DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412

[CMS–1263–F]

RIN 0938–AM84

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

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

ACTION: Final rule.

SUMMARY: This final rule updates the annual payment rates for the Medicare prospective payment system (PPS) for inpatient hospital services provided by long-term care hospitals (LTCHs). The payment amounts and factors used to determine the updated Federal rates that are described in this final rule have been determined based on the LTCH PPS rate year. The annual update of the long-term care diagnosis-related group (LTC–DRG) classifications and relative weights remains linked to the annual adjustments of the acute care hospital inpatient diagnosis-related group system, and will continue to be effective each October 1. The outlier threshold for July 1, 2004 through June 30, 2005 is also derived from the LTCH PPS rate year calculations. In this final rule, we also are making clarifications to the existing policy regarding the designation of a satellite of a LTCH as an independent LTCH. In addition, we are expanding the existing interrupted stay policy and changing the procedure for counting days in the average length of stay calculation for Medicare patients for hospitals qualifying as LTCHs.

DATES: This final rule is effective July 1, 2004.

FOR FURTHER INFORMATION CONTACT:

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

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

Michele Hudson, (410) 786–5490 (Calculation of the payment rates, relative weights and case-mix index, market basket update, and payment adjustments).

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

Miechal Lefkowitz, (410) 786–5316 (High-cost outliers and budget neutrality).

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

Kathryn McCann, (410) 786–7623 (Medigap).

Robert Nakielny, (410) 786–4466 (Medicaid).

SUPPLEMENTARY INFORMATION:

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To assist readers in referencing sections contained in this preamble, we are providing the following table of contents.

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Acronyms

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

BBA Balanced Budget Act of 1997, Pub. L. 105–33
BBRA Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999, Pub. L. 106–113
BIPA Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Benefits Improvement and Protection Act of 2000, Pub. L. 106–554
CMS Centers for Medicare & Medicaid Services
COPS Medicare conditions of participation
DRGs Diagnosis-related groups
FY Federal fiscal year
HCRIS Hospital Cost Report Information System
HHA Home health agency
HIPAA Health Insurance Portability and Accountability Act, Pub. L. 104–191
IPPS Acute Care Hospital Inpatient Prospective Payment System
IRF Inpatient rehabilitation facility
LTC–DRG Long-term care diagnosis-related group
LTCH Long-term care hospital
MedPAC Medicare Payment Advisory Commission
MedPAR Medicare provider analysis and review file
OSCAR Online Survey Certification and Reporting (System)
PPS Prospective Payment System
QIO Quality Improvement Organization (formerly Peer Review organization (PRO))
SNF Skilled nursing facility
TEFRA Tax Equity and Fiscal Responsibility Act of 1982, Public Law 97–248

I. Background

A. Legislative and Regulatory Authority

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

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

Section 123 of Public Law 106–113 requires the PPS for LTCHs to be a per discharge system with a diagnosis-related group (DRG) based patient classification system that reflects the differences in patient resources and costs in LTCHs while maintaining budget neutrality.

Section 307(b)(1) of Public Law 106–554, among other things, mandates that the Secretary shall examine, and may provide for, adjustments to payments under the LTCH PPS, including adjustments to DRG weights, area wage adjustments, geographic reclassification, outliers, updates, and a disproportionate share adjustment.

In a **Federal Register** document issued on August 30, 2002 (67 FR 55954), we implemented the LTCH PPS authorized under Public Law 106–113 and Public Law 106–554. This system uses information from LTCH patient records to classify patients into distinct long-term care diagnosis-related groups (LTC–DRGs) based on clinical characteristics and expected resource needs. Payments are calculated for each LTC–DRG and provisions are made for appropriate payment adjustments. Payment rates under the LTCH PPS are updated annually and published in the **Federal Register**.

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

In the August 30, 2002 final rule, we presented an in-depth discussion of the LTCH PPS, including the patient classification system, relative weights, payment rates, additional payments, and the budget neutrality requirements mandated by section 123 of Public Law 106–113. The same final rule that established regulations for the LTCH PPS under 42 CFR part 412, subpart O, also contained provisions related to covered inpatient services, limitation on charges to beneficiaries, medical review requirements, furnishing of inpatient hospital services directly or under arrangement, and reporting and recordkeeping requirements.

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

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

B. Criteria for Classification as a LTCH

1. Classification as a LTCH

Under the existing regulations at § 412.23(e)(1) and (e)(2)(i), which

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

Existing § 412.23(e)(3) provides that the average Medicare inpatient length of stay is determined based on all covered and noncovered days of stay of Medicare patients as calculated by dividing the total number of covered and noncovered days of stay of Medicare inpatients (less leave or pass days) by the number of total Medicare discharges for the hospital's most recent complete cost reporting period. Fiscal intermediaries verify that LTCHs meet the average length of stay requirements. We note that the inpatient days of a patient who is admitted to a LTCH without any remaining Medicare days of coverage, regardless of the fact that the patient is a Medicare beneficiary, will not be included in the above calculation. Because Medicare would not be paying for any of the patient's treatment, the patient is not a ''Medicare inpatient'' and 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, for purposes of the average length of stay calculation, a patient admitted to the LTCH must have at least one remaining benefit day as described in § 409.61.

The fiscal intermediary's determination of whether or not a hospital qualifies as an LTCH is based on the hospital's discharge data from its most recent cost reporting period and is effective at the start of the hospital's next cost reporting period (§ 412.22(d)). If a hospital does not meet the length of stay requirement, the hospital may provide the intermediary with data indicating a change in the hospital's average length of stay by the same method for the period of at least 5 months of the immediately preceding 6-month period (§ 412.23(e)(3)(ii)). (See 68 FR 45464, August 1, 2003.)

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)(iii).

LTCHs that exist as hospitals-within-hospitals or satellite facilities of LTCHs must also meet the criteria set forth in § 412.22(e) or § 412.22(h), respectively, for the LTCH to be excluded from the acute care hospital inpatient prospective payment system (IPPS) and paid under the LTCH PPS.

2. Hospitals Excluded From the LTCH PPS

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

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

C. Transition Period for Implementation of the LTCH PPS

In the August 30, 2002 final rule, we provided for a 5-year transition period from reasonable cost-based reimbursement to fully Federal prospective payment for LTCHs (67 FR 56038). During the 5-year period, two payment percentages are to be used to determine a LTCH's total payment under the PPS. The blend percentages are as follows:

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

D. Limitation on Charges to Beneficiaries

In the August 30, 2002 final rule, we presented an in-depth discussion of beneficiary liability under the LTCH prospective payment system (67 FR 55974–55975). Under § 412.507, as consistent with other established hospital prospective payment systems, a LTCH may not bill a Medicare beneficiary for more than the deductible and coinsurance amounts as specified under §§ 409.82, 409.83, and 409.87 and for items and services as specified under § 489.30(a), if the Medicare payment to the LTCH is the full LTC–DRG payment amount. However, under the LTCH PPS, Medicare will only pay for days for which the beneficiary has coverage until the short-stay outlier threshold is exceeded. (See section V.C.4.b. of this preamble.) Therefore, if the Medicare payment was for a short-stay outlier 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).

Since the origin of the Medicare system, the intent of our regulations has been to set limits on beneficiary liability and to clearly establish the circumstances under which the beneficiary would be required to assume responsibility for payment, that is, upon exhausting benefits described in 42 CFR part 409, subpart F. The discussion in the August 30, 2002 final rule was not meant to establish rates or payments for, or define, Medicare-eligible expenses. While we regulate beneficiary liability for coinsurance and deductibles for hospital stays that are covered by Medicare, payments from Medigap insurers to providers for inpatient hospital coverage after Medicare benefits are exhausted are not regulated by us. Furthermore, regulations

beginning at § 403.200 and the 1991 National Association of Insurance Commissioners (NAIC) Model Regulation for Medicare Supplemental Insurance, which was incorporated by reference into section 1882 of the Act, govern the relationship between Medigap insurers and beneficiaries.

E. Health Insurance Portability and Accountability Act Compliance

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

II. Publication of Proposed Rulemaking

On January 30, 2004, we published a proposed rule in the **Federal Register** (69 FR 4754–4817) that set forth the proposed annual update of the payment rates for the Medicare prospective payment system (PPS) for inpatient hospital services provided by long-term care hospitals (LTCHs) for the 2005 LTCH PPS rate year. (The annual update of the LTC–DRG classifications and relative weights for FY 2005 remains linked to the annual adjustments of the acute care hospital inpatient DRG system, which will be published by August 1, and will be effective October 1, 2004.)

In the January 2004 LTCH PPS proposed rule, we discussed and clarified existing policies regarding the classification of a satellite facility, or a remote location, of a LTCH as an independent LTCH and proposed new policies for certain satellite facilities and remote locations. (See section V.C.8. of this preamble.) We also proposed to revise the existing interrupted stay policy applicable under the LTCH PPS. (See section V.C.4.c. of this preamble.)

We also proposed a threshold amount for outlier payments for the 2005 LTCH PPS rate year as discussed in section V.C.3.b. of this preamble. We also proposed a change in the procedure for counting the days in the inpatient average length of stay for hospitals to qualify as LTCHs, as discussed in section V.C.7. of this preamble.

We received a total of 14 timely items of correspondence containing multiple comments on the proposed rule. The major issues addressed by the commenters included: Clarification of our policy regarding satellite facilities and remote locations becoming independent LTCHS, determining average length of stay based on the number of days of care for only the patients that were discharged during the hospital's fiscal year, and expanding the existing interrupted stay policy to include any discharges up to and including 3 days and requiring the LTCH to pay for services ''under arrangement'' during the interrupted stay.

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

III. Summary of the Major Contents of This Final Rule

In this final rule, we set forth the annual update to the payment rates for the Medicare 2005 LTCH PPS rate year and make other policy changes. The following is a summary of the major areas that we are addressing in this final rule:

A. Update Changes

- In section IV. of this preamble, we discuss the annual update of the LTC–DRG classifications and relative weights and specify that they remain linked to the annual adjustments of the acute care hospital inpatient DRG system, which are based on the annual revisions to the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD–9–CM) codes effective each October 1.
- In sections VI. through IX. of this preamble, we specify the factors and adjustments used to determine the LTCH PPS rates that are applicable to the 2005 LTCH PPS rate year, including revisions to the wage index, the excluded hospital with capital market basket that will be applied to the current standard Federal rate to determine the prospective payment rates, the applicable adjustments to payments, the outlier threshold, the short-stay outlier policy for certain LTCHs, the transition period, and the budget neutrality factor.

B. Policy Changes

- In section V.C.4.c. of this preamble, we discuss our extension of the definition of an interruption of a stay to include an interruption in which the patient is discharged from the LTCH, and returns to the LTCH within 3 days of the original discharge.
- Under section V.C.7. of the preamble to this final rule, we specify the procedure for calculating a hospital's inpatient average length of stay for purposes of classification as a LTCH when covered and noncovered days of the stay involve admission in one cost reporting period and discharge in another cost reporting period.
- In section V.C.8. of this preamble, we discuss our clarification of the procedures under which a satellite facility or a remote location of a hospital must meet the statutory and regulatory requirements to qualify as a distinct LTCH. We also provide for a clarification of the regulation text that incorporates procedures that are already established. That is, in our discussion, we are putting forth a reminder that even though the regulations governing provider-based entities did not specifically address LTCHs at the time, these regulations have always been applicable to these providers.

C. Monitoring

In section X. of this preamble, we discuss our continuing monitoring efforts to evaluate the LTCH PPS.

D. Impact

In section XII. of this preamble, we set forth an analysis of the impact of the policy and payment rate changes in this final rule on Medicare expenditures and on Medicare-participating LTCHs and Medicare beneficiaries.

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

A. Background

Section 123 of Public Law 106–113 specifically requires that the PPS for LTCHs be a per discharge system with a DRG-based patient classification system reflecting the differences in patient resources and costs in LTCHs while maintaining budget neutrality. Section 307(b)(1) of Public Law 106–554 modified the requirements of section 123 of Public Law 106–113 by specifically requiring that the Secretary examine ''the feasibility and the impact of basing payment under such a system [the LTCH PPS] on the use of existing (or refined) hospital DRGs that have been modified to account for different resource use of LTCH patients as well as the use of the most recently available hospital discharge data.''

In accordance with section 307(b)(1) of Public Law 106–554 and § 412.515 of our existing regulations, the LTCH PPS uses information from LTCH patient

records to classify patient cases into distinct LTC–DRGs based on clinical characteristics and expected resource needs. The LTC–DRGs used as the patient classification component of the LTCH PPS correspond to the hospital inpatient DRGs in the IPPS. We apply weights to the existing hospital inpatient DRGs to account for the difference in resource use by patients exhibiting the case complexity and multiple medical problems characteristic of LTCHs.

In a departure from the IPPS, we use low volume LTC–DRGs (less than 25 LTCH cases) in determining the LTC–DRG weights, since LTCHs do not typically treat the full range of diagnoses as do acute care hospitals. In order to deal with the large number of low volume DRGs (all DRGs with fewer than 25 cases), we group low volume DRGs into 5 quintiles based on average charge per discharge. (A listing of the composition of low volume quintiles appears in the August 30, 2002 LTCH PPS final rule at 67 FR 55986.) We also take into account adjustments to payments for cases in which the stay at the LTCH is five-sixths of the geometric average length of stay and classify these cases as short-stay outlier cases. (A detailed discussion of the application of the Lewin Group model that was used to develop the LTC–DRGs appears in the August 30, 2002 LTCH PPS final rule at 67 FR 55978.)

B. Patient Classifications Into DRGs

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

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

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

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

- Cases that are improperly coded. (For example, diagnoses are shown that are inappropriate, given the sex of the patient. Code 68.6, Radical abdominal hysterectomy, would be an inappropriate code for a male.)
- Cases including surgical procedures not covered under Medicare. (For example, organ transplant in a nonapproved transplant center.)
- Cases requiring more information. (For example, ICD–9–CM codes are required to be entered at their highest level of specificity. There are valid 3-digit, 4-digit, and 5-digit codes. That is, code 136.3, Pneumocystosis, contains all appropriate digits, but if it is reported with either fewer or more than 4 digits, the claim will be rejected by the MCE as invalid.)
- Cases with principal diagnoses that do not usually justify admission to the hospital. (For example, code 437.9, Unspecified cerebrovascular disease. While this code is valid according to the ICD–9–CM coding scheme, a more precise code should be used for the principal diagnosis.)

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

The GROUPER is used both to classify past cases in order to measure relative hospital resource consumption to establish the DRG weights and to classify current cases for purposes of determining payment. The records for all Medicare hospital inpatient discharges are maintained in the MedPAR file. The data in this file are used to evaluate possible DRG classification changes and to recalibrate the DRG weights during our annual update. DRG weights are based on data for the population of LTCH discharges, reflecting the fact that LTCH patients represent a different patient-mix than patients in short-term acute care hospitals.

C. Organization of DRGs

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

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

In its June 2000 Report to Congress, MedPAC recommended that the

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

D. Update of LTC–DRGs

For FY 2004, the LTC–DRG patient classification system was based on LTCH data from the FY 2002 MedPAR file, which contained hospital bills data from the December 2002 update. The patient classification system consisted of 518 DRGs that formed the basis of the FY 2004 LTCH PPS GROUPER. The 518 LTC–DRGs included two ''error DRGs.'' As in the IPPS, we included two error DRGs in which cases that cannot be assigned to valid DRGs will be grouped. These two error DRGs are DRG 469 (Principal Diagnosis Invalid as a Discharge Diagnosis) and DRG 470 (Ungroupable). (See the August 1, 2001, Medicare Program final rule, Changes to the Hospital Inpatient Prospective Payment Systems and Rates and Costs of Graduate Medical Education; Fiscal Year 2002 Rates (66 FR 40062).) The other 516 LTC–DRGs are the same DRGs used in the IPPS GROUPER for FY 2004 (Version 21.0).

In the health care industry, annual changes to the ICD–9–CM codes are 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, are also revised annually and effective for discharges occurring on or after October 1 each year. As discussed earlier, the patient classification system for the LTCH PPS (LTC–DRGs) is based on the IPPS patient classification system (CMS–DRGs), which is updated annually and effective for discharges occurring on or after October 1 through September 30 each year. The updated DRGs and GROUPER software are based on the latest revision to the ICD–9–CM codes, which are published annually in the IPPS proposed rule and final rule. The new or revised ICD–9–CM codes are not used by the industry for either the IPPS or the LTCH PPS until the beginning of the next Federal fiscal year (effective for discharges occurring on or after October 1 through September 30). (The use of the ICD–9–CM codes in this manner is consistent with current usage and the HIPAA regulations.) October 1 is also when the changes to the CMS–DRGs and the next version of the GROUPER software becomes effective.

As indicated in the June 6, 2003 LTCH PPS and the August 1, 2003 IPPS final rules (68 FR 34122 and 68 FR 45376, respectively), we make the annual update to the LTCH PPS effective from July 1 through June 30 each year. As a result, the LTCH PPS uses two GROUPERS during the course of a 12-month period: One GROUPER for 3 months (from July 1 through September 30); and an updated GROUPER for 9 months (from October 1 through June 30). The need to use two GROUPERs is based upon the October 1 effective date of the updated ICD–9–CM coding system. As previously discussed, new ICD–9–CM codes may result in changes to the structure of the DRGs. In order for the industry to be on the same schedule (for both the IPPS and the LTCH PPS) for the use of the most current ICD–9–CM codes, it is necessary for us to apply two GROUPER programs to the LTCH PPS. LTCHs will continue to code diagnosis and procedures using the most current version of the ICD–9–CM coding system.

Currently, for Federal FY 2004, we are using Version 21.0 of the GROUPER software for both the IPPS and the LTCH PPS. Discharges beginning on October 1, 2003 and before October 1, 2004 (Federal FY 2004) are using Version 21.0 of the GROUPER software for both the IPPS and the LTCH PPS. Thus, changes to the CMS–DRGs (the DRGs on which the LTC–DRGs are based) and their relative weights, as well as the LTC–DRGs and their relative weights, that will be effective for October 1, 2004 through September 30, 2005, will be presented in the FY 2005 IPPS proposed rule that will be published in the **Federal Register** in the spring of 2004 and finalized in a final rule to be published by August 1, 2004. Accordingly, we will notify LTCHs of any revised LTC–DRG relative weights based on the final DRGs and the applicable GROUPER version for the IPPS that will be effective October 1, 2004.

E. ICD–9–CM Coding System

1. Uniform Hospital Discharge Data Set (UHDDS) Definitions

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

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

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

We provide LTCHs with a 60-day window after the date of the notice of

the initial LTC–DRG assignment to request review of that assignment. Additional information may be provided by the LTCH to the fiscal intermediary as part of that review.

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

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

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

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

Section 503(a) of Public Law 108–173 includes a requirement for updating ICD–9–CM codes twice a year instead of the current process of annual updates on October 1 of each year. These requirements are included as part of the amendments to the Act relating to recognition of new medical technology under the IPPS. Section 503(a) amended section 1886(d)(5)(K) of the Act by adding a new clause (vii) which states that ''Under the mechanism under this subparagraph, the Secretary shall provide for the addition of new diagnosis and procedure codes in April 1 of each year, but the addition of such codes shall not require the Secretary to adjust the payment (or diagnosis-related group classification) * * * until the fiscal year that begins after such date.'' Because this new statutory requirement would have a significant impact on health care providers, coding staff, publishers, system maintainers, software systems, among others, we are soliciting comments on our proposed provisions. The description of these proposed provisions will be published in the **Federal Register** in the FY 2005 IPPS proposed rule.

All changes to the ICD–9–CM coding system affecting DRG assignment are addressed annually in the IPPS proposed and final rules. Because the DRG-based patient classification system for the LTCH PPS is based on the IPPS DRGs, these changes also affect the LTCH PPS LTC–DRG patient classification system.

As discussed above, the ICD–9–CM coding changes that have been adopted by the C&M Committee become effective at the beginning of each Federal fiscal year, October 1. Regardless of the annual update of the LTCH PPS on July 1 of each year, coders will use the most current updated ICD–9–CM coding book, which is effective from October 1 through September 30 of each year. This means that coders and LTCHs that use the updated ICD–9–CM coding system will be on the same schedule (effective October 1) as the rest of the health care industry. The newest version of ICD–9–CM is not available for use until October 1 of each year, which is 5 months after the date that we publish the LTCH annual payment rate update final rule. The new codes on which the LTC–DRGs are based will go into effect and be available for use for discharges occurring on or after October 1 through September 30 of each year. This annual schedule of the revision to the ICD–9–CM coding system and the change of the ICD–9–CM coding books or electronic coding programs has been in effect since the adoption of Revision 9 of the ICD in 1979.

Of particular note to LTCHs are the invalid diagnosis codes (Table 6C) and the invalid procedure codes (Table 6D) located in the annual proposed and final rules for the IPPS. Claims with invalid codes are not processed by the Medicare claims processing system.

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

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

In conjunction with the cooperating parties (AHA, the American Health Information Management Association (AHIMA), and NCHS), we reviewed actual medical records and are concerned about the quality of the documentation under the LTCH PPS, as was the case at the beginning of the IPPS. We fully believe that, with experience, the quality of the documentation and coding will improve, just as it did for the IPPS. As noted above, the cooperating parties have plans to assist their members with improvement in documentation and coding issues for the LTCHs through specific questions and coding guidelines. The importance of good documentation is emphasized in the revised ICD–9–CM Official Guidelines for Coding and Reporting (October 1, 2002): ''A joint effort between the attending physician and coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation, the application of all coding guidelines is a difficult, if not impossible, task.'' (Coding Clinic for ICD–9–CM, Fourth Quarter 2002, page 115)

To improve medical record documentation, LTCHs should be aware that if the patient is being admitted for continuation of treatment of an acute or chronic condition, guidelines at Section I.B.10 of the Coding Clinic for ICD–9–CM, Fourth Quarter 2002 (page 129) are applicable concerning selection of principal diagnosis. To clarify coding advice issued in the August 30, 2002 final rule (67 FR 55979–55981), we would like to point out that at Guideline I.B.12, Late Effects, a late effect is considered to be the residual effect (condition produced) after the acute phase of an illness or injury has

terminated (Coding Clinic for ICD–9–CM, Fourth Quarter 2002, page 129). Regarding whether a LTCH should report the ICD–9–CM code(s) for an unresolved acute condition instead of the code(s) for late effect of rehabilitation, we emphasize that each case must be evaluated on its unique circumstances and coded appropriately. Depending on the documentation in the medical record, either a code reflecting the acute condition or rehabilitation could be appropriate in a LTCH.

Since implementation of the LTCH PPS, our Medicare fiscal intermediaries have been conducting training and providing assistance to LTCHs in correct coding. We have also issued manuals containing procedures as well as coding instructions to LTCHs and fiscal intermediaries. We will continue to conduct such training and provide guidance on an as-needed basis. We also refer readers to the detailed discussion on correct coding practices in the August 30, 2002 LTCH PPS final rule (67 FR 55979–55981). Additional coding instructions and examples will be published in Coding Clinic for ICD–9–CM.

F. Method for Updating the LTC–DRG Relative Weights

As discussed in the June 6, 2003 LTCH PPS final rule (68 FR 34131), under the LTCH PPS, each LTCH will receive a payment that represents an appropriate amount for the efficient delivery of care to Medicare patients. The system must be able to account adequately for each LTCH's case-mix in order to ensure both fair distribution of Medicare payments and access to adequate care for those Medicare patients whose care is more costly. Therefore, in accordance with § 412.523(c), we adjust the standard Federal PPS rate by the LTC–DRG relative weights in determining payment to LTCHs for each case.

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

As we discussed in the August 1, 2003 IPPS final rule (68 FR 45374–45384), the LTC–DRG relative weights effective under the LTCH PPS for Federal FY 2004 were calculated using the December 2002 update of FY 2002 MedPAR data and Version 21.0 of the CMS GROUPER software. We use total days and total charges in the calculation of the LTC–DRG relative weights.

By nature, LTCHs often specialize in certain areas, such as ventilator-dependent patients and rehabilitation and wound care. Some case types (DRGs) may be treated, to a large extent, in hospitals that have, from a perspective of charges, relatively high (or low) charges. Such distribution of cases with relatively high (or low) charges in specific LTC–DRGs has the potential to inappropriately distort the measure of average charges. To account for the fact that cases may not be randomly distributed across LTCHs, we use a hospital-specific relative value method to calculate relative weights. We believe this method removes this hospital-specific source of bias in measuring average charges. Specifically, we reduce the impact of the variation in charges across providers on any particular LTC–DRG relative weight by converting each LTCH's charge for a case to a relative value based on that LTCH's average charge. (See the August 1, 2003 IPPS final rule (68 FR 45376) for further information on the hospital-specific relative value methodology.)

In order to account for LTC–DRGs with low volume (that is, with fewer than 25 LTCH cases), we grouped those low volume LTC–DRGs into one of five categories (quintiles) based on average charges, for the purposes of determining relative weights. For FY 2004 based on the FY 2002 MedPAR data, we identified 173 LTC–DRGs that contained between 1 and 24 cases. This list of low volume LTC–DRGs was then divided into one of the five low volume quintiles, each containing a minimum of 34 LTC–DRGs (173/5 = 34 with 1 LTC–DRG as a remainder). Each of the low volume LTC–DRGs grouped to a specific quintile received the same relative weight and average length of stay using the formula applied to the regular LTC–DRGs (25 or more cases), as described below. (See the August 1, 2003 final rule (68 FR 45376–45380) for further explanation of the development and composition of each of the five low volume quintiles for FY 2004.)

After grouping the cases in the appropriate LTC–DRG, we calculated the relative weights by first removing statistical outliers and cases with a length of stay of 7 days or less. Next, we adjusted the number of cases in each LTC–DRG for the effect of short-stay outlier cases under § 412.529. The short-stay adjusted discharges and corresponding charges were used to calculate ''relative adjusted weights'' in each LTC–DRG using the hospital-specific relative value method described above. (See the August 1, 2003 final rule (68 FR 45376–45385) for further details on the steps for calculating the LTC–DRG relative weights.)

We also adjusted the LTC–DRG relative weights to account for nonmonotonically increasing relative weights. That is, we made an adjustment if cases classified to the LTC–DRG ''with comorbidities (CCs)'' of a ''with CC''/''without CC'' pair had a lower average charge than the corresponding LTC–DRG ''without CCs'' by assigning the same weight to both LTC–DRGs in the ''with CC''/''without CC'' pair. (See August 1, 2003 final rule, 68 FR 45381–45382.) In addition, of the 518 LTC–DRGs in the LTCH PPS for FY 2004, based on the FY 2002 MedPAR data, we identified 167 LTC–DRGs for which there were no LTCH cases in the database. That is, no patients who would have been classified to those DRGs were treated in LTCHs during FY 2002 and, therefore, no charge data were reported for those DRGs. Thus, in the process of determining the relative weights of LTC–DRGs, we were unable to determine weights for these 167 LTC–DRGs using the method described above. However, since patients with a number of the diagnoses under these LTC–DRGs may be treated at LTCHs beginning in FY 2004, we assigned relative weights to each of the 167 ''no volume'' LTC–DRGs based on clinical similarity and relative costliness to one of the remaining 351 (518–167 = 351) LTC–DRGs for which we were able to determine relative weights, based on the FY 2002 claims data. (A list of the no-volume LTC–DRGs and further explanation of their relative weight assignment can be found in the August 1, 2003 IPPS final rule (68 FR 45374–45385).)

Furthermore, for FY 2004, we established LTC–DRG relative weights of 0.0000 for heart, kidney, liver, lung, pancreas, and simultaneous pancreas/kidney transplants (LTC–DRGs 103, 302, 480, 495, 512 and 513, respectively) because Medicare will only cover these procedures if they are performed at a hospital that has been certified for the specific procedures by Medicare and presently no LTCH has been so certified. If in the future, however, a LTCH applies for certification as a Medicare-approved transplant center, we believe that the application and approval procedure would allow sufficient time for us to propose appropriate weights for the LTC–DRGs affected. At the

present time, though, we included these six transplant LTC–DRGs in the GROUPER program for administrative purposes. As the LTCH PPS uses the same GROUPER program for LTCHs as is used under the IPPS, removing these DRGs would be administratively burdensome.

As we stated in the August 1, 2003 IPPS final rule, we will continue to use the same LTC–DRGs and relative weights for FY 2004 until October 1, 2004. Accordingly, Table 3 in the Addendum to this final rule lists the LTC–DRGs and their respective relative weights and arithmetic mean length of stay that we will continue to use for the period of July 1, 2004 through September 30, 2004. (This table is the same as Table 3 of the Addendum to the August 1, 2003 IPPS final rule (68 FR 45650–45658), except that it includes the five-sixth of the average length of stay for short-stay outliers under § 412.529.) As we noted earlier, the final DRGs and GROUPER for FY 2005 that will be used for the IPPS and the LTCH PPS, effective October 1, 2004, will be presented in the IPPS FY 2005 proposed and final rule in the **Federal Register**.

Accordingly, we will notify LTCHs of the revised LTC–DRG relative weights for use in determining payments for discharges occurring between October 1, 2004 and September 30, 2005, based on the final DRGs and the applicable GROUPER version that will be published in the IPPS rule by August 1, 2004.

V. Changes to the LTCH PPS Rates and Changes in Policy for the 2005 LTCH PPS Rate Year

A. Overview of the Development of the Payment Rates

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

The basic methodology for determining LTCH PPS Federal prospective payment rates is set forth in the regulations at §§ 412.515 through 412.532. Below we discuss the factors used to update the LTCH PPS standard Federal rate for the 2005 LTCH PPS rate year that will be effective for LTCHs discharges occurring on or after July 1, 2004 through June 30, 2005.

When we implemented the LTCH PPS in the August 30, 2002 final rule (67 FR 56029–56031), we computed the LTCH PPS standard Federal payment rate for FY 2003 by updating the best available (FY 1998 or FY 1999) Medicare inpatient operating and capital costs per case data, using the excluded hospital market basket.

Section 123(a)(1) of Public Law 106–113 requires that the PPS developed for LTCHs be budget neutral. Therefore, in calculating the standard Federal rate under § 412.523(d)(2), we set total estimated LTCH PPS payments equal to estimated payments that would have been made under the reasonable cost-based payment methodology had the PPS for LTCHs not been implemented. Section 307(a) of Public Law 106–554 specified that the increases to the hospital-specific target amounts and cap on the target amounts for LTCHs for FY 2002 provided for by section 307(a)(1) of Public Law 106–554 shall not be taken into account in the development and implementation of the LTCH PPS. Furthermore, as specified at § 412.523(d)(1), the standard Federal rate is reduced by an adjustment factor to account for the estimated proportion of outlier payments under the LTCH PPS to total LTCH PPS payments (8 percent). For further details on the development of the FY 2003 standard Federal rate, see the August 30, 2002 final rule (67 FR 56027–56037) and for the 2004 LTCH PPS rate year rate, see the June 6, 2003 final rule (68 FR 34122–34190). Under the existing regulations at § 412.523(c)(3)(ii), we update the standard Federal rate annually to adjust for the most recent estimate of the projected increases in prices for LTCH inpatient hospital services.

B. Update to the Standard Federal Rate for the 2005 LTCH PPS Rate Year

As established in the June 6, 2003 final rule (68 FR 34122), based on the most recent estimate of the excluded hospital with capital market basket, adjusted to account for the change in the LTCH PPS rate year update cycle, the LTCH PPS standard Federal rate effective from July 1, 2003 through June 30, 2004 (the 2004 LTCH PPS rate year) is $35,726.18.

In the discussion that follows, we explain how we developed the standard Federal rate for the 2005 LTCH PPS rate year. The standard Federal rate for the 2005 LTCH PPS rate year is calculated based on the update factor of 1.031. Thus, the standard Federal rate for the 2005 LTCH PPS rate year will increase 3.1 percent compared to the 2004 LTCH PPS rate year standard Federal rate.

1. Standard Federal Rate Update

Under § 412.523, the annual update to the LTCH PPS standard Federal rate must be equal to the percentage change in the excluded hospital with capital market basket (described in further detail below). As we discussed in the August 30, 2002 final rule (67 FR 56087), in the future we may propose to develop a framework to update payments to LTCHs that would account for other appropriate factors that affect the efficient delivery of services and care provided to Medicare patients. As we discussed in the January 30, 2004 proposed rule (69 FR 4762), because the LTCH PPS has only been implemented for less than 2 years (that is, for cost reporting periods beginning on or after October 1, 2002), we have not yet collected sufficient data to allow for the analysis and development of an update framework under the LTCH PPS. Therefore, we are not addressing an update framework for the 2005 LTCH PPS rate year in this final rule. However, we noted that a conceptual basis for the proposal of developing an update framework in the future can be found in Appendix B of the August 30, 2002 final rule (67 FR 56086–56090).

a. *Description of the market basket for LTCHs for the 2005 LTCH PPS rate year.* A market basket has historically been used in the Medicare program to account for price increases of the services furnished by providers. The market basket used for the LTCH PPS includes both operating and capital-related costs of LTCHs because the LTCH PPS uses a single payment rate for both operating and capital-related costs. The development of the LTCH PPS standard Federal rate is discussed in further detail in the August 30, 2002 final rule (67 FR 56027–56037).

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

to the excluded hospital market basket for use under the LTCH PPS. We refer to this index as the excluded hospital with capital market basket.

As we discussed in the August 30, 2002 final rule (67 FR 56016 and 56086), beginning with the implementation of the LTCH PPS in FY 2003, the excluded hospital with capital market basket, based on FY 1992 Medicare cost report data, has been used for updating payments to LTCHs. In the June 6, 2003 final rule (68 FR 34137), we revised and rebased the excluded hospital with capital market basket, using more recent data, that is, using FY 1997 base year data beginning with the 2004 LTCH PPS rate year. (For further details on the development of the FY 1997-based LTCH PPS market basket, see the June 6, 2003 final rule (68 FR 34134–34137)).

In the August 30, 2002 LTCH PPS final rule (67 FR 56016 and 56085–56086), we discussed why we believe the excluded hospital with capital market basket provides a reasonable measure of the price changes facing LTCHs. However, as we discussed in the June 6, 2003 final rule (68 FR 34137), we have been researching the feasibility of developing a market basket specific to LTCH services. This research has included analyzing data sources for cost category weights, specifically the Medicare cost reports, and investigating other data sources on cost, expenditure, and price information specific to LTCHs. Based on this research, we did not develop a market basket specific to LTCH services.

As we also discussed in the June 6, 2003 final rule (68 FR 34137), our analysis of the Medicare cost reports indicates that the distribution of costs among major cost report categories (wages, pharmaceuticals, capital) for LTCHs is not substantially different from the 1997-based excluded hospital with capital market basket. Data on other major cost categories (benefits, blood, contract labor) that we would like to analyze were excluded by many LTCHs in their Medicare cost reports. An analysis based on only the data available to us for these cost categories presented a potential problem since no other major cost category weight would be based on LTCH data.

Furthermore, as we also discussed in that same final rule (68 FR 34137), we conducted a sensitivity analysis of annual percent changes in the market basket when the weights for wages, pharmaceuticals, and capital in LTCHs were substituted into the excluded hospital with capital market basket. Other cost categories were recalibrated using ratios available from the IPPS market basket. On average between FY 1995 and FY 2002, the excluded hospital with capital market basket shows increases at nearly the same average annual rate (2.9 percent) as the market basket with LTCH weights for wages, pharmaceuticals, and capital (2.8 percent). This difference is less than the 0.25 percentage point criterion that determines whether a forecast error adjustment is warranted under the IPPS update framework.

As we discussed in the January 30, 2004 proposed rule (69 FR 4763), we continue to believe that an excluded hospital with capital market basket adequately reflects the price changes facing LTCHs. We continue to solicit comments about issues particular to LTCHs that should be considered in relation to the FY 1997-based excluded hospital with capital market basket and to encourage suggestions for additional data sources that may be available. We received no comments on the proposed market basket for determining the LTCH PPS standard Federal rate for the 2005 LTCH PPS rate year. Accordingly, in this final rule, we are using the FY 1997-based excluded hospital with capital market basket as the LTCH PPS market basket for determining the update to the LTCH PPS standard Federal rate for the 2005 LTCH PPS rate year.

b. *LTCH market basket increase for the 2005 LTCH rate year.* As we discussed in the June 6, 2003 final rule (68 FR 34137), for LTCHs paid under the LTCH PPS, we stated that the 2004 rate year update applies to discharges occurring from July 1, 2003 through June 30, 2004. Because we changed the timeframe of the LTCH PPS standard Federal rate annual update from October 1 to July 1, as we explained in that same final rule, we calculated an update factor that reflected that change in the update cycle. For the update to the 2004 LTCH PPS rate year, we calculated the estimated increase between FY 2003 and the 2004 LTCH PPS rate year (July 1, 2003 through June 30, 2004). Accordingly, based on Global Insight's forecast of the revised and rebased FY 1997-based excluded hospital with capital market basket using data from the fourth quarter of 2002, we used a market basket update of 2.5 percent for the 2004 LTCH PPS rate year (68 FR 34138).

Consistent with our historical practice of estimating market basket increases based on Global Insight's forecast of the FY 1997-based excluded hospital with capital market basket using more recent data from the fourth quarter of 2003, in this final rule, we are using a 3.1 percent update to the Federal rate for the 2005 LTCH PPS rate year. In accordance with § 412.523, this update represents the most recent estimate of the increase in the excluded hospital with capital market basket for the 2005 LTCH PPS rate year.

2. Standard Federal Rate for the 2005 LTCH PPS Rate Year

In the June 6, 2003 final rule (68 FR 34140), we established a standard Federal rate of $35,726.18 for the 2004 LTCH PPS rate year based on the best available data and policies established in that final rule. In the January 30, 2004 proposed rule (69 FR 4763), for the 2005 LTCH PPS rate year, we proposed a standard Federal rate of $36,762.24 based on the proposed update of 2.9 percent. Since the proposed 2005 LTCH PPS rate year standard Federal rate was already adjusted for differences in case-mix, wages, cost-of-living, and high-cost outlier payments, we did not propose to make any additional adjustments in the standard Federal rate for these factors.

In this final rule, in accordance with § 412.523, we are establishing a standard Federal rate of $36,833.69 based on the most recent estimate of the LTCH PPS market basket of 3.1 percent. Since the standard Federal rate for the 2005 LTCH PPS rate year has already been adjusted for differences in case-mix, wages, cost-of-living, and high-cost outlier payments, we did not make any additional adjustments in the standard Federal rate for these factors.

C. Calculation of LTCH Prospective Payments for the 2005 LTCH PPS Rate Year

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

In accordance with § 412.533, during the 5-year transition period, payment is based on the applicable transition blend percentage of the adjusted Federal rate and the reasonable cost-based payment rate unless the LTCH makes a one-time

election to receive payment based on 100 percent of the Federal rate. A LTCH defined as ''new'' under § 412.23(e)(4) is paid based on 100 percent of the Federal rate with no blended transition payments (§ 412.533(d)). As discussed in the August 30, 2002 final rule (67 FR 56038), and in accordance with § 412.533(a), the applicable transition blends are as follows:

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

Accordingly, for cost reporting periods beginning during FY 2004 (that is, on or after October 1, 2003, and before September 30, 2004), blended payments under the transition methodology are based on 60 percent of the LTCH's reasonable cost-based payment rate and 40 percent of the adjusted LTCH PPS Federal rate. For cost reporting periods that begin during FY 2005 (that is, on or after October 1, 2004 and before September 30, 2005), blended payments under the transition methodology will be based on 40 percent of the LTCH's reasonable cost-based payment rate and 60 percent of the adjusted LTCH PPS Federal rate.

1. Adjustment for Area Wage Levels

a. *Background.* Under the authority of section 307(b) of Public Law 106–554, we established an adjustment to account for differences in LTCH area wage levels under § 412.525(c) using the labor-related share estimated by the excluded hospital market basket with capital and wage indices that were computed using wage data from inpatient acute care hospitals without regard to reclassification under section 1886(d)(8) or section 1886(d)(10) of the Act. Furthermore, as we discussed in the August 30, 2002 final rule (67 FR 56015–56019), we established a 5-year transition to the full wage adjustment. The applicable wage index phase-in percentages are based on the start of a LTCH's cost reporting period as shown in the following table:

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

For example, for cost reporting periods beginning on or after October 1, 2004 and before September 30, 2005 (FY 2005), the applicable LTCH wage index value would be three-fifths of the applicable full wage index value without taking into account geographic reclassification under sections 1886(d)(8) and (d)(10) of the Act.

In that same final rule (67 FR 56018), we stated that we would continue to reevaluate LTCH data as they become available and would propose to adjust the phase-in if subsequent data support a change. As we discussed in the June 6, 2003 final rule (68 FR 34140), because the LTCH PPS has only been implemented for less than 2 years, sufficient new data have not been generated that would enable us to conduct a comprehensive reevaluation of the appropriateness of adjusting the phase-in. However, in that same final rule, we explained that we had reviewed the most recent data available at that time and did not find any evidence to support a change in the 5-year phase-in of the wage index.

In the January 30, 2004 proposed rule (69 FR 4764), we stated that because of the recent implementation of the LTCH PPS and the lag time in availability of cost report data, we still do not yet have sufficient new data to allow us to conduct a comprehensive reevaluation of the appropriateness of the phase-in of the wage index adjustment. As we discussed in that same proposed rule, we reviewed the most recent data available and did not find any evidence to support a change in the 5-year phase-in of the wage index. Accordingly, we did not propose a change in the phase-in of the wage index data. We received no comments, and therefore, at this time, we are not adjusting the phase-in of the wage index adjustment in this final rule.

b. *Wage Index Data.* In the June 6, 2003 final rule (68 FR 34142), for the 2004 LTCH PPS rate year, we established that we will use the same data that was used to compute the FY 2003 acute care hospital inpatient wage index without taking into account geographic reclassifications under sections 1886(d)(8) and (d)(10) of the Act because that was the best available data at that time. The acute care hospital inpatient wage index data is also used in the inpatient rehabilitation PPS (IRF PPS), the home health agency PPS (HHA PPS), and the skilled nursing facility PPS (SNF PPS). As we discussed in the August 30, 2002 final rule (67 FR 56019), since hospitals that are excluded from the IPPS are not required to provide wage-related information on the Medicare cost report and because we would need to establish instructions for the collection of such LTCH data in order to establish a geographic reclassification adjustment under the LTCH PPS, the wage adjustment established under the LTCH PPS is based on a LTCH's actual location without regard to the urban or rural designation of any related or affiliated provider.

