

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412

[CMS-1472-P]

RIN 0938-AL92

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

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

ACTION: Proposed rule.

SUMMARY: In this 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), we are proposing 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 July 1 through June 30. We also are proposing to change the publication schedule for these updates to allow for an effective date of July 1 (instead of August 1). The proposed payment amounts and factors used to determine the proposed updated Federal rates that are described in this proposed rule have been determined based on this proposed revised update rate year. In addition, we are proposing that the annual update of the long-term care diagnosis-related groups (LTC-DRG) classifications and relative weights will remain linked to the annual adjustments of the acute care hospital inpatient diagnosis-related group system, effective each October 1. The proposed outlier threshold for July 1, 2003 through June 30, 2004 would be derived from the proposed rate year calculations. In order to conform to a proposed change in the acute care hospital inpatient PPS (IPPS) outlier policy, we are proposing a change for outlier payments under the LTCH PPS.

We also are proposing 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.

DATES: Comments will be considered if received at the appropriate address, as provided below, no later than 5 p.m. on May 6, 2003.

ADDRESSES: Mail written comments (an original and three copies) to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human

Services, Attention: CMS-1472-P, PO Box 8010, Baltimore, MD 21244-1850.

If you prefer, you may deliver, by hand or courier, your written comments (an original and three copies) to one of the following addresses:

Room 443-G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or Room C5-14-03, Central Building, 7500 Security Boulevard, Baltimore, MD 21244-1850.

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

Comments mailed to those addresses specified as appropriate for courier delivery may be delayed and could be considered late.

Because of staffing and resource limitation, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code CMS-1472-P.

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

For comments that relate to information collection requirements, mail a copy of comments to the following address:

Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Security and Standards Group, Regulations Development and Issuances Group Standards, PRA Reports Clearance Office, 7500 Security Boulevard, Baltimore, MD 21244-1850. Attn: John Burke, CMS-1472-P; and

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 3001, New Executive Office Building, Washington, DC 20503, Attn: Brenda Aguilar, CMS Desk Officer.

FOR FURTHER INFORMATION CONTACT:

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

Judy Richter, (410) 786-2590 (General information, transition payments, payment adjustments, and onsite discharges and readmissions)

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

Tiffany Eggers, (410) 786-0400 (Market basket update, short-stay outliers and interrupted stays)

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

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

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

Kathryn McCann, (410) 786-7623 (Medigap)

Robert Nakielny, (410) 786-4466 (Medicaid)

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments

Comments received timely will be available for public inspection as they are processed, generally beginning approximately 4 weeks after publication of a document, in Room C5-12-08 of the Centers for Medicare & Medicaid Services, 7500 Security Blvd., Baltimore, MD, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. Please call (410) 786-7197 to schedule an appointment to view public comments.

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Acronyms

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

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

I. Background

A. Legislative and Regulatory Authority
The Medicare, Medicaid, and SCHIP [State Children's Health Insurance

Program] Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106-113) and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106-554) provide for payment for both the operating and capital-related costs of hospital inpatient stays in long-term care hospitals (LTCHs) under Medicare Part A based on prospectively set rates. The Medicare prospective payment system 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 another 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 Pub. L. 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 123 also requires that the system be implemented for cost reporting periods beginning on or after October 1, 2002.

Section 307(b)(1) of Pub. L. 106-554 mandates the examination of the feasibility and the impact of basing payment under the LTCH prospective payment system (LTCH PPS) on the use of existing (or refined) hospital DRGs that have been modified to account for different resource use of LTCH patients as well as the use of the most recently available hospital discharge data. Further, section 307(b)(1) provides 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 Pub. L. 106-113 and Pub. L. 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), Pub. L. 97-248, for payments for inpatient services provided by a LTCH with a cost reporting period beginning on or after October 1, 2002. (The regulations implementing the TEFRA hospital 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 (Pub. L. 98-21), which added section 1886(d) to the Act, certain hospitals, including LTCHs, were excluded from the PPS for acute care hospitals and 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 ceiling on payments to each hospital excluded from the acute care hospital inpatient prospective payment system (IPPS) 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 Pub. L. 106-113. That same final rule, which 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 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 must have

an average Medicare inpatient length of stay of greater than 25 days, or, for cost reporting periods beginning on or after August 5, 1997, 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), 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.

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, 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 Pub. L. 90-248 (42 U.S.C. 1395b-1) or section 222(a) of Pub. L. 92-603 (42 U.S.C. 1395b-1 (note)) (statewide all-payer systems, subject to the rate-of-increase test at section 1814(b) of the Act).

- Nonparticipating hospitals furnishing emergency services to Medicare beneficiaries.

C. Transition Period for Implementation of the LTCH PPS

In the August 30, 2002 final rule (67 FR 56038), we provided for a 5-year transition period from cost-based reimbursement to fully Federal prospective payment for LTCHs. 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
Oct. 1, 2002	20	80
Oct. 1, 2003	40	60
Oct. 1, 2004	60	40
Oct. 1, 2005	80	20
Oct. 1, 2006	100	0

The phase-in for payments to the full prospective payment Federal rate will apply according to each LTCH's cost reporting period.

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 CMS regulates 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 CMS. 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 will 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 HIPAA Administrative Simplification Standards must start submitting electronic claims in compliance with the HIPAA regulations cited above, among others.

II. Summary of the Major Contents of This Proposed Rule

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

A. Proposed Change in the Annual Update

We are proposing to change 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 rate year" of July 1 through June 30, beginning July 1, 2003, as discussed in section III. of this preamble. (In this proposed rule, we would define the LTCH rate year as the period of July 1 to June 30 for updates to the LTCH PPS.) We are proposing to publish information on the annual update in the **Federal Register** by June 1 of each year. We recognize that it may be necessary to address issues affecting LTCHs at a time that does not conform to this schedule and in those circumstances, we could utilize the IPPS proposed and final rule for this purpose.

B. Proposed Update Changes

- In section IV. of this preamble, we are proposing that the annual update of the LTC-DRG classifications and relative weights would 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 V. of this preamble, we discuss a proposed policy change in how Medicare payment under the LTCH PPS would be made to certain LTCHs that have satellite facilities.

- In sections VI. through X. of this preamble, we discuss our proposed determination of the LTCH PPS rates that would be applicable to the proposed LTCH rate year of July 1, 2003 through June 30, 2004, including proposed revisions to the wage index,

the proposed excluded hospital with capital market basket that would be applied to the current standard Federal rate to determine the prospective payment rates, the applicable adjustments to payments, the proposed outlier threshold, the transition period, and the proposed budget neutrality factor.

- We are also proposing to revise § 412.525(a) and § 412.529(c)(4) regarding adjustments to outlier payments under the LTCH PPS in order to conform the regulation to a proposed policy change under the IPPS that is published in the **Federal Register** on March 4, 2003.

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

- In section XIII. of this preamble, we set forth an analysis of the impact of the proposed changes in this proposed rule on Medicare expenditures and on Medicare-participating LTCHs and Medicare beneficiaries.

III. Proposed 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. We are proposing 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 (67 FR 55977), 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. 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 this proposed rule, we are proposing to change 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 (acute care hospital inpatient and LTCH). 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. This proposed 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).

We also are proposing to amend § 412.503 to include a definition of "long-term care hospital rate year". A "long-term care hospital rate year" would mean the 12-month period of July 1 through June 30. We would use this period for those calculations related to updating the Federal rate for payments under the LTCH PPS. The determination of the proposed fixed-loss threshold for outlier payment calculations, under § 412.525(a), would also be calculated based on the proposed LTCH rate year. (Section VI.C. of this proposed rule includes a more detailed discussion of our proposed outlier policy.)

Proposing a change for the annual Federal rate update period for the LTCH PPS has 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 adopted 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 are proposing to change the Federal rate update for the LTCH PPS from the Federal fiscal year to a 12-month year of July 1 through June 30, and the proposed rates in this proposed rule are 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 utilized for 9 months, if the proposed change in the LTCH PPS rate update year is finalized, we are proposing 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 are proposing that the change in the proposed 2004 LTCH PPS rate year be budget neutral. In section VI.B.1 of this proposed rule, we describe this proposed adjustment in greater detail.

We are proposing 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 data (as discussed in section VI.C. of this preamble).

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

As discussed in section IV.C. of this proposed rule, we are not proposing an update to the LTC-DRG classifications or relative weights at this time. Currently, the LTC-DRG patient classifications utilized 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 are not proposing any change to the timing of the annual update of the LTC-DRG classifications and relative weights. They would 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 we are reprinting as Table 3 of the Addendum to this proposed rule, contains the LTC-DRG classifications and relative weights that we propose 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 would 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 based on the annual updates to the acute care hospital inpatient DRG system. The FY 2004 DRGs and relative weights for the IPPS have not yet been proposed and we are unable to propose updated LTC-DRGs and relative weights (which would be based on the proposed updated acute care hospital inpatient DRGs and relative weights) at this time. Thus, we are proposing 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, for an effective date of October 1, 2003.

The proposed change in the 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 proposed July 1, 2003 update. We are proposing a prospective adjustment to the market basket update to take into account this 3-month differential in setting the proposed rates for July 1, 2003 through June 30, 2004.

Specifically, 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 proposed Federal rate effective for July 1, 2003 through June 30, 2004.

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

Several provisions of the LTCH PPS would not be affected by the proposed 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) would 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 would 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 would have been calculated under the TEFRA 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 would have been calculated under the

TEFRA 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) would 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 would not be affected since they would 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.

Section XII. of this proposed rule contains an impact analysis that reflects the impact of these proposed changes.

In summary, we are proposing to 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 would be published in the **Federal Register** on or before June 1 prior to the beginning of each proposed LTCH PPS rate year beginning July 1. We are proposing 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).

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

A. Background

Section 123 of Pub. L. 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 Pub. L. 106-554 modified the requirements of section 123 of Pub. L. 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 Pub. L. 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-CS (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 discussed in section III. of this proposed rule, we are proposing to make the annual update to the LTCH PPS effective from July 1 through June 30 each year. As a result of this change 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 is necessary for us to propose to apply two GROUPER programs to the LTCH PPS. Although we do not believe that this will have any adverse effect on LTCHs, we are 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), we are proposing our intent to use Version 21.0 of the GROUPER software for both the IPPS and the LTCH PPS. Thus, proposed 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 would be effective for October 1, 2003 through September 30, 2004, would be presented in the IPPS FY 2004 proposed rule that will be published in the spring of 2003 in the **Federal Register**. Accordingly, we would then 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.

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

- Diagnoses include all diagnoses that affect the current hospital stay.
- Principal diagnosis is defined as the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.
- Other diagnoses (also called secondary diagnoses or additional diagnoses) are defined as all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received or the length of

stay or both. Diagnoses that relate to an earlier episode of care that have no bearing on the current hospital stay are excluded.

- All procedures performed will be reported. This includes those that are surgical in nature, carry a procedural risk, carry an anesthetic risk, or require specialized training.

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

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

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

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

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

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 proposed change to the annual update of the LTCH PPS year to July 1, we are proposing that coders would use the most current updated ICD-9-CM coding book from October 1 through September 30 of each year. This would mean that coders and LTCHs that use the updated ICD-9-CM coding system would 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 are proposing to publish the LTCH annual payment rate update final rule. The new codes on which the LTC-DRGs are based would 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: <http://www.ahacentraloffice.org>. In addition, current coding guidelines are available at the National Center for Health Statistics (NCHS) Web site:

<http://www.cdc.gov/nchs.icd9.htm>.

In conjunction with the cooperating parties of the C&M Committee (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 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 or 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).

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

As previously discussed, 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 GROUPEX 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 previously, we are proposing that we would continue to use the same LTC-DRGs and relative weights until October 1, 2003. Accordingly, Table 3 in the Addendum to this proposed rule lists the LTC-DRGs and their respective relative weights and arithmetic mean length of stay that we are proposing 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 this

preamble, we are proposing that the final DRGs and GROUPER for FY 2004 that would 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 would 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.

V. Proposed Policy Change Related to Payments to LTCHs That Are Satellite Facilities

In the March 22, 2002 proposed rule related to the establishment of the LTCH PPS (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 applicable 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 elected to be 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, we are now proposing to eliminate the application of the bed-number restrictions set forth in § 412.22(h)(i) for LTCHs established prior to 1997 with satellite facilities, effective at the start of the first cost reporting year that the LTCH is paid under the 100 percent fully Federal prospective payment system. This would be either when the LTCH elects to be paid based on 100 percent of the Federal prospective rate or when the LTCH is transitioned to 100 percent of the Federal prospective rate, whichever comes first.

