
536	⁵ CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK	1.8658	38.6	32.2
537	LOCAL EXCIS & REMOV OF INT FIX DEV EXCEPT HIP & FEMUR W CC	1.2686	35.2	29.3
538	³ LOCAL EXCIS & REMOV OF INT FIX DEV EXCEPT HIP & FEMUR W/O CC	0.8508	24.3	20.3
539	³ LYMPHOMA & LEUKEMIA W MAJOR OR PROCEDURE W CC	0.8508	24.3	20.3
540	⁸ LYMPHOMA & LEUKEMIA W MAJOR OR PROCEDURE W/O CC	0.6064	21.1	17.6
541	TRAC W MECH VENT 96+HRS OR PDX EXCEPT FACE,MOUTH & NECK DX WITH MAJOR OR.	3.5184	56.2	46.8
542	TRAC W MECH VENT 96+HRS OR PDX EXCEPT FACE,MOUTH & NECK DX WITH-OUT MAJOR OR.	2.9337	45.9	38.3

TABLE 3.—FY 2005 LTC-DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY (EFFECTIVE FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2004 THROUGH SEPTEMBER 30, 2005)—Continued

LTC-DRG	Description	Relative weight	Geometric average length of stay	5/6ths of the geometric average length of stay
543	⁵ CRANIOTOMY W IMPLANT OF CHEMO AGENT OR ACUTE COMPLEX CNS PDX	1.8658	38.6	32.2

¹ Relative weights for these LTC-DRGs were determined by assigning these cases to low-volume quintile 1.

² Relative weights for these LTC-DRGs were determined by assigning these cases to low-volume quintile 2.

³ Relative weights for these LTC-DRGs were determined by assigning these cases to low-volume quintile 3.

⁴ Relative weights for these LTC-DRGs were determined by assigning these cases to low-volume quintile 4.

⁵ Relative weights for these LTC-DRGs were determined by assigning these cases to low-volume quintile 5.

⁶ Relative weights for these LTC-DRGs were assigned a value of 0.0000.

⁷ Relative weights for these LTC-DRGs were determined after adjusting to account for nonmonotonicity (see step 5 above).

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

TABLE 4.—A LISTING OF LONG-TERM CARE HOSPITALS' STATE AND COUNTY LOCATION; MSA-BASED LABOR MARKET AREA DESIGNATION; AND NEW CBSA-BASED LABOR MARKET AREA DESIGNATION ¹