In the January 30, 2004 proposed rule (69 FR 4764), for the 2005 LTCH PPS rate year, we proposed to use the same data used to compute the FY 2004 acute care hospital inpatient wage index without taking into account geographic reclassifications under sections

1886(d)(8) and (d)(10) of the Act to determine the applicable wage index values under the LTCH PPS, because these are the most recent available complete data. These data are the same wage data that were used to compute the FY 2004 wage indices currently used under the IPPS and SNF PPS. (We note that in the January 30, 2004 proposed rule, we mistakenly stated that these data are the same wage data that were used to compute the FY 2003 wage indices currently used under the IPPS and SNF PPS. We should have said that the proposed wage index values for the 2005 LTCH PPS rate year were computed from the same data used to calculate the FY 2004 wage indices currently used under the IPPS and SNF PPS. Also, in the January 30, 2004 proposed rule, in the example of how the proposed LTCH PPS wage index values for discharges occurring on or after July 1, 2004 through June 30, 2005 would be applied for LTCHs' cost reporting periods beginning during FY 2005, we mistakenly stated that the applicable wage index value would be three-fifths of the full FY 2005 acute care hospital inpatient wage index data, without taking into account geographic reclassification under sections 1886(d)(8) and (d)(10) of the Act. We should have said that the wage index values for the 2005 LTCH PPS rate year for LTCHs' cost reporting periods during FY 2005 would be three-fifths of the full FY 2004 acute care hospital inpatient wage index data, without taking into account geographic reclassification under sections 1886(d)(8) and (d)(10) of the Act. The proposed wage index values shown in Tables 1 and 2 in the Addendum of the January 30, 2004 proposed rule (69 FR 4790–4808) were correct.

We received no comments on the proposed wage index for the 2005 LTCH PPS rate year. Accordingly, in this final rule, we are establishing LTCH PPS wage index values for the 2005 LTCH PPS rate year calculated from the same data used to compute the FY 2004 acute care hospital inpatient wage index data without taking into account geographic reclassification under sections 1886(d)(8) and (d)(10) of the Act. The LTCH wage index values applicable for discharges occurring on or after July 1, 2004 through June 30, 2005 are shown in Table 1 (for urban areas) and Table 2 (for rural areas) in the Addendum to this final rule.

As noted above, the applicable wage index phase-in percentages are based on the start of a LTCH's cost reporting period beginning on or after October 1st of each year during the 5-year transition period. For cost reporting periods beginning on or after October 1, 2003 and before September 30, 2004 (FY 2004), the labor portion of the standard Federal rate will be adjusted by two-fifths of the applicable LTCH wage index value. Specifically, for a LTCH's cost reporting period beginning during FY 2004, for discharges occurring on or after July 1, 2004 through June 30, 2005, the applicable wage index value will be two-fifths of the full FY 2004 acute care hospital inpatient wage index data, without taking into account geographic reclassifications under sections 1886(d)(8) and (d)(10) of the Act as shown in Tables 1 and 2 in the Addendum to this final rule. Similarly, for cost reporting periods beginning on or after October 1, 2004 and before October 1, 2005 (FY 2005), the labor portion of the standard Federal rate will be adjusted by three-fifths of the applicable LTCH wage index value. Specifically, for a LTCH's cost reporting period beginning during FY 2005, for discharges occurring on or after July 1, 2004 through June 30, 2005, the applicable wage index value will be three-fifths of the full FY 2004 acute care hospital inpatient wage index data, without taking into account geographic reclassification under sections 1886(d)(8) and (d)(10) of the Act as shown in Tables 1 and 2 in the addendum to this final rule.

Because the phase-in of the wage index does not coincide with the LTCH PPS rate year (July 1st through June 30th), most LTCHs will experience a change in the wage index phase-in percentages during the LTCH PPS rate year. For example, during the 2005 LTCH PPS rate year, for a LTCH with a January 1st fiscal year, the two-fifths wage index will be applicable for the first 6 months of the 2005 LTCH PPS rate year (July 1, 2004 through December 31, 2004) and the three-fifths wage index will be applicable for the second 6 months of the 2005 LTCH PPS rate year (January 1, 2005 through June 30, 2005). We also note that some providers will still be in the first year of the 5-year phase-in of the LTCH wage index (that is, those LTCHs with cost reporting periods that began during FY 2003 and are ending during the first 3 months of the 2005 LTCH PPS rate year (July 1, 2004 through September 30, 2004). For the remainder of those LTCHs' FY 2003 cost reporting periods, for discharges occurring on or after July 1, 2004 through June 30, 2005, the applicable wage index value will be one-fifth of the full FY 2004 acute care hospital inpatient wage index data, without taking into account geographic reclassification under sections 1886(d)(8) and (d)(10) of the Act as shown in Tables 1 and 2 in the Addendum to this final rule. As noted above, we received no comments on the proposed wage index values for the 2005 LTCH PPS rate year, and, therefore, we have adopted them as final in this final rule.

c. *Labor-related share.* In the August 30, 2002 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 and capital costs of the excluded hospital with capital market basket based on FY 1992 data. In the June 6, 2003 final rule (68 FR 34142), in conjunction with our revision and rebasing of the excluded hospital with capital market basket from an FY 1992 to an FY 1997 base year, we used a labor-related share that is determined 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 1997 data. While we adopted the revised and rebased FY 1997-based LTCH PPS market basket as the LTCH PPS update factor for the 2004 LTCH PPS rate year, we decided not to update the labor-related share under the LTCH PPS pending further analysis. Accordingly, the labor-share for the 2004 LTCH PPS rate year was 72.885 percent.

In the August 1, 2002 IPPS final rule (67 FR 50041–50042), we did not use a revised labor-related share for FY 2004 because we had not yet completed our research into the appropriateness of this updated measure. In that rule, we discussed two methods that we were reviewing for establishing the labor-related share—(1) updating the regression analysis that was done when the IPPS was originally developed and (2) reevaluating the methodology we currently use for determining the labor-related share using the hospital market basket. We also explained that we would continue to explore all options for alternative data and a methodology for determining the labor-related share, and would propose to update the IPPS and excluded hospital labor-related shares, if necessary, once our research is complete.

As we explained in the August 30, 2002 final rule, which implemented the LTCH PPS, the June 6, 2003 LTCH PPS final rule, and the June 9, 2003 high-cost outlier final rule, the LTCH PPS was modeled after the IPPS for short-term, acute care hospitals. Specifically, the LTCH PPS uses the same patient

classification system (CMS–DRGs) as the IPPS, and many of the case-level and facility-level adjustments explored or adopted for the LTCH PPS are payment adjustments under the IPPS (that is, wage index, high-cost outliers, and the evaluation of adjustments for indirect teaching costs and the treatment of a disproportionate share of low-income patients).

Furthermore, as discussed in greater detail in the August 30, 2002 LTCH PPS final rule (67 FR 55960), LTCHs are certified as acute care hospitals that meet the criteria set forth in section 1861(e) of the Act to participate as a hospital in the Medicare program, and in general, hospitals qualify for payment under the LTCH PPS instead of the IPPS solely because their inpatient average length of stay is greater than 25 days, in accordance with section 1886(d)(1)(B)(iv)(I) of the Act, implemented in § 412.23(e). In the June 6, 2003 LTCH PPS final rule (68 FR 34144), we explained that prior to qualifying as a LTCH under § 412.23(e)(2)(i), hospitals generally are paid as acute care hospitals under the IPPS during the period in which they demonstrate that they have an average Medicare inpatient length of stay of greater than 25 days.

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

Section 403 of the Medicare Prescription Drug and Modernization Act of 2003 (enacted December 8, 2003, Pub. L. 108–173) amends section 1886(d) of the Act to provide that for discharges occurring on or after October 1, 2004, the labor-related share under the IPPS is reduced to 62 percent if such a change would result in higher total payments to the hospital. While the statute provides the option to hospitals of using an alternative to the current IPPS labor-related share (71 percent), the statute does not address updating the current IPPS labor-related share. We intend to discuss the details of implementing this provision in the IPPS proposed rule for FY 2005.

As we discussed in the January 30, 2004 proposed rule (69 FR 4765), although section 403 of Public Law 108–173 provides for an alternative labor share percentage, this alternative only applies to hospitals paid under the IPPS and not to LTCHs. Consequently, since we have not yet implemented a change in the labor-share methodology used under the IPPS, and the alternative provided at section 403 does not apply to LTCHs, we did not propose to change the LTCH PPS labor-share for the 2005 LTCH PPS rate year. We received no comments on our proposal to retain the current labor-related share for the 2005 LTCH PPS rate year.

Accordingly, the labor-related share for the 2005 LTCH PPS rate year will remain at 72.885 percent. As is the case under the IPPS, once our research on the labor-related share is complete, any future revisions to the LTCH PPS labor-related share will be proposed and subject to public comment.

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

In the August 30, 2002 final rule (67 FR 56022), we established, under § 412.525(b), a cost-of-living adjustment (COLA) for LTCHs located in Alaska and Hawaii to account for the higher costs incurred in those States. (We note that the OFR inadvertently omitted § 412.525(b) in the current version of the CFR (revised as of October 1, 2003). The OFR is aware of this error and will be making the necessary correction in the near future.) In the January 30, 2004 proposed rule (69 FR 4765), for the 2005 LTCH PPS rate year, we proposed to make a COLA to payments for LTCHs located in Alaska and Hawaii by multiplying the standard Federal payment rate by the appropriate factor listed in Table I. below. These factors are obtained from the U.S. Office of Personnel Management (OPM) and are currently used under the IPPS. In addition, in that same proposed rule, we proposed that if OPM released revised COLAS factors before March 1, 2004, we would use them for the development of the payments and publish then in the LTCH PPS final rule.

The OPM has not released revised COLA factors for Alaska and Hawaii since the publication of the January 30, 2004 proposed rule. We received no comments on the proposed COLA factors for Alaska and Hawaii for the 2005 LTCH PPS rate year. Therefore, under § 412.525(b), we are finalizing the COLA factors for Alaska and Hawaii shown below in Table I for the 2005 LTCH PPS rate year.

TABLE I.—COST-OF-LIVING ADJUSTMENT FACTORS FOR ALASKA AND HAWAII HOSPITALS FOR THE 2005 LTCH PPS RATE YEAR

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

3. Adjustment for High-Cost Outliers

a. *Background.* Under § 412.525(a), we make an adjustment for additional payments for outlier cases that have extraordinarily high costs relative to the costs of most discharges. Providing additional payments for outliers strongly improves the accuracy of the LTCH PPS in determining resource costs at the patient and hospital level. These additional payments reduce the financial losses that would otherwise be caused by treating patients who require more costly care and, therefore, reduce the incentives to underserve these patients. We set the outlier threshold before the beginning of the applicable rate year so that total outlier payments are projected to equal 8 percent of total payments under the LTCH PPS. Outlier payments under the LTCH PPS are determined consistent with the IPPS outlier policy.

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

We determine a fixed-loss amount, that is, the maximum loss that a LTCH can incur under the LTCH PPS for a case with unusually high costs before the LTCH will receive any additional payments. We calculate the fixed-loss amount by simulating aggregate

payments with and without an outlier policy. The fixed-loss amount would result in estimated total outlier payments being projected to be equal to 8 percent of projected total LTCH PPS payments.

Currently, under both the LTCH PPS and the IPPS, only a maximum cost-to-charge ratio threshold (ceiling) is applied to a hospital's cost-to-charge ratio and, as discussed in the June 9, 2003 high-cost outlier final rule (68 FR 34506–34507) for discharges occurring on or after August 8, 2003, a minimum cost-to-charge ratio threshold (floor) is no longer applicable. Thus, if a LTCH's cost-to-charge ratio is above the ceiling, the applicable statewide average cost-to-charge ratio is assigned to the LTCH. In addition, for LTCHs for which we are unable to compute a cost-to-charge ratio, we also assign the applicable statewide average cost-to-charge ratio. Currently, MedPAR claims data and cost-to-charge ratios based on the latest available cost report data from Hospital Cost Report Information System (HCRIS) and corresponding MedPAR claims data are used to establish a fixed-loss threshold amount under the LTCH PPS.

In the June 9, 2003 high-cost outlier final rule (68 FR 34507), consistent with the outlier policy changes for acute care hospitals under the IPPS discussed in that same final rule, we no longer assign the applicable statewide average cost-to-charge ratio when a LTCH's cost-to-charge ratio falls below the minimum cost-to-charge ratio threshold (floor). We made this policy change because, as is the case for acute care hospitals, we believe LTCHs could arbitrarily increase their charges in order to maximize outlier payments. Even though this arbitrary increase in charges should result in a lower cost-to-charge ratio in the future (due to the lag time in cost report settlement), previously when a LTCH's actual cost-to-charge ratio fell below the floor, the LTCH's cost-to-charge ratio was raised to the applicable statewide average cost-to-charge ratio. This application of the statewide average resulted in inappropriately high outlier payments. Accordingly, for LTCH PPS discharges occurring on or after August 8, 2003, in making outlier payments under § 412.525 (and short-stay outlier payments under § 412.529), we apply the LTCH's actual cost-to-charge ratio to determine the cost of the case, even where the LTCH's actual cost-to-charge ratio falls below the floor.

Also, in the June 9, 2003 high-cost outlier final rule (68 FR 34507), consistent with the policy change for acute care hospitals under the IPPS, under § 412.525(a)(4), by cross-referencing § 412.84(i), we established that we will continue to apply the applicable statewide average cost-to-charge ratio when a LTCH's cost-to-charge ratio exceeds the maximum cost-to-charge ratio threshold (ceiling) by adopting the policy at § 412.84(i)(3)(ii). As we explained in that same final rule, cost-to-charge ratios above this range are probably due to faulty data reporting or entry. Therefore, these cost-to-charge ratios should not be used to identify and make payments for outlier cases because such data are clearly errors and should not be relied upon. In addition, we made a similar change to the short-stay outlier policy at § 412.529. Since cost-to-charge ratios are also used in determining short-stay outlier payments, the rationale for that change mirrors that for high-cost outliers.

b. *Establishment of the fixed-loss amount.* In the June 6, 2003 final rule (68 FR 34144), for the 2004 LTCH PPS rate year, we used the March 2002 update of the FY 2001 MedPAR claims data to determine a fixed-loss threshold that would result in outlier payments projected to be equal to 8 percent of total payments, based on the policies described in that final rule, because these data were the best data available. We calculated cost-to-charge ratios for determining the fixed-loss amount based on the latest available cost report data in HCRIS and corresponding MedPAR claims data from FYs 1998, 1999, and 2000.

In that same final rule, in determining the fixed-loss amount for the 2004 LTCH PPS rate year (using the outlier policy under § 412.525(a) in effect on July 1, 2003), we used the current combined operating and capital cost-to-charge ratio floor and ceiling under the IPPS of 0.206 and 1.421, respectively (as explained in the IPPS final rule (67 FR 50125, August 1, 2002)). As we discussed in the June 9, 2003 high-cost outlier final rule (68 FR 34508), we concluded that it was not necessary to recalculate a new fixed-loss amount once the changes to the outlier policy discussed in that final rule became effective because the difference between the fixed-loss amount determined with or without the application of the floor would be negligible.

If a LTCH's cost-to-charge ratio was below this floor or above this ceiling, we assigned the applicable IPPS statewide average cost-to-charge ratio. We also assigned the applicable statewide average for LTCHs for which we are unable to compute a cost-to-charge ratio, such as for new LTCHs. Therefore, based on the methodology and data described above, in the June 6, 2003 final rule (68 FR 34144), for the 2004 LTCH PPS rate year, we established a fixed-loss amount of $19,590. Thus, during the 2004 LTCH PPS rate year, we pay an outlier case 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted Federal LTCH payment for the LTC–DRG and the fixed-loss amount of $19,590).

Also, in the June 6, 2003 final rule (68 FR 34145), we established that beginning with the 2004 LTCH PPS rate year, we will calculate a single fixed-loss amount for each LTCH PPS rate year based on the version of the GROUPER that is in effect as of the beginning of the LTCH PPS rate year (that is, July 1, 2003 for the 2004 LTCH PPS rate year). Therefore, for the 2004 LTCH PPS rate year, we established a single fixed-loss amount based on the Version 20.0 of the GROUPER, which was in effect at the start of the 2004 LTCH PPS rate year (July 1, 2003). As we noted above, the fixed-loss amount for the 2004 LTCH PPS rate year is $19,590.

As we proposed in the January 30, 2004 proposed rule, in calculating the fixed-loss amount for the 2005 LTCH PPS rate year, we applied the current outlier policy under § 412.525(a); that is, we assigned the applicable statewide average cost-to-charge ratio only to LTCHs whose cost-to-charge ratios exceeded the ceiling (and not when they fell below the floor). Accordingly, we used the current IPPS combined operating and capital cost-to-charge ratio ceiling of 1.366 (as explained in the IPPS final rule (68 FR 45478, August 1, 2003)). We believed that using the current combined IPPS operating and capital cost-to-charge ratio ceiling for LTCHs is appropriate for the same reasons we stated above regarding the use of the current combined operating and capital cost-to-charge ratio ceiling under the IPPS.

As stated in the January 30, 2004 proposed rule (69 FR 4766–4767), for the 2005 LTCH PPS rate year, we used the December 2002 update of the FY 2002 MedPAR claims data to determine a proposed fixed-loss amount that would result in outlier payments projected to be equal to 8 percent of total payments, based on the policies described in that proposed rule, because those data were the best LTCH data available at that time. In that same proposed rule, we explained that we considered using claims data from the September 2003 update of the FY 2003 MedPAR to determine the proposed fixed-loss amount (and the proposed budget neutrality offset discussed in section V.C.6. of this preamble) for the 2005 LTCH PPS rate year. However, initial analysis has shown that the FY

2003 MedPAR data contain coding errors. As in the case with the FY 2002 MedPAR, we have learned that a large hospital chain of LTCHs had continued to consistently code diagnoses inaccurately on the claims it submitted, and these coding errors were reflected in the September 2003 update of the FY 2003 MedPAR data. Those coding inaccuracies in the MedPAR claims data could have caused significant skewing of the fixed-loss amount and would have impacted the determination of the budget neutrality offset.

While we have corrected the coding inaccuracies in the FY 2002 MedPAR, we were unable to correct the coding errors in the FY 2003 MedPAR in time for publication of the January 30, 2004 proposed rule since the correction process required extensive programming work. Accordingly, we used the December 2002 update of the FY 2002 MedPAR claims data to determine the proposed fixed-loss amount of $21,864 for the 2005 LTCH PPS rate year. Thus, we proposed to pay an outlier case 80 percent of the difference between the estimated cost of the case and the proposed outlier threshold (the sum of the proposed adjusted Federal LTCH PPS payment for the LTC–DRG and the proposed fixed-loss amount of $21,864). We also stated that we expected to be able to use FY 2003 MedPAR data (corrected, if necessary) to calculate the fixed loss amount for the 2005 LTCH PPS rate year in this final rule.

We have reviewed LTCH claims data from the December 2003 update of the FY 2003 MedPAR data and it appears that the coding errors that were found previously in the September 2003 update of the FY 2003 MedPAR (discussed in the January 30, 2004 proposed rule (69 FR 4774)) have been corrected. Specifically, upon discovering the coding errors, we notified the large chain of LTCHs whose claims contained the coding inaccuracies to request that they resubmit those claims with the correct diagnoses codes by December 31, 2003 so that those corrected claims would be contained in the December 2003 update of the FY 2003 MedPAR data. It appears that those claims were submitted timely with the correct diagnoses codes, therefore, it was not necessary for us to correct the FY 2003 MedPAR data for the development of the rates and factors established in this final rule. Accordingly, we are using the December 2003 update of the FY 2003 MedPAR data to determine the fixed-loss amount for the 2005 LTCH PPS rate year established in the this final rule, as it is the best available data at this time.

Comment: One commenter noted that CMS proposed a fixed-loss amount of $21,864 for the 2005 LTCH PPS rate year based on FY 2002 MedPAR claims data due to coding errors found in the FY 2003 MedPAR claims data, and that CMS plans on using the corrected FY 2003 MedPAR claims data to calculate the fixed-loss amount for the final rule. The commenter believed that, as a result of the fact that a large hospital chain of LTCHs continued to make coding errors, other LTCHs would be deprived of the opportunity to make meaningful comments. The commenter recommended that the revised fixed-loss amount should be published in an interim final rule in order to allow for meaningful comments.

Response: As with all other Medicare prospective payment systems, the data that we use both for the proposed and final rules, to determine the rates, adjustments and other factors under the LTCH PPS, including the fixed-loss amount, is always the best data available at the time we are determining a rate. As we stated in the January 30, 2004 proposed rule, we expected to use the FY 2003 MedPAR data to calculate the final fixed-loss amount for the 2005 LTCH PPS rate year in this final rule. Thus, the commenters were given adequate notice for meaningful comment on our proposal. In addition, we note that this data became available to the public at the end of February 2004, which was at least 3 weeks prior to the close of the 60-day public comment period that ended on March 23, 2004. We believe that this data was sufficiently available to those interested in accessing the data, and to ensure that we correctly applied the methodology that we established to compute the fixed-loss amount in the August 30, 2002 final rule when we implemented the LTCH PPS using the FY 2003 MedPAR data. Thus, because the methodology that we use to calculate the fixed-loss amount in both the proposed rule and in this final rule continues to be the same as the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 56022–56027) when the LTCH PPS was implemented (that is, we determine a fixed-loss amount that would result in outlier payments projected to be equal to 8 percent of total payments under the LTCH PPS), the public had the opportunity to use the most recently available FY 2003 MedPAR data to calculate of the applicable fixed-loss amount prior to the close of the comment period. To the extent that the public disagreed with the outcome, they could have written to us during the comment period, and we would have addressed their concerns. However, we did not receive any comments.

Accordingly, we do not believe it is necessary or appropriate to publish the final fixed-loss amount for the 2005 LTCH PPS rate year in a separate notice. However, if LTCHs have concerns regarding the calculation of the fixed-loss amount for the 2005 LTCH PPS rate year established in this final rule based on the FY 2003 MedPAR claims data, they may bring those concerns to our attention. Based on those concerns, if we determine that our established methodology for determining the fixed loss amount was applied incorrectly, we would take the necessary steps to correct the fixed-loss amount prospectively in accordance with the Administrative Procedure Act.

Furthermore, as noted above, we determined the fixed-loss amount for the 2005 LTCH PPS rate year established in this final rule based on the version of the GROUPER that will be in effect as of the beginning of the 2005 LTCH PPS rate year (July 1, 2004), that is, Version 21.0 of the LTCH PPS GROUPER (68 FR 45374–45385). Consistent with our historical practice of using the most recent available data, we computed cost-to-charge ratios for determining the fixed-loss amount for the 2005 LTCH PPS rate year based on the latest available cost report data in HCRIS and corresponding MedPAR claims data from FYs 1999, 2000, 2001 and 2002. (We note that FY 2002 data was not used to compute cost-to-charge ratios in the proposed rule because it was not available at the time of the development of the proposed rule. The limited amount of FY 2002 data available to use to compute the cost-to-charge ratios used for determining the fixed-loss amount established in this final rule has resulted in very little change in the cost-to-charge ratios used in the proposed rule compared to those used in this final rule. Our methodology for calculating the cost-to-charge ratios remains the same.) As we explained above, the current applicable IPPS statewide average cost-to-charge ratios were applied when a LTCH's cost-to-charge ratio exceeded the ceiling (1.366). In addition, we assigned the applicable statewide average to LTCHs for which we were unable to compute a cost-to-charge ratio. (Currently, the applicable IPPS statewide averages can be found in Tables 8A and 8B of the August 1, 2003 IPPS final rule (68 FR 45637–45638).)

Based on the data and policies described in this final rule, we are establishing a fixed-loss amount of $17,864 for the 2005 LTCH PPS rate

year. Thus, we will pay an outlier case 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted Federal LTCH payment for the LTC–DRG and the fixed-loss amount of $17,864).

The final fixed-loss amount of $17,864 for the 2005 LTCH PPS rate year is lower than the $21,864 fixed-loss amount we had proposed for the 2005 LTCH PPS rate year and lower than the current fixed-loss amount of $19,590 for the 2004 LTCH PPS rate year. Both the current fixed-loss amount for the 2004 LTCH PPS rate year and the proposed fixed-loss amount for the 2005 LTCH PPS rate year were computed using the December 2002 update of the FY 2002 MedPAR data (as explained in detail in the June 6, 2003 final rule (68 FR 34145) and the January 30, 2004 proposed rule (69 FR 4774), respectively). As discussed above, we used the December 2003 update of the FY 2003 MedPAR data to determine the final fixed-loss amount for the 2005 LTCH PPS rate year established in this final rule because it is the best available data at this time. Our methodology for calculating the fixed-loss amount remains the same.

c. *Reconciliation of outlier payments upon cost report settlement.* In the June 9, 2003 high-cost outlier final rule (68 FR 34508–34512), we made changes to the LTCH outlier policy consistent with those made for acute care hospitals under the IPPS because, as we discussed in that same final rule, we became aware that payment vulnerabilities existed in the previous IPPS outlier policy. Because the LTCH PPS high-cost outlier and short-stay policies are modeled after the outlier policy in the IPPS, we believe they were susceptible to the same payment vulnerabilities and, therefore, also merited revision. Consistent with the change made for acute care hospitals under the IPPS at § 412.84(m), we established under § 412.525(a)(4)(ii), by cross-referencing § 412.84(m), that effective for LTCH PPS discharges occurring on or after August 8, 2003, any reconciliation of outlier payments may be made upon cost report settlement to account for differences between the actual cost-to-charge ratio and the estimated cost-to-charge ratio for the period during which the discharge occurs. As is the case with the changes made to the outlier policy for acute care hospitals under the IPPS, the instructions for implementing these regulations are discussed in further detail in Program Memorandum Transmittal A–03–058. In addition, in that same final rule (68 FR 34513), we established a similar change to the short-stay outlier policy at § 412.529(c)(5)(ii).

We also discussed in the June 9, 2003 IPPS high-cost outlier final rule (68 FR 34507–34512) that only using cost-to-charge ratios based on the latest settled cost report does not reflect any dramatic increases in charges during the payment year when making outlier payments. Because a LTCH has the ability to increase its outlier payments through a dramatic increase in charges and because of the lag time in the data used to calculate cost-to-charge ratios, in that same final rule (68 FR 34494–34515), consistent with the policy change for acute care hospitals under the IPPS at § 412.84(i)(2), we established that, for LTCH PPS discharges occurring on or after October 1, 2003, fiscal intermediaries will use more recent data when determining a LTCH's cost-to-charge ratio. Therefore, by cross-referencing § 412.84(i)(2) under § 412.525(a)(4)(iii), we established that fiscal intermediaries will use either the most recent settled cost report or the most recent tentative settled cost report, whichever is from the later period. In addition, in that same final rule, we established a similar change to the short-stay outlier policy at § 412.529(c)(5)(iii).

d. *Application of outlier policy to short-stay outlier 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 short-stay outlier case (as defined under § 412.529 and discussed in section V.B.4. of this preamble) and also as a high-cost outlier case. In such a scenario, a patient could be hospitalized for less than five-sixths of the geometric average length of stay for the specific LTC–DRG, and yet incur extraordinarily high treatment costs. If the costs exceeded the outlier threshold (that is, the short-stay outlier payment plus the fixed-loss amount), the discharge would be eligible for payment as a high-cost outlier. Thus, for a short-stay outlier case in the 2005 LTCH PPS rate year, the high-cost outlier payment will be 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the fixed-loss amount of $17,864 and the amount paid under the short-stay outlier policy).

Based on a comparison of the LTCH claims from the FY 2002 MedPAR data and the FY 2003 MedPAR data for the 266 LTCHs which had claims in both data sets, we found that the average LTC–DRG relative weight (based on the Version 21.0 GROUPER, as discussed above) assigned to each case increased 2.7 percent from FY 2002 to FY 2003. In addition, we found that the average covered charge per discharge (inflated to 2005 LTCH PPS rate year) increased 3.3 percent from FY 2002 to FY 2003 and total LTCH PPS payments per discharge (based on FY 2002 MedPAR data) increased 7.3 percent compared to total LTCH PPS payments per discharge estimated in this final rule (based on FY 2003 MedPAR data).

Our analysis indicates that this increase in LTCH PPS payments per discharge between the LTCH claims in the FY 2002 MedPAR data and the LTCH claims in the FY 2003 MedPAR data is largely attributable to the increase in the average LTC–DRG relative weight per discharge and the increase in the average covered charge per discharge. The increase in the average LTC–DRG relative weight assigned to each case from FY 2002 MedPAR compared to FY 2003 MedPAR data indicates that, on average, LTCH patients are being assigned to LTC–DRGs that have a higher relative weight, and, therefore, generally receive a higher LTCH PPS payment. This results in an increase in total LTCH PPS payments system-wide. In accordance with § 412.523(d)(1), we reduce the standard Federal rate by 8 percent for the estimated proportion of LTCH PPS outlier payments. Because the average payment per discharge has increased, thereby increasing total LTCH PPS payment, the fixed-loss amount must be lowered in order to maintain total outlier payments that are projected to equal 8 percent of total payments under the LTCH PPS.

As we noted above, because the LTCH PPS has only been implemented for less than 2 years, sufficient new data have not been generated that would enable us to conduct a comprehensive analysis to determine the factors contributing to the increase in the average LTC–DRG relative weight assigned to each case. As discussed in section X. of this preamble, we intend to monitor trends in the LTCHs' Medicare payments and costs once sufficient data under the LTCH PPS has been generated. For example, we may conduct medical record reviews of LTCH Medicare patients to ensure that proper coding practices are being employed.

4. Adjustments for Special Cases

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

Generally, LTCHs, as described in section 1886(d)(1)(B)(iv) of the Act, are distinguished from other inpatient hospital settings by maintaining an average inpatient length of stay of greater than 25 days. However, LTCHs may have cases that have stays of considerably less than the average length of stay and that receive significantly less than the full course of treatment for a specific LTC–DRG. As we explained in the August 30, 2002 final rule (67 FR 55954), these cases would be paid inappropriately if the hospital were to receive the full LTC–DRG payment. Below we discuss the payment methodology for these special cases as implemented in the August 30, 2002 final rule (67 FR 56002–56010).

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

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

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

As we noted in section V.C.3. of this preamble, in the June 9, 2003 high-cost outlier final rule (68 FR 34494–34515), we revised the methodology for determining cost-to-charge ratios for acute care hospitals under the IPPS because we became aware that payment vulnerabilities existed in the previous IPPS outlier policy. As we also explained in that same final rule, because the LTCH PPS high-cost outlier and short-stay outlier policies are modeled after the outlier policy in the IPPS, we believe they were susceptible to the same payment vulnerabilities and, therefore, merited revision. Consistent with the policy established for acute care hospitals under the IPPS at § 412.84(i) and (m) in the June 9, 2003 high-cost outlier final rule (68 FR 34515), and similar to the policy change described above for LTCH PPS high-cost outlier payments at § 412.525(a)(4)(ii), we established under § 412.529(c)(5)(ii) that for discharges on or after August 8, 2003, short-stay outlier payments are subject to the provisions in the regulations at § 412.84(i)(1), (i)(3) and (i)(4), and (m). In addition, short-stay outlier payments are subject to the provisions in the regulations at § 412.84(i)(2) for discharges on or after October 1, 2003 in accordance with § 412.529(c)(5)(iii). Therefore, in the June 9, 2003 high-cost outlier final rule (68 FR 34508–34513), under § 412.529(c)(5)(ii), by cross-referencing § 412.84(i)(2), we established that fiscal intermediaries will use either the most recent settled cost report or the most recent tentative settled cost report, whichever is from the later period, in determining a LTCH's cost-to-charge ratio.

In addition, by cross-referencing § 412.84(i), we established that the applicable statewide average cost-to-charge ratio is only applied when a LTCH's cost-to-charge ratio exceeds the ceiling. Thus, the applicable statewide average cost-to-charge ratio is no longer applied when a LTCH's cost-to-charge ratio falls below the floor. Furthermore, by cross-referencing § 412.84(i)(4), we established that any reconciliation of payments for short-stay outliers may be made upon cost report settlement to account for differences between the estimated cost-to-charge ratio and the actual cost-to-charge ratio for the period during which the discharge occurs. As noted in the discussion of the high-cost outlier policy in section V.C.3. of this preamble, the instructions for implementing these regulations are discussed in further detail in Program Memorandum Transmittal A–03–058.

In the June 6, 2003 final rule (68 FR 34146–34148), for certain hospitals that qualify as LTCHs under section 1886(d)(1)(B)(iv)(II) of the Act (''subclause (II)'' LTCHs) as added by section 4417(b) of Public Law 105–33, and implemented in § 412.23(e)(2)(ii), we established a temporary adjustment to the short-stay outlier policy during the 5-year transition period. Under § 412.529(c)(4), effective for discharges from a ''subclause (II)'' LTCH occurring on or after July 1, 2003, the short-stay outlier percentage is 195 percent during the first year of the hospital's 5-year transition. For the second cost reporting period, the short-stay outlier percentage is 193 percent; for the third cost reporting period, the percentage is 165 percent; for the fourth cost reporting period, the percentage is 136 percent; and for the final cost reporting period of the 5-year transition (and future cost reporting periods), the short-stay outlier percentage is 120 percent, that is, the same as it is for all other LTCHs under the LTCH PPS.

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

As we stated in that same final rule, we also expect that during this 5-year period, ''subclause (II)'' LTCHs will make every attempt to adopt the type of efficiency enhancing policies that generally result from the implementation of prospective payment systems in other health care settings. We did not propose any changes to the short-stay outlier policy in the January 30, 2004 proposed rule (69 FR 4768). We received no comments on the existing short-stay outlier policy at § 412.529.

c. *Extension of the interrupted stay policy.* At existing § 412.531(a), we define an ''interruption of a stay'' as a stay at a LTCH during which a Medicare inpatient is transferred upon discharge to an acute care hospital, an IRF, or a SNF for treatment or services that are not available in the LTCH and returns to the same LTCH within applicable fixed-day periods. (We also include transfers to swing beds under this interrupted stay policy for LTCH payment policy determinations, consistent with the SNF PPS payment policy. That is, a readmission to a LTCH from post-hospital SNF care being provided in a swing bed that is located either in the LTCH itself or in another onsite Medicare provider has the same policy consequence as a readmission to the LTCH from an onsite SNF (June 6, 2003, 68 FR 34149).)

As defined in the previous paragraph, an interrupted stay is treated as one discharge from the LTCH. The day-count of the applicable fixed-day period of an interrupted stay begins on the day of discharge from the LTCH (which is also the day of admission to the other site of care). For a discharge to an acute care hospital, the applicable fixed-day

period is 9 days, for an IRF, 27 days, and for a SNF 45 days. The counting of the days begins on the day of discharge from the LTCH and ends on the 9th, 27th, or 45th day for an acute care hospital, an IRF, or a SNF, respectively, after the discharge.

If the patient is readmitted to the LTCH within the fixed-day threshold, return to the LTCH is considered part of the first admission and only a single LTCH PPS payment will be made. For example, if a LTCH patient is discharged to an acute hospital and is readmitted to the LTCH on any day up to and including the 9th day following the original day of discharge from the LTCH, one LTC–DRG payment will be made. If the patient is readmitted to the LTCH from the acute care hospital on the 10th day after the original discharge or later, Medicare will pay for the second admission as a separate stay with an additional LTC–DRG assignment. In implementing this policy, we provide that, in the event a Medicare inpatient is discharged from a LTCH and is readmitted and the stay qualifies as an interrupted stay, the provider must cancel the claim generated by the original stay in the LTCH and submit one claim for the entire stay. (For further details, see Medicare Program Memorandum Transmittal A–02–093, September 2002.)

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

When we introduced the interrupted stay policy for LTCHs in the August 30, 2002 final rule (67 FR 56002–56006), we noted that we would consider expanding or revising the policy based on information received from the provider community or information gained from our ongoing monitoring activities. During the first year of the LTCH PPS, it has come to our attention, from both of these sources, that certain LTCHs are discharging patients during the course of their treatment for the sole purpose of receiving specific tests or procedures from another facility (that should have been furnished under arrangements by the LTCHs), and then readmitting the patient to the LTCH following the administration of the test or procedure. In other words, these patients do not stop receiving medical care that must be considered LTCH inpatient services during the period between their discharge from and readmission to the LTCH. On the contrary, they continue to receive care, often of a highly specialized type, from the other facility before being readmitted for further inpatient care at the LTCH. This sequence of care suggests that the original discharge from the LTCH may be motivated by financial considerations rather than by clinical judgment and, therefore, would be inappropriate.

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

If a LTCH obtains, from another facility ''under arrangements,'' a specific test or procedure for one of its inpatients that is not available on the LTCH's premises, as contemplated by § 412.509, a discharge and a subsequent readmission would be unnecessary and inappropriate. This is true even if it is necessary to transport the patient to another facility to receive the arranged-for service. Furthermore, no additional claim can be submitted to Medicare by the other entity that actually furnished the test or procedure because, under § 412.509(c), the LTCH must furnish all necessary covered services to the Medicare beneficiary who is an inpatient of the hospital either directly or under arrangements. In this situation, generally, the LTCH would include the medically necessary test or procedure on its patient claim to Medicare (which could have an effect on the assignment of the LTC–DRG and thus the Medicare payment to the LTCH) and the LTCH would be responsible for paying the provider directly for the test or procedure.

Patient discharges from the LTCH for tests or procedures that should have been provided under arrangements, followed by LTCH readmission, result in an inappropriate increase in Medicare costs in three ways:

First, the Medicare payment associated with the LTC–DRG that would be assigned to the patient's stay will typically already include the costs of the test or procedure. (The August 30, 2002 LTCH PPS final rule (67 FR 55977–55985), includes an in-depth description of the derivation of LTC–DRGs from ICD–9–CM codes on Medicare claims and a discussion of the development and calculation of LTC–DRG relative weights.) Second, the intervening provider will bill Medicare separately for the test or procedure. Thus, if services that should have been furnished directly or under arrangements by the LTCH are instead unbundled and billed separately, Medicare would pay the other provider for the service that should have been paid for ''under arrangements'' by the LTCH under § 412.509.

Third, a discharge for outpatient services and a subsequent readmission to the LTCH is not currently covered under the interrupted stay policy at existing § 412.531. Section 412.531(a) only includes discharges from a LTCH to an acute care hospital, an IRF, and a SNF for treatment or services not available in the LTCH and subsequent readmission to the same LTCH. If a patient is discharged and readmitted to the LTCH following an outpatient test or procedure, under current policy, after making a LTCH PPS payment for the first discharge, there would be a second Medicare payment to the LTCH when the patient is finally discharged.

In the January 30, 2004 proposed rule (69 FR 4769–4770), in order to address these concerns, we proposed to revise the definition of an interruption of a stay under § 412.531 to add situations in which a patient is discharged from the LTCH and readmitted to the same LTCH within 3 days of the discharge (revised § 412.531(a)(1)). We believe that if a patient is discharged from a LTCH for any reason to an acute care hospital, IRF, SNF, or home, and is then readmitted within 3 days, in general, the patient's original admitting diagnoses would not change significantly during those 3 days. Therefore, a readmission would not constitute a new episode of care. We questioned whether a patient

who was discharged home and then returned to the same LTCH within 3 days should have been discharged in the first place. Since LTCHs are designed to treat patients with a high level of acuity and multicomorbidities, we believed that a 3-day period was a reasonable window during which necessary offsite medical care might be delivered, under arrangements, as contemplated under § 412.509, without an appreciable change in the original admitting diagnoses. Moreover, this 3-day period is consistent with the policy under the IRF PPS under which the maximum period of time that a patient could be away from the IRF is 3 days before a new patient assessment is required. Therefore, under our proposal, if a patient were discharged on Monday to an acute care hospital, IRF, SNF, or home, and readmitted either on that Monday (the first day), Tuesday (the second day), or Wednesday (the third day), the subsequent readmission would not be considered a new admission and Medicare would pay the LTCH for only one discharge based on the combined length of stay for the period prior to, during, and after the absence from the LTCH. If a patient was readmitted to the LTCH at any time after Wednesday, (the third day), the 3-day interrupted stay policy would no longer be relevant and Medicare payments would be governed by the existing interrupted stay policy. Therefore, if following discharge from a LTCH, and treatment or services as an inpatient at an acute care hospital, IRF, or SNF for greater than 3-days, but less than the interrupted stay threshold for that provider type (9 days for an acute care hospital, 27 days for an IRF, 45 days for a SNF), when the patient is readmitted to the LTCH, only one payment would be made to the LTCH, but the intervening provider may also submit a Medicare claim for that patient. Moreover, if the patient's stay at the intervening provider exceeds the threshold, a readmission to the LTCH will be counted as a new stay for each provider, as noted above, a readmission to the LTCH will be counted as a new stay pursuant to § 412.531(a)(1). We reiterate that the provisions of the proposed 3-day or less interrupted stay policy would be only applicable for patients who are discharged from a LTCH to an acute care hospital, IRF, SNF, or home, and then are readmitted to the LTCH within 1, 2, or 3 days. After that point, when the interruption exceeds 3 days, but less than the fixed period threshold in the original interrupted stay policy, a separate payment will be made to the intervening facility under the appropriate PPS, but one payment would be made to the LTCH for one episode of care. We will hereafter refer to the original interruption of stay policy as ''the greater than 3-day interruption of stay''. This clarified and renamed policy, from day 4 forward, under revised § 412.531(a)(2), and the counting of days would begin on the first day of admission to the intervening provider (but not at day 4) for purposes of determining whether or not the episode is actually one LTCH stay with an interruption within the 9, 27, or 45 day threshold, or two separate LTCH stays that would be occasioned by a stay in excess of the applicable thresholds.

An example of when the proposed 3-day or less interrupted stay policy would govern is as follows: if a LTCH patient is discharged from the LTCH to an acute care hospital, stays at the acute care hospital for 3 days and then returns to the LTCH by midnight of the 3 days, Medicare would pay one LTC–DRG payment to the LTCH and the LTCH would be responsible for paying the acute care hospital for the costs of the tests which should have been provided under arrangements by the LTCH. In this case, the proposed payment policy was dictated by the presumption that the discharge to the acute care hospital was not warranted, but services should be provided to the LTCH patient under arrangements if the patient needed to be readmitted to the LTCH within 3 days of being discharged.

An example of when the existing greater than 3-day interruption of stay governs is as follows: A LTCH patient is discharged from the LTCH and admitted directly to an IRF where the patient remains for 16 days prior to being readmitted to the LTCH for further care. The interrupted stay threshold for IRFs is 27 days and since the stay at the IRF is within the 27 day threshold, both stays at the LTCH will be paid as one discharge under the LTCH PPS and Medicare will pay the IRF for the patient's treatment under the IRF PPS for days 1 through 16. In this case, payment policy is dictated by the presumption that the hospitalization at the intervening site was appropriate because the patient required treatment at the IRF for a number of days significantly in excess of 3 days, as specified in the less than 3-day interruption of stay policy. But the patient's readmission to the LTCH prior to reaching the 27 day threshold means that it is being paid as a continuation of the original hospitalization.

