DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412

[CMS–1472–F]

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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 establishes the annual update of the payment rates for the Medicare prospective payment system (PPS) for inpatient hospital services provided by long-term care hospitals (LTCHs). It also changes the annual period for which the rates are effective. The rates will be effective from July 1 to June 30 instead of from October 1 through September 30, establishing a ''long-term care hospital rate year'' (LTCH PPS rate year). We also change the publication schedule for these updates to allow for an effective date of July 1. The payment amounts and factors used to determine the updated Federal rates that are described in this final rule have been determined based on this revised LTCH PPS rate year. The annual update of the long-term care diagnosis-related groups (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, 2003, through June 30, 2004, is also derived from the LTCH PPS rate year calculations.

In addition, we are making an adjustment to the short-stay outlier policy for certain LTCHs and a policy change eliminating bed-number restrictions for pre-1997 LTCHs that have established satellite facilities and elect to be paid 100 percent of the Federal rate or when the LTCH is fully phased-in to 100 percent of the Federal prospective rate after the transition period.

EFFECTIVE DATE: The provisions of this final rule are effective June 30, 2003.

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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, Public Law 105–33
BBRA Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999, Public Law 106–113
BIPA Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Benefits Improvement and Protection Act of 2000, Public Law 106–554
CMS Centers for Medicare & Medicaid Services
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, Public Law 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) (Pub. L. 106–113) and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L.106–554) provide for payment for both the operating and capital-related costs of hospital inpatient stays in long-term care hospitals (LTCHs) under Medicare part A based on prospectively set rates. The Medicare prospective payment system 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 prospective payment system 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 inpatient 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 rule (67 FR 55954)for a comprehensive discussion of the research and data that supported the establishment of the LTCH PPS.

B. Criteria for Classification as a LTCH

LTCHs must have a provider agreement with Medicare and (1) must have an average Medicare inpatient length of stay of greater than 25 days, or (2), for a hospital that was first excluded from the PPS in 1986, must have an average inpatient length of stay for all patients, including both Medicare and non-Medicare inpatients, of greater than 20 days and 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 principle diagnosis that reflects a finding of neoplastic disease. Subject to the provisions of § 412.23(e)(3), for the first type of LTCHs as noted above, 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, data on the patient's stay would not be included in our systems. In order for noncovered days of a LTCH

hospitalization to be included, a patient 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, as set forth under § 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 immediately preceding 6-month period (§ 412.23(e)(3)(ii)). (For procedural efficiency and in order to comply with the timing requirement of § 412.22(d), we have a longstanding policy of allowing hospitals to submit data for a period greater than 5-months for this purpose.) 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 must also meet the criteria set forth in § 412.22(e) or § 412.22(h), respectively, to be excluded from the IPPS and paid under 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 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	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, if the Medicare payment was for a short-stay outlier case (§ 412.529) that was less than the full LTC–DRG payment amount, the LTCH could also charge the beneficiary for services for which the costs of those services or the days those services were provided were not a basis for calculating the Medicare short-stay outlier payment (§ 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. System Implementation for the LTCH PPS

When we established the regulations to implement the LTCH PPS on August 30, 2002 (67 FR 55954), effective for cost reporting periods that began on or after October 1, 2002, we did not have computer system changes in place that were necessary to accommodate claims processing and payment under the system. However, after January 1, 2003, we made the necessary system changes. Accordingly, after January 1, 2003, the fiscal intermediary has been required to reconcile the payment amounts that had been made to LTCHs for all covered inpatient hospital services furnished to Medicare beneficiaries from cost reporting periods that began on or after October 1, 2002, through January 1, 2003, with the amounts that were payable under the LTCH PPS methodology. Because the LTCH PPS was effective at the start of the LTCH's first cost reporting period that began on or after October 1, 2002, only those LTCHs with cost reporting periods that started October 1, 2002, through January 1, 2003, will experience the payment reconciliation necessitated by this 3-month period prior to systems implementation. The claims submission procedure of using ICD–9–CM codes has not changed following the systems implementation of the LTCH PPS.

We also want to 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 HIPPA Administrative Simplification Standards must start submitting electronic claims in compliance with the HIPPA regulations cited above, among others.

II. Publication of Proposed Rulemaking

On March 7, 2003, we published a proposed rule in the **Federal Register** (67 FR 11234) 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). In that rule, we proposed to change the annual period during which the updated payment rates for the LTCH PPS would be effective from October 1 through September 30 to a LTCH PPS rate year from July 1 through June 30. We also proposed to change the publication schedule for these updates to allow for an effective date of July 1. The proposed payment amounts and factors used to determine the proposed updated Federal rates that were described in the March 7, 2003, proposed rule were determined based on the proposed revised update LTCH PPS rate year. However, the annual update of the long-term care diagnosis-related groups (LTC–DRG) classifications and relative weights remain linked to the annual adjustments of the acute care hospital inpatient diagnosis-related group system, effective each October 1. In the March 7, 2003, proposed rule, we also proposed the outlier threshold for July 1, 2003, through June 30, 2004, that was derived from the proposed LTCH PPS rate year calculations. We also proposed a change for outlier payments under the LTCH PPS. In addition, we proposed a policy change eliminating bed-number restrictions for pre-1997 LTCHs that have established satellite facilities and that elect to be paid 100 percent of the Federal rate or when the LTCH is fully phased-in to 100 percent of the Federal prospective rate after the transition period.

We received a total of 32 timely items of correspondence containing multiple comments on the proposed rule. The major issues addressed by the commenters included: The establishment of the LTCH PPS rate year and its relation to the update of the Federal rates; the LTC–DRGs and the wage index; satellite policy and budget neutrality calculations; high-cost and short-stay outliers; market basket and labor share; disproportionate share (DSH) and Graduate Medical Education (GME) policies.

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 LTCH PPS and make other policy changes. The following is a summary of the major areas that we are addressing in this final rule:

A. Change in the Annual Update

We are changing the annual update to the Federal payment rate under the LTCH PPS from the Federal fiscal year (October 1 through September 30) to a ''LTCH PPS rate year'' of July l through June 30, beginning July l, 2003, as discussed in section IV. of this preamble. (In this final rule, we define the LTCH PPS rate year as the period from July 1 to June 30 for updates to the LTCH PPS.) As noted below, we will now publish information on the annual update in the **Federal Register** on or before May 1 prior to the start of each long-term care hospital prospective payment system rate year that begins July 1, unless for good cause it is published after May 1, but before June 1. We have already noted that the annual update of the LTC–DRGs will be published in the proposed and final rules for the IPPS. We also recognize that it may be necessary to address issues affecting LTCHs at a time that does not conform to the schedule above. In such a situation, we would use another **Federal Register** document (that is, the acute care hospital inpatient prospective payment system (IPPS) proposed rule or final rule) as the vehicle to present that issue.

B. Update Changes

- In section IV. of this preamble, the annual update of the LTC–DRG classifications and relative weights 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 section VI. of this preamble, we discuss a policy change on how Medicare payment under the LTCH PPS will be made to certain LTCHs that have satellite facilities.
- In sections VII. through XI. of this preamble, we discuss our determination of the LTCH PPS rates that are applicable to the LTCH PPS rate year of July 1, 2003, through June 30, 2004, 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.
- In section XII. of this preamble, we discuss our continuing monitoring efforts to evaluate the LTCH PPS.
- In section XIV. of this preamble, we set forth an analysis of the impact of the changes in this final rule on Medicare expenditures and on Medicare-participating LTCHs and Medicare beneficiaries.

IV. Changes in the Annual Update of the LTCH PPS

In existing regulations at § 412.535 that were issued in the August 30, 2002, final rule, we specify a schedule for publishing information on the LTCH PPS on or before August 1, which coincided with the statutorily mandated publication schedule for the IPPS. In the March 7, 2003, proposed rule, we proposed to revise § 412.535 to provide generally for a change in the annual rate update for the LTCH PPS, starting on July 1.

Section 1886(e)(5)(A) of the Act requires that, for the IPPS, the proposed rule be published in the **Federal Register** ''not later than the April 1 before each fiscal year; and the final rule, not later than the August 1 before such fiscal year.'' The statute imposes no such publication schedule for the LTCH PPS. In the August 30, 2002, final rule, we stated that we were considering changing the publication schedule of the LTCH PPS annual rulemaking cycle in order to avoid concurrent publication of annual rules for these two systems for purposes of administrative feasibility and efficiency (67 FR 55977). In considering a change in the publication schedule of the LTCH PPS final rule, we contemplated a change in the effective date for updating the Federal rates for the LTCH PPS. Therefore, in the March 7, 2003, proposed rule, we proposed changing the effective date of the annual update for the LTCH PPS from October 1 to July 1 of each year in order to facilitate a timely publication of these two significant payment updates (IPPS and LTCH PPS). Thus, the annual update of the LTCH PPS Federal rates would no longer be linked to the start of the Federal fiscal year, as is the update of the IPPS. We had proposed that this change would necessitate publication of the final rule for the

LTCH PPS by no later than June 1 of each year (proposed revised § 412.535).

In the March 7, 2003, proposed rule, we also proposed to amend § 412.503 to include a definition of ''LTCH PPS rate year''. A ''LTCH PPS rate year'' would mean the 12-month period of July 1 through June 30. In the proposed rule, we stated that we would use this period for those calculations related to updating the Federal rate for payments under the LTCH PPS. We also stated that the determination of the proposed fixed-loss threshold for outlier payment calculations, under § 412.525(a), would also be calculated based on the LTCH PPS rate year. (Section VII.C. of this final rule includes a more detailed discussion of our outlier policy.)

Proposing a change for the annual Federal rate update period for the LTCH PPS also necessitated a proposed recalculation of the excluded hospital market basket with capital estimate for the proposed forthcoming payment year, July 1, 2003, through June 30, 2004. In the August 30, 2002, final rule, we established a Federal rate of $34,956 that was computed based on the excluded hospital with capital market basket calculated for the 12-month Federal fiscal year of October 1, 2002, through September 30, 2003. As already noted, we proposed to change the Federal rate update for the LTCH PPS from the Federal fiscal year to a 12-month LTCH PPS rate year of July 1 through June 30, and the proposed rates in the March 7, 2003, proposed rule were based on this period. Because the Federal rate of $34,956 was originally computed based on a 12-month year, but in actuality will only be used for 9 months, if the proposed change in the LTCH PPS rate update year was finalized, we proposed, in the March 7, 2003, proposed rule, to make a budget neutral adjustment to the market basket update taking this 3-month differential into account in setting the Federal rate for July 1, 2003, through June 30, 2004. In addition, we proposed that the change in the 2004 LTCH PPS rate year would be budget neutral. In section VII.B.1 of this final rule, we describe this adjustment in greater detail.

In the March 7, 2003, proposed rule, we proposed to update the LTCH PPS wage index that adjusts for differences in area wages under § 412.525(c) using the FY 1999 IPPS wage data because these are the best available wage data (as discussed in section VII.C. of this preamble).

We also stated that we were proposing to recalculate the budget neutrality offset to account for the effect of the transition period and the policy allowing LTCHs to elect 100 percent Federal rate payments rather than the transition blend.

We also proposed an updated fixed-loss amount for determining outlier payments based on the updated proposed Federal rate (as discussed in section VII. of this preamble).

In section IV.C. of the March 7, 2003, proposed rule, we stated that we did not propose an update to the LTC–DRG classifications or relative weights at this time. Currently, the LTC–DRG patient classifications used by the LTCH PPS for FY 2003 are based directly on the same version of DRGs used by the IPPS, that is, GROUPER 20.0. Therefore, we did not propose any change to the timing of the annual update of the LTC–DRG classifications and relative weights. They will remain linked to the annual adjustments of the acute care hospital inpatient DRG system, which are based on the annual revisions to the ICD–9–CM codes, effective each October 1. Table 3 of the Addendum to the August 30, 2002, final rule (67 FR 56076–56084), which were reprinted as Table 3 of the Addendum to the March 7, 2003, proposed rule, contains the LTC–DRG classifications and relative weights that we proposed to continue to apply to discharges occurring during the period of July 1, 2003, through September 30, 2003. As an aid in calculating payment under the short-stay outlier policy, under § 412.529, we also are including, in column 3 of Table 3, the proposed five-sixths average length of stay that will be applied to each LTC–DRG in determining whether the LTCH stay is a short-stay outlier. The average length of stay for each DRG based on the FY 2001 MedPAR data, which were used for the FY 2003 LTCH PPS final rule, are still the best available complete LTCH discharge data available at this time.

The revised LTC–DRG classifications and relative weights for discharges occurring from October 1, 2003, through September 30, 2004, for payments under the LTCH PPS during that period would continue to be updated on a Federal fiscal year cycle as is the case for the acute care hospital inpatient DRG system. The FY 2004 DRGs and relative weights for the IPPS had not yet been proposed by the time the March 7, 2003, proposed rule was published and we were unable to propose updated LTC–DRGs and relative weights (which would be based on the proposed updated acute care hospital inpatient DRGs). Thus, we proposed that the LTC-DRG classifications and relative weights would be presented for public comment in the proposed rule for the IPPS and finalized in the IPPS final rule, with an effective date of October 1, 2003.

The proposed change in the LTCH PPS rate year for the LTCH PPS from October 1 through September 30 to July 1 through June 30 means that, although the Federal rate calculations in the August 30, 2002, final rule were based on a 12-month year, only 9 months will elapse before the July 1, 2003, update. In the March 7, 2003, proposed rule, we proposed to make a prospective adjustment to the market basket update to take into account this 3-month differential in setting the rates for July 1, 2003, through June 30, 2004.

Specifically, we explained that the proposed updates for the proposed 2004 LTCH PPS rate year would be affected as follows:

- The proposed update to the standard Federal rate calculated in accordance with § 412.523(c)(3) would be adjusted to account for updating the standard Federal rate on July 1, 2003, instead of October 1, 2003.
- The fixed-loss amount for determining high-cost outlier payments under § 412.525(a) would also be updated based on the Federal rate effective for July 1, 2003, through June 30, 2004.

In section VI.B.1 of the March 7, 2003, proposed rule, we discussed the proposed computational adjustments resulting from our proposed establishment of a LTCH PPS rate year beginning July 1, 2003, through June 30, 2004.

In the March 7, 2003, proposed rule, we stated that several provisions of the LTCH PPS would not be affected by the change in the annual rate update year for the LTCH PPS from October 1 to July 1 because these policies are not based on any of the Federal rate calculations for the LTCH PPS. Specifically, the following provisions would not be affected:

- The transition blends provided for under § 412.533(a) will not be affected because they are linked to the start of each LTCH's cost reporting period, rather than to the start of the Federal fiscal year. (LTCHs being paid under the transition blend methodology will receive those blends for the entire 5-year transition period, unless they elect payments based on 100 percent of the Federal rate.) For instance, for cost reporting periods that began on or after October 1, 2002, and before October 1, 2003, the total payment for a LTCH is 80 percent of the amount that will be calculated under the reasonable cost-based payment system for that specific LTCH and 20 percent of the Federal prospective payment amount. For cost reporting periods beginning on or after October 1, 2003, and before October 1, 2004, the total payment for a LTCH is

60 percent of the amount that will be calculated under the reasonable cost-based payment system for that specific LTCH and 40 percent of the Federal prospective payment amount.

• The 5-year phase-in of the adjustment for differences in area wage levels under § 412.525(c) will not be affected because they are linked to the start of each LTCH's cost reporting period, rather than to the start of the Federal fiscal year. For cost reporting periods that began on or after October 1, 2002, and before September 30, 2003, the applicable LTCH PPS wage index is one-fifth of the full LTCH wage index value, and for cost reporting periods beginning on or after October 1, 2003, and before September 30, 2004, the applicable LTCH PPS wage index is two-fifths of the full LTCH wage index value.

• The LTC–DRGs and their relative weights and the GROUPER will not be affected since they will continue to be updated effective October 1 through September 30 each year based on the changes to the DRGs published in the IPPS final rule.

We received eight comments regarding our proposal to change the effective date of the annual update for the LTCH PPS from October 1 to July 1 of each year.

Comment: Two commenters supported the establishment of the LTCH PPS rate year, but suggested that publishing the final rule each year by May 1, rather than by June 1 would allow LTCHs additional time for adjustments to their payment systems.

Response: We thank the commenters for endorsing the establishment of the revised LTCH PPS rate year. In changing the effective date of the LTCH PPS rate year update and the resulting publication dates of the proposed and final regulations for the system, we stated that this shift in the schedule would promote ''administrative feasibility and efficiency,'' by avoiding concurrent rulemaking and publishing with the IPPS final rule. As we have already noted, section 1886(e)(5)(A) of the Act requires that, for the IPPS, the proposed rule be published in the **Federal Register** ''not later than the April 1 before each fiscal year; and the final rule, not later than the August 1 before such fiscal year,'' but no similar requirement is imposed on the LTCH PPS.

Publishing a final rule annually by May 1 in order to allow 60-days between publication and effective date of the LTCH PPS rate update does not invalidate our stated objectives. Therefore, we will revise the regulations to require publication of the final LTCH rule by May 1 of each year unless for ''good cause'' we are unable to publish by that date, but before June 1. (We note that ''good cause'' used in this context is not coextensive and is broader than the ''good cause'' standard used in the Administrative Procedures Act (A.P.A.) at 5 U.S.C. section 553(d)(3).)

Comment: Several commenters took issue with the proposed change in the effective date of the annual update for the LTCH PPS from October 1 to July 1 of each year while still retaining the October 1 effective date for updating LTC–DRG classifications and weights. They believe that this policy change will be burdensome to LTCHs, requiring two separate updates during one cost reporting period as well as increased systems costs. These commenters urged us to remain with the existing update and publication schedule and some suggested deferring the change until full implementation of the LTCH PPS in FY 2006. One commenter raised the issue that this ''fragmentary'' implementation of individual updates will increase potential payment calculation errors for LTCHs. Another commenter urged us to pay LTCHs as a ''pass through'' for any expenses that they incur in complying with the new regulations, should they be made final.

One commenter stated that administrative feasibility and efficiency at CMS did not justify burdening LTCHs in this manner. One of the commenters asserted that the costs for updating LTCH billing systems to accommodate this change in the LTCH PPS rate year will have a considerable impact on LTCHs as Small Businesses and, therefore, should have been reviewed under the A.P.A and the Regulatory Flexibility Act (RFA).

Response: In response to these commenters, we first want to establish the fact that we have no requirement that LTCHs maintain payment systems or coding software in order to be paid under the LTCH PPS. We understand that it is common for many hospitals, consultants, and industry associations to do so, but we believe that some of the commenters who oppose the proposed change in the LTCH PPS rate year for the LTCH PPS to July 1 through June 30 while retaining October 1 through September 30 for the LTC–DRG update are oversimplifying what presently exists from a systems standpoint. Currently, all providers with cost reporting periods beginning in any month other than October already are subject to two separate updates. In addition, rate changes may occur during the fiscal year because of Congressional action for services rendered ''on or after'' the date that the rate change was effective. Additionally, ongoing audit and review procedures, provider-generated appeals procedures, and either administrative or judicial decisions also can produce hospital-level rate changes not associated with the start of a Federal fiscal year.

As noted above, we do not require providers to process claims or to determine LTC–DRG assignments, but should a LTCH or any other group choose to duplicate the PRICER software that is required for fiscal intermediaries, or the GROUPER software that we use, it is an individual business determination.

We primarily want to remind the commenters that the determination of Medicare payments based on submitted claims is solely a responsibility of each fiscal intermediary. Since payments to LTCHs will be based on claims processing done by fiscal intermediaries, we do not understand one commenter's assertion that we should not implement this policy because one of the payment consequences in establishing the LTCH PPS rate year will be to cause potential calculation errors by LTCHs.

Nowhere in our regulations are LTCHs required to maintain the systems capability to calculate payments. Therefore, although individual LTCHs and other groups may elect, for their own purposes, to purchase software packages in order to duplicate work done by our contractors, we do not agree that those costs should be paid as a pass-through by us. Moreover, we continue to believe that since the start of cost reporting periods for many LTCHs, as well as acute care hospitals, have not generally coincided with the October starting date of the Federal fiscal year, those hospitals that choose to have their own payment software are very familiar with the virtually seamless routine of inputting new numbers to their existing systems when a final rule is published. We do not believe that this policy will be unduly burdensome to such LTCHs. We also point out to the commenters that with publication of the proposed rule on March 7, 2003, we have complied with the A.P.A. As to the RFA, as stated in the proposed rule (68 FR 11259), this rule would not have a significant impact on small entities (this includes small businesses).

In response to the two comments suggesting that we delay implementation of this policy until full phase-in of the LTCH PPS in FY 2006, based on our evaluation of the above comments, we do not believe that such a decision is warranted.

Comment: One commenter suggested that if we found it necessary to

reschedule the effective date and publication cycle of one of the post-acute care prospective payment systems, we should do so for Home Health Agency (HHA) or Skilled Nursing Facilities (SNF) which are not DRG-based, and, therefore, not linked to the October 1 update.

Response: As we have noted elsewhere in this final rule, there is no statutory authority requiring the update of the LTCH PPS to coincide with the October 1 start of the Federal fiscal year. On the contrary, annual updates linked to the October 1 start of the Federal fiscal year are required for both the SNF PPS, under section 1888(e)(4)(H) of the Act (implemented in § 413.345), and the HHA PPS, under section 1895(b)(3)(B) (implemented in § 484.225). Therefore, although we do not have the authority to shift the annual update for the SNF PPS or the HHA PPS, we believe that such a policy is appropriate under section 123 of Public Law 106–113 and section 307(b) of Public Law 106–554, which conferred broad authority on the Secretary in designing and implementing a PPS for LTCHs.

Comment: One commenter noted that ''the use of two GROUPERs will not in and of itself create any hardship on LTCHs [which] will be able to adapt to this process. Most hospitals today do not have fiscal years that coincide with the federal (sic) fiscal year and must adapt to the use of two GROUPERs during their cost reporting year.'' This commenter did express concern, however, about the additional rate changes caused by the cost report reconciliation if the proposed outlier policy was finalized. The commenter suggested that we require fiscal intermediaries to update cost to charge ratios either at July 1 or October 1 in order to limit the number of changes during a 12-month period of time.

Response: We agree with the commenter's assessment of most LTCHs' (and acute care hospital's) ability to adapt to the use of two GROUPERs during one cost reporting period. Regarding rate changes brought about by changes in our outlier policy, as noted elsewhere in this final rule, all discussions of the outlier policy are presented in the IPPS high-cost outlier final rule.

In this final rule, we amend § 412.535 to indicate that information on the unadjusted Federal payment rates and a description of the methodology and data used to calculate the payment rates under the LTCH PPS will be published in the **Federal Register** on or before May 1 prior to the beginning of each LTCH PPS rate year beginning July 1, unless for good cause we are unable to make the May 1 publication date, but before June 1. We proposed that information on the DRG classification system and associated weighting factors, with the DRGs from which the LTC–DRGs are derived, would be published in the proposed IPPS rule and, ultimately, the final rule for the IPPS (the final IPPS rule is published on or before August 1 of each Federal fiscal year). Section XIV. of this final rule contains an impact analysis that reflects the impact of these changes.

V. Changes in 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 diagnosis-related groups (DRGs) that have been modified to account for different resource use of long-term care hospital 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 long-term care diagnosis-related groups (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 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, 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, 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 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 type 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 will determine 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 provisions.

D. Update of LTC–DRGs

For FY 2003, the LTC–DRG patient classification system was based on LTCH data from the FY 2001 MedPAR file, which contained hospital bills received through March 31, 2001, for hospital discharges occurring in FY 2001. The patient classification system consisted of 510 DRGs that formed the basis of the FY 2003 LTCH PPS GROUPER. The 510 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 508 LTC–DRGs are the same DRGs used in the IPPS GROUPER for FY 2003 (Version 20.0).

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 previously in the March 7, 2003, proposed rule, we proposed to make the annual update to the LTCH PPS effective from July 1 through June 30 each year. As a result of this change, we proposed that the LTCH PPS would

use 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 was necessary for us to propose to apply two GROUPER programs to the LTCH PPS. Although we did not believe that this would have any adverse effect on LTCHs, we were interested in receiving comments on this issue. LTCHs would continue to code diagnosis and procedures using the most current version of the ICD–9–CM coding system.

Currently, for Federal FY 2003, we are using Version 20.0 of the GROUPER software for both the IPPS and the LTCH PPS. For discharges beginning on October 1, 2003 (Federal FY 2004), in the March 7, 2003, LTCH PPS proposed rule, we proposed to use 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, 2003, through September 30, 2004, are presented in the IPPS FY 2004 proposed rule that was published on May 19, 2003, in the **Federal Register** (68 FR 27154). Accordingly, we will notify LTCHs of any revised LTC–DRG relative weights based on the final DRGs and Version 21.0 GROUPER for the IPPS that would be effective October 1, 2003.

Comment: Two commenters suggested that we synchronize the LTCH rate year (that is, July 1 through June 30) with the update of the LTC DRGs which occurs on October 1 by delaying the October 1 update until the following July 1. As an alternative, one commenter suggested that the LTCHs could continue to use the LTC–DRG weights determined the previous October 1 until the start of the next LTCH rate year (July 1, 2004), and conduct a readjustment for the LTCH PPS on July 1 of the following year.

Response: With regard to the commenters' suggestion to continue to use the current ICD–9–CM and DRG Grouper Version 20 until June 30, 2004, delaying the update until the following year, we believe that this suggestion is not feasible. This would require coders to use two different ICD–9–CM versions, one for IPPS use (Version 21 will be implemented October 1, 2003) and another for LTCH PPS. Moreover, the HIPPA (45 CFR part 162) requires that the ICD–9–CM be the standard medical code set and each code set is valid within the dates specified by the organization (Department of Health and Human Services) responsible for maintaining that code set. The use of other than the current code set (most recent update to the ICD–9–CM will be effective October 1, 2003) would be in direct violation of the current HIPPA requirements.

In this final rule, while we are adopting the proposed use of two GROUPER software programs over the course of the LTCH rate year, 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 existing GROUPER and the updated GROUPER will be in effect for 12 months. These two GROUPER programs will be the same programs in use for the IPPS.

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 wish to 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 HIPPA 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.*

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 will 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 change to the annual update of the LTCH PPS year to July 1, coders will use the most current updated ICD–9–CM coding book 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, which would be 4 months after the date that we will 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 will be 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 will not be 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, AHIMA, and NCHS), we have 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). We have received a question 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. Depending on the documentation in the medical record, either code 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, final rule (67 FR 55979–55981).

Comment: Two commenters expressed their support for our adherence to the official ICD–9–CM coding guidelines.

Response: We appreciate the commenters support and anticipate working closely with both the AHA and the AHIMA to increase awareness of proper documentation and correct coding in the LTCH setting.

F. Changes to the Method for Updating the LTC–DRG Relative Weights

As discussed in the March 7, 2003, proposed rule, 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 30, 2002, final rule (67 FR 55984–55995), the LTC–DRG relative weights effective under the LTCH PPS for Federal FY 2003 were calculated using the March 2002 update of FY 2001 MedPAR data and Version 20.0 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 30, 2002, final rule (67 FR 55985) for further information of 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 2003 based on the FY 2001 MedPAR data, we identified 161 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 32 LTC–DRGs (161/5 = 32 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 30, 2002, final rule (67 FR 55985–55988) for further explanation of the development and composition of each of the five low volume quintiles for FY 2003.)

After grouping the cases in the appropriate LTC–DRG, we calculate the relative weights by first removing statistical outliers and cases with a length of stay of 7 days or less. Next, we adjust 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 30, 2002, final rule (67 FR 55989–55995) for further details on the steps for calculating the LTC–DRG relative weights.)

We also adjust the LTC–DRG relative weights to account for nonmonotonically increasing relative weights. That is, we make 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 30, 2002, 67 FR 55990–55991). In addition, of the 510 LTC–DRGs in the LTCH PPS for FY 2003, based on the FY 2001 MedPAR data, we identified 159 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 2001 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 159 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 2003, we assigned relative weights to each of the 159 ''no volume'' LTC–DRGs based on clinical similarity and relative costliness to one of the remaining 351 (510 − 159 = 351) LTC–DRGs for which we were able to determine relative weights, based on the FY 2001 claims data. (A list of the no volume LTC–DRGs and further explanation of their relative weight assignment can be found in the August 30, 2002, final rule (67 FR 55991–55994).)

Furthermore, we establish 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 effected. At the present time, though, we only include these six transplant LTC–DRGs in the GROUPER program for administrative purposes because since 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 March 7, 2003, proposed rule, we proposed that we would continue to use the same LTC–DRGs and relative weights until October 1, 2003. Accordingly, Table 3 in the Addendum to the March 7, 2003, proposed rule lists the LTC–DRGs and their respective relative weights and arithmetic mean length of stay that we proposed would continue to be used for the period of July 1, 2003, through September 30, 2003. (This table is the same as Table 3 of the Addendum to the August 30, 2002, final rule (67 FR 56076–56084), except that it includes the proposed five-sixth of the average length of stay for short-stay outliers under § 412.529.) As we noted in section IV.D. of the March 7, 2003, proposed rule, we proposed that the final DRGs and GROUPER for FY 2004 that will be used for the IPPS and the LTCH PPS, effective October 1, 2003, would be presented in the IPPS FY 2004 final rule published no later than August 1, 2003, 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, 2003, and September 30, 2004, based on the final DRGs and Version 21.0 GROUPER published in the IPPS rule on or before August 1, 2003.

VI. Policy Change Related to Payments to LTCHs That Are Satellite Facilities

Provisions of the Proposed Rule

In proposing the LTCH PPS (March 7, 2002, 67 FR 13416), we stated that we were considering proposing the elimination of the bed limit in § 412.22(h)(2)(i) for pre-1997 excluded hospitals once the prospective payment system was fully phased-in and all payments were based on 100 percent of the Federal prospective payment rates. This statement generated a number of comments and in the August 30, 2002, final rule (67 FR 56012), we stated our agreement with commenters who urged us to adopt a policy eliminating the bed-number restrictions for pre-1997 LTCHs with satellite facilities, as soon as a LTCH is paid based on 100 percent of the Federal prospective rate. However, we also noted that we would address a change in the policy concerning bed limits in the next update of the LTCH PPS. Therefore, in the March 7, 2003, proposed rule (68 FR 11243–11244), we proposed to eliminate the application of the bed-number restrictions set forth in § 412.22(h)(2)(i) for LTCHs established prior to 1997 with satellite facilities, effective at the start of the first cost

reporting year that a LTCH is paid under the 100 percent fully Federal prospective payment system. This will be either when a LTCH elects to be paid based on 100 percent of the Federal prospective rate or when the LTCH is fully transitioned to 100 percent of the Federal prospective rate, whichever comes first.

Section 1886(b)(3) of the Act, as amended by section 4414 of Public Law 105–33, required existing LTCHs to be subject to caps on their target amounts for cost reporting periods beginning on or after October 1, 1997, through September 30, 2002. For purposes of calculating these caps, the statute required the Secretary to ''estimate the 75th percentile of the target amounts for such hospitals within [each] class for cost reporting periods ending during fiscal year 1996.'' Section 1886(b)(3)(H) of the Act, as amended by section 121 of Public Law 106–113, directed the Secretary to provide for an appropriate wage adjustment to the caps on the target amounts for psychiatric and rehabilitation hospitals and units and LTCHs effective for cost reporting periods beginning on or after October 1, 1999 through September 30, 2002. In addition, payment limits were established for new excluded hospitals or units (excluding children's hospitals) effective October 1, 1997. For new excluded hospitals (that is, post-1997 LTCHs), section 1886(b)(7) of the Act, as added by section 4416 of Public Law 105–33, specified that the payment amount for the facility's first two 12-month cost reporting periods, for which the hospital has a settled cost report, must not exceed 110 percent of the national median of target amounts of similarly classified hospitals for cost reporting periods ending during FY 1996, updated by the hospital market basket increase percentage to the first cost reporting period in which the hospital receives payment, as adjusted by section 1886(b)(7)(C) of the Act. The result of sections 4414 and 4416 of Public Law 105–33 was a distinction between the LTCHs established prior to, and those established after 1997, with lower payment caps for the post-1997 LTCHs.