LTCH provider number	Name of LTCH	SSA state and county code ²	MSA-based labor market area ³	CBSA-based labor market area ⁴
012006	USA KNOLLWOOD PARK LTC HOSPITAL	01480	5160	33660
012007	LONG TERM CARE HOSP OF JACKSON, THE	01500	5240	33860
012008	SELECT SPECIALTY HOSP-BIRMINGHAM	01360	1000	13820
012009	LONG TERM CARE HOSPITAL AT MEDICAL CENTER EAST, THE	01360	1000	13820
032000	KINDRED HOSPITAL ARIZONA PHOENIX	03060	6200	38060
032001	SELECT SPECIALTY HOSPITAL ARIZONA INC	03060	6200	38060
032002	KINDRED HOSPITAL-TUCSON	03090	8520	46060
032004	CORNERSTONE HOSPITAL OF SOUTHEAST AZ	03090	8520	46060
032005	SELECT SPECIALTY HOSPITAL ARIZONA INC	03060	6200	38060
042000	SELECT SPECIALTY HOSPITAL	04590	4400	30780
042004	ADVANCE CARE HOSPITAL	04250	04	26300
042005	SEMPERCARE HOSPITAL OF LITTLE ROCK	04590	4400	30780
042006	SELECT SPECIALTY HOSPITAL-FORT SMITH	04650	2720	22900
042007	SEMPERCARE HOSPITAL OF PINE BLUFF	04340	6240	38220
042008	ADVANCE CARE HOSPITAL OF FT SMITH	04650	2720	22900
042009	REGENCY HOSPITAL OF NORTHWEST ARKANSAS	04710	2580	22220
052031	BARLOW HOSPITAL	05200	4480	31084
052032	VENCOR HOSPITAL-LOS ANGELES	05200	4480	31084
052033	VENCOR HOSPITAL-SACRAMENTO	05440	6920	40900
052034	KINDRED HOSPITAL-SF BAY AREA	05000	5775	36084
052035	KINDRED HOSPITAL WESTMINSTER	05400	5945	42044
052036	KINDRED HOSPITAL-SAN DIEGO	05470	7320	41740
052037	VENCOR HOSPITAL-ONTARIO	05460	6780	40140
052038	KINDRED HOSPITAL-SAN GABRIEL VALLEY	05200	4480	31084
052039	KINDRED HOSPITAL BREA	05400	5945	42044
052043	KENTFIELD REHABILITATION HOSPITAL	05310	7360	41884
052044	CONTINENTAL REHABILITATION HOSPITAL	05470	7320	41740
052045	VISTA SPECIALTY HOSPITAL OF SAN GABRIEL VALLEY	05200	4480	31084
052046	PROMISE HOSPITAL OF EAST LOS ANGELES	05200	4480	31084
062008	CMHIP-GENERAL HOSPITAL	06500	6560	39380
062009	KINDRED HOSPITAL DENVER	06150	2080	19740
062011	CRAIG HOSPITAL	06020	2080	19740
062012	COLORADO ACUTE LONG TERM HOSPITAL	06150	2080	19740
062013	SCCI HOSPITAL-AURORA	06150	2080	19740
062014	NORTH VALLEY REHAB HOSPITAL-REHAB	06400	06	06
062015	SELECT SPECIALTY HOSPITAL	06150	2080	19740
062016	SEMPERCARE HOSPITAL OF COLO SPRINGS	06200	1720	17820
072003	GAYLORD HOSPITAL INC	07040	5483	35300
072004	HOSPITAL FOR SPECIAL CARE	07010	3283	25540
082000	SELECT SPECIALTY HOSPITAL WILMINGTON	08010	9160	48864
092002	MEDLINK HOSPITAL OF CAPITOL HILL	09000	8840	47894
092003	HADLEY MEMORIAL HOSPITAL	09000	8840	47894
102001	SELECT SPECIALTY HOSPITAL OF MIAMI	10120	5000	33124
102003	SEMPERCARE HOSPITAL OF ORLANDO	10470	5960	36740
102009	KINDRED HOSPITAL BAY AREA TAMPA	10280	8280	45300
102010	KINDRED HOSPITAL SOUTH FLORIDA	10050	2680	22744
102012	SPECIALTY HOSPITAL JACKSONVILLE	10150	3600	27260

TABLE 4.—A LISTING OF LONG-TERM CARE HOSPITALS' STATE AND COUNTY LOCATION; MSA-BASED LABOR MARKET AREA DESIGNATION; AND NEW CBSA-BASED LABOR MARKET AREA DESIGNATION ¹—Continued