Presently, section 1886(b)(3) of the Act, as amended by section 4414 of Pub. L. 105-33, requires 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 Pub. L. 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 Pub. L. 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 section 4414 and 4416 of Pub. L. 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 final rule for the IPPS (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), which implemented section 4414 of Pub. L. 105-33), from creating satellite arrangements 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) which implemented section 4416 of Pub. L. 105-33). Under the July 30, 1999 acute care hospital inpatient final rule (64 FR 41490), in order to address this possibility of gaming if 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 TEFRA payment system. Although the excluded hospital

could “transfer” bed capacity from the parent facility to the satellite, it could not increase its total bed capacity beyond the level it 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 (or other excluded facility) established after October 1, 1997 because it would have already been subject to the lower payment limits under § 413.40(f)(2)(ii) of 110 percent of the national median of target amounts for similarly classified hospitals. Therefore, it would not benefit from the higher 75 percent cap on target amounts under § 413.40(c)(4) by establishing a satellite facility, as would a pre-1997 LTCH.

The rationale for the bed-limit provision based on the distinction between these groups of hospitals was the potential for gaming, 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, we are proposing to eliminate the bed-limit provision once the LTCH is paid based on 100 percent of the LTCH Federal PPS rate. Finally, under this proposed policy, the bed limitation on “existing” LTCHs would, 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 TEFRA payment rules, until they transition to a rate based on 100 percent of the Federal prospective payment rate.

VI. Proposed Changes to the LTCH PPS Rates for the Proposed 2004 LTCH PPS Rate Year

A. Overview of the Development of the Proposed Payment Rates

The PPS for LTCHs was effective for cost reporting periods 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 TEFRA, 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 our regulations at §§ 412.521 through 412.529. Below we discuss the factors that we are proposing to use to update the LTCH PPS standard Federal rate for the proposed 2004 LTCH PPS rate year, which would be effective for LTCHs paid under the PPS for discharges occurring on or after July 1, 2003 through June 30, 2004.

In the August 30, 2002 final rule (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 Pub. L. 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 TEFRA methodology if the PPS for LTCHs were not implemented. Section 307(a) of Pub. L. 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 Pub. L. 106–554 shall not be taken into account in the development and implementation of the LTCH PPS. In addition, the statute provides for enhanced bonus payments for LTCHs for FY 2001 and FY 2002 provided for by section 122 of Pub. L. 106–113. 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. Proposed Update to the Standard Federal Rate for the Proposed 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. Based on the most recent estimate of the excluded hospital with capital market basket, adjusted to account for the proposed change in the rate year update cycle for the LTCH PPS rates discussed in section III. of this proposed rule, the proposed LTCH PPS standard Federal rate, effective from July 1, 2003 through June 30, 2004, would be \$35,726.64 (as discussed below).

In the discussion that follows, we explain how we developed the proposed update to the standard Federal rate. The proposed Federal rate for the proposed 2004 LTCH PPS rate year is calculated based on the proposed update factor of 1.0250. Thus, the proposed standard Federal rate for the proposed 2004 LTCH PPS rate year would increase 2.2 percent compared to the FY 2003 standard Federal rate.

1. Proposed Standard Federal Rate Update

In the August 30, 2002 final rule, we established in § 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. Because the LTCH PPS has only 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, at this time, we are not proposing an update framework for the LTCH PPS. However, 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 Proposed Market Basket for LTCHs for the Proposed 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 TEFRA reimbursement 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 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.

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 this proposed rule, we are proposing to revise and rebase the excluded hospital with capital market basket, based on more recent data, to an FY 1997 base year for application beginning with the proposed 2004 LTCH PPS rate year.

We believe it is appropriate to propose to rebase the LTCH PPS market

basket based on the most recent complete data available (FY 1997) since these data would more accurately reflect LTCH current costs. This proposed rebasing of the LTCH PPS market basket from an FY 1992 base year to a FY 1997 base year is consistent with the rebasing of both the IPPS and the excluded hospital market basket used under the TEFRA payment system for FY 2003, as discussed in the August 1, 2002 IPPS final rule (67 FR 50032–50047).

The operating portion of the proposed FY 1997-based excluded hospital with capital market basket that we are proposing to use under the LTCH PPS is derived from the FY 1997-based excluded hospital market basket used under the TEFRA payment system. The methodology we proposed to use to develop the proposed operating portion of the market basket under the LTCH PPS is the same methodology used to describe the rebasing of the excluded hospital market basket used under the TEFRA 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 added to 100.0. These weights were determined from 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 this proposed rule, in applying the proposed FY 1997-based market basket we are proposing to make the same two methodological revisions that we established when we 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 FY 1997 Medicare cost reports for excluded hospitals, the capital cost weight would be 8.968 percent. Because capital costs would 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 – 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.

The aggregate capital component of the proposed 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 the 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 proposed FY 1997 weights for the proposed excluded hospital with capital market basket are presented below in Table I. The vintage weights for the proposed FY 1997-based excluded hospital with capital market basket are presented in Table II.

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

Cost category	Price/wage variable	Weights (%), base-year FY 1992 ^{1 2}	Proposed 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: Non-Medical	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

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

Cost category	Price/wage variable	Weights (%), base-year FY 1992 ^{1 2}	Proposed weights (%), base-year FY 1997 ^{1 2}
Professional Liability Insurance	CMS—Professional Liability Insurance Premiums Index	0.983	0.733
All Other Products and Services		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 Service	CPI-U—Food Away from Home	0.998	1.043
Chemicals	PPI—Industrial Chemicals	3.413	2.133
Blood and Blood Products	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 Equipment	PPI—Machinery & Equipment	0.193	0.852
Miscellaneous Products	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 Intensive	ECI—Compensation for Private Service Occupations	4.945	4.453
All Other: Non-Labor Intensive	CPI-U—All Items	0.757	3.700
Capital-Related Costs		9.080	8.968
Depreciation		5.611	5.586
Building & Fixed Equipment	Boeckh-Institutional Construct. Index—Vintage Weighted (23 years).	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 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 final rule (67 FR 50042–50044) was multiplied by 0.91032 to determine its weight in the proposed FY 1997-based excluded hospital with capital market basket.

²Weights may not sum to 100.0 due to rounding.

TABLE II.—PROPOSED 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

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

Year (from farthest to most recent) *	Building and fixed equipment (23-year weights) *	Movable equipment (11-year weights) *	Interest: capital-related (23-year weights) *
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 proposed FY 1997-based excluded hospital with capital market basket. As shown in the table, the proposed rebased and revised 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 final rule (67 FR 50043–50047).

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

Fiscal year (FY)	Percentage change	
	FY 1992-based excluded hospital market basket	Proposed rebased FY 1997-based excluded market basket
1999	2.3	2.7
2000	3.4	3.1
2001	3.9	4.0
Average historical	3.2	3.3
2002	2.8	3.7
2003	2.8	3.1
2004	3.0	3.3
Average forecast	2.9	3.3

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, 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 (as discussed below), at this time we are not proposing to develop a market basket specific to LTCH services.

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 proposed 1997-based excluded hospital with capital market basket presented in this proposed rule. 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.

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 proposed 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. We will continue to solicit comments about issues particular to LTCHs that should be considered in relation to the proposed FY 1997-based excluded hospital with capital market basket and to encourage suggestions for additional data sources that may be available.

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

As stated earlier, for LTCHs paid under the LTCH PPS, we are proposing that the 2004 rate year update would apply to discharges occurring from July 1, 2003 through June 30, 2004. Because we are proposing to change the timeframe of the standard Federal rate annual update, we needed to calculate an update factor that would reflect this proposed change in the update cycle. Presently, the current rate cycle is October 1, 2002 through September 30, 2003. This means that the 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. Since we are proposing to change the rate update cycle and, therefore, update the standard Federal rate 3 months earlier (that is, July 1, 2003 instead of October 1, 2003), we need 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 needed 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, 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. Based on the fourth quarter 2002 forecast of the proposed rebased FY 1997-based excluded hospital with capital market basket, this calculation results in an increase that is 0.8 percentage points less than it would have been if the proposed change in the LTCH PPS rate cycle would not be made. 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, needs 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.

Consistent with our historical practice of estimating market basket increases, based on Global Insights' (formerly DRI-WEFA) fourth quarter 2002 forecast of the proposed rebased FY 1997-based excluded hospital with capital market basket, we are proposing an update of 2.5 percent, as shown in Table IV. below.

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

	Percent
Proposed 2004 rate year full market basket with capital increase*	3.3
Adjustment for the proposed change in the update cycle**	-0.8
Proposed 2004 market basket increase	2.5

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

**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.

In addition, based on the best available data for 194 LTCHs, we estimate that LTCH prospective payment system payments would be \$1.960 billion for the proposed 2004 LTCH prospective payment system rate year. As indicated previously, we are proposing to update the FY 2003 standard Federal rate and wage index data 3 months early (July 1, 2003 instead of October 1, 2003). We are proposing that this change be budget neutral because, as we discussed in the August 30, 2002 final rule (67 FR 56027), 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. Based on the most recent data, for the 3-month period from July 1, 2003 through September 30, 2003, the proposed increase in the standard Federal rate would result in an additional cost of \$5.66 million to the FY 2003 Federal budget. Accordingly, in order to maintain budget neutrality for the proposed change in the rate update cycle, under proposed § 412.523(c)(3)(ii), we are proposing to

adjust the standard Federal rate by a factor of 0.997 ((\$1.960 billion—\$5.66 million)/\$1.960 billion) or -0.003. Also, we propose to revise this adjustment factor in the final rule based on the best available data.

Therefore, we are proposing 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. This proposed update represents 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.

2. Proposed Standard Federal Rate for the Proposed 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. For the proposed 2004 LTCH PPS rate year, we are proposing 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 are not proposing any additional adjustments in the proposed standard Federal rate for these factors.

C. Calculation of Proposed LTCH Prospective Payments for the Proposed 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 § 412.521. 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 TEFRA 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	TEFRA rate percentage
Oct. 1, 2002	20	80
Oct. 1, 2003	40	60
Oct. 1, 2004	60	40
Oct. 1, 2005	80	20
Oct. 1, 2006	100	0

Accordingly, for cost reporting periods beginning 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 TEFRA rate and 20 percent of the adjusted Federal rate. For cost reporting periods beginning during FY 2004 (that is, on or after October 1, 2003 and before September 30, 2004), blended payments under the transition methodology will be based on 60 percent of the LTCH's TEFRA rate and 40 percent of the adjusted Federal rate.

1. Proposed Adjustment for Area Wage Levels

Under the authority of section 307(b) of Pub. L. 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 acute care inpatient 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. 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 have 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, we are not proposing to adjust the phase-in at this time. In addition, as stated earlier, 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 applicable proposed LTCH wage index will be two-fifths of the proposed applicable LTCH PPS index values discussed below. However, we will reevaluate LTCH data as they become available and would propose to adjust the phase-in if subsequent data support a change.

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. For the proposed 2004 LTCH PPS rate year, we are proposing that the wage index adjustment provided for under § 412.525(c) be based on the most recent available inpatient acute care hospital wage data, that is, the FY 2003 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. As we noted above, 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 are proposing to update the data used to compute the annual wage index values on the proposed 2004 LTCH PPS rate year cycle (July through June). For example, for a LTCH with a cost reporting period from January 1, 2003 through December

31, 2003, the LTCH will be paid using the one-fifth 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 would be based on the FY 2000 inpatient acute care hospital wage index data 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). Under our proposal 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) the LTCH would still be paid using one-fifth of the wage index value, but the wage index value would now be computed using FY 2003 inpatient acute care hospital wage index data without taking into account geographic reclassifications under sections 1886(d)(8) and (d)(10) of the Act (as shown in Tables 1 and 2 of the Addendum of this proposed rule). For the LTCH's cost reporting period from January 1, 2004 through December 31, 2004, the LTCH would 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-fifth wage index value would be based on the FY 2000 inpatient acute care hospital wage index data without taking into account geographic reclassifications under sections 1886(d)(8) and (d)(10) of the Act, as shown in Tables 1 and 2 of the Addendum of this proposed rule.

In the August 30, 2002 final rule (67 FR 56018), for FY 2003 we used the FY 2002 inpatient acute care hospital wage index data without taking into account geographic reclassifications under sections 1886(d)(8) and (d)(10) of the Act. The inpatient acute care hospital wage index data, without taking into account geographic reclassification under section 1886(d)(8) or section 1886(d)(10) of the Act, is also used under other postacute care PPSs, such as 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 proposed rule, for the proposed 2004 LTCH PPS

rate year, we are proposing to use the FY 2000 inpatient acute care hospital wage index data without taking into account geographic reclassifications under sections 1886(d)(8) and (d)(10) of the Act, 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 proposed LTCH wage index values for July 1, 2003 through June 30, 2004 is shown in Table 1 (for urban areas) and Table 2 (for rural areas) in the Addendum of this proposed rule. As noted above, for cost reporting periods beginning on or after October 1, 2002 and before September 30, 2003 (FY 2003), the applicable LTCH wage index is 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 September 30, 2003 (FY 2004), the applicable proposed LTCH wage index would be 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 rebase the excluded hospital with capital market basket from an FY 1992 to an FY 1997 base year (as discussed in section VI.B.1.a. of this preamble), we also are proposing to use a labor-related share that is determined from our proposed 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 this proposed rule, as discussed in further detail below, we are proposing 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.

