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**Medicare Program; Prospective Payment
System for Long-Term Care Hospitals RY
2009: Proposed Annual Payment Rate
Updates, Policy Changes, and
Clarifications; Proposed Rule**

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412

[CMS-1393-P]

RIN 0938-AO94

Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2009: Proposed Annual Payment Rate Updates, Policy Changes, and Clarifications

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would update the annual payment rates for the Medicare prospective payment system (PPS) for inpatient hospital services provided by long-term care hospitals (LTCHs). In addition, we are proposing to consolidate the annual July 1 update for payment rates and the October 1 update for Medicare severity long-term care diagnosis related group (MS-LTC-DRG) weights to a single fiscal year (FY) update.

In this proposed rule, we are also clarifying various policy issues.

This proposed rule would also describe our evaluation of the possible one-time adjustment to the Federal payment rate.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on March 24, 2008.

ADDRESSES: In commenting, please refer to file code CMS-1393-P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on specific issues in this regulation to <http://www.regulations.gov/>. Follow the instructions for "Comment or Submission" and enter the filecode to find the document accepting comment.

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

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1393-P, P.O. Box 8013, Baltimore, MD 21244-8013.

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

3. *By express or overnight mail.* You may send written comments (one original and two copies) to the following address ONLY:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1393-P, Mail Stop C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786-7195 in advance to schedule your arrival with one of our staff members.

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

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

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

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

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

FOR FURTHER INFORMATION CONTACT:

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

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

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

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

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

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

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

Table of Contents

- I. Background
 - A. Legislative and Regulatory Authority
 - B. Criteria for Classification as a LTCH
 1. Classification as a LTCH
 2. Hospitals Excluded From the LTCH PPS
 - C. Transition Period for Implementation of the LTCH PPS
 - D. Limitation on Charges to Beneficiaries
 - E. Administrative Simplification Compliance Act (ASCA) and Health Insurance Portability and Accountability Act (HIPAA) Compliance
- II. Summary of the Provisions of This Proposed Rule
- III. Medicare Severity Long-Term Care Diagnosis-Related Group (LTC-DRG) Classifications and Relative Weights
 - A. Background
 - B. Patient Classifications into MS-LTC-DRGs
 - C. Organization of MS-LTC-DRGs
 - D. Method for Updating the MS-LTC-DRG Classifications and Relative Weights
 1. Background
 2. FY 2008 MS-LTC-DRG Relative Weights
- IV. Proposed Changes to the LTCH PPS Payment Rates and other Proposed Changes for the 2009 LTCH PPS Rate Year
 - A. Overview of the Development of the Payment Rates
 - B. Proposed Consolidation of the Annual Updates for Payment and MS-LTC-DRG Weights to One Annual Update
 - C. LTCH PPS Market Basket
 1. Overview of the RPL Market Basket
 2. Market Basket Estimate for the 2009 LTCH PPS Rate Year
 - D. Discussion of a One-time Prospective Adjustment to the Standard Federal Rate
 - E. Proposed Standard Federal Rate for the 2009 LTCH PPS Rate Year
 1. Background
 2. Proposed Standard Federal Rate for the 2009 LTCH PPS Rate Year
 - F. Calculation of Proposed LTCH Prospective Payments for the 2009 LTCH PPS Rate Year
 1. Proposed Adjustment for Area Wage Levels
 - a. Background
 - b. Proposed Updates to the Geographic Classifications/Labor Market Area Definitions
 - (1) Background
 - (2) Proposed Update to the CBSA-based Labor Market Area Definitions
 - (3) New England Deemed Counties
 - (4) Proposed Codification of the Definitions of urban and rural under 42 CFR Part 412, subpart O
 - c. Proposed Labor-Related Share
 - d. Proposed Wage Index Data
 2. Proposed Adjustment for Cost-of-Living in Alaska and Hawaii

- 3. Proposed Adjustment for High-Cost Outliers (HCOs)
 - a. Background
 - b. Cost-to-Charge Ratios (CCRs)
 - c. Establishment of the Fixed-Loss Amount
 - d. Application of Outlier Policy to Short-Stay Outlier (SSO) Cases
- 4. Other Proposed Payment Adjustments
- 5. Technical Correction to the Budget Neutrality Requirement at § 412.523(d)(2)
- G. Proposed Conforming Changes
- V. Computing the Proposed Adjusted Federal Prospective Payments for the 2009 LTCH PPS Rate Year
- VI. Monitoring
- VII. Method of Payment
- VIII. RTIs Research
- IX. Collection of Information Requirements
- X. Regulatory Impact Analysis
 - A. Introduction
 - 1. Executive Order 12866
 - 2. Regulatory Flexibility Act (RFA)
 - 3. Impact on Rural Hospitals
 - 4. Unfunded Mandates
 - 5. Federalism
 - 6. Alternatives Considered
 - B. Anticipated Effects of Proposed Payment Rate Changes
 - 1. Budgetary Impact
 - 2. Impact on Providers
 - 3. Calculation of Prospective Payments
 - 4. Results
 - a. Location
 - b. Participation Date
 - c. Ownership Control
 - d. Census Region
 - e. Bed size
 - 5. Effects on the Medicare Program
 - 6. Effects on Medicare Beneficiaries
 - C. Accounting Statement
- Regulations Text
- Addendum
 - Table 1: Proposed Long-Term Care Hospital Wage Index for Urban Areas for Discharges Occurring from July 1, 2008 through September 30, 2009.
 - Table 2: Proposed Long-Term Care Hospital Wage Index for Rural Areas for Discharges Occurring from July 1, 2008 through September 30, 2009.
 - Table 3: FY 2008 MS-LTC-DRG Relative Weights, Geometric Average Length of Stay, Short-Stay Outlier Threshold and IPPS-Comparable Threshold (for Short-Stay Outlier Cases).

Acronyms

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

- 3M 3M Health Information System
- AHA American Hospital Association
- AHIMA American Health Information Management Association
- ALOS Average length of stay
- ALTHA Acute Long Term Hospital Association
- ASCA Administrative Simplification Compliance Act of 2002 (Pub. L. 107–105)
- BBA Balanced Budget Act of 1997 (Pub. L. 105–33)
- BBRA Medicare, Medicaid, and SCHIP [State Children's Health Insurance

- Program] Balanced Budget Refinement Act of 1999 (Pub. L. 106–113)
- BIPA Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Benefits Improvement and Protection Act of 2000 (Pub. L. 106–554)
- BLS Bureau of Labor Statistics
- BN Budget neutrality
- CBSA Core-based statistical area
- CC Complications and comorbidities
- CCR Cost-to-charge ratio
- C&M Coordination and maintenance
- CMI Case-mix index
- CMS Centers for Medicare & Medicaid Services
- COLA Cost of living adjustment
- COP Condition of participation
- CPI Consumer Price Index
- CY Calendar year
- DSH Disproportionate share of low-income patients
- DRGs Diagnosis-related groups
- ECI Employment Cost Index
- FI Fiscal intermediary
- FY Fiscal year
- FFY Federal fiscal year
- HCO High-cost outlier
- HCRIS Hospital cost report information system
- HHA Home health agency
- HHS (Department of) Health and Human Services
- HIPAA Health Insurance Portability and Accountability Act (Pub. L. 104–191)
- HIPC Health Information Policy Council
- HwHs Hospitals within hospitals
- ICD–9–CM International Classification of Diseases, Ninth Revision, Clinical Modification (codes)
- IME Indirect medical education
- I–O Input-Output
- IPF Inpatient psychiatric facility
- IPPS [Acute Care Hospital] Inpatient Prospective Payment System
- IRF Inpatient rehabilitation facility
- LOS Length of stay
- LTC-DRG Long-term care diagnosis-related group
- LTCH Long-term care hospital
- MAC Medicare Administrative Contractor
- MCE Medicare code editor
- MDC Major diagnostic categories
- MedPAC Medicare Payment Advisory Commission
- MedPAR Medicare provider analysis and review
- MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108–173)
- MMSEA Medicare, Medicaid, and SCHIP Extension Act of 2007 (Pub. L. 110–173)
- MSA Metropolitan statistical area
- MS-DRG Medicare severity diagnosis-related group
- MS-LTC-DRG Medicare severity long-term care diagnosis-related group
- NAICS North American Industrial Classification System
- NALTH National Association of Long Term Hospitals
- NCHS National Center for Health Statistics
- OACT [CMS'] Office of the Actuary
- OBRA 86 Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99–509)
- OMB Office of Management and Budget
- OPM U.S. Office of Personnel Management

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

I. Background

A. Legislative and Regulatory Authority

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

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

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

system with a diagnosis-related group (DRG) based patient classification system that reflects the differences in patient resources and costs in LTCHs.

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

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

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

In the August 30, 2002 final rule, we also presented an in-depth discussion of the LTCH PPS, including the patient classification system, relative weights, payment rates, additional payments, and the BN requirements mandated by section 123 of the BBRA. The same final

rule that established regulations for the LTCH PPS under 42 CFR part 412, subpart O, also contained LTCH provisions related to covered inpatient services, limitation on charges to beneficiaries, medical review requirements, furnishing of inpatient hospital services directly or under arrangement, and reporting and recordkeeping requirements. We refer readers to the August 30, 2002 final rule for a comprehensive discussion of the research and data that supported the establishment of the LTCH PPS (67 FR 55954).

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

In the Prospective Payment System for Long-Term Care Hospitals RY 2007: Annual Payment Rate Updates, Policy Changes, and Clarifications final rule (71 FR 27798) (hereinafter referred to as the RY 2007 LTCH PPS final rule), we set forth the 2007 LTCH PPS rate year annual update of the payment rates for the Medicare PPS for inpatient hospital services provided by LTCHs. We also adopted the "Rehabilitation, Psychiatric, Long-Term Care (RPL)" market basket under the LTCH PPS in place of the excluded hospital with capital market basket. In addition, we implemented a zero percent update to the LTCH PPS Federal rate for RY 2007. We also revised the existing payment adjustment for short stay outlier (SSO) cases by reducing part of the existing payment formula and adding a fourth component to that payment formula. We also sunsetted the surgical DRG exception to the payment policy established under the 3-day or less interruption of stay policy. Finally, we clarified the policy at § 412.534(c) for

adjusting the LTCH PPS payment so that the LTCH PPS payment is equivalent to what would otherwise be payable under § 412.1(a).

The Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) (Pub.L. 110-173) was enacted on December 29, 2007 and has various effects on the LTCH PPS. The new law's provisions also have varying time frames of applicability. First, we note that certain provisions of the MMSEA provided that Secretary shall not apply, for cost reporting periods beginning on or after the date of the enactment of the Act (December 29, 2007) for a 3-year period: the extension of payment adjustments at § 412.534 to "grandfathered LTCHs" (a long term care hospital identified by the amendment made by section 4417(a) of Pub. L. 105-33); and the payment adjustment at § 412.536 to "freestanding" LTCHs. In addition, the new law provides that the Secretary shall not apply, for the 3-year period beginning on the date of enactment of the Act the revision to the SSO policy at § 412.529(c)(3)(i) that was finalized in 72 FR 26904 and 26992 and the one-time adjustment to the payment rates provided for in § 412.523(d)(3). The statute also provides that the base rate for RY 2008 be the same as the base rate for RY 2007 (the revised base rate, however, does not apply to discharges occurring on or after July 1, 2007 and before April 1, 2008); for a 3-year moratorium (with specified exceptions) on the establishment of new LTCHs, LTCH satellites, and on the increase in the number of LTCH beds. The new law also revises in the threshold percentages for certain co-located LTCHs and LTCH satellites governed under § 412.534. Finally, the Act provides for an expanded review of medical necessity for admission and continued stay at LTCHs. In this proposed rule we are proposing to establish the applicable Federal rates for RY 2009 consistent with section 1886(m)(2) of the Act as amended by MMSEA. We are also proposing to amend our regulations at § 412.523(d)(3) to change the methodology for the one-time budget neutrality adjustment and to comply with section 114(c)(4) of Pub. L. 110-173. We intend to address all other policy revisions necessitated by the statutory changes of the new law in the future.

B. Criteria for Classification as a LTCH

1. Classification as a LTCH

Under the existing regulations at § 412.23(e)(1) and (e)(2)(i), which implement section 1886(d)(1)(B)(iv)(I) of the Act, to qualify to be paid under the

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

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

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

Fiscal intermediaries (FIs) verify that LTCHs meet the ALOS requirements. We note that the inpatient days of a patient who is admitted to a LTCH without any remaining Medicare days of

coverage, regardless of the fact that the patient is a Medicare beneficiary, will not be included in the above calculation. Because Medicare would not be paying for any of the patient's treatment, data on the patient's stay would not be included in the Medicare claims processing systems. 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 1 remaining benefit day (68 FR 34123).

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

As we stated in the FY 2004 Hospital Inpatient Prospective Payment System (IPPS) final rule, published in the August 1, 2003 **Federal Register**, prior to the implementation of the LTCH PPS, we did rely on data from the most recently submitted cost report for purposes of calculating the ALOS (68 FR 45464). The calculation to determine whether an acute care hospital qualifies for LTCH status was based on total days and discharges for LTCH inpatients. However, with the implementation of the LTCH PPS, for the ALOS specified under § 412.23(e)(2)(i), we revised § 412.23(e)(3)(i) to only count total days and discharges for Medicare inpatients (67 FR 55970 through 55974). In addition, the ALOS specified under § 412.23(e)(2)(ii) is calculated by dividing the total number of days for all patients, including both Medicare and non-Medicare inpatients (less leave or pass days) by the number of total discharges for the hospital's most recent complete cost reporting period. As we discussed in the FY 2004 IPPS final rule, we are unable to capture the necessary data from our existing cost reporting forms (68 FR 45464). Therefore, we notified FIs and LTCHs that until the cost reporting forms are revised, for purposes of calculating the ALOS, we will be relying upon census data extracted from Medicare Provider

Analysis and Review (MedPAR) files that reflect each LTCH's cost reporting period (68 FR 45464). Requirements for hospitals seeking classification as LTCHs that have undergone a change in ownership, as described in § 489.18, are set forth in § 412.23(e)(3)(iv).

2. Hospitals Excluded From the LTCH PPS

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

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

C. Transition Period for Implementation of the LTCH PPS

In the August 30, 2002 final rule (67 FR 55954), we provided for a 5-year transition period. During this 5-year transition period, a LTCH's total payment under the PPS was based on an increasing percentage of the Federal rate with a corresponding decrease in the percentage of the LTCH PPS payment that is based on reasonable cost concepts. However, effective for cost reporting periods beginning on or after October 1, 2006, total LTCH PPS payments are based on 100 percent of the Federal rate.

D. Limitation on Charges to Beneficiaries

In the August 30, 2002 final rule, we presented an in-depth discussion of beneficiary liability under the LTCH PPS (67 FR 55974 through 55975). In the RY 2005 LTCH PPS final rule (69 FR 25676), we clarified that the discussion of beneficiary liability in the August 30, 2002 final rule was not meant to establish rates or payments for, or define Medicare-eligible expenses. Under § 412.507, if the Medicare payment to the LTCH is the full LTC-DRG payment amount, as consistent with other established hospital prospective payment systems, a LTCH may not bill a Medicare beneficiary for more than the deductible and coinsurance amounts as

specified under § 409.82, § 409.83, and § 409.87 and for items and services as specified under § 489.30(a). However, under the LTCH PPS, Medicare will only pay for days for which the beneficiary has coverage until the SSO threshold is exceeded. Therefore, if the Medicare payment was for a SSO case (§ 412.529) that was less than the full LTC-DRG payment amount because the beneficiary had insufficient remaining Medicare days, the LTCH could also charge the beneficiary for services delivered on those uncovered days (§ 412.507).

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

Claims submitted to Medicare must comply with both the Administrative Simplification Compliance Act (ASCA) (Pub. L. 107–105), and Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Pub. L. 104–191). Section 3 of the ASCA requires that the Medicare Program deny payment under Part A or Part B for any expenses incurred for items or services “for which a claim is submitted other than in an electronic form specified by the Secretary.” Section 1862(h) of the Act (as added by section 3(a) of the ASCA) provides that the Secretary shall waive such denial in two specific types of cases and may also waive such denial “in such unusual cases as the Secretary finds appropriate” (68 FR 48805). Section 3 of the ASCA operates in the context of the HIPAA regulations, which include, among other provisions, the transactions and code sets standards requirements codified as 45 CFR parts 160 and 162, subparts A and I through R (generally known as the Transactions Rule). The Transactions Rule requires covered entities, including covered health care providers, to conduct certain electronic healthcare transactions according to the applicable transactions and code sets standards.

II. Summary of the Provisions of This Proposed Rule

In this proposed rule, we propose to revise the LTCH PPS payment rate update cycle and make other policy changes and clarifications. The following is a summary of the major areas that we are addressing in this proposed rule.

In section III. of this proposed rule, we discuss the LTCH PPS patient classification and the relative weights which are linked to the annual adjustments of the acute care hospital inpatient DRG system, and are based on the annual revisions to the International

Classification of Diseases, Ninth Revision, Clinical Modification (ICD–9–CM) codes effective each October 1. In this section, we also summarize the severity adjusted MS–LTC–DRGs and the development of the relative weights for FY 2008 as established in the FY 2008 IPPS final rule with comment period.

In section IV.B. of this proposed rule, we are proposing to extend the rate year cycle for RY 2009 to a 15-month period, from July 1, 2008 through September 30, 2009. We would continue to have an update to the MS–LTC–DRG classifications and weights effective for October 1, 2008. We are proposing to have one consolidated annual update to both the rates and the classifications and weights beginning October 1, 2009.

As discussed in section IV.E.2. of this proposed rule, we are proposing a 3.5 percent market basket update to the LTCH PPS Federal rate for the 2009 LTCH PPS rate year based on the most recent market basket estimate for the proposed 15-month 2009 LTCH PPS rate year. Also in section IV. of this proposed rule, we discuss the prospective payment rate for RY 2009.

In section IV. D. of this proposed rule, we discuss the possible one-time adjustment to the Federal payment rate under § 412.523(d)(3). Consistent with section 114(c)(4) of Public Law 110–173, we are not proposing any adjustment under § 412.523(d)(3). However, at this time, we are proposing to make a change to the methodology and changes reflecting the requirements of section 114(c)(4) of Public Law 110–173 to the regulatory text.

In section VI. of this proposed rule, we discuss the proposed updates to the payment rates, including the proposed revisions to the wage index, the labor-related share, the cost-of-living adjustment (COLA) factors, and the outlier threshold, for the 2009 LTCH PPS rate year.

In section IX. of this proposed rule, we discuss our on-going monitoring protocols under the LTCH PPS.

In section X. of this proposed rule, we present an update of Research Triangle Institute’s (RTI) analysis relating to the development of LTCH patient- and facility-level criteria.

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

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

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

A. Background

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

When the LTCH PPS was implemented for cost reporting periods beginning on or after October 1, 2002, we adopted the same DRG patient classification system (that is, the CMS DRGs) that was utilized at that time under the hospital inpatient prospective payment system (IPPS). As a component of the LTCH PPS, we refer to the patient classification system as the “LTC–DRGs.” As discussed in greater detail below, although the patient classification system used under both the LTCH PPS and the IPPS are the same, the relative weights are different. The established relative weight methodology and data used under the LTCH PPS result in LTC–DRG relative weights that reflect “the different resource use of long-term care hospital patients consistent with the statute”.

As part of our efforts to better recognize severity of illness among patients, in the FY 2008 IPPS final rule with comment period (72 FR 47130), the Medicare Severity diagnosis related groups (MS–DRGs) and the Medicare Severity long-term care diagnosis related groups (MS–LTC–DRGs) were adopted for the IPPS and the LTCH PPS, respectively, effective October 1, 2007 (FY 2008). For a full description of the development and implementation of the MS–DRGs and MS–LTC–DRGs, see the FY 2008 IPPS final rule with comment period (72 FR 47141 through 47175 and 47277 through 47299). (We note that in that same final rule, we revised the regulations at § 412.503 to specify that for LTCH discharges occurring on or

after October 1, 2007, when applying the provisions of this subpart for policy descriptions and payment calculations, all references to LTC-DRGs would be considered a reference to MS-LTC-DRGs. For the remainder of this section, we present the discussion in terms of the current MS-LTC-DRG patient classification unless specifically referring to the previous LTC-DRG patient classification system (that was in effect before October 1, 2007). We believe the MS-DRGs (and by extension, the MS-LTC-DRGs) represent a substantial improvement over the previous CMS DRGs in their ability to differentiate cases based on severity of illness and resource consumption.

The MS-DRGs represent an increase in the number of DRGs by 207 (that is, from 538 to 745) (72 FR 47171). In addition to improving the DRG system's recognition of severity of illness, we believe the MS-DRGs are responsive to the public comments that were made on the FY 2007 IPPS proposed rule with respect to how we should undertake further DRG reform. The MS-DRGs use the CMS DRGs as the starting point for revising the DRG system to better recognize resource complexity and severity of illness. We have generally retained all of the refinements and improvements that have been made to the base DRGs over the years that recognize the significant advancements in medical technology and changes to medical practice.

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

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

detailed discussion of the application of the Lewin Group "quintile" model that was used to develop the LTC-DRGs appears in the August 30, 2002 LTCH PPS final rule (67 FR 55978).) We also account for adjustments to payments for short-stay outlier (SSO) cases (that is, cases where the covered length of stay (LOS) at the LTCH is less than or equal to five-sixths of the geometric ALOS for the MS-LTC-DRG), and we make adjustments to account for nonmonotonicity, when necessary (as described below in this section).

B. Patient Classifications Into MS-LTC-DRGs

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

- Principal diagnosis.
- Up to eight additional diagnoses.
- Up to six procedures performed.
- Age.
- Sex.
- Discharge status of the patient.

Upon the discharge of the patient from a LTCH, the LTCH must assign appropriate diagnosis and procedure codes from the most current version of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). HIPAA Transactions and Code Sets Standards regulations at 45 CFR parts 160 and 162 require that no later than October 16, 2003, all covered entities must comply with the applicable requirements of subparts A and I through R of part 162. Among other requirements, those provisions direct covered entities to use the ASC X12N 837 Health Care Claim: Institutional, Volumes 1 and 2, version 4010, and the applicable standard medical data code sets for the institutional health care claim or equivalent encounter information transaction (see 45 CFR 162.1002 and 45 CFR 162.1102). For additional information on the ICD-9-CM Coding System, refer to the FY 2008 IPPS final rule with comment period (72 FR 47241 through 47243 and 47277 through 47281). We also refer readers to the detailed discussion on correct coding practices in the August 30, 2002 LTCH PPS final rule (67 FR 55981 through 55983). Additional coding instructions and examples are published in the *Coding Clinic for ICD-9-CM*.

Medicare contractors (that is, fiscal intermediaries (FIs), now called Medicare Administrative Contractors (MACs)) 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 MS-LTC-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 68.69, Other and unspecified radical abdominal hysterectomy, would be an inappropriate code for a male.)
- Cases including surgical procedures not covered under Medicare. (For example, organ transplant in a non-approved transplant center.)
- Cases requiring more information. (For example, ICD-9-CM codes are required to be entered at their highest level of specificity. There are valid 3-digit, 4-digit, and 5-digit codes. That is, code 262, Other severe protein-calorie malnutrition, contains all appropriate digits, but if it is reported with either fewer or more than 3 digits, the claim will be rejected by the MCE as invalid.)

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

The GROUPER software is used both to classify past cases to measure relative hospital resource consumption to establish the DRG weights and to classify current cases for purposes of determining payment. The records for all Medicare hospital inpatient discharges are maintained in the MedPAR file. The data in this file are used to evaluate possible MS-DRG classification changes and to recalibrate the MS-DRG and MS-LTC-DRG relative

weights during CMS' annual update under both the IPPS (§ 412.60(e)) and the LTCH PPS (§ 412.517), respectively. As discussed in greater detail in section III.D. of this preamble, with the implementation of section 503(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173), there is the possibility that one feature of the GROUPER software program may be updated twice during a Federal FY (FFY) (October 1 and April 1) as required by the statute for the IPPS (69 FR 48954 through 48957). Specifically, as we discussed in the FY 2008 IPPS final rule with comment period (72 FR 47227 through 47278), diagnosis and procedure codes for new medical technology have the potential to be created and added to existing MS–DRGs (and MS–LTC–DRGs) in the middle of the FFY on April 1. New codes would be added to their predecessor MS–DRGs and MS–LTC–DRGs; no new MS–DRGs would be created. Additionally, this policy change will have no effect on the MS–LTC–DRG relative weights (during the FY), which will continue to be updated only once a year (October 1), nor will there be any impact on Medicare payments under the LTCH PPS during the FY as result of this policy. The use of the ICD–9–CM code set is also compliant with the current requirements of the Transactions and Code Sets Standards regulations at 45 CFR parts 160 and 162, published in accordance with HIPAA.

C. Organization of the MS–LTC–DRGs

The MS–DRGs (used under the IPPS) and the MS–LTC–DRGs (used under the LTCH PPS) are based on the CMS DRG structure. As noted above in this section, we refer to the DRGs under the LTCH PPS as MS–LTC–DRGs although they are structurally identical to the DRGs used under the IPPS. The MS–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). Within most MDCs, cases are then divided into surgical DRGs and medical DRGs. Surgical DRGs are assigned based on a surgical hierarchy that orders operating room (O.R.) procedures or groups of O.R. procedures by resource intensity. The GROUPER software program does not recognize all ICD–9–CM procedure codes as procedures affecting 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).

In developing Version 25.0 of the GROUPER program (the FY 2008 MS–DRGs), the diagnoses comprising the CC list were completely redefined. The revised CC list is primarily comprised of significant acute disease, acute exacerbations of significant chronic diseases, advanced or end stage chronic diseases, and chronic diseases associated with extensive debility. In general, most chronic diseases were not included on the revised CC list. For a patient with a chronic disease, a significant acute manifestation of the chronic disease was required to be present and coded for the patient to be assigned a CC.

In addition to the revision of the CC list, each CC was also categorized as a major CC (MCC) or a CC based on relative resource use. Approximately 12 percent of all diagnoses codes were classified as a major CC (MCC), 24 percent as a CC, and 64 percent as a non CC. Diagnoses closely associated with mortality (ventricular fibrillation, cardiac arrest, shock, and respiratory arrest) were assigned as an MCC if the patient lived but as a non CC if the patient died.

The MCC, CC, and non CC categorization was used to subdivide the surgical and medical DRGs into up to three levels, with a case being assigned to the most resource intensive level (for example, a case with two secondary diagnoses that are categorized as an MCC and a CC is assigned to the MCC level). To create the MS–DRGs (and by extension, the MS–LTC–DRGs) individual DRGs were subdivided into three, two, or one level, depending on the CC impact on resources used for those cases.

As noted above in this section, further information on the development and implementation of the MS–DRGs and MS–LTC–DRGs can be found in the FY 2008 IPPS final rule with comment period (72 FR 47138 through 47175 and 47277 through 47299).

D. Method for Updating the MS–LTC–DRG Classifications and Relative Weights

1. Background

Under the LTCH PPS, relative weights for each MS–LTC–DRG are a primary element used to account for the variations in cost per discharge and resource utilization among the payment groups (that is, the MS–LTC–DRGs). To ensure that Medicare patients classified to each MS–LTC–DRG have access to an appropriate level of services and to encourage efficiency, each year based on the best available data, we calculate a relative weight for each MS–LTC–DRG

that represents the resources needed by an average inpatient LTCH case in that MS–LTC–DRG. For example, cases in a MS–LTC–DRG with a relative weight of 2 will, on average, cost twice as much as cases in a MS–LTC–DRG with a relative weight of 1. Under § 412.517, the MS–LTC–DRG classifications and weighting factors (that is, relative weights) are adjusted annually to reflect changes in factors affecting the relative use of LTCH resources, including treatment patterns, technology and number of discharges.

In the June 6, 2003 LTCH PPS final rule (68 FR 34122 through 34125), we changed the LTCH PPS annual payment rate update cycle to be effective July 1 through June 30 instead of October 1 through September 30. In addition, because the patient classification system utilized under the LTCH PPS is the same DRG system that is used under the IPPS, in that same final rule, we explained that the annual update of the LTC–DRG classifications and relative weights will continue to remain linked to the annual reclassification and recalibration of the CMS DRGs used under the IPPS (as is the case with the MS–DRGs effective for discharges occurring on or after October 1, 2007 (see § 412.503)). Therefore, we specified that we will continue to update the LTC–DRG classifications and relative weights to be effective for discharges occurring on or after October 1 through September 30 each year. We further stated at that time that we will publish the annual proposed and final update of the LTC–DRGs in same notice as the proposed and final update for the IPPS (69 FR 34125). (We note that in section IV.B. of this preamble, we are proposing to revise § 412.535 in order to consolidate the annual July 1 and October 1 LTCH PPS update cycles, so that beginning with FY 2010, both the annual update to the standard Federal rate (and other rate and policy changes) and the annual update to the MS–LTC–DRGs would be presented in a single **Federal Register** publication to be effective on October 1 each year.) Under existing § 412.535(b), the FY 2008 update of the LTCH PPS patient classification system and relative weights was presented in the FY 2008 IPPS final rule with comment (72 FR 47277 through 47299). For the reader's benefit, we are providing a summary of the discussion presented in that final rule with comment in section III.D.2. of this preamble.

For FY 2008, the MS–LTC–DRG classifications and relative weights were updated based on LTCH data from the FY 2006 MedPAR file, which contained hospital bills data from the March 2007

update. The MS-LTC-DRG patient classification system for FY 2008 consists of 745 DRGs that formed the basis of the Version 25.0 GROUPER program utilized under the LTCH PPS. The 745 MS-LTC-DRGs included two "error DRGs." As in the IPPS, we included two error DRGs in which cases that cannot be assigned to valid DRGs will be grouped. These two error DRGs are MS-LTC-DRG 998 (Principal Diagnosis Invalid as a Discharge Diagnosis) and MS-LTC-DRG 999 (Ungroupable). The other 743 MS-LTC-DRGs are the same DRGs used in the IPPS GROUPER program for FY 2008 (Version 25.0).

In the past, the annual update to the CMS DRGs was based on the annual revisions to the ICD-9-CM codes and was effective each October 1. The ICD-9-CM coding update process was revised as discussed in greater detail in the FY 2005 IPPS final rule (69 FR 48953 through 48957). Specifically, section 503(a) of the MMA includes a requirement for updating diagnosis and procedure codes twice a year instead of the former process of annual updates on October 1 of each year. This requirement is included as part of the amendments to the Act relating to recognition of new medical technology under the IPPS. (For additional information on this provision, including its implementation and its impact on the LTCH PPS, refer to the FY 2005 IPPS final rule (69 FR 48953 through 48957) and the RY 2006 LTCH PPS final rule (70 FR 24172 through 24177).) As noted above in this section, with the implementation of section 503(a) of the MMA, there is the possibility that one feature of the GROUPER software program may be updated twice during a FFY (October 1 and April 1) as required by the statute for the IPPS. Specifically, diagnosis and procedure codes for new medical technology may be created and added to existing DRGs in the middle of the FFY on April 1. No new MS-LTC-DRGs will be created or deleted. Consistent with our current practice, any changes to the MS-DRGs or relative weights will be made at the beginning of the next FFY (October 1). Therefore, there will not be any impact on MS-LTC-DRG payments under the LTCH PPS until the following October 1 (although the new ICD-9-CM diagnosis and procedure codes would be recognized April 1).

As we explained in the FY 2008 IPPS final rule with comment period (72 FR 47277), annual changes to the ICD-9-CM codes historically 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. The patient classification system used under the LTCH PPS (MS-LTC-DRGs) is the same DRG patient classification system used under the IPPS, which historically had been updated annually and was effective for discharges occurring on or after October 1 through September 30 each year. We have also explained that since we do not publish a mid-year IPPS rule, we will assign any new diagnosis or procedure codes implemented on April 1 to the same DRG in which its predecessor code was assigned, so that there will be no impact on the DRG assignments until the following October 1. Any coding updates will be available through the Web sites provided in section II.G.10. of the preamble of the FY 2008 IPPS final rule with comment period (72 FR 47241 through 47243) and through the Coding Clinic for ICD-9-CM. Publishers and software vendors currently obtain code changes through these sources to update their code books and software system. If new codes are implemented on April 1, revised code books and software systems, including the GROUPER software program, will be necessary because we must use current ICD-9-CM codes. Therefore, for purposes of the LTCH PPS, because each ICD-9-CM code must be included in the GROUPER algorithm to classify each case into a MS-LTC-DRG, the GROUPER software program used under the LTCH PPS would need to be revised to accommodate any new codes.

At the September 2007 ICD-9-CM C&M Committee meeting, there were no compelling requests for an April 1, 2008 implementation of new ICD-9-CM codes, and therefore, we expect that the next update to the ICD-9-CM coding system will not occur until October 1, 2008 (FY 2009). Therefore, we expect that the ICD-9-CM coding set implemented on October 1, 2007, will continue through September 30, 2008 (FY 2008). The next update to the MS-LTC-DRGs and relative weights for FY 2009 will be presented in the FY 2009 IPPS proposed and final rules.

2. FY 2008 MS-LTC-DRG Relative Weights

In accordance with § 412.523(c), we adjust the LTCH PPS standard Federal rate by the MS-LTC-DRG relative weights in determining payment to LTCHs for each case. Relative weights for each MS-LTC-DRG are a primary element used to account for the variations in cost per discharge and resource utilization among the payment

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

As we discussed in the FY 2008 IPPS final rule with comment period (72 FR 47282), the MS-LTC-DRG relative weights effective under the LTCH PPS for Federal FY 2008 were calculated using the March 2007 update of FY 2006 MedPAR data and Version 25.0 of the GROUPER software.

LTCHs often specialize in certain areas, such as ventilator-dependent patients and rehabilitation or wound care. Some case types (DRGs) may be treated, to a large extent, in hospitals that have (from a perspective of charges) relatively high (or low) charges. Distribution of cases with relatively high (or low) charges in specific MS-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 (HSRV) 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 MS-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 2008 IPPS final rule with comment period for further information on the application of the HSRV methodology under the LTCH PPS (72 FR 47282).)

To account for MS-LTC-DRGs with low volume (that is, with fewer than 25 LTCH cases), we grouped those "low volume" MS-LTC-DRGs into 1 of 5 categories (quintiles) based on average charges for the purposes of determining relative weights. Each of the low volume MS-LTC-DRGs grouped to a specific quintile received the same relative weight and ALOS using the formula applied to the regular MS-LTC-DRGs (25 or more cases). (See the FY 2008 IPPS final rule with comment period for further explanation of the development and composition of each of the 5 low volume quintiles for FY 2008 (72 FR 47283 through 47288).)

After grouping the cases in the appropriate MS-LTC-DRG, generally, we calculated the relative weights by

first removing statistical outliers and cases with a LOS of 7 days or less. Next, we adjusted the number of cases remaining in each MS-LTC-DRG for the effect of SSO cases under § 412.529. The short-stay adjusted discharges and corresponding charges were used to calculate “relative adjusted weights” in each MS-LTC-DRG using the HSRV method. In determining the FY 2008 MS-LTC-DRG relative weights, we also made adjustments, as necessary, to adjust for nonmonotonicity for the severity levels within a specific base MS-LTC-DRG. (Refer to the FY 2008 IPPS final rule with comment period for further information on the treatment of severity levels and adjustments for nonmonotonically increasing relative weights for FY 2008 (72 FR 47282 through 47283 and 47293 through 47295).) Furthermore, we determined FY 2008 MS-LTC-DRG relative weights for the 185 MS-LTC-DRGs for which there were no LTCH cases in the database (that is, LTCH claims from the FY 2006 LTCH MedPAR files). (A list of the FY 2008 “no-volume” MS-LTC-DRGs and further explanation of their FY 2008 relative weight assignment can be found in the FY 2008 IPPS final rule with comment period (72 FR 47289 through 47293).)

In adopting the MS-LTC-DRGs beginning in FY 2008, we established a 2-year transition. Specifically, for FY 2008, the first year of the transition, 50 percent of the relative weight for a MS-LTC-DRG is based on the average LTC-DRG relative weight under Version 24.0 of the LTC-DRG GROUPE. The remaining 50 percent of the relative weight is based on the MS-LTC-DRG relative weight under Version 25.0 of the MS-LTC-DRG GROUPE. (See the FY 2008 IPPS final rule with comment period (72 FR 47295) for additional details on the methodology used to determine the transition blended MS-LTC-DRG relative weights for FY 2008.)

In the FY 2008 LTCH PPS final rule (72 FR 26882), under the broad authority conferred upon the Secretary under section 123 of Public Law 106–113 as amended by section 307(b) of Public Law 106–554 to develop the LTCH PPS, we established that beginning with the update for FY 2008, the annual update to the MS-LTC-DRG classifications and relative weights will be done in a budget neutral manner such that estimated aggregate LTCH PPS payments would be unaffected, that is, would be neither greater than nor less than the estimated aggregate LTCH PPS payments that would have been made without the MS-LTC-DRG classification and relative weight changes. Historically, we had not updated the

LTC-DRGs in a budget neutral manner because we believed that past fluctuations in the relative weights were primarily due to changes in LTCH coding practices rather than changes in patient severity. In light of the most recently available LTCH claims data at that time, which indicated that LTCH claims data no longer appeared to significantly reflect changes in LTCH coding practices in response to the implementation of the LTCH PPS, we believed that, beginning with FY 2008, it is appropriate to update the MS-LTC-DRGs in a budget neutral manner (that is, so that estimated aggregate LTCH PPS payments will neither increase nor decrease). Accordingly, in that same final rule with comment period, we established under § 412.517(b) that the annual update to the MS-LTC-DRG classifications and relative weights be done in a budget neutral manner. (As noted above in section III.A. of this preamble, we revised the regulations at § 412.503 to specify that “MS-LTC-DRG” is used in place of “LTC-DRG” for discharges occurring on or after October 1, 2007.) Consistent with that provision, we updated the MS-LTC-DRG classifications and relative weights for FY 2008 based on the most recent available data and included a budget neutrality adjustment. For further details on the methodology and calculation of the FY 2008 MS-LTC-DRG budget neutrality factor, refer to the FY 2008 IPPS final rule with comment period (72 FR 47295 through 47296).

Table 11 of the Addendum to the FY 2008 IPPS final rule with comment period lists the MS-LTC-DRGs and their respective transition blended budget neutral relative weights, geometric mean LOS, “short-stay outlier threshold” (that is, five-sixths of the geometric mean LOS), and the “IPPS Comparable Threshold” (that is, the IPPS geometric average length of stay plus one standard deviation) for each MS-LTC-DRG for FY 2008 (see (72 FR 48143 through 48157), and the technical correction made in the October 10, 2007 correction notice (72 FR 57733), which has been reprinted in Table 3 of the Addendum of this proposed rule for convenience).

As we noted previously in this section, there were no new ICD–9–CM code requests for an April 1, 2008 update. Therefore, we expect that Version 25.0 of the MS-DRG GROUPE software established in the FY 2008 IPPS final rule with comment period will continue to be effective until October 1, 2008. Moreover, the MS-LTC-DRGs and relative weights for FY 2008 established in Table 11 of that

same IPPS final rule with comment period (78 FR 48143 through 48157) will continue to be effective until October 1, 2008, (just as they would have been even if there had been any new ICD–9–CM code requests for an April 1, 2008 update). We note that Table 11 was corrected in the FY 2008 IPPS correction notice that appeared in the October 10, 2007 **Federal Register** (72 FR 57733) and is hereinafter referred to as the second FY 2008 IPPS correction notice. Accordingly, Table 3 in the Addendum of this proposed rule lists the MS-LTC-DRGs and their respective relative weights, geometric ALOS, “Short-Stay Outlier Threshold” and “IPPS Comparable Threshold” that we will continue to use for the period of July 1, 2008 through September 30, 2009. (As noted above, this table is the same as Table 11 of the Addendum to the FY 2008 IPPS final rule with comment period, including the technical correction made in the second FY 2008 IPPS correction notice (72 FR 57733), which has been reprinted in Table 3 of the Addendum of this proposed rule for the reader's convenience.) We expect the next update to the ICD–9–CM coding system to be presented in the FY 2009 IPPS proposed rule (since we expect that there will be no April 1, 2008 updates to the ICD–9–CM coding system). In addition, the proposed MS-DRGs and GROUPE for FY 2009 that would be used for the IPPS and the LTCH PPS, effective October 1, 2008, and the proposed update to the MS-LTC-DRG relative weights for FY 2009 will be presented in the IPPS FY 2009 proposed rule that will be published in the **Federal Register**.

IV. Proposed Changes to the LTCH PPS Payment Rates and Other Proposed Changes for the 2009 LTCH PPS Rate Year

[If you choose to comment on issues in this section, please include the caption “PROPOSED CHANGES TO LTCH PPS PAYMENT RATES FOR THE 2009 LTCH PPS RATE YEAR” at the beginning of your comments.]

A. Overview of the Development of the Payment Rates

The LTCH PPS was effective beginning with a LTCH's first cost reporting period beginning on or after October 1, 2002. Effective with that cost reporting period, LTCHs are paid, during a 5-year transition period, a total LTCH prospective payment that is comprised of an increasing proportion of the LTCH PPS Federal rate and a decreasing proportion based on reasonable cost-based principles, unless

the hospital makes a one-time election to receive payment based on 100 percent of the Federal rate, as specified in § 412.533. New LTCHs (as defined at § 412.23(e)(4)) are paid based on 100 percent of the Federal rate, with no phase-in transition payments.

The basic methodology for determining LTCH PPS Federal prospective payment rates is set forth at § 412.515 through § 412.536. In this section, we discuss the proposed factors that would be used to update the LTCH PPS standard Federal rate for the 2009 LTCH PPS rate year that would be effective for LTCH discharges occurring on or after July 1, 2008 through September 30, 2009. When we implemented the LTCH PPS in the August 30, 2002 LTCH PPS final rule (67 FR 56029 through 56031), we computed the LTCH PPS standard Federal payment rate for FY 2003 by updating the best latest available (FY 1998 or FY 1999) Medicare inpatient operating and capital cost data, using the excluded hospital market basket.

Section 123(a)(1) of the BBRA requires that the PPS developed for LTCHs be budget neutral for the initial year of implementation. Therefore, in calculating the standard Federal rate under § 412.523(d)(2), we set total estimated LTCH PPS payments equal to estimated payments that would have been made under the reasonable cost-based payment methodology had the LTCH PPS not been implemented. Section 307(a)(2) of the BIPA specified that the increases to the target amounts and the cap on the target amounts for LTCHs for FY 2002 provided for by section 307(a)(1) of the BIPA shall not be considered in the development and implementation of the LTCH PPS. Section 307(a)(2) of the BIPA also specified that enhanced bonus payments for LTCHs provided for by section 122 of Public Law 106–113 were not to be taken into account in the development and implementation of the LTCH PPS.

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

24179 through 24180), RY 2007 LTCH PPS final rule (71 FR 27819 through 27827), and RY 2008 LTCH PPS final rule (72 FR 26870 through 27029).

B. Proposed Consolidation of the Annual Updates for Payment and MS–LTC–DRG Relative Weights to One Annual Update

In the August 30, 2002 final rule for the implementation of the LTCH PPS, we established a publication schedule at § 412.535 for publishing information pertaining to the LTCH PPS. That schedule set a publication date of on or before August 1 prior to the beginning of each FFY, which coincided with the statutorily mandated publication schedule for the IPPS (67 FR 55954). In the June 6, 2003 LTCH PPS final rule, we amended § 412.535 to provide that “(a) Information on the unadjusted Federal payment rates and a description of the methodology and data used to calculate the payment rates are published on or before May 1 prior to the start of each long-term care hospital prospective payment system rate year which begins July 1, unless for good cause it is published after May 1, but before June 1. (b) Information on the LTC–DRG classification and associated weighting factors is published on or before August 1 prior to the beginning of each Federal fiscal year.” At the time, we explained that the LTC–DRG patient classifications used by the LTCH PPS for FY 2003 are based directly on the same version of DRGs used by the IPPS, that is, Grouper 20 (68 FR 34126). (We note, as discussed above in section III of this proposed rule, effective for LTCH PPS discharges occurring on or after October 1, 2007, all references to LTC–DRGs and DRGs in the existing regulations are understood to represent MS–LTC–DRGs. (See § 412.503.)) Therefore, we did not make any changes to the timing for the annual update for LTC–DRG classifications and relative weights. The annual update to the DRG classifications and relative weights continues to be published on a FFY cycle, as is the update of the acute care hospital IPPS DRG system. Our intent in making the change in the payment rate update schedule for the LTCH PPS was to avoid concurrent publications of the annual updates for these two significant payment systems for purposes of administrative feasibility and efficiency. With this in mind, we changed the effective date for the annual update of the LTCH PPS payment rate from October 1 to July 1 of each year beginning with July 1, 2003. We believed this change would help use our limited resources effectively and facilitate a timely publication of both

the IPPS and LTCH PPS proposed and final rules. Thus, currently the annual update of the LTCH PPS Federal rates do not coincide with the start of the FFY, but rather, are effective prior to the FFY.

In this proposed rule, we are proposing a change to the current schedule for the annual updates of the LTCH PPS Federal payment rates. We propose to consolidate the rulemaking cycle for the annual update of the LTCH PPS Federal payment rates and description of the methodology and data used to calculate these payment rates, with the annual updating of the MS–LTC–DRG classifications and associated weighting factors for LTCHs so that the updates to the rates and the weights would both be effective on October 1 each FFY. Under this proposal, the annual updates to the LTCH PPS Federal rates would no longer be published with a July 1 effective date.