LTCH provider number	Name of LTCH	SSA state and county code ²	MSA-based labor market area ³	CBSA-based labor market area ⁴
102013	KINDRED HOSPITAL CENTRAL TAMPA	10280	8280	45300
102015	KINDRED HOSPITAL NORTH FLORIDA	10090	3600	27260
102016	SISTER EMMANUEL HOSPITAL FOR CONTINUING CARE	10120	5000	33124
102017	SEMPERCARE HOSPITAL OF PANAMA CITY	10020	6015	37460
112000	ROOSEVELT WARM SPRINGS INST FOR REHAB	11740	11	12060
112003	SHEPHERD SPINAL CENTER	11470	0520	12060
112004	KINDRED HOSPITAL - ATLANTA	11470	0520	12060
112005	WESLEY WOODS LTC	11370	0520	12060
112006	DECATUR HOSPITAL	11370	0520	12060
112007	WELLSTAR WINDY HILL HOSPITAL	11290	0520	12060
112008	SPECIALTY HOSPITAL-SELECT AUGUSTA	11840	0600	12260
112009	SELECT SPECIALTY HOSPITAL-ATLANTA	11470	0520	12060
112010	SPECIALTY HOSPITAL AT FLOYD MED CTR	11460	11	40660
112011	SEMPERCARE HOSPITAL OF SAVANNAH	11220	7520	42340
112012	COLUMBUS SPECIALTY HOSPITAL INC	11780	1800	17980
112013	SEMPERCARE HOSPITAL OF AUGUSTA	11840	0600	12260
112014	REGENCY HOSP OF SOUTH ATLANTA	11470	0520	12060
112015	SOUTHERN CRESCENT HOSPITAL FOR SPECIALTY CARE	11280	0520	12060
142006	THC CHICAGO INC DBA KINDRED HOSP	14170	1600	16974
142008	THC CHICAGO INC DBA KINDRED HOSP CHGO	14141	1600	16974
142009	THC CHICAGO INC DBA KINDRED CHICAGO	14141	1600	16974
142010	RML SPECIALTY HOSPITAL	14250	1600	16974
152007	KINDRED HOSPITAL INDIANAPOLIS	15480	3480	26900
152008	KINDRED HOSPITAL INDIANAPOLIS SOUTH	15400	3480	26900
152010	SELECT SPECIALTY HOSPITAL INDIANAPOLIS	15480	3480	26900
152011	ST ELIZABETH ANN SETON HOSPITAL INC	15260	15	15
152012	SELECT SPECIALTY HOSPITAL-NORTHWEST IN	15440	2960	23844
152013	SELECT SPECIALTY HOSPITAL-BEECH GROVE	15480	3480	26900
152014	SELECT SPECIALTY HOSPITAL-EVANSVILLE	15810	2440	21780
152015	ST ELIZABETH ANN SETON HOSPITAL OF CARMEL	15280	3480	26900
152016	SELECT SPECIALTY HOSPITAL-FT WAYNE	15010	2760	23060
152018	OUR LADY OF PEACE HOSPITAL	15700	7800	43780
152019	SELECT SPECIALTY HOSPITAL-BLOOMINGTON	15020	15	18020
152020	ST ELIZABETH ANN SETON HOSPITAL OF INDIANAPOLIS	15480	3480	26900
152021	ST ELIZABETH ANN SETON HOSPITAL OF KOKOMO	15330	3850	29020
152022	HEALTHSOUTH HOSPITAL OF TERRE HAUTE	15830	8320	45460
152024	REGENCY HOSPITAL OF NORTHWEST INDIANA	15440	2960	23844
172003	WICHITA SPECIALTY HOSPITAL	17860	9040	48620
172004	SPECIALTY HOSPITAL OF MID-AMERICA	17450	3760	28140
172005	SELECT SPECIALTY HOSPITAL OF KS CITY	17986	3760	28140
172006	SELECT SPECIALTY HOSPITAL OF TOPEKA	17880	8440	45820
172007	SELECT SPECIALTY HOSPITAL WICHITA	17860	9040	48620
182001	KINDRED HOSPITAL LOUISVILLE	18550	4520	31140
182002	CONTINUING CARE HOSP AT ST JOSEPH EAST	18330	4280	30460
182003	SELECT SPECIALTY HOSPITAL LEXINGTON	18330	4280	30460
182004	CARDINAL HILL SPECIALTY HOSPITAL	18180	1640	17140
192004	ASCENSION HOSPITAL	19020	0760	12940
192006	CORNERSTONE HOSPITAL OF BOSSIER CITY	19070	7680	43340
192007	ADVANCE CARE HOSPITAL	19250	5560	35380
192008	DIXON MEDICAL CENTER	19310	0760	12940
192009	KINDRED HOSPITAL NEW ORLEANS	19350	5560	35380
192010	LAGNIAPPE HOSPITAL	19080	7680	43340
192011	LIFECARE HOSPITAL INC	19080	7680	43340
192012	DUBUIS HOSPITAL OF ALEXANDRIA	19390	0220	10780
192013	CORNERSTONE HOSPITAL OF SOUTHWEST LA	19090	3960	29340
192014	GENESIS SPECIALTY HOSPITAL	19060	19	19
192015	LIFE CARE HOSPITAL OF NEW ORLEANS LLC	19430	5560	35380
192016	ST FRANCIS SPECIALTY HOSPITAL	19360	5200	33740
192019	EXTENDED CARE OF SOUTHWEST LOUISIANA	19090	3960	29340
192020	COMMUNITY REHABILITATION OF LAFAYETTE	19270	3880	29180
192022	HEALTHSOUTH NORTH REHAB HOSPITAL	19300	19	19
192023	SPECIALTY HOSPITAL OF NEW ORLEANS	19350	5560	35380
192024	DUBUIS HOSPITAL OF LAKE CHARLES	19090	3960	29340
192025	DUBUIS HOSPITAL OF SHREVEPORT	19080	7680	43340
192026	COMMUNITY SPECIALTY HOSPITAL OF NORTH LOUISIANA	19550	19	33740
192028	PROFESSIONAL REHABILITATION HOSPITAL	19140	19	19
192029	REHABILITATION HOSP OF ACADIANA	19270	3880	29180
192030	SELECT SPECIALTY HOSPITAL	19250	5560	35380