To determine the proposed labor-related share, we use the cost categories contained in the proposed FY 1997-based excluded hospital with capital market basket that are influenced by local labor markets, which reflect the different rates of price change for these cost categories between the base year

(FY 1997) and this period. First, we estimate the portion related to operating costs, which we estimate to be 69.075 percent for the proposed LTCH PPS rate year of July 1, 2003 through June 30, 2004, calculated based on the Medicare cost reports for excluded hospitals as the sum of the relative importance for wages and salaries (48.967), employee benefits (11.032), professional fees (4.518), and labor-intensive services (4.558), as shown in Table V. The labor-related share of capital costs in the market basket needed to be considered

as well. After an analysis of FY 1997 Medicare cost report data, we found no evidence to revise our current estimate of the portion of capital costs that is influenced by local labor markets of 46 percent (*see* 67 FR 56016, August 30, 2002). Based on the proposed change in the LTCH PPS rate update cycle, the relative importance of capital is estimated to be 7.692 percent. Because the relative importance of capital is 7.692 percent of the proposed FY 1997-based excluded hospital with capital market basket for the proposed 2004

LTCH PPS rate year, we multiplied 46 percent by 7.692 percent to determine the labor-related share of capital costs to be 3.538 percent. We then added the 3.543 that was calculated for capital costs to the 69.075 percent that was calculated for operating costs to determine the total labor-related relative importance of 72.612. Therefore, we are proposing to use a labor-related share of 72.612 percent for the proposed 2004 LTCH PPS rate year.

TABLE V.—PROPOSED LABOR-RELATED SHARE RELATIVE IMPORTANCE

Cost category	Relative importance FY 1992-based market basket (proposed 2004 LTCH PPS rate year)	Relative importance FY 1997-based market basket (proposed 2004 LTCH PPS rate year)
Wages and salaries	50.572	48.967
Employee benefits	11.882	11.032
Professional fees	2.052	4.518
Postage	0.254	
All other labor intensive services	5.242	4.558
Subtotal	70.001	69.075
Labor-related share of capital costs	3.412	3.538
Total	73.413	72.612*

* Although the weights of the cost categories appear to add to 76.213, this is due to rounding; the actual labor-related share is 72.61246.

2. Proposed 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.

For the proposed 2004 LTCH PPS rate year, under § 412.525(b), we are proposing 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 VI. below. These factors are obtained from the U.S. Office of Personnel Management (OPM). If OPM releases revised COLA factors before May 1, 2003, we propose to use them for the development of payments and will publish them in the final rule.

TABLE VI.—PROPOSED COST-OF-LIVING ADJUSTMENT FACTORS FOR ALASKA AND HAWAII HOSPITALS FOR THE PROPOSED 2004 LTCH PPS RATE YEAR

Alaska:	
All areas	1.25
Hawaii:	
Honolulu County	1.25
Hawaii County	1.165
Kauai County	1.2325

TABLE VI.—PROPOSED COST-OF-LIVING ADJUSTMENT FACTORS FOR ALASKA AND HAWAII HOSPITALS FOR THE PROPOSED 2004 LTCH PPS RATE YEAR—Continued

Maui County	1.2375
Kalawao County	1.2375

3. Proposed 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 include a provision for outlier payments under the LTCH PPS and set the outlier threshold before the beginning of the applicable proposed rate update 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 PPS for a case with unusually high costs before the hospital 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 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 hospital. 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. For the proposed 2004 LTCH PPS rate year, we are proposing 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 being equal to 8 percent of total payments, based on the policies described in this 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. Consistent with the proposed outlier policy changes for acute care hospitals under the IPPS discussed in the March 4, 2003 proposed rule, we are proposing 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 are proposing 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 are proposing 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. No longer applying the applicable statewide average cost-to-charge ratio when a LTCH's actual cost-to-charge ratio falls below the floor would result in a lower future cost-to-charge ratio. Applying this lower cost-to-charge ratio to charges in the future to determine the cost of the case would result in more appropriate outlier payments. Therefore, consistent with the proposed policy change for acute care hospitals under the IPPS, we are proposing that LTCHs would receive their actual cost-to-charge ratios no matter how low their ratios fall. Also, consistent with the proposed policy change for acute care hospitals under the IPPS, we are proposing 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). 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 are proposing to make a similar change to § 412.529(c), by cross-referencing proposed § 412.84(i), for determining short-stay outlier payments to indicate that the applicable statewide average cost-to-charge ratio would 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. Since cost-to-charge ratios are also used in determining short-stay outlier payments, the rationale for this proposed change mirrors that for high-cost outliers.

Therefore, consistent with IPPS outlier policy in determining the proposed fixed-loss amount for the proposed 2004 LTCH PPS rate year, we are proposing to use only the current combined operating and capital cost-to-charge ratio ceiling under the IPPS of 1.421 (as explained in the acute care hospital inpatient PPS 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 in order to participate in the hospital in the Medicare program. As we also discussed in the August 30, 2002 final rule (67 FR 55956), in general hospitals are paid as a LTCH only because their average length of stay is greater than 25 days in accordance with § 412.23(e). Furthermore, 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 are proposing to assign the applicable IPPS statewide average 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).) We would also assign the applicable statewide average for LTCHs for which we are unable to compute a cost-to-charge ratio. Accordingly, for the proposed 2004 LTCH PPS rate year, we are proposing a fixed-loss amount of \$19,978. Thus, we would 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).

As we discussed in section IV.D. of this preamble, 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 are proposing 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 the final rule following this proposed rule is published. To the extent that the LTC-DRG weights in the version 21.0 GROUPER may change, total LTCH PPS payments may also change. Therefore, as explained in section IV.F. of this proposed rule, 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 would 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 this 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 are proposing 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 are proposing 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 are not proposing to change the fixed-loss amount to account for changes in the version 21.0 GROUPER because we believe implementing two fixed-loss amounts would 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, as described in section IV.E.2. of this proposed rule, is effective at the beginning of the Federal fiscal year, we will continue to update the GROUPER and the relative weights on October 1. Furthermore, 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, was based on 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, as explained above, we are proposing 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 did consider an alternative proposal that would establish two separate fixed-loss amounts: one for July through September based on the current GROUPER and another for October through June based on the updated GROUPER. 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.

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 VI. 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 short-stay outlier in the proposed 2004 LTCH PPS rate year, the high-cost outlier payment would be based on 80 percent of the difference between the estimated cost of the case plus the outlier threshold (the sum of the proposed fixed-loss amount of \$19,978 and the amount paid under the short-stay outlier policy).

Under existing regulations at § 412.525(a) (as established in the August 30, 2002 LTCH PPS final rule (67 FR 56026)), 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 short-term acute care hospitals under the IPPS. However, we note that in the proposed rule on March 4, 2003, 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 4, 2003 proposed rule, we are proposing 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, we are proposing to make a similar change in § 412.529(c)(4)(ii), by cross-referencing proposed § 412.84(m), to indicate 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.

In addition, because we currently use cost-to-charge ratios based on the latest settled cost report, again consistent with the policy for acute care hospitals under the IPPS, 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 4, 2003 proposed rule, 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, we are proposing that fiscal intermediaries would use more recent data when determining a LTCH's cost-to-charge ratio. Therefore, under § 412.525(a)(4)(ii), by cross-referencing proposed § 412.84(i), we are proposing 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, we are proposing to make a similar change in § 412.529(c)(4)(ii), by cross-referencing proposed § 412.84(i), to indicate that subject to the proposed provisions in the regulations at § 412.84(i), fiscal intermediaries would use either the most recent settled cost report or the most recent tentative settled cost report, whichever is later.

4. Proposed Adjustments for Special Cases

a. General

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

Generally, LTCHs, as described in section 1886(d)(1)(B)(iv) of the Act, are distinguished from other inpatient hospital settings by maintaining an average 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 are not proposing 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 above, in section VI.C.3. of this preamble, in the March 4, 2003 proposed rule 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 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 4, 2003 proposed rule and as we are proposing above for high-cost outlier payments at § 412.525(a)(4)(ii), we are proposing under § 412.529 that short-stay outlier payments would be subject to the proposed provisions in the regulations at § 412.84(i) and (m). Therefore, consistent with the proposed changes to the high-cost outlier policy discussed above in section VI.C.3. of this preamble, we are proposing, by cross-referencing § 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. We also are proposing, by cross-referencing § 412.84(i), that the applicable statewide average cost-to-charge ratio would be applied when a LTCH’s cost-to-charge ratio exceeds the ceiling. Finally, we are proposing, by cross-referencing § 412.84(m), 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. 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.

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 transferred upon discharge to an acute care hospital, an IRF, or a SNF for treatment or services that are not available in the LTCH and returns to the same LTCH within applicable fixed day periods. 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 specified facility 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 VI.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 VI.C.4.e. of this proposed 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 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 posthospital 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), posthospital 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 posthospital 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 a 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.

We want to emphasize that our inclusion of swing beds in payment policy determinations for all patient movement between LTCHs and SNFs (see section VI.C.4.c. of this preamble) would mean that a readmission to a LTCH from posthospital 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.

5. Other Proposed Payment Adjustments

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

6. Proposed Budget Neutrality Offset to Account for the Transition Methodology

Under § 412.533, we implemented a 5-year transition period from cost-based TEFRA reimbursement 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 TEFRA payment 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 principles. In order to maintain budget neutrality as required by section 123(a)(1) of the Pub. L. 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) 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 TEFRA and 20 percent of the PPS) 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 transition period: 5.0 percent (0.950) in FY 2004; 3.4 percent (0.996) 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 TEFRA rate.

For the proposed 2004 LTCH PPS rate year, based on the best available data and the policies presented in this proposed rule, we project 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 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 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 TEFRA and 20 percent of the PPS for cost reporting periods beginning during FY 2003; and 60 percent of TEFRA and 40 percent of the PPS for cost reporting periods beginning 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. We note that, as discussed in section VIII. of this preamble, we are not proposing 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 update discussed in detail in section III. of this preamble. 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 proposed rule, based on the best available data and the proposed policy revisions described, we project 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:

Proposed LTCH PPS rate year	Estimated cost (in millions)
2004	\$120
2005	90
2006	60
2007	30

Therefore, we are proposing 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. 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 proposed 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 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. Based on the best available data at this time, we are proposing 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.

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 Pub. L. 106-113, we intend 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 proposed payments for purposes of the proposed budget neutrality calculations used the best available data at this time and necessarily reflects 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 Pub. L. 106-113 and section 307 of Pub. L. 106-554 provide the Secretary broad authority 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 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 this proposed rule, based on the best available data, we estimate that total Medicare program payments for LTCH services from the proposed LTCH PPS rate years of 2004 through 2008 would be:

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

As in our August 30, 2002 final rule (67 FR 56037), these estimates are based on the projection that 49 percent of LTCHs would elect to be paid based on 100 percent of the proposed standard Federal rate rather than the transition blend, and an update of our estimate of proposed 2004 LTCH PPS rate year payments to LTCHs using our Office of the Actuary's most recent estimate of the excluded hospital with capital market basket of 2.5 percent for proposed 2004 LTCH PPS rate year (adjusted to account for the proposed change in the rate update cycle discussed in section VI.B.1.b. of this preamble), 3.1 percent for proposed 2005 LTCH PPS rate year, 3.0 percent for proposed 2006 LTCH PPS rate year, 2.9 percent for proposed 2007 LTCH

PPS rate year, and 3.0 percent for proposed 2008 LTCH PPS rate year. We also have taken into account our Office of the Actuary's projection that there would be an increase in Medicare beneficiary enrollment of 1.3 percent in proposed 2004 LTCH PPS rate year, 1.6 percent in proposed 2005 LTCH PPS rate year, and 1.9 percent in proposed 2006 LTCH PPS rate year and 2.0 percent in proposed 2007 LTCH PPS rate year and 2.1 percent in proposed 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, we are not proposing an adjustment for budget neutrality under § 412.523(d)(3) at this time. However, we will continue to collect and interpret new data as the data become available in the future to determine if such an adjustment should be proposed.