In proposing this change to the LTCH PPS rulemaking schedule, we took into account comments on prior rules as well as recent input from the LTCH industry. After further considering those comments and concerns, we agree that having the effective date of the annual update of the LTCH PPS Federal payment rates on July 1 of each year while retaining the October 1 effective date for updating LTC–DRG classifications and weights has proved both burdensome and time-consuming for all parties involved. Although a consolidated update may also be resource intensive, it would eliminate some duplicative resource use. For example, some of our resources used for the payment simulations that are used to estimate LTCH PPS payments for purposes of the respective impact analyses are duplicated for the annual LTCH PPS rate update and the annual MS–LTC–DRG update. Moreover, we understand the concern that there are increased costs involved in updating the billing systems of LTCHs to accommodate two separate updates, one for the Federal rate and one for the DRG weights, in the same cost reporting period.

We also considered the possibility that two separate updates could increase the potential for calculating payment errors under the LTCH PPS.

In order to revise the payment rate update to an October 1 through September 30 period, we propose to first extend the 2009 rate period to September 30, 2009 such that RY 2009 would be 15 months. This proposed 15-month rate period would extend from July 1, 2008 through September 30, 2009. We believe that the additional 3 months to RY 2009 (July, August and

September), would provide for a smooth transition to a consolidated annual update for both the LTCH PPS payment rates and the LTCH PPS MS-LTC-DRG classifications and weighting factors. (We believe that proposing to revise the payment rate update to an October 1 through September 30 period by proposing to shorten RY 2009 such that it would only be 3 months (that is, July 1, 2008 through September 30, 2008), would exacerbate the current burdensome and time-consuming biannual update process by resulting in two payment rate changes within a very short (3 month) period of time.) Under this proposal, after the 2009 rate period, the rate period for the LTCH PPS payment rate and other policy changes would be October 1 through September 30. (The annual update to the MS-LTC-DRG classifications and relative weights would continue to be effective on October 1.) The October through September rate period would first begin with October 1, 2009. The next update to the LTCH PPS Federal rates after RY 2009 would be for RY 2010. (We note that if we finalize this proposal to move the annual LTCH PPS rate update cycle to October 1 effective October 1, 2009, the LTCH PPS rate year would coincide with Federal FY beginning in 2010.) We are proposing to make a change to the regulations at § 412.503 to redefine the LTCH PPS' rate year to mean October 1 through September 30. We are also proposing to revise § 412.535 to reflect the proposed change to the annual payment rate update cycle described above. The discussion of the proposed 15-month market basket update for the proposed 2009 rate year can be found below in sections IV.D.2. and 3. of this proposed rule.

C. LTCH PPS Market Basket

1. Overview of the RPL Market Basket

Historically, the Medicare program has used a market basket to account for price increases in 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 initial LTCH PPS standard Federal rate for FY 2003, using the excluded hospital with capital market basket, is discussed in further detail in the August 30, 2002 LTCH PPS final rule (67 FR 56027 through 56033).

In the August 30, 2002 final rule (67 FR 56016 through 56017 and 56030), which implemented the LTCH PPS, we established the use of the excluded hospital with capital market basket as

the LTCH PPS market basket. The excluded hospital with capital market basket was also used to update the limits on LTCHs' operating costs for inflation under the TEFRA reasonable cost-based payment system. We explained that we believe the use of the excluded hospital with capital market basket to update LTCHs' costs for inflation was appropriate because the excluded hospital market basket (with a capital component) measures price increases of the services furnished by excluded hospitals, including LTCHs. For further details on the development of the excluded hospital with capital market basket, see the RY 2004 LTCH PPS final rule (68 FR 34134 through 34137).

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

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

since it is the best available data that reflects the cost structures of LTCHs.

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

2. Proposed Market Basket Estimate for the 2009 LTCH PPS Rate Year

As discussed in greater detail above in this section, for the 2009 LTCH PPS rate year, we are proposing to consolidate the current LTCH PPS rate year (payment rates and other policy changes) update and fiscal year MS-LTC-DRG update into one annual update cycle. Presently, the next payment rate update cycle would be effective July 1, 2008 through June 30, 2009. In proposing to consolidate the annual payment rate and MS-LTC-DRG updates to be effective October 1 each year, we would extend the next rate year update by 3 months (through September 30, 2009), which would make the RY 2009 rate effective for a 15-month period. Accordingly, for the proposed 2009 LTCH PPS rate year, we are proposing to use a 15-month (that is, July 1, 2008 through September 30, 2009) estimate of the RPL market basket based on the best available data.

Consistent with our historical practice, we estimate the RPL market basket update based on Global Insight, Inc.'s forecast using the most recent available data. Global Insight, Inc. is a nationally recognized economic and financial forecasting firm that contracts with CMS to forecast the components of CMS' market baskets. To determine a 15-month market basket update for RY 2009, we calculate the 5-quarter moving average index level for July 1, 2008 through September 30, 2009 and the 4-quarter moving average index level for July 1, 2007 through June 30, 2008. The percent change in these two values represents the proposed 15-month market basket update.

Based on Global Insight's 4th quarter 2007 forecast with history through the 3rd quarter of 2007, the projected 15-month market basket estimate for the proposed 15-month 2009 LTCH PPS rate year is 3.5 percent. Therefore, consistent with our historical practice of estimating market basket increases based on the best available data, we are proposing a market basket update of 3.5 percent for the proposed 15-month 2009 rate year based on the proposed consolidation of the annual updates for payment rates and MS-LTC-DRGs. Furthermore, because the proposed RY 2009 update is based on the most recent

market basket estimate for the 15-month period (currently 3.5 percent), we are also proposing that if more recent data are subsequently available (for example, a more recent estimate of the market basket), we would use such data, if appropriate, to determine the RY 2009 update in the final rule. (The proposed update to the standard Federal rate for RY 2009 is discussed below in section IV.E. of this preamble.)

We note that the most recent estimate of the RPL market basket for July 1, 2008 through June 30, 2009, based on Global Insight's 4th quarter 2007 forecast with history through the 3rd quarter of 2007, is 3.1 percent. We determine this 12-month market basket update by calculating the 4-quarter moving average index level for July 1, 2008 through June 30, 2009 and the 4-quarter moving average index level for July 1, 2007 through June 30, 2008. The percent change in these two values represents the proposed 12-month market basket update. Consistent with our historical practice of using market basket estimates based on the most recent available data, if we were not proposing to consolidate the two annual LTCH PPS payment system updates by proposing to extend the 2009 LTCH PPS rate year by 3 months, we would have proposed a market basket update for a 12 month RY 2009 of 3.1 percent, based on the most recent estimate of the 12-month RPL market basket for July 1, 2008 through June 30, 2009.

D. One-time Prospective Adjustment to the Standard Federal Rate

As we discussed in the August 30, 2002 LTCH PPS final rule (67 FR 56027), consistent with the statutory requirement for budget neutrality in section 123(a)(1) of the BBRA, we estimated aggregate payments under the LTCH PPS for FY 2003 to be equal to the estimated aggregate payments that would be made if the LTCH PPS were not implemented. Our methodology for estimating payments for purposes of the budget neutrality calculations used the best available data at the time and necessarily reflected several assumptions (for example, costs, inflation factors and intensity of services provided). In conducting our budget neutrality calculations, we took into account the statutory requirement that certain statutory provisions that affect the level of payments to LTCHs in years prior to the implementation of the LTCH PPS shall not be taken into account in the development and implementation of the LTCH PPS. Specifically, section 307(a)(2) of the BIPA requires that the increases to the target amounts and the increases to the

cap on the target amounts for LTCHs provided for by section 307(a)(1) of the BIPA (as set forth in section 1886(b)(3)(J) of the Act) and the enhanced bonus payments for LTCHs provided for by section 122 of the BBRA (as set forth in section 1886(b)(2)(E) of the Act) are not to be taken into account in the development and implementation of the LTCH PPS.

As the LTCH PPS has progressed, we have been monitoring payment data in order to evaluate whether there is a significant difference between the payments estimated on the basis of the data available at the time of the August 30, 2002 LTCH PPS final rule (67 FR 56027 through 56037) and payment estimates based on more complete data that have become available since that time. We indicated from the inception of the LTCH PPS that it was possible for the aggregate amount of actual payments in FY 2003 to be significantly higher or lower than the estimates on which the budget neutrality calculations were based to the extent that later, more complete data differ significantly from the data that were available at the time of the original calculations.

Section 123(a)(1) of the BBRA, as amended by section 307(b) of BIPA, provides broad authority to the Secretary in developing the LTCH PPS, including the authority for establishing appropriate adjustments. Under this broad authority to make appropriate adjustments, we provided in § 412.523(d)(3) of the regulations, for the possibility of making a one-time prospective adjustment to the LTCH PPS rates by July 1, 2008, so that the effect of any significant difference between actual payments and estimated payments for the first year of the LTCH PPS would not be perpetuated in the LTCH PPS rates for future years.

In the RY 2008 LTCH PPS final rule (72 FR 26902), 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 \$4.65 billion for the 2008 LTCH PPS rate year; \$4.85 billion for the 2009 LTCH PPS rate year; \$5.04 billion for the 2010 LTCH PPS rate year; \$5.25 billion for the 2011 LTCH PPS rate year; and \$5.50 billion for the 2012 LTCH PPS rate year.

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

TABLE 4

LTCH PPS rate year	Estimated payments (\$ in billions)
2009	4.67
2010	4.82
2011	5.06
2012	5.36
2013	5.73

In accordance with the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 56027 through 56037), these estimates are based on the most recent available data. These estimates are also based on our estimate of LTCH PPS rate year payments to LTCHs using CMS' Office of the Actuary's (OACT) most recent estimate of the RPL market basket of 3.1 percent for the 2009 LTCH PPS rate year, 2.8 percent for the 2010 LTCH PPS rate year, 3.0 percent for the 2011 LTCH PPS and 2012 rate years, and 3.1 percent for the 2013 LTCH PPS rate year. (We note that OACT develops its spending projections based on existing policy. Therefore, changes that have not yet been implemented, including those proposed in this proposed rule, and changes as a result of the recent Medicare, Medicaid, and SCHIP Extension Act of 2007, are not reflected in the spending projections shown in this section.) We also considered OACT's most recent projections of changes in Medicare beneficiary enrollment that estimate increases in Medicare fee-for-service beneficiary enrollment of 0.6 percent in the 2009 LTCH PPS rate year, 0.7 percent in the 2010 LTCH PPS rate year, 1.2 percent in the 2011 LTCH PPS rate year, 2.0 percent in the 2012 LTCH PPS rate year, and 2.5 percent in the 2013 LTCH PPS rate year. It is important to note that, while we provide these estimates of future payments under the LTCH PPS in order to provide a projected estimate of payments to LTCHs, these estimates will be neither the basis for determining whether the one-time budget neutrality adjustment available under § 412.523(d)(3) should be proposed, nor are these estimates the basis for any of the proposed policy changes presented in this proposed rule. It is important to note that any proposal regarding the one-time budget neutrality adjustment would be based solely on the data related to FY 2003 that would be available at the time of the proposal, rather than on projections of payments under LTCH PPS for future years.

In the August 30, 2002 LTCH PPS final rule implementing the LTCH PPS (67 FR 55954), we set forth the implementing regulations, based upon

the broad authority granted to the Secretary, under section 123 of the BBRA (as amended by section 307(b) of the BIPA). Section 123(a)(1) of the BBRA required that the system “maintain budget neutrality.” The statute requires the LTCH PPS to be budget neutral in FY 2003, so that estimated aggregate payments under the LTCH PPS for FY 2003 should be equal to the estimated aggregate payments that would be made if the LTCH PPS were not implemented for FY 2003. The methodology for determining the LTCH PPS standard Federal rate for FY 2003 that would “maintain budget neutrality” is described in considerable detail in the August 30, 2002 final rule (67 FR 56027 through 56037). As we discussed previously in this section, our methodology for estimating payments for the purposes of budget neutrality calculations used the best available data, and necessarily reflected assumptions in estimating aggregate payments that would be made if the LTCH PPS was not implemented. In the August 30, 2002 final rule, we also stated our intentions to monitor LTCH PPS payment data to evaluate whether later data varied significantly from the data available at the time of the original budget neutrality calculations (for example, data related to inflation factors, intensity of services provided, or behavioral response to the implementation of the LTCH PPS). To the extent the later data significantly differ from the data employed in the original calculations, the aggregate amount of payments during FY 2003 based on later data may be higher or lower than the estimates upon which the budget neutrality calculations were based. In that same final rule, the Secretary exercised his broad authority in establishing the LTCH PPS and provided for the possibility of a one-time prospective adjustment to the LTCH PPS rates by October 1, 2006, in § 412.523(d)(3). This deadline was revised to July 1, 2008, in the RY 2007 LTCH PPS final rule. As we discussed in the RY 2007 LTCH PPS final rule (71 FR 27842 through 27844), because the LTCH PPS was only recently implemented, sufficient new data had not yet been generated that would enable us to conduct a comprehensive reevaluation of our budget neutrality calculations. Therefore, in that same final rule, we did not implement the one-time adjustment provided 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 would not be perpetuated in the PPS rates for

future years. However, we stated that we would continue to collect and interpret new data as it became available in order to determine whether we should propose such an adjustment in the future. Therefore, we revised § 412.523(d)(3) by changing the original October 1, 2006 deadline (established in the August 30, 2002 final rule that implemented the LTCH PPS) to July 1, 2008, to postpone the possible one-time adjustment due to the time lag in the availability of Medicare data upon which a proposed adjustment would be based. We noted that there is a lag time between the submission of claims data and cost report data, and the availability of that data in the MedPAR files and HCRIS, respectively. As also explained in that same final rule, we believed that postponing the deadline of the possible one-time prospective adjustment to the LTCH PPS rates provided for in § 412.523(d)(3) to July 1, 2008, would allow our decisions regarding a possible adjustment to be based on more complete and up-to-date data. It should be noted that, in the years following the initial implementation of the LTCH PPS, we have already adopted some revised policies and adjustments to LTCH PPS payment levels. However, none of these revised policies and payment adjustments have addressed the intended purpose of the adjustment allowed under § 412.523(d)(3) of the regulations, to ensure that any significant difference between the original estimates and calculations based on more recent data are not perpetuated in the LTCH PPS rates for future years. For example, the adjustments that we have made to account for coding changes in excess of real severity increases in RY 2007 and RY 2008 were made to account for changes in coding behavior in the years following the implementation of the LTCH PPS, and not to address any issue regarding the budget neutrality calculations that were used to establish the base rate for the LTCH PPS.

Section 114(c)(4) of MMSEA provides that the “Secretary shall not, for the 3-year period beginning on the date of the enactment of this Act, make the one-time prospective adjustment to long-term care hospital prospective payment rates provided for in section 412.523(d)(3) of title 42, Code of Federal Regulations, or any similar provision.” That provision delays the effective date of any one-time budget neutrality adjustment until no earlier than December 29, 2010. Therefore, we are proposing to revise § 412.523(d)(3) of the regulations to conform with this requirement.

Prior to the enactment of the Medicare, Medicaid, and SCHIP Extension Act of 2007, we had developed a methodology for evaluating whether to propose a one-time budget neutrality adjustment under § 412.523(d)(3) of the regulations. In order to inform the public of our thinking, and to stimulate comments for our consideration during the 3-year delay in implementing any one-time budget neutrality adjustment under the law referenced above, we have decided to discuss our analysis and its results in this proposed rule. Evaluating the appropriateness of the possible one-time prospective adjustment under § 412.523(d)(3) requires a thorough review of the relevant LTCH data (as described below). When we established the FY 2003 standard Federal rate in a budget neutral manner, we used the most recent LTCH cost data available at that time (that is, FY 1999 data), and trended that data forward to estimate what Medicare would have paid to LTCHs in FY 2003 under the TEFRA payment system if the PPS were not implemented for FY 2003 (67 FR 56033). We have conducted a thorough review of the relevant data. We now have cost data from FY 2002, representing the final year LTCHs were paid under the TEFRA payment system. The cost report data for FY 2002 is comprised of a high proportion of settled and audited cost reports submitted by LTCHs. We also have payment data on the first year of the LTCH PPS (that is, FY 2003). On the basis of our review of these data sources, we developed a potential methodology for determining whether the one-time adjustment available under § 412.523(d)(3) of the regulations should be proposed. On the basis of this methodology, we have also determined a potential method for computing an adjustment, if appropriate. Employing that methodology, our analysis has indicated that a permanent adjustment factor of 0.9625 to the LTCH PPS standard Federal rate could be warranted. Consistent with the requirements of section 114(c)(4) of the recently enacted Medicare, Medicaid, and SCHIP Extension Act of 2007, we are not proposing any adjustment for the upcoming rate year. However, we welcome public comment on our analysis, which we are presenting in this proposed rule. We will consider these comments if and when we decide to propose an actual adjustment. We note that in the final rule, we will respond to any comments on our proposed changes to § 412.523(d)(3) of the regulations that would—(1) specify

the methodology for the one-time budget neutrality adjustment; and (2) implement the requirements of section 114(c)(4) of Public Law 110–173, in the final rule.

In order to determine whether a one-time budget neutrality adjustment could be warranted, it is necessary to estimate both aggregate payments under the LTCH PPS for FY 2003 and the estimated aggregate payments that would have been made under the TEFRA system in FY 2003 if the LTCH PPS were not implemented. While we know actual TEFRA payments to LTCHs for FY 2002, the last year of payment under that methodology, it is necessary to estimate what TEFRA payments would have been in FY 2003 if the new LTCH PPS had not been implemented. In developing our methodology for evaluating a one-time adjustment, we considered whether we should employ actual FY 2003 costs to calculate estimated TEFRA payments for FY 2003 or employ costs for FY 2002 trended forward to FY 2003 as the basis for the calculation. Basing the estimate on actual FY 2003 costs would avoid the need to employ any factor to update costs from FY 2002 to FY 2003. However, since FY 2003 was the first year of payment under the LTCH PPS, the cost experience of LTCHs in that year would reflect their response to the incentives provided by the new payment system, instead of reflecting behavior under the reasonable cost payment system. Indeed, implementation of an LTCH PPS should directly affect the behavior of LTCHs, and therefore, the level of costs in LTCHs. One of the incentives of a PPS is to improve efficiency in the delivery of care, which generally results in decreased cost per discharge. For this reason, employing FY 2003 costs directly could be a poor basis for estimating payments that “would have been made if the LTCH PPS were not implemented.” On balance, we believe that trending forward for 1 year the costs incurred under the last year of the TEFRA payment system poses a smaller prospect for distortion than using costs incurred during the subsequent year, when the incentives faced by LTCHs to reduce costs could have had a significant effect. Therefore, we could base our calculation of the estimated aggregate payments that would have been made if the LTCH PPS were not implemented (that is, estimated FY 2003 TEFRA payments) on FY 2002 costs, trended forward to FY 2003 using the excluded hospital market basket. It may be worth noting in this context that some representatives of LTCHs have

expressed concern that employing FY 2003 costs directly would provide a poor basis upon which to estimate payments that “would have been made if the LTCH PPS were not implemented” for precisely the reasons we have just discussed. We believe that basing the estimate of FY 2003 TEFRA payments on FY 2002 costs trended forward should satisfy these concerns.

In determining whether a one-time budget neutrality adjustment could be warranted, the estimate of the payments that would have been made in FY 2003 under the TEFRA methodology should be compared to estimated payments under the new LTCH PPS in FY 2003. The most direct way to determine payments under the new LTCH PPS, of course, is simply to aggregate the actual payments calculated under the LTCH PPS methodology for the discharges that occurred during the first year of the LTCH PPS (FY 2003). However, that approach raises an issue of consistency in the use of data. The discharges for which we paid under the LTCH PPS during FY 2003 are obviously not the same as the discharges for which costs were incurred during the last year of payment under the TEFRA methodology, FY 2002. For the reasons we have just discussed, we believe that the best way to estimate the TEFRA payments that would have been made to LTCHs during FY 2003 is to use inflated FY 2002 costs as a proxy for FY 2003 costs. Comparing actual FY 2003 LTCH PPS payments to FY 2003 TEFRA payments estimated on the basis of FY 2002 discharges would amount to a comparison between payments related to two different sets of discharges, potentially skewing the results. Therefore consistency suggests that, rather than comparing TEFRA payments based on FY 2002 costs updated to FY 2003, to aggregate LTCH PPS payments for discharges that actually occurred in FY 2003, it would be preferable to compare estimated TEFRA payments based on updated FY 2002 costs to the estimated payments that would have been made under LTCH PPS methodology in FY 2003 for those same FY 2002 discharges. In other words, we believe that the best approach would be to compare—

- Estimated aggregate FY 2003 TEFRA payments calculated on the basis of FY 2002 costs updated to FY 2003; to
- Estimated aggregate payments that would have been made in FY 2003 under the LTCH PPS methodology, by applying the FY 2003 LTCH payment rules to the discharges that occurred in FY 2002.

In this way, we would ensure that we are comparing the estimated FY 2003 TEFRA payments, which are based on updated costs incurred for FY 2002 discharges to the estimated PPS payments that would have been made for those same FY 2002 discharges under the new LTCH PPS payment methodology.

Therefore, in the absence of the Medicare, Medicaid, and SCHIP Extension Act of 2007, we would have proposed to employ the general methodology we have just described to determine: (1) Whether the one-time adjustment available under § 412.523(d)(3) of the regulations should be proposed for RY 2009, and (2) if such adjustment should be proposed, the actual proposed adjustment factor. In this proposed rule, we would revise the current language of § 412.523(d)(3) of the regulations to conform more specifically with this preferred methodology. At the time of the final LTCH PPS rule in 2002, we described the nature of the one-time adjustment in very general terms. Specifically, that section currently provides the following:

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

Our policy objective in providing for this one-time budget neutrality adjustment has always been to ensure that computations based on the earlier, necessarily limited (but at that time best available) data available at the inception of the LTCH PPS would not be built permanently into the rates if data available at a later date could provide more accurate results. Prior to the thorough analysis we conducted in preparation for this rate year, we had believed that the only appropriate method for meeting this policy objective involved employing actual payment data from the first year of payment under the LTCH. As we have just discussed, we believe after a thorough evaluation of the currently available data in the light of this policy objective, that the most appropriate methodology for evaluating an adjustment to the original budget neutrality adjustment does not involve comparing the payments estimated in the original calculations against the “actual payments * * * for the first year,” strictly speaking. Rather, as just

discussed, considerations of consistency and other factors suggest that the most appropriate comparison would employ an estimate of FY 2003 LTCH PPS payments based on the same set of discharges (from FY 2002) which are the basis for the best estimate of what would have been paid in FY 2003 under the TEFRA system. As a result of this methodological determination, under the broad authority of section 123 of the BBRA, as amended by section 307(b) of BIPA, to make appropriate adjustments to the LTCH PPS, we are proposing to revise § 412.523(d)(3) to reflect the preferred methodology more clearly. As we have discussed previously, we are also proposing to revise that section of the regulations to correspond with the requirements of section 114(c)(4) of the Medicare, Medicaid, and SCHIP Extension Act of 2007. Specifically, we are now proposing to revise § 412.523(d)(3) of the regulations to read as follows:

The Secretary reviews payments under this prospective payment system and may make a one-time prospective adjustment to the long-term care hospital prospective payment system rates no earlier than December 29, 2010, so that the effect of any significant difference between the data used in the original computations and more recent data to determine budget neutrality is not perpetuated in the prospective payment rates for future years.

Our proposed revision to § 412.523(d)(3) of the regulations would continue to provide that the Secretary may make a one-time adjustment to the LTCH PPS rates in order to ensure that any “significant” difference is not perpetuated in the LTCH PPS rates for future years. The regulation does not specifically define what constitutes a significant difference for this purpose. In the absence of section 114(c)(4) of the Medicare, Medicaid, and SCHIP Extension Act of 2007, we would have proposed to consider as “significant” any difference greater than or equal to a 0.25 percentage point difference between the original budget neutrality calculations and budget neutrality calculations based on the more recent data now available. This threshold avoids making an adjustment to account for very minor deviations between earlier and later estimates of budget neutrality. It is also consistent with thresholds that we have employed for similar purposes in prospective payment systems. For example, under the capital IPPS, we make a forecast error correction in the framework used to update the capital Federal rate if a previous forecast of input prices varies by at least a 0.25 percentage point from actual input price changes (72 FR

47425). We do not believe that we should treat differences greater than or equal to 0.25 percent as not “significant,” since the effect of any difference will be magnified as the rates are updated each year.

As discussed previously, absent the requirement of section 114(c)(4) of the Medicare, Medicaid and SCHIP Extension Act of 2007, we would have proposed to use FY 2002 LTCH costs as a basis for estimating FY 2003 LTCH TEFRA payments in evaluating whether to propose a one-time prospective adjustment under § 412.523(d)(3). We also would have proposed to update the FY 2002 costs for inflation to FY 2003 by our Office of the Actuary’s current estimate of the actual increase in the excluded hospital market basket from FY 2002 to FY 2003 of 4.2 percent. This updated amount would serve as the proxy for actual FY 2003 TEFRA costs in the proposed budget neutrality computation for purposes of § 412.523(d)(3). We estimated FY 2003 LTCH TEFRA payments using a methodology that is similar in concept to the methodology we used to estimate FY 2003 LTCH total payments under the TEFRA system when we determined the initial standard Federal rate in the August 30, 2002 final rule (67 FR 56030 through 56033). We also made modifications to the methodology we initially used to estimate FY 2003 LTCH TEFRA payments because we are using data from a later period, as discussed in greater detail below. In general, we estimated total payments under the TEFRA payment system using the following steps:

- Estimate each LTCH’s payment per discharge for inpatient operating costs under the TEFRA system for FY 2003;
- Estimate each LTCH’s payment per discharge for capital-related costs for FY 2003; and
- Sum each LTCH’s estimated operating and capital payment per case to determine its estimated total FY 2003 TEFRA payment system payment per discharge.

We discuss each of these steps in greater detail below.

The first step in the process of estimating total FY 2003 payments under the TEFRA payment system is to estimate each LTCH’s payment per discharge for inpatient operating costs under the TEFRA. Until FY 1998, the payment methodology for inpatient operating costs under the TEFRA payment system was a relatively straightforward process. First, we calculated a target amount by dividing the Medicare total inpatient operating costs in a base year by the number of

Medicare discharges. The provider’s TEFRA target amount was then updated by a rate-of-increase percentage (§ 413.40(c)(3) of the regulations, as established by the Congress, to determine the TEFRA target amount for the subsequent cost reporting period (§ 413.40(c)(4)(i), (ii)). For any particular cost reporting period, the Medicare payment for inpatient operating costs would be the lesser of the hospital’s reasonable costs, or the updated target amount multiplied by the number of Medicare discharges during the cost reporting period, that is, the TEFRA ceiling (§ 413.40(a)(3)).

The methodology described above, broadly speaking, is the general approach that we would use to arrive at an estimate of what Medicare payments for hospital inpatient operating costs would have been in FY 2003 under the TEFRA payment system: each LTCH’s FY 2003 target amount would be calculated by updating its estimated FY 2002 target amount per discharge by the full market basket percentage increase. The sum of all LTCH payments for operating costs (TEFRA target amount multiplied by Medicare discharges), bonus or relief payments, continuous improvement bonus payments, and payments for capital-related costs yields, in general, the estimate of what total Medicare payments to LTCHs would be in FY 2003 under the TEFRA payment system if the LTCH PPS had not been implemented.

However, because sections 4413 through 4419 of the BBA of 1997, section 122 of the BBRA of 1999, and section 307(a)(1) of the BIPA made numerous changes to the TEFRA payment system, we had to make variations in the method described above to arrive at the estimate of FY 2003 payments for the inpatient operating costs of each LTCH under the TEFRA system, depending on the participation date of the hospital. Specifically, we must make the requisite computations differently for two classes of hospitals, “existing” hospitals and “new” hospitals. (A detailed explanation of the provisions affecting LTCHs, established by each of the amendments, is found in the August 30, 2002 final rule that implemented the LTCH PPS (67 FR 55959).) We discuss below these specific BBA, BBRA, and BIPA changes, and their impact on the calculations of estimated FY 2003 TEFRA payments for “existing” and “new” hospitals. As discussed in greater detail below, we would employ two approaches to estimate Medicare payments under the TEFRA system to LTCHs in FY 2003, depending on how these changes in calculating TEFRA

payments, as established by the amendments, applied to each LTCH.

The first set of changes that we had to take into account were included in the BBA. The BBA made significant changes to the TEFRA payment methodology starting with cost reporting periods beginning on or after October 1, 1997. While the changes were applicable to three types of PPS-excluded providers (rehabilitation hospitals and units, psychiatric hospitals and units, and LTCHs), the following discussion will address the provisions of the amendments as they relate to LTCHs.

The first change to consider under BBA is section 4414 that established caps on the TEFRA target amounts for cost reporting periods beginning on or after October 1, 1997, for LTCHs that were paid as IPPS excluded providers prior to that date. The cap was determined by taking the 75th percentile of target amounts for cost reporting periods ending in FY 1996 for each class of provider (rehabilitation hospitals and units, psychiatric hospitals and units, and LTCHs), updating that amount by the market basket percentage increases to FY 1998, and applying it to the cost reporting period beginning on or after October 1, 1997 (62 FR 46018). The cap calculated for FY 1998 was updated by the applicable market basket percentages to determine the cap amounts for cost reporting periods beginning during FY 1999 through 2002. Providers subject to the 75th percentile cap were paid the lesser of their inpatient operating costs or the TEFRA target amount, which was limited by the 75th percentile cap amount (67 FR 55959). In addition, section 4411 of the BBA established a formula for calculating the update factor for FY 1999 through FY 2002 that was dependent on the relationship of a provider's inpatient operating costs to its ceiling amount based on data from the most recently available cost report. Section 121 of the BBRA provided that the 75th percentile cap amount should be wage adjusted starting with cost reporting periods beginning on or after October 1, 1999 and before October 1, 2002.

The second change that we had to take into account was section 4415 of the BBA. This provision revised the percentage factors used to determine the amount of bonus and relief payments for LTCHs meeting specific criteria. If a provider's net inpatient operating costs did not exceed the hospital's ceiling, a bonus payment was made to the LTCH (§ 413.40(d)(2) of the regulations). The bonus payment was the lower of 15 percent of the difference between the

hospital's inpatient operating costs and the ceiling, or 2 percent of the ceiling. In addition, relief payments were made to providers whose net inpatient operating costs were greater than 110 percent of the ceiling (or the adjusted ceiling, if applicable). These relief payments were the lower of 50 percent of the costs in excess of 110 percent of the ceiling or (or the adjusted ceiling, if applicable) or 10 percent of the ceiling (or adjusted ceiling, if applicable) (§ 413.40(d)(3)(ii) of the regulations).

The third change was an additional incentive established by section 4415 of the BBA, the continuous improvement bonus payment (CIB) for providers meeting certain conditions and that kept their costs below the target amount. Eligibility for the CIB required that a provider had three full cost reporting periods as an IPPS-excluded provider prior to the applicable fiscal year (62 FR 46019). To qualify for a CIB, a provider's operating costs per discharge in the current cost reporting period had to be lower than the least any of the following: its target amount; its expected costs, that is, the lower of its target amount or inpatient operating costs per discharge from the previous cost reporting period, updated; or, its trended costs, that is, the inpatient operating costs per discharge from its third full cost reporting period, updated by the market basket percentage increase to the applicable fiscal year (62 FR 46019, § 413.40(d)(5)(ii)(B) of the regulations). For providers with their third or subsequent full cost reporting period ending in FY 1996, trended costs are the lower of their inpatient operating costs per discharge or target amount updated forward to the current year (§ 413.40(d)(5)(ii)(A) of the regulations). The CIB payment equals the lesser of 50 percent of the amount by which the operating costs were less than expected costs, or, 1 percent of the ceiling (§ 413.40(d)(4) of the regulations). Section 122 of the BBRA increased this percentage for LTCH's for FY 2001 to 1.5 percent of the ceiling, and beginning in FY 2002, to 2 percent of the ceiling (§ 413.40(d)(4)(ii) and (iii) of the regulations). The increase in the CIB percentage is not to be accounted for in the development and implementation of the LTCH PPS in accordance with section 307(a)(2) of BIPA.

The fourth change that we had to take into account was section 4416 of the BBA which significantly revised the payment methodology for "new" IPPS-excluded providers. This provision applies to three classes of providers—psychiatric hospitals and units, rehabilitation hospitals and units, and LTCHs—that were not paid as excluded

hospitals prior to October 1, 1997. The payment amount for a new provider for the first 12-month cost reporting period is the lower of its Medicare inpatient operating cost per discharge or a limit based on 110 percent of the national median of target amounts for the same class of hospital for cost reporting periods ending in FY 1996, updated by the market basket percentage increases to the applicable period, and wage-adjusted. The payment limit in the second 12-month cost reporting period is the same 110 percent limit as for the first year (§ 413.40(f)(2)(ii) of the regulations). A new provider's target amount would be established in its third cost reporting period by updating the amount paid in its second cost reporting period by the market basket percentage increase for hospitals and hospital units excluded from the IPPS, applicable to the specific year, as published annually in the **Federal Register**, which then becomes the target amount for its third cost reporting period. The target amount for the fourth and subsequent cost reporting periods is determined by updating the target amount from the previous cost reporting period by the applicable market basket percentage increase.

Finally, two provisions under BIPA were directed specifically at LTCHs. Section 307(a)(1) of BIPA provided a 2 percent increase to the wage-adjusted 75th percentile cap for existing LTCHs for cost reporting periods beginning in FY 2001, and a 25 percent increase to the target amount for LTCHs, subject to the increased 75th percentile cap. However, it is important to note that in accordance with section 307(a)(2) of BIPA, the 2 percent increase to the 75th percentile cap and the 25 percent increase to the target amount were not to be taken into account in the development and implementation of the LTCH PPS.

In order to determine what a LTCH's estimated payments would be under TEFRA in FY 2003, we utilized cost report data for LTCHs from the Hospital Cost Reporting Information System (HCRIS) for FYs 1999 through 2002. In addition, to determine whether a LTCH is "new," the certification date for each LTCH was obtained from the On-line Survey & Certification Automated Reporting (OSCAR) file. Based on the certification date, a LTCH would either be a "new" LTCH, meaning a LTCH that was not paid as an excluded hospital prior to October 1, 1997, or, an "existing" LTCH, meaning a LTCH that was paid as an excluded hospital prior to October 1, 1997. This could include a LTCH that was certified as an LTCH on or after October 1, 1997, but was

previously paid as another type of IPPS-excluded provider prior to October 1, 1997. Our approach to estimating Medicare payments in FY 2003 under the TEFRA payment system varied somewhat, depending on whether an LTCH was “existing” or “new” (as discussed in greater detail below).

Based on all these statutory changes mentioned above, the first step would be to estimate FY 2003 inpatient operating payments under the TEFRA system for “existing” LTCHs. “Existing” LTCHs are those receiving payment as IPPS-excluded providers in cost reporting periods prior to FY 1998. These LTCHs were subject to the 75th percentile cap on their target amounts. While section 307(a)(1) of BIPA provided for a 2 percent increase to the 75th percentile cap amount for LTCH’s for cost reporting periods beginning in FY 2001 and a 25 percent increase to the target amount for cost reporting periods beginning in FY 2001 (subject to the limiting or cap amount determined under section 1886(b)(3)(H) of the Act), section 307(a)(2) of BIPA precluded accounting for these increases in developing the LTCH PPS. In addition, section 122 of the BBRA increased the CIB payment percentage to 1.5 percent for FY 2001 and 2.0 percent for FY 2002 (§ 413.40(d)(4)(ii) and (iii) of the regulations). But these increases, also, are not to be accounted for in the development and implementation of the LTCH PPS in accordance with section 307(a)(2) of BIPA. Therefore, to ensure that these increases would be excluded from the computations, as required by the statute, we estimated an existing LTCH’s FY 2003 target amount by starting with the hospital’s target amount from the FY 2000 cost report, the year prior to when these increases were effective. Target amounts and payments for FY 2003 were simulated using the FY 2000 target amount in the hospital’s cost report and updating the target amount for each subsequent cost reporting period by the applicable rate-of-increase percentage as described in § 413.40(c)(3)(vii) through FY 2002. The target amount from FY 2002 is updated by the forecasted market basket percentage increase of 3.5 percent to arrive at the FY 2003 target amount (§ 413.40(c)(3)(viii)). (Note, the forecasted increase in the excluded hospital market basket for FY 2003 of 3.5 percent was the applicable rate-of-increase percentage used to update TEFRA target amounts in accordance with § 413.40(c)(3)(viii) in the FY 2003 IPPS final rule (August 1, 2002, 67 FR 50289)). Based on more recent data, our Office of the Actuary currently estimates

an increase of 4.2 percent in the excluded hospital market basket for FY 2003, which we used to update LTCHs’ FY 2002 costs to FY 2003, as described below.) In a small number of cases where FY 2002 operating cost data were not available, we used operating cost data from the most recent year available and trended it forward to FY 2003. In addition, we estimated FY 2003 bonus or relief payments without the inclusion of the 2 percent and 25 percent increases to the cap amount and target amount, respectively, and without the 1.5 percent and 2.0 percent increases to the CIB payments, consistent with section 307(a)(2) of BIPA as discussed above.

In addition, since comparisons are made between the target amount and Medicare inpatient operating costs to determine bonus or relief payments, we estimated FY 2003 operating costs for each LTCH by updating its FY 2002 operating costs by the actual percentage increase in operating costs for PPS-excluded hospitals from FY 2002 to FY 2003 (4.2 percent, as determined by OACT). The 3.5 percent market basket increase used to update the TEFRA target amounts from FY 2002 to FY 2003 was the forecast increase used at that time based on the most recent information from OACT, at that time. However, because we now have more recent data available for estimating the market basket increase for IPPS-excluded hospitals from FY 2002 to FY 2003, we are using that more recent data which OACT currently estimates that the IPPS-excluded hospital market basket increase from FY 2002 to FY 2003 is 4.2 percent. As discussed earlier, we estimated the FY 2003 operating costs using FY 2002 costs rather than use the costs reported on the FY 2003 cost report.

The 75th percentile cap for LTCHs for FY 2002, without the 2 percent and 25 percent increases to the cap and target amount, respectively, was \$30,783 for the wage-index adjusted labor-related share, and \$12,238 for the nonlabor-related share. If a LTCH’s costs and hospital-specific target amount were above the 75th percentile cap, Medicare’s payment under the TEFRA system would be the wage-index adjusted cap amount. If under our payment model a LTCH’s estimated FY 2002 TEFRA payment would have been limited by the wage-adjusted 75th percentile cap in FY 2002, that amount would be updated by the forecasted market basket percentage increase (of 3.5 percent) to FY 2003 to determine the LTCH’s FY 2003 target amount that was used to estimate its TEFRA payment amount for FY 2003.

The second approach that we used to estimate FY 2003 hospital operating payments under the TEFRA system applied to “new” LTCHs. A “new” LTCH is one that was first paid as an IPPS excluded hospital on or after October 1, 1997. For a “new” LTCH, payment in the hospital’s first 12-month cost reporting period is the lower of its Medicare net inpatient operating costs per discharge or the wage-adjusted 110 percent median amount determined for that particular year (§ 413.40(f)(2)(ii) of the regulations). For the hospital’s second 12-month cost reporting period, payment is the lower of their costs, or the same 110 percent median amount that was used in the first cost reporting period, that is, it is not updated. The hospital’s “target amount” is established in the third cost reporting period by updating the per discharge amount that was paid in the prior cost reporting period by the estimated market basket percentage increase for hospitals and hospital units excluded from the IPPS, applicable to the specific year, as published annually in the **Federal Register**. Therefore, if the LTCH was paid its costs in the previous cost reporting period because costs were lower than the 110 percent median amount, the hospital’s cost per discharge for the second cost reporting period is updated and becomes the target amount for the hospital’s third cost reporting period. Target amounts for subsequent cost reporting periods are determined by updating the previous year’s target amount by the applicable market basket percentage increase.

New LTCHs with their first 12-month cost reporting period beginning in FY 1998, would have had a target amount calculated under section 1886(b)(7)(A)(ii) of the Act, in FY 2000. Therefore, as with the “existing” LTCH’s, in estimating the FY 2003 target amount, we used the target amount from the FY 2000 cost report for those LTCHs and update that target amount by the applicable estimated market basket percentage increases as published annually in the **Federal Register** for the IPPS final rule, without the 25 percent increase, to FY 2003. For LTCH’s with their first 12-month cost reporting period beginning in FY 1999, we used the lower of their costs or target amount from their FY 2000 cost report, and updated that amount by the applicable estimated market basket percentage increase to establish the target amount in FY 2001, without the 25 percent increase. From this point, we would continue to update that target amount by the estimated market basket

percentage increases to FY 2003. It is necessary to compute an estimated target amount for LTCHs that are “new” in FY 1999 in order to eliminate the potential inclusion of the increase to the target amounts provided for by section 307(a)(1) of BIPA (consistent with the statute).

The 25 percent increase (under section 307(a) of the BIPA) to the target amount was not an issue for LTCHs with their first 12-month cost reporting period beginning in FYs 2000, 2001, and 2002 because they would not have a “target amount” based on sections 1886(b)(7)(A)(ii) of the Act, in FY 2001. Rather, for these LTCHs, we would have proposed to determine the estimated payment amount for their first 12-month cost reporting period by looking at their certification date from the OSCAR file, the applicable 110 percent median amount (adjusted by their wage-index) and their costs from the applicable cost report, and then proceed in accordance with the policy in § 413.40(f)(2)(ii) of the regulations, to arrive at estimated FY 2003 TEFRA payments.

In addition to the TEFRA payments for operating costs, and any bonus or relief payments made, we also added \$10 million as an estimate of the CIB payments that would have been made in FY 2003 under the TEFRA payment system. We estimated this payment by using actual CIB payments from the cost reports for FYs 1999 and 2000 as they would not include the statutory increases to the target amount as discussed above, and recalculated CIB payments for FYs 2001 and 2002 based on cost report data. Based on these historical CIB payments, we estimated that CIB payments in FY 2003 would have been approximately \$10 million. Just as the TEFRA payments and bonus and relief payments had to be recalculated in particular years to eliminate percentage increases that were not to be included in our budget neutrality calculations, it was necessary to recalculate the CIB payments in FYs 2001 and 2002 to eliminate the percentage increases to these payments as provided for under section 122 of BBRA, but not to be accounted for in the development of the LTCH in accordance with section 307(a)(2) of BIPA.

As we discussed above, the second step in estimating total payments under the TEFRA payment system is to estimate each LTCH's payment per discharge for capital-related costs. Under the TEFRA system, in accordance with section 1886(g) of the Act, Medicare allowable capital costs are paid on a reasonable cost basis. Therefore, we took each LTCH's payment for capital-related costs

directly from the FY 2002 cost report and updated it for inflation using the FY 2003 capital excluded hospital market basket estimate of 0.7 percent, consistent with the methodology used in the August 30, 2002 final rule (67 FR 56032) in which we established the initial standard Federal rate. Thus, we determined capital-related costs per case using capital cost data from Worksheets D, Parts I and II, and total Medicare discharges for the cost reporting period from worksheet S-3. (We note that since payments for capital-related costs are on a reasonable-cost basis, capital payments were the same for “existing” and “new” LTCHs.)

Once we have estimated total TEFRA payments as the sum of each LTCH's estimated operating and capital payment per case, it is necessary to estimate FY 2003 payments under the LTCH PPS. As we discussed above, in evaluating the one-time prospective adjustment at § 412.523(d)(3), we believe that the best approach is to use FY 2002 LTCH claims data as a proxy for estimating FY 2003 LTCH PPS payments. We note (as explained below) that we used the same FY 2002 LTCH MedPAR data that was used to develop the FY 2004 LTC-DRG relative weights in the FY 2004 IPPS final rule (68 FR 45376). As we discussed in that final rule, there is a data problem with the FY 2002 claims data for LTCHs where multiple bills for the stay were submitted. Specifically, given the long stays at LTCHs, some providers had submitted multiple bills for payment under the reasonable cost-based reimbursement system for the same stay. In certain LTCHs, hospital personnel apparently reported a different principal diagnosis on each bill since, under the reasonable cost-based (TEFRA) reimbursement system, payment was not dependent upon principal diagnosis, as it is under a DRG-based PPS system. As a result of this billing practice, we discovered that only data from the final bills were being extracted for the MedPAR file. Therefore, it was possible that the original MedPAR file was not receiving the correct principal diagnosis. In that same IPPS final rule, we discussed how we addressed this problem in the LTCH FY 2002 MedPAR data when we used that data to determine the FY 2004 LTC-DRG relative weights. As stated above, for the evaluation of the one-time budget neutrality adjustment at § 412.523(d)(3) in this proposed rule, we used the same “corrected” FY 2002 LTCH MedPAR data that was used to develop the FY 2004 LTC-DRG relative weights. For the reader's benefit, we are providing a

summary of how we addressed the multiple bill problem in the FY 2002 LTCH MedPAR data below. As we explained in the FY 2004 IPPS final rule (68 FR 45376), we addressed this problem by identifying all LTCH cases in the FY 2002 MedPAR file for which multiple bills were submitted. For each of these cases, beginning with the first bill and moving forward consecutively through subsequent bills for that stay, we recorded the first unique diagnosis codes up to 10 and the first unique procedure codes up to 10. We then used these codes to appropriately group each LTCH case to a LTC-DRG for FY 2004.