TABLE 4.—A LISTING OF LONG-TERM CARE HOSPITALS' STATE AND COUNTY LOCATION; MSA-BASED LABOR MARKET AREA DESIGNATION; AND NEW CBSA-BASED LABOR MARKET AREA DESIGNATION ¹—Continued

LTCH provider number	Name of LTCH	SSA state and county code ²	MSA-based labor market area ³	CBSA-based labor market area ⁴
192031	CORNERSTONE HOSPITAL WEST MONROE	19070	7680	43340
192032	LOUISIANA EXTENDED CARE HOSPITAL LAFAYETTE	19270	3880	29180
192033	MEADOWBROOK SPECIALTY HOSPITAL OF LAFAYETTE	19270	3880	29180
192034	ST LANDRY EXTENDED CARE HOSPITAL LLC	19480	3880	19
192035	LOUISIANA EXTENDED CARE HOSPITAL OF NATCHITOCHES	19340	19	19
192036	GULF STATES LTAC OF HAMMOND	19520	19	19
192037	ST ANNE REHABILITATION HOSPITAL	19280	3350	26380
192038	LIFE CARE HOSPITAL OF NEW ORLEANS KENNER REGIONAL	19350	5560	35380
192039	OASIS LONG TERM ACUTE CARE HOSPITAL	19350	5560	35380
192040	SOUTHEAST REGIONAL MEDICAL CENTER	19520	19	19
192041	CLINTON REHABILITATION HOSPITAL	19180	19	12940
192042	LOUISIANA EXTENDED CARE HOSP	19060	19	19
192043	HEALTHSOUTH OF ALEXANDRIA INC	19390	0220	10780
192044	SEMPER CARE HOSPITAL OF BATON ROUGE	19160	0760	12940
192045	CYPRESS REHABILITATION HOSPITAL	19160	0760	12940
192046	BOGALUSA COMMUNITY REHAB HOSPITAL	19580	19	19
192047	HEALTHSOUTH SPECIALTY HOSPITAL OF NEW ORLEANS	19350	5560	35380
192048	DIXON MEDICAL CENTER AT COVINGTON	19510	5560	35380
192049	PROMISE SPECIALTY HOSPITAL OF BATON ROUGE	19160	0760	12940
222000	YOUVILLE REHAB CHRONIC DISEASE HOSP	22090	1123	15764
222002	NORTHEAST SPECIALTY HOSP BRAINTREE	22150	1123	14484
222006	LEMUEL SHATTUCK HOSP	22160	1123	14484
222007	HEBREW REHABILITATION CENTER FOR AGED	22160	1123	14484
222010	JEWISH MEMORIAL HOSPITAL	22160	1123	14484
222026	SHAUGHNESSY-KAPLAN REHAB HOSP HOSP	22040	1123	21604
222027	NEW ENGLAND SINIAI HOSP & REHAB CENTER	22130	1123	14484
222035	SPAULDING REHAB HOSP	22160	1123	14484
222043	SUNHEALTH SPECIALTY HOSPITAL OF SOE MA	22020	1123	39300
222044	VENCOR HOSPITAL NORTH SHORE	22040	1123	21604
222045	KINDRED HOSPITAL-BOSTON	22160	1123	14484