In the July 30, 1999, IPPS final rule (64 FR 41532–41533), we promulgated regulations at § 412.22(h)(2)(i) to discourage pre-1997 excluded hospitals, which had the higher caps on target amounts as discussed above (under § 413.40(c)(4)(iii)), from creating satellites rather than establishing new hospitals, in order to avoid the payment impact of the lower caps that apply to new hospitals (under § 413.40(f)(2)(ii)). In the July 30, 1999, IPPS final rule (64 FR 41490), we required that where a pre-1997 excluded hospital, such as a LTCH, established a satellite facility and, in doing so, its total beds, in both the parent hospital (or unit) and the satellite facility, exceeded the number of State-licensed and Medicare-certified beds in the parent hospital on the last day of its last cost reporting period beginning before October 1, 1997, the excluded hospital would be paid under the inpatient DRG system, instead of receiving payment as an excluded hospital under the reasonable cost-based payment system. Although the excluded hospital could ''transfer'' beds from the parent facility to the satellite, it could not increase its total bed capacity (at the parent and satellite(s)) beyond the level the hospital had in the most recent cost reporting period beginning before October 1, 1997, and still be paid as a hospital excluded from the IPPS. However, no such limitation was imposed on a LTCH established after October 1, 1997. Since this type of hospital would have already been subject to the lower payment limit of 110 percent of the national median of target amounts for similarly classified hospitals under § 413.40(f)(2)(ii), it would not benefit by establishing a satellite facility instead of a separate free-standing hospital, as would a pre-1997 LTCH.

The rationale for applying the bed-limit provision only on pre-1997 hospitals was the potential for gaming by those hospitals, by creating a satellite facility with a higher TEFRA target cap where, in reality, the satellite facility should have been a separately certified excluded facility, which would have been subject to the lower cap on payments to new (post-1997) facilities paid under the TEFRA system. Once the LTCH is paid based on 100 percent of the Federal prospective rate, however, the LTCH will no longer be subject to TEFRA caps and LTCH prospective payments will be the same regardless of when the LTCH was established. Therefore, consistent with the March 7, 2003, proposed rule, we are eliminating the bed-limit provision once a LTCH is paid based on 100 percent of the LTCH Federal PPS rate. Finally, under this policy, the bed limitation on ''existing'' LTCHs will, however, continue to apply to those LTCHs while they are paid based on the transition blend, and, therefore, continue to receive a percentage of their payments based on the reasonable cost-based payment rules, until these hospitals are paid based on 100 percent of the Federal prospective payment rate.

Comment: Several commenters expressed their strong support for our proposal to eliminate the bed number limitation for pre-1997 LTCHs with satellite facilities for those LTCHs receiving 100 percent of the Federal rate. One commenter recommended that the bed number limitation should also be eliminated for the IRFs since they are now receiving payment at 100 percent of the Federal rate.

Response: We appreciate the strong endorsement in response to this proposed change. Regarding the commenter who recommended eliminating the bed size limitation for IRFs, we would suggest that the commenter look to the IRF proposed rule that was published on May 16, 2003 (68 FR 26785).

Accordingly, in this final rule, we are adopting the proposal to eliminate the bed size limitation for pre-1997 LTCHs with satellite facilities once the LTCH is paid at 100 percent of the Federal rate. We note that in the preamble to the March 7, 2003, proposed rule, we stated the two circumstances under which a LTCH would be paid based on 100 percent of the Federal rate, which are for the start of the first cost reporting period that a LTCH elects fully Federal payment, as set forth in § 412.533(c) or when the LTCH PPS is fully phased-in after the transition period. We inadvertently omitted the second circumstance in the proposed regulation text at § 412.22(h)(6), therefore, we are revising that section to reflect this policy.

VII. Changes to the LTCH PPS Rates for the 2004 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 proposed factors used to update the LTCH PPS standard Federal rate for the proposed 2004 LTCH PPS rate year published in

the March 7, 2003, proposed rule. We also discuss the factors used to establish the final update to the LTCH PPS standard Federal rate for the 2004 LTCH PPS rate year in this final rule, which will be effective for LTCHs paid under the LTCH PPS for discharges occurring on or after July 1, 2003, through June 30, 2004. In the final rule published on August 30, 2002 (67 FR 56029–56031), for cost reporting periods beginning on or after October 1, 2002 (FY 2003), we computed the LTCH PPS standard Federal payment rate 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 for FY 2003 under § 412.523(d)(2), we set total estimated 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. In addition, the statute as amended by section 122 of Public Law 106–113 provides for enhanced bonus payments for LTCHs for two years, FY 2001 and FY 2002. 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). Under the existing regulations at § 412.523(c)(3)(ii) for fiscal years after FY 2003, 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 2004 LTCH PPS Rate Year

In the August 30, 2002, final rule (67 FR 56033), we established a LTCH PPS standard Federal rate of $34,956.15 for FY 2003. As discussed in the March 7, 2003, proposed rule (68 FR 11248), based on the most recent estimate of the excluded hospital with capital market basket, adjusted to account for the change in the rate year update cycle for the LTCH PPS rates, we proposed that the LTCH PPS standard Federal rate, effective from July 1, 2003, through June 30, 2004, would be $35,726.64. Based on updated data, including the most recent estimate of the excluded hospital with capital market basket adjusted to account for the change in the rate year update cycle for the LTCH PPS rates, and the policies described in this final rule, the LTCH PPS standard Federal rate, effective from July 1, 2003, through June 30, 2004, is $35,726.18 (as discussed below).

In the discussion that follows, we explain how we developed the update to the final standard Federal rate for the 2004 LTCH PPS rate year in this final rule. The final standard Federal rate for the 2004 LTCH PPS rate year is calculated based on the final update factor of 1.0220. Thus, we estimate that the final standard Federal rate for the 2004 LTCH PPS rate year will increase 2.2 percent compared to the FY 2003 standard Federal rate.

1. Standard Federal Rate Update

In the August 30, 2002, final rule, we established at § 412.523 that, for years after FY 2003, the annual update to the LTCH PPS standard Federal rate will 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 stated in the March 7, 2003, proposed rule (68 FR 11244), because the LTCH PPS has only recently been implemented (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, in that same proposed rule, we did not propose an update framework for the 2004 LTCH PPS rate year. 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 2004 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. The excluded hospital market basket is based on operating costs from FY 1992 cost report data 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 both the August 30, 2002, final rule (67 FR 56016 and 56086–56086) and the March 7, 2003, proposed rule (68 FR 11245–11247), 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. The FY 1992-based market basket reflected the distribution of costs in FY 1992 for Medicare-participating freestanding rehabilitation, long-term care, psychiatric, cancer, and children's hospitals. This information was derived from the FY 1992 Medicare cost reports. A full discussion of the methodology and data sources used to construct the FY 1992-based excluded hospital with capital market basket is included in Appendix A of the August 30, 2001, final rule (67 FR 56085–56086). In the March 7, 2003, proposed rule, we proposed to revise and rebase the excluded hospital with capital market basket, using more recent data, that is, using FY 1997 base year data beginning with the proposed 2004 LTCH PPS rate year.

As we stated in the March 7, 2003, proposed rule (68 FR 11245–11247), we believe it was appropriate to propose to revise and rebase the LTCH PPS market basket based on the most recent complete data available (FY 1997) because these data would more accurately reflect LTCHs' current costs. Furthermore, we noted that this proposed revising and rebasing of the LTCH PPS market basket from an FY

1992 base year to a FY 1997 base year would be consistent with the rebasing of both the hospital inpatient market basket used under the IPPS and the excluded hospital market basket used to update the target amounts under the reasonable cost-based payment system for FY 2003, as discussed in the August 1, 2002, IPPS final rule (67 FR 50032–50047). We received no comments on the proposed revising and rebasing of the LTCH PPS market basket. Therefore, in this final rule, we are adopting the FY 1997-based excluded hospital with capital market basket as the LTCH PPS market basket beginning with the 2004 LTCH PPS rate year. Below we are providing a discussion of the development of the FY 1997-based excluded hospital with capital market basket, as we presented in the March 7, 2003, proposed rule (68 FR 11245–11247).

The operating portion of the FY 1997-based excluded hospital with capital market basket that we are using under the LTCH PPS beginning with the 2004 LTCH PPS rate year is derived from the FY 1997-based excluded hospital market basket used under the reasonable cost-based payment system. The methodology we used to develop the operating portion of the market basket under the LTCH PPS is the same methodology used to revise and rebase the excluded hospital market basket used under the reasonable cost-based payment system, which is described in greater detail in the August 1, 2002, IPPS final rule (67 FR 50042–50044). In brief, the operating cost category weights in the FY 1997-based excluded market basket add up to 100.0. These weights were determined based on FY 1997 Medicare cost report data, the 1997 Business Expenditure Survey, and the 1997 Annual Input-Output data from the Bureau of the Census. In determining the FY 1997-based market basket, as we discussed in the March 7, 2003, proposed rule (68 FR 11245–11247), we also revised the market basket by making the same two methodological revisions that we established when we revised and rebased the hospital inpatient market basket and the excluded hospital market basket in the August 1, 2002, IPPS final rule—(1) Changing the wage and benefit price proxies to use the Employment Cost Index (ECI) wage and benefit data for hospital workers; and (2) adding a cost category for blood and blood products.

When we add the weight for capital costs to the excluded hospital market basket, the sum of the operating and capital weights must still equal 100.0. Based on data from FY 1997 Medicare cost reports for excluded hospitals, the capital cost weight is 8.968 percent. Because capital costs account for 8.968 percent of total costs for excluded hospitals in FY 1997, operating costs must, therefore, account for 91.032 percent (100 percent minus 8.968 percent). Each operating cost category weight in the FY 1997-based excluded hospital market basket from the August 1, 2002, IPPS final rule (67 FR 50442–50444) was multiplied by 0.91032 to determine its weight in the FY 1997-based excluded hospital with capital market basket.

As we discussed in the March 7, 2003, proposed rule (68 FR 11245–11247), the aggregate capital component of the FY 1997-based excluded hospital market basket (8.968 percent) was determined from the same set of Medicare cost reports used to derive the operating component. The detailed capital cost categories of depreciation, interest, and other capital expenses were also determined using those Medicare cost reports. We needed to determine two sets of weights for the capital portion of the proposed revised and rebased market basket. The first set of weights identifies the proportion of capital expenditures attributable to each capital cost category; the second set represents relative vintage weights for depreciation and interest. The vintage weights identify the proportion of capital expenditures that is attributable to each year over the useful life of capital assets within a cost category (*see* 67 FR 50046–50047, August 1, 2002, for a discussion of how vintage weights are determined).

The cost categories, price proxies, and base-year FY 1992 and FY 1997 weights for the excluded hospital with capital market basket used under the LTCH PPS beginning with the 2004 LTCH PPS rate year are presented below in Table I. The vintage weights for the FY 1997-based excluded hospital with capital market basket are presented below in Table II.

TABLE I.— EXCLUDED HOSPITAL WITH CAPITAL INPUT PRICE INDEX (FY 1992-BASED AND FY 1997-BASED) STRUCTURE AND WEIGHTS

Cost category	Price/wage variable	Weights (%) Base-Year FY 1992[1,2]	Weights (%) Base-Year FY 1997[1,2]
Total		100.000	100.000
Compensation		57.935	57.579
Wages and Salaries	ECI—Wages and Salaries, Civilian Hospital Workers	47.417	47.335
Employee Benefits	ECI—Benefits, Civilian Hospital Workers to Capture Total Costs.	10.519	10.244
Professional fees	ECI—Compensation: Professional & Technical	1.908	4.423
Utilities		1.524	1.180
Electricity	PPI—Commercial Electric Power	0.916	0.726
Fuel Oil, Coal, etc	PPI—Commercial Natural Gas	0.365	0.248
Water and Sewerage	CPI–U—Water & Sewerage Maintenance	0.243	0.206
Professional Liability	CMS—Professional Liability Insurance Premiums Index	0.983	0.733
All Other Products and		28.571	27.117
All Other Products		22.027	17.914
Pharmaceuticals	PPI—Ethical (Prescription) Drugs	2.791	6.318
Food: Direct Purchase	PPI—Processed Foods and Feeds	2.155	1.122
Food: Contract	CPI–U—Food Away from Home	0.998	1.043
Chemicals	PPI—Industrial Chemicals	3.413	2.133
Blood and Blood	PPI—Blood and Blood Derivatives, Human Use		0.748
Medical Instruments	PPI—Medical Instruments & Equipment	2.868	1.795
Photographic Supplies	PPI—Photographic Supplies	0.364	0.167
Rubber and Plastics	PPI—Rubber & Plastic Products	4.423	1.366
Paper Products	PPI—Converted Paper and Paperboard Products	1.984	1.110
Apparel	PPI—Apparel	0.809	0.478
Machinery and	PPI—Machinery & Equipment	0.193	0.852

TABLE I.— EXCLUDED HOSPITAL WITH CAPITAL INPUT PRICE INDEX (FY 1992-BASED AND FY 1997-BASED) STRUCTURE AND WEIGHTS—Continued

Cost category	Price/wage variable	Weights (%) Base-Year FY 1992[1,2]	Weights (%) Base-Year FY 1997[1,2]
Miscellaneous	PPI—Finished Goods Less Food and Energy	2.029	0.783
All Other Services		6.544	9.203
Telephone	CPI–U—Telephone Services	0.574	0.348
Postage	CPI–U—Postage	0.268	0.702
All Other: Labor	ECI—Compensation for Private Service Occupations	4.945	4.453
All Other: Non-Labor	CPI–U—All Items	0.757	3.700
Capital-Related Costs		9.080	8.968
Depreciation		5.611	5.586
Building & Fixed	Boeckh-Institutional Construct. Index—Vintage Weighted (23)	3.570	3.503
Movable Equipment	PPI—Machinery & Equipment—Vintage Weighted (11 Years)	2.041	2.083
Interest Costs		3.212	2.682
Government/Nonprofit	Yield on Domestic Municipal Bonds (Bond Buyer 20 Bonds)—Vintage Weighted (23 years).	2.730	2.280
For-profit	Yield on Moody's Aaa Bonds—Vintage Weighted (23 Years)	0.482	0.402
Other Capital-Related Costs	CPI–U—Residential Rent	0.257	0.699

[1] The operating cost category weights in the excluded hospital market basket described in the August 1, 2002 IPPS final rule (67 FR 50042–50044) add to 100.0. When we add an additional set of cost category weights (total capital weight = 8.968 percent) to this original group, the sum of the weights in the new index must still add to 100.0. Capital costs account for 8.968 percent of the market basket; operating costs account for 91.032 percent. Each weight in the FY 1997-based excluded hospital market basket from the August 1, 2002 IPPS final rule (67 FR 50042–50044) was multiplied by 0.91032 to determine its weight in the FY 1997-based excluded hospital with capital market basket.

[2] Weights may not sum to 100.0 due to rounding.

TABLE II.—EXCLUDED HOSPITAL WITH CAPITAL INPUT PRICE INDEX (FY 1997) VINTAGE WEIGHTS

Year (from farthest to most recent)*	Building and fixed equipment (23-year weights)*	Movable equipment (11-year weights)*	Interest: capital-related (23-year weights)*
1	0.018	0.063	0.007
2	0.021	0.068	0.009
3	0.023	0.074	0.011
4	0.025	0.080	0.012
5	0.026	0.085	0.014
6	0.028	0.091	0.016
7	0.030	0.096	0.019
8	0.032	0.101	0.022
9	0.035	0.108	0.026
10	0.039	0.114	0.030
11	0.042	0.119	0.035
12	0.044		0.039
13	0.047		0.045
14	0.049		0.049
15	0.051		0.053
16	0.053		0.059
17	0.057		0.065
18	0.060		0.072
19	0.062		0.077
20	0.063		0.081
21	0.065		0.085
22	0.064		0.087
23	0.065		0.090
Total	1.0000	1.0000	1.0000

* Weights may not sum to 1.000 due to rounding.

Table III. compares the FY 1992-based excluded hospital with capital market basket to the FY 1997-based excluded hospital with capital market basket. As shown in the table and as we discussed in the March 7, 2003, proposed rule (68 FR 11247), the revised and rebased market basket grows slightly faster over the FY 1999–2001 period than the FY 1992-based market basket. The major reason for this was the switching of the wage and benefit proxy to the ECI for hospital workers from the previous occupational blend. This revision had a similar impact on the IPPS and excluded market baskets, as described in the August 1, 2002, IPPS final rule (67 FR 50043–50047).

TABLE III.—PERCENT CHANGES IN THE FY 1992-BASED AND FY 1997-BASED EXCLUDED HOSPITAL WITH CAPITAL MARKET BASKETS, FYS 1999–2004

Fiscal year (FY)	Percentage change	
	FY 1992-based excluded hospital market basket	Rebased FY 1997-based excluded market basket
1999	2.3	2.7
2000	3.4	3.1
2001	3.9	4.0
2002	2.7	3.6
Average historical	3.1	3.4
2003	3.1	3.7
2004	2.9	3.3
Average forecast	3.0	3.5

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 March 7, 2003, proposed rule (68 FR 11247), 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 propose to develop a market basket specific to LTCH services.

As we stated in the March 7, 2003, proposed rule (68 FR 11247), 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 discussed in the March 7, 2003, proposed rule (68 FR 11247), 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.

We believe that an excluded hospital with capital market basket adequately reflects the price changes facing LTCHs. In the March 7, 2003, proposed rule, we stated that we would 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.

As we noted above, we received no comments on the proposed revising and rebasing of the LTCH PPS market basket. Accordingly, in this final rule, we are adopting the FY 1997-based excluded hospital with capital market basket as the LTCH PPS market basket for application beginning with the 2004 LTCH PPS rate year.

b. LTCH Market Basket Increase for the 2004 LTCH Rate Year

As we discussed in the March 7, 2003, proposed rule (68 FR 11247), for LTCHs paid under the LTCH PPS, we proposed that the 2004 rate year update would apply to discharges occurring from July 1, 2003, through June 30, 2004. Because we are changing the timeframe of the LTCH PPS standard Federal rate annual update, as we discuss in section IV. of this preamble, we needed to calculate an update factor that will reflect this change in the update cycle. Presently, the current rate cycle is October 1, 2002, through September 30, 2003. This means that the FY 2003 standard Federal rate ($34,956.15; *see* the August 30, 2002, final rule (67 FR 56033)) was determined based on the market basket increase through September 30, 2003. As we explained in the March 7, 2003, proposed rule (68 FR 11247), since we proposed to change the rate update cycle and, therefore, update the standard Federal rate 3 months early (that is, July 1, 2003, instead of October 1, 2003), we needed to propose an adjustment to the projected full (12-month) market basket increase to eliminate the projected increase for the 3-month overlapping period (July 1, 2003, through September 30, 2003).

Thus, we need to account for the fact that the FY 2003 standard Federal rate of $34,956.15 already includes an update for the 3-month period from July 1, 2003, through September 30, 2003. In the absence of this proposed change, as we discussed in the March 7, 2003, proposed rule (68 FR 11247–11248), the update for FY 2004 would have been calculated using the estimated increase between FY 2003 and FY 2004. For the proposed update for the proposed 2004 LTCH PPS rate year, we calculated the estimated increase between FY 2003 and the proposed 2004 LTCH PPS rate year. As we discussed in that same proposed rule, based on the fourth quarter 2002 forecast of the proposed revised and rebased FY 1997-based excluded hospital with capital market basket, we determined that the projected market basket increase for the 3-month period of July 1, 2003, through September 30, 2003, would be 0.8 percentage points. The projected market basket increase for this 3-month period (0.8 percent) was already included in the FY 2003 standard Federal rate and, therefore, needed to be deducted from the projected market basket increase for the 12-month period of July 1, 2003, through June 30, 2004 (3.3 percent), in order to account for the proposed change in the update cycle. Therefore,

in the March 7, 2003, proposed rule (68 FR 11248), based on Global Insights' (formerly DRI–WEFA) fourth quarter 2002 forecast of the proposed revised and rebased FY 1997-based excluded hospital with capital market basket we proposed an update of 2.5 percent for the 2004 LTCH PPS rate year.

We received no comments on our proposed methodology for calculating the market basket increase for the 2004 LTCH PPS rate year. Therefore, consistent with our historical practice of estimating market basket increases, based on Global Insights' (formerly DRI–WEFA) first quarter 2003 forecast of the revised and rebased FY 1997-based excluded hospital with capital market basket, in this final rule using the methodology described above, we determined an update of 2.5 percent (as shown in Table IV. below) for the 2004 LTCH PPS rate year.

TABLE IV.—CALCULATION OF MARKET BASKET INCREASE FOR THE 2004 LTCH PROSPECTIVE PAYMENT SYSTEM RATE YEAR

	Percent
Full 12-month market basket with capital increase	3.3
Adjustment for the change in the update cycle*	−0.8
2004 rate year market basket increase**	2.5

*Projected market basket increase for the 3-month period of July 1, 2003, through September 30, 2003, already included in the FY 2003 standard Federal rate.

**Projected market basket increase for the 12-month period of July 1, 2003, through June 30, 2004, from FY 2003.

In addition, as we discussed in the March 7, 2003, proposed rule (68 FR 11248), based on the best available data for 194 LTCHs, we estimated that LTCH prospective payment system payments would be approximately $1.960 billion for the proposed 2004 LTCH PPS rate year. Furthermore, as we discussed in the August 30, 2002, final rule (67 FR 56027), we proposed that the proposed change to the annual update of the FY 2003 factors and rates from a rate year beginning October 1, 2003, to a rate year beginning July 1, 2003, would maintain budget neutrality. In that same final rule, we explained that, as required by statute, total estimated LTCH PPS payments in FY 2003 will equal estimated payments that would have been made under the reasonable cost-based principles if the LTCH PPS were not implemented. Therefore, in order to maintain budget neutrality for the proposed change in the rate update cycle, in the March 7, 2003, proposed rule (68 FR 11248), under proposed § 412.523(c)(3)(ii), we proposed to adjust the standard Federal rate by a factor of 0.997 (($1.960 billion − $5.66 million)/$1.960 billion) or − 0.003 to account for the resulting additional cost of $5.66 million to the FY 2003 Federal budget that we estimated based on the most recent data for the 3-month period from July 1, 2003, through September 30, 2003. Also, in that same proposed rule, we proposed to revise this adjustment factor in this final rule based on the best available data.

In this final rule, based on the best available data for 194 LTCHs, we estimated that LTCH prospective payment system payments would be approximately $1.960 billion for the 2004 LTCH PPS rate year. As we proposed in the March 7, 2003, proposed rule (68 FR 11248), the proposed change to the annual update of the FY 2003 factors and rates from a rate year beginning October 1, 2003, to a rate year beginning July 1, 2003, would be budget neutral because, as we noted above, total estimated LTCH PPS payments in FY 2003 must equal estimated payments that would have been made under the reasonable cost-based principles, if the LTCH PPS were not implemented. Therefore, in order to maintain budget neutrality for the change in the rate update cycle, in this final rule based on updated data and the final policies discussed in this final rule, under § 412.523(c)(3)(ii), we have adjusted the 2004 LTCH PPS rate year standard Federal rate by a factor of 0.997 (($1.960 billion − $5.68 million)/$1.960 billion) or − 0.003 to account for the resulting additional cost of $5.68 million to the FY 2003 Federal budget that we estimated based on the most recent data for the 3-month period from July 1, 2003, through September 30, 2003, for 194 LTCHs.

In the March 7, 2003, proposed rule (68 FR 11248), we proposed to update the current standard Federal rate ($34,956.15) established in the August 30, 2002, final rule (67 FR 56033) by 2.2 percent (2.5 percent minus 0.3 percent) for discharges paid under the LTCH PPS that occur on or after July 1, 2003, through June 30, 2004. The proposed update represented the most recent estimate of the increase in the excluded hospital with capital market basket for the proposed 2004 LTCH PPS rate year, adjusted by the above described factor to transition to the proposed change in the rate update cycle to July 1, and is based on the best available data for 194 LTCHs.

Comment: One commenter stated that the proposed 2.2 percent increase in the LTCH PPS standard Federal rate from $34.956.15 to $35,726.64 does not reflect the inflation of input hospital costs.

Response: As noted above, the proposed update of 2.2 percent was based on the most recent estimate of the increase in the proposed excluded hospital with capital market basket for the proposed 2004 LTCH PPS rate year, adjusted as explained above to transition to the proposed change in the rate update cycle to July 1. The proposed update and adjustment were based on the best available data for 194 LTCHs contained in our database. The most recent estimate of the increase in the excluded hospital with capital market basket for the 2004 LTCH PPS rate year was determined in a manner that is consistent with our historical practice of estimating market basket increases for other Medicare prospective payment systems (inpatient acute care hospitals, IRFs, SNFs, and HHAs), that is, using Global Insights' (formerly DRI-WEFA) most recent forecast of the applicable PPS market basket. Furthermore, we believe it is appropriate to adjust the most recent estimate of the 12-month increase in the LTCH PPS market basket for July 1, 2003, through June 30, 2004, because as we explained above, the FY 2003 standard Federal rate ($34,956.15) already includes inflation for the 3-month period from July 1, 2003, through September 30, 2003. Thus, the projected market basket increase for this 3-month period needs to be deducted from the projected market basket increase for the 12-month period of July 1, 2003, through June 30, 2004.

In addition, as we explained above, it is necessary that the market basket increase be further adjusted so that the proposed change in updating the FY 2003 rate 3 months early (July 1, 2003, instead of October 1, 2003) be budget neutral, as mandated by section 123 of Public Law 106–113 (that is, total estimated LTCH PPS payments in FY 2003 will equal estimated payments that would have been made under the reasonable cost-based principles if the LTCH PPS were not implemented). Therefore, we believe that the proposed methodology for determining the proposed 2.2 percent update for the 2004 LTCH PPS rate year is appropriate.

Comment: A few commenters stated that the proposed 2004 LTCH PPS rate year standardized amount of $35,726.64 is based on the identification of costs related to short-stay outlier cases which have been derived from cost-to-charge ratios that do not account for the proposed change to the short-stay outlier policy under proposed § 412.529. Specifically, in the March 7, 2003,

proposed rule (68 FR 11253), we proposed that fiscal intermediaries would use either the most recently settled cost report or most recent tentative settled cost report, whichever is later, in determining a LTCH's cost-to-charge ratio used in determining short-stay outlier payments. We also proposed, in that same proposed rule, that the applicable statewide average cost-to-charge ratio would only be applied when a LTCH's cost-to-charge ratio exceeds the ceiling (but not when a LTCH's cost-to-charge ratio falls below the floor). The commenters express concern that the proposed change to the short-stay outlier policy is not reflected in the proposed 2004 LTCH PPS rate year standard Federal rate and, therefore, CMS fails to maintain budget neutrality.

In addition, one of the commenters noted that the cost-to-charge ratio data posted on the web for the 2004 rate year proposed rule (published on March 7, 2003, in the **Federal Register**) differed for many LTCHs from the cost-to-charge ratio data posted on the web for the FY 2003 final rule (published August 30, 2002, in the **Federal Register**). The commenter believes that the observed change in the LTCHs' cost-to-charge ratios is due to the proposed change to allow fiscal intermediaries to use either the most recently settled cost report or most recent tentative settled cost report, whichever is later, in computing a LTCH's cost-to-charge ratio used to determine both short-stay outlier and high-cost outlier payments.

Response: The commenters have raised concerns that we have not taken into account the proposed changes to the policies for determining short-stay and high-cost outlier payments in calculating the proposed update to the standard Federal rate for the proposed 2004 LTCH PPS rate year. As we discuss in greater detail below in section VII.B.3. of this preamble, at this time, the finalized changes to the proposed high-cost outlier and short-stay outlier policies presented in the March 7, 2003, proposed rule (68 FR 11250–11253) are not yet effective. Accordingly, in establishing the final update factor for the 2004 LTCH PPS rate year in this final rule, we used the high-cost outlier and short-stay outlier policies established in the August 30, 2002, final rule (67 FR 55995–56000 and 56022–56027).

Nevertheless, based on the comments, there appears to be a misconception among the commenters regarding the methodology for updating the LTCH PPS standard Federal rate. While we are not finalizing the proposed changes to the outlier policies in this final rule, we believe that it is important to clarify the methodology used in the March 7, 2003, proposed rule to determine the proposed update factor for the proposed 2004 LTCH PPS rate year.

In the August 30, 2002, final rule, we established at § 412.523(c)(3)(ii) that for fiscal years after FY 2003, 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. That is, for years after FY 2003, the annual update to the LTCH PPS standard Federal rate will be equal to the percentage change in the excluded hospital with capital market basket.

In determining the proposed update for the proposed 2004 LTCH PPS rate year, we adjusted the projected proposed LTCH market basket increase in order to maintain budget neutrality (in addition to an adjustment to account for the transition to the proposed change in the LTCH PPS rate year) by accounting for the estimated increase in payments during the remainder of FY 2003 (July 1, 2003, through September 30, 2003) that would result from updating the factors and rates 3 months early (July 1, 2003, instead of October 1, 2003). This budget neutrality adjustment to the proposed rate update included the effect of the proposed increase in the LTCH PPS standard Federal rate, the effect of proposed change in the wage index values, and the effect of the proposed change in the short-stay outlier policy and high-cost outlier policy (specifically the elimination of assigning the statewide average cost-to-charge ratio when a LTCH's cost-to-charge ratio falls below the floor).

As we discussed in the March 7, 2003, proposed rule (68 FR 11251), in calculating short-stay outlier and high-cost outlier payments we currently use cost-to-charge ratios based on the latest available cost report data from HCRIS and corresponding MedPAR claims data from FYs 1998, 1999, and 2000. In some cases the latest available cost report data from HCRIS is from settled cost reports; however, in other instances, the latest available cost report data from HCRIS is from ''as submitted'' cost reports. Since the universe of LTCHs is relatively small and the substantial increase in the number of LTCHs is fairly recent, due to the lag time in the cost report settlement and the availability of cost report data in HCRIS, we used cost-to-charge ratios based on as submitted cost report data if settled cost report data were not available. Since, as we noted above, the data used to compute LTCH cost-to-charge ratios was generated prior to the implementation of the LTCH PPS (when the use of charges was not as germane), we believe that the difference between a LTCH's cost-to-charge ratio computed from the latest settled cost report and a LTCH's cost-to-charge ratio computed from the latest tentative settled cost report is immaterial for most LTCHs, and, therefore, would not have a significant impact on payment estimates.

The commenter is mistaken as to the reason behind the change in the cost-to-charge ratio data posted on the web from the FY 2003 final rule (published August 30, 2002, in the **Federal Register**) to the 2004 LTCH PPS rate year proposed rule (published on March 7, 2003, in the **Federal Register**). As discussed above, this change in LTCHs' cost-to-charge ratios is not a result of applying the proposed change to allow fiscal intermediaries to use either the most recently settled cost report or most recent tentative settled cost report, whichever is later, in determining a LTCH's cost-to-charge ratio. We note instead that the change in the LTCH cost-to-charge ratios observed by the commenter is a result of using more updated data between the development of the August 30, 2002, final rule and the March 7, 2003, proposed rule. For example, LTCHs that previously only had FY 1998 data available for the FY 2003 final rule may now have FY 1999 or FY 2000 data available. Similarly, LTCHs that previously only had as submitted cost report data available for the FY 2003 final rule may now have settled cost report data available. Therefore, we do not believe that a change in our methodology for updating the standard Federal rate for the 2004 LTCH PPS rate year is warranted.

In this final rule, we updated the current standard Federal rate ($34,956.15) established in the August 30, 2002, final rule (67 FR 56033) by 2.2 percent (2.5 percent minus 0.3 percent) for discharges paid under the LTCH PPS that occur on or after July 1, 2003, through June 30, 2004. This update represents the most recent estimate of the increase in the excluded hospital with capital market basket for the 2004 LTCH PPS rate year, adjusted to account for the change in the rate update cycle to July 1, and is based on the best available data for 194 LTCHs.

2. Standard Federal Rate for the 2004 LTCH PPS Rate Year

In the August 30, 2002, LTCH PPS final rule (67 FR 56033), we established a standard Federal rate of $34,956.15 based on the best available data and policies established in that final rule. In the March 7, 2003, proposed rule (68 FR 11248), for the proposed 2004 LTCH

PPS rate year, we proposed a standard Federal rate of $35,726.64. Since the proposed standard Federal rate has already been adjusted for differences in case-mix, wages, cost-of-living, and high-cost outlier payments, we did not propose any additional adjustments in the proposed standard Federal rate for these factors.