We estimated FY 2003 LTCH PPS payments using the same general methodology that we used to estimate FY 2003 payments under the LTCH PPS (without a budget neutrality adjustment) when we determined the initial standard Federal rate in the August 30, 2002 final rule (67 FR 56032). Specifically, we estimated FY 2003 LTCH PPS payments for each LTCH by simulating payments on a case-by-case basis by applying the final FY 2003 payment policies established in the August 30, 2002 final rule that implemented the LTCH PPS (67 FR 55954) based on the LTCH case-specific discharge information from the FY 2002 MedPAR files (as explained above), and we also used LTCH provider-specific data from the FY 2003 provider specific file (PSF), as these were the data used by FIs to make LTCH payments during the first year of the LTCH PPS (FY 2003). We used the FY 2003 LTC-DRG Grouper (Version 22.0) software program, relative weights, and average length of stay (see 67 FR 55979 through 55995); we made adjustments for differences in area wage levels established for FY 2003 as set forth at § 412.525(c) using the appropriate phase-in wage index values and cost-of-living for Alaska and Hawaii as set forth at § 412.525(b) established for FY 2003 (see 67 FR 56015 through 56020 and 56022, respectively); we made adjustments for short-stay outlier cases based on the method for determining payment applicable for discharges occurring during FY 2003 in accordance with § 412.529(c)(1) (see 67 FR 55975 and 55995–56002); and we included additional payments for high cost outlier cases as initially implemented in accordance with former § 412.525(a) for determining payments for discharges occurring in FY 2003 and the FY 2003 fixed-loss amount of \$24,450 (see 67 FR 56023). (We note that correctly billed interrupted stay cases under § 412.531 are single LTCH cases in the MedPAR files, and therefore, we estimated a

single LTCH PPS payment for those cases.) For purposes of this calculation, we simulated case-by-case payments for each LTCH as if it were paid based on 100 percent of the standard Federal rate in FY 2003 rather than the transition blend methodology set forth at § 412.533. To determine total estimated PPS payments for all LTCHs, we summed the individual estimated LTCH PPS payments for each LTCH.

The next step we did to evaluate a potential one-time adjustment under § 412.523(d)(3) was to determine a case-weighted average estimated TEFRA payment, consistent with the methodology used when we determined the initial standard Federal rate in the August 30, 2002 final rule (68 FR 56032). This step is necessary in order to determine if there is any difference between estimated total TEFRA payments and estimated LTCH PPS payments in FY 2003. Each LTCH's estimated total FY 2003 TEFRA payment per discharge was determined by summing its estimated FY 2003 operating and capital payments under the TEFRA payment system based on FY 2002 cost report data (as described above), and dividing that amount by the number of discharges from the FY 2002 cost report data. Next, we determined each LTCH's average estimated TEFRA payment weighted for its number of discharges in the FY 2002 MedPAR file (for the purpose of estimating FY 2003 LTCH PPS payments, as discussed above) by multiplying its average estimated total TEFRA payment per discharge by its number of discharges in the FY 2002 MedPAR file. We then estimated total case-weighted TEFRA payments by summing each LTCH's (MedPAR) case-weighted estimated FY 2003 TEFRA payments. This estimated FY 2003 total TEFRA payment is compared to the estimated FY 2003 total LTCH PPS payment in order to determine whether a one-time budget neutrality adjustment would be appropriate. (As discussed in greater detail above, we are determining both estimated total FY 2003 TEFRA payments and estimated total FY 2003 LTCH PPS payments based on FY 2002 cost report and claims data, respectively.) Adjusting our estimate of FY 2003 TEFRA payments for the number of discharges that we are using to estimate FY 2003 LTCH PPS payments ensures that the comparison of estimated aggregate FY 2003 TEFRA payments to estimated aggregate FY 2003 LTCH PPS payments is based on the same number of LTCH discharges.

Using the methodology and data described above, we have calculated that estimated FY 2003 LTCH PPS

payments are approximately 2.5 percent higher than estimated payments to the same LTCHs in FY 2003 if the LTCH PPS had not been implemented (that is, estimated total FY 2003 TEFRA payments). This analysis was based on approximately 91,300 LTCH cases for 250 LTCHs. As discussed above, we would have proposed that any difference greater than or equal to 0.25 percentage points "significant" for purposes of determining whether the one-time budget neutrality adjustment provided under § 412.523(d)(3) may be warranted. Although we project that estimated FY 2003 LTCH PPS payments are approximately 2.5 percent higher than estimated FY 2003 TEFRA payments, reducing the standard Federal rate by 2.5 percent would not "maintain budget neutrality" for FY 2003 (that is, estimated FY 2003 LTCH PPS payments would not be equal to estimated FY 2003 TEFRA payments) because a considerable number of LTCH discharges are projected to have received a LTCH PPS payment in FY 2003 based on the estimated cost of the case (rather than a payment based on the standard Federal rate) under the payment adjustment for short-stay outlier (SSO) cases at § 412.529. Specifically, our payment data indicate that nearly 20 percent of estimated FY 2003 LTCH PPS payments are SSO payments that were paid based on estimated cost and not based on the LTCH PPS standard Federal rate. These SSO cases that receive a payment based on the estimated cost of the case are generally unaffected by any changes to the Federal rate because the estimated cost of the case is determined by multiplying the Medicare allowable charges by the LTCH's cost-to-charge ratio (see § 412.529(d)(2)). In other words, if we were to reduce the Federal rate by 2.5 percent, estimated total FY 2003 LTCH PPS payments would still be greater than estimated total FY 2003 TEFRA payments, and therefore would not be budget neutral. This is because the estimated LTCH PPS payments for those SSO cases that in FY 2003 were estimated to have been paid 120 percent of the estimated cost of the case generally are not affected (that is, in this case, not lowered) by any budget neutrality factor that would be applied to the standard Federal rate since those payments are not derived from the Federal rate (as explained above). Therefore, it would be necessary to propose to offset the standard Federal rate by a factor that is larger than 2.5 percent in order to ensure that estimated total FY 2003 LTCH PPS payments would be equal to estimated total FY

2003 TEFRA payments in order to "maintain budget neutrality." To determine the necessary adjustment factor that would need to be applied to the standard Federal rate in order to "maintain budget neutrality," we simulated FY 2003 LTCH PPS payments using the same payment simulation model discussed above (that we used to estimate FY 2003 LTCH PPS payments without a budget neutrality factor). Using iterative payment simulations using the data from the 250 LTCHs in our database, we determined that a factor of 0.9625 (that is, approximately 3.75 percent (rather than 2.5 percent)) would need to be applied to the standard Federal rate in order to make estimated total FY 2003 LTCH PPS payments equal to estimated total FY 2003 TEFRA payments.

In the absence of section 114(c)(4) of the Medicare, Medicaid, and SCHIP Extension Act of 2007, we would have proposed to employ this methodology in determining whether it would have been appropriate to propose a one-time budget neutrality adjustment. As the discussion above indicates, that analysis suggests that an adjustment of 3.75 percent to the standard Federal rate would have been warranted. We expect to address the issue again when it is closer to the time section 114(c)(4) of the MMSEA permits us to implement a one-time adjustment under § 412.523(d)(3). In the meantime, we welcome comments on the methodology that we have described. We would take these comments into account in proposing to implement a one-time budget neutrality adjustment on or after December 29, 2010. As noted above, we will respond to any comments on our proposed changes to the methodology for the one-time budget neutrality adjustment and proposed change to implement the requirements of section 114(c)(4) of Public Law 110-173.

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

1. Background

At § 412.523(c)(3)(ii), for LTCH PPS rate years beginning RY 2004 through RY 2006, we updated the standard Federal rate by a rate increase factor to adjust for the most recent estimate of the increases in prices of an appropriate market basket of goods and services for LTCHs. We established the policy of annually updating the standard Federal rate because at that time we believed that was the most appropriate method for updating the LTCH PPS standard Federal rate annually for years after FY 2003. When we moved the date of the annual update of the LTCH PPS from

October 1 to July 1 in the RY 2004 LTCH PPS final rule (68 FR 34138), we revised § 412.523(c)(3) accordingly. At that time, we believed that was the most appropriate method for updating the LTCH PPS standard Federal rate annually for years after RY 2004.

In the RY 2007 LTCH PPS final rule (71 FR 27818), we explained that rather than solely using the most recent estimate of the LTCH PPS market basket as the basis of the update factor for the Federal rate for RY 2007, we believed it was appropriate to adjust the Federal rate to account for the changes in coding practices (rather than patient severity) as indicated by our ongoing monitoring activities. We established at § 412.523(c)(3)(iii) that the update to the standard Federal rate for the 2007 LTCH PPS rate year was zero percent, based on the most recent estimate of the LTCH PPS market basket at the time which was offset by an adjustment to account for changes in case-mix in prior periods due to changes in coding practices rather than increased patient severity in FY 2004. Therefore, effective from July 1, 2006 through June 30, 2007, the standard rate was \$38,086.04 (71 FR 27818). For the following year, we also considered changes in coding practices (rather than patient severity) in establishing the update to the Federal rate for the 2008 LTCH PPS rate year. In the RY 2008 final rule (72 FR 26887 through 27890), we adjusted the Federal rate based on the most recent estimate of market basket (3.2 percent) and an adjustment to account for changes in coding practices (2.49 percent) in FY 2005. Accordingly, we established at § 412.523(c)(3)(iv) that the update to the standard Federal rate for RY 2008 was 0.71 percent. Consequently, in the RY 2008 final rule, we established the LTCH PPS standard Federal rate, effective from July 1, 2007 through June 30, 2008, of \$38,356.45 (see 72 FR 26890).

As stated in section I.A. of this preamble, section 114(e)(1) of the Medicare, Medicaid, and SCHIP Extension Act of 2007, enacted on December 29, 2007 revises the base rate for RY 2008. Specifically, section 114(e)(1) of Public Law 110–173 adds a new subsection to the Act at 1886(m)(2), which provides that the base rate for RY 2008 “shall be the same as the base rate for discharges for the hospital occurring during the rate year ending in 2007.” In addition, section 114(e)(2) of Public Law 110–173 indicates that section 1886(m)(2) of the Act “shall not apply to discharges occurring on or after July 1, 2007, and before April 1, 2008” (that is, the first 9 months of RY 2008). We note that the statute uses the term “base

rate,” which is an undefined term in § 1886(m) of the ACT and in 42 CFR Part 412, subpart O. We are interpreting that term to mean the standard Federal rate because we believe the Congress meant to eliminate the 0.71 percent update from the RY 2008 standard Federal rate.

If the term “base rate” used in the statute refers to the standard Federal rate, then the standard Federal rate for RY 2008 would be the same as the standard Federal rate for RY 2007 and the 0.71 percent update finalized in the RY 2008 final rule would be reversed. We do not believe that the term “base rate” could refer to the “unadjusted rate” (that is, to determine the standard Federal rate for any given rate year, the previous year’s standard Federal rate, referred herein as the “unadjusted rate”, is updated by the current year’s update factor.) If the interpretation of “base rate” is the “unadjusted rate,” it would render meaningless the provision at the section 114(e)(1) of the MMSEA and Congress does not legislate a nullity. The provision would be meaningless under such an interpretation because even though the unadjusted rate for RY 2008 would be the same as the unadjusted rate for RY 2007, this unadjusted rate must still be updated by 0.71 percent, and doing so would result in the same standard Federal rate for RY 2008 as was adopted in the RY 2008 final rule. (The unadjusted rate must be updated by 0.71 percent in order to determine the standard Federal rate because it is the standard Federal rate that is the basis for Federal prospective LTCH PPS payments.) Consequently, LTCH PPS payments would be unaffected by section 114(e)(1) of the Medicare, Medicaid, and SCHIP Extension Act of 2007. We explain below why RY 2008 LTCH PPS payments would be unaffected by section 114(e)(1) of Public Law 110–173 if “base rate” means “unadjusted rate.” Specifically, if “base rate” means the “unadjusted rate,” the RY 2007 “base rate” (that is, \$38,086.04) would be the same as the standard Federal rate for RY 2007 (also \$38,086.04) since we established a zero percent update for RY 2007. Consequently, if “base rate” is interpreted to mean “unadjusted rate,” the “unadjusted rate” for RY 2008 (\$38,086.04) would be the same as the RY 2007 “unadjusted rate” (\$38,086.04). The RY 2008 “unadjusted rate” of \$38,086.04 would subsequently be updated by the 0.71 percent update factor finalized in the RY 2008 final rule, resulting in a standard Federal rate for RY 2008 of \$38,356.45, which is the same standard Federal rate that was

actually finalized in the RY 2008 final rule and which would continue to be the standard Federal rate for RY 2008 even if section 114(e)(1) of MMSEA had not been enacted. Since as we noted above, Congress does not legislate a nullity, we therefore believe that the term “base rate” used in section 114(e)(1) of MMSEA refers to the standard Federal rate and not the “unadjusted rate.” In subsequent sections of this preamble, we shall be using the term standard Federal rate instead of “base rate” when referencing the provision in section 114(e)(1) of MMSEA in order to avoid further confusion. As noted above, the standard Federal rate for RY 2007 was \$38,086.04 (71 FR 27818).

2. Proposed Standard Federal Rate for the 2009 LTCH PPS Rate Year

In the RY 2008 LTCH PPS final rule (72 FR 26890), we established a standard Federal rate of \$38,356.45 for the 2008 LTCH PPS rate year that was based on the best available data and policies established in that final rule. As discussed above, the Medicare, Medicaid, and SCHIP Extension Act of 2007, enacted on December 29, 2007, revises the standard Federal rate for RY 2008 while specifying that this rate “shall not apply to discharges occurring on or after July 1, 2007, and before April 1, 2008” (that is, the first 9 months of RY 2008). Specifically, section 114(e)(1) of MMSEA provides that under the new 1886(m)(2) to the Act the standard Federal rate for RY 2008 shall be the same as the standard Federal rate for RY 2007 (which shall not apply to discharges occurring before April 1, 2008). Thus, the standard Federal rate for RY 2008 will be \$38,086.04 (the same as standard Federal rate for 2007). In this proposed rule, consistent with our historical practice, we are proposing to update the standard Federal rate from the previous year (\$38,086.04) to determine the proposed standard Federal rate for RY 2009. Under the broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of the BIPA, we are proposing an annual update to the standard Federal rate for the proposed 15-month 2009 rate year based on the most recent LTCH PPS market basket estimate of 3.5 percent, as discussed above in section IV.C. of the preamble of this proposed rule, and an adjustment of 0.9 percent to account for the increase in case-mix in a prior period (FY 2006) that resulted from changes in coding practices rather than an increase in patient severity.

As we discussed in greater detail in the RY 2007 and RY 2008 LTCH PPS

final rules (71 FR 27819 through 27827 and 72 FR 26887 through 26890, respectively), while we continue to believe that an update to the LTCH PPS Federal rate year should be based on the most recent estimate of the LTCH PPS market basket, we believe it is appropriate that the rate be offset by an adjustment to account for any changes in coding practices that do not reflect increased patient severity. Such an adjustment protects the integrity of the Medicare Trust Funds by ensuring that the LTCH PPS payment rates better reflect the true costs of treating LTCH patients (71 FR 27819 through 27827).

We continue to believe that a proposed update to the LTCH PPS Federal rate year should be based on the most recent estimate of the LTCH PPS market basket, offset if appropriate by an adjustment to account for changes in coding practices that do not reflect increased patient severity. Furthermore, in the FY 2008 IPPS final rule, we did not finalize the proposed case-mix budget neutrality factor for the adoption of the severity adjusted MS-LTC-DRG patient classification system to the FY 2008 MS-LTC-DRG relative weights. We stated in that rule that since we have an established mechanism to adjust prospectively LTCH payments to account for the effect of changes in coding from a previous year and documentation which is based on actual LTCH data, and because at the time of the final rule we were unable to determine an appropriate adjustment factor applicable to LTCHs, we believed it was appropriate to continue using the established process rather than making a prospective adjustment based on an estimate of projected LTCH specific case-mix change due to improved coding and documentation. We also stated that consistent with past LTCH payment policy, we could propose to make future adjustments to account for improvements in coding and documentation that do not reflect real changes in case mix during these years that we are implementing MS-LTC-DRGs. We also stated in that final rule that we continue to believe more accurate and complete documentation and coding will occur, and that we will continue to monitor LTCHs' response to the MS-LTC-DRG transition and would propose an adjustment factor to LTCHs to account prospectively for coding and documentation changes if CMS is able to estimate an appropriate adjustment factor applicable to LTCHs. In determining the proposed update to the standard Federal rate for the 2009 LTCH PPS rate year, we performed a CMI analysis using the most recent available

LTCH claims data (FY 2006 MedPAR files) and estimated the observed CMI change for FY 2006 to be 1.9 percent (based on the most recent available LTCH case-mix data from FY 2005 compared to FY 2006). We continue to believe, as discussed and for the same reasons stated in the RY 2008 final rule (72 FR 26888 through 26890), that it is appropriate to utilize the estimate of real CMI increase of 1.0 percent, based on the well-established RAND study referred to in the RY 2008 final rule, as the proxy for the portion of the observed 1.9 percent CMI increase from FY 2005 to FY 2006 that represents real CMI changes for use in determining the proposed RY 2009 Federal rate update. (A more detailed discussion on the use of the RAND study estimate for real CMI change can be found in the RY 2008 final rule appearing in the **Federal Register** on May 11, 2007. (72 FR 26887 through 26890)). Accordingly, we believe that 0.9 percent ($1.9 - 1.0 = 0.9$) of the observed 1.9 percent CMI increase from FY 2005 to FY 2006 reflects CMS increase that is due to changes in coding practices (rather than patient severity).

At this time, the most recent estimate of the LTCH PPS market basket is 3.5 percent as discussed above in section IV.C.2. of this proposed rule. We are proposing to update the standard Federal Rate for RY 2009 based on the full LTCH PPS market basket estimate of 3.5 percent and a proposed adjustment to account for the increase in case-mix in the prior period (FY 2006) that resulted from changes in coding practices of 0.9 percent. Therefore, the proposed update factor to the standard Federal rate for RY 2009 is 2.6 percent ($3.5 - 0.9 = 2.6$). That is, under the broad authority conferred upon the Secretary under the BBRA and the BIPA, we are proposing to specify under § 412.523(c)(3)(v), that, for discharges occurring on or after July 1, 2008 and on or before September 30, 2009, the standard Federal rate from the previous year would be updated by 2.6 percent. In determining the proposed standard Federal rate for RY 2009, we are applying the proposed 2.6 percent update to the RY 2008 Federal rate of \$38,086.04, which is the same standard Federal rate for discharges occurring during the rate year ending in 2007, consistent with section 114(e)(1) of the Medicare, Medicaid, and SCHIP Extension Act of 2007. Consequently, the proposed standard Federal rate for RY 2009 would be \$39,076.28.

We also propose that if more recent data becomes available (such as a more recent estimate of the LTCH PPS market basket), we would use that data, if appropriate, to determine the update to

the standard Federal rate for the RY 2009 final rule, and thus, the Federal rate update noted in the proposed regulation text at § 412.523(c)(3)(v) could change.

F. Calculation of Proposed LTCH Prospective Payments for the 2009 LTCH PPS Rate Year

1. Proposed Adjustment for Area Wage Levels

a. Background

Under the authority of section 123 of the BBRA as amended by section 307(b) of the BIPA, we established an adjustment to the LTCH PPS Federal rate to account for differences in LTCH area wage levels at § 412.525(c). The labor-related share of the LTCH PPS Federal rate, currently estimated by the FY 2002-based RPL market basket (as discussed in greater detail in section IV.C.1. of this preamble), is adjusted to account for geographic differences in area wage levels by applying the applicable LTCH PPS wage index. The applicable LTCH PPS wage index is computed using wage data from inpatient acute care hospitals without regard to reclassification under sections 1886(d)(8) or 1886(d)(10) of the Act.

As we discussed in the August 30, 2002 LTCH PPS final rule (67 FR 56015), when the LTCH PPS was implemented, we established a 5-year transition to the full wage adjustment. The wage index adjustment was completely phased-in beginning with cost reporting periods beginning in FY 2007. Therefore, for cost reporting periods beginning on or after October 1, 2006, the applicable LTCH wage index values are the full (five-fifths) LTCH PPS wage index values calculated based on acute-care hospital inpatient wage index data without taking into account geographic reclassification under sections 1886(d)(8) and (d)(10) of the Act. For additional information on the phase-in of the wage index adjustment under the LTCH PPS, refer to the August 30, 2002 LTCH PPS final rule (67 FR 56017 through 56019) and the RY 2008 LTCH PPS final rule (72 FR 26891).

b. Proposed Updates to the Geographic Classifications/Labor Market Area Definitions

(1) Background

As discussed in the August 30, 2002 LTCH PPS final rule, which implemented the LTCH PPS (67 FR 56015 through 56019), in establishing an adjustment for area wage levels under § 412.525(c), the labor-related portion of a LTCH's Federal prospective payment is adjusted by using an appropriate wage index based on the

labor market area in which the LTCH is located. In the RY 2006 LTCH PPS final rule (70 FR 24184 through 24185), in regulations at § 412.525(c), we revised the labor market area definitions used under the LTCH PPS effective for discharges occurring on or after July 1, 2005 based on the Office of Management and Budget's (OMB's) Core Based Statistical Area (CBSA) designations based on 2000 Census data. We made this revision because we believe that those new CBSA-based labor market area definitions will ensure that the LTCH PPS wage index adjustment most appropriately accounts for and reflects the relative hospital wage levels in the geographic area of the hospital as compared to the national average hospital wage level. As set forth in existing § 412.525(c)(2), a LTCH's wage index is determined based on the location of the LTCH in an urban or rural area as defined in § 412.64(b)(1)(ii)(A) through (C). An urban area under the LTCH PPS is currently defined at § 412.64(b)(1)(ii)(A) and (B). Under § 412.64(b)(1)(ii)(C), a rural area is defined as any area outside of an urban area.

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

(2) Proposed Update to the CBSA-based Labor Market Area Definitions

On December 18, 2006, OMB announced the inclusion of two new CBSAs and the revision of designations for six areas (OMB Bulletin No. 07-01). This OMB bulletin is available on the OMB Web site at <http://www.whitehouse.gov/omb/bulletins/fy2007/b07-01.pdf>. The two new CBSAs outlined in this bulletin are as follows:

- Lake Havasu-Kingman, Arizona (CBSA code 29420). This CBSA comes from Mohave County, Arizona.
- Palm Coast, Florida (CBSA code 37380). This CBSA comes from Flagler County, Florida.

The six revised CBSA designations outlined in this bulletin are as follows:

- Mauldin, South Carolina and Easley, South Carolina qualify as new principal cities of the Greenville-Mauldin-Easley, South Carolina CBSA (CBSA code 24860).

- Conway, Arkansas qualifies as a new principal city of the Little Rock-North Little Rock-Conway, Arkansas CBSA (CBSA code 30780).

- Goleta, California qualifies as a new principal city of the Santa Barbara-Santa Maria-Goleta, California CBSA (CBSA code 42060).

- Franklin, Tennessee qualifies as a new principal city of the Nashville-Davidson-Murfreesboro-Franklin, Tennessee CBSA (CBSA code 34980).

- Fort Pierce, Florida no longer qualifies as a principal city of the Port St. Lucie-Fort Pierce, Florida CBSA; the new designation is Port St. Lucie, Florida CBSA (CBSA code 38940).

- Essex County, Massachusetts Metropolitan Division was renamed as the Peabody, Massachusetts Metropolitan Division, which changed the CBSA code from 21604 to 37764.

We note that these six revised CBSA designations made in OMB Bulletin No. 07-01 do not change the composition (constituent counties) of the affected CBSAs; they only revise the CBSA titles (and the CBSA code for the CBSA that consists of Essex County, MA).

In this proposed rule, under the broad authority conferred upon the Secretary by section 123 of the BBRA, as amended by section 307(b) of BIPA to determine appropriate adjustments under the LTCH PPS, we are proposing to apply these changes to the current CBSA-based labor market area definitions and geographic classifications used under the LTCH PPS effective for discharges occurring on or after July 1, 2008. We believe these revisions to the LTCH PPS CBSA-based labor market area definitions, which are based on the most recent available data, would 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. (We note that we are currently not aware of any LTCHs located in the two new proposed CBSAs (that is, proposed CBSA 29420 and proposed CBSA 37380), and as discussed above, the six proposed revisions to the CBSA designations would only revise the CBSA titles (and the CBSA code for the CBSA that consists of Essex County, MA).) Accordingly, the proposed RY 2009 LTCH PPS wage index values presented in Tables 1 and 2 in the Addendum of this proposed rule were calculated based on the proposed revisions to the CBSA-based labor market area definitions described above. We also note that these revisions to the CBSA-based designations were adopted under the IPPS effective beginning October 1, 2007 (72 FR 47308 through 47309).

(3) Clarification of New England Deemed Counties

We are also taking this opportunity to address the change in the treatment of "New England deemed counties" (that is, those counties in New England listed in § 412.64(b)(1)(ii)(B) that were deemed to be parts of urban areas under section 601(g) of the Social Security Amendments of 1983) that was made in the FY 2008 IPPS final rule with comment period. These counties include the following: Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island. Of these five "New England deemed counties," three (York County, Sagadahoc County, and Newport County) are also included in metropolitan statistical areas defined by OMB and are considered urban under both the current IPPS and LTCH PPS labor market area definitions in § 412.64(b)(1)(ii)(A) (they would also be urban under the proposed conforming changes to § 412.503). The remaining two, Litchfield County and Merrimack County, are geographically located in areas that are considered rural under the current IPPS (and LTCH PPS) labor market area definitions (however, they have been previously deemed urban under the IPPS in certain circumstances as discussed below).

In the FY 2008 IPPS final rule with comment period (72 FR 47337 through 47338), § 412.64(b)(1)(ii)(B) was revised such that the two "New England deemed counties" that are still considered rural by OMB (Litchfield county, CT and Merrimack county, NH) are no longer considered urban effective for discharges occurring on or after October 1, 2007, and therefore, are considered rural in accordance with § 412.64(b)(1)(ii)(C). However, for purposes of payment under the IPPS, acute-care hospitals located within those areas are treated as being reclassified to their deemed urban area effective for discharges occurring on or after October 1, 2007 (see 72 FR 47337 through 47338). (We note that the LTCH PPS does not provide for such geographic reclassification (67 FR 56019 through 56020)). Also in the FY 2008 IPPS final rule with comment period (72 FR 47338), we explained that we have limited this policy change for the "New England deemed counties" only to IPPS hospitals, and any change to non-IPPS provider wage indices would be addressed in the respective payment system rules. Accordingly, as stated above, we are taking this opportunity to clarify the treatment of "New England

deemed counties” under the LTCH PPS in this proposed rule.

As discussed above, under existing § 412.525(c)(2), a LTCH’s wage index is determined based on the location of the LTCH in an urban or rural area as defined in § 412.64(b)(1)(ii)(A) through (C). Under existing § 412.525(c)(2), an urban area under the LTCH PPS is currently defined at § 412.64(b)(1)(ii)(A) and (B), and a rural area is defined as any area outside of an urban area in § 412.64(b)(1)(ii)(C).

Historical changes to the labor market area/geographic classifications and annual updates to the wage index values under the LTCH PPS have been made effective July 1 each year. When we established the most recent LTCH PPS payment rate update, effective for LTCH discharges occurring on or after July 1, 2007 through June 30, 2008, we considered the “New England deemed counties” (including Litchfield county, CT and Merrimack county, NH) as urban for RY 2008 (in accordance with the definitions of urban and rural stated in the RY 2008 LTCH PPS final rule (72 FR 26891) and as evidenced by the inclusion of Litchfield county as one of the constituent counties of urban CBSA 25540 (Hartford-West Hartford-East Hartford, CT), and the inclusion of Merrimack county as one of the constituent counties of urban CBSA 31700 (Manchester-Nashua, NH)). (See 72 FR 27004 and 27008, respectively).

As noted above, existing § 412.525(c)(2) indicates that the terms “rural” and “urban” as areas are defined according to the definitions of those terms in § 412.64(b)(1)(ii)(A) through (C). As Litchfield county, CT and Merrimack county, NH would be considered rural areas in accordance with our regulations at (§ 412.525(c)(2), these two counties will be “rural” under the LTCH PPS effective with the next update of the LTCH PPS payment rates, which will be July 1, 2008 (under the LTCH PPS effective for discharges on or after July 1, 2008, Litchfield County, CT and Merrimack County, NH are not urban under § 412.64(b)(1)(ii)(A–B) and therefore are rural under § 412.64(b)(1)(ii)(C)). (We note that Litchfield and Merrimack counties will also be rural under our proposed § 412.503, discussed in greater detail below, that would incorporate the existing definitions of “urban” and “rural” areas.) Therefore, Litchfield county, CT and Merrimack county, NH will be considered “rural” effective for LTCH PPS discharges occurring on or after July 1, 2008, and will no longer be considered as being part of urban CBSA 25540 (Hartford-West Hartford-East Hartford, CT) and urban CBSA 31700

(Manchester-Nashua, NH), respectively. We note that currently we are not aware of any LTCHs located in either Litchfield county, CT or Merrimack county, NH. We also note that this policy is consistent with our policy of not taking into account IPPS geographic reclassifications in determining payments under the LTCH PPS. In addition, as discussed above, in this section, effective for discharges on or after July 1, 2008, § 412.64(b)(1)(ii)(B) is no longer applicable under the LTCH PPS.

(4) Proposed Codification of the Definitions of Urban and Rural Under 42 CFR Part 412 Subpart O

Under the current regulations at § 412.525(c), the labor-related portion of the LTCH PPS Federal rate is adjusted to account for geographical differences in the area wage levels using an appropriate wage index to reflect the relative level of hospital wages and wage-related costs in the geographic area (that is, urban or rural area) of the hospital compared to the national average level of hospital wages and wage-related costs annually. Currently, the application of the wage index under existing § 412.525(c)(2) 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) (in 42 CFR Part 412 subpart D).

In light of regulatory construct discussed above where § 412.525(c) indicated that the terms “rural area” and “urban area” as defined according to the definitions of those terms” under the IPPS in 42 CFR Part 412 subpart D, we believe it may be administratively simpler to have the LTCH PPS urban and rural labor market area definitions self-contained in (§ 412.503) 42 CFR Part 412 subpart O rather than cross-referring to the definitions of urban and rural in the IPPS regulations in 42 CFR Part 412, Subpart D. This approach is similar to the change we made in § 412.525(a) for high cost outliers and § 412.529 for short-stay outliers in the FY 2007 IPPS final rule when we embedded within Subpart O the regulatory provisions concerning the determination of cost-to-charge ratios (CCRs) and the reconciliation of outlier payments (71 FR 48115 through 48122). Under the broad authority of § 123 of the BBRA as amended by § 307(b) of BIPA we are proposing to codify in § 412.503 the definitions for “urban area” and “rural area.” The proposed definitions for “urban area” and “rural area” in § 412.503 would incorporate the provisions of § 412.62(f)(1)(ii) and (f)(1)(iii) as well as § 412.64(b)(1)(ii)(A) through (C). Furthermore, since, as

explained above in section IV.F.1.b.3., the definition of “urban area” at § 412.64(b)(1)(ii)(B) is no longer applicable under the LTCH PPS effective for discharges occurring on or after July 1, 2008, and therefore, the only remaining definition of “urban area” will be that of a Metropolitan Statistical Area (MSA) as defined by the Executive Office of Management and Budget. (See 72 FR 47337 through 47338). Thus, we omit the language of § 412.64(b)(1)(ii)(B) from the proposed definition of “urban area” that would be applicable to discharges occurring on or after July 1, 2008 in proposed 412.503. We, however, included the language from § 412.64(b)(1)(ii)(A) in the proposed definition of “urban area” that would be applicable to discharges occurring on or after July 1, 2008 in proposed 412.503. For the reason just described, we note that the proposed definitions of “urban” and “rural” that would be effective for discharges occurring on or after July 1, 2008 (in subparagraph (3) in the both the proposed definition of “rural area” and the proposed definition of “urban area”) vary slightly from the wording in the current regulations at § 412.64(b)(1)(ii)(A) through (C); however, substantively the definitions are the same. We believe that the slight difference in the wording of 412.503 more precisely conveys the treatment of New England deemed counties under the LTCH PPS, as discussed above. As a conforming change, we are also proposing to replace the cross-references to § 412.62(f)(1)(iii) and § 412.64(b)(1)(ii)(A) through (C) in § 412.525(c) with references to the proposed definitions of “urban area” and “rural area” at § 412.503. Accordingly, we are proposing to revise § 412.525(c) to specify that the application of the LTCH PPS wage index would be made on the basis of the location of the LTCH in an urban or rural area as defined in proposed § 412.503. As discussed in section VI.G.3. of this proposed rule, we are also proposing to make conforming changes to the regulations governing short-stay outlier payments (at § 412.529) and the special payment provisions for co-located LTCHs (at § 412.534) and free-standing LTCHs (at § 412.536), which refer to the definition of urban and rural under the LTCH PPS.

c. Proposed Labor-Related Share

In the August 30, 2002 LTCH PPS final rule (67 FR 56016), we established a labor-related share of 72.885 percent based on the relative importance of the labor-related share of operating costs (wages and salaries, employee benefits,

professional fees, postal services, and all other labor-intensive services) and capital costs of the excluded hospital with capital market basket based on FY 1992 data. We did not revise the labor-related share in RYs 2004 through 2006 while we conducted further analysis to determine the most appropriate methodology and data for determining the labor-related share under the LTCH PPS (70 FR 24182). After our research into the labor-related share methodology was complete, we revised the labor-related share under the LTCH PPS in the RY 2007 final rule (71 FR 27829). Specifically, beginning in RY 2007, we established a labor-related share 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 RPL market basket based on FY 2002 data, as it is the best available data that reflect the cost structure of LTCHs.

Consistent with our historical practice, the labor-related share currently used under the LTCH PPS is determined by identifying the national average proportion of operating costs and capital costs that are related to, influenced by, or vary with the local labor market. Accordingly, in the RY 2008 LTCH PPS final rule (72 FR 26892), we updated the LTCH PPS labor-related share to 75.788 percent based on the relative importance of the labor-related share of operating costs (wages and salaries, employee benefits, professional fees, and all other labor-intensive services) and capital costs of the RPL market basket based on FY 2002 data from the first quarter of 2007.

As discussed in section IV.C.2. of this preamble, we now have data from the 4th quarter of 2007 (with history through the 3rd quarter of 2007) available for determining the labor-related share of the FY 2002-based RPL market basket. Based on this more recent data, in this proposed rule, under the broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of the BIPA, consistent with our historical practice of determining the labor-related share by

identifying the national average proportion of operating costs and capital costs that are related to, influenced by, or varies with the local labor market, we are proposing to revise the LTCH PPS labor-related share from 75.788 percent to 75.920 percent based on the relative importance of the labor-related share of operating costs (wages and salaries, employee benefits, professional fees, and all other labor-intensive services) and capital costs of the FY 2002-based RPL market basket from the fourth quarter of 2007, as shown in Table 1. The proposed labor-related share is the sum of the relative importance of wages and salaries, fringe benefits, professional fees, labor-intensive services, and a portion of the capital share from an appropriate market basket.

In this proposed rule, for RY 2009, we are proposing to use the FY 2002-based RPL market basket costs based on data from the fourth quarter of 2007 to determine the labor-related share for the LTCH PPS effective for discharges occurring on or after July 1, 2008 and before September 30, 2009, as this is the most recent available data. The proposed labor-related share for RY 2009 LTCH PPS would continue to be the sum of the relative importance of each labor-related cost category, and would reflect the different rates of price change for these cost categories between the base year (FY 2002) and the (15-month) 2009 LTCH PPS rate year. (As discussed in greater detail above in section IV.B. of this proposed rule, we are proposing to move the LTCH PPS annual payment rate year beginning July 1st to a rate year beginning October 1st and have a 15-month rate year for 2009 (that is, July 1, 2008 through September 30, 2009). Accordingly, we are proposing to use the 15-month RY 2009 RPL market basket, discussed above, to determine the proposed labor-related share for RY 2009 in this proposed rule. Consistent with our historical practice of using the best data available, if more recent data are available to determine the labor-related share of the RPL market basket (used under the LTCH PPS), we propose to use it for

determining the labor-related share for the 2009 LTCH PPS rate year in the final rule.

Based on the most recent available data, we are proposing that the sum of the relative importance for the 2009 LTCH PPS rate year for operating costs (wages and salaries, employee benefits, professional fees, and labor-intensive services) would be 71.965, as shown in Table 1. The portion of capital that is influenced by the local labor market is still estimated to be 46 percent, which is the same percentage used when we established the current labor-related share in the RY 2008 LTCH PPS final rule. Since, based on the most recent available data, the relative importance for capital would be 8.597 percent of the FY 2002-based RPL market basket for the 2009 LTCH PPS rate year, we are proposing to multiply the estimated portion of capital influenced by the local labor market (46 percent) by the relative importance for capital (8.597 percent) to determine the proposed labor-related share of capital for the 2009 LTCH PPS rate year. The result would be 3.955 percent (0.46×8.597 percent), which we would add to the proposed 71.965 percent for the operating cost amount to determine the proposed total labor-related share for the 2009 LTCH PPS rate year. Thus, based on the latest available data, we are proposing to use a labor-related share of 75.920 percent (71.965 percent + 3.955 percent) under the LTCH PPS for the 2009 LTCH PPS rate year. As noted above in this section, this proposed labor-related share is determined using the same methodology as employed in calculating the current LTCH labor-related share (72 FR 26892) and the labor-related shares used under the IRF PPS and IPF PPS, which also use the RPL market basket.

Table 1 shows the 2008 LTCH PPS rate year relative importance labor-related share of the FY 2002-based RPL market basket (established in the RY 2008 LTCH PPS final rule) and the proposed 2009 LTCH PPS rate year relative importance labor-related share of the FY 2002-based RPL market basket.

TABLE 1.—RY 2008 LABOR-RELATED SHARE RELATIVE IMPORTANCE AND PROPOSED RY 2009 LABOR-RELATED SHARE RELATIVE IMPORTANCE OF THE FY 2002-BASED RPL MARKET BASKET

Cost category	RY 2008 relative importance*	Proposed RY 2009 relative importance
Wages and Salaries	52.588	52.830
Employee Benefits	14.127	14.079
Professional fees	2.907	2.907
All other labor intensive services	2.145	2.149

TABLE 1.—RY 2008 LABOR-RELATED SHARE RELATIVE IMPORTANCE AND PROPOSED RY 2009 LABOR-RELATED SHARE RELATIVE IMPORTANCE OF THE FY 2002-BASED RPL MARKET BASKET—Continued

Cost category	RY 2008 relative importance*	Proposed RY 2009 relative importance
Subtotal	71.767	71.965
Labor share of capital costs	4.021	3.955
Total Labor-related share	75.788	75.920

* As established in the RY 2008 LTCH PPS final rule (72 FR 26892).

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

d. Proposed Wage Index Data

Historically, under the LTCH PPS, we have established LTCH PPS wage index values calculated from acute care IPPS hospital wage data without taking into account geographic reclassification under sections 1886(d)(8) and (d)(10) of the Act. 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. Therefore, we would need to establish instructions for the collection of this LTCH data as well as develop some type of application and determination process before a geographic reclassification adjustment under the LTCH PPS could be implemented. Thus, 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. Acute care hospital inpatient wage index data are also used to establish the wage index adjustment used in other Medicare PPSs, such as the IRF PPS, IPF PPS, HHA PPS, and SNF PPS.

In the RY 2008 LTCH PPS final rule (72 FR 26893), we established LTCH PPS wage index values for the RY 2008 calculated from the same data (collected from cost reports submitted by hospitals for cost reporting periods beginning during FY 2003) used to compute the FY 2007 acute care hospital inpatient wage index data without taking into account geographic reclassification under sections 1886(d)(8) and (d)(10) of the Act because that was the best available data at that time. The LTCH PPS wage index values applicable for discharges occurring on or after July 1, 2007 through June 30, 2008 are shown in Table 1 (for urban areas) and Table 2 (for rural areas) in the Addendum to the RY 2008 LTCH PPS final rule (72 FR 26996 through 27019).

In this proposed rule, under the broad authority conferred upon the Secretary by section 123 of the BBRA as amended

by section 307(b) of BIPA to determine appropriate adjustments under the LTCH PPS, we are proposing that, for the RY 2009, the same data (collected from cost reports submitted by hospitals for cost reporting periods beginning during FY 2004) used to compute the FY 2008 acute care hospital inpatient wage index data without taking into account geographic reclassification under sections 1886(d)(8) and (d)(10) of the Act would be used to determine the applicable wage index values under the LTCH PPS because these data (FY 2004) are the most recent complete data. (For information on the data used to compute the FY 2008 IPPS wage index refer to the FY 2008 IPPS final rule with comment period (72 FR 47308 through 47309, 47315)). We are proposing to continue to use IPPS wage data as a proxy to determine the proposed LTCH wage index values for RY 2009 because both LTCHs and acute-care hospitals are required to meet the same certification criteria set forth in section 1861(e) of the Act to participate as a hospital in the Medicare program and they both compete in the same labor markets, and therefore, experience similar wage-related costs. We note that the IPPS wage data used to determine the proposed RY 2009 LTCH wage index values reflects our policy that was adopted under the IPPS beginning in FY 2008 that apportions the wage data for multicampus hospitals' located in different labor market areas (CBSAs) to each CBSA where the campuses are located (see the FY 2008 IPPS final rule with comment period (72 FR 47317 through 47320)). For the proposed RY 2009 LTCH PPS wage index, which is computed from IPPS wage data submitted by hospitals for cost reporting periods beginning in FY 2004 (just like the FY 2008 IPPS wage index), we allocated salaries and hours to the campuses of two multicampus hospitals with campuses that are located in different labor areas, one in Massachusetts and another in Illinois. Thus, the proposed RY 2009 LTCH PPS

wage index values for the following CBSAs are affected by this policy: Boston-Quincy, MA (CBSA 14484), Providence-New Bedford-Falls River, RI-MA (CBSA 39300), Chicago-Naperville-Joliet, IL (CBSA 16974) and Lake County-Kenosha County, IL-WI (CBSA 29404) (refer to Table 1 in the Addendum of this proposed rule). Furthermore, the proposed RY 2009 LTCH PPS wage index values presented in this proposed rule were computed consistent with the urban and rural geographic classifications (labor market areas) discussed above in section IV.F.1.b. of this proposed rule and consistent with pre-reclassified IPPS wage index policy (that is, our historical policy of not taking into account IPPS geographic reclassifications in determining payments under the LTCH PPS). Specifically, we note that the wage data of the IPPS hospitals located in Litchfield county, CT, and Merrimack county, NH, were included in the calculation of the proposed RY 2009 LTCH PPS statewide rural wage index values for Connecticut and New Hampshire, respectively (rather than urban CBSA 25540 (Hartford-West Hartford-East Hartford, CT) and urban CBSA 31700 (Manchester-Nashua, NH), respectively). In addition, the proposed RY 2009 wage index reflects our proposals (discussed in greater detail below) to establish wage index values in urban and rural areas in which there are no IPPS wage data from which to compute a wage index value under our methodology described above. As noted above, the IPPS wage data we are proposing to use are the same FY 2004 acute care hospital inpatient wage data that were used to compute the FY 2008 wage index currently used under the IPPS.

In this proposed rule, under the broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of BIPA to determine appropriate adjustments under the LTCH PPS, we are also proposing to establish a policy for determining LTCH

PPS wage index values for labor market areas in which there is no IPPS hospital wage data from which to compute a wage index value under our methodology described above.

Currently, there are no LTCHs located in labor areas where there is no IPPS hospital wage data (or IPPS hospitals). However, we believe it is appropriate to establish a methodology for determining LTCH PPS wage index values for these areas in the event that in the future a LTCH should open in one of those areas. Thus, any LTCH that would open in area in which there is no IPPS wage data for which to compute a wage index based on our established methodology would have a wage index value assigned to them for determining their LTCH PPS payments. Under this proposal, each year we would determine a wage index value for any area in which there is no IPPS wage data based on the proposed methodologies described below. As IPPS hospitals may open or close at any time, the number of areas without any IPPS wage data may change from year to year, and even when an IPPS hospital does open in area where there are currently no IPPS hospitals, because there is a lag-time between the time a hospital opens or becomes an IPPS provider and when the hospital's cost report wage data are available to include in calculating the area wage index (see 72 FR 47323), we believe it is appropriate to establish a methodology for determining LTCH PPS wage index values for these areas, if necessary. Our proposed policies for determining LTCH PPS wage index values for areas with no IPPS hospital wage data are consistent with the policies that have been established under other Medicare post-acute care PPSs, such as SNF and HHA, as well as the IPPS.