An example of a situation not governed by either of the interrupted stay policies is as follows: a LTCH patient is discharged to an acute care hospital and remains under treatment for 12 days (the greater than 3-day interrupted stay threshold for acute care hospitals is 9 days) prior to being readmitted to the LTCH. In this case, Medicare will pay the acute care hospital under the IPPS and the patient's readmission to the LTCH will be paid separately as a second bona fide admission. In this case, treatment at the acute care hospital is being paid under the IPPS and because the number of days away from the LTCH exceed the fixed threshold of 9 days under the greater than 3-day interruption of stay policy, the second admission is being seen as a separate episode of care. (§ 412.531(b)(4))

Under the proposed revision of the interruption of stay policy for LTCHs in the January 2004 proposed rule, we stated that any treatment or medical services furnished to the individual during the 3-day (or less) absence from the LTCH could not be billed separately to the Medicare program or to the beneficiary, but would be paid as ''under arrangements'' services to the LTCH. When we established the LTCH PPS (67 FR 55954, August 30, 2002), we calculated payments under the LTCH PPS using base year costs that include the numerous tests and procedures typical of the complicated medical conditions that characterize LTCH patients, including those furnished by other providers in order to satisfy the statutory requirements under section 123 of Public Law 106–113, for budget neutrality. Therefore, we believed that a readmission to the LTCH that triggers the 3-day or less interrupted stay policy should be treated as a continuation of the episode of care that occasioned the first admission. Further, we believe that the readmission to the LTCH within 3 days establishes the presumption that any treatment or services furnished during the intervening 3 (or less) days should have been provided by the LTCH ''either directly or under arrangements'' (§ 412.509(b)). The entire stay would generate one LTC–DRG payment under the LTCH PPS, which would be ''payment in full for all inpatient hospital services, as defined in § 409.10.'' (§ 412.509(a)) Under § 409.10(a) inpatient hospital services means the following services furnished to an inpatient of a qualified hospital: (1) Bed and board; (2) nursing services and other related services; (3) use of hospital or CAH facilities; (4) medical social services; (5) drugs, biologicals, supplies, appliances, and equipment; (6) certain other diagnostic or therapeutic services; (7) medical or surgical services provided by certain interns or residents-

in-training; and (8) transportation services, including transport by ambulance.

As explained above, we proposed that a readmittance to the LTCH within 3 days after a discharge will result in one LTC–DRG payment for the entire stay. Since we are treating both, the stay at the LTCH that occurred before and after the discharge to the intervening provider, parts of the stay as one episode of care, we proposed that treatment or care provided during the ''interruption'' would be considered to have occurred during that single episode of care and that payment for such services are included in the LTC–DRG payment. We also proposed to include the days of the 3-day or less interruption of stay in counting LTCH days to determine the total length of stay of the patient at the LTCH if medical treatment or care were provided during the 3 days or less because these services would be considered to have been paid for as part of the total LTCH stay (§ 412.531(b)(1)(iii)). Furthermore, we proposed that if a patient is discharged home, and within a 3-day or less period received no additional medical treatment or service, but is readmitted to the LTCH, the days away from the LTCH would not be included in the length of stay calculation.

We also proposed that this policy would be applicable to all services or procedures provided to the patient either under Medicare Part A, or Part B, except for the services which are expressly excluded from bundling under section 1886(a)(1)(H)(i) of the Act and § 411.15(m), such as services furnished by physicians under § 415.102(a) and other specific health professionals. Failure to comply with this bundling requirement could lead to sanctions such as termination of the LTCH's Medicare provider agreement or civil money penalties (under section 1866(a)(1)(H)(i) of the Act).

Although we understand that, in good faith, a patient could be discharged from a LTCH, return home for a day or two, experience a setback, and then be readmitted to the LTCH, we believe that this type of a readmission to the LTCH must be considered an extension of the original hospitalization and that Medicare will not pay for two claims for what was, in effect, one episode of care. The 3-day or less interrupted stay policy takes into account the profile of most LTCH patients, as typically very sick individuals with multicomorbidities. We believe that it is reasonable to presume that if this type of patient is discharged and then readmitted to a LTCH within 3 days, the readmission signifies a continuation of the original hospital stay and not a new episode of care. Furthermore, we are concerned about reports of LTCHs discharging and readmitting patients who are still undergoing active treatment rather than obtaining services for these patients ''under arrangements'' in accordance with section 1862(a)(14) of the Act and the regulations at § 412.509.

In the January 2004 proposed rule, we indicated that we intend to collect data on any Medicare claims for outpatient services as well as inpatient services furnished during the time that the patients are away from the LTCH under the 3-day or less interrupted stay policy. We would review data to determine whether we will expand the 3-day time period and we will consider proposing this change in a future rule. Further, if it appears that additional patients are being discharged for the purpose of receiving tests or procedures at other Medicare settings, and then readmitted to the LTCH, in order for the LTCH to avoid paying for the procedure ''under arrangements,'' we may find it appropriate for our Quality Improvement Organizations (QIO) to evaluate the medical basis for the original discharge. A patient discharge that is not clinically justifiable could constitute potential violation of the LTCH's conditions of participation in the Medicare program for inadequate discharge planning or an inappropriate discharge from the LTCH under § 482.43. Moreover, as noted above, if a separate bill is submitted by an entity other than the LTCH for services furnished during this period, this could also be a violation of the LTCH's provider agreement obligation regarding bundled services.

In proposing the policy in the January 2004 proposed rule, we did not attempt to restrict a LTCH from pursuing necessary or more appropriate clinical care from another facility. As we designed the PPS for LTCHs, the original interrupted stay policy was created for situations where sound clinical judgment could suggest a different treatment setting for LTCH patients: A patient requiring emergency surgery at an acute care hospital; a patient who would appear to benefit from a specific therapy regimen at an IRF; or a patient who had improved and, therefore, could be appropriately cared for at a SNF. The policy accounted for a readmission to the LTCH after the emergency care or in the event of a change in the patient's condition, that is, for sound clinical reasons. Fundamentally, the original interrupted stay policy resulted from our determination to allow considerable latitude to medical personnel in this regard without untoward payment consequences for the Medicare program.

We proposed a revision to the existing interrupted stay policy because we believed that 3 days in most instances represents an appropriate interval for establishing whether or not the reason for the patient's readmission is directly connected to the original episode of care and whether or not Medicare-covered services were obtained during the interruption that should have otherwise been provided ''under arrangements'' by the LTCH.

All inpatient services, under Medicare, fall within the purview of the requirement of section 1862(a)(14) of the Act, and, therefore, what we stated was not a departure from existing policy. Under section 1862(a)(14) of the Act, notwithstanding any other provision of this title, ''no payment may be made under Part A or Part B for any expenses incurred for items or services which are other than physicians' services (as defined in regulations promulgated specifically for purposes of this paragraph), services described by section 1861(s)(2)(K) of the Act (certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist) and which are furnished to an individual who is a patient of a hospital or critical access hospital by an entity other than the hospital or critical access hospital unless the services are furnished under arrangements (as defined in section 1861(w)(1) of the Act with the entity made by the hospital or critical access hospital.'' Section 1861(w)(1) of the Act states that ''[t]he term ''arrangements'' is limited to arrangements under which receipt of payment by the hospital, critical access hospital, skilled nursing facility, home health agency, or hospice program (whether in its own right or as agent), for services for which an individual is entitled to have payment made under this title, discharges the liability of such individual or any other person to pay for the services.'' We believe the objective of these statutory provisions, which were implemented for inpatient acute care hospitals in regulations at § 411.15(m) and subsequently at § 412.509 for LTCHs, was to discharge financial liability for inpatients who may have received additional care off-premises and to assign payment responsibility for the care to the hospital that is being paid for that beneficiary's total care for that spell of illness. The total care delivered by the hospital may be provided ''directly'' or ''under arrangements'' with other facilities (§ 412.509(c)) and was included in Medicare's payment to the hospital.

Over the years, we have often referred to this as the ''prohibition against unbundling'' for purposes of emphasizing that if a Medicare provider ''unbundles'' specific components of a beneficiary's total inpatient care (provided either ''directly'' or ''under arrangements'') and sends separate claims to Medicare for those tests or treatments, the provider would be acting in violation of the statute and applicable regulations. Since LTCHs treat patients with multicomorbidities who are often in need of a wide range of diagnostic and treatment modalities and lengthy hospitalizations, we believe that in this particular setting, this statutory requirement is particularly vulnerable to gaming. For that reason, we proposed to clarify the existing general unbundling prohibition and to propose specific language on the unbundling prohibition as it applies to the interrupted stay policy under the LTCH PPS and proposed to codify it in regulations. As noted above, we were concerned that LTCH patients, under active treatment, are being inappropriately discharged to other treatment sites, receiving tests or procedures related to one of the diagnoses the patient being hospitalized and which otherwise should have been provided at the LTCH either directly or under arrangements under § 412.509 and then readmitted to the LTCH. Another claim is also being submitted to Medicare by the other treatment site for those tests or procedures. As stated earlier, under the LTCH PPS, payments associated with specific LTC–DRGs include all costs associated with rendering care to the type of patients treated in LTCHs and, therefore, additional Medicare payments for such services would be inappropriate.

We noted in the proposed rule that we understand that during a particular hospitalization, a typical LTCH patient, with multicomorbidities, could suddenly require emergency care at an acute care hospital. This would be the case, for example, if a patient who was admitted to the LTCH with a principal diagnosis of chronic obstructive pulmonary disease and respirator dependence, with secondary diagnoses of hypertension, Type II diabetes mellitus, history of coronary artery disease, and history of bladder cancer suddenly exhibits symptoms consistent with a pneumothorax (lung collapse) and requires treatment that is beyond the scope of the LTCH. Services obtained at an acute care hospital, under the proposed 3-day or less policy, would be considered related to the original diagnoses, and submission of a separate claim by the acute hospital is considered a violation of the unbundling requirement established by section 1862(a)(14) of the Act. Payment to the acute hospital for any services delivered would be the responsibility of the LTCH since the critical episode was directly related to the hospitalization at the LTCH. Conversely, if the same patient had instead suddenly suffered a myocardial infarction (heart attack) that requires a cardiac workup, evaluation, and possible implantation of a cardiac stent, it may be appropriate to discharge this patient for admission to an acute care facility for appropriate evaluation and the invasive cardiac procedure. Under these circumstances, the admission to the acute hospital was totally unrelated to the patient's diagnoses in the LTCH and arguably there may be no need to bundle the services. A discharge from the LTCH and a readmission following the procedure at the acute hospital in order to resume the treatment provided by the LTCH, for which the patient was originally hospitalized, could be entirely appropriate. (Notwithstanding the necessity of the discharge, under the 3-day or less interrupted stay policy, there would be no additional separate LTC–DRG payment generated to the LTCH if the patient returns to the LTCH within the 3-day period.) We also noted in the proposed rule that it could be argued that in this type of a subsequent admission to the acute hospital, the acute care hospital should be able to submit a claim to Medicare for the procedure. (This payment to the acute hospital may be subject to the postacute care policy at § 412.4, depending upon the DRG to which it is assigned (68 FR 45404 and 45412, August 1, 2003).)

We stated that we were aware that there could be exceptions, and that in the example cited above, sound medical judgment could have dictated that the patient who needed the cardiac stent should first be discharged to the acute hospital and then readmitted to the LTCH within 3-days in order to continue necessary treatment at the LTCH. In such a case, notwithstanding our 3-day interrupted stay policy, it would be arguable that the implantation of the cardiac stent did not fall within the category of services that should be paid for by the LTCH under arrangements, and that the acute hospital should be able to submit a claim to Medicare.

Accordingly, while arguably it may be appropriate to attempt to limit the unbundling requirement that services be provided under arrangement to those that are ''related'' to the admitting diagnoses of the LTCH patient, we did not propose a methodology that would be both administratively feasible and not subject to gaming, given the multiple comorbidities typical of LTCH patients. The prospective payment system for this particular setting was designed to capture all costs associated with treating these highly complicated cases, and we believed that it would be difficult to distinguish whether a particular critical episode could be seen as arising from one of the patient's many medical conditions for which the patient is presently at the LTCH. Therefore, in the January 2004 proposed rule, we solicited comments and suggestions that were consistent with the stated policy goals described above and that would be administratively feasible. We understood that any policy adopted would need to be issued with detailed instructions to fiscal intermediaries on implementation procedures to ensure a correct and consistent interpretation of our policy objectives.

Comment: We received a comment from a LTCH chain fully endorsing the proposed 3-day interrupted stay policy.

Response: We thank the commenter for supporting the proposed policy. In order to address the essential issues raised in the proposed rule, while taking into account legitimate concerns raised by the LTCH community in public comment, we are making certain modifications to the final policy. Under this final rule, if a LTCH discharges a patient to an acute care hospital, an IRF, SNF, or home for 3 days or less and the patient returns to the same LTCH within 3 days, Medicare will make only one LTC–DRG payment to the LTCH, as the stay is paid as a single episode of care. In addition, we will make no separate payment to the intervening acute care hospital, IRF, SNF, or in the case of a beneficiary who is discharged home and who receives outpatient treatment from an acute care hospital or an IRF for medical care or services provided to the LTCH patient during the 3-day or less interrupted stay. Payments for tests, treatments, or procedures provided to the LTCH patient during the ''interruption'' at an outpatient hospital setting or for treatment or care as an inpatient at an acute hospital, IRF, or SNF would be the responsibility of the LTCH as services provided ''under arrangements'(§ 412.509(b) and (c)). Furthermore, this policy also governs if the LTCH patient receives care or treatment at more than one of these intervening sites during the 3-day or less period, that is, this policy applies if the patient is discharged from the LTCH on Monday morning, and on Monday afternoon receives an MRI at an outpatient department of an acute care

hospital then is admitted as an inpatient to the acute care hospital on Monday evening and finally is discharged home on Tuesday morning and readmitted to the LTCH on Wednesday. In response to several comments, which we will discuss in detail below, we have decided to establish a exception in this general 3-day or less rule for the 2005 LTCH PPS rate year to the payment policy discussed above in the event that during an up to 3-day interruption, a LTCH patient receives treatment in an acute care hospital that results in the case being grouped to a surgical DRG. For this limited instance we will allow the acute hospital to bill separately for the discharge that is grouped to a surgical DRG. During the 2005 LTCH PPS rate year, we will gather data on the impact of this exception in order to evaluate, among other effects, the frequency of this scenario during a 3-day interrupted stay at a LTCH, as well as what surgical DRGs are actually represented. Depending upon what information the data reveals, we may decide to propose to continue this exception or to propose appropriate policy revisions.

Therefore, the policy that we are finalizing in this final rule differs from our proposed policy. We had originally proposed that no payment would be made to intervening providers during a 3-day or less interruption in stay, but in this final rule, we are now providing a 1-year exception in the event that inpatient care provided at an acute care hospital is grouped to a surgical DRG. Under this finalized policy, where the LTCH is required to pay for care during any days of the 3-day or less interruption, all days of the 3-day or less interruption that the patient is away from the LTCH will be included in that patient's day count at the LTCH. If the LTCH patient goes home during the interruption and receives no additional medical care prior to being readmitted to the LTCH, the intervening days will not be included in the day count because the LTCH did not deliver any services to the patient during those days either directly or ''under arrangement''.

In the proposed rule, we proposed that outpatient services provided during the 3-day or less interruption of stay were considered to be part of the LTCH episode of care and, thus, are considered to be provided ''under arrangements.'' We believe that our reference to outpatient services, tests, or procedures could have been clearer. So we are taking this opportunity to clarify, to the extent it was not already clear, that our policy applies to outpatient services provided in acute care hospitals and IRFs (these two sites of care were cited in our proposed rule). SNFs, which were also mentioned in the proposed rule, do not provide outpatient care and, thus, are excluded from the outpatient reference. We note that we are clarifying this at § 412.531.

We have reviewed the proposed § 412.531 and determined that it can be simplified and clarified so that it is less cumbersome to understand and more clearly describes the division of the original interrupted stay policy into a ''3-days or less interruption of stay'' and a ''greater than 3-day interruption of stay.'' Thus, we have made significant revisions to the regulations text in an effort to accomplish this goal. Please note that the revised ''interruption of stay'' regulations text is not substantively different than the proposed interrupted stay regulations text, (except for the case of where, after further review and consideration of public comment, we have made an exception to our proposed policy for care grouped to a surgical DRG under the IPPS for the 2005 LTCH rate. We are providing, in this final rule, that under these unique circumstances, the intervening acute care hospital gets a separate Medicare payment). Consequently, we have replaced the general term ''interruption of stay'' with two definitions that reflect the division of our original policy into two specific concepts (3-days or less and greater than 3-days), as well as make conforming terminology changes throughout the section. Among other things, we have also more concisely outlined the method for determining the length of stay of the patient at a LTCH if the patient does not receive inpatient or outpatient medical care or treatment provided by an acute care hospital or IRF, or SNF services, during a 3-day or less interruption of stay. Moreover, we provided a more clear breakdown of how a LTCH and an intervening provider will be paid during a ''3-day or less'' or ''greater than 3-day'' interrupted stay. In addition, the original term ''interruption of stay'' appears throughout the existing regulation text at § 412.525 and § 412.532. We have made conforming changes to these regulations as well to reflect the two components of the interrupted stay terminology. These conforming terminology changes in § 412.525 and § 412.532 do not affect the substantive policy of these provisions.

Over the course of the first year of implementation of the revised 3-day or less interrupted stay policy, we will study relevant claims data in order to evaluate whether further proposed refinements to this policy would be warranted in next year's rule. Specifically, we will (1) analyze new data to determine whether problems associated with LTCH interrupted stays equally affected all settings to which LTCH patients may have been discharged and subsequently readmitted; and, (2) we will closely monitor patterns of discharges and readmissions under the first year of this policy using relevant claims data as soon as they become available to determine whether further proposed changes to the policy are required to ensure that beneficiary access to medically necessary services are not compromised by creating disincentives for other providers to accept patients discharged from LTCHs.

Comment: Two commenters asserted that CMS had presented no empirical evidence to support the position that the proposed expansion of the interrupted stay policy would prevent inappropriate ''unbundling'' of treatment and services or prevent ''gaming'' the system. The commenters noted that there are already processes in place for CMS to address a compliance problem (that is, QIOs, OIG investigations, fraud and abuse action). The commenters point out that CMS should take into account the fact that some QIOs are adopting medical necessity criteria and discharge standards. Furthermore, they believed that CMS was wrong to pursue a regulatory scheme that would penalize LTCHs for appropriate discharges to acute care hospitals in lieu of actually enforcing existing regulations. One commenter encouraged CMS to ''precisely target'' those LTCHs that are found to be engaging in patient discharge and readmissions policies for financial purposes rather than for clinical benefit.

Response: In the August 30, 2002 final rule that implemented the LTCH PPS, we stated that we would consider expanding or revising the interrupted stay policy based on information received from the provider community or information gained from our ongoing monitoring sources. The LTCH PPS was implemented for LTCHs beginning with the cost reporting periods beginning on or after October 1, 2002. Therefore, some LTCHs (for example, hospitals with cost reporting periods beginning August 1, 2002) may have been subject to the LTCH PPS for less than one year. Accordingly, we have only limited specific data on the impact of behavioral changes brought about by the LTCH PPS regarding patient treatment and movement among providers. However, we relied on the best information available to us when proposing and finalizing this policy. We relied on anecdotal information from the LTCH

provider community, regional offices, and fiscal intermediaries, as well as analyses of inpatient discharge records by the CMS Office of Research, Development, and Information (ORDI). In addition, it has always been our practice to rely on information from providers, regional offices, and fiscal intermediaries in determining what policies to propose, particularly when the issues we are concerned with have an unnecessarily negative impact on Medicare program expenditures.

In addition, based on the data analysis of inpatient discharge records performed by our ORDI, we believe that there is cause for concern regarding the appropriateness of many of these stays at the acute care hospital since they are of 3 or fewer days compared to the average inpatient length of stay of approximately 5.9 days. If it typically takes, on average, 5.9 days to resolve the condition chiefly responsible for an admission to an acute care hospital, we question the legitimacy of a patient discharge from a LTCH to an acute hospital for 1, 2, or at most 3 days, followed by a readmission to the LTCH. This pattern suggests that the ''discharge'' may not be legitimate and that the patient really did not need the level of care provided in an acute care hospital as evidenced by the short stay at the acute care hospital. If the ''discharge'' was ''legitimate'', we believe the length of stay at the acute care hospital would have been more reflective of a typical stay at an acute care hospital, that is, 5.9 days and not 1, 2, or 3 days. In other words, if it normally takes 5.9 days to stabilize and resolve the underlying condition requiring the admission, then stays that are far shorter than this could reasonably suggest that the patient's condition did not rise to the level of acuity of a true acute care hospital patient and that the admission to the acute care hospital was unnecessary. In this case, the LTCH should not have discharged the patient in the first place, but rather sent the patient to the acute care hospital for needed tests or procedures and paid for them ''under arrangements''. Consequently, the 3-day interrupted stay policy is a mechanism for ensuring that LTCHs do not circumvent the required ''under arrangements'' policy by ''discharging'' patients rather than sending them for isolated services or procedures. We are trying to make clear that ''discharges'' by a LTCH followed by ''readmissions'' of the same patient to the same LTCH within a 3 day or less window are not to be viewed as true discharges. Instead, the care provided at the intervening facility is care that is really an inherent part of the single episode of care at the LTCH and should be paid for as such.

We are providing a limited exception to this policy for patients who are discharged from LTCHs, admitted as inpatients to acute care hospitals and readmitted to the same LTCHs within 3 days if the treatment that they receive at the acute care hospital is grouped to a surgical DRG during the 2005 LTCH PPS rate year. This exception is discussed in greater detail in the following response.

In this final rule, therefore, we are finalizing the policy that will disallow additional Medicare payments to an intervening provider for an episode of care that we believe should have been delivered under arrangements in conformity with existing regulations at § 412.509(b)(c).

As more data become available, we may be able to formulate specific hospital policies and rely on additional comprehensive data analysis.

As noted above, in response to the comment that we are pursuing a new regulatory scheme that penalizes LTCHs for appropriately discharging patients to other sites of care, we firmly believe that we are not penalizing LTCHs for appropriate discharges. LTCHs remain free to discharge patients to acute care hospitals, for example, for necessary medical care. Our final policy does not prevent this. Instead, our 3-day or less interrupted stay policy aims to prevent LTCHs from inappropriately discharging patients only to readmit them in a short time in order to circumvent the ''under arrangement'' policy. As previously indicated, ''under arrangements'' regulations have existed since the beginning of the Medicare program, and were certainly in effect under the TEFRA payment system for hospitals excluded from the IPPS, and continue to be in effect with the implementation of the LTCH PPS in § 412.509. Thus, providers are expected to be in continual compliance with the requirements specified in § 411.15(m) and under the LTCH PPS, in § 412.509. The finalized 3-day or less interrupted stay policy, at revised § 412.531, as described in the previous response, is definitely not a new ''regulatory scheme'' as one commenter asserts.

In response to the commenter's other assertion that there are already processes in place for dealing with non-compliance issues on an individual basis, we would agree and note that, prospectively, we also have every intention of working with QIOs, the OIG, and if necessary, pursuing fraud and abuse actions against individual LTCHs, if appropriate. We do not agree that the existence of standards of medical review are employed by QIOs, and the pursuit of legal remedies is an alternative for establishing policies that disallow unnecessary and inappropriate Medicare payments. We also want to note that while we are aware that certain of our QIOs are engaged in designing medical necessity criteria for LTCHs, we do not believe that this impacts on our responsibility to assure that LTCHs comply with existing ''under arrangement'' policies and to formulate regulations that protect the Medicare program against unnecessary and inappropriate payments. Moreover, we would also emphasize that the ''under arrangements'' policy deals with appropriate payment for services, not issues of medical judgment. The policy that we are promulgating does not prohibit a physician at a LTCH from ordering tests or procedures for a patient's benefit that cannot be provided on site at the LTCH. The policy only defines how those services will be paid for under Medicare.

Comment: Two commenters asserted that ''under arrangements'' refers to what services or procedures the LTCH (primary hospital) arranges for and controls and that if a LTCH patient is subsequently admitted to an acute care hospital, the LTCH would have no control over care that the patient may receive. A third commenter joined in the assertion that under the proposed policy, LTCHs could be subject to unlimited, uncontrolled costs during the acute care stay that would discourage readmissions to the LTCH since, under the proposed policy, the LTCH would be required to pay for the costs of services beyond those that relate to the plan of care in place when the patient was discharged from the LTCH.

Response: Our regulations at § 412.509(c) specify that ''[t]he long-term care hospital must furnish all necessary covered services to the Medicare beneficiary who is an inpatient of the hospital either directly or under arrangements * * *'' When a necessary covered service is unavailable on site at the hospital, in order to comply with the regulations as well as the statute they implement at section 1862(a)(14) of the Act, the hospital must procure the specific services elsewhere. These services would be delivered at another site under orders from the original hospital because they were deemed necessary by physicians at that location, but unavailable at that site of care. Although personnel from the original hospital would not be administering the tests or treatments that were procured ''under arrangements,'' the services would be related directly to the plan of care for

that patient. Notwithstanding a sudden non-surgical medical emergency occurring during the original test or procedure that could require personnel at the secondary site to alter the original plan of care (and which would still be delivered ''under arrangements''), we believe that the very principle of ''under arrangements'' services implies that the services have been ''arranged for'' precisely because physicians at the primary hospital determined that those services were necessary. We remained thoughtful of this principle when we examined public comments and revisited the ''under arrangements'' component of the proposed 3-day or less interrupted stay policy for the LTCH PPS. Under our finalized policy, therefore, the readmission to the LTCH within 3-days of a patient's discharge is a continuation of the original episode of care for payment purposes. In order words, ''discharges'' by an LTCH followed by a ''readmission'' to the LTCH within 3 days are not viewed as a true ''discharge''. Furthermore, treatment that the patient receives during that interruption as an inpatient or outpatient at an acute care hospital or an IRF, or any services at a SNF, will be understood as also arising from the hospitalization at the LTCH and deemed to have been delivered ''under arrangements'' as governed by § 412.509(c). After considering several of the comments we received, however, we are providing for a limited exception to the above policy that addressed a LTCH's responsibility to pay for all covered services delivered during the interruption. Specifically, we are providing that if inpatient care provided at an acute care hospital is grouped to a surgical DRG for the 2005 LTCH PPS rate year, this case will be separately reimbursed by Medicare for the period July 1, 2004 to June 30, 2005. If a patient's treatment at an acute care hospital during a 1, 2, or 3-day interruption is grouped to a surgical DRG under the acute care inpatient prospective payment system, a separate Medicare payment will be made to the acute care hospital. Based on the limited information we have regarding this specific issue, we believe that this temporary and narrow exception to the general policy that we are finalizing in this regulation is appropriate and may be understood in relation to the logic that underlies our 3-day or less interruption of stay policy. The 3-day or less interruption of stay policy described above is based on the presumption that tests and procedures delivered during a 1, 2, or 3-day interruption in a LTCH stay are an outgrowth of the patient's principal and secondary diagnoses at the LTCH, not requiring a discharge from the LTCH to another site of care, but rather delivered by the LTCH either directly or under arrangements, as required by section at section 1862(a)(14) of the Act and implemented by § 411.15(m) and § 412.509. An emergency surgical procedure may not be directly related to the patient's principle or secondary diagnoses at the LTCH, but may arguably signify a distinct episode of care. Therefore, while the two LTCH discharges will be paid as one discharge, under this limited exception, the acute care hospital will receive a separate payment from Medicare for treatment that is grouped into a surgical DRG even during a 3-day or less interruption of stay from a LTCH.

We are particularly concerned about protecting the Medicare Trust Fund against unnecessary and inappropriate patient shifting and additional Medicare payments in situations where a LTCH exists as a hospital within a hospital, under § 412.22(e) in situations where both hospitals are under common ownership. In that situation, even if the LTCH received only one discharge payment under the original interrupted stay policy, the fact that a full DRG would have been paid to the host acute care hospital (which is under common ownership with the LTCH) could have served as an incentive for decisions to be made for financial purposes rather than for clinical considerations. We are also concerned that if a LTCH patient is discharged to an acute care hospital for only 1, 2, or 3 days, followed by a readmission to the LTCH, there may be reason to believe that the treatment delivered, even if it was grouped to a surgical DRG, was not a major procedure because of the relatively short length of stay, and, therefore, should have been provided under arrangements. (Under the revised interrupted stay policy established in the August 30, 2002 final rule (67 FR 56002–56006), which we are now defining as the ''greater than 3-day interruption of stay,'' at § 412.531(a)(2)(i), we have provided for a separate DRG to be paid to the acute care hospital if the treatment in the acute care hospital requires a stay of greater than 3 days, but less than or equal to 9 days, which is what we believe would commonly be the case for a ''major'' surgical procedure.) In establishing the one-year exception for surgical DRGs, set forth above, we understand that this exception addresses only some of the concerns raised by the commenters and that we are creating a distinction between surgical and non-surgical care. We believe, however, that this temporary ''exception,'' limited to surgical DRGs, is appropriate as LTCHs specialize in the treatment of complex medical cases. While they may not be set up for a complex surgical intervention, they are generally capable of handling an unexpected medical crisis and a ''discharge'' to another site of care followed by a readmission to the LTCH within 3 days or less should be unnecessary. Furthermore, we will continue to monitor ''surgical'' hospitalizations occurring during interruptions in a LTCH stays to determine whether the distinction that we have established with this policy actually accomplishes our goals of preventing unnecessary and inappropriate Medicare payments. During the 2005 LTCH PPS rate year, we will analyze records of LTCH patients who fall within this exception, particularly focusing on the surgical DRGs to which their stays are grouped.

Comment: Several commenters assert that CMS is violating budget neutrality by broadening the scope of financial responsibility beyond what was provided ''under arrangements'' for base year rates fiscal years 1998 and 1999 and that this would distort and reduce Medicare payments to LTCHs. Two commenters were concerned that if the proposed policy was finalized, there would be a significant financial impact on the LTCH and also noted that there was not regulatory impact in the proposed rule.

Response: We want to note that under the TEFRA payment system, if a LTCH patient required tests and procedures that were unavailable at a LTCH, under section 1862(a)(14) of the Act, implemented in regulations at § 411.15(m), the statute requires that they be provided under arrangements. Thus, if a LTCH patient required tests and procedures that were unavailable at the LTCH, we assume that the LTCH had provided those services ''under arrangement'' (and did not discharge the patient to another site of care and directly admit the patient following the off-site treatment) because it is required by the statute and regulations. Consequently, we can only assume that hospitals would have included the costs of medical services procured elsewhere ''under arrangements'' in a patient's Medicare claim since under the TEFRA system, these additional costs would then have been included in the hospital target amount and would be paid for by Medicare. We disagree that our policy violates budget neutrality because LTCHs should have included these

services in their claims data which we used from 1998 and 1999 to set the base rates for the LTCH PPS. We expect that as responsible corporate entities, LTCHs take necessary steps to comply with Medicare regulations which they are required to follow through their provider agreements under 42 CFR Part 489. We presume that LTCHs, to the extent that they were following our regulations, would have included the costs of services furnished under arrangement in their cost reports and, if they failed to do so, those costs may not be reflected in the base rates.

Data from analyses of FY 2000 and CY 2002 MedPAR files were analyzed in order to track patient movement related to discharges from a LTCH and admissions to other inpatient sites, which were followed by readmission to the LTCH. If tests and procedures were being provided and paid for ''under arrangements,'' in compliance with our regulations, significant patient movement would have been uncommon. Our data indicated that in FY 2000, only 1.1 percent of all Medicare patients were readmitted to a LTCH within 3 days of a discharge (912/80,893 patients) of which less than 700 were treated in acute care hospitals during the 3-day period. Our CY 2002 data revealed that 1.0 percent of Medicare patients followed the above sequence (1,077/107,643 patients), of which 850 were treated in an acute care hospital during the 3-day interruption. We believe that this data indicates that prior to the implementation of the LTCH PPS, the vast majority of LTCHs complied with the ''under arrangements'' regulations. Therefore, since the patient was not discharged in order to procure the service, but rather remained a LTCH patient, even though the LTCH moved the patient to another site for needed tests or care, those tests or care were provided under arrangements. Accordingly, the costs of these services should have been included in the patient's Medicare claim during those years and, thus, should have been factored in when we were calculating our base rates for the LTCH PPS.

The policy that we are finalizing, as described above, therefore, requires a LTCH to cover off-site tests or medical treatment, either inpatient or outpatient, delivered at an acute care hospital or an IRF, or care at a SNF, ''under arrangements'' if the patient is readmitted to the LTCH within 3 days. We are establishing an exception if the treatment is grouped to a surgical DRG under the IPPS at an acute care hospital during the 2005 LTCH PPS rate year, under the 3-days or less interruption of stay policy. In other words, if the intervening stay is ''sandwiched'' between two LTCH stays, one LTC–DRG payment will be made by Medicare representing payment in full, as described in § 412.521(b) for the entire episode of care including costs for care delivered ''under arrangements''. We reiterate that Medicare will make a separate payment to an acute hospital for care that is grouped to a surgical DRG during a 3-day or less interruption during the 2005 LTCH PPS rate year. The policy that we are finalizing adds no greater financial responsibility for LTCHs than existed prior to the implementation of the LTCH PPS. Therefore, we do not agree that this policy will reduce payments to LTCHs in any significant way. We do not believe that the policy will have a measurable impact on payments to LTCHs and therefore we did not produce an impact analysis for this policy.

Comment: Two commenters expressed concern that the proposed policy penalizes appropriate discharges disregarding the clinical needs of patients and that patients' safety could be jeopardized. They assert that the proposed rule contains financial disincentives for a LTCH to discharge a patient to an acute care hospital, even if appropriate, and also discourages readmission of a patient discharged from an acute care hospital.

Response: We disagree with the commenters concerns that the proposed policy could have a negative impact on patient care in that a LTCH would have a significant financial disincentive to seek the most appropriate care for a patient who has developed an unrelated problem that the LTCH could not treat on premises—such as the hypothetical cardiac stent mentioned above—if the LTCH would have to pay for all necessary care at the acute care hospital ''under arrangements.'' The event that would trigger the LTCH's under arrangements financial liability would be a readmission to the LTCH within a 3-day period. Since the length of stay of the patient at the non-LTCH setting is unknown, we do not believe that the LTCH will refrain from discharging the patient for appropriate care. Although we believe that readmission for necessary care to the LTCH should be controlled by the clinical needs of the beneficiary, we understand, however, that the proposed policy could serve to discourage the LTCH from readmitting the patient that had a stay of up to 3 days at a non-LTCH site.

In response to these concerns, we have revised our 3-day interrupted stay policy. Under the revised policy, as noted above, the LTCH will be responsible for medical services obtained ''under arrangements'' during the 3-day-or-less absence from the LTCH for services provided to the patient during the interruption under the following circumstances: (1) If the treatment is an outpatient service delivered by an acute care hospital or IRF within 3 days; (2) if the patient is admitted to an acute care hospital and is grouped to a medical (but not a surgical) DRG and is readmitted within 3 days; (3) If the patient was admitted to a IRF or a SNF and then readmitted to the LTCH within 3 days. Should the patient's stay be grouped to a medical DRG at the acute care hospital, no Medicare payment would be made to the acute care hospital under the IPPS and the LTCH would report any diagnoses or procedure codes provided at the acute hospital on the patients LTCH record (which could affect the LTC–DRG to which the case is assigned for payment purposes or LTCH outlier payments). Medicare will pay the LTCH based on all of the diagnoses and procedure codes listed, including those resulting from the ''under arrangements'' care and the LTCH would pay the acute care hospital for the patient's care. If the patient's treatment at the acute care hospital is grouped into a surgical DRG during the LTCH PPS rate year, however, Medicare will generate a separate payment to the acute care hospital. (The patient's readmission to the LTCH in this circumstance may also result in the acute care hospital being paid under the post-acute transfer policy at § 412.4(c).) The patient's readmission to the LTCH, however, would still be considered as a continuation of the original stay for payment purposes, and the LTCH would not receive a second LTC–DRG payment.

We also want to emphasize that any inpatient or outpatient medical treatment at an acute care hospital or IRF or care at a SNF that otherwise should have been provided by the LTCH ''under arrangements'' that occurs during a 1, 2, or 3-day interruption, is the responsibility of the LTCH. Therefore, if the same day that a patient is discharged from the LTCH, the patient obtains an outpatient test from an acute care hospital and as a result of that test, the patient is admitted to an acute care hospital for one day and is readmitted to the LTCH on the third day, the LTCH is responsible for paying for services delivered at both sites of care.

Comment: One commenter claims that this proposed policy is both arbitrary and capricious and is based on financial

concerns rather than on clinical rationale and medical necessary.

Response: We disagree with the commenter that this policy is arbitrary and capricious and based on financial concerns rather than on clinical rationale or medical necessity. We have provided throughout this final rule, as we did in the proposed rule, our rationale for this policy in conformance with the applicable Administrative Procedures Act. We have conducted thorough examinations of the issues, and our proposed and final policies were formulated on the bases of these detailed analyses. Nothing in the 3-day interrupted stay policy prevents physicians from making appropriate medical decisions for the benefit of patients. The 3-day interrupted stay policy merely addresses how Medicare will pay for the necessary services resulting from those decisions. Thus, we believe physicians make treatment decisions on the basis of clinical judgment and medical necessity and do not let Medicare payment policy dictate the course of action that they believe to be in the best interests of their patients. The requirement for hospitals to provide all inpatient services either directly or ''under arrangements'' is not new policy. We believe that the revision of the proposed 3-day interrupted stay policy in this final rule addresses the legitimate concerns of our commenters by excepting acute surgical inpatient episodes, during the 2005 LTCH PPS rate year, from the LTCH's responsibility to pay for all medical care delivered to a LTCH patient between a discharge and a subsequent readmission to the LTCH. Although protection of the Medicare Trust Fund from inappropriate and unnecessary overpayments is important, ensuring the delivery of high quality medical care to beneficiaries, which was the rationale behind the Congress' creation of the Medicare program over three decades ago, continues to be our overriding goal. We do not believe that the interrupted stay policy that we are finalizing in this rule should have any negative affect on a LTCH's responsibility or capacity to deliver high quality medical care nor do we believe that we have established a system of financial disincentives that will lead to the compromising of beneficiary care. LTCHs have been working under the principles of ''under arrangements'' since they were established as a provider category over three decades ago. We also want to note that prospective payment systems are dynamic entities. The Congress conferred broad authority on the Secretary in section 307(b)(1) of Public Law 106–554 to design a PPS for LTCHs and permitted the Secretary to ''provide for appropriate adjustments to the long-term hospital payment system * * *'' This authority did not end with the implementation of the system on October 1, 2002 and the Secretary is exercising his discretionary authority as conferred by the statute to make these adjustments. As with PPSs, we will continue to monitor the impacts of our policies to determine whether proposed changes in the payment policy are warranted or appropriate.

Comment: One commenter claims that no other provider type is subject to a more stringent ''bundling'' rule or ''under arrangement'' rule.

Response: In response to the commenter's assertion that ''no other provider is subject to a ''more stringent'' ''bundling rule'' or ''under arrangements'' rule, we would emphasize that all providers, not just LTCHs, are required to provide all inpatient services directly or under arrangements (section 1862(a)(14) of the Act), implemented by § 411.15. This final rule is doing nothing more than forcing those providers that aren't complying with the longstanding ''under arrangements'' policy to comply with this requirement. Those providers already complying with our ''under arrangement'' regulations should feel unaffected by our 3-day or less interruption of stay policy because this policy ensures that they follow the ''under arrangement'' regulations that they are already following.

Typically, LTCHs are certified as inpatient acute care hospitals, but are excluded from the IPPS and paid under a different PPS only if they demonstrate that the patients that they treat require lengthy hospital-level care for on the average, greater than 25 days. Payments under the LTCH PPS are grouped into the same DRGs as are acute care patients under the IPPS, but are weighted to reflect the high degree of resources required to treat these severely sick patients. Therefore, notwithstanding that all providers are required to provide all inpatient services ''either directly or under arrangements'' under Medicare, we would assert that in general, LTCHs are in a position to offer ''directly'' a more comprehensive range of medical services than are other excluded hospitals. We would also remind the commenter that the responsibility for the LTCH to pay for any medical care delivered during the up to 3-day interruption is only effectuated by a readmission to the LTCH for additional treatment. This readmission, which triggers the 3-day interrupted stay policy that we are finalizing, serves to link both halves of the hospitalization (that is, the stay at the LTCH before and after the discharge to the intervening provider(s)) as one episode of hospital-level care. Since a LTCH is certified as an acute care hospital, it is reasonable that if the patient needed any additional care otherwise related to the LTCH stay that was unavailable at the LTCH, the care should have been delivered ''under arrangements,'' with no need for a patient discharge. (An exception to this policy would be if a patient received care at an acute care hospital that was grouped to a surgical DRG during the 3-days or less interruption, in which event, Medicare will make a separate payment to the acute care hospital.) Furthermore, should the patient be out of the LTCH and in an intervening acute care hospital, IRF, or SNF before being readmitted to the LTCH, beyond 3-days, but before the applicable fixed periods set forth in the greater than 3-day interruption of stay policy at § 412.531(a)(2) (that is, between 4 and 9 days at an acute care hospital, between 4 and 27 days at an IRF, or between 4 and 45 days at a SNF), we believe the discharge to the facility is bona fide. It is reasonable that a LTCH patient could require a major surgical intervention at an acute care hospital, could appear to be able to benefit from more rigorous rehabilitation at an IRF, or appear to improve to the extent that hospital-level care was no longer necessary. It is also reasonable that after a period of time, which we are establishing as greater than 3 days, after the post-operative period at the acute care hospital, the patient may require further treatment at the LTCH based on the original diagnoses, or the patient at the IRF or SNF could experience a setback and require a readmission to the LTCH. Thus, we are basing this policy on the belief that the intervening provider offered a full course of treatment or care to the patient and should receive a separate Medicare payment.

Comment: One commenter expresses concern that the proposed policy would require negotiations with acute care hospitals for payment of the ''under arrangements'' services. The commenter notes that since it is customary for a LTCH to refer patients to acute care hospitals for a variety of services, many of which are very costly and involve new pharmaceutical or technological intervention, these costs would not have been included in rate-setting for the LTCH PPS. Two commenters included a list of conditions that a LTCH might not be able to treat and that, in the best interests of the patient, might require

admission to an acute care hospital. Another commenter believes that LTCHs are designed to provide a ''higher level of post acute care, not a high level of acute care.''