In this final rule, we are establishing a standard Federal rate of $35,726.18 for the 2004 LTCH PPS rate year. Since the 2004 LTCH PPS rate year standard Federal rate 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 2004 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 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 that begin during FY 2003 (that is, on or after October 1, 2002, and before September 30, 2003), blended payments under the transition methodology are based on 80 percent of the LTCH's reasonable cost-based payment rate and 20 percent of the adjusted Federal rate. For cost reporting periods that begin during FY 2004 (that is, on or after October 1, 2003, and before September 30, 2004), blended payments under the transition methodology will be based on 60 percent of the LTCH's reasonable cost-based principles rate and 40 percent of the adjusted Federal rate.

1. Adjustment for Area Wage Levels

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. For cost reporting periods beginning on or after October 1, 2002, and before September 30, 2003 (FY 2003), the applicable LTCH wage index value is one-fifth of the full FY 2002 acute care hospital inpatient wage index data, without taking into account geographic reclassification under section 1886(d)(8) and section 1886(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 stated in the March 7, 2003, proposed rule (68 FR 11249), because the LTCH PPS was only recently implemented, sufficient new data have not been generated that would enable us to conduct a comprehensive reevaluation of the appropriateness of adjusting the phase-in. However, we 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. Therefore, in the March 7, 2003, proposed rule, we did not propose to adjust the phase-in of the wage index adjustment at this time.

Comment: One commenter requested that we reconsider accelerating the phase-in of the wage index adjustment.

Response: As we stated above, because the LTCH PPS was only recently implemented, sufficient new data have not been generated that would enable us to conduct a comprehensive reevaluation of the appropriateness of adjusting the phase-in. For this final rule, we reviewed the most recent data available again and still did not find any evidence to support a change in the 5-year phase-in of the wage index. Therefore, in this final rule, we are not revising the phase-in of the wage index adjustment.

In addition, as we discussed in the March 7, 2003, proposed rule (68 FR 11249), the 5-year phase-in of the wage index would not be affected by the proposed establishment of a LTCH PPS rate year of July 1 to June 30. Instead, the 5-year phase-in of the wage index established in the August 30, 2002 final rule (67 FR 56018) will continue to follow the Federal fiscal year. That is, for cost reporting periods beginning on or after October 1, 2003, and before September 30, 2004 (FY 2004; the second year of the phase-in), the applicable LTCH wage index will be two-fifths of the applicable LTCH PPS index values discussed below. However, as we stated in that same proposed rule, we will reevaluate LTCH data as they become available and propose to adjust the phase-in if subsequent data support a change.

As we noted above, we have not found any evidence to support a change in the 5-year phase-in of the wage index adjustment at this time. Therefore, we are not adopting the commenter's

recommendation and we are not revising the phase-in to the wage index adjustment in this final rule.

Section 412.525(c) provides that the adjustment to account for differences in area wage levels is made by multiplying the labor-related portion of the Federal rate by the appropriate wage index value for the area in which the LTCH is physically located. In the August 30, 2002, final rule (67 FR 56018), based on the best available data at that time, we stated that the wage index adjustment is based on the FY 2002 inpatient acute care hospital wage index data without taking into account geographic reclassification under section 1886(d)(8) and section 1886(d)(10) of the Act. In the March 7, 2003, proposed rule, for the 2004 LTCH PPS rate year, we proposed that the wage index adjustment provided for under § 412.525(c) be based on the most recent available acute care hospital inpatient wage data, that is, the same data used to compute the FY 2003 acute care hospital inpatient wage index without taking into account geographic reclassification under section 1886(d)(8) and section 1886(d)(10) of the Act. As we noted above, we proposed that the 5-year phase-in of the wage index adjustment would not be affected by the proposed change in the LTCH PPS rate update cycle and will continue to be based on the Federal fiscal year. However, we proposed to update the data used to compute the annual wage index values on the 2004 LTCH PPS rate year cycle (July through June).

Comment: A few commenters stated that our proposal to update the data used to compute wage index values according to the LTCH PPS rate year (July 1st) would cause LTCHs whose cost reporting periods do not align with the LTCH rate year to have to make two wage index changes per year during the 5-year phase-in of the wage index adjustment. In addition to increasing provider burden, the commenters stated that two wage index changes per year would also introduce the potential for payment calculation errors. Thus, the commenters recommend that we align the phase-in of the wage index adjustment and the update of the data used to compute the wage index values to coincide with the LTCH PPS rate year.

Response: Adopting the recommendation of the commenters to align the phase-in of the wage index adjustment with the LTCH PPS rate year (July 1st) would advance the 5-year phase-in of the wage index adjustment. For instance, if the phase-in of the wage index adjustment were to change for all LTCHs on July 1st (rather than, as required under current language, for cost-reporting periods beginning on or after October 1st each year during the 5-year phase-in period), LTCH's with an April 1st cost reporting period would receive payments based on ⅕th of the wage index value for only 3 months (April 1, 2003, through June 30, 2003) before changing to ⅖th of the wage index on July 1, 2003. As we discussed in the August 30, 2002, final rule (67 FR 56018), based on the latest available LTCH data, we did not find any statistical evidence that showed a significant relationship between LTCHs' costs and their geographic location, therefore, we believed that it was appropriate to transition to a full wage index adjustment over a 5-year period.

As we discussed in the March 7, 2003, proposed rule and as we noted above, because the LTCH PPS was only recently implemented, 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, for this final rule we again reviewed the most recent data available and we still did not find any evidence to support a change in the 5-year phase-in of the wage index. Therefore, as stated above, we are not revising the phase-in of the wage index adjustment.

Moreover, we believe it is inappropriate to accelerate the phase-in of the wage index adjustment by adopting the commenters' recommendation to align the phase-in of the wage index adjustment with the LTCH PPS rate year. As we noted above, in accordance with § 412.525(c), the labor-related portion of the Federal rate is adjusted by the applicable wage index value. Because the proposed labor-related share (72.612 percent) is lower then the existing labor-related share (72.885 percent) established in the August 30, 2002, final rule, LTCHs with a wage index of less than 1.0 would be disadvantaged by the acceleration of the phase-in of the wage index adjustment that would result if we were to align the phase-in of the wage index adjustment with the LTCH PPS rate year.

In addition, we do not believe that the application of two wage index changes per year during the 5-year phase-in of the wage index adjustment, for those LTCHs whose cost reporting periods do not align with the LTCH rate year, would result in an additional burden or in payment errors to LTCHs. We do not believe LTCHs would be additionally burdened because they are not required to provide any additional information due to the change in the wage index adjustment during their cost reporting period. Also, we do not believe payment errors will occur because both the wage index data and the phase-in of the wage index adjustment are automatically performed in the PRICER software used by fiscal intermediaries to price each LTCH claim based on the date of service.

Therefore, we are not adopting the commenters' suggestion to align the phase-in of the wage index adjustment and the update of the data used to compute the wage index values to coincide with the LTCH PPS rate year. The phase-in of the wage index adjustment will continue to remain linked to each LTCH's cost reporting period beginning on or after October 1st each year during the 5-year phase-in period and the update of the data used to compute the wage index values will correspond with the LTCH PPS rate year (that is, effective beginning on July 1st each year).

For example, for a LTCH with a cost reporting period from January 1, 2003, through December 31, 2003, the LTCH will be paid using one-fifth of the wage index value for its entire cost reporting period. For the first 6 months of that period (January 1, 2003, through June 30, 2003), the one-fifth wage index value will be based on the same data used to compute the FY 2002 acute care hospital inpatient wage index without taking into account geographic reclassifications under sections 1886(d)(8) and (d)(10) of the Act as established in the August 30, 2002, final rule (67 FR 56018) and shown in Tables 1 and 2 of the Addendum to that same final rule (67 FR 56057–56075). Under the policy we are establishing in this final rule to update the data used to compute the LTCH PPS wage index values for July 1, 2003, through June 30, 2004, for the next 6 months (July 1, 2003, through December 31, 2003) that LTCH will still be paid using one-fifth of the wage index value, but the wage index value will now be computed using the same data 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 (as shown in Tables 1 and 2 of the Addendum to this final rule). In this example, for that LTCH's subsequent cost reporting period from January 1, 2004, through December 31, 2004, that LTCH will be paid using the two-fifth wage index value. For the first 6 months of that period (January 1, 2004, through June 30, 2004), the two-fifths wage index value will be based on the same data 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, as shown in Tables 1 and 2 of the Addendum to this final rule.

In the August 30, 2002, final rule (67 FR 56018), for FY 2003 we used the same data used to compute the FY 2002 acute care hospital inpatient wage index without taking into account geographic reclassifications under sections 1886(d)(8) and (d)(10) of the Act. The same data is also used in the IRF PPS and the 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 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 this final rule, we are establishing that for the 2004 LTCH PPS rate year, the same data 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 will be used to determine the applicable wage index values under the LTCH PPS, because it is the most recent available complete data. This is the same wage data that were used to compute the FY 2003 wage indices currently used under the IPPS. The final LTCH wage index values for July 1, 2003, through June 30, 2004, are shown in Table 1 (for urban areas) and Table 2 (for rural areas) in the Addendum to this final rule.

As noted above, for cost reporting periods beginning on or after October 1, 2002, and before September 30, 2003 (FY 2003), the labor portion of the standard Federal rate is adjusted by one-fifth of the applicable wage index value (that is, for LTCH PPS discharges on or after July 1, 2003, through June 30, 2004, one-fifth of the full FY 2003 acute care hospital inpatient wage index data, without taking into account geographic reclassifications under sections 1886(d)(8) and (d)(10) of the Act). For cost reporting periods beginning on or after October 1, 2003, and before October 1, 2004 (FY 2004), the LTCH wage index is two-fifths of the applicable wage index value. Therefore, for LTCHs with cost reporting periods beginning on or after October 1, 2003, through September 30, 2004, for discharges occurring on or after July 1, 2003, through June 30, 2004, the labor portion of the standard Federal rate is adjusted by two-fifths of the full FY 2003 acute care hospital inpatient wage index data, without taking into account geographic reclassification under sections 1886(d)(8) and (d)(10) of the Act.

In conjunction with our proposal to revise and rebase the excluded hospital with capital market basket from an FY 1992 to an FY 1997 base year (as discussed above in section VII.B.1.a. of this preamble), in the March 7, 2003, proposed rule (68 FR 11249–11250), we also proposed to use a labor-related share that is determined based on the FY 1997-based excluded hospital with capital market basket. 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 with an FY 1992 base-year. In the March 7, 2003, proposed rule, we proposed a labor-related share of 72.612 percent based on the relative importance of the labor-related share of operating costs (wages and salaries, employee benefits, professional fees, postal services, and all other labor-intensive services) and capital costs in the proposed FY 1997 rebased excluded hospital with capital market basket. (For further details on the development of the proposed labor share of 72.612 percent, refer to the March 7, 2003, proposed rule (68 FR 11249–11250).)

Comment: Two commenters noted that the proposed revising and rebasing of the LTCH PPS market basket coincided with the revisions made to the IPPS market basket for FY 2003 where FY 1992 data was replaced with FY 1997 data and other proxies used to measure changes in costs were replaced (*see* the August 1, 2002, IPPS final rule; 67 FR 50041–50042). While we received no comments on the effect of the proposed revising and rebasing of the LTCH PPS market basket on the LTCH PPS update factor, the commenters noted that the proposed change under the LTCH PPS, resulted in a decrease to the labor share from 72.885 percent to 72.612 percent, while under the IPPS, the use of this new data resulted in an increase in the labor share. However, under the IPPS, CMS decided not to use the updated data pending further analysis. Thus, the commenters believe that a change in the labor share under the LTCH PPS should be delayed, pending the results of the analysis being performed under the IPPS.

Response: The methodology used to determine the labor-related share presented in the March 7, 2003, proposed rule is consistent with our historical methodology of determining the labor-related share in the past for the IPPS market basket and the excluded hospital market basket, which is the summation of cost categories from the market basket deemed to vary with the local labor market. The concerns expressed by the commenters regarding the proposed revising of the LTCH PPS labor-related share are the same concerns expressed by commenters in the August 1, 2002, IPPS final rule (67 FR 50041–50042) when we proposed to revise the IPPS market basket and the excluded hospital market basket. In response to those comments in that same IPPS final rule, we stated that we are in the process of conducting further analysis to determine the most appropriate methodology for determining the labor-related share.

In the May 19, 2003, IPPS proposed rule (68 FR 27226), we explain that we have not yet completed our research into the appropriateness of this measure. In that same IPPS proposed rule, we discuss two ways that we are currently 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. While each of these alternatives have strengths and weaknesses, it is not clear at this point that any one alternative is superior to the current methodology. Thus, we want to continue researching these alternatives, in part, because changing from the current labor share methodology would impact the labor-related shares for other Medicare prospective payment systems, since they use a similar methodology.

Therefore, we agree with the commenter that it would be inappropriate to change the LTCH PPS labor share until the results of this research and analysis are complete. Accordingly, we are adopting the commenters' recommendation and the labor share for the 2004 LTCH PPS rate year will remain 72.885 percent.

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

Under § 412.525(b), we make a cost-of-living adjustment (COLA) for LTCHs located in Alaska and Hawaii to account for the higher costs incurred in those States. In the March 7, 2003, proposed rule (68 FR 11250), for the proposed 2004 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 V. below. These factors are obtained from the U.S. Office of

Personnel Management (OPM). In addition, in that same proposed rule we stated that if OPM releases revised COLA factors before May 1, 2003, we proposed to use them for the development of payments and publish them in this final rule.

The OPM has not released revised COLA factors for Alaska and Hawaii since the publication of the March 7, 2003, proposed rule. We received no comments on the proposed COLA factors for Alaska and Hawaii for the 2004 LTCH PPS rate year. Therefore, under § 412.525(b), we are finalizing the COLA factors for Alaska and Hawaii shown below in Table V. for the 2004 LTCH PPS rate year.

TABLE V.—COST-OF-LIVING ADJUSTMENT FACTORS FOR ALASKA AND HAWAII HOSPITALS FOR THE 2004 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

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.

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.

Outlier payments under the LTCH PPS are determined consistent with the IPPS outlier policy. Currently, under the IPPS, a floor and a ceiling are applied to an acute care hospital's cost-to-charge ratio and if the acute care hospital's cost-to-charge ratio is either below the floor or above the ceiling, the applicable statewide average cost-to-charge ratio is assigned to the acute care hospital. Similarly, if a LTCH's cost-to-charge ratio is below the floor or above the ceiling, currently 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. Currently, MedPAR claims data and cost-to-charge ratios based on the latest available cost report data from HCRIS and corresponding MedPAR claims data are used to establish a fixed-loss threshold amount under the LTCH PPS.

For FY 2003, based on FY 2001 MedPAR claims data and cost-to-charge ratios based on the latest available data from HCRIS and corresponding MedPAR claims data from FYs 1998 and 1999, we established a fixed-loss amount of $24,450. In the March 7, 2003, proposed rule (68 FR 11251), for the proposed 2004 LTCH PPS rate year, we proposed to continue to use 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 proposed rule, because these data are the best data available. We would calculate cost-to-charge ratios for determining the proposed 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 the March 7, 2003, proposed rule (68 FR 11251), consistent with the proposed outlier policy changes for acute care hospitals under the IPPS discussed in the March 5, 2003, IPPS high-cost outlier proposed rule (68 FR 10424), we proposed to no longer assign the applicable statewide average cost-to-charge ratio when a LTCH's cost-to-charge ratio falls below the floor. We proposed 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), currently when a LTCH's actual cost-to-charge ratio falls below the floor, the LTCH's cost-to-charge ratio would be raised to the applicable statewide average. This application of the statewide average would result in inappropriately higher outlier payments. Accordingly, we proposed to 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 March 7, 2003, proposed rule (68 FR 11251), consistent with the proposed policy change for acute care hospitals under the IPPS, we proposed under § 412.525(a)(4), by cross-referencing proposed § 412.84(i), to continue to apply the applicable statewide average cost-to-charge ratio when a LTCH's cost-to-charge ratio exceeds the ceiling by adopting the proposed policy at proposed § 412.84(i)(1)(ii). As we stated in that same proposed rule, cost-to-charge ratios above this range are probably due to faulty data reporting or entry, and, therefore, 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 also proposed to make 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 proposed change mirrors that for high-cost outliers.

Therefore, in the March 7, 2003, proposed rule (68 FR 11251), consistent with the proposed changes to the IPPS outlier policy, in determining the proposed fixed-loss amount for the proposed 2004 LTCH PPS rate year, we proposed to use only the current combined operating and capital cost-to-charge ratio ceiling under the IPPS of 1.421 (as explained in the IPPS final rule (67 FR 50125, August 1, 2002)). We believe that using the current combined

IPPS operating and capital cost-to-charge ratio ceiling for LTCHs is appropriate since, as we explained in the August 30, 2002, 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 are paid as a LTCH only because their Medicare average length of stay is greater than 25 days in accordance with § 412.23(e). In the March 7, 2003, proposed rule (68 FR 11251), we also explained that prior to qualifying as a LTCH under § 412.23(e)(2)(i), the hospitals generally are paid as acute care hospitals under the IPPS during the period in which they demonstrate that they have an average length of stay of greater than 25 days. Accordingly, if a LTCH's cost-to-charge ratio is above this ceiling, we proposed to assign the applicable IPPS statewide average cost-to-charge ratio. We also proposed to assign 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 proposed methodology and data described above, in the March 7, 2003, proposed rule (68 FR 11251), for the proposed 2004 LTCH PPS rate year, we proposed a fixed-loss amount of $19,978. Thus, we proposed to pay an outlier case 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted Federal LTCH payment for the LTC–DRG and the proposed fixed-loss amount of $19,978).

We received numerous comments on the proposed changes to the LTCH PPS high-cost outlier policy under proposed § 412.525(a) (and short-stay outlier policy under § 412.529(c)). Because many features of the proposed LTCH PPS high-cost outlier policy are based upon the proposed policy changes to the IPPS high-cost outlier policy, we believe it is appropriate to finalize the proposed changes to the LTCH PPS high-cost outlier policy together with the final policy decisions on the IPPS high-cost outlier policy. Because the existing LTCH PPS outlier policy and proposed outlier policy changes are modeled after the IPPS outlier policy, we include the summary of public comments submitted on behalf of LTCHs, which in many cases mirror the comments we received on the proposed changes to the IPPS outlier policy, and the responses to those comments in the IPPS high-cost outlier final rule. Please refer to that final rule for a full discussion of the comments and responses, as well as any other final policy decisions concerning LTCH PPS high-cost outlier policy under § 412.525(a) (and the short-stay outlier policy under § 412.529(c)).

Therefore, in this final rule in calculating the final fixed-loss amount for the 2004 LTCH PPS rate year since the finalized changes to the high-cost outlier policy (and short-stay outlier policy) are not yet effective, we applied the existing outlier policy; that is, we assigned the statewide average to LTCHs whose cost-to-charge ratios fell below the floor or exceeded the ceiling. Accordingly, we used the current IPPS combined operating and capital cost-to-charge ratio floor of 0.206 and cost-to-charge ratio ceiling of 1.421 (as explained in the IPPS final rule (67 FR 50125, August 1, 2002)). We believe that using the current combined IPPS operating and capital cost-to-charge ratio floor and 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.

In this final rule, for the 2004 LTCH PPS rate year, we continue to use the March 2002 update of the FY 2001 MedPAR claims data to establish 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 this final rule, because these data are the best LTCH data available. We also computed cost-to-charge ratios for establishing the fixed-loss amount for the 2004 LTCH PPS rate year based on the latest available cost report data in HCRIS and corresponding MedPAR claims data from FYs 1998, 1999, and 2000. As we explained above, the applicable IPPS statewide average cost-to-charge ratios were applied when a LTCH's cost-to-charge ratio exceeded the ceiling (1.421) or fell below the floor (0.206). Also, 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, 2002, IPPS final rule (67 FR 50263).)

Accordingly, based on updated data and the final rates and policies established in this final rule (including the existing cost-to-charge ratio policy described above), we are establishing a fixed-loss amount of $19,590 for the FY 2004 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 $19,590).

As we discussed in the March 7, 2003, proposed rule (68 FR 11251–11252), the IPPS standard Federal rate and relative weights are updated simultaneously, effective October 1 of each year, when the new GROUPER with the final DRGs and the new relative weights are implemented for that fiscal year. The LTCH PPS utilizes the same DRGs and Medicare GROUPER program as the IPPS. The GROUPER in effect on July 1, 2003, will be version 20.0. Although we proposed to update the LTCH PPS standard Federal rate on July 1, 2003, version 21.0 of the GROUPER will not be available at the time this final rule is published. Therefore, as we explained in the March 7, 2003, proposed rule (68 FR 11242), we are not proposing an update to the LTC–DRG weights for the period of July 1, 2003, through September 30, 2003, and the LTCH PPS will continue to use version 20.0 of the GROUPER and the LTC–DRG relative weights published in Table 3 of the Addendum to the August 30, 2002, final rule (reprinted in Table 3 of the Addendum to the March 7, 2003, proposed rule) for the period from July 1, 2003, through September 30, 2003.

The calculation of the fixed-loss amount is dependent in part on the LTC–DRG relative weights because the fixed-loss amount is set so that estimated total outlier payments are estimated to be equal to 8 percent of total LTCH PPS payments. We proposed to calculate a fixed-loss amount that would result in total estimated outlier payments being equal to 8 percent of total LTCH PPS payments for the proposed 2004 LTCH PPS rate year, using the LTC–DRG relative weights based on the version 20.0 GROUPER. We proposed to use the version 20.0 GROUPER in determining the fixed-loss amount for the period of July 1, 2003, through June 30, 2004, as it contains the best available data at the time the fixed-loss amount is determined.

As we discuss below, we did not propose to change the fixed-loss amount to account for changes in the version 21.0 GROUPER, because we believe implementing two fixed-loss amounts during the proposed LTCH PPS rate year may be administratively burdensome. Implementing a single fixed-loss amount which would be in effect for a full 12 months (July through June) would be consistent with other components of the LTCH PPS, such as the standard Federal rate and the wage index, both of which would be in effect for a full 12-month period (July through June). Similarly, the relative weights and the GROUPER program are in effect for 12 months (October through September). However, because the

update to the ICD–9–CM codes is effective at the beginning of the Federal fiscal year, as described in section IV.E.2. of the March 7, 2003, proposed rule (68 FR 11241), we explained in that same proposed rule (68 FR 11252) that we would continue to update the LTCH PPS GROUPER and the relative weights on October 1.

In addition, in the March 7, 2003, proposed rule (68 FR 11252), we also stated that we do not anticipate that the fixed-loss amount calculated using the relative weights based on the version 20.0 GROUPER would be significantly different from a fixed-loss amount calculated using the relative weights based on the version 21.0 GROUPER. We believe this based on the fact that the LTCH PPS outlier policy, one component of which is a fixed-loss amount, is modeled after the IPPS outlier policy. The annual reclassification and recalibration of DRGs under the IPPS generally does not result in a significant impact on the IPPS fixed-loss amount (although this impact would vary from year to year depending on the actual DRG changes). Therefore, we proposed to 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 July 1 of that year.

Since the proposed effective date of the updated LTCH PPS standard Federal rate would be July 1, while the updated GROUPER would not be effective until October 1, we stated in the March 7, 2003, proposed rule (68 FR 12252) that we did consider an alternative proposal that would establish two separate fixed-loss amounts during the proposed LTCH PPS rate year—one for July through September based on the current GROUPER and another for October through June based on the updated GROUPER. As we explained in that same proposed rule, we decided not to propose this alternative because, as we discussed above, calculating and implementing two fixed-loss amounts in one proposed LTCH PPS rate year is administratively burdensome.

We received no comments on our proposal to 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 July 1 of that year. Therefore, for the 2004 LTCH PPS rate year, we are establishing a single fixed-loss amount based on the version 20.0 of the GROUPER, which is in effect at the start of the 2004 LTCH PPS rate year (July 1, 2003). As we stated above, the fixed-loss amount for the 2004 LTCH PPS rate year is $19,590. As we stated 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 VII.B.4.b. 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 in the 2004 LTCH PPS rate year, the high-cost outlier payment will be 80 percent of the difference between the estimated cost of the case plus the outlier threshold (the sum of the final fixed-loss amount of $19,590 and the amount paid under the short-stay outlier policy).

Under existing regulations at § 412.525(a), we specify that no retroactive adjustment will be made to the outlier payments upon cost report settlement to account for differences between the estimated cost-to-charge ratios and the actual cost-to-charge ratios for outlier cases. This policy is consistent with the existing outlier payment policy for acute care hospitals under the IPPS. However, we note that in the March 5, 2003, IPPS high-cost outlier proposed rule (68 FR 10424), we proposed to revise the methodology for determining cost-to-charge ratios for acute care hospitals under the IPPS because, as we discussed in that notice, we became aware that payment vulnerabilities exist in the current 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 are susceptible to the same payment vulnerabilities and, therefore, merit revision. As proposed for acute care hospitals under the IPPS at proposed § 412.84(m) in the March 5, 2003, IPPS high-cost outlier proposed rule (68 FR 10429), we proposed in the March 7, 2003, proposed rule (68 FR 11252) under § 412.525(a)(4)(ii), by cross-referencing proposed § 412.84(m), that for LTCHs any reconciliation of outlier payments would be made upon cost report settlement to account for differences between the estimated cost-to-charge ratio for the period during which the discharge occurs. As is the case with the proposed changes to the outlier policy for acute care hospitals under the IPPS, we are still assessing the procedural changes that would be necessary to implement this change. In addition, in that same proposed rule (68 FR 11252), we proposed to make a similar change to the short-stay outlier policy at proposed § 412.529(c)(4)(ii).

We also stated in the March 7, 2003, proposed rule (68 FR 11252), that because we currently use cost-to-charge ratios based on the latest settled cost report, any dramatic increases in charges during the payment year are not reflected in the cost-to-charge ratios when making outlier payments. Consistent with the proposed policy change for acute care hospitals under the IPPS at proposed § 412.84(i) discussed in the March 5, 2003, IPPS high-cost outlier proposed rule (68 FR 10424–10426), 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 the March 7, 2003, proposed rule (68 FR 11252), we proposed that fiscal intermediaries would use more recent data when determining a LTCH's cost-to-charge ratio. Therefore, by cross-referencing proposed § 412.84(i) under proposed § 412.525(a)(4)(ii) in the March 7, 2003, proposed rule (68 FR 11252), we proposed that fiscal intermediaries would use either the most recent settled cost report or the most recent tentative settled cost report, whichever is later. In addition, in that same proposed rule, we proposed to make a similar change to the short-stay outlier policy at proposed § 412.529(c)(4)(ii).

As we noted above, we received numerous comments on the proposed reconciliation of outlier payments at cost report settlement and the proposed policy to allow fiscal intermediaries to use either the most recent settled cost report or the most recent tentative settled cost report, whichever is later, in computing LTCH's cost-to-charge ratios for determining high-cost outlier payments under proposed § 412.525(a) (and short-stay outlier payments under proposed § 412.529(c)). As we also noted previously, because many features of the proposed LTCH PPS high-cost outlier policy are based upon the proposed policy changes to the IPPS high-cost outlier policy, we believe it is appropriate to finalize the proposed changes to the LTCH PPS high-cost outlier together with the final policy decisions on the IPPS outlier policy. Because, however, the LTCH PPS outlier policy and proposed outlier policy changes are modeled after the IPPS outlier policy, we include the summary of public comments submitted on behalf of LTCHs, which in many cases mirror the comments we received on the proposed IPPS outlier policy, and the responses to those comments in the IPPS high-cost outlier final rule. Please

refer to that final rule for a full discussion of the comments and responses, as well as any other final policy decisions concerning LTCH PPS high-cost outlier policy under § 412.525(a) (and the short-stay outlier policy under § 412.529(c)).

In conclusion, the summary of public comments on the proposed changes presented in the March 7, 2003, proposed rule regarding the high-cost outlier policy under proposed § 412.525(a) (and the short-stay outlier policy under proposed § 412.529(c)), and the responses to those comments are presented in the IPPS high-cost outlier final rule. Therefore, in this final rule, based on the data and existing methodology described above, we are establishing a fixed-loss amount of $19,590 for the FY 2004 LTCH PPS rate year. Accordingly, 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 $19,590).

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 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 55995), such cases would be paid inappropriately if the hospital were to receive the full LTC–DRG payment. While we did not propose any changes to the payment policy for special cases at this time, below we discuss the payment methodology for these special cases as implemented in the August 30, 2002, final rule (67 FR 55955–56010).

b. 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.

As noted above, generally LTCHs are defined by statute as having an average 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 such a 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, 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 discussed in the March 7, 2003, proposed rule (68 FR 12252), in the March 5, 2003, IPPS high-cost outlier proposed rule (68 FR 10424), we proposed to revise the methodology for determining cost-to-charge ratios for acute care hospitals under the IPPS because, as we discussed in that March 7, 2003, proposed rule, we became aware that payment vulnerabilities exist in the current IPPS outlier policy. As we also explained in that March 7, 2003, proposed 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 are susceptible to the same payment vulnerabilities and, therefore, merit revision. As proposed for acute care hospitals under the IPPS at proposed § 412.84(i) and (m) in the March 5, 2003, IPPS high-cost outlier proposed rule (68 FR 10429), and as we proposed above for high-cost outlier payments at § 412.525(a)(4)(ii), we proposed under § 412.529(c) that short-stay outlier payments would be subject to the proposed provisions in the regulations at proposed § 412.84(i) and (m). Therefore, consistent with the proposed changes to the high-cost outlier policy discussed in the March 7, 2003, proposed rule (68 FR 11251), we proposed, by cross-referencing proposed § 412.84(i), that fiscal intermediaries would use either the most recent settled cost report or the most recent tentative settled cost report, whichever is later, in determining a LTCH's cost-to-charge ratio.

In the March 7, 2003, proposed rule (68 FR 11253), we also proposed, by cross-referencing proposed § 412.84(i), that the applicable statewide average cost-to-charge ratio would only be applied when a LTCH's cost-to-charge ratio exceeds the ceiling. Thus, the applicable statewide average cost-to-charge ratio would not be applied if a LTCH's cost-to-charge ratio falls below the floor. Finally, in that same proposed rule, by cross-referencing proposed § 412.84(m), we proposed that any reconciliation of payments for short-stay outliers would 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. We also noted that, as is the case with the proposed changes to the outlier policy for acute care hospitals under the IPPS, we are still assessing the procedural changes that would be necessary to implement this change.

As we discussed above in section VII.B.3 of this preamble, we received numerous comments on the proposed changes to the short-stay outlier policy under proposed § 412.529(c) (and the high-cost outlier policy under proposed § 412.525(a)). Because many features of the proposed LTCH PPS outlier policies are based upon the proposed policy changes to the IPPS high-cost outlier policy, we believe it is appropriate to finalize the proposed changes to the LTCH PPS short-stay outlier policy (and high-cost outlier policy) together with the final policy decisions on the IPPS high-cost outlier policy. Because the LTCH PPS outlier policy and proposed outlier policy changes are modeled after the IPPS outlier policy, we include the summary of public comments submitted on behalf of LTCHs, which in many cases mirror the comments we received on the proposed IPPS outlier policy, and the responses to those comments in the IPPS high-cost outlier final rule. Please refer to that final rule for a full discussion of the comments and responses, as well as any other final policy decisions concerning LTCH PPS (the short-stay outlier policy under § 412.529(c) and the high cost outlier policy under § 412.525(a)). Therefore, in this final rule, we are not making the changes to the short-stay outlier policy at § 412.529 based on the changes proposed in the March 7, 2003, proposed rule (68 FR 11252).

As noted above, we will be responding to all comments on the proposed outlier policies for the LTCH PPS and presenting any changes in

existing policy in the IPPS high-cost outlier final rule. We believe that it is appropriate, however, to respond to three commenters that submitted comments regarding the impact of our short-stay outlier policy on certain hospitals which 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).