The first situation for which we are proposing to establish a policy for determining a LTCH PPS wage index value is for urban CBSAs with no IPPS wage data. As discussed above, as IPPS wage data is dynamic, it is possible that urban areas without IPPS wage data will vary in the future. Consistent with the policy established under other PPSs, such as the HHA (70 FR 40795 and 71 FR 65892 through 65893), we are proposing to use an average of all of the urban areas within the State to serve as a reasonable proxy for determining the LTCH PPS wage index for an urban area without specific IPPS hospital wage index data. We believe that an average of all of the urban areas within the State would be a reasonable proxy for determining the LTCH PPS wage index for an urban area in the State with no wage data because it is based on pre-

reclassified IPPS wage data, it is easy to evaluate, and it uses the most geographically similar relative wage-related costs data available. (Our rationale for using pre-reclassified IPPS wage data is discussed above in the beginning of this section.) Based on the FY 2004 IPPS wage data that we are proposing to use to determine the proposed RY 2009 LTCH PPS wage index (discussed above), there is no IPPS wage data for the urban area of Hinesville-Fort Stewart, GA (CBSA 25980). Consistent with our proposal for determining a LTCH PPS wage index value for urban areas with no IPPS wage data, in this proposed rule, we calculated the proposed wage index value for RY 2009 for CBSA 25980 as the average of the wage index values for all of the other urban areas within the State of Georgia (that is, CBSAs 10500, 12020, 12060, 12260, 15260, 16860, 17980, 19140, 23580, 31420, 40660, 42340, 46660 and 47580) (refer to Table 1 of the Addendum of this proposed rule). (As noted above, there are currently no LTCHs located in CBSA 25980). We believe that this policy could be readily applied to other urban CBSAs (besides CBSA 25980) that lack IPPS wage data (possibly due to acute-care hospitals converting to a different provider type that does not submit the appropriate wage data). However, if the proposed policy is adopted, we may re-examine the application of this proposed policy should a similar situation arise in the future.

The other situation for which we are proposing to establish a policy for determining a LTCH PPS wage index value is for rural areas with no IPPS wage data. As discussed above, as IPPS wage data is dynamic, it is possible that rural areas without IPPS wage data will vary in the future. Consistent with the policy established under other PPSs, such as the HHA (71 FR 65905 through 65906) and the IPPS (72 FR 47323 through 47324), we are proposing to use the unweighted average of the wage indices from all of the CBSAs that are contiguous to the rural counties of the State to serve as a reasonable proxy in determining the LTCH PPS wage index for a rural area without specific IPPS hospital wage index data. For this purpose, we would define "contiguous" as sharing a border. We are not able to apply a similar averaging in rural areas with no wage data as we proposed above for urban areas with no wage data because there is no rural hospital data available for averaging on a state-wide basis. We believe that using an unweighted average of the wage indices from all of the CBSAs that are

contiguous to the rural counties of the State would be a reasonable proxy for determining the wage index for rural areas in a State with no wage data because it is based on pre-reclassified IPPS wage data, it is easy to evaluate, and it uses the most geographically similar relative wage-related costs data available. (Our rationale for using pre-reclassified IPPS wage data is discussed above in the beginning of this section.)

Based on the FY 2004 IPPS data that we are proposing to use to determine the proposed RY 2009 LTCH PPS wage index (discussed above), rural Massachusetts (CBSA code 11) does not have any IPPS wage data. Consistent with our proposal for determining a LTCH PPS wage index value for rural areas with no IPPS hospital wage data, in this proposed rule, we determined the proposed wage index value for RY 2009 rural Massachusetts by computing the unweighted average of the wage indices from all of the CBSAs that are contiguous to the rural counties in that State. Specifically, in the case of Massachusetts, the entire rural area consists of Dukes and Nantucket counties. We determined that the borders of Dukes and Nantucket counties are "contiguous" with Barnstable County, MA, and Bristol County, MA. Therefore, the proposed RY 2009 LTCH PPS wage index value for rural Massachusetts would be computed as the unweighted average of the proposed RY 2009 wage indexes for Barnstable county and Bristol county (refer to Tables 1 and 2 of the Addendum of this proposed rule). (As noted above, there are currently no LTCHs located in rural Massachusetts.) We believe that this proposed policy could be readily applied to other rural areas (besides Massachusetts) that lack IPPS wage data (possibly due to acute-care hospitals converting to a different provider type that does not submit the appropriate wage data). However, if the proposed policy is adopted, we may re-examine the application of this proposed policy should a similar situation arise in the future.

The proposed RY 2009 LTCH wage index values that would be applicable for LTCH discharges occurring on or after July 1, 2008 through September 30, 2009, are presented in Table 1 (for urban areas) and Table 2 (for rural areas) in the Addendum of this proposed rule. As discussed in greater detail above in section IV.B. of this preamble, we are proposing to move the LTCH PPS annual payment rate update cycle from July 1 to October 1 and to have a 15-month rate year for 2009 (that is, July 1, 2008 through September 30, 2009). Therefore, we note that if our proposal

to move the LTCH PPS annual payment rate update cycle is finalized, the next proposed update to the LTCH wage index values would be effective for discharges occurring on or after October 1, 2009 (FY 2010). In addition, as noted above, the wage index adjustment under the LTCH PPS was completely phased in beginning with cost reporting periods beginning in FY 2007 (that is, for cost reporting periods beginning on or after October 1, 2006). Therefore, for LTCH PPS discharges occurring during RY 2009, the labor related portion of the standard Federal rate will be adjusted by the applicable full (five fifths) proposed RY 2009 LTCH PPS wage index value. (As noted above, the proposed RY 2009 LTCH PPS wage index values are shown in Tables 1 and 2 of the Addendum to this proposed rule).

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

In the August 30, 2002 final rule (67 FR 56022), we established, under § 412.525(b), a COLA for LTCHs located in Alaska and Hawaii to account for the higher costs incurred in those States. In the RY 2008 LTCH PPS final rule (72 FR 26894), for RY 2008, we established a COLA to payments for LTCHs located in Alaska and Hawaii by multiplying the standard Federal payment rate by the appropriate factor listed in Table 3 of that same final rule.

Similarly, in this proposed rule, under the broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of BIPA to determine appropriate adjustments under the LTCH PPS, for RY 2009 we are proposing a COLA to payments to LTCHs located in Alaska and Hawaii by multiplying the proposed standard Federal payment rate by the proposed factors listed below in Table 2 because these are currently the most recent available data. These proposed factors are obtained from the U.S. Office of Personnel Management (OPM) and are currently also used under the IPPS (72 FR 47422). In addition, we propose that if OPM releases revised COLA factors before March 1, 2008, we would use them for the development of LTCH PPS payments for RY 2009 and publish those revised COLA factors in the final rule.

TABLE 2.—PROPOSED COST-OF-LIVING ADJUSTMENT FACTORS FOR ALASKA AND HAWAII HOSPITALS FOR THE 2009 LTCH PPS RATE YEAR

Alaska:	
City of Anchorage and 80-kilometer (50-mile) radius by road ..	1.24
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.24
City of Juneau and 80-kilometer (50-mile) radius by road	1.24
All other areas of Alaska	1.25
Hawaii:	
City and County of Honolulu	1.25
County of Hawaii	1.17
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

3. Proposed Adjustment for High-Cost Outliers (HCOs)

a. Background

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

Under § 412.525(a) (in conjunction with the revised definition of “LTC-DRG” at § 412.503), we make outlier payments for any discharges if the estimated cost of a case exceeds the adjusted LTCH PPS payment for the MS-LTC-DRG plus a fixed-loss amount. Specifically, in accordance with § 412.525(a)(3) (in conjunction with the revised definition of “LTC-DRG” at § 412.503), 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 MS-LTC-DRG and the fixed-loss amount). The fixed-loss amount is the amount used to limit the loss that a hospital will incur under the outlier

policy for a case with unusually high costs. This results in Medicare and the LTCH sharing financial risk in the treatment of extraordinarily costly cases. Under the LTCH PPS HCO policy, the LTCH's loss is limited to the fixed-loss amount and a fixed percentage (currently 80 percent) of costs above the outlier threshold (LTCH DRG payment plus the fixed loss amount). The fixed percentage of costs is called the marginal cost factor. We calculate the estimated cost of a case by multiplying the Medicare allowable covered charge by the overall hospital cost-to-charge ratio (CCR).

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

b. Cost-to-Charge Ratios (CCRs)

The following is a discussion of cost-to-charge ratios (CCRs) used in determining payments for high cost and short-stay outlier cases under the LTCH PPS, at § 412.525(a) and § 412.529, respectively. Although this section is specific to high cost outlier cases, because CCRs and the policies and methodologies pertaining to them are used in determining payments for both high cost and short-stay outlier cases, (as explained below), we are discussing the determination of CCRs under the LTCH PPS for both of these type of cases simultaneously. In section IV.G. of this proposed rule, which discusses short-stay outlier (SSO) cases, we refer the reader to this section of the preamble for a complete discussion on the determination of CCRs.

In determining both high-cost outlier payments (at § 412.525(a)) and short-stay outlier payments (at § 412.529), we calculate the estimated cost of the case by multiplying the LTCH's overall CCR by the Medicare allowable charges for the case. In general, we use the LTCH's overall CCR, which is computed based on either the most recently settled cost report or the most recent tentatively settled cost report, whichever is from

the latest cost reporting period, in accordance with § 412.525(a)(4)(iv)(B) and § 412.529(c)(4)(iv)(B) for high cost outliers and SSOs, respectively. (We note that in some instances we use an alternative CCR, such as the statewide average CCR in accordance with the regulations at § 412.525(a)(4)(iv)(C) and § 412.529(c)(4)(iv)(C), or a CCR that is specified by CMS or that is requested by the hospital under the provisions of the regulations at § 412.525(a)(4)(iv)(A) and § 412.529(c)(4)(iv)(A).) Under the LTCH PPS, a single prospective payment per discharge is made for both inpatient operating and capital-related costs. Therefore, we compute a single “overall” or “total” LTCH-specific CCR based on the sum of LTCH operating and capital costs (as described in Chapter 3, section 150.24, of the Medicare Claims Processing Manual (CMS Pub. 100–4)) as compared to total charges. Specifically, a LTCH’s CCR is calculated by dividing a LTCH’s total Medicare costs (that is, the sum of its operating and capital inpatient routine and ancillary costs) by its total Medicare charges (that is, the sum of its operating and capital inpatient routine and ancillary charges).

Generally, a LTCH is assigned the applicable statewide average CCR if, among other things, a LTCH’s CCR is found to be in excess of the applicable maximum CCR threshold (that is, the LTCH CCR ceiling). This is because CCRs above this threshold are most likely due to faulty data reporting or entry, and, therefore, these CCRs should not be used to identify and make payments for outlier cases. Such data are clearly errors and should not be relied upon. Thus, under our established policy, generally, if a LTCH’s calculated CCR is above the applicable ceiling, the applicable LTCH PPS statewide average CCR is assigned to the LTCH instead of the CCR computed from its most recent (settled or tentatively settled) cost report data.

In the FY 2008 IPPS final rule with comment period, in accordance with § 412.525(a)(4)(iv)(C)(2) for high-cost outliers and § 412.529(c)(4)(iv)(C)(2) for short-stay outliers, using our established methodology for determining the LTCH total CCR ceiling, based on IPPS total CCR data from the March 2007 update to the Provider-Specific File (PSF), we established a total CCR ceiling of 1.284 under the LTCH PPS effective October 1, 2007 through September 30, 2008. (For further detail on our methodology for annually determining the LTCH total CCR ceiling, we refer readers to the FY 2007 IPPS final rule (71 FR 48119 through 48121) and the FY 2008 IPPS

final rule with comment period (72 FR 47403 through 47404).)

Our general methodology established for determining the statewide average CCRs used under the LTCH PPS is similar to our established methodology for determining the LTCH total CCR ceiling (described above) since it is based on “total” IPPS CCR data. Under the LTCH PPS HCO policy at § 412.525(a)(4)(iv)(C) and the short-stay outlier policy at § 412.529(c)(4)(iv)(C), the FI may use a statewide average CCR, which is established annually by CMS, if it is unable to determine an accurate CCR for a LTCH in one of the following circumstances: (1) New LTCHs that have not yet submitted their first Medicare cost report (for this purpose, consistent with current policy, a new LTCH would be defined as an entity that has not accepted assignment of an existing hospital’s provider agreement in accordance with § 489.18); (2) LTCHs whose CCR is in excess of the LTCH CCR ceiling (as discussed above); and (3) other LTCHs for whom data with which to calculate a CCR are not available (for example, missing or faulty data). (Other sources of data that the FI may consider in determining a LTCH’s CCR include data from a different cost reporting period for the LTCH, data from the cost reporting period preceding the period in which the hospital began to be paid as a LTCH (that is, the period of at least 6 months that it was paid as a short-term acute care hospital), or data from other comparable LTCHs, such as LTCHs in the same chain or in the same region.)

In the FY 2008 IPPS final rule with comment period, in accordance with § 412.525(a)(4)(iv)(C) for high-cost outliers and § 412.529(c)(4)(iv)(C) for short-stay outliers, using our established methodology for determining the LTCH statewide average CCRs, based on the most recent complete IPPS total CCR data from the March 2007 update of the PSF, the LTCH PPS statewide average total CCRs for urban and rural hospitals effective for discharges occurring on or after October 1, 2007, and before October 1, 2008, are presented in Table 8C of the Addendum to that final rule with comment period (72 FR 48127). (For further detail on our methodology for annually determining the LTCH urban and rural statewide average CCRs, we refer readers to the FY 2007 IPPS final rule (71 FR 48119 through 48121) and FY 2008 IPPS final rule with comment period (72 FR 47403 through 47404).)

We note, under the LTCH PPS high cost outlier policy at § 412.525(a)(4)(iv)(D) and the LTCH PPS SSO policy at § 412.529(c)(4)(iv)(D), the

payments for high cost outlier and SSO cases, respectively, are subject to reconciliation. Specifically, any reconciliation of outlier payments is based on the CCR calculated based on a ratio of costs to charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled. For additional information, refer to the RY 2008 LTCH PPS final rule (72 FR 26899 through 26900).

c. Establishment of the Proposed Fixed-Loss Amount

When we implemented the LTCH PPS, as discussed in the August 30, 2002 LTCH PPS final rule (67 FR 56022 through 56026), under the broad authority of section 123 of the BBRA as amended by section 307(b) of BIPA, we established a fixed-loss amount so that total estimated outlier payments are projected to equal 8 percent of total estimated payments under the LTCH PPS. To determine the fixed-loss amount, we estimate outlier payments and total LTCH PPS payments for each case using claims data from the MedPAR files. Specifically, to determine the outlier payment for each case, we estimate the cost of the case by multiplying the Medicare covered charges from the claim by the LTCH’s hospital specific CCR. Under § 412.525(a)(3) (in conjunction with the revised definition of “LTC-DRG” at § 412.503), if the estimated cost of the case exceeds the outlier threshold (the sum of the adjusted Federal prospective payment for the MS-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 MS-LTC-DRG and the fixed-loss amount).

In the RY 2008 LTCH PPS final rule (72 FR 26898), in calculating the fixed-loss amount that would result in estimated outlier payments projected to be equal to 8 percent of total estimated payments for the 2008 LTCH PPS rate year, we used claims data from the December 2006 update of the FY 2006 MedPAR files and CCRs from the December 2006 update of the PSF, as that was the best available data at that time. We believe that CCRs from the PSF are the best available CCR data for determining estimated LTCH PPS payments for a given LTCH PPS rate year because they are the most recently available CCRs actually used to make LTCH PPS payments.

As we also discussed in the RY 2008 LTCH PPS rate year final rule (72 FR 26898), we calculated a single fixed-loss

amount for the 2008 LTCH PPS rate year based on the version 24.0 of the GROUPER, which was the version in effect as of the beginning of the LTCH PPS rate year (that is, July 1, 2007 for the 2008 LTCH PPS rate year). In addition, we applied the outlier policy under § 412.525(a) in determining the fixed-loss amount for the 2008 LTCH PPS rate year; that is, we assigned the applicable Statewide average CCR only to LTCHs whose CCRs exceeded the ceiling (and not when they fell below the floor). Accordingly, we used the FY 2007 LTCH PPS total CCR ceiling of 1.321 (72 FR 26898). As noted in that same final rule, in determining the fixed-loss amount for the 2008 LTCH PPS rate year using the CCRs from the PSF, there were no LTCHs with missing CCRs or with CCRs in excess of the current ceiling and, therefore, there was no need for us to independently assign the applicable Statewide average CCR to any LTCHs in determining the fixed-loss amount for the 2008 LTCH PPS rate year (as this may have already been done by the FI in the PSF in accordance with the established policy).

Accordingly, in 2008 LTCH PPS rate year final rule (72 FR 26898), as amended by the RY 2008 correction notice (72 FR 36613), we established a fixed-loss amount of \$20,738 for the 2008 LTCH PPS rate year. Thus, we pay an outlier case 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted Federal LTCH PPS payment for the MS-LTC-DRG and the fixed-loss amount of \$20,738).

In this proposed rule, for the 2009 LTCH PPS rate year, we used the March 2006 update of the FY 2006 MedPAR claims data to determine a proposed fixed-loss amount that would result in estimated outlier payments projected to be equal to 8 percent of total estimated payments, based on the policies described in this proposed rule, because these data are the most recent complete LTCH data available. Consistent with our historical practice of using the best data available, if more recent LTCH claims data become available, we propose to use it for determining the fixed-loss amount for the 2009 LTCH PPS rate year in the final rule. Furthermore, as noted previously, we determined the proposed fixed-loss amount based on the version of the GROUPER that would be in effect as of the beginning of the 2009 LTCH PPS rate year (July 1, 2008), that is, Version 25.0 of the GROUPER (as established in the FY 2008 IPPS final rule (72 FR 47278)).

We also used CCRs from the July 2007 update of the PSF for determining the

proposed fixed-loss amount for the 2009 LTCH PPS rate year as they are currently the most recent complete available data. Consistent with our historical practice of using the best data available, if more recent CCR data are available, we propose to use it for determining the fixed-loss amount for the 2009 LTCH PPS rate year in the final rule. Furthermore, in determining the proposed fixed-loss amount for the 2009 LTCH PPS rate year, we used the current FY 2008 applicable LTCH “total” CCR ceiling of 1.284 and LTCH Statewide average “total” CCRs established in the FY 2008 IPPS final rule (72 FR 47404 and 48126 through 48127) such that the current applicable Statewide average CCR would be assigned if, among other things, a LTCH’s CCR exceeded the current ceiling (1.284). We note that in determining the proposed fixed-loss amount for the 2009 LTCH PPS rate year using the CCRs from the PSF, there was no need for us to independently assign the applicable Statewide average CCR to any LTCHs (as this may have already been done by the FI in the PSF in accordance with our established policy). (Currently, the applicable FY 2008 LTCH Statewide average CCRs can be found in Table 8C of the FY 2008 IPPS final rule (72 FR 48126 through 48127).)

Accordingly, based on the data and policies described in this proposed rule, we are proposing a fixed-loss amount of \$21,199 for the 2009 LTCH PPS rate year. Thus, we would pay an outlier case 80 percent of the difference between the estimated cost of the case and the proposed outlier threshold (the sum of the adjusted proposed Federal LTCH payment for the MS-LTC-DRG and the proposed fixed-loss amount of \$21,199). We note that the proposed fixed-loss amount for the 2009 LTCH PPS rate year is somewhat higher than the current fixed-loss amount of \$20,738. In addition to being based on the most recent available LTCH data to estimate the cost of each LTCH case, this proposed change in the fixed-loss amount is primarily due to the projected increase in estimated aggregate LTCH PPS payments that is expected to result from the proposed 2.6 percent update to the Federal rate (discussed in greater detail in section IV.E. of this preamble), in conjunction with the proposed changes to the area wage adjustment (discussed in greater detail in section IV.F.1. of this preamble) and the changes to the MS-LTC-DRG relative weights for FY 2008 (as discussed in the FY 2008 IPPS final rule (72 FR 47277 through 47299)). As discussed in greater detail in the impact analysis presented

in section XII. of this proposed rule, we are projecting that the proposed changes would result in a 1.7 percent increase in estimated payments per discharge in RY 2009 as compared to RY 2008, on average, for all LTCHs. Because of the estimated increase in aggregate LTCH PPS payments proposed for the 2009 LTCH PPS rate year (as discussed above in this section), we believe that an increase in the proposed fixed-loss amount is appropriate and necessary to maintain the requirement that estimated outlier payments would be projected to be equal to 8 percent of estimated total LTCH PPS payments, as required under § 412.525(a). As we discussed in the RY 2008 final rule (72 FR 26897), maintaining the fixed-loss amount at the current level would result in HCO payments above the current regulatory requirement that estimated outlier payments would be projected to equal 8 percent of estimated total LTCH PPS payments. Based on the regression analysis that was performed when we implemented the LTCH PPS (August 30, 2002 final rule (67 FR 56022 through 56027)), we established the outlier target at 8 percent of estimated total LTCH PPS payments to allow us to achieve a balance between the “conflicting considerations of the need to protect hospitals with costly cases, while maintaining incentives to improve overall efficiency” (67 FR 56024). That regression analysis also showed that additional increments of outlier payments over 8 percent (that is, raising the outlier target to a larger percentage than 8 percent) would reduce financial risk, but by successively smaller amounts. Outlier payments are budget neutral, and therefore, outlier payments are funded by prospectively reducing the non-outlier PPS payment rates by projected total outlier payments. The higher the outlier target, the greater the (prospective) reduction to the base payment would need to be applied to the Federal rate to maintain BN.

As we discussed in the RY 2008 LTCH PPS final rule (72 FR 26898 through 26899), as an alternative to proposing to lower the fixed-loss amount for RY 2009, 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 MS-LTC-DRG and the fixed-loss amount for LTCH PPS outlier cases as specified in § 412.525(a)(3) in conjunction with the revised definition of “LTC-DRG” at § 412.503), which is currently equal to 80 percent, as a means of ensuring that estimated outlier payments would be

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

In proposing increases to the fixed-loss amount for RY 2007 and RY 2008 (71 FR 27834 and 72 FR 4799 through 4800 respectively), we also solicited comments on whether we should revisit the regression analysis discussed above in this section that was used to establish the existing 8 percent outlier target and 80 percent marginal cost factor, using the most recent available data to evaluate whether the current outlier target of 8 percent or the 80 percent marginal cost factor should be adjusted, and therefore, could have resulted in less of an increase in the fixed-loss amount for RY 2007 and RY 2008, respectively. In response to this solicitation in the RY 2007 proposed rule (as summarized in the RY 2007 LTCH PPS final rule (71 FR 27834 through 27835)), several commenters opposed any option that would allow us to revisit the regression analysis that was used to establish the existing 80 percent marginal cost factor and existing outlier target of 8 percent. The commenters stated their belief that the LTCH PPS is still in its early stages and further changes to the 80 percent marginal cost factor or 8 percent outlier target would result in instability to the system. The commenters cautioned against making any premature changes to the factors affecting HCO payments to LTCHs, particularly the marginal cost factor and outlier target established by regulation when the LTCH PPS was implemented. Also, the commenters agreed that keeping the marginal cost factor at 80 percent and the outlier pool at 8 percent better identifies LTCH patients that are truly unusually costly cases, and that this policy appropriately addresses outlier cases that are significantly more expensive than non-outlier cases. Similarly, as summarized in the RY 2008 final rule (72 FR 26897), we received no comments in support of revisiting the regression analysis discussed above that was used to establish the existing 8 percent outlier target and 80 percent marginal cost factor, using the most recent available data to evaluate whether the current outlier target of 8 percent or the 80

percent marginal cost factor should be adjusted in response to our solicitation on this issue.

In response to these comments, we agreed with the commenters that, based on the regression analysis done for the implementation of the LTCH PPS (August 30, 2002; 68 FR 56022 through 56026), a marginal cost factor of 80 percent and a outlier target of 8 percent best identifies LTCH patients that are truly unusually costly cases, and that such a policy appropriately addresses LTCH HCO cases that are significantly more expensive than non-outlier cases, which is consistent with our intent of the LTCH HCO policy as stated when we implemented the LTCH PPS in the August 30, 2002 final rule (67 FR 56025). Therefore, as supported by many commenters, in both the RY 2007 final rule (71 FR 27835) and the RY 2008 final rule (72 FR 26898), we did not revisit the regression analysis that was used to establish the existing 80 percent marginal cost factor and existing outlier target of 8 percent, and therefore, did not make any changes to the marginal cost factor or outlier target in either of those final rules.

Although proposing to increase the fixed-loss amount from \$20,738 to \$21,199 (based on the policies presented in this proposed rule) would increase the amount of the "loss" that a LTCH must incur under the LTCH PPS for a case with unusually high costs before the LTCH would receive any additional Medicare payments, as we discussed above and as we explained in greater detail in the RY 2006 LTCH PPS final rule (70 FR 24195 through 24196), we continue to believe that the existing 8 percent outlier target and 80 percent marginal cost factor continue to adequately maintain the LTCHs' share of the financial risk in treating the most costly patients and ensure the efficient delivery of services. Accordingly, we are not proposing to adjust the existing 8 percent outlier target or 80 percent marginal cost factor under the LTCH PPS HCO policy at this time. However, we continue to be interested in any comments that would support revisiting the analysis that was used to establish the existing 8 percent outlier target and the existing 80 percent marginal cost factor, using the most recent available data to evaluate whether any changes to the current HCO policy should be made, and therefore, may result in a smaller increase (or even a decrease) in the fixed-loss amount for RY 2009.

For the reasons described above, we believe the proposed fixed-loss amount of \$21,199 would appropriately identify unusually costly LTCH cases while maintaining the integrity of the LTCH

PPS. Thus, under the broad authority of section 123(a)(1) of the BBRA and section 307(b)(1) of BIPA, we are proposing a fixed-loss amount of \$21,199 based on the best available LTCH data and the policies presented in this proposed rule because we believe a proposed increase in the fixed-loss amount is appropriate and necessary to maintain estimated outlier payments are projected to be equal to 8 percent of estimated total LTCH PPS payments, as required under § 412.525(a).

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

As we discussed in the August 30, 2002 final rule (67 FR 56026), under some rare circumstances, a LTCH discharge could qualify as a SSO case (as defined under § 412.529 and discussed in section IV.G. of this preamble) and also as a HCO case. In this scenario, a patient could be hospitalized for less than five-sixths of the geometric ALOS for the specific MS-LTC-DRG, and yet incur extraordinarily high treatment costs. If the costs exceeded the high cost outlier threshold (that is, the SSO payment plus the fixed-loss amount), the discharge is eligible for payment as a HCO. Thus, for a SSO case in the 2009 LTCH PPS rate year, the HCO payment would be 80 percent of the difference between the estimated cost of the case and the proposed outlier threshold (the sum of the proposed fixed-loss amount of \$21,199 and the amount paid under the SSO policy as specified in § 412.529).

4. Other Payment Adjustments

Section 123(a)(1) of the BBRA, as amended by section 307(b) of BIPA, granted the Secretary broad authority to determine appropriate adjustments under the LTCH PPS, including whether (and how) to provide for adjustments to reflect variations in the necessary costs of treatment among LTCHs. In developing the LTCH PPS payment methodology, we conducted extensive regression analyses of the relationship between LTCH costs (including both operating and capital-related costs per case) and several factors that may affect costs such as the percent of Medicaid patients treated, the percent of Supplemental Security Income (SSI) patients treated, the hospital's geographic location, and training residents in approved medical education programs (67 FR 56014). The appropriateness of potential payment adjustments were evaluated based upon whether including each adjustment increased the accuracy of payments to LTCHs.

In the August 30, 2002 LTCH PPS final rule, we detailed the extensive data analysis performed by our contractor, 3M Health Information Systems (3M) and our resulting decisions to implement a COLA for LTCHs in Alaska and Hawaii (§ 412.525(b)) and an adjustment to account for geographical differences in area wage levels (§ 412.525(c)). In addition, we discussed the extensive data analyses that led to the decision not to implement adjustments for geographic reclassification, rural location, the treatment of a disproportionate share of low-income patients (DSH), or indirect medical education (IME) costs. We also noted that we would continue to collect data and revisit these determinations as additional data became available. (For more detailed information, see 67 FR 56014 through 56027.)

When we implemented the LTCH PPS for FY 2003, we provided for a 5-year transition period (§ 412.533), to allow LTCHs time to adjust to the new payment system (67 FR 56038). For cost reporting periods beginning on or after October 1, 2006, the final year of the 5-year transition, LTCHs are paid based on 100 percent of the Federal rate.

We continued to collect and interpret new data as they became available to determine if these data support proposing any additional payment adjustments. In both the RY 2007 and the RY 2008 LTCH PPS final rules, we stated that we believed that it was appropriate to wait for the conclusion of the 5-year transition to 100 percent of the Federal rate under the LTCH PPS to maximize the availability of data that reflected LTCH behavior in response to the implementation of the LTCH PPS. The availability of this data would allow us to conduct a comprehensive reevaluation of payment adjustments under the LTCH PPS. (See the RY 2007 and RY 2008 LTCH PPS final rules (71 FR 27839) and (72 FR 26900), respectively.)

Therefore, similar to the data analyses conducted at the inception of the LTCH PPS for FY 2003, 3M evaluated LTCH data from the most recent cost report files in our HCRIS database (updated through June 30, 2007) for providers' cost reports beginning during fiscal years 2004 through 2006. We believe that in the 5 years since the start of the LTCH PPS, there has been sufficient new data generated to allow for a comprehensive reevaluation of the appropriateness of payment adjustments such as geographic reclassification, rural location, DSH, and IME under the LTCH PPS at this time.

Our most recent data analysis which is based on the comprehensive data

analysis by 3M (referenced above), indicates that proposing payment adjustments for geographic reclassification, rural location, DSH, or indirect medical education (IME) costs would not improve the accuracy of payments to LTCHs. (3M's "Report on LTCH Payment Methodology Review and Results" is posted on our Web site at: http://www.cms.hhs.gov/LongTermCareHospitalPPS/08_download.asp#TopOfPage.)

We believe that these analyses confirm our initial determinations as we developed the LTCH PPS regarding the applicability of PPS payment adjustments. Therefore, we are not proposing to adopt any additional payment adjustments such as geographic reclassification, rural location, DSH, or IME, as features of the LTCH PPS. Proposed policies for the RY 2009 wage index adjustment and the COLA are discussed in sections IV.D.1 and 2. of this proposed rule, respectively. Furthermore, now that the 5-year transition to the LTCH PPS is completed, we have collected data that reflects LTCH behavior in response to the implementation of the LTCH PPS. We believe that our above described analyses of LTCH PPS data do not support the adoption of any additional payment adjustments. We further believe that since 3M's recent analyses confirm policy determinations that have been in place since the implementation of the LTCH PPS for FY 2003, that annual data analyses related to potential payment adjustments for geographic reclassification, rural location, DSH or IME will not be necessary barring significant transformations in the nature of the LTCH universe or substantial changes in Medicare payment outcomes that warrant additional evaluation.

5. Technical Correction to the Budget Neutrality Requirement at § 412.523(d)(2)

Section 123(a)(1) of the Public Law 106–113 requires that the PPS developed for LTCHs be budget neutral for the initial year of implementation. Furthermore, under section 307(a)(2) of the Public Law 106–554, the increases to the target amounts and the cap on the target amounts for LTCHs provided for by section 307(a)(1) of Public Law 106–554 (as set forth in section 1886(b)(3)(J) of the Act), and the enhanced bonus payments for LTCHs provided for by section 122 of Public Law 106–113 (as set forth in section 1886(b)(2)(E) of the Act) were not to be taken into account in the development and implementation of the LTCH PPS. Therefore, when we implemented the LTCH PPS, in the August 30, 2002 final rule (67 FR

56052), we established a budget neutrality requirement at § 412.523(d)(2) for calculating the standard Federal rate for FY 2003 such that estimated aggregate LTCH PPS payments were estimated to be equal to estimated payments that would have been made to LTCHs under the reasonable cost-based payment methodology had the PPS for LTCHs not been implemented, and, to implement section 307(a)(2) of the Public Law 106–554, we excluded the effects of sections 1886(b)(2) and (b)(3) of the Act.

We are proposing a technical correction to existing § 412.523(d)(2) that would more precisely describe the provisions of sections 1886(b)(2) and (b)(3) of the Act that were not taken into account when determining the standard Federal rate under § 412.523(d). The current regulatory language at § 412.523(d)(2) cites the general sections of the Act which contain the specific provisions set forth in § 307(a)(2) of Public Law 106–554 that the Secretary is required to not take into account in developing the PPS. We believe that it is clearer and more precise to cite the specific subparagraphs the Secretary did not take into account rather than to cite the general sections of the Act of which such subparagraphs are a part. In order to mitigate any confusion that may be caused by existing regulations, we are proposing to make a technical correction at § 412.523(d)(2).

Specifically, we are proposing to revise § 412.523(d)(2) to state that the effects of section 1886(b)(2)(E) of the Act (enhanced bonus payments for LTCHs, as described above) and section 1886(b)(3)(J) of the Act (increases to the hospital-specific target amounts and the cap on the target amounts for LTCHs, as described above) were excluded in the development of the FY 2003 LTCH PPS standard Federal rate. This technical correction would make the regulatory language consistent with section 307(a)(2) of Public Law 106–113 and consistent with the methodology we used to determine the LTCH PPS standard Federal rate under § 412.523, and it is not a change in policy. (Accordingly, no adjustments to the LTCH PPS standard Federal rate computed under § 412.523(d) have been proposed in conjunction with this proposed technical correction to § 412.523(d)(2).)

G. Proposed Conforming Changes

Various regulations throughout 42 CFR Part 412 Subpart O indicate that the terms "urban area" and "rural area" are defined according to the definitions of "urban area" and "rural area" found in 42 CFR Part 412 Subpart D (the IPPS

regulations). Specifically, §§ 412.525(c), 412.529(d)(4)(ii)(B) and (d)(4)(iii)(B), 412.534(d)(1), (f)(2)(ii), and (f)(3)(ii), and 412.536(c)(1), (e)(2)(ii), and (e)(3)(ii) of Subpart O refer to the definitions of “urban area” and “rural area” in either § 412.62(f)(1)(ii) and (f)(1)(iii) or § 412.64(b)(1)(ii)(A)–(C) in 42 CFR Part 412 Subpart D. As stated elsewhere in the preamble, we believe that it is administratively simpler to define the terms “urban area” and “rural area” in § 412.503 rather than cross-referencing the definitions of “urban area” and “rural area” in § 412.62(f)(1)(ii) and § 412.62(f)(1)(iii) and § 412.64(b)(1)(ii)(A)–(C). Consequently, in section IV.F.1.b(4). of this regulation, we propose to add definitions for “urban area” and “rural area” in § 412.503 which would incorporate the provisions of § 412.62(f)(1)(ii) and (f)(1)(iii) as well as § 412.64(b)(1)(ii)(A) through (C). Because we are proposing to define “urban area” and “rural area” in § 412.503, the citations to the definitions of “urban area” and “rural area” in § 412.62(f)(1)(ii) and § 412.62(f)(1)(iii) and § 412.64(b)(1)(ii)(A)–(C) which are found in §§ 412.525(c), 412.529(d)(4)(ii)(B) and (d)(4)(iii)(B), 412.534(d)(1), (f)(2)(ii), and (f)(3)(ii), and 412.536(c)(1), (e)(2)(ii), and (e)(3)(ii) would need to be replaced with references to § 412.503. We are proposing to replace the above-described references with § 412.503. (We note that provisions of the Medicare, Medicaid, and SCHIP

Extension Act of 2007, enacted on December 29, 2007 require a 3-year suspension of the payment adjustments at § 412.534 to “grandfathered LTCHs” and application of § 412.536 to “freestanding” LTCHs for cost reporting periods beginning on or after the date of enactment of the legislation. In addition, revisions to the short stay outlier policy, as well as other changes to the regulations necessitated by MMSEA will be addressed in a future notice.)

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

In accordance with § 412.525 and as discussed in section IV.C. of this proposed rule, the standard Federal rate is adjusted to account for differences in area wages by multiplying the labor-related share of the standard Federal rate by the appropriate LTCH PPS wage index (as shown in Tables 1 and 2 of Addendum A to this proposed rule). The standard Federal rate is also adjusted to account for the higher costs of hospitals in Alaska and Hawaii by multiplying the nonlabor-related share of the standard Federal rate by the appropriate cost-of-living factor (shown in Table 3 in section IV.D.2 of this preamble). In the RY 2008 LTCH PPS final rule (72 FR 4776), we established a standard Federal rate of \$38,356.45 for the 2008 LTCH PPS rate year. In this proposed rule, based on the best available data and the proposed policies described in this proposed rule, we are

proposing that the standard Federal rate for the 2009 LTCH PPS rate year would be \$39,076.28 as discussed in section IV.C.3. of this preamble. We illustrate the methodology that would be used to adjust the proposed Federal prospective payments for the 2009 LTCH PPS rate year in the following examples:

Example: During the 2009 LTCH PPS rate year, a Medicare patient is in a LTCH located in Chicago, Illinois (CBSA 16974). The proposed full LTCH PPS wage index value for CBSA 16974 is 1.0715 (see Table 1 in Addendum A to this proposed rule). The Medicare patient is classified into MS–LTC–DRG 28 (Spinal Procedures with MCC), which has a current relative weight of 1.1417 (see Table 3 of Addendum A to this proposed rule).

To calculate the LTCH's proposed total adjusted Federal prospective payment for this Medicare patient, we compute the proposed wage-adjusted Federal prospective payment amount by multiplying the proposed unadjusted standard Federal rate (\$39,076.28) by the proposed labor-related share (75.920 percent) and the proposed wage index value (1.0715). This proposed wage-adjusted amount is then added to the nonlabor-related portion of the proposed unadjusted standard Federal rate (24.080 percent; adjusted for cost of living, if applicable) to determine the proposed adjusted Federal rate, which is then multiplied by the MS–LTC–DRG relative weight (1.1417) to calculate the proposed total adjusted Federal prospective payment for the 2009 LTCH PPS rate year (\$47,035.13). Table 6 illustrates the components of the calculations in this example.

TABLE 6

Unadjusted Proposed Standard Federal Prospective Payment Rate	\$39,076.28
Proposed Labor-Related Share	× 0.75920
Proposed Labor-Related Portion of the Federal Rate	= \$29,666.71
Proposed Wage Index (CBSA 16974)	× 1.0715
Proposed Wage-Adjusted Labor Share of Federal Rate	= \$31,787.88
Proposed Nonlabor-Related Portion of the Federal Rate (\$39,076.28 × 0.24080)	+ \$ 9,409.57
Proposed Adjusted Federal Rate Amount	= \$41,197.45
MS–LTC–DRG 9 Relative Weight	× 1.1417
Proposed Total Adjusted Federal Prospective Payment	= \$47,035.13

VII. Monitoring

In the August 30, 2002 final rule (67 FR 56014), we described an on-going monitoring component to the new LTCH PPS. Specifically, we discussed on-going analysis of the various policies that we believe would provide equitable payment for stays that reflect less than the full course of treatment and reduce the incentives for inappropriate admissions, transfers, or premature discharges of patients that are present in a discharge-based PPS. As a result of our data analysis, we have revisited a number of our original policies and

have identified behaviors by certain LTCHs that lead to inappropriate Medicare payments.

In the RY 2005 LTCH PPS final rule (69 FR 25692) we revised the interruption of stay policy. We also established a payment adjustment for LTCH HwHs and satellites in the FY 2005 IPPS final rule (69 FR 49191 through 49214). In the RY 2008 final rule, at § 412.536, based on additional data monitoring and analysis, we expanded this payment adjustment to apply to LTCHs and LTCH satellites that were not co-located with their referring hospitals.

In the RY 2007 and 2008 final rules (71 FR 27798 and 72 FR 28670), we revised the SSO payment adjustment formula as a consequence of data analyses which indicated that Medicare was overpaying for certain SSO cases.

Although at this time, we are not proposing any new payment adjustments that have resulted from our monitoring activity, we continue to pursue our on-going monitoring program that involves the CMS Office of Research and Development (ORDI), existing QIO monitoring, and studies described in the RY 2006 LTCH PPS final rule (70 FR 24211).

As we discussed in the RY 2004 LTCH PPS final rule (68 FR 34157), the Medicare Payment Advisory Commission (MedPAC) endorsed our monitoring activity. Furthermore, the Commission pursued an independent research initiative that led to a section in MedPAC's June 2004 Report to Congress entitled "Defining long-term care hospitals". This study included recommendations that we develop facility and patient criteria for LTCH admission and treatment and that we require a review by QIOs to evaluate whether LTCH admissions meet criteria for medical necessity once the recommended facility and patient criteria are established (70 FR 24210). In response to the recommendation in MedPAC's June 2004 Report, we awarded a contract to Research Triangle Institute, International (RTI), on September 27, 2004, to conduct a thorough examination of the feasibility of implementing MedPAC's recommendations.

Both Part 1 and Part 2 of the RTI Report are available on our Web site at http://www.cms.hhs.gov/LongTermCareHospitalPPS/02a_RTIReports.asp#TopOfPage. We also included the Executive Summary of RTI's final report in Addendum B of the RY 2008 proposed rule (72 FR 4884 through 4886). (A comprehensive discussion of RTI's continuing work is included at section XI of this proposed rule.)

VIII. Method of Payment

Under § 412.513, a Medicare LTCH patient is classified into a MS-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 MS-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 MS-LTC-DRG rate to payment for a case as a SSO (under § 412.529) or as an interrupted stay (under § 412.531), or to determine if the case will qualify for a HCO payment (under § 412.525(a)).

Accordingly, the ICD-9-CM codes and other information used to determine if an adjustment to the full MS-LTC-DRG payment is necessary (for example, LOS or interrupted stay status) are recorded by the LTCH on the Medicare

patient's discharge bill and submitted to the Medicare FI for processing. The payment represents payment in full, under § 412.521(b), for inpatient operating and capital-related costs, but not for the costs of an approved medical education program, bad debts, blood clotting factors, anesthesia services by hospital-employed nonphysician anesthesiologists 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), based on the estimated prospective payment for the year, and may be eligible to receive accelerated payments as described in § 413.64(g). We exclude HCO payments that are paid upon submission of a discharge bill from the PIP amounts. In addition, Part A costs that are not paid for under the LTCH PPS, including Medicare costs of an approved medical education program, bad debts, blood clotting factors, anesthesia services by hospital-employed nonphysician anesthesiologists and the costs of photocopying and mailing medical records requested by a QIO, are subject to the interim payment provisions as specified in § 412.541(c).

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

IX. RTI's Research

With the recommendations of MedPAC's June 2004 Report to Congress as a point of departure, we awarded a contract to Research Triangle Institute, International (RTI) at the start of FY 2005 for a comprehensive evaluation of the feasibility of developing patient and facility level characteristics for LTCHs that could distinguish LTCH patients from those treated in other hospitals.

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

providers. This work reviewed prior analyses of these issues and included discussions with MedPAC, other researchers, CMS, the QIOs, and the hospital associations.

In Phase II, RTI collected additional information on tools currently used by the QIOs and the industry to assess patient appropriateness for admission; analyzed claims to understand differences between short term acute care hospital patients with outlier stays who were subsequently treated in LTCHs compared to those who were not and differences between patients who continued treatment as outliers in acute care hospitals with patients who had been admitted to LTCH with the same DRGs; and visited different types of hospitals to observe first-hand how LTCH patients differ from those in other settings and how this pattern varies in different parts of the country. RTI worked with different associations, including the National Association of Long Term Hospitals (NALTH), the Acute Long Term Hospital Association (ALTHA), the American Hospital Association (AHA), and the American Medical Rehabilitation Providers Association (AMRPA), as well as several of the larger LTCH chains. The final report for those phases submitted by RTI summarizes these efforts and makes recommendations to CMS regarding LTCHs.

(We have posted the reports on both Phase I and Phase II of RTI's research on our Web site at http://www.cms.hhs.gov/LongTermCareHospitalPPS/02a_RTIReports.asp#TopOfPage.)

In summary, RTI's research has resulted in an extensive and careful analysis of the Medicare populations served by LTCHs, a comparison of these populations with those treated in other acute settings, including IPPS, IRFs, and Inpatient Psychiatric populations, as well as those treated in less intensive settings such as SNFs. This work included analysis of Medicare data to compare patient characteristics and provider costs for certain types of patients; regulatory requirements governing program conditions of participation for these different types of facilities; interviews with private sector developers of level of care determinations; and site visits and interviews with physicians treating these typical and frequently overlapping populations.

The results suggested that while there are some patients who require very long term acute care hospitalization there are also many patients whose LOS at the LTCH may trigger a short stay outlier payment, suggesting that not all LTCH admissions had a LOS consistent with

the need for prolonged acute care hospitalization in an LTCH. While existing patient criteria such as Interqual are useful for distinguishing between the need for hospital-level treatment and a less intensive level, such as SNF care, RTI's analysis has determined that, in fact, the private sector criteria failed to distinguish between patients at LTCHs and patients at acute care hospitals. The criteria proposed by the National Association for Long Term Hospitals (NALTH) also had this shortcoming. While they identified the acute care patient, they failed to identify differences between LTCH admissions' clinical characteristics and those treated in a general acute care hospital, in either a step down unit, or in some cases, a general medical/surgery unit.

On January 30, 2007, RTI convened a Technical Expert Panel (TEP) comprised of physicians, nurses, and hospital administrators representing, LTCHs, acute care hospitals, IRFs, and SNFs, all of which represent the range of inpatient settings for treating medically complex patients. The goal of this meeting was to identify a set of clinical indicators that distinguish between the medically complex populations at LTCHs and acute care hospitals, including ICU, step-down, and general acute care. The panelists examined severity measures and treatment needs for medically complex patients to define the point at which ICU or acute care patients become appropriate for care at LTCHs. They focused on patient criteria currently used by some providers and QIOs. Presentations described existing systems for identifying medical complexity and severity of illness for a particular patient. In exchanges between the presenters and panel members, however, acute care hospital physicians stated that acute care hospitals treated severely ill patients with medically complex conditions for their entire episode of care and that these measures were not useful for determining whether the patient should be treated in an acute care hospital or a LTCH. After discussion, the TEP participants reached a consensus that LTCHs provide a service that is comparable to general acute step-down units and is not unique to LTCHs.