222046	PARK VIEW SPECIALTY HOSPITAL	22070	8003	44140
232012	SELECT SPECIALTY HOSPITAL-FLINT	23240	2640	22420
232019	KINDRED HOSPITAL-DETROIT	23810	2160	19804
232020	BAY SPECIAL CARE CENTER	23080	6960	13020
232021	SELECT SPECIALTY HOSPITAL-WESTERN MICH	23600	3000	34740
232023	SELECT SPECIALTY HOSP-MACOMB CTY INC	23490	2160	47644
232024	SELECT SPECIALTY HOSPITAL-ANN ARBOR	23800	0440	11460
232025	LAKELAND SPECIALTY HOSP AT BERRIEN CTR	23100	0870	35660
232026	LIFECARE HOSPITALS OF WESTERN MICHIGAN	23600	3000	34740
232027	SCCI HOSPITAL-DETROIT	23810	2160	19804
232028	SELECT SPECIALTY HOSPITAL-BATTLE CREEK	23120	3720	12980
232029	SPECTRUM HEALTH-KENT COMMUNITY CAMP	23400	3000	24340
232030 .....	.....	.....	2160	47644
232031	SELECT SPECIALTY HOSPITAL-WYANDOTTE	23810	2160	19804
232032	SELECT SPECIALTY HOSPITAL-NW DETROIT	23810	2160	19804
232033	SELECT SPECIALTY HOSPITAL-SAGINAW	23720	6960	40980
232034	BORGESS-PIPP HEALTH CENTER	23020	3000	23
232035	SELECT SPECIALTY HOSPITAL-KALAMAZOO	23380	3720	28020
232036	CARELINK OF JACKSON, A COMMUNITY-OWNED SPECIALTY H	23370	3520	27100
242004	HEALTHSOUTH BETHESDA LUTHERAN HOME	24610	5120	33460
242005	KINDRED HOSPITAL-MINNESOTA	24260	5120	33460
252003	RESTORATIVE CARE HOSPITAL, THE	25240	3560	27140
252005	SELECT SPECIALTY HOSPITAL-BILOXI	25230	0920	25060
252006 .....	.....	.....	25	25
252007	SELECT SPECIALTY HOSPITAL JACKSON	25240	3560	27140
252008	PROMISE SPECIALTY HOSPITAL OF VICKSBURG	25740	25	25
262001	MISSOURI REHABILITATION CTR	26540	26	26
262010	KINDRED HOSPITAL-ST LOUIS	26950	7040	41180
262011	KINDRED HOSPITAL-KANSAS CITY	26470	3760	28140
262012	ALL SAINTS SPECIAL CARE CENTER	26940	7040	41180
262013	SELECT SPECIALTY HOSPITAL	26940	7040	41180
282000	MADONNA REHABILITATION LTC HOSPITAL	28540	4360	30700
282001	SELECT SPECIALTY HOSPITAL-OMAHA	28760	5920	36540
292002	KINDRED HOSPITAL LAS VEGAS	29010	4120	29820
292003	HORIZON SPECIALTY HOSPITAL	29010	4120	29820
292004	TAHOE PACIFIC HOSPITAL- MEADOWS	29150	6720	39900
292006	HEALTHSOUTH HOSPITAL AT TENAYA	29010	4120	29820
292007 .....	.....	.....	4120	29820