Comment: Three commenters, two hospital associations and the other, a hospital that qualifies as a LTCH under section 1886(d)(1)(B)(iv)(II) of the Act, expressed great concern that since becoming subject to the LTCH PPS, the LTCH is experiencing considerable financial losses which it anticipates will continue to increase during the 5-year transition period. The commenters assert that these mounting losses will substantially threaten the LTCH's ability to continue to offer services in accordance with its unique mission of primarily treating cancer patients. The commenters identify our payment policy for short-stay outliers as creating the most damaging shortfall, given this ''subclause (II)'' LTCH's case mix. In order to ameliorate this situation, all three commenters suggest that we exempt ''subclause (II)'' LTCHs, from the short-stay outlier policy and establish a hospital-specific standard Federal rate to reflect this change, which would also result in a lower average payment amount for all of those LTCHs' cases and a higher high-cost outlier threshold. We were urged, by one of the commenters to make these suggested policy modifications retroactive to the start of the hospital's first cost reporting period under the LTCH PPS and also to suspend the timing requirements of § 412.533(c), which would allow this LTCH to elect fully prospective payments as of that date. A suggestion from one of the hospital associations also advanced the possibility that the necessity for any adjustment to the short-stay outlier policy would end with the completion of the 5-year transition because with implementation of the full wage index adjustment and no budget neutrality adjustment (to account for the costs incurred by the Medicare program during the transition), Medicare payments for the ''subclause (II)'' LTCH would be more in line with the costs of delivering care.

Response: By enacting section 4417(b) of Public Law 105–33, and adding the provision at section 1886(d)(1)(B)(iv)(II) of the Act, the Congress provided an exception to the general definition of LTCH as set forth in section 1886(d)(1)(B)(iv)(I) of the Act (''subclause (I)'' LTCHs), intending, we believe, to recognize the existence and importance of a distinct category of LTCHs that might not otherwise warrant exclusion from the IPPS under subclause (I), but which, nonetheless, fulfills a unique and vital role in serving a particular subset of Medicare patients. Under this provision, which we implemented at § 412.23(e)(2)(ii), to qualify as a LTCH, a hospital must have first been excluded as a LTCH in 1986, have an average inpatient length of stay of greater than 20 days, and demonstrate that 80 percent of its annual Medicare inpatient discharges in the 12-month reporting period ending in Federal fiscal year 1997 have a principal diagnosis that reflects a finding of neoplastic disease (62 FR 46016 and 46026, August 29, 1997). Moreover, we believe the Congress assumed ''subclause (II)'' LTCHs would continue to serve this population after FY 1997. Acknowledging the distinction between hospitals qualifying as LTCHs under section 1886(d)(1)(B)(iv)(I) of the Act, and those qualifying under section 1886(d)(1)(B)(iv)(II) of the Act when we developed the LTCH PPS, we revised the greater than 25 day average length of stay criteria to include only Medicare patients for these ''subclause (I)'' LTCHs. However, for LTCHs described in section 1886(d)(1)(B)(iv)(II) of the Act, no change was made to the methodology for calculating the LTCH's average length of stay, since ''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, August 30, 2002). Consistent with existing policies that differentiate ''subclause (II)'' LTCHs from other LTCHs, we agree with the commenters that it is appropriate for us to consider whether or not a policy that applies to LTCHs designated under subclause I, can reasonably and equitably be applied to ''subclause (II)'' LTCHs without some measure of adjustment. We also believe that the specificity of section 4417(b) of Public Law 105–33, which states that 80 percent or more of the annual Medicare inpatient discharges, in such a ''subclause (II)'' LTCH, in the 12-month reporting period ending in Federal fiscal year 1997 would have had a principal diagnosis that reflects a finding of neoplastic disease, indicates to us that the Congress determined that hospitals fitting this description fulfilled a unique and vital service for certain Medicare beneficiaries. Furthermore, we believe the Congress assumed that not only would a ''subclause (II)'' LTCH have at least 80 percent of its Medicare inpatient discharges with a diagnosis of neoplastic disease in FY 1997, but this type of LTCH would continue to serve this patient case-mix in years subsequent to FY 1997.

The theoretical foundations of a DRG-based PPS are that while the costs of one case may exceed its payment, the opposite is also likely to happen, and that where some types of cases are always very expensive for a hospital to treat, others are, in general, not costly. It is assumed that hospitals under a DRG-based system, therefore, can typically exercise some influence over their case-mix and their services in order to achieve fiscal stability. This is not generally the case for ''subclause (II)'' LTCHs because they continue to primarily treat patients with neoplastic diseases (97.4 percent of patients at a ''subclause (II)'' LTCH had primary diagnosis of neoplastic disease, according to data from FY 2001 MedPAR files.). According to our claims data for January 1, 2001, through December 31, 2001, at a ''subclause (II)'' LTCH, more than 93 percent of its Medicare patients expired, over half of the patients at this hospital would qualify as short-stay outliers (97 percent of those short-stay outliers expired), and 30 percent of its patient days were for high-cost outlier patients with an average length of stay of 109 days.

We have analyzed our data as well as information supplied by the commenters in order to better understand the financial impact on a ''subclause (II)'' LTCH of the payment policies established for LTCHs that will be in place during the 5-year transition to the full LTCH PPS. In identifying this category of LTCHs, Congress required that ''in the 12-month cost reporting period ending in fiscal year 1997'' the Medicare patient population would be comprised of at least 80 percent with ''* * * a principal diagnosis that reflects a finding of neoplastic disease.'' As noted above, our data indicates that the treatment of neoplastic diseases continues to be the mission of a ''subclause (II)'' LTCH. Accordingly we believe that the patient census at a ''subclause (II)'' LTCH will, by its very nature, be comprised of unusually high percentages of both short-stay cases as well as high-cost outliers. Data projections further reveal that the significant losses that are being incurred will gradually decline throughout the 5-year transition, as the percentage of payments based on the Federal rate increase and the effect of the wage index adjustment is fully transitioned. Our analyses lead us to believe that until the

full wage index is phased-in in 2006 and the transition period budget neutrality adjustments cease, the survival of such a ''subclause (II)'' LTCH is in serious jeopardy.

By establishing ''subclause (II)'' LTCHs, the Congress provided an exception to the general definition of LTCH under subclause (I), and, therein, we believe, endorsed the unique mission of a particular type of hospital. We do not believe that the Congress intended for policies that equitably apply to LTCHs described under subclause (I) to potentially undermine the viability of a LTCH described under subclause (II).

In the August 30, 2003, final rule (67 FR 55954), we stated that we believed that in establishing the short-stay outlier policy under the LTCH PPS, we were recognizing that LTCHs, as a provider category under Medicare, should not be admitting patients whose stay were considerably less than the average length of stay at a LTCH and who could otherwise receive care at an acute care hospital subject to the IPPS. Data from the FY 1999 MedPAR files revealed that 52 percent of cases being treated at LTCHs were for stays of less than two-thirds of the average length of stay for the LTC–DRG and 20 percent had a length of stay of even less than 8 days (67 FR 55970, August 30, 2002). We noted, however, that short-stay outliers could also result from a legitimate admission to a LTCH when a change in the patient's condition dictated that another treatment or care setting would be more clinically appropriate or if the patient expired early in the LTCH stay. In these situations, the patient would still not have received the full course of treatment at the LTCH and paying a full LTC–DRG would result in significant overpayment. Therefore, we created the short-stay outlier category as a feature of the LTCH PPS, so that Medicare would be rendering fair, but not excessive payment for patients who could have received treatment at an acute care hospital as well as for patients who, for valid clinical reasons, did not stay long enough at a LTCH to receive the course of treatment for which the full LTC–DRG payments were calibrated. We further believed that implementing the short-stay policy could encourage LTCHs to adopt admission policies that, for the most part, would work to limit the number of short-stay patients since there would be no inappropriate financial incentive for admitting such cases.

As we evaluate the short-stay outlier policy with regard to ''subclause (II)'' LTCHs, we believe that a LTCH in this category may not be able to readily address the length of stay of patients and the costs it incurs for those patients as would LTCHs described under subclause (I) because a ''subclause (II)'' LTCH continues to primarily serve patients with neoplastic diseases. In fact, as previously noted, FY 2001 MedPAR data demonstrate that 97.4 percent of the patients at a ''subclause (II)'' LTCH have a primary diagnosis of neoplastic disease. Accordingly, we believe that it is necessary to adjust the short-stay policy for ''subclause (II)'' LTCHs during the 5-year transition period, so that a LTCH of this type can continue to serve its community, as we believe was assumed by the Congress when it established this category of LTCHs.

All three commenters suggested that we abrogate the entire short-stay outlier policy for ''subclause (II)'' LTCHs, which would result in a revised hospital-specific standard Federal rate and high-cost outlier threshold. We do not believe that such a radical departure from the general LTCH PPS policies is either necessary or appropriate to address the problems that we have noted.

In the August 30, 2002, final rule (67 FR 55995–56000), we describe the simulations that resulted in our short-stay outlier policy of the lesser of 120 percent of the cost, 120 percent of the per diem amount of the LTC–DRG, or the full LTC–DRG. Since these simulations were established by analyzing costs and payments of a LTCH with a greater than 25 day average length of stay, we are instead providing an adjustment to the short-stay outlier payment policy for a ''subclause (II)'' LTCH, which is held to a greater than 20 day average length of stay criterion and not to the greater than 25 day average length of stay criterion which applies to ''subclause (I)'' LTCHs. Furthermore, this adjustment to the short-stay payment policy will be in place during ''subclause (II)'' LTCHs'' 5-year transition to full LTCH PPS in the form of percentages, corresponding to the 120 percent for ''subclause (I)'' LTCHs, and it will be ''phased out'' gradually as the percentage of payments under the LTCH PPS are increased, the full wage index adjustment is phased-in, and the budget neutrality adjustment is decreased. The adjustment, described below, was derived based on payment simulations using the same methodology on ''subclause (II)'' LTCH data that we used in arriving at the 120 percent for ''subclause (I)'' LTCHs. (67 FR 55995–56000, August 30, 2002)

We are establishing this formula with the expectation that an adjustment to the short-stay 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. Therefore, for example, a ''subclause (II)'' LTCH, which became subject to the LTCH PPS for their first cost reporting period which began on January 1, 2003 (and did not elect payment based on 100% of the Federal rate), 80 percent of Medicare payments would still be based on what would have been paid under the TEFRA system and only 20 percent would be based on the Federal rate (and subject to payments under the short-stay outlier policy established in the August 30, 2002, final rule). Effective for discharges from a ''subclause (II)'' LTCH occurring on or after July 1, 2003, and based on the payment simulations described above, we have revised the short-stay outlier percentage to 195 percent during the first year of the hospital's 5-year transition. For the second cost reporting period, the short-stay outlier percentage will be 193 percent; for the third cost reporting period, the percentage will be 165 percent; for the fourth cost reporting period, the percentage will be 136 percent; and for the final cost reporting period of the 5-year transition, the short-stay outlier percentage for ''subclause (II)'' LTCHs, will be 120 percent, that is, the same as it is for all other LTCHs under the LTCH PPS. We have set forth this policy by redesignating the existing paragraph (c)(4) as (c)(5) and adding a new paragraph (c)(4) to § 412.529.

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 consider the above adjustment to be a reasonable, equitable and sufficient response to the particular situation of a ''subclause (II)'' LTCH under the LTCH PPS and, therefore, we will not address at any length the other two suggestions regarding retroactive adjustments to the start of a LTCH's first cost reporting period under the LTCH PPS and the disregarding of timing requirements established in § 412.533(c) for election not to be paid under the transition period methodology. In this final rule, therefore, we are making a temporary adjustment to payments under the short-stay outlier policy for LTCHs designated under section 1886(d)(1)(B)(iv)(II) of the Act and § 412.23(e)(2)(ii) that will end upon full implementation of the LTCH PPS, at the beginning of their fifth cost reporting period in the 5-year transition period.

c. Interrupted Stay

In § 412.531(a), we define an ''interruption of a stay'' as a stay at a LTCH during which a Medicare inpatient is admitted upon discharge from the LTCH 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. For a discharge to an acute care hospital, the applicable fixed-day period is 9 days. For a discharge to an IRF, the applicable fixed-day period is 27 days. For a discharge to a SNF, the applicable fixed-day period is 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. (We refer readers to section VII.C.4.e. of this preamble for a discussion of application of this interrupted stay policy to Medicare-participating providers with approved swing beds.)

If the patient's length of stay away from the LTCH does not exceed the fixed-day thresholds, the return to the LTCH is considered part of the first admission and only a single LTCH PPS payment will be made. (From the standpoint of implementing this policy, in the event that a Medicare inpatient is discharged from a LTCH and is readmitted and the stay qualifies as an interrupted stay, the provider should cancel the claim generated by the original stay in the LTCH and submit one claim for the entire stay. For further details, see 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 LTC–DRG payments will be made, one based on the principal diagnosis for the first admittance and the other based on the principal diagnosis for the second admittance. Moreover, if the principal diagnoses are the same for both admissions, the hospital could receive two similar payments. (See section VII.C.4.e. of this final rule for application of the interrupted stay policy to transfers to swing bed hospitals.)

d. Onsite Discharges and Readmittances

Under § 412.532, generally, if a LTCH readmits more than 5 percent of its Medicare patients who are discharged to an onsite SNF, IRF, or psychiatric facility, or to an onsite acute care hospital, only one LTC–DRG payment will be made to the LTCH for 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 such discharges and readmittances to the applicable site(s) for that cost reporting period are paid as one discharge. 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 such 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.)

e. Treatment of Swing Beds Under the Interrupted Stay and Onsite Discharge and Readmittance Policies

A swing-bed hospital is defined at § 413.114(b) as a hospital or critical access hospital (CAH) participating in Medicare that has an approval from CMS to provide post-hospital SNF care as defined in § 409.20 and meets the requirements specified in § 482.66 or § 485.645. Swing beds are otherwise licensed hospital beds that may, under certain circumstances, be used temporarily as SNF beds. Under § 413.114(a)(2), post-hospital SNF care furnished in general routine inpatient beds in rural hospitals (other than CAHs) is paid in accordance with the provisions of the SNF PPS for services furnished for cost reporting periods beginning on or after July 1, 2002. Since it is possible for a Medicare beneficiary to be discharged from a LTCH for post-hospital SNF care that is being provided by another hospital-level Medicare provider with swing beds, such a discharge would be considered the same as if it were to an individual SNF. We interpret the extension of the SNF PPS to swing beds to require that all payment policy determinations regarding patient movement between LTCHs and SNFs, including the onsite policy described above, also apply to swing beds.

In the March 7, 2003, proposed rule (68 FR 11254), we stated that we want to emphasize that our inclusion of swing beds in payment policy determinations for all patient movement between LTCHs and SNFs (*see* section VII.C.4.c. of this preamble) would mean that 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 would have the same policy consequences as would a readmission to the LTCH from an onsite SNF. We received no comments on this clarification.

5. Other Payment Adjustments

As indicated earlier, we had 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. As we stated in the March 7, 2003, proposed rule (68 FR 11254), because the LTCH PPS was only recently implemented, sufficient new data have not yet been generated that would enable us to conduct a comprehensive reevaluation of these payment adjustments. Therefore, in that same proposed rule, we did not propose an adjustment for geographic reclassification, rural location, DSH, or IME at this time. Additionally, we stated

that we would continue to collect and interpret new data as they become available in the future to determine if these data support proposing any additional payment adjustments.

Comment: Two commenters objected to our proposal not to include an adjustment to account for a hospital's treatment of a disproportionate share of low-income patients (a DSH adjustment) or an adjustment to account for indirect teaching costs (an IME adjustment). One commenter stated that given that LTCHs are a heterogeneous group of facilities with widely varying costs and patient populations, it is particularly important to provide adjustments to compensate for the differences where possible. The other commenter stated that the LTCH regression analysis was among a diverse set of facilities, thus weakening CMS' conclusions not to include adjustments for DSH and IME. Accordingly, both commenters urged for the inclusion of a DSH adjustment and an IME adjustment in the LTCH PPS.

Response: As we discussed in the August 30, 2002, final rule (67 FR 56020–56022), we examined the appropriateness of an adjustment for LTCHs serving a disproportionate share of low-income patients. In that same final rule, we explained that in examining the most recent LTCH data available to us, we determined that a DSH adjustment consistent with the DSH adjustment under the IPPS for acute care hospitals (set forth at section 1886(d)(5)(F) of the Act) would reduce the ability of the LTCH PPS to predict cost per case while lowering the base payment rate. We also evaluated alternative methods to provide some type of DSH adjustment. Specifically, using regression analysis that took into account both the Medicaid patients receiving SSI and the percentage of Medicaid patients not entitled to Medicare, we found no significant empirical relationship between these variables and LTCHs' costs. Therefore, we did not establish a DSH adjustment under the LTCH PPS.

Also, in the August 30, 2002, final rule (67 FR 56022), we explained that based on a double log regression, we found that the indirect teaching cost variable was negative and not significant. In addition, we looked at different specifications for the teaching variable, including resident-to-bed ratio and resident-to-average daily census, to measure teaching intensity. In all of our payment regressions it was determined that the teaching variable was not significant; that is, no empirical evidence exists to show that LTCHs' cost per case would vary with teaching costs.

In the March 7, 2003, proposed rule (68 FR 11254), we explained that because the LTCH PPS was only recently implemented, sufficient new data have not yet been generated that would enable us to conduct a comprehensive reevaluation of these payment adjustments. Therefore, since we still do not have empirical evidence to support a DSH adjustment or an IME adjustment, we continue to believe that it would be inappropriate to establish such adjustments at this time. Accordingly, in this final rule, we are not adopting the commenters' suggestion to include a DSH adjustment and an IME adjustment in the LTCH PPS. As we stated in the March 7, 2003, proposed rule (68 FR 11254), 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

In the August 30, 2002, final rule (67 FR 56038) under § 412.533, we implemented a 5-year transition period from reasonable cost-based payment to prospective payment, during which a LTCH will be paid an increasing percentage of the LTCH PPS rate and a decreasing percentage of its payments under the reasonable cost-based principles 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 blend methodology.

As we discussed in further detail in the August 30, 2002, final rule (67 FR 56032–56037), 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 methodology that allows LTCHs to receive payments based partially on reasonable cost-based principles. 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).

For FY 2003, based on a comparison of the estimated FY 2003 payments to each LTCH based on 100 percent of the standard Federal rate and the transition blend methodology, we projected that approximately 49 percent 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. This projection was based on our estimate that those 49 percent of LTCHs would receive higher payments based on 100 percent of the standard Federal rate compared to the payments they would receive under the transition blend methodology. Similarly, we projected that the remaining 51 percent of LTCHs would choose to be paid based on the transition blend methodology (80 percent of reasonable cost-based payments and 20 percent of payments based on the Federal rate) in FY 2003, because those payments would be higher than if they were paid based on 100 percent of the standard Federal rate.

In the August 30, 2002, final rule (67 FR 56034), we projected that the full effect of the 5-year transition period and the election option would result in a cost to the Medicare program of $240 million as follows: For FY 2003, $50 million; for FY 2004, $80 million; for FY 2005, $60 million; for FY 2006, $40 million; for FY 2007, $10 million. Thus, in order to maintain budget neutrality, we applied a 6.6 percent reduction (0.934) to all LTCHs' payments in FY 2003 to account for the estimated cost of $50 million for FY 2003. 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. Based on the data available at that time, in the August 30, 2002, final rule (67 FR 56037) we estimated the following budget neutrality offsets to LTCH payments during the remainder of the transition period: 5.0 percent (0.950) in FY 2004; 3.4 percent (0.966) in FY 2005; and 1.7 percent (0.983) in FY 2006. We also stated that no budget neutrality offset is necessary in the 5th year of the transition period (FY 2007) because under the transition methodology at § 412.533, all LTCHs will be paid based on 100 percent of the standard Federal rate and zero percent of the reasonable cost-based principles.

As stated in the March 7, 2003, proposed rule (68 FR 11254–11256), for the proposed 2004 LTCH PPS rate year,

based on the best available data and the policies presented in that proposed rule, we projected that approximately 49 percent of LTCHs would be paid based on 100 percent of the proposed standard Federal rate rather than receive payment under the transition blend methodology. Using the same methodology in the August 30, 2002, final rule (67 FR 56034) described above, this projection, which uses updated data and inflation factors, is based on our estimate that these LTCHs would receive higher payments based on 100 percent of the proposed standard Federal rate compared to the payments they would receive under the transition blend methodology. Similarly, we project that the remaining 51 percent of LTCHs would choose to be paid based on the transition blend methodology (80 percent of reasonable cost-based payments and 20 percent of Federal rate payments for cost reporting periods that begin during FY 2003; and 60 percent of reasonable cost-based payments and 40 percent of Federal rate payments for cost reporting periods that begin during FY 2004 (in accordance with § 412.533(a))) because they would receive higher payments than if they were paid based on 100 percent of the proposed standard Federal rate.

In the March 7, 2003, proposed rule (68 FR 11255), based on the best available data and the proposed policy revisions described in that proposed 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 $300 million as follows: $120 million in the 2004 LTCH PPS rate year; $90 million in the 2005 LTCH PPS rate year; $60 million in the 2006 LTCH PPS rate year; and $30 million in the 2007 LTCH PPS rate year. Therefore, we proposed a 5.7 percent reduction (0.943) to all LTCHs' payments for discharges occurring on or after July 1, 2003, and through June 30, 2004, to account for the estimated cost of the $120 million for the proposed 2004 LTCH PPS rate year.

As we stated 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 fiscal year. In the March 7, 2003, proposed rule (68 FR 11255), based on the best available data at that time, we proposed the following budget neutrality offsets to LTCH payments during the transition period: 4.4 percent (0.956) in proposed 2005 LTCH PPS rate year; 2.9 percent (0.971) in proposed 2006 LTCH PPS rate year; and 1.2 percent (0.988) in proposed 2007 LTCH PPS rate year.

Comment: One commenter recommended that the budget neutrality offsets to LTCH payments during the transition period be updated periodically and adjusted to reflect any change in the percentage of LTCHs electing to receive payments during the transition period based on 100 percent of the Federal rate as provided for under § 412.533(c).

Response: As we stated in the March 7, 2003, proposed rule, the proposed budget neutrality offsets to LTCH payments during the transition period are determined using the best available data. Moreover, as we stated above, we proposed to revise the estimated budget neutrality offsets to LTCH payments during the transition period for future years annually along with the update to the Federal rate based on updated data. Therefore, in determining the budget neutrality offsets to LTCH payments during the transition period in future rate years, we will use the latest data available, including data on actual elections made by LTCHs to receive payments during the transition period based on 100 percent of the Federal rate as provided for under § 412.533(c). To update the budget neutrality offsets to LTCH payments during the transition period more often than in conjunction with the annual rate update would be an administrative burden to LTCHs and us.

Comment: A few commenters requested clarification on how we derived the estimate that 49 percent of LTCHs would elect payment based on 100 percent of the Federal rate in the proposed 2004 LTCH PPS rate year. Additionally, the commenters requested an explanation of how the estimate that 49 percent of LTCHs would elect payment based on 100 percent of the Federal rate in the 2004 LTCH PPS rate year can be determined from the proposed rule data posted on the CMS Web site. Some commenters also requested that the data files posted on the CMS Web site be consistent in the future, that is, provide the same information and title headings. One commenter, requested that the data files posted on the CMS Web site contain an indicator of which LTCHs have elected to receive payments based on 100 percent of the standard Federal rate as provided for under § 412.533(c).

Response: As we discussed above, the proposed estimate that 49 percent of LTCHs would elect payment based on 100 percent of the standard Federal rate in the proposed 2004 LTCH PPS rate year was based on our estimate that those 49 percent of LTCHs (96 out of 194) would receive higher payments based on 100 percent of the proposed standard Federal rate compared to the payments they would receive under the transition blend methodology. As we also noted above, this projection was based on the best available data and the policies presented in that proposed rule. Accordingly, in the March 7, 2003, proposed rule, when we simulated payments for each LTCH under the LTCH PPS for the proposed 2004 LTCH PPS rate year based on 100 percent of the proposed standard Federal rate, we incorporated the proposed policy changes, including the proposed standard Federal rate of $35,726.64, the proposed fixed loss amount of $19,978, the proposed labor-share of 72.612 percent, the proposed update of the wage index data, and the proposed elimination of the assignment of the applicable statewide average cost-to-charge ratio when a LTCH's cost-to-charge ratio fell below the floor. In estimating the payments that LTCHs would receive under the transition blend methodology, we projected the payments that each LTCH would receive during the proposed 2004 LTCH PPS rate year, if the LTCH PPS were not implemented. That is, we estimated payments based on reasonable cost-based principles in accordance with the methodology set forth in § 1886(b) of the Act.

Based on the LTCH's cost reporting period, we applied the applicable transition blend percentages for each LTCH during the proposed 2004 LTCH PPS rate year. For example, as we noted in the March 7, 2003, proposed rule (68 FR 11261), 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 proposed 2004 LTCH PPS rate year, such that a LTCH with an October 1, 2002, cost reporting period would have 3 months (July 1, 2003, through September 30, 2003) under the 80/20 transition blend (that is, 80 percent of payments based on reasonable cost-based principles and 20 percent based on the Federal rate) 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 principles and 40 based on the Federal rate).

If a LTCH's estimated LTCH PPS payments for the proposed 2004 LTCH PPS rate year were greater than its estimated payments under the transition period methodology for the proposed 2004 LTCH PPS rate year, then we assumed that the LTCH would elect payment based on 100 percent of the standard Federal rate for the proposed

2004 LTCH PPS rate year. Conversely, if a LTCH's estimated payments under the transition period methodology for the proposed 2004 LTCH PPS rate year were greater than its estimated LTCH PPS payments for the proposed 2004 LTCH PPS rate year, then we assumed that the LTCH would receive payment based on the transition blend methodology set forth in § 412.533(a) for the proposed 2004 LTCH PPS rate year. However, regardless of the comparison of a LTCH's estimated LTCH PPS payments and estimated payments under the transition period methodology for the proposed 2004 LTCH PPS rate year, we also took into account whether we had previously projected that a LTCH would elect payment based on 100 percent of the standard Federal rate in the August 30, 2002, final rule. Specifically, because LTCHs subject to the LTCH PPS with cost reporting periods that began prior to start of the proposed 2004 LTCH PPS rate year (July 1, 2003) would have already notified their fiscal intermediary of their election to receive payment based on 100 percent of the Federal rate in accordance with § 412.533(c)(2), and once a LTCH makes this election it cannot revert to the transition blend (§ 412.533(a)), in our proposed rule projection, we took into account our previous projection from the August 30, 2003, final rule.

Based on the clarification of how we derived the estimate that 49 percent of LTCHs would elect payment based on 100 percent of the Federal rate in the 2004 LTCH PPS rate year provided above, the March 7, 2003, proposed rule data posted on our website could be combined with the August 30, 2002, final rule data also posted on our website to derive the estimate that that 49 percent of LTCHs would elect payment based on 100 percent of the Federal rate in the proposed 2004 LTCH PPS rate year. Specifically, the variables ''Total TEFRA Payments for Impact'' and ''Total PPS Payments'' in the August 30, 2002, final rule data file posted on our website and the variables ''Estimated Total TEFRA Payment'' and ''Estimated Total PPS Payments (DRG + High-Cost Outlier)'' in the March 7, 2003, proposed rule data file posted on our website can be used to derive the estimate that 49 percent of LTCHs would elect payment based on 100 percent of the Federal rate in the 2004 LTCH PPS rate year.

In the future, we will make every attempt possible to provide the same information and title headings in the data file posted on our Web site. However, changes may be necessary in the future to reflect current policy and to more accurately reflect the data used. For example, the August 30, 2002, final rule data files posted on our website contained the variable ''Total TEFRA Payment for Budget Neutrality.'' As described in the corresponding file layout also posted on our Web site, in accordance with section 307 of Public Law 106–554, this variable used to determine the budget neutral standard Federal rate does not contain the increases to LTCHs' payments provided for under section 122 of Public Law 106–113 and section 307 of Public Law 106–554. However, that variable is no longer necessary since we are not required to determine the LTCH PPS Federal rate based on payments made under the reasonable cost-based methodology once the LTCH PPS is implemented (that is, for years beyond FY 2003). Since this variable was not required to determine the proposed rate and factors discussed in the March 7, 2003, proposed rule, there is no corresponding variable in the data files posted on our Web site. Additionally, as data on which LTCHs have elected to receive payments based on 100 percent of the standard Federal rate as provided for under § 412.533(c) become available in the future, we will incorporate that data in the LTCH PPS data files posted on the CMS' Web site.

Comment: One commenter requested clarification on why the proposed budget neutrality offsets for the transition period were increased for ''fiscal years'' 2004 through 2007, despite the fact the assumptions appear the same. The commenter recommends that the budget neutrality offsets for the transition period remain unchanged from those published in the August 30, 2002, final rule.

Response: Although the budget neutrality offsets presented in the August 30, 2002, final rule were applicable on a fiscal year basis, this is no longer true for the proposed budget neutrality offsets included in the March 7, 2003, proposed rule. The proposed budget neutrality offsets for the transition period were estimated to apply for the proposed LTCH PPS rate years 2004 through 2007, not ''fiscal years'' 2004 through 2007 as the commenter stated. The change in the period of time for which the proposed budget neutrality offsets for the transition period would be applicable is the primary reason why we determined the proposed budget neutrality offset for the transition period to be 5.7 percent for the proposed 2004 LTCH PPS rate year, beginning July 1, 2003, as compared to the previous estimate of 5.0 percent for FY 2004, beginning October 1, 2003 (presented in the August 30, 2002, final rule). Therefore, the change in the budget neutrality offsets for the transition period is primarily due to moving from the Federal FY (October 1st) rate cycle to the LTCH PPS rate year (July 1st) rate cycle. As we stated in the August 30, 2002, final rule, future budget neutrality offsets for the transition period in the proposed rule will be based on the best available data. Accordingly, in determining the proposed budget neutrality offsets for the transition period, we also took into account updated data.

Therefore, we believe that the proposed budget neutrality offset for the transition period for the proposed 2004 LTCH PPS rate year is appropriate based on the data available at that time, and we are not adopting the commenter's recommendation that the budget neutrality offsets for the transition period remain unchanged from those published in the August 30, 2002, final rule. Instead, in this final rule, we are revising the budget neutrality offsets for the transition period for the 2004 LTCH PPS rate year based on the same methodology established in the August 30, 2002, final rule, while using the best available data, and applying the offset to the 2004 LTCH PPS rate year.

In this final rule, for the 2004 LTCH PPS rate year, based on the best available data and the policies established in this final rule, we project that approximately 49 percent of LTCHs will be paid based on 100 percent of the proposed standard Federal rate rather than receive payment under the transition blend methodology. Using the same methodology described in the August 30, 2002, final rule (67 FR 56034), this projection, which uses updated data and inflation factors, is based on our estimate that either—(1) a LTCH has already elected payment based on 100 percent of the Federal rate prior to July 1, 2003, or (2) a LTCH will receive higher payments based on 100 percent of the 2004 LTCH PPS rate year standard Federal rate compared to the payments it would receive under the transition blend methodology. Similarly, we project that the remaining 51 percent of LTCHs will choose to be paid based on the transition blend methodology (80 percent of reasonable cost-based payments and 20 percent of the Federal rate for cost reporting periods beginning during FY 2003 and 60 percent of reasonable cost-based payments and 40 percent of the Federal rate for cost reporting periods beginning during FY 2004 in accordance with § 412.533(a)) because they will receive higher payments than if they were paid based on 100 percent of the 2004 LTCH PPS rate year standard Federal rate. We note that, as discussed in the March 7,

2003, proposed rule (68 FR 11256–11257), we did not propose to change the 5-year transition period set forth in § 412.533(a) in conjunction with the proposed change in the proposed 2004 LTCH PPS rate year update. Therefore, the applicable transition blend percentage will apply 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).

In this final rule, based on the best available data and the final policy revisions described above, 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 as follows:

LTCH PPS rate year	Estimated cost (in millions)
2004	$120
2005	100
2006	60
2007	30

Therefore, using the methodology established in the August 30, 2002, final rule (67 FR 56034) based on updated data and the final policies and rates established in this final rule, we are establishing a 6.0 percent reduction (0.940) to all LTCHs' payments for discharges subject to the LTCH PPS occurring on or after July 1, 2003, and through June 30, 2004, to account for the estimated cost of the election of the $120 million for the proposed 2004 LTCH PPS rate year. This offset has increased slightly over the estimate in the proposed rule (5.7 percent) primarily due to slightly higher projections of reasonable cost-based payment based on the latest available data. In addition, as we stated in the March 7, 2003, proposed rule (68 FR 12255), we emphasize that the budget neutrality offset to account for the transition methodology is calculated based on and effective for payments made for discharges occurring during the 2004 LTCH PPS rate year of July 1, 2003, through June 30, 2004, not the Federal FY 2004 of October 1, 2003, through September 30, 2004.