Response: With regard to the commenter's concern that our policy would require negotiations between LTCHs and acute care hospitals that could theoretically put the LTCH at a disadvantage, we would reiterate that even under the TEFRA payment system, LTCHs were required to provide, and actually did provide, necessary patient care either directly or ''under arrangements.'' Moreover, our other PPSs require that necessary care be provided either directly or ''under arrangements''. Thus, negotiations among hospitals for the payment of medical care or services provided by one facility to the patient of another facility has been and continues to be a common occurrence. Compliance with this requirement presumes a relationship and, therefore, a payment arrangement with an acute care hospital usually existed even prior to the August 30, 2002 publication of the final rule (67 FR 55954) establishing the LTCH PPS and its specific ''under arrangements'' regulation at § 412.509. With regards to the commenter's concern about the responsibility for LTCHs to cover costs for ''very costly'' new pharmaceutical or technological services procured ''under arrangements'' from an acute care hospital for an LTCH patient, we would reiterate that under the TEFRA payment system, LTCHs were required to provide services ''under arrangements.'' To the extent that new pharmaceutical or technological services were provided to LTCH patients ''under arrangements'' by an acute care hospital, the LTCH was responsible for those costs and should have included them in its Medicare claim for that patient. Generally, these costs would have been included in the base rate when we developed the LTCH PPS. We do not believe that in the past this imposed a significant financial burden on LTCHs, but based on the commenter's concerns, we will monitor the effects of this policy on services involving new technologies and if necessary, will consider addressing this issue in the future. Regarding the two commenters who included a list of conditions that, in their judgment, could result in a discharge from a LTCH and an admission to an acute care hospital, some surgical diagnoses were present, in the list forwarded by the commenters. In addition, there were a number of medical diagnoses included in the commenter's list. As noted earlier, we have modified the proposed policy in this final regulation, so that where the acute stay is grouped to a surgical DRG during the 2005 LTCH PPS rate year in a 3-day or less interrupted stay, the discharge to the intervening provider would not be care provided ''under arrangements'' and the intervening acute care hospital would receive a separate Medicare payment for the care associated with the surgical DRG. In response to the medical diagnoses included by the commenters, our physicians have reviewed the list and believe that in most cases, it would be within the ability of a LTCH to treat those patients, since LTCHs are certified as acute care hospitals. In response to the LTCHs which see themselves as ''providing a higher level of post acute care, not a high level of acute care'', as noted by one of the commenters, we believe that this is an issue that we and MedPAC will continue to evaluate, to determine whether higher LTCH PPS payments are appropriate for these facilities. (We anticipate that MedPAC's June 2004 Report to the Congress, will explore this issue, among others, dealing with LTCHs.)

Comment: One of the commenters stated that the proposed expansion of the interrupted stay rule could lead to more ''gaming'' of system by large LTCH chain facilities which could likely have patients readmitted to a sister LTCH facility in order to avoid this rule.

Response: We are aware of the potential for inappropriate arrangements between closely-located LTCHs owned by the same corporation that would side-step the application of the 3-day interrupted stay policy. At the outset of the LTCH PPS, we noted that as part of our monitoring efforts for the original interrupted stay policy, we would examine patient movement among providers during an episode of care and that our data analyses could, therefore, reveal discharges and readmissions between LTCHs. As data become available, we will certainly continue to monitor the activity and we will pursue appropriate remedies if we detect this behavior.

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

In applying the 5-percent threshold, we apply one threshold for discharges and readmittances with a co-located acute care hospital. There is also a separate 5-percent threshold for all discharges and readmittances with co-located SNFs, IRFs, and psychiatric facilities. In the case of a LTCH that is co-located with an acute care hospital, an IRF, or a SNF, the interrupted stay policy at § 412.531 applies until the 5-percent threshold is reached. However, once the applicable threshold is reached, all those discharges and readmittances to the applicable site(s) for that cost reporting period are paid as one discharge pursuant to § 412.532. This means that even if a discharged LTCH Medicare patient was readmitted to the LTCH following a stay in an acute care hospital of greater than 9 days, if the facilities share a common location and the 5-percent threshold were exceeded, the subsequent discharge from the LTCH will not represent a separate hospitalization for payment purposes. Only one LTC–DRG payment will be made for all those discharges during a cost reporting period to the acute care hospital, regardless of the length of stay at the acute care hospital, that are followed by readmittances to the onsite LTCH.

Similarly, if the LTCH has exceeded its 5-percent threshold for all discharges to an onsite IRF, SNF, or psychiatric hospital or unit, with readmittances to the LTCH, the subsequent LTCH discharge for patients from any of those sites for the entire cost reporting period will not be treated as a separate discharge for Medicare payment purposes. (As under the interrupted stay policy, payment to an acute care hospital under the IPPS, to an IRF under the IRF PPS, and to a SNF under the SNF PPS, will not be affected. Payments to the psychiatric facility also will not be affected.)

5. Other Payment Adjustments

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

appropriateness of these adjustments in the future once more LTCH data become available after the LTCH PPS is implemented. Because the LTCH PPS has been implemented for less than 2 years and there is a lag-time in data availability, sufficient new data have still not yet been generated that would enable us to conduct a comprehensive reevaluation of these payment adjustments. Nonetheless, in the January 30, 2004 proposed rule (69 FR 4764), we explained that we reviewed the limited data that are available and found no evidence to support additional policy changes. Therefore, we did not propose to make any adjustments for geographic reclassification, rural location, DSH, or IME. We received no comments, and therefore, in this final rule, we are not making an adjustment for geographic reclassification, rural location, DSH, or IME at this time. However, we will continue to collect and interpret new data as they become available in the future to determine if these data support proposing any additional payment adjustments.

6. Budget Neutrality Offset to Account for the Transition Methodology

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

The standard Federal rate was determined as if all LTCHs will be paid based on 100 percent of the standard Federal rate. As stated earlier, we provide for a 5-year transition period that allows LTCHs to receive payments based partially on the reasonable cost-based methodology. In order to maintain budget neutrality as required by section 123(a)(1) of the Public Law 106–113 and § 412.523(d)(2) during the 5-year transition period, we reduce all LTCH Medicare payments (whether a LTCH elects payment based on 100 percent of the Federal rate or whether a LTCH is being paid under the transition blend methodology).

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

In the June 6, 2003 final rule (68 FR 34512), based on the best available data, we projected that a certain percentage of LTCHs would elect to be paid based on 100 percent of the standard Federal rate rather than receive payment based on the transition blend methodology. As discussed in that same final rule, using the same methodology established in the August 30, 2002 final rule (67 FR 56034), this projection was based on our estimate that either: (1) A LTCH has already elected payment based on 100 percent of the Federal rate prior to the beginning of the 2004 LTCH PPS rate year (July 1, 2003); or (2) a LTCH will receive higher payments based on 100 percent of the standard Federal rate compared to the payments they would receive under the transition blend methodology. Similarly, we projected that the remaining LTCHs would choose to be paid based on the transition blend methodology at § 412.533 because those payments would be higher than if they were paid based on 100 percent of the standard Federal rate.

In the June 6, 2003 final rule (68 FR 34513), we projected that the full effect of the remaining 4 years of the transition period, including the election option, will result in a cost to the Medicare program of $310 million. Specifically, for the 2005 LTCH PPS rate year, we estimated that the cost of the transition would be $100 million. This cost would have necessitated an estimated budget neutrality offset of 4.6 percent (0.954) for payments to LTCHs in the 2005 rate year. Furthermore, in order to maintain budget neutrality, we indicated that, in the future, we would propose a budget neutrality offset for each of the remaining years of the transition period to account for the estimated payments for the respective fiscal year.

In the January 30, 2004 proposed rule (69 FR 4773), based on the best available data at that time, we projected that approximately 69 percent of LTCHs would be paid based on 100 percent of the standard Federal rate rather than receive payment under the transition blend methodology for the 2005 LTCH PPS rate year. Using the same methodology described in the August 30, 2002 final rule (67 FR 56034), this projection, which used updated data and inflation factors, was based on our estimate that either—(1) A LTCH has already elected payment based on 100 percent of the Federal rate prior to the start of the 2005 LTCH PPS rate year (July 1, 2004); or (2) a LTCH would receive higher payments based on 100 percent of the 2005 LTCH PPS rate year standard Federal rate compared to the payments it would receive under the transition blend methodology. Similarly, we projected that the remaining 31 percent of LTCHs would choose to be paid based on the applicable transition blend methodology (as set forth under § 412.533(a)) because they would receive higher payments than if they were paid based on 100 percent of the proposed 2005 LTCH PPS rate year standard Federal rate.

In that same proposed rule, based on the best available data at that time and proposed policy revisions described in that same rule, we projected that the full effect of the remaining 4 years of the transition period (including the election option) would result in a cost to the Medicare program of $170 million as follows: $80 million in the 2005 LTCH PPS rate year; $50 million in the 2006 LTCH PPS rate year; $30 million in the 2007 LTCH PPS rate year; and $10 million in the 2008 LTCH PPS rate year.

Accordingly, using the methodology established in the August 30, 2002 final rule (67 FR 56034) based on updated data and the policies and rates discussed in the January 30, 2004 proposed rule (69 FR 4774), we proposed a 3.0 percent reduction (0.970) to all LTCHs' payments for discharges occurring on or after July 1, 2004, and through June 30, 2005, to account for the estimated cost of the transition period methodology (including the option to elect payment based on 100 percent of the Federal rate) of the $80 million for the 2005 LTCH PPS rate year.

In that same proposed rule, we explained that the proposed offset of 3.0 percent had decreased relative to the prior estimate of 4.6 percent for several reasons. Specifically, we used data from more recent cost reports and were able to obtain data from more LTCHs (211 LTCHs as compared to 194 LTCHs in the June 6, 2003 final rule). In addition, in projecting the percentage of hospitals that would elect to be paid based on 100 percent of the 2005 LTCH PPS rate year standard Federal rate, we used data from the Provider Specific File (PSF), which indicates whether a LTCH opted to be paid based on 100 percent of the standard Federal rate or the transition blend methodology for the FY 2003 LTCH PPS payment year. However, based on information obtained from the PSF, we learned that, for those LTCHs that we projected would choose payment for FY 2003 based on 100 percent of the standard Federal rate (where payment based on the full Federal rate would be expected to be higher for those LTCHs than payment under the transition blend

methodology), a significant number of those LTCHs chose to be paid under the transition blend methodology that is projected to result in payment lower than that using 100 percent of the standard Federal rate.

Similarly, a significant number of those LTCHs that we expected would choose payment under the transition blend methodology (where payment under the transition blend for those LTCHs would be expected to be higher than payment based on 100 percent of the standard Federal rate) chose to be paid using 100 percent of the standard Federal rate, which is projected to result in payment lower than that under the transition blend methodology. Since a number of LTCHs opted to be paid based on a methodology in which they would receive lower payments, we assume that the overall cost of $100 million to the Medicare program of the transition period will be less than what was projected in the June 6, 2003 final rule for the 2005 LTCH PPS rate year. Thus, in the June 6, 2003 final rule, in estimating the $100 million cost to the transition, which would have necessitated a 4.6 percent reduction to all LTCHs' payments for the 2005 LTCH PPS rate year, we overstated our assumptions of the cost of the transition period.

Accordingly, to account for the projected lower cost of the transition period due to those LTCHs that chose to be paid based on a methodology in which they would receive lower payments in FY 2003, in the January 30, 2004 proposed rule (69 FR 4773), we proposed a 3.0 percent (0.970) reduction to all LTCHs' payments during the 2005 LTCH PPS rate year. We also noted that the proposed 0.970 transition period budget neutrality factor for the 2005 LTCH PPS rate year was 3 percentage points lower than the transition period budget neutrality factor for the 2004 LTCH PPS rate year (0.940). We explained that this smaller budget neutrality offset would contribute to greater LTCH payment increases between the 2004 and 2005 LTCH PPS rate years compared to the increases seen between FY 2003 and the 2004 LTCH PPS rate year. We do not expect to see these large payments per discharge increases in future years as the majority of LTCHs will have transitioned fully to the LTCH PPS and, therefore, the transition period budget neutrality factor should remain more stable.

In this final rule, based on the updated data, using the same methodology established in the August 30, 2002 final rule (67 FR 56034), we are projecting that approximately 93 percent of LTCHs will be paid based on 100 percent of the standard Federal rate rather than receive payment under the transition blend methodology during the 2005 LTCH PPS rate year. This projection, which used updated data (including data from the PSF) is based on our estimate that either: (1) A LTCH has already elected payment based on 100 percent of the Federal rate prior to the beginning of the 2005 LTCH PPS rate year (July 1, 2004); or (2) a LTCH will receive higher payments based on 100 percent of the standard Federal rate compared to the payments they would receive under the transition blend methodology. Similarly, we project that the remaining 7 percent of LTCHs will choose to be paid based on the transition blend methodology at § 412.533 because those payments are estimated to be higher than if they were paid based on 100 percent of the standard Federal rate. The applicable transition blend percentage is applicable for a LTCH's entire cost reporting period beginning on or after October 1 (unless the LTCH elects payment based on 100 percent of the Federal rate).

We note that this projection of the percentage of LTCHs that will be paid based on 100 percent of the Federal rate rather than receive payments under the transition blend methodology during the 2005 LTCH PPS rate year is higher than our estimate of 69 percent presented in the January 30, 2004 proposed rule. For this final rule, we are using the most recent available data (claims data from the FY 2003 MedPAR files, cost report data from FYs 1999–2001, and data from the December 2003 update of the PSF) and we have obtained data for more LTCHs (239 LTCHs compared to 211 in the proposed rule.) Specifically, we used data from the PSF as of December 31, 2003, which indicates whether an LTCH has notified its fiscal intermediary that it has elected to receive LTCH PPS payments based on 100 percent of the Federal rate. Based on the information obtained from the PSF, we learned that, of the 65 out of 211 LTCHs (65/211= 31 percent) that we projected in the proposed rule would choose payment under the transition blend methodology for the 2005 LTCH PPS rate year (where payment under the transition blend for those LTCHs was expected to be higher than payment based on 100 percent of the Federal rate), 61 of those 65 LTCHs have in fact already made the election to receive payment based on 100 percent of the Federal rate, even though we had projected that this election would result in a lower payment than payment under the transition blend methodology.

Furthermore, we believe that more LTCHs have elected to receive payments based on 100 percent of the Federal rate due to an increase in estimated fully Federal LTCH PPS payments relative to decreasing reasonable cost-based payments.

Specifically, as we discussed above in section V.C.3. of this preamble, based on an analysis of LTCH claims data in the latest available MedPAR files (December 2003 update of the FY 2003 MedPAR data), we have found that the average LTC–DRG relative weight assigned to each case has increased due to a comparatively larger number of cases being assigned to LTC–DRGs with higher relative weights. This increase may be attributable to a number of factors, including improvements in coding practices, which are typically found when moving from a cost-based reimbursement system to a PPS. Increase in case-mix was also observed after the IPPS was implemented in FY 1984 for acute care hospitals. Additionally, as discussed in the article ''Long-Term Care Hospitals Under Medicare: Facility-Level Characteristics'' by Liu and Associates published in the Winter 2001 Health Care Financing Review (Volume 23, Number 2), when LTCHs received cost-based reimbursement under the TEFRA system, the cap on LTCHs' target amounts created inequities between older (existing before 1983) and newer (opening after 1983) LTCHs. Specifically, older LTCHs had relatively low target amounts compared to the newer LTCHs, and, therefore, treated relatively less complicated patients in order to keep their costs below their target amount. One of the goals in implementing the PPS for LTCHs was to provide older LTCHs an incentive to treat more complex LTCH patients. The fact that older LTCHs are no longer limited by their relative lower target amounts and are now able to treat more complex patients may be another factor which has contributed to the increase in case-mix. This increase in case-mix has resulted in an increase in projected LTCH PPS payments based on 100 percent of the Federal rate for the 2005 LTCH PPS rate year. In contrast, based on the most recent cost report data (FY 2001), the average cost per discharge appears to be decreasing for many LTCHs. Decreasing costs are also to be expected when converting from a retrospective cost-based reimbursement system to a prospective DRG-based payment system. Accordingly, our projection of the reasonable cost-based portion of the transition blend payment is based on these lower costs. The cost

per discharge could be decreasing due to better operating efficiency of the hospital, which is one of the incentives of a PPS. Thus, our projection of increasing LTCH PPS payments based on 100 percent of the Federal rate and our projection of decreasing payments based on reasonable costs may explain why a much larger number of LTCHs have in fact elected to receive payments based on 100 percent of the Federal rate despite our previous projections to the contrary. Thus, we believe that, in the 2005 LTCH PPS rate year, a larger percentage of LTCHs (larger than we estimated in the January 30, 2004 proposed rule) will elect payment based on 100 percent of the Federal rate rather than the transition blend methodology.

Based on the best available data and the final policies described in this final rule, we are projecting that in the absence of a transition period budget neutrality offset, the full effect of the remaining 4 years of the transition period (including the election option) as compared to payments as if all LTCHs wouldbe paid based on 100 percent of the Federal rate would result in a cost to the Medicare program of $29 million as follows:

LTCH PPS rate year	Estimated cost (in millions)
2005	$15
2006	10
2007	4
2008	0

We are no longer projecting a small cost for the 2008 LTCH PPS rate year (July 1, 2007 through June 30, 2008) even though some LTCH's will have a cost reporting period for the 5th year of the transition period which will be concluding in the first 3 months of the 2008 LTCH PPS rate year because as we discussed above, based on the most recent available data, we are projecting that the vast majority of LTCHs will have made the election to be paid based on 100 percent of the Federal rate rather than the transition blend.

Accordingly, using the methodology established in the August 30, 2002 final rule (67 FR 56034) based on updated data and the policies and rates discussed in this final rule, we are implementing a 0.5 percent reduction (0.995) to all LTCHs' payments for discharges occurring on or after July 1, 2004, and through June 30, 2005, to account for the estimated cost of the transition period methodology (including the option to elect payment based on 100 percent of the Federal rate) of the $15 million for the 2005 LTCH PPS rate year.

We note that the 0.5 percent transition period budget neutrality offset for the 2005 LTCH PPS rate year is lower than the proposed transition period budget neutrality offset for the 2005 LTCH PPS rate year (3.0 percent). As discussed above, we are projecting that the vast majority of LTCHs (93 percent) will be paid based on 100 percent of the Federal rate during the 2005 LTCH PPS rate year. Accordingly, as discussed above, we are projecting a much lower cost ($15 million compared to $80 million in the proposed rule) of the full effect of the transition period methodology (including the election option) for the 2005 LTCH PPS rate year.

As noted above, in order to maintain budget neutrality, we indicated that we would propose a budget neutrality offset for each of the remaining years of the transition period to account for the estimated costs for the respective LTCH PPS rate years. In this final rule, based on the best available data, we estimate the following budget neutrality offsets to LTCH PPS payments during the remaining years of the transition period: 0.4 percent (0.996) for the 2006 LTCH PPS rate year, 0.1 percent (0.999) for the 2007 LTCH PPS rate year, and 0 percent (no adjustment) for the 2008 LTCH PPS rate year. As noted above, we believe there is no longer a need for a small offset in the 2008 LTCH PPS rate year because we project that the vast majority of those LTCHs whose 5th year of the transition period will be concluding in the first 3 months of the 2008 LTCH PPS rate year will be paid based on 100 percent of the Federal rate rather than the transition blend.

As we discussed in the August 30, 2002 final rule (67 FR 56036), consistent with the statutory requirement for budget neutrality in section 123(a)(1) of Public Law 106–113, we intended that estimated aggregate payments under the LTCH PPS equal the estimated aggregate payments that would be made if the LTCH PPS were not implemented. Our methodology for estimating payments for purposes of the budget neutrality calculations uses the best available data at the time and necessarily reflect assumptions. As the LTCH PPS progresses, we are monitoring payment data and will evaluate the ultimate accuracy of the assumptions used in the budget neutrality calculations (for example, inflation factors, intensity of services provided, or behavioral response to the implementation of the LTCH PPS) described in the August 30, 2002 final rule (67 FR 56027–56037). To the extent these assumptions significantly differ from actual experience, the aggregate amount of actual payments may turn out to be significantly higher or lower than the estimates on which the budget neutrality calculations were based.

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

In the June 6, 2003 final rule (67 FR 34153), we estimated that total Medicare program payments for LTCH services over the next 5 LTCH PPS rate years would be $2.17 billion for the 2004 LTCH PPS rate year; $2.29 billion for the 2005 LTCH PPS rate year; $2.42 billion for the 2006 LTCH PPS rate year; $2.56 billion for the 2007 LTCH PPS rate year; and $2.71 billion for the 2008 LTCH PPS rate year.

In the January 30, 2004 proposed rule (69 FR 4774), based on the best available data at that time, we estimated that total Medicare program payments for LTCH services over the next 5 LTCH PPS rate years would be $2.33 billion for the 2005 LTCH PPS rate year; $2.48 billion for the 2006 LTCH PPS rate year; $2.64 billion for the 2007 LTCH PPS rate year; $2.79 billion for the 2008 LTCH PPS rate year; and $2.96 billion for the 2009 LTCH PPS rate year.

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

LTCH PPS rate year	Estimated payments ($ in billions)
2005	2.96
2006	2.98
2007	2.95
2008	3.01
2009	3.12

In accordance with the methodology established in the August 30, 2002 final rule (67 FR 56037), these estimates are based on the projection that 93 percent of LTCHs will elect to be paid based on 100 percent of the 2005 LTCH PPS rate year standard Federal rate rather than the applicable transition blend, and our

estimate of 2005 LTCH PPS rate year payments to LTCHs using our Office of the Actuary's most recent estimate of the excluded hospital with capital market basket of 3.1 percent for the 2005 LTCH PPS rate year, 3.2 percent for the 2006 and 2007 LTCH PPS rate year, 2.8 percent for the 2008 LTCH PPS rate year, and 3.1 percent for the 2009 LTCH PPS rate year. We also took into account our Office of the Actuary's projection that there will be a change in Medicare beneficiary enrollment of 1.0 percent in the 2005 LTCH PPS rate year, −4.8 percent in the 2006 LTCH PPS rate year, −6.4 percent in the 2007 LTCH PPS rate year, −1.2 percent in the 2008 LTCH PPS rate year, and 0.2 percent in the 2009 LTCH PPS rate year. (We note that our Office of the Actuary is projecting a decrease in Medicare Part A enrollment, in part, because they are projecting an increase in Medicare managed care enrollment as a result of the implementation of several provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.)

Comment: Two commenters endorsed the proposed 3.0 percent transition period budget neutrality adjustment for the 2005 LTCH PPS rate year, but expressed concern that the new data sources for determining the budget neutrality offset (that is, use of cost report data from 211 LTCHs, and the PSF) suggest an error in previous budget neutrality adjustments (for FY 2003 and the 2004 LTCH PPS rate year). The commenters asked if and how CMS plans to account for errors in past estimates, and specifically asked whether CMS would use the one-time prospective adjustment to the LTCH PPS rates (effective October 1, 2006) to account for errors in previous transition period budget neutrality adjustments.

Response: The commenters are referring to the one-time prospective adjustment at 42 CFR § 412.523(d)(3), which states that the Secretary may make a one-time prospective adjustment to the LTCH PPS rates by October 1, 2006, so that the effect of any significant difference between actual payments and estimated payments for the first year of the LTCH PPS would not be perpetuated in the LTCH PPS rates for future years. The purpose of this one-time adjustment is to ensure that ultimately, total payments under the LTCH PPS are budget neutral to what total payments would have been if the LTCH PPS were not implemented in FY 2003, by correcting for possible significant errors in CMS' calculation of the LTCH PPS standard Federal rate. However, the transition period budget neutrality offset is a separate budget neutrality adjustment. The purpose of the latter adjustment is to maintain budget neutrality during the 5-year transition period, since the standard Federal rate was determined based on the assumption that all LTCHs would be paid under 100 percent of the standard Federal rate, while some LTCHs have, in fact, elected to be paid on the transition blend methodology. The budget neutrality adjustment is intended to account for those LTCHs that elected the blend methodology and, therefore, receive higher payments under the blend methodology relative to 100 percent of the standard Federal rate.

Because the transition period budget neutrality offsets are made to all LTCHs' payments under the LTCH PPS during each year of the 5-year transition period and are not a reduction to the LTCH standard Federal rate during the 5-year transition period, any errors in past estimates would not be perpetuated in the LTCH PPS rates for future years. In fact, by the end of the 5-year transition, there will be no budget neutrality offset since all LTCHs will then be paid based on 100 percent of the standard Federal rate. Thus, the one-time prospective adjustment was not intended to address possible errors in the transition period budget neutrality offsets used during the 5-year transition period. Furthermore, while we are aware that there are some limitations in the data, as with other Medicare prospective payment systems, the data that we use to determine the rates, adjustments and other factors under the LTCH PPS, including the transition period budget neutrality offsets, are always based on the best data that we have available at the time. We would expect that the projections of the budget neutrality offsets might fluctuate somewhat from rate year to rate year as more data upon which we base our projections become available, particularly, information on whether a LTCH has actually elected payment based on 100 percent of the standard Federal rate. Accordingly, we are not planning to make an adjustment by 2006 for errors in the estimates of the transition period budget neutrality offsets used in FY 2003 or in the LTCH PPS 2004 rate year.

As we discussed in the January 30, 2004 proposed rule (69 FR 4774), because the LTCH PPS has only been implemented for less than 2 years, sufficient new data have not been generated that would enable us to conduct a comprehensive reevaluation of our budget neutrality calculations. Accordingly, we did not propose to make a one-time adjustment under § 412.523(d)(3). At this time, we still do not have sufficient new data to enable us to conduct a comprehensive reevaluation of our budget neutrality calculations. Therefore, in this final rule, we are not making a one-time adjustment under § 412.523(d)(3) so that the effect of any significant difference between actual payments and estimated payments for the first year of the LTCH PPS is not perpetuated in the PPS rates for future years. However, we will continue to collect and interpret new data as the data become available in the future to determine if such an adjustment should be proposed.

7. Changes in the Procedure for Counting Days in the Average Length of Stay Calculation

Before the implementation of the PPS for LTCHs, Medicare paid LTCHs under the reasonable cost methodology subject to limitations on payments. Both the BBRA and BIPA required the development and implementation of a per discharge PPS for LTCHs based on DRGs for cost reporting periods beginning on or after October 1, 2002 (67 FR 55954, August 30, 2002).

Under the reasonable cost-based reimbursement system, the number of patient days that occurred during a cost reporting period and the costs associated with those days were reported on the hospital's cost report (Hospital and Hospital Health Care Complex Cost Report, CMS Form 2552–96), as were the number of patient discharges that occurred during that same period. This method of reporting and reimbursement did not require that all of the days of care to a patient be counted as occurring in the cost reporting period during which the patient was discharged. Under this method of reporting and reimbursement, the days of care to a patient are counted in the cost reporting period in which they occurred.

With the FY 2003 implementation of the LTCH PPS, as in other discharge-based PPS', such as those for acute care hospitals and for IRFs, all days of the patient's stay, even those occurring prior to the cost reporting period in which the discharge occurs are counted for payment purposes as occurring in the cost reporting period of the patient's discharge. An example of this distinction is as follows: A LTCH has a January 1 through December 31 cost reporting period; a Medicare patient is admitted on December 15 and discharged on February 5, 2004. Prior to the LTCH PPS, under the reasonable cost-based reimbursement system, costs and patient days occurring in December 2003 would be included in the January 1 through December 31, 2003 cost reporting period, even though the

patient was not discharged until February of the next cost reporting period that began January 1, 2004. Those patient days occurring in January and February would be counted in the next cost reporting period (2004) in which the discharge occurred. Since the implementation of the LTCH PPS, for payment purposes, all patient days for this stay would be reported in the cost reporting period in which the discharge occurred. In the above example, therefore, all of the patient stay would be counted in the next cost reporting period, which is the 2004 cost reporting period. Even if a LTCH is transitioning into fully Federal payments and a percentage of its payments is based upon what would have been paid under the former reasonable cost-based reimbursement system, under §§ 412.500 and 412.533, payment policy is governed by the LTCH PPS. At cost report settlement, payment is discharge-based. Therefore, once a LTCH is subject to the LTCH PPS, that is, for its first cost reporting period starting on or after October 1, 2002, the ''days follow the discharge,'' which means that both days and costs are linked to the patient's discharge, even when the days occurred in a previous cost reporting period.

In the August 30, 2002 final rule (67 FR 55972), which established the policies of the LTCH PPS, we stated that ''[t]he procedure by which a LTCH will be evaluated by its fiscal intermediary to determine whether it will qualify as a LTCH... is the same procedure currently employed under the TEFRA system.'' Currently, for determining whether a hospital meets the greater than 25 day average Medicare inpatient length of stay criterion, in the case of a Medicare patient who was admitted during one cost reporting period, but was discharged in a following cost reporting period, both covered and uncovered days are counted in the cost reporting period in which they occurred and not linked to the cost reporting period in which the patient is discharged.

Therefore, presently, for a LTCH with a January 1 through December 31 cost reporting period, if a patient was admitted on December 1, 2002 and discharged on January 15, 2003, patient days would be counted one way for payment purposes and another way for purposes of counting the average length of stay. For payment purposes, all 46 days of the stay and the costs associated with them would be reported during the cost reporting period that the discharge occurred, that is, January 1, 2003 through December 31, 2003. For purposes of determining whether a hospital meets the greater than 25 day length of stay criterion, under § 412.23(e)(2)(i), however, for the same patient, the 31 days in December would be counted as occurring during the January 1, 2002 to December 31, 2002 cost reporting period and the 15 days in January 2003 would be counted, along with the discharge, during the January 1, 2003 through December 31, 2003 cost reporting period.

As we stated in the January 30, 2004 proposed rule, we had received numerous inquiries from providers and fiscal intermediaries indicating that our two different ways of counting days under the LTCH PPS for payment and for average length of stay calculations have created considerable confusion. Therefore, in response to those inquiries and consistent with the payment system already in place for LTCHs as discussed above, we proposed to revise § 412.23(e)(3)(i) of the regulations to specify that 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 in calculating the average length of stay for hospitals that qualify as LTCHs under both § 412.23(e)(2)(i) and (e)(2)(ii). We did not propose any changes to the formula of dividing the number of total days for Medicare patients by discharges for LTCHs in order to determine whether a hospital qualifies as a LTCH under § 412.23(e)(2)(i) or in the formula of dividing total days for all patients by discharges for LTCHs to qualify under § 412.23(e)(2)(ii).

In the August 1, 2003 final rule for the IPPS (68 FR 45464), we discussed the inability of the present cost report (Hospital and Hospital Health Care Complex Cost Report, CMS Form 2552–96) to capture total days for Medicare patients as required under §§ 412.23(e)(2) and (e)(3) for hospitals qualifying under § 412.23(e)(2)(i) and our present use of census data gathered from the Medicare provider analysis and review (MedPAR) files for this purpose. Prior to the October 1, 2002 implementation of the LTCH PPS, we relied on data from the most recently submitted hospital cost report in order to determine whether or not a hospital qualified as a LTCH. We will continue to utilize patient days and discharge data from MedPAR files for the qualification calculation under the revised § 412.23(e)(3)(i) until the cost reporting form is revised to capture total days for Medicare inpatients. As discussed earlier, for a hospital to qualify as a LTCH under § 412.23(e)(2)(i), it must demonstrate that the Medicare inpatients require care for an average Medicare inpatient length of stay of greater than 25 days for the hospital's most recent cost reporting period. Alternatively, for cost reporting periods beginning on or after August 5, 1997, a hospital that was first excluded from the PPS in 1986, and can demonstrate that at least 80 percent of its annual Medicare inpatient discharges in the 12-month cost reporting period ending in FY 1997 have a principal diagnosis that reflects a finding of neoplastic disease must have an average inpatient length of stay for all patients, including both Medicare and non-Medicare inpatients, of greater than 20 days (§ 412.23(e)(2)(ii)). Under the previous reasonable cost-based reimbursement system to determine whether or not a hospital met this requirement, total days for all patients were divided by the total number of discharges that occurred during a cost reporting period. When we implemented the LTCH PPS on October 1, 2002, we limited this calculation to only Medicare patients for hospitals to qualify under § 412.23(e)(2)(i), but did not change the calculation for hospitals to qualify under § 412.23(e)(2)(ii). As we noted in the August 30, 2002 final rule, ''[w]e believe that excluding non-Medicare patients in determining the average inpatient length of stay for purposes of subclause (I) would be more appropriate in identifying the hospitals that warrant exclusion under the general definition of LTCH in subclause (I). However, in enacting subclause (II), the Congress provided an exception to the general definition of LTCH under subclause (I), and we have no reason to believe that the change in methodology for determining the average inpatient length of stay would better identify the hospitals that the Congress intended to exclude under subclause (II) (67 FR 55974). These hospitals will continue to have their greater than 20 days average length of stay calculated based on all days for all patients, whether Medicare or non-Medicare patients.'' As with a subclause (I) LTCH, payments for a subclause (II) LTCH have been discharge-based since the implementation of the LTCH PPS and, therefore, for consistency, days for all patients will be counted for ALOS purposes, during the cost reporting period when those patients are discharged.

Comment: We received three comments on our proposal to change the procedure for counting days in the ALOS calculation. The commenters generally supported the proposed change provided that CMS establish exceptions for LTCHs that previously

qualified under the existing criteria, but would lose LTCH status under the new procedure. Both commenters suggested that we should allow the LTCHs to present additional data to their fiscal intermediaries indicating that the LTCHs were treating Medicare LTCH patients who had not been discharged in time to comply with the ALOS requirements computed under the new procedure before losing LTCH designation. One of these commenters suggested that only after two years of failing to meet the ''days follow the discharge'' ALOS requirement, if a LTCH lose its designation. The same commenter asked us to clarify the impact of the proposed ''days follow the discharge'' policy on our existing policy which allows a LTCH that submits 5 months of data, under § 412.23(e)(3)(ii), to retain its LTCH status.

Response: We thank the commenters for their general endorsement of the proposed policy, and we understand their concern about LTCHs that are providing long-term hospital-level care for Medicare patients losing their designation under the new procedure. We want to reassure the commenters that under § 412.22(d), even if a fiscal intermediary determined that a LTCH was not meeting the ALOS under the new procedure, hospital status changes only at the start of a cost reporting period. Accordingly, even if a determination is made that the LTCH no longer meets the greater than 25 day length of stay criteria, it may be possible for the LTCH to show that for 5 of the 6 months immediately preceding the start of the next cost reporting period it meets the length of stay criteria and, therefore, not have a break in its payment status as a LTCH.

In response to one commenter's concerns, however, we are also providing a one-year grandfathering of LTCH status for all existing LTCHs that will give each hospital an additional cost reporting period to adjust to the new methodology. Therefore, for cost reporting periods beginning on or after July 1, 2004, but before July 1, 2005, no LTCH would lose its designation if it was unable to demonstrate its compliance with the ALOS requirement (§ 412.23(e)(3)(ii)) during its first cost reporting period under the new procedure. An example of our grandfathering provision is as follows: A LTCH's cost reporting period begins on October 1, 2004 and it is informed shortly thereafter by its fiscal intermediary, that it had not met the length of stay requirement under the new computational procedure based on data from its most recent cost reporting period, and the LTCH's data from April 1, 2005 through August 30, 2005 (at least 5 of the immediately preceding 6-month period before the start of its next cost reporting period) also did not show compliance. The LTCH would not lose its designation on October 1, 2005, but would have until the end of this cost reporting period (October 1, 2005 through September 30, 2006) to comply.

In response to the commenter who questioned the impact of the ''days follow the discharge'' policy on the provider's option to submit additional data demonstrating compliance with the ALOS requirement, we believe that § 412.23(e)(3)(i) is clear. The calculation resulting in the 5 months of data that the LTCH will have to present in order to indicate compliance will be made by the same method as proposed under § 412.23(e)(3)(i) for calculating the initial data reviewed by the fiscal intermediary. This means that the LTCH would not lose its status if its submitted data indicated that by dividing the patient days that represented patients who had been discharged during those 5 months by those discharges and omitting days for patients who had not yet been discharged, the LTCH served patients with a ALOS of greater than 25 days. Therefore, we do not believe that there is any incompatibility between the requirements of § 412.23(e)(3)(i) which establishes the new procedure linking days to discharges for the ALOS calculation and the presentation of 5 months of data by the LTCH by the same method under § 412.23(e)(3)(ii). In addition, while the commenter suggests that we consider an alternate method for meeting the 25 day length of stay criteria, we believe it would be inappropriate to allow a LTCH to present alternative data for indicating its inpatient census to its fiscal intermediary in situations where the LTCH fails to comply with the discharge-based day count, if it also failed to meet the revised computational procedure. We have always been aware of concerns regarding fluctuations in discharges and patient census at LTCHs that could jeopardize LTCH status and that is why, prior to the LTCH PPS, under the TEFRA system, we delay the effect of any determination to the beginning of the hospitals' next cost reporting period and we allowed a LTCH an opportunity to present its most recent data (§ 412.23(e)(3)(ii)) to maintain LTCH status, a policy that continues under the LTCH PPS. We do not believe that in establishing the discharge-based computation, it is appropriate to allow all LTCHs time to make changes, if necessary, to assure compliance with the revised criteria. Therefore, we are also finalizing the 1-year grandfathering provision described above, which gives LTCHs additional time to adjust to the new procedure without jeopardizing LTCH status. We believe that this provision addresses the concerns of the commenter who suggested that we allow non-compliance for 2 years prior to revoking LTCH status.

Finally, we want to clarify that LTCHs that qualify as LTCHs under § 412.23(e)(2)(ii) would also be subject to this requirement. We are issuing this clarification because we discovered that although we expressly provided in our January 30, 2004 proposed rule (69 FR 4775) that the total days of a patient's stay would be reported in the cost reporting periods during which the patient is discharged in calculating the ALOS for hospitals that qualify under both § 412.23(e)(2)(i) and (ii) (and our proposed regulation text is consistent with this language), we inadvertently included preamble language that may have caused confusion about this proposed policy. We also want to clarify that in the proposed regulation text at proposed § 412.23(e)(3)(i) that our ''days follow the discharge policy'' was applicable to days involving ''* * * an admission during one cost reporting period and a discharge in a second consecutive cost reporting period * * *'' This regulation text was not as refined as the articulation of the policy in the preamble where it was stated that the policy was applicable ''if a patient's stay includes days of care furnished during two or more separate consecutive cost reporting periods.'' In other words, the days follows discharge policy is not limited to stays that occur in just 2 consecutive cost reporting periods, rather, it applies to stays that span 2 or more consecutive cost reporting periods. Thus, we are making a conforming change to the regulations text to clarify this policy. We apologize for any ambiguity in the proposed rule on this subject.

8. Clarification of the Requirements for a Satellite Facility or a Remote Location To Qualify as a LTCH and Changes to the Requirements for Certain Satellite Facilities and Remote Locations

a. *Policy Change.* In § 412.22(h)(1), we define a satellite as ''a part of a hospital that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital.'' Satellite arrangements exist when an IPPS excluded hospital is either a freestanding hospital or a hospital-within-a-hospital under § 412.22(e) that

establishes an additional location by sharing space in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital. A detailed discussion of our policies regarding Medicare payments for satellite facilities of hospitals excluded from the IPPS was set forth in the IPPS final rules published on July 30, 1999 (64 FR 41532–41534) and August 1, 2003 (67 FR 49982).

We established Medicare regulations regarding satellite facilities for several reasons. First, we believe that whenever a facility that is co-located with an acute care hospital is presented as part of another IPPS-excluded hospital, it is necessary to ensure that the facility is, in fact, organized and operated as part of the IPPS-excluded hospital and is not simply a unit of the acute hospital with which it is co-located. Although we recognize that the co-location of Medicare providers, in the form of satellite facilities, hospitals-within-hospitals, and excluded units, may have some legitimate advantages from the standpoint of clinical care as well as medical efficiency, we continue to believe that the physical proximity inherent in such arrangements also has considerable potential for Medicare program payment abuse in that it may facilitate patient shifting for reasons related to payment rather than clinical benefits. In existing regulations at § 412.22(e) for hospitals-within-hospitals (59 FR 45330, September 1, 1994), at § 412.23(h) for hospital satellites (64 FR 41532–41534, July 30, 1999 and 67 FR 49982, August 1, 2002), and § 412.25(e) for satellite facilities, we established ''separateness and control'' requirements governing the relationships between these facilities and their host hospitals.

Research by The Urban Institute on the universe of LTCHs that was used in developing the LTCH PPS pointed to the considerable growth of new LTCHs (or LTCH beds, as in the case of satellite facilities) that were co-located with other Medicare providers. Our more recent data confirm that this trend has continued. Even though our existing regulations governing hospitals-within-hospitals and satellite facilities established certain functional boundaries between these entities and their hosts, we instituted a policy under the LTCH regulations at § 412.532 to discourage inappropriate patient discharges and readmissions among co-located Medicare providers (67 FR 56007–56010, August 30, 2002). Furthermore, in the June 6, 2003 LTCH PPS final rule (68 FR 34157), we noted that we are monitoring the movement of patients among onsite providers for the purpose of determining whether we should consider proposing further changes to LTCH coverage and payment policy.

LTCH hospitals-within-hospitals and LTCH satellite facilities are similar in that both are located on the same campus or in the same building as another hospital, and many of the same separateness and control regulations exist for both types of facilities. However, there is an important distinction between them. A LTCH that is co-located with another Medicare hospital (generally an acute care hospital) is itself a distinct hospital (§ 412.22(e)). Section 412.23(e)(1) requires a LTCH to have a provider agreement as described under 42 CFR Part 489 to participate as a hospital. A satellite facility of a LTCH, like all satellite facilities of hospitals excluded from the IPPS (§ 412.22(h)), is not itself a separate hospital, but a ''part of a hospital that provides inpatient services in a building also used by another hospital * * *'' Consistent with its status as another hospital, a hospital-within-a-hospital has its own Medicare provider number. A satellite facility shares the provider number of the parent hospital.

Because a satellite facility is not considered a separate hospital under Medicare, if a LTCH with a satellite facility is interested in ''spinning off'' the satellite facility and establishing the previous satellite facility as an independent LTCH, the satellite must first be separately licensed by the State. The facility must further demonstrate compliance with the Medicare conditions of participation (COPs) under part 482 and other requirements for establishing a provider agreement under parts 482 and 489 to participate under Medicare as a hospital (§ 412.23(e)(1)). (Compliance with the COPs may be either demonstrated by a State agency survey or based on accreditation as a hospital by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO or the American Osteopathic Association (AOA) (section 1865 of the Act).) Second, if the newly established hospital meets the provider agreement requirements under 42 CFR part 489, it must demonstrate that it has an average Medicare inpatient length of stay of greater than 25 days (§ 412.23(e)(2)(i)) by providing data of a period of at least 5 months of the preceding 6-month period (§ 412.22(e)(3)(ii) and (iii)). The data used by the fiscal intermediary to calculate the average length of stay would be from discharges from the newly established hospital and not from discharges attributable to stays at the previous satellite facility for the period prior to its participation as a separate hospital.

Although we believe that these requirements, under existing § 412.23(e)(1) and (e)(2), are clear and unambiguous, we have been informed that due to misinterpretation, in some circumstances, application of this policy has been inconsistent. Therefore, some facilities operating as LTCH satellite facilities have been inappropriately granted autonomous status that has resulted in the assignment of their own Medicare provider numbers as LTCHs without first obtaining provider agreements to participate in Medicare as hospitals, under § 412.23(e)(1). Apparently, in these cases, the satellite facilities were able to demonstrate that as satellite facilities of LTCHs, Medicare patients at their location had an average length of stay of greater than 25 days, in compliance with § 412.22(h)(2)(ii) which required satellite facilities of hospitals excluded from the IPPS to comply with specific requirements for their provider category. In other situations, we understand that fiscal intermediaries correctly refused to accept data from LTCH satellite facilities for purposes of qualification as an autonomous LTCH and instead required the satellites to satisfy criteria for designation as a hospital, under § 412.23 (e)(1). In these cases, the fiscal intermediary evaluated average length of stay data dating from that hospital designation forward, as required by § 412.23(e)(2).