VII. Computing the Proposed Adjusted Federal Prospective Payments

In accordance with § 412.525 and as discussed in sections VI. of this

proposed rule, the proposed standard Federal rate would be adjusted to account for differences in area wages by multiplying the labor-related share of the proposed standard Federal rate by the appropriate proposed LTCH wage index. The proposed standard Federal rate would also be adjusted to account for the higher costs of hospitals in Alaska and Hawaii by multiplying the nonlabor-related share of the proposed standard Federal rate by the appropriate adjustment factor shown in the table in section VI.C.2. of this preamble. To illustrate the methodology we are using to adjust the proposed Federal prospective payments, we are providing the following example:

During the proposed 2004 LTCH PPS rate year, a Medicare patient is in a LTCH located in Chicago, Illinois (MSA 1600) with a proposed two-fifths wage index value of 1.0418 (see Table 1 in the Addendum to this proposed rule). The Medicare patient is classified into LTC-DRG 4 (Spinal Procedures), which has a proposed relative weight of 1.2493 (see Table 3 of the Addendum to this proposed 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 proposed standard Federal rate (\$35,830.05) by the labor-related share (72.612 percent) and the proposed wage index (1.0418). This wage-adjusted amount is then added to the nonlabor-related portion of the unadjusted proposed standard Federal rate (27.388 percent) to determine the adjusted proposed Federal rate, which is then multiplied by the proposed LTC-DRG relative weight (1.2493) to calculate the total adjusted proposed Federal prospective payment for the proposed 2004 LTCH PPS rate year (\$46,121.11). In addition, as discussed in section VI.C.6. of this preamble, for the proposed 2004 LTCH PPS rate year, we are proposing to reduce the LTCH PPS payment by 5.6 percent for the proposed budget neutrality offset to account for the costs of the transition methodology. The following illustrates the components of the calculations in this example:

Proposed Unadjusted Standard Federal Prospective Payment Rate	\$35,830.05
Labor-Related Share	0.72612
Labor-Related Portion of the Federal Rate	= \$26,016.92
Proposed 2/5th Wage Index (MSA 1600)	1.0418
Wage-Adjusted Labor Share	= \$27,104.43
Nonlabor-Related Portion of the Federal Rate (adjusted for COLA if applicable)	+ \$ 9,813.36
Adjusted Proposed Federal Rate	= \$36,917.56
Proposed LTC-DRG 4 Relative Weight	× 1.2493
Total Adjusted Proposed Federal Prospective Payment (Before the Proposed Budget Neutrality Offset)	= \$46,121.11
Proposed Budget Neutrality Offset	× 0.944
Total Proposed Federal Prospective Payment (With the Proposed Budget Neutrality Offset)	= \$43,538.33

VIII. 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. 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 TEFRA 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 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

Cost reporting periods beginning on or after	Federal rate percentage	Reasonable cost principles rate percentage
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. We note that the proposed change in the effective date of the proposed 2004 LTCH PPS rate year update discussed in section III. 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 blended 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) would 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. 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 will no longer be 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 Pub. L. 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 October 15, 2003, must notify its fiscal intermediary in writing of an election before September 15, 2003.

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, before November 1, 2002 for cost reporting periods that begin on or after October 1, 2002 through November 30, 2002 and 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 rates.

IX. Proposed 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 applies to hospitals with a cost reporting period beginning on or after October 1, 2002.

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 Pub. L. 105-33. As stated in § 413.40(f)(2)(ii), for cost reporting periods beginning on or after October 1, 1997, the payment amount for a "new" (post-FY 1998) LTCH is the lower of the hospital's net inpatient operating cost per case or 110 percent of the national median target amount payment limit for hospitals in the same class for cost reporting periods ending during FY 1996, updated to the applicable cost reporting period (see 62 FR 46019, August 29, 1997). Under the PPS for LTCHs, those "new" LTCHs that meet the definition of "new" under

§ 413.40(f)(2)(ii) and that have first cost reporting periods 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 would 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 would 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 would 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 would be subject to the transition period 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.)

X. 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 made 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 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 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 outlier payment determined as of the last day for which the services have been billed.

XI. 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 believed 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 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 that will enable CMS and the fiscal intermediary to track a beneficiary to

and from a LTCH and to and from another Medicare provider.

In that same final rule, we also explained that, given that the only unique requirement that distinguishes a LTCH from other 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.

XII. 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.

XIII. Regulatory Impact Analysis

A. Introduction

We have examined the impact of this proposed rule as required by Executive Order 12866. We also have examined the impacts of this proposed rule under the criteria of the Regulatory Flexibility Act (RFA) (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 (Federalism).

1. Executive Order 12866

Executive Order 12866 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 proposed and final rules that constitute significant regulatory action, including rules that have an economic effect of \$100 million or more in any one year

(major rules). We have determined that this proposed rule would 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 VI.B.1.b. of the preamble of this proposed rule, we are proposing that the proposed change to the LTCH PPS rate update cycle be budget neutral. Therefore, we estimate that there would be no budgetary impact for the Medicare program as a result of the proposed change to the LTCH PPS rate update cycle. Based on the best available data for 194 LTCHs, we estimate that the proposed 2.2 percent increase in the standard Federal rate for the proposed 2004 LTCH PPS rate year would result in \$21.4 million and there are no significant redistributive effects among any groups of hospitals. (Section VI.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 in issuing a proposed and final rule. 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 \$25 million or less annually. For purposes of the RFA, all hospitals are considered small entities. 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 proposed rule would not have a significant impact on a substantial number of small entities, in accordance with RFA.

3. Impact on Rural Hospitals

Section 1102(b) of the Social Security Act requires us to prepare a regulatory impact analysis if a proposed or final rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of an MSA and has fewer than 100 beds. As discussed in detail in section XIII.B. of this preamble, this proposed rule would 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 proposed rule or any final rule preceded by a rule that may result in expenditures in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of \$110 million or more. This proposed rule would not mandate any requirements for State, local, or tribal governments nor would it result in expenditures by the private sector of \$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 proposed rule under the criteria set forth in Executive Order 13132 and have determined that this proposed 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 proposed rule below in terms of its fiscal impact on the Federal Medicare budget and on LTCHs.

1. Budgetary Impact

Section 123(a)(1) of Pub. L. 106-113 requires us to set the payment rates contained in this proposed 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 if all LTCHs will be paid based on 100 percent of the standard Federal rate in FY 2003. As discussed in section VI.C.6. of this proposed 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 would 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 proposed new LTCH PPS rate year (July 1, 2003 through June 30, 2004). The proposed LTCH PPS rate year overlaps the current rate period by 3 months (July 1, 2003 through September 30, 2003). The update for Federal FY 2003 is currently estimated at 3.5 percent and the proposed update factor for the proposed 2004 LTCH PPS rate year is estimated at 2.5 percent (as discussed in section VI.B. of the preamble of this proposed rule). Therefore, over the period from FY 2002 through the proposed 2004 LTCH PPS rate year (June 30, 2004), the cumulative increase would be 6.0 percent [$1.035 * 1.025 = 1.060$]. This cumulative increase matches (within rounding) the cumulative increase calculated by using the index level in the new proposed 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 proposed change to the proposed 2004 LTCH PPS rate update cycle would 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 VI.B.1.b. of the preamble of this proposed rule, we proposed to apply a budget neutrality adjustment of 0.997 in determining the proposed standard Federal rate to account for the estimated \$5.66 million budgetary impact for the Medicare program in FY 2003 as a result of the proposed change to LTCH PPS rate update cycle.

2. Impact on Providers

The basic methodology for determining a LTCH PPS payment is set forth in the regulations at § 412.521 through § 412.525. In addition to the basic LTC-DRG payment (standard Federal rate x 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 proposed changes to the LTCH PPS discussed in this proposed rule on different categories of LTCHs for the proposed 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 would be made under the proposed LTCH PPS rates and factors for the proposed 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 proposed 2004 LTCH PPS rate year payments for each category of LTCHs.

Hospital groups were based on characteristics provided in OSCAR data and FYs 1999 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 I below), we estimated payments only for those providers that 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 VII. below), we used data from 194 LTCHs. 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 VIII. 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 (proposed 2004 LTCH PPS rate year).

Proposed 2004 LTCH rate year prospective payments were based on the proposed standard Federal rate of \$35,726.64 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 VI.C.4.b. of this proposed rule) and the adjustments for area wage differences (as described in section VI.C.1. of this proposed rule) and for the cost-of-living for Alaska and Hawaii (as described in section VI.C.2. of this proposed rule). Additional payments would also be made for high-cost outlier cases (as described in section VI.C.3. of this proposed rule). As noted in section VI.C.5. of this proposed rule, we are not proposing to make adjustments for geographic reclassification, indirect medical education costs, or a disproportionate share of low-income patients.

The adjustment for area wage differences for estimated FY 2003 payments was done 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 (d)(10) of the Act (see

August 30, 2002, 67 FR 56057–56075). For the estimated proposed 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 applicable proposed LTCH wage index is 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 (d)(10) of the Act. For cost reporting periods beginning on or after October 1, 2003 and before September 30, 2004, the applicable LTCH wage index would be 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. Therefore, a provider with a cost reporting period beginning October 1, 2003, would 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 proposed 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) would 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 is 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 PPS for FY 2003. Similarly, we applied the proposed 5.7 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 VI.C.6. of this proposed rule) to each LTCH’s estimated payments under the PPS for the proposed 2004 LTCH PPS rate year. The impact based on our projection of whether a LTCH would be paid based on the transition blend methodology or would elect payment based on 100 percent of the Federal rate is shown below in Table VII.

In Table VIII. 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 proposed 2004 LTCH PPS rate year. Accordingly, the proposed 5.7 percent reduction to account for the 5-year transition methodology on LTCHs’ Medicare program payments for the proposed 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 VII. and VIII. 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; and the fourth column shows the estimated payment per discharge for FY 2003; the fifth column shows the estimated payment per discharge for proposed 2004 LTCH PPS rate year; and the sixth column shows the percent change of FY 2003 compared to proposed 2004 LTCH PPS rate year.

TABLE VII.—PROJECTED IMPACT REFLECTING APPLICABLE TRANSITION BLEND PERCENTAGES OF PROPOSED 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 Proposed 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 proposed 2004 LTCH prospective payment system rate year payment per case ³	Percent change
All Providers	194	71,811	\$26,919	\$27,227	1.1
By Location:					
Rural	7	2,153	20,668	20,864	1.0
Urban	187	69,658	27,113	27,424	1.1
Large	113	47,705	27,445	27,742	1.1

TABLE VII.—PROJECTED IMPACT REFLECTING APPLICABLE TRANSITION BLEND PERCENTAGES OF PROPOSED PROSPECTIVE PAYMENTS AND REASONABLE COST-BASED (TEFRA) PAYMENTS AND OPTION TO ELECT PAYMENT BASED ON 100 PERCENT OF THE FEDERAL RATE¹—Continued

[FY 2003 Payments Compared to Proposed 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 proposed 2004 LTCH prospective payment system rate year payment per case ³	Percent change
Other	74	21,953	26,391	26,733	1.3
By Participation Date:					
After October 1993	124	41,876	28,137	28,506	1.3
Before October 1983	16	7,836	20,060	20,270	1.0
October 1983—September 1993	45	19,990	27,194	27,427	0.9
Unknown	9	2,109	25,636	25,791	0.6
By Ownership Control:					
Voluntary	48	17,730	24,756	25,096	1.4
Proprietary	136	51,626	27,688	27,990	1.1
Government	10	2,455	26,371	26,587	0.8
By Census Region:					
New England	14	9,487	20,146	20,320	0.9
Middle Atlantic	9	3,276	28,519	28,714	0.7
South Atlantic	20	6,571	31,310	31,660	1.1
East North Central	33	9,057	28,964	29,238	0.9
East South Central	10	2,863	25,761	25,905	0.6
West North Central	11	2,898	26,611	26,947	1.3
West South Central	71	30,248	26,147	26,479	1.3
Mountain	15	2,491	28,399	28,933	1.9
Pacific	11	4,920	34,145	34,608	1.4
By Bed Size:					
Beds: 0–24	17	2,453	29,299	29,570	0.9
Beds: 25–49	88	21,725	28,091	28,373	1.0
Beds: 50–74	24	8,209	28,492	28,659	0.6
Beds: 75–124	34	16,306	27,241	27,630	1.4
Beds: 125–199	21	13,820	24,579	24,856	1.1
Beds: 200+	9	9,218	25,231	25,636	1.6
Unknown	1	80	7,787	8,043	3.3

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 cycle. 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 VIII.—PROJECTED IMPACT REFLECTING THE FULLY PHASED-IN PROPOSED PROSPECTIVE PAYMENTS

[FY 2003 Payments Compared to Proposed 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 proposed 2004 LTCH prospective payment system rate year payment per case ²	Percent change
All Providers	250	82,625	\$26,367	\$26,959	2.2
By Location:					
Rural	16	4,674	20,851	21,191	1.6
Urban	234	77,951	26,687	27,305	2.3
Large	135	52,256	27,027	27,661	2.3
Other	99	25,695	25,996	26,581	2.2
By Participation Date:					
After October 1993	177	51,656	27,308	27,822	1.9
Before October 1983	17	7,897	20,826	20,780	-0.2
October 1983—September 1993	45	20,004	26,724	27,719	3.7
Unknown	11	3,068	22,178	23,400	5.5
By Ownership Control:					
Voluntary	55	19,853	24,314	25,020	2.9
Proprietary	148	54,269	27,490	28,027	2.0
Government	47	8,503	23,893	24,672	3.3

TABLE VIII.—PROJECTED IMPACT REFLECTING THE FULLY PHASED-IN PROPOSED PROSPECTIVE PAYMENTS—Continued
[FY 2003 Payments Compared to Proposed 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 proposed 2004 LTCH prospective payment system rate year payment per case ²	Percent change
By Census Region:					
New England	16	9,609	21,094	20,937	-0.7
Middle Atlantic	15	4,162	28,982	29,622	2.2
South Atlantic	23	7,051	30,441	31,329	2.9
East North Central	48	12,145	28,356	28,860	1.8
East South Central	14	3,722	28,561	28,523	-0.1
West North Central	16	3,769	26,347	27,094	2.8
West South Central	87	33,971	24,560	25,363	3.3
Mountain	19	2,993	26,529	27,705	4.4
Pacific	12	5,203	33,836	34,369	1.6
By Bed Size:					
Beds: 0–24	21	3,073	27,130	28,027	3.3
Beds: 25–49	98	24,386	27,954	28,153	0.7
Beds: 50–74	27	9,310	27,556	27,665	0.4
Beds: 75–124	35	16,432	26,222	27,321	4.2
Beds: 125–199	21	13,838	24,945	25,564	2.5
Beds: 200+	11	9,518	25,041	26,099	4.2
Unknown	37	6,068	23,354	24,095	3.2

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 VII.) 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 VII. shows that the percent change in estimated payments per discharge for FY 2003 compared to the proposed 2004 LTCH PPS rate year for rural LTCHs would be 1.0 percent, and would be 1.1 percent for urban LTCHs. Large urban LTCHs are projected to experience a 1.1 percent increase in payments per discharge percent from FY 2003 compared to the proposed 2004 LTCH PPS rate year, while other urban LTCHs projected to experience a 1.3 percent increase in payments per discharge percent from FY 2003 compared to the proposed 2004 LTCH PPS rate year. (See Table VII.)