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 for estimated aggregate payments under the LTCH PPS to equal the estimated aggregate payments that would be made if the LTCH PPS was not implemented. Our methodology for estimating payments for purposes of the budget neutrality calculations use the best available data at that 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 provides 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 August 30, 2002, final rule (67 FR 56037), we estimated that total Medicare program payments for LTCH services over 5 years would be $1.59 billion for FY 2003; $1.69 billion for FY 2004; $1.79 billion for FY 2005; $1.90 billion for FY 2006; and $2.00 billion for FY 2007. In the March 7, 2003, proposed rule (68 FR 12255), based on the best available data, we estimated that total Medicare program payments for LTCH services for the proposed LTCH PPS rate years of 2004 through 2008 would be:

LTCH PPS rate year	Estimated payments ($ in billion)
2004	$2.17
2005	2.29
2006	2.42
2007	2.56
2008	2.71

At this time, based on the most recent and best available data, these estimates of Medicare program payments for LTCH services for the LTCH PPS rate years of 2004 through 2008 remain unchanged from those estimates presented in the proposed rule. Therefore, in this final rule, we continue to estimate that Medicare program payments for LTCH services for the LTCH PPS rate years of 2004 through 2008 will be approximately $12.2 billion as shown above.

In accordance with the methodology established in the August 30, 2002, final rule (67 FR 56037), these estimates are based on the projection that 49 percent of LTCHs will elect to be paid based on 100 percent of the 2004 LTCH PPS rate year standard Federal rate rather than the transition blend, and an update of our estimate of 2004 LTCH PPS rate year payments to LTCHs using our Office of the Actuary's most recent estimate (based on updated data) of the excluded hospital with capital market basket of 2.5 percent for the 2004 LTCH PPS rate year (adjusted to account for the proposed change in the rate update cycle discussed in section VII.B.1.b. of this preamble), 3.2 percent for the 2005 LTCH PPS rate year, 3.1 percent for the 2006 and 2007 LTCH PPS rate years, and 3.0 percent for the 2008 LTCH PPS rate year. We also took into account our Office of the Actuary's projection that there would be an increase in Medicare beneficiary enrollment of 1.3 percent in the 2004 LTCH PPS rate year, 1.6 percent in the 2005 LTCH PPS rate year, 1.9 percent in the 2006 LTCH PPS rate year, 2.0 percent in the 2007 LTCH PPS rate year, and 2.1 percent in the 2008 LTCH PPS rate year.

Because the LTCH PPS was only recently implemented, sufficient new data have not been generated that would enable us to conduct a comprehensive reevaluation of our budget neutrality calculations. Therefore, in the March 7, 2003, proposed rule (68 FR 11256), we did not propose an adjustment for budget neutrality under § 412.523(d)(3) at this time. However, we stated that 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.

Comment: A few commenters expressed concern that the retroactive one-time budget neutrality adjustment at § 412.523(d)(3) would wrongly penalize LTCHs for a CMS calculation error, thereby, weakening the intent and value of the PPS design. The commenters believe that the proposed rule lacks detail about the methodology CMS will use to implement this adjustment and requests that CMS publish the data and methodology used to assess compliance with the budget neutrality mandate under section 123 of Public Law 106–113 established in regulations at § 412.523(d)(3). In addition, one commenter states that if the Congress intended CMS to ''reduce'' future payments based on a one-time budget neutrality adjustment, the Congress would have specified this

intent more clearly in the statutory or report language.

Response: As we discussed in greater detail in the August 30, 2002, final rule, section 123(a)(1) of Public Law 106–113 requires the Secretary to develop a DRG-based PPS for LTCHs and ''shall maintain budget neutrality.'' As we stated in that same final rule (67 FR 56036), in implementing the LTCH PPS in FY 2003 we intended for estimated aggregate payments under the LTCH PPS to equal the estimated aggregate payments that would have been made if the LTCH PPS had not been implemented. Moreover, 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 of the LTCH PPS would not be perpetuated in the LTCH PPS rates for future years. This adjustment would not be ''retroactive'' as stated by the commenters; therefore, we do not believe that the one-time budget neutrality adjustment at § 412.523(d)(3) would wrongly penalize LTCHs for any calculation errors. Instead, as noted above, this adjustment is necessary so that any errors in the original budget neutrality calculations would not be perpetuated in the LTCH PPS rates for future years.

Furthermore, as we stated in the August 30, 2002, final rule (67 FR 56036–56037), if a one-time budget neutrality adjustment were proposed in the future under § 412.523(d)(3), the standard Federal rate may either increase or decrease depending on the difference between actual payments and estimated payments under the LTCH PPS.

As we also stated in the August 30, 2002, final rule (67 FR 56036–56037), when estimating payments for the purposes of the budget neutrality calculations in implementing the LTCH PPS for FY 2003, we used the best available data and any assumptions. As we explained in that same final rule, the actual data and the assumptions include inflation factors, intensity of services provided, and behavioral responses to the implementation of the LTCH PPS. To the extent that these data or assumptions significantly differ from actual experience, actual payments under the LTCH PPS may be higher *or* lower than the estimates on which the budget neutrality calculations were based, and a one-time prospective budget neutrality adjustment may be necessary to prevent perpetuating any errors in the budget neutrality calculations in future years. If in the future (but prior to October 1, 2006) after monitoring LTCH PPS payment data we believe that the assumptions used to determine the budget neutrality calculations differ significantly from actual experience, we would first propose an appropriate adjustment and publish the details of our findings in a future **Federal Register** document. At that time, we would also discuss the data and methodology used to determine the proposed one-time budget neutrality offset provided for under § 412.523(d)(3).

As we stated in the March 7, 2003, proposed rule, because the LTCH PPS was only recently implemented, sufficient new data have not been generated that would enable us to conduct a comprehensive reevaluation of our budget neutrality calculations. Therefore, in the March 7, 2003, proposed rule (68 FR 11256), we did not propose a one-time prospective adjustment for budget neutrality under § 412.523(d)(3) at that time. However, we will continue to collect and interpret new data as the data becomes available in the future to determine if such an adjustment should be proposed. Therefore, at this time we are not making a one-time prospective adjustment for budget neutrality as provided for under § 412.523(d)(3).

VIII. Computing the Adjusted Federal Prospective Payments

In accordance with § 412.525 and as discussed in section VII. 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. 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 adjustment factor shown in Table V in section VII.C.2. of this preamble. In the March 7, 2003, proposed rule (68 FR 11248), we proposed a standard Federal rate of $35,726.64 for the proposed 2004 LTCH PPS rate year. In this final rule, based on the best available data and the finalized policies present in this final rule, we are establishing a standard Federal rate of $35,892.41 for the 2004 LTCH PPS rate year. We illustrate the methodology used to adjust the Federal prospective payments in the following example:

During the 2004 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 1.0418 (see Table 1 in the Addendum to this final rule). The Medicare patient is classified into LTC–DRG 4 (Spinal Procedures), which has a relative weight of 1.2493 (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 ($35,892.41) by the labor-related share (72.885 percent) and the wage index (1.0418). This wage-adjusted amount is then added to the nonlabor-related portion of the unadjusted standard Federal rate (27.115 percent) to determine the adjusted Federal rate, which is then multiplied by the LTC–DRG relative weight (1.2493) to calculate the total adjusted Federal prospective payment for the 2004 LTCH PPS rate year ($45,992.49). In addition, as discussed in section VII.C.6. of this preamble, for the 2004 LTCH PPS rate year, we are reducing the LTCH PPS payment by 6.0 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		$35,726.18
Labor-Related Share		0.72885
Labor-Related Portion of the Federal Rate	=	$26,039.03
2/5th Wage Index (MSA 1600)		1.0418
Wage-Adjusted Labor Share	=	$27,127.46
Nonlabor-Related Portion of the Federal Rate (adjusted for COLA if applicable)	+	$9,687.15
Adjusted Federal Rate	=	$36,814.61
LTC–DRG 4 Relative Weight	×	1.2493
Total Adjusted Federal Prospective Payment (Before the Budget Neutrality Offset)	=	$45,992.49
Budget Neutrality Offset	×	0.940
Total Federal Prospective Payment (With the Budget Neutrality Offset)	=	$43,232.94

IX. 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 will provide LTCHs time to adjust their operations and capital financing to the new LTCH PPS, which is based on prospectively determined Federal payment rates. Furthermore, we believe that the 5-year phase-in of the LTCH PPS allows LTCH personnel to develop proficiency with the LTC–DRG coding system, resulting 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, 2007. 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 4 fiscal years. For cost reporting periods beginning on or after October 1, 2006, Medicare payment to LTCHs will be determined entirely under the Federal 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 a cost reporting period that began on or after October 1, 2002, and before October 1, 2003 (FY 2003), the total payment for a LTCH is 80 percent of the amount calculated under reasonable cost principles for that specific LTCH and 20 percent of the Federal prospective payment amount. For cost reporting periods beginning on or after October 1, 2003, and before October 1, 2004 (Federal FY 2004), the total payment for a LTCH will be 60 percent of the amount calculated under reasonable cost principles for that specific LTCH and 40 percent of the Federal prospective payment amount. As we noted in the March 7, 2003, proposed rule (68 FR 11257), the change in the effective date of the annual LTCH PPS rate update discussed in section IV. of this preamble 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). For example, a LTCH with a cost reporting period beginning on July 1, 2003 (which is the LTCH's first cost reporting period since the implementation of the LTCH PPS), will receive payments based on 80 percent of the reasonable cost-based rate and 20 percent of the Federal rate for its discharges occurring on or after July 1, 2003, through June 30, 2004 (if the LTCH does not elect payment based on 100 percent of the Federal rate).

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. As we discussed in the August 30, 2002, final rule (67 FR 56040), 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. We note that several reasonable cost-based payment provisions that were previously in effect are no longer effective, starting with cost reporting periods beginning in FY 2003. For instance, the caps on the target amounts for ''existing'' LTCHs provided for under section 4414 of the BBA (see § 413.40(c)(4)(iii)) for FYs 1998 through 2002 are no longer applicable for cost reporting periods beginning in FY 2003. Thus, a LTCH's target amount for FYs 2003 and beyond will be determined by updating its prior year's target amount (which for FY 2003 was subject to the FY 2002 cap). In addition, the 15-percent reduction to payments to LTCHs for capital-related costs provided for under section 4412 of Public Law 105–33 (§ 413.40(j)) is only applicable for portions of cost reporting periods occurring in FYs 1998 through FY 2002. This reduction is no longer applicable for cost reporting periods beginning in FY 2003. Therefore, the TEFRA portion of a LTCH's payment for capital-related costs during the LTCH PPS transition period is based on 100 percent of its Medicare allowable capital costs.

As we discussed in the August 30, 2002, final rule (67 FR 56038), 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 beginning 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 report 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 (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.

X. 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) and, 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 beginning on or after October 1, 2002.

As we discussed in the August 30, 2002, final rule (67 FR 56040), this definition of new LTCHs should not be confused with those LTCHs first paid under the TEFRA payment system for discharges occurring on or after October 1, 1997, described in section 1886(b)(7)(A) of the Act, 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. 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 reasonable cost-based.

For example, a ''new'' LTCH (post-FY 1998) that first began receiving payment as a LTCH on October 1, 2001, will be subject to the 110 percent of the median target amount payment limit for LTCHs (in accordance with § 413.40(f)(2)(ii)) for both its FY 2002 (October 1, 2001, through September 30, 2002) and FY 2003 (October 1, 2002, through September 30, 2003) cost reporting periods. Assuming the hospital has not elected to be paid 100 percent of the Federal rate for its cost reporting period beginning on October 1, 2002 (the first cost reporting period when the LTCH will be subject to the PPS), the hospital will be paid under the transition methodology whereby the LTCH's reasonable cost-based portion of its payment for operating costs (80 percent) is limited by the 110 percent of the median target amount payment limit for LTCHs under § 413.40(f)(2)(ii). For its cost reporting period beginning on October 1, 2003 (which is the hospital's third cost reporting period), under the transition methodology, that LTCH's reasonable cost-based portion of its payment for operating costs (60 percent) will be limited to its target amount as determined under § 413.40(c)(4)(v). Furthermore, if a hospital is designated as a LTCH on September 1, 2002, it will not be considered a new LTCH under § 412.23(e)(4), even if it had not discharged any patients or received any payments as of the implementation date of the LTCH PPS on October 1, 2002, because its first cost reporting period did not begin on or after October 1, 2002. Thus, it will be paid according to § 413.40(f)(2)(ii) from September 1, 2002, through August 30, 2003. This LTCH will not be subject to payments under the LTCH PPS until the start of its next cost reporting period on September 1, 2003. At the beginning of its second cost reporting period as a LTCH (that is, September 1, 2003), this LTCH will be subject to the transition period methodology in § 412.533(a)(1), because this provision applies to cost reporting periods beginning on or after October 1, 2002, and before October 1, 2003. Under the blended payments of the transition period in § 412.533(a)(1), 80 percent of payments for operating costs would be paid under the reasonable cost principles, as described in § 413.40(f)(2)(ii). (This hospital could also elect to be paid 100 percent of the Federal rate for its cost reporting period beginning September 1, 2003.)

XI. 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 beginning 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 and that are not receiving payment under the PIP method may bill on an interim basis (60 days after an admission and at intervals of at least 60 days after the date of the

first interim bill) and should include any high-cost outlier payment determined as of the last day for which the services have been billed.

XII. 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 systems 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. The Medicare Payment Advisory Commission (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.

Also, in the August 30, 2002, final rule (67 FR 56014), we explained that, given that the only unique requirement that distinguishes a LTCH from other inpatient acute care hospitals is an average 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 will consider future changes to LTCH coverage and payment policy based upon the results of such analyses.

XIII. Collection of Information Requirements

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

XIV. 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). We have determined that this final rule will not be a major rule within the meaning of Executive Order 12866 because the redistributive effects do not constitute a shift of $100 million in any one year. As we discuss in further detail below, and in section VII.B.1.b. of this preamble, the change to the LTCH PPS rate update cycle will be budget neutral. Therefore, we estimate that there will be no budgetary impact for the Medicare program as a result of the change to the LTCH PPS rate update cycle. Based on the best available data for 194 LTCHs, we estimate that the 2.2 percent increase in the standard Federal rate for the 2004 LTCH PPS rate year will result in an increase in payments of $32.4 million and there are no significant redistributive effects among any groups of hospitals. (Section VII.C.6. of this preamble includes an estimate of Medicare program payments for LTCH services.)

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* 65 FR 69432, November 17, 2000). Medicare fiscal intermediaries are not considered to be small entities. Individuals and States are not included in the definition of a small entity. 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 Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. For a final rule, 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 a substantial impact on the seven rural hospitals for which data were available that have fewer than 100 beds and that are located in rural areas.

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, based on the 9 State and local LTCHs in our database, 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.

B. Anticipated Effects

We discuss the impact of this final rule below in terms of its 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 VII.C.6 of this final rule, we are applying 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 reasonable cost-based payments that would have been made if the LTCH PPS had not been implemented, to the projected total Medicare program payments that will be made under the transition methodology and the option to elect payment based on 100 percent of the Federal prospective payment rate.

Our Office of the Actuary computed an update factor to update LTCH PPS payments from the current rate period (Federal FY 2003) to the new 2004 LTCH PPS rate year (July 1, 2003, through June 30, 2004). The 2004 LTCH PPS rate year overlaps the current rate period by 3 months (July 1, 2003, through September 30, 2003). The market basket increase for Federal FY 2003 is currently estimated at 3.7 percent and the most recent estimate of the LTCH PPS market basket increase for the 2004 LTCH PPS rate year is estimated at 2.5 percent (as discussed in section VII.B.1.b of this preamble). Therefore, over the period from FY 2002 through the 2004 LTCH PPS rate year (June 30, 2004), the cumulative increase would be 6.0 percent (1.037 * 1.025 = 1.063). This cumulative increase matches (within rounding) the cumulative increase calculated by using the index level in the new effective period and the index level in FY 2002, such that having two separate updates result in the same cumulative update as if we had used a single update for the entire 21-month period (October 1, 2002, through June 30, 2004). Thus, the change to the 2004 LTCH PPS rate update cycle will not result in a higher or lower update than would have been the case (except due to rounding) if no change had been made to the LTCH PPS update cycle. In addition, as discussed in section VII.B.1.b. of the preamble of this final rule, we apply a budget neutrality adjustment of 0.997 in determining the standard Federal rate to account for the estimated $5.68 million budgetary impact for the Medicare program in FY 2003 as a result of the change to the 2004 LTCH PPS rate year cycle.

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 principles. 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 principles. 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 2004 LTCH PPS rate year, it is necessary to estimate payments per discharge under the current (Federal FY 2003) LTCH PPS rates and factors (*see* the August 30, 2002, final rule) and payments per discharge that will be made under the LTCH PPS rates and factors for the 2004 LTCH PPS rate year (July 1, 2003, through June 30, 2004). We also evaluated the percent change in payments per discharge of estimated FY 2003 prospective payments to estimated 2004 LTCH PPS rate year payments for each category of LTCHs.

Hospital groups were based on characteristics provided in OSCAR data and FYs 1998 through 2000 cost report data from HCRIS. 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 principle 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 principle payments and the option to elect payment based on 100 percent of the Federal rate (Table VII below), we estimated payments only for those providers for whom we are able to calculate payments based on reasonable cost-based principles. For example, if we did not have FYs 1996 through 1999 cost data for a LTCH, we were unable to determine an update to the LTCH's target amount to estimate payment under the current reasonable cost-based principles.

Using LTCH cases from the FY 2001 MedPAR file and cost data from FYs 1996 through 2000 in HCRIS to estimate payments under the current reasonable cost-based principles, we have both case-mix and cost data for 194 LTCHs. Thus, for the impact analyses reflecting the applicable transition blend percentages of prospective payments and reasonable cost-based principle payments and the option to elect payment based on 100 percent of the Federal rate (*see* Table VI below), we used data from 194 LTCHs. While currently there are approximately 280 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 194 LTCHs in our database provide sufficient representation in the LTC–DRGs containing discharges for patients that received respiratory and ventilator-dependent care. However,

using cases from the FY 2001 MedPAR file, we had case-mix data for 250 LTCHs. Cost data to determine current payments under reasonable cost-based principle 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 VII below), we used data from 250 LTCHs.

These impacts reflect the estimated ''losses'' or ''gains'' among the various classifications of providers for the 12-month period from October 1, 2002, through September 30, 2003 (Federal FY 2003), compared to the 12-month period from July 1, 2003, through June 30, 2004 (2004 LTCH PPS rate year). 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 2001 claims data. Prospective payments for Federal FY 2003 were based on the standard Federal rate of $34,956.15 and the same FY 2001 claims data.

3. Calculation of Prospective Payments

To estimate payments under the LTCH PPS, we simulated payments on a case-by-case basis by applying the payment policy for short-stay outliers (as described in section VII.C.4.b of this final rule) and the adjustments for area wage differences (as described in section VII.C.1 of this final rule) and for the cost-of-living for Alaska and Hawaii (as described in section VII.C.2 of this final rule). Additional payments would also be made for high-cost outlier cases (as described in section VII.C.3 of this final rule). As noted in section VII.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.

We adjusted for area wage differences for estimated FY 2003 payments by using the applicable LTCH PPS wage index (one-fifth of the full FY 2002 acute care hospital inpatient wage index data, without taking into account geographic reclassification under sections 1886(d)(8) and 1886(d)(10) of the Act (*see* August 30, 2002, 67 FR 56057–56075). For the estimated 2004 LTCH PPS rate year payments, we used a weighted average of a LTCH's applicable wage index during the period from July 1, 2003, through June 30, 2004, since some providers may experience a change in the wage index phase-in percentage during the period from July 1, 2003, through June 30, 2004. 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. 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. The applicable LTCH PPS wage index values are computed using the same data to compute the acute care hospital inpatient wage index data, without taking into account geographic reclassification under sections 1886(d)(8) and 1886(d)(10) of the Act (as discussed in section VII.C.1. of this final rule). Therefore, a provider with a cost reporting period beginning 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.

We also calculated payments using the applicable transition blend percentages. For FY 2003, the applicable transition blend percentage is 80 percent of payment based on reasonable cost-based principles and 20 percent of payment under the LTCH PPS. For 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. For example during the 12-month 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 principles and 20 percent of payments under the LTCH PPS), beginning October 1, 2002) will have 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 principles and 40 percent of payments under the LTCH PPS). (The 60 percent/40 percent blend would continue until the provider's cost report period beginning on October 1, 2004.) In estimating blended transition payments, we estimated payments based on reasonable cost-based principles in accordance with the methodology in section 1886(b) of the Act. 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 a 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 6.6 percent 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 established in the August 30, 2002, final rule (67 FR 56034) to each LTCH's estimated payments under the LTCH PPS for FY 2003. Similarly, we applied the 6.0 percent 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 VII.C.6 of this final rule) to each LTCH's estimated payments under the LTCH PPS for the 2004 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 VI.

In Table VII 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 Federal FY 2003 and the 2004 LTCH PPS rate year. Accordingly, the 6.0 percent reduction to account for the 5-year transition methodology on LTCHs' Medicare program payments for the 2004 LTCH PPS rate year and the 6.6 percent reduction to account for the 5-year transition methodology on LTCHs' Medicare program payments established for FY 2003 were not applied to LTCHs' estimated payments under the PPS.

Tables VI and VII 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 FY 2003.
- The fifth column shows the estimated payment per discharge for the 2004 LTCH PPS rate year.

• The sixth column shows the percent change of FY 2003 compared to the 2004 LTCH PPS rate year.

TABLE VI.—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]

[FY 2003 payments compared to 2004 LTCH prospective payment system rate year]

LTCH classification	Number of LTCHs	Number of LTCH cases	Average federal FY 2003 payment per case [2]	Average 2004 LTCH prospective payment system rate year payment per case [3]	Percent change
All Providers	194	71,861	26,751	27,202	1.7
By Location:					
Rural	7	2,153	20,381	20,807	2.1
Urban	187	69,708	26,947	27,400	1.7
Large	113	47,743	27,232	27,695	1.7
Other	74	21,965	26,329	26,757	1.6
By Participation Date:					
After October 1993	129	42,973	27,983	28,452	1.7
Before October 1983	16	7,846	20,204	20,262	0.3
October 1983–September 1993	48	20,810	26,531	27,063	2.0
Unknown	1	232	39,515	42,895	8.6
By Ownership Control:					
Voluntary	48	17,741	24,561	25,032	1.9
Proprietary	136	51,655	27,562	27,980	1.5
Government	10	2,465	25,513	26,531	4.0
By Census Region:					
New England	14	9,499	20,371	20,286	-0.4
Middle Atlantic	9	3,282	28,390	28,069	–1.1
South Atlantic	20	6,573	30,805	31,580	2.5
East North Central	33	9,061	28,862	29,454	2.1
East South Central	10	2,863	26,516	26,163	–1.3
West North Central	11	2,906	26,278	26,940	2.5
West South Central	71	30,262	25,842	26,464	2.4
Mountain	15	2,495	28,049	28,611	2.0
Pacific	11	4,920	34,011	34,566	1.6
By Bed Size:					
Beds: 0–24	17	2,456	28,815	29,591	2.7
Beds: 25–49	88	21,734	28,129	28,507	1.3
Beds: 50–74	24	8,214	28,780	28,592	–0.7
Beds: 75–124	34	16,310	26,821	27,673	3.2
Beds: 125–199	21	13,838	24,430	24,558	0.5
Beds: 200+	9	9,228	24,671	25,559	3.6
Unknown	1	81	7,668	7,937	3.5

[1] These calculations take into account that some providers may experience a change in the blend percentage changes during the July 1, 2003, through June 30, 2004, rate year. For example, during the 12-month 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 October 1, 2002, through September 30, 2003.

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

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

[FY 2003 payments compared to 2004 LTCH prospective payment system rate year payments]

LTCH classification	Number of LTCHs	Number of LTCH cases	Average Federal FY 2003 payment per case [1]	Average 2004 LTCH prospective payment system rate year payment per case [2]	Percent change
All Providers	250	82,625	26,357	26,951	2.2
By Location:					
Rural	16	4,674	20,851	21,013	0.8
Urban	234	77,951	26,687	27,307	2.3
Large	135	52,256	27,027	27,651	2.3
Other	99	25,695	25,996	26,607	2.3
By Participation Date:					
After October 1993	182	53,246	27,178	27,740	2.1

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

[FY 2003 payments compared to 2004 LTCH prospective payment system rate year payments]

LTCH classification	Number of LTCHs	Number of LTCH cases	Average Federal FY 2003 payment per case [1]	Average 2004 LTCH prospective payment system rate year payment per case [2]	Percent change
Before October 1983	17	7,897	20,826	20,881	0.3
October 1983—September 1993	49	21,257	26,230	27,138	3.5
Unknown	2	743	25,318	26,537	4.8
By Ownership Control:					
Voluntary	55	19,853	24,314	24,833	2.1
Proprietary	148	54,269	27,490	28,052	2.0
Government	47	8,503	23,893	24,864	4.1
By Census Region:					
New England	16	9,609	21,094	21,009	−0.4
Middle Atlantic	15	4,162	28,982	28,607	−1.3
South Atlantic	23	7,051	30,441	31,289	2.8
East North Central	48	12,145	28,356	29,074	2.5
East South Central	14	3,722	28,561	28,496	−0.2
West North Central	16	3,769	26,347	27,245	3.4
West South Central	87	33,971	24,560	25,384	3.4
Mountain	19	2,993	26,529	27,567	3.9
Pacific	12	5,203	33,836	34,323	1.4
By Bed Size:					
Beds: 0–24	21	3,073	27,130	28,221	4.0
Beds: 25–49	98	24,386	27,954	28,222	1.0
Beds: 50–74	27	9,310	27,556	27,610	0.2
Beds: 75–124	35	16,432	26,222	27,475	4.8
Beds: 125–199	21	13,838	24,945	25,148	0.8
Beds: 200+	11	9,518	25,041	26,054	4.0
Unknown	37	6,068	23,354	24,284	4.0

[1] Average payment per case for the 12-month period of October 1, 2002, through September 30, 2003.
[2] Average payment per case for the 12-month period of July 1, 2003, through June 30, 2004.

4. Results

We have prepared the following summary of the impact (as shown in Table VI) of the LTCH PPS set forth in this proposed rule.

a. Location. The majority of LTCHs are in urban areas. Approximately 3 percent of the LTCHs are identified as being located in a rural area, and approximately 3 percent of all LTCH cases are treated in these rural hospitals. Impact analysis in Table VI shows that the percent change in estimated payments per discharge for FY 2003 compared to the 2004 LTCH PPS rate year for rural LTCHs will be 2.1 percent, and will be 1.7 percent for urban LTCHs. Large urban LTCHs are projected to experience a 1.7 percent increase in payments per discharge percent from FY 2003 compared to the 2004 LTCH PPS rate year, while other urban LTCHs projected to experience a 1.6 percent increase in payments per discharge percent from FY 2003 compared to the 2004 LTCH PPS rate year. (*See* Table VI.)

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) after October 1993. We did not have sufficient OSCAR data on 1 LTCH, which we labeled as an ''Unknown'' category. The majority, approximately 60 percent, of the LTCH cases are in hospitals that began participating after October 1993 and are projected to experience a 1.7 percent increase in payments per discharge from FY 2003 compared to the 2004 LTCH PPS rate year. Approximately 11 percent of the cases are in LTCHs that began participating in Medicare before October 1983 and are projected to experience a 0.3 percent increase in payments per discharge percent from FY 2003 compared to the 2004 LTCH PPS rate year. LTCHs that began participating between October 1983 and September 1993 are projected to experience a 2.0 percent increase in payments per discharge from FY 2003 compared to the 2004 LTCH PPS rate year. (*See* Table VI.)

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

Approximately 5 percent of LTCHs are government run and we expect that they will ''gain'' the most from the changes based on our projection that they will experience a 4.0 percent increase in payments per discharge from FY 2003 compared to the 2004 LTCH PPS rate year. Voluntary and proprietary LTCHs are projected to experience a 1.9 percent and 1.5 percent increase in payments per discharge percent from FY 2003 compared to the 2004 LTCH PPS rate year, respectively. (*See* Table VI.)

d. Census Region. LTCHs located in most regions are expected to experience an increase in payments per discharge percent from FY 2003 compared to the 2004 LTCH PPS rate year. Specifically, of the nine census regions, we expect that LTCHs in the South Atlantic and West North Central regions will experience the largest percent increase in payments per discharge percent from FY 2003 compared to the 2004 LTCH PPS rate year (2.5 percent). We expect LTCHs in the Pacific region will experience the smallest percent increase in payments per discharge percent from FY 2003 compared to the 2004 LTCH PPS rate year (1.6 percent). (*See* Table VI.)

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. We did not have sufficient OSCAR data on

1 LTCH, which we labeled as an ''Unknown'' category.

The percent increase in payments per discharge percent from FY 2003 compared to the 2004 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 FY 2003 compared to the 2004 LTCH PPS rate year is estimated to be greater than 1.0 percent. Other than the LTCH whose bed size is unknown, LTCHs with 200 or more beds have the highest estimated percent change in payments per discharge percent from FY 2003 compared to the 2004 LTCH PPS rate year (3.6 percent), while LTCHs with 125–199 beds have the lowest projected increase in the percent change in payments per discharge percent from FY 2003 compared to the 2004 LTCH PPS rate year (0.5 percent). (*See* Table VI.)

5. Effect on the Medicare Program

Based on actuarial projections resulting from our experience with other prospective payment systems, 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)
2004	$2.17
2005	2.29
2006	2.42
2007	2.56
2008	2.71

These estimates are based on the current estimate of increase in the excluded hospital market with capital basket of 2.5 percent for 2004 LTCH PPS rate year (adjusted to account for the change in the rate update cycle discussed in section VII.B.1.b of the preamble of this final rule), 3.2 percent for the 2005 LTCH PPS rate year, 3.1 percent for the 2006 and 2007 LTCH PPS rate years, and 3.0 percent for the 2008 LTCH PPS rate year. We currently estimate that there will be an increase in Medicare beneficiary enrollment of 1.3 percent in 2004 LTCH PPS rate year, 1.6 percent in 2005 LTCH PPS rate year, 1.9 percent in 2006 LTCH PPS rate year, 2.0 percent in 2007 LTCH PPS rate year, 2.1 percent in 2008 LTCH PPS rate year, and an estimated increase in the total number of LTCHs.

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 will 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 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). To the extent the 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 are based.

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 implemented for cost reporting periods beginning on or after October 1, 2002, we do not yet have sufficient data to determine whether such an adjustment is warranted.

6. Effect on Medicare Beneficiaries

Under the LTCH PPS, hospitals will 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. 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 412.22 is amended by revising paragraph (h)(2) introductory text and adding a new paragraph (h)(6) to read as follows:

§ 412.22 Excluded hospitals and hospital units: General rules.

* * * * *

(h) *Satellite facilities.* * * *

(2) Except as provided in paragraphs (h)(3) and (h)(6) of this section, effective for cost reporting periods beginning on or after October 1, 1999, a hospital that has a satellite facility must meet the following criteria in order to be excluded from the prospective payment systems for any period:

* * * * *

(6) The provisions of paragraph (h)(2)(i) of this section do not apply to any long-term care hospital that is subject to the long-term care hospital prospective payment system under Subpart O of this part, effective for cost reporting periods occurring on or after October 1, 2002, and that elects to be paid based on 100 percent of the Federal prospective payment rate as specified in § 412.533(c), beginning with the first cost reporting period following that election, or when the LTCH is fully transitioned to 100 percent of the Federal prospective rate, or to a new long-term care hospital, as defined in § 412.23(e)(4).

■ 3. Section 412.503 is amended by adding a definition of ''long-term care hospital prospective payment system rate year'' in alphabetical order to read as follows:

§ 412.503 Definitions.

* * * * *

Long-term care hospital prospective payment system rate year means the 12-month period of July 1 through June 30.

* * * * *

■ 4. Section 412.523 is amended by revising paragraphs (c)(3) and (d)(3) to read as follows:

§ 412.523 Methodology for calculating the Federal prospective payment rates.