We believe consistency in the application of this policy is needed, in compliance with existing regulations at § 412.23(e)(1) and (e)(2). We are emphasizing that a LTCH satellite facility that is ''a part of a hospital that provides inpatient services in a building also used by another hospital * * * '' that is seeking to become an independent LTCH, must comply with the requirements set forth in the definition of a new LTCH in existing § 412.23(e)(4). Therefore, in the January 30, 2004 proposed rule (69 FR 4775–4777), we proposed to revise § 412.23(e)(4) to include a new paragraph (e)(4)(ii) that specifies that only data reflecting the average length of stay for Medicare patients in the newly established hospital will be utilized in the qualifying calculation at § 412.23(e)(2). Thus, we proposed to clarify language that emphasized that if a satellite facility is reorganized as a separately participating hospital under Medicare with or without a concurrent change of ownership, the new hospital cannot be paid under Medicare as a

LTCH until it demonstrates that it has an average Medicare inpatient length of stay in excess of 25 days based on discharges occurring on or after its effective date of participation as a hospital and not based on discharges at the satellite facility site when it was part of another hospital (§ 412.23(e)(4)(ii)).

We proposed that this policy clarification would also be applicable to remote locations of LTCHs that are being voluntarily separated from the parent LTCHs or sold and are seeking status as independent LTCHs. A remote location of a hospital (as defined at § 413.65(a)(2)) is similar to a satellite facility because it does not participate in Medicare as a separate hospital, but only as an integral and subordinate part of another hospital. However, unlike a satellite facility, a remote location is not one that is in the same building or on the same campus as another hospital. (Because a remote location has no ''host'' hospital, it is not required to meet the separateness criteria as hospitals-within-hospitals in § 412.22(e) that would arise for satellite facilities that become independent LTCHs, as discussed above.) Since the hospital would not be a LTCH until the fiscal intermediary reviews its documentation and determines that it qualifies, during those initial months, the hospital would be paid under the IPPS.

We emphasized that notwithstanding the fact that satellite facilities of LTCHs are required to independently meet the average Medicare inpatient length of stay requirement of greater than 25 days under § 412.22(h)(2)(ii)(D), we proposed to evaluate length of stay data only from discharges occurring after the facility has become a hospital. This is the case as the prerequisite to designation as a LTCH is a provider agreement under Part 489 of Chapter IV to participate *as a hospital* in the Medicare program (§ 412.23(e)(1)). The requirement that a satellite facility independently meets the length of stay criterion was never intended as an alternative method of qualifying as a separate excluded hospital. Under § 412.23(h)(2)(ii), satellite facilities of psychiatric, rehabilitation, and children's hospitals, as well as LTCHs, are required to meet specific requirements for their provider category because we believed that it was essential to ensure that satellite facilities of excluded hospitals actually delivered the specialized care for which Medicare was paying (§ 412.23(h)(2)(ii)). Furthermore, those regulations were designed to ensure that there is both an appropriate financial and administrative linkage between the satellite facility and the parent hospital, and a clear separation of the satellite facility from the host hospital. These policies are set forth in the July 30, 1999 IPPS final rule (64 FR 41534). In the case of a LTCH, we believe that our existing requirement that a satellite facility independently meet the greater than 25-day average Medicare inpatient length of stay requirement is consistent with the guiding principles of the LTCH PPS. We do not believe patients who do not require long-term hospital-level care should be admitted to either a LTCH or its satellite facility. In addition, we were concerned that, without requiring separate compliance, shorter lengths of stay at either the LTCH or its satellite facility could be balanced by longer stays at the other. By establishing these distinct standards for satellite facilities of excluded hospitals, we also wanted to safeguard against the possibility of these facilities functioning as a part of an acute care hospital. In the case of a LTCH, that result would be inconsistent with section 1886(d)(1)(B) of the Act, which provides for excluded rehabilitation and psychiatric units to be established in acute care hospitals, but not long-term care units.

There is another situation that must be distinguished from the scenario discussed above in which a LTCH is voluntarily separating from or selling its satellite facility or remote location with the intent of the satellite facility or remote location converting into an independent hospital and eventually a LTCH. Our recent provider-based regulations under § 413.65 require a remote location of a hospital that fails to meet certain requirements at § 413.65(e)(3) to seek status as a separate hospital if it is to continue functioning and being paid by Medicare. Satellite facilities of excluded hospitals, such as LTCHs, may also be affected by these new provider-based requirements and, in those cases, the following procedure would also be applicable.

Under the provider-based regulations, which became effective for the main providers as defined in § 413.65(a)(2), for cost reporting periods beginning on or after July 1, 2003, certain facilities that were formerly treated for payment purposes by Medicare as remote locations or satellite facilities of hospitals, are now precluded from continuing in that status because they do not meet the ''common service area'' location requirement for provider-based facilities under § 413.65(e)(3) (67 FR 50078, August 1, 2002). It has come to our attention that certain satellite facilities and remote locations of LTCHs are being affected by this preclusion. Due to the compulsory nature of this separation requirement, we proposed an exception for these affected satellite facilities and remote locations of LTCHs that would allow them to utilize length of stay data from the 5 months of the previous 6 months prior to when they were compelled to separate from their main provider under § 413.65(e)(3) (§ 412.23(e)(4)(iii)).

We wanted to emphasize that the only distinction between requirements under § 412.23(e)(4)(ii), for satellite facilities and remote locations that voluntarily separate from their parent LTCHs and requirements in § 412.23(e)(4)(iii) that apply to satellite facilities and remote locations compelled by provider-based location requirements at § 413.65(e)(3) to terminate their link to their main providers, is that we proposed to allow the latter group to utilize data gathered prior to establishing themselves as distinct hospitals. Furthermore, this distinction only exists for satellite facilities and remote locations of LTCHs that are affected by (§ 413.65(e)(3)) and which were in existence prior to the effective date of the provider-based location requirements (July 1, 2003). Under the regulations at § 413.65(e)(3), we did not propose to permit these entities to be established more than 35 miles from the main providers after June 30, 2003. We will assign new Medicare provider numbers to former remote locations of LTCH hospitals or satellite facilities that fail the new location requirement in § 413.65(e)(3), but want to become new LTCHs, if the following conditions were satisfied in § 412.23(e)(4)(iii):

- The facility meets all Medicare COPs in part 482 and other participation requirements set forth in 4part 489.
- The facility provides data to its fiscal intermediary indicating that during 5 of the immediate 6 months preceding its separation from the main hospital, it has independently met the greater than 25-day average length of stay requirement for its Medicare patients (§ 412.23(e)(3)).

Comment: Two commenters endorsed our codification of existing policy that requires a satellite to be certified first as an acute care hospital prior to meeting the requirements for designation as a LTCH. The commenters also endorsed the exception that we proposed to allow a satellite or remote location that must involuntarily separate from the main hospital because it failed to meet the ''common service area'' requirements under provider-based regulations to utilize ALOS data collected prior to its separation.

Response: We thank the commenters for endorsing both the basic policy and the exception. We believe that the policy that we have proposed is well within the authority given to the

Secretary under section 1886(d)(1)(B)(I) of the Act and, therefore, we are finalizing the policy, as well as the exception to the policy.

Comment: Several commenters asserted that since satellite facilities are already required to demonstrate independent compliance with ALOS provisions, CMS has the authority to allow LTCH satellites and remote locations to gain independent status as LTCHs without waiting the required time period. Furthermore, they state that there is no statutory or regulatory authority that mandates a certification waiting period. If CMS is reluctant to immediately certify satellites as LTCHs, however, they suggest it should implement the proposed policy prospectively, beginning on or after July 1, 2004. That is, this policy should not apply to LTCH satellites and remote locations that otherwise meet the requirements and that commenced the process for obtaining independent LTCH certification status prior to the effective date of this final rule. In addition, the commenters are of the opinion that an exception to the new policy should be created allowing LTCH satellite facilities and remote locations to gain immediate independent LTCH certification status if they meet the applicable requirements and have already been a part of a LTCH for at least 3 years.

Response: As we stated earlier, under § 412.22(h)(1)(ii), we have required satellites to independently meet the specific requirements related to their provider type. In establishing these regulations, our intention was to ensure that the satellite facilities of excluded hospitals were actually delivering the specialized care and indeed existed as an extension of the LTCH and not to provide alternative methodologies for qualifying as a particular category of excluded hospital. Since the satellite facilities share the same provider number as the parent hospital and are governed in all ways by that parent, it would be consistent for us to expect that the satellite facility also meets the length of stay requirement. However, as we have stated previously, if a satellite facility wishes to become an independent LTCH, we require that the satellite facility demonstrate that it meets the necessary requirements to be certified as an acute care hospital; once the satellite facility is Medicare certified, then the hospital may consider the classification requirements for becoming a ''specialty'' hospital. We are requiring satellites to undertake the same procedures that were in effect with the implementation of the IPPS by the Congress in 1983 in order to be designated as LTCHs. As one of the commenters indicated, the Secretary is not required, but nonetheless, has the statutory authority to establish this policy under section 1886(d)(1)(B)(iv)(I) of the Act. 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.'' Thus, the statute is clear that the Secretary decides how the ALOS is calculated. By virtue of the broad authority conferred on the Secretary by the statute, we published regulations at § 412.23(e) describing how the ALOS is determined as well as specifying the procedure for designation as a LTCH. Under the regulations, an entity must be certified as an acute care hospital; the hospital would receive payment under the IPPS until such time (5 out of 6 months) that meet the classification requirement as an LTCH.

In enacting these regulations, the Secretary is exercising the discretionary authority given in section 1886(d)(1)(B)(I) of the Act in permitting an exception for those satellite facilities and remote locations that are required by § 413.65(e)(3) to separate from their parent hospitals because they fail to meet certain requirements. This particular group of satellites or remote locations will be permitted to use their length of stay data from 5 months of the previous 6 months prior to when they were compelled to separate from their main provider. This is appropriate because these satellite facilities and remote locations were compelled to ''spin off'' by our provider-based regulations at § 413.65(e)(3). With respect to satellite facilities and remote locations of LTCHs that voluntarily ''spin off'', we have not been given any compelling information that would cause us to make a change to the requirements for classifying LTCHS and, thus, under the Secretary's discretionary authority to determine the methodology for calculating the ALOS, we will continue to use discharges occurring on or after the effective date of participation as a hospital for purposes of qualifying as LTCHs.

While there may have been misunderstandings in the past regarding this policy, we believe we have clarified this long-standing policy in this final rule by unambiguously stating that a satellite facility or remote location must first be considered a hospital before being classified as a LTCH. In other words, a new hospital cannot be paid as a LTCH until it demonstrates that it has an average Medicare inpatient length of stay in excess of 25 days based on discharges occurring on or after the effective date of participation as a hospital. Therefore, we do not think that it is appropriate to apply what, in fact, is existing CMS policy only ''prospectively,'' as suggested by one of the commenters, or to establish a grandfathering provision for LTCH satellites that have existed for at least 3 years.

Comment: One commenter requested that we clarify whether the proposed change to § 412.23(e)(4)(ii) applies to only ''voluntary'' separation.

Response: Section 412.23(e)(4)(ii) states that a satellite facility that voluntarily separates from its parent LTCH in order to become an independent LTCH must comply with all requirements of § 412.23(e) which includes the 6 month waiting period. However, for a satellite facility or remote location that is being forced to separate from the main hospital ''involuntarily'' due to not meeting specific provider-based requirements, there would be an exception to this policy (§ 412.23(e)(1)(iii)). Thus, to become an independent LTCH, the remote location or satellite facility would be permitted to utilize data gathered from 5 of the preceding 6 months prior to the involuntary separation. We are finalizing our clarification of this policy as well as the exception to the policy for those providers that are involuntarily separated from the main facility.

Comment: One commenter expressed concern about our proposed policy, but the concern was based on the commenter's confusion over satellites and hospitals-within-hospitals. The commenter also requested a waiver of the provider-based location requirement for a particular facility.

Response: Under § 412.22(h), a satellite facility is defined as ''a part of a hospital that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital.'' Where a satellite shares a provider number with its parent hospital and is not in itself a hospital under § 412.22(e), we define a hospital-within-a-hospital as ''* * * a hospital that occupies space in a building also used by another hospital or in one or more buildings located on the same campus as buildings used by another hospital * * *'' Regarding the commenter's request for a waiver of the provider-based location, this request is beyond the scope of this rule and, therefore, we have no comments to make. However, we would suggest that the commenter contact appropriate CMS staff to discuss the issue.

b. *Technical correction.* In the August 30, 2002 LTCH PPS final rule (67 FR 56053), we issued regulations at § 412.532(i) that require a LTCH or a satellite of a LTCH that occupies space in a building used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital and that meets the criteria of paragraphs (h)(1) through (h)(4) of § 412.532, to notify its fiscal intermediary and us, in writing, of its co-location and any changes in co-location status. In § 412.532(i), we include a cross-reference to the Medicare regulations that contain the requirements for a satellite facility to be paid under Medicare. In the January 30, 2004 proposed rule (69 FR 4777–4778), we stated that we made an unintentional error in specifying this cross-reference as paragraphs (h)(1) through (h)(4) of § 412.532. The correct cross-reference to the requirements for satellite facilities is § 412.22(h)(1) through (h)(4).

In this final rule, we are revising § 412.532(i) to include the correct cross-reference to § 412.22(h)(1) through (h)(4).

We also received several comments that discussed issues outside the scope of the LTCH PPS. Under the circumstances, we will not be responding to these comments since they are not related to the subject of this rule.

VI. Computing the Adjusted Federal Prospective Payments for the 2005 LTCH PPS Rate Year

In accordance with § 412.525 and as discussed in section V.C. of this final rule, the standard Federal rate is adjusted to account for differences in area wages by multiplying the labor-related share of the standard Federal rate by the appropriate LTCH PPS wage index (as shown in Tables 1 and 2 of the Addendum to this final rule). The standard Federal rate is also adjusted to account for the higher costs of hospitals in Alaska and Hawaii by multiplying the nonlabor-related share of the standard Federal rate by the appropriate cost-of-living factor (shown in Table I in section V.C.2. of this preamble). In the January 30, 2004 proposed rule (69 FR 4754), we proposed a standard Federal rate of $36,762.24 for the 2005 LTCH PPS rate year. In this final rule, based on the best available data and the finalized policies described in this final rule, we are establishing a standard Federal rate of $36,833.69 for the 2005 LTCH PPS rate year as discussed in section V.B. of this preamble. We illustrate the methodology used to adjust the Federal prospective payments for the 2005 LTCH PPS rate year in the following example:

During the 2005 LTCH PPS rate year, a Medicare patient is in a LTCH located in Chicago, Illinois (MSA 1600) with a two-fifths wage index value of 1.0357 (*see* table 1 in the Addendum to this final rule). The Medicare patient is classified into LTC–DRG 9 (Spinal Disorders and Injuries), which has a relative weight of 1.5025 (*see* table 3 of the Addendum to this final rule). To calculate the LTCH's total adjusted Federal prospective payment for this Medicare patient, we compute the wage-adjusted Federal prospective payment amount by multiplying the unadjusted standard Federal rate ($36,833.69) by the labor-related share (72.885 percent) and the wage index value (1.0357). (We note that the LTCH in this example is in the second year of the wage index phase-in, thus, the two-fifths wage index value is applicable.) This wage-adjusted amount is then added to the nonlabor-related portion of the unadjusted standard Federal rate (27.115 percent; adjusted for cost of living, if applicable) to determine the adjusted Federal rate, which is then multiplied by the LTC–DRG relative weight (1.5025) to calculate the total adjusted Federal prospective payment for the 2005 LTCH PPS rate year ($56,498.72). In addition, as discussed in section V.C.6. of this preamble, for the 2005 LTCH PPS rate year, we are reducing the LTCH PPS payment by 0.5 percent for the budget neutrality offset to account for the costs of the transition methodology. The following illustrates the components of the calculations in this example:

Unadjusted Standard Federal Prospective Payment Rate	$36,833.69
Labor-Related Share	0.72885
Labor-Related Portion of the Federal Rate	= $26,846.23
2/5th Wage Index (MSA 1600)	1.0357
Wage-Adjusted Labor Share of Federal Rate	= $27,804.64
Nonlabor-Related Portion of the Federal Rate ($36,833.69 × 0.27115)	+ $9,987.46
Adjusted Federal Rate Amount	= $37,792.10
LTC–DRG 4 Relative Weight	× 1.5025
Total Adjusted Federal Prospective Payment (Before the Budget Neutrality Offset)	= $56,782.63
Budget Neutrality Offset	x 0.995
Total Federal Prospective Payment (Including the Budget Neutrality Offset)	= $56,498.72

VII. Transition Period

To provide a stable fiscal base for LTCHs, under § 412.533, we implemented a 5-year transition period from reasonable cost-based reimbursement under the TEFRA system to a prospective payment based on industry-wide average operating and capital-related costs. Under the average pricing system, payment is not based on the experience of an individual hospital. As discussed in the August 30, 2002 final rule (67 FR 56038), we believe that a 5-year phase-in provides LTCHs time to adjust their operations and capital financing to the LTCH PPS, which is based on prospectively determined Federal payment rates. Furthermore, we believe that the 5-year phase-in of the LTCH PPS also allows LTCH personnel to develop proficiency with the LTC–DRG coding system, which will result in improvement in the quality of the data used for generating our annual determination of relative weights and payment rates.

In accordance with § 412.533, the transition period for all hospitals subject to the LTCH PPS begins with the hospital's first cost reporting period beginning on or after October 1, 2002, and extends through the hospital's last cost reporting period beginning before October 1, 2006. During the 5-year transition period, a LTCH's total payment under the LTCH PPS is based on two payment percentages—one based on reasonable cost-based (TEFRA) payments and the other based on the standard Federal prospective payment rate. The percentage of payment based on the LTCH PPS Federal rate increases by 20 percentage points each year, while the reasonable cost-based payment rate percentage decreases by 20 percentage points each year, for the next 3 fiscal years. For cost reporting periods beginning on or after October 1, 2006, Medicare payment to LTCHs will be determined entirely under the Federal PPS methodology. The blend

percentages as set forth in § 412.533(a) are as follows:

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

For cost reporting periods that begin on or after October 1, 2003, and before October 1, 2004 (FY 2004), the total payment for a LTCH is 60 percent of the amount calculated under reasonable cost principles for that specific LTCH and 40 percent of the Federal prospective payment amount. For cost reporting periods that begin on or after October 1, 2004, and before October 1, 2005 (FY 2005), the total payment for a LTCH will be 40 percent of the amount calculated under reasonable cost principles for that specific LTCH and 60 percent of the Federal prospective payment amount. As we noted in the January 30, 2004 proposed rule (69 FR 4754), the change in the effective date of the annual LTCH PPS rate update from October 1 to July 1 has no effect on the LTCH PPS transition period as set forth in § 412.533(a). That is, LTCHs paid under the transition blend under § 412.533(a) will receive those blend percentages for the entire 5-year transition period (unless they elect payments based on 100 percent of the Federal rate). Furthermore, LTCHs paid under the transition blend will receive the appropriate blend percentages of the Federal and reasonable cost-based rate for their entire cost reporting period as prescribed in § 412.533(a)(1) through (a)(5).

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

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

Under § 412.533(c)(2)(i), the notification by the LTCH to make the election must be made in writing to the Medicare fiscal intermediary. Under §§ 412.533(c)(2)(ii) and (c)(2)(iii), the intermediary must receive the request on or before the specified date (that is, on or before the 30th day before the applicable cost reporting period begins for cost reporting periods beginning on or after December 1, 2002 through September 30, 2006), regardless of any postmarks or anticipated delivery dates.

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

VIII. Payments to New LTCHs

Under § 412.23(e)(4), for purposes of Medicare payment under the LTCH PPS, we define a new LTCH as a provider of inpatient hospital services that otherwise meets the qualifying criteria for LTCHs, set forth in § 412.23(e)(1) and (e)(2), under present or previous ownership (or both), and its first cost reporting period as a LTCH begins on or after October 1, 2002. We also specify in § 412.500 that the LTCH PPS is applicable to hospitals with a cost reporting period that began on or after October 1, 2002. (In section V.C.8. of this final rule, we clarify existing policy for the time frame for calculating the average length of stay of a new LTCH as it relates to a satellite facility or remote location of a LTCH that voluntarily seeks to become a separate LTCH. We are also implementing a policy for the time frame for calculating the average length of stay as it relates to a remote location of a hospital that fails to meet certain requirements at § 413.65 and is required to seek status as a separate LTCH.)

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

As noted above and in accordance with § 412.533(d), new LTCHs will not participate in the 5-year transition from reasonable cost-based reimbursement to prospective payment. As we discussed in the August 30, 2002 final rule (67 FR 56040), the transition period is intended to provide existing LTCHs time to adjust to payment under the new system. Since these new LTCHs with cost reporting periods beginning on or after October 1, 2002, would not have received payment under reasonable cost-based reimbursement for the delivery of LTCH services prior to the effective date of the LTCH PPS, we do not believe that those new LTCHs require a transition period in order to make adjustments to their operations and capital financing, as will LTCHs that have been paid under the reasonable cost-based methodology.

IX. Method of Payment

Under § 412.513, a Medicare LTCH patient is classified into a LTC–DRG based on the principal diagnosis, up to eight additional (secondary) diagnoses, and up to six procedures performed during the stay, as well as age, sex, and discharge status of the patient. The LTC–DRG is used to determine the Federal prospective payment that the LTCH will receive for the Medicare-covered Part A services the LTCH furnished during the Medicare patient's stay. Under § 412.541(a), the payment is based on the submission of the

discharge bill. The discharge bill also provides data to allow for reclassifying the stay from payment at the full LTC–DRG rate to payment for a case as a short-stay outlier (under § 412.529) or as an interrupted stay (under § 412.531), or to determine if the case will qualify for a high-cost outlier payment (under § 412.525(a)).

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

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

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

Under § 412.541(d), LTCHs with unusually long lengths of stay that are not receiving payment under the PIP method may bill on an interim basis (60 days after an admission and at intervals of at least 60 days after the date of the first interim bill).

X. Monitoring

In the August 30, 2002 final rule (67 FR 56014), we discussed our intent to develop a monitoring system that will assist us in evaluating the LTCH PPS. Specifically, we discussed the monitoring 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 prospective payment system. We also stated our intent to collect and interpret data on changes in average lengths of stay under the LTCH PPS for specific LTC–DRGs and the impact of these changes on the Medicare program. We stated that if our data indicate that changes might be warranted, we may revisit these issues and consider proposing revisions to these policies in the future. To this end, we have designed system features utilizing MedPAR data that will enable CMS and the fiscal intermediary to track beneficiary movement to and from a LTCH and to and from another Medicare provider. As we discussed in the June 6, 2003 final rule (68 FR 34157), the MedPAC has endorsed this monitoring activity and is pursuing an independent research initiative that will evaluate all aspects of LTCHs, including the accuracy of data reporting, provision of equivalent services by other providers, growth in the number of LTCHs, and clinical outcomes. We are particularly concerned with the recent significant growth in the number of LTCHs. Since the implementation of the LTCH PPS, we have observed a growth of nearly 50 percent in the number of LTCHs, and that growth is almost exclusively in the number of LTCH that are hospitals within hospitals. We intend to focus our monitoring on this growth and the potential for gaming the IPPS by the co-located acute care hospital; and gaming the LTCH PPS by the LTC hospital-within-a-hospital. Based on the outcome of that monitoring activity we may need to address either the criteria for qualifying for LTCH PPS payments for hospital within hospitals, the payment rates for patients that are discharged from acute care hospitals and admitted to a co-located LTCH, or other policy issues that may arise as a result of our monitoring activity.

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

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

Existing policy at § 412.509(c) provides that the LTCH must ''furnish all necessary covered services to the Medicare beneficiary who is an inpatient of the hospital either directly or under arrangements.'' In the January 30, 2004 proposed rule (69 FR 4780–4781), we discussed our proposed extension of the interrupted stay policy, at § 412.531, to include LTCH discharges and readmissions within a period of 3 days.

We believe that such behavior by certain LTCHs may constitute gaming of the Medicare system, circumventing existing Medicare policy, and generating unnecessary Medicare payments.

Therefore, in this final rule, we are extending our interrupted stay policy at § 412.531 to address this situation. (*See* section V.C.4.c. of this final rule for additional information regarding the extension of the interrupted stay policy.)

We did not propose any policies regarding monitoring, but we received three comments expressing support for our plans to monitor LTCHs.

Comment: Two of the commenters were concerned about some of the conclusions that emerged from the recent research initiative by MedPAC. These conclusions concerned the rapid growth in the number of LTCHs as well as whether the appropriate patients are being treated in these facilities. The independent analysis conducted by these commenters indicated different conclusions than those of MedPAC. However, while the commenters support our efforts to collect data

regarding the type of patient that stays in a LTCH for an extended period of time, they recommend that we standardize medical necessity evaluation criteria for OIOs.

Response: We appreciate the commenters support of our monitoring activities. We have been informed of proposals circulating in the LTCH community about QIO admission standards, and we are also aware of discussions regarding the MedPAC research. We continue to be very interested in QIOs reviewing the records of extremely long stays (over 6 months) at LTCHs for purposes of medical necessity. As the new LTCH PPS generates data, we will continue to evaluate patient treatment patterns; beneficiary movement between providers; growth in the number of free-standing LTCHs, HwHs, and satellite facilities; cost/benefit analyses of alternative treatment settings for LTCH patients; and other relevant topics. We will also be reviewing data with regards to the finalized 3-day interrupted stay policy (section V.C.4.c.) to determine compliance and also to evaluate whether there is an increase in the number of patients being discharged and readmitted to the LTCH within 4-days. While we continue to believe in the importance of anecdotal information that we receive from providers, consultants, trade groups, regional offices, and fiscal intermediaries, we intend to monitor these issues and obtain as much data as we can to either confirm or refute the anecdotal information. If our evaluations and investigations reveal the need for policy revisions, we will propose those revisions in a future proposed rule.

XI. Collection of Information Requirements

Under the Paperwork Reduction Act (PRA) of 1995, we are required to provide 30-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA of 1995 requires that we solicit comment on the following issues:

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

In the January 30, 2004 proposed rule, we solicited public comments on each of these issues for the information collection requirements discussed below.

The following information collection requirements and associated burdens are subject to the PRA:

Section 412.23 Excluded Hospitals: Classifications

In summary, this section requires a satellite facility or a remote location of a hospital that voluntarily reorganizes as a separate Medicare participating hospital that seeks to qualify as a new long-term care hospital for Medicare payment purposes, to demonstrate through documentation that it meets the average length of stay requirement.

The burden associated with this requirement is the time required to maintain documentation to demonstrate that a satellite facility or a remote location of a hospital has an average length of stay as specified by this section. Since this requirement is a voluntary decision that is made by each facility, we do not know the number of facilities and remote locations that will seek to become new LTCHs. However, the information to be documented is currently being collected and maintained on each facility's cost report; therefore, this information collection requirement is currently approved under OMB control number 0938–0050.

This section also requires satellite facilities and remote locations of hospitals that became subject to the provider-based status rules, that become separately participating hospitals, and that seek to qualify as long-term care hospitals for Medicare payment purposes, to submit discharge data for calculation of the greater than 25-day average Medicare inpatient length of stay requirement in § 412.23(e)(2).

The burden associated with this requirement is the time required of the satellite facilities and remote locations of hospitals that became subject to the provider-based status rules (§ 413.65) to submit discharge data to the fiscal intermediary. We estimate that it will take approximately 5 minutes for each of the 300 facilities to submit the required information for a total one-time burden of 25 hours.

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

If you comment on any of these information collection and recordkeeping requirements, please mail copies directly to the following: Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Regulations Development and Issuances Group, Attn: Dawn Willinghan, CMS–1263–F, Room C5–09–26, 7500 Security Boulevard, Baltimore, MD 21244–1850; and

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Brenda Aguilar, CMS Desk Officer.

Comments submitted to OMB may also be emailed to the following address: e-mail: *baguilar@omb.eop.gov;* or faxed to OMB at (202) 395–6974.

XII. Regulatory Impact Analysis

A. Introduction

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

1. Executive Order 12866

Executive Order 12866 (as amended by Executive Order 13258, which merely assigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any one year). In this final rule, we are using the most recent estimate of the LTCH PPS market basket, updated claims data, and updated wage index values to estimate payments for the 2005 LTCH PPS rate year. Based on the best available data for 239 LTCHs, we estimate that the 3.1 percent increase in the standard Federal rate for the 2005 LTCH PPS rate year, in conjunction with the observed increase in case-mix (discussed in section V.C.4. of this preamble) and decrease in the budget neutrality offset to account for the transition methodology (discussed in section V.C.6. of this preamble), will result in an increase in payments from the 2004 LTCH PPS rate year of $235

million for the 239 LTCHs. (Section V.C.6. of this preamble includes an estimate of Medicare program payments for LTCH services.) Because the combined distributional effects and costs to the Medicare program are greater than $100 million, this final rule is considered a major economic rule, as defined above.

2. Regulatory Flexibility Act (RFA)

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

The provisions of this final rule represent a 13.8 percent increase in estimated payments in the 2005 LTCH PPS rate year (as shown in Table II below). We do not expect an incremental increase of 9.0 percent to the Medicare payment rates to have a significant adverse effect on the overall revenues of most LTCHs. In addition, LTCHs also provide services to (and generate revenue from) patients other than Medicare beneficiaries. Accordingly, we certify that this final rule will not have a significant impact on a substantial number of small entities, in accordance with RFA.

3. Impact on Rural Hospitals

Section 1102(b) of the Social Security Act requires us to prepare a regulatory impact analysis if a proposed or final rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. As discussed in detail below, the rates and policies set forth in this final rule will not have an adverse impact on rural hospitals based on the data of the 16 rural hospitals in our database of 239 LTCHs for which data were available.

4. Unfunded Mandates

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

5. Federalism

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

We have examined this final rule under the criteria set forth in Executive Order 13132 and have determined that this final rule will not have any significant impact on the rights, roles, and responsibilities of State, local, or tribal governments or preempt State law, based on the 15 State and local LTCHs in our database of 239 LTCHs for which data were available.

B. Anticipated Effects of Payment Rate Changes

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

1. Budgetary Impact

Section 123(a)(1) of Medicare, Medicaid and State Child Health Insurance Program (SCHIP) Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113) requires us to set the payment rates contained in this final rule such that total payments under the LTCH PPS are projected to equal the amount that would have been paid if this PPS had not been implemented. However, as discussed in greater detail in the August 30, 2002 final rule (67 FR 56033–56036), the FY 2003 standard Federal rate ($34,956.15) was calculated as though all LTCHs will be paid based on 100 percent of the standard Federal rate in FY 2003. As discussed in section V.C.6 of this final rule, we would apply a budget neutrality offset to payments to account for the monetary effect of the 5-year transition period and the policy to permit LTCHs to elect to be paid based on 100 percent of the standard Federal rate rather than a blend of Federal prospective payments and reasonable cost-based payments during the transition. The amount of the offset is equal to 1 minus the ratio of the estimated payments based on 100 percent of the LTCH PPS Federal rate to the projected total Medicare program payments that would be made under the transition methodology and the option to elect payment based on 100 percent of the Federal prospective payment rate.

2. Impact on Providers

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

In order to understand the impact of the changes to the LTCH PPS discussed in this final rule on different categories of LTCHs for the 2005 LTCH PPS rate year, it is necessary to estimate payments per discharge under the LTCH PPS rates and factors for the 2004 LTCH PPS rate year (*see* the June 6, 2003 final rule; 68 FR 34122–34190) and payments per discharge that will be made under the LTCH PPS rates and factors for the 2005 LTCH PPS rate year as discussed in the preamble of this final rule. We also evaluated the percent change in payments per discharge of estimated 2004 LTCH PPS rate year payments to estimated 2005 LTCH PPS rate year payments for each category of LTCHs.

Hospital groups were based on characteristics provided in the Online Survey Certification and Reporting (System) (OSCAR) data, FYs 1999 through 2001 cost report data, and Provider Specific File data. Hospitals with incomplete characteristics were

grouped into the ''unknown'' category. Hospital groups include:

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

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

Using LTCH cases from the FY 2003 MedPAR file and cost data from FYs 1996 through 2001 to estimate payments under the current reasonable cost-based principles, we have both case-mix and cost data for 239 LTCHs. Thus, for the impact analyses reflecting the applicable transition blend percentages of prospective payments and reasonable cost-based methodology payments and the option to elect payment based on 100 percent of the Federal rate (see Table II below), we used data from 239 LTCHs. While currently there are more than 300 LTCHs, the most recent growth is predominantly in for-profit LTCHs that provide respiratory and ventilator-dependent patient care. We believe that the discharges from the MedPAR data for the 239 LTCHs in our database provide sufficient representation in the LTC–DRGs containing discharges for patients who received respiratory and ventilator-dependent care. However, using cases from the FY 2003 MedPAR file, we had case-mix data for 298 LTCHs. Cost data to determine current payments under reasonable cost-based methodology payments are not needed to simulate payments based on 100 percent of the Federal rate. Therefore, for the impact analyses reflecting fully phased-in prospective payments (see Table III below), we used data from 298 LTCHs.

These impacts reflect the estimated ''losses'' or ''gains'' among the various classifications of providers for the 2004 LTCH PPS rate year (July 1, 2003 through June 30, 2004) compared to the 2005 LTCH PPS rate year (July 1, 2004 through June 30, 2005). Prospective payments for the 2004 LTCH rate year were based on the standard Federal rate of $35,726.18 and the hospital's estimated case-mix based on FY 2003 claims data. Prospective payments for the 2005 LTCH PPS rate year were based on the standard Federal rate of $36,833.69 and the same FY 2003 claims data.

3. Calculation of Prospective Payments

To estimate payments under the LTCH PPS, we simulated payments on a case-by-case basis by applying the existing payment policy for short-stay outliers (as described in section V.C.4.b. of this final rule) and the existing adjustments for area wage differences (as described in section V.C.1. of this final rule) and for the cost-of-living for Alaska and Hawaii (as described in section V.C.2. of this final rule). Additional payments will also be made for high-cost outlier cases (as described in section V.C.3. of this final rule). As noted in section V.C.5. of this final rule, we are not making adjustments for rural location, geographic reclassification, indirect medical education costs, or a disproportionate share of low-income patients because sufficient new data have not been generated that would enable us to conduct a comprehensive reevaluation of these payment adjustments.

We adjusted for area wage differences for estimated 2004 LTCH PPS rate year payments by computing a weighted average of a LTCH's applicable wage index during the period from July 1, 2003, through June 30, 2004, because some providers may experience a change in the wage index phase-in percentage during that period. For cost reporting periods beginning on or after October 1, 2002 and before September 30, 2003, the labor portion of the Federal rate is adjusted by one-fifth of the applicable ''LTCH PPS wage index'' (that is, the FY 2004 IPPS wage index data without geographic reclassification, under sections 1886(d)(8) and (d)(10)) of the Act. For cost reporting periods beginning on or after October 1, 2003 and before September 30, 2004, the labor portion of the Federal rate is adjusted by two-fifths of the applicable LTCH PPS wage index. Therefore, a provider with a cost reporting period that began October 1, 2003, will have 3 months of payments under the one-fifth wage index value and 9 months of payment under the two-fifths wage index value. For this provider, we computed a blended wage index of 25 percent (3 months/12 months) of the one-fifth wage index value and 75 percent (9 months/12 months) of the two-fifths wage index value. Similarly, we adjusted for area wage differences for estimated 2005 LTCH PPS rate year payments by computing a weighted average of a LTCH's applicable wage index during the period from July 1, 2004, through June 30, 2005, because some providers may experience a change in the wage index phase-in percentage during that period. For cost reporting periods beginning on or after October 1, 2003 and before September 30, 2004, the labor portion of the Federal rate is adjusted by two-fifths of the applicable LTCH PPS wage index. For cost reporting periods beginning on or after October 1, 2004 and before September 30, 2005, the labor portion of the Federal rate is adjusted by three-fifths of the applicable LTCH PPS wage index. The applicable LTCH PPS wage index values for the 2005 LTCH PPS rate year are shown in Tables 1 and 2 of the Addendum to this final rule.

For those providers projected to receive payment under the transition blend methodology, we also calculated payments using the applicable transition blend percentages. During the 2004 LTCH PPS rate year, based on the transition blend percentages set forth in § 412.533(a), some providers may experience a change in the transition blend percentage during the period from July 1, 2003 through June 30, 2004. That is, during the period from July 1, 2003 through June 30, 2004, a provider with a cost reporting period beginning on October 1, 2002 (which is paid under the 80/20 transition blend (80 percent of payments based on reasonable cost-based methodology and 20 percent of payments under the LTCH PPS) beginning October 1, 2002) had 3 months (July 1, 2003 through September 30, 2003) under the 80/20 blend and 9 months (October 1, 2003 through June 30, 2004) of payment under the 60/40-transition blend (60 percent of payments based on reasonable cost-based methodology and 40 percent of payments under the LTCH PPS). (The 60 percent/40 percent blend will continue until the provider's cost reporting period beginning on October 1, 2004.)

Similarly, during the 2005 LTCH PPS rate year, based on the transition blend percentages set forth in § 412.533(a), some of the providers paid under the transition blend methodology may experience a change in the transition blend percentage during the period from July 1, 2004 through June 30, 2005. That is, during the period from July 1, 2004 through June 30, 2005, a provider with

a cost reporting period beginning on October 1, 2003 (which is paid under the 60/40 transition blend had 3 months (July 1, 2004 through September 30, 2004) under the 60/40 blend and 9 months (October 1, 2004 through June 30, 2005) of payment under the 40/60-transition blend (40 percent of payments based on reasonable cost-based methodology and 60 percent of payments under the LTCH PPS). (The 40 percent/60 percent blend will continue until the provider's cost reporting period beginning on October 1, 2005.)

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

Then we applied the 6.0 percent budget neutrality reduction to payments to account for the effect of the 5-year transition methodology and election of payment based on 100 percent of the Federal rate on Medicare program payments established in the June 6, 2003 final rule (68 FR 34153) to each LTCH's estimated payments under the LTCH PPS for the 2004 LTCH PPS rate year. Similarly, we applied the 0.5 percent budget neutrality reduction to payment to account for the effect of the 5-year transition methodology and election of payment based on 100 percent of the Federal rate on Medicare program payments (*see* section V.C.6. of this final rule) to each LTCH's estimated payments under the LTCH PPS for the 2005 LTCH PPS rate year. The impact based on our projection of whether a LTCH will be paid based on the transition blend methodology or will elect payment based on 100 percent of the Federal rate is shown below in Table II.

In Table III below, we also show the impact if the LTCH PPS were fully implemented; that is, as if there were an immediate transition to fully Federal prospective payments under the LTCH PPS for the 2004 LTCH PPS rate year and the 2005 LTCH PPS rate year. Accordingly, the 6.0 percent budget neutrality reduction to account for the 5-year transition methodology on LTCHs' Medicare program payments for the 2004 LTCH PPS rate year and the 0.5 percent budget neutrality reduction to account for the 5-year transition methodology on LTCHs' Medicare program payments established for the 2005 LTCH PPS rate year were not applied to LTCHs' estimated payments under the LTCH PPS.

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

- The first column, LTCH Classification, identifies the type of LTCH.
- The second column lists the number of LTCHs of each classification type.
- The third column identifies the number of long-term care cases.
- The fourth column shows the estimated payment per discharge for the 2004 LTCH PPS rate year.
- The fifth column shows the estimated payment per discharge for the 2005 LTCH PPS rate year.
- The sixth column shows the percent change of 2004 LTCH PPS rate year compared to the 2005 LTCH PPS rate year.

TABLE II.—PROJECTED IMPACT REFLECTING APPLICABLE TRANSITION BLEND PERCENTAGES OF PROSPECTIVE PAYMENTS AND REASONABLE COST-BASED (TEFRA) PAYMENTS AND OPTION TO ELECT PAYMENT BASED ON 100 PERCENT OF THE FEDERAL RATE [1]

[2004 LTCH PPS Rate Year Payments Compared to 2005 LTCH Prospective Payment System Rate Year]

LTCH classification	Number of LTCHs	Number of LTCH cases	Average 2004 LTCH PPS rate year payment per case [2]	Average 2005 LTCH prospective payment system rate year payment per case [3]	Percent change
All Providers	239	94,169	$27,181	$29,629	9.0
By Location:					
Rural	16	7,782	$24,309	$26,303	8.2
Urban	223	86,387	27,439	29,928	9.1
Large	107	37,759	26,212	28,360	8.2
Other	116	48,628	28,392	31,146	9.7
By Participation Date:					
Before October 1983	15	7,527	$22,088	$24,166	9.4
October 1983–September 1993	44	22,119	28,994	31,6649.	D2
October 1993–September 2002	180	64,523	27,155	29,568	8.9
By Ownership Control:					
Voluntary	58	22,630	25,656	27,887	8.7
Proprietary	166	64,680	27,882	30,444	9.2
Government	15	6,859	25,597	27,691	8.2
By Census Region:					
New England	13	9,377	22,146	24,442	10.4
Middle Atlantic	15	5,290	26,344	28,421	7.9
South Atlantic	22	7,859	32,432	35,264	8.7
East North Central	45	12,914	29,681	32,417	9.2
East South Central	14	4,281	26,934	29,224	8.5
West North Central	17	4,761	29,285	31,988	9.2
West South Central	83	39,528	25,228	27,310	8.3
Mountain	18	4,513	29,961	33,104	10.5
Pacific	12	5,646	33,159	36,930	11.4

TABLE II.—PROJECTED IMPACT REFLECTING APPLICABLE TRANSITION BLEND PERCENTAGES OF PROSPECTIVE PAYMENTS AND REASONABLE COST-BASED (TEFRA) PAYMENTS AND OPTION TO ELECT PAYMENT BASED ON 100 PERCENT OF THE FEDERAL RATE [1]—Continued

[2004 LTCH PPS Rate Year Payments Compared to 2005 LTCH Prospective Payment System Rate Year]

LTCH classification	Number of LTCHs	Number of LTCH cases	Average 2004 LTCH PPS rate year payment per case [2]	Average 2005 LTCH prospective payment system rate year payment per case [3]	Percent change
BY BED SIZE:					
Beds: 0–24	17	2,627	30,162	32,717	8.5
Beds: 25–49	117	30,558	26,480	28,712	8.4
Beds: 50–74	33	11,632	28,911	31,476	8.9
Beds: 75–124	36	16,321	28,092	30,655	9.1
Beds: 125–199	24	19,899	26,501	28,953	9.3
Beds: 200+	12	13,132	26,579	29,258	10.1

[1] These calculations take into account that some providers may experience a change in the blend percentage changes during the 2004 and 2005 LTCH PPS rate years. For example, during the period of July 1, 2003 through June 30, 2004, a provider with a cost reporting period beginning October 1 would have 3 months (July 1, 2003 through September 30, 2003) of payments under the 80/20 blend and 9 months (October 1, 2003 through June 30, 2004) of payment under the 60/40 blend.
[2] Average payment per case for the 12-month period of July 1, 2003 through June 30, 2004.
[3] Average payment per case for the 12-month period of July 1, 2004 through June 30, 2005.