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 9 LTCHs,

which we labeled as an “Unknown” category. The majority, approximately 58 percent, of the LTCH cases are in hospitals that began participating after October 1993 and are projected to experience a 1.3 percent increase in payments per discharge percent from FY 2003 compared to the proposed 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 1.0 percent increase in payments per discharge percent from FY 2003 compared to the proposed 2004 LTCH PPS rate year. (See Table VII.)

c. Ownership Control

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

Approximately 25 percent of LTCHs are government run and we expect that voluntary LTCHs would “gain” the most from the proposed changes based on our projection that they would experience a 1.4 percent increase in payments per discharge from FY 2003 compared to the proposed 2004 LTCH PPS rate year. Government and proprietary LTCHs are projected to experience a 0.8 percent and 1.1 percent increase in payments per discharge percent from FY 2003 compared to the proposed 2004 LTCH PPS rate year, respectively. (See Table VII.)

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 proposed 2004 LTCH PPS rate year. Specifically, of the nine census regions, we expect that LTCHs in the Mountain region would experience the largest percent increase in payments per discharge percent from FY 2003 compared to the proposed 2004 LTCH PPS rate year (1.9 percent). We expect LTCHs in the East South Central region would experience the smallest percent increase in payments per discharge percent from FY 2003 compared to the proposed 2004 LTCH PPS rate year (0.6 percent). (See Table VII.)

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 proposed 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 proposed 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 proposed 2004 LTCH PPS rate year (1.6 percent), while LTCHs with between 50–74 beds have the lowest projected increase in the percent change in payments per discharge percent from FY 2003 compared to the proposed 2004 LTCH PPS rate year (0.6 percent). (See Table VII.)

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 would be as follows:

Proposed 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 proposed 2004 LTCH PPS rate year (adjusted to account for the proposed change in the rate update cycle discussed in section VI.B.1.b. of the preamble of this proposed rule), 3.1 percent for proposed 2005 LTCH PPS rate year, 3.0 percent for proposed 2006 LTCH PPS rate year, 2.9 percent for proposed 2007 LTCH PPS rate year, and 3.0 percent for proposed 2008 LTCH PPS rate year. We currently estimate that there would be an increase in Medicare beneficiary enrollment of 1.3 percent in proposed 2004 LTCH PPS rate year, 1.6 percent in proposed 2005 LTCH PPS rate year, 1.9 percent in proposed 2006 LTCH PPS rate year, 2.0 percent in proposed 2007 LTCH PPS rate year, 2.1 percent in proposed 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 would be made if the LTCH PPS were not implemented. Our methodology for estimating payments for purposes of the budget neutrality calculations uses the best available data 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 (for example, 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 Pub. L. 106–113 and section 307 of Pub. L. 106–554 provide the Secretary with extremely broad authority in developing the LTCH PPS, including the authority for appropriate adjustments. In accordance with this broad authority, we may discuss in a future proposed rule a possible one-time prospective adjustment to the LTCH PPS rates to maintain budget neutrality so that the effect of the difference between actual payments and estimated payments for the first year of LTCH PPS is not perpetuated in the PPS rates for future years. As 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 proposed rule was reviewed by the Office of Management and Budget.

XIV. Response to Public Comments

Because of the large number of items of correspondence we normally receive on a proposed rule, we are not able to acknowledge or respond to them individually. However, in preparing the final rule, we will consider all comments concerning the provisions of this proposed rule that we receive by the date and time specified in the DATES section of this preamble and respond to those comments in the preamble to that rule.

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 proposes to amend 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) 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 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)(i) For discharges occurring on or after October 1, 2002 through June 30, 2003, 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.

(ii) For discharges occurring on or after July 1, 2003, high-cost outlier payments are subject to the provisions of § 412.84(i) and (m) for adjustments of cost-to-charge ratios.

* * * * *

6. Section 412.529 is amended by:

A. Revising paragraph (c)(4).

B. In paragraph (d), the term "LTCH's" is removed and the term "long-term care hospital's" is added in its place.

§ 412.529 Special payment provision for short-stay outliers.

* * * * *

(c) * * *

(4)(i) For discharges occurring on or after October 1, 2002 through June 30, 2003, no retroactive adjustments will be made to short-stay outlier payments upon cost report settlement to account for differences between cost-to-charge ratio and the actual cost-to-charge ratio of the case.

(ii) For discharges occurring on or after July 1, 2003, short-stay outlier payments are subject to the provisions of § 412.84(i) and (m) for adjustments of cost-to-charge ratios.

* * * * *

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 June 1 prior to the start of each long-term care hospital prospective payment system rate year which begins July 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: December 20, 2003.

Thomas A. Scully,
Administrator, Centers for Medicare & Medicaid Services.

Dated: February 14, 2003.

Tommy G. Thompson,
Secretary.

Addendum

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

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

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

Table 3.—Proposed 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.—PROPOSED 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	1/5 wage index ²	2/5 wage index ³
0040	Abilene, TX			

TABLE 1.—PROPOSED 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	1/5 wage index ²	2/5 wage index ³
0060	Taylor, TX	0.7792	0.9558	0.9117
	Aguadilla, PR			
	Aguada, PR			
	Aguadilla, PR			
0080	Moca, PR	0.4587	0.8917	0.7835
	Akron, OH			
	Portage, OH			
0120	Summit, OH	0.9600	0.9920	0.9840
	Albany, GA			
	Dougherty, GA			
0160	Lee, GA	1.0594	1.0119	1.0238
	Albany-Schenectady-Troy, NY			
	Albany, NY			
	Montgomery, NY			
	Rensselaer, NY			
	Saratoga, NY			
	Schenectady, NY			
	Schoharie, NY	0.8384	0.9677	0.9354
0200	Albuquerque, NM			
	Bernalillo, NM			
	Sandoval, NM			
	Valencia, NM	0.9315	0.9863	0.9726
0220	Alexandria, LA			
	Rapides, LA	0.7859	0.9572	0.9144
0240	Allentown-Bethlehem-Easton, PA			
	Carbon, PA			
	Lehigh, PA			
	Northampton, PA			
0280	Altoona, PA			
	Blair, PA	0.9225	0.9845	0.9690
0320	Amarillo, TX			
	Potter, TX			
	Randall, TX	0.9034	0.9807	0.9614
0380	Anchorage, AK			
	Anchorage, AK	1.2358	1.0472	1.0943
0440	Ann Arbor, MI			
	Lenawee, MI			
	Livingston, MI			
	Washtenaw, MI	1.1103	1.0221	1.0441
0450	Anniston, AL			
	Calhoun, AL	0.8044	0.9609	0.9218
0460	Appleton-Oshkosh-Neenah, WI			
	Calumet, WI			
	Outagamie, WI			
	Winnebago, WI	0.8997	0.9799	0.9599
0470	Arecibo, PR			
	Arecibo, PR			
	Camuy, PR			
	Hatillo, PR	0.4337	0.8867	0.7735
0480	Asheville, NC			
	Buncombe, NC			
	Madison, NC	0.9876	0.9975	0.9950
0500	Athens, GA			
	Clarke, GA			
	Madison, GA			
	Oconee, GA	1.0211	1.0042	1.0084
0520	Atlanta, GA			
	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.—PROPOSED 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	1/5 wage index ²	2/5 wage index ³
0560	Gwinnett, GA	0.9991	0.9998	0.9996
	Henry, GA			
	Newton, GA			
	Paulding, GA			
	Pickens, GA			
	Rockdale, GA			
	Spalding, GA			
Walton, GA				
0580	Atlantic-Cape May, NJ	1.1017	1.0203	1.0407
	Atlantic, NJ			
0600	Cape May, NJ	0.8325	0.9665	0.9330
	Auburn-Opelika, AL			
0640	Lee, AL	1.0264	1.0053	1.0106
	Augusta-Aiken, GA-SC			
	Columbia, GA			
	McDuffie, GA			
	Richmond, GA			
Aiken, SC				
0680	Edgefield, SC	0.9637	0.9927	0.9855
	Austin-San Marcos, TX			
	Bastrop, TX			
	Caldwell, TX			
	Hays, TX			
	Travis, TX			
Williamson, TX				
0720	Bakersfield, CA	0.9877	0.9975	0.9951
	Kern, CA			
0733	Baltimore, MD	0.9929	0.9986	0.9972
	Anne Arundel, MD			
	Baltimore, MD			
	Baltimore City, MD			
	Carroll, MD			
	Harford, MD			
	Howard, MD			
Queen Anne's, MD				
0743	Bangor, ME	0.9664	0.9933	0.9866
	Penobscot, ME			
0760	Barnstable-Yarmouth, MA	1.3202	1.0640	1.1281
	Barnstable, MA			
0840	Baton Rouge, LA	0.8294	0.9659	0.9318
	Ascension, LA			
	East Baton Rouge, LA			
	Livingston, LA			
	West Baton Rouge, LA			
0860	Beaumont-Port Arthur, TX	0.8324	0.9665	0.9330
	Hardin, TX			
	Jefferson, TX			
	Orange, TX			
0870	Bellingham, WA	1.2282	1.0456	1.0913
	Whatcom, WA			
0875	Benton Harbor, MI	0.8965	0.9793	0.9586
	Berrien, MI			
0880	Bergen-Passaic, NJ	1.2150	1.0430	1.0860
	Bergen, NJ			
	Passaic, NJ			
0920	Billings, MT	0.9022	0.9804	0.9609
	Yellowstone, MT			
0960	Biloxi-Gulfport-Pascagoula, MS	0.8757	0.9751	0.9503
	Hancock, MS			
	Harrison, MS			
	Jackson, MS			
1000	Binghamton, NY	0.8341	0.9668	0.9336
	Broome, NY			
	Tioga, NY			
1000	Birmingham, AL	0.9222	0.9844	0.9689
	Blount, AL			
	Jefferson, AL			
	St. Clair, AL			
	Shelby, AL			