* * * * *

(c) * * *

(3) *Computation of the standard Federal rate.* The standard Federal rate is computed as follows:

(i) *For FY 2003.* Based on the updated costs per discharge and estimated

payments for FY 2003 determined in paragraph (c)(2) of this section, CMS computes a standard Federal rate for FY 2003 that reflects, as appropriate, the adjustments described in paragraph (d) of this section. The FY 2003 standard Federal rate is effective for discharges occurring in cost reporting periods beginning on or after October 1, 2002 through June 30, 2003.

(ii) *For long-term care hospital prospective payment system rate years beginning July 1, 2003 and after.* The standard Federal rate for long-term care hospital prospective payment system rate years beginning July 1, 2003 and after will be the standard Federal rate for the previous long-term care hospital prospective payment system rate year, updated by the increase factor described in paragraph (a)(2) of this section, and adjusted, as appropriate, as described in paragraph (d) of this section. For the rate year from July 1, 2003 through June 30, 2004, the updated and adjusted standard Federal rate will be offset by a budget neutrality factor to account for updating the FY 2003 standard Federal rate on July 1 rather than October 1.

* * * * *

(d) * * *

(3) *One-time prospective adjustment.* The Secretary will review payments under this prospective payment system and may make a one-time prospective adjustment to the long-term care hospital prospective payment system 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 long-term care hospital prospective payment system is not perpetuated in the prospective payment rates for future years.

* * * * *

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

§ 412.525 Adjustments to the Federal prospective payment.

(a) *Adjustments for high-cost outliers.*

(1) CMS provides for an additional payment to a long-term care hospital if its estimated costs for a patient exceed the adjusted LTC–DRG payment plus a fixed-loss amount. For each long-term care hospital rate year, CMS determines a fixed-loss amount that is the maximum loss that a hospital can incur under the prospective payment system for a case with unusually high costs.

(2) The fixed-loss amount is determined for the long-term care hospital rate year using the LTC–DRG relative weights that are in effect on July 1 of the rate year.

(3) The additional payment equals 80 percent of the difference between the estimated cost of the patient care (determined by multiplying the hospital-specific cost-to-charge ratios by the Medicare allowable covered charge) and the sum of the adjusted Federal prospective payment for the LTC–DRG prospective payment system payment and the fixed-loss amount.

(4) No retroactive adjustments will be made to outlier payments upon cost report settlement to account for differences between the estimated cost-to-charge ratio and the actual cost-to-charge ratio of the case.

* * * * *

■ 6. Section 412.529 is amended by:

■ A. Revising paragraph (c)(1) introductory text.

■ B. Redesignating paragraph (c)(4) as paragraph (c)(5) and removing the term ''LTCH's'' and adding the term ''long-term care hospital's'' in its place.

■ C. Adding a new paragraph (c)(4).

§ 412.529 Special payment provision for short-stay outliers.

* * * * *

(c) *Method for determining the payment amount.*

(1) Subject to the provisions of paragraph (c)(4) of this section, the adjusted payment amount for a short-stay outlier is the least of the following amounts:

* * * * *

(4) Effective for discharges occurring on or after July 1, 2003, for long-term care hospitals described under § 412.23(e)(2)(ii), the adjusted payment amount for a short-stay outlier is determined under the formula set forth in paragraph (c)(1) of this section with the following substitution of the percentages specified for the LTG-DRG specific per diem amount and the cost of the case under paragraphs (c)(1)(i) and (c)(1)(ii) of this section:

(i) For the 1st year of the transition period, as specified at § 412.533(a)(1), the percentage is 195 percent.

(ii) For the 2nd year of the transition period, as specified at § 412.533(a)(2), the percentage is 193 percent;

(iii) For the 3rd year of the transition period, as specified at § 412.533(a)(3), the percentage is 165 percent;

(iv) For the 4th year of the transition period, as specified at § 412.533(a)(4), the percentage is 136 percent;

(v) For the 5th year of the transition period and after, as specified at § 412.533(a)(5), the percentage is 120 percent.

* * * * *

■ 7. Section 412.535 is revised to read as follows:

§ 412.535 Publication of the Federal prospective payment rates.

CMS publishes information pertaining to the long-term care hospital prospective payment system effective for each annual update in the **Federal Register**.

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

(b) Information on the LTC–DRG classification and associated weighting factors is published on or before August 1 prior to the beginning of each Federal fiscal year.

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

Dated: May 28, 2003.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Dated: May 28, 2003.

Tommy G. Thompson,

Secretary.

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, 2003, through June 30, 2004.

Table 2.—Long-Term Care Hospital Wage Index for Rural Areas for Discharges Occurring from July 1, 2003, through June 30, 2004.

Table 3.—LTC–DRG Relative Weights, Geometric Mean Length of Stay, and Short-Stay Five-Sixths Average Length of Stay for the Period of July 1, 2003, through September 30, 2003.

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2003 THROUGH JUNE 30, 2004

MSA	Urban Area (Constituent Counties)	Full Wage Index [1]	1/5th Wage Index [2]	2/5th Wage Index [3]
0040	Abilene, TX	0.7792	0.9558	0.9117
	Taylor, TX			
0060	Aguadilla, PR	0.4587	0.8917	0.7835
	Aguada, PR			
	Aguadilla, PR			
	Moca, PR			
0080	Akron, OH	0.9600	0.9920	0.9840
	Portage, OH			
	Summit, OH			
0120	Albany, GA	1.0594	1.0119	1.0238
	Dougherty, GA			
	Lee, GA			
0160	Albany-Schenectady-Troy, NY	0.8384	0.9677	0.9354
	Albany, NY			
	Montgomery, NY			
	Rensselaer, NY			
	Saratoga, NY			
	Schenectady, NY			
	Schoharie, NY			
0200	Albuquerque, NM	0.9315	0.9863	0.9726
	Bernalillo, NM			
	Sandoval, NM			
	Valencia, NM			
0220	Alexandria, LA	0.7859	0.9572	0.9144
	Rapides, LA			
0240	Allentown-Bethlehem-Easton, PA	0.9735	0.9947	0.9894
	Carbon, PA			
	Lehigh, PA			
	Northampton, PA			
0280	Altoona, PA	0.9225	0.9845	0.9690
	Blair, PA			
0320	Amarillo, TX	0.9034	0.9807	0.9614
	Potter, TX			
	Randall, TX			
0380	Anchorage, AK	1.2358	1.0472	1.0943
	Anchorage, AK			
0440	Ann Arbor, MI	1.1103	1.0221	1.0441
	Lenawee, MI			
	Livingston, MI			
	Washtenaw, MI			
0450	Anniston, AL	0.8044	0.9609	0.9218
	Calhoun, AL			
0460	Appleton-Oshkosh-Neenah, WI	0.8997	0.9799	0.9599
	Calumet, WI			
	Outagamie, WI			
	Winnebago, WI			
0470	Arecibo, PR	0.4337	0.8867	0.7735
	Arecibo, PR			
	Camuy, PR			
	Hatillo, PR			
0480	Asheville, NC	0.9876	0.9975	0.9950
	Buncombe, NC			
	Madison, NC			
0500	Athens, GA	1.0211	1.0042	1.0084
	Clarke, GA			
	Madison, GA			
	Oconee, GA			
0520	Atlanta, GA	0.9991	0.9998	0.9996
	Barrow, GA			
	Bartow, GA			
	Carroll, GA			
	Cherokee, GA			
	Clayton, GA			
	Cobb, GA			
	Coweta, GA			
	DeKalb, GA			
	Douglas, GA			
	Fayette, GA			
	Forsyth, GA			
	Fulton, GA			

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2003 THROUGH JUNE 30, 2004—Continued

MSA	Urban Area (Constituent Counties)	Full Wage Index [1]	1/5th Wage Index [2]	2/5th Wage Index [3]
	Gwinnett, GA Henry, GA Newton, GA Paulding, GA Pickens, GA Rockdale, GA Spalding, GA Walton, GA			
0560	Atlantic-Cape May, NJ Atlantic, NJ Cape May, NJ	1.1017	1.0203	1.0407
0580	Auburn-Opelika, AL Lee, AL	0.8325	0.9665	0.9330
0600	Augusta-Aiken, GA-SC Columbia, GA McDuffie, GA Richmond, GA Aiken, SC Edgefield, SC	1.0264	1.0053	1.0106
0640	Austin-San Marcos, TX Bastrop, TX Caldwell, TX Hays, TX Travis, TX Williamson, TX	0.9637	0.9927	0.9855
0680	Bakersfield, CA Kern, CA	0.9877	0.9975	0.9951
0720	Baltimore, MD Anne Arundel, MD Baltimore, MD Baltimore City, MD Carroll, MD Harford, MD Howard, MD Queen Anne's, MD	0.9929	0.9986	0.9972
0733	Bangor, ME Penobscot, ME	0.9664	0.9933	0.9866
0743	Barnstable-Yarmouth, MA Barnstable, MA	1.3202	1.0640	1.1281
0760	Baton Rouge, LA Ascension, LA East Baton Rouge, LA Livingston, LA West Baton Rouge, LA	0.8294	0.9659	0.9318
0840	Beaumont-Port Arthur, TX Hardin, TX Jefferson, TX Orange, TX	0.8324	0.9665	0.9330
0860	Bellingham, WA Whatcom, WA	1.2282	1.0456	1.0913
0870	Benton Harbor, MI Berrien, MI	0.8965	0.9793	0.9586
0875	Bergen-Passaic, NJ Bergen, NJ Passaic, NJ	1.2150	1.0430	1.0860
0880	Billings, MT Yellowstone, MT	0.9022	0.9804	0.9609
0920	Biloxi-Gulfport-Pascagoula, MS Hancock, MS Harrison, MS Jackson, MS	0.8757	0.9751	0.9503
0960	Binghamton, NY Broome, NY Tioga, NY	0.8341	0.9668	0.9336
1000	Birmingham, AL Blount, AL Jefferson, AL St. Clair, AL Shelby, AL	0.9222	0.9844	0.9689
1010	Bismarck, ND	0.7972	0.9594	0.9189

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2003 THROUGH JUNE 30, 2004—Continued

MSA	Urban Area (Constituent Counties)	Full Wage Index [1]	1/5th Wage Index [2]	2/5th Wage Index [3]
	Burleigh, ND			
	Morton, ND			
1020	Bloomington, IN	0.8907	0.9781	0.9563
	Monroe, IN			
1040	Bloomington-Normal, IL	0.9109	0.9822	0.9644
	McLean, IL			
1080	Boise City, ID	0.9310	0.9862	0.9724
	Ada, ID			
	Canyon, ID			
1123	Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH (NH Hospitals)	1.1229	1.0246	1.0492
	Bristol, MA			
	Essex, MA			
	Middlesex, MA			
	Norfolk, MA			
	Plymouth, MA			
	Suffolk, MA			
	Worcester, MA			
	Hillsborough, NH			
	Merrimack, NH			
	Rockingham, NH			
	Strafford, NH			
1125	Boulder-Longmont, CO	0.9689	0.9938	0.9876
	Boulder, CO			
1145	Brazoria, TX	0.8535	0.9707	0.9414
	Brazoria, TX			
1150	Bremerton, WA	1.0944	1.0189	1.0378
	Kitsap, WA			
1240	Brownsville-Harlingen-San Benito, TX	0.8880	0.9776	0.9552
	Cameron, TX			
1260	Bryan-College Station, TX	0.8821	0.9764	0.9528
	Brazos, TX			
1280	Buffalo-Niagara Falls, NY	0.9365	0.9873	0.9746
	Erie, NY			
	Niagara, NY			
1303	Burlington, VT	1.0052	1.0010	1.0021
	Chittenden, VT			
	Franklin, VT			
	Grand Isle, VT			
1310	Caguas, PR	0.4371	0.8874	0.7748
	Caguas, PR			
	Cayey, PR			
	Cidra, PR			
	Gurabo, PR			
	San Lorenzo, PR			
1320	Canton-Massillon, OH	0.8932	0.9786	0.9573
	Carroll, OH			
	Stark, OH			
1350	Casper, WY	0.9690	0.9938	0.9876
	Natrona, WY			
1360	Cedar Rapids, IA	0.9056	0.9811	0.9622
	Linn, IA			
1400	Champaign-Urbana, IL	1.0635	1.0127	1.0254
	Champaign, IL			
1440	Charleston-North Charleston, SC	0.9235	0.9847	0.9694
	Berkeley, SC			
	Charleston, SC			
	Dorchester, SC			
1480	Charleston, WV	0.8898	0.9780	0.9559
	Kanawha, WV			
	Putnam, WV			
1520	Charlotte-Gastonia-Rock Hill, NC-SC	0.9875	0.9975	0.9950
	Cabarrus, NC			
	Gaston, NC			
	Lincoln, NC			
	Mecklenburg, NC			
	Rowan, NC			
	Stanly, NC			
	Union, NC			
	York, SC			
1540	Charlottesville, VA	1.0438	1.0088	1.0175

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2003 THROUGH JUNE 30, 2004—Continued

MSA	Urban Area (Constituent Counties)	Full Wage Index [1]	1/5th Wage Index [2]	2/5th Wage Index [3]
	Albemarle, VA			
	Charlottesville City, VA			
	Fluvanna, VA			
	Greene, VA			
1560	Chattanooga, TN-GA	0.8976	0.9795	0.9590
	Catoosa, GA			
	Dade, GA			
	Walker, GA			
	Hamilton, TN			
	Marion, TN			
1580	Cheyenne, WY	0.8628	0.9726	0.9451
	Laramie, WY			
1600	Chicago, IL	1.1044	1.0209	1.0418
	Cook, IL			
	DeKalb, IL			
	DuPage, IL			
	Grundy, IL			
	Kane, IL			
	Kendall, IL			
	Lake, IL			
	McHenry, IL			
	Will, IL			
1620	Chico-Paradise, CA	0.9745	0.9949	0.9898
	Butte, CA			
1640	Cincinnati, OH-KY-IN	0.9381	0.9876	0.9752
	Dearborn, IN			
	Ohio, IN			
	Boone, KY			
	Campbell, KY			
	Gallatin, KY			
	Grant, KY			
	Kenton, KY			
	Pendleton, KY			
	Brown, OH			
	Clermont, OH			
	Hamilton, OH			
	Warren, OH			
1660	Clarksville-Hopkinsville, TN-KY	0.8406	0.9681	0.9362
	Christian, KY			
	Montgomery, TN			
1680	Cleveland-Lorain-Elyria, OH	0.9670	0.9934	0.9868
	Ashtabula, OH			
	Cuyahoga, OH			
	Geauga, OH			
	Lake, OH			
	Lorain, OH			
	Medina, OH			
1720	Colorado Springs, CO	0.9916	0.9983	0.9966
	El Paso, CO			
1740	Columbia, MO	0.8496	0.9699	0.9398
	Boone, MO			
1760	Columbia, SC	0.9307	0.9861	0.9723
	Lexington, SC			
	Richland, SC			
1800	Columbus, GA-ALRussell, AL	0.8374	0.9675	0.9350
	Chattahoochee, GA			
	Harris, GA			
	Muscogee, GA			
1840	Columbus, OH	0.9751	0.9950	0.9900
	Delaware, OH			
	Fairfield, OH			
	Franklin, OH			
	Licking, OH			
	Madison, OH			
	Pickaway, OH			
1880	Corpus Christi, TX	0.8729	0.9746	0.9492
	Nueces, TX			
	San Patricio, TX			
1890	Corvallis, OR	1.1453	1.0291	1.0581
	Benton, OR			

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2003 THROUGH JUNE 30, 2004—Continued

MSA	Urban Area (Constituent Counties)	Full Wage Index [1]	1/5th Wage Index [2]	2/5th Wage Index [3]
1900	Cumberland, MD-WV (WV Hospital)	0.7847	0.9569	0.9139
	Allegany, MD			
	Mineral, WV			
1920	Dallas, TX	0.9998	1.0000	0.9999
	Collin, TX			
	Dallas, TX			
	Denton, TX			
	Ellis, TX			
	Henderson, TX			
	Hunt, TX			
	Kaufman, TX			
	Rockwall, TX			
1950	Danville, VA	0.8859	0.9772	0.9544
	Danville City, VA			
	Pittsylvania, VA			
1960	Davenport-Moline-Rock Island, IA-IL	0.8835	0.9767	0.9534
	Scott, IA			
	Henry, IL			
	Rock Island, IL			
2000	Dayton-Springfield, OH	0.9282	0.9856	0.9713
	Clark, OH			
	Greene, OH			
	Miami, OH			
	Montgomery, OH			
2020	Daytona Beach, FL	0.9071	0.9814	0.9628
	Flagler, FL			
	Volusia, FL			
2030	Decatur, AL	0.8973	0.9795	0.9589
	Lawrence, AL			
	Morgan, AL			
2040	Decatur, IL	0.8055	0.9611	0.9222
	Macon, IL			
2080	Denver, CO	1.0601	1.0120	1.0240
	Adams, CO			
	Arapahoe, CO			
	Denver, CO			
	Douglas, CO			
	Jefferson, CO			
2120	Des Moines, IA	0.8791	0.9758	0.9516
	Dallas, IA			
	Polk, IA			
	Warren, IA			
2160	Detroit, MI	1.0448	1.0090	1.0179
	Lapeer, MI			
	Macomb, MI			
	Monroe, MI			
	Oakland, MI			
	St. Clair, MI			
	Wayne, MI			
2180	Dothan, AL	0.8137	0.9627	0.9255
	Dale, AL			
	Houston, AL			
2190	Dover, DE	0.9356	0.9871	0.9742
	Kent, DE			
2200	Dubuque, IA	0.8795	0.9759	0.9518
	Dubuque, IA			
2240	Duluth-Superior, MN-WI	1.0368	1.0074	1.0147
	St. Louis, MN			
	Douglas, WI			
2281	Dutchess County, NY	1.0684	1.0137	1.0274
	Dutchess, NY			
2290	Eau Claire, WI	0.8952	0.9790	0.9581
	Chippewa, WI			
	Eau Claire, WI			
2320	El Paso, TX	0.9265	0.9853	0.9706
	El Paso, TX			
2330	Elkhart-Goshen, IN	0.9722	0.9944	0.9889
	Elkhart, IN			
2335	Elmira, NY	0.8416	0.9683	0.9366
	Chemung, NY			

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2003 THROUGH JUNE 30, 2004—Continued

MSA	Urban Area (Constituent Counties)	Full Wage Index [1]	1/5th Wage Index [2]	2/5th Wage Index [3]
2340	Enid, OK	0.8376	0.9675	0.9350
	Garfield, OK			
2360	Erie, PA	0.8925	0.9785	0.9570
	Erie, PA			
2400	Eugene-Springfield, OR	1.0944	1.0189	1.0378
	Lane, OR			
2440	Evansville-Henderson, IN-KY (IN Hospitals)	0.8177	0.9635	0.9271
	Posey, IN			
	Vanderburgh, IN			
	Warrick, IN			
	Henderson, KY			
2520	Fargo-Moorhead, ND-MN	0.9684	0.9937	0.9874
	Clay, MN			
	Cass, ND			
2560	Fayetteville, NC	0.8889	0.9778	0.9556
	Cumberland, NC			
2580	Fayetteville-Springdale-Rogers, AR	0.8100	0.9620	0.9240
	Benton, AR			
	Washington, AR			
2620	Flagstaff, AZ-UT	1.0682	1.0136	1.0273
	Coconino, AZ			
	Kane, UT			
2640	Flint, MI	1.1135	1.0227	1.0454
	Genesee, MI			
2650	Florence, AL	0.7792	0.9558	0.9117
	Colbert, AL			
	Lauderdale, AL			
2655	Florence, SC	0.8780	0.9756	0.9512
	Florence, SC			
2670	Fort Collins-Loveland, CO	1.0066	1.0013	1.0026
	Larimer, CO			
2680	Ft. Lauderdale, FL	1.0297	1.0059	1.0119
	Broward, FL			
2700	Fort Myers-Cape Coral, FL	0.9680	0.9936	0.9872
	Lee, FL			
2710	Fort Pierce-Port St. Lucie, FL	0.9823	0.9965	0.9929
	Martin, FL			
	St. Lucie, FL			
2720	Fort Smith, AR-OK	0.7895	0.9579	0.9158
	Crawford, AR			
	Sebastian, AR			
	Sequoyah, OK			
2750	Fort Walton Beach, FL	0.9693	0.9939	0.9877
	Okaloosa, FL			
2760	Fort Wayne, IN	0.9457	0.9891	0.9783
	Adams, IN			
	Allen, IN			
	De Kalb, IN			
	Huntington, IN			
	Wells, IN			
	Whitley, IN			
2800	Forth Worth-Arlington, TX	0.9446	0.9889	0.9778
	Hood, TX			
	Johnson, TX			
	Parker, TX			
	Tarrant, TX			
2840	Fresno, CA	1.0169	1.0034	1.0068
	Fresno, CA			
	Madera, CA			
2880	Gadsden, AL	0.8505	0.9701	0.9402
	Etowah, AL			
2900	Gainesville, FL	0.9871	0.9974	0.9948
	Alachua, FL			
2920	Galveston-Texas City, TX	0.9465	0.9893	0.9786
	Galveston, TX			
2960	Gary, IN	0.9584	0.9917	0.9834
	Lake, IN			
	Porter, IN			
2975	Glens Falls, NY	0.8281	0.9656	0.9312
	Warren, NY			

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2003 THROUGH JUNE 30, 2004—Continued

MSA	Urban Area (Constituent Counties)	Full Wage Index [1]	1/5th Wage Index [2]	2/5th Wage Index [3]
	Washington, NY			
2980	Goldsboro, NC	0.8892	0.9778	0.9557
	Wayne, NC			
2985	Grand Forks, ND-MN	0.8897	0.9779	0.9559
	Polk, MN			
	Grand Forks, ND			
2995	Grand Junction, CO	0.9456	0.9891	0.9782
	Mesa, CO			
3000	Grand Rapids-Muskegon-Holland, MI	0.9525	0.9905	0.9810
	Allegan, MI			
	Kent, MI			
	Muskegon, MI			
	Ottawa, MI			
3040	Great Falls, MT	0.8950	0.9790	0.9580
	Cascade, MT			
3060	Greeley, CO	0.9237	0.9847	0.9695
	Weld, CO			
3080	Green Bay, WI	0.9502	0.9900	0.9801
	Brown, WI			
3120	Greensboro-Winston-Salem-High Point, NC	0.9282	0.9856	0.9713
	Alamance, NC			
	Davidson, NC			
	Davie, NC			
	Forsyth, NCGuilford, NC			
	Randolph, NC			
	Stokes, NC			
	Yadkin, NC			
3150	Greenville, NC	0.9100	0.9820	0.9640
	Pitt, NC			
3160	Greenville-Spartanburg-Anderson, SC	0.9122	0.9824	0.9649
	Anderson, SC			
	Cherokee, SC			
	Greenville, SC			
	Pickens, SC			
	Spartanburg, SC			
3180	Hagerstown, MD	0.9268	0.9854	0.9707
	Washington, MD			
3200	Hamilton-Middletown, OH	0.9418	0.9884	0.9767
	Butler, OH			
3240	Harrisburg-Lebanon-Carlisle, PA	0.9223	0.9845	0.9689
	Cumberland, PA			
	Dauphin, PA			
	Lebanon, PA			
	Perry, PA			
3283	Hartford, CT	1.1549	1.0310	1.0620
	Hartford, CT			
	Litchfield, CT			
	Middlesex, CT			
	Tolland, CT			
3285	Hattiesburg, MS	0.7659	0.9532	0.9064
	Forrest, MS			
	Lamar, MS			
3290	Hickory-Morganton-Lenoir, NC	0.9028	0.9806	0.9611
	Alexander, NC			
	Burke, NC			
	Caldwell, NC			
	Catawba, NC			
3320	Honolulu, HI	1.1457	1.0291	1.0583
	Honolulu, HI			
3350	Houma, LA	0.8317	0.9663	0.9327
	Lafourche, LA			
	Terrebonne, LA			
3360	Houston, TX	0.9892	0.9978	0.9957
	Chambers, TX			
	Fort Bend, TX			
	Harris, TX			
	Liberty, TX			
	Montgomery, TX			
	Waller, TX			
3400	Huntington-Ashland, WV-KY-OH	0.9636	0.9927	0.9854

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2003 THROUGH JUNE 30, 2004—Continued

MSA	Urban Area (Constituent Counties)	Full Wage Index [1]	1/5th Wage Index [2]	2/5th Wage Index [3]
	Boyd, KY Carter, KY Greenup, KY Lawrence, OH Cabell, WV Wayne, WV			
3440	Huntsville, AL Limestone, AL Madison, AL	0.8903	0.9781	0.9561
3480	Indianapolis, IN Boone, IN Hamilton, IN Hancock, IN Hendricks, IN Johnson, IN Madison, IN Marion, IN Morgan, IN Shelby, IN	0.9717	0.9943	0.9887
3500	Iowa City, IA Johnson, IA	0.9587	0.9917	0.9835
3520	Jackson, MI Jackson, MI	0.9532	0.9906	0.9813
3560	Jackson, MS Hinds, MS Madison, MS Rankin, MS	0.8607	0.9721	0.9443
3580	Jackson, TN Madison, TN Chester, TN	0.9275	0.9855	0.9710
3600	Jacksonville, FL Clay, FL Duval, FL Nassau, FL St. Johns, FL	0.9381	0.9876	0.9752
3605	Jacksonville, NC Onslow, NC	0.8239	0.9648	0.9296
3610	Jamestown, NY Chautauqua, NY	0.7976	0.9595	0.9190
3620	Janesville-Beloit, WI Rock, WI	0.9849	0.9970	0.9940
3640	Jersey City, NJ Hudson, NJ	1.1190	1.0238	1.0476
3660	Johnson City-Kingsport-Bristol, TN-VA Carter, TN Hawkins, TN Sullivan, TN Unicoi, TN Washington, TN Bristol City, VA Scott, VA Washington, VA	0.8268	0.9654	0.9307
3680	Johnstown, PA Cambria, PA Somerset, PA	0.8329	0.9666	0.9332
3700	Jonesboro, AR Craighead, AR	0.7749	0.9550	0.9100
3710	Joplin, MO Jasper, MO Newton, MO	0.8613	0.9723	0.9445
3720	Kalamazoo-Battlecreek, MI Calhoun, MI Kalamazoo, MI Van Buren, MI	1.0595	1.0119	1.0238
3740	Kankakee, IL Kankakee, IL	1.0790	1.0158	1.0316
3760	Kansas City, KS-MO Johnson, KS Leavenworth, KS Miami, KS	0.9736	0.9947	0.9894

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2003 THROUGH JUNE 30, 2004—Continued

MSA	Urban Area (Constituent Counties)	Full Wage Index [1]	1/5th Wage Index [2]	2/5th Wage Index [3]
	Wyandotte, KS			
	Cass, MO			
	Clay, MO			
	Clinton, MO			
	Jackson, MO			
	Lafayette, MO			
	Platte, MO			
	Ray, MO			
3800	Kenosha, WI	0.9686	0.9937	0.9874
	Kenosha, WI			
3810	Killeen-Temple, TX	1.0399	1.0080	1.0160
	Bell, TX			
	Coryell, TX			
3840	Knoxville, TN	0.8970	0.9794	0.9588
	Anderson, TN			
	Blount, TN			
	Knox, TN			
	Loudon, TN			
	Sevier, TN			
	Union, TN			
3850	Kokomo, IN	0.8971	0.9794	0.9588
	Howard, IN			
	Tipton, IN			
3870	La Crosse, WI-MN	0.9400	0.9880	0.9760
	Houston, MN			
	La Crosse, WI			
3880	Lafayette, LA	0.8452	0.9690	0.9381
	Acadia, LA			
	Lafayette, LA			
	St. Landry, LA			
	St. Martin, LA			
3920	Lafayette, IN	0.9278	0.9856	0.9711
	Clinton, IN			
	Tippecanoe, IN			
3960	Lake Charles, LA	0.7965	0.9593	0.9186
	Calcasieu, LA			
3980	Lakeland-Winter Haven, FL	0.9357	0.9871	0.9743
	Polk, FL			
4000	Lancaster, PA	0.9078	0.9816	0.9631
	Lancaster, PA			
4040	Lansing-East Lansing, MI	0.9726	0.9945	0.9890
	Clinton, MI			
	Eaton, MI			
	Ingham, MI			
4080	Laredo, TX	0.8472	0.9694	0.9389
	Webb, TX			
4100	Las Cruces, NM	0.8745	0.9749	0.9498
	Dona Ana, NM			
4120	Las Vegas, NV-AZ	1.1521	1.0304	1.0608
	Mohave, AZ			
	Clark, NV			
	Nye, NV			
4150	Lawrence, KS	0.8323	0.9665	0.9329
	Douglas, KS			
4200	Lawton, OK	0.8315	0.9663	0.9326
	Comanche, OK			
4243	Lewiston-Auburn, ME	0.9179	0.9836	0.9672
	Androscoggin, ME			
4280	Lexington, KY	0.8581	0.9716	0.9432
	Bourbon, KY			
	Clark, KY			
	Fayette, KY			
	Jessamine, KY			
	Madison, KY			
	Scott, KY			
	Woodford, KY			
4320	Lima, OH	0.9483	0.9897	0.9793
	Allen, OH			
	Auglaize, OH			
4360	Lincoln, NE	0.9892	0.9978	0.9957

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2003 THROUGH JUNE 30, 2004—Continued

MSA	Urban Area (Constituent Counties)	Full Wage Index [1]	1/5th Wage Index [2]	2/5th Wage Index [3]
	Lancaster, NE			
4400	Little Rock-North Little Rock, AR	0.9097	0.9819	0.9639
	Faulkner, AR			
	Lonoke, AR			
	Pulaski, AR			
	Saline, AR			
4420	Longview-Marshall, TX	0.8629	0.9726	0.9452
	Gregg, TX			
	Harrison, TX			
	Upshur, TX			
4480	Los Angeles-Long Beach, CA	1.2001	1.0400	1.0800
	Los Angeles, CA			
4520	Louisville, KY-IN	0.9276	0.9855	0.9710
	Clark, IN			
	Floyd, IN			
	Harrison, IN			
	Scott, IN			
	Bullitt, KY			
	Jefferson, KY			
	Oldham, KY			
4600	Lubbock, TX	0.9646	0.9929	0.9858
	Lubbock, TX			
4640	Lynchburg, VA	0.9219	0.9844	0.9688
	Amherst, VA			
	Bedford, VA			
	Bedford City, VA			
	Campbell, VA			
	Lynchburg City, VA			
4680	Macon, GA	0.9204	0.9841	0.9682
	Bibb, GA			
	Houston, GA			
	Jones, GA			
	Peach, GA			
	Twiggs, GA			
4720	Madison, WI	1.0467	1.0093	1.0187
	Dane, WI			
4800	Mansfield, OH	0.8900	0.9780	0.9560
	Crawford, OH			
	Richland, OH			
4840	Mayaguez, PR	0.4914	0.8983	0.7966
	Anasco, PR			
	Cabo Rojo, PR			
	Hormigueros, PR			
	Mayaguez, PR			
	Sabana Grande, PR			
	San German, PR			
4880	McAllen-Edinburg-Mission, TX	0.8428	0.9686	0.9371
	Hidalgo, TX			
4890	Medford-Ashland, OR	1.0498	1.0100	1.0199
	Jackson, OR			
4900	Melbourne-Titusville-Palm Bay, FL	1.0253	1.0051	1.0101
	Brevard, Fl			
4920	Memphis, TN-AR-MS	0.8920	0.9784	0.9568
	Crittenden, AR			
	DeSoto, MS			
	Fayette, TN			
	Shelby, TN			
	Tipton, TN			
4940	Merced, CA	0.9742	0.9948	0.9897
	Merced, CA			
5000	Miami, FL	0.9802	0.9960	0.9921
	Dade, FL			
5015	Middlesex-Somerset-Hunterdon, NJ	1.1213	1.0243	1.0485
	Hunterdon, NJ			
	Middlesex, NJ			
	Somerset, NJ			
5080	Milwaukee-Waukesha, WI	0.9893	0.9979	0.9957
	Milwaukee, WI			
	Ozaukee, WI			
	Washington, WI			

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2003 THROUGH JUNE 30, 2004—Continued