TABLE III.—PROJECTED IMPACT REFLECTING THE FULLY PHASED-IN PROSPECTIVE PAYMENTS

[2004 LTCH PPS Rate Year Payments Compared to 2005 LTCH Prospective Payment System Rate Year Payments]

LTCH classification	Number of LTCHs	Number of LTCH cases	Average 2004 LTCH PPS rate year payment per case [1]	Average 2005 LTCH prospective payment system rate year payment per case [2]	Percent change
All Providers	298	105,732	$28,537	$29,457	3.2
By Location:					
Rural	20	8,455	25,723	26,267	2.1
Urban	278	97,277	28,782	29,734	3.3
Large	151	45,567	27,603	28,318	2.6
Other	127	51,710	29,820	30,981	3.9
By Participation Date:					
Before October 1983	17	7,545	23,119	24,022	3.9
October 1983–September 1993	205	71,916	30,325	29,427	3.7
October 1993–September 2002	45	22,159	28,560	31,453	3.0
After October 2002	21	2,670	26,876	27,523	2.4
Unknown	10	1,442	31,342	32,268	3.0
By Ownership Control:					
Voluntary	62	23,243	26,870	27,730	3.2
Proprietary	182	69,801	29,404	30,375	3.3
Government	18	8,008	26,618	27,439	3.1
Unknown	36	4,680	27,165	27,787	2.3
By Census Region:					
New England	15	9,395	23,458	24,493	4.4
Middle Atlantic	21	6,762	27,528	28,137	2.2
South Atlantic	30	9,250	33,279	34,424	3.4
East North Central	56	14,904	31,282	32,325	3.3
East South Central	17	4,540	28,600	29,312	2.5
West North Central	17	4,761	30,882	31,937	3.4
West South Central	108	44,492	26,517	27,197	2.6
Mountain	21	5,321	31,011	32,416	4.5
Pacific	13	6,307	34,093	35,878	05.2
BY BED SIZE:					
Beds: 0–24	21	3,185	31,087	31,805	2.3
Beds: 25–49	127	33,296	28,105	28,835	2.6
Beds: 50–74	37	13,401	29,767	30,813	3.5
Beds: 75–124	37	16,982	29,353	30,426	3.7
Beds: 125–199	24	19,899	27,950	28,915	3.5
Beds: 200+	13	13,140	28,208	29,359	4.1
Unknown	39	5,829	27,155	27,322	2.6

[1] Average payment per case for the 12-month period of July 1, 2003 through June 30, 2004.
[2] Average payment per case for the 12-month period of July 1, 2004 through June 30, 2005.

4. Results

Based on the most recent available data (as described above for 230 LTCHs), we have prepared the following summary of the impact (as shown in Table II) of the LTCH PPS set forth in this final rule.

a. *Location*. Based on the most recent available data, the majority of LTCHs are in urban areas. Approximately 7 percent of the LTCHs are identified as being located in a rural area, and approximately 8 percent of all LTCH cases are treated in these rural hospitals. Impact analysis in Table II shows that the percent change in estimated payments per discharge for the 2004 LTCH PPS rate year compared to the 2005 LTCH PPS rate year for rural LTCHs will be 8.2 percent, and will be 9.1 percent for urban LTCHs. Large urban LTCHs are projected to experience a 8.2 percent increase in payments per discharge from the 2004 LTCH PPS rate year compared to the 2005 LTCH PPS rate year, while other urban LTCHs projected to experience a 9.7 percent increase in payments per discharge from the 2004 LTCH PPS rate year compared to the 2005 LTCH PPS rate year. (See Table II.)

As noted above, in addition to the update in the standard Federal rate, the estimated percent increase in payments per discharge from the 2004 LTCH PPS rate year to the 2005 LTCH PPS rate year is largely attributable to the decrease in the budget neutrality offset to account for the transition methodology (discussed in section V.C.6. of this preamble). Specifically, we are applying a 0.5 percent budget neutrality reduction (0.995) to payments in the 2005 LTCH PPS rate year to account for the effect of the 5-year transition methodology. The 0.995 transition period budget neutrality factor for the 2005 LTCH PPS rate year is lower than the transition period budget neutrality factor for the 2004 LTCH PPS rate year (0.940). This smaller budget neutrality offset contributes to greater LTCH payment increases between the 2004 and 2005 LTCH PPS rate years compared to the increases seen between FY 2003 and the 2004 LTCH PPS rate year. Furthermore, many LTCHs are experiencing increases in payments because of an increasing wage index adjustment, which is two-fifths of the applicable LTCH PPS wage index for cost reporting periods beginning on or after October 1, 2003, and three-fifths of the applicable wage index for cost reporting periods beginning on or after October 1, 2004. Additionally, many LTCHs are expected to receive an increase in high-cost outlier payments as a result of the decrease in the fixed-loss amount from the 2004 LTCH PPS rate year ($19,590) to the 2005 LTCH PPS rate year ($17,864) as discussed in section V.C.4. of this preamble. We do not expect to see these large payment per discharge increases in future years as the majority of LTCHs have transitioned fully to the LTCH PPS and, therefore, the transition period budget neutrality factor should remain more stable.

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

Based on the most recent available data, the majority, approximately 75 percent, of the LTCH cases are in hospitals that began participating between October 1993 and September 2002, and are projected to experience a 8.9 percent increase in payments per discharge from the 2004 LTCH PPS rate year compared to the 2005 LTCH PPS rate year. Approximately 23 percent of the cases are in LTCHs that began participating in Medicare between October 1983 and September 1993, and are projected to experience a 9.2 percent increase in payments per discharge from the 2004 LTCH PPS rate year compared to the 2005 LTCH PPS rate year. LTCHs that began participating before October 1983 are projected to experience a 9.4 percent increase in payments per discharge from the 2004 LTCH PPS rate year compared to the 2005 LTCH PPS rate year. (See Table II.)

As discussed above, these relatively large increases in payments for the 2005 LTCH PPS rate year are mostly due to the decrease in the budget neutrality offset to account for the transition methodology (discussed in section V.C.6. of this preamble). Furthermore, in addition to the update in the standard Federal rate, many of these LTCHs will experience an increase in payments because of an increasing wage index adjustment, which is two-fifths of the applicable LTCH PPS wage index for cost reporting periods beginning on or after October 1, 2003, and three-fifths of the applicable wage index for cost reporting periods beginning on or after October 1, 2004. As noted above, LTCHs may also experience an increase in high-cost outlier payments as a result of the decrease in the fixed-loss amount from the 2004 LTCH PPS rate year ($19,590) to the 2005 LTCH PPS rate year ($17,864). As we also explain above, we do not expect to see these large payment increases in future years as the majority of LTCHs have transitioned fully to the LTCH PPS and, therefore, the transition period budget neutrality factor should remain more stable.

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

Based on the most recent available data, approximately 6 percent of LTCHs are government run and we expect that they will experience a 8.2 percent increase in payments per discharge from the 2004 LTCH PPS rate year compared to the 2005 LTCH PPS rate year. Voluntary and proprietary LTCHs are projected to experience a 8.7 percent and 9.2 percent increase in payments per discharge from the 2004 LTCH PPS rate year compared to the 2005 LTCH PPS rate year, respectively. (See Table II.)

d. *Census Region*. LTCHs located in all regions are expected to experience an increase in payments per discharge from the 2004 LTCH PPS rate year compared to the 2005 LTCH PPS rate year. Specifically, of the nine census regions, we expect that LTCHs in the Pacific, Mountain, and New England regions will experience the largest percent increase in payments per discharge from the 2004 LTCH PPS rate year compared to the 2005 LTCH PPS rate year (11.4 percent, 10.5 percent, and 10.4 percent, respectively). LTCHs located in the East North Central and West North Central regions are also projected to experience a 9.2 percent increase in payments per discharge from the 2004 LTCH PPS rate year compared to the 2005 LTCH PPS rate year. (See Table II.)

As explained above, these relatively large increases in payments for the 2005 LTCH PPS rate year are mostly attributable to the decrease in the budget neutrality offset to account for the transition methodology (discussed in section V.C.6. of this preamble). Furthermore, in addition to the update in the standard Federal rate, many LTCHs will experience an increase in payments because of an increasing wage index adjustment, which is two-fifths of the applicable LTCH PPS wage index for cost reporting periods beginning on or after October 1, 2003, and three-fifths of the applicable wage index for cost reporting periods beginning on or after October 1, 2004. As noted above, LTCHs may also experience an increase in high-cost outlier payments as a result of the decrease in the fixed-loss amount from the 2004 LTCH PPS rate year ($19,590)

to the 2005 LTCH PPS rate year ($17,864). As we also explained above, we do not expect to see these large payment increases in future years as the majority of LTCHs have transitioned fully to the LTCH PPS and, therefore, the transition period budget neutrality factor should remain more stable.

We expect LTCHs in the MidAtlantic region to experience the smallest percent increase in payments per discharge from the 2004 LTCH PPS rate year compared to the 2005 LTCH PPS rate year (7.9 percent). We are projecting a slightly lower percent increase in payments per discharge for LTCHs located in this region because of the increasing wage index adjustment. Specifically, many LTCHs located in these areas have a wage index value of less than 1.0. (See Table II.)

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

The percent increase in payments per discharge from the 2004 LTCH PPS rate year compared to the 2005 LTCH PPS rate year are projected to increase for all bed size categories. Most LTCHs were in bed size categories where the percent increase in payments per discharge from the 2004 LTCH PPS rate year compared to the 2005 LTCH PPS rate year is estimated to be approximately 9 percent. LTCHs with greater than 200 beds have the largest estimated percent change in payments per discharge from the 2004 LTCH PPS rate year compared to the 2005 LTCH PPS rate year (10.1 percent), while LTCHs with 25–49 beds have the lowest projected increase in the percent change in payments per discharge from the 2004 LTCH PPS rate year compared to the 2005 LTCH PPS rate year (8.4 percent). (See Table II.)

5. Effect on the Medicare Program

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

LTCH PPS rate year	Estimated payments ($ in billions)
2005	2.96
2006	2.98
2007	2.95
2008	3.01
2009	3.12

These estimates are based on the current estimate of increase in the excluded hospital with capital market basket of 3.1 percent for the 2005 LTCH PPS rate year, 3.2 percent for the 2006 and 2007 LTCH PPS rate years, 2.8 percent for the 2008 LTCH PPS rate year, and 3.1 percent for the 2009 LTCH PPS rate year. We estimate that there will be a change in Medicare beneficiary enrollment of 1.0 percent in the 2005 LTCH PPS rate year, −4.8 percent in the 2006 LTCH PPS rate year, −6.4 percent in 2007 LTCH PPS rate year, −1.2 percent in the 2008 LTCH PPS rate year, 0.2 percent in the 2009 LTCH PPS rate year, and an estimated increase in the total number of LTCHs. (We note that our Office of the Actuary is projecting a decrease in Medicare fee-for-service Part A enrollment, in part, because they are projecting an increase in Medicare managed care enrollment as a result of the implementation of several provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.)

Consistent with the statutory requirement for budget neutrality, we intend for estimated aggregate payments under the LTCH PPS in FY 2003 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 budget neutrality calculations uses the best available data and necessarily reflects assumptions. As we collect data from LTCHs, we will monitor payments and evaluate the ultimate accuracy of the assumptions used to calculate the budget neutrality calculations (that is, inflation factors, intensity of services provided, or behavioral response to the implementation of the LTCH PPS).

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

6. Effect on Medicare Beneficiaries

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

C. Impact of Policy Changes

1. Requirements for Satellite Facilities and Remote Locations of Hospitals To Qualify as Long-Term Care Hospitals

Under section V.C.8. of the preamble of this final rule, we discuss our clarification of the procedures under which a satellite facility or a remote location of a hospital must meet the statutory and regulatory requirements to qualify as a distinct LTCH. In particular, we are specifying the procedure for determining the period from which the fiscal intermediaries will use discharge data in calculating the average Medicare inpatient length of stay requirement for a new, separately participating hospital that seeks classification as a LTCH.

In this final rule, we are restating in regulations our existing policy that a satellite facility or remote location of a hospital (except for those that are subject to the location requirement under the provider-based rules at § 413.65) that voluntarily reorganizes itself as a separate hospital and meets the provider agreement requirements of 42 CFR part 489 and the Medicare conditions of participation under 42 CFR part 482 will have its average Medicare inpatient length of stay calculated based on discharges that occur after the satellite facility or remote location is established as a separate participating hospital.

The policy that we are incorporating in the regulations is already in existence. Therefore, complying with the regulation amendments will pose no additional burden on LTCHs.

We are further incorporating in regulations that govern requirements for LTCHs an exception to the above policy for satellite facilities and remote locations of hospitals that became subject to the revised location-based provider-based requirements on July 1, 2003, that reorganize as separate participating hospitals, and that seek classification as LTCHs. Under this provision, calculation of the average Medicare inpatient length of stay for purposes of qualifying as a LTCH are based on discharge data during the 5 months of the immediate 6 months preceding the facility's separation from the main hospital. This specific regulation applies only to those facilities or locations that became subject to the revised provider-based location rules on July 1, 2003, and that seek classification as LTCHs for Medicare payment purposes. Therefore, we are unable to quantify how many or

when a facility or location would seek LTCH classification.

These amendments to the regulations will not impose any additional requirements on providers. The data used in the calculation of the average length of stay are already being collected. The existing procedure for application of the discharge data in calculating the average length of stay in both circumstances is consistent with existing statutory and regulatory requirements.

2. Change in Policy on Interruption of a Stay in a LTCH

Under section V.C.4.c. of the preamble of this final rule, we are expanding the definition of an interruption of a stay to include an interruption in which the patient is discharged from the LTCH, and returns to the LTCH within 3 days of the original discharge. We have found, through monitoring activities and other sources, that certain LTCHs appear to be discharging patients during the course of their treatment for the sole purpose of the patient receiving specific tests or procedures and then readmitting the patient following the administration of the test or procedure. We believe these situations are resulting in improper increases in Medicare costs through separate billings for services that are already included in the LTC–DRG payment made to the LTCH. The regulation change will prevent these inappropriate Medicare payments. However, we do not have sufficient data at this time to quantify either the number of providers that would be affected by the change nor the savings to the Medicare program.

3. Change in Procedure for Counting Covered and Noncovered Days in a Stay That Crosses Two Consecutive Cost Reporting Periods

Under section V.C.7. of the preamble to this final rule, we are specifying the procedure for calculating a hospital's inpatient average length of stay for purposes of classification as a LTCH when covered and noncovered days of the stay involve admission in one cost reporting period and discharge in another cost reporting period. We are finalizing the policy of counting the total number of days of the stay in the cost reporting period during which the inpatient was discharged. This policy revises the existing procedure to make it consistent with reporting and payment procedures already in place for discharge-based payment systems that link patient days to discharges. Effective for the 2005 LTCH PPS rate year (July 1, 2004 through June 30, 2005, we have provided for an exception in the event some providers fail to meet the 25-day ALOS criteria due to this change in policy. The fiscal intermediaries will then do an additional calculation to determine if these providers meet the old 25-day criteria. We do not envision many instances where this will be necessary and believe that it will only have minimal impact, if any.

The regulation imposes no additional requirements on providers. The discharge data are already being collected and the revision would merely change the procedure for reporting it.

D. Executive Order 12866

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

List of Subjects in 42 CFR Part 412

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

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

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

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

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

■ 2. Section 412.23 is amended by—
■ A. Revising paragraph (e)(3).
■ B. Revising paragraph (e)(4).

The revisions and additions read as follows:

§ 412.23 Excluded hospitals: classifications.

* * * * *

(e) *Long-term care hospitals.** * *

(3) *Calculation of average length of stay.* (i) Subject to the provisions of paragraphs (e)(3)(ii) through (e)(3)(iv) of this section, the average Medicare inpatient length of stay specified under paragraph (e)(2)(i) of this section is calculated by dividing the total number of covered and noncovered days of stay of Medicare inpatients (less leave or pass days) by the number of total Medicare discharges for the hospital's most recent complete cost reporting period. Subject to the provisions of paragraphs (e)(3)(ii) through (e)(3)(iv) of this section, the average inpatient length of stay specified under paragraph (e)(2)(ii) of this section 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.

(ii) Effective for cost reporting periods beginning on or after July 1, 2004, in calculating the hospital's average length of stay, if the days of a stay of an inpatient involves days of care furnished during two or more separate consecutive cost reporting periods, that is, an admission during one cost reporting period and a discharge during a future consecutive cost reporting period, the total number of days of the stay are considered to have occurred in the cost reporting period during which the inpatient was discharged. However, if after application of this provision, a hospital fails to meet the average length of stay specified under paragraphs (e)(2)(i) and (ii) of this section, Medicare will determine the hospital's average inpatient length of stay for cost reporting periods beginning on or after July 1, 2004, but before July 1, 2005, by dividing the applicable total days for Medicare inpatients under paragraph (e)(2)(i) of this section or the total days for all inpatients under paragraph (e)(2)(ii) of this section, during the cost reporting period when they occur, by the number of discharges occurring during the same cost reporting period.

(iii) If a change in a hospital's average length of stay specified under paragraph (e)(2)(i) or paragraph (e)(2)(ii) of this section is indicated, the calculation is made by the same method for the period of at least 5 months of the immediately preceding 6-month period.

(iv) If a hospital has undergone a change of ownership (as described in § 489.18 of this chapter) at the start of a cost reporting period or at any time within the period of at least 5 months of the preceding 6-month period, the hospital may be excluded from the prospective payment system as a long-term care hospital for a cost reporting period if, for the period of at least 5 months of the 6 months immediately preceding the start of the period (including time before the change of ownership), the hospital has the required average length of stay, continuously operated as a hospital, and continuously participated as a hospital in Medicare.

(4) *Rules applicable to new long-term care hospitals*—(i) *Definition.* For purposes of payment under the long-term care hospital prospective payment system under subpart O of this part, a new long-term care hospital is a provider of inpatient hospital services that meets the qualifying criteria in paragraphs (e)(1) and (e)(2) of this

section and, under present or previous ownership (or both), its first cost reporting period as a LTCH begins on or after October 1, 2002.

(ii) *Satellite facilities and remote locations of hospitals seeking to become new long-term care hospitals.* Except as specified in paragraph (e)(4)(iii) of this section, a satellite facility (as defined in § 412.22(h)) or a remote location of a hospital (as defined in § 413.65(a)(2) of this chapter) that voluntarily reorganizes as a separate Medicare participating hospital, with or without a concurrent change in ownership, and that seeks to qualify as a new long-term care hospital for Medicare payment purposes must demonstrate through documentation that it meets the average length of stay requirement as specified under paragraphs (e)(2)(i) or (e)(2)(ii) of this section based on discharges that occur on or after the effective date of its participation under Medicare as a separate hospital.

(iii) *Provider-based facility or organization identified as a satellite facility and remote location of a hospital prior to July 1, 2003.* Satellite facilities and remote locations of hospitals that became subject to the provider-based status rules under § 413.65 as of July 1, 2003, that become separately participating hospitals, and that seek to qualify as long-term care hospitals for Medicare payment purposes may submit to the fiscal intermediary discharge data gathered during 5 months of the immediate 6 months preceding the facility's separation from the main hospital for calculation of the average length of stay specified under paragraph (e)(2)(i) or paragraph (e)(2)(ii) of this section.

* * * * *

■ 3. Section 412.525 is amended by revising paragraph (d)(2) to read as follows:

§ 412.525 Adjustments to the Federal prospective payment.

* * * * *

(d) *Special payment provisions.* * * *

(2) A 3-day or less interruption of a stay and a greater than 3-day interruption of a stay, as provided for in § 412.531.

■ 4. Section 412.531 is amended by—

■ A. Revising paragraph (a).

■ B. Revising paragraph (b)(1), (b)(2) and (b)(3).

The revisions read as follows:

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

(a) *Definitions*—(1) *A 3-day or less interruption of stay defined.* ''A 3-day or less interruption of stay'' means a stay at a long-term care hospital during which a Medicare inpatient is discharged from the long-term care hospital to an acute care hospital, IRF, SNF, or the patient's home and readmitted to the same long-term care hospital within 3 days of the discharge from the long-term care hospital. The 3-day or less period begins with the date of discharge from the long-term care hospital and ends not later than midnight of the third day.

(2) *A greater than 3-day interruption of stay defined.* ''A greater than 3-day or less interruption of stay'' means A stay in a long-term care hospital during which a Medicare inpatient is discharged from the long-term care hospital to an acute care hospital, an IRF, or a SNF for a period of greater than 3 days but within the applicable fixed-day period specified in paragraphs (a)(2)(i) through (a)(2)(iii) of this section before being readmitted to the same long-term care hospital.

(i) For a discharge to an acute care hospital, the applicable fixed day period is between 4 and 9 consecutive days. The counting of the days begins on the date of discharge from the long-term care hospital and ends on the 9th date after the discharge.

(ii) For a discharge to an IRF, the applicable fixed day period is between 4 and 27 consecutive days. The counting of the days begins on the day of discharge from the long-term care hospital and ends on the 27th day after discharge.

(iii) For a discharge to a SNF, the applicable fixed day period is between 4 and 45 consecutive days. The counting of the days begins on the day of discharge from the long-term care hospital and ends on the 45th day after the discharge.

(b) *Methods of determining payments.* (1) For purposes of determining a Federal prospective payment—

(i) *Determining the length of stay.* In determining the length of stay of a patient at a long-term care hospital for payment purposes under this paragraph (b)—

(A) Except as specified in paragraphs (b)(1)(i)(B) and (b)(1)(i)(C) of this section, the number of days that a beneficiary spends away from the long-term care hospital during a 3-day or less interruption of stay under paragraph (a)(1) of this section is not included in determining the length of stay of the patient at the long-term care hospital when there is no outpatient or inpatient medical treatment or care provided at an acute care hospital or an IRF, or SNF services during the interruption that is considered a covered service delivered to the beneficiary.

(B) The number of days that a beneficiary spends away from a long-term care hospital during a 3-day or less interruption of stay under paragraph (a)(1) of this section are counted in determining the length of stay of the patient at the long-term care hospital if the beneficiary receives inpatient or outpatient medical care or treatment provided by an acute care hospital or IRF, or SNF services during the interruption. In the case where these services are provided during some, but not all days of a 3-day or less interruption, Medicare will include all days of the interruption in the long-term care hospitals day-count.

(C) The number of days that a beneficiary spends away from a long-term care hospital during a 3-day or less interruption of stay under paragraph (a)(1) of this section during which the beneficiary receives a procedure grouped to a surgical DRG under the inpatient prospective payment system in an acute care hospital during the 2005 LTCH PPS rate year is not included in determining the length of stay of the patient at the long-term care hospital.

(D) The number of days that a beneficiary spends away from a LTCH during a greater than 3-day interruption of stay, as defined in paragraph (a)(2) of this section, is not included in determining the length of stay at the LTCH.

(ii) *Determining how payment is made.* (A) Subject to the provisions of paragraphs (b)(1)(ii)(A)(*1*) and (b)(1)(ii)(A)(*2*) of this section, for a 3-day or less interruption of stay under paragraph (a)(1) of this section, the entire stay is paid as a single discharge from the long-term care hospital. CMS makes only one LTC–DRG payment for all portions of a long-term care stay.

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

(*2*) For a 3-day or less interruption of stay under paragraph (a)(1) of this section during which the patient receives inpatient or outpatient treatment or services at an acute care hospital or IRF, or SNF services, that are not otherwise excluded under § 412.509(a), the services must be provided under arrangements in

accordance with § 412.509(c). CMS does not make a separate payment to the acute care hospital, IRF, or SNF for these services. The LTC–DRG payment made to the long-term care hospital is considered payment in full as specified in § 412.521(b).

(B) For a greater than 3-day interruption of stay under paragraph (a)(2) of this section, CMS will make only one LTC–DRG payment for all portions of a long-term care stay. CMS also separately pays the acute care hospital, the IRF, or the SNF in accordance with their respective payment systems, as specified in paragraph (c) of this section.

(iii) *Basis for the prospective payment.* Payment to the long-term care hospital is based on the patient's LTC–DRG that is determined in accordance with § 412.513(b).

(2) If the total number of days of a patient's length of stay in a long-term care hospital prior to and following a 3-day or less interruption of stay under paragraphs (b)(1)(i)(A), (B), or (C) of this section or a greater than 3-day interruption of stay under paragraph (b)(1)(i)(D) of this section is up to and including five-sixths of the geometric average length of stay of the LTC–DRG, CMS will make a Federal prospective payment for a short-stay outlier in accordance with § 412.529(c).

(3) If the total number of days of a patient's length of stay in a long-term care hospital prior to and following a 3-day or less interruption of stay under paragraphs (b)(1)(i)(A), (B), or (C) of this section or a greater than 3-day interruption of stay under paragraph (b)(1)(i)(D) of this section exceeds five-sixths of the geometric average length of stay for the LTC–DRG, CMS will make one full Federal LTC–DRG prospective payment for the case. An additional payment will be made if the patient's stay qualifies as a high-cost outlier, as set forth in § 412.525(a).

* * * * *

§ 412.532 [Amended]

■ 5. In § 412.532—

■ A. In paragraph (f), the phrase ''under the policies on interruption of a stay as specified in § 412.531.'' is revised to read ''under the policies on a 3-day or less interruption of a stay and a greater than 3-day interruption of a stay as specified in § 412.531.''

■ B. In paragraph (i), the reference ''paragraphs (h)(1) through (h)(4) of this section'' is revised to read ''§ 412.22(h)(1) through (h)(4)''.

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

Dated: April 26, 2004.

Mark McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Dated: April 27, 2004.

Tommy G. Thompson,

Secretary.

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

Addendum

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

Table 1.—Long-Term Care Hospital Wage Index for Urban Areas for Discharges Occurring from July 1, 2004 through June 30, 2005

Table 2.—Long-Term Care Hospital Wage Index for Rural Areas for Discharges Occurring from July 1, 2004 through June 30, 2005

Table 3.'' FY 2004 LTC–DRG Relative Weights, Geometric Mean Length of Stay, and Short-Stay Five-Sixths Average Length of Stay for Discharges Occurring from July 1, 2004 through September 30, 2004.

Note: This is the same information provided in Table 11 of the August 1, 2003 IPPS final rule (68 FR 45650–45658), which has been reprinted here for convenience.)

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2004 THROUGH JUNE 30, 2005

MSA	Urban area (constituent counties)	Full wage index [1]	1/5th wage index [2]	2/5ths wage index [3]	3/5ths wage index [4]
0040	Abilene, TX	0.7627	0.9525	0.9051	0.8576
	Taylor, TX				
0060	Aguadilla, PR	0.4306	0.8861	0.7722	0.6584
	Aguada, PR				
	Aguadilla, PR				
	Moca, PR				
0080	Akron, OH	0.9246	0.9849	0.9698	0.9548
	Portage, OH				
	Summit, OH				
0120	Albany, GA	1.0863	1.0173	1.0345	1.0518
	Dougherty, GA				
	Lee, GA				
0160	Albany-Schenectady-Troy, NY	0.8489	0.9698	0.9396	0.9093
	Albany, NY				
	Montgomery, NY				
	Rensselaer, NY				
	Saratoga, NY				
	Schenectady, NY				
	Schoharie, NY				
0200	Albuquerque, NM	0.9300	0.9860	0.9720	0.9580
	Bernalillo, NM				
	Sandoval, NM				
	Valencia, NM				
0220	Alexandria, LA	0.8019	0.9604	0.9208	0.8811
	Rapides, LA				
0240	Allentown-Bethlehem-Easton, PA	0.9721	0.9944	0.9888	0.9833
	Carbon, PA				
	Lehigh, PA				
	Northampton, PA				
0280	Altoona, PA	0.8806	0.9761	0.9522	0.9284

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2004 THROUGH JUNE 30, 2005—Continued

MSA	Urban area (constituent counties)	Full wage index [1]	1/5th wage index [2]	2/5ths wage index [3]	3/5ths wage index [4]
	Blair, PA				
0320	Amarillo, TX Potter, TX	0.8986	0.9797	0.9594	0.9392
	Randall, TX				
0380	Anchorage, AK	1.2216	1.0443	1.0886	1.1330
	Anchorage, AK				
0440	Ann Arbor, MI	1.1074	1.0215	1.0430	1.0644
	Lenawee, MI				
	Livingston, MI				
	Washtenaw, MI				
0450	Anniston, AL	0.8090	0.9618	0.9236	0.8854
	Calhoun, AL				
0460	Appleton-Oshkosh-Neenah, WI	0.9035	0.9807	0.9614	0.9421
	Calumet, WI				
	Outagamie, WI				
	Winnebago, WI				
0470	Arecibo, PR	0.4155	0.8831	0.7662	0.6493
	Arecibo, PR				
	Camuy, PR				
	Hatillo, PR				
0480	Asheville, NC	0.9720	0.9944	0.9888	0.9832
	Buncombe, NC				
	Madison, NC				
0500	Athens, GA	0.9818	0.9964	0.9927	0.9891
	Clarke, GA				
	Madison, GA				
	Oconee, GA				
0520	Atlanta, GA	1.0130	1.0026	1.0052	1.0078
	Barrow, GA				
	Bartow, GA				
	Carroll, GA				
	Cherokee, GA				
	Clayton, GA				
	Cobb, GA				
	Coweta, GA				
	DeKalb, GA				
	Douglas, GA				
	Fayette, GA				
	Forsyth, GA				
	Fulton, GA				
	Gwinnett, GA				
	Henry, GA				
	Newton, GA				
	Paulding, GA				
	Pickens, GA				
	Rockdale, GA				
	Spalding, GA				
	Walton, GA				
0560	Atlantic-Cape May, NJ	1.0795	1.0159	1.0318	1.0477
	Atlantic, NJ				
	Cape May, NJ				
0580	Auburn-Opelika, AL	0.8494	0.9699	0.9398	0.9096
	Lee, AL				
0600	Augusta-Aiken, GA-SC	0.9625	0.9925	0.9850	0.9775
	Columbia, GA				
	McDuffie, GA				
	Richmond, GA				
	Aiken, SC				
	Edgefield, SC				
0640	Austin-San Marcos, TX	0.9609	0.9922	0.9844	0.9765
	Bastrop, TX				
	Caldwell, TX				
	Hays, TX				
	Travis, TX				
	Williamson, TX				
0680	Bakersfield, CA	0.9810	0.9962	0.9924	0.9886
	Kern, CA				
0720	Baltimore, MD	0.9919	0.9984	0.9968	0.9951
	Anne Arundel, MD				
	Baltimore, MD				

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2004 THROUGH JUNE 30, 2005—Continued

MSA	Urban area (constituent counties)	Full wage index [1]	1/5th wage index [2]	2/5ths wage index [3]	3/5ths wage index [4]
	Baltimore City, MD Carroll, MD Harford, MD Howard, MD Queen Anne's, MD				
0733	Bangor, ME Penobscot, ME	0.9904	0.9981	0.9962	0.9942
0743	Barnstable-Yarmouth, MA Barnstable, MA	1.2956	1.0591	1.1182	1.1774
0760	Baton Rouge, LA Ascension, LA East Baton Rouge, LA Livingston, LA West Baton Rouge, LA	0.8406	0.9681	0.9362	0.9044
0840	Beaumont-Port Arthur, TX Hardin, TX Jefferson, TX Orange, TX	0.8424	0.9685	0.9370	0.9054
0860	Bellingham, WA Whatcom, WA	1.1757	1.0351	1.0703	1.1054
0870	Benton Harbor, MI Berrien, MI	0.8871	0.9774	0.9548	0.9323
0875	Bergen-Passaic, NJ Bergen, NJ Passaic, NJ	1.1692	1.0338	1.0677	1.1015
0880	Billings, MT Yellowstone, MT	0.8961	0.9792	0.9584	0.9377
0920	Biloxi-Gulfport-Pascagoula, MS Hancock, MS Harrison, MS Jackson, MS	0.9029	0.9806	0.9612	0.9417
0960	Binghamton, NY Broome, NY Tioga, NY	0.8428	0.9686	0.9371	0.9057
1000	Birmingham, AL Blount, AL Jefferson, AL St. Clair, AL Shelby, AL	0.9212	0.9842	0.9685	0.9527
1010	Bismarck, ND Burleigh, ND Morton, ND	0.7965	0.9593	0.9186	0.8779
1020	Bloomington, IN Monroe, IN	0.8662	0.9732	0.9465	0.9197
1040	Bloomington-Normal, IL McLean, IL	0.8832	0.9766	0.9533	0.9299
1080	Boise City, ID Ada, ID Canyon, ID	0.9209	0.9842	0.9684	0.9525
1123	Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH (NH Hospitals) Bristol, MA Essex, MA Middlesex, MA Norfolk, MA Plymouth, MA Suffolk, MA Worcester, MA Hillsborough, NH Merrimack, NH Rockingham, NH Strafford, NH	1.1233	1.0247	1.0493	1.0740
1125	Boulder-Longmont, CO Boulder, CO	1.0049	1.0010	1.0020	1.0029
1145	Brazoria, TX Brazoria, TX	0.8137	0.9627	0.9255	0.8882
1150	Bremerton, WA Kitsap, WA	1.0580	1.0116	1.0232	1.0348
1240	Brownsville-Harlingen-San Benito, TX Cameron, TX	1.0303	1.0061	1.0121	1.0182

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2004 THROUGH JUNE 30, 2005—Continued

MSA	Urban area (constituent counties)	Full wage index [1]	1/5th wage index [2]	2/5ths wage index [3]	3/5ths wage index [4]
1260	Bryan-College Station, TX	0.9019	0.9804	0.9608	0.9411
	Brazos, TX				
1280	Buffalo-Niagara Falls, NY	0.9604	0.9921	0.9842	0.9762
	Erie, NY				
	Niagara, NY				
1303	Burlington, VT	0.9704	0.9941	0.9882	0.9822
	Chittenden, VT				
	Franklin, VT				
	Grand Isle, VT				
1310	Caguas, PR	0.4158	0.8832	0.7663	0.6495
	Caguas, PR				
	Cayey, PR				
	Cidra, PR				
	Gurabo, PR				
	San Lorenzo, PR				
1320	Canton-Massillon, OH	0.9071	0.9814	0.9628	0.9443
	Carroll, OH				
	Stark, OH				
1350	Casper, WY	0.9095	0.9819	0.9638	0.9457
	Natrona, WY				
1360	Cedar Rapids, IA	0.8874	0.9775	0.9550	0.9324
	Linn, IA				
1400	Champaign-Urbana, IL	0.9907	0.9981	0.9963	0.9944
	Champaign, IL				
1440	Charleston-North Charleston, SC	0.9332	0.9866	0.9733	0.9599
	Berkeley, SC				
	Charleston, SC				
	Dorchester, SC				
1480	Charleston, WV	0.8880	0.9776	0.9552	0.9328
	Kanawha, WV				
	Putnam, WV				
1520	Charlotte-Gastonia-Rock Hill, NC–SC	0.9760	0.9952	0.9904	0.9856
	Cabarrus, NC				
	Gaston, NC				
	Lincoln, NC				
	Mecklenburg, NC				
	Rowan, NC				
	Stanly, NC				
	Union, NC				
	York, SC				
1540	Charlottesville, VA	1.0025	1.0005	1.0010	1.0015
	Albemarle, VA				
	Charlottesville City, VA				
	Fluvanna, VA				
	Greene, VA				
1560	Chattanooga, TN–GA	0.9086	0.9817	0.9634	0.9452
	Catoosa, GA				
	Dade, GA				
	Walker, GA				
	Hamilton, TN				
	Marion, TN				
1580	Cheyenne, WY	0.8796	0.9759	0.9518	0.9278
	Laramie, WY				
1600	Chicago, IL	1.0892	1.0178	1.0357	1.0535
	Cook, IL				
	DeKalb, IL				
	DuPage, IL				
	Grundy, IL				
	Kane, IL				
	Kendall, IL				
	Lake, IL				
	McHenry, IL				
	Will, IL				
1620	Chico-Paradise, CA	1.0193	1.0039	1.0077	1.0116
	Butte, CA				
1640	Cincinnati, OH-KY-IN	0.9413	0.9883	0.9765	0.9648
	Dearborn, IN				
	Ohio, IN				
	Boone, KY				

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2004 THROUGH JUNE 30, 2005—Continued

MSA	Urban area (constituent counties)	Full wage index [1]	1/5th wage index [2]	2/5ths wage index [3]	3/5ths wage index [4]
	Campbell, KY				
	Gallatin, KY				
	Grant, KY				
	Kenton, KY				
	Pendleton, KY				
	Brown, OH				
	Clermont, OH				
	Hamilton, OH				
	Warren, OH				
1660	Clarksville-Hopkinsville, TN-KY	0.8244	0.9649	0.9298	0.8946
	Christian, KY				
	Montgomery, TN				
1680	Cleveland-Lorain-Elyria, OH	0.9671	0.9934	0.9868	0.9803
	Ashtabula, OH				
	Cuyahoga, OH				
	Geauga, OH				
	Lake, OH				
	Lorain, OH				
	Medina, OH				
1720	Colorado Springs, CO	0.9833	0.9967	0.9933	0.9900
	El Paso, CO				
1740	Columbia, MO	0.8695	0.9739	0.9478	0.9217
	Boone, MO				
1760	Columbia, SC	0.8902	0.9780	0.9561	0.9341
	Lexington, SC				
	Richland, SC				
1800	Columbus, GA-AL Russell, AL	0.8694	0.9739	0.9478	0.9216
	Chattahoochee, GA				
	Harris, GA				
	Muscogee, GA				
1840	Columbus, OH	0.9648	0.9930	0.9859	0.9789
	Delaware, OH				
	Fairfield, OH				
	Franklin, OH				
	Licking, OH				
	Madison, OH				
	Pickaway, OH				
1880	Corpus Christi, TX	0.8521	0.9704	0.9408	0.9113
	Nueces, TX				
	San Patricio, TX				
1890	Corvallis, OR	1.1516	1.0303	1.0606	1.0910
	Benton, OR				
1900	Cumberland, MD–WV (WV Hospital)	0.8200	0.9640	0.9280	0.8920
	Allegany, MD				
	Mineral, WV				
1920	Dallas, TX	0.9974	0.9995	0.9990	0.9984
	Collin, TX				
	Dallas, TX				
	Denton, TX				
	Ellis, TX				
	Henderson, TX				
	Hunt, TX				
	Kaufman, TX				
	Rockwall, TX				
1950	Danville, VA	0.9035	0.9807	0.9614	0.9421
	Danville City, VA				
	Pittsylvania, VA				
1960	Davenport-Moline-Rock Island, IA-IL	0.8985	0.9797	0.9594	0.9391
	Scott, IA				
	Henry, IL				
	Rock Island, IL				
2000	Dayton-Springfield, OH	0.9518	0.9904	0.9807	0.9711
	Clark, OH				
	Greene, OH				
	Miami, OH				
	Montgomery, OH				
2020	Daytona Beach, FL	0.9078	0.9816	0.9631	0.9447
	Flagler, FL				
	Volusia, FL				

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2004 THROUGH JUNE 30, 2005—Continued

MSA	Urban area (constituent counties)	Full wage index [1]	1/5th wage index [2]	2/5ths wage index [3]	3/5ths wage index [4]
2030	Decatur, AL	0.8828	0.9766	0.9531	0.9297
	Lawrence, AL				
	Morgan, AL				
2040	Decatur, IL	0.8161	0.9632	0.9264	0.8897
	Macon, IL				
2080	Denver, CO	1.0837	1.0167	1.0335	1.0502
	Adams, CO				
	Arapahoe, CO				
	Denver, CO				
	Douglas, CO				
	Jefferson, CO				
2120	Des Moines, IA	0.9106	0.9821	0.9642	0.9464
	Dallas, IA				
	Polk, IA				
	Warren, IA				
2160	Detroit, MI	1.0101	1.0020	1.0040	1.0061
	Lapeer, MI				
	Macomb, MI				
	Monroe, MI				
	Oakland, MI				
	St. Clair, MI				
	Wayne, MI				
2180	Dothan, AL	0.7741	0.9548	0.9096	0.8645
	Dale, AL				
	Houston, AL				
2190	Dover, DE	0.9805	0.9961	0.9922	0.9883
	Kent, DE				
2200	Dubuque, IA	0.8886	0.9777	0.9554	0.9332
	Dubuque, IA				
2240	Duluth-Superior, MN-WI	1.0171	1.0034	1.0068	1.0103
	St. Louis, MN				
	Douglas, WI				
2281	Dutchess County, NY	1.0934	1.0187	1.0374	1.0560
	Dutchess, NY				
2290	Eau Claire, WI	0.9064	0.9813	0.9626	0.9438
	Chippewa, WI				
	Eau Claire, WI				
2320	El Paso, TX	0.9196	0.9839	0.9678	0.9518
	El Paso, TX				
2330	Elkhart-Goshen, IN	0.9783	0.9957	0.9913	0.9870
	Elkhart, IN				
2335	Elmira, NY	0.8377	0.9675	0.9351	0.9026
	Chemung, NY				
2340	Enid, OK	0.8559	0.9712	0.9424	0.9135
	Garfield, OK				
2360	Erie, PA	0.8601	0.9720	0.9440	0.9161
	Erie, PA				
2400	Eugene-Springfield, OR	1.1456	1.0291	1.0582	1.0874
	Lane, OR				
2440	Evansville-Henderson, IN-KY (IN Hospitals)	0.8429	0.9686	0.9372	0.9057
	Posey, IN				
	Vanderburgh, IN				
	Warrick, IN				
	Henderson, KY				
2520	Fargo-Moorhead, ND-MN	0.9797	0.9959	0.9919	0.9878
	Clay, MN				
	Cass, ND				
2560	Fayetteville, NC	0.8986	0.9797	0.9594	0.9392
	Cumberland, NC				
2580	Fayetteville-Springdale-Rogers, AR	0.8396	0.9679	0.9358	0.9038
	Benton, AR				
	Washington, AR				
2620	Flagstaff, AZ-UT	1.1333	1.0267	1.0533	1.0800
	Coconino, AZ				
	Kane, UT				
2640	Flint, MI	1.0858	1.0172	1.0343	1.0515
	Genesee, MI				
2650	Florence, AL	0.7747	0.9549	0.9099	0.8648
	Colbert, AL				

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2004 THROUGH JUNE 30, 2005—Continued