TABLE 4.—A LISTING OF LONG-TERM CARE HOSPITALS' STATE AND COUNTY LOCATION; MSA-BASED LABOR MARKET AREA DESIGNATION; AND NEW CBSA-BASED LABOR MARKET AREA DESIGNATION ¹—Continued

LTCH provider number	Name of LTCH	SSA state and county code ²	MSA-based labor market area ³	CBSA-based labor market area ⁴
312014	MATHENY SCHOOL & HOSPITAL,THE	31350	5015	20764
322002	KINDRED HOSPITAL ALBUQUERQUE	32000	0200	10740
322003	INTEGRATED SPECIALTY HOSPITAL OF ALBUQ	32000	0200	10740
342012	KINDRED HOSPITAL GREENSBORO	34400	3120	24660
342013	LIFECARE HOSPITALS OF NC	34630	6895	40580
342014	HIGHSMITH RAINEY MEMORIAL HOSPITAL	34250	2560	22180
342015	CAROLINAS SPECIALTY HOSPITAL 7TH FLOOR SOUTH	34590	1520	16740
342016	SEMPERCARE HOSPITAL OF WINSTON-SALEM	34330	3120	49180
342017	ASHVILLE SPECIALTY HOSPITAL	34100	0480	11700
342018	SELECT SPECIALTY HOSPITAL DURHAM INC	34310	6640	20500
352004	SCCI HOSPITAL-FARGO	35080	2520	22020
352005	SCCI HOSPITAL-CENTRAL DAKOTA	35290	1010	13900
362004	DRAKE CENTER INC	36310	1640	17140
362007	ST FRANCIS HEALTH CARE CENTRE	36730	36	36
362014	REHABILITATION HOSPITAL AT HEATHER HIL	36280	1680	17460
362015	GRACE HOSPITAL	36170	1680	17460
362016	SELECT SPECIALTY HOSPITAL-NORTHEAST OHIO, INC	36780	0080	10420
362017	SELECT SPECIALTY HOSP-COLUMBUS	36250	1840	18140
362018	SELECT SPECIALTY HOSPITAL-COLUMBUS	36250	1840	18140
362019	SELECT SPECIALTY HOSPITAL-CINC	36310	1640	17140
362020	SCCI HOSPITAL LIMA	36010	4320	30620
362021	SCCI HOSPITAL-MANSFIELD	36710	4800	31900
362022	SELECT SPECIALTY HOSPITAL-COL/	36250	1840	18140
362023	MAHONING VALLEY HOSPITAL	36510	9320	49660
362024	SELECT SPECIALTY HOSPITAL-YOUNGSTOWN	36510	9320	49660
362025	SPECIALTY HOSPITAL OF LORAIN	36480	1680	17460
362026	KINDRED HOSPITAL- CLEVELAND	36170	1680	17460
362027	SELECT SPECIALTY HOSPITAL-AKRON/SHS, INC	36780	0080	10420
362028	LIFE CARE HOSPITAL OF DAYTON	36580	2000	19380
362029	REGENCY HOSPITAL OF AKRON	36780	0080	10420
362030	DRAKE PAVILION, LLC	36310	1640	17140
362031	SELECT SPECIALTY HOSPITAL-ZANESVILLE INC	36610	36	36
372004	KINDRED HOSPITAL OKLAHOMA CITY	37540	5880	36420
372005	EDMOND SPECIALTY HOSPITAL	37540	5880	36420
372006	SELECT SPECIALTY HOSPITAL-TULSA	37710	8560	46140
372007	HILLCREST SPECIALTY HOSPITAL	37710	8560	46140
372008	SELECT SPECIALTY HOSPITAL-OKLA CITY	37540	5880	36420
372009	SELECT SPECIALTY HOSPITAL-OKLA CITY	37540	5880	36420
372011	CONTINUOUS CARE CENTER OF TULSA	37710	8560	46140
372012	SPECIALTY HOSPITAL OF MIDWEST CITY	37540	5880	36420
372014	CONTINUOUS CARE CENTER OF BARTLESVILLE	37730	37	37
372015	CENTRIS	37540	5880	36420
372016	INTEGRIS BASS PAVILION	37230	2340	37
372017	LANE FROST HEALTH AND REHABILITATION CENTER	37110	37	37
372020	ADVANCE CARE HOSPITAL OF OKLAHOMA	37540	5880	36420
392024	LIFECARE HOSPITALS OF PITTSBURGH INC	39010	6280	38300
392025	MERCY SPECIAL CARE HOSPITAL	39480	7560	42540
392026	GIRARD MEDICAL CENTER	39620	6160	37964
392027	KINDRED HOSPITAL PHILADELPHIA	39640	39	39
392028	KINDRED HOSPITAL-PITTSBURGH	39010	6280	38300
392029	SELECT SPECIALTY HOSPITAL O PITTSBURGH	39010	6280	38300
392030	SELECT SPECIALTY HOSPITAL OF PHILA/AEMC	39000	39	39
392031	SELECT SPECIALTY HOSPITAL OF JOHNSTOWN	39160	3680	27780
392032	KINDRED HOSPITAL-DELAWARE COUNTY	39620	6160	37964
392033	GOOD SHEPHERD SPECIALTY HOSPITAL	39470	0240	10900
392034	SCCI HOSPITAL EASTON	39590	0240	10900
392035	SCCI HOSPITAL HARRISBURG	39280	3240	25420
392036	SELECT SPECIALTY HOSPITAL OF GREENSBURG	39770	6280	38300
392037	SELECT SPECIALTY HOSPITAL ERIE	39320	2360	21500
392038	HEALTHSOUTH REHAB HOSP FOR SPECIAL SVS	39270	3240	25420
392039	SELECT SPECIALTY HOSPITAL CTR PA (CP)	39280	3240	25420
392040	SEMPERCARE HOSPITAL OF LANCASTER	39440	4000	29540
392041	HEALTHSOUTH REHAB HOSP OF GREATER PITT	39010	6280	38300
392042	KINDRED HOSPITAL-WYOMING VALLEY	39480	7560	42540
392043	KINDRED HOSPITAL AT HERITAGE VALLEY	39010	6280	38300
392044	SELECT SPECIALTY HOSPITAL PITTSBURGH UPMC	39010	6280	38300
412001	ELEANOR SLATER HOSPITAL	41030	6483	39300
422004	SPARTANBURG HOSP FOR RESTORATIVE CARE	42110	42	42