Discussions with LTCH physicians and acute care hospital physicians practicing in areas that lack LTCHs confirmed the results of RTI's data analyses in demonstrating the widespread overlap in the patient populations treated in LTCHs and those treated in acute care hospitals. Though representatives from the LTCHs clearly described the medical complexity and

severity of illness of their patient populations, much of the difference between the LTCH and acute hospital patient populations was driven by geography and access to LTCH facilities. In the many areas of the country without access to LTCH services, acute hospitals treat the medically complex patients and receive an acute hospital IPPS payment, or outlier payment in cases where the costs of care are very high, rather than the much higher LTCH payment. As a result of the discussion, claims by the LTCH industry that medically complex patients treated in LTCHs were significantly different from medically complex patients treated in acute settings were not confirmed, though panel members did agree that more work may need to be done to measure outcomes for medically complex patients treated in each of these settings. There was also consensus among the panelists that quality of care was related to treating a sufficient volume of these difficult cases, regardless of provider setting.

On November 6, 2007, RTI convened a second TEP based upon the earlier meeting and participant responses. As with the first TEP, panel members included LTCH physicians and administrators, acute care physicians in areas without LTCHs (for example, New York and northern New England), physicians from SNFs in areas without LTCHs, and several IRF physicians.

There was an intentional focus at the second TEP on Medicare patients with respiratory conditions requiring mechanical ventilation (vent patients). RTI presented data showing the mechanical ventilator patients were relatively homogenous in their likelihood of using LTCHs whereas the medically complex (respiratory) patients were much more diverse in their distributions making it more difficult to develop measurable medical parameters and widely accepted treatment protocols for this group. However, it was acknowledged that ventilator patients (referred to as "vent patients" in the following discussion) comprise less than 15 percent of all LTCH patients. RTI believed that the category of "medically complex" cases was too amorphous and the focus on vent patients would allow for more meaningful comparisons between the provider types. Nationwide, vent patients are treated in acute care hospitals and in LTCHs while some IRFs and SNFs accept and treat this group of patients. (We would also note that, as MedPAC found in its June, 2004 Report to Congress, the highest predictor of LTCH use is whether a patient has had a tracheotomy which is

common in long-term ventilator-dependent patients. (p. 125))

RTI presented two analyses of Medicare claims data based on episodes of care constructed for beneficiaries with vent-related DRGs during their initial (acute) admission. The first analysis compared outcomes for patients living in areas with LTCHs, to outcomes for clinically similar patients living in geographically comparable areas that had no LTCHs. The second examined episodes of care only for beneficiaries in specific states with several LTCHs, and compared outcomes for clinically similar cases that remained in the acute care setting with those that were referred to an LTCH. Both analyses used a "propensity score approach" which groups patients according to the clinical and demographic characteristics that predict LTCH referral.

The first analysis found that there was very little difference in average episode length, Medicare cost, mortality or length of time before being discharged home, between areas that have LTCHs and those that do not. The second analysis found that results differed between cases with the highest probability of using LTCHs (those medically complex vent cases with tracheotomies, longer prior ICU stays), and ventilator cases with lower probability of using LTCHs. In the small group with a high likelihood, mortality was lower and the 60-day likelihood of being discharged home was higher for those referred to LTCHs than for those staying in acute settings, while Medicare payments were the same or less. Among the less complex cases, however, RTI found that LTCH referral was associated with much higher costs and same or worse performance in other outcome measures. These findings are very similar to those noted by MedPAC in the Commission's June 2004 Report to the Congress. (p. 126–127).

RTI also asked TEP members to evaluate 6 case vignettes and assess which patients were appropriate for admission to their type of facility. The case vignettes consisted of detailed medical histories of two ventilator-dependent patients admitted for weaning, two wound care patients, and two "medically complex" patients.

The TEP indicated that there were significant differences between the level of patient morbidity that the acute care hospitals and LTCHs would admit and treat as compared to the IRFs and also the SNFs, but that LTCH patients and patients treated in IPPS acute care hospital step-down units were virtually indistinguishable. In further discussion of individual case vignettes, LTCH and

acute care hospital physicians were in accord regarding appropriate therapeutic dispositions for the stabilized, post-ICU "critical care" patients and they agreed that such patients could be appropriately treated in either acute care hospital step-down units or in LTCHs. Therefore, although there was consensus regarding the medical profile of such patients, it was also noted by one acute care physician that this indicated that "there is no such thing as an LTCH-only patient." On the other hand, acute care hospital physicians noted that typically, in their facilities, their step-down units may take a slightly less stable "critical care" patient than would be treated in a LTCH, that is, patients that may have some unresolved medical issues still being diagnosed especially if there was a need to free-up an ICU bed. This was possible because such a patient would continue treatment by the same physicians and have access to the full range of acute care hospital services but also could return to the ICU without significant difficulty, if necessary.

The panelists also discussed a realistic definition of patient stability for "critical care" patients in different settings and whether this was typically based upon "vital signs," dependence on "pressors," (intravenous drugs administered to raise blood pressure) or whether patient stability was based on a physician's subjective determination (for example, "I know it when I see it"). There was additional clinically-oriented discussion of measures of medical stability. (It was also noted that while some of the "medically complex" patients currently being treated in LTCHs would fall into the "critical care" category, this is not the case for all of their patients.)

Panelists also addressed the intensity of nursing care required by a "critical care" patient and the central role of the nurse to patient ratio in identifying the level of care offered in a hospital. Both LTCHs and IPPS step-down units typically have a RN to patient ratio of 1-to-4 or 1-to-5. LTCH physicians emphasized the value of the LTCH "team approach" to patient care to the agreement of the TEP's acute care hospital physicians who noted that this approach is also the model that is in place in their facilities. One physician noted that he had little doubt that a "critical care" patient hospitalized at any of the acute care hospitals or LTCHs represented at the TEP would receive an equivalent and high level of treatment.

Members of the panel also indicated that discharges from acute care hospitals to LTCHs (in areas where this is an option) often occur because the LTCH is

known to provide specialized treatment for particular types of patients. It was also noted, however, that commonly, hospital resources drive patient placement regarding the treatment of very sick and expensive patients when there is an LTCH placement option.

Following the above exchanges, it was widely acknowledged by panelists that measures distinguishing appropriate LTCH patients from patients being treated in step-down units of acute care hospitals were not going to be developed by the TEP. There were serious questions raised as to whether developing such a product was even feasible. The group concurred on the recommendations, listed below, for a treatment model for the type of "critical care" patients who had been the focus of TEP:

- CMS should pay similar rates for similar patients regardless of setting if certain objective parameters associated with patient care were present, among which were:
 - ++ A critical mass of patients with the targeted conditions to ensure sufficient experience in those areas for the health professionals in that setting;
 - ++ Patient-level criteria to identify appropriate cases for this level of care, applicable regardless of setting;
 - ++ Quality of care should be based on structure and process standards;
 - ++ Interdisciplinary teams with physician leads, appropriate nurse staffing levels; and inclusion of treating therapists (for example, physical, respiratory, occupational);
 - Both LTCHs and these IPPS step-down units meeting these standards could be recognized as "Centers of Excellence" for patients defined as critically ill.

TEP members decided not to include "patient outcomes" on the list of recommendations because of concerns that a facility's recognition and/or payment based on patient outcomes could lead to "cherry-picking" of less sick patients which could lead to access problems for otherwise appropriate patients.

In summary, there was a consensus at the end of RTI's second TEP that LTCHs treat patients who are also treated by acute care hospitals. The "critical care" post-ICU patient who LTCHs describe as their targeted patient are treated throughout most of the country in acute care hospital step-down units. The interdisciplinary team treatment model is the standard both in many LTCHs and in many acute care hospitals with step-down units. While by definition, the patients appropriate for treatment in a LTCH require hospital-level care (as opposed to SNF level), it is not clear

that any criteria can be developed which identifies patients who belong in a LTCH exclusively.

RTI will continue to work on these issues in preparing its final report. The results thus far have shown empirically, that LTCHs treat medically stable but critically ill patients that are clinically indistinguishable from those treated in step-down units of acute care hospitals. The work has also confirmed earlier research showing that for cases other than the vent patients discussed above in this section, that in the absence of compelling data on patient outcomes, that treatment at an LTCH is less cost-effective for the same DRGs than is treatment at acute care hospitals for the same DRGs.

These TEPs have been important for furthering the discussion regarding the feasibility of developing unique criteria for LTCH patients. Over the past few years, the clinicians have agreed that LTCHs specialize in treating critically ill patients with multiple comorbidities and other longer term, acute level needs. This consensus contributes to identifying an appropriate LTCH patient by acuity of illness as well as LOS. Over the next few months, RTI will continue working with the clinical community to make recommendations regarding payment and treatment of critically ill patients, particularly in LTCHs. Further work will expand on the Centers of Excellence concept to examine the structure and process needed for such a designation. Additional analysis will examine the relative costs and payments for these patients under different payment systems.

X. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 35).

XI. Regulatory Impact Analysis

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

A. Introduction

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

(UMRA) (Pub. L. 104–4), and Executive Order 13132.

1. Executive Order 12866

Executive Order 12866 (as amended by Executive Order 13258) 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 the impact analysis, we are using the proposed rates, factors and policies presented in this proposed rule, including updated proposed wage index values, and the best available claims and CCR data to estimate the change in proposed payments for the 2009 LTCH PPS rate year. As stated in section I.A. of this preamble section 114(e)(1) of the MMSEA at the new section 1886(m)(2) to the Act revises the standard Federal rate for RY 2008 by providing that the base rate for RY 2008 shall be the same as the base rate for RY 2007 (in other words, the standard Federal rate for RY 2008 is the same as the standard Federal rate for 2007). Also, section 114(e)(2) of the MMSEA provides that the revised rate does not apply to discharges occurring on or after July 1, 2007, and before April 1, 2008. As noted in section IV.E. of this preamble, the standard Federal rate for RY 2007 was \$38,086.04. Furthermore, we note that section 114(c)(3) of MMSEA requires a 3-year suspension of our implementation of the revisions to the SSO policy at § 412.529(c)(3)(i) that was finalized in the RY 2008 final rule. Both of these revisions to RY 2008 LTCH PPS payments (that is, sections 114(c)(3) and (e)(1) through (2) of MMSEA) affect the modeling of payments in this impact analysis, which we will discuss in greater detail in section XVI.B.3. of this proposed rule. Based on the best available data for 394 LTCHs, we estimate that the proposed update to the standard Federal rate for RY 2009 (discussed in section IV.C. of the preamble of this proposed rule) and the proposed changes to the area wage adjustment (discussed in section IV.F.1. of the preamble of this proposed rule), for the 2009 LTCH PPS rate year, in addition to an estimated increase in short-stay and high cost outlier payments (as discussed in greater detail below) would result in an increase in estimated payments from the 2008 LTCH PPS rate year of approximately \$124 million (or about 2.9 percent) for

the 394 LTCHs in our database. Based on the 394 LTCHs in our database, we estimate RY 2008 LTCH PPS payments to be approximately \$4.32 billion and RY 2009 LTCH PPS payments to be approximately \$4.44 billion. Because the combined distributional effects and estimated changes to the Medicare program payments would be greater than \$100 million, this proposed rule would be considered a major economic rule, as defined in this section. We note the approximately \$124 million for the projected increase in estimated aggregate LTCH PPS payments resulting from the provisions presented in this proposed rule does not reflect changes in LTCH admissions or case-mix intensity in estimated LTCH PPS payments, which would also affect overall payment changes. (We note that due to rounding, the approximation of \$124 million is closer to the projected increase in estimated aggregate LTCH PPS payments than the difference between the approximately \$4.44 billion and approximately \$4.32 billion in estimated RY 2008 and RY 2009 LTCH PPS payments, respectively.)

We note that the average combined effect of the proposed standard Federal rate and area wage adjustment changes on estimated aggregate payments cannot be computed by simply adding up the estimated averages in columns 6 and 7 of Table 9 because each of those two columns are intended to show the isolated impact of the respective proposed change (that is, the proposed change to the standard Federal rate or the proposed change to the area wage adjustment) on estimated payments for RY 2009 as compared to RY 2008, and the interactive effects resulting from both the proposed change to the standard Federal rate and proposed change to the area wage adjustment are not accounted for in the modeling of estimated payments to produce the percent change in each of these columns. However, the interactive effects of all proposed changes are taken into account in the modeling of estimated payments for RY 2009 as compared to RY 2008 in Column 8 of Table 9. Notwithstanding this limitation in comparing the various columns in Table 9, the difference between the projected increase in payments per discharge from RY 2008 to RY 2009 for all changes of 2.9 percent (column 8) and the sum of the projected increase due to proposed change to the standard Federal rate (2.2 percent in column 6) and the proposed change due to the area wage adjustment (– 0.1 percent in column 7) of 2.1 percent (that is, 2.2 percent + (– 0.1 percent) = 2.1 percent)

is mostly attributable to the effect of the estimated increase in payments for HCO and SSO cases in RY 2009 as compared to RY 2008. That is, in calculating the estimated increase in payments from RY 2008 to RY 2009 for HCO and SSO cases, we increased estimated costs by the applicable proposed market basket (approximately 3.5 percent). We note, SSO cases comprise approximately 16 percent of estimated total LTCH PPS payments and HCO cases comprise approximately 8 percent of estimated total LTCH PPS payments. The vast majority of the payments for SSO cases (over 80 percent) are based on the estimated cost of the case.

While the effects of the estimated increase in SSO and HCO payments and the proposed change to the standard Federal rate which are projected to increase estimated payments per discharge from RY 2008 to RY 2009, the proposed changes to the area wage adjustment from RY 2008 to RY 2009 are expected to result in a small decrease of 0.1 percent in estimated aggregate LTCH PPS payments from the 2008 LTCH PPS rate year to the 2009 LTCH PPS rate year (see column 7 of Table 9). As discussed in section IV.F.1. of this proposed rule, we are proposing to update the wage index values for RY 2009 based on the most recent available data. In addition, we are proposing to increase the labor-related share from 75.788 percent to 75.920 percent under the LTCH PPS for RY 2009 based on the most recent available data on the relative importance of the labor-related share of operating and capital costs of the market basket applicable to the LTCH PPS (also discussed in section IV.F.1. of this proposed rule).

2. Regulatory Flexibility Act (RFA)

The RFA requires agencies to analyze options for regulatory relief of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of \$6.5 million to \$31.5 million in any 1 year. For further information, see the Small Business Administration's regulation at 70 FR 72577, December 6, 2005. Individuals and States are not included in the definition of a small entity. Because we lack data on individual hospital receipts, we cannot determine the number of small proprietary LTCHs. Therefore, we assume that all LTCHs are considered small entities for the purpose of the analysis that follows. Medicare FIs are not considered to be small entities. The

Secretary certifies that this proposed rule would not have a significant economic impact on a substantial number of small entities.

Currently, our database of 394 LTCHs includes the data for 88 non-profit (voluntary ownership control) LTCHs and 265 proprietary LTCHs. Of the remaining 41 LTCHs, 25 LTCHs are Government-owned and operated and the ownership type of the other 16 LTCHs is unknown (as shown in Table 9). The impact of the proposed payment rate and policy changes for the 2009 LTCH PPS rate year (including the proposed update to the standard Federal rate and the proposed changes to the area wage adjustment) is discussed in section XVI.B.4.c. of this proposed rule.

As we discuss in detail throughout the preamble of this proposed rule, based on the most recent available LTCH data, we believe that the provisions of this proposed rule would result in an increase in estimated aggregate LTCH PPS payments and that the resulting LTCH PPS payment amounts result in appropriate Medicare payments.

The impact analysis of the proposed payment rate and policy changes in Table 9 shows that estimated payments per discharge are expected to increase approximately 2.9 percent, on average, for all LTCHs from the 2008 LTCH PPS rate year as compared to the 2009 LTCH PPS rate year. We are proposing a 2.6 percent increase to the standard Federal rate for RY 2009 (as discussed in section IV.E. of this proposed rule). The projected 2.9 percent increase in estimated payments per discharge from the 2008 LTCH PPS rate year to the 2009 LTCH PPS rate year is attributable to the proposed change to the rate, the area wage adjustment (discussed in section IV.F.1. of this proposed rule) and estimated increases in short-stay outlier (SSO) and high cost outlier (HCO) payments (as discussed in greater detail below). That is, as Table 9 shows, the proposed change to the standard Federal rate is projected to result in an estimated average increase of 2.2 percent in estimated payments per discharge from RY 2008 to RY 2009, on average, for all LTCHs, while the proposed changes to the area wage adjustment are projected to result in an estimated decrease of 0.1 percent, on average, for all LTCHs (columns 6 and 7 of Table 9, respectively). A thorough discussion of the regulatory impact analysis for the proposed changes presented in this proposed rule can be found below in section XVI.B.3. of this proposed rule.

3. Impact on Rural Hospitals

For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. As shown in Table 9, we are projecting a 2.6 percent increase in estimated payments per discharge from the 2008 LTCH PPS rate year as compared to the 2009 LTCH PPS rate year for rural LTCHs as a result of the proposed changes presented in this proposed rule (that is, the proposed update to the standard Federal rate discussed in section IV.E. of the preamble of this proposed rule and the proposed changes to the area wage adjustment as discussed in section IV.F.1. of the preamble of this proposed rule) based on the data of the 25 rural LTCHs in our database of 394 LTCHs for which complete data were available.

As shown in Table 9, the estimated increase in estimated LTCH PPS payments from the 2008 LTCH PPS rate year as compared to the 2009 LTCH PPS rate year for rural LTCHs is primarily due to the proposed update to the standard Federal rate (as discussed in greater detail in section IV.E. of the preamble of this proposed rule) and the proposed change in the area wage adjustment (as discussed in greater detail in section V.F.1. of the preamble of this proposed rule) in conjunction with the estimated increased payments for SSO and HCO cases (as discussed below in section XVI.B.3. of this proposed rule). We believe that the changes to the area wage adjustment presented in this proposed rule (that is, the proposed use of updated wage data and the proposed change in the labor-related share) would result in accurate and appropriate LTCH PPS payments in RY 2009 since they are based on the most recent available data. Such updated data appropriately reflect national differences in area wage levels and identifies the portion of the proposed standard Federal rate that should be adjusted to account for such differences in area wages, thereby resulting in accurate and appropriate LTCH PPS payments.

4. Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any one year of \$100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately \$120 million. This proposed rule would not mandate any requirements for State,

local, or tribal governments, nor would it result in expenditures by the private sector of \$120 million or more in any 1 year.

5. Federalism

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

We have examined this proposed rule under the criteria set forth in Executive Order 13132 and have determined that this proposed rule would not have any significant impact on the rights, roles, and responsibilities of State, local, or tribal governments or preempt State law, based on the 25 State and local LTCHs (that is, Government ownership type) in our database of 394 LTCHs for which data were available.

6. Alternatives Considered

In the preamble of this proposed rule, we are setting forth the proposed annual update to the payment rates for the LTCH PPS for RY 2009. In this preamble, we specify the statutory authority for the provisions that are presented, identify those proposed policies when discretion has been exercised, and present rationale for our decisions as well as alternatives that were considered, and solicit comments on suggested alternatives from commenters (where relevant).

B. Anticipated Effects of Proposed Payment Rate Changes

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

1. Budgetary Impact

Section 123(a)(1) of the BBRA requires that the PPS developed for LTCHs “maintain budget neutrality.” We believe that the statute’s mandate for budget neutrality (BN) applies only to the first year of the implementation of the LTCH PPS (that is, FY 2003). Therefore, in calculating the FY 2003 standard Federal rate under § 412.523(d)(2), we set total estimated payments for FY 2003 under the LTCH PPS so that estimated aggregate payments under the LTCH PPS are estimated to equal the amount that would have been paid if the LTCH PPS had not been implemented.

2. Impact on Providers

The basic methodology for determining a per discharge LTCH PPS payment is set forth in § 412.515 through § 412.536. In addition to the basic MS–LTC–DRG payment (standard Federal rate multiplied by the MS–LTC–DRG relative weight), we make adjustments for differences in area wage levels, COLA for Alaska and Hawaii, and SSOs. Furthermore, LTCHs may also receive HCO payments for those cases that qualify based on the threshold established each rate year.

To understand the impact of the proposed changes to the LTCH PPS payments discussed in section IV. of this proposed rule on different categories of LTCHs for the 2009 LTCH PPS rate year, it is necessary to estimate payments per discharge for the 2008 LTCH PPS rate year using the rates, factors and policies established in the RY 2008 LTCH PPS final rule (72 FR 26870 through 27029), the RY 2008 LTCH PPS correction notice (72 FR 36613 through 36616) and the applicable sections of MMSEA (as described in greater detail below in section XVI.B.3. of this proposed rule). It is also necessary to estimate the proposed payments per discharge that would be made under the proposed LTCH PPS rates, factors and policies for the 2009 LTCH PPS rate year (as discussed in the preamble of this proposed rule). We also evaluated the change in estimated 2008 LTCH PPS rate year payments to estimated proposed 2009 LTCH PPS rate year payments (on a per discharge basis) for each category of LTCHs.

Hospital groups were based on characteristics provided in the OSCAR data, FY 2003 through FY 2005 cost report data in HCRIS, and PSF data. Hospitals with incomplete characteristics were grouped into the “unknown” category. Hospital groups include the following:

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

To estimate the impacts of the proposed payment rates and policy changes among the various categories of existing providers, we used LTCH cases from the FY 2006 MedPAR file to estimate payments for RY 2008 and to estimate proposed payments for RY 2009 for 394 LTCHs. While currently there are just under 400 LTCHs, the most recent growth is predominantly in for-profit LTCHs that provide respiratory and ventilator-dependent

patient care. We believe that the discharges from the FY 2006 MedPAR data for the 394 LTCHs in our database, which includes 265 proprietary LTCHs, provide sufficient representation in the MS–LTC–DRGs containing discharges for patients who received LTCH care for the most commonly treated LTCH patients’ diagnoses.

3. Calculation of Prospective Payments

For purposes of this impact analysis, to estimate per discharge payments under the LTCH PPS, we simulated payments on a case-by-case basis using LTCH claims for the FY 2006 MedPAR files. In modeling estimated LTCH PPS payments for both RY 2008 and RY 2009 in this impact analysis, we applied the RY 2008 standard Federal rate (that is, \$38,086.04) provided for by sections 114(e)(1) and (2) of Public Law 110–173, and the SSO policy provided for by section 114(c)(3) of the MMSEA7 (that is, excluding the revisions to the SSO policy at § 412.529(c)(3)(i) of the regulations). Although we realize that the effective date for the change in the SSO policy during RY 2008 in the MMSEA is December 29, 2007, and the revised standard Federal rate for RY 2008 is not applicable for discharges occurring on or after July 1, 2007 and before April 1, 2008, for purposes of this impact analysis, in estimating RY 2008 LTCH PPS payments we applied both the revised SSO policy and revised standard Federal rate for all of RY 2008. Similarly, in modeling LTCH PPS payments to project the average change in estimated payments per discharge from RY 2008 to RY 2009 due to the proposed change in the standard Federal rate (column 6 of Table 9), rather than using the RY 2008 standard Federal rate finalized in the RY 2008 final rule, we compared the RY 2008 “base rate” (which we interpret to mean the standard Federal rate) mandated by section 114(e)(1) of the Medicare, Medicaid and SCHIP Extension Act of 2007 (that is, \$38,086.04), to the proposed RY 2009 standard Federal rate of \$39,076.28 (that is, \$38,086.04 updated by 2.6 percent, as discussed in section IV.E. of this proposed rule) in order to appropriately estimate the effect of updating the rate by 2.6 percent. We took this approach for the impact analysis in this proposed rule since for the last 3 months of the 2008 LTCH PPS rate year (that is, April 2008 through June 2008), which is the 3-month period immediately preceding the start of the 2009 LTCH PPS rate year, LTCHs will be paid in accordance with the RY 2008 standard Federal rate and SSO policy established by section 114 of the Medicare, Medicaid, and

SCHIP Extension Act of 2007. Therefore, for purposes of the impact analysis in this proposed rule, we modeled the projected changes in estimated payments from RY 2008 to RY 2009 based on computing estimated RY 2008 LTCH PPS payments using a standard Federal rate of \$38,086.04 and the corresponding change to the SSO policy, which excludes the revisions to the SSO policy at § 412.529(c)(3)(i), as if those policies were applicable to all discharges occurring during RY 2008. (Additional information on section 114 of the Medicare, Medicaid and SCHIP Extension Act of 2007 can be found at section I.A. of this proposed rule.)

Furthermore, in modeling estimated LTCH PPS payments for both RY 2008 and RY 2009 in this impact analysis, we applied the RY 2008 and proposed RY 2009 adjustments for area wage differences (as described in section IV.F.1. of the preamble of this proposed rule), and the COLA for Alaska and Hawaii (as described in section IV.F.2. of the preamble of this proposed rule). Specifically, we adjusted for area wage differences for estimated 2008 LTCH PPS rate year payments using the current LTCH PPS labor-related share of 75.788 percent (72 FR 26892), the wage index values established in the Tables 1 and 2 of the Addendum of the RY 2008 final rule (72 FR 26996 through 27019) and the COLA factors established in Table 3 of the preamble of the RY 2008 final rule (72 FR 26894). Similarly, we adjusted for area wage differences for estimated 2009 LTCH PPS rate year payments using the proposed LTCH PPS labor-related share of 75.920 percent (see section IV.D.1.c. of this proposed rule), the proposed wage index values presented in the Tables 1 and 2 of the Addendum of this proposed rule and the proposed COLA factors established in Table 3 of the preamble of this proposed rule.

As discussed above, we also accounted for the payment policy for SSOs. We also estimated additional payments that would be made for HCOs (as described in section IV.F.3. of this proposed rule). As noted in section IV.F.4. of this proposed rule, we are not proposing to make adjustments for rural location, geographic reclassification, indirect medical education costs, or a DSH payment for the treatment of low-income patients because our most recent data analysis that reflects LTCH behavior subsequent to the implementation of the LTCH PPS indicates that proposing payment adjustments for geographic reclassification, rural location, DSH, or indirect medical education costs would not improve the accuracy of payments

made under the LTCH PPS to LTCHs. (See Section IV.F.4).

These impacts reflect the estimated "losses" or "gains" among the various classifications of LTCHs for the 2008 LTCH PPS rate year compared to the 2009 LTCH PPS rate year based on the proposed payment rates and policy changes presented in this proposed rule. Table 9 illustrates the estimated aggregate impact of the LTCH PPS among various classifications of LTCHs.

- The first column, LTCH Classification, identifies the type of LTCH.
- The second column lists the number of LTCHs of each classification type.

- The third column identifies the number of LTCH cases.
- The fourth column shows the estimated payment per discharge for the 2008 LTCH PPS rate year (as described above).
- The fifth column shows the estimated proposed payment per discharge for the 2009 LTCH PPS rate year (as described above).
- The sixth column shows the percentage change in estimated payments per discharge from the 2008 LTCH PPS rate year to the 2009 LTCH PPS rate year for proposed changes to the standard Federal rate (as discussed in section IV.E. of the preamble of this proposed rule).

- The seventh column shows the percentage change in estimated payments per discharge from the 2008 LTCH PPS rate year to the 2009 LTCH PPS rate year for proposed changes to the area wage adjustment at § 412.525(c) (as discussed in section IV.D.1. of the preamble of this proposed rule).
- The eighth column shows the percentage change in estimated payments per discharge from the 2008 LTCH PPS rate year (column 4) to the 2009 LTCH PPS rate year (column 5) for all proposed changes.

TABLE 9.—PROJECTED IMPACT OF PROPOSED PAYMENT RATE AND PAYMENT RATE POLICY CHANGES TO LTCH PPS PAYMENTS FOR RY 2009

(Estimated 2008 LTCH PPS Rate Year Payments Compared to Estimated Proposed 2009 LTCH PPS Rate Year Payments *)

LTCH Classification	Number of LTCHs	Number of LTCH PPS cases	Average estimated RY 2008 LTCH PPS payment per case ¹	Average estimated proposed RY 2009 LTCH PPS payment per case ²	Percent change in estimated payments per discharge from RY 2008 to RY 2009 for proposed changes to the Federal rate ³	Percent change in estimated payments per discharge from RY 2008 to RY 2009 for proposed changes to the area wage adjustment ⁴	Percent change in estimated payments per discharge from RY 2008 to RY 2009 for all changes ⁵
ALL PROVIDERS	394	134,160	\$32,166	\$33,092	2.2	−0.1	2.9
BY LOCATION:							
RURAL	25	6,076	26,951	27,643	2.4	−0.5	2.6
URBAN	369	128,084	32,414	33,351	2.2	−0.1	2.9
LARGE	193	78,292	33,732	34,736	2.2	−0.1	3.0
OTHER	176	49,792	30,341	31,172	2.3	−0.3	2.7
BY PARTICIPATION DATE:							
BEFORE OCT. 1983	28	9,779	27,864	28,849	2.2	0.4	3.5
OCT. 1983—SEPT. 1993	46	21,101	33,189	34,175	2.2	−0.1	3.0
OCT. 1993—SEPT. 2002	204	74,145	32,207	33,082	2.3	−0.3	2.7
AFTER OCTOBER 2002	112	28,598	32,793	33,783	2.3	0.0	3.0
UNKNOWN	4	537	31,300	32,442	2.3	0.7	3.6
BY OWNERSHIP TYPE:							
VOLUNTARY	88	27,948	31,061	32,017	2.2	0.0	3.1
PROPRIETARY	265	100,047	32,415	33,314	2.2	−0.2	2.8
GOVERNMENT	25	3,692	33,984	35,155	2.1	0.1	3.4
UNKNOWN	16	2,473	31,864	33,177	2.3	1.1	4.1
BY CENSUS REGION:							
NEW ENGLAND	20	9,776	27,177	28,213	2.2	0.7	3.8
MIDDLE ATLANTIC	36	10,756	31,851	32,629	2.2	−0.6	2.4
SOUTH ATLANTIC	50	13,544	35,730	36,822	2.2	0.0	3.1
EAST NORTH CENTRAL	70	19,552	35,316	36,289	2.2	−0.2	2.8
EAST SOUTH CENTRAL	30	8,667	32,736	33,565	2.2	−0.5	2.5
WEST NORTH CENTRAL	18	5,350	34,325	35,378	2.2	0.0	3.1
WEST SOUTH CENTRAL	130	51,441	28,779	29,538	2.3	−0.3	2.6
MOUNTAIN	22	5,804	35,089	36,143	2.2	0.0	3.0
PACIFIC	18	9,270	41,129	42,633	2.1	0.6	3.7
BY BED SIZE:							
BEDS: 0–24	33	4,797	30,110	30,888	2.4	−0.5	2.6
BEDS: 25–49	195	45,212	32,404	33,305	2.2	−0.2	2.8
BEDS: 50–74	72	26,064	32,145	33,040	2.2	−0.2	2.8
BEDS: 75–124	52	23,503	33,212	34,246	2.2	0.1	3.1
BEDS: 125–199	21	17,567	32,088	33,013	2.2	−0.2	2.9
BEDS: 200 +	21	17,017	30,781	31,717	2.2	0.0	3.0

¹ Estimated 2009 LTCH PPS rate year payments based on the proposed payment rates and policy changes presented in the preamble of this proposed rule.

² Estimated 2008 LTCH PPS rate year payments based on the rates, factors and policies established in the RY 2008 LTCH PPS final rule (72 FR 26870 through 27029), the RY 2008 LTCH PPS correction notice (72 FR 36613 through 36616) and the applicable sections of the Medicare, Medicaid, and SCHIP Extension Act of 2007. As described in section XVI.B.3. of this proposed rule, although we are aware that there are different effective dates for the various provisions of MMSEA that affect RY 2008 LTCH PPS payments, for the purpose of this impact analysis, we modeled estimated RY 2008 PPS payments as if those provisions were applicable to discharges for the entire 2008 LTCH PPS rate year. Specifically, in estimating RY 2008 LTCH PPS payments, we applied the RY 2008 Federal rate provided for by sections 114(e)(1) of the MMSEA (that is, \$38,086.04), and the SSO policy provided for by section 114(c)(3) of the MMSA (that is, excluding the revisions to the SSO policy at § 412.529(c)(3)(i)).

³ Percent change in estimated payments per discharge from the 2008 LTCH PPS rate year to the 2009 LTCH PPS rate year for the proposed changes to the Federal rate, as discussed in section IV.E. of the preamble of this proposed rule. (Note, because about 34 percent of all LTCH cases are projected to receive a payment adjustment under the SSO policy that is based either on the estimated cost of the case or the "blend option" (which is based in part on the "IPPS comparable amount") rather than the proposed Federal rate in RY 2009, the percent change in estimated payments per discharge due to the proposed changes to the Federal rate for most of the categories of LTCHs, 2.2 percent, is somewhat less than the proposed update to the Federal rate of 2.6 percent.)

⁴ Percent change in estimated payments per discharge from the 2008 LTCH PPS rate year to the 2009 LTCH PPS rate year for proposed changes to the area wage adjustment at § 412.525(c) (as discussed in section V.F.1. of the preamble of this proposed rule).

⁵ Percent change in estimated payments per discharge from the 2008 LTCH PPS rate year (as described in section XVI.B.3. of this proposed rule) to the 2009 LTCH PPS rate year for all of the proposed changes presented in the preamble of this proposed rule. Note, this column, which shows the percent change in estimated payments per discharge for all proposed changes, may not equal the sum of the percent changes in estimated payments per discharge for proposed changes to the Federal rate (column 6) and the proposed changes to the area wage adjustment (column 7) due to the effect of estimated changes in both payments to SSO cases that are paid based on estimated costs and aggregate HCO payments (as discussed this proposed rule), as well as other interactive effects that cannot be isolated.

4. Results

Based on the most recent available data (as described previously for 394 LTCHs), we have prepared the following summary of the impact (as shown in Table 9) of the proposed LTCH PPS payment rate and policy changes presented in this proposed rule. The impact analysis in Table 9 shows that estimated payments per discharge are expected to increase approximately 2.9 percent, on average, for all LTCHs from the 2008 LTCH PPS rate year as compared to the 2009 LTCH PPS rate year as a result of the proposed payment rate and policy changes presented in this proposed rule. We note that although we are proposing a 2.6 percent increase to the standard Federal rate for RY 2009, based on the latest proposed market basket estimate (3.5 percent) and offset by the proposed coding and documentation adjustment (0.9 percent), for most categories of LTCHs, the impact analysis shown in Table 9 (column 7) only shows a 2.2 percent increase in estimated payments per discharge from RY 2008 to RY 2009 as a result of the proposed change to the standard Federal rate. The reason that this column shows an estimated 2.2 percent increase rather than an estimated 2.6 percent increase (based on the proposed 2.6 percent update to the standard Federal rate) is because about 34 percent of all LTCH cases are projected to receive an SSO payment that would be based either on the estimated cost of the case or the "blend option" (which is based in part on the "IPPS comparable amount") rather than a LTCH PPS payment based on the proposed standard Federal rate. Therefore, because over 30 percent of *all* LTCH PPS cases would receive a payment that is not based fully on the proposed standard Federal rate, the percent change in estimated payments per discharge due to the proposed

changes to the standard Federal rate for most categories of LTCHs shown in Table 9 is projected to be 2.2 percent, which is somewhat less than the 2.6 percent proposed update to the standard Federal rate. In addition to the proposed 2.6 percent increase to the standard Federal rate for RY 2009, the projected percent increase in estimated payments per discharge from the 2008 LTCH PPS rate year to the 2009 LTCH PPS rate year of 2.9 percent shown in Table 9 (see column 8) reflects the effect of increased HCO and SSO payments as we discussed previously. That is, in calculating the estimated increase in payments for HCO and SSO from RY 2008 to RY 2009, we increased costs by applying the proposed market basket (approximately 3.5 percent). As noted above, SSOs comprise approximately 16 percent of total LTCH PPS payments and high cost outliers comprise approximately 8 percent of estimated total LTCH PPS payments. Furthermore, as discussed previously in this regulatory impact analysis, the average increase in estimated payments per discharge from the 2008 LTCH PPS rate year to the 2009 LTCH PPS rate year, on average, for all LTCHs of approximately 2.9 (as shown in Table 9) was determined by comparing estimated RY 2009 LTCH PPS payments (using the proposed rates and policies discussed in the preamble of this rule) to estimated RY 2008 LTCH PPS payments (as described above in section XVI.B.3. of this regulatory impact analysis).

a. Location

Based on the most recent available data, the majority of LTCHs are in urban areas. Approximately 6 percent of the LTCHs are identified as being located in a rural area, and approximately 5 percent of all LTCH cases are treated in these rural hospitals. The impact analysis presented in Table 9 shows that

the average percent increase in estimated payments per discharge for the 2008 LTCH PPS rate year compared to the 2009 LTCH PPS rate year for all hospitals is 2.9 percent for all proposed changes. For rural LTCHs, the percent change for all proposed changes is estimated to be 2.6 percent, while for urban LTCHs, we estimate this increase to be 2.9 percent. Large urban LTCHs are projected to experience a 3.0 percent increase in estimated payments per discharge from the 2008 LTCH PPS rate year compared to the 2009 LTCH PPS rate year, while other urban LTCHs are projected to experience a 2.7 percent increase in estimated payments per discharge from the 2008 LTCH PPS rate year compared to the 2009 LTCH PPS rate year, as shown in Table 9. Rural LTCHs are projected to experience a somewhat lower than average increase in estimated payments per discharge for all proposed changes primarily due to the proposed changes to the area wage adjustment. That is, 68 percent of the LTCHs in these areas are expected to experience a decrease in their wage index value from RY 2008 to RY 2009. In addition, because all LTCHs in rural areas have a wage index value that is less than 1.0, the proposed increase to the labor-related share (from 75.788 percent to 75.920 percent) would also contribute to the estimated lower than average increase in estimated payments from RY 2008 to RY 2009 shown in column 8 of Table 9.

b. Participation Date

LTCHs are grouped by participation date into four categories: (1) Before October 1983; (2) between October 1983 and September 1993; (3) between October 1993 and September 2002; and (4) after October 2002. Based on the most recent available data, the majority (approximately 52 percent) of the LTCH cases are in hospitals that began

participating between October 1993 and September 2002, and are projected to experience a slightly lower than average increase of 2.7 percent in estimated payments per discharge from the 2008 LTCH PPS rate year compared to the 2009 LTCH PPS rate year, as shown in Table 9, mostly because approximately 66 percent of hospitals in this category are projected to experience a decrease in their wage index value from RY 2008 to RY 2009. In addition, because the majority of hospitals (80 percent) in this category have a wage index of less than 1.0, the proposed increase to the labor-related share (from 75.788 percent to 75.920 percent) would also contribute to the slightly lower than average increase in payments from RY 2008 to RY 2009 shown in column 8 of Table 9.

LTCHs that began participating in Medicare between October 1983 and September 1993, and those LTCHs that began participating in Medicare after October 2002 are projected to experience close to the average percent increase (3.0 percent) in estimated payments per discharge from the 2008 LTCH PPS rate year compared to the 2009 LTCH PPS rate year, as shown in Table 9. Approximately 12 percent of LTCHs began participating in Medicare between October 1983 and September 1993 while approximately 28 percent of LTCHs began participating in Medicare after October 2002 (that is, the beginning of the LTCH PPS, which was implemented for cost reporting periods beginning on or after October 1, 2002).

LTCHs that began participating before October 1983 are projected to experience a 3.5 percent increase in estimated payments per discharge from the 2008 LTCH PPS rate year compared to the 2009 LTCH PPS rate year (see Table 9). We are projecting that LTCHs that began participating in Medicare before October 1983 would experience a larger than average increase in estimated payments for RY 2009 as compared to RY 2008 primarily due to the proposed changes to the area wage adjustment. This is because approximately 68 percent of the LTCHs that began participating in Medicare before October 1983 are located in areas where the proposed RY 2009 wage index value would be greater than the RY 2008 wage index value. In addition, because a significant number (75 percent) of hospitals in this category have a wage index of greater than 1.0, the proposed increase to the labor-related share (from 75.788 percent to 75.920 percent) would also contribute to the larger than average increase in estimated payments from RY 2008 to RY 2009.

c. Ownership Control

Other than LTCHs whose ownership control type is unknown, LTCHs are grouped into three categories based on ownership control type: Voluntary; proprietary; and government. Based on the most recent available data, approximately 6 percent of LTCHs are identified as government-owned and operated (see Table 9). We expect that for these government-owned and operated LTCHs, estimated 2009 LTCH PPS rate year payments per discharge would increase 3.4 percent in comparison to the 2008 LTCH PPS rate year, as shown in Table 9. We are projecting that government-run LTCHs would experience a somewhat higher than average increase in estimated payments in RY 2009 as compared to RY 2008 primarily due to the effect of the proposed changes to the area wage adjustment. Specifically, LTCHs in this category are projected to experience a higher than average increase in their estimated payments from RY 2008 to RY 2009 due to the proposed changes to the area wage adjustment primarily because the majority (60 percent) of hospitals in this category would experience an increase in their wage index value from RY 2008 to RY 2009.

We project that estimated 2009 LTCH PPS rate year payments per discharge for voluntary LTCHs, which account for approximately 22 percent of LTCHs, would increase near the average (3.1 percent) in comparison to estimated 2008 LTCH PPS rate year payments (see Table 9).

The majority (approximately 67 percent) of LTCHs are identified as proprietary. We project that 2009 LTCH PPS rate year estimated payments per discharge for these proprietary LTCHs would increase 2.8 percent (nearly average) in comparison to the 2008 LTCH PPS rate year (see Table 9).

d. Census Region

Estimated payments per discharge for the 2009 LTCH PPS rate year are projected to increase for LTCHs located in all regions in comparison to the 2008 LTCH PPS rate year. The percent increase in estimated payments per discharge from the 2008 LTCH PPS rate year to the 2009 LTCH PPS rate year for all regions is largely attributable to the proposed increase in the standard Federal rate.

Of the 9 census regions, we project that the increase in proposed 2009 LTCH PPS rate year estimated payments per discharge in comparison to the 2008 LTCH PPS rate year would have the largest impact on LTCHs in the New England and Pacific regions (3.8 percent

and 3.7 percent, respectively; see Table 9). LTCHs located in both the New England and Pacific regions are expected to experience a larger than average increase in estimated payments due to the proposed changes in the area wage adjustment (0.7 percent for the New England region, and 0.6 percent for the Pacific region, as shown in Table 9). This is because approximately 85 percent of LTCHs located in the New England region and all of the LTCHs in the Pacific region are projected to experience an increase in their wage index values for proposed RY 2009 as compared to RY 2008.

We project that in comparison to the 2008 LTCH PPS rate year, the proposed 2009 LTCH PPS rate year estimated payments per discharge for LTCHs in the East North Central region would increase by approximately 2.8 percent (nearly average). For LTCHs located in the South Atlantic and West North Central regions, we estimate that the slightly higher than average projected increase (3.1 percent for each region) in estimated payments per discharge for the 2009 LTCH PPS rate year compared to the 2008 LTCH PPS rate year is largely a result of the proposed changes to the area wage adjustment. That is, we estimate that approximately 58 percent of hospitals in the South Atlantic region and approximately 55 percent of hospitals in the West North Central region would experience an increase in their wage index values from RY 2008 to RY 2009. For LTCHs located in the Middle Atlantic, East South Central and West South Central regions, we estimate that the somewhat lower than average projected increase (2.4 percent, 2.5 percent, and 2.6 percent, respectively) in estimated payments per discharge for the 2009 LTCH PPS rate year compared to the 2008 LTCH PPS rate year is largely a result of the proposed changes to the area wage adjustment. Specifically, nearly all LTCHs in the Middle Atlantic region (approximately 89 percent) and the majority of the hospitals in the East South Central region (approximately 67 percent) and West South Central region (approximately 75 percent) would experience a decrease in their wage index value from RY 2008 to RY 2009. Furthermore, because a significant number of hospitals in these categories have a wage index of less than 1.0, the proposed increase to the labor-related share (from 75.788 percent to 75.920 percent) would also contribute to the lower than average estimated increase in payments from RY 2008 to RY 2009.

e. Bed Size

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

We are projecting an increase in estimated 2009 LTCH PPS rate year payments per discharge in comparison to the 2008 LTCH PPS rate year for all bed size categories. Most LTCHs are in bed size categories where estimated 2009 LTCH PPS rate year payments per discharge are projected to increase at or near the average increase of 2.9 percent for all LTCHs, in comparison to the 2008 LTCH PPS rate year (that is, all LTCH bed size categories except the category of LTCHs with 0–24 beds). Specifically, estimated payments per discharge for the 2009 LTCH PPS rate year are projected to increase for LTCHs with 25–49 and 50–74 beds at 2.8 percent, for LTCHs with 75–124 beds at 3.1 percent, for LTCHs with 125–199 beds at 2.9 percent, and for LTCHs with more than 200 beds, at 3.0 percent.

Estimated payments per discharge for the 2009 LTCH PPS rate year for LTCHs with 0–24 beds are projected to have a somewhat lower than average increase in comparison to all hospitals (2.6 percent; see Table 9). This lower than average increase in estimated payments per discharge for LTCHs with 0–24 beds is largely due to the proposed changes to the area wage adjustment. Specifically, LTCHs in this category are expected to experience a larger than average decrease in their payments from RY 2008 to RY 2009 due to the proposed changes to the area wage adjustment primarily because approximately 73 percent of the hospitals in this category are projected to experience a decrease in their wage index value from RY 2008 to RY 2009. In addition, because the majority (approximately 91 percent) of hospitals in this category have a wage index of less than 1.0, the proposed increase to the labor-related share (from

75.788 percent to 75.920 percent) would also contribute to the smaller than average increase in estimated payments from RY 2008 to RY 2009 shown in Table 9.