TABLE 1.—PROPOSED 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	1/5 wage index ²	2/5 wage index ³
1010	Bismarck, ND Burleigh, ND Morton, ND	0.7972	0.9594	0.9189
1020	Bloomington, IN Monroe, IN	0.8907	0.9781	0.9563
1040	Bloomington-Normal, IL McLean, IL	0.9109	0.9822	0.9644
1080	Boise City, ID Ada, ID Canyon, ID	0.9310	0.9862	0.9724
1123	Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH (NH Hospitals) Bristol, MA Essex, MA Middlesex, MA Norfolk, MA Plymouth, MA Suffolk, MA Worcester, MA Hillsborough, NH Merrimack, NH Rockingham, NH Strafford, NH	1.1229	1.0246	1.0492
1125	Boulder-Longmont, CO Boulder, CO	0.9689	0.9938	0.9876
1145	Brazoria, TX Brazoria, TX	0.8535	0.9707	0.9414
1150	Bremerton, WA Kitsap, WA	1.0944	1.0189	1.0378
1240	Brownsville-Harlingen-San Benito, TX Cameron, TX	0.8880	0.9776	0.9552
1260	Bryan-College Station, TX Brazos, TX	0.8821	0.9764	0.9528
1280	Buffalo-Niagara Falls, NY Erie, NY Niagara, NY	0.9365	0.9873	0.9746
1303	Burlington, VT Chittenden, VT Franklin, VT Grand Isle, VT	1.0052	1.0010	1.0021
1310	Caguas, PR Caguas, PR Cayey, PR Cidra, PR Gurabo, PR San Lorenzo, PR	0.4371	0.8874	0.7748
1320	Canton-Massillon, OH Carroll, OH Stark, OH	0.8932	0.9786	0.9573
1350	Casper, WY Natrona, WY	0.9690	0.9938	0.9876
1360	Cedar Rapids, IA Linn, IA	0.9056	0.9811	0.9622
1400	Champaign-Urbana, IL Champaign, IL	1.0635	1.0127	1.0254
1440	Charleston-North Charleston, SC Berkeley, SC Charleston, SC Dorchester, SC	0.9235	0.9847	0.9694
1480	Charleston, WV Kanawha, WV Putnam, WV	0.8898	0.9780	0.9559
1520	Charlotte-Gastonia-Rock Hill, NC-SC Cabarrus, NC Gaston, NC Lincoln, NC Mecklenburg, NC Rowan, NC Stanly, NC Union, NC			

TABLE 1.—PROPOSED 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	1/5 wage index ²	2/5 wage index ³
1540	York, SC	0.9875	0.9975	0.9950
	Charlottesville, VA			
	Albemarle, VA			
	Charlottesville City, VA			
	Fluvanna, VA			
	Greene, VA	1.0438	1.0088	1.0175
1560	Chattanooga, TN-GA			
	Catoosa, GA			
	Dade, GA			
	Walker, GA			
	Hamilton, TN			
	Marion, TN	0.8976	0.9795	0.9590
1580	Cheyenne, WY			
	Laramie, WY	0.8628	0.9726	0.9451
1600	Chicago, IL			
	Cook, IL			
	DeKalb, IL			
	DuPage, IL			
	Grundy, IL			
	Kane, IL			
	Kendall, IL			
	Lake, IL			
	McHenry, IL			
	Will, IL	1.1044	1.0209	1.0418
1620	Chico-Paradise, CA			
	Butte, CA	0.9745	0.9949	0.9898
1640	Cincinnati, OH-KY-IN			
	Dearborn, IN			
	Ohio, IN			
	Boone, KY			
	Campbell, KY			
	Gallatin, KY			
	Grant, KY			
	Kenton, KY			
	Pendleton, KY			
	Brown, OH			
	Clermont, OH			
	Hamilton, OH			
	Warren, OH	0.9381	0.9876	0.9752
1660	Clarksville-Hopkinsville, TN-KY			
	Christian, KY			
	Montgomery, TN	0.8406	0.9681	0.9362
1680	Cleveland-Lorain-Elyria, OH			
	Ashtabula, OH			
	Cuyahoga, OH			
	Geauga, OH			
	Lake, OH			
	Lorain, OH			
	Medina, OH	0.9670	0.9934	0.9868
1720	Colorado Springs, CO			
	El Paso, CO	0.9916	0.9983	0.9966
1740	Columbia, MO			
	Boone, MO	0.8496	0.9699	0.9398
1760	Columbia, SC			
	Lexington, SC			
	Richland, SC	0.9307	0.9861	0.9723
1800	Columbus, GA-AL			
	Russell, AL			
	Chattahoochee, GA			
	Harris, GA			
	Muscogee, GA	0.8374	0.9675	0.9350
1840	Columbus, OH			
	Delaware, OH			
	Fairfield, OH			
	Franklin, OH			
	Licking, OH			
	Madison, OH			
	Pickaway, OH	0.9751	0.9950	0.9900
1880	Corpus Christi, TX			

TABLE 1.—PROPOSED 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	1/5 wage index ²	2/5 wage index ³
1890	Nueces, TX San Patricio, TX	0.8729	0.9746	0.9492
1900	Corvallis, OR Benton, OR	1.1453	1.0291	1.0581
1920	Cumberland, MD—WV (WV Hospital) Allegany, MD Mineral, WV	0.7847	0.9569	0.9139
1950	Dallas, TX Collin, TX Dallas, TX Denton, TX Ellis, TX Henderson, TX Hunt, TX Kaufman, TX Rockwall, TX	0.9998	1.0000	0.9999
1960	Danville, VA Danville City, VA Pittsylvania, VA	0.8859	0.9772	0.9544
2000	Davenport-Moline-Rock Island, IA—IL Scott, IA Henry, IL Rock Island, IL	0.8835	0.9767	0.9534
2020	Dayton-Springfield, OH Clark, OH Greene, OH Miami, OH Montgomery, OH	0.9282	0.9856	0.9713
2030	Daytona Beach, FL Flagler, FL Volusia, FL	0.9071	0.9814	0.9628
2040	Decatur, AL Lawrence, AL Morgan, AL	0.8973	0.9795	0.9589
2080	Decatur, IL Macon, IL	0.8055	0.9611	0.9222
2120	Denver, CO Adams, CO Arapahoe, CO Denver, CO Douglas, CO Jefferson, CO	1.0601	1.0120	1.0240
2160	Des Moines, IA Dallas, IA Polk, IA Warren, IA	0.8791	0.9758	0.9516
2180	Detroit, MI Lapeer, MI Macomb, MI Monroe, MI Oakland, MI St. Clair, MI Wayne, MI	1.0448	1.0090	1.0179
2190	Dothan, AL Dale, AL Houston, AL	0.8137	0.9627	0.9255
2200	Dover, DE Kent, DE	0.9356	0.9871	0.9742
2240	Dubuque, IA Dubuque, IA	0.8795	0.9759	0.9518
2281	Duluth-Superior, MN—WI St. Louis, MN Douglas, WI	1.0368	1.0074	1.0147
2290	Dutchess County, NY Dutchess, NY	1.0684	1.0137	1.0274
2320	Eau Claire, WI Chippewa, WI Eau Claire, WI	0.8952	0.9790	0.9581
	El Paso, TX			

TABLE 1.—PROPOSED 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	1/5 wage index ²	2/5 wage index ³
2330	El Paso, TX	0.9265	0.9853	0.9706
	Elkhart-Goshen, IN			
	Elkhart, IN	0.9722	0.9944	0.9889
2335	Elmira, NY			
	Chemung, NY	0.8416	0.9683	0.9366
2340	Enid, OK			
	Garfield, OK	0.8376	0.9675	0.9350
2360	Erie, PA			
	Erie, PA	0.8925	0.9785	0.9570
2400	Eugene-Springfield, OR			
	Lane, OR	1.0944	1.0189	1.0378
2440	Evansville-Henderson, IN-KY (IN Hospitals) Posey, IN Vanderburgh, IN Warrick, IN Henderson, KY	0.8177	0.9635	0.9271
2520	Fargo-Moorhead, ND-MN Clay, MN Cass, ND	0.9684	0.9937	0.9874
2560	Fayetteville, NC Cumberland, NC	0.8889	0.9778	0.9556
2580	Fayetteville-Springdale-Rogers, AR Benton, AR Washington, AR	0.8100	0.9620	0.9240
2620	Flagstaff, AZ-UT Coconino, AZ Kane, UT	1.0682	1.0136	1.0273
2640	Flint, MI Genesee, MI	1.1135	1.0227	1.0454
2650	Florence, AL Colbert, AL Lauderdale, AL	0.7792	0.9558	0.9117
2655	Florence, SC Florence, SC	0.8780	0.9756	0.9512
2670	Fort Collins-Loveland, CO Larimer, CO	1.0066	1.0013	1.0026
2680	Ft. Lauderdale, FL Broward, FL	1.0297	1.0059	1.0119
2700	Fort Myers-Cape Coral, FL Lee, FL	0.9680	0.9936	0.9872
2710	Fort Pierce-Port St. Lucie, FL Martin, FL St. Lucie, FL	0.9823	0.9965	0.9929
2720	Fort Smith, AR-OK Crawford, AR Sebastian, AR Sequoyah, OK	0.7895	0.9579	0.9158
2750	Fort Walton Beach, FL Okaloosa, FL	0.9693	0.9939	0.9877
2760	Fort Wayne, IN Adams, IN Allen, IN De Kalb, IN Huntington, IN Wells, IN Whitley, IN	0.9457	0.9891	0.9783
2800	Forth Worth-Arlington, TX Hood, TX Johnson, TX Parker, TX Tarrant, TX	0.9446	0.9889	0.9778
2840	Fresno, CA Fresno, CA Madera, CA	1.0169	1.0034	1.0068
2880	Gadsden, AL Etowah, AL	0.8505	0.9701	0.9402
2900	Gainesville, FL Alachua, FL	0.9871	0.9974	0.9948
2920	Galveston-Texas City, TX			

TABLE 1.—PROPOSED 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	1/5 wage index ²	2/5 wage index ³
2960	Galveston, TX	0.9465	0.9893	0.9786
	Gary, IN			
	Lake, IN			
2975	Porter, IN	0.9584	0.9917	0.9834
	Glens Falls, NY			
	Warren, NY			
2980	Washington, NY	0.8281	0.9656	0.9312
	Goldsboro, NC			
2985	Wayne, NC	0.8892	0.9778	0.9557
	Grand Forks, ND—MN			
	Polk, MN			
2995	Grand Forks, ND	0.8897	0.9779	0.9559
	Grand Junction, CO			
3000	Mesa, CO	0.9456	0.9891	0.9782
	Grand Rapids-Muskegon-Holland, MI			
	Allegan, MI			
	Kent, MI			
	Muskegon, MI			
3040	Ottawa, MI	0.9525	0.9905	0.9810
	Great Falls, MT			
3060	Cascade, MT	0.8950	0.9790	0.9580
	Greeley, CO			
3080	Weld, CO	0.9237	0.9847	0.9695
	Green Bay, WI			
3120	Brown, WI	0.9502	0.9900	0.9801
	Greensboro-Winston-Salem-High Point, NC			
	Alamance, NC			
	Davidson, NC			
	Davie, NC			
	Forsyth, NC			
	Guilford, NC			
	Randolph, NC			
	Stokes, NC			
3150	Yadkin, NC	0.9282	0.9856	0.9713
	Greenville, NC			
3160	Pitt, NC	0.9100	0.9820	0.9640
	Greenville-Spartanburg-Anderson, SC			
	Anderson, SC			
	Cherokee, SC			
	Greenville, SC			
	Pickens, SC			
3180	Spartanburg, SC	0.9122	0.9824	0.9649
	Hagerstown, MD			
3200	Washington, MD	0.9268	0.9854	0.9707
	Hamilton-Middletown, OH			
3240	Butler, OH	0.9418	0.9884	0.9767
	Harrisburg-Lebanon-Carlisle, PA			
	Cumberland, PA			
	Dauphin, PA			
	Lebanon, PA			
3283	Perry, PA	0.9223	0.9845	0.9689
	Hartford, CT			
	Hartford, CT			
	Litchfield, CT			
	Middlesex, CT			
3285	Tolland, CT	1.1549	1.0310	1.0620
	² Hattiesburg, MS			
	Forrest, MS			
3290	Lamar, MS	0.7659	0.9532	0.9064
	Hickory-Morganton-Lenoir, NC			
	Alexander, NC			
	Burke, NC			
	Caldwell, NC			
3320	Catawba, NC	0.9028	0.9806	0.9611
	Honolulu, HI			
3350	Honolulu, HI	1.1457	1.0291	1.0583
	Houma, LA			
	Lafourche, LA			
	Terrebonne, LA	0.8317	0.9663	0.9327

TABLE 1.—PROPOSED 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	1/5 wage index ²	2/5 wage index ³
3360	Houston, TX Chambers, TX Fort Bend, TX Harris, TX Liberty, TX Montgomery, TX Waller, TX	0.9892	0.9978	0.9957
3400	Huntington-Ashland, WV-KY-OH Boyd, KY Carter, KY Greenup, KY Lawrence, OH Cabell, WV Wayne, WV	0.9636	0.9927	0.9854
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			