MSA	Urban Area (Constituent Counties)	Full Wage Index [1]	1/5th Wage Index [2]	2/5th Wage Index [3]
	Waukesha, WI			
5120	Minneapolis-St. Paul, MN-WI	1.0903	1.0181	1.0361
	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	0.9157	0.9831	0.9663
	Missoula, MT			
5160	Mobile, AL	0.8108	0.9622	0.9243
	Baldwin, AL			
	Mobile, AL			
5170	Modesto, CA	1.0498	1.0100	1.0199
	Stanislaus, CA			
5190	Monmouth-Ocean, NJ	1.0674	1.0135	1.0270
	Monmouth, NJ			
	Ocean, NJ			
5200	Monroe, LA	0.8137	0.9627	0.9255
	Ouachita, LA			
5240	Montgomery, AL	0.7734	0.9547	0.9094
	Autauga, AL			
	Elmore, AL			
	Montgomery, AL			
5280	Muncie, IN	0.9284	0.9857	0.9714
	Delaware, IN			
5330	Myrtle Beach, SC	0.8976	0.9795	0.9590
	Horry, SC			
5345	Naples, FL	0.9754	0.9951	0.9902
	Collier, FL			
5360	Nashville, TN	0.9578	0.9916	0.9831
	Cheatham, TN			
	Davidson, TN			
	Dickson, TN			
	Robertson, TN			
	Rutherford TN			
	Sumner, TN			
	Williamson, TN			
	Wilson, TN			
5380	Nassau-Suffolk, NY	1.3357	1.0671	1.1343
	Nassau, NY			
	Suffolk, NY			
5483	New Haven-Bridgeport-Stamford-Waterbury-	1.2408	1.0482	1.0963
	Danbury, CT			
	Fairfield, CT			
	New Haven, CT			
5523	New London-Norwich, CT	1.1767	1.0353	1.0707
	New London, CT			
5560	New Orleans, LA	0.9046	0.9809	0.9618
	Jefferson, LA			
	Orleans, LA			
	Plaquemines, LA			
	St. Bernard, LA			
	St. Charles, LA			
	St. James, LA			
	St. John The Baptist, LA			
	St. Tammany, LA			
5600	New York, NY	1.4414	1.0883	1.1766
	Bronx, NY			
	Kings, NY			
	New York, NY			
	Putnam, NY			
	Queens, NY			

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2003 THROUGH JUNE 30, 2004—Continued

MSA	Urban Area (Constituent Counties)	Full Wage Index [1]	1/5th Wage Index [2]	2/5th Wage Index [3]
	Richmond, NY			
	Rockland, NY			
	Westchester, NY			
5640	Newark, NJ	1.1381	1.0276	1.0552
	Essex, NJ			
	Morris, NJ			
	Sussex, NJ			
	Union, NJ			
	Warren, NJ			
5660	Newburgh, NY-PA	1.1387	1.0277	1.0555
	Orange, NY			
	Pike, PA			
5720	Norfolk-Virginia Beach-Newport News, VA-NC	0.8574	0.9715	0.9430
	Currituck, NC			
	Chesapeake City, VA			
	Gloucester, VA			
	Hampton City, VA			
	Isle of Wight, VA			
	James City, VA			
	Mathews, VA			
	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	1.5072	1.1014	1.2029
	Alameda, CA			
	Contra Costa, CA			
5790	Ocala, FL	0.9402	0.9880	0.9761
	Marion, FL			
5800	Odessa-Midland, TX	0.9397	0.9879	0.9759
	Ector, TX			
	Midland, TX			
5880	Oklahoma City, OK	0.8900	0.9780	0.9560
	Canadian, OK			
	Cleveland, OK			
	Logan, OK			
	McClain, OK			
	Oklahoma, OK			
	Pottawatomie, OK			
5910	Olympia, WA	1.0960	1.0192	1.0384
	Thurston, WA			
5920	Omaha, NE-IA	0.9978	0.9996	0.9991
	Pottawattamie, IA			
	Cass, NE			
	Douglas, NE			
	Sarpy, NE			
	Washington, NE			
5945	Orange County, CA	1.1474	1.0295	1.0590
	Orange, CA			
5960	Orlando, FL	0.9640	0.9928	0.9856
	Lake, FL			
	Orange, FL			
	Osceola, FL			
	Seminole, FL			
5990	Owensboro, KY	0.8344	0.9669	0.9338
	Daviess, KY			
6015	Panama City, FL	0.8865	0.9773	0.9546
	Bay, FL			
6020	Parkersburg-Marietta, WV-OH	0.8127	0.9625	0.9251
	Washington, OH			
	Wood, WV			
6080	Pensacola, FL	0.8610	0.9722	0.9444
	Escambia, FL			
	Santa Rosa, FL			
6120	Peoria-Pekin, IL	0.8739	0.9748	0.9496
	Peoria, IL			

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2003 THROUGH JUNE 30, 2004—Continued

MSA	Urban Area (Constituent Counties)	Full Wage Index [1]	1/5th Wage Index [2]	2/5th Wage Index [3]
	Tazewell, IL			
	Woodford, IL			
6160	Philadelphia, PA-NJ	1.0713	1.0143	1.0285
	Burlington, NJ			
	Camden, NJ			
	Gloucester, NJ			
	Salem, NJ			
	Bucks, PA			
	Chester, PA			
	Delaware, PA			
	Montgomery, PA			
	Philadelphia, PA			
6200	Phoenix-Mesa, AZ	0.9820	0.9964	0.9928
	Maricopa, AZ			
	Pinal, AZ			
6240	Pine Bluff, AR	0.7962	0.9592	0.9185
	Jefferson, AR			
6280	Pittsburgh, PA	0.9365	0.9873	0.9746
	Allegheny, PA			
	Beaver, PA			
	Butler, PA			
	Fayette, PA			
	Washington, PA			
	Westmoreland, PA			
6323	Pittsfield, MA	1.0235	1.0047	1.0094
	Berkshire, MA			
6340	Pocatello, ID	0.9372	0.9874	0.9749
	Bannock, ID			
6360	Ponce, PR	0.5169	0.9034	0.8068
	Guayanilla, PR			
	Juana Diaz, PR			
	Penuelas, PR			
	Ponce, PR			
	Villalba, PR			
	Yauco, PR			
6403	Portland, ME	0.9794	0.9959	0.9918
	Cumberland, ME			
	Sagadahoc, ME			
	York, ME			
6440	Portland-Vancouver, OR-WA	1.0667	1.0133	1.0267
	Clackamas, OR			
	Columbia, OR			
	Multnomah, OR			
	Washington, OR			
	Yamhill, OR			
	Clark, WA			
6483	Providence-Warwick-Pawtucket, RI	1.0854	1.0171	1.0342
	Bristol, RI			
	Kent, RI			
	Newport, RI			
	Providence, RI			
	Washington, RI			
6520	Provo-Orem, UT	0.9984	0.9997	0.9994
	Utah, UT			
6560	Pueblo, CO	0.8820	0.9764	0.9528
	Pueblo, CO			
6580	Punta Gorda, FL	0.9218	0.9844	0.9687
	Charlotte, FL			
6600	Racine, WI	0.9334	0.9867	0.9734
	Racine, WI			
6640	Raleigh-Durham-Chapel Hill, NC	0.9990	0.9998	0.9996
	Chatham, NC			
	Durham, NC			
	Franklin, NC			
	Johnston, NC			
	Orange, NC			
	Wake, NC			
6660	Rapid City, SD	0.8846	0.9769	0.9538
	Pennington, SD			
6680	Reading, PA	0.9295	0.9859	0.9718

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2003 THROUGH JUNE 30, 2004—Continued

MSA	Urban Area (Constituent Counties)	Full Wage Index [1]	1/5th Wage Index [2]	2/5th Wage Index [3]
	Berks, PA			
6690	Redding, CA	1.1135	1.0227	1.0454
	Shasta, CA			
6720	Reno, NV	1.0648	1.0130	1.0259
	Washoe, NV			
6740	Richland-Kennewick-Pasco, WA	1.1491	1.0298	1.0596
	Benton, WA			
	Franklin, WA			
6760	Richmond-Petersburg, VA	0.9477	0.9895	0.9791
	Charles City County, VA			
	Chesterfield, VA			
	Colonial Heights City, VA			
	Dinwiddie, VA			
	Goochland, VA			
	Hanover, VA			
	Henrico, VA			
	Hopewell City, VA			
	New Kent, VA			
	Petersburg City, VA			
	Powhatan, VA			
	Prince George, VA			
	Richmond City, VA			
6780	Riverside-San Bernardino, CA	1.1365	1.0273	1.0546
	Riverside, CA			
	San Bernardino, CA			
6800	Roanoke, VA	0.8614	0.9723	0.9446
	Botetourt, VA			
	Roanoke, VA			
	Roanoke City, VA			
	Salem City, VA			
6820	Rochester, MN	1.2139	1.0428	1.0856
	Olmsted, MN			
6840	Rochester, NY	0.9194	0.9839	0.9678
	Genesee, NY			
	Livingston, NY			
	Monroe, NY			
	Ontario, NY			
	Orleans, NY			
	Wayne, NY			
6880	Rockford, IL	0.9625	0.9925	0.9850
	Boone, IL			
	Ogle, IL			
	Winnebago, IL			
6895	Rocky Mount, NC	0.9228	0.9846	0.9691
	Edgecombe, NC			
	Nash, NC			
6920	Sacramento, CA	1.1500	1.0300	1.0600
	El Dorado, CA			
	Placer, CA			
	Sacramento, CA			
6960	Saginaw-Bay City-Midland, MI	0.9650	0.9930	0.9860
	Bay, MI			
	Midland, MI			
	Saginaw, MI			
6980	St. Cloud, MN	0.9700	0.9940	0.9880
	Benton, MN			
	Stearns, MN			
7000	St. Joseph, MO	0.9544	0.9909	0.9818
	Andrew, MO			
	Buchanan, MO			
7040	St. Louis, MO-IL	0.8855	0.9771	0.9542
	Clinton, IL			
	Jersey, IL			
	Madison, IL			
	Monroe, IL			
	St. Clair, IL			
	Franklin, MO			
	Jefferson, MO			
	Lincoln, MO			
	St. Charles, MO			

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2003 THROUGH JUNE 30, 2004—Continued

MSA	Urban Area (Constituent Counties)	Full Wage Index [1]	1/5th Wage Index [2]	2/5th Wage Index [3]
	St. Louis, MO			
	St. Louis City, MO			
	Warren, MO			
7080	Salem, OR	1.0500	1.0100	1.0200
	Marion, OR			
	Polk, OR			
7120	Salinas, CA	1.4623	1.0925	1.1849
	Monterey, CA			
7160	Salt Lake City-Ogden, UT	0.9945	0.9989	0.9978
	Davis, UT			
	Salt Lake, UT			
	Weber, UT			
7200	San Angelo, TX	0.8374	0.9675	0.9350
	Tom Green, TX			
7240	San Antonio, TX	0.8753	0.9751	0.9501
	Bexar, TX			
	Comal, TX			
	Guadalupe, TX			
	Wilson, TX			
7320	San Diego, CA	1.1131	1.0226	1.0452
	San Diego, CA			
7360	San Francisco, CA	1.4142	1.0828	1.1657
	Marin, CA			
	San Francisco, CA			
	San Mateo, CA			
7400	San Jose, CA	1.4145	1.0829	1.1658
	Santa Clara, CA			
7440	San Juan-Bayamon, PR	0.4741	0.8948	0.7896
	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			
7460	San Luis Obispo-Atascadero-Paso Robles, CA	1.1271	1.0254	1.0508
	San Luis Obispo, CA			
7480	Santa Barbara-Santa Maria-Lompoc, CA	1.0481	1.0096	1.0192
	Santa Barbara, CA			
7485	Santa Cruz-Watsonville, CA	1.3646	1.0729	1.1458
	Santa Cruz, CA			
7490	Santa Fe, NM	1.0712	1.0142	1.0285
	Los Alamos, NM			
	Santa Fe, NM			
7500	Santa Rosa, CA	1.3046	1.0609	1.1218
	Sonoma, CA			
7510	Sarasota-Bradenton, FL	0.9425	0.9885	0.9770

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2003 THROUGH JUNE 30, 2004—Continued

MSA	Urban Area (Constituent Counties)	Full Wage Index [1]	1/5th Wage Index [2]	2/5th Wage Index [3]
	Manatee, FL			
	Sarasota, FL			
7520	Savannah, GA	0.9376	0.9875	0.9750
	Bryan, GA			
	Chatham, GA			
	Effingham, GA			
7560	Scranton--Wilkes-Barre--Hazleton, PA	0.8599	0.9720	0.9440
	Columbia, PA			
	Lackawanna, PA			
	Luzerne, PA			
	Wyoming, PA			
7600	Seattle-Bellevue-Everett, WA	1.1474	1.0295	1.0590
	Island, WA			
	King, WA			
	Snohomish, WA			
7610	Sharon, PA	0.7869	0.9574	0.9148
	Mercer, PA			
7620	Sheboygan, WI	0.8697	0.9739	0.9479
	Sheboygan, WI			
7640	Sherman-Denison, TX	0.9255	0.9851	0.9702
	Grayson, TX			
7680	Shreveport-Bossier City, LA	0.8987	0.9797	0.9595
	Bossier, LA			
	Caddo, LA			
	Webster, LA			
7720	Sioux City, IA-NE	0.9046	0.9809	0.9618
	Woodbury, IA			
	Dakota, NE			
7760	Sioux Falls, SD	0.9257	0.9851	0.9703
	Lincoln, SD			
	Minnehaha, SD			
7800	South Bend, IN	0.9802	0.9960	0.9921
	St. Joseph, IN			
7840	Spokane, WA	1.0852	1.0170	1.0341
	Spokane, WA			
7880	Springfield, IL	0.8659	0.9732	0.9464
	Menard, IL			
	Sangamon, IL			
7920	Springfield, MO	0.8424	0.9685	0.9370
	Christian, MO			
	Greene, MO			
	Webster, MO			
8003	Springfield, MA	1.0927	1.0185	1.0371
	Hampden, MA			
	Hampshire, MA			
8050	State College, PA	0.8941	0.9788	0.9576
	Centre, PA			
8080	Steubenville-Weirton, OH-WV (WV Hospitals)	0.8804	0.9761	0.9522
	Jefferson, OH			
	Brooke, WV			
	Hancock, WV			
8120	Stockton-Lodi, CA	1.0506	1.0101	1.0202
	San Joaquin, CA			
8140	Sumter, SC	0.8273	0.9655	0.9309
	Sumter, SC			
8160	Syracuse, NY	0.9714	0.9943	0.9886
	Cayuga, NY			
	Madison, NY			
	Onondaga, NY			
	Oswego, NY			
8200	Tacoma, WA	1.0940	1.0188	1.0376
	Pierce, WA			
8240	Tallahassee, FL	0.8504	0.9701	0.9402
	Gadsden, FL			
	Leon, FL			
8280	Tampa-St. Petersburg-Clearwater, FL	0.9065	0.9813	0.9626
	Hernando, FL			
	Hillsborough, FL			
	Pasco, FL			
	Pinellas, FL			

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2003 THROUGH JUNE 30, 2004—Continued

MSA	Urban Area (Constituent Counties)	Full Wage Index [1]	1/5th Wage Index [2]	2/5th Wage Index [3]
8320	Terre Haute, IN	0.8599	0.9720	0.9440
	Clay, IN			
	Vermillion, IN			
	Vigo, IN			
8360	Texarkana,AR-Texarkana, TX	0.8088	0.9618	0.9235
	Miller, AR			
	Bowie, TX			
8400	Toledo, OH	0.9810	0.9962	0.9924
	Fulton, OH			
	Lucas, OH			
	Wood, OH			
8440	Topeka, KS	0.9199	0.9840	0.9680
	Shawnee, KS			
8480	Trenton, NJ	1.0432	1.0086	1.0173
	Mercer, NJ			
8520	Tucson, AZ	0.8911	0.9782	0.9564
	Pima, AZ			
8560	Tulsa, OK	0.8332	0.9666	0.9333
	Creek, OK			
	Osage, OK			
	Rogers, OK			
	Tulsa, OK			
	Wagoner, OK			
8600	Tuscaloosa, AL	0.8130	0.9626	0.9252
	Tuscaloosa, AL			
8640	Tyler, TX	0.9521	0.9904	0.9808
	Smith, TX			
8680	Utica-Rome, NY	0.8465	0.9693	0.9386
	Herkimer, NY			
	Oneida, NY			
8720	Vallejo-Fairfield-Napa, CA	1.3354	1.0671	1.1342
	Napa, CA			
	Solano, CA			
8735	Ventura, CA	1.1096	1.0219	1.0438
	Ventura, CA			
8750	Victoria, TX	0.8756	0.9751	0.9502
	Victoria, TX			
8760	Vineland-Millville-Bridgeton, NJ	1.0031	1.0006	1.0012
	Cumberland, NJ			
8780	Visalia-Tulare-Porterville, CA	0.9418	0.9884	0.9767
	Tulare, CA			
	Tulare, CA			
8800	Waco, TX	0.8073	0.9615	0.9229
	McLennan, TX			
8840	Washington, DC-MD-VA-WV	1.0851	1.0170	1.0340
	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			

TABLE 1.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2003 THROUGH JUNE 30, 2004—Continued

MSA	Urban Area (Constituent Counties)	Full Wage Index [1]	1/5th Wage Index [2]	2/5th Wage Index [3]
8920	Waterloo-Cedar Falls, IA Black Hawk, IA	0.8069	0.9614	0.9228
8940	Wausau, WI Marathon, WI	0.9782	0.9956	0.9913
8960	West Palm Beach-Boca Raton, FL Palm Beach, FL	0.9939	0.9988	0.9976
9000	Wheeling, WV-OH Belmont, OH Marshall, WV Ohio, WV	0.7670	0.9534	0.9068
9040	Wichita, KS Butler, KS Harvey, KS Sedgwick, KS	0.9520	0.9904	0.9808
9080	Wichita Falls, TX Archer, TX Wichita, TX	0.8498	0.9700	0.9399
9140	Williamsport, PA Lycoming, PA	0.8544	0.9709	0.9418
9160	Wilmington-Newark, DE-MD New Castle, DE Cecil, MD	1.1173	1.0235	1.0469
9200	Wilmington, NC New Hanover, NC Brunswick, NC	0.9640	0.9928	0.9856
9260	Yakima, WA Yakima, WA	1.0569	1.0114	1.0228
9270	Yolo, CA Yolo, CA	0.9434	0.9887	0.9774
9280	York, PA York, PA	0.9026	0.9805	0.9610
9320	Youngstown-Warren, OH Columbiana, OH Mahoning, OH Trumbull, OH	0.9358	0.9872	0.9743
9340	Yuba City, CA Sutter, CA Yuba, CA	1.0276	1.0055	1.0110
9360	Yuma, AZ Yuma, AZ	0.8589	0.9718	0.9436

[1] Prereclassification wage index from Federal FY 2003 based on fiscal year 1999 audited acute care hospital inpatient wage data that excludes wages for services provided by teaching physicians, interns and residents, and nonphysician anesthetists under Part B of the Medicare program.

[2] One-fifth of the full wage index value, applicable for LTCH's cost reporting period beginning on or after October 1, 2002 through September 30, 2003 (Federal FY 2203). For example, for a LTCH's cost reporting period begins during Federal in FY 2003 and located in Chicago, Illinois (MSA 1600), the 1/5th of the wage index value is computed as (1.1044 + 4)/5 = 1.0209. For further details on the 5-year phase-in of the wage index, see section VI.C.1. of this final rule.

[3] Two-fifths of the full wage index value, applicable for LTCH's cost reporting period beginning on or after October 1, 2003 through September 30, 2003 (Federal FY 2004). For example, for a LTCH's cost reporting period begins during Federal in FY 2004 and located in Chicago, Illinois (MSA 1600), the 2/5th of the wage index value is computed as ((2*1.1044) + 3))/5 = 1.0418. For further details on the 5-year phase-in of the wage index, see section VI.C.1. of this final rule.

TABLE 2.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR RURAL AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2003 THROUGH JUNE 30, 2004

Nonurban Area	Full Wage Index [1]	1/5th Wage Index [2]	2/5th Wage Index [3]
Alabama	7660	9532	9064
Alaska	2293	0459	0917
Arizona	8493	9699	9397
Arkansas	7666	9533	9066
California	9899	9980	9960
Colorado	9015	9803	9606
Connecticut	2394	0479	0958
Delaware	9128	9826	9651
Florida	8827	9765	9531
Georgia	8230	9646	9292
Hawaii	0255	0051	0102
Idaho	8747	9749	9499
Illinois	8204	9641	9282

TABLE 2.—LONG-TERM CARE HOSPITAL WAGE INDEX FOR RURAL AREAS FOR DISCHARGES OCCURRING FROM JULY 1, 2003 THROUGH JUNE 30, 2004—Continued

Nonurban Area	Full Wage Index [1]	1/5th Wage Index [2]	2/5th Wage Index [3]
Indiana	8755	9751	9502
Iowa	8315	9663	9326
Kansas	7900	9580	9160
Kentucky	8079	9616	9232
Louisiana	7580	9516	9032
Maine	8874	9775	9550
Maryland	8946	9789	9578
Massachusetts	1288	0258	0515
Michigan	9009	9802	9604
Minnesota	9151	9830	9660
Mississippi	7680	9536	9072
Missouri	7881	9576	9152
Montana	8481	9696	9392
Nebraska	8204	9641	9282
Nevada	9577	9915	9831
New Hampshire	9839	9968	9936
New Jersey [4]	.....	.....	.....
New Mexico	8872	9774	9549
New York	8542	9708	9417
North Carolina	8669	9734	9468
North Dakota	7788	9558	9115
Ohio	8613	9723	9445
Oklahoma	7590	9518	9036
Oregon	0259	0052	0104
Pennsylvania	8462	9692	9385
Puerto Rico	4356	8871	7742
Rhode Island [4]	.....	.....	.....
South Carolina	8607	9721	9443
South Dakota	7815	9563	9126
Tennessee	7877	9575	9151
Texas	7821	9564	9128
Utah	9312	9862	9725
Vermont	9345	9869	9738
Virginia	8504	9701	9402
Washington	0179	0036	0072
West Virginia	7975	9595	9190
Wisconsin	9162	9832	9665
Wyoming	9007	9801	9603

[1] Pre-reclassification wage index from Federal FY 2003 based on fiscal year 1999 audited acute care hospital inpatient wage data that exclude wages for services provided by teaching physicians, residents, and nonphysician anesthetists under Part B of the Medicare program.

[2] One-fifth of the full wage index value, applicable for LTCH's cost reporting period beginning on or after October 1, 2002 through September 30, 2003 (Federal FY 2203). For example, for a LTCH's cost reporting period begins during Federal in FY 2003 and located in rural Illinois, the 1/5th of the wage index value is computed as (0.8204 + 4)/5 = 0.9641. For further details on the 5-year phase-in of the wage index, see section VI.C.1. of this final rule.

[3] Two-fifths of the full wage index value, applicable for LTCH's cost reporting period beginning on or after October 1, 2003 through September 30, 2003 (Federal FY 2004). For example, for a LTCH's cost reporting period begins during Federal in FY 2004 and located in rural Illinois, the 2/5th of the wage index value is computed as ((2*0.8204) + 3))/5 = 0.9282. For further details on the 5-year phase-in of the wage index, see section VI.C.1. of this final rule.

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

TABLE 3.—LTC–DRG RELATIVE WEIGHTS, GEOMETRIC MEAN LENGTH OF STAY, AND SHORT-STAYS OF FIVE-SIXTHS AVERAGE LENGTH OF STAY FOR THE PERIOD OF JULY 1, 2003 THROUGH SEPTEMBER 30, 2003

LTC–DRG	Description	Relative Weight	Geo-metric Mean Length of Stay	Short-Stays of 5/6th Aver-age Length of Stay
1	CRANIOTOMY AGE >17 W CC [5]	1.8783	46.3	38.5
2	CRANIOTOMY AGE > 17 W/O CC [5]	1.8783	46.3	38.5
3	CRANIOTOMY AGE 0-17 *	1.8783	46.3	38.5
4	SPINAL PROCEDURES [4]	1.2493	31.3	26.0
5	EXTRACRANIAL VASCULAR PROCEDURES [4]	1.2493	31.3	26.0
6	CARPAL TUNNEL RELEASE *	0.4055	16.8	14.0
7	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC	1.7829	43.8	36.5
8	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC [4]	1.2493	31.3	26.0
9	SPINAL DISORDERS & INJURIES	1.4118	34.6	28.8
10	NERVOUS SYSTEM NEOPLASMS W CC [7]	0.8537	24.5	20.4
11	NERVOUS SYSTEM NEOPLASMS W/O CC [7]	0.8537	24.5	20.4

TABLE 3.—LTC–DRG RELATIVE WEIGHTS, GEOMETRIC MEAN LENGTH OF STAY, AND SHORT-STAYS OF FIVE-SIXTHS AVERAGE LENGTH OF STAY FOR THE PERIOD OF JULY 1, 2003 THROUGH SEPTEMBER 30, 2003—Continued

LTC–DRG	Description	Relative Weight	Geo-metric Mean Length of Stay	Short-Stays of 5/6th Aver-age Length of Stay
12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	0.7773	27.1	22.5
13	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	0.7207	25.6	21.3
14	INTERCRANIAL HEMORRHAGE & STROKE W INFARCT	0.8816	26.6	22.1
15	NONSPECIFIC CVA & PRECEREBRAL OCCULUSION W/O INFARCT	0.9053	29.4	24.5
16	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	0.8864	27.0	22.5
17	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC[2]	0.6655	21.9	18.2
18	CRANIAL & PERIPHERAL NERVE DISORDERS W CC	0.7770	24.9	20.7
19	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	0.5486	22.0	18.3
20	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	1.2331	29.3	24.4
21	VIRAL MENINGITIS[1]	0.4055	16.8	14.0
22	HYPERTENSIVE ENCEPHALOPATHY[2]	0.6655	21.9	18.2
23	NONTRAUMATIC STUPOR & COMA	0.9623	27.2	22.6
24	SEIZURE & HEADACHE AGE >17 W CC	0.8831	24.8	20.6
25	SEIZURE & HEADACHE AGE >17 W/O CC	0.4830	20.4	17.0
26	SEIZURE & HEADACHE AGE 0-17*	0.4055	16.8	14.0
27	TRAUMATIC STUPOR & COMA, COMA >1 HR	1.1126	31.6	26.3
28	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W CC	1.1507	29.0	24.1
29	TRAUMATIC STUPOR & COMA, COMA >1 HR AGE >17 W/O CC	0.9268	27.2	22.6
30	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0-17*	0.8284	23.3	19.4
31	CONCUSSION AGE >17 W CC[2]	0.6655	21.9	18.2
32	CONCUSSION AGE >17 W/O CC*	0.4055	16.8	14.0
33	CONCUSSION AGE 0-17*	0.4055	16.8	14.0
34	OTHER DISORDERS OF NERVOUS SYSTEM W CC	0.8385	25.1	20.9
35	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	0.6561	25.3	21.0
36	RETINAL PROCEDURES*	0.4055	16.8	14.0
37	ORBITAL PROCEDURES*	0.4055	16.8	14.0
38	PRIMARY IRIS PROCEDURES*	0.4055	16.8	14.0
39	LENS PROCEDURES WITH OR WITHOUT VITRECTOMY*	0.4055	16.8	14.0
40	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17*	0.4055	16.8	14.0
41	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17*	0.4055	16.8	14.0
42	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS*	0.4055	16.8	14.0
43	HYPHEMA[3]	0.8284	23.3	19.4
44	ACUTE MAJOR EYE INFECTIONS[2]	0.6655	21.9	18.2
45	NEUROLOGICAL EYE DISORDERS[1]	0.4055	16.8	14.0
46	OTHER DISORDERS OF THE EYE AGE >17 W CC[2]	0.6655	21.9	18.2
47	OTHER DISORDERS OF THE EYE AGE >17 W/O CC[1]	0.4055	16.8	14.0
48	OTHER DISORDERS OF THE EYE AGE 0-17*	0.4055	16.8	14.0
49	MAJOR HEAD & NECK PROCEDURES*	1.8783	46.3	38.5
50	SIALOADENECTOMY*	0.6655	21.9	18.2
51	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY*	0.6655	21.9	18.2
52	CLEFT LIP & PALATE REPAIR*	0.6655	21.9	18.2
53	SINUS & MASTOID PROCEDURES AGE >17*	0.6655	21.9	18.2
54	SINUS & MASTOID PROCEDURES AGE 0-17*	0.6655	21.9	18.2
55	MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES[2]	0.6655	21.9	18.2
56	RHINOPLASTY*	0.6655	21.9	18.2
57	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17*	0.6655	21.9	18.2
58	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17*	0.6655	21.9	18.2
59	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17*	0.6655	21.9	18.2
60	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17*	0.6655	21.9	18.2
61	MYRINGOTOMY W TUBE INSERTION AGE >17[5]	1.8783	46.3	38.5
62	MYRINGOTOMY W TUBE INSERTION AGE 0-17*	0.6655	21.9	18.2
63	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES[5]	1.8783	46.3	38.5
64	EAR, NOSE, MOUTH & THROAT MALIGNANCY	1.0447	25.5	21.2
65	DYSEQUILIBRIUM	0.5056	19.8	16.5
66	EPISTAXIS[1]	0.4055	16.8	14.0
67	EPIGLOTTITIS[1]	0.4055	16.8	14.0
68	OTITIS MEDIA & URI AGE >17 W CC[3]	0.8284	23.3	19.4
69	OTITIS MEDIA & URI AGE >17 W/O CC[3]	0.8284	23.3	19.4
70	OTITIS MEDIA & URI AGE 0-17*	0.4055	16.8	14.0
71	LARYNGOTRACHEITIS*	0.4055	16.8	14.0
72	NASAL TRAUMA & DEFORMITY[1]	0.4055	16.8	14.0
73	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17	0.8097	23.7	19.7
74	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0-17*	0.4055	16.8	14.0
75	MAJOR CHEST PROCEDURES[5]	1.8783	46.3	38.5
76	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.7674	50.6	42.1
77	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC[5]	1.8783	46.3	38.5
78	PULMONARY EMBOLISM	0.6348	20.5	17.0

TABLE 3.—LTC–DRG RELATIVE WEIGHTS, GEOMETRIC MEAN LENGTH OF STAY, AND SHORT-STAYS OF FIVE-SIXTHS AVERAGE LENGTH OF STAY FOR THE PERIOD OF JULY 1, 2003 THROUGH SEPTEMBER 30, 2003—Continued