MSA	Urban area (constituent counties)	Full wage index [1]	1/5th wage index [2]	2/5ths wage index [3]	3/5ths wage index [4]
	Lauderdale, AL				
2655	Florence, SC	0.8709	0.9742	0.9484	0.9225
	Florence, SC				
2670	Fort Collins-Loveland, CO	1.0108	1.0022	1.0043	1.0065
	Larimer, CO				
2680	Ft. Lauderdale, FL	1.0163	1.0033	1.0065	1.0098
	Broward, FL				
2700	Fort Myers-Cape Coral, FL	0.9816	0.9963	0.9926	0.9890
	Lee, FL				
2710	Fort Pierce-Port St. Lucie, FL	1.0008	1.0002	1.0003	1.0005
	Martin, FL				
	St. Lucie, FL				
2720	Fort Smith, AR-OK	0.8424	0.9685	0.9370	0.9054
	Crawford, AR				
	Sebastian, AR				
	Sequoyah, OK				
2750	Fort Walton Beach, FL	0.8966	0.9793	0.9586	0.9380
	Okaloosa, FL				
2760	Fort Wayne, IN	0.9585	0.9917	0.9834	0.9751
	Adams, IN				
	Allen, IN				
	De Kalb, IN				
	Huntington, IN				
	Wells, IN				
	Whitley, IN				
2800	Fort Worth-Arlington, TX	0.9359	0.9872	0.9744	0.9615
	Hood, TX				
	Johnson, TX				
	Parker, TX				
	Tarrant, TX				
2840	Fresno, CA	1.0094	1.0019	1.0038	1.0056
	Fresno, CA				
	Madera, CA				
2880	Gadsden, AL	0.8206	0.9641	0.9282	0.8924
	Etowah, AL				
2900	Gainesville, FL	0.9693	0.9939	0.9877	0.9816
	Alachua, FL				
2920	Galveston-Texas City, TX	0.9279	0.9856	0.9712	0.9567
	Galveston, TX				
2960	Gary, IN	0.9410	0.9882	0.9764	0.9646
	Lake, IN				
	Porter, IN				
2975	Glens Falls, NY	0.8475	0.9695	0.9390	0.9085
	Warren, NY				
	Washington, NY				
2980	Goldsboro, NC	0.8622	0.9724	0.9449	0.9173
	Wayne, NC				
2985	Grand Forks, ND-MN	0.8636	0.9727	0.9454	0.9182
	Polk, MN				
	Grand Forks, ND				
2995	Grand Junction, CO	0.9633	0.9927	0.9853	0.9780
	Mesa, CO				
3000	Grand Rapids-Muskegon-Holland, MI	0.9469	0.9894	0.9788	0.9681
	Allegan, MI				
	Kent, MI				
	Muskegon, MI				
	Ottawa, MI				
3040	Great Falls, MT	0.8809	0.9762	0.9524	0.9285
	Cascade, MT				
3060	Greeley, CO	0.9372	0.9874	0.9749	0.9623
	Weld, CO				
3080	Green Bay, WI	0.9461	0.9892	0.9784	0.9677
	Brown, WI				
3120	Greensboro-Winston-Salem-High Point, NC	0.9166	0.9833	0.9666	0.9500
	Alamance, NC				
	Davidson, NC				
	Davie, NC				
	Forsyth, NC				
	Guilford, NC				

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2004 THROUGH JUNE 30, 2005—Continued

MSA	Urban area (constituent counties)	Full wage index [1]	1/5th wage index [2]	2/5ths wage index [3]	3/5ths wage index [4]
	Randolph, NC				
	Stokes, NC				
	Yadkin, NC				
3150	Greenville, NC	0.9098	0.9820	0.9639	0.9459
	Pitt, NC				
3160	Greenville-Spartanburg-Anderson, SC	0.9335	0.9867	0.9734	0.9601
	Anderson, SC				
	Cherokee, SC				
	Greenville, SC				
	Pickens, SC				
	Spartanburg, SC				
3180	Hagerstown, MD	0.9172	0.9834	0.9669	0.9503
	Washington, MD				
3200	Hamilton-Middletown, OH	0.9214	0.9843	0.9686	0.9528
	Butler, OH				
3240	Harrisburg-Lebanon-Carlisle, PA	0.9164	0.9833	0.9666	0.9498
	Cumberland, PA				
	Dauphin, PA				
	Lebanon, PA				
	Perry, PA				
3283	Hartford, CT	1.1555	1.0311	1.0622	1.0933
	Hartford, CT				
	Litchfield, CT				
	Middlesex, CT				
	Tolland, CT				
3285	Hattiesburg, MS [2]	0.7307	0.9461	0.8923	0.8384
	Forrest, MS				
	Lamar, MS				
3290	Hickory-Morganton-Lenoir, NC	0.9242	0.9848	0.9697	0.9545
	Alexander, NC				
	Burke, NC				
	Caldwell, NC				
	Catawba, NC				
3320	Honolulu, HI	1.1098	1.0220	1.0439	1.0659
	Honolulu, HI				
3350	Houma, LA	0.7748	0.9550	0.9099	0.8649
	Lafourche, LA				
	Terrebonne, LA				
3360	Houston, TX	0.9834	0.9967	0.9934	0.9900
	Chambers, TX				
	Fort Bend, TX				
	Harris, TX				
	Liberty, TX				
	Montgomery, TX				
	Waller, TX				
3400	Huntington-Ashland, WV-KY-OH	0.9595	0.9919	0.9838	0.9757
	Boyd, KY				
	Carter, KY				
	Greenup, KY				
	Lawrence, OH				
	Cabell, WV				
	Wayne, WV				
3440	Huntsville, AL	0.9245	0.9849	0.9698	0.9547
	Limestone, AL				
	Madison, AL				
3480	Indianapolis, IN	0.9916	0.9983	0.9966	0.9950
	Boone, IN				
	Hamilton, IN				
	Hancock, IN				
	Hendricks, IN				
	Johnson, IN				
	Madison, IN				
	Marion, IN				
	Morgan, IN				
	Shelby, IN				
3500	Iowa City, IA	0.9548	0.9910	0.9819	0.9729
	Johnson, IA				
3520	Jackson, MI	0.8986	0.9797	0.9594	0.9392
	Jackson, MI				

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2004 THROUGH JUNE 30, 2005—Continued

MSA	Urban area (constituent counties)	Full wage index [1]	1/5th wage index [2]	2/5ths wage index [3]	3/5ths wage index [4]
3560	Jackson, MS	0.8357	0.9671	0.9343	0.9014
	Hinds, MS				
	Madison, MS				
	Rankin, MS				
3580	Jackson, TN	0.8984	0.9797	0.9594	0.9390
	Madison, TN				
	Chester, TN				
3600	Jacksonville, FL	0.9529	0.9906	0.9812	0.9717
	Clay, FL				
	Duval, FL				
	Nassau, FL				
	St. Johns, FL				
3605	Jacksonville, NC	0.8544	0.9709	0.9418	0.9126
	Onslow, NC				
3610	Jamestown, NY	0.7762	0.9552	0.9105	0.8657
	Chautauqua, NY				
3620	Janesville-Beloit, WI	0.9282	0.9856	0.9713	0.9569
	Rock, WI				
3640	Jersey City, NJ	1.1115	1.0223	1.0446	1.0669
	Hudson, NJ				
3660	Johnson City-Kingsport-Bristol, TN-VA	0.8253	0.9651	0.9301	0.8952
	Carter, TN				
	Hawkins, TN				
	Sullivan, TN				
	Unicoi, TN				
	Washington, TN				
	Bristol City, VA				
	Scott, VA				
	Washington, VA				
3680	Johnstown, PA	0.8158	0.9632	0.9263	0.8895
	Cambria, PA				
	Somerset, PA				
3700	Jonesboro, AR	0.7794	0.9559	0.9118	0.8676
	Craighead, AR				
3710	Joplin, MO	0.8681	0.9736	0.9472	0.9209
	Jasper, MO				
	Newton, MO				
3720	Kalamazoo-Battlecreek, MI	1.0500	1.0100	1.0200	1.0300
	Calhoun, MI				
	Kalamazoo, MI				
	Van Buren, MI				
3740	Kankakee, IL	1.0419	1.0084	1.0168	1.0251
	Kankakee, IL				
3760	Kansas City, KS-MO	0.9715	0.9943	0.9886	0.9829
	Johnson, KS				
	Leavenworth, KS				
	Miami, KS				
	Wyandotte, KS				
	Cass, MO				
	Clay, MO				
	Clinton, MO				
	Jackson, MO				
	Lafayette, MO				
	Platte, MO				
	Ray, MO				
3800	Kenosha, WI	0.9761	0.9952	0.9904	0.9857
	Kenosha, WI				
3810	Killeen-Temple, TX	0.9159	0.9832	0.9664	0.9495
	Bell, TX				
	Coryell, TX				
3840	Knoxville, TN	0.8820	0.9764	0.9528	0.9292
	Anderson, TN				
	Blount, TN				
	Knox, TN				
	Loudon, TN				
	Sevier, TN				
	Union, TN				
3850	Kokomo, IN	0.9045	0.9809	0.9618	0.9427
	Howard, IN				

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2004 THROUGH JUNE 30, 2005—Continued

MSA	Urban area (constituent counties)	Full wage index [1]	1/5th wage index [2]	2/5ths wage index [3]	3/5ths wage index [4]
	Tipton, IN				
3870	La Crosse, WI-MN	0.9247	0.9849	0.9699	0.9548
	Houston, MN				
	La Crosse, WI				
3880	Lafayette, LA	0.8189	0.9638	0.9276	0.8913
	Acadia, LA				
	Lafayette, LA				
	St. Landry, LA				
	St. Martin, LA				
3920	Lafayette, IN	0.8584	0.9717	0.9434	0.9150
	Clinton, IN				
	Tippecanoe, IN				
3960	Lake Charles, LA	0.7841	0.9568	0.9136	0.8705
	Calcasieu, LA				
3980	Lakeland-Winter Haven, FL	0.8811	0.9762	0.9524	0.9287
	Polk, FL				
4000	Lancaster, PA	0.9282	0.9856	0.9713	0.9569
	Lancaster, PA				
4040	Lansing-East Lansing, MI	0.9714	0.9943	0.9886	0.9828
	Clinton, MI				
	Eaton, MI				
	Ingham, MI				
4080	Laredo, TX	0.8091	0.9618	0.9236	0.8855
	Webb, TX				
4100	Las Cruces, NM	0.8688	0.9738	0.9475	0.9213
	Dona Ana, NM				
4120	Las Vegas, NV-AZ	1.1528	1.0306	1.0611	1.0917
	Mohave, AZ				
	Clark, NV				
	Nye, NV				
4150	Lawrence, KS	0.8677	0.9735	0.9471	0.9206
	Douglas, KS				
4200	Lawton, OK	0.8267	0.9653	0.9307	0.8960
	Comanche, OK				
4243	Lewiston-Auburn, ME	0.9383	0.9877	0.9753	0.9630
	Androscoggin, ME				
4280	Lexington, KY	0.8685	0.9737	0.9474	0.9211
	Bourbon, KY				
	Clark, KY				
	Fayette, KY				
	Jessamine, KY				
	Madison, KY				
	Scott, KY				
	Woodford, KY				
4320	Lima, OH	0.9522	0.9904	0.9809	0.9713
	Allen, OH				
	Auglaize, OH				
4360	Lincoln, NE	1.0033	1.0007	1.0013	1.0020
	Lancaster, NE				
4400	Little Rock-North Little Rock, AR	0.8923	0.9785	0.9569	0.9354
	Faulkner, AR				
	Lonoke, AR				
	Pulaski, AR				
	Saline, AR				
4420	Longview-Marshall, TX	0.9113	0.9823	0.9645	0.9468
	Gregg, TX				
	Harrison, TX				
	Upshur, TX				
4480	Los Angeles-Long Beach, CA	1.1795	1.0359	1.0718	1.1077
	Los Angeles, CA				
4520	Louisville, KY-IN [1]	0.9242	0.9848	0.9697	0.9545
	Clark, IN				
	Floyd, IN				
	Harrison, IN				
	Scott, IN				
	Bullitt, KY				
	Jefferson, KY				
	Oldham, KY				
4600	Lubbock, TX	0.8272	0.9654	0.9309	0.8963

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2004 THROUGH JUNE 30, 2005—Continued

MSA	Urban area (constituent counties)	Full wage index [1]	1/5th wage index [2]	2/5ths wage index [3]	3/5ths wage index [4]
	Lubbock, TX				
4640	Lynchburg, VA	0.9134	0.9827	0.9654	0.9480
	Amherst, VA				
	Bedford, VA				
	Bedford City, VA				
	Campbell, VA				
	Lynchburg City, VA				
4680	Macon, GA	0.8953	0.9791	0.9581	0.9372
	Bibb, GA				
	Houston, GA				
	Jones, GA				
	Peach, GA				
	Twiggs, GA				
4720	Madison, WI	1.0264	1.0053	1.0106	1.0158
	Dane, WI				
4800	Mansfield, OH	0.9180	0.9836	0.9672	0.9508
	Crawford, OH				
	Richland, OH				
4840	Mayaguez, PR	0.4795	0.8959	0.7918	0.6877
	Anasco, PR				
	Cabo Rojo, PR				
	Hormigueros, PR				
	Mayaguez, PR				
	Sabana Grande, PR				
	San German, PR				
4880	McAllen-Edinburg-Mission, TX	0.8381	0.9676	0.9352	0.9029
	Hidalgo, TX				
4890	Medford-Ashland, OR	1.0772	1.0154	1.0309	1.0463
	Jackson, OR				
4900	Melbourne-Titusville-Palm Bay, FL	0.9776	0.9955	0.9910	0.9866
	Brevard, Fl				
4920	Memphis, TN-AR-MS	0.9009	0.9802	0.9604	0.9405
	Crittenden, AR				
	DeSoto, MS				
	Fayette, TN				
	Shelby, TN				
	Tipton, TN				
4940	Merced, CA	0.9690	0.9938	0.9876	0.9814
	Merced, CA				
5000	Miami, FL	0.9894	0.9979	0.9958	0.9936
	Dade, FL				
5015	Middlesex-Somerset-Hunterdon, NJ	1.1366	1.0273	1.0546	1.0820
	Hunterdon, NJ				
	Middlesex, NJ				
	Somerset, NJ				
5080	Milwaukee-Waukesha, WI	0.9988	0.9998	0.9995	0.9993
	Milwaukee, WI				
	Ozaukee, WI				
	Washington, WI				
	Waukesha, WI				
5120	Minneapolis-St. Paul, MN-WI	1.1001	1.0200	1.0400	1.0601
	Anoka, MN				
	Carver, MN				
	Chisago, MN				
	Dakota, MN				
	Hennepin, MN				
	Isanti, MN				
	Ramsey, MN				
	Scott, MN				
	Sherburne, MN				
	Washington, MN				
	Wright, MN				
	Pierce, WI				
	St. Croix, WI				
5140	Missoula, MT	0.8718	0.9744	0.9487	0.9231
	Missoula, MT				
5160	Mobile, AL	0.7994	0.9599	0.9198	0.8796
	Baldwin, AL				
	Mobile, AL				

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2004 THROUGH JUNE 30, 2005—Continued

MSA	Urban area (constituent counties)	Full wage index [1]	1/5th wage index [2]	2/5ths wage index [3]	3/5ths wage index [4]
5170	Modesto, CA Stanislaus, CA	1.1275	1.0255	1.0510	1.0765
5190	Monmouth-Ocean, NJ Monmouth, NJ Ocean, NJ	1.0956	1.0191	1.0382	1.0574
5200	Monroe, LA Ouachita, LA	0.7922	0.9584	0.9169	0.8753
5240	Montgomery, AL Autauga, AL Elmore, AL Montgomery, AL	0.7907	0.9581	0.9163	0.8744
5280	Muncie, IN Delaware, IN	0.8775	0.9755	0.9510	0.9265
5330	Myrtle Beach, SC Horry, SC	0.9112	0.9822	0.9645	0.9467
5345	Naples, FL Collier, FL	0.9790	0.9958	0.9916	0.9874
5360	Nashville, TN Cheatham, TN Davidson, TN Dickson, TN Robertson, TN Rutherford TN Sumner, TN Williamson, TN Wilson, TN	0.9855	0.9971	0.9942	0.9913
5380	Nassau-Suffolk, NY Nassau, NY Suffolk, NY	1.3140	1.0628	1.1256	1.1884
5483	New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT Fairfield, CT New Haven, CT	1.2385	1.0477	1.0954	1.1431
5523	New London-Norwich, CT New London, CT	1.1631	1.0326	1.0652	1.0979
5560	New Orleans, LA Jefferson, LA Orleans, LA Plaquemines, LA St. Bernard, LA St. Charles, LA St. James, LA St. John The Baptist, LA St. Tammany, LA	0.9174	0.9835	0.9670	0.9504
5600	New York, NY Bronx, NY Kings, NY New York, NY Putnam, NY Queens, NY Richmond, NY Rockland, NY Westchester, NY	1.4018	1.0804	1.1607	1.2411
5640	Newark, NJ Essex, NJ Morris, NJ Sussex, NJ Union, NJ Warren, NJ	1.1518	1.0304	1.0607	1.0911
5660	Newburgh, NY-PA Orange, NY Pike, PA	1.1509	1.0302	1.0604	1.0905
5720	Norfolk-Virginia Beach-Newport News, VA-NC Currituck, NC Chesapeake City, VA Gloucester, VA Hampton City, VA Isle of Wight, VA James City, VA Mathews, VA	0.8619	0.9724	0.9448	0.9171

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2004 THROUGH JUNE 30, 2005—Continued

MSA	Urban area (constituent counties)	Full wage index [1]	1/5th wage index [2]	2/5ths wage index [3]	3/5ths wage index [4]
	Newport News City, VA Norfolk City, VA Poquoson City, VA Portsmouth City, VA Suffolk City, VA Virginia Beach City VA Williamsburg City, VA York, VA				
5775	Oakland, CA Alameda, CA Contra Costa, CA	1.4921	1.0984	1.1968	1.2953
5790	Ocala, FL Marion, FL	0.9728	0.9946	0.9891	0.9837
5800	Odessa-Midland, TX Ector, TX Midland, TX	0.9327	0.9865	0.9731	0.9596
5880	Oklahoma City, OK Canadian, OK Cleveland, OK Logan, OK McClain, OK Oklahoma, OK Pottawatomie, OK	0.8984	0.9797	0.9594	0.9390
5910	Olympia, WA Thurston, WA	1.0963	1.0193	1.0385	1.0578
5920	Omaha, NE-IA Pottawattamie, IA Cass, NE Douglas, NE Sarpy, NE Washington, NE	0.9745	0.9949	0.9898	0.9847
5945	Orange County, CA Orange, CA	1.1372	1.0274	1.0549	1.0823
5960	Orlando, FL Lake, FL Orange, FL Osceola, FL Seminole, FL	0.9654	0.9931	0.9862	0.9792
5990	Owensboro, KY Daviess, KY	0.8374	0.9675	0.9350	0.9024
6015	Panama City, FL Bay, FL	0.8202	0.9640	0.9281	0.8921
6020	Parkersburg-Marietta, WV-OH Washington, OH Wood, WV	0.8039	0.9608	0.9216	0.8823
6080	Pensacola, FL Escambia, FL Santa Rosa, FL	0.8707	0.9741	0.9483	0.9224
6120	Peoria-Pekin, IL Peoria, IL Tazewell, IL Woodford, IL	0.8734	0.9747	0.9494	0.9240
6160	Philadelphia, PA-NJ Burlington, NJ Camden, NJ Gloucester, NJ Salem, NJ Bucks, PA Chester, PA Delaware, PA Montgomery, PA Philadelphia, PA	1.0883	1.0177	1.0353	1.0530
6200	Phoenix-Mesa, AZ Maricopa, AZ Pinal, AZ	1.0129	1.0026	1.0052	1.0077
6240	Pine Bluff, AR Jefferson, AR	0.7865	0.9573	0.9146	0.8719
6280	Pittsburgh, PA Allegheny, PA	0.8901	0.9780	0.9560	0.9341

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2004 THROUGH JUNE 30, 2005—Continued

MSA	Urban area (constituent counties)	Full wage index [1]	1/5th wage index [2]	2/5ths wage index [3]	3/5ths wage index [4]
	Beaver, PA				
	Butler, PA				
	Fayette, PA				
	Washington, PA				
	Westmoreland, PA				
6323	Pittsfield, MA	1.0276	1.0055	1.0110	1.0166
	Berkshire, MA				
6340	Pocatello, ID	0.9042	0.9808	0.9617	0.9425
	Bannock, ID				
6360	Ponce, PR	0.4708	0.8942	0.7883	0.6825
	Guayanilla, PR				
	Juana Diaz, PR				
	Penuelas, PR				
	Ponce, PR				
	Villalba, PR				
	Yauco, PR				
6403	Portland, ME	0.9949	0.9990	0.9980	0.9969
	Cumberland, ME				
	Sagadahoc, ME				
	York, ME				
6440	Portland-Vancouver, OR-WA	1.1213	1.0243	1.0485	1.0728
	Clackamas, OR				
	Columbia, OR				
	Multnomah, OR				
	Washington, OR				
	Yamhill, OR				
	Clark, WA				
6483	Providence-Warwick-Pawtucket, RI	1.0977	1.0195	1.0391	1.0586
	Bristol, RI				
	Kent, RI				
	Newport, RI				
	Providence, RI				
	Washington, RI				
6520	Provo-Orem, UT	0.9976	0.9995	0.9990	0.9986
	Utah, UT				
6560	Pueblo, CO	0.8778	0.9756	0.9511	0.9267
	Pueblo, CO				
6580	Punta Gorda, FL	0.9510	0.9902	0.9804	0.9706
	Charlotte, FL				
6600	Racine, WI	0.8814	0.9763	0.9526	0.9288
	Racine, WI				
6640	Raleigh-Durham-Chapel Hill, NC	0.9959	0.9992	0.9984	0.9975
	Chatham, NC				
	Durham, NC				
	Franklin, NC				
	Johnston, NC				
	Orange, NC				
	Wake, NC				
6660	Rapid City, SD	0.8806	0.9761	0.9522	0.9284
	Pennington, SD				
6680	Reading, PA	0.9133	0.9827	0.9653	0.9480
	Berks, PA				
6690	Redding, CA	1.1352	1.0270	1.0541	1.0811
	Shasta, CA				
6720	Reno, NV	1.0682	1.0136	1.0273	1.0409
	Washoe, NV				
6740	Richland-Kennewick-Pasco, WA	1.0609	1.0122	1.0244	1.0365
	Benton, WA				
	Franklin, WA				
6760	Richmond-Petersburg, VA	0.9349	0.9870	0.9740	0.9609
	Charles City County, VA				
	Chesterfield, VA				
	Colonial Heights City, VA				
	Dinwiddie, VA				
	Goochland, VA				
	Hanover, VA				
	Henrico, VA				
	Hopewell City, VA				
	New Kent, VA				

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2004 THROUGH JUNE 30, 2005—Continued

MSA	Urban area (constituent counties)	Full wage index [1]	1/5th wage index [2]	2/5ths wage index [3]	3/5ths wage index [4]
	Petersburg City, VA				
	Powhatan, VA				
	Prince George, VA				
	Richmond City, VA				
6780	Riverside-San Bernardino, CA	1.1341	1.0268	1.0536	1.0805
	Riverside, CA				
	San Bernardino, CA				
6800	Roanoke, VA	0.8700	0.9740	0.9480	0.9220
	Botetourt, VA				
	Roanoke, VA				
	Roanoke City, VA				
	Salem City, VA				
6820	Rochester, MN	1.1739	1.0348	1.0696	1.1043
	Olmsted, MN				
6840	Rochester, NY	0.9430	0.9886	0.9772	0.9658
	Genesee, NY				
	Livingston, NY				
	Monroe, NY				
	Ontario, NY				
	Orleans, NY				
	Wayne, NY				
6880	Rockford, IL	0.9666	0.9933	0.9866	0.9800
	Boone, IL				
	Ogle, IL				
	Winnebago, IL				
6895	Rocky Mount, NC	0.9076	0.9815	0.9630	0.9446
	Edgecombe, NC				
	Nash, NC				
6920	Sacramento, CA	1.1845	1.0369	1.0738	1.1107
	El Dorado, CA				
	Placer, CA				
	Sacramento, CA				
6960	Saginaw-Bay City-Midland, MI	1.0032	1.0006	1.0013	1.0019
	Bay, MI				
	Midland, MI				
	Saginaw, MI				
6980	St. Cloud, MN	0.9506	0.9901	0.9802	0.9704
	Benton, MN				
	Stearns, MN				
7000	St. Joseph, MO	0.9757	0.9951	0.9903	0.9854
	Andrew, MO				
	Buchanan, MO				
7040	St. Louis, MO-IL	0.9033	0.9807	0.9613	0.9420
	Clinton, IL				
	Jersey, IL				
	Madison, IL				
	Monroe, IL				
	St. Clair, IL				
	Franklin, MO				
	Jefferson, MO				
	Lincoln, MO				
	St. Charles, MO				
	St. Louis, MO				
	St. Louis City, MO				
	Warren, MO				
7080	Salem, OR	1.0482	1.0096	1.0193	1.0289
	Marion, OR				
	Polk, OR				
7120	Salinas, CA	1.4339	1.0868	1.1736	1.2603
	Monterey, CA				
7160	Salt Lake City-Ogden, UT	0.9913	0.9983	0.9965	0.9948
	Davis, UT				
	Salt Lake, UT				
	Weber, UT				
7200	San Angelo, TX	0.8535	0.9707	0.9414	0.9121
	Tom Green, TX				
7240	San Antonio, TX	0.8870	0.9774	0.9548	0.9322
	Bexar, TX				
	Comal, TX				

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2004 THROUGH JUNE 30, 2005—Continued

MSA	Urban area (constituent counties)	Full wage index [1]	1/5th wage index [2]	2/5ths wage index [3]	3/5ths wage index [4]
	Guadalupe, TX Wilson, TX				
7320	San Diego, CA San Diego, CA	1.1147	1.0229	1.0459	1.0688
7360	San Francisco, CA Marin, CA San Francisco, CA San Mateo, CA	1.4514	1.0903	1.1806	1.2708
7400	San Jose, CA Santa Clara, CA	1.4626	1.0925	1.1850	1.2776
7440	San Juan-Bayamon, PR Aguas Buenas, PR Barceloneta, PR Bayamon, PR Canovanas, PR Carolina, PR Catano, PR Ceiba, PR Comerio, PR Corozal, PR Dorado, PR Fajardo, PR Florida, PR Guaynabo, PR Humacao, PR Juncos, PR Los Piedras, PR Loiza, PR Luguillo, PR Manati, PR Morovis, PR Naguabo, PR Naranjito, PR Rio Grande, PR San Juan, PR Toa Alta, PR Toa Baja, PR Trujillo Alto, PR Vega Alta, PR Vega Baja, PR Yabucoa, PR	0.4909	0.8982	0.7964	0.6945
7460	San Luis Obispo-Atascadero-Paso Robles, CA San Luis Obispo, CA	1.1429	1.0286	1.0572	1.0857
7480	Santa Barbara-Santa Maria-Lompoc, CA Santa Barbara, CA	1.0441	1.0088	1.0176	1.0265
7485	Santa Cruz-Watsonville, CA Santa Cruz, CA	1.2942	1.0588	1.1177	1.1765
7490	Santa Fe, NM Los Alamos, NM Santa Fe, NM	1.0653	1.0131	1.0261	1.0392
7500	Santa Rosa, CA Sonoma, CA	1.2877	1.0575	1.1151	1.1726
7510	Sarasota-Bradenton, FL Manatee, FL Sarasota, FL	0.9964	0.9993	0.9986	0.9978
7520	Savannah, GA Bryan, GA Chatham, GA Effingham, GA	0.9472	0.9894	0.9789	0.9683
7560	Scranton-Wilkes-Barre-Hazleton, PA Columbia, PA Lackawanna, PA Luzerne, PA Wyoming, PA	0.8412	0.9682	0.9365	0.9047
7600	Seattle-Bellevue-Everett, WA Island, WA King, WA Snohomish, WA	1.1562	1.0312	1.0625	1.0937

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2004 THROUGH JUNE 30, 2005—Continued

MSA	Urban area (constituent counties)	Full wage index [1]	1/5th wage index [2]	2/5ths wage index [3]	3/5ths wage index [4]
7610	Sharon, PA	0.7751	0.9550	0.9100	0.8651
	Mercer, PA				
7620	Sheboygan, WI	0.8624	0.9725	0.9450	0.9174
	Sheboygan, WI				
7640	Sherman-Denison, TX	0.9700	0.9940	0.9880	0.9820
	Grayson, TX				
7680	Shreveport-Bossier City, LA	0.9083	0.9817	0.9633	0.9450
	Bossier, LA				
	Caddo, LA				
	Webster, LA				
7720	Sioux City, IA-NE	0.8993	0.9799	0.9597	0.9396
	Woodbury, IA				
	Dakota, NE				
7760	Sioux Falls, SD	0.9309	0.9862	0.9724	0.9585
	Lincoln, SD				
	Minnehaha, SD				
7800	South Bend, IN	0.9821	0.9964	0.9928	0.9893
	St. Joseph, IN				
7840	Spokane, WA	1.0901	1.0180	1.0360	1.0541
	Spokane, WA				
7880	Springfield, IL	0.8944	0.9789	0.9578	0.9366
	Menard, IL				
	Sangamon, IL				
7920	Springfield, MO	0.8457	0.9691	0.9383	0.9074
	Christian, MO				
	Greene, MO				
	Webster, MO				
8003	Springfield, MA	1.0543	1.0109	1.0217	1.0326
	Hampden, MA				
	Hampshire, MA				
8050	State College, PA	0.8740	0.9748	0.9496	0.9244
	Centre, PA				
8080	Steubenville-Weirton, OH–WV (WV Hospitals)	0.8398	0.9680	0.9359	0.9039
	Jefferson, OH				
	Brooke, WV				
	Hancock, WV				
8120	Stockton-Lodi, CA	1.0404	1.0081	1.0162	1.0242
	San Joaquin, CA				
8140	Sumter, SC	0.8243	0.9649	0.9297	0.8946
	Sumter, SC				
8160	Syracuse, NY	0.9412	0.9882	0.9765	0.9647
	Cayuga, NY				
	Madison, NY				
	Onondaga, NY				
	Oswego, NY				
8200	Tacoma, WA	1.1116	1.0223	1.0446	1.0670
	Pierce, WA				
8240	Tallahassee, FL	0.8520	0.9704	0.9408	0.9112
	Gadsden, FL				
	Leon, FL				
8280	Tampa-St. Petersburg-Clearwater, FL	0.9103	0.9821	0.9641	0.9462
	Hernando, FL				
	Hillsborough, FL				
	Pasco, FL				
	Pinellas, FL				
8320	Terre Haute, IN	0.8325	0.9665	0.9330	0.8995
	Clay, IN				
	Vermillion, IN				
	Vigo, IN				
8360	Texarkana, AR-Texarkana, TX	0.8150	0.9630	0.9260	0.8890
	Miller, AR				
	Bowie, TX				
8400	Toledo, OH	0.9381	0.9876	0.9752	0.9629
	Fulton, OH				
	Lucas, OH				
	Wood, OH				
8440	Topeka, KS	0.9108	0.9822	0.9643	0.9465
	Shawnee, KS				
8480	Trenton, NJ	1.0517	1.0103	1.0207	1.0310
	Mercer, NJ				
8520	Tucson, AZ	0.8981	0.9796	0.9592	0.9389

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2004 THROUGH JUNE 30, 2005—Continued

MSA	Urban area (constituent counties)	Full wage index [1]	1/5th wage index [2]	2/5ths wage index [3]	3/5ths wage index [4]
	Pima, AZ				
8560	Tulsa, OK	0.9185	0.9837	0.9674	0.9511
	Creek, OK				
	Osage, OK				
	Rogers, OK				
	Tulsa, OK				
	Wagoner, OK				
8600	Tuscaloosa, AL	0.8212	0.9642	0.9285	0.8927
	Tuscaloosa, AL				
8640	Tyler, TX	0.9404	0.9881	0.9762	0.9642
	Smith, TX				
8680	Utica-Rome, NY	0.8403	0.9681	0.9361	0.9042
	Herkimer, NY				
	Oneida, NY				
8720	Vallejo-Fairfield-Napa, CA	1.3377	1.0675	1.1351	1.2026
	Napa, CA				
	Solano, CA				
8735	Ventura, CA	1.1064	1.0213	1.0426	1.0638
	Ventura, CA				
8750	Victoria, TX	0.8184	0.9637	0.9274	0.8910
	Victoria, TX				
8760	Vineland-Millville-Bridgeton, NJ	1.0405	1.0081	1.0162	1.0243
	Cumberland, NJ				
8780	Visalia-Tulare-Porterville, CA	0.9794	0.9959	0.9918	0.9876
	Tulare, CA				
8800	Waco, TX	0.8394	0.9679	0.9358	0.9036
	McLennan, TX				
8840	Washington, DC-MD-VA-WV	1.0904	1.0181	1.0362	1.0542
	District of Columbia, DC				
	Calvert, MD				
	Charles, MD				
	Frederick, MD				
	Montgomery, MD				
	Prince Georges, MD				
	Alexandria City, VA				
	Arlington, VA				
	Clarke, VA				
	Culpeper, VA				
	Fairfax, VA				
	Fairfax City, VA				
	Falls Church City, VA				
	Fauquier, VA				
	Fredericksburg City, VA				
	King George, VA				
	Loudoun, VA				
	Manassas City, VA				
	Manassas Park City, VA				
	Prince William, VA				
	Spotsylvania, VA				
	Stafford, VA				
	Warren, VA				
	Berkeley, WV				
	Jefferson, WV				
8920	Waterloo-Cedar Falls, IA	0.8366	0.9673	0.9346	0.9020
	Black Hawk, IA				
8940	Wausau, WI	0.9692	0.9938	0.9877	0.9815
	Marathon, WI				
8960	West Palm Beach-Boca Raton, FL	0.9798	0.9960	0.9919	0.9879
	Palm Beach, FL				
9000	Wheeling, WV-OH	0.7494	0.9499	0.8998	0.8496
	Belmont, OH				
	Marshall, WV				
	Ohio, WV				
9040	Wichita, KS	0.9238	0.9848	0.9695	0.9543
	Butler, KS				
	Harvey, KS				
	Sedgwick, KS				
9080	Wichita Falls, TX	0.8341	0.9668	0.9336	0.9005
	Archer, TX				

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2004 THROUGH JUNE 30, 2005—Continued

MSA	Urban area (constituent counties)	Full wage index [1]	1/5th wage index [2]	2/5ths wage index [3]	3/5ths wage index [4]
	Wichita, TX				
9140	Williamsport, PA	0.8158	0.9632	0.9263	0.8895
	Lycoming, PA				
9160	Wilmington-Newark, DE-MD	1.0882	1.0176	1.0353	1.0529
	New Castle, DE				
	Cecil, MD				
9200	Wilmington, NC	0.9563	0.9913	0.9825	0.9738
	New Hanover, NC				
	Brunswick, NC				
9260	Yakima, WA	1.0372	1.0074	1.0149	1.0223
	Yakima, WA				
9270	Yolo, CA	0.9204	0.9841	0.9682	0.9522
	Yolo, CA				
9280	York, PA	0.9119	0.9824	0.9648	0.9471
	York, PA				
9320	Youngstown-Warren, OH	0.9214	0.9843	0.9686	0.9528
	Columbiana, OH				
	Mahoning, OH				
	Trumbull, OH				
9340	Yuba City, CA	1.0196	1.0039	1.0078	1.0118
	Sutter, CA				
	Yuba, CA				
9360	Yuma, AZ	0.8895	0.9779	0.9558	0.9337
	Yuma, AZ				

[1] Wage index calculated using the same wage data used to compute the wage index used by acute care hospitals under the IPPS for Federal FY 2004 (that is, fiscal year 2000 audited acute care hospital inpatient wage data) without regard to reclassification under section 1886(d)(8) or section 1886(d)(10) of the Act.

[2] One-fifth of the full wage index value, applicable for a LTCH's cost reporting period beginning on or after October 1, 2002 through September 30, 2003 (Federal FY 2003). That is, for a LTCH's cost reporting period that began during Federal FY 2003 and located in Chicago, Illinois (MSA 1600), the 1/5th wage index value is computed as (1.0892 + 4)/5 = 1.0178. For further details on the 5-year phase-in of the wage index, see section V.C.1. of this final rule.

[3] Two-fifths of the full wage index value, applicable for a LTCH's cost reporting period beginning on or after October 1, 2003 through September 30, 2004 (Federal FY 2004). That is, for a LTCH's cost reporting period that begins during Federal FY 2004 and located in Chicago, Illinois (MSA 1600), the 2/5ths wage index value is computed as ((2*1.0892) + 3)/5 = 1.0357. For further details on the 5-year phase-in of the wage index, see section V.C.1. of this final rule.

[4] Three-fifths of the full wage index value, applicable for a LTCH's cost reporting period beginning on or after October 1, 2004 through September 30, 2005 (Federal FY 2005). That is, for a LTCH's cost reporting period that begins during Federal FY 2004 and located in Chicago, Illinois (MSA 1600), the 3/5ths wage index value is computed as ((3*1.0892) + 2)/5 = 1.0535. For further details on the 5-year phase-in of the wage index, see section V.C.1. of this final rule.

TABLE 2.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR RURAL AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2004 THROUGH JUNE 30, 2005

Nonurban area	Full wage index [1]	1/5th wage index [2]	2/5ths wage index [3]	3/5ths wage index [4]
Alabama	0.7492	0.9498	0.8997	0.8495
Alaska	1.1886	1.0377	1.0754	1.1132
Arizona	0.9270	0.9854	0.9708	0.9562
Arkansas	0.7734	0.9547	0.9094	0.8640
California	1.0027	1.0005	1.0011	1.0016
Colorado	0.9328	0.9866	0.9731	0.9597
Connecticut	1.2183	1.0437	1.0873	1.1310
Delaware	0.9557	0.9911	0.9823	0.9734
Florida	0.8870	0.9774	0.9548	0.9322
Georgia	0.8595	0.9719	0.9438	0.9157
Hawaii	0.9958	0.9992	0.9983	0.9975
Idaho	0.8974	0.9795	0.9590	0.9384
Illinois	0.8254	0.9651	0.9302	0.8952
Indiana	0.8824	0.9765	0.9530	0.9294
Iowa	0.8416	0.9683	0.9366	0.9050
Kansas	0.8034	0.9607	0.9214	0.8820
Kentucky	0.7973	0.9595	0.9189	0.8784
Louisiana	0.7458	0.9492	0.8983	0.8475
Maine	0.8812	0.9762	0.9525	0.9287
Maryland	0.9125	0.9825	0.9650	0.9475
Massachusetts	1.0432	1.0086	1.0173	1.0259
Michigan	0.8884	0.9777	0.9554	0.9330
Minnesota	0.9330	0.9866	0.9732	0.9598

TABLE 2.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR RURAL AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2004 THROUGH JUNE 30, 2005—Continued

Nonurban area	Full wage index [1]	1/5th wage index [2]	2/5ths wage index [3]	3/5ths wage index [4]
Mississippi	0.7778	0.9556	0.9111	0.8667
Missouri	0.7892	0.9578	0.9157	0.8735
Montana	0.8800	0.9760	0.9520	0.9280
Nebraska	0.8822	0.9764	0.9529	0.9293
Nevada	0.9806	0.9961	0.9922	0.9884
New Hampshire	1.0030	1.0006	1.0012	1.0018
New Jersey [5]	.....	.....	.....	.....
New Mexico	0.8270	0.9654	0.9308	0.8962
New York	0.8526	0.9705	0.9410	0.9116
North Carolina	0.8458	0.9692	0.9383	0.9075
North Dakota	0.7778	0.9556	0.9111	0.8667
Ohio	0.8820	0.9764	0.9528	0.9292
Oklahoma	0.7537	0.9507	0.9015	0.8522
Oregon	0.9994	0.9999	0.9998	0.9996
Pennsylvania	0.8378	0.9676	0.9351	0.9027
Puerto Rico	0.4018	0.8804	0.7607	0.6411
Rhode Island [5]	.....	.....	.....	.....
South Carolina	0.8498	0.9700	0.9399	0.9099
South Dakota	0.8195	0.9639	0.9278	0.8917
Tennessee	0.7886	0.9577	0.9154	0.8732
Texas	0.7780	0.9556	0.9112	0.8668
Utah	0.8974	0.9795	0.9590	0.9384
Vermont	0.9307	0.9861	0.9723	0.9584
Virginia	0.8498	0.9700	0.9399	0.9099
Washington	1.0388	1.0078	1.0155	1.0233
West Virginia	0.8018	0.9604	0.9207	0.8811
Wisconsin	0.9304	0.9861	0.9722	0.9582
Wyoming	0.9110	0.9822	0.9644	0.9466

[1] Wage index calculated using the same wage data used to compute the wage index used by acute care hospitals under the IPPS for Federal FY 2004 (that is, fiscal year 2000 audited acute care hospital inpatient wage data) without regard to reclassification under section 1886(d)(8) or section 1886(d)(10) of the Act.

[2] One-fifth of the full wage index value, applicable for a LTCH's cost reporting period beginning on or after October 1, 2002 through September 30, 2003 (Federal FY 2003). That is, for a LTCH's cost reporting period that began during Federal FY 2003 and located in rural Illinois, the 1/5th wage index value is computed as (0.8254 + 4)/5 = 0.9651. For further details on the 5-year phase-in of the wage index, see section V.C.1. of this final rule.

[3] Two-fifths of the full wage index value, applicable for a LTCH's cost reporting period beginning on or after October 1, 2003 through September 30, 2004 (Federal FY 2004). That is, for a LTCH's cost reporting period that begins during Federal FY 2004 and located in rural Illinois, the 2/5th wage index value is computed as ((2*0.8254) + 3))/5 = 0.9302. For further details on the 5-year phase-in of the wage index, see section V.C.1. of this final rule.

[4] Three-fifths of the full wage index value, applicable for a LTCH's cost reporting period beginning on or after October 1, 2004 through September 30, 2005 (Federal FY 2005). That is, for a LTCH's cost reporting period that begins during Federal FY 2004 and located in rural Illinois, the 3/5ths wage index value is computed as ((3*0.8254) + 2))/5 = 0.8952. For further details on the 5-year phase-in of the wage index, see section V.C.1. of this final rule.