TABLE 1.—PROPOSED 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	1/5 wage index ²	2/5 wage index ³
3740	Calhoun, MI	1.0595	1.0119	1.0238
	Kalamazoo, MI			
	Van Buren, MI			
3760	Kankakee, IL	1.0790	1.0158	1.0316
	Kankakee, IL			
3800	Kansas City, KS—MO	0.9736	0.9947	0.9894
	Johnson, KS			
	Leavenworth, KS			
	Miami, KS			
	Wyandotte, KS			
	Cass, MO			
	Clay, MO			
	Clinton, MO			
	Jackson, MO			
	Lafayette, MO			
	Platte, MO			
3810	Kenosha, WI	0.9686	0.9937	0.9874
	Kenosha, WI			
3840	Killeen-Temple, TX	1.0399	1.0080	1.0160
	Bell, TX			
3850	Coryell, TX	0.8970	0.9794	0.9588
	Knoxville, TN			
	Anderson, TN			
	Blount, TN			
	Knox, TN			
	Loudon, TN			
	Sevier, TN			
Union, TN				
3870	Kokomo, IN	0.8971	0.9794	0.9588
	Howard, IN			
3880	Tipton, IN	0.9400	0.9880	0.9760
	La Crosse, WI—MN			
	Houston, MN			
3920	La Crosse, WI	0.8452	0.9690	0.9381
	Lafayette, LA			
	Acadia, LA			
	Lafayette, LA			
	St. Landry, LA			
3960	St. Martin, LA	0.9278	0.9856	0.9711
	Lafayette, IN			
3980	Clinton, IN	0.7965	0.9593	0.9186
	Tippecanoe, IN			
4000	Lake Charles, LA	0.9357	0.9871	0.9743
	Calcasieu, LA			
4040	Lakeland-Winter Haven, FL	0.9078	0.9816	0.9631
	Polk, FL			
4080	Lancaster, PA	0.9726	0.9945	0.9890
	Lancaster, PA			
	Lansing-East Lansing, MI			
4100	Clinton, MI	0.8472	0.9694	0.9389
	Eaton, MI			
4120	Ingham, MI	0.8745	0.9749	0.9498
	Laredo, TX			
4150	Webb, TX	1.1521	1.0304	1.0608
	Las Cruces, NM			
	Dona Ana, NM			
4200	Las Vegas, NV—AZ	0.8323	0.9665	0.9329
	Mohave, AZ			
4243	Clark, NV	0.8315	0.9663	0.9326
	Nye, NV			
4280	Lawrence, KS	0.9179	0.9836	0.9672
	Douglas, KS			
4280	Lawton, OK	0.9179	0.9836	0.9672
	Comanche, OK			
4280	Lewiston-Auburn, ME	0.9179	0.9836	0.9672
	Androscoggin, ME			
4280	Lexington, KY	0.9179	0.9836	0.9672
	Bourbon, KY			

TABLE 1.—PROPOSED 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	1/5 wage index ²	2/5 wage index ³
4320	Clark, KY Fayette, KY Jessamine, KY Madison, KY Scott, KY Woodford, KY	0.8581	0.9716	0.9432
4360	Lima, OH Allen, OH Auglaize, OH	0.9483	0.9897	0.9793
4400	Lincoln, NE Lancaster, NE	0.9892	0.9978	0.9957
4420	Little Rock-North Little Rock, AR Faulkner, AR Lonoke, AR Pulaski, AR Saline, AR	0.9097	0.9819	0.9639
4480	Longview-Marshall, TX Gregg, TX Harrison, TX Upshur, TX	0.8629	0.9726	0.9452
4520	Los Angeles-Long Beach, CA Los Angeles, CA	1.2001	1.0400	1.0800
4600	¹ Louisville, KY-IN Clark, IN Floyd, IN Harrison, IN Scott, IN Bullitt, KY Jefferson, KY Oldham, KY	0.9276	0.9855	0.9710
4640	Lubbock, TX Lubbock, TX	0.9646	0.9929	0.9858
4680	Lynchburg, VA Amherst, VA Bedford, VA Bedford City, VA Campbell, VA Lynchburg City, VA	0.9219	0.9844	0.9688
4720	Macon, GA Bibb, GA Houston, GA Jones, GA Peach, GA Twiggs, GA	0.9204	0.9841	0.9682
4800	Madison, WI Dane, WI	1.0467	1.0093	1.0187
4840	Mansfield, OH Crawford, OH Richland, OH	0.8900	0.9780	0.9560
4880	Mayaguez, PR Anasco, PR Cabo Rojo, PR Hormigueros, PR Mayaguez, PR Sabana Grande, PR San German, PR	0.4914	0.8983	0.7966
4890	McAllen-Edinburg-Mission, TX Hidalgo, TX	0.8428	0.9686	0.9371
4900	Medford-Ashland, OR Jackson, OR	1.0498	1.0100	1.0199
4920	Melbourne-Titusville-Palm Bay, FL Brevard, FL	1.0253	1.0051	1.0101
4940	Memphis, TN-AR-MS Crittenden, AR DeSoto, MS Fayette, TN Shelby, TN Tipton, TN	0.8920	0.9784	0.9568
	Merced, CA			

TABLE 1.—PROPOSED 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	1/5 wage index ²	2/5 wage index ³
5000	Merced, CA	0.9742	0.9948	0.9897
	Miami, FL			
	Dade, FL	0.9802	0.9960	0.9921
5015	Middlesex-Somerset-Hunterdon, NJ			
	Hunterdon, NJ			
	Middlesex, NJ			
	Somerset, NJ	1.1213	1.0243	1.0485
5080	Milwaukee-Waukesha, WI			
	Milwaukee, WI			
	Ozaukee, WI			
	Washington, WI			
	Waukesha, WI	0.9893	0.9979	0.9957
5120	Minneapolis-St. Paul, MN-WI			
	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	1.0903	1.0181	1.0361
5140	Missoula, MT	0.9157	0.9831	0.9663
5160	Mobile, AL			
	Baldwin, AL			
	Mobile, AL	0.8108	0.9622	0.9243
5170	Modesto, CA			
	Stanislaus, CA	1.0498	1.0100	1.0199
5190	Monmouth-Ocean, NJ			
	Monmouth, NJ			
	Ocean, NJ	1.0674	1.0135	1.0270
5200	Monroe, LA			
	Ouachita, LA	0.8137	0.9627	0.9255
5240	Montgomery, AL			
	Autauga, AL			
	Elmore, AL			
	Montgomery, AL	0.7734	0.9547	0.9094
5280	Muncie, IN			
	Delaware, IN	0.9284	0.9857	0.9714
5330	Myrtle Beach, SC			
	Horry, SC	0.8976	0.9795	0.9590
5345	Naples, FL			
	Collier, FL	0.9754	0.9951	0.9902
5360	Nashville, TN			
	Cheatham, TN			
	Davidson, TN			
	Dickson, TN			
	Robertson, TN			
	Rutherford, TN			
	Sumner, TN			
	Williamson, TN			
	Wilson, TN	0.9578	0.9916	0.9831
5380	Nassau-Suffolk, NY			
	Nassau, NY			
	Suffolk, NY	1.3357	1.0671	1.1343
5483	New Haven-Bridgeport-Stamford-Waterbury- Danbury, CT			
	Fairfield, CT			
	New Haven, CT	1.2408	1.0482	1.0963
5523	New London-Norwich, CT			
	New London, CT	1.1767	1.0353	1.0707
5560	New Orleans, LA			
	Jefferson, LA			
	Orleans, LA			

TABLE 1.—PROPOSED 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	1/5 wage index ²	2/5 wage index ³
5600	Plaquemines, LA St. Bernard, LA St. Charles, LA St. James, LA St. John The Baptist, LA St. Tammany, LA	0.9046	0.9809	0.9618
5640	New York, NY Bronx, NY Kings, NY New York, NY Putnam, NY Queens, NY Richmond, NY Rockland, NY Westchester, NY	1.4414	1.0883	1.1766
5660	Newark, NJ Essex, NJ Morris, NJ Sussex, NJ Union, NJ Warren, NJ	1.1381	1.0276	1.0552
5720	Newburgh, NY-PA Orange, NY Pike, PA	1.1387	1.0277	1.0555
5775	Norfolk-Virginia Beach-Newport News, VA-NC Currituck, NC Chesapeake City, VA Gloucester, VA Hampton City, VA Isle of Wight, VA James City, VA Mathews, VA 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	0.8574	0.9715	0.9430
5790	Oakland, CA Alameda, CA Contra Costa, CA	1.5072	1.1014	1.2029
5800	Ocala, FL Marion, FL	0.9402	0.9880	0.9761
5880	Odessa-Midland, TX Ector, TX Midland, TX	0.9397	0.9879	0.9759
5910	Oklahoma City, OK Canadian, OK Cleveland, OK Logan, OK McClain, OK Oklahoma, OK Pottawatomie, OK	0.8900	0.9780	0.9560
5920	Olympia, WA Thurston, WA	1.0960	1.0192	1.0384
5945	Omaha, NE-IA Pottawattamie, IA Cass, NE Douglas, NE Sarpy, NE Washington, NE	0.9978	0.9996	0.9991
5960	Orange County, CA Orange, CA	1.1474	1.0295	1.0590
	Orlando, FL Lake, FL Orange, FL Osceola, FL			

TABLE 1.—PROPOSED 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	1/5 wage index ²	2/5 wage index ³
5990	Seminole, FL	0.9640	0.9928	0.9856
	Owensboro, KY			
	Daviess, KY	0.8344	0.9669	0.9338
6015	Panama City, FL			
	Bay, FL	0.8865	0.9773	0.9546
6020	Parkersburg-Marietta, WV-OH			
	Washington, OH			
	Wood, WV	0.8127	0.9625	0.9251
6080	Pensacola, FL			
	Escambia, FL			
	Santa Rosa, FL	0.8610	0.9722	0.9444
6120	Peoria-Pekin, IL			
	Peoria, IL			
	Tazewell, IL			
	Woodford, IL	0.8739	0.9748	0.9496
6160	Philadelphia, PA-NJ			
	Burlington, NJ			
	Camden, NJ			
	Gloucester, NJ			
	Salem, NJ			
	Bucks, PA			
	Chester, PA			
	Delaware, PA			
	Montgomery, PA			
	Philadelphia, PA	1.0713	1.0143	1.0285
6200	Phoenix-Mesa, AZ			
	Maricopa, AZ			
	Pinal, AZ	0.9820	0.9964	0.9928
6240	Pine Bluff, AR			
	Jefferson, AR	0.7962	0.9592	0.9185
6280	Pittsburgh, PA			
	Allegheny, PA			
	Beaver, PA			
	Butler, PA			
	Fayette, PA			
	Washington, PA			
	Westmoreland, PA	0.9365	0.9873	0.9746
6323	Pittsfield, MA			
	Berkshire, MA	1.0235	1.0047	1.0094
6340	Pocatello, ID			
	Bannock, ID	0.9372	0.9874	0.9749
6360	Ponce, PR			
	Guayanilla, PR			
	Juana Diaz, PR			
	Penueles, PR			
	Ponce, PR			
	Villalba, PR			
	Yauco, PR	0.5169	0.9034	0.8068
6403	Portland, ME			
	Cumberland, ME			
	Sagadahoc, ME			
	York, ME	0.9794	0.9959	0.9918
6440	Portland-Vancouver, OR-WA			
	Clackamas, OR			
	Columbia, OR			
	Multnomah, OR			
	Washington, OR			
	Yamhill, OR			
	Clark, WA	1.0667	1.0133	1.0267
6483	Providence-Warwick-Pawtucket, RI			
	Bristol, RI			
	Kent, RI			
	Newport, RI			
	Providence, RI			
	Washington, RI	1.0854	1.0171	1.0342
6520	Provo-Orem, UT			
	Utah, UT	0.9984	0.9997	0.9994
6560	Pueblo, CO			
	Pueblo, CO	0.8820	0.9764	0.9528

TABLE 1.—PROPOSED 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	1/5 wage index ²	2/5 wage index ³
6580	Punta Gorda, FL			
6600	Charlotte, FL	0.9218	0.9844	0.9687
6600	Racine, WI			
6640	Racine, WI	0.9334	0.9867	0.9734
6640	Raleigh-Durham-Chapel Hill, NC			
	Chatham, NC			
	Durham, NC			
	Franklin, NC			
	Johnston, NC			
	Orange, NC			
	Wake, NC	0.9990	0.9998	0.9996
6660	Rapid City, SD			
6680	Pennington, SD	0.8846	0.9769	0.9538
6680	Reading, PA			
6690	Berks, PA	0.9295	0.9859	0.9718
6690	Redding, CA			
6720	Shasta, CA	1.1135	1.0227	1.0454
6720	Reno, NV			
6740	Washoe, NV	1.0648	1.0130	1.0259
6740	Richland-Kennewick-Pasco, WA			
	Benton, WA			
	Franklin, WA	1.1491	1.0298	1.0596
6760	Richmond-Petersburg, VA			
	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	0.9477	0.9895	0.9791
6780	Riverside-San Bernardino, CA			
	Riverside, CA			
	San Bernardino, CA	1.1365	1.0273	1.0546
6800	Roanoke, VA			
	Botetourt, VA			
	Roanoke, VA			
	Roanoke City, VA			
	Salem City, VA	0.8614	0.9723	0.9446
6820	Rochester, MN			
6840	Olmsted, MN	1.2139	1.0428	1.0856
6840	Rochester, NY			
	Genesee, NY			
	Livingston, NY			
	Monroe, NY			
	Ontario, NY			
	Orleans, NY			
	Wayne, NY	0.9194	0.9839	0.9678
6880	Rockford, IL			
	Boone, IL			
	Ogle, IL			
	Winnebago, IL	0.9625	0.9925	0.9850
6895	Rocky Mount, NC			
	Edgecombe, NC			
	Nash, NC	0.9228	0.9846	0.9691
6920	Sacramento, CA			
	El Dorado, CA			
	Placer, CA			
	Sacramento, CA	1.1500	1.0300	1.0600
6960	Saginaw-Bay City-Midland, MI			
	Bay, MI			
	Midland, MI			
	Saginaw, MI	0.9650	0.9930	0.9860
6980	St. Cloud, MN			