5. Effect on the Medicare Program

Based on actuarial projections, an estimate of Medicare spending (total estimated Medicare program payments) for LTCH services over the next 5 years based on current LTCH PPS policy (as established in previous LTCH PPS final rules) is shown in Table 4 in section IV.D. of the preamble of this proposed rule. As noted previously, we project that the provisions of this proposed rule would result in an increase in estimated aggregate LTCH PPS payments in RY 2009 of approximately 124 million (or about 2.9 percent) for the 394 LTCHs in our database.

Consistent with the statutory requirement for BN, as we discussed in the August 30, 2002 final rule that implemented the LTCH PPS, in developing the LTCH PPS, we intended estimated aggregate payments under the LTCH PPS in FY 2003 be projected to equal the estimated aggregate payments that would have been made if the LTCH PPS were not implemented. Our methodology for estimating payments for purposes of the BN calculations for determining the FY 2003 standard Federal rate used the best available data and necessarily reflects assumptions. As discussed in section IV.D. of this proposed rule, section 114(c)(4) of the Medicare, Medicaid and SCHIP Extension Act of 2007 provides that the “Secretary shall not, for the 3-year period beginning on the date of the enactment of this Act, make the one-time prospective adjustment to long-term care hospital prospective payment rates provided for in section 412.523(d)(3) of title 42, Code of Federal Regulations, or any similar provision.” That provision delays the effective date of any one-time budget neutrality

adjustment until no earlier than December 29, 2010. However, prior to the enactment of the MMSEA of 2007, we had developed a methodology for evaluating the appropriateness of proposing a one-time budget neutrality adjustment under existing § 412.523(d)(3). In order to inform the public of our thinking, and to stimulate comments for our consideration during the three-year delay in implementing any adjustment under the recent legislation, we have presented our analysis and its results in section IV.D. of the preamble of this proposed rule.

6. Effect on Medicare Beneficiaries

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

D. Accounting Statement

As discussed in section XVI.A.1., the impact analysis of this proposed rule results in an increase in estimated aggregate payments of approximately \$124 million (or about 2.9 percent) for the 394 LTCHs in our database. Therefore, as required by OMB Circular A–4 (available at <http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf>), in Table 10, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this proposed rule. Table 10 provides our best estimate of the proposed increase in Medicare payments under the LTCH PPS as a result of the provisions presented in this proposed rule based on the data for the 394 LTCHs in our database. All expenditures are classified as transfers to Medicare providers (that is, LTCHs).

TABLE 10.—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES, FROM THE 2008 LTCH PPS RATE YEAR TO THE 2009 LTCH PPS RATE YEAR

[In millions]

Category	Transfers
Annualized Monetized Transfers	Positive transfer—Estimated increase in expenditures: \$124 million.
From Whom To Whom?	Federal Government To LTCH Medicare Providers.

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

List of Subjects in 42 CFR Part 412

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

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

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

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

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

Subpart O—Prospective Payment System for Long Term Care Hospitals

2. Section 412.503 is amended by—

A. Revising the definition of “Long-term care hospital prospective payment system rate year”.

B. Adding new definitions of “rural” and “urban” in alphabetical order.

The revision and additions read as follows:

§ 412.503 Definitions.

* * * * *

Long-term care hospital prospective payment system rate year means—

(1) From July 1, 2003 and ending on or before June 30, 2008, the 12-month period of July 1 through June 30.

(2) From July 1, 2008 and ending on September 30, 2009, the 15-month period of July 1, 2008 through September 30, 2009.

(3) Beginning on or after October 1, 2009, the 12-month period of October 1 through September 30.

* * * * *

Rural area means—(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, an area defined in § 412.62(f)(1)(iii);

(2) For discharges occurring on or after July 1, 2005, and before July 1, 2008, an area as defined in § 412.64(b)(1)(ii)(C); and

(3) For discharges occurring on or after July 1, 2008, any area outside an urban area.

Urban area means—(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, an area defined in § 412.62(f)(1)(iii);

(2) For discharges occurring on or after July 1, 2005, and before July 1, 2008, an urban area means an area as defined in § 412.64(b)(1)(ii)(A) and (B); and

(3) For discharges occurring on or after July 1, 2008, a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget.

3. Section 412.523 is amended by—

A. Adding new paragraph (c)(3)(v).

B. Revising paragraph (d)(2) by removing the phrase “sections 1886(b)(2) and (b)(3) of the Act” and adding “section 1886(b)(2)(E) and (b)(3)(J) of the Act” in its place.

C. Revising paragraph (d)(3).

The addition and revisions read as follows:

§ 412.523 Methodology for calculating the Federal prospective payment rates.

* * * * *

(c) * * *

(3) * * *

(v) *For long-term care hospital prospective payment system rate year beginning July 1, 2008 and ending September 30, 2009.* The standard Federal rate for long-term care hospital prospective payment system rate year beginning July 1, 2008 and ending September 30, 2009 is the standard Federal rate for the previous long-term care hospital prospective payment system rate year updated by 2.6 percent. The standard Federal rate is adjusted, as appropriate, as described in paragraph (d) of this section.

* * * * *

(d)(3) The Secretary reviews payments under this prospective payment system and may make a one-time prospective adjustment to the long-term care hospital prospective payment system rates no earlier than December 29, 2010, so that the effect of any significant difference between the data used in the original computations and more recent data to determine budget neutrality is not perpetuated in the prospective payment rates for future years.

* * * * *

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

§ 412.525 Adjustments to the Federal prospective payment.

* * * * *

(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 the definitions set forth in § 412.503) 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.

5. Section 412.529 is amended by revising paragraphs (d)(4)(ii)(B) and (d)(4)(iii)(B) to read as follows:

§ 412.529 Special payment provision for short-stay outliers.

* * * * *

(d) * * *

(4) * * *

(ii) * * *

(B) Is adjusted for different area wage levels based on the geographic classifications set forth at § 412.503 and the applicable hospital inpatient prospective payment system labor-related share, using the applicable hospital inpatient prospective payment system wage index value for nonreclassified hospitals. For LTCHs located in Alaska and Hawaii, this amount is also adjusted by the applicable hospital inpatient prospective payment system cost of living adjustment factors.

* * * * *

(iii) * * *

(B) Is adjusted for the applicable geographic adjustment factors, including local cost variation based on the geographic classifications set forth at § 412.503 and the applicable full hospital inpatient prospective payment system wage index value for nonreclassified hospitals, and applicable large urban location cost of living adjustment factors for LTCHs in Alaska and Hawaii, if applicable.

* * * * *

6. Section 412.534 is amended by revising paragraphs (d)(1), (f)(2)(ii), and (f)(3)(ii) to read as follows:

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

* * * * *

(d) * * *

(1) Subject to paragraphs (g) and (h) of this section, in the case of a long-term care hospital or satellite facility that is located in a rural area as defined in § 412.503 and is co-located with another hospital for any cost reporting period beginning on or after October 1, 2004 in which the long-term care hospital or satellite facility has a discharged Medicare inpatient population of whom more than 50 percent were admitted to the long-term care hospital or satellite facility from the co-located hospital, payments for the patients who are admitted from the co-located hospital and who cause the long-term care hospital or satellite facility to exceed the 50 percent threshold for discharged patients who were admitted from the co-located hospital are the lesser of the amount otherwise payable under this subpart or the amount payable under this subpart that is equivalent, as set forth in paragraph (f) of this section, to the amount that were otherwise payable under subpart A, § 412.1(a). Payments

for the remainder of the long-term care hospital's or satellite facility's patients are made under the rules in this subpart at § 412.500 through § 412.541 with no adjustment under this section.

* * * * *

(f) * * *

(2) * * *

(ii) Is adjusted for different area wage levels based on the geographic classifications set forth at § 412.503 and the applicable hospital inpatient prospective payment system labor-related share, using the applicable hospital inpatient prospective payment system wage index value for non-reclassified hospitals. For LTCHs located in Alaska and Hawaii, this amount is also adjusted by the applicable hospital inpatient prospective payment system cost of living adjustment factors;

* * * * *

(3) * * *

(ii) Is adjusted by the applicable geographic adjustment factors, including local cost variation based on the applicable geographic classifications set forth at § 412.503 and the applicable full hospital inpatient prospective payment system wage index value for nonreclassified hospitals, applicable large urban location and cost of living adjustment factors for LTCHs for Alaska and Hawaii, if applicable;

* * * * *

7. Section 412.535 is amended by—

A. Revising the introductory text.

B. Revising paragraph (a).

C. Redesignating paragraph (b) as paragraph (d).

D. Adding new paragraphs (b) and (c).

The revisions and additions read as follows:

§ 412.535 Publication of the Federal prospective payment rates.

Except as specified in paragraph (b) of this section, CMS publishes information pertaining to the long-term care hospital prospective payment system effective for each annual update in the **Federal Register**.

(a) For the period beginning on or after July 1, 2003, and ending on June 30, 2008, information on the unadjusted Federal payment rates and a description of the methodology and data used to calculate the payment rates are published on or before May 1 prior to the start of each long term care hospital prospective payment system rate year which begins July 1, unless for good cause it is published after May 1, but before June 1.

(b) For the period beginning on July 1, 2008 and ending on September 30, 2009, information of the unadjusted

Federal payment rates and a description of the methodology and data used to calculate the payment rates are published on or before May 1 prior to the start of the long-term care hospital prospective payment system rate year which begins July 1, unless for good cause it is published after May 1, but before June 1.

(c) For the period beginning on or after October 1, 2009, information on the unadjusted Federal payment rates and a description of the methodology and data used to calculate the payment rates are published on or before August 1 prior to the start of the Federal fiscal year which begins October 1, unless for good cause it is published after August 1, but before September 1.

* * * * *

7. Section 412.536 is amended by revising paragraphs (c)(1), (e)(2)(ii), and (e)(3)(ii) to read as follows.

§ 412.536 Special payment provisions for long-term care hospitals and satellites of long-term care hospitals that discharged Medicare patients admitted from a hospital not located in the same building or on the same campus as the long term care hospital or satellite of the long-term care hospital.

* * * * *

(c) *Special treatment of rural hospitals.* (1) Subject to paragraph (f) of this section, in the case of a long-term care hospital or long-term care hospital satellite facility that is located in a rural area as defined in § 412.503 that has a discharged Medicare inpatient population of whom more than 50 percent were admitted to the long-term care hospital or long term care hospital satellite facility from a hospital not co-located with the long-term care hospital or with the satellite of a long-term care hospital, payment for the Medicare discharges who are admitted from that hospital and who cause the long-term care hospital or satellite facility to exceed the 50 percent threshold for Medicare discharges is determined at the lesser of the amount otherwise payable under this subpart or the amount payable under this subpart that is equivalent, as set forth in paragraph (e) of this section, to the amount that is otherwise payable under subpart A, § 412.1(a). Payments for the remainder of the long-term care hospital's or long-term care hospital satellite facility's Medicare discharges admitted from that referring hospital are made under the rules in this subpart at § 412.500 through § 412.541 with no adjustment under this section.

* * * * *

(e) * * *

(2) * * *

(ii) Is adjusted for different area wage levels based on the geographic classifications defined at § 412.503 and the applicable hospital inpatient prospective payment system labor-related share, using the applicable hospital inpatient prospective payment system wage index value for non-reclassified hospitals. For long-term care hospitals located in Alaska and Hawaii, this amount is also adjusted by the applicable hospital inpatient prospective payment system cost of living adjustment factors;

* * * * *

(3) * * *

(ii) Is adjusted by the applicable geographic adjustment factors, including local cost variation based on the applicable geographic classifications set forth at § 412.503 and the applicable full hospital inpatient prospective payment system wage index value for nonreclassified hospitals, applicable large urban location and cost of living adjustment factors for long-term care hospitals for Alaska and Hawaii, if applicable;

* * * * *

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

Dated: December 13, 2007.

Kerry Weems,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: January 16, 2008.

Michael O. Leavitt,

Secretary.

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

Addendum

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

Table 1.—Proposed Long-Term Care Hospital Wage Index for Urban Areas for Discharges Occurring from July 1, 2008 through September 30, 2009

Table 2.—Proposed Long-Term Care Hospital Wage Index for Rural Areas for Discharges Occurring from July 1, 2008 through September 30, 2009

Table 3.—FY 2008 MS-LTC-DRG Relative Weights, Geometric Average Length of Stay, Short-Stay Outlier Threshold and IPPS-Comparable Threshold (for Short-Stay Outlier Cases) (effective for discharges occurring on or after July 1, 2008 through September 30, 2009). (**Note:** This table is the same information provided in Table 11 of the FY 2008

IPPS final rule (72 FR 48143 through 48157), which has been reprinted here for convenience.)

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2008 THROUGH SEPTEMBER 30, 2009

CBSA code	Urban area (constituent counties)	Proposed wage index
10180	Abilene, TX Callahan County, TX. Jones County, TX. Taylor County, TX.	0.7957
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.	0.3448
10420	Akron, OH Portage County, OH. Summit County, OH.	0.8794
10500	Albany, GA Baker County, GA. Dougherty County, GA. Lee County, GA. Terrell County, GA. Worth County, GA.	0.8514
10580	Albany-Schenectady-Troy, NY Albany County, NY. Rensselaer County, NY. Saratoga County, NY. Schenectady County, NY. Schoharie County, NY.	0.8588
10740	Albuquerque, NM Bernalillo County, NM. Sandoval County, NM. Torrance County, NM. Valencia County, NM.	0.9554
10780	Alexandria, LA Grant Parish, LA. Rapides Parish, LA.	0.7979
10900	Allentown-Bethlehem-Easton, PA-NJ Warren County, NJ. Carbon County, PA. Lehigh County, PA. Northampton County, PA.	0.9865
11020	Altoona, PA Blair County, PA.	0.8618
11100	Amarillo, TX Armstrong County, TX. Carson County, TX. Potter County, TX. Randall County, TX.	0.9116
11180	Ames, IA Story County, IA.	1.0046
11260	Anchorage, AK Anchorage Municipality, AK. Matanuska-Susitna Borough, AK.	1.1913
11300	Anderson, IN Madison County, IN.	0.8827
11340	Anderson, SC Anderson County, SC.	0.9086
11460	Ann Arbor, MI Washtenaw County, MI.	1.0539
11500	Anniston-Oxford, AL Calhoun County, AL.	0.7926
11540	Appleton, WI Calumet County, WI. Outagamie County, WI.	0.9598
11700	Asheville, NC Buncombe County, NC. Haywood County, NC.	0.9185

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2008 THROUGH SEPTEMBER 30, 2009—Continued

CBSA code	Urban area (constituent counties)	Proposed wage index
12020	Henderson County, NC. Madison County, NC. Athens-Clarke County, GA	1.0517
	Clarke County, GA. Madison County, GA. Oconee County, GA. Oglethorpe County, GA.	
12060	Atlanta-Sandy Springs-Marietta, GA	0.9828
	Barrow County, GA. Bartow County, GA. Butts County, GA. Carroll County, GA. Cherokee County, GA. Clayton County, GA. Cobb County, GA. Coweta County, GA. Dawson County, GA. DeKalb County, GA. Douglas County, GA. Fayette County, GA. Forsyth County, GA. Fulton County, GA. Gwinnett County, GA. Haralson County, GA. Heard County, GA. Henry County, GA. Jasper County, GA. Lamar County, GA. Meriwether County, GA. Newton County, GA. Paulding County, GA. Pickens County, GA. Pike County, GA. Rockdale County, GA. Spalding County, GA. Walton County, GA.	
12100	Atlantic City, NJ	1.2198
	Atlantic County, NJ.	
12220	Auburn-Opelika, AL	0.8090
	Lee County, AL.	
12260	Augusta-Richmond County, GA-SC	0.9645
	Burke County, GA. Columbia County, GA. McDuffie County, GA. Richmond County, GA. Aiken County, SC. Edgefield County, SC.	
12420	Austin-Round Rock, TX	0.9544
	Bastrop County, TX. Caldwell County, TX. Hays County, TX. Travis County, TX. Williamson County, TX.	
12540	Bakersfield, CA	1.1051
	Kern County, CA.	
12580	Baltimore-Towson, MD	1.0134
	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	0.9978
	Penobscot County, ME.	
12700	Barnstable Town, MA	1.2603
	Barnstable County, MA.	
12940	Baton Rouge, LA	0.8034
	Ascension Parish, LA. East Baton Rouge Parish, LA.	

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2008 THROUGH SEPTEMBER 30, 2009—Continued

CBSA code	Urban area (constituent counties)	Proposed wage index
	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	1.0179
	Calhoun County, MI	
13020	Bay City, MI	0.8897
	Bay County, MI	
13140	Beaumont-Port Arthur, TX	0.8531
	Hardin County, TX. Jefferson County, TX. Orange County, TX.	
13380	Bellingham, WA	1.1474
	Whatcom County, WA.	
13460	Bend, OR	1.0942
	Deschutes County, OR.	
13644	Bethesda-Gaithersburg-Frederick, MD	1.0511
	Frederick County, MD. Montgomery County, MD.	
13740	Billings, MT	0.8666
	Carbon County, MT. Yellowstone County, MT.	
13780	Binghamton, NY	0.8949
	Broome County, NY. Tioga County, NY.	
13820	Birmingham-Hoover, AL	0.8898
	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	0.7225
	Burleigh County, ND. Morton County, ND.	
13980	Blacksburg-Christiansburg-Radford, VA	0.8192
	Giles County, VA. Montgomery County, VA. Pulaski County, VA. Radford City, VA.	
14020	Bloomington, IN	0.8915
	Greene County, IN. Monroe County, IN. Owen County, IN.	
14060	Bloomington-Normal, IL	0.9325
	McLean County, IL.	
14260	Boise City-Nampa, ID	0.9465
	Ada County, ID. Boise County, ID. Canyon County, ID. Gem County, ID. Owyhee County, ID.	
14484	Boston-Quincy, MA	1.1792
	Norfolk County, MA. Plymouth County, MA. Suffolk County, MA.	
14500	Boulder, CO	1.0426
	Boulder County, CO.	
14540	Bowling Green, KY	0.8159
	Edmonson County, KY. Warren County, KY.	
14740	Bremerton-Silverdale, WA	1.0904
	Kitsap County, WA.	
14860	Bridgeport-Stamford-Norwalk, CT	1.2735
	Fairfield County, CT.	
15180	Brownsville-Harlingen, TX	0.8914

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2008 THROUGH SEPTEMBER 30, 2009—Continued

CBSA code	Urban area (constituent counties)	Proposed wage index
15260	Cameron County, TX. Brunswick, GA	0.9475
	Brantley County, GA. Glynn County, GA. McIntosh County, GA.	
15380	Buffalo-Niagara Falls, NY	0.9568
	Erie County, NY. Niagara County, NY.	
15500	Burlington, NC	0.8747
	Alamance County, NC.	
15540	Burlington-South Burlington, VT	0.9660
	Chittenden County, VT. Franklin County, VT. Grand Isle County, VT.	
15764	Cambridge-Newton-Framingham, MA	1.1215
	Middlesex County, MA.	
15804	Camden, NJ	1.0411
	Burlington County, NJ. Camden County, NJ. Gloucester County, NJ.	
15940	Canton-Massillon, OH	0.8935
	Carroll County, OH. Stark County, OH.	
15980	Cape Coral-Fort Myers, FL	0.9396
	Lee County, FL.	
16180	Carson City, NV	1.0003
	Carson City, NV.	
16220	Casper, WY	0.9385
	Natrona County, WY.	
16300	Cedar Rapids, IA	0.8852
	Benton County, IA. Jones County, IA. Linn County, IA.	
16580	Champaign-Urbana, IL	0.9392
	Champaign County, IL. Ford County, IL. Piatt County, IL.	
16620	Charleston, WV	0.8289
	Boone County, WV. Clay County, WV. Kanawha County, WV. Lincoln County, WV. Putnam County, WV.	
16700	Charleston-North Charleston, SC	0.9124
	Berkeley County, SC. Charleston County, SC. Dorchester County, SC.	
16740	Charlotte-Gastonia-Concord, NC-SC	0.9520
	Anson County, NC. Cabarrus County, NC. Gaston County, NC. Mecklenburg County, NC. Union County, NC. York County, SC.	
16820	Charlottesville, VA	0.9277
	Albemarle County, VA. Fluvanna County, VA. Greene County, VA. Nelson County, VA. Charlottesville City, VA.	
16860	Chattanooga, TN-GA	0.8994
	Catoosa County, GA. Dade County, GA. Walker County, GA. Hamilton County, TN. Marion County, TN. Sequatchie County, TN.	
16940	Cheyenne, WY	0.9308
	Laramie County, WY.	
16974	Chicago-Naperville-Joliet, IL	1.0715

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2008 THROUGH SEPTEMBER 30, 2009—Continued

CBSA code	Urban area (constituent counties)	Proposed wage index
	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	1.1290
	Butte County, CA.	
17140	Cincinnati-Middletown, OH-KY-IN	0.9784
	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	0.8251
	Christian County, KY. Trigg County, KY. Montgomery County, TN. Stewart County, TN.	
17420	Cleveland, TN	0.8052
	Bradley County, TN. Polk County, TN.	
17460	Cleveland-Elyria-Mentor, OH	0.9339
	Cuyahoga County, OH. Geauga County, OH. Lake County, OH. Lorain County, OH. Medina County, OH.	
17660	Coeur d'Alene, ID	0.9532
	Kootenai County, ID.	
17780	College Station-Bryan, TX	0.9358
	Brazos County, TX. Burleson County, TX. Robertson County, TX.	
17820	Colorado Springs, CO	0.9719
	El Paso County, CO. Teller County, CO.	
17860	Columbia, MO	0.8658
	Boone County, MO. Howard County, MO.	
17900	Columbia, SC	0.8800
	Calhoun County, SC. Fairfield County, SC. Kershaw County, SC. Lexington County, SC. Richland County, SC. Saluda County, SC.	
17980	Columbus, GA-AL	0.8729
	Russell County, AL. Chattahoochee County, GA. Harris County, GA. Marion County, GA. Muscogee County, GA.	
18020	Columbus, IN	0.9537
	Bartholomew County, IN.	
18140	Columbus, OH	1.0085
	Delaware County, OH. Fairfield County, OH.	

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2008 THROUGH SEPTEMBER 30, 2009—Continued

CBSA code	Urban area (constituent counties)	Proposed wage index
18580	Franklin County, OH. Licking County, OH. Madison County, OH. Morrow County, OH. Pickaway County, OH. Union County, OH. Corpus Christi, TX	0.8588
18700	Aransas County, TX. Nueces County, TX. San Patricio County, TX. Corvallis, OR	1.0959
19060	Benton County, OR. Cumberland, MD—WV	0.8294
19124	Allegany County, MD. Mineral County, WV. Dallas-Plano-Irving, TX	0.9915
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	0.8760
19180	Murray County, GA. Whitfield County, GA. Danville, IL	0.8957
19260	Vermilion County, IL. Danville, VA	0.8240
19340	Pittsylvania County, VA. Danville City, VA. Davenport-Moline-Rock Island, IA—IL	0.8830
19380	Henry County, IL. Mercer County, IL. Rock Island County, IL. Scott County, IA. Dayton, OH	0.9190
19460	Greene County, OH. Miami County, OH. Montgomery County, OH. Preble County, OH. Decatur, AL	0.7885
19500	Lawrence County, AL. Morgan County, AL. Decatur, IL	0.8074
19660	Macon County, IL. Deltona-Daytona Beach-Ormond Beach, FL	0.9031
19740	Volusia County, FL. Denver-Aurora, CO	1.0718
19780	Adams County, CO. Arapahoe County, CO. Broomfield County, CO. Clear Creek County, CO. Denver County, CO. Douglas County, CO. Elbert County, CO. Gilpin County, CO. Jefferson County, CO. Park County, CO. Des Moines-West Des Moines, IA	0.9226
19804	Dallas County, IA. Guthrie County, IA. Madison County, IA. Polk County, IA. Warren County, IA. Detroit-Livonia-Dearborn, MI	0.9999
20020	Wayne County, MI. Dothan, AL	0.7270
	Geneva County, AL.	

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2008 THROUGH SEPTEMBER 30, 2009—Continued

CBSA code	Urban area (constituent counties)	Proposed wage index
20100	Henry County, AL. Houston County, AL. Dover, DE	1.0099
20220	Kent County, DE. Dubuque, IA	0.9058
20260	Dubuque County, IA. Duluth, MN–WI	0.9975
20500	Carlton County, MN. St. Louis County, MN. Douglas County, WI. Durham, NC	0.9816
20740	Chatham County, NC. Durham County, NC. Orange County, NC. Person County, NC. Eau Claire, WI	0.9475
20764	Chippewa County, WI. Eau Claire County, WI. Edison, NJ	1.1181
20940	Middlesex County, NJ. Monmouth County, NJ. Ocean County, NJ. Somerset County, NJ. El Centro, CA	0.8914
21060	Imperial County, CA. Elizabethtown, KY	0.8711
21140	Hardin County, KY. Larue County, KY. Elkhart-Goshen, IN	0.9611
21300	Elkhart County, IN. Elmira, NY	0.8264
21340	Chemung County, NY. El Paso, TX	0.8989
21500	El Paso County, TX. Erie, PA	0.8495
21660	Erie County, PA. Eugene-Springfield, OR	1.0932
21780	Lane County, OR. Evansville, IN–KY	0.8662
21820	Gibson County, IN. Posey County, IN. Vanderburgh County, IN. Warrick County, IN. Henderson County, KY. Webster County, KY. Fairbanks, AK	1.1050
21940	Fairbanks North Star Borough, AK. Fajardo, PR	0.4375
22020	Ceiba Municipio, PR. Fajardo Municipio, PR. Luquillo Municipio, PR. Fargo, ND–MN	0.8042
22140	Cass County, ND. Clay County, MN. Farmington, NM	0.9587
22180	San Juan County, NM. Fayetteville, NC	0.9368
22220	Cumberland County, NC. Hoke County, NC. Fayetteville-Springdale-Rogers, AR–MO	0.8742
22380	Benton County, AR. Madison County, AR. Washington County, AR. McDonald County, MO. Flagstaff, AZ	1.1687
22420	Coconino County, AZ. Flint, MI	1.1220
22500	Genesee County, MI. Florence, SC	0.8249
	Darlington County, SC.	

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2008 THROUGH SEPTEMBER 30, 2009—Continued

CBSA code	Urban area (constituent counties)	Proposed wage index
22520	Florence County, SC. Florence-Muscle Shoals, AL	0.7680
	Colbert County, AL. Lauderdale County, AL.	
22540	Fond du Lac, WI	0.9667
	Fond du Lac County, WI.	
22660	Fort Collins-Loveland, CO	0.9897
	Larimer County, CO.	
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL	1.0229
	Broward County, FL.	
22900	Fort Smith, AR—OK	0.7933
	Crawford County, AR. Franklin County, AR. Sebastian County, AR. Le Flore County, OK. Sequoyah County, OK.	
23020	Fort Walton Beach-Crestview-Destin, FL	0.8743
	Okaloosa County, FL.	
23060	Fort Wayne, IN	0.9284
	Allen County, IN. Wells County, IN. Whitley County, IN.	
23104	Fort Worth-Arlington, TX	0.9693
	Johnson County, TX. Parker County, TX. Tarrant County, TX. Wise County, TX.	
23420	Fresno, CA	1.0993
	Fresno County, CA.	
23460	Gadsden, AL	0.8159
	Etowah County, AL.	
23540	Gainesville, FL	0.9196
	Alachua County, FL. Gilchrist County, FL.	
23580	Gainesville, GA	0.9216
	Hall County, GA.	
23844	Gary, IN	0.9224
	Jasper County, IN. Lake County, IN. Newton County, IN. Porter County, IN.	
24020	Glens Falls, NY	0.8256
	Warren County, NY. Washington County, NY.	
24140	Goldsboro, NC	0.9288
	Wayne County, NC.	
24220	Grand Forks, ND—MN	0.7881
	Polk County, MN. Grand Forks County, ND.	
24300	Grand Junction, CO	0.9864
	Mesa County, CO.	
24340	Grand Rapids-Wyoming, MI	0.9315
	Barry County, MI. Ionia County, MI. Kent County, MI. Newaygo County, MI.	
24500	Great Falls, MT	0.8675
	Cascade County, MT.	
24540	Greeley, CO	0.9658
	Weld County, CO.	
24580	Green Bay, WI	0.9727
	Brown County, WI. Kewaunee County, WI. Oconto County, WI.	
24660	Greensboro-High Point, NC	0.9010
	Guilford County, NC. Randolph County, NC. Rockingham County, NC.	
24780	Greenville, NC	0.9402
	Greene County, NC.	

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2008 THROUGH SEPTEMBER 30, 2009—Continued

CBSA code	Urban area (constituent counties)	Proposed wage index
24860	Pitt County, NC. Greenville-Mauldin-Easley, SC Greenville County, SC. Laurens County, SC. Pickens County, SC.	0.9860
25020	Guayama, PR Arroyo Municipio, PR. Guayama Municipio, PR. Patillas Municipio, PR.	0.3064
25060	Gulfport-Biloxi, MS Hancock County, MS. Harrison County, MS. Stone County, MS.	0.8773
25180	Hagerstown-Martinsburg, MD–WV Washington County, MD. Berkeley County, WV. Morgan County, WV.	0.9013
25260	Hanford-Corcoran, CA Kings County, CA.	1.0499
25420	Harrisburg-Carlisle, PA Cumberland County, PA. Dauphin County, PA. Perry County, PA.	0.9280
25500	Harrisonburg, VA Rockingham County, VA. Harrisonburg City, VA.	0.8867
25540	Hartford-West Hartford-East Hartford, CT Hartford County, CT. Middlesex County, CT. Tolland County, CT.	1.0959
25620	Hattiesburg, MS Forrest County, MS. Lamar County, MS. Perry County, MS.	0.7366
25860	Hickory-Lenoir-Morganton, NC Alexander County, NC. Burke County, NC. Caldwell County, NC. Catawba County, NC.	0.9028
25980	Hinesville-Fort Stewart, GA Liberty County, GA. Long County, GA.	0.9187
26100	Holland-Grand Haven, MI Ottawa County, MI.	0.9006
26180	Honolulu, HI Honolulu County, HI.	1.1556
26300	Hot Springs, AR Garland County, AR.	0.9109
26380	Houma-Bayou Cane-Thibodaux, LA Lafourche Parish, LA. Terrebonne Parish, LA.	0.7892
26420	Houston-Sugar Land-Baytown, TX Austin County, TX. Brazoria County, TX. Chambers County, TX. Fort Bend County, TX. Galveston County, TX. Harris County, TX. Liberty County, TX. Montgomery County, TX. San Jacinto County, TX. Waller County, TX.	0.9939
26580	Huntington-Ashland, WV–KY–OH Boyd County, KY. Greenup County, KY. Lawrence County, OH. Cabell County, WV. Wayne County, WV.	0.9041
26620	Huntsville, AL Limestone County, AL.	0.9146

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2008 THROUGH SEPTEMBER 30, 2009—Continued

CBSA code	Urban area (constituent counties)	Proposed wage index
26820	Madison County, AL. Idaho Falls, ID	0.9264
26900	Bonneville County, ID. Jefferson County, ID. Indianapolis-Carmel, IN	0.9844
26980	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. Iowa City, IA	0.9568
27060	Johnson County, IA. Washington County, IA. Ithaca, NY	0.9630
27100	Tompkins County, NY. Jackson, MI	0.9329
27140	Jackson County, MI. Jackson, MS	0.8011
27180	Copiah County, MS. Hinds County, MS. Madison County, MS. Rankin County, MS. Simpson County, MS. Jackson, TN	0.8676
27260	Chester County, TN. Madison County, TN. Jacksonville, FL	0.9021
27340	Baker County, FL. Clay County, FL. Duval County, FL. Nassau County, FL. St. Johns County, FL. Jacksonville, NC	0.8079
27500	Onslow County, NC. Janesville, WI	0.9702
27620	Rock County, WI. Jefferson City, MO	0.8478
27740	Callaway County, MO. Cole County, MO. Moniteau County, MO. Osage County, MO. Johnson City, TN	0.7677
27780	Carter County, TN. Unicoi County, TN. Washington County, TN. Johnstown, PA	0.7543
27860	Cambria County, PA. Jonesboro, AR	0.7790
27900	Craighead County, AR. Poinsett County, AR. Joplin, MO	0.8951
28020	Jasper County, MO. Newton County, MO. Kalamazoo-Portage, MI	1.0433
28100	Kalamazoo County, MI. Van Buren County, MI. Kankakee-Bradley, IL	1.0238
28140	Kankakee County, IL. Kansas City, MO-KS	0.9504
	Franklin County, KS. Johnson County, KS. Leavenworth County, KS. Linn County, KS. Miami County, KS. Wyandotte County, KS.	

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2008 THROUGH SEPTEMBER 30, 2009—Continued

CBSA code	Urban area (constituent counties)	Proposed wage index
	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	1.0075
	Benton County, WA. Franklin County, WA.	
28660	Killeen-Temple-Fort Hood, TX	0.8249
	Bell County, TX. Coryell County, TX. Lampasas County, TX.	
28700	Kingsport-Bristol-Bristol, TN-VA	0.7658
	Hawkins County, TN. Sullivan County, TN. Bristol City, VA. Scott County, VA. Washington County, VA.	
28740	Kingston, NY	0.9556
	Ulster County, NY.	
28940	Knoxville, TN	0.8036
	Anderson County, TN. Blount County, TN. Knox County, TN. Loudon County, TN. Union County, TN.	
29020	Kokomo, IN	0.9591
	Howard County, IN. Tipton County, IN.	
29100	La Crosse, WI-MN	0.9685
	Houston County, MN. La Crosse County, WI.	
29140	Lafayette, IN	0.8869
	Benton County, IN. Carroll County, IN. Tippecanoe County, IN.	
29180	Lafayette, LA	0.8247
	Lafayette Parish, LA. St. Martin Parish, LA.	
29340	Lake Charles, LA	0.7777
	Calcasieu Parish, LA. Cameron Parish, LA.	
29404	Lake County-Kenosha County, IL-WI	1.0603
	Lake County, IL. Kenosha County, WI.	
29420	Lake Havasu City-Kingman, AZ	0.9333
	Mohave County, AZ.	
29460	Lakeland, FL	0.8661
	Polk County, FL.	
29540	Lancaster, PA	0.9252
	Lancaster County, PA.	
29620	Lansing-East Lansing, MI	1.0119
	Clinton County, MI. Eaton County, MI. Ingham County, MI.	
29700	Laredo, TX	0.8093
	Webb County, TX.	
29740	Las Cruces, NM	0.8676
	Dona Ana County, NM.	
29820	Las Vegas-Paradise, NV	1.1799
	Clark County, NV.	
29940	Lawrence, KS	0.8227
	Douglas County, KS.	
30020	Lawton, OK	0.8025
	Comanche County, OK.	
30140	Lebanon, PA	0.8192

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2008 THROUGH SEPTEMBER 30, 2009—Continued

CBSA code	Urban area (constituent counties)	Proposed wage index
30300	Lebanon County, PA. Lewiston, ID-WA	0.9454
30340	Nez Perce County, ID. Asotin County, WA. Lewiston-Auburn, ME	0.9193
30460	Androscoggin County, ME. Lexington-Fayette, KY	0.9191
30620	Bourbon County, KY. Clark County, KY. Fayette County, KY. Jessamine County, KY. Scott County, KY. Woodford County, KY. Lima, OH	0.9424
30700	Allen County, OH. Lincoln, NE	1.0051
30780	Lancaster County, NE. Seward County, NE. Little Rock-North Little Rock-Conway, AR	0.8863
30860	Faulkner County, AR. Grant County, AR. Lonoke County, AR. Perry County, AR. Pulaski County, AR. Saline County, AR. Logan, UT-ID	0.9183
30980	Franklin County, ID. Cache County, UT. Longview, TX	0.8717
31020	Gregg County, TX. Rusk County, TX. Upshur County, TX. Longview, WA	1.0827
31084	Cowlitz County, WA. Los Angeles-Long Beach-Glendale, CA	1.1771
31140	Los Angeles County, CA. Louisville-Jefferson County, KY-IN	0.9065
31180	Clark County, IN. Floyd County, IN. Harrison County, IN. Washington County, IN. Bullitt County, KY. Henry County, KY. Jefferson County, KY. Meade County, KY. Nelson County, KY. Oldham County, KY. Shelby County, KY. Spencer County, KY. Trimble County, KY. Lubbock, TX	0.8680
31340	Crosby County, TX. Lubbock County, TX. Lynchburg, VA	0.8732
31420	Amherst County, VA. Appomattox County, VA. Bedford County, VA. Campbell County, VA. Bedford City, VA. Lynchburg City, VA. Macon, GA	0.9541
31460	Bibb County, GA. Crawford County, GA. Jones County, GA. Monroe County, GA. Twiggs County, GA. Madera, CA	0.8069
31540	Madera County, CA. Madison, WI	1.0935
	Columbia County, WI.	

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2008 THROUGH SEPTEMBER 30, 2009—Continued

CBSA code	Urban area (constituent counties)	Proposed wage index
31700	Dane County, WI. Iowa County, WI. Manchester-Nashua, NH Hillsborough County, NH.	1.0273
31900	Mansfield, OH Richland County, OH.	0.9271
32420	Mayagüez, PR Hormigueros Municipio, PR. Mayagüez Municipio, PR.	0.3711
32580	McAllen-Edinburg-Mission, TX Hidalgo County, TX.	0.9123
32780	Medford, OR Jackson County, OR.	1.0318
32820	Memphis, TN-MS-AR Crittenden County, AR. DeSoto County, MS. Marshall County, MS. Tate County, MS. Tunica County, MS. Fayette County, TN. Shelby County, TN. Tipton County, TN.	0.9250
32900	Merced, CA Merced County, CA.	1.2120
33124	Miami-Miami Beach-Kendall, FL Miami-Dade County, FL.	1.0002
33140	Michigan City-La Porte, IN LaPorte County, IN.	0.8914
33260	Midland, TX Midland County, TX.	1.0017
33340	Milwaukee-Waukesha-West Allis, WI Milwaukee County, WI. Ozaukee County, WI. Washington County, WI. Waukesha County, WI.	1.0214
33460	Minneapolis-St. Paul-Bloomington, MN-WI Anoka County, MN. Carver County, MN. Chisago County, MN. Dakota County, MN. Hennepin County, MN. Isanti County, MN. Ramsey County, MN. Scott County, MN. Sherburne County, MN. Washington County, MN. Wright County, MN. Pierce County, WI. St. Croix County, WI.	1.1093
33540	Missoula, MT Missoula County, MT.	0.8953
33660	Mobile, AL Mobile County, AL.	0.8033
33700	Modesto, CA Stanislaus County, CA.	1.1962
33740	Monroe, LA Ouachita Parish, LA. Union Parish, LA.	0.7832
33780	Monroe, MI Monroe County, MI.	0.9414
33860	Montgomery, AL Autauga County, AL. Elmore County, AL. Lowndes County, AL. Montgomery County, AL.	0.8088
34060	Morgantown, WV Monongalia County, WV. Preston County, WV.	0.8321
34100	Morristown, TN Grainger County, TN.	0.7388

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2008 THROUGH SEPTEMBER 30, 2009—Continued

CBSA code	Urban area (constituent counties)	Proposed wage index
34580	Hamblen County, TN. Jefferson County, TN. Mount Vernon-Anacortes, WA	1.0529
34620	Skagit County, WA. Muncie, IN	0.8214
34740	Delaware County, IN. Muskegon-Norton Shores, MI	0.9836
34820	Muskegon County, MI. Myrtle Beach-Conway-North Myrtle Beach, SC	0.8634
34900	Horry County, SC. Napa, CA	1.4476
34940	Napa County, CA. Naples-Marco Island, FL	0.9487
34980	Collier County, FL. Nashville-Davidson-Murfreesboro-Franklin, TN	0.9689
35004	Cannon County, TN. Cheatham County, TN. Davidson County, TN. Dickson County, TN. Hickman County, TN. Macon County, TN. Robertson County, TN. Rutherford County, TN. Smith County, TN. Sumner County, TN. Trousdale County, TN. Williamson County, TN. Wilson County, TN.	1.2640
35084	Nassau-Suffolk, NY	1.1862
35300	Nassau County, NY. Suffolk County, NY. Newark-Union, NJ-PA	1.1871
35380	Essex County, NJ. Hunterdon County, NJ. Morris County, NJ. Sussex County, NJ. Union County, NJ. Pike County, PA. New Haven-Milford, CT	0.8897
35644	New Haven County, CT. New Orleans-Metairie-Kenner, LA	1.3115
35660	Jefferson Parish, LA. Orleans Parish, LA. Plaquemines Parish, LA. St. Bernard Parish, LA. St. Charles Parish, LA. St. John the Baptist Parish, LA. St. Tammany Parish, LA. New York-White Plains-Wayne, NY-NJ	0.9141
35980	Bergen County, NJ. Hudson County, NJ. Passaic County, NJ. Bronx County, NY. Kings County, NY. New York County, NY. Putnam County, NY. Queens County, NY. Richmond County, NY. Rockland County, NY. Westchester County, NY.	1.1432
36084	Niles-Benton Harbor, MI	1.5685
36100	Berrien County, MI. Norwich-New London, CT	0.8627
36140	New London County, CT. Oakland-Fremont-Hayward, CA	1.0988
	Alameda County, CA. Contra Costa County, CA.	
	Ocala, FL	
	Marion County, FL.	
	Ocean City, NJ	

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2008 THROUGH SEPTEMBER 30, 2009—Continued

CBSA code	Urban area (constituent counties)	Proposed wage index
36220	Cape May County, NJ. Odessa, TX	1.0042
36260	Ector County, TX. Ogden-Clearfield, UT	0.9000
36420	Davis County, UT. Morgan County, UT. Weber County, UT. Oklahoma City, OK	0.8815
36500	Canadian County, OK. Cleveland County, OK. Grady County, OK. Lincoln County, OK. Logan County, OK. McClain County, OK. Oklahoma County, OK. Olympia, WA	1.1512
36540	Thurston County, WA. Omaha-Council Bluffs, NE-IA	0.9561
36740	Harrison County, IA. Mills County, IA. Pottawattamie County, IA. Cass County, NE. Douglas County, NE. Sarpy County, NE. Saunders County, NE. Washington County, NE. Orlando-Kissimmee, FL	0.9226
36780	Lake County, FL. Orange County, FL. Osceola County, FL. Seminole County, FL. Oshkosh-Neenah, WI	0.9551
36980	Winnebago County, WI. Owensboro, KY	0.8652
37100	Daviess County, KY. Hancock County, KY. McLean County, KY. Oxnard-Thousand Oaks-Ventura, CA	1.1852
37340	Ventura County, CA. Palm Bay-Melbourne-Titusville, FL	0.9325
37380	Brevard County, FL. Palm Coast, FL	0.8945
37460	Flagler County, FL. Panama City-Lynn Haven, FL	0.8313
37620	Bay County, FL. Parkersburg-Marietta-Vienna, WV-OH	0.8105
37700	Washington County, OH. Pleasants County, WV. Wirt County, WV. Wood County, WV. Pascagoula, MS	0.8647
37764	George County, MS. Jackson County, MS. Peabody, MA	1.0650
37860	Essex County, MA. Pensacola-Ferry Pass-Brent, FL	0.8281
37900	Escambia County, FL. Santa Rosa County, FL. Peoria, IL	0.9299
37964	Marshall County, IL. Peoria County, IL. Stark County, IL. Tazewell County, IL. Woodford County, IL. Philadelphia, PA	1.0925
	Bucks County, PA. Chester County, PA. Delaware County, PA. Montgomery County, PA. Philadelphia County, PA.	