TABLE 4.—A LISTING OF LONG-TERM CARE HOSPITALS' STATE AND COUNTY LOCATION; MSA-BASED LABOR MARKET AREA DESIGNATION; AND NEW CBSA-BASED LABOR MARKET AREA DESIGNATION ¹—Continued

LTCH provider number	Name of LTCH	SSA state and county code ²	MSA-based labor market area ³	CBSA-based labor market area ⁴
422005	KINDRED HOSPITAL CHARLESTON	42090	1440	16700
422006	INTERMEDICAL HOSPITAL OF SC	42390	1760	17900
422007	REGENCY HOSPITAL OF FLORENCE	42200	2655	22500
422008	NORTH GREENVILLE LONG TERM ACUTE CARE HOSPITAL	42220	3160	24860
432002	SELECT SPECIALTY HOSPITAL	43490	7760	43620
442007	KINDRED HOSPITAL-CHATTANOOGA	44320	1560	16860
442010	BAPTIST MEMORIAL RESTORATIVE CARE HOSP	44780	4920	32820
442011	SELECT SPECIALTY HOSPITAL-NASHVILLE	44180	5360	34980
442012	SELECT SPECIALTY HOSPITAL-KNOXVILLE	44460	3840	28940
442013	METHODIST EXTENDED CARE HOSPITAL	44780	4920	32820
442014	SELECT SPECIALTY HOSPITAL MEMPHIS	44780	4920	32820
442015	SELECT SPECIALTY HOSPITAL-NORTH KNOXVILLE	44460	3840	28940
442016	SELECT SPECIALTY HOSPITAL-TRICITIES	44810	3660	28700
452015	KINDRED HOSPITAL DALLAS	45390	1920	19124
452016	KINDRED HOSPITAL SAN ANTONIO	45130	7240	41700
452017	BAYLOR CENTER FOR RESTORATIVE CARE	45390	1920	19124
452018	HARRIS CONTINUED CARE HOSPITAL	45910	2800	23104
452019	KINDRED HOSPITAL FORT WORTH	45910	2800	23104
452022	SELECT SPECIALTY HOSPITAL-DALLAS	45390	1920	19124
452023	KINDRED HOSPITAL-HOUSTON	45610	3360	26420
452027	SCCI HOSPITAL HOUSTON CENTRAL	45610	3360	26420
452028	KINDRED HOSPITAL-TARRANT COUNTY	45910	2800	23104
452029	HENDRICK CENTER FOR EXTENDED CARE	45911	0040	10180
452031	MEMORIAL SPECIALTY HOSPITAL	45020	45	45
452032	CORNESTONE HOSPITAL OF HOUSTON	45610	3360	26420
452034	CORNERSTONE HOSPITAL OF AUSTIN	45940	0640	12420
452035	MESA HILL SPECIALTY HOSPITAL	45480	2320	21340
452036	CORPUS CHRISTI SPECIALTY HOSPITAL	45830	1880	18580
452038	TEXAS NEURO REHABILITATION CENTER	45940	0640	12420
452039	KINDRED HOSPITAL	45610	3360	26420
452040	SPECIALTY HOSPITAL OF SAN ANTONIO	45130	7240	41700
452041	TEXOMA MEDICAL CTR RESTORATIVE CARE	45564	7640	43300
452042	DUBUIS HOSP OF BEAUMONT	45700	0840	13140
452043	GULF POINTE SPECIALITY HOSPITAL	45610	3360	26420
452044	LIFECARE HOSPITAL OF DALLAS	45390	1920	19124
452045	COMPASS HOSP OF SAN ANTONIO,THE	45130	7240	41700
452046	PLAZA SPECIALTY HOSP	45610	3360	26420
452049	SELECT SPECIALTY HOSPITAL-HOUSTON HEIG	45610	3360	26420
452050	SOUTHWEST REGIONAL SPEC HOSPITAL	45770	4600	31180
452051	EAST TEXAS MED CTR SPECIALTY HOSP	45892	8640	46340
452053	CORNERSTONE HOSPITAL OF CENTRAL TEXAS	45940	0640	12420
452054	PLANO SPECIALTY HOSPITAL	45310	1920	9124
452055	DUBUIS HOSPITAL OF HOUSTON	45610	3360	26420
452056	SCCI HOSPITAL OF VICTORIA	45948	8750	47020
452057	BEACON SPECIALITY HOSPITAL	45610	3360	26420
452059	LIFECARE HOSPITAL OF SAN ANTONIO	45130	7240	41700
452060	SCCI HOSPITAL OF AMARILLO	45860	0320	11100
452061	DUBUIS HOSPITAL OF TEXARKANA	45170	8360	45500
452062	WARM SPRING SPECIALITY HOSPITAL AT LULING	45562	45	45
452063	LIFECARE HOSPITALS OF SOUTH TX INC	45650	4880	32580
452064	SCCI HOSPITAL-SAN ANGELO	45930	7200	41660
452066	PLUM CREEK SPECIALTY HOSPITAL	45860	0320	11100
452067	IHS HOSPITAL AT DALLAS	45390	1920	19124
452068	IHS HOSPITAL AT WICHITA FALLS	45960	9080	48660
452071	KINDRED HOSPITAL-WHITE ROCK	45390	1920	19124
452072	MEMORIAL HERMANN CONTINUING CARE HOSPI	45610	3360	26420
452073	SELECT SPECIALTY HOSPITAL SAN ANTONIO	45130	7240	41700
452074	TRIUMPH HOSPITAL OF NORTH HOUSTON	45610	3360	26420
452075	TRIUMPH HOSPITAL EAST HOUSTON	45610	3360	26420
452077	HOUSTON REHABILITATION ASSOCIATES	45610	3360	26420
452078	SELECT SPECIALTY HOSPITAL SOUTH DALLAS	45390	1920	19124
452079 .....	.....	.....	2320	21340
452080	TRIUMPH HOSPITAL SOUTHWEST	45610	3360	26420
452081	TRIUMPH HOSPITAL NORTHWEST	45610	3360	26420
452082	DUBUIS HOSPITAL OF PARIS	45750	45	45
452083	GOLDEN SPECIALTY MEDICAL CENTER	45840	0840	13140
452084	SELECT SPECIALTY HOSPITAL OF MIDLAND INC	45794	5800	33260
452085	REGENCY HOSPITAL OF ODESSA	45451	5800	36220