TABLE 1.—PROPOSED 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	1/5 wage index ²	2/5 wage index ³
7000	Benton, MN Stearns, MN	0.9700	0.9940	0.9880
	St. Joseph, MO			
7040	Andrew, MO Buchanan, MO	0.9544	0.9909	0.9818
	St. Louis, MO—IL			
	Clinton, IL			
	Jersey, IL			
	Madison, IL			
	Monroe, IL			
	St. Clair, IL			
	Franklin, MO			
	Jefferson, MO			
	Lincoln, MO			
	St. Charles, MO			
	St. Louis, MO			
	St. Louis City, MO			
	Warren, MO			
7080	Salem, OR	0.8855	0.9771	0.9542
7120	Marion, OR Polk, OR	1.0500	1.0100	1.0200
	Salinas, CA			
7160	Monterey, CA	1.4623	1.0925	1.1849
7200	Salt Lake City-Ogden, UT Davis, UT Salt Lake, UT Weber, UT	0.9945	0.9989	0.9978
	San Angelo, TX			
	Tom Green, TX			
	San Antonio, TX			
7240	Bexar, TX Comal, TX Guadalupe, TX Wilson, TX	0.8374	0.9675	0.9350
7320	San Diego, CA	0.8753	0.9751	0.9501
7360	San Diego, CA	1.1131	1.0226	1.0452
	San Francisco, CA			
	Marin, CA San Francisco, CA San Mateo, CA			
7400	San Jose, CA	1.4142	1.0828	1.1657
7440	Santa Clara, CA	1.4145	1.0829	1.1658
	San Juan-Bayamon, PR			
	Aguas Buenas, PR			
	Barceloneta, PR			
	Bayamon, PR			
	Canovanas, PR			
	Carolina, PR			
	Catano, PR			
	Ceiba, PR			
	Comerio, PR			
	Corozal, PR			
	Dorado, PR			
	Fajardo, PR			
	Florida, PR			
	Guaynabo, PR			
	Humacao, PR			
	Juncos, PR			
	Los Piedras, PR			
	Loiza, PR			
	Luguillo, PR			
	Manati, PR			
	Morovis, PR			
	Naguabo, PR			
	Naranjito, PR			
	Rio Grande, PR			
	San Juan, PR			
	Toa Alta, PR			
	Toa Baja, PR			

TABLE 1.—PROPOSED 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	1/5 wage index ²	2/5 wage index ³
	Trujillo Alto, PR Vega Alta, PR Vega Baja, PR Yabucoa, PR	0.4741	0.8948	0.7896
7460	San Luis Obispo-Atascadero-Paso Robles, CA San Luis Obispo, CA	1.1271	1.0254	1.0508
7480	Santa Barbara-Santa Maria-Lompoc, CA Santa Barbara, CA	1.0481	1.0096	1.0192
7485	Santa Cruz-Watsonville, CA Santa Cruz, CA	1.3646	1.0729	1.1458
7490	Santa Fe, NM Los Alamos, NM Santa Fe, NM	1.0712	1.0142	1.0285
7500	Santa Rosa, CA Sonoma, CA	1.3046	1.0609	1.1218
7510	Sarasota-Bradenton, FL Manatee, FL Sarasota, FL	0.9425	0.9885	0.9770
7520	Savannah, GA Bryan, GA Chatham, GA Effingham, GA	0.9376	0.9875	0.9750
7560	Scranton—Wilkes-Barre-Hazleton, PA Columbia, PA Lackawanna, PA Luzerne, PA Wyoming, PA	0.8599	0.9720	0.9440
7600	Seattle-Bellevue-Everett, WA Island, WA King, WA Snohomish, WA	1.1474	1.0295	1.0590
7610	Sharon, PA Mercer, PA	0.7869	0.9574	0.9148
7620	Sheboygan, WI Sheboygan, WI	0.8697	0.9739	0.9479
7640	Sherman-Denison, TX Grayson, TX	0.9255	0.9851	0.9702
7680	Shreveport-Bossier City, LA Bossier, LA Caddo, LA Webster, LA	0.8987	0.9797	0.9595
7720	Sioux City, IA—NE Woodbury, IA Dakota, NE	0.9046	0.9809	0.9618
7760	Sioux Falls, SD Lincoln, SD Minnehaha, SD	0.9257	0.9851	0.9703
7800	South Bend, IN St. Joseph, IN	0.9802	0.9960	0.9921
7840	Spokane, WA Spokane, WA	1.0852	1.0170	1.0341
7880	Springfield, IL Menard, IL Sangamon, IL	0.8659	0.9732	0.9464
7920	Springfield, MO Christian, MO Greene, MO Webster, MO	0.8424	0.9685	0.9370
8003	Springfield, MA Hampden, MA Hampshire, MA	1.0927	1.0185	1.0371
8050	State College, PA Centre, PA	0.8941	0.9788	0.9576
8080	Steubenville-Weirton, OH—WV (WV Hospitals) Jefferson, OH Brooke, WV Hancock, WV	0.8804	0.9761	0.9522
8120	Stockton-Lodi, CA San Joaquin, CA	1.0506	1.0101	1.0202

TABLE 1.—PROPOSED 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	1/5 wage index ²	2/5 wage index ³
8140	Sumter, SC			
	Sumter, SC	0.8273	0.9655	0.9309
8160	Syracuse, NY			
	Cayuga, NY			
	Madison, NY			
	Onondaga, NY			
	Oswego, NY	0.9714	0.9943	0.9886
8200	Tacoma, WA			
	Pierce, WA	1.0940	1.0188	1.0376
8240	Tallahassee, FL			
	Gadsden, FL			
	Leon, FL	0.8504	0.9701	0.9402
8280	Tampa-St. Petersburg-Clearwater, FL			
	Hernando, FL			
	Hillsborough, FL			
	Pasco, FL			
	Pinellas, FL	0.9065	0.9813	0.9626
8320	Terre Haute, IN			
	Clay, IN			
	Vermillion, IN			
	Vigo, IN	0.8599	0.9720	0.9440
8360	Texarkana, AR-Texarkana, TX			
	Miller, AR			
	Bowie, TX	0.8088	0.9618	0.9235
8400	Toledo, OH			
	Fulton, OH			
	Lucas, OH			
	Wood, OH	0.9810	0.9962	0.9924
8440	Topeka, KS			
	Shawnee, KS	0.9199	0.9840	0.9680
8480	Trenton, NJ			
	Mercer, NJ	1.0432	1.0086	1.0173
8520	Tucson, AZ			
	Pima, AZ	0.8911	0.9782	0.9564
8560	Tulsa, OK			
	Creek, OK			
	Osage, OK			
	Rogers, OK			
	Tulsa, OK			
	Wagoner, OK	0.8332	0.9666	0.9333
8600	Tuscaloosa, AL			
	Tuscaloosa, AL	0.8130	0.9626	0.9252
8640	Tyler, TX			
	Smith, TX	0.9521	0.9904	0.9808
8680	Utica-Rome, NY			
	Herkimer, NY			
	Oneida, NY	0.8465	0.9693	0.9386
8720	Vallejo-Fairfield-Napa, CA			
	Napa, CA			
	Solano, CA	1.3354	1.0671	1.1342
8735	Ventura, CA			
	Ventura, CA	1.1096	1.0219	1.0438
8750	Victoria, TX			
	Victoria, TX	0.8756	0.9751	0.9502
8760	Vineland-Millville-Bridgeton, NJ			
	Cumberland, NJ	1.0031	1.0006	1.0012
8780	Visalia-Tulare-Porterville, CA			
	Tulare, CA	0.9418	0.9884	0.9767
8800	Waco, TX			
	McLennan, TX	0.8073	0.9615	0.9229
8840	Washington, DC—MD—VA—WV			
	District of Columbia, DC			
	Calvert, MD			
	Charles, MD			
	Frederick, MD			
	Montgomery, MD			
	Prince Georges, MD			
	Alexandria City, VA			
	Arlington, VA			

TABLE 1.—PROPOSED 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	1/5 wage index ²	2/5 wage index ³
	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	1.0851	1.0170	1.0340
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 1/5 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 proposed 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 2/5 of the wage index value is computed as $((2 \cdot 1.1044) + 3)/5 = 1.0418$. For further details on the 5-year phase-in of the wage index, see section VI.C.1. of this proposed rule.

TABLE 2.—PROPOSED 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	1/5 wage index ²	2/5 wage index ³
Alabama	0.7660	0.9532	0.9064
Alaska	1.2293	1.0459	1.0917
Arizona	0.8493	0.9699	0.9397
Arkansas	0.7666	0.9533	0.9066
California	0.9899	0.9980	0.9960
Colorado	0.9015	0.9803	0.9606
Connecticut	1.2394	1.0479	1.0958
Delaware	0.9128	0.9826	0.9651
Florida	0.8827	0.9765	0.9531
Georgia	0.8230	0.9646	0.9292
Hawaii	1.0255	1.0051	1.0102
Idaho	0.8747	0.9749	0.9499
Illinois	0.8204	0.9641	0.9282
Indiana	0.8755	0.9751	0.9502
Iowa	0.8315	0.9663	0.9326
Kansas	0.7900	0.9580	0.9160
Kentucky	0.8079	0.9616	0.9232
Louisiana	0.7580	0.9516	0.9032
Maine	0.8874	0.9775	0.9550
Maryland	0.8946	0.9789	0.9578
Massachusetts	1.1288	1.0258	1.0515
Michigan	0.9009	0.9802	0.9604
Minnesota	0.9151	0.9830	0.9660
Mississippi	0.7680	0.9536	0.9072
Missouri	0.7881	0.9576	0.9152
Montana	0.8481	0.9696	0.9392
Nebraska	0.8204	0.9641	0.9282
Nevada	0.9577	0.9915	0.9831
New Hampshire	0.9839	0.9968	0.9936
New Jersey ⁴ .....	.....	.....	.....
New Mexico	0.8872	0.9774	0.9549
New York	0.8542	0.9708	0.9417
North Carolina	0.8669	0.9734	0.9468
North Dakota	0.7788	0.9558	0.9115
Ohio	0.8613	0.9723	0.9445
Oklahoma	0.7590	0.9518	0.9036
Oregon	1.0259	1.0052	1.0104
Pennsylvania	0.8462	0.9692	0.9385
Puerto Rico	0.4356	0.8871	0.7742
Rhode Island ⁴ .....	.....	.....	.....
South Carolina	0.8607	0.9721	0.9443
South Dakota	0.7815	0.9563	0.9126
Tennessee	0.7877	0.9575	0.9151
Texas	0.7821	0.9564	0.9128
Utah	0.9312	0.9862	0.9725
Vermont	0.9345	0.9869	0.9738
Virginia	0.8504	0.9701	0.9402
Washington	1.0179	1.0036	1.0072
West Virginia	0.7975	0.9595	0.9190
Wisconsin	0.9162	0.9832	0.9665
Wyoming	0.9007	0.9801	0.9603

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 1/5 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 proposed 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 2/5 of the wage index value is computed as $((2 \cdot 0.8204) + 3)/5 = 0.9282$. For further details on the 5-year phase-in of the wage index, see section VI.C.1. of this proposed rule.

⁴ All counties within the State are classified as urban.

TABLE 3.—PROPOSED 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 % average 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 CC4	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
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 OCCULSION 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

TABLE 3.—PROPOSED 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 % average length of stay
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
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

TABLE 3.—PROPOSED 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	Geometric mean length of stay	Short-stays of 5/6 average length of stay
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
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	HEPATOBIILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY ³	0.8284	23.3	19.4

TABLE 3.—PROPOSED 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	Geometric mean length of stay	Short-stays of 5/6 average length of stay
200	HEPATOBIILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY ⁴	1.2493	31.3	26.0
201	OTHER HEPATOBIILIARY 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 HEPATOBIILIARY 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
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 & BURISITIS	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

TABLE 3.—PROPOSED 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	Geometric mean length of stay	Short-stays of 5/6 average length of stay
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
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	19.4
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

TABLE 3.—PROPOSED 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	Geometric mean length of stay	Short-stays of 5/6 average length of stay
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
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 IMMATUREITY*	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

TABLE 3.—PROPOSED 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	Geometric mean length of stay	Short-stays of % average length of stay
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
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

TABLE 3.—PROPOSED 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 5/6 average length of stay
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	54.6	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
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).