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

TABLE 3.—FEDERAL FY 2004 LTC–DRG RELATIVE WEIGHTS, GEOMETRIC MEAN LENGTH OF STAY, AND SHORT-STAYS OF FIVE-SIXTHS AVERAGE LENGTH OF STAY FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2004 THROUGH SEPTEMBER 30, 2004

LTC–DRG	Description	Relative weight	Geometric average length of stay	5/6th of the average length of stay
1	CRANIOTOMY AGE >17 W CC [5]	2.0841	40.0	33.3
2	CRANIOTOMY AGE >17 W/O CC [8]	2.0841	40.0	33.3
3	CRANIOTOMY AGE 0–17 [8]	2.0841	40.0	33.3
6	CARPAL TUNNEL RELEASE [8]	0.4964	18.5	15.4
7	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC [7]	1.5754	41.0	34.1
8	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC [7]	1.5754	41.0	34.1
9	SPINAL DISORDERS & INJURIES	1.5025	32.9	27.4
10	NERVOUS SYSTEM NEOPLASMS W CC	0.7549	23.4	19.5
11	NERVOUS SYSTEM NEOPLASMS W/O CC	0.7281	22.0	18.3
12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	0.7485	25.8	21.5
13	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	0.7530	25.9	21.5
14	INTERCRANIAL HEMORRHAGE & STROKE W INFARCT	0.9196	27.4	22.8
15	NONSPECIFIC CVA & PRECEREBRAL OCCULUSION W/O INFARCT	0.8714	28.8	24.0
16	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	0.9125	23.9	19.9
17	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	0.5262	20.4	17.0
18	CRANIAL & PERIPHERAL NERVE DISORDERS W CC	0.8225	23.9	19.9

TABLE 3.—FEDERAL FY 2004 LTC–DRG RELATIVE WEIGHTS, GEOMETRIC MEAN LENGTH OF STAY, AND SHORT-STAYS OF FIVE-SIXTHS AVERAGE LENGTH OF STAY FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2004 THROUGH SEPTEMBER 30, 2004—Continued

LTC–DRG	Description	Relative weight	Geometric average length of stay	5/6th of the average length of stay
19	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	0.6236	22.7	18.9
20	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	1.0097	24.8	20.6
21	VIRAL MENINGITIS [2]	0.7372	23.5	19.5
22	HYPERTENSIVE ENCEPHALOPATHY [2]	0.7372	23.5	19.5
23	NONTRAUMATIC STUPOR & COMA	0.9033	28.8	24.0
24	SEIZURE & HEADACHE AGE >17 W CC	0.8527	26.2	21.8
25	SEIZURE & HEADACHE AGE >17 W/O CC	0.7727	24.1	20.0
26	SEIZURE & HEADACHE AGE 0–17 [8]	0.7372	23.5	19.5
27	TRAUMATIC STUPOR & COMA, COMA >1 HR	1.1929	30.4	25.3
28	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W CC [8]	1.0211	29.0	24.1
29	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC	0.9056	26.6	22.1
30	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0–17 [8]	0.9562	26.1	21.7
31	CONCUSSION AGE >17 W CC [7]	0.9562	26.1	21.7
32	CONCUSSION AGE >17 W/O CC [7]	0.9562	26.1	21.7
33	CONCUSSION AGE 0–17 [8]	0.7372	23.5	19.5
34	OTHER DISORDERS OF NERVOUS SYSTEM W CC	0.9140	27.8	23.1
35	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	0.6651	24.5	20.4
36	RETINAL PROCEDURES [8]	0.4964	18.5	15.4
37	ORBITAL PROCEDURES [8]	0.4964	18.5	15.4
38	PRIMARY IRIS PROCEDURES [8]	0.4964	18.5	15.4
39	LENS PROCEDURES WITH OR WITHOUT VITRECTOMY [8]	0.4964	18.5	15.4
40	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17 [5]	2.0841	40.0	33.3
41	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0–17 [8]	0.4964	18.5	15.4
42	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS [8]	0.4964	18.5	15.4
43	HYPHEMA [8]	0.4964	18.5	15.4
44	ACUTE MAJOR EYE INFECTIONS [1]	0.4964	18.5	15.4
45	NEUROLOGICAL EYE DISORDERS [8]	0.4964	18.5	15.4
46	OTHER DISORDERS OF THE EYE AGE >17 W CC [1]	0.4964	18.5	15.4
47	OTHER DISORDERS OF THE EYE AGE >17 W/O CC [1]	0.4964	18.5	15.4
48	OTHER DISORDERS OF THE EYE AGE 0–17 [8]	0.4964	18.5	15.4
49	MAJOR HEAD & NECK PROCEDURES [8]	1.3569	32.5	27.0
50	SIALOADENECTOMY [8]	0.9562	26.1	21.7
51	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY [8]	0.9562	26.1	21.7
52	CLEFT LIP & PALATE REPAIR [8]	0.9562	26.1	21.7
53	SINUS & MASTOID PROCEDURES AGE >17 [2]	0.7372	23.5	19.5
54	SINUS & MASTOID PROCEDURES AGE 0–17 [8]	0.9562	26.1	21.7
55	MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES [8]	0.9562	26.1	21.7
56	RHINOPLASTY [8]	0.7372	23.5	19.5
57	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17 [8]	0.9562	26.1	21.7
58	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17 [8]	0.9562	26.1	21.7
59	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17 [8]	0.9562	26.1	21.7
60	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17 [8]	0.9562	26.1	21.7
61	MYRINGOTOMY W TUBE INSERTION AGE >17 [2]	0.7372	23.5	19.5
62	MYRINGOTOMY W TUBE INSERTION AGE 0–17 [8]	0.9562	26.1	21.7
63	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES [3]	0.9562	26.1	21.7
64	EAR, NOSE, MOUTH & THROAT MALIGNANCY	1.2540	27.5	22.9
65	DYSEQUILIBRIUM [1]	0.4964	18.5	15.4
66	EPISTAXIS [1]	0.4964	18.5	15.4
67	EPIGLOTTITIS [8]	0.9562	26.1	21.7
68	OTITIS MEDIA & URI AGE >17 W CC	0.8243	21.9	18.2
69	OTITIS MEDIA & URI AGE >17 W/O CC [1]	0.4964	18.5	15.4
70	OTITIS MEDIA & URI AGE 0–17 [8]	0.4964	18.5	15.4
71	LARYNGOTRACHEITIS [8]	0.4964	18.5	15.4
72	NASAL TRAUMA & DEFORMITY [2]	0.7372	23.5	19.5
73	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17	0.7215	20.3	16.9
74	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0–17 [8]	0.4964	18.5	15.4
75	MAJOR CHEST PROCEDURES [5]	2.0841	40.0	33.3
76	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.4382	43.9	36.5
77	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC [5]	2.0841	40.0	33.3
78	PULMONARY EMBOLISM	0.8896	24.2	20.1
79	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	0.8985	22.6	18.8
80	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC	0.7645	22.3	18.5
81	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0–17 [8]	0.4964	18.5	15.4
82	RESPIRATORY NEOPLASMS	0.7480	20.3	16.9
83	MAJOR CHEST TRAUMA W CC [3]	0.9562	26.1	21.7
84	MAJOR CHEST TRAUMA W/O CC [2]	0.7372	23.5	19.5
85	PLEURAL EFFUSION W CC	0.8514	23.5	19.5

TABLE 3.—FEDERAL FY 2004 LTC–DRG RELATIVE WEIGHTS, GEOMETRIC MEAN LENGTH OF STAY, AND SHORT-STAYS OF FIVE-SIXTHS AVERAGE LENGTH OF STAY FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2004 THROUGH SEPTEMBER 30, 2004—Continued

LTC–DRG	Description	Relative weight	Geometric average length of stay	5/6th of the average length of stay
86	PLEURAL EFFUSION W/O CC	0.6540	22.4	18.6
87	PULMONARY EDEMA & RESPIRATORY FAILURE	1.6513	31.9	26.5
88	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	0.7653	20.7	17.2
89	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	0.8428	23.1	19.2
90	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	0.7318	21.7	18.0
91	SIMPLE PNEUMONIA & PLEURISY AGE 0–17 [8]	0.7372	23.5	19.5
92	INTERSTITIAL LUNG DISEASE W CC	0.7702	20.4	17.0
93	INTERSTITIAL LUNG DISEASE W/O CC [1]	0.4964	18.5	15.4
94	PNEUMOTHORAX W CC	0.6571	18.9	15.7
95	PNEUMOTHORAX W/O CC [1]	0.4964	18.5	15.4
96	BRONCHITIS & ASTHMA >17 W CC AGE	0.7381	20.5	17.0
97	BRONCHITIS & ASTHMA AGE >17 W/O CC	0.5296	18.7	15.5
98	BRONCHITIS & ASTHMA AGE 0–17 [8]	0.4964	18.5	15.4
99	RESPIRATORY SIGNS & SYMPTOMS W CC	1.0622	26.6	22.1
100	RESPIRATORY SIGNS & SYMPTOMS W/O CC	1.0579	26.1	21.7
101	OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	0.9009	22.6	18.8
102	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	0.7011	21.0	17.5
103	HEART TRANSPLANT [6]	0.0000	0.0	0.0
104	CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W CARDIAC CATH [8]	2.0841	40.0	33.3
105	CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W/O CARDIAC CATH [8]	2.0841	40.0	33.3
106	CORONARY BYPASS W PTCA [8]	2.0841	40.0	33.3
107	CORONARY BYPASS W CARDIAC CATH [8]	2.0841	40.0	33.3
108	OTHER CARDIOTHORACIC PROCEDURES [5]	2.0841	40.0	33.3
109	CORONARY BYPASS W/O PTCA OR CARDIAC CATH [8]	2.0841	40.0	33.3
110	MAJOR CARDIOVASCULAR PROCEDURES W CC [5]	2.0841	40.0	33.3
111	MAJOR CARDIOVASCULAR PROCEDURES W/O CC [8]	2.0841	40.0	33.3
113	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE	1.5629	38.7	32.2
114	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	1.3604	38.3	31.9
115	PRM CARD PACEM IMPL W AMI, HRT FAIL OR SHK, OR AICD LEAD OR GNRTR P [5]	2.0841	40.0	33.3
116	OTH PERM CARD PACEMAK IMPL OR PTCA W CORONARY ARTERY STENT IMPLNT [5].	2.0841	40.0	33.3
117	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT [3]	0.9562	26.1	21.7
118	CARDIAC PACEMAKER DEVICE REPLACEMENT [5]	2.0841	40.0	33.3
119	VEIN LIGATION & STRIPPING [4]	1.3569	32.5	27.0
120	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	1.2435	34.4	28.6
121	CIRCULATORY DISORDERS W AMI & MAJOR COMP, DISCHARGED ALIVE	0.7467	22.1	18.4
122	CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE	0.6440	18.8	15.6
123	CIRCULATORY DISORDERS W AMI, EXPIRED	0.8527	18.8	15.6
124	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG [4]	1.3569	32.5	27.0
125	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG [4]	1.3569	32.5	27.0
126	ACUTE & SUBACUTE ENDOCARDITIS	0.8706	25.6	21.3
127	HEART FAILURE & SHOCK	0.7719	22.1	18.4
128	DEEP VEIN THROMBOPHLEBITIS [2]	0.7372	23.5	19.5
129	CARDIAC ARREST, UNEXPLAINED [3]	0.9562	26.1	21.7
130	PERIPHERAL VASCULAR DISORDERS W CC	0.7712	24.4	20.3
131	DISORDERS W/O CC PERIPHERAL VASCULAR	0.6398	23.1	19.2
132	ATHEROSCLEROSIS W CC	0.8092	22.4	18.6
133	ATHEROSCLEROSIS W/O CC	0.7044	21.9	18.2
134	HYPERTENSION	0.9154	27.9	23.2
135	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC	0.9039	23.1	19.2
136	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC	0.7186	22.4	18.6
137	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0-17 [8]	0.7372	23.5	19.5
138	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	0.7430	22.7	18.9
139	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	0.6032	20.3	16.9
140	ANGINA PECTORIS	0.6094	19.3	16.0
141	SYNCOPE & COLLAPSE W CC	0.6453	22.9	19.0
142	SYNCOPE & COLLAPSE W/O CC	0.5041	20.3	16.9
143	CHEST PAIN	0.7314	21.8	18.1
144	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	0.7921	22.2	18.5
145	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	0.6983	20.7	17.2
146	RECTAL RESECTION W CC [8]	2.0841	40.0	33.3
147	RECTAL RESECTION W/O CC [8]	2.0841	40.0	33.3
148	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC [5]	2.0841	40.0	33.3
149	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC [1]	0.4964	18.5	15.4
150	PERITONEAL ADHESIOLYSIS W CC [4]	1.3569	32.5	27.0
151	PERITONEAL ADHESIOLYSIS W/O CC [8]	1.3569	32.5	27.0
152	MINOR SMALL & LARGE BOWEL PROCEDURES W CC [4]	1.3569	32.5	27.0

TABLE 3.—FEDERAL FY 2004 LTC–DRG RELATIVE WEIGHTS, GEOMETRIC MEAN LENGTH OF STAY, AND SHORT-STAYS OF FIVE-SIXTHS AVERAGE LENGTH OF STAY FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2004 THROUGH SEPTEMBER 30, 2004—Continued

LTC–DRG	Description	Relative weight	Geometric average length of stay	5/6th of the average length of stay
153	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC[8]	1.3569	32.5	27.0
154	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC[5]	2.0841	40.0	33.3
155	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC[8]	1.3569	32.5	27.0
156	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0-17[8]	1.3569	32.5	27.0
157	ANAL & STOMAL PROCEDURES W CC[4]	1.3569	32.5	27.0
158	ANAL & STOMAL PROCEDURES W/O CC[3]	0.9562	26.1	21.7
159	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC[8]	1.3569	32.5	27.0
160	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC[8]	1.3569	32.5	27.0
161	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC[4]	1.3569	32.5	27.0
162	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC[8]	0.4964	18.5	15.4
163	HERNIA PROCEDURES AGE 0–17[8]	0.4964	18.5	15.4
164	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC[8]	2.0841	40.0	33.3
165	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC[8]	0.4964	18.5	15.4
166	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC[8]	2.0841	40.0	33.3
167	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC[8]	0.4964	18.5	15.4
168	MOUTH PROCEDURES W CC[5]	2.0841	40.0	33.3
169	MOUTH PROCEDURES W/O CC[8]	0.7372	23.5	19.5
170	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	1.7006	40.3	33.5
171	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC[4]	1.3569	32.5	27.0
172	DIGESTIVE MALIGNANCY W CC	0.8702	22.5	18.7
173	DIGESTIVE MALIGNANCY W/O CC	0.7092	20.2	16.8
174	G.I. HEMORRHAGE W CC	0.7874	23.7	19.7
175	G.I. HEMORRHAGE W/O CC	0.6345	21.1	17.5
176	COMPLICATED PEPTIC ULCER	0.7728	21.2	17.6
177	UNCOMPLICATED PEPTIC ULCER W CC[2]	0.7372	23.5	19.5
178	UNCOMPLICATED PEPTIC ULCER W/O CC[1]	0.4964	18.5	15.4
179	INFLAMMATORY BOWEL DISEASE	1.0023	25.2	21.0
180	G.I. OBSTRUCTION W CC[7]	0.8222	22.9	19.0
181	G.I. OBSTRUCTION W/O CC[7]	0.8222	22.9	19.0
182	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC	0.8449	23.5	19.5
183	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC	0.6362	20.3	16.9
184	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0–17[8]	0.7372	23.5	19.5
185	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17[2]	0.7372	23.5	19.5
186	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0–17[8]	0.7372	23.5	19.5
187	DENTAL EXTRACTIONS & RESTORATIONS[8]	0.7372	23.5	19.5
188	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	1.0308	25.3	21.0
189	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	0.7826	21.8	18.1
190	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0–17[8]	0.7372	23.5	19.5
191	PANCREAS, LIVER & SHUNT PROCEDURES W CC[4]	1.3569	32.5	27.0
192	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC[1]	0.4964	18.5	15.4
193	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC[2]	0.7372	23.5	19.5
194	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC[3]	0.7372	23.5	19.5
195	CHOLECYSTECTOMY W C.D.E. W CC[4]	1.3569	32.5	27.0
196	CHOLECYSTECTOMY W C.D.E. W/O CC[8]	0.9562	26.1	21.7
197	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC[3]	0.9562	26.1	21.7
198	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC[8]	0.9562	26.1	21.7
199	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY[8]	0.7372	23.5	19.5
200	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY[2]	0.7372	23.5	19.5
201	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES[5]	2.0841	40.0	33.3
202	CIRRHOSIS & ALCOHOLIC HEPATITIS	0.7254	22.3	18.5
203	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	0.6758	18.9	15.7
204	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	0.9986	23.4	19.5
205	DISORDERS OF LIVER EXCEPT MALIG, CIRR, ALC HEPA W CC[7]	0.7029	22.1	18.4
206	DISORDERS OF LIVER EXCEPT MALIG, CIRR, ALC HEPA W/O CC[7]	0.7029	22.1	18.4
207	DISORDERS OF THE BILIARY TRACT W CC[7]	0.6671	20.5	17.0
208	DISORDERS OF THE BILIARY TRACT W/O CC[7]	0.6671	20.5	17.0
209	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF LOWER EXTREMITY[4]	1.3569	32.5	27.0
210	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC[4]	1.3569	32.5	27.0
211	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC[2]	0.7372	23.5	19.5
212	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0–117[8]	0.7372	23.5	19.5
213	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS	1.3851	33.8	28.1
216	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE[4]	1.3569	32.5	27.0
217	WND DEBRID & SKN GRFT EXCEPT HAND, FOR MUSCSKELET & CONN TISS DIS	1.4038	39.3	32.7
218	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W CC[3]	0.9562	26.1	21.7
219	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W/O CC[8]	0.9562	26.1	21.7
220	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE 0–17[8]	0.9562	26.1	21.7
223	MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC[3]	0.9562	26.1	21.7

TABLE 3.—FEDERAL FY 2004 LTC–DRG RELATIVE WEIGHTS, GEOMETRIC MEAN LENGTH OF STAY, AND SHORT-STAYS OF FIVE-SIXTHS AVERAGE LENGTH OF STAY FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2004 THROUGH SEPTEMBER 30, 2004—Continued

LTC–DRG	Description	Relative weight	Geometric average length of stay	5/6th of the average length of stay
224	SHOULDER, ELBOW OR FOREARM PROC, EXC MAJOR JOINT PROC, W/O CC[8]	0.9562	26.1	21.7
225	FOOT PROCEDURES[3]	0.9562	26.1	21.7
226	SOFT TISSUE PROCEDURES W CC[7]	1.3569	32.5	27.0
227	SOFT TISSUE PROCEDURES W/O CC[7]	1.3569	32.5	27.0
228	MAJOR THUMB OR JOINT PROC, OR OTH HAND OR WRIST PROC W CC[4]	1.3569	32.5	27.0
229	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC[8]	0.9562	26.1	21.7
230	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR[4]	1.3569	32.5	27.0
232	ARTHROSCOPY[2]	0.7372	23.5	19.5
233	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC[3]	0.9562	26.1	21.7
234	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC[3]	0.9562	26.1	21.7
235	FRACTURES OF FEMUR	0.8396	29.6	24.6
236	FRACTURES OF HIP & PELVIS	0.7368	27.1	22.5
237	SPRAINS, STRAINS, & ISLOCATIONS OF HIP, PELVIS & THIGH[2]	0.7372	23.5	19.5
238	OSTEOMYELITIS	0.8432	27.9	23.2
239	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY	0.6610	22.0	18.3
240	CONNECTIVE TISSUE DISORDERS W CC	0.6685	21.2	17.6
241	CONNECTIVE TISSUE DISORDERS W/O CC	0.4538	18.7	15.5
242	SEPTIC ARTHRITIS	0.7721	26.4	22.0
243	MEDICAL BACK PROBLEMS	0.6616	23.2	19.3
244	BONE DISEASES & SPECIFIC ARTHROPATHIES W CC	0.5563	20.0	16.6
245	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	0.4721	18.5	15.4
246	NON-SPECIFIC ARTHROPATHIES	0.5128	22.2	18.5
247	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE	0.5536	20.2	16.8
248	TENDONITIS, MYOSITIS & BURSITIS	0.7274	24.5	20.4
249	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	0.7829	27.0	22.5
250	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC	0.8206	29.9	24.9
251	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC	0.6009	27.3	22.7
252	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0–17[8]	0.9562	26.1	21.7
253	FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE >17 W CC	0.8176	27.6	23.0
254	FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE >17 W/O CC	0.6691	25.1	20.9
255	FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE 0–17[8]	0.9562	26.1	21.7
256	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	0.8294	25.9	21.5
257	TOTAL MASTECTOMY FOR MALIGNANCY W CC[3]	0.9562	26.1	21.7
258	TOTAL MASTECTOMY FOR MALIGNANCY W/O CC[8]	0.9562	26.1	21.7
259	SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC[8]	0.9562	26.1	21.7
260	SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC[8]	0.9562	26.1	21.7
261	BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION[5]	2.0841	40.0	33.3
262	BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY[3]	0.9562	26.1	21.7
263	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	1.4522	42.4	35.3
264	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC	1.2892	44.1	36.7
265	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC[7]	1.2215	34.8	29.0
266	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC[7]	1.2215	34.8	29.0
267	PERIANAL & PILONIDAL PROCEDURES[8]	0.9562	26.1	21.7
268	SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES[5]	2.0841	40.0	33.3
269	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.4466	43.0	35.8
270	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC	0.9916	33.9	28.2
271	SKIN ULCERS	0.9620	30.4	25.3
272	MAJOR SKIN DISORDERS W CC	0.7121	22.8	19.0
273	MAJOR SKIN DISORDERS W/O CC[1]	0.4964	18.5	15.4
274	MALIGNANT BREAST DISORDERS W CC	0.9072	24.9	20.7
275	MALIGNANT BREAST DISORDERS W/O CC[2]	0.7372	23.5	19.5
276	NON-MALIGANT BREAST DISORDERS[1]	0.4964	18.5	15.4
277	CELLULITIS AGE >17 W CC	0.7409	23.6	19.6
278	CELLULITIS AGE >17 W/O CC	0.5982	20.7	17.2
279	CELLULITIS AGE 0–17[8]	0.9562	26.1	21.7
280	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC	0.9724	29.5	24.5
281	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC	0.7386	26.4	22.0
282	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0–17[8]	0.7372	23.5	19.5
283	MINOR SKIN DISORDERS W CC	0.6508	19.3	16.0
284	MINOR SKIN DISORDERS W/O CC[1]	0.4964	18.5	15.4
285	AMPUTAT OF LOWER LIMB FOR ENDOCRINE, NUTRIT, & METABOL DISORDERS	1.5176	37.4	31.1
286	ADRENAL & PITUITARY PROCEDURES[8]	0.7372	23.5	19.5
287	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS	1.3982	39.7	33.0
288	O.R. PROCEDURES FOR OBESITY[5]	2.0841	40.0	33.3
289	PARATHYROID PROCEDURES[8]	0.7372	23.5	19.5
290	THYROID PROCEDURES[8]	0.7372	23.5	19.5
291	THYROGLOSSAL PROCEDURES[8]	0.7372	23.5	19.5

TABLE 3.—FEDERAL FY 2004 LTC–DRG RELATIVE WEIGHTS, GEOMETRIC MEAN LENGTH OF STAY, AND SHORT-STAYS OF FIVE-SIXTHS AVERAGE LENGTH OF STAY FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2004 THROUGH SEPTEMBER 30, 2004—Continued

LTC–DRG	Description	Relative weight	Geometric average length of stay	5/6th of the average length of stay
292	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC [4]	1.3569	32.5	27.0
293	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC [8]	0.9562	26.1	21.7
294	DIABETES AGE >35	0.8061	25.9	21.5
295	DIABETES AGE 0–35 [3]	0.9562	26.1	21.7
296	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	0.8207	24.1	20.0
297	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC	0.6524	24.5	20.4
298	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0–17 [8]	0.7372	23.5	19.5
299	INBORN ERRORS OF METABOLISM [3]	0.9562	26.1	21.7
300	ENDOCRINE DISORDERS W CC	0.7704	22.3	18.5
301	ENDOCRINE DISORDERS W/O CC [2]	0.7372	23.5	19.5
302	KIDNEY TRANSPLANT [6]	0.0000	0.0	0.0
303	KIDNEY, URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM [8]	2.0841	40.0	33.3
304	KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC [5]	2.0841	40.0	33.3
305	KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC [1]	0.4964	18.5	15.4
306	PROSTATECTOMY W CC [8]	1.3569	32.5	27.0
307	PROSTATECTOMY W/O CC [8]	1.3569	32.5	27.0
308	MINOR BLADDER PROCEDURES W CC [4]	1.3569	32.5	27.0
309	MINOR BLADDER PROCEDURES W/O CC [2]	0.7372	23.5	19.5
310	TRANSURETHRAL PROCEDURES W CC [4]	1.3569	32.5	27.0
311	TRANSURETHRAL PROCEDURES W/O CC [1]	0.4964	18.5	15.4
312	URETHRAL PROCEDURES, AGE >17 W CC [4]	1.3569	32.5	27.0
313	URETHRAL PROCEDURES, AGE >17 W/O CC [8]	0.4964	18.5	15.4
314	URETHRAL PROCEDURES, AGE 0–17 [8]	0.4964	18.5	15.4
315	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	1.5070	36.8	30.6
316	RENAL FAILURE	0.9214	23.8	19.8
317	ADMIT FOR RENAL DIALYSIS [3]	0.9562	26.1	21.7
318	KIDNEY & URINARY TRACT NEOPLASMS W CC	0.7048	21.1	17.5
319	KIDNEY & URINARY TRACT NEOPLASMS W/O CC [1]	0.4964	18.5	15.4
320	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	0.7223	23.0	19.1
321	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	0.6260	23.2	19.3
322	KIDNEY & URINARY TRACT INFECTIONS AGE 0–17 [8]	0.4964	18.5	15.4
323	URINARY STONES W CC, &/OR ESW LITHOTRIPSY [2]	0.7372	23.5	19.5
324	URINARY STONES W/O CC [2]	0.7372	23.5	19.5
325	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC [3]	0.9562	26.1	21.7
326	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC [1]	0.4964	18.5	15.4
327	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0–17 [8]	0.4964	18.5	15.4
328	URETHRAL STRICTURE AGE >17 W CC [8]	0.4964	18.5	15.4
329	URETHRAL STRICTURE AGE >17 W/O CC [8]	0.4964	18.5	15.4
330	URETHRAL STRICTURE AGE 0–17 [8]	0.4964	18.5	15.4
331	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC	0.8473	23.2	19.3
332	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC	0.5722	21.1	17.5
333	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0–17 [8]	0.4964	18.5	15.4
334	MAJOR MALE PELVIC PROCEDURES W CC [8]	2.0841	40.0	33.3
335	MAJOR MALE PELVIC PROCEDURES W/O CC [8]	2.0841	40.0	33.3
336	TRANSURETHRAL PROSTATECTOMY W CC [8]	0.7372	23.5	19.5
337	TRANSURETHRAL PROSTATECTOMY W/O CC [8]	0.7372	23.5	19.5
338	TESTES PROCEDURES, FOR MALIGNANCY [8]	0.7372	23.5	19.5
339	TESTES PROCEDURES, NON-MALIGNANCY AGE >17 [2]	0.7372	23.5	19.5
340	TESTES PROCEDURES, NON-MALIGNANCY AGE 0–17 [8]	0.7372	23.5	19.5
341	PENIS PROCEDURES [2]	0.7372	23.5	19.5
342	CIRCUMCISION AGE >17 [1]	0.4964	18.5	15.4
343	CIRCUMCISION AGE 0–17 [8]	0.7372	23.5	19.5
344	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY [1]	0.4964	18.5	15.4
345	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY [5]	2.0841	40.0	33.3
346	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC [7]	0.7150	22.3	18.5
347	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC [7]	0.7150	22.3	18.5
348	BENIGN PROSTATIC HYPERTROPHY W CC [1]	0.4964	18.5	15.4
349	BENIGN PROSTATIC HYPERTROPHY W/O CC [1]	0.4964	18.5	15.4
350	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM [1]	1.1820	26.6	22.1
351	STERILIZATION, MALE [8]	0.7372	23.5	19.5
352	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES [3]	0.9562	26.1	21.7
353	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY [8]	2.0841	40.0	33.3
354	UTERINE, ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC [8]	2.0841	40.0	33.3
355	UTERINE, ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC [8]	2.0841	40.0	33.3
356	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES [8]	1.3569	32.5	27.0
357	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY [8]	1.3569	32.5	27.0
358	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC [8]	1.3569	32.5	27.0

TABLE 3.—FEDERAL FY 2004 LTC–DRG RELATIVE WEIGHTS, GEOMETRIC MEAN LENGTH OF STAY, AND SHORT-STAYS OF FIVE-SIXTHS AVERAGE LENGTH OF STAY FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2004 THROUGH SEPTEMBER 30, 2004—Continued

LTC–DRG	Description	Relative weight	Geometric average length of stay	5/6th of the average length of stay
359	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC[8]	1.3569	32.5	27.0
360	VAGINA, CERVIX & VULVA PROCEDURES[4]	1.3569	32.5	27.0
361	LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION[8]	0.4964	18.5	15.4
362	ENDOSCOPIC TUBAL INTERRUPTION[8]	0.4964	18.5	15.4
363	D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY[8]	0.4964	18.5	15.4
364	D&C, CONIZATION EXCEPT FOR MALIGNANCY[8]	0.4964	18.5	15.4
365	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES[5]	2.0841	40.0	33.3
366	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	0.8139	23.1	19.2
367	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC[1]	0.4964	18.5	15.4
368	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	0.6963	19.3	16.0
369	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS[3]	0.9562	26.1	21.7
370	CESAREAN SECTION W CC[8]	0.9562	26.1	21.7
371	CESAREAN SECTION W/O CC[8]	0.4964	18.5	15.4
372	VAGINAL DELIVERY W COMPLICATING DIAGNOSES[8]	0.4964	18.5	15.4
373	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES[8]	0.4964	18.5	15.4
374	VAGINAL DELIVERY W STERILIZATION &/OR D&C[8]	0.4964	18.5	15.4
375	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C[8]	0.4964	18.5	15.4
376	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE[1]	0.4964	18.5	15.4
377	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE[8]	0.4964	18.5	15.4
378	ECTOPIC PREGNANCY[8]	0.9562	26.1	21.7
379	THREATENED ABORTION[8]	0.4964	18.5	15.4
380	ABORTION W/O D&C[8]	0.4964	18.5	15.4
381	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY[8]	0.4964	18.5	15.4
382	FALSE LABOR[8]	0.4964	18.5	15.4
383	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS[8]	0.4964	18.5	15.4
384	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS[8]	0.4964	18.5	15.4
385	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY[8]	0.4964	18.5	15.4
386	EXTREME IMMATURITY[8]	0.4964	18.5	15.4
387	PREMATURITY W MAJOR PROBLEMS[8]	0.4964	18.5	15.4
388	PREMATURITY W/O MAJOR PROBLEMS[8]	0.4964	18.5	15.4
389	FULL TERM NEONATE W MAJOR PROBLEMS[8]	0.4964	18.5	15.4
390	NEONATE W OTHER SIGNIFICANT PROBLEMS[8]	0.4964	18.5	15.4
391	NORMAL NEWBORN[8]	0.4964	18.5	15.4
392	SPLENECTOMY AGE >17[8]	0.7372	23.5	19.5
393	SPLENECTOMY AGE 0–17[8]	0.7372	23.5	19.5
394	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS[3]	0.9562	26.1	21.7
395	RED BLOOD CELL DISORDERS AGE >17	0.7782	24.0	20.0
396	RED BLOOD CELL DISORDERS AGE 0–17[8]	0.4964	18.5	15.4
397	COAGULATION DISORDERS	0.9454	23.5	19.5
398	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	0.8372	22.0	18.3
399	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC[1]	0.4964	18.5	15.4
401	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC[5]	2.0841	40.0	33.3
402	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC[3]	0.9562	26.1	21.7
403	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	0.8941	22.4	18.6
404	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	0.7394	18.0	15.0
405	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0–17[8]	0.7372	23.5	19.5
406	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W CC[5]	2.0841	40.0	33.3
407	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R. PROC[8]	0.9562	26.1	21.7
408	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R. PROC[3]	0.9562	26.1	21.7
409	RADIOTHERAPY	0.8871	25.1	20.9
410	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS[3]	0.9562	26.1	21.7
411	HISTORY OF MALIGNANCY W/O ENDOSCOPY[8]	0.4964	18.5	15.4
412	HISTORY OF MALIGNANCY W ENDOSCOPY[8]	0.4964	18.5	15.4
413	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	0.9541	25.5	21.2
414	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC[1]	0.4964	18.5	15.4
415	O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	1.6849	40.1	33.4
416	SEPTICEMIA AGE >17	0.9191	24.9	20.7
417	SEPTICEMIA AGE 0–17[8]	0.9562	26.1	21.7
418	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	0.8304	25.2	21.0
419	FEVER OF UNKNOWN ORIGIN AGE >17 W CC[3]	0.9562	26.1	21.7
420	FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC[2]	0.7372	23.5	19.5
421	VIRAL ILLNESS AGE >17[2]	0.7372	23.5	19.5
422	VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0–17[8]	0.7372	23.5	19.5
423	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	0.9024	23.1	19.2
424	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS[4]	1.3569	32.5	27.0
425	ACUTE ADJUSTMENT REACTION & PSYCHOLOGICAL DYSFUNCTION	0.5981	27.5	22.9
426	DEPRESSIVE NEUROSES	0.4660	22.3	18.5

TABLE 3.—FEDERAL FY 2004 LTC–DRG RELATIVE WEIGHTS, GEOMETRIC MEAN LENGTH OF STAY, AND SHORT-STAYS OF FIVE-SIXTHS AVERAGE LENGTH OF STAY FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2004 THROUGH SEPTEMBER 30, 2004—Continued

LTC–DRG	Description	Relative weight	Geometric average length of stay	5/6th of the average length of stay
427	NEUROSES EXCEPT DEPRESSIVE [4]	1.3569	32.5	27.0
428	DISORDERS OF PERSONALITY & IMPULSE CONTROL [1]	0.4964	18.5	15.4
429	ORGANIC DISTURBANCES & MENTAL RETARDATION	0.6438	27.4	22.8
430	PSYCHOSES	0.4689	22.7	18.9
431	CHILDHOOD MENTAL DISORDERS [1]	0.4964	18.5	15.4
432	OTHER MENTAL DISORDER DIAGNOSES [1]	0.4964	18.5	15.4
433	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA [1]	0.4964	18.5	15.4
439	SKIN GRAFTS FOR INJURIES	1.3663	40.5	33.7
440	WOUND DEBRIDEMENTS FOR INJURIES	1.5854	40.0	33.3
441	HAND PROCEDURES FOR INJURIES [5]	2.0841	40.0	33.3
442	OTHER O.R. PROCEDURES FOR INJURIES W CC	1.4971	44.6	37.1
443	OTHER O.R. PROCEDURES FOR INJURIES W/O CC [4]	1.3569	32.5	27.0
444	TRAUMATIC INJURY AGE >17 W CC	0.9609	30.6	25.5
445	TRAUMATIC INJURY AGE >17 W/O CC	0.7552	26.6	22.1
446	TRAUMATIC INJURY AGE 0–17 [8]	0.7372	23.5	19.5
447	ALLERGIC REACTIONS AGE >17 [3]	0.9562	26.1	21.7
448	ALLERGIC REACTIONS AGE 0–17 [8]	0.7372	23.5	19.5
449	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC [7]	0.9562	26.1	21.7
450	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC [7]	0.9562	26.1	21.7
451	POISONING & TOXIC EFFECTS OF DRUGS AGE 0–17 [8]	0.7372	23.5	19.5
452	COMPLICATIONS OF TREATMENT W CC	0.9692	24.9	20.7
453	COMPLICATIONS OF TREATMENT W/O CC	0.8633	24.2	20.1
454	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC [2]	0.7372	23.5	19.5
455	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC [2]	0.7372	23.5	19.5
461	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES	1.3216	36.5	30.4
462	REHABILITATION	0.6471	23.2	19.3
463	SIGNS & SYMPTOMS W CC	0.7541	26.8	22.3
464	SIGNS & SYMPTOMS W/O CC	0.6170	25.5	21.2
465	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS [2]	0.7372	23.5	19.5
466	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	0.7365	22.0	18.3
467	OTHER FACTORS INFLUENCING HEALTH STATUS [1]	0.4964	18.5	15.4
468	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	2.0686	42.5	35.4
469	PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS [6]	0.0000	0.0	0.0
470	UNGROUPABLE [6]	0.0000	0.0	0.0
471	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY [5]	2.0841	40.0	33.3
473	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17 [3]	0.9562	26.1	21.7
475	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	2.1358	35.2	29.3
476	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	1.0032	31.9	26.5
477	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	1.8998	40.0	33.3
478	OTHER VASCULAR PROCEDURES W CC [7]	1.2567	34.2	28.5
479	OTHER VASCULAR PROCEDURES W/O CC [7]	1.2567	34.2	28.5
480	LIVER TRANSPLANT [6]	0.0000	0.0	0.0
481	BONE MARROW TRANSPLANT [8]	0.9562	26.1	21.7
482	TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES [5]	2.0841	40.0	33.3
483	TRACH W MECH VENT 96+ HRS OR PDX EXCEPT FACE, MOUTH & NECK DIAG	3.2131	55.7	46.4
484	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA [8]	2.0841	40.0	33.3
485	LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TR [8]	1.3569	32.5	27.0
486	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA [4]	1.3569	32.5	27.0
487	OTHER MULTIPLE SIGNIFICANT TRAUMA	1.2484	32.7	27.2
488	HIV W EXTENSIVE O.R. PROCEDURE [5]	2.0841	40.0	33.3
489	HIV W MAJOR RELATED CONDITION	0.9254	21.3	17.7
490	HIV W OR W/O OTHER RELATED CONDITION	0.7361	19.6	16.3
491	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY [8]	1.3569	32.5	27.0
492	CHEMOTHERAPY W ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS OR W USE HIGH DOSE CHEMOTHERAPY AGENT [8].	0.9562	26.1	21.7
493	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC [7]	1.3569	32.5	27.0
494	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC [7]	2.0841	40.0	33.3
495	LUNG TRANSPLANT [6]	0.0000	0.0	0.0
496	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION [8]	1.3569	32.5	27.0
497	SPINAL FUSION W CC [7]	0.9562	26.1	21.7
498	SPINAL FUSION W/O CC [4 7]	0.9562	26.1	21.7
499	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC [5]	2.0841	40.0	33.3
500	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC [4]	1.3569	32.5	27.0
501	KNEE PROCEDURES W PDX OF INFECTION W CC [5]	2.0841	40.0	33.3
502	KNEE PROCEDURES W PDX OF INFECTION W/O CC [2]	0.7372	23.5	19.5
503	KNEE PROCEDURES W/O PDX OF INFECTION [3]	0.9562	26.1	21.7
504	EXTENSIVE 3RD DEGREE BURNS W SKIN GRAFT [8]	2.0841	40.0	33.3

TABLE 3.—FEDERAL FY 2004 LTC–DRG RELATIVE WEIGHTS, GEOMETRIC MEAN LENGTH OF STAY, AND SHORT-STAYS OF FIVE-SIXTHS AVERAGE LENGTH OF STAY FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2004 THROUGH SEPTEMBER 30, 2004—Continued

LTC–DRG	Description	Relative weight	Geometric average length of stay	5/6th of the average length of stay
505	EXTENSIVE 3RD DEGREE BURNS W/O SKIN GRAFT [4]	1.3569	32.5	27.0
506	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA [7]	0.7372	23.5	19.5
507	FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA [7]	0.7372	23.5	19.5
508	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ W CC OR SIG TRAUMA [2]	0.7372	23.5	19.5
509	FULL THICKNESS BURN W/O SKIN GRFT OR INH INJ W/O CC OR SIG TRAUMA [2]	0.7372	23.5	19.5
510	NON-EXTENSIVE BURNS W CC OR SIGNIFICANT TRAUMA [2]	0.7372	23.5	19.5
511	NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA [1]	0.4964	18.5	15.4
512	SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT [6]	0.0000	0.0	0.0
513	PANCREAS TRANSPLANT [6]	0.0000	0.0	0.0
515	CARDIAC DEFIBRILATOR IMPLANT W/O CARDIAC CATH [5]	2.0841	40.0	33.3
516	PERCUTANEOUS CARDIVASCULAR PROCEDURE W AMI [8]	0.9562	26.1	21.7
517	PERCUTANEOUS CARDIVASCULAR PROC W NON-DRUG ELUTING STENT W/O AMI [4].	1.3569	32.5	27.0
518	PERCUTANEOUS CARDIVASCULAR PROC W/O CORONARY ARTERY STENT OR AMI [3].	0.9562	26.1	21.7
519	CERVICAL SPINAL FUSION W CC [4]	1.3569	32.5	27.0
520	CERVICAL SPINAL FUSION W/O CC [8]	0.9562	26.1	21.7
521	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	0.4753	20.5	17.0
522	ALCOHOL/DRUG ABUSE OR DEPENDENCE W REHABILITATION THERAPY W/O CC	0.4061	20.4	17.0
523	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W/O CC.	0.4214	19.8	16.5
524	TRANSIENT ISCHEMIA	0.5885	22.9	19.0
525	HEART ASSIST SYSTEM, OTHER THAN IMPLANT [8]	2.0841	40.0	33.3
526	PERCUTANEOUS CARVIOVASCULAR PROC W DRUG-ELUTING STENT W AMI [8]	1.3569	32.5	27.0
527	PERCUTANEOUS CARVIOVASCULAR PROC W DRUG-ELUTING STENT W/O AMI [8]	1.3569	32.5	27.0
528	INTRACRANIAL VASCLUAR PROCEDURES WITH PDX HEMORRHAGE [8]	2.0841	40.0	33.3
529	VENTRICULAR SHUNT PROCEDURES WITH CC [2]	0.7372	23.5	19.5
530	VENTRICULAR SHUNT PROCEDURES WITHOUT CC [8]	0.7372	23.5	19.5
531	SPINAL PROCEDURES WITH CC [4]	1.3569	32.5	27.0
532	SPINAL PROCEDURES WITHOUT CC [3]	0.9562	26.1	21.7
533	EXTRACRANIAL VASCULAR PROCEDURES WITH CC [5]	2.0841	40.0	33.3
534	EXTRACRANIAL VASCULAR PROCEDURES WITHOUT CC [8]	1.3569	32.5	27.0
535	CARDIAC DEFIB IMPLANT WITH CARDIAC CATH WITH AMI/HF/SHOCK [8]	2.0841	40.0	33.3
536	CARDIAC DEFIB IMPLANT WITH CARDIAC CATH WITHOUT AMI/HF/SHOCK [5]	2.0841	40.0	33.3
537	LOCAL EXCISION AND REMOVAL OF INTERNAL FIXATION DEVICES EXCEPT HIP AND FEMUR WITH CC [4].	1.3569	32.5	27.0
538	LOCAL EXCISION AND REMOVAL OF INTERNAL FIXATION DEVICES EXCEPT HIP AND FEMUR WITHOUT CC [1].	0.4964	18.5	15.4
539	LYMPHOMA AND LEUKEMIA WITH MAJOR O.R. PROCEDURE WITH CC [8]	2.0841	40.0	33.3
540	LYMPHOMA AND LEUKEMIA WITH MAJOR O.R. PROCEDURE WITHOUT CC [1]	0.4964	18.5	15.4
541	IMPLANT, PULSATILE HEART ASSIST SYSTEM [6]	0.0000	0.0	0.0

[1] Relative weights for these LTC–DRGs were determined by assigning these cases to low volume quintile 1.
[2] Relative weights for these LTC–DRGs were determined by assigning these cases to low volume quintile 2.
[3] Relative weights for these LTC–DRGs were determined by assigning these cases to low volume quintile 3.
[4] Relative weights for these LTC–DRGs were determined by assigning these cases to low volume quintile 4.
[5] Relative weights for these LTC–DRGs were determined by assigning these cases to low volume quintile 5.
[6] Relative weights for these LTC–DRGs were assigned a value of 0.000.
[7] Relative weights for these LTC–DRGs were determined after adjusting to account for nonmonotonicity.
[8] Relative weights for these LTC–DRGs were determined by assigning these cases to the appropriate low volume quintile because they had no LTCH cases in the FY 2002 MedPAR.

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