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2008 THROUGH SEPTEMBER 30, 2009—Continued

CBSA code	Urban area (constituent counties)	Proposed wage index
38060	Phoenix-Mesa-Scottsdale, AZ	1.0264
	Maricopa County, AZ.	
	Pinal County, AZ.	
38220	Pine Bluff, AR	0.7839
	Cleveland County, AR.	
	Jefferson County, AR.	
	Lincoln County, AR.	
38300	Pittsburgh, PA	0.8525
	Allegheny County, PA.	
	Armstrong County, PA.	
	Beaver County, PA.	
	Butler County, PA.	
	Fayette County, PA.	
	Washington County, PA.	
	Westmoreland County, PA.	
38340	Pittsfield, MA	1.0091
	Berkshire County, MA.	
38540	Pocatello, ID	0.9465
	Bannock County, ID.	
	Power County, ID.	
38660	Ponce, PR	0.4450
	Juana Díaz Municipio, PR.	
	Ponce Municipio, PR.	
	Villalba Municipio, PR.	
38860	Portland-South Portland-Biddeford, ME	1.0042
	Cumberland County, ME.	
	Sagadahoc County, ME.	
	York County, ME.	
38900	Portland-Vancouver-Beaverton, OR-WA	1.1498
	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, FL	1.0016
	Martin County, FL.	
	St. Lucie County, FL.	
39100	Poughkeepsie-Newburgh-Middletown, NY	1.0982
	Dutchess County, NY.	
	Orange County, NY.	
39140	Prescott, AZ	1.0020
	Yavapai County, AZ.	
39300	Providence-New Bedford-Fall River, RI-MA	1.0574
	Bristol County, MA.	
	Bristol County, RI.	
	Kent County, RI.	
	Newport County, RI.	
	Providence County, RI.	
	Washington County, RI.	
39340	Provo-Orem, UT	0.9557
	Juab County, UT.	
	Utah County, UT.	
39380	Pueblo, CO	0.8851
	Pueblo County, CO.	
39460	Punta Gorda, FL	0.9254
	Charlotte County, FL.	
39540	Racine, WI	0.9498
	Racine County, WI.	
39580	Raleigh-Cary, NC	0.9839
	Franklin County, NC.	
	Johnston County, NC.	
	Wake County, NC.	
39660	Rapid City, SD	0.8811
	Meade County, SD.	
	Pennington County, SD.	
39740	Reading, PA	0.9356
	Berks County, PA.	
39820	Redding, CA	1.3541

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2008 THROUGH SEPTEMBER 30, 2009—Continued

CBSA code	Urban area (constituent counties)	Proposed wage index
39900	Shasta County, CA. Reno-Sparks, NV Storey County, NV. Washoe County, NV.	1.0715
40060	Richmond, VA Amelia County, VA. Caroline County, VA. Charles City County, VA. Chesterfield County, VA. Cumberland County, VA. Dinwiddie County, VA. Goochland County, VA. Hanover County, VA. Henrico County, VA. King and Queen County, VA. King William County, VA. Louisa County, VA. New Kent County, VA. Powhatan County, VA. Prince George County, VA. Sussex County, VA. Colonial Heights City, VA. Hopewell City, VA. Petersburg City, VA. Richmond City, VA.	0.9425
40140	Riverside-San Bernardino-Ontario, CA Riverside County, CA. San Bernardino County, CA.	1.1100
40220	Roanoke, VA Botetourt County, VA. Craig County, VA. Franklin County, VA. Roanoke County, VA. Roanoke City, VA. Salem City, VA.	0.8691
40340	Rochester, MN Dodge County, MN. Olmsted County, MN. Wabasha County, MN.	1.0755
40380	Rochester, NY Livingston County, NY. Monroe County, NY. Ontario County, NY. Orleans County, NY. Wayne County, NY.	0.8858
40420	Rockford, IL Boone County, IL. Winnebago County, IL.	0.9814
40484	Rockingham County-Strafford County, NH Rockingham County, NH. Strafford County, NH.	1.0111
40580	Rocky Mount, NC Edgecombe County, NC. Nash County, NC.	0.9001
40660	Rome, GA Floyd County, GA.	0.9042
40900	Sacramento-Arden-Arcade-Roseville, CA El Dorado County, CA. Placer County, CA. Sacramento County, CA. Yolo County, CA.	1.3505
40980	Saginaw-Saginaw Township North, MI Saginaw County, MI.	0.8812
41060	St. Cloud, MN Benton County, MN. Stearns County, MN.	1.0549
41100	St. George, UT Washington County, UT.	0.9358
41140	St. Joseph, MO-KS Doniphan County, KS.	0.8762

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2008 THROUGH SEPTEMBER 30, 2009—Continued

CBSA code	Urban area (constituent counties)	Proposed wage index
41180	Andrew County, MO. Buchanan County, MO. DeKalb County, MO. St. Louis, MO—IL	0.9024
	Bond County, IL. Calhoun County, IL. Clinton County, IL. Jersey County, IL. Macoupin County, IL. Madison County, IL. Monroe County, IL. St. Clair County, IL. Crawford County, MO. Franklin County, MO. Jefferson County, MO. Lincoln County, MO. St. Charles County, MO. St. Louis County, MO. Warren County, MO. Washington County, MO. St. Louis City, MO.	
41420	Salem, OR	1.0572
	Marion County, OR. Polk County, OR.	
41500	Salinas, CA	1.4775
	Monterey County, CA.	
41540	Salisbury, MD	0.8994
	Somerset County, MD. Wicomico County, MD.	
41620	Salt Lake City, UT	0.9399
	Salt Lake County, UT. Summit County, UT. Tooele County, UT.	
41660	San Angelo, TX	0.8579
	Irion County, TX. Tom Green County, TX.	
41700	San Antonio, TX	0.8834
	Atascosa County, TX. Bandera County, TX. Bexar County, TX. Comal County, TX. Guadalupe County, TX. Kendall County, TX. Medina County, TX. Wilson County, TX.	
41740	San Diego-Carlsbad-San Marcos, CA	1.1492
	San Diego County, CA.	
41780	Sandusky, OH	0.8822
	Erie County, OH.	
41884	San Francisco-San Mateo-Redwood City, CA	1.5195
	Marin County, CA. San Francisco County, CA. San Mateo County, CA.	
41900	San Germán-Cabo Rojo, PR	0.4729
	Cabo Rojo Municipio, PR. Lajas Municipio, PR. Sabana Grande Municipio, PR. San Germán Municipio, PR.	
41940	San Jose-Sunnyvale-Santa Clara, CA	1.5735
	San Benito County, CA. Santa Clara County, CA.	
41980	San Juan-Caguas-Guaynabo, PR	0.4528
	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.	

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2008 THROUGH SEPTEMBER 30, 2009—Continued

CBSA code	Urban area (constituent counties)	Proposed wage index
	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	1.2488
	San Luis Obispo County, CA.	
42044	Santa Ana-Anaheim-Irvine, CA	1.1766
	Orange County, CA.	
42060	Santa Barbara-Santa Maria-Goleta, CA	1.1714
	Santa Barbara County, CA.	
42100	Santa Cruz-Watsonville, CA	1.6122
	Santa Cruz County, CA.	
42140	Santa Fe, NM	1.0734
	Santa Fe County, NM.	
42220	Santa Rosa-Petaluma, CA	1.4696
	Sonoma County, CA.	
42260	Sarasota-Bradenton-Venice, FL	0.9933
	Manatee County, FL.	
	Sarasota County, FL.	
42340	Savannah, GA	0.9131
	Bryan County, GA.	
	Chatham County, GA.	
	Effingham County, GA.	
42540	Scranton-Wilkes-Barre, PA	0.8457
	Lackawanna County, PA.	
	Luzerne County, PA.	
	Wyoming County, PA.	
42644	Seattle-Bellevue-Everett, WA	1.1572
	King County, WA.	
	Snohomish County, WA.	
42680	Sebastian-Vero Beach, FL	0.9412
	Indian River County, FL.	
43100	Sheboygan, WI	0.8975
	Sheboygan County, WI.	
43300	Sherman-Denison, TX	0.8320
	Grayson County, TX.	
43340	Shreveport-Bossier City, LA	0.8476
	Bossier Parish, LA.	
	Caddo Parish, LA.	
	De Soto Parish, LA.	
43580	Sioux City, IA-NE-SD	0.9251

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2008 THROUGH SEPTEMBER 30, 2009—Continued

CBSA code	Urban area (constituent counties)	Proposed wage index
43620	Woodbury County, IA. Dakota County, NE. Dixon County, NE. Union County, SD. Sioux Falls, SD	0.9563
43780	Lincoln County, SD. McCook County, SD. Minnehaha County, SD. Turner County, SD. South Bend-Mishawaka, IN-MI	0.9617
43900	St. Joseph County, IN. Cass County, MI. Spartanburg, SC	0.9422
44060	Spartanburg County, SC. Spokane, WA	1.0455
44100	Spokane County, WA. Springfield, IL	0.8944
44140	Menard County, IL. Sangamon County, IL. Springfield, MA	1.0366
44180	Franklin County, MA. Hampden County, MA. Hampshire County, MA. Springfield, MO	0.8695
44220	Christian County, MO. Dallas County, MO. Greene County, MO. Polk County, MO. Webster County, MO. Springfield, OH	0.8694
44300	Clark County, OH. State College, PA	0.8768
44700	Centre County, PA. Stockton, CA	1.1855
44940	San Joaquin County, CA. Sumter, SC	0.8599
45060	Sumter County, SC. Syracuse, NY	0.9910
45104	Madison County, NY. Onondaga County, NY. Oswego County, NY. Tacoma, WA	1.1055
45220	Pierce County, WA. Tallahassee, FL	0.9025
45300	Gadsden County, FL. Jefferson County, FL. Leon County, FL. Wakulla County, FL. Tampa-St. Petersburg-Clearwater, FL	0.9020
45460	Hernando County, FL. Hillsborough County, FL. Pasco County, FL. Pinellas County, FL. Terre Haute, IN	0.8805
45500	Clay County, IN. Sullivan County, IN. Vermillion County, IN. Vigo County, IN. Texarkana, TX-Texarkana, AR	0.7770
45780	Miller County, AR. Bowie County, TX. Toledo, OH	0.9431
45820	Fulton County, OH. Lucas County, OH. Ottawa County, OH. Wood County, OH. Topeka, KS	0.8538
	Jackson County, KS. Jefferson County, KS. Osage County, KS.	

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2008 THROUGH SEPTEMBER 30, 2009—Continued

CBSA code	Urban area (constituent counties)	Proposed wage index
45940	Shawnee County, KS. Wabaunsee County, KS. Trenton-Ewing, NJ	1.0699
46060	Mercer County, NJ. Tucson, AZ	0.9245
46140	Pima County, AZ. Tulsa, OK	0.8340
46220	Creek County, OK. Okmulgee County, OK. Osage County, OK. Pawnee County, OK. Rogers County, OK. Tulsa County, OK. Wagoner County, OK. Tuscaloosa, AL	0.8303
46340	Greene County, AL. Hale County, AL. Tuscaloosa County, AL. Tyler, TX	0.9114
46540	Smith County, TX. Utica-Rome, NY	0.8486
46660	Herkimer County, NY. Oneida County, NY. Valdosta, GA	0.8098
46700	Brooks County, GA. Echols County, GA. Lanier County, GA. Lowndes County, GA. Vallejo-Fairfield, CA	1.4666
47020	Solano County, CA. Victoria, TX	0.8302
47220	Calhoun County, TX. Goliad County, TX. Victoria County, TX. Vineland-Millville-Bridgeton, NJ	1.0133
47260	Cumberland County, NJ. Virginia Beach-Norfolk-Newport News, VA-NC	0.8818
47300	Currituck County, NC. Gloucester County, VA. Isle of Wight County, VA. James City County, VA. Mathews County, VA. Surry County, VA. York County, VA. Chesapeake City, VA. Hampton City, VA. Newport News City, VA. Norfolk City, VA. Poquoson City, VA. Portsmouth City, VA. Suffolk City, VA. Virginia Beach City, VA. Williamsburg City, VA. Visalia-Porterville, CA	1.0091
47380	Tulare County, CA. Waco, TX	0.8518
47580	McLennan County, TX. Warner Robins, GA	0.9128
47644	Houston County, GA. Warren-Troy-Farmington Hills, MI	1.0001
47894	Lapeer County, MI. Livingston County, MI. Macomb County, MI. Oakland County, MI. St. Clair County, MI. Washington-Arlington-Alexandria, DC-VA-MD-WV	1.0855
	District of Columbia, DC. Calvert County, MD. Charles County, MD. Prince George's County, MD.	

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2008 THROUGH SEPTEMBER 30, 2009—Continued

CBSA code	Urban area (constituent counties)	Proposed wage index
	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 Black Hawk County, IA. Bremer County, IA. Grundy County, IA.	0.8519
48140	Wausau, WI Marathon County, WI.	0.9679
48260	Weirton-Steubenville, WV-OH Jefferson County, OH. Brooke County, WV. Hancock County, WV.	0.7924
48300	Wenatchee, WA Chelan County, WA. Douglas County, WA.	1.1469
48424	West Palm Beach-Boca Raton-Boynton Beach, FL Palm Beach County, FL.	0.9728
48540	Wheeling, WV-OH Belmont County, OH. Marshall County, WV. Ohio County, WV.	0.6961
48620	Wichita, KS Butler County, KS. Harvey County, KS. Sedgwick County, KS. Sumner County, KS.	0.9062
48660	Wichita Falls, TX Archer County, TX. Clay County, TX. Wichita County, TX.	0.7920
48700	Williamsport, PA Lycoming County, PA.	0.8043
48864	Wilmington, DE-MD-NJ New Castle County, DE. Cecil County, MD. Salem County, NJ.	1.0824
48900	Wilmington, NC Brunswick County, NC. New Hanover County, NC. Pender County, NC.	0.9410
49020	Winchester, VA-WV Frederick County, VA. Winchester City, VA. Hampshire County, WV.	0.9913
49180	Winston-Salem, NC Davie County, NC. Forsyth County, NC. Stokes County, NC. Yadkin County, NC.	0.9118
49340	Worcester, MA Worcester County, MA.	1.1287
49420	Yakima, WA Yakima County, WA.	1.0267
49500	Yauco, PR Guánica Municipio, PR. Guayanilla Municipio, PR.	0.3284

TABLE 1.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2008 THROUGH SEPTEMBER 30, 2009—Continued

CBSA code	Urban area (constituent counties)	Proposed wage index
49620	Peñuelas Municipio, PR. Yauco Municipio, PR. York-Hanover, PA	0.9359
49660	York County, PA. Youngstown-Warren-Boardman, OH-PA	0.9002
49700	Mahoning County, OH. Trumbull County, OH. Mercer County, PA. Yuba City, CA	1.0756
49740	Sutter County, CA. Yuba County, CA. Yuma, AZ	0.9488
	Yuma County, AZ.	

TABLE 2.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR RURAL AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2008 THROUGH SEPTEMBER 30, 2009

CBSA code	Nonurban area	Proposed wage index
01	Alabama	0.7533
02	Alaska	1.2109
03	Arizona	0.8479
04	Arkansas	0.7371
05	California	1.2023
06	Colorado	0.9704
07	Connecticut	1.1119
08	Delaware	0.9727
10	Florida	0.8465
11	Georgia	0.7659
12	Hawaii	1.0612
13	Idaho	0.7920
14	Illinois	0.8335
15	Indiana	0.8576
16	Iowa	0.8566
17	Kansas	0.7981
18	Kentucky	0.7793
19	Louisiana	0.7373
20	Maine	0.8476

TABLE 2.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR RURAL AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2008 THROUGH SEPTEMBER 30, 2009—Continued

CBSA code	Nonurban area	Proposed wage index
21	Maryland	0.9034
22	Massachusetts	1.1589
23	Michigan	0.8953
24	Minnesota	0.9079
25	Mississippi	0.7700
26	Missouri	0.7930
27	Montana	0.8379
28	Nebraska	0.8849
29	Nevada	0.9272
30	New Hampshire	1.0470
31	New Jersey *
32	New Mexico	0.8940
33	New York	0.8268
34	North Carolina	0.8603
35	North Dakota	0.7182
36	Ohio	0.8714
37	Oklahoma	0.7492

TABLE 2.—PROPOSED LONG-TERM CARE HOSPITAL WAGE INDEX FOR RURAL AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2008 THROUGH SEPTEMBER 30, 2009—Continued

CBSA code	Nonurban area	Proposed wage index
38	Oregon	0.9906
39	Pennsylvania	0.8385
41	Rhode Island *
42	South Carolina	0.8656
43	South Dakota	0.8549
44	Tennessee	0.7723
45	Texas	0.7968
46	Utah	0.8116
47	Vermont	0.9919
49	Virginia	0.7896
50	Washington	1.0259
51	West Virginia	0.7454
52	Wisconsin	0.9667
53	Wyoming	0.9287

* All counties within the State are classified as urban.

TABLE 3.—FY 2008 MS-LTC-DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, SHORT-STAY OUTLIER THRESHOLD AND IPPS-COMPARABLE THRESHOLD

MS-LTC-DRG	MS-DRG title	Relative weight ¹	Geometric average length of stay	Short stay outlier threshold ²	IPPS comparable threshold ³
001	Heart transplant or implant of heart assist system w MCC	0.0000	0.0	0.0	0.0
002	Heart transplant or implant of heart assist system w/o MCC	0.0000	0.0	0.0	0.0
003	ECMO or trach w MV 96+ hrs or PDX exc face, mouth & neck w maj O.R.	4.2380	64.3	53.6	53.6
004	Trach w MV 96+ hrs or PDX exc face, mouth & neck w/o maj O.R	3.0249	46.7	38.9	38.9
005	Liver transplant w MCC or intestinal transplant	0.0000	0.0	0.0	0.0
006	Liver transplant w/o MCC	0.0000	0.0	0.0	0.0
007	Lung transplant	0.0000	0.0	0.0	0.0
008	Simultaneous pancreas/kidney transplant	0.0000	0.0	0.0	0.0
009	Bone marrow transplant	1.1417	29.0	24.2	24.2
010	Pancreas transplant	1.1417	29.0	24.2	0.0
011	Tracheostomy for face, mouth & neck diagnoses w MCC	1.5545	35.2	29.3	25.2
012	Tracheostomy for face, mouth & neck diagnoses w CC	1.5545	35.2	29.3	16.7
013	Tracheostomy for face, mouth & neck diagnoses w/o CC/MCC	1.5545	35.2	29.3	11.2
020	Intracranial vascular procedures w PDX hemorrhage w MCC	1.5545	35.2	29.3	29.3
021	Intracranial vascular procedures w PDX hemorrhage w CC	0.5472	20.3	16.9	16.9

TABLE 3.—FY 2008 MS—LTC—DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, SHORT-STAY OUTLIER THRESHOLD AND IPPS-COMPARABLE THRESHOLD—Continued

MS—LTC— DRG	MS—DRG title	Relative weight ¹	Geometric average length of stay	Short stay outlier threshold ²	IPPS com- parable threshold ³
022	Intracranial vascular procedures w PDX hemorrhage w/o CC/MCC	0.5472	20.3	16.9	16.1
023	Cranio w major dev impl/acute complex CNS PDX w MCC or chemo implant.	1.5545	35.2	29.3	22.2
024	Cranio w major dev impl/acute complex CNS PDX w/o MCC	0.5472	20.3	16.9	15.8
025	Craniotomy & endovascular intracranial procedures w MCC	1.5545	35.2	29.3	22.1
026	Craniotomy & endovascular intracranial procedures w CC	1.5545	35.2	29.3	13.2
027	Craniotomy & endovascular intracranial procedures w/o CC/MCC	1.5545	35.2	29.3	7.5
028	Spinal procedures w MCC	1.1417	29.0	24.2	24.2
029	Spinal procedures w CC or spinal neurostimulators	1.1417	29.0	24.2	12.4
030	Spinal procedures w/o CC/MCC	0.5472	20.3	16.9	5.9
031	Ventricular shunt procedures w MCC	1.5545	35.2	29.3	22.9
032	Ventricular shunt procedures w CC	0.5472	20.3	16.9	9.4
033	Ventricular shunt procedures w/o CC/MCC	0.5472	20.3	16.9	4.7
034	Carotid artery stent procedure w MCC	1.5545	35.2	29.3	12.5
035	Carotid artery stent procedure w CC	1.1417	29.0	24.2	4.4
036	Carotid artery stent procedure w/o CC/MCC	1.1417	29.0	24.2	2.2
037	Extracranial procedures w MCC	1.5545	35.2	29.3	14.9
038	Extracranial procedures w CC	1.1417	29.0	24.2	5.8
039	Extracranial procedures w/o CC/MCC	1.1417	29.0	24.2	2.6
040	Periph/cranial nerve & other nerv syst proc w MCC	1.2704	36.2	30.2	22.7
041	Periph/cranial nerve & other nerv syst proc w CC or periph neurostim ...	1.0810	34.3	28.6	12.3
042	Periph/cranial nerve & other nerv syst proc w/o CC/MCC	0.7305	22.9	19.1	5.7
052	Spinal disorders & injuries w CC/MCC	1.0629	32.3	26.9	10.7
053	Spinal disorders & injuries w/o CC/MCC	1.0629	32.3	26.9	6.4
054	Nervous system neoplasms w MCC	0.7205	23.6	19.7	11.7
055	Nervous system neoplasms w/o MCC	0.6779	22.0	18.3	8.1
056	Degenerative nervous system disorders w MCC	0.7407	26.4	22.0	12.3
057	Degenerative nervous system disorders w/o MCC	0.6309	24.4	20.3	7.6
058	Multiple sclerosis & cerebellar ataxia w MCC	0.7305	22.9	19.1	12.5
059	Multiple sclerosis & cerebellar ataxia w CC	0.5595	22.6	18.8	8.0
060	Multiple sclerosis & cerebellar ataxia w/o CC/MCC	0.5472	20.3	16.9	6.2
061	Acute ischemic stroke w use of thrombolytic agent w MCC	0.7897	24.2	20.2	16.0
062	Acute ischemic stroke w use of thrombolytic agent w CC	0.6563	22.7	18.9	9.6
063	Acute ischemic stroke w use of thrombolytic agent w/o CC/MCC	0.5472	20.3	16.9	6.8
064	Intracranial hemorrhage or cerebral infarction w MCC	0.7746	25.1	20.9	12.7
065	Intracranial hemorrhage or cerebral infarction w CC	0.6691	23.3	19.4	8.2
066	Intracranial hemorrhage or cerebral infarction w/o CC/MCC	0.5472	20.3	16.9	5.8
067	Nonspecific cva & precerebral occlusion w/o infarct w MCC	0.5472	20.3	16.9	10.1
068	Nonspecific cva & precerebral occlusion w/o infarct w/o MCC	0.5472	20.3	16.9	5.6
069	Transient ischemia	0.5472	20.3	16.9	4.7
070	Nonspecific cerebrovascular disorders w MCC	0.7897	24.2	20.2	12.7
071	Nonspecific cerebrovascular disorders w CC	0.6563	22.7	18.9	8.8
072	Nonspecific cerebrovascular disorders w/o CC/MCC	0.5472	20.3	16.9	5.8
073	Cranial & peripheral nerve disorders w MCC	0.7849	25.6	21.3	10.2
074	Cranial & peripheral nerve disorders w/o MCC	0.6260	23.4	19.5	6.9
075	Viral meningitis w CC/MCC	0.7305	22.9	19.1	12.1
076	Viral meningitis w/o CC/MCC	0.5472	20.3	16.9	6.5
077	Hypertensive encephalopathy w MCC	0.7305	22.9	19.1	11.4
078	Hypertensive encephalopathy w CC	0.7305	22.9	19.1	7.2
079	Hypertensive encephalopathy w/o CC/MCC	0.5472	20.3	16.9	5.3
080	Nontraumatic stupor & coma w MCC	0.6312	24.6	20.5	7.8
081	Nontraumatic stupor & coma w/o MCC	0.5618	23.1	19.3	5.3
082	Traumatic stupor & coma, coma >1 hr w MCC	0.8864	29.5	24.6	10.9
083	Traumatic stupor & coma, coma >1 hr w CC	0.7305	22.9	19.1	8.6
084	Traumatic stupor & coma, coma >1 hr w/o CC/MCC	0.7305	22.9	19.1	4.9
085	Traumatic stupor & coma, coma <1 hr w MCC	0.9044	28.3	23.6	13.2
086	Traumatic stupor & coma, coma <1 hr w CC	0.7437	25.1	20.9	8.2
087	Traumatic stupor & coma, coma <1 hr w/o CC/MCC	0.6361	20.4	17.0	5.3
088	Concussion w MCC	1.1417	29.0	24.2	9.9
089	Concussion w CC	1.1417	29.0	24.2	6.0
090	Concussion w/o CC/MCC	1.1417	29.0	24.2	3.7
091	Other disorders of nervous system w MCC	0.8019	25.6	21.3	10.7
092	Other disorders of nervous system w CC	0.6704	22.0	18.3	6.9
093	Other disorders of nervous system w/o CC/MCC	0.5811	20.1	16.8	4.9
094	Bacterial & tuberculous infections of nervous system w MCC	1.0328	27.9	23.3	20.8
095	Bacterial & tuberculous infections of nervous system w CC	0.9306	27.0	22.5	14.9
096	Bacterial & tuberculous infections of nervous system w/o CC/MCC	0.9306	27.0	22.5	10.1
097	Non-bacterial infect of nervous sys exc viral meningitis w MCC	0.9289	26.8	22.3	19.6

TABLE 3.—FY 2008 MS—LTC—DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, SHORT-STAY OUTLIER THRESHOLD AND IPPS-COMPARABLE THRESHOLD—Continued

MS—LTC— DRG	MS—DRG title	Relative weight ¹	Geometric average length of stay	Short stay outlier threshold ²	IPPS com- parable threshold ³
098	Non-bacterial infect of nervous sys exc viral meningitis w CC	0.8629	22.7	18.9	13.7
099	Non-bacterial infect of nervous sys exc viral meningitis w/o CC/MCC	0.7305	22.9	19.1	10.1
100	Seizures w MCC	0.7904	26.5	22.1	10.1
101	Seizures w/o MCC	0.6177	21.4	17.8	5.8
102	Headaches w MCC	0.8249	25.0	20.8	8.1
103	Headaches w/o MCC	0.8249	25.0	20.8	5.0
113	Orbital procedures w CC/MCC	0.7305	22.9	19.1	9.2
114	Orbital procedures w/o CC/MCC	0.7305	22.9	19.1	4.1
115	Extraocular procedures except orbit	0.8249	25.0	20.8	7.2
116	Intraocular procedures w CC/MCC	0.8249	25.0	20.8	5.2
117	Intraocular procedures w/o CC/MCC	0.8249	25.0	20.8	2.8
121	Acute major eye infections w CC/MCC	0.7305	22.9	19.1	9.1
122	Acute major eye infections w/o CC/MCC	0.5472	20.3	16.9	6.3
123	Neurological eye disorders	0.5472	20.3	16.9	4.5
124	Other disorders of the eye w MCC	1.1417	29.0	24.2	8.4
125	Other disorders of the eye w/o MCC	0.8249	25.0	20.8	5.5
129	Major head & neck procedures w CC/MCC or major device	1.1977	26.4	22.0	8.1
130	Major head & neck procedures w/o CC/MCC	0.7305	22.9	19.1	4.8
131	Cranial/facial procedures w CC/MCC	1.5545	35.2	29.3	9.5
132	Cranial/facial procedures w/o CC/MCC	1.5545	35.2	29.3	4.0
133	Other ear, nose, mouth & throat O.R. procedures w CC/MCC	0.7305	22.9	19.1	9.4
134	Other ear, nose, mouth & throat O.R. procedures w/o CC/MCC	0.7305	22.9	19.1	3.2
135	Sinus & mastoid procedures w CC/MCC	0.7305	22.9	19.1	10.8
136	Sinus & mastoid procedures w/o CC/MCC	0.7305	22.9	19.1	3.9
137	Mouth procedures w CC/MCC	1.5545	35.2	29.3	8.7
138	Mouth procedures w/o CC/MCC	1.5545	35.2	29.3	3.7
139	Salivary gland procedures	1.5545	35.2	29.3	2.5
146	Ear, nose, mouth & throat malignancy w MCC	1.1977	26.4	22.0	16.9
147	Ear, nose, mouth & throat malignancy w CC	1.0416	24.9	20.8	9.3
148	Ear, nose, mouth & throat malignancy w/o CC/MCC	0.7305	22.9	19.1	5.6
149	Dysequilibrium	0.5472	20.3	16.9	4.2
150	Epistaxis w MCC	0.7305	22.9	19.1	8.8
151	Epistaxis w/o MCC	0.7305	22.9	19.1	4.5
152	Otitis media & URI w MCC	0.7305	22.9	19.1	7.4
153	Otitis media & URI w/o MCC	0.7305	22.9	19.1	5.2
154	Nasal trauma & deformity w MCC	0.7703	21.0	17.5	10.5
155	Nasal trauma & deformity w CC	0.7703	21.0	17.5	7.2
156	Nasal trauma & deformity w/o CC/MCC	0.7305	22.9	19.1	4.9
157	Dental & Oral Diseases w MCC	0.8249	25.0	20.8	11.3
158	Dental & Oral Diseases w CC	0.8249	25.0	20.8	7.1
159	Dental & Oral Diseases w/o CC/MCC	0.5472	20.3	16.9	4.8
163	Major chest procedures w MCC	2.2157	39.7	33.1	23.6
164	Major chest procedures w CC	1.5545	35.2	29.3	13.0
165	Major chest procedures w/o CC/MCC	1.5545	35.2	29.3	8.3
166	Other resp system O.R. procedures w MCC	2.4392	42.3	35.3	20.6
167	Other resp system O.R. procedures w CC	2.1594	38.0	31.7	13.1
168	Other resp system O.R. procedures w/o CC/MCC	1.1417	29.0	24.2	8.9
175	Pulmonary embolism w MCC	0.7160	22.0	18.3	11.6
176	Pulmonary embolism w/o MCC	0.5989	20.1	16.8	8.4
177	Respiratory infections & inflammations w MCC	0.8393	23.5	19.6	14.9
178	Respiratory infections & inflammations w CC	0.7671	22.2	18.5	11.7
179	Respiratory infections & inflammations w/o CC/MCC	0.6885	19.0	15.8	8.9
180	Respiratory neoplasms w MCC	0.8140	20.2	16.8	13.1
181	Respiratory neoplasms w CC	0.7103	19.3	16.1	9.7
182	Respiratory neoplasms w/o CC/MCC	0.5472	20.3	16.9	6.9
183	Major chest trauma w MCC	0.5472	20.3	16.9	11.5
184	Major chest trauma w CC	0.5472	20.3	16.9	7.3
185	Major chest trauma w/o CC/MCC	0.5472	20.3	16.9	5.0
186	Pleural effusion w MCC	0.8259	23.6	19.7	12.2
187	Pleural effusion w CC	0.7042	21.1	17.6	8.8
188	Pleural effusion w/o CC/MCC	0.7042	21.1	17.6	6.5
189	Pulmonary edema & respiratory failure	0.9743	24.0	20.0	10.1
190	Chronic obstructive pulmonary disease w MCC	0.6858	20.9	17.4	10.2
191	Chronic obstructive pulmonary disease w CC	0.6256	19.5	16.3	7.9
192	Chronic obstructive pulmonary disease w/o CC/MCC	0.5832	17.2	14.3	6.2
193	Simple pneumonia & pleurisy w MCC	0.7088	21.6	18.0	10.9
194	Simple pneumonia & pleurisy w CC	0.6429	19.8	16.5	8.2
195	Simple pneumonia & pleurisy w/o CC/MCC	0.5962	18.2	15.2	6.3

TABLE 3.—FY 2008 MS—LTC—DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, SHORT-STAY OUTLIER THRESHOLD AND IPPS-COMPARABLE THRESHOLD—Continued

MS—LTC— DRG	MS—DRG title	Relative weight ¹	Geometric average length of stay	Short stay outlier threshold ²	IPPS com- parable threshold ³
196	Interstitial lung disease w MCC	0.6529	20.0	16.7	11.6
197	Interstitial lung disease w CC	0.6133	19.6	16.3	8.5
198	Interstitial lung disease w/o CC/MCC	0.5956	19.7	16.4	6.7
199	Pneumothorax w MCC	0.8249	25.0	20.8	13.8
200	Pneumothorax w CC	0.7305	22.9	19.1	8.3
201	Pneumothorax w/o CC/MCC	0.5472	20.3	16.9	6.5
202	Bronchitis & asthma w CC/MCC	0.6903	21.1	17.6	6.9
203	Bronchitis & asthma w/o CC/MCC	0.5650	17.1	14.3	5.3
204	Respiratory signs & symptoms	0.8187	22.0	18.3	4.4
205	Other respiratory system diagnoses w MCC	0.8207	22.4	18.7	9.0
206	Other respiratory system diagnoses w/o MCC	0.7667	21.5	17.9	5.5
207	Respiratory system diagnosis w ventilator support 96+ hours	2.0266	34.3	28.6	22.6
208	Respiratory system diagnosis w ventilator support <96 hours	1.5514	27.8	23.2	12.5
215	Other heart assist system implant	0.8249	25.0	20.8	20.5
216	Cardiac valve & oth maj cardiothoracic proc w card cath w MCC	1.5545	35.2	29.3	28.7
217	Cardiac valve & oth maj cardiothoracic proc w card cath w CC	0.8249	25.0	20.8	17.7
218	Cardiac valve & oth maj cardiothoracic proc w card cath w/o CC/MCC ..	0.8249	25.0	20.8	12.7
219	Cardiac valve & oth maj cardiothoracic proc w/o card cath w MCC	1.5545	35.2	29.3	22.6
220	Cardiac valve & oth maj cardiothoracic proc w/o card cath w CC	0.8249	25.0	20.8	12.5
221	Cardiac valve & oth maj cardiothoracic proc w/o card cath w/o CC/MCC ..	0.8249	25.0	20.8	8.7
222	Cardiac defib implant w cardiac cath w AMI/HF/shock w MCC	1.5545	35.2	29.3	20.9
223	Cardiac defib implant w cardiac cath w AMI/HF/shock w/o MCC	1.5545	35.2	29.3	11.0
224	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w MCC	1.5545	35.2	29.3	18.2
225	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w/o MCC	1.5545	35.2	29.3	9.2
226	Cardiac defibrillator implant w/o cardiac cath w MCC	1.5545	35.2	29.3	16.8
227	Cardiac defibrillator implant w/o cardiac cath w/o MCC	1.5545	35.2	29.3	4.1
228	Other cardiothoracic procedures w MCC	1.5410	35.0	29.2	23.2
229	Other cardiothoracic procedures w CC	1.2681	30.8	25.7	13.5
230	Other cardiothoracic procedures w/o CC/MCC	0.8249	25.0	20.8	10.2
231	Coronary bypass w PTCA w MCC	1.5545	35.2	29.3	20.9
232	Coronary bypass w PTCA w/o MCC	0.8249	25.0	20.8	13.1
233	Coronary bypass w cardiac cath w MCC	1.5545	35.2	29.3	21.0
234	Coronary bypass w cardiac cath w/o MCC	0.8249	25.0	20.8	12.2
235	Coronary bypass w/o cardiac cath w MCC	1.5545	35.2	29.3	17.0
236	Coronary bypass w/o cardiac cath w/o MCC	0.8249	25.0	20.8	9.0
237	Major cardiovasc procedures w MCC or thoracic aortic anuerysm repair ..	1.5545	35.2	29.3	19.6
238	Major cardiovasc procedures w/o MCC	0.8249	25.0	20.8	8.1
239	Amputation for circ sys disorders exc upper limb & toe w MCC	1.3794	37.4	31.2	24.7
240	Amputation for circ sys disorders exc upper limb & toe w CC	1.2872	36.1	30.1	16.6
241	Amputation for circ sys disorders exc upper limb & toe w/o CC/MCC	1.1417	29.0	24.2	10.7
242	Permanent cardiac pacemaker implant w MCC	1.5545	35.2	29.3	14.5
243	Permanent cardiac pacemaker implant w CC	1.5545	35.2	29.3	8.5
244	Permanent cardiac pacemaker implant w/o CC/MCC	1.1417	29.0	24.2	4.6
245	AICD lead & generator procedures	0.7305	22.9	19.1	4.9
246	Perc cardiovasc proc w drug-eluting stent w MCC or 4+ vessels/stents ..	0.8249	25.0	20.8	9.1
247	Perc cardiovasc proc w drug-eluting stent w/o MCC	0.8249	25.0	20.8	3.3
248	Perc cardiovasc proc w non-drug-eluting stent w MCC or 4+ ves/stents ..	1.5545	35.2	29.3	10.3
249	Perc cardiovasc proc w non-drug-eluting stent w/o MCC	1.5545	35.2	29.3	3.9
250	Perc cardiovasc proc w/o coronary artery stent or AMI w MCC	0.8249	25.0	20.8	12.7
251	Perc cardiovasc proc w/o coronary artery stent or AMI w/o MCC	0.8249	25.0	20.8	4.6
252	Other vascular procedures w MCC	1.5410	35.0	29.2	15.1
253	Other vascular procedures w CC	1.2681	30.8	25.7	10.2
254	Other vascular procedures w/o CC/MCC	0.8249	25.0	20.8	4.3
255	Upper limb & toe amputation for circ system disorders w MCC	1.1713	33.7	28.1	16.7
256	Upper limb & toe amputation for circ system disorders w CC	0.9516	29.4	24.5	12.3
257	Upper limb & toe amputation for circ system disorders w/o CC/MCC	0.9516	29.4	24.5	8.2
258	Cardiac pacemaker device replacement w MCC	1.5545	35.2	29.3	12.6
259	Cardiac pacemaker device replacement w/o MCC	1.5545	35.2	29.3	4.0
260	Cardiac pacemaker revision except device replacement w MCC	1.5545	35.2	29.3	17.4
261	Cardiac pacemaker revision except device replacement w CC	0.5472	20.3	16.9	6.4
262	Cardiac pacemaker revision except device replacement w/o CC/MCC ...	0.5472	20.3	16.9	3.7
263	Vein ligation & stripping	0.8249	25.0	20.8	9.2
264	Other circulatory system O.R. procedures	1.0667	31.6	26.3	15.4
280	Acute myocardial infarction, discharged alive w MCC	0.7263	21.4	17.8	12.0
281	Acute myocardial infarction, discharged alive w CC	0.6931	22.8	19.0	7.8
282	Acute myocardia infarction, discharged alive w/o CC/MCC	0.6931	22.8	19.0	5.1
283	Acute myocardial infarction, expired w MCC	0.6609	17.0	14.2	9.0
284	Acute myocardial infarction, expired w CC	0.6609	17.0	14.2	5.4

TABLE 3.—FY 2008 MS—LTC—DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, SHORT-STAY OUTLIER THRESHOLD AND IPPS-COMPARABLE THRESHOLD—Continued

MS—LTC— DRG	MS—DRG title	Relative weight ¹	Geometric average length of stay	Short stay outlier threshold ²	IPPS com- parable threshold ³
285	Acute myocardial infarction, expired w/o CC/MCC	0.6609	17.0	14.2	3.3
286	Circulatory disorders except AMI, w card cath w MCC	1.1417	29.0	24.2	11.6
287	Circulatory disorders except AMI, w card cath w/o MCC	0.8249	25.0	20.8	5.0
288	Acute & subacute endocarditis w MCC	0.9082	26.4	22.0	19.7
289	Acute & subacute endocarditis w CC	0.8580	26.4	22.0	13.7
290	Acute & subacute endocarditis w/o CC/MCC	0.7664	25.5	21.3	10.6
291	Heart failure & shock w MCC	0.6968	21.4	17.8	10.7
292	Heart failure & shock w CC	0.6252	20.4	17.0	7.7
293	Heart failure & shock w/o CC/MCC	0.5775	18.5	15.4	5.6
294	Deep vein thrombophlebitis w CC/MCC	0.8249	25.0	20.8	8.6
295	Deep vein thrombophlebitis w/o CC/MCC	0.8249	25.0	20.8	6.7
296	Cardiac arrest, unexplained w MCC	0.6609	17.0	14.2	4.8
297	Cardiac arrest, unexplained w CC	0.6609	17.0	14.2	2.7
298	Cardiac arrest, unexplained w/o CC/MCC	0.6609	17.0	14.2	1.9
299	Peripheral vascular disorders w MCC	0.7152	24.8	20.7	11.2
300	Peripheral vascular disorders w CC	0.6150	22.2	18.5	8.2
301	Peripheral vascular disorders w/o CC/MCC	0.5557	19.4	16.2	6.0
302	Atherosclerosis w MCC	0.6170	21.9	18.3	6.9
303	Atherosclerosis w/o MCC	0.5673	20.5	17.1	3.9
304	Hypertension w MCC	0.8249	25.0	20.8	8.3
305	Hypertension w/o MCC	0.5856	22.6	18.8	4.4
306	Cardiac congenital & valvular disorders w MCC	0.8786	24.2	20.2	10.2
307	Cardiac congenital & valvular disorders w/o MCC	0.7767	23.1	19.3	5.5
308	Cardiac arrhythmia & conduction disorders w MCC	0.7431	24.7	20.6	9.3
309	Cardiac arrhythmia & conduction disorders w CC	0.5940	20.4	17.0	6.2
310	Cardiac arrhythmia & conduction disorders w/o CC/MCC	0.5184	17.0	14.2	4.2
311	Angina pectoris	0.7305	22.9	19.1	3.5
312	Syncope & collapse	0.5336	19.7	16.4	4.9
313	Chest pain	0.5472	20.3	16.9	3.1
314	Other circulatory system diagnoses w MCC	0.8123	23.1	19.3	11.8
315	Other circulatory system diagnoses w CC	0.7114	21.6	18.0	7.3
316	Other circulatory system diagnoses w/o CC/MCC	0.6243	18.9	15.8	4.7
326	Stomach, esophageal & duodenal proc w MCC	1.8646	36.2	30.2	28.1
327	Stomach, esophageal & duodenal proc w CC	1.5545	35.2	29.3	16.8
328	Stomach, esophageal & duodenal proc w/o CC/MCC	0.5472	20.3	16.9	7.2
329	Major small & large bowel procedures w MCC	1.5545	35.2	29.3	25.3
330	Major small & large bowel procedures w CC	1.5545	35.2	29.3	14.6
331	Major small & large bowel procedures w/o CC/MCC	0.5472	20.3	16.9	8.7
332	Rectal resection w MCC	1.5057	36.1	30.1	22.6
333	Rectal resection w CC	1.3309	30.7	25.6	13.0
334	Rectal resection w/o CC/MCC	0.8249	25.0	20.8	8.6
335	Peritoneal adhesiolysis w MCC	1.5545	35.2	29.3	22.9
336	Peritoneal adhesiolysis w CC	0.7305	22.9	19.1	14.6
337	Peritoneal adhesiolysis w/o CC/MCC	0.7305	22.9	19.1	9.3
338	Appendectomy w complicated principal diag w MCC	0.8884	24.1	20.1	16.7
339	Appendectomy w complicated principal diag w CC	0.7667	22.2	18.5	10.8
340	Appendectomy w complicated principal diag w/o CC/MCC	0.6856	19.9	16.6	6.6
341	Appendectomy w/o complicated principal diag w MCC	0.8884	24.1	20.1	12.0
342	Appendectomy w/o complicated principal diag w CC	0.7667	22.2	18.5	6.8
343	Appendectomy w/o complicated principal diag w/o CC/MCC	0.6856	19.9	16.6	3.4
344	Minor small & large bowel procedures w MCC	0.8884	24.1	20.1	19.1
345	Minor small & large bowel procedures w CC	0.7667	22.2	18.5	10.9
346	Minor small & large bowel procedures w/o CC/MCC	0.6856	19.9	16.6	7.4
347	Anal & stomal procedures w MCC	1.1417	29.0	24.2	13.8
348	Anal & stomal procedures w CC	0.8249	25.0	20.8	8.9
349	Anal & stomal procedures w/o CC/MCC	0.5472	20.3	16.9	4.7
350	Inguinal & femoral hernia procedures w MCC	1.5545	35.2	29.3	13.6
351	Inguinal & femoral hernia procedures w CC	1.1417	29.0	24.2	7.4
352	Inguinal & femoral hernia procedures w/o CC/MCC	0.8249	25.0	20.8	3.7
353	Hernia procedures except inguinal & femoral w MCC	0.8249	25.0	20.8	14.5
354	Hernia procedures except inguinal & femoral w CC	0.8249	25.0	20.8	8.2
355	Hernia procedures except inguinal & femoral w/o CC/MCC	0.8249	25.0	20.8	4.4
356	Other digestive system O.R. procedures w MCC	1.5057	36.1	30.1	22.5
357	Other digestive system O.R. procedures w CC	1.3309	30.7	25.6	13.3
358	Other digestive system O.R. procedures w/o CC/MCC	0.8249	25.0	20.8	7.6
368	Major esophageal disorders w MCC	1.1417	29.0	24.2	10.5
369	Major esophageal disorders w CC	1.1417	29.0	24.2	7.1
370	Major esophageal disorders w/o CC/MCC	1.1417	29.0	24.2	5.2

TABLE 3.—FY 2008 MS—LTC—DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, SHORT-STAY OUTLIER THRESHOLD AND IPPS-COMPARABLE THRESHOLD—Continued