LTC–DRG	Description	Relative Weight	Geo-metric Mean Length of Stay	Short-Stays of 5/6th Average Length of Stay
79	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	0.8916	22.2	18.5
80	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC	0.7947	22.8	19.0
81	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0-17*	0.4055	16.8	14.0
82	RESPIRATORY NEOPLASMS	0.7976	20.9	17.4
83	MAJOR CHEST TRAUMA W CC	0.7384	24.8	20.6
84	MAJOR CHEST TRAUMA W/O CC[1]	0.4055	16.8	14.0
85	PLEURAL EFFUSION W CC	0.8207	23.6	19.6
86	PLEURAL EFFUSION W/O CC	0.6194	21.1	17.5
87	PULMONARY EDEMA & RESPIRATORY FAILURE	1.6597	32.3	26.9
88	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	0.7532	20.9	17.4
89	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	0.8533	23.6	19.6
90	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	0.7921	23.0	19.1
91	SIMPLE PNEUMONIA & PLEURISY AGE 0-17*	0.8284	23.3	19.4
92	INTERSTITIAL LUNG DISEASE W CC	0.7251	19.1	15.9
93	INTERSTITIAL LUNG DISEASE W/O CC	0.5573	18.5	15.4
94	PNEUMOTHORAX W CC	0.7885	22.7	18.9
95	PNEUMOTHORAX W/O CC[1]	0.4055	16.8	14.0
96	BRONCHITIS & ASTHMA AGE >17 W CC	0.8173	24.2	20.1
97	BRONCHITIS & ASTHMA AGE >17 W/O CC	0.5940	17.9	14.9
98	BRONCHITIS & ASTHMA AGE 0-17*	0.4055	16.8	14.0
99	RESPIRATORY SIGNS & SYMPTOMS W CC	1.1164	27.3	22.7
100	RESPIRATORY SIGNS & SYMPTOMS W/O CC	1.0015	25.4	21.1
101	OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	0.9763	23.4	19.5
102	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	0.9313	24.5	20.4
103	HEART TRANSPLANT[6]	0.0000	0.0	0.0
104	CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W CARDIAC CATH*	1.8783	46.3	38.5
105	CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W/O CARDIAC CATH*	1.8783	46.3	38.5
106	CORONARY BYPASS W PTCA*	1.8783	46.3	38.5
107	CORONARY BYPASS W CARDIAC CATH*	1.8783	46.3	38.5
108	OTHER CARDIOTHORACIC PROCEDURES[2]	0.6655	21.9	18.2
109	CORONARY BYPASS W/O PTCA OR CARDIAC CATH*	1.8783	46.3	38.5
110	MAJOR CARDIOVASCULAR PROCEDURES W CC[5]	1.8783	46.3	38.5
111	MAJOR CARDIOVASCULAR PROCEDURES W/O CC[5]	1.8783	46.3	38.5
113	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE	1.4103	36.9	30.7
114	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	1.3377	40.2	33.5
115	PRM CARD PACEM IMPL W AMI,HRT FAIL OR SHK,OR AICD LEAD OR GNRTR P[5]	1.8783	46.3	38.5
116	OTH PERM CARD PACEMAK IMPL OR PTCA W CORONARY ARTERY STENT IMPLNT[3]	0.8284	23.3	19.4
117	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT*	0.4055	16.8	14.0
118	CARDIAC PACEMAKER DEVICE REPLACEMENT[1]	0.4055	16.8	14.0
119	VEIN LIGATION & STRIPPING*	0.6655	21.9	18.2
120	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	1.4091	36.4	30.3
121	CIRCULATORY DISORDERS W AMI & MAJOR COMP, DISCHARGED ALIVE	0.7167	21.6	18.0
122	CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE	0.5144	19.0	15.8
123	CIRCULATORY DISORDERS W AMI, EXPIRED	0.9412	20.9	17.4
124	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG[3]	0.8284	23.3	19.4
125	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG[5]	1.8783	46.3	38.5
126	ACUTE & SUBACUTE ENDOCARDITIS	0.7689	24.8	20.6
127	HEART FAILURE & SHOCK	0.7616	22.4	18.6
128	DEEP VEIN THROMBOPHLEBITIS	0.6042	20.8	17.3
129	CARDIAC ARREST, UNEXPLAINED	1.0534	20.9	17.4
130	PERIPHERAL VASCULAR DISORDERS W CC	0.7914	24.8	20.6
131	PERIPHERAL VASCULAR DISORDERS W/O CC	0.7081	23.7	19.7
132	ATHEROSCLEROSIS W CC	0.8183	21.8	18.1
133	ATHEROSCLEROSIS W/O CC	0.5484	18.5	15.4
134	HYPERTENSION	0.6985	24.0	20.0
135	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC	0.7331	20.3	16.9
136	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC	0.7075	21.0	17.5
137	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0-17*	0.6655	21.9	18.2
138	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	0.7187	23.4	19.5
139	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	0.6482	20.4	17.0
140	ANGINA PECTORIS	0.7690	20.1	16.7
141	SYNCOPE & COLLAPSE W CC	0.6252	23.2	19.3
142	SYNCOPE & COLLAPSE W/O CC	0.5452	21.5	17.9
143	CHEST PAIN	0.7316	22.7	18.9
144	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	0.7870	21.9	18.2
145	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	0.7637	25.0	20.8
146	RECTAL RESECTION W CC[4]	1.2493	31.3	26.0

TABLE 3.—LTC–DRG RELATIVE WEIGHTS, GEOMETRIC MEAN LENGTH OF STAY, AND SHORT-STAYS OF FIVE-SIXTHS AVERAGE LENGTH OF STAY FOR THE PERIOD OF JULY 1, 2003 THROUGH SEPTEMBER 30, 2003—Continued

LTC–DRG	Description	Relative Weight	Geo-metric Mean Length of Stay	Short-Stays of 5/6th Average Length of Stay
147	RECTAL RESECTION W/O CC*	1.2493	31.3	26.0
148	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	2.8488	47.6	39.6
149	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC[2]	0.6655	21.9	18.2
150	PERITONEAL ADHESIOLYSIS W CC[1]	0.4055	16.8	14.0
151	PERITONEAL ADHESIOLYSIS W/O CC*	0.4055	16.8	14.0
152	MINOR SMALL & LARGE BOWEL PROCEDURES W CC[4]	1.2493	31.3	26.0
153	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC*	0.8284	23.3	19.4
154	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC[4]	1.2493	31.3	26.0
155	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC*	0.8284	23.3	19.4
156	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0-17*	0.8284	23.3	19.4
157	ANAL & STOMAL PROCEDURES W CC[1]	0.4055	16.8	14.0
158	ANAL & STOMAL PROCEDURES W/O CC*	0.4055	16.8	14.0
159	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC[4]	1.2493	31.3	26.0
160	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC*	0.6655	21.9	18.2
161	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC*	0.6655	21.9	18.2
162	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC*	0.6655	21.9	18.2
163	HERNIA PROCEDURES AGE 0-17*	0.6655	21.9	18.2
164	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC*	0.8284	23.3	19.4
165	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC*	0.8284	23.3	19.4
166	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC*	0.6655	21.9	18.2
167	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC*	0.6655	21.9	18.2
168	MOUTH PROCEDURES W CC[3]	0.8284	23.3	19.4
169	MOUTH PROCEDURES W/O CC*	0.6655	21.9	18.2
170	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	1.5543	35.0	29.1
171	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC[3]	0.8284	23.3	19.4
172	DIGESTIVE MALIGNANCY W CC	0.8553	24.2	20.1
173	DIGESTIVE MALIGNANCY W/O CC	0.5513	18.9	15.7
174	G.I. HEMORRHAGE W CC	0.8741	23.6	19.6
175	G.I. HEMORRHAGE W/O CC	0.8359	25.6	21.3
176	COMPLICATED PEPTIC ULCER	0.7661	24.4	20.3
177	UNCOMPLICATED PEPTIC ULCER W CC[3]	0.8284	23.3	19.4
178	UNCOMPLICATED PEPTIC ULCER W/O CC[2]	0.6655	21.9	18.2
179	INFLAMMATORY BOWEL DISEASE	1.0975	23.4	19.5
180	G.I. OBSTRUCTION W CC	0.8457	22.8	19.0
181	G.I. OBSTRUCTION W/O CC	0.5638	19.5	16.2
182	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC	0.8829	25.9	21.5
183	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC	0.6913	21.5	17.9
184	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0-17*	0.6655	21.9	18.2
185	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17[3]	0.8284	23.3	19.4
186	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0-17*	0.8284	23.3	19.4
187	DENTAL EXTRACTIONS & RESTORATIONS*	0.8284	23.3	19.4
188	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	1.0490	24.2	20.1
189	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	0.5852	17.4	14.5
190	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17*	0.6655	21.9	18.2
191	PANCREAS, LIVER & SHUNT PROCEDURES W CC[5]	1.8783	46.3	38.5
192	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC*	1.2493	31.3	26.0
193	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC[4]	1.2493	31.3	26.0
194	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC*	0.8284	23.3	19.4
195	CHOLECYSTECTOMY W C.D.E. W CC*	0.8284	23.3	19.4
196	CHOLECYSTECTOMY W C.D.E. W/O CC*	0.8284	23.3	19.4
197	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC[5]	1.8783	46.3	38.5
198	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC[5]	1.8783	46.3	38.5
199	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY[3]	0.8284	23.3	19.4
200	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY[4]	1.2493	31.3	26.0
201	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES[5]	1.8783	46.3	38.5
202	CIRRHOSIS & ALCOHOLIC HEPATITIS	0.5736	18.4	15.3
203	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	0.5897	18.2	15.1
204	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	0.9444	22.1	18.4
205	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC	0.6825	21.5	17.9
206	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC[2]	0.6655	21.9	18.2
207	DISORDERS OF THE BILIARY TRACT W CC	0.6979	21.5	17.9
208	DISORDERS OF THE BILIARY TRACT W/O CC[1]	0.4055	16.8	14.0
209	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF LOWER EXTREMITY[5]	1.8783	46.3	38.5
210	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC[4]	1.2493	31.3	26.0
211	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC*	0.8284	23.3	19.4
212	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17*	0.8284	23.3	19.4
213	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS	1.2591	33.0	27.5

TABLE 3.—LTC–DRG RELATIVE WEIGHTS, GEOMETRIC MEAN LENGTH OF STAY, AND SHORT-STAYS OF FIVE-SIXTHS AVERAGE LENGTH OF STAY FOR THE PERIOD OF JULY 1, 2003 THROUGH SEPTEMBER 30, 2003—Continued

LTC–DRG	Description	Relative Weight	Geo-metric Mean Length of Stay	Short-Stays of 5/6th Average Length of Stay
216	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE[4]	1.2493	31.3	26.0
217	WND DEBRID & SKN GRFT EXCEPT HAND,FOR MUSCSKELET & CONN TISS DIS	1.3602	38.8	32.3
218	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W CC[3]	0.8284	23.3	19.4
219	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W/O CC*	0.8284	23.3	19.4
220	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE 0-17*	0.8284	23.3	19.4
223	MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC[4]	1.2493	31.3	26.0
224	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC, W/O CC[1]	0.4055	16.8	14.0
225	FOOT PROCEDURES[4]	1.2493	31.3	26.0
226	SOFT TISSUE PROCEDURES W CC[4]	1.2493	31.3	26.0
227	SOFT TISSUE PROCEDURES W/O CC[3]	0.8284	23.3	19.4
228	MAJOR THUMB OR JOINT PROC,OR OTH HAND OR WRIST PROC W CC*	0.6655	21.9	18.2
229	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC[2]	0.6655	21.9	18.2
230	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR[1]	0.4055	16.8	14.0
231	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES EXCEPT HIP & FEMUR[5]	1.8783	46.3	38.5
232	ARTHROSCOPY*	0.4055	16.8	14.0
233	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC[4]	1.2493	31.3	26.0
234	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC[1]	0.4055	16.8	14.0
235	FRACTURES OF FEMUR	0.7540	28.5	23.7
236	FRACTURES OF HIP & PELVIS	0.7381	27.2	22.6
237	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH[2]	0.6655	21.9	18.2
238	OSTEOMYELITIS	0.8275	27.5	22.9
239	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY	0.6689	21.9	18.2
240	CONNECTIVE TISSUE DISORDERS W CC	0.9260	26.0	21.6
241	CONNECTIVE TISSUE DISORDERS W/O CC	0.5805	22.7	18.9
242	SEPTIC ARTHRITIS	0.7725	26.3	21.9
243	MEDICAL BACK PROBLEMS	0.6596	23.4	19.5
244	BONE DISEASES & SPECIFIC ARTHROPATHIES W CC	0.5756	20.6	17.1
245	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	0.4426	17.5	14.5
246	NON-SPECIFIC ARTHROPATHIES	0.6053	21.4	17.8
247	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE	0.5590	20.4	17.0
248	TENDONITIS, MYOSITIS & BURSITIS	0.7288	23.9	19.9
249	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	0.8005	27.1	22.5
250	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC	0.8373	31.8	26.5
251	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC	0.6904	26.0	21.6
252	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0-17*	0.4055	16.8	14.0
253	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W CC	0.8054	28.0	23.3
254	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W/O CC	0.6999	26.4	22.0
255	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE 0-17*	0.4055	16.8	14.0
256	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	0.8002	25.1	20.9
257	TOTAL MASTECTOMY FOR MALIGNANCY W CC[2]	0.6655	21.9	18.2
258	TOTAL MASTECTOMY FOR MALIGNANCY W/O CC*	0.6655	21.9	18.2
259	SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC*	0.6655	21.9	18.2
260	SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC*	0.6655	21.9	18.2
261	BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION*	0.4055	16.8	14.0
262	BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY[1]	0.4055	16.8	14.0
263	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	1.5388	45.0	37.5
264	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC	1.1645	38.8	32.3
265	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC	1.6569	45.6	38.0
266	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC[3]	0.8284	23.3	19.4
267	PERIANAL & PILONIDAL PROCEDURES*	0.4055	16.8	14.0
268	SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES[4]	1.2493	31.3	26.0
269	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.3915	41.7	34.7
270	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC	1.3879	41.6	34.6
271	SKIN ULCERS	0.9714	31.1	25.9
272	MAJOR SKIN DISORDERS W CC	0.6846	21.0	17.5
273	MAJOR SKIN DISORDERS W/O CC[2]	0.6655	21.9	18.2
274	MALIGNANT BREAST DISORDERS W CC[7]	0.7872	22.0	18.3
275	MALIGNANT BREAST DISORDERS W/O CC[7]	0.7872	22.0	18.3
276	NON-MALIGANT BREAST DISORDERS[2]	0.6655	21.9	18.2
277	CELLULITIS AGE >17 W CC	0.7704	24.4	20.3
278	CELLULITIS AGE >17 W/O CC	0.6353	22.4	18.6
279	CELLULITIS AGE 0-17*	0.6655	21.9	18.2
280	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC	1.0097	30.9	25.7
281	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC	0.7363	27.4	22.8
282	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0-17*	0.6655	21.9	18.2
283	MINOR SKIN DISORDERS W CC	0.8574	24.8	20.6
284	MINOR SKIN DISORDERS W/O CC[1]	0.4055	16.8	14.0

TABLE 3.—LTC–DRG RELATIVE WEIGHTS, GEOMETRIC MEAN LENGTH OF STAY, AND SHORT-STAYS OF FIVE-SIXTHS AVERAGE LENGTH OF STAY FOR THE PERIOD OF JULY 1, 2003 THROUGH SEPTEMBER 30, 2003—Continued

LTC–DRG	Description	Relative Weight	Geo-metric Mean Length of Stay	Short-Stays of 5/6th Average Length of Stay
285	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DISORDERS	1.3692	31.7	26.4
286	ADRENAL & PITUITARY PROCEDURES*	1.2493	31.3	26.0
287	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS	1.3195	39.6	33.0
288	O.R. PROCEDURES FOR OBESITY[5]	1.8783	46.3	38.5
289	PARATHYROID PROCEDURES*	0.4055	16.8	14.0
290	THYROID PROCEDURES[1]	0.4055	16.8	14.0
291	THYROGLOSSAL PROCEDURES*	0.4055	16.8	14.0
292	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC[4]	1.2493	31.3	26.0
293	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC*	0.6655	21.9	18.2
294	DIABETES AGE >35	0.7678	25.1	20.9
295	DIABETES AGE 0-35[3]	0.8284	23.3	19.4
296	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	0.7710	24.3	20.2
297	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC	0.6321	21.1	17.5
298	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0-17*	0.6655	21.9	18.2
299	INBORN ERRORS OF METABOLISM[3]	0.8284	23.3	19.4
300	ENDOCRINE DISORDERS W CC	0.8670	23.3	19.4
301	ENDOCRINE DISORDERS W/O CC[1]	0.4055	16.8	14.0
302	KIDNEY TRANSPLANT[6]	0.0000	0.0	0.0
303	KIDNEY,URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM[5]	1.8783	46.3	38.5
304	KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC[4]	1.2493	31.3	26.0
305	KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC[2]	0.6655	21.9	18.2
306	PROSTATECTOMY W CC[3]	0.8284	23.3	19.4
307	PROSTATECTOMY W/O CC[1]	0.4055	16.8	14.0
308	MINOR BLADDER PROCEDURES W CC[3]	0.8284	23.3	19.414.0
309	MINOR BLADDER PROCEDURES W/O CC*	0.4055	16.8	26.0
310	TRANSURETHRAL PROCEDURES W CC[4]	1.2493	31.3	14.0
311	TRANSURETHRAL PROCEDURES W/O CC[1]	0.4055	16.8	38.5
312	URETHRAL PROCEDURES, AGE >17 W CC[5]	1.8783	46.3	14.0
313	URETHRAL PROCEDURES, AGE >17 W/O CC*	0.4055	16.8	14.0
314	URETHRAL PROCEDURES, AGE 0-17*	0.4055	16.8	14.0
315	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	1.5800	39.5	32.9
316	RENAL FAILURE	0.9308	24.1	20.0
317	ADMIT FOR RENAL DIALYSIS[4]	1.2493	31.3	26.0
318	KIDNEY & URINARY TRACT NEOPLASMS W CC	0.8075	21.5	17.9
319	KIDNEY & URINARY TRACT NEOPLASMS W/O CC[2]	0.6655	21.9	18.2
320	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	0.7424	23.9	19.9
321	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	0.6123	20.4	17.0
322	KIDNEY & URINARY TRACT INFECTIONS AGE 0-17*	0.6655	21.9	18.2
323	URINARY STONES W CC, &/OR ESW LITHOTRIPSY[2]	0.6655	21.9	18.2
324	URINARY STONES W/O CC[2]	0.6655	21.9	18.2
325	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC	0.8123	26.7	22.2
326	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC[2]	0.6655	21.9	18.2
327	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0-17*	0.4055	16.8	14.0
328	URETHRAL STRICTURE AGE >17 W CC*	0.6655	21.9	18.2
329	URETHRAL STRICTURE AGE >17 W/O CC[1]	0.4055	16.8	14.0
330	URETHRAL STRICTURE AGE 0-17*	0.4055	16.8	14.0
331	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC	0.9267	24.6	20.5
332	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC	0.6393	20.9	17.4
333	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0-17*	0.4055	16.8	14.0
334	MAJOR MALE PELVIC PROCEDURES W CC*	1.2493	31.3	26.0
335	MAJOR MALE PELVIC PROCEDURES W/O CC*	0.8284	23.3	19.4
336	TRANSURETHRAL PROSTATECTOMY W CC[3]	0.8284	23.3	19.4
337	TRANSURETHRAL PROSTATECTOMY W/O CC*	0.6655	21.9	18.2
338	TESTES PROCEDURES, FOR MALIGNANCY*	0.6655	21.9	18.2
339	TESTES PROCEDURES, NON-MALIGNANCY AGE >17[1]	0.4055	16.8	14.0
340	TESTES PROCEDURES, NON-MALIGNANCY AGE 0-17*	0.4055	16.8	14.0
341	PENIS PROCEDURES[2]	0.6655	21.9	18.2
342	CIRCUMCISION AGE >17[4]	1.2493	31.3	26.0
343	CIRCUMCISION AGE 0-17	0.4055	16.8	14.0
344	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY[4]	1.2493	31.3	26.0
345	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY[3]	0.8284	23.3	19.4
346	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC	0.7070	21.6	18.0
347	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC[2]	0.6655	21.9	18.2
348	BENIGN PROSTATIC HYPERTROPHY W CC[1]	0.4055	16.8	14.0
349	BENIGN PROSTATIC HYPERTROPHY W/O CC*	0.4055	16.8	14.0
350	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	0.6058	19.9	16.5
351	STERILIZATION, MALE*	0.4055	16.8	14.0

TABLE 3.—LTC–DRG RELATIVE WEIGHTS, GEOMETRIC MEAN LENGTH OF STAY, AND SHORT-STAYS OF FIVE-SIXTHS AVERAGE LENGTH OF STAY FOR THE PERIOD OF JULY 1, 2003 THROUGH SEPTEMBER 30, 2003—Continued

LTC–DRG	Description	Relative Weight	Geo-metric Mean Length of Stay	Short-Stays of 5/6th Average Length of Stay
352	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES [3]	0.8284	23.3	19.4
353	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY *	1.8783	46.3	38.5
354	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC *	1.2493	31.3	26.0
355	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC *	1.2493	31.3	26.0
356	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES *	1.2493	31.3	26.0
357	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY *	1.2493	31.3	26.0
358	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC [5]	1.8783	46.3	38.5
359	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC [1]	0.4055	16.8	14.0
360	VAGINA, CERVIX & VULVA PROCEDURES [1]	0.4055	16.8	14.0
361	LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION *	0.6655	21.9	18.2
362	ENDOSCOPIC TUBAL INTERRUPTION *	0.6655	21.9	18.2
363	D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY *	0.8284	23.3	19.4
364	D&C, CONIZATION EXCEPT FOR MALIGNANCY *	0.6655	21.9	18.2
365	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES [5]	1.8783	46.3	38.5
366	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	0.9654	23.9	19.9
367	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC [3]	0.8284	23.3	19.4
368	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM [4]	1.2493	31.3	26.0
369	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS [2]	0.6655	21.9	18.2
370	CESAREAN SECTION W CC *	0.8284	23.3	19.4
371	CESAREAN SECTION W/O CC *	0.6655	21.9	18.2
372	VAGINAL DELIVERY W COMPLICATING DIAGNOSES *	0.6655	21.9	18.2
373	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES *	0.4055	16.8	14.0
374	VAGINAL DELIVERY W STERILIZATION &/OR D&C *	0.4055	16.8	14.0
375	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C *	0.4055	16.8	14.0
376	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE *	0.4055	16.8	14.0
377	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE *	0.4055	16.8	14.0
378	ECTOPIC PREGNANCY *	0.6655	21.9	18.2
379	THREATENED ABORTION *	0.4055	16.8	14.0
380	ABORTION W/O D&C *	0.4055	16.8	14.0
381	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY *	0.4055	16.8	14.0
382	FALSE LABOR *	0.4055	16.8	14.0
383	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS *	0.4055	16.8	14.0
384	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS *	0.4055	16.8	14.0
385	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY *	0.4055	16.8	14.0
386	EXTREME IMMATURITY *	0.6655	21.9	18.2
387	PREMATURITY W MAJOR PROBLEMS *	0.6655	21.9	18.2
388	PREMATURITY W/O MAJOR PROBLEMS *	0.4055	16.8	14.0
389	FULL TERM NEONATE W MAJOR PROBLEMS [4]	1.2493	31.3	26.0
390	NEONATE W OTHER SIGNIFICANT PROBLEMS *	0.6655	21.9	18.2
391	NORMAL NEWBORN *	0.4055	16.8	14.0
392	SPLENECTOMY AGE >17 *	0.8284	23.3	19.4
393	SPLENECTOMY AGE 0-17 *	0.6655	21.9	18.2
394	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS [5]	1.8783	46.3	38.5
395	RED BLOOD CELL DISORDERS AGE >17	0.8584	25.1	20.9
396	RED BLOOD CELL DISORDERS AGE 0-17 *	0.4055	16.8	14.0
397	COAGULATION DISORDERS	0.7567	19.4	16.1
398	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	0.9008	23.4	19.5
399	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC)[1]	0.4055	16.8	14.0
400	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE [3]	0.8284	23.3	19.4
401	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC [4]	1.2493	31.3	26.0
402	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC *	0.8284	23.3	19.4
403	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	0.9651	23.9	19.9
404	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	0.8980	19.1	15.9
405	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0-17 *	0.6655	21.9	18.2
406	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC [5]	1.8783	46.3	38.5
407	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC *	0.8284	23.3	19.4
408	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC [4]	1.2493	31.3	26.0
409	RADIOTHERAPY	0.5220	19.5	16.2
410	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS [1]	0.4055	16.8	14.0
411	HISTORY OF MALIGNANCY W/O ENDOSCOPY *	0.4055	16.8	14.0
412	HISTORY OF MALIGNANCY W ENDOSCOPY *	0.4055	16.8	14.0
413	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC [7]	0.9061	23.7	19.7
414	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC [7]	0.9061	23.7	19.7
415	O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	1.4933	38.7	32.2
416	SEPTICEMIA AGE >17	0.9612	25.9	21.5
417	SEPTICEMIA AGE 0-17 *	0.8284	23.3	19.4
418	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	0.8771	25.8	21.5

TABLE 3.—LTC–DRG RELATIVE WEIGHTS, GEOMETRIC MEAN LENGTH OF STAY, AND SHORT-STAYS OF FIVE-SIXTHS AVERAGE LENGTH OF STAY FOR THE PERIOD OF JULY 1, 2003 THROUGH SEPTEMBER 30, 2003—Continued

LTC–DRG	Description	Relative Weight	Geo-metric Mean Length of Stay	Short-Stays of 5/6th Average Length of Stay
419	FEVER OF UNKNOWN ORIGIN AGE >17 W CC	0.5948	20.5	17.0
420	FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC[1]	0.4055	16.8	14.0
421	VIRAL ILLNESS AGE >17[4]	1.2493	31.3	26.0
422	VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0-17*	0.4055	16.8	14.0
423	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	0.8701	24.7	20.5
424	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS[5]	1.8783	46.3	38.5
425	ACUTE ADJUSTMENT REACTION & PSYCHOLOGICAL DYSFUNCTION	0.6177	26.0	21.6
426	DEPRESSIVE NEUROSES	0.5739	26.9	22.4
427	NEUROSES EXCEPT DEPRESSIVE[2]	0.6655	21.9	18.2
428	DISORDERS OF PERSONALITY & IMPULSE CONTROL[4]	1.2493	31.3	26.0
429	ORGANIC DISTURBANCES & MENTAL RETARDATION	0.5466	25.0	20.8
430	PSYCHOSES	0.4479	22.9	19.0
431	CHILDHOOD MENTAL DISORDERS	0.4345	22.7	18.9
432	OTHER MENTAL DISORDER DIAGNOSES[2]	0.6655	21.9	18.2
433	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	0.2489	13.1	10.9
439	SKIN GRAFTS FOR INJURIES	1.3200	42.5	35.4
440	WOUND DEBRIDEMENTS FOR INJURIES	1.3567	40.1	33.4
441	HAND PROCEDURES FOR INJURIES*	0.6655	21.9	18.2
442	OTHER O.R. PROCEDURES FOR INJURIES W CC	1.6442	39.7	33.0
443	OTHER O.R. PROCEDURES FOR INJURIES W/O CC[2]	0.6655	21.9	18.2
444	TRAUMATIC INJURY AGE >17 W CC	0.9614	30.7	25.5
445	TRAUMATIC INJURY AGE >17 W/O CC	0.8448	27.3	22.7
446	TRAUMATIC INJURY AGE 0-17*	0.8284	23.3	19.4
447	ALLERGIC REACTIONS AGE >17[2]	0.6655	21.9	18.2
448	ALLERGIC REACTIONS AGE 0-17*	0.4055	16.8	14.0
449	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC[3]	0.8284	23.3	19.4
450	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC[2]	0.6655	21.9	18.2
451	POISONING & TOXIC EFFECTS OF DRUGS AGE 0-17*	0.4055	16.8	14.0
452	COMPLICATIONS OF TREATMENT W CC	0.9596	25.5	21.2
453	COMPLICATIONS OF TREATMENT W/O CC	0.6666	23.1	19.2
454	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC[3]	0.8284	23.3	19.4
455	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC[1]	0.4055	16.8	14.0
461	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES	1.3383	38.0	31.6
462	REHABILITATION	0.6469	23.5	19.5
463	SIGNS & SYMPTOMS W CC	0.7618	26.8	22.3
464	SIGNS & SYMPTOMS W/O CC	0.6234	24.3	20.2
465	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS[3]	0.8284	23.3	19.4
466	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	0.8119	23.9	19.9
467	OTHER FACTORS INFLUENCING HEALTH STATUS[2]	0.6655	21.9	18.2
468	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	2.2177	45.5	37.9
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*	1.8783	46.3	38.5
473	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	0.8047	17.1	14.2
475	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	2.0906	35.5	29.5
476	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS[5]	1.8783	46.3	38.5
477	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	1.6791	39.7	33.0
478	OTHER VASCULAR PROCEDURES W CC	1.6244	37.8	31.5
479	OTHER VASCULAR PROCEDURES W/O CC[2]	0.6655	21.9	18.2
480	LIVER TRANSPLANT[6]	0.0000	0.0	0.0
481	BONE MARROW TRANSPLANT*	1.8783	46.3	38.5
482	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES*	0.6655	21.9	18.2
483	TRACH W MECH VENT 96+ HRS OR PDX EXCEPT FACE,MOUTH & NECK DIAG	3.2319	4.6	45.5
484	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA*	1.8783	46.3	38.5
485	LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TR*	1.8783	46.3	38.5
486	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA[3]	0.8284	23.3	19.4
487	OTHER MULTIPLE SIGNIFICANT TRAUMA	1.0885	29.5	24.5
488	HIV W EXTENSIVE O.R. PROCEDURE[5]	1.8783	46.3	38.5
489	HIV W MAJOR RELATED CONDITION	0.8846	22.9	19.0
490	HIV W OR W/O OTHER RELATED CONDITION	0.6952	20.4	17.0
491	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY*	1.8783	46.3	38.5
492	CHEMOTHERAPY W ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS[3]	0.8284	23.3	19.4
493	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC[3]	0.8284	23.3	19.4
494	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC[1]	0.4055	16.8	14.0
495	LUNG TRANSPLANT[6]	0.0000	0.0	0.0
496	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION*	1.2493	31.3	26.0
497	SPINAL FUSION W CC[5]	1.8783	46.3	38.5

TABLE 3.—LTC–DRG RELATIVE WEIGHTS, GEOMETRIC MEAN LENGTH OF STAY, AND SHORT-STAYS OF FIVE-SIXTHS AVERAGE LENGTH OF STAY FOR THE PERIOD OF JULY 1, 2003 THROUGH SEPTEMBER 30, 2003—Continued

LTC–DRG	Description	Relative Weight	Geo-metric Mean Length of Stay	Short-Stays of 5/6th Aver-age Length of Stay
498	SPINAL FUSION W/O CC[3]	0.8284	23.3	19.4
499	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC[5]	1.8783	46.3	38.5
500	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC*	0.8284	23.3	19.4
501	KNEE PROCEDURES W PDX OF INFECTION W CC[5]	1.8783	46.3	38.5
502	KNEE PROCEDURES W PDX OF INFECTION W/O CC*	0.8284	23.3	19.4
503	KNEE PROCEDURES W/O PDX OF INFECTION[5]	1.8783	46.3	38.5
504	EXTENSIVE 3RD DEGREE BURNS W SKIN GRAFT*	1.8783	46.3	38.5
505	EXTENSIVE 3RD DEGREE BURNS W/O SKIN GRAFT[4]	1.2493	31.3	26.0
506	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA[5]	1.8783	46.3	38.5
507	FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA*	0.8284	23.3	19.4
508	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ W CC OR SIG TRAUMA[3]	0.8284	23.3	19.4
509	FULL THICKNESS BURN W/O SKIN GRFT OR INH INJ W/O CC OR SIG TRAUMA[3]	0.8284	23.3	19.4
510	NON-EXTENSIVE BURNS W CC OR SIGNIFICANT TRAUMA	1.0734	32.2	26.8
511	NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA[3]	0.8284	23.3	19.4
512	SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT[6]	0.0000	0.0	0.0
513	PANCREAS TRANSPLANT[6]	0.0000	0.0	0.0
514	CARDIAC DEFIBRILATOR IMPLANT W CARDIAC CATH*	0.8284	23.3	19.4
515	CARDIAC DEFIBRILATOR IMPLANT W/O CARDIAC CATH[4]	1.2493	31.3	26.0
516	PERCUTANEOUS CARDIVASCULAR PROCEDURE W AMI*	0.8284	23.3	19.4
517	PERCUTANEOUS CARDIVASCULAR PROC W NON-DRUG ELUTING STENT W/O AMI[5]	1.8783	46.3	38.5
518	PERCUTANEOUS CARDIVASCULAR PROC W/O CORONARY ARTERY STENT OR AMI[4]	1.2493	31.3	26.0
519	CERVICAL SPINAL FUSION W CC[3]	0.8284	23.3	19.4
520	CERVICAL SPINAL FUSION W/O CC[2]	0.6655	21.9	18.2
521	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	0.3755	18.6	15.5
522	ALCOHOL/DRUG ABUSE OR DEPENDENCE W REHABILITATION THERAPY W/O CC[1]	0.4055	16.8	14.0
523	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W/O CC	0.3860	21.2	17.6
524	TRANSIENT ISCHEMIA	0.6250	23.1	19.2
525	HEART ASSIST SYSTEM IMPLANT*	1.8783	46.3	38.5
526	PERCUTANEOUS CARVIOVASCULAR PROC W DRUG-ELUTING STENT W AMI*	0.8284	23.3	19.4
527	PERCUTANEOUS CARVIOVASCULAR PROC W DRUG-ELUTING STENT W/O AMI*	0.8284	23.3	19.4

* 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 2001 MedPAR.

[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 0.0.
[7] Relative weights for these LTC–DRGs were determined after adjusting to account for nonmonotonically (see step 5 above).

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