TABLE 4.—A LISTING OF LONG-TERM CARE HOSPITALS' STATE AND COUNTY LOCATION; MSA-BASED LABOR MARKET AREA DESIGNATION; AND NEW CBSA-BASED LABOR MARKET AREA DESIGNATION ¹—Continued

LTCH provider number	Name of LTCH	SSA state and county code ²	MSA-based labor market area ³	CBSA-based labor market area ⁴
452086	DUBUIS HOSPITAL OF CORPUS CHRISTI	45830	1880	18580
452087	SEMPERCARE HOSPITAL OF LONGVIEW	45570	4420	30980
452088	KINDRED HOSPITAL FORT WORTH	45910	2800	23104
452089	SELECT SPECIALTY HOSPITAL CONROE	45801	3360	26420
452090 .....	.....	.....	7240	41700
462003	SOUTH DAVIS COMMUNITY HOSPITAL	46050	7160	36260
462004	SALT LAKE SPECIALITY MEDICAL CENTER	46180	46	46
492001	LAKE TAYLOR HOSP	49641	5720	47260
492007	HOSPITAL FOR EXTENDED RECOVERY	49641	5720	47260
502001	REG HOSP FOR RESP AND COMPLEX CARE	50160	7600	42644
502002	KINDRED HOSPITAL-SEATTLE	50160	7600	42644
512002	SELECT SPECIALITY HOSPITAL	51190	1480	16620
522004	KINDRED HSPTL MILWAUKEE	52390	5080	33340
522005	LAKEVIEW REHAB CTR	52500	6600	39540
522006	SELECT SPECIALTY HSPTL MILWAUKEE	52390	5080	33340
522007	LIFECARE HSPTLS OF MILWAUKEE	52390	5080	33340

¹ Missing values denote unavailable information.

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

³ Under the MSA-based labor market area designations, a 4-digit code denotes an urban area and a 2-digit code denotes a rural area.

⁴ Under the CBSA-based labor market area designations, a 5-digit code denotes an urban area and a 2-digit code denotes a rural area.

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