MS—LTC— DRG	MS—DRG title	Relative weight ¹	Geometric average length of stay	Short stay outlier threshold ²	IPPS com- parable threshold ³
371	Major gastrointestinal disorders & peritoneal infections w MCC	0.8884	24.1	20.1	14.1
372	Major gastrointestinal disorders & peritoneal infections w CC	0.7667	22.2	18.5	10.6
373	Major gastrointestinal disorders & peritoneal infections w/o CC/MCC	0.6856	19.9	16.6	7.7
374	Digestive malignancy w MCC	0.8340	22.9	19.1	14.4
375	Digestive malignancy w CC	0.7563	19.7	16.4	9.7
376	Digestive malignancy w/o CC/MCC	0.5472	20.3	16.9	6.5
377	G.I. hemorrhage w MCC	0.7032	22.5	18.8	10.3
378	G.I. hemorrhage w CC	0.6334	21.5	17.9	6.8
379	G.I. hemorrhage w/o CC/MCC	0.5472	20.3	16.9	5.2
380	Complicated peptic ulcer w MCC	0.8249	25.0	20.8	11.4
381	Complicated peptic ulcer w CC	0.8249	25.0	20.8	7.9
382	Complicated peptic ulcer w/o CC/MCC	0.7305	22.9	19.1	5.5
383	Uncomplicated peptic ulcer w MCC	0.8249	25.0	20.8	9.1
384	Uncomplicated peptic ulcer w/o MCC	0.7305	22.9	19.1	5.9
385	Inflammatory bowel disease w MCC	0.8874	24.6	20.5	14.4
386	Inflammatory bowel disease w CC	0.7655	22.9	19.1	9.0
387	Inflammatory bowel disease w/o CC/MCC	0.7655	22.9	19.1	6.9
388	G.I. obstruction w MCC	0.8967	22.8	19.0	12.0
389	G.I. obstruction w CC	0.7893	21.9	18.3	8.0
390	G.I. obstruction w/o CC/MCC	0.7893	21.9	18.3	5.5
391	Esophagitis, gastroent & misc digest disorders w MCC	0.8509	24.4	20.3	8.7
392	Esophagitis, gastroent & misc digest disorders w/o MCC	0.6943	20.4	17.0	5.5
393	Other digestive system diagnoses w MCC	0.9915	25.5	21.3	11.4
394	Other digestive system diagnoses w CC	0.8523	22.0	18.3	7.7
395	Other digestive system diagnoses w/o CC/MCC	0.7214	20.9	17.4	5.3
405	Pancreas, liver & shunt procedures w MCC	1.5545	35.2	29.3	29.0
406	Pancreas, liver & shunt procedures w CC	1.5545	35.2	29.3	16.0
407	Pancreas, liver & shunt procedures w/o CC/MCC	1.1417	29.0	24.2	9.2
408	Biliary tract proc except only cholecyst w or w/o c.d.e. w MCC	1.5545	35.2	29.3	23.7
409	Biliary tract proc except only cholecyst w or w/o c.d.e. w CC	1.5545	35.2	29.3	15.4
410	Biliary tract proc except only cholecyst w or w/o c.d.e. w/o CC/MCC	1.5545	35.2	29.3	10.6
411	Cholecystectomy w c.d.e. w MCC	1.1417	29.0	24.2	20.3
412	Cholecystectomy w c.d.e. w CC	1.1417	29.0	24.2	13.5
413	Cholecystectomy w c.d.e. w/o CC/MCC	1.1417	29.0	24.2	9.3
414	Cholecystectomy except by laparoscope w/o c.d.e. w MCC	1.1417	29.0	24.2	18.4
415	Cholecystectomy except by laparoscope w/o c.d.e. w CC	1.1417	29.0	24.2	11.6
416	Cholecystectomy except by laparoscope w/o c.d.e. w/o CC/MCC	1.1417	29.0	24.2	7.5
417	Laparoscopic cholecystectomy w/o c.d.e. w MCC	1.5545	35.2	29.3	13.5
418	Laparoscopic cholecystectomy w/o c.d.e. w CC	1.1417	29.0	24.2	9.0
419	Laparoscopic cholecystectomy w/o c.d.e. w/o CC/MCC	1.1417	29.0	24.2	5.0
420	Hepatobiliary diagnostic procedures w MCC	1.1417	29.0	24.2	24.2
421	Hepatobiliary diagnostic procedures w CC	0.8249	25.0	20.8	12.9
422	Hepatobiliary diagnostic procedures w/o CC/MCC	0.8249	25.0	20.8	7.3
423	Other hepatobiliary or pancreas O.R. procedures w MCC	1.1417	29.0	24.2	24.2
424	Other hepatobiliary or pancreas O.R. procedures w CC	0.8249	25.0	20.8	17.1
425	Other hepatobiliary or pancreas O.R. procedures w/o CC/MCC	0.8249	25.0	20.8	9.2
432	Cirrhosis & alcoholic hepatitis w MCC	0.6223	19.0	15.8	11.1
433	Cirrhosis & alcoholic hepatitis w CC	0.6223	19.0	15.8	7.7
434	Cirrhosis & alcoholic hepatitis w/o CC/MCC	0.5472	20.3	16.9	5.7
435	Malignancy of hepatobiliary system or pancreas w MCC	0.7422	20.2	16.8	12.6
436	Malignancy of hepatobiliary system or pancreas w CC	0.7086	19.6	16.3	9.5
437	Malignancy of hepatobiliary system or pancreas w/o CC/MCC	0.7086	19.6	16.3	7.1
438	Disorders of pancreas except malignancy w MCC	1.0057	24.3	20.3	12.5
439	Disorders of pancreas except malignancy w CC	0.8437	21.9	18.3	8.5
440	Disorders of pancreas except malignancy w/o CC/MCC	0.7204	18.8	15.7	5.9
441	Disorders of liver except malig, cirr, alc hepa w MCC	0.7588	21.8	18.2	11.3
442	Disorders of liver except malig, cirr, alc hepa w CC	0.6925	21.2	17.7	8.1
443	Disorders of liver except malig, cirr, alc hepa w/o CC/MCC	0.6925	21.2	17.7	6.0
444	Disorders of the biliary tract w MCC	0.8181	24.0	20.0	10.7
445	Disorders of the biliary tract w CC	0.6977	21.7	18.1	7.6
446	Disorders of the biliary tract w/o CC/MCC	0.5472	20.3	16.9	5.2
453	Combined anterior/posterior spinal fusion w MCC	1.5545	35.2	29.3	24.9
454	Combined anterior/posterior spinal fusion w CC	1.5545	35.2	29.3	12.7
455	Combined anterior/posterior spinal fusion w/o CC/MCC	1.5545	35.2	29.3	7.1
456	Spinal fus exc cerv w spinal curv/malig/infec or 9+ fus w MCC	1.5545	35.2	29.3	24.9
457	Spinal fus exc cerv w spinal curv/malig/infec or 9+ fus w CC	1.5545	35.2	29.3	11.6
458	Spinal fus exc cerv w spinal curv/malig/infec or 9+ fus w/o CC/MCC	1.5545	35.2	29.3	6.8
459	Spinal fusion except cervical w MCC	1.5545	35.2	29.3	14.7

TABLE 3.—FY 2008 MS—LTC—DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, SHORT-STAY OUTLIER THRESHOLD AND IPPS-COMPARABLE THRESHOLD—Continued

MS—LTC— DRG	MS—DRG title	Relative weight ¹	Geometric average length of stay	Short stay outlier threshold ²	IPPS com- parable threshold ³
460	Spinal fusion except cervical w/o MCC	1.5545	35.2	29.3	6.4
461	Bilateral or multiple major joint procs of lower extremity w MCC	1.5545	35.2	29.3	12.6
462	Bilateral or multiple major joint procs of lower extremity w/o MCC	1.1417	29.0	24.2	5.8
463	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w MCC	1.3514	38.8	32.3	27.4
464	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w CC	1.1906	36.3	30.3	16.8
465	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w/o CC/MCC	1.0747	29.6	24.7	10.0
466	Revision of hip or knee replacement w MCC	1.5545	35.2	29.3	14.5
467	Revision of hip or knee replacement w CC	1.5545	35.2	29.3	8.0
468	Revision of hip or knee replacement w/o CC/MCC	1.5545	35.2	29.3	5.5
469	Major joint replacement or reattachment of lower extremity w MCC	1.5545	35.2	29.3	12.6
470	Major joint replacement or reattachment of lower extremity w/o MCC	1.5545	35.2	29.3	5.4
471	Cervical spinal fusion w MCC	1.5545	35.2	29.3	17.3
472	Cervical spinal fusion w CC	1.5545	35.2	29.3	7.0
473	Cervical spinal fusion w/o CC/MCC	1.5545	35.2	29.3	2.9
474	Amputation for musculoskeletal sys & conn tissue dis w MCC	1.3338	36.6	30.5	20.4
475	Amputation for musculoskeletal sys & conn tissue dis w CC	1.1390	32.7	27.3	13.9
476	Amputation for musculoskeletal sys & conn tissue dis w/o CC/MCC	1.1390	32.7	27.3	8.0
477	Biopsies of musculoskeletal system & connective tissue w MCC	1.5545	35.2	29.3	20.7
478	Biopsies of musculoskeletal system & connective tissue w CC	1.1417	29.0	24.2	11.9
479	Biopsies of musculoskeletal system & connective tissue w/o CC/MCC	1.1417	29.0	24.2	4.3
480	Hip & femur procedures except major joint w MCC	1.5545	35.2	29.3	14.1
481	Hip & femur procedures except major joint w CC	1.5545	35.2	29.3	8.4
482	Hip & femur procedures except major joint w/o CC/MCC	1.1417	29.0	24.2	6.8
483	Major joint & limb reattachment proc of upper extremity w CC/MCC	1.5545	35.2	29.3	6.6
484	Major joint & limb reattachment proc of upper extremity w/o CC/MCC	1.1417	29.0	24.2	3.6
485	Knee procedures w pdx of infection w MCC	1.5545	35.2	29.3	18.9
486	Knee procedures w pdx of infection w CC	1.1417	29.0	24.2	12.3
487	Knee procedures w pdx of infection w/o CC/MCC	1.1417	29.0	24.2	8.5
488	Knee procedures w/o pdx of infection w CC/MCC	1.5545	35.2	29.3	7.8
489	Knee procedures w/o pdx of infection w/o CC/MCC	1.5545	35.2	29.3	4.7
490	Back & neck proc exc spinal fusion w CC/MCC or disc device/neurostim	1.1417	29.0	24.2	7.6
491	Back & neck proc exc spinal fusion w/o CC/MCC	1.1417	29.0	24.2	3.4
492	Lower extrem & humer proc except hip, foot, femur w MCC	1.5545	35.2	29.3	13.6
493	Lower extrem & humer proc except hip, foot, femur w CC	1.1417	29.0	24.2	8.2
494	Lower extrem & humer proc except hip, foot, femur w/o CC/MCC	0.8249	25.0	20.8	5.1
495	Local excision & removal int fix devices exc hip & femur w MCC	1.3650	38.1	31.8	18.2
496	Local excision & removal int fix devices exc hip & femur w CC	1.1981	36.8	30.7	9.8
497	Local excision & removal int fix devices exc hip & femur w/o CC/MCC	1.1417	29.0	24.2	4.9
498	Local excision & removal int fix devices of hip & femur w CC/MCC	1.5545	35.2	29.3	13.4
499	Local excision & removal int fix devices of hip & femur w/o CC/MCC	0.7305	22.9	19.1	4.9
500	Soft tissue procedures w MCC	1.3212	35.2	29.3	18.8
501	Soft tissue procedures w CC	1.2903	30.7	25.6	9.6
502	Soft tissue procedures w/o CC/MCC	0.8249	25.0	20.8	4.5
503	Foot procedures w MCC	1.1417	29.0	24.2	14.6
504	Foot procedures w CC	0.8249	25.0	20.8	10.5
505	Foot procedures w/o CC/MCC	0.5472	20.3	16.9	5.3
506	Major thumb or joint procedures	0.7305	22.9	19.1	5.0
507	Major shoulder or elbow joint procedures w CC/MCC	0.8249	25.0	20.8	8.4
508	Major shoulder or elbow joint procedures w/o CC/MCC	0.8249	25.0	20.8	3.0
509	Arthroscopy	0.5472	20.3	16.9	4.2
510	Shoulder,elbow or forearm proc,exc major joint proc w MCC	1.1417	29.0	24.2	10.7
511	Shoulder,elbow or forearm proc,exc major joint proc w CC	1.1417	29.0	24.2	6.2
512	Shoulder,elbow or forearm proc,exc major joint proc w/o CC/MCC	0.5472	20.3	16.9	3.1
513	Hand or wrist proc, except major thumb or joint proc w CC/MCC	1.5545	35.2	29.3	8.4
514	Hand or wrist proc, except major thumb or joint proc w/o CC/MCC	0.7305	22.9	19.1	4.0
515	Other musculoskelet sys & conn tiss O.R. proc w MCC	1.3230	34.8	29.0	18.1
516	Other musculoskelet sys & conn tiss O.R. proc w CC	1.1417	29.0	24.2	10.1
517	Other musculoskelet sys & conn tiss O.R. proc w/o CC/MCC	0.8249	25.0	20.8	4.5
533	Fractures of femur w MCC	0.8249	25.0	20.8	11.2
534	Fractures of femur w/o MCC	0.7305	22.9	19.1	6.3
535	Fractures of hip & pelvis w MCC	0.7305	22.9	19.1	10.1
536	Fractures of hip & pelvis w/o MCC	0.5998	23.7	19.8	6.0
537	Sprains, strains, & dislocations of hip, pelvis & thigh w CC/MCC	0.5472	20.3	16.9	7.3
538	Sprains, strains, & dislocations of hip, pelvis & thigh w/o CC/MCC	0.5472	20.3	16.9	4.8
539	Osteomyelitis w MCC	0.9013	29.7	24.8	16.2
540	Osteomyelitis w CC	0.8107	28.7	23.9	11.3
541	Osteomyelitis w/o CC/MCC	0.7787	26.9	22.4	8.9
542	Pathological fractures & musculoskelet & conn tiss malig w MCC	0.7359	21.7	18.1	14.0

TABLE 3.—FY 2008 MS—LTC—DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, SHORT-STAY OUTLIER THRESHOLD AND IPPS-COMPARABLE THRESHOLD—Continued

MS—LTC— DRG	MS—DRG title	Relative weight ¹	Geometric average length of stay	Short stay outlier threshold ²	IPPS com- parable threshold ³
543	Pathological fractures & musculoskelet & conn tiss malig w CC	0.6347	21.3	17.8	9.4
544	Pathological fractures & musculoskelet & conn tiss malig w/o CC/MCC	0.5472	20.3	16.9	6.8
545	Connective tissue disorders w MCC	0.8501	23.9	19.9	14.7
546	Connective tissue disorders w CC	0.6492	20.7	17.3	8.7
547	Connective tissue disorders w/o CC/MCC	0.5472	20.3	16.9	6.1
548	Septic arthritis w MCC	0.8584	28.2	23.5	15.0
549	Septic arthritis w CC	0.7347	26.4	22.0	9.8
550	Septic arthritis w/o CC/MCC	0.6704	23.5	19.6	7.2
551	Medical back problems w MCC	0.7305	26.6	22.2	11.6
552	Medical back problems w/o MCC	0.6022	22.8	19.0	6.5
553	Bone diseases & arthropathies w MCC	0.8249	25.0	20.8	9.6
554	Bone diseases & arthropathies w/o MCC	0.4822	20.5	17.1	5.8
555	Signs & symptoms of musculoskeletal system & conn tissue w MCC	0.7305	22.9	19.1	7.8
556	Signs & symptoms of musculoskeletal system & conn tissue w/o MCC ..	0.7305	22.9	19.1	5.0
557	Tendonitis, myositis & bursitis w MCC	0.8177	25.9	21.6	11.0
558	Tendonitis, myositis & bursitis w/o MCC	0.6919	21.4	17.8	6.6
559	Aftercare, musculoskeletal system & connective tissue w MCC	0.7157	26.2	21.8	11.9
560	Aftercare, musculoskeletal system & connective tissue w CC	0.6393	24.6	20.5	7.5
561	Aftercare, musculoskeletal system & connective tissue w/o CC/MCC	0.5889	21.7	18.1	4.2
562	Fx, sprn, strn & disl except femur, hip, pelvis & thigh w MCC	1.1417	29.0	24.2	10.4
563	Fx, sprn, strn & disl except femur, hip, pelvis & thigh w/o MCC	0.5472	20.3	16.9	5.7
564	Other musculoskeletal sys & connective tissue diagnoses w MCC	0.8134	24.9	20.8	11.6
565	Other musculoskeletal sys & connective tissue diagnoses w CC	0.7382	24.8	20.7	8.1
566	Other musculoskeletal sys & connective tissue diagnoses w/o CC/MCC ..	0.6862	22.1	18.4	5.9
573	Skin graft &/or debrid for skn ulcer or cellulitis w MCC	1.3068	38.0	31.7	22.2
574	Skin graft &/or debrid for skn ulcer or cellulitis w CC	1.1567	37.1	30.9	14.9
575	Skin graft &/or debrid for skn ulcer or cellulitis w/o CC/MCC	0.9938	31.7	26.4	9.4
576	Skin graft &/or debrid exc for skin ulcer or cellulitis w MCC	1.5545	35.2	29.3	20.3
577	Skin graft &/or debrid exc for skin ulcer or cellulitis w CC	1.1417	29.0	24.2	9.9
578	Skin graft &/or debrid exc for skin ulcer or cellulitis w/o CC/MCC	0.7305	22.9	19.1	5.4
579	Other skin, subcut tiss & breast proc w MCC	1.2793	36.8	30.7	18.5
580	Other skin, subcut tiss & breast proc w CC	1.1001	34.8	29.0	9.0
581	Other skin, subcut tiss & breast proc w/o CC/MCC	0.9100	29.9	24.9	3.9
582	Mastectomy for malignancy w CC/MCC	1.5545	35.2	29.3	4.3
583	Mastectomy for malignancy w/o CC/MCC	1.5545	35.2	29.3	2.6
584	Breast biopsy, local excision & other breast procedures w CC/MCC	1.1417	29.0	24.2	9.5
585	Breast biopsy, local excision & other breast procedures w/o CC/MCC ...	1.1417	29.0	24.2	3.2
592	Skin ulcers w MCC	0.8875	27.1	22.6	14.2
593	Skin ulcers w CC	0.7877	26.8	22.3	10.0
594	Skin ulcers w/o CC/MCC	0.7342	24.3	20.3	7.7
595	Major skin disorders w MCC	0.7525	24.5	20.4	13.2
596	Major skin disorders w/o MCC	0.6155	23.8	19.8	7.6
597	Malignant breast disorders w MCC	0.8249	25.0	20.8	13.7
598	Malignant breast disorders w CC	0.7305	22.9	19.1	9.0
599	Malignant breast disorders w/o CC/MCC	0.7305	22.9	19.1	5.7
600	Non-malignant breast disorders w CC/MCC	0.7305	22.9	19.1	8.5
601	Non-malignant breast disorders w/o CC/MCC	0.7305	22.9	19.1	6.0
602	Cellulitis w MCC	0.6643	22.5	18.8	11.1
603	Cellulitis w/o MCC	0.5528	19.4	16.2	7.3
604	Trauma to the skin, subcut tiss & breast w MCC	0.8249	25.0	20.8	8.8
605	Trauma to the skin, subcut tiss & breast w/o MCC	0.5685	21.2	17.7	5.4
606	Minor skin disorders w MCC	0.8324	23.2	19.3	9.5
607	Minor skin disorders w/o MCC	0.6776	22.6	18.8	5.9
614	Adrenal & pituitary procedures w CC/MCC	1.2008	33.1	27.6	11.6
615	Adrenal & pituitary procedures w/o CC/MCC	0.7305	22.9	19.1	5.1
616	Amputat of lower limb for endocrine, nutrit, & metabol dis w MCC	1.4505	41.0	34.2	24.2
617	Amputat of lower limb for endocrine, nutrit, & metabol dis w CC	1.2414	33.3	27.8	14.5
618	Amputat of lower limb for endocrine, nutrit, & metabol dis w/o CC/MCC ..	0.8249	25.0	20.8	9.9
619	O.R. procedures for obesity w MCC	0.8249	25.0	20.8	14.6
620	O.R. procedures for obesity w CC	0.8249	25.0	20.8	6.3
621	O.R. procedures for obesity w/o CC/MCC	0.8249	25.0	20.8	3.6
622	Skin grafts & wound debrid for endoc, nutrit & metab dis w MCC	1.1462	35.6	29.7	21.1
623	Skin grafts & wound debrid for endoc, nutrit & metab dis w CC	1.0197	32.2	26.8	13.5
624	Skin grafts & wound debrid for endoc, nutrit & metab dis w/o CC/MCC ..	0.8249	25.0	20.8	9.4
625	Thyroid, parathyroid & thyroglossal procedures w MCC	1.3385	36.6	30.5	12.4
626	Thyroid, parathyroid & thyroglossal procedures w CC	1.2008	33.1	27.6	5.0
627	Thyroid, parathyroid & thyroglossal procedures w/o CC/MCC	0.7305	22.9	19.1	2.1
628	Other endocrine, nutrit & metab O.R. proc w MCC	1.3385	36.6	30.5	20.1

TABLE 3.—FY 2008 MS—LTC—DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, SHORT-STAY OUTLIER THRESHOLD AND IPPS-COMPARABLE THRESHOLD—Continued

MS—LTC— DRG	MS—DRG title	Relative weight ¹	Geometric average length of stay	Short stay outlier threshold ²	IPPS com- parable threshold ³
629	Other endocrine, nutrit & metab O.R. proc w CC	1.2008	33.1	27.6	14.3
630	Other endocrine, nutrit & metab O.R. proc w/o CC/MCC	0.7305	22.9	19.1	8.4
637	Diabetes w MCC	0.7726	25.8	21.5	9.8
638	Diabetes w CC	0.6757	24.0	20.0	6.7
639	Diabetes w/o CC/MCC	0.6064	20.6	17.2	4.7
640	Nutritional & misc metabolic disorders w MCC	0.7879	23.2	19.3	9.1
641	Nutritional & misc metabolic disorders w/o MCC	0.6889	22.0	18.3	6.0
642	Inborn errors of metabolism	0.7305	22.9	19.1	8.3
643	Endocrine disorders w MCC	0.7358	24.9	20.8	12.4
644	Endocrine disorders w CC	0.7358	24.9	20.8	8.6
645	Endocrine disorders w/o CC/MCC	0.5472	20.3	16.9	6.1
652	Kidney transplant	0.0000	0.0	0.0	0.0
653	Major bladder procedures w MCC	1.1417	29.0	24.2	24.2
654	Major bladder procedures w CC	0.7305	22.9	19.1	14.7
655	Major bladder procedures w/o CC/MCC	0.5472	20.3	16.9	10.0
656	Kidney & ureter procedures for neoplasm w MCC	0.8249	25.0	20.8	16.8
657	Kidney & ureter procedures for neoplasm w CC	0.8249	25.0	20.8	9.2
658	Kidney & ureter procedures for neoplasm w/o CC/MCC	0.8249	25.0	20.8	5.7
659	Kidney & ureter procedures for non-neoplasm w MCC	1.1417	29.0	24.2	18.5
660	Kidney & ureter procedures for non-neoplasm w CC	0.7305	22.9	19.1	10.6
661	Kidney & ureter procedures for non-neoplasm w/o CC/MCC	0.5472	20.3	16.9	5.1
662	Minor bladder procedures w MCC	0.8249	25.0	20.8	17.7
663	Minor bladder procedures w CC	0.8249	25.0	20.8	8.5
664	Minor bladder procedures w/o CC/MCC	1.5545	35.2	29.3	3.0
665	Prostatectomy w MCC	0.8249	25.0	20.8	20.2
666	Prostatectomy w CC	0.8249	25.0	20.8	10.7
667	Prostatectomy w/o CC/MCC	1.1417	29.0	24.2	4.0
668	Transurethral procedures w MCC	1.5545	35.2	29.3	14.4
669	Transurethral procedures w CC	1.5545	35.2	29.3	7.0
670	Transurethral procedures w/o CC/MCC	0.8249	25.0	20.8	3.7
671	Urethral procedures w CC/MCC	0.7305	22.9	19.1	9.6
672	Urethral procedures w/o CC/MCC	0.5472	20.3	16.9	3.8
673	Other kidney & urinary tract procedures w MCC	1.3255	33.6	28.0	17.6
674	Other kidney & urinary tract procedures w CC	1.2557	30.6	25.5	11.1
675	Other kidney & urinary tract procedures w/o CC/MCC	1.1417	29.0	24.2	2.7
682	Renal failure w MCC	0.8553	23.6	19.7	12.1
683	Renal failure w CC	0.7752	21.8	18.2	9.0
684	Renal failure w/o CC/MCC	0.7121	20.5	17.1	5.9
685	Admit for renal dialysis	0.7726	26.0	21.7	5.4
686	Kidney & urinary tract neoplasms w MCC	0.8933	23.6	19.7	13.2
687	Kidney & urinary tract neoplasms w CC	0.7305	22.9	19.1	8.5
688	Kidney & urinary tract neoplasms w/o CC/MCC	0.5472	20.3	16.9	5.1
689	Kidney & urinary tract infections w MCC	0.6624	22.9	19.1	9.9
690	Kidney & urinary tract infections w/o MCC	0.5655	20.2	16.8	6.6
691	Urinary stones w esw lithotripsy w CC/MCC	1.5545	35.2	29.3	6.6
692	Urinary stones w esw lithotripsy w/o CC/MCC	1.5545	35.2	29.3	3.4
693	Urinary stones w/o esw lithotripsy w MCC	0.7305	22.9	19.1	8.4
694	Urinary stones w/o esw lithotripsy w/o MCC	0.7305	22.9	19.1	3.9
695	Kidney & urinary tract signs & symptoms w MCC	0.8249	25.0	20.8	9.1
696	Kidney & urinary tract signs & symptoms w/o MCC	0.5472	20.3	16.9	5.0
697	Urethral stricture	0.5472	20.3	16.9	5.1
698	Other kidney & urinary tract diagnoses w MCC	0.7919	22.6	18.8	10.9
699	Other kidney & urinary tract diagnoses w CC	0.7293	22.1	18.4	7.7
700	Other kidney & urinary tract diagnoses w/o CC/MCC	0.6052	19.6	16.3	5.4
707	Major male pelvic procedures w CC/MCC	0.7305	22.9	19.1	6.9
708	Major male pelvic procedures w/o CC/MCC	0.5472	20.3	16.9	3.5
709	Penis procedures w CC/MCC	1.1417	29.0	24.2	10.3
710	Penis procedures w/o CC/MCC	1.1417	29.0	24.2	2.7
711	Testes procedures w CC/MCC	1.1417	29.0	24.2	13.2
712	Testes procedures w/o CC/MCC	1.1417	29.0	24.2	4.6
713	Transurethral prostatectomy w CC/MCC	1.5545	35.2	29.3	6.5
714	Transurethral prostatectomy w/o CC/MCC	0.5472	20.3	16.9	2.9
715	Other male reproductive system O.R. proc for malignancy w CC/MCC ..	1.5545	35.2	29.3	10.1
716	Other male reproductive system O.R. proc for malignancy w/o CC/MCC	1.5545	35.2	29.3	2.0
717	Other male reproductive system O.R. proc exc malignancy w CC/MCC	1.1417	29.0	24.2	12.4
718	Other male reproductive system O.R. proc exc malignancy w/o CC/ MCC.	0.5472	20.3	16.9	4.1
722	Malignancy, male reproductive system w MCC	0.8249	25.0	20.8	12.1

TABLE 3.—FY 2008 MS—LTC—DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, SHORT-STAY OUTLIER THRESHOLD AND IPPS-COMPARABLE THRESHOLD—Continued

MS—LTC— DRG	MS—DRG title	Relative weight ¹	Geometric average length of stay	Short stay outlier threshold ²	IPPS com- parable threshold ³
723	Malignancy, male reproductive system w CC	0.7305	22.9	19.1	8.6
724	Malignancy, male reproductive system w/o CC/MCC	0.5472	20.3	16.9	5.3
725	Benign prostatic hypertrophy w MCC	1.1417	29.0	24.2	9.0
726	Benign prostatic hypertrophy w/o MCC	0.5472	20.3	16.9	5.5
727	Inflammation of the male reproductive system w MCC	0.7754	25.9	21.6	10.4
728	Inflammation of the male reproductive system w/o MCC	0.6172	20.8	17.3	6.2
729	Other male reproductive system diagnoses w CC/MCC	1.0319	26.6	22.2	8.4
730	Other male reproductive system diagnoses w/o CC/MCC	0.7305	22.9	19.1	4.9
734	Pelvic evisceration, rad hysterectomy & rad vulvectomy w CC/MCC	1.1417	29.0	24.2	11.8
735	Pelvic evisceration, rad hysterectomy & rad vulvectomy w/o CC/MCC	0.5472	20.3	16.9	5.3
736	Uterine & adnexa proc for ovarian or adnexal malignancy w MCC	1.1417	29.0	24.2	21.5
737	Uterine & adnexa proc for ovarian or adnexal malignancy w CC	0.8249	25.0	20.8	11.0
738	Uterine & adnexa proc for ovarian or adnexal malignancy w/o CC/MCC	0.5472	20.3	16.9	5.6
739	Uterine,adnexa proc for non-ovarian/adnexal malig w MCC	1.1417	29.0	24.2	15.9
740	Uterine,adnexa proc for non-ovarian/adnexal malig w CC	0.8249	25.0	20.8	7.7
741	Uterine,adnexa proc for non-ovarian/adnexal malig w/o CC/MCC	0.5472	20.3	16.9	4.5
742	Uterine & adnexa proc for non-malignancy w CC/MCC	0.8249	25.0	20.8	6.9
743	Uterine & adnexa proc for non-malignancy w/o CC/MCC	0.5472	20.3	16.9	3.3
744	D&C, conization, laparoscopy & tubal interruption w CC/MCC	0.8249	25.0	20.8	9.3
745	D&C, conization, laparoscopy & tubal interruption w/o CC/MCC	0.8249	25.0	20.8	3.8
746	Vagina, cervix & vulva procedures w CC/MCC	0.8249	25.0	20.8	6.4
747	Vagina, cervix & vulva procedures w/o CC/MCC	0.8249	25.0	20.8	2.8
748	Female reproductive system reconstructive procedures	0.8249	25.0	20.8	2.6
749	Other female reproductive system O.R. procedures w CC/MCC	0.8249	25.0	20.8	16.3
750	Other female reproductive system O.R. procedures w/o CC/MCC	0.8249	25.0	20.8	5.1
754	Malignancy, female reproductive system w MCC	1.1417	29.0	24.2	14.7
755	Malignancy, female reproductive system w CC	0.8249	25.0	20.8	9.1
756	Malignancy, female reproductive system w/o CC/MCC	0.5472	20.3	16.9	5.1
757	Infections, female reproductive system w MCC	0.8375	22.6	18.8	13.9
758	Infections, female reproductive system w CC	0.8317	27.2	22.7	9.5
759	Infections, female reproductive system w/o CC/MCC	0.5472	20.3	16.9	7.2
760	Menstrual & other female reproductive system disorders w CC/MCC	1.1417	29.0	24.2	6.0
761	Menstrual & other female reproductive system disorders w/o CC/MCC ..	0.5472	20.3	16.9	3.8
765	Cesarean section w CC/MCC	0.8249	25.0	20.8	7.4
766	Cesarean section w/o CC/MCC	0.7305	22.9	19.1	4.3
767	Vaginal delivery w sterilization &/or D&C	0.7305	22.9	19.1	4.1
768	Vaginal delivery w O.R. proc except steril &/or D&C	0.7305	22.9	19.1	8.9
769	Postpartum & post abortion diagnoses w O.R. procedure	0.7305	22.9	19.1	8.6
770	Abortion w D&C, aspiration curettage or hysterotomy	0.7305	22.9	19.1	3.5
774	Vaginal delivery w complicating diagnoses	0.7305	22.9	19.1	4.5
775	Vaginal delivery w/o complicating diagnoses	0.7305	22.9	19.1	3.1
776	Postpartum & post abortion diagnoses w/o O.R. procedure	1.1417	29.0	24.2	5.4
777	Ectopic pregnancy	0.7305	22.9	19.1	3.0
778	Threatened abortion	0.5472	20.3	16.9	4.2
779	Abortion w/o D&C	0.5472	20.3	16.9	3.6
780	False labor	0.5472	20.3	16.9	2.7
781	Other antepartum diagnoses w medical complications	1.1417	29.0	24.2	5.9
782	Other antepartum diagnoses w/o medical complications	0.5472	20.3	16.9	3.6
789	Neonates, died or transferred to another acute care facility	0.5472	20.3	16.9	1.5
790	Extreme immaturity or respiratory distress syndrome, neonate	0.5472	20.3	16.9	16.9
791	Prematurity w major problems	1.1417	29.0	24.2	13.3
792	Prematurity w/o major problems	0.5472	20.3	16.9	8.6
793	Full term neonate w major problems	1.1417	29.0	24.2	17.6
794	Neonate w other significant problems	1.1417	29.0	24.2	1.7
795	Normal newborn	0.5472	20.3	16.9	3.1
799	Splenectomy w MCC	1.1417	29.0	24.2	23.5
800	Splenectomy w CC	0.8249	25.0	20.8	13.0
801	Splenectomy w/o CC/MCC	0.8249	25.0	20.8	7.5
802	Other O.R. proc of the blood & blood forming organs w MCC	1.5545	35.2	29.3	21.4
803	Other O.R. proc of the blood & blood forming organs w CC	0.7305	22.9	19.1	10.8
804	Other O.R. proc of the blood & blood forming organs w/o CC/MCC	0.7305	22.9	19.1	5.2
808	Major hematomol/immun diag exc sickle cell crisis & coagul w MCC	0.8009	20.7	17.3	12.8
809	Major hematomol/immun diag exc sickle cell crisis & coagul w CC	0.8009	20.7	17.3	7.9
810	Major hematomol/immun diag exc sickle cell crisis & coagul w/o CC/MCC ..	0.8009	20.7	17.3	6.2
811	Red blood cell disorders w MCC	0.6655	23.2	19.3	9.0
812	Red blood cell disorders w/o MCC	0.5699	19.5	16.3	5.9
813	Coagulation disorders	0.8015	21.5	17.9	8.3
814	Reticuloendothelial & immunity disorders w MCC	0.7474	22.6	18.8	11.7

TABLE 3.—FY 2008 MS—LTC—DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, SHORT-STAY OUTLIER THRESHOLD AND IPPS-COMPARABLE THRESHOLD—Continued

MS—LTC— DRG	MS—DRG title	Relative weight ¹	Geometric average length of stay	Short stay outlier threshold ²	IPPS com- parable threshold ³
815	Reticuloendothelial & immunity disorders w CC	0.7305	22.9	19.1	7.8
816	Reticuloendothelial & immunity disorders w/o CC/MCC	0.7305	22.9	19.1	5.3
820	Lymphoma & leukemia w major O.R. procedure w MCC	0.8249	25.0	20.8	20.8
821	Lymphoma & leukemia w major O.R. procedure w CC	0.8249	25.0	20.8	13.3
822	Lymphoma & leukemia w major O.R. procedure w/o CC/MCC	0.8249	25.0	20.8	5.9
823	Lymphoma & non-acute leukemia w other O.R. proc w MCC	1.1417	29.0	24.2	24.2
824	Lymphoma & non-acute leukemia w other O.R. proc w CC	1.1417	29.0	24.2	14.8
825	Lymphoma & non-acute leukemia w other O.R. proc w/o CC/MCC	0.5472	20.3	16.9	7.8
826	Myeloprolif disord or poorly diff neopl w maj O.R. proc w MCC	0.8249	25.0	20.8	20.8
827	Myeloprolif disord or poorly diff neopl w maj O.R. proc w CC	0.8249	25.0	20.8	12.4
828	Myeloprolif disord or poorly diff neopl w maj O.R. proc w/o CC/MCC	0.8249	25.0	20.8	5.9
829	Myeloprolif disord or poorly diff neopl w other O.R. proc w CC/MCC	1.5545	35.2	29.3	17.8
830	Myeloprolif disord or poorly diff neopl w other O.R. proc w/o CC/MCC	1.5545	35.2	29.3	5.5
834	Acute leukemia w/o major O.R. procedure w MCC	1.1417	29.0	24.2	24.2
835	Acute leukemia w/o major O.R. procedure w CC	0.8249	25.0	20.8	13.5
836	Acute leukemia w/o major O.R. procedure w/o CC/MCC	0.5472	20.3	16.9	8.0
837	Chemo w acute leukemia as sdx or w high dose chemo agent w MCC ..	1.5545	35.2	29.3	29.3
838	Chemo w acute leukemia as sdx w CC or high dose chemo agent	0.8249	25.0	20.8	13.7
839	Chemo w acute leukemia as sdx w/o CC/MCC	1.5545	35.2	29.3	9.1
840	Lymphoma & non-acute leukemia w MCC	0.8718	20.8	17.3	16.1
841	Lymphoma & non-acute leukemia w CC	0.8026	20.1	16.8	10.7
842	Lymphoma & non-acute leukemia w/o CC/MCC	0.7305	22.9	19.1	6.9
843	Other myeloprolif dis or poorly diff neopl diag w MCC	1.1417	29.0	24.2	14.5
844	Other myeloprolif dis or poorly diff neopl diag w CC	1.1417	29.0	24.2	9.7
845	Other myeloprolif dis or poorly diff neopl diag w/o CC/MCC	1.1417	29.0	24.2	6.8
846	Chemotherapy w/o acute leukemia as secondary diagnosis w MCC	1.6788	37.4	31.2	13.8
847	Chemotherapy w/o acute leukemia as secondary diagnosis w CC	1.4350	27.6	23.0	5.0
848	Chemotherapy w/o acute leukemia as secondary diagnosis w/o CC/ MCC.	0.7305	22.9	19.1	4.6
849	Radiotherapy	0.8994	23.5	19.6	9.5
853	Infectious & parasitic diseases w O.R. procedure w MCC	1.7687	38.1	31.8	27.6
854	Infectious & parasitic diseases w O.R. procedure w CC	1.4381	30.8	25.7	17.4
855	Infectious & parasitic diseases w O.R. procedure w/o CC/MCC	0.7305	22.9	19.1	12.2
856	Postoperative or post-traumatic infections w O.R. proc w MCC	1.4470	36.1	30.1	26.5
857	Postoperative or post-traumatic infections w O.R. proc w CC	1.1886	31.5	26.3	14.1
858	Postoperative or post-traumatic infections w O.R. proc w/o CC/MCC	1.1109	28.4	23.7	9.5
862	Postoperative & post-traumatic infections w MCC	0.8670	25.2	21.0	13.4
863	Postoperative & post-traumatic infections w/o MCC	0.7478	23.4	19.5	8.2
864	Fever of unknown origin	0.7305	22.9	19.1	6.4
865	Viral illness w MCC	0.7823	21.8	18.2	11.0
866	Viral illness w/o MCC	0.6431	21.2	17.7	5.4
867	Other infectious & parasitic diseases diagnoses w MCC	1.0954	23.6	19.7	16.2
868	Other infectious & parasitic diseases diagnoses w CC	0.8869	22.0	18.3	9.3
869	Other infectious & parasitic diseases diagnoses w/o CC/MCC	0.5472	20.3	16.9	6.8
870	Septicemia w MV 96+ hours	1.9505	30.5	25.4	23.6
871	Septicemia w/o MV 96+ hours w MCC	0.8299	23.5	19.6	13.0
872	Septicemia w/o MV 96+ hours w/o MCC	0.7340	21.9	18.3	9.1
876	O.R. procedure w principal diagnoses of mental illness	0.7305	22.9	19.1	19.1
880	Acute adjustment reaction & psychosocial dysfunction	0.5472	20.3	16.9	5.0
881	Depressive neuroses	0.5472	20.3	16.9	6.6
882	Neuroses except depressive	0.5472	20.3	16.9	6.9
883	Disorders of personality & impulse control	0.5472	20.3	16.9	11.8
884	Organic disturbances & mental retardation	0.4883	23.3	19.4	8.3
885	Psychoses	0.4140	23.8	19.8	12.3
886	Behavioral & developmental disorders	0.5472	20.3	16.9	9.4
887	Other mental disorder diagnoses	0.5472	20.3	16.9	7.1
894	Alcohol/drug abuse or dependence, left ama	0.5472	20.3	16.9	4.5
895	Alcohol/drug abuse or dependence w rehabilitation therapy	0.5472	20.3	16.9	16.8
896	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC	0.8249	25.0	20.8	10.6
897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	0.5472	20.3	16.9	6.4
901	Wound debridements for injuries w MCC	1.3395	35.2	29.3	23.7
902	Wound debridements for injuries w CC	1.1605	33.5	27.9	12.9
903	Wound debridements for injuries w/o CC/MCC	0.7305	22.9	19.1	7.9
904	Skin grafts for injuries w CC/MCC	1.3351	40.8	34.0	18.8
905	Skin grafts for injuries w/o CC/MCC	0.7305	22.9	19.1	7.7
906	Hand procedures for injuries	0.5472	20.3	16.9	4.9
907	Other O.R. procedures for injuries w MCC	1.6622	36.8	30.7	19.4
908	Other O.R. procedures for injuries w CC	1.3966	34.1	28.4	11.3

TABLE 3.—FY 2008 MS—LTC—DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, SHORT-STAY OUTLIER THRESHOLD AND IPPS-COMPARABLE THRESHOLD—Continued

MS—LTC— DRG	MS—DRG title	Relative weight ¹	Geometric average length of stay	Short stay outlier threshold ²	IPPS com- parable threshold ³
909	Other O.R. procedures for injuries w/o CC/MCC	0.8249	25.0	20.8	5.7
913	Traumatic injury w MCC	0.8462	26.9	22.4	10.0
914	Traumatic injury w/o MCC	0.6448	21.9	18.3	5.3
915	Allergic reactions w MCC	0.5472	20.3	16.9	7.5
916	Allergic reactions w/o MCC	0.5472	20.3	16.9	3.2
917	Poisoning & toxic effects of drugs w MCC	0.7305	22.9	19.1	8.3
918	Poisoning & toxic effects of drugs w/o MCC	0.7305	22.9	19.1	4.2
919	Complications of treatment w MCC	0.9858	26.3	21.9	10.1
920	Complications of treatment w CC	0.8518	24.6	20.5	6.8
921	Complications of treatment w/o CC/MCC	0.7511	23.0	19.2	4.5
922	Other injury, poisoning & toxic effect diag w MCC	0.5472	20.3	16.9	10.0
923	Other injury, poisoning & toxic effect diag w/o MCC	0.5472	20.3	16.9	5.0
927	Extensive burns or full thickness burns w MV 96+ hrs w skin graft	1.5545	35.2	29.3	29.3
928	Full thickness burn w skin graft or inhal inj w CC/MCC	1.1417	29.0	24.2	24.2
929	Full thickness burn w skin graft or inhal inj w/o CC/MCC	0.7305	22.9	19.1	13.1
933	Extensive burns or full thickness burns w MV 96+ hrs w/o skin graft	1.5545	35.2	29.3	8.5
934	Full thickness burn w/o skin grft or inhal inj	0.6998	24.2	20.2	11.1
935	Non-extensive burns	0.7525	24.9	20.8	8.8
939	O.R. proc w diagnoses of other contact w health services w MCC	1.2500	33.8	28.2	18.9
940	O.R. proc w diagnoses of other contact w health services w CC	1.1066	33.8	28.2	10.5
941	O.R. proc w diagnoses of other contact w health services w/o CC/MCC	0.9719	28.8	24.0	4.8
945	Rehabilitation w CC/MCC	0.5867	22.2	18.5	16.3
946	Rehabilitation w/o CC/MCC	0.4935	18.9	15.8	11.7
947	Signs & symptoms w MCC	0.6340	22.7	18.9	7.9
948	Signs & symptoms w/o MCC	0.5642	23.4	19.5	5.3
949	Aftercare w CC/MCC	0.6693	22.1	18.4	6.1
950	Aftercare w/o CC/MCC	0.5735	18.5	15.4	5.1
951	Other factors influencing health status	1.5837	26.2	21.8	5.0
955	Craniotomy for multiple significant trauma	1.5545	35.2	29.3	21.9
956	Limb reattachment, hip & femur proc for multiple significant trauma	0.7305	22.9	19.1	14.4
957	Other O.R. procedures for multiple significant trauma w MCC	1.5545	35.2	29.3	29.1
958	Other O.R. procedures for multiple significant trauma w CC	1.1417	29.0	24.2	17.9
959	Other O.R. procedures for multiple significant trauma w/o CC/MCC	1.1417	29.0	24.2	9.9
963	Other multiple significant trauma w MCC	1.5545	35.2	29.3	16.5
964	Other multiple significant trauma w CC	0.7305	22.9	19.1	10.2
965	Other multiple significant trauma w/o CC/MCC	0.5472	20.3	16.9	6.5
969	HIV w extensive O.R. procedure w MCC	1.5545	35.2	29.3	29.3
970	HIV w extensive O.R. procedure w/o MCC	1.5545	35.2	29.3	15.8
974	HIV w major related condition w MCC	0.8908	21.9	18.3	17.5
975	HIV w major related condition w CC	0.7492	21.3	17.8	11.5
976	HIV w major related condition w/o CC/MCC	0.7382	18.0	15.0	7.7
977	HIV w or w/o other related condition	0.7305	22.9	19.1	8.3
981	Extensive O.R. procedure unrelated to principal diagnosis w MCC	2.2339	42.0	35.0	24.6
982	Extensive O.R. procedure unrelated to principal diagnosis w CC	1.8277	37.6	31.3	16.3
983	Extensive O.R. procedure unrelated to principal diagnosis w/o CC/MCC	1.1417	29.0	24.2	9.0
984	Prostatic O.R. procedure unrelated to principal diagnosis w MCC	1.5545	35.2	29.3	23.7
985	Prostatic O.R. procedure unrelated to principal diagnosis w CC	1.1417	29.0	24.2	16.6
986	Prostatic O.R. procedure unrelated to principal diagnosis w/o CC/MCC	1.1417	29.0	24.2	8.5
987	Non-extensive O.R. proc unrelated to principal diagnosis w MCC	1.6972	37.9	31.6	21.9
988	Non-extensive O.R. proc unrelated to principal diagnosis w CC	1.3386	33.2	27.7	13.2
989	Non-extensive O.R. proc unrelated to principal diagnosis w/o CC/MCC	0.8249	25.0	20.8	6.7
998	Principal diagnosis invalid as discharge diagnosis	0.0000	0.0	0.0	0.0
999	Ungroupable	0.0000	0.0	0.0	0.0

¹ Transition blended relative weights for FY 2008 determined as described in Step 7 in section II.I.4. of the preamble of the FY 2008 IPPS final rule (72 FR 47295).

² The "short-stay outlier threshold" is calculated as 5/6ths of the geometric average length of stay of the LTC—DRG (as specified at § 412.529(a), in conjunction with § 412.503).

³ The "IPPS-comparable threshold" is calculated as one standard deviation from the geometric average length of stay of the same DRG under the IPPS as specified at § 412.529(c)(3)(i).